Getting person-centred care right: Good practice models of integrating HIV and other health needs
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Session presenters:

- Brent Allan, ICASO, Australia
- Tung Doan, Lighthouse, Vietnam
- Erick Luc, Lighthouse, Vietnam
- Baker Bakashaba, TASO, Uganda
- Rodenie Olete, Gabay sa Pulang Laso, Philippines
- Daisy Kwala, BHESP, Kenya
### Overview of the session

**Getting person-centred care right: Good practice models of integrating HIV and other health needs**

- **Person-centred care to ensure quality of life for people living with HIV – conceptual framework and considerations for implementation**, Brent Allan, ICASO, Australia

- **A model of people-centered, peer-led and one-stop clinic for young key populations and young people living with HIV in Vietnam**, Tung Doan & Erick Luc, Lighthouse, Vietnam

- **A person-centred care approach for adolescents and young people living with and affected by HIV**, Baker Bakashaba, TASO, Uganda

- **Open Doors Home – temporary shelter programme & SEGT-based psychosocioeconomic support for people living with HIV in the Philippines**, Rodenie Olete, Gabay sa Pulang Lao, Philippines

- **Person-centred care model for sex workers who use drugs in Kenya**, Daisy Kwala, Bar Hostess Empowerment & Support Program, Kenya

- Q&A / Discussion
Getting person-centred care right: Good practice models of integrating HIV and other health needs

Satellite Session SA070 31/07/2022

Person-centred care to ensure quality of life for people living with HIV – conceptual framework and considerations for implementation

Brent Allan
Senior Advisor – ASHM
Civil Society Representative – ILF/IAS
Acknowledgement

I want to begin my presentation by thanking the people living with HIV who have generously shared their time, experiences, and perspectives for the purposes of this project. Much of the fight against HIV and AIDS relies upon people living with HIV continuing to put themselves forward and this research and our fight against HIV and AIDS is indebted to those past and present.

Conflict of interest disclosure

Consultant Advisor to NAPWHA (Australia) for a ViiV Healthcare Australia funded project through an unrestricted educational grant.

Co-author on a manuscript on Client-led care in HIV funded through an unrestricted education grant from Gilead sciences
National Association of People with HIV Australia (NAPWHA)

Advocacy, representation, policy & health promotion for people with HIV.
Achieving Quality of Life for All Project

Research Paper: Population Medicine

Quantifying unmet treatment needs among people living with HIV in Australia and other countries

Eveet Allen, Fraser Stewart, Anna Mertens, Benjnahm Young, Clarrisa Goh

Economic empowerment.
Project Outputs
The Australian Community Accord on Quality of Life for People Living with HIV

Daniel Reeders* and Brent Allen** with artwork by Daniel Gardiner**

A person-centred framework for eliciting and addressing the drivers of self-perceived quality of life.

Background
The multi-country Positive Perspectives 2 study, conducted by UNAIDS through partners living with HIV in Australia reported very high satisfaction with treatment (80%), but experienced lower overall well-being (40%) (Khan et al., 2020).

In response, the National Association of People Living with HIV Australia (NAPAWA) undertook a series of web-based community engagement events to build an understanding of how people with HIV in Australia define good quality of life.

The result is an Australian Community Accord on Quality of Life for People with HIV which is both a commitment and a call to action for the partners in the Australian HIV response.

The Accord defines a framework, based on thematic analysis of our extensive consultation-based, for identifying and addressing the drivers of self-perceived quality of life in people with HIV. It outlines a prioritized list of domains and measures such as PartQOL and the WHODAS-II-HIV scales.

** DRIVERS **
- Meaning
  - Where HIV fits in your life narrative and what meaning and purpose you find in living with HIV.
- Belonging
  - Feeling a sense of belonging and enough of the key of social connection that matter to the person living with HIV.
- Voice
  - What does HIV care that goes beyond viral suppression and include the HIV spectrum of health and experiences that affect quality of life for people with HIV.
- Support
  - How support is valued and experienced.

** POSITIVE INFLUENCES **
- Older age, higher education, religiosity and spirituality
- Good HIV treatment & experiences
- Community involvement
- Good relationships
- Good health
- Good nutrition

** NEGATIVE INFLUENCES **
- Older age, lower education, religiousness, and spirituality
- Poor HIV treatment & experiences
- Disengagement
- Poor health
- Poor nutrition

** REFERENCE **

The Accord Framework
The Accord calls for action to Advocate, Complain, Address, Review, Enhance and Develop the drivers of quality of life, including the social determinants of health and health inequities.

"The Australian Community Accord on Quality of Life for People living with HIV" by Daniel Reeders and Brent Allen, with artwork by Daniel Gardiner.

(Refer to the poster for detailed content and visual elements.)
# AusQoL: A PLHIV Community Accord on Quality of Life

## The Accord Framework

The Accord calls for action to Advocate, Consider, Address, Reduce, Enhance and Evaluate the drivers of quality of life, including the social determinants of health and health inequities.

<table>
<thead>
<tr>
<th>Advocate</th>
<th>Consider</th>
<th>Address</th>
<th>Reduce</th>
<th>Enhance</th>
<th>Evaluate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of life for all people with HIV by 2030</td>
<td>Social determinants of quality of life</td>
<td>Comorbidities</td>
<td>Stigma</td>
<td>Meaning</td>
<td>Clients/patients</td>
</tr>
<tr>
<td>Healthy living</td>
<td>Isolation</td>
<td>Belonging</td>
<td>polypharmacy</td>
<td>Insecurity</td>
<td>Support</td>
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<tr>
<td>Mental health</td>
<td>Distress</td>
<td>Care</td>
<td>Treatment literacy</td>
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<td>Communities</td>
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<td>Polypharmacy</td>
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<td>Population</td>
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<td>Treatment literacy</td>
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</table>
A step further…

Models of care:

**Client-centred:**
recognised model that acknowledges the care experienced by a person is influenced by the way their health is managed

**Client-led:**
less well-defined model of care that goes beyond client-centred care for PLHIV who can and want to lead their own care

**Objective:**
to propose a definition of client-led care in the Australian context and its supporting principles.

Volume 22, Issue S1
Special Issue: Client-led care in HIV: Perspectives from community and practice
July 2021

Authors conclude...
“A client-led approach can complement conventional HIV care strategies and enable empowerment and greater engagement with care, potentially improving the care continuum and overall QoL for individuals living with HIV who can, and want to, lead their own care.”
What makes a difference?

1. The quality of the healthcare provider and patient relationship
   • acknowledging the changing nature of care over time
   • one size doesn’t fit all

2. A shared understanding of the complexity of care between patient and provider

3. Our desire to be …

Happy…Healthy…Connected
With thanks...

The hundreds of people who took part in the AusQoL Consultation process most notably

- **Ann Maccarone** & **Fraser Drummond** - ViiV Healthcare Australia
- **Aaron Coogle** & staff from NAPWHA
- **Damien Faegan** & co-authors from the Client-led care in HIV paper (July 2021)
- #PeersExplain colleagues – **Heather, Beau and Anth**
- **Daniel Cordner** – artist, activist and graphic designer extrodinaire
- **Dr Graham Brown, Dr Lucy Stackpool-Moore** and **Dr Jeffery Lazarus** for continued inspiration and leadership
- **Daniel Reenders** (NAPWHA) – co-author on AusQoL and amazing partner in practice

With thanks...
Thanh Tung and Erick Luc, Lighthouse Social Enterprise, Vietnam

Getting person-centred care right: Good practice models of integrating HIV and other health needs

Lighthouse Community Clinic: A person-centred, peer-led clinic for young key populations and young people living with HIV in Viet Nam
Conflict of interest disclosure

I have no relevant financial relationships with ineligible companies to disclose.
A Future of Better Health, Equal Rights, and Sustainable Development for young key populations
Lighthouse’ practice areas

- Educate and generate demands
- Build and deliver friendly, quality services
- Conduct the community-led/participatory action research
- Advocate for community’ rights
- Build capacity and empower community
- Mobilize, connect & unite the community
Populations we’re serving
Person-centred care is always listening to and respecting clients, caring and meeting the needs of each individual in a comprehensive and appropriate way, empowering people to take care of their own health and well-being, and meaningfully participate in improving the quality of health care for the community.
Person-centred care model: overview

Problem statement: Low uptake of HIV services among young key populations due to unfriendly services.

Solution:
• Raise awareness of young key populations on sexual health, HIV, safe & healthy lifestyle.
• Provide peer-led, client-centred, and one-stop services to young key populations.
• Maximize the client/community engagement into services

Impact:
• Young key populations equipped with adequate knowledge on sexual health, HIV and healthy lifestyle, and proactively access to related services.
• Increased number of young key populations accessing and utilizing HIV related services, improved their quality of health and meet their health outcomes.
• Young key populations contributed significantly in design the services that they receive
## Building blocks of service model at Lighthouse Clinic

<table>
<thead>
<tr>
<th>WHEN</th>
<th>HIV testing</th>
<th>PrEP/nPrEP</th>
<th>HIV confirmatory test and ARV treatment</th>
<th>STI testing and treatment</th>
<th>Mental health screen and care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>According to client’s preference</td>
<td>After HIV testing service and according to client’s preference</td>
<td>After HIV testing service and according to client’s preference</td>
<td>Integrated with HIV testing and according to client’s preference</td>
<td>According to client’s preference</td>
</tr>
<tr>
<td>WHERE</td>
<td>At clinic</td>
<td>At clinic</td>
<td>At clinic</td>
<td>At clinic</td>
<td>At clinic</td>
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<tr>
<td></td>
<td>At community events</td>
<td>At community events</td>
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<td>At community events</td>
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<td>At hotspots</td>
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<tr>
<td></td>
<td>At client home/comfort venue</td>
<td>At client home/comfort venue</td>
<td>At client home/comfort venue</td>
<td>At client home/comfort venue</td>
<td>At client home/comfort venue</td>
</tr>
<tr>
<td>WHO</td>
<td>Trained-, sensitized peers &amp; medical staffs Client</td>
<td>Trained-, sensitized peers, medical staffs who are KPs.</td>
<td>Trained-, sensitized peers, medical staffs</td>
<td>Trained-, sensitized peers, medical staffs</td>
<td>Trained-, sensitized peers, medical staffs, psychologists</td>
</tr>
<tr>
<td>WHAT</td>
<td>Risk screening, counseling on risk reduction and protection, healthy lifestyle, introduce and perform HIV testing service, referrals.</td>
<td>Information of PrEP/nPrEP, its effectiveness, side effects, myths and facts, PrEP retention and healthy lifestyle, referrals.</td>
<td>Mental support, information of HIV confirmatory test and ARV treatment, its effectiveness, side effects, myths and facts, retention and U=U, HIV neutral status, referrals.</td>
<td>Risk screening, information on STI and importance of taking periodically STI testing and checkup, risk reduction and protection, introduce other HIV services, referrals.</td>
<td>Mental health screening, counseling on client’ mental health status, information on mental selfcare, plan to improve mental health, and referrals.</td>
</tr>
</tbody>
</table>
Person-centred care elements

- HIV plus COVID preventive commodities
- ARV treatment & TB screening and referrals
- PrEP/nPEP & STIs and viral hepatitis
- NCD services (Diabetes, hypertension, Cancer screening, etc.)
- HIV counseling and testing: HIV community testing, HIVST, ICT/PNS
- Mental health screening and support
- Chemsex and ATS counseling and support
- Other services according to community’s needs

Diversify services to meet the comprehensive needs of the community
Quantitative outcomes

HIV service
Sep 2021 – June 2022

Test 1623
PrEP 568
ARV treatment 72

STI service
Sep 2021 – June 2022

Counseling 728
Testing 431
Treatment 106

Mental health service
April 2022 – June 2022

Counseling 1058
Screen 189
Received Support 132
Quantitative outcomes

**Key takeaways:**

1. Person-centered PrEP services/approaches need to be **tailored to different sub-groups of KPs** such as young MSM, older MSM, TG, and hard-to-reach KP (e.g. Chemsex).

2. Providing a **comprehensive needs-based service** package that helped generate demand for HIV services. **STI, Mental health, Harm reduction, SGBV, Hormone and gender affirmation** care need to be integrated in service package.

3. Providing **friendly, flexible, services led-by peer** greatly increased the uptake of HIV service.

4. Mobilize the **participation of KP** in the service that helped reach the hidden and high-risk communities.

5. Invest in **customer services** helped to increase the retention rate of services.
Client satisfaction

1. Availability and accessibility of services
   86% very satisfied and 14% satisfied

2. Welcome and service instructions process
   93% very satisfied and 7% satisfied

3. Attitude and expertise of staff.
   98% very satisfied and 2% satisfied

4. Service delivery procedure
   88% very satisfied and 12% satisfied

5. Client care services
   92% very satisfied and 8% satisfied
“In the first time, before I came here, I was extremely worried that I could be judged for having a same-sex relationship. But as soon as I arrived, I felt very comfortable from the clean and friendly space, the staff were all very welcoming and enthusiastic, the procedures were quick and informative. All in all, everything is so nice ...

NDT, 19 years old, a PrEP user at Lighthouse clinic

The clinic has made positive and rapid changes when receiving feedback from the community such as changing working hours to be more flexible, improving the community-friendly space, adding services including support psychology, providing free condoms, and for sexually transmitted diseases ...

NQA, a member of community advisory board
Integration of services

- Mobilize trained peers to be service providers with appropriate supervision and technical support to peer service providers
- Develop and provide clear SOPs of services
- Engage community in design the services
- Diversify the services and its delivery according to the community's needs (Mobile, Tele, homebased-services, flexible hours..)
- Mobilize the community in monitoring and service quality improvement.
- Community exchange and network development
1. Document the Lighthouse clinic model and share widely to other community organizations with the support from IAS.

2. Regularly collect data of the issues and needs of the community, and engage them in design the new services/delivery methods.

3. Continue to strengthen and expand HIV services to the community by various ways (Mobile, Tele services, home-delivered, community event ...)

4. Integrate harm reduction services, hormone therapy and gender affirmation counseling, reproductive health and NCD in current HIV package.

5. Strengthening mental health care services through art-therapy, peer counseling, mental health friendly service map.

6. Develop a platform for HIV service facilities to exchange and learn about person-centered care model and how to apply in their site.

7. Advocate for a national guideline on person-centered care model in Viet Nam.
Person-centered care is important because everyone has the rights to equitably access quality health care. It's the right thing to do to ensure key populations and people living with HIV to achieve the best health outcomes and well-being.

It's a vital approach to eliminate HIV/AIDS by 2030.
Baker Bakashaba, TASO, Uganda

Getting person-centred care right: Good practice models of integrating HIV and other health needs

A person-centred care approach for adolescents and young people living and affected by HIV
Conflict of interest disclosure

I have no relevant financial relationships with ineligible companies to disclose.

"The findings and conclusions in this presentation are those of the author(s) and do not necessarily represent the official position of the funding agencies."
The AIDS Support Organization (TASO) Uganda

TASO Uganda Ltd is a non-governmental organisation established in 1987 to offer HIV counseling and medical services to people living with and affected by HIV and AIDS.

Vision: "A World Without HIV and AIDS"

TASO is implementing a 5 year health systems strengthening project since 04/01/2017 in Soroti region with a purpose to "Achieve Epidemic Control through attainment of 95-95-95 UNAIDS targets by 2020 and strengthening health systems in Soroti Region in the Republic of Uganda under the President’s Emergency Plan for AIDS Relief (PEPFAR)."

Soroti region consists of 15 districts in North Eastern Uganda.
Organization’s current practice areas

- HIV Prevention, Care and Treatment
- TB prevention and treatment services
- Health systems strengthening

Young Persons and Adolescents Peer Support (YAPS) at one of the implementing sites
TASO provides HIV care and treatment services to over 193,000 PLHIV in the 11 TASO Centers of Excellence spread across the country and in public health facilities supported in the regions of Soroti, Ankole and Acholi sub-regions of Uganda. The populations served include:

- Adults, pregnant and breastfeeding adolescents and children
- Key populations such as sex workers and their clients, men who have sex with men, people who inject drugs, incarcerated persons
The specific objectives are:

1. To increase the proportion of adolescents and young people living with HIV who know their HIV status from 68% to 95% by 2023.
2. To improve ART treatment coverage of adolescents and young people living with HIV from 68% to 95% by 2023.
3. To increase VL suppression among adolescents and young people living with HIV from 77% to 95% by 2023.
4. To improve psychosocial wellbeing among AYPLHIV through improved quality of psychosocial care and support.
The YAPS model has been implemented since 2019, in collaboration with Ministry of Health and with funding from PEPFAR through CDC Uganda.

It was adopted from the Zvandiri Community ART Group (CAG) model in Zimbabwe following a South-to-South learning visit facilitated by Coverage Quality Impact Network (CQUIN) project of International Center for AIDS Care and Treatment Programs (ICAP) at Columbia University.

Piloted in two districts, each with 5 implementing facilities:
- Soroti district: 1 Center of excellence, 1 health centre IV and 3 health centre IIIs
- Kumi district: 1 Hospital, 1 health centre IV and 3 health centre IIIs

Currently, implementation has been scaled up to 4 districts and 20 health facilities.

Key District stakeholders led by District Chairperson attended YAPS orientation in Soroti District, June 2019.
Overview of the YAPS person-centered care model

- YAPS target population is adolescents (10-19yrs) and young people (20-24yrs)
  - The peers aged 18 to 22 years are formally recruited and facilitated to participate in the management of this sub-population
  - They follow the nationally adopted guidance on: Case identification, linkage to ART, adherence support, follow ups, intensive adherence counselling, home visits and school visits among others
  - They participate in the performance review meeting and contribute towards identification and adoption of strategies

Hand over of Bicycles to Soroti District Authorities and to the YAPS, October 2020
Across each of the Health system building blocks

**Leadership and Governance**
- The peer leaders are allocated 3 days a week to support their fellow Adolescents and Young Persons (AYP), 1 day at the facility and 2 days in the community

**Health Workforce**
- Additional workers to manage AYPs
- YAPS take the lead role in planning and implementation
- For both facility and community based care of AYPs:
  - Community includes: home and school visits
  - Facility include: Reminders by phone calls and use of WhatsApp groups.
  - forming income generating groups

**Retention/Follow up**
- This cuts across the 95-95-95 cascade for the AYPs
- They closely work with the facility YAPS supervisor, and a district YAPS mentor

**Care and support to AYPS/care givers**
- The established on ART are: suppressed, adhering to treatment and require less support
- Those with advanced HIV disease are: usually newly identified, with adherence challenges, suffering stigma and the non-suppressed and require more frequent support

**AYP is established on ART or has Advanced HIV**
Building blocks of YAPS model Cont.

YAPS facilitating physical education on a clinic day

AYPs learning how to make liquid soap, as one of the Income Generating Activities
1. **YAPS Model elements**

   The YAPS model intends to address the complex health needs of adolescents and young people, including health needs other than HIV-related through:
   - Multi sectoral coordination and engagement: Facility level; sub-county level and district level. To ensure every stakeholder is brought on board and their valuable contribution factored into the programing for effective implementation.

   The YAPS model, other than HIV; integrates other services and referrals accordingly:
   - Screening: Nutrition, Gender Based Violence screening and prevention, depression
   - Referral for: Family planning services, Cervical cancer screening, VMMC
   - Linkage to OVC services.

   ![YAPS peer leaders for seeing food distribution to AYPs during the lockdown period](image-url)
Quantitative data ct’d

1. **Active AYPLHIV**
   623 in YAPs Program

2. **Self Test Kits**
   263 given self test Kits for testing

3. **HIV testing Yield**
   An improvement in yield from 0.4% in 2019 to 0.8% in 2022

4. **Linkage**
   Improvement in linkage from 71% to 100% in 2022

5. **Retention**
   100% follow up of lost AYPLHIV 10-24yrs
Quantitative outcomes

Viral Load Coverage
Viral load coverage has moved from 84% in 2019 to 97% in 2022.

Viral load coverage
Viral load suppression has moved from 82% to 95% among the 3 facilities.

Intensive Adherence Counseling Completion
IAC completion has moved from 83% to 100% by 2022.

ART optimization
ART optimization to DTG has improved to 96% due to availability of DTG 10mg.

Data source:
YAPS MIS
DATIM Data
"I did not quite accept my diagnosis of having HIV, was bitter with everyone and asking, why me? I could not take those medicines well, they were even bitter and too big. I was falling sick all the time and knew I would die anytime. Thank God, all that changed when I was linked up to fellow young people in TASO who encouraged me to be positive and to take my drugs well and now I am healthy and I believe I have a future to achieve. Those young people saved my life." E J, 18 years, a beneficiary of YAPS peer-peer support.

Shared in an Interview with TASO Staff after receiving his drug refill from the YAPS at his Uganda Martyrs Vocational Institute, June 2022.
Integration of services

- Integrating care for HIV and other health needs, improves health seeking behavior.

- Right from the planning stage to implementation and performance review, the AYPs should be part to realize program objectives.

- Peer to peer mentorship among the AYPs is key for cross learning and better understanding of the model.

- The YAPS have been pivotal in mobilizing young people for COVID-19 vaccination.

A YAPS led group session, under supervision of facility supervisor.
Next steps

- TASO will continue to implement the YAPS model to reap from its benefits so far realized.
- Working with other key stakeholders at national and regional levels, more districts will be engaged to scale up the model and reach all AYPs in care.
The YAPS model has led to significant improvement in the outcomes for adolescent and young people across the continuum of care.

The model is scalable and this is now being adopted nationally in Uganda.

The model has empowered young people and adolescents to take charge of their lives and the lives and health of their peers.

**Conclusion**

Adolescent drama group welcoming Alan Patterson, US Deputy Assistant Secretary of Defence (DASD) for African Affairs and CDC Uganda Country Director Dr. Lisa Nelson to TASO Soroti.
This project has been supported by the President's Emergency Plan for AIDS Relief (PEPFAR) through the Centers for Disease Control and Prevention (CDC) under the terms of Cooperative Agreement NU2GGH0020660
Getting person-centred care right: Good practice models of integrating HIV and other health needs

Open Doors Home – temporary shelter programme & SEGT-based psycho-socioeconomic support for people living with HIV in the Philippines

Rodenie Olete, MSc, RN
Director of Programs & Research / Nurse Case Manager
Gabay sa Pulang Laso Inc., Philippines
Conflict of interest disclosure

I have no relevant financial relationships with ineligible companies to disclose.
Gabay sa Pulang Laso Inc. (GPLI)

- Filipino word which means “Guiding the Red Ribbon”
- Started in 2018, became SEC-registered in 2019
- Goal: Equity in provision of psychologic and other non-biomedical support programs which protect social determinants of health

- Four-pronged approach:
  - Psychosocial support
  - Spiritual counselling
  - Stigma reduction
  - Advocacy
Gabay Core Framework

PSYCHOSOCIAL

ADVOCACY

SPIRITUAL

STIGMA REDUCTION
WHAT KEEPS US GOING

Open Doors Home

Supportive-Expressive Group Therapy
GABAYanihan Convenience Store
Education Support For Young PLHIV
Career Guidance & Livelihood Training
Person-Centered Care is focused on holistic well-being of our *housemates* at Gabay sa Pulang Laso; housemates are empowered to take control of their mental wellness and physical health in attaining their ideal quality of life.

*housemates – People living with HIV who are cared for by Gabay sa Pulang Laso Inc.’s Open Doors Home Program*
ODH care model

Homelessness, Domestic Violence or Discrimination from Family

Open Doors Home

Physical & Mental Health Assessment
Supportive-Expressive Group Therapy
Other Biomedical Needs
Education Support For Young PLHIV
Career Guidance & Livelihood Training

29 July – 2 August · Montreal & virtual
aids2022.org
#AIDS2022
1. Physical and Mental Health Assessment
   • Entry assessment, monitoring, exit evaluation of physical and mental health needs

2. Nutrition and Basic Needs Provision
   • Three to five meals per day
   • Toiletries and hygiene
   • Bed and shelter

3. Supportive-Expressive Group Therapy (SEGT)
   • One-hour per week group sessions over 12 weeks (3 months)
   • Journal writing, catharsis training, positive reframing
   • Monitoring and evaluation of GAD7, PHQ9, and WHOQOL-Bref

4. Education, Profession, and Livelihood
   • Professional career guidance
   • Formal education or livelihood training

5. Other Biomedical Needs
   • Referral to in-house physician or partner treatment hub
   • Adherence counseling and monitoring
ODH-SEGT Implementation Process

**RECRUITMENT:** Screening and admission of PLHIV needing psychosocial support

**BASELINE ASSESSMENT:** Gather baseline data (use PHQ-9 and GAD-7), and coordinate with Attending Physician.

**END-OF-CARE EVALUATION:** Members with mild to no anxiety or depression (both GAD-7 and PHQ-9 < 10) at the end of 3-month session will exit the program, while inconsistent PHQ-9/GAD-7 result will extend.

**PRE-ORIENTATION:** Discuss case of PLHIV to the shelter case manager. Contact social worker, nurse manager, and other housemates to facilitate shelter intake.

If GAD-7 and PHQ-9 scores ≥ 10

**SEGT Sessions:** Implement catharsis and expressive therapy, processing of emotions, motivational interviewing, and logotherapy; with continuous progress monitoring every two weeks. End-of-care evaluation at 3rd month.

**ORIENTATION:** First meeting with the housemate; clarifying goals and objectives of the shelter program and SEGT sessions; determine roles and relationships of staff and other housemates.

**EXIT** Shelter and SEGT
## ODH-SEGT Module

### Orientation: Setting of Goals and Expectations

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<th>Module Title</th>
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<td>Orientation: Setting of Goals and Expectations</td>
</tr>
<tr>
<td>2</td>
<td><strong>SEGT-A: Building Meaningful Relationship with Self</strong></td>
</tr>
<tr>
<td></td>
<td>1. Who I truly am: Self-awareness, self-compassion, and meaning of existence</td>
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<td>2. Positive body image, self-perception, and acceptance of physical changes</td>
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<td>3. Discussing and developing acceptable ways of self-expression</td>
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<tr>
<td>4</td>
<td><strong>SEGT-B: Establishing Long-Lasting Relationships with Others</strong></td>
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<td>4. Mutual understanding and support from each other in the group</td>
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<td>5. Emotional and social support from the family</td>
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<td>6. Establishing meaningful collaboration and relationship with health providers</td>
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<tr>
<td>7</td>
<td><strong>SEGT-C: Preparing for Overwhelming Emotions</strong></td>
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<td>7. Locus of Control: Acknowledging what can and cannot be controlled</td>
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<td>8. Practicing emotional catharsis in dealing with overwhelming experience</td>
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<td>9. Identifying, processing, and acknowledging trauma</td>
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<td>10. Gray, Grief, and Grave: Introspective processing of the concept of death</td>
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<tr>
<td>11</td>
<td><strong>SEGT-D: Developing optimistic outlook and quality of life</strong></td>
</tr>
<tr>
<td></td>
<td>11. Planning for the future and developing a life project</td>
</tr>
<tr>
<td></td>
<td>12. Defining personal standards and strategies in achieving a “high-quality life”</td>
</tr>
</tbody>
</table>

### Saying Goodbye
# Quantitative Evaluation of ODH Care

## Table 1. Profile of Housemates\(^a\) in ODH Care (N=17)

<table>
<thead>
<tr>
<th>Demographics</th>
<th>mean</th>
<th>s.d.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age in years</td>
<td>31.7</td>
<td>14.4</td>
</tr>
<tr>
<td>Length of stay in days</td>
<td>117.6</td>
<td>138.8</td>
</tr>
</tbody>
</table>

**Referred by**

<table>
<thead>
<tr>
<th>Referral</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>NGO / CBO</td>
<td>10</td>
<td>58.8</td>
</tr>
<tr>
<td>Direct Contact</td>
<td>5</td>
<td>29.4</td>
</tr>
<tr>
<td>Health Facility</td>
<td>2</td>
<td>11.8</td>
</tr>
</tbody>
</table>

**Reason for Admission**

<table>
<thead>
<tr>
<th>Reason</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homelessness</td>
<td>10</td>
<td>58.8</td>
</tr>
<tr>
<td>Discrimination from family</td>
<td>4</td>
<td>23.5</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>3</td>
<td>17.7</td>
</tr>
</tbody>
</table>

**Reason for Discharge**

<table>
<thead>
<tr>
<th>Reason</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Independence(^b)</td>
<td>9</td>
<td>52.9</td>
</tr>
<tr>
<td>Reunited with family</td>
<td>5</td>
<td>29.4</td>
</tr>
<tr>
<td>Shelter rule violation</td>
<td>2</td>
<td>11.8</td>
</tr>
<tr>
<td>Permanent shelter transfer</td>
<td>1</td>
<td>5.9</td>
</tr>
</tbody>
</table>

**Note:**

\(^a\)Housemates’ data included were only between July 2020 to September 2021

\(^b\)Full Independence – housemate who found a job and can financially sustain himself for at least a year after exiting ODH
### Quantitative Evaluation of ODH Care

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**Reason for Admission**
- Homelessness
- Discrimination from family
- Domestic Violence

**Reason for Discharge**
- Full Independence\(^b\)
- Reunited with family
- Shelter rule violation
- Permanent shelter transfer

---

Note:
\(^a\)Housemates’ data included were only between July 2020 to September 2021
\(^b\)Full Independence – housemate who found a job and can financially sustain himself for at least a year after exiting ODH

---

**Key takeaway:**
- More than 50% of housemates gained full independence after exiting OHD
- Average of stay in the ODH program was 118 days (3.9 months)
- More than half of the housemates were referred by NGO/CBO
- Homelessness was the main reason for more than half of shelter admissions
Quantitative Evaluation of ODH Care

Figure 1. Mean GAD-7 Comparison during admission and after discharge (N=17)

Figure 2. Mean PHQ-9 Comparison during admission and after discharge (N=17)
Quantitative Evaluation of ODH Care

Figure 1. Mean GAD-7 Comparison during admission and after discharge (N=17)

Figure 2. Mean PHQ-9 Comparison during admission and after discharge (N=17)

Key takeaway:
• There is a noticeable decrease in GAD-7 and PHQ-9 scores
• Likelihood for anxiety-related symptoms lessens among housemates in ODH
• Likelihood for depression-related symptoms lessens among housemates in ODH
## Quantitative Evaluation of ODH Care

### Table 2. Wilcoxon Signed-Rank test of difference in PHQ-9 and GAD-7 scores upon admission and discharge of housemates in ODH shelter care (n=17)

<table>
<thead>
<tr>
<th>Assessment Tools</th>
<th>M</th>
<th>SD</th>
<th>negative rank (n)</th>
<th>positive rank (n)</th>
<th>ties (n)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9 upon admission</td>
<td>15.41</td>
<td>5.799</td>
<td>12</td>
<td>1&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4&lt;sup&gt;b&lt;/sup&gt;</td>
<td>0.002*</td>
</tr>
<tr>
<td>PHQ-9 upon discharge</td>
<td>7.76</td>
<td>7.774</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GAD-7 upon admission</td>
<td>11.65</td>
<td>3.840</td>
<td>13</td>
<td>0</td>
<td>4&lt;sup&gt;b&lt;/sup&gt;</td>
<td>0.001*</td>
</tr>
<tr>
<td>GAD-7 upon discharge</td>
<td>5.65</td>
<td>4.756</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup>One housemate with increased PHQ-9 score (mild to moderate) was discharged for grave misconduct

<sup>b</sup>Four housemates had no change in PHQ-9 and GAD-7 scores were those who stayed ≤ 18 days
## Quantitative Evaluation of ODH Care

Table 2. Wilcoxon Signed-Rank test of difference in PHQ-9 and GAD-7 scores upon admission and discharge of housemates in ODH shelter care (n=17)

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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key takeaway:

- There is a statistically significant difference in the PHQ-9 and GAD-7 scores during discharge from ODH compared to the baseline assessment.
- Four housemates with no change in PHQ-9 and GAD-7 scores stayed fewer days in the ODH programme.
- One housemate reported an increase in anxiety-related symptoms after being discharged prematurely because of grave misconduct (sexual assault).
Quantitative Evaluation of ODH Care

**Figure 3. Perception of Housemates towards ODH Program upon shelter exit (N=17)**

<table>
<thead>
<tr>
<th>Perception</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The beds and shelter are comfortable</td>
<td>6</td>
<td>10</td>
<td>5</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>The shelter environment is clean</td>
<td>11</td>
<td></td>
<td></td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Nutritious food is served enough</td>
<td>14</td>
<td></td>
<td></td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Learned enough livelihood skills here</td>
<td>13</td>
<td></td>
<td>3</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Developed my coping skills here</td>
<td>11</td>
<td></td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Gained spiritual guidance in problem-solving</td>
<td>14</td>
<td></td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Understood my life direction after all activities here</td>
<td>14</td>
<td></td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Realized that HIV+ diagnosis is not the end of my life</td>
<td>15</td>
<td></td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Not bothered by how others may perceive my HIV+ condition</td>
<td>13</td>
<td></td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>I have plans how to earn a living after the shelter program</td>
<td>14</td>
<td></td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>The shelter and the staff made me feel safe</td>
<td>11</td>
<td>14</td>
<td>6</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>I know who to call during emergency if I encountered problems outside the shelter</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Quantitative Evaluation of ODH Care

Figure 3. Perception of Housemates towards ODH Program upon shelter exit (N=17)

Key takeaway:

- Housemates generally perceived a positive experience of ODH program

- Majority of the housemates realized that life does not end after HIV+ diagnosis (15/17); believed that they have learned enough livelihood skills (16/17); p=learned coping skills in ODH (14/17)

- All housemates felt safe because of ODH and the staff
“Wala akong masabi kundi maraming salamat sa family ko kasi lagi kami nag-uusap, at salamat sa Open Doors Home! More blessings to come!”

~ Former Housemate RF

[I have nothing else to say but many thanks to my family because we talk more often now, and thanks to Open Doors Home! More blessings to come]
“Ang Gabay Sa Pulang Laso ang nagpaalala sa akin na mahalaga ang PAGPAPAHALAGA SA SARILI. Dito nagsisimula ang lahat bago makapagpatuloy muli sa buhay na dati ay akala ko wala ng halaga…”

- Former Housemate GM

[Gabay Sa Pulang Laso reminded me of the value of SELF WORTH. This is where everything starts before moving forward in life which I thought had no more meaning...]
Person-centered care elements

- Identifying the needs of the housemate, by the housemates
- Concentrates more on other social determinants of health as potential barriers to quality of life after HIV diagnosis
- SEGT-based psychosocial support has the main goal of implementing a more evidence-informed, peer-led support system among people living with HIV
- Health providers only serve as facilitators
ODH can be integrated to already-existing HIV prevention and treatment cascade

- Psycho-socioeconomic support should be integrated into local Service Delivery Networks
- HIV Care Providers extend to psychologists, social workers, and even people living with HIV themselves
- SEGT integration in the HIV management improves emotional faculty of people living with HIV
- ODH as complementary approach to ensuring ART adherence and prevent LTFU
What’s next for ODH?

✓ A comprehensive implementation manual being developed
✓ Proposed to a national agency for funding of ODH-SEGT operational/implementation study
✓ Lobby ODH-SEGT to the city social welfare department for scale-up

Supportive-Expressive Group Therapy (SEGT) for People Living With HIV in the Philippines: An Implementation Manual

Rodnie Ambo-Cliete, RN, BSc, Charmaine Faye M. Chu, RPsych, BSc, Angela Tam Sin-Hang, RN, Joseph Cadiz, RN, MHSS, RN, Inez Guiongse Randert, Dhranchlis Reyes, Aminah Rivera, Anna Liza Mercado, MAEd, Carol Strong, PhD, MPH, Ko Nai-Ying, PhD, RN*
Conclusion

• Open Doors Home (ODH) is currently the only SEGT-based temporary shelter program in the Philippines. ODH is centered on psycho-socioeconomic interventions which are complementary to the already-existing biomedical management of HIV in the country.

• ODH addresses other social determinants of health, according to the perceived needs of the person living with HIV, to attain high quality of life as they deem ideal.
Thank you.
Daisy Kwala, Bar Hostess Empowerment and Support Programme, Kenya

Getting person-centred care right: Good practice models of integrating HIV and other health needs

Person-centred care model for sex workers who use drugs in Kenya
I have no relevant financial relationships with ineligible companies to disclose.
Organization: Bar Hostess Empowerment and Support Programme

- Registered NGO in Kenya
- Mission: To influence policy and facilitate access to quality health services, human rights awareness, legal services and economic empowerment for bar hostesses, female sex workers, women who use drugs and vulnerable young women in Kenya.
- BHESP has over 15 years experience in implementing HIV prevention, care and treatment programs, gender-based violence/human rights violation monitoring and response for female sex workers and young women in informal settlements of Nairobi, Kenya.
Current practice areas

Strategic Areas of Focus

01. HIV/AIDS Prevention, Care and Treatment and Support
02. Research to inform policy change.
03. Gender/Human Rights and Advocacy
04. Economic empowerment
Populations served by BHESP

#Forsexworkers
Bysexworkers

- Female sex workers
- Women having sex with other women
- Women using drugs
- Bar hostesses
- Adolescent girls and young people
- Minority Women
Person-centred care (PCC) is improving overall health care outcomes of individuals by putting them and their needs at the center while ensuring their dignity and human rights is upheld.

In our context, PCC focuses on the specific needs of sex workers in their diversities and the ability to empower them on taking individual responsibility of their own health by being treated with dignity and respect and being involved on decisions regarding their health and bodily autonomy while receiving healthcare services.
Person-centred care model: overview

• Due to the adverse effects of Covid-19 on the mental health and psychosocial state of sex workers that was negatively affecting their treatment outcomes, it was alarming to also learn that many sex workers resolved to the use of drugs to keep them “sane” as some would describe it.

• Integrating this population to the existing structures was a huge challenge due to the package of care that was available. As a result of a client-led support group, the challenges presented saw the need to tailor make personalized patient centered approach for sex workers who use drugs.

• In February 2021, onsite sensitizations on a rolling basis was done at the 4 BHESP drop in centers to centers harm reduction interventions within the normal service delivery criteria. Ever since, the community has been engaged in implementation and tailor-making the intervention to ensure no one is left behind.
Peer operated Services (P.O.S)- Use of peer supporters assist fellow peers seek access to legal representation, health, welfare, and social services. The P.O.S work with dedicated peer needle exchange programme, alcohol and drug services, sexual health, and community AIDS organizations and organizes monthly dissemination forms at the drop-in centers specifically for sex workers who use drugs.

Clinic Specific Days for sex workers use drugs- Specific for sex workers who use drugs with specific and tailor made interventions on harm reduction, HIV prevention, care, treatment and support

Theme days every Wednesday to advocate for Gender Responsive Harm Reduction Services- Knowledge management and awareness creation.
# BUILDING BLOCKS: BHESP’s person-centred care model

<table>
<thead>
<tr>
<th>WHEN</th>
<th>Peer Operated Services</th>
<th>Clinical Specific Days</th>
<th>Theme Days</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WHERE</strong></td>
<td>Every day</td>
<td>Once every week</td>
<td>Monthly</td>
</tr>
<tr>
<td><strong>WHO</strong></td>
<td>Community, Virtual Spaces</td>
<td>Drop In Centre, Community</td>
<td>Drop In Centre, virtually and in the community</td>
</tr>
<tr>
<td><strong>WHAT</strong></td>
<td>Peer Educators, Social Worker, Field Officer, Adherence Counsellor</td>
<td>HIV testing and counselling, ART, harm reduction services, HIV prevention and support, psychosocial support</td>
<td>advocate for gender-responsive harm reduction services, SRHR, harm reduction, NSP</td>
</tr>
</tbody>
</table>

- **Peer Operated Services**
  - Every day
  - Community, Virtual Spaces
  - Peer Educators, Social Worker, Field Officer, Adherence Counsellor
  - Legal representation, health, welfare, and social services, referral and linkage, needles and syringes

- **Clinical Specific Days**
  - Once every week
  - Drop In Centre, Community
  - Clients, Health Care workers, Allies
  - HIV testing and counselling, ART, harm reduction services, HIV prevention and support, psychosocial support

- **Theme Days**
  - Monthly
  - Drop In Centre, virtually and in the community
  - Legal Aid, CSOs, Partner organizations
  - Advocate for gender-responsive harm reduction services, SRHR, harm reduction, NSP
Quantitative outcomes

<table>
<thead>
<tr>
<th></th>
<th>Ages 20-24</th>
<th>Ages 25-29</th>
<th>Ages 30-34</th>
<th>Ages 35+</th>
<th>Total # Of Clients in Person Centered Care</th>
<th>Total # of clients tested</th>
<th>Total # of clients positive</th>
<th>Total # of clients linked to care</th>
<th>Total # of clients virally suppressed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Peer Operated Services</strong></td>
<td>357</td>
<td>191</td>
<td>79</td>
<td>51</td>
<td>678</td>
<td>678</td>
<td>21</td>
<td>19</td>
<td>16</td>
</tr>
<tr>
<td><strong>Clinical Specific Days</strong></td>
<td>41</td>
<td>62</td>
<td>47</td>
<td>32</td>
<td>182</td>
<td>182</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Theme Days</strong></td>
<td>89</td>
<td>102</td>
<td>63</td>
<td>51</td>
<td>305</td>
<td>305</td>
<td>11</td>
<td>11</td>
<td>4</td>
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*all female clients
BHESP’s good practice model has worked towards educating and sensitizing harm reduction service providers and other civil society organizations on the personalized and specific needs of sex workers who use drugs which has resulted in improved health outcomes of the sex workers drug users with good adherence to ART and improved viral suppression amongst those living with HIV.
“Sometimes a client can encourage you to use more drugs but I fear overdose because of the side effects that are usually mentioned during theme day”
Linda (not her real name) one of the clients attending BHESP clinic

“Me relapsing had nothing to-do with you as my appointment manager, you are doing great work in my follow ups, its just peer pressure at the injecting den”
Mercy during differentiated service delivery

“Sometime you can meet a clients who use a certain drug for example cocaine but you don’t use...he insists you have to use ...and since you want money you have to”
Cecilia, during a hotspot peer session

“The meaningful participation of sex workers and people who use drugs in policy, programmatic discussions, and dialogue is imperative”
Jackson a Lawyer during one of the legal aids clinics
‘Nothing for us without us’
Person-centred care elements

• Person-centred care model intends to address the complex health needs of sex workers using drugs by having them at the center of implementation and involving the community to advocate for the sex workers using drugs rights as human rights.

• Through the personalized approach BHESP has managed to individualize clients management which provides an opportunity to deal with specific issues that are client centered thus improved service uptake amongst sex workers using drugs, in both approaches all clients needs are met both HIV related, legal representation, economic empowerment and psychosocial issues.

• Human Rights lens in programming for Key Population.

• Guiding principles of community action.

• Taking a holistic approach to assessing people’s needs and providing care.
Integration of services

- Integration of services has helped improve health outcomes of the sex workers drug users, clients are offered psychosocial support amidst other HIV prevention and care services thus the holistic support which improves health outcomes of the sex workers drug users.

- In both drop in center and service delivery in the community we have harm reduction services, mental health screening and support integrated with HIV prevention and care services.

- Person-centred has also been integrated in outreaches and in-reaches to offer comprehensive package of care that includes TB, STI, mental health, overdose management, Hepatitis B & C, Alcohol and drug abuse, Cervical cancer, Prep, Violence, Family planning, Risk assessment and reduction, HIV testing prevention and care.

- Legal aid clinics and are integrated with theme days.

- We are able to do NSP during our differentiated service delivery program.
Next steps

• Engagement of the community through participatory approach as BHESP pilots for the person-centred care a result based approach that will help in exploring the challenges and barriers that hinders sex workers drug users from accessing care.

• BHESP will work to map all the sex workers drug users hotspots within Nairobi, especially in the slum areas and work with grassroots organizations and community to deliver person-centred care services that are clients-centred to improve their health outcomes.
Conclusion

• BHESP recommends the person-centred care model to all service delivery points and to all key population subgroups as it individualizes client management and results in better patient management outcomes.

• Through implementation of PCC Models, BHESP has been able to deliver individualized services to clients in need of services. BHESP has prioritized a Person centered care approach to reach the hard to reach yet highly vulnerable sex workers.

• With this documentation of PCC models, BHESP will use this (Best practices and lesson learnt) as an evidence based approach tends to advocate for recognition of this models as strategies towards global goal of reducing new HIV infections and AIDS-related deaths by 90% between 2010 and 2030.