

# PATA 2017 CONTINENTAL SUMMIT

‘TOWARDS AN AIDS FREE AFRICA - DELIVERING ON THE FRONTLINE’

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**WAITING EFFICIENTLY: IMPLEMENTING  
DIFFERENTIATED SERVICE DELIVERY MODELS HAS  
REDUCED CLIENT WAITING TIME**

*Dr. Naiga Fairuzi*

*Baylor College of Medicine Children’s Foundation Uganda Clinical  
Center of Excellence*

**UGANDA**

# What you did and how you did it

## What we did

- In 2014 we adopted fast track (pharmacy) refills for children aged 6 years and above, all adolescents and adults.
- The inclusion criteria was any person on ART aged 6 or more years, on cART for at least 12 months, had a current viral load below 1, 000 cp/ ml, was T- Stage 1 or 2 and did not have any DAIDS event grade 3 or 4.
- In 2015, we deployed young people PLHIV to support health workers at the clinic e. g pill counting, TB screening, health education.
- In April 2016 we introduced an electronic queuing system at the clinic.
- In April 2017, after the MoH guidelines we segregated our HTS, HIV care and treatment to fit the community and facility based DSDM models proposed and adopted a community volunteer led model (clients aged 18 years and above or their adult care givers) to deliver ART to homes or agreed upon venues of clients who met the eligibility criteria for fast track refills. We sought clients opinions on the models.



## How we did it

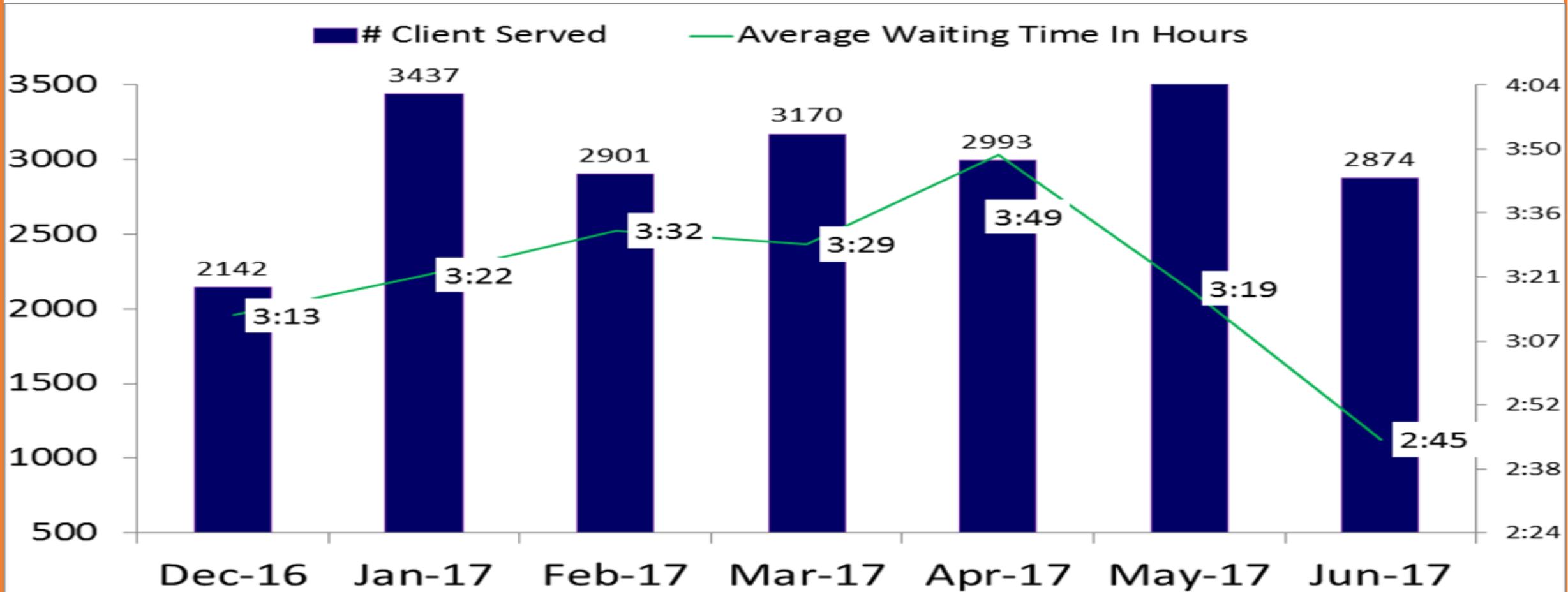
- The M& E team provided an electronic list of eligible clients eligible for fast track refills or community volunteer supported ART distribution and placed stickers on the their electronic medical records such that any nurse or doctor could see who was eligible and offer the service.
- Job adverts were run during peer support meetings and also on clinic days to encourage young people to apply and support the clinic. Those who scored 50% or more on interviews and were virologically suppressed were recruited as volunteers (33 of them to support a clinic with 7, 600 clients) to work under the direct supervision of a health worker. The PATA peer led model training materials were among tools used to train the new volunteers.
- All clinic staff and clients aged 10 or more years were trained on how to use the electronic queuing system.



## Challenges encountered

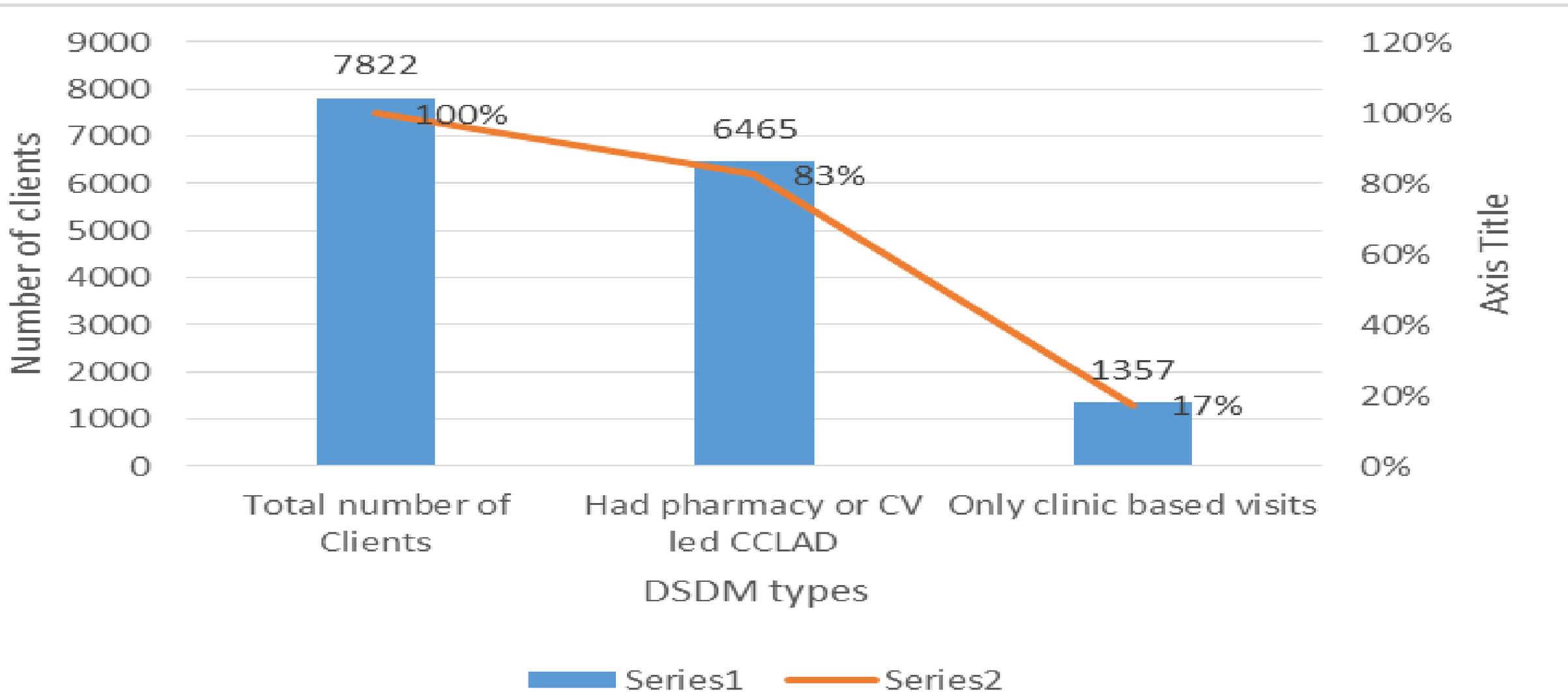
- Scheduling pediatric and adolescent clients was almost impossible due to the requirement to draw blood for VL every 6 months. If today was a VL bleed visit the next was for results review followed by another blood draw appointment. Visits were 3 monthly.
- Older adolescent and young people objected to community ART refills, they considered the health facility as a social meeting place.
- September- January were peak months with heavy clinic bookings for viral load testing since they coincided with national scale up for this service.
- Periodic low staffing levels especially when those engaged with the conduct of research could not attend to general care clients.

## Successes: Reduced waiting time



## Successes:

Approximately 83% of the clients have had either a fast track refill or a community based ART delivery. VL suppression is between 90 and 99%.



## Best practices/ key lessons

- Scheduling for 6 monthly VL is possible and clients with detected VL are identified and recalled for intensive adherence counselling within one week of the facility receiving results. No need to have return VL review visit as clients get.
- Clients were engaged in developing community based HIV care and treatment models. Over 750 clients and their care givers were involved in planning how to implement differentiated service delivery models (DSDM). Through voting by show of hands in various engagements it was observed that 77% of 277 adults preferred the community volunteer program to deliver ART to their homes while 65% of 214 adolescents, young people and youth opted for facility based fast track pharmacy refill visits.
- Engaging PLHIV to offer less technical services at the health facility relieved workers of heavy work loads yet bringing satisfaction to clients because they were a part of decision makers for their care.
- Multiple factors affect waiting and should be addressed collectively.

- Clients report to the receptionist first before their fast track refills and whoever has a detected VL is redirected to see a clinician and counsellor and disqualified from the visit.
- Clients represented by community volunteers to collect their medicines are screened for tuberculosis, assessed for adherence, malnutrition, SGBV and this information is delivered to the clinician on a health screening tool.
- Need to carefully select eligible clients from the same villages/ zones so that their clinic assessments and community ART pick ups by a volunteer coincide.



## **How these lessons are applicable/ scalable to frontline providers**

- Selecting role model PLHIV with viral suppression to support health workers with the less technical roles.
- Selecting children older than 6 years and adolescents stable on ART for community ART delivery and fast track refills.
- Screening clients returning for fast track refills for tuberculosis and viral load status and redirecting them to see a clinician as needed.
- Engaging PLHIV to give their views on how DSDM models should be run.



**Thank you!**

