COMMUNITY COMMODITY DISTRIBUTION, APRIL 2020

Community Commodity Distribution Concept Note

Background: As of Tuesday, April 21st 2020, the Kingdom of Eswatini has 31 confirmed cases of COVID-19, with an upward trend of community transmission. Models based on the current data show that by the middle of May the country could be faced with up to 10,000 cases.[1] Eswatini is in the process of establishing and strengthening measures such as COVID-19 case tracking, adjustment of national health program delivery and launching COVID-19 laboratory testing platforms, while continuing to enforce a national lockdown to reduce travel and exposure to citizens.

Simultaneously, the country continues its fight against the HIV epidemic, with an estimated 202,608 citizens living with HIV and 94% of those on treatment. In addition, there are an estimated 1,753 TB patients, 41,000 diabetes patients and, 120,000 hypertension patients who need regular access to drug refills. These patients are at a higher risk of both contracting, and suffering severe complications from, COVID-19 infection. In normal times, ensuring that patients have uninterrupted access to medications they need is achievable, but in the presence of COVID-19, patients will be continually be put at risk of infection through the simple task of collecting their necessary medication.

Eswatini currently has a strong differentiated delivery program which offers several different models implemented in over 121 facilities throughout the country. Of note are the facility distribution/outreach model, in which 15 facilities serve approximately 1,637 PLHIV, and Community ART groups (CAGs), in which groups are formed and one member collects medication for all members of the group, active in 61 facilities serving 3,025 people.

Approach: Implement a National Community Commodity Distribution Plan, built upon a hybrid of current differentiated service delivery models to ensure sustainability and ongoing access to a variety of medicines without unnecessary client exposure to risk of COVID-19 infection. The facility distribution/outreach model will be introduced and/or scaled up across facilities nationally, with multiple, well-chosen distribution points per facility and distribution of a full spectrum of tools such as ART, TB medicines, NCD medicines (anti-diabetic, anti-hypertension), family planning, PrEP, HIV prevention commodities and the ability to add more as the program is strengthened. Taking advantage of the systems in place for CAG will allow one person from each homestead to collect medicines needed for all those residing together or nearby. Front-end communication between client and facilities and follow-up will ensure patients are aware of how they can collect their medications regularly and safely, keep adequate stocks at home and ensure patient confidentiality through pre-packaging and discreet pick-up.

Objectives:

1. Establish continuous and reliable community access to a standardized list of medicines and selected health commodities
2. Reduce risk of COVID-19 acquisition in at-risk populations by reducing the need to take public transport, queue in lines and travel significant distances from their homesteads
3. Decongest facility-level service delivery burden, crowding and queuing
4. Reduce silo programs and associated stigma through integrated commodity delivery

[1] Projection of early spread of COVID19 in Africa as of 25 March 2020 Carl A.B. Pearson (LSHTM, SACEMA), Cari Van Schalkwyk (SACEMA), Anna Foss (LSHTM) Kathleen O'Reilly (LSHTM) SACEMA's Modelling and Analysis Response Team (SMART), CMMID COVID19 working group (LSHTM) Juliet Pulliam (SACEMA)

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Key Activities:

1. Information gathering: understand the HRH needs, the data collection models and what would be needed to scale up the a) number of locations services are offered, and b) number of commodities distributed. Form core team that will engage NCD, SRH and other programs, along with PEPFAR implementing partners for best practices and logistics. Engage and sensitize the facilities and RHMTs. List considerations: transport, CMS stock availability, facility stock availability, client refill dates, MMS, etc.
2. Map catchment areas of each facility. Ensure there are no gaps in coverage areas throughout the country. Have each participating facility identify delivery points within their catchment areas. These delivery points can be existing structures (i.e. pharmacies, markets, churches, etc.) or a non-structural location established by the HCF (mobile services, tent, etc.). Delivery points should be determined based upon maximizing population coverage, and delivery schedule should be established based on the number of clients expected to be served.
3. Establish effective data management solutions using information gathered in Step 1. Consider patient encounter forms and CMIS downtime forms. Differentiate between CMIS sites and non-CMIS sites. Ensure HRH needs for data entry are accounted for. Clients coming from different facilities should be treated as visitors. Have facilities use existing lists of patients who will need prescription refills to estimate number of clients served, reach out to clients, communicate distribution points, schedule pick-ups and communicate with their families about this delivery method.
4. Communication Plan. Create a national communication plan to ensure people can communicate with their nearest health facility to receive the drugs they need, at the earliest possible time. In the case of clients who are unaware of their closest facility or do not know the contact information, create or strengthen a current national hotline to deliver this information. Create campaigns that deliver information to people at home and when visiting facilities.
5. Create guidance on best practices for the establishment/scaleup of community commodity distribution, including guidance related to HRH; ensure flexibility is allowed in facility response; and optimize existing HRH and facility resources.
    a. Ensure each facility has HR to answer the phone, respond to information, schedule and organize community deliveries, pre-pack medications, follow-up on missed pick-ups, etc.
    b. Ensure all participating staff have been trained on COVID-19 response, COVID-19 screening, and are given tools to minimize risk.
6. Identify facilities that will need additional resources based on Community Commodity Distribution Plans. Ensure clinical partners support these activities through mentorship and resources, and that community partners support with staff, cars and additional resources where needed.
7. Using enrollment and distribution data at facility, regional and national levels, evaluate rollout and scaleup of program. Determine and address bottlenecks to improve program. Once optimized, build upon this program for additional service delivery such as consultations, assisted testing, vaccination delivery, etc.