I ACT Implementation
Standard Operating Procedure

August 2014
Acknowledgements

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# Table of Contents

Acknowledgements ........................................................................................................... 1  
List of Abbreviations and Acronyms .................................................................................. 4  
Purpose of the Standard Operating Procedure .................................................................. 5  
1. Introduction and Background Context ........................................................................... 6  
2. Free State Provincial Profile ......................................................................................... 8  
3. Integrated Access to Care and Treatment (I ACT) ......................................................... 9  
   3.1. I ACT Strategy ........................................................................................................ 9  
      3.1.2. Strategic Objectives of I ACT .................................................................... 9  
      3.1.3. Guiding Principles ..................................................................................... 9  
      3.1.4. I ACT Package for PLHIV ......................................................................... 11  
      3.1.5. I ACT Logic Model .................................................................................... 13  
   3.2. Major Components of the I ACT Strategy .............................................................. 14  
      3.2.1. Introduction and Adoption of I ACT: Creating Buy-in and Ownership .... 14  
      3.2.2. Implementation of the I ACT Strategy ....................................................... 15  
4. Key Elements of the Implementation of I ACT ............................................................. 17  
   4.1. Training ................................................................................................................ 17  
      4.1.1. Training of PDoH Programme Managers and Implementers ............... 17  
      4.1.2. Master Trainers Training ......................................................................... 18  
      4.1.3. Training of Trainers (ToT) ...................................................................... 18  
      4.1.4. Training of Health Care Workers (HCWs) including Support Group Facilitators (SGFs) .................................................................................................................. 18  
   4.2. Information and Education Sessions ...................................................................... 20  
   4.3. Support Groups .................................................................................................... 21  
      4.3.1. Open Support Groups ............................................................................. 21  
      4.3.2. Closed Support Groups .......................................................................... 21  
   4.4. Linkage and Referrals ........................................................................................... 22  
      4.4.1. Linkages and Referrals within the Health Facility .................................. 22  
      4.4.2. Linkages and Referrals between the Health Facility and Community .. 22  
   4.5. Mentoring and Supportive Supervision ................................................................. 23  
      4.5.1. Provincial Support to the Districts ............................................................... 24  

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**I ACT Implementation SOP**
4.5.2. District and Sub-district Support to the Health Facilities ............... 25
4.5.3. Social Worker’s Support to the I ACT Facilitators ....................... 25
4.6. Reporting, Monitoring and Evaluation ........................................... 25
  4.6.1. Reporting Levels and Responsibilities ....................................... 26
  4.6.2. I ACT Core Indicators ............................................................. 30

Appendices .......................................................................................... 31
  1. I ACT Algorithm .............................................................................. 31
  2. I ACT Indicator Definitions ............................................................. 32
  3. Stakeholder Roles and Responsibilities ............................................. 37
  4. I ACT Data Collection Tool .............................................................. 39
  5. I ACT Support Group Register ......................................................... 40
  6. I ACT Support Group Registration Form .......................................... 41
# List of Abbreviations and Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC</td>
<td>Ante Natal Care</td>
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<tr>
<td>ART</td>
<td>Anti-Retro-Viral Treatment</td>
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<td>CBO</td>
<td>Community-based Organizations</td>
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<td>CD4</td>
<td>Cell Differentiation 4</td>
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<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<td>CCMT</td>
<td>Comprehensive Care, Management and Treatment of HIV and AIDS</td>
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<td>FSDoH</td>
<td>Free State Department of Health</td>
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<td>HAST</td>
<td>HIV and AIDS, Sexually Transmitted Infections and Tuberculosis</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>I ACT</td>
<td>Integrated Access to Care and treatment</td>
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<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>IG</td>
<td>I ACT Guide</td>
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<tr>
<td>INH</td>
<td>Isoniazid, Isonicotinic Acid Hydrazine</td>
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<td>NASTAD</td>
<td>National Alliance of State &amp; Territorial AIDS Director</td>
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<td>NGO</td>
<td>Non-Governmental Organization</td>
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<td>NSP</td>
<td>National Strategic Plan</td>
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<td>OVC</td>
<td>Orphaned and Vulnerable Children</td>
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<td>PDoH</td>
<td>Provincial Department of Health</td>
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<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PLHIV</td>
<td>People Living with HIV</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<td>PWG</td>
<td>Provincial Working Group</td>
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<td>RTC</td>
<td>Free State Regional Training Centre</td>
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<td>SOP</td>
<td>Standard Operating Procedures</td>
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<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<td>TA</td>
<td>Technical Assistance</td>
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<td>UNAIDS</td>
<td>Joint United Nation Programme on HIV/AIDS</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Purpose of the Standard Operating Procedure

This SOP is designed to enable all stakeholders at the provincial, district, sub-district and facility level to follow a standardized approach to planning, implementing, monitoring, and evaluating the I ACT strategy. This Guide is designed for use by programme managers, coordinators, supervisors, operational managers and other relevant facility-based health care workers (HCWs) at different levels within the DoH. In an effort to strengthen and standardize the FSDoH HIV Care and Support approach, other care and support non-governmental organizations (NGOs) and community-based organizations (CBOs) are encouraged to use the SOP.
1. Introduction and Background Context

South Africa is a middle income country located at the southernmost tip of Africa with a population of over 52 million. According to the (United Nations Population fund) UNFPA South Africa 2013 Annual Report, South Africa has the largest HIV epidemic in the world with prevalence estimated at 17.3% among South Africans aged between 15 and 49 years. According to the Statistics South Africa Mid-year population estimates (2013), about 5.6 million people were living with HIV in South Africa by 2013.

According to the HRSC National Prevalence, Incidence and Behavioral Survey 2012, the comparison of HIV-prevalence estimates by province between 2005 and 2008 shows that the three areas with the highest HIV prevalence rate were KwaZulu-Natal, Mpumalanga and the Free State. But in 2012, the Free State’s prevalence increased to the level of prevalence in Mpumalanga. The lowest HIV prevalence rate continues to be in the Western Cape, although it increased from 1.9% in 2005 to 5.0% in 2012. HIV prevalence in the Eastern Cape, which had remained stable since 2005, increased from 9.0% in 2008 to 12.2% in 2012, moving closer to the levels of prevalence found in Gauteng and the North West (see Figure I). A similar increase is observed in Gauteng.

Figure I. HIV Prevalence by sex and age, South Africa 2012

(Source: 2012 HSRC Survey)
South Africa’s response to the HIV epidemic is guided by the National Strategic Plan (NSP). The 2012 – 2016 NSP, the country’s third, outlines the national priorities related to the prevention of HIV, TB and STIs, and the provision of treatment and care to those who are infected. The primary goals, as listed in the NSP, include:

- Reducing new HIV infections by at least 50%, using combination prevention
- Initiating at least 80% of eligible patients on ART, with 70% alive and on treatment five years after initiation
- Reducing the number of new TB infections, as well as the number of TB deaths, by 50%
- Ensuring an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the NSP.

South Africa has the largest antiretroviral treatment (ART) programme in the world. By the end of 2011, there were approximately 1.4 million people receiving ARTs. Treatment initiation rates have reached 30,000 per month, on average, attributed to the 2009 revision of the treatment guidelines and a massive HIV testing campaign.\(^2\) It is anticipated that these rates will only increase overtime.

However, despite successful ART scale-up, the proportion of patients alive and on treatment remains below expectations due to poor linkage-to-care, high loss-to-follow-up, and weak patient outreach; the Integrated Access to Care and Treatment Strategy (I ACT) was adopted as a national response to improve health outcomes in 2009.

2. Free State Provincial Profile

The Free State comprises four districts and a Metro (Figure II): Mangaung Metro, Xhariep, Lejweleputswa, Fezile Dabi and Thabo Mofutsanyane. There are 23 sub-districts in the province.

The Statistics South Africa mid-year population estimates 2013 estimates the Free State as having the second smallest share of the South African population, constituting just over 5% of the population (2 753 142). The Free State Provincial Strategic Plan (2012-2016) quotes that an estimated 355,000 people are living with HIV in the Free State Province. Provincial HIV prevalence from the ANC Sentinel Survey was estimated at 27.74% in 2012. Young people 15-24 years of ages were estimated to account for about 45% of all new infections.

Figure II: Overall HIV Prevalence by Province, South Africa 2012


Figure II: HIV prevalence by sex and age, South Africa 2012

- Males
- Females
3. Integrated Access to Care and Treatment (I ACT)

3.1 I ACT Strategy

3.1.1 I ACT Goal

The Integrated Access to Care and Treatment (I ACT) is a strategy designed to improve the health outcomes of PLHIV and retention in care through linkage to HIV treatment, care and support.

3.1.2 Strategic Objectives of I ACT

- To improve early enrolment into HIV care, especially newly diagnosed
- To improve pre-ART retention in care and prolong pre-ART
- To improve ART retention in care and adherence to ART
- To enhance knowledge for self-health advocacy and positive living amongst PLHIV
- To empower HCWs with knowledge and skills to manage HIV

3.1.3 Guiding Principles

I ACT strategy is guided by the following important principles:

- PLHIV involvement at all levels
- Enhancement of PLHIV knowledge and skills
- Linkages and referral systems
- PLHIV self-health advocacy
- Community engagement
- Free State DoH commitment, leadership and ownership
**PRE ART CARE**
- Screening for TB, STIs and other OIs
- Cotrimoxazole prophylaxis
- IPT/INH
- Nutrition assessment and support
- Support groups
- Psychosocial support/Education
- Family planning/ANC

**I ACT**
- Engages PLHIV early in their diagnosis
- Supports linkage to care
- Increases knowledge about treatment adherence, disclosure, nutrition
- Supports PLHIV to accept their status and keep themselves healthy
- Provides Psychosocial support
- Supports retention in PRE ART Care
- Strengthens community and health facility referral and linkage
- Supports with Clinical assessment follow-up visits, ART & PRE ART defaulter tracing and lost-to follow-up
- Supports retention in care and treatment adherence

**Notes.** This diagram shows how I ACT program integrates PLWH into the overall continuum of care. The continuum includes: initial diagnosis of HIV through HCT; linkage to medical care for initial clinical; counseling about current medical status and follow-up; provision of cotrimoxazole, isoniazid preventive therapy; other preventive measures; education about measures to remain healthy; initiation of ART and other appropriate treatments in a timely fashion; and continued retention in care and adherence to treatments. Throughout the continuum, it is very important to maintain clients' physical well-being, psychological health, and social support.
Clearly, I ACT is about successfully enrolling and integrating HIV patients into the HIV care system, retaining patients enrolled in care, promoting adherence to treatment and healthy living, and reducing patient loss to follow up.

### 3.1.4 I ACT Package for PLHIV

The I ACT PLHIV package is composed of six educational sessions that are offered to PLHIV in support group sessions (see Figure IV). The PLHIV modular course covered in the 6 sessions contains the following six major topics:

1. HIV Transmission and Opportunistic Infections
2. Acceptance of Status
3. Disclosure
4. Treatment Literacy & Adherence Counseling
5. Nutritional Assessment/Counseling
6. Positive Prevention
Figure IV. I ACT PLHIV Educational Sessions

**HIV/AIDS & Opportunistic Infections**
- Basic understanding of HIV disease
- Different types of transmission & points of entry
- Sexually transmitted infections
- Opportunistic infections
- Prophylactic Treatment
- Importance of keeping appointments (Self Reliance)

**Treatment Literacy & Adherence Counseling**
- Progression of HIV disease (what to expect) and AIDS
- Treatment options for HIV infection
- CD4 count and viral load
- Adverse drug events & reporting these
- Participant’s responsibility to adhering to treatment
- Positive aspects of Anti-Retroviral Therapy

**Acceptance of Status**
- The first step in empowering the client to take charge of their health
- Focuses on stigma, what it is & how to cope as a PLHIV
- Defines denial
- Explores social discrimination factors that inhibit acceptance of status
- Discusses the benefits of accepting status

**Prevention with Positives**
- How the participant can be a Positive role model
- Accessing PLHIV support organizations
- Highlights family planning options
- Emphasizes primary prevention
- Focus on symptoms of TB and prevention of other STI
- Positive Living with a Positive Diagnosis

**Disclosure**
- Builds a support base for the client
- Strengthens relationship of Participant with health care provider and family
- Builds a base for adherence support
- Helps de-stigmatize HIV (shows others a positive life)
- Encourages partners, family and friends to get tested

**Nutrition and Healthy Living Principles**
- The relationship between healthy eating & infection
- Provides information about nutritional support
- Assesses nutritional needs
- Outlines how to access nutritional food
- Discusses & demonstrates preparation of healthy meals
- Discussions on Healthy Living Principles and activities

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I ACT Implementation SOP

12
3.1.5 I ACT Logic Model

**Goal:**
To improve the quality of life of PLHIV by linking them to HIV treatment, care and support (PRE ART and ART care).

**Outcomes:**
- Improved linkage and enrolment of newly diagnosed PLHIV in PRE ART and ART Care
- Improved Knowledge and skill of PLHIV
- Improved retention in PRE and ART Care
- Improved adherence to scheduled clinical assessment and HIV Treatment
- Reduced stigma related to HIV

**Objectives:**
- To improve early retention of patients to HIV care
- To reduce loss to follow-up for people newly diagnoses HIV positive
- To improve knowledge for self-health advocacy
- To reduce stigma related to HIV
- To empower HIV support group facilitators with educational and facilitation skills
- To reduce treatment failure

**Expected results/Output:**
- Full integration and oversight of IACT activities within HAST
- Number of IACT reported during HAST meetings (provincial and district level)
- Number of trainings conducted on content and skills
- Number of supporting supervision orientation trainings conducted
- Number of mentorship visits conducted
- Number of Support group facilitators recruited, trained and placed within health facilities
- Number of IEC material printed and disseminated
- Number of monthly report submitted by SGFs
- Number of quarterly reports submitted

**Activities/Input:**
- Strategic Leadership and Ownership
- Strategic Partnership
- Capacity and skills development, mentorship and coaching (Training, mentoring and coaching and supporting supervision, development of monitoring tools)
- Human Resources (recruitment and placement of SGFs within health facilities)
- Outreach and marketing (IEC material)
- Linkage between PHC and ward-based outreach teams
- Monitoring and reporting
3.2 Major Components of the I ACT Strategy

The I ACT strategy has two major components:

a. I ACT Introduction and Adoption: Creating Buy-in and Ownership
b. I ACT Implementation

3.2.1 Introduction and Adoption of I ACT: Creating Buy-in and Ownership

The implementation of I ACT strategy requires the active involvement of different stakeholders at different levels of the Provincial Department of Health (PDoH). The PDoH-HIV/AIDS Directorate office should ensure the establishment, functionality and coordination of these structures for the effective and sustainable implementation of I ACT in the province. Creating buy-in for the programme is the most critical step in programme planning and implementation. In fact, this step cuts across all the phases of programme implementation. Strong buy-in helps to ensure commitment and ownership from key stakeholders and team members. The Free State PDoH’s buy-in for the I ACT strategy will guarantee that resources are allocated to the I ACT implementation. PDoH buy-in, throughout the different stages of implementation is critical to the success of I ACT. This paragraph provides a two-stage approach to gaining critical buy-in and cultivating stakeholder commitment to I ACT implementation.

**Stage 1: Consultative Discussion Sessions to Gain Initial Buy-in**

Involving stakeholders and team members from the beginning of I ACT implementation would greatly assist in increasing the department’s ability to maintain support implementation. Consultative discussion sessions are one of proven and effective tools that can engage stakeholders prior to the start of implementation.

**Stage 2: Ensuring Sustained Commitment**

Building ongoing commitment is a second crucial step towards ensuring that the initial buy-in for I ACT is sustained. Successful programmes not only have stakeholders involved when the programmes begin; they have stakeholders who are engaged throughout. By using proven techniques, PDoH can ensure that
there is ongoing commitment to I ACT implementation. These techniques include, among others:

a. **Task Ownership**: It is very important to engage key stakeholders in identifying the specific tasks necessary to implement the strategy. This ensures ownership and commitment for implementation of all the tasks that need to be carried out. As mentioned previously, successful projects not only have stakeholders involved during inception stage, but stakeholders exist at each level of implementation. One way to involve project team members is to have them brainstorm a list of tasks necessary to create each deliverable or to reach milestones. The team members can then identify appropriate resources to complete the tasks. These tasks are then put into a project schedule or action plan to manage and monitor progress.

b. **Regular Reporting and Feedback**: Providing regular updates, feedback and reports ensures that stakeholders are constantly involved in the management of the programme.

c. **Communication**: Ongoing communication ensures that all stakeholders are informed of the progress achieved. Two-way communication between PDoH and the districts will make certain that issues and concerns are dealt with. A detailed communication plan (that includes reporting time frames) also helps in keeping key stakeholders and programme team members informed of status, progress, issues and milestones.

### 3.2.2 Implementation of the I ACT Strategy

Implementation of the I ACT strategy is composed of the following key elements:

a. Training
b. Information and Education Sessions
c. Closed Support Groups
d. Linkages and Referrals

Refer to section 4 for more details on the individual elements of the implementation of the I ACT strategy.
Figure VI. I ACT Coordination Structure

**Provincial DoH-HIV/AIDS Directorate**
Provision of provincial level leadership, guidance and direction for the planning, roll-out and M&E of I ACT strategy.

**HIV AIDS, STIs and TB (HAST)**
Coordinate the planning, implementation and M&E of I ACT strategy at the district and sub-district levels. **HIV/AIDS/STIs, RTC, TB, Partnership, Provincial M&E, PLHIV representatives, Districts representatives (CCMT, M&E and Partnerships), Partners, etc...**

**District/sub-district HAST**
Coordinate the planning, implementation and monitoring of I ACT strategy at the district, sub-district and health facility levels. **District Managers, Partnerships, Sub-Districts, PLHIV representative, CBO/NGO partners and district M&E representative**

**Health Care Facility**
Supervise the day-to-day implementation of I ACT support group sessions and SGFs and ensure integration of I ACT with other clinical and HIV/AIDS strategies/services. **Facility operation managers (Nurses), counsellors, Health promoters, SGFs, HBC providers. PHC re-engineering teams to refer PLHA from communities to I ACT in Health Facilities.**

**Sustainable Support Groups**

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I ACT Implementation SOP
4. Key Elements of the Implementation of I ACT

The Provincial Department of Health HIV/AIDS Directorate Office in collaboration with the Regional Training Centre (RTC), provincial M&E and Partnership Directorate should lead and provide provincial level guidance and direction for the planning, roll-out and implementation, and M&E of the I ACT strategy.

The PDoH HIV/AIDS Directorate should ensure uniform standard of 1) Training, 2) Information and Education Sessions, 3) Support Groups, 4) Strengthening of Linkages and Referrals and 5) Mentorship and Supportive Supervision and 6) as well as the Reporting and M&E systems thereof across implementing health facilities, CBOs and other services providers and development partners.

Implementation of the I ACT strategy should follow the following step-by-step process to ensure organized, uniformed and effective implementation of the strategy across the province.

4.1. Training

The I ACT strategy relies on a cadre of well-trained trainers and peer support group facilitators (SGFs) to lead community and health facility-based support groups that build knowledge and skills of PLHIV in key focus areas. To ensure sustained quality implementation of I ACT, I ACT trainers must be identified, trained, mentored and supported.

4.1.1: Training of PDoH Programme Managers and Implementers

While I ACT has been identified as the strategy to be utilized within the wellness programme, it cuts across a number of HIV programmes. Therefore, it is crucial that Programme Managers within HIV/AIDS be trained on I ACT so that they are able to oversee the implementation and integration of I ACT.

The planning and implementation of Programme Managers and Implementers training should be coordinated and conducted with the full participation and approval of the PDoH/RTC.

- Programme Managers and PDoH/RTC should be sensitized/ orientated on the I ACT programme by the FSDoH.
- Provincial Programme Managers should conduct and facilitate orientation training to the district level implementers.
4.1.2: Master Trainers Training

I ACT Master Trainers should be identified within the pool of existing RTC trainers and should possess extensive training skills to enable them to execute high-level training of trainers.

- The planning and implementation of master trainers training should be coordinated and conducted by the FSDoH in collaboration with a lead national level partner.
- Master trainers should be selected from the PDoH/RTC and there should at least be two master trainers at the PDoH/RTC at all times.
- Master trainers should be responsible for the planning, implementation and monitoring of all provincial level I ACT trainings.

4.1.3: Training of Trainers (ToT)

Trainers are selected based on their previous training experience and knowledge of HIV. Ideally, the trainers should be selected from RTC’s pool of trainers. The planning and implementation of the training of trainers should be coordinated and conducted with the full participation and approval of the Regional Training Centre.

- The RTC I ACT Master Trainers should identify and train their peers to conduct all I ACT trainings in the province.

This training of trainers is conducted over a period of 5 days.

4.1.4: Training of Health Care Workers (HCWs) including Support Group Facilitators (SGFs)

Support group facilitators should implement I ACT from and in coordination with a health care facility. PDoH-HIV/AIDS and RTC, with the assistance of the districts will be involved in the selection and training of Support Group Facilitators (FSGs) in close consultation with the health facilities.

4.1.4.1. Identification of SGFs

- The identification and selection of SGFs should be guided by transparent and standardized criteria, noted below.
• Health Facilities should take the lead in identifying appropriate SGF candidates and submit their list to district/Sub-district HAST or CCMT managers for selection consideration.

• Health Facilities should identify SGF candidates from existing community health care workers (home based care providers, lay counsellors, health promoters, etc.) who are already in the PDoH system (salaried or on stipend) and who meet the minimum recruitment selection criteria’s for SGFs role, noted below.

4.1.4.2. Recruitment of SGFs

• District/Sub-district HAST or CCMT managers in collaboration with the PDoH RTC should review the list provided by health facilities in line with the following minimum recruitment and selection criteria:

**Minimum Requirements/ Selection Criteria**
- Passed Grade 11
- Good understanding of English- able to write and read, understand and explain what has been read and understood to the next person
- Preferable have experience in running support groups
- Must be professional in dress and manner
- Preferable be able to work with people living with HIV, good communication skills (including appropriate language proficiency), able to manage conflict
- Willing to work as part of a multidisciplinary team with multiple stakeholders
- Maturity and experience

• District/Sub-district HAST or CCMT managers should conduct a one-one-one or telephonic interviews with selected candidates before final recruitment decisions.

The final list of SGF candidates should be provided to RTC and HIV/AIDS Directorate office for final verification and approval before the planning and implementation of trainings. The training curriculum is divided into two distinct pieces namely, 1) a 6.5 day content training and 2) a 4.5 day skills training. The I ACT training curriculum is described in Section 3, Figure IV.
4.1.4.3. Training of SGFs

Training Content: The standard I ACT curriculum serves as a standard resource for information focusing on key topics relevant to people living with HIV. It is designed to instruct and guide support group facilitators in the implementation of six support group/education sessions (closed or open) at a health care facility or community level, to help reduce the rate of new infections, and mitigate the impact of the disease. The sessions provide the building blocks necessary to understand one’s HIV diagnosis, and how to manage one’s illness.

This training should be provided by I ACT trainers who completed the ToT training successfully under the supervision of PDoH/RTC master trainers. Pre- and post- training tests should be administrated in all I ACT trainings and the results should be used to inform post training follow-ups and mentorship activities. SGFs should be directly observed both during training and while conducting actual closed and open group sessions with feedbacks provided on performance to monitor the quality of their facilitation and the content of the strategy.

4.2. Information and Education Sessions

Information sessions are held in the facility waiting areas to provide information and build interest for the I ACT groups, and people are allowed to participate by dropping in for the sessions they are most interested in.

Health facility staff should market I ACT in the health care facilities (distribute IEC materials, conduct open sessions at clinic waiting areas) and to the community during outreach events.
4.3. Support Groups

4.3.1: Open Support Groups

Open support groups are targeted towards newly diagnosed PLHIV (minimum of two per week). Facilitators present in-depth information on six topics that include: Learning about HIV, Treatment, Prevention Strategies and Healthy Living. During each group meeting, facilitators conduct approximately two hours of curriculum, discussion and activity. Closed groups typically have ten to fifteen participants, all of whom would commit to attending all six meetings.

Resources Required for the Facility
- Financial: Monthly stipend
- Supplies/stationery: Name tags, access to telephone, fax and photocopy, facilitation manual, posters, brochures, etc.,
- Reporting and referral Forms.
- On-site and off-site meeting space/office for the support groups sessions.

Open groups should be conducted in health care facilities. Members of the open support groups can be mixed (e.g. PLHIV on ARVs and newly diagnosed attended the same support group), and will not have any obligation to attend subsequent sessions. This will address gaps in knowledge or information for support group members who felt they had information on other topics but needed more information in a specific area.

4.3.2: Closed Support Groups

Closed support groups for newly diagnosed PLHIV (minimum of two per week), are also a key component of I ACT. These support groups should exclusively serve newly diagnosed PLHIV, irrespective of CD4 count. This type of support group should remain closed until the end of the six sessions with the same members attending all the six I ACT sessions. PLHIV who are already on treatment should also be encouraged to participate in closed group sessions.

The minimum number of attendees within a support group (closed) should be 5 and the maximum should be 15 for a fruitful deliberation and effective monitoring. Each support group session should be conducted for a minimum of one hour and maximum of two hours.
4.4. Linkage and Referrals

4.4.1. Linkages and Referrals within the Health Facility

- Health facility operational managers should introduce and link all SGFs with the health facility clinical staff and provide them with all the necessary orientation.
- All clinical staff (operation managers, nurses, lay counselors, etc.) should be sensitized/orientated or trained about I ACT and existence of support groups in the facility to improve the referral and linkage process within the facility.

**Resources Required for the Facility**

- **Financial:** Monthly stipend
- **Supplies/stationery:** Name tags, access to telephone, fax and photocopy, facilitation manual, posters, brochures, etc...
- **Reporting and referral forms.**
- **On-site and off-site meeting space/office for the support groups sessions.**

- There should be at least one or two (in high volume facilities) SGFs per health care facility for continuity of services, holding regular I ACT open and closed sessions and referral of PLHIV to other NGOs/CBOs and support structures within the community.
- Facility operation managers should ensure integration of I ACT with other clinical and HIV/AIDS strategies/services (HCT, ART, TB, PMTCT, OVC). I ACT should be incorporated with the package of services offered to PLHIV and should be introduced both during pre and post counselling sessions.
- Please refer to the I ACT Algorithm in Appendix 1.

4.4.2: Linkages and Referrals between the Health Facility and Community

Linkage to community based NGOs upon completion of the six from I ACT sessions is very crucial to encourage PLHIV to remain connected in support networks. All clinical staff (operation managers, nurses, lay counselors, etc.) should be orientated or trained about I ACT and existence of support groups in the facility to improve the referral and linkage process within the facility and in the community.
• Facility operation managers should ensure there is a partnership with Community Health Workers (CHWs) for follow-up on pre-ART/ART patients’ adherence to scheduled clinical visits and referral to other clinical, social and legal services.
  o Ensure availability, use and distribution of IEC materials (I ACT facilitation guideline, leaflets, brochures, posters, etc.).
• Marketing and awareness of HIV care and treatment services offered by the health care facilities in the communities they serve and subsequent referral to the facilities and other social and legal services outside the facility.

4.5. Mentoring and Supportive Supervision

Regular and ongoing supervision and mentoring of district, sub-district and health facility operational managers as well as the SGFs is important in ensuring their effectiveness and the quality delivery of I ACT. The supportive supervision of facility operational managers on I ACT should be implemented following the guidelines outlined in the Primary Health Care (PHC) Supervision Manual of the National Department of Health.

The PHC Supervision Manual provides a guide to structured supervision that is evidence-based and whose requirements can be implemented and measured, thus ensuring good quality primary health care provision in health facilities. The purpose of the PHC Supervision Manual is to support supervisors, programme managers and PHC facility managers in their roles with the aim of improving the quality of primary health care in PHC facilities. Along similar lines, it is envisioned that the proposed model of provincial supportive supervision will assist in strengthening the leadership of district programme managers in I ACT implementation. Regular supportive supervision of districts ensures that I ACT is fully integrated with the HIV/AIDS programme and that it is fully functional. The supervisory support to PHC facilities by clinic supervisors has been adapted with a view of suggesting a model for provincial support of districts.

Supportive supervision of SGFs is the responsibility of facility-based operational managers, district officials and social workers assigned for that community. Social workers will support the quality of psychosocial services offered by the SGFs whilst the other team members will support the other deliverables of I ACT including the quality of services offered.
4.5.1: Provincial Support to the Districts

Provincial supervisors will be responsible for ensuring that the resources needed for proper integration and implementation of I ACT are available. Their role would involve identifying issues that need to be addressed in order for the districts to drive I ACT in the best direction.

The provincial support should incorporate the same elements of supervision as outlined in the PHC Supervisory Manual. These include the following:

- In-depth programme review
- Problem-solving discussion and improvement planning
- Staff support
- Regular review and monitoring of district performance
- Reporting, monitoring and evaluation and; constructive feedback

This flowchart has been adapted from the PHC Supervision Manual to illustrate the flow of activities encompassed within the provincial support model.

**Figure VII. Provincial Supportive Supervision Flowchart**
4.5.2: District and Sub-district Support to the Health Facilities

The PHC Supervision Manual provides clear guidelines on the supervisory framework for Primary Health Facilities.

4.5.3: Social Workers’ Support to the I ACT Facilitators

- Post-training coaching, mentoring, debriefing and technical assistance should be provided to help SGFs to plan and implement support groups, master the various content of the I ACT and manage the relationship with health care facilities, community based NGOs and districts/sub-districts.
- The Free State department of Health has employed various categories of social workers that are based in the districts and sub-districts. Social workers possess a unique technical expertise to provide supervision to the SGFs. Because of their professional background, social workers should supervise SGFs in the facilities on a regular basis to ensure the implementation of I ACT and provide the necessary on-site technical support.
- Social workers should supervise the implementation of I ACT support group sessions and mentor support group facilitators on a regular basis. One-on-one meetings should be conducted between SGFs and a social worker once a month to provide the necessary mentorship.
- In addition, social workers should communicate regularly with the health facility operational managers to provide updates on the mentorship and supervision of SGFs and address challenges in a timely manner.
- All regular supportive supervisions, mentorship and coaching activities should be conducted using standard tools and checklists.

4.6. Reporting, Monitoring and Evaluation

To realize the maximum benefits of I ACT, it is necessary to closely monitor and evaluate the day-to-day implementation process. An effective reporting, monitoring and evaluation system allows for the timely identification and prioritization of problems and issues that can be addressed. For more details, please refer to the M & E Framework for IACT.
4.6.1: Reporting Levels and Responsibilities

Data on selected indicators for I ACT will flow from the health facility level to sub-district level, to district, provincial and then to the national M&E Unit at national level, and back to the lowest level for feedback and utilization.

- The M&E Unit in the PDoH should be responsible for the co-ordination of the monitoring and evaluation framework at provincial level. The M&E units at the district level will assume the same responsibility at district and sub-district levels. These coordinating structures will oversee capacity development, data quality assurance, resource mobilization for M&E and data archiving.
- All stakeholders involved in the processes of implementation and coordination should be involved in reporting, monitoring and evaluation to ensure that standardized data collection and reporting occurs at different levels of the program implementation.

Figure VIII. I ACT Indicator Reporting Flow

- The regular reporting, monitoring and evaluation process should take place at different levels as indicated in the above diagram and table below and all efforts should be made to align reporting requirements, reporting frequencies and data flows with the existing data flow structure of the province.
- Supervisors and mentors at different levels of the I ACT program implementation should supervise the completion, collation, and submission of reports.
Reporting Procedure

Step 1
Operational managers should support the compilation, verify and submit I ACT reports (see Appendix 4 for reporting forms) together with all other monthly reports to district/sub-district by the scheduled deadline.

1.1 Operational managers must ensure that copies of the report are also maintained in the facility in a file easily accessible by support personnel.

Step 2
The I ACT reports from the facilities will be submitted to an assigned person at district/sub-district level e.g. Assistants to the Home Based Care Coordinators who will capture and collate in either the (DHIS standalone) I ACT dataset or excel spreadsheet and submits collated report to I ACT responsible person at that level.

Step 3
The I ACT responsible person at district and sub-district level verifies and compiles reports to HAST coordinators/CCMT coordinators according to the district structure.

Step 4
HAST coordinators or CCMT managers or the I ACT responsible person should submit I ACT reports to the provincial I ACT responsible person after the necessary review and verification process.
Long-term Reporting Algorithm

**Step 1**
In the HIV Counselling and Testing (HCT) register, there is a comment column that should be utilized to indicate referral to the next step of the I ACT continuum for all patients newly diagnosed HIV positive. The HCW who provides the HCT i.e. lay counsellor (or professional nurse in the case of provider-initiated HCT) must document the referral through the I ACT continuum. The HCT register is a facility-based register used to record/capture all the HCT conducted in a health facility i.e. all HCT client-initiated and provider-initiated HCT conducted within the health facility is entered into the HCT register.

**Step 2**
The Pre-ART register will have an addendum at the 1st page with instructions to indicate how to denote participation of a client in I ACT groups and how many sessions he/she completed (Example: IACT/05:- meaning he/she completed 5 sessions).

**Step 3**
The participant registration form gets attached to the clinical stationery indicating the same information with the pre-ART registers (number of sessions attended). The I ACT attendance register sitting in a clinic file indicates folder number and is used to track adherence patterns to I ACT sessions.
**Step 4**

Upon provincial/district approval for capturing of Pre-ART onto tier.net at facility level, I ACT data above will be captured automatically from the Pre-ART register using the alternative number field to denote number of sessions completed and an I ACT specific report can be queried out of Tier.net. see example report below

**Figure X. I ACT and Tier.Net**

![Image of I ACT and Tier.Net report](image)

These reports can be generated on-site and follow the same reporting flow as the current reports but preferably as in the table below.

**Table 2. I ACT Reporting: Responsibility and Timeline**

<table>
<thead>
<tr>
<th>Level</th>
<th>Who</th>
<th>Reports To</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Support Group Facilitator (SGF)</td>
<td>Health facility- Facility manager</td>
<td>1st-5th</td>
</tr>
<tr>
<td>2</td>
<td>Health facility- Facility manager</td>
<td>District-M&amp;E officer/Information officer/Local area coordinator</td>
<td>5th-10th of each month</td>
</tr>
<tr>
<td>4</td>
<td>District-M&amp;E Officer District Information Officer CCMT Coordinator PEPFAR Partner</td>
<td>Provincial information officer Programme managers</td>
<td>15th of each month</td>
</tr>
<tr>
<td>5</td>
<td>Province- Provincial information officer Programme Managers M&amp;E Managers</td>
<td>NDoH</td>
<td>25th of each month</td>
</tr>
</tbody>
</table>
4.6.2: I ACT Core Indicators

The overall impact of the I ACT implementation should be measured through the following impact indicators

Table 3. I ACT Impact Indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Target</th>
<th>Data Source</th>
<th>Frequency</th>
<th>Disaggregation</th>
</tr>
</thead>
<tbody>
<tr>
<td>I ACT implementation coverage</td>
<td>100%</td>
<td>Information system collecting IACT data</td>
<td>Quarterly</td>
<td>Implementing facilities per Districts</td>
</tr>
</tbody>
</table>
| Number of newly diagnosed HIV-infected individuals who had a CD4 tests done and received Pre-ART Care. | HCT targets | HCT registers, Pre-ART registers, tier.net                              | Monthly   | Adult males, >15yrs – 45yrs
|                                                                            |            |                                                                           |           | Adult Females, > 15yrs
|                                                                            |            |                                                                           |           | Children, 0-15yrs                   |
| Number of HIV positive patients started on INH preventative therapy.      | 100%       | Pre-ART registers, ART registers, tier.net, ETR.net DHIS                  | Monthly   | No Disaggregation                   |
| Percentage of active IACT support group facilitators                     | 100%       | RTC Databases                                                              | Bi-annual |                                                    |
| Rate of enrolled into IACT Support Groups                                 |            | IACT registers, HCT registers, Pre-ART registers, Tier.net                | Monthly   | Males and Females                   |
| Number of non-eligible (ART) patients enrolled into IACT support groups  |            | IACT registers, HCT registers, Pre-ART registers, Tier.net                | Monthly   | Males and Females                   |
| IACT support group completion rate                                        |            | IACT registers, HCT registers, Pre-ART registers, Tier.net                | Cohort report, quarterly | |

See more detailed Definitions of Indicators in Appendix 3.
Appendix 1: I ACT Algorithm

HIV Testing Algorithm

Introducing the IACT support strategy.

Comprehensive Clinical management according to Guidelines including TB Screening, INH screening.

All documentation in all stationery.

Link all newly diagnosed PLHIV to Social Worker.

Provide next appointment Date for clinical assessment and 1st or next I ACT session.

Refer to Support Group facilitator

HIV Testing Algorithm

Introducing the IACT support strategy.

TB Screening, INH screening. CD4 testing

All documentation in HCT register and demographics

Refer to Clinician

If client is receiving ongoing counseling, refer to support group facilitator

Orientate newly diagnosed client on sessions’ content and method of delivery.

If old client, resume sessions

Confirm next appointment date for both Clinical and IACT session.

Complete all necessary records as per clinic agreement especially the pre-ART register.
Appendix 2: I ACT Indicator Definitions

1. I ACT Coverage

**Definition:**
The percentage of Facilities implementing I ACT in the districts and the number of I ACT support groups commenced, comparing with the target population size. A facility is said to be implementing the I ACT support group intervention if there is one or more active Support Group Facilitator(s) for that period under reporting (An active SGF (s) and conducting regular closed support group sessions).

**Justification and Management Utility:**
This indicator monitors the implementation of the I ACT support group intervention, the availability of I ACT support groups in communities through the nearest clinic and accessibility of the groups, via referral systems by newly diagnosed HIV positive patients.

**Disaggregation:**
a) Disaggregated by implementing facilities per Districts

**Units of Measure:**
1. Percentage of Facilities implementing IACT Support groups in the district
   Numerator: Number of facilities implementing IACT support groups
   Denominator: Total number of facilities or clinics in the District

2. Proportion of groups commenced during the reporting period

**Data Sources:** I ACT registers

**Frequency of Collection:** Monthly

**Data Collection Method:**
- The data element: Number of new closed support groups commenced: is compiled and submitted every month by the Support Group Facilitator (s)

**Review of Data:**
Quarterly at district review meetings, HAST meetings, Provincial Working groups and National Working group meetings

**Reporting of Data**
Quarterly to DOH, Partners, CDC and other stakeholders.

2. Newly diagnosed HIV-infected individuals who had a CD4 test done and received Pre-ART Care.

**Definition:**
The number of HIV-infected individuals provided with pre-ART care and support services in health care facilities. The minimum requirements for someone having received care and support are that the individual must have received at least one form of clinical or physical care and one other type of non-clinical care. The six categories of Care and Support services are: clinical/medical; psychological; spiritual; social; integrated prevention; and nutrition and food security.

**Justification and Management Utility:**
One of the key priorities of SAG is the provision of care and support to HIV-infected individuals not yet on ART. This indicator measures the number of individuals in a health care facility who received care and support whilst not yet on ART during the reporting period. Monitored over time, this indicator can be used to assess the extent to which the pre-ART population of an ART clinical program is receiving services commensurate with the size of the overall ART clinic population. This indicator should be analyzed along with the number of persons on ART at a facility.

**Disaggregation:**
- Adult males, >15yrs
- Adult Females, > 15yrs
<table>
<thead>
<tr>
<th><strong>Unit of Measure:</strong></th>
<th>Cumulative number of clients newly diagnosed HIV positive in the facility.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Sources:</strong></td>
<td>HCT registers, Pre-ART registers, tier.net</td>
</tr>
<tr>
<td><strong>Frequency of Collection:</strong></td>
<td>monthly</td>
</tr>
<tr>
<td><strong>Data Collection Method:</strong></td>
<td>• This indicator can be measured using a proxy indicator, number of newly diagnosed HIV positive patients with the assumption that a positive patient receives a cd4 test on the day of testing and being diagnosed HIV positive.</td>
</tr>
</tbody>
</table>

**Review of Data:**
Quarterly at district review meetings, HAST meetings, Provincial Working groups and National Working group meetings

**Reporting of Data:**
Quarterly to DOH, Partners, CDC and other stakeholders.
Key reports: APP, NSP

### 3. HIV positive new client initiated on IPT rate

**Definition:**
The number of HIV-infected individuals who start IPT during the reporting period.

**Justification and Management Utility:**
This indicator measures the number of individuals in a reporting period that are started on Isoniazid Preventive Therapy (IPT). IPT should be provided to HIV-infected patients to prevent the onset of TB as per the South African guidelines. The purpose of this indicator is to assess the scale-up of IPT as an appropriate clinical intervention.

**Disaggregation:** No disaggregation

**Unit of Measure:** Percentage of patients initiated on IPT out of all the patients eligible for IPT

**Numerator:** HIV positive client initiated on IPT

**Denominator:** HIV positive client eligible for IPT

**Data Sources:** IPT Register

**Frequency of Collection:** monthly

**Data Collection method:**
• This indicator is already collected by the Health Information system, stored in the DHIS and part of NIDS.

**Known Data Limitations and Significance:**
The denominator, which is the number of clients eligible for IPT is not easy to collect since it follows from the TB case finding algorithm, Patients screened for TB and the results of screening are not collected under the current NIDS.

**Review of data:**
Quarterly at district review meetings, HAST meetings, Provincial Working groups and National Working group meetings

**Reporting of Data**
Quarterly to DOH, Partners, CDC and other stakeholders.
Key reports: APP, NSP
4. Percentage of active I ACT support group Facilitators.

**Definition:**
The percentage of I ACT support group facilitators still actively involved or was actively on duty at a health facility during the month under report. An active SGF reports every month on Wellness related activities undertaken during the month, including number of IACT closed groups conducted.

**Justification and Management Utility:**
This indicator measures the input status of the implementing vehicle behind the effectiveness of the IACT strategy. A lot of investment in monetary terms goes towards training this cadre of health care workers and budgeting for future trainings hinges on this indicator.

**Disaggregation:** No Disaggregation

**Units of Measure:** Percentage of support group facilitators active at the end of the month under report.

Numerator: Number of S.G.Fs still actively involved in Wellness and IACT related duties at the clinic
Denominator: Number of Support Group Facilitators ever trained in that District.

**Data Sources:** Information systems responsible for collecting IACT / Wellness data, The regional training Center Databases

**Frequency of Collection:** Quarterly

**Data Collection Method:**
- The data element: Number of active support group facilitators is compiled and submitted every quarter by the IACT focal persons at the districts in after verification with Operational managers and Social Workers,
- The data element: Number of support group facilitators ever trained is obtained from the Regional training Center database.

**Known Data Limitations:**
Activity verification can be a tricky business as some facilitators may turn up at Health facilities but not rendering the services required. Operational managers are the only people who can verify this indicator as reports are sometimes fabricated.

**Review of Data:**
Quarterly at district review meetings, HAST meetings, Provincial Working groups and National Working group meetings

**Reporting of Data:**
Quarterly to DOH, Partners, CDC and other stakeholders.

5. Rate of enrolled into IACT Support Groups

**Definition:**
The number of all HIV positive patients (newly diagnosed and known positives) who were enrolled into IACT Support groups. **Number of Individuals who joined/enrolled into I ACT Support Groups are those individuals who turned up for the 1st session of the support group, NOT those that showed interest and later did not turn up at the 1st session.**

**Justification and Management Utility:**
This indicator monitors acceptability of the IACT support groups by the communities as well as the functionality of the referral linkages between HCT, the community and the IACT support groups.

**Disaggregation:** Disaggregated by males and Females

**Units of Measure:** Percentage of patients enrolled into IACT support groups.

Numerator: **Number of HIV positive Individuals who joined/enrolled into IACT Support**
### Groups for the 1st time

**Denominator:** All HIV positive individuals who had who are registered at the facility

### Data Sources

I ACT registers, HCT registers, Pre-ART registers, Tier.net

### Frequency of Collection

Monthly

### Data Collection method

- The data element: Number of individuals enrolled into I ACT groups is compiled and submitted every month by the Support Group Facilitator.
- The denominator is (All newly diagnosed from HCT registers + all registered patients on Pre-ART register, not yet on ART + All registered patients on ART)

### Known Data Limitations

Verification of the attendance of such activities remains a challenge. Signatures of participants per each group setting are sometimes similar. It is the assumption that individuals who attend IACT support groups are somehow connected (registered) to the facility for the denominator to make sense.

### Review of data

Quarterly at district review meetings, HAST meetings, Provincial Working groups and National Working group meetings

### Reporting of Data

Quarterly to DOH, Partners, CDC and other stakeholders.

### 6. Percentage of diagnosed individuals enrolled into IACT not yet eligible for ART.

#### Definition

The number of IACT sessions group members who are not yet eligible for ART according to guidelines at the time of enrolment into the support groups.

#### Justification and Management Utility

This indicator measures the outreach to a section of the target population that has greater benefits from the IACT intervention. One of the main aims of the IACT is to make non-eligible patients live healthier lives whilst still not on ART.

#### Disaggregation

- b) Disaggregated by males and Females

#### Units of Measure

Percentage of patients enrolled into IACT support groups who are not yet eligible for ART.

**Numerator:** Number of individuals enrolled into IACT Support groups but not yet eligible for ART

**Denominator:** Total Number of individuals enrolled into the support groups.

### Data Sources

I ACT registers, HCT registers, Pre-ART registers, Tier.net

### Frequency of Collection

Monthly

### Data Collection method

- The data element: Number of individuals enrolled into IACT groups, number enrolled who are not yet eligible for ART is compiled and submitted every month by the Support Group Facilitator.

### Known Data Limitations

It is with the assumption that every patient knows their eligibility status after being tested for CD4 and Clinically assessed. It is this self-reporting that we will use for this indicator. Verification through the clinical records has confidentiality issues that may have adverse effects on the support group ethics.
I ACT Implementation SOP

7. I ACT Support Group Completion Rate

Definition:
The percentage of individuals who enroll into the closed Support groups and complete at least 5 sessions. Count number of participants who completed at least 5 out of the available 6 sessions, not necessarily consecutive. These individuals strictly belong to the closed groups that completed all six sessions.

Justification and Management Utility:
This indicator measures the success rate of the support groups. This indicator also gives an indication to the quality of Facilitation, and other underlying challenges around coordination and scheduling of support groups and generally acceptability of the sessions.

Disaggregation: Disaggregated by males and females

Units of Measure: Percentage of patients enrolled into IACT support groups.
Data Elements also used: 1.Number of completed Support Groups.

Numerator: Number of individuals who completed at least 5 sessions
Denominator: Number of individuals enrolled into the support group

Data Analysis Plan: Data will be analyzed as cohort data a quarter later than all other indicators to give enough time for the subjects to finish the sessions and still be part of the analysis.

Data Sources: IACT registers, HCT registers, Pre-ART registers, Tier.net

Frequency of Collection: Quarterly, as a cohort report

Data Collection method:
- The data element: Number of individuals enrolled into IACT groups, number who completes at least 5 sessions and number of groups that completed are all compiled and submitted every month by the Support Group Facilitator

Known Data Limitations:
Verification of whether participants indeed went on to complete all sessions remains a challenge. Signatures of participants per each group setting are sometimes have a similar handwriting.

Review of data:
Quarterly at district review meetings, HAST meetings, Provincial Working groups and National Working group meetings

Reporting of Data
Quarterly to DOH, Partners, CDC and other stakeholders.
## Appendix 3: Stakeholder Roles and Responsibilities

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Roles and Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NDoH</strong></td>
<td>✓ Provides overall strategic guidance and technical support for the planning and implementation of I ACT strategy at the national level. ✓ Ensures consistency and accuracy of I ACT training curriculum, content and services, recognizes and communicates best practices and develops evaluative measures. ✓ Supports and guides the work of the provincial, district and other technical working groups (M&amp;E).</td>
</tr>
<tr>
<td><strong>PDoH (HAST)</strong></td>
<td>✓ Provide Provincial level guidance and direction in the implementation and roll-out of I ACT strategy. ✓ Organize and facilitate regular quarterly review meetings at provincial and district levels. ✓ On an ongoing basis, plan and ensure communication and information sharing among different stakeholders. ✓ Ensure uniform standard of training for support group trainers and facilitators. ✓ Ensure uniform standard for mentorship and supportive supervision activities. ✓ Strengthen linkages and referral systems between implementing community based CBOs, health facilities and other services available. ✓ Strengthening Monitoring and Evaluation of I ACT through development of indicators, standard reporting tools and M&amp;E framework in collaboration with partners and DoH. ✓ Assign I ACT focal person at the provincial level that will coordinate and supervise the overall implementation of the strategy at the provincial level. ✓ Provide all the necessary resources required for the smooth day-to-day operation and sustainability of the strategy.</td>
</tr>
<tr>
<td><strong>DISTRICT HAST</strong></td>
<td>✓ Coordinated by PDoH-HIV/AIDS Directorate office ✓ Provides overall technical support and oversees the planning, implementation and M&amp;E of I ACT strategy at the provincial, district and sub-district levels. ✓ Meet quarterly to review implementation progress. ✓ Ensure the integration of I ACT strategy at different structures, strategies within the province. ✓ Ensures the integration of I ACT into the provincial annual business plan ✓ Share and disseminate best practices and lessons learned and other information as needed</td>
</tr>
<tr>
<td><strong>Regional Training Centre</strong></td>
<td>Under the leadership of the HIV/AIDS Directorate office, the RTC: ✓ Coordinate and offer periodic I ACT training sessions in collaboration with partners. ✓ Coordinate on-going supportive supervision and capacity building support to districts, sub-districts, health facilities and support group facilitators.</td>
</tr>
<tr>
<td><strong>District HAST</strong></td>
<td>Under the leadership of the District Manager, the District/sub-district HAST should: ✓ Coordinated by District/Sub-district DoH (HIV/AIDS Coordinator/I ACT Focal person) ✓ Provides overall technical support and oversees the planning, implementation and M&amp;E of I ACT strategy at the district, sub-district and health facility levels. ✓ Facilitate and ensure quarterly implementation review meetings. ✓ Ensure the integration of I ACT strategy in the district.</td>
</tr>
<tr>
<td>Health Care Facilities/Operation Managers</td>
<td>Under the leadership of the District/sub-district HIV/AIDS CCMT Coordinator, Health Care Facilities should:</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>✓ Ensure the integration of I ACT into the district/sub-district annual business plan</td>
<td></td>
</tr>
<tr>
<td>✓ Share and disseminate best practices and lessons learned and other information as needed.</td>
<td></td>
</tr>
<tr>
<td>✓ Identify strong candidates to run support groups.</td>
<td></td>
</tr>
<tr>
<td>✓ Roll-out I ACT within the facility.</td>
<td></td>
</tr>
<tr>
<td>✓ Provide infrastructure for support groups, which could include on-site meeting and office space.</td>
<td></td>
</tr>
<tr>
<td>✓ Supervise the implementation of I ACT support group sessions and Support Group Facilitators.</td>
<td></td>
</tr>
<tr>
<td>✓ Ensure integration of I ACT with other clinical and HIV/AIDS strategies (HCT, ART, TB, PMTCT, etc...)</td>
<td></td>
</tr>
<tr>
<td>✓ Ensure referral and linkages between different service points at the facility.</td>
<td></td>
</tr>
<tr>
<td>✓ Ensure that support group facilitators are able to access support and help as required.</td>
<td></td>
</tr>
<tr>
<td>✓ Supervise the completion, collation, and submission of support group monitoring forms.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Support Group Facilitators</th>
<th>Under the guidance and supervision of Facility Operational Managers, SGFs should:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Be well versed in all I ACT and support group facilitation content.</td>
<td></td>
</tr>
<tr>
<td>✓ Liaise with NGOs/CBOs, DoH and other government services.</td>
<td></td>
</tr>
<tr>
<td>✓ Recruit PLHIV for the support groups.</td>
<td></td>
</tr>
<tr>
<td>✓ Link with all primary health care clinics in the sub-district especially HCT, TB, PMTCT, STI, HIV and ART services.</td>
<td></td>
</tr>
<tr>
<td>✓ Link with other government services in the sub-district- social services etc.</td>
<td></td>
</tr>
<tr>
<td>✓ Run 6 sessions according to agreed schedules.</td>
<td></td>
</tr>
<tr>
<td>✓ Refer support group members as appropriate to DoH and other government and NGO services.</td>
<td></td>
</tr>
<tr>
<td>✓ Ensure that standards of information sharing with support group members are consistent with what is in the training manual</td>
<td></td>
</tr>
<tr>
<td>✓ Run open support groups as required to provide ongoing support to PLHIV.</td>
<td></td>
</tr>
<tr>
<td>✓ Complete and submit appropriate monitoring form fully, accurately, and on time, following each support group.</td>
<td></td>
</tr>
<tr>
<td>✓ Register all clients referred from HCT (PRE ART Register).</td>
<td></td>
</tr>
<tr>
<td>✓ Keep the monitoring forms in a safe, clean and confidential manner.</td>
<td></td>
</tr>
<tr>
<td>✓ Respect participant privacy and confidentiality.</td>
<td></td>
</tr>
<tr>
<td>✓ Actively participate during mentorship and supportive supervision visits</td>
<td></td>
</tr>
<tr>
<td>✓ Actively participate at different community outreach events to market/promote I ACT strategy.</td>
<td></td>
</tr>
<tr>
<td>✓ Distribute I ACT IEC materials at health facilities and different venues and events within the community</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4: I ACT Data Collection Tool

Form AI: Integrated Access to Care and Treatment (I ACT)

Support Group Facilitator Monthly Aggregated Report

Name of Support Group facilitator: ___________________ District: ___________ Month: ______ Year: ______

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of information sessions conducted (where components of I ACT are discussed) during the month</td>
<td></td>
</tr>
<tr>
<td>2. Number of new, ongoing and completed I ACT support groups in the Month.</td>
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<td>a) New</td>
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<td>b) Ongoing</td>
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<td>c) Completed</td>
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<tr>
<td>3. Number of individuals who joined/enrolled into I ACT support group sessions</td>
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<td>4. Subset of (3): Number of individuals who joined I ACT support group sessions who were not eligible for ART.</td>
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<tr>
<td>5. Number of individuals who completed at least 5 I ACT Sessions (belonging to completed groups only)</td>
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</table>

Part 2: To be completed in consultation with a Health Professional at I ACT Health Facility sites:

<table>
<thead>
<tr>
<th>Indicator</th>
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<tbody>
<tr>
<td>1. Number of all newly diagnosed HIV positive patients from HCT in the Facility (Pre-ART)</td>
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<tr>
<td>2. Number of HIV-positive &quot;new&quot; patients started on INH prevention therapy</td>
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<tr>
<td>3. Number of HIV-positive &quot;new&quot; patient started on Cotrimoxazole (Bactrim) or Dapsone</td>
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## Appendix 5: I ACT Support Group Register

I ACT Support Group Attendance Register  
Integrated Access to Care and Treatment (I ACT)

<table>
<thead>
<tr>
<th>No</th>
<th>Initials</th>
<th>Birth date (dd/mm/yyyy)</th>
<th>Age</th>
<th>Gender M/F</th>
<th>Registration Session 1</th>
<th>Session 2</th>
<th>Session 3</th>
<th>Session 4</th>
<th>Session 5</th>
<th>Completion Session 6</th>
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### Appendix 6: I ACT Support Group Registration Form

**Integrated Access to Care and Treatment Support Group Registration**

**Personal details:**
- **First name:**
- **Surname:**
- **Birthdate:**
- **Gender:** (Male/Female)

**First language:**
- Xhosa
- English
- Afrikaans
- Other

**Marital status:**
- Single
- Married
- Separated
- Divorced
- Widowed

**Employment status:**
- Employed
- Self Employed
- Unemployed
- Retired
- Student

**Qualifications:**
- Highest Grade in School
- Diploma
- Degree
- Post graduate
- Other (specify)

**Contact details:**
- **Address:**

**Cell no:**
- **Alternative phone no (optional):**

**How long ago were you diagnosed?**
- 0-5 months
- 6-11 months
- 1 year or more

**Care and treatment**
- Not eligible for ART
- Eligible for ART or On ART
- Do not know

**Latest CD4 count**

**Prevention and other medication:**
- Isoniazid (INH) Preventive Therapy (IPT)
- Cotrimoxazole (Bactrim) or Dapsona
- TB medication
- Other (please specify)

**How did you hear about this support group?**
- Clinic
- NGO/CBO/FBO (specify name)
- Church
- Other

**Which clinic do you attend?**

**How do you think the support group will help you?**