ZIMBABWE: RESPONDING TO CLIENT PREFERENCES THROUGH DIFFERENTIATED SERVICE DELIVERY

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BACKGROUND

Zimbabwe was among the founding CQUIN network member countries in 2017, with five other countries present. At that time, the country had just revised its operational and service delivery manual (ODSM), thus expanding guidance on differentiated service delivery (DSD).

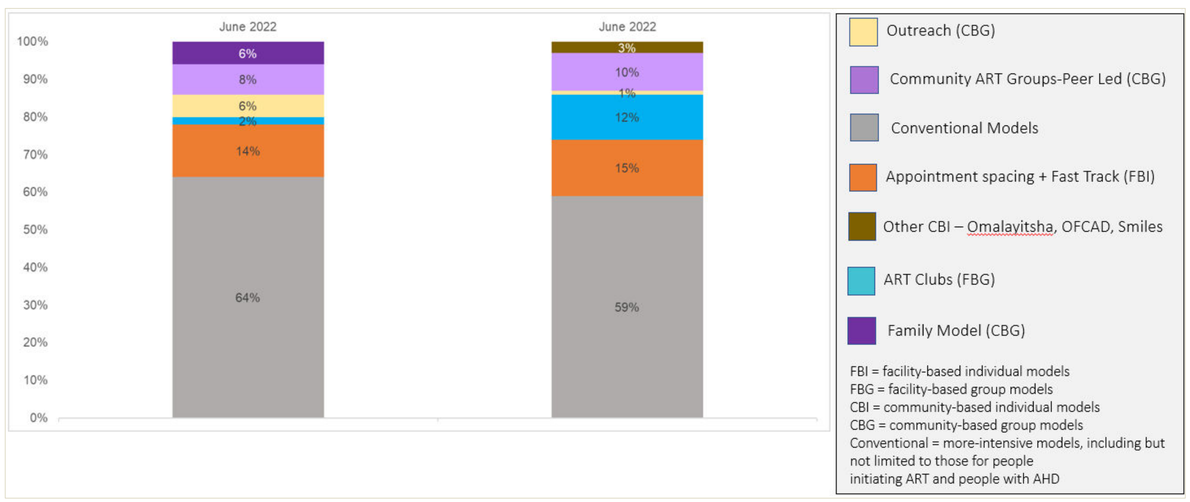
Currently, the country's key DSD implementation-related priorities include capacity-building for health care workers and increasing the availability of differentiated services for diverse sub-populations, such as children, men, and key population groups (KP). Zimbabwe is also prioritizing quality improvement (QI) initiatives to increase implementation with fidelity and to improve enrollment of recipients of care (RoC) in DSD models.

There is a stand-alone DSD technical working group composed of representatives from the Ministry of Health and Child Care (MOHCC), implementing partners (IP), civil society organizations, RoC, and funders, as well as a DSD focal person within the national HIV programme. As of June 2022, there were 406,820 RoC (41%) enrolled in DSD models for people established on ART. RoC choose to enroll in models that meet their preferences and needs after receiving education on the advantages of different models.

DSD IMPLEMENTATION

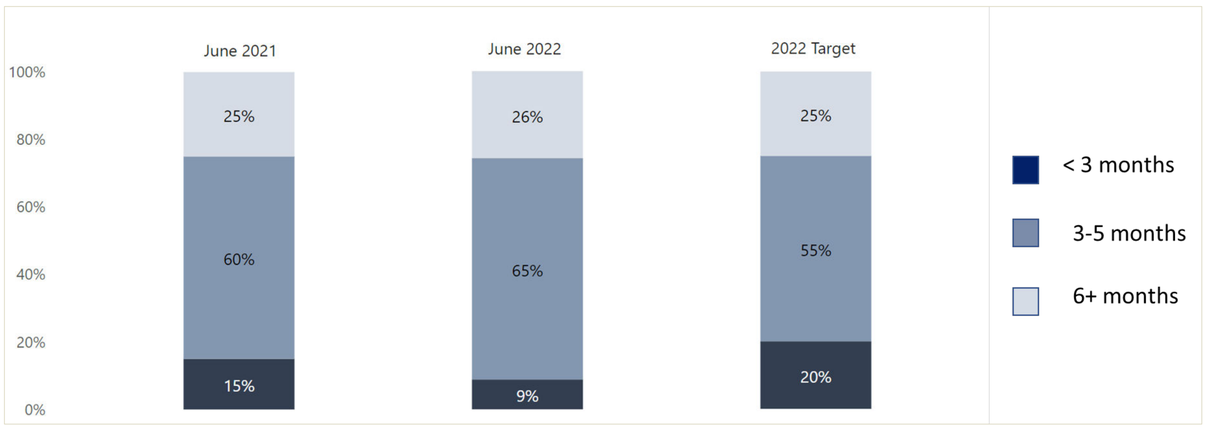
DSD was first offered in Zimbabwe in 2009 when the MOHCC launched the Outreach model nationwide. Concurrently, IP began piloting the **Community ART Refill Groups (CARG)** model. Currently, Zimbabwe's national treatment models include the **Fast Track Refill, Facility Club Refill, CARG**, and **Outreach** models. In addition to these standard model types, Zimbabwe also offers the **Family Refill** Model, which allows one member of a family with multiple adults receiving ART services to collect medication refills for all family members. Other recently adopted models include the **Omalayitsha** model, **Drop-in-Centers**, and the **Community ART Distribution** model.

Figure 1: DSD Model Mix: Results



Zimbabwe does not have targets for different DSD models, as these should be based on RoC choice rather than MOHCC decisions. The DSD model with the highest enrollment is Fast Track (16%), followed by Community ART Refill Groups (10%). The DSD model with the lowest enrollment is the Outreach model, which is appropriate due to resource limitations.

Figure 2: Multi-month Dispensing (MMD): Results *vs.* Targets



Between June 2021 and June 2022, there was a 5% increase in the proportion of people on ART receiving MMD. By June 2022, more than 90% of people on ART were receiving 3+ MMD. The proportion of those receiving <3MMD fell from 15% to 9%, and the proportion receiving 6+ MMD rose from 25% to 26%.

DART CAPABILITY MATURITY MODEL STAGING RESULTS

Figure 3: DART Capability Maturity Model Staging Results - 2022

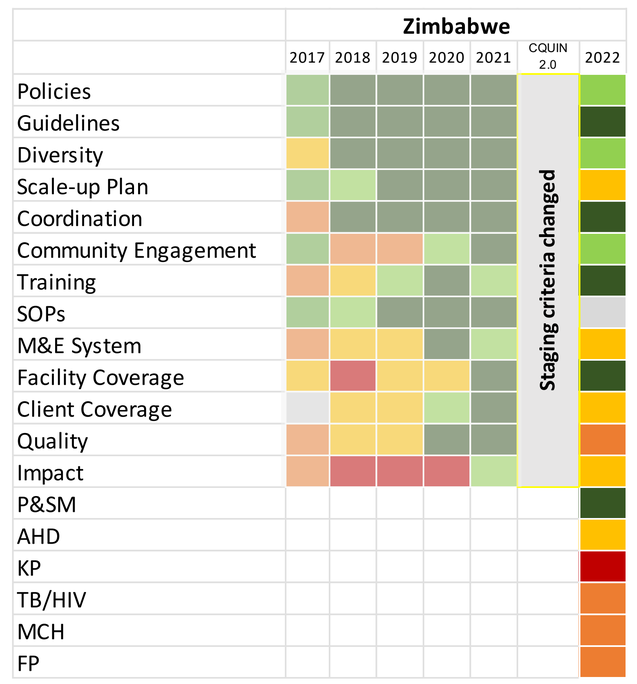
Facility Coverage		Impact		
Procurement		AHD	Quality	
Training	Community	Client Coverage	Family Planning	
Coordination	Diversity	M&E System	MCH	
Guidelines	Policies	Scale Up Plan	TB/HIV	Key Populations

Most mature domains — Least mature domains

Figure 3 shows the results of the Zimbabwe country team's recent self-assessment using the CQUIN DART capability maturity model. In 2022, Zimbabwe achieved the most mature stage (dark green) in five domains, while one domain was in the least mature (red) stage.

Figure 4 describes DART capability maturity model dashboard progress over time and results of the revised and expanded DART capability maturity model used in 2022.

Figure 4: DART Dashboard 2017 – 2022



CQUIN ENGAGEMENT AND ACHIEVEMENTS

Zimbabwe joined all current CQUIN communities of practice, including TB/HIV, DSD Coordinators, QI for DSD, and M&E; however, half of the COPs are still new for the country. We conducted CQUIN-supported DSD Performance Reviews in four provinces between 2021 and 2022—Mashonaland Central, Mashonaland West, Matabeleland South, and Midlands— which included both IP-supported and non-IP supported facilities. CQUIN also supported QI for DSD trainings and support visits for Matabeleland South and Mashonaland West, covering a total of 14 facilities.

KEY SUCCESSES

Since the beginning of DSD implementation, the program has been cognizant of the need to respond to the needs of RoCs. Evident gaps were seen among children, mobile populations, and KP; and the revision of the OSDM (which included substantial input from stakeholders) helped address these gaps. The guidelines were also expanded to include integration of non-HIV-related health issues (NCDs, FP) in HIV and DSD programming. DSD is now fully integrated into national M&E systems. Community engagement in DSD implementation has been strengthened through the integration of DSD indicators in community-led monitoring tools and client satisfaction surveys that are conducted by the Zimbabwe National Network of PLHIV (ZNNP+). Engagement with the KP national steering committee has also improved significantly, as evidenced by their inputs into the revision of the OSDM and national Joint HIV Strategy, and the expansion of models of care for KP groups. National scale up of DSD QI strategies will be informed by the demonstration of the effectiveness of DSD QI trainings through observation of improvement in skills of the trained health care workers and in DSD quality.

NEXT STEPS/WAY FORWARD

The Zimbabwe MOHCC is looking forward to:

- Continue building on progress made to date, with additional focus on implementation with fidelity and scaling-up of QI initiatives
- Continue strengthening the electronic systems for M&E for DSD
- Conducting QI for DSD best practice-sharing meetings and exchange visits to encourage buy-in among health workers and to ensure consistent implementation of DSD nationwide
- Continuing to find opportunities for capacity-building of the private sector on TB/HIV services