Overall, stakeholders felt that:
- DSD would improve HIV management, reduce the burden of ART pickup, and build social support
- Success would be dependent upon rigorous, advance and ongoing communication efforts with patients, HCWs, and communities to:
  - raise awareness
  - manage treatment expectations & address emerging myths or misconceptions
- For Test and Treat, pre-implementation sensitisation was viewed as necessary
- to prepare patients for the possibility of immediate ART initiation
- to avoid risk of families and communities accusing newly-initiated persons of having hidden their HIV status
- For models incorporating dedicated ART dispensaries prioritizing clinically stable patients, sensitisation was needed to avoid perceptions of HCW nepotism, favouritism, or corruption.
- For off-hours facility-based and off-site community-based drug-collection groups, patient and community sensitisation was described as critical to minimize stigma, unintentional disclosure and community backlash due to rumours

Background

- In Zambia, over 800,000 adults and children have started antiretroviral therapy (ART)³
- Most patients access ART at “first-generation” services, a network of decentralized, static primary health facilities
- Patient visits are scheduled at inflexible and relatively short intervals ranging from 1-3 months
- Over 25% of patients are lost to follow-up at one year and 33% at two years²
- Differentiated service delivery (DSD) models can leverage community resources, lower patient-side barriers, and improve quality of care

Objective:
We sought to inform implementation of DSD models through understanding and addressing provider, patient and community perceptions about:
- Acceptability – How stakeholders ‘felt’ about and responded to the model overall
- Appropriateness – Stakeholders’ assessment of the psychosocial or clinical implications of the model, including its ability to tackle disengagement from care
- Feasibility – Stakeholders’ perceptions regarding the material capacity of health centre and broader health system to support, to scale-up and sustain the model

Methods

From March to June 2016, in one urban and one rural health centre each in Lusaka, Southern and Western Provinces, we conducted:
- 34 Focus Group Discussions with patients, family members, and health workers (HCWs)
- 26 In-Depth Interviews with government officials and local leaders across 3 provinces

Audio-recordings were transcribed directly into English. Nivo QSR™ was used to sort and organise the data to enable Framework Analysis (Figure 1) and interpretation.

Conclusions

- Prior to DSD implementation, engaging patients, providers, and the community will be key in determining when, with whom, and how frequently sensitisation should take place.
- Both initial and on-going success of DSD strategies in Zambia will depend on:
  - model and audience specific communication
  - timed to the implementation stage
    - to manage change and expectations of which DSD models of care will be offered and to whom.
- Not communicating effectively to the appropriate target groups could negatively impact patient-provider relations and ultimately patient health outcomes.

Acknowledgements:
This work was funded with a grant from the Bill & Melinda Gates Foundation

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