THE BUILDING SUCCESS SERIES: VOLUME I

COMPREHENSIVE HIV/AIDS CARE AND TREATMENT SITE START-UP AND MANAGEMENT

[Image of three men in white lab coats]
ACRONYMS:

AIDS  Acquired immune deficiency syndrome
ART  Antiretroviral therapy
ARV  Antiretroviral
CBO  Community-based organization
CCT  Comprehensive care and treatment
CSO  Civil society organization
CQI  Continuous quality improvement
CUBS  Community-Based Support for Orphans and Vulnerable Children
DOTS  Directly observed therapy short course
EID  Early infant diagnosis
FBO  Faith-based organization
GON  Government of Nigeria
HCT  HIV counseling and testing
HIV  Human immunodeficiency virus
IEC  Information, education, communication
IP  Implementing partner
LGA  Local government authority
M&E  Monitoring and evaluation
MDAs  Ministries, departments, and agencies
MSH  Management Sciences for Health
NGO  Nongovernmental organization
OPD  Out patient department
OVC  Orphans and vulnerable children
PABA  People Affected By AIDS
PEPFAR  U.S. President's Emergency Fund for AIDS Relief
PITC  Provider-initiated HIV testing and counseling
PLAN-Health  Program to Build Leadership and Accountability in Nigeria’s Health System
PLWHA  People living with HIV and AIDS
PMTCT  Prevention of mother-to-child transmission
ProACT  Prevention and Organizational Systems—AIDS Care and Treatment
SACA  State Action Committee on AIDS
SBCC  Social and behavior change communication
SMOH  State Ministry of Health
SOP  Standard operating procedure
STI  Sexually transmitted infection
TB  Tuberculosis
USAID  United States Agency for International Development
WHO  World Health Organization

Cover Photo:
John Tiva (center) leads the dynamic General Hospital Michika Lab Team.

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COMPREHENSIVE HIV/AIDS CARE AND TREATMENT: SITE START-UP AND MANAGEMENT

THE BUILDING SUCCESS SERIES VOL 1

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FOREWORD

This manual is one component in BUILDING SUCCESS, a series of guides offering practical, concrete, and innovative approaches that have proven effective in strengthening the response to HIV/AIDS and tuberculosis (HIV/AIDS/TB) in Nigeria. Each manual can stand alone, but the manuals will be most effective if you view them as components of an integrated package.

Each manual contains references to relevant information in other components of the series. The series synthesizes and expands the learning gained from MSH’s Nigerian projects, supported by the United States Agency for International Development (USAID) through the U.S. President’s Emergency Fund for AIDS Relief (PEPFAR):

- Prevention and Organizational Systems—AIDS Care and Treatment (ProACT)
- Community-Based Support for Orphans and Vulnerable Children (CUBS) Project
- Program to Build Leadership and Accountability in Nigeria’s Health System (PLAN-Health)

In 18 states, these three projects are striving to achieve USAID’s strategic objective for the country: “Increased Nigerian capacity for a sustainable HIV/AIDS and TB response.”

They are equally committed to MSH’s mission: “To save lives and improve the health of the world’s poorest and most vulnerable people by closing the gap between knowledge and action in public health.”

Project staff members work with state and local governments, CBOs, and targeted health facilities and communities to bring high-quality services to people living with HIV/AIDS and TB, and to their families. (See box 1.)

OUR GUIDING PRINCIPLES

This manual, with the others in the series, embodies the principles that guide the day-to-day activities of everyone who works for MSH Nigeria projects. We are grounded in the recognition that people—both the users and providers of health services—are at the core of our work. We believe that—

- Success depends on empowering all the players: community leaders and members—including people living with HIV/AIDS—as well as health providers at all levels, government officials, and employees of civil society organizations.
- The solutions to people’s problems lie within themselves.
- We can celebrate our successes and use each failure as a learning opportunity.
- Small successes add up to big changes.
- Freely shared information and insights are essential to achieving common goals.
Who Created This Series?

The staff of the ProACT Project has written BUILDING SUCCESS with input from the other MSH Nigeria projects. Most of the approaches, lessons learned, and success stories come from clients and colleagues in the six states where ProACT is working to improve systems for service delivery: Adamawa, Kebbi, Kogi, Kwara, Niger, and Taraba.

ProACT's clients have used the approaches described here to successfully implement a quality program despite many challenges. The series is based on the belief that successes in any project can be replicated in other settings, bringing high-quality, sustainable, gender-responsive HIV/AIDS/TB services to the people who need them.

How Can You Use the Building Success Series?

The reason this project, or any development project, exists is to empower people to save lives and improve the quality of life for themselves and their fellow citizens. You, like all of our readers, can make a significant contribution to this challenge. To support you in this effort, BUILDING SUCCESS will enable you to do the following:

- Use the “software”—the approaches, concepts, processes, and examples in these manuals—to put into action the “hardware”—the systems, structures, standards, and guidelines that already exist in your professional and geographic area
- Apply proven approaches to strengthen your organization and its HIV/AIDS/TB programs
- Translate guidelines into action and apply them for the greatest possible effect
- Benefit from the examples of health professionals at all levels who have overcome challenges to bring better health to the people they serve
- Enthusiastically carry out your responsibilities for providing or supporting the quality care that will prolong and improve the lives of people living with HIV/AIDS and their families

The manuals provide real-life examples of these successes, drawn from experience in the six project states. The manuals also refer to some documents—tools, government guidelines, standards of practice, forms—that you and your colleagues can use in carrying out these approaches and that are readily available to those working with HIV/AIDS/TB programs. You will find a few other important documents, newly developed and not yet widely distributed, in the annexes.

The manuals in this series are yours to read, re-read, discuss, adapt, and apply. But they are not all you need—no document by itself can enable you provide all the information necessary to carry out a successful program. We strongly recommend that you and your colleagues supplement the information in each manual with other useful documents, including guidelines, standards of practice, checklists, reports, and success stories.
You can seek assistance from a variety of sources: government agencies, IPs, civil society organizations, and other groups that have successfully implemented initiatives like the one you are undertaking. With the support of these entities, you can use the manuals as a starting place and an ongoing point of reference.

We welcome you, our readers, as partners in the effort to provide the HIV/AIDS/TB services that will contribute to a long and meaningful life for all our fellow citizens.

—The MSH Nigeria Team

Maimuna Abdullahi, one of the lucky mothers who benefited from HIV-counseling, with her healthy negative baby
INTRODUCTION

Less than two decades ago, people living with HIV/AIDS (PLWHA) had little hope. HIV infection brought a steady and inevitable destruction of the immune system culminating in death. The introduction of antiretroviral (ARV) medicines and effective antiretroviral therapy (ART) in 1996 was a turning point for hundreds of thousands of people who had no access to any effective palliative remedy. Although ART cannot yet cure HIV/AIDS, it has dramatically reduced mortality and morbidity, prolonged lives, and improved the quality of life of many PLWHA.

Comprehensive care and treatment (CCT) services are the backbone of this effort—the doorway through which people must pass to know their status and, if they are HIV positive, to begin and maintain treatment. In resource-poor settings throughout the developing world, most of these services are supported by grants from donors such as the United States Government and the governments of other donor countries; the Global Fund to Fight AIDS, TB and Malaria; the World Bank; and similar large donors. Projects supported by these funds are often implemented by international development agencies, most of whom are foreign to the project locality.

Despite the enormous investments already committed, these international agencies lack the financial resources to fully scale up access to care and treatment and to meet the increasing needs of underserved populations (box 2). Furthermore, it is difficult for foreign implementing agencies to respond to local culture and local needs. For these reasons, it is becoming increasingly apparent that federal and state government structures need to take the lead in bringing high-quality care and treatment to underserved communities.

Why This Manual?

In Nigeria, ProACT has been working since 2007 to increase meaningful state government support of CCT services in the project states. Through the project, the six states have established 25 CCT sites and introduced basic care and treatment services at numerous primary health care centers. Thousands of clients are receiving ART and other forms of care.

This manual reflects ProACT’s wealth of experience in rolling out service delivery approaches that have worked. The manual is designed to share what we have learned with state governments, IPs, and civil society organizations (CSOs), large and small. It puts state government in the lead position in establishing CCT services. And in states whose govern-
ments have already established their own CCT services, the manual highlights the mentoring, monitoring, and evaluation that will greatly improve the quality of services.

The processes described here can be tailored to meet varied state needs and budgets. The manual will also serve as a guide to new IPs and other organizations who want to establish comprehensive services or introduce some components of care and treatment in a health facility.

**Using This Manual**

This manual describes the building blocks for success in establishing and managing CCT services in resource-constrained environments. It highlights the individuals and groups that play crucial roles in the effort: employees of state, local, and federal government health departments, health facility managers and staff, CBOs and other nongovernmental organizations (NGOs), USAID partners, United Kingdom Department for International Development partners, and private for-profit organizations. It details the step-by-step process for establishing and managing a high-quality, sustainable HIV/AIDS treatment and care program. It acknowledges the many challenges you might encounter in this effort, and it offers success stories of innovative approaches that others have used successfully to face those challenges.

**What Is Comprehensive Care and Treatment?**

CCT is a service delivery package that offers the minimum acceptable range of HIV-related care and treatment services. It is most effective when integrated with other health care services in the same facility. It requires well-defined referral channels for other specialized and community care the client might require.

This basic minimum care package includes the following:

- **Provider-initiated HIV testing and counseling (PITC)**
- **Medical records integrated with monitoring and evaluation (M&E) functions**
- **Adult and pediatric ARTs**
- **Management of opportunistic infections**
- **Patient education, ongoing adherence counseling, and psychosocial support**
- **HIV-related laboratory services capable of using CD4 serology to test for levels of immunity and chemistry and hematology testing for treatment monitoring**
- **Prevention of mother-to-child transmission (PMTCT) and the ability to provide early infant diagnosis (EID)**
- **Pharmacy and logistic support for ARVs and other related commodities**
- **Community care and support structures**

Referral linkages for viral load assessments may not be part of the minimum package in resource-limited settings but are highly desirable when medically indicated.
STEP 1. GETTING STARTED

1.1. Assessing the Need for CCT Services

When you assess the need for CCT in a specific location, identifying existing CCT sites in the state, identifying geographic areas that lack CCT services, and determining the population of these areas are important tasks. To conduct this assessment, you will need the following:

- Service mapping of the state to determine underserved communities and areas of need, as well as existing infrastructure and community support structures to build upon
- A desk review of literature and data on HIV/AIDS, including prevalence in those areas of need and the outcomes of CCT services where they exist in the state
- A review of the State Strategic Plan for HIV/AIDS and the Health Sector Strategic Plan, to be sure that both of them include goals, objectives, and activities for the establishment and maintenance of CCT services in underserved communities. Note: This review should ensure that the state has allocated the necessary funds for establishing and sustaining CCT services.
- A review of available or potential funding to support CCT services
- A review of IPs’ relevant activities in the state

WHAT MIGHT YOU INCLUDE IN AN ADVOCACY PACKET?

The packet could summarize key findings from the needs assessment, emphasizing the following:

- State HIV/AIDS data and distribution of service outlets
- Data on outcomes of existing CCT services
- The state HIV/AIDS prevalence rate and its implications for services
- A state map of underserved communities, their populations, and their predominant economic activities
- HIV/AIDS prevalence in underserved communities, disaggregated by sex

1.2. Advocating for CCT Services

The state coordinating entities—the SACA and the SMOH—should passionately and confidently introduce the findings of the assessment to the political leadership. They will need to make a persuasive argument, supported by the facts revealed in the assessment, to advocate for increasing access to ART and other CCT services in underserved communities.

This important advocacy visit is most likely to succeed if the SACA and SMOH representatives bolster their presentation with a packet of information (box 3) summarizing the main points of their assessment. Of utmost importance is showing how
addressing HIV/AIDS will lead to achievement of state political and social commitments. The best presentations are brief but comprehensive, lively with human beneficiary faces, and accurate. The presenters will find it very helpful to review the packet of materials and practice the presentation ahead of time with colleagues.

Note: Those making the advocacy visit should know the state planning/budget cycle and make the advocacy visit well in advance of the state planning process. Usually the cycle commences in August and ends around November each year (see Figure 1) and roughly follows this chronology:

**Figure 1. Typical planning and budgeting cycle**

**PLANNING**
- ADVOCACY GROUPS circulate plans to ministries, departments, and agencies (MDAs) to prepare budgets
- MDAs circulate plans and collate budgets

**BUDGETING**
- MDAs submit their budgets to the finance department
- FINANCE DEPARTMENT reviews budgets and advises executives

**REVIEW AND RECOMMENDATION**
- EXECUTIVES review the comprehensive budget and submit to the House of Assembly
- HOUSE OF ASSEMBLY reviews the budget, and MDAs defend their budgets

**APPROVAL**
- HOUSE OF ASSEMBLY passes budget and sends back to EXECUTIVES for approval and plan implementation.

**IMPLEMENTATION**
1.3. Building Partnerships to Support Common Goals and a Coordination Platform

Many stakeholders in your area could play a part in an efficient start-up and smoothly running CCT services. The stakeholders can be divided into five broad groups:

- **State and local governments**
  - State Governor
  - State Commissioners of Health, Budget, and Planning
  - State AIDS Program Coordinator and relevant officers: procurement, finance, technical representative
  - Desk officer for SACA
  - Local government authority (LGA) chairman
  - Staff of the health department in the LGA
  - Hospital management board members
  - Members of site selection and implementation committees
  - Members of the state technical mentoring team

- **Units within facilities**
  - Hospital management committee members
  - Patient care team members
  - Officers in the different units
  - Facility referral coordinators

- **Care and support groups**
  - Referral network
  - PLWHA support groups
  - Home-based care team

- **Community structures and organizations**
  - Traditional leaders
  - Religious leaders
  - Community health and development committees
  - Representatives of the following:
    - CSOs
    - Groups of PLWHA
    - Women’s associations
    - Male peer groups
    - Private-sector organizations
    - Youth groups

- **Development partners and IPs**
  - Organizations or agencies that are providing or receiving donor funding to carry out health and other development projects
Within these categories, you and your colleagues can look for groups whose missions, mandates, and priorities are consistent with the development of CCT services. When you identify these groups, you can determine whether they are ready to join in a common effort. To enlist their support, you might turn to the advocacy presentations and materials that were convincing in meetings with state officials.

If the partnership is to be really effective, the participating groups will need to make a formal commitment to working together to initiate and maintain CCT services. Once they have made that commitment, each stakeholder group needs to agree to a scope of work that details its contribution to the common effort. A clear action plan and guidelines should be developed based on the complementary scopes of work (boxes 4 and 5).

Some states have found it helpful to form a state coordination committee with representatives from all five stakeholder groups, to oversee CCT planning and implementation.
1.4. Assessing and Prioritizing

Following the initial needs assessment, with service mapping and identification of sites in underserved communities, an intensive site assessment and prioritization of needs can be conducted in three phases: assessing facilities, assessing community capacity, and identifying and prioritizing needs.

1.4.1. Assessing Facilities

The SMOH, with technical support from experienced IPs, has developed a set of customized, standardized tools for assessing the facility and catchment community structures. This activity will include verifying infrastructure, space, and personnel. Your facility assessment should cover the following:

- General health facility setup and management structure
- Available qualified personnel
- Existing collaboration with stakeholders in the community and/or international development organizations and their IPs providing HIV/AIDS and other health services
- HIV counseling and testing (HCT) services available
- Clinical care system, including TB/HIV, client flow, and clinic space
- Laboratory space, infrastructure, equipment, and services already available
- Pharmacy services
- Prenatal care activities and availability of PMTCT services, including integration with family planning and maternal and child health services
- Strategic information and record-keeping systems
- Training needs
- Linkages with community systems and structures for care and support
- Patient load
- Waste management facilities and practices
- Sources of power and potable water

1.4.2. Assessing Community Capacity

Using a set of standardized tools, the SMOH will want to determine the capacity of the catchment community to support the new services. Support may come from CSOs—large and small—working in the community; community stakeholders and influencers; other development projects running in the community; community initiatives that could promote HIV prevention, care and support; established health- or development-focused committees; LGA involvement in health; and PLWHA groups and structures.
1.4.3. Identifying and Prioritizing Needs

Based on the findings from the assessment, you can determine CCT service needs within six categories:

- Numbers and qualifications of personnel
- Equipment
- Infrastructure, including space allocation for CCT points of service
- Training needs
- Service delivery tools
- Community support from individuals and groups

STEP 2. PREPARING TO IMPLEMENT CCT SERVICES

2.1. Defining the Points of Service at a CCT Site

Once the assessments are complete and needs have been prioritized, it is time to determine the points within the facility that will provide and support the CCT services. Nine priority CCT points of service are described below.

2.1.1. HIV Counseling and Testing

HCT serves as the entry point for HIV care and treatment services; it is here that clients learn their HIV status and can be referred to the care and treatment units if they are confirmed to be HIV positive. The ProACT approach is to offer PITC at multiple service delivery points within the facility. Doing this ensures that as many people as possible who come to the facility—for whatever reason—have access to HCT. It is important to ensure high-quality, individual-based posttest counseling to ensure client comprehension and subsequent retention in care. A process to assure the quality of testing done at these points should be institutionalized in collaboration with the facility laboratory.

2.1.2. Medical Records Unit

The medical records unit is responsible for documenting the use of services and facilitating client monitoring and tracking. It is in this unit that data is entered, extracted, reported, and made available for decision making to improve the quality of care. This unit serves as the entry and exit point for information that the Government of Nigeria (GON) and other funding agencies often request to support strategic planning and decision-making.

2.1.3. Triage Unit

The client’s health status is assessed in the triage unit each time he or she reports to the facility to receive care and treatment. The staff of this unit document and monitor
basic anthropometric measurements, including vital signs: blood pressure, weight, pulse rates, and temperature. Triage staff members provide these data to the physicians who use them as part of the information they need to determine the care and treatment services each client requires. Triage staff also perform assessments to determine which patients require emergency care and then to fast track those patients to see physicians immediately.

2.1.4. Clinical Unit

The clinical unit provides care and treatment services to HIV-positive clients. The clinicians working in this unit carry out the initial assessment of a client’s eligibility for ART services according to national guidelines. They then treat and place eligible clients on ART and monitor their progress, ensuring that clients who start on first-line therapy are maintained on their regimen with little or no drug resistance.

2.1.5. Laboratory

Laboratory services provide the client with the baseline and routine laboratory tests that determine eligibility for ART. These tests also provide the framework for critical decisions about the long-term management of the client’s regimen and follow-up plans.

2.1.6. Adherence Unit

Adherence unit staff members provide clients with information on HIV/AIDS treatment and counsel them on the importance of taking ARVs consistently and appropriately. This unit also provides ongoing psychosocial support and refers clients to other services within their communities.

2.1.7. Pharmacy

In addition to dispensing prescribed medications, the pharmacy unit emphasizes adherence and educates clients on adverse drug reactions. It works with other units to monitor adherence to ART regimens and to promote PMTCT and EID.

2.1.8. TB Services

Due to the high prevalence of TB among those who are HIV positive, it is important to have a TB DOTS center or unit in all CCT sites to give clients easy access to accurate diagnosis and quality care of TB.

2.1.9. Maternal, Neonatal, and Child Health Services

Each HIV-positive pregnant mother is assessed and placed on a regimen to reduce the chances of passing the HIV virus to her unborn baby (PMTCT). The regimen consists of safe obstetric practices prenatally and during delivery, ARVs for the mother and child, and safe infant feeding practices. Exposed children have their blood samples assessed at 6 weeks or soon thereafter to determine if they are truly infected with HIV (EID).
2.2. Designing a CCT Service Delivery Model

The most common CCT model is the “hub and spoke,” a series of feeder facilities—mostly primary health care centers—that provide CCT services clustered around a higher level facility in a way that facilitates referral linkages (figure 2). This model is important for decentralization of services to further increase access to care and treatment closer to where clients live.

Figure 2. Service network and referral anchored at the community cluster
2.3. Finding the Resources Needed to Set up CCT Services

The success of your CCT initiative will depend to a great extent on accurate estimates of the costs of setting up CCT sites and establishing community care and support systems and structures. Most of the resources needed to set up a CCT site are already provided by the government, so here we propose only the additional resources that may be required. MSH has also found that SMOH and health facility heads who are good at networking and building partnerships get the resources supplied by different partners, making the CCT site a truly collaborative success.

2.3.1. Fixed Resources

Infrastructural costs are determined by the needs identified during the initial assessment to facilitate client flow, ensure confidentiality, and create a receptive environment for service-delivery.

Medical equipment such as stethoscopes, sphygmomanometers, weighing scales, and other items, if not available, need to be procured since clinicians require them for full evaluation of clients before and during treatment. Weight and height of clients is particularly important to determine ARV dosage in children. To ensure efficiency and value, equipment specifications must be thoroughly prepared in consultation with technical staff to ensure, first, that the equipment is highly sensitive and specific to the staff’s needs, conforms to the country power and electricity situation, works well within country room temperature, is robust enough not to breakdown frequently, and has built-in after-sale servicing and, second, that the available human resources and infrastructure are capable of handling the equipment.

2.3.2. Recurrent Resources

- Equipment and supplies:
  - Recurrent consumable budget per year for rapid HIV test kits, reagents for CD4, chemistry and hematology, ARVs, medicines for management of opportunistic infections such as TB and malaria, and supplies
  - M&E tools and registers
  - Equipment maintenance
- Human resources:
  - Mentoring and supervisory visits
  - Client tracking and home-based care
  - Hosting referral network meetings
  - Engaging trained volunteers for tasks in settings with limited human resources (e.g., PITC, data collection, adherence counseling)
  - Community interventions to generate demand and reduce stigma
2.4. Strengthening Systems for Continuous Availability of Commodities

For comprehensive CCT services to be sustained, a supply chain must be in place that delivers an uninterrupted supply of high-quality, low-cost products that will flow through a transparent and accountable system. Box 6 provides an example.

2.4.1. Using Key Elements of an Effective State Supply Chain Management System

An effective supply chain management system at the state level is marked by the following:

- Pooled procurement: working with partners in the state to stabilize supply and to plan for capacity expansion for ownership and sustainability
- A site-driven process: from initial product selection and forecasting through product delivery to clients in need, the sites are engaged in determining needs and monitoring the distribution and use of commodities
- State supply systems: strengthening existing supply chains, rather than replacing functioning systems
- Regional warehousing and distribution: strengthening national supply chains by using state depots to warehouse commodities (see box 7)
- A “pull” system: allowing each health facility to determine the amount of stock that it needs to order, so that commodities are distributed in quantities that the infrastructure can handle reliably and safely

2.4.2. Using Key Supply Chain Management Systems Strategies

In collaboration with state governments and other U.S. Government IPs, ProACT has found that the following supply chain management strategies work well to ensure a regular supply of HIV/AIDS commodities:

- Strengthen existing systems and avoid building parallel systems.
- Create a multisectoral coordinating platform—a logistics technical working group—for commodity availability.
- Aggregate procurement across IPs.
- Use regional or state distribution centers to manage inventory efficiently and at reasonable cost.
TURNING AN ABANDONED SPACE INTO A MODEL WAREHOUSE FOR CCT COMMODITIES

To increase access to ARVs and affordable medicines, the Niger SMOH worked with ProACT to completely rehabilitate an abandoned section of the state medical stores. The work included major masonry, carpentry, and painting. Workers replaced electrical fittings and installed an air conditioning unit, racks, and electrical power generating equipment.

The pharmacist-in-charge was trained in every aspect of supply chain management and logistics management information systems; he was also provided with all the tools needed for inventory management according to the standard operating procedures. The SMOH seconded a trained pharmacist to head the unit. The seconded pharmacist heads the unit that accommodates the ARVs, and the pharmacist-in-charge heads the whole central medical store, which also has other units.

The result was a model warehouse with the space, infrastructure, systems, and staff capacity to effectively quantify, store, and distribute the medicines essential for the expanded CCT program. This initiative also built a strong sense of state ownership and sustainable CCT services in the Niger State.

2.5. Identifying Infrastructural Support and Renovation Needs

Once points of service are identified, basic renovations and infrastructural support should commence before the site is activated to ensure the smooth take-off of services. These activities may include partitioning of spaces, installation of burglar proofing devices to secure the equipment area, reorganizing spaces to meet the standard requirements, painting, and providing furniture.

- The basic spaces required will include the following:
- PITC points in the general outpatient department (OPD)
- Laboratory
- Immunization clinics
- Family planning clinics
- Prenatal care clinic
- Pediatrics and medical wards
- TB unit

- Improve availability and use of logistics information for supply chain decision-making at state and national levels.
- Monitor the quantification of needs and the coordination of efforts.
- Provide sustainable solutions that build capacity in quantification, procurement, quality assurance, inventory management, distribution, and logistics management information systems.
Other points of service could include the following:

- Adherence counseling units
- An M&E and records unit with shelves set aside for HIV-positive client records
- A triage nurse station
- Consulting rooms
- Laboratory space
- Pharmacy space, with shelves for CCT medicines and commodities
- Space to host facility-based support group meetings

Once spaces are identified and renovated, the facility can now receive all the essential laboratory equipment and other long-lasting items required to provide CCT services.

2.6. Building Capacity

A series of training workshops will enable different stakeholder groups to implement the process efficiently and in a well-coordinated manner. The workshops should be structured, with clear learning, attitudinal, and performance objectives. Note: All training modules must adhere to relevant national guidelines and training curricula.

Table 1 displays some possible topics to meet the needs of various stakeholder groups. You and your colleagues may choose different or additional topics that are appropriate to your setting.

Lady pastes action plan developed during the Gombe LDP Held in Niger State
<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Training Topic</th>
<th>Purpose</th>
</tr>
</thead>
</table>
| State government, relevant government agencies, site selection committee, health care managers | ■ The HIV/AIDS burden, existing services, and underserved populations in this area  
■ CCT components  
■ Setting up and managing a CCT site  
■ Coordinating interdependent stakeholder roles and responsibilities | ■ Orient key players to CCT services and their roles  
■ Build enthusiasm for the new CCT site and the services it will provide  
■ Foster collaboration                                                                 |
| Facility staff (service providers) and community services support personnel | ■ The HIV/AIDS burden, existing services, and underserved populations in this area  
■ Technical updates on key HIV/AIDS and TB topics  
■ Facility and community responsibilities  
■ Working together | ■ Build or refresh clinical skills  
■ Generate pride in and ownership of the new CCT site and its services  
■ Foster collaboration                                                                 |
| Health care managers                                   | ■ The HIV/AIDS burden, existing services, and underserved populations in this area  
■ Leadership and management                             | ■ Develop skills for strong leadership, effective management, and supportive supervision          |
| State technical mentoring team                         | ■ The HIV/AIDS burden, existing services, and underserved populations in this state  
■ Technical updates on key HIV/AIDS and TB topics  
■ Mentoring skills refresher                             | ■ Orient mentors to CCT services and their roles  
■ Strengthen technical and mentoring skills for ongoing coaching and mentoring                        |
| CCT providers                                          | ■ The HIV/AIDS burden, existing services, and underserved populations in this area  
■ Hands-on training and mentoring during site activation | ■ Assess and strengthen providers’ skills  
■ Set the stage for future mentoring                                                                       |
2.7. Involving the Community to Support the Establishment of CCT Services

Sometimes you may feel that involving the community complicates and slows down the process—that you and a few colleagues, with government approval, could do the work more quickly and efficiently by yourselves. But ProACT experience confirms what so many other projects and programs have found: community involvement is essential to the long-term success of CCT and other health services.

2.7.1. Why Do You Need to Involve the Community?

- All CCT clients and potential clients live in communities. It is community members who will use the services provided in your facility.
- Informed community leaders can provide accurate information about HIV/AIDS issues and dispel the myths that create a negative mindset (box 8).
- Community involvement can create an enabling environment to promote demand for HIV/AIDS services and reduce stigma and discrimination.
- In an involved community, actions are taken by community members and not done to them. Time invested early in the process may mean the difference between active, meaningful ownership of CCT services and passive acceptance of the services.
- Engaging community members throughout the process will build a sense of pride, ownership, and responsibility—a commitment to CCT services that is essential to sustainability.

2.7.2. Entering the Community

Now is the time to build relationships and trust among the stakeholders and influencers—the gatekeepers to community support. You will want to hold one or more meetings with political and religious leaders, representatives of key community organizations, and community-based service providers to familiarize these stakeholders with the need for CCT services and to share the plans for the site.

The meetings with the gatekeepers should be followed by outreach to other members of the community, to bring them the same information and sensitize them to the value of CCT services to everyone in the community.

These meetings should not be a one-way street. Advocacy provides an avenue for dialogue with people at all levels of the hierarchy. It is a chance for them to express their views on how they may be affected by a CCT site in their community and to of-
fer valuable information and ideas. By hearing their voices and paying attention to their viewpoints, you and your colleagues will generate strong support for the start-up and maintenance of the services.

One proven format for this kind of dialogue is a town hall meeting with the community leaders and other stakeholders. This meeting will be most effective if community leaders invite stakeholders, provide the venue for the meeting, and have a chance to review and modify the agenda.

### STEP 3. INITIATING SERVICES

#### 3.1. Orienting the Staff

When all the training workshops have been completed, the state’s technical mentoring team, with support from IPs, should conduct a week-long orientation and capacity-building exercise for the facility staff. This event should encompass the following:

- Introducing the CCT services to all staff
- Holding training sessions with any service providers who have not yet participated in the previous trainings
- Defining clinic flow
- Planning for systematic follow-up
- Setting up all points of service and labeling them so that clients can find them easily
- Initiating service delivery
- Providing hands-on mentoring on service delivery at the different points of service
- Evaluating clients’ status and enrolling HIV-positive clients in care and treatment regimens
- Conducting hospital walk-throughs from the first point of entry to the exit point for clients
- Linking with CSOs identified in the initial assessment

#### 3.2. Activating the Site

Many items must be on hand and ready for use if things are to go smoothly when the doors open and the first clients walk in. The site should have the following:

- Training packs, including flip chart stands and paper, markers, tape, staplers, and other materials that will be needed during the staff orientation workshop
- Job aids that are easy for service providers to use and that cover all the information they need to carry out their responsibilities
- National guidelines for HCT, PMTCT, ART, and TB/HIV
- Step-down training materials, including notes on the key information and messages presented during the orientation workshop
- National M&E tools available in the relevant units, staff trained in their correct use, and a system to ensure the appropriate flow of information
- Social and behavior change communication (SBCC) materials posted at strategic locations in the facility and available as handouts if appropriate, to provide basic education and information on HIV/AIDS
- Pharmacy and laboratory stocked with medicines, equipment, supplies, and logistics monitoring tools, including tally cards, dispensary cards, ledgers, monthly report sheets, and combined requisition and utilization sheets

3.3. Mobilizing the Community and Generating Demand for Services

This stage of the process depends on the positive relationship you and your colleagues have built with the community during the planning phase. To fully mobilize community leaders and begin to generate demand for CCT services, you can—

- Engage in dialogues with individual community leaders and key community members
- Conduct focus group discussions with community groups, including women, men, youth, PLWHA, members of most at-risk populations
- Help to organize community activities, including interactive theater, films, community health talks, and other events that will draw crowds
- Provide HCT within the community, making referrals when necessary
- Distribute SBCC materials in strategic locations
- Organize a tour of the facility for key stakeholders

3.4. Establishing Care and Support Structures

Along with successful activation of the treatment site and community referral structures, it is important to establish structures in the facility and community that will provide care and support to PLWHA and their families. Other CCT programs have established various teams to support these efforts. Examples are provided below. If you and your colleagues assemble any of these teams, you will want to provide them with clear scopes of work and standard operating procedures (SOPs). See annexes A and B for information on these documents.

3.4.1. Patient Tracking Team

This group is made up of members of the hospital patient care team and treatment support partners, a group of volunteers who are HIV positive, on ARV, and offer psychosocial support to new people living with AIDS who are commencing ARVs. This team
ensures that each client adheres to clinic appointments. If a client defaults, team members will investigate the situation and initiate whatever measures are needed to retain the client in care.

### 3.4.2. Adherence and Ongoing Counseling Team

This group could be based in a CCT or primary health care setting, and is responsible for continuous counseling for every client, with an emphasis on adherence to therapy, prevention behaviors among PLWHA, and psychosocial support.

### 3.4.3. Support Group of PLWHA

This group is a cohort of HIV-positive persons who meet regularly to provide peer counseling and psychosocial support. They may also advocate for other needs of PLWHA within the community, such as nutrition, economic empowerment, and spiritual support needs.

### 3.4.4. Community Home-Based Care Teams

Members of this team will make home visits to provide care and support to clients, children, and family members including orphans and vulnerable children (OVC). These team members will offer health and hygiene education and nutritional counseling. Their visits will also serve as a means of observing adherence and use of basic care materials.

### 3.4.5. Referral Network Team

This team facilitates the “hub-and-spoke” organization of services (see figure 2). It brings together the focal persons who are involved in providing care at the CCT site, the feeder primary health care centers, and the community. The team facilitates referrals between caregivers in the primary health care centers and those at the CCT site. It establishes and maintains a two-way referral system: referring HIV-positive clients for care and treatment and then referring those clients back to the primary health care centers and community, from which the tracking team monitors their attendance at scheduled clinic visits. This team also tracks clients referred to other health facilities to access services that are not offered within the CCT scope, such as specialized mental health services.

### 3.5. Integrating CCT with Other Health Services

HIV/AIDS care and treatment services are most effective when they are integrated into existing hospital services. A facility that is providing integrated services needs to co-locate key service delivery points, integrate personnel, and integrate the infrastructure.
3.5.1. Co-Locating Key Service Delivery Points

The co-location of points of service for HIV/AIDS/TB and other health services allows easy access to CCT. It reduces the stigma that could result from public knowledge of a client’s visits to an HIV/AIDS site (box 9). It helps to identify HIV-positive clients who are using other services and who might have fallen through the cracks without CCT being easily available. It facilitates the detection and treatment of TB. It makes the most efficient use of the facility’s staff and encourages caregivers in every part of the facility to feel a connection with and ownership of CCT services. In this context, shared confidentiality among caregivers should be accommodated. Co-location applies to the following areas:

- **Testing points.** Testing points can be found in the outpatient unit, prenatal clinic, medical wards, TB DOTS unit, family planning unit, immunization units, pediatric outpatient unit, pediatrics ward, and laboratory.

- **Records unit.** Co-location of all patient folders ensures access to patient folders at all times including call hours. In the past, HIV patient folders were locked up in separate cabinets away from other patients’ folders. Information was, therefore, not readily available to consulting physicians caring for HIV-positive patients presenting for emergencies or other health issues. Physicians didn’t always have all the necessary past medical history needed to arrive at an informed decision about the care needed. Today, emphasis is on co-location of all folders at hospital records units though they may be kept in a separate section of the records unit and marked with unique identification numbers to show that they are HIV positive. Co-location allows caregivers and consulting physicians to easily access the information they need to monitor and adjust individual treatment regimens.

- **Outpatient service.** All clients should receive services at the same outpatient unit, whatever their medical condition. For people who are HIV positive or at risk for HIV/AIDS, this stipulation helps to protect confidentiality and reduce the stigma of registering at a separate CCT site. Clients requiring specialized care for any disease or condition can be referred appropriately.

THE BENEFITS OF CO-LOCATION

In most ProACT sites, PITC is offered at all points of care. This supports earlier and more frequent HIV testing among clients presenting for other services such as malaria, TB, and prenatal care and increases uptake of ARVs for those who test positive.

Some facilities have integrated the ART clinic into routine medical clinics and attend to HIV patients alongside patients with other medical conditions. Such integration reduces the stigma associated with attending a separate HIV clinic and improves clinic appointment adherence and patient follow-up. Clients often express their satisfaction with this approach.

“I feel better attending general outpatient department with every other person, compared to when our GOPD [general outpatient department] was separate and everyone knew those of us on the other side were HIV positive,” a patient reacting to relocation of HIV clinic to the general outpatient clinic in General Hospital Abejukolo north central Nigeria commented.
3.5.2. Integrating Personnel

Every staff member should be trained and conversant in care and treatment strategies for PLWHA. Duty rosters should be drawn to ensure that all staff are involved in care and all service points are covered. Emphasis is on training all health workers (e.g., ART nurses, ART physicians, counselors) to be proficient in all aspects of service delivery. Duty rosters should be drawn to involve additional health workers at various ART service delivery points as needed.

3.5.3. Integrating the Infrastructure

CCT support services such as laboratories, pharmacies, and welfare units function best when they are located within the same facility. This allows for rotation of trained personnel and fosters integrated care. Rotation uses a roster system where all staff have the basic skills required to care for PLWHA and can be assigned to such duty posts in addition to their primary duties.

3.6. Integration of Other Associated Services

Other key services can complement CCT at the same facility. TB services located in the facility—with rigorous infection control—make it easy to refer clients with TB/HIV co-infection for treatment of both conditions. HIV prevention services should be available both at the facility and in the community. Income-generating activities are particularly important for PLWHA, whose economic status tends to be imperiled by their condition and the stigma attached to it. And finally, services for OVC make a valuable contribution to the entire prevention-treatment-care package.

3.7. Maintaining High-Quality Services: Continuous Quality Improvement

Continuous quality improvement (CQI) is an approach to quality management that builds upon traditional quality assurance methods. It engages the staff of a health facility in assessing their own organization, systems, and practices through the collection, analysis, and use of objective data. By focusing on the process rather than the individual, the staff generate feasible improvements that will ensure high-quality health care delivery and, ultimately, client safety and satisfaction.

With the CQI approach, the staff of a CCT site can identify where gaps exist between expectations for services and services actually provided. They can find the best ways to close these gaps to meet the clients’ needs and expectations. Because of their collective ownership of the CQI approach—the selection of data, the analysis, and the proposed improvements—CCT staff will be highly motivated to accept the results and actually carry out the proffered solutions for closing the gaps.

Several activities will contribute greatly to the effectiveness of CQI and the steady improvement of CCT services: providing ongoing mentoring and supportive supervision, holding patient care team meetings, reviewing patient charts, ensuring the quality of data and its use for decision-making, monitoring laboratories, and annually assessing patient outcomes.
3.7.1. Providing Ongoing Mentoring and Supportive Supervision

An external consultant with training and experience in the CQI methodology assists the staff members engaged in CQI. In Nigeria, the ideal CQI consultant is a trained member of the state technical mentoring team. This person helps to initiate the CQI process and returns periodically to check on the staff’s progress and help them move forward.

Routine site visits provide essential technical support to the staff. These visits should be conducted at least monthly in the initial stages and tapered down to quarterly as the facility staff gain expertise in provision of high-quality services.

These visits can take two forms:

- **Precepting**: direct observation of health care workers as they provide services, to assess their knowledge, attitudes, and practices. The preceptor can identify gaps, give feedback, and promote the use of best practices.

- **Topical discussions**: group meetings designed to provide on-the-job training, update staff with current information about HIV/AIDS, address observed deficiencies in the quality of services, and build the confidence and skills of clinicians. They can be based on real cases that speak to the direct experience of the staff. These discussions can be especially effective if health care workers are encouraged to make presentations and lead the discussions. They will both improve their presentation skills and address common obstacles to the quality of CCT services.

3.7.2. Holding Patient Care Team Meetings

A multidisciplinary team with representatives from the different units of the facility should meet monthly to discuss quality issues that affect patient care. At each meeting, the units can routinely present their progress and challenges in attaining the unit-specific standards of care stipulated by the facility. This team draws on cases or scenarios from the different units to identify and review ways of improving the quality of care throughout their facility. These meetings are a good format for integrating CCT with the other units in the facility.

3.7.3. Reviewing Patient Charts

Biannual or quarterly reviews of patients’ charts can provide an excellent measure of quality of care. The reviewers—both internal and external—should score patient charts according to the national quality-of-care indicators. It is important for facility staff to be involved throughout the process, to see for themselves what gaps need to be filled to achieve the desired patient outcomes and improve the quality of CCT services.
3.7.4. Ensuring the Quality of Data and Its Use for Decision-Making

Because the success of CQI depends so heavily on objective information, external reviewers conduct a quarterly data audit to guarantee the availability, validity, reliability, and consistency of the data generated within the facility. Those who provide services at all levels need to be trained to generate and analyze data that meet the quality criteria. When they are providing quality data, service providers should not simply submit their reports to the government as required; they should use the information they have provided as the basis for CQI decision-making.

3.7.5. Monitoring Laboratories

Systems should also be in place to continuously review the quality of laboratory procedures and results. The laboratories at a CCT site, whether stand-alone or integrated with the facility laboratory, must be in strict compliance with job aids and guidelines. All personnel who come into contact with the laboratory should adhere to the prescribed safety measures to prevent infection. Equipment and reagents should be monitored routinely for compliance with temperature and other storage conditions to ensure the accuracy of laboratory results.

3.7.6. Annually Assessing Patient Outcomes

Desired treatment outcomes depend largely on adherence to an ART regimen that meets national quality standards. The level of viral suppression is a strong indicator of the quality of ART delivery, and this indicator can be measured through an annual assessment of viral load among a randomly selected cohort of patients who are representative of the general patient pool and have been on treatment for one year or more. This assessment may be conducted internally, if the facility’s laboratory has the capacity, or in collaboration with an external institution, if a more sophisticated laboratory is required. In addition to a viral load assessment, the patient level outcome also involves a chart abstraction and an adherence survey or interview, which helps correlate patient medication adherence and clinical events to the patient’s viral load. A site capacity survey and a client satisfaction assessment may also be administered at this time. The facility staff should use the results of these assessments to review the quality of the ART program and, in particular, to follow up with clients with virologic failure to address barriers and improve adherence and ultimately to ensure regimen switching.
STEP 4. COORDINATING MECHANISMS

Several mechanisms indicate whether CCT sites run smoothly and CCT services meet the highest quality standards. At the state level, CCT site managers can turn to the state steering committee for setting up CCT sites, the state technical mentoring team, and the state quality assurance/improvement team. Within the facility, support can come from the hospital management, program management, and patient care teams. Outside the hospital, network and referral teams are good sources of assistance. And within the community, officials of PLWHA support groups offer a valuable resource.

At the state level, the SACA can play an important role by developing a multisectoral service directory that includes all health, education, and social service outlets in the state, as well as secondary support services. This directory is essential to coordinate the provision of CCT services and maximize the use of all available opportunities.
COMMONLY ENCOUNTERED CHALLENGES AND HOW THEY HAVE BEEN OVERCOME

In providing care to PLWHA, certain unique challenges may be encountered due to stigma, social and cultural factors in sub-Saharan Africa, and other related factors. Thirteen of the most frequently observed challenges, in our experience, and strategies adopted to overcome them are discussed here.

1. **Challenge**: non-enrollment of clients who tested positive at PITC points across our supported facilities; patients testing positive are occasionally lost in transit before enrollment at the records unit. This loss could be due to denial on the part of the patient or a complex patient flow system.

   **Recommendations:**
   - Providing escort services to guide the clients to the records unit for enrollment
   - Improving counseling skills and services
   - Documenting detailed and traceable contact addresses and phone numbers of HIV-positive clients on the back of the HCT result slip for tracking purposes

2. **Challenge**: loss to follow-up and retaining patient in care

   **Recommendations:**
   - Providing good adherence counseling targeted at all clients in care and treatment to help them appreciate the importance of regularly taking their medications and promoting good health
   - Making regular clinic appointments for both clients in care and treatment (monthly for all or less frequently for clients with a greater than 90 percent adherence to ARVs record and a high CD4 count)
   - Using an effective client tracking system that commences at the point of enrollment with detailed contact addresses and initiates client tracking after two missed clinic appointments
   - Co-scheduling of mother-baby pair appointments
   - Initiating ART early for eligible clients

3. **Challenge**: dispensing wrong ARV regimens

   **Recommendations:**
   - Using job aids properly and placing them at strategic positions in the consulting rooms, pharmacy and dispensing areas, and adherence rooms
   - Checking prescriptions against standards at the pharmacy and adherence units
• Referring regularly to training materials. In the case of TB/HIV co-infection, always get detailed information on the client’s medication and other history to serve as a guide. A simple intrafacility referral tool may be okay.

4. **Challenge**: improper staging of patients according to WHO criteria

**Recommendations:**

- Paying close attention to signs and symptoms during clinical evaluation and follow up visits
- Always making reference to available job aids to serve as a guide

5. **Challenge**: delays in identifying ARV toxicity

**Recommendations:**

- Paying close attention to clinical signs and symptoms at each visit
- Requiring more regular clinic visits, especially during the period following initiation of ARVs
- Performing routine laboratory monitoring tests as required; the laboratory staff should flag risk results and physically let the clinician reassess the client before the latter leaves the facility
- Having a high index of suspicion

6. **Challenge**: infrequent coordination meetings

**Recommendations:**

- Identifying focal persons who will be accountable for each of the teams and for scheduling and leading meetings
- Limiting the number of teams
- Integrating teams into already existing committees in the facility

7. **Challenge**: poor mother-baby pair tracking

**Recommendations:**

- Tracking of expected date of delivery
- Tracking of pregnancy as it progresses—a simple tool to track dates in weeks has proved helpful for commencing ARV prophylaxis for eligible clients
- Ensuring early baseline investigations and follow-up, for example, at due date
- Establishing effective collaboration between maternity and prenatal clinic staffs
- Providing health education on PMTCT to all pregnant women to give them simple information on ARV prophylaxis for mothers and infants and its usefulness
- Setting an appointment for exposed infants at 6 weeks to coincide with routine immunization for collection of first dried blood spot sample
- Giving a realistic appointment with the background knowledge of turnaround time for collection of results

8. **Challenge**: inadequate pediatric ART uptake and retention in care

**Recommendations:**
- Providing routine PITC for all children
- Providing health education on pediatric ART
- Co-scheduling mother-baby pair appointments
- Using family-centered testing to ensure all children of an HIV-positive client are reached with HCT
- Ensuring early baseline investigation and possibly CD4 percentage
- Using job aids appropriately
- Sending reminders through text messages on initiation criteria for children

9. **Challenge**: non-repeat or low uptake of CD4 count and baseline investigations

**Recommendations:**
- Using regularly updated laboratory calendars for tracking investigations
- Shifting the request-for-investigation task to other cadres of health workers

10. **Challenge**: work overload

**Recommendations:**
- Integrating the clinic and running ART services daily
- Shifting tasks (e.g., trained nurses have successfully provided ART refill services including initial clinical evaluation, laboratory investigation requests, and ARV patient follow-up at ProACT-supported facilities)
- Seeking staff support from local government or other bodies
- Using trained staff to conduct onsite step-down trainings for other staff

11. **Challenge**: poor infrastructural support

**Recommendation:**
- Collaborating with other stakeholders (e.g., government, individuals, community leaders, community organizations, and corporate bodies) who offer such support
12. **Challenge**: stock-outs of commodities

**Recommendation:**

- Using an efficient forecasting system and tool that involves all service providers
- Practicing timely compilation and submission of utilization data to central warehouse

13. **Challenge**: gaps in clients’ documentation.

- Providing continuous support to emphasize that “if it is not documented, it is not done” and that service delivery is not complete until documented
- Charging records staff to track gaps in documentation and calling gaps to the attention of those responsible for addressing them

**THE LAST WORD…**

Did you ever lose someone close to you from HIV/AIDS before effective medicines became available? Now that we have effective ART, would you allow anyone to die as before? Be it a parent or spouse of an HIV-infected person, or health worker or a community leader or a director or commissioner for health in a state, shouldn’t you declare death from HIV/AIDS “a cause” that is not acceptable in society and work diligently to stimulate action by all? Availability of ARV medicines is not the major problem anymore; the problem now is the lack of “all the systems needed to deliver the medicines to people who need them—a trained and motivated health workforce, consistent mentoring and supervisory teams to assure quality of services, proper compilation of information and its use to manage the medicines and supply chain to avoid stock-outs, good laboratory and pharmaceutical practices, and taking ART services to the poor and vulnerable people wherever they live through well-managed decentralized systems.”

May this knowledge help you to take responsibility proactively for increasing the number of HIV/AIDS treatment centers at the grassroots level and help more PLWHAs to live quality, long, and productive lives.
Table A1. Standard Operating Procedures

<table>
<thead>
<tr>
<th>Name of Procedure</th>
<th>Where to Get a Copy</th>
<th>Link to Website*</th>
<th>Purpose</th>
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</thead>
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<tr>
<td>National PMTCT Guidelines, GON</td>
<td>Nearest health facility or SMOH or the office of the State AIDS/STI Control Program</td>
<td><a href="http://www.nascp.gov.ng">www.nascp.gov.ng</a></td>
<td>- Deborah Odoh <a href="mailto:nascpbako@yahoo.com">nascpbako@yahoo.com</a>; 08037880967</td>
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<td></td>
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<td>- Gabriel Kogo <a href="mailto:gkogo@msh.org">gkogo@msh.org</a>; 08077099623</td>
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<td>National PMTCT Participants Manual, GON</td>
<td>National AIDS/STI Control Program, MSH-supported health facilities in the state, or SMOH Disease Control Unit</td>
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<td>National Scale up Plan for PMTCT, GON</td>
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<td>National Pediatric ART Guidelines, GON</td>
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<td><a href="http://www.nascp.gov.ng">www.nascp.gov.ng</a></td>
<td>- Ifeanyi Ononuju <a href="mailto:mbbsfigo2004@yahoo.com">mbbsfigo2004@yahoo.com</a>; 08057310752</td>
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<td>National Early Infant Diagnosis Trainers Manual, GON</td>
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<tr>
<td>National Guidelines for HIV/AIDS Treatment and Care in Adolescents and Adults, GON</td>
<td>National AIDS/STI Control Program, MSH-supported health facilities in the state, or SMOH Disease Control Unit</td>
<td><a href="http://www.nascp.gov.ng">www.nascp.gov.ng</a></td>
<td>- Dr. Emeka Asadu <a href="mailto:ecasadu@yahoo.com">ecasadu@yahoo.com</a> 08062444273</td>
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<td>- Dr.Amana Effiong <a href="mailto:aeffiong@msh.org">aeffiong@msh.org</a> 08055098024</td>
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*All the documents above will soon be loaded onto this website.
### ANNEX B.

Table B1. Scope of Work for Selected Service Providers

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<tr>
<th>Provider</th>
<th>Scope of Work</th>
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| Initiated Testing Counseling Volunteers | Support the provision of PITC services to all clients visiting the clinics at all testing points including the prenatal care setting for PMTCT and strengthen intrafacility referrals from point of testing to point of enrollment.  
Ensure 100 percent enrollment of all identified HIV-positive persons.  
Ensure that all HIV-positive clients receive a basic care kit at enrollment.  
Promote a family-centered approach by ensuring that all family members of identified HIV-positive clients are counseled and tested.  
Create a personal counselor-client relationship by completing the counselor client cohort form and following up with the client to improve client retention in care.  
Carry out quarterly visits to clients to ensure that the basic care kit is put to use and that they maintain optimum level of sanitation and hygiene practices.  
Work with other volunteers to strengthen referral systems by identifying and mapping CBOs, philanthropists, leaders, schools, and other community resources in order to refer clients to the most appropriate sources for support.  
Reach PABAs with care and support services, and keep records of all PABAs reached.  
Collaborate with support group leadership in the formation and functionality of support group cells (small groups of 5 to 10 persons living in the same area), and mentor them toward becoming community-based support groups.  
Work with other volunteers to carry out community mobilization and sensitization in churches and mosques to increase uptake of health services in supported facilities, and keep track of people who access services through this strategy.  
Meet with other volunteers; collate and submit weekly statistics of services provided to the specialist through the referral coordinator or the focal person.  
Carry out any emerging activity as directed by the community HIV services specialist.  
Work with the referral coordinator to write and submit quarterly reports detailing all activities carried out. |
| OVC Volunteers                  | Identify, enroll, and provide OVC services at PITC points and support groups, during home visits, and at immunization and pediatric clinics, and categorize children into different groups based on levels of vulnerability and needs as identified by the national OVC forms.  
Ensure that all data documentation using the national OVC forms (e.g., CSI, VI, enrollment, service forms) and registers are accurately administered and reliably completed.  
Ensure that CSI tools are administered to all OVC before service delivery and repeated after 6 months to check improvement in the child's status; determine needs for service delivery.  
Offer care and support services through home visits to enrollees PLWHA and the OVC, respectively, in the communities. Clients (PLWHA/OVC) should be visited at least once every quarter.  
Mentor caregivers to be able to understand the needs of the child, and provide them with appropriate services.  
Work with other volunteers to strengthen referral systems by identifying and mapping CBOs, philanthropists, leaders, schools, and other community resources in order to refer clients to the most appropriate sources for support.  
Provide PwP messages to all caregivers of OVC, reach PABAs with care and support services, and keep records of all PABAs reached.  
Collaborate with support group leadership in the formation and functionality of support group cells (small groups of 5 to 10 persons living in the same area), and mentor them becoming community-based support groups.  
Work with OVC caregivers to establish and run a savings and loan association that will empower them economically toward meeting the needs of OVC.  
Meet with other volunteers; collate and submit weekly statistics of services provided to the specialist through the referral coordinator or the focal person.  
Carry out any emerging activity as directed by the community HIV services specialist.  
Work with the referral coordinator to write and submit quarterly reports detailing all activities carried out. |
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| Adherence Volunteers | - Conduct treatment preparation for all new patients and provide routine adherence counseling to all patients attending ART and care clinics.  
                      | - Provide continuing adherence counseling for follow-up patients.            
                      | - Ensure proper documentation of services provided.                          
                      | - Ensure that all HIV-positive clients receive PwP messages every clinic day and at support group meetings.  
                      | - Encourage clients to choose a treatment partner who will receive information and education to support the client’s adherence to ART and clinic day appointments; keep telephone contact of client’s treatment partners.  
                      | - Ensure that water guard or purr is replenished and documented at every clinic day.  
                      | - Work with the referral coordinator and M&E/records unit to ensure effective tracking of clients.  
                      | - Collaborate with support group leadership in the formation and functionality of the of support group cells (small groups of 5 to 10 persons living in the same area), and mentor them toward becoming community-based support groups as well as establishing an economic empowerment program together.  
                      | - Meet with other volunteers; collate and submit weekly statistics of services provided to the specialist through the referral coordinator or the focal person.  
                      | - Carry out any emerging activity as directed by the community HIV services specialist  
                      | - Work with the referral coordinator to write and submit quarterly reports detailing all activities carried out. |
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