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Community commodity distribution
A client centered DSD model in Eswatini

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BACKGROUND / INTRODUCTION

Community Commodity Distribution (CCD) started in early 2020 in response to travel restrictions during the significant surge of COVID-19 cases and continues to be an opportunity to achieve and sustain 95-95-95 goals. Antiretroviral therapy (ART), tuberculosis (TB) and TB preventive therapy (TPT), pre-exposure prophylaxis (PrEP), family planning (FP) and non-communicable diseases (NCD) commodities are refilled at community Pick up Points (PUP). HIV testing and laboratory services are also provided where possible. A study in 2021 showed the substantial opportunity cost savings (less time seeking, waiting for, and receiving services of ~$4.90 per refill) when accessing services through the PUPs compared to going to existing health facilities. With the great achievements to date, it is important to focus on innovative solutions to offer differentiated service delivery models to stable clients to increase retention and maintain high viral load suppression rate and to decongest health facilities.

METHODS

Eligible recipients of care (ROCs) were identified at facility level from the ART records and at community level from the existing support groups. Interested ROCs are registered into the CCD service delivery model at the public health facilities. The CCD team (nurse, expert client and data clerk) reviewed appointment plans a day prior to service delivery. The CCD facility team contacted the eligible ROCs to confirm their PUP and prepare the necessary medications and commodities. Those accepting the service were recorded into the CCD Register. On the appointment day, the CCD nurse and the expert client carry all the necessary medications and commodities with additional buffer stock to the PUP. ROCs access the service and pick up the medication(s) at the designated PUP. Some ROCs also showed up without appointments but still received the services. Referral to the health facility was recommended when the ROCs was not meeting the CCD eligibility criteria or when the ROCs opted out of the community delivery service.

Figure 1: Summarized facility process before the CCD visit.

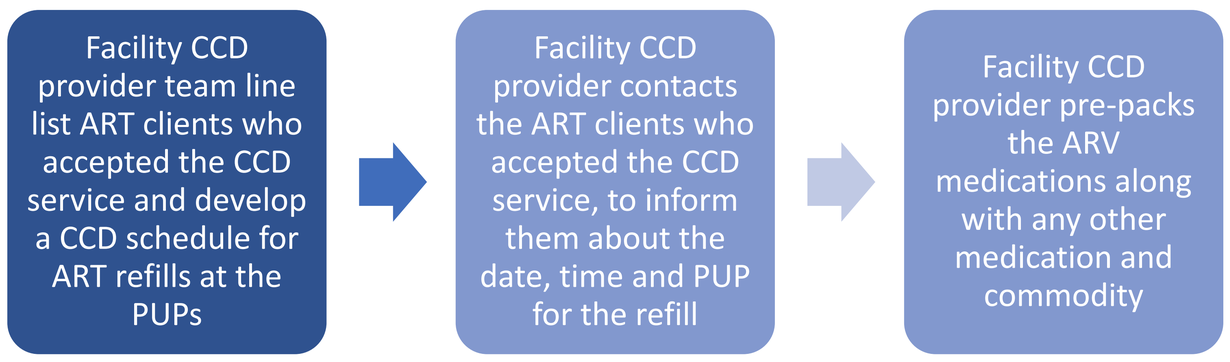
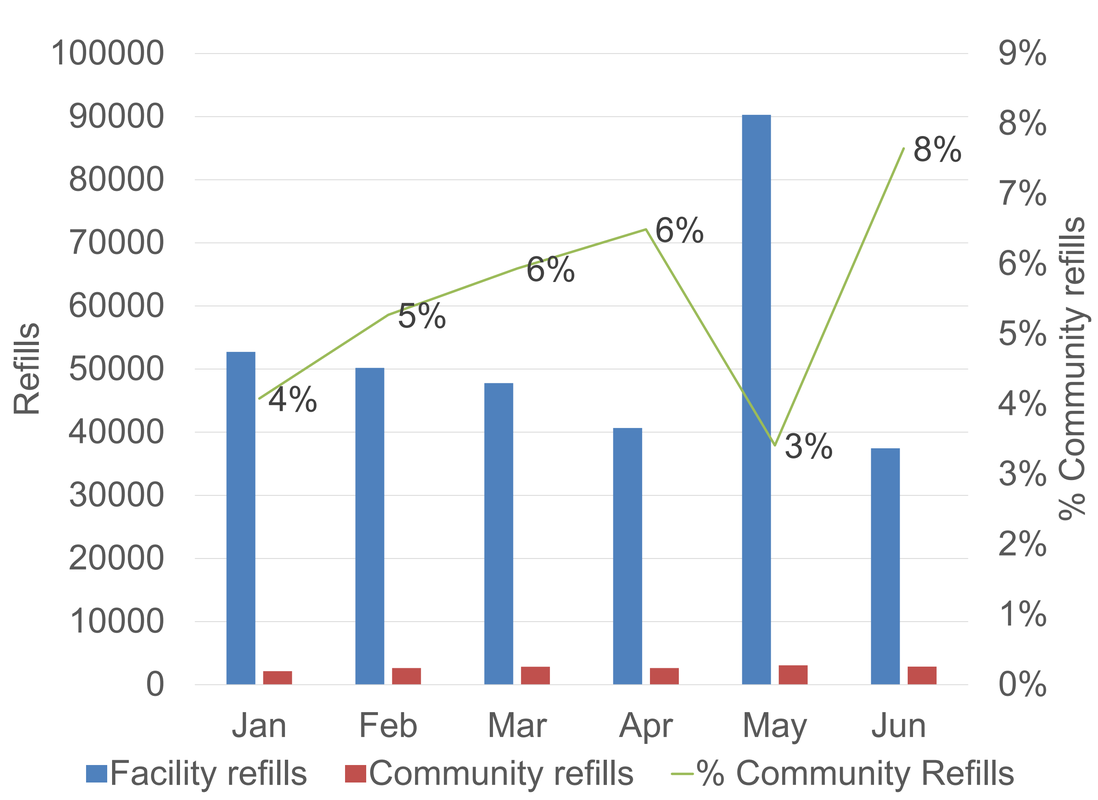


Figure 2: Community Vs facility refills – January to June 2022.

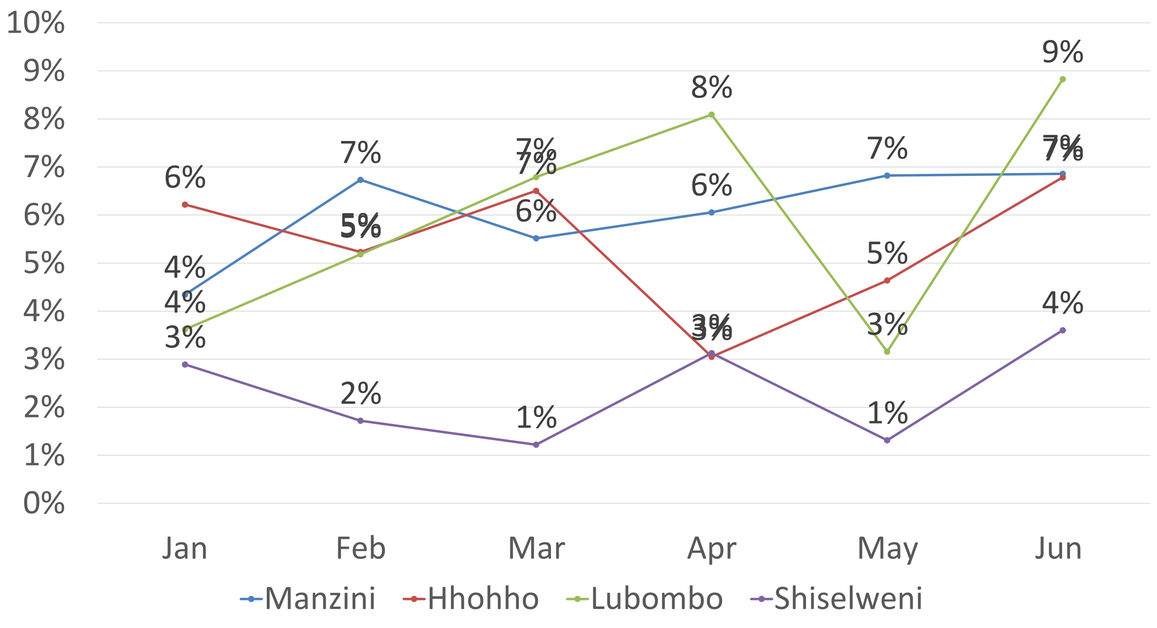


RESULTS

As of June 2022, 109 health facilities planned to implement CCD but the number of health facilities actually implementing CCD were 78 (71%). 686 community distribution points were planned for, but the number of functional community distribution points were 638 (93%). There were more than 20 types of distribution points recorded across the country which ROCs preferred to collect their commodities from. The most preferred PUP in order of preference were the neighborhood care point (community structures centrally located), under a tree, church, school, football pitches, shops, community halls and bus stops. Report from January to June shows that on average, 5.3% of ROCs picked up their commodities from the community PUPs whilst 94.7% refilled through routine facility care (figure 2). Recent HMIS data showed the VL suppression of 98% among CCD / outreach ROCs which was just above the national VLS rate of 97.8%.

Figure 3 below shows CCD from PEPFAR supported sites by regions. Manzini region has the highest in average proportion of ROC receiving commodities through CCD (6%). This is followed by Hhohho and Lubombo (5%). Shiselweni region has the lowest (2%).

Figure 3: Community refills proportions by regions



DISCUSSION

CCD increases access to commodities for people with chronic illnesses beyond the COVID19-driven lockdown period. It reduces costs which otherwise would have been incurred by ROC and supports hard to reach ROC to get services. CCD also decongested facilities and increased service coverage as ROC get ART and other commodities from their comfort areas. It is also worth to noting that due to heavy reliance on implementing partners to implement CCD, meaningful engagement with the MOH is critical to ensure sustainability. Based on the uptake of CCD, public health facilities need to integrate CCD in their outreach programs. Data capturing in the community is not up to scale and the HMIS needs to speed up the roll out of community based electronic medical records capturing. To reduce stigma associated with CCD, full integration of other chronic medications for stable clients would improve coverage and retain clients into care.

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