What happened to Zambia's differentiated service delivery models after the 2025 PEPFAR funding cuts?

WHAT IS THE ISSUE?

- January 2025 "stop-work order" (SWO) halted all support for PEPFAR activities in Zambia.
  - ≈84% of Zambia's HIV program was funded by PEPFAR in 2024.
  - Many of Zambia's differentiated service delivery (DSD) models for antiretroviral therapy (ART) were implemented by PEPFAR implementing partners (IPs) with USAID or CDC support.
- USG support gradually returned for some IPs and services over the following months, with funding evolving from month to month.
- We explored the implications of the funding cuts for the sustainability of DSD models.

WHAT DID WE DO?

- **Sites**: Collected data from 24 outpatient healthcare facilities
  - 12 Central and Copperbelt Province sites previously supported with technical assistance and direct service delivery by USAID IPs.
  - 12 Lusaka and Southern Province sites previously supported with technical assistance by CDC IPs.
- **Data**:
  - Facility assessments at all 24 sites in Feb 2026 covering the period from Oct 2024 to Dec 2025.
  - 30 in-depth provider interviews at 10 sites conducted between 30 Nov and 13 Dec 2025.
- **Outcomes**: Changes to DSD model delivery at the study sites as reported by providers.

WHAT DID WE LEARN?

➢ **All core (Ministry of Health-supported) DSD models offered before the SWO were still active at all study sites in December 2025 (Table 1).**
- These included 3- and 6-month dispensing (MMD), scholar/adolescent models, and fast track.
- Two Copperbelt facilities temporarily paused 6MMD, conserving drug stock amid funding uncertainty rather than actual shortage, offering 3-month or shorter dispensing intervals.

➢ **Losses were concentrated in the non-core, IP-supported DSD models (Figure 1, Table 2).**
- 10/24 sites discontinued at least one IP-supported model due to loss of staff, vehicles, other resources.
- One facility in Lusaka discontinued 4 models; another in Copperbelt discontinued 3 models.
- Previously CDC-supported sites reported losing more models than previously USAID-supported sites.

➢ **Facilities adapted models to sustain services.**
- One site reported that the discontinuation of a nearby key population centre increased enrolment in facility-based models, as clients transferred to this facility.
- One site shifted community ART distribution to MOH staff and cut fast-track to once weekly.
- Another site now prioritises men for fast track.
- Other sites scaled back DSD enrolment to match reduced staffing.

Table 1: Continuation of DSD models at the 24 study sites, January-December 2025

DSD model	Number of facilities offering model (n=24)		
	Offered before SWO	Still offered in Dec 2025	Stopped
Core models (mainly supported by Ministry of Health)			
Three-month dispensing (3MMD)	24	24	0
Scholar/adolescent models	23	23	0
Six-month dispensing (6MMD)†	22	22	0
Fast track*	20	20	0
Non-core models (mainly supported by IPs)			
Home delivery	20	18	**2**
Community ART distribution*	13	11	**2**
Community adherence groups (CAGs)	9	6	**3**
Night/weekend clinics	9	5	**4**
Community ART access points (CAPs)*	8	3	**5**
Other facility-specific models	5	5	0

***Fast track** – rapid drug pick-up for stable clients, bypassing consultation and queues. ***Community ART distribution** – refills delivered to clients in the community by outreach teams. ***CAPs** – fixed community pick-up points where stable clients collect refills instead of attending the facility.

Figure 1: Selected DSD models offered at each study site, Jun/Sept 2025 and Dec 2025 comparison

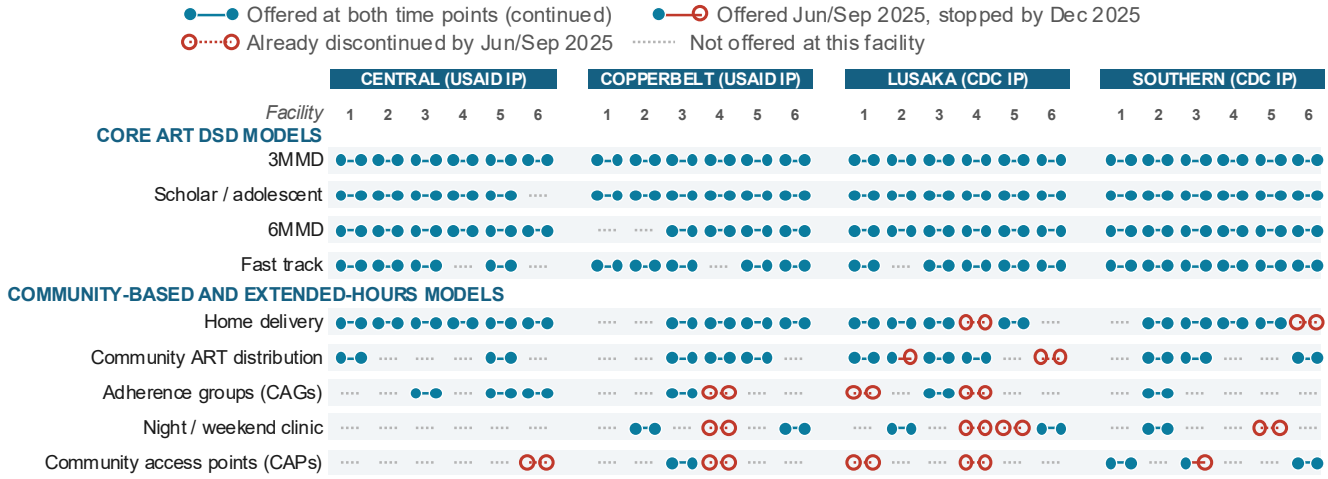

Table 2: Reasons for closures of models across the study sites (N=16 instances of model closure)

Reason cited (multiple responses allowed per model)	Times cited
Loss of IP-funded staff, tasks not reassigned	9
Loss of IP-funded vehicles or transport	6
The model itself was IP-financed	5
Clients were moved into another model	1
Not funding-related (clients were not attending for lab tests)	1

What providers told us:

"The [IP] team that were doing community were completely laid off; we don't have them going in the community to dispense anymore."

"We used to go out for community dispensation, we have stopped. Those people now have to come to the clinic between eight to sixteen (08:00-16:00). This means we have so many clients between eight to sixteen [hours], we are overwhelmed."

"The one which was affected the most was weekend ART because of the reduction in manpower. We were working from morning to 18:00 hours, but because of the shortage in manpower the working hours had to reduce by two hours and also weekend ART had to be put to an end."

"The normal is that if a client is a stable client, the fast-track service would see them fast… We don't have enough manpower and that is making us have clients stay longer at the facility, which is a bit cumbersome for them."

CONCLUSIONS

- Core, MOH-supported, facility-based DSD models largely survived the funding cuts. Fast track, multi-month dispensing, and scholar/adolescent models were still operating in December 2025.
- Across 10 facilities, 16 community-based models and extended hours models that depended heavily on PEPFAR-funded inputs were discontinued, indicating a substantial loss of service delivery choices for clients.
- Facility-based models were sustained by task shifting of responsibilities from IP-supported staff to MOH staff and the return of IP-supported staff.
- Going forward, differentiated models of service delivery should be designed to rely on resources that the facilities and MOH can provide, rather than on external funding.

Ngoma T, Mutanda N, Marri A, Mwale M, Morgan A, Scott N, Haimbe P, Shakwelele H, Sivile S, Rosen S, Mokhele I. What happened to Zambia's differentiated service delivery models when PEPFAR support was withdrawn? SHIFT Policy Brief, September 15, 2026