



# Taking Differentiated Service Delivery to Scale in Zimbabwe: Championing Data for Decision-Making

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## BACKGROUND

Zimbabwe has made significant progress in curbing its HIV epidemic with 90% of people living with HIV aware of their status and 88% on antiretroviral therapy (ART) in 2018 (UNAIDS 2019). This year, major strides were made in monitoring and evaluation (M&E) of differentiated service delivery (DSD): the introduction of a DSD quarterly reporting template and integration of DSD data collection into the new electronic patient management system (EPMS). Through implementing partners, Zimbabwe was able to collect DSD data from 41 districts that represent 80% of the clients in care in Q1 and Q2. With support from CQUIN, the Ministry of Health and Child Care (MOHCC) also convened a DSD Review Meeting, with four provinces, to discuss DSD implementation bottlenecks and innovations to address them.

Recipients of care continue to play an integral role in the DSD response and to provide input on how DSD affects them through their participation in the Meaningful Involvement of People Living with HIV and AIDS Forum (MIPA), which works together with the MOHCC to receive updates on new information in HIV programming as well as discuss issues affecting clients in care.

## DSD IMPLEMENTATION

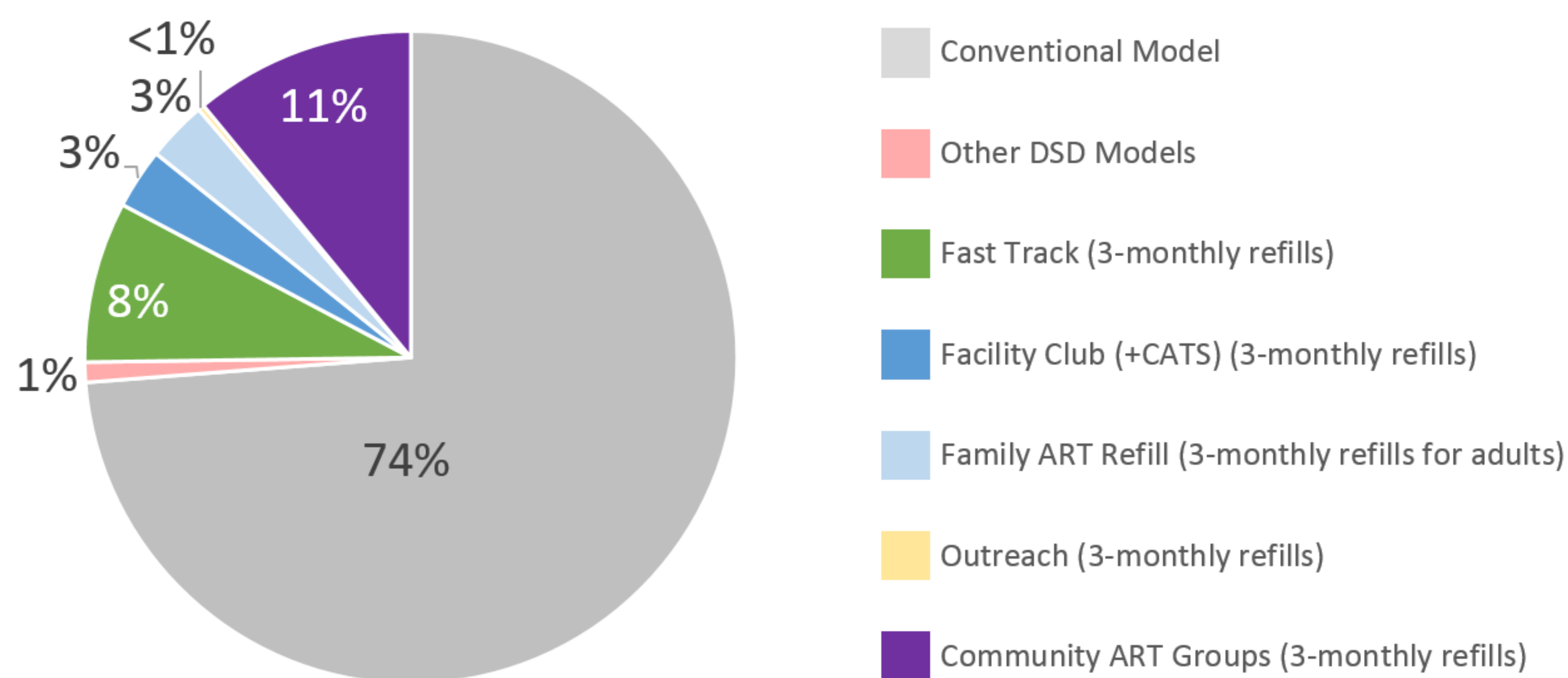
Zimbabwe currently has six main less-intensive DSD treatment models, including two facility-based individual models (**3-month MMS** and **Fast Track**); one facility-based group model (**Facility Club Refill Model**) which includes the CATS teen club model; one community-based individual model (**Outreach Model**); and two community-based group models (**Community ART Refill Groups [CARGs]** and **Family ART Refill Groups**).

In mid-2019, Zimbabwe changed its categorization of the 3-month MMS model. Previously included in the “standard of care” model definition, MoHCC determined that because not all people on ART are eligible for this model, it is best defined as a less-intensive DSD model.

At the June DSD Review Meeting, participants noted the need for a specific DSD model for people on ART in the diaspora and mobile populations, and worked to develop innovations, such as a specific DSD model that addresses issues such as movement of medicines across borders. A task team is currently finalizing the new model for inclusion in the national guidelines. In addition, the MoHCC is also working on developing clearer guidance on DSD models for other subpopulations, such as adolescents and mothers with younger children on ART.

The DSD Review Meeting also highlighted that less-intensive DSD models are being implemented with variable fidelity, and that recipients of care move between models with some regularity, complicating monitoring and evaluation.

Figure 1: DSD Model Mix, March 2019



Facility-level DSD coverage is very high in Zimbabwe, with 100% of the 1,201 ART facilities offering at least one of the less-intensive DSDM. As of March 2019, 26% of people on ART were known to be enrolled in less-intensive models; however, the proportion is likely higher, because many people receiving 3-MMD were still categorized in “conventional care” at the time these data were collected. Of the less-intensive models, CARGs were the most popular, including 11% of all those on ART.

The CQUIN DSD Dashboard staging was conducted in October 2019, at a time when people receiving 3-MMD had been re-categorized as in a less-intensive model; Figure 1 will be updated when more data are available.

## DSD DASHBOARD - CONTINUED

Figure 2: Dashboard Results 2019



In October 2019, stakeholders conducted a systematic self-assessment of DSD program maturity using the CQUIN DSD Dashboard (Figure 2), finding the highest-possible level of maturity in nine of the 13 domains (Policies, Guidelines, Diversity, Facility Coverage, Patient Coverage, SOPs, Scale-Up Plan, Coordination, and Community Engagement,).

Figure 3: Dashboard Results 2018 vs. 2019

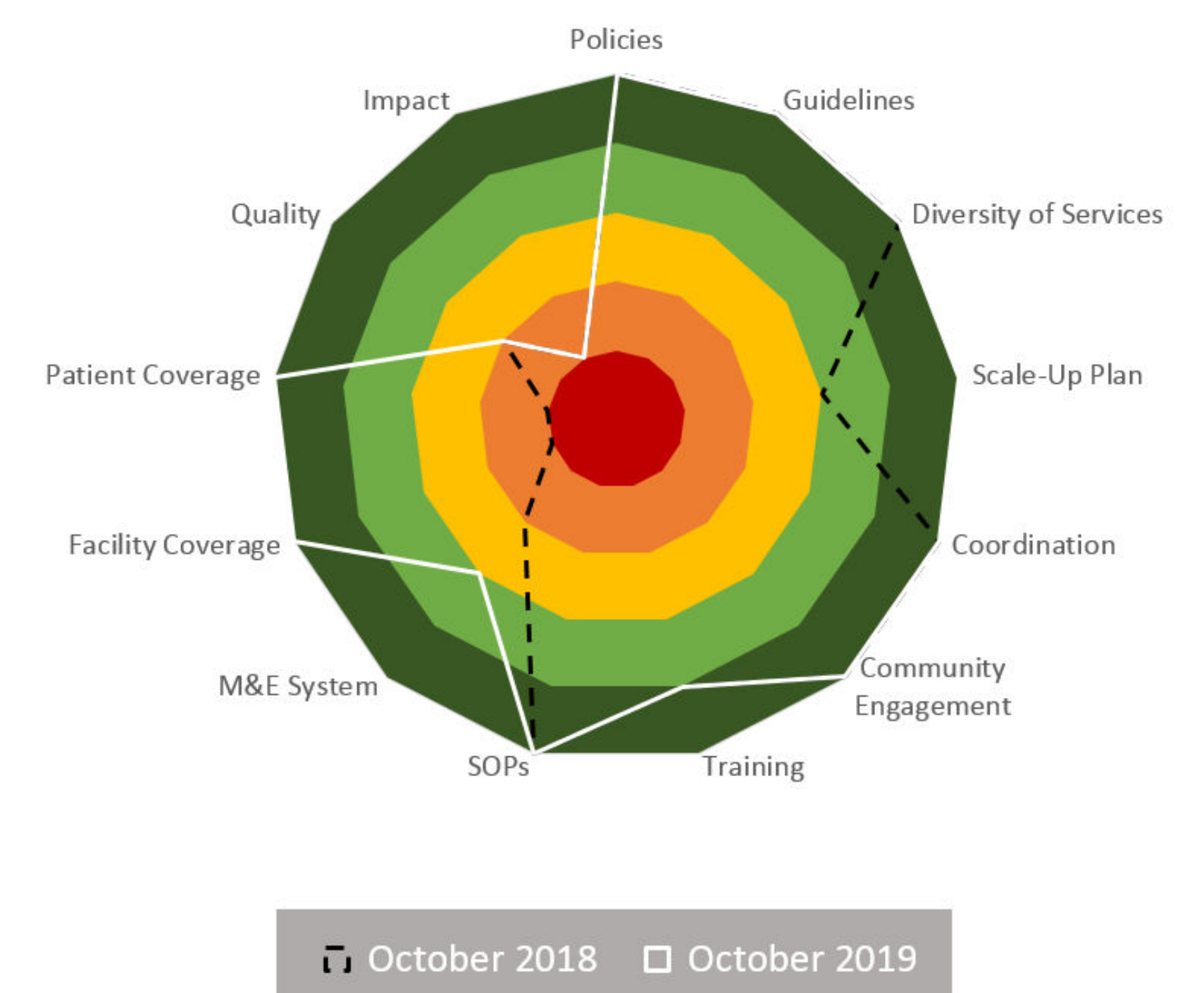


Figure 3 shows Zimbabwe’s progress in the maturity of DSD domains from October 2018 to October 2019, including progress in Scale-Up Plan and M&E System domains. Of note, the lower scores in patient and facility coverage from 2018 are exaggerated by the fact that limited coverage data were available at that time.

## CASE STUDY/BEST PRACTICE

Zimbabwe has made rapid progress in its ability to accurately monitor and evaluate DSD implementation. In 2018, the country developed a DSD-specific M&E Plan with support from CQUIN. The MOHCC designed a standardized DSD quarterly reporting template with input from implementing partners (IP) and provides instructions and reminders to ensure data are received quarterly. The June 2019 DSD Review Meeting also provided important insights into DSD implementation in selected provinces. In addition, DSD data collection and integration into the new electronic patient management system (EPMS) was deployed for use in Case-Based Surveillance pilot districts (Mutare and Umzingwane). Staff at health facilities in these districts were oriented on how to enter data from patient care booklets into the EPMS. These contributions will lead to more timely and accurate understanding of the coverage and quality of DSDM moving forward.

## NEXT STEPS/WAY FORWARD

The MOHCC is looking forward to building on existing progress. Priorities include:

- Disseminating national quality standards for DSD with all stakeholders and finalizing national quality assurance tools for DSD.
- While electronic systems lag behind in capturing and including DSD data, efforts will continue to extend routine reporting coverage to 100% of the facilities offering HIV services. DSD data points have been selected for inclusion in the next revision of national ART Registers to occur in Q4 2019 and Q1 2020.
- A DSD-related QI project is underway at Murewa District Hospital to increase the proportion of clients enrolled in DSD models. The goal of the project has not yet achieved (uptake increased to 72%) and implementation will continue.

