DIFFERENTIATED MODELS OF ANTIRETROVIRAL THERAPY (ART) DELIVERY:

REPORT ON THE RAPID ASSESSMENT STUDY MAY - JULY 2016

ARASA AIDS & Rights Alliance for Southern Africa

ITPC INTERNATIONAL TREATMENT PREPAREDNESS COALITION

Cameroon | Côte D'Ivoire | Kenya | Malawi | Morocco | Tanzania | Zambia

ACRONYM LIST

AIDS	Acquired Immune Deficiency Syndrome
ARASA	AIDS and Rights Alliance for Southern Africa
ART	Antiretroviral therapy
ARV	Antiretroviral
CDDPs	Community drug distribution points
HCW	Health care worker
IAS	International AIDS Society
ITPC	International Treatment Preparedness Coalition
MSM	Men who have sex with men
NGO	Non-governmental organisation
PLHIV	People living with HIV
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organisation

CONTENTS

EXECUTIVE SUMMARY

The ambitious UNAIDS 90-90-90 goals [1] and the implementation of the World Health Organisation (WHO) 2015 recommendation to "treat all HIV-positive individuals on antiretroviral therapy (ART)", has meant that already overstretched "health systems will have to re-examine how ART care is delivered." [2] There is a clear appreciation for the pivotal role that communities have played in the HIV response over the last 32 years. Given the ambitious targets, there is a need to maximise on functional models of HIV service delivery already being utilised in various communities, which are often 'undocumented'.

In this context, the International AIDS Society (IAS) is working on a two-year project to support the implementation of differentiated models of ART delivery. Differentiated care is defined as "a client-centred approach that simplifies and adapts HIV services across the cascade to reflect the preferences and expectations of various groups of people living with HIV, while reducing unnecessary burdens on the health system. By providing differentiated [models of] care, the health system can refocus resources to those most in need." [3] The core underlying principle with Differentiated Care, is to provide ART delivery in a way that acknowledges diversity and preferences in how PLHIV access ART services, taking into considerations the various contexts within which people living with HIV present for care, and how they perform on treatment. These models are piloted, with the appreciation of the barriers faced by specific groups and to advance models that essentially "empowers them to manage their disease with the support of the health system." [4]

Recognising the critical role played by communities in ensuring sustainable, responsive and effective HIV treatment outcomes, the IAS has been collaborating with the AIDS and Rights Alliance for Southern Africa (ARASA) and the International Treatment Preparedness Coalition (ITPC) conduct a rapid assessment in 7 countries in Africa to gauge the 'readiness' of patients and communities to advocate for differentiated models of ART delivery, rather than assuming that this would be a positive development for all communities across the region. The aim of the rapid assessment was to collect real-time information on the perceptions of people living with HIV and communities around existing needs and gaps in the delivery of ART care, and to identify what they may see as potential barriers to the implementation of differentiated (and community-suited) ART delivery models.

Data collectors in Morocco, Cote D'Ivoire, Cameroon, Egypt [5], Tanzania, Kenya, Malawi, and Zambia administered the questionnaire to 35 to 50 respondents in each country, comprising mostly of recipients of treatment and care (PLHIV, including key populations,

[1] By 2020, 90 % of all PLHIV should be aware of their status, 90 % of those that know their status should be on ART and, of those, 90 % should be virally suppressed by 2020.
[2] International AIDS society. Differentiated Care For HIV: It's Time To Deliver Differently. A Decision Framework For Antiretroviral Therapy Delivery. IAS, 2016.
[3] Ibid.
[4] Ibid.
[5] The Egyptian team later dropped out of the study, as they were unable to collect the required data within the time period specified.

EXECUTIVE SUMMARY

adolescents and others) and between five to ten health workers.

Among 266 respondents (221 PLHIV and 45 health workers) surveyed across the nine countries, several key trends were highlighted:

- Challenges related to collective ARVs include lack and cost of transport, lack of time, long queues and waiting times at clinics, and having to miss work and/or school. In addition to challenges related to finances and time, some respondents also described negative experiences related to collecting ARVs, including unfriendly staff, a lack of privacy and discrimination. An analysis of the responses showed that the most frequently mentioned positive impact that people perceive of differentiated ART delivery is the potential to mitigate these challenges.

- Perceptions related to differentiated ART delivery varied widely across countries and key demographics. While the vast majority of respondents across countries indicated that this was of interest to them and that one or more of the proposed models for differentiated ART delivery would make collecting their ARVs easier, results varied across countries in terms of the most popular options (e.g. community drug distribution points (CDDPs) vs. a fast track window within the clinic). Additionally, the survey revealed perceptions on the potential negative impact of differentiated ART delivery models. For example, 37% of responded expressed fear that delivery of their ARVs closer to home would lead to exposure of their status and consequent stigma and discrimination. Similarly, the majority of health workers that were interviewed also expressed the opinion that fear of stigma and discrimination could hinder the successful implementation of differentiated ART delivery, among other key factors including the need for comprehensive training and awareness-raising for health care workers and the communities that they served.

The issues highlighted in the key findings of this rapid assessment should be evaluated whilst developing human rights-based approaches to implementing differentiated ART delivery programmes. Further research and examination could be of use in terms of programme design and advocacy. Nevertheless, increasing awareness and understanding of differentiated ART delivery, and its role in improving health service delivery systems, will have a critical role in successful implementation at any level.

PART 1

SURVEY METHODOLOGY

Countries:
During the planning phase, eight countries were selected, two from each of the four regions within the African continent - for the rapid assessment. These were Morocco, Cote D'Ivoire, Cameroon, Egypt,[7] Tanzania, Kenya, Malawi, and Zambia.

Data Collectors:
Two data collectors were chosen per country. To diversify the coverage, the assessment was undertaken in two different regions/ provinces in one country. The point of this was to document varied views from cohorts in the same country, who could potentially be experiencing care differently due to the specificities of their region or province. For instance, in Cameroon interviews were carried out in the capital city, Yaounde, as well as in the coastal city of Douala. In Tanzania, Dar es Salaam and the Coastal region were covered and in Kenya interviews were carried out in several counties, including Nairobi County, Kericho, Kakamega and Migori County in the west of the country. [8]

The sixteen individuals were selected based on prior knowledge of HIV treatment literacy, access issues and understanding of human rights; as well as their demonstrable capacity to collect data using surveys. These were trusted partners, with clearly aligned experience in the subject matter and realistic prospects of being able to reach out to community stakeholders during the interview process. The data collectors were strategically selected from ARASA and ITPC partner organisations who have been the driving force behind the ARASA/ ITPC Know your Viral Load Campaign which was launched in October 2015 in Lusaka, Zambia.[9] Some of these individuals continue to undertake advocacy under the Know Your Viral Load campaign, which has strong linkages to this piece of work.

Information Provided:
Each data collector was sent the complete questionnaire, a methodological brief and an information sheet with extra guidance. Data collectors were asked to administer the questionnaire to 35 to 50 respondents per country, comprising mostly of recipients of treatment and care (PLHIV, including key populations, adolescents and others) and between five to ten health workers.

Scope of the Research:
The questionnaire contained a mixture of multiple choice and open-ended questions, with the aim of allowing respondents the space to express their views on differentiated ART delivery in their own terms, whilst still providing a framework within which to assess critical trends and links. [10]

[7] The Egyptian team later dropped out of the study, as they were unable to collect the required data within the time period specified.
[8] Annexure III contains a list of data collectors for each country and the provinces that were covered.
[9] International Treatment Preparedness Coalition (ITPC) and the AIDS and Rights Alliance for Southern Africa (ARASA). Be Healthy, Know your Viral Load Campaign. Available at www.knowyourviralload.org
[10] See Annexure 2 for the questionnaire and annexure 3 for the additional information sheet

SURVEY METHODOLOGY

Some key research questions that the questionnaire was aiming to address among PLHIV receiving treatment and care, included

- Are respondents familiar with the idea of differentiated models of care for ART delivery?
- Do respondents perceive splitting up ART delivery from clinical check-ups as a positive development?
- What are the main challenges related to regularly collecting antiretrovirals?
- What specific models of differentiated ART delivery are communities most interested in and what do they think the advantage of this would be?
- What are the primary concerns expressed by communities in terms of the perceived

Limitations:
The survey aimed to be a rapid assessment to gather information across a wide range of countries and communities and to provide a glimpse into some of the existing community perceptions, or the lack thereof, on differentiated ART delivery. Resource and time limitations meant that the sample sizes were small and the sampling was limited to areas where the data collectors could easily and quickly collect responses. Responses were collected from 221 PLHIV and 45 health workers.

Therefore, the findings are not definitive or widely generalisable within regions or countries. They are also limited in terms of being able to extrapolate findings for specific groups, such as key populations. They do however provide insights into some key areas of concern for recipients of treatment and care and potentially indicate areas for advocacy and further in-depth research.

PART 2

KEY FINDINGS

A. Challenges Related to collecting ARVs

Findings show that primary challenges related to collecting antiretrovirals (ARVs) include:

- Lack and cost of transport
- Lack of time
- Long queues and waiting time at the clinics
- Having to miss work and school

Also mentioned:

- Unfriendly health workers, illness and depression, and family contraints

A large proportion of respondents living with HIV described long journeys, several modes of transport and serious issues with transport costs and many hours of waiting at the clinic in long queues every time antiretrovirals are to be collected. It was also apparent that for specific groups such as younger respondents or single income households the break from schedules, such as the day off school or the day off work, was particularly problematic. For instance, younger respondents mentioned challenges around missing exams or test days. Other respondents, especially women, who were the only income earners for their household, also mentioned the difficulty of losing a day's wages. As one respondent from Tanzania explained, "As a single mother with four children who depend on me as the breadwinner, it costs me dearly to come for ARV refilling." [11]

In addition to challenges related to finances and time, some respondents also described negative experiences related to collecting ARVs, including unfriendly staff, a lack of privacy and discrimination. As one respondent from Morocco explained, "At the hospital, we face many difficulties and discrimination from the health staff and deplorable access conditions: waiting outside of the pavilion for PLHIV, no waiting room, collecting ARVs outside under heavy sun and exposed to the sight of all, so no privacy."
However, it is worth mentioning too that responses from specific areas, such as Nairobi county in Kenya, emphasised the positive experiences that PLHIV were having with committed, respectful and compassionate health workers at their facilities.

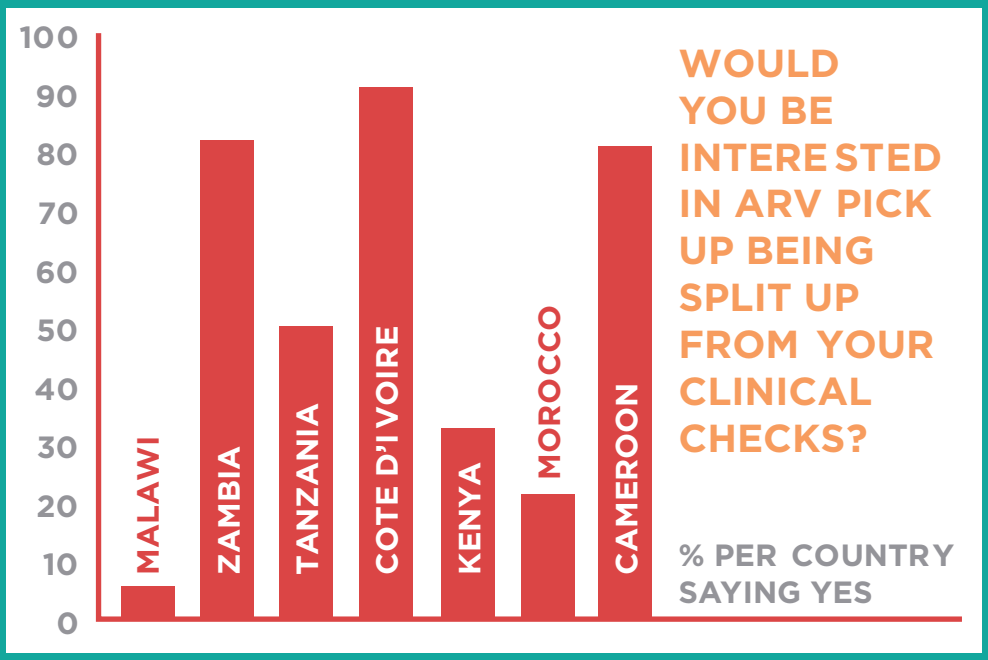
[11] Interview with Female respondent (20-35), Tanzania.

KEY FINDINGS

B. Perceptions Related to Differentiated ART Delivery

As shown in figure 1 below, when asked if ARV collection should be separated from clinical checks, results varied widely between countries, ranging from 92% of respondents in Cote D'Ivoire responding affirmatively, compared to only 6% in Malawi. However, even where respondents did not want this separation, they indicated that one or more of the differentiated delivery options were desirable.

Figure 1: Would you be interested in ARV collection being separation from your clinical checks?



KEY FINDINGS

Four General Models of Differentiated ART Delivery

Only 18 % of all PLHIV interviewed had heard of differentiated models of delivering ART. Once the definition was provided, the vast majority of respondents across countries indicated that this was of interest to them and that one or more of the proposed models for differentiated ART delivery (see text box) would make collecting their ARVs easier. As shown in Figure 2, when asked which delivery model would most suit their needs, although results varied across countries, the most popular options were community drug distribution points (CDDPs) and a fast track window within the clinic.

These options may have been perceived as preferable to the client managed group model/ roster system (which may have been perceived to be a preferable choice, in the context of saving time and money) because of other issues, such as a lack of a supportive peer group, fear of gossip from neighbours, lack of confidentiality and stigma.

1. Facility-based individual models, wherein ART refill visits have been separated from clinical consultations, and clients can proceed directly to a 'fast track window' to get their medication.

2. Out-of-facility individual models where ART refills can be collected at a community drug distribution point (CDDP)

3. Health care worker-managed group models/adherence group, wherein clients receive their ART refills in a group either within and/or outside of health care facilities.

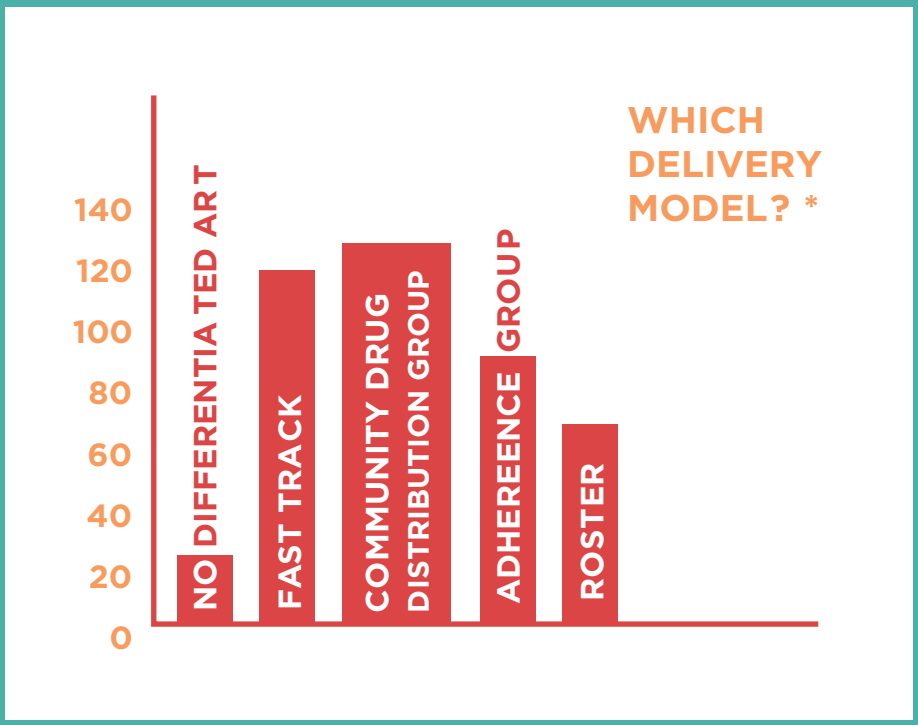
4. Client-managed group model which works on a roster system sharing collection and distribution duties where one person collects the drugs while at a clinic consultation and delivers to other group members, who each get a turn at the clinic.

> **"Participating in a community group is like advertising to the community that I am HIV-positive. This makes me afraid."**
>
> Male,
> 20-35 year-old,
> Tanzania

KEY FINDINGS

In addition, it is possible that adolescent or much older people could find the idea of a roster group intimidating, since they may simply have fewer peers with whom they can share their status. As one 70-year-old man pointed out, "Who will understand why an old man of 70 years has HIV? What can I share with these young people? I am an old man, how do I sit in a support group with people the age of my children and grandchildren." [12]

Figure 2: Which Delivery Model is Preferable?



***Respondents opted for more than one, so results add up to more than the total number of respondents.**

[12] Interview with male respondent, 70 years old, Kakamega County, Kenya.

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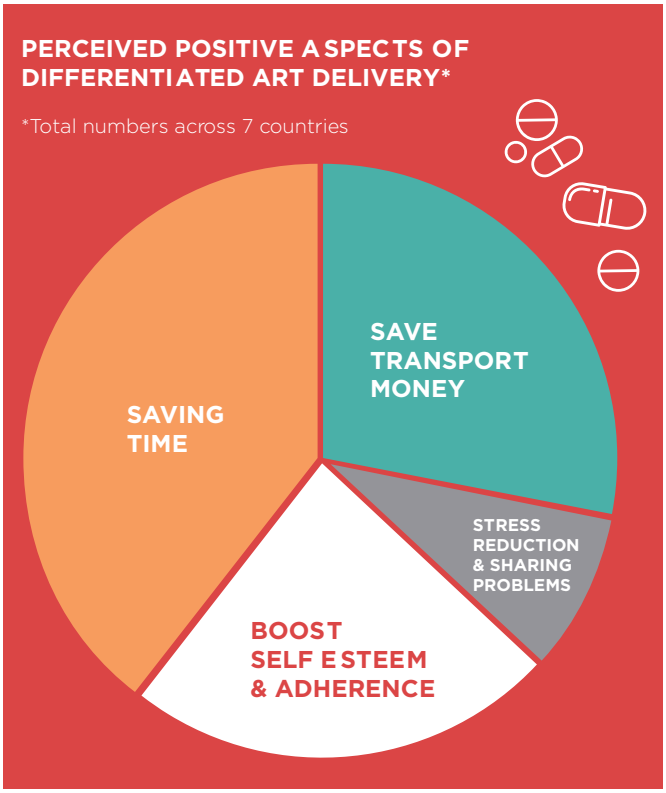
C. What positive impacts might differentiated ART delivery have on your life and treatment?

An analysis of the responses showed that the most frequently mentioned positive impact that people perceive, is the potential of saving time and saving money, specifically on transport costs. As one Zambian respondent explained, "There will be a lot of stigma from my fellow marketeers [other vendors] but I feel I will manage this rather than looking for transport money every time." [13]

> **"This [any of the four models] will save time. I won't have to wait in the long queue. I would recommend this system highly. I won't have to explain why I was seen going to the CCC clinic."**
>
> **Female, 20-35 years old, Kenya**

Figure 3: Perceived Positive Aspects of Differentiated ART Delivery*



Many respondents also mentioned that a system that puts their needs at the forefront would encourage others to join, promote better adherence, provide a sense of autonomy and improve their self-esteem. In the words of one respondent from Morocco, "with differentiated ART delivery, we would feel ourselves [we] exist and less alone." [14]

[13] Interview with female respondent, 20-35 years old, Zambia.
[14] Interview with male respondent, 36-50 years old, Agadir, Morocco.

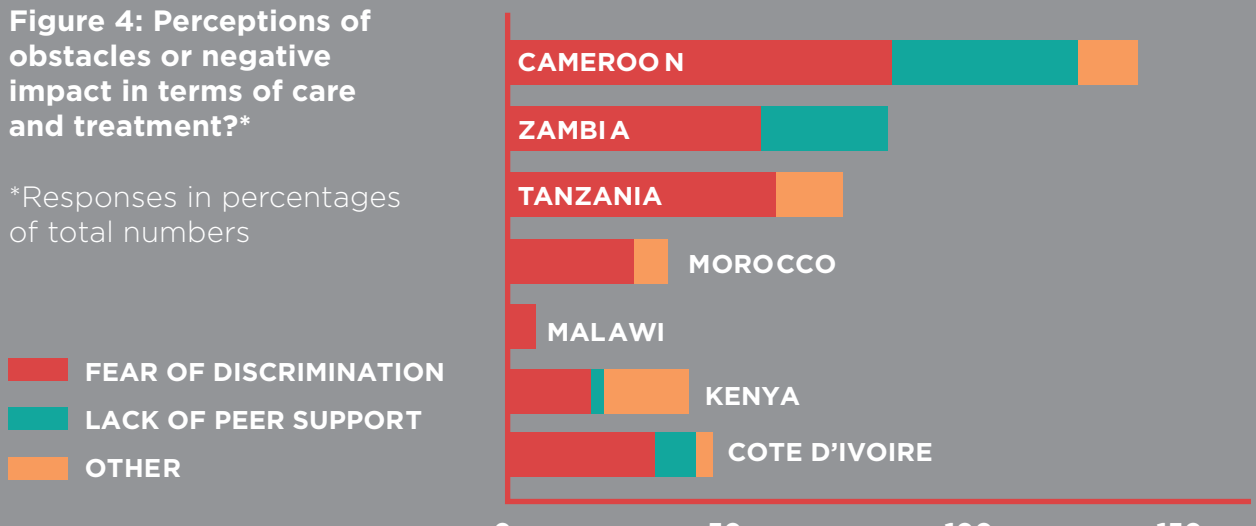
KEY FINDINGS

D. Community Perceptions on Potential Negative Impact of Differentiated ART Delivery models

37 % of all PLHIV interviewed across the seven countries expressed the fear that delivery of their ARVs closer to home would lead to exposure of their status and consequent stigma and discrimination. As seen in the figure above, the country-specific results varied widely, with only 2 % of respondents in Malawi mentioning this as a concern compared to 79 % of respondents from Cameroon. The majority of health workers that were interviewed also expressed the opinion that fear of stigma and discrimination could be a factor hindering the successful implementation of differentiated ART delivery.

Figure 4: Perceptions of obstacles or negative impact in terms of care and treatment?*

*Responses in percentages of total numbers



KEY FINDINGS

It is worth noting that fear of stigma and discrimination was expressed strongly among certain groups, such as younger respondents. As one adolescent girl explained, "most patients would not like other people to know their health status. AIDS is still perceived as a shameful disease. If people, especially my friends, know I am a victim, they might abandon me." [15] Health care worker (HCW) respondents reiterated the fact that certain groups might be impacted by differentiated ART delivery more negatively than others. Most mentioned that school-going adolescents and young people would potentially be among those most adversely affected by implementation, since they would be extremely reluctant to do anything that might expose their status to their friends or broader community. In the words of one adolescent respondent from Zambia, "I have to miss school in order to access treatment, regardless of whether a clinical check is required or not. People at school don't know I am HIV-positive, but they know I go to the clinic like anyone else when I am sick. I worry that with a different system I would be exposed." [16]

This indicates a continuing need for specific types of interventions geared towards addressing the isolation and lack of peer support that many HIV-positive adolescents are experiencing within their communities.

Health workers also suggested that other marginalised groups, such as men who have sex with men and sex workers experience high levels of self-stigma and may avoid any care model which involves collecting drugs closer to their homes.

"Most patients would not like other people to know their health status. AIDS is still perceived as a shameful disease. If people, especially my friends, know I am a victim, they might abandon me."

**Female,
20-35 years old,
Kenya**

[15] Interview with female respondent, 15-20 years old, Tanzania Coastal region.
[16] Interview with female respondent, 15-20 years old, Zambia Kafue District.

KEY FINDINGS

E. Perceptions of Health Care Workers

Although the focus of the rapid assessment was to gather responses from PLHIV, health care workers also constituted a small percentage of respondents in most of the countries. More than 40 health workers were interviewed and most stated that they spent insufficient time with each person living with HIV. Primary challenges mentioned by almost all the respondents were: lack of time; overcrowding; exhaustion; insufficient medical resources and a lack of support or stipends for their work.

"With differentiated ART delivery, more patients get covered and critical patients will get more care."

HCW
Tanzania

The majority expressed the view that differentiated ART delivery would be useful in terms of easing congestion at clinics, ensuring that those needing critical care received more attention and would improve convenience and coverage for PLHIV. However, in addition to concerns about stigma and discrimination discussed above, several also mentioned concerns relating to maintaining adherence, PLHIV becoming less regular with their consultations and people dropping out of treatment if they did not have to go to the clinic.

Almost all health care workers mentioned that any roll out of differentiated ART delivery models would need to be accompanied by comprehensive training and awareness-raising for health care workers and the communities that they served. They specifically mentioned the need for additional training measures to deal with stigma and discrimination within communities so that PLHIV can access treatment and care without fear.

The implementation of treatment literacy programs to educate communities about differentiated ART was also mentioned several times.

PART 3

KEY CHALLENGES AND LESSONS LEARNED

Time Constraints:
A two-month period for planning and design of the questionnaire, recruiting and confirming participation from all data collectors, collation and analysis of data from the countries was insufficient. Given the inevitable delays in terms of local holidays, other project deadlines, communication glitches etc., it would have been useful to have an additional four weeks as a buffer time period. In the event, four of the countries returned the responses in late June rather than by the stipulated deadline of 17th of June, leaving a relatively small window of time to analyse and collate the data. More time (and perhaps financial resources) devoted to this process would also have meant that more could have been expected from the data collectors.

Respondent Profiles and Numbers:
A gap that has become apparent is that in some countries there was very little diversity amongst the respondents. Although various age ranges were represented, it was not clear which respondents represented key populations and therefore more nuanced points relating to their perspectives may have been missed. This could be rectified through additional questions in the questionnaire or through ensuring more clarity with the data collectors in terms of identifying respondents from key populations. One lesson learned is that data collectors could have been asked to set a broader context for the individuals that they are interviewing, as well as the clinic/community wherein the interviews were taking place. It would have been useful to know for instance if an area where only one person mentioned discrimination was a community with stronger peer support, a longer history of training and awareness raising etc.

In relation to numbers, the data collectors were asked to gather between 35-50 responses per country. Strict guidelines beyond this were not provided, so country responses were very varied. For instance, 35 responses from Malawi were received, which did not include any health care worker responses, whereas 50 responses from Tanzania were received, 21 of which were from health care workers. To ensure greater uniformity, more specific numbers could have been stipulated, whilst asking for more information in case specific collectors had limitations in a particular region.

PART 4

RECOMMENDATIONS FROM RESPONDENTS AND FURTHER RESEARCH

1. Integrate sites utilised for ARV delivery with that of medicines for other chronic illnesses so that PLHIV do not feel 'singled out'.

2. Change timings at facilities so that PLHIV can collect their medicines after the end of the school and workday.

3. Recruit more nurses and health workers so that PLHIV do not have to wait for many hours in long queues to receive their medicines or to have their check ups.

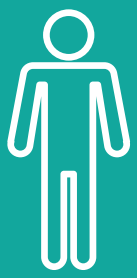
4. Task shift to peers who have an understanding of how to distribute ARVs.

5. In areas where peer educators and health workers make home visits to check on clients and remind them of their next appointment, they should be able to deliver their ARVs as well.

6. Train/re-train health workers and communities on differentiated ART delivery and what it means in diverse contexts. Address concerns related to less monitoring of stable patients to alleviate fear and insecurity about changes in the treatment system leading to illness and even death.

"Time spent to collect ARVs will be saved. The drug distribution point should also distribute other drugs so that patients of all kinds go there. This will be better than the current situation where we have a special place in the health centre and everyone can notice that you are a victim [of HIV]."

Interview with male respondent
36-50 year old,
Dar es Salaam,
Tanzania



7. Raise awareness among health workers and communities on issues related to stigma and discrimination so that HIV is treated like any other illness.

8. Train all community health care workers and ART delivery practitioners in all matters of human rights, sexuality and reproductive health in order to address and solve issues related to ART delivery within the community. This should include further training on confidentiality, which will be more critical than ever if drugs are being delivered closer to home.

9 Ensure that all drugs and essential reagents are available all the time.

10. Encourage more PLHIV to become peer educators.

ANNEXES

I. QUESTIONNAIRE

II. ADDITIONAL INFORMATION SHEET

III. DATA COLLECTOR DETAILS

ANNEXURE I

DIFFERENTIATED MODELS OF ART DELIVERY

ITPC & ARASA QUESTIONNAIRE FOR KEY STAKEHOLDERS

Zambia | Malawi | Kenya | Morocco | Tanzania | Cameroon | Côte D'Ivoire

This survey should be administered to between 35-50 individuals per country. Sources should primarily be individuals who are recipients of treatment and care (PLHIV including key populations) but may also include community health workers and representatives of civil society organisations.

I consent to being interviewed for this project and to having my answers written down/recorded and used in the subsequent data analysis on this topic.

Signature: **Date:**

SECTION 1
PROFILE OF RESPONDENT:

1. What is your gender?

Female ☐ Male ☐ Other ☐

2. How old are you?

15-20 ☐ 20-35 ☐ 36-50 ☐ 50-60 ☐ Above 60 ☐

3. Are you currently receiving ART?

Yes ☐ No ☐

(NB: Section II is relevant for PLHIV currently receiving care and ARV treatment. Section III is relevant for those who are not PLHIV but are health care workers or represent civil society organisations.)

SECTION 2
CLIENT PERSPECTIVES:

4. Can you tell us about how you usually collect your ARVs?

(NB: Encourage the respondents to explain in their own words but please include the following in the data- How often do you visit a clinic/facility? Does it take a long time? How long? What does the transport cost? Where is it? Do you go with anyone? The experience of collection)

5. Can anyone else go to pick up your treatment?

Yes ☐ No ☐

6. Have you ever missed an appointment or been unable to pick up your ARVs?

Yes ☐ No ☐

If yes, why?

Could not take the day off work ☐
Didn't have the time ☐
Too unwell to travel that day ☐
Transport unavailable ☐
Sick family member ☐

Other

If other, please explain.

7. What are the main challenges you face in obtaining your ARV's regularly?

Lack of transport ☐
Cost of transport ☐
Cost of missing work ☐
Lack of time ☐
Illness/depression ☐
Family constraints ☐
Other ☐

If other, please explain.

8. **Would you be interested in ARV pick up being split up from your clinical check ups? (getting medicines without having to have a clinical check up as well each time?)**

Yes ☐ No ☐

9. **When would be the best time of day for you to take delivery of your ARV's?**

10. **What would make it simpler for you to pick up your ARVs?**
(NB: Ask client to express what they might think about this)

11. **Have you heard of 'differentiated ART delivery'?** (NB: Interviewer to provide definition)

Yes ☐ No ☐

12. **Does this sound interesting?**

13. **Would any of the options below make it simpler to regularly obtain your ARVs?**
(Tick one or all that apply)

- Picking up my ARV's at the facility/clinic but at a 'fast track' window rather than having to complete a clinical check every time as well ☐
- Picking up my ARV's close to my home at a community drug distribution point ☐
- Participating in a peer support group or health care worker led group at the facility or in a home or hall close by, where the drugs are distributed ☐
- Participating in a community group and working on a roster system: sharing pick up and distribution duties where one person picks up the drugs while at a clinic consultation and delivers to other group members, who each get a turn at the clinic. ☐

14. **If you feel that the above options would not be useful/relevant to your circumstances, can you explain why?**
(Please tick any that apply)

- I am comfortable with the health workers at the clinic/facility ☐
- I do not want to change my doctor or get used to a new system ☐
- I am worried that I will face discrimination if people living near by find out I am HIV positive ☐
- I do not want my health being discussed by neighbours ☐
- There is no peer support group where I live ☐
- Other ☐

If other, please explain.

15. If implemented within your area, do you think any of the above ways would have a negative impact on you in terms of your care and treatment?

Yes ☐ No ☐

If other, please explain.

16. If implemented within your area, do you think any of the above ways would have a positive impact on you in terms of your care and treatment?

Yes ☐ No ☐

If other, please explain.

SECTION 3
NON-PLHIV PERSPECTIVES:

(NB: These are relevant to health care workers, representatives of civil society organisations working with support groups or community members affected by HIV)

17. How long do patients usually wait at the facility to obtain their ARVs?

Up to one hour ☐ 1 - 3 hours ☐ 3 - 6 hours ☐ All day ☐

18. Are you able to spend enough time with each client?

Yes ☐ No ☐

19. What challenges do you face as a health care worker providing treatment and care within the community to PLHIV?

Lack of time to deal with each client properly ☐

Lack of equipment/medical resources ☐

Lack of information/training or awareness on certain subjects, which might be helpful to clients ☐

Overcrowding at the clinics ☐

Exhaustion ☐

Lack of adequate support for health workers ☐

Other ☐

If other, please explain.

20. Have you heard of 'differentiated ART delivery'?

Yes ☐ No ☐

21. Does this sound interesting?

22. In your opinion, would any of the options below make it simpler for PLHIV to regularly obtain their ARV's?

(Please tick any that apply)

Picking up ARV's at the facility/clinic but at a 'fast track' window rather than having to complete a clinical check every time as well ☐

Picking up ARV's close to home at a community drug distribution point ☐

Participating in a peer support group or health care worker led group at the facility or in a home or hall close by, where the drugs are distributed ☐

Participating in a community group and working on a roster system: sharing pick up and distribution duties where one person picks up the drugs while at a clinic consultation and delivers to other group members, who each get a turn at the clinic. ☐

23. Would any of the above approaches be appropriate in your region /community?

Yes ☐ No ☐

24. What specific barriers or challenges do you feel would hinder the implementation of different models of ART delivery in your region/community?

(NB: this is deliberately open ended to find out what the person thinks)

25. Are there specific sub groups that might be adversely affected by changing how ART is delivered? If yes, please explain?

26. What additional support do you think might be needed to effectively implement a differentiated approach to ART delivery within the region where you work?

(NB: for instance think about additional training so that health workers can adequately communicate to the community, establishing or engaging with peer support networks, ensuring specific criteria are met and monitoring viral load as well as being aware of implications related to stigma/discrimination)

ITPC & ARASA ADDITIONAL INFORMATION SHEET FOR DATA COLLECTORS

1. CONSENT AND INTRODUCTION

Please ensure that everyone you interview specifically provides consent to being interviewed and to having their answers recorded, and provides a signature at the top of each questionnaire.

Please briefly introduce the project in your own words - the following information from the methodology brief could be included:

The International AIDS Society (IAS) is working on a 2-year project to support the implementation of differentiated models of ART delivery, as part of efforts to reach the ambitious "90-90-90" targets. As one part of this project, IAS will be undertaking a series of in-country consultations to pilot these deliverables.

In order to provide better treatment delivery options at community level and to effectively promote patient-centered models of care, through this concept of 'differentiated models of ART delivery'; the IAS will be working with the AIDS and Rights Alliance for Southern Africa (ARASA) and the International Treatment Preparedness Coalition (ITPC) to engage with civil society and communities on the continent.

Aligning this work to the on-going "BE HEALTHY-Know your Viral Load" campaign; ARASA and ITPC have engaged us to assist them in undertaking targeted assessments of community and patient perceptions; looking into what community think works and what needs to be improved, in order to promote decentralized and patient-centered models of ART delivery.

NB: Throughout the questionnaire you will see 'NBs' in blue-these are brief notes to the data collector as points to speak about or be aware of for the specific question.

2. WARM UP QUESTIONS

The primary point of this questionnaire is to gather information on what perceptions PLHIV receiving care and treatment might think about differentiated ART delivery. In order to make the questionnaire manageable in terms of length, the questions are therefore very specific. However, if the data collector feels they need to chat more and provide some context before getting to the main body of questions, that is fine. Suggested examples of questions that you might want to use if you feel the respondent needs to speak more about their experiences:

Do you feel that health workers at the clinic listen to you?

Do health care workers understand /respond appropriately when you ask for something?

Do you feel your confidentiality is respected?

Have you faced discrimination from other clients at the clinic?

Please note -we do not need these responses recorded.

3. DEFINITIONS

In question 10- the data collector needs to provide the definition of 'differentiated ART delivery.' Please use the following definition:

> **"Differentiated care is a client-centered approach that simplifies and adapts HIV services across the cascade to reflect the preferences and expectations of various groups of people living with HIV (PLHIV) while reducing unnecessary burdens on the health system. By providing differentiated care the health system can refocus resources to those most in need."**

4. DATA SOURCES AND SUBMISSIONS

We will require data from between 35-50 individuals in each country.

Sources should primarily be individuals who are recipients of treatment and care (PLHIV including key populations) but if possible should also include community health workers and representatives of civil society organisations.

Please scan and send completed questionnaires via email. These may be sent in clusters rather than waiting until, the end of the process. For instance data collectors could send completed interviews at the end of each week. Please label each questionnaire by country, respondent/questionnaire number and category: For instance-

Kenya Resp. 10 PLHIV

Kenya Resp. 13 Health worker

ANNEXURE III

COUNTRY	NAME	ORGANISATION	REGION
CAMEROON	Yves Yomb Jules Eloundou	Alternatives Cameroon Humanity First	Yaoundé Douala
COTE D'IVOIRE	Iriebi Gboh Coulibaly Gaoussou	I-CHANGE - Abidjan STOP TB Bouake	Abidjan Bouake
MOROCCO	Morgane Ahmar Myriam Benhamou	ALCS - Casablanca ALCS - Agadir	Casablanca Agadir
KENYA	Patricia Ascero Charles Odhiambo Orony	DACASA DACASA	Nairobi Rongo
TANZANIA	Joan Chamungu Samwel Ebenezeri	TNW+ Childrens' Dignity Forum (CDF)	Dar es Salaam Coastal Towns
MALAWI	Gift Trapence Safari Mbewe	CEDEP Malawi Network of People Living with HIV (MANET+)	Lilongwe North Malawi
ZAMBIA	Owen Mulenga Michael Gwaba	TALC	Kafue District Shibuyunji District