

Taking Differentiated Service Delivery to Scale in Zambia: Using Diverse DSD Models to Achieve Coverage, Quality, and Impact

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BACKGROUND/INTRODUCTION

In November 2017, Zambia's National Differentiated Service Delivery (DSD) Guidelines were finalized and incorporated into the National HIV Consolidated Guidelines. These guidelines outline a diverse set of DSD models (DSDM) for antiretroviral therapy (ART) and were the result of months of coordination between the Zambian Ministry of Health (MoH), the National DSD Coordinator, the National DSD Task Force, and supporting partners.

During the process of designing DSD models, implementing partners in Zambia were involved in piloting and evaluating a variety of DSD models for stable patients. Current models include community ART groups in both rural and urban areas, community ART distribution, streamlined ART with multi-month scripting, and fast-track ART initiation.

As implementation scales up, Zambia is working towards standardization of monitoring and evaluation tools; advancing national DSD policies; including non-communicable disease management as part of scale-up; and developing models for key and priority populations. An additional priority of the Zambia MoH is to understand cost-effectiveness of DSD, as preliminary data have shown modest cost savings compared to standard ART care.

DSD MODELS OFFERED AND UPTAKE

Zambia has implemented DSDM at 198 health facilities in three of the country's 10 provinces and is supported by 11 of the 21 implementing partners that provide ART in the country.

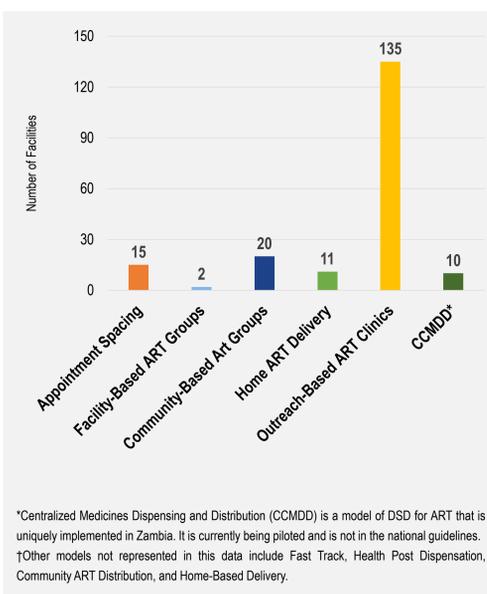


Figure 1. DSDM for ART in Zambia, by Facilities Offering Each Model[†]

Zambia is still in the early stages of DSDM scale-up, with fewer than 25% of the ART facilities in the country providing DSDM. Among the 198 facilities offering DSDM in Zambia, the most widely-implemented models are **Outreach-Based ART Clinics**. A total of 135 facilities (70%) offer ART services in an outreach setting (Figure 1) and the majority of those (124) also offer ART initiation. **Community-Based ART Groups**, offered in 20 (10%) of the participating facilities, is the model with the second-highest uptake.

Among the 34,866 patients currently enrolled in any DSDM, the models with the highest uptake by far are the **Outreach-Based Clinic** model. Uptake of the remaining models falls somewhat below that of the outreach models, from 6,843 (20%) in **Community-Based ART Groups** to 1,758 (5%) in **Facility-Based Groups**.

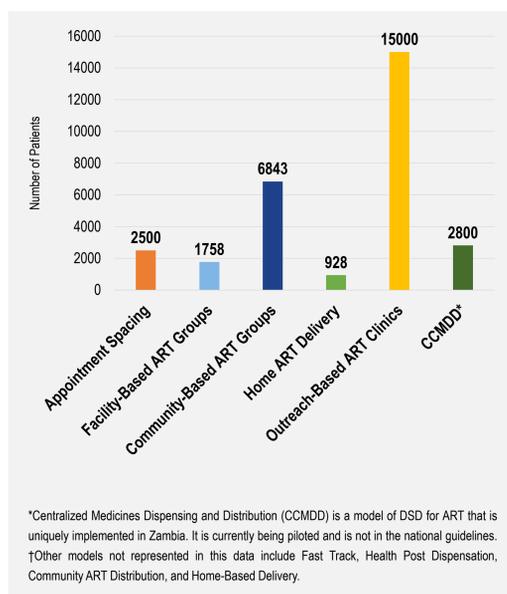


Figure 2. DSDM for ART in Zambia, by Patients Enrolled in Each Model[†]

DSD DASHBOARD

The CQUIN DSD Dashboard self-assessment tool was used to quantify the progress being made as Zambia scaled up implementation of DSD for ART. Across 12 different domains, a five-step color scale was used to rank progress and performance from red, indicating no activity, to dark green, indicating significant and robust implementation.

Zambia has achieved the highest level of development in the **National Policies** and **Diversity of DSDM Services** (Figure 3). In these domains, Zambia's DSD implementation has met these clearly-defined set of standards: the country's National Policies actively promote use of DSDM and Diversity of DSDM Services has been reached by providing DSDM for diverse patient groups. Two other domains assessing **Coordination** of the DSD scale-up efforts and **Community Engagement** during implementation are also reaching high levels of development in the light green category, indicating substantial progress has been made.

DSD DASHBOARD, cont.

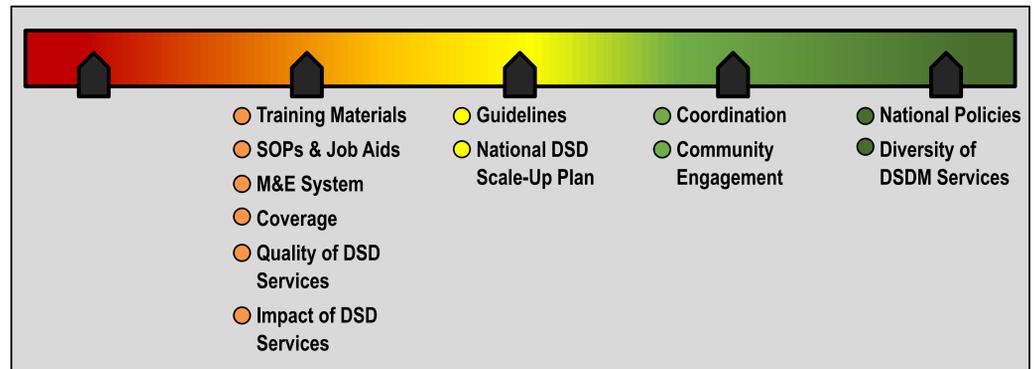


Figure 3. Zambia DSD Dashboard, January 2018

Other aspects of Zambia's DSD implementation remain in the early stages of development, with half (6/12) the domains assessed at the orange level. These rankings indicate opportunities for improvement in domains including **Training Materials**, **SOPs & Job Aids**, the **M&E System**, and others. These domains are crucial components of a high-quality DSD program, but represent some of the most difficult issues faced by countries as DSDM implementation is scaled up. As Zambia continues to make progress in these areas, the MoH may find a valuable resource in the experiences of other countries and the strategies employed to overcome these common challenges.

CASE STUDY/BEST PRACTICE

Differentiated Service Delivery for Patients on 3rd Line ART:

One of Zambia's diverse DSD models is designed for patients on 3rd line ART. These patients are managed at four selected tertiary health care facilities called Advanced Treatment Centers (ATCs), where they are seen on specific days of the week by HIV Specialists. As of January 2018, 368 patients were enrolled at ATCs. The majority (93%) of patients are enrolled at University Teaching Hospital (UTH), where the retention rate is at 83% with an overall viral suppression rate of 74% (using a cut off of 50 copies/ml) and 95% (using a cut off of 400 copies/ml).¹

Successful Task Shifting of Services to Community Health Workers:

Zambia has increased the engagement of Community Health Workers (CHW) in some services related to ART provision as a strategy to address health care worker HCW burden and other staffing challenges. The use of a CHW cadre has helped in the scale-up of ART services at lower level health facilities and at those with smaller HCW staff. In addition, some DSD models have employed CHW by assigning a number of clients to workers in this cadre for regular follow-up. Through these procedures, there has been an increase in index client tracking and testing, as well as partner notification.

NEXT STEPS/WAY FORWARD

A number of priorities to be addressed as DSDM scale-up progresses have been identified by Zambia's DSD leaders. As part of the process of developing scale-up plans, there is interest in determining the perceptions of communities regarding the acceptability of various models to the patients and to the health care system.

In concert with scaling up the coverage of DSDM, there is an anticipated need for the development of M&E tools and systems capable of capturing DSDM-specific data. One area of program monitoring that is of great interest is the ability to measure the rate of transfers between community-based models and facility-based models, particularly if the transfer from the community- to the facility-based model is due to the client becoming unstable. With appropriately-specific M&E tools, it would also become possible to measure the cost effectiveness of various DSDM models and the impact on treatment outcomes that DSDM scale-up has for patients.

While Zambia already has a diverse offering of models for DSD of ART, there is interest in DSDM for specific patient groups, such as people living with both HIV and non-communicable diseases, and members of key and vulnerable populations.

Zambia is actively contributing to the body of knowledge of DSDM through current and future research :

- **EQUIP Zambia:** With support from MoH, an economic evaluation of Zambia's DSDM is being conducted to determine cost effectiveness information by population group, not necessarily what is cost effective for Zambia as a whole.
- **M&E of DSDM:** The MoH, in collaboration with the University of Zambia, will be conducting M&E of all DSDM in 2018. This results of this evaluation will be used to inform policy.
- **ZAMBART** is currently conducting a three-arm cluster randomized non-inferiority trial for clinical, immunological, and virological outcomes in patients receiving care via community-based DSDM (CAGs, home delivery) and those receiving care in the health facility (Standard of Care).

REFERENCES:

1. Paul Zulu et al, yet to be published