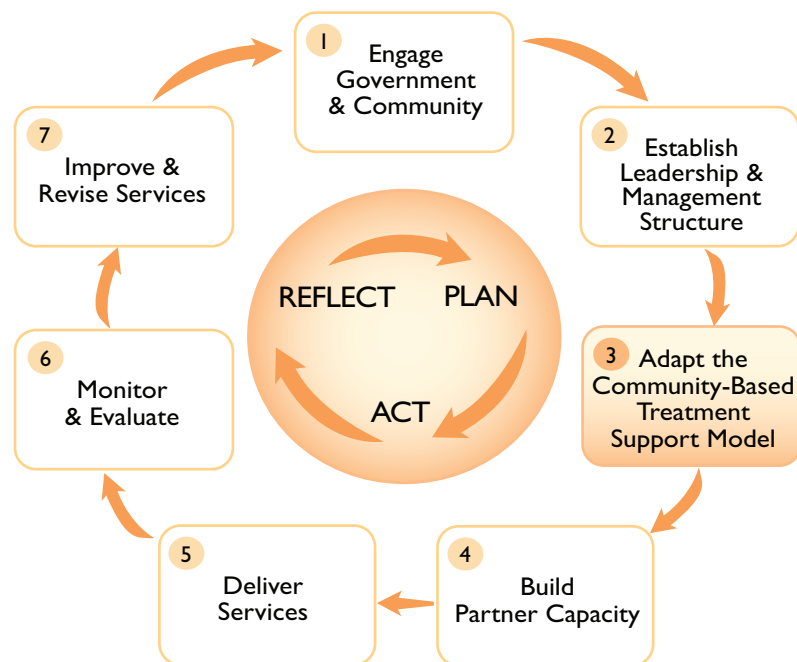


### Step 3: Adapt Community-Based Treatment Support Model



This section describes how to adapt the model to a community in terms of the clinical and community services that will be offered and how they will be integrated to create a continuum of care for people living with HIV/AIDS.

#### Objectives

- Identify clinical sites
- Define which clinical and community services to offer
- Identify community-based organizations to offer the services
- Map referral points and patient flow
- Establish a patient documentation system
- Develop an implementation plan

#### Expected Outcomes

- Clinical site selection
- Community services selection
- Map of patient flow
- Patient documentation system
- Implementation plan

## Clinical Site Selection

Clinical services for patients with HIV/AIDS in resource-limited settings can be organized in several ways depending on the resources available, the geography of the catchment area and the degree of stigma in the community. Decisions about this organization may be currently determined by the government as part of a rollout plan, and thus your project may not have flexibility in this area. Since transportation is often a big issue, having more than one site makes it much easier for people to access the services they greatly need. Therefore, some communities may choose to create decentralized services, and this also decreases the burden on one single facility.

## District Hospital

It is probably easiest to initiate and focus service delivery at the district hospital level. Such a clinic is usually located relatively close to other critical hospital services, including in-patient care, surgical care and pharmacy and laboratory services. The clinic can be dedicated solely to HIV/AIDS or jointly provide HIV/AIDS services and other relevant services, such as TB services, care for other sexually transmitted diseases or family planning.

A dedicated clinic enjoys the benefit of focused staff and services. This is probably preferable in areas with a high HIV prevalence because of the large number of patients who will access the services. However, at the same time, this can create a greater risk of stigma because a patient visiting that clinic is identifiable to observers and potentially others who know the patient's identity. Coordinated community mobilization and disease education efforts provided by the CBTS programme can help reduce such stigma.

## General Out-Patient Department (OPD)

HIV/AIDS patients can also receive care in a general out-patient department (OPD). This was not feasible at the model CBTSP sites because focused services for large numbers of patients were required. But in the long term, integration of HIV/AIDS services into regular OPD services will “regularize” the disease and help reduce stigma.

## Primary Health Centre Linked to Central District Hospital

Large, heavily populated catchment areas encompassing remote villages are best served by a network of primary health centres linked to a central district hospital. In that way, patients do not have to travel long distances to a hospital, which is a barrier to care and a disincentive for many patients. Decentralization of services to primary health centres also reduces the burden on the hospital clinic. For example, if there are large numbers of patients, some communities may choose primary health centres to do screening, and the district hospital to treat patients.

However, depending on the resources and personnel available at the centre, services provided at a primary health centre may be less comprehensive or specialized than those at a district hospital.

Key issues to be aware of in relation to the location of clinical services are summarized in Table 1.

TABLE 1 ADVANTAGES AND DISADVANTAGES OF DIFFERENT CLINICAL SITES

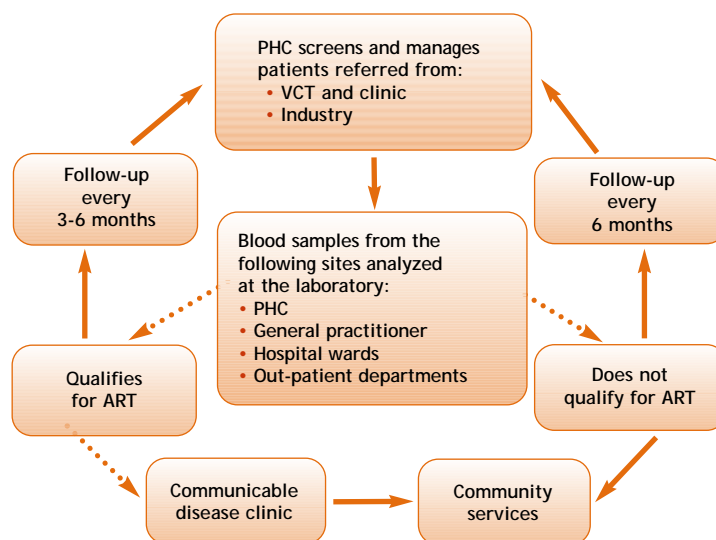
Type of facility	Advantages	Disadvantages
District hospital	<p>Can be dedicated solely to HIV/AIDS or jointly provide HIV/AIDS and other relevant services—TB treatment, sexually transmitted disease treatment or family planning</p> <p>Usually located close to other critical hospital services, including in-patient care, surgical care, pharmacy and laboratory services</p>	<p>Can create a greater risk of stigma for a patient, who is identifiable to observers and potentially others who know the patient's identity.</p> <p>Depending on geography, patients may have to travel long distances to site</p>
General out-patient department	Regularizes the disease and thus reduces the associated stigma	Services not focused and personnel not so specialized in HIV
Primary health clinic linked to district hospital	Close to patients and thus minimizes transport issues	Less comprehensive and less specialized

### Decentralized Service

Decentralization of services is necessary for scale-up HIV/AIDS services, and STF recommends that it be introduced in a gradual manner. Essentially, it is an orderly process of transferring select tasks that are delivered initially at the district hospital to the primary health centres. For example, primary health centres may be used for VCT, the staging of the disease and drawing of blood for CD4 counts. The blood sample is submitted to a central laboratory for analysis (although developments in the technology of CD4 measurement may allow this to be done easily at peripheral sites in the future). Patients qualifying for ARV therapy can then be referred to a secondary health facility for medication and continued laboratory and clinical monitoring. All HIV-positive patients not initially requiring ARVs can also be followed up at the primary health centres until their disease has progressed to a point where ARV therapy is indicated. The primary health centres can begin to care for patients on ARVs as they gain experience and confidence, their pharmacy services develop to the point where they can begin dispensing ARVs, and health authorities gain experience with and develop specific policies for less specialized personnel caring for HIV/AIDS patients.

Figure 4 shows the process of decentralized patient flow after implementation of the model.

FIGURE 4 DECENTRALIZED PATIENT FLOW



Services provided at the primary health centre may be less comprehensive or less specialized than those at the district hospital. This depends on the resources and personnel available at the primary health centre and health authorities' willingness to decentralize and permit less expert personnel to care for HIV/AIDS patients. The exclusive approach often taken toward HIV/AIDS has meant that in many locations even today, only expert personnel can prescribe ARV treatment.

## Define which clinical and community services to offer

### Clinical Service Selection

Clinical services delivered in the CBTS programme include diagnosis, disease monitoring, clinical management including antiretroviral treatment, PMTCT, pharmacy and laboratory services. A description of each of these clinical services is beyond the scope of this manual, because clinical care is determined largely by national guidelines.

### Community Services Selection

In the creation of the CBTS model, the added value of the community services was intuitively understood by SECURE THE FUTURE staff at the outset. Definitive data on the relative value of various services were collected through an Enhanced Patient Evaluation study conducted from 2004 through 2006. The data showed that some community services were accessed by more patients than others (e.g., home-based care, which was accessed by 55%). The study also determined that some services contributed to a better clinical outcome than others such as food security and home-based care.

#### Key Finding: Most-accessed community services

Through experience implementing the model in resource-limited settings in rural Africa, the CBTS site found that the three community services that are most useful and most frequently accessed by patients are:

- Home-based care
- Food security
- Patient support groups

This does not mean, however, that others are not valuable to particular patients or that a particular location may dictate differently. For example, some otherwise very resource-limited settings may have an abundance of readily available food (e.g., rural Thailand) so that food security programmes are not necessary. The enhanced evaluation shows, however, in general in rural Africa, the three most important and impactful community services to support ARV therapy programmes are home-based care, food security and patient support groups.

**TABLE 2 CRITERIA FOR CHOOSING COMMUNITY SERVICES**

Community Support Service	Targeted Outcomes	Activities	Required Resources
Mobilization	<ul style="list-style-type: none"> <li>• Increase community awareness of/access to:                             <ul style="list-style-type: none"> <li>• HIV/TB/STI facts</li> <li>• Prevention methods</li> <li>• Care services</li> <li>• Treatment</li> </ul> </li> <li>• Increase community involvement and ownership</li> <li>• Reduce stigma</li> <li>• Increase VCT uptake</li> </ul>	<ul style="list-style-type: none"> <li>• Large or small community events</li> <li>• Media campaigns</li> <li>• Project-launching events</li> </ul>	<ul style="list-style-type: none"> <li>• Community leaders</li> <li>• Community participation</li> <li>• Accessible venue</li> <li>• Catering</li> <li>• Distribution materials</li> <li>• Advertisement</li> </ul> <p>Cost: Mid-range Reach: Large groups Impact: High</p>
Prevention and Education Outreach	<ul style="list-style-type: none"> <li>• Minimize new infections</li> <li>• Increase VCT uptake</li> <li>• Reduce stigma</li> <li>• Increase behavior change</li> <li>• Increase access to condoms</li> </ul>	<ul style="list-style-type: none"> <li>• Community events</li> <li>• Education workshops</li> <li>• Youth events</li> <li>• Distribution of health literature</li> <li>• Distribution of condoms</li> <li>• Media campaigns</li> </ul>	<ul style="list-style-type: none"> <li>• Outreach strategies</li> <li>• Distribution materials</li> <li>• Well-developed messages</li> <li>• Accessible venue</li> <li>• Access to media</li> </ul> <p>Cost: Mid-range to high Reach: Broad reach Impact: High</p>
VCT	<ul style="list-style-type: none"> <li>• Individual awareness of HIV status</li> <li>• Reduction of stigma</li> <li>• Increased health education</li> <li>• Increased patient ownership of health</li> <li>• ARV education/awareness</li> <li>• Increased ARV adherence</li> </ul>	<ul style="list-style-type: none"> <li>• Counselling of patients and families</li> <li>• Pre- and post-test counselling</li> <li>• Testing</li> <li>• Risk management counselling</li> <li>• Treatment &amp; adherence counselling</li> <li>• Ongoing psychosocial support</li> </ul>	<ul style="list-style-type: none"> <li>• Training</li> <li>• Counsellors</li> <li>• Remuneration system</li> <li>• Referral system</li> <li>• Testing facilities and materials</li> <li>• Accessible venue</li> </ul> <p>Cost: Mid-range Reach: Potential large reach Impact: High</p>
Home-Based Care	<ul style="list-style-type: none"> <li>• Increase patient well-being</li> <li>• Increase adherence</li> <li>• Minimize defaulter rate</li> <li>• Improve symptom management</li> <li>• Increase health education</li> <li>• Increase community knowledge of prevention, care and treatment services</li> </ul>	<ul style="list-style-type: none"> <li>• Health and social service referrals</li> <li>• Adherence counselling</li> <li>• Management of opportunistic infections &amp; side effects</li> <li>• Assistance returning to full and rewarding lifestyle</li> <li>• Advice on growing food gardens</li> <li>• Ongoing psychosocial support</li> </ul>	<ul style="list-style-type: none"> <li>• Interested community members</li> <li>• Intensive training</li> <li>• Basic health care materials</li> <li>• Referral systems</li> <li>• Remuneration systems</li> <li>• Monitoring systems</li> </ul> <p>Cost: High Reach: Potential large reach Impact: High</p>

Community Support Service	Targeted Outcomes	Activities	Required Resources
Food Security	<ul style="list-style-type: none"> <li>• Increase individual response to treatment</li> <li>• Increase adherence</li> <li>• Increase self-sufficiency</li> </ul>	<ul style="list-style-type: none"> <li>• Nutritional assessment</li> <li>• Short-term food parcels</li> <li>• Training in gardening and animal husbandry</li> <li>• Nutritional education, including selection and preparation of food</li> </ul>	<ul style="list-style-type: none"> <li>• Trained nutritionist</li> <li>• Consistent supply of food parcels</li> <li>• Transportation of goods</li> <li>• Trainers</li> <li>• Training venues</li> <li>• Gardening materials</li> </ul> <p>Cost: High Reach: Targets most needed Impact: High</p>
Support Groups	<ul style="list-style-type: none"> <li>• Increase patient well-being</li> <li>• Increase adherence</li> <li>• Minimize defaulter rate</li> <li>• Reduce stigma</li> <li>• Increase health education</li> </ul>	<ul style="list-style-type: none"> <li>• Weekly group meetings for PLWHA</li> <li>• Discussions of coping skills for challenges</li> <li>• Positive-living activities</li> <li>• Participation in IGAs</li> </ul>	<ul style="list-style-type: none"> <li>• Trained leader</li> <li>• Meeting venue</li> </ul> <p>Cost: Low Reach: Potentially large Impact: High</p>
Positive-Living Workshops	<ul style="list-style-type: none"> <li>• Increase patient well-being</li> <li>• Increase adherence</li> <li>• Increase knowledge, skills, competencies to limit transmission and impact</li> <li>• Reduce stigma</li> <li>• Increase behavior change</li> </ul>	<ul style="list-style-type: none"> <li>• Targeted community workshops on HIV facts, treatment literacy, nutrition etc.</li> <li>• Skills-building workshops in coping mechanisms and life skills</li> </ul>	<ul style="list-style-type: none"> <li>• Trained facilitator</li> <li>• Community participation</li> <li>• Accessible venue</li> <li>• Catering</li> </ul> <p>Cost: Low Reach: Potentially large Impact: High</p>
Buddy Programme	<ul style="list-style-type: none"> <li>• Increase adherence</li> <li>• Minimize defaulter rate</li> <li>• Increase patient well-being</li> <li>• Improved symptom management</li> </ul>	<ul style="list-style-type: none"> <li>• Ongoing psychosocial support</li> <li>• Information on HIV/AIDS</li> <li>• Guidance in recognizing symptoms of HIV progression</li> <li>• Assistance in managing opportunistic infections and medication side effects</li> <li>• Assistance adhering to ART</li> </ul>	<ul style="list-style-type: none"> <li>• PLWHA openly and positively</li> <li>• Intensive training in counselling</li> <li>• Remuneration system</li> <li>• Labor-intensive</li> <li>• Referral systems between clinics and buddies</li> </ul> <p>Cost: High Reach: Low/difficult to offer to all Impact: High</p>

Community Support Service	Targeted Outcomes	Activities	Required Resources
Income-Generating Activities	<ul style="list-style-type: none"> <li>• Increase patient well-being</li> <li>• Increase community-based responses</li> <li>• Increase patient ownership over health and well-being</li> <li>• Provide forum for ongoing psychosocial support</li> </ul>	<ul style="list-style-type: none"> <li>• Forming cooperatives</li> <li>• Identifying markets</li> <li>• Identifying existing skills</li> <li>• Skills training in craft, catering, agriculture etc.</li> <li>• Skills training in small business</li> <li>• Group discussion about positive living, health care access, nutrition, psychosocial support</li> </ul>	<ul style="list-style-type: none"> <li>• Community participation</li> <li>• Facilitators</li> <li>• Training</li> <li>• Ongoing mentoring</li> <li>• Access to start-up capital</li> </ul> <p>Cost: Mid-range to high Reach: Low/difficult to offer to all Impact: Mid-range</p>
Patient Tracing	<ul style="list-style-type: none"> <li>• Minimize defaulter rate</li> </ul>	<ul style="list-style-type: none"> <li>• Community-based tracing of treatment defaulters</li> </ul>	<ul style="list-style-type: none"> <li>• Referral systems</li> <li>• Community health workers</li> <li>• Confidentiality agreements</li> <li>• Transportation</li> <li>• Training</li> </ul> <p>Cost: Low Reach: Low Impact: High</p>
Care for Orphans and Vulnerable Children	<ul style="list-style-type: none"> <li>• Minimize impact of HIV on most vulnerable population affected by HIV</li> <li>• Mobilize community-based responses</li> <li>• Increase patient well-being</li> <li>• Minimize new infections</li> <li>• Increase health education for youth</li> </ul>	<ul style="list-style-type: none"> <li>• Nutritional support, including feeding schemes and gardening projects</li> <li>• Life skills training</li> <li>• Grief counselling</li> <li>• Assistance with access to: <ul style="list-style-type: none"> <li>• Education</li> <li>• Health care</li> <li>• Identification documents</li> <li>• Government grants</li> <li>• Child advocacy</li> <li>• Child support forums</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Community participation</li> <li>• Food</li> <li>• Care venues</li> <li>• Trained child minders</li> <li>• Remuneration systems</li> <li>• Social workers</li> <li>• Referral systems</li> </ul> <p>Cost: High Reach: Potentially large Impact: High</p>

### Identify Community-Based Organizations to Offer the Services

Once the community services to be offered have been determined, it is important to conduct an assessment of community organizations that could provide such services. These organizations are usually well-known in the communities where they operate, but some organizations may not be providing all the services they can or may require capacity building to do so. In choosing community groups to participate in a CBTS programme, be sure to rationalize these groups' activities, avoid duplication and provide an avenue for them to collaborate.

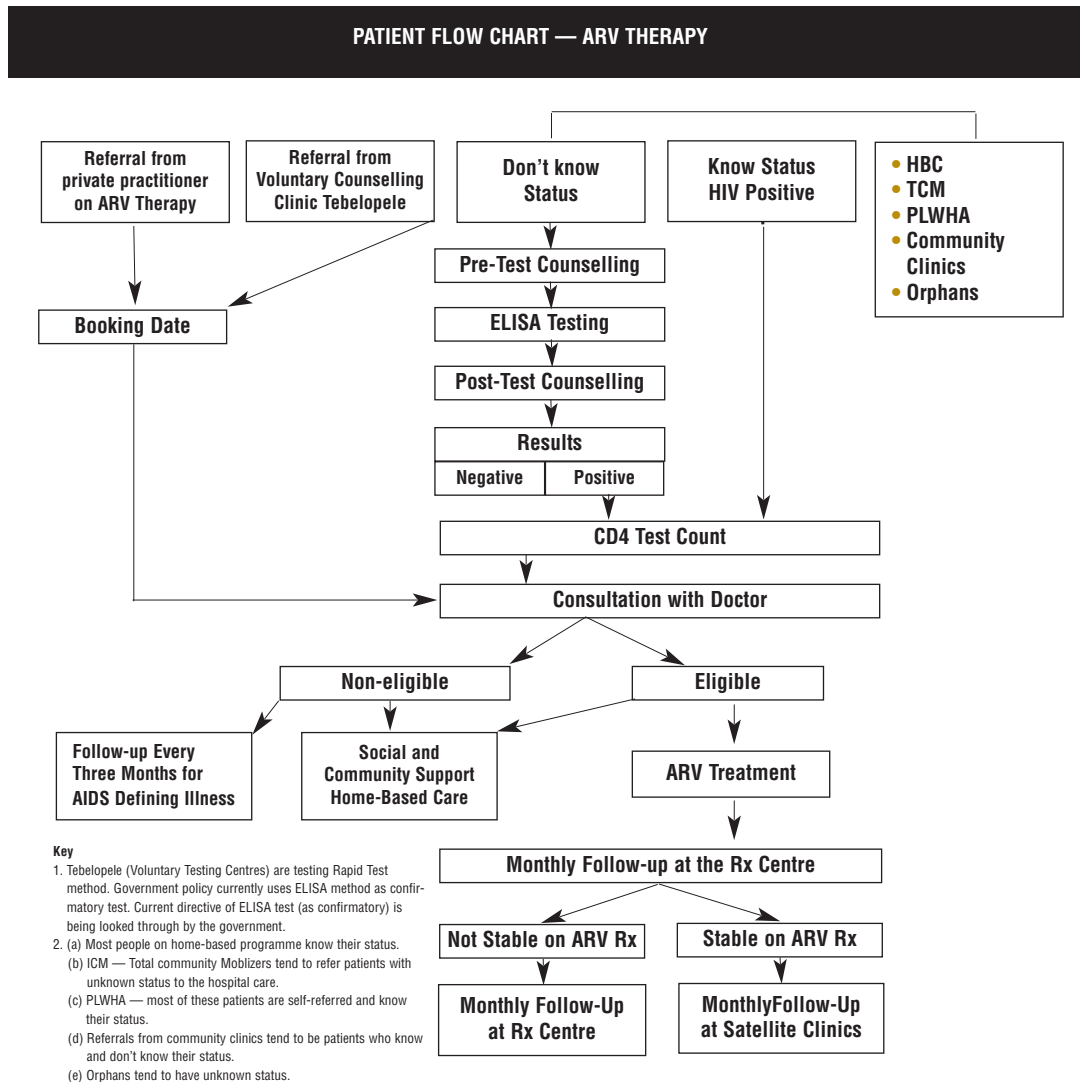
### Map Referral Points and Patient Flow

Developing a clear, detailed diagram of how patients will navigate the continuum of care and be referred between the clinical and community services was one of the most crucial exercises in the design of an effective programme and allocation of resources and personnel. A patient flow diagram should be constructed with input from all stakeholders. Inclusion of patients and family members in this process will help ensure that the proposed flow is patient friendly, and engagement of other stakeholders will help guarantee the system is as effective and efficient as possible. Establishing patient flow between clinical and community services reinforces the crucial linkages between the two and helps create the necessary formal referral processes. Patient flow should be reassessed and adjusted over time as part of an ongoing process of quality assurance and control.

*SECURE THE FUTURE* found that the best way to determine the optimal patient flow is to organize a workshop in which all stakeholders in the patient flow process are invited to participate. The project manager should play a central role in facilitating the workshop and provide the broad perspective of the overall programme. At the workshop, individual groups can be asked to diagram the patient flow into and out of their component (e.g., flow through the pharmacy). All the participants can then collectively examine the Big Picture. As indicated above, the process of defining patient flow also identifies points where referral mechanisms are required. Therefore, this workshop can produce a comprehensive picture of the referral system and the accompanying necessary documentation. A guide to facilitate the workshop on developing a map of patient flow is to be found in **Tool No. 11**.

The resulting patient flow at the STF-funded site in Bobonong, Botswana, is shown in Figure 5.

FIGURE 5 EXAMPLE OF PATIENT FLOW FROM BOBONONG, BOTSWANA



### Establish a Patient Documentation System

Documentation of each patient's history and progress is an essential programme component. The specific method of documentation will depend on local and national requirements. An example of a comprehensive form used to collect such information is shown in **Tool No. 12**. For a CBTS programme, the documentation should ideally include not only clinical data, but information on referrals to and from community services. It then becomes a master record, kept at the clinic and available to both clinical and community personnel, although care must be taken to ensure patient confidentiality.

Referrals from the community to the clinic are as important as those from the clinic to the community. Community workers can raise awareness, mobilize clients to access VCT and treatment, refer patients on ARVs back to the clinic if problems are detected and, perhaps most importantly, trace patients who miss a clinic appointment and reengage them.

## Develop a Implementation Plan

At this stage, the project manager should assume overall responsibility for facilitating the development of an implementation plan in consultation with all the partners. The plan includes the following:

- Prioritized clinical and community services
- Clear objectives for each service
- Major action strategies to address the objectives for each service
- Timeline for implementing the services
- Definitions of the planning partners and their roles
- Estimates of the programme costs and funding sources
- Overall achievement targets, including aggregate indicators (or benchmarks) and how they will be measured (see Step 6 for a more detailed discussion of this task)
- Referral systems
- Roles and responsibilities and communication platforms

**Tool No. 13** provides a template for an implementation plan.

The technical working groups should try to manage activities pursuant to the plan, making sure that they are properly resourced and progressing on time. Significant deviations from the plan can be addressed and managed through an Implementers' Forum or a similar team.

## Communication and Documentation Processes

The implementation plan should also include the processes for communication and documentation for the project. Such processes could include the following:

- Learning and sharing session either electronically, in written reports or during local and national meetings
- Monthly reports to all partners
- Monthly programme teleconferences if covering a wide geographical area
- Quarterly reports to governments, donors and community leaders

Projects initiated as pilots should document their processes, outcomes and lessons because this will be important when they report back and want to advocate for new policies and additional resources that would allow the programme to be scaled up or replicated.

An example of a monthly report to all partners is to be found in **Resource No. 5**.

### Lessons Learned

- One size does not fit all. The configuration of clinical services must match the geography and the needs of the patient population targeted.
- Decentralization of services to primary health centres brings services closer to patients and reduces the burden on hospital clinics.
- Not all the community services may be needed. Choose the ones that will have the greatest impact because they address a gap or strengthen currently impactful services.
- Establish a clear patient flow and referral points. Once the patient flow is defined, everything else will fall into place.
- Include all stakeholders in the workshop where the patient flow is established.

### Tools for this step

- Tool No. 11 Guide to facilitating a workshop on developing a map of patient flow
- Tool No. 12 Client documentation form
- Tool No. 13 Project implementation plan

### Resource for this step

- Resource No. 5 Monthly status report