



Activity 1: Perspectives on Optimal Care

Case 1 - Patient with HIV: Kwabena is a 35-year-old man who presents to the hospital outpatient department (OPD) complaining that his clinic visits make him spend too much time away from his work. He lives in a small village about 5 km from the hospital. He has been on treatment for 7 years with an undetectable viral load. He attends the ART clinic in the hospital outpatient department in the district every two months to collect his ART. The clinic is not too far for Kwabena, but he dislikes having to visit the clinic so often. He works in a local factory and has difficulty explaining to his boss why he needs to take a day off every two months. Physically, he feels really well and is happy to be at work. He arrives at the clinic at 7:00, or earlier if he can, so he can get into the queue. Usually there are about 60 people waiting there, and he sees the nurse around 11:00. As he is feeling well, he spends less than five minutes in her room. His next stop is the pharmacy, where there is a very long queue as everyone from the outpatient department are also there to collect their medicines. Finally, by 14:00, he is on his way home with his ART refill.

What are the barriers to optimal care faced by Kwabena? What would it mean to deliver more 'person-centered care' for him? Should the stage or severity of Kwabena's HIV disease affect the care offered?

Case 2 - HIV Nurse: The HIV nurse works in a clinic within Kwabena's district. He knows that many of his patients walk several hours each way to collect their ART and that many, like Kwabena, have to take a lot of time off work to attend clinic. The nurse told the HIV manager that he feels badly because he can only spend a few minutes with each patient, regardless of their needs. The clinic offers HIV care two days a week, so the HIV nurse has to see 80 clients each clinic day.

What barriers does the HIV nurse face to delivering high quality care? What strategies could the nurse (or the clinic) employ to address these challenges? Does the population (i.e. adults, pregnant women, key populations, men, etc.) the clinic serves affect what strategies are employed?

Case 3 - HIV Manager: The district HIV manager has just attended a national review meeting where concerns were raised about poor ART retention in her district (i.e. how many people with ART 'retained' in care). Health care workers in this district complain that they are seeing too many ART clients each day, and they feel overburdened. The HIV manager wants to consider solutions that might help address the challenges they face.

What are the different factors the HIV manager must consider? What strategies could be employed to address the challenges she faces? Does the context matter (urban vs. rural, high HIV burden vs. low burden, etc.)? If so, how?

Activity 2: Community-based HIV service delivery models

Community-based HIV service delivery models

Example 1: Medication adherence clubs, Kenya

In Kibera, Kenya, the priMercy health care system was seeing a high volume of ART clients, as well as clients with hypertension and diabetes. Building on experiences of group models for stable clients, the idea of medication adherence clubs (MACs) was developed for stable clients with HIV, hypertension or diabetes to meet quarterly in nurse-facilitated groups for health discussions and pre-packed medication pick-up. A total of 1,432 clients have been enrolled into 47 clubs. Clients were predominantly HIV-positive (71%), with 29% having diabetes or hypertension. Diagnosis disclosure was voluntary. A total of 2,208 consultations were offloaded from the routine outpatient clinic and loss to follow up from the MACs was 3.5%. MACs are an example of lay health care worker-managed groups.

Example 2: Community ART Groups (CAGs), Mozambique

In Mozambique, long travel distances and long wait times challenged the scale-up of ART services and long-term adherence and retention. In response, stable patients were invited to self-form into CAGs to take turns attending facility visits for clinical assessment and tests, to report significant events occurring for any of the group members, and for the entire group's ART refill. Group members also provide each other adherence verification and psychosocial support. Between 2008 and 2013, a pilot involving 5,729 PWH demonstrated high rates of retention (98% at 12 months, 96% at 24 months, 93% at 36 months, and 92% at 48 months). CAGs are an example of a client-managed group model.

Example 3: Harm reduction clinic, Mauritius

In response to the growing HIV epidemic among PWIDs, a partnership between civil society and the government of Mauritius initiated harm reduction practices in 2006 that includes methadone maintenance, therapy, and needle and syringe exchange, in conjunction with the scale up of HIV testing and ART access. In 2014, 3,078 individuals accessed the services through fixed sites, vans, backpack outreach workers and peer educators. In total, 719,427 clean needles and syringes were distributed. The incidence of HIV among PWIDs in Mauritius declined from 68.1% in 2011 to 31.1% in 2014. This is an example of a lay health care worker prevention model.

Example 4: "Points de distribution communautaires" (PODIs), Democratic Republic of the Congo (DRC)

In Kinshasa, DRC, HIV services were centralized within hospitals, resulting in overcrowding and long queues with clients travelling long distances, leading to low coverage of ART. In response, fixed community locations managed by expert client volunteers called PODIs were set up to support ART provision. Clients collect ART every three months and visit a health facility annually for clinical assessment. Nearly half of the ART clients (43%) were receiving their ART refills from a PODI. High rates of retention have been observed (94.9% at six months, 89.3% at 12 months, 82.4% at 24 months) and transport costs have been reduced by two-thirds. The waiting time for a PODI ART refill is 12 minutes, compared with 85 minutes in the hospital. The PODI is an example of an individual ART distribution model.

Activity 3: Effectiveness of service delivery models

Patient-level Metrics	
System-level Metrics	