The CQUIN Learning Network

Second Annual Meeting Report

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Empowering Health for 15 years ICAP
Columbia University Mailman School of Public Health

HIV LEARNING NETWORK
The CQUIN Project for Differentiated Service Delivery

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Resumo Executivo

Contexto

Em Março de 2017 o ICAP, da Universidade de Columbia, lançou a Rede de Cobertura, Qualidade e Impacto de e sobre o HIV, ou CQUIN, para promover a difusão da prestação de serviços diferenciados (PSD) dera o HIV na África subsariana, com apoio da Fundação Bill and Melinda Gates. A primeira reunião anual da CQUIN teve lugar em Maputo, Moçambique, em Fevereiro de 2018. Reconhecendo que o mês de Novembro era uma data mais propícia para reunir todos os intervenientes, a CQUIN realizou a sua segunda reunião anual para 4 – 7 de Novembro de 2018 em Adis Abeba, Etiópia. O workshop incluiu os onze países membros da rede (Costa do Marfim, Essuatíni, Etiópia, Quénia, Malawi, Moçambique, África do Sul, Tanzânia, Uganda, Zâmbia e Zimbabwe), bem como outros intervenientes globais e regionais.

A segunda reunião anual da CQUIN constitui o sexto workshop multinacional realizado pela rede desde o seu lançamento. A CQUIN realizou também três reuniões satélites em conferências internacionais, apoiou seis visitas sul-sul para oito países, convocou quatro comunidades virtuais de prática, as quais incidiram sobre a monitorização e avaliação de serviços diferenciados, a identificação sistemática de doentes com alto risco de progressão de doença de HIV, a PSD para adolescentes e coordenadores da PSD, e lançou quatro projectos de investigação catalisadores para colmatar as lacunas nos conhecimentos relacionados com o envolvimento masculino nos grupos de reabastecimento de TAR comunitário no Zimbabwe, as preferências dos adolescentes relativamente à PSD no Quénia, modelos de PSD para o HIV e hipertensão em Essuatíni e reacções dos doentes e prestadores de serviços aos intervalos entre consultas na Etiópia. Além disso, a CQUIN endossou coordenadores nacionais da PSD em ministérios da saúde, apoiou reuniões nacionais de revisão da PSD, viabilizou assistência técnica focalizada e lançou um website, uma série de webinários, um boletim electrónico e um clube de jornais. A CQUIN introduziu ainda o Painel da PSD, uma ferramenta de autoavaliação que ajuda os ministérios da saúde e seus parceiros a descrever a fase de difusão da PSD nos seus respectivos países, e a priorizar as lacunas e desafios.

A segunda reunião anual permitiu que os países membros da CQUIN efectuassem uma revisão do seu progresso em direcção à difusão da PSD, partilhassem as melhores práticas e desafios, estabelecessem as suas prioridades e planos para 2019, bem como novas metas para a cobertura da PSD, e descrevessem a sua combinação ideal de modelos de PSD.

Datas e Objectivos das Reuniões

O Ministério Federal da Saúde da Etiópia realizou a segunda reunião anual da CQUIN no Hilton Hotel em Adis Abeba, a 4 – 7 de Novembro de 2018. Os objectivos da reunião foram os seguintes:

- Rever o progresso dos países membros em termos da difusão da PSD aos beneficiários de cuidados em estado "estável"
- Facilitassem o intercâmbio de conhecimento, melhores práticas, inovações, recursos e estratégias para a difusão de diferentes modelos de tratamento da PSD (MPSD)
- Discutir estratégias diferenciadas para as análises, bem como as melhores práticas, inovações e recursos para alcançar os "primeiros 90"
- Identificar lacunas, desafios e oportunidades comuns para o futuro aprendizado conjunto, para a cocriação de ferramentas e recursos e para futuras visitas de intercâmbio sul-sul

Participantes da Reunião

A reunião contou com representantes dos onze países membros da rede: Costa do Marfim, Essuatíni, Etiópia, Quénia, Malawi, Moçambique, África do Sul, Tanzânia, Uganda, Zâmbia e Zimbabwe. As equipas nacionais incluíram representantes dos ministérios da saúde (MdS), de agências e parceiros de implementação do Plano de Emergência do Presidente dos EUA para Alívio do SIDA (PEPFAR) e da sociedade civil. Além disso, o grupo de intervenientes globais e regionais incluiu representantes do ICAP, Universidade de Columbia, da Fundação Bill & Melinda Gates, dos Centros de Controlo e Prevenção de Doenças dos EUA (CDC), da Organização Mundial da Saúde (OMS), do Programa Conjunto da Organização das Nações Unidas para combate ao HIV e SIDA (ONUSIDA), do Fundo Global para o SIDA, tuberculose e malária (GF), dos CDC África, dos Médecins Sans Frontières (MSF), da Sociedade Internacional contra o SIDA (IAS), da Aliança Internacional de Preparação para Tratamento (ITPC), da Universidade de Boston e outros. O Apêndice contém uma lista completa dos participantes.

Temas Principais

A reunião incluiu 13 sessões, nomeadamente sessões plenárias e apresentações em painéis, discussões moderadas, sessões em subgrupos, um "laboratório de ferramentas" e revisões de cartazes. Os temas principais incluíram o progresso em direcção à difusão de modelos de PSD para beneficiários estáveis de cuidados, desafios e inovações para a MeA de programas de PSD, debates sobre a combinação ideal de modelos de PSD e uma exploração de serviços diferenciados de testes.

A reunião anual salientou o progresso alcançado pelos países da rede em relação à difusão da PSD para doentes adultos estáveis, bem como os desafios enfrentados por cada país. Cada país descreveu sistematicamente, com a ajuda do painel CQUIN, a maturidade dos seus programas nacionais de PSD, e apresentou o seu progresso em cartazes nacionais (consultar o Apêndice). Segue-se abaixo uma lista das principais lições extraídas:

- Quase todos os países fizeram um progresso considerável em direcção ao desenvolvimento de políticas de apoio à PSD e de planos, directrizes e materiais de formação para a difusão dos serviços. Muitos dos países aumentaram também a coordenação dos serviços de PSD, por meio de coordenadores nacionais da PSD e de grupos técnicos de trabalho.
- Todos os países progrediram em termos da difusão da PSD para beneficiários adultos estáveis de cuidados, tendo aumentado a cobertura a nível individual e de estabelecimento. Alguns países estão também a trabalhar no sentido de difundir modelos de PSD para adolescentes, populações-chave, populações migrantes e móveis, homens e outros grupos, porém a maioria destes modelos encontra-se na fase piloto.
- Muitos países desenvolveram protocolos operacionais padronizados, auxílios de trabalho e ferramentas de monitorização e avaliação (MeA), embora a MeA completa da PSD continue a constituir um desafio na maioria dos países da CQUIN.
- As equipas nacionais consideram que fizeram um progresso considerável no sentido de incluir as pessoas a viver com HIV na implementação da PSD; os membros da sociedade civil e representantes de organizações nacionais de pessoas a viver com HIV acharam que é necessário conseguir mais progresso neste sector.
- Quase todos os países consideram que os domínios da qualidade e impacto continuam a precisar de mais desenvolvimento. Muito poucos países desenvolveram normas de qualidade para os serviços de PSD, e não se difundiu ainda a utilização de uma metodologia de melhoramento da qualidade para aumentar os serviços de PSD. Nenhum país avaliou ainda os resultados ou impacto da difusão da PSD, embora a maioria considere isso uma prioridade.

Outro tema importante foi a importância de envolver os beneficiários de cuidados e a sociedade civil no design, implementação e avaliação de modelos de PSD. A CQUIN organizou uma pré-reunião de representantes de redes nacionais de pessoas a viver com HIV, bem como várias apresentações e painéis. Teve lugar uma discussão moderada, muito dinâmica, sobre o tema, a qual sublinhou ser necessário que os beneficiários de cuidados tivessem voz, e não apenas um "lugar na mesa".

As discussões em painéis exploraram diferentes abordagens à MeA da PSD, uma prioridade contínua da CQUIN. Embora muitos países continuem a trabalhar no sentido de desenvolver sistemas nacionais de MeE, utilizando para tal dados de registos médicos em formato electrónico ou em papel, na maioria dos países da CQUIN estes registos não se encontram ainda na internet. Entretanto, vários países têm-se esforçado por recolher dados numa base *ad hoc*, por exemplo em reuniões de revisão a nível nacional ou provincial, a fim de adquirirem mais conhecimentos sobre a difusão da PSD. Os Ministérios da Saúde do Quénia, Essuatíni e Zimbabwe comunicaram-nos as suas experiências com reuniões de revisão da PSD, as quais prestam apoio aos estabelecimentos de saúde para a realização de recolhas de dados suplementares para avaliação da cobertura de PSD. Estes três países consideram que esta é uma forma útil de obter um "instantâneo" da percentagem de estabelecimentos de saúde que viabilizam a PSD e dos números de beneficiários de cuidados de diferentes modelos de PSD. Os Ministérios da Saúde da Etiópia, Uganda e Zâmbia comunicaram as suas experiências de avaliação da PSD, utilizando para tal dados de rotina de MeA, e as apresentações dos Ministérios da Tanzânia, Costa do Marfim, Malawi e Moçambique contribuíram também para a discussão sobre como acompanhar melhor a difusão e propagação de modelos de PSD.

As sessões em grupos deram-nos oportunidade para "mergulhar mais a fundo" nas questões de monitorização e avaliação. As equipas nacionais proporcionaram feedback sobre uma versão subnacional do painel da CQUIN, o que tinha sido requisitado em reuniões prévias da CQUIN. As equipas nacionais descreveram também as suas combinações actuais de modelos de PSD para beneficiários adultos estáveis de cuidados, bem como o estabelecimento de metas de "combinações modelo" para 2019. Por exemplo, o Zimbabwe pretende aumentar a proporção de adultos a fazer TAR que se encontram registados em PSD, de 35% em Fevereiro de 2018, para 80% em Dezembro de 2019, bem como aumentar a proporção de indivíduos na PSD, que se encontram inseridos no modelo acelerado, de 20% para 50%.

Dois dos painéis exploraram a questão de testes diferenciados, salientando a importância dos "primeiros 90" para o controlo epidémico e a necessidade de conceber diferentes abordagens aos testes para diferentes populações. As apresentações utilizam uma estrutura de decisões sobre testes diferenciados que foi desenvolvida pela International AIDS Society (IAS – Sociedade Internacional do SIDA) para descrever ideias inovadoras para contactar homens, no Quénia, através de testes para múltiplas doenças, testes inovadores de base comunitária na Tanzânia, intervenções para aumentar a conexão entre os testes e o tratamento no Malawi e Tanzânia, e experiências iniciais com autotestes na Zâmbia.

A reunião anual salientou também as actividades da rede CQUIN que foram concebidas para aumentar o aprendizado, o intercâmbio das melhores práticas e o trabalho em conjunto a nível sul-sul. Os coordenadores da PSD do Uganda, Malawi, Essuatíni e Moçambique comunicaram as experiências e lições aprendidas pelos seus países em visitas sul-sul a outros países da rede. Muitas destas visitas resultaram em modificações de políticas, adopções de novos modelos de PSD e alterações de modelos existentes. Criou-se um "laboratório de ferramentas" que permitirá que os países e organizações comuniquem activamente as suas ferramentas de PSD. Nove equipas apresentaram uma gama diversificada de ferramentas, incluindo auxílios de trabalho, registos, manuais, vídeos e outras.

Problemas e Desafios Comuns e Intersectoriais

- Têm-se estado a propagar modelos de PSD para doentes estáveis, mas nenhum país conseguiu ainda alcançar uma cobertura total. O financiamento da coordenação e implementação especificamente para a PSD continua a ser limitado, o que impede a implementação de actividades e planos priorizados. Os países foram encorajados a advogar a obtenção de fundos do Fundo Global e do PEPFAR para apoiar as suas actividades.
- Os países têm adoptado abordagens muito diferentes à combinação de modelos de PSD oferecidos aos doentes estáveis, e alguns concentram-se num único modelo, ao passo que outros encorajam a propagação de cinco ou seis modelos. Nenhum país tinha dados sólidos sobre a combinação actual de modelos (p. ex., a percentagem de beneficiários de cuidados em cada modelo) e a reunião deu às equipas a oportunidade de reflectirem sobre os seus modelos actuais e identificarem uma "combinação ideal de modelos" para 2019.
- Os países da rede têm feito um progresso considerável no sentido de envolver os beneficiários de cuidados e a sociedade civil. Porém, os participantes, incluindo os representantes da sociedade civil presentes na reunião, consideraram que é preciso trabalhar mais no sentido de aumentar um envolvimento genuíno por parte da sociedade civil. Em reacção a isto, a CQUIN vai lançar, em 2019, uma nova Comunidade de Prática para Beneficiários de Cuidados.
- À medida que os países vão difundindo a PSD, vai-se verificando mais interesse nos dados para a tomada de decisões. A maioria dos países tem um número limitado de dados sobre a cobertura, e muito poucos ou nenhuns dados sobre a qualidade, resultados e impacto da PSD. É necessário trabalhar continuamente no sentido de aumentar os sistemas nacionais de MeA, bem como adoptar abordagens mais "ágeis", tais como a recolha *ad hoc* de dados constatada nas reuniões de revisão da PSD. A Comunidade de Prática da MeA da CQUIN vai ter continuidade em 2019, o mesmo se verificando com a assistência técnica viabilizada pela CQUIN aos países individuais que a requisitarem.
- Quase todos os países acharam que o Painel Subnacional da PSD vai ser uma ferramenta útil, e vários países tencionam pilotar a ferramenta no próximo ano.
- Os testes e aconselhamento de HIV continuam a constituir o maior gargalo em termos de se alcançar o controlo epidémico. São necessárias mais inovações e estratégias para testes, para se conseguir chegar ao último quilómetro dos primeiros 90. Até mesmo os países que já alcançaram os primeiros 90 deixaram ficar para trás algumas populações-chave e prioritárias.
- Verificaram-se inconsistências entre os países no que se refere à nomenclatura utilizada para os modelos de PSD. A definição daquilo que constitui a PSD, ou se a abordagem à prestação de determinados serviços constitui ou não um modelo de PSD, varia de país para país. Em 2019, a CQUIN vai trabalhar no sentido de desenvolver uma abordagem mais normalizada à descrição de modelos de PSD.

Resultados-chave

- Todos os países submeteram um painel e um cartaz de PSD actualizados, documentando o seu progresso na propagação da PSD.
- Todos os países membros da CQUIN desenvolveram uma descrição preliminar da sua "combinação modelo" de PSD, bem como metas para 2019.
- Os países submeteram actividades prioritárias para 2019 e uma lista de actividades que vão recomendar ao PEPFAR e ao Fundo Global.

- Todos os países submeteram sugestões sobre as visitas sul-sul para intercâmbio da aprendizagem, em linha com as suas prioridades de difusão para 2019.

Etapas Seguintes

- Comunicar aos participantes o relatório sobre a reunião e as apresentações da mesma
- Refinar a nomenclatura da PSD utilizada pela CQUIN, para ajudar a harmonizar as definições e interpretação dos diferentes modelos de PSD nos países da rede
- Finalizar o Painel Subnacional e comunicá-lo aos países da rede
- Estabelecer uma comunidade de prática para os representantes das redes nacionais de PVHIV, para ajudar a melhorar o envolvimento comunitário na PSD
- Estabelecer uma comunidade de prática sobre a qualidade relacionada com a PSD e o melhoramento da qualidade, e planear um workshop sobre este tópico para 2019
- Acompanhar os países nas suas actividades prioritárias de PSD e apoiar a advocacia para financiamento destas actividades por meio do COP 19 e do Fundo Global

Introdução

Contexto

A Rede de Cobertura, Qualidade e Impacto de e sobre o HIV (CQUIN) foi lançada em Março de 2017 para promover a difusão da prestação de serviços diferenciados de HIV (PSD) na África subsariana. Implementada em escala e com fidelidade, a PSD oferece-nos a promessa de cobrir melhor as necessidades e expectativas dos beneficiários de cuidados, ao mesmo tempo que aumenta os resultados de saúde e as eficácias dos sistemas de saúde. A rápida difusão de programas de PSD de boa qualidade é uma abordagem prometedora ao constante desafio para controlo epidémico do HIV e à necessidade de acelerar a nossa resposta ao HIV, de forma a cumprir os objectivos 90-90-90 da ONUSIDA para o ano 2020

A Rede de Aprendizado CQUIN foi concebida para acelerar a expansão de modelos eficazes de PSD, através do apoio prestado ao aprendizado sul-sul, à difusão de inovação, à cocriação de ferramentas e conhecimentos práticos, a níveis focalizados de assistência técnica e a projectos de investigação catalíticos. Nos seus primeiros 18 meses, 11 countries[1] aderiram à Rede CQUIN, a qual organizou cinco workshops multinacionais em grande escala e três reuniões-satélite em conferências internacionais, tendo também prestado apoio a seis visitas sul-sul a oito países, convocado quatro comunidades virtuais de prática e lançado quatro projectos catalíticos de investigação. A CQUIN endossou também coordenadores nacionais de PSD em ministérios da saúde seleccionados, apoiou reuniões nacionais de revisão da PSD, viabilizou assistência técnica focalizada e lançou um website, uma série de webinários, um boletim electrónico e um clube de jornais.

A CQUIN realizou a sua primeira reunião anual em Março de 2017. Os países da rede serviram-se do Painel da CQUIN para efectuar um processo sistemático de autotestes, identificando os seus pontos fortes e as melhores práticas a comunicar aos restantes países, e ainda os sectores em que era necessário progredir no ano seguinte. Teve lugar uma troca dinâmica de lições aprendidas, que alimentou planos para subsequentes intercâmbios sul-sul, assistência técnica e advocacia de políticas. Todas as subsequentes reuniões foram transferidas para o mês de Novembro, num melhor alinhamento do ciclo de projectos da CQUIN e dos ciclos de financiamento de outros intervenientes importantes.

A segunda reunião anual da CQUIN foi concebida para desenvolver workshops anteriores, viabilizando aos países da rede a oportunidade de reverem o seu progresso em direcção à propagação da PSD, intercambiarem as melhores práticas e lições aprendidas, identificarem desafios comuns e determinarem prioridades para o ano seguinte.

Objectivos

- Rever o progresso dos países membros em direcção à propagação da PSD para doentes "estáveis"
- Facilitar o intercâmbio de conhecimento, melhores práticas, inovações, recursos e estratégias para a difusão de diversos modelos de tratamento da PSD (MPSD)
- Discutir estratégias diferenciadas de testes, melhores práticas, inovações e recursos, a fim de alcançar os primeiros 90

[1] Costa do Marfim, Essuatíni, Etiópia, Quénia, Malawi, Moçambique, Uganda, África do Sul, Tanzânia, Zâmbia, Zimbabwe

- Identificar lacunas, desafios e oportunidades comuns para um futuro aprendizado conjunto, para a cocriação de ferramentas e recursos e para futuras visitas de intercâmbio sul-sul

Meeting Agenda

Sunday 4 November: Opening Reception

Dr. Wafaa El-Sadr, Global Director, ICAP at Columbia University
Dr. Miriam Rabkin, Director for Health Systems Strategies, ICAP
Ato Bayisa Chala, Executive Director, NEP+
Dr. Peter Ehrenkranz, Senior Program Officer for HIV Treatment, Bill & Melinda Gates Foundation
Dr. Kebede Worku, State Minister, Federal Ministry of Health

Monday 5 November

Session 1: Setting the Scene
Co-Moderators: Wafaa El-Sadr (ICAP) & Peter Preko (ICAP/CQUIN)

- DSD: The View from Recipients of Care – Solange Baptiste (ITPC)
- DSD: The View from WHO – Nathan Ford (WHO)
- DSD: The View from the Global Fund - Ade Fakoya (GFTAM)
- DSD: The View from PEPFAR – Catherine Godfrey (OGAC), *presented by CQUIN*

Session 2: Panel Presentations | Country Status Reports: Monitoring DSD Scale-Up with DSD Review Meetings
Co-Moderators: Rose Nyirenda (MOH Malawi) & Isaac Zulu (CDC Atlanta)

- Bill Reidy (ICAP NY)
- Nomthandazo Lukhele (MOH Eswatini)
- Tsitsi Apollo (MOH Zimbabwe)
- Lilly Muthoni (MOH Kenya)

Session 3: Panel Presentations | Peer Learning with South-to-South Visits
Co-Moderators: Siphiwe Shongwe (ICAP/CQUIN) & Joseph Kabanda (CDC Uganda)

- Peter Preko (ICAP/CQUIN)
- Josen Kiggundu (MOH Uganda)
- Stanley Ngoma (MOH Malawi)
- Herve Kambale (MOH Eswatini)
- Sonia Chilundo (CDC Mozambique)

Session 4: Breakout #1 | Optimizing National DSD Scale-up Plans
Co-Moderators: Maureen Syowai & Baker Bakashaba (TASO)

Tuesday 6 November

Session 5: Panel Presentations | Country Status Reports: Monitoring DSD Scale Up with Routine M&E
Co-Moderators: Bill Reidy (ICAP NY) & Nicole Buono (CDC Malawi)

- Zerihun Hika (FMOH Ethiopia)
- Hudson Balidawa (MOH Uganda)
- Priscilla Lumano-Mulenga (MOH Zambia)

Session 6: Panel Presentations | Differentiated Testing – Part 1
Co-Moderators: Tanya Shewchuk (Gates Foundation) & Stella Kentutsi (Nafophanu Uganda)

- Reaching the "First 90" – Wafaa El-Sadr (ICAP NY)
- Update from WHO – Nathan Ford (WHO)
- A decision framework for HIV testing services – Anna Grimsrud (IAS)

Session 7: Panel Presentations | Differentiated Testing – Part 2
Co-Moderators: Anna Grimsrud (IAS) & Felix Mwanza (TALC Zambia)

- Reaching men with multi-disease testing – Rukia Aksam (JOORTH Kenya)
- Reaching men with community outreach – Peris Urasa (NACP Tanzania)
- Linkage from testing to prevention – Rose Nyirenda (MOH Malawi)
- Linking from testing to treatment – Neema Makyao (NACP Tanzania)
- Self-testing in Zambia – Izukanji Sikazwe (CIDRZ), Amenan Kouassi (RIP+ Côte d'Ivoire)

Session 8: Breakout #2 | Data for Decision-Making about DSD Scale-Up
Co-Moderators: Caroline Ryan (CDC Eswatini), Natalie Kruse-Levy (USAID Zimbabwe)

Session 8 continued: Breakout #2 | Report Back
Co-Moderators: Caroline Ryan (CDC Eswatini), Natalie Kruse-Levy (USAID Zimbabwe)

Wednesday 7 November

Session 9: Panel Presentations | Country Status Reports
Co-Moderators: Philippe Chiliade (CDC SA) & Greet Vandebriel (ICAP CI)

- Mastidia Rutaihwa (MOH Tanzania)
- Koffi Simplice Bohoussou (MOH Cote d'Ivoire)
- Stanley Ngoma (MOH Malawi)
- Aleny Couto (MOH Mozambique)
- Respondents: Tanya Shewchuk (BMGF) & Sthembile Gombarume (USAID South Africa)

Session 10: Moderated Discussion | Are Recipients of Care Sufficiently Engaged in Scale-up?
Co-Moderators: Tom Ellman (MSF) & Peter Godfrey-Faussett (UNAIDS)

- Solange Baptiste (ITPC)
- Izukanji Sikazwe (CIDRZ)
- Tonderai Mwareka (ZNNP+)
- Alain Somian (RIP+)
- Nelson Otwoma (Kenya National HIV Association)
- Stella Kentutsi (Nafophanu Uganda)

Session 11: Tools Lab / Demonstrations

Session 12: Breakout #3 | Optimizing Scale-Up for DSD
Co-Moderators: Peter Preko & Siphiwe Shongwe

Session 13: Closing Remarks and Way Forward
Dr. Peter Ehrenkranz, Senior Program Officer for HIV Treatment, Bill & Melinda Gates Foundation

Sunday, 4 November

Opening Reception

Setting the stage for the meeting, Dr. Wafaa El-Sadr, ICAP Global Director, reminded the audience that while remarkable progress has been made towards HIV epidemic control, much more remains to be accomplished. Using data from the Population HIV Impact Assessment (PHIA) surveys, she highlighted and debunked important myths about HIV epidemic control, noting that CQUIN champions interventions focused on the actual impediments, while providing collaborative thought leadership in areas vital to achieving national and global goals.

Dr. Miriam Rabkin, CQUIN Principal Investigator and ICAP Director for Health Systems Strategies, gave a brief summary of recent CQUIN activities. Since February 2018, CQUIN supported: three south-to-south visits involving 11 country delegates; DSD review meetings in Kenya and Zimbabwe; a four-country Quality Improvement (QI) for DSD workshop in Malawi (for Eswatini, Malawi, Uganda, and Zimbabwe); updates to the CQUIN Dashboard and SOPs and development of a Sub-National Dashboard; a multi-country workshop in Eswatini on DSD scale-up; and M&E technical assistance visits to Zimbabwe and Zambia, among others.

Dr. Kebede Worku, State Minister, Federal Ministry of Health in Ethiopia

The Executive Director of the Network of Networks of HIV Positives in Ethiopian (NEP+), Mr. Baysia Chala Feyisa, stressed on the importance of true engagement of recipients of care in developing DSD programs. He cautioned that "True success will elude us if we do not make the effort to ensure recipients of care are at the table as respected stakeholders from program conceptualization, through planning, implementation, and evaluation of DSD". He also encouraged his colleagues leading national networks and associations of people living with HIV to be proactive in engaging with policy makers and national programs to ensure they are not left behind, reminding them that true engagement is a two-way affair.

Dr. Peter Ehrenkranz, Senior Program Officer for HIV Treatment at the Bill and Melinda Gates Foundation, encouraged participants to recognize that DSD addresses important concerns for recipients of care and health care workers, and if delivered at national scale within the right context, can deliver measurable benefits to both. He recommended prioritizing the rapid scale-up of evidence-informed DSD models for stable adults, supported by right-sized monitoring and evaluation, regular data reviews, and use of data for QI.

The meeting was officially opened by the State Minister of Ethiopia's Federal Ministry of Health, who expressed the country's appreciation to ICAP and the Gates Foundation for CQUIN's support of scale-up in Ethiopia. According to the State Minister, Ethiopia's engagement with CQUIN has enabled the country to identify additional DSD models which will increase the diversity of ART services available to recipients of care in order to meet their needs and preferences. He emphasized the need to address the issue of HIV-related stigma and discrimination and highlighted the role of DSD in minimizing their impact.

Session 1: Setting the Scene

Moderators

Drs. Wafaa El-Sadr and Peter Preko (ICAP at Columbia)

Presentations and Panelists

- DSD: The View from Recipients of Care – Ms. Solange Baptiste (ITPC)
- DSD: The View from WHO – Dr. Nathan Ford (WHO)
- DSD: The View from the Global Fund – Dr. Ade Fakoya (GFTAM)
- DSD: The View from PEPFAR – Dr. Catherine Godfrey (OGAC)

Summary (View the Presentations)

Ms. Baptiste shared ITPC's global insights on DSD from the perspective of recipients of care, explaining that quality is the most desired trait of health care for people living with HIV. She concluded by sharing the key elements needed to improve DSD scale-up.

Sharing the view of DSD from WHO, Dr. Ford gave an update on the uptake of WHO DSD Guidance, noting the ongoing challenge of service delivery for patients with advanced HIV. Dr. Ford discussed WHO's next steps, including ongoing technical support for countries and 2019 Guideline updates.

Ms. Solange Baptiste, Executive Director, ITPC

Dr. Fakoya discussed the Global Fund's investment in and impact on DSD, noting key observations on progress toward 90-90-90 and recommendations for DSD scale-up. A presentation delivered on behalf of Dr. Godfrey closed the session, presenting the view of DSD from PEPFAR, and highlighting the different models of care in PEPFAR-supported countries and their support of DSD for stable patients and key populations with examples from Nigeria, Rwanda, Vietnam, South Africa, India, and Thailand.

Session 2: Panel Presentations – Country Status Reports: Monitoring DSD Scale-Up with DSD Review Meetings

Moderators

Drs. Rose Nyirenda (MOH Malawi) and Isaac Zulu (CDC Atlanta)

Presentations and Panelists

- Dr. Bill Reidy (ICAP NY)
- Dr. Nomthandazo Lukhele (MOH Eswatini)
- Dr. Tsitsi Apollo (MOHCC Zimbabwe)
- Dr. Lilly Muthoni (MOH Kenya)

Summary (View the Presentations)

Dr. Reidy discussed the status of "differentiated M&E" – e.g., monitoring and evaluation of DSD scale-up – at the global, national, and program levels. He highlighted the potential of targeted periodic data collection in the format of DSD review meetings as a means to bridging gaps and solving challenges related to monitoring DSD.

Dr. Lukhele discussed Eswatini's performance data for DSD coverage, quality, and impact, including 2017 regional results from DSD models in Eswatini.

Dr. Nomthi Lukhele

Dr. Apollo highlighted the institutionalization of DSD approaches and the challenge of change management and task-shifting. She discussed the DSD indicators on uptake, coverage, and outcomes Zimbabwe plans to monitor, and provided an overview of Zimbabwe's M&E plan, which has been supported by CQUIN.

Dr. Muthoni presented an overview of Kenya's implementation of DSD models at 400 health facilities, the availability of ART patient data, as well as DSD data elements collected in Kenya's electronic medical record (EMR) system. She provided an overview of their DSD Review Meeting in August 2018 and best practices.

Session 3: Panel Presentations: Peer Learning with South-to-South Visits

Moderators

Ms. Siphiwe Shongwe (ICAP Eswatini) and Dr. Joseph Kabanda (CDC Uganda)

Presentations and Panelists

- Dr. Peter Preko (ICAP at Columbia)
- Dr. Josen Kiggundu (MOH Uganda)
- Dr. Stanley Ngoma (MOH Malawi)
- Dr. Herve Kambale (MOH Eswatini)
- Dr. Sonia Chilundo (CDC Mozambique)

Summary (View the Presentations)

Dr. Preko opened the session with a presentation on CQUIN's curated approach to south-to-south learning exchange visits – including selection, implementation, evaluation, and follow-up. These are prioritized by their potential impact on visiting country DSD scale-up. He discussed illustrative impacts from the 12 completed visits, lessons learned, and next steps, and reminded participants of the CQUIN poster on the south-to-south visits and their impact (see Appendix).

CQUIN south-to-south visits as of November 2018

Dr. Kiggundu gave an overview of Uganda's experience and lessons learned from a south-to-south visit to Eswatini in June 2018. He and his team gained important insights into early morning refills, data collection, and ART outreach and service delivery.

Drs. Ngoma (Malawi) and Kambale (Eswatini) discussed what their country teams learned during a south-to-south visit to Uganda, also in June 2018. Both teams learned about strategies for client engagement, noting the high rates of client satisfaction, involvement of community leaders and champions, and effective methods for community data collection.

Dr. Chilundo concluded with a recap of Mozambique's visit to Malawi, where her team gained knowledge on DSD implementation for adolescent clubs and community ART dispensing.

Session 4: Breakout Session 1 – Optimizing National DSD Scale-Up Plans

This first breakout session challenged the eleven country teams to reflect on the progress made in DSD scale-up over the past year using results from the October 2018 CQUIN Dashboard self-staging. Following internal discussions, country teams comprised of stakeholders from ministries of health, civil society, recipient of care networks, implementing partners, and donors met with counterparts from other countries with similar staging results. Countries shared lessons learned, discussed challenges towards scale-up, and identified best practices and priorities for the coming year. Following is a list of shared priorities for scale-up:

Cote d'Ivoire, South Africa, and Zimbabwe

Strengthening comprehensive M&E system to collect routine DSD data

Ethiopia and Malawi

Developing quality indicators for DSD services

Eswatini and Tanzania

Improving DSD patient coverage

Kenya and Zambia

Boosting uptake for more than one DSD model

Mozambique and Uganda

Developing an impact evaluation for DSD activities

Session 5: Panel Presentations – Country Status Reports: Monitoring DSD Scale-up with Routine M&E

Moderators

Dr. Bill Reidy (ICAP at Columbia) and Ms. Nicole Buono (CDC Malawi)

Presentations and Panelists

- Dr. Zerihun Hika (FMOH Ethiopia)
- Dr. Hudson Balidawa (MOH Uganda)
- Dr. Priscilla Lumano-Mulenga (MOH Zambia)

Summary (View the Presentations)

Dr. Hika highlighted Ethiopia's improvement in four domains of the CQUIN dashboard (DSD scale-up, community engagement, diversity, and SOPs) compared to February 2018. He stated that 77% of ART facilities have enrolled ≥10% of eligible patients on DSD within their facilities, with 66% of all eligible clients enrolled in DSDM. He concluded by explaining the need for Ethiopia to diversify DSDM and evaluation plans.

Dr. Balidawa discussed Uganda's integration of DSD into their national HMIS tools. Uganda has also developed new tools to capture DSD data for community models, adapted from other tools shared by CQUIN countries. Uganda is currently planning to conduct a community DSD pilot for children and adolescents, and a DSD cost and outcomes study.

Dr. Lumano-Mulenga highlighted Zambia's improvement in five domains (scale-up plan, guidelines, trainings, SOPs, and community engagement) – all outcomes of the establishment of the DSD Task Force. She discussed Zambia's challenges with assessing DSD coverage and impact, noting these measures will be improved in 2019 with the rollout of new M&E tools, developed with support from CQUIN and the CQUIN M&E Community of Practice.

Session 6: Panel Presentations – Differentiated Testing (Part 1)

Moderators

Ms. Tanya Shewchuk (Bill & Melinda Gates Foundation) and Ms. Stella Kentutsi (Nafophanu Uganda)

Presentations and Panelists

- Reaching the First 90 – Dr. Wafaa El-Sadr (ICAP at Columbia)
- Update from WHO – Dr. Nathan Ford (WHO)
- A Decision Framework for HIV Testing Services – Dr. Anna Grimsrud (IAS)

Summary (View the Presentations)

Dr. El-Sadr presented evidence on the "first 90" from PHIA surveys in ten countries, highlighting that HIV testing is the foundation for achieving epidemic control and emphasizing the need to engage key populations, men, and youth. She discussed new methodologies that may enable more focused HIV testing including self-testing, index-based testing, and recency testing, which may allow interventions to prevent transmission.

Dr. Wafaa El-Sadr

Dr. Ford stressed the importance of being strategic in order to reach the greatest number of HIV-positive individuals who don't know their status. He stated the importance of considering and balancing methods to make core testing more efficient and to strategically expand additional testing.

Dr. Grimsrud discussed how DSD applies across the HIV continuum. She presented the IAS Decision Framework for HIV Testing Services and how it highlights the principles of DSD to support a systematic approach to reaching people living with HIV who do not know their status.

Session 7: Panel Presentations – Differentiated Testing (Part 2)

Moderators

Dr. Anna Grimsrud (IAS) and Mr. Felix Mwanza (TALC Zambia)

Presentations and Panelists

- Reaching Men with Multi-Disease Testing – Dr. Rukia Aksam (JOOTRH Kenya)
- Reaching Men with Community Outreach – Ms. Peris Urasa (NACP Tanzania)
- Linkage from Testing to Prevention – Dr. Rose Nyirenda (MOH Malawi)
- Linking from Testing to Treatment – Ms. Neema Makyao (NACP Tanzania)
- HIV Self-Testing in Zambia – Dr. Izukanji Sikazwe (CIDRZ)

Summary (View the Presentations)

Dr. Aksam presented on Jaramogi Oginga Odinga Teaching and Referral Hospital's (JOOTRH) project to increase the uptake of HIV testing services among men in Western Kenya through a multi-disease screening program. Kiosks outside of health facilities were used for drop-in testing for TB, high blood pressure, nutritional status, and HIV – an appealing approach for men. Men comprised a higher proportion of people tested for HIV with this approach than in either the inpatient wards or outpatient clinics. HIV testing yield was 1.4%, similar to that in the outpatient setting.

Ms. Urasa discussed male engagement strategies for HIV testing with the Sauti Project in Tanzania, including physical mapping of male hotspots and workplaces, sexual partner consultations, and community engagement.

Ms. Neema Makyao

Ms. Nyirenda presented a case study from Malawi's designed to increase men's knowledge of HIV status and uptake of Voluntary Medical Male Circumcision (VMMC) services, highlighting that combining HIV self-testing and VMMC increased the uptake of first-time male testers by 68%, compared to 26% for community-based testing.

Ms. Makyao discussed lessons learned regarding community-level HIV testing and ART initiation services from the FIKIA project in Tanzania. FIKIA provides community-based testing and prevention services, as well as same-day community-based ART initiation. She noted that early initiation at the point of diagnosis in the community improves linkage to treatment. Dr Sikazwe concluded the panel with a presentation on Zambia's "Test Yourself Now" Campaign, which targets men, adolescents, and young adults 16-24 years of age, noting improvement in acceptance of HIV self-testing by the community and reduced waiting times at facilities, as well as challenges including a lack of standardized data collection tools.

Session 8: Breakout Session 2 – Data for Decision-Making About DSD Scale-Up

This breakout was designed to spark discussion around alternative sources of data for tracking DSD scale-up in the absence of routine reporting on DSD from existing M&E systems. Countries met individually to talk about challenges and opportunities, then paired up to share and reflect. A major point of discussion for this session was the Sub-National DSD Dashboard, which is designed to provide ministries of health with information on provincial or district progress in DSD scale-up.

Dr. Clorata Gwanzura of Zimbabwe participates in the second breakout session.

Country teams reviewed the draft Dashboard and developed priority recommendations. Following the meeting, the ICAP-CQUIN team will work to incorporate this feedback and develop a final Sub-National DSD Dashboard template which can then be adapted by countries to fit individual contexts and priorities.

Session 9: Panel Presentations – Country Status Reports

Moderators

Drs. Philippe Chiliade (CDC South Africa) and Greet Vandebriel (ICAP Côte d'Ivoire)

Presentations and Panelists

- Dr. Mastidia Rutaihwa (MOH Tanzania)
- Dr. Koffi Simplice Bohoussou (MOH Côte d'Ivoire)
- Dr. Stanley Ngoma (MOH Malawi)
- Dr. Aleny Couto (MOH Mozambique), presented by CQUIN

Summary (View the Presentations)

Tanzania, Cote d'Ivoire, Malawi, and Mozambique showcased the progress of their national DSD scale-up initiatives over the past year, and their plans to implement program monitoring systems and strategies for enhancing national scale-up in 2019.

Session 9 moderators and panelists, left to right: Philippe Chiliade, Greet Vandebriel, Stanley Ngoma, Koffi Bohoussou, and Mastidia Rutaihwa

Dr. Rutaihwa presented Tanzania's current DSD self-assessment, and priorities for further DSD scale-up, including completing national M&E tools, developing electronic databases, and launching the National DSD Implementation Plan which will include patient and facility coverage targets. Dr. Bohoussou cited Côte d'Ivoire's 2018 achievements, including completion of its National Operational Procedures for DSD. Cote d'Ivoire will make development of M&E tools and identification of indicators for program monitoring a priority in 2019.

Mr. N'goma presented Malawi's progress, which included the completion of its National HIV Treatment Guidelines, noting that Malawi is currently drafting a strategy for M&E of DSD. Dr. Peter Preko, the CQUIN Project Director, presented on behalf of Mozambique's National Program, whose scale-up plans for 2019 include expanding facility-based DSD models to reach 30% more patients.

Session 10: Moderated Discussion – Are Recipients of Care Sufficiently Engaged in DSD Scale-up?

Moderators

Drs. Tom Ellman (MSF) and Peter Godfrey-Faussett (UNAIDS)

Presentations and Panelists

- Ms. Solange Baptiste (ITPC)
- Dr. Izukanji Sikazwe (CIDRZ)
- Mr. Tonderai Mwareka (ZNNP+)
- Mr. Alain Somian (RIP+)
- Mr. Nelson Otwoma (Kenya National HIV Association)
- Ms. Stella Kentutsi (Nafophanu Uganda)

Summary (View the Presentations)

This interactive panel included representatives from national associations of people living with HIV, implementing partners, and the International Treatment Preparedness Coalition (ITPC). A show of hands from the meeting audience indicated a consensus that recipients of care were not meaningfully engaged in scale-up efforts – so moderators encouraged panelists to focus the discussion on how to increase demand for DSD on the part of recipients of care.

Ms. Baptiste, ITPC's executive director, suggested that communities should be involved in every stage of DSD scale-up, but most importantly, must be consulted in initial stages of model planning and design. Panelists observed that stigma remains a central issue that varies by country, population, and setting; and that national scale-up campaigns should consider the context in which models are implemented.

Session 10 moderators and panelists, left to right: Peter Godfrey-Faussett, Tom Ellman, Solange Baptiste, Stella Kentutsi, Izukanji Sikazwe, Tonderai Mwareka, Nelson Otwoma, and Alain Somian.

The panel urged policymakers to consider evaluating the quality of current DSD services to inform future implementation. Another common issue cited was a lack of education and communication on DSD models to communities.

Session 11: Tools Lab and Demonstrations

The Tools Lab was an interactive session where nine representatives from ministries of health and organizations presented practical resources that are being used in CQUIN countries to support DSD implementation across the health system. Each representative presented their organizations tools to colleagues in a timed live demonstration. Following are summaries of each presentation:

ICAP Cote d'Ivoire

Tools: Cote d'Ivoire DSD Registry

Presented by Dr. Franck Boraud (pictured right), HIV Clinical Team Leader

Dr. Franck Boraud presents during the tools lab

Tanzania MOH

Tools: Comprehensive Supportive Supervision Tool, Revised National HIV & AIDS Guidelines, Operational Manual, Job Aides for Comprehensive DSD (English and Swahili), Dissemination Package, and the National Implementation Plan

Presented by Dr. Mastidia Rutaiwha, Pediatrics and Adolescent Program Officer, National AIDS Control Program (NACP)

Eswatini MOH

Tools: Community ART Group (CAG)/Treatment Club Registers

Presented by Dr. Herve Kambale, DSD Technical Advisor, Eswatini National AIDS Control Programme (SNAP)

ICAP at Columbia University – MSPH

Tools: ICAP Viral Load Toolkit

Presented by Dr. Ruby Fayorsey, Deputy Director, Clinical and Training Unit

ICAP Kenya

Tools: Utilization of Viral load Test Results: A Quality Improvement Collaborative Change Package

Presented by Ms. Redempta Mutei, Quality Improvement Coordinator

International AIDS Society (IAS)

Decision Framework Series

Presented by Dr. Anna Grimsrud, Lead Technical Advisor, and Dr. Helen Bygrave

International Treatment and Preparedness Coalition (ITPC)

ITPC Activist Toolkit

Presented by Ms. Solange Baptiste, Executive Director

TB/HIV Care South Africa

TB/HIV Care CareView Patient Tracking

Presented by Dr. Laurene Booyens, Care and Treatment Programme Manager

Zimbabwe MoHCC

Tools: Data Collection Tool and SOP for Periodic Monitoring of DSD Implementation

Presented by Dr. Clorata Gwanzura, DSD Medical Officer

Dr. Laurene Booyens (far left), presents to the Uganda team during the Tools Lab.

Session 12: Breakout Session 3 – Optimizing Scale-Up for DSD

During the final breakout, individual country teams convened once more to determine the current distribution of stable adult recipients of care among different models of ART services. Countries used available data to estimate enrollment in each DSD model and the mainstream model of ART, or the standard of care and discussed targets for DSD enrollment scale-up for November 2019. The resulting "model mix" for both the current time period and 2019 targets were rendered as pie charts and presented for discussion in plenary. This activity set off vibrant conversations around determining optimal models for increased enrollment and strategies for demand creation. This breakout session challenged countries to create action plans for the coming year with specific goals and priority activities, such as south-to-south learning visits linked to scale-up.

Closing Remarks and Way Forward

Mr. Jeffrey Walimbwa, program manager at ISHTAR MSM Kenya, began the meeting recap by emphasizing that DSD was not only a game-changer, but an opportunity to actively engage community organizations and populations that are considered hard-to-reach.

Dr. Cordelia Katureebe Mboijana, National Coordinator for HIV Care and Treatment at the Uganda MOH reflected that it is essential to ensure that quality is maintained as DSD services are taken to scale, and that DSD activities are aligned with the preferences of the diverse groups that the Ministry of Health aims to serve. She noted that it is critical to obtain data and to develop M&E systems. She also stated that it is equally important to interpret that data and to present it in forms that everyone, including recipients of care, can access and use. She urged the CQUIN community to continue to think about the best way to invest, involve, and integrate recipients of care, and to define what optimal engagement really looks like.

Dr. Peter Ehrenkranz, Senior Program Officer for HIV Treatment at the Bill & Melinda Gates Foundation, thanked the Ethiopian MOH, USG partners, civil society, and the many international partners who were actively engaged in the meeting. He encouraged participants to complete the innovations, discussions, and action plans that were discussed, and to put them into action by seeking funding from Global Fund and PEPFAR. He also highlighted the importance of clearly identifying targets including, but not limited to, DSD coverage, including frequency of clinical and lab visits, retention, viral suppression, and engagement of recipients of care.

Ms. Mirtie Getachew, HIV Team Lead at FMOH Ethiopia, concluded by thanking ICAP and CQUIN leadership, the Bill & Melinda Gates Foundation, MOH representatives from CQUIN Network countries, UNAIDS, Global Fund, PEPFAR, CDC, USAID, IAS, and all other participating organizations present. She stated that, through CQUIN, the MOH now has partnerships to build a better health care system for the people of Ethiopia.

Participants

Not Pictured

Mekonnen Alemu is the newly appointment Executive Director of NEP+ Ethiopia.

Not Pictured

Solomon Ahmed is a Care and Treatment Specialist at CDC Ethiopia.

Irma Pascale Ahoba is the Deputy Coordinator, Care and Treatment for the Programme National Le Sida (PNLS) in Cote D'Ivoire.

Rukia Aksam is a medical doctor in charge of Jaramogi Oginga Odinga Teaching and Referral Hospital (JOOTRH) comprehensive Center in Kisumu, Kenya. She has been working as a Medical Officer for five years and is currently implementation of differentiated care models using a quality improvement approach.

David Allen is Deputy Director, HIV Southern Africa for the Bill & Melinda Gates Foundation. Dr. Allen received his MD from the New York University School of Medicine and his MPH degree from the Johns Hopkins School of Public Health. He worked as a pediatrician in Washington D.C. before joining the Centers for Disease Control and Prevention (CDC) for a twenty-year career. At CDC, Dr. Allen worked in a variety of public health areas including infant mortality, homeless health, community health, epidemiology training and HIV/AIDS. He served as an advisor to the South African Department of Health, and as Director of the CDC Global AIDS Program for South Africa, the Regional Director of the Global AIDS Program for Southern Africa, and the Director of the Global AIDS Program, Caribbean Regional Office before moving to the Bill & Melinda Gates Foundation in 2006.

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Worknesh Amdino is the Monitoring and Evaluation Department Director at ICAP Ethiopia.

Tsitsi Apollo is Deputy Director for HIV/AIDS and STIs at the Zimbabwe Ministry of Health and Child Care. She is a medical doctor and public health specialist who has been practicing in Zimbabwe's public health system for over 18 years. Dr. Apollo is an active member of the Zimbabwe National Medicines Therapeutics Advisory and Policy Committee and participated in the 2013 and 2015 World Health Organization Guidelines Development Group for Consolidated ARV Guidelines. She plays an Advisory role to the WHO Director General as a member of the Strategic and Technical Advisory Committee for HIV/AIDS and Hepatitis. Dr. Apollo is also a member of the CQUIN Advisory Group.

Tsegaye Argaw is the Director for Regional Program Support and In-Service Training at ICAP Ethiopia. Mr. Tsegaye has led strategic planning and expansion of HIV/AIDS programs and other and health system strengthening interventions in Ethiopia and South Sudan. He has keen interests in community involvement, monitoring & evaluation, and stakeholder partnerships. Mr. Tsegaye has co-authored papers and lectures in public health at Jimma University.

Tamrat Assefa is the Director for Regional Programs at ICAP Ethiopia. He has over 20 years of experience in public health, specializing in health systems strengthening, HIV, and quality improvement. Mr. Assefa received his MPH in health system management and policy from Prince Leopold Institute of Tropical Medicine in Belgium, an MPH from Addis Ababa University and a BSc in Nursing from Jimma University. He is also a fellow of the visionary leadership program funded by the Packard Foundation, a fellow of the Management Development Institute at UCLA, and a member of the Ethiopia Reproductive Health Leadership network.

Baker Bakashaba is the Regional Project Manager, Soroti Region, for the AIDS Support Organization (TASO) in Uganda. For seven years, Dr. Bakashaba has managed HIV/AIDS programs at TASO, focusing on design and implementation of facility- and community-based, client-centered projects, and health systems strengthening. He's contributed to the design of community ART models, such as community drug distribution points (CDDP) and community-client-led ART delivery (CCLAD), as well as other national-level DSD models. He is currently the Regional Project Manager for the Accelerating HIV Epidemic Control in Soroti Region project funded by the President's Emergency Plan for AIDS Relief (PEPFAR) via CDC. He received his Bachelor of Medicine & Surgery Degree from Makerere University in Uganda, and is pursuing his MS in Project Management at the University of SalD, UK. Dr. Bakashaba is a member of the CQUIN Advisory Group.

Hudson Balidawa is a Public Health and M&E Specialist/QI Focal Person for the Ministry of Health, Uganda. He has experience in design, monitoring, and research for public health programs in resource-limited settings. He is a pediatrician who has worked in design and implementation of public health interventions for maternal and child health for the last 15 years. He has supported scale-up of the public health approach to ART management in Uganda, Namibia, Zimbabwe and Nigeria. He is an Honorary Senior Quality Improvement Advisor for URC and has supported HIV care quality initiatives that have spread to other health services programs. He worked with the Global Fund consulting teams on Program Quality Assessment (PQA) to develop the Toolkit for Health Facilities Differentiated Care for HIV and Tuberculosis. He currently monitors Global Fund-funded interventions for HIV and TB, and heads the National Technical Working Group for DSD Models (DSDM) in Uganda.

Solange Baptiste has worked with the International Treatment Preparedness Coalition (ITPC) since 2008, when she was hired to manage a small grant-making program called the HIV Collaborative Fund. Over the past seven years, Solange has served as Program Manager and Director of Global Programs and Advocacy, in which she provided technical expertise and support in monitoring and evaluation, treatment access knowledge building, health financing, accountability projects, global advocacy and small grants. Previously, Solange worked at John Snow Inc. in Boston, Massachusetts, mainly on USAID-funded health and development projects across Africa and Asia. Solange is constantly inspired by the power of communities across the world to mobilize and improve their own lives. As an activist, she is compelled to act against injustice, and believes in the power of education and the importance of evidence-informed advocacy to bring about change. Solange has a Master's degree in Population and International Health from the Harvard School of Public Health and a Bachelor's of Science in Biology, from Tuskegee University. She has worked in Pakistan, Ukraine, Tanzania, South Africa, and Trinidad.

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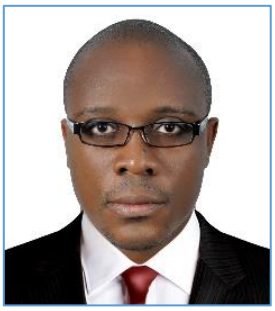
Berhanu Shibru is the Regional Program Support Director at ICAP Ethiopia.

Teferi Beyene is a medical and public health specialist with 21 years of progressive experience in clinical and preventive medicine, health systems strengthening, HIV treatment and care, PMTCT, HIV prevention, quality improvement, and program management in Ethiopia, Liberia and Malawi. He is currently the Medical Manager at Baylor Malawi.

Koffi Simplice Bohoussou is an assistant in the Care and Treatment Department of the National AIDS Program (Programme Nationale de Lutte Contre le VIH-PNLS). He coordinates all interventions and stakeholders working in Pediatric HIV Care and Treatment. He also ensures the integration and scale up of Pediatric HIV Care and Treatment interventions at all levels of the health system and in all sectors (public, private and community) according to national guidelines. Before his current position, Dr. Bohoussou was a medical doctor at the General Hospital of Tabou in the Sanitary District of Tabou. During this period, he was in charge of the Pediatric Department of Tabou General Hospital where he provided pediatric HIV care. He holds a Ph.D. in Human Medicine and a Master's degree in Business Administration (MBA) with additional focus in Health Services Management and Management of Health Programs.

Laurene Booyens heads the PEPFAR-funded Care and Treatment Programme of TB HIV Care, which supports the South Africa Department of Health in providing comprehensive HIV and TB services to communities in three districts in the Eastern Cape province, in addition to providing technical assistance as the official support partner. Laurene is responsible for the overall strategic direction and reporting of the programme. Laurene concluded her MBChB degree at the University of Pretoria (SA) in 2008 and is currently in the final stage of her Executive MBA at Henley Business School, University of Reading (UK). Prior to joining TB HIV Care, she worked as a clinician in both the private and public sectors, involved in the disciplines of paediatrics, primary health care, urology, emergency medicine and minimally invasive surgery. She has been involved in the not-for-profit sector, in a senior management capacity, since 2014, and has worked in various programme areas, including VMMC and Key Populations. Laurene is passionate about the optimisation of business management principles within the complex context of the clinical sector, by incorporating technical, operational and strategic perspectives. She strongly identifies with the vision of attaining maximal and sustainable impact for vulnerable and less fortunate populations.



Franck Euloge Boraud, is HIV Clinical Team Leader at ICAP Cote d'Ivoire. Prior to joining ICAP, Dr. Boraud was a physician in the District Hospital of Agnibilekrou and the Health District focal point for malaria, pediatric HIV, quality improvement and nutrition. During this period, he supervised district health providers implementing health services including HIV activities, malaria, and nutrition. He has over 12 years' experience in medicine and public health and holds MD and MPH degrees.

Nicole Buono has over twenty years' experience implementing HIV prevention, care and treatment programs including 15 years working on PEPFAR-supported programs in Africa. For the past two years, she has served as the Health Services Branch Chief with CDC's Division of Global HIV and TB based in Malawi, responsible for HIV and TB prevention and treatment services. Her work focuses on developing, monitoring, and evaluating PEPFAR programs to help accelerate and achieve HIV epidemic control. Ms. Buono also serves as a member of the oversight committee of the Global Fund Country Coordinating Mechanism. Prior to joining CDC, Ms. Buono worked for the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) as the Country Director in Malawi and prior to that she served as the Project Director for EGPAF's Track 1.0 program which was implemented in five countries, as well as a Program Officer supporting the initial scale-up of HIV prevention and treatment services across numerous countries in Africa. Ms. Buono was also a Public Health Institute Fellow working on family planning and reproductive health services at USAID in Washington, DC and West Africa, and also served as a Mellon Foundation Fellow in Ghana at a Ministry of Health Research Center.

Helen Bygrave trained as a physician in Cambridge and London and continues to work as a GP in London. As an HIV/TB advisor in MSF's Southern Africa Medical Unit (SAMU), she has supported programmes across Sub-Saharan Africa and Asia since 2005 and now works as a consultant for the International AIDS Society and WHO, developing international and national guidance on how to provide differentiated service delivery models for HIV. Building on the lessons learned from the scale-up of HIV care, she has just started to work with the MSF Access Campaign as a technical advisor on non-communicable diseases focusing on diabetes and cardiovascular disease.

Epse Aka Camara is the Deputy Director of Evaluation at Direction de l'Informatique et de l'Information sanitaire (DIIS) in the Ministry of Health and Sanitation in Cote d'Ivoire.

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Yohanes Chala is a Medical Doctor and leads the Addis Ababa Regional Health Bureau under the Federal Ministry of Health of Ethiopia.

Stella Stephen Chale is the Interim Country Representative for the International Training and Education Center for Health (I-TECH) in Tanzania. In this capacity she oversees I-TECH's program in Tanzania, while also functioning as the Clinical Programs Director. Before taking up this leadership position, she worked with the department of Internal Medicine at Muhimbili National Hospital, Tanzania for more than two decades and was a lecturer at the Department of Internal Medicine of the Muhimbili University College of Health Sciences and an active member of the HIV Vaccine Research Group. She has previously held positions with the Tanzania Country office of World Health Organization and the National AIDS Control Program (NACP) of the Ministry of Health and Social Welfare.

Philippe Chiliade joined CDC-South Africa as Senior Treatment Advisor within the Care & Treatment Branch in June 2018, after serving as Chief Medical Officer at DHHS/HRSA. In this role, Philippe supervised the HIV treatment, TB/HIV, and HSS/HRH teams, served as project officer for two large implementing partners, and managed a multi-million-dollar portfolio that supported HIV and TB prevention and treatment services in more than 14 countries. In his 13 years working with PEPFAR, he worked intensively with ministries of health and education to expand quality ART services and strengthen the health care workforce. Philippe is board-certified in Internal Medicine and Infectious Diseases. He completed his medical training at the Free University of Brussels, his Master's in Health Care Administration at Trinity University in San Antonio, Texas, and his fellowship in Infectious Diseases at New York University, NY.

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Sonia Chilundo is a medical doctor and holds a master's in public health. She is currently working for CDC Mozambique.

Lastone Chitembo has over twenty years' experience in public health, including strategic planning, management, implementation, monitoring, and resource mobilization for HIV/AIDS and maternal, newborn and childhood survival. He currently works at the World Health Organization in Zambia as Technical Advisor to the Ministry of Health on prevention, control and management of HIV, TB and Hepatitis. His career includes clinical experience as medical doctor in Poland and Zambia; District Director of Health, Paediatrician, honorary lecturer at the University of Zambia School of Medicine, and technical officer at UNICEF Zambia. He has also worked in Sierra Leone and Sudan as UNICEF technical advisor on paediatric HIV care.

Regis Choto is a medical doctor and public health specialist, currently working as the National ART Coordinator for the Ministry of Health and Child Care in Zimbabwe. He has MBChB and MPH degrees from the University of Zimbabwe.

Aleny Mahomed Couto is a Mozambican physician with over seven years of experience in public health. She is the head of the HIV program at the Ministry of Health,and has experience in management and implementation of national and provincial level health programs with specific focus on HIV/AIDS, as well designing policies, country guidelines, and strategic plans following WHO guidelines. She has also worked at District level (mainly in primary care) and implemented a wide range of public health programs. Prior to 2011, Dr. Couto was a clinician in the local hospital, treating HIV patients in the HIV Day Hospital. Dr. Couto is also a member of the CQUIN Advisory Group.

Pamela Donggo is a specialist physician, having graduated from the Makerere University College of Health Sciences in Kampala (Uganda) and certified for medical practice in 2004. She currently serves as the Deputy Chief of Party / Director Health Services Delivery at the USAID Regional Health Integration to Enhance Services-North Project. In this role, she spearheads the project's technical programs with the key aim to increase the effective use of sustainable health services in nine districts of the Lango region of Northern Uganda and contribute to measurable improvements in key Ugandan national health indicators.

Rumbidzai Dhliwayo is a medical doctor who has six years' experience in HIV care and has been involved in differentiated service delivery for three years, initially with Médecins Sans Frontières and currently with FHI360 Zimbabwe. Her role has been mainly in offering technical support on DSD in HIV care to implementing teams within the projects. She has special interest in the role of differentiated service delivery models in assisting HIV epidemic control in low resource settings and maintaining quality of care in these models of care for the clients living with HIV.

Peter Ehrenkranz is Senior Program Officer for HIV Treatment at the Bill & Melinda Gates Foundation. From 2010 to 2015, Dr. Ehrenkranz worked in Eswatini with CDC, first as the PEPFAR Care and Treatment Lead, and later as the Country Director. Prior to that, he spent two years in Liberia with a joint appointment as the senior advisor to the National AIDS Control Program and the medical director for CHAI-Liberia. He earned an undergraduate degree in history from Yale, medical and public health degrees from Emory, and trained in internal medicine and completed the Robert Wood Johnson Clinical Scholars Program at the University of Pennsylvania.

Tom Ellman is Director of the Médecins Sans Frontières (MSF) Southern Africa Medical Unit (SAMU). Since first working for MSF in Rwanda in 1995, he has over 15 years of experience in humanitarian medical work, mostly with MSF. His focus has been on HIV, TB, and malaria in Africa and South-East Asia, apart from a three-year 'break' working on Chagas disease – the 'AIDS of the Americas' – in Bolivia. Dr. Ellman received his medical training in Edinburgh, has a Diploma from the School of Tropical Medicine and Hygiene (Liverpool), and a Masters in Communicable Disease Epidemiology from the School of Tropical Medicine and Hygiene (London). He is a member of the Royal College of Physicians, UK and a beekeeper.

Wafaa El-Sadr is the Director of ICAP, University Professor of Epidemiology and Medicine and Mathilde Krim-amfAR Professor of Global Health at Columbia University, and leads the Global Health Initiative at Columbia's Mailman School of Public Health. Dr. El-Sadr's interests include: HIV/AIDS, tuberculosis maternal/child health, capacity building and health systems strengthening. She has led research studies focusing on HIV prevention and management and currently co-leads the NIH-funded HIV Prevention Trials Network (HPTN). Through ICAP, the center she established 15 years ago at Columbia University, she has led efforts that enabled the establishment of large-scale programs in 24 countries in Africa and Asia that link research, education, training and practice with a focus on HIV, other public health threats and health system strengthening.

Through ICAP's work, more than two million people have received access to HIV programs around the world. This was accomplished in partnership with ministries of health, academic institutions, non-governmental and community-based organizations. ICAP has championed the integration of research into programs and investment in health system strengthening and quality improvement. Dr. El-Sadr received her medical degree from Cairo University in Egypt, a master's in public health from Columbia School of Public Health and a master's in public administration from Harvard University's Kennedy School of Government. Her scholarly work has appeared in leading scientific journals. She was named a MacArthur Fellow in 2008 and is a member of the National Academy of Medicine.

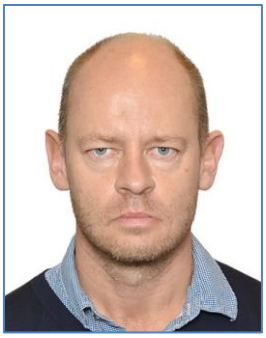
Ade Fakoya is a clinician and specialist in HIV and International Health with over 20 years national and international experience in HIV, STI clinical care, service management, and programme delivery. He is currently Senior Disease Coordinator, HIV at the Global Fund to Fight AIDS, Tuberculosis and Malaria based in Geneva. Dr. Fakoya has previously held technical, senior management, and research posts working in the UK and Internationally. Over the last three years his team have provided technical support and coordinated partner technical cooperation which has seen the approval of over 5 billion USD in Global Fund HIV grant approvals.

Dr. Fakoya's areas of expertise include HIV clinical care and treatment, prevention, and care, ARV scale up and provision of STI clinical services. He has provided technical support to national HIV programmes in Africa, Asia, Eastern Europe, and Latin America. He has sat on several national and international advisory committees, including those for HIV treatment guidelines, prevention of mother to child transmission guidelines, and sexual and reproductive health. He is currently a member of the Global HIV Coalition working group, the International Grants Committee for the UK's Comic Relief Charity, and has previously held trustee positions at the British HIV Associations and the Terence Higgins Trust. His present interests include improving program quality by using robust data to drive program effectiveness and efficiencies, increasing access to ART and combination prevention towards ending HIV as a public health threat, HIV and TB integration and the role of disease-specific funding initiatives in health systems strengthening.

Peter Godfrey-Faussett is the Senior Science Advisor at UNAIDS, a professor at the London School for Hygiene and Tropical Medicine (LSHTM), and consultant physician at the Hospital for Tropical Diseases. After training in clinical infectious diseases and molecular genetics, he spent five years leading the Zambian AIDS-related TB (ZAMBART) project, a collaborative research programme between the LSHTM, Lusaka Urban District Health Management Team and the University of Zambia. Thereafter, he spent a year working with WHO's Global TB Programme, where he was responsible for developing strategies to address the combined epidemic of TB and HIV. Following his return to London, he has maintained an interest in global policies around TB and HIV and served as chairman for the Technical Review Panel of the Global Fund against AIDS, Tuberculosis and Malaria. A regular member of WHO expert groups, his research interests remain focused on the impact that the HIV epidemic is having on TB control and on interventions to reduce both diseases. He is currently seconded full-time to UNAIDS, where he is the Senior Science Adviser with a wide-ranging portfolio including HIV cure, ARV-based HIV prevention, HIV vaccines and synergies between the HIV and the non-communicable disease response.

Ruby N. Fayorsey is a pediatric infectious disease specialist, and Deputy Director of the Clinical and Training Unit at ICAP Columbia. She provides clinical and programmatic support to ICAP's programs in sub-Saharan Africa including those in Kenya, Tanzania, Democratic Republic of Congo, Ethiopia, and South Sudan. She has over 18 years of experience working with women, infants, children, adolescents and young adults with HIV and families in impoverished environments in the U.S. and sub-Saharan Africa. Dr. Fayorsey has served as a consultant to the WHO on several topics including IMCI, pediatric HIV disclosure, HIV diagnosis in infants, children and adolescent HIV. She is also involved in implementation science research to improve retention of HIV-infected pregnant and breastfeeding women. Dr. Fayorsey is an attending physician at Harlem Hospital, NYC, where she provides HIV prevention, care and treatment to infants, children, adolescents and young adults at the Family Care Center.

Bayisa Chala Feyisa is the Executive Director of NEP+, Ethiopia. He has worked in HIV for over twenty years in various capacities, including as a project coordinator, program officer, and executive director. Mr. Chala holds an MSc. in International Trade and Finance from Addis Ababa University.



Nathan Ford is a Scientific Officer with the Department of HIV/AIDS and Global Hepatitis Programme of the World Health Organization in Geneva, and chair of WHO's Guidelines Review Committee. Prior to joining WHO in 2012, Dr. Ford worked with Médecins Sans Frontières for 14 years supporting HIV programmes in southern Africa and South-East Asia. He holds a degree in Microbiology and Virology, a Master's in Public Health and Epidemiology, and a PhD in Clinical Epidemiology, and is a Fellow of the Royal College of Physicians of Edinburgh. He has published over 400 peer-reviewed publications and is an editorial adviser for the WHO Bulletin and a member of the editorial boards of JAIDS, JIAS, Tropical Medicine and International Health, and Conflict and Health. Dr. Ford is also a member of the CQUIN Advisory Group.

Ignace Gashongore is the Chief of Party at UMD Zambia. Dr. Gashongore's career in HIV care and treatment spans more than a decade. He began his career in 2004 with the basic day-to-day care of patients and has since worked at the district, provincial and National levels, including as a member of the Zambian Ministry of Health PMTCT and ART Technical Working Groups. Currently, Dr. Gashongore is Chief of Party and Senior Technical Advisor for the SMACHT-*Plus* and Z-CHECK projects of the University of Maryland under PEPFAR (CDC) support. He is responsible for managing all aspects of the projects including providing strategic technical direction and overall guidance on implementation.

Mirtie Getachew holds an MPH degree and is HIV Team Lead at the Federal Ministry of Health of Ethiopia. She has more than ten years of clinical and programmatic experience in HIV and currently works in the Disease Prevention and Control Directorate as the HIV/AIDS Program Coordinator. She was previously a Global Fund M&E officer and IGAD regional HIV/AIDS prevention partnership program coordinator for five years at Amhara Regional State HAPCO.

Denis Giles is the Associate Director for Science and Systems at CDC Mozambique.

George Githuka has over eight years' experience in National HIV/AIDS programmes management and coordination at the National AIDS & STI Control Program (NASCOP), Ministry of Health, Kenya. At NASCOP, he has coordinated HIV control programs among key populations, HIV Testing Services programs, Voluntary Medical Male Circumcision programs and currently the Prevention of Mother to Child Transmission of HIV and Syphilis Programs in Kenya. Dr. Githuka is a Medical Doctor with an MSc. in Field Epidemiology.

Sthembile Gombarume is a Project Development Specialist – Care & Support at USAID, South Africa. She has 18 years' experience in managing HIV and AIDS Programs in the Southern African region and has worked in Malawi, Mozambique, South Africa, Tanzania, Zambia and Zimbabwe supporting community development. She has worked for regional and international NGOs, including FHI360, Save the Children UK, World ORT International Cooperation and the Southern African AIDS Trust in various capacities, namely program management, capacity building, and monitoring and evaluation. Sthembile holds a Master's Degree in Development Studies from the University of the Free State, a Master's Degree in Business Administration from Nottingham Business School, and a BSc. (Honours) from the University of Zimbabwe.

Anna Grimsrud is the Lead Technical Advisor for the International AIDS Society (IAS). Dr. Grimsrud focuses on supporting the implementation of differentiated models of antiretroviral therapy delivery in sub-Saharan Africa. She holds a Master of Public Health and PhD from the University of Cape Town, and has been involved in research with IeDEA-Southern Africa Collaboration, the Desmond Tutu HIV Foundation and Médecins Sans Frontières.

Not Pictured

Yoseph Gutema is a medical doctor and the Pediatric Technical Advisor at ICAP Ethiopia.

Clorata Gwanzura, is the Differentiated Care Medical Officer: HIV Care and Treatment at the Ministry of Health and Child Care (MoHCC) Zimbabwe. With support from the CQUIN project, she supports DSD projects in the AIDS and TB Unit, focusing on the scale-up of DSD models nationwide. She has 5 years' experience working at various levels in the Zimbabwe MoHCC, implementing and managing health programs including HIV programming. Clorata is a medical doctor and holds an MPH.

Dr. Zerihun Hika attended Medical School at Gondar University, where he received his Doctor of Medicine degree in 2003 and Master of Public Health degree in 2013. He practiced medicine as a general practitioner in public hospitals for four years, and then worked with international NGOs for more than 10 years, supporting public health and HIV programs. He provided technical support as a mentor, trainer and program coordinator and worked for ICAP Ethiopia as a program officer. Dr. Hika was the medical director of St. Gabriel Catholic health center and worked at Addis Ababa Regional Health Bureau as the Lead Hospital Catchment Program Coordinator for a CDC-funded HIV project. He is currently working at Federal Ministry of Health with responsibility of CDC- TB/HIV project coordinator and providing technical support to DCPD HIV program.

Ivete Francisca Cuamba Joaquim is a general practitioner who has worked for ICAP Mozambique as a Manager of Clinical Systems in Nampula Province since 2014. She graduated from Eduardo Mondlane University in Maputo and held several senior positions at the district and provincial levels in Maputo and Sofala Provinces before becoming a supervising doctor for Médecins Sans Frontières (MSF) - Belgium and later joining ICAP. She now manages ICAP's provincial portfolio in Nampula, including care and treatment for adults and children with HIV, SMI/PTV Tuberculosis, psychosocial support, monitoring and evaluation, Quality Improvement and management of human resources. Ms. Ivete's international experience includes management training by MSF - Brussels and a course in Leadership, Supervision and Evaluation organized by CEGOC-Portugal.

Joseph Kabanda is an HIV Care and Support Specialist at CDC Uganda where he provides technical assistance to the ministry of health, implementing partners and health facilities, including the development of national guidelines for differentiated service delivery models (DSDM). Dr. Kabanda received his medical degree from Makerere University College of Health Sciences and a Master of Science in Public Health degree from Makerere University. His current work includes providing support and input for implementation manuals, job aides, and SOPs for implementation of DSDMs in Uganda.

Beatrice Kafulubiti is one of the Clinical Directors of the USAID-funded *Supporting an AIDS Free Era* (SAFE) project being implemented by John Snow Inc (JSI) in Zambia. She is based in Central Province in Kabwe, Zambia and oversees the clinical aspects of the project implementation across 107 facilities supported by JSI SAFE in 11 districts. Dr. Kafulubiti graduated with a Bachelor's Degree in Medicine and General Surgery from the University of Zambia in 1995. She worked for many years for

the Ministry of Health including as District ART Coordinator, District Health Director, Public Health Specialist and Provincial Clinical Care Specialist. She recently worked as Project Coordinator for the RMNCH Trust Fund under the UN agencies in Central Province. She has been involved in HIV prevention and treatment for the last 15 years at the community, facility, district, and provincial levels. Some DSD models were piloted in selected facilities in her province and the benefits of these models were clearly seen by both the clients and the facility staff. She is looking forward to leading her provincial team in scaling up and implementation of DSD.

Hervé Nzereka Kambale is a Differentiated Care Advisor, seconded to the Eswatini National AIDS Programme (SNAP) with support from CQUIN. He is dedicated to scaling up DSD in Eswatini, with a special interest in DSD for patients at high risk of disease progression. Dr. Kambale has 8 years' experience in HIV clinical and program management, as well as five years of clinical experience in general medicine. His major contributions include health education and capacity building, mentoring and supervision, and effective collaboration with the Ministry of Health and other non-governments agencies in the following fields: Palliative Care, Cancer Management, PMTCT, HIV/AIDS, Maternal and Child Care. Dr. Kambale graduated with an MPhil, in HIV/AIDS Management from Stellenbosch University in 2013, and an MBChB from the Catholic University of Bukavu in 2005. He has previously worked in Rwanda, DR Congo, Botswana, and Eswatini.

Wamaka Kaminyoge has been the Technical Advisor for Care and Treatment for the Elizabeth Glaser Paediatric AIDS Foundation (EGPAF)-Malawi since August 2017. In this role, he is responsible for rolling-out differentiated service delivery models and continuously refining their implementation. In addition, he is responsible for providing input and coordinating all HIV-related care and treatment activities for adults and children including EID, PMTCT, VL scale-up, monitoring of treatment failure and management of patients initiated on 2nd-line ART. Prior to his new position, he was working for EGPAF as the district lead in implementing the Accelerating Children's HIV/AIDS Treatment (ACT) Program, which aimed to double the number of children on ART in sub-Saharan Africa over two years. Wamaka holds a Bachelor's degree of Medicine and Surgery from the University of Malawi (2013).

Muthoni E. Karanja is a Kenyan public health doctor with over 7 years of public health and clinical experience. She has strong passions for infectious diseases as well as public health. Her current professional position is at the Ministry of Health of Kenya as the lead for TB/HIV co-infection management, as well as supporting HIV care and treatment. She has participated in a number of collaborations as pertains to policy formulation and providing strategic direction to HIV, TB, public and private mix, and NCDs. She played a key role in development of the National 2018 HIV guidelines as well as the differentiated care operational guide; she currently serves as the National CQI coach.

Prisca Kasonde is the Country Director for ICAP in Zambia. She is an experienced Zambian medical doctor/Public Health specialist with a career spanning over 25 years in the public and private health sector as well as in international non-governmental organizations. She has a Master's degree in Public Health with a focus on HIV/AIDS epidemiology as well as a Master's degree in Medicine specializing in Obstetrics and Gynecology. Dr. Kasonde's experience includes both clinical as well as program management in the area of HIV/AIDS, STIs, reproductive health, Obstetrics and Gynaecology, and health systems strengthening. She has successfully provided technical leadership and programmatic guidance to the design, development, introduction, implementation and monitoring and evaluation of HIV/AIDS prevention, care and treatment programs in donor funded projects. Prior to joining ICAP, Prisca worked on large PEPFAR/USAID funded HIV/AIDS projects in Zambia (- ZPCT/ZPCTIIB) and has experience implementing differentiated service delivery models. She has co-authored over 20 different publications in peer-reviewed journals.

Mathew Kawogo served as the Programme Manager for HIV and AIDS for more than four years with HelpAge International in Tanzania where he also served as the Coordinator of Capacity Building to strengthen CSOs and Councils' capacity on ageing, and HIV programme management in more than 15 district councils and 100 villages. He previously worked with World Vision International in various posts including designing, managing and coordinating projects overseeing program developments for children of Tanzania. He was appointed as the Country Director of Action on Disability International in Tanzania for a year and a half and then moved to UNAIDS to serve as a Programme Officer for Alliance of Mayor's Initiative for HIV and AIDS at Local Level (AMICAALL) in Tanzania. Since June 2017, Mathew has served as the Manager of Community Mobilization and Engagement with the National Council of People Living with HIV and AIDS in Tanzania (NACOPHA).

Not Pictured

Abrehem Kebede is a member of the National Network of Positive Women in Ethiopia.

Stella Kentutsi is the Executive Director of the National Forum of People Living with HIV/AIDS Networks in Uganda (NAFOPHANU). Stella is an expert in HIV/AIDS programming with over 15 years' experience at different levels, ranging from coordinating school HIV/AIDS activities to currently coordinating networks of PLHIV across the country. She holds a Master of Arts Degree in Development Studies and a Bachelor of Arts in Education. She has expertise in design, implementation and evaluation of HIV programs, research, capacity building, systems strengthening, advocacy, community engagement, resource mobilization and strengthening partnerships. Stella sits on a number of committees that guide the national HIV/AIDS response such as Joint UN Programme of Support on AIDS (JUPSA) and Uganda AIDS Commission's Message Clearance and HIV Prevention Committees.

Lawrence Khonyongwa is the Executive Director of the Malawi Network of People living with HIV (MANET+). He has worked to improve the lives of communities living with HIV/AIDS for more than 20 years with resilient and sustainable systems for health. Skilled in program design and management, coordination and networking, he is also a trainer of trainers in participatory methodologies with a good understanding of gender and development. He is currently managing the Global Fund project on Sustainable and Resilient systems for health with the main aim of achieving the UNAIDS 90:90:90 targets towards ending AIDS by 2030.

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Gavin Khumalo is a community activist at the Eswatini Network for People Living with HIV (SWANNEPA).

Altaye Kidane has over 25 years of experience in HIV/TB programs, In his current position as technical director for ICAP's TB/HIV care and treatment project in Eswatini, Dr. Kidane supports ICAP's technical assistance to strengthen local capacity to deliver sustainable quality assured universal coverage of clinical HIV/TB services in Manzini Region, and provides central-level technical assistance to the National Tuberculosis Control Program (NTCP) in the Kingdom of Eswatini with support from PEPFAR. Dr. Kidane has worked in the implementation of TB/HIV programs in Zambia, Tanzania, Ethiopia, Lesotho, and Eswatini. He holds a medical degree and certificate of specialty in Internal medicine from Addis Ababa University, an MSc in Infectious Diseases Immunology from the University of London and a diploma in Tropical Medicine and Hygiene from the Royal College of Physicians of London.

Josen Kiggundu is the National Technical Advisor for DSD at the Ministry of Health AIDS Control Program in Uganda. Dr. Kiggundu is a public health professional with training and practical experience in managing health programs within the public sector and non-government organization setting, including district-led health services, maternal and child health programs and comprehensive HIV/AIDS programs. He worked with the Baylor College of Medicine Children's Foundation in Uganda as an acting program manager, Care and Treatment Coordinator and Regional Coordinator from 2014 - 2017. He was a Program Officer with Protecting Families Against HIV/AIDS (PREFA) from February 2012 to March 2014, and a District Health Officer and Medical officer with Manafwa District Local Government between August 2007 and February 2012. He holds a Master's degree in public health (Uganda Christian University), a post graduate diploma in Project Planning and Management (Uganda Management Institute) and a Bachelor of Medicine and Bachelor of Surgery (Makerere University).

Bactrin Killingo is an independent consultant. Dr. Killingo is a medical doctor by training, and has been involved in community HIV treatment education and advocacy for the past 10 years. As a palliative care practitioner, Dr. Killingo has been involved with resource-poor communities facing severe challenges regarding access to essential HIV medicines and has mobilized communities to advocate for increased access to HIV-related services. In addition, he has been instrumental in empowering communities with the knowledge and skills needed to mobilize resources and take charge not only of the small projects they run but also of their own health.

Edward Katto Kiranda is the Senior Community Linkages Coordinator (West and West Nile Region) for the Infectious Disease Institute in Uganda. He has seven years of experience in HIV programs and holds an MPH.

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Nathalie Krou Dahno is a Medical Doctor and the Program Director at ARIEL, a CDC implementing partner in Cote D'Ivoire.

Delphine M'boh Achi Epouse Kouassi is the Deputy Care and Treatment Branch Chief of health facility-based HIV programs at CDC Cote d'Ivoire. She is a physician, health economist and public health specialist with over 15 years' experience in implementing HIV prevention, care and treatment for national and international companies at multiple levels.

Natalie Kruse-Levy is a public health expert with more than twenty years of experience in HIV/AIDS, reproductive health and gender programming. Currently Ms. Kruse-Levy is the Senior Health Program Advisor for USAID/Zimbabwe where she is the Team Leader for Prevention, Care and Support and a key member of the PEPFAR inter-agency HIV team. Prior to joining USAID/Zimbabwe in 2015, Ms. Kruse-Levy was the USAID PEPFAR Program Director in Eswatini and lived and worked in several countries in Africa and Southeast Asia including Cambodia, Vietnam, Malawi, South Sudan and Madagascar. Ms. Kruse-Levy has a Master's in Public Health from Tulane University and a Bachelor of Arts in Anthropology from the State University of New York at Geneseo.

Ivan Lukabwe is a statistician and Program Officer for Monitoring and Evaluation with the STD/AIDS Control Programme of Ministry of Health, Uganda. He has accrued over ten years' experience in management of HIV/AIDS data, serving in several strategic information positions with the Government of Uganda through the Ministry of Health; PEPFAR-supported projects (Baylor College of Medicine, Infectious Diseases Institute, Rakai Health Sciences Program & The AIDS Support Organization

(TASO); and international organizations (KNCV Tuberculosis foundation, GOAL). Mr. Lukabwe obtained a B.S. from Makerere University, Kampala and a Masters in Statistics. He also holds a Post Graduate Diploma in Monitoring and Evaluation from Uganda Management Institute and is a registered Practitioner-Projects in Controlled Environment (PRINCE 2).

Nomthandazo G. Lukhele is the National ART Coordinator at the Eswatini Ministry of Health. Dr. Lukehele coordinates HIV care and treatment services in Eswatini, and has extensive hands-on experience in the delivery of HIV care and treatment services at both clinical and programme level. She holds a Bachelor of Medicine and Surgery Degree (MBCB) from Witwatersrand University, South Africa (2006) and a Bachelor of Science Degree from the University of Swaziland (2000). She is currently studying for a Master of Public Health degree at Witwatersrand University, majoring in Health systems strengthening. Dr. Lukhele is also on the CQUIN Advisory Group.

Sileshi Lulseged is a Professor of Paediatrics and Child Health at Addis Ababa University and Senior Associate Research Scientist at Columbia University's Mailman School of Public. He is also Senior Advisor at ICAP Ethiopia. He has served as Head of the Department of Paediatrics and Child Health and Director of Clinical Epidemiology Service at AAU, Director of the WHO Regional INCI Training Center, Associate Director for HIV Treatment Program at U.S. CDC in Ethiopia, and Editor-in-Chief of the Ethiopian Medical Journal. He has published extensively. He is the recipient of the U.S. PEPFAR Lahya Shiimi Memorial Award; the Ethiopian Medical Association Medal Award, and Certificates of Merit from the Minster of Health of Ethiopia and U.S. Embassy, Addis Ababa.

Priscilla Lumano-Mulenga is an Infectious Disease specialist who is currently working as Technical Advisor to the HIV Unit at the Ministry of Health, Zambia. She has been involved with the National Anti-Retroviral (ARV) Program since its inception in 2002. In 2005 she joined the Centre for Infectious Disease Research in Zambia (CIDRZ), where she held various positions including that of Head – Quality Assurance/Quality Control (QAQI) before moving to the Elizabeth Glaser Paediatrics AIDS Foundation (EGPAF) as the Technical Director.

Tonderai Mabuto is the Director for HIV Research within the Implementation Research Division at the Aurum Institute in South Africa. He is a trained Epidemiologist and Biomedical Scientist, who holds a Master's Degree in Epidemiology and Biostatistics from the University of Witwatersrand. He is passionate about pragmatic research that improves delivery of HIV treatment services through routine public sector HIV programmes. In the past decade, he has led several multi-site implementation research studies to promote engagement of people living with HIV into appropriate care and treatment interventions. His work in this area also includes pioneering research on interventions to retain ex-inmates on HIV treatment after release from correctional centres in South Africa. In addition, Mr. Mabuto serves as Principal Investigator on strategic information projects, notably bio-behavioural surveys among key populations in South Africa and evaluations of public-sector HIV programmes in districts supported by the Aurum Institute. He is a member of the South Africa National HIV Think Tank.

Neema Makyao is a trained socio-anthropologist and public health specialist with robust experience in the behavioral and social aspects of health, specifically on HIV/AIDS programmes in Tanzania. She has been involved in community health programmes and participated in HIV/AIDS research projects in Tanzania targeting key and vulnerable populations as well as the general population. She has been working in HIV/AIDS prevention program since 2008 at the Ministry of Health's National AIDS Control Program (NACP) as coordinator of key population programming and HIV Prevention at epidemiology and prevention units. She has vast experience working with key and vulnerable populations (KVP), both research and programming and coordinated development of policy documents for HIV prevention. She led development of KVP guidelines on HIV health services provision and a training manual on stigma reduction to increase access to HIV services among KVPs in Tanzania.

Edias Mandere is a Program Coordinator for the University of Zimbabwe College of Health Sciences Clinical Trials Research Centre (UZCHS-CTRC)/International Training Education Centre for Health (I-TECH). Edias has 10 years of experience in the field of TB/HIV in Zimbabwe with the Ministry of Health & Child Care (MOHCC) and non-governmental organisations such as MSF-Belgium and COMPRE Health Services.

Joanne E. Mantell is a research scientist at the HIV Center for Clinical and Behavioral Studies and a Professor of Clinical Psychology (in Psychiatry), Department of Psychiatry, Columbia University Medical Center. Currently, Dr. Mantell is the Principal Investigator of a bar/club-based intervention for male and female sex workers and their clients in Mombasa, Kenya, a qualitative study of ARV-based prevention and treatment in high-risk women in Durban, South Africa, an implementation science study on integrating PrEP into primary care in New York City, and studies on reducing health disparities in access to HIV prevention among women of color in New York City, and decision-making around PrEP among providers in different practice settings in New York City. She also is a Co-Investigator on studies of HIV testing and engagement in HIV care in Kenya's Lake Victoria region, a combination strategy for HIV prevention among young female sex workers in Kisumu, Kenya, differentiated HIV service delivery in Zimbabwe, and an intervention for miner-friendly services for integrated HIV/TB care in Lesotho. Other recent studies included HIV self-testing among male truck drivers in Kenya, medical male circumcision in South Africa, female condom promotion among South African university students, a national evaluation of South Africa's female condom program, integration of sexual and reproductive health services into HIV care in Cape Town, South Africa, and pathways to care for people living with HIV in the Durban area.

Munyaradzi Paul Mapingure joined ICAP in Zimbabwe in January 2016 as the Strategic Information Coordinator responsible for research and SI activities. He was previously Director of Research, Metrics and Information Systems at Population Services International and held similar senior positions and UNICEF, RTI, Letten Foundation and also taught at the University of Zimbabwe College of Health Sciences. He has authored 35 scientific public publications.

Haruka Maruyama is ICAP's Director of Prevention Services in Tanzania. In this role, she leads the technical and programmatic components for ICAP's projects, currently overseeing a five-year CDC PEPFAR-funded project on provision of comprehensive community-based HIV prevention, linkage, and retention services reaching key populations, adolescent girls and young women, and other vulnerable populations – known in Tanzania as the "FIKIA" project. She initially joined ICAP in Tanzania as a Research Advisor working on the Bukoba Combination Prevention Evaluation (BCPE) research project and the community-based key populations service delivery projects. Prior to joining ICAP, she worked for the University of Texas Health Science Centre based at the Muhimbili University of Health and Allied Sciences in Dar es Salaam,

Tanzania, managing a project delivering HIV services and medication assisted therapy to people who inject drugs. Haruka holds a Master's degree in public health from the University of Texas Health Science Center in Houston, and a Bachelor's degree in African Studies from Rice University.

Takura Matare is the Senior Monitoring and Evaluation Officer for the Ministry of Health and Child Care, AIDS & TB program in Zimbabwe. He has more than 7 years of university teaching experience in health sciences. He received his Master's of Public Health degree from the University of Zimbabwe in 2014. He holds a Bachelor's degree in Occupational Therapy and a Postgraduate Diploma in Project Planning and Management from the University of Zimbabwe. Mr. Matare also holds a Master's of Science in Disaster Management from the National University of Science and Technology.

Eva Matiko is the CDC Tanzania Clinical Services Branch Chief. She leads a team of eight public health professionals providing strategic and technical support for HIV clinical services across the cascade of identification, care and treatment including facility-based HIV testing, comprehensive HIV care and treatment, TB-HIV integrated services, PMTCT and EID as well as related scientific endeavors. She had direct responsibility over four core implementing partners and several collaborators supporting comprehensive HIV care and treatment services in Tanzania, working in collaboration with government stakeholders and development partners. Differentiated service delivery of ART is among the initiatives under her leadership. Dr. Eva joined CDC Tanzania in September 2009 as Key Populations Programs Specialist, also providing leadership support at Deputy Branch Chief for Prevention until 2017. Dr. Eva Matiko's academic credentials include MD from the University of Dar es Salaam and MPH from Columbia University Mailman School of Public Health.

Sikathele Mazibuko is the Care and Treatment lead for PEPFAR Swaziland. A medical doctor by training, he graduated with an MBChB from the University of Zimbabwe in 2000 and later received training as a Clinical Epidemiologist at the University of Pretoria, South Africa. Dr. Mazibuko has extensive HIV management experience and has worked as an HIV clinician at the facility level and a program officer at provincial and national level before joining CDC Swaziland in his current position.

Lawrence Mbae has 12 years' experience in health care systems management having worked across the public (MOH) and private for- and not-for-profit sectors. He has robust experience in HIV programming, quality improvement and service integration. Dr. Mbae is currently the Technical Advisor for DSD at ICAP Kenya. He previously worked for FHI (Goldstar) and PSI and consulted on quality improvement for Aga Khan University and JHPIEGO.

Jean-Jacques Kouassi M'bea is the Senior Strategic Information Manager at ICAP in Cote d'Ivoire. Under the oversight of the SI Director, he coordinates M&E activities, including data collection, reporting, analysis, dissemination, and quality improvement. He liaises with the Ministry of Health (MOH) to provide training and mentorship of Data Managers for M&E of HIV/AIDS-related services. He works closely with programmatic and management staff to increase and enhance the quality and use of health information at site, district and regional levels to support informed program decision-making. Prior to his current position, Jean-Jacques spent five years as Head of Service in charge of Monitoring & Evaluation at the MOH National Child Health Program. During this time, he was actively involved in national child survival processes. He was also member of a research team within the Epidemiology & Statistics Unit of the Cote d'Ivoire National Institute of Public Health before he joined the National Child Health Program.

Cordelia Katureebe Mboijana is a pediatrician and child health specialist currently working as a National Coordinator for HIV care and treatment at the Uganda Ministry of Health AIDS Control Program. She has over 15 years' experience in clinical care, strategic planning, and implementation of programs addressing HIV care and treatment for pregnant women and children infected with HIV. In the last three years, she has been the MOH coordinator for adolescent HIV services, developing and reviewing adolescent HIV-related program policies and monitoring their implementation and evaluation. Her recent work has focused on the roll-out of standards of care for adolescent HIV services across the country with the aim of improving retention and viral load suppression among adolescents living with HIV. Dr. Katureebe has just completed a short course on public health policy and aspires to be a leader in HIV care and treatment across all populations.

Zenebe Melaku is ICAP's country director in Ethiopia. He has over 20 years of clinical, academic, programmatic, and managerial experience in medicine and public health in Ethiopia. In his current role, Dr. Melaku oversees the planning and implementation of comprehensive and high- quality HIV/AIDS care and treatment services at ICAP-supported sites in eight regions of Ethiopia. He provides technical and managerial oversight to program activities at the national, regional, and site levels and liaises with the Federal Ministry of Health and other project partners and collaborators. Before joining ICAP, Dr. Melaku was an associate professor of internal medicine at Addis Ababa University and served as the technical advisor for HIV/AIDS Care and Treatment at the U.S. Centers for Diseases Control and Prevention (CDC) in Ethiopia. His areas of expertise include HIV/AIDS, tuberculosis, health systems strengthening, program management, organizational development, and strategic planning. He holds a medical degree with a specialty in internal medicine from Addis Ababa University, a certificate of fellowship in neurology from the University of Limoges (France), and certificates in rheumatology, advanced epidemiology, and research methodology and clinical field trials from the University of Bergen (Norway).

Not Pictured

Ambachew Minda is the Addis Ababa City Administration Project Director for Project Hope on a USAID-supported project in Ethiopia.

Alemtsehay Abebe Wolde Micheal is the Senior HIV Program Officer at Ethiopia's Federal Ministry of Health (FMoH). She is a nurse with a MPH and has over 14 years of experience in HIV/AIDS programs. She is currently the HIV Care & Treatment Focal person for differentiated service delivery and provides technical and managerial oversight to program activities at the national, regional, and site levels. Mrs. Abebe is an active member of the Ethiopia Public Health Association.

Luckyboy Edison Mkhondwane (Lucky), is the Prevention and Treatment Literacy Training Coordinator at Treatment Action Campaign, and represents South Africa on the CHAI (Clinton Health Access Initiative) Optimal ARV Project Community Advisory Board. Lucky has been openly with living with HIV after being diagnosed in June 2002, which prompted him to become an access to treatment advocate. He has a great passion for HIV and TB treatment literacy and community education. Lucky has worked as a Prevention and Treatment Literacy Trainer, Capacity Building Officer, and Policy, Communications and Research Coordinator at TAC Gauteng, amongst other positions, since joining in 2002. Lucky has written articles for community newspapers and *Equal Treatment,* the TAC magazine, on living with HIV and issues around

treatment literacy. He used to co-present present "Siyayinqoba Beat It", a South Africa television talk show on HIV, health and human rights, and is a former ambassador of a South African Positive Living Campaign "Positive Heroes".

John Waiharo Motoku is a medical officer who has spent the last 10 years engaged in clinical care of PLHIV and TB patients at EDARP a faith-based organization operating in the eastern slums of Nairobi, Kenya. He is a member of various National and County Technical working groups primarily focused on HIV treatment and prevention. He is currently involved in implementing differentiated service delivery at all 14 EDARP facilities.

Martin Msukwa is the Project Director for ICAP's HRSA-funded OpCon Project and a Regional QI Advisor based at ICAP South Africa. He has BSN and MPH degrees, and has spent the past 16 years designing, developing, and implementing large-scale public health programs, including eight years in senior management roles in a number of countries in sub-Saharan Africa (Cote d'Ivoire, Kenya, Lesotho, Malawi, Mozambique, South Sudan, Swaziland, Uganda, Zambia and Zimbabwe). He has worked extensively in: health systems strengthening to deliver quality HIV diagnosis and treatment, sexual and reproductive health, leading diverse teams through change, capacity building, fundraising, and managing large USG grants and private funds from individuals and foundations. In his current role, he oversees a portfolio of OpCon projects, and supports "QI for DSD" activities within CQUIN network.

Mpande Mukumbwa-Mwenechanya is a Technical Advisor at the Center for Infectious Disease Research in Zambia (CIDRZ). She has over five years of experience in clinical pharmacy, including in managing large-scale surveys and healthcare facility audits, health promotion, design and delivery of training materials, implementation, and monitoring and evaluation. She currently leads a mixed methods study on ART pick-up and retention monitoring funded by the Bill & Melinda Gates Foundation. The study seeks to determine the best strategies to implement decentralized community group-led HIV services and assesses various domains of healthcare facility management to determine how, for example, clinic patient flow and supply chain management impact retention and viral load suppression. She holds a Doctorate Degree in Clinical Pharmacy from the University of Zambia and is currently pursuing a Masters in Epidemiology at the London School of Hygiene and Tropical Medicine. She is a part-time lecturer at the University of Zambia School of Medicine for undergraduate Pharmacy students.

Redempta Mutei is a Quality Improvement Coordinator at ICAP Kenya. She has eleven years of experience in HIV prevention, care, and treatment. Ms. Mutei holds a BSc. in Clinical Medicine and Surgery and an MPH in Health Systems Management.

John Nkengasong is the Director of Africa CDC. A veteran of more than 20 years at the CDC, Cameroon-born Dr. John Nkengasong was appointed director of the newly created Africa CDC in early 2017. Previously, Nkengasong served as acting deputy principal director for the CDC's Center for Global Health in Atlanta. He began his career at the U.S. CDC in 1995 as head of the virology lab in Abidjan, Cote d'Ivoire. Nkengasong earned master's degrees in tropical biomedical science and in medical and pharmaceutical sciences from institutions in Belgium, and has a doctorate in Medical Sciences (Virology) from the University of Brussels.

Lilly Nyagah is a Medical Doctor with a postgraduate degree in Applied Epidemiology. She works at the National AIDS & STI Control Programme (NASCOP) at the Kenya Ministry of Health where she heads the Surveillance sub-branch in the Strategic Information Unit. She has spearheaded several HIV surveillance initiatives including a pilot of Case-Based Surveillance and eventual roll out plans at national scale including development of National Case-Based Surveillance Strategy guidelines, implementation of Longitudinal Care and Treatment Surveillance activities and planning and implementation for nationwide population-based surveys including KENPHIA and the IBBS.

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Beatrice Matanje-Mwagomba is a Public Health Physician with a Medical Degree, an MSc in Epidemiology and over 10 years of experience in health management, including 5 years (2012-2017) as National NCD Control Program Manager for Malawi. She is currently (since March 2017) a Medical Director at Lighthouse Trust in Lilongwe, Malawi and also a PhD Fellow in a joint Global Health Implementation Program at University of St Andrews, Scotland and College of Medicine, Malawi.

Felix Mwanza is the National Director of the Treatment Advocacy and Literacy Campaign (TALC), a leading civil society organization in Social Mobilisation in Zambia that promotes equitable access to HIV treatment for people living with HIV. He is an international HIV/AIDS activist and has vast experience in mobilizing resources for program implementation at national and international levels. He holds a Diploma in Computer Science and a BA in Social Work and previously worked as an Information Technology (IT) Specialist.

Tonderai Mwareka is a social scientist who has supported HIV/AIDS programming since 2003. Mr. Mwareka has experience in program design, implementation, management, M&E, research and resource mobilization. He is currently a Programme Officer with the Zimbabwe National Network of People Living with HIV (ZNNP+) and is responsible for coordinating and representing the interests of PLHIV throughout Zimbabwe. Mr. Mwareka's DSD work includes working with PLHIV and ZNNP+ Provincial Coordinators to roll out models of care such as Family Centered care, appointment spacing, fast-track and facility adherence clubs. In 2018, he led research on community monitoring/surveillance on enablers and barriers to differentiation of service. Mr. Mwareka has a BSc. in Psychology from the University of Zimbabwe and is currently pursuing a Master's degree in Child Rights and Childhood Studies at Africa University.

Keith Mweebo is a Public Health Specialist in PMTCT/ART at CDC Zambia. He works with implementing partners to support adult HIV treatment, including DSD; is lead activity manager for two CDC-funded treatment partners; and is a member of the DSD committee. He spent six weeks as experiential attachment at TASO Uganda to implement DSD (Community Drug Distribution).

Afework Negash served as program officer since 2006 at different international Non-Governmental Organizations for the implementation and scale up of comprehensive HIV AIDS services in Ethiopia. Since 2009, he has been serving at a capacity of HIV/AIDS care and support advisor at USAID/PEPFAR.

Bibole Ngalamulume is a Senior Project Officer at ICAP New York. She specializes in project management and serves as the primary project interface between ICAP's field operations in selected countries and the organization's technical, grants management and administrative support platform in New York. She provides broad managerial support to the development, implementation, and evaluation of diverse health projects in Sub-Saharan Africa. Prior to her current role, Ngalamulume spent two years as Program Quality Manager at Catholic Relief Services. During this time, she provided technical and operational support to the health program portfolio in eastern DR Congo. She has a MPH and over 15 years of experience in public health disease intervention program development, implementation, monitoring, and reporting and documenting best practices in developing countries.

Stanley Ngoma studied at the Warwick Medical School. He has 8 years of experience in HIV program management and is presently working in the Malawi Ministry of Health Department of HIV and AIDS, where he is a program officer for HIV treatment, care and support. He is a focal point person for Differentiated Service Delivery Models (DSDM). He is a member of the National HIV Technical Working Group and has participated in the development of national HIV guidelines, policies, tools and job aides/SOPs to promote and standardize good clinical practice within the national HIV treatment and care program.

Boniface Nguhuni is a medical doctor who graduated from Muhimbili University of Health and Allied Sciences (MUHAS) in Dar es Salaam, Tanzania in 2008. He also holds a Master's of Science in Infectious Diseases from the London School of Hygiene and Tropical Medicine of the University of London. He has over 8 years' experience in clinical practice as a general practitioner and an HIV physician. He has also been involved in a number of operational research studies on HIV, TB, emerging and re-emerging infectious diseases and healthcare-associated infections. He has worked as Project Coordinator for the Italian National Institute for Infectious Diseases, Lazzaro Spallanzi. Currently, he is a Program Coordinator for HIV/TB and the Global Fund at the Division of Health – President's Office Regional Administration and Local Government in Tanzania.

Brooke Nichols is a health economist and mathematical modeler with 10 years' experience in HIV research. She is currently a Research Scientist in the Department of Global Health at Boston University and is based at the Health Economics and Epidemiology Research Office (HE2RO) in Johannesburg, South Africa. She holds a Master's of Science in epidemiology from the University of Massachusetts Amherst, and a PhD in mathematical modeling and health economics from the Erasmus Medical Center in the Netherlands. Her area of expertise is in the combination of local data with optimization modeling for both improved program delivery and policy decisions, within the HIV testing, PrEP, viral load scale-up, and differentiated care spaces.

Frehiwot Nigatu is a medical doctor and the Community Service Delivery Director at Project Hope in Ethiopia. Prior to joining Project Hope, Dr. Nigatu worked for the Ethiopian Federal Ministry of Health as the National HIV/AIDS focal. Dr. Nigatu attended medical school at Jimma University.

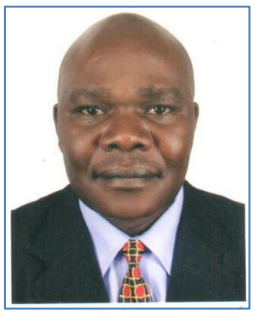
Rose Nyirenda is the Director of the HIV Treatment Unit in the Ministry of Health in Malawi. She is a Community Health and Interprofessional Health Care Leadership Specialist. Currently a PhD candidate at the University of Malawi, her previous assignments include working as a Director of Mzuzu Referral Hospital in the northern region of Malawi, heading the Ministry of Health's Community Health Nursing program, and acting as Nurse Educator and Principal of a Nursing College. She is a researcher and was a Principal Investigator of the EARNEST ART clinical trial; she is currently a member of the National Health Research Ethical Review Board in Malawi. Her achievements have been the accreditation of the Mzuzu Central Hospital laboratory (SLIMTA) with 3-star status, and accreditation of the hospital in Standards-based Infection Prevention and Reproductive Health Standards. She received a special award of recognition on Leadership in Quality improvement from JHPIEGO in 2013. Ms. Nyierenda is also a member of the CQUIN Advisory Group.

Velephi Okello holds a degree in Medicine from Mbarara University in Uganda and a MPH degree from Harvard University. She is currently the Deputy Director of Health Services in charge of clinical services at the Eswatini Ministry of Health. Dr. Okello was in charge of the HIV Care and Treatment Programme at the Eswatini National AIDS Programme (SNAP), where she spearheaded policy changes to ensure access to quality ARV medicines for people living with HIV (PLHIV) in Eswatini.

Not Pictured

Nelson Onekalit is the Community Coordinator for the URC Acholi Project in Uganda.

Dennis Osiemo is a medical doctor working for Aya Ziwani as the Senior Technical Advisor Care and Treatment, TB, and PMTCT. His organization is a PEPFAR/USAID-funded program working in five counties in the Nyanza region in Kenya. Dr. Osiemo has 10 years' experience supporting programs implementing HIV service delivery and support. He has a MSc in Public Health (Health Services Management) from the London School of Hygiene and Tropical Medicine.



Nelson Juma Otwoma is a long time AIDS and TB advocate with keen interest in TB and HIV prevention and treatment. He advocates for better, safer, cheaper HIV and TB diagnostics and medicines. He has over 15 years' experience working with networks of people living with HIV (PLHIV) and the affected communities in Kenya. He is currently the Executive Director, the National Empowerment Network of people living with HIV/AIDS in Kenya (NEPHAK) where his main role is to provide strategic, accountable and committed leadership to ensure the visibility and voice of PLHIV and affected communities in the response to HIV. He belongs to a number of national, regional and global bodies and structures that work to reduce the spread of HIV and TB. He is member of the Kenya CCM to the Global Fund as well as member of the Kenya HIV Tribunal.

Sara Page-Mtongwiza is a Health Education- Health Promotion Specialist with over 17 years' experience in the field of HIV/AIDS prevention, care and treatment, gender and development in sub-Saharan Africa. As a writer, facilitator and researcher, she has developed and contributed to a wide range of regional policies, programs and publications related to HIV prevention, treatment literacy, and care, as well as food security/nutrition, maternal and child health, and sexual and reproductive health. In her previous capacity as Deputy Director of SAfAIDS (Southern Africa HIV and AIDS Information Dissemination Service), Sara led the development, management and mobilisation of resources for a range of national and regional health and development programs. She is passionate about using new media and information technologies for improved health promotion, development, knowledge management, behavior change communication. In her current post as Director of Programs with OPHID Trust, Sara manages a consortium of partners providing technical support in HIV Care.

Peter Preko is the Project Director for ICAP's CQUIN Learning Network. Dr. Preko started his career in HIV work as the CEO and co-founder of AIDS ALLY, a local NGO that provided care and treatment in Ghana before national HIV treatment programs started in Africa. Prior to his current role, he was with I-TECH – University of Washington, seconded to the Malawi Ministry of Health as the Senior HIV Care and Treatment Advisor. Dr. Preko worked with CDC Eswatini from 2011 to 2016 as the PEPFAR Eswatini Care and Treatment Lead. Before joining CDC, he was the Senior Care and Treatment Specialist at ICAP in Eswatini. In Ghana, before moving to Eswatini, Dr. Preko was the Senior Program Manager (HIV/AIDS) at AED-SHARP and Engender Health respectively. Dr. Preko obtained a BSc in Human Biology and medical degrees from the Kwame Nkrumah University of Science and Technology and an MPH from the London School of Hygiene and Tropical Medicine.

Miriam Rabkin is the principle investigator for the CQUIN project at ICAP. She has worked in the field of HIV/AIDS for 20 years, focusing on strengthening health systems to improve the delivery of prevention and treatment services for underserved populations. Dr. Rabkin is an associate professor in epidemiology and medicine at the Mailman School of Public Health, and director for health systems strategies at ICAP. At ICAP, she focuses on strengthening health systems, improving access to HIV services in resource-limited settings, and the design, delivery, and evaluation of chronic care programs for HIV and non-communicable diseases. Dr. Rabkin's current research focuses on implementation science, and on ways to leverage the successes and lessons of HIV scale-up to strengthen broader health systems, to enhance the quality of programs for HIV, maternal/child health, non-communicable diseases, and infection prevention and control (IPC) in sub-Saharan Africa, and to improve refugee health services in Turkey, Jordan, and Lebanon.

Not Pictured

Angela Ramadhani is the Program Manager at the Ministry of Health and Social Welfare and National AIDS Control Program in Tanzania.

Bill Reidy is a Senior Strategic Information Advisor at ICAP and an Assistant Professor of Epidemiology in the Mailman School of Public Health at Columbia University. He has more than 15 years of experience in HIV/AIDS program implementation, research, and evaluation. Dr. Reidy's work has taken place in the United States and internationally—primarily in sub-Saharan Africa—with a wide range of populations. In his current role at ICAP, he is an investigator or collaborator on numerous studies and projects with

aims to optimize HIV/AIDS programs, and has provided key support for implementation of large-scale or targeted government-led HIV/AIDS programs in countries including Eswatini, Myanmar, South Africa, Tanzania, and Kenya. As a collaborator on several US Government-funded grants, he worked extensively on designing and implementing efforts to use routinely-collected data from health records to assess the performance of HIV programs, including HIV testing and care and treatment, prevention of mother-to-child HIV transmission, and HIV prevention, including HIV pre-exposure prophylaxis services.

Sydney Rosen is Research Professor in the Department of Global Health of the Boston University School of Public Health and the Co-Division Head of the Health Economics and Epidemiology Research Office (HERO) of the Wits Health Consortium at the University of the Witwatersrand in Johannesburg, South Africa. She is a health economist and policy analyst who has conducted research on the outcomes, costs, and benefits of health interventions in resource-constrained countries in sub-Saharan Africa for 16 years. In collaboration with HERO and colleagues at BUSPH, she leads an interdisciplinary team that is carrying out a set of studies on HIV/AIDS care and treatment, tuberculosis case finding and treatment, and noncommunicable chronic diseases.

Mastidia Rutaihwa is the Pediatrics and Adolescent Program Officer at National AIDS Control Program (NACP) under the Ministry of Health, Tanzania. At NACP, Dr. Mastidia is a focal point for the implementation of policies, guidelines and standards for comprehensive HIV/AIDS services for children and adolescents. Dr. Mastidia also leads the development of guidelines, operational manuals and job aides for the rollout of national DSDMs. She previously worked as a research scientist and principal investigator in clinical trials at Ifakara Health Institute, which is affiliated with the Swiss TPH in Basel, Switzerland. She was formerly a District Chief Medical Officer and holds a masters in Internal Medicine from Muhimbili University and Allied Sciences.

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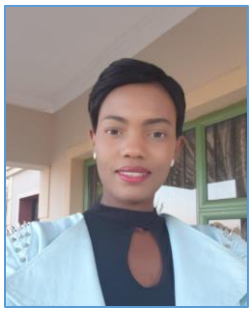
Caroline Ryan is the Country Director at CDC, PEPFAR in Eswatini.

Ruben Sahabo has been the country director for ICAP in Eswatini since 2011. Previously, he was the ICAP country director in Rwanda, where he led the rapid expansion of care and treatment activities, overseeing technical and financial assistance to over 50 urban and rural clinics that enrolled over 50,000 patients enrolled in HIV care and treatment. He also supported the start-up of ICAP's programs in Cote d'Ivoire in 2008 and the Democratic Republic of Congo in 2010. Dr. Sahabo has managed numerous program evaluations and research studies in Rwanda and Eswatini.

Aji-Mallen Sanneh is a Project Specialist-HIV Program Quality and Efficiency with the Global Fund to Fight AIDS, Tuberculosis and Malaria, where she coordinates the design, application, evaluation and improvement of program quality and efficiency by supporting the roll-out of differentiated service delivery models in Global Fund priority countries. She also serves as the coordinator and focal point of the HIV Situation Room to leverage technical and programmatic support with partners such as PEPFAR, UNAIDS and the WHO for the implementation of Global Fund grants. Prior to joining the Global Fund, Ms. Sanneh served as Senior Manager for the American Society for Clinical Pathology (ASCP), managing quality improvement programs in laboratories across PEPFAR countries. Preceding ASCP, she worked for Management Sciences for Health (MSH) to support Principal Recipients and Country Coordinating Mechanisms in managing their Global Fund activities at the country level. Her interests include HIV quality improvement, health financing, maternal and child health and health system strengthening. Aji-Mallen holds a joint master's degree in Health Policy, Planning & Financing from the London School of Hygiene and Tropical Medicine (LSHTM) and the London School of Economics and Political Science (LSE).

Andrea Schaaf is a Strategic Information Specialist at ICAP in New York, where she supports CQUIN's portfolio of "differentiated M&E" activities. In addition to coordinating a facility-level survey of DSD scale-up in 11 countries, Andrea works with the CQUIN M&E team to provide technical assistance on M&E of DSD to ministries of health, and to backstop provincial DSD review meetings. Andrea joined the CQUIN project following her graduation from the MPH program at the Mailman School of Public Health at Columbia University.

Tanya Shewchuck is a Senior Program Officer for Integrated Delivery at the Bill and Melinda Gates Foundation. Prior to joining the foundation, she was one of the Project Directors for ACTwatch. Before that, Tanya was responsible for Somalia's Global Fund Malaria Control Program (2005-2009) through UNICEF, and managed the transition to artemisinin-based combination therapy and rapid diagnostic testing services amongst by collaborating with a variety of governments, research bodies and non-governmental organizations. From 1997 to 2003, she worked for MSF in various capacities including as country director in emergency and post-conflict settings such as DRC and South Sudan. Over the course of her career, she has also provided consultant support to projects and organizations mainly in East Africa including Oxfam and VSF. She holds a joint MSc from the London School of Economics and the London School of Hygiene and Tropical Medicine.



Siphiwe Mabaka Shongwe is a CQUIN Clinical Advisor based at ICAP Eswatini. She has a Master's degree in international public health from the University of New South Wales, Australia and a nursing degree and midwifery certificate from the University of Swaziland. She has worked in different non-governmental organizations and also for the Ministry of Health, providing clinical services including HIV prevention and treatment and comprehensive sexuality education, as well as working in public health research. From 2009 – 2012, she worked for the MOH at the Mbabane public health unit as a nurse and midwife, then joined the World Bank as a project officer for the Maternal, Neonatal and Child Health project. She joined World Vision Eswatini as a TB/HIV project coordinator in 2015 before joining ICAP Eswatini as a research advisor.

Chimuka Sianyinda is currently working at the Zambia Ministry of Health as a Strategic Information Officer. He holds a Bachelor of Arts in Demography and Economics and a Master of Arts in Demography both obtained from the University of Zambia. He has received several professional certificates in topics such as monitoring and evaluation, quality improvement, quality assurance, and spectrum estimates. He has been involved in HIV programs ranging from HIV case-based surveillance to self-testing.

Izukanji Sikazwe is the Chief Executive Officer at the Centre for Infectious Disease Research in Zambia (CIDRZ). Dr. Sikazwe earned her medical degree from the University of Zambia, School of Medicine in 2002. She completed Internal Medicine specialty training at the Good Samaritan Hospital in Baltimore, Maryland and Infectious Disease specialty training at the University of Maryland. She has a Master's degree in Public Health from Michigan State University. Dr. Sikazwe has worked for several years providing direct clinical patient care to people living with HIV and other infectious diseases in both urban and rural communities in Zambia. She continues to practice clinical medicine at the Adult Infectious Disease Centre of Excellence at University Teaching Hospital. She served as the technical advisor to the Zambian Ministry of Health National ART program from 2010 - 2012. In addition to her executive management role as the CEO of CIDRZ, Dr. Sikazwe is the Principal Investigator of a PEPFAR/CDC-funded HIV Care & Treatment cooperative agreement focused on transitioning HIV programs to the Ministry of Health. Dr. Sikazwe has special research interests in HIV and seizure disorders as well as implementation research focused on improving access and outcomes of patients in ART care and treatment programs.

Khulekani Similane has 10 years of experience overseeing Monitoring and Evaluation (M&E) aspects of HIV/AIDS prevention and treatment programs in eSwatini. He joined URC-CHS in September 2018 where he holds the position of M&E Advisor. Previously, he worked as the Associate M&E Advisor for Elizabeth Glazer Pediatric AIDS Foundation (EGPAF) in eSwatini, Mr. Simelane leads reporting efforts, supports data quality and validation initiatives, and supervises Regional M&E Improvement Officers and Health Information Management Associates in carrying out clinic-level data collection activities. Prior to working for EGPAF, Mr. Simelane worked on PEPFAR projects under The Diocese of Manzini/Roman Catholic Church as well as Save the Children Swaziland. Under the Roman Catholic Church, he supported HIV data collection activities as an M&E Officer. Prior to this, Mr. Simelane worked as an M&E Assistant for Save the Children in eSwatini, where he supported the M&E team to design, direct, implement, and evaluate PEPFAR initiatives across the nation, ensuring regular communication across field offices and staff levels.

Maureen Simwenda is the Director of Clinical Services on the USAID funded *Supporting an AIDS Free Era* (SAFE) project being implemented by John Snow Inc (JSI) in Zambia. She graduated with a Bachelor's Degree in Medicine and General Surgery from the University of Zambia in 2006. She also specialized and graduated with a Master's Degree in Pediatrics and Child Health from the same university. Prior to joining JSI, she worked for the Ministry of Health as a medical officer and pediatrician and was involved in clinical research. She also worked for the Elizabeth Glaser Pediatric AIDS Foundation, where she served in different positions including Research Advisor, Clinical Advisor and Country Program Manager. Maureen is currently a member of the DSD task force, a subcommittee of the National HIV Technical Working Group.

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Hiwot Solomon is a Director at the Disease Prevention and Control Directorate of the Federal Ministry of Health in Ethiopia.

Alain Somian is a lawyer by training and has been involved in the fight against HIV and AIDS since 2006. He is one of the first community actors to form an HIV alliance and to contribute to the national response in Côte d'Ivoire. He has been a representative of QAYN in Côte d'Ivoire for the mapping of social justice advocacy actors in West Africa and Cameroon, and a member of the National Committee on Research Ethics in Côte d'Ivoire. At present, he is the Executive Director of the Ivorian Network of Organizations of People Living with HIV and coordinator of the Project RIP + Alliance CI NMF2 Global Fund.

Cleopatra Sokhela is Head of Strategic Information, University of Witwatersrand: Wits Reproductive Health and HIV Institute (Wits RHI). Cleopatra has 16 years of combined experience in the health care sector and HIV/TB programmes, serving in various capacities within government, the private sector and NGOs in South Africa. Cleo leads the Strategic Information, Decanting and Pharmaceutical team under the Wits RHI Health Systems Strengthening (HSS) project, funded by USAID PEPFAR with the aim to improve HIV/TB outcomes in South Africa. Cleo has contributed to streamlining of the HSS project's primary interventions which include the provision of technical and direct service support as well as capacity building to the Department of Health (DOH) at province, district and facility level. Recently, Cleo has been part of the CQUIN P@HR community of practice team that developed the CQUIN P@HR CoP Tool, and supports the National Department of Health Care and Treatment programme.

Martin Ssuuna is a Ugandan Public Health Specialist with over eight years' progressive experience in supporting health system strengthening efforts towards HIV/AIDS epidemic control. He is involved in design, implementation and monitoring of large-scale HIV/AIDS care programs in rural and urban settings in Uganda. He is the current Regional Manager for the PEPFAR/CDC-funded Kampala HIV project at the Infectious Diseases Institute, Makerere University. He's charged with leading day-to-day project implementation efforts in line with standard guidelines, policies and scientific evidence; supporting efficient and data-driven programming of comprehensive HIV/AIDS services through District, health facility and community efforts; guiding capacity building initiatives (including operational research) and development of service delivery models that address improvements in the overall HIV/AIDS care continuum. He is involved in several outreach programs directly supporting over 200,000 HIV/AIDS patients spread across 17 Ugandan districts including Kampala City.

Maureen Syowai is a HIV Care and Treatment Advisor at ICAP Kenya, where she supports the OPTIMIZE project, a consortium using innovation and partnership to accelerate the introduction of better, less expensive antiretroviral treatment (ART) regimens for HIV patients in low- and middle-income countries. Dr. Syowai is a physician and public health specialist. In her previous role at ICAP, she worked to support the Kenyan Ministry of Health National AIDS Control Program to design, implement, and monitor DSD for HIV in Kenya. Within CQUIN, Dr. Syowai supports south-to-south learning and knowledge exchange focused on the implementation of differentiated care programs.

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Anani Tesfaye is a member of the National Network of Positive Women in Ethiopia.

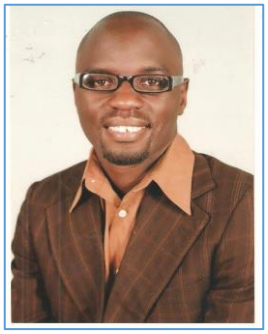
Peris Urasa works for Tanzania's Ministry of Health, Community Development, Gender, Elderly and Children. She is a public health professional and a Programme Officer for HIV Testing Services at the National AIDS Control Programme (NACP). She provides leadership and oversight of the HIV Testing Services programme for diverse population groups. She has led and provided guidance for introducing new initiatives in HIV Testing Services programming that included provider-initiated testing and counselling (PITC) and Community HIV Testing services, and is now introducing Non- Health HTS providers to support HTS, Index testing, and Partner notification services. She also coordinates HIV Self Testing Implementation Science in the country and its TWG.

Marilena Urso is the HIV Treatment Teal Lead at CDC Mozambique.

Greet Vandebriel is a medical doctor specialized in tropical medicine and public health with advanced training in TB and TB/HIV management and quality improvement. She has 20 years of experience providing clinical health care in Africa, serving for five years as a medical officer at the General Reference Hospital in Walungu in the Democratic Republic of the Congo, for five years as a resident technical advisor to the Ministry of Health in Rwanda responsible for integration of TB and HIV programs and services, supported by both ICAP at Columbia University and the Damien Foundation. For 5 years she served as the Technical Director for ICAP in Rwanda and since 2014 has worked as the Technical Program Director for ICAP in Cote d'Ivoire.

Not Pictured

Sambu Vereyh is a Strategic Information Specialist for the Ministry of Health in Tanzania.



Jeffery Walimbwa is the Program Manager at ISHTAR MSM Kenya. Mr. Walimbwa has been working at ISHTAR-MSM, a community-based organization that advances the sexual health rights of men who have sex with men. ISHTAR MSM aims to reduce stigma and discrimination for MSM by advocating for their rights to access health care, including STI/HIV and AIDS-related care and treatment. ISHTAR-MSM is a member group of The Gay & Lesbian Coalition of Kenya (GALCK). As Program Manager, Mr. Walimbwa has taken part in various activities on advocacy, policy and strategy formulation, and analysis. He is experienced in evidence-based HIV and sexual health programming and has sat on a variety of technical working groups at the national level. He has a keen interest in community research and is a Co-Chair of the G10 a research agency at the Gay and Lesbian Coalition of Kenya.

Not Pictured

Rebecca Wangusi is a Medical Doctor working at UMD in Kenya.

Bilaal Wilson is an HIV Support, Care, and Treatment Senior Program Officer in Malawi`s Ministry of Health. He is part of the team that formulates; implements, and monitors HIV/AIDS policy in Malawi. Dr. Wilson is also part of the team that provides support and clinical guidance on HIV/AIDS related issues and has previously worked as a general practitioner in Malawi`s main central hospitals (QECH, KCH).

Anteneh Worku is currently the Senior HIV Treatment Advisor within the HIV Team at USAID Malawi. Before joining USAID Malawi, Dr. Worku worked in various capacities at the Botswana Ministry of Health, USAID Ethiopia, and the University of Gondar. He is a Medical Doctor and has an MSc in Information Science.

Isaac Zulu is a Medical Epidemiologist on the Adult HIV Treatment Team, HIV Care and Treatment Branch (HCTB) of the Division of Global HIV/AIDS and Tuberculosis at the U.S. Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia. He joined the Division of Global HIV/AIDS in 2012 and co-leads the Service Delivery Unit of the HCTB. Dr. Zulu is also a member of the Epidemic Control Leadership Team under the Office of the Global AIDS Coordinator. Before moving to CDC-Atlanta, Dr. Zulu was the Branch Chief of the Prevention, Care and Treatment Branch at CDC Zambia. Dr. Zulu trained as a medical doctor graduating with a Bachelor of Medicine and Surgery (MBChB) degree from the University of Zambia in 1989, has specialty training in internal medicine with a Master of Medicine in Internal Medicine (MMed) degree from the University of Zambia, and a Doctor of Medicine (MD) degree in Gastroenterology from Queen Mary College, University of London, United Kingdom (2008). He obtained a Masters' degree in Public Health (M.P.H.) at the University of Alabama, at Birmingham, USA, in 2002. Dr. Zulu served as Clinical Chair (2004-2006) and Consultant (Attending) Physician (1999-2006) in the Department of Internal Medicine, University Teaching Hospital (UTH), Lusaka, Zambia. He is an internationally recognized public health leader, clinician and researcher who has co-authored more than 50 articles in peer reviewed scientific journals. Dr. Zulu is also a member of the CQUIN Advisory Group.

Paul M. Zulu is an infectious and tropical diseases physician at the University Teaching Hospital in Lusaka, Zambia. As an Infectious and tropical diseases physician his duties involve follow up of patients with infectious diseases including HIV, Malaria, other neglected tropical diseases. He actively serves on various infectious diseases programs including the running of the HIV third-line antiretroviral clinic at University Teaching Hospital. He participates in the national epidemic preparedness committees and is currently doing research on the treatment outcomes of multi-class ART-experienced HIV patients on third-line ART. He is a member of the national task force for the implementation and scale-up of differentiated service delivery models of HIV to improve patient treatment outcomes in Zambia.

Khozya D. Zyambo is a paediatrician, researcher and manager of primary health care services in Zambia's Lusaka district, composed of 52 health facilities. He is involved in overall supervision and coordination of the HIV program and the different partners implementing DSD models within the district. He is currently working as a research physician on the SHINE multicentre trial "short course therapy for minimal TB in children" and is a GBV and adolescent health care advocate involved in policy formulation, care, and capacity building.

DSD Model Posters

View All

Measuring Uptake of ART Scholar Model in 3 Provinces in Zambia. An Analysis of Differentiated Service Delivery

Mpande M Mwenechanya[1] Helen B Mulenga[1] Muhau Mubiana[1] Mwansa Lumpa [1]Mwanza Wa Mwanza[1] Izukanji Sikazwe[1] Carolyn Bolton-Moore[1,2]Mwangelwa Mubiana[1]
[1]Centre for Infectious Diseases Research in Zambia [2]University of Alabama at Birmingham, US

REPUBLIC OF ZAMBIA

BACKGROUND/INTRODUCTION

- In Zambia, the aggressive scale up of ART to achieve the 90-90-90 global targets has resulted in over 800,000 adults and children accessing HIV care and treatment services[1]. Unfortunately, in the expansion of ART programs, adolescents and children remain an underserved priority population[2] resulting in significantly higher rates of loss to follow-up from HIV care and treatment compared to adults, which contributes to their comparatively poorer health outcomes[3]
- The Ministry of Health is promoting implementation of Differentiated Services Delivery in this population to better meet their needs and for better engagement by removing age-related barriers to care, developing new HIV testing modalities and improving management of transition from pediatric to adult care[4]
- Retaining young people in care requires strategies that target varying needs among adolescents and children while abiding by national HIV guidelines and health systems goals.
- The Scholar model is a facility-based model that operates within the ART clinic after regular clinic hours between 4-6PM during the week and Saturday and Sunday mornings when most scholars are out of regular school.
- This model offers its services in conducive environments free of adult patients, allowing providers to dedicate their time to this population. Clinicians are available to conduct symptom screening, patient assessments and provide on-going treatment plans including medication pick-up based on the scholars' needs and schedule. The model is designed to improve patient adherence and outcomes
- **OBJECTIVE:** To describe uptake of the Scholar model in Zambia using an implementation cascade for individuals offered.

METHODS

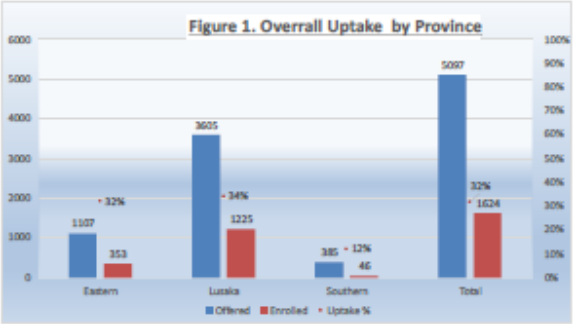
Setting: From April 2018, we began implementing the Scholar model in medium and high ART patient load (>1500) facilities in Lusaka, Eastern and Southern Provinces.

• **Population:** All school going children and adolescents (6-19 years) who's school schedules interfere with adherence to clinic appointments.

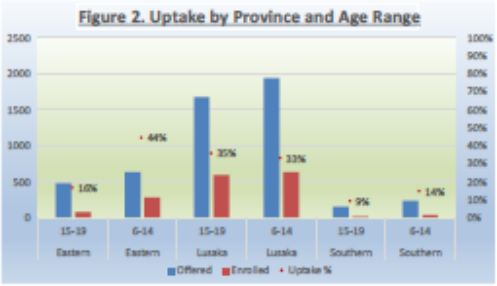
• **Data/Analyses**: We recorded number of persons that were: (a) Offered the model (b) enrolled into the model (c) Attended first pick up. We characterized uptake by documenting uptake to the model by age group (6-14years and 15-19 years) and sex (male and female)

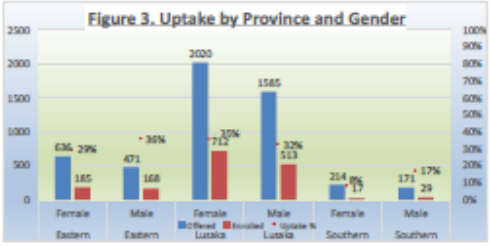
RESULTS

- From April to September 2018 19 facilities had began model implementation in Lusaka (11), Eastern (5) and Southern (3) Provinces.



RESULTS, continued





DISCUSSION

- Among the 5097 offered the model, 1624 (32%) enrolled by Sept 2018.
- Enrollments are ongoing, with Lusaka Province in the lead (1225, 75%)
- Enrollments were highest among girls (ranging 52-60%)
- Acceptance varied by age group (range 25-93%), with highest aceptance among 6-14 years olds
- Uptake was similar in Eastern and Lusaka Provinces (range 29-36%)
- Scholar uptake was lowest in Southern Province, as implementation only began in July 2018.
- Scholar model has demonstrated gradual but heterogeneous uptake across health Facilities in Zambia.
- Further operations research is required to investigate age-specific challenges with patient acceptance of the Scholar model to enhance the public health benefits of this model at scale

NEXT STEPS/WAY FORWARD

- Scale Up of enrolments within implementing facilities and expand coverage of the model by rolling to other facilities.
- Strengthen M&E systems to measure the impact of model at scale.

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3. Okoboi, S., et al., *Factors associated with long-term antiretroviral therapy attrition among adolescents in rural Uganda: a retrospective study.* Journal of the International AIDS Society, 2016. 19(5Suppl 4): p. 20841
4. Zambia Differentiated Service Delivery Operational Framework 2018

PEPFAR

CDC

The IDI-KCCA Community Pharmacy ART Refill Program

Martin Ssuuna[1], Shamim Nakade[1], Sarah Zalwango[2], Julius Mubiru[2], Daniel Okello[2], Lawrence Otim[1], Joanita Kigozi[1]

[1]Infectious Diseases Institute - College of Health Sciences, Makerere University; [2]Kampala Capital City Authority (KCCA)

BACKGROUND/INTRODUCTION

The Kampala Capital City Authority (KCCA) is the governing body of the Capital City and administers Kampala on behalf of the Uganda central government. KCCA is responsible for provision of social services to all city dwellers. The Infectious Diseases Institute (IDI) is the lead PEPFAR/CDC-funded implementing partner responsible for strengthening health systems for provision of comprehensive HIV/AIDS care in Kampala. Over 8 years, both KCCA and IDI have successfully led efforts towards the scale up of quality HIV/AIDS services within public HFs. This coupled with the steady supply of antiretroviral medicines has led to a significant increase in the number of HIV+ patients surviving and seeking chronic care. This surge strains the already limited resources (infrastructure and HR) resulting in high patient-provider ratios, congestion, and long clinic waiting time. These affect client retention and adherence to treatment. The stable PLHIV do not need frequent review; so the convenience with which they access ART needs to be continuously improved to guarantee favourable treatment outcomes. The IDI-KCCA community pharmacy ART refill program involves the use of selected private pharmacies to conveniently provide low frequency high quality HIV services (including ART refill) for qualifying stable clients under IDI-KCCA care. The partner pharmacies are; typically located along easy access routes, have operational licensure by the national drug regulatory bodies, are spacious to accommodate patient traffic, and secure enough to guard against burglary. Formal partnerships are guided by MoUs with clear roles and responsibilities and the model is regularly supervised by MoH and KCCA.

METHODS

Each patient's medicines is sourced from their respective primary KCCA health facility and delivered to the community pharmacy by IDI logistics teams. A total of four high volume HFs (>5500 active PLHIV) are linked to 6 pharmacies that are conveniently located within the City. Each pharmacy opens daily until late in the evenings and over the weekends and public holidays.

At their respective community pharmacy, each client is attended to by an IDI-supported nurse dispenser who:

- Refills free bimonthly doses of antiretroviral medicines for all clients
- Provides routine health education messages and sensitization
- Elicits medical complaints, screens for danger signs and manages minor ailments
- Appropriately refers clients for specialised care and management in HFs
- Tracks client appointments and follows up with those who miss scheduled visits
- Manages all program-related data (including inventory) and reporting activities.

Individuals visit their parent clinic every 6 months for clinical review and routine labs

Visit 1	Reviewed inclusion criteria, doctor visit, counsellor visit (regarding refill program and adherence), received refillable prescription (2 months supply)
Visit 2	Community Pharmacy refill visit (2 months supply)
Visit 3	Community Pharmacy refill visit (2 months supply)
Visit 4	Doctor visit, lab investigation, received refillable prescription (2 months supply)
Visit 5	Community Pharmacy refill visit (2 months supply)
Visit 6	Community Pharmacy refill visit (2 months supply)

RESULTS

Over a period of 21 months, a total of 8820 (2558 males) PLHIV have been enrolled onto this ART refill model. 99.4 % of all scheduled clients have successfully been able to refill their medicines, and 12-month retention in care for clients on this model is 98%. Over 99% of clients on this model are still virally suppressed.

FIGURE 1: IDI COMMUNITY PHARMACY ART REFILL PROGRAM CUMULATIVE MONTHLY ENROLMENTS

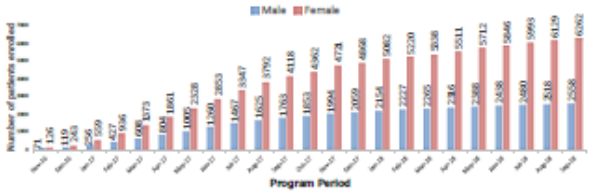


Figure 1: Shows monthly enrollment in program from November 2016 to September 2018.

FIGURE 2: CLIENTS DUE FOR APPOINTMENT VS CLIENTS WHO KEPT APPOINTMENT AT COMMUNITY PHARMACY

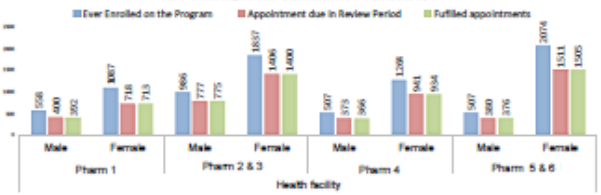


Figure 2: Indicates adherence to pharmacy refill appointments by gender

RESULTS, continued

Pharmacy Name	Individuals enrolled		# dropped [cumulative]		# ACTIVE	
	M	F	M	F	M	F
CE	287	1136	6	17	281	1119
SH	220	938	3	29	217	909
OA	446	793	2	7	444	786
AS	540	1044	7	17	533	1027
HE	558	1087	7	15	551	1072
AY	507	1264	10	25	497	1239
Total	2558	6262	35	110	2523	6152

Figure 3: Indicates the number of individuals who were initially enrolled in the program, the number of individuals who were dropped from the program, and number of individuals who remained active throughout the program.

The Community Pharmacy program has additionally addressed several issues;

- The case load per Health care worker per day has been reduced.
- The level of patient congestion within the KCCA health facilities has reduced
- Average patient waiting time has decreased from >3hrs to less than 1.5 hrs
- Has allowed for clients with conflicting work-clinic schedules to access chronic care. Such include; security personnel, bankers, shop attendants etc
- Improved adherence to clinic appointments among the PLHIV attending facility-based care

FIGURE 4: PROPORTION OF CLIENTS ACTIVE ON ART ENROLLED ON THE ARV REFILL PROGRAM

Indicator	Males	Females
No of PLHIV receiving services at the 4 HFs	8907	23736
No of PLHIV enrolled onto the Community pharm refill model	2558	6262
Proportion enrolled	29%	26%

Figure 4: Indicates the proportion of clients from health facilities on ART who are enrolled in the program

FIGURE 5: REASONS FOR DROPPING

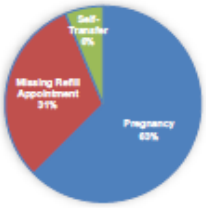


Figure 5: Indicates the proportion of individuals who dropped based on reason

DISCUSSION

This model of ART delivery demonstrates the enormous potential that exists in leveraging the private sector through public partnerships to accelerate efforts towards HIV epidemic control. Urban HIV care within resource-limited settings can still be optimized through continuous innovations and non-conventional multi-sectoral engagements. Approval and support for simplified HIV care is a universal desire among policy makers, program managers, HCW, leaders, patients and their families. The rapid increase in number of stable PLHIV enrolled onto this model over 21 months indicates high acceptability levels and flexibility among beneficiaries towards newer care approaches. Proportionately, the stable men have slightly higher preference (29%) for the IDI-KCCA community pharmacy ART refill program. This implies that continuous modification of existing service delivery models can allow for customization to meet the unique HIV care needs of difficult urban sub-populations. Quality of care can be improved, and adherence to standard treatment guidelines maintained through community-based service delivery models. Beneficiaries on the IDI-KCCA community pharmacy ART refill program have exhibited favorable treatment outcomes including sustained viral suppression (>99%), 12-month cohort retention rates of >98%, and appointment adherence levels of 99% and above. With the right measures in place, quality HIV care can still be made readily accessible to stable patient groups through differentiated urban community models led by supervised low cadre health care providers.

NEXT STEPS/WAY FORWARD

- Work with all key stakeholders to broaden the service package within the IDI-KCCA community pharmacy program to include condom distribution, Family planning commodities, chronic NCD care and medication, INH prophylaxis, HIVST kits, PREP services, and emergency PEP.
- Integrate mHealth technologies to facilitate real-time transmission of data between facility, community pharmacy, and the clients to inform timely patient management.
- Use this experience to develop hybrid community care models to attend to the unique needs of urban key populations for HIV prevention, care and treatment.
- Continue to engage with key stakeholders to address existing HR, policy, and regulatory obstacles that have slowed the scale up efforts of such non-conventional care models

PEPFAR CDC Makerere University KCCA

November 2018

Uptake of HIV services among Men who have sex with Men (MSM) at Ishtar MSM. Nairobi County

Authors: Jeffrey Walimbwa; ISHTAR- Kenya. Email: jwalimbwa@ishtarmsm.org

BACKGROUND/INTRODUCTION

ISHTAR MSM wellness Centre is a community urban clinic with diverse services such as free, confidential, non-judgmental routine HIV testing and counselling, STI screening and treatment, health education, condom and lubricants distribution and psychosocial support for Men who have Sex with Men in Nairobi County. The centre provides a clinical consultation and services at the community level that forms a building block for differentiated care model for key populations.

Objective: To demonstrate uptake of HIV testing services among MSM in Nairobi

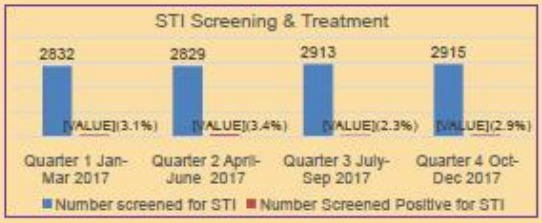
METHODS

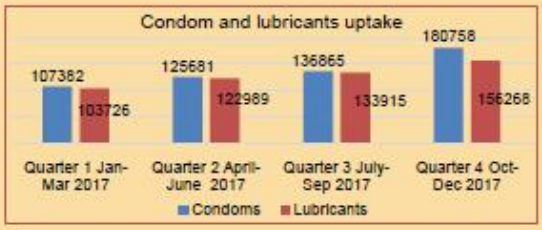
Ishtar has a robust peer education model that creates demand for health services, conduct information education for their peers, and distribute communication materials and commodities at both community and wellness level. Moonlight outreaches were conducted by the clinic at identified hotspots within Nairobi County. A comprehensive package of care that included HIV testing services, provision of condoms and lubes, and STI screening and treatment was provided where linkage and enrolment for HIV positives was done. Services were documented in standard MOH tools and where referrals done a follow-up internal tools were used. A review of records of MSM accessing HIV testing services at the ISHTAR wellness centre between January and December 2017 was done.

RESULTS

In quarter 1 Jan-March 2017, 2061 MSM were reached with HTS services where 61(3%) tested positive; in quarter 2 April-June 2017, 2087 MSM were reached with HTS services where 83(4%) tested positive; in quarter 3 July-Sep 2017, 2586 MSM were reached with HTS services where 38(1.5%) tested positive; and in quarter 4 (Oct-Dec) 2017, 2036 MSM were reached with HTS services where 14(0.7%) tested positive.

RESULTS, continued





Conclusion

Positivity among MSM still remains a challenge in HIV prevention. A robust peer model, clinical service provision at the community, is critical to increase access to HIV and SRH services to the key populations in public health facilities.

Mobile van in an outreach

November 2018

University of the Witwatersrand
WITS RHI

The implementation of iACT clubs in South Africa

Improving patient Antiretroviral Treatment (ART) outcomes through the implementation of iACT clubs in an Inner City healthcare facility, Johannesburg, South Africa

Authors: Mazvita Naome Mberi[1], Cleopatra Sokhela[1], Melanie Bisnauth[1], Cornelius Nattey[2], Gloria Maimela[1], Lee Fairlie[1], Sthembile Gombarume[3]

1. Wits Reproductive Health and HIV Institute (Wits RHI), University of the Witwatersrand, Johannesburg
2. Health Economics and Epidemiology Research Office (HE2RO), University of the Witwatersrand, Johannesburg
3. U.S Agency for International Development (USAID)

Background

ART adherence and retention in care are factors associated with viral load suppression (VLS) and are essential for sustainable HIV epidemic control, however, they remain a challenge globally.[1-4] Confidence and self-efficacy have been found to be associated with greater medication adherence.[1] The Integrated Access to Care and Treatment (iACT) program is a curriculum- based support group strategy which aims to empower newly diagnosed HIV infected individuals to effectively self-manage and actively engage with HIV healthcare services for better health outcomes.[5] This study aims to assess the effects of introducing iACT clubs on ART patient outcomes.

Method

Patients who tested HIV-positive and consented to join iACT clubs were taken through iACT curriculum in the first six months of taking ART, and managed as a club cohort for another six months (Fig.1). Patients that did not enrol into iACT were managed according to standard clinic practices. Programmatic Tier.net patient visit data, was exported to Excel and Stata and analysed. Odds ratios were calculated for various patient outcomes, and variables that were significantly associated with various patient outcomes were included in a multivariate logistic regression model.

Results Cont.

A total of 4569 preliminary patients' data was included in the analysis. The study population consisted of 66.2% females (2985/4569), with 27.7% (1249/4569) of the study population enrolled in iACT clubs. Regression results showed that the odds of being transferred out were higher in non iACT patients (OR: 2.64, p=0.040) while the odds of being "in care and on treatment" (OR: 0.24, p=0.000) and having VLS (OR: 0.55, p=0.001) were significantly higher in patients that were enrolled in iACT groups

More patients enrolled in iACT clubs were retained in care and on treatment than non iACT patients.

Conclusion

Preliminary data suggest that iACT program implementation results in improved retention and viral load outcomes in patients that enrol into the program. More robust studies are recommended to further strengthen this evidence. More patients enrolled in iACT clubs were retained in care and on treatment than non iACT patients.

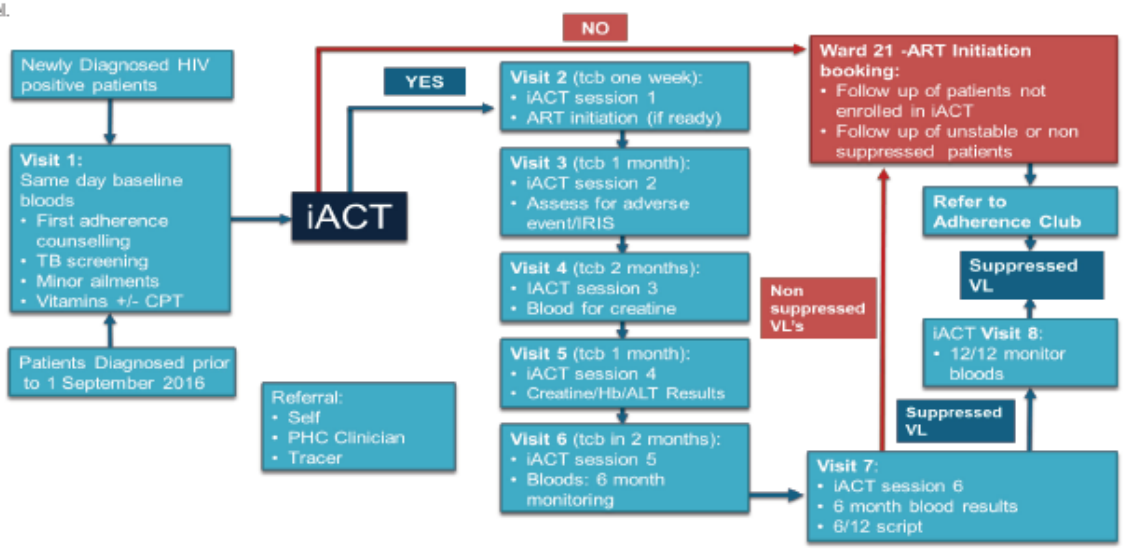


Figure 1: iACT Process Flow. HCHC.

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National Program Posters

View All

Implementing and scaling-up Differentiated Service Delivery requires Multi-sectoral Coordination Approach involving Collaboration Among Various Stakeholders including the Ministry of Health, Civil Society, and Implementing Partners

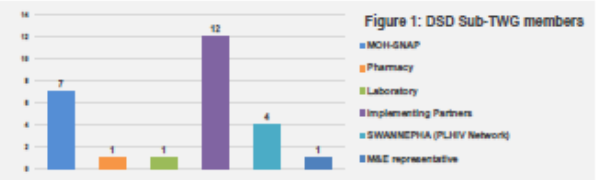
Hervé N. Kambale[1], Nomthandazo Lukhele[1], Nobuhle Mthethwa[1], Sindy Matse[1], Nompilo Gwebu[1], Themble Dlamini[1], Lydia Mpango[2], Bridget Mugisa[3], Victoria Masuku[3], Zororayi Madavirashe[4], Lorraine Pasipamire[4], Ian Kaayo[5], Gavin Khumalo[5], Allie Hughey[6]

1. Eswatini National AIDS Programme (SNAP), 2. AIDS Free, 3. University Research Co. LLC (URC), 4. Médecins Sans Frontières (MSF), 5. Eswatini Network of People Living with HIV/AIDS (SWANNEPHA), 6. Clinton Health Access Initiative (CHAI)

BACKGROUND/INTRODUCTION

The Kingdom of Eswatini is one of the few countries which has developed specific Guidelines and Standards Operating Procedures (SOPs) for Differentiated Service Delivery (DSD). Beside the fact that these specific documents are in place and used in health facilities, it has been observed through a baseline assessment conducted in December 2017 that clients are not actively enrolled into DSD, and a number of facilities preferred implementing only one DSD model, limiting or constraining clients to a particular DSD model. Scaling up DSD requires rigorous planning and innovative solutions to ensure high coverage and provision of high-quality services for people living with HIV (PLHIV). In October 2017, The Ministry of Health (MOH) recruited a focal person to coordinate the implementation and scale-up of DSD in Eswatini through a National DSD Sub-Technical Working Group drawn from the existing National Care and Treatment Technical Working Group (TWG), the team meets quarterly or as per request (refer to Figure 3). The DSD Sub-TWG had its first meeting in November 2017, and was tasked to conduct a baseline assessment to guide the design and implementation of a National DSD scale-up plan. The team included representatives from the following departments: Eswatini National AIDS Programme (SNAP), Pharmacy, Laboratory, PLHIV representatives, and Partners.

The figure below shows the proportion of DSD Sub-TWG members according to their institutions



METHODS

Cross sectional review of existing DSD Sub-TWG meeting reports, and baseline assessment and follow-up programme data as of September 2018

RESULTS

Through the work of the DSD Sub-TWG the Eswatini ART Programme has achieved the following:

- Developed a national scale up plan with targets to be achieved by March 2019, including the Roll-out of four DSD models including specific models for Key populations, OVC and AGYM.
- Developed indicators to be used for routinely monitoring DSD coverage and patients outcomes twice a year.
- PLHIV network (Swannepha) have been included in DSD Sub-TWG and are actively engaged at all implementation phases including, policy development, design of models, design of IEC materials and training curriculum, community mobilization and dissemination, monitoring and evaluation.
- All key implementing partners (IPs) are actively involved in the Sub-TWG.
- Paper based DSD registers have been printed and distributed to all implementing Facilities and the Electronic System (CMIS) have been upgraded to include DSD models.

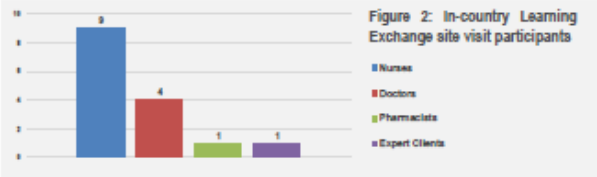
RESULTS, continued

- DSD indicators are routinely reported at regional and national data review meetings
- DSD modules have been included in Pre-service and in-service training curriculum
- DSD quality standards have been finalized and a pilot assessments have been conducted in selected facilities before roll-out

The Eswatini ART Programme has also initiated Quality Improvement initiatives consisting of in-country Learning Exchange to sites with high patient's coverage of DSD with good outcomes. This initiative is targeting sites with low coverage of DSD, and mentors from implementing Partners. The first learning exchange visit was conducted for FHI 360 mentors interested to learn how to conduct Outreach for KPs, and the second learning exchange targeted Doctors, Nurses, Pharmacists, and mentors from two ICAP supported sites interested to learn about integration of NCDs management into DSD. Details of the visits are provided in Table 1.

Table 1: In-country Learning Exchange site visit

Date	Visiting team	Host Site	# of Participants	Learning Goals	Outputs
13/06/2018	Doctor, Nurse, and HTS Counsellor from FHI 360, SNAP KP Unit	Mankayane Hospital	3	To learn how to conduct ART refills through Outreach model	Lessons learnt informed development of DSD for KPs SOPs
29/10/2018	Doctors, Nurses and Pharmacists from, RFM & Mankayane Hospitals, and ICAP mentors	Nhlangano Health Centre	13	To learn how to integrate NCDs and DSD	To develop facility specific SOPs to guide the integration of NCDs management in DSD models



DISCUSSION

Implementation and scale-up of DSD models should be coordinated by a multi-sectoral team, the leadership role of the Ministry of Health is key in the process, but the involvement and engagement of implementing partners and PLHIV networks should also be considered as a priority .

NEXT STEPS/WAY FORWARD

Eswatini through the DSD working group has planned to conduct a clients and HCWs satisfaction survey, this will include assessment of DSD cost vs mainstream care.

Scale up in-country DSD Learning Exchange site visit activities targeting low performing sites.

Sensitize Regional Health Management Teams and the four key regional partners on DSD

Expand QI for DSD project to all Hospitals and Health Centres, and two High volume Clinics

Figure 3: DSD Core Team Milestone Chart

November 2018

Taking Differentiated Service Delivery to Scale in Côte D'Ivoire: Phased Implementation to Achieve Impact

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BACKGROUND

The national implementation of DSD in Côte d'Ivoire began in April 2017 following the completion of national guidance on differentiated service delivery (DSD) by le Programme National de la Lutte Contre le Sida (PNLS). The national guidelines currently recommend the implementation of facility based models, detailed below, for stable patients. The PNLS is supporting the implementation and scale-up of DSD through a phased implementation approach that is monitored through training and continuous medical education at the regional, district, and facility levels. To maximize the impact of national implementation, the PNLS has enabled recipients of care to actively engaged in the development of DSD guidelines, as well as in DSD demand creation, through participation in national and sub-national DSD meetings.

At the community level, recipients of care have been instrumental in conducting patient education initiatives, including sensitization on the availability of DSD models. At the facility level, patient education on availability of DSD models is routinely conducted following a positive HIV test or during routine clinic follow-up visit. The PNLS has developed and integrated DSD related information into the national HIV monitoring and evaluation paper-based system particularly in the clinical check-list, monthly patient follow-up tool, DSD register as well as in the supervision sheet. Côte d'Ivoire has 20 regions encompassing 86 districts which through support from PNLS and seven implementing partners have successfully began the nationwide implementation and scale-up of DSD. Non-standard approaches are undertaken to assess patient and provider satisfaction at the facility level.

DSD MODELS OFFERED

The DSD models recommended by PNLS for implementation include the facility-based individual mode, **Dispensation Acelerée ARV** (Fast Track ART Refills). The features of this model include a reduction in the frequency of clinical visits to twice year, with shortened hospital waiting times for ART refill visits. The other model that has been adopted are the facility-based group model, **Club Observance** (Facility Adherence Clubs) where members attend health care worker-led group meetings at the health facility for ARV refill pickup, symptom screening, and psychosocial and adherence support. The PNLS is reviewing the feasibility of introducing community-based ART groups in Côte d'Ivoire .

DSD COVERAGE

As of end of June 2018, 856 out of 1,7533 (49%) health facilities in Côte d'Ivoire were implementing DSD services.

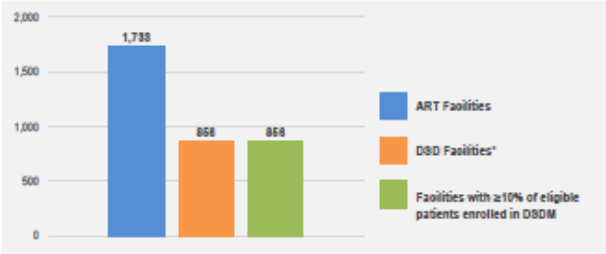

Figure 1: Facility Coverage of DSD for ART

The Patients eligible to be enrolled in a DSD model were 41,071 and of these, 30,518 (74%) had been enrolled in either the facility fast track or adherence club DSD models of care.

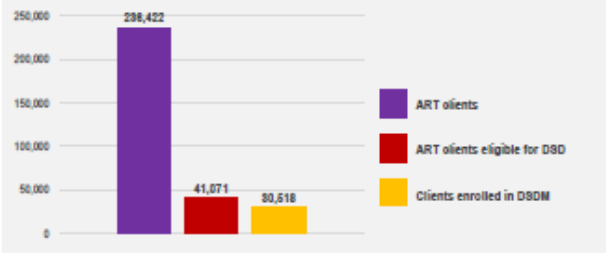

Figure 2: Patient Coverage of DSD for ART

DSD DASHBOARD

The CQUIN DSD Dashboard was used by Côte d'Ivoire to monitor the country's maturing DSD program. Across 13 domains, a five-step color scale was used to rank progress and performance—from red, indicating no activity, to dark green, indicating significant and robust implementation.

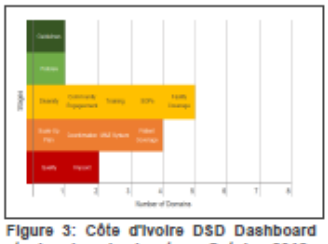

Figure 3: Côte d'Ivoire DSD Dashboard staging domains by stage, October 2018

In a systematic, inclusive staging process undertaken in October 2018, Côte d'Ivoire was found to meet the standards for the highest-possible ranking, dark green, in 1 of the 13 domains (Figure 3) and light green in an additional domain.

While Côte d'Ivoire remains in the early stages of DSD program development and scale-up, the country has made great strides in recent months, as described in Figure 4, which shows the staging of eight key domains in November 2017 and October 2018. In the domains of National Guidelines, Diversity of DSD Services, and SOPs, the country advanced two stages, indicating advancement from very early stages of development to a high level of achievement. Additionally, in the Scale-Up Plan and Training domains, the country made progress by advancing one stage.

As Côte d'Ivoire continues to make progress, repeated assessments using the DSD Dashboard will provide valuable information on achievements reached and highlight areas where challenges may require targeted attention.

Figure 4: Radar chart of Côte d'Ivoire DSD Dashboard staging, November 2017 and October 2018

LESSONS LEARNED

A number of lessons have been identified that PNLS believes could be of benefit to other countries just beginning to scale up DSD or those facing similar challenges.

Côte d'Ivoire found that the need for a structured approach to DSD implementation could not be overvalued. The country recently finalized the national DSD standard operating procedures (SOP) to support health care providers in the implementation of DSD, a process which was streamlined through a structured approach. As part of this strategy, upcoming capacity building activities for health care providers have been identified as necessary to be sustained to achieve the goals and objectives of DSD.

The need for a national scale-up plan is also demonstrated by the country's success. As of June 2018, 49% of the country's facilities were implementing the recommended DSD models according to the national DSD guidelines. These advances could not have been possible without scaling up the recommended models to additional facilities and patients.

Finally, while there has been active community participation in the development of policies, guidelines, and implementation, ongoing engagement is necessary. There are opportunities to expand engagement through involvement in community ART service delivery, regular assessment of the quality of care, and providing feedback at the national and sub-national levels.

NEXT STEPS/WAY FORWARD

In coming months, PNLS is leading a review on the implementation of DSD through the engagement of stakeholders by reviewing the recommended DSD models and considering expansion to other models, especially community based models of DSD. A DSD orientation program in addition to the national training of trainers is in development and other next steps include the development of a DSD implementation strategy and national scale-up plan. Côte d'Ivoire will continue to engage in the CQUIN network, as it has a keen interest in learning best practices in the implementation of community DSD models and how other countries are undertaking M&E for DSD.

November 2018

Taking Differentiated Service Delivery to Scale in Eswatini

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BACKGROUND

The Kingdom of Eswatini has made significant progress in the fight against HIV/AIDS, increasing the number of people living with HIV (PLHIV) on antiretroviral therapy (ART) to 174,103 (85%) with 91% viral suppression in 2017 (MOH 2017). The Eswatini Ministry of Health (MOH) through the Eswatini National AIDS Programme (SNAP) launched differentiated service delivery (DSD) in 2014, via pilot projects supported by Médecins Sans Frontières and ICAP. The MOH then developed and disseminated the National Policy Guidelines for Community-Centered Models of ART Service (CommART) Delivery in June 2016. A DSD technical working group (TWG) has also been established in November 2017, guiding and overseeing DSD implementation in the Kingdom of Eswatini, developing tools for monitoring and evaluation (M&E) of DSD, information education communication (IEC) materials and DSD protocols.

The training materials have begun to be used to train health care workers, including expert clients, to deliver high quality DSD services. As seen in Figure 1, 73% of nurses and 83% of Expert Clients (ECs) from ART units have been trained to implement DSD treatment models.

Figure 1. DSD training status of health care workers by cadre

DSD MODELS OFFERED

Eswatini offers both facility-based and community-based DSD treatment models (DSDM). Facility-based DSDM include **Fast Track, Teen Clubs, Facility Treatment Clubs for Adults,** and the **Family Centered Model**. Community-based models include **Community-Based Art Groups** and **Outreach Models**. In Eswatini, outreach models provide both ART initiation and ART refill services outside the facility in locations chosen to best reach and meet the needs of the specific population group.

DSD UPTAKE AND COVERAGE

DSDM is currently available in all 4 regions of Eswatini. The country has 153 ART facilities eligible to provide DSD and 123 of these (80%) offer DSD. All 123 DSD HF (100%) have enrolled at least 10% of DSD-eligible clients in a DSDM. Some facilities offer more than one DSDM, but facility uptake of DSD model varies by model type, with more facilities offering facility-based models than community-based models (Figure 2). The most commonly-implemented model is the Facility Treatment Club, which is available at 97 facilities, followed by Fast Track, offered at 71 facilities.

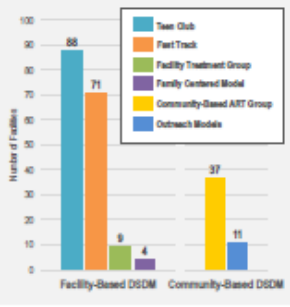

Figure 2. Facility uptake by DSM

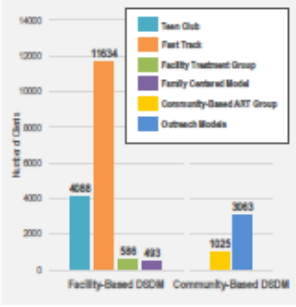

Figure 3. Client uptake by DSDM

Out of an estimated 134,906 clients eligible for DSD in the country, 20,889 (15.5%) are enrolled in a DSDM. Figure 3 describes client uptake of DSD by model type, illustrating that there is more client uptake of facility-based models than community-based and far more clients have enrolled in Fast Track (11,634 clients) compared to any other model type.

DSD DASHBOARD

The CQUIN DSD Dashboard measures DSD scale-up across 13 domains, using a five-step color scale to rank progress and performance—from red, indicating no activity, to dark green, indicating significant and robust implementation. The October 2018 staging process showed that Eswatini had the highest-possible ranking, dark green, in eight of the 13 domains (Figure 4), which reflects the high level to which the country has advanced DSD implementation.

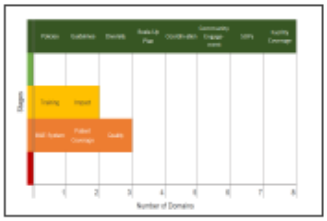

Figure 4. Eswatini DSD Dashboard staging domains by stage, October 2018

While Eswatini has identified three domains that are still in the early stages of scale-up (orange), progress has been made since the last DSD staging was completed in February of 2018. Figure 5 describes the staging of eight key domains at two different time points eight months apart. This chart highlights the extent to which Eswatini has achieved recent progress in the Scale-Up Plan and Community Engagement domains.

While it does appear that there has been a regression in progress for the Training and Impact domains, these discrepancies are artifacts of recent improvements to the staging process and are not reflective of actual backwards movement by the Eswatini DSD program.

With ongoing, regular assessments using the updated DSD Dashboard staging procedures, Eswatini will be able to better monitor the progress made in scaling up DSD, highlight the achievements made, and identify areas where remaining challenges may require targeted strategies to reach goals.

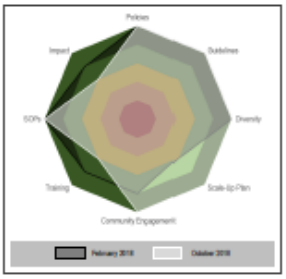

Figure 5. Radar chart of Eswatini DSD Dashboard staging, February and October 2018

OPPORTUNITIES FOR CROSS-BORDER LEARNING

While Eswatini has made great progress in further refining the operations of its DSD program, SNAP recognizes that it stands to benefit from the experience of other countries. To that end, three areas where Eswatini hopes to learn from other CQUIN member countries have been identified.

Eswatini faces challenges in enrolling clients with non-communicable diseases (NCDs) on DSD and would be eager to learn and explore best practices from countries that have implemented DSD models for non-stable clients. On a related note, DSD for key populations (KP) is another area where Eswatini would like to learn more, particularly how challenges related to the implementation of DSD for KP can be overcome.

Finally, Eswatini has learned that some countries have implemented drug distribution points to allow clients to collect ART refills outside of the health facility. This service is not currently offered in Eswatini and SNAP would be grateful for the opportunity to learn more about this from a country that has implemented it.

NEXT STEPS/WAY FORWARD

Following participation in a recent CQUIN-supported DSD quality improvement (QI) workshop in Malawi, Eswatini will pilot a QI project in 3 high-volume ART clinics with the aim to increase the proportion of eligible ART clients enrolled in DSD. Other QI-related initiatives include plans to conduct an in-country learning exchange to sites with high patient coverage of DSD.

In upcoming research initiatives, a protocol has been drafted to survey patient and health worker satisfaction with regard to DSD implementation and models offered.

ICAP · World Health Organization · Elizabeth Glaser Pediatric AIDS Foundation · Until no child has AIDS. · URC University Research Co., LLC · Médecins Sans Frontières · Clinton Health Access Initiative · SNAP

November 2018

Taking Differentiated Service Delivery to Scale in Ethiopia: A Focused Approach Leads to Rapid Expansion

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BACKGROUND

Ethiopia's Federal Ministry of Health (FMOH) launched national differentiated service delivery (DSD) in October 2017 with a focus on a single facility-based DSD model for stable patients. DSD oversight is provided by a technical working group (TWG) of the National HIV Prevention, Care and Treatment team within FMOH. Representatives of people living with HIV (PLHIV) are members of the DSD TWG and have been involved with policy development, guideline and standard operating protocol (SOP) development, demand generation and adherence support at the community level.

DSD MODELS AND COVERAGE

In contrast to countries in which multiple DSD models (DSDM) were launched at the same time, FMOH decided to prioritize one model, **Appointment Spacing**, pilot it at six hospitals, and then take it to scale nationwide. Ethiopia's appointment spacing DSDM is designed for stable patients, who are offered the option of having twice-yearly clinical visits, and to receive a six months' supply of ART at each visit.

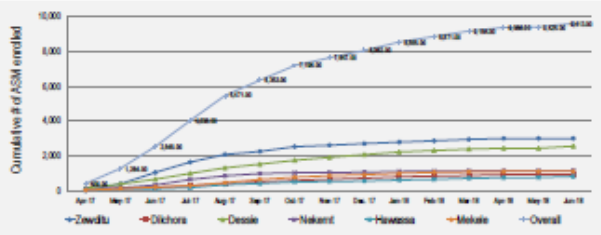

Figure 1: Enrollment in appointment spacing pilot project at 6 hospitals

The pilot project was supported by ICAP at Columbia University with support from CDC, and included systematic development of guidelines, training materials, job aides and client education materials, facility readiness assessments, drug quantification exercises, revised adherence counseling guidelines, and adaptation of M&E tools.

By October 2017, almost 7,200 patients had enrolled in DSD at six hospitals (Figure 1), and FMOH decided to take the approach to scale. By October 2018, appointment spacing was offered at 1,210 health facilities in all 11 provinces (Figure 2).

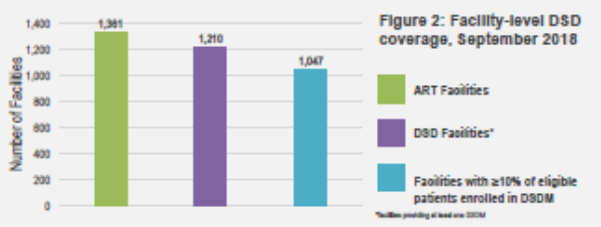

Figure 2: Facility-level DSD coverage, September 2018

DSD coverage at the patient level has expanded equally rapidly. Although the latest numbers are estimates, they suggest that more than 117,000 patients – 26% of all patients on ART in Ethiopia – had transitioned to the appointment spacing model as of October 2018 (Figure 3).

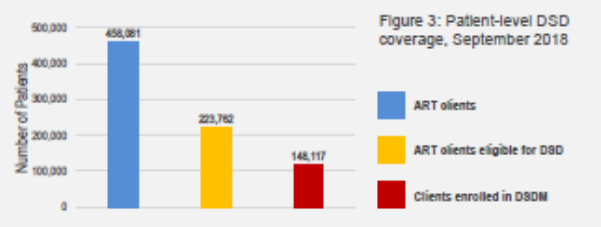

Figure 3: Patient-level DSD coverage, September 2018

In September 2018, a pilot of a second DSDM was launched, supported by Project Hope Ethiopia. This community-based group model consists of **Community Antiretroviral Groups (CAGs)** managed by Urban Health Extension Workers (UHEW).

DSD DASHBOARD

Ethiopia completed a CQUIN self-assessment dashboard exercise in October 2018. The dashboard includes 13 domains, and a five-step color scale is used to rank progress and performance—from red, indicating no activity, to dark green, indicating significant and robust implementation.

Ethiopia's performance was assessed as "dark green" or "light green" in 10 of 13 domains (Figure 4). The domain assessing diversity of DSDM models fell into the "yellow" zone, and the absence of data on quality or impact resulted in "red" scores in those domains, as it does in most CQUIN network countries.

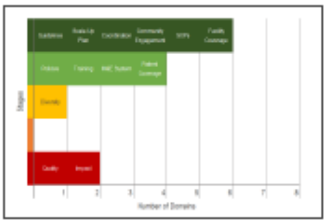

Figure 4: Ethiopia DSD Dashboard staging domains by stage, October 2018

Figure 5 compares the staging of eight key domains from assessments taken at two different time points: November 2017 and October, 2018. The greatest progress was found in the SOPs domain, with Ethiopia advancing from the yellow stage to dark green in only eight months. Other advances were found in four domains during this period: the diversity domain has advanced from orange to yellow; the scale-up plan and community engagement domains have advanced from light to dark green; the training domain has advanced from yellow to light green.

As Ethiopia continues to make progress in scaling up DSD and improving the national DSD program, regular assessments using the DSD Dashboard will provide valuable information on achievements reached and highlight areas where challenges may require targeted attention.

Figure 5: Radar chart of Ethiopia DSD Dashboard staging, November 2017 and October 2018

LESSONS LEARNED / NEXT STEPS

Ethiopia is unique amongst CQUIN network countries in its choice to launch a single DSDM and take it to national scale prior to diversifying models and approaches. Practical advantages of this strategy included the ability to create a comprehensive and standardized portfolio of guidelines, standard operating protocols, training materials and job aides, client education materials and M&E tools for use nationwide. This standardization, combined with effective engagement of recipients of care at both the policy and implementation levels, facilitated rapid scale-up, and the enrollment of more than 223,000 people on ART in the appointment spacing DSDM.

Key lessons learned included:

- A focused and standardized approach enabled rapid scale-up;
- Not all clients were interested in appointment spacing. In the pilot project, nearly 25% of eligible clients declined enrollment, with the most common reason being concerns about storage of six months' worth of ART. Concerns about this included fear of inadvertent disclosure and/or the safety and storage of this much medicine for prolonged periods of time.

Next steps include diversification of DSDM, including the launch of UHEW-led CAGs. A qualitative research study exploring client and provider reaction to appointment spacing will be conducted in 2019 with support from CQUIN.

November 2018

Taking Differentiated Service Delivery to Scale in Kenya: Improving HIV Service Delivery for All

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BACKGROUND

The Kenya Ministry of Health through the National AIDS and STI Control Program (NASCOP), provided guidance for the national implementation of differentiated service delivery (DSD) in July 2016. Populations prioritized to receive DSD models of care include adult patients on antiretroviral therapy (ART); stable children; and adolescents.

NASCOP has invested heavily in training health care providers on DSD and leading discussion of DSD activities during regional technical working group meetings and facility multi-disciplinary team meetings. NASCOP also hosts annual DSD experience sharing fora and a DSD symposium at the Kenya annual HIV scientific conference. In addition to government engagement in the DSD program, there is active involvement of the community of people living with HIV (PLHIV) under the National Empowerment Network of People Living with HIV/AIDS in Kenya (NEPHAK). Community representatives are involved in the design, implementation and monitoring of DSD.

DSD demand creation hinges on the health care provider providing the necessary information and guidance to the patients. Ongoing capacity-building activities for lay health care providers take place during scheduled ART refill appointments and also serve as the link between the facility and community.

DSD MODELS OFFERED

Kenya currently recommends a total of four national-approved DSD models (DSDM) including **Fast Track**, which features reduced waiting times to pick up ART refills and only two clinical consultations per year, and **Six Monthly Appointments** (SMA), which spaces out both ART pickups and clinical visits. There are also two group models, **Facility ART Groups** (FAG), led by a health care provider, and **Community ART Groups** (CAGs), which can be led by a peer or a health care provider.

DSD COVERAGE

The Kenya health management information system (HMIS) supports both paper and electronic tools to help measure DSD uptake, coverage, outcomes, and impact. These systems have been adapted to include DSD variables and work to improve the electronic medical record (EMR) is aimed at obtaining more granular DSD data.

Kenya has 47 semi-autonomous counties, all of which (100%) have support for DSD. With an average of four implementing partners (IP) per county, an estimated two IPs per county (50%) support the implementation of DSD at the health facility (HF) level.

There are a total of 3,546 HF providing ART services in Kenya. Of these, 1,464 (41%) offer at least one model of DSD for ART (Figure 1). As part of Kenya's DSD scale-up plan, models will be rolled out to all facilities providing ART June 2019.

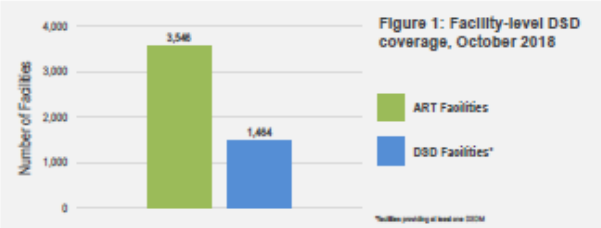

Figure 1: Facility-level DSD coverage, October 2018

There are about 1.2M PLHIV in Kenya receiving ART services (Figure 2). While an exact estimate of the number of clients enrolled in DSD nationwide is not available, in a survey of 400 high-volume HF, 162,627 (14%) clients were found to be receiving ART services through a DSDM.

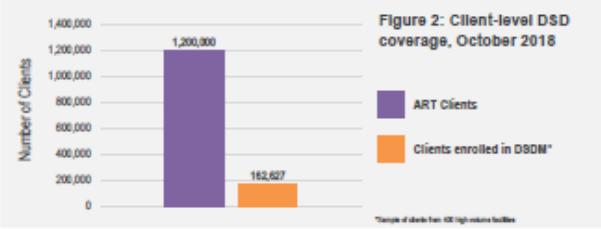

Figure 2: Client-level DSD coverage, October 2018

DSD DASHBOARD

The CQUIN DSD Dashboard was used by Kenya to monitor the country's maturing DSD program. Across 13 domains, a five-step color scale was used to rank progress and performance—from red, indicating no activity, to dark green, indicating significant and robust implementation.

In a systematic, inclusive staging process undertaken in October 2018, Kenya was found to meet the standards for the highest-possible ranking, dark green, in five of the 13 domains (Figure 3) and light green in an additional three domains.

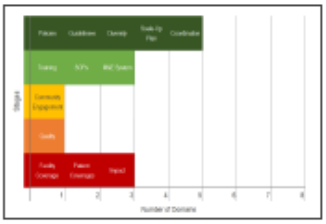

Figure 3. Kenya DSD Dashboard staging domains by stage, October 2018

While Kenya has identified four domains that have yet to be addressed or are still in the early stages of scale-up (red and orange), progress has been made in the eight months since the DSD Dashboard staging was last completed. Figure 4 describes the staging of eight key domains in February and October, 2018. Progress in the Scale-Up Plan has resulted in that domain having achieved the level of dark green and the country has increased the level to which community members are engaged, moving from orange to yellow in this domain.

While it appears that the staging has regressed in the domain of SOPs, this discrepancy is an artifact of improvements in the process used to complete the staging and is not indicative of an actual reduction in the staging of the country in this domain.

As Kenya continues to make progress in scaling up DSD and improving the national DSD program, regular assessments using the DSD Dashboard will provide valuable information on achievements reached and highlight areas where challenges may require targeted attention.

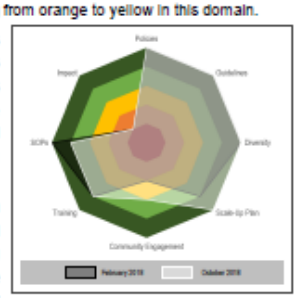

Figure 4. Radar chart of Kenya DSD Dashboard staging, February and October 2018

CHALLENGES AND SUCCESSES

Kenya has faced a number of challenges in sustaining the pace of DSD scale-up, some of which have required the formulation of novel approaches and targeted interventions.

One challenge, which is common to many countries, is a shortage of trained health care workers. Kenya found that rapid DSD scale-up was being thwarted by staff turnover and lack of staff skilled in DSD implementation. Onsite staff training and mentorship has been employed and, once a critical number of health care providers are trained and skilled in provision of DSD, this challenge will diminish.

Low demand for DSD among clients due to lack of knowledge was another challenge Kenya has recently addressed. Through NASCOP support for capacity building, clear information is provided to patients on DSD options and associated benefits. Thereafter, the patient is empowered to make a voluntary choice of models.

NEXT STEPS/WAY FORWARD

With the 2018 national ART guidelines, which highlight DSD as integral to routine HIV care and treatment, ongoing DSD implementation will focus on scaling up client-focused demand creation activities as well as national- and facility-level data collection and analysis. Continuous mentorship to health care workers is critical.

In addition, a DSD costing study and a patient and provider satisfaction survey are planned to launch in early 2019 with the aim of understanding the economic and programmatic efficiencies gained when DSD is implemented through a quality improvement collaborative vs routine DSD implementation approach.

November 2018

Taking Differentiated Service Delivery to Scale in Malawi
Expanding Promising Models to Address Gaps

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BACKGROUND

Malawi introduced differentiated service delivery (DSD) in 2006 as part of a national strategy to build a robust national HIV program around the needs of the country's diverse population of people living with HIV (PLHIV). Strong political support for DSD scale-up has created an enabling environment for the DSD sub-technical working group (TWG) to work with stakeholders to mainstream DSD.

Engagement with civil society and the PLHIV community has been crucial to the success and scale-up of DSD in Malawi. To improve treatment outcomes among adolescents and young people, the Teen Club DSD model (DSDM) has been scaled up across priority districts with support from the Global Fund. Task-shifting has been a focus of Malawi's strategy to differentiate HIV services since 2006, when nurse-led ART initiation was introduced, and the country is now scaling up nurse-led community-based ART refills.

As an active member of the CQUIN Learning Network, Malawi has hosted several south-to-south visits to share best practices, including the Teen Club model and nurse-led community ART refill model, with other network countries. Malawi also hosted the recent CQUIN Quality Improvement for DSD Workshop, which built capacity amongst network members to apply quality improvement (QI) methods to improve DSD services.

Left: Malawi's Lighthouse Clinic hosts a team from Mozambique to share lessons on nurse-led community ART delivery model. Mozambique has since adopted the model.

DSD MODELS OFFERED

Currently, Malawi offers five DSDM: **3-Month ART Refills** for stable patients, first instituted in 2006, the highly successful **Teen Club** model and the **Extended-Hour ART Refill** model (Figure 1). The **Nurse-Led Community ART Refill** and **Drop-In Center** models are the newest models adopted in Malawi, both of which were endorsed in 2018. In addition, a **Fast Track** pilot project is ongoing, with plans to officially adopt the model in the near future, and 6-month ART refills is being evaluated.

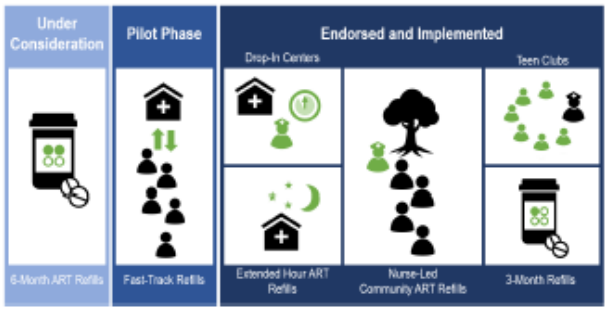

Figure 1. Graphic representations of the models of Differentiated Service Delivery currently implemented, in pilot phase, and under consideration in Malawi, November 2018

DSD UPTAKE AND COVERAGE

DSD is supported in all 28 districts in Malawi. Additionally, 6 of the 12 (50%) implementing partners currently supporting antiretroviral therapy (ART) services in the country are also supporting DSD implementation.

A total of 740 facilities in the country provide ART services, all of which (100%) also offer at least one DSDM. The 3-Month ART Refill model has been widely implemented among clients, with >90% of eligible clients enrolled in this model.

Fast Track Dispensing and CAGs are piloted at 5% and 10% of sites, respectively.

DSD DASHBOARD

The CQUIN DSD Dashboard was used by Malawi to monitor the country's maturing DSD program. Across 13 domains, a five-step color scale was used to rank progress and performance—from red, indicating no activity, to dark green, indicating significant and robust implementation.

Preliminary results of a systematic, inclusive staging process undertaken in October 2018, indicate Malawi has met the standards for the highest-possible ranking, dark green, in five of the 13 domains (Figure 2) and light green in an additional domain.

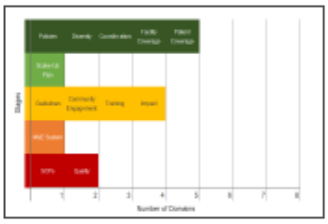

Figure 2. Preliminary Malawi DSD Dashboard staging domains by stage, October 2018

While Malawi has identified three domains that have yet to be addressed or are still in the early stages of scale-up (red and orange), progress has been made in the eight months since the DSD Dashboard staging was last completed. Figure 3 describes the staging of eight key domains in February and October, 2018. The Diversity domain staging has advanced from light green—DSDM are available for adult and adolescent patients and one additional patient group—to dark green, indicating that DSDM are now available for two or more additional patient groups. Additional progress has been made in the Scale-Up Plan and Training domains, which have seen improvement from orange to light green and orange to yellow, respectively. While it appears that the staging has regressed in some domains, these discrepancies are artifacts of improvements in the process used to complete the staging and increased understanding of the staging criteria.

As Malawi continues to make progress in scaling up DSD and improving the national DSD program, regular assessments using the DSD Dashboard will provide valuable information on achievements reached and highlight areas where challenges may require targeted attention.

Figure 3. Radar chart of Malawi DSD Dashboard staging, February and October 2018*

*Data are preliminary

CHALLENGES AND SUCCESSES

Malawi completed a formal quantitative and quantitative evaluation of DSD in 2016. This showed that most of the potential efficiency and cost savings had already been realized through successful national implementation of 3-Month ART refills. However, there were challenges with accurate patient differentiation, probably due to the severe HRH constraints at most sites. To address this challenge, Malawi—with Global Fund support—has instituted a Master Mentor program, to train and capacitate a 10-person team of mentors to complement the centralized ART trainings. These master mentors are available to be deployed to facilities in all 28 districts of Malawi.

The planned introduction of dolutegravir-based ART regimens and new routine diagnostic tools (urine-LAM, serum CrAg) will require closer clinical follow-up in 2019.

NEXT STEPS/WAY FORWARD

Building on the successful enrollment of >90% of eligible ART clients enrolled in the 3-Month ART Refill model, the scale up the Teen Club and Nurse-Led Community ART Refill models will continue. The adoption of further extended refill intervals and the fast track model will be informed by the evaluation of pilot findings.

The ongoing rapid deployment of electronic medical records systems to cover >70% of the national ART patient cohort will be used to establish routine detailed reporting on DSD without adding more workload to the sites.

I-TECH International Training & Education Center for Health

November 2018

Taking Differentiated Service Delivery to Scale in Mozambique
Evidence-Based Expansion of Community ART Groups

Aleny Couto[1], Irénio Gaspar[1], Hélder Maculi [1]
1. Ministry of Health, Mozambique

BACKGROUND

Mozambique's 2008 pilot of community-based services for people living with HIV (PLHIV) has become a foundational case example for the impact of differentiated service delivery. Recent data from Médecins Sans Frontières shows a high retention in care after patients (76.4%) were enrolled in community-based group models for 10 years (Haida, 2018). Mozambique's Ministry of Health (MoH) *National HIV and AIDS Response 2013-2017 Strategic Acceleration Plan* prioritizes enrollment of more people living with HIV (PLHIV) on antiretroviral therapy (ART).

The MoH has identified that insufficient health systems resources and infrastructure; weak monitoring systems; demand creation; stigma and discrimination; patient-flow organization; communication between health facilities and communities; and viral load monitoring and coverage are all challenges to the scale-up of DSD models (DSDM).

DSD MODELS OFFERED

Mozambique currently offers both facility-based and community-based DSDM, with the national guidelines recognizing three distinct models: **Three-Month Drug Distribution**; **Six-Month Clinical Visit Spacing**; and **Community Adherence Support Groups**, also known by the Portuguese acronym, GAAC. The adoption of multiple models ensures each health facility can implement a suitable DSDM based on its resources and challenges. In addition, services tailored for specific patient populations—the **Family Approach** and **One-Stop** models—offer customized opportunities for picking up ART refills that reduce the burden of accessing care.

While Mozambique has long implemented some standard DSDM, the MoH is interested in the experience of other countries, such as Malawi in implementing diverse DSDM. To expand the understanding of models implemented by other countries, representatives from the MoH have taken advantage of south-to-south learning opportunities to meet with their counterparts in other countries to learn and share experiences.

Above: Representatives from the Mozambique MoH visit the Balaka District Hospital Teen Club in Malawi for a south-to-south exchange in June 2017.

DSD COVERAGE

As of October 2018, provision of DSDM is supported in all 11 provinces of Mozambique (Figure 1). Additionally, 10 of the 12 (83%) implementing partners supporting ART services also support DSDM and 1,377 of the 1,407 (98%) ART facilities in the country provide at least one model of DSD.

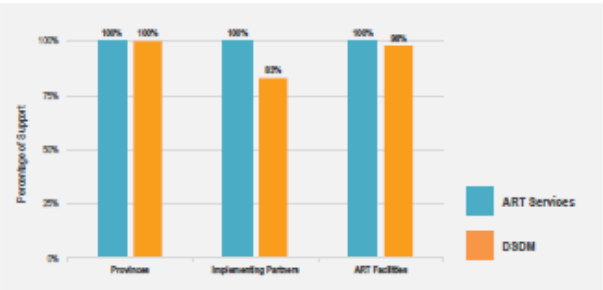

Figure 1: Support for ART Services and DSDM by percentage among Provinces, Implementing Partners, and ART Facilities

DSD DASHBOARD

The CQUIN DSD Dashboard measures DSD scale-up across 13 domains, using a five-step color scale to rank progress and performance—from red, indicating no activity, to dark green, indicating significant and robust implementation.

In a staging process conducted by the MoH in October 2018, Mozambique was found to meet the standards for the highest-possible ranking, dark green, in four of the 13 domains (Figure 2) and light green in an additional two domains.

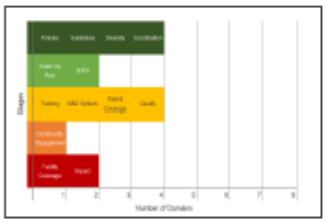

Figure 2. Mozambique DSD Dashboard staging domains by stage, October 2018

While Mozambique has identified three domains that have yet to be addressed or are still in the early stages of scale-up (Community Engagement, Facility Coverage, and Impact), progress has been made since February 2018 when the last DSD staging was completed. Figure 3 describes the staging of eight key domains from these two time periods, highlighting the progress made in the domains of National Guidelines, Scale-Up Plan, Community Engagement, and Training. While it appears that the staging has regressed in some domains, this is merely an artifact of improvements that have been made in the staging proves and the understanding of the staging criteria.

As Mozambique continues to make progress in scaling up DSD and improving the national DSD program, regular assessments using the DSD Dashboard will provide valuable information to the MoH on achievements reached and highlight areas where challenges may require targeted attention.

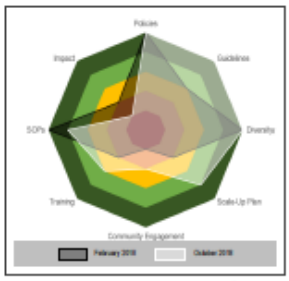

Figure 3. Radar chart of Mozambique DSD Dashboard staging, February and October 2018

LESSONS LEARNED

A number of lessons have been identified that the MoH believes could be of benefit to other countries just beginning to scale up DSD or those facing similar challenges.

One such lesson is the need for strengthening community capacity when implementing GAACs. Although GAACs have made an effective impact, communities are the key to achieving impacts. To meet this challenge, MoH is engaging recipients of care in the implementation of DSD, with plans to continue this engagement as DSD services are expanded to include peer support and delivery of medication by providing supportive supervision.

A second lesson involved M&E for DSD. Mozambique's M&E system did not allow for the collection of DSD-specific data. This is currently being addressed through a new M&E framework and updates to the electronic patient tracking system (EPTS) and program evaluation plans.

Finally, Mozambique has found that setting ambitious retention goals can help motivate scale-up of DSD, as demonstrated through the recent data showing long-term retention from GAACs. Mozambique will continue to set goals to improve patient outcomes through the monitoring of DSD coverage and impact.

NEXT STEPS/WAY FORWARD

In the next 6-12 months, Mozambique will conduct a phased implementation of outreach with ART initiation. The Ministry also plans to identify data on DSDM on EPTS to closely follow implementation of DSDM. Other priorities include establishing targets for DSDM, investing in mentorship in health facilities, and launching and disseminating new DSDM guidelines. In addition, with the implementation of the new scale-up plan, Mozambique plans to establish minimum targets for the number of stable patients enrolled in DSDM, which may encourage higher uptake.

November 2018

Taking Differentiated Service Delivery to Scale in South Africa: Leveraging Diverse Resources for Diverse Patient Needs

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1. National Department of Health

BACKGROUND

South Africa has the world's largest HIV epidemic, with more than 7 million adults and children living with HIV, and an adult HIV prevalence of almost 19%. HIV case detection and provision of antiretroviral treatment (ART) has expanded dramatically in recent years, with 4.4 million people living with HIV (PLHIV) on ART in 2018 and a national goal of initiating an additional 2 million PLHIV on ART by 2021. To improve the effectiveness of health services for PLHIV and other populations, the South Africa national department of health (NDOH) introduced national adherence guidelines (AGL) for chronic diseases in 2015. The AGL includes standard operating procedures for the set of nationally-implemented differentiated service delivery (DSD) models for

DSD MODELS OFFERED

With a clinician's confirmation, DSD models are offered to stable patients, defined as those ≥18 years who have been on the same ART regimen for at least 12 months, have two consecutive undetectable viral load (VL) results, two consecutive normal results for diabetes and hypertension, and no medical conditions requiring regular clinical consultations, such as TB.

Patients enrolled in the **Spaced and Fast Lane Appointments** (SFLA) receive 6 months' prescription for their medication, and must attend the clinic once a year for clinical assessment and laboratory testing. Facilities offering SFLA maintain a dedicated fast lane pick up point at the pharmacy for a specified period decided by each facility. Patient files and pre-packaging of medicines for patients are prepared a day in advance of scheduled visits to facilitate the fast lane system.

Adherence Clubs (AC) consist of no more than 30 patients, who meet every 2 months as a group for approximately 1 to 1.5 hours. Clubs may meet at health facilities during standard clinic hours or extended hours, or in community locations such as a patient's home or a community venue such as NGO or church. Pre-packed ART medications are provided to club members by a facilitator. AC members are required to visit the health facility annually for lab tests and clinical consultations.

Lastly, under the **Central Chronic Medicine Dispensing and Distribution** (CCMDD) model, eligible patients choose a community-based pick-up point (PuP), such as a retail pharmacy, from which they receive ART. Patients may also nominate a person to collect the medicine on their behalf. The patient is provided prescriptions for 6 months, with drug refills at the PuP occurring every 2 months. At the point of refill, the person distributing the ART parcel is expected to inquire about the patient's treatment, and request patient to return to their originating health facility if they are not feeling well or perceived unstable.

DSD COVERAGE

South Africa has successfully introduced DSD models for ART across all 9 provinces nationally, with each of approximately 4,000 health facilities providing ART enrolling at least 10% of eligible ART patients in a DSD model. Both facility-based and community-based DSD options are common, with more than 900,000 patients receiving SFLA and over 700,000 receiving ART refills in community settings via CCMDD (Figure 1). In addition, nearly 275,000 patients are enrolled in ART adherence clubs, a slight majority of whom belong to facility-based clubs.

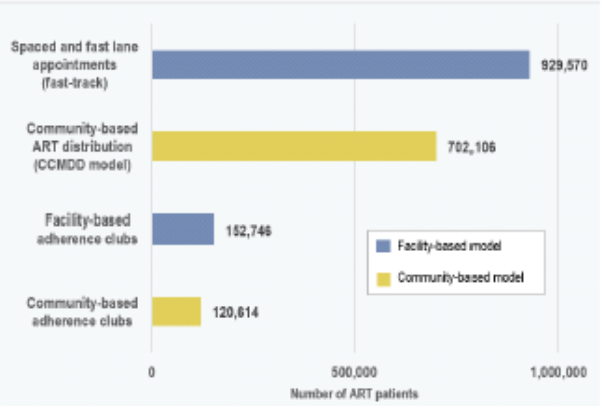


Figure 1. Numbers of patients enrolled in DSD models for ART, South Africa

DSD DASHBOARD

The CQUIN DSD Dashboard self-assessment was used to quantify progress being made as South Africa rolls out its national DSD program. Across 13 different domains, a five-step color scale was used to rank progress and performance from red, indicating no activity, to dark green, indicating significant and robust implementation.

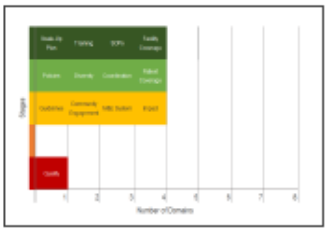


Figure 2. Preliminary South Africa DSD Dashboard staging domains by stage, October 2018

In a preliminary assessment undertaken in October 2018, South Africa was found to meet the standards for dark green in four of the 13 domains (Figure 2) and light green in an additional four domains.

Only one domain, Quality, was classified as red, indicating that South Africa has progressed beyond the earliest stages of DSD program development in the majority of domains.

Figure 3 describes the staging of 8 key domains in February 2018 and the preliminary data from October 2018. Visible progress has been made in the Training domain—in which South Africa has moved from yellow to dark green—and Community Engagement, with improvement from orange to yellow. While it appears that the staging has regressed in some domains, these discrepancies are artifacts of improvements in the process used to complete the staging and increased understanding of the staging criteria.

Regular DSD Dashboard assessments will provide valuable information to the NDOH on achievements reached and highlight areas that may require targeted attention.

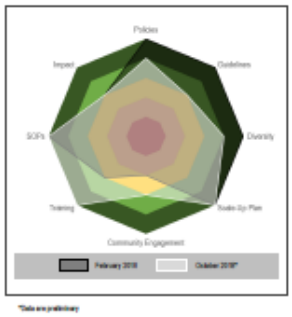


Figure 3. Radar chart of South Africa DSD Dashboard staging, February and October 2018*

CASE STUDY/BEST PRACTICE

The NDOH—with the World Bank, Boston University & HE2RO—recently evaluated the impact of early implementation of AGL interventions for PLHIV, including DSD ART models. The evaluation was conducted in 24 facilities across four provinces: Gauteng, Kwa Zulu Natal, Limpopo and North West. Data collection occurred in three phases, including an initial formative qualitative research phase and retrospective comparative analysis phases. Results of the evaluation are publicly available at the web locations listed below.

https://openknowledge.worldbank.org/handle/10986/28873
https://openknowledge.worldbank.org/handle/10986/28874

NEXT STEPS/WAY FORWARD

NDOH is designing a standardized Advanced Clinical Care (ACC), with a national training curriculum under development and plans to convene a national workshop on ACC underway. Ultimately, NDOH is planning to implement the ACC approach in all 9 provinces.

In addition, South Africa plans to focus efforts on strengthening M&E for DSD by standardizing tools, such as registers used for DSD models and documentation for referrals. Further, the NDOH plans to explore creative ways to incorporate DSD M&E indicators into routine health management information systems (HMIS) including the TIER.net patient electronic ART medical record, and the aggregate facility-level reports maintained in the national District Health Information System (DHIS2). It is envisioned that the updated M&E system will be utilized to capture and possibly compile data for reporting in electronic national HMIS.

November 2018

Taking Differentiated Service Delivery to Scale in Uganda
Diverse Models for HIV Care and Treatment

Josen Kiggundu[1] Cordelia Katureebe [1], Hudson Balidawa[1], Ivan Lukabwe[1],
1. Ministry of Health AIDS Control Program, Uganda

BACKGROUND

The AIDS Control Program (ACP) of the Ministry of Health (MOH) Uganda has made a significant impact in the country's fight against HIV. However, despite ongoing success, lifesaving antiretroviral therapy (ART) services are not yet available to all people living with HIV (PLHIV) in Uganda and health outcomes vary by geography as well as across society by economic, demographic, and social characteristics.

According to the results of the 2016 Uganda Population HIV Impact Assessment (UPHIA), 6% of adults aged 15-64 years in Uganda are living with HIV.[1] Of the estimated 1.2 million adults aged 15-64 living with HIV, 73% are aware of their HIV status, 90% of those aware of their status were receiving ART, and 84% of those on ART were virally suppressed (Figure 1). Comparing these results to the UNAIDS 90-90-90 goals, it is clear that Uganda has made great progress. In order to continue the pace of this progress, the Uganda National Consolidated HIV Prevention, Care and Treatment Guidelines of 2016 and 2018 identified a number of strategies to enable Uganda to meet these goals—of which, differentiated service delivery (DSD) is an important component.

As part of the strategy to scale up DSD, a DSD Technical Working Group (TWG) was formed to lead the country in activities such as incorporating DSD into national policy guidelines, developing implementation guides and trainings, revising existing health management information systems (HMIS) tools and developing new tools, pre-testing DSD implementation packages, and overseeing capacity-building efforts at all levels of the health system.

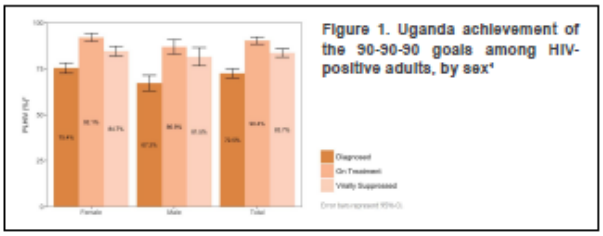


Figure 1. Uganda achievement of the 90-90-90 goals among HIV-positive adults, by sex[1]

DSD MODELS OFFERED

DSD was first adopted for national implementation in Uganda in 2016, but standalone models have long been offered by implementing partners such as TASO, RHITES Southwest, IDI, and others. Under Uganda's National Guidelines for Differentiated Service Delivery Models, five nationally-endorsed models of DSD have been adopted and all PLHIV in the country are eligible for at least one model.

Clients who have newly started ART, are not virally suppressed, or have other risk factors for disease progression are prioritized for the **Facility Based Individual Management** (FBIM) model, otherwise known as Comprehensive Clinical Evaluation (CCE), which is analogous to the standard of care. The other two facility-based models are the **Facility Based Group** (FBG) and **Fast Track Drug Refill** (FTDR) models. Two community based models complete the package of DSD models (DSDM) offered in Uganda: **Community Client Led ART Delivery** (CCLAD) and **Community Drug Distribution Points** (CDDP).

DSD COVERAGE

Uganda is currently in the process of scaling up DSD models (DSDM) in the country. While DSD is currently available in 82 (64%) of the 128 districts in Uganda where ART is offered and 19 (95%) of the 20 implementing partners who support ART services are supporting DSD, overall facility uptake of DSD currently stands at 40% (734 / 1,832 facilities).

Of the 1,140,550 PLHIV receiving ART in Uganda, 580,104 (51%) are enrolled in a DSDM. Of all DSD clients, most (338,100; 58%) are enrolled in FBIM (Figure 2). The model with the second-highest uptake is FDTR, in which 140,955 (24%) of DSD clients have enrolled.

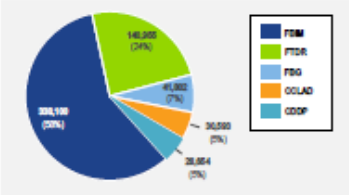


Figure 2. Patient uptake by DSD model

DSD DASHBOARD

The CQUIN DSD Dashboard measures DSD scale-up across 13 domains, using a five-step color scale to rank progress and performance—from red, indicating no activity, to dark green, indicating significant and robust implementation. The October 2018 staging process showed that Uganda had the highest-possible ranking, dark green, in seven of the 13 domains (Figure 3) and light green in an additional three domains. Only one domain, each, was found to be unaddressed (red) or in the early stages of scale-up (orange).

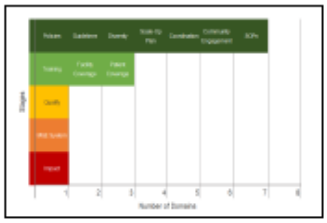


Figure 3. Uganda DSD Dashboard staging domains by stage, October 2018

Figure 4 describes the staging of eight key domains at two different time points (February and October 2018) for comparison. This chart highlights the high-level progress made by Uganda in most domains and the recent progress the country has made in the Community Engagement domain—moving from yellow to dark green in only eight months.

While it may appear that staging of the impact domain has regressed, this is an artifact of recent improvements in the process used to complete the staging and increased understanding of the staging criteria.

As Uganda continues to make progress in scaling up DSD, regular assessments using the DSD Dashboard will provide valuable information on achievements reached and highlight areas where remaining challenges may require targeted attention.

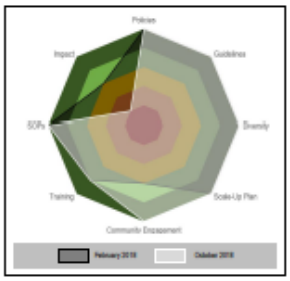


Figure 4. Radar chart of Uganda DSD Dashboard staging, February and October 2018

LESSONS LEARNED

A number of lessons learned by the Uganda MOH have been identified as of potential benefit to other countries just beginning to scale up DSD or those facing similar challenges.

As highlighted by Uganda's HIV guidelines, the importance of DSD to reaching the 90-90-90 goals cannot be discounted, particularly when it comes to the critical first 90, which highlights the need for differentiated testing services.

Expanding DSDM to all clients, including those not stable on ART is necessary for ensuring the needs of all PLHIV are addressed. Additionally, this strategy provides additional support to promote retention and viral suppression.

Finally, the need for targeted mentorship as a supplement to training is necessary for supporting health care workers during the roll-out of DSDM

NEXT STEPS/WAY FORWARD

As Uganda is continually adapting the DSD program to better serve all PLHIV in the country, the MOH has plans to pilot a community-based care and treatment program designed specifically to better meet the needs of children and adolescents. Additionally, development a national toolkit for DSD for key populations and adolescent girls and young women is slated for the near future.

Upcoming research projects in the country include an assessment of the costs and outcomes of DSDM, which is being implemented by EQUIP with support from USAID and a study on the use of quality improvement models to maximize impact and efficiency of DSD implementation, which is being implemented by the Makerere University School of Public health with funding from the Global Fund.

1. Preliminary Findings, Uganda Population HIV Impact Assessment (UPHIA), 2016

November 2018

Taking Differentiated Service Delivery to Scale in Zambia: A Coordinated Strategy to Increase Coverage

Priscilla Lumano-Mulenga[1], Daniel Mwamba[2], Maureen Simwenda[3], Ernest Mwila[4], Ivin Chibanda[5], Felix Mwanza[6], Chimuka Sianyinda[1], Mohammed Limbada[7], Linah Kamplimba Mwango[8], Mpande Mukumbwa Mwenechanya[2],
1. Zambian Ministry of Health (MoH), 2. CIDRZ, 3. JSI USAID SAFE, 4. JSI USAID DISCOVER Health, 5. EQUIP, 6. Treatment Advocacy Literacy Campaign (TALC), 7. ZAMBART, 8. University of Maryland

BACKGROUND

Differentiated Service Delivery (DSD) was introduced to Zambia in 2013 in the form of standalone models and pilot projects offered by implementing partners. Since then, DSD has become a fundamental service delivery mechanism for the National HIV/ART program. The formation of Zambia's National DSD Task Force, led by a National DSD Coordinator, has been a dynamic contributing factor to DSD scale-up through interagency collaboration. The Task Force has developed key national guidance documents for implementation, including the DSD Framework that was recently launched by the Minister of Health at the annual National ART Technical Update Conference in October 2018.

To meet the needs of the healthcare system, Zambia identifies the nationwide availability of DSD services as a priority objective. The national program seeks to expand access to DSD models (DSDM) for stable clients, as well as prioritizing models for adolescents. Zambia routinely engages people living with HIV (PLHIV) and civil society organizations in all aspects of the DSD implementation process through their inclusion on the DSD Task Force.

DSD MODELS OFFERED

Currently, nine main DSDM for ART are available in Zambia, including three facility-based models—**Fast-Track, Multi-Month Scripting, and Urban/Rural Adherence Groups** (UAG)—and four community-based models—**Community Adherence Groups/Clubs** (CAG), **Chronic Centralized Medicines Dispensing & Distribution** (CCMDD), the **Community (Retail) Pharmacy** model, and **Health Post (HP) Model Dispensation**—plus two outreach models—the **Mobile ART Distribution Model** and **Home ART Delivery**. In addition to these models, Zambia also offers a specialty adherence group model for adolescents and young adults, known as the **Scholars (Adolescent) Model**.

DSD UPTAKE AND COVERAGE

As of October 2018, DSD is supported in all 10 provinces of Zambia and DSDM is provided by 7 (88%) of the 8 implementing partners (IP) supporting ART services in the country. Overall, there are 2,961 facilities in Zambia that provide ART and, of those, 303 (10%) offer at least one DSDM.

Data on the facility and client uptake of specific DSDM is available for some select models. With results for seven of the nine available models and 303 facilities providing DSD, it is clear that most of these facilities offer more than one model. The most commonly-offered model is the HP Model Dispensation, at 224 facilities, followed distantly by the CAG model at 75 facilities and the UAG model at 46 facilities (Figure 1).

When looking at client uptake by DSDM, we can again see that uptake of HP Model Dispensation far outpaces the uptake of all other models, with 61,002 clients currently enrolled (Figure 2). While uptake of the CAG model among clients again comes in second, with 17,081 clients enrolled, the third-most commonly enrolled model is Fast-Track, with 6,128 clients.

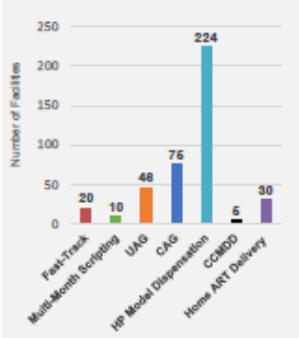


Figure 1. Facility uptake of DSD in Zambia by DSDM, October 2018

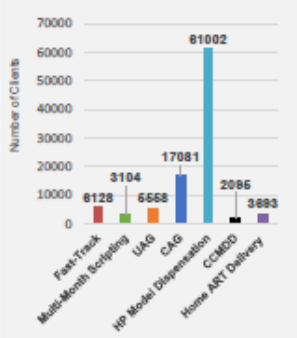


Figure 2: Client uptake of DSD in Zambia by DSDM, October 2018

DSD DASHBOARD

The CQUIN DSD Dashboard measures DSD scale-up across 13 domains, using a five-step color scale to rank progress and performance—from red, indicating no activity, to dark green, indicating significant and robust implementation. The October 2018 staging found that Zambia had the highest-possible ranking, dark green, in six of the 13 domains (Figure 3) and had achieved light green in an additional two domains. The five remaining domains were found to be unaddressed or in the early stages of scale-up.

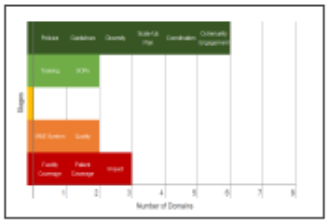


Figure 3. Zambia DSD Dashboard staging domains by stage, October 2018

Figure 4 describes the progress Zambia has achieved between February and October of 2018, with advancements in five of the eight key domains highlighted here. While it may appear that there was a regression in progress under the Impact domain, this discrepancy has been identified as an artifact of recent improvements in the process used to complete the DSD Dashboard staging.

As Zambia continues to make progress in scaling up DSD, regular assessments using the improved CQUIN DSD Dashboard will provide valuable information on achievements reached and highlight areas where remaining challenges may require targeted attention.

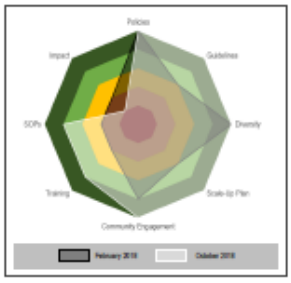


Figure 4. Radar chart of Zambia DSD Dashboard staging, February and October 2018

LESSONS LEARNED

As Zambia has made enormous strides in recent months, a number challenges addressed by the Ministry of Health (MoH) have provided the opportunity to identify lessons learned that may benefit other countries in the early stages of DSD scale-up or those facing similar challenges.

First, Zambia has learned that the importance of oversight from a DSD Task Force cannot be understated. In Zambia, the Task Force comprises diverse stakeholders with an interest in DSD and provides the driving force to ensure timelines are met and the DSD scale-up plan stays on track.

Second, it is important to nest the DSD program within the national HIV treatment program. In Zambia's experience, this is important for coordinating with the National HIV Program and includes providing regular updates to the central HIV Technical Working Group for the endorsement of new DSD activities. This process is iterative and ensures that input can be given before policies are endorsed by senior leadership within MoH.

Finally, Zambia recommends implementing DSDM within existing structures by taking advantage of the pre-existing community and facility-based ART delivery structures. This strategy promotes national ownership, maximizes acceptance from providers and community volunteers, and fosters program sustainability.

NEXT STEPS/WAY FORWARD

The immediate objective of the Zambia MoH is to scale up DSD nationwide. By putting to use the lessons learned from many years of IP-implemented standalone models and through the leadership of the DSD Task Force, Zambia is looking forward to a rapid and systematic scale-up of the DSD program.

November 2018

Taking Differentiated Service Delivery to Scale in Zimbabwe: Building on a Strong Foundation

Tsitsi Apollo[1], Clorata Gwanzura[1], Nyikadzino Mahachi[2], Daniela Belen Garone[3], Ann Sellberg[4], Chiwedzere Nzou[5], Tafadzwa Bepe[6]
1. Ministry of Health and Child Care, 2. FHI360, 3. MSF Belgium, 4. Africaid, 5. Zimbabwe Association of Church-related Hospitals, 6. OPHID

BACKGROUND

The Government of Zimbabwe and its Ministry of Health and Child Care (MOHCC) have championed the scale-up of Differentiated Service Delivery (DSD) as a way to promote MOHCC priorities, such as enabling patients on antiretroviral therapy (ART) to provide psychosocial support to one another, reducing the workload of health care workers (HCW), and separating simple drug refill processes from clinical care.

As DSD scale-up continues, one focus area for MOHCC has been training different cadres of HCW to capacitate and empower them to provide high-quality DSD services. Through sensitization trainings, HIV Integrated Training (HIT) blended learning, and mentorship platforms, HCW in Zimbabwe are better able to ensure that all patients receive high-quality services, whether they access services in the facility or the community. To ensure that HCW are supported and engaged in the scale-up of DSD, support and supervisory visits are conducted periodically, and HCW experience and satisfaction is also assessed.

Throughout the process of developing, implementing, and scaling up the national DSD program, the MOHCC has engaged members of the community of people living with HIV (PLHIV) and representatives from civil society organizations (CSO). Community members influence policy development through involvement in the national DSD technical working group (TWG), national Community TWG and are active in conducting site support visits and promoting peer-to-peer support.

DSD MODELS OFFERED

DSD was first offered in Zimbabwe in 2009 when the Ministry of Health and Child Care (MOHCC) launched the Outreach model nationwide. At the same time, implementing partners (IP) began piloting the **Community ART Refill Group (CARG)** model. Currently, Zimbabwe's national models of DSD for ART include the **Fast Track Refill, Facility Club Refill**, CARG, and **Outreach** models.

In addition to these standard model types, Zimbabwe also offers the **Family Refill** Model, which allows one member of a family of multiple adults receiving ART services to collect medication refills for all family members, and the **Zvandiri Model** for adolescents and young people. Finally, there is one model currently being piloted in one district: **Out of Facility Community ART Distribution (OFCAD).**

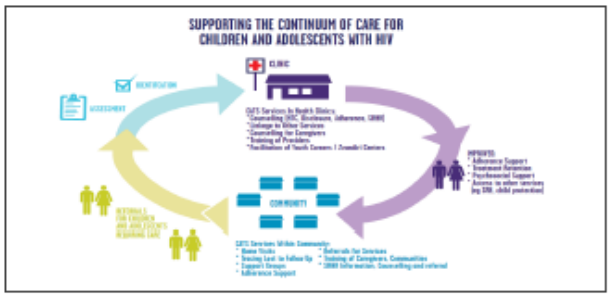


Figure 1. The Zvandiri Approach (Picture adopted from the Zvandiri Case Study)

DSD UPTAKE AND DEMAND CREATION

DSD is supported in all 65 districts in Zimbabwe's 10 provinces where ART services are provided. Of 20 implementing partners currently supporting ART services, 8 are also supporting DSD. 1601 health facilities in the country provide ART and, of those, 901 (56%) have been capacitated to provide at least one DSD model (DSDM).

Information about available DSDM is disseminated to the community through community health care cadres, expert clients, and training offered via the HIV Literacy Manual used for client education in the community. These informational activities and continuous promotion of DSD through health talks in the community and the facility, mean that demand is continuously being built for DSD services.

To ensure DSDM are meeting patient needs and expectations, assessment of patient experience and satisfaction have recently been initiated with the learning sites and the plan is have them conducted periodically at scale. MOHCC has also worked with CQUIN to explore male engagement in DSD, and with currently ICAP to explore the preferences of urban PLHIV for different DSDM.

DSD DASHBOARD

The CQUIN DSD Dashboard was used by Zimbabwe to monitor the country's maturing DSD program. Across 13 domains, a five-step color scale was used to rank progress and performance—from red, indicating no activity, to dark green, indicating significant and robust implementation.

In a systematic, inclusive staging process undertaken in October, 2018, Zimbabwe was found to meet the standards for the highest-possible ranking, dark green, in six of the 13 domains (Figure 2) and light green in an additional domain.

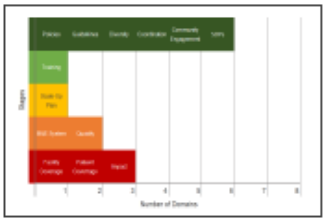


Figure 2. Zimbabwe DSD Dashboard staging domains by stage, October 2018

While Zimbabwe has identified five domains that have yet to be addressed or are still in the early stages of scale-up, progress has been made in the eight months since the DSD Dashboard staging was last completed. Figure 3 describes the staging of eight key domains in February and October, 2018. The Training domain staging has advanced from yellow—national curricula are in development but have not yet been implemented—to light green, indicating that the training curricula have been finalized and are in use as in-service HCW training.

While it appears that the staging has regressed in some domains, these discrepancies are, in fact, artifacts of improvements in the process used to complete the staging and increased understanding of the staging criteria.

As Zimbabwe continues to make progress in scaling up DSD and improving the national DSD program, regular assessments using the DSD Dashboard will provide valuable information to the MOHCC on achievements reached and highlight areas where challenges may require targeted attention.

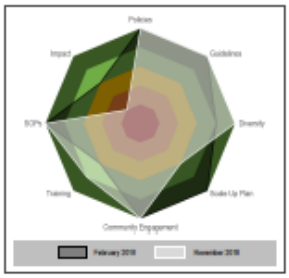


Figure 3. Radar chart of Zimbabwe DSD Dashboard staging, February and October 2018

OPPORTUNITIES FOR CROSS-BORDER LEARNING

As countries work separately to scale up DSD, there are benefits to sharing knowledge, best practices, and research findings. Zimbabwe has identified three priority areas for seeking input from other countries in the coming year.

First, the CARG model is already being implemented in Zimbabwe, but only for adult populations. There is interest in expanding the model to children, adolescents, and young adults living with HIV; however, the country is seeking the perspective of others that have conducted research or have experience implementing similar programs.

Secondly, Zimbabweans are very mobile—particularly those between the ages of 19 and 24—and adherence and loss to follow-up are greatly affected by this. The MOHCC is very interested to learn more from other countries facing similar challenges or implementing models for mobile populations—miners, in particular.

Finally, the country would be interested to learn how others may have used community-based PMTCT adherence clubs to address poor retention among mothers receiving PMTCT services.

NEXT STEPS/WAY FORWARD

The Zimbabwe MOHCC is looking forward to continuing to build on progress already made, with additional focus on aspects of scale-up that have proven challenging, such as the slower than expected pace of developing M&E tools and low acceptability of the Fast Track Refill model among HCW. Strategies planned to address gaps include the adoption of an intermittent data review process to allow for the collection of DSD data while the national M&E system is still in development. The MOHCC is also planning best practice sharing meetings and exchange visits to encourage buy-in among HCW and ensure consistent implementation of DSD nationwide.

November 2018

Partner Posters

View All

Accelerating DSD Scale-Up With South-to-South Learning Exchange Visits

Authors: Peter Preko, Siphiwe Shongwe, Miriam Rabkin

HIV LEARNING NETWORK
The CQUIN Project for Differentiated Service Delivery

BACKGROUND

The CQUIN learning network is designed to accelerate the scale up of high-quality HIV differentiated service delivery (DSD). Peer-to-peer demonstration of successful implementation strategies is known to be a high-impact approach, and is therefore a core element of the CQUIN framework (Figure 1). Seeing is believing, and south-to-south (S2S) learning visits are a powerful way to exchange information, review data, and create the "experiential evidence" that empowers S2S participants to advocate for implementation and adaptation of new approaches in their home settings.

Figure 1: CQUIN Framework

APPROACH

Selection of S2S Exchanges: CQUIN member countries formally propose S2S visits based on DSD-related best practices they wish to observe; often they learn of these opportunities at CQUIN workshops and meetings. Country teams submit concept notes, including visit objectives, proposed activities and expected outcomes; these are reviewed by CQUIN leadership and prioritized based on alignment with visiting country DSD action plans, likelihood that the trip will contribute to DSD scale-up, and balance amongst network members.

Planning and Preparation: S2S visits are planned to maximize impact, with an eye to ensuring the correct participants on both visiting and hosting teams. Activities are aligned with proposed objectives. To date, nominations for specific travelers have been made by ministries of health and/or PEPFAR agencies.

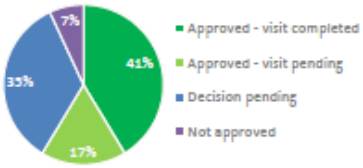
Implementation: CQUIN staff participate in all S2S visits, accompanying visitors, "curating" activities, focusing strategic discussions on visit objectives, identifying opportunities for joint learning, and supporting logistics.

Evaluation and Follow Up: After each trip, the visiting country team submits an action plan, which is systematically tracked by CQUIN over time. In 2018, CQUIN also piloted a post-visit evaluation survey for visiting teams; this was used for a learning visit by Eswatini, Malawi and Kenya to Uganda.

OUTCOMES

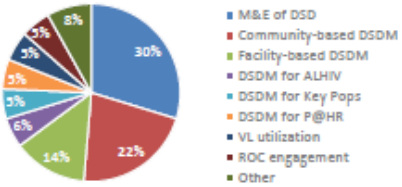
Between March 2017 and September 2018, CQUIN country teams made 29 requests for S2S visits. Of these, 17 were approved and 12 of those have been completed, 10 are pending a final decision, and 2 were not approved (Figure 2). The most commonly-requested destinations were Eswatini, South Africa, Uganda, and Kenya, although bureaucratic requirements have thus far prevented visits to South Africa.

Figure 2: Status of S2S Requests



The S2S proposals focused on diverse DSD-related topics and learning objectives. The most common area of interest was M&E of DSD (30%), followed by community-based M&E models (22%) (Figure 3).

Figure 3: Topics of Interest for S2S Visit Requests

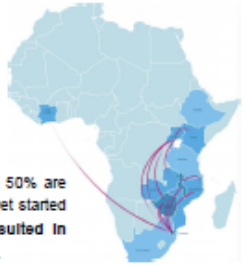


OUTCOMES, continued

To date, CQUIN has supported 12 S2S visits for eight countries (Figure 4):

- Malawi hosted Eswatini in June 2017
- Eswatini hosted Zimbabwe in July 2017
- Eswatini hosted Mozambique in August 2017
- Malawi hosted Mozambique in August 2017
- Uganda hosted Malawi, Eswatini and Kenya in June 2018
- Eswatini hosted Cote d'Ivoire, Malawi, Uganda, Zambia and Zimbabwe in June 2018

Figure 4. Map of completed S2S visits



These visits generated 40 action items. Of these, 50% are complete, 37% are underway, and 13% have not yet started (Figure 5). **Five of the visits have already resulted in changes to policies and/or guidelines** (Figure 6).

Figure 5: Status of S2S Action Items

Figure 6: Impact of S2S Visit on Policy/Guidelines

Examples of completed action items include:

- **Eswatini to Malawi** (June 2017): Eswatini Teen Clubs upgraded to Treatment Clubs, relevant indicators added to CMIS module, systems to transition adolescents to adult care completed.
- **Mozambique to Malawi** (August 2017): Mozambique national DSD guidelines adapted to include ART refills during Teen Club sessions
- **Mozambique to Eswatini** (August 2017): Mozambique is piloting the Outreach Refill model, with plans to scale up in FY19
- **Uganda to Eswatini** (June 2018): Uganda national DSD guidelines reviewed, and implementation of Early Morning Refill model was clarified
- **Zambia to Eswatini** (June 2018): Early Morning Refills added to Zambia's National DSD framework.

Figure 7 (left to right): Mozambique in Malawi; Uganda in Eswatini; Eswatini, Kenya and Malawi in Uganda; Uganda, Malawi, Zambia and Zimbabwe in Eswatini.

LESSONS LEARNED

- Well-organized S2S visits are an effective way to exchange implementation know-how, and to catalyze implementation of new or adapted DSD models.
- It is critical to have principal decision makers – or their representatives – on S2S visits. If individuals with the seniority to change policies and practice are not engaged in planning and visits, post-trip action plans may not move forward.
- Focusing S2S visits with the use of consensus-based scopes of work and clear objectives is important to avoid distractions and *ad hoc* requests for activities unrelated to DSD scale-up.
- In some countries, protocol-related bureaucracy has hindered exchange visits. This is especially problematic when international travel requires approvals from outside the ministry of health. Visits to and from these countries require a much longer planning timeframe.

NEXT STEPS/WAY FORWARD

- ✓ Refine S2S selection criteria for both visits and participants
- ✓ Assess utility of the post-visit evaluation survey and expand to all visits, if useful
- ✓ Continue to follow-up on individual country action plans and provide catalytic technical assistance as needed, to improve post-trip uptake of DSD best practices and/or change in DSD policies and guidelines.

November 2018

ALTERNATIVE MODELS OF ART DELIVERY: OPTIMIZING THE BENEFITS

AMBIT

A SYSTEM-WIDE LOOK AT ALTERNATIVE MODELS FOR DELIVERING HIV TREATMENT

BACKGROUND

Most high HIV-prevalence countries are experimenting with and scaling up alternative service delivery approaches, or differentiated models of care, for providing antiretroviral treatment (ART) for HIV. Hopes for such approaches include better access to and outcomes of treatment for patients; increased clinic capacity; and lower costs for providers and patients.

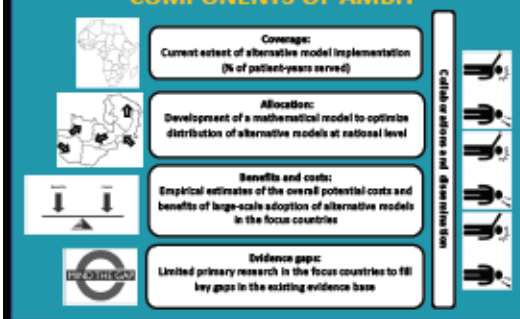
Although many evaluations are underway, we have little evidence on the big picture: the proportion of clinics offering alternative models, eligibility criteria and numbers of patients eligible, number of patients actually participating, program-wide outcomes, resource utilization and costs compared to traditional care, fidelity to guidelines, financial sustainability, and other system-wide indicators.

PROJECT

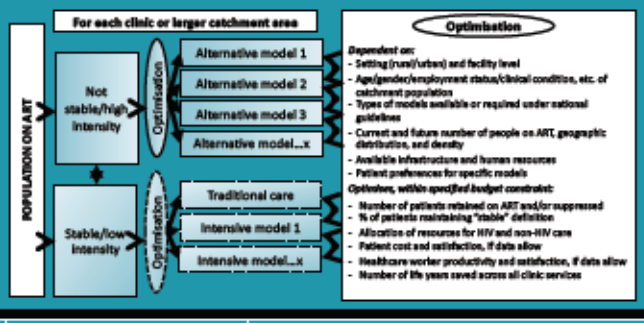
AMBIT is a 2.5-year research and evaluation project in sub-Saharan Africa supported by the Bill & Melinda Gates Foundation and implemented by the Boston University School of Public Health in the U.S., the Health Economics and Epidemiology Research Office (HE^{2}RO) in South Africa, and other local partners. The project, launched in September 2018, will include data synthesis, data collection, data analysis, and modeling activities aimed at generating information for near- and long-term decision making and creating an approach and platform for ongoing evaluation.

Activities will include literature reviews, analysis of retrospective data and implementation reports, cost estimates, surveys, modeling, and modest primary data collection and analysis, with an anticipated emphasis on Malawi, Zambia, and South Africa.

COMPONENTS OF AMBIT



ALLOCATION OPTIMIZATION MODEL



COVERAGE

Using routine electronic medical records, cohorts under observation, existing M&E reports from government and partners, implementation science studies, and primary quality assessment, AMBIT aims to estimate:

- Percentage of current ART patients meeting national definition of stable; distribution of reasons for not meeting definition
- Geographic distribution and description of alternative models
- Number (proportion) of patients in each model at time of data collection; patient-months enrolled in each model. (Anecdotal evidence indicates discrepancies between aggregate reports and actual practice.)
- Location, duration, and frequency of dispensing
- Number of facility visits per patient per year, by model of care
- Number of viral load tests per patient per year, by model of care

BENEFITS AND COSTS

AMBIT will attempt to identify the universe of potential costs and benefits, as shown in the table to the right, and generate some empirical information for each domain, depending on data availability.

The AMBIT team (so far):

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BOSTON UNIVERSITY HE^{2}RO

Domain	Expectation	Comments
1. Clinical outcomes		
For ART patients	Improve outcomes for all or some ART patients; maintain outcomes for all.	Retention and suppression for all ART patients in site's catchment area, not just those eligible for or served by alternative models.
For non-ART patients	Better uptake of ART among HIV+ and of screening and treatment for TB and NCDs.	Outcomes should improve or number of patients managed should increase due to more provider time/patient and other resources.
2. Non-clinical outcomes		
Costs to patients	Lower financial and opportunity costs to patients enrolled in alternative models.	Costs to patients should fall but may not in all cases, depending on model and patient.
Patient satisfaction	Satisfaction with services and quality of life should improve for all patients.	Details TBD; could include HIV and non-HIV patients.
3. Clinic resource utilization and performance		
Costs to provider	Lower overall costs to providers.	Cost of ART program at site divided by total number of patients in all models, including traditional care. Reallocation of costs without reduction is possible. Program costs could increase if outcomes improve.
Service delivery capacity	Increased or equal clinic capacity (patient volumes).	If alternative models reduce # or duration of visits, clinic may have capacity to take on more clients for ART or non-ART care. Only relevant if there is unmet demand and if clinic's resources are unchanged.
Staff utilization	More efficient use of available staff (professional and lay).	Staff numbers, cadres, and roles could change, but only if managers respond. Alternative is longer tea breaks, shorter hours, etc. Role of un- or minimally trained and/or un- or minimally-paid staff raises concerns for quality and sustainability.
Facility performance	Improvements in overall clinic performance.	Metric for this measure does not exist. May need to create an index, scale, or graph to incorporate multiple aspects of performance.
4. Healthcare worker experience		
Satisfaction	Higher HCW satisfaction due to lower burden, more time with patients	Improvement depends heavily on how clinic management adapts to use of alternative models
Guideline compliance	Better compliance with national guidelines for HIV and non-HIV care	Compliance could improve or diminish, depending on supervision of alternative models, reallocation of HCWs' time, etc.
Productivity	Patient load/HCW decreases	Ideally, alternative models will allow HCWs to produce a larger amount of health by making service delivery for each patient more efficient.

Challenges faced by PLHIV in Uganda with the DSDM Model

NAFOPHANU

Author: Stella Kentutsi; Executive Director, National Forum of People Living with HIV/AIDS Networks in Uganda (NAFOPHANU), Uganda

BACKGROUND/INTRODUCTION

The Implementation Guidelines for Differentiated Service Delivery (DSD) Models of HIV Services in Uganda (2017) led to the roll out of DSD to enable stable People Living with HIV (PLHIV) to serve them better but also remove unnecessary burdens on the health care as part of a deliberate move for retention in care and adherence to effective treatment.

METHODS

Open discussion was applied in a formal meeting between the PLHIV Coordinators, expert clients and service providers. Forty (40) PLHIV were selected from thirteen (13) PEPFAR implementing districts representing three (3) regions. Data was collected in September 2018.
November 2018

DISCUSSION

RESULTS

PLHIV in the 13 districts of Kayunga, Kamuli, Mayuge, Bugiri, Busia, Mbale, Pallisa, Kumi, Mityana, Luwero, Kalangala, Mpigi and Bushenyi revealed that DSD had been introduced in the districts.The PLHIV were accessing treatment largely through Community Drug Distribution Points (CDPPs), Community ART Group, Community Client-led ART Delivery(CCLAD) and Fast-track drug pickup.

The main challenges highlighted included high levels of stigma and discrimination that stop PLHIV from accessing the drugs from the nearest distribution point, sporadic stock outs of drugs, complacency to visit health facilities as required to check on viral load suppression, minimal monitoring of clients by health workers as DSD limits health worker-client interaction, limited primary health care funds to enable health workers follow upon their patients, treatment illiteracy and supply chainrelated issues such as the National Medical Stores supplies ART following atwo month cycle yet PLHIV are meant to refill atleast after 3 months.

NEXT STEPS/WAY FORWARD

Where as the DSD models have worked effectively in a community where drugs are available, health workers facilitated to follow up on their patients and PLHIV living in a stigma free environment, alot remains to be done especially in a country where sporadic stock outs are common, internal stigma is still high and there have been no deliberate efforts to increase domestic funding of the HIV & AIDS response

University of the Witwatersrand
WITS RHI

Comparing the Male Attrition Rate

Comparing the Male Attrition Rate for Differentiated Care versus Facility ART Patients in Sub-district F, City of Johannesburg.

Authors: Sarah Monyela[1], Cleopatra Sokhela[1], Melanie Bisnauth[1], Josephine Otchere-Darko[1], Gloria Maimela[1], Sthembile Gombarume[2].

1. Wits Reproductive Health and HIV Institute (Wits RHI), University of the Witwatersrand, Johannesburg, South Africa;
2. U.S. Agency for International Development (USAID)

Background

South Africa has made significant progress in improving the provision of care for HIV-positive patients. However, retention of patients in care is still a challenge in South Africa, with males accounting for only 29.8% when compared to females 70.2% of ART patients that were retained in care in the Johannesburg Health District (JHD) in 2017.1 Research suggests that offering differentiated care to stable ART patients does improve adherence to treatment and retention in care when compared to facility based ART services. Differentiated care (DC) is offered to eligible patients based on the following criteria: Above 18 years of age and stable on ART with two consecutive viral loads suppressed, no opportunistic infections and on the same regimen for 12+ months. DC patients are rewarded with an opportunity to choose a convenient collect point for medication without seeing a clinician for six months. Facility care (FC) is defined as ART services offered at a facility to patients also eligible for differentiated care but who have not yet been offered DC. We sought to analyse confirmed loss to follow-up (cLTFU) between the two groups (DC and FC) and compare the difference in attrition between the two groups for both males and females to better understand if DC offered to patients lowered the attrition rate particularly for males at 13 primary healthcare clinics at Sub-district F in JHD

Method

For a 3 year period from January 2015-December 2017, data from TIER.Net was extracted to compare a) We examined a) total number of DC and FC patients across 13 clinics in JHD; b) total cLTFU for DC versus FC; c) total number of male versus female cLTFU; and d) cLTFU for males offered DC versus FC and for female offered DC versus FC. cLTFU was compared between males and females to determine the highest attrition rate per age and gender for DC and FC patients.

Results Cont.

In January 2015-December 2017, a total of 13 clinics in JHD Sub-district F had a 22% attrition rate. A total of 21,782 patients were offered DC and a total of 48,611 were FC (Fig.1). Of these, 7011 (32%) males were offered DC versus 16,020 (33%) receiving FC. For female patients, 14,771 (68%) were offered DC and 32,591(67%) received FC. cLTFU was lower for patients offered DC: 774 (3%) compared to 10,599 (22%) for FC patients. Of males offered DC, fewer: 198 (3%) were cLTFU compared to males receiving FC treatment: 3179 (30%). Similarly, there were fewer females offered DC LTFU: 576 (4%) compared to those receiving FC: 7420 (70%). The highest attrition rate for males was 54%: amongst the age group of 36-49 years: DC = 106 (54%) and FC = 1425 (45%). In comparison, females between the age group 25-35 years old had the highest attrition rate: DC= 226 (46%) and FC = 4328 (58%).

The results revealed there was only a 1% difference between DC males and females indicating that providing DC improved male retention.

Conclusion

Through comparing the cLTFU for males versus females in both groups of DC versus FC patients, there was a higher attrition rate amongst FCs for both males and females when compared to DC. FC patients require more attention to strengthen their retention in care by offering DC to all patients, especially males in accessing care. Further research is needed to analyse the reasons why the age group of 36-49 year old men are primarily defaulters from ART at the Sub-district level.

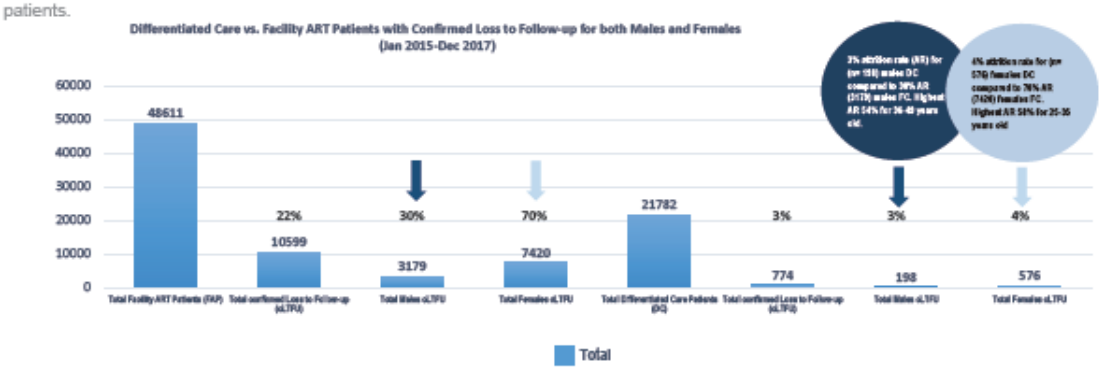

Figure 1. Differentiated Care vs. Facility ART Patients with Confirmed Loss to Follow-up for both Males and Females (Jan 2015-Dec 2017)

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Leaving no one behind, reaching hard to reach populations

Muhau Mubiana[1] Mpande Mukumbwa-Mwenechanya[1] Clement Moonga[1] Helen Bwalya Mulenga[1] Mwanza Wa Mwanza[1] Izukanji Sikazwe[1] Carolyn Bolton-Moore[1,2]
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REPUBLIC OF ZAMBIA

BACKGROUND/INTRODUCTION

- The 2016 UNAIDS gap report showed that globally, there were over 2 million new HIV infections in 2015.

-Members of key populations (KPs):
female sex workers (FSW) , men who have sex with men (MSM), people who inject drugs, transgender, prisoners
and their sexual contacts accounted for 45% of the new infections.[1]

- Despite the high incidence of HIV infections among KPs, specific sub populations living with HIV are
  - **underrepresented in the HIV care cascade**[2,3]
  - have **low access to treatment**, face challenges in remaining on treatment, are faced with lack of adherence, stigma, low retention and insecurity in accessing health services
  - are **disproportionately at risk of HIV acquisition**, attributable to both behavior and specific legal and social barriers that further increase their vulnerability.
- The 2017-2021 Zambian National strategic framework recommends
  a public health approach for all sup population to be part of the HIV response if the 90-90-90 UNAIDS sets goals are to be achieved[4]
  embracing existing opportunities for the multi-sectoral HIV national response that includes among others: Expanding service coverage to reach geographical areas with highest burden of HIV and groups that have historically been marginalized, underserved and neglected to ensure that **"no one is left behind"** .

•In May 2018,with the support from PEPFER through CDC, we implemented activities to:
- Provide HIV services to KP
- Highlight our experience, lessons learnt and challenges

In Zambia where some key population activities are illegal and unacceptable (socially, religious, culturally and politically).

METHODS

Setting: 6 densely populated urban communities
6 Health Centers in Lusaka District.

- **Mobilization and demand creation for HIV services in communities:**
  - Networking and collaborating with Civil Society Organizations(CSOs) working with KPs
  - Mapping 'Hot spots/safe zones' (bars, brothels, homes) to identify operation areas with KP communities.
- **Monthly community visits** by a team of trained health care providers (Nurse, Pharmacist, Clinical Officer, Lay Health Care Worker and Laboratory Technologist) for case identification, screening and follow up visits (drug dispensation, symptom screening, condom distribution and adherence counselling) of clients already enrolled in care.
- **Linking screened clients** to Health Centers with Health Care Providers trained to provide KP friendly services.
- **Fast-tracking clients referred** to the clinic through Lay Health Care Workers to ease access to health services

Implementation period: May –September 2018
Data/Analyses: We recorded number of KPS that were: (a) reached (b) tested for HIV (c) linked to HIV services depending on HIV status.

RESULTS

Figure 1. Positivity yield among KP screened

RESULTS, continued

Figure 2: Continuum of care among FSW and MSM

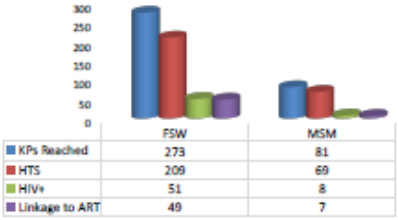
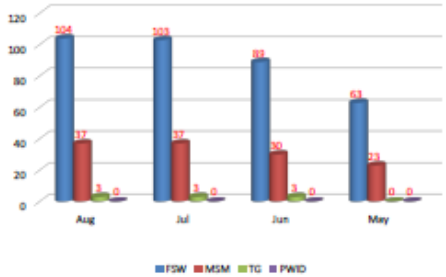


Figure 3: Cumulative numbers on PrEP among FSW, MSM, TG, PWID



DISCUSSION

- Of 354 KP reached,
  - 273 (77%) self-identified as FSWs and 81 (23%) MSM.
  - 278 (78.5%) agreed to HIV testing
  - Refusal rate for testing was similar for both the FSWs and the MSM (range 21-23%)
- From 278 people tested,
  - 59(21%) tested positive with a higher positivity rate among FSW (21%).
  Overall linkage was 95%; 3 people (5%) did not link to care as they required further time to adjust to their new HIV status.
- Among 219 (79%) testing negative,
  - 144 (66%) were put on Pre–Exposure Prophylaxis (PrEP) services.
  - 75 did not fit the eligibility criteria or refused.
- Partnering with CSO working with these populations was key for networking and community mobilization with KPs.
- Having trained Peers was cardinal in the identification of the safe spaces as convenient locations for KPs to access services within reach.
- In addition, training health care workers in provision of services for this population increased KP confidence to seek care .

NEXT STEPS/WAY FORWARD

- Strengthen follows up of:
  - PrEP patients to ensure retention
  - KPs testing positive who refused to be linked into care
  - Support the development of tools to strengthen the M&E among this population

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4. 2017-2021 National AIDS Strategic Framework

November 2018

Taking DSD Services to Scale: Strategic Decisions, Paths, and Priorities

HIV LEARNING NETWORK
The CQUIN Project for Differentiated Service Delivery

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BACKGROUND / DISCUSSION

The 11 countries in the CQUIN network are pioneers of HIV differentiated service delivery (DSD) implementation at scale. Recognizing that differentiated HIV services must be delivered at scale and with fidelity – *e.g.*, that **both coverage and quality are required for impact** – network members face a similar set of strategic decisions about how best to design, implement and monitor large-scale DSD programs. In August 2018, the CQUIN team reviewed data collected from member countries in the context of south-to-south visits, workshops, and routine calls with national DSD coordinators. Table 1 shows a preliminary synthesis of key strategic decisions, commonly-selected options, and illustrative country examples. These are likely to be useful to other countries scaling up DSD services.

TABLE 1: STRATEGIC DECISIONS FOR DSD SCALE-UP

Strategic Decisions	Common Options	Country Examples
How will leadership and/or oversight of national DSD guidelines and implementation strategies be organized?	Sub-DSD Technical Working Group	• Uganda, Zambia and Zimbabwe each have a stand-alone sub-TWG that meets regularly for DSD planning and coordination.
	DSD Task Force	• Eswatini, Malawi, Mozambique and Kenya have task teams that work on specific tasks and report to a main TWG.
	DSD Coordinator	• Eswatini, Uganda, Zambia and Zimbabwe have dedicated DSD coordinators.
	DSD Technical Advisors	• Kenya, and Cote d'Ivoire have technical advisors from other organizations who support the ministry of health in developing documents, planning DSD activities, and training.
	MoH Officers with added DSD oversight	• South Africa, Ethiopia, Malawi and Mozambique use MoH staff that have been assigned added responsibility as DSD leads.
Will the roll-out of DSD models be implemented using a phased approach?	Simultaneous nation-wide implementation of diverse models	• Eswatini, South Africa, Zambia and Zimbabwe are scaling up multiple facility-based and community-based DART models for stable patients nationwide.
	Phased approach with initial prioritization by geography and/or DART model	• Cote d'Ivoire and Ethiopia are scaling up facility-based models (only) nationwide.
	Hybrid approach, implementing some models simultaneously nationwide and phasing in others	• Kenya prioritized national roll-out of appointment spacing and fast track models, and is phasing in community-based models based on a readiness assessment tool. • Malawi, Eswatini, Zimbabwe, Uganda and Kenya are implementing models for unstable patients in a phased manner, starting with referring facilities. • Mozambique is scaling up appointment spacing and fast track using a global approach, but using a phased approach for community outreach and facility-based adherence clubs for adults and adolescents.
How will countries determine if roll-out of DSD has been successful? What are the relevant goals and targets?	Development of DSD-specific coverage targets focusing on % of facilities offering DSD	• Ethiopia, Malawi, Mozambique, Eswatini, Uganda, Zambia and Zimbabwe have set national DSD coverage targets at the facility level. For example, Malawi and Uganda plan to increase coverage of DSD by 70% and 30% respectively by end of 2018. Ethiopia plans to reach 95% of health facilities by 2018.
	Development of DSD-specific coverage targets focusing on % of eligible patients receiving DSD	• Zambia, and Uganda are among the countries with patient level coverage targets. Zambia plans to enroll 20% (34,800) of stable PLHIV in DSD community models by December 2019, while Uganda is targeting 70% of all ART patients in DSD by 2018.
	Use of existing programmatic targets	• Kenya and South Africa do not have DSD specific targets. They will use existing targets for testing, linkage, retention and viral suppression.
In addition to the Ministry of Health (national and subnational levels), which organizations/ institutions will implement DSD roll out?	International partners	• International PEPFAR implementing partners play a critical role in DSD implementation and scale-up in all 10 countries. • In some countries, IPs are intensively supporting all DSD models. For example, PEPFAR IPs are leading scale up of diverse DSD models in all four regions of Eswatini. In other countries, IP support is focused on DSD for patients @ high risk of disease progression (P@HR), adolescents, key populations, and other groups with more complex needs.
	Domestic partners	• ISHTAR Kenya implements specific DSDMs for MSM • MANRELA+ in Malawi has involved faith-based leaders in DSD demand creation and implementation activities. • TASO in Uganda is involved in the training and capacity building of expert clients, providers, and community health workers who play a key role in DSD rollout. • The Global Fund is supporting national PLHIV networks (e.g. ZNNP+ in Zimbabwe and RIP+ in Cote d'Ivoire) to scale up community-based adherence groups • Lighthouse and CAPRISA are supporting MOH Malawi and DOH South Africa, respectively, to scale up DSD models for P@HR.
What strategy will be implemented for collecting and reporting DSD relevant monitoring and evaluation (M&E) data?	Adapt routine M&E tools to collect DSD data on all patients	• South Africa, Uganda, Kenya, Zimbabwe and Eswatini have updated paper-based DSD registers and/or are in the process of updating their Electronic Medical Records (EMRs). • Malawi plans to update only electronic medical records.
	Episodic data collection (Review Meetings)	• Zimbabwe, Kenya and Eswatini are currently implementing (or planning) the use of annual review meetings that include site-level DSD data • South Africa has Quarterly Review Meetings in Districts and Provinces where DSD data and program performance are assessed.
When/how often will data on DSD be collected and reported?	Scheduled periodic reporting (e.g., annual, quarterly, monthly)	• Mozambique, Kenya, and Zimbabwe hold Annual National Review Meetings at which DSD data is reviewed. • Eswatini, Zimbabwe and other countries produce annual program reports that will incorporate DSD data. • Eswatini has semi-annual review meetings at which DSD data will be reported. • Ethiopia has a paper-based register on which appointment spacing data is collected by the Regional Health Bureau monthly and shared with MoH. • South Africa collects Quarterly Provincial data on DSD and program performance.
	Ad hoc requests	• Cote d'Ivoire, Zambia and Malawi compile DSD data for CQUIN Meetings. • IPs in Uganda and Kenya compile DSD data when requested by MOH and/or PEPFAR
How will recipients of care be involved in planning, implementing and/or evaluating DSD services?	Participation in DSD TWG or Task Team	• South Africa includes both PLHIVs and specifically youth living with HIV in their DSD TWGs. • Eswatini, Kenya, Uganda, Malawi, Zimbabwe, and Zambia all include PLHIVs in their DSD TWGs where DSD planning, coordination and program evaluation are discussed
	Demand Creation and Patient Education	• Eswatini and Malawi use PLHIV networks to support demand creation, and to develop IEC material. • Uganda engages PLHIV to conduct treatment literacy campaigns and community health talks
	Service Delivery	• Eswatini, Ethiopia, Uganda and Zambia use expert clients and/or peer educators to deliver diverse DSD related services, including adherence monitoring and patient tracking.
	M&E	• PLHIV in Cote d'Ivoire monitor DSD service availability in the context of ITPC's Community Observatory project
How will countries support and monitor DSD quality?	Via routine national quality assurance assessment	• In Eswatini, the national quality management program and the DSD task team have developed DSD Quality Standards which will be added to the national HIV service assessment tool to monitor DSD service quality
	Stand-alone quality assurance (QA) and/or quality improvement (QI) projects	• In Zambia and Kenya, IPs providing HIV services engage in different QI projects • Cote d'Ivoire engages PLHIV via the coordination of an early "early warning system" for ART stock outs. • Zimbabwe has integrated DSD quality review into national quality assurance meeting.
	Standing National Quality Assurance Meetings and DSD review meetings	• Kenya, Eswatini and Zimbabwe have review meetings at which data on DSD implementation fidelity will be monitored.

November 2018

Videos

Videos about innovative DSD models and solutions from CQUIN partner organizations were featured at the marketplace and before plenary sessions. Following is a listing of all the videos displayed:

Adolescent Treatment Coalition
A series of animated films launched at AIDS 2018 discussing DSD and young people

Vincent from Sao Paulo

Poon from Bangkok

Namusoke from Kampala

Jane from South Africa

Center for Infectious Disease Research in Zambia (CIDRZ)

Community ART for Retention in Zambia (CommART) study (video series)

Gates Notes

Tom Ellman: Leaving No One Behind

ICAP at Columbia University

Teen Clubs in Eswatini

International AIDS Society (IAS)
#IASYouthVoices series

What is Differentiated Care?

The Power of Peers

The Difference is in Delivery

Médecins Sans Frontières (MSF)
Short films focused on MSF's community and award-winning ART adherence club models

Community Model for HIV Treatment

Join the Club

Join the Club (extended)

Right to Care

Africa's First 'ATM Pharmacy' Set Up in Jo'burg to Aid Treatment Access

Pharmacy Dispensing Unit (PDU) in Alexandra with All Sponsors

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