Taking Differentiated Service Delivery to Scale in Zimbabwe: Building on a Strong Foundation

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BACKGROUND

The Government of Zimbabwe and its Ministry of Health and Child Care (MOHCC) have championed the scale-up of Differentiated Service Delivery (DSD) as a way to promote MOHCC priorities, such as enabling patients on antiretroviral therapy (ART) to provide psychosocial support to one another, reducing the workload of health care workers (HCW), and separating simple drug refill processes from clinical care.

As DSD scale-up continues, one focus area for MOHCC has been training different cadres of HCW to capacitate and empower them to provide high-quality DSD services. Through sensitization trainings, HIV Integrated Training (HIT) blended learning, and mentorship platforms, HCW in Zimbabwe are better able to ensure that all patients receive high-quality services, whether they access services in the facility or the community. To ensure that HCW are supported and engaged in the scale-up of DSD, support and supervisory visits are conducted periodically, and HCW experience and satisfaction is also assessed.

Throughout the process of developing, implementing, and scaling up the national DSD program, the MOHCC has engaged members of the community of people living with HIV (PLHIV) and representatives from civil society organizations (CSO). Community members influence policy development through involvement in the national DSD technical working group (TWG), national Community TWG and are active in conducting site support visits and promoting peer-to-peer support.

DSD MODELS OFFERED

DSD was first offered in Zimbabwe in 2009 when the Ministry of Health and Child Care (MOHCC) launched the Outreach model nationwide. At the same time, implementing partners (IP) began piloting the **Community ART Refill Group (CARG)** model. Currently, Zimbabwe's national models of DSD for ART include the **Fast Track Refill, Facility Club Refill,** CARG, and **Outreach** models.

In addition to these standard model types, Zimbabwe also offers the **Family Refill** Model, which allows one member of a family of multiple adults receiving ART services to collect medication refills for all family members, and the **Zvandiri Model** for adolescents and young people. Finally, there is one model currently being piloted in one district: **Out of Facility Community ART Distribution (OFCAD).**

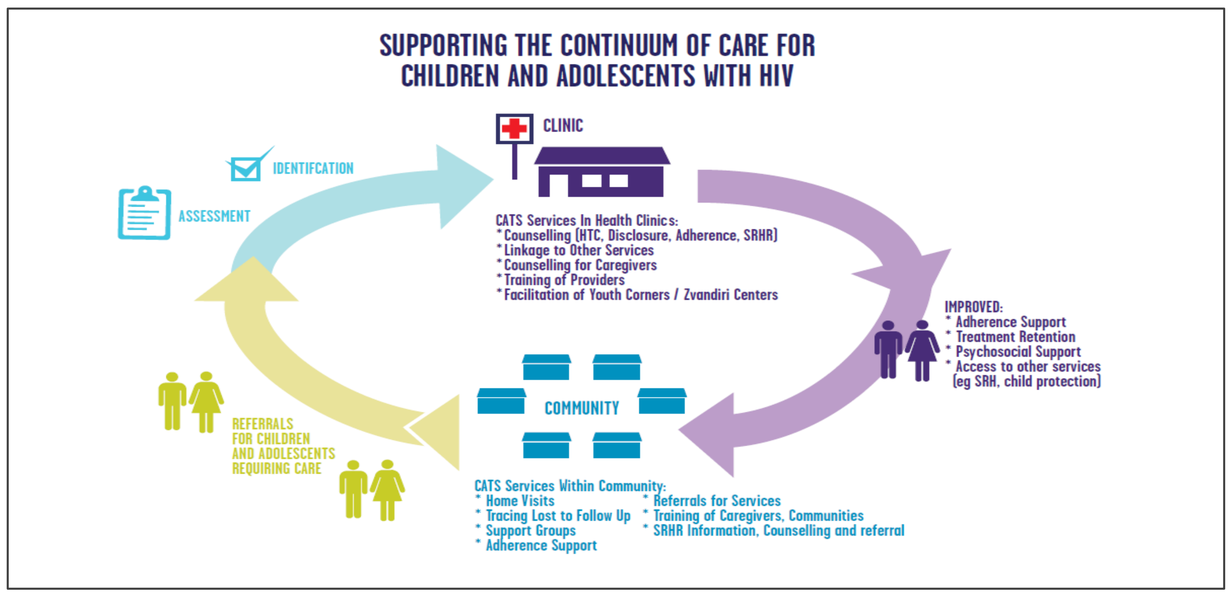

Figure 1. The Zvandiri Approach (Picture adopted from the Zvandiri Case Study)

DSD UPTAKE AND DEMAND CREATION

DSD is supported in all 65 districts in Zimbabwe's 10 provinces where ART services are provided. Of 20 implementing partners currently supporting ART services, 8 are also supporting DSD. 1601 health facilities in the country provide ART and, of those, 901 (56%) have been capacitated to provide at least one DSD model (DSDM).

Information about available DSDM is disseminated to the community through community health care cadres, expert clients, and training offered via the HIV Literacy Manual used for client education in the community. These informational activities and continuous promotion of DSD through health talks in the community and the facility, mean that demand is continuously being built for DSD services.

To ensure DSDM are meeting patient needs and expectations, assessment of patient experience and satisfaction have recently been initiated with the learning sites and the plan is have them conducted periodically at scale. MOHCC has also worked with CQUIN to explore male engagement in DSD, and with currently ICAP to explore the preferences of urban PLHIV for different DSDM.

DSD DASHBOARD

The CQUIN DSD Dashboard was used by Zimbabwe to monitor the country's maturing DSD program. Across 13 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.

In a systematic, inclusive staging process undertaken in October, 2018, Zimbabwe was found to meet the standards for the highest-possible ranking, dark green, in six of the 13 domains (Figure 2) and light green in an additional domain.

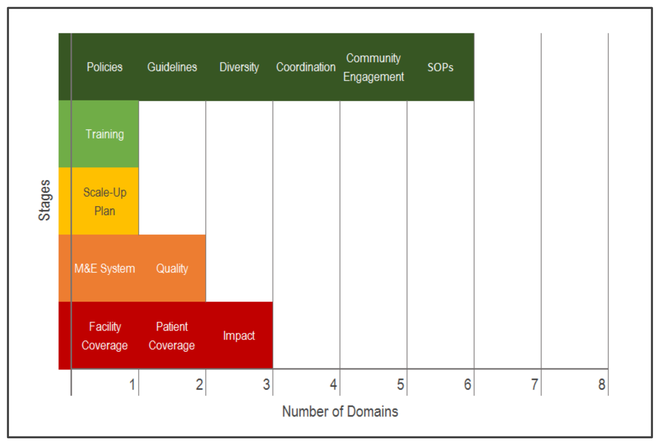

Figure 2. Zimbabwe DSD Dashboard staging domains by stage, October 2018

While Zimbabwe has identified five domains that have yet to be addressed or are still in the early stages of scale-up, progress has been made in the eight months since the DSD Dashboard staging was last completed. Figure 3 describes the staging of eight key domains in February and October, 2018. The Training domain staging has advanced from yellow—national curricula are in development but have not yet been implemented—to light green, indicating that the training curricula have been finalized and are in use as in-service HCW training.

While it appears that the staging has regressed in some domains, these discrepancies are, in fact, artifacts of improvements in the process used to complete the staging and increased understanding of the staging criteria.

As Zimbabwe continues to make progress in scaling up DSD and improving the national DSD program, regular assessments using the DSD Dashboard will provide valuable information to the MOHCC on achievements reached and highlight areas where challenges may require targeted attention.

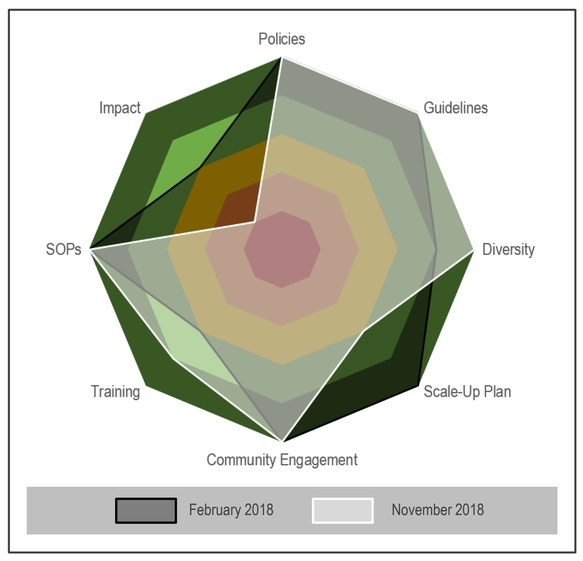

Figure 3. Radar chart of Zimbabwe DSD Dashboard staging, February and October 2018

OPPORTUNITIES FOR CROSS-BORDER LEARNING

As countries work separately to scale up DSD, there are benefits to sharing knowledge, best practices, and research findings. Zimbabwe has identified three priority areas for seeking input from other countries in the coming year.

First, the CARG model is already being implemented in Zimbabwe, but only for adult populations. There is interest in expanding the model to children, adolescents, and young adults living with HIV; however, the country is seeking the perspective of others that have conducted research or have experience implementing similar programs.

Secondly, Zimbabweans are very mobile—particularly those between the ages of 19 and 24—and adherence and loss to follow-up are greatly affected by this. The MOHCC is very interested to learn more from other countries facing similar challenges or implementing models for mobile populations—miners, in particular.

Finally, the country would be interested to learn how others may have used community-based PMTCT adherence clubs to address poor retention among mothers receiving PMTCT services.

NEXT STEPS/WAY FORWARD

The Zimbabwe MOHCC is looking forward to continuing to build on progress already made, with additional focus on aspects of scale-up that have proven challenging, such as the slower than expected pace of developing M&E tools and low acceptability of the Fast Track Refill model among HCW. Strategies planned to address gaps include the adoption of an intermittent data review process to allow for the collection of DSD data while the national M&E system is still in development. The MOHCC is also planning best practice sharing meetings and exchange visits to encourage buy-in among HCW and ensure consistent implementation of DSD nationwide.

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