IAS International AIDS Society iasociety.org

SAC SOUTHERN AIDS COALITION

Community Education Group 30 YEARS

Day 3: Tuesday 8 April

Person-Centred Care Advocacy Academy

Southern US edition, 2025

In partnership with

GILEAD Creating Possible

The Person-Centred Care programme of IAS – the International AIDS Society – is implemented with financial support from, and in collaboration with, Gilead Sciences. The IAS has full control over all the activities and decisions relating to, and forming part of, the Person-Centred Care programme.

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Today's programme

Time	Session
8:30am – 10:00am	**Session 6 – PCC implementation tools**
	Elvin Geng, Washington University in St. Louis
	Keynote address - Researcher advocate
	Jessica Sales, Rollins School of Public Health, Emory University
	Group work
10:00am – 10:30am	Refreshments break
10:30am – 12:00pm	**Session 7 – Reflections and next steps**
	Group photos!!

Session 6 –Approaches for the implementation of person-centred care

Elvin Geng

Operational principles of person-centred care

Adapted from 1. Health Foundation, 2016 | 2. Scholl et al., 2014 | 3. IAS, April-June 2023

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What do clients want?
They want person-centred care!

Quality care that responds to their needs

- In general, people perceive quality services to include: readily available medications with low pill burden and few side effects, infrequent facility visits, short travel distances, short waiting times, flexible facility opening hours, low or no fees, and courteous and supportive healthcare workers(1,2,3).
- However, different people value different things(1,2,4).

Choice and participation in shared decision making

- Most clients prefer to share decisions and the responsibility for care with their provider(5).
- Participation in shared decision making requires informed choice, which in turn requires a range of options, including whether or not to receive psychosocial support from healthcare workers(3).
- It also requires positive relationships with healthcare providers to facilitate understanding, find common ground and allow space to make decisions(3).

1. Belay et al., 2021 | 2. Zanolini et al., 2018 | 3. Waweru et al., 2019 | 4. Eshun-Wilson et al., 2020 | 5. Kumar et al., 2010

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Operationalization of person-centred care principles

Adapted from Scholl et al., 2014

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Categories of activities used to implement person-centred care

1. Service structure and organization
2. Healthcare provider competencies and support
3. Data collection, feedback and utilization
4. Client-healthcare provider interactions
5. Governance and leadership commitment

Four case studies

A. The Welcome Service in South Africa

B. InfoPlus Adherence in Haiti

C. Person-Centred Public Health for HIV Treatment in Zambia

D. Linkage to care in Kenya and Uganda

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Case study characteristics

A. Welcome Service intervention	B. InfoPlus Adherence	C. Person-Centred Public Health for HIV Treatment	D. Linkage to care
Khayelitsha, **South Africa** (August 2020 – June 2022)	**Haiti** (12 October 2017 – 7 September 2018)	Lusaka, **Zambia** (August 2019 – November 2021)	Rural **Kenya and Uganda** (June 2013 – June 2014)
Focused on reorganizing triage, optimizing clinical management, enhancing counselling services, and addressing healthcare provider attitudes toward disengagement	Combination of electronic medical record-based alert for low antiretroviral adherence and risk of antiretroviral treatment failure and provider-delivered brief problem-solving counselling	Improved person-centredness of HIV care using three components: 1) Healthcare provider training and mentoring; 2) systematic measurement and feedback of client experience metrics; and 3) supporting facility improvement plans and providing small facility-level incentives for improved performance	A client-centred, multicomponent linkage strategy. After population-based HIV testing, eligible participants were: 1) introduced to clinic staff after testing; 2) provided with a telephone "hotline" for enquiries; 3) provided with an appointment reminder phone call; 4) given transport reimbursement on linkage; and 5) tracked if linkage appointment was missed
Mixed-methods design, programmatic evaluation of implementation at **two clinics**	**Quasi-experimental** mixed-methods with historical controls in **two clinics**	**Stepped-wedge, cluster randomized trial** in **24 public health facilities**	**Cluster randomized trial, community** based

A. Keene et al., 2019 and Arendse et al., 2023 | B. Puttkammer et al., 2020 | C. Mwamba et al., 2022, and Mwamba et al., 2023 | D. Ayieko et al., 2019

1. Service structure and organization

- Services should be integrated beyond HIV care to address the client as a whole person.
- Services should be efficient and structured to minimize burden on the client.
  - For example, digitized medical records and registers reduce burden on staff and clients.
- DSD models structure services around the client and are rooted in person-centred care principles.
- Person-centred services should have flexible processes and resource distribution to be responsive to people's needs.

Malia et al., 2022| IAS meeting report, 2023 | IAS, July 2017 | WHO, 2021

Four models of DSD for HIV treatment

Adherence clubs

Community adherence clubs

Private pharmacy

Fast track models

Home delivery

Community pharmacy

Community-based organization

Drop-in centres

Mobile/outreach services

- Multi-month dispensing is an enabler.
- Clinical consultations can be considered separately to ART refills and psychosocial support.

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1. Service structure and organization

What are the challenges and opportunities in implementing person-centred care?

Challenges

- Practical barriers like limited infrastructure impede the implementation of person-centred care.
- Medical record systems need to be utilized efficiently to streamline healthcare delivery
- Provision of care involves intricate processes that include addressing time constraints and managing high client volumes.

Opportunities

- Funders are increasingly seeing the value in integrated, holistic care.
- Integration of services across HIV, non-communicable diseases and mental health encourages a learning health system where evidence of impact influences improvements in all sectors.
- Digital innovation creates more options to support efficient services.

2. Healthcare provider competencies and support

- Continuous professional development through training and mentoring should build knowledge and skills to support sustainable uptake of the principles.
  - Understand context to adapt person-centred principles.
  - Understand person-centred care implementation challenges and opportunities.
- Encourage sharing of lessons learnt and best practices between providers.
- Healthcare providers need support with burnout and overload and to connect with their intrinsic motivation to care for clients.
- Recognition and incentives encourage uptake.

Welcome Service – "Welcome Handshake"

Arendse et al., 2023

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2. Healthcare provider competencies and support

What are the challenges and opportunities in implementing person-centred care?

Challenges

- Providers often prioritize physical health, encouraged by the focus on the biomedical model emphasis in education.
- Healthcare providers are undervalued and suffer burnout.
- Individualized care and diversity is difficult to manage with limited resources.
- There are power dynamics between cadres.
- Understanding of ART guidelines is insufficient.

Opportunities

- The availability of online training materials and the widespread use of smartphones makes dissemination of training and provision of quality mentorship more feasible.
- Existing provider networks and continuing professional development forums can be used to share learning.
- Increasing recognition of the importance of providers for person-centred care can help advocate for resources to support them.

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3. Data collection, feedback and utilization

- Collect and analyze data on the implementation and application of person-centred care to:
  - Monitor the progress of interventions and make adjustments.
  - Build the evidence base on person-centred care.
- Provide feedback on findings to healthcare providers and clients to interpret the data and reinforce change.
- Client feedback mechanisms use data to improve services
- Leadership commitment is required in creating structures to measure and monitor performance of person-centred interventions.

3. Data collection, feedback and utilization

What are the challenges and opportunities in implementing person-centred care?

Challenges

- Practical and political challenges hinder the collection, interpretation, and utilization of data for assessing impact.
- There is a noticeable feedback gap within health information systems, impeding effective communication between stakeholders.
- Challenges abound in developing quality improvement programs that are tailored to meet the diverse needs of clients.

Opportunities

- There is increasing support for client and staff involvement in quality improvement programmes
- A growing evidence base provides examples of success.
- Development of cheaper, more user-friendly technology makes data collection and utilization more feasible.
- Community-led monitoring approaches include the community in the data collection, for example, the Ritshidze Programme.

1. Ritshidze 2023

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4. Client-healthcare provider interactions

Person-centred care requires active engagement of clients as partners in their care.

- Provider must facilitate power sharing and empower the development of client agency.
- Clients should be invited to ask questions and suggest solutions to challenges during clinical consultations and counselling sessions.
- Counselling should be individualized and respond to client needs rather than didactic information delivery.
- Appointment scheduling is a two-way discussion of what is possible for the facility and what works for the client.
- Language is important and should facilitate teamwork rather than reinforce power imbalances.

Healthcare provider discretion is needed in the application of person-centred activities.

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4. Client-healthcare provider interactions

What are the challenges and opportunities in implementing person-centred care?

Challenges

- Healthcare providers have limited theoretical understanding of person-centred care
- Clients with low literacy levels struggle to engage with complex health information.
- Cultural differences strain communication between healthcare providers and clients.
- Limited understanding of cultural nuances undermines communication
- High client volumes make it difficult for healthcare providers to engage fully in individualized care
- Healthcare provider resistance to change gets in the way of providing person-centred care

Opportunities

- Community-led monitoring approaches, like the Ritshidze Programme, reinforce positive changes and identify areas for improvement.
- DSD models reduce the burden on healthcare facilities, affording providers time to engage more constructively with fewer clients .
- Supportive supervisors are a starting point for making providers feel appreciated and able to adopt person-centred principles.

1. Ritshidze 2023

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5. Governance and leadership commitment

- Person-centred care must be implemented at the individual provider level and at the organizational and structural level of the health system.
- Leaders should acknowledge the intricate link between client-centredness and provider-centredness.
- It is important to establish a positive person-centred care culture at an organizational level to support the implementation of person-centred activities.
- Leadership teams are key in harmonizing person-centred principles and narrowing the policy-practice gap.
- Leadership training programmes that emphasize the value of person-centred approaches can foster commitment to person-centred approaches.

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5. Governance and leadership commitment

What are the challenges and opportunities in implementing person-centred care?

Challenges

- Inconsistent commitment to person-centred care principles from leadership undermine implementation
- There is often resistance to change within the organizational hierarchy to align with person-centred care initiatives
- Securing necessary resources and support for the implementation of person-centred care is a challenge
- Working with different partners can make consistent governance difficult

Opportunities

- The evidence of impact for person-centred care is growing and creates a compelling case for implementation.
- Person-centred care aligns with policies of guiding organizations, such as the World Health Organization.
- Organizational policies are regularly reviewed, and this process can be targeted to ensure person-centred principles are incorporated.

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Key messages

- The core principle of person-centred care is simple: **it is just putting people at the centre of everything we do.**
- Implementing person-centred care requires an understanding and appreciation of the principles and support to adapt them to the local context.
- Clients AND providers are both central to person-centred care. Both need investment and support.
- Person-centred care is a system approach, but individuals can implement person-centred care in small ways every day.

Acknowledgements

All the clients and healthcare providers who have given their opinions and contributed to building consensus on what person-centred care is and how it should be implemented

Author team

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- International AIDS Society, Switzerland

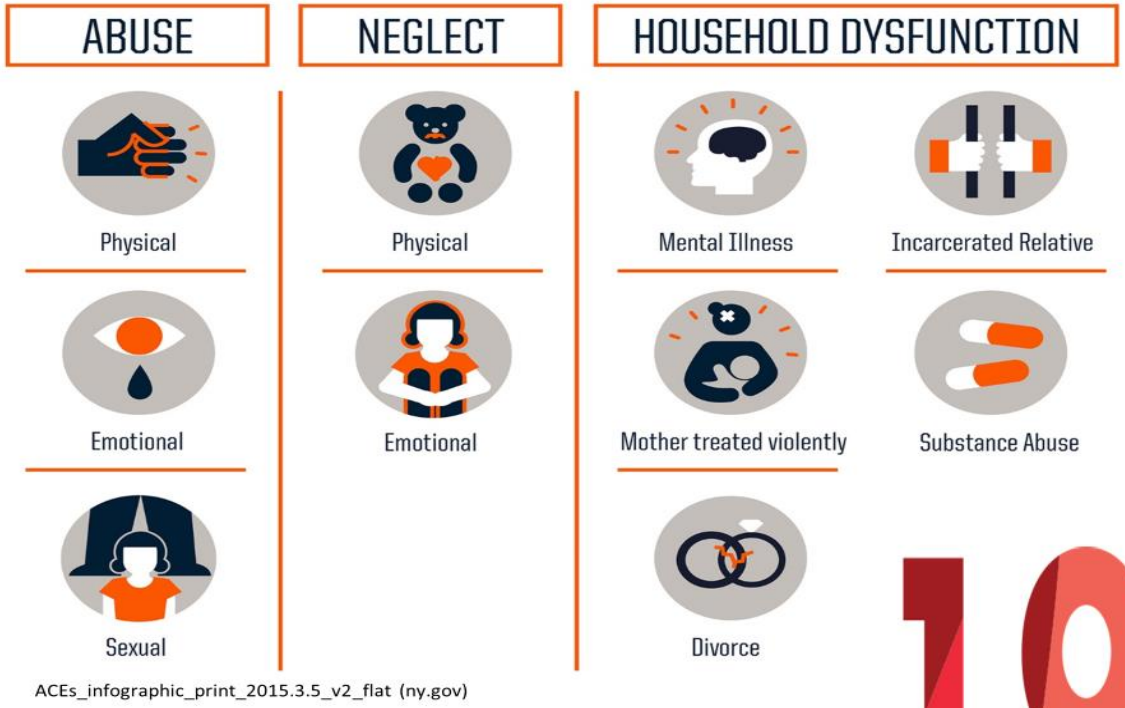
PROVIDING TRAUMA-INFORMED CARE USING A HEALING-CENTERED APPROACH IN RYAN WHITE CLINICS

JESSICA M. SALES, PHD
EMORY UNIVERSITY

APRIL 8, 2025

ACEs

Adverse childhood experiences



ACEs_infographic_print_2015.3.5_v2_flat (ny.gov)

1998

Trauma Stock Photo - Download Image Now - Shock, Emergency Room, Mental Health - iStock (istockphoto.com)

Traumatic experience: event(s)/circumstances *"**experienced** by an individual **as physically or emotionally harmful** or life threatening and that has **lasting adverse effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."*

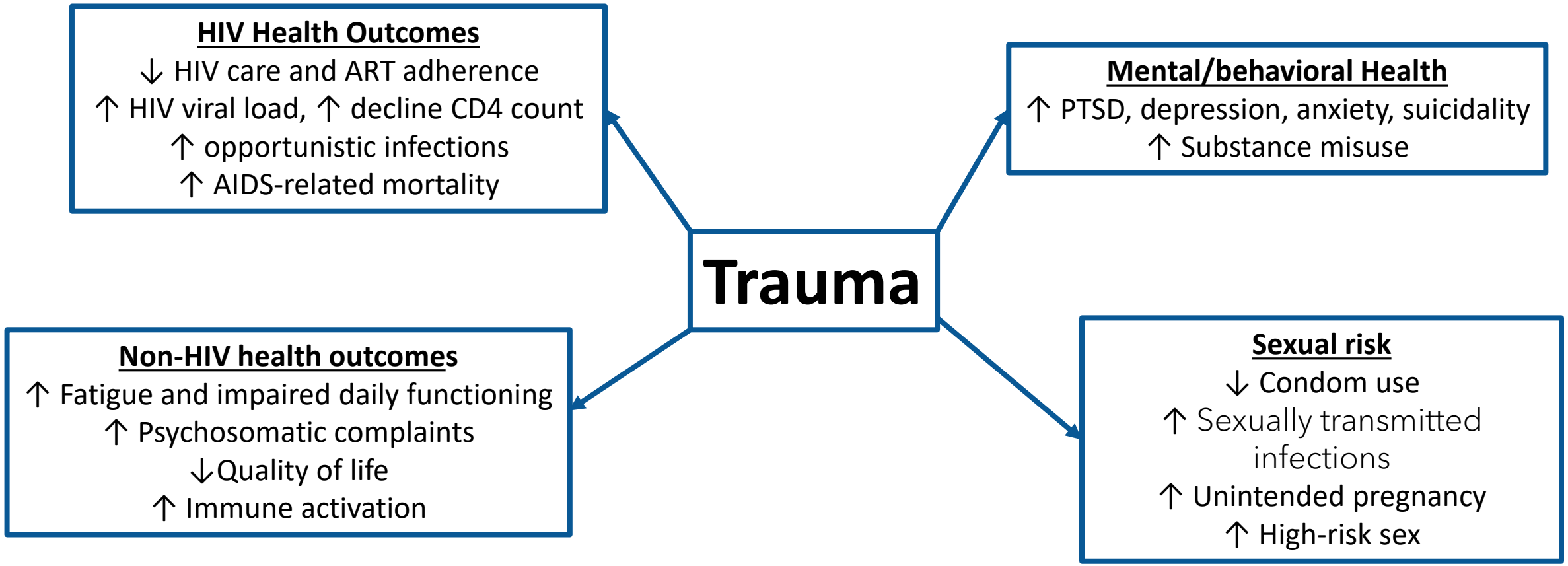
- Substance Abuse and Mental Health Services Administration (SAMHSA)

Trauma includes (but is not limited to):

- childhood abuse, sexual assault, intimate partner violence
- school violence, community violence, bullying
- military trauma, natural disasters, forced displacement
- traumatic grief and separation

https://www.samhsa.gov/trauma-violence

WHY ADDRESS TRAUMA AMONG PEOPLE WITH HIV IN HIV CARE SETTINGS?



IMPACT OF TRAUMA ON HEALTHCARE PROVIDERS AND TEAM

- **Vicarious trauma (secondary traumatic stress):** Effect on perspective/worldview through indirect exposure to a traumatic event (e.g., narration).

- **Compassion fatigue:** emotional/physical fatigue from feeling compassion for patients without adequate time away to refuel and care for self.

- Burnout: prolonged response to chronic emotional and interpersonal stressors on the job

WHAT IS TRAUMA-INFORMED CARE (TIC)?

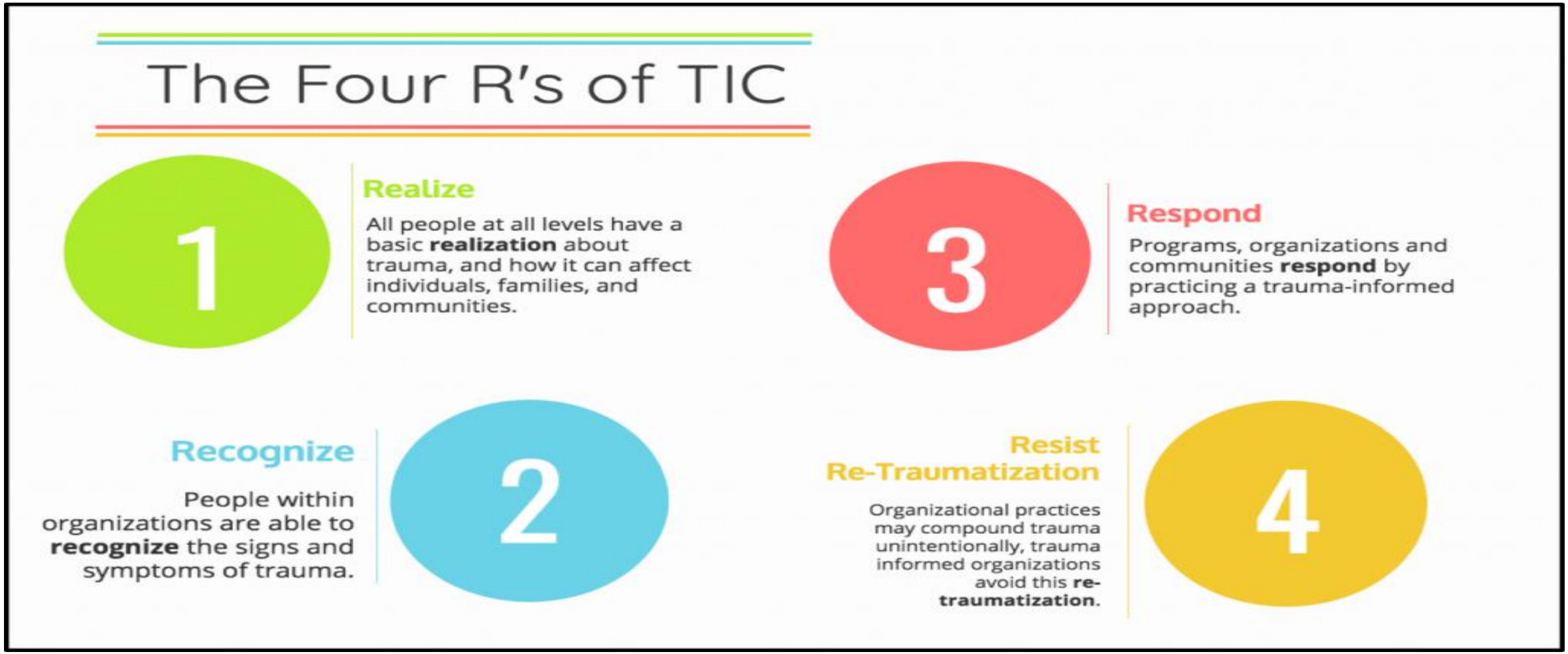
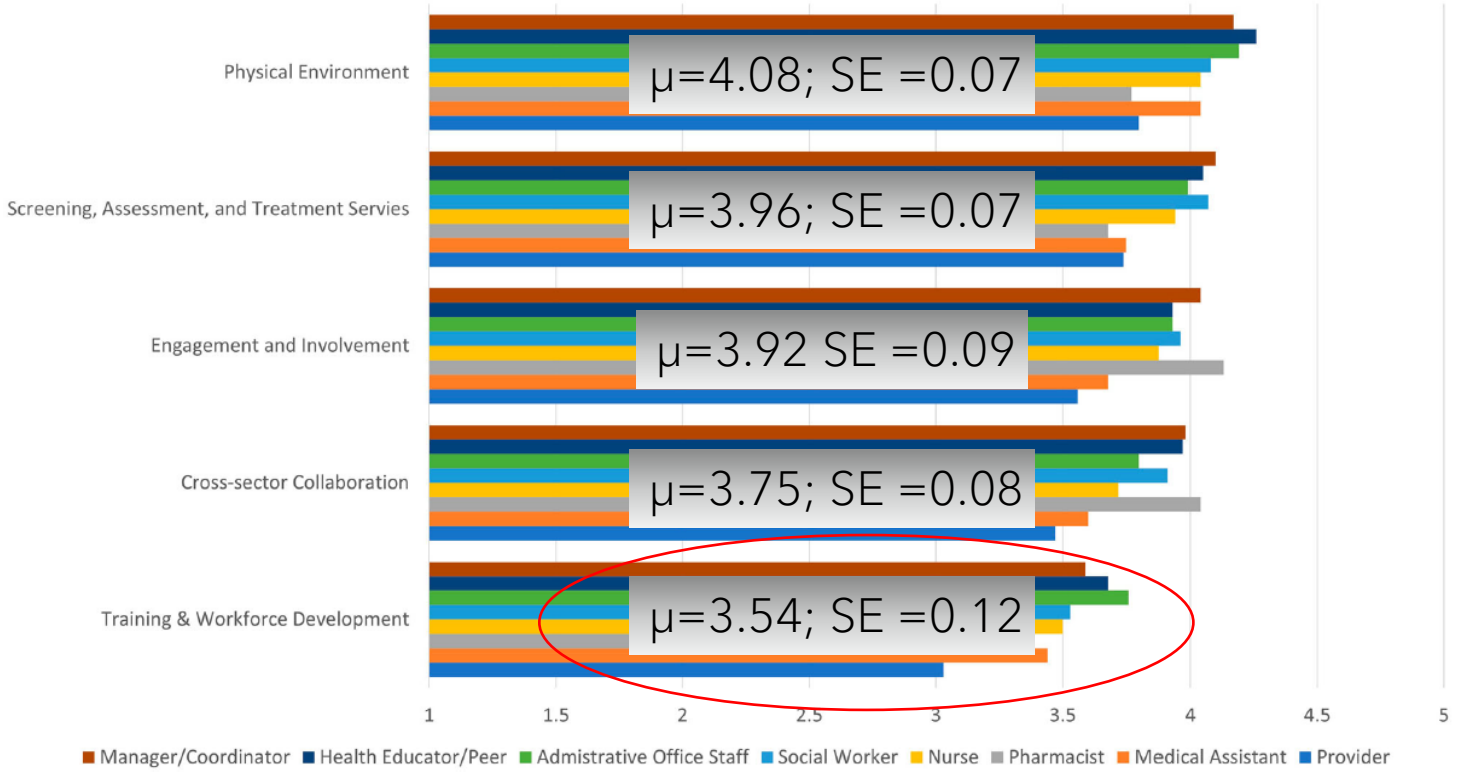


Image from Trauma Informed Occupational Therapy - The OT Toolbox

TIC TRAINING AND STAFF SUPPORT IS A KEY GAP FOR RYAN WHITE CLINICS

NIH/NIMH R56 Mixed-methods study

- 321 admin/staff/providers from 46 RWCs in SE US
- Level of TIC adoption and factors associated with TIC adoption
- 140-item National Center on Family Homelessness' TIC toolkit



Kalokhe AS et al. *AIDS Care*. 2022
Kalokhe AS et al. *AIDS & Behavior. 2022*

EXISTING TIC TRAININGS & GAPS

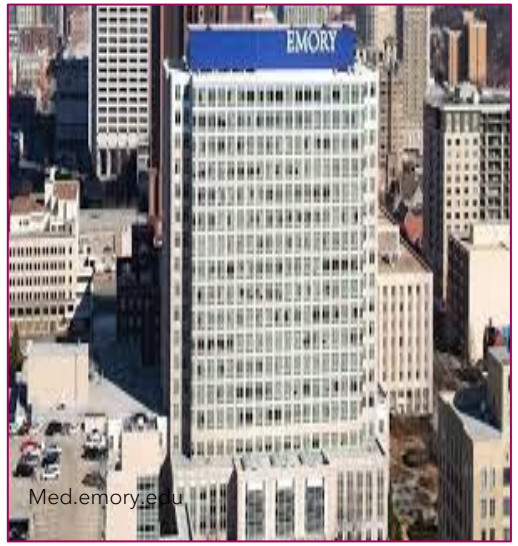
- Many RW programs are now being required to complete TIC trainings
- Existing trainings: NASTAD's TIC toolkit, SAMHSA's TI-HIV Care Manual
- Gaps:
  - Real-time coaching in parallel to ensure knowledge is integrated into clinic practice
  - Thorough understanding of RW clinic training/support needs through formal needs assessment
  - Consideration of how to leverage existing resources
  - Use of a centralized training home (e.g., AIDS Educational and Training Centers) to sustainably support TIC implementation across RWCs

TIC TRAINING AND SUPPORT NIH/NIMH R34

- Aim 1: To develop a TI-HIV care training, support and implementation coaching package tailored to clinic needs/resources

- Aim 2: to refine the TIC trainings, support and implementation coaching package using feedback from Southeastern US RW stakeholders

- Aim 3: to pilot and evaluate the preliminary effectiveness of the refined training/support/coaching package at two high-volume RW clinics in Metro Atlanta



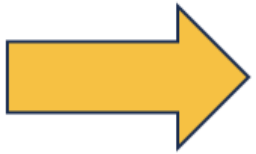
Med.emory.edu

https://www.practicelink.com/facility/Ponce-De-Leon-Center-Grady-Health-System/Grady-Health-System/

SHIFT IN TERMINOLOGY: TRAUMA INFORMED CARE (TIC) TO HEALING CENTERED CARE (HCC)

TRAUMA INFORMED CARE

- Highlighting *trauma* as the core of the approach
- Individuals are treated in response to their traumatic event
- Changes aimed to benefit the individual



HEALING CENTERED CARE

- Highlighting *healing* as the core of the approach
- Individuals are the agents of their own well-being and healing
- Changes to promote individual & collective healing

THE BIG PICTURE….

Step-by-step:

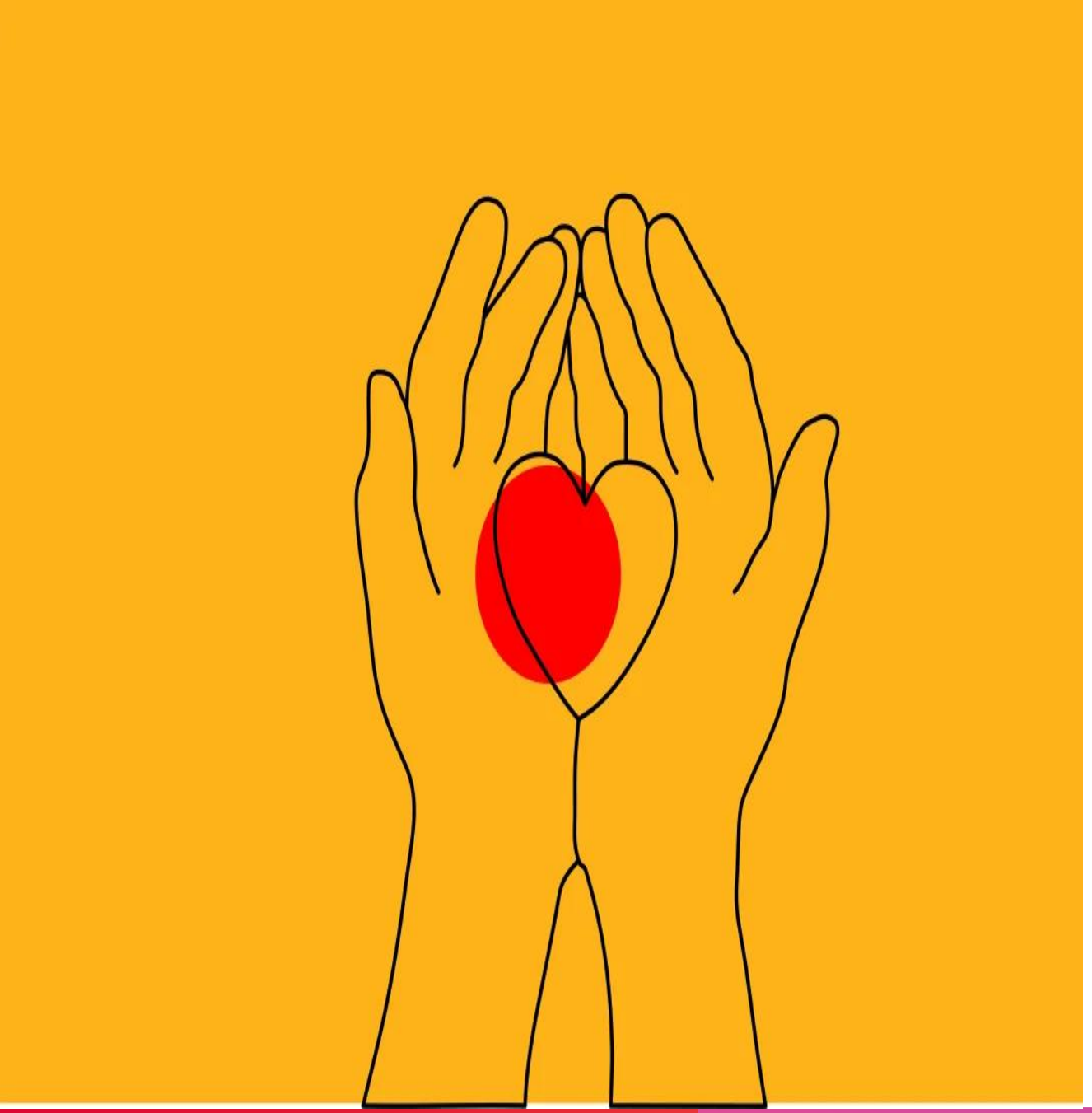
- Leadership buy-in
- Assess trauma-informed care practices within clinic
- Appoint a Trauma-informed HIV Care Change Team
- Train the entire clinic team on trauma/TIC/HCC
- Prioritize which TIC/HCC practices are best for your organization to implement (for patients, staff and clinic)
- Plan, Implement and Evaluate along the way

TIC/HCC TRAINING OVERVIEW

- 6 one-hour sessions to be delivered ideally over 4-6 months
- In-person, interactive (i.e., case-based, reflections, group discussions)
- Facilitated by 'Coach' with HIV/TIC/RWC expertise (ultimate goal is that it would be housed in AETC)
- Coach works with Clinic's Change Team to integrate changes into clinic in real-time over 6-month period

TIC/HCC TRAINING OVERVIEW

Session Name	Session Content
1. Introduction to Healing-Centered Care	Overview on 'Healing-Centered Care:" purpose, advantages, and strategies to implement in RWC settings
2. Healing-Centered Care to Strengthen Clinic Culture	Guides the clinic through identification of barriers to their creation of a healing-centered culture and development of strategies to address barriers
3. Healing-Centered Care for Self	Importance of self-care, brainstorm methods for incorporating self-care strategies inside/outside workplace
4. Healing-Centered Care for the Team	Importance of members of the team demonstrating compassion and care for one another; consider incorporation of "team-care" practices in the workplace
5. Healing-Centered Care for Patients	Discusses impact of patient trauma experience on health/engagement in care; group reflection on clinic practices that may be retraumatizing; brainstorming of strategies to enhance their support for patients who experience trauma
6. Healing-Centered Care of the Clinic Environment / Wrap up	Reflection of how existing clinic's physical and emotional environment could be improved to reduce re-traumatization, be more supportive/healing-centered



QUESTIONS?

Thank you!

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Emory ID Clinic and Grady Ponce Center

All of you!

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AGENDA

1. Grounding Activity
2. North Star
3. Outline Overall Purpose and Objectives for the Training Program
4. Setting Group Norms - Group Discussion
5. Define Trauma-Informed Care (TIC) & Healing-Centered Care
    - Discuss why this curriculum approaches TIC from a healing-centered lens
6. Group Discussion: Value and Challenge of creating a Healing-Centered Workplace
7. Getting to Know You Activity
8. Grounding Activity

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SESSION 2 – OVERVIEW

2. Healing-Centered Care to Strengthen Clinic Culture	Guides the clinic through identification of barriers to their creation of a healing-centered culture and development of strategies to address barriers

AGENDA

1. Grounding Activity
2. North Star
3. Recap of Last Session and Change Team update (if applicable)
4. Case Scenario Activity
5. Barriers and Strategies to creating a culture for Healing-Centered Care
6. Healing-Centered Care in the Clinic Culture Discussion and steps
7. Group Commitment Activity
8. Connecting the Dots
9. Revisit the North Star
10. Action Plan
11. Grounding Activity

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NORTH STAR

"Empower, not overpower"

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SESSION 2 ACTIVITY

STEPS TO CREATING A HEALING-CENTERED CLINIC CULTURE

1. Develop a collective statement of values on healing centered care showing the clinic's shared commitment to creating a healing-centered care clinic
2. Set up basic infrastructure to begin, support, and guide changes
3. Involve key parties, including those who have experienced HIV and trauma
4. Assess if the organization's current rules and operations help or hinder healing centered care
5. Develop an organizational plan to implement and support healing centered care
6. Build partnerships between the clinic and patients and with other community groups
7. Put the plan into action
8. Review, on an ongoing basis, how well the plan is working and if it meets staffs' and patients' needs for healing-centered care
9. Make quality improvements as needs and problem areas are identified
10. Establish practices that support sustainability, such as ongoing training, clinical supervision, consumer participation and feedback, and resource allocation

Trauma-Informed Care in Behavioral Health Services, TIP 57, SAMHSA, page 160 https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4816.pdf

CREATE A COLLECTIVE VALUE STATEMENT TO CREATE A HEALING-CENTERED CARE CULTURE

- Example Value Statements:
  - We commit to fostering a culture of empathy and compassion, where both patients and staff feel seen, heard, and valued for their unique experiences and contributions.
  - We pledge to prioritize the well-being and resilience of both patients and staff, recognizing that healing is a collaborative journey that requires mutual support and understanding.
  - We commit to providing trauma-informed care that acknowledges the impact of past experiences on both patients and staff, and we pledge to create a culture of safety and trust that promotes healing and resilience.
  - We aspire to be a beacon of hope and positivity within our community, fostering a culture of resilience, connection, and healing that uplifts both patients and staff alike.

SESSION 3 - OVERVIEW

3. Healing-Centered Care for Self	Importance of self-care, brainstorm methods for incorporating self-care strategies inside/outside workplace

AGENDA

1. Grounding Activity
2. North Star
3. Recap of Last Session
4. Change Team Update
5. Healing-Centered Care for Self
6. Case Scenario Activity
7. Concepts of Well-Being
8. Gives-Drains Activity
9. Supportive Factors for Self-Care
10. Individual Self-Care Plan Activity
11. Barriers to Creating Healing-Centered Care for Self
12. Connecting the Dots
13. Grounding Activity

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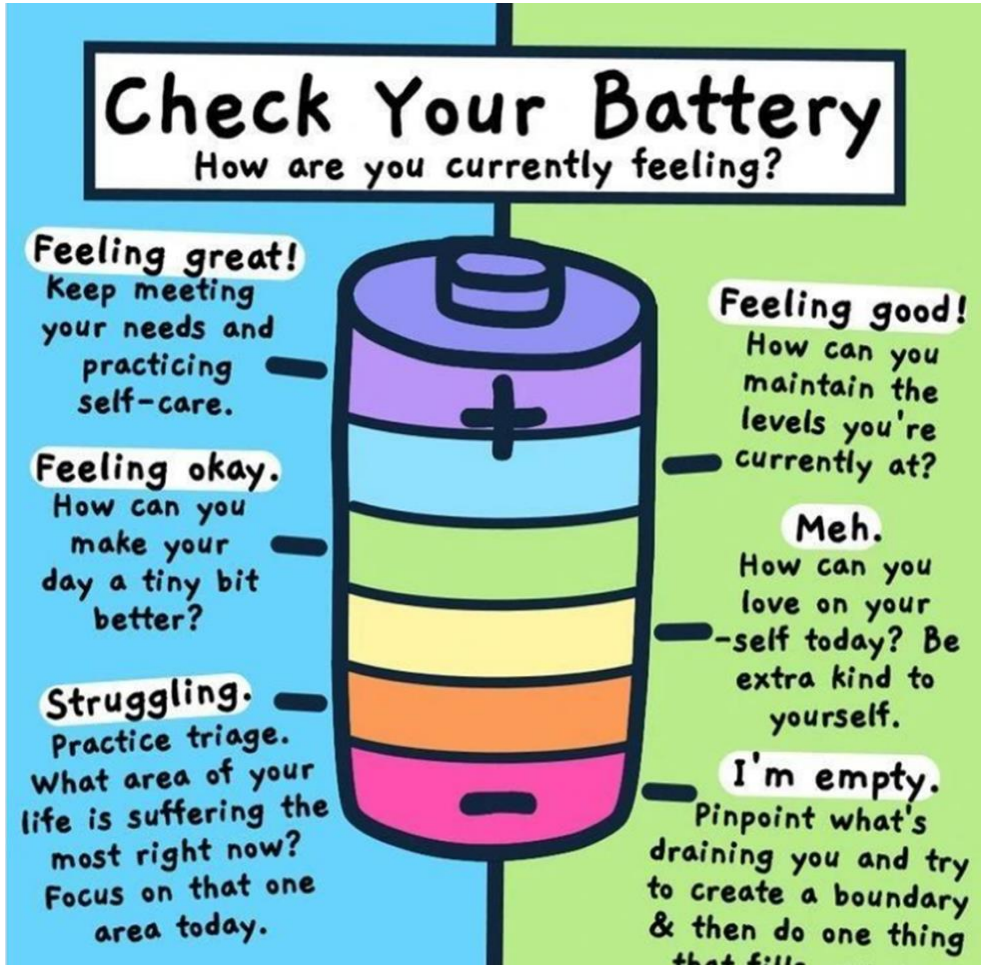


SESSION 3 ACTIVITY

Scenario

In a busy clinic, a staff member named Nina works alongside a newer staff member named Cameron. Like most staff members in the clinic, Nina is known for going above and beyond for her patients, often giving out her personal phone number for emergencies and staying after hours to make sure everyone is taken care of. Cameron, on the other hand, is strict about maintaining his work-life balance and makes sure to clock out on time every day. He feels if he worked like Nina, he would end up being burnt out and unable to work in the clinic long term. One day, a patient calls Nina late after hours, desperate for advice. She answers and spends an hour on the phone with the patient, calming them down and providing guidance. The next day, Cameron notices that Nina seems exhausted and overwhelmed. Cameron states, "That's why I don't give my phone number out. I don't want to be burnt out." Nina brushes it off, saying, "We can't do that at this clinic. Everyone works after hours at this clinic to get it all done. Plus, I enjoy devoting my time to patients even when it's exhausting." Now Cameron feels as though he should work longer hours to prove his dedication to the patients.

Group Discussion

- What are the benefits to Cameron's boundary setting?
- Is Nina practicing self-care? Why or why not?
- What are some potential drawbacks of Nina's work style? Cameron's work style?
- How can Nina maintain her commitment to patient care while also practicing self-care?
- What could change so that Cameron does not feel pressured to sacrifice his boundary setting?

SESSION 4 - OVERVIEW

4. Healing-Centered Care for the Team	Importance of members of the team demonstrating compassion and care for one another; consider incorporation of "team-care" practices in the workplace

AGENDA

1. Grounding Activity
2. North Star
3. Recap of Last Session
4. Change Team Update
5. Case Scenario Activity
6. Problem Solving Challenge
7. Connecting the Dots
8. Action Plan
9. North Star
10. Grounding Activity

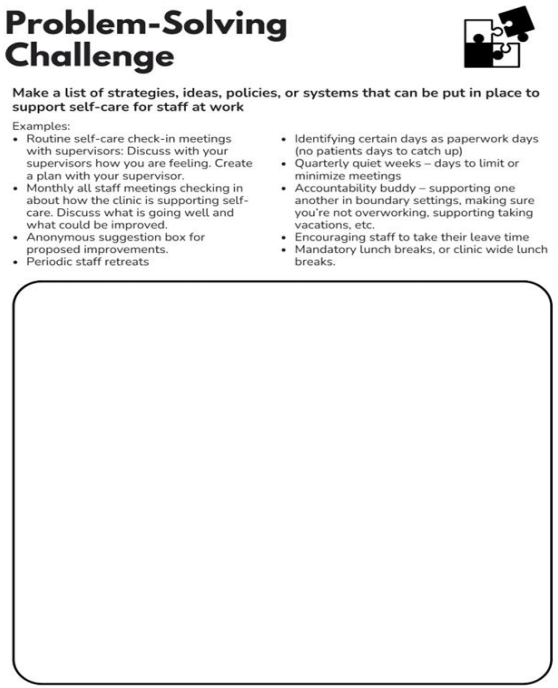
NORTH STAR

"You can't pour from an empty cup"

SESSION 4 ACTIVITY: SELF-CARE PROBLEM-SOLVING CHALLENGE

In groups:

- list strategies, ideas, policies, or systems that can be put in place to support self-care for staff at work
- Sort them into prioritization table

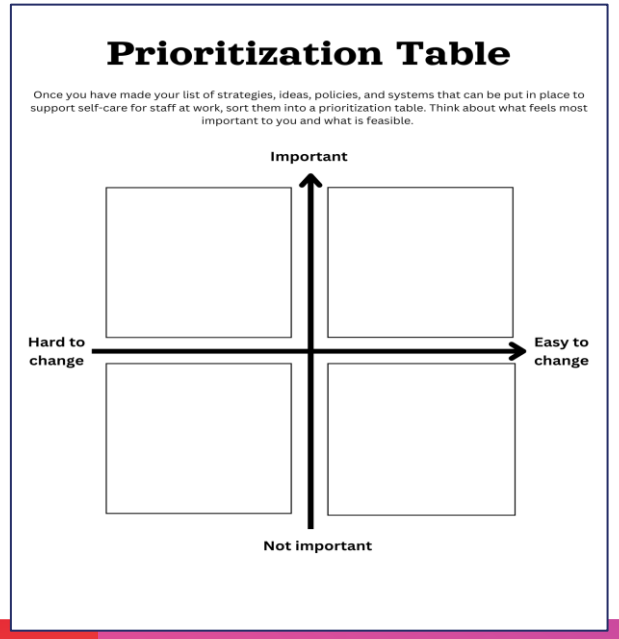


Problem-Solving Challenge

Make a list of strategies, ideas, policies, or systems that can be put in place to support self-care for staff at work

Examples:

- Routine self-care check-in meetings with supervisors: Discuss with your supervisors how you are feeling. Create a plan with your supervisor.
- Monthly all staff meetings checking in about how the clinic is supporting self-care. Discuss what is going well and what could be improved.
- Anonymous suggestion box for proposed improvements.
- Periodic staff retreats
- Identifying certain days as paperwork days (no patients days to catch up)
- Quarterly quiet weeks – days to limit or minimize meetings
- Accountability buddy – supporting one another in boundary settings, making sure you're not overworking, supporting taking vacations, etc.
- Encouraging staff to take their leave time
- Mandatory lunch breaks, or clinic wide lunch breaks.



Prioritization Table

Once you have made your list of strategies, ideas, policies, and systems that can be put in place to support self-care for staff at work, sort them into a prioritization table. Think about what feels most important to you and what is feasible.

Important

Hard to change

Easy to change

Not important

Discuss:

- How can the change team/coach support these changes?
- How can an individual advocate for these changes?
- What are some challenges/barriers you foresee in making changes? What would be easy? What resources can you leverage?

SESSION 5 - OVERVIEW

5. Healing-Centered Care for Patients	Discusses impact of patient trauma experience on health/engagement in care; group reflection on clinic practices that may be retraumatizing; brainstorming of strategies to enhance their support for patients who experience trauma

AGENDA

1. Grounding Activity
2. North Star
3. Recap of Last Session
4. Presentation – What is Trauma, Understanding Immediate and Delayed Responses to Trauma and its impact
5. Case Scenario Activity – Re-traumatization
6. Experiential Learning: Setting Boundaries and Responding to Other's Trauma
7. Connecting the Dots
8. Personal Action Plan
9. North Star
10. Grounding Activity

NORTH STAR

"One size does not fit all"

SESSION 5 ACTIVITY

Scenario: A new patient presents to the front desk. They are presented with a clipboard to fill out their medical history. After waiting, a nurse leads them to the back where they are asked a series of questions, some related to the patients' childhood and current living situation.

The patient responds to the questions, noticeably distraught. The patient recalls past trauma. The nurse leaves to call the physician in. The physician enters and goes through similar motions as the nurse: asking about how the patient is doing, and receives responses where the patient is noticeably distraught, recalling past and recent trauma. The patient, atop their trauma, is currently experiencing housing insecurity. The physician carries forward with an initial assessment and spends most of the visit counseling the patient on HIV, ART, ART adherence, and further discusses the patient's personal experiences.

At the end the physician refers the patient to social work, who can see the patient that same day. The social worker goes through the similar motions as the nurse and physician: asking about how the patient is doing, what the patient's living situation is like, and the patient responds in frustration and pain, recalling past and recent trauma, and reaches an emotional breaking point about how their current living situation is.

The social worker and the patient complete all the necessary paperwork to enroll in the Ryan White Program, and refers the patient to a Community-Based Organization (CBO) that can help address housing needs.

SESSION 5 ACTIVITY

Discussion Questions

- In this scenario, what went well? What could have been improved upon?
- Did the scenario differ from procedures at your clinic? If so, how?
- What is the impact of this process on the patient? How do you think they feel about this clinic?
- What events in this scenario could have caused re-traumatization?
- What are other common practices in HIV care settings that may be retraumatizing for patients?
- What resources would your clinic be able to provide for the patient in this scenario? Internally? Externally?

Clinic Pain Points for Re-traumatization

Action Plan

	What do you do now	What you would like to change	What steps will you take	What you hope to achieve
Clinic Culture				
Self				
Others				
Environment				

SESSION 6 - OVERVIEW

6. Healing-Centered Care of the Clinic Environment / Wrap up	Reflection of how existing clinic's physical and emotional environment could be improved to reduce re-traumatization, be more supportive/healing-centered

AGENDA

1. North Star
2. Pre-Grounding Activity
3. Recap of Last Session
4. Change Team Updates
5. Discussion Questions
6. De-escalation
7. Introduction to Healing-Centered Environment
8. T-Chart Activity
9. Discussion Questions
10. Case Scenario Activity
11. Group Discussion Questions
12. Healing-Centered Care Closing
13. Wrap-Up Action Planning Activity
14. Post-Grounding Activity

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3

NORTH STAR

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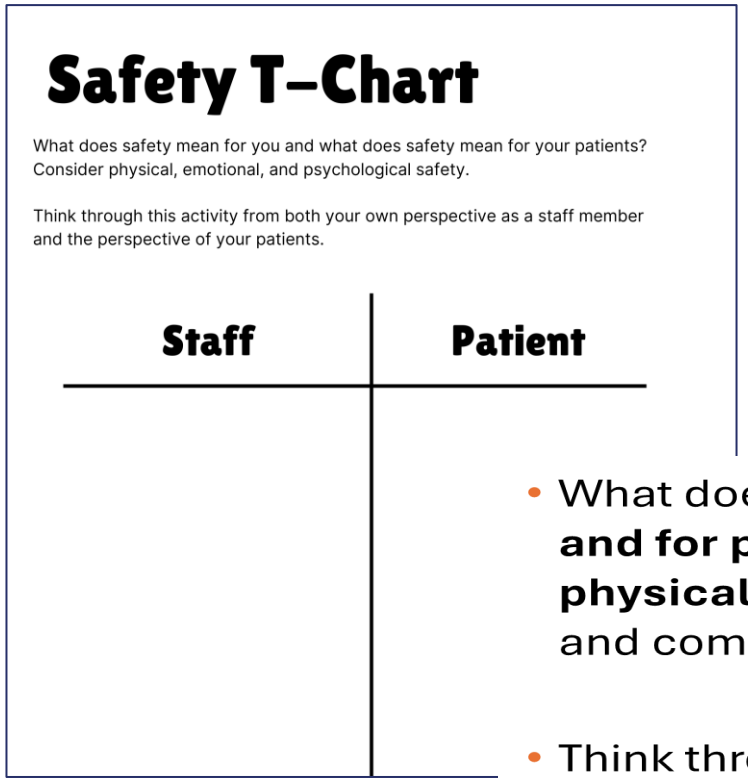
4

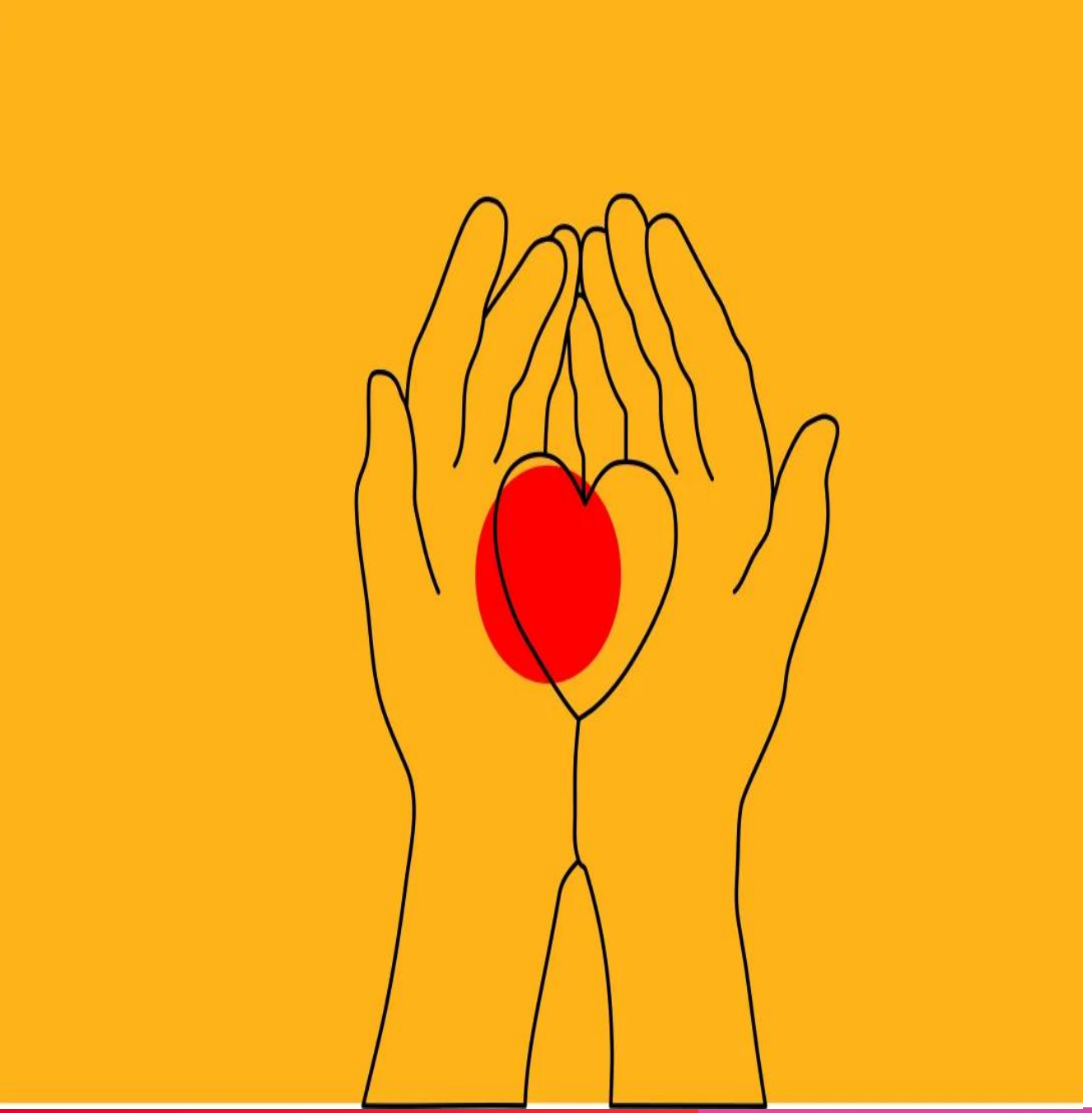
SESSION 6 ACTIVITY



- What does safety mean for **you and for patients**? Consider both **physical and emotional** safety and comfort.
- Think through this both from the perspective of **staff** and from the perspective of **patients**.

DISCUSSION

- How do staff considerations differ from patient considerations?
- Given this activity, of the elements of safety already existing in your clinic, what works well? What could be improved?
- Does the patients' perspective outlined in the T-Chart feel truly representative?
  - How would the patients' side of the chart change if patients were in this room during the decision-making process?
- Why would it be important to include patients' voices in the decision-making process?
  - Are there moments where decision-making needs to be held by staff alone?
    - Is safety and environment one of those moments?



QUESTIONS?

Thank you!

Emory Centers for Public Health Training & Technical Assistance: Candace Meadows, Neena Smith-Bankhead
MPH/MSN Team (Shachi Hansoti, Taylor Brown, Samantha Hodge, Amariah Jackson)
Emory ID Clinic and Grady Ponce Center
All of you!

Jessica M. Sales

jmcderm@emory.edu

Refreshments break

- Location: outside Hub 2
- Please be back in Hub 2 by 10:25am

Session 7 – Reflections and next steps

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Let's RECAP together

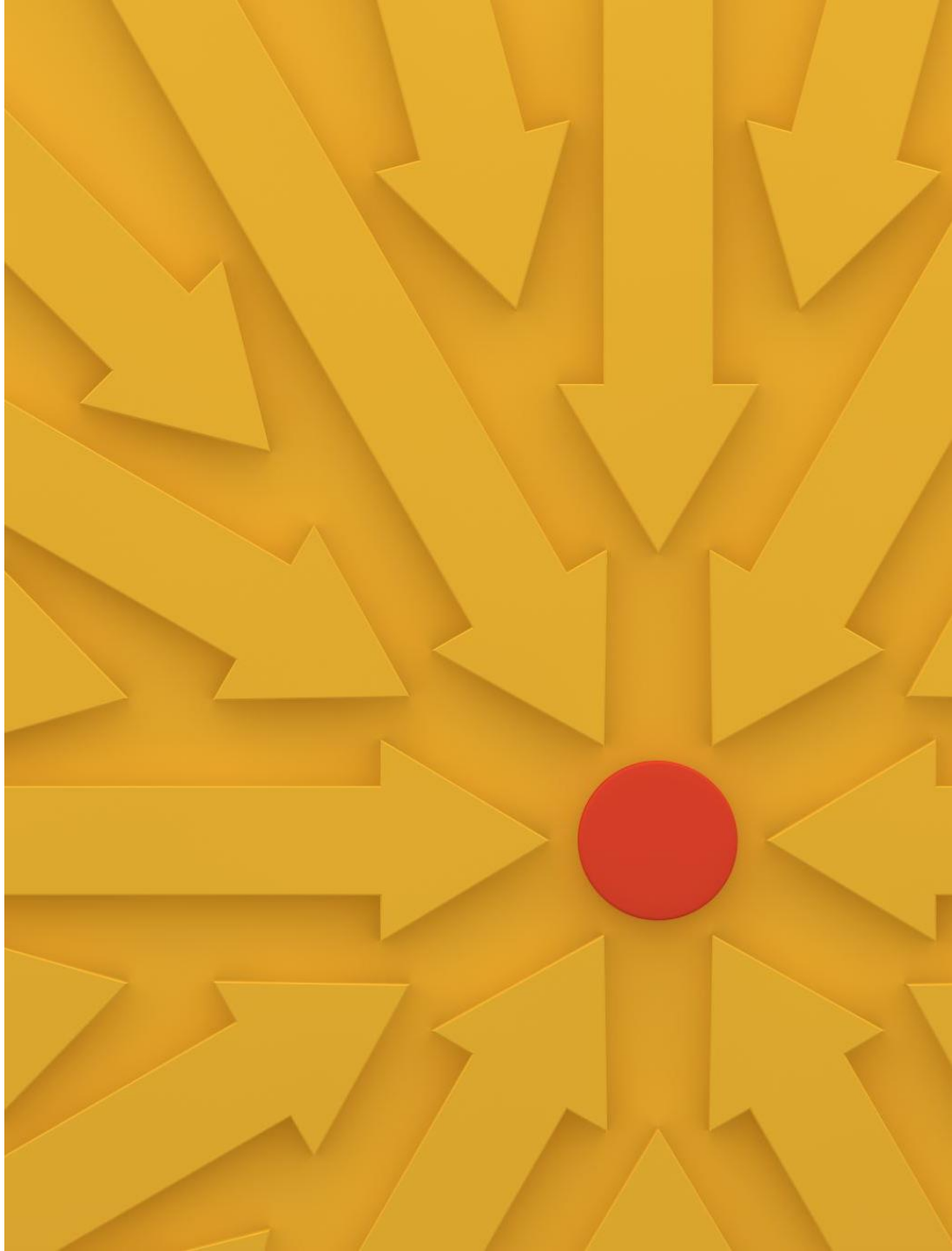
R	Reflect on what you learnt
E	Explain something you learnt
C	Compare what you learnt with what other's learnt
A	Apply your learning
P	Pledge - what will you do now?

See page 34 of workbook

Reflections and goal setting

See page 34 of workbook

Anyone want to share their pledge?



Continuing our journey together

Emma Williams

Meet the IAS change makers

IAS change makers are recipients of our grant, fellowship or mentorship opportunities. They are the next generation of HIV researchers, advocates and healthcare providers taking action to improve the lives of people living with and affected by HIV.

Search through the directory to learn more about their work and the impact they are making worldwide:

Search change makers: Search...

Class of...

Region

Country of residence

Profession or occupation

Interest & expertise

Programme

Apply Filters →

Alumni network

- Join LinkedIn (free platform for professional networking)
- Update your profile, include a photo, be credible!
- Join the group and engage
- Post questions, share links, comment and reflect on other's posts
- Everyone benefits from engagement

IAS Person-Centred Care Advocacy Academies Alumni Network (LinkedIn)

IAS+ courses

Differentiated service delivery for HIV treatment and prevention

Monitoring, evaluation and learning 101

Project management 101

Fundraising 101

Theme
Type of content
Language
Region
Country
Convening
Convening session type
Tracks
Year

Introducing the IAS Youth Hub

View →

IAS+ - the award-winning, interactive learning platform

View →

Introducing a new National Stigma and Discrimination Review and Planning Tool

View →

National Stigma and Discrimination Review and Planning Tool

View →

IAS Educational Fund summary report 2024

View →

Ending HIV criminalization: lessons from Zimbabwe

View →

Responding to HIV in humanitarian and conflict settings

View →

Person-Centred Care Research Collaborative - Meeting February 2025

IAS 2025

Fully hybrid conference

You can join online and learn from global leaders!

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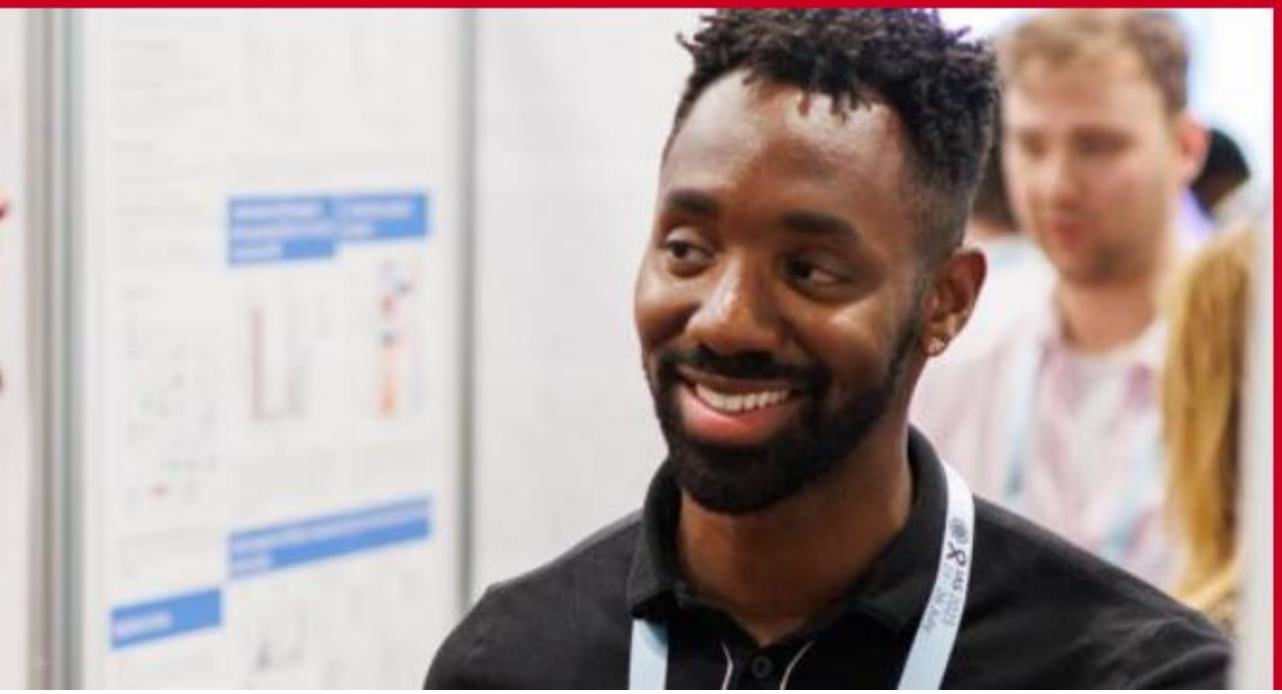

Late-breaker and mpox abstract submissions are now open and close on 29 April

IAS

+ Track A: Basic science

+ Track B: Clinical science

+ Track C: Epidemiology and prevention science

+ Track D: Social and behavioural sciences

+ Track E: Implementation science, economics, systems and synergies

What are JIAS Field Notes?

- Focused articles providing timely insights regarding contemporary challenges in HIV public health practice.
- This includes observations about the mechanisms of change, contextual influences, and findings that emerge from implementation of evidence-based interventions and programmes.
- Field Notes can inform others, spread best practices and promote innovative ideas.
- 1200-word limit
- No publication fee!

Mwangi Pet al. *Journal of the International AIDS Society* 2024, **27**:e26378
http://onlinelibrary.wiley.com/doi/10.1002/jia2.26378/full | https://doi.org/10.1002/jia2.26378

JIAS JOURNAL OF THE INTERNATIONAL AIDS SOCIETY

FIELD NOTES

Bridging the access gaps in HIV services for female sex workers who use drugs with person-centred DSD models in Nairobi, Kenya: lessons learnt

Peninah Mwangi, Josephine Achieng, Beryl Abade, Janeffer Gacheru, Maureen Wanjiku and Daisy Kwala§

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The Bar Hostess Empowerment & Support Programme (BHESP) was established in 1998 in Nairobi, Kenya, to provide a voice for women vulnerable to sexual and gender-based violence to influence policy, reduce HIV acquisitions, support access to justice and reduce stigma and discrimination. BHESP operates for and by female sex workers (FSWs), women having sex with women and women using drugs and bar hostesses, many of whom live in informal settlements. BHESP engages their clients in HIV prevention, treatment and support services; gender and human rights awareness; legal services; advocacy and economic empowerment opportunities.

In 2020, BHESP observed that FSWs using drugs were alienated from accessing the current service delivery models due to community stigma, cultural and religious barriers. Consistent with BHESP's principles of community action, human rights and an evidence-based response that puts the client at the centre of service delivery, FSWs who use drugs, peer educators, outreach workers, support group coordinators and clinicians were convened to lead the development, implementation and evaluation of tailored interventions to improve access for FSWs who use drugs. This was carried out in three parts: a community needs assessment; participatory processes and stakeholder consultations; and continuous monitoring and evaluation.

BHESP initiated this process by conducting a comprehensive community needs assessment with FSWs who use drugs to understand their diverse needs and challenges at each point of service delivery, including experiences of stigma, violence or geographic isolation (hidden sex workers). This individualized approach ensured that differentiated service delivery (DSD) models were tailored to the specific needs and circumstances of the FSW community.

BHESP organized community forums, focus group discussions and stakeholder meetings where FSWs and other key stakeholders, including clinicians, could contribute their perspectives, share experiences and co-design solutions. By fostering collaboration and dialogue among diverse stakeholders, BHESP ensured that DSD models were informed by a holistic understanding of the social, cultural and structural factors influencing access to healthcare for FSWs who use drugs. The participants evaluated the unique individual needs of the clients and worked consultatively to come up with a mix of models that would best address those needs. This collaborative approach also enhanced the ownership and sustainability of DSD interventions within the community.

BHESP established robust monitoring and evaluation mechanisms to assess the effectiveness and impact of DSD models on the health outcomes and wellbeing of FSWs who use drugs. This involved tracking key indicators related to service utilization, health status and client satisfaction, as well as conducting regular assessments of programme implementation fidelity and quality. BHESP also solicited feedback from FSWs who use drugs and other stakeholders through surveys, focus groups and feedback forms to identify areas for improvement and adaptation. By continuously monitoring and evaluating DSD interventions, BHESP was able to identify emerging needs, gaps or challenges within the FSW who use the drug community and adjust approaches accordingly. This iterative process of learning and adaptation ensured that DSD models remained responsive to the evolving needs and preferences of FSWs who use drugs, ultimately enhancing the effectiveness and sustainability of the healthcare service delivery provided by BHESP.

Recognizing the intersectional nature of substance use within the FSW community, BHESP conducted targeted training sessions for healthcare providers, peer navigators and other stakeholders to raise awareness about the unique challenges faced by FSWs who use drugs and the importance of adopting a harm reduction approach. These sensitization efforts included workshops, seminars and peer-led discussions that addressed stigma, discrimination and misconceptions surrounding drug use among FSWs. BHESP also facilitated dialogue between FSWs who use drugs and service providers to foster mutual understanding and empathy.

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Membership

Join the largest network of HIV professionals and enjoy benefits such as:

- Connecting and networking with thousands of HIV professionals through the **IAS Membership Directory**
- Amplifying the reach and targeting new audiences for your upcoming events through the **IAS Members' Area**
- Browsing exclusive career opportunities in HIV research, advocacy, implementation **and many more benefits**

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Membership prices

Price for US-based members	Without our special offer	With our special offer!
USD 70	1 year	1.5 years
USD 130	2 years	3 years
USD 190	3 years	4.5 years

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Seed grant criteria

Deadline for applications: 31 May 2025

- Feasible within 9,000 USD budget
- Only three seed grants available
- Priority on interventions aimed to change policies or implementation
  - Integration of HIV services with other health needs
  - Focused on client empowerment for key and vulnerable populations

Application form elements

- Title, team, host organization
- Introduction: background, rationale
- Project description / design / intervention logic:
  what you are trying to achieve and how
- Participatory elements / research gaps addressed
- Impact goals / sustainability
- Planning and implementation – milestones and methods, risk assessment, communication, data collection and protection
- Financing need

Tips for success

- The project addresses an **unmet need** and **adds value**
- The proposal demonstrates **understanding of the context**
- Arguments are backed by **evidence**
- **The intervention logic** is clear and SMART: Specific, Measurable, Achievable, Relevant, Time-bound
- The proposed work is **complementary** to other existing initiatives (not duplicative) and creates synergies

Tips for success

- All sections of the proposal are **consistent, clearly structured**, and not repetitive
- **Transparent budget**
- The proposal demonstrates **value for money**
- You demonstrate your **potential and capacity to deliver**: strengths, uniqueness, what you do differently, experience, learning

Follow up virtual learning events and technical support

- Complete follow-up survey to let us know your priorities for courses and resources
- Plans for follow up online meetings, as needed
- Review of abstracts
- Review of funding proposals
- Review of field notes

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Share your feedback on the academy:
How did we do?
How can we improve?
What else do you want to learn about PCC or advocacy?

Presentation of participation certificates