THYOLO DISTRICT HEALTH OFFICE

COMMUNITY ANTIRETROVIRAL THERAPY GROUPS (CAGs)

FACILITATOR'S MANUAL

MEDECINS SANS FRONTIERES

JUNE 2012

TABLE OF CONTENTS

FOREWORD

Several developments over the past couple of years have contributed to increasing the attention to the role of lay people and the broader community in HIV/AIDS treatment and care [1;2].

On one hand, the challenge of scaling-up ART in the sub-Saharan African countries with the highest HIV burden and the most severe HRH constraints made it necessary to not only task-shift within the range of the established health worker cadres (from medical doctors, to non-physician clinicians and nurses) but further to community health workers and the patients themselves [3;4]. Today, Malawi, like other countries, has quite successfully scaled up its ART programme, using a task-shifted ART delivery model, and is now facing the challenge of keeping an ever-growing patient cohort alive on treatment. ART uptake continue to increase through new initiations, especially in view of the latest WHO recommendations, which Malawi has adopted.

On the other hand, retaining hundreds of thousands of people on ART requires different HRH solutions than those for reaching a specific scale-up target. And the insights from research into chronic disease care and HIV have shown that social support from peers (in various forms, with the most known one the expert client concept) is associated with better health outcomes and higher retention in care, as well as improved self-efficacy [5-7]. Thus, the increasing focus on the patient and the community is not just a necessary response to existing HRH constraints. It is also HIV itself which has revived concepts of participation and empowerment.

In Thyolo district, 36,697 people had initiated ART by the end of 2011: 76.3% were alive on treatment, 11.0% died and 12.5% were lost-to-follow-up. In order to reduce the workload in the hospitals the ART follow-up had been rolled out to 8 health centres in the district since 2006 and gradually further delocalised to 14 improved health posts (IHPs). By September 2011 ART follow-up was provided in 24 sites (8 health centres, 2 hospitals, 14 IHPs). With the implementation of the PMTCT B+ programme in the 4th quarter of 2011, the number of ART follow-up sites in the district increased to 41 (25 health centres/dispensaries/tea estate clinics, 2 hospitals, 14 IHPs).

Despite this decentralised approach, the health facilities are still overwhelmed by the sheer numbers of people accessing ARVs. Furthermore, a programme evaluation of the IHPs showed that the delocalisation of ARV refills to these posts had proceeded less well than expected and proved to be not efficient in terms of health worker time and transport costs. The MOH and the MSF mission therefore concluded that the IHPs for ARV provision were not likely to be a sustainable model for the MOH.

Against this background and because the need for ‘decongesting’ the health centres and workable long-term ART retention models was still acute and even growing, the MOH in Thyolo decided to pilot an ART delivery model, called ‘Community ART Groups’ (CAG), which is based on the model that has been successfully implemented and rolled out by MSF and the Ministry of Health in Tete, Mozambique over the past couple of years [8]. CAGs are self-forming groups of six people on ART (or pre-ART) who are accessing their ARVs at the same health facility. Whereas in the conventional ART model the individual patient has to access a health facility every three months for his/her ARV refill, in the CAG model the six group members take monthly turns so that each member has only two annual health facility visits for routine ARV collection. The objectives of the CAG model are to reduce the workload of the existing health workers in the health facilities and to improve long-term retention in care by reducing access barriers and enhancing the role of the ART client in the management of his/her condition.

This manual will be a valuable resources to CAG Model facilitators when equipping the health workers and CAG members with knowledge about the model. The manual represents an important tool for the spread of correct information to the target participants.

ACKNOWLEDGEMENTS

The Thyolo District Health Office in collaboration with the Medecins Sans Frontieres – Belgium would like to thank the following individuals and their respective organizations for participating in development of this first edition of facilitators manual and piloting CAG Model of care in Thyolo District:

Dr Andrew Likaka	: District Health Officer – Thyolo DHO
Dr Micheal Murowa	: District Medical Officer – Thyolo DHO
Richard Chidakwani	: HIV Coordinator – Thyolo DHO
Kingsley Mbewa	: ART/PMTCT coordinator – Thyolo DHO
Hellen Mathotho	: Community Matron – Thyolo DHO
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Daniel Von Rege	: Field Coordinator – MSFB
Katharina Herman	: HRH Unit – MSFB
Bote Zamadenga	: CAG Focal person – MSFB
Paul Majawa	: District Coordinator – Thyolo NAPHAM

ACRONYMS

AIDS	: Acquired Immune Deficiency Syndrome
ART	: Antiretroviral Therapy
ARV	: Antiretroviral
CAG	: Community ARV Groups
CPT	: Contrimoxazole Prophylaxis Therapy
DAPP	: Development Aid from People to People
DHMT	: District Health Management Team
DHO	: District Health Office
FP	: Focal Person
HF	: Health Facility
HIV	: Human Immune Deficiency Virus
HSA	: Health Surveillance Assistance
MA	: Medical Assistant
MoH	: Ministry of Health
MSF	: Medecins Sans Frontiere
NAPHAM	: National Association of People with HIV and AIDS in Malawi
PLHIV	: People Living with HIV
WVI	: World Vision International
HRH	: Human Resource for Health
IHP	: Improved Health Post

INTRODUCTION

The Manual

The manual has been designed to be used to train health workers (COs, MAs, Nurses, HSAs) both at health facility and community, and CAG members for improved delivery of Community ARV Group Model of care in order to improve long-term retention in care by reducing access barriers and enhancing the role of the ART client in the management of his/her condition. It will act as a guide and reference to facilitators when giving briefing to different cadres on CAG Model of care.

Course aim

The one-day course is designed to equip health workers and CAG members with knowledge, skills, and attitudes so that they are able to run the CAG model in their various catchment area.

Course Objectives

By the end of the session participants should have knowledge about:

1. Community ARV Groups (CAG) formation
2. Functioning of CAGs and organization at community level
3. Organization at health facility level
4. Communication in CAG model of care
5. Tools used in CAG model of care

Each topic has been explained and step by step activities included for easy follow up of the content. However not every issue has been settled as regard to CAGs. New scientific findings will keep coming and need to be studied, interpreted, and discussed. Discussions will have to be made about changing the tools and information about CAGs. This process will help us keep improving the CAG Model of ARV delivery.

CHAPTER 1: COMMUNITY ARV GROUPS(CAG) FORMATION

Time Allocation: 1 hour

Purpose: This session introduces and enables health care workers and CAG members to acquire knowledge on CAG and group formation.

Learning objectives:

By the end of this session, participants should be able to;

- ♣ Define Community ARV Group
- ♣ State the clients' criteria to join CAG
- ♣ Mention the benefits of CAG model of care
- ♣ Explain how Community ART Group is formed
- ♣ Explain the roles of partners when forming Community ART Group

Suggested teaching/learning methods: Lecture, discussion, brainstorming

Suggested teaching and learning materials: Chalk and chalkboard, flip chart papers, permanent markers, transparencies and overhead projectors, audio visiual aids.

Teaching and learning activities

Activity 1: Overview of Community ARV Group
The facilitator should facilitate the discussion on the definition of CAG, benefits, creteria to join CAG. The facilitator should conclude the session with the presentation on Overview of CAG as below:

Definition of CAG
CAGs are self-forming groups of HIV-positive persons (who are on ARVs), living in the same community and organized in groups of maximum 6 members. These members take turns to pick up ARVs at the health facility and distribute them among the other group members in the community. The members of the CAGs manage their own health and share experiences about living positive with HIV.

Goal of CAG

The objectives of the CAG model of care are to reduce the workload of the existing health workers in the health facilities and to improve long-term retention in care by reducing access barriers and enhancing the role of the ART client in the management of his/her condition.

Why CAG
Despite the decentralization of ART to the health centres, many patients continue to face difficulties in accessing to ARVs due to:

- ♣ Long distances from community to the health facility (HC) that supply ARVs
- ♣ Cost and availability of transport
- ♣ The patients have other competing activities (work, social, family,...)

Criteria to join CAG

For an individual who is HIV positive and on ARVs want to join CAG, need to meet the following criteria:

- ♣ Be stable on ART (without any complication and severe opportunistic infections).
- ♣ Be on ART for six months and more.
- ♣ Access ARVs at the same health facility with other members.
- ♣ Live in the same community or neighbourhood, or share the same social network with other members.

Benefits of CAGs:

Benefits to CAG members

- ♣ Facilitates ARV refill while meeting at their convenient time right in their homes
- ♣ Decreases frequency of health centre visits, thereby reducing transport cost, waiting time in the queue, risk of catching other diseases
- ♣ Share experiences with other people on ART in the neighbourhood
- ♣ Taking responsibility for own health improves practice of problem solving skills, increases motivation to adhere, and results in improved treatment outcomes and long-term retention in care
- ♣ Other member doing their household cores
- ♣ Able to help and encourage each other on treatment
- ♣ Increased social network among members
- ♣ Help reduce defaulters since they know the where abouts of each member

Benefits to the staff at the health facilities

- ♣ Having only one person collecting the ARVs for a group of six, means that the workload for the **health workers** is decreased. He/she will have more time for the individual care of sick patients.
- ♣ Accurate information on treatment outcomes of patients on ART
- ♣ Decreases need for patient tracing, as community members update the health workers about the whereabouts of CAG members and possible deaths within the community
- ♣ The meetings with CAG representatives, on the days of refill facilitate diffusion of information among other clients on ART

Activity 2: CAG formation

The facilitators should explain that the formation of these groups(CAG) is voluntary and MA/Nurse, HSAs, NAPHAM are there just to facilitate the selection by meeting with those patient on ART either at the facility where they are get their refill, villages or in respective support groups in case of NAPHAM member.

During the sensitization meetings, CAG model of care is introduce to the audience and clients, explaining what CAG means, how it works, the benefits both to the patient and health workers. Then the audience is given a chance to think about it. If the clients are willing and interested to join or form CAG, they are told to find their partners themselves within the neighborhood. Once they identify themselves members of the group choose their group leader called focal person. Then they report to the MA/Nurse at the health facility for screening(to exclude complication while on ART) and registration. If they are in the

support group members register with NAPHAM coordinator and they just go to the health facility for screening.

The facilitator should emphasis on voluntary group formation, household closeness of the member for easy to meet.

Activity 3: Partners role in CAG
The facilitator should explain the roles of partners in the CAG model of care as follows;

Ministry of Health –

- Sensitise patients about CAGs at health facility level, and how they can become involved, supervision on medical and general functioning of CAGs.

As implementers:

- Prescribe and dispense ARV for each group member to CAG representative
- Follow-up monthly with CAG representative on member adherence and outcomes.
- Do clinical consultation for group representatives every six months and any unplanned visit by members.
- Update of CAG facility group card at each monthly visit of group representative.
- Update of CAG register at health facility monthly .
- Processes data from CAG registers at health facilities, analyse programme data and conducts quality improvement exercises
- Organise trainings and meetings,
- Supervise CAG-related tasks of health workers (as part of quarterly SV)
- Ensure follow up of patients with a negative outcome (home visits)
- Ensure continuous quality improvement of CAG programme and functioning of CAGs
- Evaluate the pilot CAG, and disseminate CAG experience.
- Organise possible roll-out of CAGs after pilot

NAPHAM –

- Sensitise patients about CAGs and how they can become involved at community level.
- Supervising CAG functioning for those in support groups,
- Communicating problems(concerning relationship at health facility) faced by CAGs to program manager,
- Follow up quarterly with CAG focal points on member adherence and outcomes
- Supports CAG focal points in monitoring (group card filling) – frequency?
- Consults and links with MOH focal point for CAGs
- Participates in regular meetings with MOH, MSF and other partners.
- Organise and train CAG members in treatment literacy????

MSF –

- Support MoH and NAPHAM technically (M&E and supervision) and logistically (transportation training materials),
- Enhancing link among clients, health centres, NAPHAM and MoH district level,
- Support the implementation of the pilot program and roll out in Thyolo District

Local leaders –

- Support the CAGs by recognizing their existence in the communities,
- Social support and settle dispute for CAGs if any.

Other partners – incorporate expert clients and their activities in CAG model or vise versa.

CHAPTER 2: FUNCTIONING OF CAGs AND ORGANIZATION AT COMMUNITY LEVEL

Time Allocation: 1:30 hours

Purpose: This session enables participants to acquire knowledge on how CAGs function and organized in the community.

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Learning objectives:

By the end of this session, participants should be able to;

- ♣ Define Focal person
- ♣ State the roles of focal person
- ♣ State the roles of group members
- ♣ Explain how CAGs are organized at community level
- ♣ List the rationale of meeting twice
- ♣ Demonstrate how to fill the community group card
- ♣ Demonstrate how to fill the quarterly supervision form for HSAs

Suggested teaching/learning methods: Lecture, discussion, brainstorming

Suggested teaching and learning materials: Chalk and chalkboard, flip chart papers, permanent markers, transparencies and overhead projectors, audio visiual aids.

Teaching and learning activities

Activity 1: Who is focal person and members roles
The facilitators should lead the discussion who is the focal person of the group and what could be the possible roles of the focal person and group members. Then the facilitator need to conclude as follows:

Definition of a Focal Person
Once the groups are formed each group choose focal person for the groups. These Focal persons are trained on how to fill the community group card***(see Annex 2)*** and how to assess some side effect at community level.
A focal person is a group leader selected to lead the group and acting as a contact person for the CAG. The focal person should be a person who at least is able to read and write local language (for example chichewa in Malawi)

Focal person roles in the group
The following are roles of the focal person:

- ♣ Facilitating group meetings before and after drug refilling day.
- ♣ Leading discussion during meetings.
- ♣ Recording the pill count on the group card during the meeting before drug refilling.
- ♣ Checking on the adherence of group members.
- ♣ Monthly filling in of the community group card.
- ♣ Keeping the community group card
- ♣ Assuring communication between the health worker (HSA) and the group members in case any problems occur in the group.

Group member roles in the group
Equally the group members has their roles to play in a group as listed below:

- ♣ Attend each group meeting.
- ♣ Visit the health facility once every six month to represent the group members and for him/her to be assed by the clinician/nurse.
- ♣ Be able to explain what is going on in their group when asked by the clinician/nurse.
- ♣ Inform the focal person if they want to move from one CAG to another.

CAG organization at community level
The facilitator should explain how the CAG is organized at community level once it is in existence and why members are supposed to meet twice as below:

The group members at community, meet twice every month at their convenient time and place. The first meeting is done on the day before the refill day and the following meeting is on the refill day after the member come back from the health facility every month.

During the first meeting all members bring their ARV bottles with the remaining pills. The focal person leads the group that each members to count the remaining pills in the bottle one by one and he cross check then records on the group card(date and remaining pills against each member). Each member signed below where his/her pill count is recorded on the community group card. After doing pill count the group choose the representative to go to the health facility on the next day(refill day), who is then given the bottles with remaining pills and group card to present at the health facility. Each members visit the health facility on behalf of the group members, on rotational basis, twice a year (once every six months not two consecutive visits) for routine ARV refills. This will allow the representative to have consultation with the clinician. When-ever the CAG member feel or is sick (i.e. has fever, headache, etc...), he/she should go to a health facility any time for treatment not waiting the routine ART refill visit.

When the representative comes back from the health facility, the group meet in the afternoon, so that each member should collect his/her supply and the group card to be handed over to the focal person.

When meeting on the third month during the first meeting the focal person assesses each member on the side effects and record on the community group card. The assessment is repeated every three months there after ***(see Annex 2)***.

Monthly and quarterly, the CAGs in the community are supervised by NAPHAM district team(if the groups are in the support group) and HSAs respectively.

The NAPHAM district team their supervision is more looking on the smooth running and social relationship of the CAG members themselves also with the health worker***(see Annex 8)***.

The HSAs from the villages where there is CAG are identified and given training on how to supervise and assist the CAGs. The HSAs mostly do discuss with the focal person to assess how the individual CAG is doing and the challenges so that he/she can assist the focal person, discuss with individual member concerned in case of adherence problem or pass the problem to the clinician. The HSAs uses the 'Quarterly CAG supervision form for HSAs'***(see Annex 4).***
The facilitator should give **exercise 2** to the community HSAs on how to fill the quarterly CAG supervision form while referring to the filled community group card.

Rationale behind meeting twice

Meeting before refill day:

- ♣ Check pill count
- ♣ Chose representative to go to the health facility
- ♣ Assess adherence for members more especially on every third month.
- ♣ Share observations, challenges and see the way forward – among members themselves or at the health facility.
- ♣ Strengthening social interaction among members..????

Meeting on the refill day (afternoon)

- ♣ Share observations, challenges and see the way forward – especially at the health facility.
- ♣ Collect drugs from representative to avoid mistaken the individual drugs
- ♣ Communicate the next drug refilling day

Activity 2: Filling the community group card

The facilitator should explain the variable on the community group card and show the participants the sample of the card. Then the facilitator should give the participants the following exercise for the participant(especially the focal person) to practice filling in the given information.

Exercise 1: Focal person (30 minutes)

The facilitator should write the question on the board or flip chart and distribute the blank community group card to the focal persons for practice.

Question:

On the blank group card given:

1. Fill in your group name, village and Traditional Authority where you meet.

2. Your group representative went to collect drugs for other group members three times, and the information of dates you met and
tablets left for each member is shown in the table below:

Member	**1**	**2**	**3**	**4**	**5**	**6**
Date meet at community	Pills left	Pills left	Pills left	Pills left	Pills left	Pills left
6 / 01 / 2012	4	5	4	4	3	4
3 / 02 / 2012	4	5	4	4	4	3
2 / 03 / 2012	4	5	4	4	4	4

With the information given in the table fill the Community CAG group card.

3. On 2 / 03/ 2012 when meeting ;
   - one member was pregnant,
   - one member had peripheral neuropathy,
   - one member had a cough for two weeks.

Show this information on the Community CAG group card

Activity 3: Filling of quarterly supervision form for HSAs

The facilitator should explain the variable on the quarterly supervision form for HSAs and show the participants the sample of the form. Then the facilitator should give the

participants the following exercise for the participant(especially the community HSAs) to practice filling in the given information and advise the focal person.

Exercise 2: HSAs at community (20 minutes)
For the is exercise the facilitator will distribute to the participants the filled community group card in exercise 3 and blank quarterly supervision form for HSAs – Annex 4)

Question:
On 10th January 2012 you went to supervise CHANGU COMMUNITY ART GROUP(CHANGU CAG), which started ART delivery on 28/02/2011 and you meet with Pepala Pancha the Focal Point of the group.

The members of the group are as follows:

Member 1. Kapinga Masache, who is on ARV regimen 1A.
Member 2. Failo Mapini, who is on ARV regimen 1A.
Member 3. Njinga Mtengo, who is on ARV regimen 5A.
Member 4. Pepala Pancha, who is on ARV regimen 5A.
Member 5. Kapado Mpando, who is on ARV regimen 1A.
Member 6. Foni Sofa, who is on ARV regimen 1A.

No problems were faced since last supervision visit end October 2011. Focal Point check adherence by asking how they are taking their drugs (eg: 6 am one tablet and 6 pm one tablet for 1A regimen and one tablet 6 am only for those on regimen 5A). On early signs to seek medical help the Focal Point mentioned diarrhoea , severe headache, skin rash.

You were also informed by the Focal Point that:
In November 2011, Njinga Mtengo got married to a new wife far from his village and moved to another CAG in the same catchment area.
In January 2012, Kapado Mpando got employment in Blantyre, and was given a transfer on 20/01/12 to get her treatment at QECH.

Required
With the information given above:

i. Fill the Quarterly CAG supervision form.
ii. What other information will you seek from the Focal Point regarding adherence, and signs to seek medical help at health facility?
iii. What general advise will you give to the Focal Point regarding group membership and group card filling?

CHAPTER 3: ORGANIZATION AT HEALTH FACILITY LEVEL

Time Allocation: 1.30 hours

Purpose: This session enables health care workers to acquire knowledge on how to handle Community Arv Groups at health facility.

Learning objectives:

By the end of this session, participants should be able to;

- ♣ Define facility CAG register
- ♣ Define facility group card
- ♣ Define community group card
- ♣ Describe the patient flow at health facility
- ♣ Demonstrate how to fill the facility group card
- ♣ Demonstrate how to fill the CAG facility register
- ♣ Identify mistakes on community group card

Suggested teaching/learning methods: Lecture, discussion, brainstorming, exercise, question and answer

Suggested teaching and learning materials: Chalk and chalkboard, flip chart papers, permanent markers, paper and pens, transparencies and overhead projectors, audio visual aids.

Teaching and learning activities

Activity 1: Overview of facility register and group cards
Once the groups are formed the MA, Nurses or HSA register the group members in the CAG health facility register***(see Annex 5)***, facility group card***(see Annex 1)*** and focal person fills in community group card***(see Annex 2, 3)*** given at the health facility. The health centre staff (MA, Nurses, HSAs) are trained on how to handle CAGs at health facility see chapter 3.??

The **CAG register** keeps patient personal data including outcomes and their reasons. The register has the following variables

- ♣ ART Number
- ♣ Patient name
- ♣ Sex
- ♣ Age
- ♣ Name of CAG
- ♣ Date patient joined CAG
- ♣ ART initiation date
- ♣ Adverse ART out come
- ♣ Date of adverse outcome
- ♣ CAG status change(returned to conventional care/moved to another CAG(name?)/other
- ♣ Date of changed status
- ♣ Reason for change(write not know or reason)

The **facility group card** keeps all members treatment information on independent individual rows. It has two major row heading row and bottom six rows for members (each row has information for individual member) with the following variables:

Heading row:

- ♣ Name of CAG
- ♣ Site of ARV delivery
- ♣ Date CAG started ARV delivery

Six individual(members) row

- ♣ Personal data, ARV information including regimen, CPT, FP and condom information.
- ♣ Viral load information
- ♣ Pills delivered, date and signature of the collector
- ♣ TB status information
- ♣ Findings during consultation and side effects
- ♣ Outcome

The **community group card** same as facility group card, but with few variables, keeps pill count information of group members and adherence status in independent individual rows. It has two major row heading row and bottom six rows for members (each row has information for individual member) with the following variables:

Heading row:

- ♣ Name of CAG
- ♣ Village and Traditional Authority where group is meeting

Six individual(members) row

- ♣ Members name and phone number
- ♣ Pills left, date and members signature
- ♣ Assessment of adherence, side effects and HIV status of partner/children

Patient flow at the health facility

The facilitator should explain to the participants both at health facility and community about the CAG patient flow. The facilitator should mention the background as regard to ART/PMTCT guidelines and setup at health facility as follows;

According to the new ART/PMTCT guideline(Malawi MoH), clinician or nurse is the one prescribing and dispensing ARVs. In case of task shifting the ARV dispersing alone, not prescription, is done by the HSA and a two setup of patient flow at the health centre come in.

At the health facility, in preparation for the following day CAG appointments, in the afternoon the HSAs assist the Clinician/Nurse to sort the ARV master cards using the facility group card and put them against each group card for those groups whose their refill days are due.

The first setup is when the Clinician/Nurse is prescribing and dispensing ARVs in the same room and desk. In this case the facility group cards are kept in the ARV room and all ARV consultations are done in there. Therefore the group representative when visiting the health facility queues with other clients and inform the clinician/nurses about their presence and group name. Then the representative will be given the group card together with master cards and queue on the consultation line. After the representative is consulted is given the ARV refills there and then.

The other setup is when Clinician/Nurse is prescribing ARV in a different room and the HSA is assisting dispensing in another room. This setup the facility group cards are kept in

the clinicians room where consultation is done and ARV refills is done in ARV room by HSA. As the first setup when the group representative visits the health facility queues with other clients and inform the clinician/nurses about their presence and group name. Then the representative will be given the group card together with master cards and queue on the consultation line. After the representative is consulted is given the ARV master cards and referred to ARV room for refills.

Activity 2: Filling CAG facility register and facility group card
The facilitators after explaining the variables and sample of facility register, facility group card, community group card, should give the following exercise to the participants to fill in the information given on the cards/forms.

Exercise 3: Health Facility Staff (20 minutes)
The facilitator should distribute the question below with filled community group card and two blank forms one for the facility register sample and the other facility group card.

Question:
CHANGU COMMUNITY ART GROUP(CHANGU CAG) - DATE STARTED ART DELIVERY 28/02/2011.

Members:
1. KHO 234/09, Kapinga Masache, M, 35yrs, started on 5/11/09, 1A, WHO III, initial CD4 not checked.

2. KHO 550/10, Failo Mapini, F, 45yrs, started on 12/02/10, 1A, WHO II, initial CD4-202.

3. KHO 1723/11, Njinga Mtengo, M, 26yrs, started on 25/01/11, 5A, WHO II, initial CD4 not checked.

4. KHO 3984/10, Pepala Pancha, F, 50yrs, 5A, started on 17/12/10, WHO II, initial CD4 - 567.

5. KHO 434/09, Kapado Mpando, F, 23yrs, started on 30/01/09, 1A, WHO III, initial CD4 not checked.

6. KHO 1658/10, Foni Sofa, M, 33yrs, started on 8/12/10, 1A, WHO III, initial CD4 not checked.

On 27/03/2011 Kapinga Masache was sent to sent to collect group drugs and his weight was 50kgs, no side effects, no TB suspect.
On 23/04/2011 Foni sofa was sent to sent to collect group drugs and his weight was 45kg, had peripheral neuropathy, no TB suspect.
On 21/05/2011 Failo Mapini was sent to sent to collect group drugs and her weight was 67kg, she was 5 months pregnant, no side effects, no TB suspect.

In November 2011, Njinga Mtengo got married to a new wife far from his village and moved to another CAG in the same catchment area.
In January 2012, Kapado Mpando got employment in Blantyre, and was given a transfer on 20/01/12 to get her treatment at QECH.

All group members are alive, during each consultation you gave 60 tables of contrimoxazole for each group member and 60 condoms for all.
Refer also the attached group card (brought by the group representative but filled at the community by the Focal Point)

Filled community group card:

Khadi yolembedwa kumudzi

Dzina la gulu CHANGU	Mudzi/TA likukumanirana gulu KUMADZI/KAPICHI

	Dzina	Tsiku 26/03/11	Tsiku 22/04/11	Tsiku 20/04/11	imiyezi itatu (3) iliyonse:	Tsiku ../../.....	Tsiku ../../.....	Tsiku ../../.....	imiyezi itatu (3) iliyonse:
membala 1	KAPINGA MASACHE	Mapilisi otsala 4	Mapilisi otsala 4	Mapilisi otsala 4	Akukhulupirika? Inde/Ayi Dzanzi? Inde/Ayi Kutsokomola? Inde/Ayi Kutsekula? Inde/Ayi Oyembekezera? Inde/Ayi Okondedwa/Ana: anayezetsa HIV? Inde/Ayi	Mapilisi otsala	Mapilisi otsala	Mapilisi otsala	Akukhulupirika? Inde/Ayi Dzanzi? Inde/Ayi Kutsokomola? Inde/Ayi Kutsekula? Inde/Ayi Oyembekezera? Inde/Ayi Okondedwa/Ana: anayezetsa HIV? Inde/Ayi
		sayini KM	sayini KM	sayini KM		sayini	sayini	sayini	
membala 2	FAILO MAPINI	Mapilisi otsala 3	Mapilisi otsala 6	Mapilisi otsala 5	Akukhulupirika? Inde/Ayi Dzanzi? Inde/Ayi Kutsokomola? Inde/Ayi Kutsekula? Inde/Ayi Oyembekezera? Inde/Ayi Okondedwa/Ana: anayezetsa HIV? Inde/Ayi	Mapilisi otsala	Mapilisi otsala	Mapilisi otsala	Akukhulupirika? Inde/Ayi Dzanzi? Inde/Ayi Kutsokomola? Inde/Ayi Kutsekula? Inde/Ayi Oyembekezera? Inde/Ayi Okondedwa/Ana: anayezetsa HIV? Inde/Ayi
		sayini FM	sayini FM	sayini FM		sayini	sayini	sayini	
membala 3	NJINGA MTENGO	Mapilisi otsala 4	Mapilisi otsala 4	Mapilisi otsala 4	Akukhulupirika? Inde/Ayi Dzanzi? Inde/Ayi Kutsokomola? Inde/Ayi Kutsekula? Inde/Ayi Oyembekezera? Inde/Ayi Okondedwa/Ana: anayezetsa HIV? Inde/Ayi	Mapilisi otsala	Mapilisi otsala	Mapilisi otsala	Akukhulupirika? Inde/Ayi Dzanzi? Inde/Ayi Kutsokomola? Inde/Ayi Kutsekula? Inde/Ayi Oyembekezera? Inde/Ayi Okondedwa/Ana: anayezetsa HIV? Inde/Ayi
		sayini NM	sayini NM	sayini NM		sayini	sayini	sayini	
membala 4	PEPALA PANCHA	Mapilisi otsala 2	Mapilisi otsala 2	Mapilisi otsala 1	Akukhulupirika? Inde/Ayi Dzanzi? Inde/Ayi Kutsokomola? Inde/Ayi Kutsekula? Inde/Ayi Oyembekezera? Inde/Ayi Okondedwa/Ana: anayezetsa HIV? Inde/Ayi	Mapilisi otsala	Mapilisi otsala	Mapilisi otsala	Akukhulupirika? Inde/Ayi Dzanzi? Inde/Ayi Kutsokomola? Inde/Ayi Kutsekula? Inde/Ayi Oyembekezera? Inde/Ayi Okondedwa/Ana: anayezetsa HIV? Inde/Ayi
		sayini PP	sayini PP	sayini PP		sayini	sayini	sayini	
membala 5	KAPADO MPANDO	Mapilisi otsala 4	Mapilisi otsala 4	Mapilisi otsala 4	Akukhulupirika? Inde/Ayi Dzanzi? Inde/Ayi Kutsokomola? Inde/Ayi Kutsekula? Inde/Ayi Oyembekezera? Inde/Ayi Okondedwa/Ana: anayezetsa HIV? Inde/Ayi	Mapilisi otsala	Mapilisi otsala	Mapilisi otsala	Akukhulupirika? Inde/Ayi Dzanzi? Inde/Ayi Kutsokomola? Inde/Ayi Kutsekula? Inde/Ayi Oyembekezera? Inde/Ayi Okondedwa/Ana: anayezetsa HIV? Inde/Ayi
		sayini KM	sayini KM	sayini KM		sayini	sayini	sayini	
membala 6	FONI SOFA	Mapilisi otsala 4	Mapilisi otsala 4	Mapilisi otsala 4	Akukhulupirika? Inde/Ayi Dzanzi? Inde/Ayi Kutsokomola? Inde/Ayi Kutsekula? Inde/Ayi Oyembekezera? Inde/Ayi Okondedwa/Ana: anayezetsa HIV? Inde/Ayi	Mapilisi otsala	Mapilisi otsala	Mapilisi otsala	Akukhulupirika? Inde/Ayi Dzanzi? Inde/Ayi Kutsokomola? Inde/Ayi Kutsekula? Inde/Ayi Oyembekezera? Inde/Ayi Okondedwa/Ana: anayezetsa HIV? Inde/Ayi
		sayini FS	sayini FS	sayini FS		sayini	sayini	sayini	

Required

With the group information given above, fill:

i. CAG REGISTER for Health Centre.

ii. Facility group card.

Solution/Answer:

The facilitator should move around to check if the participants are filling the forms correctly and assist accordingly, later conclude by showing and explaining the correct filling as shown below.

CAG REGISTER for Health Centres

Health facility name: _____KHONJENI_____

No	ART No.	NAME	M/F	Age	Name of CAG	Date the pat joined the CAG	ART initiation date	Adverse ART out come(which)	Date of adverse outcome	CAG status change(returned to conventional care/moved to another CAG(name?)/other)	Date of changed status	Reason for change(write not know or reason)
1	KH234/09	KAPINGA MASACHE	M	35	CHANGU	28/02/11	05/11/09					
2	KH550/10	FAILO MAPINI	F	45	CHANGU	28/02/11	12/02/10					
3	KH1723/11	NJINGA MTENGO	M	26	CHANGU	28/02/11	25/01/11			Move to another CAG	Dec 2011	Following wife
4	KH3984/10	PEPALA PANCHA	F	50	CHANGU	28/02/11	17/12/10					
5	KH434/09	KAPADO MPANDO	F	23	CHANGU	28/02/11	30/01/09	T/O	20/01/12			Employed in Blantyre
6	KH1658/10	FONI SOFA	M	33	CHANGU	28/02/11	08/12/10					
7												

To be filled in at the Health Facility

name CAG **CHANGU** | SITE of ARV delivery **KHONJENI H/C** | DATE CAG started ARV delivery **28/02/2011**

---

member 1

Name & phone no: ...**KAPINGA MASACHE 088888112**..... Age: **35** .. M / F

ART No: KH234/09 | start ART ...**05/ 11 /09** | CD4 at ART initiation: ..... | WHO stage: **III**

ART regimen 1A 2A 3A 4A 5A 6A 7A 8A Oth

CTX given for group Y/N | No of tabl **360** | Family planning: Depo: Y/N Condoms: Y/N

Viral Load			Date	Date	Date	Date	Date	Date
At 6m Result	Last VL Date	Last VL Result	27/3/11	../../....	../../....	../../....	../../....	../../....
			pills delivered	pills delivered	pills delivered	pills delivered	pills delivered	pills delivered
			300					
			sign. repres.	sign. repres.	sign. repres.	sign. repres.	sign. repres.	sign. repres.
			KM					

TB Status (curr): Suspected (No) Yes noRx Rx | Confirmed No Yes noRx Rx

consult every 6 M ...../...../.....

consult done? Y / N — Weight **50** Kg.

Adhere nt? Y / N — Pregnant? Y / N

Side Effects (circle at least one option):

No PN HP SK Lip Oth

Outcomes: Alive (Y) N | Death | Default | Stop | TO

Date:

---

member 2

Name & phone no: ...**FAILO MAPINI**..... Age: **45** .. M / F

ART No: KH550/10 | start ART ...**12/ 02 /10** | CD4 at ART initiation: **202** | WHO stage: **II**

ART regimen 1A 2A 3A 4A 5A 6A 7A 8A Oth

CTX given for group Y/N | No of tabl **360** | Family planning: Depo: Y/N Condoms: Y/N

Viral Load			Date	Date	Date	Date	Date	Date
At 6m Result	Last VL Date	Last VL Result	../../....	../../....	21/5/11	../../....	../../....	../../....
			pills delivered	pills delivered	pills delivered	pills delivered	pills delivered	pills delivered
					300			
			sign. repres.	sign. repres.	sign. repres.	sign. repres.	sign. repres.	sign. repres.
					FM			

TB Status (curr): Suspected (No) Yes noRx Rx | Confirmed No Yes noRx Rx

consult every 6 M ...../...../.....

consult done? Y / N — Weight **67** Kg.

Adhere nt? Y (N) — Pregnant? (Y) N

Side Effects (circle at least one option):

(No) PN HP SK Lip Oth

Outcomes: Alive (Y) N | Death | Default | Stop | TO

Date:

---

member 3

Name & phone no: ...**NJINGA MTENGO 0111943001**..... Age: **26** .. M / F

ART No: KH1723/11 | start ART ...**25/ 01 /11** | CD4 at ART initiation: ..... | WHO stage: **II**

ART regimen 1A 2A 3A 4A 5A 6A 7A 8A Oth

CTX given for group Y/N | No of tabl ..... | Family planning: Depo: Y/N Condoms: Y/N

Viral Load			Date	Date	Date	Date	Date	Date
At 6m Result	Last VL Date	Last VL Result	../../....	../../....	../../....	../../....	../../....	../../....
			pills delivered	pills delivered	pills delivered	pills delivered	pills delivered	pills delivered
			sign. repres.	sign. repres.	sign. repres.	sign. repres.	sign. repres.	sign. repres.

TB Status (curr): Suspected No Yes noRx Rx | Confirmed No Yes noRx Rx

consult every 6 M ...../...../.....

consult done? Y / N — Weight .....

Adhere nt? Y / N — Pregnant? Y / N

Side Effects (circle at least one option):

No PN HP SK Lip Oth

Outcomes: Alive (Y) N | Death | Default | Stop | TO

Date:

---

member 4

Name & phone no: ...**PEPALA PANCHA 0999991111**..... Age: **50** .. M / F

ART No: KH3384/10 | start ART ...**17/ 12 /10** | CD4 at ART initiation: **567** | WHO stage: **II**

ART regimen 1A 2A 3A 4A 5A 6A 7A 8A Oth

CTX given for group Y/N | No of tabl ..... | Family planning: Depo: Y/N Condoms: Y/N

Viral Load			Date	Date	Date	Date	Date	Date
At 6m Result	Last VL Date	Last VL Result	../../....	../../....	../../....	../../....	../../....	../../....
			pills delivered	pills delivered	pills delivered	pills delivered	pills delivered	pills delivered
			sign. repres.	sign. repres.	sign. repres.	sign. repres.	sign. repres.	sign. repres.

TB Status (curr): Suspected No Yes noRx Rx | Confirmed No Yes noRx Rx

consult every 6 M ...../...../.....

consult done? Y / N — Weight .....

Adhere nt? Y / N — Pregnant? Y / N

Side Effects (circle at least one option):

No PN HP SK Lip Oth

Outcomes: Alive (Y) N | Death | Default | Stop | TO

Date:

---

member 5

Name & phone no: ...**KAPADO MPANDO**..... Age: **23** .. M / F

ART No: KH434/09 | start ART ...**30/ 01 /09** | CD4 at ART initiation: ..... | WHO stage: **III**

ART regimen 1A 2A 3A 4A 5A 6A 7A 8A Oth

CTX given for group Y/N | No of tabl ..... | Family planning: Depo: Y/N Condoms: Y/N

Viral Load			Date	Date	Date	Date	Date	Date
At 6m Result	Last VL Date	Last VL Result	../../....	../../....	../../....	../../....	../../....	../../....
			pills delivered	pills delivered	pills delivered	pills delivered	pills delivered	pills delivered
			sign. repres.	sign. repres.	sign. repres.	sign. repres.	sign. repres.	sign. repres.

TB Status (curr): Suspected No Yes noRx Rx | Confirmed No Yes noRx Rx

consult every 6 M ...../...../.....

consult done? Y / N — Weight .....

Adhere nt? Y / N — Pregnant? Y / N

Side Effects (circle at least one option):

No PN HP SK Lip Oth

Outcomes: Alive (Y) N | Death | Default | Stop | (TO) — Date: **20/01/12**

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member 6

Name & phone no: ...**FONI SOFA**..... Age: **33** .. M / F

ART No: KH1658/10 | start ART ...**08/ 12 /10** | CD4 at ART initiation: ..... | WHO stage: **III**

ART regimen 1A 2A 3A 4A 5A 6A 7A 8A Oth

CTX given for group Y/N | No of tabl **360** | Family planning: Depo: Y/N Condoms: Y/N

Viral Load			Date	Date	Date	Date	Date	Date
At 6m Result	Last VL Date	Last VL Result	../../....	23/4/11	../../....	../../....	../../....	../../....
			pills delivered	pills delivered	pills delivered	pills delivered	pills delivered	pills delivered
				300				
			sign. repres.	sign. repres.	sign. repres.	sign. repres.	sign. repres.	sign. repres.
				FS				

TB Status (curr): Suspected (No) Yes noRx Rx | Confirmed No Yes noRx Rx

consult every 6 M ...../...../.....

consult done? (Y) N — Weight **45** Kg.

Adhere nt? (Y) N — Pregnant? Y (N)

Side Effects (circle at least one option):

No (PN) HP SK Lip Oth

Outcomes: Alive (Y) N | Death | Default | Stop | TO

Date:

TB Status: N = TB not suspected, Y = TB suspected, C = TB confirmed not (yet) on treatment, Rx = TB confirmed & currently on treatment

Side effects: No = no side effects, PN = peripheral neuropathy, HP = hepatitis, SK = skin rash, Lip = lipodystrophy, Oth = other side effects

CHAPTER 4: COMMUNICATION IN CAG MODEL OF CARE

Time Allocation: 45 minutes

Purpose: This session introduces and enables participants to acquire knowledge on how to community effectively within the CAG model of care.

Learning objectives:

By the end of this session, participants should be able to;

- ♣ Define communication
- ♣ State the importance of communication in CAG model of care
- ♣ Describe the communication flow in CAG model of care
- ♣ State the roles of different cadres regarding communication in CAG model of care

Suggested teaching/learning methods: Lecture, discussion, brainstorming, demonstration, role play

Suggested teaching and learning materials: Chalk and chalkboard, flip chart papers, permanent markers, transparencies and overhead projectors, audio visual aids.

Teaching and learning activities

Activity 1:
The facilitator should lead in the discussions of to define communication and importance of communication in CAG model of care. Then the facilitator should conclude the discussions by presenting the following:

Definition of communication
Communication is a process through which messages are transmitted from one person to another. The messages may be in the form of information, instruction, thoughts, feelings, signals or activities and are transmitted most effectively when communication is a two-way process between the sender or initiator and the intended receiver.
The overall aim of communication is to enable the sender to send his/her message to the targeted receiver in a clear and effective manner. In CAG model of care this means the ability to effectively transmit information, instructions, guidance, advice, feelings, or thoughts to CAG members, health workers or supervisors(program managers) in either way.

Importance of communication
Communication starts with the care/service providers and clients themselves. There is need to be more Self-aware because once we are self aware, we become in charge of our lives and that can influence the way we communicate with others. Same with the clients if they are more aware about their condition they become in-charge of their lives [10].

The major purpose of communication in CAG model of care is to encourage the community and enhance the role of the ART clients in the management of their condition by:

- ♣ Establishing & maintaining relationship with health workers(community & facility)
- ♣ Promoting equality in the group relationship
- ♣ Gathering information about their treatment and condition
- ♣ Providing information about any side effects and any observation in the groups functioning.
- ♣ Self-expression when meeting at village level and at the health facility

Activity 2: Communication flow in CAG model of care
Participants should brain storm the cadres involved when communicating in CAG model of care and the flow lead by the facilitator. Then the facilitator should explain the communication flow as shown in Figure 1 below:

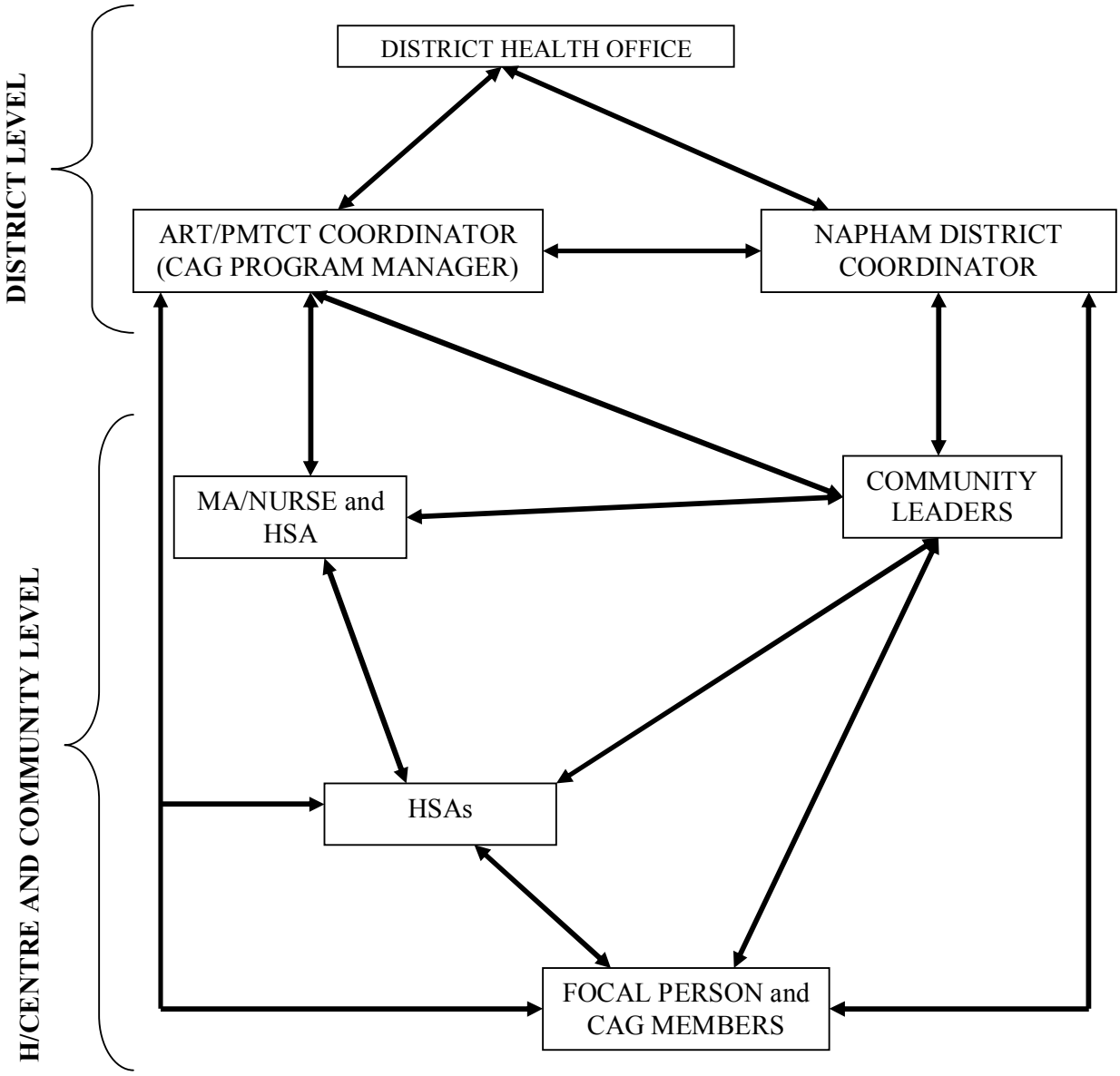

FIGURE 1: COMMUNICATION FLOW IN CAG MODEL OF CARE

ROLES AND RESPONSIBILITIES OF DIFFERENT CADRES

1. District Health Office

- ♣ Liaise with MOH national level
- ♣ Disseminate CAG experience

2. ART/PMTCT Coordinator(CAG Program manager)

- Manage the CAG programme
- Organise regular meetings with team members in CAG program(monthly or bimonthly)
- Analyse CAG programme data
- Supervise CAG-related tasks of health workers (as part of quarterly supervision)
- Organise and conduct initial trainings and briefings of HC staff, HSAs in communities, HIMS staff, CAG focal points and expert clients
- Conduct homes visits with individual members of a convenience sample of CAGs every three months to audit quality of functioning of CAGs
- Report to the DHO and to the HIV/ART Technical Working Group
- Ensure follow up of patients with a negative outcome (as part of home visits)
- Continuous quality improvement of CAG programme
- Evaluate the pilot CAG, including collection of baseline data
- Organise possible roll-out of CAGs after pilot

3. NAPHAM District Coordinator

- Sensitise patients about CAGs and how they can become involved
- Follow up quarterly with CAG focal points on member adherence and outcomes
- Supports CAG focal points in monitoring (group card filling)
- Consults with and links with MOH focal point for CAGs
- Participates in regular meetings with MOH and MSF
- Organise and train CAG members in treatment literacy??

4. MA/Nurse and/or HSA at health facility

- Sensitise patients about CAGs and how they can become involved
- Follow-up monthly with CAG representative on member adherence and outcomes
- Dispense ARV for each group member to CAG representative
- Update CAG group card at each monthly visit of group representative
- Prescribe ARV refills – (MA/Nurse)
- Regular clinical consultation for group representatives every six months and any unplanned visit by members(MA/Nurse)
- Draw blood for VL?

5. Community leaders

- Recognize existence of CAGs in there community
- Support CAG activities if involves local leaders
- Encourage CAG members unity and indirectly reinforce drug adherence
- Involve CAGs fully on issues concerning HIV and ARVs in the community
- Settle CAG disputes if any

6. HSAs at community level

- Supervising the CAGs on quarterly basis
- Assisting the focal persons in problems of group card filling
- Identifying areas need support and coach them(focal perso/members)
- Advise the CAG members on adherence issues

7. Focal Person and CAG members

- Own the group and run the group affairs
- Know each other better
- Strengthen the social interaction within the groups
- Enhancing communication between the health workers and the CAG

CHAPTER 5: TOOLS USED IN CAG MODEL OF CARE

Time Allocation: 45 minutes

Purpose: This session enables participants to acquire knowledge on tools used in CAG program.

Learning objectives:

By the end of this session, participants should be able to;

- ♣ Define each tool used in CAG model of care
- ♣ State the importance of filing each tool correctly
- ♣ Demonstrate proper filing of each tool (1,2,3,4)

Suggested teaching/learning methods: Lecture, discussion, brainstorming, question and answer, exercise

Suggested teaching and learning materials: Chalk and chalkboard, flip chart papers, permanent markers, pens and papers, transparencies and overhead projectors, audio visual aids.

For this chapter, it is more relevant that the facilitator should explain the tools used in the CAG model of care especially during health workers training. This will enable the health workers understand the importance of accurate data collect, and early submission. The facilitator should explain each tool as follows;

1. **Group card for Health facility –** Discussed in chapter 3, clinician/Nurse is responsible for filling it and is stored at the health facility***(see Annex 1)***.

2. **Community group card -** Discussed in chapter 2, focal points is responsible for filling and storage of it***(see Annex 2)***.

3. **CAG register for Health centres –** Discussed in chapter 3, staff at ARV room is responsible for updating the register and is stored at the health facility***(see Annex 5)***.

4. **Quarterly CAG supervision form for HSAs –** Discussed in chapter 2, HSAs at community level is responsible for filling it quarterly and submits it to the in-charge of mother health facility for filing***(see Annex 4)***.

5. **CAG data base-** This is a soft copy kept at District level which has information of the individual patient (exact information in the register and facility group card). Data manager at district level is responsible for updating it on monthly basis. Helps to keep tract of the outcomes as soon as possible***(see Annex 7)***.

6. **Monthly and quarterly CAG report -** CAG program Manager is responsible for this, compiles data from the facility group card and CAG facility register. The file for the forms is kept by the program manager at district level. This helps to compare the month to month or quarter to quarter data and intervene where necessary***(see Annex 9)***.

7. **CAG audit form for program managers –** CAG program manager is responsible for this, helps to asses the acceptance of CAGs by the individual group members,

and pick other problems faced by CAG. The file for this is kept by the program manager at district level***(see Annex 6)***.

8. **CAG supervision form for NAPHAM community supervision –** NAPHAM district coordinator is responsible for this, need to visit the groups every 3 months to assess how the focal person is doing with leading the group, the comfort ability of members acting as representative and if any problems as regard to interaction with the health workers at the health facility. The file of this forms is kept by the NAPHAM District coordinator***(see Annex 8)***.

ANNEX 1: GROUP CARD FOR HEALTH FACILITY

To be filled in at the Health Facility

name CAG	SITE of ARV delivery	DATE CAG started ARV delivery

		Viral Load	Date	Date	Date	Date	Date	Date	TB Status (curr)		consult every 6 m	Outcomes	Date
member 1	Name & phone no: ..... Age: ..... M / F ART No..... start ART: ...../...../..... CD4 at ART initiation:..... WHO stage: ..... ART regimen 1A 2A 3A 4A 5A 6A 7A 8A Other CTX given for group Y/N No of tabl ..... Family planning: Depo: Y/N Condoms: Y/N	At 6m Last VL Result Date Result	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	Suspected No Yes	Confirmed noRx Rx	consult done? Y / N WEIGHT ..... Adherent? Y / N Pregnant? Y / N Side Effects: No PN HP SK Lip Oth	Alive Death Default Stop TO	
member 2	Name & phone no: ..... Age: ..... M / F ART No..... start ART: ...../...../..... CD4 at ART initiation:..... WHO stage: ..... ART regimen 1A 2A 3A 4A 5A 6A 7A 8A Other CTX given for group Y/N No of tabl ..... Family planning: Depo: Y/N Condoms: Y/N	At 6m Last VL Result Date Result	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	Suspected No Yes	Confirmed noRx Rx	consult done? Y / N WEIGHT ..... Adherent? Y / N Pregnant? Y / N Side Effects: No PN HP SK Lip Oth	Alive Death Default Stop TO	
member 3	Name & phone no: ..... Age: ..... M / F ART No..... start ART: ...../...../..... CD4 at ART initiation:..... WHO stage: ..... ART regimen 1A 2A 3A 4A 5A 6A 7A 8A Other CTX given for group Y/N No of tabl ..... Family planning: Depo: Y/N Condoms: Y/N	At 6m Last VL Result Date Result	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	Suspected No Yes	Confirmed noRx Rx	consult done? Y / N WEIGHT ..... Adherent? Y / N Pregnant? Y / N Side Effects: No PN HP SK Lip Oth	Alive Death Default Stop TO	
member 4	Name & phone no: ..... Age: ..... M / F ART No..... start ART: ...../...../..... CD4 at ART initiation:..... WHO stage: ..... ART regimen 1A 2A 3A 4A 5A 6A 7A 8A Other CTX given for group Y/N No of tabl ..... Family planning: Depo: Y/N Condoms: Y/N	At 6m Last VL Result Date Result	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	Suspected No Yes	Confirmed noRx Rx	consult done? Y / N WEIGHT ..... Adherent? Y / N Pregnant? Y / N Side Effects: No PN HP SK Lip Oth	Alive Death Default Stop TO	
member 5	Name & phone no: ..... Age: ..... M / F ART No..... start ART: ...../...../..... CD4 at ART initiation:..... WHO stage: ..... ART regimen 1A 2A 3A 4A 5A 6A 7A 8A Other CTX given for group Y/N No of tabl ..... Family planning: Depo: Y/N Condoms: Y/N	At 6m Last VL Result Date Result	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	Suspected No Yes	Confirmed noRx Rx	consult done? Y / N WEIGHT ..... Adherent? Y / N Pregnant? Y / N Side Effects: No PN HP SK Lip Oth	Alive Death Default Stop TO	
member 6	Name & phone no: ..... Age: ..... M / F ART No..... start ART: ...../...../..... CD4 at ART initiation:..... WHO stage: ..... ART regimen 1A 2A 3A 4A 5A 6A 7A 8A Other CTX given for group Y/N No of tabl ..... Family planning: Depo: Y/N Condoms: Y/N	At 6m Last VL Result Date Result	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	...../...../..... pills delivered sign. repres.	Suspected No Yes	Confirmed noRx Rx	consult done? Y / N WEIGHT ..... Adherent? Y / N Pregnant? Y / N Side Effects: No PN HP SK Lip Oth	Alive Death Default Stop TO	

TB Status: N = TB not suspected, Y = TB suspected, C = TB confirmed not (yet) on treatment, Rx = TB confirmed & currently on treatment

Side effects: No = no side effects, PN = peripheral neuropathy, HP = hepatitis, SK = skin rash, Lip = lipodystrophy, Oth = other side effects

ANNEX 2: COMMUNITY GROUP CARD – ENGLISH VERSION

To be filled in the community

Name of the group:	Village/TA where group is meeting:

	Name & phone no	ART regimen	Date …/…/……	Date …/…/……	Date …/…/……	every 3 months:	Date …/…/……	Date …/…/……	Date …/…/……	every 3 months:
member 1			Tablets left signature	Tablets left signature	Tablets left signature	Adherent? Y / N Neuropathy? Y / N Cough Y / N Diarrhea? Y / N Pregnant? Y / N Partners/ Children : tested for HIV? Y / N	Tablets left signature	Tablets left signature	Tablets left signature	Adherent? Y / N Neuropathy? Y / N Cough Y / N Diarrhea? Y / N Pregnant? Y / N Partners/ Children : tested for HIV? Y / N
member 2			Tablets left signature	Tablets left signature	Tablets left signature	Adherent? Y / N Neuropathy? Y / N Cough Y / N Diarrhea? Y / N Pregnant? Y / N Partners/ Children : tested for HIV? Y / N	Tablets left signature	Tablets left signature	Tablets left signature	Adherent? Y / N Neuropathy? Y / N Cough Y / N Diarrhea? Y / N Pregnant? Y / N Partners/ Children : tested for HIV? Y / N
member 3			Tablets left signature	Tablets left signature	Tablets left signature	Adherent? Y / N Neuropathy? Y / N Cough Y / N Diarrhea? Y / N Pregnant? Y / N Partners/ Children : tested for HIV? Y / N	Tablets left signature	Tablets left signature	Tablets left signature	Adherent? Y / N Neuropathy? Y / N Cough Y / N Diarrhea? Y / N Pregnant? Y / N Partners/ Children : tested for HIV? Y / N
member 4			Tablets left signature	Tablets left signature	Tablets left signature	Adherent? Y / N Neuropathy? Y / N Cough Y / N Diarrhea? Y / N Pregnant? Y / N Partners/ Children : tested for HIV? Y / N	Tablets left signature	Tablets left signature	Tablets left signature	Adherent? Y / N Neuropathy? Y / N Cough Y / N Diarrhea? Y / N Pregnant? Y / N Partners/ Children : tested for HIV? Y / N
member 5			Tablets left signature	Tablets left signature	Tablets left signature	Adherent? Y / N Neuropathy? Y / N Cough Y / N Diarrhea? Y / N Pregnant? Y / N Partners/ Children : tested for HIV? Y / N	Tablets left signature	Tablets left signature	Tablets left signature	Adherent? Y / N Neuropathy? Y / N Cough Y / N Diarrhea? Y / N Pregnant? Y / N Partners/ Children : tested for HIV? Y / N
member 6			Tablets left signature	Tablets left signature	Tablets left signature	Adherent? Y / N Neuropathy? Y / N Cough Y / N Diarrhea? Y / N Pregnant? Y / N Partners/ Children : tested for HIV? Y / N	Tablets left signature	Tablets left signature	Tablets left signature	Adherent? Y / N Neuropathy? Y / N Cough Y / N Diarrhea? Y / N Pregnant? Y / N Partners/ Children : tested for HIV? Y / N

ANNEX 3: COMMUNITY GROUP CARD – CHICHEWA VERSION

Khadi yolembedwa kumudzi

Dzina la gulu	**Mudzi/TA likukumanirana gulu**

		Tsiku	Tsiku	Tsiku		Tsiku	Tsiku	Tsiku	
	Dzina	.../.../.....	.../.../.....	.../.../.....	imiyezi itatu (3) iliyonse:	.../.../.....	.../.../.....	.../.../.....	imiyezi itatu (3) iliyonse:
membala 1		Mapilisi otsala	Mapilisi otsala	Mapilisi otsala	Akukhulupirika? Inde/Ayi Dzanzi? Inde/Ayi Kutsokomola? Inde/Ayi Kutsekula? Inde/Ayi	Mapilisi otsala	Mapilisi otsala	Mapilisi otsala	Akukhulupirika? Inde/Ayi Dzanzi? Inde/Ayi Kutsokomola? Inde/Ayi Kutsekula? Inde/Ayi
		sayini	sayini	sayini	Oyembekezera? Inde/Ayi Okondedwa/Ana: anayezetsa HIV? Inde/Ayi	sayini	sayini	sayini	Oyembekezera? Inde/Ayi Okondedwa/Ana: anayezetsa HIV? Inde/Ayi
membala 2		Mapilisi otsala	Mapilisi otsala	Mapilisi otsala	Akukhulupirika? Inde/Ayi Dzanzi? Inde/Ayi Kutsokomola? Inde/Ayi Kutsekula? Inde/Ayi	Mapilisi otsala	Mapilisi otsala	Mapilisi otsala	Akukhulupirika? Inde/Ayi Dzanzi? Inde/Ayi Kutsokomola? Inde/Ayi Kutsekula? Inde/Ayi
		sayini	sayini	sayini	Oyembekezera? Inde/Ayi Okondedwa/Ana: anayezetsa HIV? Inde/Ayi	sayini	sayini	sayini	Oyembekezera? Inde/Ayi Okondedwa/Ana: anayezetsa HIV? Inde/Ayi
membala 3		Mapilisi otsala	Mapilisi otsala	Mapilisi otsala	Akukhulupirika? Inde/Ayi Dzanzi? Inde/Ayi Kutsokomola? Inde/Ayi Kutsekula? Inde/Ayi	Mapilisi otsala	Mapilisi otsala	Mapilisi otsala	Akukhulupirika? Inde/Ayi Dzanzi? Inde/Ayi Kutsokomola? Inde/Ayi Kutsekula? Inde/Ayi
		sayini	sayini	sayini	Oyembekezera? Inde/Ayi Okondedwa/Ana: anayezetsa HIV? Inde/Ayi	sayini	sayini	sayini	Oyembekezera? Inde/Ayi Okondedwa/Ana: anayezetsa HIV? Inde/Ayi
membala 4		Mapilisi otsala	Mapilisi otsala	Mapilisi otsala	Akukhulupirika? Inde/Ayi Dzanzi? Inde/Ayi Kutsokomola? Inde/Ayi Kutsekula? Inde/Ayi	Mapilisi otsala	Mapilisi otsala	Mapilisi otsala	Akukhulupirika? Inde/Ayi Dzanzi? Inde/Ayi Kutsokomola? Inde/Ayi Kutsekula? Inde/Ayi
		sayini	sayini	sayini	Oyembekezera? Inde/Ayi Okondedwa/Ana: anayezetsa HIV? Inde/Ayi	sayini	sayini	sayini	Oyembekezera? Inde/Ayi Okondedwa/Ana: anayezetsa HIV? Inde/Ayi
membala 5		Mapilisi otsala	Mapilisi otsala	Mapilisi otsala	Akukhulupirika? Inde/Ayi Dzanzi? Inde/Ayi Kutsokomola? Inde/Ayi Kutsekula? Inde/Ayi	Mapilisi otsala	Mapilisi otsala	Mapilisi otsala	Akukhulupirika? Inde/Ayi Dzanzi? Inde/Ayi Kutsokomola? Inde/Ayi Kutsekula? Inde/Ayi
		sayini	sayini	sayini	Oyembekezera? Inde/Ayi Okondedwa/Ana: anayezetsa HIV? Inde/Ayi	sayini	sayini	sayini	Oyembekezera? Inde/Ayi Okondedwa/Ana: anayezetsa HIV? Inde/Ayi
membala 6		Mapilisi otsala	Mapilisi otsala	Mapilisi otsala	Akukhulupirika? Inde/Ayi Dzanzi? Inde/Ayi Kutsokomola? Inde/Ayi Kutsekula? Inde/Ayi	Mapilisi otsala	Mapilisi otsala	Mapilisi otsala	Akukhulupirika? Inde/Ayi Dzanzi? Inde/Ayi Kutsokomola? Inde/Ayi Kutsekula? Inde/Ayi
		sayini	sayini	sayini	Oyembekezera? Inde/Ayi Okondedwa/Ana: anayezetsa HIV? Inde/Ayi	sayini	sayini	sayini	Oyembekezera? Inde/Ayi Okondedwa/Ana: anayezetsa HIV? Inde/Ayi

ANNEX 4: QUARTERLY CAG SUPERVISION FORM FOR HSAs

Quarterly CAG SUPERVISION FORM for HSAs **Name of supervisor** _____

Name of CAG	
Name of Village/TA	
Name of focal point (FP)	
Date of supervision	

Did you experience any problems since the last SV visit? Y/N	
If yes, which? Describe	
Describe how do you check adherence of members? *FP should be able to explain about pill counts*	
When do you advise a patient to seek health care? *FP should be able to name all side effects and other issues on group card*	
Check the group card: filled correctly? If not, record what the problem is	

Did this CAG lose anyone? Y/N	
If yes, WHEN (Date)?	
Why?	

Any other observations/comments regarding the group:	

ANNEX 5: CAG REGISTER FOR HEALTH CENTRES

Health facility name: _____

No	ART No	Name	M/F	Age	Name of CAG	Date the pat joined the CAG	ART initiation date	Adverse ART outcome (which)	Date of adverse outcome	CAG status change (returned to conventional care / moved to another CAG (name?) /other)	Date of changed status	Reason for change (write not known OR reason)

ANNEX 6: CAG AUDIT FORM FOR PROGRAM MANAGER

CAG AUDIT Form for programme manager **Name of interviewer** _____

CAG Name _____ **Village/TA** _____

Name and role in CAG (focal person or member)	Interview		Date of interview	Cough		Diarrhea		Skin lesions		Mouth lesions		Weight loss		Pregnant		When did he/she last receive ARV from group rep	Current ARV regimen	Taking ARV as prescribed?	Happy with CAG?	Reasons
	at HC	in com	dd/mm/yy	Y/N	No of days	Y/N	No of days	Y/N	No of days	Y/N	No of days	Y/N	No of days	Y/N	No of weeks	Date or no of days ago		Y/N	Y/N	

Did this CAG lose anyone? Y / N If YES: when (date)? _____ Reasons know Y / N Which? _____

Where are ARVs distributed? at home / in group / other How often does the group meet (e.g. per month)? _____

Any other observations/comments regarding the group: _____

_____

_____

ANNEX 7: CAG DATA BASE

ART No	Name	M/F	Age on joining CAG	Health facility where representative collects ARVs	Name of CAG	Date the pat joined the CAG	ART initiation date	Months on ART on joining CAG	ARV regimen	ART Outcome	Date of last ART outcome	Date of last data entry	Days on FU in CAG at last data entry	Months on FU in CAG at last data entry	Date pat exit CAG programme (if appl)	Baseline CD4	First VL (at 6m)	VL at 24m	VL at 48m	Latest VL	Observations/comments
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ANNEX 8: CAG SUPERVISION FORM FOR NAPHAM COMMUNITY SUPERVISION

CAG Supervision Form for NAPHAM community supervision

Name of Supervisor_____ **Date of Supervision**_____

Name of CAG	
Name of Village/TA	
Name of focal point (FP)	

FOR THE FOCAL POINT	
Does the focal point feel confident in filling the CAG group card?	**Yes /No**
If not, explain where he/she has problems	
Check CAG group card: Is it filled in correctly?	**Yes /No**
If not, record what the problem is	
Does the focal point think there any problems in this group?	**Yes /No**
If yes, describe	

FOR THE MEMBERS	
Do all members feel confident to act as representatives?	**Yes /No**
Can the members report confidently what they have to do as representatives?	**Yes /No**
If no, why not? Which problems?	
If not: how many do not feel confident?	
Does any of the members think there are problems in this group?	**Yes /No**
If yes, describe	

INTERACTION WITH HEALTH WORKERS	
When the representative went to refill ARVs, was he/she seen by a MA/nurse?	**Yes / No**
Did the healthworker ask the representative about ARV side effects?	**Yes / No**
Did the representative feel treated in a friendly manner by the health worker?	**Yes / No**
Was the representative content with the health facility visit?	**Yes / No**
If the answer is NO to one of the previous two questions, ask why not? *Describe*	
Any other comments about the experience as representative in the health centre	

Monthly and Quarterly CAG Report

Name of health facility:_____

Year_____

		Jan	Feb	Mar	Quarter 1
A1	**# of new CAGs registered**				0
A2	**# CAGs dissolved**				0
A3	**# cumulative CAGs registered** *(A3 prev month + A1 - A2 present month)*	0	0	0	0
B1	**# of new members in CAGs**				0
B2	**# patients left CAGs (all reasons)**				0
B3	**# cumulative members registered in CAGs** *(B3 previous month + B1 - B2 this month)*	0	0	0	0
B4	**# returned to conventional care** *(B5+B6+B7)*				0
B5	**Total # for medical reasons**				0
B6	**Total # because of TO to other health facility**				
B7	**Total # for other reasons**				0
	OUTCOMES				
C1	**# cumulative alive on ART in CAGs**	0	0	0	0
C2	**# side effects in CAGs**	0	0	0	0
	NVP hypersensitivity				0
	Lipodistrophy				0
	Jaundice				0
	PSN				0
	Lactic Acidosis				0
C3	**# defaulted from ART in CAGs**				0
C4	**# deaths in CAGs**				0

TENTATIVE TIME TABLE FOR THE TRAINING

	8.30 – 8.45	**8.45 – 9.45**	**9.45 – 10.00**	**10.00 – 10.30**	**10.30 – 12.00**	**12.00 – 13.00**	**13.00– 13.45**	**13.45 – 14.30**	**14.30 – 14.45**	**14.45 – 15.00**
HEALTH WORKERS TRAINING	Climate setting and welcome remarks	*CAG formation* -Overview of CAG -CAG formation -Partners role in CAG	**B R E A K**	Function of CAG and organization at community level	Organization at health facility level -Overview of facility register and group cards -Patient flow at health facility -Exercise 3(filling CAG register & facility group card	**B R E A K**	Communication in CAG model of care	Tools used in CAG model of care	Closing remarks	Facilitators meeting
	8.30 – 8.45	**8.45 – 9.45**	**9.45 – 10.00**	**10.00 – 10.50**	**10.50 – 12.00**	**12.00 – 13.00**	**13.00– 13.45**	**13.45 – 14.30**	**14.30 – 14.45**	**14.45 – 15.00**
COMMUNITY HSAs TRAINING	Climate setting and welcome remarks	*CAG formation* -Overview of CAG -CAG formation -Partners role in CAG	**B R E A K**	Function of CAG and organization at community level -Exercise 2 (filling quarterly supervision form for HSAs)	Organization at health facility -Patient flow at health facility	**B R E A K**	Communication in CAG model of care	Tools used in CAG model of care	Closing remarks	Facilitators meeting
	8.30 – 8.45	**8.45 – 9.45**	**9.45 – 10.00**	**10.00 – 11.00**	**11.00 – 12.00**	**12.00 – 13.00**	**13.00– 13.45**	**13.45 – 14.30**	**14.30 – 14.45**	**14.45 – 15.00**
FOCAL PERSONS' TRAINING	Climate setting and welcome remarks	*CAG formation* -Overview of CAG -CAG formation -Partners role in CAG	**B R E A K**	Function of CAG and organization at community level -Exercise 1 (filling community group card)	Organization at health facility -Patient flow at health facility	**B R E A K**	Communication in CAG model of care	Tools used in CAG model of care	Closing remarks	Facilitators meeting

REFERENCES

(1) Schwartlaender B, Stover J, Hallett T, Atun R, Avila C, Gouws E et al. Towards an improved investment approach for an effective response to HIV/AIDS. Lancet 2011.

(2) Assefa Y, Hermann K, Van Damme W. Human resource aspects of antiretroviral treatment delivery models: current practices and recommendations. Current Opinion in HIV & AIDS 2010;10(5):78-82.

(3) WHO, UNAIDS, and UNICEF. Towards Universal Access. Scaling up priority HIV/AIDS interventions in the health sector. Progress Report 2010. Geneva: WHO;UNAIDS;UNICEF; 2010.

(4) Hermann K, Van Damme W, Pariyo G, Schouten E, Assefa Y, Cirera A et al. Community health workers for ART in sub-Saharan Africa: learning from experience - capitalizing on new opportunities. Human Resources for Health 2009;7(31).

(5) Van Olmen J, Ku G, Bermejo R, Kegels G, Hermann K, Van Damme W. The growing caseload of chronic life-long conditions calls for a move towards full selfmanagement in low-income countries. Globalization and Health 2011;7(38).

(6) Kober, K and Van Damme, W. Expert patients and AIDS care. A literature review on expert patient programmes in high-income countries, and an exploration of their relevance for HIV/AIDS care in low-income countries with severe human resource shortages. Antwerp: Institute of Tropical Medicine; 2006.

(7) Farrell K, Wicks M, Martin J. Chronic Disease Self-Management Improved With Enhanced Self-Efficacy. Clinical Nursing Research 2004;13:289-308.

(8) Decroo, T, Telfer, B, Maikere, J, Dezembro, S, das Dores, C, Ford, N, and Biot, M. Community ART groups: distribution of ARVs through self-forming groups in Tete province, Mozambique. 2010.

(9) Decroo T, Telfer B, Biot M, Maikere J, Dezembro S, Chumba L et al. Distribution of Antiretroviral Treatment Through Self-Forming Groups of Patients in Tete Province, Mozambique. J Acquir Immune Defic Syndr 2011;56(2):e39-e44.

(10) Malawi Community Home Based Care Service Providers'manual – October 2010