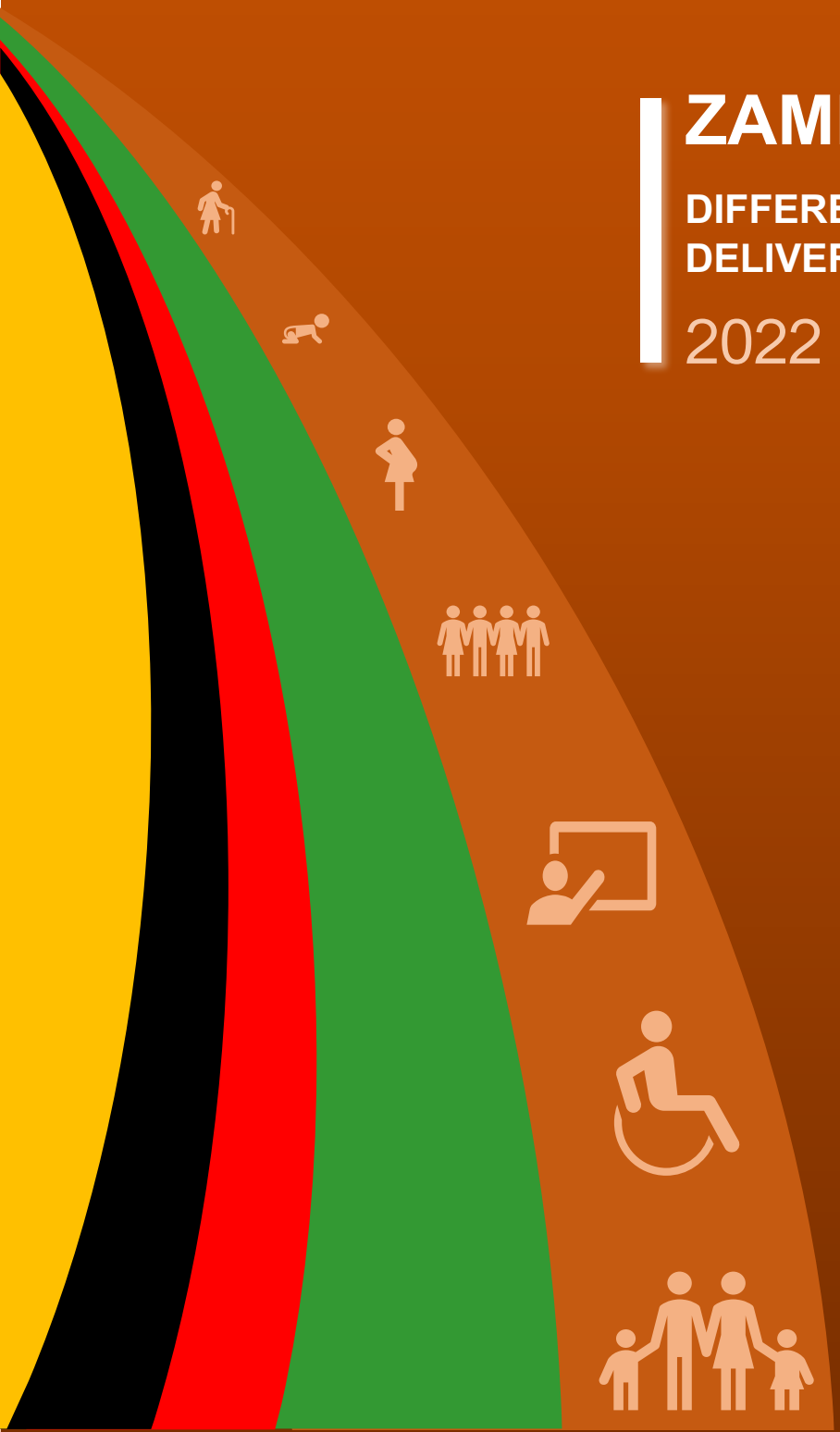
Republic of Zambia
Ministry of Health

ZAMBIA

DIFFERENTIATED SERVICE DELIVERY (DSD) FRAMEWORK

2022 - 2026



ZAMBIA

DIFFERENTIATED SERVICE DELIVERY FRAMEWORK

2022 - 2026

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LIST OF ACRONYMS

AAG	Adolescent Adherence Group
AGYW	Adolescents Girls and Young Women
AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ATS	Amphetamine Type Stimulant
AYFS	Adolescent and Youth-friendly Space
CAAP	Community ART Access Point
CAD	Community ART Dispensation
CAG	Community Adherence Group
ART	Combination Antiretroviral Therapy
CBO	Community-based Organization
CCO	Clinical Care Officer
CD4	Cluster of Differentiation 4
CO	Clinical Officer
CQUIN	Coverage, Quality and Impact Network
CTX	Co-trimoxazole
DAR	Daily Activity Register
DHIO	District Health Information Officer
DHIS	District Health Information System
DSD	Differentiated Service Delivery
EAC	Enhanced Adherence Counselling
EHR	Electronic Health Record
eLMIS	Electronic Logistics Management Information System
FSW	Female Sex Worker
FT	Fast Track
GRZ	Government of the Republic of Zambia
HCW	Healthcare Worker
HIA	Health Information Aggregation
HIA4B	Health Information Aggregation Form Four B
HIV	Human Immunodeficiency Virus
HIV ST	HIV Self-Testing
HMIS	Health Management Information System
HP	Health Post
HTS	HIV Testing Services
IEC	Information, Education and Communication
IPT	Isoniazid Prevention Therapy
IRIS	Immune Reconstitution Inflammatory Syndrome
KP	Key Populations
KYCS	Know Your Child HIV Status
LGBTQ	Lesbian, Gay, Bisexual, Transgender, (Questioning, Queer)

LHCW	Lay Healthcare Worker
MAT	Medically Assisted Therapy
M&E	Monitoring and Evaluation
MCH	Maternal Child Health
MDT	Multidisciplinary Team
MMS	Multi-Month Scripting
MO	Medical Officer
MOH	Ministry of Health
MSL	Medical Stores Limited
MSM	Men who have Sex with Men
N&S	Needle and Syringe Programme
NCD	Non-communicable Disease
NHC	Neighborhood Health Committee
OI	Opportunistic Infection
OPD	Out-Patient Department
OST	Opioid Substitution Therapy
PITC	Provider-initiated Testing and Counselling
PLHIV	People Living with HIV
PrEP	Pre-Exposure Prophylaxis
PUP	Pickup Point
PWUD	People Who Use Drugs
QI	Quality Improvement
R/UAC	Rural/Urban Adherence Club
R/UAG	Rural/Urban Adherence Group
ROC	Recipient of Care
SM	Scholar Model
SOP	Standard Operating Procedure
STIs	Sexually Transmitted Infections
TALC	Treatment Advocacy Literacy Campaign
TB	Tuberculosis
TDB	Transport Database
TWG	Technical Working Group
VCT	Voluntary Counselling and Testing
VL	Viral Load
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
ZAMPHIA	Zambia Population-based HIV Impact Assessment
ZCGs	Zambia Consolidated Guidelines for Treatment and Prevention of HIV
ZDHS	Zambia Demographic and Health Survey

FOREWORD

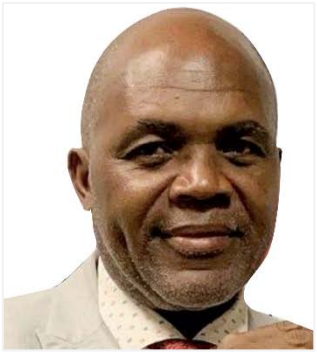
Zambia is running the last mile towards HIV epidemic control. Bringing the HIV epidemic under control is integral to the socioeconomic development and health welfare of all Zambians. Providing health services to PLHIV requires improving efficiencies in the health system to meet their expectations and continually improve their satisfaction. Modalities of service provision should enhance engagement not only into care and retention on Antiretroviral Therapy (ART) but also finding the hard-to-reach populations and link them into care.

To achieve epidemic control, improved health system delivery approaches and innovative interventions must be employed. Differentiated Service Delivery (DSD) is one such approach which is person centered and cuts across the continuum of care with the aim of improving case finding among the hard-to-reach population, health outcomes and system efficiencies. This should reflect in the health outcomes of individualized care, better coverage, and improved quality of services. For the sustainability of DSD, the implementation should leverage on existing structures and resources.

This framework is intended to provide guidance on how DSD models will be implemented at different levels (national, provincial, district, facility, and community) with the goal of fast-tracking progress towards HIV epidemic control. It is the responsibility of all stakeholders to take the leadership role in ensuring the successful implementation of DSD models and meeting the national targets.

Honorable Sylvia T. Masebo, MP
Minister of Health

ACKNOWLEDGEMENTS



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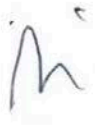

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BACKGROUND AND RATIONALE

With an estimate of 1, 348, 041 (Spectrum 2022) People Living with HIV (PLHIV), Zambia is making steady progress towards the 95/95/95 UNAIDS targets. Zambia has achieved the first and second 95 of the UNAIDS targets. According to the Zambia population-based HIV impact assessment (ZAMPHIA) 2022, the UNAIDS targets among 15–59-year-old PLHIV were 88.7/98.0/96.3. While substantial progress has been made in the last two decades, they are variations among the PLHIV, treatment targets among Adolescents and young people (AYP) aged 15-24 years which were estimated at 75/74/70. Furthermore, there are reported inequalities and vulnerabilities particularly with underserved populations such as Pregnant and Breastfeeding Women (PBFW), men and key and priority populations as they continue to face barriers to better health, this is negatively affecting Zambia's efforts to Human immunodeficiency virus (HIV) epidemic control by 2030. Therefore, to adequately address the HIV epidemic consented and innovative efforts are required to ensure that no one is left behind.

In 2017, the country adopted Differentiated Service Delivery (DSD) strategy with a focus for treatment established PLHV. However, the gaps among the non-established PLHIV such as key and priority populations, underscored the country's approach to expand DSD to transcend the continuum of care, be patient-centered, non- discriminatory and inclusive of all.

The 2023 Differentiated Service Delivery framework will provide guidance that extends the provision of differentiated services across the HIV continuum of care. Additionally, highlights evidence-based models that could be adapted in the health facilities and communities across the country. Before setting up DSD models the following steps should be considered:

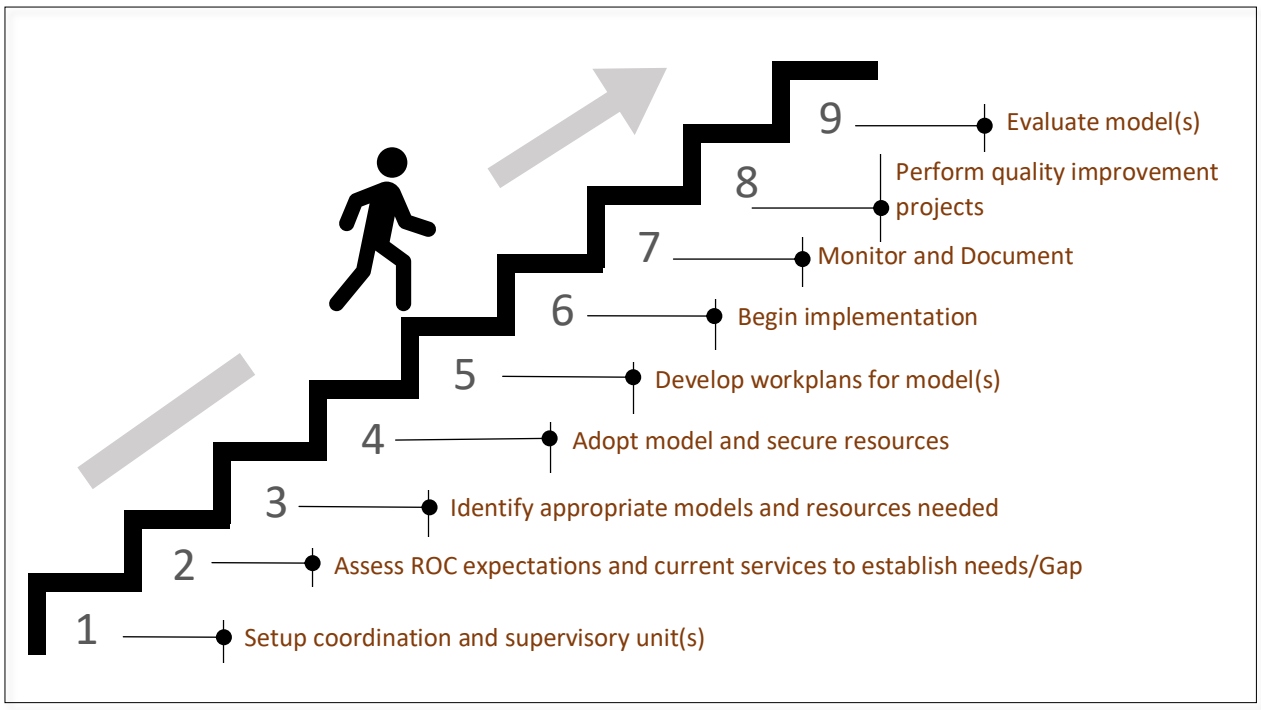

Figure 1: Steps for Setting up DSD Models

Chapter 1. HIV SERVICE DELIVERY

1.1. OVERVIEW OF STANDARD OF CARE FOR HIV SERVICES

HIV testing, prevention, and treatment are all included in Zambia's HIV healthcare package. Additionally, the "test and treat" approach is the main component of the care plan for all Recipients of Care (ROC).

HIV testing and prevention, includes

- differentiated HIV testing services
  - Social Network Testing
  - Index testing and partner notification
  - Self-testing
  - venue based testing
  - Provider initiated counselling and testing
  - and other targeted testing modalities
- Linkage of all High-risk HIV negative individuals to comprehensive HIV preventive services, such as Pre-Exposure Prophylaxis (PrEP), Post Exposure Prophylaxis (PEP), VMMC, cervical cancer screening, Sexually transmitted screening, condom promotion and distribution and PMTCT

- Psychosocial support which includes educating ROC on
  - Positive health dignity prevention
  - Adherence counseling to care and treatment services
  - risk reduction of other Sexually Transmitted Infections (STIs)
  - importance of VL monitoring
  - emphasis on the freedom of the ROC to transfer to the facility of their choice to improve retention in care
  - addressing and coping with HIV related stigma and discrimination
  - available DSD models

- Clinical care and provision of ART, which consists of
  - history taking and physical examination
  - dispensation of Antiretroviral drugs (ARVs)
  - monitoring for side-effects
  - screening and prompt management of Advanced HIV Disease (AHD)
  - screening and management of Non-Communicable Diseases (NCDs) and other co-morbidities
  - adherence to care and treatment
  - nutritional support
  - Mental Health Support for ROC

- Provide preventive care (Presumptive, Pre-emptive and Prophylaxis)
    - Vaccinations such as HPV, COVID-19 and others
    - TB Preventive Therapy (TPT)
    - Co-trimoxazole
    - Pre-emptive treatment and secondary prevention for Cryptococcal disease with Fluconazole

- Virological (viral load) monitoring
    - All ROC should have viral load monitored according to the Zambia Consolidated Guidelines for Prevention and Treatment of HIV

- Immunological monitoring
    - CD4 cell count monitored in line with the Zambia Consolidated Guidelines for Prevention and Treatment of advanced HIV disease

- Standard services provided at health facilities (as shown in the patient flow chart below) vary depending on the medical record system used at the facility, which may be paper-based or electronic systems.

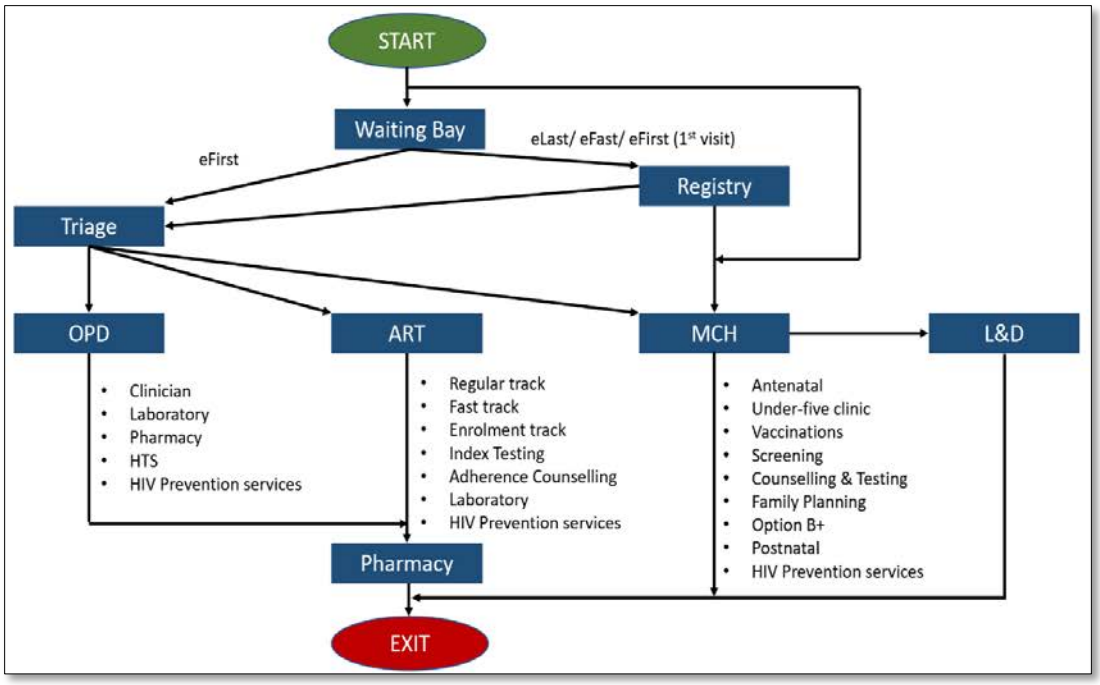

Figure 1.1: ROC Flow Chart

Chapter 2. PRINCIPLES AND BUILDING BLOCKS OF DIFFERENTIATED SERVICE DELIVERY

2.1. DIFFERENTIATED SERVICE DELIVERY

WHO defines DSD as a public health approach that responds to the increased diversity of needs of PLHIV and enable access to treatment and care. CQUIN (2021) further defines DSD as a person-centered approach to HIV service delivery that moves away from a one size fits all model. This approach is designed to streamline care along the HIV cascade in ways to better serve the needs of PLHIV, reduce unnecessary burdens/costs on the healthcare system, and improve ROC outcomes. With this approach, ROC receive appropriate care in the environment best suited to their needs and those with complex needs receive intensified care. DSD employs simplified and standardized ART, which promotes care decentralization, task sharing and shifting, community delivery, and efficient procurement and supply management (WHO, 2021). Furthermore, DSD should be used in HIV prevention, testing, linkage to care, ART introduction, follow-up, and the integration of HIV care with co-infections and comorbidities.

Goal, Aim and Objectives of the DSD Program in Zambia

GOAL: To improve health outcomes and system efficiencies in an equitable manner through the delivery of person-centered health care services.

AIM: Simplifying and adapting HIV services to the preferences and needs of the while maximizing health system efficiency.

STRATEGIES: To achieve the aim, differentiated service delivery models respond to diverse needs, contexts and population groups based on the building 4 W blocks "**When, Where, Who and What**".

OBJECTIVES

1. To increase health system efficiencies and outcomes across the continuum of HIV diagnosis, treatment and care
2. To provide evidence-based options for person-centered HIV service engagement and minimize interruption in treatment
3. To realize equity of access to person-centered HIV testing, prevention, treatment, and care across all populations including children, adolescents and young people, men, PBFW, persons living with disabilities and Key populations
4. To improve and enhance ROC satisfaction in the quality of HIV services and foster optimal retention with sustained viral load suppression among all sub-populations receiving HIV services
5. To accelerate and sustain achievement of the UNAIDS targets of 95-95-95 across all populations

ROC Classification of DSD

In Zambia, all ROC are eligible for DSD models.

Overview of ROC Classification for Differentiated Care

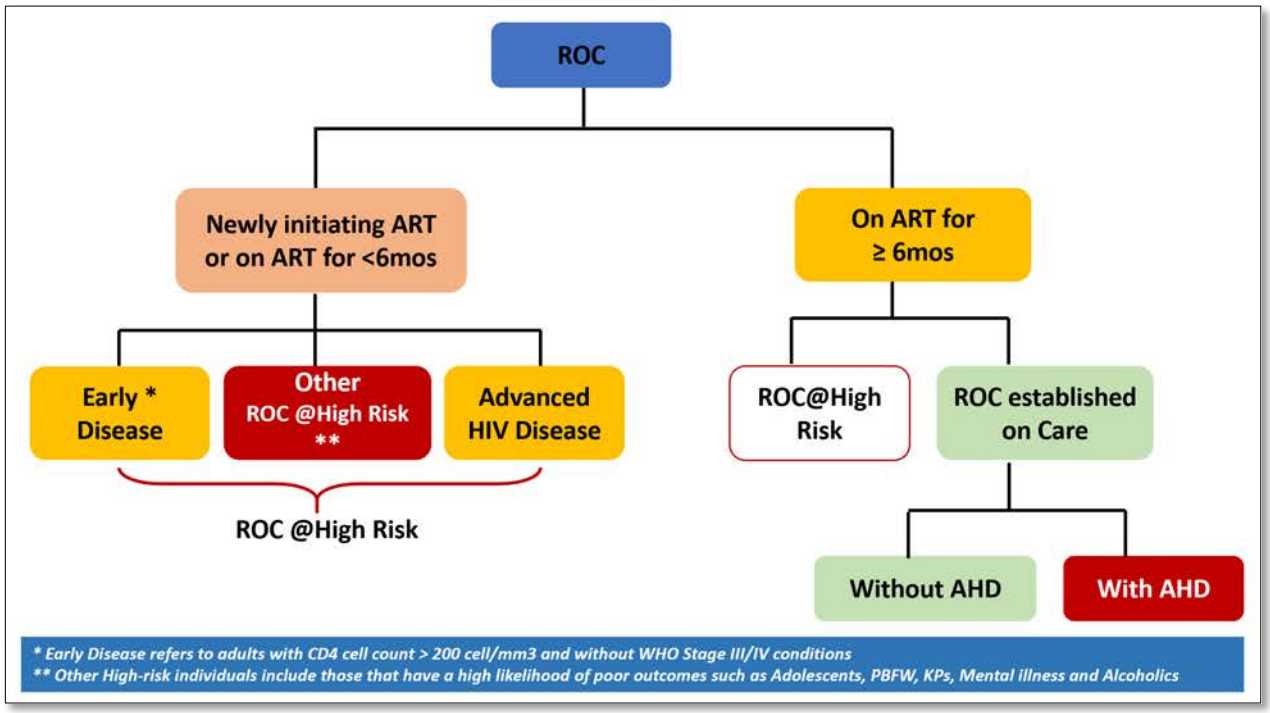

Figure 2.1: ROC Classification for Differentiated Care

2.2. BUILDING BLOCKS OF DSD

Figure 4 below highlights the building blocks of DSD.

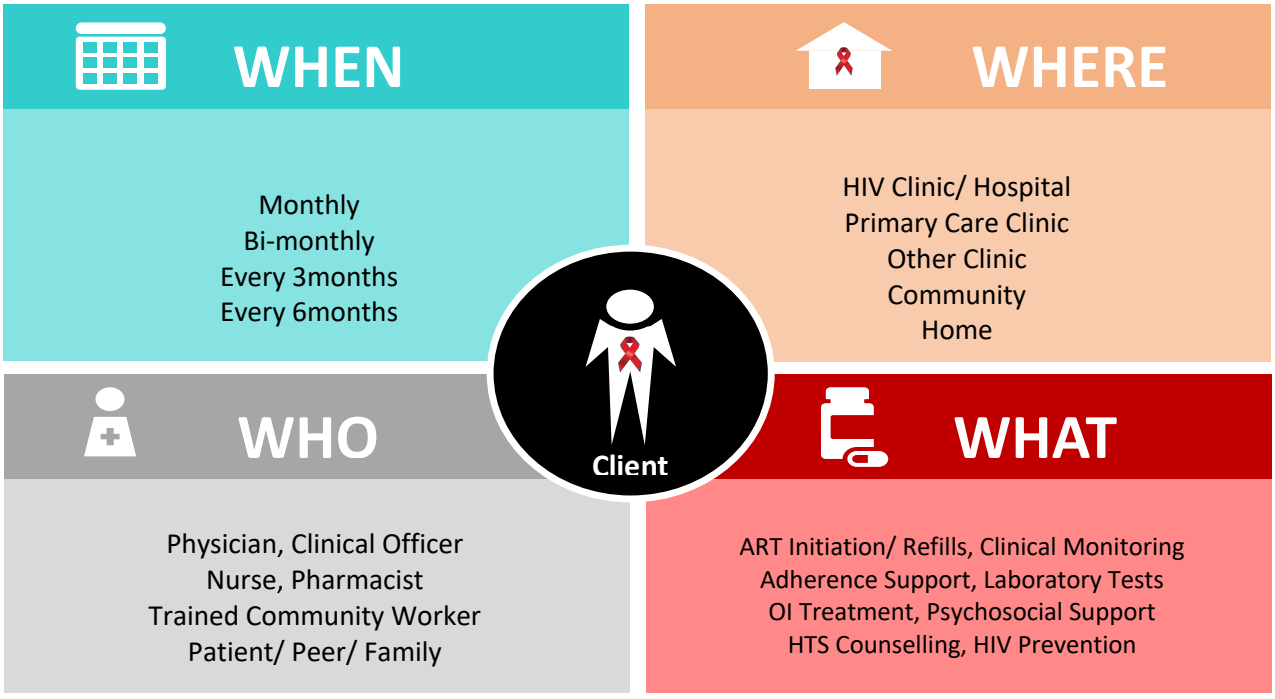

Figure 2.2: Building Blocks of DSD

2.3. GUIDING PRINCIPLES FOR IMPLEMANTATION OF DSD

Implementation of DSD models should be guided by the following principles.

- Adequate and consistent supply of ART, essential drugs, and other health commodities
    - To sustain provision of DSD models, health facilities should have sufficient stocks of ARVs, essential drugs, health commodities including laboratory supplies and reagents. In addition, the health facilities should have sufficient storage capacity to adequately store and maintain the supplies

- Trained and skilled healthcare providers
    - To increase health systems efficiencies and outcomes, the health facility should have trained and skilled health providers and well linked community support systems, with basic understanding of person-centered care principles for ongoing support of the ROC sustainability and maintenance of the DSD models

- Monitoring and Evaluation (M&E) systems
    - To monitor the pace of DSD scale-up and further promote collation across the health facilities, districts and provinces, there is need to ensure that all DSD activities are adequately and consistently monitored. The ROC data and information should be documented in appropriate registers, files, and electronic data systems, and routinely aggregated and reported. At the district, provincial and national level, aggregated routine indicators already captured in the Health Management Information System (HMIS) will be used to measure the outcomes of DSD implementation

- Adequate Information and Education
    - All ROC should be provided with information of the available DSD models at each health facility. The ROC should make an informed choice and provide verbal consent to join the desired DSD models. In addition, HCWs should allow for flexibility and adaptations to the DSD model promoting a person-centered approach to avoid a 'one size fits all' type of service

- Human Rights and Dignity

  As part of the requirement of the provision of health services in Zambia, all DSD models should meet the standards for privacy and confidentiality with every precaution taken to protect the ROC personal information. This will improve ROC's trust in the various models, increasing acceptability and uptake.

- Quality of Care and good Clinical Practice
    - Health facilities should have active Quality Control (QC) measures and should be able to implement Quality Improvement (QI) activities that will ensure that quality of care for ROC in the DSD models is not inferior to the standard of care. HCWs should routinely use the DSD M&E data in the QI programming

- Person-Centered Health Services
    - The World Health Organization (WHO) Framework on Integrated People centered Health Services[6] (IPCHS) calls for a shift in the way health services are funded, managed, and delivered. Person-centered health services entail an approach to care that consciously adopts the perspectives of individuals, families and communities and views them as participants and beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways. This approach acknowledges the experiences and perspectives of healthcare providers that may enable or prevent the delivery of person-centered care that is of high quality
    - IPCHS discourages the focus on health facility- based, disease-based and self-contained 'silo' curative care models as they undermine the ability of health systems to provide universal, equitable, high quality and financially sustainable care.[6] Integrated person-centered DSD models have the potential of providing benefits to the health systems and healthcare of ROC. Some of the benefits include improved access to care, improved health and clinical outcomes, better self-care, increased ROC satisfaction with care, improved efficiency of services and reduced overall costs

- Controlled Flexibility
    - ROC should be empowered to choose models to belong to, given their clinical condition without interrupting their treatment. However, should a ROC feel that a different model would be more suitable to their needs, they should be allowed to change to their model of preference

- Community Engagement

    Gatekeepers (civic, religious and traditional leaders), Neighborhood Health Committee (NHC) members, and other key community stakeholders, should be provided with adequate information on the DSD models being offered in their respective community health facilities. This will ensure the community has a better understanding of the DSD models. Failure to communicate effectively to the appropriate target groups may negatively impact ROC-provider relationship and ultimately ROC health outcomes

Chapter 3. DIFFERENTIATED HIV TESTING AND PREVENTION SERVICES

Differentiated HIV Testing and Prevention services are HIV testing service-delivery models and approaches that are adapted to address specific barriers of a sub-group of individuals to enable them know their HIV status. HIV Testing and prevention programs are still not equally accessible or used, with some groups encountering specific difficulties. For instance, males with HIV are less likely than women to be aware of their status. There are 140 undiagnosed men worldwide for every 100 undiagnosed women *(Differentiated HIV Testing and Treatment Service Delivery in Africa Call to Action to Leave "No One Behind" UNAIDS 2021).* There is still a gap for HIV cases among men, despite Zambia achieving the second and third 95 UNAIDS targets. It is necessary to deploy DSD more widely, based on community-based, people-centered, needs-responsive, and context-specific approaches, to assist close the gaps in the HIV response. Additionally, issues with linkage to care when people test positive, particularly those from Key and other Priority populations, and to HIV prevention services when people at high risk test negative continue to be insufficiently addressed. Differentiated HIV Testing Services (dHTS) will facilitate early diagnosis of HIV-infected individuals with the aim of supporting immediate linkage to treatment or prevention, efficiency, and cost effectiveness of the country's HTS program. Specifically, differentiating HTS will result in:

- focusing attention on those in need, based on available data
- ensuring that service delivery addresses the needs and preferences of people in need of HTS (for example, targeting the most at-risk and vulnerable populations), and the constraints of service providers in delivering HTS
- enhancing HTS integration with other health services
- decentralizing HTS to primary healthcare facilities and in the community
- encouraging and supporting task-shifting and task-sharing
- ensuring improved linkage to treatment and prevention services

3.1. THREE CORE COMPONENTS OF DIFFERENTIATED HIV TESTING SERVICES

There are three core components of Differentiated HIV Testing Services (Mobilizing, Testing and Linkage)

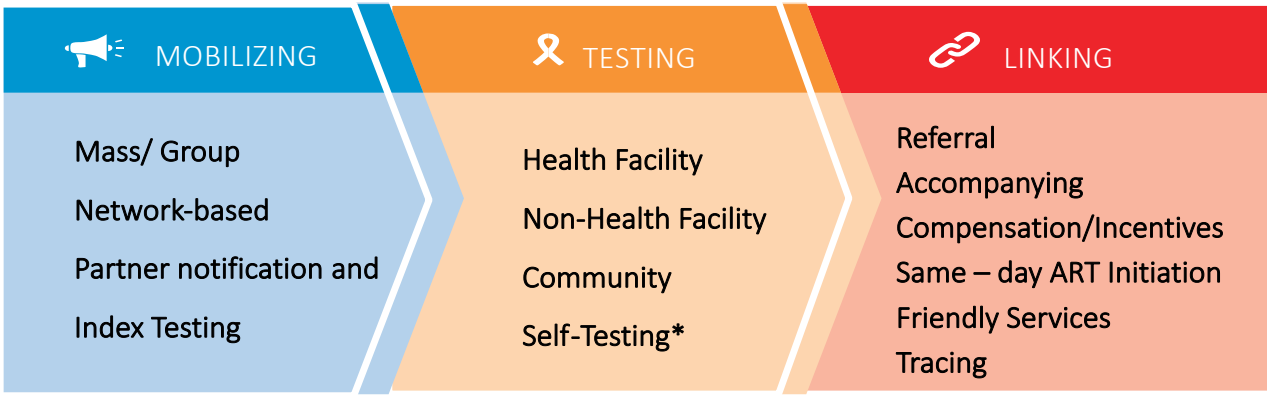

Figure 3.1: The three core components of dHTS

3.2. COMPONENTS AND BUILDING BLOCKS FOR AN HIV TESTING SERVICE DELIVERY MODEL

When designing DSD models for HIV Testing Services, the three core components are considered together with the four building blocks of the Differentiated Service Delivery models; "WHO, WHEN, WHERE, WHAT". Refer to annex 1 and 2 for the Six steps and the three elements used for designing dHTS models.

Components and Building Blocks for an HTS Delivery Model

	MOBILIZING	TESTING	LINKING
WHEN	Time of day and frequency	Time of day and frequency	Time period for linking and frequency of tracing
WHERE	Location of mobilization activities	Health Facility Non-Health Facility Community	Location of linkage activities
WHO	Who does the mobilization?	Who does the HIV Testing?	Who supports linkage to prevention? Who supports linkage to ART initiation?
WHAT	For HIV testing alone or with other services	For HIV testing alone or with other services	**Prevention:** SMS/Phone, Community-based tracing **ART initiation:** SMS/Phone, Community based tracing

Figure 3.2: Components and building Blocks for an HTS delivery model

3.3. CLASSIFICATION OF dHTS MODELS

dHTS models are classified into two categories; Facility based and community-based models. Facility Based testing models are delivered within the health facility which can be standalone or integrated into other services. Community based models are those in which testing services are provided outside the health facilities. However, several models may be delivered at facility and community level. Testing models may further be categorized as; Health care worker managed or client managed models.

3.3.1. Facility Based Testing

These are HIV testing services offered within the facility settings as standalone or integrated into other facility health or screening services. For example, Provider Initiated Testing and Counseling, Client Initiated Counselling and Testing, Partner Notification Services and Index Testing, HIVST, Social Network Testing, and Know Your Child HIV Status (KYCS).

3.3.2. Community Based Testing

These are HIV testing services offered in community settings, (outside the confines of the health facility) for example home-based index testing, outreach, or service provision in schools, workplaces, and other community venues. The selected testing venue needs to respect privacy and confidentiality. Figure 7 below shows the various classifications.

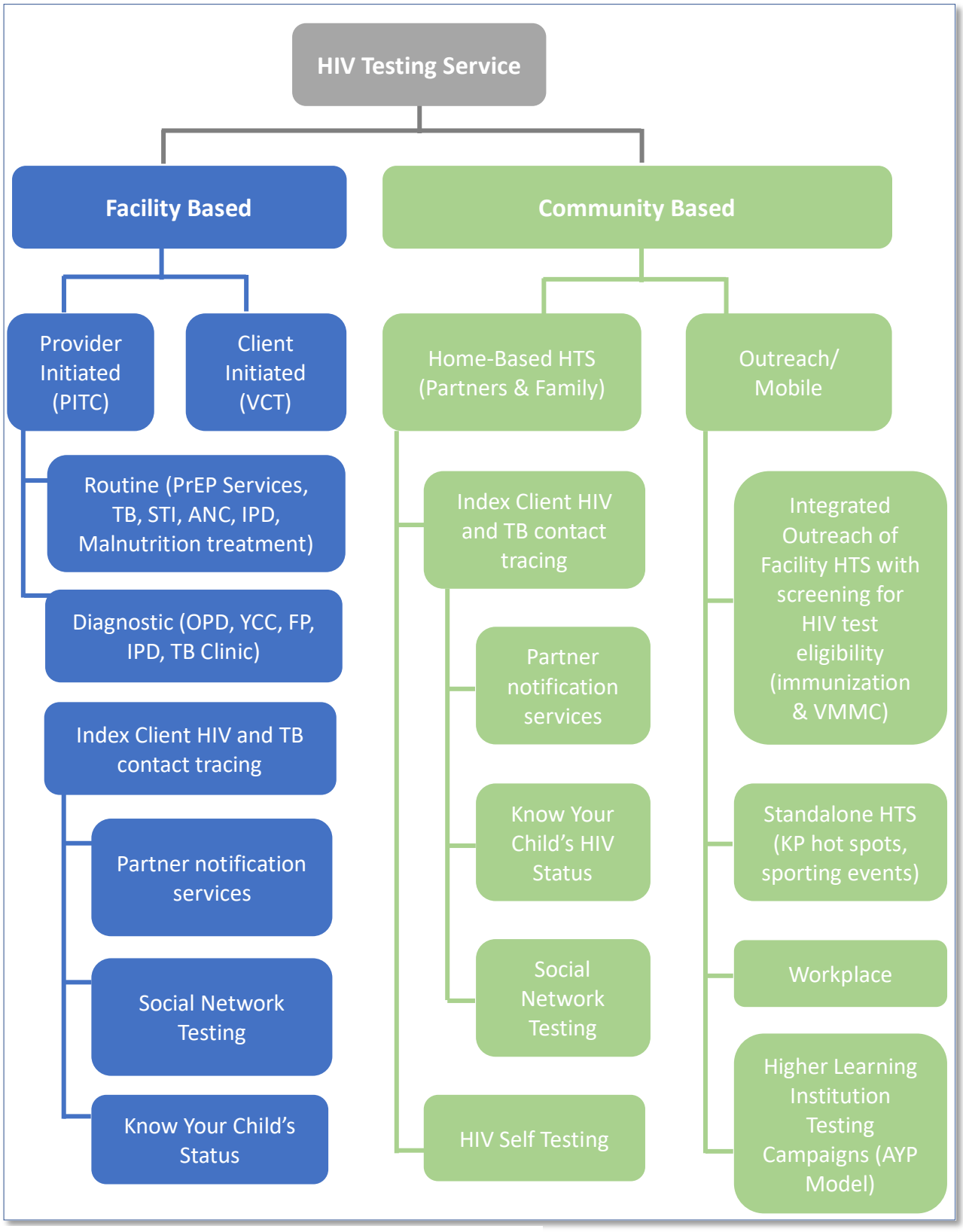

Figure 3.3: Classification of HIV Testing Services

3.3.3. Home-Based HTS

This is where the HCW/CBV (preferably the one who tested the index client) provides HTS in a home setting through an index client's consent or masked door-to-door HIV testing approach. Index clients should be prioritized for household members.

3.3.4. Safe and Ethical Index Testing (SEIT) Partner Notification Services (PNS)

Safe Ethical Index testing, sometimes known as partner notification services, is a case-finding strategy that focuses on eliciting the sexual or needle-sharing partners and biological children less than 19 years of people living with HIV and offering them HIV testing services. MOH recognizes the need of providing all HIV Testing Services (HTS) in accordance with globally established standards in order to ensure that all ROC receive safe and ethical HTS. Adherence to the 5Cs (Consent, Confidentiality, Counseling, Correct, and Connection), inclusion of Intimate Partner Violence risk assessment, monitoring adverse events as a result of partner notification, and training and supervising providers on client rights, informed consent, and ethics are among the minimum standards for safe and ethical Index/Partner Notification HTS. Index testing is a completely voluntarily service provided to people living with HIV to help them have their partner(s) and child(ren) tested for HIV with the option of accepting or declining this service. Index testing should be client-centered, with a focus on the index client's needs and the safety of his or her partner(s) and children. All people who have recently tested HIV-positive or have recently had unsuppressed viral loads must be offered all available HIV prevention, care, and treatment options, regardless of whether they choose to participate in partner notification services. ROC may never be denied services, and clients may never be coerced into providing the names and contact information of their partner(s). Partner notification is provided using passive or assisted approaches, through provider, client, contract and dual referrals however, assisted notification is recommended.

The goal of index testing is to break the chain of HIV transmission by offering HTS to persons who have been exposed to HIV and linking them to either HIV treatment or prevention services.

Components and Building Blocks for Index Testing

	MOBILIZING	TESTING	LINKING
WHEN	Client of Health Care Worker contacts at agreed time	At agreed time with partner	Follow-up tracing
WHERE	Facility of Home	Facility of Home	Follow-up tracing
WHO	Trained Health Workers and Index Client	Trained Health Workers	Trained Health Workers Trained Lay Workers
WHAT	Index Client notifies partner. Health Care Worker telephones or caries out home visit	Rapid HIV testing at Facility or in the Community	SMS Home-based tracing

Figure 3.4: Components and Building Blocks for Index Testing

Social Network Testing

Social Network Testing Strategy (SNS) is an evidence-based strategy for identifying, engaging, and motivating people with undiagnosed HIV infection to accept HIV testing. SNS is founded on the basic principles that people in the same social network engage in the same activities that increase the chances of contracting or transmitting HIV, and that people in the same social network know and trust one another. SNS is an effective HIV testing approach for increasing new HIV diagnoses, SNS has a high acceptability for HIV partner services, and is feasible for deployment across diverse populations. The principle of SNS is that peers reach out to and recruit their network members into HIV care. An advantage of SNS is that recruiters with varying behavioral risks and HIV statuses are more likely to have access to a diverse range of HIV at-risk groups. The HIV testing center identified recruiters among HIV negative and at risk or those Living with HIV. With the help of qualified psychosocial counselors, the recruiters identify members of their Network, or others in their social networks (such as friends, sex or drug use partners, family members, etc.), who are more likely to contract or transmit HIV. After interacting with individuals in their network, recruiters then distribute the coupon to invite their network members to access HIV testing services. Once network members of a participant are tested for HIV, they may be screened, enlisted and offered to become recruiters, if they accept they are coached and given coupons to distribute to their network members. The process of enrolling priority and key populations to test and recruit their social and/or sexual network members continues producing successive waves of recruitment that can extend into hidden and hard-to-reach networks.

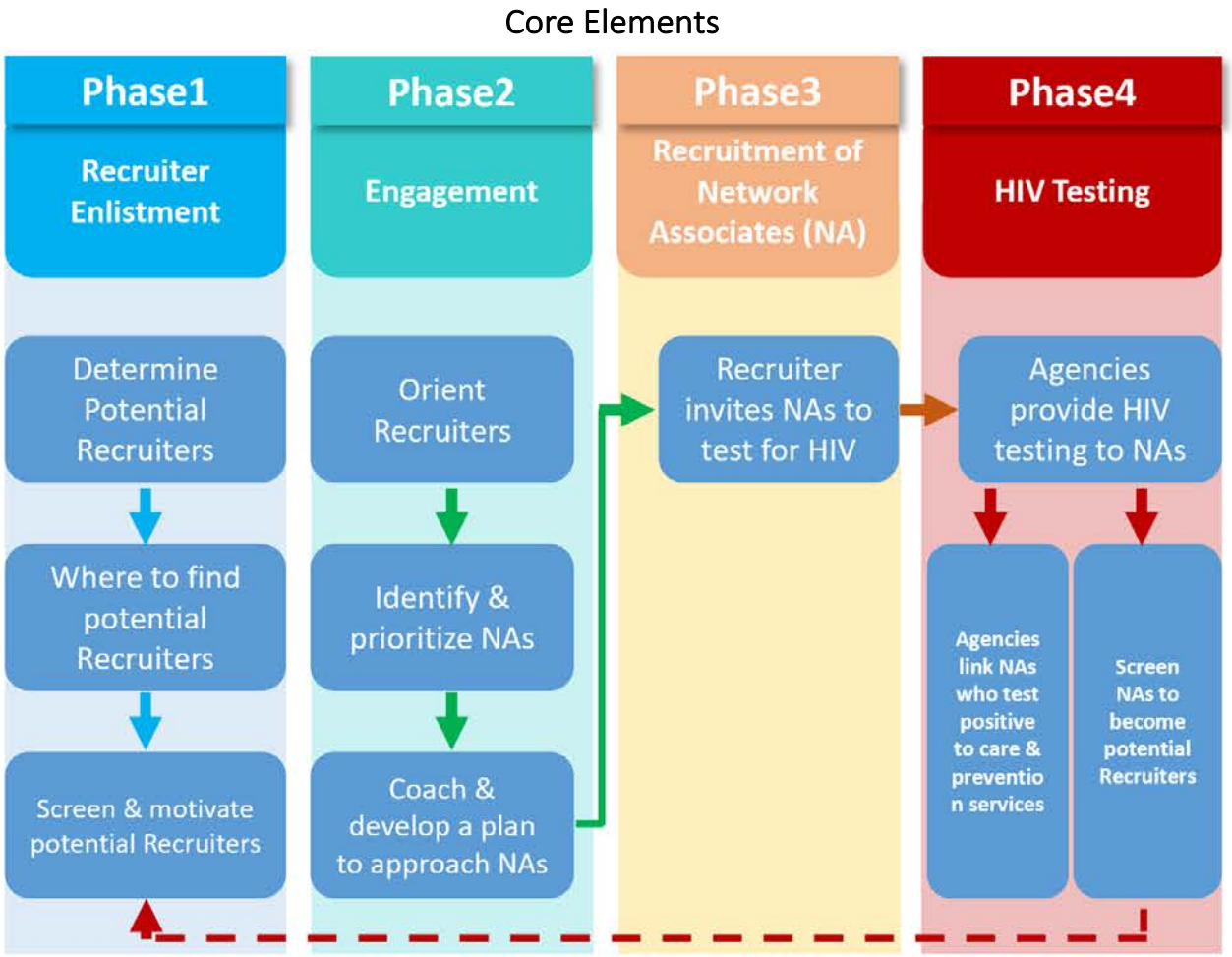

Figure 3.5: Social Network Testing Core Elements (Source: Social Network Testing Strategy CDC, 2020) chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.cdc.gov/hiv/effective-interventions/library/social-network-strategy/implementation-materials/cdc-hiv-ei-sns-four-phases-for-hiv-testing.pdf

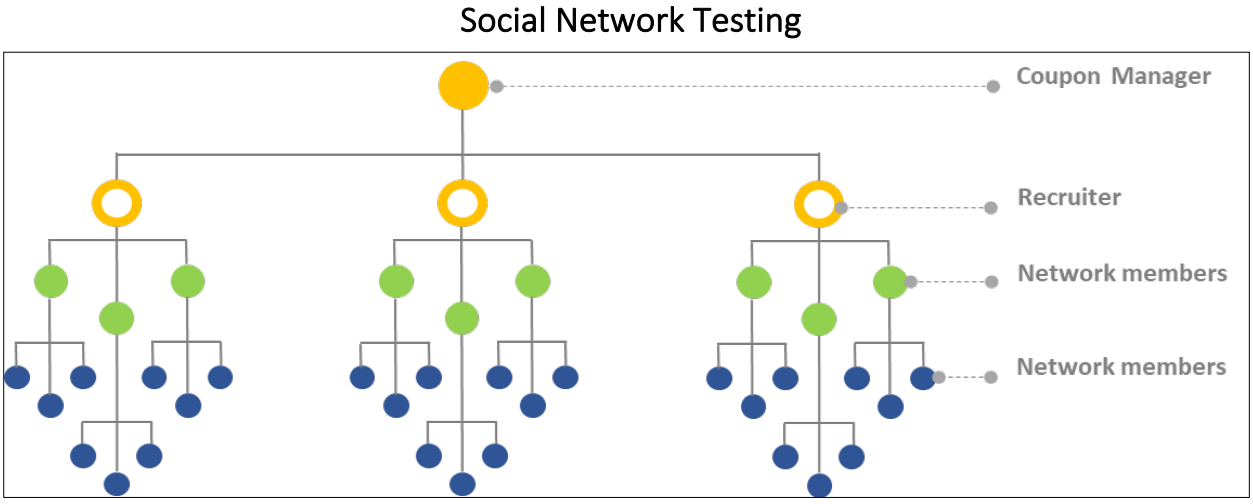

Figure 3.6: Social Network Testing Flow Chart 16 (Source: USAID Open Doors Project, 2020)

Components and building blocks for Social Network Testing (SNT) Service Delivery Model

	MOBILIZING	TESTING	LINKING
WHEN	During the day or at any time convenient for the network members	Any time convenient for the network member and as agreed upon with the tester	As agreed upon between ROC and the provider
WHERE	Community	Health Facility Non-Health Facility Community	Facility or Community
WHO	HIV High Risk connected through Social Networks	Outreach workers or at HIV testing Facilities by Clinic staff	Outreach workers, HCW, network members
WHAT	For HIV testing and prevention services	HIV testing of priority and Key Populations at High Risk of HIV	Prevention SMS/ Phone Community-based tracing, ART initiation

Figure 3.7: Building Blocks for Social Network Testing (SNT)

3.3.5. HIV Self-Testing

In this approach, an individual performs their own test and interprets the results. In certain circumstances, an individual may be assisted to perform the test. This strategy is ideal for populations who are at high risk of getting infected with HIV and less likely to access the standard HIV testing services at the facility. HIV Self-Testing (HIVST) does not provide a diagnosis for HIV. All positive self-test results should be confirmed using the approved national HIV testing algorithm.

3.3.6. Outreach/Mobile HTS

This approach should target priority/key populations that otherwise have limited access to HTS. This can be conducted to reach out to specific under-served populations either because of geographical inaccessibility, high HIV prevalence rates or low uptake of HTS. The testing may be conducted in places where high-risk people are found, thus also called 'venue-based HTS' for example in fishing camps and brothels targeting fish mongers/fishermen and sex workers/ moonlight service workers respectively. The temporal testing venue is set with respect to the 5Cs.

3.3.7. Integrated Out-of-Facility HTS

HTS is offered together with the primary health service. The outreach is intended to extend to the under-served community/population. HTS can be integrated in:

- Primary health services (immunizations-EPI, child days, child health week and others)
- Voluntary Male Medical Circumcision (VMMC)
- Mobile health/MCH clinics
- Family health days and
- Other outreach campaigns

This is likely to increase access and uptake of HIV testing services to people with difficulty in accessing HTS at health facilities. However, the screening for HIV risk will increase the yield of such activity.

3.3.8. Venue Based Testing

This is where HTS is offered to people at their places of work to target both formal and informal workers. This population may have limited access to clinical services due to their work schedules that do not allow them to leave their workplaces in search of health care.

3.3.9. Higher Learning Institution HTS

This is where HTS is offered to students (AYP) in institutions of higher learning. This population may have limited access to clinical services due to their school schedules and other barriers.

3.4. PREVENTION INTERVENTIONS

HIV Prevention programs should be targeted towards high risk groups especially adolescent and young people and key populations with behavioral and biomedical preventive intervention such as psychosocial counselling, health promotion messages, condom promotion and distribution, VMMC, and ARV based Prevention such as PrEP, PEP and PMTCT. Combination prevention is a mix of biomedical, behavioral, and structural interventions that decrease risk of HIV acquisition. Combining approaches may result in greater impact than using single interventions alone. Refer to Figure 3.8 below.

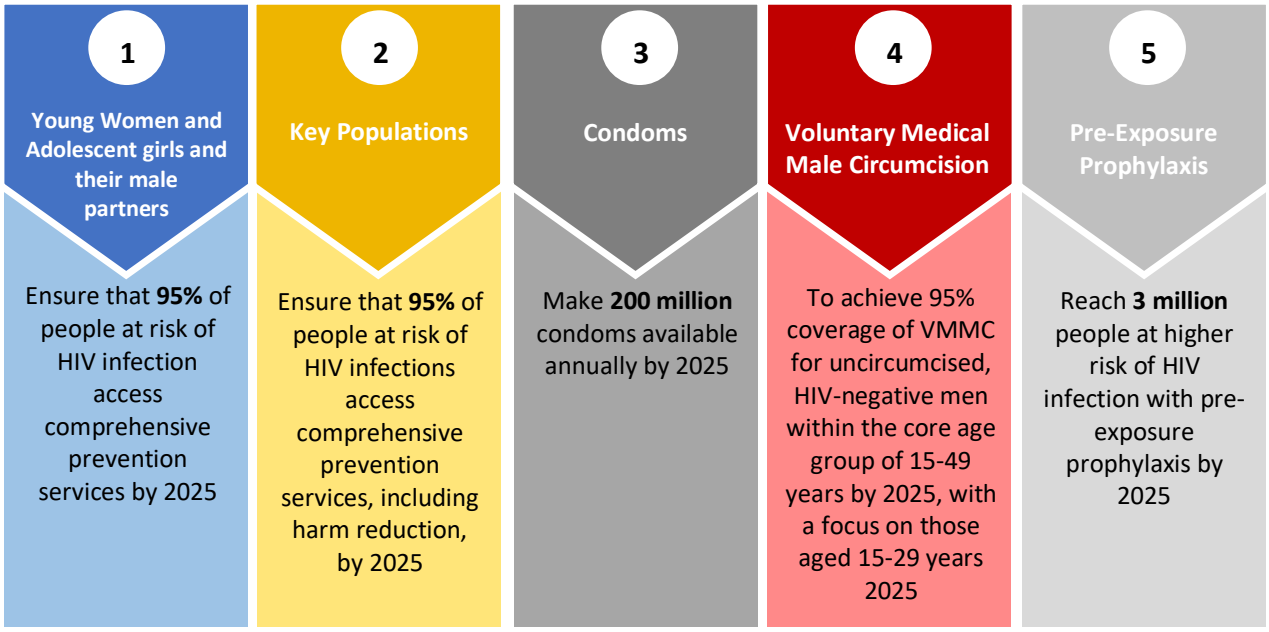

Figure 3.8: Prevention Interventions

DSD can be applied to HIV prevention. The DSD models are designed based on the target population and the type of combination preventive services being provided.

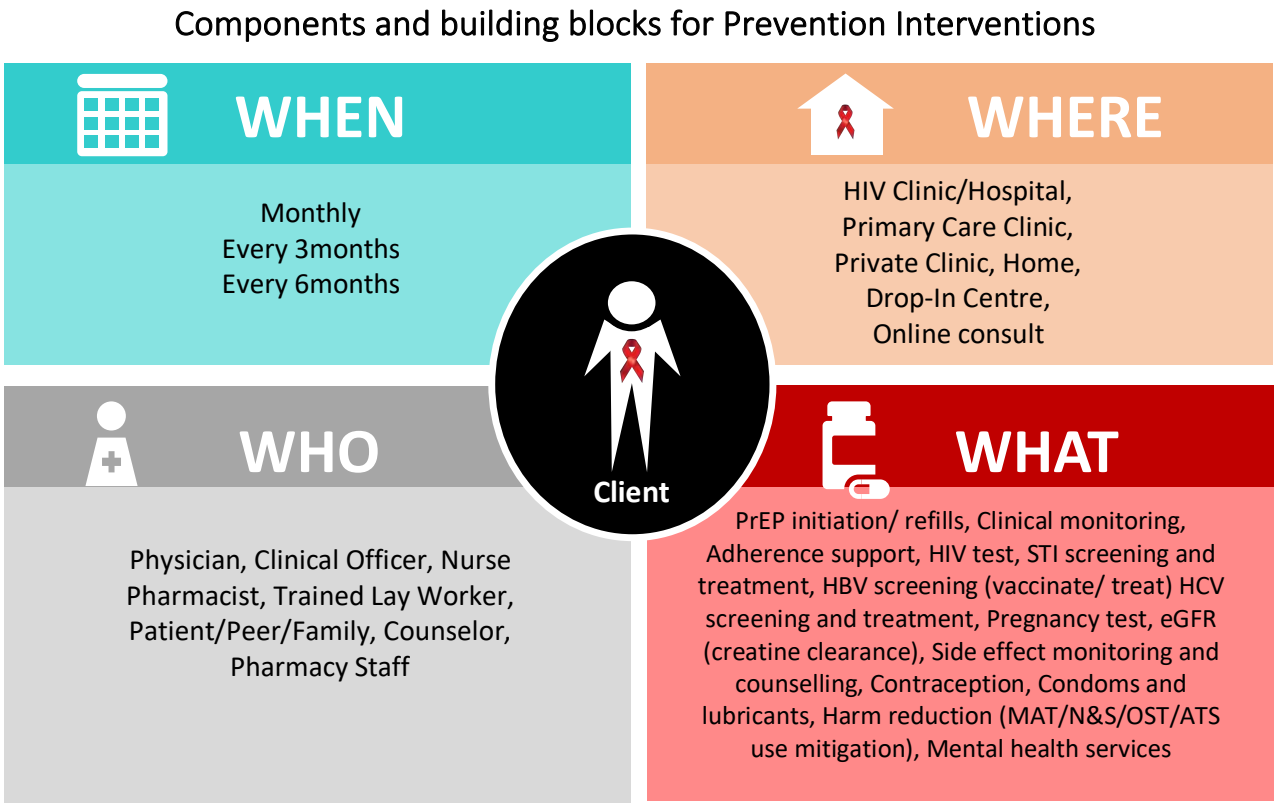

Figure 3.9: Building Blocks for Prevention Interventions

3.5. CLASSIFICATION OF DSD MODELS FOR PREVENTION

3.5.1. Facility Based

Facility based models should offer preventive services including PrEP, condom distribution, VMMC and specific prevention interventions for AYP and KPs. Examples of models include: PrEP in MCH, OPD, STI clinics, Youth friendly spaces, Family planning and other service delivery points.

3.5.2. Community Based

These models offer prevention services in community settings such as schools, KP hubs, markets, DREAM houses. Examples of models include: DREAMS, Pink Houses (DREAMS like), Coaching Boys into Men (CBiM), KP Hubs, Outreach drives, and many others

3.5.2.1. Determined Resilient Empowered AIDS-Free Mentored and Safe (DREAMS)

DREAMS is a program that targets Adolescent Girls and Young Women (AGYW) with a package of services, to achieve the following goals: (i) to reduce the risk of sexual partners for adolescent girls and young women, (ii) to strengthen AGYW families by assisting parents in developing better parenting techniques, and (iii) to mobilize communities for change. The layered interventions are as follows:

- **Primary Services/Interventions:** Interventions that ALL AGYW in a given age group should receive if they participate in DREAMS. AGYW are taken through a structured 13 weeks Sexual and Reproductive Health and Relationship Communication Skills and Empowerment sessions by trained mentors.

- **Secondary Interventions/Services:** Needs-based interventions included in the DREAMS core package but may not be available to all AGYW in that age group (that is only AGYW who earn an income should participate in a savings group).
- **Contextual Services/Interventions:** Interventions that are part of the DREAMS core package but are not associated with a specific AGYW (that is community mobilization).

The details are in the package of service below.

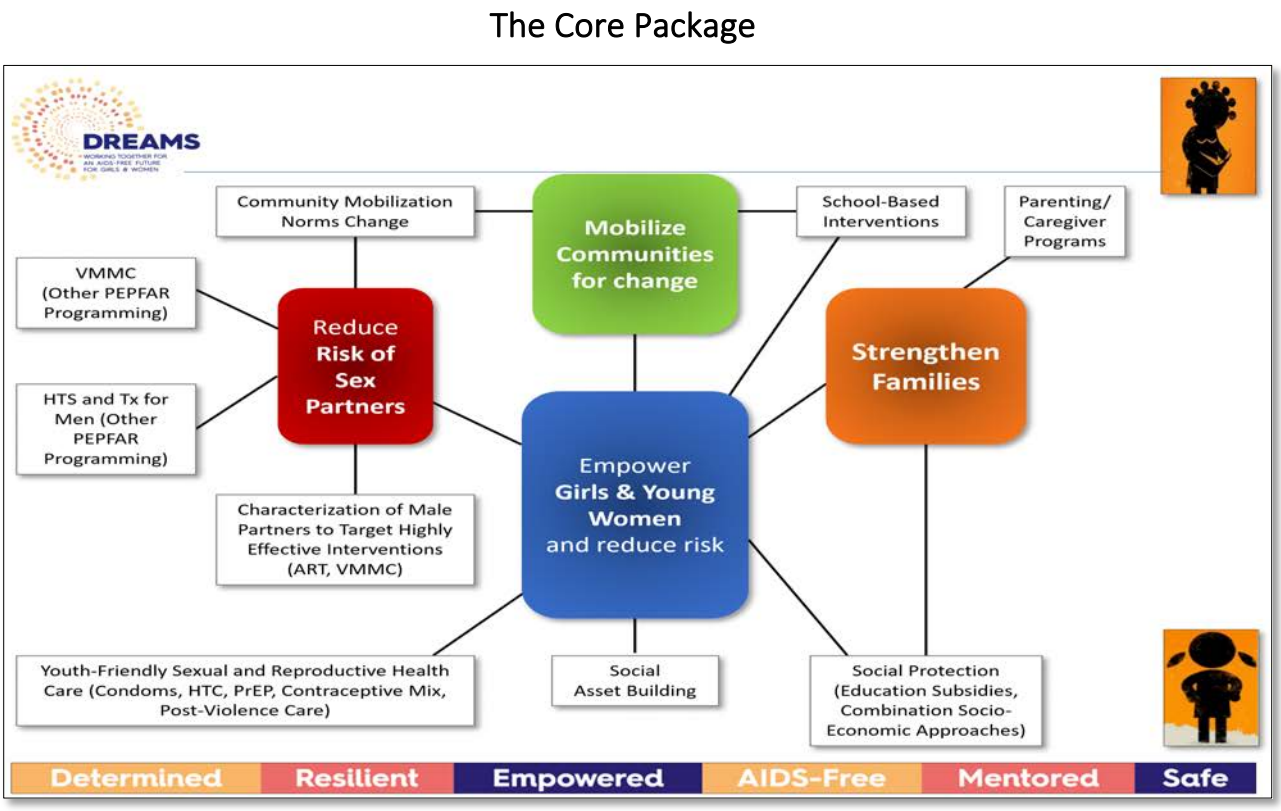

Figure 3.10: The DREAMS Core Package

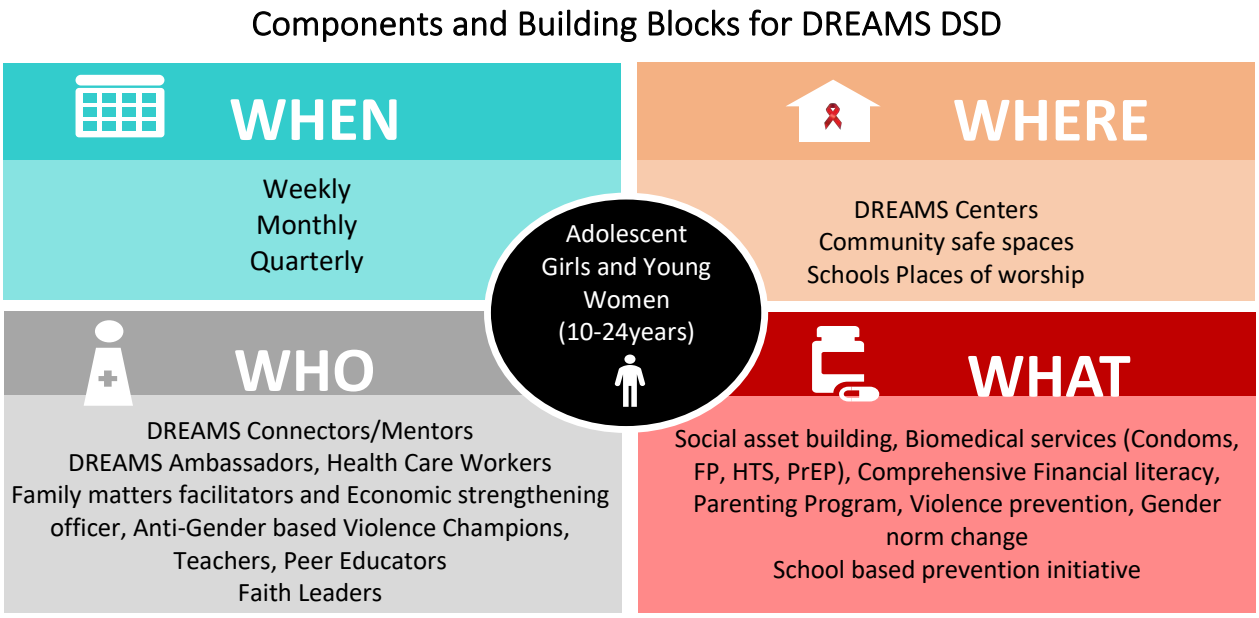

Figure 3.11: Building Blocks for DREAMS DSD

3.5.2.2. Digital Prevention models

This includes innovations for utilizing various digital platforms for the provision of HIV preventive services. For example, (i) Information Education and Communication (IEC): delivery of HIV prevention information and linking to facilities that offer the HIV services. (ii) digital appointment services: individuals make appointments for drug pick-ups before visiting the facility. (iii) peer to peer support: promote PrEP continuation.

One example of DSD prevention is the provision of PrEP. A DSD for HIV prevention approach to PrEP adapts the building blocks in order to support initiation and early PrEP as well as maintenance on PrEP. Using the building blocks, PrEP services can be separated into: (i) initiation and early follow up (0-3months), and (ii) PrEP continuation (>3months).

Chapter 4. DSD MODELS FOR HIV TREATMENT AND CARE

DSD models for HIV treatment and care aim at optimizing treatment outcomes for treatment established ROCs and ROCs at high risk

Ministry of Health has approved the following DSD models for implementation in Zambia. These models could be managed either by HCW or ROC.

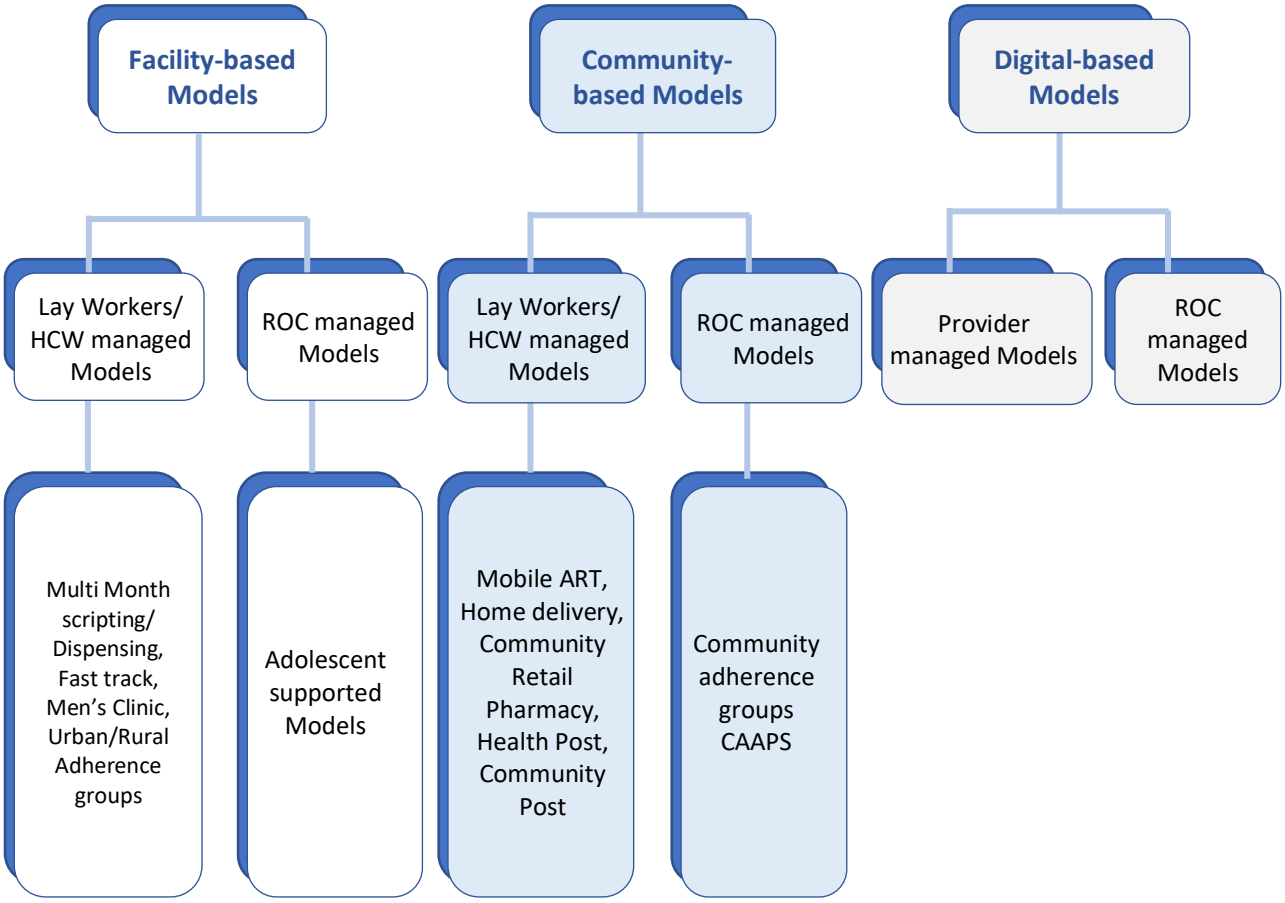

Figure 4.1: Approved DSD Models for Implementation in Zambia

The principles of DSD models remain person centered therefore, should take into consideration the following:

- Clinical characteristics of the ROC (ROC established on treatment, High Risk ROCs, co-morbid/coinfections)
- Accessibility and acceptability of the service
- Cost of providing the service
- Minimizing stigma and discrimination
- Catering for diverse population categories

At a minimum, all facilities providing ART services should implement facility managed DSD models which are cost effective and easy to implement before considering other models.

These include:

- Multi Month Scripts
- Fast Track Models

ROC Classification for Differentiated Services Delivery

DSD should be provided to all eligible ROC across the HIV continuum of care cascade including those with co-morbidities.

ROC established (stable) on treatment is defined as one who satisfies ALL of the following:

- ≥ 2 years
- On ART for ≥ 6months
- No adverse drug reactions
- No current illness
- Viral suppression below 1,000 copies /mL within the last 12 months

High Risk ROC (unstable) is defined as one who meets ANY ONE of the following:

- < 2 years
- On ART for < 6months
- Presenting with
    - Advanced HIV Disease (AHD) (WHO stage 3 or 4)
    - Advanced immunosuppression (CD4 < 200 cells/mm^3)
- Not virally suppressed (VL ≥ 1,000 copies/mL)
- Presence of
    - Adverse drug reactions
    - Uncontrolled chronic condition/comorbidity like NCDs
- Evidence of
    - Suboptimal adherence to ART
    - Substance abuse
    - Mental illness

Note: At 6 months from ART initiation, HCW should prepare and assess (order VL, IEC on DSD models) the ROC for enrolment into treatment established models at the next visit.

4.1. MODELS FOR THE ROC ESTABLISHED ON TREATMENT

4.1.1. FACILITY BASED MODELS

4.1.1.1. Urban & Rural Adherence Group Model

This model is appropriate for urban sites and high-volume rural sites. This model supports a group of 5-30 ROC and facilitates peer support among the group members. should be facilitated, if possible, by the same HCW or facility-based volunteer depending on availability, for each refill visit to establish rapport with the group.

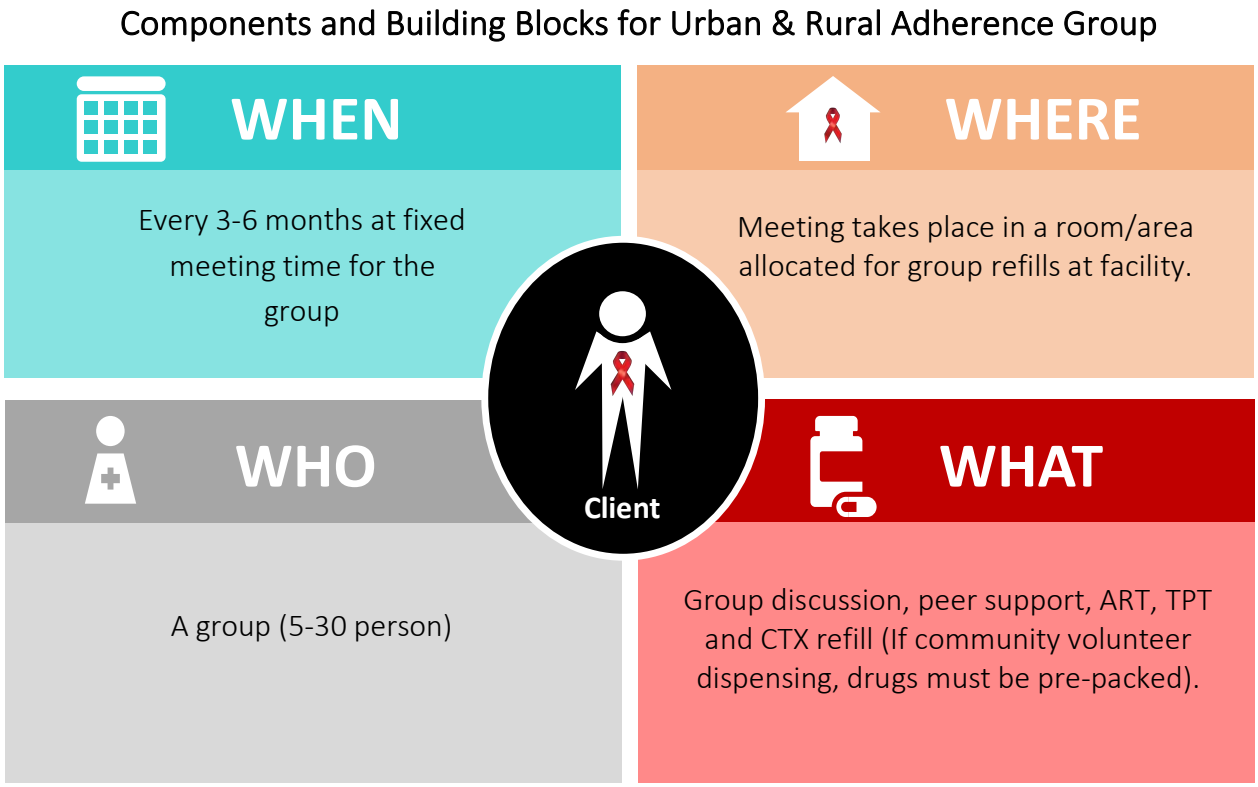

Figure 4.2: Building Blocks for U/RAG

4.1.1.2. Fast Track ART Services Model

This model allows for ROC to be attended to in the shortest possible time (30-60 minutes) separate from the standard ART service. ROC will proceed directly to the dedicated Fast Track room at the facility and there will receive adherence support and medication. Integration of services such as MCH, VMMC, NCD, TPT, etc. should be facilitated at all times including dispensation of other non-required ART. The model also utilizes an appointment system where ROC and provider agree on a specific day and time for the next visit.

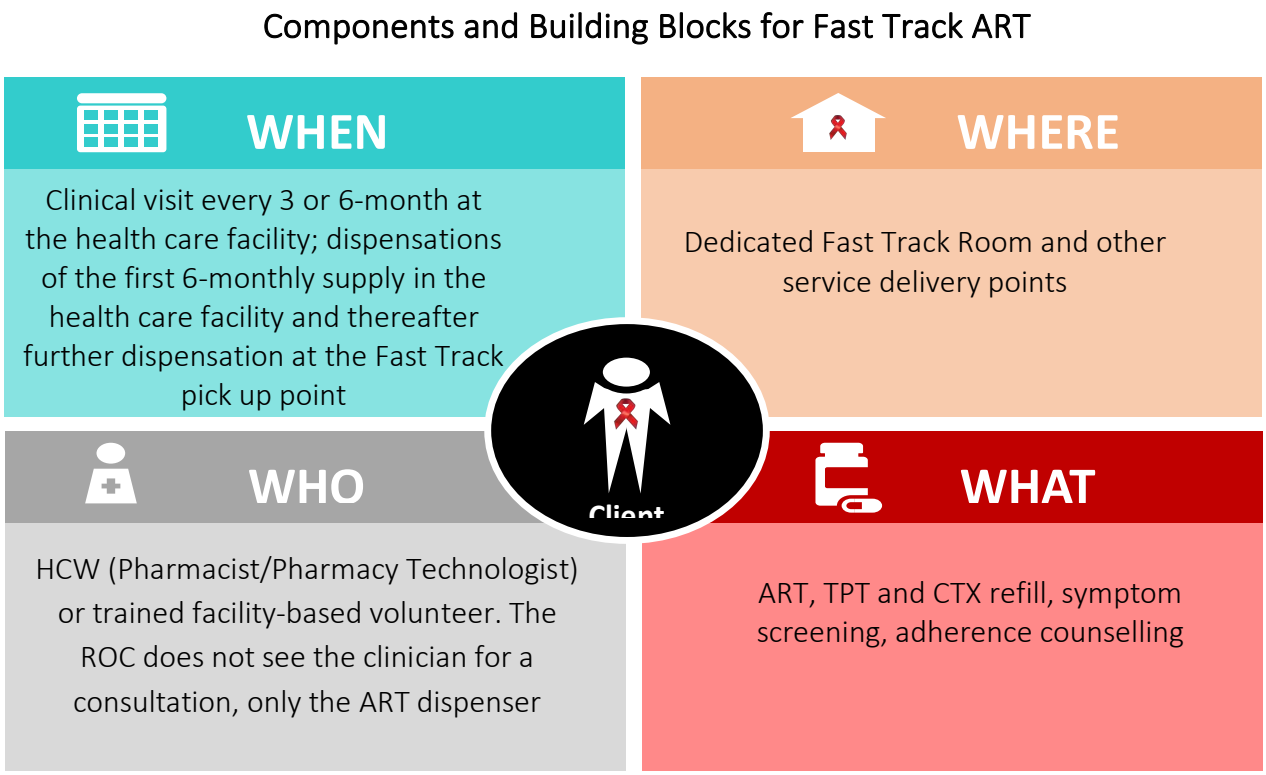

Figure 4.3: Building Blocks for Fast Track Model

4.1.1.3. Multi-Month Scripting and Dispensation Model

Multi-month scripting and dispensation is defined as the prescription of 6 months ART by a clinician and 6 months ART dispensation by the Pharmacy personnel. The ROC visit the facility every 6 months with 12 monthly VL and other lab monitoring.

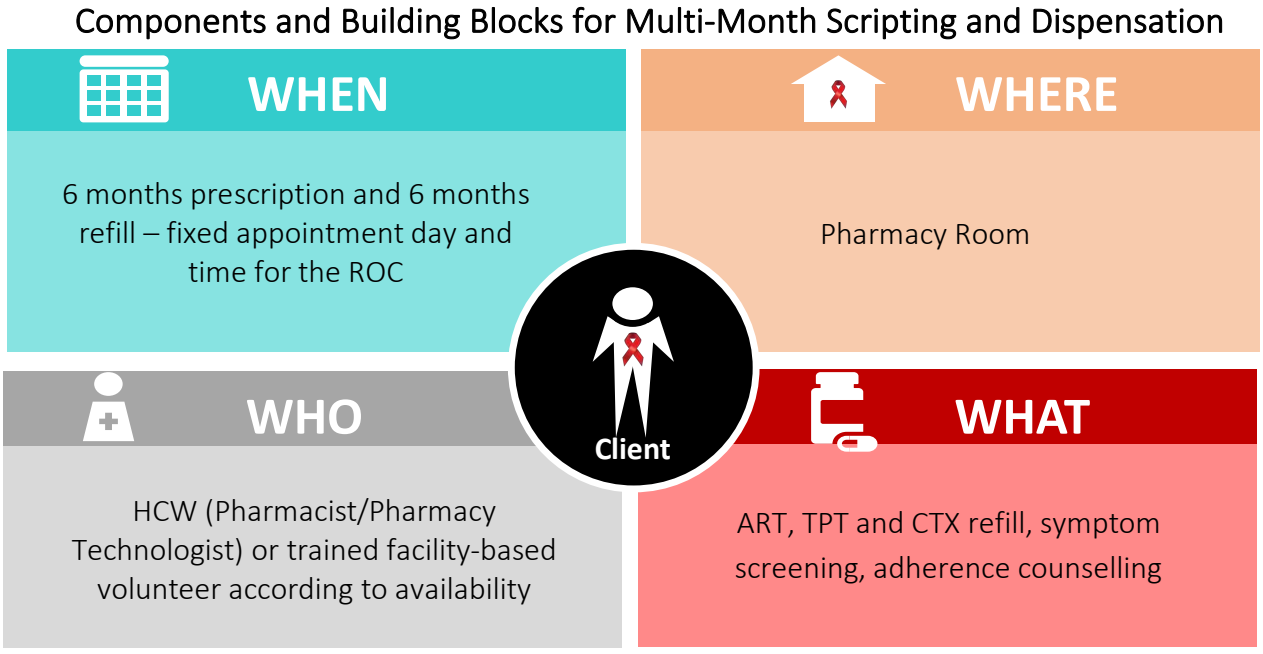

Figure 4.4: Building Blocks for Multi Month Scripting

4.1.1.4. Before/After Hours and Weekend Model

Before/After Hours and Weekend Models allow the ROC to collect their drugs outside the standard ART Clinic operation times at the health facility (08:00 to 17:00 hours, Monday to Friday). These models benefit ROC that have various competing priorities such as school or work schedules and not able to access services during the regular Clinic operations. The models should allow for lab, clinical visits and drug pick-ups at alternative times/days such as in the early mornings, evenings and over weekends. Facilities may need to restructure to the shift system to support the model.

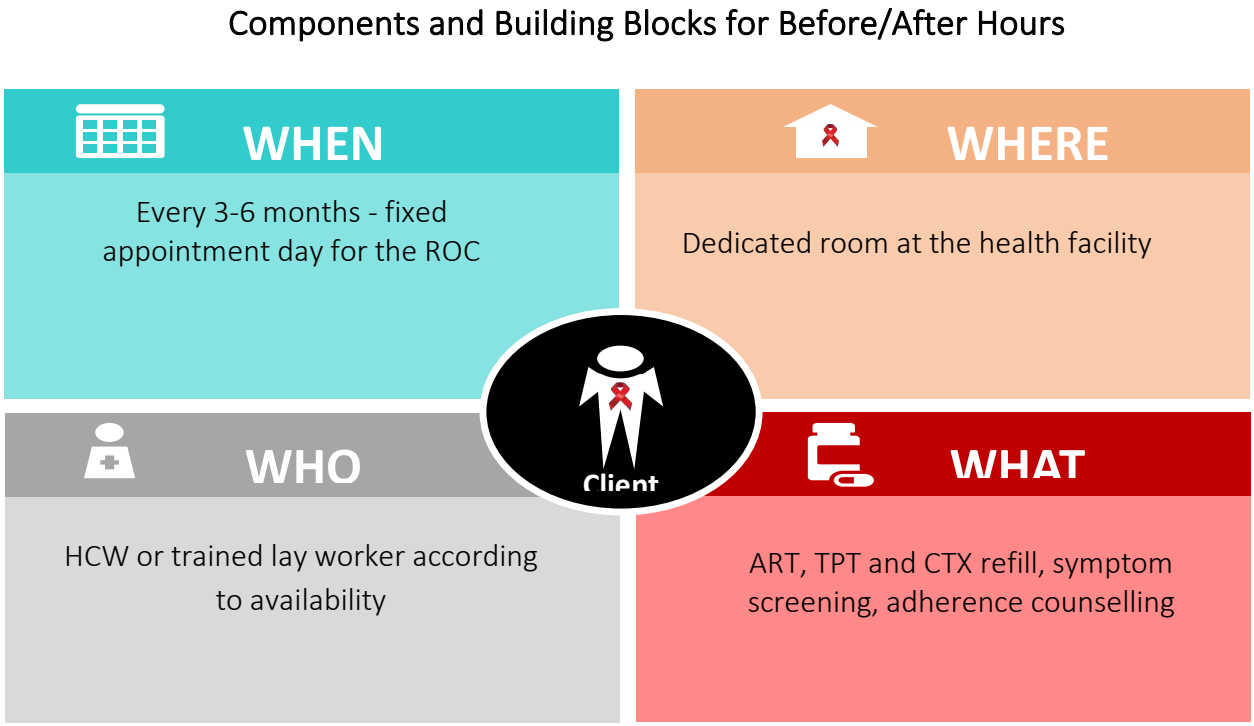

Figure 4.5: Building Blocks for the Before and After Hours Model

4.2. COMMUNITY BASED MODELS

Community-based models vary according to the services delivered and by whom and where in the community these services are provided. In these models, ROC established on treatment are provided the option to pick up their drug refills at a designated place in the community or have their drugs delivered to their homes by a health care worker or trained lay worker. All information collected during the community visit (adherence, symptom screening and vital signs) is entered in SmartCare (paper based or electronic). ROC who is/ becomes symptomatic during the community visits will be referred to the health care facility for further management.

4.2.1. Community ART Distribution Points Model

ART refills are provided to ROC outside the health facilities. ART is distributed in the community at fixed points, and these can be any formally recognized structures such as schools, places of worship, community centers, Retail Pharmacies, etc.

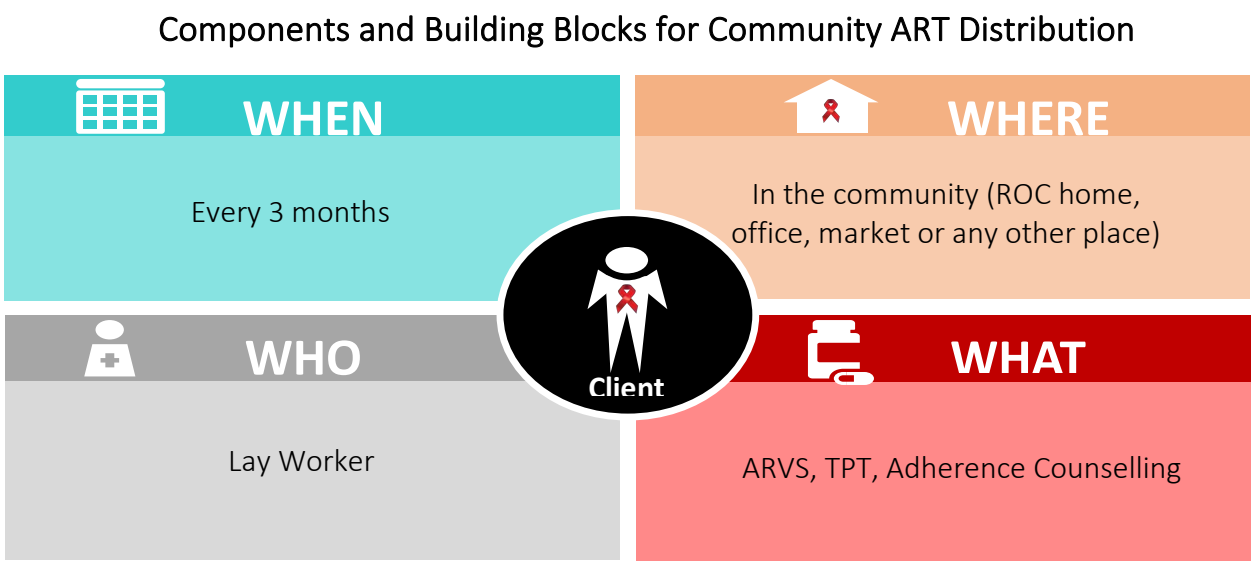

Figure 4.6: Building Blocks for Community ART Distribution Points

4.2.2. Health Post Model

In this model, ARVs and prophylaxis medicines are pre-packed for each ROC at the health care facility and delivered to the health post where they are dispensed to ROC. This model allows ROC to collect their drug refills at posts close to their homes and only visit the health care facility every 6 months for their clinical review and laboratory monitoring.

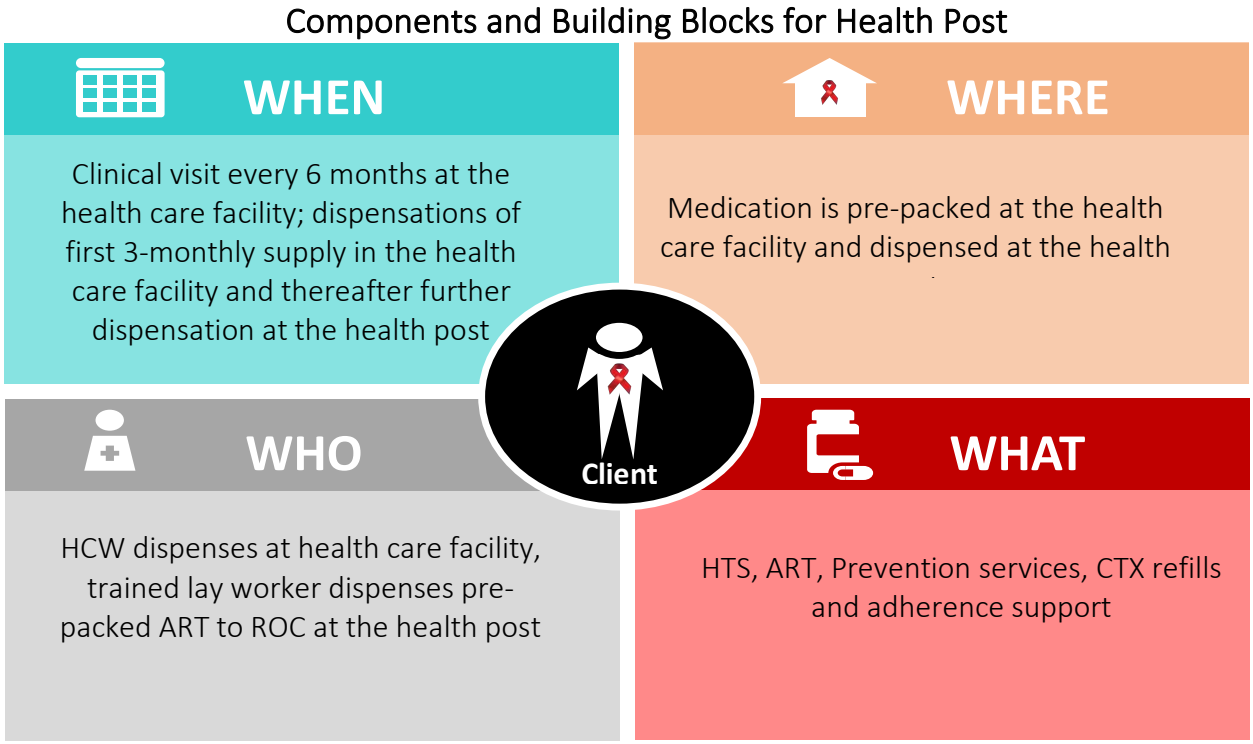

Figure 4.7: Building Blocks for Health Post Model

4.2.3. Community Post Model

A community post is a static satellite or outreach site from the health facility. It is an easily accessible site (market, bus stations, places of worship grounds and fishing camps) in the community to support decentralized service delivery. It is operated by trusted HCWs or Community Volunteers trained in customer care and in the core values which includes responsibility, empathy, compassion, integrity, passion, and ethics (RECIPE), which are essential to its operation and support of the model. Community post could be used as entry points for hard-to-reach populations, such as adolescents, KPs, etc with referral to health facility for further management.

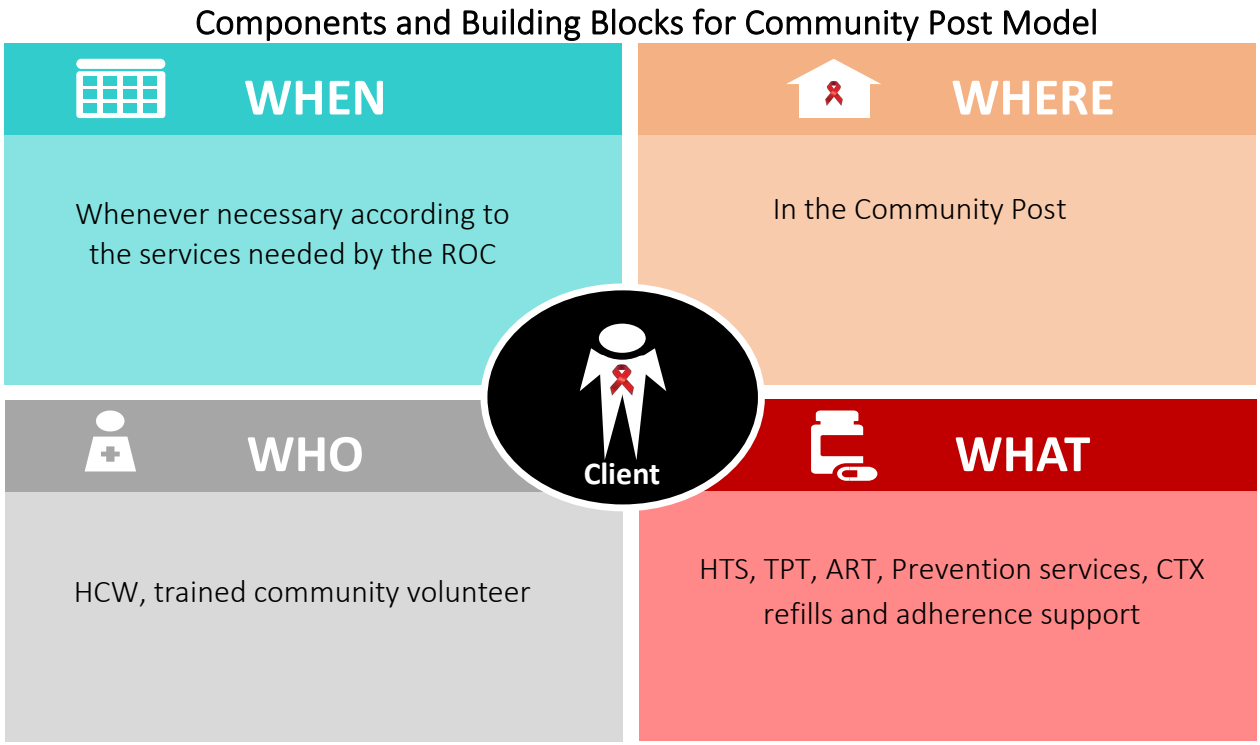

Figure 4.8: Building Blocks for the Community Post Model

** Community Post model provides for both ROC established on treatment and the newly initiated on treatment without AHD.*

4.2.4. Retail Pharmacy Model

For this model medication (ART, TPT, CTX) is prepared at the health facility and the delivered and dispensed to ROCs at a retail pharmacy.

Additionally, adherence support will be provided at the Retail Pharmacy.

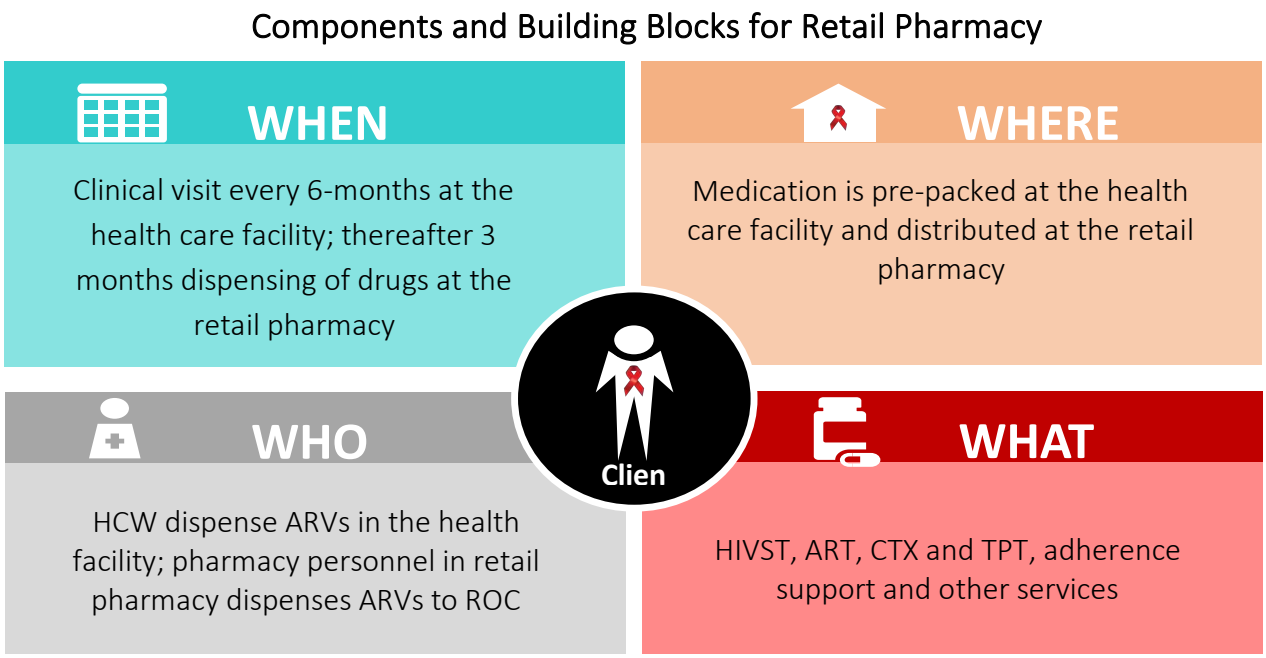

Figure 4.9: Building Blocks for Retail Pharmacy Model

4.2.5. Mobile ART Distribution Model

This model is ideally implemented in hard-to-reach areas. Every 3-6 months a clinic outreach team from the health facility will conduct clinical assessments at the community distribution points (temporal structures, such as fishing camp on an island). This model should be implemented only where the logistics for regular outreach to (every three months) are guaranteed. This model should be used if significant numbers of ROCs (30 and above) will benefit from provision of ART at a designated mobile outreach point in a hard-to-reach area.

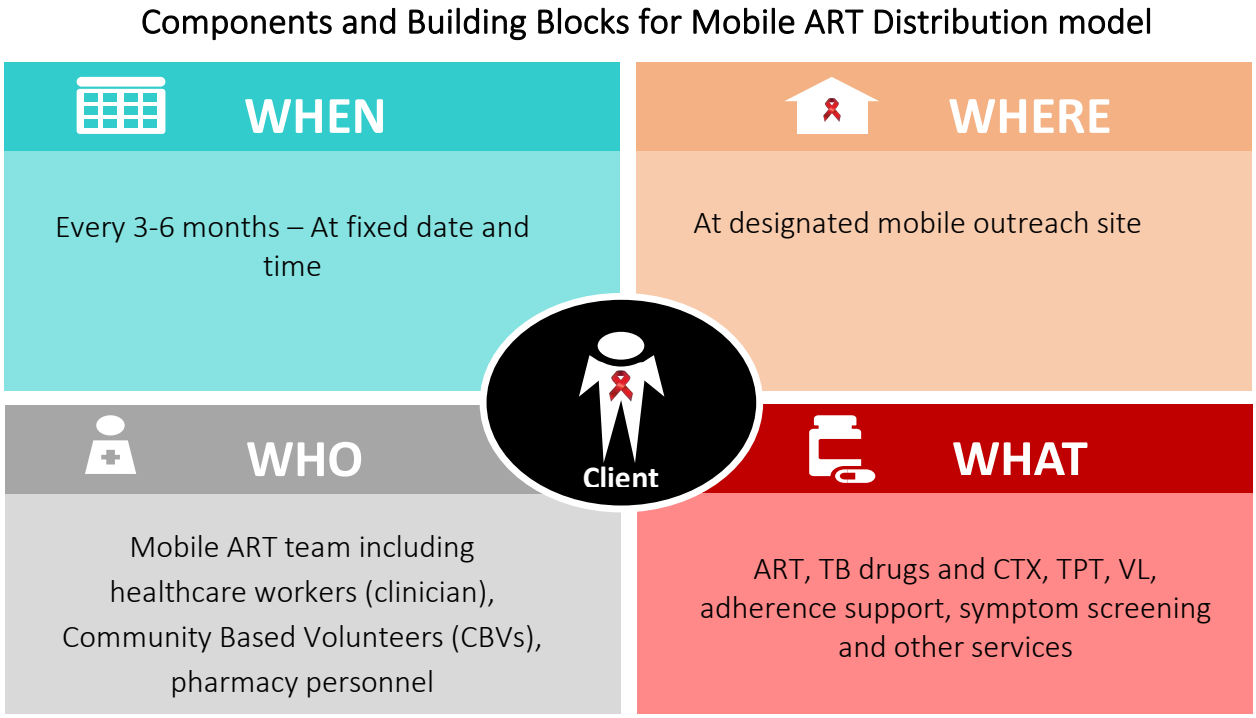

Figure 4.10: Building Blocks for Mobile ART Distribution Model

4.2.6. Community ART Service Delivery

In this model, ART services are delivered to ROC in the home/ community by HCW or trained lay worker. ROC will visit the health facility every 6 months at for routine clinical and laboratory monitoring. Adherence support and symptom screening will be conducted during community visits. All information collected during the community visit (adherence, symptom screening and vital signs) will be entered in SmartCare (paper based or electronic). ROC who is/ becomes symptomatic during the community visits will be referred to the health care facility for further management.

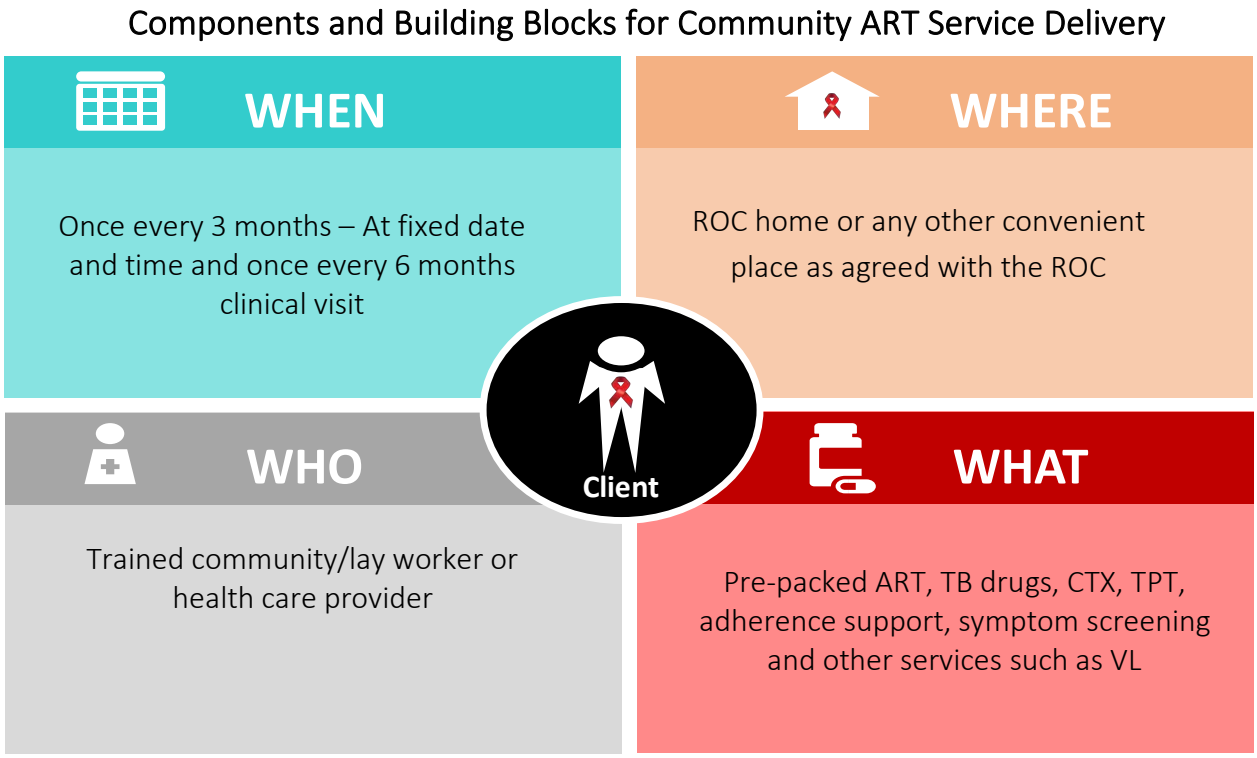

Figure 4.11: Buildings Blocks for the Community ART Service Model

4.2.7. Community Adherence Groups (CAGS)

In this model, ROC form a group (2-6) and receive their ART refills during the group meeting in the community. The group is self-managed by ROC members, each group member takes turn collecting ART, TPT and CTX from the health facility for all group members. Each group meets up either monthly or 3-monthly depending on the settings and available resources. During the meetings the ROC will provide peer and adherence support.

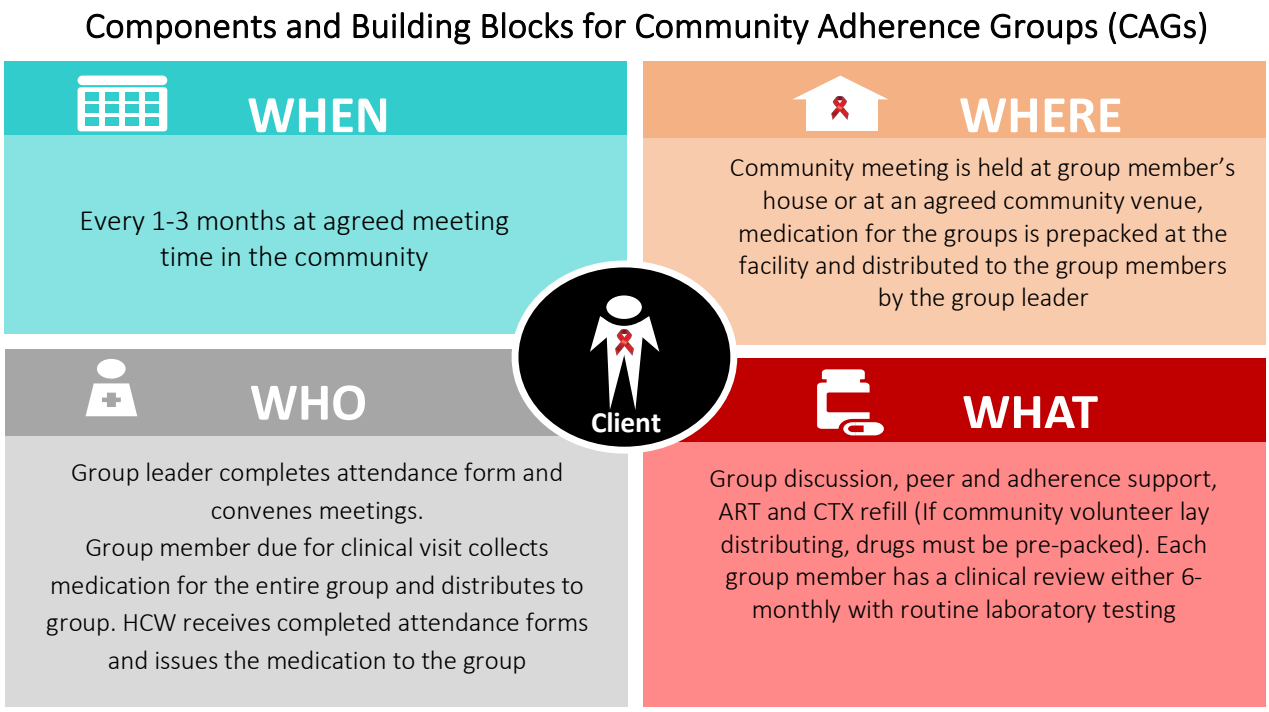

Figure 4.12: Building Blocks for Community Adherence Groups (CAGs)

4.2.8. Community ART Access Points (CAAPs)

Community ART Access Points (CAAPs) are community-based structures, affiliated to the health facility and support a maximum of 8 ROC. Each CAAP is managed a PLHIV Lay Worker identified by the health facility and reside within the health facility catchment area. On behalf of the 8 ROC, The Lay Worker collects medication (ARVs and prophylaxis medicines from the health facility and will meet the ROC at the designated CAAP where the medication (ARVs, TPT and CTX) is distributed and adherence counselling provided. The ROC in this model will visit the health facility for the clinical appointment and during this time the Lay Worker will not collect the ROC medication.

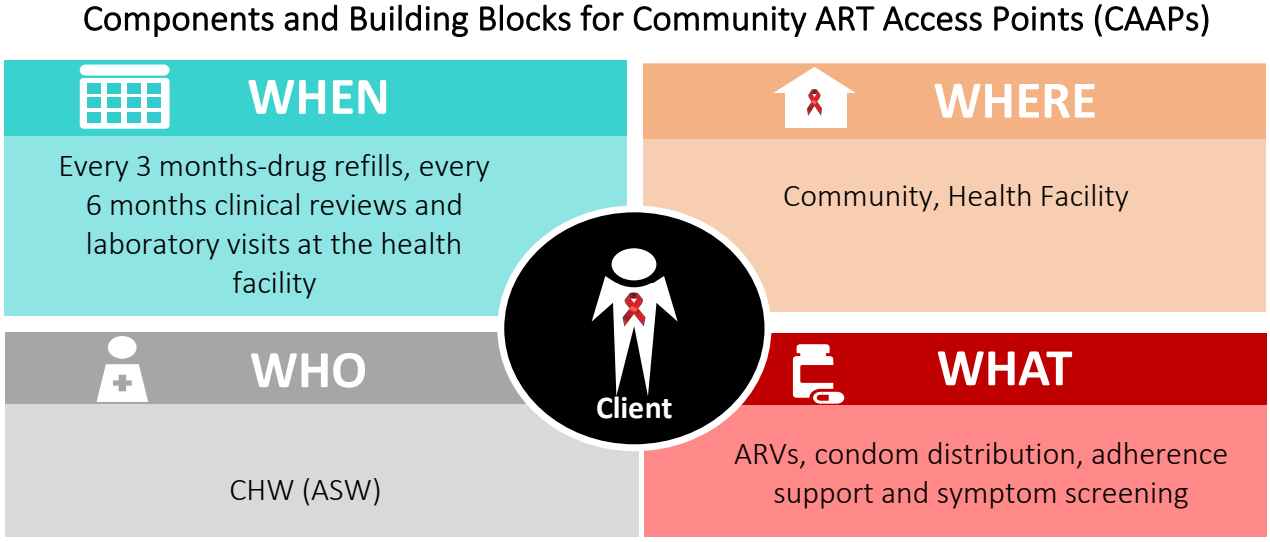

Figure 4.13: Building Blocks for Community ART Access Points (CAAPs)

4.3. MODELS FOR HIGH-RISK ROC

In Zambia high risk ROC are classified as those with early disease, advanced HIV disease and on treatment for less than 6 months or unsuppressed. When planning for high-risk ROC DSD models the following should be considered.

Table 4.1: Building Blocks for DSD Models for High Risk ROC

Building blocks /Populations	high-risk ROC (NCDs, High VL, Poor adherence, AHD)
What	• Index Testing offered to ROC with High Viral Load • Enhanced adherence counselling (EAC) offered to HVL • Management of Non- Communicable Diseases (NCDs) • Laboratory, Pharmacy, and clinical visits • Family planning – Condoms and oral contraceptive • Opportunistic Infections (OI) prophylaxis and (OI) management • Re-engagement services
Who	• Peer/Psychosocial counsellor • Adherence counsellor • Clinicians (CO, MO, ML) Nurse and Pharmacy
When	• Monthly- EAC • Lab/clinical as indicated
Where	• Facility • Community

Examples of DSD Models for HIGHRISK ROC

Examples of DSD models for high-risk ROC are as follows:

- Direct Observed Therapy
- Viraemic ART specific clinics
- Peer Patient Pairing

4.3.1. Direct Observed Antiretroviral Therapy (DOART)

This is a facility-based model designed to improve adherence and ensure viral suppression among ROC. It is suitable for paediatric ROC with HVL after 6 months of ART or suboptimal medication adherence due to various factors. ROC may be enrolled in this model prior to 6 months if barriers to adherence are identified. DOART can be extended to adults in need of support.

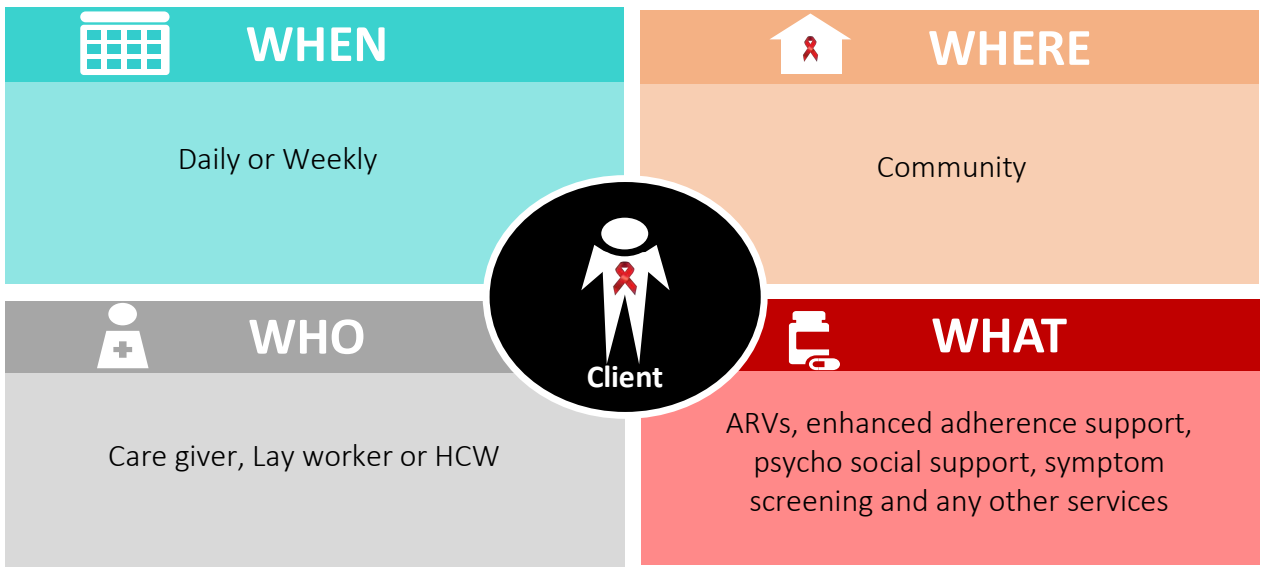

Figure 4.14: Building Blocks for DOART

4.3.2. Viraemia ART Specific Clinics

Viremia clinics, offers tailored treatment for ROC with high VL, provides a chance to address gaps and barriers in the monitoring and management of ROC. The multidisciplinary team (MDT) model is used in the viremia clinic, which is held at least once a month and stresses on enhanced case-management and a patient-centered approach. A Doctor clinical officer, nurse, adherence counselor, data officer, and lay counselors are included on the MDT. In some facilities the MDT may consist of just a clinician and a counselor. MDTs have the chance to see fewer patients (on average, 20 patients per clinic visit) on dedicated clinic days. This allows for the MDT to have more time for complex (such multiple comorbidities) and difficult case reviews as well as ROC case talks. The involvement of sub-national HIV coordinators, technical partners, or other outside clinical mentors is advised for facilities with only one provider. Trained Community Health Workers/Volunteers do a variety of support tasks between clinic visits, including acting as case managers, making home visits to increase support, finding other reasons that might contribute to ART non-adherence, and handling missing appointments. For ROC who may require more assistance, additional visits might be conducted. This model enables treatment to be adapted to the particular requirements and adherence issues of each ROC. Additionally, the ROC are given an opportunity to decide together with their health care providers in order to increase their adherence to ART.

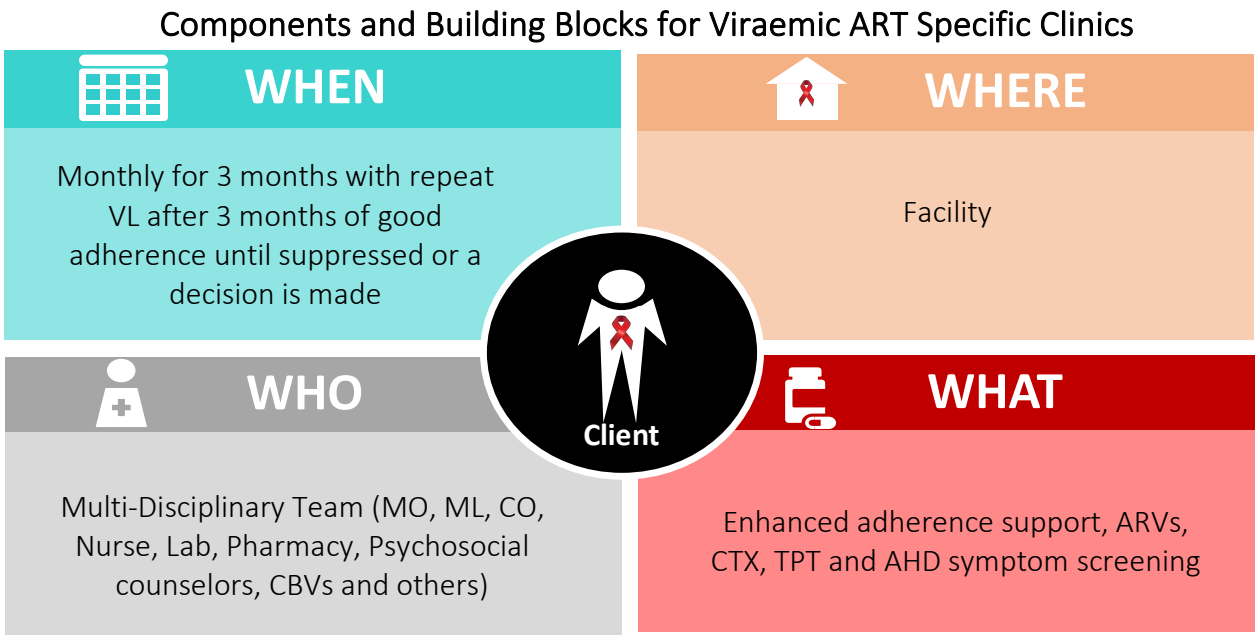

Figure 4.15: Building Blocks for the Viraemic Clinics Model

4.3.3. Peer Patient Pairing (PPP)

The peer patient pairing is a facility-based model where every ROC new in care is attached to a lay Health worker from the day of diagnosis until the ROC is established on ART (< 6 months on ART). The PPP aims to provide a person-centered approach to care and treatment with a goal of improving early retention in care and achieving viral suppression within 6 months of treatment. At 6 months, when VL suppression has been achieved the ROC is eligible for enrollment into established DSD models, should the ROC be unsuppressed, they can be transited to the Viraemia clinic.

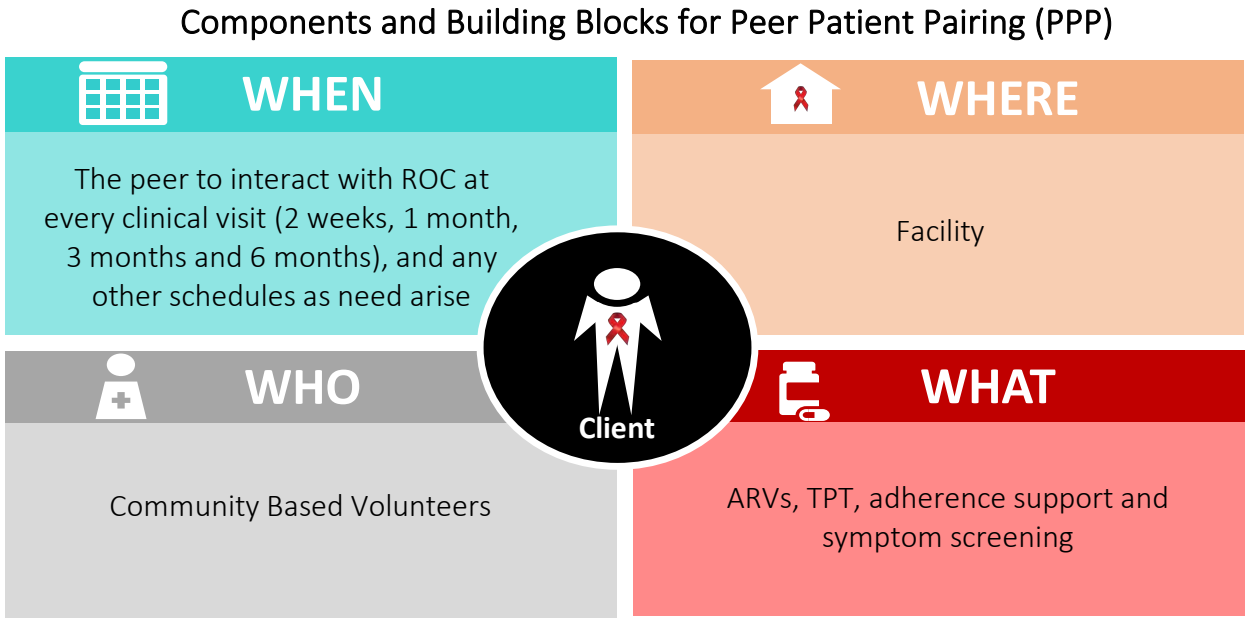

Figure 4.16: Building Blocks for Peer Patient Pairing Model

Chapter 5. DIFFERENTIATED HIV SERVICES DELIVERY FOR SPECIFIC SUB POPULATIONS

Despite health gains in HIV/AIDS response, gaps have been noted with specific sub populations living with HIV as they are underrepresented in the HIV care cascade.[9,10] The HIV prevalence among the key and priority populations is substantially higher than it is among general population living with HIV[11]. These populations have low access to treatment, face challenges in remaining on treatment, are faced with lack of adherence, stigma, low retention, and insecurity in accessing health services when compared to the general population living with HIV. These populations are being left behind in the fight against HIV.

The 2022 - 2026 National Health Strategic Plan recognizes the need to reach these sub-populations in order to mount up an effective all rounded response to the HIV epidemic. These specific subpopulations must be prioritized in the response if the 95-95-95 UNAIDS set targets are to be achieved. WHO highlights that differentiated HIV services can address inequities and inequalities that are associated with hindering access of these sub-populations to HIV treatment services by developing HIV service delivery models that meet the specific needs of the subpopulations who may be marginalized, criminalized, stigmatized and geographically disadvantaged groups. DSD also enables key communities to be more involved in HIV care and treatment. The framework recommends specific and separate models to target the three categories of the subpopulations as highlighted below.

CATEGORIES OF SPECIFIC SUB POPULATIONS

- High-risk ROC
- Key Populations
    - Sex Workers (SW)
    - Prisoners/Inmates
    - Men who have sex with men (MSM)
    - People who use drugs (PWUD)
    - Transgender (TG)

- Priority Populations
    - Pregnant & Breast-feeding women
    - Children
    - Men (due to poor health seeking behavior)
    - Migrant and mobile populations
    - Adolescents and Young People (AYP)

SPECIAL CONSIDERATIONS

Based on the building blocks of HIV differentiated service delivery, the following table summarizes the various services that should be offered to the specific sub populations accessing the DSD models.

Table 5.1: Packages of services to be offered to specific subpopulations accessing DSD

Building blocks / Populations	Key populations: MSM, FSW, Transgender, People who use or Injecting drug and Inmates	Priority populations AGYW, Pregnant & Breast feeding, Men Children, and migrants
What	• HIV Testing Services and Partner notification services (PNS) if tested HIV positive at facility and community level • Psychosocial support • Clinical, pharmacy (ART Refills/drug pickups) and laboratory services appointment and visits at facility and community level • Adherence counselling • Family planning – Condoms and oral contraceptive • PrEP (If tested HIV negative) • STI screening • Reproductive Health Counselling • GBV	• HIV Testing Services and Partner Notification Services (PNS) if tested HIV positive at facility and community level • Clinical, pharmacy (ART Refills/drug pickups) and laboratory services • Psychosocial support • Adherence counselling • Family planning – Condoms and oral contraceptive • PrEP (if tested HIV negative at high risk) • STI screening • Reproductive health Counselling • GBV
Who	• Peer/Psychosocial counsellors • Adherence counsellor Nurse, Pharmacy, Clinicians- (Li, CO, MO)	• Peer/Psychosocial counsellors • Adherence counsellor • Clinicians- (CO, MO, Li) Nurse and Pharmacy
When	• 3 Monthly • 6 monthly for Clinical/lab visits • Those with special needs may require frequent visits	• 3 Monthly • 6 monthly for Clinical/lab visits • Those with special needs may require frequent visits including children < 24 months who need monthly visits
Where	• Safe space – Patient's home, community, facility • Facility – Health post, clinic, hospital	• Community • Facility

5.1. Scholars Model

This is a model for all the ROCS that are still in schools (Primary, Secondary or Tertiary) where appointments are provided during the holidays, weekend or after hours. Facilities may need to restructure to the shift system to support the health workers and compensatory time may be provided.

Components and Building Blocks for Scholars model

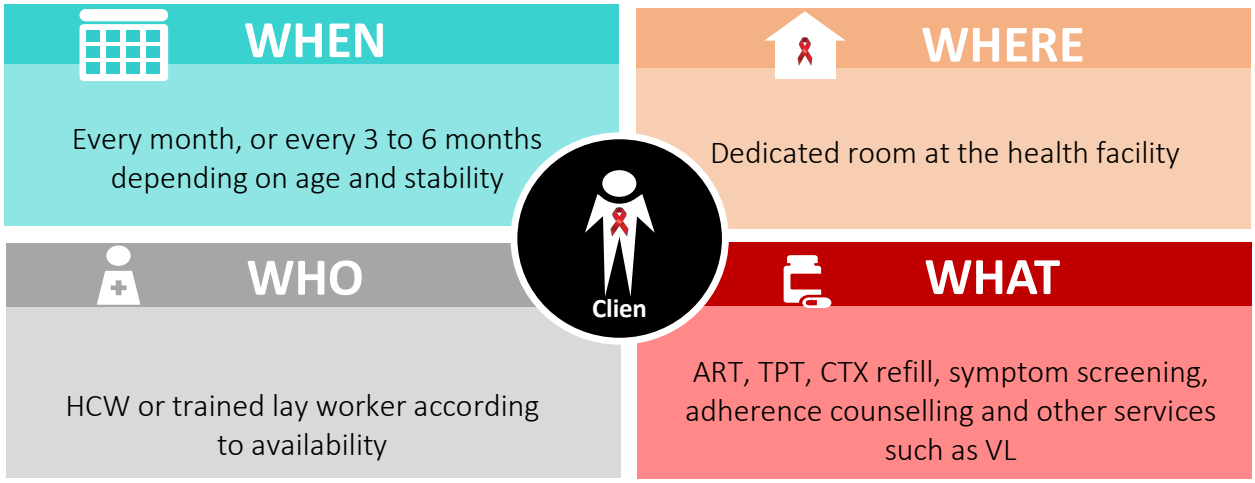

Figure 5.1: Building Blocks for Scholar Model

5.2. Paediatric Specific ART Day

This is a facility based individual model where the health facility allocates a dedicated day to support children (< 19 years). Clinical visits are synchronized with drug pick-ups and made in such a way that such visits are aligned with school holidays. Children requiring clinician's attention (including children < 24 months) should be seen as often as required.

Components and Building Blocks for Paediatric Specific ART Day

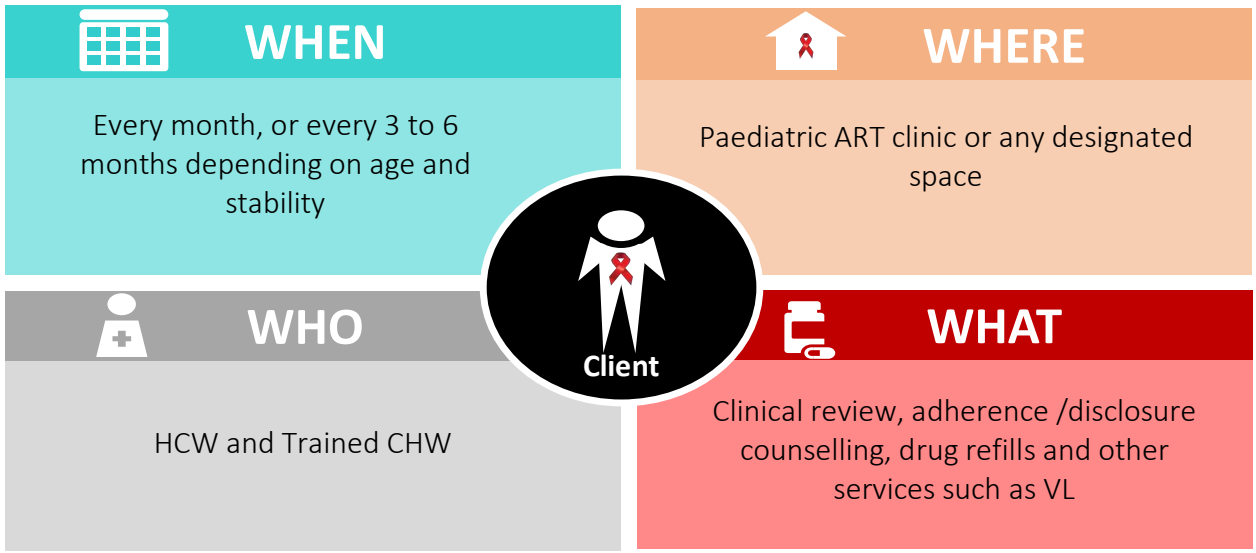

Figure 5.2: Building Blocks for Paediatric Specific Day Model

5.3. Family Centered Care Model (FCCM)

The family-centered care model (FCCM) HIV care and treatment services are offered to the entire family unit. Family unit defined as at least one ROC child (0 to 19 years) with at least one other ROC family member (related either by blood or adoption) leaving in the same household.

The FCCM allows for member of the families to support each other and consequently improve retention and ART adherence. The model also promotes family HIV testing by actively offering HIV testing services to all family members.

Table 5.2: Building Blocks for Family-Centered Care Model (FCCM)

	Clinical consultation	**Refill**
When	• 1-6 monthly	• 1-6 monthly
Where	• Facility	• Facility
Who	• HCW, lay health care workers	• HCW, lay health care workers
What	• ART refill • IPT/CPT initiation or refill • TB Screening • Adherence Support • Clinical Reviews • Laboratory Monitoring (VL, CD4 count, HB, Creatinine and LFTs) • Cervical Screening • NCD Screening + management • Family Planning • Growth monitoring • Expanded Program Immunization (EPI)	• ART refill • IPT initiation or refill • CPT refill • TB Screening

5.4. Teen Treatment Clubs

The teen treatment club (also referred as facility- based adolescents support groups) is a facility-based model for adolescents aged 10 – 24 years. The model aims to ensure uninterrupted, coordinated, developmentally, age-appropriate, and comprehensive care before, during, and after the transition to adult care. This model promotes social, psychological wellbeing of ALHIV, optimized treatment, virological suppression, and retention in care. Only adolescents with care giver consent and full disclosure are eligible for enrolment into teen clubs or equivalent adolescent support groups.

Table 5.3: Building Blocks for Teen Treatment Clubs

	Clinical consultation	Refill	Psychosocial support
When	• 1-6 Monthly	• 1-6 Monthly	• 1-6 Monthly
Where	• ART clinic	• ART clinic	• ART clinic
Who	• HCW, lay health care workers • Teen leaders • Teen club facilitators	• Providers: • HCW	• Providers: • Lay health providers • Psychosocial counsellors • HCW • Teen leaders • Teen club facilitators • Clinical Mentors
What	• Clinic assessment • VL • SRH	• ART • CTX • TPT • Condoms	• On-one-adherence counselling • Peer led health education • Networking with peers • Social games and play

5.5. Youth Engaging for Success (YES) Peer Mentoring

The Youth Engaging for Success (YES) model is an adolescent or youth focused peer mentoring support intervention model for Adolescents and Young People (AYP). The aim of the YES DSD model is to improve adolescent and young people HIV care self-management thus lead to better retention, ART adherence and mental health outcomes and reduction in internalized self-HIV stigma.

Table 5.4: Building Blocks of the YES DSD Model

	Activities for adolescents and youth	Care giver activities
When	• Monthly individualized (one on one) and once a month group session with other youth living with HIV undergoing YES program. Prescribed minimum of 6 months	• 3 care giver sessions with health care provider (2 monthly)
Where	• Health facility	• Health Facility
Who	• Trained Youth peer mentors. Youth peer mentors trained for 2 weeks	• Health care workers e.g., ART nurse. Health care workers oriented for 3 days on curriculum for supporting caregivers
What	• YES, curriculum that provides life skills in a structured manner. Curriculum covers many topics including Family factors, Understanding HIV, treatment and adherence, Communication skills, growing and changing, nutrition, stigma and discrimination, sexual and reproductive health, coping with loss and grief	• YES curriculum for caregivers structured to capacitate caregivers to positively support adolescent and HIV self-management

5.6. Transitioning Treatment Clubs

The transitioning treatment club is a facility-based model for adolescents >16 - 24 years. The model aims to ensure uninterrupted, coordinated, developmentally and age-appropriate, and comprehensive care before, during, and after the transition to adult care. This model promotes optimized treatment, virological suppression, and retention in care. These adolescents usually graduate from teen clubs or equivalent adolescent support groups.

Table 5.5: Building Blocks for Transitioning Treatment Clubs

	Clinical consultation	Refill
When	• 1-6monthly	• 1-6 months
Where	• Facility – (usually on Saturdays)	• Facility (usually on Saturdays)
Who	• HCW, lay health care workers • Teen leaders • Teen club facilitators	• HCW, lay health care workers • Teen leaders • Teen club facilitators
What	• ART refill • IPT/ CPT initiation or refill • TB Screening • Adherence Support • Clinical Reviews • Laboratory Monitoring (VL, CD4 count, HB, Creatinine and LFTs) • Index testing, SNT • Family Planning	• Psychosocial support • ART refill • IPT /CPT initiation or refill • TB Screening • Index testing

5.7. Men's Clinic Model

This is a facility-based model that offers services to males aged 15years and above. The operation of the clinic is at a separate space (away from the main clinic) with a distinct waiting area (could be prefabs where rooms are unavailable). Male service providers are recommended for this model. The various integrated services provided in this model include the following:

- Diabetes services
- Prostate cancer screening
- Erectile dysfunction screening
- Psychosocial counselling
- Benign Prostate Enlargement (BPH) screening
- Male infertility screening
- STI Management
- HTS
- ART Services

  HIV Prevention services: VMMC, PEP, PrEP, Condom distribution

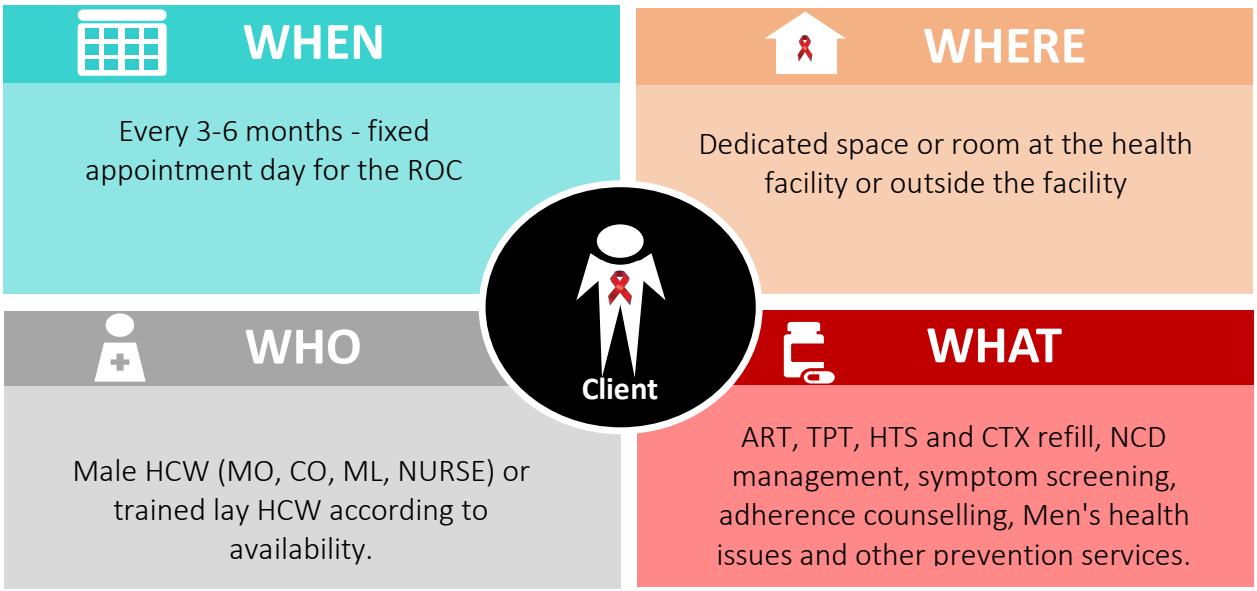

Figure 5.3: Building Blocks for Men's Clinic Model

5.8. KEY POPULATIONS

The implemented KP DSD models in the country all Peer supported and led and are classified either as facility-based or community-based

5.8.1. Facility Based KP DSD Models

- **Fast Track (public Health facility**) - a trained KP community CBV receives the KP ROC and helps navigate around for service provision processes.
- **Multi-month scripting/dispensation** as determined by HCW/Clinician for highly mobile KPs, for example Sex Worker and others.
- **Extended hours** done by appointment with ROC and HCW/clinician, usually on identified day/s in a week
- **Weekend clinics** provided as scheduled by providers to respond to opportunity timing, for example, KP ROC unable to access services during the week.

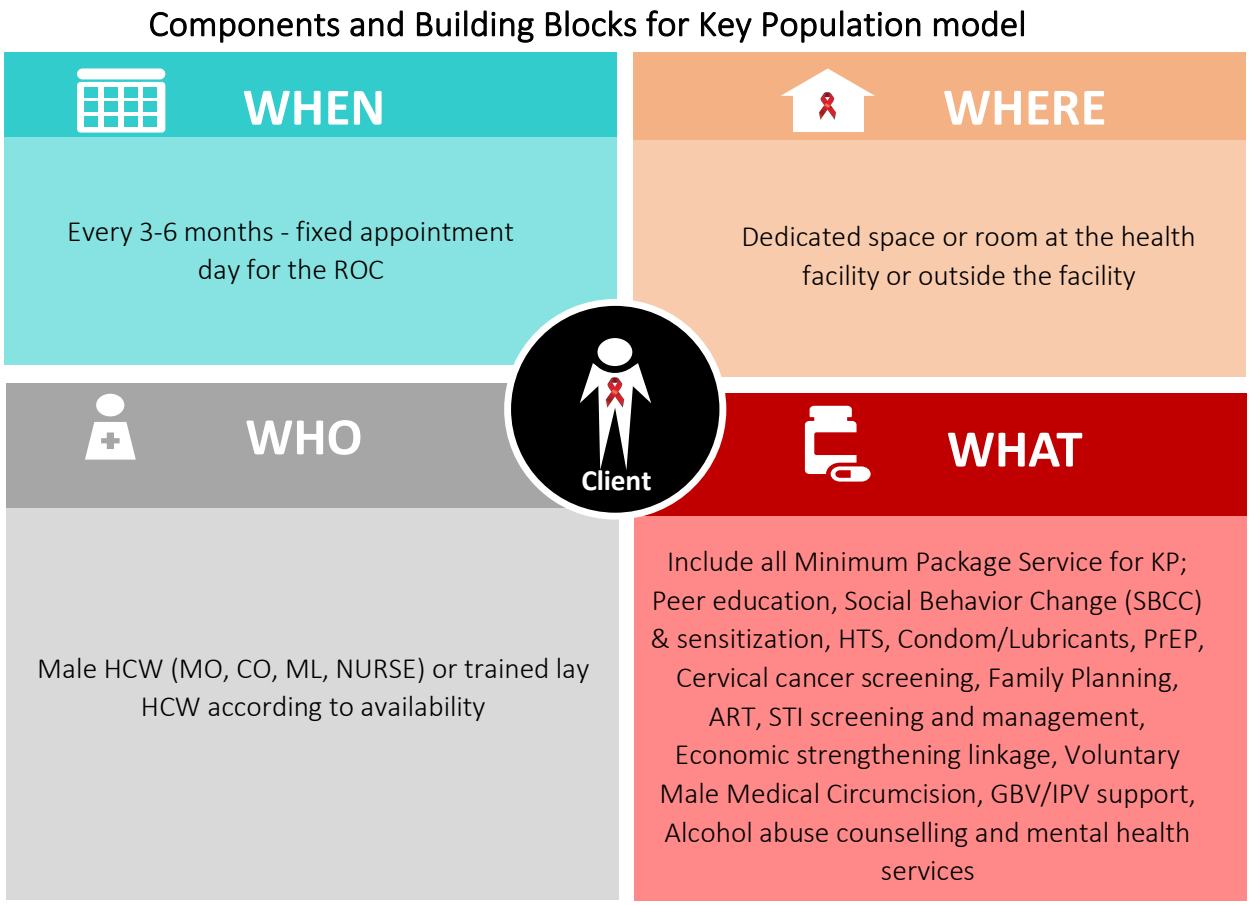

Figure 5.4: Building Blocks for Facility-Based KP Models

5.8.2. Community Based KP Model

Wellness center are KP led models which are established at a fixed site in the community which are linked to a public health facility (mother facility) that provides comprehensive HIV services to KPs. It receives logistical support including pharmacy, lab and HCW support from the mother facility. The wellness centers are established after conducting hot spot mapping and selecting a place with majority of the KP, easy to access and linked to a public health facility. This model supports access to health care services among the KP and service is provided by KP sensitive HCWs who work hand in hand with the community key gate keepers and the KP civil society organization.

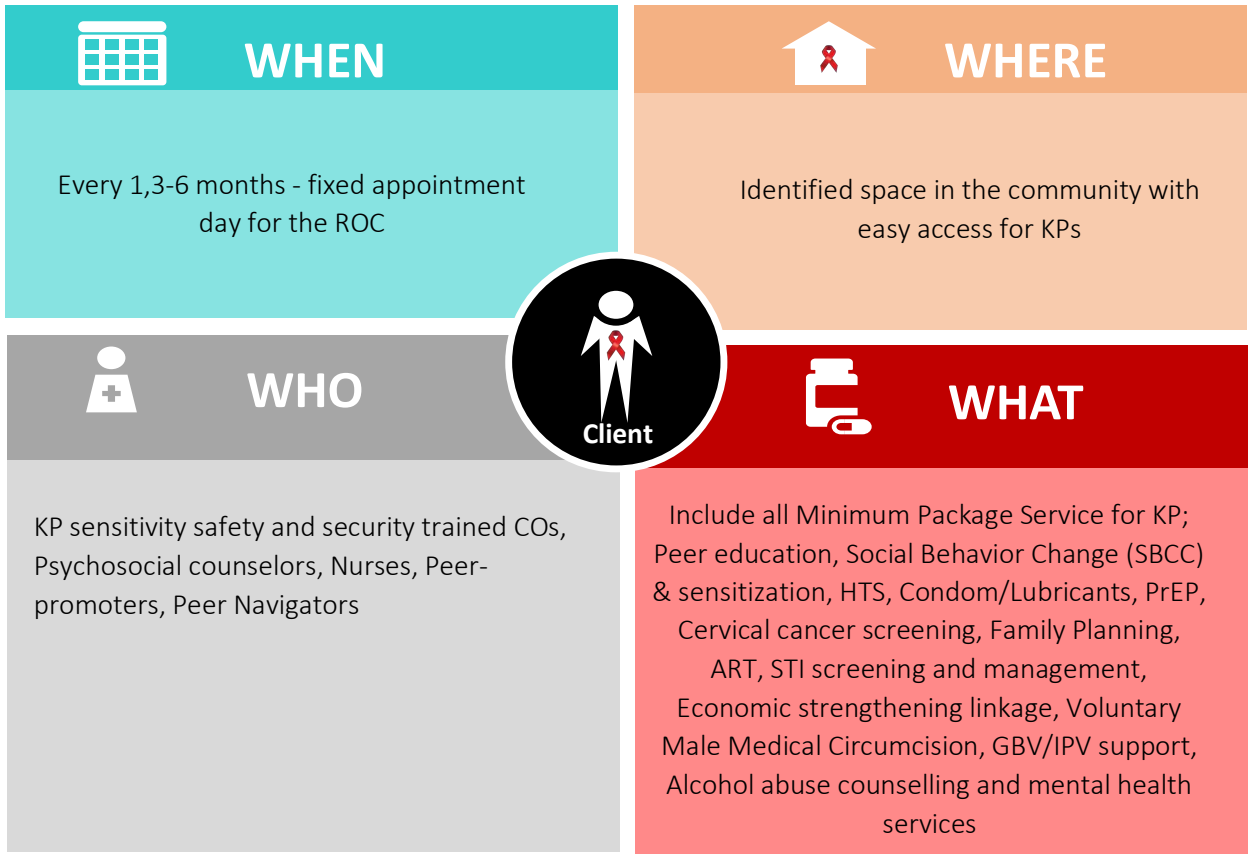

Figure 5.5: Building Blocks for Key Population Model

5.8.3. Digital Engagement

Use of innovative digital space to mobilise KPs for services, for example, QuickRes, Grinder and other closed social engagement Apps.

Chapter 6. DEMAND CREATION

A well-structured communication strategy is critical in establishing the trust and confidence required to scale up DSD Models in the country. With DSD being person centered, its success is dependent on the ROC having detailed information of the various models of care available. Therefore, it is the responsibility of the health care workers to provide comprehensive information through health education in the facilities and communities. This will ensure that ROC have information and understanding thus allowing them to make an informed decision. Equally, ROC must be assured that HIV services provided through DSD models are equivalent with services offered under the standard of care. Confidentiality, efficiency, quality care should be maintained in DSD as well as in standard of care. These virtues are contributing factors to ROC satisfaction and ultimately retention in care.

6.1. HEALTH FACILITY

All Health Facilities should incorporate DSD models of care in the health promotion and provide key thematic topics on HIV conducted by HCWs and facility-based volunteers. Additionally, IEC material with detailed information of the available DSD models should be distributed in the health facilities. The CBV may identify and recommend a ROC to the HCW for further clinical and psychosocial assessment for DSD eligibility. However, ROC can also request to be enrolled in a DSD model and ask HCWs to assess their eligibility. Once eligible, ROC should be encouraged to choose their preferred model for accessing ART services. Figure 36 below summarizes the enrolment process for DSD models at health facilities.

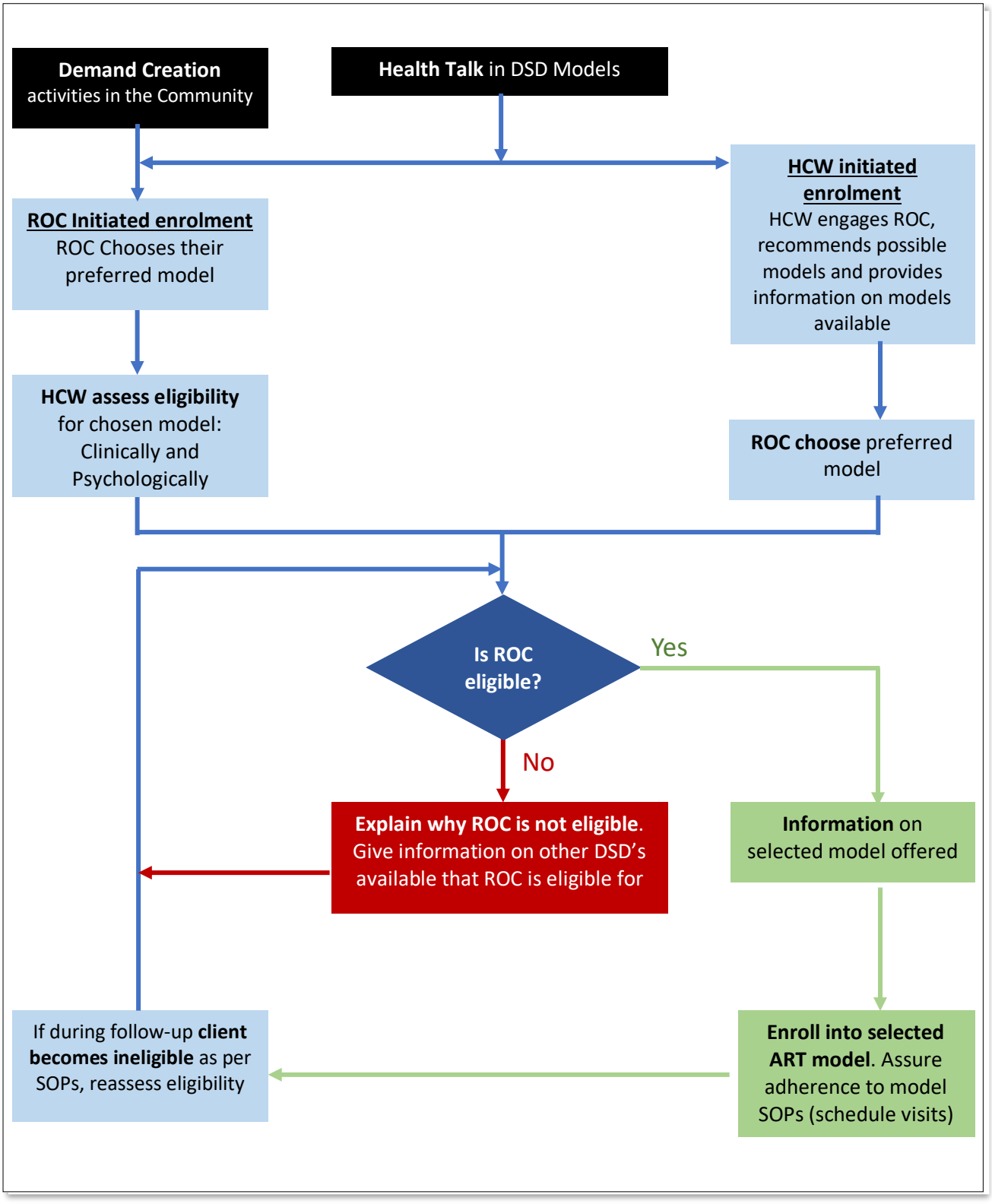

Figure 6.1: Enrolment Process for DSD Models at Health Facility

6.2. COMMUNITY

At community level, collaboration with existing networks, especially support groups of PLHIV, Neighborhood Health Committees (NHC), and other critical community stakeholders should be enhanced to create demand for DSD. Demand creation activities should also target various workplaces and groups that shun conventional health services, such as key and priority populations. ROC should be provided with sufficient information of the benefits of belonging to the different DSD models. This can be done through existing support groups, networks of PLHIV, digital interventions and others.

Demand creation for DSD can be done using the following sensitization activities both at facility and community level.

Table 6.1: Sensitization activities for DSD Demand Creation

Method of Sensitization	Description
Drama Groups	Mass sensitization using local community theatre groups
Media (Print and electronic)	Use of national and community radio and TV stations, flyers, posters, brochures banners, billboards,
Door to Door sensitization	Use of trained community volunteers targeting households
Focus Group Discussions	Use of already existing community support structures to disseminate information on the available models to groups consisting of 12-15 people
Community Dialogues	Use of gatekeepers (traditional, community, religious, and civic leaders)
Commemorative events	Use of global/national commemorative calendar days (such as World AIDS Day)
Digital Interventions	Short Messages Service (SMS) such as End AIDS Portal and MOH initiated texts; Social media platforms like WhatsApp; Websites
Interpersonal communication	One-on-one sensitization and dissemination
Testimonials	Use of PLHIV as role models

Measuring ROC's satisfaction/feedback with use of DSD Models.

DSD being person centered requires feedback from ROC on their experience and satisfaction using DSD models. This is key for program improvement. Whilst this approach might not have directly increase demand, it can however lead to increase in ROC retention in DSD models. Adopting three domains from the CIDRZ-MOH ROC experience conceptual framework which includes three fundamental elements: (1) capacitating providers to improve the ROC's experience, (2) measuring ROC experience and data feedback to health care workers required to priorities quality improvement initiators and (3) gentle facility level incentive.

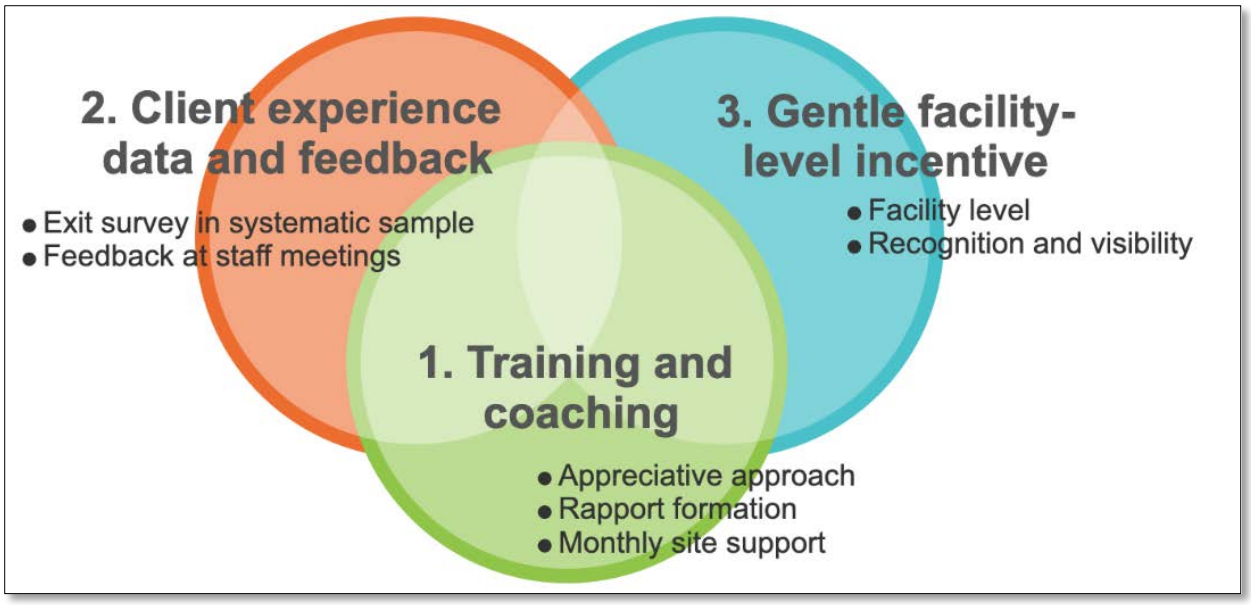

Figure 6.2: MOH ROC Experience Conceptual Framework

6.2.1. Capacitating providers to improve the ROC's experience

Health care workers will be provided with training and mentorship to interpret ROC feedback data and initiate intervention that are driven by data from ROCs feedback for quality improvement. In addition, the training and mentorship for providers will focus improve the quality of interactions between the providers and ROC, for example, communication skills, use of discretionary help, warmth and friendliness.

6.2.2. Measuring the ROC experience and data feedback

At facility level and community level ROC will be provided with an exit questionnaire to provide feedback on their experiences with accessing DSD model. This can be self-administered or by a trained lay healthcare worker. The questionnaire can be paper based or electronic and will include simple to understand and utilize indicators such length of time spent accessing the DSD model.

Data feedback to health care workers

The feedback from the ROC regarding experiences using the DSD models will be used by providers to initiate interventions to improve on underperforming indicators.

6.2.3. Gentle facility level incentive

Health care workers' efforts to improve ROC experience will be appreciated using reputational incentives as they are low cost and require minimal financial investment.

Chapter 7. OPERATIONAL GUIDANCE

Emerging evidence from country DSD evaluations, have shown benefits to both ROC enrolled in DSD models and HCW who are directly and indirectly involved in DSD implementation. When compared to ROCs in conventional care, ROCS in DSD models were more satisfied and had better retention in HIV treatment. At Health Facilities that were implementing DSD models, HCW have reported reduction in daily ROC load and workloads allowing adequate time allocation to the ROC resulting in provision of patient centered services a high job satisfaction among the HCW. These findings support the country's decision to scale up DSD Implementation at all health facilities offering ART services. The Zambia DSD Framework should be adopted and used to plan, implement and evaluate the differentiated care services at national, provincial, district and health facility levels. The Framework should be utilized in concurrence with available national documents such as the ZCGs and the DSD implementation plan that supports the scale up of DSD models of care.

Leadership and Governance

The DSD framework is nested under the Directorate of Infectious Disease under MoH. Coordination is led by the National DSD Coordinator who works with various stakeholders. The implementation of this is further decentralized to subnational levels as shown in figure 37. This section outlines the steps required to implement DSD at the facility and community level. In addition, it defines the roles and responsibilities of each stakeholder in the implementation process. MoH recommends incorporation of DSD into the already existing committees at district and facility levels to facilitate the adoption and implementation of DSD. It is however important to identify the focal point person at all levels to push the DSD agenda. The focal point person at the district can be the District HIV focal point person, District pharmacy personnel, the Clinical Care Officer (CCO) or facility ART Coordinator. The DSD focal point person will coordinate the following: human resource for health including volunteers, capacity building, supply chain, M&E and QI.

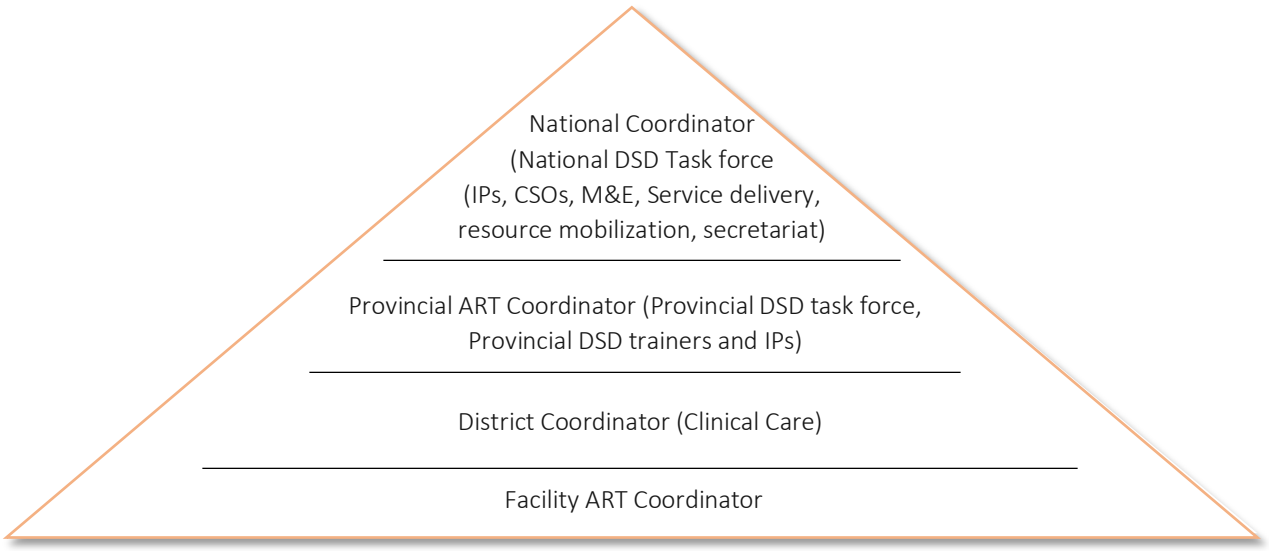

Figure 7.1: MoH Leadership and Governance

7.1. Work Planning

DSD activities should be integrated in the annual work plans at all levels of implementation as illustrated in the above figure 37. Data should inform DSD programming and prioritize activities with alignment to the national guidelines.

7.2. Capacity Building on Differentiated Service Delivery

Trainings

To strengthen the roll-out of DSD according to this framework, a tailored training manual on DSD has been developed for managers, HCWs, and community/facility volunteers as outlined in Table 8 below. The district-level sensitization and the HCW training should be combined with the sensitization/training on the latest Zambia Consolidated Guidelines on Treatment and Prevention of the HIV infection whenever possible. Trainings will be scaled down from national level down to the subnational level with the national trainers providing oversight of all trainings.

Table 7.1: Capacity Building on Differentiated Service Delivery

Level	Target Audience	Training Package	Structure of Training
District	☐ District Program Officers ☐ District/Regional Mentors ☐ Implementing Partners	☐ PowerPoint Slides	☐ Didactic half day sensitization ☐ (Zambia Consolidated Guideline dissemination when possible)
Health Facility	☐ Healthcare Workers (Clinical, Pharmacy, Laboratory, Community Liaison, Data)	☐ Power point slides ☐ Facilitators guide ☐ Participants workbook ☐ Algorithms/SOPs ☐ Case Studies ☐ Role-plays ☐ DSD Framework ☐ ZCGs ☐ SmartCare/Registers	☐ 5 days training (4- didactic and 1 practicum)
Community	☐ Facility based/ Community volunteers/ Lay Workers ☐ PLHIV attending HIV clinic services ☐ Facility tailored training in models available in the facility	☐ PowerPoint slides ☐ Facilitators guide ☐ Participants workbook ☐ Case studies ☐ Role-plays ☐ Desk Card Flip chart ☐ Desk Card IEC Materials ☐	☐ Didactic and case-based two-day training ☐ Daily health talks with groups and ☐ individuals

Technical Support and Supervision (TSS)

Technical Support and Supervisory Visits (TSS) on implementation of DSD models should be integrated in the already existing system at National, Provincial and District Levels. Additionally, TSS should also be provided on a data driven basis.

7.3. Strengthening Health System

7.3.1. Supply Chain Management

An efficient and secure process for storage, distribution and appropriate utilization of HIV commodities is critical to ensure a reliable supply at all levels. If not properly planned, implementation of various DSD models (such as multi-month scripting) can add pressure to the existing HIV commodities. There is need for pooled distribution of commodities. Management of HIV commodities is necessary for successful implementation of these models.

It is essential to comply with the established national and health facility pharmaceutical standard operating procedures (SOPs) manual at all levels, while adapting and finding specific solutions to bottlenecks in the implementation of these practices. For example, preparing medicines for adherence groups or clubs, mobile ART outreach and/or designated fast-track distribution points all facilitate the implementation of the models and partly ensures that the aim of all the models is realized.

7.3.2. Laboratory Strengthening

Laboratory diagnosis and monitoring of HIV infection, staging of disease progression, monitoring of therapies, including management of antiretroviral toxicities, and the response to therapy are essential components of ART management. General laboratory management will follow requirements described in the ZCGs and should be integrated within the existing laboratory network.

The existing national sample courier system will facilitate the transportation of specimens from lower-level facilities to higher-level testing laboratories, including the return of ROC results. Laboratory specimen collection, handling, storage and transport will follow the established facility specific or generic laboratory handbook.

7.3.3. Monitoring and Evaluation

Monitoring of DSD services is critical for tracking performance towards achieving the 95-95-95 HIV care and treatment goals, while ensuring high quality of care, optimal clinical outcomes and improving other HIV services. Successful DSD programming will leverage existing site-level paper-based and electronic HMIS tools to monitor quality of care and overall management. The data collection tools may be revised to accommodate new DSD models. The framework provides guidance to program officers, health care providers and implementing partners on the processes and indicators to be used for monitoring of DSD.

7.3.3.1. DSD M&E INDICATORS

Table 7.2: Selected DSD Key Performance Indicators

Objectives	Indicators	Numerator	Denominator	Means of verification	Data collection frequency
HIV Testing Services	Percentage on individuals Tested by HTS DSD model	Number of individuals tested by HTS DSD models	Number of individuals tested	HTS Register, SmartCare	Monthly
	Proportion of individuals that tested positive and linked to care (disaggregated by sub-population and model)	Number of individuals that tested positive and linked to care (disaggregated by sub-population and model)	Number of individuals that tested positive (disaggregated by sub-population and model)	HTS Register, SmartCare	Monthly
	Percentage of health facilities implementing at least one HST DSD model	Number of Facilities implementing at least one HTS DSD model.	Number of Health Facilities	HTS Register, SmartCare	Monthly
Prevention	Percentage of health facilities implementing at least one facility-based DSD models (disaggregated by sub-population)	Number of facilities implementing at least - one facility-based DSD models (disaggregated by sub-population)	Number of Health Facilities	HTS Register, SmartCare	Monthly
	Percentage of health facilities implementing at least one community-based DSD model (disaggregated by sub population)	Number of health facilities implementing at least one community-based DSD model (disaggregated by sub population)	Number of Health Facilities	HTS Register, SmartCare	Monthly
	Percentage of High Risk individuals that tested Negative	Number of High Risk individuals that tested negative.	Number of high-risk individuals tested	HTS Register, SmartCare	Monthly
	Percentage of High Risk individuals that tested Negative and linked to prevention services (disaggregated by sub population and model)	Number of high-risk individuals that tested negative and linked to prevention services (disaggregated by sub population and model)	Total Number of high-risk individuals that tested HIV Negative (disaggregated by sub population and model)	HTS Register, SmartCare PEP, PREP Register	Monthly

Objectives	Indicators	Numerator	Denominator	Means of verification	Data collection frequency
Treatment	Percentage of health facilities implementing at least one facility-based DSD models for ROC established on treatment	Number of health facilities implementing at least - one facility-based DSD models for ROC established on treatment	Number of Health Facilities	SmartCare	Monthly
	Percentage of health facilities implementing at least on community-based DSD model for ROC established on treatment. disaggregated by model)	Number of health facilities implementing at least - one Community -based DSD models for ROC established on treatment. disaggregated by model)	Number of Health Facilities	SmartCare	Monthly
	Percentage of health facilities implementing at least on facility-based DSD model for high-risk ROC (disaggregated by sub population and model)	Number of health facilities implementing at least - one facility-based DSD models for high-risk ROC (disaggregated by sub population and model)	Number of Health Facilities	SmartCare	Monthly
	Percentage of health facilities implementing at least on community-based DSD model for high-risk ROC (disaggregated by sub population and model)	Number of health facilities implementing at least - one facility-based DSD models for high-risk ROC (disaggregated by sub population and model)	Number of Health Facilities	SmartCare	Monthly
	Percentage of facilities implementing at least one facility-based DSD models for KPs (disaggregated by sub population and model)	Number of facilities implementing at least one facility-based DSD models for KPs (disaggregated by sub population and model)	Number of Health Facilities	SmartCare	Monthly
	Percentage of facilities implementing at least one community -based DSD models for KPs (disaggregated by sub population and model)	Number of facilities implementing at least one community -based DSD models for KPs (disaggregated by sub population and model)	Number of Health Facilities	SmartCare	Monthly

Objectives	Indicators	Numerator	Denominator	Means of verification	Data collection frequency
	Percentage of ROC established on treatment enrolled into DSDs, disaggregated by model	Number on of ROC established on treatment enrolled into DSDs, disaggregated by model	Total # of ROC established on treatment receiving ART	SmartCare	Monthly
	Percentage of High-risk ROC enrolled in DSDs, disaggregated by model and sub population	Number of High-risk ROC enrolled into DSDs, disaggregated by model and sub population	Total # of high-risk ROC receiving ART	SmartCare	Monthly
	Number of ROC in established on treatment DSD models switching between models	Number of ROC in established on treatment DSD models switching between models	Total # of ROC in established on treatment DSD models	SmartCare	Monthly
	Number of ROCs in high-risk DSD models switching between models	Number of ROC in high-risk DSD models switching between models	Total # of ROC in high-risk DSD models	SmartCare	Monthly
	Number of ROC in established on treatment DSD models switching to high-risk DSD models	Number of ROC in established on treatment DSD models switching to high-risk DSD models	Total # of ROC in DSD models	SmartCare	Monthly
	Number of ROC in high-risk DSD models switching to established on treatment DSD models	Number of ROC in high-risk DSD models switching to established on treatment DSD models	Total # of ROC in DSD models	SmartCare	Monthly
	VL suppression by DSD model at 6 and 12mos in care – cohort analysis	VL suppression by DSD model at 6mos, 12mos in care – cohort analysis	Total # of ROC receiving ART on by cohort (6months, 12 months)	SmartCare	Monthly
	Retention by DSD model at 6, 12 and 24 months in care -	Retention by DSD model at 5, 12, and 24 months in care	Total # of ROC receiving ART at 6, 12 and 24 months	SmartCare	Monthly
	Number of ROC on Established model who develop AHD	Number of ROC on Established model who develop AHD	Number of ROC on Established model	SmartCare	Monthly

Sub-population not limited to (AYP, MSM, SW, PWUDs, Men, Transgender)

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APPENDICES

9.1. The Three Elements for Differentiated HIV Testing

Differentiated HIV testing must be influenced by the 3 elements which puts the People Living with HIV at the center. These includes

1. Clinical Characteristics of a person (e.g STI, TB may be tested differently)
2. Specific Population, 3 Context. The figure below expands of the 3 elements.

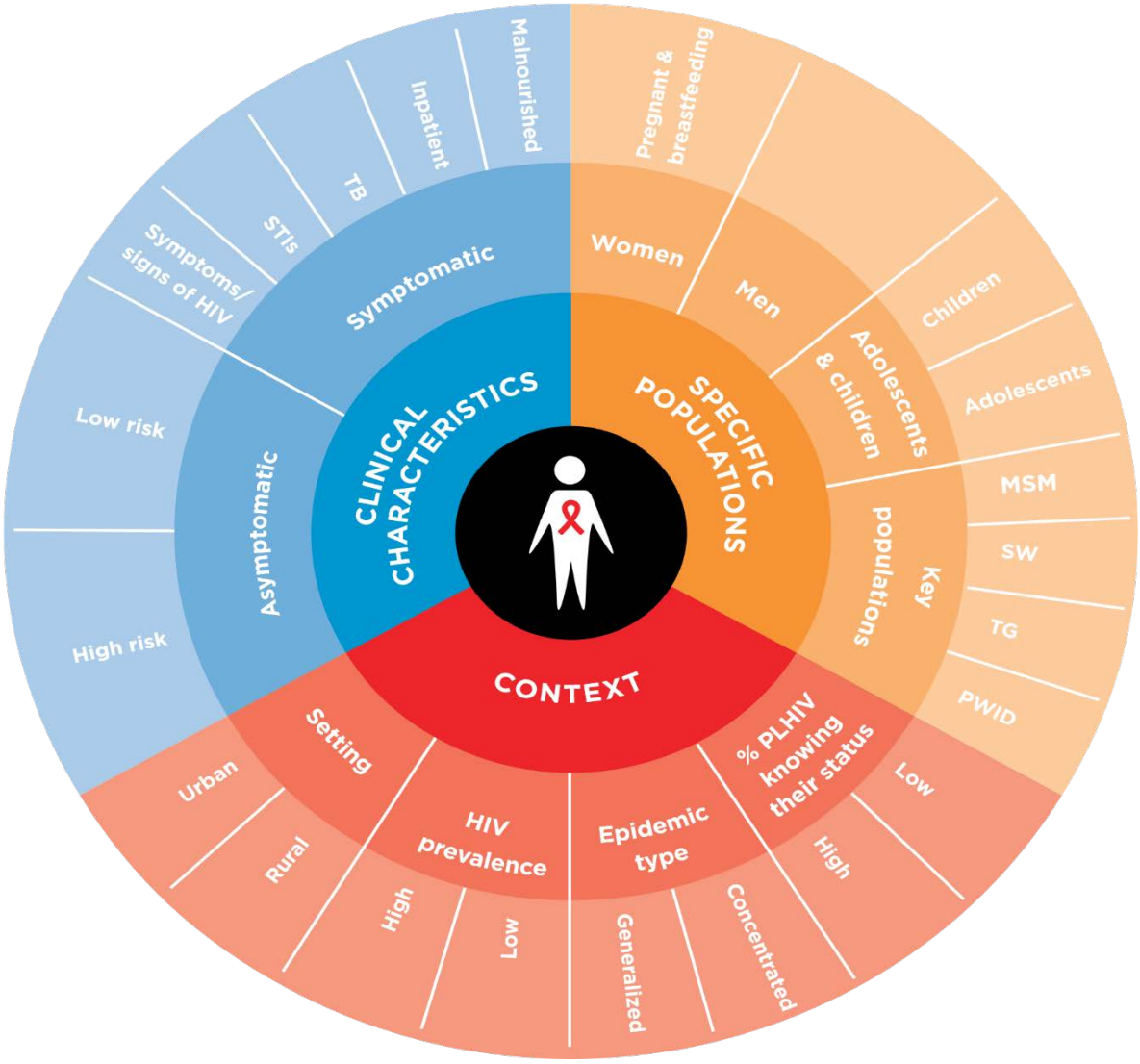
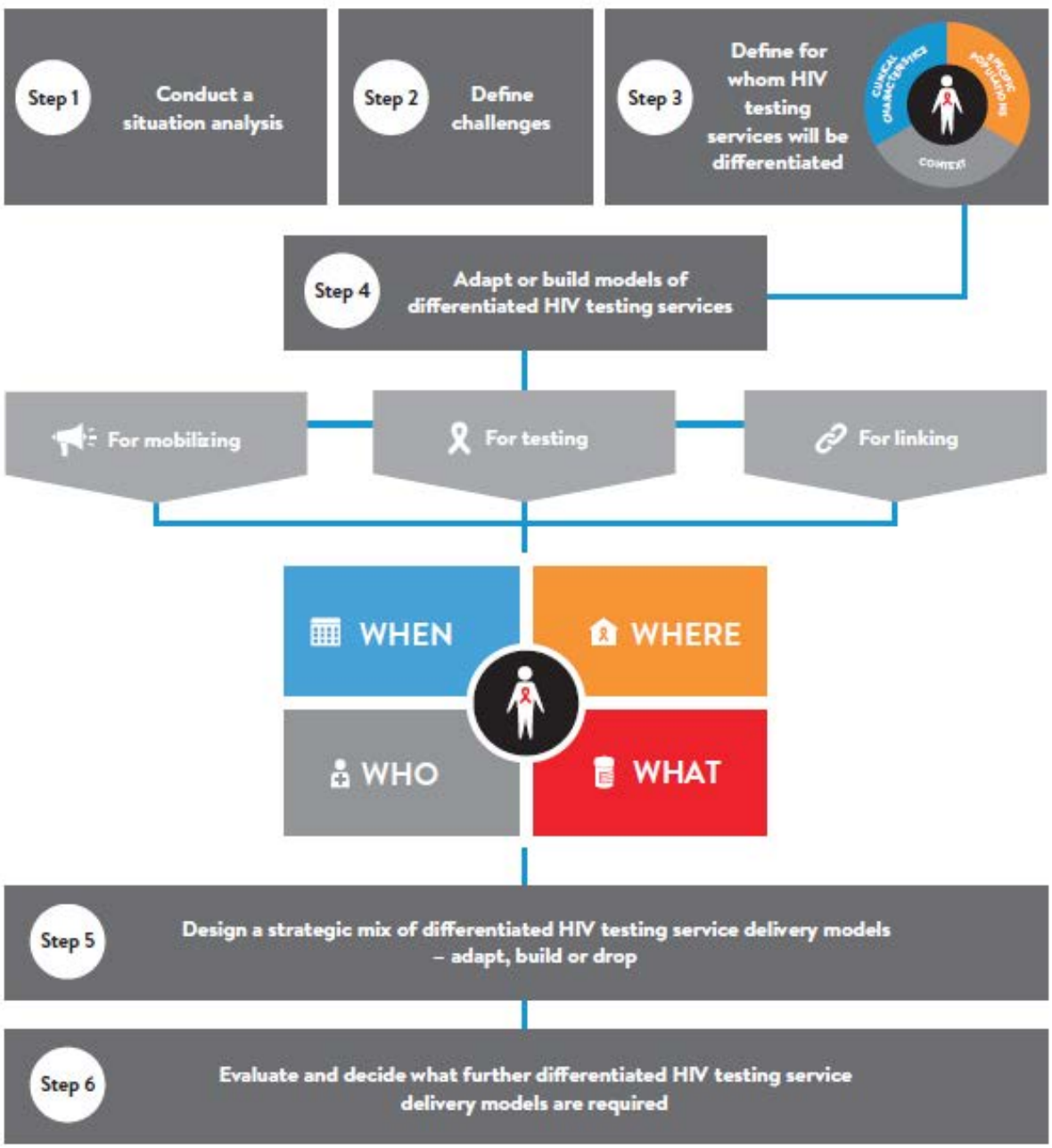


Figure 9.1: Three Elements for Differentiated HIV Testing

9.2. Six Step Approach

Six step approach figure 39 provides guidance to the implementers in planning how to differentiate HIV Testing Services



source: https://www.differentiatedservicedelivery.org/models/testing

Figure 9.2: Six Step Approach to Differentiate HIV Testing Services

9.3. WORKPLAN TEMPLATE

Table 9.1: DSD Workplan

ACTIVITY	RESPONSIBLE PERSON	INPUTS	OUTPUT	STATUS	TIMELINE

9.1. LOGBOOK

Table 9.2: Log Book

Date	Number of Drug Pack Delivered	Name & Sign	Number of Drug Packs Received	Name & Sign	Drug Packs Returned to the Main Facility	Name & Sign

9.2. Facility-level questionnaire for baseline assessment of differentiated ART delivery

Table 9.3: Baseline Assessment Questionnaire

Facility questionnaire on differentiated ART delivery	**Site:**			
The elements of differentiated ART delivery				
Is ART delivery differentiated for stable patients?				
Is ART delivery differentiated for patients with a high viral load?				
Is ART delivery differentiated for patients with other medical needs?				
Is ART delivery differentiated for pregnant and breastfeeding women?				
Is ART delivery differentiated for children?				
Is ART delivery differentiated for adolescents?				
Is ART delivery differentiated for men?				
Is ART delivery differentiated for key populations?				
Is ART delivery differentiated for any other population? specify population				
Is ART delivery differentiated for any contextual factors?				
The building blocks of differentiated ART delivery	**Adults**	**Adolescents**	**Children**	**Pregnant & breastfeeding women**
Where is ART delivered? (Facility or facility & community)				
What is the schedule for clinical follow up in the clinic?				
What is the schedule for counselling follow up?				
What is the schedule for laboratory follow up?				
What is the maximum ART refill allowed for patients?				
What maximum refill (X months) is given routinely for stable clients?				

Do patients see the nurse every visit or are clinical and refill visits differentiated?				
Who performs the ART consultation?				
Do patients collect ART as individuals?				
Do patients collect ART in any group dynamic?				
Health care worker perspective	**Adults**	**Adolescents**	**Children**	**Pregnant & breastfeeding women**
How many days of the week is ART given?				
From what time is ART provided from and to?				
How many clients does each HCW see on an ART Day?				
Client perspective	**Adults**	**Adolescents**	**Children**	**Pregnant & breastfeeding women**
How far are patients travelling to reach your clinic?				
How long do clients wait from when they arrive to when they leave?				
Monitoring and Evaluation	**Adults**	**Adolescents**	**Children**	**Pregnant & breastfeeding women**
Number on ART				
Retention at 12 months %				
Retention at 48 months %				
Is there an appointment and tracing system?				

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