A peri-urban model of community-based care with integrated HIV services

Médecins Sans Frontières

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Summary

Background and objectives
In Khayelitsha, a township of nearly 500,000 people, health services are generally no more than a 15 minute walk from any one location, yet still many people do not access care at health facilities for a variety of reasons. Reaching these patients is vital, particularly in the attempt to manage the HIV epidemic. Community-based services support the principles of differentiated service delivery (DSD) and community-orientated primary care, creating patient-centred healthcare that reduces or removes some facility barriers to engagement. Community outreach services also offer a potential avenue to decant busy clinics. For HIV services particularly, there is a need to find and link those not accessing antiretroviral therapy (ART); community-based models are believed to provide a route to find those not accessing facilities and provide an acceptable option to encourage testing, initiation and retention in care.

In 2017, together with the community, the Treatment Action Campaign and the Department of Health (DoH), Médecins Sans Frontières (MSF) designed the Outreach Initiation and Management (OIM) pilot as a comprehensive out-of-clinic service designed to address specific barriers to care for populations that weren’t accessing facility based care. The particular focus was HIV services but integrated preventative, acute and chronic disease management into the model. The aim was to evaluate the use of outreach models as a strategy in Khayelitsha (a large peri-urban settlement outside Cape Town with over half a million inhabitants and nearly 50 000 people on ART) to: attract people from difficult to reach subpopulations (e.g. youth and males), initiate and retain HIV-positive people on ART, decant primary health care facilities, and feasibly provide comprehensive and acceptable services in a community setting.

Description of OIM
OIM offered services with extended working hours (9am-6pm weekdays and 9am-2pm on Saturdays) in a mobile trailer in one neighbourhood (two separate sites) in Khayelitsha. It was an extension of a DoH primary healthcare clinic, which supported with medication, laboratory testing, referral and complex clinical management. The OIM staff, employed by MSF (one nurse, one patient usher and two lay counselors) provided HIV testing and treatment, family planning, screening and management for sexually transmitted infections and non-communicable diseases. MSF also provided support for monitoring and evaluation, community engagement and health promotion.

Lessons learned
Quantitative and qualitative evaluations demonstrated several insights:

1. Attract people from difficult to reach subpopulations, e.g. youth and males,
Overall, 50% of the headcount was made up men (particularly employed men), youth and those with previous infrequent testing habits – populations who are traditionally difficult to reach with routine services. OIM was successful in attracting these populations with targeted adaptations to make the service more appealing, such as extended opening hours and free WIFI.
Despite male and youth specific adaptations such as prioritisation on specific days (male-focused Saturday services) or times of day (prioritisation of school-going youth in the afternoons), in creating a service that overcomes barriers that reduce access to care for ‘hard to reach’ populations, the service was bound to be a more convenient and acceptable for all patients. Even those who reported good health-seeking behaviour and would otherwise have engaged with DoH clinics, preferred OIM to facility-based services as it was more convenient, safer and friendlier. These patients can be seen as ‘collateral benefit’ in reaching the target populations, regardless of proportions of the headcount.

2. **Initiate and retain HIV-positive people on ART**

Already well-described elsewhere, OIM demonstrated that initiating patients on ART at the site of HIV testing results in excellent linkage: the linkage to care for initiating ARVs was significantly higher than that expected for the same population in a community setting in Khayelitsha, with 71% of patients initiated ‘same day’ and 79% initiated within three months (compared with 62% in facilities). However, retaining people in ART care remained a challenge; an expected outcome when targeting those who traditionally have difficulty engaging with facility services. Those who were retained had good outcomes, with virological suppression equivalent to national averages.

3. **Decant primary health care facilities, primarily HIV services**

The decanting potential was never fully realised, with only 384 ART patients and three DSD clubs. Differentiated models like adherence clubs and quick pick-up clubs could be expanded to relieve more of the burden on the host primary care facility, as OIM provides a site where ART medication could be dispensed, support activities could be conducted and clinical procedures could be completed.

4. **Feasibly provide comprehensive and acceptable services in a community setting.**

The strong partnership between MSF and the DoH meant that OIM did not require a significant injection of resources, as the host clinic was able to manage all support functions. The human resources were however, an addition to the system and are an expensive component of the model. The same comprehensive package of services could be provided in a static community venue, such as a community hall or in a school, which avoids the need for a mobile trailer and the associated logistics and security concerns. However, wherever services are provided, it is important to choose a location with a large enough population that testing saturation is not reached and that the service can sustainably provide value in the long term.

The pilot reinforced that it is crucial to include the community in discussions from start to finish; ensuring security, buy-in, attendance and relevance. The steadily increasing headcount showed that it takes time for a community to trust new services and consider them as an option when faced with a health issue that requires attention (clinical problems being the trigger to seek care reported by most interviewed patients). Intensive mobilisation (including door-to-door) was needed upfront to build momentum, but once the service had become established in the community, word of mouth was the best form of advertisement. Continued marketing on low-cost platforms (like social media and radio) combined with good visibility and continued community engagement, helped to keep OIM an option at the front of people’s minds.

Handover processes require wide engagement to establish buy-in and should adapt the systems to the capacity and priorities of the incoming organisation. They should be started as early as possible, as time is required for
proper training and mentorship, troubleshooting problems as well as handover of the community relationship without breaking their trust.

Conclusions and recommendations

The OIM model demonstrated that using an existing primary care facility to support outreach community services, traditionally used extensively in rural settings, is feasible and valuable in a peri-urban, low income setting. A primary care facility can provide all support functions, with the main additional cost to the system being human resources. Managing patients entirely in the community is beneficial and acceptable. This was particularly successful for HIV care, from testing to initiation and maintenance on treatment, but integration of other preventative and management services made the model more attractive and reduces HIV-associated stigma. Community models also provide a service to people who are traditionally difficult to reach and may not otherwise be accessing health facilities.

Further adaptations could optimise the use of resources and find feasible ways to scale the decanting potential for HIV and other chronic health services. Addressing barriers to accessing treatment is crucial in managing an evolving HIV epidemic as well as for other health issues, and peri-urban settings similar to Khayelitsha should consider community outreach models as a feasible, patient-centred option to decant busy clinics and reach people not otherwise accessing care.

Summary of the adaptations to OIM services (compared to facility-based services)

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Adaptation</th>
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<tbody>
<tr>
<td>Providing convenient and patient-centred primary care services in a feasible way</td>
<td>Provision of services in the community as an outreach of the host primary care clinic</td>
</tr>
<tr>
<td>Patients employed or studying full-time have difficulty accessing services during working hours</td>
<td>Extended late afternoon (until 6pm) and Saturday services (9am-2pm)</td>
</tr>
<tr>
<td>Long waiting times deters people from accessing services for treatment</td>
<td>Fast service with limited waiting times</td>
</tr>
<tr>
<td>HIV stigma deters people from testing or accessing services for treatment</td>
<td>Comprehensive package of preventative, acute and chronic care located in the community</td>
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<tr>
<td>New service not yet established in the community</td>
<td>Marketing of services including door-to-door mobilisation initially, then through social media, radio, community engagement and visibility of the service in the community</td>
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<tr>
<td>In general, men do not engage optimally with services</td>
<td>Male-focused Saturday service</td>
</tr>
<tr>
<td>In general, youth do not engage optimally with services</td>
<td>Male patients prioritised</td>
</tr>
<tr>
<td>Negative staff attitudes deter engagement with services</td>
<td>Male-specific services including prostate cancer screening and assessment and referral for erectile dysfunction</td>
</tr>
<tr>
<td>Difficulty linking patients to ART from HIV testing sites</td>
<td>Free WIFI in the waiting area</td>
</tr>
<tr>
<td>Challenging retaining ART patients in care</td>
<td>Youth in school uniform are prioritised after 3pm</td>
</tr>
<tr>
<td>Security concerns providing services in the community</td>
<td>Counsellors trained on youth-friendly approach</td>
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<tr>
<td><strong>Challenge</strong></td>
<td><strong>Adaptation</strong></td>
</tr>
<tr>
<td>Staff trained on a ‘Welcome approach’</td>
<td>Initiation of ART at the site of testing in the community</td>
</tr>
<tr>
<td>Introduction of the ‘Welcome approach’ to support a welcoming attitude towards patients, as well as manage patients who are struggling with ART in a differentiated model of care</td>
<td>Community engagement and employment of an usher from the community</td>
</tr>
<tr>
<td>Storage of the trailer on the hospital ground with 24 hour security at night</td>
<td></td>
</tr>
</tbody>
</table>
## Contents

Summary ........................................................................................................................................... 2

1. Abbreviations and Figures ........................................................................................................... 6

2. Introduction and aims .................................................................................................................. 7

3. Description of the OIM service .................................................................................................. 10

4. Results, lessons learned and discussion .................................................................................... 16

   4.1. Attract people from difficult to reach subpopulations ....................................................... 16

   4.2. Initiate and retain people on ART ...................................................................................... 25

   4.3. Decant primary healthcare facilities ................................................................................... 29

   4.4. Feasibly provide comprehensive and acceptable services in a community setting .......... 31

5. Summary and conclusions .......................................................................................................... 39

6. References .................................................................................................................................... 42

7. Appendix ...................................................................................................................................... 47

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1. Abbreviations and Figures

Table of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
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<tr>
<td>CHC</td>
<td>Community health center</td>
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<tr>
<td>CoCT</td>
<td>City of Cape Town</td>
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<tr>
<td>COPC</td>
<td>Community-orientated primary care</td>
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<td>DoH</td>
<td>Department of health</td>
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<tr>
<td>DSD</td>
<td>Differentiated service delivery</td>
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<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<tr>
<td>IQR</td>
<td>Interquartile range</td>
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<tr>
<td>MSF</td>
<td>Médecins Sans Frontières</td>
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<td>NIMART</td>
<td>Nurse initiation and management of ART</td>
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<td>NPO</td>
<td>Non-profit organization</td>
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<tr>
<td>OIM</td>
<td>Outreach initiation and management</td>
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<tr>
<td>QPUP</td>
<td>Quick pick-up</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<tr>
<td>TAC</td>
<td>Treatment action campaign</td>
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<tr>
<td>VL</td>
<td>Viral load</td>
</tr>
<tr>
<td>VPUU</td>
<td>Violence Prevention through Urban Upgrading</td>
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<tr>
<td>WCDOH</td>
<td>Western Cape department of Health</td>
</tr>
</tbody>
</table>

Table of Figures

Figure 1 Proportion of males and youth in OIM headcount over time ........................................... 16
Figure 2 Day of first attendance by gender ....................................................................................... 17
Figure 3 Employment statuses of survey respondents by sex and age .................................................. 18
Figure 4 Proportion HIV-positive among those testing over time ....................................................... 18
Figure 5 Survey results of self-reported health issues in the preceding 12 months ............................. 19
Figure 6 Proportion of patients who were first-time testers or who had not tested in over a year, by quarter ........................................................................................................................................ 20
Figure 7 Survey results showing where patients would seek care if experiencing various ailments .... 20
Figure 8 Hours of patient arrival on weekdays and Saturdays .............................................................. 22
Figure 9 How attendees first heard about OIM (self-reported), by sex and age ................................ 23
Figure 10 OIM linkage to ART initiation over time .............................................................................. 25
Figure 11 Route of entry into the OIM ART cohort .............................................................................. 26
Figure 12 6- and 12-month retention in care by quarter of ART initiation ........................................... 27
Figure 13 Retention in care at 6- and 12-months at OIM, CoCT male-only, youth-only, and general PHC clinics, June 2017-December 2019 ........................................................................ 27
Figure 14 4- and 12-month viral load completion and suppression by quarter of ART initiation ........ 28
Figure 15 OIM headcount by quarter .................................................................................................... 29
Figure 16 Number attending OIM ART care (“OIM”), clubs, and QPUP by quarter ............................. 30
Figure 17 Snapshot of the OIM handover dashboard timeline ................................................................. 35
2. Introduction and aims

2.1. HIV in South Africa

In South Africa there are 7.7 million people living with HIV, constituting 13.2% of the South African population\(^1\) and making South Africa the country with the largest HIV-positive population in the world\(^2\). Being on antiretroviral therapy (ART) reduces HIV-associated morbidity and mortality\(^3,4\), and without ART to suppress their viral loads, people living with HIV are more likely to transmit the disease to their sexual partners\(^5-7\), perpetuating the epidemic. Although South Africa has the largest ART program in the world, in 2019 34% of HIV-positive people were not on ART and HIV led to an estimated 69 162 deaths\(^1\). To meet the 95-95-95 targets and the sustainable development goal to “end the HIV epidemic by 2030”, we need to intensify efforts to find and link those not accessing ART services.

2.2. Specific Challenges for Males and Youth

Two populations with elevated risk of poor engagement with ART services (both in linking to and retention in care) are males\(^8,9\) and youth\(^10,11\), compared to females and older adults respectively. Both of these are priority populations in PEPFAR’s Country Operational Plan 2020\(^12\).

In South Africa just 58% of HIV-positive men are on ART, compared to 64% of women. Moreover, in 2017 36% of HIV-positive South Africans were male, but males accounted for 52% of AIDS deaths in that year\(^1\). This has been observed throughout sub-Saharan Africa, where men are less likely to present for HIV testing and initiate ART\(^13-19\). Men in ART programs are also more likely to be lost from care\(^8,9,17,20-31\) and have worse clinical outcomes\(^15-17,29,32-40\). Despite this, there is limited evidence for successful interventions to address poor male HIV outcomes in low- and middle-income countries\(^36,37,41\).

Like men, youth are hesitant users of public health facilities, expressing concerns about privacy and confidentiality, health care worker attitudes, cost and access to services as barriers to enter facility based HIV care\(^42\). Among South African youth aged 15-25, 7.1% are HIV-positive\(^1\), with a 1% annual incidence, translating to 88000 new infections in 2017\(^43\). In that year, just 40% were on ART, compared to 63% of HIV-positive adults aged 25-49\(^44\). South African adolescents consistently show poorer retention in care compared to adults\(^45\). Similarly, throughout sub-Saharan Africa youth (aged 15-25) have poorer retention than adults over 25 years old\(^10\). HIV-positive youth are a growing population\(^46\) facing many years on ART, so it is important to identify strategies to engage them with ART services.

2.3. Differentiated service delivery and community orientated primary care

Differentiated service delivery (DSD) models have been an important tool in the scale-up of ART. DSDs include patient-led community adherence groups, facilitator-led adherence clubs, and the use of ART pick-up points\(^47\). These models often benefit ART patients through reducing waiting times and provision of peer support, and have also helped to make the health system more efficient by freeing up clinicians’ time. While DSDs can be run from healthcare facilities, many DSDs use community venues, often decreasing travel time and costs for patients, and helping to decant facilities. Stable patients in
Community-based adherence clubs have shown good retention and clinical outcomes in South Africa\textsuperscript{48,49} (including among adolescents\textsuperscript{50}), Democratic Republic of Congo\textsuperscript{51}, and Mozambique\textsuperscript{52}.

While much emphasis has been placed on the efficiency gains of DSDs in the management of stable patients\textsuperscript{53}, models catering to specific subgroups also add value. Improved retention has been observed in DSDs targeting virally unsuppressed patients\textsuperscript{54}, youth\textsuperscript{55–57}, and postnatal mothers\textsuperscript{58}. There is a growing recognition that adapting services to specific contexts, clinical needs, and subpopulations can contribute to improved ART coverage\textsuperscript{47,53}.

Community-orientated primary care (COPC) is a long-standing strategy emanating from the Alma Ata Declaration in 1978 that aims to integrate primary care and community medicine to bring relevant, accessible and comprehensive services to people where they live\textsuperscript{59}. This strategy supports the involvement of the community in the promotion of its health and creates comprehensive and holistic programmes that respond to needs evident in a particular setting. Extension of health services beyond the primary care facilities is an integral component, including outreach services\textsuperscript{59}.

The COPC approach is supported by the National and Western Cape Department of Health\textsuperscript{60}, and is prioritised in setting targets as a way to strengthen healthcare delivery to address the burdens of chronic diseases as well as HIV and TB\textsuperscript{60}.

2.4. Outreach Initiation and Management

From 2017 to 2019, Médecins Sans Frontières (MSF) piloted the “Outreach Initiation and Management” (OIM) DSD in Khayelitsha, South Africa. Building on the lessons of community adherence clubs and another community based pilot named “Wellness Hubs”, OIM is a community-based model that offers the full spectrum of HIV services as well as some other medical services. OIM is an example of a DSD that addresses the needs of specific hard-to-reach groups, aiming to address barriers to initial engagement with HIV testing services and continued engagement that men and youth are particularly sensitive to. These barriers include transport costs, waiting times and the stigma associated with attending known ART facilities\textsuperscript{42}. There is also some evidence that when HIV testing and ART initiation are both conducted in the community, linkage is improved, possibly by reducing the delay between diagnosis and initiation\textsuperscript{61}. We thus hypothesized that OIM could overcome some of the challenges in reaching, linking, and retaining those that are not already engaging with facility-based services, including men and youth.

This report evaluates the use of a community outreach health service as a strategy to

5. Attract people from difficult to reach subpopulations, e.g. youth and males,
6. Initiate and retain HIV-positive people on ART,
7. Decant primary health care facilities, primarily HIV services;
8. Feasibly provide comprehensive and acceptable services in a community setting.
2.4.1. Setting

Khayelitsha is a large peri-urban community located on the outskirts of Cape Town, South Africa. It is home to approximately 500 000 people, with children under the age of 14 representing 30% of the population, and a further 46% of the population between 15 and 34 years old. The ratio of men to women is approximately 50:50. Over 50% of the population is living in informal housing (shacks), with the remaining people living in formal (brick) housing. The population is extremely mobile, with many people moving between the informal settlement and a neighbouring province. Most adult Khayelitsha residents were born in the Eastern Cape and retain close links to the rural areas where they are from. Additionally, high rates of unemployment, violence, mental health issues and substance abuse contribute to poor engagement with health services.

Khayelitsha has the highest HIV prevalence in the Western Cape province with an antenatal sero-prevalence of 31% and nearly 50 000 adults on ART in 2020 - one of the longest standing and largest treatment programmes in South Africa. There are two main government health service providers in Khayelitsha: City of Cape Town Health (CoCT) and Western Cape Provincial Department of Health (WCDOH). The CoCT runs 11 slightly smaller health clinics in Khayelitsha (including two specialized youth clinics: Site B Youth and Site C Youth, and two specialized male clinics: Site B Male and Kuyasa Male) while the WCDOH run three very large Community Health Centres (CHC), with ART cohorts approaching 10 000 patients each.

2.4.2. Endlovini

The OIM services are based in Endlovini an informal area in Khayelitsha, with a population of approximately 26 000. Endlovini is the first major and unplanned expansion of Khayelitsha and has fewer resources than other areas of Khayelitsha, with no tarred roads and mostly informal housing. It is served by Michael Mapongwana Community Health Centre, a provincial clinic, with 8790 patients on ART as of June 2020. The clinic is an approximate 10-15 minute walk from Endlovini.
3. **Description of the OIM service**

3.1. **Development of the model**

In 2013 MSF collaborated with the Western Cape Department of Health and the Treatment Action Campaign (TAC) to start the ‘Wellness Hub’ project. The Wellness Hubs are small, permanent health structures, staffed by one nurse and one counselor, and provide free HIV services integrated with other health services like TB screening, chronic disease medication refills and family planning services. There were two Wellness Hubs in Khayelitsha in informal areas, one linked to Site B CHC and one linked to Site C CHC.

The Wellness Hubs were developed in line with the ward based approach - established in 2011 in South Africa as part of a series of strategies to strengthen primary health care. Community mobilization and engagement was a key part of the model. Its main success was in increasing HIV testing for adolescent females. However, men were poorly represented and extension of HIV services into under-served communities was never fully realised. This limited the alleviation of the burden on existing health care facilities and promotion of better health care outcomes through early testing and linkage to care. Both hubs were handed over in 2014 and have been fully managed and staffed since by the WCDOH. However one of these hubs has since closed, primarily due to vandalism in 2018.

This Wellness Hub pilot showed that community-based health services are well accepted but need continuity in their community messaging, that they are not expensive to run and they reduce the burden of existing health facilities. The OIM model was an evolution of the Wellness Hub concept, and was developed in line with DSD and COPC principles: with participation from the community it serves, the sub-structure DoH, the host clinic Michael Mapongwana CHC, TAC and MSF.

Mobile services have been successful in providing care for rural patients where distance is a major challenge in accessing services. In the urban settlement of Khayelitsha where all people are within a few kilometres of a facility, OIM attempted to use mobile services to apply COPC principles and bring care closer to communities to address other challenges to access such as stigma, travel time and cost and waiting times.

The community and community forums were consulted at the start once an agreement had been reached between MSF and the WCDOH to launch the activity. Community engagement assisted in planning, varying from decisions on location and service provision, to designing and the painting of the trailer and toilets. A slogan for OIM came out of the community participation: “Ithuba lakho” which means “your health, your responsibility”. OIM opened its doors to patients in June 2017.
3.2. OIM facility

OIM services were situated at two sites in Endlovini: on the main road (Ezipalini zika gas) and adjacent to the soccer field at the VPUU (Violence Prevention through Urban Upgrading, another organization that operates in the area). The services were provided from a mobile clinic trailer with three consulting rooms. A separate trailer provided toilets for staff and patients, and a gazebo and chairs were provided for the waiting area. Electricity was obtained from the community and VPUU. Free wireless internet was offered to all patients, particularly targeting youth, while they were in the waiting area.

3.3. OIM services

OIM offered services five days a week, open from 9am to 6pm during the week (closing slightly earlier in winter if no patients are waiting), and 9am to 2 pm on Saturday. Males were prioritized on a Saturday and youth after 3pm on a weekday. The OIM clinic was closed on Wednesdays to allow for maintenance, data capturing, medication inventory and to allow the staff off-time. Free WIFI was provided for patients in the waiting area.

OIM functioned as an extension of Michael Mapongwana Provincial Community Health Centre. The provincial clinic supported OIM with medication, consumables, laboratory services and clinical support: Michael Mapongwana was the referral centre for OIM patients and DoH clinicians supported the OIM staff in the clinical management of more complex cases. OIM was staffed by a professional nurse (with a specific HIV
management qualification - NIMART), two lay counselors and a lay usher employed through MSF.

All patients accessing the OIM were first seen by the usher (health navigator) who managed the queue and referred them to the counsellor to offer them HIV testing, irrespective of their reasons for presentation. The usher also provided a liaison with the community and assisted with security information. The counsellors provided HIV testing and ART management counselling. The nurse provided diagnostic and clinic management services for HIV (ART initiation and management), sexually transmitted infections (STIs - screening and treatment), family planning and non communicable diseases (screening and treatment).

3.3.1. ART management

Newly diagnosed HIV positive patients were initiated on ART under Universal Test and Treat guidelines. ART was provided by the NIMART nurse to newly initiated patients, patients restarting treatment at OIM after previously disengaging from other facilities or patients transferred in to OIM from Michael Mapongwana CHC. PIMA point-of-care CD4 was offered during the beginning of the service but was stopped one year later as it was a barrier to sustainability and easy handover. Patients with low CD4 counts or significant acute illness were referred to Michael Mapongwana CHC for medical management. Stable patients were referred back to receive care at OIM.

Stable ART patients had the option of two differentiated service delivery models: community adherence clubs and Quick Pick-up (QPUP), which were facilitated by the OIM counselors and for which the clinical visits were completed at OIM once a year. These were managed according to Western Cape DSD model guidance and eligibility.

Patients who were restarting or struggling with their ART (e.g. gaps in care or a high viral load indicative of poor adherence) were managed with a ‘Welcome Approach’ – incorporating principles from another MSF pilot, the Welcome Service (a differentiated model of care for patients who are not coping well with ART and are not engaging optimally with HIV services – see appendix). This included specific counselling content and support, the following of an algorithm for clinical management and a welcoming attitude from the staff.
3.3.2. Other services

Additional services were offered to reduce the stigma of an ‘HIV service’ in the community and to attract people who would not otherwise access facilities, in order to increase the reach of HIV testing. Patients were screened and referred to Michael Mapongwana CHC for initiation of chronic disease treatment, and OIM continued the management of these patients once they were referred back. Patients were screened symptomatically for sexually transmitted infections (STIs) and treated syndromically as per guidelines. Partners were also traced and managed.

Family planning (oral or injectable hormonal contraception and condoms) was offered at OIM as a mechanism of attracting youth to the clinic. Prostate cancer screening and erectile dysfunction assessment with private prescriptions for treatment (not available through the DoH) was offered to attract men.

3.3.3. Targeting men and youth

OIM practiced general principles to create a patient-centred service for all attendees, including providing differentiated models of ART collection, a welcome and friendly approach, confidentiality and provision of counselling. Some adaptations targeted men and youth in particular but had some collateral benefit for other patient groups.

MSF’s experience with male services in Khayelitsha and elsewhere in South Africa showed that men appreciate extended hours, prefer interacting with male staff and make use of STI screening and management services as an entry point into the system, and can then be opportunistically offered HIV testing. Thus OIM was planned to open earlier and stay later than DoH facilities, as well as open on a Saturday. OIM was also operated mostly by male staff and a male nurse led the team for most of the pilot’s duration (from Q2 2017 until Q2 2019). STI screening and management was also integrated into the package of care and advertised widely.

Community consultation provided an opportunity for the men in Endlovini to express that they did not want to sit in the waiting area with women and wanted services that specifically addressed male health concerns. Thus the Saturday service was designated as a ‘male-focused’ day, where men were prioritised (rather than not allowing women to attend at all) and male-specific services like prostate cancer screening and the assessment of erectile dysfunction (with referral for medication from private pharmacies as it is not provided by the DoH) were promoted.
Based off the success of youth-focused services piloted by MSF in Khayelitsha, the lessons learned were applied to OIM in order to attract youth, including point of care CD4 testing and rapid ART initiation to reduce losses between HIV diagnosis and ART initiation\textsuperscript{76}. The point of care testing was later dropped to make the model more scalable. Family planning services were integrated into the model as these had shown success in attracting young women in the Wellness Hub pilot and free WIFI was also advertised as being available while waiting to see the OIM clinician. Extended hours were also found previously to be important to encourage youth engagement with services\textsuperscript{76}, particularly late afternoons and weekends to accommodate school-going children. In order to increase numbers further, OIM started to prioritise patients in school uniform in the afternoons.

3.4. Community engagement

Community engagement was vital for a number of reasons

1. It established ownership of the programme and buy-in from the community and community leaders
2. It ensured that services were relevant to the community’s needs: an important tenant of the COPE approach\textsuperscript{59}
3. It contributed to the security of the trailer and the team
4. It facilitated advertisement of the service and health promotion activities

The team undertook mobilisation and health promotion activities to both advertise the OIM services and attempt to change health-seeking behaviour, particularly of men and youth. A TAC member voluntarily coordinated a team of community mobilisers, identified by community stakeholders, to conduct door-to-door mobilisation on Wednesdays when the clinic was closed. The MSF staff also advertised the services on local radio, through social media and via community events such as soccer tournaments. Public holidays like ‘Youth Day’ were capitalised on for events that attracted specific target groups like the youth.

Community consultation and feedback sessions were held quarterly, and workshops were conducted to identify ways for the service to respond to the community’s needs. Male-focused Saturdays were implemented in response to suggestions brought up at a community consultation meeting.
3.5. **M&E data**

OIM Data was captured by the MSF data clerk on Wednesday when the clinic was not operating. The data was captured from the patient folders and HIV consent forms into tier.net. Monthly reports were sent to the WCDoH substructure (including the headcount, HCT tallies and the Tier.net dispatch file). This was an important component to ensure that the service was embedded in the DoH system and that the headcount from OIM continued to count towards Michael Mapongwana CHC’s totals.

3.5.1. **Data Sources**

We evaluated this pilot using a mixed methods approach that encompassed both quantitative and qualitative research.

Quantitative data included the collection of routine medical data through registers and audits and tier. Unless otherwise specified, routine clinical data is reported for the period June 2017 to December 2019. As the first two quarters of the service represent small numbers and an evolving service, these are excluded when describing trends over time. We also conducted a self-reported survey with patients attending OIM for the first time (conducted by the counsellors) on health-seeking behaviour, and in particular HIV testing. We conducted a small audit of family planning data for a selected quarter, as this was not routinely electronically captured.

The qualitative component consisted of 16 individual interviews conducted with participants aged between 20 and 42 years old. A focus group interview was conducted with five participants. The individual interviews looked at motivations for attending OIM and current health-seeking behaviour. The focus group explored health seeking behaviour. The majority of the participants in the focus group were new to OIM services, though one had attended numerous visits for family planning. Table 1 below summarises the participant demographics.

**Table 1 Summary of interview and focus group participant characteristics**

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>% female</th>
<th>median age (IQR)</th>
<th>% HIV-positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual interviews</td>
<td>16</td>
<td>43.8%</td>
<td>32 (29.8-36)</td>
<td>18.8%</td>
</tr>
<tr>
<td>Focus group</td>
<td>5</td>
<td>100%</td>
<td>26 (26-29.3)</td>
<td>unknown</td>
</tr>
</tbody>
</table>

Where data is available we compared our outcome data to that of clinics run by the City of Cape Town Health Department, and other available data in the literature.
4. Results, lessons learned and discussion

The implementation of OIM aimed to:

1. **Attract people from difficult to reach subpopulations**, e.g. youth and males,
2. **Initiate** and retain HIV-positive people on ART,
3. **Decant** primary health care facilities, primarily HIV services;
4. **Feasibly** provide comprehensive and acceptable services in a community setting.

4.1. **Attract people from difficult to reach subpopulations**

OIM was developed to target people who were under-represented in accessing clinic services, particularly men and youth. Here we describe the demographics, health characteristics and health-seeking behaviour of OIM attendees to evaluate whether the model did reach the intended targets.

4.1.1. **Demographics**

OIM had an average headcount of 506 people per quarter. The median age was 29 (IQR: 23-37). The proportion of youth under 25 years old rose from 29% in Q4 of 2017 to 48% in Q4 2019, due in large part, we suspect, to the prioritisation of youth after 3pm, the availability of WIFI and the easy access to family planning out of a clinic setting. Our overall proportion of youth (33%) compares favourably with CoCT clinics in Khayelitsha over the first four quarters of OIM’s operation, where the proportion of the headcount aged 15-25 was 20%.

Despite creating a Saturday service where men were prioritised, and offering male-focused services such as erectile dysfunction assessment and prostate cancer screening, women predominate in the OIM population. Women also have a strong presence in Khayelitsha, with 42% of households headed by women\(^4\). Overall, men made up 26% of the headcount over the period of evaluation, comparable to 31% in the abovementioned CoCT clinics. The proportion of male attendees remained fairly constant (21% to 29%) over the two year period (Q4 2017-Q4 2019), with a peak of 38% coinciding with a soccer tournament that was held to attract males in Q4 2017 (when headcount was lower and a single event could change the proportion significantly). These trends are shown by quarter in Figure 1.

![Figure 1 Proportion of males and youth in OIM headcount over time](image-url)
Male-focused Saturdays were implemented in response to requests from men in the community during a community consultation meeting. There were still a greater proportion of women than men attending the Saturday clinic, but Saturday services did attract both a larger proportion (47%) and a larger number (nearly 1.5 times greater than a Friday) of men than weekdays, particularly impressive considering OIM closed after lunch on the weekend (Figure 2).

![Figure 2 Day of first attendance by sex](image)

Of 983 patients surveyed from 5 March (end of Q1) 2019 to the end of Q4 2019 (58% of 1685 new patients in the period), 21.6% were male and 39.4% under 25 years old (Table 2).

<table>
<thead>
<tr>
<th>N</th>
<th>983</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>median [IQR]</td>
<td>28 [22.2-35.9]</td>
</tr>
<tr>
<td>under 25, n (%)</td>
<td>387 (39.4%)</td>
</tr>
<tr>
<td>Over 25, n (%)</td>
<td>589 (60.6%)</td>
</tr>
<tr>
<td><strong>Gender</strong>, n (%)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>214 (21.6%)</td>
</tr>
<tr>
<td>Female</td>
<td>769 (78.2%)</td>
</tr>
<tr>
<td>Missing</td>
<td>2 (0.2%)</td>
</tr>
</tbody>
</table>

Table 2 Demographics of survey respondents

Overall, 38% were employed (Figure 3) compared to about 46% for adults (aged 20 to 59) in Khayelitsha. Employed patients were a target group during the planning of OIM, as employment is often cited as a barrier to accessing facility services as they are only open during working hours. However a large proportion of the male attendees were employed (61%) suggesting that OIM is particularly convenient for this group.
4.1.2. Health Characteristics

4.1.2.1. HIV status

Over the course of our presence in Endlovini, 100 known positive patients (evidence of HIV on routine data systems) joined the OIM ART program. Among those attending OIM who did not know their status, nearly all patients were tested for HIV, and in the last quarter of 2019, 97.5% of the attendees received an HIV test. The positivity rate declined over the two-year period OIM was present in the community, from 9-11% in the latter half of 2017 to 3-4% in the latter half of 2019 (Figure 4). After the initial high positivity rates, we continued to find positive cases, which is a valuable contribution to controlling the epidemic.

![Figure 3 Employment statuses of survey respondents by sex and age](image)

4.1.2.2. General health

Most participants in the qualitative interviews reported never having been seriously ill and only one referred to herself as a ‘sickly person’. Most patients that were surveyed had had minor medical issues...
in the preceding 12 months but a fifth had had a major medical issue (see Figure 5). Only 2% reported mental health concerns in the preceding year, but this may be under-reported due to stigma surrounding mental health. 11% of the participants used services for preventative medicine. In a three-month period (Q1 2019), 42.9% of the 630 patients that visited the OIM, primarily engaged with services for family planning.

![Survey results of self-reported health issues in the preceding 12 months](image)

**Figure 5** Survey results of self-reported health issues in the preceding 12 months

### 4.1.3. Health seeking behaviour of OIM attendees

Health seeking behaviour was explored using quantitative and qualitative evaluations. It has been sub-divided into accessing care in general, accessing OIM care and choice of OIM for services.

#### 4.1.3.1. Prior engagement with the health system

**HIV testing history**

Overall, 12% of those tested for HIV had not tested in over a year and 5% had never tested (of which 6.7% tested positive and 63.3% of these initiated ART). These were an important target population of OIM as they are people who had not been reached by standard testing services.

The proportion of first-time testers remained fairly constant between 1 and 3%, peaking at 12% in the first quarter of 2018 when the service was still new. In 2019 we began to monitor the number of people who had not tested in over a year, which ranged between 10 and 16% (Figure 6).
Proportion of patients who were first-time testers or who had not tested in over a year, by quarter

Self-reported health-seeking behaviour

All the participants indicated that they would seek out care if they experienced clinical signs and symptoms. Some appropriately waited prior to accessing care to see if the symptoms would resolve.

'I normally go to the clinic. I stay a day or two at home. If it [headache] persists then I go to the clinic.' Male, 32 years old (IDI)

Most reported that in the absence of OIM, they would have gone to the DoH clinic if unwell, but a few reported that they would seek help at a pharmacy or general practitioner (particularly if finances allowed). Only one participant indicated that depending on the signs and symptoms they would visit a traditional healer first. Participants reported that the intention to seek care and the choice of facility would depend on the severity of symptoms. This was supported by the data from the survey (Figure 7) that showed that, for the full range of ailments, patients would seek help at a clinic first.
4.1.3.2. Reasons for attending OIM

Most participants sought care at OIM because they had a symptom that concerned them or they required specific follow-up. Patients sought care for a variety of complaints both acute and chronic, including: pain (headache, earache, back pain, abdominal pain), ARV treatment supply, STI symptoms, family planning, screening for HIV, and minor ailments which include, gout, flu, fever, shingles, and tonsillitis.

This is consistent with the aforementioned data, showing that in Q1 2019, 42.9% of the 630 patients that visited OIM primarily went for family planning.

In the qualitative interviews, participants described differences between the primary healthcare facility and OIM that made OIM a more convenient option, including being closer to where they lived, requiring less travel, having fewer patients wanting services and shorter waiting times.

‘I attended for that it is closer and it is easy to get to even on rainy day I can reach it As they say it is closer two minutes’ walk unlike the CHC [clinic] where you stay for hours and end up feeling hungry, but there you know only 30 minutes maximum or minimum you come back home and eat what you want’ Female, 29 years old (FGD)

‘A lot of people are reluctant to go to the [primary healthcare] clinic. So having that clinic [OIM] in this community is great because it’s closer to where people live. It really helps most of us who don’t want to go to full clinics and having to wake up early and get home late. There is good health service given here and the clinic [OIM] is not full so we can go to the clinic anytime we feel like....I dread coming to the [primary healthcare] clinic. It’s always full and you have to wake up so early in the morning. You will take the whole day at the clinic, sitting there. That is why I am so reluctant to go to the [primary healthcare] clinic.’ Male, 32 years old (IDI)

The extended hours may have contributed to the perceived convenience. The original intention was to be open earlier and later than facility services (which open 8am to 4pm). The time patients arrived was noted by the usher (Figure 8): the most popular times to attend OIM were mid morning and after lunch. Based on this information, opening hours were subsequently adjusted: to open later in the morning at 9am (as few patients came before 8am), and stay open later in the afternoon until 6pm (although it closed earlier in winter when it gets darker earlier if patients were not waiting).

Fewer patients arrived during lunch hours. This may have been due to staff taking lunch at the same time (as the team was small and it was difficult to take turns) and the clinic appearing closed or staff not noting that patients arrived until they were back from lunch.
The short waiting time and later hours allowed patients to access OIM later in the day compared to facility services where patients are expected to be waiting when the clinic opens at 7.30/8am. An unexpected finding from the qualitative study was that this also contributed to general safety as the patients did not have to travel through dangerous areas early in the morning to get to a facility early enough to be seen. 91% of people surveyed in 2005 said that they did not feel safe walking in their neighbourhood after dark, compared to 38% during the day.

‘When we go to CHC [primary healthcare clinic]. It is a risk, we sometimes wake up at four o’clock we pass dangerous places from Endlovini to there when it [OIM] is closer ...It helps us as community it is not like the CHC service, where you stay the whole day’ Male, 29 years old (IDI)

Participants also reported experiencing friendly, welcoming staff. Participants expressed the wish that OIM could become a permanent service in the community and that it would expand its services further, including paediatric-specific services.

’They don’t have attitude.... They don’t change attitude and then I decided to go back... They explain everything clear especially when they turn you back....They inform you and are open’ Female, 37 years old (IDI)

Most people (55%) had heard about OIM through word of mouth (Figure 9). Friends recommended OIM’s service and people brought family members to the service.

’I was advised by my friend [to attend the OIM]’ Male, 29 years old IDI

’[I] came from [another area] and told my sister that I am on treatment and I am unable to take them because I did not bring transfer from where I came from since I left in a hurry. Sister took me to that clinic [OIM] they gave me my treatment’ Female, 24 year old (FGD)
A large proportion (36%) noticed the clinic opportunistically as they were travelling past it (Figure 9). The service was noticeable in the community, which created interest.

‘When something is in the community you become interested as a community member...to go and see how you will be serviced.’ Female, 42 years old (IDI)

‘I saw that clinic while passing by the road ...I asked what these people are about and was told they are a clinic’ Male, 31 years old (IDI)

It was also visibly uncongested and easy to access, which encouraged patients to use it.

‘I also saw it while passing as it is closer to my home I realized that I can get help there ....What I noticed in that clinic they are quicker you do not stay for a long time and waste your day like other clinics’ Female 26 years old (FGD)

The OIM team designed health promotion material for awareness in the community and facilitated community events, specifically aimed at youth and males, in which the services were marketed. Door-to-door visits by health promoters ensured that the community was given an opportunity to ask questions and engage with the health promotion team. Social media and radio was also used to market the service. WIFI in the patient waiting area was also provided to promote the use of the Facebook page, provide patients with entertainment while in the queue and appeal to youth in order to attract them to the clinic.

Posters, door-to-door mobilisation and social media (Facebook) made up a very small proportion of the effective advertising (Figure 9). The door-to-door activities were the most labour intensive of the health promotion techniques and had a small effect (5% of reported method of awareness). However, as seen by the gradually increasing headcount (Figure 15) it takes time for a community to accept and start to
use a new service. Intensive mobilisation, while resource-intensive, may be necessary to build momentum and spread enough awareness that a critical mass of patients can spread the information by word-of-mouth.

It was also unclear where the people that heard about the service from word of mouth had heard it from and which of the initial means of information dissemination (visibility in the community, social media, posters, events or door-to-door mobilisation) had been the source of the information. However it appears that making a service visible and noticeably convenient – both in location and in how the service is presented – are important to encourage patients to attend.

4.1.4. Conclusions: did OIM attract the difficult-to-reach patients?

Overall, 50% of our headcount was made up men, youth and those with previous infrequent testing habits – populations who are traditionally difficult to reach with routine services. The high proportion of youth and people with previous poor HIV-testing behaviour (never tested or had not tested in over a year) demonstrates that OIM was able to reach people who we suspect are not otherwise accessing facility services. The fact that males were present in similar proportions to City clinics shows that the service is as acceptable as formal facilities, but may not have overcome other barriers to health seeking behaviour present in the male population. While OIM was planned as a method for overcoming inconvenient opening hours for patients who were employed, the proportion of employed attendees (38%) was lower than the Khayelitsha employment rates (46%), but higher within the male population (61%), suggesting that OIM is particularly convenient for this group (employed men).

The patients who were interviewed had good health-seeking behaviour and would otherwise have engaged with DoH clinics, but OIM was preferred to facility-based services as it was perceived as more convenient, safer and friendly. However, it must be considered that in creating a service that overcomes barriers that reduce ‘hard to reach’ populations’ access to care, the service was bound to be a more palatable and convenient option for all patients, even those who do access services, and inevitably also attract patients not in the target group. Thus the proportions within the OIM clinic population of men, youth and people with poor HIV-testing histories may not be a good reflection of whether or not these populations were reached adequately. Rather the fact that youth, men and people who had not previously engaged frequently with services did attend OIM, and that patients interviewed reported choosing OIM over other formal options, can be seen as a success.
4.2. **Initiate and retain people on ART**

The main focus of OIM services was on HIV care. Encouraging good patient engagement with ART is a challenge for facility services and many interventions have been developed and implemented in different settings to attempt to improve linkage and retention in care for people living with HIV.

4.2.1. **Linkage into ART care**

In the era of same-day initiation, there is a push to link people testing positive to ART services as soon as possible. There is a large egress of patients from the HIV cascade between testing and ART initiation\textsuperscript{77,78} and there is a need to find ways to improve linkage, particularly from community testing.

OIM proposed to improve linkage by initiating and managing people at the same site as they are tested. Community initiation on its own, without follow up ART management, has been shown to be effective in other settings\textsuperscript{61}.

OIM services successfully linked patients to ART care, with overall 34% of patients initiating on the same day (71% in the most recent quarter) and 63% within three months (79% in the most recent quarter - see Figure 10). This compares favourably with data from all Khayelitsha CoCT clinics: patients tested in facilities had a same day initiation rate of 13% and a 3 month linkage rate of 63%. A comparison to community testing is even more favourable. A study following patients testing positive in a similar community setting, found 66% of patients returned for a CD4 count, and of those returning (already a select group), just 62% of those eligible had initiated ART within six months of testing\textsuperscript{77}.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{Figure_10.png}
\caption{OIM linkage to ART initiation over time}
\end{figure}
Of the ART cohort, 69% were tested and initiated on ART at OIM, while 29% were transferred in and 2% were restarted at OIM after disengaging from other facility ART programmes (Figure 11).

![Figure 11 Distribution of OIM clients by route of entry into the OIM ART cohort (n=348)](image)

**4.2.2. Retention in ART care**

Cumulatively, OIM had 348 ART patients that regularly received treatment at the clinic. This included two adherence clubs and one “quick pick-up” (QPUP) group. The median age of those on ART was 30.7 (25.8-36.6) and 20% are men.

In addition, the concept of ‘sticky linkage’ is important – merely linking patients to treatment and starting ART is not enough of a success. This linkage needs to be maintained and these patients need to be retained in care for a significant period after initiation.

OIM had lower retention rates than had been anticipated, with 12-month retention in care (RIC) for the first year averaging 66%. This is lower than facility-initiated patients (Figure 13). However, these results should be considered in light of the improved linkage compared to the abovementioned study, where 62% of the eligible among the 66% of HIV-positive testers returning for CD4 counts actually initiated. In other words (ignoring the now-irrelevant issue of eligibility), approximately 42% (66% of 62%) of all eligible patients initiated (within six months), compared to 63% of our patients (within three months). It is thus likely that, 35% of those who initiated at OIM would not have initiated elsewhere. With this in mind, a 9-17% lower six-month retention than facilities still represents a higher overall retention from the time of testing positive.
Figure 12 Six- and twelve-month retention in care by quarter of ART initiation

Figure 13 Retention in care at 6- and 12-months at OIM, CoCT male-only, youth-only, and general PHC clinics, June 2017-December 2019
4.2.3. Viral load completion and suppression

Overall, viral load completion was 65% at four months (window period: 3-9 months) and 54% at 12 month (window period: 9-18 months). Low viral load completion partly reflects high mobility of this population. However, viral load completion varied over time (Figure 14), reflecting varying degrees of attention paid to this issue by different nurses employed to provide clinical services at OIM. Viral load completion is an important metric for quality of care, but it should be noted that even in facility settings, completion is typically only about 84% overall in Khayelitsha\textsuperscript{79}, and this is similar among stable adherence club patients\textsuperscript{80}.

Among those with a complete viral load, viral load suppression (<400 copies/ml) was very high at both month 4 (95% overall) and month 12 (94% overall). This compares favourably to the national virological suppression rate of 87.3% in 2017 among those on treatment\textsuperscript{81}. This suggests that the OIM model was successful in supporting patients who may not have accessed services otherwise, to engage successfully with their ART.
4.3. **Decant primary healthcare facilities**

A secondary aim of the OIM intervention was to use community-based services to decant the busy host facility, Michael Mapongwana CHC. The Endlovini area that OIM was situated in drains to Michael Mapongwana, and any patients attending OIM would otherwise have had the option to attend Michael Mapongwana or go further afield to clinics in other areas.

4.3.1. **Headcount**

The headcount at OIM gradually increased over the period. December is a very quiet period for health services as many people in Khayelitsha leave the Western Cape for the holidays. Many DSDs provide a 4 month refill of ART to cover this period. The trend in headcount is shown in Figure 15.

![Figure 15 OIM headcount by quarter](image)

From quarter 2 (Q2) 2018 to Q2 2019, overall headcount almost doubled (384 to 697 patients per quarter), of which 91% were tested for HIV.

4.3.2. **Decanting of ART patients**

OIM has initiated 384 people on ART since Q2 2017. Figure 16 shows the growing number of unique patients attending ART visits in each quarter, broken down by routine clinician care, adherence club care, and QPUP visits. There were 80 ever in adherence club care and 20 ever in QPUP care.
4.3.3. ART decanting potential through DSD

While complex ART patients were managed at OIM, the group most likely to contribute to significant decanting of the parent facility’s ART clinic are the stable ART patients. The addition of OIM DSD options such as the clubs and QPUP came after the service was established, and started slowly with one club then the addition of a second club and the QPUP option as the ART cohort grew. There is further room to optimise these options.

The host primary care clinic, Michael Mapongwana CHC, has a well-established club (over 2500 patients) and QPUP (over 600 patients) programme. The clubs are based at both the facility and in the community, and the QPUP service is based only at the facility. Regardless of whether patients usually collect treatment in the facility or the community, all club blood and clinical visits (which take place once a year each – 2 visits per year) take place in the facility, as the community club sites are not appropriately equipped to take patient blood samples or allow for proper examination of patients. This reliance on the primary care facility results in periods of overwhelm for the clinicians when community clubs return to the clinic for facility-based visits.

OIM provides a site for community pick up of medication where club support activities can be conducted as well as clinical procedures completed. While the headcount currently represents a small proportion of Michael Mapongwana’s clinic population, OIM has shown that it is an acceptable and safe model to manage ART, creating an opportunity to explore moving community DSD models fully into the community: expansion of Michael Mapongwana’s community club cohort, relocation of QPUP pick-ups, as well as decanting the clinical visits out of the clinic. The model could also be applied at other sites in Michael Mapongwana’s drainage area to fully maximise the decanting of stable patients outside the facility.
4.4. **Feasibly provide comprehensive and acceptable services in a community setting**

Once it is established that the model is effective at reaching people who do not traditionally engage easily with facility services, is a safe and acceptable option for receiving care and has the potential to decant stable patients from primary healthcare services, feasibility is an important consideration in evaluating whether the model can in fact continue to be provided long-term or even scaled up.

4.4.1. **Logistics and security**

The support functions (data, pharmacy stock take and cleaning) needed a day to access the records and trailer while the clinic was not running. Closing the service on Wednesday worked well to give the staff a day off, the support team access to the trailer and stay open on a Saturday to maintain a 5 day work week. This would be feasible if adapted to other organisations.

A vehicle with 4x4 capabilities was required to tow the heavy trailer over the rough terrain to the VPUU site. The medication was stored in two portable pharmacy boxes and moved from the trailer into the MSF office (in a temperature controlled pharmacy storage room) at night due to security and storage environment concerns. While this complicates the implementation, it is not an onerous process and was easily manageable.

While parked at the MSF office overnight there was a break-in (where equipment including the point of care CD4 PIMA machine was taken). The trailer was subsequently moved to the Khayelitsha District Hospital parking at night, next door to the Michael Mapongwana CHC, as it had better 24 hour security. One further break-in took place (a heater was stolen through the window). Burglar bars were installed and no further incidents took place. The toilets continued to be kept in the MSF office parking lot over night.

Security at the service delivery site was also ensured through engagement with the community leaders in the area and through the employment of the usher from early on in the pilot –a TAC member who is from Endlovini and acted as a link between the MSF programme and the community. This helped to improve trust, alert the team to potential issues (such as riots) and provide a platform for addressing issues. The MSF team reported feeling safe and protected working at the community site, despite the break-ins after hours.

4.4.2. **Resources**

OIM was implemented as a partnership between the supporting DoH primary care clinic and MSF as the implementing non-profit organization (NPO). Table 3 outlines the contributions from each partner. MSF and the OIM staff had a good relationship with the parent clinic Michael Mapongwana CHC, which was important to ensure support for clinical management but also in solving challenges.
Table 3 Division of input between the Department of Health and MSF

<table>
<thead>
<tr>
<th>Human Resources</th>
<th>MSF</th>
<th>Michael Mapongwana CHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Professional Nurse</td>
<td>Management</td>
<td>Clinical mentoring and support from clinic doctors</td>
</tr>
<tr>
<td>2 Counsellors</td>
<td>Management</td>
<td>Provided all medication and consumables</td>
</tr>
<tr>
<td>1 Usher</td>
<td>Storage of medication in the office over night</td>
<td>When the MSF pharmacy assistant position was closed, the CHC staff were willing to fill this role with the clinic’s pharmacy assistant.</td>
</tr>
<tr>
<td>Management</td>
<td>Initially point of care CD4 testing was provided, but procedures were adapted without this to align with DoH guidelines</td>
<td></td>
</tr>
<tr>
<td>Medication and consumables</td>
<td>Laboratory services</td>
<td>Transport of samples from OIM to the laboratory at Khayelitsha District Hospital</td>
</tr>
<tr>
<td></td>
<td>Logistic services</td>
<td>MSF data team captured folders into tier.net and fed this information back into the clinic data system.</td>
</tr>
<tr>
<td>Data systems and monitoring</td>
<td>Logistics</td>
<td>MSF drivers towed the trailer to and from the sites.</td>
</tr>
<tr>
<td></td>
<td>Community</td>
<td>MSF team engaged with the community stakeholders on behalf of the partnership and provided staff through the Treatment Action Campaign to conduct door-to-door mobilisation. Other health promotion was conducted using MSF resources</td>
</tr>
<tr>
<td></td>
<td>engagement and health promotion</td>
<td>Repairs and maintenance</td>
</tr>
</tbody>
</table>

The qualitative interviews revealed how much impact individual staff members have on patient attendance and retention, which is more visible in a small team like at OIM than in a large clinic where patients see different staff members at each visit.

Table 4 outlines the resources MSF put into the programme from 2016 to the end of 2019.
Table 4 Resources required to set up and manage the OIM service (details and costs are outlined in the appendix)

<table>
<thead>
<tr>
<th><strong>Infrastructure</strong></th>
<th><strong>Equipment</strong></th>
<th><strong>For queue</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trailer</strong></td>
<td><strong>Toilets</strong></td>
<td>• Gazebo</td>
</tr>
<tr>
<td><strong>Equipment</strong></td>
<td><strong>Trailer contents</strong></td>
<td>• Table</td>
</tr>
<tr>
<td><strong>Medical equipment</strong></td>
<td>• <strong>Blood transport</strong></td>
<td>• Chairs</td>
</tr>
<tr>
<td></td>
<td>• <strong>Pharmacy box</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• <strong>For patient assessment</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• <strong>Appliances (kettle, heater etc)</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Repairs and upgrades**
Upgrades were made as the service developed and the needs were refined
- To the mobile trailer (furniture, adjustment of consultation rooms, addition of burglar bars)
- To the sites (electrical and structural work)
Artistic painting of exterior of trailer and toilets

**Maintenance**
- **Vehicle**
- **Trailer**
- **Toilets**

**Regular services and costs**

**Cleaning and upkeep**
- Toilets were cleaned monthly by a company
- Trailer is cleaned weekly by MSF staff on a Wednesday when it was closed for services with cleaning products purchased by MSF

**Electricity**
- Electricity for the Ezapileni site was provided through one of the neighbouring residents, negotiated through the community forum, and the price negotiated directly with the resident. Prepaid electricity vouchers are purchased and given to the resident
- Electricity for the VPUU site is provided from VPUU.

**WIFI**
- Contract for 20 Gb per month

**Health promotion and community engagement**
- Printing of clinic stationery and promotional material (fliers for advertisements)
- Community engagement and events

**Human resources**

**Clinic team**
- Nurse
- Counsellor
- Usher

**Support team**
- Manager
- Pharmacy assistant
- Research assistant
- Data clerk
4.4.3. Handover and sustainability

OIM has shown that it is feasible to use provincial clinic resources and support systems to provide outreach clinical services in an urban environment where distance to facilities is not a major barrier in accessing care. It is possible to entirely manage patients in the community, with human resources as the main additional cost to the health system. With this in mind when MSF was required to withdraw support, OIM was handed over to another NPO, TB HIV Care, to continue to implement on behalf of the Department of Health.

The handover planning and discussion process was initiated in the second half of 2019, almost a year before the planned handover date, in order to give enough time:

1. For the Department of Health to evaluate the model and explore potential adaptations to ensure that the model fits with their broader plans and priorities (COPC focus)
2. With the support of the provincial Department of Health, to identify the right NPO to take over management of the service, whose aims aligned with that of OIM
3. To workshop and adapt the procedures and support systems with the Department of Health, the parent primary care clinic and the incoming NPO
4. To properly train and mentor the new NPO staff
5. To involve the community in the process and get their buy-in for the handover to a new organisation, and gently hand over the relationship with the community without letting them feel abandoned

It is very essential not to rush the handover process to ensure the process runs smoothly and increase the likelihood of sustainability.

4.4.3.1. Steering Committee

The steering committee was formed after the provincial Department of Health had agreed to continuing the model and the new NPO had been identified. The steering committee was made up of decision-makers, including the substructure provincial Department of Health, the parent clinic Michael Mapongwana CHC, MSF, TB HIV Care and the community

The steering committee had multiple meetings including discussions on responsibilities, a site visit and a workshop to discuss processes and adaptations.

The process was driven by the MSF team, and monitored using a dashboard (Figure 17). The aim of this dashboard was to provide a comprehensive snapshot of activities, and it formed a key tool for communication and tracking progress. The timeline, specific objectives and named individuals responsible for each activity were clearly laid out and agreed on by the steering committee.
Figure 17 Snapshot of the OIM handover dashboard and timeline

It was agreed that TB HIV Care would take over the staffing and management of OIM, and that Michael Mapongwa CHC would continue to provide supportive functions. The trailer, toilets and equipment were donated to TB HIV Care directly, as the substructure DoH was unable to take on the responsibility for maintenance.

OIM was a community model and community stakeholders were a critical part of the implementation. It was essential to involve the community in the handover process and stakeholders were invited to be part of the steering committee once a clear plan was set and agreements were in place with the new NPO and the DoH. Transparency is very important, however the decision not to inform the community immediately was made because there were concerns that involving the community prematurely could create confusion and create expectations that may not be possible to be met. Lack of clarity could potentially upset the community members who had built trust in the service, thus it was decided to only approach the community with certainty about what services could be offered and who the new stakeholders would be.
4.4.3.2. Adaptation of OIM for handover

To ensure sustainability, the procedures and support systems at OIM required adaptation to the working processes, priorities and capacity of a different organisation. This also presented an opportunity to use the experience gained in the preceding two years and address some inefficiencies in the existing system.

A workshop was organised to adapt the existing standard operating procedures (SOPs). It was made up of decision-makers as well as those directly involved with the service to give practical input on how services should take place, including:

1. **Community** leaders and community members
2. The **substructure provincial Department of Health**
3. **The parent clinic Michael Mapongwana CHC**, including the facility manager, family physician, pharmacist, pharmacy assistant, data clerk mentor
4. **MSF** including the OIM team and support teams (particularly pharmacy, data and logistics)
5. **TB HIV Care** including the nurse and field team taking over from MSF as well as management, logistics and data capturers

The background on the service, objectives of the model and data trends were presented, then an overview of the handover process was given. The existing SOPs had been circulated beforehand, and the attendees were divided into 4 groups to workshop specific SOPs (final products included in the appendix):

- **Logistics**: establish the procedures for transporting and storing the trailer and medications as well as security procedures and opening hours
- **Pharmacy**: establish systems for monitoring consumption and inventory, processes for ordering routine and emergency stock, storage and transport plans, management of DSD models.
- **Clinical Management**: establish the job description and scope of practice of the nurse and counsellors, outline management of DSD models, processes for referral and tracing, use of support systems (including the laboratory, pharmacy and clinical support) and establish the slow of patients through the clinic.
- **Data**: establish processes to organise information, manage patient data, trace patients, take consent, manage stationery supply, capture data and put together reports

This workshop afforded all participants an opportunity to contribute to the new version of the model – both to gain buy-in and ownership but also to use a diverse set of experience and knowledge to create a robust set of practices that reflected a realistic approach to community services. Adaptations to improve efficiency as well as align the service with TB HIV Care’s priorities were also made. It was important for the incoming NPO to take ownership of the service and ensure that the SOPs were aligned to what services they could offer, the capacity of their team, their targets and their objectives. At the same time it was important to ensure that the lessons the MSF team had learned was not lost and that their experience could help shape the handover version of OIM.
4.4.3.3. Training and mentorship

TB HIV Care took over the OIM model in a stepwise fashion – providing a nurse, then counsellors, then logistic support and finally taking over the data management. This allowed time for the MSF staff to train and mentor the incoming team thoroughly and identify any gaps, as well as for the incoming team to familiarise themselves with the procedures. One MSF counsellor provided support until one month before official handover, then was available to provide technical input as needed until handover was complete. The manager of the service provided technical and organisational input throughout. The long handover process allowed time for problem solving and improvements to be made.

4.4.3.4. Community engagement during handover

Community engagement is essential in making sure the community members and leaders are aware of the service, getting buy-in and in creating a support system for the pilot. When the model was in a planning phase the community was consulted and involved in the implementation of the model. It was therefore important to go back into the community and have the same engagement as in the early stages. The credibility of MSF as an organisation is dependent on its reputation with its beneficiaries: the organisation should not leave the people without consulting with them and preparing them for the handover, especially considering their role in developing and implementing the service, providing security and protection and in advertising and spreading awareness.

Community leaders were consulted once agreements were in place regarding which stakeholders would take-over and what services were possible to be provided. Meetings with the community leaders were held and they were invited to take part in the workshop to be part in order to have input on the proposed logistics in particular.

TB HIV Care was introduced to the community. The new team members had the opportunity to work closely with the old OIM team, which gave the community time to get to know them and to give feedback to the old OIM team who they trusted. The long handover process allowed MSF to withdraw without breaking the trust of the community which had been so hard won, and hand over the relationships to the incoming NPO. Community engagement meetings took place once a month to provide the community with a platform to air grievances and for issues to be identified so that they could be addressed. This helped make the handover process much smoother.

4.4.3.5. Take away lessons on handover

- The handover process should start at a very early stage - as soon as a deadline for pilot closure is established, the handover process should start.
- Buy-in from all levels of the incoming organisation is vital. Everyone that will be part of the project should be involved in the discussion from an early stage. This allows them to have input to make proposals more feasible and increases ownership.
- The incoming organisation should be encouraged to make adaptations to the models to accommodate their capacity and priorities.
• The experience of the outgoing organisation should be leveraged, particularly in understanding what worked or didn’t work and in smoothing the handover of the relationship with the community.
• Training and mentorship is crucial to the handover process and takes time, particularly to identify gaps that need support.

4.4.4. Further proposed adaptations to improve sustainability and scalability

Certain adaptations to the model could maximise the scalability and subsequently the decanting potential OIM provides, and make the model more sustainable within current health system resource constraints. The biggest change would be adapting the model to be implemented without the mobile trailer.

Challenges with the trailer could potentially hamper the sustainability and scalability of the model, such as cost of purchasing, maintaining, transporting and running the trailer, the requirement for a 4x4 vehicle to tow it and the small size.

The same comprehensive package of services provided by OIM could be provided in a static community venue, such as a community hall or in a school closer to where people live than a clinic facility. Community ART clubs already take place in community venues, and expansion of the services offered to include clinical care in addition to ART dispensing and patient support activities would be the next step in evolving services to fulfil the principles of COPC more fully.

When adapting this model careful consideration should be taken, in regard to what services are being provided. Providing HIV services without the full package might not be successful, because stigma is still an issue in the community and other services allow people to access the ART care without inhibition.

The proportion of testers that tested positive dropped over the time OIM was running, from a high of 12% in Q1 2018 to 3% in Q4 of 2019 (Figure 4). Considering the rate of first time testers and those that had not tested in over a year remained at a fairly steady level (Figure 6) it is unclear whether ‘saturation’ was reached in testing the Endlovini population for HIV. However, to ensure continued value and sustainability, a site with a large enough population should be chosen to receive such services.
## 5. Summary and conclusions

### 5.1. Challenges and solutions

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Contributing factors</th>
<th>Measures to mitigate or overcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low headcount initially</strong></td>
<td>It took a while for people to know and understand the services provided at OIM</td>
<td>Intensive marketing of services and mobilisation (including door-to-door) was implemented to build momentum in awareness. Advertising through platforms such as social media and radio should continue throughout the implementation to support word of mouth spread. Door-to-door mobilisation is very resource intensive. Training and incorporation of the ‘Welcome Approach’ (see appendix) If independent staff are not available, more clinical governance is needed to ensure quality care</td>
</tr>
<tr>
<td><strong>Mobilising males and youth to access the OIM services</strong></td>
<td>Males felt that OIM was more for family planning, they also did not want to be in the same waiting area with the females Most of the youth were in schools, including colleges</td>
<td>Community engagement and health promotional activities helped encourage men to attend. During community engagement the men suggested having a day focusing on them staffed with males – this was implemented on a Saturday. Further adaptations to attract men may increase male attendance further. Provision of family planning and prioritising the youth after 3pm was successful in increasing numbers. Provision of WiFi in the waiting area also helped</td>
</tr>
<tr>
<td><strong>Retaining patients on effective treatment</strong></td>
<td>Possible contributors are that the OIM attendees may not have accessed services otherwise and their RIC was likely to be poor Poor VL completion rates made it difficult to properly evaluate VL suppression</td>
<td>Introduction of the ‘Welcome approach’ to support a welcoming attitude towards patients, as well as manage patients who are struggling with ART in a differentiated model of care Addressed VL completion rates repeatedly with reminders to the clinician and review of data</td>
</tr>
<tr>
<td><strong>Security</strong></td>
<td>Khayelitsha is a low income settlement with high rates of unemployment and high rates of violence through crime and through political action (e.g. protests).</td>
<td>Engagement with the community stakeholders and employment of an usher from the community (through the Treatment Action Campaign) helped make the staff feel safe and avoided any security incidents on site Storage of the trailer within the hospital’s gates and the medication in the MSF office at night</td>
</tr>
</tbody>
</table>
## 5.2. Successes

<table>
<thead>
<tr>
<th>Success</th>
<th>Contributing factors</th>
<th>Measures to ensure continuation</th>
</tr>
</thead>
</table>
| Patients were satisfied with the service they received, chose to attend OIM over other facilities and spread awareness through word of mouth | Friendly attitudes and staff  
Convenient due to short waiting times and geographic proximity  
Service easily visible | To cut down cost of overtime, maybe the staff could rotate                                                    |
| Buy-in from the community made the services more relevant, increased attendance and provided a measure of protection | Buy-in led to ownership: the community wanted to see OIM succeed because they were part of it from implementation | Community engagement should be continuous and the community should be given regular feedback on what is happening in the clinic |
| Relationship with the host facility was very good and OIM received appropriate support | The host facility was very supportive, providing stationery, medication, laboratory services and clinical management support | To ensure continuity, the host facility must take a lead in the implementation                                      |
| The number of youth accessing OIM services increased over time          | At times the schools close late, this make it challenging for the youth to access health care services like family planning. Prioritising youth in the afternoon had positive results | Youth friendly facilities that accommodate school children.                                                        |
| People who had never tested for HIV before, or who had not tested in over a year, continued to be found through OIM | OIM may have provided an acceptable alternative to facility-based or other community testing | Continue to provide testing in the community                                                                     |
| Linkage rates were excellent and same day initiation rates far exceeded usual rates for the population | The ability to initiate treatment at the point of testing has been demonstrated to improve linkage | Continue to initiate patients on ART in the community                                                             |
5.3. Conclusions

OIM has demonstrated that it is feasible to use existing primary care facilities to support outreach community services (which have traditionally been used extensively in rural populations) in a peri-urban, low income setting. The objective of the outreach was not to overcome distance as a barrier but rather to overcome other barriers that were reducing the attendance of key populations to facility based services. The main additional cost to the system was human resources, but the pilot was able to successfully manage patients entirely in the community. This was particularly successful for HIV care, from testing to initiation and maintenance on treatment, but integration of other preventative and management services made the model more attractive and acceptable.

Community services offer a safe and acceptable option for decanting stable patients from facilities, and also offer an option that can reach people who may not otherwise be accessing health services. Adaptations to make the service more attractive to men and youth had collateral benefit for other patients as well. Saturday services were better attended by men, and the combination of WIFI, family planning and prioritisation of the youth in the afternoons successfully attracted large numbers of younger patients.

Community engagement was vital in the creation of the service and security of the staff. Once the service had become established in the community, word of mouth was the best form of advertisement. However, intensive mobilisation at the start was required and continued marketing on low resource platforms (like social media and radio) combined with continued community engagement was helpful in making OIM a valued and well-used service.

Addressing the barriers to care for key populations, such as males and youth, remains critical for HIV but as well for other health issues. Services such as OIM are the “last mile” to reach those hard to reach populations: attempting to address these barriers by leverage the role of the community. Peri-urban settings similar to Khayelitsha should consider community outreach models as a feasible, patient-centred way to decant busy clinics and reach people not otherwise accessing care.
6. References


68. Western Cape Government. The harms and risks of alcohol in Khayelitsha Department of Community Safety. Published online 2015.

45
7. Appendix

7.1 Resources required to set up and manage the OIM service

7.2 Standard Operating Procedures developed through the handover workshop

7.3 Summary of the Welcome Service DSD for patients struggling with ART
### Resources required to set up and manage the OIM service

<table>
<thead>
<tr>
<th>Resources</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equipment</strong></td>
<td></td>
</tr>
<tr>
<td>Trailer</td>
<td>R166 000 in 2016</td>
</tr>
<tr>
<td>Toilets</td>
<td>R54 316.44 in 2016</td>
</tr>
<tr>
<td><strong>For queue</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Gazebo with walls R39 248.26</td>
</tr>
<tr>
<td></td>
<td>● Sputum booth R799</td>
</tr>
<tr>
<td></td>
<td>● Folding table R1796</td>
</tr>
<tr>
<td></td>
<td>● Chairs R8972</td>
</tr>
<tr>
<td></td>
<td>● Plastic storage box R417.80</td>
</tr>
<tr>
<td><strong>Trailer contents</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Appliances</td>
</tr>
<tr>
<td></td>
<td>o Heater R567</td>
</tr>
<tr>
<td></td>
<td>o Kettle R549</td>
</tr>
<tr>
<td></td>
<td>o Lamp R779</td>
</tr>
<tr>
<td></td>
<td>o Microwave R799</td>
</tr>
<tr>
<td></td>
<td>● Medical equipment</td>
</tr>
<tr>
<td></td>
<td>o Cooler box for bloods</td>
</tr>
<tr>
<td></td>
<td>R369</td>
</tr>
<tr>
<td></td>
<td>o Pharmacy tool boxes x 2</td>
</tr>
<tr>
<td></td>
<td>R999</td>
</tr>
<tr>
<td></td>
<td>o Blood pressure cuff R928</td>
</tr>
<tr>
<td></td>
<td>o Sharps container</td>
</tr>
<tr>
<td></td>
<td>R1640 for sharps disposal</td>
</tr>
<tr>
<td><strong>Repairs and upgrades</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Upgrades to the clinic trailer as the service developed and the needs were refined, and are not ongoing costs (R102 789,53):</td>
</tr>
<tr>
<td></td>
<td>● Electrical installation and additional plug points</td>
</tr>
<tr>
<td></td>
<td>● Installation of furniture (cupboards, bed etc) and extraction fans</td>
</tr>
<tr>
<td></td>
<td>● Adjustment to consultation rooms – wooden shelving and woodworking</td>
</tr>
<tr>
<td></td>
<td>● Addition of burglar bars to windows</td>
</tr>
<tr>
<td></td>
<td>Upgrades to the sites (R8694,70)</td>
</tr>
<tr>
<td></td>
<td>● Gravel for VPUU site</td>
</tr>
<tr>
<td></td>
<td>● Concrete block</td>
</tr>
<tr>
<td></td>
<td>● Installation of circuit breakers</td>
</tr>
<tr>
<td></td>
<td>Artistic painting of exterior of trailer and toilets (R25 029,70)</td>
</tr>
<tr>
<td></td>
<td>Maintenance since 2017 (R18 000)</td>
</tr>
<tr>
<td></td>
<td>● Number plate (Jan 2017)</td>
</tr>
<tr>
<td></td>
<td>● Wheel adjustment (July 2017)</td>
</tr>
<tr>
<td></td>
<td>● Repair jockey wheel (August 2017 and October 2018)</td>
</tr>
<tr>
<td></td>
<td>● Door and window maintenance (June 2018)</td>
</tr>
<tr>
<td></td>
<td>● Tyre patch (July 2018)</td>
</tr>
<tr>
<td></td>
<td>● Fit flat bar (October 2018)</td>
</tr>
<tr>
<td></td>
<td>● Repair two windows (October 2018)</td>
</tr>
<tr>
<td></td>
<td>● Trailer door lock (November 2018)</td>
</tr>
<tr>
<td></td>
<td>● Prop-stand and bracket (Jan 2019)</td>
</tr>
<tr>
<td></td>
<td>● Repair of gazebos (May 2019)</td>
</tr>
<tr>
<td></td>
<td>● Weld and repair trailer (May 2019)</td>
</tr>
<tr>
<td></td>
<td>● Install prop stand and fix electrical problem (July 2019)</td>
</tr>
<tr>
<td></td>
<td>Annual servicing: R1500 per year</td>
</tr>
</tbody>
</table>

48
### Regular services

<table>
<thead>
<tr>
<th>Cleaning and upkeep</th>
<th>Toilets are cleaned by Mshengu Toilet Hire (R782 per call out – once a week)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Trailer is cleaned weekly by MSF staff on a Wednesday when it is closed for services with cleaning products purchased by MSF (Cleaning products: R3 500 per year)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Electricity</th>
<th>Electricity for the Ezapileni site is provided through one of the neighbouring residents for R300 a month. The provision of this was negotiated through the community forum, and the price negotiated directly with the resident. Prepaid electricity vouchers are purchased and given to the resident.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Electricity for the VPUU site is provided from VPUU. This electricity is not pre-paid. MSF offered to pay for this but the logistics were complicated to monitor thus VPUU provides free electricity.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WIFI</th>
<th>Contract for 20 Gb per month at R602 a month</th>
</tr>
</thead>
</table>

| Printing of clinic stationery and promotional material (fliers for advertisements) | R25 000 over 3 years |
| Community engagement and events | R75 000 for events (food and entertainment) |
|                                 | R10 000 for social media campaigns |

### Human resources

<table>
<thead>
<tr>
<th>Manager</th>
<th>Proportion of monthly salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
<td>Monthly salary</td>
</tr>
<tr>
<td>Counsellor</td>
<td>Monthly salary x 2</td>
</tr>
<tr>
<td>Usher</td>
<td>Monthly salary</td>
</tr>
<tr>
<td>Pharmacy assistant</td>
<td>Proportion of monthly salary</td>
</tr>
<tr>
<td>Data clerk</td>
<td>Proportion of monthly salary</td>
</tr>
<tr>
<td>Research assistant</td>
<td>Proportion of monthly salary</td>
</tr>
</tbody>
</table>
7.2. **Standard Operating Procedures developed through the handover workshop**

**Logistics SOP**

**Location**
Sites are located in Endlovini:
1. On the main road (Ezipalini zika gas)
2. Adjacent to the soccer field at the VPUU

**Opening times and days**
Time: 9am to 6pm Mon,
Closed on Public Holidays and Wednesday

**Logistics roles and responsibilities**

- **Driver**
  - Move the trailer and toilet from the parking at KDH to the site
  - Ensure flushing water is available for the toilet
  - To make sure the drugs are transported to the TB/HIV care offices
  - To pick the blood samples from OIM and to drop them at KDH

- **Usher**
  - To clean the trailer

**Trailer**

- **Storage and movement**
  - The trailer is stored on Khayelitsha District Hospital’s property at night
  - The toilets are stored in the parking lot of the MSF offices at the Isivivanna Centre at night
  - Moving the trailer to the site: a 4x4 is required to move the trailer and toilets to and from the storage areas to the service sites. A 4x4 is required due to the weight of the trailer. The terrain en route to VPUU is also rugged.

- **Maintenance:** the trailer should be services annually

**Electricity**

- Electricity is used to power the WIFI router, a kettle, a microwave, a fan and a heater. Invertors were installed in the trailer but are not powerful enough to support multiple appliances, thus external electricity is used to power the kettle, heater etc
- Electricity for the Ezapileni site is provided through one of the neighbouring residents for R300 a month. The provision of this was negotiated through the community forum, and the price negotiated directly with the resident. Prepaid electricity vouchers are purchased and given to the resident.
- Electricity for the VPUU site is provided from VPUU. This electricity is not pre-paid. MSF offered to pay for this but the logistics were complicated to monitor thus VPUU provides free electricity.

**WIFI**
- Contract WIFI with a router in the mobile trailer

**Processes**
- Set up
  - The gazebo and chairs should be set up at the start of each day and packed away at the end of each day after the last patient has been seen
  - If it is very windy the gazebo should not be used
- Cleaning and upkeep
  - Toilets are cleaned by Mshengu Toilet Hire (R195.50 per call out – once a week)
  - Trailer is cleaned weekly by MSF staff on a Wednesday when it is closed for services with cleaning products purchased by MSF.
- Pharmacy and medication
  - Medication is stored in two portable, lockable toolboxes. During the day these are transferred into the trailer and medication is dispensed from them. After services are complete, the toolboxes are transferred into the temperature controlled medical storeroom at the office in order to keep the medication safe and in a suitable environment. This system is currently under review and new boxes will be purchased.
  - Ordered medication should be collected from Michael Mapongwana CHC weekly
- Blood samples
  - Stored in a cooler box and taken to the laboratory at Khayelitsha District Hospital once a day
## Clinical Management and Flow SOP

<table>
<thead>
<tr>
<th>Activity</th>
<th>Who</th>
<th>When</th>
<th>Where</th>
<th>How</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HR scope</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Scope – PN (NIRMARTED)**

- Comprehensive
  1. ART initiation and management
  2. STI screening and Mx
  3. FP
  4. NCDs as per PACK
     a. Screening and referral to start medication
     b. Follow up treatment for patient on Tx already
  5. **PrEP** (15-24 young women and those at risk: MSM, discordant couples, SW, LGTBQ)
  6. Emergency contraception
  7. PEP
  8. TB screening

**Specimens**

- Bloods as required as per PACK

**Seasonal**

- Flu vaccines – liaise with MM to get the vaccines and choose days

**Scope - Counsellor**

- Triage – ask patients why they came HCT
- Adherence counseling
- Clubs (usual AC eligibility criteria)
- QPUP (standard AC eligibility)

**Offer HCT to every patient**

**Differentiated models**

<table>
<thead>
<tr>
<th>Clubs x 3</th>
<th>Stable ART patients – patient choice</th>
<th>Two-monthly</th>
<th>Adherence talks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Ezapileni x2 (30 - will split into 2 + one is new)</td>
<td></td>
<td>Bloods and clinical visits once a year</td>
</tr>
<tr>
<td></td>
<td>2. VPUU x 1 (30 – will split into 2)</td>
<td></td>
<td>Run by counselors and overseen by PN</td>
</tr>
<tr>
<td></td>
<td>As of August will have 5 clubs of 15.</td>
<td></td>
<td><strong>Cap club size at 15 not 30, so that on clinical days the clubs don’t take over the PN’s time.</strong> Next clinical visit (August) split them into two clubs and bring half back a day early for each further visit, so that it doesn’t derail services for other patients</td>
</tr>
<tr>
<td></td>
<td>Bloods and clinical visits once a year</td>
<td></td>
<td>Do flu vaccine campaigns</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>QPUP x 1</th>
<th>Stable ART patients – patient choice 22 patients</th>
<th>Two-monthly</th>
<th>Bloods and clinical visits once a year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Run by counselors and overseen by PN</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Youth | Prioritise school kids after 2pm
? start a club for the youth | Draw with free WIFI, PrEP, youth clubs, prioritization in the afternoon, PEP
Start a club for the youth: consider a QPUP model with a WhatsApp support group |  |
|---|---|---|---|
| Men | Prioritise men on a Saturday | Men2men programme: TB HIV Care has subcontracted to grassroots this year
Do events at OIM again on some Saturdays |  |
| Welcome Service | ART patients with a high VL or who have missed appointments (intermittently or dropped out of care) | When a patient has a high VL/ re-engages | At OIM
Use same stationery and system as MM
Send ones for switch to MM
**Need training on WS**
Fetch stationery from MM |  |
| Using OIM more to decant MM | ? NCD clubs – down the line not now
?QUP – keep on hold until sorted out at MM – revisit in June
Youth clubs – have a good one at the clinic already can refer kids to it if they are not doing or continue to see at OIM
PEP, emergency contraception
? 6 months – Erin to review in 2021
EPI vaccinations – MM would have to staff it
OIM a site for MM outreach campaigns
OIM a site for TB HIV Care community nurses to do outreach campaigns | Need to consider
Need to figure out what the ceiling gis so that the OIM PN’s time is not 100% clinical visits and don’t get to do other comprehensive services – for OIM patients not to decant all the MM patients to OIM. Defers other patients and creates stigma that OIM is just for ART club patients. |  |
| Referral | Advanced HIV
1. CD4<100
2. OI
Any medication can’t prescribe
Pregnant patients
Patients that are ill
New NCD
PAP smear (go straight to PAP smear room, don’t need to book, just go straight there)
Youth that are struggling or not quite managing – can refer to youth club at facility as well
Sputum on any patients – send to the TB EN | Reception
Present with their referral letter
Won’t be turned away without a letter | Don’t need to be discussed with the clinic first – can just send
Catch and match referral system
1. Small book that the referral is written in
   a. Original copy goes with the patient
   b. Copy left with the clinician
   c. Space on the form for feedback
2. Easy to review linkage |  |
<p>| Referral to MM allied | Refer directly using the catch and match referral system. |  |  |</p>
<table>
<thead>
<tr>
<th><strong>Referral from MM to OIM</strong></th>
<th><strong>Stable NCD patients for follow up treatment – from OPD and from ART clinic (OIM PN is the down referral option)</strong></th>
<th><strong>When stable</strong></th>
<th><strong>OPD/ART clinician</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patients for PrEP until province has sorted out the processes</td>
<td></td>
<td>1. Write CDU script</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. Check with the patient if OIM would be a pick up point. If it is, make a note on the script to inform pharmacy that this will be the pick up point</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3. Pharmacy puts a sticker on the card with the pick up dates</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>4. Pharmacy will receive the CDU parcel and send to OIM</strong></td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>5. MM clinician writes a down referral letter</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>a. If they don’t write the referral, still accept them.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>OIM PN will review the patients once a year</strong></td>
</tr>
<tr>
<td><strong>Patient presenting at MM rather than OIM</strong></td>
<td></td>
<td><strong>MM will just see them. Won’t turn them away</strong></td>
<td><strong>Send a referral letter when goes back to OIM</strong></td>
</tr>
<tr>
<td><strong>Referral to emergency services</strong></td>
<td>Acutely sick patients</td>
<td><strong>Discuss with MM clinicians – as below</strong></td>
<td><strong>Refer via MM for assessment by a doctor first</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Unless present late (if they will get to MM after 3pm) then send straight to Site B rather than KDH</strong></td>
</tr>
<tr>
<td><strong>Tracing</strong></td>
<td></td>
<td><strong>Weekly</strong></td>
<td><strong>MM</strong></td>
</tr>
<tr>
<td><strong>Tracing for missed referrals</strong></td>
<td>CHW team</td>
<td></td>
<td><strong>Catch and match system</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1. Small book that the referral is written in</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. Easy to review linkage</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>a. OIM PN will create a list on a Tuesday of those that were referred to MM that week</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>b. Give list to TB HIV Care clerk at MM to confirm when they go on a Wednesday who actually did come</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>c. Send list of who came and who didn’t to TB HIV Care Mx = Reporting</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>d. Clerk reports back to OIM PN and activate list and give to TB HIV Care CHW Mx (Sr Mlambo TB HIV Care nurse) at MM\rightarrow tracing done through MM system</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>e. Feedback given from CHW to OIM PN (telephonically/ in person depending on the CHW Mx decision)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>i. Join the existing MM MDT meeting: the OIM PN and CHW Mx at MM and two members of the CHW team at MM on Tuesday mornings.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1. Be part of the MM team</td>
</tr>
<tr>
<td><strong>Tracing for missed appointments</strong></td>
<td></td>
<td><strong>Appointment register/ diary – OIM nurse checks appointment list</strong></td>
<td><strong>Don’t come for booked appointment: refer to CHW Mx</strong></td>
</tr>
<tr>
<td>Tracing TB household contacts</td>
<td>Through MM system as the patient will be referred to MM for TB treatment anyway</td>
<td>Back up with MSF data team until handover – catch those that are missed Routine capturing – trigger usual LTFU list and processes</td>
<td></td>
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<tr>
<td>Support for OIM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MM clinical support</td>
<td>Patients beyond scope</td>
<td>Create a WhatsApp group with OIM PN and MM clinicians 1. Moira, Cobus, Germanie 2. Nomvana</td>
<td></td>
</tr>
<tr>
<td>Labs</td>
<td>PN</td>
<td>When required In the OIM and send to KDH</td>
<td></td>
</tr>
<tr>
<td>Labs</td>
<td>PN</td>
<td>N4 register for bloods – PN follow up and check results</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>From MM</td>
<td>Keep a certain amount of ward stock and have a pre-specified level that triggers ordering more (based on the previous weeks consumption) – on a Monday or Thursday</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>From MM</td>
<td>Bin cards and consumption reports by OIM PN</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>From MM</td>
<td>Ordering done by OIM PN</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>From MM</td>
<td>Medication dispensed from MM pharmacy to OIM as ward stock. Handed out by OIM PN</td>
<td></td>
</tr>
<tr>
<td>MM relationship</td>
<td></td>
<td>MDT on Tuesdays</td>
<td></td>
</tr>
<tr>
<td>Flow</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queue management</td>
<td>CHW – one of the counsellors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flow of patients</td>
<td></td>
<td>Counselor for everyone Then PN if needed</td>
<td></td>
</tr>
<tr>
<td>Folders</td>
<td></td>
<td>ART patients – all under MM. Folder will be opened. Will have an MM number.</td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td>All non positive patients – under TB HIV Care outreach sites. No folder. Use the OIM number for bloods</td>
<td></td>
</tr>
<tr>
<td>Advertising services</td>
<td>TB HIV Care</td>
<td>Word of Mouth Mobilisation for OIM and for PrEP – do the two at the same time</td>
<td></td>
</tr>
<tr>
<td>Advertising services</td>
<td>TB HIV Care</td>
<td>1. Need training on OIM information</td>
<td></td>
</tr>
<tr>
<td>Community relationship</td>
<td>TB HIV Care CHWs/ counselors?</td>
<td>Community liaison/ relationship with communities – TB HIV Care CHWs take on the engagement and report back to the community Build a relationship between the CHWs and the OIM team, and introduce the TB HIV Care OIM team to the community</td>
<td></td>
</tr>
<tr>
<td>Community relationship</td>
<td>TB HIV Care CHWs/ counselors?</td>
<td>Quarterly 6-7pm</td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td>Community</td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td>Who</td>
<td>When</td>
<td>Where</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Consumption monitoring   | 1. The consumption and monitoring tool will be filled by the assistant Pharmacist  
                            2. The nurse will fill the daily consumption tool, weekly consumption tool | 1. Consumption tools will be filled by the nurse daily and Weekly Monitoring will be done weekly / Fridays | 1. Consumption monitoring will be done at OIM | 1. Consumption sheet will be filled by the nurse  
                                                                       2. Consumption register will be filled by the nurse  
                                                                       3. Weekly order sheets will be filled by the nurse and given to the assistant pharmacist |
| Inventory and stock take | 1. The inventory and stock take will be done by the assistant pharmacist  
                            2. Stock take will be done by the assistant pharmacy from Michael M/ TB/HIV care Pharmacist | 1. Inventory and stock take will be done Once a month | 1. Inventory and stock taking will be done at TB HIV care | 1. KESS/ TB/HIV care assistant pharmacist assisted will go to the mobile for inventory and stock take |
| Ordering and delivery    | 1. Ordering will be done by the OIM Nurse weekly using ordering forms from Michael M  
                            2. The order form will be taken by the driver to Michael M to put the order | 1. Ordering will be done on Mondays by the nurse  
                                                                       2. Orders will be collected on Tuesdays by the nurse with the driver | 1. Ordering of drugs will be done at OIM | 1. The medication will be picked up by the nurse with TB/HIV care |
| Drug storage             | 1. During the day drugs will be stored in the trailer  
                            2. After hours the Drugs will be stored at TB HIV care offices  
                            3. They will be transported by the TB/HIV care | 1. Drugs will be stored Daily after hours at TB/HIV care offices  
                                                                       2. They will be taken to the trailer every morning | 1. Drugs will be stored in the TBHIV care offices in Khayelitsha after hours  
                                                                       2. They will be stored at the trailer during the day | 1. The drugs will be transported by the TB/HIV care driver to TB/HIV care offices |
| Reconciliation of stock  | 1. Reconciliation will be done by the Pharmacy assistant with the OIM nurse | 1. Reconciliation will be done once a week, weekly | 1. Reconciliation will be done at OIM | 1. Reconciliation tools will be done using reconciliation tools |
| Clubs and QPUP           | 1. Pharmacist assistant will be responsible for OIM clubs.  
                            2. The pharmacist assistant Q - pup clubs registered as well | 1. The Ezizalini Community clubs will be held at the community hall  
                                                                       2. The VPUU community club will be held at VPUU | 1. All clubs will be registered other CDU | 1. All clubs will be registered other CDU |
## Data SOP

<table>
<thead>
<tr>
<th>Activity</th>
<th>Who</th>
<th>When</th>
<th>Where</th>
<th>How</th>
</tr>
</thead>
</table>
| Registers and reporting for non-HIV services | 1. Counselor Fills HTS register  
2. PN fills tally sheet for each patient non–HIV patients  
3. TB/HIV M&E Team captures the information | 1. The counselors fills the HTS register after each HTS  
2. PN fills the tally after when seeing the patients  
3. The data capturing team will capture all the information once a week  
4. Report will be compiled by the M&E team on the 1st to the 4th of every month | 1. HCT register will be in the counselor room  
2. Tally sheet – in the consultation room of the PN  
3. Capturing will be done at TB HIV care office | 1. The DOH HST register will be used by the counselors  
2. The nurse will use the nurse register to register every patient seen by the nurse  
3. The DOH daily tally sheet will be used for record keeping  
4. Data will be captured electronically on excel sheet that will be provided by the department of health |
| Stickers & folder numbers | 1. Both the nurse and The clerk will be responsible for the stickers and the folders number of HIV positive patients | 1. The nurse will be responsible when they are consulting with the patients  
2. The clerk will make sure all patients have folder numbers when she is capturing | 1. Consultation room  
2. Michael Mapongwana | 1. Keep temporary stickers at OIM  
2. Patients assigned temporary FNs  
3. When captured, clerk looks up patient in PHCIS and either links temp number to existing patient or enters new patient details under new folder number |
| HIV positives (known and new positives): Known patients (with card/FN) | 1. Nurse  
2. Clerk | 1. During consultation  
2. At Capture | 3. Consultation room  
4. Michael Maphongwana | If patient has card they are assigned same folder number.  
When folder is captured, clerks print new stickers. |
| HIV positives (known and new positives): Unknown FNs | 1. The nurse will be responsible for folders | 1. The folder will be opened once a | 1. The folders will be left in the trailer overnight and will | 1. New folders will be opened for all HIV+ patients, |

<p>| Folders | 1. The nurse will be responsible for folders | 1. The folder will be opened once a | 1. The folders will be left in the trailer overnight and will | 1. New folders will be opened for all HIV+ patients, |</p>
<table>
<thead>
<tr>
<th>Patient tests positive.</th>
<th>Be taken out once it is time for capturing. The trailer will be parked at the department of health property</th>
<th>Regardless of if they have a folder at MM.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. If patients transfer between OIM and MM clinicians should write a note on clinical stationery.</td>
<td>3. The folders should be clearly labelled “OIM” with highlighter on outside center of folder</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Capturing</th>
<th>1. The PN will capture patient information in the folder</th>
<th>1. The nurse will fill the folders daily</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. The TB/HIV care driver will take the folders to Michael M for capturing</td>
<td>2. The folders will be delivered at Michael M on Tuesdays at 3:30 for capturing</td>
</tr>
<tr>
<td></td>
<td>3. Capturing will be done by the TB/HIV care clerk</td>
<td>3. Capturing will be done on Wednesday when OIM is closed</td>
</tr>
<tr>
<td></td>
<td>4. The folders will be returned to OIM on Thursday morning</td>
<td>3. Trauma room??</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clubs/Q-pup &amp; Welcome Service</th>
<th>1. The clerk will capture the clubs/q-pup patients as well as welcome service patients</th>
<th>1. Capturing will be done on Wednesday</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. The clubs will be Captured separately as community club and Welcome service respectively</td>
<td>1. The clubs will be Captured separately as community club and Welcome service respectively</td>
</tr>
<tr>
<td></td>
<td>2. The capturing process for clubs/ Q-pup and welcome services will be the same process as the folders process</td>
<td>2. The capturing process for clubs/ Q-pup and welcome services will be the same process as the folders process</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Labs</th>
<th>1. The Nurse will be responsible for bloods</th>
<th>1. Bloods will be taken at patient visit/club visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. The TB/HIV clerk will support with the capturing of bloods</td>
<td>2. Capturing of bloods will be done at Michael M</td>
</tr>
<tr>
<td></td>
<td>1. Bloods will be taken at OIM</td>
<td>1. Blood will be taken at OIM</td>
</tr>
<tr>
<td></td>
<td>2. Capturing of bloods will be done on Wednesday</td>
<td>2. Capturing of bloods will be done at Michael M</td>
</tr>
<tr>
<td></td>
<td>1. Blood samples will be recorded in N4 book</td>
<td>1. Blood samples will be recorded in N4 book</td>
</tr>
<tr>
<td></td>
<td>2. Results will be looked up on NHLS</td>
<td>2. Results will be looked up on NHLS</td>
</tr>
<tr>
<td></td>
<td>3. The results will be printed by the clerk and put on the folders for HIV+ patients, for the negative patients results will be put in a booklet</td>
<td>3. The results will be printed by the clerk and put on the folders for HIV+ patients, for the negative patients results will be put in a booklet</td>
</tr>
<tr>
<td></td>
<td>4. The results will be captured into PHCIS</td>
<td>4. The results will be captured into PHCIS</td>
</tr>
<tr>
<td></td>
<td>5. If results are not printed the nurse can look them</td>
<td>5. If results are not printed the nurse can look them</td>
</tr>
</tbody>
</table>
| **Tracing** | 1. Michael Maphongwana tracing protocol will be followed  
2. Patients that are traced will be reflected on MMP lists. | 1. The OIM nurse will have contact details of the community health care workers at Endlovini  
2. The OIM nurse and counselors can call specific patients that need to be followed up |  
| **HTS consent forms** | 1. Counselor | After HTS visit | Kept in file for negatives  
Folder for positives | Counselor fills in and is responsible for filing |  
| **Stationery supply** | 1. The stationer will be supplied by MR Matiso from KESS and provided to the PN  
2. Stationery will be supplied to the PN/Counselor | 1. The stationery will be supplied as needed  
2. Stationery will be provided when the stationery runs out or on Wednesday | 1. The stationery will be From KESS or Michael M  
2. They can be sent with the captured folders on Thursday | 1. The Registers will be supplied by Mr Matiso when requested by PN  
2. Blank folders and stationery (HTS forms, clinical stationery), patient cards, and N4 booklet supplied by Mr Mpu (AO) at MMP. Nurse/counselor to call/email to request, copy in/call FM. |
7.3. **Summary of the Welcome Service DSD for patients struggling with ART**

The Welcome Service is a differentiated service delivery (DSD) model for HIV care to support clients who are not coping with treatment, including those who have difficulty with adherence to antiretroviral therapy (ART) resulting in a high viral load (VL) and clients who struggle with clinic attendance (missed appointments or complete disengagement, i.e. loss to follow up). In a systematic review of qualitative literature, Eshun-Wilson *et al* explore how different factors influence adherence and long term retention in HIV care\(^8^3\). They describe how clients experience a multitude of competing stressors that combine to a point at which clients are unable to cope and “tip over” into disengagement (i.e. stop taking treatment or miss appointments).

The Welcome Service, developed on this theory, aims to build patient resilience and long-term retention through improved identification and management of barriers to engagement with ART. Clients who have disengaged from care are at risk of advanced HIV, can often be challenging to manage and are time- and resource intensive. Many staff members feel overwhelmed when managing these clients which may result in negative attitudes and punitive behaviours toward this group.

The Welcome Service aims to improve retention in care by supporting healthcare workers through tools and training to better manage these clients in an environment that is more welcoming and client-centred. The focus is on: improving the identification and triage of clients who need support, ensuring they receive the support they need through a differentiated system of care, streamlining the clinic experience to minimize unnecessary delays, ensuring optimal clinical management of HIV (i.e. promoting same-day re-initiation, high VL management, early and appropriate ART-switching, prevention and management of opportunistic infections), identification and management of psychosocial barriers through improved adherence counselling and promotion of more supportive staff behaviour. The service was first implemented by the Western Cape Department of Health and Médecins Sans Frontières through a mentoring programme at Michael Mapongwana Community Health Centre in Khayelitsha and is currently being developed into a model for upscale to all primary care facilities in Khayelitsha.

For more information please contact [msfocb-khayelitsha-wbsdr@brussels.msf.org](mailto:msfocb-khayelitsha-wbsdr@brussels.msf.org)