Operational Guide for Community-Based ARV Dispensation in Cameroon

December 2017
Preface

The Republic of Cameroon is committed to universal access to the treatment of HIV through the “Test and Treat” strategy advocated by WHO and UNAIDS. This commitment was materialized into a number of initiatives whose aim is to accelerate access to ART for people living with HIV. One of the initiatives put in place is the community-based dispensation of ARVs, a strategy that allows for greater community participation in the provision of community-based HIV care services. Its implementation will contribute to:

✓ Decongest health facilities with high volumes of active files;
✓ Improving patient follow-up;
✓ Their retention on treatment;
✓ Community involvement in the national response to HIV/AIDS
✓ Ensure care continuum for people living with HIV in the community and by the community

This guide was developed for the operationalization of the community dispensation strategy. It provides strategic guidelines for the implementation of the different models of community dispensation chosen by the country. It is divided into three major parts, these are: (i) community dispensation by PODIC; (iii) community dispensation by support groups, (iii) community ART groups (CAGs)

This document targets all actors of health facilities and community-based organizations involved or wishing to intervene in community-based ARV dispensation.

This document should be widely distributed to all actors involved in this activity in Cameroon.

I thank all resource persons who contributed to the drafting and validation of this strategy document.

I therefore urge all actors involved in the fight against HIV/AIDS to appropriate this strategy, in order to offer quality and comprehensive care to our populations.

The Minister of Public Health
Table of contents

Preface ........................................................................................................................................... 1
Table of contents ............................................................................................................................. 2
List of abbreviations ....................................................................................................................... 4
List of tables .................................................................................................................................... 5
List of resource persons who participated in the validation of the Guide ...................................... 6
Introduction ..................................................................................................................................... 7
Definition of concepts .................................................................................................................. 9
I. Community Dispensation of ARVs by Community Dispensation Points (PODIC) ..................... 13
   1. Description ............................................................................................................................ 13
   2. Conditions necessary for the smooth operation of the PODICs ............................................. 13
   3. Actors and their role in the community dispensation by PODIC ........................................... 14
   4. Criteria for eligibility of beneficiary patients of this dispensation model ......................... 17
   5. Identification of eligible patients ......................................................................................... 18
   6. Conducting the dispensation within the PODIC ................................................................. 18
   7. Training and awareness of actors ....................................................................................... 20
   8. Coordination and monitoring-evaluation ............................................................................ 20

9. BENEFITS AND CHALLENGES TO THIS MODEL ................................................................. 22
10. Establish opening hours of PODIC ......................................................................................... 23

II. Community-Based ARV dispensation by adherence clubs or support groups within the CBOs and HFs .......................................................................................................................... 25
   1. Description ........................................................................................................................... 25
   2. Basic principles of adherence clubs or support group ......................................................... 25
   3. Actors and their role in the community dispensation by support groups or adherence club .... 26
   4. Patients targeted by the adherence club or support group .................................................. 27
   5. Community-based ARV dispensation progress within support groups ............................. 28
   6. Training stakeholders ......................................................................................................... 30

Operational guide for community-based ARV dispensation in Cameroon
7. Monitoring and evaluation of activities ................................................................. 30
8. Benefits and challenges of this model ............................................................... 31

III. Dispensation of ARVs by Community Therapy Groups (CTGs) ............................. 34
1. Description of the CTG ...................................................................................... 34
2. Basic principles to be applied as part of this model .......................................... 34
3. Stakeholders, roles and responsibilities in community-based ARV dispensation by community therapy groups .......................................................... 35
4. Patient eligibility criteria for the CTG ............................................................ 36
5. Procedure for setting up a CTG ......................................................................... 37
6. Training CTG members ...................................................................................... 38
7. Dispensation flow within CTGs .......................................................................... 38
8. Monitoring and evaluation of activities achieved by CTGs ............................... 39
9. Defining a system of referring patients to their home HF .................................... 40
10. Benefits and challenges of this model ............................................................. 40

APPENDICES ........................................................................................................... 44
References ............................................................................................................... 44
Data collection tools ............................................................................................... 0
List of abbreviations

AIDS : Acquired immune deficiency syndrome
ANC : Ante Natal Consultation
ART : Anti Retro Viral Treatment
ARV: Anti Retro Viral
ATC : Accredited Treatment Centre
CAG : Community ART Group
CARVD: Community-Based ARV Dispensation
CBO : Community Based Organization
CTG : Central Technical Group
HF : Health Facility
HIV : Human Immunodeficiency Virus
HV : Home visit
NACC : National Aids Control Committee
PLWHA : Person Living with HIV
PMTCT : Prevention of from Mother to Child Transmission of HIV
PODIC : Community Dispensation Point
PSC: Psychosocial Counsellor
PTE: Patient Therapeutic education
RTG : Regional Technical Group
UNAIDS : United Nations Programme on HIV/AIDS
VL : Viral load
WHO : World Health Organization
List of tables

Table 1: Actors and their role in the coordination and monitoring/evaluation of PODICs

Table 2: Summary of the PODIC model

Table 3: Summary of the Support Group Model or adherence clubs

Table 4: Summary of the Community Anti-Retroviral Therapy Group Model (CAG)
List of resource persons who participated in the validation of the Guide
Introduction

The prevalence of HIV in Cameroon in 2011 was 4.3%\textsuperscript{1} in the general population (15-49 years), ranking the country among those with a generalized epidemic. In order to manage this epidemic, the country committed itself to the UNAIDS targets of putting 90% of people known to be HIV-positive on ARV by 2020, which is in line with the objectives of the 90-90-90 advocated by UNAIDS, an ambitious goal to end the epidemic by 2030. To do this, innovative strategies needed to be developed and implemented to scale up antiretroviral therapy by 2020. WHO and UNAIDS guidelines advocate for differentiated HIV management and increased community involvement in HIV service delivery and ARV dispensation to improve patient retention on treatment. Differentiated management is a patient-centred approach that aims to simplify and adapt the cascade of HIV-related services to reflect the preferences and expectations of different groups of people living with HIV while reducing the burden on the health system. Differentiated care also enables the health system to refocus resources on those who need them most, and aims to improve the quality of patient experience by putting the client-patient at the heart of service delivery while ensuring that the health system functions in a medically efficient and responsible manner. The adaptation of service delivery is based on the needs of the patient.

Cameroon has adopted this approach by implementing the 3-month supply interval spacing approach for stable patients and by adopting a national strategy for community-based ARV dispensation in 2016. This strategy was proposed with the aim of decongesting high-volume health facilities with active files, to improve the adherence of patients to ARV treatment and to improve patient retention in the PLHIV management system, in a context where the active file exponentially increases with the adoption by the country of the "Test and Treat" strategy advocated by the WHO.

In order to ensure a scaling up of antiretroviral therapy in Cameroon, the involvement of community actors is imperative in the management of patients on ARVs. In the light of the experience of community actors in the mobilization, the implementation of prevention interventions and the support of care continuum for our targets, these community actors have been selected as partners to support healthcare providers in their tasks. Experience have shown that ARV dispensation at the community level contributes to the participation of

\textsuperscript{1} DHS 2011

Operational guide for community-based ARV dispensation in Cameroon
patients in their care and thus to their empowerment. This approach can also be the basis for further decentralization of ARV service provision. However, there is a certain weakness in the community sector resulting in:

- poorly supplied community fabric ;
- lack of community actors involved in the provision of prevention and care continuum services for PLHIV ;
- lack of a harmonized minimum package of activities within the framework of care continuum for PLHIV ;
- deficiency in reference and counter reference between the hospital and community ;
- weakness in the monitoring and evaluation of community interventions.

In order to facilitate the implementation of the community ART dispensation, a national guide: The National Strategy for Community-based ARV Dispensation was developed and validated in April 2017. This document known as the “Operational Guide for Community-Based ARV Dispensation" is a tool that indicates the approach to be followed for the implementation of the different models adopted by the country.

It is divided into three main parts (i) community dispensation by Community ARV Dispensation Points (PODIC), (ii) community dispensation by adherence clubs or support groups (iii) community dispensation by community antiretroviral therapy groups (CAG) ;
Definition of concepts

- **Community Based Organization (CBO)**

The CBO is a group, an association of people within a community, united to defend common interests with defined goals.

Within the framework of community-based ARV dispensation, it is an association of people living with HIV or affected by HIV, based in community, whose existence is recognized by an authentic document (creation certificate) issued by a competent administrative authority.

Within the context of this strategy, it may include:

- Identity organizations;
- Organizations that work with key populations;
- Generalist organizations with a wide audience;
- Network of people living with HIV and AIDS: this is a national network with wide coverage.

- **Community actor**

A community actor is any member of the community providing care and support to people living with HIV in the community. The concept of community actor can represent very diverse groups of service providers in the community.

- **Community ARV Distribution Point (PODIC)**

Also called PODI in some countries, for Cameroon, PODICs are functional entities created within associations of PLHIV or affected people involved in the fight against HIV for the community dispensation of ARVs and support to PLHIV on ART.

They serve as a relay for HIV management structures, public or private, for the extension of ARV dispensation and psychosocial support for PLHIV
- **Adherence Club or Support Group**

Support Groups, also called adherence clubs, are a group of people regularly constituted of patients on ARV followed up in the same HF.

These are groups of stable patients on ART attached to a HF with the help of a non-medical staff of the HF (PSC or other) trained in ARV dispensation. Adherence clubs are aimed at facilitating the collection of ARV while offering experience sharing, adherence and mutual support. Adherence clubs are made up of 10 to 20 persons, which allow each person to express their suffering and know the experiences of others to strive to a resolution of personal difficulties.

- **Community Antiretroviral Therapy Group (CAG)**

The community antiretroviral therapy group consists of persons collecting their ARV within the same management centre whose number is defined according to the context and time of refill. These people come together either on their own initiative or through the initiative of the health facility based on where they live. These groups meet regularly to share experience and for adherence, mutual support and aid. The Community ART Group allows members of the group to develop affinities with the PLHIV of their community.

- **Community response to HIV**

Community response to HIV is any action taken in the fight against HIV for the community, by the community, or with the participation of the community. These may be (1) advocacy actions; (2) awareness campaigns and civil society participation in decision-making; (3) monitoring and evaluation of progress in service delivery in response to the HIV epidemic, (4) direct involvement in service delivery, (5) participatory community-based research, etc.

- **Community-Based ARV Dispensation**

Community-based ARV dispensation is an action which consists in supplying ARV to PLHIV in the community through a non-medical facility, based in the community or group of people living in the same area, united by ties of common interests. The dispensation ARV is performed by people who do not necessarily have medical training, but remain under the supervision of a health facility (supervising HF) and coordination of the NACC.
Community-based ARV dispensation models are adopted according to the context of each country. For Cameroon, three models are selected, namely: the PODIC model, the support groups or adherence clubs model and the CAG model.

- Confidentiality

It is a relationship of trust that exists or must prevail between a patient in general or a PLHIV in particular and a provider with parental, professional or official rights, giving him access to information on the health of the individual that he must keep secret².

- Informed consent

Voluntary agreement of a person (oral or written), who commits to an act without being forced by anyone or anything, having been informed about all the conditions, and received all the information about the benefits, risks and disadvantages; "there is no valid consent if the consent was only given in error or was obtained by force³".

**Free and informed consent:** It is the manifestation of the will of a person to submit to a procedure, following complete information, that this will be manifested in writing, verbally or tacitly⁴.

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² Article 2 Law No. 030 AN/2008 on the fight against HIV and the protection of persons infected and affected by HIV

³ Cf Article 1109 Civil code Burkina Faso

⁴ ILO law of 11 July 2014 on the prevention, protection and enforcement of the fight against HIV/AIDS

Operational guide for community-based ARV dispensation in Cameroon
Community Dispensation of ARVs by PODICs within CBOs
I. Community Dispensation of ARVs by Community Dispensation Points (PODIC).

1. Description

PODICs are managed by CBOs identified for this purpose. The CBO is in partnership with one or more supervising health facilities (HF) specialized in the follow-up of people living with HIV on ART. An HF can establish partnerships with several CBOs according to its active file and its ability to ensure their appropriate follow-up. The supervising HF identifies and selects patients who meet the eligibility criteria and offers them to obtain ARV treatment in these CBOs, who are generally in a radius close to their place of residence. The CBO staff provides ARVs, psychosocial support, therapeutic education, missed appointments, search for the lost to follow up and management of the drug stock received for referrals from supervising HFs. This model is considered an outreach strategy for HFs and is adapted to urban areas.

2. Conditions necessary for the smooth operation of the PODICs

The principles to be respected are as follows:

- Good organizational capacity of CBOs to achieve the assigned objectives;
- Remuneration of community actors;
- Supervision of actors from CBOs to ensure quality work;
- Availability of a suitable room (ARV storage room and a patient reception room);
- Good organizational capacity to achieve the assigned objectives. Organizational capacity building of these CBOs may be necessary;
- Competent and well-trained staff paid and supervised to ensure quality work;
- Good collaboration between the supervising HF and the CBO;
- The HF is the guarantor of the referral system of stable patients from HFs to PODIC, the clinical monitoring of patients and supply of ARVs and inputs.
- Effective management of central and local pharmacy supplies and stocks;
- Respect of the eligibility criteria of patients on ARV;
- Minimum capacity of the PODIC to perform clinical surveillance (weight, blood pressure, verbal TB screening) and a needs assessment in terms of psychosocial support, adherence support and therapeutic education;
- Permanent and continuum of the services provided by the CBOs;
- Monitoring and evaluation system available to facilitate accountability and steering;
- Monitoring and evaluation system, integrated into the national health system, is needed to maintain the quality of services and monitor the supply chain of drugs. A national normative framework supporting differentiated models of ARV refilling will facilitate the establishment of PODIC.

3. **Actors and their role in the community dispensation by PODIC**

a). **Health facility (HF)**

It is in charge of:
- Formalizing the partnership with PODIC;
- Selecting eligible PLHIV and referring them to partner PODIC;
- Involving actors intervening in the HF (health staff, PSC), or the sensitization and the identification of eligible patients;
- Listing the treatments of eligible patients according to the protocols, checking the compliance of the protocols and the quantities requested by the CBOs;
- Establishing the delivery slip and have both parties sign it;
- Supplying the PODICs with ARVs according to their needs, provide the CBOs with the necessary quantities of ARVs;
- Providing coaching and formative supervision of PODIC actors;
- Integrating monthly PODIC data into the ART register and updating the stock cards;
- Validating monthly the activity report of the partner CBOs;
- Providing biological monitoring of PLHIV referred to PODIC once a year;
- Ensuring renewal of prescriptions of PLHIV every six months;
- Developing a monthly report on the active file of PODIC and their ARV consumption.
NB: Community actors in charge of the psychosocial support of PLHIV within the HF must play the role of facilitators in the implementation of the Community Dispensation of ARVs. They will have to sensitize the patients and contribute to their identification according to the predefined criteria, in consultation with the medical team and the community actors, partners of the HF.

b. Community Dispensation Point (PODIC) within the CBOs

The PODIC should:

- have safe site adapted for community dispensation with two rooms at least, one for ARV storage and one for dispensing, counselling and therapeutic education;
- receive monthly ARV drug stocks with signature of the acceptance report and the delivery note;
- update the stock cards;
- provide patients with ARVs daily from Monday to Saturday;
- measure the weight, height, search for TB using four questions (weight loss, high temperature, sweating at night, persistent cough longer than 2 weeks) and suggestive signs of STIs in patients before dispensing drugs;
- transmit monthly dispensation data to the supervising HF for compilation;
- multiply the tools of data management;
- prepare the monthly technical and financial report to be submitted to the RTG;
- lead IEC sessions every day before the dispensation;
- provide psychological and social support and adherence support to patient
- look for the patients who missed appointments and the lost to follow up;

Community actors should carry out:

Promotional activities:

- educate patients and the community;
- communicate on the concept of community-based ARV dispensation using all media and non-media channels;
- communicate on treatment adherence;
- communicate on the lifestyle of patients on ARV treatment.
Prevention Activities:
- raise awareness on STI/HIV/AIDS;
- raise awareness and direct for VCT;
- distribute condoms and lubricants.

Care Support Activities:
- Procuring ARVs;
- dispensing ARVs;
- providing counselling, adherence support and therapeutic education;
- giving nutritional advice;
- Making an active search for patients who missed their appointments and the lost to follow-up.

Monitoring evaluation activities:
- Data collection, analysis and feedback;
- Data transmission and report writing within the time limit;
- Archiving of documents and notification and reporting tools.

The roles and responsibilities of the actors must be very precise. Within the framework of the management of PODIC three (3) community actors are trained and must perform the following roles:

The agent in charge of dispensing and stock management: receives patients, dispenses ARVs, offers adherence support and schedules patient follow-up appointments. He manages the pharmacy and programmes the order of ARVs and inputs from the HF. He must be versatile.

Animator: ensures the animation of support groups, adherence clubs, educational talks and counselling. He participates in the psychosocial support of patients and provides them with adherence support to treatment and ensures the filling of the data collection tools, he must be equally versatile.
The agent in charge of the search patients who missed their appointment for treatment and promotes community-based ARV dispensation in the community; he must be equally versatile.

c. The patient

He is in charge of:

- Signing the consent form;
- Respecting appointments both at the level of the HF and in the CBO;
- Going to PODIC with the prescription;
- Following the customer circuit in force at PODIC;
- Participating in CBO counselling and support activities;
- Receiving his medication against signature;
- Going to the HF in case of referral;
- Going to the HF for planned follow-up.

4. Criteria for eligibility of beneficiary patients of this dispensation model

- PLHIV on ARV, aged 20 years and above and having a follow-up on treatment for more than 12 months;
- Be clinically stable i.e. with an undetectable viral load and/or CD4 cell count > 500 cell / mm3 (in the absence of viral load, patient with no clear evidence of current immunologic or clinical failure);
- No visible signs of an ongoing opportunistic infection (TB, or other);
- Patient not pregnant;
- Patient on first line of treatment;
- Patient consenting to the initiative. This membership is materialized by an informed consent document signed by the patient.
5. **Identification of eligible patients**

Eligible patients are identified by the supervising HF according to the criteria described above. Each HF according to its organization will adopt an approach that will facilitate the awareness of patients and their adherence to this strategy.

For patient awareness, several approaches can be used: the individual approach that consists of raising patient awareness during the consultation or the group approach that consists of group sensitization within the HF before consultation. Sensitization sessions in the waiting room of the HF can be conducted to make all patients aware of how the PODIC work. The community actors working in the HF (PSC) should be used for the sensitization and identification of stable patients.

Communication materials such as video or posters and leaflets can be used for literate patients and placed in waiting and consultation rooms of health facilities.

Patient adherence to the strategy is voluntary by signing an informed consent form. It should be noted, however, that the final decision to refer a patient to the PODIC lies with the healthcare provider.

6. **Conducting the dispensation within the PODIC**

a) **Supply of input and stock management**

Inputs (ARVs, Cotrimoxazole and condoms) must be available in PODIC in sufficient quantities. At the launch of PODIC, an order must be made for the first time based on an estimate of the number of patients expected.

In the context of procurement, the CBO must:

- Collect prescriptions from eligible patients;
- Establish the order form for ARVs according to the prescriptions;
- Go to the HF for supply;
- Check the conformity of the delivery note;
- Sign the delivery note;
- Collect drugs and bring them back to PODIC;
- Establish the report of receipt of drugs by the PODIC;
b. Dispensation of ARVs

**Step 1: Receive the patient**, by greeting; inquire about the reason for the visit. Ensure a good reception of the patient because the quality of the reception can be determining for the continuation. If the patient is coming for an ARV dispensing, verify that the patient is in the active PODIC file (ask the patient to submit the prescription and the dated and signed referral form from the provider who received it). Register the patient in the dispensing register reserved for this purpose.

**Step 2: take the patient's weight and blood pressure**, assess the general health of the patient by asking him a number of questions about the symptoms he may feel, make a screening for the search for tuberculosis with a search for suggestive symptoms. Evaluate the patient's needs for psychosocial support; assess their level of adherence and provide support when needed.

In the event of proven symptoms of tuberculosis or any other sign of concern, the patient is immediately referred to his/her care centre, at the supervising HF.

**Step 3: Dispense ARVs**: ask the name of the HF where the patient comes from (if the CBO collaborates with several HFs). Analyse the prescription of the patient to ensure the protocol of the treatment to provide to him, give him his treatment and fill in the various tools. Have client signed for the drugs.

**Step 4: schedule the date of the next appointment** and take leave of the patient.

In this model, individual interviews are the most appropriate.

c. search for patients who missed their appointment

Based on the dates scheduled for appointments, patients who missed their appointments must be listed for active search. Firstly, the patient can be contacted by telephone, if he is not reachable, the community agent in charge of the search for the missed appointment for treatment will organize a home visit (HV) for their search with the help of his network in the
community. The search for absentees at the appointment can only be effective if the patient's contact details (at least 2 functional telephone numbers) are regularly updated in the dispensing register.

7. Training and awareness of actors

It is necessary to have community actors trained and equipped to ensure a quality service offer within the PODIC. As part of the management of the PODIC, three (03) community actors are recruited, trained to ensure the functioning of the PODIC. During the training, a focus must be placed on the care continuum for PLHIV and on the filling of the tools developed as part of this initiative.

**Raising awareness and preparing health care workers in Health Facilities**

Health facility personnel are the key actors who inform and refer eligible patients to PODIC. It is therefore essential that staff understand the role and functioning of the PODIC and be able to refer patients to the PODIC according to the eligibility criteria. A good collaboration between PODIC and HF is therefore necessary. Experience has shown that health workers may initially be reluctant to refer patients to PODIC, fearing that the follow-up may be of lower quality for patients, or that they may lose some of their activity. It is therefore necessary to set targets for referring patients to the PODIC using an indicator and to communicate regularly with staff on the progress of referrals to PODIC.

8. Coordination and monitoring-evaluation

In order to strengthen the community dispensation of ARVs, good coordination and a good monitoring and evaluation system are needed. To do this, the data transmission circuit must be clearly defined and a certain number of tools developed (see appendices) to ensure a better capitalization of the data. The table below summarizes the roles of the actors in the coordination and monitoring evaluation of the PODIC.

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5 Cf Training manual developed to this effect

Operational guide for community-based ARV dispensation in Cameroon
Table 1: Actors and roles in the coordination and monitoring evaluation PODIC

<table>
<thead>
<tr>
<th>ACTORS</th>
<th>ROLES</th>
</tr>
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</table>
| CTG    | - Ensure national coordination;  
          - Develop normative and strategy documents;  
          - Mobilize resources to support PODIC;  
          - Capitalize the data at the National level;  
          - Write every six months a report on the PODIC. |
| RTG    | - Coordinate PODIC interventions regionally;  
          - Monitor the structure involved in the PODIC at the regional level (HF and CBOs);  
          - Organize all quarterly consultation meetings with all the actors involved in the PODIC at the regional level;  
          - Transmit quarterly report on the fight against HIV in the region integrating data from the PODIC. |
| HF     | - The ATC and MU must provide monthly supportive supervision and close coaching of community actors within CBO;  
          - Monthly consultations meetings should be organized between supervising HF and CBOs;  
          - Consider CBO data in the report to be sent to the district. |
| CBO    | - Fill notification and reporting tools;  
          - Transmit monthly data on Community dispensation to the supervising HFs that uses it to update its data;  
          - Develop and submit a monthly progress report to the RTG, co-signed by the head of the health facility and RTG. |
9. **BENEFITS AND CHALLENGES TO THIS MODEL**

A). **Advantages**

- Offer community dispensation services in the community close to patients;
- Reduced financial and geographical barriers within the framework of access to care, PODIC are in urban areas and well served by public transport;
- A non-stigmatizing access to care: the patient is sometimes received by peers and has the opportunity to share experiences without fear with other PLHIV. Providers sometimes themselves PLHIV, know the difficulties faced by patients every day and can provide support, and respect for privacy;
- Saving time, reducing the time wasted for the supply, the patient spends less time waiting in PODIC than in HFs;
- The PODIC offers an access to care and empowers patients to manage their disease by giving them more responsibility;
- Decongesting health facilities, which allows taking care of those who are really in need (bedridden patients, patients’ treatment failure, co-infected patients, etc.);
- Services tailored to the needs of PLHIV (psychosocial support and adherence support tailored to the needs of patients and discussion sessions organized by the self-support groups);
- Free access to PODIC, the patient pays no fees, no registration fees or entrance fees. All drugs are free.

b. **Challenges**

- Ensure proper quantification of ARVs, taking into account the needs of PODIC;
- Close monitoring of the work of community actors in the CBO;
- The CBO being an outreach strategy of the health facility should ensure constant supportive supervision of community actors by HFs;
- A good monitoring and evaluation system is necessary to ensure better capitalization of interventions by CBOs.
10. Establish opening hours of PODIC

The PODIC are currently open from Monday to Friday, some PODIC are also open on Saturdays. Each CBO fixes the days and hours depending on specific targets. They are required to inform their opening days and hours to their targets, and respect them.

Some CBOs may decide to open the PODIC few days in the week to concentrate on patient visits and maintain an acceptable workload.

*Table 2: Summary of the PODIC Model*

<table>
<thead>
<tr>
<th>Implementation context:</th>
<th>Urban</th>
</tr>
</thead>
</table>
| **Target group:**       | - PLHIV aged 20 and above;  
                          - Clinically stable that is to say have an undetectable viral load and/or CD4 > 500 cell/mm³;  
                          - In the absence of viral load, patient without obvious signs of immunological or clinical failure);  
                          - With a follow-up on treatment for more than 12 months. |
| **Refilling ARVs within PODIC:** | Every 3 months |
| **Medical consultation at the supervising HF:** | - Once a year for laboratory tests (viral load and CD4 count);  
                          - Every six months for prescription renewals. |
| **Type of support**     | - Individual interviews for psychological help;  
                          - Individual interviews with adherence support;  
                          - Individual PTE... |
COMMUNITY-BASED ARV DISPENSATION
BY ADHERENCE CLUBS OR SUPPORT GROUPS WITHIN CBOS AND HEALTH FACILITIES
II. Community-Based ARV dispensation by adherence clubs or support groups within the CBOs and HF

1. Description

Adherence clubs or support groups are groups consist of ARV patients followed in the same health facility. This support group holds regular meetings either in health facilities or in the community and aims at: (i) the supply of ARV to patients, (ii) experience sharing; (iii), (iv) adherence support; (v) mutual support; (iv) mutual assistance. When the support group meets in the health facility, a staff of the HF facilitates the meetings and provides ARVs to each patient according to his protocol. When the group meets in the CBO, it is a trained member of the CBO or a member of the group (facilitator) who dispenses the ARV to each client according to their protocol.

2. Basic principles of adherence clubs or support group

Community dispensation of ARVs by adherence clubs is based on five principles:

- availability of ARVs on the basis of a needs assessment;
- group dispensation of ARV by the HF or CBO for eligible patients;
- patient monitoring: weight, blood pressure and symptoms of TB patients' needs in terms of psychosocial support;
- support provided by peers or the community counsellor before dispensing ARV;
- the availability of suitable premises that can accommodate the group.
3. **Actors and their role in the community dispensation by support groups or adherence club**

a). **HF**

The role of the health facilities in the animation of adherence clubs or support group is to:

- facilitate the creation of support groups or adherence club or rely on existing groups;
- rely on expert patients and train them for the animation of these groups and identify staff who facilitate these meetings within the HF;
- provide groups with a suitable space for meetings;
- prepare the ARV stock sufficient for the number of patients who constitute the group;
- supervise the provision of ARVs by staff designated for this purpose;
- provide clinical monitoring of members of the support group;
- ensure the renewal of patient prescriptions every six months;
- prepare a monthly report on support groups and their consumption of ARVs;
- ensure the planning of meetings of different groups and pre-packaging of drugs before each meeting of the groups.

b. **Community Based Organization (CBO)**

The role of CBOs in the animation of adherence clubs or support group is:

- ensure suitable premises for the organization of support groups or adherence club;
- provide a good estimate of input requirements (ARV, Cotrimoxazole, and condom);
- receive stocks of ARV drugs with signing the receipt of the minutes and the delivery note;
- update the stock card;
- make a schedule of meetings of support groups and adherence clubs;
- Take the weight, size, look for TB using four questions (weight loss, high temperature, night sweats, persistent cough for more than 2 weeks), general signs of STIs in patients before dispensing drugs;
- Forward monthly dispensation data to the supervising HF for compilation
- Integrating report of support groups in the monthly report to be transmitted to the supervising HF and RTG;
- Search for missed appointment and the lost to follow up;
- organize group discussion sessions for members of the support group.
c. The role of members of the support group or adherence club:

Their role involves:

- Making available to prescriptions to the Support Group representative;
- Respect the scheduled appointments for the organization of support groups in the health facility or CBO;
- Receive their treatment against signature;
- Give individually to the CBO, information received at the health facility during the clinical and biological assessment;
- Go to the health facility in case of reference;
- Respect the appointments for the planned clinical and laboratory follow-up.

4. Patients targeted by the adherence club or support group

Within HFs

These are all the patients belonging to an adherence club or a support group or any patient followed up within HFs. The HF can also constitute homogeneous and stable groups and ensure that all group members have an appointment on the same day.

Within CBOs

Form adherence clubs or support groups with patients referred by the HF and meeting the following criteria:

- PLHIV on ARVs, aged 20 years and above, and being followed-up under treatment for more than 12 months;
- be clinically stable, i.e. with undetectable viral load and/or CD4 count > 500 cell/mm3 (in the absence of a viral load, patient with no clear evidence of current immunologic or clinical failure);
- no visible signs of an ongoing opportunistic infection (TB, or other);
- non-pregnant patient;
- patient under the first line of treatment;
- patient consenting to the initiative. This membership is materialized by an informed consent document signed by the patient.

5. Community-based ARV dispensation progress within support groups

a. Supply of inputs

- establish the list patients who are beneficiaries of the support group;
- establish the list of drugs according to the prescribed protocols;
- check the conformity of the protocols and the quantities requested by the support group;
- set the delivery slip and have both parties sign;
- make ARVs available to the dispensation worker.

b. ARV Dispensation

Step 1: Formation of the group
Forming a group as homogeneous as possible of 10 to 20 persons (age group, phase of the disease, gender,) and identify a group leader who will be responsible for: preparing the venue to accommodate the group, distributing the talking time, helping with the dispensation of ARVs and filling in data collection tools

Step 2: carry out the group discussion: Discussion is a group entertainment technique. It is a means of interpersonal communication to promote exchanges between members of a group in order to achieve set goals.

The steps of an educational talk are as follows:

Before the discussion
This is a crucial step for the success of the discussion. This must lead the facilitator to:

- identify the target audience;
- Set up the discussion objectives;
- determine the date, time and venue of the discussion;
- plan the duration of the talk;
- identify the method to use;
- determine which visual aids to use;
- prepare the theme well;
- draft the detailed plan of major ideas;
- inform the target population;
- prepare the venue before the arrival of participants;
- indicate where participants should seat.

**During the discussion**

- greet (with courtesy, and according to the target audience);
- introduce yourself (the facilitator introduces him/herself by giving his/her name (first name), the structure where he/she comes from, and eventually his/her experience) and, if necessary, let each participant introduce themselves.

**NB:** get yourself introduced by an important person of the structure, if necessary;

- ask questions that will motivate participants or develop an entertainment technique (story-telling, anecdote, image, proverb, ...); master proverbs, maxims or short funny stories to motivate participants;
- tell participants what the theme and objectives of the session are;
- develop the discussion content: the session can be introduced by an image, a proverb or a real life situation, a very brief presentation of the content and especially of questions and answers to enable exchanges on the theme of discussion.

**Evaluation of the discussion session**

The facilitator must evaluate the session by preparing questions beforehand. Go "round the table", if the number of participants allows it. Otherwise, ask questions to some of them.

**Round off the discussion session**

- Pick up points that need clarification and come back to it
- at the next meeting. It is not necessary to go all over the discussion session at this stage, because the participants are tired.
- Thank the audience for their participation and interest in the subject, the commitments made to continue the discussion in families, neighbourhoods, and among themselves.
- Announce the theme of the next meeting.
- Determine the date, time and location of the next session according to Participants’ availability and constraints.
- Greet each other: Saying goodbye formally or informally depending on the audience.

**Step 3: Take patient parameters (weight and blood pressure, verbal TB screening)**
Assess the overall health status of patients by asking them a number of questions about the symptoms they may feel.

**Step 4: Proceed with ARV dispensation** according to the protocol of each member of the group and proceed to the filling in of the tools.

**Step 5: Agree on a date for the next meeting and close the session.**

---

**6. Training stakeholders**

Adherence club or support group facilitators should be trained on facilitation techniques, the continuum of care with a focus on adherence support.

They must also be trained on the filling in of tools developed for this purpose (see Appendix) and be equipped with communication media (image box, posters, artificial penises and vaginas, etc.).

---

**7. Monitoring and evaluation of activities**

Activities of adherence clubs or support groups are carried out within HFs or CBOs. At the end of the session of adherence clubs within CBOs, the facilitator completes the data collection form and hands it over to the person in charge of the CBO for data to be taken into account in the ARV dispensation register and their monthly compilation to be forwarded to the HF and to the RTG.

The grid is filled in by the facilitator or the staff designated for the dispensation within the HF. Data thus provided help to update the dispensation register and the patient's file.

**NB: As part of this model, discussion groups are the most appropriate.**
8. Benefits and challenges of this model

a. Benefits
- Support groups or adherence clubs facilitate access to drugs for patients by reducing the waste of time for both caregivers and patients: they reduce the workload of health workers;
- they encourage peer support between patients experiencing similar difficulties (adherence problems, status disclosure, etc.);
- they promote social relationship between patients and reduce stigma, isolation and self-esteem issues;
- organized patient groups can create a mechanism of mutual accountability with the health system, requiring appropriate and quality services;
- they promote self-management and empower patients as part of their treatment.

b. Challenges to be met
- an effective management of the pharmacy and supply chain is essential for setting up the groups. Supply chain weaknesses can lead to ARV stock-outs;
- ensure a good estimate of needs taking into account those in support groups, in order to avoid stock-outs;
- the promotion, composition, training and supervision of support groups/adherence clubs must be clearly assigned to a specific supervisory staff;
- provide training for the facilitators of these groups to ensure the quality of the information conveyed;
- monitor the activities carried out, with a simplified system for collecting and capitalizing data;
- identify groups with operational difficulties to instil right dynamics for better functioning;
- identify absentees at appointments and lost to follow-up, and set up a search system for those absentees.

Table 1: Summary of adherence clubs or support groups model

<table>
<thead>
<tr>
<th>Implementation context</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target group for groups established within HF</strong>s</td>
<td>These are all patients belonging to an adherence club or a support group or any patient followed up within HF. The HF can also constitute homogeneous and stable groups and ensure that all group members have an appointment on the same day</td>
</tr>
</tbody>
</table>
| **Target group for groups established within CBOs** | - PLHIV aged 20 years and above;  
- clinically stable i.e. have an undetectable viral load and/or CD4 > 500 cell/mm3;  
- in the absence of a viral load, patient with no clear evidence of current immunologic or clinical failure;  
- with a follow-up under treatment for more than 12 months. |
| **ART refills** | Every 3 months within the HF or the CBO |
| **Medical consultation at the supervising HF** | - once a year for the biological assessment (viral load and CD4 count);  
- every six months for prescription refills |
| **Types of support** | Group discussion, adherence clubs, group PTE session |
Dispensation of ARVs by Community Therapy Groups (CTG)
III. Dispensation of ARVs by Community Therapy Groups (CTGs)

1. Description of the CTG

Community Antiretroviral Therapy Groups consist of 6 to 10 patients who meet the following criteria: (i) belong to the treatment centre; (ii) be recruited from eligible patients; (iii) having developed a certain affinity relationship between them; (iv) reside in the same area or locality where the HF or CBO is located.

This model aims to:

- Share experiences;
- Provide support for adherence, mutual support and/or mutual assistance

This model applies not only where there are no CBOs playing the role of PODIC, but also applies for rural, semi-rural, peri-urban populations far from treatment centres. These populations, for the majority, face geographical and/or financial difficulties to reach a treatment centre.

In practice, a client group member is appointed on a monthly basis for ARV refills of other group members on behalf of the entire group (when he/she goes there for his/her prescription refill appointment or biological monitoring). The group then identifies a place in the community for the dispensation of ARVs to other members of the group by rotation to involve as many members as possible. It is also noted that group members with specific health problems should go to the supervising HF for their management.

2. Basic principles to be applied as part of this model

This distribution model is based on the following basic principles:

- the availability of ARVs in the HF;
- the members of the group consist of eligible patients followed up in the same HF, and living in the same zone or locality (quarter, village);
- the members of the group take turns to the HF to collect ARVs for the group;
- the members of the group must undergo the routine assessment (follow-up);
- the dispensation of ARVs in the community is done by the members of the group;
- the adherence support and the monitoring of therapeutic results by group members.

3. Stakeholders, roles and responsibilities in community-based ARV dispensation by community therapy groups

a. HF

The role of the HF is to:

- inform eligible persons about the possibility of setting up CTGs;
- select eligible patients for CTGs;
- synchronize appointment dates of CTG members for the provision of ARVs;
- support and monitor the implementation of CTGs;
- train group members in the functioning of the CTG and the use of CTG tools;
- make the directory of groups and their members;
- list treatments according to the prescribed treatment protocols of each CTG member;
- check the conformity of the regimes and the quantities requested by the group
- provide ARVs with the representative of the group selected;
- set the delivery slip and have both parties sign;
- carry out the follow up of the CTG representative adherence during the clinical visit and identify challenging CTGs;
- provide clinical and biological follow-up of group members respecting appointments once every six months;
- Ensure prescription refills of patients who are group members.
b. CTG Members

They are in charge of:

- making their prescriptions available to the group representative who must go to the HF;
- receiving their treatment and those of the group members after signing a receipt;
- respecting appointments at the HF for clinical follow-up and prescription refills every 6 months and the biological assessment once a year;
- drawing up an ARV collection planning at the HF (dates and group representatives);
- promoting CTGs in the community;
- gathering members of the group and giving the treatments to each according to their therapeutic protocol after signing a receipt;
- returning to other CTG members the information received at the HF;
- giving back prescriptions to each group member.

CTG Delegate

Elected by the members of the group, he/she is in charge of:

- leading the group;
- serving as intermediary between group members and the HF.

4. Patient eligibility criteria for the CTG

- PLHIV on ARVs, aged 20 years and above, and being followed-up under treatment for more than 12 months;
- Be clinically stable, i.e. with undetectable viral load and/or CD4 count > 500 cell/mm³ (in the absence of a viral load, patient with no clear evidence of current immunologic or clinical failure);
- No visible signs of an ongoing opportunistic infection (TB, or other);
- Non pregnant patient ;
- Patient under the first line of treatment;
- Informed consent of patients for the constitution of the CTG;
- Be available;
- Live in the same locality is beneficial (quarter, village, etc.).

The above criteria should be adapted according to the reality of the context.

5. Procedure for setting up a CTG

a. Identification of eligible patients

Once considered as a stable client based on the defined criteria, the client can decide to join a CTG or be referred to the PSC who coordinates the CTG.

b. Setting up CTGs

Setting up CTGs can also be done before criteria verification. Patients volunteer, and once the number of patients required to form a group is reached, they report to the health worker for criteria verification to ensure they are clinically ready to form a CTG as active members. Some patients do not know enough people on ARVs in order to form a CTG. In most cases, the PSC can play a vital role in bringing together patients who are interested in setting up groups. Assistance in setting up CTGs is an important task to enable the effective establishment of CTGs and should therefore be clearly assigned to a specific health worker or a PSC. Each group shall elect a delegate. It is about the person who will coordinate the activities of the group and act as an intermediary between group members and the HF. The delegate is elected by group members.
6. Training CTG members

Training CTG members should include the following topics:

- Group dynamics (see rule governing group functioning);
- Tools to be used by patients in a CTG;
- Roles and responsibilities of each person involved in a CTG;
- Events and symptoms that need referral to the clinic;
- Adherence to treatment

7. Dispensation flow within CTGs

**Step 1:** CTG meeting in the community before the collection of drugs by the group representative. Members meet at one of the members’ home or in any other location chosen by mutual agreement in the community to talk about their adherence, their condition, and day-to-day issues. One member is appointed each month by the group to get the drugs for the rest of the group.

**Step 2:** The representative of the CTG reports on the members' adherence and the functioning of the group at the HF and collects drugs for all group members.

**Step 3:** **CTG meeting after ART collection** upon the return of the group representative. The group meets on the same day preferably at one of the members’ home or in any other location chosen by mutual agreement in the community, for ARV dispensation to each CTG member. Then, a grid containing the date, member code, ARV protocol and the signature is completed.

**Step 4:** **Finally,** the group agrees on a date for the next appointment.
8. Monitoring and evaluation of activities achieved by CTGs

The use of a number of tools is necessary for data capitalization, monitoring and evaluation of CTGs.

- A registry for CTG activities must be designed and completed to follow-up group members and group appointments. This register should be filled in by a medical staff or a PSC chosen for this purpose. Appointment dates will be recorded in this registry to plan members’ visits and locate defaulters. When registering a new CTG member, the CTG register must be completed and updated in the event of a change in the composition of the group.

- A data collection grid for use by CTGs shall be completed before each visit.

    Upon refills, the CTG delegate completes the grid and forwards it to the HF's health worker through the representative in charge of CTG drug refill;

- At each clinical visit of the CTG, the health worker will indicate the drug prescription for each member and enter the data from the CTG follow-up card into the client's personal ART record;

- The health worker completes the periodic report forwarded to the health district.

CTGs with operational problems must be identified and supported through monitoring. The following criteria may be used during the consultation with the CTG representative to determine support needs of the group:

- CD4 drop more than 30% or detectable viral load in more than one member;

- Same representative always presenting for refill;

- Conflicts or problems within the group;

- CTG follow-up grid inadequately completed;

- CTG member absent at the appointment, lost to follow-up or deceased.

Support can be given by immediately solving problems with the group representative during the consultation. If needed, the CTG can be gathered at the health centre where they pick up their drugs or be visited by the healthcare workers in the community. Community health workers or lay counsellors can play an important role in supporting poorly functioning CTGs.
9. **Defining a system of referring patients to their home HF**

A CTG member may choose to return to the supervising HF at any time.

Some CTG members will need to return to traditional care for closer monitoring and drug refills for the following cases:

- TB signs and symptoms (weight loss, high temperature, sweating at night, persistent cough longer for more than 2 weeks);
- signs and symptoms of other serious opportunistic infections or other comorbidities;
- Pregnant women (PMTCT)
- etc.

**NB:** In this case, the group member must be referred to the supervising HF.

10. **Benefits and challenges of this model**

**a. Benefits**

Community ART Groups (CTG)

- facilitate access to drugs for patients by reducing financial and time costs associated with frequent clinic visits;
- promote mutual support at the community level, which improves the social relationship between patients and reduces stigma; create a stronger engagement of the community in HIV care;
- create a mechanism of mutual accountability with the health system, calling for adequate and quality services;
- reduce the workload of health workers by reducing the number of patients visiting the HF;
- improve the clinical and biological monitoring of group members;

Encourage patients to self-management and independence from the health service.
b. Challenges to be met

The introduction of CTGs may face a number of challenges to be met. Adequate solutions will have to be found to highlight the potential benefits of CTGs. They are:

- The scrupulous respect of appointments by the group representative (an appointment missed by the group representative may lead to poor adherence for all group members);

- For the functioning of CTGs, new key tasks such as promotion, composition of CTGs training and supervision, must be clearly entrusted to a specific management staff (this can be entrusted to the PSC intervening within the hospital). It would be necessary to look for a sustainable means of motivation for the staff responsible for supervising CTGs.

- Self-management is highly dependent on how quickly a CTG member will address a health worker in the event of a problem. A minimum of clinical surveillance should be provided through a direct link with a health professional in charge of antiretroviral care. Mechanisms to target problems with other CTG members should be established and patients should be prepared for possible TB signs and symptoms and common opportunistic infections. It will also be necessary to monitor any weight loss and remain vigilant about the side effects of ART, requiring the patient to return to health services;

- Simplified monitoring systems with simplified tools are needed to ensure the maintenance of quality service and data capitalization.

*Table 2: Summary of the Community Group Anti Retroviral Therapy Model (CTG)*
<table>
<thead>
<tr>
<th>Implementation context</th>
<th>Rural, semi-rural, peri-urban</th>
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</thead>
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| **Target group:**      | - PLHIV on ARVs, aged 20 years and above;  
                         - Be clinically stable i.e. have an undetectable viral load and/or CD4 > 500 cell/mm³;  
                         - In the absence of a viral load, patient with no clear evidence of current immunologic or clinical failure;  
                         - with a follow-up under treatment for more than 12 months. |
| **ART refills**         | Every month within the CTG: |
| **Medical consultation at the supervising HF:** | Every 6 months for drug refills and once per year for clinical and biological assessment. |
| **Types of support**    | Group talks, support for treatment adherence, group PTE session, mutual support. |
APPENDICES
APPENDICES

References

4. MSF, the price for forgetfulness: Millions of People in West and Central Africa are being left out of the Global HIV Response. April 2016.
5. Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection, November 2015, Guidance notes, latest information, WHO.
10. Community Administration of Antiretroviral Therapy UNAIDS and Médecins Sans Frontières MSF 2015
11. Differentiated management of HIV: Decision-making framework for the provision of antiretroviral therapy.
Data collection tools
DELIVERY SLIP No. ____________________

DELIVERY SLIP No.

Client _____________________________

Date ______________________________

Order form item _________________

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Signature of the supplier

Signature of the Client
Date: --------------------------------------------------------
Venue -----------------------------------------------
Delivery slip No. -------------------------------------
Driver’s arrival time ---------------------------------
Number of parcels: ------------------------------------
Amount: ---------------------------------------------
Name of the supplier: ---------------------------------
Were present: name(s) and first name(s), quality of members
Other remarks:
----------------------------------------------------------------------------------------------------
----------------------------------------------------------------------------------------------------
---------------------------------------------------------------------------------------------------------------------------
---------------------------------------------------------------------------------------------------------------------------
----------------------------------------------------------------------------------------------------
----------------------------------------------------------------------------------------------------
Other remarks: ---------------------------------------------
Name of the structure: _________________________________________________________

Designation _____________________ Maximum level ____________________________

Presentation ___________________ Minimum level ____________________________

$C_{MM}$ __________________________

SS ____________________________

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<th>Origin</th>
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Operational guide for community-based ARV dispensation in Cameroon
PATIENT CONSENT FORM
FOR COMMUNITY-BASED ARV DISPENSATION

Region: Health District: .......................... Health Area ...........................................................

Name of the supervising ATC/MU: .................................................................

Name of the CBO: .....................................................................................

Patient Code: ............................................................................................

Patient registration No: ..............................................................................

Orientation date: ..........................................................................................

Date of the next visit/Prescription refill: ..................................................

Age: ................ Gender: .................................................. Location: ..................

I the undersigned ......................................................................................... After
having received explanations and modalities on the community-based ARV dispensation, agrees to receive ARVs at the community level at the .................................................................

Names and signature of the consulting doctor .......................... Names and signature of the Patient

Operational guide for community-based ARV dispensation in Cameroon
Identification of the structure

Name of the health facility:
Region:
Town:
Quarter:
Health District:
Email:
Tel.:

Date of Home visit: /.../..../....../

Identification of the beneficiary

Beneficiary code: /_/_/_/_/_/_/ Gender ............ Age ........

Marital status ..................... Region:..........................................................

Town/Quarter/ ....................................... Tel.: .................

Medical management structure .................................................................
Nature of the visit

Occasional request □ by appointment □ Reference □
Research for absence from treatment □

Psychological and social situation

Abandoned □ In conflict with relatives □ Depressed □ Isolated □
Sexual problems □ Lack of hygiene □
Behavioural Disorder □ Others (Specify) □ …………………………………………

Food problem

Number of meals the beneficiary had per day for the past 3 days:
None (0) □ one □ two □ three □
More than three meals □

Information raising public awareness

Family knowledge regarding HIV: good □ insufficient □ none □
Beneficiary knowledge regarding HIV: Yes □ No □

Patient autonomy

<table>
<thead>
<tr>
<th>Eats and drinks:</th>
<th>Yes</th>
<th>No</th>
<th>Moves</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alone</td>
<td></td>
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<tr>
<td>With help</td>
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<td>Not at all</td>
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<td>Not at all</td>
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</tbody>
</table>
Mild symptoms

Diarrhoea □  Breathing Problem □  mouth or throat problem □
Genital problem □  Bedsores □  Nutritional problem □  Nausea/Vomiting □
Weight loss □  itching □  pain □  others □

Adherence level
Adherent □  Non-adherent □

Interventions
Psychological and social support □
Raising awareness activities carried out □
Community care □
Hygiene messages □

Support to adherence □

Number of condoms distributed  Male/_____ / Female /_______ /

Reference: Health Facility □  Community management association □

Other activities carried out ……………………………………………………………………………
…………………………………………………………………………………………………………………………

Conclusion:………………………………………………………………………………………………
…………………………………………………………………………………………………………………………
…………………………………………………………………………………………………………………………

Duration of the visit ………….. Date of the next visit …………………

Name and signature of the community health worker
ADULT THERAPEUTIC EDUCATION FILE FOR CD

Patient Code: …………………… Date: ……/……/………………
Name and surname: ………………………………………………………………………………………………
Tel.: …………………………… Gender: M □ F □ Date of birth: ……/……/…… Age:
………… Marital status: ………………… Profession: ………………………………………
Patient condition: □ ambulatory □ In-patient Education: …………………………………………………
Date of the first PTE session: ……/……/……………………………………………………………………
Town: ………………………………………………. Quarter: …………………………………………………
Precise location: ………………………………………………………………………………………………..
Referred in PTE for: Treatment initiation □ adherence problem □ Monitoring PTE □
Other: …………………………………………………………………………………………………………………

- OTHER DISEASES AND TREATMENTS
  TB  Hepatitis  Diabetes  HBP  Other(s):
  ……………………………………………………………………………………………………………………..
  Current ARV protocol: ………………………………………………………………………………………
  Starting date: ……/……/…………

- RELATIVES (with whom do you live?)
  Partner  Member of the family  Friend  Other(s): ………………………………………

- PATIENT’S PROFESSION (hobbies, sports, cultural/religious activities, etc.)
  ………………………………………………………………………………………………………………………

- KNOWLEDGE/ (about the disease, the treatment) According to you, what is HIV? List the HIV
  transmission modes. How do you think you have been contaminated?
  ………………………………………………………………………………………………………………………

- PSYCHOLOGICAL STATUS
  PERCEPTION OF HIV (What did you do after the disclosure of your HIV status? How did you
  react when you were given your result? How do you live with it? How did you feel when your status
  was disclosed?) …………………………………………………………………………………………………
  On this ruler, where do you place what people think about you?
  Rather negative look  Rather fair look  Rather positive look
  0  5  10

Operational guide for community-based ARV dispensation in Cameroon
How do you feel now? **Patient point of view**

How would you describe yourself? .................................................................

FEELINGS OF SELF-EFFICACY: (What is your perception of your ability to cope with your health problems?)

Where do you put your ability to tackle your condition, on this ruler?

| 0 | 5 | 10 |

Patient point of view:

.................................................................

MORAL SUPPORT: Have you told someone about your HIV status? YES NO

Who knows about your HIV status? Partner Member of the family Colleague Friend

Other(s): ....................................................................................

What did you feel telling others about your HIV status? ........................................

.................................................................

- **PROJECTS** (life/professional/educational) help the patient to talk about his projects in the short or medium term ........................................................................

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- **OTHERS**: What other information would you like to share with others?

.................................................................

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- **SUMMARY OF EDUCATION DIAGNOSIS**

Factors fostering learning: ........................................................................

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Factors hindering learning: ........................................................................

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What (s) he should learn: ........................................................................

.................................................................

.................................................................

What (s) he should relearn: .........................................................................

.................................................................

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- **PRIORITY LEARNING OBJECTIVES OF THE NEXT VISIT**

Name of the educator ........................................................................
# THERAPEUTIC EDUCATION MONITORING FORM

<table>
<thead>
<tr>
<th>Date/Educator</th>
<th>Objective (s) covered</th>
<th>PTE Type (personal/group)</th>
<th>Tools used</th>
<th>Summary of the activity</th>
<th>Objective of the next session</th>
<th>Date of the appointment:</th>
<th>Duration of the session (in minutes)</th>
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<td>Duration of the session:</td>
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Session report of adherence clubs or support group held in the HF

I. Identification of the HF

Name of the health facility:
Region:
Town:
Quarter:
Health District:
Email:
Tel.:
Date the activity is carried out …/…/…/
Duration of the session: .......................  

Number of participants expected /--------/

I. Number of participants present /--------/

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<th>Number of beneficiaries</th>
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Subject matter: (Problems tackled)

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Operational guide for community-based ARV dispensation in Cameroon
Summary of support group/self-support/adherence clubs

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<tr>
<th>Problems tackled</th>
<th>Solutions provided</th>
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Lessons learnt:

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Problems encountered and proposed solutions

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II. Community-Based ARV Dispensation (if applicable)

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Total of participants

Number of people who benefited from community compensation with support group/self-support /...... /
III. List of participants:

<table>
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<th>No.</th>
<th>Patient Code</th>
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<th>Signature</th>
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Name surnames and signature of the facilitator  Name surnames and signature of the provider
Session report of adherence clubs or support group drafted by the CBO

I. Identification of the CBO

Name of the CBO:
Region:
Town:
Health District:
Supervising HF:
Email:
Tel.:

Date the activity is carried out   /…/…/…/

Duration of the session: ......................

Number of participants expected /--------/

   I. Number of participants present /--------/

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<tr>
<th>Number of beneficiaries</th>
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Subject matter:
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Summary of support group/self-support/adherence clubs

Operational guide for community-based ARV dispensation in Cameroon
I. Community-Based ARV Dispensation (if applicable)

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Total of participants

Number of people who benefited from community compensation with support group/self-support /----/

II. List of participants:

Operational guide for community-based ARV dispensation in Cameroon
<table>
<thead>
<tr>
<th>No.</th>
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Name surnames and signature of the facilitator   Name surnames and signature of the provider
**Name of the CBO:** ………………………………………………………………………………………………………

**Supervising HF:** ……………………………………………………………………………………………………………

### MONTHLY PLANNING

**Month:** ………………………………………………………………………………………………………

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**Date and signature of the president of the structure**
Name of the CBO: ………………………………………………………………………………………………………

Supervising HF: ………………………………………………………………………………………………………

**WEEKLY PLANNING**

Week from: ………………………………… to ………………………………………………………………………

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</table>
I. Identification of the CBO

Name of the CBO: 
Acronym: 
Region: 
Town: 
Quarter: 
Health District: 
Supervising HF: 
Email: 
Tel.: 
Month: Year: 
Date the report is drafted: /----/ /----/ /-----/

II. Monitoring patients

<table>
<thead>
<tr>
<th>Headings</th>
<th>Number of people affected</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20 - 24 years old</td>
</tr>
<tr>
<td></td>
<td>M</td>
</tr>
<tr>
<td>Number of new patients registered during the month</td>
<td></td>
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<tr>
<td>Total number of patients followed up (new + old patients)</td>
<td></td>
</tr>
<tr>
<td>Number of patients absent from their appointment during the month</td>
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<tr>
<td>Number of patients absent from their appointment during the previous month and found</td>
<td></td>
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<tr>
<td>Number of patients lost to</td>
<td></td>
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</tbody>
</table>
### III. Protocols administered during the month

This part deals with the summary dispensation according to the type of protocol received by the CBO. It is about informing the active file by type of protocol.

<table>
<thead>
<tr>
<th>Protocols</th>
<th>Number of people affected</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20 old -24 years</td>
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<tr>
<td></td>
<td>M</td>
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<tr>
<td>TDF+3TC+EFV</td>
<td></td>
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<tr>
<td>TDF+3TC+NVP</td>
<td></td>
</tr>
<tr>
<td>AZT+3TC+NVP</td>
<td></td>
</tr>
<tr>
<td>AZT+3TC+EFV</td>
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<tr>
<td>Total</td>
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</tbody>
</table>
IV. Drug Inventory Management

<table>
<thead>
<tr>
<th>Protocols</th>
<th>Quantity at the beginning of the month</th>
<th>Quantity received during the month</th>
<th>Quantity given out during the month</th>
<th>Total quantity at the end of the month</th>
<th>The most recent expiring date</th>
<th>Lot No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>TDF+3TC+EFV</td>
<td></td>
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<tr>
<td>TDF+3TC+NVP</td>
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<tr>
<td>AZT+3TC+NVP</td>
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<tr>
<td>AZT+3TC+EFV</td>
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<td><strong>Total</strong></td>
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</tbody>
</table>

III. Psychological support and adherence support

<table>
<thead>
<tr>
<th>headings</th>
<th>Number of people affected</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>20 - 24 years old</td>
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<tr>
<td></td>
<td>F</td>
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<tr>
<td>Number of patients who were personally interviewed for psychological support</td>
<td></td>
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<tr>
<td>Number of patients who took part in a support group</td>
<td></td>
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<tr>
<td>Number of patients who took part in therapeutic education sessions</td>
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<tr>
<td>Number of patients who were personally interviewed for adherence support</td>
<td></td>
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<tr>
<td>Number of people who benefited from a home visit.</td>
<td></td>
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</tbody>
</table>
IV. Difficulties encountered and recommendations

<table>
<thead>
<tr>
<th>Difficulties encountered</th>
<th>Recommendations</th>
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</thead>
<tbody>
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Remarks:

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Name Surnames and signature of the head of the CBO

Name, surnames and signature of the head of the HF