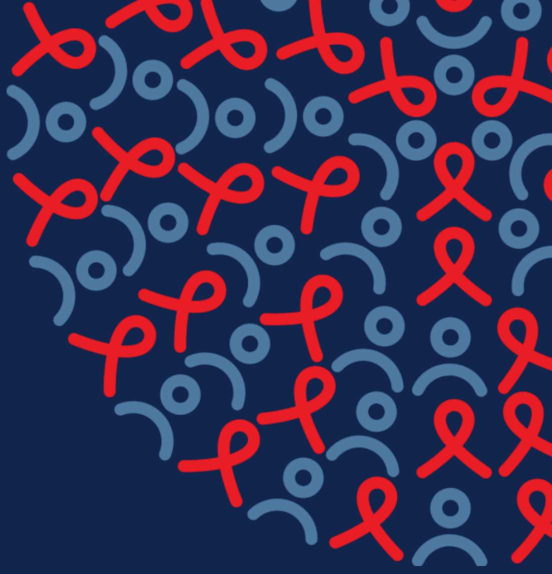
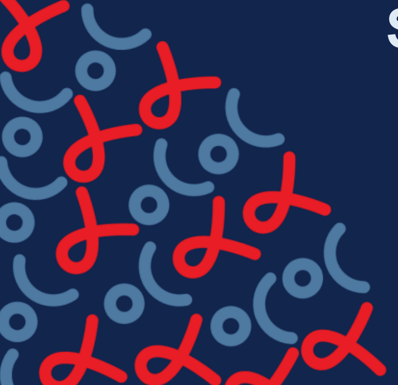


Community Distribution of ART

Decentralized Drug Distribution (DDD) Learning Collaborative

September 10, 2020



Introduction to community ART

Differentiated service delivery models fall into four categories

- **Facility based individual models** e.g. fast track
- **Out of facility individual models** e.g PODI in which refills and clinical consultations are provided outside of health care facilities
- **Health care worker-managed group models** where individuals receive ART in a group e.g. community adherence clubs (CARC)
- **client-managed group models** clients get their ARVs in groups run by clients themselves examples are CARGs (Zimbabwe, GAC Mozambique)

Session 4 agenda

- **Les postes de distribution ARV**
  Isabelle Ambunga | Responsable communautaire projet SIDA, DRC
- **Emergency Community Distribution of Commodities in Eswatini**
  Laura Muzart | Country Director, EpiC, Eswatini
  Dr. Christopher Makwindi | EGPAF-Eswatini
- **“Jak-Anter”: Home-based antiretroviral treatment delivery platform to ensure sustained and safe access to HIV treatment among PLHIV during COVID-19**
  Caroline Francis | Chief of Party, LINKAGES, Indonesia
- **Community ART Refill Groups (CARGs) Model**
  Auxilia Muchedzi | Project Director, Zimbabwe HIV Care and Treatment (ZHCT), Lusaka Zambia

PANELISTS

Isabelle Ambunga
Community AIDS Project Manager

Laura Muzart
Country Director, EpiC, Eswatini

Dr. Christopher Makwindi
EGPAF-Eswatini

Caroline Francis
Chief of Party, LINKAGES, Indonesia

Auxilia Muchedzi
Project Director, Zimbabwe HIV Care and Treatment (ZHCT), Lusaka Zambia

FACILITATORS

Tom Minior
Adult Clinical Branch Chief, Prevention Care & Treatment Division, GH/OHA

James Batuka
EpiC Consultant

Les postes de distribution ARV

Isabelle Ambunga

Responsable communautaire projet SIDA

MSF/ OCB – Kinshasa - RDC

Septembre 2O2O

Plan de la présentation

- Motivation
- Histoire et Quelques statistiques nationales
- Les principaux services du PODI
- Les activités du PODI
- Les avantages du PODI
- Les défis
- Les leçons retenues
- Conseils pratiques
- Le PODI face au COVID 19

Motivation

- **Réponses aux besoins liées aux vécus des patients et du personnel soignant**

Patients	Agents de santé
Le cout du traitement	Le nombre élevé de consultation /personnel soignant
La stigmatisation dans les services	La saturation des services sanitaires
Le temps d'attente	Pas suffisamment de temps pour les sessions de suivi -adhérence
La non –adhérence au traitement	Difficulté de gestion des PVV

Historique: dates importantes

2O1O: Mise en place des 1er PODI a KINSHASA par MSF et RNOAC , **PODI- est** et **PODI-ouest**

2011: Ouverture d'un nouveau PODI dans l'axe centre de la ville

2014: Modèle reconnu par le PNLS, et repris dans le PSN

2014-2017: Model repris dans la Note Conceptuelle de FM

2015: Le PODI est repris dans le COP15 de PEPFAR

2016: Passation à d'autres partenaires d'appui technique et financier **PODI centre AdS (FM) et le PODI Est ICAP (PEPFAR)**

2017: Ouverture de 2 PODI: RNOAC appuyé par PROVIC

2O17: Début de la mise en place de nouveaux PODI hors Kinshasa (Katanga, Lomami, Maniema)

2O17-2O2O: Appuie MSF limité a 1 PODI

Quelques statistiques nationales

- 14 PODI sur l'étendue de la république (3 provinces et la ville de Kinshasa)
- Nombre de staff : 98
- Nombre des patients actif : 7364
- Nombre de décès : 0
- Nombre d'abandon : 0
- Nombre des perdus de vue : – 2%

Les principaux services dans un PODI

- La réception
- La pharmacie
- Le conseil

Les services auxiliaires:

- Le service d'entretient et le gardiennage

Le service social selon la perception du partenaire

NB: le personnel est polyvalent

Les activités dans le PODI

- Gestion et Distribution des ARV
- Éducation-therapeutique du patient
- Accompagnement a l'adhérance
- Recherche communautaire des présumes perdus de vues et des perdus de vue
- Conseils et dépistage volontaire
- Sensibilisation communautaire sur le dépistage et les droits des PVV
- Références vers les structures sanitaires
- Orientation vers les groupes d'auto-support
- Réinsertion sociale des PVV rejetés et abandonnés

Les activités

Distribution des ARV et éducation thérapeutique

Dépistage et référence

Réinsertion sociale de patient rejeté et abandonnés

Les avantages

- Désengorgement des structures sanitaires
- Rapidité = gain de temps = préservation de la vie professionnelle
- Accès facile
- Pas de stigmatisation
- Acces gratuit
- Acces facile au dépistage
- Bonne rétention (98%)
- Réduction et maintient d’une bonne CV
- Réduction du cout
- Éducation par des paires

Les défis

- Monitoring CV
- La réponse au besoin de tout les patients stables
    - Ex: femme enceinte / enfant / ado /…
    - Zones urbaines versus zones rurales
    - La population clées

Les leçons retenues

- CV supprimée et maintenue a un bon niveau
- Rapidité dans le retrait des médicaments
- Bonne intégration dans le système sanitaire
- Responsabilisation des PVV
- Implémentation dans plusieurs province
- Bon accompagnement des zones de santé et du programme nationale

Quelques conseils pratiques

Des éléments a prendre en compte :

- Une Association de PVV bien organisée
- Des membres activistes
- Paires motivés dans l'accompagnement de PVV
- Bonne collaboration avec les structures de santé /la zone de santé et l' association de PVV
- Partenaires de mise en place des PODI engagé dans le suivi (appui technique et financier)
- Création d' activité génératrice de revenus pour réponde a certains besoin (réinsertion sociale)
- Bonne implémentation des activités communautaires (sensibilisation communautaires, promotion du dépistage) pour la visibilité

LE PODI et le COVID

Problématique :

- Manque d'information fiable
- RDV planifié depuis plusieurs mois avant la crise
- Non respect des règles d'hygiene
- Lieu de réception des PVV
- Transmission par voie aérienne
- Personnel PODI PVV

Mesures face au COVID

Approvisionnement en ARV dans les PODI

- Ravitaillement des ARV 3 mois avec un réserve d'un mois
- En cas de rupture, Le numéro de contact sont opérationnel entre le programme , les partenaires et le staff PODI
- Amélioration de la communication pour un meilleur suivi des activités
- Identifications des points focaux communautaires
- Mise en place de la cartographie des points de ravitaillement   très rapproches pour les patients
- Le PODI reste ouvert avec un service minimum
- Sensibilisation sur les mesures de prévention a tout usagers des Podi

Fin

Merci pour l’attention

Emergency Community Distribution of Commodities in Eswatini

Decentralized Distribution of Commodities learning series, 10 September 2020

Dr Christopher Makwindi - EGPAF & Laura Muzart – FHI 360

Background

- In response to the COVID19 pandemic, the government of Eswatini engaged the ART stakeholders in designing and implementing the so-called **Mother-Baby Community** (i.e. MoBaCo) through which services to stable ART clients are decentralized from “mother facilities” to satellite (baby) facilities and from those baby facilities to the community sites

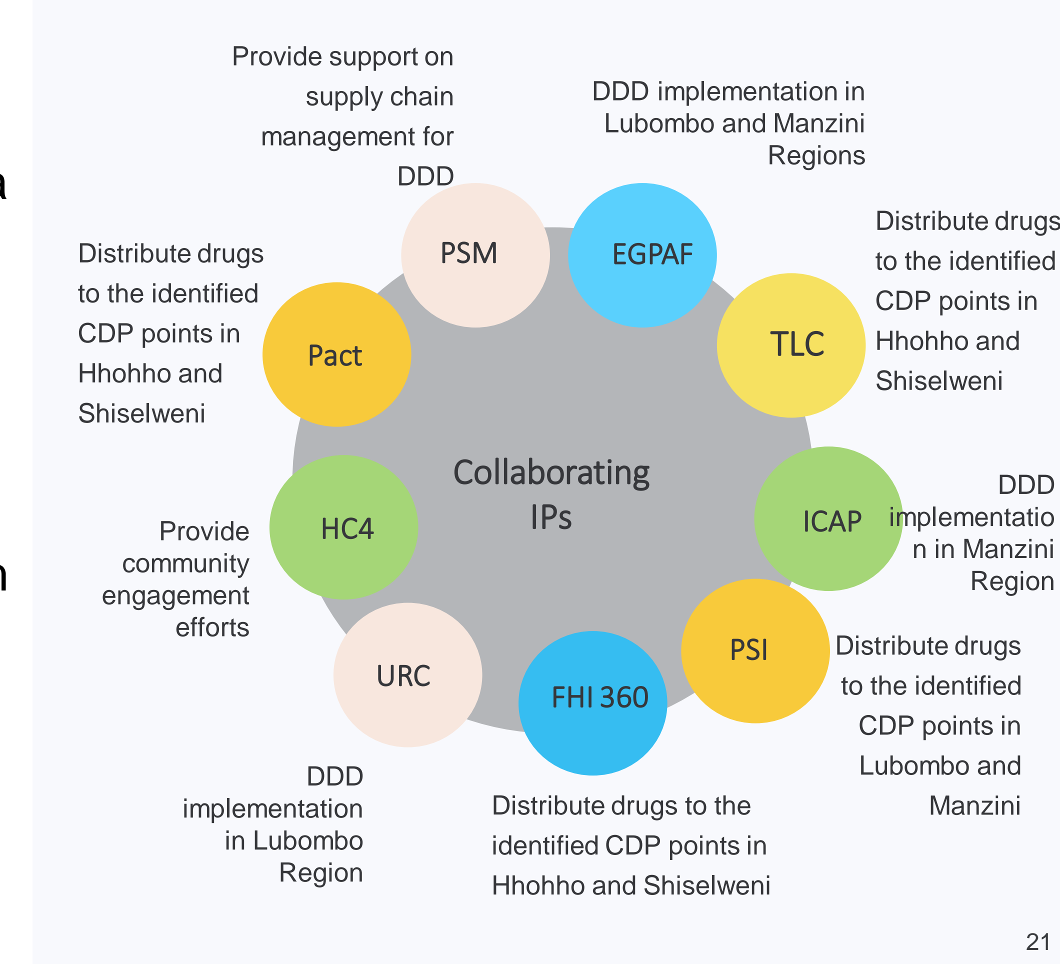
- Community sites comprise of drug shops, closed schools, churches, neighborhood care points or other locations identified by community leadership or by IPs.

- The MoBaCo represents a hybrid of the current DSD models, which aims at ensuring sustainability and ongoing access to ARVs and other medications without exposing clients to the risk of COVID-19

- The model allows for the distribution ARVs, TB and NCD medications (anti-diabetic, anti-hypertensives), family planning products, as well as PrEP, condoms; so it doesn’t only target ART clients

Implementation

- A national technical working group "*Community Commodities Health Distribution Framework*" that serves as a guide for the rollout of the services
- *So,* what's globally referred to as DDD, is called *Community Health Commodities Distribution (CHCD)* in Eswatini; the framework doesn't include the private sector distribution under MoBaCo.
- CHCD was rolled out as an emergency approach and is now being integrated into routine programming; FHI 360/EpiC project is supporting MOH and PEPFAR partners to move from emergency to more standard DDD in terms of larger scale, data driven and integrating key M&E and data needs, etc.
- Focus areas include:
  - Rapid start up, by actively calling eligible clients
  - Sensitize clients on the model, and its benefits
  - Identifying and expanding community distribution points
  - Improve the M&E system and tools to accommodate custom indicators related to this service modality
  - FHI 360 is supporting MOH to assess the possibilities of CHCD through private pharmacies



Objectives of the CHCD/DDD Model

- Establish continuous and reliable community access to a standardized list of essential medicines and selected health commodities and strengthen the facility-community continuum of care
- Reduce risk of COVID-19 acquisition in at-risk populations by reducing the need to take public transport, queuing for services at health facilities, and traveling significant distances from their homesteads
- Decongest facility-level service delivery burden, crowding and queuing
- Reduce silo programs and associated stigma through integrated commodity delivery

CHCD Inclusion criteria for ART clients

- Stable ART clients (Virally Suppressed)
- Clients on ART for more than 3 months
- Clients on first-line ART
- Clients willing to receive ARVs in a community setting

Milestones

April 2020

- Enrolment of clients into emergency community distribution
- Mapping of community delivery points (CDP)
- Advocacy and sensitization of RHMTs and Health Facilities
- Development of the CHCD Framework

May 2020

- Provision of COVID19 screening at community delivery points
- Distribution of commodities

June 2020

- 183 CDPs with 3331 clients. Added DSTB services

July 2020

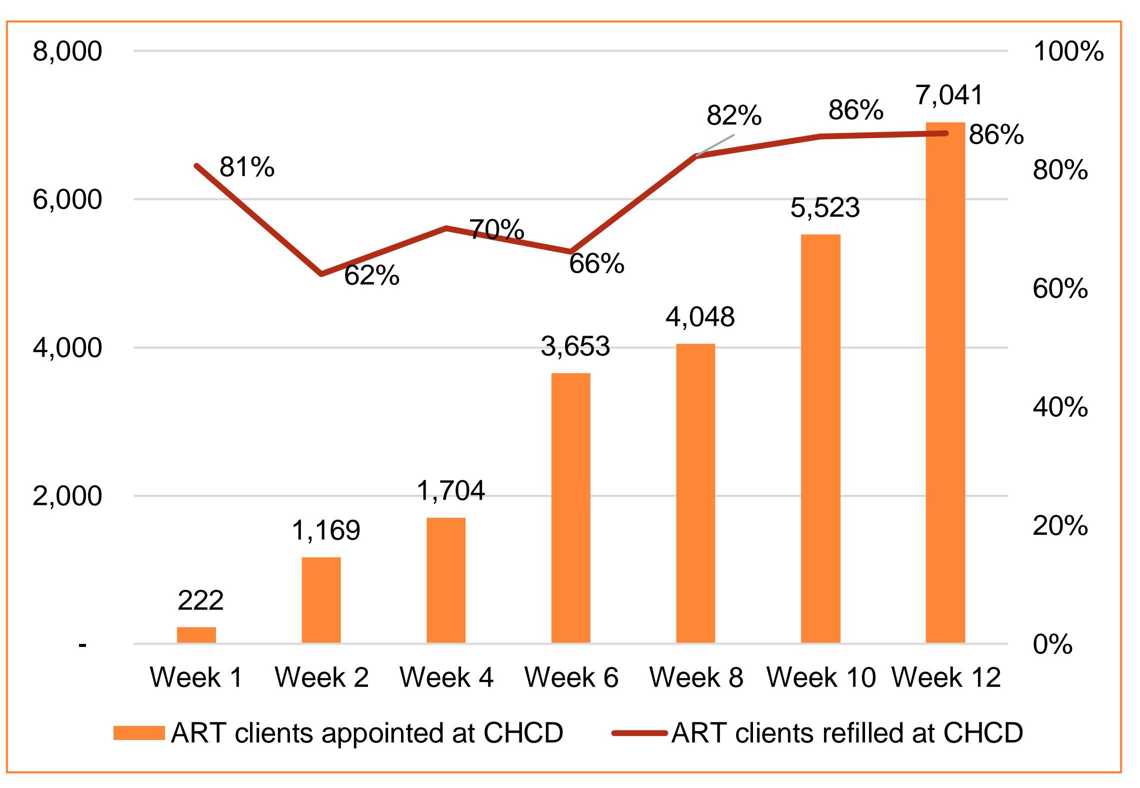
- 190 CDPs with 4725 clients

August 2020

- 297 CDPs with 6,063 clients

Implementation Progress: Facilities and Distribution Points

EGPAF-Supported regions			
	Total	Hhohho	Shiselweni
Number of health facilities planned to implementing CHCD	65	44	21
Number of health facilities implementing CHCD	33	24	9
Number of planned community distribution points	371	245	126
Number of functional community distribution points	297	217	80



Acceptance rate of CHCD Services

Acceptance rate of CHCD Services, by region (May-July 2020)

14,000
12,000
10,000
8,000
6,000
4,000
2,000
-

60%
50%
40%
30%
20%
10%
0%

53% 53% 53%

4,945
1,118
6,063

Hhohho Shiselweni Total

Offered CHCD services
Accepted CHCD services
% Accepted CHCD service

Acceptance rate of CHCD Services by month, FY20*

6,000
5,000
4,000
3,000
2,000
1,000
-

60%
50%
40%
30%
20%
10%
0%

51% 55% 52%

3,309
1,692
5,372
2,935
2,752
1,436

May June July

Offered CHCD services
Accepted CHCD services
% Accepted CHCD service

About half of the ART clients accept CHCD; no differences across regions, nor over time

***July: mentorship teams diverted for 2 weeks to collect data for Q3 reporting**

Uptake of CHCD Services by Age and Sex

Acceptance rate of CHCD Services, by Sex, by Month, FY20

4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
-

60%
50%
40%
30%
20%
10%
0%

53%
55%
55%
49%
53%
48%

May
June
July
Female
May
June
July
Male

Offered CHCD services
Accepted CHCD services
% Accepted CHCD service

Acceptance rate CHCD Services, by Age, by Month, FY20

6,000
5,000
4,000
3,000
2,000
1,000
-

70%
60%
50%
40%
30%
20%
10%
0%

65%
46%
51%
51%
55%
52%

May
June
July
<15 Years
May
June
July
15+ Years

Offered CHCD services
Accepted CHCD services
% Accepted CHCD service

No difference in acceptance rate when disaggregated by sex and age

Facility and Community ART Refills (June, July 2020)

June 2020

Community Refill on time appointments
- 86% followed-up and reached
- 96% re-appointed

	Facility Refill	Community Refill	Total
ART clients due for refill	22,478	4,280 (16%)	26,758
Came for refill	16,413 (73%)	3,770 (88%)	20,183 (75%)
Missed Refills	6,065 (27%)	510 (12%)	6,575 (25%)

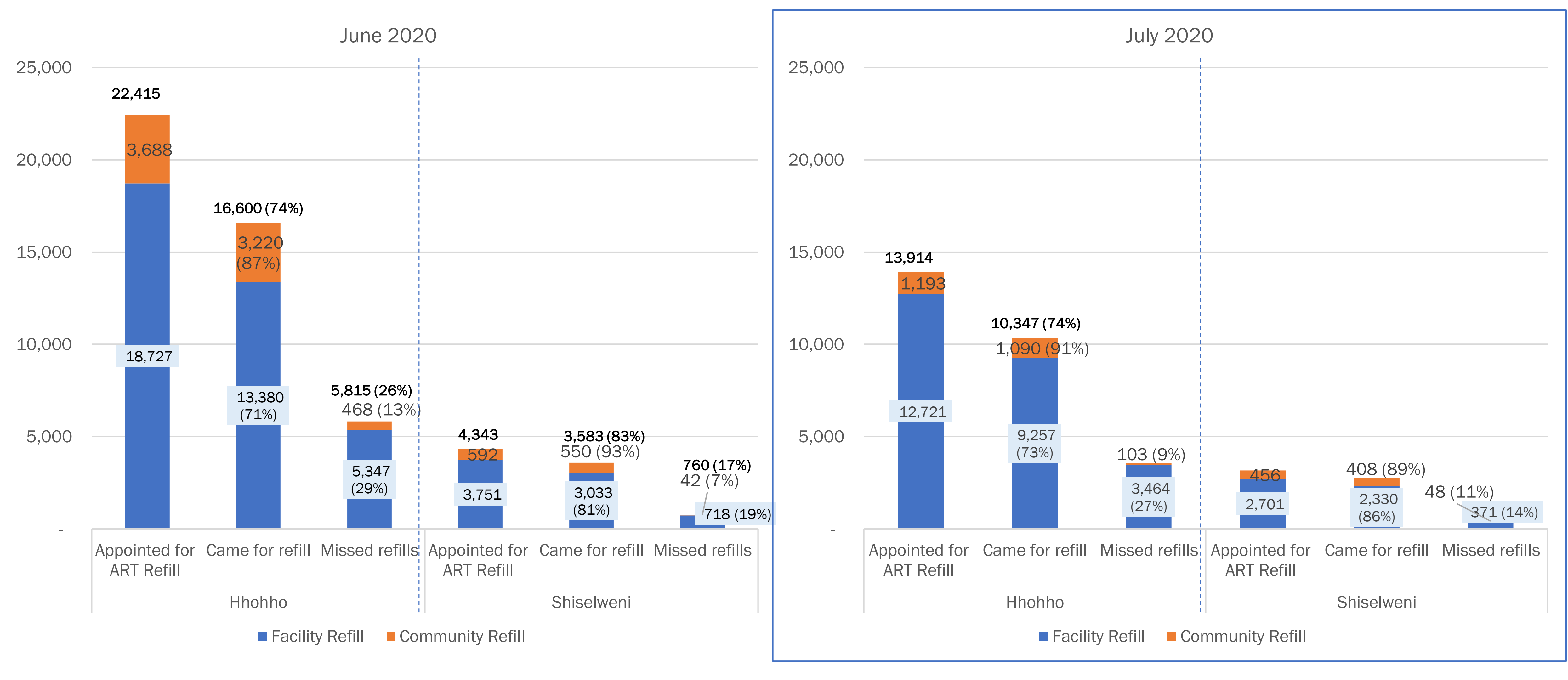
July 2020

Community Refill on time appointments
- 95% followed-up and reached
- 97% re-appointed

	Facility Refill	Community Refill	Total
ART clients due for refill	15,422	1,649 (10%)	17,071
Came for refill	11,587 (75%)	1,498 (91%)	13,085 (77%)
Missed Refills	3,835 (25%)	151 (9%)	3,986 (23%)

Proportionally less CHCD clients missed their refills compared to facility-based clients (12% versus 27%)

Facility and Community ART Refills (June, July 2020) by Region



Distribution of Other Commodities and DSD Models (July 2020)

DSD Models among clients enrolled on CHCD Services, Jul 2020

Other models 1%

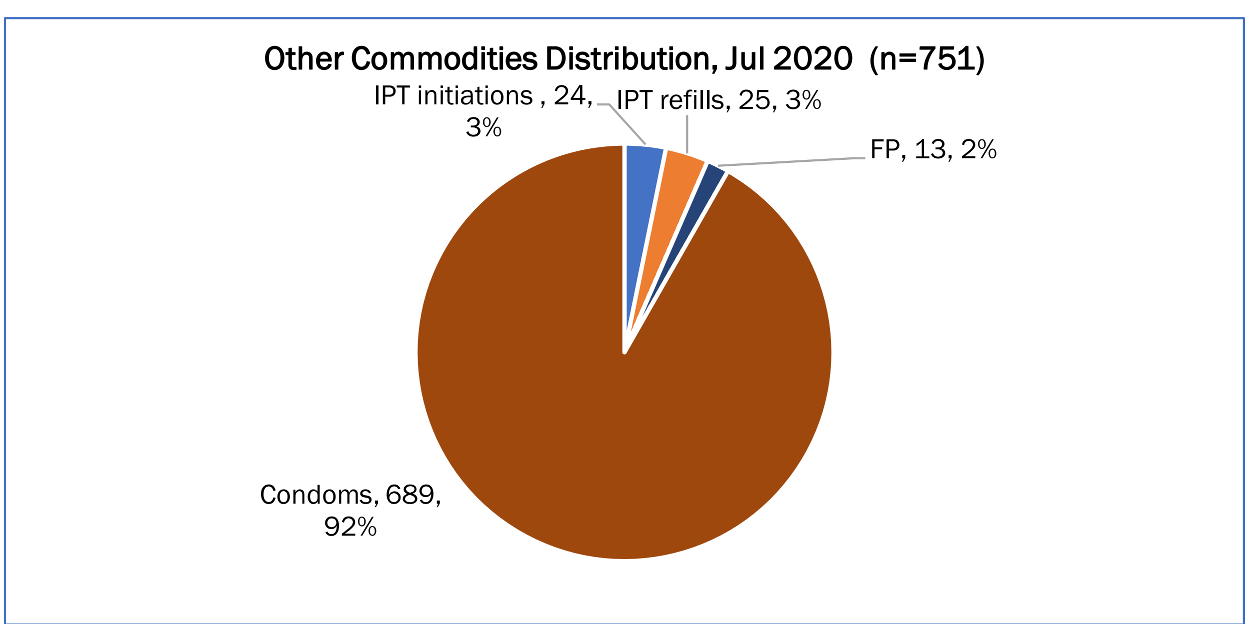
Fast Track 25%

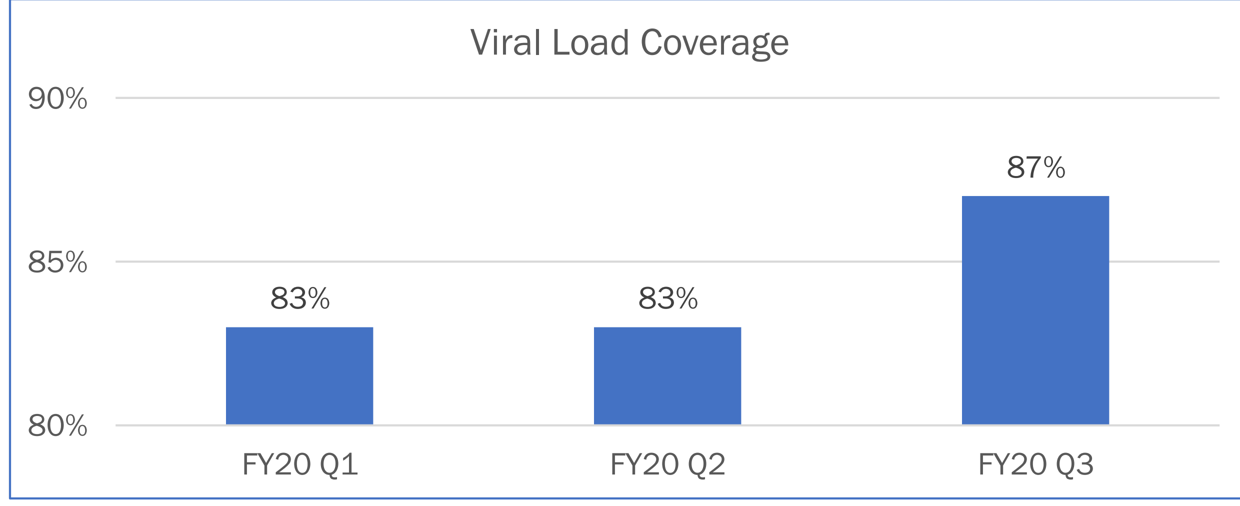
Mainstream 52%

Facility Based ART groups 8%

Community ART distribution 9%

CAGs 5%





Gaps and proposed solutions

Gaps	Reasons	Mitigation
Low acceptance of CHCD among the offered	1. Perceived stigma 2. Most adolescents have not disclosed, leading to preference for facility based models 3. Poor understanding of the initiative 4. Initiative offered telephonically and not on the last visit 5. Lack of trust on the providers of CHCD	1. Integration of non-HIV services to de-stigmatize CHCD services 2. Continue to offer CHCD to those who may initially declined enrolling into the initiative 3. Community sensitization on CHCD 4. Include CHCD in the early morning health talks in facilities 5. Collect reasons why clients refuse CHCD and develop remedial actions 6. Scale up community delivery points
High proportion missing the appointment date	1. Long walking distances to the CDPs - some still on their way. 2. Change of mind and preference of receiving services at facility level	1. Procure phones and support facilities for follow up Miss App 2. Education of patients at every contact on CHCD and retention in care 3. Virtual support as needed 4. Collect reasons for missing appointments and develop remedial actions
Not everyone reached after follow up for missed appointment	1. Phone not reachable	1. Continued follow up on patients who cannot be reached after or during a CHCD visit 2. Conduct home visits while observing all the precautions

Lessons to Share and Challenges

Lessons Learnt

- **Further engagement of adolescents**: Gap with disclosure and many may not want to be ‘seen’ collecting ART. Preference to facility based models.
- **Need for Regional Health Management Teams (RHMTs), community leaders and facility manager buy-in**: Gave MOH the initiative and enhanced acceptability of the initiative
- **Increasing the number of CDPs:** Improved access and hence acceptability of the initiative
- **Leveraging partner resources**: - Collaboration of facility and community based IPs with coordination from EGPAF availed resources to start.
- **Early initiation of client follow-up**: Follow up should be commenced before leaving the CDP

Challenges

- Drug stock outs if the current COVID19 situation continues
- Sustainability of the DDD model using government resources

Thank You!

“Jak-Anter”: Home-based antiretroviral treatment delivery platform to ensure sustained and safe access to HIV treatment among PLHIV during COVID-19

Caroline Francis, Irvin Romyco, Afifan Haryawan and Aulia Human
LINKAGES Indonesia

Community Distribution of ART webinar

September 10, 2020

Section 1: The problem

- *Indonesia COVID-19 situation*
- *COVID-19 restrictions in Jakarta*

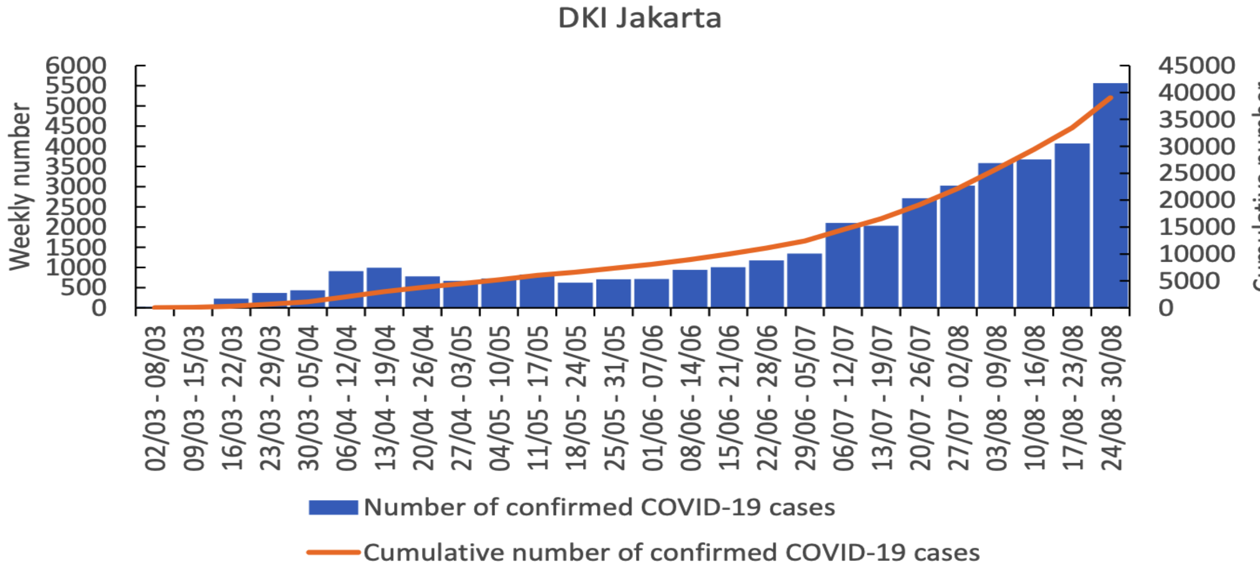
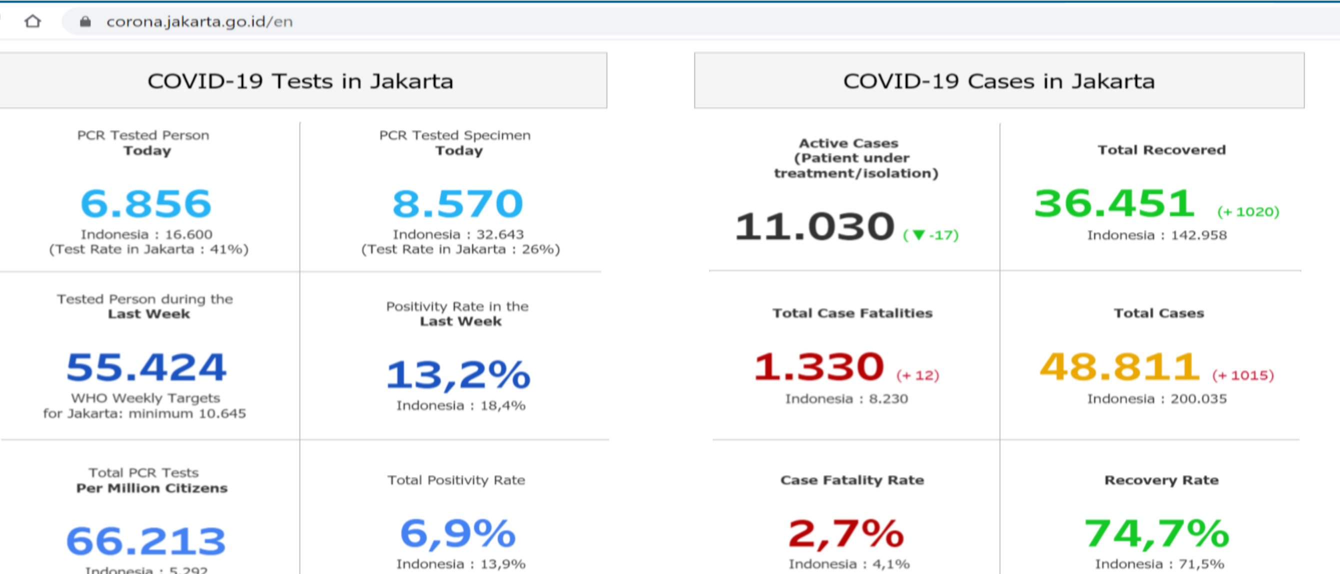


Figure 6: Weekly and cumulative number of confirmed COVID-19 cases in DKI Jakarta, as of 30 August 2020. *Source of data*



As of early September 2020, Jakarta has reported close to 50,000 COVID-19 positive cases and 1,330 deaths.

COVID-19 positivity testing rates currently stand at 13.2%

Jakarta shows the highest confirmed COVID-19 mortality per one million population in Indonesia

https://corona.jakarta.go.id

Jakarta, Indonesia
Over 25,000 PLHIV on ART
National state of emergency declared on March 20, 2020
Large-scale social restrictions (PSBB) introduced in Jakarta on April 10, 2020 – restricted movement; reduced service accessibility; to be reintroduced on September 14, 2020
ARV shortages/stockouts throughout the country – multi-month dispensing roll out curtailed

Section 2: Ensuring treatment continuity for PLHIV

- *Policy to practice*
- *Introducing Jak Anter*

Shaping policy: PHO circular letter, No. 57 / SE / 2020

DINAS KESEHATAN
PROVINSI DAERAH KHUSUS IBUKOTA JAKARTA

Jakarta, Maret 2020

Kepada
Yth 1. Para Kepala Suku Dinas Kesehatan Kabupaten/ Kota Administrasi Provinsi DKI Jakarta
2. Para Direktur Rumah Sakit di Provinsi DKI Jakarta
3. Para Kepala Puskesmas Kecamatan Provinsi DKI Jakarta
4. Yayasan Lembaga Swadya Masyarakat Peduli AIDS

di
Jakarta

SURAT EDARAN
Nomor : 57 /SE /2020

TENTANG

KEBERLANGSUNGAN LAYANAN HIV DI PROVINSI DKI JAKARTA SELAMA MASA PANDEMI COVID-19

Sehubungan dengan situasi pandemi COVID-19, pelaksanaan program HIV di fasilitas layanan kesehatan di Provinsi DKI Jakarta tetap berlangsung dengan ketentuan sebagai berikut :

1. TEMUKAN
   a. Pelaksanaan pemeriksaan HIV di fasilitas layanan kesehatan tetap berlangsung seperti biasa.
   b. Pelaksanaan pemeriksaan HIV melalui *mobile VCT* (dokling) dihentikan sementara sampai pandemi COVID-19 dapat dikendalikan.
   c. Kegiatan penjangkauan populasi kunci oleh Lembaga Swadaya Masyarakat (LSM) Peduli AIDS dihentikan sementara sampai pandemi COVID-19 dapat dikendalikan.
2. OBATI
   a. Pemberian ARV dapat diberikan 2 (dua) bulan untuk pasien yang memenuhi kriteria *Multi Month Dispensing* (MMD) dengan mempertimbangkan stok ARV di fasilitas layanan kesehatan.
   b. Pemberian ARV dapat dikirimkan melalui jasa pengiriman untuk pasien yang memenuhi kriteria MMD namun terkendala dengan stok di fasilitas layanan kesehatan.

1. Continuation of static HIV testing services

2. <u>Suspension</u> of community-based HIV testing services

3. Transitioning of CSO outreach and “Lost and Link” contact tracing to <u>virtual</u> service delivery

4. Provision of two-month ARV dispensing, as per stock availability

5. Provision of home-based ARV delivery services

6. <u>Prioritization</u> of VL testing for pregnant women and treatment failure PLHIV

7. <u>Suspension</u> of VL specimen transport system; utilization of GeneXpert for VL testing

Jak-Anter: from creation to implementation

Section 3: Initial results and next steps

- *Jak Anter results and costs*
- *Client and provider feedback*
- *Practice to policy, expansion and monitoring*

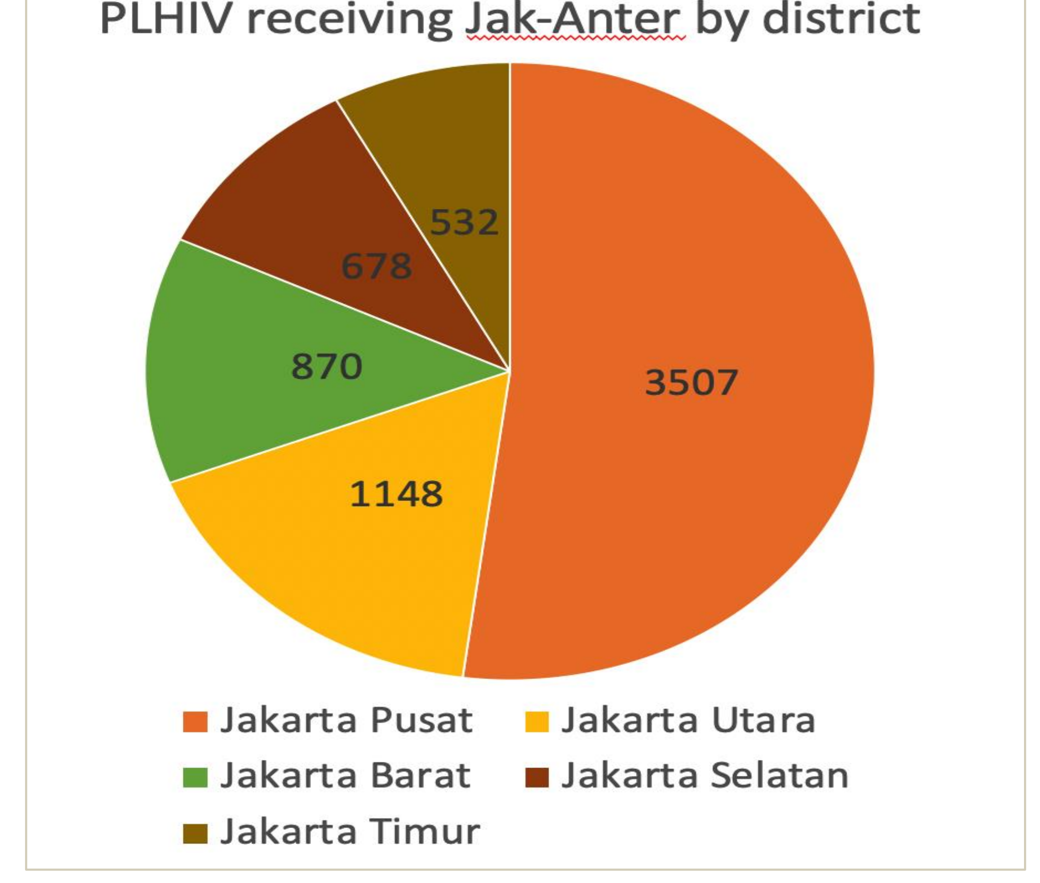
Jak Anter coverage, 60 facilities

April – August 2020

Cumulative PLHIV receiving JAK-ANTER (weekly)

Week	PLHIV with Jak-Anter
30 Maret	0
3 April	240
10 April	436
17 April	706
24 April	922
1 Mei	1170
8 Mei	1425
15 Mei	1800
22 Mei	2133
31 Mei	2443
7 Juni	2832
14 Juni	3379
21 Juni	3753
26 Juni	4162
4 Juli	4642
11 Juli	5051
17 Juli	5401
25 Juli	5730
1 Agu	5991
8 Agu	6375
14 Agu	6735
21 Agu	6933
29 Agu	7046

Cumulative data period of 30 March – 29 August 2020. Data extracted on 8 September 2020



40% of PLHIV at 60 sites – or 27.9% of total PLHIV – have received home-based delivery services through Jak-Anter and community-based supporters

Central Jakarta district provides majority of home-based ARVs, followed by North and West Jakarta (August 14)

Jak-Anter Disbursements

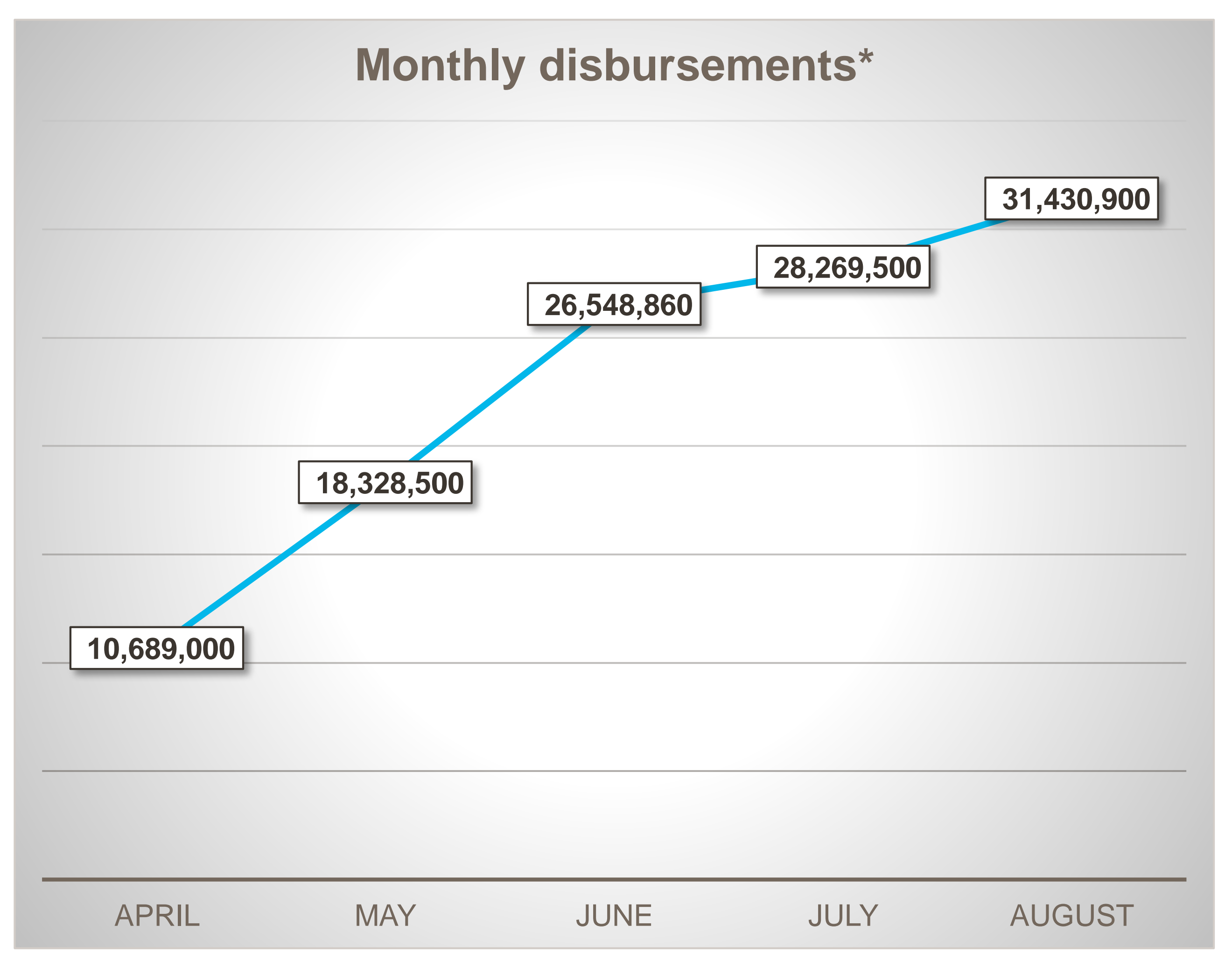
April – August 2020, 60 sites

IDR 38,334 or $2.59

Average cost of delivery per patient

IDR 188,571,468 or $12,750

Total delivery costs 5-month provision



Home-based ARV delivery

"When we provide two-months of ARVs – or send medications through Jak-Anter – our workload decreases and we can focus on other key tasks, including COVID-19 contact tracing." - Health care provider in South Jakarta

"Having my medications delivered to my home has helped me stay on HIV treatment and lowered my risk of COVID-19. The medicine is wrapped to protect my identity and the use of Go-Jek [a ride-based app] means that my neighbors do not know the contents of the delivery." - PLHIV client

Next steps

Practice to policy, expansion and more rigorous monitoring

1. **Practice to policy.** In August 2020, the Jakarta PHO agreed to incorporate home-based delivery into technical guidance and formal policy, provided that client confidentiality is protected and delivery is verified.
2. **Expansion.** Under the leadership of the PHO, LINKAGES is expanding Jak Anter to all Jakarta treatment facilities. Delivery services have also been expanded to allow for community-based service delivery and direct client-organized delivery in the transitional PSBB period.
3. **More rigorous monitoring.** Efforts are being undertaken now assess the relative costs of home dispensing and identify potential longer-term benefits in terms of retention in care and achievement of viral suppression.

As Jakarta moves back to full lockdown status on September 14, 2020, Jak-Anter is more important than ever to ensure the continuity of treatment for Jakarta's PLHIV

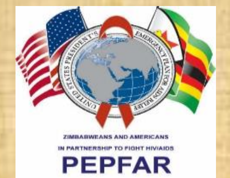
Thank you for your attention

FHI360
Zimbabwe HIV Care and Treatment Project

Community ART Refill Groups (CARGs) Model
Community Distribution of ART

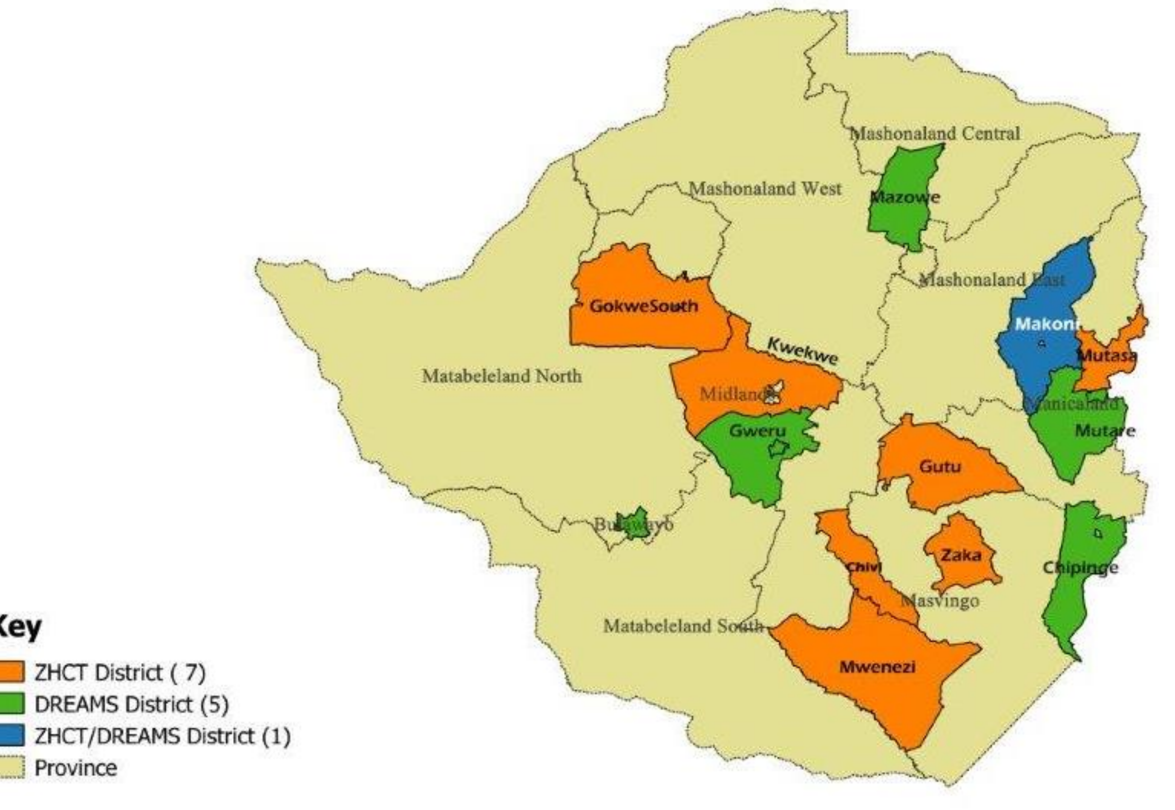
Auxilia Muchedzi
Chief of Party

Sept 10, 2020



FHI360/ ZHCT FY20 Project Activity Overview

- Project objectives:
  - To increase the availability of HIV care and treatment services at community level.
  - To strengthen retention in care through defaulte tracking **and community DSD models**
- DSD Models Objectives:
  - To improve long-term retention in care by reducing access barriers and enhancing the role of the ART client in the management of his/her condition
  - Reduce the workload of the existing health workers in the health facilities allowing them to have more time to attend to patients in urgent need



ZHCT Implementation districts 2015-2021

Community ART Refill Groups (CARGs) Model

- Self-forming groups of HIV-positive persons;
  - who are stable on ART as confirmed by the health facility/OI-ART clinic
  - living in the same community and are willing to disclose their HIV status to each other.
  - Each group is organized and consists of about 4 to 12 members.
- Group members take turns to pick up ARVs at the health facility
  - they then distribute ART to the other group members in the community
  - when a group member collects ART for the group at the clinic, s/he also gets his scheduled clinical assessment and monitoring
- CARGs provides a means of accessing ART for the group members and a source of social support.

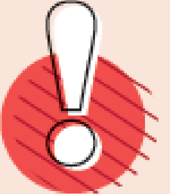
How are CARGs Formed?

- The formation of CARGs is a voluntary exercise
  - Health facility nurses, Community nurses and CBHWs facilitate CARG formation
  - Meet up with clients on ART either at the facility, villages or in their respective support groups
- Clients willing and interested in joining or forming a CARG assemble
  - they identify other possible members within the neighbourhood with the assistance of the facility nurses and CHCWs.
- Once a possible group has been formed, members of the group choose their group leader (CARG focal person)
- they then report to the health facility for screening and registration

2.5.3 Differentiated ART for stable clients

Eligibility criteria for differentiated ART delivery for stable clients

For all the differentiated models of ART delivery for stable clients, the following eligibility criteria should be met.



A stable client on ART (first- or second-line) is defined as someone who:

- Where viral load is available:
  - has no current OIs,
  - has a VL <1000 copies/ml,
  - is at least six months on their current regimen
- Where viral load is not available:
  - has no current OIs,
  - a CD4 >200cells/mm^3,
  - been at least six months on their current regimen.

ZHCT Tools used in monitoring CARGs

- CARG monitoring tool
- CARG register
- CARG VL register
- CARG summary register
- CARG leader job
- CARG mentorship and support supervision tool

Process of CARG Medication Collection

1. CARG Meeting in the Community before Collection of ART by the Group Representative

- The group meets the day before or the same day as the ART refill date
  - at the homestead of a CARG member or any agreed community venue.
- Meeting agenda and processes;
  - check pill count and document on CARG monitoring form
  - each CARG member signs the form in the presence of the CARG leader
  - peer-peer assessment of ART adherence for individual CARG members
  - peer moral support among members.
  - symptom screening among group members
  - choose representative to go to the health facility (may opt to all contribute financially for transport).

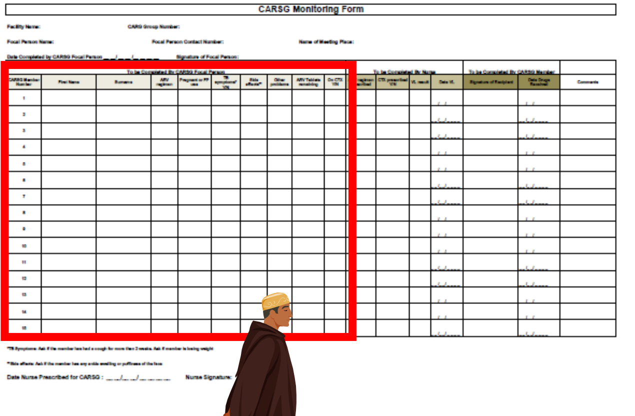
2. CARG Representative Reports to the Health Facility

- When the CARG representative reports to the clinic nurse;
  - they book in for a clinical consultation
  - they report on the adherence and general health of other CARG members
  - collect ART medicines for the CARG.
- At registration of a CARG, all individual OI/ART patient care booklets (green booklets) are put together in one folder.
  - When the CARG representative comes for drug refill, the folder is pulled out
  - the individual CARG member green booklets are updated by the nurse
  - the update is based on information provided by the CARG monitoring form.
- The health facility nurse completes the CARG monitoring form

3. CARG Meeting after ART Collection upon the Return of Group Representative

- The group reconvenes on the same day of the ART refill date
  - at the homestead of a member or any chosen community venue,
  - the group representative distributes the drugs to each CARG member.
- Activities during the meeting on the refill day (afternoon),
  - CARG members collect ART medicines from the representative
  - CARG members sign the CARG monitoring form to confirm receipt of ART medicines.
  - members may share observations, challenges and map the way forward
  - communicate the next ART refilling day as scheduled by the health facility

Step by Step Community ART Refill Process



CARSG Monitoring Form

Facility Name: CARG Group Number:

Focal Person Name: Focal Person Contact Number: Name of Meeting Place:

Date Completed by CARSG Focal Person ___/___/___ Signature of Focal Person:

To be Completed By CARSG Focal Person | To be Completed By Nurse | To be Completed By CARSG Member

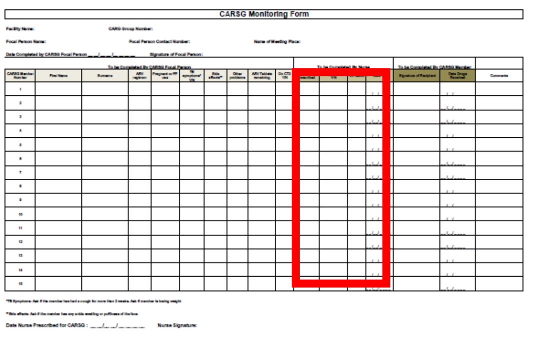
Date Nurse Prescribed for CARSG : ___/___/______ Nurse Signature:

Step 1: CARG meet on day (or day before) of drug pick up.

The CARG focal person fills their section of the **Refill form**

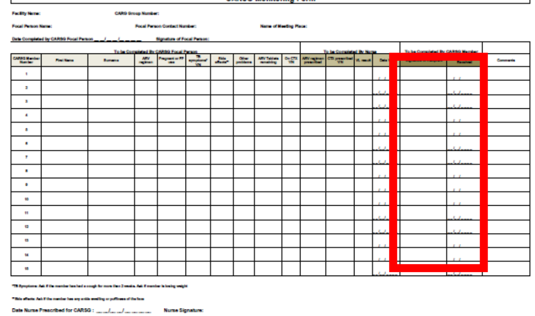
All members submit their **patient booklets**

Step 2: CARGS representative walks to clinic



CARSG Monitoring Form

Step 3: CARG group folder with all green books has been pulled ready. Nurse fills **CARG refill form , patient booklets** and the standard **green-book.** Drugs are dispensed in individual named bags at the pharmacy appointment diary updated



CARSG Monitoring Form

Step 4: CARG representative walks back to group with drugs.

Step 5: Each member signs that he has received his drugs

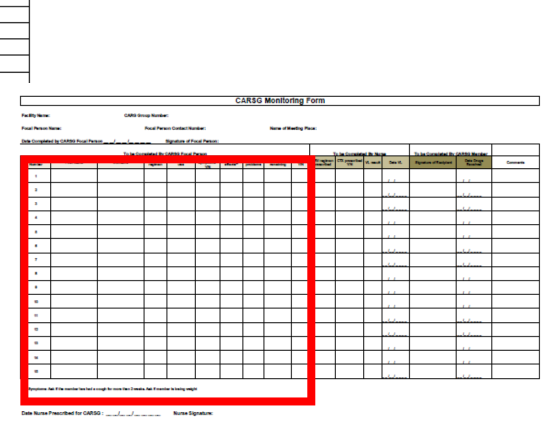
The next time the group meets for drug pick up all the steps are repeated EXCEPT the representative takes both the signed form from the previous visit and that day's form to the clinic

The nurse checks that all recipients signed for their drugs on the previous visits form.

This completed refill form is filed in the CARGS group folder in the clinic for reference

She/he then proceeds to complete today's visit

Form from previous visit



CARSG Monitoring Form

Facility Name: CARG Group Number:

Focal Person Name: Focal Person Contact Number: Name of Meeting Place:

Date Completed by CARSG Focal Person __/__/____ Signature of Focal Person:

Form for todays visit

CARG Model Benefits

For CARG Members

- Decreases frequency of health centre visits,
  - reduces transport cost, waiting time in the queue and risk of contracting communicable diseases
- Facilitates ARV refill while meeting at their convenient times right in their homes
- Empowered individuals
  - Taking responsibility for own health improves practice of problem solving skills, increases motivation to adhere, and results in improved treatment outcomes and long-term retention in care
- Increased peer support among members
- Stronger engagement of the community in HIV care may reduce perceived stigma in the community
- Potentially reduces defaulters since CARG members know the whereabouts of each member

For staff at health facilities

- Reduced workload for the health workers
  - as only one person will be collecting the ARVs for a group of four to twelve.
- More time for the individual care of sick patients.
- Accurate information on treatment outcomes of patients on ART
- Decreased need for patient tracing,
  - as community members update the health workers about the whereabouts of CARG members and possible deaths within the community

Introduction: Zimbabwe COVID 19 Context

- First case was confirmed in Zimbabwe on 20th of March 2020
  - As at Sept 9, 2020, Zimbabwe had 7,429 confirmed COVID 19 cases, 222 deaths and 5542 recoveries
- In response to the pandemic, the Government instituted a response
  - A total national lockdown was declared for 21 days (30 March – 20 April)
  - Social distancing, handwashing (recommended)
- Eased lockdown to level 2 indefinitely
  - reopening of industry, schools and business in a phases approach
  - Testing and screening for COVID-19

This next slides highlight the ZHCT Project innovations during COVID-19 lockdown

Adapting Community ART Refill to COVID 19 Pandemic

CARG leader provide symptom screening before ART resupply

CARG leader facilitating pill count before resupply

Adapting Community ART Refill Groups to COVID 19 Pandemic

- Ensuring retention in HIV care and protecting the gains made by HIV program in Zimbabwe
  - Adapted CARGs
    - Revision of project SOPS to include COVID 19 infection prevention and control guidelines i.e. Social/physical distancing, wearing of face masks, provision of hand sanitizers, and washing system
    - ART home deliveries to CARGs that fail to access health facilities

High CARG ART resupply during the lockdown period: Mar 23-Sept 4, 2020

District	CARGs Due	CARGs Collected	% Collected
Makoni	588	588	100%
Mutasa	232	232	100%
Gokwe South	333	333	100%
Kwekwe	296	296	100%
Chivi	213	213	100%
Zaka	265	265	100%
Gutu	205	205	100%
Mwenezi	68	68	100%

Aim: Ensuring clients in CARGs accessed ART during the COVID lockdown era.

Overall CARG ART Collection was at **100% (2,200/2,200)**

2,190 CARGs collected their ARVs at the facility in all ZHCT districts and **10** CARGs were delivered at home in Kwekwe.

Contact details:

Auxilia Muchedzi- ZHCT Project Chief of Party

Email: amuchedzi@fhi360.org

www.fhi360.org

Q+A

Upcoming Session

Supply chain and last-mile delivery considerations critical to DDD

Thursday, September 24, 2020

7:00 AM-8:30 AM EST | 13:00-14:30 CAT | 14:00-15:30 EAT

Register Here