Circle of Hope

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CDC
CENTERS FOR DISEASE
CONTROL AND PREVENTION

PEPFAR

Community Post Model

PARTICIPANT'S GUIDE

TRAINING MANUAL AND TOOLS FOR
IMPLEMENTING THE COMMUNITY POST MODEL

Epidemic Control 90/90/90 (EpiC 3-90) (2017-2022) is a five-year initiative in Zambia funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the Centers for Disease Control and Prevention (CDC). EpiC 3-90 is implemented by Catholic Relief Services (CRS), in coordination with the Ministry of Health (MoH), and with partners Churches Health Association of Zambia (CHAZ) and Chreso Ministries. The project aims to strengthen the capacity of faith-based organizations (FBOs) to accelerate a comprehensive and integrated approach to providing HIV/AIDS/TB/STI Care, Treatment, and Prevention Services, in pursuit of the UNAIDS Fast Track goals for epidemic control: 90% of all people living with HIV (PLHIV) know their status; 90% of those diagnosed receive sustained antiretroviral therapy (ART); 90% of all people receiving ART have viral suppression. EpiC 3-90 contributes to comprehensive HIV/AIDS service delivery by supporting health facilities to improve HIV prevention, treatment, and laboratory services; strengthen key health system functions and structures to deliver quality HIV services; and promote the strategic collection and utilization of health information to improve HIV service delivery.

Cover photo by Georgina Goodwin for CRS

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Acknowledgments

Acronyms

ART	Antiretroviral Therapy
ALHIV	Adolescents Living with HIV
AYFS	Adolescent and Youth Friendly Services
CAF	Charities Aid Foundation
CDC	Centers for Disease Control and Prevention
CHAZ	Churches Health Association of Zambia
CHW	Community Health Worker
CoH	Circle of Hope
CP	Community Post
CRS	Catholic Relief Services
DA	Data Associate
DBS	Dried Blood Spot
DSD	Differentiated Service Delivery
EAC	Enhanced Adherence Counseling
EID	Early Infant Diagnosis
ELMIS	Electronic Management Information System
FBO	Faith-Based Organization
FCI	Faith Community Initiative
FIFO	First In First Out
GBV	Gender-Based Violence
HTS	HIV Testing Services
IEC	Information Education Communication
IP	Implementing Partner
IT/ICT	Index Testing/Index Case Testing
ITT	Interruption in Treatment
MCH	Maternal Child Health
MLS	Medical Logistic Supply
MMD	Multi-Month Dispensing
MoH	Ministry of Health
MUAC	Mid-Upper Arm Circumference
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PITC	Provider-Initiated Testing and Counseling

PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PNS	Partner Notification Services
PrEP	Pre-Exposure Prophylaxis
PSS	Psychosocial Support
SBCC	Social Behavior Change Communication
SNS	Social Network Strategy
STI	Sexually Transmitted Infection
TB	Tuberculosis
TPT	TB Preventive Therapy
U=U	Undetectable = Untransmittable
VL	Viral Load
VLS	Viral Load Suppression
WCC	World Council of Churches
VLS	Viral Load Suppression
WCC	World Council of Churches

Introduction

FAITH-ENGAGED COMMUNITY POSTS IN CONTEXT, 2018-2022

Historically, UNAIDS had set forth global Fast-Track 90-90-90 targets to achieve by 2020: 90% of people living with HIV (PLHIV) to know their HIV status; 90% of people who know their status to be on treatment; 90% of people on treatment to have viral load suppression. By the end of 2019, fourteen countries across three regions achieved these targets. Yet there were still significant gaps in achieving the 90-90-90 targets.

In Zambia, during the course of the PEPFAR Epidemic Control 90/90/90 Project (see Preface), a plateau was observed in the uptake of HIV treatment: only an estimated 70% of PLHIV were accessing ART with low coverage among children, men, and young adults. Challenges emerged in ineffective targeting for testing (with low community positivity rates); failures in efficiently linking individuals testing positive to treatment; and inadequacies in initiating ART quickly. In light of the need for renewed efforts to identify PLHIV and efficiently link them to treatment, CRS and its local partner Circle of Hope (COH) in Lusaka Urban District designed and piloted the Faith-Engaged Community Post (CP) model. The CP model gained attention when COH exceeded its testing and treatment targets by more than any other partner, with success in closing gaps for men, women, youth, and children. After site visits and data review, the success of the CP model emerged as a best practice to address challenges in case identification and treatment scale-up.

The next set of UNAIDS 95-95-95 targets aims to end the AIDS epidemic by 2030: 95% of people living with HIV knowing their HIV status; 95% of people who know their status being on treatment; and 95% of people on treatment having suppressed viral loads so that at least 86% of PLHIV will have viral load suppression. Achieving these targets requires HIV testing for the majority of PLHIV, initiating PLHIV on treatment, and ensuring their adherence to and continuity of treatment.

From 2019 through 2022, the success of the Zambia COH Faith-engaged Community Post model led to its promotion as a PEPFAR Solution[1], expanded support and evaluation during the PEPFAR Faith and Community Initiative, scaling within government-supported facilities in Zambia, and successful replication in Zimbabwe.

FAITH-ENGAGED COMMUNITY POSTS AND PEPFAR'S FIVE-YEAR STRATEGY, DECEMBER 2022 AND BEYOND

PEPFAR's 5-year strategy, *Fulfilling America's Promise to End the HIV/AIDS Pandemic by 2030 (December 2022)*, sets a bold vision for ending HIV/AIDS as a global health threat. The Strategy emphasizes the pivotal role that faith and community leadership play in ensuring success and sustainability of the Strategy, particularly since in most countries with high HIV burdens, 60-75 percent of the population regularly attends religious services [2]. The Strategy also emphasizes the priority of closing 1st 95 equity gaps in priority populations, such as AGYW, youth, children, key populations, and in many high burden countries, men.

1. PEPFAR Solution: https://www.pepfarsolutions.org/solutions/2019/9/30/circle-of-hope-using-faith-based-community-outreach-posts-to-increase-hiv-case-finding-linkage-and-retention-on-treatment-in-urban-and-rural-settings-in-zambia
2. Pew-Templeton Global Religious Futures: http://www.globalreligiousfutures.org/.funding in FCI

PEPFAR's collaboration with faith and traditional community leaders and Faith-Based Organizations (FBOs) helps accelerate 95-95-95 treatment targets and the new UNAIDS 95% combination prevention target -- which aims for 95% of PLHIV to be engaged in evidence-based combination prevention.

PROGRESS IN CLOSING EQUITY GAPS

Through collaborations with FBOs and faith and traditional leaders, the Faith-Engaged Community Posts model helps optimize HIV testing and assure continuing care. This model overcomes key barriers to seeking care, including cost of travel, poor customer care, distance, time spent in facilities, and stigma.

Zambia's and Zimbabwe's, Faith-engaged Community Posts (CPs) support decentralized person-centered care by faith-engaged staff through CPs located in hotspots. This program reaches more men than the Non-Faith-Engaged CPs, to close gaps in the 1st 95 (Fig. 2); In men, viral load suppression was greater in the Faith-Engaged CPs (94.8) than in Non-Faith-Engaged CPs (90.4). Faith-engaged CPs also show higher performance in AGYW, adolescent boys and young men, women, and children than the comparison models.

THE COMMUNITY POST MODEL

The Community Post (CP) Model is a community model of care designed to expand HIV services by improving the efficiency and efficacy of HIV case finding, linkage to treatment, and continuity of treatment in care. It focuses on identifying PLHIV and linking them to same-day ART initiation. First envisioned and developed for the Zambian context by Circle of Hope (CoH) with support from Catholic Relief Services (CRS), the model decentralizes HIV service delivery, including HIV testing; comprehensive HIV care and treatment, including differentiated ART delivery models; and HIV prevention services, from ART facilities to static CPs. The CP model aims to harnesses community platforms — such as churches, markets, and bus stops — and resources to deliver more accessible HIV continuum of care services and alleviate the burden on overwhelmed health systems in high HIV burden countries. The model is designed to address the time, resource, and stigma constraints of accessing HIV treatment and care from traditional clinic settings.

Critical elements of the model's success are its acceptability by individuals, the location of the CPs, the stakeholder engagement of the local community and faith leaders, and the selection of local community health workers (CHWs) who know the geographic and social terrain of the surrounding community. The model has been successful
in increasing case identification among those at high risk of HIV through targeted HIV testing strategies, in particular index case testing and partner notification improving linkage to treatment rates; improving continuity of treatment in care and viral load suppression; and increasing access to hard-to-reach populations, such
as men, adolescents, and female sex workers. The model generated quick wins in Lusaka: case identification among those at high risk of HIV increased; linkage to treatment rates improved; continuity of treatment in care and viral load suppression improved; and access to hard-to-reach populations increased, specifically men and adolescent boys and young men. The model is being expanded in Zambia and beyond, with Community Posts established throughout Zambia, as well as in Nigeria and Zimbabwe. The Community Post Model training package and accompanying tools aim to support further scale-up of this model as a strategic approach to ending HIV/AIDS as a public health threat by 2030.

TRAINING CURRICULUM PACKAGE

The CP Model training package consists of a Facilitator's Guide with presentations to provide orientation and training to various CP stakeholders. This CP Model Participant's Guide is part of the CP Model Training Package and complements the content delivered through CP Model Facilitator's Training Guide. The content of this guide corresponds to the different modules in the Facilitator's Training Manual. It is designed to provide training participants with tools to support planning for scale-up, implementing, and monitoring the CP model in different contexts following the training. While some users may utilize the training and tools to support expansion of the CP model to additional sites in Zambia, others may use the training and tools to initiate the model for the first time in a new country. The tools in this Participant's Guide are designed with flexibility to support adaptation of the CP model in different contexts.

Each module of this Participant's Guide contains a brief summary of the key messages from the corresponding module in the training. This guide is not exhaustive, and does not cover every intervention or aspect of an intervention that could be useful. It provides various resources for scaling up and implementing the CP model.

MODULE 1:
Introduction and Overview of the Community Post Model

INTRODUCTION

Module 1 describes the context of the local HIV epidemic (Zambia) and the contextual challenges in achieving epidemic control, including the six key barriers to HIV service delivery. The module provides an overview of the CP model, including a description of a CP; the CP model's three-pronged response strategy; and the core values and principles of the CP model, known as the RECIPE. Module 1 provides an overview of the process of setting up a CP from stakeholder engagement to mapping for strategic site selection, securing infrastructure and supply needs, and identifying the CP team. It summarizes the strategies that CPs employ for case identification, treatment and viral load suppression, staff capacity building, and ongoing team motivation. Finally, Module 1 discusses some of the key successes of the CP model in Zambia, and presents data on these successes. Module 1 of the Participant's Guide includes tools to support implementation of this content.

KEY MESSAGES FROM MODULE 1 INCLUDE:

- In Zambia, the CPs address critical gaps in HIV service access, including HIV testing, ART coverage, and VLS, in particular for underserved and high-risk groups, such as men, children, adolescents, and female sex workers.
  - In each context there are key barriers to service delivery, including demand-side and supply-side barriers; the CP model aims to address these key contextual barriers.
  - CPs have been successful in improving case identification and linkage to ART, in particular among men and adolescents.
- The CP entails a three-pronged approach designed to address these gaps:
  - Decentralized service delivery: CP services are conveniently located closer to the community — thereby addressing important barriers to service access.
  - Strategic partnerships: establishing and operating CPs requires engaging community members as key stakeholders and leveraging community assets, which build trust.
  - Core values (RECIPE): critical to addressing key barriers to HIV service access and an integral part of CP model implementation.
- The RECIPE core values are embodied in the day-to-day implementation of the CP at all levels and are critical to its success.
- This module discusses the various steps involved in establishing and implementing a CP, including the preparatory steps, as well as the service delivery strategies and monitoring of service delivery within the CP.
  - High-level steps for CP model implementation include stakeholder engagement, mapping for strategic site selection, securing infrastructure and supply needs, identifying the CP team, employing diversified case identification strategies, adopting sustainable treatment and viral suppression strategies, CP staff capacity building and mentoring, ongoing team motivation, and ongoing monitoring.

1.1 KEY BARRIERS TO HIV SERVICE DELIVERY

DESCRIPTION

The training highlighted the key barriers to HIV service delivery that the original CP model addresses. This tool helps participants think through what the key barriers are to HIV service delivery in their own context and how the CP model can address these context-specific barriers.

USERS

This tool can be used for planning purposes for all audiences from IP and MoH during high-level planning to CP staff on the ground to think through context-specific barriers and how the CP will address these barriers.

CONTEXT-SPECIFIC KEY BARRIERS TO HIV SERVICE DELIVERY

DEMAND-SIDE BARRIERS	HOW THE CP MODEL CAN ADDRESS THESE BARRIERS

SUPPLY-SIDE BARRIERS	HOW THE CP MODEL CAN ADDRESS THESE BARRIERS

1.2 CP CONCEPTUAL FRAMEWORK

DESCRIPTION

The CP conceptual framework summarizes the key features of the CP model. It serves as a reference for the RECIPE and the key components of the CP model.

USERS

The CP conceptual framework can be a resource for all stakeholders from a CP staff member that references it for the components of quality customer care to a donor/agency/IP that is summarizing the different components of the CP model. The CP model is aimed at delivering quality customer care through its core values, or **"RECIPE" (responsibility, empathy, compassion, integrity, passion, and ethics),** which are critical to its operation and underpin its success. Linkage to care through community and faith-based structures mobilized through the model are also major elements. The model features service provision in non-stigmatizing settings, evidence-informed approaches to case identification, differentiated service delivery, innovative strategies for demand creation and linkage, and service delivery at high-volume, easily accessible locations.

1.3 CP STEP-BY-STEP COMMUNITY POST START-UP GUIDE

DESCRIPTION

The Step-by-Step Community Post Start-Up Guide provides an illustrative process for starting up the CP model in a new context. It is important to note that the process outlined is for illustrative purposes only. Each context is unique, and therefore has different requirements to secure government permission, as well as local stakeholders that must be engaged to establish buy-in and other contextually specific requirements in accordance with the health system.

USERS

Users of this tool include IPs, MoHs, or local agencies (CDC/PEPFAR/USAID/DOD) planning to start up the CP model in a new context.

STEP	NOTES	CONSIDERATIONS
PLANNING PHASE		
Step 1: Interest from a local agency (CDC/PEPFAR/USAID/DOD) or IP.	• Interest from an IP typically comes from learning about the CP model at a conference. • A local CDC/PEPFAR/USAID/DOD may have an interest to scale up the CP model in the particular context and let the IP know about it. • A local agency (CDC/PEPFAR/USAID/DOD). • may have learned about the CP model through a (virtual) conference and wants to scale it up in their own country.	• How was the CP model introduced in your context? • Are there opportunities for CP model expansion in your context?
Step 2: Lead IP receives funding from local agency (CDC/PEPFAR/USAID/DOD) to implement CP model.	• It is possible that more than one IP will support the scale-up of the model in a certain district or region, including sub-partners.	• Which agency is funding the CP model in your context? • Is there one or are there multiple IPs scaling up the CP model? • Which other IPs should be involved to support scale-up of the model (including sub partners)?
Step 3: Lead IP and local agency (CDC/PEPFAR/USAID/DOD) showcase the CP model to the MoH to achieve their approval and buy-in.	• Sometimes CoH gets involved in the advocacy process with the MoH in other countries.	• Who within the national government/MoH is the decision-maker for the CP model?

Step 4: IP secures the buy-in of the local decision-maker.	• This could be provincial or district official. • Often this is the most important/determining step in the process. Without the approval of these stakeholders in those contexts, it was not possible to move forward with implementation of the model. • This could be a state health secretary (e.g., Nigeria) or the city health director (e.g., Zimbabwe).	• Who is the key local decision-maker in your context?
Step 5: Selection of district or local IP to support scale-up.	• Once local permission or buy-in is established, the lead IP selects district IP(s) to support scale-up to new provinces/districts.	• Who are potential local or district IP(s) to support CP model scale-up in your context?
Step 6: District IP(s) conducts pre-scanning activities.	• This involves identifying the general communities where CP will be located. • Identification of parent health facilities. • Lead IP provides remote technical assistance for this process (with remote technical assistance from lead IP).	• What are the local protocols for this process?

PRE-IMPLEMENTATION/PREPARATION PHASE

Step 7: Lead IP/district IP engages with community leaders to establish their buy-in for the CP Model.	• Community leaders may include religious leaders, market executives, etc. • Emphasize the benefits of the CP model in accordance with interests. • For example, to cultivate the enthusiasm of market leaders, emphasize how the CP model can help keep members healthy and the economy going.	• Who are the key community leaders to engage in your context?
Step 8: Conduct site scanning and selection.	• This process is to identify specific locations (e.g., specific markets or bus stations, and the actual space to be utilized for the CP). • This process should include local community leaders.	• Are there local requirements for site scanning and selection?
Step 9: Secure infrastructure and supply needs.	• Once the location of a CP is identified, certain infrastructure and supplies are needed for start-up. • This may vary slightly in each context and in accordance with what is available. • To avoid stigma, the CP location is not branded.	• Consider any additional infrastructure or supply needs relevant to your context.
Step 10: Lead IP engages with other IPs.	• Affirm to IPs that the CP model will supplement their work so they don't feel threatened. • Highlight potential collaboration and partnerships.	• Who are the other IPs working in HIV service delivery to engage in your context?
Step 11: CP team recruitment.	• This includes the recruitment of the team leader, data associate, psychosocial counselor, and CHWs.	• Are there local processes for CP team recruitment? • Are there specific requirements/qualifications for CP staff to note?

Step 12: Lead IP conducts CP model training for different stakeholders and site activation.	• Training occurs once the CP team recruitment is complete. • Participants in the training may include CP staff and management; parent facility staff and management, IP, MoH at different levels; and community and faith organization participants.	• Who are the stakeholders that will attend a training in your context?
Step 13: Training of CP staff and site activation.	• CP and parent facility staff receive initial training that covers select modules, with emphasis on CP core values/RECIPE, Customer Care, Index Testing, and the Walk and Celebration Strategies.	• What is the context specific orientation, based on CP service package?

IMPLEMENTATION PHASE

Step 14: CP teams receive onsite mentorship.	• A mentor clinician, who is well-versed in the operational aspects of the CP model, works with the team leader/clinician for a week and provides mentorship around case identification, use of screening tool, index testing, and data collection /use/sharing. • The mentor clinician also helps the CP team to troubleshoot problems as they arise.	
Step 15: Service delivery.	• Employ diverse case identification strategies and linkage to HIV care or prevention. • Adopt sustainable treatment and viral suppression strategies.	• What service package can be offered in the CP: which additional services may be offered in the CP beyond the basic HIV testing, care and treatment services?
Step 16: Ongoing capacity building.	• Once established, CPs receive various ongoing training, mentoring, and support supervision to help them deliver quality services in pursuit of epidemic control. • Examples of ongoing capacity-building efforts include daily morning Pep talk, expert community health worker placement, CP team meetings, needs-based technical and refresher training, team leader meetings and performance reviews, quarterly award ceremonies, technical assistance visits, and CP WhatsApp group. • Trainings are typically organized by CP cluster, which are designated groups of CPs located in the same zone. Each cluster is comprised of approximately five to six CPs.	
Step 17: Ongoing monitoring and reporting.	• Occurs daily. • Includes data reviews. • Includes performance improvement strategies.	• What are the context-specific reporting requirements?
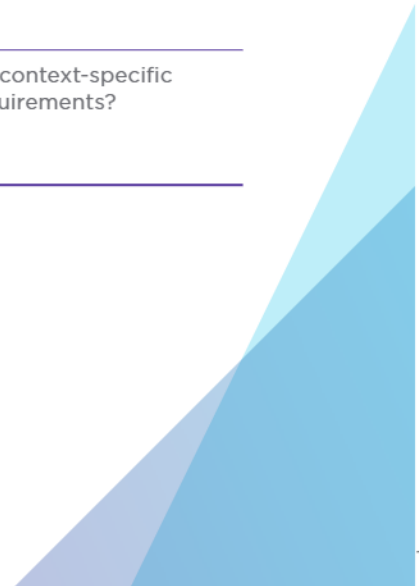
1.4 KEY STAKEHOLDER ROLES AND RESPONSIBILITIES

DESCRIPTION

This tool provides an overview of key stakeholders involved in implementing the CP model and a description of their potential roles. Depending on the context, stakeholders may take on different roles. For example, in some contexts, the MoH may take on the role of the lead implementing partner and spearhead implementation of the CP model.

USERS

This tool can be a resource for all stakeholders.

KEY STAKEHOLDER ROLES AND RESPONSIBILITIES	
Donor/local agency (CDC/PEPFAR/USAID/DOD)	• Decision to adopt and implement CP model. • Funds implementation of CP models by MoH and/or IPs. • Facilitates orientation of IPs on the model.

Implementing partner	• Work with all levels of the MoH to promote and reinforce the MoH ownership and capacity for scale-up and oversight of CP model.
	• Introduce CP model to community stakeholders and district health staff.
	• Train all stakeholders on CP model.
	  – Train parent-facility on CP model and oversight role.
	  – Train CP staff and ongoing capacity building (mentorship, coaching, and additional training).
	• Recruitment of CP staff.
	• Ongoing TA for parent/facility and CP staff.
	• Submit CP data to donor.

Ministry of Health	• Provide drugs/laboratory consumables through its supply chain systems. • Provide policy and guidelines. • Pay salary of MoH staff allocated at the CP. • Promote ownership of CP at lower levels.
Provincial Health Directorate	• Promote and take ownership of CP, including oversight role. • Include CP staff in relevant provincial level trainings (e.g., new policies and guidelines).
District Health Directorate	• Promote and take ownership of CP, including oversight role. • Include CP needs in supply chain system. • Include CP sample referral in sample referral system. • Include CP staff in relevant district-level trainings.
Parent health facility	• Ensure availability of necessary equipment, job aids/tools for CP. • Ensure availability of daily supplies (medications, commodities, test kits, registers, etc.) as per checklist for CP. • Function as referral facility for services not provided at the CP • Provide laboratory services (see Module 7). • Support sample referral and results communication.

Parent facility in-charge /ART coordinator	• Participate in community scanning process—identify location and infrastructure of site. • Foster relationship with community (e.g., neighborhood health, community health committees, or similar groups. • Provide regular oversight to ensure quality of service delivery • Data review/QI with CP staff and community stakeholders.
Community Post team leader	• Participate in scanning to identify CP location. • Ensure daily functioning of CP and quality of service delivery • Provide management, oversight, and leadership to CP staff, modeling RECIPE in leadership, management, and all interactions with clients and the wider community. • Provide daily pep talk to CP staff. • Provide clinical client care/service provision as per JD. • Regular data review; ensure implementation of improvement action plans.
Community Post staff: data associate (1); psychosocial counselor (1); community health workers (4+)	• Service provision as per JDs, embodying RECIPE in all interactions with clients and the wider community.
Community leaders/faith leaders	• Participate in monthly/weekly data review meetings, provide input based on client feedback. • Support demand creation: support community outreaches, continuity of treatment activities, community ART dispensation, faith-based initiatives. • Spread Messages of Hope within faith community - (see https://www.faithandcommunityinitiative.org/hiv). • In some cases, provide space for CP.

1.5 OVERVIEW OF TRAINING CONTENT FOR DIFFERENT STAKEHOLDERS

DESCRIPTION

This table provides an overview of the content of the CP model training and a summary of which training modules different stakeholders should receive. Within the table X indicates the modules that should be included in the training, while (X) indicates that a module is optional as a certain stakeholder may not need to receive that particular training module. For example, it would most likely not be necessary for community and FBO leaders to receive training on Monitoring and Reporting in the Community Post Model.

USERS

The user for this tool would be the Lead IP or MoH involved in orienting various stakeholders on the CP model and planning a CP model training. Some stakeholders may only need an introduction to the CP model, with other modules optional, as indicated in the table.

TRAINING CONTENT OVERVIEW AND SESSION PLANNING TABLE

	Session duration (min.)	CP staff	Parent facility/ CP mana-gement	Commu-nity/ faith leaders	National MoH	Prov./ Sub-Nat'l MoH	District/ MoH	IP	Donor agency
Module 1: Introduction to the Community Post Model.	120	X	X	X	X	X	X	X	X
Module 2: Critical Elements of the Community Post Model - RECIPE.	55	X	X	(X)	(X)	(X)	X	X	(X)
Module 3: Customer Care in the Community Post Model.	195	X	X	(X)	(X)	(X)	X	X	(X)
Module 4: Stakeholder Engagement in the Community Post Model.	70		X		(X)	(X)	X	X	(X)
Module 5: Community Post Site Selection and Preparation.	60		X		(X)	(X)	X	X	(X)
Module 6: Staffing and Capacity Building in the Community Post Model.	65		X		(X)	(X)	X	X	(X)
Module 7: Service Delivery in the Community Post Model.	55	X	X		(X)	(X)	X	X	(X)
Module 8: Finding and Linking Clients to Services in the Community Post: Case Identification and Linkage Strategies.	155	X	X	(X)	(X)	(X)	X	X	(X)
Module 9: Supporting ART Adherence, Continuity of Treatment, and Viral Load Suppression in the Community Post Model.	75	X	X	(X)	(X)	(X)	X	X	(X)
Module 10: Monitoring and Reporting of Community Post Performance.	85	X	X		(X)	(X)	X	X	(X)
Module 11: Addressing Community Post Model Implementation Challenges.	50		X					X	

1.6 BUDGET TEMPLATE

DESCRIPTION

This budget template provides a summary of anticipated cost line items for starting up and operating a CP. It is important to note that costs will vary, and even significantly in the case of salaries, in different contexts.

USERS

The user for this budget template would be the lead IP or the national or district MoH that is trying to estimate or plan actual costs of operating a CP. You may consider national MoH salaries plus a 10 - 20 percent markup.

DETAILS	UNIT COST	QTY	TOTAL	NOTES
RECURRING COSTS				
Clinical officer		1		CP team lead; responsible for day-to-day CP management and client care; gross salary per month.
Counselor		1		Responsible for client counseling and recording of services in registers; gross salary per month.
Data associate		1		Entering data at the CP; gross salary per month.
Community health workers		4		Stipends for CHW for community engagement and mobilization; per month.
Market office contribution		1		Market contribution toward electricity, water, levies, waste management, etc.
Talk time (phone airtime)		1		Program communication and follow-up to support continuity of treatment.
Transportation				Transportation of samples; transportation of staff from parent facility to CP, CHW to community.
Supportive supervision				Travel for regular supportive supervision and mentorship of CP staff by IP staff and parent facility.

EQUIPMENT AND SUPPLIES			
Tables/desks	3		Required for smooth operation of the program.
Chairs	8		Used by clinicians and counselors during client care.
Bench	1		Used for clients waiting to be attended to by the CP staff.
Cabinet (with lock)	1		To keep ARV and other drugs.
Examination couch	1		Used for clients' physical examinations.
Filing cabinet (with lock)	1		To keep clients' files.
Sphygmomanometer	2		Required for client management.
Thermometers	4		Required for client management.
Adult scale	1		Required for client management.
Baby scale	1		Required for client management.
Screens	2		Provide privacy in the provision of client care.
Stationery	1		Paper for printing clinical forms, suspension files, etc.
Stadiometer	1		Measuring client height.
Stapler	1		Required for management of files and forms.
Plastic water basin	1		Hand hygiene and infection control.
Waste bins	3		Waste management.
Stethoscope	1		Required for client management.
Fans	2		Room climatization.
Disinfectant	1		Infection control per month.
Sharp boxes	2		Used for storage of sharps, cotton wool; wastes per month.
Consumables	1		Lab supplies required to carry out tests at community per month (gloves, spirit, mutton cloths, etc.)
Computer	1		Computer for use by data associate for data management and reporting.

MODULE 2:
Critical Elements of the Community Post Model - RECIPE

INTRODUCTION

Module 2 describes the core values and principles of the CP model, known as the model's RECIPE. This module presents the CP model's conceptual framework and its different components. It also explores each component of the **RECIPE: Responsibility, Empathy, Compassion, Integrity, Passion, and Ethical**, and provides examples of each of these core values in action. The tool in Module 2 of this Participant's Guide serves as a reference for different audiences to remember the RECIPE.

KEY MESSAGES FROM MODULE 2 INCLUDE:

- The core values comprising the RECIPE are Responsibility, Empathy, Compassion, Integrity, Passion, and Ethics.

- The RECIPE underpins the success of the CP model. Instilling the core values embodied in the RECIPE across all stakeholders is a contributing factor to quality customer care, which is an important component of the model.

- The RECIPE helps to refocus and re-energize those providing critical HIV services around their role and purpose.

- Reflection on the core values of the RECIPE is part of the daily routine among CP staff and part of the daily morning inspirational pep talk.

2.1 SUMMARY OF RECIPE

DESCRIPTION

This tool is a brief summary of the CP model's core values, or RECIPE. The core values are a critical component of operating the CP and underpin its success. Each person involved in setting up, operating, and supporting the CP needs to understand and embody the core values in their daily work.

USERS

The users for this tool include anyone involved in setting up, operating, and supporting a CP.

CP MODEL CORE VALUES: THE RECIPE

Responsibility	• Everyone involved in implementing the CP model has a shared responsibility to improve and deliver quality services. • Identify challenges/gaps in delivering efficient HIV services (e.g., challenges in case identification, linkage, continuity of treatment, and VLS), own problems, and work collectively with colleagues and other stakeholders to address problems.
Empathy	• Bring an empathetic approach to each client. • Try to walk in the shoes of clients to understand his/her social, economic, psychological, and clinical health needs, and reflect on what kind of care he/she needs.
Compassion	• Compassion involves proactively helping someone with his/her challenges and needs. Think not only about the clinical needs of clients, but also their emotional and psychological aspects.
Integrity	• Integrity is the practice of showing consistent and uncompromising adherence to strong moral and ethical principles and values. • Integrity is key in all areas of service.
Passion	• Bring energy to work on a daily basis, including energy to serve for the good of others, serve clients with undivided attention, overcome new barriers and challenges, and sustain a high level of performance.
Ethical	• Respect and follow all guidelines and quality standards pertaining to service delivery, without taking any shortcuts. • Respect clients and co-workers, and enforce confidentiality.

MODULE 3:
Customer Care in the Community Post Model

INTRODUCTION

Module 3 defines customer care and its importance to the success of the CP model. It describes how poor customer care drives clients out of services. The module explains how customer care is put into action. It summarizes the critical competencies associated with good customer care as well as how to integrate building customer care competencies into staff training, coaching, and mentoring. Module 3 summarizes communication tips for providers, and describes how health providers can overcome personal stigma that affects customer care. Finally, Module 3 provides insight on sustaining and monitoring customer care.

KEY MESSAGES FROM MODULE 3 INCLUDE:

- Customer care is critical to the CP model RECIPE and achieving the 95-95-95 targets; clients must be at the centre of CP programming and activities.

  - Customer care is a process of looking after the client to ensure her/his satisfaction. It is practiced throughout the continuum of care, and involves the provision of services to the whole client in the right way, in a timely manner, and according to approved protocols/standards.

  - It is essential for management and leadership to model customer care in the way they manage and lead CP staff, and for CP staff to provide customer care to new and existing clients.

  - New ideas for customer care are generated by encouraging staff to generate these ideas, and promoting creativity and innovation around customer care.

- Critical competencies for customer care include strong communication skills, professional knowledge/ competence, humility, passion, flexibility and responsiveness, commitment, initiative, integrity, sound judgement, and resilience.

- It is important to understand what clients want and expect from services in relation to customer care.

- The CP model includes different mechanisms to monitor customer care and use information from customer care feedback loops to address any customer care issues.

  - Customer care assessment/feedback tools should be structured to assess customer care along the HIV cascade of care, the six barriers, and RECIPE. The team assesses gaps in any of these three elements, formulates remedial strategies, and sets timelines for measurement and review.

3.1 COMMUNICATION TIPS FOR PROVIDERS

DESCRIPTION

This tool is for CP staff to provide verbal and nonverbal communication and conduct tips in a CP context.

USERS

The users for this tool are service providers in CP. This list can also be used by supervisors to observe communication within the CP model.

General Communication	• Use multiple forms of communication, i.e., texts, phone calls, visits, gestures, or tokens (priority cards in which elderly and children are served first).
Verbal	• Practice two-way, interactive communication with clients; listen, avoid lecturing, and never use an aggressive tone or raise your voice.
Dress	• Dress appropriately for the setting, community environment, and to relate to clients.
Language	• Minimise the use of medical jargon and acronyms • Use local language, as appropriate, and even slang to facilitate understanding by clients
Listening	• Learn the art of listening to clients; allow clients to fully explain concerns/issues without interruption.
Attitude	• Show empathy to defaulters. • Listen and counsel.

3.2 RESOURCES TO ADDRESS STIGMA

DESCRIPTION

This tool provides a summary of how stigma and discrimination are addressed within the CP model and includes additional resources to provide training to CP staff and others involved in CP implementation.

USERS

The users for this tool are IP program managers planning and overseeing CP implementation and supporting CP staff who will offer stigma-free, welcoming services.

THE CP MODEL AND STIGMA REDUCTION

HIV-stigma and discrimination refer to prejudice, negative attitudes, and mistreatment directed at people living with HIV and AIDS. UNAIDS and the World Health Organization (WHO) recognize fear of stigma and discrimination as the main reason why people are reluctant to get tested, disclose their HIV status, and take antiretroviral drugs (ARVs)[I]. There is a relationship between stigma and HIV: people who experience stigma and discrimination become more vulnerable to HIV, while those living with HIV are more vulnerable to experiencing stigma and discrimination.

Stigma and discrimination affect PLHIV and HIV care outcomes in different ways:

- Self-stigma, or internalized stigma, refers to the negative consequences that result when people believe that stigmatizing public attitudes apply to them;
- HIV-related discrimination in health care settings ("health care stigma");
- Government policy stigma;
- Community- and household-level stigma.

Across sub-Saharan African, Zambia included, stigma and discrimination continue to constitute an important barrier to utilization of HIV prevention, care, and support and treatment services[II]. CoH lists stigma at the community, health care provider, and sectorial levels among the implementation challenges of the CP model. Stigma reduction is critical to ending AIDS. PEPFAR: Blueprint for Creating an AIDS-Free Generation, as well as the UNAIDS' HIV investment framework, cite stigma reduction as a key priority[III].

TO REDUCE STIGMA AND MITIGATE THE IMPACT ON CLIENTS, THE CP MODEL INCLUDES THE FOLLOWING APPROACHES.

To address <u>health care stigma:</u>

■ Coach, mentor, and train health care providers and CHWs.

To address <u>self-stigma or internalized stigma:</u>

■ Build capacity of and empower expert clients (PLHIV) among CHWs, community leaders, faith leaders.

To address <u>community- and household-level stigma:</u>

■ Invite community leaders to tour main CP facilities and offices, especially during scanning and at inception.

■ Provide CP services in buildings that are not branded as HIV health care facilities.

■ Involve local and faith leaders of respective communities in the dissemination of HIV messaging, including messages that address stigma.

■ Support community role models to demonstrate leadership by openly and publicly testing for HIV and providing testimonials.

■ Facilitate invitation of CP clinicians to community meetings to address and convey U=U messaging; provide additional training resources for stigma prevention and mitigation.

The following provide additional resources to address stigma within HIV programs:

1. Engender Health's *Reducing Stigma and Discrimination Related to HIV and AIDS:* Training for Health Care Workers. The course had a trainer's guide and participants' manual available in French and English. The training invites health workers to explore the root causes of stigma and prejudice, while helping them to understand their own attitudes toward HIV, AIDS, and people affected by these conditions, as well as how these attitudes can affect the care they provide. https://www.engenderhealth.org/pubs/hiv-aids-sti/reducing-stigma/

2. *Integrating Stigma Reduction into HIV Programming:* Lessons from the Africa Regional Stigma Training Programme: The toolkit helps trainers plan and coordinate training sessions with community leaders or coordinated groups, raise awareness, and encourage meaningful action to challenge HIV stigma and discrimination. https://www.iasociety.org/web/webcontent/file/integratingstigmareductionintohivprogramming_lessonsafrica_alliance.pdf

3. Washington, DC: Futures Group, Health Policy Project's *Facilitator's Training Guide for a Stigma-Free Health Facility: Training Menus, Facilitation Tips, and Participatory Training Modules:* This is a training guide designed to help facilitators promote "stigma-free" HIV services through training of health care facility staff. The facilitator's guide includes a set of educational exercises to raise awareness and promote advocacy and action to challenge HIV stigma and discrimination, in particular among key populations. https://www.healthpolicyproject.com/pubs/281_SDTrainingGuide.pdf

3.3 CUSTOMER CARE FEEDBACK GUIDE

DESCRIPTION

This tool provides an overview of client feedback and its importance in the CP model, and describes how this feedback is shared among staff and management to optimize CP model service delivery.

USERS

This tool can be used with multiple stakeholders at all levels to understand the different mechanisms for collecting feedback in the CP model, and how feedback is shared to improve CP and the overall model.

IMPORTANCE OF CLIENT FEEDBACK

Collecting feedback from clients and using this feedback to optimize services is key to delivering quality, patient-centered care. Providing different modalities for clients to provide [confidential and safe] feedback empowers clients to play an active role in their own care and communicate their experience. Client feedback provides critical insight regarding which aspects of community health post services are working well and which need improvement.

Client surveys	• Clients who are not adherence or IIT/defaulting are followed up, and feedback is solicited to better understand reasons for defaulting that may be related to the care experience in the CP and may be addressed through improved customer care. • **Annex 1** provide a list of sample questions.
Exit interviews	• Exit interviews can be conducted (by independent staff) on an occasional basis to obtain feedback from clients attending the CP, as well as from clients transferring out of the CP. • Clients can be randomly selected to provide feedback upon leaving the CP. • Exit interviews can also be anonymously conducted by asking clients to fill out a form and drop it in the suggestion box when leaving the CP. • See **Annex 2** for adaptable sample exit interview guides.
Suggestion boxes	• These consist of locked boxes located in waiting areas or outside clinics into which client can submit a piece of paper with private/anonymous feedback. These boxes provide patients with a confidential and safe mechanism to share feedback. Blank paper is currently used in the CP, but a standard printed format can also be used. • See **Annex 3** for a sample suggestion box feedback form.
Walk-throughs	• IP program staff observe service provision in the CP and assess and highlight key points about customer care. • This is when the clients walk into the CP to enquire about the services provided or give feedback.

MECHANISMS FOR COLLECTING CLIENT FEEDBACK IN THE COMMUNITY POST MODEL

The Community Post model harnesses a combination of mechanisms to capture client feedback in accordance with the setup and structure of different CPs.

MECHANISMS FOR SHARING CLIENT FEEDBACK IN THE COMMUNITY POST MODEL

Once client feedback is collected, it is shared with community post staff and management via multiple forums to address any concerns that emerge and optimize CP model service delivery.

Internal newsletters	• These are produced occasionally to highlight key achievements, changes and plans.
WhatsApp groups	• These are groups for all CP staff and CoH management that are used to communicate challenges and successes, including performance-related issues. In this way, other CPs are able to learn from other teams (see also Module 10).
Quarterly staff review meetings	• These meetings are held to review all aspects of CP operations.
Daily pep talk	• These are internal meetings at CP level that are used to prepare for the day and discuss any pending issues related to CP operation, client feedback, and targets. RECIPE values are emphasized during the pep talk.
Posting client survey results	• Shared with CP management to inform improvements in service delivery.

SUMMARY OF CLIENT FEEDBACK GUIDE RESOURCES:

Annex 1: Sample Client Survey

Annex 2: Exit Interview Questions/Sample Questionnaire

Annex 3: Suggestion Box Feedback Form

ANNEX 1: SAMPLE CLIENT SURVEY

THE SURVEY FOLLOWS THE HIV CASCADE OF CARE

1. Prevention

    • How satisfied are you with HIV prevention messages?

    • Have you noticed or received any HIV prevention messages from the CP or staff of the CP?

    • Have you been told about PrEP and how it works to prevent HIV?

    • Has anyone at the CP explained to you the benefits of HIV prevention?

2. Treatment

    • How are you treated each time you come to get your drugs?

    • Do the clinician and staff sufficiently explain the treatment regimen and adherence?

    • Do the clinician and staff ask you questions regarding how you are coping with treatment, side effects, etc.?

3. Continuity of Treatment

    • Does anyone at the CP check in on you from time to time through phone calls, texts, or visits?

    • Does anyone affirm your attendance to appointments?

    • What benefits have you experienced from adherence to treatment and appointments?

4. Suppression

    • Was your VL checked six months after commencing treatment?

    • Is your VL checked every year?

    • What benefits have you derived from having a suppressed VL?

HIV access barriers

    1. Location: how is the location and general environment of the CP?

    2. How much time do you usually spend in the CP?

    3. Do you experience any form of stigma at the CP?

    4. In your opinion, do CP staff collaborate in service delivery at the CP?

    5. Are you receiving any external support and/or information and encouragement from the community and faith leaders during your treatment journey?

    6. Are there any services you think the CP should add to its offering?

    7. How can we improve in our service delivery?

RECIPE

Questions around RECIPE are also asked in reference to the client experience at the CP.

ANNEX 2: EXIT INTERVIEW QUESTIONS/SAMPLE QUESTIONNAIRE

a. Exit Interview Questions:

QUESTION	RESPONSE
Are you happy with the services provided?	
Would you recommend the services provided to someone you know?	
How did the staff respond to your problems or questions?	
If you felt the service was excellent, what stood out or made it that way?	
If you felt that the service was poor, what stood out or made it that way?	
How much time did you spend in the facility/CP?	
In which department did you spend the longest time?	
In which department did you feel the most welcome, free, and at home?	
Were all of your needs, questions, and fears addressed during your last visit?	
In what areas do you think we can improve?	

b. Community Post Client Feedback Form

(Adapted from EGPAF's Adolescent and Young Client Service Feedback Form; this form can be completed anonymously and put in suggestion box)

Thank you for agreeing to give anonymous feedback on the use of health services at this Community Post. This information will be used to improve care provided at this Community Post.

This is a voluntary opportunity to give your views on the care received. We will not ask for your name or contact information.

Name of Health Facility: _____

Date: __mm_ / _dd_ / _yyyy_   Age: _____   Sex: ☐ Male   ☐ Female

Please complete the feedback questions from your perspective. If not applicable to you, mark "NA".

1. Why did you visit the clinic today?

_____

2. Why did you decide to visit this clinic?

_____

   If you have come to this clinic before, for how long have you been using services here?

   _____ months _____ years

3. How did you get to the clinic today?

_____

4. Did anyone accompany you at the clinic?   ☐ Yes   ☐ No

   a. Who?_____

5. What time did you arrive at the clinic? _____:_____ am / pm

6. Was the area outside the clinic clean?

   ☐ Very clean   ☐ Okay   ☐ Dirty

7. Was it clean inside the clinic?

   ☐ Very clean   ☐ Okay   ☐ Dirty

8. How were you greeted and welcomed into the clinic?

   ☐ Greeted at entry   ☐ No greeting or welcome

9. How long did you wait to be seen for your service? _____ hours _____ minutes

   a. How did you feel about the waiting time?

   ☐ Short waiting time   ☐ Just okay   ☐ Too long
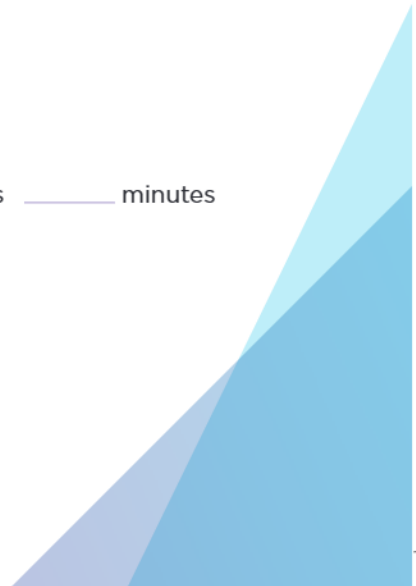
10. Was there any health information posted or available to you inside the community post?

☐ Yes ☐ No

11. Was there a list of patient's rights posted for you to see?

☐ Yes ☐ No

12. How many staff attended to you during your visit (clinician, counselors, community health worker, or volunteer)? _____ (number)

13. How would you judge the attitudes of providers who served you today?

☐ Very friendly ☐ Some friendly ☐ Okay ☐ Not friendly at all

14. Describe the service received today:
   a. Was the service room private? ☐ Yes ☐ No
   b. Did you feel comfortable while receiving the service? ☐ Yes ☐ No
   c. Were you assured of confidentiality? ☐ Yes ☐ No
   d. Was your medical history taken? ☐ Yes ☐ No
   e. Was your sexual history taken? ☐ Yes ☐ No
   f. Did the provider talk to you about HIV infection? ☐ Yes ☐ No
   g. Were you offered an HIV test for yourself or a family member? ☐ Yes ☐ No
   h. Were you provided counseling? ☐ Yes ☐ No
   i. Did the provider explain how to use the treatment? ☐ Yes ☐ No
   j. Did the provider give you a chance to ask questions? ☐ Yes ☐ No
   k. How long did the provider spend with you? _____ minutes

15. How much did your service cost? _____

16. What do you think about the cost?

☐ Cheap ☐ Affordable ☐ Expensive

17. Based on your overall experience, will you return to this clinic for services? ☐ Yes ☐ No

   a. Explain why or why not: _____

18. If a friend asked for health advice, would you recommend this service? ☐ Yes ☐ No

   a. Explain why or why not: _____

Thank you for your time and valuable insight! Please give this form back to the clinic or place it in a feedback box.

ANNEX 3: FEEDBACK FORM FOR SUGGESTION BOX

HOW WAS YOUR EXPERIENCE TODAY?

Very Satisfied   Somewhat Satisfied   Just Okay   Dissatisfied   Very Dissatisfied

Comments

MODULE 4:
Stakeholder Engagement in the Community Post Model

INTRODUCTION

Module 4 focuses on stakeholder engagement in the CP model. It provides an overview of stakeholder engagement in the CP model, and describes the steps that are typically associated with stakeholder engagement from a local agency's (CDC/PEPFAR/USG/DOD) or IP's initial interest in the model to inclusion of local stakeholders in site scanning. Module 4 highlights the importance of stakeholder buy-in for the CP model, and emphasizes the difference between buy-in and approval. This module discusses the importance of 1) acknowledging the key contextual barriers to HIV service delivery, and 2) emphasize how the CP model can address the barriers in a particular context when pitching the CP model to different stakeholders. The module provides overviews of two case studies of stakeholder engagement in Nigeria and Zimbabwe.

KEY MESSAGES FROM MODULE 4 INCLUDE:

- Stakeholder engagement is a first, critical step in introducing the CP model in a new context, and involves building relationships with different stakeholders at every level. Engagement should happen continuously.

- It is critical to secure stakeholder buy-in, which involves enlisting support and involvement to ensure the success of the model, as opposed to approval only.

- A powerful strategy to promote adoption of and win support for the CP model is to present the key barriers to HIV service delivery in a given context and explain how to CP model can address those barriers.

4.1 STAKEHOLDER ENGAGEMENT/KEY MESSAGES

DESCRIPTION

This stakeholder engagement tool helps IPs think through the different stakeholders from whom they need to receive permission and/or establish buy-in to implement the CP model and/or set up a CP.

USERS

Users for this tool include IP trying to implement for the first time or scale-up the CP model.

	SPECIFIC CONTEXT - SPECIFIC ENTITY	KEY MESSAGES / TALKING POINTS TO ADDRESS WITH STAKEHOLDERS
Advocacy to national MoH.	• [List who to engage].	• Data supporting the impact of the CP model. • Explain how the CP model addresses key barriers to HIV service delivery. • Clarify importance of engagement and role in scale-up.
Advocacy to local decision maker (district MoH, city authority, etc.)	• [List who to engage].	• Data supporting the impact of the CP model. • Explain how the CP model addresses key barriers to HIV service delivery. • Clarify importance of engagement and role in scale-up.
Advocacy to local community stakeholders.	• These could be faith leaders market executives, others.	• Emphasize the benefits of the CP model in accordance with interests (e.g., convince market executives of the CP health benefits on workers). • Emphasize one fight. • Explain how the CP model addresses key barriers to HIV service delivery and the role the community plays.
Other IPs working in the area.	• [List who to engage].	• Let them know that the CP model supplements their work so they don't feel threatened. • Highlight potential collaboration and partnership. • Emphasize one fight
Other.	• [List any other entities who should be engaged].	• [Identify purpose/messages for these entities]

4.2 LOCAL BARRIER ANALYSIS TOOL

DESCRIPTION

This tool helps stakeholders think through the context-specific demand and supply-side barriers, and how the CP model can address these barriers. This tool can be used to think through key messages for advocacy at all levels.

USERS

Users for this tool are any stakeholders trying to conduct advocacy and establish buy-in for the CP model.

EXAMPLE

LOCAL BARRIER TO HIV SERVICE DELIVERY	HOW THE CP MODEL CAN ADDRESS THE BARRIER
DEMAND SIDE	
Long distances and lack of time to seek and wait for services.	• CPs are conveniently located so that accessing services does not take a lot of time. • Fast-tracking ensures that clients don't encounter long wait times.
Cost of transportation to reach services and/or miss work.	• CPs are conveniently located near places of business so transport costs and missing time from work are less of an issue.
Stigma associated with accessing HIV services.	• CPs are not branded, and therefore provide access to services in a non-stigmatizing way.
SUPPLY SIDE	
Poor leveraging of relationship capital between community stakeholders (gate keepers) and clinic-based providers (silo mentality).	• The CP model is based on building relationships and achieving the buy-in of the community.
Poor customer care from service providers.	• The CP model is based on RECIPE and providing excellent customer care.
Competition among sector players and stakeholders at various levels limits coordination and effectiveness.	• Achieving buy-in and working with local and other stakeholders as part of the process to set up a CP helps to diffuse competition.

Use the table below to note barriers to HIV services delivery, including those with clients themselves (demand side) and those with the system (supply side). Then think through the key messages for stakeholders that explain how the CP will address these specific barriers in your context.

LOCAL BARRIER TO HIV SERVICE DELIVERY	HOW THE CP MODEL CAN ADDRESS THE BARRIER
DEMAND SIDE	
SUPPLY SIDE	

MODULE 5:
Community Post Site Selection and Preparation

INTRODUCTION

Module 5 focuses on community post site selection and preparation. It describes the purpose and process of site scanning and selection, as well as considerations when selecting the location and space for a CP. The module highlights the qualities of a successful site scanning process. Module 5 explains different aspects of site preparation, including the infrastructure and equipment necessary to set up a CP. It clarifies the roles of the parent facility lab and pharmacy in relation to the CP. Module 5 also presents different budget considerations for implementing the CP model.

KEY MESSAGES FROM MODULE 5 INCLUDE:

- A targeted and well-planned community scanning and site selection process, including engagement of the local community leaders, is important to identify strategic locations within a community to place a CP.

  - The purpose of site scanning is to assess the most strategic locations to set up the CP, gather information on local resources to potentially support the functioning of the CP, and introduce the model to community leaders (e.g., civic/political leaders, clergy, market chairperson, etc.), and engage them in identifying strategic positioning of the CP.

  - A technical site scanning team is formed and identifies and works with a local person in the target community who understands the area geographically and socio-culturally, and can walk with the site scanning team to assess different locations.

  - It is critical to communicate with, and enlist and work with the community, and community leadership, through the whole process.

  - Decisions on location of CPs are made following site scanning, submission of a field report, joint management and site scanning team review, and agreement on whether the location and existing infrastructure are appropriate/conducive to setting up a CP.

- A number of important criteria should be considered when selecting the location and infrastructure to establish the CP (Tool 5.4 Community Post Infrastructure Requirements and Features Checklist).

- Basic equipment must be made available (Tool 5.5 Community Post Basic Equipment Checklist).

- All necessary drugs, consumables, supplies, etc., are provided by the parent facility (Tool 5.6 Community Post Medications and Supplies Checklist).

- Budget considerations are discussed in this module. Budgeting for adequate logistical support is critical and includes transportation needs. (Tool 1.6 Budget Template).

5.1 COMMUNITY SCANNING PROCESS

DESCRIPTION

This tool describes the scanning process to select a community and site[s] to set up CP[s].

USERS

Users for this tool are IP, MoH and other stakeholders involved in the community scanning process.

COMMUNITY SCANNING PROCESS

CPs should be set up in consultation with IPs and stakeholders offering HIV services.

Broad criteria/considerations for selection of a community/site for a CP include:

- A community with an ART linkage and treatment gap validated by MoH and IPs.
- A densely populated area with an existing health facility (parent facility).
- Unavailability of or limited access to nearby parent health facility if the available facility is congested.
- Reasonable number of clients already living in the community (reverse mapping).
- A community with hot spots such as bars/nightlife or transportation hubs.
- Presence of social, economic and spiritual activities.
- Presence of local leadership structures (community leaders, market executives, political leaders, faith leaders).

SUMMARY OF STEPS TO IDENTIFY THE LOCATION OF A CP

STEPS	CONSIDERATIONS
1. Review community data, establish treatment gaps, and identify prospective communities based on data.	Communities that would be good candidates for setting up a CP have: • Low percentage of people with knowledge of their HIV status and low treatment coverage; • Higher rate of interruptions in treatment (ITT); • High number of HIV-positive patients receiving care at parent facility; • Population[s] with suspected high level of risk for HIV; • Reasonable distance to existing health facilities with high volume of clients on ART/client overload

2. Set up a technical team to conduct scanning and pre-scanning activities in identified community[ies].	Team members should include: • Program officers from implementing partner; organization (with at least one person conversant in the local language of the community); • Community leaders; • In-charge/ART coordinator of the parent facility; • Other select health facility staff, e.g., clinicians, CHW.

3. Conduct pre-scanning activities in which the technical team does a walk-through with a community guide.
  – During the community walk-through, the team:
  – Visits strategic individuals/potential local partners, including faith-based leaders in the community.
  – Discovers and maps out areas that are possible locations for a CP.
	• The pre-scanning process helps gather general information on potential areas to set up a CP in advance of the actual scanning, and helps to focus the scanning in areas most appropriate for a CP.
	• The community guide should be a local community member conversant with the geographical map of the community, as well as socio-cultural dynamics.
	• Pre-scanning can include incognito visits to the community; evening drives in community can provide insight into possible hot spots and social activities relevant to setting up CPs.

4. Once a is selected and potential CP location identified community, connect with community leaders and find out more information about potential CP location.	• Identify the formal community leader (e.g., market chairperson) and visit leaders to introduce technical team and the concept of CP (including core values/RECIPE) to community leaders. • Confirm existence and activity of faith organizations operating in the area.

5. Select potential locations for the CP and collect information/quotes for office space contributions.	• The technical team selects the location of the CP in conjunction with sensitized community leaders. Location must be:
	  – Within the community scanned;
	  – Easy to access while also exhibiting some privacy;
	  – A building that blends into existing physical structures (no branding) with a minimum physical size of 3.5 meters by 3.5 meters and one or two large windows;
	  – In rural areas; if a dedicated building is not available, the activities of the CP can be conducted in a schoolroom or local council meeting room close to location of the market on market days.

5.2 COMMUNITY SCANNING ACTION PLAN

DESCRIPTION

This tool helps to develop an action plan for preparing and carrying out a site scanning. It is important to consider:

- Who should be involved in the process (from the IP, from the community, etc.)?
- What local networks/resources can be tapped to gather information and gain access to the community?
- What time and resources are needed for each activity?

USERS

Users for this tool include IP, MoH, and other stakeholders involved in the community scanning process.

Pre-Scanning Activities

Directions: In this section, you should list activities involved in the pre-scanning exercise. Pre-scanning is done as part of the preparation for site selection. It involves gathering and analyzing information to help determine which community[ies] within a given zone/town are most suitable for situating the community post (CP).

Questions to consider:
- What data will be collected to determine community[ies] with greatest need?
- From where will we capture this data?
- Who will be responsible for analyzing this data?
- Are any advance visits needed to the community prior to the scanning process?

QUESTIONS	PERSON[S] RESPONSIBLE	MONTH											
		1	2	3	4	5	6	7	8	9	10	11	12
		1	2	3	4	5	6	7	8	9	10	11	12
		1	2	3	4	5	6	7	8	9	10	11	12
		1	2	3	4	5	6	7	8	9	10	11	12
		1	2	3	4	5	6	7	8	9	10	11	12
		1	2	3	4	5	6	7	8	9	10	11	12

Scanning Logistics Preparation

Directions: In this section, you should list preparation steps needed for carrying out the scanning activity.

Questions to consider:
• When will the scanning activity take place?
• Who will be participating on the day of the activity (lead and district implementing partner program staff, support staff)?
• What transport will be needed?
• How many communities will be visited?
• What courtesy calls are needed on the day of the scanning?
• Do we need to contact local authorities ahead of our arrival? If so, which ones?
• What community leaders will we connect with to help us with the scanning? What kind of advance notice do they need?

QUESTIONS	PERSON[S] RESPONSIBLE	MONTH											
		1	2	3	4	5	6	7	8	9	10	11	12
		1	2	3	4	5	6	7	8	9	10	11	12
		1	2	3	4	5	6	7	8	9	10	11	12
		1	2	3	4	5	6	7	8	9	10	11	12
		1	2	3	4	5	6	7	8	9	10	11	12
		1	2	3	4	5	6	7	8	9	10	11	12

Scanning Logistics Preparation

Directions: In this section, you should list the scanning agenda activities, participants, and time allocated for each activity.

ACTIVITY	PARTICIPANTS	START TIME	END TIME

5.3 COMMUNITY POST SCANNING REPORT OUTLINE

DESCRIPTION

This template provides a format to write a CP scanning report.

USERS

Potential users for this tool are IP, MoH, and other stakeholders involved in the CP scanning process.

COMMUNITY POST SCANNING REPORT OUTLINE:

SECTION TITLE	COMMUNITY POST SCANNING REPORT: [NAME OF PARENT FACILITY/COMMUNITY]
Background/ Data	Describe sources of data reviewed and key findings from data review, including justification for selection of geographical area selected for establishing CP (see Criteria Module, based on evaluation of program data and gaps): • HIV cascade: percentage of people knowing HIV status; ART coverage. • Rate of interruptions in treatment (ITT). • Number of HIV-positive patients receiving care at parent facility. • Population[s] with suspected high level of risk for HIV. • Existing health facilities with high volume of clients on ART.
Participants	List the CP scanning technical team participants (including position/role). • IP • Parent facility • Community • Others
Pre-scanning activities	Describe the pre-scanning activities, including visits with strategic individuals/ potential local partners, including faith-based leaders in the community; incognito visits to the community; evening drives in community to gain insight into possible hot spots; and other social activities relevant to setting up CPs.
Potential CP sites	Describe potential areas for a CP based on the pre-scanning activities and evaluation of Area Selection Factors: • Population density. • Distance to health facility (1-2 km from parent health facility). • Ongoing social, economic, and spiritual activities (markets, churches, busy residential areas). • Presence of men engaging in social and economic activities. • Presence of local leadership structures and stakeholders (e.g., market executive committees, pastor fellowships, local development committees). • Presence of community hot spots (bars/taverns, lodges, football fields, markets, bus stops, night clubs, business offices, churches, large shops/grocery chains). • Presence of social networks (e.g., brothel rings, commercial sex workers) • Number of existing clients seeking care in parent facility living in that community (reverse mapping).
Community stakeholders	Describe the formal community leaders of the area selected and findings from meetings with them to orient and introduce them to the CP model. Describe efforts to validate the faith organizations operating in the area.

CP site selection	Describe specific locations for CP and evaluate the possible options, focusing on key criteria (see criteria under 5.4): • Location is within the community scanned; • Easy to access while also exhibiting some privacy; • Building blends into existing physical structures (no branding) with a minimum physical size of 3.5 meters by 3.5 meters and one or two large windows; • In rural areas, if a dedicated building is not available, the activities of the CP can be conducted in a schoolroom or local council meeting room close to location of the market on the market days. Provide recommendation for CP location selection and justification.
Next steps	Describe planned next steps.

5.4 COMMUNITY POST INFRASTRUCTURE CRITERIA CHECKLIST

DESCRIPTION

This tool describes infrastructure necessary to set up a CP.

USERS

Potential users for this tool are IP, MoH, and other stakeholders involved in identifying the location to support the establishment of a CP.

CHECKLIST

Broad criteria/considerations for selection of a community/site for a CP include:

- ☐ Community with an ART linkage and treatment gap validated through review of ART coverage data (by MoH and IP).
- ☐ Densely populated area with an existing health facility (parent facility).
- ☐ Unavailability of or limited access to nearby [parent] health facility if the available facility is congested.
- ☐ Reasonable number of clients already living in the community (reverse- mapping).
- ☐ A community with hot spots such as bars/nightlife, transportation hubs, or areas of increased risk.
- ☐ Presence of social, economic, and spiritual activities.
- ☐ Presence of local leadership structures (community leaders, market executives, political leaders, faith leaders).

CHECKLIST

Physical requirements for CP:

☐ Accessible, but not on main road to ensure privacy for patients entering.

☐ One or two rooms; one room should at least be 3.5 meters by 3.5 meters to allow for dividing the space (curtains/room dividers).

☐ Waiting area.

☐ Bathroom should be available.

☐ Windows (with grills).

☐ Running water.

☐ Electricity.

☐ Affordability (rent).

5.5 CHECKLIST FOR FURNISHINGS AND EQUIPMENT

DESCRIPTION

This tool describes furnishings and equipment necessary to set up CP[s].

USERS

Potential users for this tool are IP, MoH, and other stakeholders involved in supporting the set-up of a CP(s).

ITEM	NUMBER	PURPOSE/SPECIFICATIONS
Benches	1	For waiting area
Cabinet (with lock)	1	Equipped with lock to keep drugs safe
Chairs	8	
Cooler box	1	For sample storage and transportation
Desk/tables	3	
Examination couch	1	
Fans	1/room	Consider wall-mounted
Filing cabinet	1	Equipped with lock to keep client files safe
Fridge	1	Small/table height
Handwashing station	1	Portable for provider and client handwashing before entering consultation room
Laptop	1	For data entry
Privacy screen	2	
Sharps boxes	2	

Sphygmomanometer	2	
Stadiometer (height meter)	1	
Thermometers	4	
Waste bins	3	Color-coded
Weight scale-adult	1	
Weight scale-child	1	
STATIONERY		
Suspension files	Based on expected number of patients	
Lab request forms		
Pharmacy ordering forms		
Registers		
Client charts/clinical forms		
Pens		
Referral slips		

5.6 CHECKLIST FOR CP MEDICATIONS AND SUPPLIES

DESCRIPTION

This tool describes the medications and supplies that should be stocked in a CP. This tool should be adapted in accordance with MoH policies and guidelines.

USERS

Users for this tool are IP, MoH, parent-facility, and CP management, as well as other stakeholders involved in supporting the establishment of a CP.

CP MEDICATIONS AND SUPPLIES:

Medications

☐ Medications

☐ Antiretroviral drugs

☐ Cotrimoxazole

☐ TB preventive treatment

Basic essential medicines (see also 7.3 Pharmacy Services):

☐ Children

☐ Adults

Laboratory supplies/consumables

☐ HIV rapid tests

☐ HIV/syphilis rapid test

☐ Syphilis rapid test

☐ EID sample collection material

☐ VL sample collection material

☐ Sputum sample collection material

Infection control

☐ Disinfectant

☐ Gloves

☐ Soap

☐ Masks

Job aids and stationery (please list)

☐ Algorithms, screening tools, counseling guides, etc.

IEC materials

☐ As appropriate for the country

M&E tools

☐ Appointment register

☐ ART pharmacy daily activity register

☐ Community tracking register

☐ HIV care and treatment register

☐ HI test kits daily activity register

☐ HTS register

☐ HVL register

☐ Index case testing register

☐ Linkage register

☐ Supply requisition book

☐ TB presumptive case register

☐ TPT register

☐ VL lab requisition register

☐ VL sample tracking register

MODULE 6:
Staffing and Capacity Building in the Community Post Model

INTRODUCTION

Module 6 focuses on staffing and capacity building in the CP model. This module explains the community post team composition and organization. It describes the soft skills that are critical for all CP team members, and why these skills are essential. Module 6 provides an overview of the role of each CP staff member. It explains the recruitment process, and provides an overview of initial training, onsite mentorship, and ongoing capacity building for CP staff. Module 6 provides an overview of the morning pep talk, which has been a bedrock for the success of the CP model.

KEY MESSAGES FROM MODULE 6 INCLUDE:

- A CP reporting structure includes the following: the CP team leader (who reports to the in-charge in the ART clinic at the parent facility); a data associate and a psychosocial support counselor (who report to the CP team leader) and four CHWs (who report to the PSS counselor).

- It is critical for all CP team members to have the core competencies (or soft skills) necessary to embody the CP core values/RECIPE.

- The selection process of CP staff—particularly the team leader and the CHWs – is a critical component in establishing successful CPs.

- The demands and nature of these positions in particular, require certain characteristics/competencies that need to be considered and assessed in the staff selection process.

- In addition to careful selection, ongoing capacity building—through refresher trainings, ongoing coaching and mentoring, and supportive supervision, and in particular the daily pep talk—are critical in ensuring that CP staff continue to embody the characteristics/attributes needed to deliver high-quality, client-centered care.

6.1 COMMUNITY POST COMPOSITION

DESCRIPTION

This tool provides an overview of the staff organization and reporting structure within a CP and between the CP and parent facility.

USERS

Potential users for this tool could include any stakeholders that want to understand the organization and reporting structure within a CP and in relation to the parent facility.

PARENT FACILITY

Parent Facility ART In-Charge

COMMUNITY POST

Community Post Team Lead (Clinician or Nurse) (1)

Data Associate (1)

Psychosocial Counselor (1)

Community Health Workers (4)*

*additional CHW if number of clients on ART > 1000
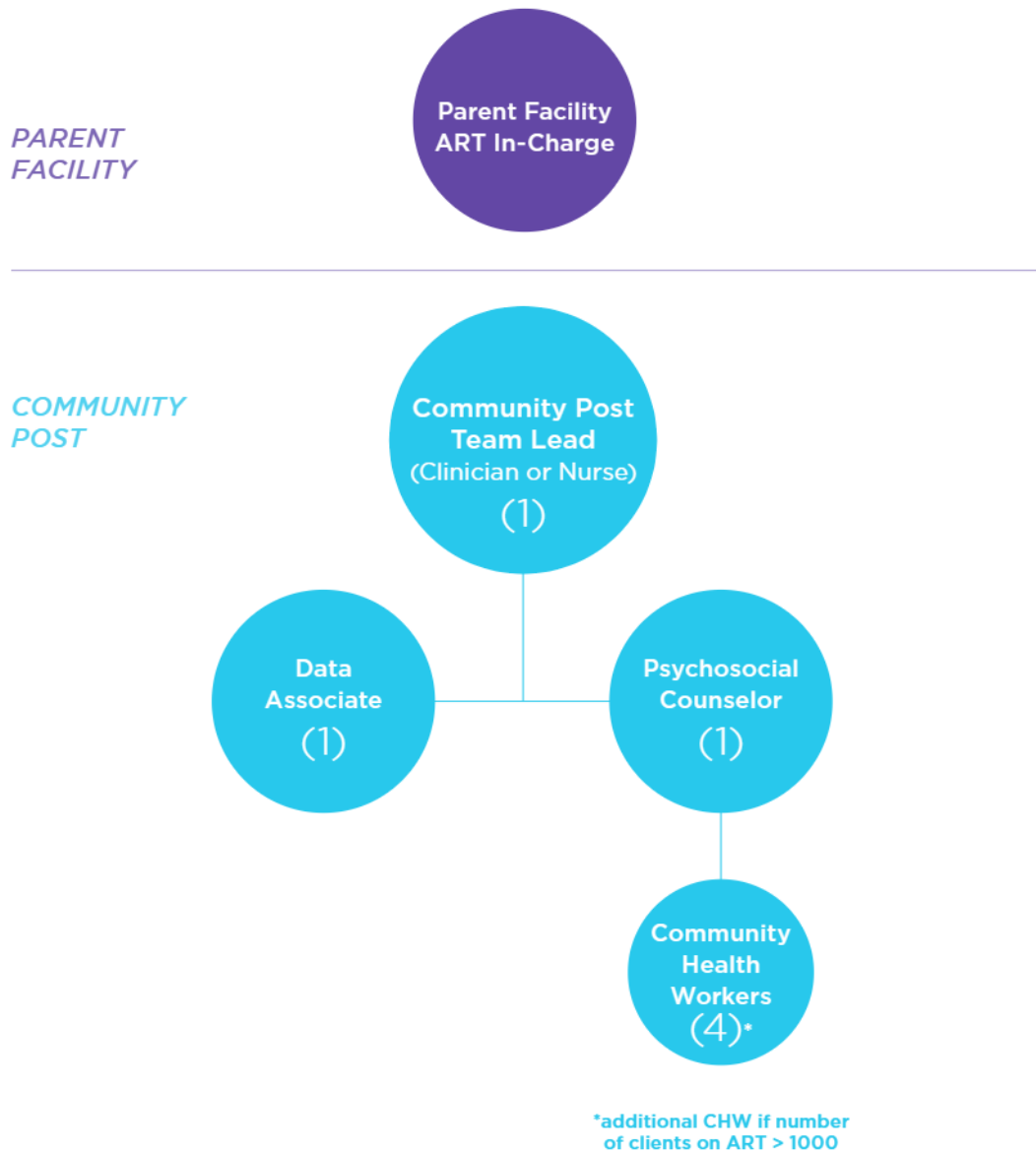
6.2 COMMUNITY POST SAMPLE TEAM LEADER JOB DESCRIPTION

DESCRIPTION

This tool provides a summary of the responsibilities, minimum qualifications, and competencies required of a CP team leader. These responsibilities and minimum qualifications should be adapted to the local context in accordance with any existing guidelines from the local MoH.

USERS

Potential users for this tool are IPs, national/local MoH, or parent facility management responsible for hiring CP staff.

CP Team Leader Responsibilities, Minimum Qualifications, and Competencies Reports to ART facility in-charge at parent health facility.

RESPONSIBILITIES

Management

- Manages the day-to-day operations of a CP.
- Provides leadership and oversight to all CP staff, including a psychosocial counselor, data associate, and four community health workers (CHWs).
- Responsible for capacity building of the CP team and community leaders.

Client care

- As the only clinician at a CP, responsible for patient care in accordance with MoH policies and guidelines, including diagnosis and treatment of HIV, sample collection, dispensing medication, minimal emergency care to non-HIV patients as necessary, and makes appropriate referrals to higher levels of care.
- Ensures quality of patient care.
- Oversees the forming of support groups in the communities surrounding the Community Post.

CP performance

Monitors and reports on drugs and supplies; request additional supplies from parent facility as needed on a daily basis.

- Reviews, analyzes, and presents CP data.
- Identifies patients that have missed appointments using the appointment register so CHWs can trace.
- Review reports prepared by the data associate before submission.
- Conduct data analysis, formulate presentations, and present in data review meetings.

MINIMUM QUALIFICATIONS

- Diploma in clinical medical sciences or HIV nurse practitioner (prescriber);
- Comprehensive ART training;
- Minimum of two years of work experience in HIV programming with progressive responsibilities;
- Certificate in counseling with related experience and/or training;
- Must be a registered practitioner of [add: relevant bodies].

COMPETENCIES

- Person of high integrity.
- Proficient in the local language(s) [add: relevant local language].
- Highly motivated to serve communities and client population served through CP and able to motivate others.
- Ability to influence and get buy-in from people both under and not under direct supervision and to work with individuals in diverse geographical and cultural settings.
- Excellent relationship management skills.
- Ability to solve practical problems and deal with situations in which only limited standardization exists; ability to define problems, collect and interpret data, establish facts, and draw valid conclusions.

6.3 COMMUNITY POST SAMPLE DATA ASSOCIATE JOB DESCRIPTION

DESCRIPTION

This tool provides a summary of the responsibilities, minimum qualifications, and competencies for the CP Data Associate. These responsibilities and minimum qualifications should be adapted to the local context in accordance with any existing guidelines from the local MoH.

USERS

Potential users for this tool are IPs, national/local MoH, or parent facility management responsible for hiring CP staff.

Data Associate Responsibilities, Minimum Qualifications, and Competencies Reports to CP Team Leader.

RESPONSIBILITIES

- Assists in the management of and responsible for the accuracy and completeness of CP service data recorded in patient files, registers, and electronic databases and reporting of this data.

■ Works with CP Team Leader to resolve questions, inconsistencies, or missing data, and verifies accuracy to ensure documentation is correct, consistent, and complete.

■ Ensures confidentiality of patient-level information in paper-based and electronic records.

■ Generates all CP-level reports required to support daily activities and performance monitoring.

■ Triangulates data in electronic database with pharmacy and laboratory records to ensure they are complete, correct, and up-to-date.

■ Tracks summary data and source documents, and assists in updating and preparation of summary reports.

■ Ensures that all data tools are available at the CP.

MINIMUM QUALIFICATIONS

■ Diploma in computer science, social sciences, or related field.

■ At least two (2) years of work experience in monitoring and evaluation-related activities working with medical records; SmartCare/local electronic system experience is an added advantage.

■ Experience working on HIV and AIDS activities is an added advantage.

■ Training in monitoring and evaluation is an added advantage.

COMPETENCIES

■ Ability to analyze and interpret program data.

■ Ability to interpret a variety of instructions furnished in written, oral, diagram, or schedule form.

■ Ability to visualize data for presentations and reports.

■ Ability to present information and respond to questions from managers.

■ Ability to operate Microsoft office package: word-processing software, spreadsheets, etc.

6.4 COMMUNITY POST SAMPLE PSYCHOSOCIAL COUNSELOR JOB DESCRIPTION

DESCRIPTION

This tool provides a summary of the responsibilities, minimum qualifications, and competencies for the CP Psychosocial Counselor. These responsibilities and minimum qualifications should be adapted to the local context in accordance with any existing guidelines from the local MoH.

USERS

Potential users for this tool are IPs, national/local MoH, or parent facility management responsible for hiring CP staff.

Psychosocial Counselor Responsibilities, Minimum Qualifications, and Competencies Reports to CP Team Leader.

RESPONSIBILITIES

■ Oversees and conducts confidential HIV counseling service delivery to clients at CP to support HIV testing uptake, continuity of treatment in care, and positive living.

■ Facilitates creation of support groups and support group meetings.

■ Collaborates closely with the CP team members to determine client follow-up needs, and to support effective follow-up of index contacts in the community.

■ Provides supportive supervision to CHWs in client counseling, follow-up, client visits, index, and elicitation, and oversees CHW data capture efforts.

■ Brings passion and energy for delivering nonjudgmental, high quality counseling and psychosocial support services to support client care and treatment.

■ Documents counseling sessions, maintains up-to-date client records/files, and ensures confidentiality of all CP recordkeeping systems in coordination with the Data Associate.

■ Participates in meetings with and makes presentations to community leaders.

MINIMUM QUALIFICATIONS

■ Certificate or Diploma in Psychosocial Counseling or Social Work.

■ Registration with [add: relevant local body].

■ At least two years of experience in a professional counseling role.

■ Three or more years of experience in a management or supervisory position.

■ Oral and written proficiency in English and local languages.

COMPETENCIES

■ Computer literacy is a plus.

■ Exceptional communication skills and ability to relate to and engage with people from diverse backgrounds, age groups, etc.

■ Passion and energy for delivering nonjudgmental, high-quality counseling and psychosocial support services to support clients' care and treatment.

■ Understanding of and commitment to adhere to standards of care, including confidentiality principles.

■ Ability to speak effectively in front of groups of clients or employees of organization.

■ A reliable team player who is able to adapt to changing situations and priorities.

6.5 COMMUNITY POST SAMPLE COMMUNITY HEALTH WORKER JOB DESCRIPTION

DESCRIPTION

This tool provides a summary of the responsibilities, minimum qualifications, and competencies for CP Community Health Workers (CHWs). These responsibilities and minimum qualifications should be adapted to the local context in accordance with any existing guidelines from the local MoH. Note: Among the CHWs, one younger CHWs is recruited and trained in adolescent and youth-friendly services to enable stronger response and support to young people receiving care in the CP.

USERS

Potential users for this tool are IPs, national/local MoH, or parent facility management responsible for hiring CP staff.

Community Health Worker Responsibilities, Minimum Qualifications, and Competencies Reports to CP Psychosocial Counselor.

RESPONSIBILITIES

- Work collaboratively with other CHWs to create demand for and provide linkages to a range of HIV prevention and treatment services at the CP.
- Understand and apply targeted HIV testing approaches to identify and link community members to services, including children, adolescents and men.
- Oversee and support client preliminary enrollment in the CP, and facilitate referrals to parent health facility for clients requiring additional services.
- Support client continuity of treatment and utilization of VL testing services through home visits.
- Organize/lead various activities to support demand creation, health education, and client continuity of treatment in care.
- Facilitate community-based referrals to the parent health facility for clients needing additional services.
- Assist with other activities, as needed, to enhance patient care.

MINIMUM QUALIFICATIONS

- Must be literate and able to read and write.
- Experience working with clients; previous experience working as a CHW highly desired.
- Strong understanding of the community landscape/dynamics (e.g., barriers to service access, community hot spots, social norms affecting service uptake, etc.) and the context in which clients are living.
- Respected/trusted by his/her community.
- Resides within [insert name of the community].

COMPETENCIES

- Exceptional communication skills and ability to relate to and engage with people from diverse backgrounds, age groups, etc.

- Passion and energy for delivering nonjudgmental, high-quality counseling and psychosocial support services to support client care and treatment.

- Understanding of and commitment to adhere to standards of care, including confidentiality principles.

- Ability to speak effectively in front of groups of clients or employees of organization.

- A reliable team player who is able to adapt to changing situations and priorities.

- Must be proficient in the national and local language(s) [add local language].

6.6 CP ONGOING CAPACITY DEVELOPMENT

DESCRIPTION

After CPs are established, they receive ongoing capacity-building, including training, mentoring, and supportive supervision to help them deliver quality services. Trainings are typically organized by the CP cluster, which is a designated group of CPs located in the same zone. Each cluster is comprised of approximately five to six CPs. This tool provides a summary of ongoing capacity-building activities for CP staff.

USERS

Potential users of this tool include IP, MoH, or parent facility or CP management planning for ongoing capacity building of CP staff.

CAPACITY BUILDING ACTIVITY	DESCRIPTION
Daily morning pep talk	The daily morning pep talk is fundamental to the success of CP model. It provides a platform to disseminate and discuss any new information, updates, guidelines, and policy changes, and coordinate the HIV services continuum at the community level. Each day a different aspect of the RECIPE is discussed. A full description and summary of content is described in 6.6 CP Ongoing Capacity Development.
Expert community health worker placement	Placement of an expert CHW provides initial support to CP CHWs at outset to help them understand their roles and responsibilities, as well as the core values of the model.

Community post team meetings	These meetings occur monthly on a Saturday, and address any concerns with a focus on making work a transformative experience for staff and clients through sharing experiences and best practices.
Needs-based technical and refresher training	Needs-based technical assistance occurs two to three times a year to train participants on updated national guidelines/policies/standards related to client care.
Quarterly data review sessions	These quarterly meetings occur to review data and progress against starts among CPs operating in a specific zone.
Quarterly CHW trainings	These meetings occur to provide CHWs with refresher training on selected topics.
Monthly team leader meetings and performance reviews	These meetings are held in the context of the data reviews of the reports in the previous month. Any gaps identified in the CP operations are highlighted, and these would include case identification, clinical (linkage to treatment), customer care (feedback), continuity of treatment, VL suppression results, index testing elicitation and yields, community relations, other partnerships relations such as MoH, CRS, CDC, other IPs etc. The barriers and RECIPE application are also discussed.
Quarterly award ceremonies	These are held every quarter as a celebration to affirm, recognize, and appreciate all CP and facility staff. Up to 18 different categories can be acknowledged, including best case-finding CP, best RECIPE-exhibiting CP and staff, best linkage CP, best customer care CP, best VL results, executive director's prize, best disciplined staff, best innovative CP and staff, best index testing contribution, best index testing positivity yield, cleanest CP, best continuity of treatment CP, best relation with local market leadership CP, best relationship with faith community CP, best overall positivity yield CP, best CP team leader selected by other team leaders, best CHW selected by other CHWs, etc. All awards/gifts are nonmonetary and could include wall clocks, blankets, dinner sets, etc.
Technical assistance visits	IP staff conducts TA visits to community posts to observe the functioning of CP operations and provide targeted support and troubleshooting of challenges.
Community post WhatsApp group	These groups are a forum to share progress of CP (within a given district or zone) compared to daily performance indicators and for CPs to share successes and challenges that underlie the data.

6.7 COMMUNITY POST GUIDANCE FOR DAILY PEP TALK

DESCRIPTION

This tool provides an overview of the content covered in the daily pep talk that CP staff attend.

USERS

Users of this tool could be IP, MoH, or parent facility or CP management planning the content for the daily pep talk.

DAILY MORNING PEP TALK

The daily morning pep talk is fundamental to the success of the CP model. It provides a platform to disseminate and discuss any new information, updates, guidelines, and policy changes, as well as coordinate the HIV services continuum at the community level. Each day the pep talk highlights a different element of the RECIPE, which participants are asked to reflect on for sustained daily inspiration and support. In addition, the morning pep talk serves as a daily platform for CP staff to interact with CP leadership, which encourages and inspires staff.

The following is a summary of the potential elements of the morning pep talk and a brief description.

Structure of daily pep talk:

■ Start promptly at designated time.

■ Provide handouts as appropriate.

■ Discuss different components below as listed below.

DAILY PEP TALK COMPONENT	DESCRIPTION OF DISCUSSION POINTS
Updates/announcements	• Emerging issues from the CPs in relation to utilities, security, community relationships-continuous leveraging of relationship capital and the physical condition of the CP.
RECIPE element inspiration for the day	Any element of the RECIPE is used to inspire and lift each day: • RESPONSIBILITY – Monday. • EMPATHY – Tuesday. • COMPASSION – Wednesday. • INTEGRITY – Thursday. • PASSION – Friday. • ETHICAL – Monday.

Client Feedback	This may come from any of the following: • Oral feedback • Client surveys • Exit interviews • Suggestion boxes • Walk-throughs
Clinical	• Case presentations, interesting cases, viral load issues, TB updates, pediatric or nutrition updates, clinical feedback related to clients, innovation, and continuous community customer care.
Pharmacy	• Supply of drugs, MMD/TLD transitioning, stocking of essential drugs, use of stock monitoring bin cards, frequent checks of expiry dates, and FIFO.
Lab	• Collection of lab samples and results, ordering of daily requirements/lab supplies, and ordering of daily activity registers.
HTS	• Hot spot identification and mapping, index testing, elicitation of index contacts, continuity of treatment issues, and emerging issues in counseling.
Data	• Status of daily targets; M&E short briefing. • Collecting the following tools: • **laptops** to be used for data input using the database (SmartCare), data analysis, and report preparations. • **external hard drives** for transporting the database to the parent facility to be merged with the central database. • **Wi-Fi** to provide internet services to use when submitting reports. • **registers and patient forms** to use at CP for documenting patient interaction. • **lab results,** e.g., VL results, and also ensure collection of ART numbers allocated from HTS department.
Logistics	• Transport allocation to CPs, purchase and supply of cleaning materials, and availability of folders and file clips.

MODULE 7:
Service Delivery in the Community Post Mode

INTRODUCTION

Module 7 describes the comprehensive package of HIV prevention, care, and treatment services delivered in the CP, and how clients are linked to additional care, as necessary. The module also describes possible expansion of the package to include additional services, as appropriate in a given context, taking into account local needs and national policies and guidelines. Module 7 includes considerations for pregnant and breastfeeding women, children and adolescents, and TB/HIV co-infected patients. Finally this module provides an overview of client referral to parent facilities.

KEY MESSAGES FROM MODULE 7 INCLUDE:

- The CP offers a comprehensive package of HIV prevention, care, and treatment service designed to improve access and continuity of treatment in HIV care.

- Services in the CP are offered in an integrated manner, providing a one-stop service for clients seeking care.

- CP staff have multiple and cross-cutting roles in HIV service delivery.

- The package of services delivered in the CP service package can be adapted and further expanded as national policy and guidelines allows and as appropriate in the local context (e.g., pre/postnatal care, family planning, cervical cancer screening).

7.1 COMMUNITY POST PACKAGE OF HEALTH SERVICES

DESCRIPTION

These standard operating procedures (SOP) describe the package of health services provided in the CP and processes for delivery of these services. Services are delivered to anyone seeking HIV testing and to HIV-positive clients of any age. All services are provided according to national guidelines for the delivery of HIV prevention, care, and treatment services. The CP package of services can be adapted and expanded as allowed by national policies and guidelines, and as appropriate in the local context.

USERS

Users for this tool can be stakeholders, such as IP/MoH, of parent facility management planning the implementation of the CP model or CP staff that will be offering services within the CP.

Primary health care	Services are offered to all individuals of all ages seeking HIV testing, care and treatment, and include:
	• **Basic screening for noncommunicable diseases** acknowledging that some individuals, men in particular, may not seek health services specifically to seek HIV testing.
	  – Malaria testing and treatment.
	  – Hypertension screening.
	  – Diabetes screening.
	• **STI screening and treatment.**
	• **TB screening.**

HIV testing	The CP offers HIV testing to all seeking care in the CP and not aware of their HIV status. Facility-based testing includes: • **Optimized Provider Initiated Testing and Counseling (oPITC)** using age-appropriate, context-specific HIV-risk screening tools applied to all individuals seeking care to identify and offer HIV testing to individuals at risk of HIV. • **Index case testing/assisted partner notification** offered to all new PLHIV to ensure all their sexual partners, as well as all biological children, are offered HIV screening and testing. Index case testing is also offered to all clients with high VL. • **HIV self-testing** is offered as part of partner notification, in case other options to reach the sexual partner(s) have been exhausted. Index cases are provided with an HIV self-test kit to provide this to their sex partner(s).
HIV prevention	• **HIV prevention/PrEP:** All individuals testing HIV negative are offered HIV/STI prevention counseling and screened for PrEP eligibility. • **Post-Exposure Prophylaxis (PEP):** Clients are screened for gender-based and sexual violence, and offered PEP in line with national guidance (and PrEP as appropriate). Community post staff members are trained in first-line GBV care and support (LIVES). A PEP kit is available at all CPs. • **STI screening and treatment:** STI prevention education, screening, and management are integrated into HIV testing and HIV care and treatment services. • **VMMC:** The CP provides VMMC education as part of HIV prevention education, as well as referral to a health facility with VMMC capacity.

HIV care and treatment	• **Same day ART initiation:** All individuals testing HIV positive, either in the CP or the community, are immediately linked to care for same-day ART initiation (see Walk strategy, Module 8).
	• **Comprehensive HIV care:**
	  – WHO screening and staging, including screening for OIs and advanced HIV disease (CrAg, CD4, TB LAM).
	  – OI treatment and prevention (Cotrimoxazole prophylaxis).
	  – TB diagnosis and treatment.
	  – Tuberculosis Preventive Treatment (TPT).
	• **Viral load monitoring** (see Laboratory services).
	• **Continuity of treatment support** (see Module 9).
	  – Monitoring and supporting continuity of treatment in care:
	   - Monitoring of ARV adherence.
	   - Adherence counseling: treatment literacy for clients new on ART; enhanced adherence counseling for clients not virally suppressed.
	   - Psychosocial support: linkage to additional community-based support. services and ongoing support by community-based volunteer (see Module 8).

Considerations for a status neutral approach to testing services	– A status neutral approach to HTS is not the same as universal testing; rather, it is ensuring individuals in need of HTS, receive safe and ethical HTS and support to ensure timely linkage to appropriate prevention and/or treatment services based on the individual's needs.

Considerations for women, including pregnant and breastfeeding women.	• **CECAP:** Cervical cancer screening is offered in the CP on a weekly basis only using a single-visit approach, i.e., inspection with acetic acid (VIA) for screening with same-day cryotherapy treatment for eligible women. Women with larger lesions are referred to the parent facility for LEEP. • **Pre-/post-natal care:** HIV-positive women on ART in the CP who become pregnant continue ART services in the CP while receiving ANC/MCH services in the parent facility, or are transferred for MCH/PMTCT services, including ART, to the parent facility. **Note:** Select CPs offer integrated MCH/PMTCT once per week. Pregnant and breastfeeding women receive services on a dedicated day, provided by an MCH nurse. In this case, DBS EID samples are collected at the CP and sent for analysis using established sample referral system.
Considerations for infants and children.	• **HIV-exposed infants**-see *Considerations for women, including pregnant and breastfeeding women* (above). If early infant diagnosis: DBS sample collection is done in the CP with sample referred to the parent facility using a hub-and-spoke model. • For immunization, infants are referred to the parent facility. • **Nutritional assessment:** Use of MUAC tapes; children are referred as needed.
Considerations for adolescents.	• **Adolescent and Youth Friendly Services (AYFS):** CP staff is trained in the provision of AYFS. During recruitment of CHWs, one younger volunteer is selected and trained to work with adolescents. **Note:** Adolescent support groups have not been implemented in the CP given the relatively low numbers of ALHIV in each CP. ALHIV are linked to the parent facility for participation.
Considerations for TB/HIV co-infected patients.	• Ensuring their contacts are traced and screened for TB. • Ensuring they have a documented HIV status. • Ensuring they are on anti-TB drugs and ART.
Differentiated ART services.	Client-responsive care is at the core of the CP model. CPs offer differentiated service delivery (DSD) for ART services to clients stable on ART (adherent to ART, no concurrent illnesses, virally suppressed) following existing SOPs for the implementation of these DSD models. • Multi-month refills. • Community ART groups. • Community support groups with ARV refills.
Referral	Clients are referred to the parent facility for the following services:* • HIV prevention: VMMC. • HIV care and treatment: advanced HIV disease: severe illness that cannot be managed at the CP. • Extra pulmonary TB. • SRH services. • GBV forensic examination. • Cervical cancer screening (if not offered in the CP)*. • Antenatal care: see Considerations for women, including pregnant and breastfeeding women (above)*. * Some countries/contexts may choose to include these services in the CP service package.

7.2 LABORATORY SERVICES

DESCRIPTION

This tool describes the laboratory services offered within the CP model, as well as the process of sample referral and results reporting for services not offered at CPs.

USERS

Users of this tool will include MoH and IPs considering the CP laboratory service offering and the process of sample referral and results reporting for services not offered within the CP.

Laboratory services on site (point of care)	As CPs do not have a laboratory, select point-of-care tests are offered and administered by the clinician: • HIV rapid test • Rapid syphilis test • Random blood sugar • Urinalysis • TB LAM • Hepatitis B **Note:** Currently CPs do not offer POC VL for cost efficiency reasons.
Laboratory services through sample referral.	CPs collect samples for analysis in their parent facility laboratory or other referral laboratory for the following tests: • Viral load testing (DBS specimen). • CD4 count • EID: DBS PCR • Full blood count • Serum creatinine (PrEP initiation). • Blood lipids • Urine MCS • Sputum for TB diagnosis • CrAg • [Hepatitis B]* • [Syphilis - RPR]* For any other necessary tests, patients are referred to the parent facility. *In case test stock out at CP.
Viral load monitoring sample referral process.	It is important to integrate CPs into the existing sample referral system. In this spoke sample referral model, CPs in the catchment of a parent facility (spokes) send their samples to the parent facility (hub) for analysis. Samples that cannot be processed at parent facilities are shipped to other referral laboratories. There are existing SOPs to follow for sample collection, packaging, handling, transportation, and chain of custody. SOPs should address steps 1 through 6 that follow.

Step 1	**Sample collection:** • In the CP, the clinician (team lead) collects specimens from clients. Samples are stored following existing national SOPs for appropriate packaging, transportation, and storage of specimens until they are packed up for transportation to the parent facility. The clinician fills also out the following registers: – VL lab requisition register. – VL sample tracking register.
Step 2	**Sample transportation:** • At the end of each day, a driver from the parent facility collects samples from CPs in its catchment area (in case of multiple CPs) and delivers these samples to the laboratory in the parent facility.
Step 3	**Sample receipt and processing:** • The laboratory in the parent facility receives and processes the samples that can be processed at parent facility.
Step 4	**Results dispatch and receipt:** • Samples processed by the facilities use a paper-based system. • Samples processed centrally, such as VL, are transmitted electronically to the parent facility, which prints them. • Results are dispatched to the CP at the point of collecting other samples. • Results are entered in SmartCare (electronic patient management system) and then filed in patient files.
Step 5	**Results communication to clients:** • By the client's next appointment, the results will be on file for clinical decisions to be made. • Clients with high VL or results suggestive of other commodities are called immediately for review and referral if required.
Step 6	**Quality Assurance:** • Team leaders discuss the VL received from the lab during the daily pep talk. Issues regarding sample quality, transportation, and results are discussed.

7.3 PHARMACY SERVICES

DESCRIPTION

This tool describes essential drugs and commodities and supply chain management within the CP model.

USERS

Users of this tool include MoH, IPs, and parent facilities planning CP supply chain management to ensure uninterrupted availability of necessary drugs and commodities.

General overview	The CP should be integrated into the existing supply chain management system:
	• CP drug and commodity requirements are included in the [monthly/quarterly] drug forecasts of the parent facility. Parent facility pharmacists are responsible for ensuring that the CP(s) have adequate drug supply. Supplies are brought to the CP on a daily basis as most CPs do not have space conducive to drug storage.
	• Each day the CP team leader fills out:
	– HIV rapid test kit daily activity register;
	– ARV daily activity register;
	– Supply requisition book.
	• At the end of each day, the CP team leader submits the request for replenishment of drugs and commodities to the parent facility pharmacy.
	• At the start of each day, the CP team brings HIV test kits/drugs/commodities from the parent facility pharmacy to the CP.
	• Since there is no separate pharmacy in the CP, the team leader, who is a clinician, provides drugs to client and explains their usage.
Drugs available at the CP	The minimum medications and other commodities that should be available in CPs include:
	Medications
	• Antiretroviral drugs
	• Cotrimoxazole
	• TB preventive treatment: Isoniazid and vitamin B6
	• Basic essential medicines:
	– Paracetamol
	– Brufen
	– Amoxicillin
	– Metronidazole
	– Doxycycline
	– Ciprofloxacin
	– Deworming
	– Injectable penicillin
	Laboratory supplies/consumables
	• HIV rapid test
	• HIV/syphilis rapid test
	• Syphilis rapid test
	• EID sample collection material
	• VL sample collection material
	• Sputum sample collection material
	Infection control
	• Disinfectant
	• Gloves
	• Soap
	• Masks

MODULE 8:
Finding and Linking Clients to Services in the Community Post: Case Identification and Linkage Strategies

INTRODUCTION

Module 8 focuses on demand creation, case identification, and linkage strategies. This module describes the evidence-informed strategies used in the CP model for targeted demand creation, case identification, and linkage of tested individuals to care and treatment. Case identification includes provider initiated targeted community testing and counseling, HIV risk screening, index contact testing and assisted partner notification, and the social network strategy. Module 8 discusses the CP walk and celebration strategy as a unique way of linking newly diagnosed people living with HIV to CP care and treatment services.

KEY MESSAGES FROM MODULE 8 INCLUDE:

- CP implements various focused strategies to improve identification of high-risk clients, offer HIV testing and link clients to HIV prevention, care, and treatment services to reduce existing gaps to achieving the 95-95-95, including specific strategies to reach men.

- The core values of the CP model (RECIPE) are critical in promoting quality customer care, which in turn leads to increasing demand for CP services.

- Faith and community leaders/stakeholders and trusted relationships with the community play a critical role in promoting and creating demand for CP services; ongoing investment/training/engagement of these stakeholders is needed.

- Index case testing is a core strategy to successful HIV case identification.

- The Walk Strategy and Celebration Strategy aim to build trust with prospective clients and are critical in promoting (index) testing, including contact elicitation and partner notification, and build the basis for long-term continuity of treatment among CP clients.

8.1 STRATEGIES FOR DEMAND GENERATION AND LINKING CLIENTS TO THE CP MODEL

DESCRIPTION

This tool summarizes strategies and activities to generate demand for services, facilitate case finding, and linkage to services in the CP model. All clients seeking HIV testing and those diagnosed HIV positive are eligible for ICT, PNS, and linkage services. This tool will help MoH and IPs align ICT, PNS, and linkage services in their CPs to global and national guidelines for delivering HIV prevention, care, and treatment services.

USERS

Users of this tool include MoH and IPs planning the implementation of the CP model, as well as CP teams that will offer services within the CP.

The CP model utilizes a range of targeted strategies to create demand for services of the CP. The model combines demand creation with strategies to identify and link those most in need of testing to services. Through a combination of evidence-informed case identification strategies and targeted promotion approaches, CPs have been successful in increasing the number of individuals tested and linked to care, particularly from certain populations (e.g., men).

STRATEGIES FOR DEMAND GENERATION IN THE CP MODEL

STRATEGY	DESCRIPTION
Mobilization of community and faith leaders.	• Identify community and faith leaders in CP catchment area. • Train leaders using a set curriculum; include range of services available at the CP. • Trained leaders use their platforms to promote utilization of services, and deliver messages of hope and U=U. • Resources to engage communities of faith and faith leaders to promote HIV services can be found here: https://www.faithandcommunityinitiative.org/.
CP teams leveraging community and faith platforms.	• CP team attends community meetings and presents on available services to create awareness of CP services, including prevention services and PrEP to specific community groups.
Mobilization of CHWs.	• Recruit CHWs living in the catchment of the CP; give priority to PLHIV familiar with community social-cultural dynamics and accessible to community members. • Mobilized and engaged CHWs use community meetings and one-on-one sessions to promote services and link customers to services.

Update: Considerations for a status neutral approach to testing services	–A status neutral approach to HTS is not the same as universal testing; rather, it is ensuring individuals in need of HTS, receive safe and ethical HTS and support to ensure timely linkage to appropriate prevention and/or treatment services based on the individual's needs.
Focus on quality customer care.	• Recruit CHWs living in the catchment of the CP; give priority to PLHIV familiar with community social-cultural dynamics and accessible to community members. • Mobilized and engaged CHWs use community meetings and one-on-one sessions to promote services and link customers to services.
Art of graceful persuasion.	• Community leaders, partners, and other clients identify and refer potential clients (in the community and at the CP). • The CP team uses advanced counseling skills —graceful persuasion— to convince potential clients to test and link clients to treatment or HIV prevention services.

STRATEGIES TO LINK CLIENTS TO THE CP MODEL

STRATEGY	DESCRIPTION
HIV risk and known positive-factor screening tool.	• Use enhanced probing skills and counseling of the whole person to screen, identify known positives, and prevent new positives.
Know Your Child's HIV Status (CRS EpiC 3-90 Strategy).	• Follow-up HIV-positive women (ages 15-49 years) who have been on ART for more than 3 months and who have children of unknown HIV status to offer HIV screening and testing.
The Walk and Celebration Strategies.	• The CHW walks to the CP with the individual that tests positive in the community. • During the walk, the CHW builds the relationship and captures information on index contacts, including PNS. • During handover of the client, counselors and clinician (all CP staff present) pause to congratulate and celebrate (i.e., offer a hug, smile or handshake and refreshments, depending on sex of client) the client for testing. • The celebration makes the client feel comfortable and ultimately promotes acceptance of treatment on the same day and solicitation of contacts for ICT and PNS. • The CHW exits, signaling to the team leader with a thumbs up or thumbs down. • Thumbs up means the CHW asked the question about sexual contacts, and thumbs down means the team leader needs to ask about sexual contacts. • The client is connected to the team leader/clinician for ART initiation.
Index Case Testing (ICT).	• ICT, also referred to as index case testing, index patient, or index partner HIV testing, is an HTS approach that offers HIV testing to the household, family members (including children), and partners of people diagnosed with HIV. • CHWs and PSS counselors providing ICT gather index case contact info, and record phone numbers and the physical location of contacts and biological children of index cases; contact sexual contacts and biological children of index cases; and conduct community/door-to-door testing of index case sexual contacts/family members; link positives to CP via walk and celebration strategy.

Update: Case Identification with HIV 'Screen-in' Validated Methods	In COP/ROP23 Guidance and FY24 Tech Cons, there's a shift away from risk screening and toward increased use of more affordable HIVST. Risk screening in CPs uses 'screen-in tools' to identify high-risk individuals for HIV testing, such as anyone with: rapid weight loss; persistent cough; fever or night sweats; unexplained tiredness; prolonged swelling of lymph glands in armpits, groin, or neck; sores of the mouth, anus, or genitals; For children: recurrent skin problems or infection, swollen abdomen, delayed growth and development, poor health in the last 3 months or hospitalized, swollen lymph nodes, intermittent diarrhea, oral thrush, history of TB or TB symptoms, pus from the ear, discharge, sores in genital area; For women: any mother of a child born with HIV or with unexplained illness who died before age 2 years.

Partner Notification Services (PNS).	• Training for the CHWs and PSS counselors on partner notification:
	  – Gather index case contact info, including phone numbers and the physical location in CP registers.
	  – Make appointments for clinic or home visits for partner testing.
	  – Perform face-to-face conversations with partners, make phone calls, and/or send text messages.
	  – Conduct testing of index case sexual contacts and link positives to CP via the Walk and Celebration Strategies.
	• Care is necessary when using methods such as phone calls and text messaging to ensure that the correct person receives the message, and that the anonymity of both the HIV-positive client and notified partner is maintained.
	• Countries should review laws and policies that have coercive partner notification practices. Supportive policies are essential for effective and safe HIV partner notification programs.

Social Network Strategy (SNS) Community-to-Facility Referrals.	• Enlist HIV-positive, high-risk negative individuals to identify people in their social (sexual and other) networks for HTS. • This is based on the principle that people may be more likely to accept testing when encouraged by someone within the same social network who they know and with whom they share similar risk behaviors. • CP team enlists HIV-positive/high-risk, HIV-negative individuals to identify people in their social (sexual and other) network for HTS.

8.2 GUIDANCE ON WALK AND CELEBRATION STRATEGIES

DESCRIPTION

This tool provides an overview of the Walk and Celebration Strategies.

USERS

Users of this tool include MoH and IPs planning for implementation of the CP model, as well as CP and parent facility staff.

THE COMMUNITY POST (CP) WALK AND WELCOME / CELEBRATION STRATEGIES

The CP model has high linkage and continuity of treatment rates attributed to the model's Walk and Welcome/Celebration Strategies. Data from the CP model in Zambia shows the success of the model in notifying partners and initiating same day testing of approximately 50% of index case contacts. Most HIV testing and counseling occurs in the community via CHWs and PSS counselors. If the test is positive, the client becomes an index, and is accompanied to the CP for a confirmatory test and linkage to treatment at the facility. By design, the CP is within walking distance (typically takes 10-20 minutes).

WALK STRATEGY

After an initial HIV-positive test (in the community), the CHW walks the client to the CP (Walk Strategy). During the walk, the CHW/PSS counselor uses customer care and emotional intelligence concepts to discuss and connect with the newly diagnosed client.

Objectives of the walk:

- Accompany client to CP.
- Build a relationship of trust and respect between CHW and the client—help client open up to discuss sensitive topics, such as number of sexual partners.
- Capture information on index contacts, including PNS.
- Prepare the client for index testing and linkage.
- Provide information about CP services.

The CHW uses 4 levels of connecting:

1. Emotional – empathize with the client and ask questions to help the client share his/her feelings.
2. Social – get information about family marital status and children and economic and financial status using a conversational approach.
3. Spiritual – get information about belief system and his/her faith.
4. Physical – culturally appropriate physical touch for reassurance.

WELCOME/CELEBRATION STRATEGY

The CHW (or PSS counselor, depending on who provided HTS to the client) accompanies a newly diagnosed client to the CP (the Walk Strategy), and hands over the client to the Team Leader. The CHW(or PSS counselor) signals at the CP using a thumbs up (meaning that the CHW asked the question about sexual contacts) or a thumbs down (meaning that the team leader or PSS counselor still needs to ask the question about sexual contacts). As part of the welcome, the TL, DA, and PSS counselor (all CP staff present) pause to welcome and acknowledge and celebrate the arrival of the newly diagnosed client; extend smile and culturally appropriate greeting (depending on the sex of client); provide newly diagnosed client with refreshments (water/juice); and conduct confirmatory test and link to treatment and other services.

Objectives of Welcome/Celebration Strategy:

- Help the client feel comfortable with all CP staff.
- Consolidate information gathered during the walk regarding ICT contacts and PNS.
- Promote acceptance of treatment on the same day.

8.3 OVERVIEW OF 5 CS OF HIV TESTING

DESCRIPTION

This tool provides a reminder of the critical standards to which quality HIV testing should adhere, also referred to as the 5Cs of HIV testing.

USERS

Users of this tool include CP staff that require a reference for the 5Cs of HIV testing.

HIV testing services (HTS) are a critical component of the CP model. HTS includes pre-test preparation, testing, and post-test counseling with linkage to treatment for HIV-positive clients. The World Health Organization (WHO) recommends HTS align with the five Cs: Consent, Confidentiality, Counseling, Correct [test] results, and Connection[2].

Consent: HIV testing should always be voluntary. Clients should be informed of the process for HIV testing and counseling and of their right to accept/decline testing. Before testing and counseling, client must give verbal or written consent. Coerced testing is never acceptable, whether by a health care provider, employer, spouse, or family member.

Confidentiality: The HTS provider cannot disclose what the HTS provider and client discuss to anyone else without the expressed consent of the client. Confidentiality should be respected and should not reinforce secrecy, stigma, or shame. Counselors should discuss with clients, among other issues, whom they may wish to inform about their HIV status, and how they would like to disclose their status. Disclosure and shared confidentiality with a partner, family member, or health care provider are often highly beneficial.

Counseling: HCWs can provide pre-test information in a group setting, but all clients may ask questions in a private setting. High-quality, post-test counseling, as per specific HIV test results and HIV status, should accompany all HIV testing. Quality assurance (QA) mechanisms, supportive supervision, and mentoring systems should be in place to ensure high-quality counseling.

Correct: To ensure that clients receive correct test results—and a correct diagnosis—providers of HIV testing should strive for high-quality testing services and QA mechanisms. QA, with internal and external measures, should receive support from the national reference laboratory. Re-testing and verification of HIV-positive diagnoses are mandatory before initiating HIV care or treatment.

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2 World Health Organization (2015). Consolidated guidelines on HIV testing services: 5Cs: consent, confidentiality, counselling, correct results and connection 2015. World Health Organization. https://apps.who.int/iris/handle/10665/179870

MODULE 9:
Supporting ART Adherence, Continuity of Treatment, and Viral Load Suppression in the Community Post Model

INTRODUCTION

Module 9 focuses on client continuity of treatment in care. This module describes overall CP model continuity of treatment strategies, including continuity of treatment strategies for new clients, differentiated service delivery (DSD), ART adherence strategies for stable clients, and enhanced support for clients with difficulty achieving VLS. Module 9 describes protocols for addressing interruption in treatment (ITT) in clients and linking client from CP to support services. Finally, this module outlines different continuity of treatment services and which staff are responsible for these services.

KEY MESSAGES FROM MODULE 9 INCLUDE:

- CP approaches that support continuity of treatment include convenient location, the customer care and RECIPE values implemented, the client peer support system, and ensuring drug and lab results are available.

- Specific strategies are implemented for clients new on ART and clients stable on ART (as per national guidelines).

  - Continuity of treatment strategies for new client include treatment literacy, disclosure support/support for the family, preventive home visits for new clients on ART, and stratifying new clients by risk of ITT and providing targeted support for clients at increased risk.

  - For stable clients, the CP model employs differentiated service delivery (DSD) adherence strategies: community ART refill groups (CARGs), multi-month scripting/dispensation (MMS/MMD), urban and rural adherence support groups (U/RASGs), client fast tracking, and adolescent support groups.

- Clients with difficulty achieve VLS receive enhanced support, while systems and tools are in place to ensure immediate tracing of clients missing an appointment or with ITT to bring them back into care.

- Processes are in place to ensure clients with ITT are immediately tracked and linked back to care, and that clients are linked to additional support services.

9.1 OVERVIEW OF STRATEGIES TO SUPPORT CONTINUITY OF CARE AND PREVENT INTERRUPTION IN TREATMENT

DESCRIPTION

This tool provides a summary of strategies used in the CP to support continuity of treatment and prevent interruption in treatment (ITT).

USERS

Users of this tool could include MoH or IP planning for the implementation of the CP model or CP staff using this tool as a reference during implementation.

OVERALL CLIENT CONTINUITY OF CARE STRATEGIES

Appointment and Community Tracking Register.	• CPs maintain this register to capture information on appointment history and future appointments. • Each day, the CP (DA) generates a list of clients from SmartCare that have appointments or are scheduled to pick up medicines at the pharmacy. • All client appointments are recorded in the appointment register. Any client who misses an appointment is called and rescheduled following first missed appointment. • If a client misses a next appointment, that client is transferred to the community tracking register. Clients in the community register are followed up with phone calls, visits, etc.
Phone Outreach.	• CPs are supported with airtime to enable efficient tracking of clients via follow-up calls and texts. • CPs maintain updated client locator forms with individual client info (address, phone number) and contact history to ensure communication with clients as necessary. • The CP prints a list of clients due for visits the following day. • CHWs call clients to inform them that they are due for an appointment, pharmacy pick-up, or VL monitoring as appropriate/ indicated. • For client who can't make it to the CP, a follow-up visit to their home is scheduled to take their VL and bring drugs.
Face-to-Face Contact.	• CHWs meet clients in person at home, in hot spots, and at other places within the community. • Face-to-face contact is used in cases of frequent defaulting, unsuppressed VL, and in cases of excellent adherence and suppression (affirmation and role model).
Documented Transfer.	• There is documentation of all clients transferring from the health facility to CP or vice versa (the latter is rare) so that all new clients can be appropriately tracked and reached with services.
TB Contact Tracing.	• CHWs facilitate linkage between community and facility. • TB contact tracing starts with elicitation and follow-up. • There is a particular focus on close family members, spouses/partners, and workmates. • Intensified focus is placed on contacts already on ART that are tested for TB as appropriate.

CONTINUITY OF TREATMENT STRATEGIES FOR NEW CLIENTS

New Client Fast Tracking.	• New clients are seen quicker than clients already on ART, both at the CP and health facilities. They are given priority as an incentive and for encouragement.
Treatment Literacy[2].	• Compulsory adherence sessions are given at each visit with particular focus on U=U messaging. This is included in the HIV cascade of care.
Disclosure Support.	• CPs provide support for disclosure to any client needing support to disclose his/her new status to spouse, next of kin, close family members, etc. • This support is given through accompaniment, family sessions, etc.
Stratification of New Client by Risk of Interruption in Treatment with Targeted Support.	• Clients appearing in the community tracking register are classified in terms of days after due date, priority populations, gender, age, adherence history, etc. • CPs provide targeted support for clients at increased risk.
Preventive Home Visits for New Clients on ART.	• These are conducted when clients are deemed to have acceptance challenges, spouse violence, child-headed households, or grandparent-headed households.

DSD ADHERENCE STRATEGIES FOR STABLE CLIENTS

Community ART Refill Groups (CARGs).	• Clients are formed into groups of six. • Each month one of the clients comes to collect drugs for all group members.
Urban and Rural Adherence Support Groups (U/RASGs).	• These are client-led support groups in which members encourage each other and share experiences in the treatment journey. • They are linked to the CP and provide support to new and old clients.
Multi-Month Scripting/ Dispensation (MMS/MMD).	• Depending on the stability of the client, client receives three to six months of drug regimen. • This helps eligible clients with confidentiality, adherence, and time management between work and facility visits. • This creates a win-win situation in relation to continuity of treatment.
Adolescent Support Groups.	• An adolescent focal person from the CP or the parent facility leads and facilitates these meetings, which are usually held once per month with additional ad hoc meetings set up in accordance with need. • A committee of adolescents is set up that will work and plan with the focal person. • These are beginning to form. However, the CP model has not enrolled a high number of adolescents to date and therefore this is a nascent strategy within the model.

ENHANCED SUPPORT FOR CLIENTS WITH DIFFICULTY ACHIEVING VL

Enhanced Adherence Counseling[3].	• Counseling that includes application of the RECIPE. • Targets the whole person (social, emotional, spiritual, financial and economic, worth, legacy, etc.). • Also employs overall client continuity of treatment strategies.

Please also refer to Overall Client Continuity of Treatment Strategies (p. 63)

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2 Refer to 9.2: Overview of Activities to Prevent Interruption in Treatment and Conduct Defaulter Tracing

3. Refer to existing guidance on Enhanced Adherence Counseling.

9.2 OVERVIEW OF ACTIVITIES TO PREVENT INTERRUPTION IN TREATMENT AND CONDUCT DEFAULTER TRACING

DESCRIPTION

This tool provides an overview of activities to prevent interruption in treatment and conduct defaulter tracing in the CP model.

USERS

Users of this tool include CP staff that require a reference for prevention of interruption in treatment and defaulter tracing.

OVERVIEW OF ACTIVITIES TO PREVENT INTERRUPTION IN TREATMENT

- Assessment of individual barriers to ART at enrollment and provision of support as necessary.
- Conduct home visits or supportive phone calls for clients new on ART.
- Conduct home visits or supportive calls for clients at increased risk of missing appointments (risk factors).
- Call clients a few days before appointment dates to remind them of upcoming visit.

OVERVIEW OF ACTIVITIES TO PREVENT INTERRUPTION IN TREATMENT

- All clients who are on ART are recorded in an appointment register.
- When a client misses an appointment date, she/he is entered into a community tracking register for follow-up.
- The clinician coordinates follow-up activities; he/she assigns CHWs to clients who have missed their appointment dates.
- CHWs follow up with client by phone calls or home visitation; it can be difficult to reach those with unknown addresses and/or phones.

MODULE 10: Monitoring and Reporting of Community Post Performance

INTRODUCTION

Module 10 focuses on monitoring and data use for program improvement in the CP model. This module highlights why daily monitoring is important, and how it improves CP performance. Module 10 presents the key indicators assessed in the CP model performance and describes performance expectations for CPs. It describes the logistics, roles, and responsibilities associated with data associates, and the flow of data from CP to high levels. Also included in Module 10 is an overview of best practices in CP robust M&E, which includes reporting and feedback, daily reporting, use of the WhatsApp platform for weekly and monthly reporting, and WhatsApp as a tool to communicate on performance.

KEY MESSAGES FROM MODULE 10 INCLUDE:

■ CPs in this model have been recognized for their high performance in routine HIV indicators; daily monitoring of key performance indicators is critical to improving/maintaining high CP performance.

■ On a daily basis, key indicators are reviewed and feedback on performance provided.

■ Data associates play a key role in monitoring for the CP; logistics, roles, and responsibilities of the DAs are discussed in this module, as well as data flow from the CP to higher levels.

■ Best practices in the CP's robust M&E system include daily reporting and feedback, use of the WhatsApp platform for weekly and monthly reporting, and WhatsApp as a tool to communicate on performance.

  • Daily reporting and feedback are key to the CoH model, and influence positive performance in multiple ways, including motivating CPs to perform better as they compare their performance to other CPs and want to do better and/or learn how another team achieves success. Daily reporting facilitates taking action quickly (whenever the problem is identified).

  • WhatsApp is used as a data review platform; M&E staff deliver weekly and monthly updates via WhatsApp to the CPs associated with a health facility; they post data on how CPs have performed to facilitate quick delivery of feedback. CPs provide feedback on data, and M&E managers provide feedback for improvement.

10.1 DATA COLLECTION AND FLOW

DESCRIPTION

This tool describes in detail the data flow and steps in a CP.

USERS

Users for this tool include IPs and MOH planning the implementation of the CP model, as well as parent facility staff and the CP teams that will be offering services within the CP.

Data collection tools	CP data collection and reporting uses the same tools and procedures as other health facilities. The following data collection and reporting tools are in use in the CP: • Patient charts/files. • Appointment register. • Community tracking register. • HIV care and treatment register. • HTS register. • HVL register. • Index case testing register. • Linkage register. • TB presumptive case register. • TPT register. • VL sample tracking register.
Data collection process	Depending on resources, CP data can be collected using: 1. Point-of-care medical records (Zambia E-first); 2. Electronic database with immediate data onsite (Zambia E-fast); or 3. Paper-based system followed by data entry into an electronic database (Zambia E-last). In most CPs, especially when a DA supports more than one CP, Option 3 is used. If a DA is present full-time at a CP, another option can be used. Data from a CP is linked to the parent health facility; the CP data feeds into the parent facility database, and the parent facility reports CP data up to next levels. The following steps describe data collection for Options 2 and 3.
Step 1	**Data recording:** Clinicians add data to patient chart, and data is recorded in the registers, including: • HIV care and treatment register. • HVL register. • TB presumptive case register. • TPT register. • [VL sample tracking register].

Step 2	**Data entry:** The DA enters data from client charts into the patient-level database (SmartCare), and runs a transport database to capture and migrate weekly CP data to the main server for SmartCare. Data entry occurs: • Before patient leave the health facility (E-fast; one DA per facility). • At a later moment (E-last; a DA supports more than one CP).
Step 3	**Data management:** The transport database that is run at the CP is saved on laptop and external hard drive on a weekly basis. The DA brings hard drive with CP data to the parent facility where the M&E officer merges CP data into the parent facility database (the national patient medical record system).
Step 4	**Daily reporting and feedback:** The DA and CP team leader report daily results for key indicators in WhatsApp group: • Number of clients tested for HIV (HTS_TST). • Number of clients testing HIV positive (HTS_POS). • Number of client newly enrolled on ART (TX_NEW). * WhatsApp group includes CP team leaders, data associates, parent facility in-charge and ART coordinator, and relevant IP/MOH program staff.
Step 5	**Data Quality:** DA conducts quality checks of CP data on a weekly and monthly basis.
Step 6	**Monthly and quarterly reporting:** Parent facility validates, consolidates, and reports CP data to higher levels (MOH/IP).

10.2 PERFORMANCE REVIEW AND FEEDBACK

DESCRIPTION

A best practice in the CP model is regular provision of feedback on performance to CP teams. This facilitates recognition for good performance, as well as rapid response in case of underperformance. This tool provides an overview of data use to improve CP performance.

USERS

Users for this tool include MOH and IPs planning the implementation of the CP model and the CP team that will receive feedback and benefit from the performance review and feedback mechanisms.

ACTIVITY	CONTENT/ISSUES ADDRESSED	WHO
WhatsApp group	• Results for key indicators are reports by DA via WhatsApp on a daily basis. • CP weekly and monthly results are consolidated. • Results for all CPs are shared via the WhatsApp. • Response is given to the results, applauding well-performing CPs for good results.	CP teams, parent facility staff ART coordinator IP staff.
Daily pep talk	• CP team meets at the start of the day to discuss results for reported key indicators, performance, and challenges. The meeting is used to troubleshoot and encourage results.	CP team leader with CP team.
Monthly data review meetings	• Discuss performance of all program indicators and identify improvement strategies. • Assess progress toward improvement action plans. • Share updates regarding policy or guideline changes. • Share other program updates.	IP with CP team leads in catchment area of parent facility.

Quarterly data review meetings	• Organized and facilitated by IP with all CPs and their parent facilities to:
	  – Discuss performance of all program indicators and identify improvement strategies.
	  – Assess progress toward improvement action plans.
	  – Share updates regarding policy or guideline changes.
	  – Provide other program updates on overall program performance, challenges, solutions and recommendations.
		IP/MOH with CP team leaders of all CPs facility and ART in-charges of parent facilities of CPs.

MODULE 11:
Monitoring and Reporting of Community Post Performance

INTRODUCTION

Module 11 focuses on the challenges experienced by CoH during the implementation and scale-up of the CP model. The module describes these challenges that IPs should be aware of and anticipate. The module also discusses the strategies employed by CoH to address these challenges. Challenges can be categorized as challenges experienced with 1) communities and community leadership; 2) other implementing partners and/or the MoH; 3) service providers; and 4) logistical challenges.

KEY MESSAGES FROM MODULE 10 INCLUDE:

■ CP implementation has not been without its challenges;

■ Various challenges experienced by CoH during CP implementation and scale-up should be anticipated by other IPs planning CP implementation;

■ Mitigation strategies discussed in this module.

11.1   DATA COLLECTION AND FLOW

DESCRIPTION

As in any other implementation model, a number of barriers and challenges may affect the implementation and outcomes of the CP model. This tool describes barriers and challenges experienced in the implementation of the CP and strategies that CRS/CoH and CP staff have used to overcome these challenges.

USERS

Users for this tool include MoH and IPs planning the implementation of the CP model and the CP team providing services within the CP. Training facilitators use this tool as a reference to discuss challenges and response strategies throughout the training.

MODULE 11

CHALLENGES	STRATEGIES
COMMUNITY/COMMUNITY LEADERSHIP	
• People think the CP will not be a permanent facility. • Suspicion, belief systems, and stigma in communities.	• Regular meetings with communities and their leaders. • Invite community and faith leaders to see the parent facility and IP officers, especially during scanning process and launch (participation in scanning). • Foster relationships with the community; build trust. • Attend community events. • Share results and obtain community feedback during meetings (with focus on customer care).
IMPLEMENTING PARTNERS/MOH	
• Local politics of ownership/success attribution. • Jealousy of other partners/stakeholder/facilities. • IP claims to targeted geographical area. • Partners implementing the model take time to know the model and adapt supervision approach, monitoring, and logistical support needed.	• Orientation of stakeholders on the CP model (IPs, MoH, agencies), including RECIPE and customer care and how this applies also to partnership. • Share data on the success of the CP. • Leveraging stakeholder relationships; participate in events when invited to foster relationships.
SERVICE PROVIDERS	
• Lack of understanding of the model by service providers and CHW. • Orientation and training needed for CHW to really grasp the CP model and RECIPE. • Lack of capable local CHW compromising the quality of support provided by CHW. • Silo mentality of service providers and CHW. • Stigma among HCP.	• Orientation on CP and RECIPE. • Ongoing coaching and mentorship of the CP teams. • Customer care training across the full cascade. • Pep talk, performance feedback (encouragement, praise via WhatsApp). • Stigma training for HCP (see 3.2: Resources to Address Stigma).
LOGISTICS	

• Findings the best fit between a suitable space and an affordable space.
• Partners implementing the model take time to know the model and adapt supervision approach, monitoring, and logistical support needed.
• Resource gaps:
  – Inadequate funding to support logistics, including transportation;
  – Gaps in supply chain (OI drugs).
	• Community scanning.
	• Orientation of MoH/IPs on the model, including planning for logistics (including for SV and monitoring).
	• Facilitate redistribution/stock sharing with other facility partners to ensure steady supply.
	• Leverage stakeholder relationships/sharing of resources.

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References

1 World Health Organization (WHO) (2011). Global HIV/AIDS Response: Epidemic update and health sector progress towards Universal Access: Progress report 2011, and UNAIDS (2014). Guidance note: Reduction of HIV-related stigma and discrimination [pdf]

2 Kalichman S. C., Pope H., White D., Cherry C., Amaral C. M., Swetzes C., Flanagan J. & Kalichman M. O. (2008). Association between health literacy and HIV treatment adherence: further evidence from objectively measured medication adherence. Journal of the International Association of Physicians in AIDS Care (Chicago, Ill. : 2002), 7(6), 317–323. https://doi.org/10.1177/1545109708328130

3 Wolf M., Davis T., Arozullah A., Penn R., Arnold C., Sugar M., Bennett C. (2005). Relation between literacy and HIV treatment knowledge among patients on HAART regimens. AIDS Care.17:863–873. [PubMed] [Google Scholar]

Endnotes

I   World Health Organization (WHO) (2011) 'Global HIV/AIDS Response: Epidemic update and health sector progress towards Universal Access: Progress report 2011' and UNAIDS (2014) 'Guidance note: Reduction of HIV-related stigma and discrimination'[pdf]

II https://www.iasociety.org/web/webcontent/file/integratingstigmareductionintohivprogramming_lessonsafrica_alliance.pdf

III PEPFAR. PEPFAR blueprint: creating an AIDS-Free generation. Washington, DC: The Office of the Global AIDS Coordinator; 2012