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M&E of DSD: What's Next?

CQUIN M&E COP Parallel Session

Annual Meeting Session 11b

CQUIN 7th Annual Meeting

November 13 – 17, 2023 | Johannesburg, South Africa

M&E Parallel Session: Run of Show

Moderators: Clorata Gwanzura (MOH Zimbabwe) & Michelle Sherlock Williams (CDC Atlanta)

Time	Activity	Responsible
0-10 min	Arrival in the room, settling down Welcome and introductions	**Dr. Karam Sachathep, ICAP NY**
10-20 min	**Framing remarks (10 mins): Future of M&E of DSD**	
20-65 min	**Presentations (15 min each x 3)** 1. Future of DART (MOH Uganda, Moses Luwunzu) 2. M&E of AHD (EGPAF Global, Reuben Musarandega) 3. Case study for dHTS- (MOH Mozambique, Orrin Tiberi)	**Moderators**
65-115 min	**Additional Panelist Introductions** **Mentimeter Polling** **Panel discussion Q&A** **Panelists:** 1. Mozambique MOH: Orrin Tiberi 2. Uganda MOH: Moses Luwunzu 3. EGPAF Global: Reuben Musarandega 3. ITPC: Pragashnee Murugan 4. WHO: Hiwot Haile-Selassie	**Moderators**
5 min	Closing Remarks and Next Steps	**Moderators/Dr. Sachathep**

Objectives of the Session

- Brief review of the M&E of DART – challenges countries are facing and looking ahead, what are the big-picture questions/issues that remain?

- As the vision of DSD expands to include differentiated services along the cascade, what are we learning about M&E of differentiated testing? What are we learning about M&E of AHD? What are the challenges?

- What are the next steps? What should countries consider including in their annual action plans?

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M&E of DSD: *Change is on the horizon*

Karam Sachathep, PhD

CQUIN Senior SI Manager

CQUIN 7th Annual Meeting

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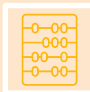
Outline

Future of M&E of DART: Where are we headed now?

Challenges and opportunities within M&E of dHTS

Challenges and opportunities within M&E of AHD

Community engagement in M&E


Conclusions

Setting the Stage: M&E of DSD 2.0?

OPEN

Expanding the Vision for Differentiated Service Delivery: A Call for More Inclusive and Truly Patient-Centered Care for People Living With HIV

Peter Ehrenkranz, MD, MPH,[a] Anna Grimsrud, PhD,[b] Charles B. Holmes, MD, MPH,[c] Peter Preko, MBChB, MPH,[d] and Miriam Rabkin, MD, MPH[d]

Background: Simplifying antiretroviral therapy for clinically stable people living with HIV (PLHIV) is important but insufficient to meet their health care needs, including prevention and treatment of tuberculosis and noncommunicable diseases, routine primary care, and family planning. Integrating these services into differentiated service delivery (DSD) platforms is a promising avenue to achieve such coverage. We propose a transition from an HIV-focused "DSD 1.0" to a patient-centered "DSD 2.0" that is inclusive of additional chronic care services for PLHIV.

Discussion: The lack of coordination between HIV programs and these critical services puts a burden on both PLHIV and health systems. For individual patients, fractionated services increase cost and time, diminish the actual and perceived quality of care, and increase the risk that they will disengage from health care altogether. The burden on the health system is one of inefficiency and suboptimal outcomes resulting from the parallel systems required to manage multiple vertical programs.

Conclusions: DSD 2.0 provides an opportunity for the HIV and Universal Health Coverage agendas—which can seem to be at odds—to achieve greater collective impact for patients and health systems by integrating strong vertical HIV, tuberculosis and family planning programs, and relatively weaker noncommunicable disease programs. Increasing coordination of care for PLHIV will increase the likelihood of achieving and sustaining UNAIDS' goals of retention on anti-retroviral therapy and viral suppression. Eventually, this shift to DSD 2.0 for PLHIV could evolve to a more person-centered vision of chronic care services that would also serve the general population.

Key Words: HIV, ART, differentiated service delivery, Universal Health Care, noncommunicable diseases, family planning, tuberculosis preventive therapy, sustainability

(*J Acquir Immune Defic Syndr* 2021;86:147–152)

INTRODUCTION

Differentiated service delivery (DSD)—a "patient-centered approach that simplifies and adapts HIV services across the cascade to serve the needs of people living with HIV (PLHIV) better and reduce unnecessary burdens on the health system[1]"— has emerged as a core tenet of HIV programs in resource-limited settings.[2–4] Practically speaking, DSD is operationalized by adjusting the frequency of visits, the location of service delivery, the cadre of health care worker, and the package of services according to the needs of different groups of PLHIV. Varying the configuration of these factors results in DSD treatment models that often separate clinical visits from antiretroviral therapy (ART) refills including "fast track" refill pick-ups in the facility or community, client-managed community adherence groups and health care worker managed groups.[5]

Efforts are ongoing to define the extent and impact of DSD scale-up in sub-Saharan Africa.[6,7] Current data are sufficient to show that the numbers of people receiving extended medication refills, which is one component of DSD, has risen dramatically. A recent analysis of US President's Emergency Plan for AIDS Relief (PEPFAR)-supported countries (excluding South Africa) reported an increase in the percentage of patients receiving 3 or more months of refills from 46% to 69% between October 2019 and June 2020.[8] The COVID-19 epidemic accelerated this rapid change in dispensing practices and the uptake and adaptation of various DSD models across sub-Saharan Africa.[9]

Preliminary data evaluating the outcomes of DSD treatment programs across multiple countries[10] support the concept that continued scale-up of DSD is critical to attaining the ambitious coverage, retention, and quality targets of the global HIV response.[11] However, simplifying ART delivery for clinically stable PLHIV is not sufficient to meet all of their health care needs, which often include prevention and treatment of tuberculosis (TB), routine preventive and

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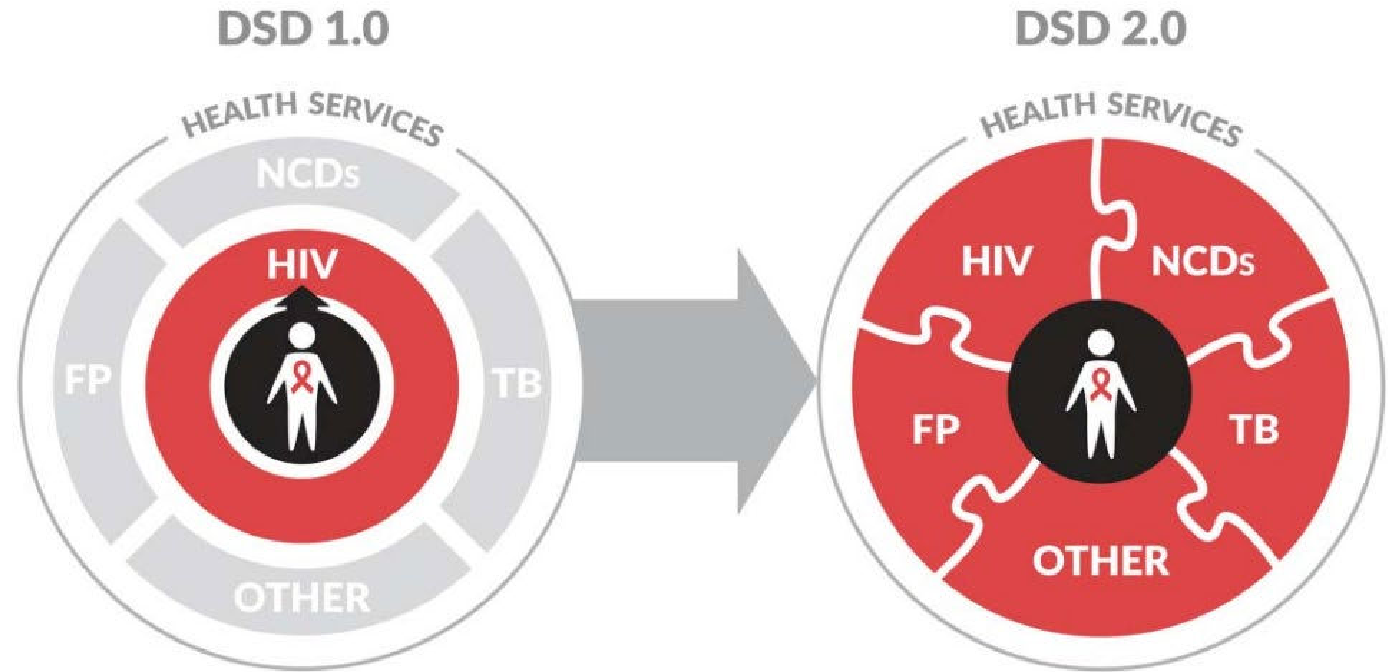


FIGURE 1. A description of the proposed transition from an HIV-focused "DSD 1.0" to a patient-centered "DSD 2.0." DSD 2.0 is inclusive of additional chronic care services for PLHIV, such as TB, FP, NCDs, and others. full color online

M&E of DART

2023 CMM Results: Data sorted by maturity with each stage

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Policies																					
Guidelines																					
Diversity of DART services																					
DSD Scale-up Plan																					
Coordination																					
Meaningful Community Engagement																					
Training																					
M&E system																					
Procurement and Stock Management																					
Less Intensive DART facility coverage																					
Less Intensive DART Client Coverage																					
Advanced HIV Disease																					
DART Services for Key Populations																					
TB/HIV																					
Differentiated MCH Services																					
HTN																					
Integration of FP into DART Models																					
Quality of DART Services																					
Impact of DART Services																					

Least mature — Most mature

Rows = domains in the 2023 Treatment CMM
Columns = not meaningful

HIV Learning Network
The CQUIN Project for Differentiated Service Delivery

DART CMM: M&E Domain

M&E System	Elements of a national system for M&E of DART are in development but have not yet been implemented **OR** there is no element of a national system for M&E of DART, nor are any in development	The national M&E system produces summaries of ART enrollment disaggregated by frequency of multi-month dispensing for at least 75% of recipients of care on ART **OR** the national M&E system produces summaries of ART enrollment disaggregated by model type[8] for at least 75% of recipients of care on ART	The national M&E system produces summaries of ART enrollment disaggregated by frequency of multi-month dispensing for at least 75% of recipients of care on ART **AND** the national M&E system produces summaries of ART enrollment disaggregated by model type for at least 75% of recipients of care on ART	In addition to meeting the criteria for the yellow stage, the national M&E system reports: o retention and VL suppression rates for PLHIV disaggregated by frequency of multi-month dispensing and model type for at least 75% of recipients of care on ART **OR** o mean and median numbers of: a) clinic visits AND b) ART pickups per recipient of care per year for PLHIV in less-intensive vs. more-intensive DART models for at least 75% of recipients of care on ART	**In addition** to meeting the criteria for the light green stage, the national M&E system reports: 1. retention and VL suppression rates disaggregated by frequency of multi-month dispensing AND model type for at least 75% of recipients of care on ART **AND** 2. mean and median numbers of a) clinic visits per recipient of care AND b) of ART pickups per recipient of care per year for PLHIV in less-intensive vs. more-intensive DART models for at least 75% of recipients of care on ART

Key Summaries from recent Virtual Key Informant Interviews (N=5 CQUIN Countries, June-August 2023)

- Respondents: Cote d'Ivoire, Malawi, Mozambique, Uganda, and Zimbabwe
- Key Lessons Learned:
  - Basic components of M&E of DSD are established in all 5 countries
  - DSD is well-established across all 5 countries and has increasingly become a standard of care – rather than a new innovation
  - ***Changes are brewing***... in Uganda for now, but anecdotally elsewhere too
  - Some countries are introducing *flexibility* in DART eligibility criteria across models
  - Countries may increasingly envision DSD models as adaptable to individuals' needs across time – for example RoC can "stay in their DSD model" while receiving high viral load services, and models can incorporate elements of integrated services (such as FP and NCD services) on a need-to basis
  - Critical need for 'adaptive M&E' of DSD (for monitoring the impact (ie. outcomes) due to changes in guidelines/policies)

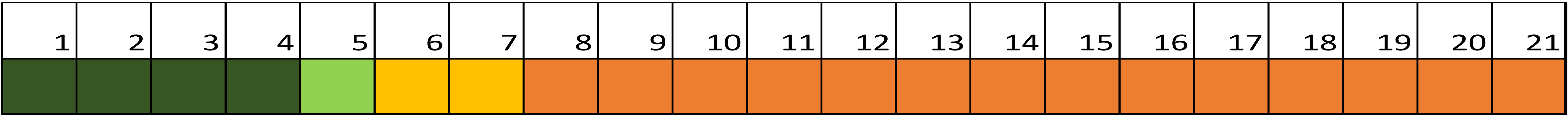
M&E of dHTS

Country staging results for the dHTS CMM 2023

		CMM Domains	CQUIN Member Countries January / February 2023
1	Policies/ Guidelines	1. Strategic model mix and decentralisation	
2		2. Optimizing HIV Testing	
3		3: Linkage	
4		Financing and resource allocation	
5		SOPs	
6		Implementation and scale up plan	
7		Meaningful community engagement	
8		Private sector engagement/oversight	
9		Coordination	
10		dHTS Training	
11		M&E	
12		Procurement & supply chain management	
13		Population coverage	
14	Linkage to tx	1: Timely Linkage	
15		2: Confirmatory/ Verification testing	
16		Linkage to prevention and other services	
17	Quality of testing services	1: EQA/IQC	
18		2: Proficiency Testing	
19		3: Clinical services	
20	Impact	1: Knowledge of HIV status	
21		2: Linkage to treatment	
22		3: Linkage to prevention	

M&E-specific Domain: Self Staging Results (N=21)

Country self-staging results:



Most countries (16/21) had **substantive challenges**:

- 14 scored **orange:** "**Only some (not all)** of the six dHTS priority indicators have been **integrated into the national Health Information System**."
- 2 scored **yellow** "**All the six dHTS priority indicators are integrated** into the National Health Information System but the **reports are not routinely utilized**."

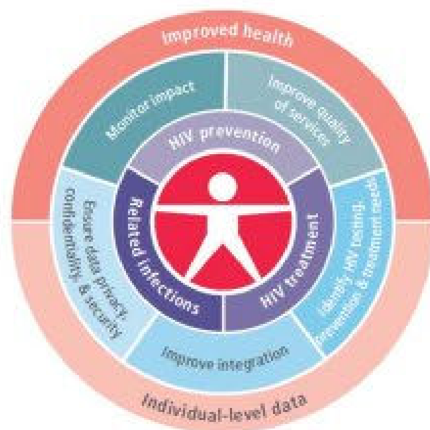
dHTS CMM: M&E Domain

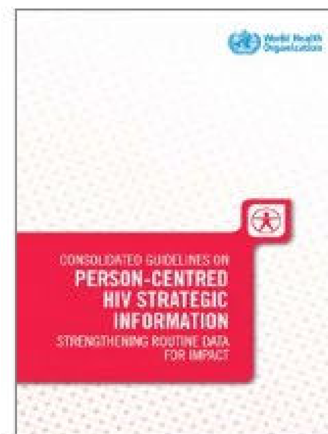
M&E *dHTS data are integrated into the national M&E system, which captures and disaggregates relevant dHTS indicators by model and these data are used regularly at the national, subnational, facility, and community levels to assess performance against targets and improve the quality, efficiency, and coverage of HTS*	None of the dHTS priority indicators are currently incorporated in the National Health Information System **Priority indicators,** disaggregated by dHTS modality/ testing approach[1] (*refer to the footnote below). 1. Testing rate 2. Testing outcome 3. Geographic coverage 4. Population coverage 5. Linkage to treatment 6. Linkage to combination prevention for people tested HIV negative.	Only some (not all) of the six dHTS priority indicators have been integrated into the national Health Information System.	All the six dHTS priority indicators are integrated into the National Health Information System but the reports are not routinely utilized.	All the six dHTS priority indicators are integrated into the National Health Information System and the dHTS performance reports are produced and routinely used at **some BUT not all levels** (i.e., national, sub-national, facility, and community levels).	All the six dHTS priority indicators are integrated into the National Health Information System and dHTS performance reports are produced and routinely used at all levels (i.e., national, sub-national, facility, and community levels

What's new in HIV testing in 2022 WHO HIV strategic information guidelines

World Health Organization

Scope of monitoring extended to include HIV testing recognizing need for robust longitudinal monitoring & linkage across entire HIV care cascade





NEW!

HIV testing

- Guidance on HTS focusing on early diagnosis, strengthening data use to support linkage to care, community & HIVST, HIV partner testing and notification and HTS for key populations
- New recommendation for monitoring testing
- New core indicator added HTS.3 **People testing positive for HIV** in addition to HTS.2 test volume and positivity
- HTS registers included in annexes

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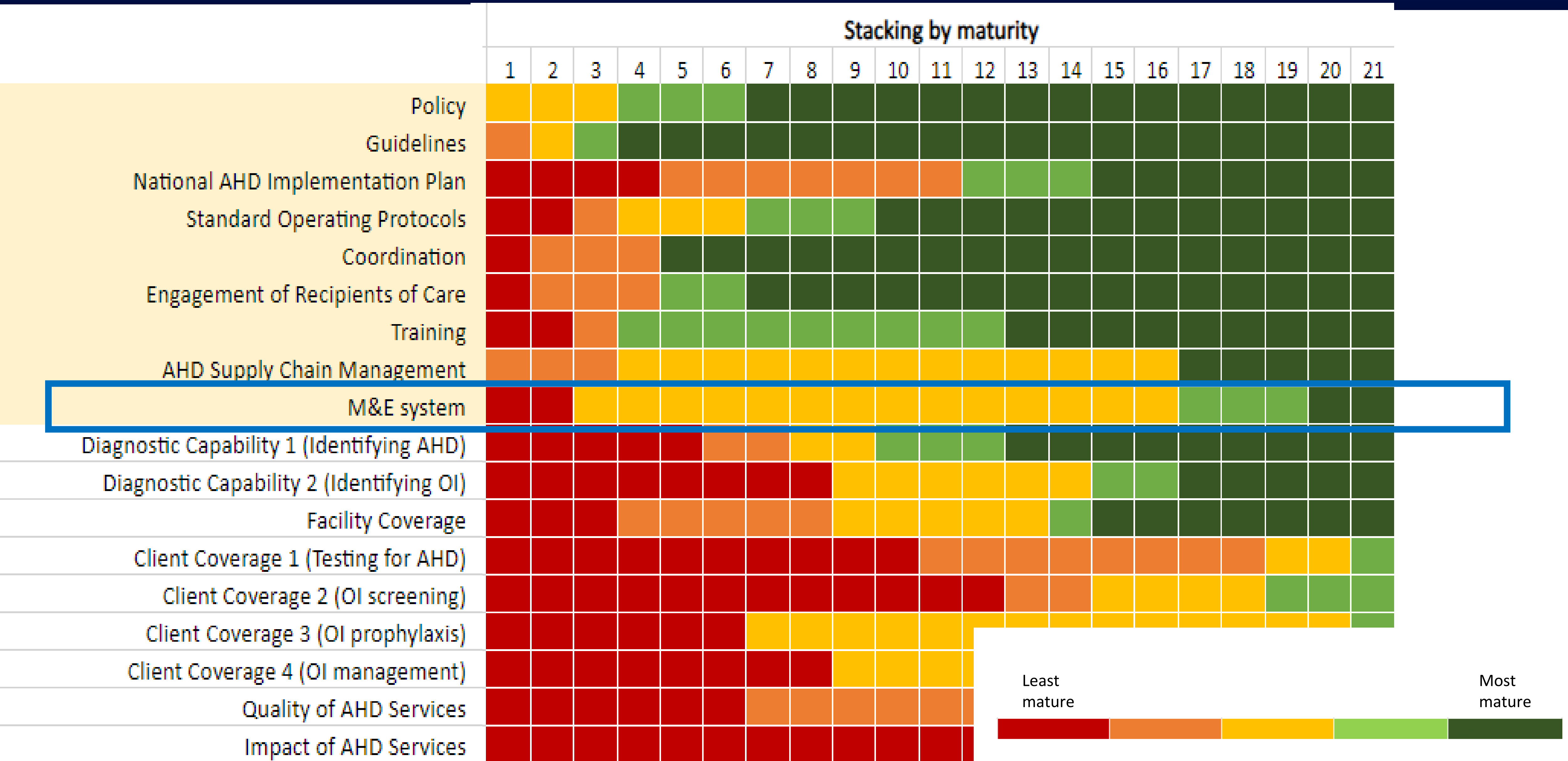
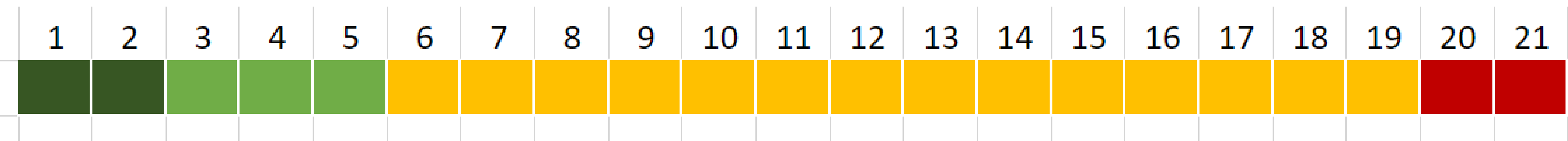
M&E of AHD

AHD CMM Results 2023 (N=21)



M&E Specific Domain – AHD CMM

Country self-staging results:



Most countries (16/21) had **substantive challenges**:

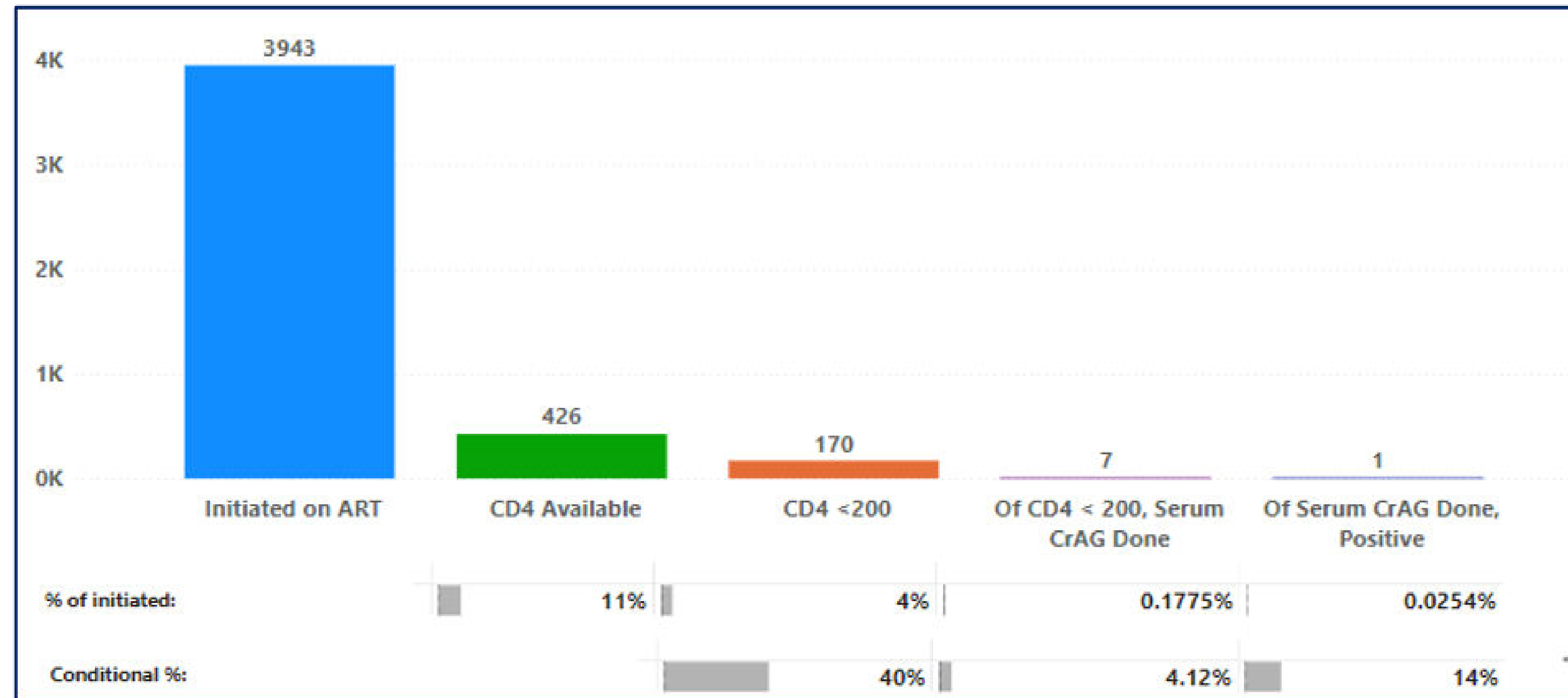
- 14 scored **yellow:** "**At least one** necessary AHD-related data element is **being systematically documented, and reported**, but data elements **are not comprehensive** (e.g., not all data are included) **and/or are not fully integrated** into national M&E tools or the national HMIS"
- 2 scored **red**: "**Some data necessary for M&E of AHD services (e.g., data needed to determine eligibility, track recipients enrolled in AHD services, determine recipient outcomes, etc.) may be documented, but not in a systematic and structured way**"

AHD CMM: M&E Domain

M&E System	Some data necessary for M&E of AHD services (e.g., data needed to determine eligibility, track recipients enrolled in AHD services, determine recipient outcomes, etc.) may be documented, but not in a systematic and structured way	At least some necessary AHD-related data elements are being documented in a systematic and structured way, but none are reported routinely via national M&E tools/HMIS *AND* Revisions to national M&E tools to structure routine reporting or collection of additional AHD data are planned	At least one necessary AHD-related data element is being systematically documented, and reported but data elements are not comprehensive (e.g., not all data are included) and/or are not fully integrated into national M&E tools or the national HMIS	Most of the necessary AHD-related data elements are being systematically collected, reported, analyzed, and reviewed regularly and refinements to the data elements are needed to fully integrate into national M&E tools or the national HMIS for HIV/ART services.	All the necessary AHD-related data elements are being systematically collected, reported, analyzed, and reviewed regularly and are integrated into national M&E tools and the national HMIS for HIV/ART services.

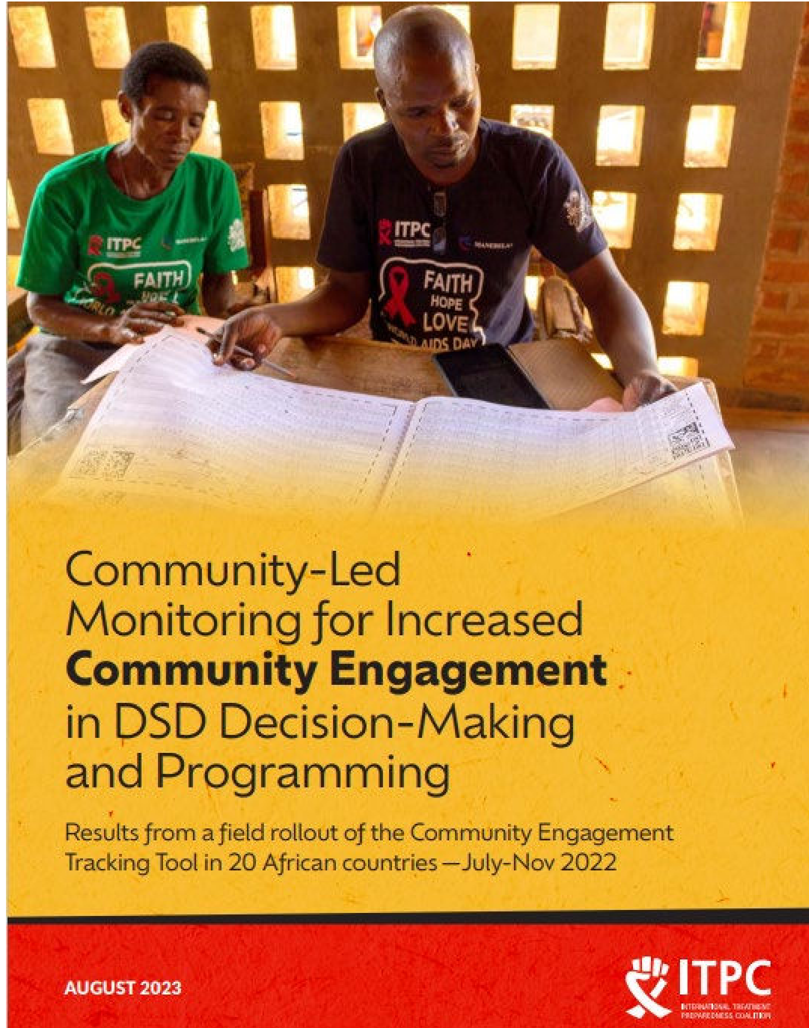
Data Performance Reviews: AHD cascade

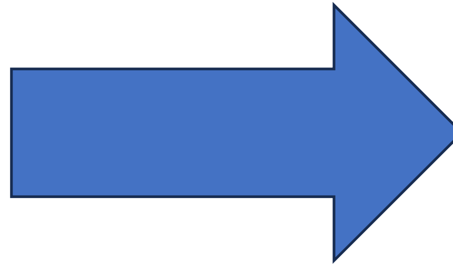
- DPRs allow for more in-depth analyses of various aspects of coverage and quality due to the use of client-level of interest
- The AHD cascade is more recently part of some of the additional indicators countries have been opting to include in their DPRs
- Following DPR data collection, countries come up with action plans: in this case the country advocated for revamping CD4 testing platforms



Community Engagement in M&E

Community Engagement *in* M&E





Key findings

Communities are most often involved in the design of DSD policies and programs and far less in the M&E of DSD programs.

Strong engagement at policy and community levels within the design levels was linked to decision-makers understanding the need to involve Recipients of Care (RoC) in DSD for its success when compared with the historical involvement of RoC in HIV service delivery.

Low levels of CE were linked to M&E activities

Conclusions

Few CQUIN countries reported mature national M&E systems for differentiated ART, AHD, or HTS

Additional work will be needed to address M&E needs of DSD 2.0 and evolving DSD of ART

More data/research is required to determine whether model eligibility criteria are appropriate for client populations; especially with changing eligibility criteria

More resources are required (national guidelines, funding, infrastructure, etc.) to support countries that are moving towards a 'client-centered' approach

Patient-centered care: how is this possible *without* community engagement?

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Thank you!