**IDI guide for policy makers (national, provincial, district)**

**Introduction and aim of the interview:**

My name is…..

In am conducting interviews on behalf of [NAME OF ORGANIZATION] and MOH.

[NAME OF ORGANIZATION] and the Government of [Name of Country] are evaluating other ways of delivering antiretroviral therapy (ART) that may be more efficient and may improve how many patients who are started on ART continue to stay in care.

For this study, interviews are conducted with different groups involved in HIV care, such as health care workers, community leaders and ART patients.

We would also feel it is extremely important to hear from experienced policy makers at the national, provincial and district level, and understand their opinions on these activities.

That is why we have asked to speak with you; we would like to hear your opinion on these alternative models of ART care.

The interview will take about one hour. Your information will be confidential.

*[NB: informed consent forms should be signed and collected]*

**Introduction**

1. Could you briefly describe your current role and how it relates to HIV care and treatment in [Name of Country]?
2. Based on your experience, what do you think are the major challenges facing HIV treatment services in [Name of Country] today?

**Retention**

1. As you are probably aware, retention of HIV patients in care can be very challenging. In [Name of Country], we know that a large number of patients (some estimates suggest 40%) are not retained in care beyond 12 months. What do you think are the best ways to improve retention in care for these HIV clients?

**Model description**

As I mentioned above, the MOH and [NAME OF ORGANIZATION] are collaborating to test some alternative ways to deliver ART, in order to try to improve retention in care and decongest clinics. I would like to describe four models and ask some questions about each one.

1. Model 1: Rural Community Based ART Adherence Group (CAG)
	1. What do you think about the rotating medication pick-up?
	2. This model relies heavily on ART patients to support each other to meet regularly and pick up medications for each other. What do you think about this?
	3. This model relies heavily on support and supervision from lay healthcare workers. What are the policy implications of this? (Explain)
	4. In this model, patients would only go to the clinic themselves every six months. What do you think about this?
	5. Stigma is a common concern for patients accessing HIV services. What, if any, concerns would you have relating to stigma for this model?
	6. What would you see as the major strengths of this model?
	7. What would see as the major weaknesses of this model?
	8. If this model were to be scaled-up, are there any policies that would need revising? (Probe: human resourcing; task shifting; ART guidelines etc.)

*[Issues to probe as appropriate: stigma; supervision & support by & for lay health workers; monitoring and data collection]*

1. Model 2 Urban Facility Based Adherence Groups (UAG)
	1. An important part of this model is service delivery outside of regular clinic hours. In your opinion, how do you think a) patients and b) health workers will respond to this?
	2. Do you think that lay health workers and pharmacy techs are the appropriate health workers to handle UAG services? [Explain]
	3. Stigma is a common concern for patients accessing HIV services. What, if any concerns would you have relating to stigma for this model?
	4. What would you see as the major strengths of this model?
	5. What would see as the major weaknesses of this model?
	6. What do you see as challenges to implementation of this model?
	7. If this model were to be scaled-up, are there any policies that would need revising? (Probe: human resourcing; tasking shifting; ART guidelines etc.)

*[Issues to probe as appropriate: human resource issues; stigma; clinic security and accountability for drug dispensation; monitoring and data collection]*

1. Model 3 Urban Facility Based Fast-tracking (FAST-TRACK)
	1. What do you think about the idea of a fast-track mechanism in urban clinics?
	2. The model relies on having space and staff to handle rapid drug-dispensing. What do you think about this? (Explain)
	3. The model relies heavily on lay health workers (to perform symptom screening) and pharmacy techs (to dispense medications). What do you think about this?
	4. What would you see as the major strengths of this model?
	5. What would see as the major weaknesses of this model?
	6. If this model were to be scaled-up, are there any policies that would need revising? (Probe: human resourcing; tasking shifting; ART guidelines etc.)

*[Issues to probe as appropriate: human resource issues; accountability for drug dispensation; logistics; monitoring and data collection]*

1. Model 4 Streamlined ART Start strategy (START)
	1. This model relies heavily on training current health care workers to start ART earlier in certain patients. How do you think providers will feel about this model? (Explain)
	2. What would you see as the major strengths of this model?
	3. What would see as the major weaknesses of this model?
	4. If this model were to be scaled-up, are there any policies that would need revising? (Probe: human resourcing; tasking shifting; ART guidelines etc.)

*[Issues to probe where appropriate: provision of counselling; referral systems, patient readiness; human resource issues; training; logistics]*

**Alternative models**

1. We have described and asked your opinion about these four models. Do you have any ideas or suggestions for alternative models (or changes to the above models) that might help address patient retention and clinic congestion?
2. Are there any implications of any of these models for [Name of Country] health policy that we haven’t discussed? [Please explain]

**Closing**

1. Any other issues we did not mention that you would like to discuss?

**Thank you very much for your cooperation and contribution.**