Tutorial session P10

The aims of this tutorial session are to:

* Reflecting on a quality improvement (QI) initiative to address breakpoints in a continuum of care
* Identifying priority areas for QI and formulating interventions to address major breakpoints
* Formulating policy questions which could be addressed with Implementation Cascade Analysis (scenarios)

You are asked to **work in groups** and continue on the same topic as before (diabetes, HIV, TB, hypertension). The session will last for **45 minutes**, including a brief report-back from your group to present conclusions to the other participants.

**Consider the following situations:**

a) Large differentials at *screening/testing* stage

|  |  |  |  |
| --- | --- | --- | --- |
| Group 1 - Diabetes | Group 2 - HIV | Group 3 - TB | Group 4 - Hypertension |
| *Glucose screening* | *Testing* | *Symptom screen (SS)* | *BP screen* |
| *By setting + gender* | *By sub-population* | *By HIV status + site* | *By district + age* |
| Urban 70% screening coverage among eligible, rural 35%, women much more likely to get screened than men. PHC level poorly equipped for DM case finding. Staff lacks confidence in DM control. | Risk factors for low testing coverage:  Women who have not had children, men unemployed or in informal jobs. Districts with low HIV prevalence have particularly scarce HIV testing resources. | Known HIV+ 90% SS coverage, others 40%. Large facilities overall much higher (donor TA support) than small clinics. Linkage to lab diagnosis could be improved. | 30 districts, of which 6 reach target of universal adult BP screen (80%), lowest performance in 8 districts (<50%). Large problem in under 40 year olds not getting screening attention. Linkage to full diagnosis unknown. |

b) Also some large differentials in *treatment adherence*

|  |  |  |  |
| --- | --- | --- | --- |
| Group 1 - Diabetes | Group 2 - HIV tx | Group 3 - TB | Group 4 - HTN |
| Adherence to anti-diabetic treatment, especially low in rural patients who struggle to get to clinics for monitoring, re-scripting and refills. Low treatment literacy, fears of hypoglycaemia and monitoring/drug costs major barriers. | Adherence to ART especially difficult for people who do not have time to queue, cannot go to clinic during work time, or live far away from ART sites. Many still don’t want it to be known that they are on ART. | Adherence to MDR/XDR treatment especially poor due to side effects, length of treatment and distance to MDR treatment sites. HIV negative patients who don’t get the extra health staff attention via ART struggle most. | Adherence especially low in younger patients who tend to have low risk perception and unhealthy lifestyles. The 8 districts with low screening also face biggest problem due to dispersed populations, poor access to health centres and under-performing health posts. |

Task: Answer Q1-Q4.

1. Where are the breakpoints in the cascade?

* Reflect on a quality improvement initiative to address breakpoints in a continuum of care. Remember the five principles shown on previous slide.
* Identifying priority areas for QI and formulating interventions to address major breakpoints

2. How do interventions impact the cascade?

* Consider possible service delivery modalities (”facility-level QI”)
* Consider health system-level interventions (”system-level reform”)

3. How could different programmatic strategies lead to different/better cascades?

* Formulate your ideas on change into policy questions for local and national level
* Translate at least one into a scenario analysis question for Implementation Cascade Analysis

4. What would be the optimal programmatic strategy to maximize successes along the cascade?

* Consider data system needs to determine the baseline and measure change