



Ministry of Health

PEER NAVIGATION PROTOCOL



JAMAICA 2017

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LINKAGES
Across the Continuum of HIV
Services for Key Populations



Peer Navigation Protocol

Jamaica 2017

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Acronyms

AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
BCC	Behavior change communication
CPE	Community peer educator
HIV	Human immunodeficiency virus
JASL	Jamaican AIDS Support for Life
MOH	Ministry of Health
MSM	Men who have sex with men
NFPB	National Family Planning Board
PLHIV	People living with HIV
STI	Sexually transmitted infection
SW	Sex worker

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MODULE 1: PEER NAVIGATION GUIDELINES, DEFINITION AND PROFILE

Introduction ¹

The purpose of this protocol is to provide standardized guidelines for peer navigation services. The guidelines will provide a framework, process, roles and responsibilities and forms to be used by a peer navigator. Regional health authorities and civil society organizations can use the protocol to ensure that peer navigation fits within a core package of HIV-related interventions offered at community and facility-based HIV services.

The objectives of a peer navigator are:

- To provide prevention services in risk reduction and counseling and testing
- To effectively link newly diagnosed HIV-positive clients with HIV/AIDS clinical services
- To improve continuity of care
- To increase retention rates among people living with HIV (PLHIV), especially key populations²
- To improve quality of life
- To improve health outcomes

A peer navigator's success in achieving these goals will be based on his/her ability to develop trusting relationships with clients, and his/her ability to follow up with clients to help them make their medical appointments and adhere to antiretroviral therapy (ART) to reduce viral load and prevent future transmission of HIV.

Peer Navigator Guiding Principles³

Peer navigation should be respectful, confidential and appropriate to PLHIV. The following fundamental principles have been developed to guide the process of delivering a quality peer navigation service:

1. Participation in Peer Navigation Services is Voluntary: Peer navigation services are provided only to those who accept support and guidance from a peer navigator. Peer navigators respect the individual rights of someone living with HIV to choose whether or not they would like to receive ongoing support.
2. Self-sufficiency and Independence of Clients: Peer navigators provide initial support with the goal of helping clients become self-sufficient and independent in making health-related decisions. From the start of the relationship, peer navigators should work to build this self-sufficiency and minimize dependence.
3. Part of the Continuum of Care: Peer navigation is a service, which is part of the continuum of care for PLHIV and provides more choice of services to PLHIV to address barriers and receive timely clinical and social support services.

¹ Goggin-Kehm, Molly, Peer Navigation: Literature Review/Best Practices/Challenges, 2016.

² Key populations include men who have sex with men, commercial sex workers, transgender individuals and at-risk youth.

³ Adapted from Community and Home-based Care Standard Operating Procedure Manual, Family Health International/Nepal, August 2007.

4. Continuity of Care: A client matched to a peer navigator will receive routine visits and follow-up. A peer navigator will establish a routine time for follow-up with the client so the client knows when to expect the peer navigator. Client contact will vary from low to high intensity, with the peer navigator deciding on the frequency of visits/contacts with the client.

5. Service Provision is Based on Need: A peer navigator conducts an assessment that will support the content and style of services provided and will map other available services to link clients to. An action plan will be developed and followed by the peer navigator.

6. Client Confidentiality: Client information is confidential. A peer navigator will take an oath of client confidentiality. A limited number of authorized staff members manage client records. All files related to information collected during peer navigation will be kept in a locked and secure location. These records are separate from clinical records kept at a health facility.

7. Interdisciplinary Team: Peers will be part of a team that possesses health worker skills, community outreach skills and psychosocial support/social work skills. Job responsibilities of peer navigators need to be well-defined by the National Family Planning Board (NFPB) and National Program for HIV/Sexually Transmitted Infections (STIs). Training and supervision provided will be based on an agreed-upon job description. A well-balanced team might consist of the following combinations: peer navigator, case manager, social worker, adherence counselor and clinician.

8. Provide Optimal Care within Resources: A peer navigator needs to balance the number of clients in need of services with the resources available. Programs are clear about the number of clients they can reasonably support given resources available to the program. If needed, programs can place limits on intake if there are concerns about not being able to deliver a quality service.

9. Peer Navigators are Full-time Staff: The role of the peer navigator has evolved to include encouragement and promotion of positive behavior change, particularly related to treatment adherence and retention in care. These are areas in which peer navigators can play a particularly critical role and should be available on a full-time basis as members of both the prevention and HIV care teams.

Peer Navigation Profile and Competencies

Definition

A peer navigator is defined as an HIV champion, friend, sounding board, health educator, facilitator for health care, guide, coach, advocate, case-finder and community resource. A peer navigator identifies barriers in accessing prevention, care and treatment services and is a connector to health care staff or services who can address barriers. He/she may be an HIV-positive, medication-adherent role model who shares experiences and membership with the populations with which he/she works, or may be a suitable officer with the desired skill set.

Peer navigators are full-time (funding permitted) workers, and depending on their qualifications and experience, their work may include most or all of the following responsibilities:

- Outreach
- HIV education and risk reduction
- Condom promotion and access
- HIV counseling and testing

- Linkage of client to clinical and social services
- Ongoing follow-up and support to newly diagnosed HIV-positive clients
- Navigation of health services for newly diagnosed HIV-positive clients
- Adherence motivation
- Identification of barriers to care and skill building to address barriers
- Patient empowerment
- Referral to support groups

Peer Navigator Competencies

A peer navigator must be qualified and trained to build the trust of clients without judgment or prejudice. He/she must be knowledgeable on the health services available in his/her catchment area and be a trusted and respected resource for clients and health facility staff in the prevention and HIV care teams. Key competencies and related tasks a peer navigator will perform are defined in the table below:

Competencies ⁴	Tasks
Ability to provide quality HIV prevention services	<ul style="list-style-type: none"> • Outreach • Prevention and risk-reduction messages • Counseling and testing • Able and comfortable to discuss sex, sexuality and gender and to work comfortably with key populations
Communication skills	<ul style="list-style-type: none"> • Motivational interviewing with clients • Gains trust with clients • Able to demonstrate empathy and sympathy • A connector and networker • Presents information in a professional, efficient manner free of bias and prejudice • Presents client information and challenges when communicating with providers • Encourages clients to ask providers productive questions, getting them the information they need • Behavior change communication (BCC) for action planning
Understanding of the health care system (including availability of local medical and social services)	<ul style="list-style-type: none"> • Provides ongoing follow-up to ensure clients are routinely meeting with their HIV care team • Links with case management and HIV care team • Links to social worker to address housing, substance use and mental health treatment • Develops follow-up/monitoring plan

⁴AIDS United. Best Practices for Integrating Peer Navigators into HIV Models of Care. Washington, DC, 2015.

HIV and healthful living	<ul style="list-style-type: none"> Provides treatment and adherence motivation
Confidentiality	<ul style="list-style-type: none"> Adheres to Ministry of Health (MOH) policy on confidentiality Understands consequences if confidentiality is breached Secures information in a safe and locked location
Documentation	<ul style="list-style-type: none"> Adheres to existing MOH protocols Documents relevant information on the client and can share with the HIV care team
Other	<ul style="list-style-type: none"> Knowledgeable on social support services and MOH referral process

The peer navigation training will provide further depth in the core competencies listed above. Peer navigators will be skilled in providing quality HIV prevention services and to be able to effectively communicate with a range of clientele. Essential skills in empathy, communication, motivational interviewing, sexuality, gender identity and confidentiality will be part of the peer navigation training to prepare candidates to meet the requirements in the terms of reference.

A sample terms of reference for a peer navigator has been included in Annex A.

Role of Peer Navigator, Peer Educator and Case Manager

In Jamaica, the National HIV/AIDS Program will introduce a Test and Start strategy in 2016, with the aim of increasing the number of PLHIV on ART as part of a treatment as prevention approach. With this strategy, patients who are HIV-positive will be placed on ART regardless of CD4 count and will need ongoing follow-up to monitor adherence to achieve viral load suppression.

Given this shift to focus on treatment outcomes, additional resources are needed to support clients across the continuum of care (see client flow diagram below). On the prevention side, community peer educators (CPEs) have been responsible for identifying and reaching clients and often providing the services of risk assessment, risk reduction and HIV tests, among others. They also provide education in HIV prevention techniques. Support by a CPE traditionally ends at the referral stage to health services; however, in some regions, CPEs have had an informal role in linking HIV-positive clients into care and treatment services with ongoing follow-up.

As the number of people on ART increases, resources will be needed to provide support from the referral stage into the clinical care and treatment stage. The clientele will be diverse, with various challenges and barriers to accessing and receiving routine health care. The function of a peer navigator has been introduced to address this gap. The peer navigator will formalize services and links from the community to clinical settings for people who are HIV-positive, and will build upon existing relationships formed during community outreach and HIV testing. He/she will be expected to accompany an HIV-positive client on the journey toward his/her goal of viral suppression. Ideally, a peer navigator will be drawn from a pool of existing CPEs to provide enhanced support to monitor, support and track the client's activities as part of a larger care and treatment team based in a health facility.

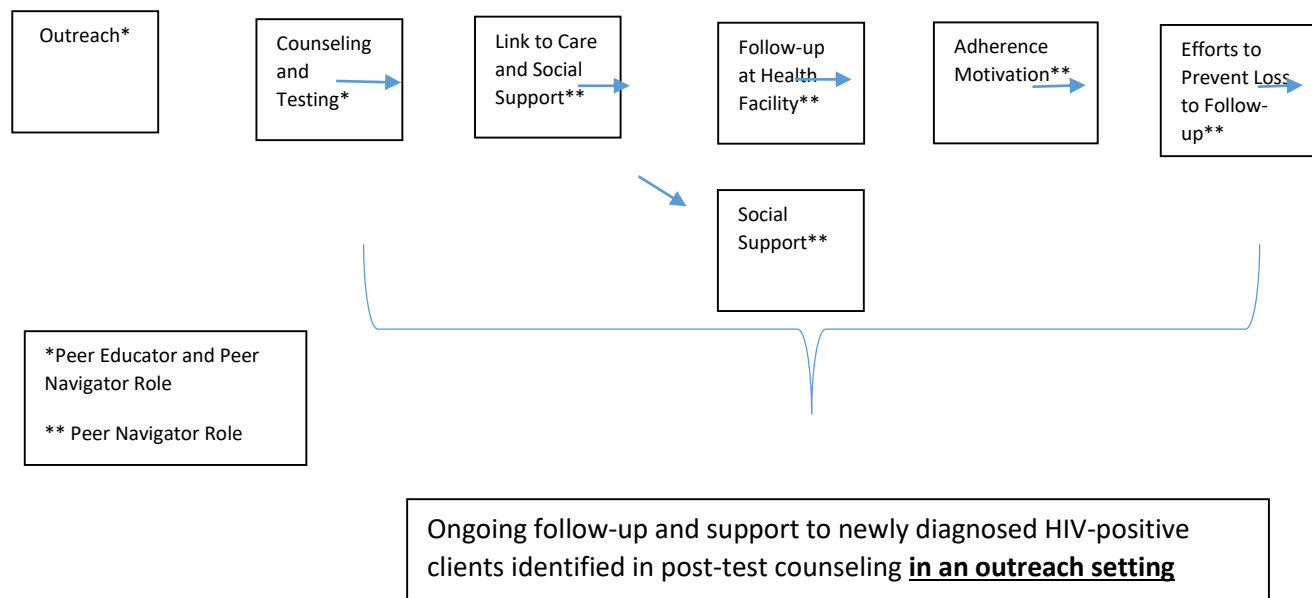
In Annex B, clear differences between the role of a CPE and that of a peer navigator have been outlined.

In a health facility, peer navigators will work closely with case managers and clinicians who are part of a comprehensive HIV care team. A case manager will lead the management of clients who are actively receiving ART in a clinic. In coordination and collaboration, a case manager and a peer navigator will work together to manage newly identified HIV-positive clients to support them in receiving quality HIV care in a health facility.

In Module 4: Care and Treatment, the roles of the case manager and care team have been defined in detail. Annex C includes a description of each position on the HIV care team. Coordination will be key to minimize overlap and duplication and to provide reinforcement to clients to promote positive health-seeking behaviors.

Specific to key populations, a peer navigator will have an important role in addressing barriers that may limit a client in accessing or returning to services. Among key population groups, vulnerabilities remain with human rights and equity — a significant barrier to accessing services. Stigma and discrimination, violence, homophobia and criminalization are events experienced by key populations on an almost daily basis. Criminalization of private, consensual, same-sex sexual acts, as well as sex work, also makes it more difficult for these populations to access HIV prevention information, services and treatment. A peer navigator will work to reduce and address barriers through his/her ongoing relationship with the client.

The client flow across the continuum will be as follows and is further detailed in Annex D:



MODULE 2: PREVENTION SERVICES

- Risk reduction
- Condoms
- Referral to counseling and testing

Outreach⁵

In coordination with the targeted intervention officer and BCC teams, geographic and hot spot areas targeted for outreach will be identified in advance to maximize time peer navigators, peer educators and peer links spend performing

outreach in the field.

Outreach will be weekly and carried out in teams. A peer link, peer educator and peer navigator will work together when a peer link is available in the parish. The peer link may be the first contact with a person who might be at risk, and may refer to a peer educator or peer navigator for an in-depth one-on-one discussion or be invited to a small group conversation.

It is anticipated that there is potential for overlap among the roles of the peer link, peer educator and peer navigator. Early on, before carrying out field work, a clear distinction should be made on who will make the first contact and who will be able to continue the relationship with the client to provide HIV prevention services and motivate them for testing and continued follow-up support, if needed.

During outreach, relevant contact information will be collected to be able to reach the client after the first contact. The information should be safeguarded.

Relationship Building

Building and fostering a trusting relationship with a peer will be essential for long-term support. Clients should feel they are working with a peer navigator or peer educator in a safe space and secure environment. ***The client should choose whom he/she feels comfortable in engaging with (i.e., peer educator or peer navigator) and should receive support by a peer who has adequate skills to address clients with short- and long-term health and social support needs.*** Clients may also be mobile, moving from various locations across the island. A strong and trusting relationship with a peer is key to maintaining in contact for long-term tracking and ongoing follow-up into care and treatment services.

Difference among a Peer Link, Peer Educator and Peer Navigator:

Peer Link: Recruits key population members through snowballing and social media to mobilize and refer peers to a peer educator/navigator to conduct one-on-one prevention sessions.

Peer Educator: Provides HIV prevention, risk reduction, condom distribution, negotiation skills, demonstration on condom use, HIV counseling and testing and referral to HIV/STI clinical services.

Peer Navigator: Has the responsibilities of a peer educator **plus** navigates clients to reach and be retained in care and treatment services.

⁵ Refer to Jamaica NFPB and Sexual Health Agency (NFPB-SHA) Outreach Manual for full process to be followed.

Disclosure

Many clients in the community may already be HIV-positive but prefer not to disclose their status. A strong relationship in which trust (and comfort) is in place has anecdotally led to increased rates of HIV disclosure to a counselor or peer educator. This principle of trust should be part of every interaction between a peer and his/her clients.

Prevention Services

In the community, prevention-related services may be provided by a CPE or peer navigator. Services may be provided individually or in a group setting, and will cover the themes below:

- Risk assessment
- Referral to testing for HIV/syphilis
- Test and Start
- Condom skill building and negotiation
- Choosing a contraception method, if applicable

Government-funded peer educators and peer navigators will follow the *National Family Planning Board Outreach Manual*, which provides a detailed process and steps to be completed during outreach. Should a client test HIV-positive, a peer navigator will take the lead in providing follow-up support for care and treatment services. ***However, the client may choose to work with a peer educator or another peer navigator.***

NOTE: Peer navigators based in civil society organizations may have different outreach strategies and profiles.

Forms Completed by a Peer Navigator during Outreach

Reporting Form: Peer navigators use a client log to track outreach services provided to each client. This form records the unique ID and contact information of each client and confirms all services that the client has received through outreach.

Class 1 Notification Form: This form **MUST** be completed for all identified cases of HIV or syphilis (whether old or new cases). It must be handed to the contact investigator within 24 hours (or, in the case of a weekend, on the following working day).

MODULE 3: HIV COUNSELING AND TESTING⁶

- Pre/post-test counseling
- Condom and contraception promotion and access
- Encouragement of partner disclosure
- Referral and accompaniment for confirmation of HIV/syphilis

Peer navigators and select peer educators will be trained to perform counseling and testing and HIV/syphilis rapid tests per the MOH protocol *HIV and Syphilis Testing in Non-Clinical Settings, Jamaica*. Materials and forms for rapid testing will be provided to a peer navigator or peer educator.

HIV-positive clients identified during community counseling and testing by a peer educator will be handed over to a peer navigator to lead post-test counseling. By taking the lead on newly diagnosed HIV-positive clients, a peer navigator will ensure the clients reach the health facility to confirm their status and to schedule an appointment with a health care provider.

At post-test counseling, a peer navigator will focus on building a relationship with a newly diagnosed client. Peer navigators will need to be empathetic and sympathetic to a client who has received a potentially life-altering diagnosis, is likely to be processing a lot of information at once and can be overwhelmed by too much information. Active listening, empathy, questioning and reflecting are important skills a peer navigator will need to rely on during counseling sessions with clients. Training on these skills will be provided to incoming peer navigators.

During a post-test counseling session, a peer navigator will:

- *Provide empathy and support to the client*
- *Educate the client on HIV/syphilis infection and its implications for his/her health*
- *Encourage the client to disclose his/her status to his/her partner and discuss HIV/syphilis testing*
- *Support informed choices about sexual behavior (partner reduction and condom use) and family planning options*
- *Identify barriers to accessing HIV care through an initial assessment (see Assessment and Action Plan Development below)*
- *Provide an orientation on the HIV care team and services offered at an ART treatment site (see Module 5 on Care and Support)*
- *Refer or accompany the client to a laboratory or HIV/STI treatment site for confirmatory testing and follow-up*
- *Accompany the client on the first visit to the health facility*

Newly Diagnosed Clients:

Confirmation is needed to ensure that “newly diagnosed” clients are not already in the system or were not lost to follow-up.

Assessment and Action Plan Development

At post-test counseling, a peer navigator will complete an intake assessment of clients who are HIV-positive. An intake assessment (Annex E) will identify each client’s needs and help to understand his/her current use of health services. A barriers checklist is also completed; however, a peer

⁶ HIV and Syphilis Testing in Non-Clinical Settings, Jamaica, National Public Health Laboratory/National HIV/STI Programme, Ministry of Health, Jamaica, January 2014.

navigator will need to gauge the readiness of a client to complete this step at post-test counseling. Peer Navigators must also be mindful that the post-test counselling may not be the appropriate time to be giving all this information. They may need to do this at the second meeting.

Disclosure

Support for disclosure is managed by the contact investigator or other professionals in the multidisciplinary care team. Peer navigators may, however, be exposed to questions and concerns about disclosure. They must refer these to the appropriate professional while giving accurate and empathetic information to the client.

Intake Assessment

The intake assessment is more of a conversation than it is data collection, to learn more about the client and his/her daily life. Areas covered are:

- Living situation
- HIV risk behaviors and current partners
- Employment
- Current health status and health-seeking behaviors

Barriers Checklist

After completing the intake assessment, a peer navigator will work with the client to complete a barriers checklist (Annex E) to evaluate any key barriers to accessing medical and non-medical services. The intake form and barriers checklist may be completed on separate visits if convenient. Clients may underestimate the amount of help that is available to them. The role of a peer navigator is to identify challenges that may keep a client from accessing health care and to help him/her work through basic challenges. Information collected at this stage will be shared with a social worker who will provide additional support to address barriers to care.

Asking questions and assessing barriers are starting points for helping clients. The peer navigator should not follow the same script and offer the same assistance to all clients, because each client is starting with different strengths, levels of knowledge and personal gaps and barriers. To produce effective, relevant and tailored assistance, a peer navigator will assess a client's knowledge, attitudes, beliefs and readiness⁷ by asking the following questions:

- What does the client know already?
- What are the client's attitudes and beliefs?
- How ready is the client?

Tips For Asking and Assessing*

Listen: Patient expresses worries, fear, concern, anger

Look: Expression of doubt or anger, disinterest

Clarify: You sound worried that you will not be able to...

Ask: What may make it difficult to attend your appointment?

⁷Oncology Patient Navigator Training: The Fundamentals. 2014. George Washington University, Cancer Institute, Page 99.

Mental Health

PLHIV, including those from key populations, and their families and caregivers may have a wide range of mental health needs. Common mental health co-morbidities include depression and anxiety. Dementia and other cognitive disorders are also associated with longer-term HIV infection. HIV care settings can provide an opportunity for the detection and management of mental health problems, including pre-existing mental health issues, among PLHIV.

In addition to being disproportionately burdened by HIV, key populations experience higher rates of depression, anxiety, smoking, harmful alcohol use and alcohol dependence, other substance use and suicide because of chronic stress, social isolation, violence and disconnection from a range of health and support services.

Studies suggest that mental health disorders in PLHIV may interfere with treatment initiation and adherence and lead to poor treatment outcomes. The presence of mental health co-morbidities may affect adherence to ART because of forgetfulness or poor organization, motivation or understanding of treatment plans. Psychosocial support, counseling, appropriate drug therapies and interventions such as case management may help to improve adherence to ART and retention in care.

Peer navigators should be able to recognize signs of mental health issues during the intake assessment and understand how to provide support to their clients. The peer navigator should be able to effectively refer clients to mental health and other professionals. It is also important for the peer navigators to recognize that they, too, may experience negative mental health outcomes as a result of their work. The peer navigator training will provide skills to understand and manage mental health issues.

Action Plan Development

Following the intake assessment, peer navigators work with their clients to develop an action plan (Annex F). Social and behavior change communication tools that are specific to culture and key populations may also support action planning at this stage. Peer navigators should be careful to allow clients to identify their own needs and barriers, as the client is the expert in this regard. The peer navigator can make suggestions, but the priority goals are based on what the client identifies. In some cases, this may mean the client's needs and barriers have nothing to do with his/her HIV diagnosis; peer navigators should respect and work with the client to overcome identified barriers to the best of their abilities. The peer navigator should help the client develop realistic short- and long-term objectives and support him/her in determining appropriate steps and time lines. The peer navigator should help the client brainstorm potential challenges (or roadblocks) to these goals and strategize ways to overcome any potential challenges.

Peer navigators should continue to follow up with clients who identify few or no goals at the initial assessment, to assist with emerging needs. Remember that the goal of peer navigation is more than just providing direct assistance, and includes helping clients to develop skills, identify their own needs and gain access to services independently.

Peer navigators can refer clients to support groups as part of the action plan. Support groups are led by people trained in positive health and dignity to support anyone who is HIV-positive.

The next few visits are likely to be the most intensive, particularly for clients with high needs. During this time, peer navigators should encourage, support and help build the skills of their clients based on their specific needs and barriers. Peer navigators should regularly review and update the client's action plan as appropriate during each visit. In the first six months, case management staff and peer navigators may want to meet weekly to review cases and discuss recommendations. Based on the capacity of peer navigators and client outcomes, the review sessions can be held monthly after six months. At that time, peer navigators should begin ensuring that the client is in a more stable situation and has the skills and support to keep meeting his/her goals. Peer navigators should make sure that they link clients with all relevant services for any unmet needs. Clients with critical needs will be linked to case management services.

Forms Completed by Peer Navigators during Counseling and Testing

- Complete post-test counseling form including assessment form
- Provide the HIV and syphilis test results to the client on the prescribed card
- Indicate the date and place for follow-up testing on the card
- Refer people with positive HIV or syphilis results or inconclusive HIV results for confirmation and follow-up
- Immediately complete class 1 notification form for people with positive HIV or syphilis results or inconclusive HIV results, to be handed/sent to the contact investigator at the Parish Health Department within 24 hours
- Completed outreach forms should be submitted to the relevant supervisor

MODULE 4: REFERRALS AND LINKAGE⁸

- Follow MOH referral protocol
- Identify and accompany client to medical appointment and contact investigator
- Coordinate with case manager and social worker
- Serve as a knowledgeable resource on social and clinical services

Peer navigators will use the MOH-established referral and linkage process for people who have tested HIV-positive in an outreach setting. Per the protocol, the following steps are completed after post-test counseling:

NOTIFICATION: Within 24 hours, peer navigators will be responsible for informing the parish, regional and national disease surveillance systems when a new case of HIV is diagnosed. In Jamaica, HIV is a class 1 disease. It is critical to note that the class 1 notification form should be generated even if the individual is asymptomatic.

IDENTIFICATION OF APPROPRIATE HEALTH FACILITY: In an outreach setting, a referral will be made to an appropriate HIV testing site for a confirmatory HIV test as soon as possible. A referral form containing details of the client is produced and given to the client from the referring facility to submit to the facility he/she will attend. The peer navigator can accompany the client or can contact the focal point at the health facility.

Peer navigators will be able to refer to nongovernmental organizations, private providers or government health facilities (see Case Management Protocol for a list of all health facilities).

REFERRAL: The referral process should include helping patients connect to services, such as setting up appointments, accompanying a client, giving directions to facilities, sending contact details of clients to the referral facility and undertaking reasonable follow-up efforts to facilitate contact between the client and service providers in the referred facility.

ASSESSMENT: The peer navigator will orient clients on HIV care and treatment services and conduct a review of each patient's situation to identify barriers that he/she may face in getting follow-up care, such as location of treatment site (referral), financial constraints, substance use or mental health issues. Assessment will be used to develop a plan together with the client to address barriers identified, using resource available at the HIV treatment facility and the client's personal resources. These activities should happen on the same day of HIV testing (see Assessment and Action Plan in Module 3).

SAME-DAY APPOINTMENT SCHEDULING: On the same day of HIV testing, appointments should be scheduled for a doctor's visit and CD4 test for newly diagnosed HIV patients. If appointments are not scheduled on the same day of HIV testing, particularly for those clients who need to be referred to a different facility, appointment scheduling should be done no later than the day of the referral visit.

Training will be provided to peer navigators on the guidelines and tools to be used with their clients.

⁸ Referral and Linkage Protocol for HIV. 2014. National HIV/STI Programme Treatment, Care and Support Unit, Ministry of Health. Kingston, Jamaica.

Referral between Civil Society Organizations and Government Health Facilities

Health services for key populations are available both in government clinic sites and in select local organizations. Many clients are aware of community organizations, such as Jamaican AIDS Support for Life (JASL), that provide clinical care at their local offices. To ensure clients receive optimal care and will be motivated to return to care, they should be presented with options on where they can receive clinical care if they are HIV-positive. Should a client want to receive his/her health care at a community site or be transferred from an existing government clinic, a letter of referral would be the standard mechanism for referrals between government and community clinic sites. Peer navigators will need to follow the MOH protocol to ensure the referral is completed and documented.

Note: A referral is not complete until the client has reached his/her medical appointment.

Coordination

Case Manager

Each peer navigator will coordinate with the case manager assigned to a health facility. Should the position of case manager not exist at the clinical site, a social worker will be the main point of contact for a peer navigator. The peer navigator will inform the case manager (or social worker) of a newly identified HIV-positive client to receive services and will share information collected on the client's status and initial needs identified by the client.

Clients may cycle between having high-intensity and low-intensity needs. Some clients may begin with low-intensity needs and then develop needs that require more intervention from the peer navigator during the program. Together, the peer navigator and case manager/social worker will decide who is

Difference between Case Management and Peer Navigation

Supportive Case Management:* Supportive or non-medical case management includes advice and assistance in obtaining medical, social, community, legal, financial and other needed support services and is appropriate for people who are largely pre-ART or have uncomplicated medical profiles.

Comprehensive Case Management:* This type of management incorporates activities to promote and support client engagement in the HIV continuum of treatment and care, HIV viral suppression and a reduction in new infections.

Peer Navigation: Peer navigators perform outreach, counseling and testing plus ongoing follow-up to newly diagnosed clients to support clients across the continuum of care. Peer navigators provide similar services as supportive case management.

best suited to provide follow-up support to the client in these cases.

Some clients may already be accessing care and treatment services but are not routinely making their appointments as planned or are having difficulty adhering to ART. Peer navigators can alert the case manager to such clients as people at risk of being lost to follow-up, and case managers can judge the need for additional support from other team members.

An intake assessment and barriers checklist need to be completed with new incoming clients. Support and follow-up will also be provided to help clients be self-sufficient and independent in their medical care.

Social Worker

When reviewing the barriers checklist with the client, a peer navigator will identify barriers that may limit a client from accessing a health service. The barriers can range from financial to spiritual to other factors, such as those related to literacy or readiness of a client. A social worker may be in a better position to address these needs and to provide formal referral to social support programs. A peer navigator will share the barriers checklist with the social worker, and the checklist will inform an in-depth discussion between the social worker and the client. The social worker can also provide and coordinate formal referrals to receive select social services.

A peer navigator may need to coordinate with the social worker to confirm the client has reached services, and can be available to accompany the client to the desired services.

Below is a sample of social services that clients may need to access:

Type of Service	Name of Organization
Social security	PATH
Birth certificates	Registrar General Department
Welfare	Poor Relief
Food security/shelter	Food for the Poor
Education	Jamaica Foundation for Lifelong Learning

Note: The Ministry of Health Case Management Protocol has a list of social services and addresses.

Form Completed by a Peer Navigator during Referrals and Linkage

Referral Form: The MOH referral form is used for any formal referrals to a health facility.

MODULE 5: CARE AND TREATMENT SUPPORT

- Accompany client to medical appointment
- Ongoing follow-up
- Connect and network with HIV care team
- Adherence motivation
- Identify barriers to care
- Motivate PLHIV to return to care

At the health facility, peer navigators **will be assisting HIV-positive** clients to reach their medical appointments and facilitate follow-up support to improve retention in care and adherence to ART.

As applicable, peer navigators will accompany clients to the health facility for the first medical appointment. A peer navigator will ensure the client knows where to receive services in the health facility, provide support on the type of questions a client may ask to be better informed on his/her health and introduce the client to other members of the HIV

care team.

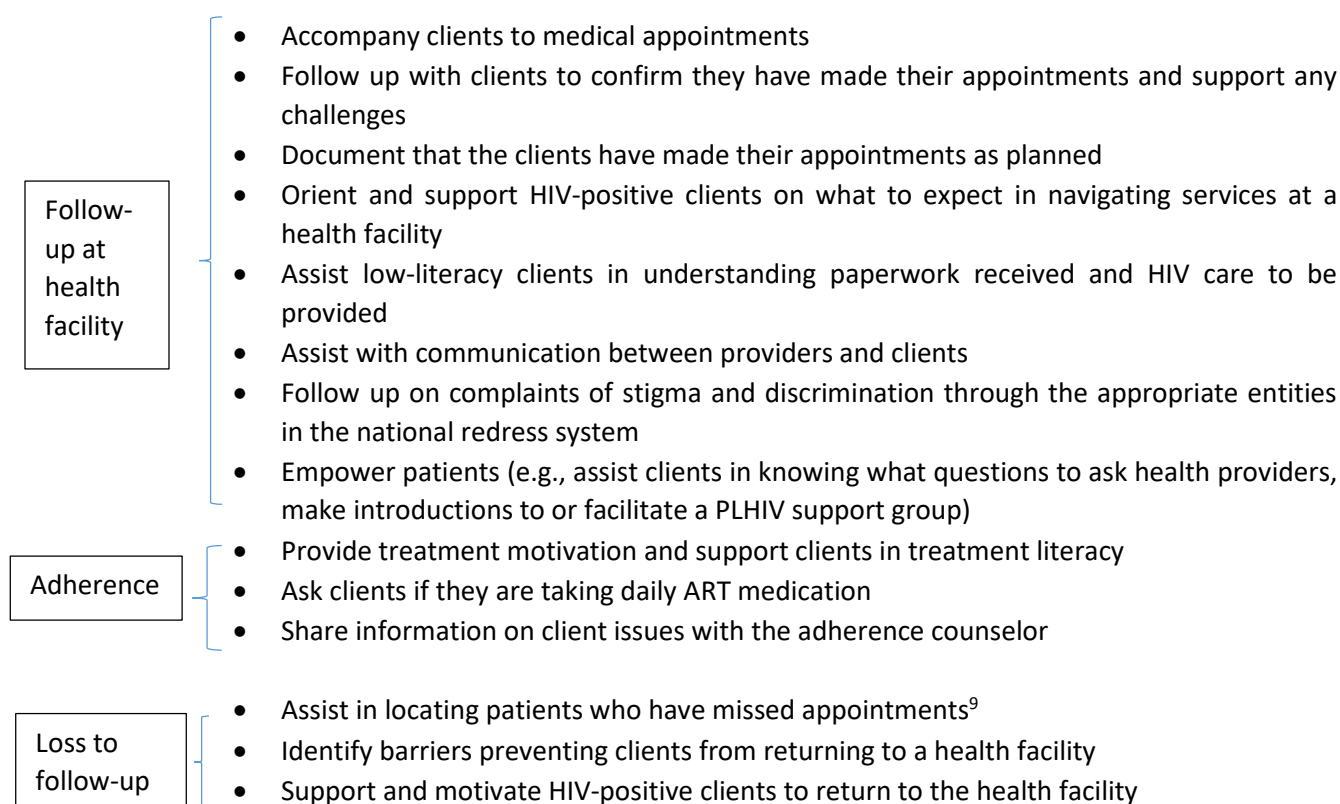
The HIV care team may vary by health facility. The peer navigator will need to prepare clients on the role of each HIV care team member and the value each member brings to support positive health outcomes. Relationships between the peer navigator and members of the care team will be important to facilitate navigation among the various services a client may receive. The peer navigator can physically take the client to meet with each provider or, at a minimum, provide guidance and support to ensure the client can make his/her appointments as planned and understands the value of routine follow-up with each provider.

To ensure clients have access to a range of services, a diverse set of service providers will be made available. However, depending on the needs of a client, he/she may not need to meet with all providers who are part of the HIV care team, described below:

- *Case Manager*: Provides case management oversight and coordinating role for care and treatment services to newly diagnosed patients
- *Contact Investigator*: Responsible for HIV confirmatory test and has the important role of linking the patient with the health care system
- *Social Worker*: Represents the link between newly diagnosed patients and support services that are essential for initial engagement in care
- *Psychologist*: Provides a core element in a holistic model of health care, in which psychosocial issues are recognized as an integral part of managing the patient
- *Adherence Counselor*: Supports the client in care and treatment adherence by teaching him/her about treatment literacy, and provides support for the client to incorporate treatment in his/her lifestyle
- *Liaison Officer*: Acts as a critical support to other members of the health care team in providing treatment, care and support services
- *Nutritionist*: Provides information on healthy eating habits and overall nutrition needs to minimize complications of taking ART

A peer navigator will be an essential link across all clinical services a client may receive. A peer navigator is not expected to be an expert in each of the services but rather a facilitator and support mechanism to

ensure that a client is aware of the services he/she needs for routine care and to address barriers that may keep the client from returning to clinical care. A sample of tasks to be completed by a peer navigator in a health facility are listed below:



Peer Navigation is NOT intended:

- To provide clinical information or diagnosis to the client or family
- To provide counseling for or diagnose a mental illness
- To be a sole source of support for a client

Case Conferences

To ensure services provided to a client are holistic, coordinated and integrated across providers, HIV care teams will participate in case conferences. A peer navigator will be part of this case conference team and will be able to share information on the clients he/she is following.

Note: Case conference guidelines are available in the Case Management HIV/AIDS Protocol.

Monitoring and Follow-up

The responsibility of confirming the client has reached the health facility to make his/her first and subsequent appointments will be task-shared between the peer navigator and contact investigator. The peer navigator will also provide routine follow-up and guidance to support positive health-seeking behaviors.

⁹Patient Retention and Recovery Standard Operating Procedure, National HIV/STI Programme Treatment, Care, and Support Unit Ministry of Health, October 2013.

Initially, meeting with clients will be more frequent (once a week) to help a client adjust to his/her diagnosis. During this time, a client may need spiritual comfort or psychosocial support, which can form referrals made by the peer navigator to specialized services. Over time, a peer navigator may want to meet with clients once a month to review the action plan (see Action Plan Development in Module 3: HIV Counseling and Testing) and to ensure their medical appointments are met with minimal challenges. When a client has been initiated on ART, the peer navigator can check in to ensure the client has adjusted to taking routine medication.

The following is a sample routine a peer navigator may want to use for follow-up:

Month 1: Weekly calls, one-on-one check-ins with the client. During this time, a peer navigator is providing additional support to the client in accepting his/her HIV-positive diagnosis, ensuring medical appointments are being met and re-visiting the action plan agreed upon during the initial assessment.

Months 2-3: Bi-weekly or monthly check-ins with the client. These can be via phone or in person depending on the client's needs. Ongoing check-in to ensure client is making medical appointments and meeting with the HIV care team. If the client is on ART, the peer navigator can support the client to transition to medication. Ongoing follow-up on the action plan.

Months 4-12: Monthly check-in on the client via phone or in person. This is used to confirm the client is making his/her medical appointments, taking his/her medication and completing items agreed upon in the action plan.

Months 12+: Semi-annual to yearly check-in on the client to ensure there is no relapse and that the client continues to access health facility services and can stay on ART.

Forms Completed by Peer Navigator during Treatment, Care and Support

- Tracking Form: A peer navigator should use a simple tracking form to track clients and document that they have reached appointments as planned (see Annex G).
- Ongoing Action Plan Review: A peer navigator should review the agreed-upon action plan with the client during each meeting to know how much he/she has accomplished and what barriers are being faced. The plan will also help assess a client's ability to attain self-sufficiency.

MODULE 6: SUPERVISION

The peer navigator is a member of the prevention/BCC team, the HIV care team, or both.

In the outreach setting, the **primary job supervision** will be provided by the targeted interventions officer/BCC officer, who will meet routinely with the peer navigator to review his/her caseload, manage time between community and facility-based services, identify challenges and support the peer navigator to be successful in his/her role.

The performance of each peer navigator should be monitored using established procedures and reviewed on a regular schedule. Programs will determine a plan for access to emergency clinical supervision in the case of a critical situation. The supervisor will determine in advance how peer navigators should handle working hours and appropriate locations for meetings, as well as how peer navigator schedules will be tracked.

Within a health facility, the case manager (or social worker) will be the **main point of contact** for the peer navigator. The case manager will review the caseload with the peer navigator to ensure that the clinic has a complete list of newly diagnosed patients, and will discuss any challenges a peer navigator may have within his/her current caseload. Should clients have needs beyond the skills of the peer navigator, a determination will be made in discussions with the case manager, who should be the primary lead to support the client.

Caseload

The caseload of the peer navigator will be the total number of HIV-positive clients for which the peer navigator is responsible for providing ongoing follow-up for a finite period.

An ideal caseload is 20-30 HIV-positive clients per peer navigator per year. Within this caseload, client needs will vary, with some clients transitioning and becoming self-sufficient in a shorter period than other clients. Review of the caseload with the targeted interventions officer/ BCC officer and case manager should be routine to minimize burnout and overload of the peer navigator.

Care for Caregivers

The strains of working with HIV-positive clients can be heavy. Stress and burnout are common among staff who work in this field because of heavy workloads, lack of support or recognition, fear of stigma and many other factors that can influence the morale and well-being of health care workers. Stress and burnout should be monitored, and outlets should be provided to staff to share their experiences so they do not feel alone or carry the burden on their own.

Every month, peer navigators should come together to share experiences in working with their clients. Each meeting should be a safe space where what is disclosed is not shared outside of the group, and staff should feel comfortable to speak candidly and honestly about any stressors experienced. Specific names of clients should be kept to a minimum to avoid breaching confidentiality and trust with a client.

Peers should also feel comfortable sharing their experiences with other peers or with their supervisor in the event of an immediate or critical situation. Supervisors need to encourage the peer navigators to share rather than to carry the burden of the experience, to minimize any long-term emotional buildup.

MODULE 7: TRANSITION AND SELF-SUFFICIENCY

It is important to inform each client early on that there will be an end to peer navigation services. The goal of peer navigation is for clients to be self-sufficient in managing their care. Planning for self-sufficiency or self-management of care should start at the first conversation with a client. When a client meets criteria for self-sufficiency, a recommendation will be made to the case manager to transition the client off peer navigation. A client will remain in the system with annual follow-up provided by the case manager to ensure that the client doesn't relapse over the long term.

Self-sufficiency is achieved when a client has demonstrated the following:^{10,11}

- Is able to track symptoms
- Is able to determine what to do when symptoms cause problems
- Has adopted healthy behaviors
- Is taking medications as prescribed
- Is scheduling and keeping doctors' and other appointments and lab visits

Have a Plan

As the transition period approaches, the peer navigator and client should discuss how the remaining goals of the action plan, if any, will be met or plan together for how the goals can be met afterwards. The peer navigator should think in advance about what the client has accomplished and what goals are outstanding, and should have a plan in mind for how the last visit will go.

Make it Collaborative

Engagement with the client occurs through the collaboration of goal setting. Inviting the client to brainstorm and set his/her goals allows for more ownership of the goals. The peer navigator is encouraged to help set the time line for the goals, but ultimately should help the client take ownership of his/her personal goals. Drafting a plan for and with the client is vital to the peer navigator process.

Accomplishments

Progress and success are not objective — rather, they are dependent on the individual. The goal of the peer navigator is to applaud and praise successes the client has attained and to help the client recognize what he/she has achieved. These successes may be as simple as showing up for and participating in a peer navigator session, or beginning to recognize and discuss with another person what needs he/she has. Developing a trusting relationship with the peer navigator may be a significant accomplishment for the client. Other successes may include the reduction of risky sexual behavior, the reduction of drug use or the maintenance of adherence. Focusing on strengths and accomplishments may be the impetus to move forward. Putting these accomplishments on paper for the client to take with him/her can make the successes more “real,” and can help provide closure to the relationship.

¹⁰ Jamaica HIV/AIDS Case Management Protocol, Prepared for World Learning, August 20, 2015.

¹¹ Pearson ML, Mattke S, Shaw R, Ridgely MS, Wiseman SH. Patient Self-Management Support Programs: An Evaluation. Final Contract Report (Prepared by RAND Health under Contract No. 282-00-0005). Rockville, MD: Agency for Healthcare Research and Quality; November 2007. AHRQ Publication No. 08-0011.

Address Unresolved Needs

Some clients may have unresolved needs. At the last official encounter, it is important to identify these needs and to collaboratively plan the steps the client may take to meet those needs, including referrals to available community resources. Putting these not-yet-met goals on paper for the clients to take with them may help them stay focused once they are on their own, and may help them perceive their outstanding needs as manageable. The case manager will retain all records used by the peer navigator.

Determination for Transition

When a client has achieved self-sufficiency per the criteria above and has reached the goals agreed upon in the action plan, he/she is ready to transition off peer navigation services. A peer navigator will make a recommendation to the case manager (or social worker). At the last meeting between a peer navigator and client, the following steps will take place:

- Review and celebrate accomplishments
- Identify remaining challenges and how those might be met
- Provide referrals
- Document closure of the relationship (see Annex H)

Once a client has transitioned off of peer navigation, the case manager (or social worker) will be responsible for any follow-up.

MODULE 8: CONFIDENTIALITY AND DO NO HARM

Confidentiality

The fact that peer navigators work off-site and interact on the clients' behalf with health care providers and others who are not necessarily program staff may increase the risk of a breach in confidentiality of client information. Each peer navigator will sign an employment agreement that includes a confidentiality clause to protect the disclosure of information related to any client met during the period of employment.

Peer navigators should therefore receive extensive training and follow strict procedures to safeguard confidential information. Programs should develop procedures for ensuring that peer navigators do not remove materials with client-identifying information from program sites. Peer navigators who are meeting a client off-site should carry only de-identified notes or contact information.

Peer navigators may also be members of the same community as their clients and therefore may encounter clients in social settings. They should take care in approaching clients during these situations and should be careful not to reveal a client's participation in the program to anyone without the consent of the client. Clients and peer navigators may have a pre-existing relationship or share acquaintances. Every effort should be made to ensure that the peer navigator and client are comfortable in their working relationship. Where necessary, it may make sense to re-assign peer navigators if relationship boundaries are unclear or stressed.

Do No Harm

Peer navigators are to follow a "do no harm" policy. Engagement in a sexual relationship with clients will be prohibited. A peer navigator should show professionalism at all times. The nature of the discussions and empathy provided by a peer navigator may create feelings of emotional attachment. In situations in which a peer navigator is not able to perform his/her duties, he/she will need to discuss with the supervisor whether there is another peer navigator who would be better suited to provide support to the client.

MODULE 9: ADDITIONAL CONSIDERATIONS FOR KEY POPULATIONS

In Jamaica, key populations are disproportionately impacted by HIV. Biological surveillance studies show higher HIV prevalence among key populations, including men who have sex with men (MSM) (32.8 percent) and female sex workers (2.9 percent), with a prevalence of 7.0 percent among street-based sex workers. The MOH prevalence data for other vulnerable populations include 12.0 percent among homeless people and 2.5 percent among inmates, according to the Global AIDS Response Progress Report of 2014. National surveillance data for the period 2010–2012 show that 4 to 7 percent of adult clients admitted to hospitals were HIV-positive, and the prevalence at STI clinics was 2.4 percent. Although injecting drug use has not been identified as a significant mode of transmission, there have been increasing reports of HIV transmission via the sharing of contaminated needles. There are no specific data on HIV or other STI epidemiology for transgender individuals.¹²

To reach the goal of improved retention and viral suppression among key populations, barriers to care need to be addressed. HIV-related stigma and discrimination continue to undermine efforts to reduce the spread of the virus in Jamaica. Perceived associations with HIV, homosexuality and sex work engender stigma and discrimination and expose MSM and sex workers (SWs) to “layered” stigma — the discrediting of people based on both their HIV status and their sexual practices. This discourages MSM and SWs from using health services, making it harder for HIV prevention interventions to reach them and restricting their access to HIV information and treatment.¹³

Losses are higher among key populations at every step of the HIV care continuum.¹⁴ Specific guidance to help peer navigators promote services that are friendly to key populations and minimize losses are included below, by type of intervention:

Community

- Provide services free of judgment or prejudice
- Provide condoms and lubricants
- Educate and promote routine testing for STIs among key population groups who are at higher risk
- Provide voluntary HIV counseling and testing free from coercion, especially for persons whose behavior is criminalized
- Intensify post-test counseling combined with follow-up counseling to increase the proportion who enroll in HIV care
- Promote STI screening, diagnosis and treatment

¹² LINKAGES Work plan. Linkages Across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES) Project, October 1, 2015 – September 30, 2016.

¹³ Brown A, Tureski K, Bailey A, Rogers S, Cushnie A, Palmer Q, Adelaja A. Layered Stigma among Health Facility and Social Services Staff toward Most-at-Risk Populations in Jamaica. Washington, DC: C-Change/ FHI360; 2012.

¹⁴ <http://www.who.int/hiv/pub/guidelines/keypopulations/en/>

Link to Care and Social Support

- Be aware of psychological and social barriers that hinder linkage to care for people newly diagnosed with HIV
- Be aware that key populations experience higher rates of depression, anxiety, smoking, harmful alcohol use and alcohol dependence, other substance use and suicide because of chronic stress, social isolation, violence and disconnection from a range of health and support services

Health Facility

- Be aware of client-specific barriers that may affect access to health care services
- Be aware of how PLHIV perceive both their own health and the effectiveness of ART on their well-being, as their perspective may affect their willingness to seek clinical care
- Provide ongoing encouragement and support to key populations to access health care services
- Provide feedback to health providers on stigma and discrimination experienced by PLHIV/key populations
- Provide follow-up and support on the use of the redress system
- Promote confidentiality

Love, Sex and Relationships

Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all people must be respected, protected and fulfilled.

Promoting positive sexual health messages will encourage a person to be aware of his/her current health and to notice any changes that may occur soon after a sexual encounter. The more comfortable a person is with his/her sexuality, the easier it will be for him/her to make decisions about when to seek medical attention. Longer-term health prevention is also important to encourage positive health-seeking behaviors and encourage planning for routine check-ups.

In working with key populations, love, sexuality and relationships should be part of a positive sexual health approach. Peer navigators will need to develop a comfort level to discuss sexual orientation, sexual identity, gender identity, basic reproductive organ anatomy and sexual practices.

The peer navigation training will be an opportunity for peer navigators to practice these skills and to develop comfort and confidence in discussing sex, love and relationships with clients — particularly those from key populations.

ANNEX A: PEER NAVIGATOR TERMS OF REFERENCE

OVERALL OBJECTIVE OF PEER NAVIGATION SYSTEM

NFPB's peer navigation is a component of the broader behavior change program. It engages members from the key populations of SWs, MSM, transgender individuals and PLHIV. These members assist their peers to adopt healthier behaviors to reduce risk of and vulnerability to HIV/AIDS and other STIs, and to improve their sexual and reproductive health outcomes. The peer navigator will formalize services and links to be provided from community to clinical settings for people who are HIV-positive, and will build upon existing relationships formed during community outreach or HIV testing. A peer navigator will be expected to accompany an HIV-positive client on his/her journey toward the goal of viral suppression.

SCOPE OF WORK

A peer navigator is defined as an HIV champion, friend, sounding board, health educator, facilitator for health care, guide, coach, advocate, case finder and community resource. A peer navigator identifies barriers in accessing prevention, care and treatment services and is a connector to health care staff or services who can address barriers. He/she may be an HIV-positive, medication-adherent role model who shares experiences and community membership with the populations with which he/she works.

SPECIFIC DUTIES

1. Identify, reach and mobilize members of the target populations for HIV/syphilis testing
2. Provide HIV/syphilis testing during outreach
3. Accompany clients to treatment sites (*required for the first visit*)
4. Navigate health services, as required by clients, and ongoing follow-up
5. Follow up with health care providers regarding client visits
6. Meet regularly (based on need and agreed-upon schedule) with clients to help connect and keep them enrolled in treatment services
7. Empower the target population to overcome barriers to accessing health care
8. Use the referral protocol to link participants to appropriate social services
9. Assist clients in getting prescriptions filled, and provide adherence motivation
10. Build professional contacts and remain on top of changes in organizations providing services
11. Act as a peer supporter during enrollment and follow-up visits
12. Ensure that clients manage and meet their appointments
13. Maintain contact with health care workers to monitor progress of clients
14. Assist with relevant training sessions, with the support of the targeted interventions officer/liaison officer
15. Attend relevant interventions for monitoring and evaluation purposes
16. Attend weekly/monthly meetings with health facilities as required
17. Assess the contraceptive needs of clients and refer appropriately as needed
18. Perform other program-related duties as assigned

DELIVERABLES/PERFORMANCE STANDARDS

1. Prepare and submit weekly work schedules to the targeted intervention officer or case manager/social worker
2. Prepare and submit monthly reports to the targeted intervention officer or case manager/social worker
3. Identify sites for targeted interventions
4. Link a minimum of four clients to treatment sites per month
5. Conduct follow-up with five clients per month

Note: The specific duties listed above are intended to describe the normal duties of this job. The list is not intended to be exhaustive.

EDUCATION/QUALIFICATIONS

- Five CXC/O'Levels
- One year of experience working among the targeted communities/PLHIV
- Two years of experience in a BCC or public health program for marginalized populations or comparable experience is an asset
- HIV, family planning and sexual reproductive health training is an asset
- Previous training in positive health dignity and prevention is an asset

KEY COMPETENCIES

- Confident, open-minded, dependable and non-judgmental
- Excellent networking skills
- Oral and written communication skills, along with group facilitation and counseling skills
- Understands health care system
- Ability to develop, plan and implement short- and long-term goals
- Ability to coordinate and implement multiple projects and events
- Ability to handle a large workload in a professional and timely manner
- Skill in establishing priorities and organizing resources
- Ability to use independent judgment and to manage and impart confidential information
- Ability to work professionally and cooperate with team members and representatives of other agencies
- Excellent report writing skills
- Ability to use Microsoft Office (specifically Word and Excel)
- Ability to work on own initiative with minimum supervision
- Good work ethic
- Flexible and adaptable

SPECIAL CONDITIONS ASSOCIATED WITH THE JOB

- Available to work weekends, late nights and public holidays when necessary

ANNEX B: DIFFERENCE BETWEEN A PEER EDUCATOR AND A PEER NAVIGATOR

	Function	Peer Navigator	Peer Educator
Community	Serves as HIV+, treatment-adherent role model	X	Optional
	Represents one or more key populations	Not required	X
	Conducts community outreach	Optional	X
	Provides essential commodities like condoms and lubricants	X	X
	Conducts motivational interviewing	X	X
	Develops trusting relationships with clients	X	X
	Identifies health and social support needs of clients	X	
	Agrees on goals to be achieved with clients	X	
	Links clients to clinical and social support services	X	
	Monitors progress clients are making toward goals	X	
Clinical	Provides post-test guidance on available diagnostic and clinical services	X	
	Supports clients to complete referrals to clinical services for HIV+ clients	X	
	Provides routine follow-up for clients	X	
	Supports clients to maintain treatment adherence	X	
	Supports clients to make medical appointments	X	
	Provides input and experience on positive living and on prevention for sexual partners	X	

ANNEX C: LIST OF HIV-RELATED STAFF

Peer Link: Is a member of a key population group (e.g., MSM, SW) who can serve as a trusted resource in the community. He/she will meet with members of the key population group to mobilize and refer peers to a peer navigator to conduct one-on-one prevention sessions. A peer link will use recruitment techniques such as snowballing or social media outlets to reach into networks of existing key population groups. Peer links are not active in all parishes and can be funded by government and civil society organizations.

Community Health Aide:¹⁵ Is an auxiliary health worker who can fulfill basic functions at the community level. He/she can provide home visits and is trained to provide basic health services (e.g., taking temperature, weighing and measuring patients). Given his/her knowledge of the community and community members, he/she can serve as a resource to identify hot spots or areas for community-wide HIV prevention programs. Peer navigators may want to coordinate and introduce themselves to community health aides in the communities where they will be working (as applicable).

Contact Investigator: Is a member of the HIV care team. He/she conducts post-test counseling (if the tester); generates class 1 notification forms and submits them to the medical officer of health and MOH surveillance unit; generates confidential reporting forms and submits them to the medical officer of health and MOH surveillance unit; traces contacts; liaises with the post-test counselor to link patients to appropriate treatment sites; refers patient to other treatment sites as required, using the referral form under the referral and linkage forms section; documents outcomes of the referral and linkage forms; ensures that patients have an appointment on the same day of testing; follows up with patients to ensure that the appointments are kept and monitors the referral and linkage process.

Social Worker: Is a member of the HIV care team. He/she conducts comprehensive assessments to identify the social, emotional and economic factors that are barriers to linkage; addresses identified barriers, which may include referring patients to support services in collaboration with the liaison officer; documents the outcomes of referrals to other support services; documents relevant information about appointments and establishes and maintains contact among patients, relatives, treatment sites and other relevant institutions in collaboration with the liaison officer.

Adherence Counselor: Is part of the HIV care team. He/she orients the new clients to treatment sites; makes recommendations about the most effective approaches to ensure that PLHIV adhere to care and treatment; closely monitors and follows up with the patient to ensure that appointments are kept and other aspects of treatment are adhered to; provides the necessary psychological support to PLHIV and their caregivers to improve efficacy in meeting these needs while the patient is on ART and tracks patients who are lost to follow-up.

Psychologist: Is a member of the HIV care team. He/she provides psychosocial counseling and guidance; provides services that assist PLHIV and their families; recommends, selects and arranges services and provides conditions favorable to PLHIV; maintains contact with referral agencies to provide ongoing

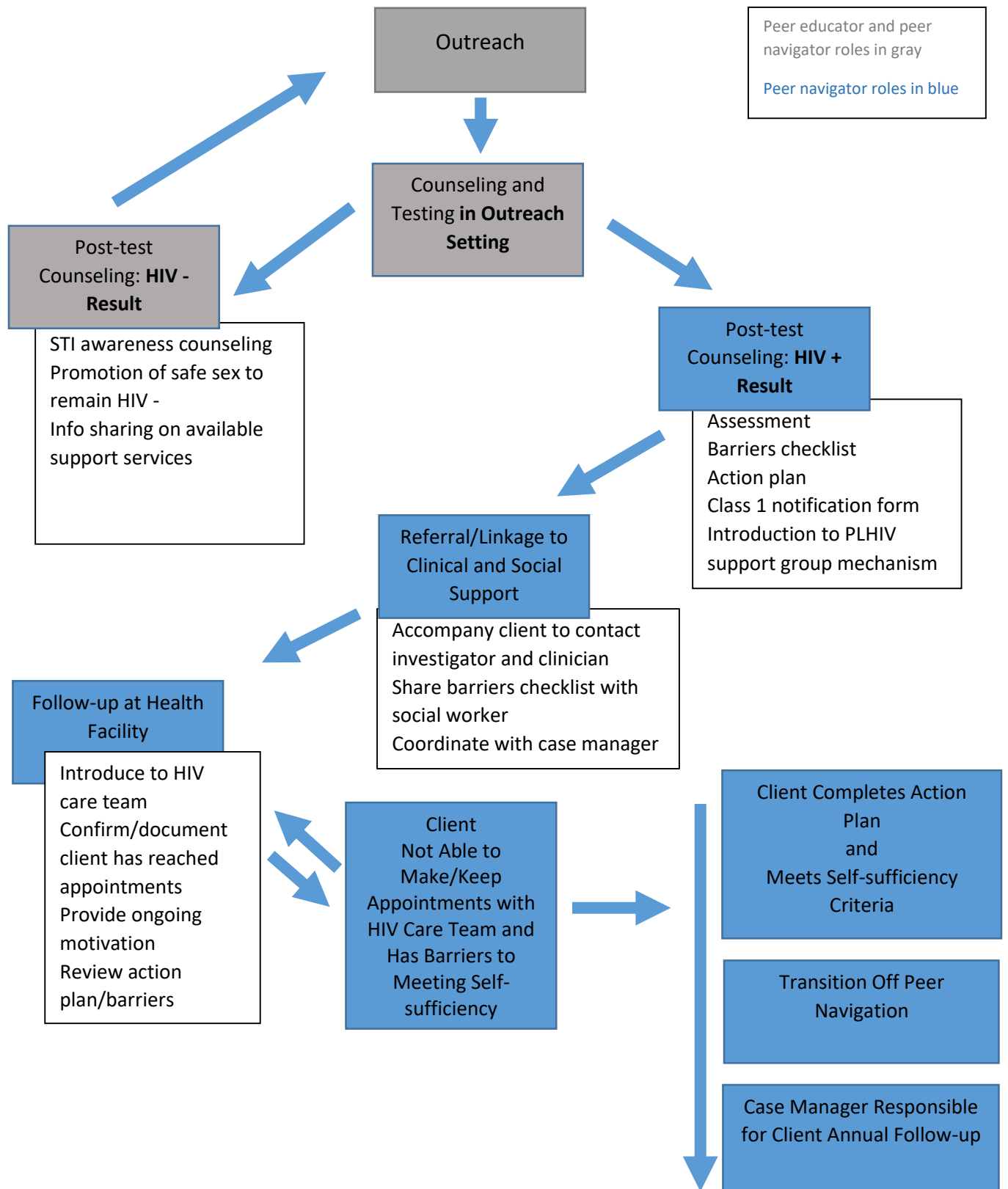
¹⁵ <http://www.poline.org/node/390292>

communication between the regional health authorities and their treatment agencies and provides communication with and acts as a liaison to social agencies/agents of the state.

Liaison Officer: Is a member of the HIV care team. He/she facilitates linkage of PLHIV (newly diagnosed) to treatment and care services; promotes, among health care workers, the establishment of PLHIV peer support groups at treatment sites and at the community level and facilitates access and referral to treatment and support services for PLHIV and addresses individual patient barriers.

Nutritionist: Is a member of the HIV care team. He/she screens for nutritional deficiencies and provides guidance to improve individual nutrition among clients who are HIV-positive and on ART.

ANNEX D: FLOWCHART OF SERVICES



ANNEX E: INTAKE ASSESSMENT AND BARRIERS CHECKLIST

Sample Patient Intake Form

Unique Identification Code: _____

Name _____ Birth Date _____ / _____ / _____

Street Address _____

Email _____

Phone Numbers: Home () _____ Work () _____ Cell () _____

Sex at birth:

Gender:

- ☐ Female
- ☐ Male
- ☐ Prefer not to answer
- ☐ Other _____

Can you tell me a little bit about your current living situation?

- ☐ Please circle all that apply: own, rent, roommates, live at workplace (brothel), homeless, live alone, live with someone
- ☐ If living with someone, how is that relationship going? How long have you been in the current relationship?
- ☐ Are you currently homeless or have been homeless at any time in the past 6 months?

Tell me about your current partner(s):

- ☐ Type of partner (circle): male, male and female, transgender
- ☐ HIV status of partners: _____
- ☐ Number of partners in the past 6 months: _____
- ☐ Condom use (circle): sometimes, always, never

Tell me how you would rate your own health?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Do you have any chronic medical conditions?

- ☐ Asthma
- ☐ Hypertension
- ☐ Diabetes
- ☐ Heart disease
- ☐ Kidney disease

- ☐ Cancer
- ☐ Severe dermatitis
- ☐ Epilepsy
- ☐ Arthritis
- ☐ Sexually transmitted infections
- ☐ Other

Where do you go for health care?

- ☐ Government health facility
- ☐ Nongovernmental organization clinic
- ☐ Private provider
- ☐ Other _____

What helps you to visit a health facility? Is there a person or action you take to encourage you to visit a health facility?

Barriers Checklist¹⁶

Would the following be barriers to accessing health services?

<p>Financial and Social Support</p> <ul style="list-style-type: none"> <input type="checkbox"/> Food/nutrition <input type="checkbox"/> Housing <input type="checkbox"/> Lack of clothing <input type="checkbox"/> Transportation <input type="checkbox"/> Utilities <input type="checkbox"/> Substance abuse <input type="checkbox"/> No documentation/birth certificate <input type="checkbox"/> Welfare <input type="checkbox"/> Child care <input type="checkbox"/> Other 	<p>Cultural, Spiritual and Distress</p> <ul style="list-style-type: none"> <input type="checkbox"/> Beliefs conflict with treatment <input type="checkbox"/> Difficulty coping with diagnosis <input type="checkbox"/> Difficulty coping with treatment <input type="checkbox"/> End of life concerns <input type="checkbox"/> Lack of support <input type="checkbox"/> Negative perceptions of medical team <input type="checkbox"/> Mental health <input type="checkbox"/> Spiritual crisis <input type="checkbox"/> Stigma/discrimination <input type="checkbox"/> Treatment-related depression or anxiety <input type="checkbox"/> Other _____
<p>Other</p> <ul style="list-style-type: none"> <input type="checkbox"/> Non-literate or low-level literacy <input type="checkbox"/> Unemployed <input type="checkbox"/> No understanding of ART <input type="checkbox"/> Unable/unwilling to work through treatment <input type="checkbox"/> Difficulty making an appointment <input type="checkbox"/> Prefer to access health facilities away from your place of residence 	

Note: This will be shared with the social worker and kept in his/her files. The peer navigator will debrief the social worker on issues identified.

¹⁶ Adapted from Oncology Patient Navigator Training: The Fundamentals. George Washington University Cancer Institute, 2015.

ANNEX F: EXAMPLE OF CIVIL SOCIETY PATIENT INTAKE ASSESSMENT FORM

We'd like to welcome you as a new patient. Please take the time to fill out this form as accurately as possible so we can most appropriately address your health needs.

Name: _____

Date of birth: _____

Address: _____

Sex/Gender: M F Intersex Transgender _____

Home Tel (____) ____ - ____

Next of Kin _____

Work Tel (____) ____ - ____

Highest level of education attained: _____

Email address: _____

Do you live with anyone? Y N

Do you feel safe at home? Y N

Occupation _____

HIV status _____

Date of positive result (if applicable) _____

Medical History

Please check all that apply.

____ Emphysema ____ Tuberculosis ____ Pneumonia ____ Bronchitis ____ Asthma ____ Allergies ____ Heart Disease ____ Stroke ____ High blood pressure ____ Elevated cholesterol ____ Diabetes ____ Venous thrombosis ____ Hepatitis A ____ Hepatitis B ____ Hepatitis C ____ Cirrhosis ____ Anaemia ____ Thyroid trouble ____ Gallbladder disease ____ Ulcers ____ Frequent urinary tract infections ____ Sexually transmitted infections ____ Prostate trouble ____ Cancer ____ Arthritis ____ Osteoporosis ____ Fractures ____ Migraines ____ Depression ____ Anxiety or panic disorder ____ Posttraumatic stress disorder ____ Alcohol or substance use problem

General: ____ Recent weight loss ____ Recent weight gain ____ Fatigue ____ Fever ____ Changes in appetite ____ Night sweats

Skin: ____ Rashes ____ Lumps ____ Itching ____ Dryness ____ Color change ____ Hair or nail change

Head: ___ Headaches ___ Head injuries ___ Dizziness

Eyes: Date of last exam: ___/___/___

___ Glasses ___ Contacts ___ Pain ___ Double vision ___ Redness ___ Glaucoma ___ Cataracts

Nose: ___ Frequent colds ___ Nasal stuffiness ___ Hay fever ___ Nosebleeds ___ Sinus trouble
___ Sust/animal allergies

Ears: ___ Hearing loss

Mouth & Throat: Date of last dental exam: ___/___/___

___ Bleeding gums ___ Frequent sore throats ___ Hoarseness

Neck: ___ Goitre ___ Lumps/swollen glands ___ Pain

Breasts: Date of last mammogram: ___/___/___

___ Lumps ___ Pain ___ Nipple discharge

Respiratory: ___ Cough ___ Wheezing ___ Shortness of breath ___ Coughing up blood

Cardiac: ___ Heart murmur ___ Chest pain ___ Palpitations ___ Swelling of feet ___ Shortness of breath

Gastrointestinal: ___ Trouble swallowing ___ Heartburn or gas ___ Nausea ___ Vomiting ___ Rectal
bleeding ___ Constipation ___ Diarrhoea ___ Abdominal pain ___ Haemorrhoids ___ Jaundice (skin or
whites of eyes turning yellow)

Urinary: ___ Frequent urination ___ Painful urination ___ Blood in urine ___ Stones ___ Difficulty urinating
or difficulty holding urination ___ Waking up to go to the bathroom several times at night

Musculoskeletal: ___ Joint stiffness ___ Arthritis ___ Gout ___ Backache ___ Muscle pains ___ Muscle
cramps

Peripheral Vascular: ___ Leg cramps while walking ___ Varicose veins ___

Neurological: ___ Fainting ___ Blackouts ___ Seizures ___ Weakness ___ Numbness ___ Tremors
___ Tingling hands or feet ___ Change in memory

Psychiatric/Psychological: ___ Anxiety ___ Depression ___ Phobias ___ Family problems ___ Tating
disorder

Endocrine: ___ Heat or cold intolerance ___ Excessive sweating ___ Excessive hunger ___ Excessive
urinating

Do you experience chronic pain? Yes No

If YES, **Current Medications:** (Please include any non-prescription drugs as well (e.g., vitamins, aspirin)
Medication Name/Dose. _____

Family Medical History

Please check all that apply.

☐ Stroke ☐ Heart disease ☐ High blood pressure ☐ Thyroid disease ☐ Kidney disease
☐ Diabetes ☐ Arthritis ☐ Osteoporosis ☐ Migraine headaches ☐ Alcoholism ☐ Asthma
☐ Depression ☐ Anxiety ☐ Cancer/Type(s): _____

Sexual Orientation & Sexual History

How do you identify in terms of sexual orientation? _____

Are you attracted to (check all that apply): ☐ Men ☐ Women ☐

Transgendered Men ☐ Transgender Women ☐

Have you had sex with (check all that apply): ☐ Men ☐ Women ☐ Transgendered Men
☐ Transgendered Women

Please check any of the following infections that you have had: ☐ Syphilis ☐ Gonorrhea ☐ Pelvic inflammatory disease ☐ Herpes ☐ Trichomonas ☐ Genital warts

Have you ever taken birth control pills? Yes, for _____ (how long?) No ☐

Are you currently pregnant or planning to become pregnant? Yes No ☐

Lifestyle & Health Habits

Do you follow a special diet? Yes No ☐

Substance Use History

How many drinks containing alcohol do you have, on average, per week? _____

Have you ever been concerned about your drinking? Yes No Not sure ☐

ANNEX G: ACTION PLAN

Unique Identification Code: _____

Name: _____

Date	Identified Need	Client Will...	Responsible Person	Time Line	Status

Things that could make it difficult to achieve my goals include:

My plan for overcoming these difficulties includes:

My confidence that I can achieve my goal:

1	2	3	4	5
Very Not Confident	Not Confident	Neutral	Confident	Very Confident

ANNEX H: SAMPLE TRACKING FORM¹⁷

Unique Identification Code: _____

Name: _____

Name of Referred Health Facility: _____

No	Type of Service	Date	Date of Follow-up Visit	Date of Follow-up Visit	Date of Follow-up Visit	Date of Follow-up Visit	Date of Follow-up Visit	Comments
1	Met with Medical Doctor							
2	Met with Contact Investigator							
3	Met with Social Worker							
4	Met with Psychologist							
5	Met with Nutritionist							
6	Performed Viral Load Test							
7	Performed CD4 Count							
8	Met with Adherence Counselor							
9	Other							
10	Other							

¹⁷ Type of service can be tailored to the client's needs.

ANNEX I: TRANSITION FORM

Unique identification code: _____

Peer navigator: _____

Enrollment date: _____ Date of first visit: _____

Date of last visit: _____ Total number of peer navigator encounters: _____

In the past 6 months, the client (please tick):

- ☐ Has been able to track symptoms
 - Nausea
 - Fever
 - Weight loss
 - Extreme fatigue
 - Diarrhea for more than a week
- ☐ Has been able to determine what to do when symptoms cause problems
 - Made a medical appointment with doctor on own
 - Shared symptoms with adherence counselor (if on ART)
- ☐ Has adopted healthy behaviors
 - Has good nutrition
 - Has reduced substance use (including alcohol intake)
 - Appears to show joy, happiness
- ☐ Has been taking medications as prescribed
 - Has taken ART consecutively for the past 30 days
- ☐ Has been scheduling and making doctors' appointments and lab visits
 - Visited doctor and labs as planned

Goals achieved per the action plan:

- ☐ Yes
- ☐ No
- ☐ Partial (with comments)

Comments:

Recommendation:

ANNEX J: HEALTH FACILITY CHECKLIST

Has the peer navigator done the following?

- ☐ Completed an intake assessment
- ☐ Completed a barriers checklist and shared with social worker
- ☐ Accompanied clients to medical appointment
- ☐ Followed up with clients to confirm they have made appointments
- ☐ Understood barriers as to why clients are not returning to care
- ☐ Provided support if clients missed appointments (phone call)
- ☐ Made a successful referral
- ☐ Documented clients have made appointments as planned
- ☐ Oriented and supported HIV-positive clients on what to expect, and helped navigate services at health facility
- ☐ Assisted low-literacy clients to understand paperwork received and HIV care to be provided
- ☐ Assisted with communication between providers and clients
- ☐ Followed up on stigma and discrimination complaints through the appropriate entities in the national redress system
- ☐ Empowered patients (e.g., assisted clients in knowing what questions to ask to health provider)
- ☐ Supported clients to stay motivated to take their ART
- ☐ Asked clients if they are taking daily ART medication
- ☐ Shared information on client issues with adherence counselor
- ☐ Assisted in locating patients who missed appointments
- ☐ Identified barriers preventing clients from returning to health facility
- ☐ Supported and motivated HIV-positive clients to return to health facility
- ☐ Shared information on why clients have missed appointments with social workers and clinician

ANNEX K: SCHEDULE OF KEY CLINICAL CARE SERVICES TO BE PROVIDED TO HIV-POSITIVE CLIENTS¹⁸

- Clients test HIV-positive: Within 24 hours, notify contact investigator of HIV-positive test result to report HIV as a class 1 disease
- Schedule a medical appointment at a health facility on the same day as the HIV-positive result given to the client
- Schedule CD4 testing on the same day as medical appointment for newly diagnosed clients
- At first medical appointment, physician will take patient history, comprehensive physical examination and laboratory evaluation
- Monitor CD4 count 6-12 months
- Initiate ART per the criteria established in the HIV clinical care guidelines
- Refer to other social or clinical services based on initial evaluation of the client
- Viral load test scheduled for 6 months post-ART commencement
- Monitor adherence to ART
- Monitor appointments to other required health and social support services

¹⁸ Ministry of Health. Jamaica. HIV Clinical Management Guidelines