IAS

Differentiated service delivery for chronic conditions beyond HIV

A workshop on implementing differentiated service delivery (DSD) models for clients established on treatment across chronic diseases

A workshop convened by
IAS - the International AIDS Society – with partners
Tuesday, 5 December, and Thursday, 7 December 2023,
Brontë Hotel, Harare, Zimbabwe

International AIDS Society

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Executive summary

The workshop, "Differentiated service delivery for chronic conditions beyond HIV", took place alongside the International Conference on AIDS and STIs in Africa (ICASA 2023) in Harare, Zimbabwe. It was convened by IAS – the International AIDS Society – over two half-days, the mornings of 5 and 7 December 2023. The primary objective was to explore the potential application of differentiated service delivery (DSD) principles beyond HIV, specifically for clients living with hypertension and diabetes. Country teams from Malawi, Nigeria, Uganda and Zimbabwe participated, representing ministries of health, civil society, researchers and implementing partners.

The first day focused on setting the scene, covering introductions, the rationale for DSD in chronic diseases, key enablers, integration perspectives and guidance. Sessions were designed to provide an overview of DSD principles, share experiences and highlight global and national policies supporting DSD. Presenters emphasized the adaptability of DSD models for different chronic conditions. After each set of presentations, country groups discussed lessons learnt and applicability in their countries.

The second day concentrated on developing country action plans. Country teams, guided by facilitators, delved into national policies, eligibility criteria and DSD building blocks for hypertension and diabetes. Discussions centred around potential DSD models and action points for multi-month scripting, step-wise algorithms, single-pill combinations and monitoring and evaluation. Teams collaboratively mapped these actions based on feasibility and impact. The day concluded with each team presenting three to five priority actions, specifying responsible individuals, timelines and required resources. Common themes across country action plans included establishing governance structures, developing non-communicable-disease (NCD) treatment literacy strategies involving networks of people living with NCDs, adapting guidelines or standard operating procedures (SOPs), and enhancing monitoring and evaluation systems to support DSD for NCDs.

The workshop successfully facilitated knowledge exchange and collaboration among country teams, emphasizing the importance of extending DSD principles beyond HIV to address a spectrum of chronic diseases. The country action plans represent tangible steps toward implementing DSD for hypertension and Type 2 diabetes. The outcomes of the workshop contribute to the broader goal of integrating chronic disease care into existing health systems, fostering sustainable, person-centred approaches across diverse healthcare contexts.

Background

The principles of DSD for HIV have now been included in the global normative guidance of the World Health Organization (WHO), and many countries, particularly in central, eastern, southern and western Africa, have made DSD part of their national HIV guidance. WHO has also recommended the integration of hypertension and diabetes care into HIV treatment services, and there are components of DSD in the 2021 WHO guidelines for hypertension. Importantly, since the inception of DSD, its principles have been designed to support a person-centred approach to service delivery for any disease requiring life-long medication – it was never intended to be limited to the provision of HIV services.

To date, efforts to expand DSD to include other disease areas have focused on integration for people living with HIV, in other words, on integrating additional services into DSD for HIV treatment models. DSD principles have not been widely adopted by service delivery systems for people living with other chronic diseases.

Workshop aim and objectives

The workshop, "Differentiated service delivery for chronic conditions beyond HIV", reflected on the potential opportunities of DSD for HIV treatment for clients established on treatment with any chronic disease – not only for those living with HIV and another chronic disease. The workshop was held over the mornings of 5 and 7 December 2023 in parallel with the International Conference on AIDS and STIs in Africa (ICASA 2023) in Harare, Zimbabwe.

IAS – the International AIDS Society – brought together four country teams from Malawi, Nigeria, Uganda and Zimbabwe. Each included representatives from ministries of health and civil society, as well as researchers and implementing partners. In addition, stakeholders from global normative agencies, funders and collaborators were invited to participate (see Annex 1: List of participants).

The aim was for each country team to develop a country-led and context-specific action plan to enable DSD for chronic diseases in their country. The workshop agenda is available as Annex 2.

The workshop objectives were:

- To provide an overview of the principles of DSD for chronic diseases
- To provide an overview of current WHO recommendations for the building blocks of DSD for HIV treatment and hypertension care delivery
- To identify key enablers for DSD for hypertension and diabetes, such as simplified algorithmic clinical guidance and access to monitoring
- To present and analyse current global and national policies and practices to enable DSD for chronic disease
- To share experiences of integrated chronic disease service delivery
- To contribute to a roadmap outlining future actions at global and national levels

In preparation for the workshop, country teams were connected via email to receive detailed information on the workshop content. The introductory email also included a country-specific slide template based on current national policies. This template was intended to facilitate country group work on the second day of the workshop.

Day 1
Setting the scene

The first day was divided into five complementary sessions to set the scene: 1) introductions; 2) why DSD for chronic disease; 3) key enablers for DSD for chronic disease, the hypertension example; 4) what we mean by integration; and 5) national guidance on DSD for chronic disease. After each session (2-5), country teams had time to discuss what they had learnt from the session and what lessons were relevant to their country context.

Introductions

Anna Grimsrud, IAS Senior Technical Advisor, facilitated the overview and introductory session. She outlined the workshop objectives, emphasizing the desire for the workshop to be interactive and participatory.

She briefly reviewed the building blocks of DSD (Figure 1) and referenced the shift from integrating services into DSD for HIV towards a DSD 2.0 person-centred approach (Ehrenkranz et al, 2021, JAIDS).

Figure 1: The building blocks of differentiated service delivery

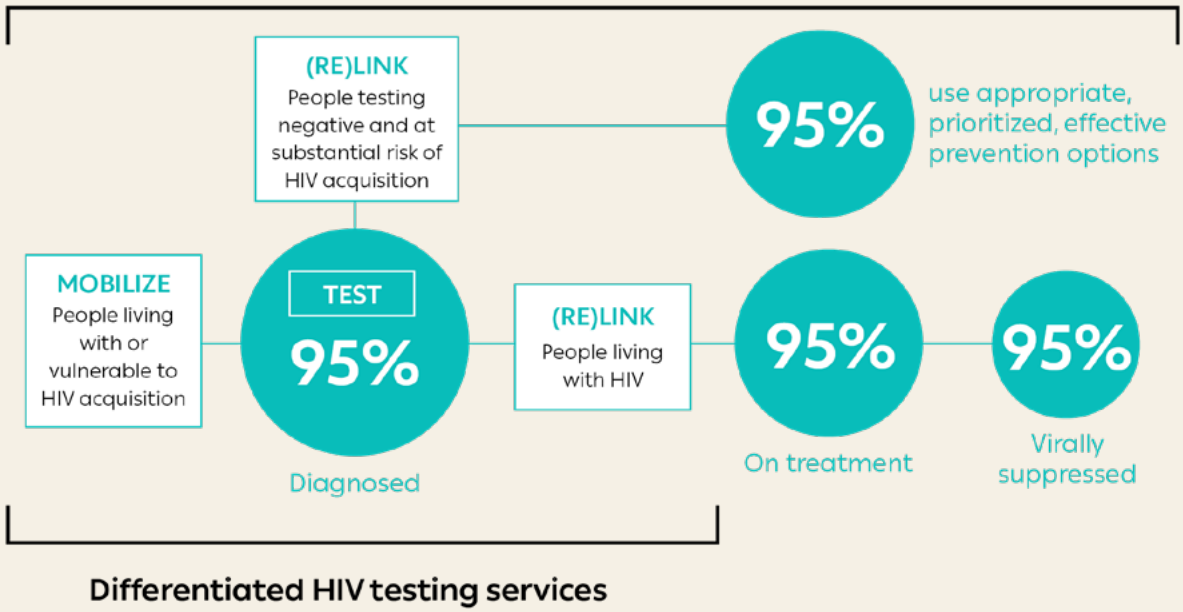
Anna walked all participants through their workshop booklet. The booklet included the agenda and objectives, as well space for goals and reflections and links to complementary resources. She directed participants to a specific page on www.differentiatedservicedelivery.org where all resources for the workshop could be accessed and downloaded (QR code).

Why DSD for chronic disease

The second session included a presentation by Helen Bygrave, a DSD specialist consultant with the IAS, outlining the fundamentals of DSD. This was followed by some reflections from Patricia Asero Ochieng, founder and Executive Director of the Ringa Women Fighting AIDS group in Kenya, on whether recipients of care need DSD for chronic disease.

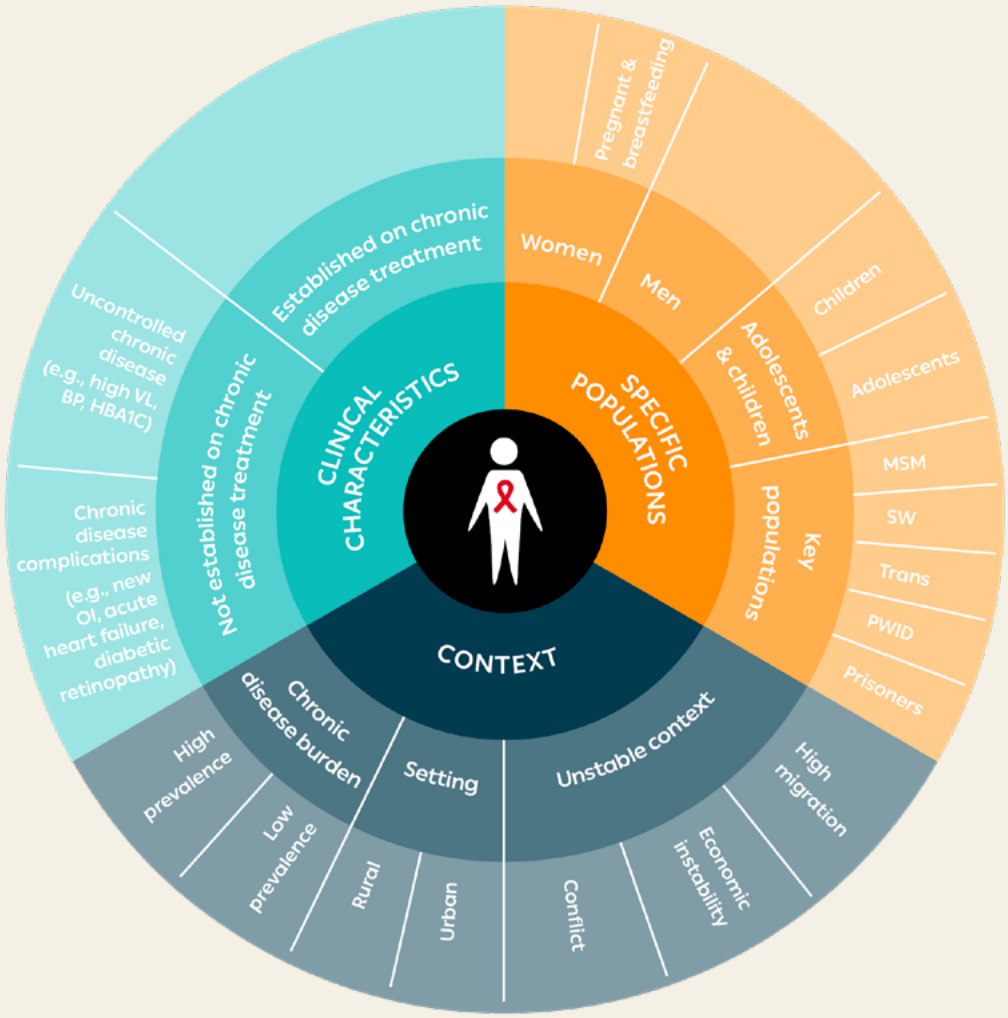
Helen's presentation began with tracing the origins of DSD for HIV from 2008 with adherence clubs in the Western Cape of South Africa and community antiretroviral therapy (ART) refill groups in Mozambique. She shared the original consensus definition of DSD and described how over time, DSD has expanded to include HIV testing services and prevention, in addition to HIV treatment (Figure 2).

Figure 2: DSD for HIV is relevant across the HIV care continuum



Helen outlined the three elements of DSD and how these are also relevant for other chronic diseases (Figure 3). She described how clients are defined as "established on treatment" in HIV, highlighting that the criteria generally include a component of time on treatment, other current illnesses, evidence of treatment success and a measure of adherence. Helen reflected how previously, clinical stability for HIV relied on CD4 and how access to viral load has been an enabler of DSD for HIV treatment. She drew a parallel with how for hypertension, blood pressure testing is available and accessible as a measure of clinical stability, and for Type 2 diabetes, HbA1c could be a key enabler of DSD.

Figure 3: Three elements



Helen explained that once clients are established on treatment, clinical visits can be separated from drug refill visits, and refill visits do not require seeing a clinician. She also emphasized that this is possible if clients have strong treatment literacy of symptoms and signs and seek clinical care outside of clinical visits as required. With the separation of clinical visits and refill visits, the building blocks can be adapted for each visit type. Helen highlighted the guidance provided by WHO for the "when" building block for HIV and hypertension (Table 1).

Table 1: WHO recommendations for frequency of visits for people established on treatment for HIV and hypertension

HIV	Hypertension
"People established on ART should be offered clinical visits every 3-6 months, preferably every six months if feasible", 2021 recommendation "People established on ART should be offered refills of ART lasting 3-6 months, preferably six months if feasible", 2021 recommendation	"WHO suggests a follow up every 3-6 months for patients whose blood pressure is under control," 2022 recommendation

Helen acknowledged that access to longer supplies, especially of other chronic disease medications, can be a challenge. She presented definitions of prescribing, dispensing and distributing, and she emphasized that, particularly when longer supply is a challenge, DSD can facilitate the refill by separating the clinical and refill visits. Where multi-month dispensing is not feasible because of supply constraints, multi-month prescribing should still be used to enable refill models that reduce the burden of chronic care, both for the client and the healthcare system.

Regarding "where" services are provided, she shared WHO recommendations for HIV moving towards out-of-facility ART initiation and maintenance enabled by strong mentorship and supervision and a robust supply chain. On the "who" building block, Helen emphasized WHO guidelines for HIV and hypertension, with distribution of refills being task shifted (Table 2).

Table 2: WHO recommendations for task sharing for people established on treatment for distribution of treatment for HIV and hypertension

HIV	Hypertension
"People established on ART should be offered clinical visits every 3-6 months, preferably every six months if feasible", 2021 recommendation	"WHO suggests that pharmacological treatment of hypertension can be provided by nonphysician professionals such as pharmacists and nurses, as long as the following conditions are met: proper training, prescribing authority, specific management protocols and physician oversight."

Finally, she presented the basics of the four DSD models: group models managed by healthcare workers; group models managed by clients; individual models based at facilities; and individual models not based at facilities. Helen highlighted how any of these could be adapted for other chronic conditions to address client and health system challenges.

From a client perspective, Patricia Asero Ochieng highlighted the pressing need for DSD to be expanded to other chronic diseases. Increasing numbers of people living with HIV are also diagnosed with other chronic diseases like hypertension and diabetes. They are asked to attend multiple clinic visits and are rarely able to collect longer medication refills. Patricia shared her experience of providing services for chronic diseases in Kenya where DSD principles are applied for all chronic diseases and medication provided every three months using a club model. On behalf of people living with chronic diseases, Patricia urged that lessons learnt from scaling up DSD for HIV be looked at for other conditions.

Key enablers for DSD for chronic disease, the hypertension example

Taskeen Khan from WHO started the third session of the workshop, outlining the significant global impact of hypertension. Her presentation provided an overview of the 2021 WHO "Guideline for the pharmacological treatment of hypertension in adults". She emphasized the benefits of a simplified algorithm for hypertension treatment, which includes the use of single-pill combinations to support adherence. Benefits of the algorithm approach include enabling task sharing, simplified implementation, and improvements in logistics and the supply chain. Taskeen shared the two algorithms approved by WHO.

Workshop attendees were invited to view a pre-recorded presentation from Dike Ojji, titled "Experience of stepwise algorithm and single-pill combinations from Nigeria". He summarized the experience of the Managing Hypertension Among People Living with HIV: an Integrated Model (MAP-IT) trial in Nigeria. Dike emphasized the key enablers of: a simplified hypertension protocol; fixed-dose combinations; training of primary care physicians and non-physician health workers on the management of hypertension; favourable policies; and community delivery of services. Details of the study design have been published.

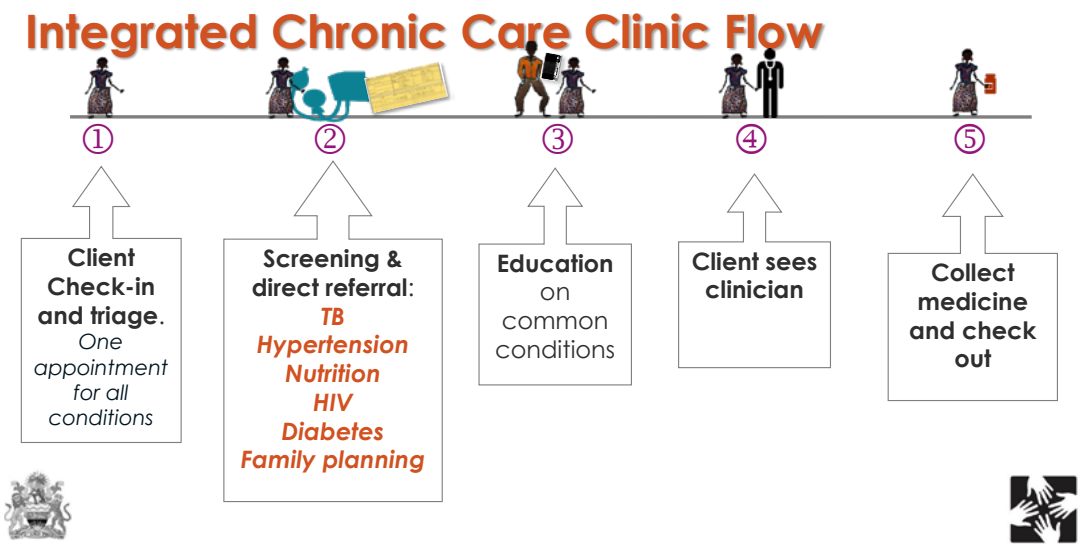
What do we mean by integration?

The emphasis of this workshop was on how DSD could support hypertension and diabetes care, and not on how to integrate hypertension and diabetes care into HIV services. In alignment with this, Gerald Mutungi presented on the "Integrating and decentralising HIV, diabetes and hypertension services in Africa" (INTE-AFRICA) study and Noel Kasomekera presented on the experience of delivering a chronic care service in Malawi. In the final presentation, Martin Muddu shared data from Uganda, where hypertension treatment has been integrated into HIV care.

Gerald Mutungi shared how in the INTE-AFRICA study, primary healthcare facilities in Tanzania and Uganda were randomized to provide integrated or standard care for HIV, diabetes and hypertension. Integrated care in this study meant that any clients with HIV, hypertension, diabetes or any combination of the three conditions were managed in the same clinic setting by the same healthcare workers. Medications were provided from the same pharmacy; medical records, registration and waiting areas and laboratory services were all integrated. Outcomes included better retention, attitudes and experiences of clients, and reduced health system costs.
Gerald outlined the building blocks – "who", "when", "where" and "what" – for both arms of the trial. Retention was high and comparable between groups, with no adverse impact on HIV outcomes and slight improvements noted in blood pressure and blood sugar control in the integrated arm compared with the standard-of-care arm. Stakeholders reported that integrated models reduced duplication of services and HIV-related stigma, as well as led to greater sharing of knowledge. The cost per participant with multiple conditions in the integrated care arm was significantly lower than in the standard-of-care arm, with no cost differences for participants with single conditions.

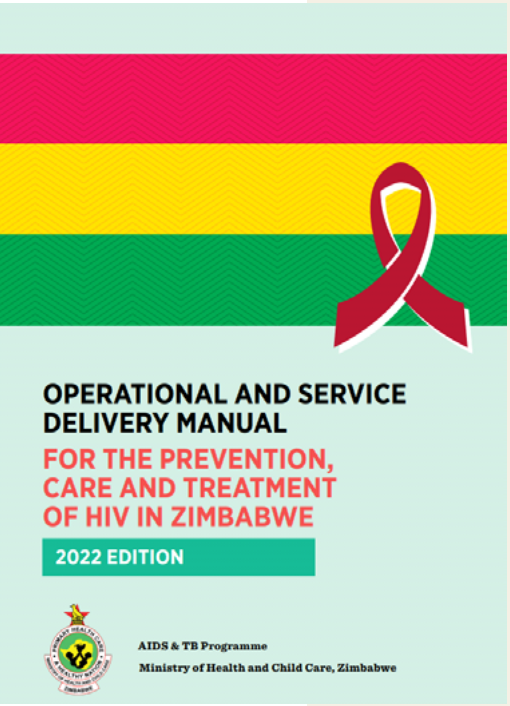
Noel Kasomekera shared the experience of the Neno district's one-stop shop model, implemented by Partners in Health in Malawi (Figure 4). In the 14 facilities in the district, services for several chronic diseases (most commonly HIV, hypertension and diabetes) are provided in one chronic disease clinic. The presentation included qualitative experiences of clients receiving care in this integrated setting, which highlighted the advantages of having one appointment for all conditions. The approach reduced stigma, as one client explained: "When we are accessing care at this clinic, we do not hear any rumours outside that disgrace us … we just come here and receive our drugs [and] then off we go, we don't hear any hearsay …" Economic evaluations were also previously published (McBain et al, Wroe et al).

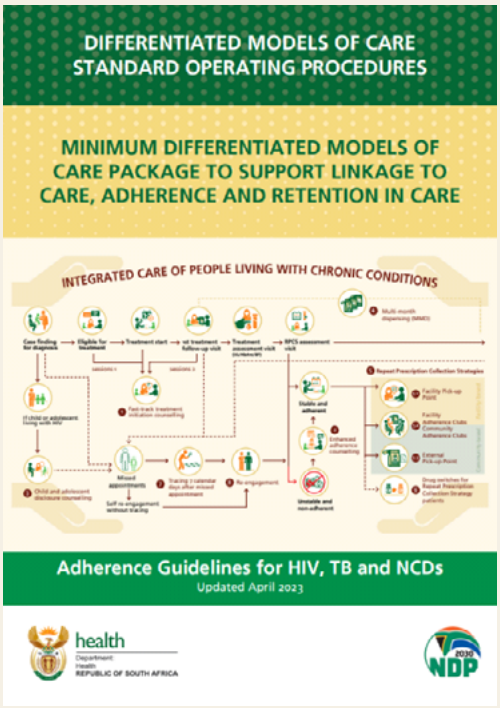
Figure 4: Integrated chronic care clinic flow in Malawi

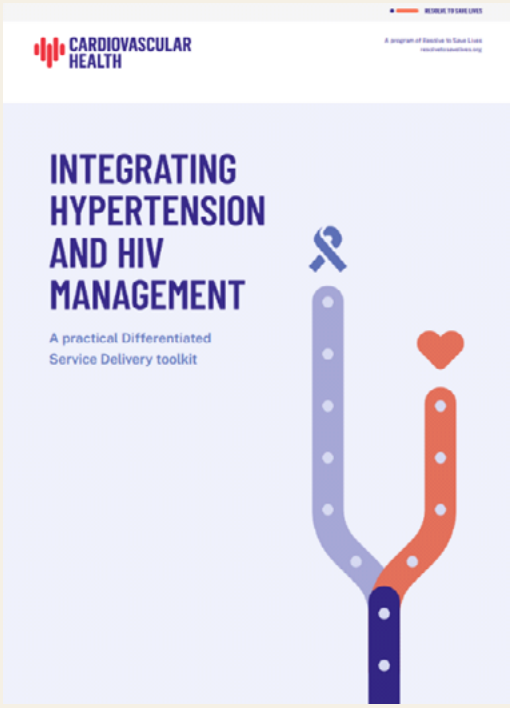


National guidance on DSD for chronic disease

The final series of presentations focused on guidance from and for countries, with presentations from Musa Manganye from the National Department of Health in South Africa, Ronald Nyabereka from the Ministry of Health and Child Care in Zimbabwe, and Osi Kufor from Resolve to Save Lives.







Musa Manganye shared DSD guidelines from South Africa that were developed across chronic diseases. Standard operating procedures (SOPs) have been published to accompany clinical guidelines and present three options for "differentiated models of care" (DMOCs), South Africa's less-intensive DSD models for people living with HIV, hypertension and/or diabetes. DSD models in South Africa include facility pick-up points (FAC-PUPs) and external pick-up points (Ex-PUPs) primarily through private pharmacies and adherence clubs (ACs) in both facility and community locations. More than 2.7 million people living with HIV and another chronic condition were in a DSD model, including 788,995 in a FAC-PuP, 1,707,795 in an EX-PuP and 214,458 in an AC.

Ronald Nyabereka presented the 2022 "Operational and Service Delivery Manual for the Prevention, Care and Treatment of HIV in Zimbabwe". He shared the guideline development process and how there is a definition of "established on treatment" for HIV, hypertension and Type 2 diabetes in the manual, as well as building blocks for screening and diagnosis, initiation, titration, clinical visits and refill visits for hypertension and Type 2 diabetes. To support implementation, the manual is accompanied by a set of job aides and SOPs.

The final presentation, from Osi Kufor, was titled "Integrating hypertension and HIV management: A practical differentiated service delivery toolkit". The toolkit was developed by Resolve to Save Lives. In Osi's overview, he outlined the toolkit contents, which include a resource and needs assessment, criteria for DSD eligibility, and a description of the building blocks and DSD models for NCDs. Osi also shared insights about how the toolkit's support for implementation of multi-month dispensing for hypertension in Nigeria led to improvements in blood pressure control and reduced missed visits.

Day 2
Country action plans

The second day of the workshop focused on developing country action plans. Country teams from Malawi, Nigeria, Uganda and Zimbabwe, each guided by two facilitators, undertook a comprehensive review of national policies related to eligibility criteria and the building blocks for DSD for hypertension and diabetes. The country groups continued discussions on potential DSD models for adaptation, emphasizing multi-month scripting, step-wise algorithms, single-pill combinations, and monitoring and evaluation (M&E). Teams assessed the feasibility and impact of each action point on a continuum, mapping them for consideration.

Teams collaboratively agreed on three to five priority actions, specifying individuals responsible, timelines and required resources. These priorities were then presented in a plenary session.

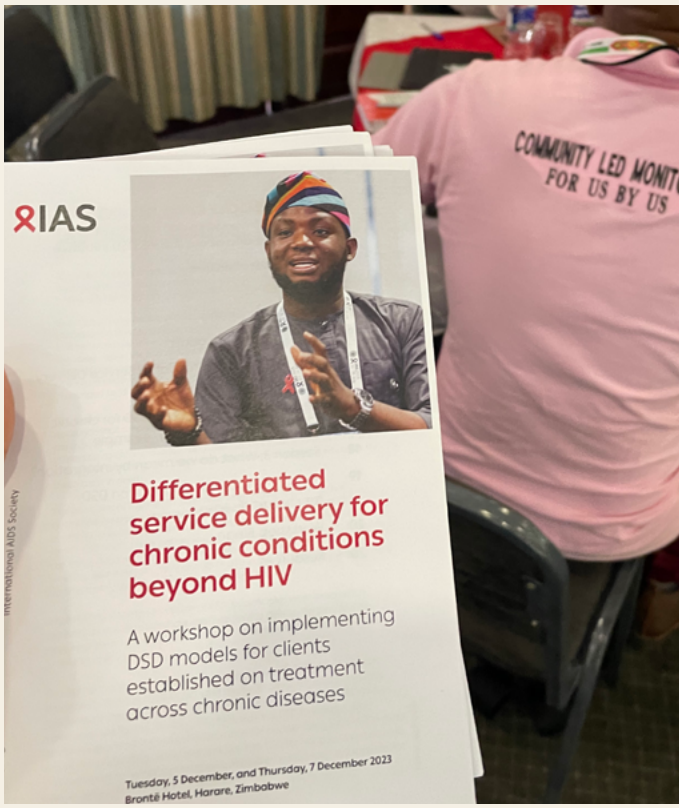


Table 2: Country action plans for DSD for hypertension and diabetes

Nigeria

Action point (in priority order)	By who	Timeline	Resources required
1. **Enhancing coordination and leadership for the integration of HIV and NCD services**	Led by MoH level – HIV, NCD include donors PEPFAR, implementing partners, clients	Start Q1 2024	Human resources (coordinator), financial support
2. **Develop and/or finalize missing SOPs or guidelines, protocols, diabetes algorithm, etc.**	Led at MoH level – HIV, NCD and review committees with experts and involve implementing partners and donors	Develop separate timelines for each of the missing guidance pieces Q2 2024	Human resources, technical expertise, financial support
3. **Disseminate the guidelines to healthcare workers**	Led at MoH level – HIV and NCD	In 2024, all year	Human resources, technical expertise, financial support
4. **Capacity development of healthcare workers and clients**	Led at MoH level – HIV and NCD	In 2024, all year	Human resources, technical expertise, financial support

Malawi

Action point (in priority order)	By who	Timeline	Resources required
1. **Governance structure - debrief meeting to relevant directorates**	Noel Kasomekera, Stanley Ngoma, Beatrice Matanje and Lawrence Khonyongwa	January 2024	Meeting place, conference packages
2. **Revised standardized SOPS**	Beatrice Matanje	March 2024	Conference package, fuel, etc.
3. **Interoperability of M&E system discussions with HIV Department and partners**	Noel Kasomekera, Stone, Stanley Ngoma, CMED, NAC	January 2024	
4. **Operationalization of the initiative – SOPs, tools**	Stanley Ngoma with liaison with Noel Kasomekera	May 2024	Conference packages, travel expenses, stipends, printing expenses

Uganda

Action point (in priority order)	By who	Timeline	Resources required
1. **Develop and implement guidelines for a chronic care model @ PHC**	Gerald Mutungi and Mina Nakawuka	• June 2024 (to develop) • December 2024 (to implement)	Activities: workshops, benchmark, trainings Resources: TA
2. **Increase treatment literacy for people living with chronic conditions & identify approaches to increase client engagement on NCDs chronic care**	Jackson Bitarabeho (Uganda NCD Alliance), Stella Kentusi and Cissy Ssuuna (NAFOPHANU)	Join the guideline development too • Develop a group, look at what's there now (take stock) • Draft a roadmap to define how treatment literacy and client engagement will be done	Activities: input from experts Resources: Financial and TA
3. **Integrate HTN T2DM M&E**	Hudson Balidawa and Baker Bakashaba	Understand what is currently in place in chronic care model • June 2024 (to develop) • December 2024 (to implement)	Activities: workshops, benchmark, trainings Resources: TA
4. **Preferred pricing negotiations with manufacturers & PPPs with pharmacies to sell NCD commodities at discounted rates**	Gerald Mutungi and Martin Muddu	December 2024	Activities: meetings Resources: TA Partners: CHAI, ARC [Pooled procurement? Multi-country conversations?]

Zimbabwe

Action point (in priority order)	By who	Timeline	Resources required
1. WHO country office to support the review of the hypertension guidelines - Need for simplified algorithm	Justice Mudavanhu to reach out to WHO Zimbabwe representative	12 months	Funding
2. Integrated chronic disease training package (HIV, HTN, DM)	HIV integration representative and NCD representative	12 months	Funding
3. Demand creation (using the HIV platforms), advocacy	CSOs, health promotion at the MoH		Funding, Community platforms/ groups
4. Opportunity for adaptation of OSDM for chronic disease			
5. Strengthening M&E for chronic diseases			

In closing

The workshop wrapped up with closing remarks from workshop participants. Mike Reid, PEPFAR's Chief Science Officer, emphasized how timely the workshop was and acknowledged how the HIV epidemic is evolving. As part of this, PEPFAR is working towards sustainable, country-owned progress that includes not just HIV but also other chronic diseases. He mentioned a forthcoming PEPFAR initiative to support five countries to integrate hypertension treatment into their HIV programmes.

Taskeen Khan emphasized the need for countries to adopt a simplified algorithmic approach to hypertension care. Through this, a public health approach to hypertension management could be supported, encouraging task sharing and decentralization of care to primary care.

Anna Grimsrud spoke about activities coming up, starting with an ICASA session on ageing and HIV, including a presentation by Helen Bygrave, the following day. She encouraged the country teams to bring their action plans back to colleagues working with the CQUIN network and discuss how to make progress through CQUIN's integration community of practice and planned workshop in 2024. Anna added that discussions about an integration pre-conference before AIDS 2024, the 25th International AIDS Conference, were taking place. She closed by thanking all those in attendance, including those who had travelled to be there, the Zimbabwe team for hosting the workshop, global partners for their active participation, and IAS colleagues for ensuring good technical content and logistics.

Annex 1: Agenda

A workshop on implementing DSD models for clients established on treatment across chronic diseases

Mornings of Tuesday, 5 December, and Thursday, 7 December, Brontë Hotel, Harare, Zimbabwe

Day 1 – Tuesday, 5 November, 08:00-13:15

Time	Session	Speaker/Moderator
08:00 - 09:35	**1. Introductions and why DSD for chronic disease**	
08:00 - 08:30	**Welcome and introductions**	Anna Grimsrud (IAS, South Africa)
08:30 - 08:45	**Objectives of the workshop**	Anna Grimsrud (IAS, South Africa)
08:45 - 09:00	**DSD: The fundamentals**	Helen Bygrave (IAS, UK)
09:00 - 09:15	**Do recipients of care need DSD for chronic diseases?**	Patricia Asero Ochieng (ICW, Kenya)
09:15 - 09:35	**Country reflection**	All
09:35 - 10:20	**2. Key enablers for DSD for chronic disease: The hypertension example**	
09:35 - 09:50	**How do the World Health Organization's 2021 hypertension guidelines enable DSD for hypertension?**	Taskeen Khan (WHO, Switzerland)
09:50 - 10:00	**The Nigerian experience: The stepwise algorithm and single-pill combinations**	Dike Ojji (University of Abuja, Nigeria)
10:00 - 10:20	**Country reflection**	All
10:20 - 10:50	**Break**	
10:50 - 11:55	**3. What do we mean by Integration?**	
10:50 - 11:05	**INTE-Africa study: Integration of HIV, hypertension (HTN) and diabetes mellitus (DM) within a chronic disease service**	Gerald Mutungi (MoH, Uganda) TBC
11:05 - 11:20	**Delivering a chronic care service: The Malawi experience**	Noel Kasomekera (MoH, Malawi)
11:20 - 11:35	**HTN integration into HIV services: The Uganda experience**	Martin Muddu (Makerere University, Uganda)
11:35 - 11:55	**Country reflection**	All

Time	Session	Speaker/Moderator
11:55 - 13:00	**4. National guidance on DSD for chronic disease**	
11:55 - 12:10	**DSD manual for HIV and non-communicable diseases in South Africa: A chronic disease approach**	Musa Manganye (NDoH, South Africa)
12:10 - 12:25	**Operational and service delivery manual Zimbabwe: Integration of hypertension and diabetes into DSD models for clients established on treatment**	Ronald Nyabereka (MoHCC, Zimbabwe)
12:25 - 12:40	**DSD guidance for chronic disease: Resolve to Save Lives toolkits**	Osi Kufor (Resolve to Save Lives, Nigeria)
12:40 – 13:00	**Country reflection**	All
13:00 - 13:15	**5. Planning for day 2**	
13:00 – 13:15	**Introduction of workshop template**	Helen Bygrave (IAS, UK)
13:15 - 14:15	**Lunch – Brontë Hotel**	

Day 2 – Thursday, 7 November, 08:00-12:30

Time	Session	Speaker/Moderator
08:00 - 08:30	**6. Recap of day 1**	
08:00 - 08:30	**Recap of Day 1**	Helen Bygrave & Anna Grimsrud (IAS)
08:30 - 10:30	**7. Country workshopping**	
08:30 - 10:30	**Country workshopping** Malawi Nigeria Uganda Zimbabwe	With facilitators
10:30 - 10:50	**Break**	
10:50 - 12:10	**8. Country report back**	
10:50 - 11:10	**Country 1**	TBD
11:10 - 11:30	**Country 2**	TBD
11:30 - 11:50	**Country 3**	TBD
11:50 - 12:10	**Country 4**	TBD
12:10 - 12:30	**Reflections and way forward**	
12:10 - 12:20	**Reflections**	TBD
12:20 - 12:20	**DSD for chronic disease road map**	Anna Grimsrud (IAS, South Africa)
12:30 - 13:30	**Lunch – Brontë Hotel**	

Annex 2: List of participants

First name	Second name	Country	Stakeholder group
Patricia	Asero	Kenya	Civil society (HIV)
Baker	Bakashaba	Uganda	Civil society (HIV)
Hudson	Balidawa	Uganda	MoH (HIV)
Neeta	Bhandari	USA	BMGF
Paul	Bitarabeho	Uganda	Researcher/implementer
Besthy Mbua	Bombum	Nigeria	Civil society (HIV)
Marlene	Bras	Switzerland	IAS
Helen	Bygrave	UK	IAS
Claire	Calderwood	Zimbabwe	Researcher/implementer
Cleophas	Chimbetete	Zimbabwe	Researcher/implementer
Jonathan	Chiwanda	Malawi	MoH (NCD)
Peter	Ehrenkranz	USA	BMGF
Lina	Golob	Switzerland	IAS
Anna	Grimsrud	South Africa	IAS
Noel	Kasomekera	Malawi	MoH (NCD)
Taskeen	Khan	Switzerland	WHO
Lawrence	Khonyongwa	Malawi	Civil society (HIV)
Katharina	Kranzer	Zimbabwe	Researcher/implementer
Nicholas	Leydon	USA	BMGF
Musa	Manganye	South Africa	MoH (HIV)
Laytone	Marisa	Zimbabwe	Civil society (HIV)
Beatrice	Matanje	Malawi	Civil society (NCD)
Justice	Mudavanhu	Zimbabwe	MoH (NCD)
Martin	Muddu	Uganda	Researcher/implementer
Gerald	Mutungi	Uganda	MoH (NCD)
Maud	Mwakasungula	Malawi	Civil society (NCD)
Mina	Nakawuka	Uganda	MoH
Stanley	Ngoma	Malawi	MoH (HIV)

First name	Second name	Country	Stakeholder group
Ronald	Nyabereka	Zimbabwe	MoH (HIV)
Tendai	Nyagura	Zimbabwe	Genesis Analytics
Khumbo	Nyirenda	Malawi	Researcher/implementer
Geoffrey	Ogbeke	Nigeria	MoH (HIV)
Kudirat	Olabisi Obelawo	Nigeria	Civil society (NCD)
Kufor	Osi	Nigeria	Resolve to Save Lives
Paul	Otu	Nigeria	Researcher/implementer
Sam	Phiri	Malawi	Researcher/implementer
Mike	Reid	USA	PEPFAR
Amir	Shroufi	Switzerland	Global Fund
Isaac	Ssinabulya	Uganda	Researcher/implementer
Cissy	Ssuuna Nakalema	Uganda	Civil society (NCD)
Sunday	Victor Eze	Nigeria	MoH (NCD)
Maeva	Villard	Switzerland	IAS

Contact details

Find out more

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www.differentiatedservicedelivery.org

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