



# Key Messages

- The Kingdom of Eswatini has successfully scaled up differentiated service delivery (DSD) for HIV treatment, and currently has eight less-intensive DSD models for people established on treatment
- The proportion of people on antiretroviral therapy (ART) enrolled in a less-intensive DSD model increased from 7.9% in 2017 to 80.4% in 2020
- Viral suppression rates for people on ART increased from 91% to 97% during this timeframe
- Improvements in monitoring and evaluation systems are needed to capture key DSD data and to disaggregate outcomes such as retention, viral suppression, and visit frequency by DSD model

## Differentiated Service Delivery in Eswatini: Adaptation, Scale-up, and Monitoring

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### Background

In 2016, the Eswatini Ministry of Health (MOH) prioritized the expansion of differentiated service delivery (DSD) for HIV, including scale-up of differentiated treatment (DT) models.

Routine monitoring and evaluation (M&E) systems did not capture key DT data, so MOH took the following steps:

- Adaptations to the national electronic Client Management Information System (CMIS) to enable tracking of DSD-relevant data,
- Collection of *ad hoc* data on DT scale-up,
- Annual DSD system self-assessments using a capability maturity model designed by the multi-country CQUIN learning network to capture enabling systems as well as the coverage, quality and impact of DT

### Description

We triangulated scale-up of DT in Eswatini using national HIV annual program reports (2016-2020), CMIS quarterly reports (2020-2021), results from a study of DT client satisfaction, and Eswatini's CQUIN annual meeting reports and capability maturity model dashboard staging (2018-2021).

### Lessons Learned

#### Scale-up of DT models:

- The proportion of health facilities (HF) implementing DT grew from 22/176 (13%) in 2016 to 193/202 (96%) in 2020 (Figure 1).
- The proportion of recipients of care on ART enrolled in DT rose from 13,791/174,103 (7.9%) in 2017 to 164,336/204,286 (80.4%) in 2020 (Figure 2).

#### Diversity of DT models:

- The diversity of DT models also increased over time; the eight current models include 5 facility-based, (Mainstream, Fast Track, Family Centered Care, Treatment Clubs, Teen Clubs) and 3 community-based models (Outreach, Community Drug Distribution, and Community Antiretroviral Therapy (ART) groups).
- Tailored DT models are available for adults, adolescents, people with HIV and co-morbidities, advanced HIV disease, men, pregnant and breast-feeding women, high viremic, and key and vulnerable populations (Figure 3).
- All DT models offer 3-multimonth dispensing (MMD) or 6MMD.

#### Client satisfaction:

- *Ad hoc* studies indicate high levels of client satisfaction.

#### Outcomes:

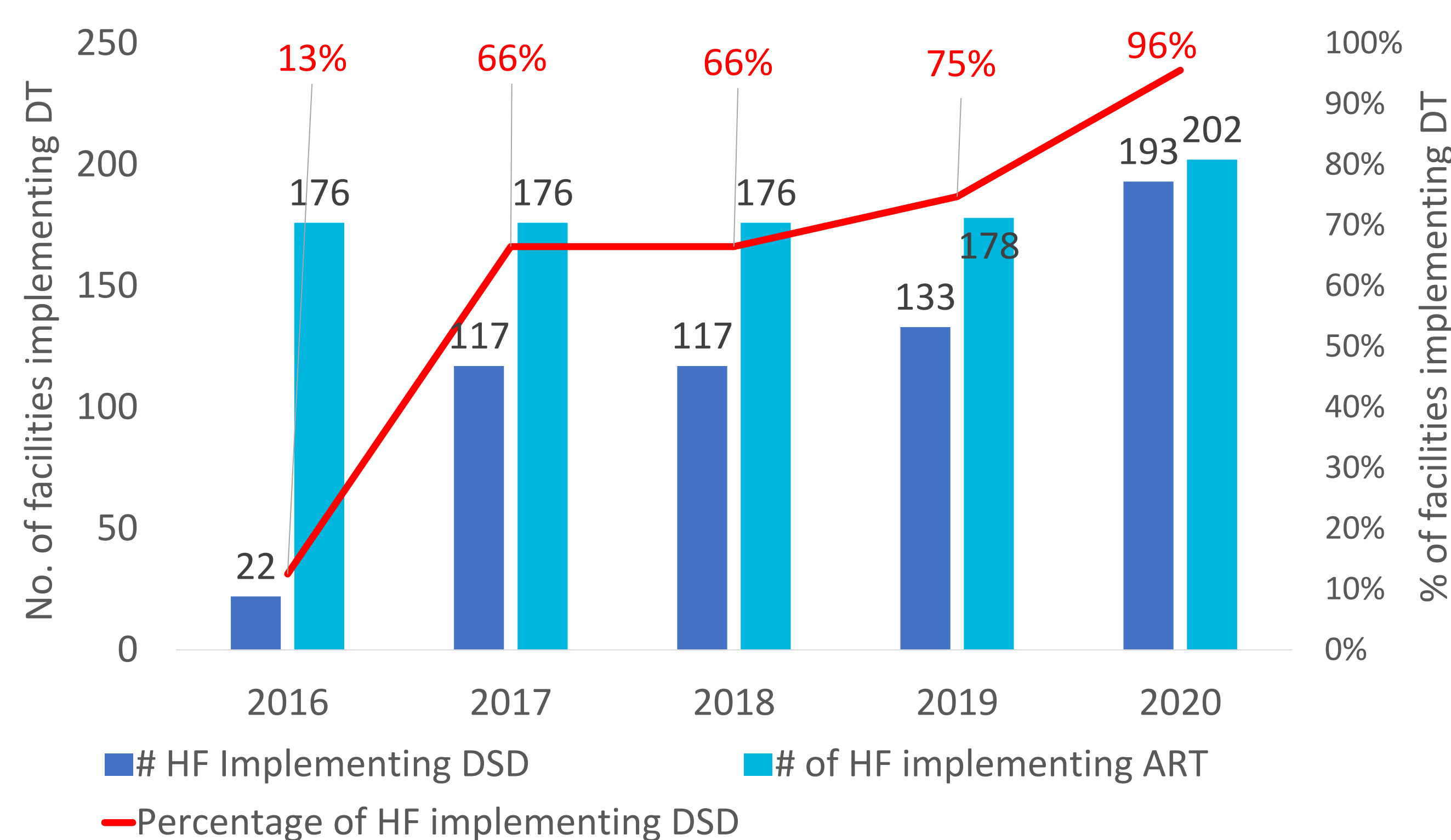
- National systems cannot yet compare viral load suppression (VLS) for clients in different models
- VLS for all PLHIV on ART increased from 90% (males) and 91% (females) in 2017 to 96% and 97% respectively in 2020 (Figure 2).

### Conclusions

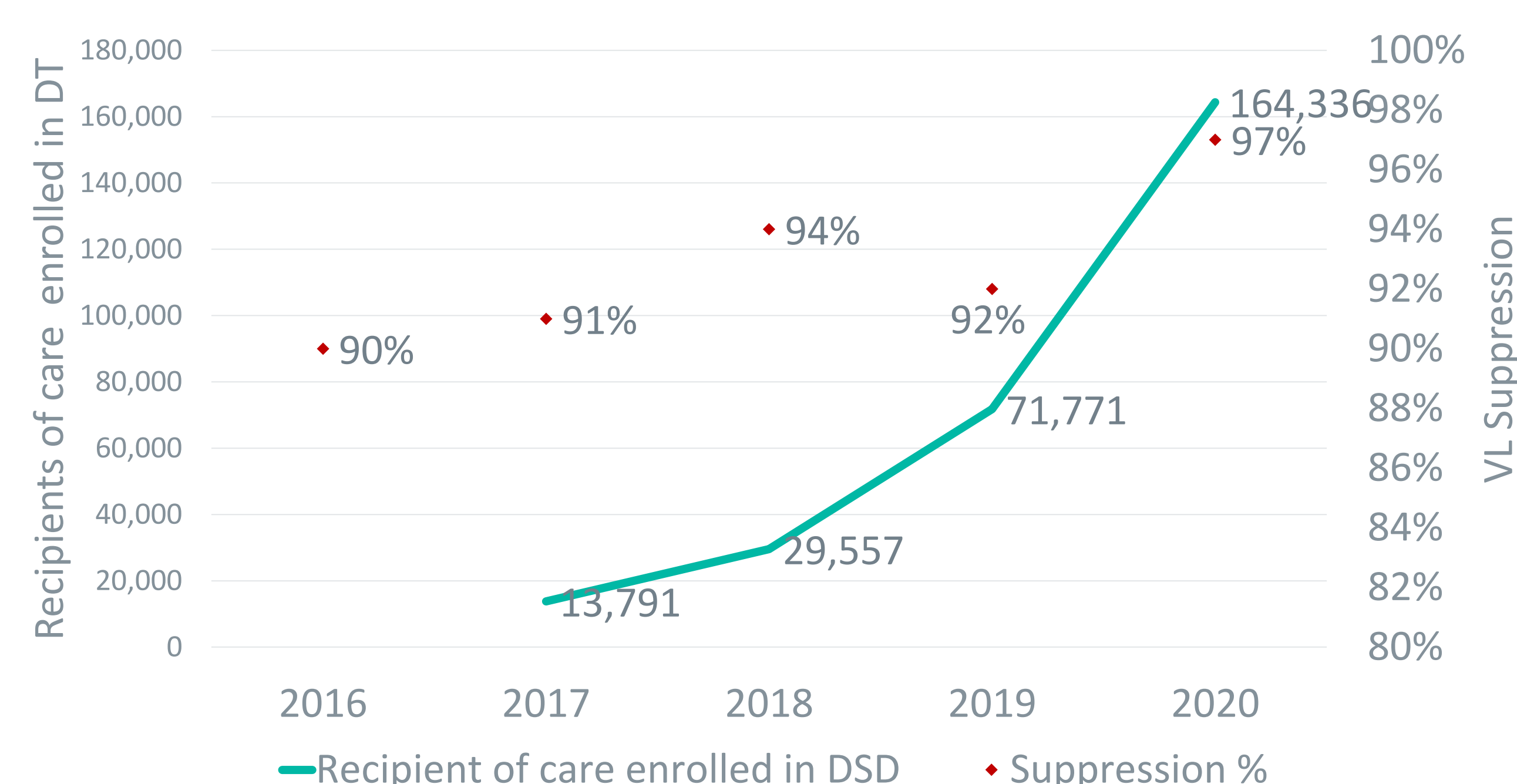
Eswatini has markedly scaled up DT coverage and diversity, ensuring that HIV treatment is responsive to the needs of different groups and sub-populations. An increasing proportion of PLHIV are virally suppressed, receiving their HIV treatment through DSD models with extended ART refills and less frequent clinical visits.

Moving forward, ongoing investments in CMIS will allow MOH to use routine program data for in-depth monitoring of DT model uptake and outcomes.

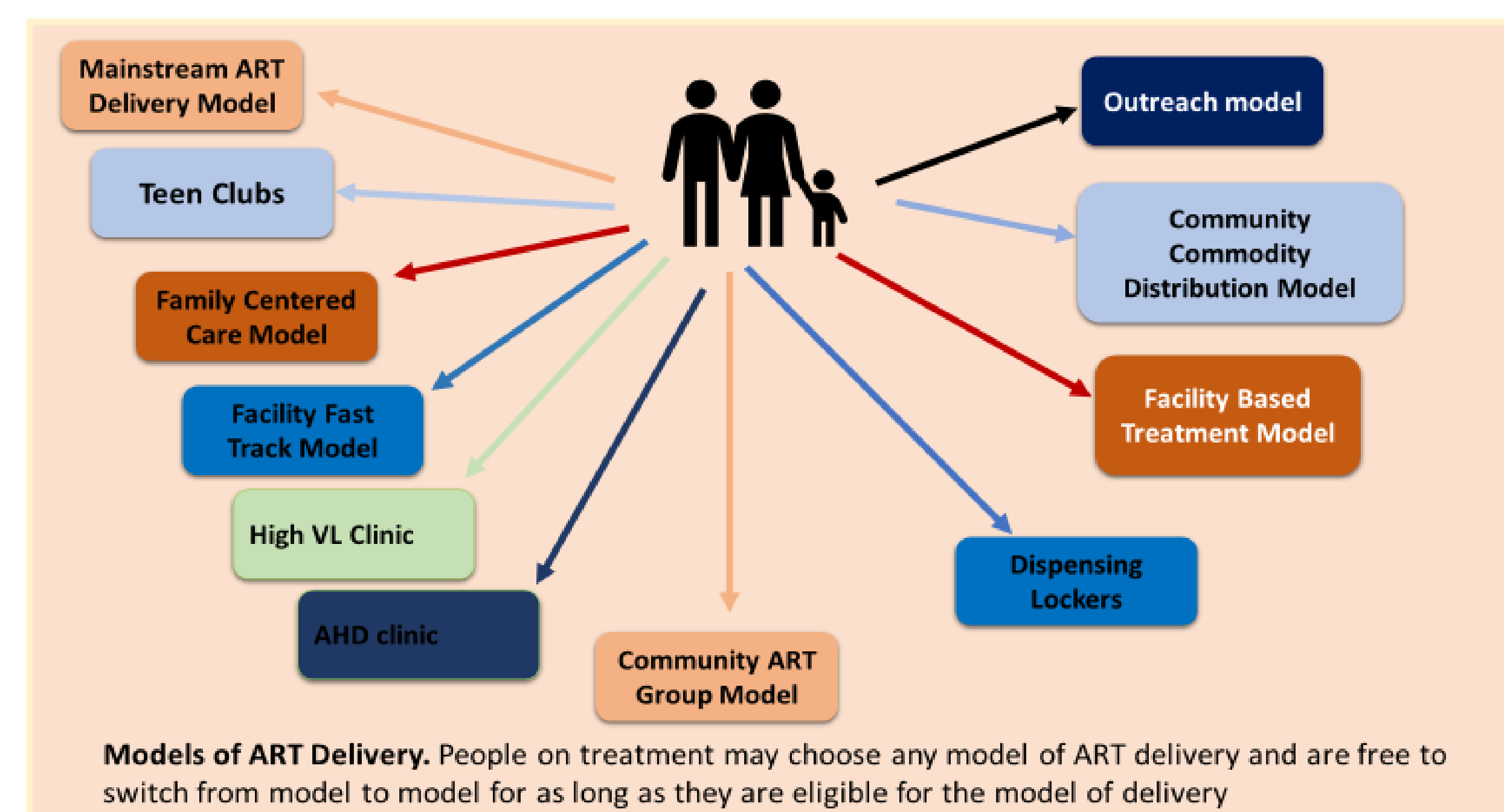
**Figure 1: Scale up of DT at health facilities: 2016 – 2020**



**Figure 2: Enrollment in DT and viral suppression rates: 2016 - 2020**



**Figure 3: Differentiated Treatment Models in Eswatini**



### Additional Resources

<https://cquin.icap.columbia.edu/the-work/eswatini/>



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