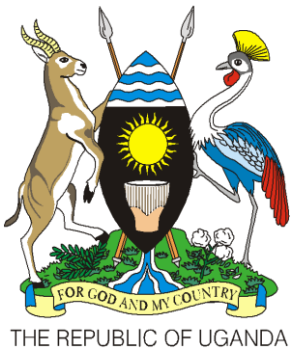


THE REPUBLIC OF UGANDA

Ministry of Health

# Implementation Guide for Differentiated Service Delivery Models of HIV and TB Services in Uganda

March 2020

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# Abbreviations and Acronyms

| | |
|---|---|
| ACP | AIDS Control Program |
| AIDS | Acquired Immune Deficiency Syndrome |
| AMC | Average Monthly Consumption |
| ANC | Antenatal Care |
| ART | Antiretroviral Therapy |
| ARV | Antiretroviral |
| APN | Assisted Partner Notification |
| BP | Blood Pressure |
| CAO | Chief Administrative Officer |
| CASA | Community ART Support Agent |
| CBC | Complete Blood Count |
| CBO | Community Based Organization |
| CCE | Comprehensive Clinical Evaluation |
| CCLAD | Community Client-Led ART delivery |
| CCM | Cryptococcal Meningitis |
| CD4 | Cluster of Differentiation 4 |
| CDC | Centres for Disease Prevention and Control |
| CDDP | Community-based Drug Distribution Point |
| CDO | Community Development Officer |
| CHEWS | Community Health Extension Workers |
| CICT | Client Initiated Counselling and Testing |
| CME | Continuous Medical Education |
| CO | Clinical Officer |
| CPHL | Central Public Health Laboratories of the Republic of Uganda |
| CQI | Continuous Quality Improvement |
| CrAg | Cryptococcal Antigen |
| CSO | Civil Society Organization |
| CTX | Cotrimoxazole |
| CXR | Chest X-Ray |
| DCDO | District Community Development Officer |
| DBS | Dried Blood Spot |
| DELTA | Delivering Technical Assistance Project |
| DHIS | District Health Information System |
| DHO | District Health Officer |
| DHT | District Health Team |
| DM | Diabetes Mellitus |
| DNA | Deoxyribonucleic Acid |
| DOTS | Directly Observed Therapy |
| DSD | Differentiated Service Delivery |
| DSDM | Differentiated Service Delivery Model |
| EGPAF | Elizabeth Glazer Pediatric AIDS Foundation |
| EID | Early Infant Diagnosis |
| FBG | Facility Based Group |
| FBIM | Facility Based Individual Management |
| FP | Family Planning |
| FSAT | Facility Self-Assessment Tool |
| FSG | Family Support Group |
| FTDR | Fast Track Drug Refill |
| GFATM | The Global Fund to Fight AIDS, Tuberculosis and Malaria |
| HB | Hemoglobin |
| HBHTS | Home Based HIV Testing and Screening |
| HBsAg | Hepatitis B Surface Antigen |
| HBV | Hepatitis B Virus |
| HCG | Human Chorionic Gonadotrophin |
| HCW | Health Care Worker |
| HCV | Hepatitis C Virus |
| HEI | HIV-Exposed Infant |
| HF | Health Facility |
| HIV | Human Immunodeficiency Virus |
| HIVST | Human Immunodeficiency Virus Self-Testing |
| HMIS | Health Management Information Systems |
| HR | Human Resources |
| HT | Hypertension |
| HTC | HIV Testing and Counselling |
| HTS | HIV Testing Services |
| HUMC | Health Unit Management Committee |
| IAC | Intensive Adherence Counselling |
| IGA | Income Generating Activity |
| IP | Implementing Partner |
| IPD | In-Patient Department |
| JMS | Joint Medical Stores |
| KP | Key Populations |
| KYCS | Know Your Child's Status |
| Lab | Laboratory |
| L&D | Labour and Delivery |
| LFT | Liver Function Tests |
| LTFU | Lost To Follow Up |
| M&E | Monitoring and Evaluation |
| MARPI | Most At Risk Populations Initiatives |
| MARPs | Most At Risk Populations |
| MAUL | Medical Access Uganda Limited |
| MBCP | Mother Baby Care Point |
| MCH | Maternal Child Health |

| | |
|---|---|
| MDR | Multi Drug Resistance |
| MDRTB | Multi Drug Resistance Tuberculosis |
| MNCAH | Maternal Neonatal Child Adolescent Health |
| MNCH | Maternal Neonatal Child Health |
| MO | Medical Officer |
| MOH | Ministry of Health |
| MRS | Medical Records System |
| MSM | Men who have Sex with Men |
| MTCT | Mother-to-Child Transmission (of HIV) |
| MUAC | Mid-Upper Arm Circumference |
| NACS | Nutritional Assessment Counselling and Support |
| NCD | Non Communicable Disease |
| NMS | National Medical Stores |
| NVP | Nevirapine |
| OI | Opportunistic Infections |
| OPD | Out-Patient Department |
| OR | Operations Research |
| OVC | Orphans and Vulnerable Children |
| PCR | Polymerase Chain Reaction |
| PDSA | Plan-Do-Study Act |
| PEP | Post Exposure Prophylaxis |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PHA | People with HIV/AIDS |
| PHDP | Positive Health, Dignity, and Prevention |
| PITC | Provider-Initiated Testing and Counselling |
| PLHIV | People Living with HIV |
| PMTCT | Prevention of Mother-to-Child Transmission (of HIV) |
| PNC | Post Natal Care |
| PNS | Partner Notification Services |
| PP | Priority Populations |
| PSS | Psychosocial Support |
| PTB | Pulmonary Tuberculosis |
| PWID | People Who Inject Drugs |
| QI | Quality Improvement |
| RCT | Routine Counselling and Testing |
| RFTs | Renal Function Tests |
| RH | Reproductive Health |
| RPMTs | Regional Performance Monitoring Teams |
| SBCC | Social Behaviour Change Communication |
| SMC | Safe Male Circumcision |
| SOPs | Standard Operating Procedures |
| SRH | Sexual Reproductive Health |
| STI | Sexually Transmitted Infection |
| TA | Technical Assistance |
| TASO | The AIDS Support Organization |
| TB | Tuberculosis |
| TFTs | Thyroid Function Tests |
| TG | Transgender |
| TLD | Tenofovir, Lamuvidine, Dolutegravir |
| TLE | Tenofovir, Lamuvidine, Efavirenz |
| TWOS | TB medicines Web-based Ordering System |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| USAID | United States Agency International Development |
| VCT | Voluntary Counselling and Testing |
| VHT | Village Health Team |
| VL | Viral load |
| VSLA | Village Savings Loan Activities |
| VMMC | Voluntary Medical Male Circumcision |
| WAOS | Web-based ARVs Ordering System |
| WHO | World Health Organization |
| Wt. | Weight |
| YCC | Young Child Clinic |

# Operational Definitions

**Client/patient disaggregation:** Grouping of clients/patients into subgroups which have similar or nearly the same characteristics

**Community ART group (CAG):** These are community-based groups formed voluntarily by persons living with HIV who are taking lifelong antiretroviral drugs

**Community ART Support Agent (CASA**): This is an expert client, experienced in ART, with an excellent adherence record and has been trained to provide basic psychosocial support to fellow clients

**Community client-led ART delivery (CCLAD):** This is delivery of antiretroviral drugs at community level to a community ART group by one of the community ART group members on a rotational basis

**Community drug distribution points (CDDP):** These are designated points within the community where antiretroviral drugs are dispensed to persons who are on lifelong antiretroviral therapy

**Community:** A group of people with common characteristics or interests living together within a larger society

**Comprehensive clinical evaluation (CCE):** This is a clinical evaluation for all stable adult clients, complex/unstable clients, children, adolescents, eMTCT ANC, eMTCT mother-baby pairs, and key populations due for their clinical evaluation and any other related services

**Differentiated care:** A client-centred approach that simplifies and adapts HIV services across the cascade to reflect the preferences and expectations of various groups of people living with HIV (PLHIV) while reducing unnecessary burdens on the health system. By providing differentiated care, the health system can refocus resources to those most in need.

**Differentiated drug delivery approaches:** Drug delivery models that are adapted or customized to provide drugs (ARVs) to clients living with HIV in the most convenient manner without compromising quality of care

**Differentiated HIV testing services:** Service-delivery models that are adapted to address the specific barriers/bottlenecks of a subgroup of individuals to enable them to know their HIV status

**Differentiated HIV care and treatment:** Service-delivery models that are adapted to provide HIV care and treatment to either address specific barriers/bottlenecks or ease access to HIV care and treatment for a subgroup of persons living with HIV

**Differentiated services:** These are services that are tailored to or centred on the needs of an individual or a group of individuals for example HIV testing services for priority populations, provision of ARVs at community level for stable patients and having a one-stop care point for TB/HIV co-infected patients

**Facility Based Groups:** These are support groups of stable or unstable/complex clients based in the facilities (e.g., family support groups, adolescent support groups, etc.) that may be used as avenues for ART refills

**Facility Based Individual Management**: This is an approach where an individual client is given a scheduled appointment for a thorough clinical assessment, review of blood tests and other services e.g. counselling. It is for unstable clients needing extra attention e.g. newly initiating ART, sick clients needing multi-disease management, viral non-suppression from FTDR, CCLAD, CDDP and stable clients returning for their bi-annual clinical evaluation.

**Fast-track drug refill (FTDR):** This is where stable clients pick their drugs from the pharmacy without going through the normal clinic flow, including a doctor's review

**Health facilities:** Designated places where health services are offered/provided; they can range from small health centres/posts to larger dispensaries or hospitals

**Health facility client flow:** The pathway followed by clients as they receive services between care points in a health facility from their time of arrival to departure

**Index HIV client contact testing:** A focused approach in which the household and family members (including children), sexual partners of people diagnosed with HIV are offered HIV testing services

**Key populations:** These include sex workers (SW), people who inject drugs (and other people who use drugs) (PWID), men who have sex with men (MSM), transgender persons (TG), and people in prisons and other closed settings. The defined groups, owing to specific higher-risk behaviours, are at increased risk of acquiring or transmitting HIV irrespective of the epidemic type or local context.[1]

**Lost to follow up:** A patient is classified as lost to follow up if they have not been to the HIV care centre for more than 90 days since their last appointment date.

M**issed appointment:** A client is classified as having missed an appointment if they are more than 3 days, but less than or equal to 7 days, late to their expected appointment.

**Priority populations:** These are people who are likely to have a high chance of acquiring or transmitting HIV due to one or more of the listed circumstances: level of vulnerability in the population, have limited access to HIV testing services, post-test prevention services, and HIV care and treatment services. These circumstances include but are not limited to hard to reach areas, socioeconomically disadvantaged, pregnant & breastfeeding women, incarceration, children and adolescents, people living with disabilities (PLWDs), etc.

**Stable HIV+ client**: A client on the same ART regimen for at least 12 months, with a suppressed viral load, good adherence to ARVs of >95%, on 1st or 2nd line regimen, in WHO stage 1 or 2 and if HIV/TB co-infected has finished intensive phase of Anti-TB treatment and is sputum negative.

**Unstable/complex HIV+ Clients**: These include: ART naïve patients, PLHIV who have been on the same ART regimen for less than 12 months, PLHIV with a non-suppressed viral load, experiencing treatment failure, on 3rd line regimen, in advanced disease stages (WHO stage 3 or 4), TB/HIV co-infected clients in intensive phase of anti-TB treatment or are still sputum positive or with MDRTB.

[1] PEPFAR Technical Considerations for COP/ROP 2016

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# Foreword

The Government of Uganda in her national consolidated HIV prevention, care and treatment guidelines 2020[1] has continued to recommend the implementation of differentiated service delivery (DSD) models for HIV Testing Services (HTS), care and treatment for Persons Living with HIV (PLHIV) and Tuberculosis (TB).

This revised version of the Differentiated Service Delivery Models (DSDM) Implementation Guide presents the details on how to implement the recommended DSD models. It focuses on reorganizing the structure of service delivery models already being implemented at the health facility and in the community, with the aim of improving the efficiency and convenience in delivery of HIV and TB services along the cascade of HIV prevention and care. It will rely on the existing infrastructure and will not require significant additional resources.

The guide recommends adoption of continuous quality improvement (CQI) by health facilities as they implement DSD towards ensuring a continuum of HIV care that accurately addresses client needs in a respectful, effective and efficient manner. Implementation of this guidance will strengthen the capacity of health facilities and communities to monitor quality of care and use care data for decision-making and promoting accountable leadership for achievement of results.

This document is to guide policy makers, managers and health service providers (including health facility In Charges, clinicians, nurses, allied healthcare workers and community-based health services organizations), AIDS Development Partners, implementing partners, training institutions, researchers, civil society organizations and the entire community of people living with HIV. It aims to set standards for the implementation of DSD while ensuring quality Antiretroviral Therapy (ART) services in Uganda.

Due to the importance of this document, I strongly appeal to all stakeholders to use it as the reference point during the planning and implementation of DSDM in Uganda.

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# 1 Introduction

The AIDS Control Program (ACP) of the Ministry of Health (MOH) Uganda has made a significant impact in the fight against HIV. However, despite this growing success, lifesaving services are not yet available to everyone who needs them in Uganda. Variations in health outcomes exist across different districts and health facilities and are further affected by a range of geographic, economic, demographic and social factors.

The results of the 2016 Uganda Population HIV Impact Assessment (UPHIA) indicate that 6.2% of adults aged 15-49 years in Uganda are living with HIV. Based on the survey results, the total number of adults and children of all ages living with HIV in Uganda is estimated to be approximately 1.3 million with overall viral load suppression standing at 59.6%[2]. Based on Health Management Information Systems (HMIS) reports submitted into the District Health Information System (DHIS2) 1,040,015 PLHIV were aware of their HIV status and 1,028,909 were active clients initiated on ART as at end June 2017[3].

Only 80% of PLHIV in Uganda are aware of their HIV status against the goal of 90% of PLHIV identified and linked to care and treatment. Identifying the remaining 20% requires more innovative and efficient HIV screening and testing approaches. ***Reaching the UNAIDS 90–90–90 targets requires a synergistic way of working, one based on efficiencies gained through continuous improvement of existing models of service delivery.***

As Uganda transitions to 'Test and Start', the number of patients that will require treatment will increase, and coupled with improved survival among the PLHIV, the total number needing care is anticipated to increase further, resulting in the health system being stretched in terms of resources to support care provision. Measures to reduce the frequency of seeking health care for stable HIV patients are critical if we are to improve the capacity of health systems to manage growing numbers of clients without compromising quality of care. Over the past decade, a range of innovative strategies on how to provide comprehensive HIV services more effectively and efficiently, and to enhance retention and adherence to ART have been documented. These programmatic adaptations have been described as ways of "differentiating" how services are delivered, including identifying, preventing, diagnosing, treating and supporting people in need of HIV and/TB services. This is also sometimes called tiered care, client-centred care or client-tailored care. Differentiated Service Delivery (DSD) would lead to better outcomes, improved coverage and quality of services, while using resources effectively and efficiently.

Health facilities that have tried innovative approaches that respond to needs of sub-populations still lack guidance on how to standardize these interventions. As a result, there are no documented health outcomes of site specific DSD across health facilities who have begun to implement innovative models. To standardize quality of care across the country, dissemination of replicable practical programmatic adoptions in Uganda's decentralized system of government cannot be over-emphasized.

The Uganda national consolidated HIV prevention, care and treatment guidelines 2016, recommend DSD as a critical strategy to enable Uganda to achieve the UNAIDS 90-90-90 goals. This implementation guide provides information and practical steps on how health facilities can implement differentiated approaches. The aim is to encourage greater use of differentiated care in increased numbers of facilities and to achieve the same or better results with the same or less resources, and without policy changes or additional resources.

# 2 Transforming Routine Care Data into Information for Differentiated Services

Plans for differentiated care need to be supported by evidence. This is best done with data collected at the facility level. Rigorous and regular data collection and analysis processes help to:

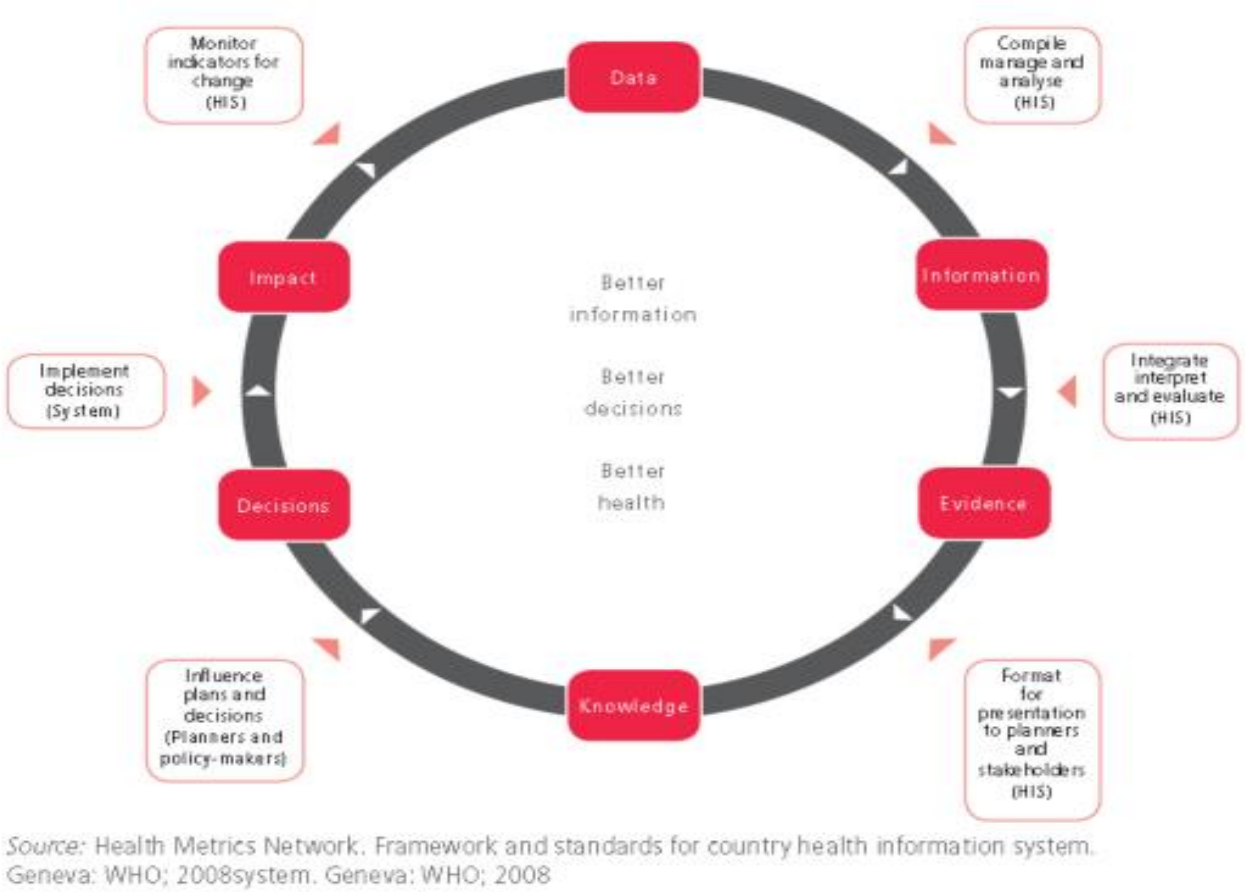
a. Understand the specific situation at a given level (e.g., service, sub-national or program level),
b. Identify strengths on which to build and key areas for improvement, and
c. Define and implement concrete quality improvement activities.

At the service level, data can be generated through routine patient monitoring and case reporting, with additional information from, for example, surveillance and health facility assessments (including quality of services and vital registration when available). These enable health-care providers to:

a. Ensure regular/rigorous clinical patient management (with a focus on quality),
b. Monitor loss to follow-up and drug resistance,
c. Establish accountability for quality improvement initiatives, and
d. Improve facility management by identifying efficiencies and areas for improvement.

At the program level, strategic information forms the evidence base for programming disease-specific responses: routine indicator reporting; surveillance/sentinel data; program reviews; evaluations; operational/implementation research and modelling. These data are only of strategic value if they are analyzed, synthesized and transformed into information that is accessible and understandable to site managers, planners and other stakeholders (Figure 1 below).

*Figure 1: Transforming data into information and evidence for decision makers*




*Source:* Health Metrics Network. Framework and standards for country health information system. Geneva: WHO; 2008system. Geneva: WHO; 2008

MOH recommends regular data collection, analysis and usage, including frequent monitoring meetings, regular performance review, and action as a best practice for replication or adaptation in all settings countrywide. Facilities benefit from using routine data and data from additional sources to help with decision-making, adapt ways of working, and support improvements in quality of care. Data collection and use should be included as early as possible in planning processes.

# 3 The Core Principles and Building Blocks of Differentiated Service Delivery

## 3.1. The Core Principles

### a) Client-centred care

The core principle for differentiating care is to provide ART delivery in a way that acknowledges specific barriers identified by clients and empowers them to manage their disease with the support of the health system. WHO highlights the need for client-centred care to improve the quality of HIV care services.[4]

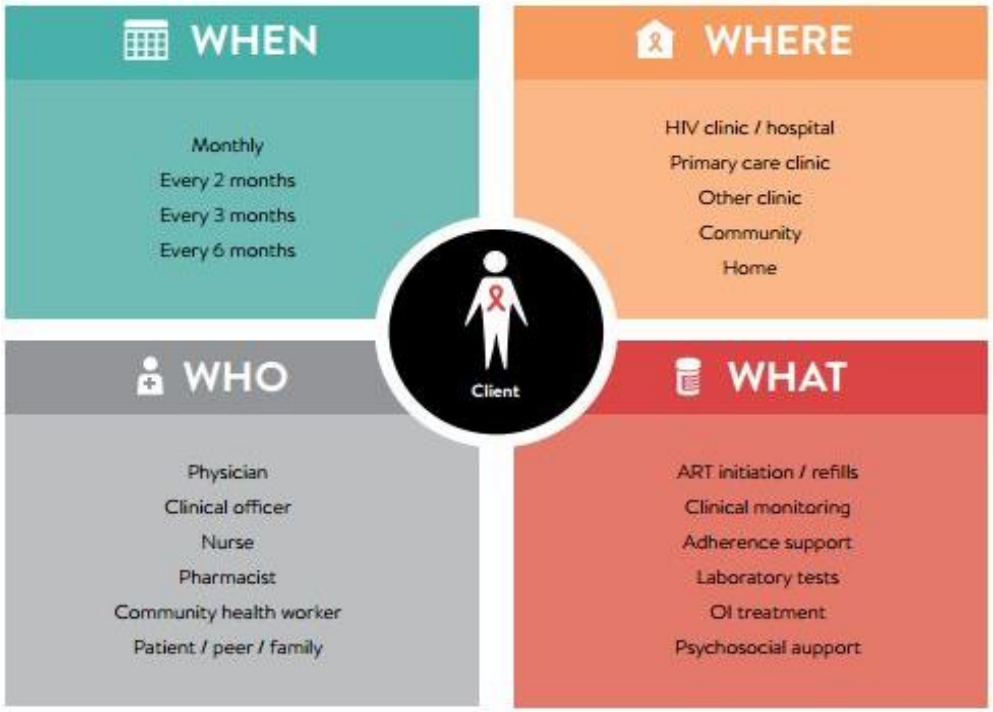
### b) Health system efficiency

With the population of PLHIV having increasingly diverse needs, it is acknowledged that health systems will have to adapt away from a "one-size-fits-all" approach. DSD supports shifting resources to clients who are the most in need by supporting stable clients to have fewer and less intense interactions with the health system.[4]

## 3.2. The Building Blocks

The building blocks of DSD centre on four questions: (1) When, (2) Where, (3) Who and (4) What. The building blocks are the key components of building a differentiated model of service delivery (Figure 2).
In all models of service delivery, the client is at the centre. It is up to the Ministry of Health (MoH) and District Health Teams (DHTs) to work with health care workers and clients to determine which of the **WHEN** (service frequency), **WHERE** (service location), **WHO** (Service provider) and **WHAT** (Type of service) blocks to consider in the model that they select to implement. The stakeholders must balance the goal of improving client outcomes with their ability to utilize the available health system resources.

Figure 2: The building blocks



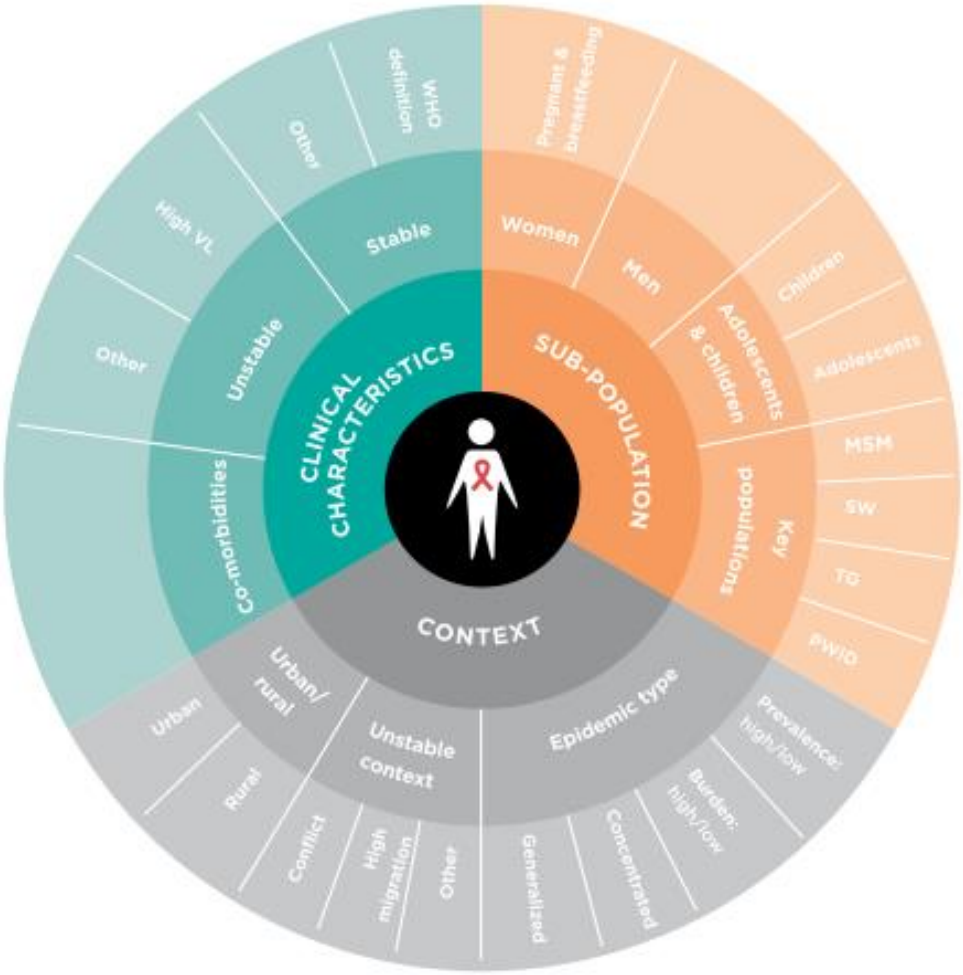
# 4 The Elements to Consider in Differentiated Care

In order to provide client-centred care, there is a need to consider the following:

- The clinical characteristics of the client (stable, unstable or complex)
- The specific populations (e.g., adults, children and adolescents, pregnant and breastfeeding women, key populations, men)
- The context (e.g., urban/rural, unstable context, epidemic type.)

This will allow you to build appropriate models of HIV Testing and Screening and HIV Care and Treatment using the building blocks described in the previous chapter. The elements are presented in figure 3.

*Figure 3: The three elements*




*Source: Differentiated Care for HIV: A Decision Framework for Antiretroviral Therapy Delivery*

## 4.1. How Do We Differentiate Based On Clinical Characteristics?

Based on clinical characteristics, clients can be defined as stable or unstable/complex. A differentiated approach based on clinical characteristics provides care that is responsive to the needs of PLHIV e.g. if a client

is clinically unstable, he/she may require an intensified level of follow up and support; on the other hand, a stable client, may not need frequent visits to the health facility.

*Table 1: Unique needs and potential solutions through DSD based on clinical characteristics*

| Unique needs | Potential solutions through DSD |
|---|---|
| **Stable clients** | |
| • Well<br>• On ART for > 1 year<br>• Suppressed viral load | • Opportunity to be attached to peers for psychosocial support<br>• Adherence and retention support<br>• Reduced frequency of clinic visits<br>• Multi-month or longer ART refills<br>• Opportunity to receive services in the community |
| **Unstable/Complex clients** | |
| • Co-morbidities<br>• High viral load<br>• Have risk factors that increase chances of sub-optimal adherence and poor retention in care and treatment<br>• Require an intensified level of follow up and support | • Frequent clinical reviews for monitoring and management of co-morbidities<br>• Clinical package to reduce morbidity and mortality<br>• Adherence support<br>• Frequent clinical reviews for monitoring and management of high viral load<br>• Intensive follow up by phone calls and home visits after any missed appointment<br>• Monitoring for drug resistance |

## 4.2. How Do We Differentiate Based On The Sub-Population?

Services should be differentiated by considering the unique needs (Table 1) of each specific sub-population (Figure 3). As models of DSD are being designed and implemented, special attention should be given to finding possible solutions addressing these unique needs rather than seeing them as barriers to implementation. Sub-population groups include:

- Children
- Adolescents
- Pregnant women
- Lactating women
- Adult men and women
- Key populations including female sex workers, men who have sex with men i.e. MSMs, Transgender i.e. TGs, people who inject drugs i.e. PWIDs, fishing communities, truckers etc.; marginalized or minority groups such as un-documented migrants, ethnic and sexual minorities etc.

*Table 2: Unique needs and potential solutions through DSD for the respective sub-population*[5]

| Unique needs | Potential solutions through DSD |
|---|---|
| **Children** | |
| • Period of physical growth and rapid cognitive development<br>• Require dosage adjustments<br>• Dependent on caregiver/s | • Opportunity for caregiver mentoring and introducing peer support in group models<br>• Less frequent clinical visits and longer ART refills after 2 years of age when dosage adjustments become infrequent |

| | |
|---|---|
| • Attending school<br>• Transitioning into adolescence | • Aligning visits with school holidays and caregiver appointments<br>• Transitioning from paediatric to adolescent care as part of an ART delivery and psychosocial support group |
| **Adolescents** | |
| • Period of rapid cognitive, social and sexual development<br>• Attending school<br>• Pushing for independence while still requiring caregiver support<br>• New and changing sexual reproductive health (SRH) needs<br>• Increased prevalence of mental health challenges and sexually transmitted infections (STIs)<br>• Transitioning to early adulthood | • Opportunity for peer mentoring in group models<br>• Visits outside of school time to support both school and clinic attendance<br>• Additional services related to mental health and SRH needs can be incorporated<br>• Transitioning adolescent to adult care as part of an ART delivery and psychosocial support group |
| **Pregnant and Breast Feeding women and their Infants** | |
| • Adapting to additional clinical needs of pregnancy or postnatal period<br>• Demands of exposed young infant, including infant clinical follow up<br>• Increased frequency of health visits during pregnancy and postnatally<br>• Diagnosed HIV during pregnancy and lactation for many women.<br>• Increasing numbers of women already stable on ART when conceiving | • Alignment of clinical visits for mothers and their children<br>• Integration of maternal, new-born and child health (MNCH) care, including testing of exposed infants and maternal ART delivery services within model<br>• Access to differentiated ART delivery models post-delivery if stable<br>• Opportunity for women stable on ART at conception to remain within their differentiated ART delivery model |
| **Men** | |
| **Characteristics**<br>• Increased risk of death while on ART compared to women<br>• Poor health seeking habits<br>• Stigma<br>• Late diagnosis<br>• Likely to start ART late | • Specialized clinics<br>• Opportunity to receive services in the community<br>• Opportunity for services delivered during flexible times and differentiated schedules |
| **Key Populations (KPs)** | |
| **Characteristics**<br>• Poor treatment access<br>• Challenges with treatment retention<br>• Stigma<br>• Discrimination<br>• Human rights abuses<br>• Criminalization of their activities leading to marginalization<br>• Fear of disclosure of their activities<br>• High risk behaviour<br>• More likely to have addictions | • Integrating services (one-stop)<br>• Decentralized ART delivery to locations within their communities<br>• Task shifting to KP peers for differentiated ART delivery<br>• Involving key population communities and organizations in service delivery<br>• Adherence support |

Each sub population will require a unique and comprehensive package of health care services to overcome particular challenges. (*Refer to section on service packages for various client groups*).

## 4.3. How Do We Differentiate Based On Context?

The prevalence of HIV in a specific population in a given geographical setting (e.g., rural or urban, conflict, high migration) determines the concentration of clients. It will also impact on the specific challenges faced by clients. This will in turn affect the appropriateness or extent of certain specific interventions and hence

influence the choice of differentiated ART and HTS delivery models. Table 3 summarizes the unique needs and potential solutions through DSD based on context.

*Table 3: Unique needs and potential solutions through DSD based on context*

| Unique needs/characteristics | Potential solutions through DSD |
|---|---|
| **Urban/rural setting** | |
| **Urban**<br>• High prevalence<br>• High risky behaviour<br>• Presence of key populations<br>**Rural**<br>• Long distances to the facilities<br>• Poverty<br>• Hard to reach communities | **Urban**<br>• Opportunity to implement weekly HIV-focused service clinics for sub-populations due to high numbers<br>• Opportunity to provide same day appointments for children and their family members<br>• Mobile outreaches for key populations<br>**Rural**<br>• Mobile outreaches to hard-to-reach communities by health facility staff |
| **Unstable setting** | |
| • Conflict<br>• High migration<br>• Insecurity affecting access to ART services<br>• Internally displaced people | • Opportunity to offer multi-month drug refills<br>• Setup ART centres within the camps<br>• Mobile outreaches to the camps |
| **Epidemic type** | |
| • Generalized epidemic<br>• Concentrated epidemic<br>• High/low prevalence<br>• High/low burden | • Peer support<br>• Decentralized services closer to home |

# 5 Differentiated HIV Testing Services

Of an estimated 1.3 million[2] people living with HIV in Uganda, approximately 1,045,015[3] (80%) have been diagnosed. Diagnosing the remaining 20% will require innovative HTS approaches.

This module discusses the differentiated HTS approaches with the aim of helping health facility managers, facility in-charges, health care workers (HCWs), community- based health service providers and other stakeholders to adopt efficient HTS approaches for reaching the undiagnosed PLHIV.

## 5.1. Definition

Differentiated HIV Testing Services are service-delivery models that are adapted to address the specific barriers or bottlenecks requirements of a subgroup of individual clients to enable them to know their HIV status.

## 5.2. Rationale for Differentiated HIV Testing Services

The reason behind introducing differentiated HIV Testing services is to tailor HIV testing services testing services to individual, community, sub-population needs and preferences.

The current HIV counselling and testing services do not meet individual, community and sub-population needs as they are mainly facility based and are characterized by:

1. Client stigmatization
2. Partial integration
3. Low yield in some populations
4. Less attention to those in need of HTS
5. Restrictive legal environment hindering optimal utilization of the current HTS by some populations e.g. MSM, commercial sex workers (CSWs)
6. Untailored group counselling and health education due to the mix of clients

## 5.3. Benefits for Differentiated HIV Testing Services

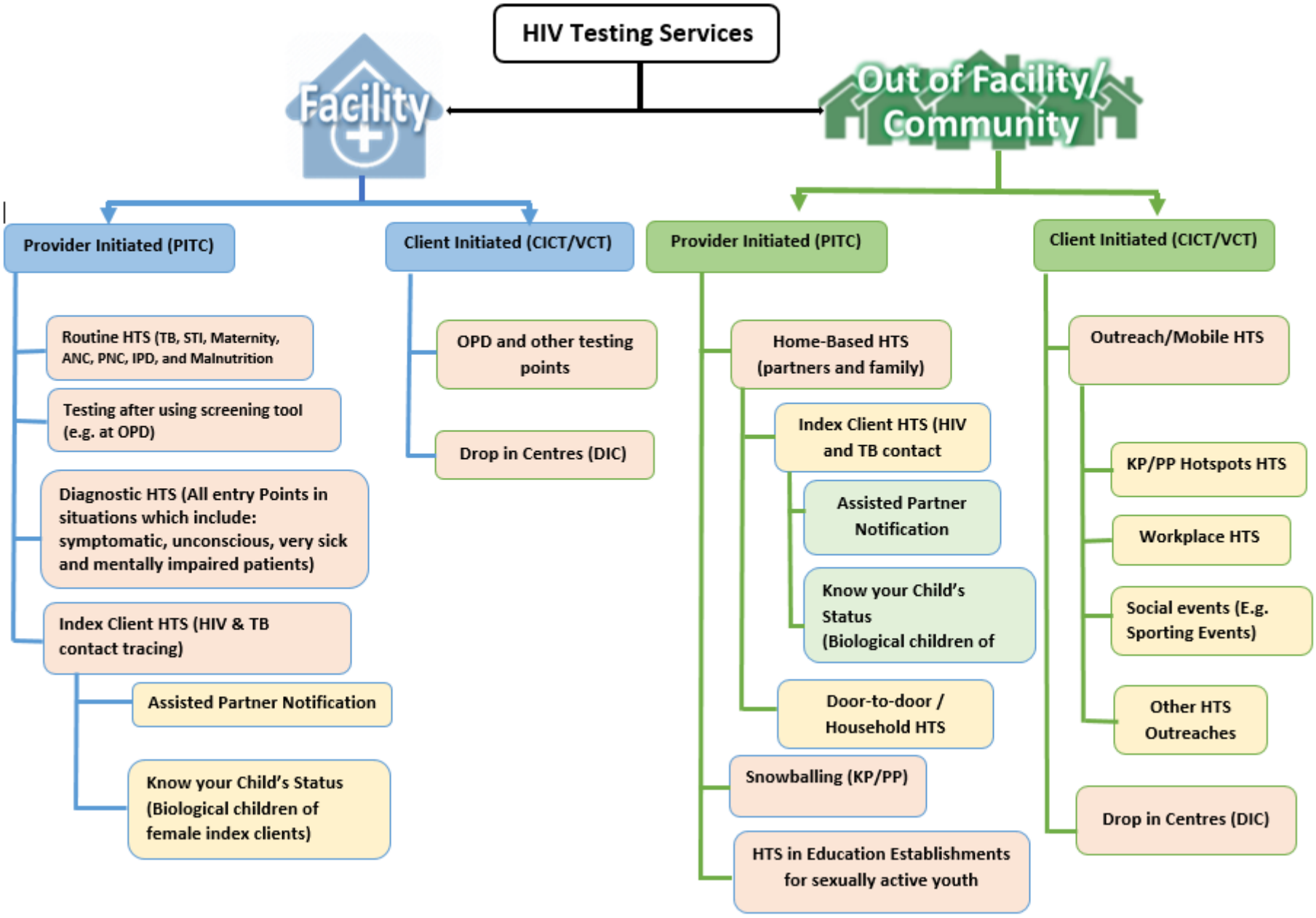
Differentiated HTS will facilitate early diagnosis of HIV-positive people with the aim to maximize yield, efficiency, and cost effectiveness of the country HTS program. Specifically, differentiating HTS will result in:

1. Assessing for HIV risk/exposure and eligibility for testing
2. Targeting to maximize the yield with focus on the high risk and vulnerable sub populations
3. Focusing attention on those in need, based on available data
4. Adapting service delivery to the needs and preferences of patient groups and the constraints of services providers
5. Providing service options and ensuring linkage to treatment and prevention services
6. Integrating of HIV testing and screening with other health service
7. Decentralizing HIV testing and screening to primary healthcare facilities and outside the health system
8. Encouraging and supporting task-shifting

## 5.4. The Recommended Models and Approaches

The recommended ways of differentiating HIV testing and screening include 1) facility-based models and 2) community-based models, summarized in the figure below.

*Figure 4: Recommended differentiated HTS delivery models*



## 5.5. Differentiated HTS Models

### 5.5.1. Facility-Based HTS

These are HIV testing and counselling services offered within existing health facilities and include the following;

I. Provider-initiated testing and counselling (PITC)
II. Client-initiated counselling and testing (CICT or voluntary counselling and testing i.e. VCT)

**Rationale for Facility-Based HTS**

Facility-based HTS provides an opportunity to offer HIV testing to clients coming to the health facility for various reasons.

### 5.5.2. Provider-Initiated Testing and Counselling (PITC)

Under this approach, HTS should be initiated by the health worker as part of standard health care and will be offered as an 'opt–out' HTS service. This can be offered as:

#### a) Routine HTS

This approach shall be offered to clients on a routine basis targeting specific high-risk groups of clients in the facility/clinical settings. The target group for this approach includes patients receiving services in the following units in the health facility: ART, tuberculosis (TB), STI, maternal child health (MCH), maternity, nutrition rehabilitation units and all in-patient wards. At low yield service points like outpatient departments (OPD), routine testing will be guided by HTS eligibility screening tools for children, adolescents and adults who are most at risk, or by use of AIDS related symptom checks or risk of HIV infection.

#### b) Testing after using screening tool

Within OPD settings, HIV testing should be guided by a Screening tool to determine eligibility for HIV testing using the adult and Paediatric & Adolescent Screening Tools.

#### c) Diagnostic HTS

Here HTS is offered in a targeted manner mainly for diagnostic purposes. It shall be carried out on individuals as deemed necessary by the attending health care team with the purpose of better patient management. Such situations may include symptomatic, unconscious, very sick and mentally impaired patients. Through PITC, the patient or attendant should be given an opportunity to know his/her status to promote adherence; prevent further transmission and enhance psychosocial support for the patient[6].

#### d) Index Client HIV and TB Contact Tracing

In this approach, the index client is used to help identify subsequent clients for testing. Partners, children and close family members to the index client are screened for HIV and TB. ART will be an entry point for index client testing. Index client tracing is done through;

##### i. Partner Notification Services (PNS)

This is also known as **Assisted Partner Notification (APN),** a strategy where index clients are interviewed to elicit information about their past and present sexual partners (for HIV infected index clients) and close contacts (for TB infected index clients). Working with the index clients, their

partners can then be confidentially notified of their possible exposure or potential risk to HIV infection and TB and encouraged to test for HIV and TB.

Partner Notification Services should always be voluntary, confidential, and patient-centred and free for both the index patient and his/her partner(s).

#### ii. Know Your Child's HIV Status (KYCS)

This is where HIV positive clients and or TB patients in care are mobilized to bring their children and other household members for HIV testing. This also refers to HIV exposed infants whose mothers come in for postnatal care (PNC), young child clinic (YCC), family planning (FP), gynaecological services e.g. cervical cancer screening

### 5.5.3. Client-Initiated HTS (CITC)

Client Initiated Counselling and Testing (CITC) formerly known as voluntary counselling and testing is where individuals and couples seek HIV testing services on their own. These clients should receive HIV testing and counselling from any trained and certified HTS providers or designees who may be lay providers, counsellors, laboratory personnel and medical workers at any entry point in the facility including drop-in centres at the health facility. This helps avoid missed opportunities.

The table below summarizes the different client sub-populations who can benefit from facility-based integrated HTS as recommended by the WHO and adopted in the 2016 consolidated guidelines for prevention and treatment of HIV in Uganda (WHO HIV[2]).

[2]Consolidated guidelines on HIV testing services. WHO, July 2015. Available from: http://www.who.int/hiv/pub/guidelines/hiv-testing-services/en/

*Table 4: Population groups to be accessed through facility-based HTS approaches and their associated linkage strategies*

| CLIENT POPULATION GROUPS | WHO | WHEN | WHERE | WHAT | WHY? (Unique characteristics) | LINKAGE STRATEGIES |
|---|---|---|---|---|---|---|
| Patients with active TB | • Health care workers at TB clinic/ward i.e. Physician, Clinical Officer, Nurse, Laboratory staff, Routine Counselling and Testing (RCT) volunteer | • At the time of diagnosis<br>• At 4 weeks after initial testing (for those with initial HIV negative result)<br>• During contact tracing<br>• During sputum re-checks<br>• During TB treatment refills | • TB clinic<br>• TB ward | • Routine HIV testing for HIV clients<br>• Diagnostic HTS<br>• Re-test HIV as per HTS guidelines | • Very likely to have HIV co-infection | • Same point/provider enrolment/initiation |
| Patients with presumptive TB | • Department health care workers i.e. Physician, Clinical Officer, Nurse, Laboratory staff, RCT volunteer | • During TB screening<br>• During sputum-collection campaigns | • All departments especially:<br>• MCH clinic<br>• YCC<br>• OPD | • Routine HIV screening | • Very likely to have HIV infection | • Same point/provider initiation/ enrolment in care |
| Pregnant and breastfeeding women and their partners | • Department health care workers i.e. Physician, Clinical Officer, Nurse, Midwife, Laboratory staff, RCT volunteer, Vaccinator | • 1st trimester/1st ANC visit<br>• 3rd trimester/during labour and delivery<br>• Every 3 months until 3 months after cessation of breast feeding | • Antenatal care (ANC), labour and delivery (L&D), PNC<br>• FP clinics<br>• YCC<br>• Mother baby care points | • Routine HIV screening | • These are sexually active and HTS will inform eMTCT interventions | • Same point/provider initiation/ enrolment in care<br>• Mentor mothers escort client to next point of care |

| CLIENT POPULATION GROUPS | WHO | WHEN | WHERE | WHAT | WHY? (Unique characteristics) | LINKAGE STRATEGIES |
|---|---|---|---|---|---|---|
| HIV exposed Infants and children below 18 months | • Department health care workers i.e. Physician, Clinical Officer, Nurse, Midwife, Laboratory staff, RCT volunteer, Vaccinator | • At 6 weeks or at the earliest opportunity thereafter<br>• 6 weeks after cessation of breastfeeding | • Mother Baby Care Point (MBCP)<br>• OPD<br>• Inpatient department (IPD)<br>• Immunization<br>• YCC<br>• PNC | • Routine early infant diagnosis through virological DNA/PCR | • High risk of morbidity and mortality if not diagnosed and initiated on ART early<br>• Likely to be severely ill and HIV infection could be the underlying cause of disease severity<br>• Likely to have delayed development milestones | • Mentor mothers<br>• Other expert clients at various entry points<br>• Same point/provider initiation/ enrolment in care |
| Children 18 months to below 10 years | Department health care workers i.e. Physician, Clinical Officer, Nurse, Midwife, Laboratory staff, RCT volunteer, Vaccinator | • Admitted<br>• Malnourished<br>• Orphans and vulnerable children (OVC)<br>• Symptomatic<br>• Mother is HIV positive<br>• History of hospitalization in the last 6 months<br>• Diagnosed with presumptive TB<br>• TB diagnosed<br>• History of TB treatment<br>• Sexually abused<br>• Accidental exposure | • In-patient department<br>• Out-patient department<br>• Young Child Clinics<br>• TB Clinics<br>• HIV care and treatment Clinics<br>• Nutrition Clinics | • PITC<br>• KYCS (including holiday campaigns)<br>• Index client tracing and testing | To identify HIV infected children who were missed by the EID program | • Linkage facilitators<br>• Same point/provider initiation/ enrolment in care |

| CLIENT POPULATION GROUPS | WHO | WHEN | WHERE | WHAT | WHY? (Unique characteristics) | LINKAGE STRATEGIES |
|---|---|---|---|---|---|---|
| Adolescents (10-19 years) in and out of school | • Department health care workers i.e. Physician, Clinical Officer, Nurse, Midwife, Laboratory staff, RCT volunteer. Youth Peers | • During safe male circumcision (SMC)<br>• Admitted<br>• Malnourished<br>• OVC<br>• Symptomatic<br>• Mother is HIV positive<br>• History of hospitalization in the last 6 months<br>• Diagnosed with presumptive TB<br>• TB diagnosed<br>• History of TB treatment<br>• Sexually abused<br>• Accidental exposure | • IPD<br>• OPD<br>• Adolescent friendly clinics/corners<br>• ANC<br>• FP clinics<br>• STI clinics<br>• Youth centres<br>• Institutions of higher learning (if located within the health facility e.g. training schools) | • PITC<br>• Index client tracing and testing<br>○ KYCS (including holiday campaigns)<br>• Special facility campaigns<br>• Special/flexible hours, walk-ins or same-day appointments | • Characterized with vulnerabilities which increase risk to HIV infection and yet they have a poor health seeking behaviour<br>• May be sexually active and/or abusing drugs<br>• Inadequate adolescent friendly services in facilities | • Adolescent peer educators<br>• Linkage facilitators<br>• Adolescent Health services focal persons |
| Youth (20 – 24 years) | • Department health care workers i.e. Physician, Clinical Officer, Nurse, Midwife, Laboratory staff, RCT volunteer, Vaccinator, Youth Peers | • During SMC<br>• During sporting events<br>• When they meet the criteria as per the adult screening tool | • IPD<br>• OPD<br>• ANC<br>• FP clinics<br>• STI clinics<br>• Youth centres<br>• Institutions of higher learning if located within the health facility e.g. training schools) | • PITC<br>• Index client tracing and testing<br>• Special facility campaigns<br>• Special/flexible hours, walk-ins or same-day appointments | • Have a low risk perception<br>• They have a need to experiment with sex and therefore engage in high risk sexual behaviour | • Youth Peer educators<br>• Linkage facilitators<br>• Same point/provider initiation/ enrolment in care |

| CLIENT POPULATION GROUPS | WHO | WHEN | WHERE | WHAT | WHY? (Unique characteristics) | LINKAGE STRATEGIES |
|---|---|---|---|---|---|---|
| Men | • Department health care workers i.e. Physician, Clinical Officer, Nurse, Midwife, Laboratory staff, RCT volunteer, Vaccinator | • During SMC<br>• Routine care when they accompany their wives for ANC, L&D and PNC<br>• When they meet the criteria as per the adult screening tool | • MNCH clinics<br>• STI/Most At Risk Populations (MARPs) clinics<br>• In non-communicable diseases' clinics (diabetes mellitus, i.e. DM, hypertension, i.e. HT)<br>• IPD (male ward)<br>• OPD<br>• Reproductive health clinics | • VCT<br>• PITC<br>• Index client contact tracing<br>○ Partner notification<br>Self-testing**<br>Testing for men can be provided during evening/weekends/after work hours | • Poor seeking health behaviour<br>• Least likely to access HTS under routine health care due to fear, stigma, perception that health services are for females | • Male change Agents<br>• Same point/provider initiation/ enrolment in care |
| Adults | • Department health care workers i.e. Physician, Clinical Officer, Nurse, Midwife, Laboratory staff, RCT volunteer | • When they meet the criteria as per the adult screening tool | • IPD<br>• OPD<br>• Non-communicable diseases clinics (DM, HT, cancer)<br>• Rehabilitation units | • PITC<br>• VCT | • If seeking care in HFs, are likely to be very sick and HIV could be the underlying infection | • Linkage facilitators<br>• Same point/provider initiation/ enrolment in care |
| Persons With Disabilities (PWDs) | • Department health care workers i.e. Physician, Clinical Officer, Nurse, Midwife, Laboratory staff, RCT volunteer | • Routine care<br>• When there is history of sexual abuse | • Rehabilitation units<br>• Physiotherapy clinics<br>• IPD<br>• OPD<br>• Orthopaedic<br>• Occupational therapy units | • PITC<br>• VCT | • May not easily negotiate for safe sex, and often are sexually violated<br>• May have low literacy rates<br>• Communication of HIV and AIDS messages may be more difficult<br>• HTS may be physically inaccessible | • Peer educators for PWDs<br>• Linkage facilitators<br>• Same point/provider initiation/ enrolment in care |

| CLIENT POPULATION GROUPS | WHO | WHEN | WHERE | WHAT | WHY? (Unique characteristics) | LINKAGE STRATEGIES |
|---|---|---|---|---|---|---|
| Health workers* | • Fellow health care workers i.e. Physician, Clinical Officer, Nurse, Midwife, Laboratory staff, RCT volunteer | • Routine care<br>• When there is history of high risk exposure | • Staff clinics<br>• Work places | • PITC<br>• VCT<br>• Post exposure prophylaxis (PEP)<br>• HIV Self-testing** | • Likely to face self-stigma and may not access HTS easily<br>• Occupational exposure/hazard at the workplace puts them at a higher risk | • Same point/provider initiation/ enrolment in care |
| Couples and sexual partners | • Department health care workers i.e. Physician, Clinical Officer, Nurse, Midwife, Laboratory staff, RCT volunteer | • During routine care<br>• During discordant couples' meetings | • MNCH clinics<br>• Couple meetings<br>• HIV care and treatment clinics<br>• STI and FP clinics<br>• IPD<br>• OPD | • Index client contact tracing and Partner Notification<br>• VCT<br>• Couple and Partner HTS | • Have high incidence of HIV infection<br>• May be in discordant relationships, distant relationships and/or have multiple sexual partners | • Linkage facilitators<br>• Mentor mother<br>• Male change Agents<br>• Same point/provider initiation/ enrolment in care |
| Inpatients | • IPD HCWs | • Routine patient care services | • IPD | • PITC | • Likely to have underlying HIV infection | • Same point/provider initiation/ enrolment in care |

**Health workers can fall in all the other categories of the population*

***Self-testing will be applicable after the Ministry of Health has adopted it*

### 5.5.4. Out-Of-Facility-Based HTS

These are HIV testing services offered in community settings, (outside the confines of the health facility) for example home-based index testing, door-to-door, outreach, or service provision in schools, workplaces and other community venues.

These include the following;

I. Provider-initiated testing and counselling (PITC)
II. Client-initiated counselling and testing (CICT or voluntary counselling and testing i.e. VCT)

**Rationale for Out-Of-Facility/Community-Based HTS**

Out-of-facility-based HTS provides an opportunity to offer HIV testing to clients who do not come to the health facility. It aims to take services closer to potential clients as well as reaching under-served groups

### 5.5.5. Provider-initiated HIV testing and counseling (PITC)

This is HIV testing and counselling offered by health care providers to persons in a setting out of the health care facilities. Under this approach, HTS can be initiated by the health worker as home-based HTS or snowballing.

### 5.5.6. Home-Based HTS (HBHTS)

This is where the health care worker (preferably the one who tested the index client) provides HTS in a home setting through an index client's consent or a door-to-door approach. Index client HBHTS should be prioritized for household members of all HIV-positive individuals in care/treatment; newly identified HIV positive; and confirmed and presumptive TB patients

#### a) Index Client Contact Tracing And Testing

This is a strategy whereby partners and family members of an identified HIV-positive client or TB patient are identified and offered HTS. It is recommended that at first contact with the index client, the health care providers should capture family members' details and ensure un-tested members are contacted and offered HTS. Health workers should routinely review their clients' HIV care cards and the Family Tracking Tool to identify family members that have not been offered an HIV test.

Index client testing approaches include:

i. ***HIV and TB Contact Tracing and Assisted Partner Notification (Partner Services).***
Index clients are interviewed to elicit information about their past and present sexual partners (for HIV infected index clients) and close contacts (for TB infected index clients). Working with the index clients, their partners can then be confidentially notified of their possible exposure or potential risk to HIV infection and TB and encouraged to test for HIV and TB.

***ii. Know Your Child Status:***
Households of HIV+ clients and/or TB patients in care are visited to test their children and other household members for HIV testing.

**b) Snowball Approach:**

In this approach, the HTS team works with the index client to invite other members of his/her group for HTS using a peer-to-peer approach. This approach is recommended for use among sex workers (SW), men who have sex with men (MSM), and people who inject drugs (PWIDs).

**HIV Self-Testing (HIVST)**

This is a screening approach in which a client performs their own test and interprets the results. HIVST does not provide a diagnosis for HIV. All reactive self-test results should be confirmed using the approved national HIV testing algorithm.

### 5.5.7. Client-Initiated HTS (CICT)

Client Initiated Counselling and Testing (CICT) formerly known as voluntary counselling and testing is where individuals and couples seek HIV testing services on their own. These clients should receive HIV testing and counselling by trained and certified HTS providers or designees who may be lay providers, counsellors, laboratory personnel and medical workers. CICT in the community can be provided at an outreach point (e.g. KP/PP hotspot, social events, workplace etc) or at a community drop in centre.

### 5.5.8. Outreach/Mobile HTS

This approach should target priority populations that otherwise have limited access to HTS services. Outreach HTS can include:

i. ***HTS outreaches in locations frequented by target populations*** like key population hotspots, sporting events. These outreaches could include moonlight testing and mobile clinics.

ii. **Workplace HTS**
This approach gives opportunities to employees, their families, and communities to access HTS services in the workplace. Workplace HIV testing should be confidential, delivered in a safe environment and should not be abused. Disclosure of HIV sero-status is at the discretion of the employee.

### 5.5.9. Drop in centres

Drop-in centres are service delivery points targeting special sub-populations (e.g. commercial sex workers (CSW), mem who have sex with fellow men (MSM), transgender, long distance truck drivers etc) who would otherwise fail to access health services including HTS. These can be established by Community Based Organizations or ministry of health together with its partners.

The table below summarizes the population groups that can be accessed through community-based HTS approaches

*Table 5: Population groups to be accessed through out-of-facility/community-based HTS approaches and their associated linkage strategies:*

| CLIENT POPULATION GROUP | WHO | WHEN | WHERE | WHAT | WHY? (Unique characteristics) | LINKAGE STRATEGY |
|---|---|---|---|---|---|---|
| Household members of index clients with TB and/or HIV | • Health Care Workers i.e. Clinical officer, Nurse, Midwife, Laboratory staff, RCT volunteer | • During sputum-collection campaigns<br>• During contact tracing | • At home<br>• Community-based stand-alone-testing points<br>• In establishments<br>• In high prevalence areas | • Index client contact testing<br>• Targeted mobile outreaches | There may be at-risk individuals (e.g. sexual partners, partners in discordant relations, children of the index client) in that household who may not know their HIV status and are unlikely to attend the health facility | • Index client<br>• Linkage facilitators<br>• Health Care Workers |
| OVCs, adolescent girls, and young women | • Health Care Workers i.e. Clinical officer, Nurse, Midwife, Laboratory staff, RCT volunteer, Youth Peer | • During OVC-HTS integrated outreach camps<br>• During integrated immunization outreaches<br>• During integrated Sexual and Reproductive Health outreaches | • Home visits to OVC-headed household families<br>• Homes<br>• In communities<br>• Churches<br>• Orphanages | • Index client contact testing<br>• Outreaches | Have difficulty in accessing HIV services due to limited socio-economic capacity | • Adolescent peer educators<br>• Linkage facilitators<br>• Health Care Workers |
| Infants and children | • Health Care Workers i.e. Clinical officer, Nurse, Midwife, Laboratory staff, RCT volunteer, Vaccinator | • During integrated immunization outreaches<br>• During scheduled home visits<br>• During contact tracing | • At home<br>• Community | • EID through virological DNA/PCR<br>• Index client contact tracing<br>• Integrated Immunization outreach campaigns | • High risk of morbidity and mortality if not diagnosed early and initiated on ART.<br>• To identify HIV infected children who were missed by the Early Infant Diagnosis (EID) program | • Same point/provider initiation/ enrolment in care<br>• Linkage facilitators<br>• Village health teams (VHTs)/Community health extension workers (CHEWS) |

| CLIENT POPULATION GROUP | WHO | WHEN | WHERE | WHAT | WHY? (Unique characteristics) | LINKAGE STRATEGY |
|---|---|---|---|---|---|---|
| Lactating women | • Health Care Workers i.e. Nurse, Midwife, Laboratory staff, RCT volunteer | • During integrated immunization outreaches | • Communities | • Outreaches | • Women and their partners are sexually active<br>• HTS will inform PMTCT interventions | • Mentor mothers<br>• Linkage facilitators<br>• VHTs/CHEWS<br>• Health Care Workers |
| People with limited access to HIV Testing Services *(minorities, PWDs, elites)* | • Health Care Workers i.e. Physician, Clinical officer, Nurse, Midwife, Laboratory staff, RCT volunteer | • During integrated HTS outreaches<br>• During index contact tracing<br>• When there is history of sexual abuse | • Community-based stand-alone testing points.<br>• In establishments<br>• Underserved areas<br>• Homes<br>• Workplace | • Index contact tracing<br>• Outreaches to workplaces (camps)<br>• Stand-alone HTS<br>• Door-to-door outreach services in high prevalence geographical areas | • Limited access due to lack of confidentiality and privacy<br>• Sometimes criminalized<br>• Often stigmatized due to their status<br>• Poor health seeking behaviour (elites)<br>• May not easily negotiate for safe sex, and often are sexually violated<br>• May have low literacy rates<br>• HTS may be physically inaccessible | • Index client<br>• Peer educators<br>• Change agents/role models<br>• Linkage facilitators<br>• Health Care Workers |
| Rural communities | • Health Care Workers i.e. Clinical officer, Nurse, Midwife, Laboratory staff, RCT volunteer | • During mother and child health outreaches<br>• During SMC<br>• During events e.g. football matches | • Community-based stand-alone testing points<br>• In establishments<br>• In underserved areas<br>• Homes<br>• In high prevalence geographical areas | • Mobile testing<br>• Index contact tracing<br>• Door-to-door outreach services<br>• Targeted integrated outreach services | • Limited access to HTS and other health care services | • VHTs/CHEWs<br>• Linkage facilitators<br>• Health Care Workers |

| CLIENT POPULATION GROUP | WHO | WHEN | WHERE | WHAT | WHY? (Unique characteristics) | LINKAGE STRATEGY |
|---|---|---|---|---|---|---|
| Men | • Health Care Workers i.e. Clinical officer, Nurse, Midwife, Laboratory staff, RCT volunteer<br>• Client | • During VMMC<br>• During sports events<br>• During religious and other organization gatherings (Fathers union, Rotary club etc.)<br>• During index client contact tracing<br>• When they meet the criteria as per the adult screening tool | • Community based stand-alone testing points<br>• At home<br>• Work places – offices, boda stages, betting halls, brothels etc.<br>• Recreation places (sports venues, saunas, bars etc.) | • Index client contact tracing<br>• HIV self-testing<br>• Targeted HTS integrated within outreach services<br>• Targeted mobile outreaches<br><br>Testing for men can be provided during evening/weekends/after work hours | • Least likely to access HTS under routine health care due to fear, stigma, and/or the perception that health services are for females | • Change agents/role models<br>• Same provider initiation/ enrolment in care<br>• Index clients<br>• Linkage facilitators |

There is still a big unmet need for HTS among key populations due to limited access to health services in Uganda, yet HIV incidence and prevalence is high amongst this population[7]. HTS for key populations should be offered through innovative community and facility-based approaches (see Table 6). Peer-led strategies should be prioritized for key populations.

*Table 6: Key population and other high risk population-specific differentiated approaches and their associated linkage strategies*

| POPULATION CATEGORY | WHO | WHEN | WHERE | WHAT | WHY? (Unique characteristics) | Linkage approaches |
|---|---|---|---|---|---|---|
| MSM | • Health Care Workers i.e. Clinical officer, Nurse, Midwife, Laboratory staff, RCT volunteer<br>• Client | • Routinely as part of healthcare<br>• Every 3 month i.e. re-testing for the HIV negatives | • High prevalent areas<br>• Safe places<br>• At health facilities<br>• Hot spots<br>• Drop-in centres<br>• Friendly clinics<br>• Organized network meetings<br>• Community-based stand-alone testing points<br>• Moonlight clinics<br>• Mobile clinics<br>• Specialized clinics | • HIV self-testing<br>• Outreaches<br>  ○ Targeted<br>  ○ Stand-alone<br>• Snow ball approach<br>• PITC<br>• VCT | • Unlikely to seek health services because of the unfavourable legal environment because they are not recognized<br>• Have stigma that may stop them from accessing HTS | • MSM Peer leaders<br>• KP focal persons |
| Sex workers and their clients | • Health Care Workers i.e. Clinical officer, Nurse, Midwife, Laboratory staff, RCT volunteer | • Routinely as part of healthcare<br>• Every 3 month i.e. re-testing for the HIV negatives | • Hot spots<br>• Brothels<br>• Drop-in centres<br>• Specialized clinics | • HIV and TB Index client contact tracing<br>• HTS outreaches<br>• Moonlight services<br>• Snow ball approach<br>• PITC<br>• VCT | • Highly mobile<br>• Are stigmatized<br>• Drivers of the epidemic | • SW Peer educators<br>• KP focal persons |

| POPULATION CATEGORY | WHO | WHEN | WHERE | WHAT | WHY? (Unique characteristics) | Linkage approaches |
|---|---|---|---|---|---|---|
| People who use and inject Drugs (PWID) and transgender (TG) people | • Health Care Workers i.e. Clinical officer, Nurse, Midwife, Laboratory staff, RCT volunteer | • Routinely as part of healthcare<br>• Every 3 month i.e. re-testing for the HIV negatives | • Specialized clinics e.g. MARPI<br>• STI clinics | • Snowball approach<br>• PITC<br>• VCT<br>• Index client contact tracing | • Are stigmatized<br>• Because of their high risky behaviour | • PWID Peer leaders<br>• KP focal persons |
| Fisher Folk | • Health Care Workers i.e. Clinical officer, Nurse, Midwife, Laboratory staff, RCT volunteer | • Routinely as part of healthcare<br>• Every 3 month i.e. re-testing for the HIV negatives | • Landing sites<br>• Brothels | • Targeted community outreaches<br>• PITC<br>• VCT<br>• Index client contact tracing | • Because of their high risky behaviour<br>• Their lifestyles keep them in water for long hours<br>• Migratory nature | • Peer educators<br>• Linkage facilitators<br>• VHTs/CHEWs<br>• Health Care Workers |
| Long distance track drivers | • Health Care Workers i.e. Physician, Clinical officer, Nurse, Midwife, Laboratory staff, RCT volunteer | • Routinely as part of healthcare<br>• Every 3 month i.e. re-testing for the HIV negatives | • Hot spots – along major highways<br>• Drop-in centres<br>• Specialized clinics | • HIV and TB Index client contact tracing<br>• HTS outreaches<br>• Moonlight services<br>• Snow ball approach<br>• PITC<br>• VCT | • Highly mobile<br>• Drivers of the epidemic | • Same point/provider initiation/ enrolment in care<br>• Linkage facilitators |
| Sexual gender based violence (SGBV) survivors | • Health Care Workers i.e. Physician, Clinical officer, Nurse, Midwife, Laboratory staff, RCT volunteer | • Routinely as part of healthcare<br>• At first contact, then 1 month, 3 months and 6 months after completing PEP course | • Facilities | • PITC<br>• VCT | • Have history of sexual abuse<br>• SGBV has the potential to increase the risk of acquiring HIV | • Linkage facilitators<br>• Health Care Workers |
| Uniformed personnel: Armed forces, Police, Prison Services | • Health Care Workers i.e. Physician, Clinical officer, Nurse, | • Routinely as part of healthcare | • Institution health facilities e.g. Military barracks etc. | • Targeted HTS campaigns/testing events | • Migratory nature<br>• Because of their high risky behaviour | • Peer educators<br>• Same point/provider |

| POPULATION CATEGORY | WHO | WHEN | WHERE | WHAT | WHY? (Unique characteristics) | Linkage approaches |
|---|---|---|---|---|---|---|
| and private guards | Midwife, Laboratory staff, RCT volunteer | • Every 3 month i.e. re-testing for the HIV negatives | | • PITC at their health facilities<br>• Workplace testing | | initiation/ enrolment in care<br>• Linkage facilitators |
| People in prisons and other closed settings | • Health Care Workers i.e. Clinical officer, Nurse, Midwife, Laboratory staff, RCT volunteer | • At reception<br>• Every 3 month i.e. re-testing for the HIV negatives | • Within prisons<br>• At refugee settlements | • PITC<br>• Targeted outreaches | • Incarcerated and hence have restricted access to health facilities | • Same point/provider initiation/ enrolment in care |
| Refugees and other persons of concern to UNHCR | • Health Care Workers i.e. Clinical officer, Nurse, Midwife, Laboratory staff, RCT volunteer | • Routinely as part of standard care | • Health facilities within catchment area<br>• Refugee settlements | • PITC<br>• Targeted HTS outreaches in refugee settlements<br>• VCT | • Because of their refugee status<br>• Lack information about where to go<br>• Fear travelling<br>• Have limited access to HTS<br>• More susceptible to discrimination, violence, sexual abuse and abandonment upon disclosure of an HIV positive result | • VHTs/CHEWs<br>• Linkage facilitators<br>• Health Care Workers |
| Plantation workers e.g. sugar cane. Tea, palm trees | • Health Care Workers i.e. Physician, Clinical officer, Nurse, Midwife, Laboratory staff, RCT volunteer | • Routinely as part of healthcare | • Institution health facilities<br>• At Health facilities<br>• At workplaces | • Targeted HTS campaigns/testing events<br>• PITC at their health facilities<br>• Workplace testing | • Because of their high risky behaviour | • Peer educators<br>• Same point/provider initiation/ enrolment in care<br>• Linkage facilitators |

| POPULATION CATEGORY | WHO | WHEN | WHERE | WHAT | WHY? (Unique characteristics) | Linkage approaches |
|---|---|---|---|---|---|---|
| People in mining industry e.g. petroleum, gold, sand etc. | • Health Care Workers i.e. Physician, Clinical officer, Nurse, Midwife, Laboratory staff, RCT volunteer | • Routinely as part of healthcare | • Institution health facilities<br>• At Health facilities<br>• At workplaces | • Targeted HTS campaigns/testing events<br>• PITC at their health facilities<br>• Workplace testing | • Because of their high risky behaviour | • Peer educators<br>• Same point/provider initiation/ enrolment in care<br>• Linkage facilitators |
| Migrant workers e.g. Road construction workers | • Health Care Workers i.e. Physician, Clinical officer, Nurse, Midwife, Laboratory staff, RCT volunteer | • Routinely as part of healthcare | • At Health facilities<br>• At workplaces | • Targeted HTS campaigns/testing events<br>• PITC at health facilities<br>• Workplace testing | • Because of their high risky behaviour | • Peer educators<br>• Same point/provider initiation/ enrolment in care<br>• Linkage facilitators |
| Other people in the transport industry e.g. Boda boda riders, Taxi drivers etc. | • Health Care Workers i.e. Physician, Clinical officer, Nurse, Midwife, Laboratory staff, RCT volunteer | • Routinely as part of healthcare<br>• Every 3 month i.e. re-testing for the HIV negatives | • At Health facilities<br>• At workplaces | • Targeted HTS campaigns/testing events<br>• PITC at health facilities<br>• Workplace testing | • Because of their high risky behaviour | • Peer educators<br>• Same point/provider initiation/ enrolment in care<br>• Linkage facilitators |

## 5.6. HIV SELF-TESTING (HIVST)

HIV Self-Testing (HIVST) is a process in which a person collects his or her own specimen (oral fluid or blood), then performs a test and interprets the result, often in a private setting, either alone or with someone he or she trusts.

HIV self-testing shall be offered as an additional approach to HIV Testing Services in Uganda. HIVST does not confirm a diagnosis for HIV. All reactive self-test results should be confirmed using the approved national HIV testing algorithm.

Refer to the HTS policy and implementation guidelines addendum 2018 for further guidance on implementation of HIVST.

## 5.7. Integration of TB Screening with HIV Testing Services

All clients tested for HIV should also be screened for TB. Family members of index HIV+ clients should be screened for TB at the time of index client HIV contact testing. Clients/family members presumed to have TB should be registered in the TB presumptive register and thoroughly investigated for TB.

## 5.8. Opportunities for Addressing Barriers to HTS

Facilities should use the following three approaches to increase yield:

**a) Integration**

Offering HTS together with other care services (e.g. primary care, antenatal care, immunization).

**b) Focusing on specific population groups at an increased risk of having HIV**

This increases the yield from HTS.

**c) Geographical targeting of people most at risk**

This helps reach under-served populations or those at increased risk of having HIV who cannot easily access HTS, including higher risk and specific localized epidemics (so-called “hotspots”), for example; mines and factories with high levels of air pollution (TB risk), fishing encampments, truck stops and areas of poverty or overcrowding where there is the greatest need for HIV and /or TB treatment and prevention.

## 5.9. Quality Assurance for HIV Testing Services

This refers to adherence to HTS standards, conducting quality control and continuous quality improvement for HTS.

**a) Adherence to HTS standards**

This includes working by and sticking to the national protocols, algorithms and guidelines for HTS. All sites/points that provide HTS should have standard operating procedures that provide detailed instructions on all aspects of testing including:

- Request for the test
- Environmental requirements
- Quality control instructions
- Appropriate use of the testing algorithm
- Steps for conducting the test
- Test interpretation

- Reporting and recording of results
- Storage of HIV test kits
- Inventory information and
- Any internal and external quality assurance requirements.

Adherence to HTS standards requires conformity to the core principles of HTS including: Confidentiality, Consent, Counselling, Correct test results and Connection to care, treatment and support.

**b) Conducting quality control**

Routine internal and external quality assurance and quality control for HIV testing should be performed and documented at all HTS sites/points. For external quality assurance, all testers must be enrolled on the MOH Proficiency Testing (PT) program and must participate routinely upon receipt of panels sent to them.

Quality assurance for HTS is important and paramount, especially in the community where it is likely to be done by less skilled cadres such as counselors or expert clients. Technical laboratory personnel should supervise HIV testing at the community, conduct competency assessments of personnel performing HTS, and regularly pick samples for quality assurance testing.

**c) Continuous Quality Improvement for HTS**

HTS data should be used to track performance, identify gaps and apply continuous quality improvement approaches to improve performance at different levels.

## 5.10. Differentiating for Linkage to Care

Incorporation of linkage to HIV Care and Treatment into the differentiated HIV testing and screening models is key to achieving enrolment into care. This enhances the effectiveness of testing models and reduces the number of confirmed cases that are lost to follow up along the way. Individuals who test HIV negative should also be referred to appropriate HIV prevention services, including SMC, Pre-exposure prophylaxis (PrEP), STI prevention and management, and condoms. Individuals who test HIV positive should be linked to care and treatment services through:

- Use of triplicate referral and linkage forms between units/departments within the same facility
- Linkage facilitators including Expert Clients and volunteers can accompany clients between units
- HCWs escorting clients to various units/departments

Facility and community models can use existing linkage opportunities to maximize the enrolment of all HIV infected referred individuals. For all linkages, verification must be made to ensure that clients have received the services. (Refer to the National HIV Testing Services Policy and Implementation Guidelines 2016).

Tables 2, 3, 4, 5 and 6 summarize the linkage strategies for populations that access services at the facility, community as well as the key populations and high-risk populations, respectively.

# 6 Differentiated HIV Care and Treatment

Of an estimated 1.3 million[2] people living with HIV in Uganda, approximately 1,045,015 (80%) have been diagnosed and 1,028,909 (79.1%) initiated on ART[3]. Achieving the second '90' of the UNAIDS goal of having 90% of all HIV-positive individuals on treatment requires innovative approaches to HIV Care and Treatment services.

This module aims to explain to the health care workers the different HIV care and treatment approaches that can accelerate the achievement of this target.

## 6.1. Definition

Differentiated HIV Care and Treatment refers to a strategic mix of approaches to address the specific requirements of a subgroup of clients living with HIV.

It includes approaches aimed at modifications of client flow, schedules and location of HIV Care and Treatment services for improved access, coverage, and quality of care.

## 6.2. Rationale for Differentiated HIV Care and Treatment

The current service delivery models in most health facilities in Uganda are characterized by:

- Overcrowding of clients on clinic days
- Delays in service delivery
- Heavy work load due to monthly refills, poor appointment management, etc.
- Repetitive and unnecessary clinic visits (to stable clients)
- Unnecessary mixing of clients and services e.g. adolescents and adults; weak and stable patients
- Untailored group counselling and health education due to the mix of clients

Majority of the clients are stable and now need HIV care and treatment services tailored to their needs. This will result into client-focused and health system benefits (table 7), in addition to

- Reduce pressure for medicine refills at the health facility
- Optimize staff work load hence increase service delivery cost-efficiency
- Reduce the frequency/burden of travels to facilities hence provide clients more opportunities to engage in other activities (e.g. house hold activities, Income generating activities, etc.)
- Provide opportunities for tailored counselling and health education
- Improve client care and treatment outcomes

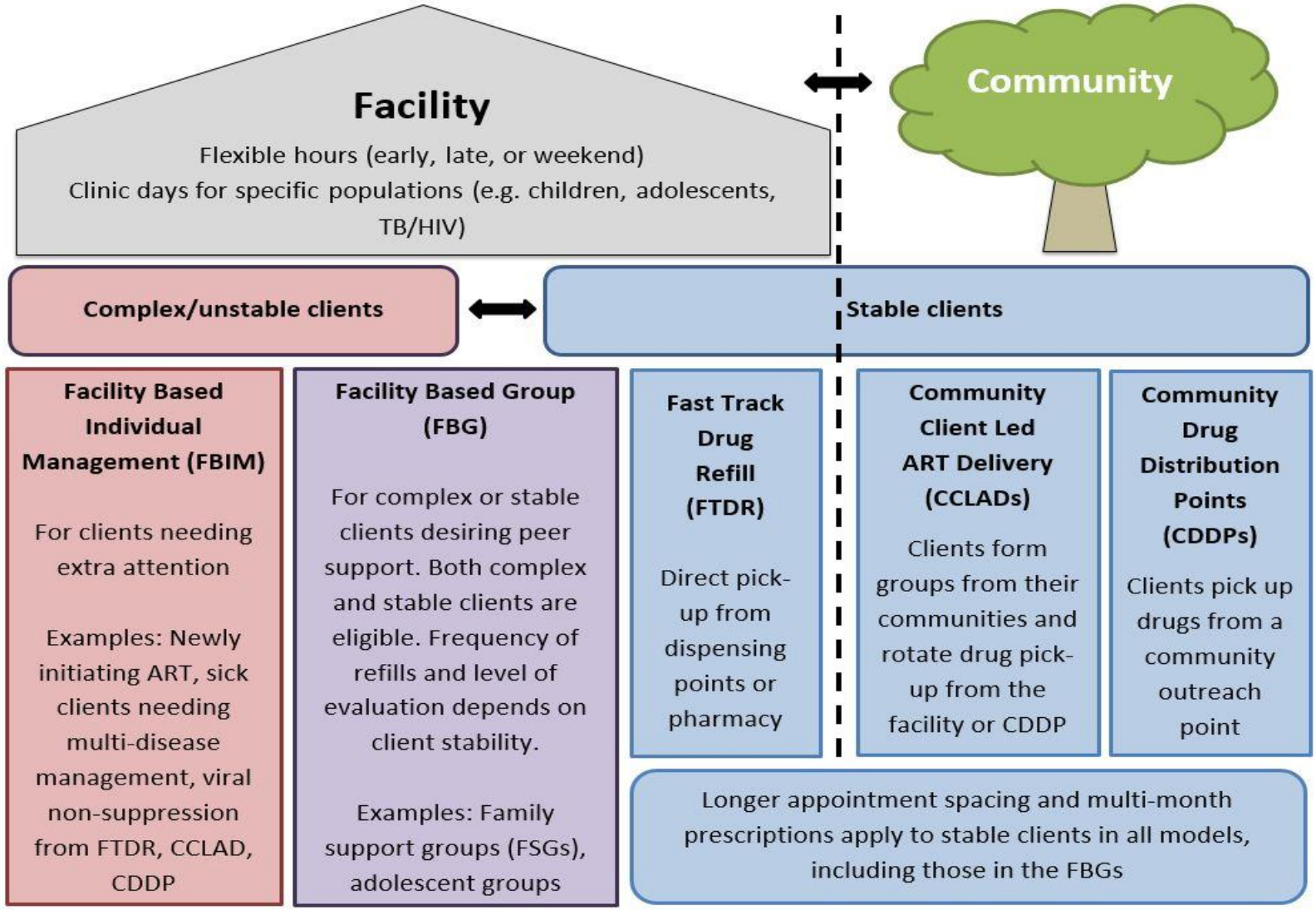
*Table 7: Benefits of differentiated HIV care and treatment*

| System focus | Benefit |
|---|---|
| Client-focused benefits | • Reduced number of visits for stable clients leading to reduced costs<br>• Empowerment and involvement/rights – clients will be able to better manage their own care<br>• Reduced waiting time leading to client satisfaction<br>• Increased access and adherence (for community delivery)<br>• Increased/improved linkage to supportive services (e.g. gender based violence (GBV), nutrition support, psychosocial support e.g. family support groups - FSGs)<br>• Promotes GIPA (greater involvement of people living with HIV) e.g. expert clients |
| Systems benefits | **Human Resource**<br>• Anticipated to improve health workers' attitudes through training, reduced workload through task-shifting/sharing hence spreading the burden to many health workers.<br>• Targets skill to those that are in more need<br>**Governance/leadership**<br>• There will be an opportunity to engage leadership at the district and health facility levels.to lead and coordinate; advocate for; and conduct social mobilization for DSD implementation<br>**Service Delivery**<br>• Increased coverage<br>• Improved quality of services<br>• Facilitate the 90-90-90 target<br>**Medicines/logistics systems**<br>• Improved supply chain management<br>**Financial management**<br>• Improved efficiency – achieving program goals at lower costs<br>**HMIS**<br>• Less data for a clinic per day/encounter<br>• Improved quality of data |

## 6.3. The Recommended Models and Approaches

The recommended ways of differentiating HIV care and treatment include 1) facility-based models and 2) community-based models, summarized in the figure below.

*Figure 5: Recommended differentiated care and treatment service delivery models and their respective target populations*



## 6.4. Differentiated Facility-Based HIV Care and Treatment Models

These refer to HIV Care and Treatment services offered within the confines of the health facility. The various differentiated approaches are described below.

## 6.5. Who Are the Clients?

There are two categories of clients (1) Stable and (2) Unstable/complex. The table below summarizes the minimum characteristics for categorization:

*Table 8: The differentiated client categories and their characteristics*

| **Stable Clients** | **Unstable/Complex Clients** |
|---|---|
| • PLHIV (Children, Adolescents, Pregnant and lactating women and adults) on current ART regimen for more than 6 months*<br>• On 1st or 2nd line ART regimens<br>• Virally suppressed: Most recent viral load result suppressed and still valid as per the viral load algorithm<br>• WHO stages 1 or 2<br>• Demonstrated good adherence (over 95%) in the last 6 consecutive months<br>• TB clients who have completed 2 months intensive phase treatment and are sputum negative for PTB | • PLHIV (Children, Adolescents, Pregnant and lactating women and adults) on current ART regimen for less than 6 Months<br>• On 3rd line ART regimen<br>• Not virally suppressed or with a valid suppressed viral load result.<br>• Has current or history of WHO stages 3 or 4 opportunistic infections within the past one year<br>• Poor adherence (less than 95%)<br>• TB clients in intensive phase of treatment (< 2 months) or who are still sputum positive after intensive phase treatment for PTB.<br>• MDRTB/HIV co-infected clients |

***All stable clients transitioned to new regimen due to policy changes (e.g. ART optimization) shall still be considered stable if all other factors stay constant. Pharmacovigilance MUST be emphasized.***

Clients must first be categorized as either stable or unstable/complex. This will determine the model and approach that they will be differentiated to.

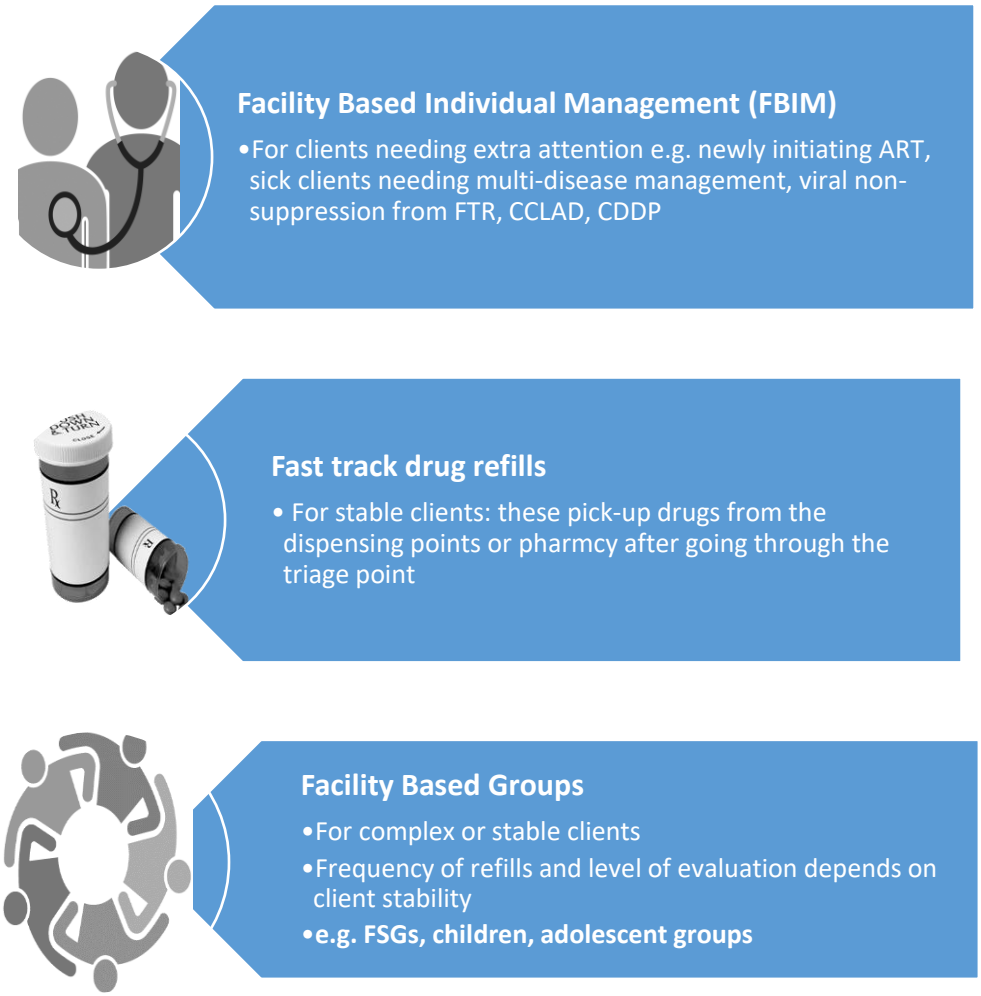
**KEY CONSIDERATIONS:**

1. For a client to be stable, must meet all the above criteria for stable clients.
2. Clients with uncontrolled chronic co-morbidities (e.g. Hypertension, Diabetes, Cardiac diseases and renal diseases) should be considered unstable until control is achieved.
3. Pregnant women can fall in either stable or unstable/complex categories, depending on their characteristics. They are, however, differentiated to only facility-based approaches.
4. Health workers may take into consideration other issues not included in the lists above, e.g. psychosocial problems/issues, family support, etc. to determine whether a client is stable or not.

## 6.6. What are the Approaches?

There are three facility-based approaches as summarized in the figure below

*Figure 6: Summary of the facility-based approaches*




### a) Facility Based Individual Management (FBIM)

This is also referred to as Comprehensive Clinical Evaluation (CCE). It is an approach for all unstable/complex clients where an individual client is given a scheduled appointment for a thorough clinical assessment, review of blood tests and other services e.g. counselling. All stable clients will also undertake a clinical evaluation every six months.

#### i. Categorization and Entry into Facility Based Individual Management (FBIM)

- Health worker uses the minimum characteristics for categorization (Table 8) to identify unstable patients prior to or during their routine clinic visit
- Unstable clients are sensitized about why they are categorized as 'unstable' and hence the need for facility-based individual management on a monthly basis
- Clients who decline other approaches and prefer getting monthly ART refills are also differentiated into FBIM

#### ii. Before Day of Appointment:

- The health worker/Lay provider reviews the Appointment Book to identify clients who are expected on the following day

- Files for expected clients are retrieved and temporarily stored in a designated place in preparation for the appointment visit

**iii. On Day of Appointment:**

- Upon arrival at the facility, the patient goes to the reception/triage desk where registration, health education, weight, height, symptomatic OI screening, adherence assessment and documentation are done
- The client is then referred for clinical review and depending on findings, is referred according to the ART clinic client flow (Figure 10)
- The client receives a service package as detailed in Table 11

**iv. Follow-up Appointments**

- All FBIM clients are scheduled for one month appointments
- At the end of the clinic day, the health workers review the appointment book(s) to establish if all expected clients came for the clinic visit. If any clients did not come for their review as expected, they should be entered into the facility's Search List Form (Figure 16) for immediate follow-up

**b) Fast Track Drug Refill**

This is the simplest approach for a health facility to implement. It ensures that stable clients are fast-tracked to get their drug refills without having unnecessary clinical evaluations and hence spending minimal time at the facility. However, the clients pass through the triage desk where basic assessments are conducted. He/she returns to the health facility at three 3 months' intervals, with every 6 month's encounter consisting of a comprehensive clinical evaluation (CCE).

The fast track drug refill approach is outlined below.

**i. Categorization and Entry into Fast Track Drug Refill (FTDR)**

- The health worker uses the minimum characteristics for categorization (Table 8) to identify stable patients prior to or during their routine clinic visit
- The Stable patient is sensitized about the fast track drug refill approach and enrolled if he/she agrees to it
- He/she undergoes a comprehensive clinical evaluation and receives the service package of care (Table 10)
- Client receives a 3 months ART drug refill and is booked for an FTDR appointment in the appointment book

**ii. Before Day of Refill Appointment:**

- The health worker/Lay provider reviews the Appointment Book to identify clients who are expected to on the following day
- Files for expected clients are retrieved and temporarily stored in a designated place in preparation for the appointment visit
- The files are accessed by the pharmacy staff in-order to pre-pack ARVs and other medicines (CTX, Anti-TB, etc.) ahead of the patient appointment date. Each client's drugs are bound together and clearly labelled with the client's name and ART number.

**iii. On Day of:**

- Upon arrival at the facility, the client goes to the reception/triage desk where registration, health education, weight, height, symptomatic OI and TB screening, adherence assessment and documentation are done
- A client who has clinical signs and symptoms and/or is categorized as 'unstable' is referred to the clinician for further evaluation
- A client who has no complaints and is categorized as 'stable' has his/her next appointment dates recorded in his/her file, in the appointment book and in his/her client hand-held card or book. This next appointment will be for a comprehensive clinical evaluation.
- The client is then fast tracked to the pharmacy dispensing window or dispensing point to receive his/her three months ART refill and other medications
- The dispenser records the dispensed drugs in the ARVs and medicines dispensing log
- At the end of the clinic day, the health workers review the appointment books to establish if all expected clients came to pick their refills. If any clients did not come for their refill as expected, they should be entered into the facility's Search List Form (Figure 16) for immediate follow-up

**iv. Day of Comprehensive Clinical Evaluation Appointment**

- Every six months, the client comes for a comprehensive clinical evaluation and follows the standard client flow (Figures 10 and 12) and receives the service package of care (Table 10)
- Re-categorization as a stable patient is confirmed

**c) Facility Based Groups (FBGs)**

This approach is applicable for both stable and unstable/complex clients desiring peer support or needing special attention. This includes family support groups for pregnant and lactating mothers, children, adolescent groups etc., regardless of the age and duration on ART (but most likely clients will have AT LEAST made a month on ART). Occasionally some clients who are still hesitant to begin ART, are still finding it difficult to cope with diagnosis of HIV, or have other issues like adherence, non-disclosure, poor compliance, denial or stigma (complex/unstable clients) may join the groups to learn from the testimonies and gain support from the members in the group.

The group sizes may range from 15-40 clients. The number of groups is dependent on the volume of clients in the facility. Stable clients attend FBG meetings quarterly while the unstable clients attend monthly to receive their ART refills and undergo basic screening for adherence, nutrition, TB and other OIs.

For stable clients, Peer Leaders collect their drugs from the pharmacy, distribute, and account for them while for unstable clients, arrangements should be made to provide CCE and drug refills within these groups. Clients in the group who require an individual assessment or comprehensive evaluations (e.g. VL bleeding, poor adherence, OI management, post puerperal management, obstetric exam, nutritional assessment etc.) are sent to see a clinician after the group activities.

Each health facility has to develop the meeting schedules for the groups as well as the health education sessions.

**Role of the Health Care Worker**

- Guide the clients in the process of identifying an appropriate Peer Leader
- Orient Peers Leaders on their roles and responsibilities
- Follow up clients that miss appointments
- Conduct health education talks

- Assess and categorize clients
- Provide services to the clients (Tables 10, 11, 12, 13, 14 and 15)
- Pre-pack ART and other medicines
- Update records

**Selecting the FBG Peer Leader**

For each group, the HCW guides the clients in the process of identifying an appropriate Peer Leader but the group members have the right to select a peer leader of their choice. The selected person should be oriented on his/her roles. He/she should be one who;

- Will be most accepted by majority of clients in the clinic (looked upon as a Champion)
- Regularly attends the clinic
- Should have good treatment outcomes (over 95% adherence, virally suppressed and healthy)
- Has disclosed to his/her partner, if any
- Has no stigma
- Has time to carry out the group activities and to coordinate the group
- Can keep confidentiality
- Can read and write and communicate
- Should have gone through all the stages of the psychosocial support groups

**Roles of the FBG Peer Leader**

These include, but are not limited to the following:

- Leads the group as he/she works closely with the health care worker
- Identifies clients who need CCE and refers them to see the clinician
- Receives clients referred from the routine clinics
- Reviews appointment logs for group appointments
- Reminds clients to come for their missed appointments and follows them up to ensure they attend the clinic
- Ensures clients attend the group visits as required
- Together with and under supervision of the clinic staff, pre-pack drugs for the groups
- Helps in distributing ARVs to group members
- Completing records i.e. Appointment Book
- Organizes and plans village savings and loan activities (VSLA)
- Sensitize group members

**Services received in the FBGs**

Examples of services received in the groups include:

- Sharing experiences through testimonies
- Psychosocial support
- Adherence counselling by the health worker
- Weights and mid upper arm circumference (MUAC) measurements
- Records completion
- Drug refill (ART, Anti-TB, CTX, etc.)
- Saving and Loans schemes activities

The groups may meet in the health facility compound on a regular basis.

In all groups, ARVs are distributed on the same day of the group meeting (usually after the group activities are done) through different ways. Clients get a three-month refill. Any remaining drugs are taken back to the pharmacy store. However, efforts should be made to track the clients that missed the meeting.

**Pre-Packing of Drugs for the Groups**

The Peer Leaders work with the health facility staff to retrieve and submit patient files to the pharmacy before the meeting. The pharmacy staff;

- Dispense ARVs and OI medicines required for each group member
- Record ARVs issued to each member in a dispensing log
- Label individual patient medicines and package in a box ready for pick up by the group leader or health worker facilitating the group meeting

After the group meeting, the peer leader or clinic staff pick the medicines from the pharmacy and distribute to each group member. Any un-dispensed medicines are returned to the pharmacy. The HIV Care Cards are updated there and then, while the ART registers are updated later.

The nurse/Peer Leader ensures that clients in the group who require an individual assessment or comprehensive evaluations (e.g. VL bleeding, poor adherence, OI management, post puerperal management, obstetric exam, nutritional assessment etc.) are sent to see a clinician after the group activities.

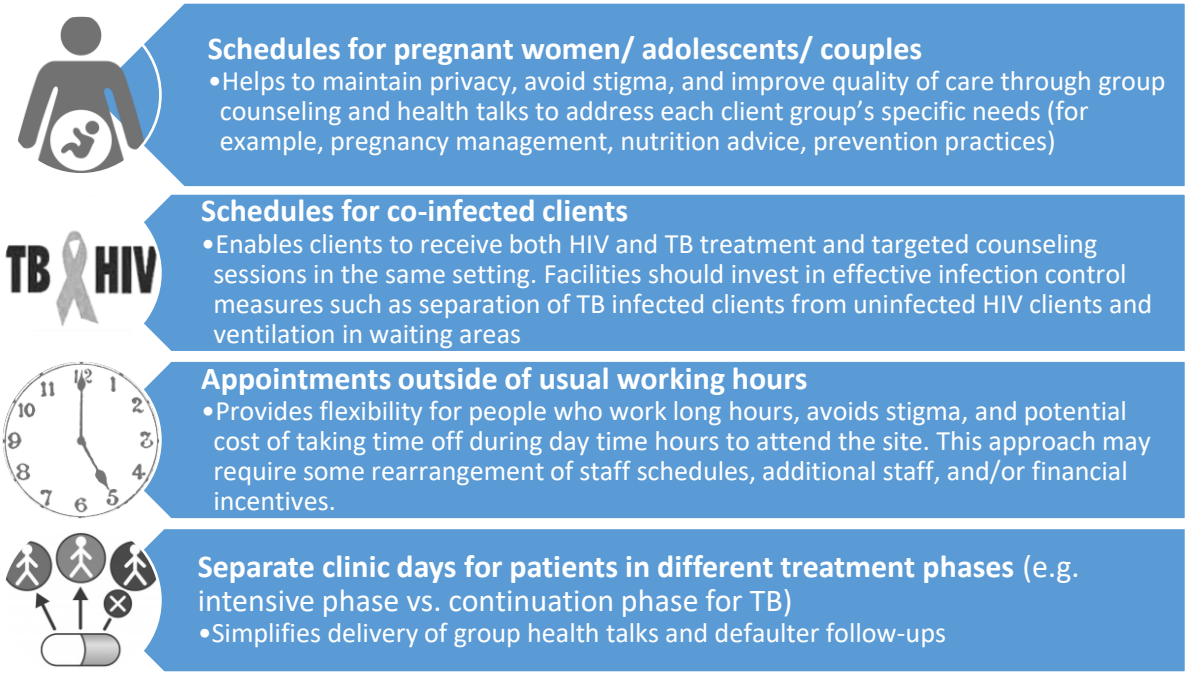
The next appointment dates are documented in the appointment book and communicated to the clients/groups.

**d) Flexible Time (Differentiated Schedules)**

Health facilities can also dedicate specific time (early, late, weekends) to specific groups of clients such as the men, key populations, mobile populations etc. This has the added advantage that it provides opportunity for clients to attend the clinic at their convenient time and receive targeted counselling sessions as well as targeted health talks.

The number of clinic hours and days to be dedicated to these specific groups/sub-populations depends on the size of the target client group, but may range from one day a month to several days per week. Health workers should aim to see at least as many clients during the dedicated hours as are seen in the regular schedule.

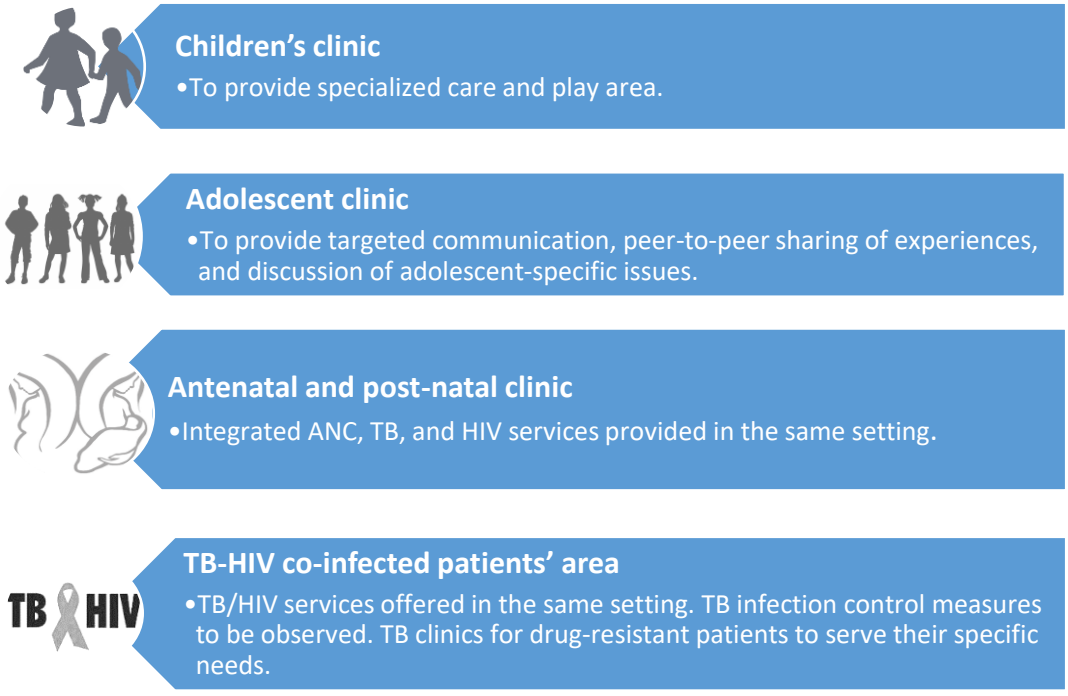
Figure 7: Differentiated schedules and appointments examples




### e) Differentiated clinics

Health facilities can also dedicate specific clinic days for specific populations e.g. children, adolescents, TB-HIV co-infected clients, Hepatitis etc.). Once identified, health facilities need to dedicate space for these categories. Typical examples of dedicated spaces are shown in figure 8 below.

*Figure 8: Differentiated clinic examples*



When space is limited, innovative approaches such as using temporary structures (such as tents), providing dedicated space to specific groups on specific days or times of day, can be considered.

Where the target group is small, health workers may discuss with clients the possibility of transferring them to another preferred facility that has sufficient clients and is able to offer dedicated space and times for them. This will require appropriate referral systems that allow the service provider to follow-up the referral to ensure that the client is receiving treatment at the referred facility.

Clients receiving HIV Care and Treatment under the facility- and community-based models can be summarized in the table below

*Table 9: Client categories for HIV Care and Treatment services under the various differentiated flow categories*

| **Categories** | **Qualifying Clients** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Stable* Client | Complex Unstable**/ New/ Transfers in | Children | | Adolescents | | PMTCT (ANC→3 months postpartum) | PMTCT (Mother-Baby Pair 3-18 months) | Key Populations |
| | | | <2 years | 2 - <10 years | 10-14years | 15-19years | | | |
| Facility Based Individual Management (Comprehensive clinical evaluation) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Facility Based Group | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Fast track drug pick-up | ✓ | | | ✓ **1** | ✓ | ✓ | | | ✓ |
| Community Client Led ART Distribution (CCLAD) | ✓ | | | | ✓ **3** | ✓ **5** | | | ✓ |
| Community Drug Distribution Points (CDDPs) | ✓ | | | ✓ **2** | ✓ **4** | ✓ **6** | | | ✓ |

**NOTE:**

- **1 and 2**, Stable children 2 - <10years can join FTDR or CDDP if their parents/care givers are stable and choose to join these approaches
- **3 and 4**, Stable adolescents 10 – 14years can join CCLADs or CDDP if their parents/care givers are stable and choose to join these approaches
- **3**, Stable adolescents (10 – 14years) can be CCLAD members if their parents/care givers are stable and choose to join CCLADs but they cannot pick drugs on behalf of the other members. The responsibility of picking drugs will be for the parent/care giver in a given CCLAD group.
- **5 and 6**, Stable adolescents 15 – 19years can join CCLADs or CDDPs if they choose to.
- **5**, Adolescents 15 – 19years can form an adolescent only group if they choose to.

## 6.7. Service Packages for Various Client Groups

*Table 10: Service package for stable clients*

| | Clinical consultations | Refills (ART, CTX, FP) | Laboratory tests | Adherence support |
|---|---|---|---|---|
| **When** | Every 6 months (twice a year) | Every 3 months/ 4 times a year | VL annually | At every visit |
| **Where** | Facility or Community | Facility or community | Facility or community | Facility or community |
| **Who** | Clinician (MO, CO Nursing Officer) | Dispenser / nurse / trained lay providers (expert client) | Laboratory staff | Counsellor/ Nurse/ Trained Peer |
| **What** | • History taking<br>• Physical examination (Vital signs including weight, BP, MUAC, nutritional assessment counselling and support, i.e. NACS)<br>• Symptom screen (TB, STIs, other OIs)<br>• Referral for other conditions including non-communicable disease (NCD) screening & management<br>• Adherence assessment (ART/CTX)<br>• Update register<br>• New appointment – clinical or for VL | • Pre-packed ARVs (label)<br>• Dispense<br>• Fill dispensing log | • VL sample collection<br>• Transport to hub | Adherence support |
| **How** | • Through Facility Based Individual Management (FBIM) when the clinical evaluation is due for those who are in Fast Track Drug Refill, CCLAD, FBGs<br>• Through Community Based Individual Management for the CDDP | • Fast Track (Pick-up from dispensing points or pharmacy after going via the triage desk)<br>• Longer appointment spacing and multi-month prescriptions<br>• Through peers (CCLAD)<br>• Through health care worker outreaches (CDDP) | • From the facility laboratory following the FBIM<br>• Clients are bled during the community outreaches and results communicated as soon as possible | • During the FBGs<br>• During the CDDPs<br>• During the monthly refill meetings for CCLADs |

*Table 11: Service package for unstable/complex/new clients*

| | Clinical consultations | Refills (ART, CTX, FP) | Laboratory tests | Adherence support |
|---|---|---|---|---|
| **When** | • Clients already in care:<br>  ○ Monthly<br>• New/naïve clients:<br>  ○ Monthly | • Unstable/complex clients:<br>  ○ Monthly<br>• New/naïve clients:<br>  ○ Monthly | • Baseline tests at initiation<br>• VL:<br>  ○ First VL at 6 months (new clients) and then annually<br>• For cases of VL *non-suppression*:<br>  ○ Offer intensive adherence counselling (IAC) at least 3 consecutive sessions, 1 month apart<br>  ○ Repeat VL 1 month after 3 consecutive IAC sessions with documented good adherence | • At every visit |

| | | | | |
|---|---|---|---|---|
| **Where** | Facility | Facility | Facility | Facility and community |
| **Who** | Clinician (medical officer, i.e. MO; clinical officer, i.e. CO; Nursing officer) | Dispenser /nurse / Trained lay providers (expert client) | Laboratory staff | Counsellor/ Nurse/ Trained Peer |
| **What** | • New clients: Rapid initiation of ART<br>• OI screening, e.g. CRAG<br>• Nutrition screening<br>• NCDs<br>• History taking and physical examination (vital signs including weight, blood pressure - BP) | Pre-packed ARVs (label) | CD4; HBsAg; CrAg if CD4<100 or VL is not suppressed; VL test for pregnant women on ART at 1st ANC in that pregnancy<br>Other tests as indicated:<br>• Complete blood count - CBC (if risk of anaemia)<br>• TB test (if presumed)<br>• HCG when indicated<br>• Renal function tests - RFT (for hypertension & DM)<br>• Liver function tests - LFT (HBV or HCV infection)<br>• Lipid profile & blood glucose<br>• HCV antibody test | Adherence support |

*Table 12: Service package for children and adolescents*

| |  | **Clinical consultations** | **Refills (ART, CTX, FP)** | **Laboratory tests** | **Adherence support** |
|---|---|---|---|---|---|
| **When** | | **Stable**<br>Children 2 years and above: Quarterly<br>Children under 2 years: Monthly<br>Adolescents 10-19 years: Quarterly<br><br>**Unstable**<br>All children and adolescents: Monthly | At every visit | • Baseline tests at initiation<br>• VL:<br>○ First VL at 6 months and then every 6 months for children (up to 9 years) and adolescents (10 years to 19 years)<br>• For cases of VL *non-suppression*:<br>○ Offer IAC at least 3 consecutive sessions, 1 month apart<br>Repeat VL 1 month after 3 consecutive IAC sessions with documented good adherence | At every visit |
| **Where** | | Facility (adolescent corner, special clinic days, space for group meetings) | Facility dispensing | Facility lab | Facility |
| **Who** | | Clinician (MO, CO, Nursing officer) | Dispenser/ nurse | Laboratory staff | Counsellor/ nurse/ expert clients/ peer |

| | Clinical consultations | Refills (ART, CTX, FP) | Laboratory tests | Adherence support |
|---|---|---|---|---|
| **What** | • **Children:**<br>○ ARV dose adjustment<br>○ disclosure and adherence support<br>○ Weight<br>○ Routine care (CTX & ART refills, OI & screening NACS, STI screening, Positive Health, Dignity, and Prevention - PHDP)<br>• **Adolescents:**<br>○ More psychosocial support on stigma, disclosure, hormonal changes<br>○ Need FP, SRH, adolescent corner, STI care/ counselling; different clinic days<br>• Consider school going; space for group meeting, entertainment; consider visits in holidays for adolescents | • Dispense<br>• Fill dispensing log<br>• Update the ART register and OpenMRS | • VL at 6 months, 12 months<br>• STIs, such as syphilis (as indicated for others)<br>• Urine HCG<br>• Other tests as guided by clinical assessment | • Disclosure<br>• Adherence support<br>• Psychosocial support on stigma and discrimination reduction, disclosure, hormonal changes/sexual development, life skills<br>• Health education, counselling and provision of SRH - FP, STI care, safe conception<br>• Career development – schooling, vocational training, IGA<br>• Entertainment and individual coping/stress management activities consider visits in holidays for adolescents<br>• PHDP |

*Table 13: Service package for pregnant and breastfeeding women and their HIV-exposed infants*

| | Clinical consultations & screening | Refills (ART, CTX, FP) | Laboratory tests | Adherence support |
|---|---|---|---|---|
| **When** | Stable pregnant women**<br>○ All ANC Visits (goal-oriented ANC)<br>New/unstable pregnant women***<br>○ 2 weeks after initiation of ART and then monthly until delivery<br>○ Follow routine MCH schedule after delivery<br><br>Stable breastfeeding mothers<br>○ Together with the exposed infant schedule 10 PNC Visits:<br>▪ 6 weeks, 10 weeks, 14 weeks, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months | **Mothers**<br>• At every ANC and PNC visit, clinical visits<br><br>**HIV Exposed Infants (HEI)**<br>• Low risk infant – nevirapine (NVP) syrup for 6 weeks after birth<br>• High risk infant – NVP syrup for 12 weeks after birth<br>• CTX at 6 weeks until confirmed HIV negative | Pregnant /breastfeeding Mother:<br>○ CD4 at enrolment<br>○ Pregnant women on ART at 1st ANC: VL, then annually if suppressed<br>○ For those newly initiated on ART: 1st VL done at 6 months after ART initiation<br>○ Syphilis and CBC at ANC 1<br>○ Blood chemistry as need arises<br>HEI:<br>○ At 6 weeks: 1st DNA PCR<br>○ 2nd DNA PCR 6 weeks after stopping breastfeeding<br>○ At 18 months: Rapid HIV antibody test | At every visit |
| **Where** | ANC Clinics, MBCP*/PNC/YCC | MBCP/MNCAH, Maternity, Pharmacy | MBCP/MCH, Lab | ANC, MBCP/PNC/YCC, pharmacy, in PSS groups |
| **Who** | Midwives, MO/CO, Nurses, Counselors, Clinicians | Counselors, Midwives, Nurses, dispensers | Midwives, Nurses, Counselors, Lab personnel | Midwives, Nurses, dispensers, counselors, MO/CO, mentor mothers & FSG |
| **What** | • ANC, PNC & Immunizations,<br>• Rapid initiation of ART of new clients<br>• Screening for OI e.g. TB, nutrition, & NCDs<br>• History taking and physical examination (Vital signs including wt, BP)<br>• Assessment and care for the HIV exposed infant | • Dispense ARVs<br>• CTX & OI meds<br>• FP commodities<br>• NVP and CTX for HEI | • Rapid HIV test<br>• Syphilis test<br>• HIV viral load test<br>• DNA PCR for infant HIV diagnosis<br>• Other tests as per clinical assessment | • Adherence support<br>• Psychosocial support |

*Mother Baby Care Points

**Stable HIV-positive pregnant/breastfeeding woman already on ART: Viral suppression; Adherence above 95%; been on ART for more than 1 year; stages T1 and T2; Not due for vital laboratory tests in the next 2 months, e.g., VL; disclosed to significant other/ household member/family member

*** HIV-positive pregnant woman initiating ART in ANC (new clients): Unstable pregnant and breastfeeding women: Recently initiated on ART (less than 1 year on ART); poor viral suppression: most recent VL above 1000 copies/ml; adherence less than 95%; stages T3 and T4; comorbidities/co-infection; CD4 <500; due for vital laboratory tests in the next 2 months, e.g., VL; has not disclosed to significant other/ household member/family member; MDR TB/HIV

*Table 14: Service package for stable key populations*

|  | **Clinical consultations & screening** | **Refills** (ART, CTX, FP) | **Laboratory tests** | **Adherence support** |
|---|---|---|---|---|
| **When** | Every 6 months | Every 3 months | • Annual VL<br>• Quarterly STI screening tests | • At every visit |
| **Where** | Specialized Key Pop clinics, general ART clinics, community outreach Modified hours of operation<br>• Outreach service points<br>• FP services | Specialized KP clinics, general ART clinics, pharmacy, community ARV refill points | • Specialized KP clinics, lab<br>• Facility lab & community mobile laboratory points | • Specialized KP clinics, general ART clinics, Pharmacy, Psychosocial groups |
| **Who** | MO/CO, Nurses | Dispensers nurse/peer | • Laboratory personnel | • Counsellor/ nurse/ expert clients/ peer |
| **What** | • Clinical assessment<br>• Management of OIs and other clinical problems<br>• Prescribe ARVs and other medicines | • Dispense ARVs, CTX and other medicines<br>• Fill the dispensing log<br>• Update the ART register/OpenMRS | • STIs, syphilis (as indicated for others)<br>• VL | • Adherence support |

*Table 15: Service package for patients with TB*

|  | **Clinical consultations** | **ART and TB drug refills** | **Laboratory tests** | **Adherence support (ART and TB** |
|---|---|---|---|---|
| **When** | • New TB Clients (already on ART):<br>○ Fortnightly for 2 months<br>○ Do repeat sputum at 2 months for PTB<br>○ Consider Community DSDM if sputum conversion occurred for stable clients<br>• New TB patients (ART New/naïve clients):<br>○ Fortnightly for 2 months<br>○ Then monthly for 4 months | • Clients in Intensive phase of TB treatment (Unstable):<br>○ Fortnightly for 2 months<br>○ Do repeat sputum at 2 months<br>○ Consider Community DSDM if sputum conversion occurred and client categorized as stable<br>• New/naïve clients:<br>○ ART initiation at 2 weeks of TB treatment<br>○ Fortnightly for 2 months<br>○ Then monthly for 4 months | • Sputum at 2, 5, and 6 months<br>• Baseline tests<br>• VL:<br>○ First VL at 6 months (new clients)<br>○ Then annually<br>• For cases of VL *non-suppression*:<br>○ Offer IAC at least 3 sessions, 1 month apart<br>○ Repeat VL 1 month after 3rd IAC session | • At every visit |
| **Where** | Facility for 2 months and moves to community care model when stable | Facility for 2 months and moves to community care model when stable | Facility | Facility or community |
| **Who** | Clinician (MO, CO Nursing officer) | Dispenser /nurse / Trained lay providers (expert clients) | Laboratory staff | Counsellor/ Nurse/ Trained Peer |
| **What** | • History taking<br>• Physical examination (vital signs including weight, BP)<br>• Regimen review for drug interactions<br>• Rapid initiation of ART | • Pre-packed ARVs (label) and anti-TB medications<br>• Facility refills fortnightly in the first 2 months and then monthly or quarterly depending on stability | • Gene Xpert test<br>• Sputum at 2, 5 and 6 months.<br>• CXR at baseline | • Adherence support (both TB and ART)<br>• TB and HIV Index Client Contact tracing |

| | | | | |
|---|---|---|---|---|
| | • Clinical evaluation every 2 weeks for the first 2 months; thereafter at 2, 5 and 6 months.<br>• TB symptom screening<br>• TB and other OI screening, e.g. CRAG<br>• Nutrition screening<br>• NCDs | | • LFT if on MDR treatment or reacted to medication<br>• Thyroid function tests (TFTs), monthly smear and culture for multi drug resistant (MDR) patients.<br>• CD4, HBsAg, CrAg if CD4<100, VL test for pregnant women at 1st ANC and Lactating mothers<br>Other tests as indicated:<br>• CBC (if at risk of anaemia)<br>• Test for TB (if suspected)<br>• RFT (for hypertension & DM)<br>• Lipid profile & blood glucose<br>• HCV antibody test | and screening for TB |
| *PTB includes both P-BC and P-CD<br>*For EPTB patients consider categorization into stable DSD C&T approaches after significant (NTLP Manual) clinical Improvement as ascertained by the Clinician<br>*__MDR TB/HIV Co-infected__ are considered unstable throughout the course of their treatment. Stable DSD care and treatment approaches can start after this. Refer them to a MDR Treatment Initiation Unit. For every client who has been on anti-TB medication the DSDM team must evaluate them individually to assign the appropriate outcomes | | | | |

## 6.8. Managing Special Situations

Once sites begin implementing DSD, the health care workers and other service providers in direct contact with clients need to be familiar with some isolated circumstance or services required by some clients such as;

**a) Managing transitions from PMTCT to ART and from pediatric/adolescent groups to adult clinics**

For the clients transitioned from PMTCT or Adolescent groups (e.g. Ariel), when they complete their time in their respective clinics, they automatically transition to the adult ART clinics and are enrolled in the respective approaches for the adults. They should be supported to cope with the new service delivery models and refill periods if different from the previous services they have been receiving.

**b) Managing clients who do not qualify for specific models and yet demand for them**

Despite the guidance on the eligibility for the various models and approaches, clients should be managed on individual basis. Should a client make a request contrary to the guidance, they should be listened to and supported accordingly (e.g. long-distance track drivers, uniformed men, etc. who haven't made a year in treatment but need longer refills).

**c) Managing clients who transfer in**

For clients who come in as 'transfers in', manage as if they were new in care and conduct a comprehensive evaluation to determine which differentiated care approach they qualify for and manage them accordingly.

**d) Managing clients who falter or drop out of a specific differentiated service delivery model**

Should a previously stable client present with any of the features of unstable clients, they automatically revert to the comprehensive approach and are closely monitored until they become stable and qualify to re-join their former DSD model again.

### e) Managing new clients with a suppressed 6 months VL

It is important that clients have an updated VL to determine the appropriate DSD approach to assign them to. For new clients who have had a suppressed 6 months VL can be enrolled into other facility approaches other than Facility Based Individual Management at the end of 12 months on ART. These can only be transitioned to the community approaches (i.e. CDDP or CCLAD) after the second consecutive suppressed VL.

### f) Couple enrolment into DSDM

A couple receiving care at the same health facility, if stable and disclosed to each other, should receive care under the same model. This allows each one to alternately pick drugs for the other and minimizes the costs of travel to the facility.

In the event that one partner is stable and the other is not, then they should be enrolled in their respective models and/or approaches.

If the couple come together and both are eligible for fast track in the facility or CCLAD in the community, both undergo a comprehensive clinical evaluation and receive their 3 months' ART supply. If they are enrolled on fast track, they alternate drug pickup every three months. The partner picking drugs also receives a comprehensive clinical evaluation at every visit. If enrolled into CCLAD, the group members will decide on the member that will pick the drugs.

*Table 16: Schedule for stable couple under fast track drug refill approach*

| Month 0 | Month 3 | Month 6 | Month 9 | Month 12 |
|---|---|---|---|---|
| Partner 1 enrolled & comprehensive clinical review | Does not come | Refill visit and comprehensive clinical evaluation | Does not come | Refill visit and comprehensive clinical evaluation |
| Partner 2 enrolled & comprehensive clinical review | Refill and comprehensive clinical evaluation | Does not come | Refill and comprehensive clinical evaluation | Does not come |

If a couple has disclosed to each other and one member of a couple presents on the initial visit and from chart review both are stable, enrol both clients on FTDR and schedule the absent partner for clinical review at the next visit as per the schedule below.

*Table 17: Schedule for facility visits for couples who enrol at different times*

| Month 0 | Month 3 | Month 6 | Month 9 | Month 12 |
|---|---|---|---|---|
| Partner 1 enrolled | Clinical Review | Refill visit | Clinical Review | Refill visit |
| Partner 2 enrolled | Refill visit | Clinical Review | Refill visit | Clinical Review |

**g) Managing a TB/HIV co-infected client**

TB/HIV co-infected clients should be managed at the same point of care i.e. receive their clinical evaluation for TB and HIV and also receive ART and Anti-TB drug refills at the same point.

While in the community, the CCLAD or CDDP group members should take collective responsibility to carry out surveillance for symptoms of TB amongst themselves. If any group member develops symptoms of TB they should be encouraged to go to the health facility for investigation. If found to have active TB, this client will have to pull out of the group temporarily and receive both HIV and TB treatment from the health facility until the end of the intensive phase of anti-TB treatment.

TB/HIV co-infected clients are eligible to join or re-join community care and treatment approaches if they have completed intensive phase and are sputum negative. These clients should receive their anti-TB and ART drugs from the community. The CCLAD or CDDP group leaders and other group members should provide adherence support, psychosocial support and community based directly observed therapy (DOTS) to these clients. TB/HIV co-infected clients should be supported to return to the health facility for their TB monitoring reviews at the end of 5 and 6 months on anti-TB treatment.

**h) Managing clients whose regimen has been substituted due to policy changes**

PLHIV (Children, Adolescents, Pregnant and lactating women and adults) with a regimen change within the past one year are considered unstable as per the categorization criteria however clients who receive a regimen substitution due to policy changes will retain their previous category and differentiated care and treatment approach. Efforts should be made to strengthen pharmacovigilance by;

a. Sensitizing clients about the side effects of the new drugs
b. Encouraging the clients to return to the facility if the develop any of the side effects
c. Scheduling a comprehensive clinical review visit within a month of regimen substitution
d. All side effects reported by the clients should be reported against using the Adverse Drug Reaction (ADR) forms.

## 6.9. Community-Based HIV Care and Treatment Models

These are HIV Care and Treatment services offered outside the existing health facilities.

**Rationale for Community-Based HIV Care and Treatment Models**

The current HIV care and treatment models partially provide for community-based services yet there is substantial loss to follow up (LTFU) in the facility based HIV care clinics with data from the Uganda National ART programs showing LTFU standing at 21% in the first 6 months and at 26-30% in the first 2 years due to a range of factors including

**a) Client Factors**

1. Physical barriers to access (distance to the facility, difficult travel conditions)
2. Time and cost constraints (e.g. remote location, constraining work hours, travel cost, loss of income while accessing health services, long waiting times, selling drugs instead of taking them)
3. Stigma and discrimination from self, community, family or service provider. The clients may meet at the health facility (e.g. lack of privacy, confidentiality or respect)
4. Lack of treatment support from peers, community, partner or family
5. Non-disclosure: children/adolescents whose parents have not told them their status

**b) Facility-Based Health System Factors**

1. Congestion and long waiting times during clinical appointments and at the pharmacy arising from high volume of clients at the facility.
2. Inadequate space for clinical care, counselling, dispensing medicines, record keeping, drug storage and security against theft.
3. Limited human resources for facility based service delivery

## 6.10. Benefits of Community Based HIV Care and Treatment Models

1. It provides an opportunity to offer ART to clients who prefer to receive their care and treatment in the community for various reasons
2. Fewer and focused visits to the health facility (for CCE and laboratory monitoring for CCLAD groups)
3. Minimizes on transport costs
4. Increased client satisfaction and empowerment

Decentralization of provision of some components of HIV care and treatment from the health facilities should be considered as a way to increase access to and improve retention in care (WHO Guidelines 2016). The two delivery approaches recommended for the differentiated community-based HIV care and treatment model include:

1. Community Client Led ART Delivery (CCLAD)
2. Community Drug Distribution Points (CDDPs)

## 6.11. Community Client-Led ART Delivery (CCLAD)

The Community Client Led ART Delivery (CCLAD) are psychosocial community ART groups comprising of stable clients living in the same community/locality. The CCLAD group members take turns to pick up ARVs at the health facility and distribute them among the other group members in the community. They manage their own health and take action with the support of HCWs. The CCLAD group members share experiences about living positive with HIV, and are empowered to offer and receive peer psychosocial support and follow-up.

The group members, in collaboration with the health workers, select a Team Leader to coordinate communication between group members and the health facility. Clients can return or be referred to the facility at any point in the cycle for any issues that may arise between scheduled health facility visits.

## 6.12. Management of CCLAD

### 6.12.1. What Is The CCLAD Group Size?

It is recommended that the CCLAD groups comprise of 3 to 6 members.

### 6.12.2. Organizing for CCLAD

**a) Step 1 – Preparations In The Health Facility**

1. Orientation of health workers on the CCLAD approach
2. Identify a Focal Person from amongst the health workers to coordinate the following activities
    - Identify and map clients by their locations
    - Lead, promote and sensitize clients about CCLAD
    - Oversee completeness of tools
    - Train, monitor, supervise and follow up with CCLAD Group Leaders
    - Ensure implementation and quality assurance of the groups' functionality and operations
    - Coordinate the preparation for clinic visits for patients in CCLAD e.g. retrieval of files, prepacking medicines, ensure availability of blank CCLAD monitoring forms etc.

**b) Step 2 – CCLAD Group Formation**

1. Conduct client mapping using the existing facility client data to categorize the clients into stable or unstable ART clients.
2. Stable clients are listed in accordance to their locations, preferably villages. **Note: Pregnant women, breastfeeding women, infants, children and adolescents are generally not eligible to receive services in the community and should be encouraged to remain in the facilities for continuous monitoring. They should be encouraged to join the facility based groups.**
3. Sensitize all stable clients, one-on-one or as a group, explaining the implications and benefits of joining a CCLAD group.
4. Schedule a meeting with clients coming from the same location
5. Encourage stable clients to form groups on their own to foster ownership and belonging. These groups should be formed guided by;
    a. Locality of proposed group members
    b. Ability to read and write for at least one of the proposed group members
    c. Group size i.e. 3 – 6 members per group
6. Ask clients to choose their preferred group size.
7. Assess each client's readiness to join a group. In this assessment process, the following questions will be asked:
    *a. Have you disclosed to anyone? If yes, to who? If not, why not?*
    *b. Would you like to know other clients who would like to form a group in your community?*
    *c. Are you willing to be known by them?*
    *d. Would you like to consent to join a group?*

If all answers are "Yes" then the client will be signed up for group formation. If "No" to any question the health worker should support the client accordingly.

**NB. Signed readiness forms should be kept in the client's file**

8. Orient the newly formed groups in the approach about their roles and responsibilities (the do's and don'ts of the group)
9. Support the group to develop a visit plan that ensures that they all attend at six months' intervals for comprehensive clinical evaluations and every twelve months for VL monitoring.
10. Support the group to develop a drug refill schedule and appoint a representative group representative to collect ART from the health facility at three months' intervals
11. At three months' intervals drug refills will be given to each individual during group drug refill meetings or during comprehensive clinical evaluation
12. Communicate the new group appointment dates to the members and record them in the facility appointment book.
13. VL monitoring will be done for all group members during the comprehensive clinical evaluation visits. The group members' VL monitoring visits should be harmonized to ensure that all group members are bled at the same time. This will be guided by Central Public Health Laboratories of the Republic of Uganda (CPHL's) bleeding window of 10 – 12 months from the previous VL date and can be done over a period of 12 months.
14. Support the CCLAD group members to select a leader to undergo additional training (e.g. TB screening, OI identification and referral, nutritional and adherence assessment). The leader must have basic reading/writing skills.
15. Assign each group and group member a unique identifier (CCLAD Group Code) using the following format: Facility name 3 letter abbreviation/CL/group serial number/group member serial number in

the group. **E.g. "KWL/CL/001/01" i.e. KWL standing for Kawolo Hospital, CL for CCLAD, group serial number 001 and group member serial number 01. The CCLAD Group Code will exclude the group member serial number.**

NOTE: The group and group member serial numbers should never be given to another group or group member even if the group is dissolved or the group member leaves the group.

16. Maintain a serial filing system based on client number (do not file according to CCLAD groups)
17. Record all patients joining CCLAD groups in the appropriate registers and update registers as patients enrol into groups.
18. Consider use of hand-held calendars (based on group size) or exercise books for appointment reminders

**c) Organizing CCLAD Groups In The Community**

i. Group members will agree on the location of the group meeting and communicate to the health worker.

ii. Group members will agree on the mode of facilitation for the group member that will be selected to pick drugs on behalf of the group in a given month, e.g. group contributions or from their savings

iii. Group members will be encouraged to meet monthly to promote bonding, provide psychosocial support to each other and also conduct their other group activities e.g. Income generating activities, loans and saving activities.

iv. At the end of the three months after their comprehensive clinical evaluation, group members hold two meetings, 1 for community clinical assessment and the other for community ART delivery. The community clinical assessment will be conducted during the pre-drug pick-up meeting and the findings are filled on the CCLAD monitoring form using the codes to be discussed below.

**d) Pre-Drug Pick-Up Meeting (Assessment):**

*1.* This meeting takes place a day or 2 before the drug refill

*2.* Group Leader does pill count for each member and records the number of the *remaining pills (i.e. ARVs, CTX and TB drugs)* on CCLAD monitoring form against *each member.*

*i. Group Leader assesses the health status of each member and records on the CCLAD monitoring form using the codes as indicated in the table 18 below.*

*Table 18: Codes for health status during community clinical assessment*

| Code | What it stands for | Instructions |
|---|---|---|
| **1** | Attended Community Assessment | The group leader writes this number '1' if the member came to attend the group meeting. |
| **2** | Missed Community Assessment | The group leader writes this number '2' if the member did not come to attend the group meeting. |
| **3** | Dead | The group leader writes this number '3' if the member died prior to the group meeting. |
| **4** | Returned to health facility | The group leader writes this number '4' if the member has been referred back to the facility prior the meeting. |

*ii. Group Leader assesses the TB status of each member and records on the CCLAD monitoring form using the codes as indicated in the table 19 below.*

*Table 19: Codes for TB status during community clinical assessment*

| Code | What it stands for | Instructions |
|---|---|---|
| **1** | No signs | The group leader writes the number '1' if the member does not have cough, evening fevers, night sweats and weight loss |
| **2** | Presumptive TB | The group leader writes the number '2' if the member has any of these symptoms i.e. cough or evening fevers or night sweats or weight loss |
| **3** | TB Diagnosed | The group leader writes the number '3' if the member was diagnosed with TB prior to the meeting. |
| **4** | Currently on TB treatment | The group leader writes the number '4' if the member is receiving treatment for TB. |

*iii. Group Leader assesses for pregnancy/Family planning status of each female member and records on the CCLAD monitoring form using the codes as indicated in the table below.*

*Table 20: Codes for pregnancy/family planning status during community clinical assessment*

| Code | What it stands for | Instructions |
|---|---|---|
| **P** | Pregnancy | The group leader writes this letter/code 'P' if the female member is pregnant. |
| **FP** | On Family planning | The group leader writes this letter/code 'FP' if the member is using family planning or condoms (specifically for men). |
| **No FP** | Not on Family planning | The group leader writes this letter/code 'No FP' if the member is not using family planning or condoms (specifically for men). |

*iv. Group Leader assesses nutritional status of each member and records on the CCLAD monitoring form using the codes as indicated in the table below.*

*Table 21: Codes for nutritional status during community clinical assessment*

| Code | What it stands for | Instructions |
|---|---|---|
| **G** | Green | The group leader writes the letter/code 'G' if the member's MUAC measurement falls under the green section of the tape. |
| **Y** | Yellow | The group leader writes the letter/code 'Y' if the member's MUAC measurement falls under the yellow section of the tape. |
| **R** | Red | The group leader writes the letter/code 'R' if the member's MUAC measurement falls under the red section of the tape. |

***NOTE:***

1. *The fully filled form is handed over to the person representing the group on the refill day*
2. *Whenever the group member feels unwell or is sick (i.e. has fever, headache, cough etc...), he/she should go to a health facility any time for treatment and not wait for the routine ART refill visit*

**e) Post-Drug Pick-Up Meeting (Drug Refill And Accountability):**

This happens on the day (or a day after) the member returns from the health facility with the drugs to distribute to other members

1. Group members re-convene to collect their supply/refill
2. The CCLAD monitoring form is handed over to the Group Leader
3. The group members acknowledge receipt of their drugs on the CCLAD monitoring form
4. The group shares observations, challenges and they discuss and agree on the way forward
5. Communication is made about the next meeting date

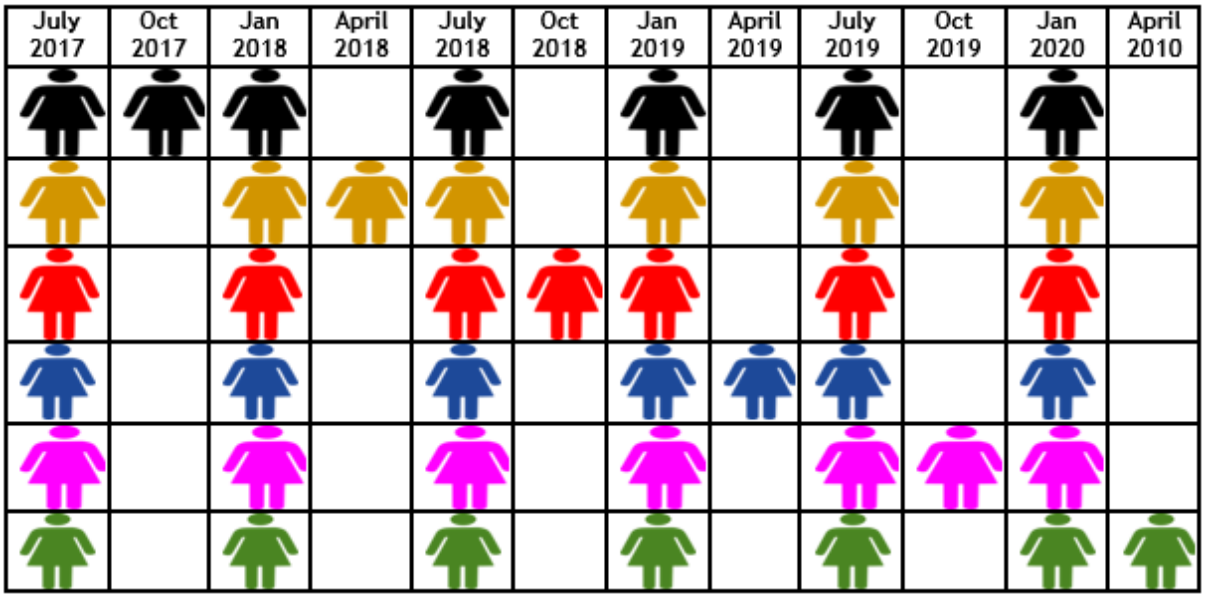
**NOTE:**

1. If there is a member who has not picked his/her drugs within two days, the group leader should immediately follow up
2. If the member cannot be traced within 7 days, the group leader should inform the health facility immediately.
3. The drugs for these clients should be stored well and taken back to the facility within the next 7 days by the group leader or designated group member. The group members contribute towards the transport costs.
4. If the group member returns after his/her medicines have been returned to the facility, he/she should be advised to return to the facility immediately. This will give an opportunity to the health workers to provide interventional adherence counselling before issuing medicines
5. All drugs returned to the facility must be delivered to the dispensing point.
6. Pharmacy staff check the returned medicines for expiry, any damages, broken seal or dirt.
7. These should be recorded on the **medicines return form** clearly indicating the name of drug, quantity and expiry date.
8. Expired medicines should be entered into expired medicine register (HMIS 088)

### 6.12.3. How Is The CCLAD Group Scheduled For Visits?

1. At the initiation of the group, all the group members attend for a comprehensive clinical evaluation and receive their 3 months' ART refill.
2. At the next visit, which is three months later, one selected group member comes to the facility to pick drugs for him/herself and the other group members
3. At the next visit, which is six months' later, all the group members return to the facility for their comprehensive clinical evaluation and each receives his/her drugs
4. Then at a subsequent visit which will be nine months later, one selected group member comes to the facility to pick drugs for him/herself and the rest of the group members
5. The scheduling is illustrated in the figure below. It ensures that each member of the group visits the facility at least twice in a year.

*Figure 9: Scheduling appointments for the CCLAD group*




### 6.12.4. Roles and Key CCLAD Group Actors

**Group Leader**

1. Ensure that each group member signs the CCLAD monitoring form for accountability of the drugs and store it until the next visit
2. Conduct monthly monitoring of groups members
3. Inform the HCW about clients that have missed meetings and/or drug refill pick ups
4. Conduct group counselling and education sessions and record health education topics/issues discussed in the group
5. Carry out clinical assessment of the group members i.e. symptomatic TB screening, adherence assessment, TB treatment support, TB treatment medications, and nutrition assessment (using MUAC tape)
6. Facilitate referrals and linkages as well as provide the group psychotherapy sessions
7. Identify and report any adverse outcomes or drug interactions (side effects), assess ability to perform simple tasks (functionality) etc.
8. Ensure each group member undergoes a clinical consultation twice a year

**Group Members**

1. Attend clinic on their appointment date for a clinical and laboratory review
2. Pick drug refills for all group members on their clinic appointment days
3. Sign the CCLAD monitoring form as acknowledgement of receipt of his/her drugs
4. Provide peer-to-peer adherence support and psychosocial support
5. Report to the facility, the status of other group members
6. Take his/her pill balances, if any, to the health facility during their turn to visit the clinic
7. Finish the old supply of pills before starting the new refill, if there are any pill balances
8. Bring a bag to the health facility to carry the pre-packed drugs to members
9. Attend meetings with the other group members

**Health Workers**

1. Orient CCLAD Group Leaders as one-on-one or as a group

2. Supervise the CCLAD groups under their care at least once every 6 months (a minimum of twice a year)
3. Track and follow up missed appointments of individual group members as reported by the group leader
4. Link CCLAD members to other services at the facility, including FP, cervical and breast cancer screening, etc.
5. Provide comprehensive ART clinical evaluation for clients coming to the facility for drug pick up
6. Review information in the CCLAD monitoring form to ascertain community clinical assessment findings (TB status, adherence, family planning status, nutritional status) and take appropriate action
7. Transfer the information from the CCLAD monitoring form & TB Treatment Card to the HIV Care Card and the registers (ART and TB)
8. Review the list of appointments of CCLAD members prior to clinic appointments, retrieve their files, and pre-pack and label the drugs (the latter can be delegated to expert clients/lay counsellors under supervision)
9. Dispense the correct drugs to the CCLAD members
10. Receive and file the CCLAD monitoring forms and supply new ones
11. Give and document the next appointment in the appointment book and the client hand-held card

### 6.12.5. Service Package at Community Level for CCLAD Groups

The following service package is recommended for the CCLAD groups:

1. ARVs refills
2. Anti-TB drug refills
3. Refills for cotrimoxazole
4. RH commodities refills, e.g. FP pills, condoms.
5. Symptomatic TB screening done by the group leader for all group members
6. Nutrition assessment within group using MUAC (by a trained member of the group)
7. Adherence and peer psychosocial support
8. Community DOTS for TB/HIV con-infected clients
9. Follow up of group members who miss meeting appointments
10. Referral and linkages to facilities to address any identified issues

*Table 22: Service package for community groups in the CCLAD approach*

|  | **Clinical consultations** | **Refills** (ART, CTX, TB, FP) | **Laboratory tests** | **Adherence support** |
|---|---|---|---|---|
| **When** | • A visit every 6 months | • 4 refills per year (quarterly) | • Annual VL<br>• Quarterly STI screenings<br>• Other tests as needed | • At every visit |
| **Where** | • Facility | • Community & facility | • Facility | • Community & facility |
| **Who** | • MO/CO, Nurses | • Nurses, Counselors, Expert Clients, Clients | • Laboratory personnel<br>• Trained nurse/clinician | • Counsellor/ nurse/ expert clients/ peers |
| **What** | • OI & TB screening<br>• Adherence assessment<br>• Nutrition assessment<br>• STI screening & treatment<br>• Positive Health Dignity and Prevention (PHDP) | • Dispense ARVs and OI drugs<br>• STI treatment<br>• TB treatment | • STIs, other tests as indicated<br>• VL<br>• Sputum collection | • Adherence support |

### 6.12.6. Resource Needs for CCLAD Approach

#### a) Human Resource Needs

*Table 23: Human resource cadres and their responsibilities - CCLAD*

| Cadre | Responsibilities |
|---|---|
| **HCWs (Nurse/Counselor)** | Refer to section on roles of key CCLAD group members |
| **Expert clients/Peer educators** | Dispense drugs, conduct symptom-based general health assessments; provide counselling and support while dispensing drugs |
| **CCLAD group leaders** | Refer to section on roles of key CCLAD group members |
| **Records person (Data Clerk/Monitoring & Evaluation (M&E) Manager** | Collect, verify and enter data contained in the health assessment forms collected in the community by the expert clients, into the facility registers |
| **Pharmacy team** | Pre-pack drugs for individual clients marked with their name and details, and ensure safe transportation of packages |
| **PLHIV networks** | Support to PLHIV groups and linkage to other support networks including peer support, oversee functionality of groups |
| **CHEWs/VHTs** | Mobilize and raise awareness and support linkage to social services |

#### b) Logistics Needs

*Table 24: Logistics needs - CCLAD*

| Location | Logistics Needs |
|---|---|
| **Facility** | 1. Enough stock of drugs for all clients<br>2. Masking tape for binding each client's drugs together for pick-up<br>3. Markers for labelling<br>4. File folders<br>5. Tools (CCLAD monitoring forms, DSDM categorization tool, CCLAD enrolment form, CCLAD group summary form, HIV Care Cards, client hand-held cards, appointment books, ART register, dispensing log, etc.<br>6. Health education job aids, client flyers, etc. |
| **Community** | 1. Appropriate venue for the group meetings where members feel free (Safe zone/meeting point)<br>2. Assessment tools e.g. MUAC tapes, CCLAD monitoring form<br>**3.** Health education job aids, client flyers, etc. |

#### c) Termination and Replacement of Group Membership

When one member, or more, withdraws from a group due to ineligibility, transfer out, death, or LTFU, the group can be supported to replace the member.

A group member can become ineligible and will need to be referred back to the facility when he/she;

1. Develops signs and symptoms of disease
2. Has unsuppressed VL
3. Becomes pregnant
4. Misses 2 consecutive pre-drug pick-up or post-drug pick-up CCLAD group meetings
5. Requests to exit the group for any reason

The HCW should be notified and approve the termination and replacement of group members.

**NOTE:**

***Health facilities not yet offering CCLADs but yet meet the criteria will need 3-6 months to adequately prepare i.e. categorization, identification, mapping, sensitization and consenting of eligible clients, identification and training of group leaders and CASAs, harmonization of comprehensive clinical evaluation and VL appointments***

## 6.13. Community Drug Distribution Point (CDDP) Approach

The CDDP approach is an outreach that targets clients in remote/underserved areas with poor access to health facilities for ART such as hard to reach areas (islands, landing sites, pastoral areas, etc.), districts with few facilities accredited to offer ART, etc. This approach offers increased community participation and most importantly, ownership of ART care by the clients.

### 6.13.1. What Is The CDDP Group Size?

The groups range from 10-50 clients who come from a common area/location distant from the health facility. Additional eligible clients can join the group at any point.

### 6.13.2. Who is Eligible for the CDDP Approach?

Only clients **stable on ART** are eligible to receive care under this approach.

### 6.13.3. Steps in Establishing a CDDP

**a) Step 1. Identify need for CDDP**

1. The facility should have identified it as a priority approach

**b) Step 2. Form the CDDP group and orient members**

1. The HCW reviews all files of all clients coming from that community or location to establish their eligibility status (Stable/Unstable)
2. All eligible members at an opportune time are called upon by a HCW to discuss about CDDP and informed consent is obtained from those interested
3. A minimum of 10 members will be grouped together to form a CDDP group. If more than 50 are interested, another group must be formed. Enrollment into the CDDP model is strictly voluntary.
4. A CDDP group list is generated and a code is given to the group. Assign each group and group member a unique identifier (CDDP Group Code) using the following format: Facility name 3 letter abbreviation/CD/group serial number/group member serial number in the group. **E.g. KWL/CD/001/01 i.e. KWL standing for Kawolo Hospital, CD for CDDP, group serial number 001 and group member serial number 01.** The CDDP Group Code excludes the group member serial number.

   NOTE: The group and group member serial numbers should never be given to another group or group member even if the group is dissolved or the group member leaves the group.

5. The health facility will organize a two-day workshop for all the CASAs/Group leaders for orientation on the CDDP approach and sensitization about roles and responsibilities.
6. Assessment for group formation and group re-assignment in this approach will be an on-going process.

**c) Step 3. Agree on the distribution point**

1. The group decides where they will regularly meet (drug distribution point) with the guidance of the health worker.
2. The health worker then maps and visits the site and seeks the consent of the stakeholders and local authorities.
3. The minimum requirements for the distribution point include;
   - A public place e.g. Health Centre II, church, mosque, school, community based organization (CBO) premises etc.
   - Offers some kind of privacy
   - Has a room to be used for safe blood sample collection

**d) Step 4. Implement the CDDP**

1. Health workers retrieve files of the CDDP members and put them together in one big file folder that they will take to the community when services are delivered
2. The first refill for the CDDP group will be at the facility and members will receive a 3-month supply of ARVs. **Subsequent members who join the group will be given drugs up to the next appointment date.**
3. Thereafter, members are given an appointment at the CDDP for subsequent ART refills, consultation and ART monitoring by the clinical team.
4. The Group Leader of HCW mobilizes group members to come for their appointments.
5. ARV drugs are pre-packed for the CDDP members. Additional supplies to be pre-packed include FP supplies, OI drugs, condoms, etc.
6. Transportation is organized.
7. The facility agrees on the health team to visit the CDDP.

**NOTE: VL monitoring should be synchronized for all clients on one date (The date when the CDDP outreach is held).**

### 6.13.4. Services offered in the CDDP approach

1. ARV drug refills
2. Anti-TB drug refills
3. VL monitoring
4. Monitoring
5. Psychosocial support
6. Family planning and pregnancy screening
7. Nutrition assessment and referral
8. TB screening and referral
9. O.I screening and management

*Table 25: Service package for community groups in the CDDP approach*

| | **Clinical consultations** | **Refills** (ART, CTX, TB, FP) | **Laboratory tests** | **Adherence support** |
|---|---|---|---|---|
| **When** | • Every 6 months | • 4 refills per year (quarterly) | • Annual VL<br>• Quarterly STI screenings<br>• Other tests as needed | • At every visit |
| **Where** | • Community | • Community<br>• Specialized KP clinic outreaches | • Community<br>• Specialized KP clinic outreaches | • Community<br>• Specialized KP clinic outreaches |
| **Who** | • MO/CO, Nurses | • Nurses, Counselors, Expert Clients | • Laboratory personnel<br>• Trained nurse/clinician | • Counsellor/ nurse/ expert clients/ peers |
| **What** | • OI & TB screening<br>• Nutrition assessment<br>• Adherence assessment<br>• STI screening & treatment<br>• PHDP | • Dispense ARVs and OI drugs<br>• STI treatment<br>• TB treatment | • STIs, other tests as indicated<br>• VL<br>• Sputum collection<br>• Point of care testing | • Adherence support |

### 6.13.5. Resource Needs for the CDDP Approach

*Table 26: Human resource cadres and their responsibilities - CDDP*

| Cadre | Responsibilities |
|---|---|
| Nurse/Counselor | Dispense drugs, measure clients' weights, support the group to select one volunteer to become the CASA or a known CASA from another group is invited to join. |
| CASA | Provide peer support and counselling at the time of drug distribution, client mobilization and follow-up. |
| Laboratory Technician | Collect samples |
| Pharmacist | Liaise with supervisors of expert clients and community HCWs, plan for required drug supplies on the specific days, and ensure safe transportation of packages |
| Clinician/Nurse | Support team on six-monthly appointments to collect blood samples and conduct health assessments |

### 6.13.6. Logistic needs

*Table 27: Logistics needs - CDDP*

| Location | Logistics Needs |
|---|---|
| **Facility** | 1. Enough stock of drugs for all clients<br>2. Markers for labelling<br>3. Portable scales, MUAC tapes<br>4. Big file folders (box files)<br>5. Tools (HMIS tools—data collection/reporting, registers, patient cards, informed consent form (ICF) )<br>6. Health education, job aids, client flyers, etc.<br>7. Transport means to deliver drugs to the CDDP group<br>8. Cool box with ice packs, sputum containers, triple packaging |
| **Community** | 1. Appropriate venue for the group meetings where members feel free (safe zone/meeting point)<br>2. Health education job aids, client flyers, etc. |

**NOTE:**

**Health facilities not yet offering CDDPs but yet meet the criteria will need 3-6 months to adequately prepare i.e. categorization, identification, mapping, sensitization and consenting of eligible clients, identification and training of group leaders and CASAs, harmonization of comprehensive clinical evaluation and VL appointments**

## 6.14. Multi- month prescriptions

Multi-month prescriptions may apply to stable clients in all models. This is defined as prescriptions for 3- or 6-months Previous guidelines have recommended 3 months prescriptions for stable clients on stable approaches i.e. FTDR, CDDP and CCLAD. These guidelines recommend the introduction of 6 months prescription for high risk clients in whom frequent drug pickups may compromise their adherence to ART. Clients will be assessed against the following criteria prior to considering a 6-month refill of ART:

- Stable client
- ≥15 years
- Not pregnant or breastfeeding
- Repeat VL not due in less than 6 months
- Not TB/HIV co-infected
- No regimen switch or substitution in the last 6 months
- Completed INH prophylaxis

## 6.15. DSD implementation in the context of ART optimization

ALL stable PLHIV transitioning to other regimens due to policy changes (e.g. ART optimization) shall still be considered stable if all other factors stay constant. Efforts should be made to strengthen pharmacovigilance. The following are recommended;

- Providing one-month refill at regimen change
- Providing patient education about side effects and when to return to facility
- Scheduling a clinical review one-month post regimen change
- If no major concerns stable clients can resume multi-month refills (MMRs)

Clients enrolled Community Drug Distribution Point (CDDP) approach shall have their regimen optimization done as follows;

- Regimen change done by clinician at the CDDP
- Patient education about side effects and when to return to facility provided at the CDDP
- 3-months refill provided
- Clinical review scheduled at 1 month later at the facility. If no major concerns identified the client is referred back to the CDDP for the next scheduled visit.

## 6.16. DSD implementation in the context of TB Preventive Therapy (TPT)

TB Preventive Therapy (TPT) is recommended for specific sub-populations who are at an increased risk of getting TB disease as per details in consolidated ART guidelines 2020. The following should be followed while providing TPT in the context of DSD;

- TPT to be initiated by a clinician regardless of which approach the client is in. Efforts should be undertaken to have baseline tests done (i.e. LFTs) prior to initiation of TPT.
- TPT should be initiated at the health facility for all clients receiving ART services through FBIM, FBG, FTDR and CCLAD
- For clients enrolled onto CDDPs, TPT should be initiated from the CDDP during the clinicians visit. Efforts should be undertaken to have baseline tests done (i.e. LFTs) prior to initiation of TPT.
- Patient education about side effects and when to return to facility provided at the time of TPT initiation regardless of DSD approach.
- TPT and ART refills should be aligned
- Clients in more intensive approaches (i.e. FBIM and FBG) should be reviewed every month for TPT and ART toxicities
- Clients in less intensive approaches (i.e. FTDR, CDDP and CCLAD) should be reviewed at least once every three months. Review at 3- and 6-months post TPT initiation should happen at the facility for clients enrolled onto FTDR and CCLAD. Review at 3- and 6-months post TPT initiation for clients enrolled onto CDDP should happen at the CDDP.

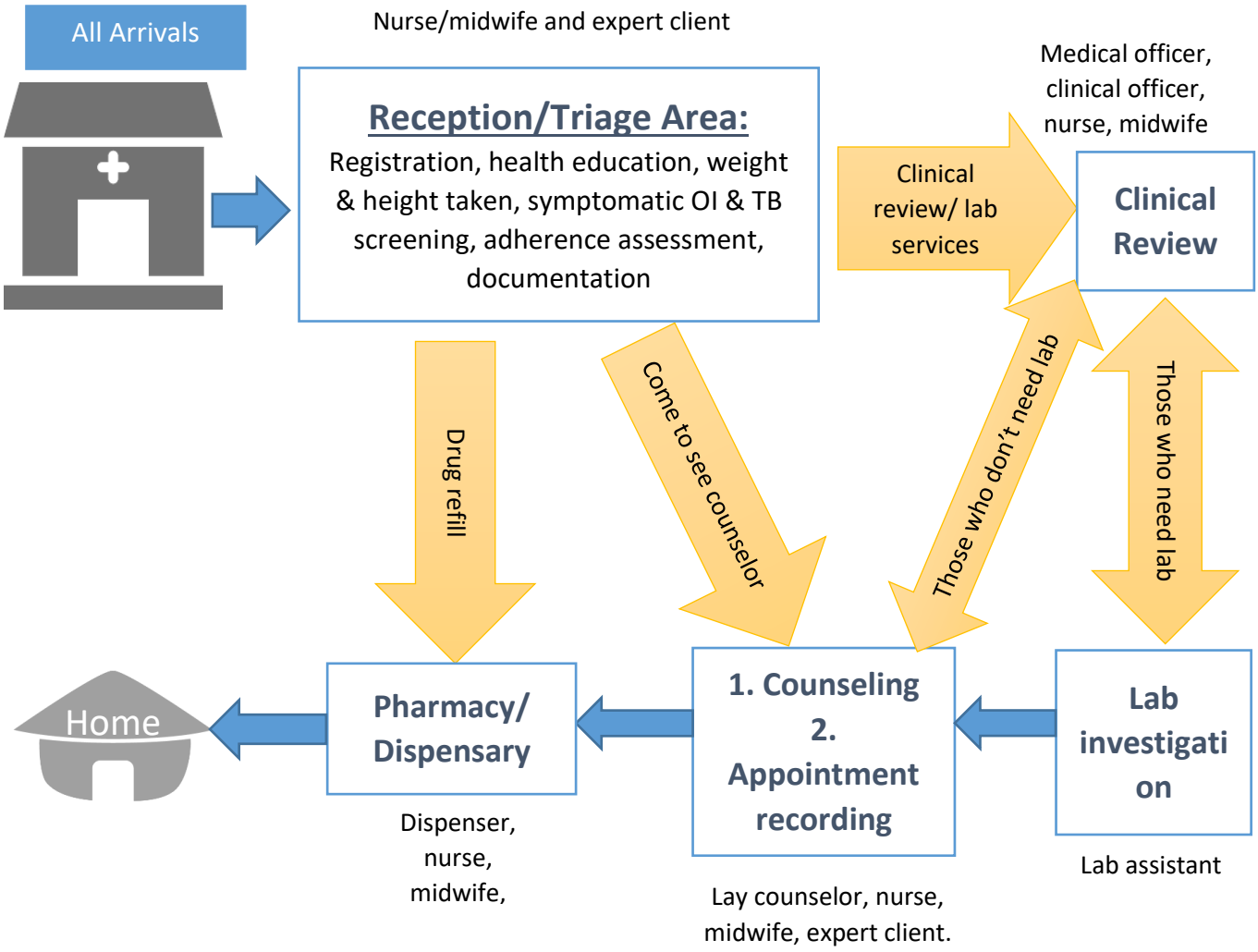
# 7 Client Flow, Client Tracking and Follow Up in Care in the Context of DSD

## 7.1. Definition

Client flow is the pathway followed by clients as they receive services between care points in a health facility or in a community from the time of arrival to departure

## 7.2. Recommended ART Clinic Client Flow

*Figure 10: Recommended ART client flow*



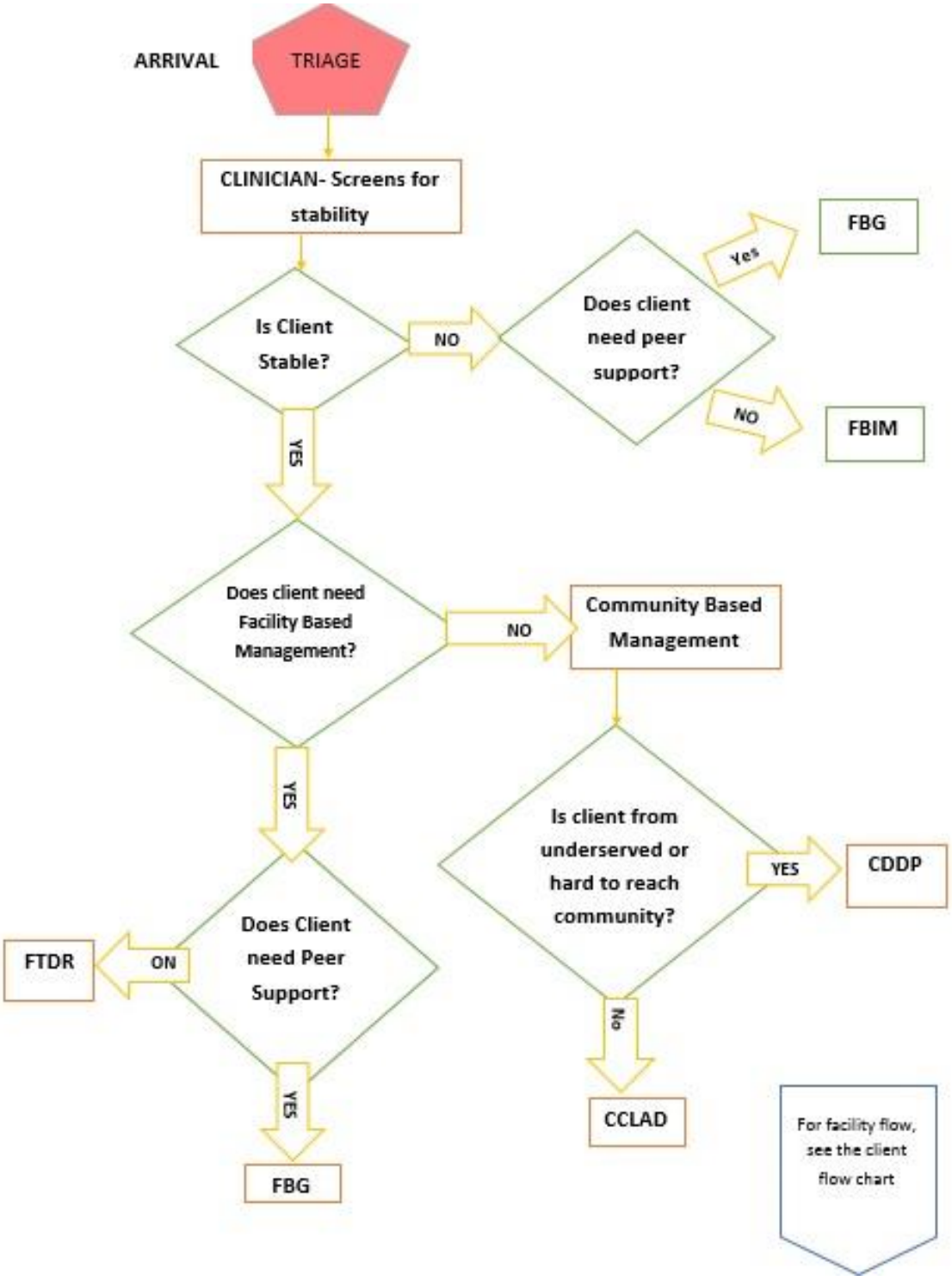

The above client flow may not be appropriate for the FBGs, especially the stable ones, as they arrive directly to their groups where they receive all the services. However, should they have complications they are referred to see a clinician.

At triage, the stability checklist should always be used for all clients previously categorised as stable.

## 7.3. Flow Chart for Categorization of Clients at the Point of Differentiation

All clients will need to be categorized and allocated an appropriate care and treatment approach. The flow chart below details steps to be taken to allocate an appropriate care and treatment approach for clients at the point of differentiation.

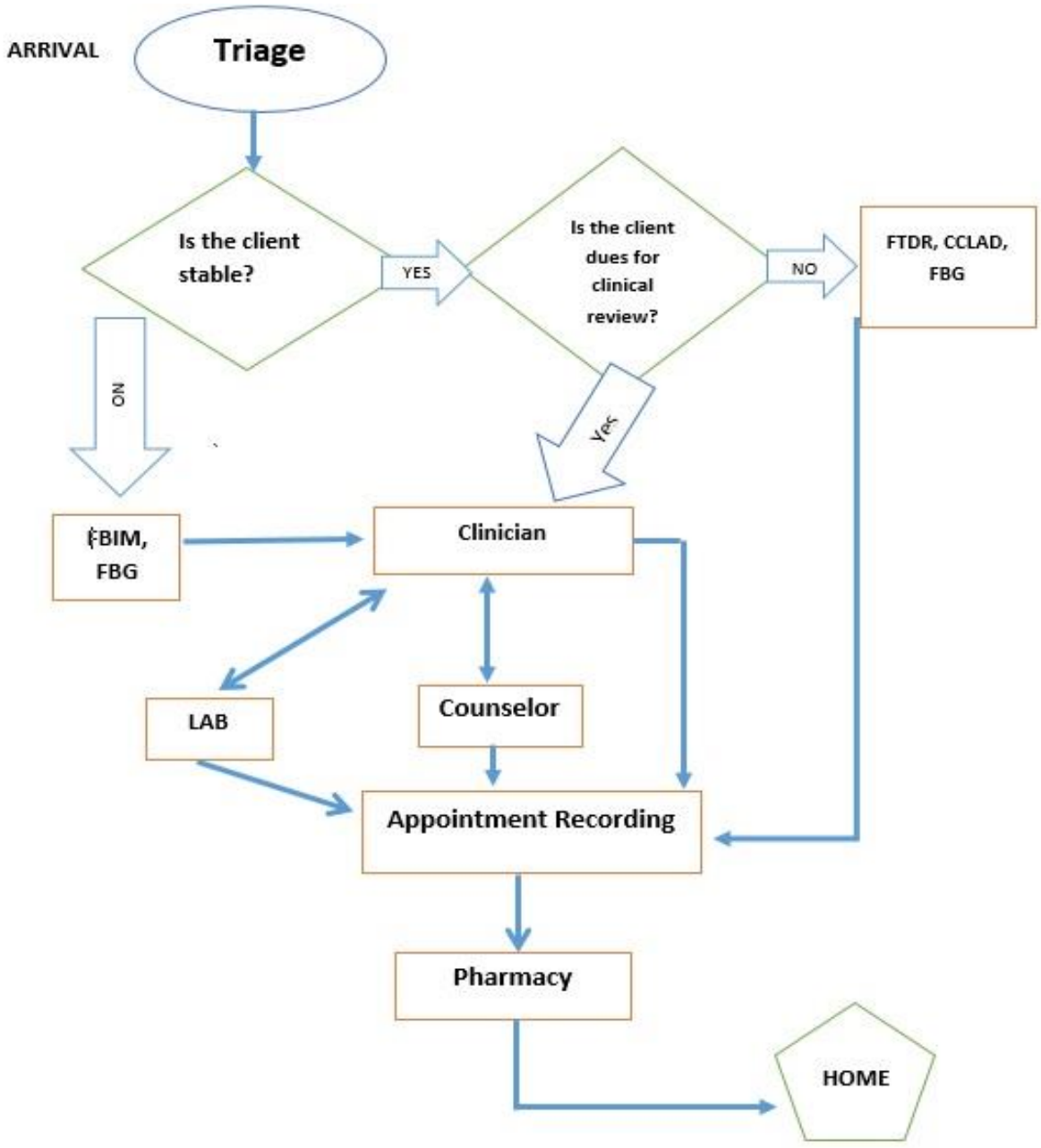
*Figure 11: Flow chart for categorization of clients into DSDM*



## 7.4. Client Flow for Clients Already Differentiated Into Care at the Health Facility

All HIV positive clients already differentiated into care need regular/continuous assessment to determine stability. This is done at the triage point. The figure below summarizes the flow for such clients at the facility with the exception of the CDDP groups whose assessment happens at the CDDP point.

*Figure 12: Flow chart for clients already differentiated into care*




## 7.5. Retention

Retention refers to keeping (or "retaining") or continuous engagement of clients in appropriate medical care throughout the HIV care and treatment continuum, regardless of whether they are receiving care in the facility or community. Data from the Uganda National ART programs shows LTFU stands at 21% in the first 6 months and at 26-30% in the first 2 years. The achievement of the UNAIDS goal relies on retention of clients.

## 7.6. Rationale for Retention

1. For clients on antiretroviral therapy (ART)
   - Prevent drug interruptions
   - Maintain immunologic benefits
   - Prevent HIV resistance
   - Monitor the effects of treatment
2. For clients not on ART, continuous monitoring is needed to prevent development of advanced disease
3. All patients benefit from the health education sessions, counselling, and other services provided at regular clinical visits.

## 7.7. How to Prevent Missed Appointments both in the Facility and Community Models

1. Provide client-centred care, i.e. appropriate a model of care and appointment timing according to the client's convenience
2. Get and document client contacts – phone, home directions etc. (explain importance of contact information)
3. Schedule appointments in line with the amount of medicine given to the client
4. Give actual appointment day and date (not weeks/months) and check client's understanding of the next appointment. Emphasize that the facility will be expecting him/her on that given date. Document appointment dates in the appointment book and client held cards
5. Provide continuous client education and adherence counselling
6. Utilize routine data to monitor retention in care (data capture & data review for client tracing)
7. Use of reminder SMS/phone calls for reminders about appointments.
8. Use of Treatment Buddies/Peers. For the CDDP, HCWs will need to remind clients (through their Group/Peer Leaders) about upcoming appointments

## 7.8. How to Identify a Missed Appointment

**Data sources for identifying defaulters**

1. Client appointment books
2. ART register
3. Pharmacy records (e.g., dispensing logs)
4. Community programming records (e.g., CCLAD monitoring form)

*Figure 13: Client appointment book*

**PATIENT APPOINTMENT BOOK (HMIS FORM 053)**

Name of Health Unit.....Month.....Financial Year.....

| | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) |
|---|---|---|---|---|---|---|---|---|
| | Patient Name | Patient File Number | Patient Phone Number | Type of care (please tick) | Number of visits after enrollment (please tick) | Patient Attended? | If No, patient followed up? | Reason/ notes from follow up (why patient missed appointment?) |
| 1 | Surname<br>First Name | | | ☐ Pre-ART<br>☐ ART<br>☐ ANC<br>☐ EID | ☐ 1 - 3 VISITS<br>☐ 4 or MORE VISITS | ☐ YES<br>☐ NO | ☐ YES<br>☐ NO | METHOD OF FOLLOW UP:<br>RE-SCHEDULED DATE: |
| 2 | Surname<br>First Name | | | ☐ Pre-ART<br>☐ ART<br>☐ ANC<br>☐ EID | ☐ 1 - 3 VISITS<br>☐ 4 or MORE VISITS | ☐ YES<br>☐ NO | ☐ YES<br>☐ NO | METHOD OF FOLLOW UP:<br>RE-SCHEDULED DATE: |

## 7.9. Filling in the Appointment Book for the CCLAD Approach

### a) Suggested Modification to the Appointment Book

The appointment book will be modified to include DSDM approaches.

### b) Appointment Scheduling

1. All the names of the members in a given CCLAD group will be listed in the appointment book one after the other
2. The CCLAD member that has come to the facility will have his/her reason for attendance ticked as comprehensive clinical evaluation.
3. The other members in the group will have reason ticked as CCLAD pick-up
4. Each of the members of that CCLAD group will be given an appointment date of the next date which will be that of their CCE, when they are all expected to return to the health facility

## 7.10. How to Identify Defaulters

### a) In the Health Facility or CDDP

1. At the end of each clinic day, review the appointment book and identify those who didn't come (i.e., those not ticked). This can only be useful if one correctly and consistently documents all the attended appointments (i.e. by ticking the clients that came)
2. Verify with other data sources for harmonization in case of omission e.g. the dispensing log
3. Manually compile or generate electronically, a list of those who did not attend for follow up

### b) In the Community for the CCLAD Group

1. Group Leaders should document (on the CCLAD monitoring form) any clients that miss meetings prior to drug collection. The group member picking the drugs should relay this information to the health workers. The health worker should take note of this but should not deny this client his/her drugs
2. The health worker should follow up with the group leader to establish whether the said client picked/received his/her drugs

3. If any group member does not pick his/her drugs within two days, the group leader should initiate the process of tracking through home visits or phone calls
4. If the group member cannot be traced within 7 days or has travelled a long distance, the group leader should inform the parent health facility immediately and return the medicines to the facility within seven days.

## 7.11. How to Follow Up/Track Clients Who Have Missed Appointments

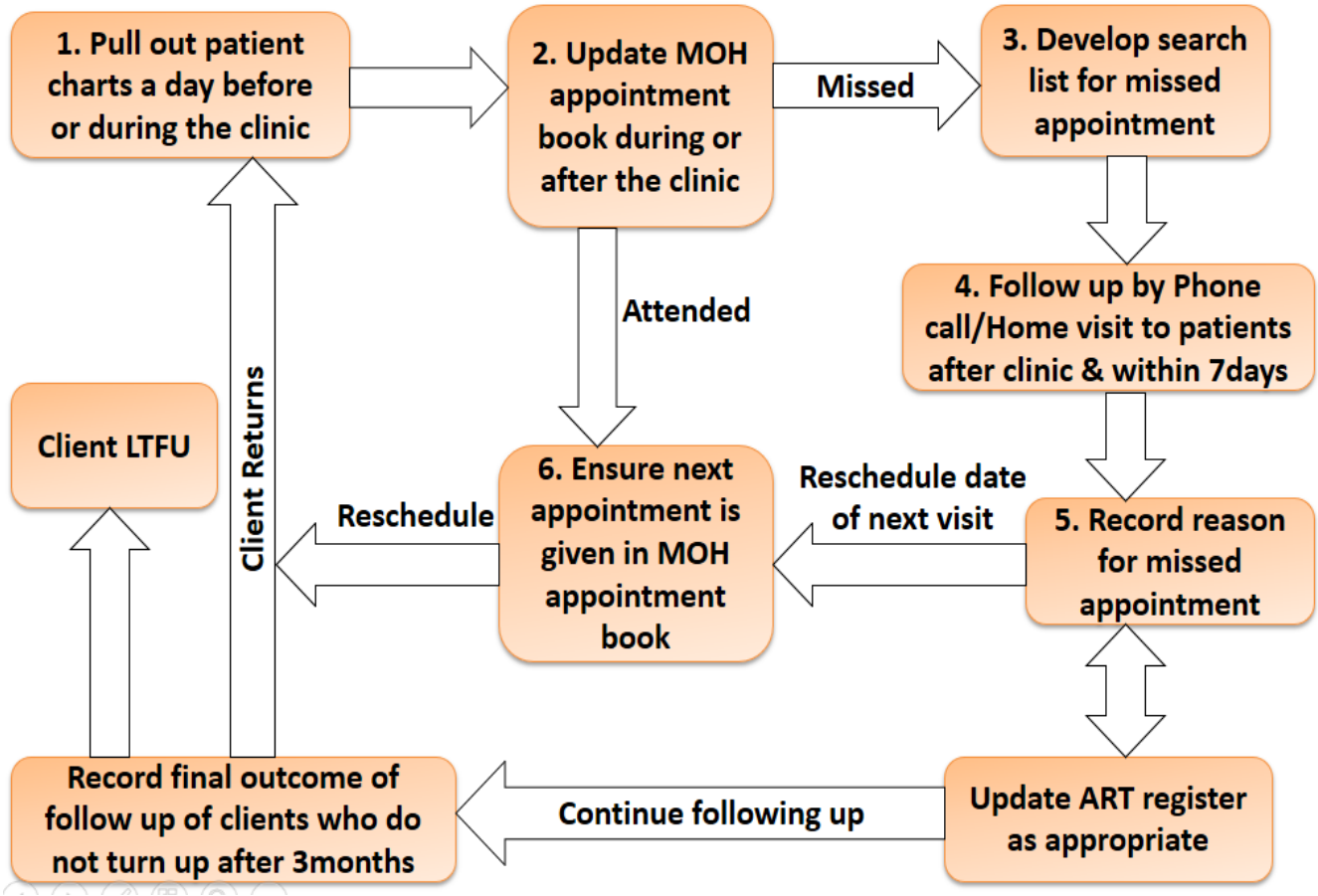
Once a loss is confirmed, tracking of the clients should commence straight away using the following steps:

a) Using phone calls where a contact number exists or reaching out to a treatment buddy or emergency contacts, and SMS reminders.
   - Make effective calls that gather all necessary information
   - One call with a response of "unavailable" is not enough; make further attempts
   - Record all phone calls and SMs reminders for evidence and accountability

b) Where clients are not reachable by phone, a search plan should be developed to include:
   - Who is visiting which clients at home and when
   - Mode of transport
   - Peers to visit clients in their vicinity
   - Consultation with community-based programs, VHTs, and CHEWS regarding the status of a client in their area through phone calls and by sharing the list of defaulting clients

The diagram below summarizes the steps to identifying and tracking lost clients. Consistent and correct use of the follow-up strategy (standard operating procedures) for tracking lost clients is recommended.

*Figure 14: Standard operating procedure for tracking lost clients*



## 7.12. Roles and Responsibilities for Client Follow-Up

Effective referrals are **Facilitated**, **Documented**, and **Confirmed** and there are key stakeholders to ensure this happens.

**Role of HCWs**

1. Consistently and correctly use the SOPs
2. Routinely analyze and utilize data for monitoring clients under DSD to identity lost clients and generate the search lists (see search list form below)
3. Cost the search plan and inform the In-Charge for funds
4. Conduct a home visit as necessary once the client is confirmed available in the setting
5. Facilitate referrals:
    a. Identify clients who potentially will transfer
    b. Ensure client record has good history of demographics, including geographical location
    c. Understanding, proposing, and linking clients to the nearby (or preferred) HIV service delivery point
6. Document referrals:
    - Complete formal written referral form (HMIS form 032 and ART clinic referral form)
    - Update the client chart and register
    - File copies of the referral forms sent and those received from the other sites
    - Write the client's service number (e.g. FSG) in the clinical chart, pre-ART in HCT register
    - Fill the triplicate referral forms for intra-facility referrals (1 copy for referring point, 1 for destination point, and the original for the client)
7. Confirm referral:
    - Dial out to the service providers at the destination sites
    - Ask the client to return the tear-off slip of the referral form
    - Harmonize data during the data review meetings
    - Engage partners/stakeholders in the regular facility or district based meetings

**Role of Peer Educators**

1. Support the HCWs to fill the Follow-Up Form and identify clients who missed their appointments
2. Provide group and individual counselling
3. Facilitate referrals
4. Conduct home-based visits
5. Defaulter tracing for ART clients who have not returned to the clinic within two weeks after missing an appointment
6. Follow-up defaulting clients in their homes
7. Document the health status of the client
8. Encourage them to return

**Role of Counsellors**

1. Conducting group and/or individual counselling (including adherence counselling)
2. Updating the appointment book
3. Developing search lists
4. Calling defaulting clients
5. Conducting home visits
6. Updating the corresponding tools

## 7.13. How to Utilize Data to Capture Lost Clients

Three main ways data can be used to identify lost clients and improve ART retention.

*Figure 15: How to utilize data to capture lost clients*

**DATA CAPTURE**

- Health facilities should improve the systems used to collect routine data by consistently and correctly using the appointment book or electronic medical record system that alerts staff when clients default

**DATA REVIEW**

- Health facilities should review facility and community data through audit meetings with a multidisciplinary clinic staff, community workers, and others to discuss how ART retention can be improved using techniques already established or identifying new methods

**CLIENT TRACING**

- Clients who miss a pharmacy, clinical, community, or laboratory appointment are identified using the records and contacted to determine status and/or bring them back to care

In addition, this process helps the health facilities to collect reasons why the clients are defaulting and have them addressed to increase retention.

*Figure 16: Search list form*

Month: .....Year: .....

| Missed appointment Date | Client Names | Sex/Age | Client No ART/EID | Client Telephone No. and/or address | Responsible staff | Follow up date / method | Outcome/Comments /Rescheduled date |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |

*Figure 17: SOP for filling the Search List Form*

| # | Column | Notes |
|---|---|---|
| 2 | Client Name | Write the full client's name. |
| 3 | Age/Sex | Write both parameters eg F 23 |
| 5 | Telephone contact | In case you write another person's contact please indicate |
| 6 | Responsible person | Indicate who of the staff will follow up the client especially where the phone call doesn't yield the desired result or is unavailable |
| 7 | Follow up date and method | Useful in monitoring duration between missing appointments and the institution of follow up mechanisms |
| 8 | Outcome/comment/re scheduled date | Record the final outcome of all possible attempts. Indicate reason for missed appointment & agreed on date |

## 7.14. Tools for Tracking

Some basic tools used in tracking clients include:

1. Follow up SOP
2. Client Tracking tool
3. Appointment Book
4. Search List Form
5. Guide for making a phone call
6. Missed appointment/client tracking summary report form
7. Phone accountability forms/booklet
8. List of contacts of various health facilities and other organizations (non-governmental organizations - NGOs/CBOs) nearest to the health facility
9. List of VHTs and PLHIV networks
10. Monthly ART data harmonization tool

# 8 Commodity Management for DSD

## 8.1. Definition

Commodity management is a supply chain management component that is used to meet customer demands through the planning, control, and implementation of the effective movement and storage of goods services, and related information, from point of origin to destination.

## 8.2. Importance of commodity management

1. Commodity availability promotes demand for HIV care services
2. Commodity availability ensures high quality of HIV care services
3. HIV/AIDS commodities are costly to procure and to manage and hence the need for good commodity management
4. Many HIV/AIDS commodities have short shelf life
5. ART is life-long and requires strict adherence.
6. It leads to customer satisfaction as well as that of health workers.
7. Well-managed logistics increase access to therapy and improve treatment outcomes (Without stringent methods of management of suppliers, stock outs and expiries may lead to reduced access to medicines, poor adherence, and poor outcomes of the antiretroviral therapy, drug resistance and death).

## 8.3. Guidance on Managing Supplies and Logistics for Differentiated Service Delivery

### a) Quantification

1. Sites should continue to quantify and order supplies based on their consumption or client volumes. The minimum and maximum stock levels remain at 2-4 months of stock.
2. All stock consumed at the various service delivery points should be aggregated to come up with total facility consumption to ensure accurate projection of requirement and avoid stock outs of medicines during implementation.
3. Any increase in consumption should be well documented and this information should be used for planning.
4. Enrolment of patients on to treatment should be planned in a collective manner to ensure adequate availability of stock.

**NOTE:** Where stock out is anticipated, priority should be given to those already on treatment.

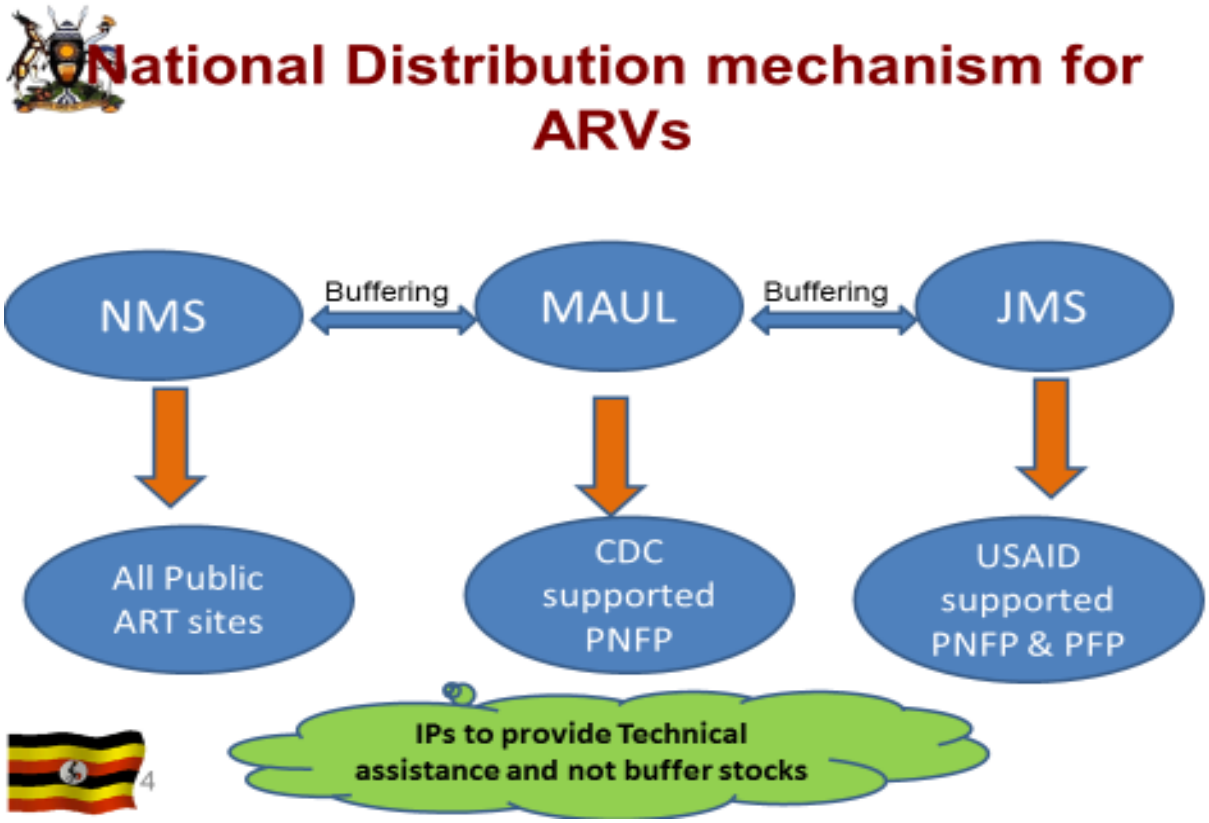
In preparation for the implementation of DSDM, sites should undertake the following:

1. Determine current consumption for each commodity **(AMC).**
2. Review and assess the current stocks of the ARV supplies **(SOH).**
3. Use the current consumption to determine how long the available stock can last **(MOS).**
4. Use the current consumption to determine how many more new patients can be enrolled in to treatment during the cycle.
5. If the stock at hand falls below the minimum level before reorder period **(2 MOS)**, make an emergency order to secure enough supplies before starting enrolment. Otherwise follow the routine ordering cycle.
6. Establish logistics management committees to monitor the stock levels on a monthly basis
7. Ensure the viability of a functional open MRS and all manual logistics management tools

### b) Distribution from warehouses to facilities

The distribution mechanism for ARVs under DSD will remain the same as it has been under the routine system outlined below:

*Figure 18: National ARV distribution mechanism*




The three central warehouses; National Medical Store (NMS), Joint Medical Store (JMS) and Medical Access Uganda Limited (MAUL) will continue to distribute ARVs to respective health facilities on a bi-monthly basis according to the respective warehouse published schedules. The health facilities will be supported by implementing partners to order accurately during the transition period to DSDM to ensure availability of the required supplies.

To avoid supply interruptions, warehouses are required to adhere to the delivery schedules and supply the drugs as per the Health Facility orders and avoid rationing.

### c) Ordering and storage at facilities

All Health facilities should always make correct and timely orders to the warehouses.

Health facilities should submit all HIV commodity orders and reports to the appropriate warehouse in line with their delivery schedules. Orders can be submitted electronically through the DHIS2 Web Based Ordering System **(WAOS for ARVS/TWOS for Anti-TB drugs)** at the facility or through the district. Where it is not possible to submit an electronic order, facilities should submit paper-based orders through the district.

Health facilities will maintain one store-one stock card systems for all medicines. The FEFO/FIFO Principles and all good storage and record keeping practices shall apply.

**Note:**

With the introduction of DSDM, the consumption will increase, moving the buffer stocks below the current recommended minimum stock levels **(2 MOS)**. Therefore, in calculating the quantities required for the next order cycle, the quantity required by the health facilities will increase above the original maximum stock level **(4 MOS)** taking into consideration the adjusted consumption. This implies that the buffer stock (minimum stock level) held at a site and central stores will have to increase to cater for the adjusted consumption arising from the longer refills.

### d) Dispensing at facilities

The health workers shall adhere to the standards of good dispensing practices.

1. Health facilities are expected to have a functional open MRS or appointment books to allow generation of the drug pick-up list to be used by the expert clients/lay providers in the pharmacy/dispensary for drug pre-packaging for the DSDM clients.
2. Health facilities are encouraged to accommodate task shifting. E.g. under the guidance of a Pharmacy personnel, they shall consider use of lay providers for pre-packing ARV drugs for client groups and adopt approaches and tools for tracking medicines.
3. Dispensed medicines should be well labelled to ensure correct patient receives correct treatment
4. All dispensed medicines should have quantities dispensed recorded in the dispensing logs

## 8.3.1. Refilling drugs for clients on fast-track and facility-based groups

1. The pharmacy team should obtain the drug pick-up list from Open MRS, or manually where there is no electronic medical record system.
2. Daily calculations/estimates should be done to determine the total quantity of medicines required for the clients expected on that day.
3. Pre-packaging should be done for each of the clients ensuring that they receive a full supply to cover the period to the next drug refill. This may be done by the pharmacy or by supervised support staff.
4. Labelling and dosing should be done correctly

## 8.3.2. Refilling drugs for clients on community-based models

Pre-packaged drugs make distribution of drug refills to individual clients quicker and easier. Pre-packaging should be done for each of the clients ensuring that they receive their designated supply. This may be done by the pharmacy or by supervised support staff. The pharmacy staff should do labelling and dosing. Each client package should contain enough supplies until the next appointment.

### a) CCLAD Clients

1. One client will pick up the pre-packed medicines for the rest of the group and distribute them to the rest of the group members.
2. All medicines issued to the group members should be recorded in the dispensing tool
3. The health worker should schedule the next appointment for the patient according to their schedule
4. TB co-infected clients on Anti-TB drugs continuation may receive their refill of the Anti-TB drugs together with the ARVs for TB/HIV co-infected patients in the CCLAD group

### b) Managing drug balances in the CCLAD

1. The Team Leader should document any remaining pill balances in the CCLAD Monitoring Form (adherence column) for each of the group members during the pre-pick up meeting
2. In the event of any pill balances, the client should first take the remaining pills before starting on the newly supplied drugs.
3. Each client will bring all his/her pill balances during his/her time for picking drugs for the group.
4. Clients on TB medication will count and report blister packs of the medicines left at every meeting

### c) CDDP Clients

1. Pharmacy staff should ensure safe transportation to the sites.
2. At the community site; dispensing is done by the health worker.
3. Dispensed medicines should be recorded in the dispensing log
4. The health worker should schedule the next appointment for the patients according to their schedule

### d) Instructions for Pre-Packaging

The health workers are expected to adhere to the standard dispensing practices including requirements for medicines' packing and packaging.

1. Sites shall order envelopes to pack individual OI drugs while ARVs & Anti-TB drugs should be left in their original secondary packages and shall be clearly labelled with dose and patient name.
2. The individual client drugs will be tied together with masking tape bearing the name of that individual.
3. For the CCLAD & CDDP models, all the drugs for the members of one group will then be put together and labelled with the group name.
4. The group representative will be expected to come with a bag for carrying the drugs back for distribution at the community.
5. Ensuring clear packaging and labelling of drugs with clear instructions for each individual client in the CCLAD and CDDP approaches will be done by a trained expert client a day before the clinic, under supervision of the dispenser/pharmacist.
6. Once medicines are issued, they should be recorded in the dispensing log

### e) Managing drugs returned to the facility after failing to trace a CCLAD group member.

1. Drugs returned to the facility must be received at the dispensing point
2. Check the returned medicines for expiry, any damages, broken seal or dirt.
3. These drugs should be recorded on the medicines return form clearly indicating the name of drug, quantity and expiry date.
4. Expired medicines should be entered into the expired medicine register (HMIS088)

## 8.4. Reporting Consumption

1. Facility orders are consumption based and thus it is important to pay attention to consumption reporting for all DSD models and how this will feed into the bi-monthly orders.
2. The HCW must ensure that the ARVs & anti-TB drugs dispensed are captured into the dispensing logs in a timely manner.
3. Health facilities shall stock and utilize these tools to account for the community dispensing and report to facility. Some of the necessary tools include Dispensing lists/Drug pick up lists (automatically generated by the Open MRS system) among others.

# 9 Monitoring & Evaluating the Implementation of DSD

Monitoring the roll-out and implementation of DSD in the continuum of the HIV response is critical for tracking performance towards achieving the 90-90-90 goals, while ensuring high quality of care and optimal clinical outcomes and improving services for HIV-infected individuals.

This module aims at providing guidance to district health teams, health facility In Charges and the HCWs on the processes and indicators to be used for monitoring DSD in Uganda.

## 9.1. Definitions

**Monitoring** is the systematic collection and analysis of information as an activity progresses

**Evaluation** is the periodic comparison of actual outcomes or/and impacts against set targets

## 9.2. Rationale for Monitoring & Evaluation

Monitoring DSD implementation shall enable the managers, health facility In Charges, HCWs, and other stakeholders to:

- Make informed **decisions** for programme and policy planning
    - Understand eligibility for and participation in existing models of care
    - Understand implementation of DSD models including processes, benefits and challenges
    - Explore client perspectives on benefits, challenges, and costs associated with DSD
    - Align client record forms to facilitate client differentiation.
    - Monitor emerging issues at health facilities that affect DSD uptake and client quality of care
- **Assess performance** against set targets
    - Track extent of DSD implementation in participating facilities
    - Obtain feedback from providers on various DSD models and approaches implemented at their facility
    - Monitor quality of care provided to clients within various models and their clinical outcomes
    - Monitor the outcomes of clients receiving HIV care under the various DSD models
    - Allow for the comparison between what was planned to occur and what is actually occurring
    - Determine the extent to which the health facility/project/program is on track to meet its targets or /and to make any needed corrections accordingly
    - Evaluate the extent to which the program/project is having or has had the desired outcomes and/or impacts
- Provide **accountability**
    - Develop feedback channels to understand and address challenges in specific models and approaches
    - Monitor commodity stock availability and any other supply chain mechanism
    - Produce and share information with stakeholders

## 9.3. How to Monitor Differentiated Service Delivery

Understanding how to capture data and report data on DSD is the first key step to monitoring implementation. Data for DSD will be captured using the HIV data collection tools which will be modified appropriately to include DSD variables.

## 9.4. DSD Data Capture and Flow for Differentiated HIV Testing Services

HIV Testing Services are differentiated within the facility and community. The existing tools will be used to record and report all HTS related data within the facility and the community.

### a) HIV Testing Services Data recording

HMIS data recording Tools

- HMIS ACP 019: HIV Testing Services Client Card
- HMIS ACP 020: HIV Testing Services (HTS) Register
- HMIS MCH 005: Integrated Antenatal Register
- HMIS MCH 006: Integrated Maternity Register
- HMIS MCH 008: Integrated Postnatal Register
- HMIS LAB 016: Daily Activity Register for Recording HIV Tests
- HMIS ACP 004: HIV Comprehensive Referral and Linkage form
- HMIS Form 080: Linkages and Pre-ART Register

There are several entry points within the health facility where testing takes place (OPD, Ward/IPD, ART Clinic, TB Clinic, Nutrition Unit, STI Clinic, Young Child Clinic, ANC, Maternity, PNC, Family Planning, SMC, EID). At the community, several testing points will be arranged based on the approaches and the groups targeted (Workplace, Home-Based Testing, Drop-in centre, Hotspots).

At every testing point, complete an HIV Testing Services Client Card (HMIS ACP 019) for each person who is eligible for an HIV test. The HTS client cards from all the testing points within the facility (with the exception MCH) are collected and data entered into the HIV Testing Services (HTS) Register (HMIS ACP 020). HIV tests done within MCH are recorded directly in the three MCH registers (Integrated Antenatal register – HMIS MCH 005, Integrated Maternity register – HMIS MCH 007 and Integrated Postnatal register – HMIS MCH 008).

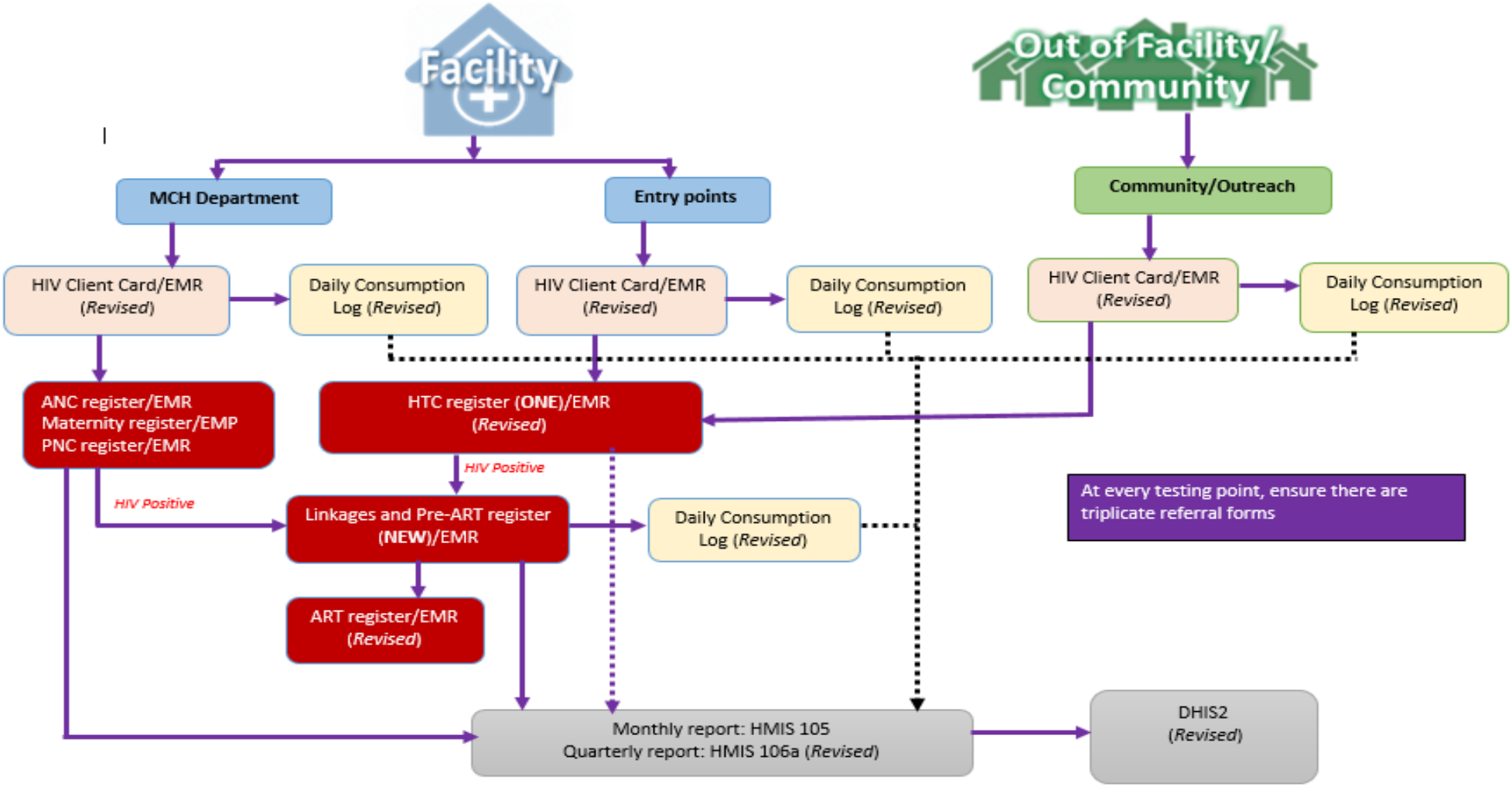
The HTS register has been revised to capture patient level data by HTS models (Facility based HTS and Community based HTS), HTS Approaches (CICT/VCT and PITC), entry Point for Health Facility Testing and Community Testing points.

For every HIV test done at any point, record in the Daily Activity Register for Recording HIV Tests (HMIS LAB 016) the test kits used and results guided by the standardized HIV testing algorithm.

Details of any person identified HIV positive at any testing point within and out of facility are transferred from the primary registers (HMIS ACP 020, HMIS MCH 005, HMIS MCH 006 and HMIS MCH 008) into the Linkages and Pre-ART register for follow up and documentation of complete linkage to HIV care services.

An HIV Comprehensive Referral and Linkage form (HMIS ACP 004) is completed for all HIV positive persons identified at every testing point and this facilitates linkage to HIV care services.

Figure 19: Data flow chart for differentiated HTS



### b) HIV Testing Services Data Reporting

The following data elements will be monitored and reported on using the existing Health Unit Outpatient Monthly Report (HMIS 105)

*Table 28: HTS data elements, data sources and disaggregation levels*

| Data Element | Data source | Disaggregation levels |
|---|---|---|
| Number of clients tested | **ALL entry points except MCH**<br>HMIS ACP 020: HIV Testing Services (HTS) Register<br>**MCH entry points**<br>HMIS MCH 005: Integrated Antenatal Register<br>HMIS MCH 006: Integrated Maternity Register<br>HMIS MCH 008: Integrated Postnatal Register | • HTS models (Facility, Community)<br>• HTS approaches (PITC, VCT)<br>• Entry points for Facility-based testing and testing points for community-based testing<br>• Age groups (<1, 1-4, 5-9, 10-14, 15-19, 20-24, 25 – 29, 30-34, 35-39, 40-44, 45-49 and 50+)<br>• Sex (Male, Female) |
| Number of clients tested HIV Positive | **ALL entry points except MCH**<br>HMIS ACP 020: HIV Testing Services (HTS) Register<br>**MCH entry points**<br>HMIS MCH 005: Integrated Antenatal Register<br>HMIS MCH 006: Integrated Maternity Register<br>HMIS MCH 008: Integrated Postnatal Register | |
| Number of identified HIV positive clients linked to care | HMIS Form 080: Linkages and Pre-ART Register | |

The facilities will report on individual cases and the table below summarizes models and approaches to be reported against.

*Table 29: Monthly HTS reporting by models and approaches*

| Models | Approaches | Tested | Tested HIV positive | Linked to Care |
|---|---|---|---|---|
| **Facility** | PITC | | | |
| | CITC (VCT) | | | |
| **Community** | PITC | | | |
| | CITC (VCT) | | | |

HIV testing services will be reported by model (Facility and Community), entry points at facility (OPD, Ward/IPD, ART Clinic, TB Clinic, Nutrition Unit, STI Clinic, Young Child Clinic, ANC, Maternity, PNC, Family Planning, SMC, EID), testing points in the community (Workplace, Home-Based Testing, Drop-in centre and Hotspots) and testing approach disaggregated by age and sex. This data can be analysed routinely by facilities for programming improvement.

## 9.5. Data Capture and Flow for Differentiated HIV Care and Treatment Services

Differentiated HIV Care and Treatment services will be monitored through the existing HIV/AIDS HMIS, with slight modifications in some of the data tools. Where necessary, new tools will be designed to support data capture and flow especially within the community models.

### a) HIV Care and Treatment Services Data Recording

HMIS Data recording tools:

- HMIS ACP 003: HIV ART Care card
- HMIS ACP 005: ART Register
- HMIS ACP 022: Peer Psychosocial Support Group (PPSG) Activity Tracking Log
- HMIS ACP 006: Patient Appointment Book
- HMIS LAB 002 Daily Activity Register for Viral Load, CD4, TB LAM & CRAG

- HMIS ACP 001Viral Load Non-Suppressed Register
- HMIS ACP 010 Community Client led ART delivery Monitoring form (CCLAD)

In general, the primary data recording tool for differentiated HIV care and treatment services will be the HIV ART Care card (HMIS ACP 003). Each visit made by/represented for an HIV+ client on treatment must be documented on the HIV care/ART card and the current DSD approach recorded on the same card by the clinician (Medical Officer, Clinical Officer or Nurse) conducting the client's clinical review. The DSD approach (DSDM code) will be recorded on the Encounter page of the HIV care/ART card under the DSDM column. The various DSD approaches have been coded for inclusion into the data tools as shown in the table below.

The ART register will be updated using a DSD codes and will be captured in the DSDM box in the follow up section.

*Table 30: Data flow by DSD approach*

| DSD approach | Data Flow |
|---|---|
| Facility Based Individual Management (FBIM) | • Clinician at the facility records patient data on HIV care/ART card each time patient is seen/represented; highlighting patient's DSD approach (i.e. ***FBIM***)<br>• At month end, the Records Assistant at the facility updates the ART register with details for the last visit made in that particular month, highlighting the DSD approach in the DSDM box (i.e. ***FBIM***) |
| Facility Based Groups (FBG) | • Clinician at the facility records patient data on HIV care/ART card each time patient is seen/represented; highlighting patient's DSD approach (i.e***. FBG***)<br>• Additional data is captured in the Peer Psychosocial Support Group (PPSG) Activity Tracking Log (HMIS ACP 022)<br>• At month end, the Records Assistant at the facility updates the ART register with details for the last visit made in that particular month, highlighting the DSD approach in the DSDM box (***i.e. FBG***) |
| Fast Track Drug Re-fills (FTDR) | • Triage Nurse at the facility records patient data on HIV care/ART card each time patient is seen/represented (Quarterly); highlighting patient's DSD approach (i.e***. FTDR***)<br>• The Records Assistant at the facility updates the ART register with details for the last visit made in that particular quarter, highlighting the DSD approach in the DSDM box (***i.e. FTDR***) |
| Community Drug Distribution Points (CDDP) | • Clinician at CDDP records patient data on HIV care/ART card each time patient is seen/represented (Quarterly); highlighting patient's DSD approach (i.e. ***CDDP***)<br>• The Records Assistant at the facility updates the ART register with details for the last visit made in that particular quarter, highlighting the DSD approach in the DSDM box (***i.e. CDDP***) |
| Community Client Led ART Delivery (CCLAD) | • CCLAD Group leader completes the community assessment section of the CCLAD form for each group member during the pre-drug pickup meetings.<br>• At the end of each quarter, the CCLAD Group leader or one of the group representative returns the completed CCLAD form to the health facility for drug refills:<br>• For a drug refill visit, the Triage nurse:<br>○ Updates each of the CCLAD group members' HIV care/ART card with data from the submitted CCLAD form; highlighting patient's DSD approach (i.e***. CCLAD***)<br>○ Issues a new CCLAD form, indicating drugs given to each CCLAD group member and return visit date<br>• For a comprehensive clinical assessment visit:<br>○ A clinician reviews each of the CCLAD group members, including doing the recommended laboratory tests. Details are recorded on each CCLAD members HIV care/ART card; highlighting patient's DSD model (i.e. ***CCLAD***)<br>○ Triage nurse then issues a new CCLAD form, indicating drugs given to each CCLAD group member and return visit date<br>• The Records Assistant at the facility updates the ART register with details for the last visit made in that particular quarter, highlighting the DSD approach in the DSDM box (i.e. ***CCLAD***) |

*Figure 20: Community client led ART delivery (CCLAD) monitoring form*

**SEC A:** Health facility Name: _____ Health Facility level: _____ District: _____ Sub county: _____ Parish: _____

**SEC B:** CCLAD Group Code: _____ Unique Identifiier for group member who pic Name of attending Health worker: _____ Next Appointment Date: _____

| SEC C | | | | | SEC D | | | SEC E | | SEC F | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Patient Identifiers** | | | | | **Facilty Drug Refill Details Date** | | | **Drug Refill Accountability** | | **COMMUNITY PRE-DRUG PICK-UP MEETING (ASSESSMENT)** | | | | |
| Group member Unique identifier (Serial #) | Patient clinic # (ART #) | Patient Initials | Sex | Age | Drugs given | # of pills | # of days | Date drugs received by patient | Patient signature | Patient status | TB status | # of Pills returned | Preg/FP status (P, FP, No FP) | MUAC |
| | | | | | ARV regimen code | | | | | | | ARVs | | |
| | | | | | CTX/Dapsone | | | | | | | CTX/Dap | | |
| | | | | | TB Drugs | | | | | | | TB drugs | | |

| Patient status codes | TB Status codes | Pregnancy/Family Planning Status codes | MUAC codes |
|---|---|---|---|
| *1-Attended Community Assessment* | *1- No signs* | *P- Pregnant* | *G- Green* |
| *2-Missed Community Assessment* | *2- Presumptive TB* | *FP- On Family Planning* | *Y- Yellow* |
| *3-Dead* | *3- TB Diagnosed* | *No FP- Not on Family Pl* | *R- Red* |
| *4-Returned to health facility* | *4- Currently on TB treatment* | | |

*Figure 21: Data flow for differentiated HIV care and treatment*

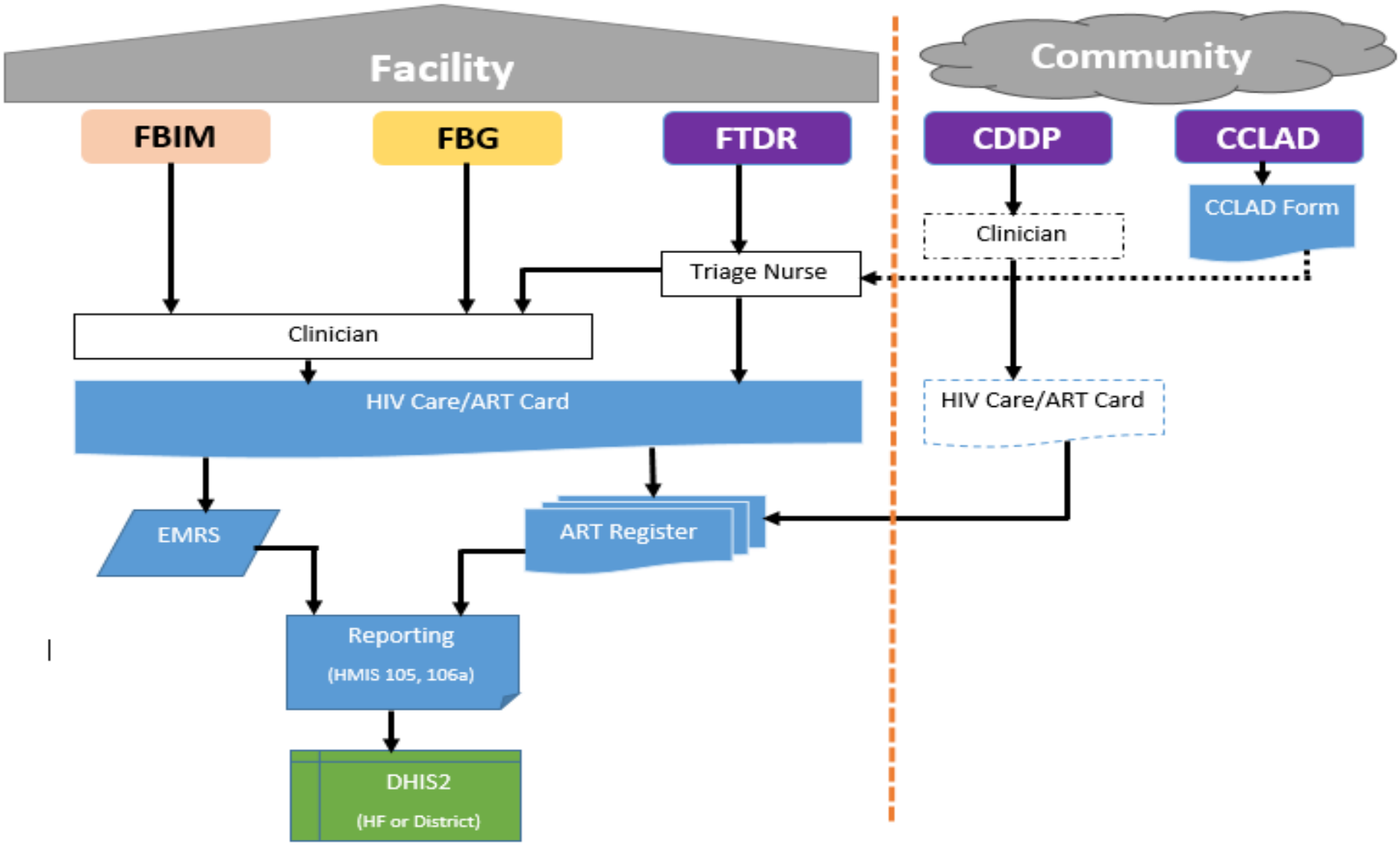
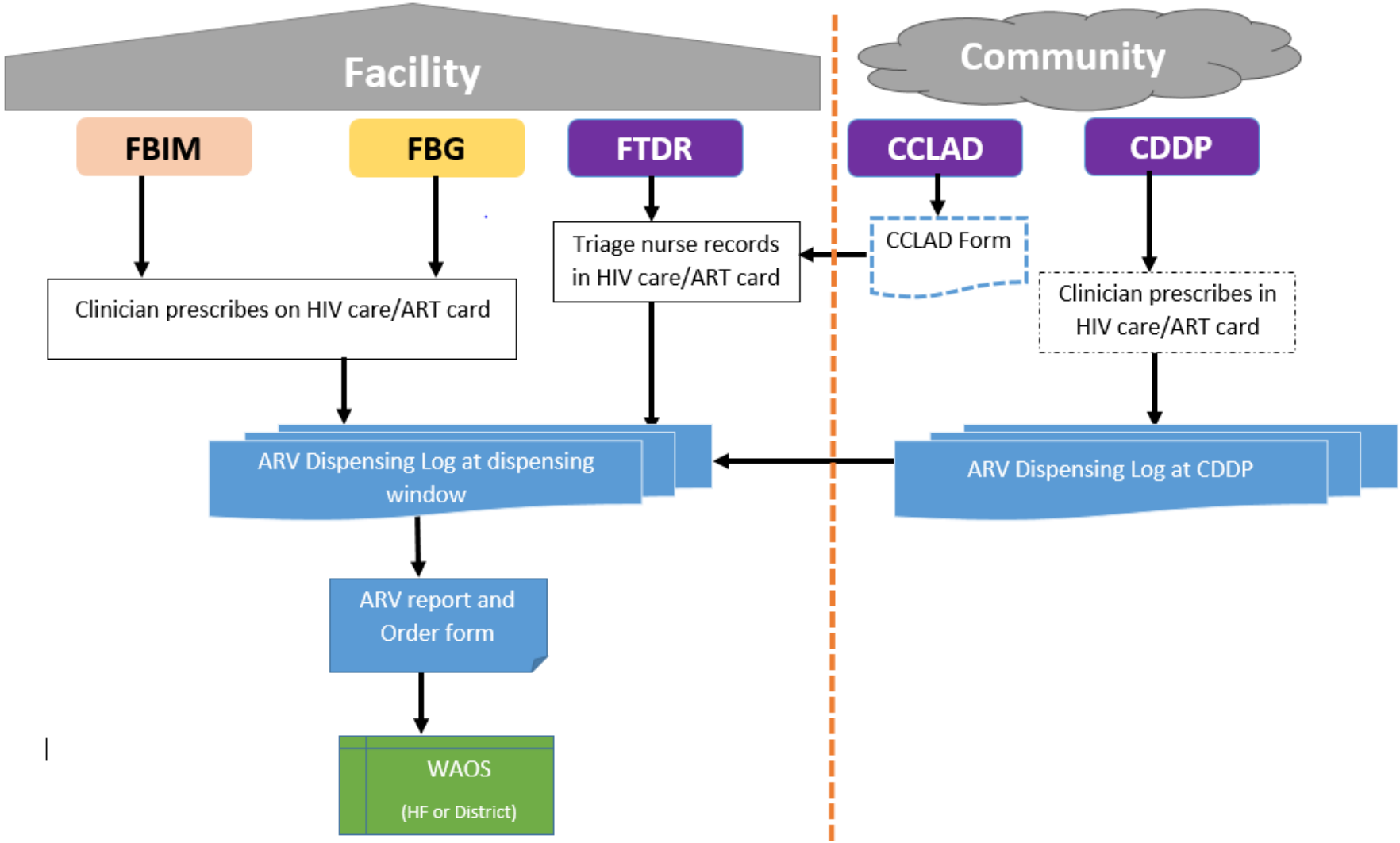


*Figure 22: Drugs (ARVs) data flow chart*



### b) HIV Care and Treatment Services Data Reporting

The following data elements will be monitored using the existing Health Unit Quarterly Report (HMIS 106a)

*Table 31: HIV Care and Treatment data elements, data sources and disaggregation levels*

| Data Element | Data source | Disaggregation levels |
|---|---|---|
| Number of clients newly enrolled in each DSD model during the reporting quarter | ART Register (HMIS ACP 005) | • DSD approaches<br>• Age groups (<1, 1-4, 5-9, 10-14, 15-19, 20-24, 25 – 29, 30-34, 35-39, 40-44, 45-49 and 50+)<br>• Sex: Male, Female |
| Number active on ART by DSD approach | | |
| Number active on ART achieving viral suppression by DSD approach during the reporting quarter | | |

These data elements will be aggregated and summarized at the health facilities based on the tables below

*Table 32: Cross sectional quarterly HIV care and treatment reporting by approaches*

| DSD Approaches | Number of clients newly enrolled in each DSD approach during the reporting quarter | Number active on ART | Number active on ART achieving viral suppression |
|---|---|---|---|
| **Facility Based Individual Management (FBIM)** | | | |
| **Facility Based Groups (FBG)** | | | |
| **Fast Track Drug Re-fills (FTDR)** | | | |
| **Community Drug Distribution Points (CDDP)** | | | |
| **Community Client Led ART Delivery (CCLAD)** | | | |

## 9.6. Key Considerations for Successful M&E of DSD

1. Accurate and timely documentation of all HIV care and treatment data recording and reporting tools
2. Right coding specific to DSDM is key to tracking outcomes of clients
3. Keeping a functional and up-to-date medical records system is vital for routine categorization, tracking and reporting of patients under different DSD models
4. The points of data capture within the client flow system should be known, have the appropriate tools and the responsible persons in place
5. For clients that may cross over into another DSD approach, the most recent/current approach as at end of the reporting period is what will be reported

## 9.7. Evaluating DSD Implementation

DSD process and outcome evaluations shall be conducted to evaluate program fidelity (i.e. if DSD roll out is being implemented as planned), patient outcomes, etc.

### a) Process evaluations

Process evaluations shall be used to identify facilitators and barriers to DSD implementation from multiple perspectives (e.g. patient, provider, community, laboratory technician, M&E officer, etc.) and to identify and document lessons learned to inform further scale-up efforts.

**Examples of Process Evaluation Questions:**

- Was DSD scaled-up and implemented as planned?
    - What worked? What did not work?
- How are M&E, program/clinical, and lab staff working together to review and use DSD data on:
    - HIV Testing Services?
    - HIV Care and Treatment?
- Were staff adequately trained or oriented to use data to monitor clients on DSDM?
- Was there adequate support for DSD implementation (including providers at sites, lab transporters, laboratory technicians, and M&E staff)?
- Which models of HIV Testing Services result in more people receiving HIV testing and results?
- As a measure of quality of DSD implementation, how effective is VL in enabling categorization and monitoring of clients in the various DSD models of service delivery both in facilities and community ART groups?

### b) Outcome evaluations

The outcome evaluations shall be conducted to determine program effectiveness. Baseline data shall be collected in order to measure change and therefore shall be planned before or during the early stages of DSD implementation. By planning ahead, the program together with the sites and regional teams will be able to articulate evaluation questions, develop protocols, collect baseline data, and plan for subsequent data collection for a high-quality outcome evaluation.

**Examples of Outcome Evaluation Questions:**

- What were the best practices that ensured patients on DSD received VL testing and results in a timely fashion, understood VL results, and received adherence counselling to improve ART adherence?
- Which DSD models had the most success with adherence or VL testing and suppression? Were there any significant differences in clinical outcomes between different sub-populations? Why?
- How has quality of HIV services, particularly adherence counselling and support, changed as a result of DSD?
- What were the optimal DSD models of enhanced adherence counselling that ensured patients are adhering to HIV treatment and are virally suppressed?
- How well did self-reported adherence rates predict viral suppression under the DSD?
- How did the implementation of DSD impact the timely switch of patients to appropriate second-line and third line therapies?

It is critical that the national M&E plan is allocated an appropriate budget for the execution of an effective evaluation plan to support effective DSD implementation. Engaging stakeholders early in the implementation planning process will help the country prioritize evaluation questions and resources required to execute the evaluation (i.e. technical, budget, and staff time). Once there is

agreement on evaluation priorities and resources have been allocated, plans to execute the evaluation can move forward. Evaluation protocols should be developed as soon as possible so that programs have adequate time to collect baseline data, where required.

### c) Operations Research

Operations Research (OR) is the use of scientific methodology to evaluate systems whose design or operation require human decision making or will give us the means to study how effective the design and implementation of DSD models are and make subsequent decisions based on the results.

**Examples of Research and Evaluation Topics**

1. Acceptability and feasibility of a given differentiated care model: health care workers, clients, and care givers (in the context of children)
2. Descriptive cohort study to determine effects of a given differentiated care model in client cascade: testing, linkage to treatment, enrolment on ART, retention, treatment outcomes.
3. Client satisfaction survey for a given differentiated care model: a multi-country study.
4. Impact of a given differentiated care model: cluster randomized study or using pre and post method
5. Cost effectiveness and cost efficiency of a given differentiated care model.
6. Evaluation of patients' outcomes in a given differentiated care model.
7. Evaluating quality of care in a given differentiated care model
   Resources should be allocated to examine the following important topic areas that will further strengthen the evidence-base on how differentiated models of care work

1. How to most effectively bring together various interventions to create holistic systems of differentiated care
2. How decentralized or community-based care may also be applied to unstable patients
3. How to best ensure that we are also improving care for late presenting or unstable patients when implementing differentiated models of care
4. How innovative tools may affect models of differentiated care (e.g. better tolerated ART or injectable ART; decentralization and scale-up of point-of-care VL monitoring)
5. Differentiated laboratory monitoring for various populations – for example, more frequent virologic monitoring for pregnant women or paediatric populations.

## 9.8. DSD M&E Roles and Responsibilities

Implementation of DSD will require completion of additional M&E tools and analysis of the new data in order to ensure patient care is not being compromised by introducing new models of care. It is key that all staff know their role in monitoring these clients.

- All stakeholders (policy makers, program managers, Regional Performance Monitoring Teams (RPMTs), District Health Teams (DHTs), health facility in charges, caregivers, health workers, community leaders and CBOs) working with PLHIV are expected to monitor key indicators to measure progress of DSD model implementation (rollout and functionality) and PLHIV outcomes both in the health facilities and in the community.
- Various levels of health care should analyse and compare the review data routinely

**Clinician**

- Document every clinical encounter on the HIV care/ART card/TB Treatment card
- Update all registers e.g. HTS, ART, TB
- Participate in data review meetings for the HIV clinic
- Participate in quality improvement review meetings

**Pharmacist/Pharmaceutical Technologist/Dispenser**

- Complete the commodities accountability tools e.g. Dispensing logs, daily consumption logs
- Participate in data review meetings for the HIV clinic
- Participate in quality improvement review meetings

**Health Records Information Officer/Data Entry Clerk**

- Mentor lay health workers on data entry into the primary data source documents like appointment books
- Summarize HIV data from the various HMIS tools in line MoH Reporting Requirements
- Conduct and facilitate monthly data review meetings at the facility level
- Conduct Data Quality Assessments (DQA) based on reports that are routinely submitted to through the HMIS
- Liaise with the district HMIS focal point and ensure consistent supply of data tools at the facility
- Ensure timely submission of reports to the DHOs office for entry into DHIS2 on time

**Implementing Partners' Strategic Information Units**

- Collate electronic medical records (EMR) data into the national Data Warehouse
- Conduct quarterly analysis of DSD indicators
- Offer technical assistance (TA) to DHTs and HCWs at the health facility level on implementation of DSD
- Support district and regional data reviews and make evidence-based recommendations for program improvements

**MoH Strategic Information Unit**

- Collate EMR data into the national Data Warehouse
- Conduct quarterly analysis of DSD indicators
- Offer TA to implementing partners, DHTs and HCWs at the health facility level n implementation of DSD
- Lead the process of review for primary data collection tools, registers and summary HMIS tools

Support regional and national data reviews and make evidence-based recommendations for program improvement

# 10 Application of Quality Improvement Strategies in Differentiated Service Delivery

Quality of care emphasizes that services should be effective in achieving desired health outcomes and that health-care practices should be people-centred and safe[8].

## 10.1. Definitions

**Quality** in health care is defined as the degree to which a health service meets or exceeds established standards of service delivery and clients' expectations. This is in concurrence with Walter Deming's definition of quality as: doing the right things, in the right way, at the right time.

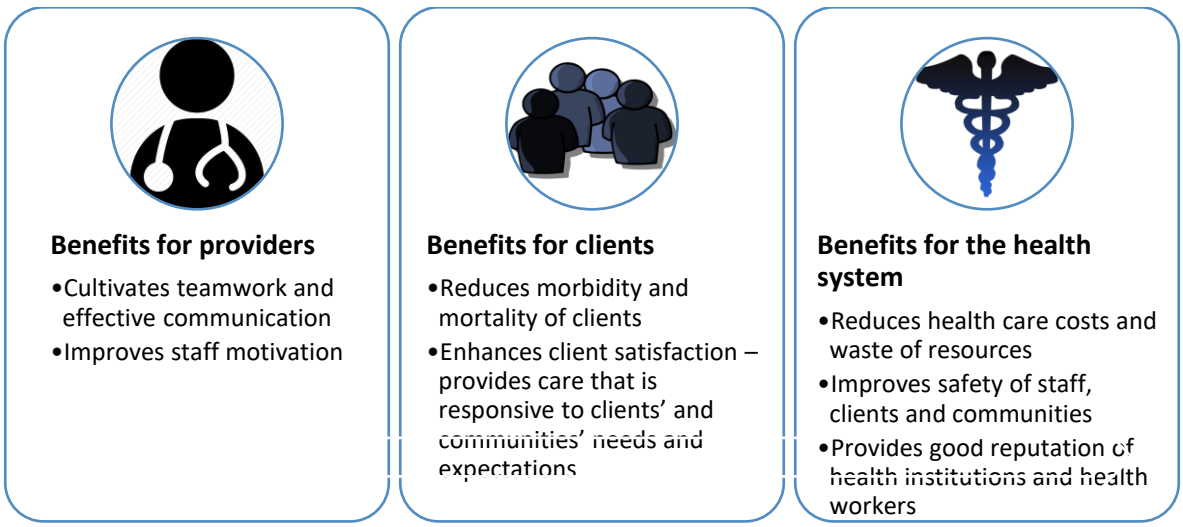
**Quality improvement** (QI) is the continuous, day-to-day process of identifying opportunities for improvement and implementing solutions to them. QI is a systematic approach that applies scientific methods (qualitative or quantitative) to the analysis of performance and systematic efforts to improve it.

## 10.2. Rationale for Quality Improvement

The MOH recommends the use of continuous quality improvement (CQI) as a means to ensure the provision of high-quality differentiated health services for attainment of the 90-90-90 HIV target. CQI is an approach to work that seeks to achieve small, incremental changes in processes in order to improve efficiency and quality. It focuses on improving service systems and processes through the routine use of health and program data to meet patient, and program needs. It is critical to maintain the quality of services as facilities introduce and implement the differentiated service delivery models of care. With national DSD guidelines, healthcare workers need to provide HIV services in accordance with these standards. They need to analyze their current work processes to see if they meet the guidelines and develop projects/activities to address performance gaps.

## 10.3. Benefits of Quality Improvement

*Figure 23: Benefits of QI*



## 10.4. Principles of Quality Improvement

1. **Client focus**
    - DSD models are tailored to the client's needs and expected benefits.
2. Teamwork/collaboration
    - This approach brings together actors from across the health care process (e.g., laboratory, community, nurses, midwives, etc.)
3. **Use of data for quality improvement**
    - Sites need to know where they are in terms of the care they are currently providing and what results they are getting now, and what they will get when they implement DSD. They need to collect data to determine under which model they provide clients with the best care. They must also check if there's been a change, not only in numbers, but in the **experiences and client perspectives.**
4. **Focus on systems and processes**
    - Providers need to evaluate the current work processes to introduce and institutionalize DSD in their routine work, e.g., map the patient flow for patients under DSD
    - Providers constantly need to review implementation process of the DSD models to identify areas of improvement, identify projects to address gaps, and promote best practices.

## 10.5. Steps for Implementing a Quality Improvement Project

1. **Identify the problem**
    - Understand the expected performance standard
    - Review performance data
    - Compare current performance with expected performance
    - Identify performance gaps
    - Define an aim/goal for improvement

**QI Tools**

- QI documentation journals
- Client satisfaction survey
- Fishbone diagram (cause-effect)
- PDSA
- Client flow diagrams

2. **Analyze the problem**
    - Identify possible reasons for performance gap through use of tools such as flow charts, cause-effect (fishbone diagram), etc.
    - Classify the reasons as health system related, health worker related, or patient related
    - Prioritize the major causes of the problem based on scale, ease of addressing, etc.

3. **Develop possible solutions to the problem**
    - Ask: What changes can be made that will lead to improvement?
    - Prioritize the possible changes

*Figure 24: Plan, Do, Study, Act (PDSA) cycle*

4. **Plan, Do, Study, Act (PDSA)**
    - PDSA is a tool used to test and implement proposed solutions (changes). It involves:
        - Planning for the change (deciding on who, what, when, how, where)
        - Doing – Execute the plan
        - Studying—learning from the test whether the change leads to improvement
        - Acting—a decision to implement it, take it to scale, modify it, or discard it.


## 10.6. Quality Indicators for DSD

The indicators are categorized for each differentiated service (HTS, Care and Treatment) by:

- Input
- Process
- Outcome

*Table 33: Examples of HTS quality measures*

| Category | Measures | Definition | Data Source | Frequency |
|---|---|---|---|---|
| Input | • Supplies<br>• Logistics<br>• Human resources | | | |
| Process | Proportion of individuals testing HIV positive who are linked into care within one week | **Numerator:** #of individuals testing HIV positive and linked to care<br>**Denominator**: Total number of clients tested for HIV | Linkages and Pre-ART register | Monthly |
| Output | Percentage of individuals tested HIV positive disaggregated by approaches | **Numerator:** Number of individuals tested HIV positive disaggregated by approaches<br>**Denominator:** Number of individuals tested disaggregated by approaches | HTC register<br>ANC register | |

*Table 34: Examples of HIV care and treatment quality measures*

| Category | Indicator | Indicator Definition | Data Source | Frequency |
|---|---|---|---|---|
| Input | • Supplies/commodities<br>• Logistics<br>• Human resources | | | |
| Process | Proportion of clients who missed appointments (disaggregate by DSDM) | **Numerator:** # of clients who missed appointments (disaggregate by DSDM)<br>**Denominator:** Total # of clients in care and on ART disaggregated by DSDM | Appointment book | Monthly |
| Outcome | Proportion of clients enrolled into DSDM program who virally suppressed (disaggregate for facility and community models). | **Numerator:** # of clients enrolled into DSDM program who virally suppressed.<br>**Denominator:** Total # of clients on ART | ART register | Annually |

## 10.7. QI Roles, Responsibilities and Considerations for Successful QI Implementation

A continuous quality improvement approach shall be used to improve provision of HIV care and treatment in the DSD models at both the health facility and community levels. 'Below are key roles, responsibilities and ingredients for successful QI implementation.

**Health facilities should:**

- Ensure functional QI teams evidenced by holding monthly meetings with minutes recorded for the last six months, updated documentation journals, displayed data (run charts) on QI projects, in the facility and teams to provide the oversight role
- Ensure the facility QI teams participate in conducting both the baseline and subsequent data collection on DSD enrolment and retention to inform QI projects.
- Implement QI projects and innovations to improve service delivery
- Routinely, on a monthly basis, QI teams should review performance, discuss progress, and update journals
- Document innovative outcomes using documentation journals
- Hold peer learning meetings between different facilities to share and spread innovations
- Incorporate feedback from DSD clients and other community members into QI projects through regular client satisfaction interviews and feedback from comment boxes

**District Health Officers, health facility in-charges and Implementing partners should endeavour to:**

- Train and coach HIV care service providers on QI principles and use of necessary QI tools
- Ensure health providers have access to MoH guiding documents e.g. the health sector QI Framework, HIV services Indicators manual etc.
- Functionalize QI structures at regional, district and facility level to provide the oversight role
- Provide oversight through mentorship and supportive supervision
- Coordinate learning sessions to facilitate facility-facility learning on challenges and promising practices. Develop change packages where possible

## 10.8. How to Introduce Differentiated Service Delivery Models

Health care workers and other service providers in direct contact with clients need to be familiar with DSDM and therefore need to be trained to implement the selected approaches, and to enter data and maintain records that will help in future analysis of results.

During and immediately following the training of health care workers on DSD, MoH recommends the stepwise approach detailed in table 37 to be followed in your facility to introduce differentiated models of service delivery. This approach will facilitate effective implementation and coordination of DSDM.

## 10.9. The Differentiated Services Delivery Self-Assessment Tool

MOH will support initial and regular targeted district and health facility assessments using tools such as the DSD self-assessment tool to harmonize district and health facility assessments.

The self-assessment tools capture information/data on HIV related programming in the district and health facility based on the health system building blocks, including quality improvement. The objective of the self-assessment is to

a. Assist the district/facility in identifying current strengths and weakness of the district/health systems that are relevant for implementation of DSD
b. Assess what models the facility can implement
c. Gather information to help design QI projects to close the gaps
d. Provide information to the facility, district, Implementing Partners and Ministry of Health on the optimal technical support for the facility

*Table 35: Stepwise approach to introduce differentiated models of service delivery*

**Step 1: Establish a committee to coordinate DSDM activities**

1. Strengthen an existing committee to undertake DSDM activities. At a minimum they should include;
    - ART In Charge
    - HTS Focal Person
    - HMIS/Data Clerk
    - Logistics Focal Person
    - QI Focal Person
    - PMTCT/EID Focal Person
    - Community Representative (Health Assistant, CDO, VHTs, CHEWs)
    - TB Focal Person
    - Laboratory Focal Person

**NOTE:**

- ✓ This team should be supervised by the Health Facility In Charge

2. To ensure buy-in and facilitate quick and easy DSDM implementation in the facility, the established committee will be in charge of coordinating the development and implementation of the work plan including, but not limited to the following:
    - Continuous creation of awareness and consensus building within the facility and community about differentiated service delivery (Refer to the communication plan) and the need to consider what works
    - Conducting analyses using the facility self-assessment tool (FSAT), to inform the models and approaches to be adapted, as well as the optimal technical support required by the health facility
    - Continuous categorization and re-categorization of clients into stable, unstable/complex and their enrolment into the appropriate models and approaches (Refer to Care and Treatment section)

- Implementation of DSDM in the facility and community (Refer to HTS and Care and Treatment sections)
- Assessing gaps and QI needs, implementation of agreed upon QI projects, and implementation of recommended actions (Refer to QI section)
- Convening review meetings on progress
- Identification of any capacity gaps within the committee and liaise with the districts and implementing partners (IPs) to bridge them
- Monthly and quarterly reporting to Ministry of Health (Refer to M&E section)
- Any other activities as required by MOH (e.g. evaluations)

**NOTE:**

✓ Orientation of all staff on expectations of them in relation to rolling out DSDM is key

**Step 2: Conduct the following assessments**

**1.** Determine the current practices i.e. what models and approaches are being implemented in the facility and community based on the building blocks and the elements.

**2.** Define the priority sub populations receiving services in your facility and communities. These will be the populations for whom both HTS and Care and Treatment services will be differentiated. They include

- Children
- Adolescents
- Pregnant women
- Lactating women
- Adult men and women
- Key populations including female sex workers, men who have sex with men i.e. MSMs, Transgender, people who inject drugs i.e. PWIDs, fishing communities, truckers etc.; marginalized or minority groups such as un-documented migrants, ethnic and sexual minorities etc.

**3.** In collaboration with clients, CHEWs and VHTs, determine the characteristics of each of the sub populations above. Some of these characteristics may include

- **Health conditions**: those with TB-HIV co-infection, pregnant women, people with drug-resistance, or with chronic conditions
- **Physical constraints**: for example, people who have disabilities live or work far from facilities, or have little or no financial means
- **Increased vulnerability**: such as injecting drug users, sex workers, men who have sex with men (MSM),
- **Special needs**: Key populations, children and adolescents

**4.** Engage with community members and volunteers. For each client group/sub population, determine/understand its needs and constraints. Additionally, determine the best places (e.g. hotels, clubs, and markets) and specific times to reach them.

**5.** Determine the challenges by service providers in delivering different services to specific groups. This may be done using informal discussions, focus group interviews, and surveys (Refer to annexes for examples)

**NOTE:**

✓ The initial assessment will be conducted during the onsite training, using the Differentiated Services Delivery Facility Self-Assessment Tool (DSD FSAT)

**Step 3A: Review results from the various assessments to determine the appropriate model(s) and approach(es) for your facility.**

1. **Care and Treatment:** All PLHIV are eligible for differentiated care and treatment. However, the model and approach depends on their stability
   a. Facility-based models
      - Facility-based individual management
      - Facility based groups
      - Fast track drug refills
   b. Community-based models
      - Community Client Led ART Distribution
      - Community Drug Distribution Points

**Step 3B**: **HIV Testing Services:** All communities are eligible for HTS. However, the HTS model depends on the population vulnerability and their unique needs

- Review data on the current HTS approaches and identify opportunities to adapt:
    - Determine the testing efficiency of each approach. *Testing efficiency is the number of confirmed cases divided by the total number of people tested for each approach*
    - Determine the cost of the different testing options. *These are the resources per costs dedicated for each approach*
    - Establish how the facility can improve the testing and cost-efficiency
    - Establish how the facility can improve the site's mix of testing approaches. *The best combination of in-facility and community approaches*

a. Facility-based models
    - PITC
    - VCT
    - Index HIV/TB Client Contact Tracing

b. Community-based models
    - Home based HTC
    - Index Client Testing
    - Outreaches/mobile testing
    - HIV Self-Testing
    - Work place HTC

**Step 4: Assess resource needs**

The approaches do not require additional resources in the run phase. However, they will require upfront investments. The facility needs to have a clear understanding of resource requirements before starting. Resources may include human resources, extra materials/equipment, and financial support.

**1. Care and Treatment**

Resource needs for differentiated treatment approaches require mainly some re-allocation of resources, minimal upfront investment in training and/or additional materials, including:

- Awareness: Ensure adequate communication to staff and clients about DSDM via wall posters, education charts and leaflets; display client flow charts, provide job aides, etc. (Refer to the communication plan)
- Needs assessments: On questions such as whether the facility will implement longer working hours or weekend services, and whether additional financial compensation to existing staff or hiring additional staff is needed
- Human resources: Numbers and training needs/skills e.g. conducting group counselling sessions and targeted health talks (Refer to Annex: Human Resources)
- Training, forming, supervising and monitoring the approaches: sites need to ensure that these tasks are clearly defined and assigned to specific staff in the facilities
- Logistics and supplies: ARVs (Refer to Logistics section), anti-TB medicines and drugs for OIs
- Transport to outreaches: Bicycles, motorcycles, vehicles, safari day allowances and per diem for outreaches to KPs or hard-to-reach areas, etc.
- Documentation: Tools (Guide for data collection and analysis process, Eligibility criteria SOP, registers; referral forms; documentation journals; DSD SOPS; computers e.g. functional open MRS to generate the appointment lists /drug pick lists and reports, etc.). There may be need to upgrade the tools
- Space
- Financial support for any other items or equipment not listed above

**2. HIV Testing Services**

- Logistics and supplies – test kits
- Transport for outreaches and tracking linkages (bicycles, motorcycles, vehicles), safari day allowances and per diem for outreaches to KPs or hard-to-reach areas
- Capacity building (including ensuring quality assurance)
- Human resources (Refer to annex: Human Resources)
- Community mobilization, education and demand creation for HTS (Refer to the communication plan)

- Documentation – tools and registers (eligibility screening tools, tracking and linkage forms, etc.) referral forms, documentation journals, DSDM SOPs,
- Equipment - computers, etc.
- Infrastructure/Space
- Financial support for any other items or equipment not listed above

**Step 5A: Devise a clear work plan and implement selected model(s), with key milestones. Designate responsible persons**

1. Work with the district and regional teams to mobilize resources needed
2. Conduct health education talks for the clients both within the facility and in the community
3. Orient /train the CASA – including their roles and responsibilities and the tools they will be using. Agree on routine meeting schedules and where feasible, expectations at the meetings (Refer to the Group Leaders training package)

**Step 5B: Implement and Monitor the model(s)**

1. Refer to details for each model and approach on how to implement (Differentiated HTS and differentiated HIV Care and Treatment sections)
2. Utilize relevant SOPs, job aides, tools and registers for each model
3. Monitor set indicators for each model and approach (Refer to M&E section)
4. Review progress through CMEs, review meetings, etc.
5. Identify areas for improvement and use QI approach to address them (Refer to QI section)
6. Assess impact of the QI interventions and make necessary adaptations
7. Report (Refer to M&E section)

**NOTE:**

- ✓ At the end of each month report how many new approaches (by model) have been formed

**Step 6: Document best practices**

1. For facility
2. For community

Documentation for best practices should be detailed enough, addressing aspects such as:

- ✓ Processes that were undertaken
- ✓ Structures/systems that were developed and/or strengthened
- ✓ Positions that were designated for key DSD activities
- ✓ Resources used, including how they were mobilized - from who or which organization and whether they fostered TB/HIV collaboration efforts
- ✓ Networks that were developed – within the community, across facilities etc. and how this was done
- ✓ Successes attained
- ✓ Challenges encountered and how they were addressed or attempted to be address (if the challenges still exists); etc.

# 11 Social Behaviour Change Communication (SBCC) in Differentiated Service Delivery

This section of the implementation guide stipulates the role of health communication in implementing DSD. It defines health communication activities, materials, tools and approaches that are needed to implement DSD in a simple and efficient manner.

## 11.1. Definition

Social Behaviour Change Communication (SBCC) is the systematic application of interactive and evidence-based communication processes and strategies to equip and empower audiences with knowledge and skills to adopt and utilize differentiated care services at the individual, community, and social levels.

## 11.2. Rationale for SBCC in DSD

There is low literacy about DSD amongst stakeholders. Effective communication becomes an important element to increase both client and provider literacy and eventual adoption and utilization of differentiated care services.

The ability to give and receive information on DSD effectively and efficiently is vital to the success of the 90:90:90 HIV strategy. Implementers and health care workers at various levels should have the knowledge, skills, materials and tools to facilitate the sharing of information on DSD with clients at the facility and community levels.

## 11.3. The Social Behaviour Change Communication Process

SBCC materials development on the differentiated HIV testing, care and treatment services shall follow a proven and tested process based on five steps; inquire, design strategy, create and test, mobilize and monitor, evaluate and evolve (See illustration below). The implementation and roll out of the DSDM health communication package will involve.

*Figure 25: The social behavior change communication process*


1. Evidence based and participatory design with clients, districts, Implementing Partners, AIDS Development Partners, Uganda AIDS Commission and Ministry of Health
2. Development and standardization of DSDM health communication materials, tools and activities in line with national DSDM guidelines
3. Dissemination of DSDM health communication materials and tools at the national, regional, district, facility and community levels
4. Mobilization and implementation of DSDM activities at facility and community level.
5. Continuous monitoring to identify and troubleshoot emerging gaps and needs and learning and adapting best practices.

## 11.4. The Communication Plan

This communication plan provides a framework within which the design, implementation and evaluation of SBCC interventions for DSD will be undertaken.

### a) Purpose

To guide the designing, implementing and evaluating of SBCC to promote DSD.

### b) Objectives

The specific objectives of the communication plan are as follows:

1. To equip individuals and communities with knowledge and skills in DSDM and to seek services.
2. To ensure that SBCC interventions target the right audiences
3. To encourage implementers to integrate SBCC at all levels of DSD.
4. To create an environment for leadership support and sustainability

### c) Guiding Principles

SBCC interventions will be based on the following principles:

1. **Participation and community ownership** so that the community members are empowered to decide their own messages and become agents for behaviour change.
2. **Rights-centred** so that all clients know their rights and every intervention is anchored to the wellbeing of the client and promotion of their right to health and information.
3. **Simplicity and specificity** so that messages and channels are simplified to the level of the respective audiences for easy comprehension.
4. **Partnerships** to allow collaboration and complementation of activities among stakeholders and increase audience reach.
5. **Evidence-based** so that adequate data is gathered about each audience and their perspectives are incorporated.

### d) Audiences

All SBCC interventions will be targeted to reach specific DSD audiences including; leaders, service providers and the community. SBCC will consider the specific characteristics of each audience such as gender, age, location, socio-economic status, education and culture, amongst others.

### e) Communication Channels and Approaches

The primary channel will be interpersonal communication supported by mass media channels including electronic, outdoor, print and social media channels.

*Table 36: Communication Plan*

| Audience | Communication Objectives | Channels | Materials |
|---|---|---|---|
| **Leaders** | • To provide information about DSD<br>• To encourage leaders to support DSD programs | • Stakeholder meetings<br>• Orientation meetings | • Talking points for leaders.<br>• Fact sheets |
| **Service providers** | • To provide comprehensive information about DSD<br>• To discuss the DSD process<br>• To promote the benefits of DSD<br>• To equip service providers with Interpersonal Communication skills of delivering DSD<br>• To encourage service providers to support clients to take up and utilise DSDMs | • Continuous Medical Education (CME) Sessions<br>• Trainings/Orientation meetings<br>• On job mentoring<br>• Peer to peer learning (learning session)<br>• Social media | • Flip charts<br>• Wall charts<br>• Grain sacks<br>• Standard Operating Procedures<br>• Information booklets<br>• Discussion guides |
| **Community** | • To introduce DSD<br>• To provide basic information on DSD<br>• To discuss the DSD process<br>• To educate the community about benefits of DSD<br>• To provide opportunity for clients to ask questions and receive answers on DSD.<br>• To guide audience on how and where to access DSDMs<br>• To encourage individuals to seek and demand for DSD. | • Health talks in waiting areas<br>• Clinical consultations/ counselling sessions<br>• Through Champions<br>• Support groups<br>• Drama groups<br>• Home visits/Station Visits, engagement & referral<br>• One-on-one and Small Group Sessions & referral<br>• Targeted and integrated community activations<br>• Broad cast media; Radio and TV<br>• TVs in strategic places like clinics, buses, video shacks, film vans<br>• Print and Outdoor Placement Posters<br>• Social media | • Flyers and leaflets<br>• Palm cards<br>• Trigger Posters<br>• Trigger Videos<br>• Radio spots and mentions |

## 11.5. Monitoring and Evaluation of SBCC interventions

To ensure attainment of the stated SBCC goals and objectives, monitoring and evaluation (M&E) shall be integrated as a key component of implementation of the plan. Monitoring shall help to provide information to assess whether implementation is of quality, attainment of targets is on track, and will help to detect and correct weaknesses in implementation.

At every level of implementation, implementing partners are expected to establish their own monitoring mechanisms for tracking progress. E.g. Data analysis and tracking, audience survey (Mini surveys), learning events, Champion follow-up etc. It is expected that best practices and lessons learned will be shared and disseminated to provide benchmarks for other programs with similar interventions.

The communication plan promotes evidence based communication interventions and so all SBCC interventions shall be preceded by formative assessment and baseline indicators. These shall provide a key input in the evaluation of programmes. Evaluation of SBCC interventions shall be undertaken to assess the extent to which set objectives have been achieved. The table below gives examples of M&E indicators that can be used for SBCC interventions that aim at promoting DSD in Uganda.

*Table 37: M&E indicator examples*

| Communication Objectives | Example of Indicators |
|---|---|
| • To provide information about DSD<br>• To educate the audience about benefits of DSD<br>• To encourage individuals to seek and demand for DSD. | Knowledge indicators<br>% of individuals who know about DSD and its benefits<br>Attitude indicators<br>% individuals who believe that DSD is beneficial<br>Behavioural indicators<br>% of individuals who adopt DSDMs |

# 12 Annexes

## 12.1. Roles and Responsibilities in the Implementation of Differentiated Service Delivery

**A. National Level – AIDS Control Program (ACP)/Community Department**

1. Develop and cost the implementation plan to determine what resources are required and/ or are available. Finances, human resources (HR), drugs, or other materials are needed for proper dissemination and implementation of the policies
2. Fill the gaps needed in Step 1 above for a conducive environment implementation.
3. Carry out Advocacy and Social Mobilization which should be done at 3 levels during the process of actual dissemination of the policies:
    - National level: Stakeholders meeting involving MoH Leadership, all the District Health officers and municipal health officers, IPs, medical councils, etc.
    - Facility and community level: HUMC Chairperson. PHAS, all Facility staffs.
    - Other Media: TV, radio, IEC materials, and printed press can be used to create awareness and ownership of the delivery models. Radio programs at local stations and spot messages can cause change.
    - Support implementation of DSD models using a CQI approach through capacity building at national, district, and facility levels
4. Monitor and evaluate the implementation
    - Establish M&E indicators that will be used to assess performance. The monitoring can be done by use of meetings quarterly and reports submitted to DHO and then MoH.
5. Track and determine any changes in the course of action that may be needed in the implementation
6. Conduct technical support supervision and oversight

**B. District Health Office**

1. Fill the gaps needed in Step 1 above for a conducive environment implementation.
2. Carry out advocacy and social mobilization which should be done at 2 levels of care:
    - This will also involve the actual dissemination of the policies at District level, Facility Level and Community Level. District level dissemination - District Chairperson, Secretaries for health, Chief Administrative Officer (CAO), District Community Development Officer (DCDO), PHA Networks. All facility-in-charges.

**C. Health Facility Level**

1. Identification of a lead person in charge of the introduction and coordination of DSD activities in the sites such as conducting the analysis and categorizing the clients, identifying the appropriate models and approaches and reporting on progress
2. Devising of a clear plan and schedule for the processes of implementation and monitoring, with key milestones
3. Planning for and communication of differentiated care to staff and clients.
4. Conduct the following analyses before starting:
    - Assessment of which approaches are relevant to the site among the options, based on: current testing approaches, populations with increased risk of HIV infection and specific needs (such as key populations; infants, children and adolescents), accessibility of services and demographics of clients
    - Assessment of current barriers to service delivery and the resources available
    - Prioritization of which relevant approaches should be implemented. It is safer to implement new approaches one at a time, so that staff can more easily manage disruption, and sites can learn from the experiment.

## 12.2. Human Resources for the Implementation of Differentiated Service Delivery

With the decentralization and integration of HIV and TB prevention, care and treatment activities across all levels of the health system and the introduction of 'Test and Treat' as recommended by the 2016 Consolidated Guidelines for Prevention and Treatment of HIV in Uganda, a critical review of the tasks and working practices of health workers is required. Specific tasks should be re-assigned to HCWs with shorter training and fewer qualifications to optimize the available human resources Task shifting and task sharing is essential in the implementation of DSD.

Task shifting and task sharing relating to initiation, maintenance and dispensing of ART as provision of HIV prevention, care and treatment services requires a multi-disciplinary team of health care providers at the different levels of service delivery and is in line with a 2013 WHO recommendation. It includes strengthening the community systems (role clarification, assignment and supervision) and shall be adopted and supplemented by mentorship, supportive supervision of HCWs, including lay providers, and continuous quality improvement. The lay providers should be facilitated to carry out their tasks, as experience indicates that it is difficult to sustain health services based on volunteerism alone.

Adoption of task shifting can enhance linkage to care and treatment adherence and assists HIV and TB programs to cope with shortages of professional HCWs. Guidelines, job aides and SOPs shall be provided to support consistent quality of service.

### a) Implementation Considerations

#### A. Management

1. Reviewing capacity of existing staff to provide differentiated care
2. Training, forming, supervising and monitoring the approaches: health facilities need to ensure that these tasks are clearly defined and assigned to specific staff in the facilities
3. Health facilities should embrace the recommended task shifting and task sharing of activities
4. Deploy staff appropriately to the ART clinics and avoid unnecessary absenteeism through implementation of staff performance management
5. Appropriate delegation if need arises
6. Organize routine meetings to review workload and ensure that staff deployment is related to workload
7. Ensure that staff rotations do not negatively affect DSDM implementation
8. Motivation of the clinic teams by IPs and the DHO's Office through; exchange learning visits, performance management, facilitation of QI meetings with refreshments, ensuring different health workers attend learning sessions other than favouring the same individuals
9. Ensure that the QI site team is functional, with minutes for every monthly meeting held, updated documentation journals, and with evidence of data use, i.e. display of data on walls/notice boards and site level sharing of periodic performance after reviewing the filled documentation journals.
10. Ensuring adequate communication to staff and clients about differentiated service delivery models – via signboards, leaflets, or wall posters among others
11. Client (including health worker) surveys

## B. Capacity Building

1. Each site should have at least 5 critical skilled personnel (clinician, nurse, counselor, records/HMIS focal person and laboratory person) trained in the basic knowledge and skills to provide differentiated care
2. Promote peer to peer mentorships and sharing of what works during providers' interaction
3. Capacity building/training. The HF teams together with DHO/IPs should:
    - Select training participants according to the selection criteria described in the National Plan for the roll out of DSD and block off suitable time for onsite trainings
    - Conduct onsite training for all the critical clinic staff using site specific data and scenarios
    - Plan and conduct post training mentorship according to schedule (Refer to the National Plan for the roll out of DSD)
    - Ensure timely supervision of HCWs and lay providers including aiding them to carry out their tasks
    - Train staff to conduct group-counselling sessions and targeted health talks

It is important that the supply chain system especially at facility level takes into account task shifting and sharing responsibilities, and community models of ARV drug delivery to ensure adequate stock and effective supply chain management. The site supply chain needs to take note of all the ARV drug distribution outlets, including community lay providers' distribution sites.

The table below highlights the different cadres and the designated services that they can provide (or roles that they can take on) after undergoing appropriate training complimented by on-going mentorship and supportive supervision.

*Table 38: Cadres and the designated services they can provide*

| | Doctor/ Clinical Officer | Nurse/ Midwives | Trained Nursing Assistants | Pharmacists/ Pharm Technicians/ Dispensers/ Nurses/ storekeepers | Laboratory Technicians/ Laboratory Assistants | Lay providers (Expert Clients, VHTs, CHEWS, Mentor Mothers), CBOs and CSOs working with PLHIV VHT | Health Information Assistants/ Data Clerk |
|---|---|---|---|---|---|---|---|
| Comprehensive clinical services including, NACS, symptom screening for NCDs, TB, STIs and hepatitis | X | X | | | | | |
| Prescription of ART, initiation and follow up for adults, adolescents and children | X | X | | | | | |
| Switching and substituting ART regimens by a multidisciplinary 'switch team' | X | | | | | | |
| Management of complicated cases (e.g. cryptococcal meningitis (CCM); second line treatment failure etc.) | X | | | | | | |
| TB initiation of smear or gene X-pert positive cases for adults, adolescents and children | X | X | | | | | |
| TB initiation for adults and adolescents requiring chest x-ray (CXR) interpretation, and for children where no sputum is available | X | | | | | | |
| HIV testing services | X | X | X | X | X | X | X |
| Health Education | X | X | X | | | X | |
| Registration and filling of appointment diaries | | X | X | X | X | | |
| Performing vital signs (triage) | X | X | X | | | | |
| Dried blood spot (DBS), VL sample collection, testing and results delivery | X | X | X | | X | X | |
| Coordinating and supervising the community groups | X | X | X | | | | |

| | Doctor/ Clinical Officer | Nurse/ Midwives | Trained Nursing Assistants | Pharmacists/ Pharm Technicians/ Dispensers/ Nurses/ storekeepers | Laboratory Technicians/ Laboratory Assistants | Lay providers (Expert Clients, VHTs, CHEWS, Mentor Mothers), CBOs and CSOs working with PLHIV VHT | Health Information Assistants/ Data Clerk |
|---|---|---|---|---|---|---|---|
| Linkage facilitation | X | X | X | | | X | |
| Pre-packing medicines, picking drug refills, distribution of refills, Forecasting and ordering of commodities from the warehouses, Dispensing, Filling/updating the dispensing log and tracking tools | | X | X | | | X* | X |
| ART preparation and adherence counselling for adults, adolescents, children and pregnant women including treatment failure | X | X | X | | X | X | X |
| Defaulter tracing | | X | X | | X | X | X |
| Client records management/data entry & updating registers (for area of service) | | X | X | | X | X | X |
| Phlebotomy | X | X | | | X | | |
| Reporting on community activities/client groups, support; coordinate and supervise their peers | | | | | | X | |
| Community – facility referrals and vice versa | | | | | | X | |

**These service providers must be supervised while undertaking the listed/designated tasks*

## 12.3. Facility Self-Assessment Tool

**Facility Self-Assessment Tool to Support Decision Making for Differentiated Service Delivery**

**BACKGROUND**

This differentiated service delivery facility self-assessment tool (DSD FSAT) is designed to capture current information on HIV related programming in the facility based on the health system building blocks, including quality improvement:

1. Leadership and governance, including coordination and health finance
2. Human resources for health
3. Service delivery
4. Commodity management
5. Strategic information (Health Information Systems)
6. Quality Improvement

**Objectives of the tool:**

The primary objectives of the assessment tool are to:

1. Assist the facility in identifying current strengths and weakness of the health systems that are relevant for implementation of DSD
2. Assess the facility and establish what differentiated HIV Testing Services and HIV Care and Treatment models and approaches are in existence in the facility, and from the identified gaps, determine what further differentiation needs to be done
3. Gather information to help design QI projects to close the gaps
4. Provide information to the facility, district, Implementing Partners and Ministry of Health on the optimal technical support for the facility for efficient and cost effective DSD implementation

**Who completes the tool:**

The tool will be administered during the onsite DSD training by the facility clinical team, with guidance from the trainers

**Instructions:**

Complete all sections of this tool

**Site Name:** _____ **Site Level:** _____

**District:** _____

**Name and contact of the Facility in Charge:** _____

**Regional IP supporting the site:** _____

**Dates of training: (dd/mm/yyyy): From:** _____ **To:** _____

## 1. LEADERSHIP AND GOVERNANCE

| Area of Assessment | Completed /Yes (Green) | In progress (Yellow) | Not Started/No (Red) | Comments |
|---|---|---|---|---|
| 1.1 The facility has a Health Unit Management Committee (HUMC) that includes representatives from the community | | | | |
| 1.2 The Health Unit Management Committee is functional and meets regularly to discuss service delivery issues | | | | |
| 1.3 The health facility has identified a Focal Person to coordinate DSD activities | | | | |
| 1.4 The DSD Focal Person has clear terms of reference | | | | |
| 1.5 The staff working in the ART clinic have clear roles and duty schedules | | | | |
| 1.6 The health facility has reviewed its data and mapped (WHO and WHERE) the sub populations in its catchment area | | | | |
| 1.7 The health facility receives regular support supervision (technical and integrated) from the districts, implementing partners and MOH | | | | |

## 2. HUMAN RESOURCES

| Area of Assessment | Completed /Yes (Green) | In progress (Yellow) | Not Started/No (Red) | Comments |
|---|---|---|---|---|
| 2.1 The ART clinic has sufficient human resources to provide HIV and TB differentiated service delivery | | | | |
| 2.2 The ART clinic staff are oriented on the consolidated guidelines for prevention and treatment of HIV in Uganda, 20182016 Uganda national consolidated HIV prevention, care and treatment guidelines | | | | |

## 3. SERVICE DELIVERY

### A. HIV TESTING SERVICES (HTS)

| | Completed/ Yes (Code Green) | In progress (Code Yellow) | Not Started/No (Code Red) | Comments |
|---|---|---|---|---|
| 3.1 Facility provides HTS at all its entry points. | | | | |
| 3.2 The health facility confidentially notifies all the partners of HIV positive and/or TB infected index clients of their possible exposure or potential risk to HIV infection and/ or TB and encourages them to test for HIV and/ or TB | | | | |
| 3.3 HIV positive clients and/or TB patients in care are mobilized to bring their children and other household members for HIV testing as part of Know Your Child's HIV Status (KYCS) | | | | |
| 3.4 The facility offers integrated Outreach or Mobile Services | | | | |
| 3.6 Testing for HIV in children, adolescents, and adults is guided by the respective HTS eligibility screening tools | | | | |
| 3.7 The health facility offers Home Based HTS to partners and children of HIV positive clients (as part of Index Client and HIV TB Contact Tracing) | | | | |
| 3.8 The health facility offers HTS services during the weekend | | | | |
| 3.9 The health facility offers HTS services after 5:00pm | | | | |
| 3.10 The health facility offers HTS services in the night (overnight) | | | | |
| 3.11 The health facility offers HTS services at special times for children and adolescents during holidays | | | | |

## B. HIV CARE AND TREATMENT

| Area of Assessment | Completed/Yes (Code Green) | In progress (Code Yellow) | Not Started/No (Code Red) | Comments |
|---|---|---|---|---|
| 3.12 The facility runs the ART clinic on a daily basis including weekends | | | | |
| 3.13 The facility staff have reviewed facility data and categorized clients into 'Stable' and 'Unstable' | | | | |
| 3.14 The facility has a client flow for newly diagnosed HIV clients initiating ART treatment | | | | |
| 3.15 The facility has a client flow for clients re-attending the ART clinic | | | | |
| 3.16 The facility has a client flow for special groups e.g. children, adolescents, pregnant & breastfeeding women | | | | |
| 3.17 The facility offers HIV ART services to unstable / complex clients on a monthly basis | | | | |
| 3.18 The facility offers HIV ART services to specific subpopulations in groups i.e. pregnant women (FSGs) children and adolescents in groups (e.g. ARIEL clubs), etc. | | | | |
| 3.19 The facility has a client flow for stable clients coming back for drug refills. | | | | |
| 3.20 The facility routinely gives ARV drug refills for 3 or more months (multi-month refill) to stable clients | | | | |
| 3.21 The facility has dedicated specific time (early, late, weekends) to specific groups of clients such as the men, key populations, mobile populations etc. | | | | |
| 3.22 The facility has dedicated specific clinic days for specific populations e.g. children, adolescents, TB-HIV co-infected clients, Hepatitis etc. | | | | |
| 3.23 The facility has community outreaches where clients pick their ARV drugs (CDDP) | | | | |
| 3.24 The facility has clients who have formed groups in the community and rotate to pick drugs from the facility (CCLAD) | | | | |
| 3.25 The facility has trained the community group leaders for these groups (CDDP and CCLAD) | | | | |
| 3.26 The facility has an appointment system (Paper or electronic) | | | | |
| 3.27 The facility has standard operating procedure for tracing clients who have missed their appointments or who are lost to follow up | | | | |
| 3.28 The facility has a system for flagging clients due for viral load testing | | | | |
| 3.29 The viral load turn-around time for the facility is less than 2 weeks | | | | |
| 3.30 The facility has a system for flagging clients who have VL >1000 copies/ml i.e. non suppressed clients | | | | |
| 3.31 The facility has a system that notifies clients with non-suppressed viral load | | | | |
| 3.32 The facility has a system for managing clients with non-suppressed VL, including Intensive Adherence Counselling (IAC) | | | | |

## 4. COMMODITY MANAGEMENT

| Area of Assessment | Completed/ Yes (Code Green) | In progress (Code Yellow) | Not Started/ No (Code Red) | Comments |
|---|---|---|---|---|
| 4.1 The facility has a functional medicines management and therapeutic committee' (MTC) that monitors the stock levels on a monthly basis (amongst other functions) | | | | |
| 4.2 The facility maintains a minimum and maximum stock at 2 MOS and 4 MOS, respectively | | | | |
| 4.3 The facility submits the medicines orders as per the warehouses schedule | | | | |
| 4.4 The facility uses the web based ordering system (WAOs) for making drug orders from the warehouses | | | | |
| 4.5 The facility has identified staff to pre-pack and label ART and other drugs for stable clients | | | | |
| 4.6 The facility has a system for generating appointment lists to enable pre-packaging of drugs. (Specify system in place) | | | | |
| 4.7 The facility has a system for confirming dispatch of drugs from the health facility to the community (CDDP or CCLAD) | | | | |
| 4.8 The facility has a system for acknowledging receipt of drugs by each client at the community (CDDP or CCLAD) | | | | |
| 4.9 The facility has a system for acknowledging accountability of the drugs distributed in the community (CDDP or CCLAD) to the health facility | | | | |

## 5. STRATEGIC INFORMATION (Health Information Systems)

| Area of Assessment | Completed/Yes (Code Green) | In progress (Code Yellow) | Not Started/No (Code Red) | Comments |
|---|---|---|---|---|
| 5.3 The facility has a functional and up-to-date Electronic Medical Records (EMR) system that can be used for routine categorization, tracking and reporting of patients under different DSD models | | | | |
| 5.2 The facility has a well organized filing system | | | | |
| 5.4 The facility has<br>• A file back-up system<br>• Stable power supply<br>• Updated anti-virus | | | | |
| 5.5 The facility has a system OR access to systems to monitor patient level outcomes e.g. retention, lost to follow up, mortalities and viral load suppression | | | | |
| 5.6 There is accurate and timely documentation of all HIV care and treatment data in the facility | | | | |
| 5.7 There is accurate and timely reporting by the facility | | | | |
| 5.8 The points of data capture within the client flow system are known, have the appropriate tools and the responsible persons in place. Explain | | | | |

## 6. CONTINUOUS QUALITY IMPROVEMENT

| Area of Assessment | Completed/Yes (Code Green) | In progress (Code Yellow) | Not Started/No (Code Red) | Comments |
|---|---|---|---|---|
| 6.1 The site has a copy of the National Quality Improvement Framework and Strategic Plan 2015/2016 – 2020/2021 | | | | |
| 6.2 The health facility has a QI facility work plan | | | | |
| 6.3 The site has a functional QI team (i.e. holds regular QI meetings as evidenced by meeting minutes and documentation journals | | | | |
| 6.4 The site has received QI coaching and mentorship in the last three months. (Evidence in the visitors book and/or site QI file) | | | | |
| 6.5 The facility uses QI to improve client outcomes (evidenced by documentation journals, reports and learning session reports) | | | | |

**Summary Sheet**

| # | Domain | Completed | In progress | Not Started | % completed |
|---|---|---|---|---|---|
| 1 | Leadership and Governance | _____/7 | _____/7 | _____/7 | |
| 2 | Human Resources | _____/2 | _____/2 | _____/2 | |
| 3 | Service Delivery - HTS | _____/10 | _____/10 | _____/10 | |
| | Service Delivery – HIV Care and Treatment | _____/21 | _____/21 | _____/21 | |
| 4 | Commodity Management | _____/9 | _____/9 | _____/9 | |
| 5 | Strategic Information/Health Information Management | _____/7 | _____/7 | _____/7 | |
| 6 | Continuous Quality Improvement (CQI) | _____/5 | _____/5 | _____/5 | |

## 12.4. District Self-Assessment Tool

### District Readiness Self-Assessment Tool to Support Decision Making for Differentiated Service Delivery

**BACKGROUND**

This differentiated service delivery district readiness self-assessment tool is designed to capture current information on HIV related programming in the district based on the health system building blocks, including quality improvement:

1. Leadership and governance, including coordination and health finance
2. Human resources for health
3. Service delivery
4. Commodity management
5. Strategic information (Health Information Systems)
6. Quality Improvement

**Objectives of the tool:**

The primary objectives of the assessment tool are to:

1. Assist the district in identifying current strengths and weakness of the health systems that are relevant for implementation of DSD
2. Gather information to inform the national program on district specific needs for optimal technical support

**Completing the tool:**

The tool will be administered before or during the health facility-based training

**Instructions:**

Complete all sections of this tool

**District Name:** _____

**Name and contact of the DHO:** _____

**Regional IP supporting the site:** _____

**Dates of completion:** _____

| Area of Assessment | Yes | No | Comments |
|---|---|---|---|
| **Leadership and Governance** | | | |
| 1.8 Does the district have an extended DHT? | | | |
| 1.9 Does the extended DHT meet regularly to discuss HIV program progress with documented minutes? | | | |
| 1.10 Does the district keep reports of the actual allocation and use of finances for HIV services for the last financial year? | | | |
| 1.11 Is the funding and the available resources sufficient to support differentiated care? Explain your response | | | |
| 1.12 Does the DHT provide regular (quarterly) support supervision? | | | |
| **Human Resource** | | | |
| 2.1 Have the consolidated guidelines for prevention and treatment of HIV in Uganda, 2018 been rolled out to the DHT in the district? | | | |
| 2.2 Have HCWs at all facilities offering HIV services been trained or oriented on the consolidated guidelines for prevention and treatment of HIV in Uganda, 2018? | | | |
| 2.3 Do all the ART sites in the district have sufficient human resources to provide HIV services? Explain your response | | | |
| **Infrastructure** | | | |
| 3.1 Does the district have adequate space to store supplies and commodities for HIV services? | | | |
| 3.1 Does the district have transport to supervise HIV services within the facilities? | | | |
| **Commodity Management** | | | |
| 4.1 Does the district have a functional Medicines Management and Therapeutic Committee? | | | |
| 4.2 Does the district have a reliable supply chain management system to support facilities, prevent stock-outs, and re-distribute medicines? | | | |
| **Quality Improvement & Supervision** | | | |
| 5.1 Does the district have a functional Quality Improvement Management team? | | | |
| 5.2 Does the district QI management team review and support the health facility QI teams? | | | |
| **Strategic Information** | | | |
| 6.1 Does the district have access to open MRS? | | | |
| 6.2 Does the district have a Biostatician or M&E Officer who manages the open MRS system? | | | |
| 6.3 Is the DHT oriented on the revised M&E tools (in line with the 2016 guidelines) | | | |

# 13 References


1. [1] Consolidated Guidelines for Prevention and Treatment of HIV In Uganda, February 2020
2. [2] 2016 Uganda Population HIV Impact Assessment (UPHIA)
3. [3] DHIS2
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5. [5] A Decision Framework for Differentiated Antiretroviral Therapy Delivery For children, adolescents and pregnant and breastfeeding women and key populations
6. [6] National HIV Testing Services Policy and Implementation Guidelines August 2016; 4th Edition
7. [7] UAC 2016, KYE, KYR Modes of Transmission Synthesis study 2015
8. [8] Brown C, Lilford R. Evaluating service delivery interventions to enhance patient safety. BMJ. 2008;337:a2764.
9. The Global Fund Toolkit for Health Facilities; Differentiated Care for HIV and Tuberculosis
10. Differentiated Care: Operational Guide 2017 Kenya
11. ICAP Approach to Differentiated Service Delivery 2017
12. National Laboratory QA/QC Guidelines
13. National Plan for the roll out of DSD; Uganda 2017