SUMMARY OF DIFFERENTIATED SERVICE DELIVERY MODELS

SEPTEMBER 2018

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	:	Acquired Immune Deficiency Syndrome
ART	:	Antiretroviral Therapy
ARV	:	Antiretroviral
CASA	:	Community ART Support Agent
CDC	:	US Centers for Disease Control and Prevention
CDDP	:	Community Drug Distribution Point
CCLAD	:	Community Client Led ART Delivery
CSO	:	Civil Society Organization
DSDM	:	Differentiated Service Delivery Model
DSD	:	Differentiated Service Delivery
FSW	:	Female Sex Workers
HIV	:	Human Immunodeficiency Virus
KP	:	Key Population
MSM	:	Men who have sex with Men
M&E	:	Monitoring and Evaluation
MOH	:	Ministry of Health
PEPFAR	:	Presidents' Emergency Plan for AIDS Relief
PLHIV	:	People Living with HIV/AIDS
TASO	:	The AIDS Support Organization
WHO	:	World Health Organization

DSD MODEL FOR CHILDREN AND ADOLESCENTS

Differentiated [ART delivery] for [Children and Adolescents], [Uganda]

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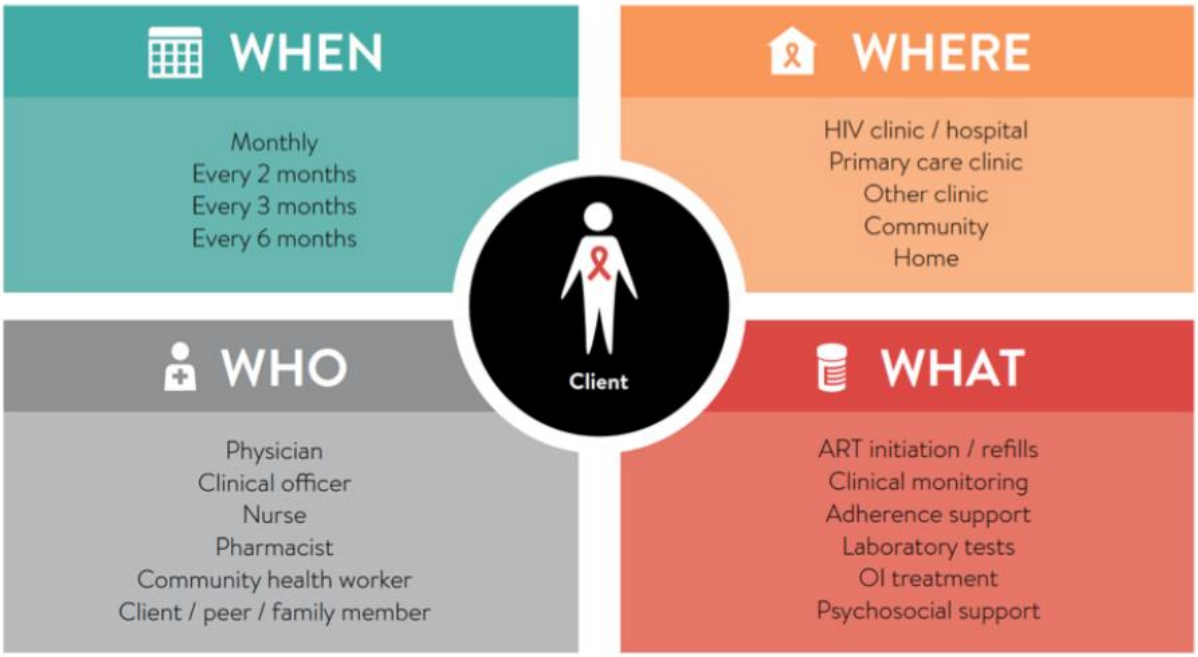
OVERVIEW

TASO operates community ART care models in different communities within 75km in the radius of the facility (organisation, 2015). Different service delivery points were identified in the community attached to an adult CDDP. These were formed basing on the numbers in those particular communities (4- 30 children and adolescents per group), distance to a public health facility, and distance to the TASO facility and availability of pediatric regimens at the public health facilities. ART monitoring is done by health worker personnel every one month, two months and three months depending on health status. Services offered include, medical reviews, treatment of opportunistic infections, routine laboratory tests, counselling, referral and linkage for other services. The model focuses on retention and viral suppression among children and adolescents in the HIV care cascade. Adolescents who outgrow the age are taken through a transition process to later join the adult CDDP and later the CCLAD groups. However, this good practice is not well documented.

Figure 2: Building blocks for ART refills



If you provide ART – present the building blocks for ART refills, clinical consultations, and psychosocial support

Table 2: The building blocks of a differentiated ART delivery model for children, and adolescents

	ART refills	Clinical consultations	Psychosocial support
WHEN	Every 1 month- for the unstable. Every 2 months- for the stable ones	Every 1 month Every 2months	1month 2 months

	ART refills	Clinical consultations	Psychosocial support
	Every 3 months- for the stable	Every 3months	3 months
WHERE	Community	Community, facility, home	Facility, community, home
WHO	Doctor, Clinical officer, Pharmacy technician, A nurse, Counsellor, Peer client	Doctor, Clinical officer, Nurse	Counsellor, Doctor, Nurse Clinical officer
WHAT	ART refills, clinical monitoring, OI treatment, Adherence support, Laboratory test.	Clinical monitoring, OI screening and treatment, Adherence support, Laboratory tests	Adherence support, ART refills, family support

Describe the intervention HOW

This model focuses on viral suppression and retention among children, adolescents and their caretakers in HIV care cascade.

A dispensing list is printed by M&E and taken to records for file retrieval. *Files are retrieved basing on the Client list. Pharmacy staff prepacks drugs basing on the dispensing list. Pre-packaged drugs are picked from the pharmacy by the attending clinician/pharmacy technician/Nurse dispenser. The team of staff leaves to the DSDM clinic at a greed time. Health talks are given. Triage is carried out by the clinician and the counsellors. Nutrition assessment and growth monitoring are done. Children and adolescents are taken through transitioning process for adult CDDP. Individual or group counselling is done. Individual clinical review and Laboratory tests are conducted. Provide treatment for OIs and manage side effects if any. Clinician/Counsellor records in the client book and in appointment book the return date. Educate the patients/care taker about how to take different medication prescribed. Dispensing of drugs. Follow-ups are done for missed appointments by a clinician / a counsellor/linkages officer/expert client following the missed appointment procedure. From the community dispensing lists are taken to pharmacy for updating.*
Client files are taken to M&E for entry.

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Eligibility criteria

The following criteria is what was based on at the start;

- *An HIV positive child, adolescent and a guardian or parent to that child.*
- *Coming from far distance of around 75 kilometres from the TASO centre.*
- *The number of children and adolescents coming from the same location 4 or more.*
- *Child should be on ART despite duration or ART regimen.*
- *Lack of paediatric regimen at the nearby community public health facility.*

Type of model

It is both Health care worker managed group and out of facility individual model. Community drug distribution points (CDDP) were identified from the community basing on the existence of an adult community dug distribution point run by TASO, groups of 4-30 were formed basing on the number of children in those particular community who were already on ART, distance to the public health facility to access ART services, distance to the TASO centre and lack of paediatric regimens at the public health facilities.

The services offered are Medical reviews, Treatment of Opportunistic Infections, Routine laboratory tests, counselling, Referral and linkage for other services.

It's a community based service offered by a Non-Government Organisation (indigenous).Review is done every one Month, two months and three months depending to the health status of the client.

The unstable children adolescents and care takers are reviewed monthly. The stable review is done 2 months or 3 months basing on appointment schedule.
The district and community leadership structures are vital to the delivery process of DSDM in terms of structural support.
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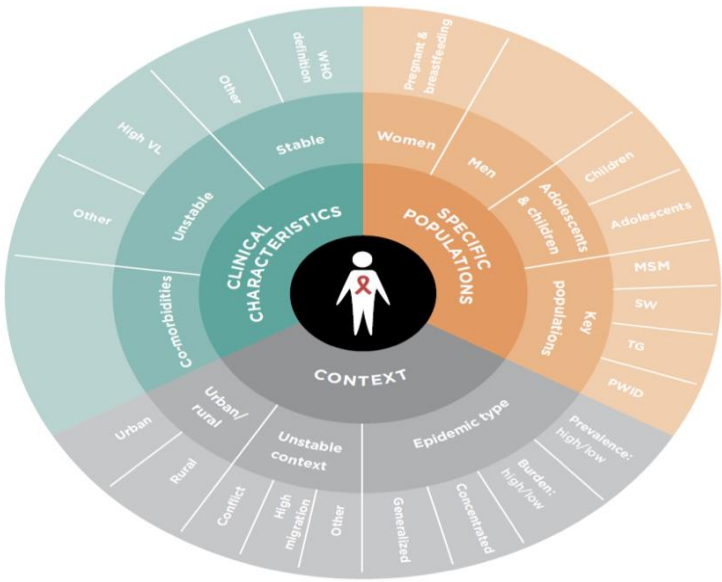
Figure 1: The three elements – clinical characteristics, specific populations, and context



IMPLEMENTING THE INTERVENTION

Describe the highlights of steps to get this service(s) operational

- *Files are retrieved basing on the Client list*
- *Prepackaged drugs are picked from the pharmacy by the attending clinician/pharmacy technician/Nurse dispenser guided by the client CDDP list.*
- *The team of staff leaves to the DSDM clinic at a greed time.*
- *Health talks are given.*
- *Triage is carried out by the clinician and the counselors*
- *Growth monitoring through taking anthropometric measurements*
- *Nutrition assessment is done.*
- *Individual or group counselling is done.*
- *Individual clinical review and Laboratory tests are conducted.*
- *Clinician/Counselor records in the client book and in appointment book the return date.*
- *Dispensing of drugs.*
- *Follow-up are done for missed appointments by a clinician / a counsellor.*
- *From the community dispensing lists are taken to pharmacy for updating.*

Was this a pilot project? *Has it been expanded? Taken to scale?*

- *It was an innovation by The AIDS Support Organization- Mbarara branch not yet scaled out to other TASO sites*

Did you train staff? What teaching materials did you use? Was a lot of supervision required?

- *Yes, staffs were trained in paediatric and adolescent HIV care and management, Principles of ART, Clinical Management of HIV in Uganda, Child counselling and TB/ HIV co-infection.*
- *The training materials were Standardised training guides (participants and facilitators), assorted illustrated materials (visual Aids, audios, videos) and Practical field experience.*
- *Yes, Monthly supervisions were conducted during the first one year thereafter quarterly in order to achieve the results of the model.*

What kind of training do clients receive?

- *Basics on identifying sick children and referral, basics on communicating with children, reporting, updates on HIV care and treatments through review meetings and health talks*

How did you track progress? What M&E elements did you build into the model?

- *Progress was trucked during review visits, clients attendance, Monthly and quarterly reports and quantitative and qualitative progress reports.*
- *M&E through conducting Quarterly performance reviews.*
- *Client satisfactory surveys.*

How much do you estimate getting the services operational cost? Where did this money come from?

- *TASO's experience with community-based ART service delivery has shown that this model can reduce costs from **US$332** to **US$233** per patient per year and has been highlighted as a model for scale-up globally.*

Overall was this feasible?

***Yes it was feasible because**:*

- *It is far less costly than the national which is 420 USD.*
- *Skilled personnel who were already in the organisation.*
- *Free community venues.*
- *Stake holder's willingness.*
- *Community willingness, participation and involvement.*
- *Peer leaders to work on voluntary basis with minimal incentives.*
- *It was integrated into the already existing adult ART community delivery program.*

DATA

Share any data, quantitative or qualitative, on outcomes or perspectives – could be uptake of the intervention, anecdotes from clients, etc.

- *The model serves 93 children and adolescents in 6 community drug distribution points.*
- *Children less than 10 years are 15 then 10-19 years are 78.*
- *A retention analysis shows that 91% (93 out of 102) are retained in care since inception of program 2010.*
- *Viral suppression was 89% by December 2017 (TASO Mbarara MIS)*
- *Transfer out were 6 (5.9%)*
- *2 (1.96%) lost to follow*
- *1 refused drugs- an adolescent.*

CHALLENGES AND SUCCESS

What made this a success? What challenges arose and how did you respond to them?

Success

- *Attaching specific service providers to attend to the children and adolescents*
- *Internal streamlined systems focusing on community routine visits (schedules)*
- *Active and committed peer leader to coordinate the CDDP.*

- *Periodic evaluation to monitor treatment success*
- *Team work among service providers leading to reduced workload.*
- *Reduced waiting time benefited the clients promoting retention*
- *Timely follow ups for the missed appointments*
- *Accessibility since the services are brought nearer with in the community.*
- *Good working relationship with community stakeholders*
- *Identification and clustering HIV positive children and adolescents from same locality.*
- *Availability of resources and logistics(personnel, drugs, means of transport, stationary)*

Challenges

CHALLENGE	SOLUTION
Drug distribution care points- environment does not meet the standards for child friendly recreation needs.	*Create a child/adolescent places when funds are available*
Social economic needs of the children not addressed like education, social well-being, skills building, housing, Nutrition	*Integrate OVC support into the community program if funds are available.*
Sexual and reproductive health (SRH) needs not addressed for the growing adolescents	*Include the package for SRH in the community services*
Elderly and illiterate care takers	*Continued efforts towards strengthening family support systems, ongoing counselling and health education.*
School schedules that have affected honouring the appointments.	*Increased on the refill periods to three months for the stable ones.* *Realigning appointments with holiday period.* *Accepting representation by caretakers where necessary.*

NEXT STEPS

Do you have plans to expand or take your intervention(s) to scales?

- *Yes, we would like this model to be scaled up across all TASO clinics.*

How are you working with government and other partners?

- *Joint planning and review meetings*
- *Sharing reports*
- *They carry out support supervision*
- *Through referral and linkages*
- *For networking and advocacy.*
- *Capacity building through mentorships and coaching.*
- *Using the existing government community health structural systems to support the success of the model.*
- *Some drugs and supplies are accessed through the government supply chain and other implementing partners*

STANDARD OPERATING PROCEDURE (SOP) FOR CHILDREN AND ADOLESCENTS

Purpose: *The goal of the following SOP is to provide guidance for TASO implementers to improve rates of viral suppression and retention of children, adolescents and their caretakers in CDDP for HIV care in the community. It is meant to define a series of minimum procedures which are both efficient and sustainable to enhance viral suppression and retention in HIV care in a community model*

Scope: *Children, adolescents and their caretakers on ART care in a community model (unstable and stable)*

Prerequisites

- *ART register*
- *Appointment book*
- *Client's book*
- *Clients file*
- *Dispensing lists*
- *Monitoring tools (weighing scale, Height measure, MUAC tapes)*
- *Drugs (ARVs, for OI treatment)*
- *Job Aids*
- *Airtime*
- *Laboratory equipment and reagents.*

Responsibilities

- *Doctor/Clinical officer/Laboratory technician/Linkage facilitator/Nurse/M&E officer/Records clerk /Counsellor/Expert clients.*

Doctor/Clinician:

- *Clinical monitoring and review of the client on every visit.*
- *Screens and Manages opportunistic infections.*
- *Referral and linkage:*
- *Laboratory monitoring.*
- *ART refills.*
- *Home care.*
- *Health education*

M&E:

- *M&E Officer generates a list of DSDM clients*
- *Records clerk retrieves files for all clients on the list generated by M&E.*
- *Compiles reports of patient tracking activities and ensures update of information in the databases*
- *Filing and record keeping*

Nurse

- *Makes home care visits to unstable clients*
- *ART refills/ administering OI treatment.*
- *Adherence support.*
- *Carry out Health talks.*
- *Nursing care.*
- *Clinical assessment.*

Counsellor

- *Home visits.*
- *ART refills.*
- *Adherence support.*
- *Psychosocial support.*
- *Health talks.*

Expert client

- *Follow up clients.*
- *Peer support and experiential sharing*
- *Coordinate the DSDM activities.*
- *Involved in generation and submission of reports.*

Linkage Facilitator

- *Follow ups for missed appointments. (Phone calls/physical visits)*
- *Coordinates all the follow up activities.*
- *Compiles reports of patient tracking activities and submits information to the M&E Officer for updating in the electronic system*

Laboratory technician.

- *Conduct phlebotomy.*
- *Conduct the tests*
- *Provide result and disseminate.*

Pharmacy technician.

- *Prepacks the drugs for the generated list of DSDM clients.*
- *Dispenses drugs.*
- *Updating the dispensing list in the electronic system*
- *Health talks.*

Procedure for clinic with Electronic Appointment System

- *Basing on the appointment schedule, a list is printed out and drugs are packed accordingly.*
- *Retrieval of the files for patients who are on this list.*
- *If a client missed appointment, it's reported to the linkage facilitator for follow-up.*
- *If returned, its updated and entered in the electronic system.*
- *If lost to follow, it's still updated and entered in the electronic system*
- *Transfers are also updated accordingly.*

Procedure for clinic with manual appointment system

- *Clients who turn up on their appointment dates are updated in the appointment book.*
- *A return date is noted in the client's book and also noted in the appointment book.*
- *All clients who miss appointment are followed up immediately by phone calls or physically to their homes by a staff or peer Leader.*
- *If the client not seen then handed over to a linkages facilitator and continuous efforts are made for follow up.*
- *Immediately when client is brought back, it's updated in the appointment book.*

Procedure for operating children, adolescent and their care taker DSDM Clinic.

- A dispensing list is printed by M&E and taken to records for file retrieval
- *Files are retrieved basing on the Client list*
- *Pharmacy staff prepacks drugs basing on the dispensing list.*
- *Prepackaged drugs are picked from the pharmacy by the attending clinician/pharmacy technician/Nurse dispenser*
- *The team of staff leaves to the DSDM clinic at a greed time.*
- *Health talks are given.*

- *Triage is carried out by the clinician and the counselors*
- *Nutrition assessment and growth monitoring are done*
- *Children and adolescents are taken through transitioning process for adult CDDP.*
- *Individual or group counselling is done.*
- *Individual clinical review and Laboratory tests are conducted.*
- *Provide treatment for OIs and manage side effects if any.*
- *Clinician/Counselor records in the client book and in appointment book the return date.*
- *Educate the patients/care taker about how to take different medication prescribed.*
- *Dispensing of drugs.*
- *Follow-ups are done for missed appointments by a clinician / a counsellor/linkages officer/expert client following the missed appointment procedure.*
- *From the community dispensing lists are taken to pharmacy for updating.*
- *Client files are taken to M&E for entry.*

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References

- *National Peadiatric and Adolescent HIV Treatment Guidelines*
- *Patient Charter*
- *Uganda Clinical Guidelines*
- *TASO Medical Guidelines*
- *TASO clinic flow chart.*
- *National Counselling guidelines*

DIFFERENTIATED TESTING FOR MSM PEER DRIVEN REFERRAL MODEL

Differentiated [Testing] for [MSM] Peer Driven Referral Model, [Uganda]
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OVERVIEW

In 2013, TASO Entebbe started engaging Men who have sex with Men (MSM) peers to identify and link others for prevention, testing, treatment and care. This was because these men could not freely come out to seek services due to the prevailing legal environment in Uganda about MSM and associated social stigma from communities yet the prevalence rate of HIV among MSM was noted to be high (13.7%) (Kajubi, et al 2008). The prevalence among MSM is double that of the general population (6.4%) and triple that of men (4.7%) (UPHIA, 2012). It is therefore upon this background that TASO Entebbe started implementing Peer Driven Referral (PDR) for the HIV prevention package among MSM to increase on uptake of health services.

Peer Driven Referral (PDR) is a chain referral mechanism which was adopted to be used among hidden populations. It encourages peers to recommend HIV prevention and treatment services to their colleagues. It is more like the snowballing sampling technique that enables a service provider reach as many members of a disenfranchised community. This model also derives basic tenets from Respondent Driven Sampling (RDS), and it has been modified to identify MSM for HCT and other “male friendly” reproductive health services**.** TASO Entebbe piloted this model with ten (10) initial MSM peers. They were provided with 3 referral coupons for each participant. The network expanded to 799 MSM of whom were diagnosed with HIV and initiated on ART. This intervention has enabled the team to address the challenges of retention due to the very mobile nature of this group, the associated social stigma and discrimination from the general population among others. Continued use of the PDR model has bridged the accessibility gap to quality health care services since MSM are vulnerable to the transmission of HIV and STIs due to frequent alcohol use and low condom use (Kabaale et al, 2017). In addition, they also have multiple sexual partners (Kajubi et al, 2008). Since there is neither National data available to show performance on major indicators on MSM collected such as number of MSM on ART, retention, viral load suppression nor minimum service package received by MSM as recommended in the minimum service package, the PDR model is anticipated to address this challenge.

ELIGIBILITY CRITERA

Please provide a more detailed description of who is eligible for you practice example? Eligibility for HIV negative MSM)

- Man who has ever had sex with a man irrespective of sero status
- 18 years and above
- Willing to receive coupons
- Accept to work as seeds and enthusiastic to recruit others
- Consent to be tested for HIV and access MSM service package
- Willing to return for services
- Willing to disclose sexual orientation to significant others

Eligibility for HIV positive MSM

- Man who has ever had sex with fellow man
- 18 years and above
- HIV positive and willing to enroll on ART.
- Willing to join a CCLAD group

For stable MSM

- *The MSM must be virally suppressed ≤1000copies/ml of blood after six months on ART*

- *MSM should not have an active WHO stage 3 or 4 disease.*
- *MSM should not indulge in harmful behavior that affects adherence (substance abuse e.g. smoking, alcoholism, Gender Based Violence)*
- *Should not be a highly mobile MSM for more than six months.*
- *In case of switch of ART regimen, then client should have been on the current regimen for 6 months*

For the unstable MSM

- *Just been initiated on ART*
- *Not yet bled for viral load*
- *Likely to have comorbidity*
- *Actively involved in harmful behavior especially alcoholism and drug abuse*
- *On second line ART regimen despite reasons for switching.*

Figure 2: Building blocks for ART refills

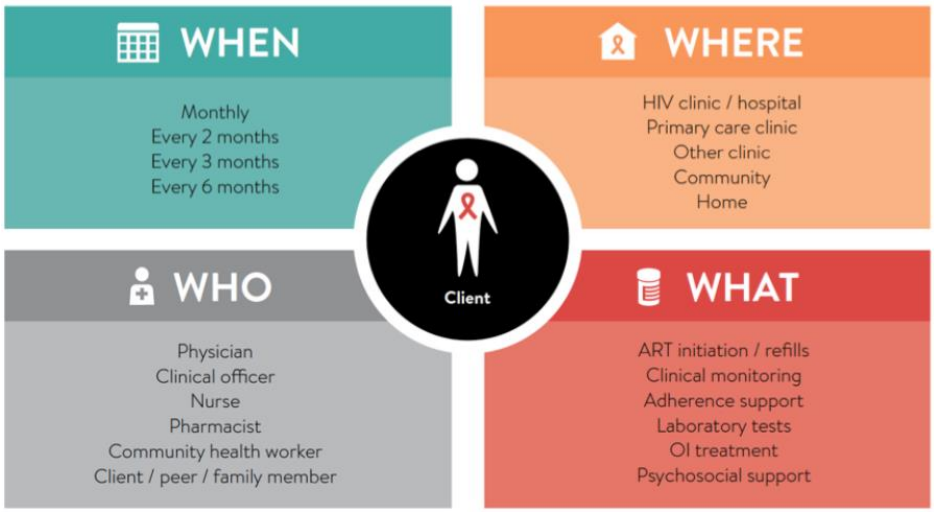
If you do HIV testing – present the building blocks for mobilizing (mass/group, network-based, partner notification and index testing), testing (health facility, non-health facility, community, self-testing) and linking (referral, accompaniment, compensation/incentives, same day ignition, friendly services, tracing)

Table 1: The building blocks of a differentiated HIV testing

	Mobilization	Testing	Linkage
WHEN	All time	• Any convenient time.	• Immediate and/ or within 01 month
WHERE	Community, hotspots,	• Community, • MSM hotspots, • TASO primary care clinic, • KP CSO offices, • Drop in centres	• TASO clinic • Public health facility • Most at Risk Population Initiative (MARPI) clinic.
WHO	MSM peers (seeds and peers)	• Lab technician, • counsellor, • Self, • Trained peer	• Counsellor • Clinicians • Seeds • Peers
WHAT	Distribute: IEC materials, coupons, condoms and lubricants, AIDS awareness/sensitization on availability of men's health services	• HIV testing, • Health education • STI screening and treatment, • Pre and post- test counselling, • ART initiation, • HBV screening • condoms and lubricants	• Referral form • Follow up: Telephone or physical visit • Recording ART number in the referral and linkage register

		• Family Planning (for bisexuals) • GBV screening	

Figure 2: Building blocks for ART refills (Unstable)



When • **ART refills:** Monthly refill • **Clinical reviews:** Monthly for the non-stable ones. • **Psychosocial Support:** Routinely as need arises. • **Service hours:** Flexible as per group • **Drug dosage adjustment:** Adjustment is done depending on client context. • **Longer ART supplies:** Not applicable for the unstable	**Where** • Hired room in lodge/bar • Both TASO Facility and community (by the MSM peer Leader) for those who are just initiated • Tent (with screens) for private examination • Open place (for non- clinical examinations) i.e. for psychosocial support/client education
Who • Social Worker/Counselor (ART refill) • MSM Peer Leader (ART delivery to final client) • Doctor and clinical officer (clinical consultations) • Counselor (psychosocial support)	**What** • Clinical Services: (Nutrition monitoring, adherence measurement, Tuberculosis screening, Opportunistic Infections examinations if any, Laboratory investigation (Viral Load and CD4 count); weight monitoring, Mental Health screening. • Psychosocial Services: (adherence counseling, condom/lubricant education/distribution, GBV screening, peer counseling, risk reduction counseling, behavior change communication, referral for other psychosocial needs not provided such as economic needs and education. • Assisted Partner Notification

If you provide ART – present the building blocks for ART refills, clinical consultations, and psychosocial support

Table 2: The building blocks of a differentiated ART delivery model (Stable)

	ART refills	Clinical consultations	Psychosocial support
WHEN	Every two months/ 6 times a year for the stable. One monthly refill for the non-stable **Longer ART supplies:** 3 – 4 months for the very mobile MSM.	Semi-annually for the stable ones and monthly for the non-stable ones.	6 times a year for the stable ones and routinely/as need arises for the non-stable ones.
WHERE	Hired room in lodge/bar or TASO facility	TASO Entebbe Facility, hired room in lodge/bar in the community	Hired room in lodge/bar in the community or TASO facility
WHO	• Counselor/Clinician • MSM Peer Leader (ART delivery to final client) •	Doctor and clinical officer (clinical consultations)	• Social Worker/Counsel or (psychosocial support)
WHAT	Stable MSM - ARVs, condoms, lubricants	Clinical Services: (Nutrition monitoring, adherence measurement, Tuberculosis screening, Opportunistic Infections examinations if any, Laboratory investigation (Viral Load and CD4 count); weight monitoring, Mental Health screening. Unstable – Management of OIs. STI	Psychosocial Services: (adherence counselling, condom/lubricant education and distribution, GBV screening, peer counseling, risk reduction counseling, behaviour change communication, referral for other psychosocial needs not provided such as economic needs and education MSM partner services

- ***Describe the intervention HOW***
  - If it is an ART delivery model, what type? (Health care worker managed group, client-managed group, facility-based individual model, or out-of-facility individual model?

Procedure (HOW)

Conduct stakeholder meeting between clinic staff and self- identified MSM leaders to identify primary seeds and map out the hotspots. Discuss logistics required, service package and the implementation modalities. Primary seeds are then given three coupons each to recruit their peers and link them to the service.

The recruited peers are then provided with MSM recommended service package that includes HIV testing, STI screening and treatment, Condoms and lubricants, risk reduction counselling , behavior change communication and health education.

The first wave of peers is given coupons at exit to recruit more peers and the process of recruitment, referral and linkage continues,

MSMs who test positive are linked to care and treatment services at TASO clinic or any preferred facility of their choice.

The negative MSM are re-tested after every 03 months and continue receiving prevention service package to remain HIV negative.

For those diagnosed with STIs are treated and encouraged to re-test after one month

The serialized coupons that seeds took are returned by peers and are linked to the recruiter manually by the coupon manager before the recruits receive the services. Thereafter, the primary seeds who were able to recruit the peers and link them to services are given some incentive and for any linked peer, they redeem.

At the third wave, the initial seeds no longer redeem any incentive but continue to receive HIV/STIs and other opportunistic infections health services.

Pharmacy staff generates lists of HIV +MSM in the groups and for the negatives presenting with STIs and opportunistic infections to be served at least one week before the activity is due

Pre-pack the drugs for each group and package for each HIV positive MSM separately with appropriate labeling then for STIs and opportunistic infections general.

Pharmacy staff issues the ARVs and drugs for STIs / opportunistic infections other commodities to the clinician and counsellor in charge who verify the correctness and acknowledges receipt.

Counselor makes a call reminder to the MSM CCLAD peer leader of the due appointment for ART refills and general reviews for the HIV negatives who presented with STIs. MSM leaders conduct health talks, behavior change communication and TB screening to the group members in CCLAD and HIV testing services outreaches.

Counselor issues drugs and other commodities to MSMs CCLAD group leader who acknowledge receipt. This can be done at either the Facility or at a hotspot/bar.

CCLAD leaders document information about individuals in the group on the form and issue drugs whose receipt is acknowledged by the MSM through signing or thumb printing.

The MSMs leaders follow up clients that have missed appointments at CCLAD and HIV testing outreaches for those who presented with STIs in previous activities.

Submit the forms and reports to the Counselor in charge.

Counselor in charge transcribes the data collected into the appropriate client monitoring tools (HIV care cards) before it is entered electronically into the databases.

If you provide ART – present the building blocks for ART refills, clinical consultations, and psychosocial support
Describe the intervention HOW

PDR is a chain- referral model which embraces the concepts of snowballing but largely borrows the principles of Respondent Driven Sampling (RDS) technique and Multi-level marketing (MLM) also called pyramid selling, network marketing, and referral marketing. Peer identification is done by fellow MSM peers. The services are delivered through three approaches of community outreach to drop in centers (hotspot), CSO office, static (facility) and moonlight Key partnerships include the MSM led CSOs, Public Health facilities, owners of facilities located in hotspots such as bars, lodges and restaurants and local leaders.

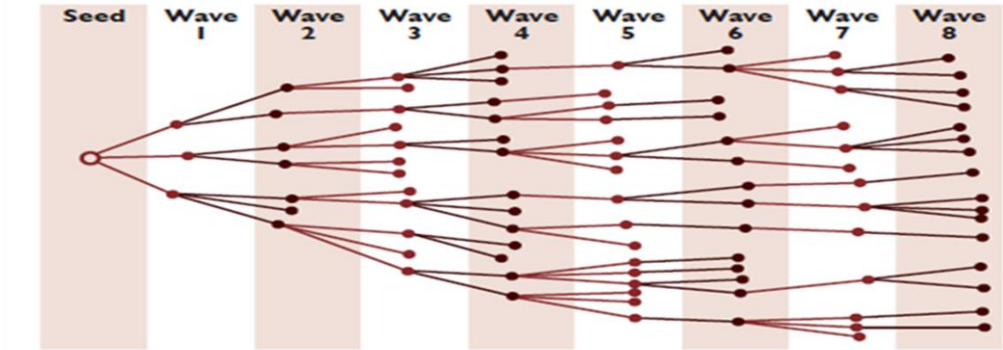
Describe the type of service (Government/NGO, community-based, community-led, health facility satellite, DIC, outreach, involving/employing peers)
The service is provided by a National level NGO with service centers spread across the country.
Employs a mix of approaches with CCLAD for stable and unstable MSM. The service package for stable include 2 months ART refill and VL monitoring annually while for unstable MSM in CCLAD groups are refilled monthly and monitored for OIs as and when need arises.
It also both community – led , health facility for HIV / STIs testing to cater for HIV prevention.

What kinds of partnerships are vital to the delivery process?
- ✓ Partnership with the local community leaders and law enforcement agents like police.
- ✓ Public health facilities for referral for management of specialized conditions.

IMPLEMENTING THE INTERVENTION

Describe the highlights of steps to get this service(s) operational

Conduct stakeholder meeting between clinic staff and self- identified MSM leaders. The purpose of the meeting is to identify primary seeds and map out the hotspots, discuss logistics required, service package and the implementation modalities. Primary seeds are then given three coupons each to recruit their peers and link them to the service. The recruited peers are then provided with MSM recommended service package that includes HIV testing, STI screening and treatment, Condoms and lubricants, health education. The first wave of peers is given coupons at exit to recruit more peers and the process of recruitment, referral and linkage continues as illustrated below



MSM who test positive are linked to care and treatment services at TASO clinic or any preferred facility of their choice. The negative MSM are re-tested after every 03 months and continue receiving prevention service package to remain HIV negative. For those diagnosed with STIs are treated and encouraged to re-test after one month.

Coupons and incentive management
The serialized coupons that seeds took are returned by peers and are linked to the recruiter manually by the coupon manager before the recruits receive the services.

Thereafter, the primary seeds who were able to recruit the peers and link them to services are given 5,000/= and for any linked peer, they redeem 3000/=. At the third wave, the initial seeds no longer redeem any incentive but continue to receive HIV/AIDS services.

Was this a pilot project? Has it been expanded? Taken to scale?

Yes, this was pilot model at TASO Entebbe and expanded to Regional Referral Hospital in Soroti

Did you train staff? What teaching materials did you use? Was a lot of supervision required?

The KP focal person and other 05 colleagues were trained at WHO collaborating Center Andrija Stampar School of medicine in Zagreb-Croatia in prevention, diagnosis and care for Key populations and programme evaluation. Subsequent to the training, the team was able to design and implement peer driven pilot study among MSM at TASO Entebbe Center

What kind of training do clients receive?

- *Clients are trained on how to approach their peers, address issues of recruitment, benefits and referral*

How did you track progress? What M&E elements did you build into the model?

- *Monthly meetings to assess progress and discuss challenges and solutions*
- *Utilized TASO program tools with MSM unique identifiers*
- *Quarterly Performance review meetings*

How much do you estimate getting the services operational cost? Where did this money come from?

- *TASO's experience with community-based ART service delivery has shown that this model can reduce costs from **US$332** to **US$233** per patient per year and has been highlighted as a model for scale-up globally.*

Overall was this feasible?

- *Yes compared to unit cost of identifying one HIV positive person at 45$*

3 DATA

Is there evidence of success? (Including client outcomes, client satisfaction, HCW perspectives, waiting times, etc.)

Sept 2016 to March 2018

Number given coupons	799
Number returned	694
Number tested	694
Number positive	19

Share any data, quantitative or qualitative, on outcomes or perspectives – could be uptake of the intervention, anecdotes from clients, etc.

MSM Outcome comparison with other KP categories at TASO Entebbe-

Category	No. on Art	No. Monitored for VL	No. suppressing	%
CSW	**86**	**61**	**57**	**93%**
Truckers	**22**	**17**	**16**	**94%**
Fisher Folks	**254**	**221**	**199**	**90%**
MSM	**17**	**11**	**11**	**100%**

Quotes

". There is a personal relationship you develop with group members and become a brother's keeper. It encourages us to socialize with each other at a personal level.

"Generally as humans or LGBT. I prefer a place I am free with, where I normally come and I am free with them, when I come they just give it to me"

"To me, a peer always has people that trust him, so I think if he is a peer distributing the test kits, it can be good for me then he will be the one to refer me to hospital in case he finds that he is positive, he will have to go hospital"

4 CHALLENGES AND SUCCESS

What made this a success?

- *Committed TASO team*
- *Proactive seeds and responsiveness in terms of recruitment*
- *Partnership with key stakeholders*
- *Rich service package*

What challenges arose and how did you respond to them?

Challenge	Solution
Stigma and Discrimination	Continuous counselling
High Mobility of MSM,	Appointment and use of coupons
Harsh legal environment that criminalizes MSM activities,	Engaging law enforcement agents
High expectations (financial incentives)	Sensitization through peers and provision of free services

5 NEXT STEPS

Do you have plans to expand or take your intervention(s) to scales?

- *Finger print scanners and coupon readers*
- *Pre-printed serialized coupons*

How are you working with government and other partners?

- Referral and linkage - those who are HIV+ but are not willing to receive services from TASO due to distance from their area of operation are referred to private or public/government health facilities providing Key population friendly services.

6 STANDARD OPERATING PROCEDURE FOR MEN WHO HAVE SEX WITH MEN (MSM); DIFFERENTIATED HIV/STIS TESTING AND ART DELIVERY

1. Purpose

The purpose of the model is to encourage MSMs to identify and link their peers to HIV testing, treatment and care services. The goal is to increase accessibility and efficiency of delivery of STI/HIV prevention and treatment services.

The objectives are;

- To increase sustainability of health services delivery
- To decongest facility clinics.
- To involve MSM in their own health monitoring to maximize retention in care.
- To provide customized health care service delivery to a special group
- To reach the hidden population.
- To reach the highly stigmatized and criminalized groups.

2. Scope

This model serves HIV negative and positive MSMs that meet the following criteria:

Eligibility for HIV negative MSM

- Man who has ever had sex with a man irrespective of sero status
- 18 years and above
- Willing to receive coupons
- Accept to work as seeds and enthusiastic to recruit others
- Consent to be tested for HIV and access MSM service package
- Willing to return for services
- Willing to disclose sexual orientation to significant others

Eligibility for HIV positive MSM

- Man who has ever had sex with fellow man
- 18 years and above
- HIV positive and willing to enroll on ART.
- Willing to join a CCLAD group

For stable MSM

- *The MSM must be virally suppressed ≤1000copies/ml of blood after six months on ART*
- *MSM should not have an active WHO stage 3 or 4 disease.*
- *MSM should not indulge in harmful behavior that affects adherence (substance abuse e.g. smoking, alcoholism, Gender Based Violence)*
- *Should not be a highly mobile MSM for more than six months.*
- *In case of switch of regimen, then client should have been on the current regimen for 6 months*

For the unstable MSM

- *Just been initiated on ART*
- *Not yet bled for viral load*
- *Likely to have comorbidity*
- *Actively involved in harmful behavior especially alcoholism and drug abuse*
- *On second line ART regimen despite reasons for switching.*

3. Prerequisites

- Health talk forms – these are filled by both MSM peer leaders and TASO health worker to monitor health education.
- HIV /STIs screening, counselling and testing.
- Treatment for those who present with STIs and other opportunistic infections.
- Serialised coupon is given out to a willing seed to pass on to the peers. It contains unique identifiers to differentiate who took which particular coupon.
- Coupon register.
- Consent forms.
- TASO ART initiation registration

national guidelines for the management of HIV/AIDS . (2017). *National guidelines for the management of HIV/AIDS .* Kampala: Ministry of Health.

the AIDS support organisation. (2014). *TASO CCLAD operation guidelines.* kampala: The AIDS support organisation.

uganda ministry of health. (2017). *national policy guidelines for hiv counselling and testing .* kampala: uganda ministry of health.

World Health Organisation. (2014). *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for Key Populations.* Geneva: WHO press.

- form.
- Behaviour Change Communication forms (BCC).

- Counselling session forms – these are filled to monitor psychosocial issues and treatment adherence for those who are HIV+.
- Psychosocial form – filled to assess one's readiness to start ART
- Consent form – filled to register consent to receiving ART
- Client health cards – for ART refills, adherence monitoring parameters (Middle Arm Upper Circumference (MAUC), weight, height).
- Gender Based Violence (GBV) form – this is filled by the TASO health worker and MSM peer Leader for GBV support.
- Tuberculosis screening Form – this is filled to assess those who present signs of TB for further management.
- Pre ART register – filled for those who consented to start ART immediately after testing.
- Assisted Partner Notification register – filled by TASO staff to provide a platform for HIV status disclosure and increasing the uptake of HIV testing of sexual partners of the index client.
- Key Population ART register – filled for all those who are HIV+ key populations index to TASO Entebbe.
- Key population HIV prevention register – this is filled for positive prevention for those who are HIV+ and HIV prevention for those who are HIV-.
- Key Population classification tool – this is filled only once during first time contact with any key population.
- Key Population service provision form and register – this is filled on every provision of service to the key population regardless of HIV status.
- Appointment lists – to guide planning process for those who are already on ART.
- Pharmacy Drug distribution lists – to know who receives ART refills when and as confirmation of receiving ARV drugs.
- Packaging material
- Means of Transport
- Human resources.
- Venues
- Incentives for the seeds (monetary and non)
- Consent from the legal enforcement agents.

4. Responsibilities

Personnel	**Responsibility**
Counselor/Social worker	**Psychosocial Services**: (adherence counselling, condom/lubricant education and distribution, GBV screening, peer counselling, risk reduction counselling, behaviour change communication, referral for other psychosocial needs not provided such as economic needs and education,

	coupon distribution to seeds.
MSM Peer Leader	• Mobilize peers for health services. • Conduct Health talk/ education to peers • Peer counselling • Coupon delivery to willing peers. • Referral for health services. • Basic Drug Adherence support • ART delivery to HIV positive peers. • Provide feedback to counselor about challenges in the group • Ensure accountability for drugs and coupons. • Distribute condoms and lubricants • Record client data variables on the data form (weight taking, MUAC, height) • Behavior Change Communication • Initial TB screening
Doctor /clinical officer	**Clinical Services**: (Nutrition monitoring, adherence measurement, Tuberculosis screening and diagnosing, Opportunistic Infections examinations if any, Laboratory investigation (Viral Load and CD4 count); weight monitoring, Mental Health screening, coupon distribution to MSM peers.

5. Procedure

- Conduct stakeholder meeting between clinic staff and self- identified MSM leaders to identify primary seeds and
- map out the hotspots,
- Discuss logistics required, service package and the implementation modalities.
- Primary seeds are then given three coupons each to recruit their peers and link them to the service.
- The recruited peers are then provided with MSM recommended service package that includes HIV testing, STI screening and treatment, Condoms and lubricants, health education.
- The first wave of peers is given coupons at exit to recruit more peers and the process of recruitment, referral and linkage continues,
- MSM who test positive are linked to care and treatment services at TASO clinic or any preferred facility of their choice.
- The negative MSM are re-tested after every 03 months and continue receiving prevention service package to remain HIV negative.
- For those diagnosed with STIs are treated and encouraged to re-test after one month
- The serialized coupons that seeds took are returned by peers and are linked to the recruiter manually by the coupon manager before the recruits receive the services.

- Thereafter, the primary seeds who were able to recruit the peers and link them to services are given some incentive and for any linked peer, they redeem.
- At the third wave, the initial seeds no longer redeem any incentive but continue to receive HIV/AIDS services
    - Pharmacy staff generates lists of HIV+MSM in the groups and for the negatives presenting with STIs and opportunistic infections to be served at least one week before the activity is due
    - Pre pack the drugs for each group and package for each MSM separately with appropriate labeling.
    - Pharmacy staff issues the ARVs and drugs for STIs / opportunistic infections other commodities to the clinician and counsellor in charge who verify the correctness and acknowledges receipt.
    - Counselor makes a call reminder to the MSM CCLAD peer leader of the due appointment for ART refills and general reviews for the HIV negatives who presented with STIs.
    - Counselor in charge of CCLAD group conducts briefing with MSM CCLAD group leader to discuss emerging issues.
    - Counselor issues drugs and other commodities to MSM CCLAD group leader who acknowledge receipt. This can be done at either the Facility or at a hotspot/bar.
    - MSM CCLAD leaders conduct health talks as well as TB screening to the group members.
    - CCLAD leaders document information about individuals in the group on the form and issue drugs whose receipt is acknowledged by the MSMs through signing or thumb printing.
    - The MSMs leaders follow up clients that have missed appointments.
    - Submit the forms and reports to the Counselor in charge.
    - Counselor in charge transcribes the data collected into the appropriate client monitoring tools (HIV care cards) before it is entered electronically into the databases.

6. References

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DIFFERENTIATED ART DELIVERY FOR FSW

Differentiated [ART Delivery] for [FSW] [Uganda]
[Dr. Etukoit Bernard Michael], [The AIDS Support Organization], [etukoitm@tasouganda.org], [www.tasouganda.org]

OVERVIEW

FSW CCLAD is a Community Client Led ART delivery model carried out in hotspots. This involves clients from more less the same locality willing to form a peer support group of five (5) to ten (10) members that are receiving ARVs drug refills at an identified hotspot/bar. They select a CCLAD leader, who is responsible for collecting 3 monthly ART refills from the Counselor, distribution of drugs to peers, documentation and monitoring of adherence to treatment among peers.

For stable FSW*,* all group members attend their six-monthly reviews and annual viral load monitoring at the hotspots.

For unstable FSW*,* the reviews are conducted whenever clients or peers' reports challenge with any infection. They are reviewed on monthly basis at the TASO facility or at the hotspot. However, those who test negative for HIV, TASO continues to give them health services for prevention. In case they sero - convert, they are already in the TASO records and can be initiated on ART.

Figure 1: The three elements – clinical characteristics, specific populations, and context

- ***What challenges is the service responding to? These could be health system or client that how the programme was designed.***

Some HIV positive TASO Entebbe registered FSWs expressed challenges faced while receiving ART refills together with the general population at FDDP and CDDPs. Challenges expressed were:

- *Spending a lot of time waiting in the queues yet they had to attend to their customers back in places of work/lodges.*
- *Having to wake up early in the morning to get to the CDDP for ART refills after working all night.*
- *Facing stigma and discrimination from the general population because of their dress code and general appearance.*
- *Poor adherence especially amongst those who are mobile and those who abuse alcohol.*

7 ELIGIBILITY CRITERA

- ***Please provide a more detailed description of who is eligible for your practice example?***
    - ***Are there criteria regarding the duration on ART, duration on same regimen, viral load/evidence of treatment success, etc. to access this model of care?***

Criteria
General criteria

- *Female Sex Workers operating within the areas of Abayita Ababiri, Kasenyi Kigungu , Lugonjo and Kajjansi hot spots.*
- *Should have tested positive for HIV*
- *FSW should have consented to start Antiretroviral Therapy (ART)*

- *The FSW should consent (signed consent form) to receive their drug refills in CCLAD*
- *FSW should have disclosed their HIV status to peers*
- *Must not be pregnant*
- *Should be 18 years and above*

For those who are stable

- *The FSW must be virally suppressed ≤1000copies/ml of blood after six months on ART*
- *FSW should not have an active WHO stage 3 or 4 disease.*
- *FSW should not indulge in harmful behavior that affects adherence (substance abuse e.g. smoking, alcoholism, Gender Based Violence)*
- *Should not be a highly mobile FSW for more than six months.*
- *In case of switch of regimen, then client should have been on the current regimen for 6 months*

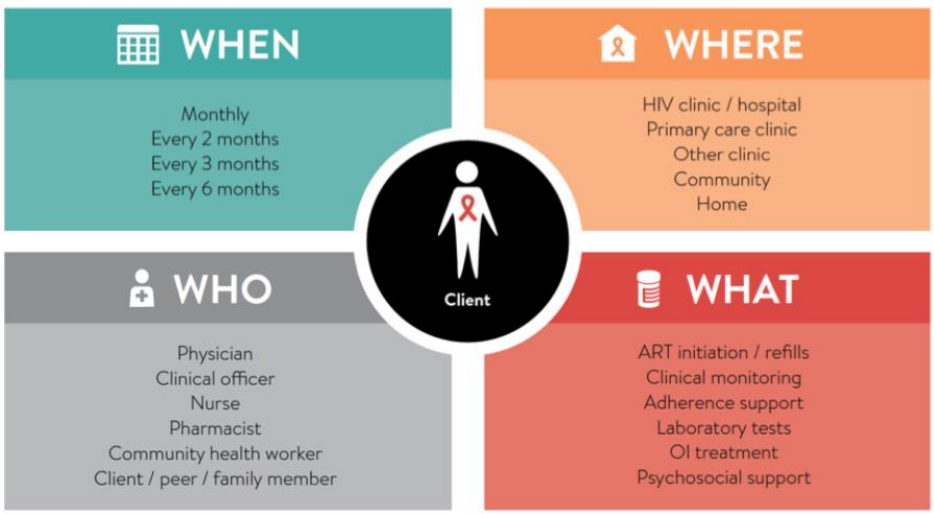
For the non-stable

- *Just been initiated on ART*
- *Not yet bled for viral load*
- *Likely to have comorbidity*
- *Actively involved in harmful behavior especially alcoholism and drug abuse*

8 BUILDING BLOCKS

- ***Present the building blocks (Figure 2) of your intervention(s)***
  - ***WHEN – at what frequency are clients seen***
  - ***WHERE – where is care provided***
  - ***WHO –what cadre of staff facilities/provides the services***
  - ***WHAT – services are provided***

Figure 2: Building blocks for ART refills



When	Where
• **ART refills:** every two months/ 6 times a year for the stable. One monthly refill for the non-stable • **Clinical review**: Semi-annually for the stable ones and monthly for the non-stable ones. • **Psychosocial Support:** 6 times a year	• Hired room in lodge/bar • TASO Facility (by the FSW peer Leader) • Tent (with screens) for private examination • Open place (for non- clinical examinations) i.e. for psychosocial support/client education

for the stable ones and routinely/as need arises for the non-stable ones. • **Service hours:** Flexible as per group • **Drug dosage adjustment:** Adjust is done for the non-stable. • **Longer ART supplies:** 3 – 4 months for the very mobile FSWs.	
Who • Social Worker/Counselor (ART refill) • FSW Peer Leader (ART delivery to final client) • Doctor and clinical officer (clinical consultations) • Counselor (psychosocial support)	**What** • Clinical Services: (Nutrition monitoring, adherence measurement, Tuberculosis screening, Opportunistic Infections examinations if any, Laboratory investigation (Viral Load and CD4 count); weight monitoring, Mental Health screening. • Psychosocial Services: (adherence counseling, condom/lubricant education/distribution, GBV screening, peer counseling, risk reduction counseling, behavior change communication, referral for other psychosocial needs not provided such as economic needs and education. • Assisted Partner Notification

If you do HIV testing – present the building blocks for mobilizing (mass/group, network-based, partner notification and index testing), testing (health facility, non-health facility, community, self-testing) and linking (referral, accompaniment, compensation/incentives, same day ignition, friendly services, tracing)

Table 1: The building blocks of a differentiated HIV testing

	Mobilization	**Testing**	**Linkage**
WHEN	Monthly	Monthly for those who present Sexually Transmitted Infections and 3 months for those who did not.	Those who test HIV positive are linked to care.
WHERE	Hotspots – Lodge/Bars/ fishing Islands/Landing Sites	Lodge/Bar/Fishing Islands/ Landing sites	TASO Entebbe
WHO	Counsellors, clinical officers, FSW Peer Leaders	Counsellors, clinical Officers/Laboratory technicians	Counsellors, clinical officers, FSW Peer Leaders
WHAT	HIV Awareness talks by FSW peer leaders/counsellors at hotspots	Clinical Services: (Tuberculosis screening, Opportunistic Infections examinations if any, Laboratory investigation (HIV testing, STIs, Hepatitis B). Reproductive Health Services (Family Planning).	**Clinical Services**: (Nutrition monitoring, adherence measurement, Tuberculosis screening, Opportunistic Infections examinations if any,

			Laboratory investigation (Viral Load and CD4 count); weight monitoring, Mental Health screening. Psychosocial Services: (adherence counseling, condom/lubricant education/distribution, GBV screening, peer counseling, risk reduction counseling, behavior change communication, referral for other psychosocial needs not provided such as economic needs and education. Assisted Partner Notification

If you provide ART – present the building blocks for ART refills, clinical consultations, and psychosocial support

Table 2: The building blocks of a differentiated ART delivery model

	ART refills	Clinical consultations	Psychosocial support
WHEN	Every two months/ 6 times a year for the stable. One monthly refill for the non-stable **Longer ART supplies:** 3 – 4 months for the very mobile FSWs.	Semi-annually for the stable ones and monthly for the non-stable ones.	6 times a year for the stable ones and routinely/as need arises for the non-stable ones.
WHERE	Hired room in lodge/bar – TASO facility	TASO Entebbe Facility, hired room in lodge/bar	Hired room in lodge/bar , facility
WHO	• Counselor/Clinician • FSW Peer Leader (ART delivery to final client) •	Doctor and clinical officer (clinical consultations)	• Social Worker/Counselor (psychosocial support)
WHAT	Stable FSW - ARVs, condoms, lubricants Unstable FSW– OI drugs, ARVs, condoms, lubricants	Clinical Services: (Nutrition monitoring, adherence measurement, Tuberculosis screening, Opportunistic Infections examinations if any, Laboratory investigation (Viral Load and CD4	Psychosocial Services: (adherence counselling, condom/lubricant education and distribution, GBV screening, peer counseling, risk reduction counseling, behaviour change

		count); weight monitoring, Mental Health screening. Unstable – Management of OIs. STI	communication, referral for other psychosocial needs not provided such as economic needs and education FSW partner services

- ***Describe the intervention HOW***
  - If it is an ART delivery model, what type? (Health care worker managed group, client-managed group, facility-based individual model, or out-of-facility individual model?

Procedure (how)

Conduct stakeholder meeting between clinic staff and self- identified FSWs leaders to support in mapping out the hotspots. Discuss logistics required, service package and the implementation modalities.

The mobilized FSWs peers are then provided with Key population recommended service package that includes HIV testing, STI screening and treatment, Condoms and lubricants, health education, reproductive health, psychosocial support, GBV issues support, behavior change communication.

FSWs who test positive are linked to care and treatment services at TASO clinic or any preferred facility of their choice.

The negative FSWs are re-tested after every 03 months and continue receiving prevention service package to remain HIV negative.

Pharmacy staff generates lists of HIV +FSWs in the groups and for the negatives presenting with STIs and opportunistic infections to be served at least one week before the routine activity is due

Pre-pack the drugs for each group and package for each HIV positive FSWs separately with appropriate labeling then for STIs and opportunistic infections general.

Pharmacy staff issues the ARVs and drugs for STIs / opportunistic infections other commodities to the clinician and counsellor in charge who verify the correctness and acknowledges receipt.

Counselor makes a call reminder to the FSWs peer leaders of the due appointment for ART refills and general reviews for the HIV negatives who presented with STIs.

Counselor in charge of CCLAD group conducts briefing with FSW CCLAD group leader to discuss emerging issues.

FSW leaders conduct health talks, behavior change communication and TB screening to the group members in CCLAD and HIV testing services outreaches.

Counselor issues drugs and other commodities to FSW CCLAD group leader who acknowledge receipt. This can be done at either the Facility or at a hotspot/bar.

CCLAD leaders document information about individuals in the group on the form and issue drugs whose receipt is acknowledged by the FSWs through signing or thumb printing.

The FSWs leaders follow up clients that have missed appointments at CCLAD and HIV testing outreaches.

Submit the forms and reports to the Counselor in charge.
Counselor in charge transcribes the data collected into the appropriate client monitoring tools (HIV care cards) before it is entered electronically into the databases.

- ***Describe the type of service (Government/NGO, community-based, community-led, health facility satellite, DIC, outreach, involving/employing peers)***

Employs a mix of approaches with CCLAD for stable and unstable FSWs . The service package for stable include 2-3 months ART refill and VL monitoring annually while for unstable FSWs in CCLAD groups are refilled monthly and monitored for OIs as and when need arises. It also both community – led health facility for HIV / STIs testing to cater for HIV prevention.

- ***What kinds of partnerships are vital to the delivery process?***

- Partnership between the TASO staff, FSW peer leaders and the local community leaders
- Public health facilities for referral for management of specialized conditions.

9 IMPLEMENTING THE INTERVENTION

Describe the highlights of steps to get this service(s) operational.

- *Identification of a hotspot*
- *Mobilization by FSW peer leaders for HTS*
- *Provision of customised Integrated HTS outreach by TASO staff*
- *On spot ART counselling for FSWs who test HIV positive*
- *ART Initiation for those who are psychosocially ready and have consented (sign consent form)*
- *Those who test HIV positive but are not ready for ART initiation are given appointments to come to the TASO facility for further psychosocial support. If the FSW does not turn up on the date of appointment, they are contacted two days after that date by the Counsellor and FSW peer leader and a fresh appointment is made. On failure to appear on second appointment, the peer leader is notified for further follow up.*
- *For those who consent to begin ART, initiation is done by both medical and counselling staff.*
- *The ART newly initiated FSW is integrated into an already existing CCLAD group for peer support.*
- *They are then eligible to receive the comprehensive package including;*
    - **Clinical Services**: (Nutrition monitoring, adherence measurement, Tuberculosis screening, Opportunistic Infections examinations if any, Laboratory investigation (Viral Load and CD4 count); weight monitoring, Mental Health screening.
    - **Psychosocial Services**: (adherence counseling, condom/lubricant education/distribution, GBV screening, peer counseling, risk reduction counseling, behavior change communication, referral for other psychosocial needs not provided such as economic needs and education.
    - **FSW partner services**

- ***Was this a pilot project? Has it been expanded? Taken to scale?***
  TASO was already operating the Community Client Led ART Distribution (CCLAD) model targeting the general population. However, the CCLAD project specifically for FSWs was an innovation in TASO Entebbe (an urban setting) in 2017 and has now been expanded to TASO Masaka (a more rural setting), TASO Mulago (urban setting).

- ***Did you train staff? What teaching materials did you use? Was a lot of supervision required?***
    - *Staff had been trained to implement the CCLAD model, however in order to implement the new FSW component, they were given a refresher training through Continuous Medical Education on topics such as Key Population programming.*

    - *Rigorous supervision and follow up was done for the unstable clients.*

- ***What kind of training do clients receive?***
  Clients received a sensitization session on how the CCLAD model works. On-going support is then given during implementation.
- ***How did you track progress? What M&E elements did you build into the model?***
  Progress is tracked using the following monitoring and evaluation tools;
    - *Health talk forms – these are filled by both FSW peer leaders and TASO health worker to monitor health education.*
    - *Behaviour Change Communication forms (BCC) – filled by both FSW peer leaders and TASO health worker, to give HIV awareness to both HIV positive and negative FSWs in the hotspot.*
    - *Counselling session forms – these are filled to monitor psychosocial issues and treatment adherence for those who are HIV+.*
    - *Psychosocial form – filled to assess one's readiness to start ART*
    - *Consent form – filled to register consent to receiving ART*
    - *Client health cards – for ART refills, adherence monitoring parameters (Middle Arm Upper Circumference (MAUC), weight, height).*
    - *Gender Based Violence (GBV) form – this is filled by the TASO health worker and FSW peer Leader for GBV support.*
    - *Tuberculosis screening Form – this is filled to assess those who present signs of TB for further management.*
    - *Pre ART register – filled for those who consented to start ART immediately after testing.*
    - *Assisted Partner Notification register – filled by TASO staff to provide a platform for HIV status disclosure and increasing the uptake of HIV testing of sexual partners of the index client.*
    - *Key Population ART register – filled for all those who are HIV+ key populations index to TASO Entebbe.*
    - *Key population HIV prevention register – this is filled for positive prevention for those who are HIV+ and HIV prevention for those who are HIV negative.*
    - *Key Population classification tool – this is filled only once during first time contact with any key population.*
    - *Key Population service provision form and register – this is filled on every provision of service to the key population regardless of HIV status.*
    - *Appointment lists – to guide planning process for those who are already on ART.*
    - *Pharmacy Drug distribution lists – to know who receives ART refills when and as confirmation of receiving ARV drugs.*
      *monthly reviews, Quarterly performance reviews,
- ***How much do you estimate getting the services operational cost? Where did this money come from?***
    - *TASO's experience with community-based ART service delivery has shown that this model can reduce costs from **US$332** to **US$233** per patient per year and has been highlighted as a model for scale-up globally.*

- ***Overall was this feasible?***

- *It was more cost effective because it was less than the national average cost which is around US$420 annually for a single client.*

10 DATA

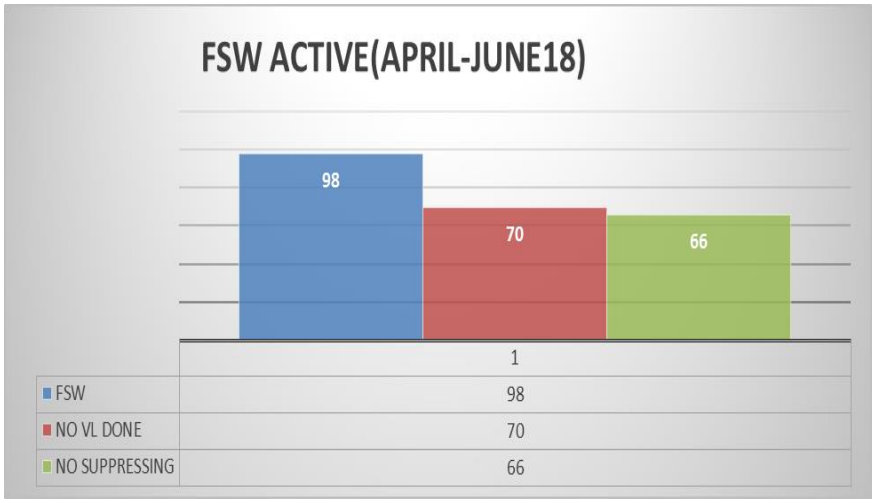
- ***Is there evidence of success? (Including client outcomes, client satisfaction, HCW perspectives, waiting times, etc.)***

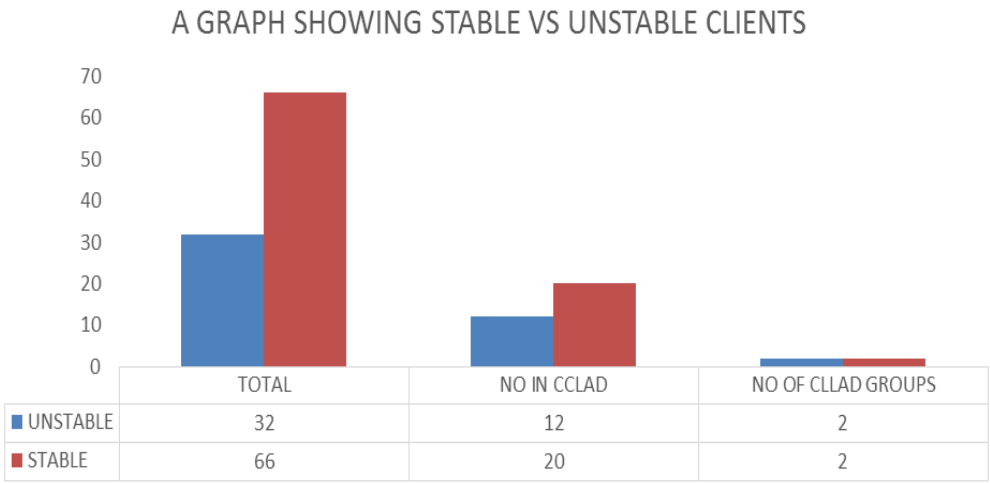
  - *All FSW registered under the CCLAD model have suppressed viral load.*
  - *Through the CCLAD model and APN, male sexual partners who registered HIV+ were linked to care and some are members of the FSW CCLAD groups.*
  - *Increased demand for HIV testing from the FSW community*
  - *Registered improved behavior change such as reduced substance abuse, ART drug adherence, some have set up steady homes with steady sexual partners.*
  - *Development of a saving culture amongst themselves for future set up of a Savings Cooperative Society.*
  - *Reduced lost to follow up of FSWs on ART due to increase "peer treatment buddies" follow up leading to increased retention on ART.*
  - *It has addressed the challenges of stigma and discrimination amongst FSWs since they receive customized services away from the general population and reduced the waiting time.*
  - *Flexible working hours for drug pick up by the FSW peer leader also increased uptake of ART and led to 100% turn up of all for ART refills.*
  - *Condoms and lubrication education and distribution has increased use and therefore reduced cases of HIV and STIs.*

Share any data, quantitative or qualitative, on outcomes or perspectives – could be uptake of the intervention, anecdotes from clients, etc.

***FSWs HIV testing and information giving**

Items	Number
Number tested	229
Number who tested HIV positive	15
Those Linked to TASO for care	10
Those linked to other Implementing Partners for ART	5
Number initiated on ART with TASO	10
Number screened for STIs	188
Number treated for STIs	71
Number of Condoms given	25,518





11 CHALLENGES AND SUCCESS

- ***What made this a success? What challenges arose and how did you respond to them?***

In spite of the challenges faced as shared below, this was a success because solutions were found to respond to the challenges.

Challenge	Solution
Mobility of FSWs while in search of more customers.	More involvement of FSW peer leaders in implementation. Sustainable provision of comprehensive friendly health services to the FSWs which encourages them to return for services.
Closure of hotspots leading to change of location of the CCLAD areas	Dialogue meetings between TASO and the local community where the hotspots for CCLAD are found to ensure that the hotspots are not closed.
Insecurity for the FSWs due to the nature of their work	Increased Gender Based Violence screening and referral for further support.

Challenge	Solution
Stigma and discrimination from HIV Negative peers who are not familiar with the CCLAD model for HIV positive FSWs.	Implementation of continuous Health talks and Behaviour Change Communication.
Non-disclosure to new steady sexual partners.	Implementation of FSW Partner services.

12 NEXT STEPS

- ***Do you have plans to expand or take your intervention(s) to scales?***
  - Plans are underway to roll out this project within all TASO Facilities
  - Sell the idea to public health facilities.

- ***How are you working with government and other partners?***
  - Referral and linkage - those who are HIV+ but are not willing to receive services from TASO due to distance from their area of operation are referred to private or public/government health facilities.

STANDARD OPERATING PROCEDURE FOR FEMALE SEX WORKERS HIV/STIS TESTING AND ART DELIEVERY

Purpose

The purpose of the model is to encourage FSWs to identify and link their peers to HIV testing, treatment and care services. The goal is to increase accessibility and efficiency of delivery of STI/HIV prevention and treatment services while maintaining high quality.

The objectives are;

- To increase sustainability of health services delivery
- To decongest facility clinics.
- To involve FSWs in their own health monitoring to maximize retention in care.
- To provide customized health care service delivery to a special group
- To reach the highly stigmatized and criminalized groups
- To provide customized ART delivery to a special group.

Scope

This model serves both HIV positives and negatives**.**

Eligibility for HIV negative FSWs

- Woman above 18 years of age who receive money or goods in exchange for sexual services either regularly or occasionally.
- Consent to be tested for HIV / STIs and access FSWs service package
- Willing to return for services.

Eligibility criteria for HIV+ FSWs.

General criteria

- Female Sex Workers operating within the areas of Abayita Ababiri, Kasenyi Kigungu , Lugonjo and Kajjansi hot spots.
- Should have tested positive for HIV
- FSW should have consented to start Antiretroviral Therapy (ART)
- The FSW should consent (signed consent form) to receive their drug refills in CCLAD
- FSW should have disclosed their HIV status to peers
- Must not be pregnant
- Should be 18 years and above.

For those who are stable

- The FSW must be virally suppressed ≤1000copies/ml of blood after six months on ART
- FSW should not have an active WHO stage 3 or 4 disease.
- FSW should not indulge in harmful behavior that affects adherence (substance abuse e.g. smoking, alcoholism, Gender Based Violence)
- Should not be a highly mobile FSW for more than six months.
- In case of switch of regimen, then client should have been on the current regimen for 6 months

For the non-stable

- Just been initiated on ART
- Likely to have comorbidity

- Actively involved in harmful behavior especially alcoholism and drug abuse

7. Prerequisites

- Health talk forms – these are filled by both FSW peer leaders and TASO health worker to monitor health education.
- Behaviour Change Communication forms (BCC) – filled by both FSW peer leaders and TASO health worker, to give HIV awareness to both HIV positive and negative FSWs in the hotspot.
- Counselling session forms – these are filled to monitor psychosocial issues and treatment adherence for those who are HIV+.
- Psychosocial form – filled to assess one's readiness to start ART
- Consent form – filled to register consent to receiving ART
- Client health cards – for ART refills, adherence monitoring parameters (Middle Arm Upper Circumference (MAUC), weight, height).
- Gender Based Violence (GBV) form – this is filled by the TASO health worker and FSW peer Leader for GBV support.
- Tuberculosis screening Form – this is filled to assess those who present signs of TB for further management.
- Pre ART register – filled for those who consented to start ART immediately after testing.
- Assisted Partner Notification register – filled by TASO staff to provide a platform for HIV status disclosure and increasing the uptake of HIV testing of sexual partners of the index client.
- Key Population ART register – filled for all those who are HIV+ key populations index to TASO Entebbe.
- Key population HIV prevention register – this is filled for positive prevention for those who are HIV+ and HIV prevention for those who are HIV-.
- Key Population classification tool – this is filled only once during first time contact with any key population.
- Key Population service provision form and register – this is filled on every provision of service to the key population regardless of HIV status.
- Appointment lists – to guide planning process for those who are already on ART.
- Pharmacy Drug distribution lists – to know who receives ART refills when and as confirmation of receiving ARV drugs.
- Packaging material
- Means of Transport
- Means of Transport
- Human resources.
- Venues
- Incentives for the seeds (monetary and non)
- Consent from the legal enforcement agents

8. Responsibilities

Personnel	Responsibility
Counselor/Social worker	**Psychosocial Services**: (adherence counselling, condom/lubricant education and distribution, GBV screening, peer counselling, risk reduction counselling, behaviour change communication, referral for other psychosocial needs not provided such as economic needs and education
FSW Peer Leader CCLAD	• ART delivery to final client • Provide feedback to counselor about challenges in the group • Ensure accountability for drugs • Conduct health talks/group education • Distribute condoms and lubricants • Record client data variables on the data form (weight taking, MUAC, height) • Basic adherence support • Behavior Change Communication • Initial TB screening
Doctor /clinical officer	**Clinical Services**: (Nutrition monitoring, adherence measurement, Tuberculosis screening and diagnosing, Opportunistic Infections examinations if any, Laboratory investigation (Viral Load and CD4 count); weight monitoring, Mental Health screening.

9. Procedure

- Pharmacy staff generates lists of clients in the groups to be served at least one week before the activity is due.
- Pre pack the drugs for each client and package for each separately with appropriate labeling.
- Pharmacy staff issues the drugs (ARVs and Cotrimoxazole) and other commodities to the counselor in charge who verifies the correctness and acknowledges receipt.
- Counselor makes a call reminder to the FSW CCLAD peer leader of the due appointment for ART refills.
- Counselor in charge of CCLAD group conducts briefing with FSW CCLAD group leader to discuss emerging issues.
- Counselor issues drugs and other commodities to FSW CCLAD group leader who acknowledge receipt. This can be done at either the Facility or at a hotspot/bar.
- FSW CCLAD leaders conduct health talks as well as TB screening to the group members.
- CCLAD leaders document information about individuals in the group on the form and issue drugs whose receipt is acknowledged by the FSWs through signing or thumb printing.
- The FSWs leaders follow up clients that have missed appointments.
- Submit the forms and reports to the Counselor in charge.

- Counselor in charge transcribes the data collected into the appropriate client monitoring tools (HIV care cards) before it is entered electronically into the databases.

10. References

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