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

June 2017
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# Abbreviations and Acronyms

<table>
<thead>
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<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>AMC</td>
<td>Average Monthly Consumption</td>
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<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>BP</td>
<td>Blood Pressure</td>
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<tr>
<td>CCLAD</td>
<td>Community Client-Led ART delivery</td>
</tr>
<tr>
<td>CD4</td>
<td>Cluster of Differentiation 4</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control</td>
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<tr>
<td>CDDP</td>
<td>Community-based Drug Distribution Point</td>
</tr>
<tr>
<td>CHEWS</td>
<td>Community Health Extension Workers</td>
</tr>
<tr>
<td>CQI</td>
<td>Continuous Quality Improvement</td>
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<tr>
<td>CSO</td>
<td>Civil Society Organization</td>
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<tr>
<td>CTX</td>
<td>Cotrimoxazole</td>
</tr>
<tr>
<td>DBS</td>
<td>Dried Blood Spot</td>
</tr>
<tr>
<td>DELTA</td>
<td>Delivering Technical Assistance Project (EGPAF)</td>
</tr>
<tr>
<td>DHIS</td>
<td>District Health Information System</td>
</tr>
<tr>
<td>DHO</td>
<td>District Health Officer</td>
</tr>
<tr>
<td>DHT</td>
<td>District Health Team</td>
</tr>
<tr>
<td>DSD</td>
<td>Differentiated Service Delivery</td>
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<tr>
<td>DSDM</td>
<td>Differentiated Service Delivery Model</td>
</tr>
<tr>
<td>EGPAF</td>
<td>Elizabeth Glazer Pediatric AIDS Foundation</td>
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<tr>
<td>EID</td>
<td>Early Infant Diagnosis</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
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<tr>
<td>FSG</td>
<td>Family Support Group</td>
</tr>
<tr>
<td>GFATM</td>
<td>The Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<tr>
<td>H/PE</td>
<td>History and Physical Examination</td>
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<tr>
<td>HB</td>
<td>Hemoglobin</td>
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<tr>
<td>HBHTS</td>
<td>Home Based HIV Testing and Screening</td>
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<tr>
<td>HCW</td>
<td>Health Care Worker</td>
</tr>
<tr>
<td>HEI</td>
<td>HIV-Exposed Infant</td>
</tr>
<tr>
<td>HF</td>
<td>Health Facility</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information Systems</td>
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<tr>
<td>HR</td>
<td>Human Resources</td>
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<tr>
<td>HTC</td>
<td>HIV Testing and Counseling</td>
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<tr>
<td>HTS</td>
<td>HIV Testing Services</td>
</tr>
<tr>
<td>IPD</td>
<td>In-Patient Department</td>
</tr>
<tr>
<td>KP</td>
<td>Key Populations</td>
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<tr>
<td>Lab</td>
<td>Laboratory</td>
</tr>
<tr>
<td>LTFU</td>
<td>Lost To Follow Up</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MARPs</td>
<td>Most At Risk Populations</td>
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<tr>
<td>MCH</td>
<td>Maternal Child Health</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MRS</td>
<td>Medical Records System</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>MTCT</td>
<td>Mother-to-Child Transmission (of HIV)</td>
</tr>
<tr>
<td>MUAC</td>
<td>Mid-Upper Arm Circumference</td>
</tr>
<tr>
<td>NMS</td>
<td>National Medical Stores</td>
</tr>
<tr>
<td>OIs</td>
<td>Opportunistic Infections</td>
</tr>
<tr>
<td>OPD</td>
<td>Out-Patient Department</td>
</tr>
<tr>
<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
</tr>
<tr>
<td>PCR</td>
<td>Polymerase Chain Reaction</td>
</tr>
<tr>
<td>PDSA</td>
<td>Plan-Do-Study Act</td>
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<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<tr>
<td>PITC</td>
<td>Provider-Initiated Testing and Counseling</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission (of HIV)</td>
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<tr>
<td>PNC</td>
<td>Post Natal Care</td>
</tr>
<tr>
<td>PP</td>
<td>Priority Populations</td>
</tr>
<tr>
<td>QI</td>
<td>Quality Improvement</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>SOPs</td>
<td>Standard Operating Procedures</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TASO</td>
<td>The AIDS Support Organization</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency International Development</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
</tr>
<tr>
<td>VL</td>
<td>Viral load</td>
</tr>
<tr>
<td>VMMC</td>
<td>Voluntary Medical Male Circumcision</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>Wt.</td>
<td>Weight</td>
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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 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.

**Community-based HIV treatment and care models:** These are HIV treatment and care models where services are offered outside the existing health facilities.

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

**Differentiated services:** This is an approach where services are tailored to or centered 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 HIV treatment and care models:** These refer to HIV treatment and care models where services are offered within the confines of the health facility.

**Facility Based Individual Management:** This is an approach for both stable and unstable clients desiring peer support. It includes family support groups for pregnant and lactating mothers, adolescent groups etc., regardless of the age and duration on ART.
Fast-track drug pickup: 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 behaviors, 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 center for more than 90 days since their last appointment date.

Missed 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 treatment and care 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 patient: An adult patient receiving ART for at least 12 months, without treatment regimen change for the same period, with a suppressed viral load, good adherence to ARVs of >95%, not pregnant or lactating, on 1st or 2nd line regimen, and with no concurrent illnesses.

Unstable/complex HIV patient: These include: ART naïve patients, PLHIV who have been on ART for less than 12 months, children and adolescents, pregnant and lactating women, PLHIV with a non-suppressed viral load, experiencing treatment failure, on 3rd line regimen, in advanced disease stages (3-4), or with co-morbidities.

¹ PEPFAR Technical Considerations for COP/ROP 2016
Acknowledgements

This guide on the recommended implementation of the strategy for the Differentiated HIV prevention and care Service Delivery models for Uganda has drawn on a highly participatory process that included literature review, consultations and stakeholder engagements led by the Ministry of Health AIDS Control Program (MOH/ACP) with financial support from the Centers for Disease Control & Prevention, through the DELTA project under EGPAF. It is based on innovative work from health facilities in Uganda, Senegal, Kenya and elsewhere, and on models of care pioneered by Médecins Sans Frontières and The AIDS Support Organization (TASO) in Uganda. The Ministry of Health thanks all the stakeholders who participated in the guidelines development. Special gratitude goes to the following individuals who provided technical input:

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**Jinja District Local Government:** Suzan

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------------------------------------------------------------------------

Dr Joshua Musinguzi
PROGRAMM MANAGER, AIDS CONTROL PROGRAM
FOREWORD

This guide presents the details on how the recommended differentiated service delivery (DSD) models for HIV Testing Services (HTS) and treatment and care for Persons Living with HIV (PLHIV) and Tuberculosis (TB) will be implemented in Uganda in a bid to improve efficiency and convenience in delivery of HIV and TB services along the cascade of HIV prevention and care. It will complement the standard of care as described in the Consolidated Guidelines for Prevention and Treatment of HIV in Uganda - 2016 Edition.

The DSDM Implementation Guide focuses on reorganizing the structure of service delivery models already being implemented at the health facility level. It will rely on the existing infrastructure and will not require significant additional resources.

The guide recommends adoption of continuous quality improvement 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 guide is intended for use by planners, managers and health service providers (including health facility In Charges, clinicians, nurses, allied healthcare workers and community-based health services organizations) seeking greater efficiencies in quality HIV healthcare service delivery. It aims to set standards for the implementation of differentiated services in Uganda while ensuring quality 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 differentiated service delivery models in Uganda.

Prof. Anthony K. Mbonye
AG. DIRECTOR GENERAL HEALTH SERVICES
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 also exist across different districts and health facilities and are further affected by a range of geographic, economic, demographic and social factors. It is estimated that only 65% 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 35% requires more innovative and efficient HIV screening and testing approaches, and starting the remaining 35% on ART calls for adoption of innovative and efficient strategies for delivering HIV and TB prevention, care, and treatment services that address the needs of the different sub-populations. 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.

Current health facility based models of care often provide care that has not allowed for adoption or tailoring care approaches to sub-populations but are more individualized. Health facilities which have tried to innovate approaches which can respond to needs of sub-populations still lack guidance on how to standardize their innovations. As a result the country cannot document health outcomes across different health facilities under these site specific differentiated care models. 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 number needing care is anticipated to increase drastically. It is therefore anticipated that the health system will be 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 HIV care and ART services are delivered. This is aimed at identifying, preventing, diagnosing, treating and supporting people in need of HIV and/TB services. This is also sometimes called tiered care, client-centered care or client-tailored care. Differentiated service delivery (DSD) would lead to better outcomes for clients based on meeting individual needs, including improved coverage and quality of services, while using resources effectively and efficiently.

In most cases, these approaches do not require significant policy changes or additional resources, since they are adaptations of what is already being implemented. Some initial investment may be necessary to support professional development and quality improvement, but the intention is not to implement new programs or processes requiring extra resources. In addition, these innovations relate to management of human resources, distribution of roles and responsibilities at health facility and community levels, health facility client flow design, management and commitment, country specific strategies, availability of the required supplies and commodities and availability of the appropriate health information management tools. 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 gives details on how to implement these recommended innovative service delivery approaches.
2 TRANSFORMING ROUTINE CARE DATA INTO INFORMATION FOR DIFFERENTIATED SERVICES

Plans for differentiated services 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 modeling. 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

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.

2.1 THE DIFFERENTIATED SERVICES DELIVERY FACILITY SELF-ASSESSMENT

As part of the national scale up of differentiated services delivery, the Ministry of Health Uganda has embarked on innovative strategies in using data. The MOH is strengthening its support of program assessment based on a differentiated and customized approach. MOH will support initial and regular targeted health facility assessments using tools such as the DSD facility self-assessment tool (DSD FSAT) to harmonize health facility assessments.

The DSD FSAT captures information/data on HIV related programming in the facility based on the health system building blocks, including quality improvement. The objective of this facility self-assessment is to

a. Assist the facility in identifying current strengths and weakness of the 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

This strategy will ensure high-quality differentiated services delivery programs for impact.
3 HOW TO INTRODUCE DIFFERENTIATED SERVICE DELIVERY MODELS IN YOUR FACILITY

In Uganda, it is policy that all facilities providing ART should implement DSDM. Health facility and community buy-in is recommended.

Health care workers and other service providers in direct contact with clients need to be familiar with the differentiated services delivery models 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 following stepwise approach to be followed in your facility to introduce differentiated models of service delivery. This approach will facilitate effective implementation and coordination of DSDM.

Table 1. Stepwise approach to introduce differentiated models of service delivery

<table>
<thead>
<tr>
<th>Step 1: Establish a committee to coordinate DSDM activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Strengthen an existing committee to undertake DSDM activities. At a minimum they should include;</td>
</tr>
<tr>
<td>• ART In Charge</td>
</tr>
<tr>
<td>• HTS Focal Person</td>
</tr>
<tr>
<td>• HMIS/Data Clerk</td>
</tr>
<tr>
<td>• Logistics Focal Person</td>
</tr>
<tr>
<td>• QI Focal Person</td>
</tr>
<tr>
<td>• PMTCT/EID Focal Person</td>
</tr>
<tr>
<td>• Community Representative (Health Assistant, CDO, VHTs, CHEWs)</td>
</tr>
<tr>
<td>• TB Focal Person</td>
</tr>
<tr>
<td>• Laboratory Focal Person</td>
</tr>
</tbody>
</table>

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 enrollment into the appropriate models and approaches (Refer to Treatment and Care section)
   • Implementation of DSDM in the facility and community (Refer to HTS and Treatment and Care 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 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 Treatment and Care 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. **Treatment and Care**: All PLHIV are eligible for differentiated treatment and care. 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

<table>
<thead>
<tr>
<th>Step 3B: HIV Testing Services:</th>
<th>All communities are eligible for HTS. However, the HTS model depends on the population vulnerability and their unique needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Review data on the current HTS approaches and identify opportunities to adapt:</td>
<td></td>
</tr>
<tr>
<td>o Determine the testing efficiency of each approach. <em>Testing efficiency is the number of confirmed cases divided by the total number of people tested for each approach</em></td>
<td></td>
</tr>
<tr>
<td>o Determine the cost of the different testing options. <em>These are the resources per costs dedicated for each approach</em></td>
<td></td>
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<tr>
<td>o Establish how the facility can improve the testing and cost-efficiency</td>
<td></td>
</tr>
<tr>
<td>o Establish how the facility can improve the site’s mix of testing approaches. <em>The best combination of in-facility and community approaches</em></td>
<td></td>
</tr>
<tr>
<td>a. Facility-based models</td>
<td></td>
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<tr>
<td>• PITC</td>
<td></td>
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<tr>
<td>• VCT</td>
<td></td>
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<tr>
<td>• Index HIV/TB Client Contact Tracing</td>
<td></td>
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<tr>
<td>b. Community-based models</td>
<td></td>
</tr>
<tr>
<td>• Home based HTC</td>
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<tr>
<td>• Index Client Testing</td>
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<tr>
<td>• Outreaches/mobile testing</td>
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<tr>
<td>• HIV Self Testing</td>
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<tr>
<td>• Work place HTC</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 4: Assess resource needs</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Treatment and Care</td>
<td>Resource needs for differentiated treatment approaches require mainly some re-allocation of resources minimal upfront investment in training and/or additional materials, including:</td>
</tr>
<tr>
<td>• 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. <em>(Refer to the communication plan)</em></td>
<td></td>
</tr>
<tr>
<td>• 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</td>
<td></td>
</tr>
<tr>
<td>• Human resources: Numbers and training needs/skills e.g. conducting group counseling sessions and targeted health talks <em>(Refer to Annex: Human Resources)</em></td>
<td></td>
</tr>
<tr>
<td>• 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</td>
<td></td>
</tr>
<tr>
<td>• Logistics and supplies: ARVs <em>(Refer to Logistics section)</em>, anti-TB medicines and drugs for OIs</td>
<td></td>
</tr>
<tr>
<td>• Transport to outreaches: Bicycles, motorcycles, vehicles, safari day allowances and per diem for outreaches to KPs or hard-to-reach areas, etc.</td>
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</tr>
</tbody>
</table>
- 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 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 Treatment and Care 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.

1. **Differentiated Care for HIV: A Decision Framework Work for Antiretroviral Therapy Delivery**
2. **The Global Fund Toolkit for Health Facilities: Differentiated Care for HIV and Tuberculosis**
3. **Differentiated Service Delivery Facility Self-Assessment Tool**
4. **Orientation Package for Group Leaders for Community Client-Led ART Distribution**
4 THE CORE PRINCIPLES AND BUILDING BLOCKS OF DIFFERENTIATED CARE

4.1 THE CORE PRINCIPLES

4.1.1 Client-centered 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.
- Improve the quality of HIV care services.

4.1.2 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 and respond to sub – population needs.
- Differentiated care 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.

4.2 THE BUILDING BLOCKS

The building blocks of differentiated ART delivery 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 1).

In all models of ART delivery, the client is at the centre. It is up to the Ministry of Health and District Health Team to work with health care workers and clients to determine which of the when, where, who and what blocks to include in the differentiated models of care 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

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

2. **The Global Fund Toolkit for Health Facilities: Differentiated Care for HIV and Tuberculosis**

3. **The WHO Fact Sheet. What is New in Service Delivery**
5 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 sub-population (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 Treatment and Care using the building blocks described in the next chapter. The elements are presented in figure 3.

Figure 3. The three elements

1. DIFFERENTIATED CARE FOR HIV: A DECISION FRAMEWORK FOR ANTIRETROVIRAL THERAPY DELIVERY
5.1 HOW DO WE DIFFERENTIATE BASED ON CLINICAL CHARACTERISTICS?

Based on clinical characteristics, clients can be defined as stable or unstable/complex (Table 6). A differentiated care approach provides care that is responsive to the needs of the stable or unstable PLHIV.

5.2 HOW DO WE DIFFERENTIATE BASED ON THE SUB-PopULATION?

Services should be differentiated based not only on clinical characteristics, but also by considering the challenges of sub-populations (Figure 3), including:

- 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.

Each sub population will require a unique and comprehensive package of health care services to overcome particular challenges (Tables 8 to 13).

5.3 HOW DO WE DIFFERENTIATE BASED ON CONTEXT?

In order to maintain quality ART delivery in specific challenging settings (e.g., conflict, urban/rural, high migration, low prevalence), modifications to how ART and HTS are delivered are required.

In addition to the consideration of contextual stability, the prevalence of HIV in a given setting will also impact on the specific challenges faced by clients and the appropriateness or extent of certain specific interventions.

1. DIFFERENTIATED CARE FOR HIV: A DECISION FRAMEWORK FOR ANTIRETROVIRAL THERAPY DELIVERY
6 DIFFERENTIATED HIV TESTING SERVICES

Of an estimated 1.5 million people living with HIV in Uganda, approximately 1.13 million (75%) have been diagnosed, and 1,081,206 are on treatment. With progressively fewer individuals remaining undiagnosed, the HTC yield has been declining over the past three years. The current yield is between 3% and 3.5%. More focused approaches are still needed for direct services to geographic areas and subpopulations considered at elevated risk of HIV infection. The national focus is on identification and enrollment in treatment of those remaining undiagnosed.

The National HIV Testing Services Policy and Implementation Guidelines (2016) have been revised with a goal of enhancing targeted testing and quality of services in line with the WHO guidance. Uganda will discontinue low-yield HTS activities and concentrate on high-yield activities. HTS will emphasize on the principles of the “5 Cs” - Consent, Confidentiality, Counseling, Correct test results and Connection (linkage) to care.

This module aims to help health facility managers, facility in-charges, HCWs, community-based health service providers and other stakeholders to identify how to improve efficiency and reduce costs of existing HIV prevention and screening approaches. It will also inform discussion of how to prioritize areas or population segments for out-of-facility/community testing.

6.1 WHAT ARE DIFFERENTIATED HIV TESTING SERVICES?

These are HIV testing service-delivery models and approaches that are adapted to address specific barriers/bottlenecks of a sub-group of individuals to enable them know their HIV status.

6.2 WHY 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:

- Focusing attention on those in need, based on available data
- Ensuring that service delivery addresses the needs and preferences of people in need of HTS (e.g. targeting the most at-risk and vulnerable subgroups), and the constraints of services providers
- Enhancing HTS integration with other health services
- Decentralizing HTS to primary healthcare facilities and in the community
- Encouraging and supporting task-shifting
- Ensuring improved linkage to treatment and prevention services

Optimizing the use of resources at the health facility level should aim to increase the number of confirmed cases found and/or decrease the cost of testing.

It is important to recognize that there may be higher costs for offering HIV testing services using models and approaches that reach the underserved groups (e.g. displaced persons) who may have greater barriers to access. Costs will also vary depending on which diagnostic tools are routinely available in any given setting, both for HIV testing and for TB screening and testing.
6.3 WHAT ARE THE RECOMMENDED MODELS?

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 service delivery models and target populations
6.4 DIFFERENTIATED HTS MODELS

6.4.1 Facility-based HTS

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

- Provider-initiated testing and counseling (PITC)
- Index Client HIV and TB Contact Tracing
- Client-initiated counseling and testing (VCT)

6.4.1.1 Provider-initiated testing and counseling (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:

I. 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, TB, STI, ANC, PNC, nutrition rehabilitation units and all in patient wards. At low yield service points like 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.

II. Diagnostic HTS:

Here HTS is offered in a targeted manner mainly for diagnostic purposes.

III. Index Client HIV and TB Contact Tracing

In this approach, the index client is used to help identify subsequent clients for testing. Index client tracing is done through;

- Partner Notification Services (PNS)

This is a strategy where index patients (i.e., infected persons) are interviewed to elicit information about their sexual partners, who can then be confidentially notified of their possible exposure or potential risk to HIV infection. Index patients should be encouraged to notify past partners (in addition to current partners), and encourage them to test for HIV. Clients should also be interviewed to elicit information about contacts with (in order to initiate treatment) or at risk for TB (in order to initiate preventive therapy).

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

- 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 on specific designated days. This involves deliberate planning for logistics and human resources to meet the big numbers of clients that turn up.

6.4.1.2 Client-initiated HTS (VCT)

This is where HIV testing is provided to clients who voluntarily request for the service to 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\(^2\)).

**Table 2. Population groups to be accessed through facility-based HTS approaches**

<table>
<thead>
<tr>
<th>WHO</th>
<th>WHEN</th>
<th>WHERE</th>
<th>WHAT</th>
<th>WHY? (Unique characteristics)</th>
</tr>
</thead>
</table>
| Patients with active TB    | • At the time of diagnosis  
• At 4 weeks after initial testing (for those with initial HIV negative result)  
• During contact tracing  
• During sputum re-checks  
• During TB treatment refills | • TB clinic  
• TB ward | • Routine HIV testing for HIV clients  
• Diagnostic HTS  
• Re-test HIV as per HTS guidelines | • Very likely to have HIV co-infection |
| Patients with presumptive TB | • During TB screening  
• During sputum-collection campaigns | • All departments especially:  
  o MCH clinic  
  o YCC  
  o OPD | • Routine HIV screening | • Very likely to have HIV infection |
| Pregnant and breastfeeding women and their partners | • 1st trimester/1st ANC visit  
• 3rd trimester/during labor and delivery  
• Every 3 months until 3 months after cessation of breastfeeding | • ANC, L&D, PNC  
• FP clinics  
• YCC  
• Mother baby care points | • Routine HIV screening | • These are sexually active and HTS will inform eMTCT interventions |
| HIV exposed Infants and children below 18 months | • At 6 weeks or at the earliest opportunity thereafter  
• 6 weeks after cessation of breastfeeding | • Mother Baby Care Point  
• OPD  
• IPD  
• Immunization  
• YCC  
• PNC | • Routine early infant diagnosis through virological DNA/PCR | • High risk of morbidity and mortality if not diagnosed and initiated on ART early  
• Likely to be severely ill and HIV infection could be the underlying cause of disease severity  
• Likely to have delayed development milestones |

<table>
<thead>
<tr>
<th>WHO</th>
<th>WHEN</th>
<th>WHERE</th>
<th>WHAT</th>
<th>WHY? (Unique characteristics)</th>
</tr>
</thead>
</table>
| Children 18 months to   | When they meet the criteria as per the pediatric and adolescent HIV test screening tool:  
| below 10 years          | • Child is OVC  
|                         | • If mother is HIV positive  
|                         | • If child is symptomatic  
|                         | • If child is malnourished  
|                         | • If child has history of hospitalization in the last 6 months  
|                         | • If child is diagnosed with TB (presumptive or confirmed) or if the child has history of TB treatment  
|                         | • If child has history of sexual abuse  
|                         | • If child has a history of accidental exposure  
|                         | • Inpatient department  
|                         | • Outpatient department  
|                         | • Young Child Clinics  
|                         | • TB Clinics  
|                         | • HIV care and Treatment Clinics  
|                         | • Nutrition Clinics  
|                         | • OVC Programs  
|                         | • PITC  
|                         | • KYCS (including holiday campaigns)  
|                         | • Index client tracing and testing  
|                         | To identify HIV infected children who were missed by the EID program  
| Adozenets (10-19 years) | • When they meet the criteria as per guidance in the pediatric and adolescent screening tool  
| in and out of school    | • During VMMC  
|                         | • IPD  
|                         | • OPD  
|                         | • Adolescent friendly clinics/corners  
|                         | • ANC  
|                         | • FP clinics  
|                         | • STI clinics  
|                         | • OVC Programs  
|                         | • Youth centers  
|                         | • Institutions of higher learning (if located within the health facility e.g. training schools)  
|                         | • PITC  
|                         | • Index client tracing and testing  
|                         | • KYCS (including holiday campaigns)  
|                         | • Special facility campaigns  
|                         | • 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 behavior  
|                         | • May be sexually active and/or abusing drugs  
|                         | • Inadequate adolescent friendly services in facilities  
| Youth (20 – 24 years)   | • During VMMC  
|                         | • When they meet the criteria as per the adult screening tool  
|                         | • IPD  
|                         | • OPD  
|                         | • ANC  
|                         | • FP clinics  
|                         | • STI clinics  
|                         | • Youth centers  
|                         | • Institutions of higher learning (if located within the health facility e.g. training schools)  
|                         | • PITC  
|                         | • Index client tracing and testing  
|                         | • Special facility campaigns  
|                         | • Special/flexible hours, walk-ins or same-day appointments  
|                         | • Have a low risk perception  
|                         | • They have a need to experiment with sex and therefore engage in high risk sexual behavior  

<table>
<thead>
<tr>
<th>WHO</th>
<th>WHEN</th>
<th>WHERE</th>
<th>WHAT</th>
<th>WHY? (Unique characteristics)</th>
</tr>
</thead>
</table>
| Men                 | • During VMMC  
• Routine care when they accompany their wives for ANC, L&D and PNC  
• When they meet the criteria as per the adult screening tool | • MNCH clinics  
• STI/MARPs clinics  
• In non-communicable diseases’ clinics (DM, HT)  
• IPD (male ward)  
• OPD  
• Reproductive health clinics | • VCT  
• PITC  
• Index client contact tracing  
  o Partner notification  
• Self-testing** | • Poor seeking health behavior  
• Least likely to access HTS under routine health care due to fear, stigma, perception that health services are for females |
| Adults              | • When they meet the criteria as per the adult screening tool | • IPD  
• OPD  
• Non-communicable diseases clinics (DM, HT, cancer)  
• Rehabilitation units | • PITC  
• VCT | • If seeking care in HFs, are likely to be very sick and HIV could be the underlying infection |
| PWDs                | • Routine care  
• When there is history of sexual abuse | • Rehabilitation units  
• Physiotherapy clinics  
• IPD  
• OPD  
• Orthopedic  
• Occupational therapy units | • PITC  
• VCT | • May not easily negotiate for safe sex, and often are sexually violated  
• May have low literacy rates  
• HTS may be physically inaccessible |
| Health workers*     | • Routine care  
• When there is history of high risk exposure | • Staff clinics  
• Work places | • PITC  
• VCT  
• PEP  
• HIV Self testing** | • Likely to face self-stigma and may not access HTS easily  
• Occupational exposure/hazard at the workplace puts them at a higher risk |
| Couples and sexual partners | • During routine care  
• During discordant couples’ meetings | • MNCH clinics  
• Couple meetings  
• HIV care and treatment clinics  
• STI and FP clinics  
• IPD  
• OPD | • Index client contact tracing and Partner Notification  
• VCT  
• Couple and Partner HTS | • Have high incidence of HIV infection  
• May be in discordant relationships, distant relationships and/or have multiple sexual partners |
| Inpatients          | • Routine patient care services | • IPD | • PITC | • Likely to have underlying HIV infection |

*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
6.4.2 Out-of-facility/Community-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

6.4.2.1 Home-Based HTS (HBHTS):

This is where the HCW (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

i. **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 providers should capture family members’ details, and ensure untested 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:

- o **HIV and TB Contact tracing and assisted Partner notification (Partner services).** Refer to section 5.4.1.2
- o **Know Your Child Status approach:** Refer to section 5.4.1.2
- o **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).

ii. **HIV self-testing (HIVST)**

In this approach, 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. Currently, self-testing is still under pilot studies and has not yet been included among the service delivery approaches for HIV testing in Uganda

6.4.2.2 Outreach/Mobile HTS

This approach should target priority/key populations that otherwise have limited access to HTS. These may include:

- o **Targeted stand-alone HTS:** This can be conducted to reach out to specific under-served populations either because of geographical inaccessibility, high HIV prevalence rates or low uptake of HTS. The testing may be conducted in places where high-risk people are found thus also called ‘venue based HTS’ e.g. in landing sites targeting fishermen and brothels targeting sex workers, moonlight services; index
client contact testing in the community or in the index client’s home through home-based HIV testing or at workplaces.

- **Integrated out-of-facility HTS**: HTS is offered together with the primary health service the outreach is intended to extend to the under-served community/population. HTS can be integrated in outreaches for TB screening, primary health services (immunization, child days plus and others), VMMC and STD screening and management, mobile health/MCH clinics and family health days. This is likely to increase access and uptake of HIV testing services to people with difficulty in accessing HTS at health facilities at a marginal cost

- **Work place HTS**: This is where HTS is offered to people at their places of work to target both formal and informal. This population may have limited access to clinical services due to their work schedules that do not allow them to leave their workplaces in search for health care.

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

**Table 3. Population groups to be accessed through out-of-facility/community-based HTS approaches**

<table>
<thead>
<tr>
<th>WHO? (Population)</th>
<th>WHEN</th>
<th>WHERE</th>
<th>WHAT</th>
<th>WHY? (Unique characteristics)</th>
</tr>
</thead>
</table>
| Household members of index clients with TB and/or HIV | • During sputum-collection campaigns  
• During contact tracing | • At home  
• Community-based stand-alone-testing points  
• In establishments  
• In high prevalence areas | • Index client contact testing  
• Targeted mobile outreaches | There may be at-risk individuals (e.g. sexual partner, partners in discordant relation, children of the index client) in that household who may not know their HIV status and are unlikely to attend the health facility |
| OVCs, adolescent girls, and young women | • During OVC-HTS integrated outreach camps  
• During integrated immunization outreaches | • Home visits to OVC-headed household families  
• Homes  
• In communities  
• Churches | • Index client contact testing  
• Outreaches | Have difficulty in accessing HIV services due to limited socio-economic capacity |
| Infants and children | • During integrated immunization outreaches  
• During scheduled home visits  
• During contact tracing | • At home  
• Community | • EID through virological DNA/PCR  
• Index client contact tracing  
• Integrated Immunization outreach campaigns | • High risk of morbidity and mortality if not diagnosed early and initiated on ART.  
• To identify HIV infected children who were missed by the EID program |
| Lactating women | • During integrated immunization outreaches | • Communities | • Outreaches | • Women and their partners are sexually active  
• HTS will inform PMTCT interventions |
<table>
<thead>
<tr>
<th>WHO? (Population)</th>
<th>WHEN</th>
<th>WHERE</th>
<th>WHAT</th>
<th>WHY? (Unique characteristics)</th>
</tr>
</thead>
</table>
| People with restricted access to treatment (minorities, PWDs, elites) | • During integrated HTS outreaches  
• During index contact tracing  
• When there is history of sexual abuse | • Community-based stand-alone testing points.  
• In establishments  
• Underserved areas  
• Homes  
• Workplace | • Index contact tracing  
• Outreaches to workplaces (camps)  
• Stand-alone HTS  
• Door-to-door outreach services in high prevalence geographical areas | • Limited access due to lack of confidentiality and privacy  
• Sometimes criminalized  
• Often stigmatized due to their status  
• Poor health seeking behavior (elites)  
• May not easily negotiate for safe sex, and often are sexually violated  
• May have low literacy rates  
• HTS may be physically inaccessible |
| Rural communities | • During mother and child health outreaches  
• During VMMC  
• During events e.g. football matches | • Community-based stand-alone testing points.  
• In establishments  
• In underserved areas  
• Homes  
• In high prevalence geographical areas | • Mobile testing  
• Index contact tracing  
• Door-to-door outreach services  
• Targeted integrated outreach services | • Limited access to HTS and other health care services |
| Men | • During VMMC  
• During sports events  
• During index client contact tracing  
• When they meet the criteria as per the adult screening tool | • Community based stand-alone testing points  
• At home  
• Work places – offices, boda boda stages, betting halls, brothels etc.  
• Recreation places (sports venues, saunas, bars etc.) | • Index client contact tracing  
• HIV self-testing  
• Targeted HTS integrated within outreach services  
• Targeted mobile outreaches  

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 |
<table>
<thead>
<tr>
<th>WHO? (Population Category)</th>
<th>WHEN</th>
<th>WHERE</th>
<th>WHAT</th>
<th>WHY? (Unique characteristics)</th>
</tr>
</thead>
</table>
| MSM                       | • Routinely as part of healthcare  
  • Every 3 month i.e. re-testing for the HIV negatives | • High prevalent areas  
  • Safe places  
  • At health facilities  
  • Hot spots  
  • Drop-in centres  
  • Friendly clinics  
  • Organized network meetings  
  • Community-based stand-alone testing points  
  • Moonlight clinics  
  • Mobile clinics  
  • Specialized clinics | • HIV self-testing  
  • Outreachs  
  • Targeted  
  • Stand-alone  
  • Snow ball approach  
  • PITC  
  • VCT | • Unlikely to seek health services because of the unfavorable legal environment because they are not recognized |
| Sex workers and their clients | • Routinely as part of healthcare  
  • Every 3 month i.e. re-testing for the HIV negatives | • Hot spots  
  • Brothels  
  • Drop-in centres  
  • Specialized clinics | • HIV and TB Index client contact tracing  
  • HTS outreaches  
  • Moonlight services  
  • Snow ball approach  
  • PITC  
  • VCT | • Highly mobile  
  • Are stigmatized  
  • Drivers of the epidemic |
| People who inject Drugs (PWID) and transgender (TG) people | • Routinely as part of healthcare  
  • Every 3 month i.e. re-testing for the HIV negatives | • Specialized clinics  
  • e.g. MARPI  
  • STI clinics | • Snowball approach  
  • PITC  
  • VCT  
  • Index client contact tracing | • Are stigmatized  
  • Because of their high risky behavior |
| Fisher Folk | • Routinely as part of healthcare  
  • Every 3 month i.e. re-testing for the HIV negatives | • Landing sites  
  • Brothels | • Targeted community outreaches  
  • PITC  
  • VCT  
  • Index client contact tracing | • Because of their high risky behavior  
  • Their lifestyles keep them in water for long hours  
  • Migratory nature |
| Long distance track drivers | • Routinely as part of healthcare  
  • Every 3 month i.e. re-testing for the HIV negatives | • Hot spots – along major highways  
  • Drop-in centres  
  • Specialized clinics | • HIV and TB Index client contact tracing  
  • HTS outreaches  
  • Moonlight services  
  • Snow ball approach  
  • PITC  
  • VCT | • Highly mobile  
  • Drivers of the epidemic |
| Sexual gender based violence (SGBV) survivors | • Routinely as part of healthcare  
  • At first contact, then 1 month, 3 months and 6 months after completing PEP course | • Facilities | • PITC  
  • VCT | • Have history of sexual abuse  
  • SGBV has the potential to increase the risk of acquiring HIV |
| Uniformed personnel: Armed forces, | • Routinely as part of healthcare  
  • Every 3 month i.e. re-testing for the | • Institution health facilities e.g. Military barracks etc. | • Targeted HTS campaigns/testing events  
  • PITC at their health facilities  
  • Workplace testing | • Migratory nature  
  • Because of their high risky behavior |
### 6.5 What is the Testing Efficiency and Cost of the Different Testing Approaches?

Implementers should establish which HTS approaches to prioritize by doing the following:

- **a.** List all the HIV testing approaches (facility-based and/or out-of-facility/community-based) conducted in a year.
- **b.** Calculate the
  - i. Number of people being tested and the number of confirmed cases (testing efficiency) for each approach

  \[
  \text{No. of confirmed cases} = \frac{\text{Number of people tested}}{\text{Total number of people tested}}
  \]

  **NOTE:** This ratio can be compared to the prevalence of people not knowing their status in the health facility’s catchment area. The testing efficiency can be increased by focusing HIV testing on specific groups

- **ii.** Cost of each approach, (including human resources, testing supplies and equipment, and other expenses such as travel costs). This gives the cost efficiency

  \[
  \text{Resources used} = \frac{\text{Total number of positives found}}{\text{Resources used}}
  \]
For each approach, compare the results of the two ratios (i.e. testing efficiency and cost efficiency). This, in combination with the data collected on client needs and preferences, and information about the locations and populations most in need will support decision-making on the most suitable approach to be planned and implemented by the facility (and community).

Figure 5. Calculation of testing efficiency and costs of a testing approach

### 6.6 HOW CAN A FACILITY IMPROVE THE YIELD?

Facilities should use the following three approaches to increase yield:

1. **Integration** – offering HTS together with other care services (e.g. primary care, antenatal care, immunization).
2. **Focusing on specific population groups at an increased risk of having HIV** – This increases the yield from HTS.
3. **Geographical targeting of people most at risk** – This helps in reaching out to under-served populations or at increased risk of having HIV where as they cannot easily access HTS. Very useful for reaching out to people in 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 TB treatment and prevention.

### 6.7 MONITORING IMPLEMENTATION OF DIFFERENTIATED DSD MODELS

Health facilities will need to collect data on baseline values (before implementation of differentiated approaches) so that they can compare them with the actual values when the approach has been used for a defined amount of time. The difference between the two sets of values will help with assessing the effects of differentiated HTS delivery.

Three types of indicators that will be needed for monitoring testing and screening include the following:

#### 6.7.1 Indicators at the health facility and community levels

Simple ratios, such as:

- Determining the testing efforts. This is got by disaggregating the numbers tested by testing approach
- Testing efficiency. This is the number testing positive from each testing approach (yield)
6.7.2 Indicators at national, regional, and district levels

- Cost-effectiveness
  - Unit cost per person tested per approach: *This is the* total cost of the testing over the total number of clients tested in a given approach
- Testing efficiency. This is the proportion of the total number testing positive from each of the testing approaches (yield). It is the contribution of differentiation of HTS to the first 90%

6.8 Quality Assurance for HIV Testing Services

Routine internal and external quality assurance and quality control for HIV testing should be performed and documented at all HTS sites and settings.

All sites that provide HTS should have standard operating procedures that provide detailed instructions on all aspects of the testing including test requesting, environmental requirements, test performance, a stepwise process for conducting the test, quality control instructions, test interpretation, reporting and recording results, appropriate use of the testing algorithm, storage, inventory information and any internal and external quality assurance requirements.

Quality assurance for HTS is important, especially in the community where it is likely to be done by less skilled cadres such as counselors or expert clients, is paramount. 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.

6.9 Linkage to Care

Incorporation of linkage to HIV treatment and care into the differentiated HIV testing and screening models is key to achieving enrollment in care. This enhances the testing models and reduces the number of confirmed cases that are lost along the way. Individuals who test HIV negative should also be referred to appropriate HIV prevention services, including VMMC, 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 enrollment of all HIV infected referred individuals. For all linkages, verification must be made to ensure that clients have received the services. (Refer linkage section in the HTS Policy Guidelines 2016)

3. 2016 Consolidated Guidelines for Prevention and Treatment of HIV in Uganda
4. National Laboratory QA/QC Guidelines
7 DIFFERENTIATED HIV TREATMENT AND CARE

Achieving the second ‘90’ of the UNAIDS goal of having 90% of all HIV-positive individuals on treatment requires innovative approaches to HIV treatment and care services. This module aims to explain to the health care workers the different HIV treatment and care approaches that can accelerate the achievement of this target.

7.1 WHAT IS DIFFERENTIATED HIV TREATMENT AND CARE?

Differentiated HIV treatment and care 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 treatment and care services for improved access, coverage, and quality of care.

7.2 WHY DIFFERENTIATED HIV TREATMENT AND CARE?

Approximately 70% of patients in Uganda are considered stable\(^3\) on treatment. Differentiated HIV treatment and care approaches will improve the quality of services offered to these clients and will maximize efficiency and cost effectiveness of the country ART program. Differentiating HIV treatment and care will result in reduced clinic visits for stable clients leading to decreased systems and client challenges. Some benefits are listed in the table below:

<table>
<thead>
<tr>
<th>System focus</th>
<th>Benefit</th>
</tr>
</thead>
</table>
| **Client-focused benefits** | • Reduced number of visits leading to reduced costs  
• Empowerment and involvement/rights – clients will manage their care  
• Reduced waiting time leading to client satisfaction  
• Increased access and adherence (for community delivery)  
• Increased/improved linkage to supportive services (e.g. GBV, nutrition support, psychosocial support - FSGs)  
• Promotes GIPA (greater involvement of people living with HIV) e.g. expert clients |
| **Human Resource** | • Anticipated to improve health workers’ attitudes through training, reduced workload through task-shifting/sharing hence spreading the burden to many health workers.  
• Targets skill to those that are in more need |
| **Governance/leadership** | • There will be an opportunity to engage leadership at the district and health facility levels, hence building capacity  
• Empowerment |
| **Service Delivery** | • Increased numbers of clients on treatment  
• Improved quality of services  
• Facilitate the 90-90-90 target |
| **Medicines/logistics systems** | |

\(^3\) Stable clients include adults and adolescents on ART for more than 12 months, virally suppressed with no concurrent illness or co-morbidity and demonstrated good adherence. Complex/unstable clients include children, pregnant women, non-virally suppressed adults, clients with co-morbidities.
• Delivery of drugs to individual patients at facilities/community
• Longer drug refills

**Financial management**
• Improved efficiency
• Improved fund allocation

**HMIS**
• Less data for a clinic per day/encounter
• Improved quality of data

The above listed benefits will result in improved client retention in care and treatment outcomes.

### 7.4 **What Are the Recommended Models?**

The recommended ways of differentiating HIV treatment and care include 1) facility-based models and 2) community-based models, summarized in the figure below.
Figure 6. Recommended differentiated treatment and care service delivery models and their respective target populations

**Facility**
- Flexible hours (early, late, or weekend)
- Clinic days for specific populations (e.g., children, adolescents, TB/HIV)

**Complex/unstable clients**

**Facility Based Individual Management (FBIM)**
- For clients needing extra attention
  - Examples: Newly initiating ART, sick clients needing multidisease management, viral non-suppression from FTR, CCLAD, CDDP

**Facility Based Group (FBG)**
- For complex or stable clients desiring peer support. Both complex and stable clients are eligible. Frequency of refills and level of evaluation depends on client stability.
  - Examples: Family support groups (FSGs), adolescent groups

**Stable Clients**

**Fast Track Drug Refill (FTR)**
- Pick-up from dispensing points or pharmacy after going via the triage desk

**Community Client Led ART Delivery (CCLADs)**
- Clients form groups within their communities and rotate drug pick-up from the facility or CDDP

**Community Drug Distribution Points (CDDPs)**
- Clients pick up drugs and receive their clinical evaluation when due, from a community outreach point

**Out-of-facility/Community**

**Longer appointment spacing and multi-month prescriptions apply to stable clients in all models, including those in the FBGs**
7.5 **DIFFERENTIATED FACILITY-BASED HIV TREATMENT AND CARE MODELS**

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

7.6 **WHY FACILITY-BASED HIV TREATMENT AND CARE MODELS**

Facility-based model has been the cornerstone of HIV treatment and care. Majority of PLHIV are tested and initiated on care within the health facilities. Health facilities offer an opportunity for testing clients that attend for other co-morbidities to also start on treatment. They also serve as a referral points for community services.

7.7 **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 6. The differentiated client categories and their characteristics*

<table>
<thead>
<tr>
<th>Stable Clients</th>
<th>Unstable/Complex Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>• PLHIV (Children, Adolescents, Pregnant and lactating women and adults) on current ART regimen for more than 12 months</td>
<td>• PLHIV (Children, Adolescents, Pregnant and lactating women and adults) on current ART regimen for less than 12 Months</td>
</tr>
<tr>
<td>• Virally suppressed: 1 virally suppressed test result within 12 months</td>
<td>• Not virally suppressed</td>
</tr>
<tr>
<td>• No opportunistic infections (WHO stages 1,2)</td>
<td>• Has current or history of stage 3 or 4 opportunistic infections (WHO stages 3 or 4) within the past one year</td>
</tr>
<tr>
<td>• TB clients who have completed 2 months intensive phase treatment and are sputum negative</td>
<td>• TB clients in intensive phase of treatment (&lt; 2 months) or who are still sputum positive after intensive phase treatment</td>
</tr>
<tr>
<td>• On 1st or 2nd line ART regimens</td>
<td>• MDRTB/HIV co-infected clients</td>
</tr>
<tr>
<td>• Demonstrated good adherence (over 95%) in the last 6 consecutive months</td>
<td>• On 3rd line treatment</td>
</tr>
<tr>
<td></td>
<td>• Poor adherence (less than 95%)</td>
</tr>
</tbody>
</table>

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

**NOTE:**

1. Stable clients must meet all stable criteria
2. Clients with co-morbidities should be differentiated into facility-based approaches
3. Children, adolescents, pregnant and lactating 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.
7.8 WHAT ARE THE APPROACHES?

7.8.1 Facility-based approaches

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

Figure 7. Summary of the facility-based approaches

- **Facility Based Individual Management (FBIM)**
  - For clients needing extra attention e.g. newly initiating ART, sick clients needing multi-disease management, viral non-suppression from FTR, CCLAD, CDDP

- **Fast track drug refills**
  - For stable clients: these pick-up drugs from the dispensing points or pharmacy after going through the triage point

- **Facility Based Groups**
  - For complex or stable clients
  - Frequency of refills and level of evaluation depends on client stability
  - e.g. FSGs, children, adolescent groups

7.8.1.1 **Facility Based Individual Management (FBIM)**

This is also referred to as Comprehensive Clinical Evaluation. 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 once in every six months.

a. **Categorization and Entry into Facility Based Individual Management (FBIM)**

- Health worker uses the patient categorization checklist (Table 6) to identify unstable patients prior to or during their routine clinic visit
• Unstable client is sensitized about why he/she is categorized as ‘unstable’ and hence the need for individual management on a monthly basis
• Clients who decline other approaches and prefer getting monthly ART refills are also differentiated into FBIM

b. Before Day of Appointment:
• The health worker/Lay provider reviews the Appointment Book to identify clients who are expected to pick their ART refills on the following day
• Files for expected clients are retrieved and temporarily stored in a designated place in preparation for the appointment visit

c. 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 9

d. 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 14) for immediate follow-up

NOTE: All stable clients will also undertake a clinical evaluation once in every six months. The health workers should pre-pack each of the clients’ ART drugs (3 months) prior to their appointments for ease of dispensing on the clinic day

7.8.1.2 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 passes 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.

The fast track drug refill approach is outlined below.

a. Categorization and Entry into Fast Track Drug Refill (FTDR)
• Health worker uses the patient categorization checklist (Table 6) 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 8)
• Client receives a 3 months ART drug refill and is booked for an FTDR appointment in the appointment book
b. Before Day of Refill Appointment:

- The health worker/Lay provider reviews the Appointment Book to identify clients who are expected to pick their ART refills on the following day.
- Files for expected clients are retrieved and temporarily stored in a designated place in preparation for the appointment visit.
- The ART and other medicines (CPT, family planning, etc.) are pre-packed by the pharmacy staff and clearly labeled with the patient’s name and ART number.

c. On Day of ART Refill 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.
- Clients who have any “danger signs” are referred to the clinician for further evaluation.
- Clients who have no “danger signs” have their next appointment date recorded in the files 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 3 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 book 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 14) for immediate follow-up.

d. Day of Comprehensive Clinical Evaluation Appointment:

- Every six months, the client comes for a comprehensive clinical evaluation and follows the standard client flow (Figure 10) and receives the service package of care (Table 8).
- Re-categorization as a stable patient is confirmed.

7.8.1.3 Facility Based Groups (FBGs)

This approach is applicable for both stable and unstable clients desiring peer support. 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 15-30 clients. Large volume facilities can have 2-3 groups. They meet on a regular basis e.g. once every two to three months to receive their ART refills and undergo basic screening for adherence, nutrition, TB and other OIs. In these groups, their Peer Leaders collect the drugs for the group members from the pharmacy, distribute, and account for them.

7.8.1.3.2 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 8, 9, 10, 11, 12 and 13)
- Pre-pack ART and other medicines
- Update records
7.8.1.3.3 Selecting the FBG Peer Leader
For each group, the HCW guides the clients in the process of identifying an appropriate Peer Leader. 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
- Regularly attends the clinic
- Has good adherence to ART
- Has disclosed to his/her partner, if any
- Has no stigma
- Seems to have some time to carry out the group activities and to coordinate the group
- Can be trusted to ensure that drugs are dispensed, accounted for and any balances are returned to the pharmacy
- Can keep confidentiality

7.8.1.3.4 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 facility worker
- Encourages clients in the clinic who meet the criteria, to join the groups
- Reviews appointment books for group appointment reminders and ensures the missing clients are tracked
- Together with (and under supervision of the clinic staff), pre-pack drugs for the groups
- ARVs distribution
- Completing records i.e. Appointment Book
- Organizes and plans village savings and loan activities (VSLA)
- Ensures clients attend the group visits as required
- Sensitize group members

7.8.1.3.5 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
- Saving and Loans schemes activities
- Weights and MUAC
- Records completion
- ART refill

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 pre-pack drugs for the clients expected for a given group meeting. The pre-packed drugs are distributed by the Peer Leader or clinical staff or both. The HIV Care Cards are updated there and then, while the ART registers are updated later.
The nurse/Pear 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.

### 7.8.2 Flexible hours (Differentiated schedules)

Health facilities can also dedicate specific hours (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 counseling 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 8. Differentiated schedules and appointments examples**

- **Schedules for pregnant women/adolescents/couples**
  - Helps to maintain privacy, avoid stigma, and improve quality of care through group counseling and health talks to address each client group’s specific needs (for example, pregnancy management, nutrition advice, prevention practices)

- **Schedules for co-infected clients**
  - Enables clients to receive both HIV and TB treatment and targeted counseling sessions in the same setting. Facilities should invest in effective infection control measures such as separation of TB infected clients from uninfected HIV clients and ventilation in waiting areas

- **Appointments outside of usual working hours**
  - Provides flexibility for people who work long hours, avoids stigma, and potential cost of taking time off during day time hours to attend the site. This approach may require some rearrangement of staff schedules, additional staff, and/or financial incentives.

- **Separate clinic days for patients in different treatment phases (e.g. intensive phase vs. continuation phase for TB)**
  - Simplifies delivery of group health talks and defaulter follow-ups
7.8.3 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 below.

*Figure 9. Differentiated clinic examples*

- **Children’s clinic**
  - To provide specialized care and play area.

- **Adolescent clinic**
  - To provide targeted communication, peer-to-peer sharing of experiences, and discussion of adolescent-specific issues.

- **Antenatal and post-natal clinic**
  - Integrated ANC, TB, and HIV services provided in the same setting.

- **TB-HIV co-infected patients’ area**
  - TB/HIV services offered in the same setting. TB infection control measures to be observed. TB clinics for drug-resistant patients to serve their specific needs.

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, clients who would benefit from this approach could be referred to another nearby facility that has sufficient clients and is able to offer dedicated spaces and times for different types of clients. 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 treatment and care under the facility- and community-based models can be summarized in the table below.

**Table 7. Clients qualified for HIV treatment and care services under the various differentiated flow categories**

<table>
<thead>
<tr>
<th>Categories</th>
<th>Qualifying Clients</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Key Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Based Individual Management (Comprehensive clinical evaluation)</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Facility Based Group</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fast track drug pick-up</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Community Client Led ART Distribution (CCLAD)</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Drug Distribution Points (CDDPs)</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✔</td>
</tr>
</tbody>
</table>
### 7.8.4 Service Packages for Various Client Groups

**Table 8. Service package for stable clients**

<table>
<thead>
<tr>
<th></th>
<th>Clinical consultations</th>
<th>Refills (ART, CTX, FP)</th>
<th>Laboratory tests</th>
<th>Adherence support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When</strong></td>
<td>Every 6 months (twice a year)</td>
<td>Every 3 months/ 4 times a year</td>
<td>VL annually</td>
<td>At every visit</td>
</tr>
<tr>
<td><strong>Where</strong></td>
<td>Facility or Community</td>
<td>Facility or community</td>
<td>Facility or community</td>
<td>Facility or community</td>
</tr>
<tr>
<td><strong>Who</strong></td>
<td>Clinician (MO, CO Nursing Officer)</td>
<td>Dispenser / nurse / trained lay providers (expert client)</td>
<td>Lab staff</td>
<td>Counsellor/ Nurse/ Trained Peer</td>
</tr>
</tbody>
</table>
| **What**         | • H/PE (Vital signs including weight, BP, MUAC, NACS)  
                  • Symptom screen (TB, STIs, other OIs)  
                  • Referral for other conditions including NCD screening & management  
                  • Adherence assessment (ART/CTX)  
                  • Update register  
                  • New appointment –clinical or for VL  
                  • Pre-packed ARVs (label)  
                  • Dispense  
                  • Fill dispensing log  
                  • From the facility laboratory following the FBIM  
                  • Clients are bled during the community outreaches and results communicated as soon as possible |  
| **HOW**          | • Through Facility Based Individual Management (FBIM) when the clinical evaluation is due for those who are in Fast Track, CCLAD, FBGs  
                  • Through Community Based Individual Management for the CDDP  
                  • Fast Track (Pick-up from dispensing points or pharmacy after going via the triage desk)  
                  • Longer appointment spacing and multi-month prescriptions  
                  • Through peers (CCLAD)  
                  • Through health care worker outreaches (CDDP)  
                  • During the FBGs  
                  • During the CDDPs  
                  • During the monthly refill meetings for CCLADs |  
|                  |  |  |  |  |
### Table 9. Service package for unstable/complex/new clients

<table>
<thead>
<tr>
<th>When</th>
<th>Clinical consultations</th>
<th>Refills (ART, CTX, FP)</th>
<th>Laboratory tests</th>
<th>Adherence support</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Clients already in care:</td>
<td>• Unstable/complex clients:</td>
<td>• Baseline tests at initiation</td>
<td>• At every visit</td>
</tr>
<tr>
<td></td>
<td>o Monthly</td>
<td>o Monthly until stable</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• New/naive clients:</td>
<td>• New/naive clients:</td>
<td>• VL:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Monthly for the 1st 3 months</td>
<td>o Monthly for the 1st 3 months</td>
<td>o First VL at 6 months (new clients) and then annually</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Then at 6 months and 9 months</td>
<td>o Then at 6 months and 9 months</td>
<td>• For cases of VL non-suppression:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Offer IAC at least 3 consecutive sessions, 1 month apart</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Repeat VL 1 month after 3 consecutive IAC sessions with documented good adherence</td>
<td></td>
</tr>
<tr>
<td>Where</td>
<td>Facility</td>
<td>Facility</td>
<td>Facility</td>
<td>Facility and community</td>
</tr>
<tr>
<td>Who</td>
<td>Clinician (MO, CO Nursing officer)</td>
<td>Dispenser /nurse / Trained lay providers (expert client)</td>
<td>Lab staff</td>
<td>Counsellor/ Nurse/ Trained Peer</td>
</tr>
<tr>
<td>What</td>
<td>• Rapid initiation of ART</td>
<td>Pre-packed ARVs (label)</td>
<td>CD4, HBsAg, CrAg if CD4&lt;100 or VL is not suppressed, VL test for pregnant women on ART at 1st ANC in that pregnancy</td>
<td>Adherence support</td>
</tr>
<tr>
<td></td>
<td>• OI screening, e.g. CRAG</td>
<td></td>
<td>Other tests as indicated:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Nutrition screening</td>
<td></td>
<td>• CBC (if risk of anaemia)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• NCDs</td>
<td></td>
<td>• TB test (if presumed)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• H/PE (vital signs including weight, BP)</td>
<td></td>
<td>• HCG when indicated</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• RFT (for hypertension &amp; DM)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• LFT (HBV or HCV infection)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Lipid profile &amp; blood glucose</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• HCV antibody test</td>
<td></td>
</tr>
</tbody>
</table>
### Table 10. Service package for children and adolescents

<table>
<thead>
<tr>
<th>When</th>
<th>Clinical consultations</th>
<th>Refills (ART, CTX, FP)</th>
<th>Laboratory tests</th>
<th>Adherence support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children 5 yrs and above: Quarterly</td>
<td></td>
<td>At every visit</td>
<td>VL twice a year for the suppressed</td>
<td>At every visit</td>
</tr>
<tr>
<td>Children under 5 yrs: Monthly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where</td>
<td>Facility - adolescent corner, special clinic days, space for group meetings</td>
<td>Facility dispensing</td>
<td>Facility lab</td>
<td>Facility</td>
</tr>
<tr>
<td>Who</td>
<td>Clinician (MO, CO, Nursing officer)</td>
<td>Dispenser/nurse</td>
<td>Lab staff</td>
<td>Counsellor/nurse/expert clients/peer</td>
</tr>
<tr>
<td><strong>Children:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o ARV dose adjustment</td>
<td>• Dispense</td>
<td>• VL at 6 months, 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o disclosure and adherence support</td>
<td>• Fill dispensing log</td>
<td>• STIs, such as syphilis (as indicated for others)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Weight</td>
<td>• Update the ART register and OpenMRS</td>
<td>• Urine HCG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Routine care (CTX &amp; ART refills, OI &amp; screening NACS, STI screening, PHDP)</td>
<td></td>
<td>• Other tests as guided by clinical assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Adolescents:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o More psychosocial support on stigma, disclosure, hormonal changes</td>
<td>• Disclosure</td>
<td>• Health education, counseling and provision of SRH - FP, STI care, safe conception</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Need FP, SRH, adolescent corner, STI care/ counseling; different clinic days</td>
<td>• Adherence support</td>
<td>• Career development – schooling, vocational training, IGA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider school going; space for group meeting, entertainment; consider visits in holidays for adolescents</td>
<td>• Psychosocial support on stigma and discrimination reduction, disclosure, hormonal changes/sexual development, life skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Health education, counseling and provision of SRH - FP, STI care, safe conception</td>
<td>• Entertainment and individual coping/stress management activities consider visits in holidays for adolescents</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Career development – schooling, vocational training, IGA</td>
<td>• PHDP</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 11. Service package for pregnant and breastfeeding women and their HIV-exposed infants

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

*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; stage T1 and no active OIs; Not due for vital lab 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 of above 1000 copies/ml; adherence less than 95%; stage T3,4 and active OIs; comorbidities/co-infection; CD4 <500; due for vital lab tests in the next 2 months, e.g., VL; has not disclosed to significant other/ household member/family member; MDR TB/HIV
### Table 12. Service package for stable key populations

<table>
<thead>
<tr>
<th>Clinical consultations &amp; screening</th>
<th>Refills (ART, CTX, FP)</th>
<th>Laboratory tests</th>
<th>Adherence support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When</strong></td>
<td>2 visits per year</td>
<td>4 times per year</td>
<td>At every visit</td>
</tr>
<tr>
<td><strong>Where</strong></td>
<td>Specialized Key Pop clinics, general ART clinics, community outreach Modified hours of operation • Outreach service points • FP services</td>
<td>Specialized KP clinics, general ART clinics, pharmacy, community ARV refill points</td>
<td>Specialized KP clinics, general ART clinics, Pharmacy, PSS groups</td>
</tr>
<tr>
<td><strong>Who</strong></td>
<td>MO/CO, Nurses</td>
<td>Dispensers nurse/peer</td>
<td>Lab personnel</td>
</tr>
<tr>
<td><strong>What</strong></td>
<td>• Clinical assessment</td>
<td>• Dispense ARVs, CTX and other medicines</td>
<td>• Counsellor/nurse/expert clients/peer</td>
</tr>
<tr>
<td></td>
<td>• Management of OIs and other clinical problems</td>
<td>• Fill the dispensing log</td>
<td>• Adherence support</td>
</tr>
<tr>
<td></td>
<td>• Prescribe ARVs and other medicines</td>
<td>• Update the ART register/OpenMRS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Annual VL</td>
<td>• STIs, syphilis (as indicated for others)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Quarterly STI screening tests</td>
<td>• VL</td>
<td></td>
</tr>
</tbody>
</table>
# Table 13. Service package for patients with TB

<table>
<thead>
<tr>
<th>When</th>
<th>Clinical consultations</th>
<th>ART and TB drug refills</th>
<th>Laboratory tests</th>
<th>Adherence support (ART and TB)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New TB Clients (already on ART):</td>
<td>• New TB Clients (already on ART):</td>
<td>• Clients in Intensive phase of TB treatment (Unstable):</td>
<td>• Sputum at 2 months</td>
<td>• At every visit</td>
</tr>
<tr>
<td>o Fortnightly for 2 months</td>
<td>o Fortnightly for 2 months</td>
<td>o Fortnightly for 2 months</td>
<td>• Sputum at 5 months</td>
<td>• Preparations for DSDM at the 9 months visit</td>
</tr>
<tr>
<td>o Do repeat sputum at 2 months for PTB</td>
<td>o Do repeat sputum at 2 months</td>
<td>o Consider Community DSDM if sputum conversion occurred</td>
<td>• Sputum at 6 months</td>
<td></td>
</tr>
<tr>
<td>o Consider Community DSDM if sputum conversion occurred</td>
<td>• New/naive clients:</td>
<td>• Consider Community DSDM if sputum conversion occurred</td>
<td>• Baseline tests</td>
<td></td>
</tr>
<tr>
<td>• New TB patients (ART New/naive clients):</td>
<td>o ART initiation at 2 weeks of TB treatment</td>
<td>• New/naive clients:</td>
<td>• VL:</td>
<td></td>
</tr>
<tr>
<td>o Fortnightly for 2 months</td>
<td>o Fortnightly for 2 months</td>
<td>o ART initiation at 2 weeks of TB treatment</td>
<td>o First VL at 6 months (new clients)</td>
<td>o Offer IAC at least 3 sessions, 1 month apart</td>
</tr>
<tr>
<td>o Then monthly for 6 months</td>
<td>o Then monthly for 6 months</td>
<td>o Consider Community DSDM if sputum conversion occurred</td>
<td>o Then annually</td>
<td>o Repeat VL 1 month after 3rd IAC session</td>
</tr>
<tr>
<td>o Then at 9 months</td>
<td>o Then at 9 months</td>
<td>• At 9 month visit:</td>
<td>• For cases of VL non-suppression:</td>
<td></td>
</tr>
<tr>
<td>• At 9 month visit:</td>
<td>• Prepare for DSDM</td>
<td>• Prepare for DSDM</td>
<td>o Offer IAC at least 3 sessions, 1 month apart</td>
<td></td>
</tr>
<tr>
<td>o Prepare for DSDM</td>
<td></td>
<td></td>
<td>o Repeat VL 1 month after 3rd IAC session</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Where</th>
<th>Facility for 2 months and moves to community care model</th>
<th>Facility for 2 months and mover to community care model</th>
<th>Facility</th>
<th>Facility or community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who</td>
<td>Clinician (MO, CO Nursing officer)</td>
<td>Dispenser /nurse / Trained lay providers (expert client)</td>
<td>Lab staff</td>
<td>Counsellor/ Nurse/ Trained Peer</td>
</tr>
<tr>
<td>What</td>
<td>Rapid initiation of ART</td>
<td>Pre-packed ARVs (label) and anti-TB medications</td>
<td>• Gene Xpert test</td>
<td>• Adherence support (both TB and ART)</td>
</tr>
<tr>
<td></td>
<td>• Clinical evaluation every 2 weeks for the first 2 months; thereafter at 2, 5 and 6 months.</td>
<td>Facility refills fortnightly in the first 2 months and monthly in the next 4 months within the community.</td>
<td>• Sputum at 2, 5 and 6 months.</td>
<td>• TB and HIV Index Client Contact tracing and screening for TB</td>
</tr>
<tr>
<td></td>
<td>• TB symptom screening</td>
<td></td>
<td>• CXR at baseline</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• TB and other OI screening, e.g. CRAG</td>
<td></td>
<td>• LFT if on MDR treatment or reacted to medication</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Nutrition screening</td>
<td></td>
<td>• TFTs, monthly smear and culture for MDR patients.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• NCDs</td>
<td></td>
<td>• CD4, HBsAg, CrAg if CD4&lt;100, VL test for pregnant women at 1st ANC and Lactating mothers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• H/PE (vital signs including wt, BP)</td>
<td></td>
<td>Other tests as indicated:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• CBC (if at risk of anaemia)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Test for TB (if suspected)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• RFT (for hypertension &amp; DM)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Lipid profile &amp; blood glucose</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• HCV antibody test</td>
<td></td>
</tr>
</tbody>
</table>

*PTB includes both P-BC and P-CD

*For EPTB patients consider DSDM after significant (NTLP Manual) clinical improvement as ascertained by the Clinician

*MDR TB/HIV Co-infected are considered unstable throughout the course of their treatment. DSDM 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
7.9 **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;

7.9.1 **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.

7.9.2 **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.

7.9.3 **Managing clients who transfer in**

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

7.9.4 **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 rejoin their former DSD model again.

7.9.5 **Managing new clients with a suppressed 6 months VL**

It is important that clients have an updated VL to determine eligibility for community DSD model. 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 at 18 months.

7.9.6 **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, one of them will return three months later to pick drugs for both of them. Then at six months, they both return for their comprehensive clinical evaluation. If enrolled into CCLAD, the group members will decide on the member that will pick the drugs.
Table 14. Schedule for stable couple under fast track drug refill model

<table>
<thead>
<tr>
<th>Month</th>
<th>Month 0</th>
<th>Month 3</th>
<th>Month 6</th>
<th>Month 9</th>
<th>Month 12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Partner 1 enrolled &amp;</td>
<td>Does not come</td>
<td>Refill visit and</td>
<td>Does not come</td>
<td>Refill visit and</td>
</tr>
<tr>
<td></td>
<td>comprehensive</td>
<td></td>
<td>comprehensive</td>
<td></td>
<td>comprehensive</td>
</tr>
<tr>
<td></td>
<td>clinical review</td>
<td></td>
<td>clinical evaluation</td>
<td></td>
<td>clinical evaluation</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Partner 2 enrolled &amp;</td>
<td>Refill visit</td>
<td>Does not come</td>
<td>Refill and</td>
<td>Does not come</td>
</tr>
<tr>
<td></td>
<td>comprehensive</td>
<td></td>
<td></td>
<td>comprehensive</td>
<td></td>
</tr>
<tr>
<td></td>
<td>clinical review</td>
<td></td>
<td></td>
<td>clinical evaluation</td>
<td></td>
</tr>
</tbody>
</table>

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, enroll both clients on FTDR and schedule the absent partner for clinical review at the next visit as per schedule below.

Table 15. Schedule for couples’ facility visits who enroll at different times

<table>
<thead>
<tr>
<th>Month</th>
<th>Month 0</th>
<th>Month 3</th>
<th>Month 6</th>
<th>Month 9</th>
<th>Month 12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Partner 1 enrolled</td>
<td>Clinical Review</td>
<td>Refill visit</td>
<td>Clinical Review</td>
<td>Refill visit</td>
</tr>
<tr>
<td></td>
<td>Partner 2 enrolled</td>
<td>Refill visit</td>
<td>Clinical Review</td>
<td>Refill visit</td>
<td>Clinical Review</td>
</tr>
</tbody>
</table>

7.10 COMMUNITY-BASED HIV TREATMENT AND CARE MODELS

These are HIV treatment and care services offered outside the existing health facilities.

7.11 WHY COMMUNITY-BASED HIV TREATMENT AND CARE MODELS?

Decentralization of provision of some components of HIV treatment and care 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 treatment and care model include:

- Community Client Led ART Delivery (CCLAD)
- Community Drug Distribution Points (CDDPs)

7.12 COMMUNITY CLIENT-LED ART DELIVERY (CCLAD) MODEL

The Community Client Led ART Delivery (CCLAD) are psychosocial community ART groups comprising of stable ART clients in the same community/locality. The CCLAD model will improve access and empower clients to rotate collection and delivery of ART to group members. Clients monitor their own health and take action with the support of HCWs. It also empowers clients to offer peer psychosocial support and follow-up.

7.12.1 Description of the CCLAD

The CCLAD model comprises of client groups living in the same community. 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 share experiences about living positive with HIV. Information regarding their health is recorded on the CCLAD monitoring form and taken to a health facility during the next refill, to update their facility records. Each member of the group must visit a health facility twice a year for a comprehensive clinical assessment.
A Team Leader is selected by the group members, in collaboration with the health workers, 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 while in the community.

7.12.2 What is the CCLAD group size?

It is recommended that the CCLAD groups comprise of 3 to a maximum of 12 members.

7.12.3 Steps for Implementing the CCLAD model

7.12.3.1 Organizing for CCLAD in the health facility

7.12.3.1.1 Preparation

i. Orientation of health workers on the CCLAD model

ii. Identify a Focal Person to coordinate the following activities
   - identification of patients in groups
   - Lead promotion and sensitization about CCLAD
   - Oversee completeness of records
   - Follow up with CCLAD Group Leaders
   - Oversee clinic flow for patients in groups
   - Prepare for visits for patients in CCLAD e.g. retrieval of files, pre-packing medicines

7.12.3.1.2 CCLAD group formation

i. Use the existing facility client data to categorize the clients into stable or unstable ART clients. Stable clients are listed in accordance to their locations. 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 FBGs.

ii. Sensitize all stable clients, one-on-one or as a group, explaining the different group sizes and their implications on the number of clients coming for drug refills at each visit (options available). Explain what they mean, how they work, and the benefits both to the patient and health workers

iii. Ask clients to choose their preferred group size

iv. Obtain a documented informed consent from each client. In the consenting process, the following questions will be asked:
   - Are other members of your household disclosed to?
   - Is the head of your household disclosed to?
   - If not, to whom have you disclosed your HIV status?
   - Would you like to know other clients who would like to form a group in your community?
   - Are you willing to be known by them?
   - Would you like to consent to join a group?

If all answers are “Yes” then the client will be signed up for group formation. Signed consent forms should be kept in the client’s file

v. Orient the newly formed groups in the approach, their roles and responsibilities (the do’s and don’ts of the group)

vi. Support the group to develop a rotational visit plan that ensures that they all attend at six month’ intervals, and appoint a representative three months in-between.
vii. Three months’ drug refills will be given to each individual during group drug refill or comprehensive clinical evaluation or to a group representative during drug refill schedule to distribute to other group members.

viii. Communicate the new group appointment dates to the members and record in the facility appointment book.

ix. VL will be done for all group members during the comprehensive clinical evaluation visits.

x. 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.

xi. Assign each group and group member a unique identifier using the following format: Facility Name/group serial number/patient ART number. E.g., Kawolo Hospital/G1/001 for a CCLAD group client in Kawolo Hospital whose group is 1 and client ART number is 001.

xii. Keep clients files as currently done (Maintain current filing system)

xiii. Record all patients joining CCLAD groups in the appropriate registers and update registers as patients enroll into groups.

xiv. Consider use of hand-held calendars (based on group size) or exercise books for appointment reminders.

7.12.3.2 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. The group members meet three months after their comprehensive clinical evaluation at their convenient time and place.

Meeting 1: Day before the refill day

- Group Leader does pill count for each member and records on CCLAD monitoring form (date and remaining pills against each member)
- Group Leader assesses health status each member on the side effects and record on the CCLAD monitoring card. The assessment is repeated every two months thereafter.
- Refer to schedule on who is/are representing the group on the refill day.

NOTE: Whenever the group member feels or is sick (i.e. has fever, headache, etc...), he/she should go to a health facility any time for treatment and not wait for the routine ART refill visit.

Meeting 2: Refill day after the member returns from the health facility

- Group members re-convene to collect their supply/refill and
- The CCLAD monitoring card is handed over to the Group Leader
- The group shares observations, challenges and they discuss and agree on the way forward
- Communication is made about the next drug refilling date and person(s)

NOTE: If there is a member that has not collected his/her drugs within 2 days, the Group Leader should notify the parent facility as soon as possible, to allow them track the individual within the remaining 5 days.
7.12.4 How is the CCLAD group scheduled for visits?

- At the initiation of the group, all the group members attend for a comprehensive clinical evaluation and receive their 3 months’ ART refill.
- 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.
- 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.
- 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 other group members.

The scheduling is illustrated in the schema below. It ensures that each member of the group visits the facility twice in a year.

**Figure 10. Scheduling appointments for the CCLAD group**

### Visualizing CCLAD Members Visits at the Health Facility

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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><img src="image1.png" alt="Icons" /></td>
<td><img src="image2.png" alt="Icons" /></td>
<td><img src="image3.png" alt="Icons" /></td>
<td><img src="image4.png" alt="Icons" /></td>
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<td><img src="image23.png" alt="Icons" /></td>
<td><img src="image24.png" alt="Icons" /></td>
</tr>
</tbody>
</table>

7.12.5 Roles of key CCLAD group actors

6.12.4.1. 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 counseling 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

6.12.4.2 Group Member
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

6.12.4.3 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 to the HIV Care Card and the registers
8. Review the list of appointments of CCLAD members prior to clinic appointment, retrieve their files, and pre-pack and label the drugs (the latter can be delegated to expert clients/lay counselors)
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/exercise book

7.12.6 Service package at community level for CCLAD groups
The following service package is recommended for these groups:

- ARVs refills
- Refills for Cotrimoxazole
- RH commodities refills, e.g. FP pills, condoms.
- Symptomatic TB screening done by the group leader for all group members
- Nutrition assessment within group using MUAC (by a trained member of the group)
- Adherence and peer psychosocial support
- Follow up of group members who miss meeting appointments
- Referral and linkages to facilities to address any identified issues

NOTE: TB clients will get their drugs from the sub county health workers
7.12.7 Resource needs for CCLAD approach

7.12.7.1 Human Resource Needs

Table 16. Human Resource Cadres and their Responsibilities

<table>
<thead>
<tr>
<th>Cadre</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCWs (Nurse/Counselor)</td>
<td>Refer to section 6.2.5.3</td>
</tr>
<tr>
<td>Expert clients/Peer educators</td>
<td>Dispense drugs, conduct symptom-based general health assessments; provide counseling and support while dispensing drugs</td>
</tr>
<tr>
<td>CCLAD group leaders</td>
<td>Refer to section 6.2.5.1</td>
</tr>
<tr>
<td>Records person (Data Clerk/M&amp;E Manager)</td>
<td>Collect, verify and enter data contained in the health assessment forms collected in the community by the expert clients, into the facility registers</td>
</tr>
<tr>
<td>Pharmacy team</td>
<td>Pre-pack drugs for individual clients marked with their name and details, and ensure safe transportation of packages</td>
</tr>
<tr>
<td>PLHIV networks</td>
<td>Support to PLHIV groups and linkage to other support networks including peer support, oversee functionality of groups</td>
</tr>
<tr>
<td>CHEWs/VHTs</td>
<td>Mobilize and raise awareness and support linkage to social services</td>
</tr>
</tbody>
</table>

7.12.7.2 Logistic needs

Facility

- Enough stock of drugs for all clients
- Masking tape for binding each client’s drugs together for pick-up
- Markers for labeling
- File folders
- Tools (CCLAD drug accountability forms, community eligibility form, group formation forms, HIV Care Cards, client hand-held cards, appointment books) and registers (ART register, dispensing log)
- Health education job aids, client flyers, etc.

Community

- Appropriate venue for the group meetings where members feel free (Safe zone/meeting point)
- Assessment tools e.g. MUAC tapes, community HMIS tools, drug acknowledgement forms, CCLAD monitoring tool,
- Health education job aids, client flyers, etc.

7.12.8 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. Otherwise, the gap can be filled by increasing the period to refill.

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

7.12.9 Monitoring the CCLAD approach

The CCLADs will be monitored using the following set of tools and indicators that include (but not limited to):

- Differentiated Services Register- Gives details on group members and also the number of groups formed
- Drug acknowledgement form
- Community ART Group Assessment card to document health status, missed appointment, lost and client follow up
- Appointment book
- Record of health education topics/issues discussed in the group

<table>
<thead>
<tr>
<th>No.</th>
<th>Indicator</th>
<th>Definition</th>
<th>Data source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Number of clients who picked their drugs in the month</td>
<td>Number of clients who acknowledged receipt of their ARVs</td>
<td>Acknowledgement form</td>
</tr>
<tr>
<td>2.</td>
<td>Number of clients followed up after missing CCLAD appointment</td>
<td>Number of clients who never acknowledged receipt of their ARVs</td>
<td>CCLAD monitoring tool</td>
</tr>
<tr>
<td>3.</td>
<td>Number of clients who had OI symptoms</td>
<td>Number of clients with T-Stage 2, 3 or 4</td>
<td>CCLAD monitoring tool</td>
</tr>
<tr>
<td>4.</td>
<td>Number of clients with adherence challenges</td>
<td>Number with less than good adherence (less than 95%)</td>
<td>CCLAD monitoring tool</td>
</tr>
</tbody>
</table>

Other basic M&E activities for CCLAD models (data collection and reporting) will include:
- Client satisfaction surveys
- Learning sessions where group leaders from different villages share best practices and challenges (how best to handle their clients)
- Performance reviews of the peers themselves

**7.13 COMMUNITY DRUG DISTRIBUTION POINT (CDDP) APPROACH**

**7.13.1 What is the CDDP approach?**

This is where ART care is delivered at a community-based site. The CDDP approach has less human resource demands with use of laypersons. This offers increased community participation and most importantly, ownership of ART care by the clients.

In this approach, with the help of community ART support agents (CASAs), health workers pre-pack medicines and deliver ART services to a group of clients appointed at a particular community venue. The groups range from 10-50 ART stable clients who come from a common area/location distant from the health facility. Additional eligible clients can always be added to the group at any point.

**7.13.2 Services offered in the CDDP approach**

- ARV drug refills
- VL monitoring
- Monitoring
- Psychosocial support
- Family planning and pregnancy screening
- Nutrition assessment and referral
- TB screening and referral
- O.I screening and management
7.13.3 Who is eligible for the CDDP approach?

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

7.13.4 Steps in establishing a CDDP

Step 1. Identify need for CDDP

- The facility should have identified it as a priority model using the steps described in the chapter on how to introduce DSDM in the facility

Step 2. Form the CDDP group and orient members

- The HCW reviews all files of all clients coming from that community or location to establish their eligibility status (Stable/Unstable)
- 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
- 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.
- A CDDP group list is generated and a name is given to the group.
- The health facility will organize a one-day workshop for all the CASAs for orientation on the CDDP approach and sensitization about roles and responsibilities.
- Assessment for group formation and group re-assignment in this approach will be an on-going process.

Step 3. Agree on the distribution point

- The group decides where they will regularly meet (drug distribution point) with the guidance of the health worker.
- The health worker then maps and visits the site and seeks the consent of the stakeholders and local authorities.

Step 4. Implement the CDDP

- 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.
- 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.
- Thereafter, members are given an appointment at the CDDP for subsequent ART refills, consultation and ART monitoring by the clinical team.
- The Group Leader of HCW mobilizes group members to come for their appointments.
- ARV drugs are pre-packed for the CDDP members. Additional supplies to be pre-packed include FP supplies, OI drugs, condoms, etc.
- Transportation is organized.
- 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).
Table 18. Service package for community groups in the CDDP approach

<table>
<thead>
<tr>
<th>Clinical consultations &amp; screening</th>
<th>Refills (ART, CTX, FP)</th>
<th>Laboratory tests</th>
<th>Adherence support</th>
</tr>
</thead>
<tbody>
<tr>
<td>When</td>
<td>2 visits per year</td>
<td>4 refills per year</td>
<td>Annual VL</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>At every visit</td>
</tr>
<tr>
<td>Where</td>
<td>Community outreaches</td>
<td>Community</td>
<td>Community</td>
</tr>
<tr>
<td></td>
<td></td>
<td>outreaches</td>
<td>outreaches</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specialized KP</td>
<td>Specialized KP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>clinic outreaches</td>
<td>clinic outreaches</td>
</tr>
<tr>
<td>Who</td>
<td>MO/CO, Nurses,</td>
<td>Nurses, Counselors,</td>
<td>Lab personnel</td>
</tr>
<tr>
<td></td>
<td>Laboratory, counselors</td>
<td>Expert Clients</td>
<td>Trained nurse/clinician</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Counsellor/ nurse/</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>expert clients/</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>peers</td>
</tr>
<tr>
<td>What</td>
<td>OI &amp; screening</td>
<td>Dispense ARVs and</td>
<td>STIs, syphilis,</td>
</tr>
<tr>
<td></td>
<td>NAC</td>
<td>OI drugs</td>
<td>others as</td>
</tr>
<tr>
<td></td>
<td>STI screening &amp;</td>
<td>STI treatment</td>
<td>indicated</td>
</tr>
<tr>
<td></td>
<td>treatment</td>
<td>Client tracking</td>
<td>VL</td>
</tr>
<tr>
<td></td>
<td>PHDP</td>
<td></td>
<td>Point of care</td>
</tr>
<tr>
<td></td>
<td>Sample collection for</td>
<td></td>
<td>testing</td>
</tr>
<tr>
<td></td>
<td>lab monitoring</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7.13.5 Tasks and support at the CDDPs

Table 19. Tasks and support for CDDPs

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

**Facility**
- Enough stock of drugs for all clients
- Markers for labeling
- Portable scales, MUAC tape
- Big file folders (box files)
- Tools (HMIS tools—data collection/reporting, registers, patient cards, ICF forms, community eligibility form)
- Health education, job aids, client flyers, etc.
- Transport means to deliver drugs to the CDDP group

**Community**
- Appropriate venue for the group meetings where members feel free (safe zone/meeting point)
- Health education job aids, client flyers, etc.
- CASA agents

### 7.14 Monitoring Implementation of HIV Treatment and Care Models

Health facilities will need to collect data on baseline values (before implementation of differentiated approaches) so that they can compare them with the actual values when the approach has been used for a defined amount of time; the difference between the two sets of values will help with assessing the effects of differentiated treatment and care models. Facilities should also track the outcomes and costs of delivering differentiated HIV treatment and care services.

See M&E section for indicators and further details.

### 7.15 Reporting

Facility reporting into WAOS / DHIS2 will remain the same.
8 CLIENT FLOW, CLIENT TRACKING AND FOLLOW UP IN CARE IN THE CONTEXT OF DSD

8.1 WHAT IS CLIENT FLOW?
This is the pathway followed by clients as they receive services between care points in a health facility or in a community from their time of arrival to departure.

8.2 RECOMMENDED ART CLINIC 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 as per the flow above.
8.3 **What Is Retention?**

Refers to keeping (or “retaining”) clients in a program throughout the HIV treatment and care continuum, regardless of whether they are receiving care in the facility or community.

8.4 **Why Is Retention Important?**

Retention in care is important if we want to curtail transmission of HIV and achieve an AIDS-free generation. Poor retention results in loss of clients and if greater than 90 days results into loss to follow-up (LTFU). The latter is common in ART programmes in sub-Saharan Africa for both the people already on treatment and those waiting to start treatment. LTFU can lead to treatment interruptions, development of viral resistance to ART and hampers HIV prevention efforts. 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.

Good-quality data and better use of them are the low-hanging fruit to achieve retention on ART, because we can do that now.

8.5 **How to Prevent Missed Appointments Both in the Facility and Community Models**

- Provide client-centered care, i.e. appropriate a model of care and appointment timing according to the client’s convenience
- Get and document client contacts – phone, home directions etc. (explain importance of contact information)
- Schedule appointments in line with the amount of medicine given to the client
- 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
- Provide continuous client education and counseling
- Utilize routine data to monitor retention in care (data capture & data review for client tracing)
- Use of reminder SMS/phone calls for reminders about appointments.
- Use of Treatment Buddies/Peers. For the CDDP, HCWs will need to remind clients (through their Group/Peer Leaders) about upcoming appointments

8.6 **How to Identify a Missed Appointment**

8.6.1 **Data sources for identifying defaulters**

- Client appointment books
- Pharmacy records (e.g., dispensing logs)
- Community programming records (e.g., CCLAD monitoring form)
8.6.2 Filling in the appointment book for the CCLAD approach

8.6.2.1 Suggested modification to the appointment book

In the appointment book, a column for ‘Reason attended’ is proposed. It will have options for CCLAD pick up/CDDP pick up/Facility Based Group/Facility Individual Based Management/Fast track etc.

8.6.2.2 Appointment Scheduling

- All the names of the members in a given CCLAD group will be listed in the appointment book one after the other
- The CCLAD member that has come to the facility will have his/her reason for attendance ticked as comprehensive clinical evaluation.
- The other members in the group will have reason ticked as CCLAD pick-up
- Each of the members of that CCLAD group will be given an appointment date of the next date when the next member of the group will be reporting to the health facility
8.6.3 How to identify defaulters

8.6.3.1 In the health facility or CDDP

- 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)
- Verify with other data sources for harmonization in case of omission e.g. the dispensing log
- Manually compile or generate electronically a list of those who did not attend for follow up

8.6.3.2 In the community for the CCLADS

- Team Leaders should document (in an exercise book) any clients that miss meetings prior to drug collection. This information should be relayed to the health workers by the client picking the drugs. The health worker should take note of this but should not deny this client his/her drugs
- The health worker should follow up with the group leader whether the said client picked/received his/her drugs
- If the said client above or another client has not picked the drugs within two days, the Team Leader should initiate the process of tracking these clients through home visits or phone calls
- If the client cannot be traced within 7 days or has travelled a long distance, the Team Leader should inform the parent health facility immediately. The drugs for these clients should be stored well and taken back to the facility during the next drug refill
8.6.4 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*
8.6.5 Roles and responsibilities for Client Follow-Up

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

8.6.5.1 Role of HCWs

- Consistently and correctly use the SOPs
- Routinely analyze and utilize data for monitoring clients under DSD to identity lost clients and generate the search lists (see search list form below)
- Cost the search plan and inform the In-Charge for funds
- Make home visit as necessary once client is confirmed available in the setting
- Facilitate referrals:
  - Identify clients who potentially will transfer
  - Ensure client record has good history of demographics, including geographical location
  - Understanding, proposing, and linking clients to the nearby (or preferred) HIV service delivery point
- 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 original for the client)
- 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

8.6.5.2 Role of peer educators

- Support the HCWs to fill the Follow-Up Form and identify clients who missed their appointments
- Provide group and individual counselling
- Facilitate referrals
- Conduct home-based visits
- Defaulter tracing for ART clients who have not returned to the clinic within two weeks after missing an appointment
- Follow-up defaulting clients in their homes
- Document the health status of the client
- Encourage them to return
8.7 **How to Utilize Data to Capture Lost Clients**

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

**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 15. Search List Form Template*
8.8 **KEY TOOLS REQUIRED FOR TRACKING**

- Follow up SOP
- Client Tracking tool
- Appointment Book
- Search List Form
- Guide for making a phone call
- Missed appointment/client tracking summary report form
- Phone accountability forms/booklet
- List of contacts of various health facilities and other organizations (NGOs/CBOs) nearest to the health facility
- List of VHTs and PLHIV networks
- Monthly ART data harmonization tool
9 LOGISTICS IMPLICATIONS FOR DSD

9.1 WHAT IS LOGISTICS MANAGEMENT?

This is a supply 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.

9.2 WHY LOGISTICS MANAGEMENT?

Logistics management facilitates control of the flow and storage of supplies and commodities for DSD. It leads to customer satisfaction as well as that of health workers.

Antiretroviral therapy remains the only way to save and prolong life of those individuals infected with HIV. 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.

Health facilities must therefore have strong logistics management functions and information. All medicines issued from the store should be well documented. Medicines dispensed to users should be recorded. This information must be processed at the time of ordering to determine the quantities of medicines required for the next period. Well managed logistics will increase access to therapy and improve treatment outcomes.

9.3 GUIDANCE ON MANAGING SUPPLIES AND LOGISTICS FOR DIFFERENTIATED SERVICE DELIVERY

9.3.1 Quantification

1. Sites should continue to quantify and order supplies based on their 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 patient numbers 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.

Before establishment of DSDM, sites should undertake the following:

- Determine current consumption for each commodity.
- Review and assess the current stocks of the ARV supplies
- Use the current consumption to determine how long the available stock can last
- Use the current consumption to determine how many more new patients can be enrolled in to treatment during the cycle. If the stock at hand falls below the minimum level before re order period, make an e order to secure enough supplies before starting enrolment. Otherwise follow the routine ordering cycle.
- Establish logistics management committees to monitor the stock levels on a monthly basis
- Ensure the viability of a functional open MRS and all manual logistics management tools
9.3.2 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 17. National ARV Distribution Mechanism*

The three central warehouses of National medical store, Joint medical Store and Medical Access Uganda limited will continue to distribute ARVs to respective health facilities on a bi monthly basis according to the respective warehouse published schedules. The health facilities shall be supported by implementing partners to order accurately initially for the first one or two cycles of transitioning to DSDM to ensure availability required supplies.

- To avoid supply interruptions, warehouses are required to adhere to the delivery schedules and supply the drugs as per the HF orders and avoid rationing.
- All Health facilities should make correct and timely orders to the warehouses.

9.3.3 Ordering and storage at facilities

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) 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.
With the introduction of DSDM, the consumption will increase moving the buffer stocks towards/below the current recommended minimum (quantity required for 2 months). 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 (quantity required 4 months) 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.

Health care workers are required to estimate the number of new clients to be started on DSDM each month and add the stock for these new clients in the bi-monthly stock orders. Warehouses have been sensitized to consider the new clients to be brought on board in each cycle.

9.3.4 Instructions for pre-packaging

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

- Sites shall order envelopes to pack individual OI drugs while ARVs should be left in their original secondary packages and shall be clearly labeled (name and dosing).
- The individual client drugs will be tied together with masking tape bearing the name of that individual.
- For the CCLAD & CDDP models, all the drugs for the members of one group will then be put together and labeled with the group name.
- The group representative will be expected to come with a bag for carrying the drugs back for distribution at the community.
- Ensuring clear packaging and labeling 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.

9.3.5 Dispensing at facilities

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

- Health facilities are expected to have a functional open MRS to allow for the automated 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 community groups especially in the large volume sites.
- Health facilities are required to accommodate task shifting. E.g. under the guidance of a supplies personnel, they shall consider use of lay providers for pre-packaging ARV drugs for client groups and adopt approaches and tools for tracking medicines.

9.3.5.1 Refilling drugs for clients on Fast-Track and Facility Based Groups

- The pharmacy team should obtain the drug pick-up list from Open MRS, or manually where there is no electronic medical record system.
- Daily calculations/estimates should be done to determine the total quantity of medicines required for the clients expected on that day.
- Pre-packaging should be done for each of the clients ensuring that they receive a 3-month supply at the next drug refill. This may be done by the pharmacy or by supervised support staff. Labelling and dosing should be done by the pharmacy staff.
9.3.5.2 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 at the next drug refill. This may be done by the pharmacy or by supervised support staff. Labelling and dosing should be done by the pharmacy staff. Each client package should contain enough supplies until the next appointment.

CCLAD approach

- 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.
- The health worker should schedule the next appointment for the patient according to their schedule

CDDP approach

- Pharmacy staff should ensure safe transportation to the sites.
- At the community site; dispensing is done by the health worker at the community distribution point.
- The health worker should schedule the next appointment for the patient according to their schedule

9.3.5.3 Managing drug balances in the CCLAD

- 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
- In the event of any pill balances, the client should first take the remaining pills before starting on the newly supplied drugs.
- Each client will bring all his/her pill balances during his/her time for picking drugs for the group.

9.4 Reporting Consumption

The facilities 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.

The HCW must ensure that the ARVs dispensed are captured into the dispensing logs in a timely manner.

Health facilities shall stock and utilize these tools to account for the community dispensing and report to facility. Facility reporting into WAOS / DHIS2 will remains the same. Some of the necessary tools include Dispensing lists/Drug pick up lists (automatically generated by the Open MRS system) among others
10 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. The use of existing site-level M&E tools and systems for patient/client tracking, monitoring quality of care and overall management is strongly encouraged. It is acknowledged that a number of the more complex monitoring indicators will most likely only be routinely collected from a select number of sites or sentinel sites during the early phases of implementation of differentiated care models and, where necessary, data tools may be revised to accommodate new models of ART, as well as client groupings.

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

10.1 WHY 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 various models 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 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
  - Monitor commodity stock availability and any other supply chain mechanism
  - Produce and share information with stakeholders
10.2 **HOW TO MONITOR DIFFERENTIATED SERVICE DELIVERY**

10.2.1 **DSD data capture and flow**

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 variable. The various DSD models have been coded for inclusion into the primary data tools (see coding below).

10.2.2 **HTS SECTION**

The following indicators will be monitored

- Number of clients tested disaggregated by the DSD models and approaches
- Proportion of clients testing HIV Positive disaggregated by the DSD models and approaches
- Proportion of clients linked to care disaggregated by the DSD models and approaches
- Proportion of tests done following national algorithm disaggregated by DSD models and approaches

**Data Tools**

- HCT Client Card (MHIS 055b)
- HCT Register (HMIS 055)
- Daily consumption log
- Linkages and PRE-ART Register

**Reporting**

Done monthly using the HMIS 105

The facilities should report on individual cases and the table below summarizes models and approaches to be reported against. Snowballing, partner notification, index client tracking and testing, know your child status, standalone HTS, integrated HTS outreaches all can be implemented as part of the approaches summarized below. Clients tested through the above approaches should be reported as per table below.

*Table 20. Monthly HTS Reporting by Models & Approaches*

<table>
<thead>
<tr>
<th>Models</th>
<th>Approaches</th>
<th>Tested</th>
<th>Tested HIV positive</th>
<th>Linked to Care</th>
<th>Tests followed HTS Algorithm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Based</td>
<td>PITC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CITC (VCT)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Based</td>
<td>Outreach/Mobile</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HBHCT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Provision has been made in the register to capture data by entry point. However entry points vary by level of health facility and geographical location. This data can be analyzed routinely by facilities for programming improvement.
Figure 18. Data Flow Chart for Differentiated HTS

- **Facility**
  - MCH Department
  - HIV Client Card/EMR (Revised)
  - Daily Consumption Log (Revised)
  - HIV Client Card/EMR (Revised)
  - Daily Consumption Log (Revised)
  - HTC register (ONE)/EMR (Revised)
  - HIV Positive
  - Linkages and Pre-ART register (NEW)/EMR
  - ART register/EMR (Revised)
  - Monthly report: HMIS 105
  - Quarterly report: HMIS 106a (Revised)

- **Out of Facility/Community**
  - Community/Outreach
  - HIV Client Card/EMR (Revised)
  - Daily Consumption Log (Revised)
  - Daily Consumption Log (Revised)

- **At every testing point, ensure there are triplicate referral forms**

Implementation Guide for Differentiated HIV Services in Uganda
10.2.3 ART SECTION

10.2.3.1 DSDM data capture and flow

Data for DSDM will be captured using the HIV data collection tool which will be modified appropriately to include DSDM variable. The various DSD models have been coded for inclusion into the primary data tools (see coding below). These codes will be aligned accordingly

Table 21. Coding of DSD models for data capture

<table>
<thead>
<tr>
<th>Code</th>
<th>DSD</th>
<th>Examples of treatment regimen</th>
<th>Combination with treatment regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1</td>
<td>Facility Based Individual Management</td>
<td>1f</td>
<td>1f-d1</td>
</tr>
<tr>
<td>D2</td>
<td>Facility Based Groups</td>
<td>1f</td>
<td>1f-d2</td>
</tr>
<tr>
<td>D3</td>
<td>Fast Track Drug Re-fills</td>
<td>1f</td>
<td>1f-d3</td>
</tr>
<tr>
<td>D4</td>
<td>CDDP</td>
<td>1f</td>
<td>1f-d4</td>
</tr>
<tr>
<td>D5</td>
<td>CCLAD</td>
<td>1f</td>
<td>1f-d5</td>
</tr>
</tbody>
</table>

10.2.4 Changes in the ART Card and ART register

In the Card, in the column for ART regimen, insert the combined code, e.g. 1f-d1 where “1f” is the drug regimen (TDF+ 3TC + EFV) and “d1” is the DSD (Facility Based Individual Management).

In the ART register, insert the combined code in the cell for “ARVs/FU status”.

Note: if the client changes the DSD model, the change should be reflected for that particular visit.

10.2.5 Indicators

DSDM will build on the already existing indicators for ART monitoring as spelt in the HIV/AIDS M&E framework for the health sector. Monitoring will be based on the already existing cohort analysis as indicated in the HMIS quarterly report 106a.

The following indicators will be monitored for care and treatment:

Cross sectional
1. No of active patients on ART disaggregated by DSDM
2. No of active patients on ART achieving viral suppression disaggregated by DSDM
3. No of active patients newly enrolled in each DSDM approach within the reporting period

Frequency of reporting: Quarterly using HMIS 106a

Source document:

- ART register
- OpenMRS
### Table 22. Quarterly C&T Reporting by Models & Approaches

<table>
<thead>
<tr>
<th>Models</th>
<th>Approaches</th>
<th>Active on ART</th>
<th>Active on ART achieving viral suppression</th>
<th>Active on ART newly enrolled onto approach</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facility Based</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>D1</td>
<td></td>
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<tr>
<td></td>
<td>D2</td>
<td></td>
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<tr>
<td></td>
<td>D3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Community Based</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>D4</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>D5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
10.2.6 Data flow for DSDM

Figure 19. Data Flow for Differentiated HIV Treatment and Care
Figure 20. Drugs (ARVs) Data Flow Chart

In the Facility:
- **FBIM**
  - Clinician prescribes on HIV care/ART card

- **FBG**
  - Triage nurse records in HIV care/ART card
  - ARV Dispensing Log at dispensing window
  - ARV report and Order form

- **FTDR**
  - WAOS (HF or District)

In the Community:
- **CCLAD**
  - CCLAD Form
  - Clinician prescribes in HIV care/ART card

- **CDDP**
  - Prescription list
10.3 Key Considerations for Successful M&E of DSDM

- Correct and proper documentation should take place at the Triage desk for all clients coming into the facility.
- For clients coming for drug refills only, their next appointment scheduling must be done and documented at the triage desk.
- For VL suppression reporting, the most recent VL done for the client will be reported.
- For all clients in the community DSDMs, the ART card and ART register must be updated.
- While health facilities will innovatively implement the various DSDM approaches as outlined in the flow chart, for M&E purposes only the differentiated flow will be reported on given that the other approaches fit into them.
- LOST clients will not be part of the quarterly reporting.
- The reporting is aligned to HMIS 106a which stops at 72 months and which does not disaggregate for age.
- For clients that may cross over into another DSDM, the most recent/current model is what will be reported.
- All unstable clients will be in the Comprehensive clinical evaluations DSM.
- Clients who come for routine or scheduled clinical evaluations remain in their DSM (or should be counted within that DSM). However, if the client becomes unstable then he/she is transferred to another DSM.
- To disaggregate by age or to acquire missing information, surveys may be conducted.
- Another area for surveys may be reasons for crossing over.

10.4 Evaluating DSD Implementation

The 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.

10.4.1 Process evaluations

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

Examples of Process Evaluation Questions:

- Was DSD scaled-up and implemented as planned? Why? What worked? What did not work?
- How are M&E, program/clinical, and lab staff working together to review and use DSD data on HTS, treatment and care performance?
- Were staff adequately trained or oriented to use data to monitor clients on DSD?
  - Was there adequate support for DSD implementation (including providers at sites, lab transporters, lab technicians, and M&E staff)?
- Which models of HTS 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?
10.4.2 Outcome evaluations

The outcome evaluations shall be conducted to determine program effectiveness. They require the collection of baseline data from which to measure change and therefore should be planned before or during the early stages of DSD implementation. If the MOH/ACP begins an outcome evaluation mid-way through implementation, it will not be able to answer critical questions due to limited or poor quality baseline data. By planning ahead, the program together with the sites and regional teams can 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 are the best practices to ensure patients on DSD receive VL testing and results in a timely fashion, understand VL results, and receive adherence counseling 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 counseling and support, changed as a result of DSD?
- What are the optimal DSD models of enhanced adherence counseling to ensure patients are adhering to HIV treatment and are virally suppressed?
- How well do self-reported adherence rates predict viral suppression under the DSD?
- How has the implementation of DSD impacted 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.

10.4.3 Operations Research

Examples of the 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, enrollment on ART, retention, treatment outcomes.
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 lab monitoring for various populations – for example, more frequent virologic monitoring for pregnant women or pediatric populations.

10.5 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, RPMTs, 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 analyze and compare the review data routinely
- Health facilities and communities should also track the outcomes and costs of delivering differentiated services.

**Clinical Officer/Nurse at the HIV Clinic**

- Update the clinical encounter form on the HIV care/ART card
- Update the Patient Categorization Checklists/Screening tool
- Complete the ART prescription forms
- Participate in data review meetings for the HIV clinic
- Participate in quality improvement review meetings

**Lay Health Worker**

- Complete the ARV Medicines and Dispensing Log/Distribution Form
- Complete the ART Refill Register
- File the ART Distribution Forms in the individual patient files

**Pharmacist/Pharmaceutical Technologist**

- Complete the appointment diary tool for ART refills
- Track ART refill appointments with the appointment diary tool
- Report missed appointments, lost to follow ups and defaulters to initiate defaulter tracing

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

- Mentor lay health workers on data entry into the ART Distribution Forms and ART Refill Register
- Conduct ART data aggregation from the ART Refill Registers/UGEMR in line MoH Reporting Requirements
- Conduct and facilitate monthly data review meetings at the facility level
• Conduct DQA and harmonization between Differentiated Care Facility Summary Form, ART Refill Registers and the ART Distribution Forms
• Liaise with the district HMIS focal point and ensure consistent supply of data tools at the facility
• Ensure timely submission of summary data reports are submitted to the DHOs office for entry into DHIS2 on time

**MoH and Implementing Partners’ Strategic Information Units**

- Collate EMR data nationwide into the national Data Warehouse
- Conduct quarterly analysis of DSD indicators
- Offer TA to implementing partners, HCWs at the health facility level and county/sub-county on implementation of DSD
- Lead the process of review for primary data collection tools, registers and summary HMIS tools
- Support district and national data reviews and make evidence based recommendations for program improvements

**References**

1. A Toolkit for Health Facilities Differentiated Care for HIV and Tuberculosis, November 2015 Geneva, Switzerland
3. The WHO Consolidated strategic information guidelines for HIV in the health sector
11 APPLICATION OF QUALITY IMPROVEMENT STRATEGIES IN DIFFERENTIATED SERVICE DELIVERY

11.1 WHAT IS QUALITY?

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 Damming’s definition of quality as: doing the right things, in the right way, at the right time.

11.2 WHAT IS QUALITY IMPROVEMENT?

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

11.3 WHY 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 these national guidelines on DSDM, 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.

11.4 BENEFITS OF QUALITY IMPROVEMENT

Figure 21. Benefits of QI

**Benefits for providers**
- Cultivates teamwork and effective communication
- Improves staff motivation

**Benefits for clients**
- Reduces morbidity and mortality of clients
- Enhances client satisfaction – provides care that is responsive to clients’ and communities’ needs and expectations

**Benefits for the health system**
- Reduces health care costs and waste of resources
- Improves safety of staff, clients and communities
- Provides good reputation of health institutions and health workers
11.5 **Principles of Quality Improvement**

- **Client focus**
  - DSD models are tailored to the client’s needs and expected benefits.

- **Teamwork/collaboration**
  - This approach brings together actors from across the health care process (e.g., laboratory, community, nurses, midwives, etc.)

- **Use of data for quality improvement**
  - Sites need to know where they are in terms of the care they are currently providing and what result they are getting now, and what they will get when they implement DSD. They need to collect data to see if patients are better with the current process or DSD. They must also check if there’s been a change, not only in numbers, but in the experiences and client perspectives.

- **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 model to identify areas of improvement, identify projects to address gaps, and promote best practices.

11.6 **Steps for Implementing a Quality Improvement Project**

- **Step 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

- **Step 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 on the basis of scale, ease of addressing, etc.

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

- **Step 4: Plan, Do, Study, Act**
  - 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.

### 11.7 Quality Indicators for DSD

The indicators are categorized for each differentiated service (HTS, treatment and care) by:
- Input
- Process
- Outcome

**Table 23. HTS quality measures**

<table>
<thead>
<tr>
<th>Category</th>
<th>Measures</th>
<th>Definition</th>
<th>Data Source</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Input</strong></td>
<td>Supplies, Logistics, Human resources</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Process</strong></td>
<td>Proportion of index HIV clients whose family members and partners are tested for HIV</td>
<td><strong>Numerator</strong>: # of index HIV clients whose family members and partners are tested for HIV. <strong>Denominator</strong>: Total number of index HIV clients with documented family members and partners.</td>
<td>Family tracking tool</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Proportion of targeted outreaches (stand-alone and integrated) conducted for all key and priority populations.</td>
<td><strong>Numerator</strong>: # of stand-alone or targeted outreaches conducted for key populations e.g. sex workers, truckers, MSM. <strong>Denominator</strong>: # of total HTS outreaches conducted.</td>
<td>ANC register; HTC register</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Proportion of tests done following national algorithm</td>
<td><strong>Numerator</strong>: # of tests done following national algorithm. <strong>Denominator</strong>: # of total HIV tests done.</td>
<td>Daily activity consumption log (HMIS 055a)</td>
<td>Monthly</td>
</tr>
</tbody>
</table>
### Table 24. Treatment and care quality improvement indicators

<table>
<thead>
<tr>
<th>Category</th>
<th>Indicator</th>
<th>Indicator Definition</th>
<th>Data Source</th>
<th>Frequency</th>
</tr>
</thead>
</table>
| Input    | • Supplies/commodities  
          • Logistics  
          • Human resources |                     |             |           |
| Process  | Proportion of clients who missed appointments (disaggregate by DSDM) | Numerator: # of clients who missed appointments (disaggregate by DSDM)  
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.  
Denominator: Total # of clients on ART | ART register | Annually |

### 11.8 Ingredients for a Successful QI Application

- Leadership support:
Team formation:
- Review your current team composition and ensure that the implementation process includes all the DSDM key actors (e.g., clients, peer leaders, community leaders, etc.)

Functionalize the team:
- Hold regular meetings to review progress on improvement
- Active documentation of projects/activities/data
- Reporting and dissemination

Coaching and mentorship:
- District and site level teams should receive regular coaching and mentorship (internal and external)

11.9 QI ROLES AND RESPONSIBILITIES

Continuous quality improvement approach shall be used to improve provision of HIV care and treatment in the DSD models both at the health facility and community levels.

Health facilities should:
- Ensure functional QI committees, 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 project selection.
- Routinely, on monthly basis, review performance, discuss progress, and update journals
- Implement QI projects and innovations to improve service delivery
- 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

Implementing partners, District Health Officers, and health facility in-charges should endeavor 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 like the health sector QI Framework, HIV services Indicators manual etc.
- Functionalyze 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
12 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.

12.1 WHAT IS SBCC IN THE CONTEXT OF DSD?

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.

12.2 WHY IS SBCC NECESSARY 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.

12.3 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 5 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:

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.
12.4 The Communication Plan

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

12.4.1 Purpose

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

12.4.2 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 audience.
3. To encourage implementers to integrate SBCC at all levels of DSD.
4. To create an environment for leadership support and sustainability.

12.4.3 Guiding Principles

SBCC interventions will be based on the following principles:

- **Participation and community ownership** so the community members are empowered to decide their own messages and become agents for behaviour change.
- **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.
- **Simplicity and specificity** so that messages and channels are simplified to the level of the respective audiences for easy comprehension.
- **Partnerships** to allow collaboration and complementation of activities among stakeholders and increase audience reach.
- **Evidence-based** so that adequate data is gathered about each audience and their perspectives are incorporated.

12.4.4 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.

12.4.5 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 25. Communication Plan

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

12.5 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 26. M&E indicator examples

<table>
<thead>
<tr>
<th>Communication Objectives</th>
<th>Example of Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To provide information about DSD</td>
<td>Knowledge indicators</td>
</tr>
<tr>
<td>• To educate the audience about benefits of DSD</td>
<td>% of individuals who know about DSD and its benefits</td>
</tr>
<tr>
<td>• To encourage individuals to seek and demand for DSD</td>
<td>Attitude indicators</td>
</tr>
<tr>
<td></td>
<td>% individuals who believe that DSD is beneficial</td>
</tr>
<tr>
<td></td>
<td>Behavioural indicators</td>
</tr>
<tr>
<td></td>
<td>% of individuals who adopt DSDMs</td>
</tr>
</tbody>
</table>
13 ANNEXES

13.1 ANNEX 1: TOOLS, SOPs AND JOB AIDS

- Site readiness assessment checklist
- Drug pick-up lists
- Eligibility criteria for DSD clients
- Eligibility criteria for community-based treatment and care models
- Additional tasks for differentiated drug delivery
- SOP: Client flow
- Client flow template
- Group Refill Monitoring Form
- ART register
- Stock cards
- ARV Order form
- HIV Care Card/ART Card
- Daily Activity Register for VL
- ARV and Medicines Dispensing Log
- Patient Appointment Book
- DSD Facility Aggregation Form
- Data abstraction SOP
- Customer Satisfaction Survey
- Open MRS
- Poster that defines the various differentiated service models for client reference
- SOPs to guide data collection and analysis process
- SOP: How to manage ARV Adherence Clubs
- SOP: Group formation SOP
13.2 ANNEX 2: ROLES AND RESPONSIBILITIES IN THE IMPLEMENTATION OF DIFFERENTIATED SERVICE DELIVERY

A) National Level – ACP/Community department
1. Develop and cost the implementation plan to determine what resources are required and/available. Finances, HR, drugs 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:
   o National level: Stakeholders meeting involving, MoH Leadership, all the District Health officers and municipal health officers, IPs, medical councils, etc.
   o Facility and community level: HUMC Chairperson. PHAS, All Facility staffs.
   o 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.
   o Support implementation of DSD models using CQI approach through capacity building at national, district, and facility levels
4. Monitor and evaluate the implementation
   o The monitoring can be done by use of meetings quarterly and reports submitted to DHO and then MoH. Establish M&E indicators that will be used to assess performance.
5. Track and Determine any changes in the course of action that may be needed in the implementation
6. Conduct technical support supervision and over sight

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:
   o 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, CAO, DCDO, PHA Networks. All facility-in-charges.

C) Health Facility Level
1. Identification of a lead person in charge of the introduction and coordination's 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 differentiated care to staff and clients.
4. Conduct the following analyses before starting:
   o 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
   o 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.
13.3 ANNEX 3: 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.

Implementation considerations

Management

- Reviewing capacity of existing staff to provide differentiated care
- 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
- Health facilities should embrace the recommended task shifting and task sharing of activities
- Deploy staff appropriately to the ART clinics and avoid unnecessary absenteeism through implementation of staff performance management
- Appropriate delegation if need arises
- Organize routine meetings to review workload and ensure that staff deployment is related to workload
- Ensure that staff rotations do not negatively affect DSDM implementation
- 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 favoring the same individuals
- 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.
- Ensuring adequate communication to staff and clients about differentiated service delivery models – via signboards, leaflets, or wall posters among others
- Client (including health worker) surveys
**Capacity building**

- 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
- Promote peer to peer mentorships and sharing of what works during providers’ interaction
- Capacity building/training. The HF teams together with DHO/IPs should:
  - Select training participants according to the selection criteria described in the scale up plan 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 scale up plan)
  - Ensure timely supervision of HCWs and lay providers including aiding them to carry out their tasks
  - Train staff to conduct group-counseling 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 27. Cadres and the designated services they can provide*

<table>
<thead>
<tr>
<th>Cadres</th>
<th>Doctor/ Clinical Officer</th>
<th>Nurse/ Midwives</th>
<th>Trained Nursing Assistants</th>
<th>Pharmacists/Pharm Technicians/Dispensers/Nurses/storekeepers</th>
<th>Lab Technicians/ Lab Assistants/ Pharmacy Technicians</th>
<th>Mentors MTCT-01 (MTCT-02)</th>
<th>MDG/FBO/CSOs working with PLHIV</th>
<th>Health Information Assistants/Data Clerk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive clinical services including, NACS, symptom screening for NCD’s, TB, STIs and hepatitis</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Prescription of ART, initiation and follow up for adults, adolescents and children</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Switching and substituting ART regimens by a multidisciplinary ‘switch team’</td>
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<tr>
<td>Management of complicated case (e.g. CCM; second line treatment failure etc.)</td>
<td>X</td>
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<tr>
<td>TB initiation of smear or gene X-pert positive cases for adults, adolescents and children</td>
<td>X</td>
<td>X</td>
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<tr>
<td>TB initiation for adults and adolescents requiring CXR interpretation, and for children where no sputum is available</td>
<td>X</td>
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<tr>
<td>HIV testing services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Service Provider</td>
<td>Doctor/ Clinical Officer</td>
<td>Nurse/ Midwives</td>
<td>Trained Nursing Assistants</td>
<td>Pharmacists/ Pharm Technicians/ Dispensers/ Nurses/ Storekeepers</td>
<td>Lab Technicians/ Lab Assistants/ CBOs/ CSOs working with PLHIV</td>
<td>Health Information Assistants/ Data Clerk</td>
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<tr>
<td>Health Education</td>
<td>X</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Registration and filling of appointment diaries</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Performing vital signs (triage)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>DBS, VL sample collection, testing and results delivery</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Coordinating and supervising the community groups</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Linkage facilitation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>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</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>ART preparation and adherence counselling for adults, adolescents, children and pregnant women including treatment failure</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Defaulter tracing</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Client records management/data entry &amp; updating registers (for area of service)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Phlebotomy</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Reporting on community activities/client groups, support; coordinate and supervise their peers</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Community – facility referrals and vice versa</td>
<td>X</td>
<td>X</td>
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</tbody>
</table>

*These service providers will be supervised while undertaking these tasks*