Barriers and Enablers Associated with Differentiated Models of ART Distribution at the Community Level: A Three-Country Study

Nikki Davis[1], Malia Duffy[2], Sabrina Eagan[2], Melissa Sharer[1, 3], Ugochukwu Amanyeiwe[4]

[1]JSI Research & Training Institute, Inc. Arlington, VA, United States, [2]JSI Research & Training Institute, Inc., Boston, MA, United States,
[3]St. Ambrose University, Davenport, Iowa, United States, [4]United States Agency for International Development, Washington, D.C., United States

Fifth Global Symposium on Health Systems Research • Liverpool, UK • October 8-12, 2018

Background

In an effort to expand access to antiretroviral treatment (ART), countries across sub-Saharan Africa have begun to implement and scale up differentiated approaches to ART distribution, particularly at the community level. These distribution models are typically designed to cater to stable adult patients and aim to bring ART closer to where patients live, which, in turn, serves to decongest clinics and reduce the overall strain on a country's health system. **While documentation on the results of these models exists, there is limited information on the specific barriers and enablers that have impacted the implementation of such models.** This cross-country study describes various models of differentiated ART distribution and the barriers and enablers associated with their implementation.

Differentiated Models of ART Distribution are mechanisms through which the dispensing of ART is decentralized. These models aim to expand ART access—usually for stable patients—by providing multiple options through which they can collect their ART less frequently and/or closer to home.

Community Models Of ART Distribution Explored

Community Adherence Clubs

Groups meet in the community and members take turns collecting everyone's ART from the facility each month and bringing it back to the group.

Outreach

Health facility staff provide ART distribution services to remote communities or patients with transport challenges. Also includes ART distribution at worksites.

Community Distribution Points

Clients pick up ART from a pre-identified distribution point in the community, such as a church, meeting hall, or retail pharmacy.

Methodology

The assessment was conducted between October 2016 and November 2017 and aimed to document existing models of differentiated ART distribution and their associated barriers and enablers in three countries:

South Africa
Uganda
Zimbabwe

These three countries were chosen because of their varied HIV prevalence, different strengths of their overall health system, and the fact that they were implementing differentiated models at the community level.

The research team conducted the assessment utilizing a **qualitative** participatory action approach to uncover a comprehensive understanding of barriers and enablers associated with the implementation of differentiated models for ART distribution. Data was collected through semistructured interviews and focus group discussions with **163 participants** across the three countries. Respondents were multilevel stakeholders representing **policy, programmatic, provider, and patient perspectives.**

Results

Community models for ART distribution typically faced additional challenges and considerations due to the decentralization of services outside of the health facility and into the community, making oversight and management a more difficult process. Respondents discussed multiple barriers and enablers associated with the implementation of these programs and often found effective ways to address barriers and harness enablers in order to implement each model.

Enablers

Patient and Provider Education was cited by respondents as absolutely necessary for successful implementation. Once patients were oriented to the available models, they were able to choose the one that best fit their needs. Since providers are the ones who "market" the idea of enrolling in a differentiated model of ART distribution to patients, it is key for providers to not only buy in to the models but to also have a clear understanding of models in order to properly identify patients for enrollment.

Peer Support was the most-cited enabler for implementing community-level models. This factor was most often associated with the Community Adherence Club model which has an inherent element of peer support.

Both Barriers and Enablers

Provider Attitudes were often described as a common barrier before and during the early stages of implementation, but later became an enabler once positive outcomes such as improved patient adherence or reduced workloads for clinic staff began to emerge.

Barriers

Stigma and Discrimination is an inherent issue associated with community-level models. Because patients are receiving services in the community, many expressed concern that their HIV status was likely to be exposed.

Poor Linkage to Care was cited most often by health care providers as a potential barrier to implementing differentiated models of ART distribution at the community level. Many providers expressed fear that community-level models reduce their ability to monitor patients routinely and effectively.

Peer Support

Patient and Provider Education

Provider and Patient Attitudes

Poor Linkage to Care

Stigma and Discrimination

ENABLERS ← → **BARRIERS**

Conclusions

While differentiated models of ART distribution aim to broaden patient access to ART, models that provide these services at the community level have additional challenges and considerations that should be assessed and planned for prior to implementation. Two important barriers seen across all countries assessed included stigma and poor linkage to care; considerations for addressing these barriers should be included in the design of the models.

Peer support and education for both patients and providers were noted as important drivers of the success of community models. Peer support was a desirable element of some of these models for patients, and providers reported increased support for community interventions as the programs evolved and the gains became more apparent. Intensive education at the front-end of scale-up can help providers effectively market the community-level models and help patients pick a model that would work best for them.

Understanding these barriers and enablers will help country programs effectively and efficiently implement differentiated models of ART distribution to fit varying contexts, and allow for rapid scale-up, resulting in expanded access to ART and the ability to better meet the demands of patients on ART on a global level.

This publication is made possible by the generous support of the American people through the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) with the United States Agency for International Development (USAID) under the Cooperative Agreement Strengthening High Impact Interventions for an AIDS-free Generation, number AID-OAA-A-14-00046. The information provided does not necessarily reflect the views of USAID, PEPFAR, or the U.S. Government.