



Ministry of Health

Standard Operating Procedures for Implementing Community-centred Models of ART Service Delivery (CommART) in Swaziland

SWAZILAND NATIONAL AIDS PROGRAMME (SNAP)

DIFFERENTIATED CARE FOR HIV CLIENTS IN SWAZILAND

[JUNE 2016]



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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal care
APMR	ART patient monitoring records
ART	Antiretroviral therapy
ARV	Antiretroviral Agent
CAG	Community ART group
CCF	Chronic care file
CEC	Community expert client
CMIS	Client management information system
CommART	Community/client-centered models of antiretroviral therapy service delivery
EC	Expert client
FP	Family planning
HCW	Health care worker
HIV	Human Immunodeficiency Virus
IEC	Information, education and communication
IPT	Isoniazid preventive therapy
LTBI	Latent TB Infection
M&E	Monitoring and evaluation
MDT	Multi-disciplinary Team
NCDs	Non-communicable diseases
NCPs	Neighbourhood care points
NGO	Non-governmental organization
OIs	Opportunistic infections
RHMs	Rural health motivators
SMS	Short message service
SOP	Standard operating procedure
TB	Tuberculosis
VL	Viral Load
WHO	World Health Organization

I. CHOICE AND ENROLMENT PROCESS FOR ART DELIVERY MODELS

1.1 CHOICE OF MODEL OF CARE

The standard operating procedures (SOPs) outline the criteria to guide health care workers (HCWs) on how to enroll and transition clients between the ART delivery models. Clients have the right to choose a convenient model for accessing ART services. HCWs still need to assess if the eligibility criteria for the chosen model are met. Health care facilities have to account for clients moving into any model of chronic care and strive for maximum retention in care. Figure 1 depicts the choices available for clients, as well as flexibility in transitioning in between the five ART service delivery models.

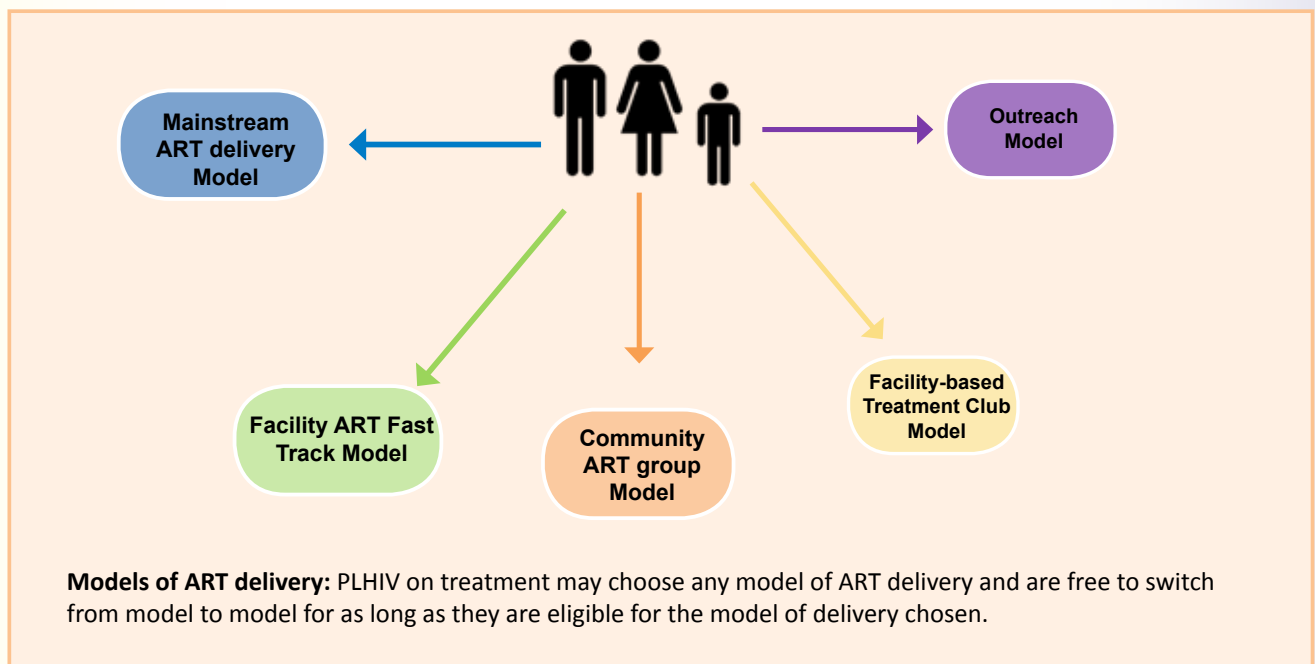


Figure 1: Free choice of model when eligibility requirements are met

- ART clients who do not satisfy the specific eligibility criteria as outlined for each model at any point in time should be referred back to mainstream ART care; they can join alternative ART models of care only when issues are resolved.
- Any changes in the model of ART care must be updated in the facility tools. Clients have to be actively engaged and capacitated to actively take their responsibilities in all the models of HIV care with the aim of maximizing their retention in care and improving treatment outcomes.



CHOICE AND ENROLMENT PROCESS FOR ART CARE MODELS

Overview of client flow in ART models of care

New procedures arising from the implementation of ART service delivery models should be aligned to the existing activities in the current client flow at health facilities. Figure 2 summarizes how the enrolment process should be conducted.

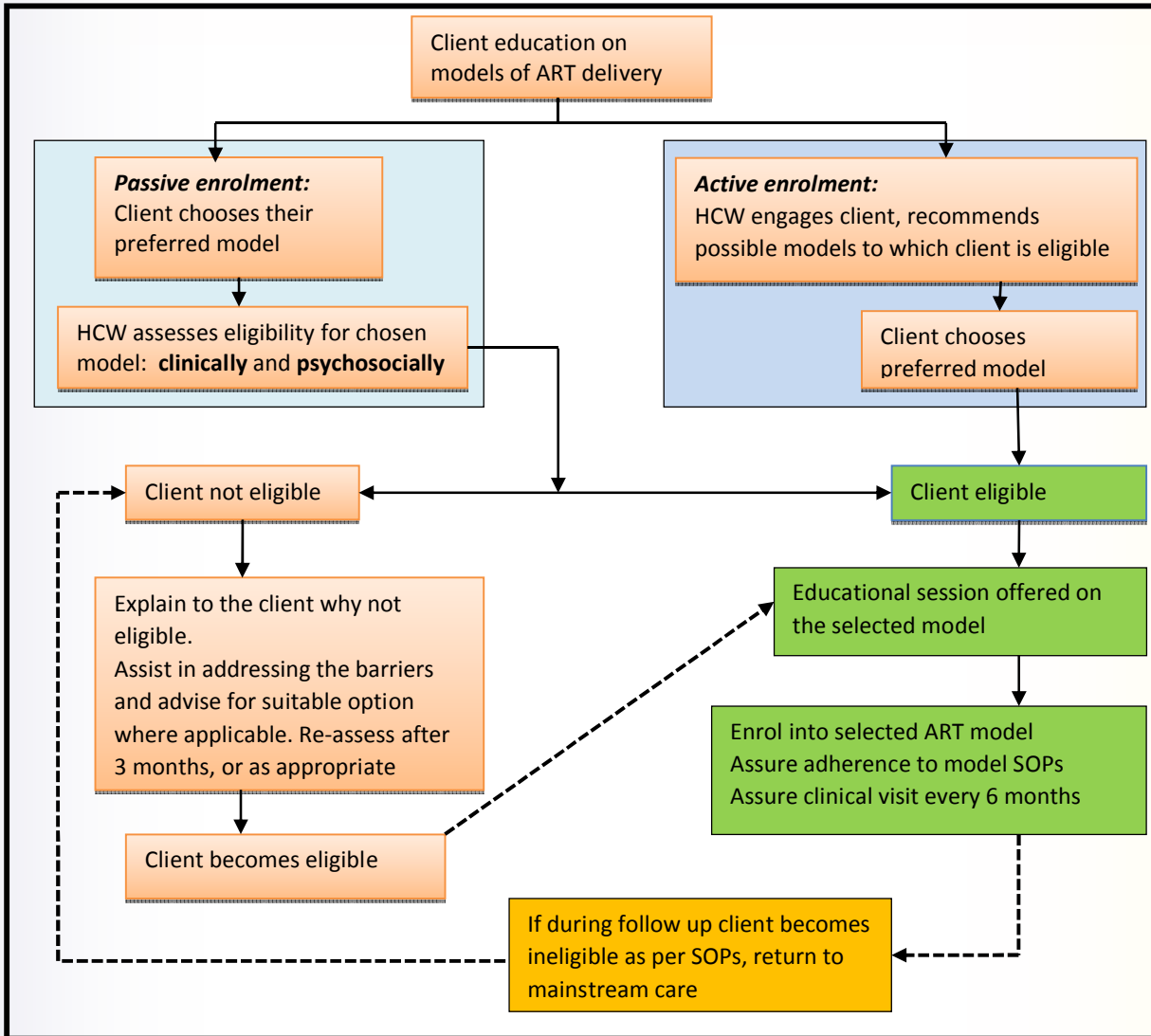


Figure 2: Summarizes how the enrolment process should be conducted both passively and actively.

There are criteria for enrolling into delivery models other than the mainstream. Clients with certain conditions must remain in the mainstream ART care unless care is provided in different services.





1.2 DEMAND CREATION AT FACILITY LEVEL

1.2.1 Sensitization of clients to ART service models

Clients must be introduced to the models of ART delivery at the health facilities and at community events. This crucial step is key to increase the uptake of ART delivery models at facilities. These processes can happen:

1. At community level: within the clinic catchment area, HCWs (facility based and community based) in collaboration with community-based non-governmental organizations (NGOs) and community structures can sensitize and engage community members about these models of care.
2. At health facility level: HCWs will introduce these models to the ART clients. Two main strategies can be implemented:
 - o Passive enrolment: In routine communication forums, such as morning health talks, individual contacts, information, education and communication (IEC) materials may be available for clients to have deeper understanding. Client chooses a preferred model and ask the HCW to enrol him/her.
 - o Active enrolment: Health care workers can review clients and their files, and actively engage those who may be considered eligible and recommend these models of care.

Demand-creation tools can support this strategy in the form of job aids and IEC materials. Examples of tools that can be used to support these initiatives are attached in Annex 1.

1.2.2 Client's education and counselling for chronic care

ART delivery models require full engagement of ART clients. This higher level of responsibility for client requires that health care providers empower clients on self-management to ensure that clients are pro-active in reporting their health needs. A tool has been designed to support the health care workers in engaging stable ART clients, see Annex 2.

1.3 ROLES AND RESPONSIBILITIES OF HEALTH CARE WORKERS AND CLIENTS

Although each model of care has some specific tasks for implementation, there are general procedures that can benefit implementation of this program and retention of clients in care. The roles and responsibilities are outlined below.

Health care workers' roles and responsibilities:

- Create demand by conducting health talks at the health facilities and community to disseminate information
- Identify clients to benefit from the ART models of care
- Deliver client education on ART models, roles and responsibilities using education tools
- Provide mainstream care model (usual clinical refills) as per ART national recommendations
- Facilitate the implementation of the ART models of care as per facilities' needs
- Support ART clients with a more robust clinical and psychosocial assessment
- Discuss and provide care for any significant health findings: pregnancy, TB screening positive, household events that compromise adherence
- Ensure that pharmacy, laboratory and M&E procedures are accomplished according to the national program requirements
- Respect client's privacy at all times
- Allow client to give feedback on current model of ART delivery.

Note: HCWs' roles are not limited to this listing.

Clients' roles and responsibilities:

- Demand for services
- Express willingness and confirm with the HCW that he/she wants to be part of the ART models of care, agreeing on whether they meet eligibility criteria, and adhere to the procedures
- Go through an educational session provided by HCWs before starting the selected model of care (stable clients)



CHOICE AND ENROLMENT PROCESS FOR ART CARE MODELS

- Have basic understanding of their treatment regimen (ART), including other medicines
- Take ARVs and other prescribed medicines daily as prescribed
- Ensure other clinical and laboratory services are fulfilled as advised by the health care provider
- Report at any visit events that may need further evaluation: pregnancy, TB screening positive, household circumstances that compromise adherence, etc.
- Be responsible for keeping the medication in a safe and secure location, and not lending, selling or giving the medication away to any other person
- Seek medical attention when sick or as per need
- Ensure that they always have ARV supply. Clients must collect ARVs on time.

2. STANDARD OPERATING PROCEDURES FOR MAINSTREAM CARE

As a standard, eligibility for ART service delivery models is continuously assessed by HCWs and/or clients. Transition from mainstream care to other ART delivery models can be as a result of many factors; the process is depicted in Figure 3.

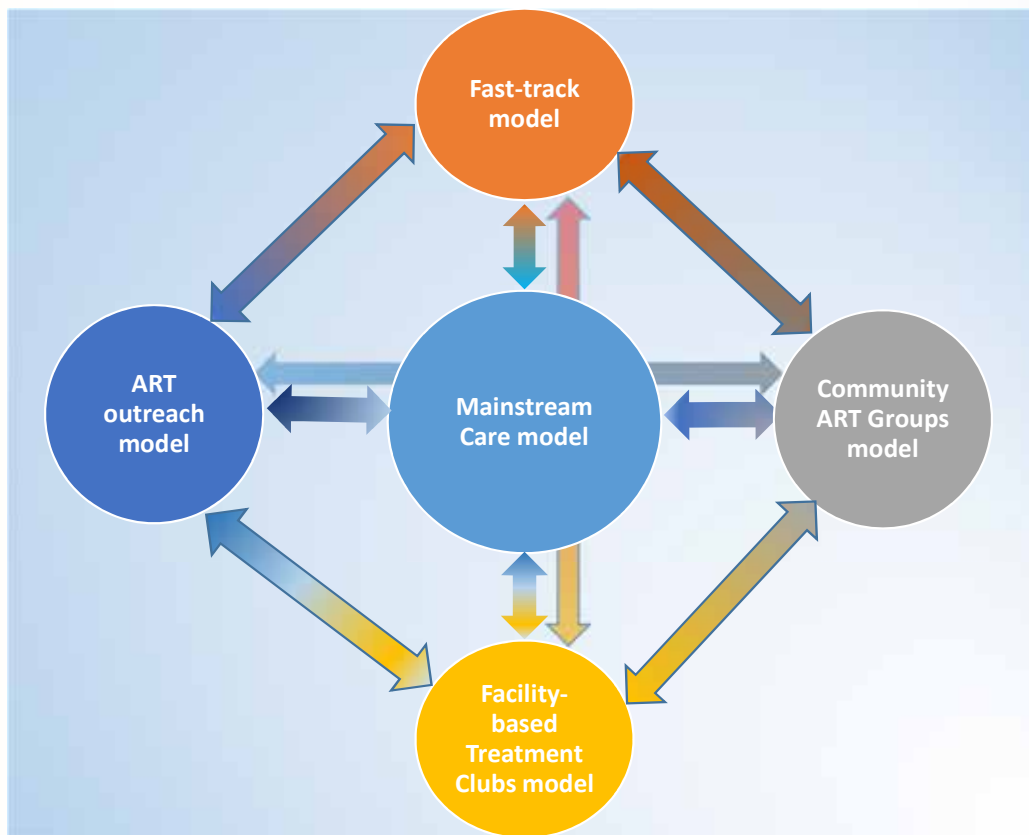


Figure 3: Process for transition from mainstream care to other models

Table 1 outlines the inclusion criteria for mainstream care and causes of referral back to mainstream care.

Table 1: Inclusion criteria for mainstream care

- Clinical complaints
- Side-effects
- Suspected treatment failure (clinical, immunological and/or virological)
- Recent regimen switch (less than six months)
- Adherence issues, including missed appointments (defaulters)
- Newly initiated on ART (less than 12 months on ART)
- Detectable viral load
- Children and adolescents requiring close monitoring (unless in a facility based family group)
- Pregnant and breastfeeding women (Note: Pregnant women should receive ART refills during their focused ANC visits, breastfeeding women can be eligible for clubs under special considerations)
- Co-morbidities: TB disease, mental illness and substance abuse, or other conditions as justified by the clinician
- Clients missing two consecutive refills within the same ART model
- Transfer-in clients with less than two ART visits at the new facility.

* **Important note:** All clients have the right to remain in the mainstream care if they wish so.



2.1 CLINICAL REVIEW VISITS

All clients are entitled to clinical review regardless of the model of care. Clients must have at least one clinical review every six months.

2.2 SOP FOR CLINICAL ART VISITS

ART clients receiving care under the differentiated models of ART delivery for clients living with HIV should receive clinical review and laboratory monitoring for long-term HIV care. Laboratory procedures can still be provided in community settings. This visit is necessary:

1. For reviewing relevant aspects of the client's health (see Table 2)
2. To provide an opportunity for the clinical notes to be updated thus ensuring good continuity of care, when ever necessary
3. For assessing if client is still comfortable with the model.

Table 2: Checklist for clinical visits

Checklist for client ART clinical visits conducted at a minimum every 6 months

- Take clinical history, do physical examination and WHO staging or WHO T-staging.
- Explore/manage opportunistic infections (OIs) and investigate all presumptive cases for TB.
- Check and review if there are any available test results that are still to be communicated to the client.
- Review the client's adherence record: check if client is on the right regimen and taking regimen correctly.
- Assess any changes in the psychosocial well-being of the client that may influence chronic ART care.
- Ensure that all necessary fields are completed in the chronic care file, appointment registers, client booklet and the ART patient monitoring records (APMR) or client management information system (CMIS). Prescription forms should be fully completed.
- Screen the client for continued eligibility on the preferred model and find any relevant feedback from the client.
- Assure integration of other components of care: FP, IPT, NCDs, cervical cancer screening etc.
- Document significant incidents in the client file.

Annex 3 provides a checklist to assess the readiness of a facility to implement differentiated models of ART delivery in Swaziland. Annexes 4 and 5 summarize these new CommART models and list the eligibility criteria for each model of ART delivery in Swaziland.



2.3 CARE PACKAGE FOR CLIENTS WITH ADVANCED HIV DISEASE

Clients who present late with advanced HIV disease having a baseline CD4 count of less than 200 cells/ml should be offered more frequent intensified clinical reviews to rule out as well as treat any identified opportunistic infections. This group of clients is also at risk of developing immune reconstitution inflammatory syndrome (IRIS). The package of care, as adapted from WHO recommendations¹, should include:

- Rapid ART initiation after ruling out opportunistic infections
- Intensified follow up
- Systematic tuberculosis screening

In addition, those presenting with a CD4 count <100 cells/ml should be prioritized for opportunistic infections screening using the following tests and be given appropriate treatment:

- (i) Cryptococcal antigen screening (CrAg) using plasma
 - Clients testing positive should receive pre-emptive prophylaxis for Cryptococcal disease with fluconazole (800 mg/day for 2 weeks, followed by 400 mg/day for 8 weeks, and finally 200 mg/day maintenance dose until CD4 count is >200 cells/ml twice over 6 months)².
- (ii) TB Lipoarabinomannan (TB LAM) test conducted **provided they are symptomatic for TB (pulmonary and/or extra-pulmonary), or are seriously ill***. (NB TB LAM should not be used as a replacement to the existing TB screening tool or for routine TB screening)³.
 - Those testing positive (only for the above mentioned group of clients) may be started on TB treatment using the national TB LAM algorithm.
 - Where ever possible a confirmatory test by Xpert MTB/Rif or sputum culture should be done after TB LAM testing.

* Definition of **seriously ill** is based on four danger signs namely: Respiratory rate >30/minute, Temperature >39°C, Heart rate >120 beats/minute and unable to walk unaided.

¹ World Health Organization. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection recommendations for a public health approach. Second ed. Geneva: World Health Organisation; 2016

² World Health Organization. Rapid Advice: Diagnosis, prevention and management of Cryptococcal disease in HIV-infected adults, adolescents and children. Geneva: World Health Organisation; 2011

³ World Health Organization. The use of lateral flow urine lipoarabinomannan assay (LF-LAM) for the diagnosis and screening of active tuberculosis in people living with HIV. Geneva: World Health Organisation; 2015



3. STANDARD OPERATING PROCEDURES FOR ART FAST-TRACK MODEL

3.1 BRIEF DESCRIPTION OF MODEL

This model is offered to stable ART clients who wish to refill at the facility individually. The implementation of the fast-track model is closely guided by the mainstream activities. The minimum standard is that **clinical reviews must be done every six months coupled with laboratory tests if necessary. In between the clinical visits (i.e., at three months), refills should be fast-tracked** (Figure 4). Stable ART clients eligible for fast-track should be educated on basic self-care management and empowered to conduct self-assessments to decide whether they can directly pick up their ARVs from the pharmacy or return to mainstream care if they are unwell. Adequate client empowerment is critical to limit loss to follow up, non-adherence to their ARVs, disease progression and treatment failure.

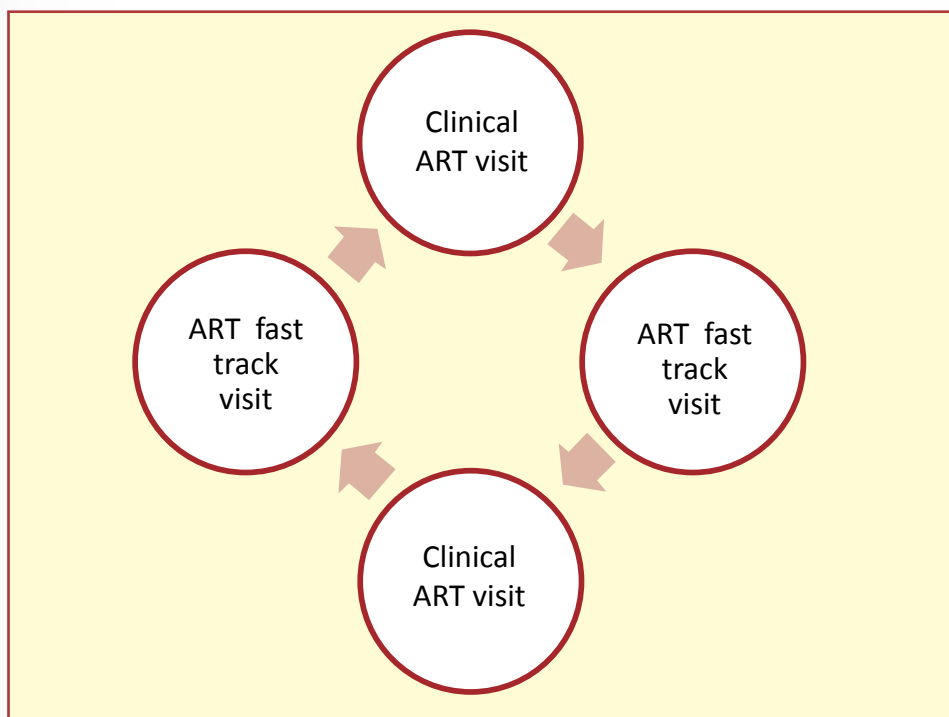


Figure 4: Cycle of client visits in the fast-track model

3.2 STANDARD OPERATING PROCEDURES

3.2.1 Eligibility for fast track

Eligibility criteria for stable client models

- Adult (18 years or older)
- At least 12 months on ART
- Most recent consecutive viral loads **undetectable** (the most recent VL should have been taken within the past six months)
 - In the absence of viral load monitoring, rising CD4 cell counts or CD4 counts above 350 cells/mm³
- No current TB
- Not currently pregnant or breastfeeding
- No medical condition requiring regular clinical consultations
- At least two ART visits at the facility, in cases of transfer-in from other facilities



3.2.2 Recruitment of clients for the fast-track model

If the client prefers to be fast tracked at the next visit, the following should be done.

If eligibility is met:

- Provide education and clinical services as appropriate.
- Complete all documentation in the chronic care file as required and write both expected dates.
- Remember
 - To consider pill count and pill balance when appointing clients for both visits
 - A maximum of three months' supply of ARVs is to be given per client.
- Write the triplicate prescription form and appoint two "next visit dates".
- Tear all three pages (white, blue and pink coloured) and use these copies as indicated below:
 - White (1st) original: put in the CCF (for both mother sites and baby sites)
 - Blue (2nd) copy:
 - Baby site: send to mother site for data entry (both APMR and RxSolution)- this is the prescription form to be used for dispensing medicines at this visit
 - Mother site: give to patient to use for collecting medicines at pharmacy- this copy will remain at the pharmacy.
 - Pink (3rd) copy: give to patient for use to collect medicines at fast track visit (for both mother sites and baby sites). Ensure this copy is legible enough for use during the fast-track visit, otherwise a new prescription for the fast-track visit will be required if not legible.

***NOTE: CMIS will enable onsite real time data entry once installed at a facility**

- Fill in appropriate columns in the ART booklet and write down clearly the next fast track visit and also the scheduled clinical visit as shown in Figure 5.
Note: visit date columns in the booklet should only be filled-in in real time when the patient is seen at the facility.

Visit Date	Wt (kg)	CD4 Count %	VL (c/ml)	T3 Screen	Diagnosis/comments	Treatment	IPT	CTX / Dapsone	FP Method	Next Visit	Signature
04/01/2018	78	420	<20	[P]	Refilled for fast-track visit	TDF/3TC/EFV *% ₁₂	No	CTX	implant	(A) 04/01/2018 (B) 07/01/2018	Leah
				[P]							

Figure 5: ART booklet entries at clinical visit preceding the fast-track visit

- Provide clear guidance to the client on how the fast-track client flow is designed.

If eligibility criteria are not met:

- Explain the reason(s) why the client does not qualify for fast track.
- Provide appropriate counselling to assist client to become eligible in future visits.

Key points

- Appointment systems for all clients remain the same regardless of model of care. In this case, both the two appointed dates should be recorded in the appointment register.
- If client was fast tracked in the previous visit, adherence by pill count should be back-tracked to the last clinical visit.



STANDARD OPERATING PROCEDURES FOR ART FAST-TRACK MODEL

3.2.3 Standard procedures during fast-track visit

Facilities must develop clear guidance on client flow during the fast-track visits. The flow of clients may vary between facilities as a result of the uniqueness in the setup of health facilities. During the visit, clients are expected to be fast tracked to collect their medicines either at the ART clinic or at the pharmacy directly or via the ART clinic. All clients for fast track refill should be booked prior. **Clients not booked for fast track should not be fast tracked.** For a fast track visit, the following steps must be done:

- Client presents with pink prescription form/refill encounter.
- Write the date of attendance on top of the prescription form.
- Expert client/nurse receives the client in the facility.
- Conduct quick TB screening where possible.
- Triage clients for fast track.
- If a client under fast track generally looks unwell, refer for consultation.
- Update client ART booklet according to whether client presents on the scheduled date as follows (see Figure 6 and Figure 7):
 - o If client presents on-time or kept appointment (i.e. visit date is not more than 7 days earlier and not more than 3 days later than scheduled or appointment date): only tick the fast track visit date indicating patient came and sign

Visit Date	Wt (kg)	CD4 Count %	VL (c/ml)	TB Screen	Diagnosis/comments	Treatment	IPT	CTX / Dap-ones	FP Method	Next Visit	Signature
04/01/2016	78	420	<20	<input checked="" type="checkbox"/>	refilled, for fast-track next visit	TDF/3TC/EFV ^{30/30/60}	No	CTX	Dispense	04/07/2016 04/07/2016	Flow Luthi
				<input type="checkbox"/>							

Figure 6: Updating ART booklet at fast-track visit- drug pick up on-time

- o If client presentation is not on-time or did not keep appointment (i.e. visit date is more than 7 days earlier or more than 3 days later than scheduled or appointment date): document the visit date, link to the clinical visit date and sign, provided the deviation from scheduled or appointment date does not require referral back to mainstream care

Visit Date	Wt (kg)	CD4 Count %	VL (c/ml)	TB Screen	Diagnosis/comments	Treatment	IPT	CTX / Dap-ones	FP Method	Next Visit	Signature
04/01/2016	78	420	<20	<input checked="" type="checkbox"/>	refilled, for fast-track next visit	TDF/3TC/EFV ^{30/30/60}	No	CTX	Dispense	04/07/2016 04/07/2016	Luthi
08/04/2016				<input type="checkbox"/>	fast-tracked					1/7/2016	Flow

Figure 7: Updating ART booklet at fast-track visit- drug pick up **not** on-time

- Remind the client of his/her next clinical visit and reinforce that the next visit is not fast track.
- Direct the client to the fast-track ARV dispensing point or pharmacy for drug pick up.
- Check and ensure appointment date is entered in appointment register.
- For direct pharmacy refills (walk-in straight to pharmacy), ART clinic nurse should ensure pharmacy scripts are collected in order to update client appointment tools and, where necessary, initiate defaulter tracing for missed appointments

Key points

- It is recommended that especially high-volume centres create fast-track corners to rapidly clear clients on fast track.
- Pill count is not mandatory during fast track visits.
- Routine laboratory investigation can be done if pre-requested. Results for such tests should be reviewed at the next clinical visit.
- Fast-track visits should always be alternated with clinical reviews.
- Update these data tools: prescription forms/refill encounters, ART booklets and appointment registers.



4. STANDARD OPERATING PROCEDURES FOR FACILITY-BASED TREATMENT CLUBS

4.1 DESCRIPTION OF THE MODEL

To maximize efficiencies in the delivery of ART care, a group of stable clients is enrolled into a treatment club where they receive their ART refills, quick symptom screening and counselling support. Treatment clubs meet four times per year as a club and receive their treatment refill within the club. Following every other club visit, i.e., every six months, each member of the club will have a clinical consultation following their meeting. Clients will be enrolled to an FTC by an expert client (EC) or nurse.

Facility-based treatment clubs serve the interest of the club members. Through the club care model, services are provided at club level, resulting in shared general review time, as well as shared dispensing time although medicines are distributed to individuals. Clinically significant matters (e.g., an illness) should, however, be addressed at individual level through referral back to the mainstream care.

A club will consist of a group of stable clients (maximum 20) that meet at the facility. HCWs, including facility counsellors and expert clients, facilitate the assessment of TB screening and distribution of ARVs. Nurses and doctors should write the prescription forms for the club members in advance so that medicines are prepared at least a day prior to the club visit. Nurses and doctors must also update client ART booklets and CCFs. Club members will receive three months' supply of ARVs at every club visit. Club members' files are to be kept in a club folder.

The client-related benefits of facility-based treatment clubs include promotion of peer-to-peer psychological support and reduction in average client waiting time due to shared consultation times. The sharing of consultation time by stable clients is likely to result in savings in time and therefore will promote equitable distribution of the service provider time between the pooled stable clients and the unwell clients who need more individual consultation time.

Treatment clubs seek to empower clients through promotion of self-management skills and exposing them to community support networks. Members are free to consult at any time they feel unwell, and they have access to all other services, including laboratory monitoring and referrals to other facilities or other services.

4.2 ELIGIBILITY FOR FACILITY-BASED TREATMENT CLUBS

Eligibility criteria for stable client models

A client may qualify to join a treatment group if (s)he meets the following criteria:

- Adult (18 years or older)
- At least 12 months on ART
- Most recent consecutive viral loads are undetectable; the most recent of these taken within the last six months of eligibility
 - In the absence of viral load monitoring, rising CD4 cell counts or CD4 counts above 350 cells/mm³
- No current TB
- Not currently pregnant or breastfeeding
- No medical condition requiring intensified regular clinical consultations
- At least two ART visits at the facility in case of transfers in from other facility
- Clinicians confirm the client's eligibility for membership
- Membership is voluntary.

Once members are identified and a club is formed, the club members are registered into a CommART club register which will be made available for recording the clubs at the facilities. An interested would-be club member can be added and registered at any day provided (s)he is willing to review at the next club visit. The size of each club should be limited to a maximum of 20 clients.



STANDARD OPERATING PROCEDURES FOR FACILITY-BASED TREATMENT CLUBS

4.3 FIRST VISIT FOLLOWING ENROLMENT FOR A FACILITY-BASED TREATMENT CLUB AND SUBSEQUENT NON-CLINICAL REVIEW VISITS

Within three days preceding enrolment visit

During these days, the club facilitator will:

- Need to have a club registration book
- Retrieve folders/files for all new club members and make sure they are all labelled appropriately
- Deliver folders/files to club nurse to prescribe drugs to be prepared for the club visit
- Deliver request or prescriptions to the pharmacy for medicines for club members
- Help with preparing medication for club visit
- Prepare welcome talk for new club members.

During these days, the club nurse will:

- Write the prescriptions for all club members
- Give club facilitator prescriptions within THREE DAYS before club visit to enable the pharmacy to prepare and dispense the medicines for the club members.

Visit day

During the visit:

- Club facilitator will give welcome talk
- Weight taken and recorded into CCFs and patient ART booklets
- TB symptom screen, individually/in group/both, recorded into CCFs and patient ART booklets
- Referral for clinical consultation if indicated
- Next visit date is entered on client ART appointment booklet and CCF
- Assisting facilitator will distribute medication.

After the visit:

- Club nurse should ensure individual prescriptions for members whose medicines were distributed reach the pharmacy
- Facilitator should return medication to the pharmacy for those members whose medicines were not distributed
- Facilitator should update the appointment register and forward the files of clients who have missed their appointments to the person responsible for client follow-up and tracing of clients.

4.4 CLINICAL REVIEW VISITS FOR FACILITY-BASED TREATMENT CLUBS

Three days preceding standard visit

During these days, the club facilitator will:

- Draw files for all club members
- Facilitate preparation of medicines by the pharmacy personnel
- Prepare welcome talk topic for club members.

Visit day

During the visit:

- Club facilitator will give talk and lead group discussion
- Symptom screen, individually/in group /both, recorded in patient records
- Next visit date entered on ART patient card and CCF
- Client joins the queue to see the club nurse for their semi-annual clinical consultation
- Assisting facilitator should distribute ART to club members.



After the visit:

- Club nurse should ensure individual prescriptions for members whose medicines were distributed reach the pharmacy
- Facilitator should return medication to the pharmacy for those members whose medicines were not distributed
- Facilitator should update the appointment register and forward the files of clients who have missed their appointments to the person responsible for client follow-up and tracing of clients.

Post-club visit activities:

- All members arriving within one week of the club visit will be referred to the pharmacy to collect their medication
- Facilitator will update attendance in appointment register and indicate date medication was collected and refer client to club nurse for annual clinical consultation.

Key points

- Club members must have clinical visit at least every six months.
- Appointment registers should be filled for each individual in the group to enable individual client tracking.
- Club members' ART can be refilled in absentia only once in two consecutive periods, provided their ART booklet is produced by a treatment buddy.

4.5 ROLES AND RESPONSIBILITIES OF KEY PERSONNEL

Clubs manager

Nurse responsible for the activities required to run successful ART clubs.

The clubs manager is responsible for:

- Ensuring facility clubs team is in place
- Ensuring club standard operating procedures are being carried out, including recruitment, club preparation, club sessions, clinical governance, club follow up, and that clients who need to be referred back mainstream care are returned to mainstream care
- Ensuring six-monthly clinical visits for club clients
- Overview of clubs outcomes – new clubs, new enrolments, retention in care
- Clinical oversight of clubs
- Responsible for completing monthly clubs statistics sheet for submission to facility manager
- Keeps facility manager updated on clubs progress in the facility.

Clubs facilitator

Nurse/ Expert client (EC) are responsible for preparing and running the club sessions.

The clubs facilitator is responsible for:

- Preparing for the club session, including ensuring ART prepared, ordered and ready for the club session
- Procedures during a club visit day:
 - Registering members
 - Conducting support/education group
 - Conducting TB symptom screening, including taking weight
 - Referring clients to club nurse – sick/blood/clinical visit
 - Distributing ARV medicines
 - Completing necessary tools and registers





STANDARD OPERATING PROCEDURES FOR FACILITY-BASED TREATMENT CLUBS

- After-club management: returning uncollected ART to pharmacy and following up clients who missed session.

A club facilitator should be always present during club sessions.

Club nurse

The club nurse is responsible for:

- Clinical oversight of a club on the day of the club session
- Available during or after club session to see symptomatic clients, take blood and conduct semi-annual clinical consultation.

Pharmacist/pharmacy assistant

- Responsible for preparing ART medicines for clubs
- Participating in the dispensing and/or distribution of drugs during club sessions

Data capturer

- Responsible for capturing club members' visits from client files into facility electronic register



5. STANDARD OPERATING PROCEDURES FOR SPECIAL CLUBS

ADOLESCENT / TEEN CLUB

5.1 DESCRIPTION OF ADOLESCENT TEEN CLUBS

These are facility based treatment clubs that cater for HIV-positive adolescents. With the facilitation of a lay health care workers and a nurse, it is made up of a quick clinical assessment (with referral where necessary), peer support and distribution of ART to adolescents who are stable with undetectable viral load. Teen clubs can be complemented with other activities around life skills education and psychosocial support. Adolescents have a clinical visit every six months as per guidelines.

Adolescent / Teen treatment clubs provide a safe environment to share adolescent concerns and growth of adolescents / Teen to responsible adults. Adolescent / Teen clubs are based on respect for peers' privacy and education about adolescents' topical issues, which are crucial for the club to function well. It is mandatory that the six-monthly clinical visits must happen as per protocols.

5.2 ELIGIBILITY FOR TEEN CLUBS

Clients can be enrolled to any club at any time after a thorough assessment of eligibility. The client must be unconditionally willing to be appointed on the next available club meeting date for the chosen club regardless of the closeness of the dates. A club folder must have all clients' files for that club.

Inclusion criteria

Age to align with the criteria of each club (10-15 years, 16-19 years):

- Full disclosure
- On the same ART regimen for at least six months (first or second line)
- Client has been refilling in the same facility for at least six months.

Eligibility to receive ART with the teen club:

- No clinical and / or immunological failure
- Viral load should be undetectable
- ARV should be well tolerated.

Exclusion criteria

- Pregnant or lactating adolescent
- Failure to get assent from child and consent from care giver if client is <18 years old
- Presence of co-morbidities, e.g., TB, mental health problems, substance abuse or any condition deemed significant by the medical officer or nurse.

5.3 SOPS FOR TEEN CLUBS

The SOPs for teen clubs are the same as for facility-based treatment groups. In addition, it is essential for a clinician to always be present at teen clubs when there is dispensing and distribution ARVs being distributed. In addition, staff involved with teen clubs should have undergone specific training on adolescent-friendly services. Counselling messages should be designed in an appropriate manner.





FAMILY CENTERED CLUBS

5.4 DESCRIPTION OF FAMILY CENTERED CLUBS

Smaller sized clubs that addresses specific needs of smaller groups can be also be formed. Family centered clubs comprise of family members that receive ART refill services at the same facility. Parents and/or care givers and their children may form such clubs. The SOPs are similar to that of facility-based treatment clubs.

OTHER CLUBS

5.5 OTHER FORMS FACILITY-BASED CLUBS

Clubs addressing the needs of those with non-communicable disease can also be formed. Similarly clubs for specific populations can be formed at facilities. Breastfeeding women may form clubs with specific focus on mother and child health including infant feeding and nutrition. Such clubs must not create any form of discrimination.



6. STANDARD OPERATING PROCEDURES FOR COMMUNITY ART GROUPS

6.1 BRIEF DESCRIPTION OF MODEL

Community-based ART groups (CAGs) are self-forming groups that provides a community-initiated strategy to reduce barriers to care. CAGs have been commonly implemented with hard-to-reach groups and in settings where there are economic difficulties in accessing care. They rely on pre-existing social networks, such as support groups, workmates and family relations. In urban settings, it is recommended that CAGs be promoted for groups of family members and workmates. A CAG must have a minimum of two clients (referred to as “*treatment buddies*”) and a maximum of six clients. The efficiency (time and monetary) of this model is through cost sharing achieved by the rotation of clients (group members) in visiting the facility to collect ART treatment for group members.

The group members must meet at least 24 hours prior to the members’ scheduled refill date. During this initial meeting, the booklets for group members are handed over to the group representative. The representative, with the support of the group leader, will also ask general screening questions as elaborated in the standard operating procedures. Unwell group members should accompany the representative to the clinic so that their conditions are reviewed.

Since every member must have at least one clinical review in six months with a nurse or a doctor, the length of period of the refill is dependent upon the size of the group. The smaller the group, the less frequent the refills, and the bigger the group, the more frequent the refills, e.g., “*treatment buddies*” should receive three-monthly refills while a larger group of six members will receive monthly refills each.

After the visit to the facility, the group representative should meet with the group members within 24 hours preferably on the same day of collection, to distribute and return the members’ medicines and booklets. If necessary, the facility-based HCWs can conduct random follow-up checks on group members to confirm timely receipt of drugs.

6.2 ELIGIBILITY FOR COMMUNITY ART GROUPS

Eligibility criteria for stable client models

A client may qualify to join a CAG if (s)he meets the following criteria:

- Adult (18 years or older)
- At least 12 months on ART
- Most recent consecutive viral loads undetectable; the most recent of these taken within the past six months from eligibility date
 - In the absence of viral load monitoring, rising CD4 cell counts or CD4 counts above 350 cells/mm³
- No current TB
- Not currently pregnant or breastfeeding
- No medical condition requiring regular clinical consultations
- At least two ART visits at the facility in case of transfer in clients
- Clinicians confirm the client’s eligibility for membership
- Membership is voluntary.

CAGs should be prioritized for pre-existing social networks, such as support groups, workmates and family relations, particularly from hard-to-reach populations.

6.3 SOPs TO ESTABLISH COMMUNITY ART GROUPS AT FACILITIES

Preparing to set up community ART group model at facility level

For the implementation of this model at facility level, a multidisciplinary team (MDT) should meet to discuss client flow, roles and responsibilities and identify focal persons to follow the process in the facility. The team should decide on the information flow, in terms of monitoring and evaluation procedures. Facilities should also work



STANDARD OPERATING PROCEDURES FOR COMMUNITY ART GROUPS

together with community partners and community support groups to facilitate demand creation in the community. The following questions should be addressed by the MDT:

- Who is responsible for the registration of the CAG when the group representative comes for review?
- How are the CAG client files going to be organized?

Each group's files should be stored at the same place, facilitating recording of information, finding test results and identifying which member has come to represent the group. Group folders containing all members' files can be used to improve filing efficiency.

The pharmacy department should be actively engaged and be able to support with preparation of medicines for the groups. All test results should be inside the client file prior to the visit.

6.4 RECRUITMENT OF CLIENTS TO A CAG

There are two ways in which screening and establishing groups can be organized:

1. **At the health facility:** The health care worker should screen clients to assess them based on eligibility criteria for the groups during a clinical visit. Once assessed as stable by the HCW, the client can choose to join a CAG and be referred to the HCW focal point coordinating CAG formation.
2. **In the community:** If the clients have been informed about the existence of groups as a model of care in the community and have shown interest in joining a group, they can be directed to the health care staff of the designated clinic offering the model. If they wish to create a community ART group of their own, they must visit the facility together and seek guidance from the nurse or medical officer. The nurse or medical officer must assess the group members for eligibility.

As a standard clients who have joined a CAG should have an orientation session to the model which should highlight expected procedures for CAG members and representative. Annex 6 outlines steps that should be covered during the visit by a CAG representative which should be covered during the orientation session.

The group members rotate for the clinical consultation every month; the person going to the facility that month will be the representative of the group. Hence each group must have a maximum of six members to ensure that each member has at least one clinical review every six months according to national guidelines. Figure 8 represents the rotation of group members to attend facility visits for a group of six.

Twenty-four hours before the group representative has the scheduled consultation, the group will meet in the community. The group representative will screen members of the group, and this will include TB screening. If a group member presents with signs and symptoms of TB or is unwell, that member will accompany the representative to the facility.

The group representative attends the health facility for the scheduled consultation at the facility leaving behind other group members who are well. The remaining group members, will have "ART refilled on their behalf" by the group representative. Such information will be document in their records, including electronic records. After the consultation, the representative will have a meeting within 24 hours with other group members at a convenient community point to distribute the drugs. A community expert client and/or rural health motivator provides additional support to the group (he/she will visit the group at its meeting point at least once per year).

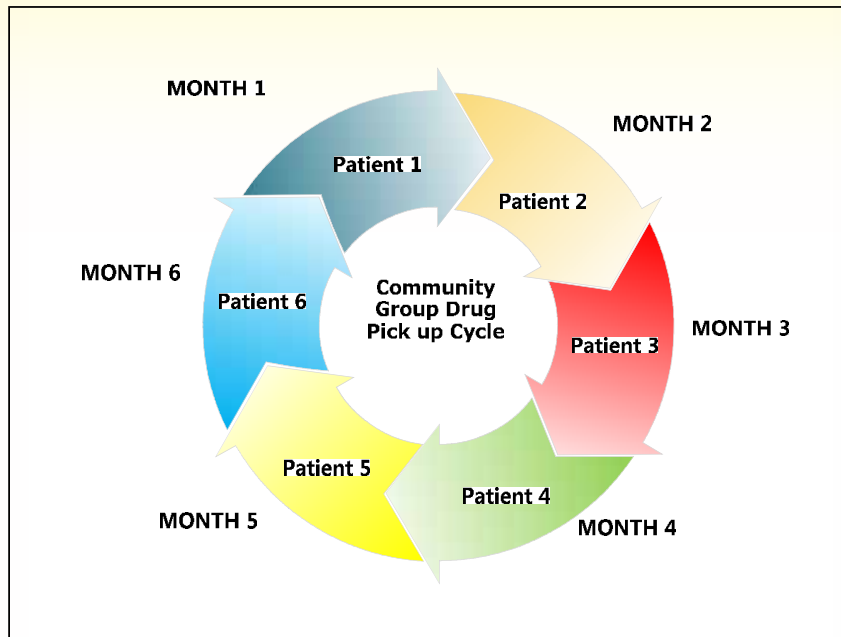


Figure 8: Illustration of the rotation in community ART groups for clinical care and ART refills

CAGs can have **active and social members**. Active members fulfil all the eligibility criteria, and these members participate fully in all the activities at community and/or facility level. Social members form part of the CAG peer network, but attend the health facility in person for individual clinical follow up and drug refills. Social members either do not fulfil eligibility or they were once active members who then returned to mainstream care for various reasons.

Each group must have a **group leader** to oversee the well-being of the group, including ensuring that meetings are conducted and group ethics are observed.

Community ART groups considerations

- Group educational session and orientation must explicitly describe the roles and responsibilities of members; group leaders and group representatives.
- Members forming CAGs should have identifiable relationships which should serve the purpose of promoting trust and cohesion within the group, and readiness to appropriately share existing health issues. These relationships include:
 - o Family members, husband and wife
 - o Workmates who have disclosed to one another
 - o Members staying close to one another in a defined hard to reach locality
- CAGs should be registered and specific registration tools will be developed to serve this purpose.

On the day the group is formed

All CAG members meet at the facility to form the group:

- The CAG members have all their files reviewed and eligibility is confirmed by the nurse.
- Group members are informed about CAG rules and confirm understanding of ethical considerations.
- The newly formed group is trained on: (a) the approaches, roles and responsibilities of members; (b) how to monitor the adherence of members and (c) how to provide group counselling and education sessions.
- EC/counsellor facilitates the identification of adherence topics and barriers that the members have already experienced and possible solutions. These will form part of the discussions at each group meeting.
- Group leader is selected by the members. Each group will designate a member of the group as a leader.
- The group is trained on how to screen each other for TB and other OIs; how to refer each other for care and





STANDARD OPERATING PROCEDURES FOR COMMUNITY ART GROUPS

how to strengthen trust relationships within the group

- CAG is registered and the community ART group membership card is completed and given to the group leader.
- All CAG members' files are grouped together in one file.
- All clients receive refills and same appointment date but will rotate the visits to the facility.

6.5 STANDARD VISIT FOR A CAG

Preparation for the group's visit at facility level

- Collect the files of the group.
- Ensure all pending test results are inside the client files.
- A group prescription form is filled to account for all drugs to be taken out of the pharmacy.
- The pharmacy prepares the drugs according to the prescribed names and quantities.
- All prepared drugs remain at the pharmacy and are only to be collected on the day of group visit.

Group meeting in the community prior to the consultation visit

- CAG members meet in the community at a convenient venue and time for all of them.
- Each member of the group reports on his/her adherence. The representative or focal person (if other group members are illiterate) will collect the information of each member's adherence assessment result.
- Clients must be empowered to self-screen for TB and report symptoms of TB or any other condition. Group members who are unwell or have TB symptoms must join the group representative to attend a consultation at the health facility.
- Unwell group members will be identified and must join the group representative to attend a consultation at the health facility.
- The group representative attending the facility for consultation and on behalf of the other members must collect all ART booklets and other group monitoring tools for the group members and bring them to the clinic for refill.
- Members of the group may opt to all contribute financially for transport fare.
- Members discuss the venue for meeting when the representative is back from the facility to distribute the drugs.

Procedures on the day of the consultation

- During consultation, the group representative will report back on the adherence and general health of other group members.
- ART booklets are updated (visit date, comment on refill, i.e., group representative refilled, and next visit date to be written).
- Chronic care files must also be updated with this information for each group member file.
- The visiting group representative has the opportunity to have a clinical review, as well as adherence counselling.
- All routine and other required laboratory investigations must be done on this visit day.
- Pending results for any member who might have been consulted prior to this must only be communicated as "normal" if there are no abnormalities. Otherwise, individual clients with abnormal results are supposed to be called at the time of receipt of their results by healthcare workers.
- Any member requiring additional clinical follow up should be identified and asked to attend the clinic.
- Prescription sheets should be written for all group members.
- The community ART group tools including registers should be updated by the nurse whenever there are any changes in CAG composition or an outcome occurs.

Community ART group meeting after drug pick up by group representative

- The group must meet within 24 hours at a convenient place for drug distribution.
- When necessary and as advised by the staff at the health facility, the group representative may request a group member to go to the clinic for a special consultation.





6.5.1 Summary of key steps and schedule to be followed by the group

The steps to be undertaken *by the group* until all members receive their drugs are outlined in Figure 9.

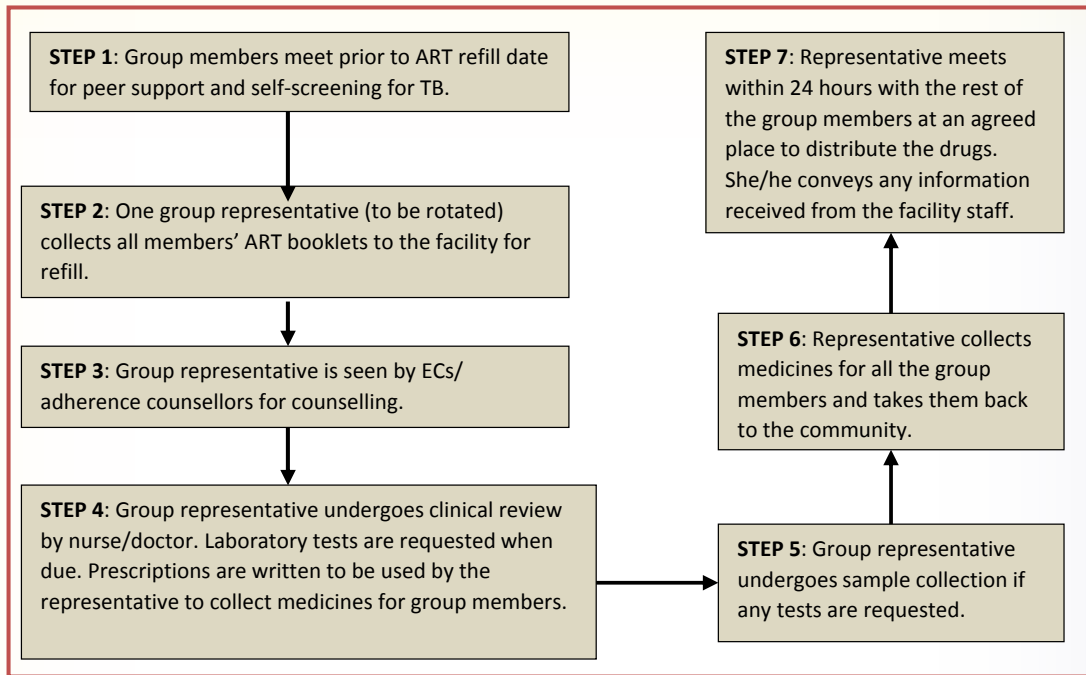


Figure 9: Operating steps for the conduct of established community ART groups

The rotational schedule for clinic visits for group members depends on the size of the group, as well as health care provider views of the current situation, such as adherence of group members. Figure 10 illustrates the minimum number of clinical appointments (in blue) that a group will have in relation to the group size.

Number of members in group	Individual Member Clinical Visits					
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
2	✓	X	X	✓	X	X
3	✓	X	✓	X	✓	X
4**	✓	X	✓	X	✓	✓
5**	✓	X	✓	✓	✓	✓
6	✓	✓	✓	✓	✓	✓

Key

✓	Group member scheduled for visit
X	No member scheduled to visit the clinic
**	The actual month(s) without scheduled member may differ but all members must be reviewed within 6 months

Figure 10: Schedule for rotational clinic visits by group members



STANDARD OPERATING PROCEDURES FOR COMMUNITY ART GROUPS

6.6 ROLES AND RESPONSIBILITIES OF KEY PERSONNEL

The roles and responsibilities of expert clients, cough officers, nursing assistants, nurses, doctors and laboratory and pharmacy personnel in the delivery of ART through CAGs are outlined as follows:

Nurse/medical officer

- Decide upon individual client's eligibility for the CAG.
- Support the establishment of the CAG.
- Train group members in the handling of tools e.g. patient booklets and also medicines.
- Train group members on how to screen each other for TB and other OIs, and how to refer each other for care.
- Train group members on group ethics and how to strengthen trust relationships
- Review group representative at clinic visit on adherence and ask about well-being of other group members.
- Identify CAGs with problems and provide support on problem solving.
- Prescribe ART for all group members.
- Ensure routine blood monitoring tests are conducted.
- Ensure groups are registered.
- Promote the establishment of CAGs at facilities.
- Ensure monitoring, supervision, training, quality improvement and risk management of CAG model implementation.
- Analyse and report on community ART groups' outcomes to facility MDTs.

EC/counsellors

- Support the establishment of CAGs.
- Provide adherence support to group representatives coming to the facility.
- Identify CAGs with problems.
- Follow up of CAGs with problems at health facility and community.
- Promotion of CAGs at health facility and community.
- Establish and maintain conduct with Rural health motivators and Community expert clients (CEC) to improve coordination and support of CAGs in communities.

Expert client (Facility-based or community-based)

- Visits a group meeting in the community at least once every six months.
- Support adherence assessment and counselling, as well as monitoring treatment refills by group members.
- Identify and report if community ART groups have problems.
- Coach group leader on their activities during group meeting.

Pharmacy personnel

- Dispense ART and provide necessary information on medicines to all CAG members.

Laboratory personnel

- Collect blood for CD4, viral load and other laboratory tests.

CAG leader

- Facilitate group meetings before and after medicines refilling day.
- Lead discussions during meetings.
- Record the pill count on the group card during the meeting before drug refilling.
- Check on the adherence of group members.
- Keep the community group card.
- Ensure communication between the health worker and the group members in case any problems occur in the group.



Roles of CAG's members

- Support the establishment and promotion of CAGs in the community.
- Support health education and adherence messaging within membership.
- Report any adverse drug effects, OIs or other issues to the group leader.
- Facilitate pill counts within membership for their medicines and report pill counts to the group representative or group leader.
- Attend health facility on behalf of the whole membership when their turn is due.
- Attend health facility at any time they feel unwell even if they are not due
- Pick up the medication for themselves and for other group members.
- Distribute medicines correctly to other group members.
- Advise other members to seek medical care at clinics when needed.

The information box below outlines some key issues related to private information as well as confidential client medical history that must be observed when dealing with clients through a client representative.

Key ethical considerations when dealing with groups

Key points on group ethics

- Facility HCWs must call clients to come for further care upon receipt of abnormal laboratory results instead of waiting for their next appointment date.
- Every HCW must empower clients to report back to the facility in case members have not received correct medicines and/or correct quantities of their medicines.
- A visiting group member cannot receive more than the amount specified for his/her fellow group members.
- The HCW cannot share confidential client information with a group representative, i.e. any personal or medical history related to individual clients.
- Group members need to be informed and understand the conditions to be part of CAGs:
 - o Confidentiality
 - o Other members can come to the facility together with group representative if needed
 - o Adhering to the group meetings
 - o Effort to support to other members
 - o Communication with the facility in case of issues in the group.



7. STANDARD OPERATING PROCEDURES FOR ART OUTREACH MODEL

7.1 DESCRIPTION OF THE ART OUTREACH MODEL

Health facilities and implementing partners carry out outreach activities regularly using Government and partner transport and other logistics support. This model relies on professional health care workers extending health care services to the communities. The team conducting the outreach activities is composed of doctors, nurses, expert clients and counsellors, pharmacy and laboratory personnel whose main task is to visit communities and provide a comprehensive package of health care services. Sometimes, targeted outreach visits are conducted to deliver defined care packages, as in the case of HIV services. Services can be delivered to lower-level clinics that do not offer such services or in temporary clinics housed in community structures, such as churches, schools or neighbourhood care points (NCPs).

The outreach team must have a schedule for community visits, and communities should be made aware of the visits in advance in order to generate demand for the services being provided. Most outreach services already include HIV testing services and health education, but there is an increasing demand for HIV treatment services. Two options for the ART outreach model exist:

- (i) Integration of HIV care and treatment services to existing routine outreach service
- (ii) Set up of new outreach services to communities where there is high unmet demand.

It is possible for ART initiation to be easily integrated into this model. The facility represented by the outreach team will be responsible for, and should take ownership of, the client including full registration of the client to their facility. Mobile community outreach teams supporting facilities should be linked to the health facility serving that community and initiation should be conducted with support and agreement from the catchment area health facility. ART initiation should follow national ART initiation guidelines and clients must **still benefit from a comprehensive clinical visit every six months** that includes attention to integration with other services and laboratory monitoring. Special attention is required for children and adolescents receiving services in this model.

7.2 ELIGIBILITY FOR ART OUTREACH MODEL

Clients will be enrolled into this model if they satisfy the following inclusion criteria:

- Stable pre-ART or ART client
- Willing to refill their medicines from an outreach service point closest to their residence
- Willingness to be linked to a community expert client servicing the community outreach point with follow-up monitoring and adherence support services
- Have a functioning mobile phone in order to receive SMS reminders for outreach service.

Exclusion criteria

- Clients with co-morbid conditions for which drugs cannot be dispensed to outreach teams
- Unwell clients.

7.3 RECRUITMENT OF CLIENTS INTO THE ART OUTREACH MODEL

- ART nurses, nursing assistants and doctors must be tasked with enrolling clients into the outreach model.
- Client education on the ART models must be conducted. Posters may be used.
- Like any other model, an opt-in approach must be used when enrolling clients.
- Register clients enrolled for outreach care in outreach file indicating the selected outreach point.
- Provide ART refill date and mutually agree on the outreach service point: exact date and location of the outreach; where possible, provide printed calendar with location and date.
- Children <16 years only qualify if accompanied by a caregiver.
- All enrolled clients must still be appointed according to standard appointment procedures to facilitate individual-based tracing mechanisms.



7.4 STANDARD OUTREACH VISIT

SOPs for refilling ART outreach clients

Before outreach visit:

- Ensure all logistics for outreach are in place, including transport, human resource, equipment, supplies and drugs. A checklist is a useful tool to fulfill this requirement.
- Retrieve all files for clients to be reviewed on that specific outreach day.
- Requisitions for pharmacy supplies should be made at least a day prior to the visit in order to give the pharmacy time to prepare the drugs.
- Liaise with community expert clients to support outreach services within their communities.

During outreach visit:

- Health education, adherence assessment and support, TB screening, pill counts and vital signs check are all conducted during outreach services.
- Clients are reviewed as individuals at the outreach point. However, depending on the personnel capacity and as ART outreach services mature, ART groups embedded within the outreach model are still permissible.
- Screening for eligibility should be constantly done on all visits.
- Client care should remain the same as facility-based care. History taking, physical examination, appropriate investigations and management of infections should be carried out. Referrals should be done whenever required.
- Chronic care files and ART booklets must be duly completed.
- Data sources should be sent to update electronic systems as soon as possible after return from the outreach area.
- Appointment registers should be updated upon return from the outreach visit.

7.5 CLINICAL OUTREACH VISIT

7.5.1 Components of the health outreach team

The health outreach team will comprise of various health care workers, either from a health facility and/or an approved NGO specialized in provision of ART services. The minimum composition should include a NARTIS-trained nurse, laboratory and pharmacy personnel, counsellors and cough officers. Where possible, a doctor should accompany the outreach team for mentoring and provision of oversight.

7.5.2 Roles and responsibilities of key personnel

The following outlines the roles and responsibilities of expert clients, cough officers, nursing assistants, nurses, doctors, and laboratory and pharmacy personnel in the delivery of ART outreach services.

Community expert client/expert client and/or cough officer

- Conduct pill counts and assessment of adherence and document this in the client file.
- Screen clients for TB and document TB screening results in the appropriate data tools.
- Document the client's attendance in the appointment register.
- Conduct follow up on missed appointments with a phone call and document outcomes of the call.
- Support client education and adherence with SMSs.

Pharmacy personnel

- Where possible, accompany the outreach team to the community, ensuring that all clients receive appropriately prescribed medication and counselling on adherence.
- Follow up with outreach nurse to ensure the correct drugs were distributed during the outreach visit.
- Update necessary pharmacy documentation after an outreach service, including updating electronic pharmacy systems



STANDARD OPERATING PROCEDURES FOR ART OUTREACH MODEL

Data clerks

- Data clerks receive the chronic care file and prescriptions from the outreach visit.
- Enter clients' data collected at outreach into electronic systems
- Client's data collected on outreach visit should be entered in the available electronic systems. With improved systems, data collected at outreach shall be differentiated from that collected at the facilities.
- Ensure prescriptions are sent to pharmacy to update electronic systems whether onsite or offsite including CMIS and/or RxSolution respectively.
- Where electronic systems (APMR or CMIS) are not available, the prescriptions from outreach should be sent to mother facilities that have electronic systems.

Laboratory personnel

- Ensures sample handling and storage procedures are followed.
- Assists the outreach team with developing sample handling procedures and maintain reliability of results.
- Participates in outreach services and help collect and handle samples

Nurse/medical officer

- Reviews all outreach clients every six months to assess the clinical situation.
- Assists in the recruitment of clients to the outreach model.
- Participates in the outreach visit.
- Nurse must submit prescription/ medicines order forms to the pharmacy at least 24 hours prior to the outreach visit date.
- Nurses must return all remaining medicines and prescriptions of drugs so that the pharmacy inventory systems are correctly updated.
- Provide oversight in patient follow up for defaulters and missed appointments.

7.6 CLIENT SENSITIZATION, MESSAGING AND EDUCATION ON OUTREACH ACTIVITIES

Community structures and leadership must be observed when setting up community outreach points. Community expert clients and rural health motivators can assist in getting community support to set up outreach locations in areas where such services do not exist. Messages to promote uptake of HIV services using the outreach model must be disseminated at both health facility and community levels. The key activities to be done at community and health facility level are outlined here:

At community level:

- In the clinic catchment area, the HCW can engage the community members to give details about ART outreach care points and refer clients to the clinic for HCWs to assess eligibility criteria to the outreach refill model.
- The facility-based health care workers should liaise with existing community structures with the support of partners and NGOs to activate demand creation on for these activities.
- The community expert client can engage ART clients during adherence counselling visits on community ART groups and the outreach sites and dates.
- Community support groups and networks should be sensitized on "CommART" to promote ART delivery models in their communities

At health facility level:

- HCWs (nurses, ECs and doctors) will introduce these models to the ART clients. Two main strategies can be implemented:
 - o Passive information delivery: This can take place in routine communication forums, such as morning health talks and individual contacts. IEC materials should be available for clients to enable deeper understanding.
 - o Active recruitment: Health care workers can review clients and their files, and actively engage those that may be considered to be eligible for ART delivery models. The facility-based health care workers should liaise with CECs and RHMs on ART clients having challenges with facility-based refill models to be enrolled for ART outreach model.



Key points

- ART clients in outreach model should have laboratory follow up regularly as per antional ART monitoring guidelines.
- Differentiated models of ART delivery must accommodate this.

8. INTEGRATING ART INITIATION WITHIN COMMART MODELS

Among the ART refill models, the outreach model (in addition to the existing mainstream model of care) offers the possibility of ART initiation because comprehensive services are available at individual level. With integration of other service within outreach models it is still possible to provide linkages services and ART initiation for patients tested in outreach settings as well as those tested elsewhere presenting to outreach teams. With time, evolution of the outreach model may make it possible to create clubs and CAGs within the outreach model but measures are required to facilitate such evolution. Table 3 provides comments regarding feasibility of ART initiation per each model of care.

Table 3: Feasibility of ART initiation in ART delivery models

ART Delivery Model	Is ART initiation feasible?	Comments
Fast-track model	No	- Clients are not given adequate time to enable the full implementation of initiation procedures.
Facility-based treatment club	No	- Clubs consist of clients already on ART.
Community-based ART groups	No	- Groups consist of clients already on ART. -It is not possible to initiate a client in absentia.
Outreach	Yes	- Initiation services are possible since the outreach model is a form of decentralization of all possible services.
Teen Refill Clubs	No	- Require support of a caregiver if <18 years. - Privacy is required during the individual counselling with caregiver present.





9. GLOSSARY

- Appointment keeping** An appointment is kept if the client visit date is not more than 7 days earlier and not more than 3 days later than scheduled date but their visit date \neq scheduled date
- CommART models** CommART models are differentiated models of ART delivery that seek to ensure efficient management of clients, paying particular attention to the needs, responsibilities and time away from work of stable clients, as well as equitable allocation of service time between sick clients and well clients. They are client-centred models, and clients need to be informed and able to negotiate their health care needs and take ownership of their health.
- Laboratory personnel** Refers to any one of laboratory scientist, laboratory technician or phlebotomist. The scope of service should be within the scope of the specific officer
- Mainstream care** Mainstream care mainly provides HIV care to clients who require close clinical attention and/or monitoring from nurses and doctors. All facilities have mainstream care to provide clinical services to clients.
- On-time client visit** These are visits where clients come on the exact date they were scheduled (visit date = scheduled date)
- Pharmacy personnel** Refers to any one of pharmacist, pharmacy technician or pharmacy assistant. The service provided should be within the scope of the specific officer
- Stable client** A stable client is eligible to join the fast-track, facility-based treatment club or community adherence group model of care. Stable clients are defined as:
- Adult (18 years or older)
 - At least 12 months on ART
 - Most recent consecutive viral loads **undetectable**; the most recent of these taken in past six months
 - In the absence of viral load monitoring, rising CD4 cell counts or CD4 counts above 350 cells/mm³
 - No current TB
 - Not currently pregnant or breastfeeding
 - No medical condition requiring regular clinical consultations



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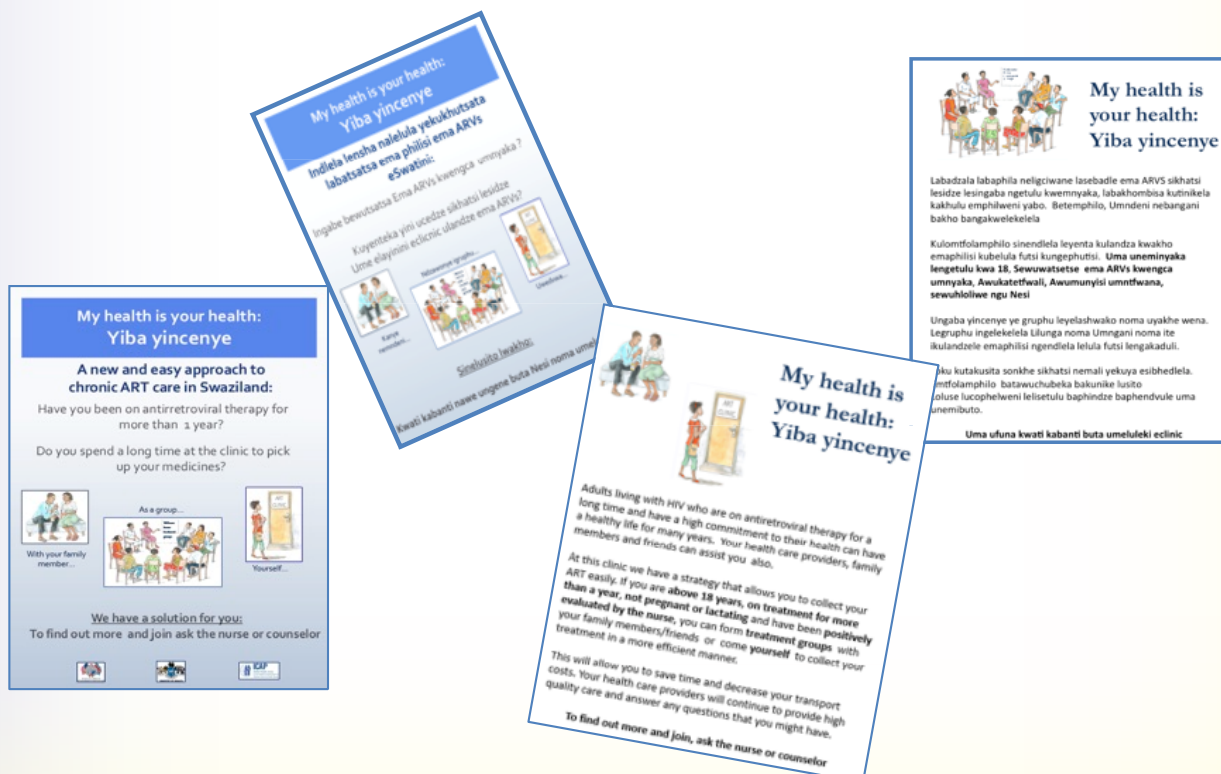
Standard Operating Procedures for Implementing Community-centred Models of ART Service Delivery (CommART) in Swaziland

ANNEXES

ANNEX 1: DEMAND-CREATION TOOLS USED IN NATIONAL PILOTS



IEC materials used by MSF in the Sishelweni region



IEC materials used by ICAP in the Hhohho, Manzini and Lubombo regions



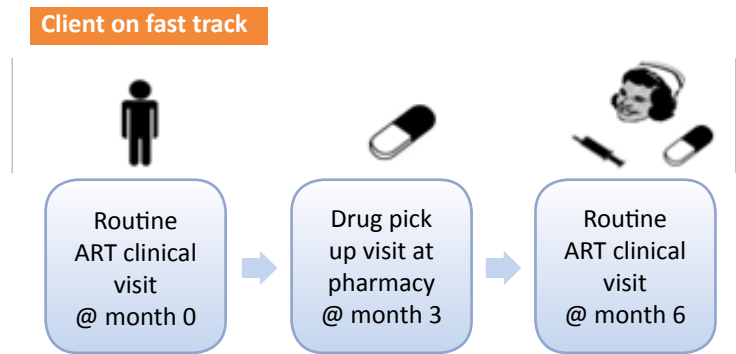


ANNEX 2: MODELS OF ART CARE AND COUNSELLING MESSAGES

This **job aid** informs the counselling messaging content that HCWs will be giving to clients visiting the health facility, who are interested in CommART models.



Describe the models to the client.



Eligibility criteria

- Adult (18 years or older)
- At least 12 months on ART
- Most recent viral load is **undetectable** and taken within the last six months of date of enrollment
o In the absence of viral load monitoring, rising CD4 cell counts or CD4 counts above 350 cells/mm³
- No current TB
- Not currently pregnant or breastfeeding
- No medical condition requiring regular clinical consultations
- At least two ART visits at the facility
- Clinicians confirm the clients' eligibility for membership
- Membership is voluntary.

Congratulating the client

Welcome them into the refill model of their choice



You have demonstrated a great commitment to your antiretroviral treatment for several months and we have observed:

- Good adherence to clinic visits
- Increase in your CD4 and/or undetectable VL
- Good adherence to pill count
- That you have good understanding of your HIV treatment.



You also meet the eligibility criteria to enrol into a model of your choice.

Core message: The client must be applauded for their adherence to care and treatment services and encouraged to continue to do so. They should feel like they have earned this offer and that we trust them. Clients should be motivated to take responsibility for their care, as well as others around them.

Being adherent is linked to viral suppression and a great life free from diseases.

Done when: On enrolment

Lifelong commitment

As you remember, this is a lifelong commitment, and continuing with good adherence is essential to keep the virus under control and prevent resistance. This facility is ready to help you through this journey. You can also move between models as appropriate.



Graphic showing different types of virus. Those that are different are the mutated viruses, and they will not be killed by the ARVs. Use as a reminder for clients who may not know the basics of HIV resistance well.

Viral load

- Viral load means the **quantity of virus in your blood**. So with the test result we could know how much HIV is in your blood.
- An **undetectable result** means that ARVs are successfully controlling the HIV: the treatment is working well and HIV cannot be detected in your blood with our machines. (Not detected here does not mean no virus anymore. The virus still exists, but at much lower levels and may be found in other tissues.)
- Remember your goal when taking your ARVs: to maintain your viral load at undetectable levels for as long as possible.

Self-management of own's health

- Remember that you can come to the facility any time you have a concern. Remember that you can still discuss your changing choices with your health care worker.
- You have demonstrated that you can manage your infection in a responsible way, so now you will be assisted to demonstrate this responsibility at any even higher level and also to show this attribute to other peers in your treatment group/club.

Good self-management has the following attributes:

- o Being responsible for taking ARVs daily – in the right dose and at the right time
- o Ability to keep clinic appointments (for ARV pickups and laboratory)
- o Being able to come to the clinic to consult a health care worker if you are feeling sick
- o Being a champion and offering support to other PLHIV
- o Ability to make suggestion to the health care workers on how to better the service delivery to suit the needs of people living with HIV, including yourself.



TB screening

- You must screen yourself for TB before collecting the medicines. If you have any symptoms suggestive of TB, you will come to the clinic yourself to be assessed by a HCW.
 - If you develop TB symptoms at any time, you will also attend the facility.
- Remember the conditions that make us think of TB, namely:
 - Any cough
 - Weight loss
 - Night sweats for more than two weeks
 - Fever for more than two weeks
 - History of TB contact.

Clinic visits for refill vs. drug pick-up visits

- Every six months, you must see a nurse or a doctor who must be sure that you are clinically stable by performing a clinical visit review, which is basically a “check-up”.
- Drug pick-ups happen in between clinical visits: you must assess yourself and you will be fast tracked to pick up the medication from a designated dispensing point or pharmacy.

Roles and responsibilities of clients and health care workers

- You are now even more responsible for taking your medication appropriately, honouring the clinic appointments and preventing new HIV infections.
 - If you miss an appointment or come with many tablets or they finish too early, you can be asked to see a doctor or nurse to assist you in addressing the situation.

Keeping medication safe

- When you collect medicines on behalf of other clients, you commit to give the ARVs to the owner in a timely manner, and to keep them safe in a secure location.
- You must not lend, sell or give the medication away to any other person other than those to whom the drugs were dispensed. Also, you must not lend your own medicines to other people.
- The facility staff may call other group members to verify receipt of their medicines.
- You are accountable for all the drugs you receive.

Duration of the care

- You are aware that if you don't fulfil your promise, or if you become sick, the HCW can ask you to be removed from the group and return to the mainstream care until the problems are solved.
- You can always attend the clinic to consult questions or seek appropriate medical help as you usually do.

What happens when you want to leave CommART models?

- The mainstream model of care is always available for you.
- When you leave any model, you automatically go back to mainstream care unless you have specifically moved to another model.
- You can freely transition between models for as long as you are eligible in your chosen model.
 - However, we encourage clients to remain on a single chosen model for as long as possible to facilitate better tracking and programming of activities.
- You can still remain a passive member in a group to receive the adherence support benefits from your membership in this program.



ANNEX 3: CHECKLIST TO IMPLEMENT THE ART MODELS OF CARE AT FACILITY LEVEL

Component	Recommendations
Training of health care workers	<ul style="list-style-type: none"> • Health care workers have been trained on implementation details of the models. • Laboratory, M&E and pharmacy procedures are adapted to the facility-existing procedures. • Discuss roles and responsibilities of each sector for implementation.
Marketing and client education	<ul style="list-style-type: none"> • IEC materials are available in the facility and HCWs can utilize them. • Forums for distribution of information are identified: morning health talks, community events, support groups, etc. • Individual client education is done correctly according to the selected model. • Clinicians and counsellors conduct marketing during individual visits.
Community mobilization	<ul style="list-style-type: none"> • Carry out activities to market the models. • Personnel and tools are available.
Identification of eligible clients	<ul style="list-style-type: none"> • HCWs and counsellors are aware of the eligibility criteria and can identify eligible clients appropriately. • Feedback for non-eligible clients is given adequately and they are assisted to become eligible. • Clients that become non-eligible for refill in one of these models are brought back to mainstream care: e.g. pregnancy, active TB disease.
Enrolment of eligible clients	<ul style="list-style-type: none"> • Enrolment takes place following the necessary M&E procedures. • Individual client education is done correctly according to the selected model.
Running of the model	<ul style="list-style-type: none"> • Stationary, logistic support, etc. is available. • Identified HCWs are identified and understand their role. • Feedback meeting sessions happen routinely within the MDT context to discuss implementation issues.
Laboratory component	<ul style="list-style-type: none"> • HCWs are aware of the ART guidelines recommendations for client follow up. • Booking of blood draws are scheduled for the same day of the consultation. • Identification of clients that need laboratory tests happens correctly. • Feedback of results to the clients happens adequately. • Action on abnormal results happens adequately.
Pharmacy component	<ul style="list-style-type: none"> • ART prescriptions are done according to facility procedures. • ART stocks and supply chain are dealt within an MDT approach. • ART refills are prepared with each client's name.
M&E components	<ul style="list-style-type: none"> • Paper-based tools are utilized correctly and ART refills are documented properly: kind of model the ART client is using, medical information, psychosocial information, laboratory follow up. • Utilize key paper-based tools: chronic care Files, ART cards, appointment registers, etc. • If available, APMR/CMIS tools are used.
Routine care	<ul style="list-style-type: none"> • TB screening takes place. • Client flow is clear for each model. • Documentation • ART refills are available.



ANNEX 4: SUMMARY OF ART DELIVERY MODELS IN SWAZILAND

Models of ART delivery in Swaziland				
	Overview	Number of visits/ year	Priority implementation	Benefits
Mainstream care	For clients who require close clinical attention and/or monitoring	Variable	For client who require clinical care	Intense clinical services available
Outreach*	Mobile teams from facilities take the available services to the community	Variable – between 4 and 12 visits/year	Hard-to-reach areas	Increasing access, reduced time/cost for clients
Fast-track	Clients skip the consultation and directly collect their ART refill	4 (2 ART refill visits + 2 clinical consultations)	High-volume sites, crowded facility, where clients have constrained working hours	Reduced time in the facility, decreased congestion
Treatment clubs	Groups of clients meet for group counselling and ART collection	4 (2 ART refill visits and group + 2 clinical consultations and group)	High-volume sites, crowded facility, where clients have constrained working hours	Reduced time in the facility, decreased congestion, peer support
Teen clubs	Groups of adolescent clients meet for group counselling, psychosocial support and, if stable, ART collection	Monthly teen club meetings, ART distributed every 3 months for stable adolescents	Sites with adolescents	Increased peer support, psychosocial support
Community ART groups (CAGs)	Groups of 2-6 clients who take turns to visit the facility to get refills on behalf of the other group members	Variable – 4-12 CAG meetings for ART refills and support + 2 clinical consultations at the facility	Where there are pre-existing networks (families, workmates and friends), where clients stay in hard-to-reach areas	Increased peer support, decreased visits to the facility, reduced cost

*Clients who are acutely ill, develop an OI, miss outreach appointments or who are pregnant will be up-referred to mainstream care.





ANNEX 5: SUMMARY OF INCLUSION CRITERIA BY MODEL OF ART DELIVERY±

CRITERIA	MODEL OF ART DELIVERY				
	Fast track	Treatment Club	Teen Club*	CAG	Outreach
Adult (18+years)	X	X	N/A	X	X
Adolescent (10-19 years)	N/A	N/A	X	N/A	X
12 months on ART	X	X	X	X	N/A
Undetectable viral load (two consecutive viral load measurements are undetectable with the latest one taken within the last 6 months of eligibility date) OR CD4 above 350 OR Evidence of rising CD4	X	X	X	X	N/A
No current TB	X	X	X	X	X
Not currently pregnant or breastfeeding±	X	X	X	X	X
No other medical condition requiring intensified clinical consultations	X	X	X	X	X
At least two ART visits at the facility	X	X	X	X	X

± All clients are eligible for the mainstream model.

*Only adolescents with an undetectable viral load are eligible for ART refills within a teen club. However, adolescents with high viral load will be encouraged to participate in the group, but will receive their ART refill through mainstream care with engagement of the parent/guardian.



ANNEX 6: PROCEDURES FOR A CAG REPRESENTATIVE'S VISIT

A summary of the counselling steps required for clients who have formed or joined a CAG

Type of session: Individual
Focus group: CAG members
Duration: 30 to 45 mins

1. Before starting the session:

- Introduce yourself (name and function);
- Explain the main objectives of the session:
 - To evaluate the CAG member's adherence to treatment, assess client satisfaction related to being part of CAG and identify possible problems and/or conflicts in the group.

2. Counselling steps:

- Try to understand from the client how the group is organized in terms of responsibilities, participation during meetings and this member's satisfaction related to being part of the group.

"We are happy to see you at the facility today. Because it has been some time since we have seen you, we would like to take this opportunity to know how you are doing and how the group's activities are."

"Could you tell me how is the group organized?"

In this question, we expect the client to share the processes of the group, such as:

- Monthly meetings with the group:
 - o Including one meeting at the day BEFORE the trip to the facility for:
 - Monitoring of member's treatment uptake
 - Pill count and record in the card
 - Screen for common diseases
 - Collection of all group members the cards to take to the facility
 - o Including one meeting the day AFTER the trip to the facility for:
 - The group representative distributes drugs to each client
 - Returns each client card
 - When necessary (according to staff at health centre) requests a group member to go to the health facility for a special consultation
 - Clients sign receipt of drugs on the CAG monitoring form.
- Make sure that all members have regular access to medicines and that the group works well.
- Explore the difficulties encountered within the group and how the group plans to have the problem solved.
"What are the difficulties you have experienced being part of the CAG?"
"What are the activities you need to engage into as a group member? Here and in the community?"

In this question, we expect the client to talk about their responsibility as a group member, such as:

- Attend health facility when their appointment date has arrived.
- Pick up the medication for himself and for other group members.
- Distribute to other group members their medication in the community.
- Keep confidentiality.
- Advise clients to seek medical care at clinics when needed.

Experience shows that each group develops its own way of organizing themselves with regard to the distribution of the drugs. Please listen to the client and, if by any chance you notice that there might be a specific problem that can affect the group's functioning, contact the CAG focal person at the facility for the follow up needed.

NOTE: Do not force the member to change the way the group is organized, refer to the health staff responsible for the CAG follow up in the facility for further arrangements.



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- Apply the client satisfaction survey to clients when they have completed the first six months of follow up on CAG (when the member has being part of the group for more than 12 months).
- Assess group member's adherence at the first six months and afterwards each year, through:
 - o Adherence assessment self-report tool
 - o Alcohol consumption questionnaire
 - o PHQ9.
- Emphasize the importance of the members' participation in counselling sessions, whenever necessary.