ICAP Grand Rounds

Differentiated HIV Service Delivery and COVID-19: Resilience, Innovation, and Lessons Learned

July 27, 2021

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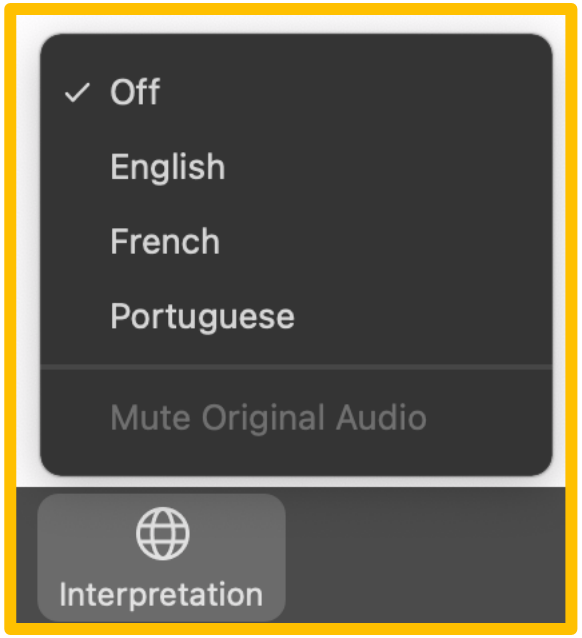

Agenda

1. **Welcome, Framing Remarks and Introductions**

   Fatima Tsiouris, MS
   Deputy Director, Human Resources for Health Development
   ICAP at Columbia University

2. **DSD and COVID-19: Resilience, Innovation, and Lessons Learned**

   Catherine Godfrey, MD, FRACP
   Senior Technical Advisor, HIV Care and Treatment
   PEPFAR/Office of the Global AIDS Coordinator

   Tiffany Harris, PhD, MS
   Director, Strategic Information Unit
   ICAP at Columbia University

   Peter Preko, MB.ChB, MPH
   CQUIN Project Director
   ICAP at Columbia University

3. **Q&A and Discussion**

Reminders:

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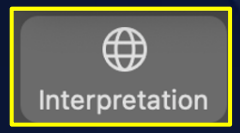

For questions to the panelists, use the **Q&A box**

Please use the **chat box** to indicate your name and organization

The webinar recording and slides will be posted on **www.icap.columbia.edu**

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Differentiated Service Delivery and COVID-19

DSD is a client-centered approach to the design of HIV programs that simplifies and adapts HIV services across the prevention, testing and treatment cascade to reflect the preferences and expectations of various groups of people living with HIV while reducing unnecessary burdens on the health system

- Less-intensive models for people doing well on treatment
- More-intensive models for people starting care, with advanced disease, with co-morbidity and/or need for more frequent support

DSD is about the "how" of service delivery: where, when, how often, and by whom services are provided

- Facility-based *vs.* community based
- Group vs. individual models
- HCW-led *vs.* peer-led

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Differentiated Service Delivery and COVID-19 – continued

- In recent years, countries across the world have scaled up less-intensive models for people doing well on HIV treatment
- Key elements include:
  - De-linking drug pickups and clinical services
  - Multi-month dispensing of ART
  - Increasingly diverse options for community-based service delivery
- This experience proved highly valuable when the COVID-19 pandemic hit health systems around the world
  - Enabled innovative and resilient responses
  - Accelerated the scale-up of DSD in many settings

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Introductions

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Senior Technical Advisor
HIV Care and Treatment
PEPFAR/ Office of the Global AIDS Coordinator

Tiffany Harris, PhD, MS
Director, ICAP Strategic Information Unit
Associate Professor, Epidemiology
Columbia University Mailman School of Public Health

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PEPFAR

U.S. President's Emergency Plan for AIDS Relief

DSD in the time of COVID-19: PEPFAR's response

Katy Godfrey MD | 30 July 2021

18 YEARS OF SAVING LIVES THROUGH AMERICAN GENEROSITY AND PARTNERSHIPS

In the context of COVID-19, PEPFAR is firmly focused on

1. Ensuring continuity of care for people living with HIV
2. Leveraging PEPFAR-supported health systems and infrastructure
3. Reducing exposure of staff and HIV clients to health care settings that may be overburdened and/or sources for potential exposure to COVID-19
4. Providing flexibility for PEPFAR programs in how to optimally serve our HIV clients in areas affected by COVID-19

PEPFAR
U.S. President's Emergency Plan for AIDS Relief

Key Interventions: Emphasis on convenient, client-centered care

- Minimize interruptions in treatment.
- Support re-engagement in care
- De-linking of clinical care from drug delivery
- "The critical intervention for all programs and individuals is to accelerate and complete scale-up of 3-6 multi-month dispensing (MMD) of ART and decentralized distribution for all people living with HIV including pregnant and breast-feeding women and children."*
- Use of virtual platforms to communicate with recipients of care

- **DSD is more than multi month dispensing!**

*PEPFAR technical guidance during COVID-19 https://www.state.gov/pepfar/coronavirus/

Expanded eligibility for MMD

- Children
- Pregnant and breast-feeding women
- Clients newly on ART
- Clients not meeting definition of “clinically stable”
- Remove the requirement for viral load measurement prior to offering DSD

MMD Data Collection

MMD data collection began fiscal year 2020 (Oct 2019 – Sept 2020)

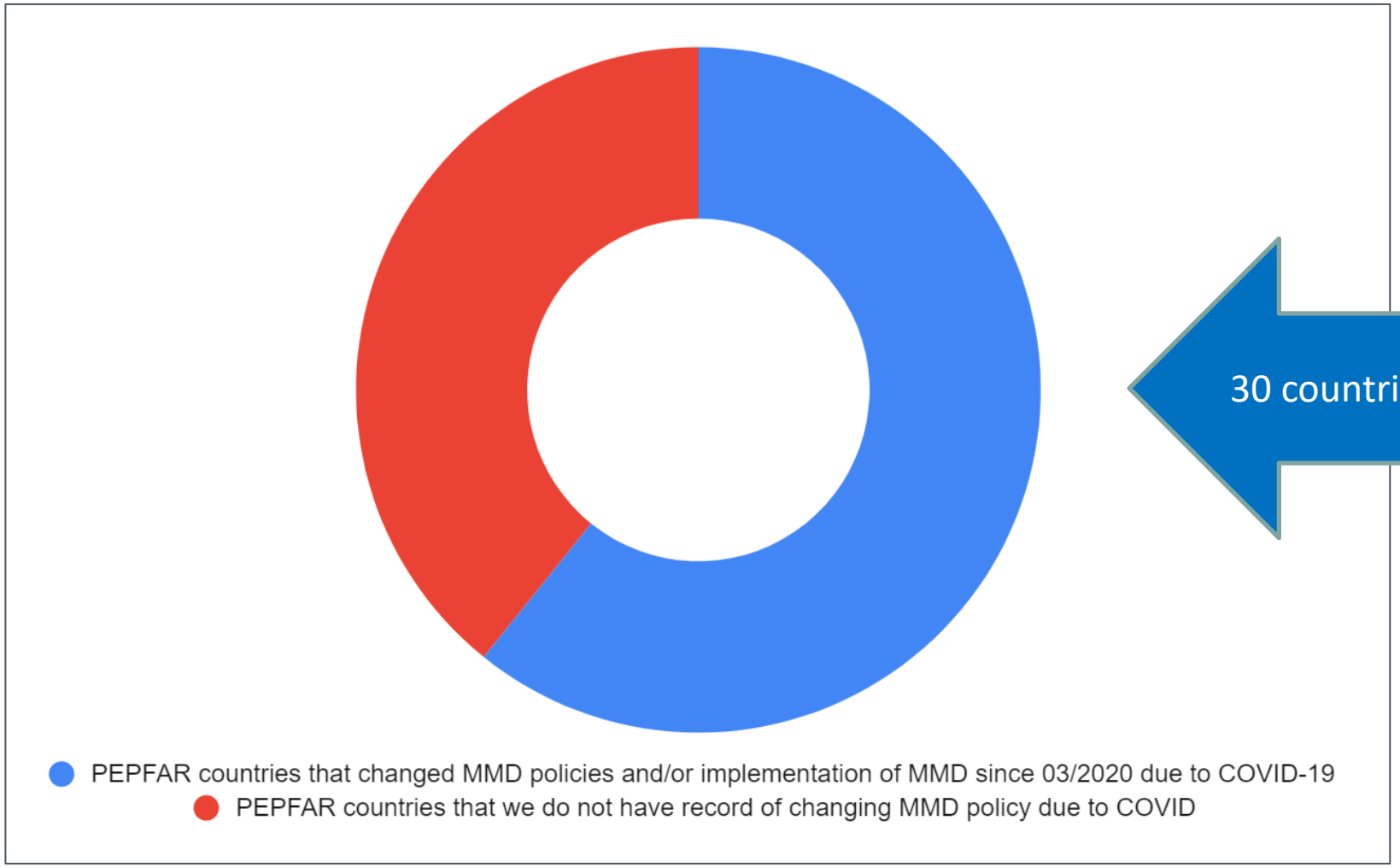
Collected quarterly in 51 countries

Number of clients receiving MMD / total number of clients on treatment

Three treatment categories

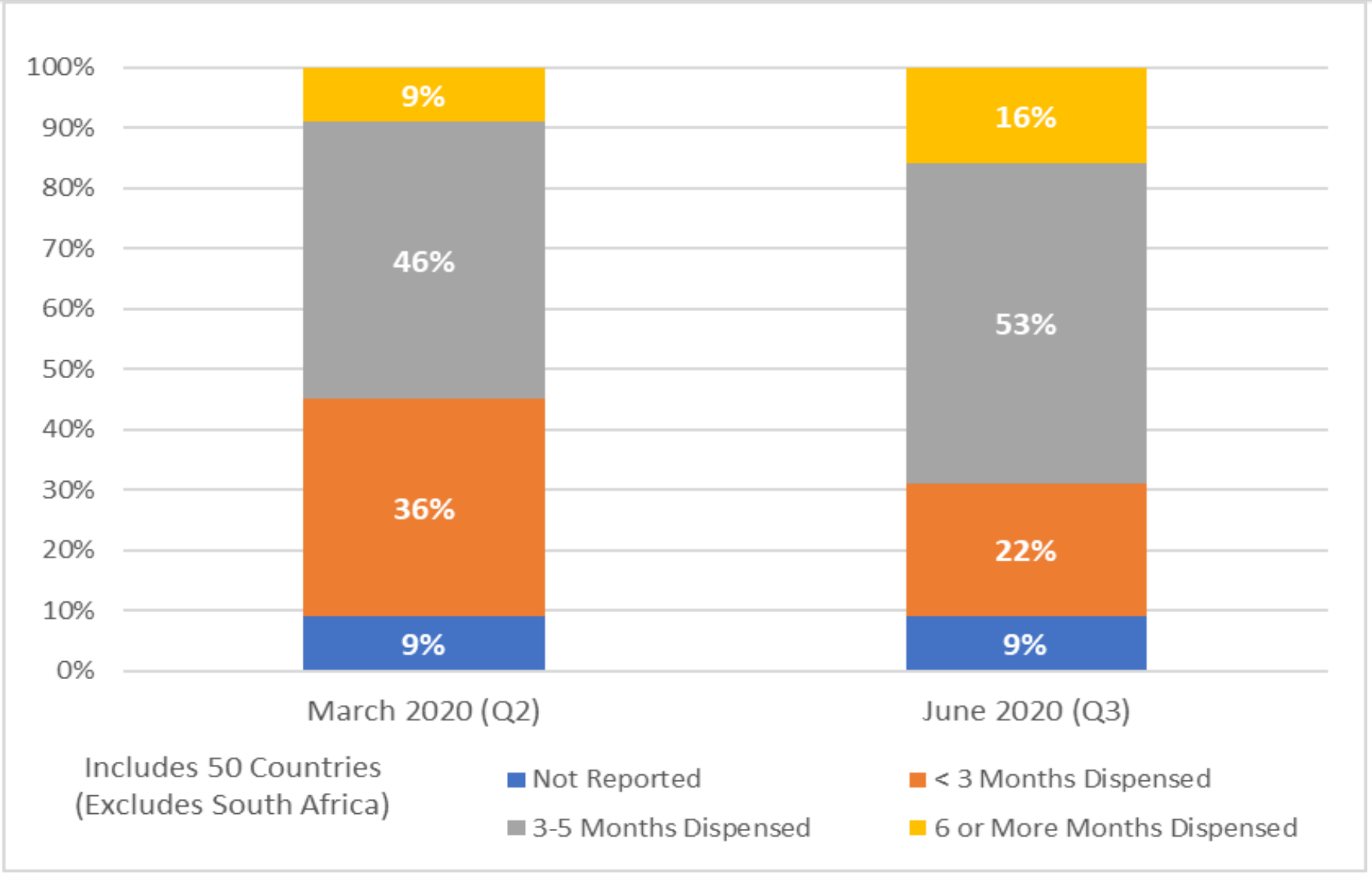
- –ARV dispensing quantity < 3 months (not considered MMD)
- –ARV dispensing quantity 3-5 months
- –ARV dispensing quantity 6 or more months

Country Specific adaptations

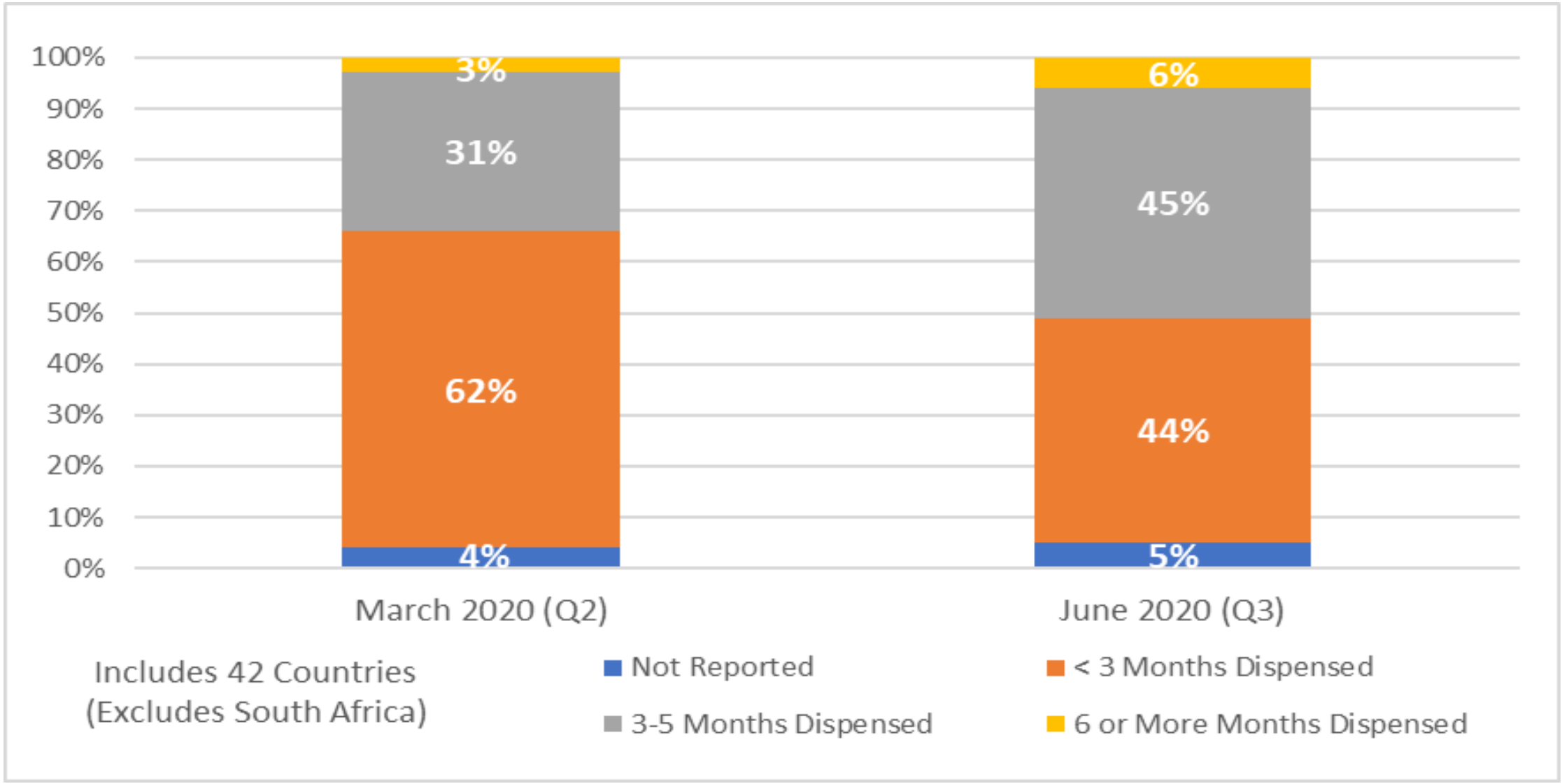


30 countries changed MMD guidelines

Dispensing Changes in 50 Countries: March – June 2020



Pediatric MMD



Mozambique: Delivery Adaptations Facilitated Treatment Growth

- **Expanded patient-centered, differentiated service delivery models, further scaled in the context of COVID-19**
  - Community/decentralized ART distribution through health providers, mobile brigades and private pharmacies
  - Multi-month visits and drug dispensing (for ART and TB preventive therapy), and expanded eligibility criteria
  - Models for families, “Mentor mother” support and one-stop-shop options for pregnant and breastfeeding women and infants

ART provision in the community

Mobile brigade delivering community ART services

- **Strengthened patient literacy and adherence support systems**
  - Psychosocial support, provided remotely during COVID-19
  - Mental health and faith-based services
  - Male engagement (and planned youth case management) programs
  - Strategic marketing and stigma reduction campaigns
  - Patient tracking, tracing and return-to-care interventions, leveraging phone calls for remote outreach during COVID-19
- **Optimized site-level support**
  - Adapted site monitoring and mentorship framework
  - Targeted human resource allocation

Source: CDC/PEPFAR Mozambique

Implementation

- ✓ Supply chain
- ✓ Facility level planning
- ✓ Client/community engagement

Supply Chain

- Supply chain integrity compromised in the early days
  - Drug manufacturing
  - Delays in delivery of both raw materials and finished products
- Unexpected rapid scale-up of MMD led to extreme pressure
- Buffer stocks used to replenish facilities, led to central shortages
- Requantification of need, changes in SOPs for drug ordering, early placement of orders

Client/community engagement

- Involving CHWs, patient navigators and psychologists to improve treatment literacy and support clients newly enrolled on MMD
- Coupling MMD with community-based drug distribution

Facility-level planning

Early ordering of drugs

- Focused support to sites with low uptake
- MMD focal person to review patient charts and identify MMD candidates
- Family centered approach that aligns pickups

Laboratory supplies also affected: reagents, equipment used for COVID-19 testing

Other supplies (e.g. PPE) less well organized, but adapting drug model for these essential supplies

From Guidance to Rollout

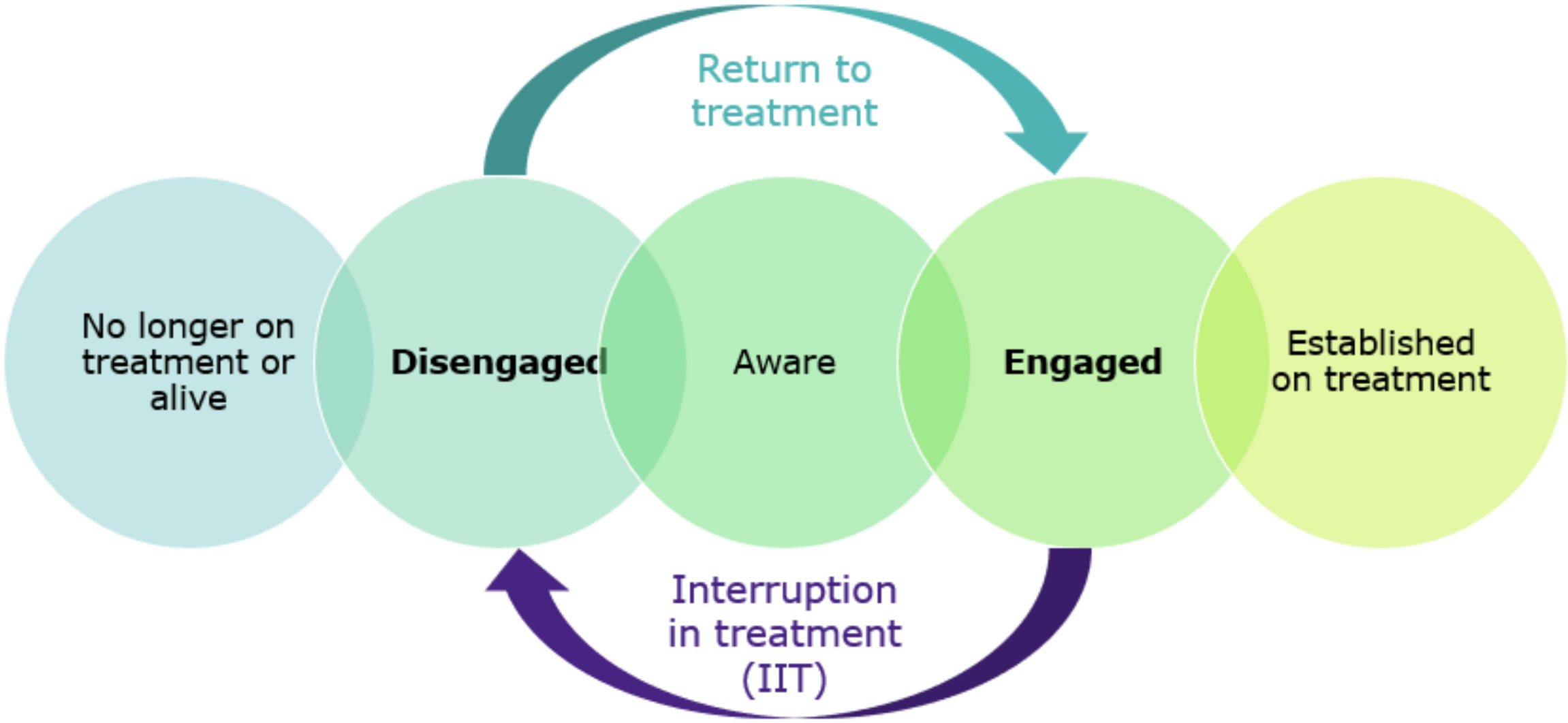
- PEPFAR has been providing regular technical guidance throughout the pandemic https://www.state.gov/pepfar/coronavirus/

- ***What is most important for PEPFAR teams to implement at this time?***
  The critical intervention for all programs and individuals is to accelerate and complete scale-up of 3-6 multi-month dispensing (MMD) of ART and decentralized distribution for all people living with HIV including pregnant and breast-feeding women and children.

Reimagining Treatment continuity in the setting of COVID-19

- Emphasis on shared goals, client centered services
- Churn, normalizing “hiccups”
- Understand and plan for disruptions
- Understanding the local context is critical

Churn: Engagement and reengagement



Who has treatment interruptions?

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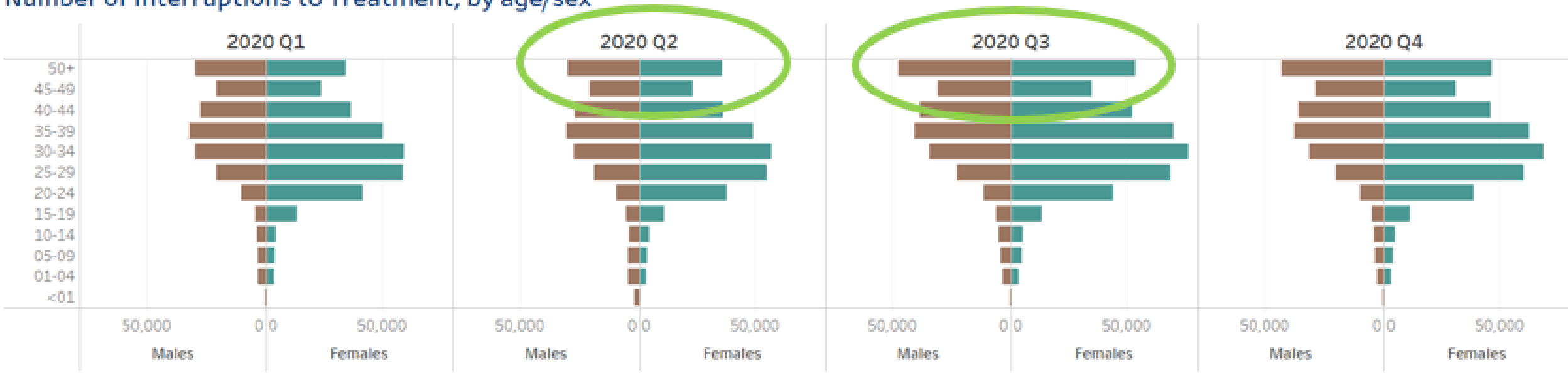
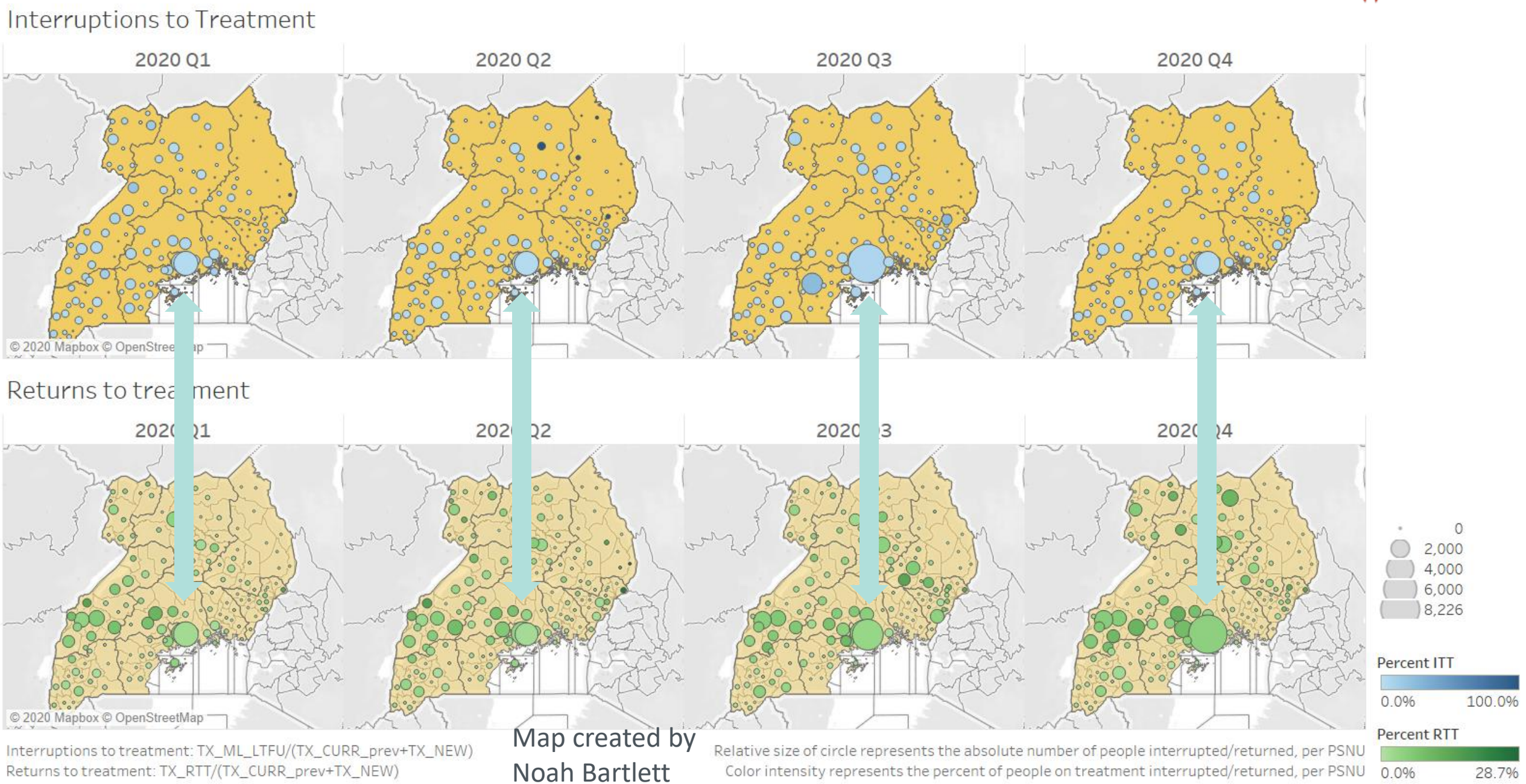
Number of Interruptions to Treatment, by age/sex



Uganda churn: IIT and return trends by Region



Interruptions to treatment: TX_ML_LTFU/(TX_CURR_prev+TX_NEW)
Returns to treatment: TX_RTT/(TX_CURR_prev+TX_NEW)

Map created by
Noah Bartlett

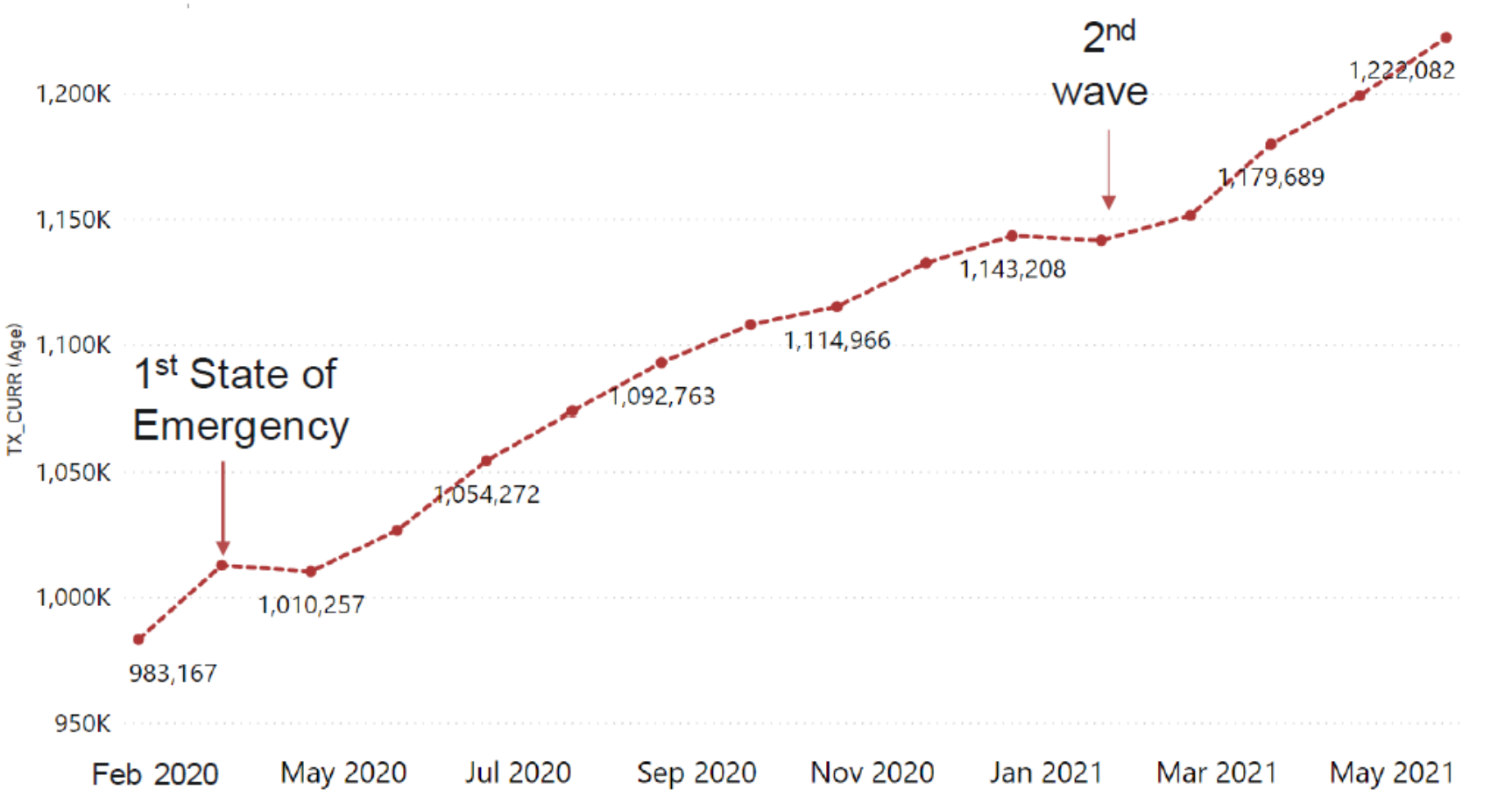
Relative size of circle represents the absolute number of people interrupted/returned, per PSNU
Color intensity represents the percent of people on treatment interrupted/returned, per PSNU

Strategic Program Adaptations Facilitate Growth Despite COVID-19

Adaptations in Response to the COVID-19 Pandemic

- Community ARV distribution by health providers
- ARV distribution in alternative points in HF
- Revision of 3MDD inclusion criteria
- Expedited rollout of 3MDD of INH (TPT)
- Remote psycho-social support by telephone
- Adapted PEPFAR site monitoring framework

TX_CURR at AJUDA Sites* - February 2020 to May 2021



*Only AJUDA sites with EPTS and consistently reporting since the start of FY21 (n= 573, >90% of quarterly reported TX_CURR from AJUDA sites)

Summary

- Differentiated service delivery has provided a mechanism for improving continuity of care
- Evaluation of the impact of COVID-19 is ongoing, but treatment programs seem preserved
- Need to take into context local conditions and plan for interruptions.
- Many Covid-related adaptations are helpful and are here to stay

Acknowledgements

Lauren Bailey

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Patrica Agaba

Isaac Zulu

Bob Ferris

Introductions

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RESILIENCE OF HIV SERVICES DURING THE COVID-19 PANDEMIC AT HEALTH FACILITIES IN AFRICA

July 27, 2021

Tiffany G. Harris, Edward Jaszi, Matthew R. Lamb, Carlos Laudari, Maria Lúcia Furtado, Bonaparte Nijirazana, Ndayizeye Aimé, Gabriel Loni Ekali, Lifanda Ebiama Lifanda, Hermann Brou, Eboi Ehui, Faustin Malele, Aime Mboyo, Ruben Sahabo, Nkhosikhona Advocate Dlamini, Zenebe Melaku, Mirtie Getachew, Mark Hawken, Catherine Ngugi, Mirriah Vitale, Munira Abudou, Florence Bayoa, Victoria Acut, Prisca Kasonde, Paul Munsanje, Wafaa M. El-Sadr

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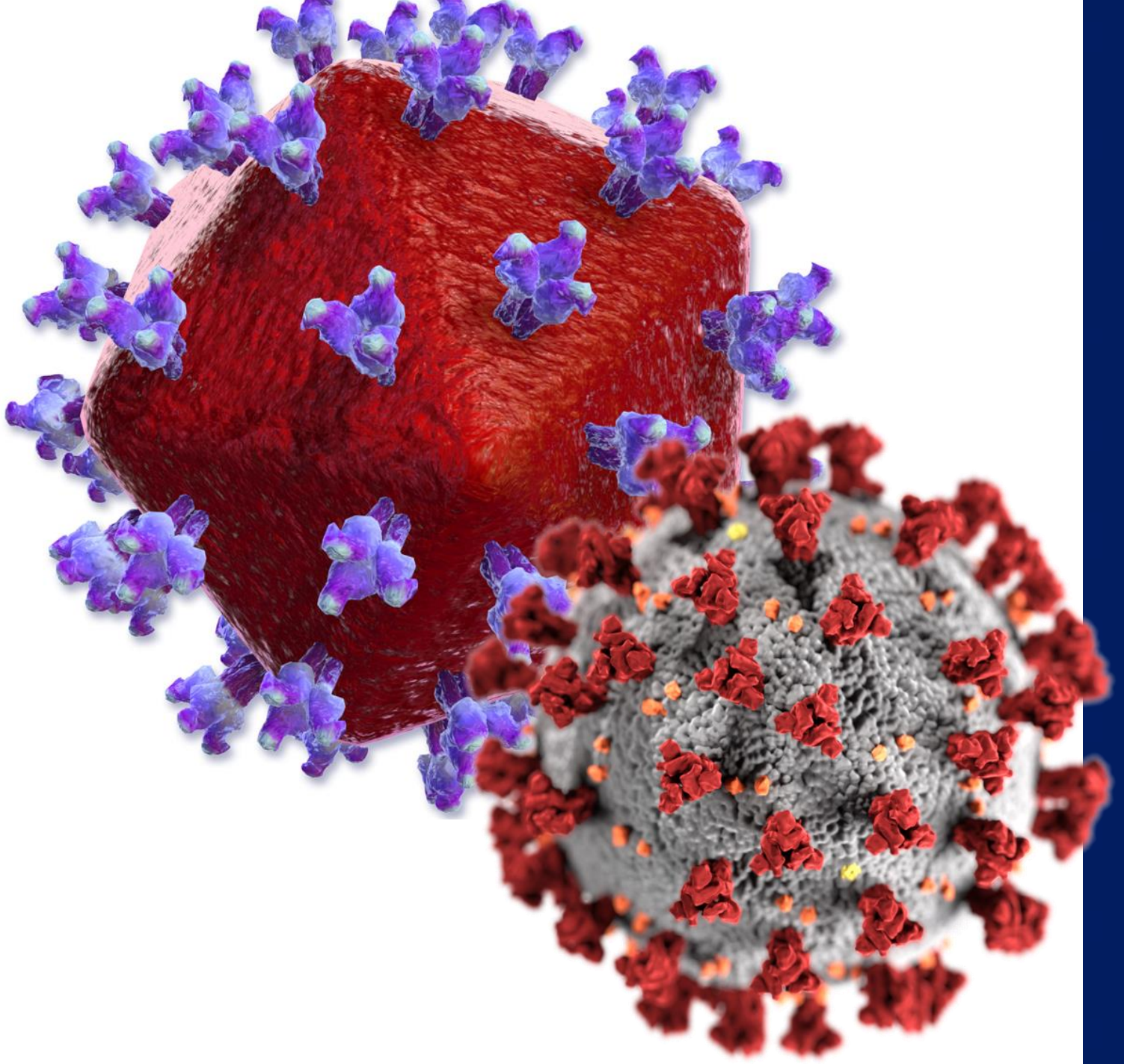


Background

- The COVID-19 pandemic has affected access to health services due to:
  - travel restrictions
  - fear of exposure at health facilities (HF)
  - changes in national policies and redirection of resources

- In response to the pandemic, there has been an expansion of differentiated service delivery models (e.g., multi-month dispensing of antiretroviral [ARV] drugs) and other innovations

- We examined the effect of the COVID-19 pandemic on specific HIV services, including HIV testing, use of antiretroviral therapy (ART), and viral load (VL) testing as well as VL suppression (VLS) at ICAP supported HF in 11 African countries

Q1 → **Q2** → **Q3** → **Q4**

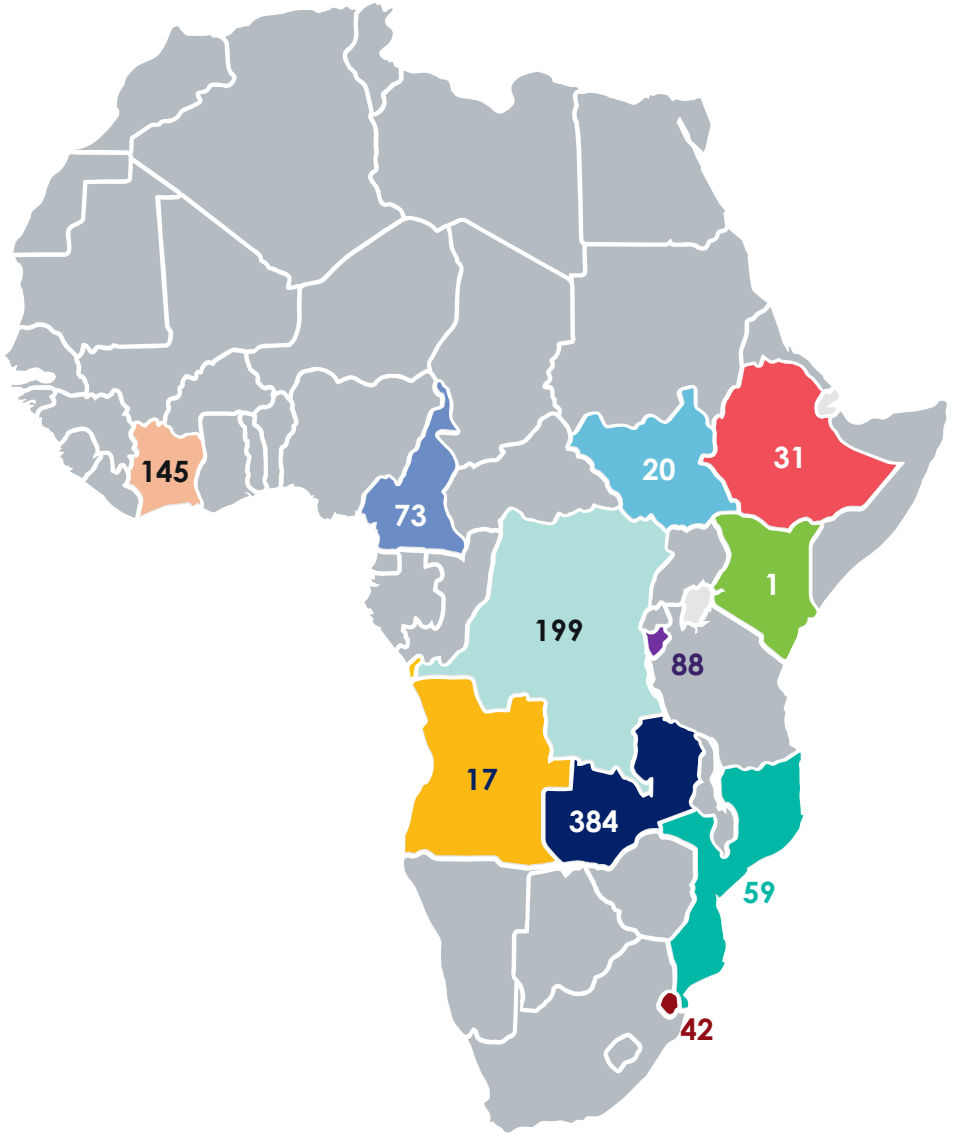
Q1 Pre-COVID-19

Q2 COVID-19 restrictions start

Q3 Some countries begin relaxing restrictions

1,059 ICAP-supported Health Facilities

- Angola (HF=17)
- Burundi (HF=88)
- Cameroon (HF=73)
- Cote d'Ivoire (HF=145)
- Democratic Republic (DR) of Congo (HF=199)
- Eswatini (HF=42)
- Ethiopia (HF=31)
- Kenya (HF=1)
- Mozambique (HF=59)
- South Sudan (HF=20)
- Zambia (HF=384)



Methods

- Retrospective routine aggregate PEPFAR Monitoring, Evaluation and Reporting (MER) data on adults and children collected quarterly (Q) from October 1, 2019 to September 30, 2020 as follows:
  - **Q1: October-December 2019**
  - **Q2: January-March 2020** ***(restrictions start)***
  - **Q3: April-June 2020**
  - **Q4: July-September 2020**
- Included data from 1,059 ICAP-supported, PEPFAR-funded HF that reported HIV testing data in all four quarters in 11 African countries
- Examined quarterly trends along the HIV testing and treatment cascade

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Effect of Stringency of Mitigation Measures

- Dichotomized the 11 countries based on their median score on the Oxford COVID-19 Government Response Tracker (OxCGRT) Stringency index from April 1-September 30, 2020
  - OxCGRT is a composite measure (range: 0-100) based on 9 pandemic responses: school closure, workplace closure, cancellation of public events, restrictions on public gatherings, closure of public transport, public information campaigns, stay at home orders, restrictions on internal movement, and international travel bans
  - More stringent (median score: ≥75%, range: 78-84%): Angola, DRC, Eswatini, Ethiopia, Kenya, South Sudan
  - Less stringent (median score: <75%, range: 14-63%): Burundi, Cameroon, Cote d'Ivoire, Mozambique, Zambia
- Difference in difference design was used to assess whether changes in services differed from Q1-2 ("before") to Q3-4 ("after") by stringency category

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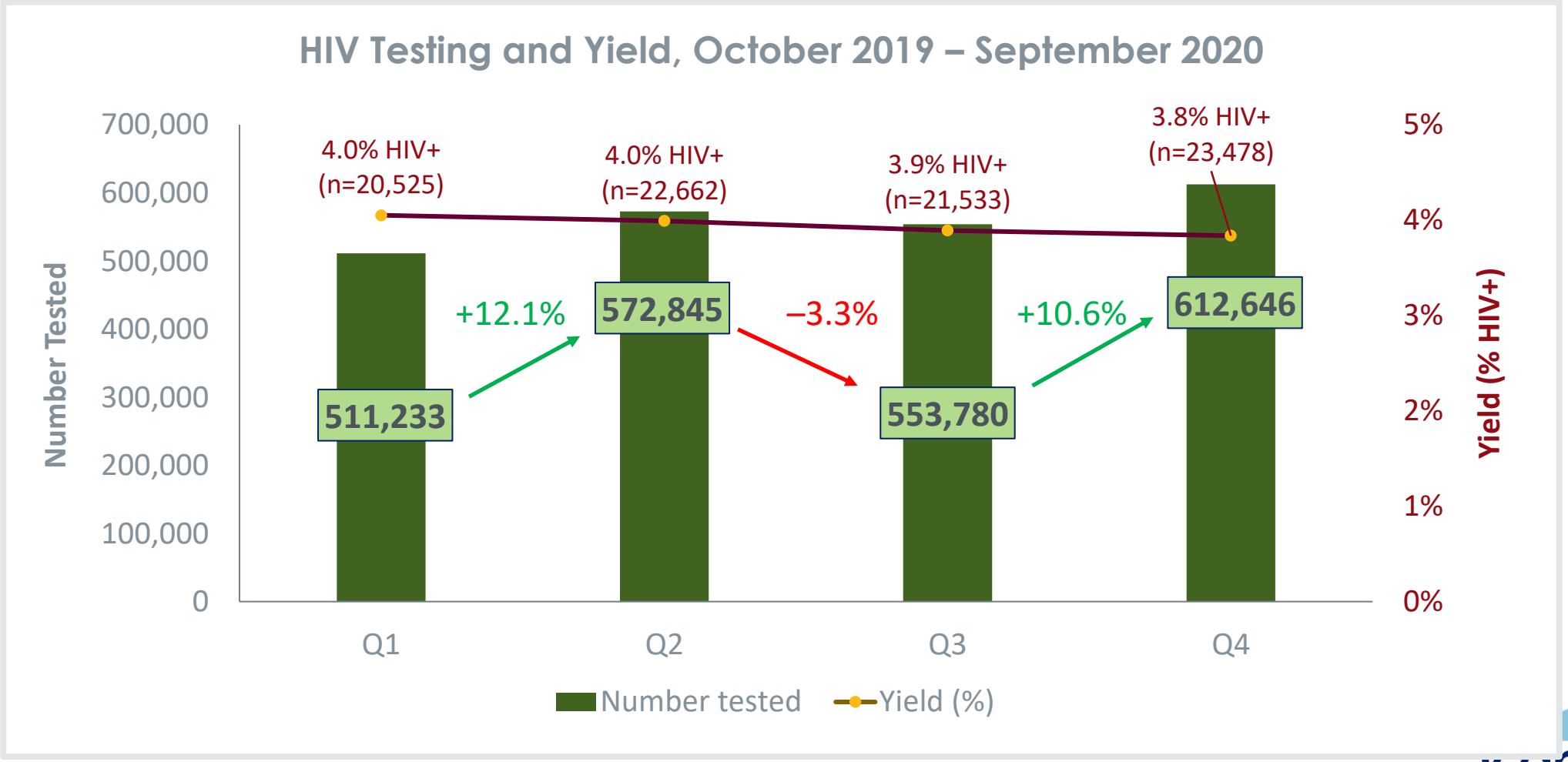
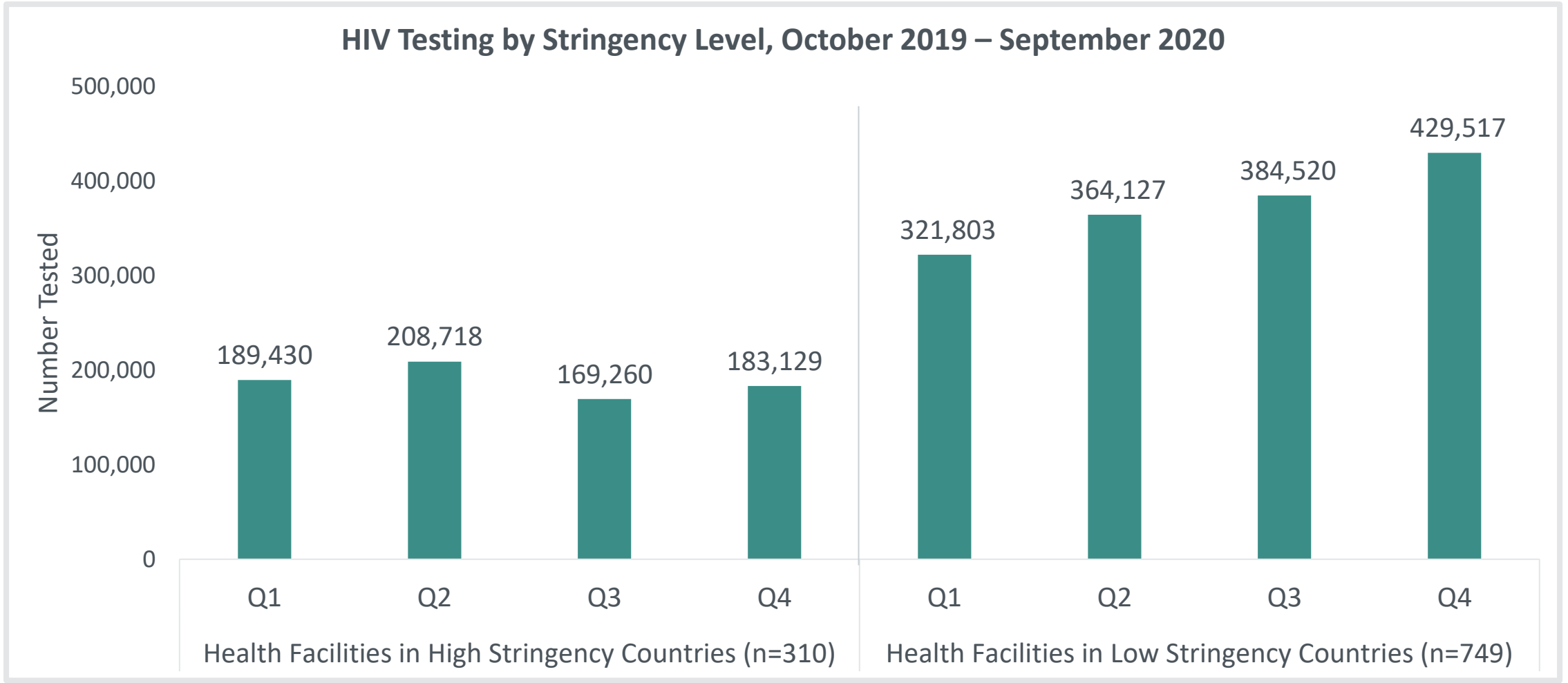
HIV testing declined slightly from Q2 to Q3 and then increased in Q4 with little change in yield

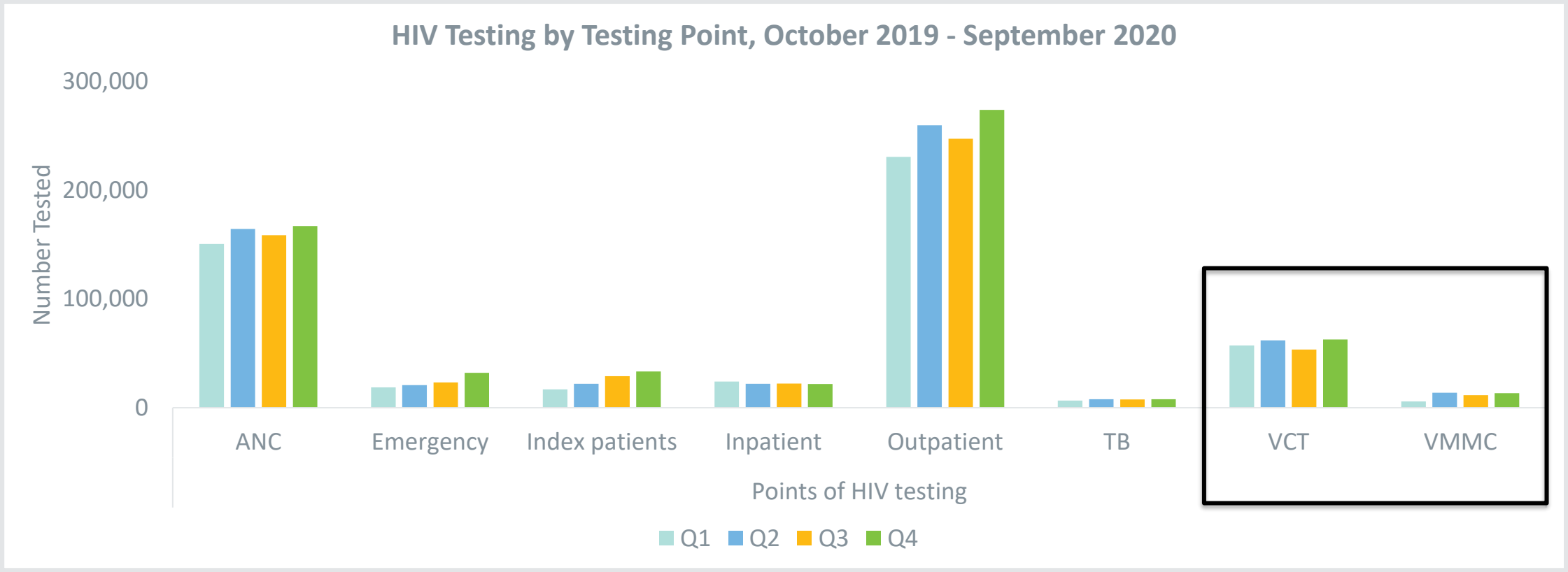


Health facilities in countries with high stringency had a decrease in HIV testing from Q2 to Q3 and modest increases from Q3 to Q4, while those in countries with low stringency showed increases in each quarter



There were significant differences between higher and lower stringency countries comparing Q3-4 to Q-1

Patterns differed by testing point, with the largest declines from Q2 to Q3 for voluntary counseling and testing (14% decline) and testing occurring as part of voluntary medical male circumcision services (16% decline)



There were significant differences between high and low stringency countries for voluntary counseling and testing (VCT), index patient testing, and outpatient testing comparing Q3-4 to Q1-2

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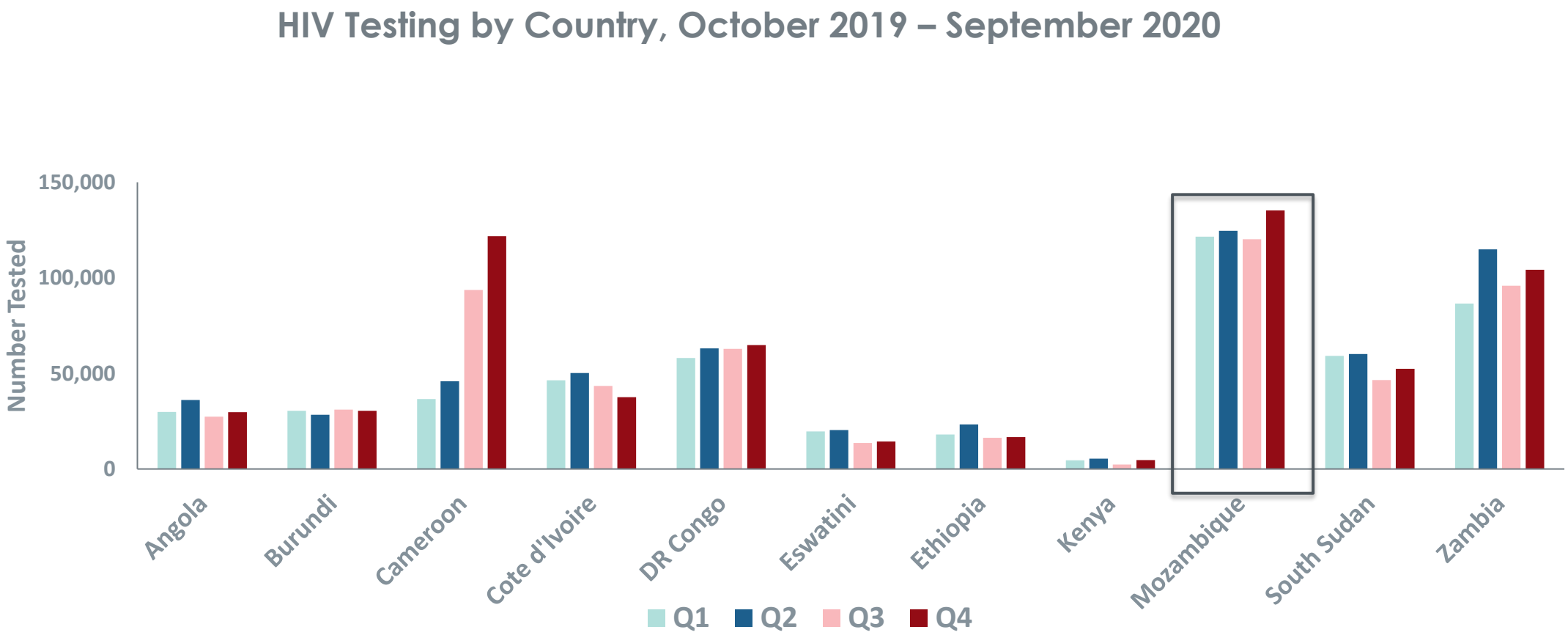
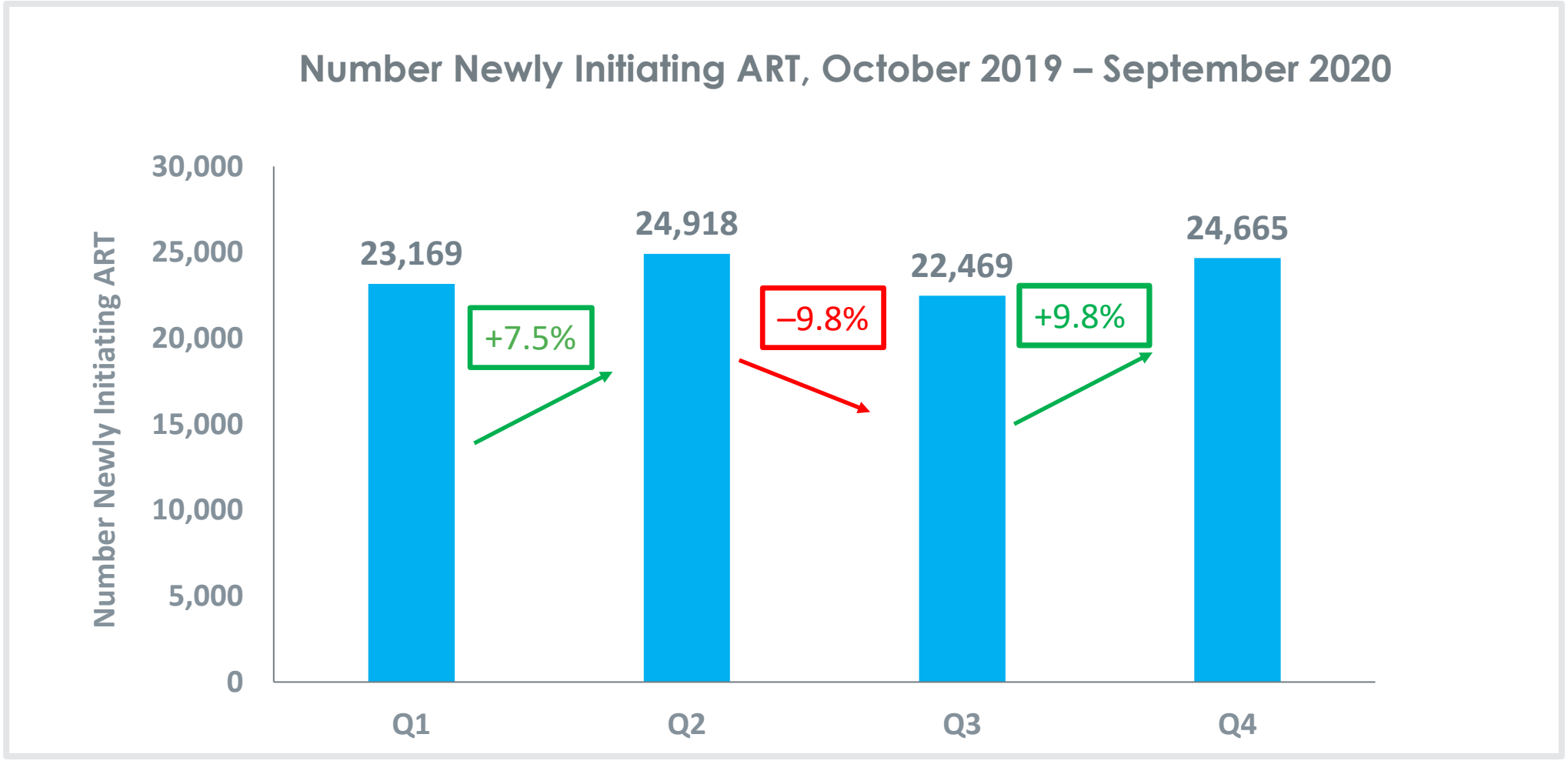
In most countries there was a decline in HIV testing from Q2 to Q3 and recovery from Q3 to Q4

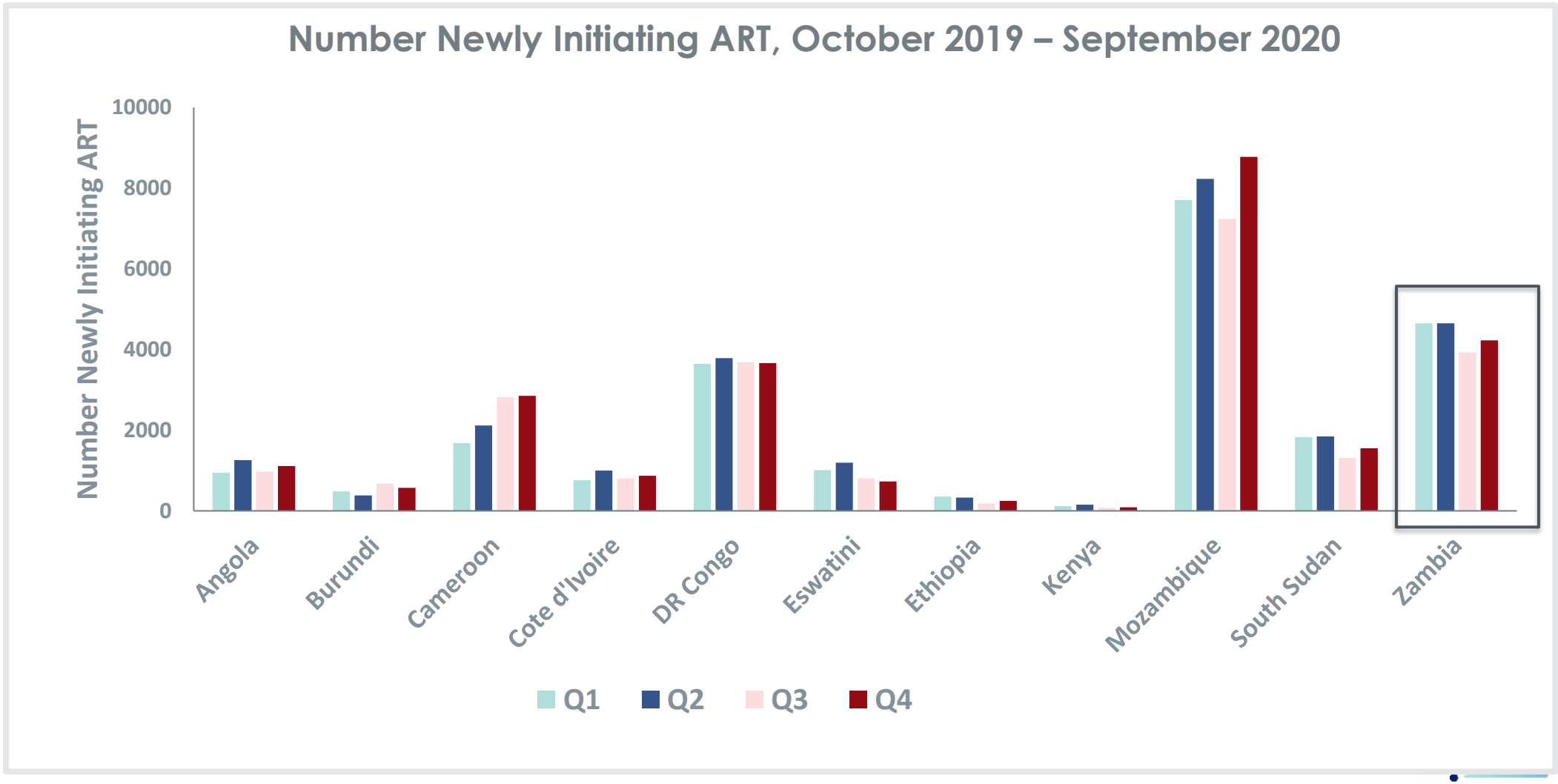


New ART initiations declined from Q2 to Q3 with recovery in Q4

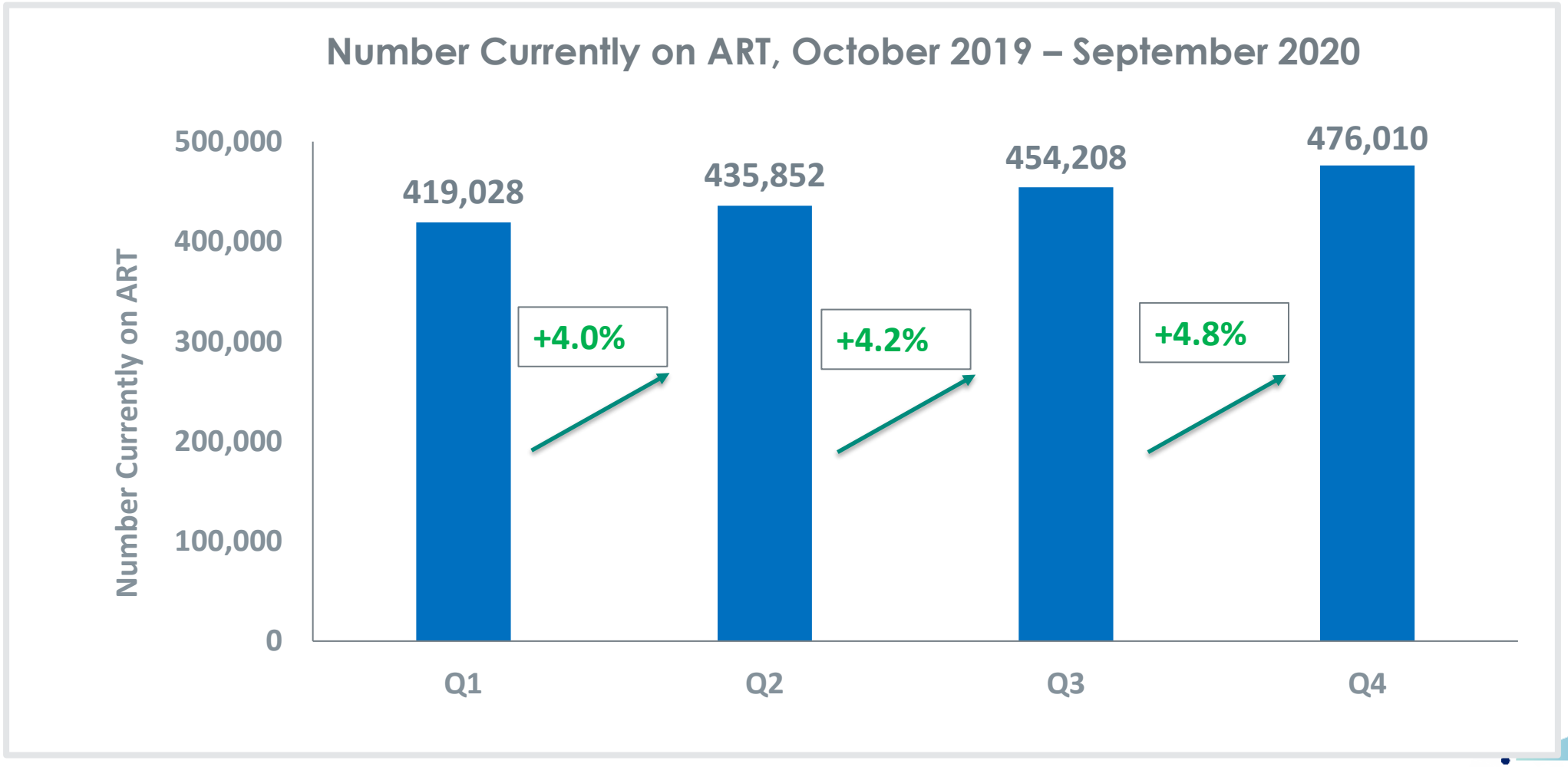


When stratified by stringency category, countries with lower stringency indices had less of decline from Q2 to Q3 and a larger increase from Q3 to Q4 and in statistical analyses comparing Q3-4 to Q1-2 there was a significant difference.

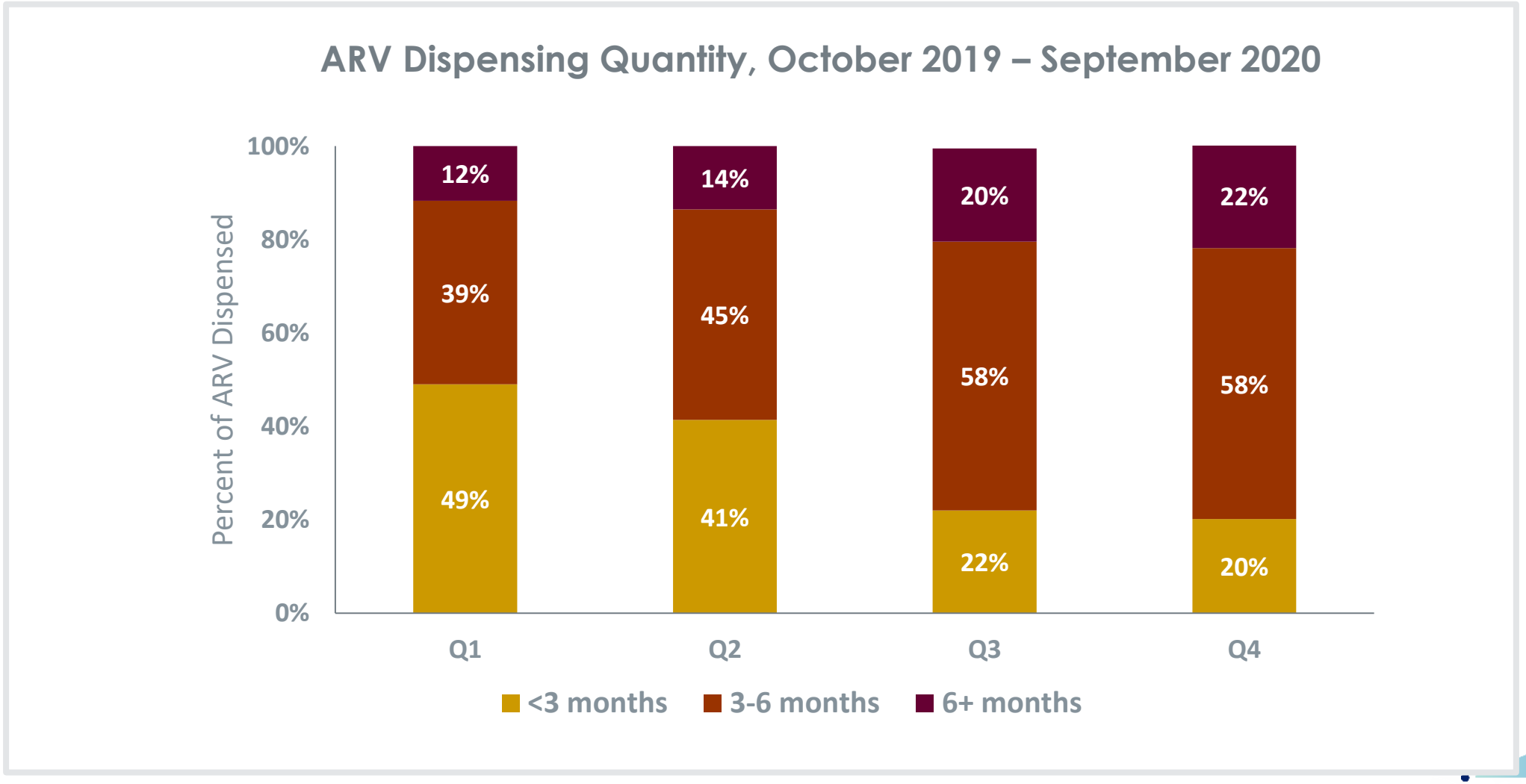
Most countries noted a decline in the number of PLHIV newly initiating ART from Q2 to Q3, followed by an increase in Q4



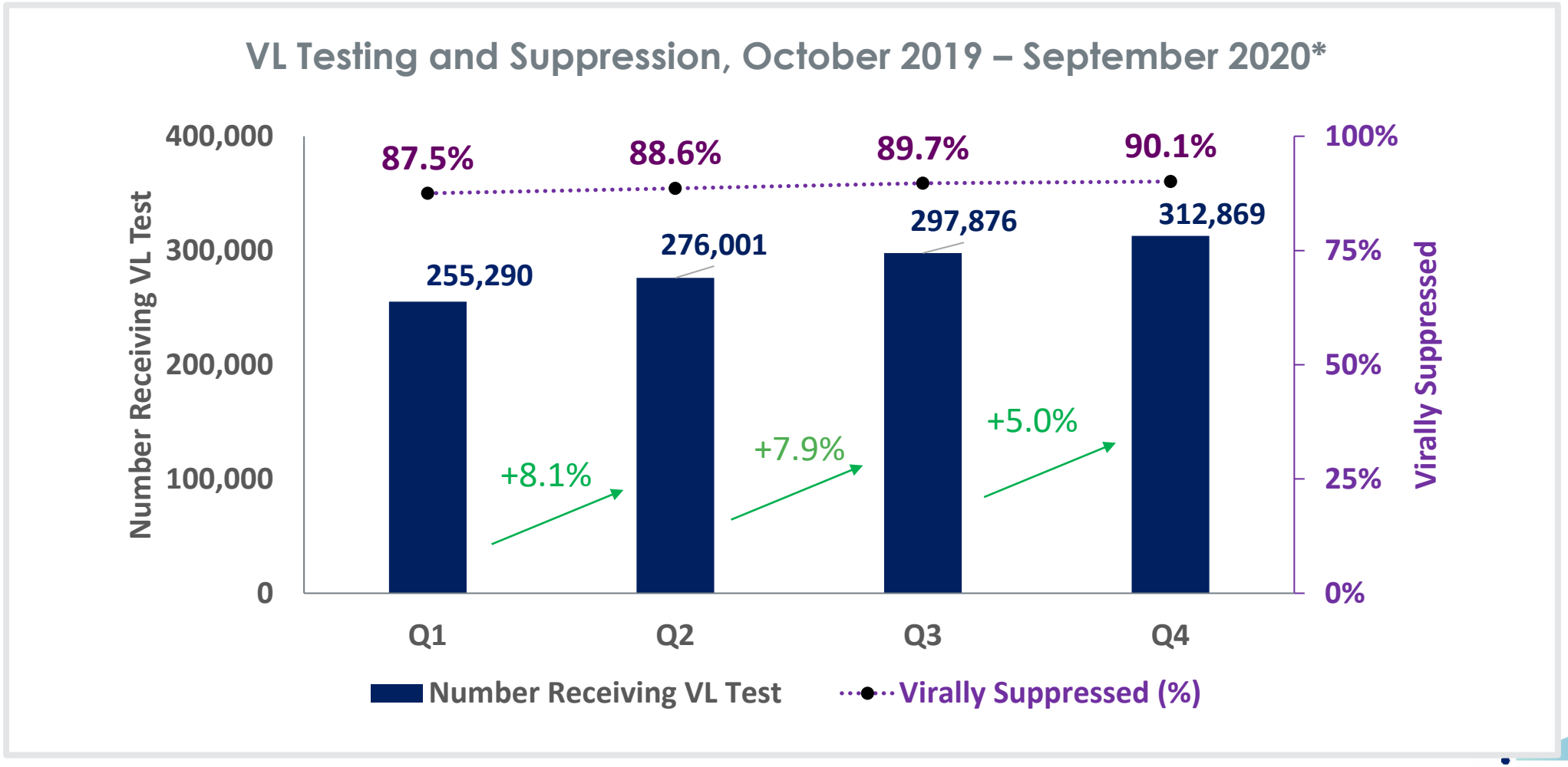
The number of PLHIV on ART increased each quarter



Multi-month dispensing antiretrovirals (ARV): 3-6 and 6+ months prescriptions increased over the year with the largest increase noted from Q2 to Q3

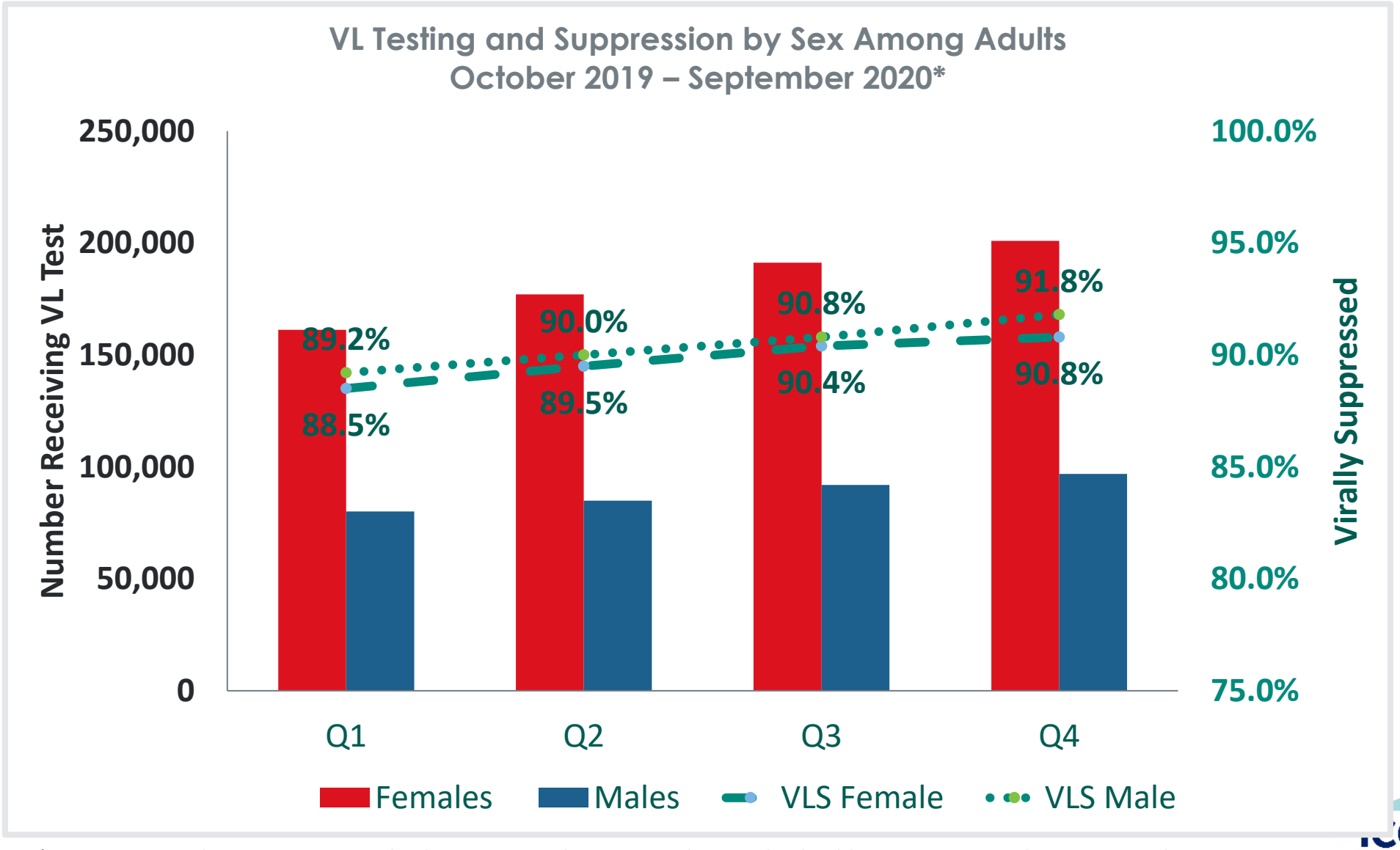


Viral load (VL) testing in the last 12 months increased throughout the year with consistently high levels of VL suppression (<1000 copies/mL) noted



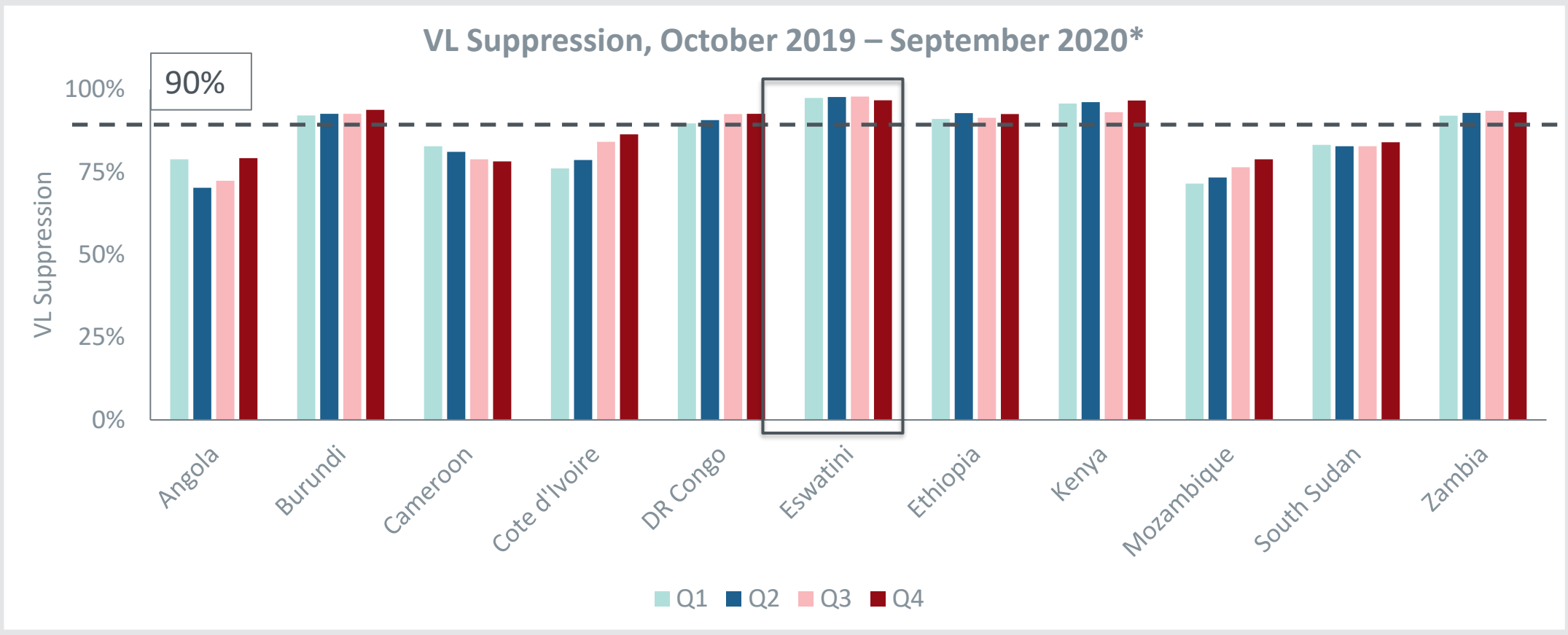
*VL testing and suppression in the last 12 months among those who had been on ART at least 3 months

VL testing and VL suppression in the last 12 months showed similar patterns for adult males and females



*VL testing and suppression in the last 12 months among those who had been on ART at least 3 months

In most countries, PLHIV achieved VL suppression at 90% or greater throughout the year



*VL suppression in the last 12 months among those who had been on ART at least 3 months

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Conclusions

- Our findings from over 1000 HF in 11 African countries observed over one year showed a transient effect of the COVID-19 pandemic on HIV services with evidence of rapid recovery
  - From Q2 to Q3, the number of persons HIV tested decreased with associated declines in number of HIV-positive persons identified and number of new ART initiations, particularly in countries with high stringent response measures
    - However, from Q3 to Q4, recovery in HIV testing and new ART initiations was noted
  - Over the entire year there was an increase in overall number of persons on ART
- Viral load suppression remained high through all four quarters and during the COVID-19 pandemic, in the context of expansion of multi-month dispensing of ARV
- Rebound was brisk demonstrating HIV program resilience, likely due to expansion of differentiated service delivery models and other innovations including:
  - Expansion of multi-month dispensing as noted in our findings
  - ART distribution in the community
  - Virtual adherence consultations

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- Partner organizations and recipients of care
- ICAP in-country and headquarter staff

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- US Agency for International Development (USAID)
- Centers for Disease Control and Prevention (CDC)

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PEPFAR

USAID

RISE
Reaching Impact, Saturation, and Epidemic Control

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Introductions

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DSD and COVID-19: Program Innovations and Adaptations

Dr. Peter Preko
CQUIN Director
ICAP at Columbia University

July 27, 2021

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HIV Learning Network
The CQUIN Project for Differentiated Service Delivery

Outline

- The CQUIN Learning Network
- DSD Policy and Practice Adaptations
- Country Case Studies

The CQUIN Learning Network

- The HIV Coverage, Quality and Impact Network is a 21-country learning network designed to advance differentiated service delivery (DSD) to achieve HIV epidemic control
- Funded by the Bill & Melinda Gates Foundation
- Convened/led by ICAP at Columbia University
- Advisory Group inclusive of Ministries of Health, civil society, PEPFAR, CDC, USAID, WHO, Global Fund, UNAIDS, International Treatment Preparedness Coalition (ITPC)
- Supported by a Community Advocacy Network
- Focuses on the gap between policy and implementation at scale

Burundi
Cameroon
Cote d'Ivoire
DRC
Eswatini
Ethiopia
Ghana
Kenya
Liberia
Malawi
Mauritania
Mozambique
Nigeria
Rwanda
Senegal
Sierra Leone
South Africa
Tanzania
Uganda
Zambia
Zimbabwe

Network Focus Areas

- **Knowledge exchange**
  - Sharing information across countries as well as generating new knowledge and spreading best practices
- **Joint learning**
  - Solving problems together via collaboration and joint work to develop strategies, tools, and other resources
- **Innovation and Catalytic Research**
  - Collaboratively adapting existing knowledge and/or generating new interventions and strategies

Selected CQUIN Activities: 2017 – 2021

- 13 multi-country workshops and meetings
- 24 south-to-south learning visits
- 46 country visits
- Substantive technical assistance including support for guidelines, SOPs, strategic plans, DSD coordination, M&E of DSD and DSD Performance Reviews (*ad hoc* data collection)
- Seconded national DSD coordinators to 8 Ministries of Health
- 8 active communities of practice co-creating tools and resources
- CQUIN website, newsletter, WhatsApp groups

24 South-to-South Visits

2017

- Malawi hosted Eswatini
- Eswatini hosted Zimbabwe
- Eswatini hosted Mozambique
- Malawi hosted Mozambique

2018

- Uganda hosted Malawi, Eswatini and Kenya
- Eswatini hosted Côte d'Ivoire, Malawi, Uganda, Zambia and Zimbabwe
- South Africa hosted Malawi and Zimbabwe

2019

- Uganda hosted Tanzania and Zambia
- Ethiopia hosted Eswatini and Mozambique

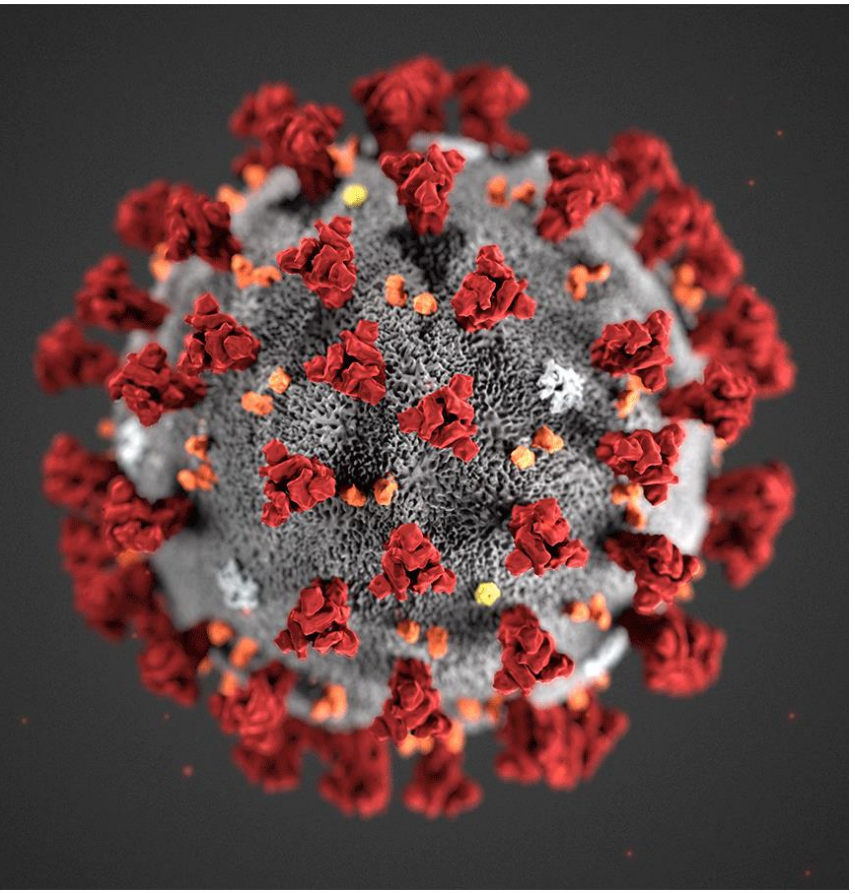
2020

- Zimbabwe hosted Côte d'Ivoire and Ethiopia
- Ethiopia hosted Liberia and Uganda

2021

- Côte d'Ivoire hosted Senegal
- Eswatini hosted Côte d'Ivoire

The CQUIN Response to COVID-19



Activating the Learning Network:

- CQUIN website COVID section
- Established CQUIN-COVID WhatsApp groups
  - Anglophone
  - Francophone
- Shared online resources
- Weekly webinar series cohosted with IAS and ITPC
  - Countries shared adaptations to service delivery policy and practice, along with resources, tools and lessons learned
- DSD Coordinators shared monthly updates

Outline

- The CQUIN Learning Network
- DSD Policy and Practice Adaptations
- Country Case Studies

CQUIN Survey of COVID-19 adaptations – 1

- In April-May 2020, CQUIN surveyed 14 member countries to understand the impact of COVID-19 on DSD policy and implementation during the first wave of the pandemic
- Within weeks of the first report of COVID-19 in Africa, all 14 countries had made substantive changes to their national DSD programs

CQUIN Survey of COVID-19 Adaptations – 2

Country	Expanding eligibility criteria for multi-month dispensing (MMD)?	Moving to 3-MMD or 6-MMD?	MMD for any non-ART meds?	Stopping or suspending any DSDM?	Changes to how group models work?	Changing approach to la monitoring?
[illegible]	3-MMD	Some pilots of 6-MMD underway.	No	models suspended.	No	No
DRC	Yes. Clinical stability can now be used to assess eligibility for 6-MMD. People newly on ART who are doing well after 3 months can receive 3-MMD.	Yes, for people who are "stable" on ART	Yes, for TB preventive tx (TPT) & cotrimoxazole (CTX)	No although larger groups discouraged.	Peers will supply ART to people difficult for health care workers to reach.	No
Eswatini	Yes. 3-MMD newly available for adults initiating ART and for virally suppressed children > 2 years of age	Yes. Aim is to provide 6-MMD to 20,000 clients on TLD and 20,000 clients on TLE	Yes, for TB treatment, TPT and NCD treatment	Yes. Facility-based teen clubs and adult treatment clubs have been suspended.	Community ART Group (CAG) meetings replaced by individual ARV distribution. Fast Track may change to 6-MMD, ART stock permitting	Yes. Deferring routine VL testing in some contexts.
Ethiopia	Yes. 3-MMD newly available to people w/ unsuppressed VL engaged in adherence counseling, people newly starting ART, children, adolescents, and pregnant & breastfeeding women.	No change. Both 3-MMD 6-MMD already available.	Yes, for TB treatment, TPT and NCD treatment	Yes. Some adolescent models and community group meetings suspended	Some community ART group members now receive 6MMD.	No
Kenya	Yes. Everyone on ART will now receive 3-MMD, irrespective of VL results.	No	Yes, for TB treatment.	No	No CAG meetings in the community. Members collect meds and leave.	Yes: No VL results required for 3-MMD
Liberia	Yes. MMD newly available to people on ART irrespective of VL. Those with advanced disease and newly initiating ART remain ineligible for MMD.	Strongly recommending 3-MMD for all and 6-MMD for virally suppressed clients when stocks allow	Yes, for TB treatment and TPT	No	N/A	No
[illegible]	Yes. 6-MMD newly available for adults	Yes. Pregnant women and lactating	Yes, for PrEP and some people on	Yes. Group models suspended, including	Virtual support services encouraged for teens	

CQUIN Survey of COVID-19 adaptations – 3

The most common adaptation was the expansion of MMD to decrease health facility visit frequency

- 10 countries expanded MMD eligibility including:
  - 4 waived requirements for viral suppression
  - 6 newly permitted MMD for people initiating ART
  - 3 newly permitted MMD for pregnant/BF women and virally suppressed children
- 7 countries increased the amount of ART dispensed via MMD
- 9 countries enabled MMD for TB preventive treatment

CQUIN Survey of COVID-19 adaptations – 4

Other changes included cancelling or redesigning group models to enhance social distancing:

- 8 countries canceled ≥ 1 model, including facility-based groups and Teen clubs

Countries also increased clinic hours, enhanced Fast Track services and expanded community- and home-based drug delivery

Outline

- The CQUIN Learning Network
- DSD Policy and Practice Adaptations
- Country Case Studies

Sierra Leone: Rapid Introduction and Scale Up of DSD

- Country at the planning stages of DSD when COVID19 pandemic started
- Rapidly adapted 3-MMD, including for new initiations
- Also introduced 3-MMD for pregnant women and children
- Synchronized 3-MMD drug refills for ART and TB meds
- Partnered with stakeholders to introduce 3-MMD community-based ART refills, including home-based ART delivery

Mozambique: Virtual Patient Follow Up and Program Monitoring

- Psychosocial support done by phone call
- High viral load results and enhanced adherence counselling delivered by phone call
- Monthly Zoom calls with provincial HIV teams to identify problems, share best practices and gather information to update guidelines
- HFs were trained on how to fill the patient file in order to be possible to distinguish between patients who were included in DSD because of COVID-19 and those who had the “formal” criteria
- Monthly data analysis to identify gaps and realign strategies

Eswatini: Expanded Multi-Month Dispensing and Suspended Group Meetings

- More matured DSD program at the onset of COVID19
- Rapidly moved to introduce 3MMD for newly initiated on ART
- Children >2yrs and virally supressed also received 3-MMD
- Scaled up 6-MMD, including for community models and adolescents
- Introduced MMD for TB treatment, TPT and NCD medications
- Teen Clubs suspended
- CAG group meetings suspended; activities are limited to drugs distribution
- Introduced outreach ART services to new communities

Zambia: No specific DSD Policy Change Due to COVID-19

- Reinforced existing DSD policy on 6-MMD through enhanced monitoring
- Disintegration of group-based models such as CAGs in some areas as members switched to 6-MMD
- 3-MMD for children above 2 years
- Halted TLD transition due to concerns of continued stock
- TPT dispensation was aligned to ART refill
- No explicit changes to community meetings for CAGs except to observe physical distancing and face masks
- Teen clubs continued; reduced duration & group size

DRC: Expanded MMD and Mobile Health

- Expanded 3-MMD to all patients previously not eligible for less intensive models (on ART for <12months)
  - New initiations; pregnant and lactating mothers; all children; TB patients
- Monthly close patient monitoring using phone calls for first 6-months on ART
- Scaled up 6-MMD for those eligible for less intensive DSDM
- Home-based visits by peer educators for ART refills based on a plan developed by HCWs and peer educators
- Scheduled appointments (phone calls to set appointment date and time)
- Follow-up by phone based on an agreed schedule (WhatsApp, SMS reminders and phone calls)

Malawi: Introduced 3-MMD for Other Medications and Suspended Routine VL Monitoring

- Suspended routine VL monitoring for people established on ART
  - Exceptions included children, pregnant and breastfeeding women
  - Targeted VL monitoring if treatment failure is suspected
- Suspended PrEP and TPT initiations
- 3-MMD for IPT if already initiated for 3months with no side effects
- 3-MMD for PrEP if already initiated
- 3-MMD Cotrimoxazole Preventive Therapy for HIV exposed infants
- No 3-MMD for TB patients

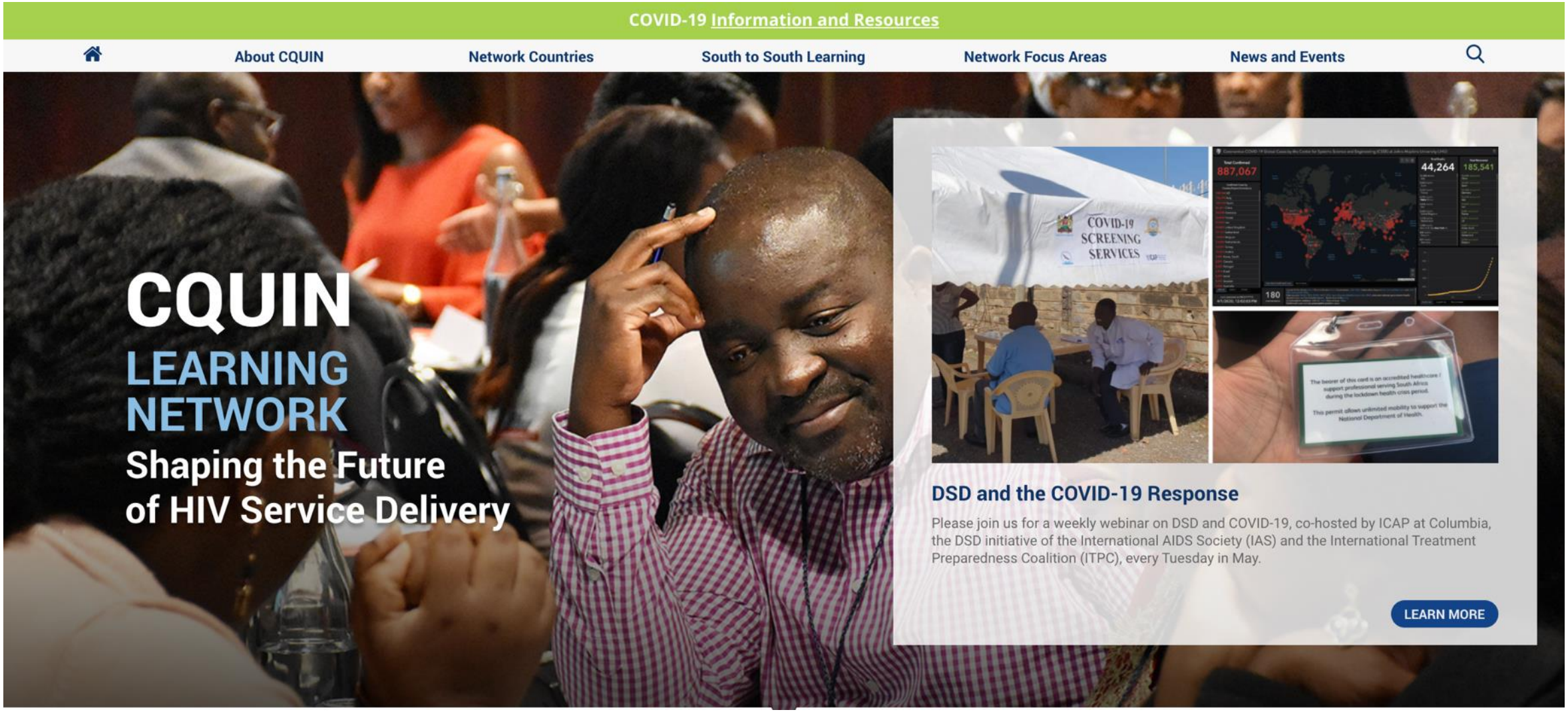
Uganda: Expanded Community Based Refills with Support from Implementing Partners

- Additional community ART distribution points were opened
- Home ART delivery using motorcycles
- Community adherence groups not suspended
  - IPC measures were encouraged
- Facility-based groups were suspended
- MMD was recommended for all recipients of care regardless of age and VL status
  - Exemptions included clinically symptomatic, new initiations, pregnant and lactating mothers with babies < 6months

Summary

- CQUIN network countries quickly adapted DSD policy and practice to help sustain service delivery and program resilience
- Adaptions put both healthcare workers and recipients of care in the centre to protect lives
- CQUIN pivoted its activities to facilitate exchange of COVID19 related information and share best practices in DSD policy and practice adaptions

CQUIN Website: www.cquin.icap.columbia.edu



Q&A and Discussion

Thank You

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