Taking Differentiated Service Delivery to Scale in Zambia: Innovating, Adapting, and Scaling Up DSD

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BACKGROUND

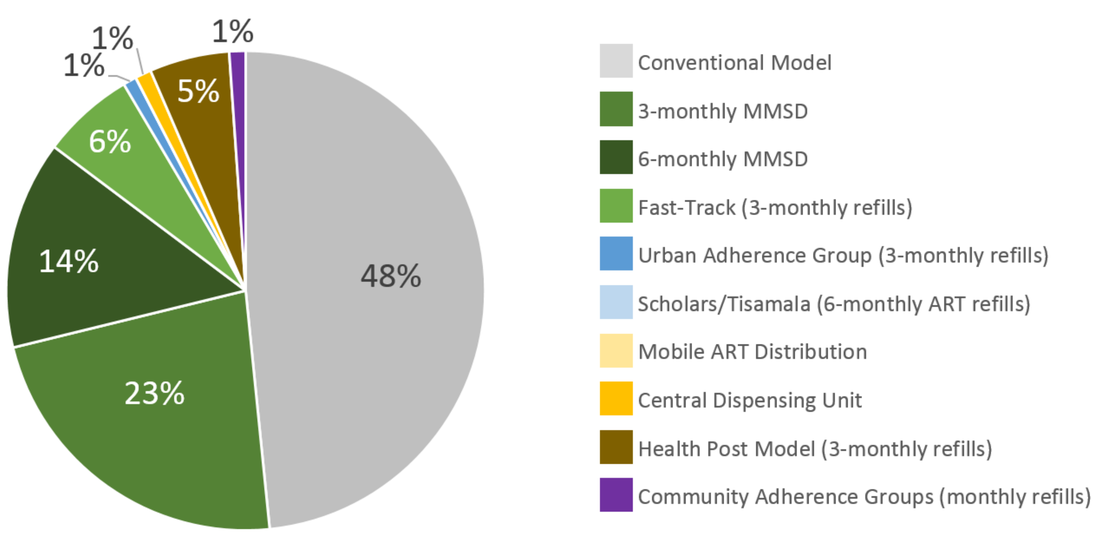
Zambia has made notable progress in addressing its HIV epidemic with an estimated 90% of people living with HIV aware of their status; 81.4% of people living with HIV on antiretroviral therapy (ART); and 61.4% viral suppression among those on ART as of June 2019 (Zambia HMIS 2019). Differentiated service delivery (DSD) was introduced to Zambia in 2013 in the form of single models and pilot projects offered by implementing partners and has since become a fundamental service delivery mechanism for the National HIV program. The DSD Framework, which includes DSD national quality standards, was finalized in 2018 by the DSD Task Force and launched the same year at the National ART Technical Update in October 2018. Recent achievements include the introduction of six-month multi-month scripting (MMS); introduction of an early morning refill model adapted from Eswatini after a CQUIN-supported south-to-south visit; integration of DSD data elements into the national M&E system, and development of the DSD national training package. Zambia is also implementing a pilot of TB preventive treatment for people in the Fast Track Model, after winning an “shark tank” award from CQUIN in 2019.

DSD IMPLEMENTATION

Currently, Zambia has nine less-intensive DSD treatment models. These include four facility-based individual models (**3-monthly multi-month scripting and dispensing [MMSD], 6-month MMSD, and Fast Track)**, two facility-based group models (**Scholars/Tisamala,** a facility-based teen club model, and **Urban Adherence Groups),** two community-based individual models (**Community ART Distribution [CAD]** and the **Health Post Model)** and one community-based group model (**Community Adherence Groups [CAG]).** Two community organizations, Treatment Advocacy and Literacy Campaign (TALC) and the Network of Zambian People Living With HIV/AIDS (NZP+), are implementing another DSD model called Community ART Adherence Access Points (CAAP).

In addition to implementing these custom models, recipients of care are meaningfully engaged at all stages of development, implementation, and evaluation of the DSD program. They are a valued part of the DSD Task Force, which only has a quorum for the meeting once there is representation from RoC.

Figure 1: DSD Model Mix, August 2019

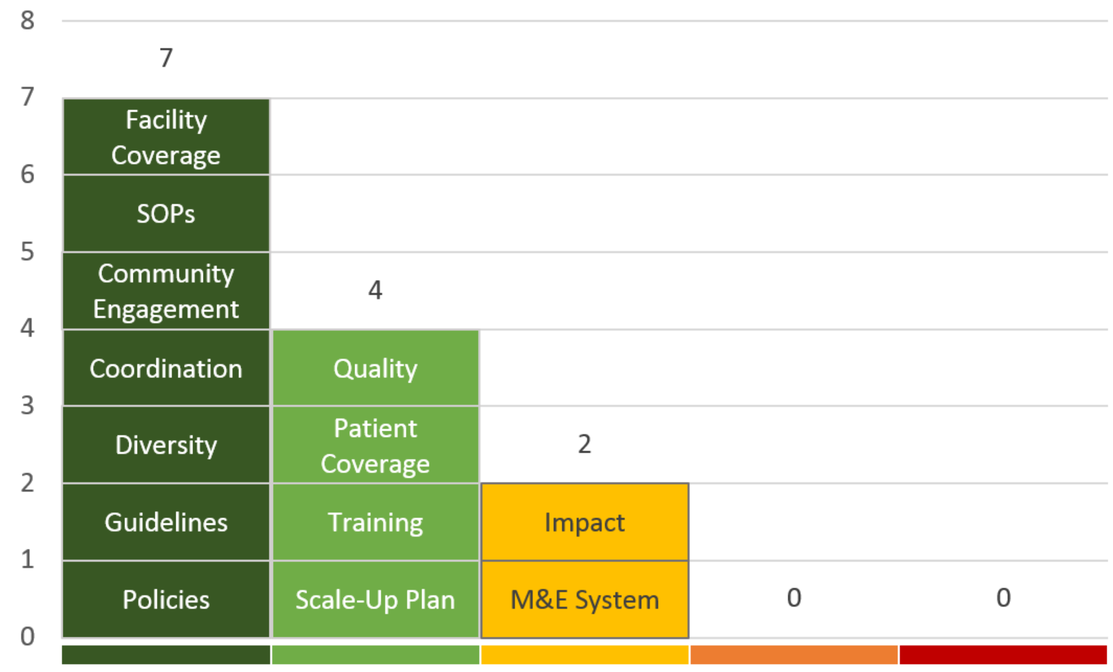


As of the CQUIN DSD Dashboard staging conducted in October 2019, there were 2,143 ART facilities in Zambia, of which 1,822 (86%) offer at least one of the national DSDM. Based on August 2019 data sourced from Implementing Partner and Health Management Information System (HMIS) reporting throughout the country, Zambia estimates that 52% of all those on ART were enrolled in any less-intensive model, as compared to 48% who received ART services through the conventional model (Figure 1). Notably, the majority of people enrolled in less-intensive models are in facility-based individual models.

Members of the DSD Task Force joined a south-to-south visit to Eswatini where they learned of the early morning refill model, which has since been implemented at the University Teaching Hospital Adult ART Clinic in Lusaka, with an estimated 1,000 ROCs in care. Another facility in Central Province is also implementing the model with slightly over 50 people in care.

DSD DASHBOARD

Figure 2: Dashboard Results 2019

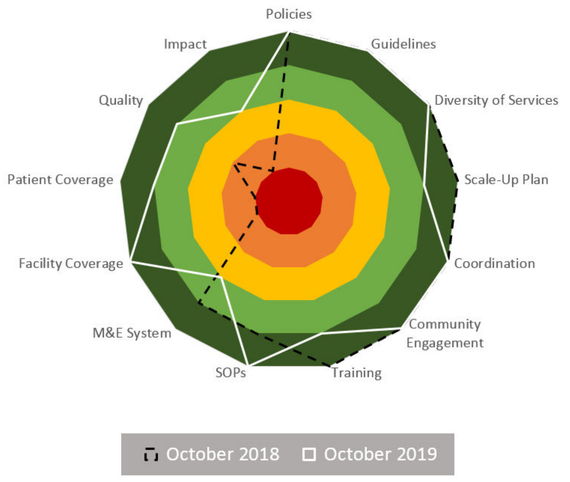


The CQUIN DSD Dashboard measures DSD scale-up across 13 domains, using a five-step color scale to rank progress and performance. In the October 2019 staging (Figure 2), Zambia had the highest-possible ranking, dark green, in seven of the 13 domains (Policies, Guidelines, Diversity of Services, Coordination, Community Engagement, SOPs, and Facility Coverage) and the next-highest ranking, light green, in four additional domains (Scale-Up Plan, Training, Patient Coverage, and Quality). Only two domains remain in the mid-level maturity stage.

Figure 3 describes the changes in Zambia’s DSD program staging from October 2018 - October 2019, illustrating robust progress in the domains of SOPs, Facility Coverage, Patient Coverage, Quality, and Impact in the last year.

While the results show slight regression in three domains (scale-up plan, training, and M&E) this may be due to differences in the rigor with which staging was performed in 2019; the team feels no actual regression has occurred.

Figure 3: Dashboard Results 2018 *vs.* 2019



CASE STUDY/BEST PRACTICE

The DSD Task Force received funding from CQUIN for a DSD QI project called “Zisamale na TPT” (a local word meaning self-care) designed to provide isoniazid (INH) TB preventive treatment to people in less-intensive DSD models (either 3-MMSD or 6-MMSD). The approach addresses the need for close follow up of people on TPT in less-intensive models by substituting clinical visits with follow up phone calls at specific time points. This minimizes the number of clinical visits for recipients of care and highlights the potential for self-management. With MOH approval the project is being implemented at one of the facilities in Lusaka, the newly upgraded Chipata First-Level Hospital. The QI project launched in September 2019 and has provided TPT to more than 650 people to date.

NEXT STEPS/WAY FORWARD

Current priorities for the DSD Task Force include:

- Continuing to monitor and improve DSD program quality. Following the CQUIN workshop on DSD Quality and QI, the DSD Task Force has been working to introduce DSD quality standards.
- In 2019, the Clinton Health Access Initiative (CHAI) evaluated DSD models in children and adolescents in Lusaka and Copperbelt provinces and showed that there are gaps in DSD activities for these groups. In response, the Task Force has formed a core team composed of those with experience in pediatric HIV to further explore and address these gaps.
- Scaling up of the use of electronic patient information system for services provided to recipients of care