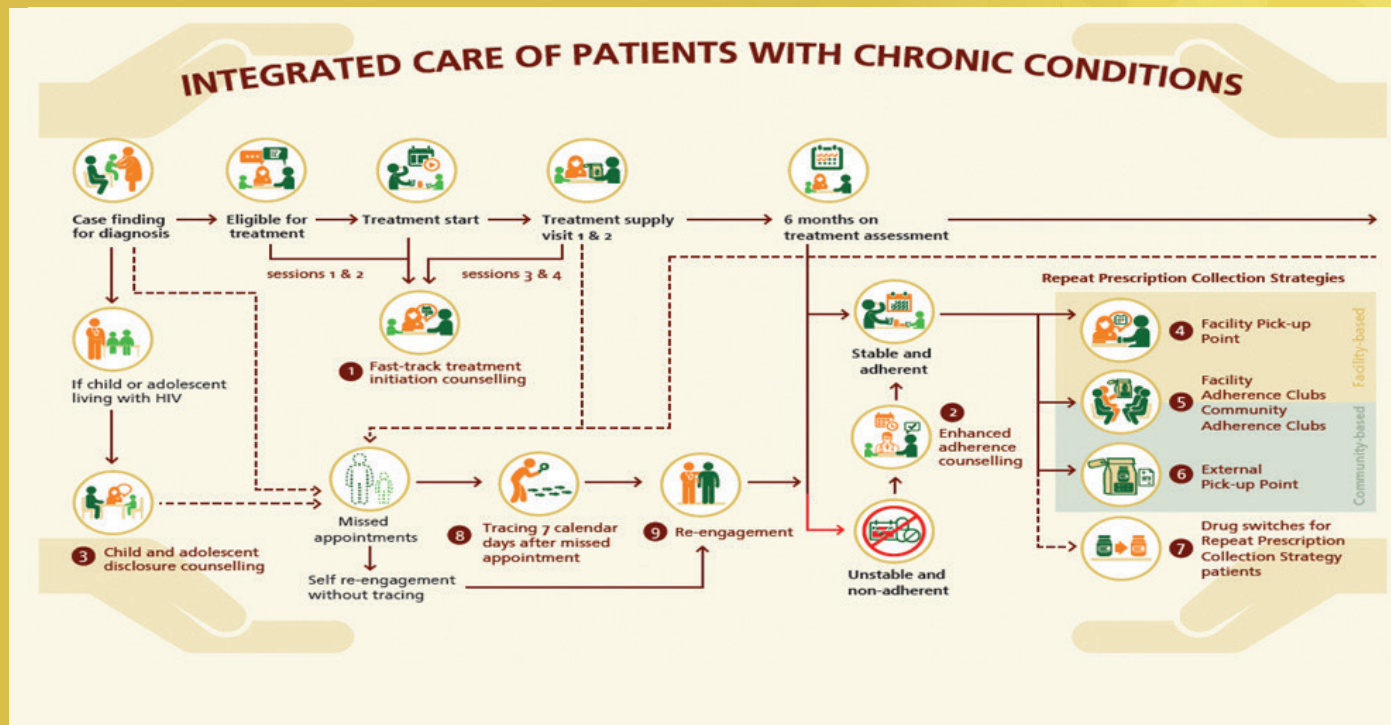


STANDARD OPERATING PROCEDURES

Adherence Guidelines for HIV, TB and NCDs: Training Course for Health Care Workers

PARTICIPANT GUIDE



This Participant Guide has been designed to assist health facilities and community based non-clinicians to develop skills to provide linkage to care, adherence and retention in care services for chronic conditions.

Updated November 2020



health

Department:
Health
REPUBLIC OF SOUTH AFRICA

A long and healthy life for all South Africans



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FOREWORD

Differentiated care applies a patient-centered approach throughout the care cascade. It enhances adherence and retention by recognizing the importance of integrated chronic care service provision. Thus, the Adherence Guidelines provide the minimum package of interventions to support linkage to care, adherence to treatment, and retention in care in South Africa. It further aims at ensuring the delivery of effective differentiated care to clients within the health care system in a sequential manner. The participant manual intends to empower non-clinicians and other health care service providers to make a positive contribution to ensure effective client care and a strong, supportive, adherent, and healthy community.

The issuing of new ART Guidelines 2019 warranted the revision of the 2016 Adherence Guidelines SOPs to produce 2020 Adherence Guideline SOPs. The rationale for revision was to ensure alignment with the new ART Guidelines and to align with the treatment goals for TB and NCDs. Thus, the participant manual has been reviewed to align with the revised Adherence guidelines SOPs.

The 'minimum package of interventions' includes 9 models, which focus on:

- Integrated care of patients with chronic conditions.
- Standardized, updated education, and counselling approaches.
- Differentiated models of care (DMoC) for stable patients on treatment.
- Patient tracing Re-engagement.

The introduction of revised Adherence Guidelines SOPs – minimum package of interventions in public sector health facilities and communities will require staff re-orientation as well as some training on specific intervention models, especially for non-clinicians. The successful implementation of the Adherence Guidelines will be dependent on services provided by non-clinicians in health facilities and communities. The non-clinicians include enrolled nursing assistants, enrolled nurses, health promoters, lay counsellors, home-based carers, community health workers, and ward-based outreach team leaders, support group facilitators, and other non-clinicians doing similar work.

Mentorship and support of non-clinicians from facility managers, supporting NGOs and Partners to implement the Adherence Guidelines effectively will enable the National Department of Health to realize the vision of a “better life for all” in South Africa.

ACKNOWLEDGEMENTS

The development of the Adherence Guidelines participant training manual has been a collective effort and extensive consultative process. The Department of Health would like to acknowledge and thank all those who have contributed to this process, through research, attending meetings, writing, commenting on the many drafts and importantly engaging in robust discussions and debate. The collaboration and involvement of the National and Provincial Departments of Health representatives, support partner organisations and technical experts has ensured a valuable resource to implement an effective adherence programme. The National Department of Health would like to acknowledge the resources provided by support partners to finalise this process.

Development of this training manual was co-ordinated by Ms M Phokojoe, Care and Support Programmes, National Department of Health.

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ACRONYMS

| | |
|---------|--|
| AC | Adherence Club |
| AGL | Adherence Guidelines for HIV, TB and NCDs |
| ANC | Antenatal Care |
| AIDS | Acquired Immune Deficiency Syndrome |
| ART | Anti-retroviral Therapy |
| ASSA | Actuarial Society of South Africa |
| BP | Blood Pressure |
| CADC | Child and Adolescent Disclosure Counselling |
| CBO | Community Based Organisation |
| CCG | Community Care Giver |
| CCMDD | Central Chronic Medicine Dispensing and Distribution |
| CHW | Community Health Worker |
| DAART | Directly Administered Antiretroviral Therapy |
| EAC | Enhanced Adherence Counselling |
| EX- PUP | External Pickup Point |
| FAC–PuP | Facility Pick up Point |

| | |
|--------|--|
| FBC | Full Blood Count |
| FBO | Faith Based Organisation |
| FTIC | Fast Track Initiation Counselling |
| FPG | Fasting Plasma Glucose |
| HbA1c | Haemoglobin Adult type 1c |
| HBC | Home Based Care |
| HTS | HIV Testing Services |
| HIV | Human Immunodeficiency Virus |
| I ACT | Integrated Access to Care and Treatment |
| ICDM | Integrated Chronic Disease Model |
| IEC | Information, Education and Communication |
| ID | Identity Document |
| LTFU | Lost to Follow Up |
| M | Month |
| MDR-TB | Multi Drug Resistant Tuberculosis |
| MSM | Men who have Sex with Men |
| NCD | Non-Communicable Disease |
| PMP | Patient Medicine Parcel |
| TB | Tuberculosis |

| | |
|---------|---|
| OI | Opportunistic Infections |
| PCR | Polymerase Chain Reaction |
| PHC | Primary Health Care |
| PICT | Provider Initiated Counselling and Testing |
| PLHIV | People Living with HIV |
| PMTCT | Prevention of Mother to Child Transmission of HIV |
| PN | Professional Nurse |
| PuP | Pick-up Point |
| RIC | Retention in Care |
| RPCs | Repeat Prescription Collection Strategies |
| SRQ20 | Self-Reporting Questionnaire 20 |
| STI | Sexually Transmitted Infection |
| VL | Viral Load |
| WBPHCOT | Ward Based Primary Healthcare Outreach Teams |
| XDR-TB | Extensively Drug Resistant Tuberculosis |

INTRODUCTION

What is the purpose of the training curriculum?

Goal

To enhance the capacity of non-clinicians especially home-based carers, community caregivers, community health workers, lay counsellors, health promoters, nursing assistants, enrolled nurses, and other non-clinicians to scale up adherence programmes in health facilities and communities across South Africa.

The training guide is aimed at equipping non-clinicians to provide linkage to care, adherence, and retention in care services for chronic conditions treatment in line with the Adherence Guidelines for Chronic Diseases (HIV, TB, and non-communicable diseases (NCDs).

Objectives

- To introduce the Adherence Guidelines and minimum package of interventions to be implemented in both health facility and community structures.
- To provide non-clinicians with the skills required to support linkage to care, adherence, and retention in care services for chronic conditions (HIV, TB, and non-communicable diseases).
- To re-orientate non-clinicians in their role of strengthening the implementation of linkage to care, adherence, and retention in care programmes and interventions.

Note: It is important to note that teaching counselling techniques and skills are not the focus of this training course. These competencies are discussed more fully during other non-clinicians training programmes, including HIV for lay counsellor training.

There are six sections in this training guide:

- Section 1: Overview of the Adherence Guidelines for HIV, TB, NCDs
- Section 2: Education on Illness and Treatment
- Section 3: Minimum package of interventions
- Section 4: Additional Adherence Interventions
- Section 5: Monitoring, Evaluation, and Reporting
- Section 6: Quality planning for implementation



SECTION 1: OVERVIEW OF THE ADHERENCE GUIDELINES FOR HIV, TB, NCDs

Learning objectives

- Know the background to Adherence Guidelines.
- Know the stepwise approach in strengthening adherence across care cascade.
- Know the overview of key adherence strategies.
- Understand roles and responsibilities of non-clinicians to support Adherence Guidelines implementation.

Background

South Africa continues to face a quadruple burden of diseases, communicable, and non – communicable diseases. The South African government adopted UNAIDS 90-90-90 targets in 2014, which emphasizes that by 2020: 90% of People Living with HIV (PLHIV) know their HIV status, 90% of people who know their status are on treatment and 90% of those in treatment are virally suppressed.

South Africa has the largest ART programme in the world, with 5million on Antiretroviral treatment by end of March 2020.

As a result of ART, people with HIV are living longer and therefore are developing non-HIV-related chronic conditions similar to the rest of the population.

Adherence to HIV, TB, and NCD treatments remains a challenge. Non-adherence to long-term therapies results in poor health outcomes and increases overall health care costs. However, effective implementation of the minimum package of interventions to support linkage to care adherence to treatment and retention in care is essential in reducing the burden or strain in health facilities.

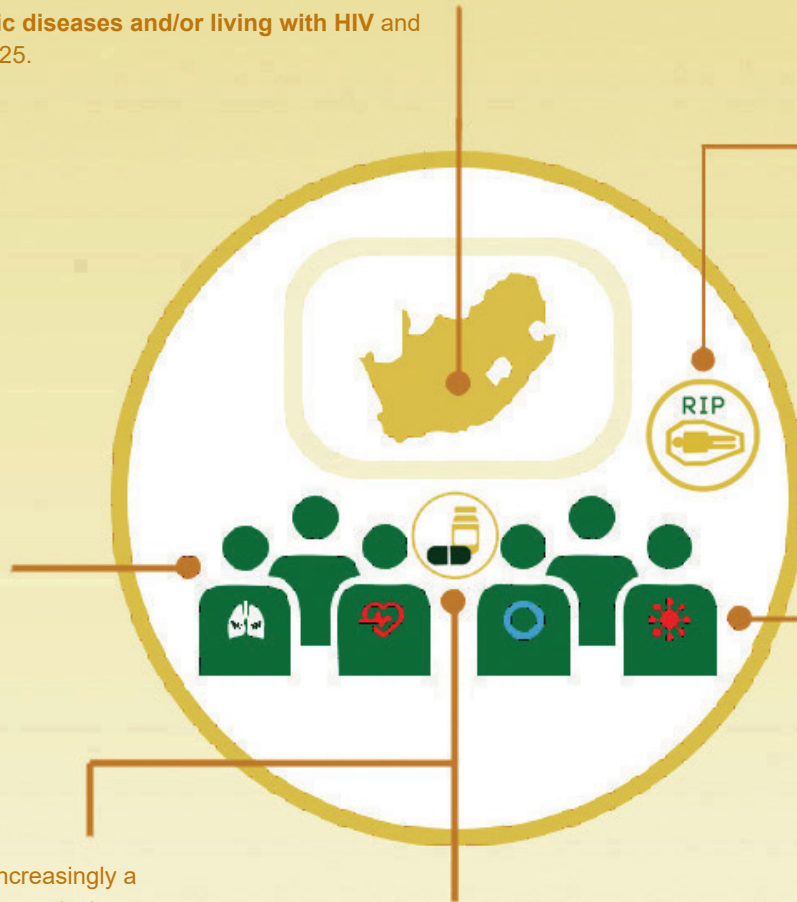


Epidemic Profile and Rationale for Adherence

There are currently 7,5 million PLHIV, and 5 million on Antiretroviral treatment – which is the largest ART programme in the world. It is estimated that there will be a total of 12.3 million **people being treated for chronic diseases and/or living with HIV** and receiving antiretroviral treatment (ART) by 2025.

Globally, South Africa is among the high **TB burden** countries ranked six after India, Indonesia, China, Nigeria and Pakistan. South Africa's TB problem is complicated by the elevated caseload of DR-TB. According to the NHLS data, 4% of all TB is MDR-TB. Although Tuberculosis (TB) Tuberculosis remains the leading cause of death amongst communicable diseases, mortality due to tuberculosis has reduced in the past few years by about 25% (39 695 in 2014 to 29 513 in 2016). TB case notifications have also declined significantly in the last decade, which due to improvement in Antiretroviral Treatment coverage and TB preventative care offered in the country for those people living with HIV.

Adherence to HIV, TB and NCD treatment is increasingly a challenge. Non-adherence to longterm therapies results in poor health outcomes and increases overall health care costs. However, effective implementation of the minimum package of interventions to support linkage to care adherence to treatment and retention in care is essential in reducing the burden or strain in health facilities



The number of deaths due to HIV reduced significantly from 214 365 in 2009 (accounting for 35.4% of deaths), to 115 167 in 2018 (22% of total deaths). HIV interventions have resulted in a steady decline in HIV incidence. Premature mortality has been observed between the ages of 30 and 70, due to selected NCDs including cardiovascular disease, cancer, diabetes, and chronic respiratory diseases, which is 34% for males and 24% for females – total 29%. According to Stats – SA, NCDs contribute 57.4% of all deaths, of which 60% are premature (under 70 years of age). The leading single cause of death from NCDs is cardiovascular disease, followed by cancer, diabetes, and chronic respiratory disease. Many of these deaths are preventable through health promotive/preventive and control measures.

The Covid-19 Pandemic, which is a global concern, has created challenges on the continuum of care of patients within the healthcare system, including people living with HIV, TB and NCDs. Thus, raising concerns about access to quality treatment, care and support including access to medication refills.

The quadruple burden of diseases in South Africa, with HIV/AIDS, TB, Hypertension, and Diabetes on the lead and the massive expansion of the ART programme put a considerable strain, put considerable strain on health care services, which presents challenges of maintaining high-quality public services.

Challenges to non-adherence

The challenge of non-adherence is multifaceted, with patients facing barriers to adherence as a result of both supply- and demand-side factors. Circumstances that negatively affect linkage to care, adherence and retention in care vary between individuals and across populations.

Barriers to linkage to care, adherence and retention in care







This section covers the identified barriers to linkage to care, retention in care and adherence to treatment of people living with chronic diseases including HIV, TB, NCDs and chronic mental health diseases.

It identifies the gaps on both the demand or patient (Table 1) and supply or provider (Table 2) sides of health care delivery.

Factors that negatively affect linkage to care, adherence and retention in care are complex and vary between individuals and across different populations.

Demand perspective




Table 1: Patient-related barriers to linkage, adherence and retention in care

| | | |
|--|------------------------------|--|
|  | Cognitive | Poor knowledge and understanding of results, disease and treatment options. |
|  | Affective | Depression, anxiety, denial, lack of motivation, stigma, discrimination and fear of violence. |
|  | Behavioural | Forgetfulness, alcohol and drug consumption, missed appointments. |
|  | Medical | Pill burden and regimen complexity, treatment adverse effects, medication toxicity, medication palatability. |
|  | Family/social support | Lack of social support, lack of community involvement and dependency on partner. |
|  | Socio-demographic | Age, sex, socio-economic status, level of education, stigma, and non-disclosure of status. |

Supply perspective

Table 2: Provider-related and structural barriers to linkage to care, adherence and retention in care

Provider-related

| | | |
|---|----------------------|--|
|  | Communication | Poor client – provider communication, Inadequate health education, lack of assessment and understanding of the clients reasons for non-adherence, weakness in measuring adherence. |
|  | Behavioural | Attitude of health care providers towards clients, level of engagement and empathy towards the client. |
|  | Training | Inadequate training of staff in breaking bad news, educating and supporting clients in adhering to treatment, limited capacity to screen and identify mental health issues. |

Note: The categories are not mutually exclusive. They can also be shared across supply and demand. The classification above is only meant to provide guidance to identify strategies to improve linkage, adherence and retention in care.

Structural

| | | |
|---|-----------------------------|---|
|  | Organisational | <ul style="list-style-type: none">• Distance to the clinic.• Long waiting time.• Lack of integration and coordination between services.• Medicine shortages and stockouts.• Inflexible clinic hours. |
|  | Intervention quality | <ul style="list-style-type: none">• Lack of tools to guide health care workers on ways to support client's adherence.• Lack of confidentiality.• Inconvenient linkage to care.• Delayed treatment initiation.• Inadequate assessment of treatment adaption needed.• Poor tracing system.• Inadequate resources and laboratory services.• Poor management and support of health care workers. |



Objectives of the Adherence Strategy and Guidelines

Given this context, the National Department of Health developed an Adherence Strategy and Guidelines for HIV, TB and other chronic diseases, which includes a minimum package of interventions to be implemented by all facilities, communities and key implementing partners.

The objectives of the adherence strategy and guidelines are:

- To strengthen access to appropriate services and interventions in order to improve clinical outcomes.
- To assist service providers to ensure that people with chronic diseases are linked to care, retained in care and supported in adhering to treatment.
- To address client and service-provider barriers.

Patient-centred approach

The Adherence Guidelines interventions proposed place a greater value on patients' self-assisted monitoring and a more patient-centred approach through:

- empowering chronic care patients.
- improving patient's health care experience.
- providing information to enable patients to make informed decisions about their own health.

The stepwise approach along care cascade

In considering what strengthening adherence means, the National Department of Health defined the following seven steps in the continuum of care or 'care cascade'. Linkage to care, Adherence and Retention in care can be weakened or strengthened at different steps of the care cascade.

Linkage to care

Step 1 – Screening to testing.

Step 2 – Testing to enrollment in care.



Retention in Care and Adherence to Treatment

Step 3 – Universal test and treat

Step 4 – Treatment initiation to treatment stabilization (intensive phase).

Step 5 – Regular reviews for stable patients on treatment (consolidation and maintenance).

Step 6 – Review adherence and treatment for unstable patients on treatment

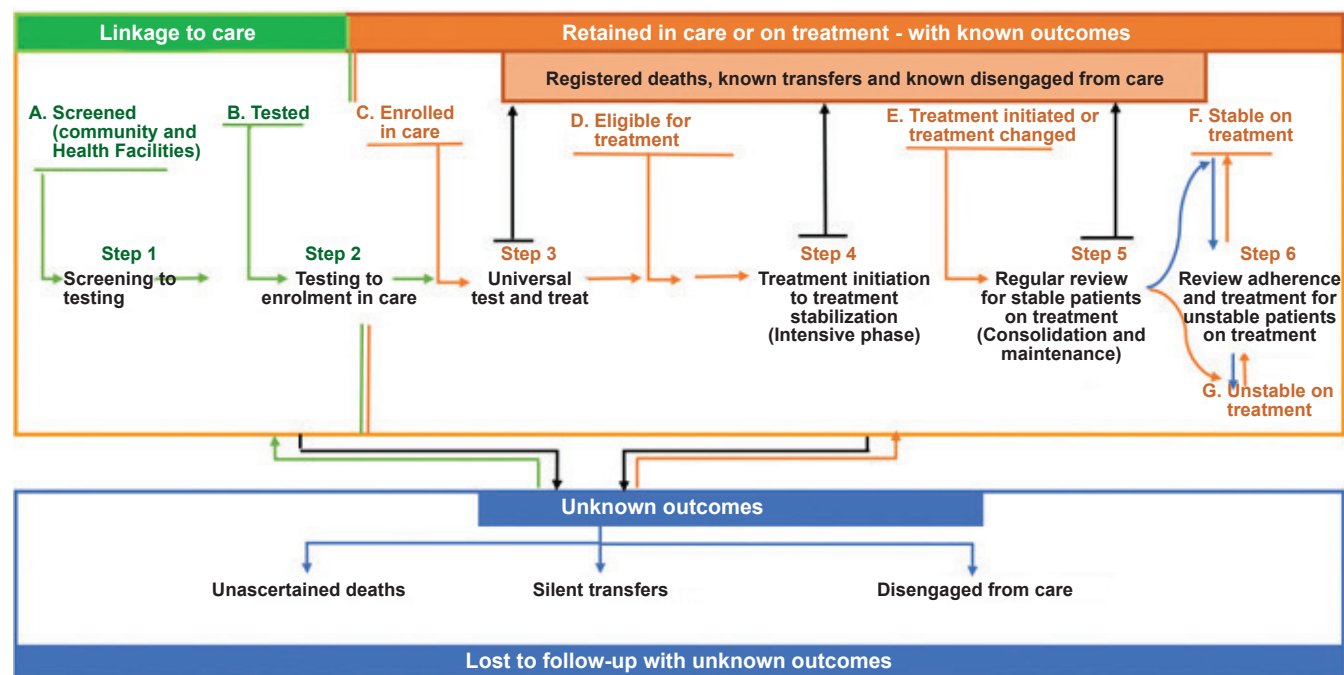
Note: Screening for children and adolescents include case finding in communities, schools and health facilities.

An individual may not necessarily go through all the stages in different chronic conditions, or go through them sequentially.

Some patients may pass rapidly through the first five steps in one consultation and start treatment on the first visit.

Others may take weeks or months for each transition depending on patient- and service delivery-related factors.

Figure: The Stepwise Approach



Clients may engage, disengage, and re-engage in treatment and care, a behaviour which is sometimes referred to as “churning”.

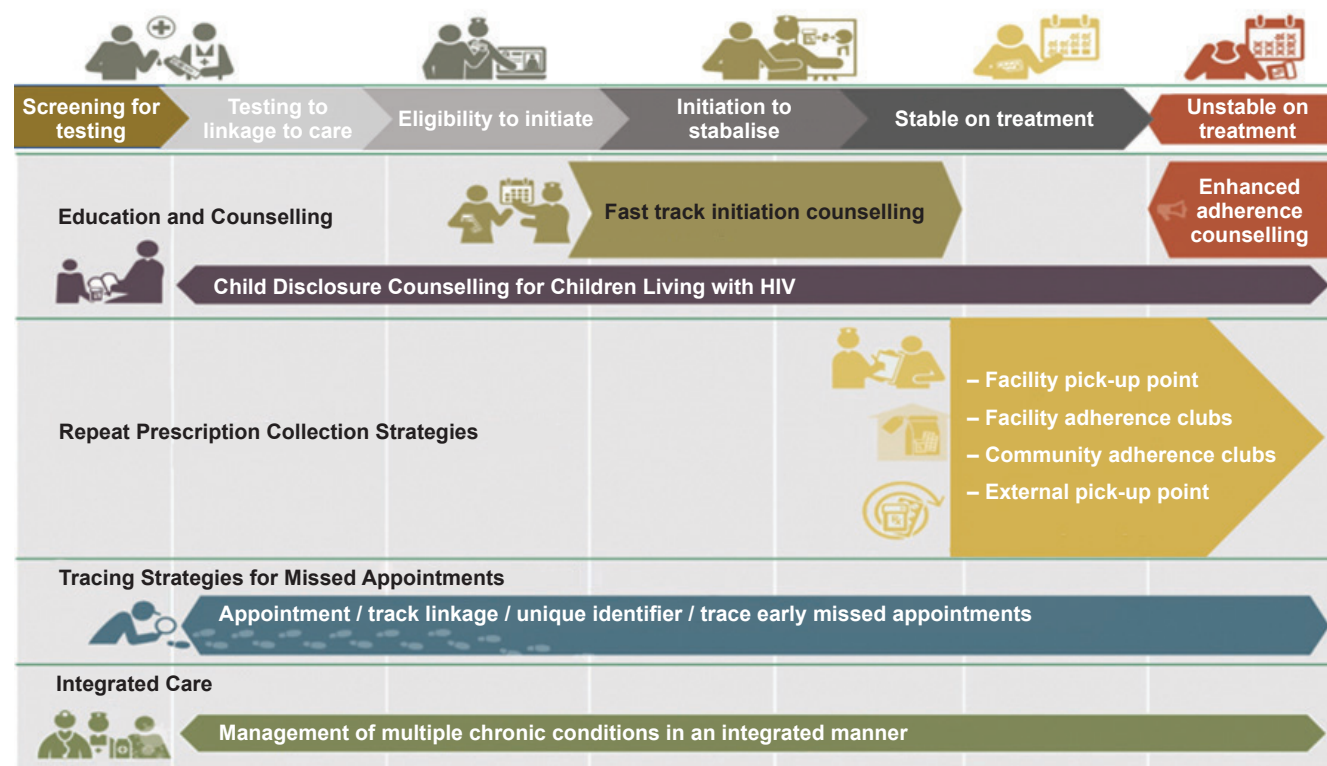
The role of the health sector is to ensure smooth transition of an individual from one stage to the next, as clinically indicated. With each transition or step between these stages there is a chance that clients will be lost to follow up, with an increased risk of adverse outcomes over time.

There are distinct opportunities at each step to facilitate and maximise the effective transition of people into the next stage of the continuum of care, as their disease progression dictates.

The Adherence Guidelines outlines strategies to decrease losses along the care cascade based on available evidence and resources.

The minimum package of interventions

The Adherence Guidelines centers on the provision of a minimum package of interventions to increase linkage to care, adherence to treatment, retention in care along care cascade in health facilities, and communities in South Africa. These interventions introduce some several innovations aimed at improving adherence services and strengthening adherence for chronic conditions.



The 'minimum package' of interventions to support linkage, adherence and retention in care includes:

- Integrated care for patients with chronic conditions.
- Standardized education sessions and counselling approach for:
 - i) Treatment initiation.
 - ii) Patients struggling with adherence (while in care or when re-engaging in care).
 - iii) Supporting child and adolescent disclosure.
- Differentiated models of care (DMoC) for stable patients on treatment.
 - i) Repeat Prescription Collection strategies (RPCs) after 6 months on treatment.
 - ii) Switching first-line regimens for stable patients utilizing an RPCs.
- Patient tracing and re-engagement.

A number of additional interventions are presented for provinces to consider, to be implemented according to the available resources and the context- and patient-specific needs:

- Peer support (including peer education).
- mHealth technologies (including WhatsApp tools).
- Community Adherence (ART) Groups.
- Adaptation of services to specific populations and contexts.



“We are already doing this”

In many respects, much of what is included in the Adherence Strategy and Guidelines is already being done.

This includes:

- Counselling clients on the importance of adherence and returning for follow-up care.
- Tracing clients who do not come back for follow up.
- Counselling those who need more support.
- Making sure clients only come back to the clinic when they need to.
- Starting to integrate some services.

Why do we need to change?

- Education or counselling for HIV, TB, high blood pressure and diabetes is not standardised across facilities. Ensuring that all clients get the best quality education and counselling has proved difficult without a ‘gold standard’ against which to measure quality.
- Many clients are not successfully linked to the health system before they are initiated on treatment.
- It has also been reported that clients may have a delay of up to 6 weeks between qualifying to start treatment and actually starting treatment.
- Routine counselling of clients with **TB, high blood pressure** and **diabetes** in the same way we do our HIV+ clients on antiretroviral therapy is not taking place.
- There is a need to focus on disclosure among children and adolescents who are HIV-positive.
- Counselling for non-adherence is not always structured or client-centered.
- Reasons for non-adherence are not understood or dealt with, e.g. Poor pre-treatment counselling may impact adherence.
- We need to strengthen data capturing and records. **“If it was not recorded then it was not done!”**





A large green rounded rectangle containing a question mark icon in the top left corner. Below the icon are several horizontal white lines for writing, arranged in two columns.

What is new with the Adherence Guidelines?

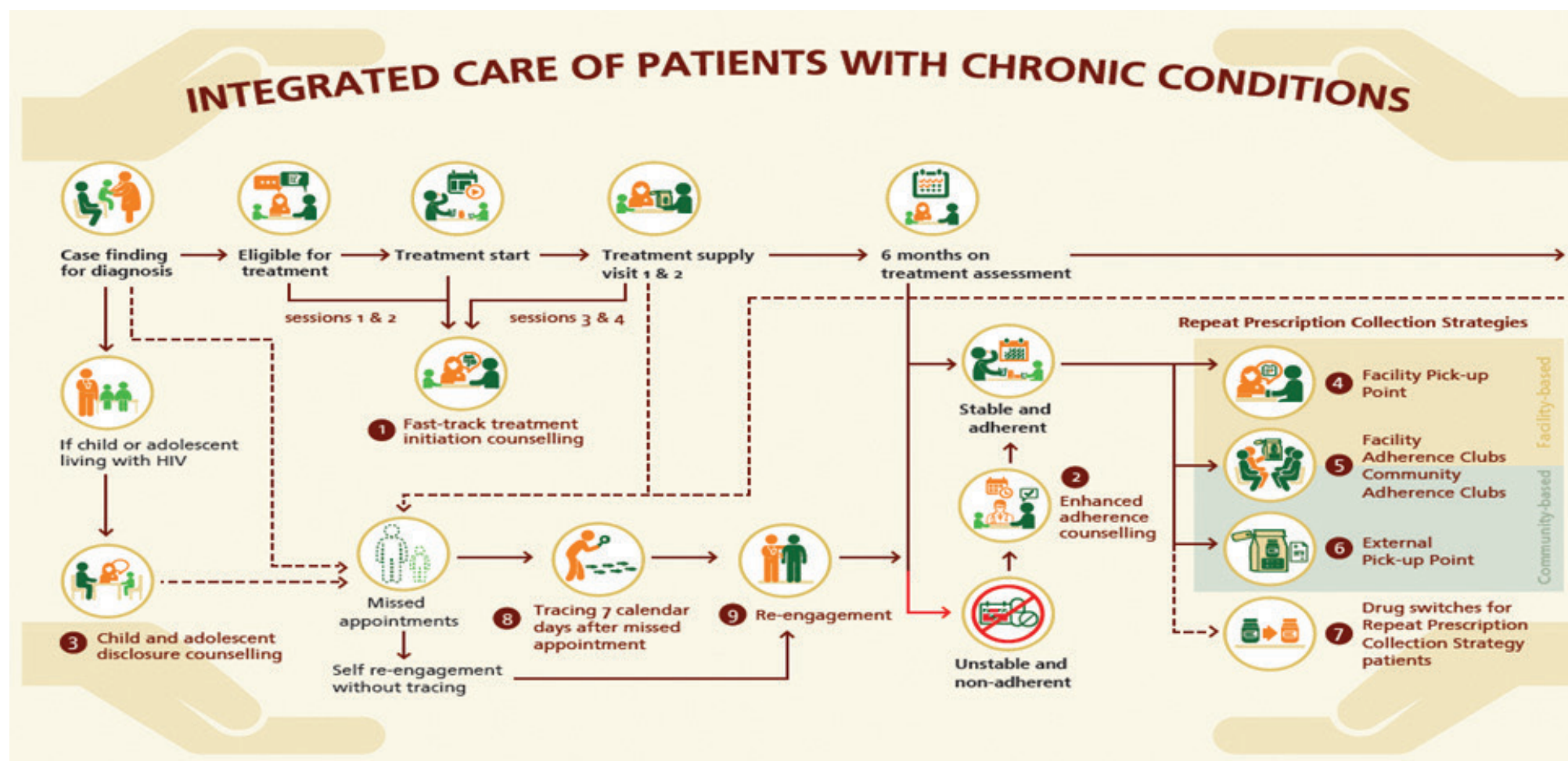
The minimum package of interventions put forward in the Adherence Guidelines, introduces a number of innovations aimed at improving adherence services and strengthening adherence for chronic conditions:

- 1 Integrated care for patients with chronic conditions
- 2 Standardized education sessions and counselling approach for treatment initiation, patients struggling with adherence, child and adolescent disclosure support.
- 3 Differentiated models of care (DMoC) for stable patients on treatment.
- 4 Patient Tracing and Re-engagement.



Minimum Package of Interventions to support linkage to care, Adherence, and Retention in Care

The Care flow diagram – Integrated care of patients with chronic conditions; reflects the minimum package of interventions to support linkage to care, adherence, and retention in care, which should be implemented in all healthcare facilities. These interventions have been shown to improve adherence and retention in care. Through the integrated approach, multiple diseases are treated at once, services, and models integrated. Integrate the ICDM as a one-stop-shop approach for all chronic conditions. The Clinicians should offer integrated consultations to clients with co-morbidities and use an integrated counselling model adapted for different conditions.





There are 9 interventions, and numbering in the diagram sequentially according to the interventions. These interventions have been designed in a manner that enables integrated management of chronic conditions. The table below summarises each of the interventions as stipulated in the Care – Flow diagram:

Table 3: Key Interventions to support linkage to care, adherence and retention in care

| Interventions | SOP # | SOP Label | Brief Explanation |
|--|--------------|--|---|
| New clients starting treatment ... Fast-track Initiation Counselling. | SOP 1 | Fast Track Initiation and Counselling (FTIC) | <ul style="list-style-type: none"> • A standardized approach using standardized tools for HIV, TB, and NCDs (the education on adherence flip file). • Tailored sessions for different groups (HIV, TB, and NCDs). • Client-centered focus (assist the client to make their adherence plan). • Speed up treatment initiation without compromising adherence. |
| If they are non- adherent...Enhanced adherence counselling. | SOP 2 | Enhanced Adherence Counselling (EAC) | <ul style="list-style-type: none"> • Identify clients early, Providing clients with their results. • Client-focused strategy – assessing the barriers to adherence and discussing effective strategies that are aligned to the cause of non-adherence and acceptable to the clients. • Setting new objectives according to the next step on treatment. • Providing additional individual support in case of switching to another regimen. |
| HIV Disclosure Counselling to Children and Adolescents. | SOP 3 | Child and Adolescent Disclosure Counselling (CADC) | <p><i>“Problems arise when parents do not disclose to the children. They tell them they are taking medications for something else.”</i></p> <ul style="list-style-type: none"> • An incremental and standardized approach to disclosure. • Providing education on HIV and ART in adapted language respecting the needs of the child (client-centered focus). • Start partial disclosure from the age of 3 years. • Ensure full disclosure before the age of 12 years. |





| Interventions | SOP # | SOP Label | Brief Explanation |
|---|-------|---|---|
| <p>If they are adherent... Graduate to Differentiated Models of Care (DMoC)</p> <p>Repeat Prescription Collection Strategies (RPCs):</p> <p>Three Options:</p> <p>(4) FAC-PUP</p> <p>(5) AC</p> <p>(6) EX-PUP</p> | SOP 4 | Facility Pick – up Point (FAC-PUP) | <ul style="list-style-type: none"> Adherent and stable clients should be rewarded with faster service and flexibility to choose their preferred medication collection service (client-centered focus). |
| | SOP 5 | Adherence Club (AC) | <ul style="list-style-type: none"> 6-monthly prescriptions. |
| | SOP 6 | External Pick – up Point (EX-PUP) | <ul style="list-style-type: none"> Dispensing of 2-3 months medication. Comprehensive Clinical Assessment at 6 months. |
| | SOP 7 | Switching the first-line regimen for stable patients utilizing RPCs (DRUG SWITCH) | <ul style="list-style-type: none"> This is a new standard operating procedure / Intervention. Supports access for stable clients in RPCs to new regimens while remaining in their RPCs. |
| <p>Preventing Loss to Follow – up A core part of tracing strategy.</p> | SOP 8 | Tracing and Recall (TRACING) | <ul style="list-style-type: none"> Re-enforce the importance of follow-up care at every visit. Give clients an appointment. Verify contact details at every visit. Issue a list of clients who have missed their scheduled appointments early. Trace clients immediately Use SMS/phone and involve non-clinicians to trace clients when needed. Record the information about the clients to be traced and the outcomes on standardized tracing forms. |
| | SOP 9 | Re-engagement in care (RE-ENGAGEMENT) | <ul style="list-style-type: none"> Supports re-engagement after tracing or self-re-engagement. There is a need to differentiate adherence support interventions for clients re-engaging. Clients can be referred for EAC or preferred RPCs depending on the assessment on return to the facility. |



Additional interventions to support Linkage to care, Adherence and RIC

- Integrated Access to Care and Treatment (I ACT).
- Support groups
- Youth clubs
- Buddy systems
- Collaboration with traditional authorities.
- SMS encouraging adherence and appointment reminders.
- Community Adherence (ART) Groups to be adapted for other chronic diseases.
- Outreach services (WBPHCOT).
- After-hours services and MSM, LGBTI and sex worker-friendly clinics.

Table 4: Adherence strategies for Key Populations

| Key Population | Recommended interventions |
|------------------------------|--|
| Children and adolescent | Disclosure counselling adolescents. |
| Adolescent and Youth | Youth clubs mHealth (B-WIZE). |
| Pregnant and lactating women | MomConnect |
| Men who have sex with men | MSM-friendly services |
| Sex workers | Outreach peer support interventions. |
| Inmates | Tailored prevention, treatment, care, and support services and referral networks to external health, social and community services on release. |
| Older persons | Include family member or caregiver when providing information to older persons. |
| Persons with disabilities | Ensure communication material is available in accessible formats such as Braille. |
| Mental health disorders | Screening, management, and treatment for psychological stress, depression and other mental illnesses integrated into the management of chronic diseases. |
| Substance use disorders | Screening for substance use and appropriate referral should be integrated into the management of chronic conditions. |

Roles and Responsibilities

Everyone from the National, Provincial, District Department of health, facilities, implementing partners, communities, civil society, and patients have a role to play in the implementation of Adherence Guidelines. The following tables indicate thematic areas and proposed core activities to inform the optimal roll-out of the AGL-SOPs across the country at all levels.

Table 5: Roles and Responsibilities at All Levels

| Thematic Area | | Key Activities |
|---------------|---|---|
| National | Adherence Policy & Strategy | <ul style="list-style-type: none"> Develop, Review and Disseminate AGL SOPs. Publish on NDoH online Platforms. Coordinate & provide oversight through Differentiated Models of Care (DMoC) TWG. Provide on-going DMoC Implementation Support for Provincial Managers. |
| | Welcome Back Campaign (WBC) | <ul style="list-style-type: none"> Develop, Review and Disseminate WBC strategy. Align WBC with AGL SOPs. Develop Adherence Communication Material – Welcome Back Messages. |
| | Adherence Guideline Training Materials | <ul style="list-style-type: none"> Review AGL training material and align with revised AGL SOPs. Review AGL flip file. Review the current I-ACT training materials and align with revised AGL SOPs. |
| | Adherence Communication, Demand Creation and Social Mobilization | <ul style="list-style-type: none"> Create and orientate Provincial Program Managers on adherence materials. Share information through social media & identified platform. |
| | Mass Printing and distribution of AGL Materials | <ul style="list-style-type: none"> Print and distribute AGL SOPs, AGL Training and implementation materials. |
| | Human Resource | <ul style="list-style-type: none"> Leverage resources to appoint DMoC Advisor to lead and support provinces with the AGL-SOPs roll-out. |
| | Capacity Building | <ul style="list-style-type: none"> Develop and share training plans for Master Trainers, Training of Trainers, and Implementers Training. Develop and share Mentorship plans on AGL SOPs implementation. |
| | Monitoring, Evaluation and Reporting | <ul style="list-style-type: none"> Review, harmonize and Develop Monitoring, Evaluation and Reporting Framework. Finalise the DMoC Register and advocate for inclusion in clinical stationery. Track and monitor implementation of DMoC. |
| | Technical Support | <ul style="list-style-type: none"> Conduct technical support visits poor performing districts/virtual programme support meetings. Support development of improvement plans and monitor improvements. |
| | Publication and sharing best practices & Lessons learned | <ul style="list-style-type: none"> Presenting at national & International conferences and meetings of professional associations. Publishing project findings in national journals and state-wide publications platforms. |



| Provinces | | Thematic Area | Key Activities |
|-----------|--|---|--|
| | | Adherence Policy & Strategy | <ul style="list-style-type: none"> • Publish AGL SOPs on PDoH online Platforms. • Coordination & provide oversight through Differentiated Models of Care (DMoC) Provincial TWGs. • Provide on-going DMoC implementation Support for District Program Managers. |
| | | Welcome Back Campaign (WBC) | <ul style="list-style-type: none"> • Align the provincial Welcome Back Campaign Strategy with the National Strategy. • Develop operational plans for WBC roll-out. |
| | | Adherence Guideline Training Material | <ul style="list-style-type: none"> • Adopt NDoH adherence training materials. • Support implementation of AGL flip file and I-ACT in the districts. |
| | | Adherence Communication, Demand Creation and Social Mobilization | <ul style="list-style-type: none"> • Orientate District Program Managers on adherence materials. • Share DMoC information through Provincial identified platforms (e.g. Radio Stations and social media). • Participate in provincial IMBIZO and ensure linkage, adherence and retention in care is part of the agenda. |
| | | Mass Printing and distribution of AGL Materials | <ul style="list-style-type: none"> • Coordinate the distribution of printed AGL SOPs, AGL Training and implementation materials. • Monitor and support the optimal implementation of the AGL materials in the districts. |
| | | Human Resource | <ul style="list-style-type: none"> • Designate HAST Managers in Provinces to lead the DMoC roll-out and support Districts & Sub-Districts HAST Managers. |
| | | Capacity Building | <ul style="list-style-type: none"> • Operationalize training plans for Master Trainers, Training of Trainers, and Implementers Training. • Where possible, integrate AGL training with other trainings e.g. HTS for non-clinicians. |
| | | Monitoring, Evaluation and Reporting | <ul style="list-style-type: none"> • Adopt and own the monitoring, Evaluation and Reporting Framework. • Capacitate M&E officials on the DMoC M&E framework. • Encourage reporting at all levels using the provided programme reporting tools. • Conduct programme performance reviews. |
| | | Technical Support | <ul style="list-style-type: none"> • Conduct technical support visits poor performing districts/ facilities. • Conduct monthly Virtual programme support meetings. • Support development of improvement plans and monitor improvements. |
| | | Publication and sharing best practices & Lessons learned | <ul style="list-style-type: none"> • Conduct provincial review and learning platforms workshops/ seminars (Virtual or face to face). |





| Districts & Sub Districts & DSPs | |
|---|--|
| Thematic Area | Key Activities |
| Adherence Policy & Strategy | <ul style="list-style-type: none"> • Publish AGL SOPs on DDoH online Platforms. • Coordination & provide oversight through Differentiated Models of Care (DMoC) District and Sub-district TWGs. • Conduct dissemination Workshops and provide on-going DMoC implementation Support for Sub-District Program Managers. • Engage District Support Partners (DSPs) to provide mobile services to collect and deliver pre-packed medicines to the patients' nearest easily accessible PUP during lockdown. |
| Welcome Back Campaign (WBC) | <ul style="list-style-type: none"> • Strengthen implementation of the existing Welcome Back Campaign interventions. • Support facilities in welcoming back to care patients who missed appointments by ensuring optimal track and trace. |
| Adherence Guideline Training Material | <ul style="list-style-type: none"> • Disseminate all promotional material to the facilities. |
| Adherence Communication, Demand Creation and Social Mobilization | <ul style="list-style-type: none"> • Orientate District & Sub-District Program Managers on adherence materials. • Share DMoC information through District & Sub-District platforms (e.g. Radio Stations and social media). • Participate in District & Sub-District IMBIZO and ensure linkage, adherence and retention in care is part of the agenda • Utilize social platforms to advocate for the care and treatment package. |
| Mass Printing and distribution of AGL Materials | <ul style="list-style-type: none"> • Disseminate all AGL material from the province to the facilities. |
| Human Resource | <ul style="list-style-type: none"> • Designate HAST Managers in Districts / Sub-Districts to lead the DMoC roll-out and support facilities HAST Champions. |
| Capacity Building | <ul style="list-style-type: none"> • District Master trainers to ensure that all facility staff are trained on the SOPs. • Encourage facility managers to offer support and mentoring. • Ensure that there is a dedicated focal person in the facility. |
| Monitoring, Evaluation and Reporting | <ul style="list-style-type: none"> • Adopt and own NDoH Monitoring, Evaluation and Reporting Framework. • Disseminate the framework to the facilities. • Capacitate M&E officials on the DMoC M&E framework. • Encourage reporting from facilities utilizing the provided programme reporting tools. • Conduct programme performance reviews. |
| Technical Support | <ul style="list-style-type: none"> • Conduct technical support visits poor performing districts/ facilities. • Support development of improvement plans and monitor improvements. |
| Publication and sharing best practices & Lessons learned | <ul style="list-style-type: none"> • Conduct district & sub-district review and learning platforms workshops/ seminars (Virtual or face to face). |





| Facilities | | Thematic Area | Key Activities |
|------------|--|---|---|
| | | Operationalizing Adherence Policy, Strategy & SOPs | <ul style="list-style-type: none"> • Develop operational plans for roll-out of AGL SOPs in the facilities. • Convene weekly nerve centre meetings. • Attend / participate in Virtual Orientation Workshops convened by District the AGL SOPs. • Conduct District orientation meetings which will encourage effective implementation of DMoC interventions. • Ensure that communication/ circulars / guidelines is disseminated to all clinicians. • Ensure that every consulting room has the AGL SOPs booklet. • Support staff and provide mentorship when needed. • Implement facility appointment system to reduce facility congestion at peak times (1 – 2 hours). • Accelerate decanting of all eligible patients from in-facility to external pick-up point (PUP). |
| | | Welcome Back Campaign (WBC) | <ul style="list-style-type: none"> • Ensure effective implementation of the existing Welcome Back Campaign interventions. • Encourage the facility staff in welcoming back to care patients who missed appointments. |
| | | Adherence Guideline Training Material | <ul style="list-style-type: none"> • Ensure clinicians and the CHW are trained on AGL education and communication materials. |
| | | Adherence Communication, Demand Creation and Social Mobilization | <ul style="list-style-type: none"> • Orientate facility Operational Managers and Clinicians and Non-clinicians on adherence materials. • Share DMoC information through social media or community Radio Stations. • Participate in facility committee meetings & community IMBIZO. |
| | | Mass Printing and distribution of AGL Materials | <ul style="list-style-type: none"> • Access to printed AGL SOPs, AGL Training and implementation materials. |
| | | Human Resource | <ul style="list-style-type: none"> • Designate HAST Champion to lead DMoC activities. |
| | | Capacity Building | <ul style="list-style-type: none"> • Train all clinicians and non – clinicians on DMoC. • Offer support and mentoring. • Ensure that there is a dedicated focal person in the facility. |
| | | Monitoring, Evaluation and Reporting | <ul style="list-style-type: none"> • Provide in-service training on NDoH Monitoring, Evaluation and Reporting Framework. • Capacitate M&E officials on the DMoC M&E framework. • Produce weekly, monthly reports. • Ensure weekly facility nerve centre meeting. |
| | | Best practices & Lessons learned | <ul style="list-style-type: none"> • Conduct ongoing TRAP meetings in the facilities. |



Core roles and responsibilities for non-clinicians

The following diagram depicts the core roles and responsibilities for non-clinicians such as home-based carers, community caregivers, community health workers, lay counsellors, health promoters, nursing assistants and enrolled nurses.

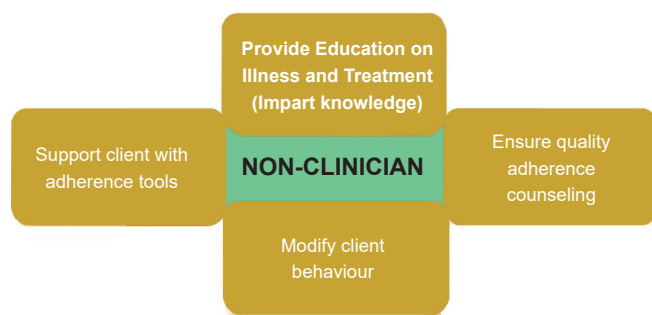


Table 6: Specific details for each of the four core responsibilities depicted above, are set out below:

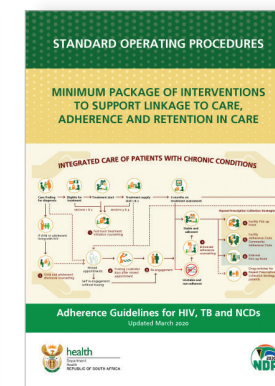
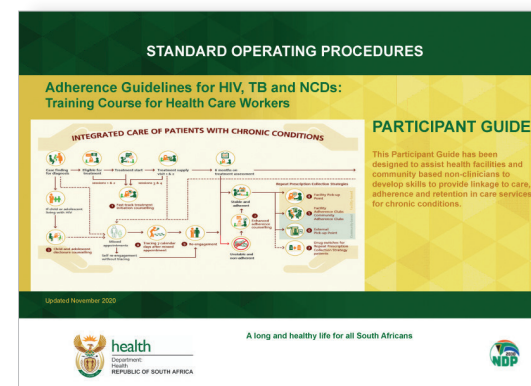
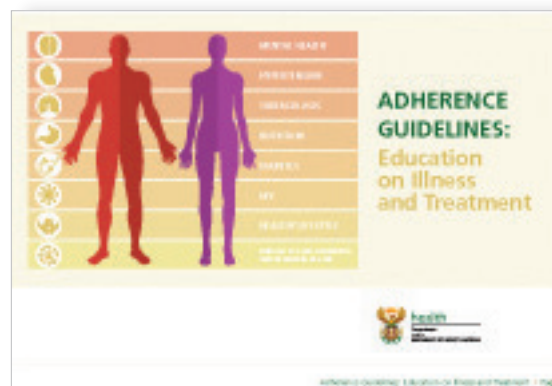
| Core Responsibilities | Key Activities |
|---|---|
| Impart knowledge | <ul style="list-style-type: none"> • Improve understanding: clients often have limited knowledge and understanding about why they must take chronic medication, how it works, and how it benefits them. • Focus on client-provider shared decision-making. • Involve the client's family or caregiver wherever possible. • Advice on how to cope with medication costs. • Provide prescription instructions. • Reinforce all discussions often. • Provide pre-treatment information and education as per the visit schedule. |
| Ensure quality adherence counselling | <ul style="list-style-type: none"> • Spend time with the client and explain the disease, the goals of therapy, and the need for adherence. • Discuss the role of treatment in the management of chronic condition. • Negotiate a treatment adherence plan that the client can understand and commit to. • Explain to clients how to avoid adverse drug-drug interactions. • Assist clients to understand the possible consequences of mixing other prescribed or recreational drugs and substances. |
| Modify client behaviour | <ul style="list-style-type: none"> • Empower clients to manage their condition. • Ensure clients understand the risk of not taking their medication. • Address fears and concerns regarding treatment and adherence. • Provide encouragement and recognition for adherence. • Encourage attendance and participation in a support group. |
| Support clients with adherence tools | <ul style="list-style-type: none"> • Encourage self-reporting on adherence. • Reinforce use of pillboxes or a daily dosing diary. • Encourage treatment buddy. • Introduce client or caregiver to the therapeutic counsellor and client advocate, if available. |

Adherence Guidelines implementation support tools

Adherence Guidelines implementation support tools have been developed to support non-clinicians and clinicians in the health facilities and communities. These were developed in consultation with HIV, TB, NCDs, Child Health and Sector-Wide procurement programmes, implementation support tools are aligned to existing NDoH programmes and priorities.

The following Adherence Guidelines implementation support tools have been developed:

- Patient Adherence Plan
- Patient Treatment Adherence Pamphlet
- Education and counseling flip file
- Training manual
- Standard Operating Procedures (SOPs)



Patient treatment adherence plan

The purpose is to assist patients to make their own commitment during counselling sessions so that they become accountable for adherence of their treatment. Upon each visit, the adherence plan sheet will be retrieved as a means to review patient commitment.

Patient treatment adherence pamphlet

The purpose is to provide a patient with reference material after counselling on treatment adherence for reference when they get home. This includes: Treatment Adherence and importance; what to do when patient forgets to take medications; side effects, disclosure and why it is important to inform health facility when changing health facilities or moving away.

Education and counselling flip file

An adherence education and counseling flip file has been developed for home based carers, support group facilitators, lay counsellors, health promoters, community health workers, enrolled nursing assistants and other HCWs to help patients understand the explanations of their condition. Depending on the condition(s) of the patient, the appropriate content will be facilitated before and on the day of initiation on treatment and throughout the care cascade.



Training manual and mentorship guide

A training manual has been developed to introduce the Adherence Guidelines and minimum package of interventions to support adherence and retention in care in public sector health facilities and communities. Furthermore, a mentorship guide has been developed to support non-clinicians during implementation.

Standard Operating Procedures (SOPs) for minimum package interventions

SOPs have been developed for 9 minimum package interventions to support linkage to care, adherence and retention in care. The SOPs are recommended for all health facilities and communities in South Africa to support both clinicians and non-clinicians to implement the Adherence Guidelines.

In conclusion

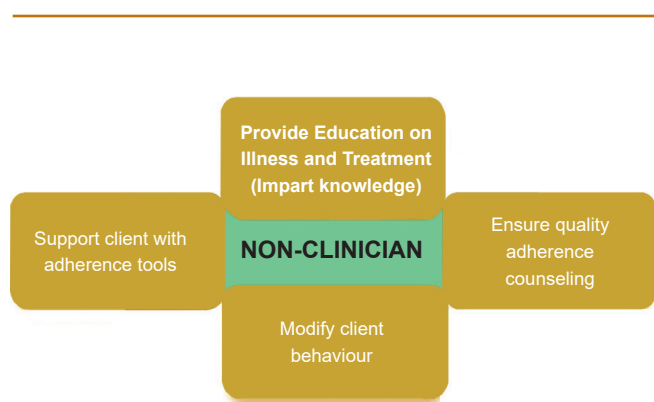
- Linkage to care, adherence and retention in care:
 - is key for better clinical outcomes hence the proposed innovative Adherence Guidelines interventions.
- Linkage to care is everyone’s responsibility:
 - Patients
 - Clinicians
 - Non-clinicians
 - Communities
 - Traditional authorities
 - Implementing partners
 - Civil Society Organisations
- Standardisation of adherence interventions should be done consistently to ensure that we deliver the right things, in the right places to the right people along the care cascade.

A light green rounded rectangular box containing a speech bubble icon with a question mark and several horizontal lines for writing.



SECTION 2: EDUCATION ON ILLNESS AND TREATMENT

Overview



This section provides the key information that you require to effectively counsel clients on:

- TB
- HIV
- Hypertension
- Diabetes

It focuses on key elements of the condition, so as to assist you in counselling clients on the importance of adherence to treatment.

Learning objectives:

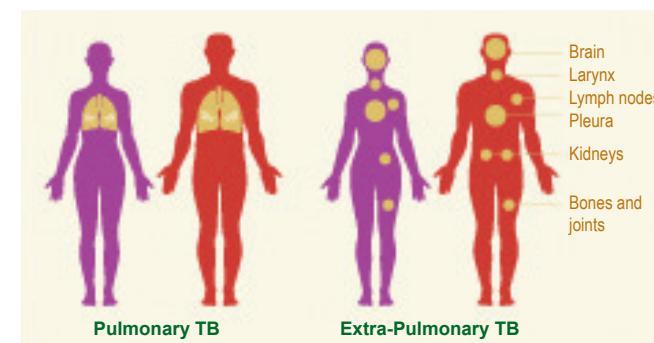
- Demonstrate the ability to provide education and counselling for the following chronic conditions so as to ensure adherence to treatment:
 - TB
 - HIV
 - Hypertension
 - Diabetes
- Discuss impact of poor or non-adherence on these chronic conditions.
- Understand mental health issues, substance abuse and healthy living as they relate to adherence education.

Tuberculosis

Learning objectives:

- Describe what TB is.
- Discuss how TB is spread.
- Describe the results of poor adherence to TB treatment.
- Explain the link between poor adherence to TB treatment and the spread of TB.

Education and Counselling on TB



What is TB?

- TB is an infectious disease.
- TB is caused by a bacteria called Mycobacterium TB that you breathe in.
- TB mainly damages the lungs by growing and causing local destruction.
 - This form is called Pulmonary TB and is infectious to others.
- TB can also occur in some parts of the body outside of the lungs such as:
 - brain,
 - larynx,

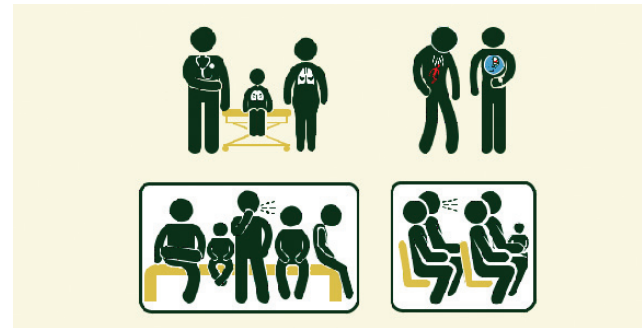
- lymph nodes,
- pleura (the membrane surrounding each lung),
- kidneys, or
- bones and joints.
- These forms are called Extra-Pulmonary TB and are not infectious to others.



How is TB spread?

- TB is spread in the air when people who have active TB are:
 - coughing,
 - sneezing, or
 - singing,
 - Other people can breathe in the Mycobacterium TB and may get sick sooner or later.
 - This happens more in crowded spaces.

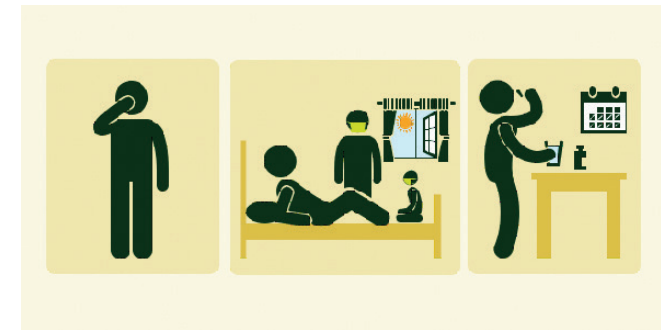
- TB cannot be spread by:
 - shaking hands,
 - sharing cups, or
 - sharing utensils.



Who is at high risk of getting TB?

- Children under 5 years.
- People with weak immune systems such as HIV infected or people with diabetes.
- People who work or live in crowded spaces such as miners, prisoners and not well ventilated closed environment.

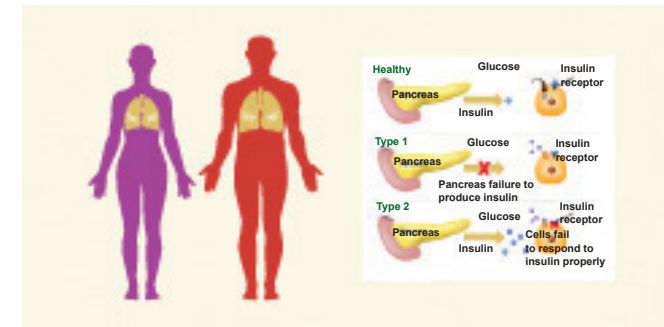
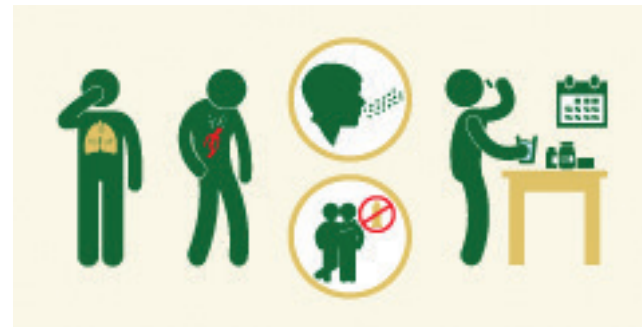
Remember: All children under 5 living with someone diagnosed with TB should be taken to the clinic for a TB test and preventive treatment.



How can you prevent passing TB on to others?

- Cover your mouth with a tissue or your sleeve when you cough or sneeze.
- Let sunshine and fresh air in:
 - open windows and doors in your house, cars, taxis, schools, crèches, early learning centers and hospital wards.
- Wear a mask when in contact with someone who has been diagnosed with or may have TB.
- Avoid close contact with others until you have completed at least 14 days of treatment:
 - if possible sleep in a room on your own during this time.

Remember: The best way to avoid spreading TB is to complete your TB treatment.



What are the symptoms of TB?

Table 7: Main TB Symptoms

| Adults | Children |
|---|--|
| <ul style="list-style-type: none"> - Cough for 2 weeks or more. - Fever for 2 weeks or more. - Unexplained weight loss. - Night sweats. | <ul style="list-style-type: none"> - Cough for 2 weeks or more which is not improving on treatment. - Persistent fever for 2 weeks or more. - Documented weight loss (check ROAD TO HEALTH CARD). - Fatigue (less playful) |

- Other symptoms can be specific to the part of the body where the TB bacteria is growing such as:
 - larynx, - the lymph nodes,
 - the brain, - the kidneys,
 - the bones and joints,
 - the pleura (the membrane surrounding each lung).

Remember: If you have any of these signs or symptoms, you need to go to the clinic to be tested for TB.

What is the link between TB and HIV?

- TB is the most common serious opportunistic infection among people living with HIV and AIDS.
- HIV attacks the soldiers (CD4 cells) of the immune system that protect the body from infection.
- As the immune system of people living with HIV is weak, TB easily develops in the body.
- TB can be treated and can be cured.
- HIV can be treated but cannot be cured.
- TB and HIV are spread in different ways:
 - TB bacteria are breathed in.
 - HIV is most commonly spread through unprotected sex.

Remember: When you have HIV and TB at the same time and have not been started on ART, you will be started on TB treatment first, followed by ART as advised by the health care worker.

What is the link between TB and diabetes?

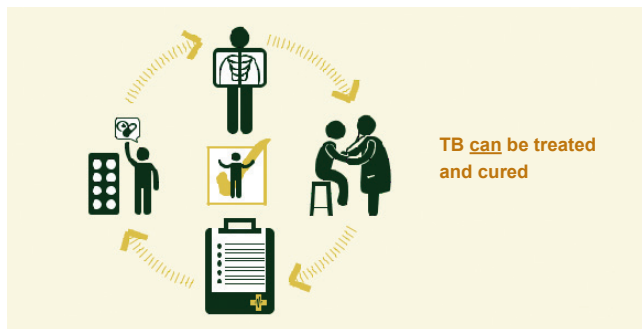
- Diabetes Mellitus also known as Diabetes increases the risk of developing TB.
- Rates of TB are higher in people with diabetes compared to the rest of the population.
- TB infection may progress at a faster rate in people with diabetes than in those without diabetes.
- Diabetes can delay TB treatment response and reduce the likelihood of a good outcome, increasing the risk of relapse or death.





- TB may trigger the onset of diabetes or worsen control of blood sugar in people who already have diabetes.

Remember: It is important to get tested for TB if you have diabetes, and for diabetes if you have TB.



How does TB treatment work?

- TB hides deep in the lungs and grows slowly.
 - A combination of at least four medicines will fight TB.
 - The medicines are put together into one tablet called fixed dose combination or FDC.
 - It takes 6 months to kill the TB bacteria.



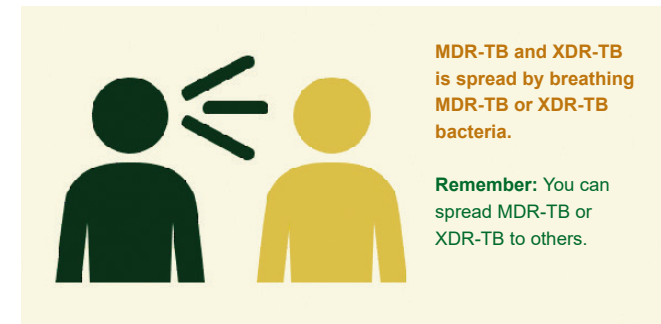
How should TB treatment be taken?

- TB medicines need to be taken, as prescribed, every single day, for a minimum of 6 months.
- When you miss a dose, you should take the forgotten dose as soon as you remember and then get back to your usual medication schedule.
- Medicines should be kept in a safe, dry place that is not too hot.

Remember: Your goal when taking TB treatment is to complete 6 months TB treatment and be cured of TB!

How does TB become medicine (Drug) resistant?

- If you stop taking TB treatment before 6 months or do not take TB treatment regularly, you may develop.



Drug Resistant TB (DR-TB).

- This kind of TB cannot be cured with Drug sensitive TB treatment.
- The common types of DR-TB are:
 - a) Multi Drug Resistant TB (MDR-TB).
 - b) Extensive Drug Resistant TB (XDR-TB).
- You can also spread MDR-TB or XDR-TB to others and as such, people you have had close contact with you should be traced and tested for MDR-TB or XDR-TB.
- Sometimes you can get MDR-TB or XDR-TB when you breathe in MDR-TB or XDR-TB bacteria.
- MDR-TB and XDR-TB are more difficult to treat.
- You will have to take treatment longer to get rid of the bacteria.
- You will be hospitalised to take treatment if you have been diagnosed with MDR-TB or XDR-TB.





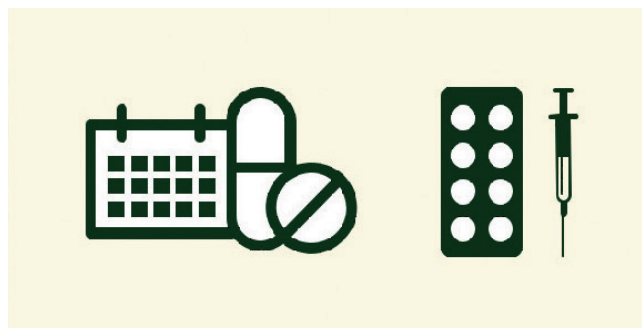
How does treatment for DR-TB medication work?

- DR TB treatment takes up to 2 years:
 - with 6 months intensive phase with daily injections and oral treatment, and
 - a continuation phase of 18 months with daily oral treatment.

Remember: Your goal when taking DR-TB treatment is to complete treatment and be cured of DR-TB!

TB medicine and contraceptives

- If you are taking oral contraception or using injectable contraception, and diagnosed with TB, medicines could affect their effectiveness.
 - Let your health care provider know about your method of contraception because the TB treatment can make the contraceptive less protective against unwanted pregnancy.



What are the side effects of TB treatment?

Minor side effects

- Most people do not get side effects.
- Some people could experience mild side effects like:
 - heartburn,
 - nausea,
 - rash,
 - painful feet, or
 - urine turning orange.

Serious side effects

- A few people may experience serious side effects like:
 - yellow skin/eyes,
 - severe abdominal pain,
 - bruising, or
 - problems with sight and hearing.



Remember: If you have any of these serious side effects, go to facility to be seen by a doctor or nurse.



TB treatment and alcohol

- It is better not to drink any alcohol during the period that you are taking TB treatment.
- The combination of TB treatment and alcohol will have a bad effect on your liver and your nerves.
- If you experience difficulty in reducing alcohol consumption, do not stop the TB treatment and rather inform the health care provider immediately.





Role Play Activity

- Divide into groups of 3.
- Each group member to assume one of the following roles: Counsellor, Client, and Observer.
- Role play the following scenario:
A Counsellor is visiting a client with TB who has been taking her medicine for over 4 months. When the counsellor arrives, the client appears sad. She tells the counsellor that she is feeling better and she wants to stop taking her medicine. She does not like swallowing pills and often the pills make her feel dizzy.

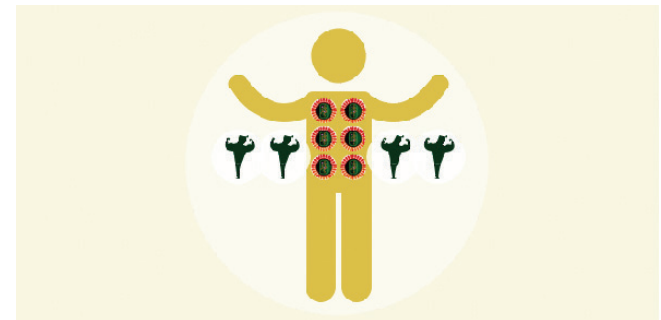


HIV

Learning objectives:

- Describe what HIV is.
- Discuss how HIV is spread.
- Explain the difference between poor adherence to HIV treatment and spread of HIV.
- Describe results of poor adherence to HIV treatment.

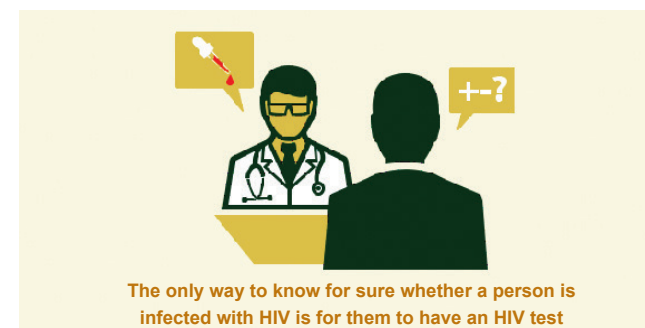
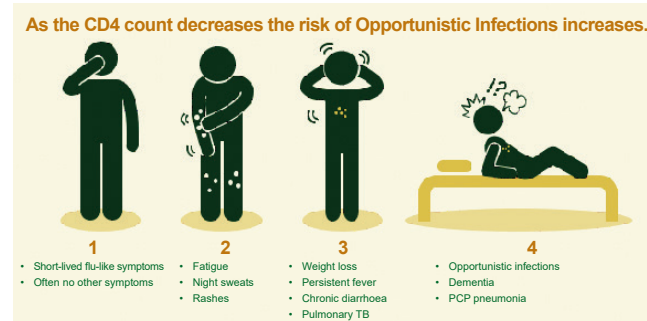
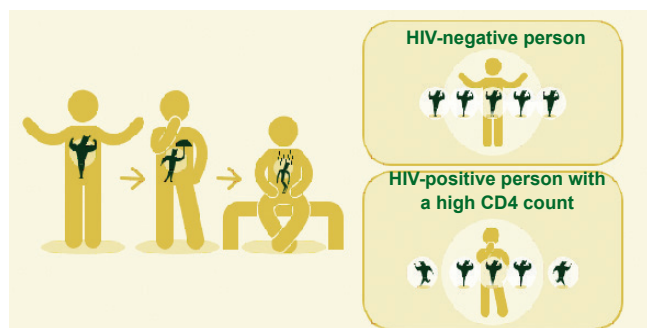
Education and Counselling on HIV:



What is HIV?

- HIV is a virus that enters your body.
- This virus is clever. It uses the human body's own cells to make copies of itself.
- It makes more and more HIV when it enters the body and attacks our CD4 cells, destroying the immune system (our body's defence system, soldiers).





What are CD4 cells?

- CD4 cells are cells that live inside our blood and protect the body against diseases.
- They are like 'soldiers' of the body and they fight against diseases.
- Together with other cells, CD4 cells form the body's 'army', which is called the immune system.
- The blood test you took after testing HIV positive is called CD4 count test.
- It measures how strong the immune system is and how many soldiers you are left with to fight infections.

What happens when your immune system gets too weak?

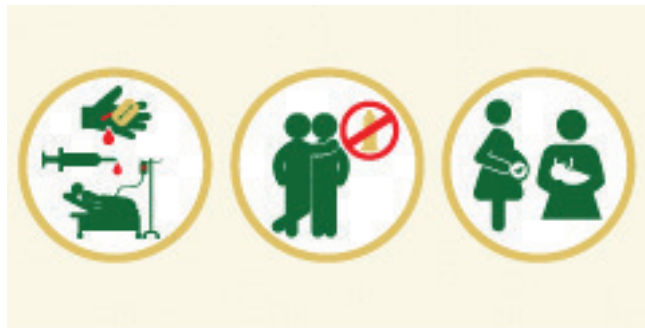
- When the HIV kills your CD4 cells (your body's soldiers) infections can enter into the body and make you sick.
- We call these opportunistic infections (the infection is taking the opportunity to spread because your soldiers of the body are weak).
- The most common opportunistic infections are:
 - TB,
 - Pneumonia,
 - Diarrhoea, and
 - Skin diseases.

What are signs and symptoms of HIV?

- Some people who become infected with HIV do not notice any immediate change in their health.
- Some suffer from flu-like symptoms within a few weeks of becoming infected, or develop a rash or swollen glands.
- HIV symptoms are very similar to the symptoms of other illnesses, so it is not possible to diagnose HIV infection based on symptoms alone.

Remember: The only way to know for sure whether a person is infected with HIV is for them to have an HIV test.

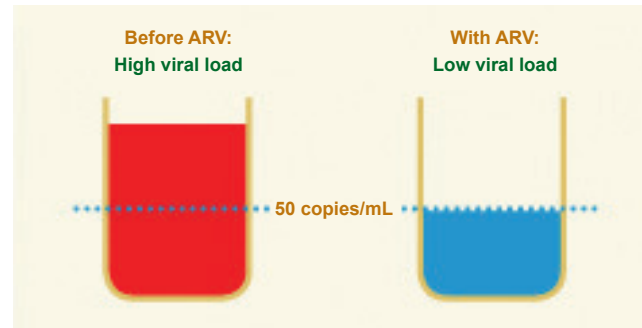




How is HIV spread?

- Through contact with HIV-positive blood through open wounds or broken skin.
- Through the transfusion of HIV-positive blood, use of infected blood products, or accidents in the healthcare setting.
- From sharing unsterilised, contaminated drug needles, razor blades and other skin-piercing instruments.
- Having unprotected sexual intercourse with a person who is HIV positive.
- From an HIV-positive mother to the baby before or during birth, or through breast milk.

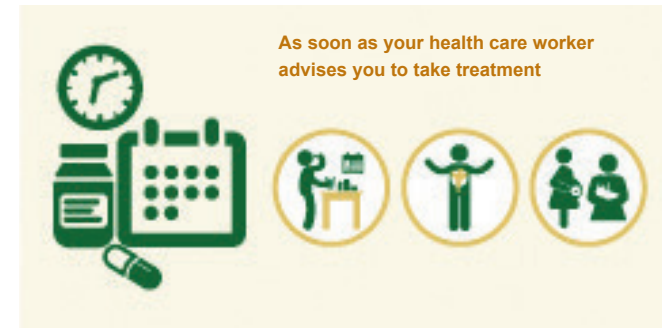
Remember: HIV cannot be spread by shaking hands, sharing cups or eating utensils.



How is HIV treated?

- HIV is treated with antiretroviral (ARV) medicines.
- ARVs are medicines that stop the multiplication of HIV.
- ARVs do not kill all HIV in the body but they kill enough to keep us healthy.
- When you are taking ARV medicines, you will have viral load blood taken to check if ARV medicines are working.
 - Viral load test should be done at 6 months and every 12 months unless your viral load measure is more than 50 copies/mL.
 - You will have to go to the facility at 6 and every 12 months thereafter.
- When HIV stops multiplying in our bodies, our CD4 cells grow strong again, helping our immune system to fight off infections.

Remember: There is no cure for HIV, however, lifelong ARV treatment allows most people with HIV to live a long and healthy life.

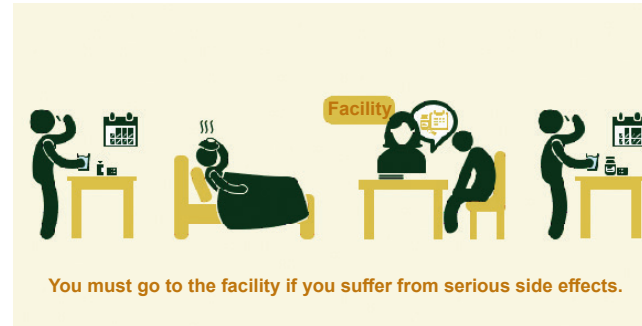
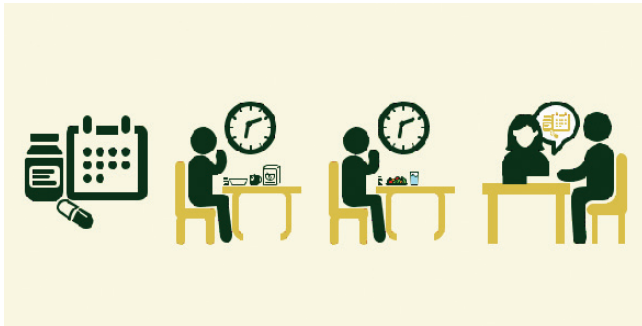


The goal is to have viral load suppressed and thereafter remain below 50 copies/mL.

When should Antiretroviral (ARV) treatment be started?

- The best time to start taking ARV treatment is as soon as advised by health care worker.
- If you do not take the advise to take ARV treatment as advised by health care worker, you will be at a higher risk of getting opportunistic infections like TB.
- The earlier you start ARVs, the faster your CD4 count will return to normal and the smaller the chance that you will get sick.
- Starting ARVs early reduces the chance of infecting your partner or your unborn or breastfeeding baby with HIV.
- For pregnant or breastfeeding women it is important to start ARV treatment early, at any CD4 count.
 - Taking ARV treatment protects the baby from getting HIV and keeps mothers healthy.





How is ARV treatment taken?

- ARV treatment is lifelong.
- ARV treatment needs to be taken every day, at the same time, as prescribed for the rest of your life to keep HIV under control.
- Your doctor or nurse will decide which ARV treatment is right for you.
- ARV treatment should not be stopped and restarted again and again, without informing your health care worker.
- Any missed dose should be taken as soon as you remember.

Remember: The better you are at taking your treatment, the healthier you will be and the longer you will live!

Do ARVs have side effects?

- Some patients may have some minor side effects at the start of their ARV treatment.
- Some side effects are normal in the first few weeks, like feeling sick, dizziness, diarrhoea, headaches.
- You must continue the ARV treatment even if you have side effects but tell your doctor or nurse about them.
- If you vomit in the first hour of taking your ARV treatment, you will need to take your dose again.

Remember: You must go to the facility if you suffer from serious side effects.

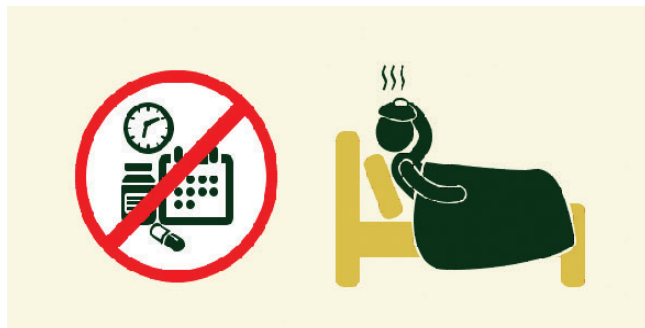
Family and friends you trust can help you to:

- Take your treatment as advised by the health care worker.
- Remind you about your facility appointments.
- Listen to your concerns and provide psychosocial support.
- Pick up your treatment if you are unable to go to your medicine parcel pick up point.
- Inform the facility if you are too sick or call a WBOT leader for help.

What are the risks of poor adherence?

- If you do not take your ARVs every day you will not have enough ARVs in your blood to fight the HIV.
- So the HIV will multiply and destroy the CD4, which means you will get sick.



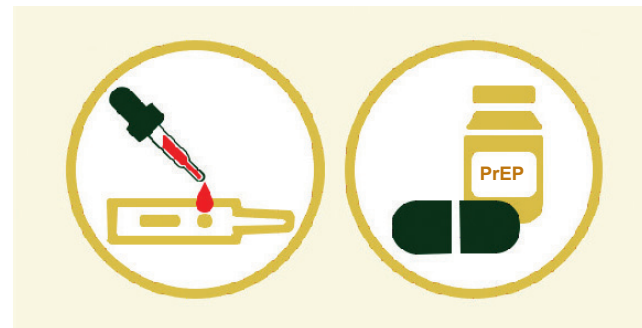


- Another consequence of not taking medicine properly is resistance to ARVs.
 - If the HIV virus encounters few ARVs in the blood, it multiplies and transforms itself and becomes able to resist ARV treatment, meaning that your ARVs will no longer work to kill your HIV.

Remember: If you are struggling with taking treatment, you should discuss with health care worker to assist you with strategies to cope with poor adherence.

What is PrEP?

- Pre-exposure prophylaxis, also known as PrEP, is a new HIV combination prevention option for HIV negative women and men with ongoing HIV risk exposure. For example,
 - if you cannot always have protected sex with partners who you do not know the status of, or who are HIV positive;

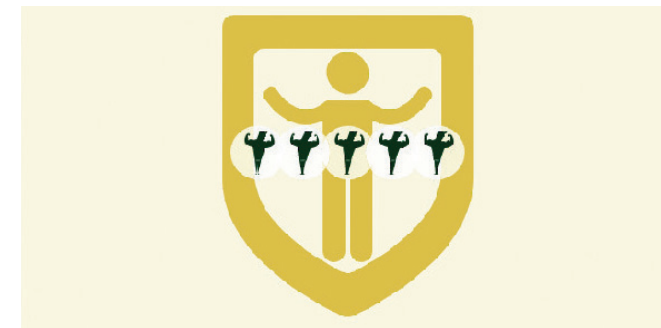


- if you are not always able to negotiate condom use; or
- if you find it difficult to control the risk of being infected with HIV.

Remember: PrEP cannot be taken by everyone. PrEP is a prevention option for HIV negative people with ongoing HIV risk.

How does PrEP work?

- PrEP combines some types of ARV medicines that are commonly used as part of ARV group of medicines to treat HIV infection in HIV-positive people in one tablet.
- When you take PrEP, it makes a shield around your soldiers (CD4).
- It takes approximately 3 weeks for your shield to be well built and protect you well against HIV.



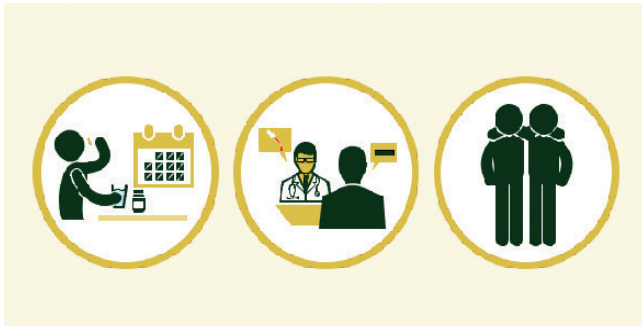
- When HIV comes in your body, the shield protects the CD4 cells, HIV does not survive the battle with the shield and dies.
- When you stop taking PrEP the shield around your soldiers will become weaker and eventually disappear.

Remember: PrEP does not cure HIV, but can prevent HIV infection if you are HIV negative.

Why is adherence to PrEP important?

- You need to take PrEP during periods in your life when you think you may be at high risk of getting HIV, this can be several months to many years.
- To give you a high chance to remain HIV negative, PrEP needs to be taken around the same time, every day, even on days when you do not have sex.





- It is important to take PrEP with other combination prevention methods for optimal protection against HIV infection, sexually transmitted infections and unwanted pregnancies.
- If you are taking PrEP, you need to attend the facility periodically for laboratory monitoring including scheduled HIV tests and adherence support.
- You can stop taking PrEP if you feel you are not at risk of getting HIV, however you should still take PrEP for one month following the last time you had unprotected sex or risky behaviour.
- If you decide to stop taking PrEP, you must inform the health care worker, so that you can be advised about other HIV prevention options.
- Most people who take PrEP do not experience side effects, however, if you experience side-effects, it is important to keep taking your PrEP and come to the health facility to inform the health care worker about your experience and to find appropriate support.

Remember:

- PrEP is most effective if it is taken routinely, around the same time, every day.
- For the best protection against HIV it is recommended that people taking PrEP should still use other combination prevention methods, such as consistent and correct use of condoms when they have sex, since PrEP is not 100% effective at preventing HIV infection.



Role Play Activity

- Divide into groups of 3.
- Each group member to assume one of the following roles: Counsellor, Client, and Observer.
- Role play the following scenario:
A client has been diagnosed with TB and has started treatment. He does not want to have an HIV test because he does not believe that he is at high risk for HIV.

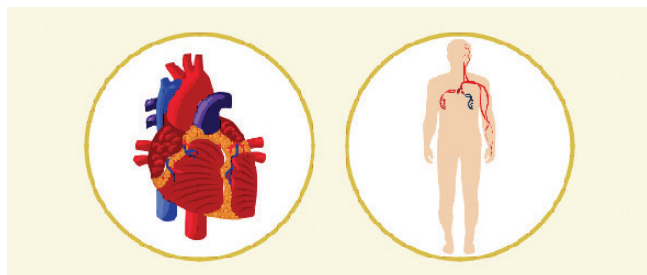


High Blood Pressure

Learning Objectives

- Discuss what high blood pressure is.
- Describe the results of poor adherence to high blood pressure treatment.

Education and Counselling on High Blood Pressure



How does our heart and blood work?

- Our heart works like a pump and makes the blood circulate around the body.
- With every heart beat blood is pushed through the veins and sent through the body carrying oxygen and nutrition.
- Blood pressure is the force of blood as it flows through your veins.



How is blood pressure measured?

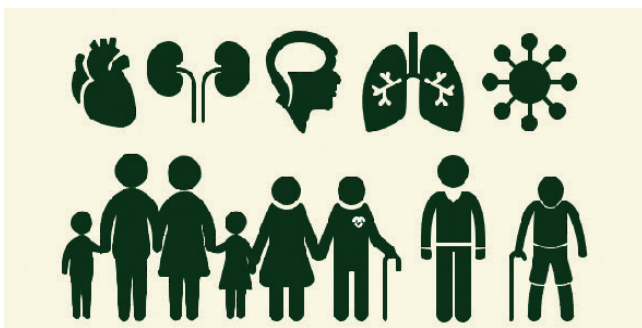
- Blood pressure is measured with a blood pressure machine, ideally at the facility.
- Two numbers are used to describe blood pressure:
 - Systolic is the upper number used to measure blood pressure when your heart pumps, and
 - Diastolic is the lower number used to measure blood pressure when your heart is at rest.
- When blood pressure remains high, meaning above 140 over 90 after several tests taken on different days, the doctor diagnoses high blood pressure.
 - Blood pressure can be different over time; therefore a number of readings need to be done to properly diagnose high blood pressure.

Remember: Your goal when taking blood pressure medicine is to have blood pressure less than 140/90.



What causes high blood pressure?

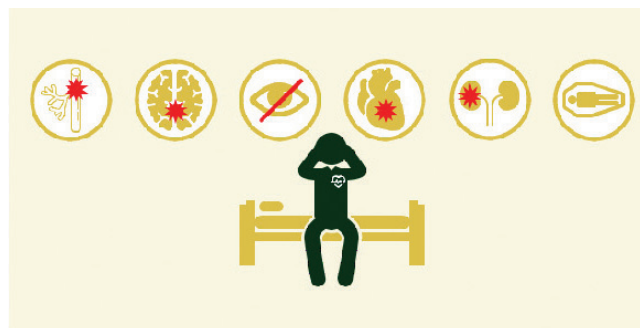
- High blood pressure can be caused by multiple factors.
- Some factors can be controlled and some cannot.
- Factors that cause high blood pressure that can be controlled by making lifestyle changes include:
 - Smoking,
 - being overweight,
 - eating a lot of salt and fat,
 - drinking a lot of alcohol,
 - being very stressed, and
 - not getting exercise.
- These factors will increase your risk of high blood pressure and therefore should be managed through lifestyle changes.



Who is more at risk for high blood pressure?

- People who are at risk for high blood pressure should get their blood pressure measured on a regular basis.
- The following people are more likely to have high blood pressure:
 - People who have heart or kidney diseases, as well as people who have had a stroke.
 - People who have a history of high blood pressure in the family.
 - People with another chronic condition like diabetes or HIV.
 - People over 50 years.

Remember: People who are at risk for high blood pressure should get their blood pressure measured on a regular basis.



What happens if you do nothing to lower blood pressure?

- Due to high blood pressure, blood vessels can break if pressure is too high.
- In other cases, blood vessels can be blocked so that the blood can no longer pass.
- The rupture or blockage can lead to a stroke, blindness, heart attack, heart failure, kidney failure and even death.
- The higher your blood pressure is over time, the greater the risk of complication or death.

Remember: When you have high blood pressure and you do nothing to lower your blood pressure, your chances will be high to develop complications.



What can you do to lower high blood pressure?

- Controlling high blood pressure means a lifelong change of eating and lifestyle habits for all people with high blood pressure. This means:
 - Lose weight if overweight.
 - Do not smoke.
 - No excessive alcohol use.
 - Reduce stress.
 - Eat food low in salt, saturated fats and cholesterol.
 - Increase fruit and vegetables to five servings per day.
 - Exercise 30 minutes a day or more by walking, dancing, or playing a sport.

Remember: Medications may also be necessary to bring high blood pressure back to normal for some people with high blood pressure, if the high blood pressure is not controlled by lifestyle changes or too high.

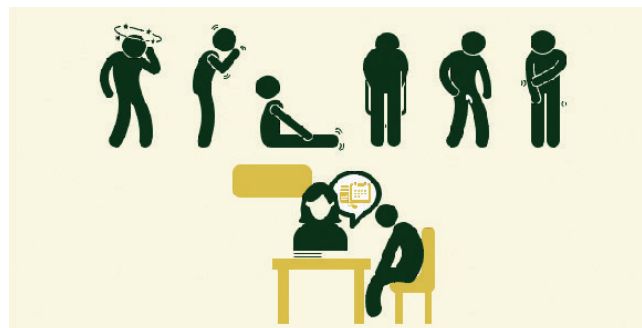


Can medicines control high blood pressure?

- When lifestyle changes alone do not help to control blood pressure enough, the clinician may prescribe medications.
- Lifestyle changes should continue to help you manage your blood pressure.
- The doctor will choose suitable treatment for you depending on your blood pressure and medical history.
 - This means you might take different medicines than somebody with the same condition.
- Some people need just one medicine to control their blood pressure, others need three or more.

Remember:

- It is very important to take your blood pressure medicines as prescribed.
 - Blood pressure medicines should not be taken just when you feel sick but should be continued even if blood pressure is well controlled.
- Interrupting or stopping blood pressure medicines can be dangerous and should be discussed with your doctor or nurse first.



What are some of the side effects of blood pressure medicines?

- If you have unpleasant side effects, rather than getting discouraged and stopping the blood pressure medicines on your own, consult with your doctor who may be able to change your medicines or adjust your dosage to reduce the side effects.
- Possible side effects depending on specific medicine include:
 - Dizziness
 - Cough
 - Swelling
 - Increased urination
 - Sexual dysfunction
 - Muscle cramps



How often should I go to the clinic for my high blood pressure check up?

- If you are not on blood pressure medicines:
 - You should have your blood pressure checked every 3-6 months and see the doctor once a year for a check-up.
- If you are on blood pressure medicines:
 - Regular check-ups with the doctor in the clinic are important to determine the effectiveness of the medicines by checking your blood pressure and to have a physical examination.
 - At the start of your blood pressure treatment we will help you to make a plan on how to adapt your lifestyle and adhere to your medicines.

Remember: You can live, love and improve quality of your life when you manage your blood pressure as advised.



Role Play Activity

- Divide into groups of 3.
- Each group member to assume one of the following roles: Counsellor, Client, and Observer.
- Role play the following scenario:

You are new at the clinic, and a regular client who is taking high blood pressure medication, is acting up, asking why he should take his medication every day, as he is tired of it. Explain to the client what the benefits of adhering to their high blood pressure medication are, as well as the harm or damage caused to the body if high blood pressure treatment is not taken.



Individual Activity

You are a counsellor working at a health facility that provides Chronic Care Services. You are responsible for group education talks on Hypertension.

- Write 1 page on how to reduce high blood pressure.



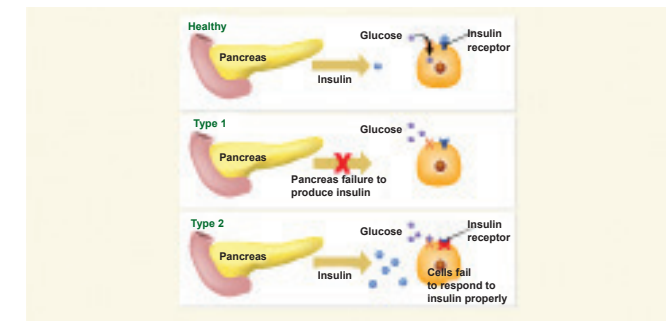
A large green rectangular area with horizontal white lines, intended for writing notes or reflections.

Diabetes

Learning Objectives

- Discuss what diabetes is.
- Describe results of poor adherence to diabetes treatment.

Education and Counselling for Diabetes Mellitus (DM)



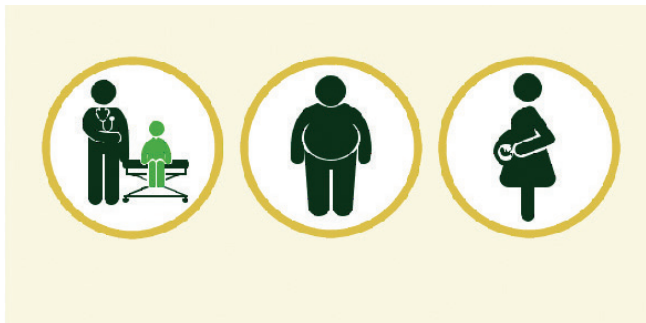
What is Diabetes?

- Diabetes Mellitus also commonly known as diabetes is a chronic disease which increases the level of the sugar in your blood above normal.
- The pancreas, an organ that lies near the stomach, makes a hormone called insulin to help 'sugar' get into the cells of our bodies.





- When you have diabetes, the pancreas does not produce enough insulin or cannot use its own insulin as well as it should.
- The blood will have very high sugar levels. The sugar concentrated blood circulates around your body and destroys blood vessels and nerves in some parts of your body.



What are the types of diabetes?

Type 1

- Often develops in children.
- Children will lose weight, feel very thirsty and urinate more than normal.

Type 2

- Often develops in adults.
- Over 30 years old, and often overweight.

Type 3

- Occurs during pregnancy due to hormonal changes in the body.
- Goes away after birth, but can develop Type 2 later.

Remember: It is important to be screened for Diabetes throughout your pregnancy but especially from week 24 of your pregnancy.



Who is at risk of diabetes?

- Overweight people.
- Large waist circumference: Women: more than 80cm and Men: more than 94cm.
- People with high blood pressure.
- People who have had a stroke in the past.
- Family history of diabetes.
- History of diabetes in pregnancy.



What are the signs and symptoms of diabetes?

- Frequent urination.
- Excessive thirst.
- Unexplained weight loss.
- Extreme hunger.
- Sudden vision changes such as blurred vision.
- Tingling or numbness in hands or feet.
- Feeling very tired most of the time.
- Very dry skin, sores that are slow to heal.
- Erectile dysfunction.
- Persistent vaginal thrush and urinary tract infections.





How is diabetes prevented?

Type 1

- Cannot be prevented.
- Should be diagnosed as early as possible, when the symptoms present.

Type 2

- Can be prevented with lifestyle changes.
- Correct body weight, regular exercise and healthy diet.
- Reducing alcohol intake and stop smoking.

Type 3

- Cannot be prevented.
- Will resolve at the end of the pregnancy.



What should you do to manage your diabetes?

It is important:

- To lose weight if you are overweight.
- To care for your feet.
- To stop smoking.
- To have your blood pressure checked regularly.
- To have your eyes checked.
- To take the recommended dosage and avoid taking traditional medicines for diabetes.

Remember: Lifelong treatment and lifestyle changes allows most people with diabetes to live a long and healthy life.



How is diabetes treated?

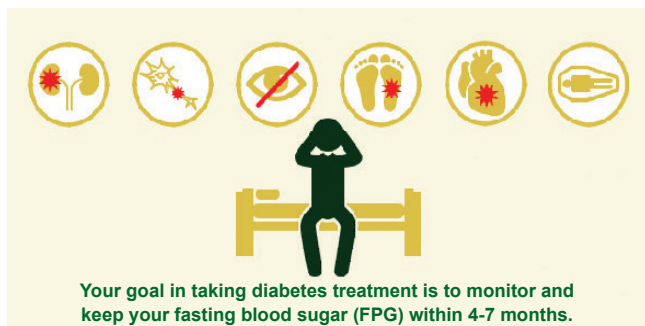
Type 1

- Regular blood glucose testing and insulin injections.

Type 2

- Regular blood glucose testing and insulin injections.
- Lose weight if overweight, stop smoking, regular physical activity, follow a healthy diet and eat smaller meals, more often.
- Good foot care, regular blood pressure and eye tests.

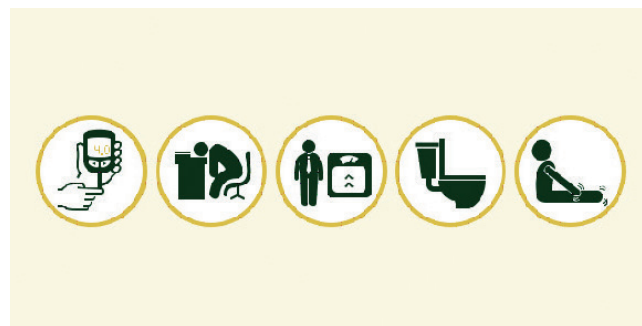




Why is it important to keep blood sugar controlled?

- If you do not keep the level of sugar controlled, the sugar will go round and destroy blood vessels and nerves and cause complications including:
 - Kidney disease,
 - Nerves not functioning properly,
 - Eye problems,
 - Sores and wounds, especially on the feet, not healing well which could lead to amputation,
 - Damage to the heart muscle and blood vessels, and
 - Death.

Remember: Your goal in taking diabetes treatment is to monitor and keep your blood sugar at HbA1c $\leq 7\%$. The more sugar in your blood, the more it sticks to the hemoglobin.

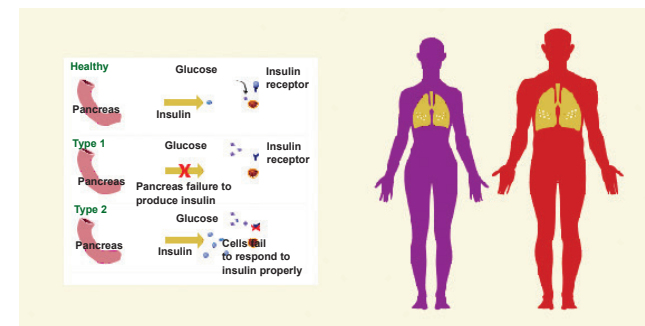


HbA1c measures the percentage of sugar stuck to the hemoglobin in your blood instead of measuring your sugar in a drop of blood.

HbA1c is a longer-term measurement that is able to show your average blood sugar over the three months.

What are the side effects of diabetes treatment?

- Side effects are different, depending on the types of medicines that you are taking. Examples can be:
 - Low blood sugar,
 - Tiredness or dizziness,
 - Upset stomach,
 - Swelling of legs and ankles, and
 - Weight gain.



Remember: If side effects are experienced, you MUST NOT stop treatment but go to the nearest health facility.

What is the link between Diabetes and TB?

- Diabetes increases the risk of developing TB.
- Rates of TB are higher in people with diabetes compared to the rest of the population.
- TB infection may progress at a faster rate in people with diabetes than in those without diabetes.

Remember: It is important to screen people with diabetes for TB and to screen people with TB for diabetes.





Small Group Activity

- Divide into groups of 3.
- Each group member to assume one of the following roles: Counsellor, Client, and Observer.
- Each group member identifies three possible complications of diabetes.
- They each take a turn telling a newly diagnosed person with diabetes about these.
- 15 minutes.



Individual Activity

Some of the issues related to the treatment of diabetes include:

- Storing your treatment in a fridge.
- Taking treatment twice a day.
- Doing a finger prick on yourself to check your glucose levels.
- Injecting yourself with medicine.
- Think about your own life and what it would be like to face these issues on a daily basis.
- What would your fears be?
- Make notes for feedback session and group discussion.
- 15 minutes.

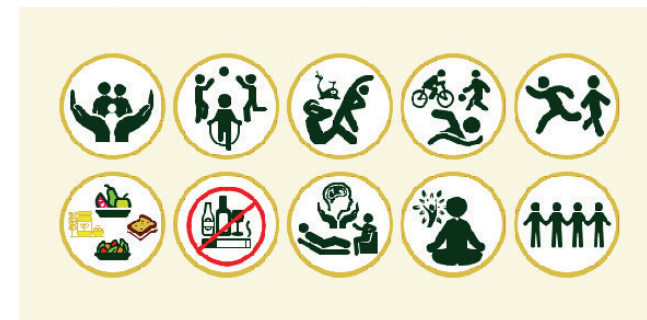


Education on Healthy Living

Learning Objectives

- Know recommendations to lead a healthy lifestyle.
- Know what a basic, healthy diet is made of.

Education and Counselling on healthy living



Healthy lifestyle

- For all chronic illnesses, it is recommended that one leads a healthy lifestyle by:
 - Getting regular exercise,
 - Adopting healthy eating habits, and
 - Managing stress.

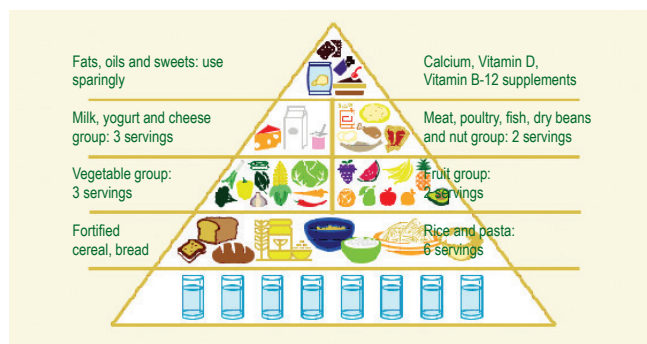


Remember: Talk to your health care worker about what healthy living options such as exercise and diet are suitable for you.

– Everyone’s body is different.

What is a basic, healthy diet made of?

- See the Food Triangle below to understand what a basic, healthy diet is made up of.
- It is recommended that you eat most of the products that are at the base of the triangle, and the least of the products on top.
- Foods have different things that they give us. It is important to eat a variety of of foods to ensure that we get complete nutrition.
- Carbohydrates and fats give us energy. Some examples include:
 - Maize
 - Oats
 - Sugar
 - Rice
 - Potato
 - Oil
- Proteins help our bodies repair and work smoothly. Some examples include:
 - Maize
 - Meat
 - Fish
 - Milk
 - Soya
 - Rice
 - Chicken
 - Eggs
 - Beans
 - Peanuts



- Vitamin rich foods are important to help us fight disease. Some examples include:
 - Maize
 - Rice
 - Fruits and vegetables

Remember: Drinking a lot of water or tea without sugar is important.

Healthy living and water

- The most accessible way to stay healthy is to drink plenty of fluids.
- Drinking water helps:
 - Digestion
 - Regulate body temperature.
 - Prevent colds and flu.
 - Maintain healthy blood pressure.
 - Decrease risk of kidney stones.



- When urine is clear or pale yellow = hydrated.
- When urine is yellow or gold = need more water.

Remember: Drink plenty of water every day. Drink more when you have diarrhoea, vomit or sweating.



Safe food preparation

- Maintain a clean environment in the kitchen.
- Clean cloths, sponges and scourers with bleach or let them dry in sun.



- Wash dishes with hot, soapy water.
- Wash hands before touching food, cover all wounds.
- Keep uncooked food separate from cooked food.
- Clean up immediately after spills.
- Avoid food that has passed its sell-by date.



Small Group Activity

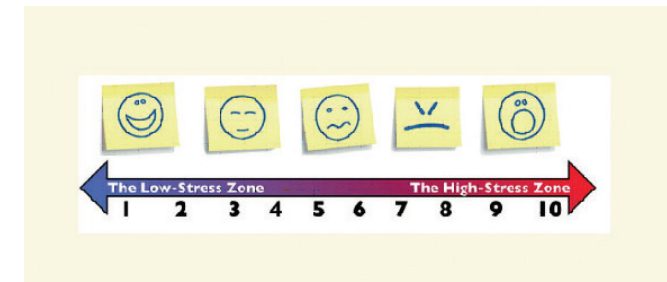
- Divide into groups of 3.
- Each group member to assume one of the following roles: Counsellor, Client, and Observer.
- Role play the following scenario:
A client is brought to you for counselling on healthy living. What would you encourage client about healthy living?

Education on Mental Health

Learning objectives

- To provide education and counselling support for clients with mental health issues.
- To refer clients with mental health issues.

Education and Counselling on healthy living



What is Mental Health?

- Mental health refers to a state of well-being in which every individual realises his or her own potential and can positively cope with the normal stresses of life, can work productively and fruitfully and is able to contribute to his or her community.





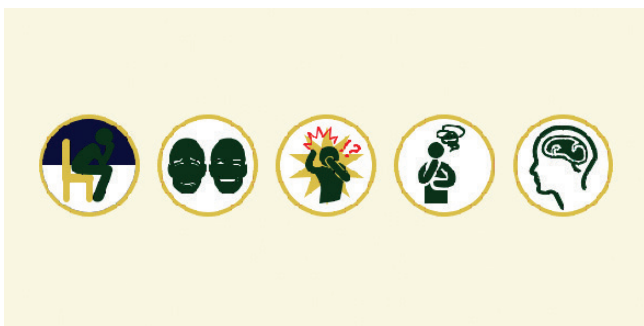
- Mental health also includes a person's ability to enjoy life and cope when bad things happen.
- Mental health problems are real and sometimes very serious.
- Your mental health can affect your daily life, relationships and even your physical health.

Remember: If you are sad or stressed, this can affect your adherence to treatment.

- Need to use alcohol or drugs.
- Exercise, diet and/or eat obsessively.
- Hurt other people or destroy things.
- Do irresponsible things that could harm you or others.

Remember: Mental health can significantly affect how a person thinks, behaves and interacts with other people.

- Changes in eating habits and or appetite such as eating too much or refusing to eat.
- Having problems sleeping or feeling tired and not having energy.
- Feeling anxious, looking or feeling 'jumpy' or upset, having panic attacks.
- Not wanting to spend time with people; spending too much time in bed.
- Hearing and seeing things that others do not see.



When do you need help with mental health?

- You might need help if you:
 - Always feel very angry or very worried.
 - Feel very sad for a very long time after a loss or death.
 - Think your mind is controlled or out of control.

What are the signs and symptoms of mental health issues?

- Losing interest in things that you are used to enjoy doing.
- Extreme changes in mood which are not normal for you.
- Hurting yourself, such as cutting yourself.

What can I do for myself in case I have some of these signs and symptoms of mental health issues?

- **Do's** (Things that can help you to deal with the symptoms):
 - Share your feelings and spend time with other people you trust.





- Get back to daily routine as much as possible such as work, school, housework.
- Participate in religious or spiritual activities.
- Play sports or get regular exercise.
- Eat regular meals.
- Get adequate rest.
- Take a break and relax.
- Participate in enjoyable activities such as singing, dancing, reading even if at the moment it may be hard for you to enjoy them.
- Help other people talk about how they feel, but also respect if they choose not to talk about it.
- **Don'ts** (Things to try to avoid to cope with signs and symptoms of mental health issues)
 - Using alcohol or drugs to cope.
 - Withdrawing from family and friends.
 - Withdrawing from daily activities.
 - Overworking.
 - Blaming yourself or others.
 - Neglecting your health and self-care such as sleep, hygiene or diet.

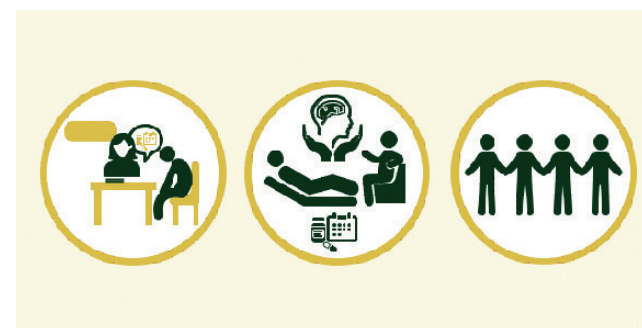
Remember: You may need to seek professional help from a psychiatric nurse, social worker or psychologist if you want to talk with someone outside of your family or circle of friends or if your symptoms do not improve with the coping strategies.



What are the specific issues people with mental health issues are faced with?

- They may be stigmatised as people do not understand that it is a medical condition.
- Families of people with mental health issues may be ashamed of them and hide them away from the community.
- They may be locked away because their behaviour is unacceptable.

Remember: People who show symptoms of mental health issues should be referred to a health facility for further assessment and treatment.



Mental health treatment and adherence

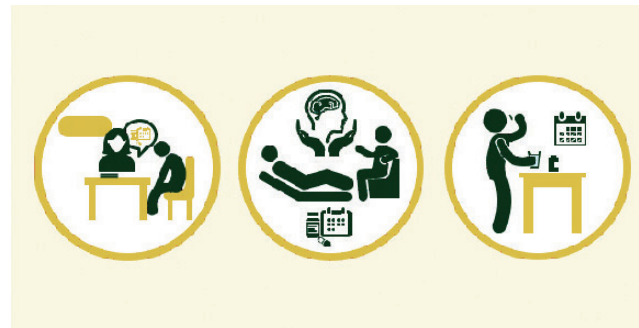
- Can mental health issues be treated?
 - Yes, mental health issues can be treated.
 - Many people who have mental health issues, and are treated, recover well or even completely.
 - However, because there are many different factors that lead to someone getting a mental health issue, it can sometimes be difficult to tell how, when, or to what extent a person is going to get better.
- Why must treatment be adhered to?
 - Treatment for mental health issues must be adhered to, to make sure that the mental health issue is under control.
 - This will help clients live and work with their mental health issue.





How and when should mental health treatment be taken?

- There are different ways that mental health issues can be treated.
- These can involve medication, individual therapy or counselling and different forms of support in the community, as well as people with the mental health issue helping themselves.
- How and when should medicines for mental health issues be taken?
 - It is very important that medicines be taken as prescribed.
 - Medication should not just be taken when you are not feeling well, but should be continued even if you are feeling well.
 - Interrupting or stopping treatment can be dangerous and should be discussed with a doctor or nurse first.



What are the side effects of mental health treatment?

- Side effects are different, depending on the types of medicines that the client is taking.
- If side effects are experienced, clients **MUST NOT** stop treatment.
- They should go to the nearest facility immediately.
- How often should a client visit the facility?
 - The client should visit the facility based on the follow up schedule that the healthcare workers provide.
 - It is important that clients keep all their scheduled appointments.



Role Play Activity

- Divide into groups of 3.
- Each group member to assume one of the following roles: Counsellor, Client, and Observer.
- Role play the following scenario:
A client who has signs of mental health issues, feels that no one understands her. What would you advise clients about mental health issues, treatment, adherence and side effects of mental health treatment?





Education on Substance Abuse

Learning objectives:

- To provide education and counselling support for clients who abuse substances.
- To refer clients who abuse substances.

Education and Counselling on Substance Abuse



What is substance abuse?

- Substance abuse is the regular or too much use of a drug or substance which leads to addiction and physical and psychological cravings.

- Substance include:
 - Alcohol
 - snuff
 - mandrax
 - acid and LSD
 - nyaope
 - medication like cough syrup and pain killers.
 - everyday household substances such as glue, turpentine, benzene, cooking spray and petrol.
 - tobacco
 - dagga
 - cocaine
 - tik (meth)

Remember: Alcohol and substance use increases the risk of forgetting to take treatment or to come to the facility for scheduled appointment.

What does it mean if someone is dependent on substances?

- Someone is dependent on substances if they do at least three of the following for a period of time for several binge episodes, and it becomes a recurring cycle of behavior:
 - Use substances in larger amounts over a longer period of time than originally intended;
 - Excessive use is recognised but their ability to control is lacking;



- Daily activities focus on getting, using, and recovering from the effects of the substance, and/or
- Substance use and intoxication (or withdrawal) interferes with their everyday functioning.
- If you are worried about yourself or a friend, inform health care worker or contact South Africa Anxiety and Depression Group Substance Abuse Helpline on 0800 12 13 14 or SMS 32312. Open 7 days a week.

Adherence to treatment and substance use

- It can be difficult to adhere to long term treatment if you are using or abusing alcohol or drugs.
 - It is better to try to limit your consumption of alcohol or drug when being on long term treatment.



- If you drink alcohol or use drugs, it is very important to make sure that you keep on taking your treatment correctly.
- In case you are planning to drink alcohol or use drugs, there is a risk that you will forget to take the treatment.
 - To make sure you do not forget to take treatment:
 - make a plan to take the treatment before using alcohol or drugs, or
 - make sure someone (who is not using alcohol or drugs) can remind you to take medication even if you are under the influence of alcohol or drugs.

Remember: If you feel that your consumption of drug or alcohol is problematic, we can refer you to a specialised service that can support you to cut down your consumption.



Role Play Activity

- Divide into groups of 3.
- Each group member to assume one of the following roles: Counsellor Client, and Observer.
- Role play the following scenario:
A client shares with you that he has problems with substance abuse (alcohol and dagga) and sometimes forgets to take treatment.

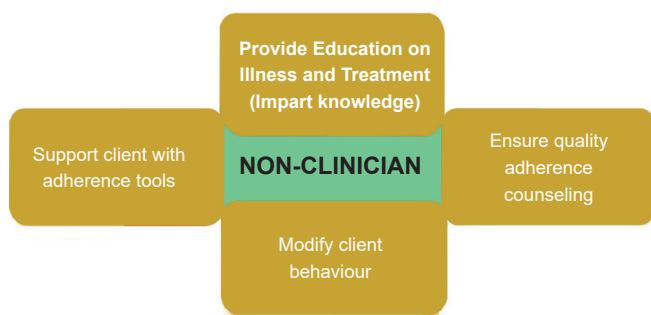
What would you advise the client about treatment and substance abuse?

Where would you refer the client to get more assistance if they are dependent on alcohol and dagga?



SECTION 3: MINIMUM PACKAGE OF INTERVENTIONS TO SUPPORT LINKAGE TO CARE, ADHERENCE AND RETENTION IN CARE

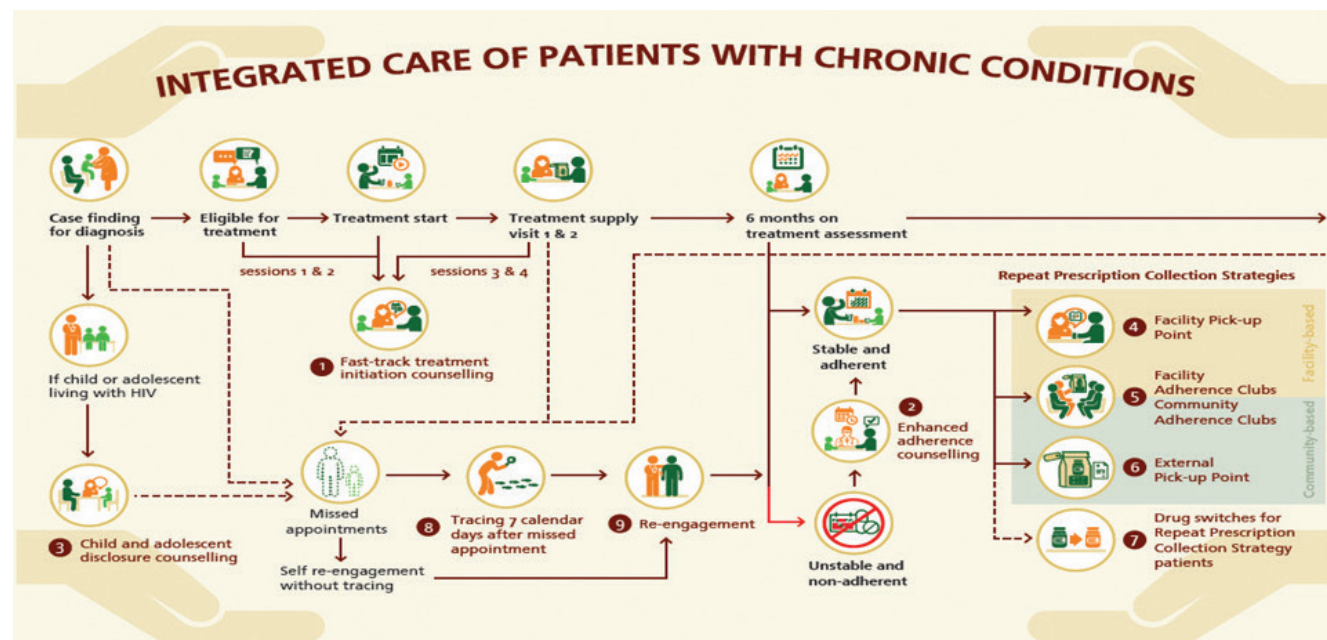
Overview



The minimum package of interventions models to support linkage to care, adherence and retention in care are to be implemented in all facilities across South Africa. These models were chosen to be included in the Adherence Guidelines minimum package because they have been shown to improve adherence and retention in care.

Learning objectives:

1. Understand 9 minimum package of adherence interventions models.



- Fast Track Initiation Counselling (FTIC 1)
 - Enhanced Adherence Counselling (EAC 2)
 - Child and Adolescent disclosure Counselling (CADC 3)
 - Facility Pick up Point (FAC-PUP 4)
 - Adherence Club (AC 5)
 - External Pick up Point (EX-PUP 6)
 - Drug Switches for Repeat Collections Strategies (RPCs) Patients (7)
 - Tracing and Recall (8)
 - Re-engagement (9)
2. Understand the role of non-clinicians to support minimum package of interventions models.



I. Fast Track Initiation Counselling (FTIC 1) model?

Learning objectives

- Know what FTIC 1 model is.
- Know what patients qualify for FTIC 1 model.
- Understand how to implement FTIC 1 model.
- Understand role of a non-clinician to support FTIC 1.

What is Fast Track Initiation Counselling (FTIC 1) model?

FTIC 1 model is one of the minimum package intervention models that focuses on providing education and counselling mainly for newly diagnosed clients.

Fast track initiation counselling focuses on:

- Providing pre- and post-initiation support to newly diagnosed patients with particular focus on adherence support.
- Providing education and support to patients without delaying initiation of treatment.
- Assist the patient to develop an individualised adherence plan and set clear treatment milestones.
- Provide standardised education and counselling using Adherence Education flip file for HIV, TB, Hypertension and Diabetes.
- Assist patient with problem solving around the most common barriers to adherence including the need for support, alcohol and substance use issues and clearing misperceptions about adherence.

What patients qualify for Fast Track Initiation Counselling (FTIC 1) model?

- All newly diagnosed patients who are pre-treatment and treatment patients.
- Patients co-infected with TB who need to initiate ART shortly after TB treatment.
- Pregnant women who initiate on the same day as HTS.

What tools are needed to implement FTIC 1 model?

- Minimum package SOPs for Fast Track Initiation Counselling.
- Patient Adherence Plan sheet.
- Adherence education flip file.
- Mental Health assessment tool.
- Adherence treatment pamphlet.
- List of supporting organisations (CBOs, FBOs) to assist with referral to psychosocial support.

How is the FTIC 1 model implemented?

Newly diagnosed pre-treatment and treatment are referred for education counselling and to start their adherence plan.

There are four sessions in the adherence plan:

(Refer adherence plan and SOPs FTIC 1)

- **Session 1:** Day of linkage into care – provide education on the health condition and start an adherence plan.
- **Session 2:** Day of initiation – continue with the adherence plan. Session 1 and 2 must be combined if same day initiation.





- **Session 3:** First treatment refill (1 month from treatment start) – finalise the last steps of the adherence plan and outline the treatment pathway ahead if adherent.
- **Session 4:** Second treatment refill (2 months from treatment) – educate on assessment, restate goals and treatment pathway ahead if assessment results are normal.

Adherence Plan has been revised to include additional step 11 on the treatment pathway ahead.

The following activities form part of FTIC 1 model:

- Assist the patient to complete their own adherence plan by completing the sessions throughout patient's visit.
- The first session of adherence plan is education on illness.
- Use flip file to provide standardised education and counselling depending on patient's condition to help patients understand the explanations of their condition during counselling sessions.
- Use the adherence plan sheet to assist patients to make their own commitment during counselling.

It is important to remind patients of their Adherence Plan treatment goals as follows:

- **Hypertension goal:** My Blood Pressure is less than 140/90.
- **Diabetes goal:** blood glucose at HbA1c $\leq 7\%$. The more sugar in your blood, the more it sticks to the hemoglobin. HbA1c measures the percentage of sugar stuck to the hemoglobin in your blood instead of measuring your sugar in a drop of blood. HbA1c is a longer-term measurement that is able to show your average blood sugar over the three months.
- **ARV goal:** The goal is to attain VL < 50 copies /ml according the revised SOPs.
- **TB goal** have completed 6 months TB treatment and I am cured of TB!

sessions so that they become accountable for adherence to their treatment – the completed adherence plan should be placed on the patient folder and updated with sessions provided.

- Upon each visit, the adherence plan sheet should be retrieved as a means to review patient commitment.
- Referral and comprehensive support for patients including pregnant or lactating women on any chronic treatment such as ART or HIV/TB, TB/diabetes co-infected patients or hypertensive patients.
- Trace patients if they miss scheduled appointment.

What is your role as a non-clinician to support FTIC 1 model?

- Provide education on illness, treatment, adherence, treatment pathway ahead, side effects and risk of non-adherence.
- Assist the patient to complete adherence plan at every visit to:
 - Identify a support system.
 - Create a medication schedule.
 - Deal with missed doses.
 - Identify reminders.
 - Identify where to store medication
 - Deal with side effects.
 - Know what to do in case travelling.





- Take medication in case of substance or alcohol use.
 - Educate on the future steps on treatment such as VL, sputum, or HbA1c.
 - Set treatment goals.
- c) Inform the patient about tracing and retention in care system.
- d) Document all processes appropriately.



Role Play Activity

- Divide into groups of 3.
- Each group member to assume one of the following roles: Counsellor, Client, and Observer.
- Role play the following scenario:

A client has recently been diagnosed with HIV and has been referred to you for counselling. The client has not started treatment. What tools would you use to counsel the client?

What are some of the issues that you will cover during counselling?





II. Enhanced Adherence Counselling (EAC 2) model

Learning objectives

- Know what EAC 2 model is.
- Know what patients qualify for EAC 2 model.
- Understand how to implement EAC 2 model.
- Understand role of a non-clinician to support EAC 2 model.

What is Enhanced Adherence Counselling (EAC 2) model?

The EAC 2 model is one of the minimum package intervention models that focuses on providing education and counselling to clients who are non-adherent.



Patients can be counselled by clinicians or experienced non-clinicians. Counselling of unstable patients is mainly done by clinicians. Where possible, the facility manager can identify non-clinicians with experience in counselling unstable patients on adherence issues.

Enhanced adherence counselling model focuses on:

- Providing enhanced adherence monitoring, counselling and targeted interventions for unstable patients and referring patients for support as soon as possible.

What patients qualify for the Enhanced Adherence Counselling (EAC 2) model?

- Patients ascertained by the clinician as having adherence problems.
Clinicians would have assessed them on Adherence, Bugs (Infections), correct dose, drug interactions, Resistance.
- Patients with abnormal results on treatment:
 - Hypertension: persistent high BP (> 140/90).
 - Diabetes: patients with blood sugar level on treatment with HbA1c more than 7%.
 - TB: positive smear on treatment for 2 months.

- HIV: high HIV viral load on ART. Viral load of more than 50 copies/ml.

- Patients with adherence problems to prescribed chronic medication.

What tools are needed to implement EAC 2 model?

- Minimum package SOPs for Enhanced Adherence Counselling.
- Patient Adherence Plan sheet.
- Mental Health assessment tool.
- List of supporting organisations (CBOs, FBOs) to assist with referral to psychosocial support.

How is EAC 2 model implemented?

The facility shall establish a system to identify all files of unstable patients. The EAC identification system can consist of coloured stickers or note on the file or in pulling out the files in a separate folder. A prioritised file should trigger referral for enhanced adherence counselling as soon as the patient comes back to the facility.

There are two sessions for Enhanced Adherence Counselling. (Refer SOPs EAC 2)

Session 1:

- Initial enhanced adherence counselling for unstable patients.

Session 2:

- Enhanced adherence counselling for persistent unstable patient.

The following activities form part of EAC 2 model:

- Prioritise identification of clients with abnormal results early.
- Provide clients with education on their latest results.
- Client-focused strategy – assess barriers to adherence (including misconceptions and fears linked to taking medication in case of alcohol or substance abuse or missed treatment doses),
 - discuss effective strategies that are aligned to the true cause of non-adherence and acceptable to the client (go back to the initial adherence plan sheet and see where things went wrong).





- Set new objectives according to the next step on treatment.
- Provide additional individual support in case of switching to another regimen.
- Make an active referral of clients for appropriate psychosocial support and support services.
- Trace patients if they miss scheduled appointment.
- Inform patients about tracing and retention in care system.
- Document all processes appropriately.

What is your role as a non-clinician to support EAC 2 model?

- Provide education on abnormal results and common cause for treatment failure.
- Assess and address barriers to adherence.
- Assess misconceptions and beliefs about treatment.
- Provide support to elaborate strategies to overcome barriers such as taking treatment even if drinking alcohol.
- Assist patients to set new goals for next test or appointment such as having undetectable VL, less than 50 copies per/ml, blood pressure less than 140/90, blood glucose with HbA1c less than 7% or negative sputum.
- Encourage adherence to influence next result.



Role Play Activity

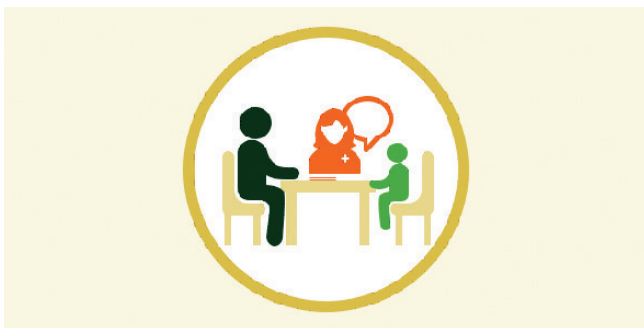
- Divide into groups of 3.
- Each group member to assume one of the following roles: Counsellor, Client, and Observer.
- Role play the following scenario:

A 68 year old pensioner, who lives alone in a squatter camp, has been on ART for a year. His viral load keeps going up, and his CD4 count drops below baseline. He cannot manage his pension; as a result he is often hungry. He does not keep his clinic appointments and fails to collect his ART.

What are some of the key issues you will cover during counselling?

Where would you refer the client for psychosocial support and other interventions?





III. Child and Adolescent Disclosure Counselling (CADC 3) model

Learning objectives

- Know what CADC 3 model is.
- Know what patients qualify for CADC 3 model.
- Understand how to implement a CADC 3 model.
- Understand the role of non-clinicians to support CADC 3 model.

What is the Child and Adolescent Disclosure Counselling (CADC 3) model?

- Child and Adolescent Disclosure Counselling (CADC 3) model is one of the minimum package intervention models providing education and counselling mainly for children and adolescents living with HIV and their caregivers. The health care worker or non-clinician prepares and supports the caregiver to disclose to the child or adolescent.
- Child and adolescent disclosure counselling model focuses on:
 - Providing step-by-step, incremental, and standardized approaches to HIV disclosure counselling in children and adolescents.
 - The process of disclosure is progressive and ongoing as new information or deeper levels of information are shared with the child.
 - It is important that disclosure follows a planned process and to understand that there are levels of disclosure over time.

What patients qualify for child and adolescent disclosure counselling (CADC) model?

Caregivers and all children from 3 years old should start being prepared for partial disclosure. Disclosure criteria are as follows:

- Non- Disclosure (3 – 5 yrs)
- Partial Disclosure (6 – 9 yrs)
- Full disclosure (10 – 12 yrs)

What tools are needed to implement the CADC 3 model?

- Minimum package SOPs for Child and adolescent disclosure counselling.
- Disclosure talk tool.
- Disclosure plan.
- Disclosure IEC material.

How is the CADC 3 model implemented?

It is important to ensure that the caregiver is the primary caregiver who lives with the child or adolescent.

There are two sessions:





- **Session 1:** Partial disclosure.
- **Session 2:** Full disclosure.

For each session, the caregiver is prepared separately to support the child during the disclosure session. Images or drawings must be used to help children and adolescents understand the explanations during counselling sessions.

The following activities form part of the CADC 3 model:

- Educate caregivers on the importance and the advantages of progressive disclosure.
- Provide a step-by-step approach to disclosure, providing education on HIV and ART in adapted language respecting the needs of the child.
- As a first step, children are taught about a special germ that enters the body, and treatment to keep the germ asleep.
- This is termed 'partial disclosure'.
- The second stage involves explaining to children they are HIV positive and educating them about HIV transmission ('full disclosure').
- Trace patients if they miss a scheduled appointment.

What is your role as a non-clinician to support CADC 3?

Support caregiver and child with the process of disclosure as recommended. (Refer to CADC 3 SOPs) Refer caregiver and child or adolescent to other psychosocial services as necessary. Inform patients about tracing and retention in the care system. Document all processes appropriately.



Role Play Activity 1

- Divide into groups of 3 to 5.
- Take a few minutes to take out items in your handbag, purse, and briefcase that you do not want others to see. Participants then share with others the contents of their handbag, purse, and briefcase. The other group members then write a list of the habits, likes, dislikes, and probable hopes or fears of the person whose belongings were shared, based on the contents of that person's handbag, purse, briefcase. The person can be described through the objects shared, such as 'This person cares about family because they have lots of photos of them'. The person is then asked whether the group's observations are consistent with what their habits are.

Think about:

- How you felt when you compared your items to other people's?
- What items did you not want to share and why?
- What feelings did you have about individual items of yours, sadness, pride, etc.?
- Are you surprised by what items others showed?
- How are the contents of your handbag, purse, or briefcase the same as others? How are they different? How did this make you feel?





Role Play Activity 2

Divide into groups of three.

- Describe your experience with discussing information on a child's condition without naming HIV. If you have not done so, think about what you expect the experience to be like
- Describe how you started or will start the discussion with the child.
- What are your fears and concerns about disclosing a child's status?
- Participate in a group discussion and give feedback to the larger group.
- 2-3 volunteers are needed to narrate the scenarios below.
- Following the completion of the scenario, under each counsellor sentence, say what skills the counsellor is using, what more could they say or do and is this beneficial?

Scenario A – Class activity

A child's caregiver with the child not present

Giving information to pre-school children under the age of 5-6 years

- Emphasis should be on the child's health and illness.
- Full disclosure of HIV status will generally be delayed until later.
- Give information in response to the child's questions ("why does the doctor take my blood?") or reaction (e.g. refusing to co-operate with procedure).
- Give explanations that answer questions – do not add unnecessary detail.
- Use play activities (e.g. doctor – doctor or dolls) to allow child to communicate any concerns or express feelings indirectly.







Thembisa and Gladys

Thembisa is 4 years old. She has lived with her grandmother/caregiver Gladys since her mother died three years ago. Thembisa and Gladys have been visiting the clinic since Thembisa started to become symptomatic. The doctor wants her to start ART soon. Gladys is having problems giving Thembisa her Bactrim (cotrimoxazole) and she believes that Thembisa would co-operate better if she understands more about the medication and why she needs it, especially since ART is now about to become part of their lives. The HCW has suggested that Gladys sees the counsellor, first without Thembisa present, to help her explain to Thembisa why she needs to take her medicine and to support her through the long process of disclosure.

C: Gladys, good morning. (Welcome and introduction).

G: Good morning counsellor.

C: I see from the note that you want to speak to me before you bring your grandchild for ARV treatment?

G: Counsellor my grandchild, Thembisa, is getting sick now. She has the HIV and the doctor says she must start drinking more pills to make her strong. She doesn't like to take the Bactrim because her sister doesn't take it. Now with more pills, there will be more trouble and the nurse has told me that she has to drink them every day, twice. If she misses, the pills won't work and she will get weak and very sick.

C: You are worried about Thembisa's health and want some help in getting her to take the medicine because it's going to be more difficult now with more pills.

G: Yes, that's right – and I am so worried that she will get very sick.

C: I can see that you understand how important it is for Thembisa to take her pills to keep her strong and healthy. It's very hard for a granny (or a mother) to talk to their children about HIV, so I'm glad that you are here today because we can start looking at ways to make Thembisa understand why she needs to take her medication. This will be the first of many steps in telling her about her illness.

G: I will be glad of that. But I don't want to frighten her – telling her could make her get sick.

C: Yes, Gladys, I understand you're worried, but trying to work this out for herself and getting things wrong, or finding out by accident could also be very scary for her. So that's why it's important that Thembisa learns about her HIV from you – not everything at once, but slowly, just a little bit at a time. She's still a little girl, so you have to tell her only what she needs to know now. As she gets older and can understand more, you'll tell her more.

G: But she is too clever – that child. She asks all the time why the doctor takes her blood.

C: And what do you tell her Gladys?

G: No, I tell her it's because she is sick and the doctor needs to look at her blood.

C: That's a good way of starting to explain things, Gladys. You're using words that she can understand. But what if she asks what the doctor is looking for? What would you say then?





G: *She already asked that and I didn't know what to say! So I pretended I didn't hear her and she didn't ask again.*

C: *It is hard to know what to say. But Thembisa's questions are telling you that she wants to know more – and they're telling you what she wants to know. If she stops asking, it could be because she doesn't want to upset you. Let's think what you could say.*

G: *I really don't know what to say. If I tell her about viral load and CD4, then I'll have to tell her about HIV and she's too little to have to know that.*

C: *You're right. She's too young to understand about viral load and CD4. Maybe you could say that the doctor takes her blood to look for germs that are making her sick. You probably don't need to say more than that unless she asks and she might – you did say that she is a clever child and she seems to want to understand more.*

G: *(Nods) Then, what would I say?*

C: *She might want to know what a germ is – you could say to her: A germ is a small thing that comes into your body and that makes you sick. If she doesn't ask more, then she is probably satisfied with that explanation for now. She will*

*show you when she's ready to know more. Try to answer her questions as she asks them. Remember, you don't need to tell her everything in one day. It can take a long time before you get round to talking about HIV. But when she's older and ready to know more, she will already know about germs. Then, you can use the idea of germs to start talking to her about her HIV. (*They often learn about hand washing and germs, why it is important to wash your hands to get rid of germs)*

G: *How will I know when she is ready to know more?*

C: *When she asks you, or does something that shows she wants to know. After a while you will understand how to answer her questions. Remember to be open and honest with her. In that way she will trust you more and feel comfortable to ask you questions.*

G: *So now when I go home, I can tell her about germs in the blood?*

C: *If you think she wants to know more...*

G: *But will knowing about germs make her want to take her Bactrim and the other drugs the doctor gives her? I'm not sure about that.*

C: *It may help – you can explain that taking it will help to stop germs in her blood from making her sick. But getting her to take drugs probably depends more on how you are with her. Shouting because you are worried won't help. Showing you love and care about her will help. Make her feel that she is being really good and grown-up when she takes her Bactrim and that will help, too.*

G: *I'm not sure. She gets so cross because Thandi, her sister, is not getting medicine. She says it's not fair and nothing I say seems to help.*

C: *Can you tell me a little bit about Thandi?*

G: *Yes, Thandi is eight and has many friends. She doesn't think about Thembisa. She is busy with her homework and her playing. She is also too clever and good at school. Like her mother was.*

C: *So Thandi reminds you of your daughter. It must be very difficult for you, Gladys, to have lost your daughter.*

G: *Too difficult. But my church is helping with praying and... these children are taking my time. I don't think too much.
(Silence for a few moments)*





But what must I do about Thembisa and the medicine then?

C: Maybe you would help if you can show that you understand it's not nice to have to take medicine. To make up, if she takes her medicine every day for a week, you two – just the two of you – will do something special together. Talk to her about some things you could do. Some examples might be going to the park together, going shopping together, a small treat that you can afford (e.g. a chocolate) or a special meal that she likes at the end of the week. You could make a calendar showing the days of the week and make a big red cross every time she takes the medicine. Give her lots of praise and hugs at the time. At the end of the week, make sure you give her lots of praise for being such a big girl. Make sure you do what you agreed to do together. Then plan for the next week. How would that work for you?

G: I could try that (and then gets into discussing of the details)

C: Now we should talk about giving the new medicines – how many pills, when they should be taken and so on....

Scenario B – Group Work

A pre-school child with a caregiver (Without using a doll)

C: Hullo Ma, this must be Thembisa? Hullo Thembisa, my name is _____

Contracting

T: Hullo. (Shyly)

C: So how have things been since our last session?

G: Like I told you last week, Thembisa doesn't like to take her medicine.....

And now the doctor says she needs to take the other medicines. We talked about that – about things she would like to do if she takes all her medicine like a big girl. She says she'll try to take it, but she is still not happy about it...

C: (Smiling) Thembisa, Is what your granny saying right?

*T: (Looks down and says nothing)
(Silence for a few moments while Thembisa fidgets.)*

C: Thembisa, it's OK not to like taking your medicine. What don't you like about it?

T: I don't like it. My sister doesn't have to take it.

C: Yes, it's not nice to have to take medicine... But you must take it.

T: Why do I have to take it?

C: To stop you from getting sick.

T: Why will I get sick?

C: Because there's a germ in your blood that makes it easy for you to get sick.

T: What's a germ?

C: A germ is something very small that can get in your body and make you sick, like when you have cold.

G: Remember last week when you were coughing and coughing all the time?

T: Yes.

G: And after a few days you felt better and could play with Tshepo again?

T: Yes.

G: Well... the medicine killed the cough germ and that is why you got better...and you need to take the medicine every day to try and keep the germs from making you sick again.





C: *That's right. So, Thembisa, the medicine was too strong for the cough germ. How can you try to make sure that another germ doesn't try to make you sick?*

T: *Take my medicine every day ...*

C: *Yes, Thembisa, you're right! Granny, you said you talked with Thembisa about what will happen if she takes her medicine every day – what did you decide?*

T: *Granny said, if I take all my medicine, I can ask my cousin to play on Saturday – and Granny will take me shopping with her on Friday. So I'm going to try.*

C: *Your granny and I spoke in the last session about the best time to give you the medicine and worked out that 7 in the morning and 7 in the night is a good time. That's when your Granny listens to her church programme on the radio in the morning and you have your supper at night. Will you be a big girl and try to help your granny remember?*

T: *OK, but I don't want Thandi to be there when I take it. Can we do it in the other room?*

G: *That's fine, Thembisa. (Session winds down).*

Scenario C – Individual Activity

A pre-school child with a caregiver (using a doll)

Introduce the concept of communicating with children through a doll or a teddy bear. The doll should be perched on the trainers facing the child and caregiver. The trainer should model the skill of listening to the doll as though it is talking and then report back to the child what the doll has said. Note that this is NOT a puppetry method.

C: *Hello Ma, this must be Thembisa? Hullo Them-bisa, my name is _____*

T: *Hello. (Shyly)*

C: *So how have things been since our last session?*

G: *Like I told you last week, Thembisa doesn't like to take her medicine... And now the doctor says she needs to take the other medicines. We talked about that – about things she would like to do if she takes all her medicine like a big girl. She says she'll try to take it, but she's still not happy about it...*

C: *(Smiling) Thembisa, is what your granny is saying right?*

T: *(Looks down and says nothing)
(Silence for a few moments while Thembisa fidgets)*

C: *Thembisa, today I have this doll who is called Mpho – Mpho is four years old like you. He's also been sick. He would like to talk with you about being sick. You can touch Mpho if you like.*

T: *(Tentatively touches the doll)*

C: *Mpho says that it's OK not to like taking your medicine. He also doesn't like taking his medicine. He wants to know what you don't like about it...*

T: *I don't like it. My sister doesn't have to take it.*

C: *Yes it's not nice to have to take medicine...but it's very important that you take it.*

T: *Why do I have to take it?*

C: *(Putting her ear close to Mpho) Hey what do you say about this Mpho? ...
Mpho says: To stop you getting sick.*





T: *Why will I get sick?*

C: *(Pause while she listens to Mpho) Mpho says: a germ is something very small that can get in your body and make you sick, like when you have a cold.*

G: *Remember last week when you were coughing and coughing all the time?*

T: *Yes*

G: *And after a few days you felt better and could play with Tshepo again?*

T: *Yes.*

G: *Well... The medicine killed the cough germ and that is why you got better. And you need to take medicine every day to try and keep the germs from making you sick again.*

C: *That's right. What are you saying Mpho? (Listens for a moment, nodding her head) Mpho says the medicine was too strong for the cough germ. He is asking you – how can you try to make sure that another germ doesn't try to make you sick.*

T: *Take my medicine every day... (Looking at Mpho)*

C: *Yes, Thembisa, you're right! She's right, hey Mpho? (Listens to Mpho). Mpho says you are a clever girl. (Turning to Gladys) Granny, you said you talked with Thembisa about what will*

happen if she takes her medicine every day – what did you decide?

T: *Granny said, if I take all my medicine, I can ask my cousin to play on Saturday – and Granny will take me shopping with her on Friday. So I'm going to try.*

C: *Your Granny and I spoke in the last session about the best time to give you the medicine and worked out that 7 in the morning and 7 in the night is a good time.*

Mpho says he also takes his medicine at 7 and 7. That's when your Granny listens to her church programme on the radio in the morning and you have your supper at night. Will you be a big girl and try to help your Granny remember?

T: *OK, but I don't want Thandi to be there when I take. Can we do it in the other room?*

G: *That's fine, Thembisa.*

C: *Mpho says he is tired now. He wants to have a sleep, but he says he will be here next time to talk to you again. Do you want to say goodbye to Mpho?*

T: *Bye, Mpho.*

Scenario D – Individual Activity

A primary school child with a caregiver

Giving information to primary school children

- Give more detailed information with concrete examples
- If a child asks for more information (e.g. "What's the germ called?", "How did the germ get in my body?"), give short, clear answers.
- Stop when the child seems satisfied. S/He can always ask for more information later when s/he is ready.
- Help the child deal with possible stigma.
- Reassure the child s/he can ask further questions or share any concerns now or later.

Lucky and Agnes

Lucky is 8 years old. Some time ago, he developed shingles and respiratory problems. His caregiver, Agnes, brought him to the clinic where he was diagnosed as HIV positive, with a very low CD4 count and TB. Agnes was shocked as she had no idea that Lucky was infected.





His mother had left Lucky with Agnes (her aunt) when he was 5 years old, saying she would be back once she had found a job. She never returned and has never been traced. Agnes seems to love Lucky very much. Agnes has a good understanding of HIV, but was concerned about whether she should disclose his status to him. She felt that she needed help. She attended three counselling sessions without Lucky, and spoke to the counsellor about her fears.

Lucky successfully completed his TB treatment and his ART will start in two weeks. The counsellor has supported Agnes and spoken about the process of disclosure. Agnes felt better prepared after a few weeks. She was firm with Lucky about his TB treatment and has answered all his questions honestly and openly. Lucky appears to have a healthy relationship with Agnes.

Last month, after Lucky asked about HIV for the second time, Agnes gently told him he was infected. Lucky seemed to accept this well. Through counselling, Agnes identified the supervisor at Luck's school as being someone

important to disclose to. The supervisor has been helpful in assisting with monitoring Luck's health and emotional state. Agnes feels less alone, but is now concerned about having to give Lucky more medication.

C: Hello, Agnes and Lucky

A: Hello – Lucky say hello to...

L: Hello

C: Lucky you must be wondering why you are here.

L: No, Agnes told me you are going to talk to me about my new pills.

C: And we are going to spend a short time talking more about all the things you have been asking Agnes about. You know that you have an illness called TB – you have been coughing quite a bit lately and the doctor wanted you to take medicine to help take away the germs that are causing you to cough.

L: Yes.

C: Do you know what germs are, Lucky?

L: Yes, I know some things.

C: Do you want to tell me what they are?

L: Ok, germs are things that make you sick. That's right, Lucky. Let's do some drawings to find out more.

(Draws a germ on paper) Germs are very small things that make people sick. This is a drawing of a germ but made bigger. Germs can get into the body in lots of different ways, like through a cut. (Draws a picture of a person with a cut on the skin and shows how a germ goes into the blood)

L: (Nods)

C: Germs are carried in the blood. In the blood we have germ fighters, called CD4 cells, to keep the body safe from germs.

L: Like soldiers?

C: (Drawing a soldier cell). Yes in the blood the CD4 cells are a lot like soldiers. What do soldiers do?

L: I think soldiers defend the people.

C: That's right, Lucky. The same happens in the blood. The soldiers are called CD4 cells.





We all have them. They fight the germs in our body. How about doing a drawing for Agnes and me...of the CD4 cells fighting the germs?

- L: Ok. (He draws a soldier and a germ on paper)*
- C: Wow, that's a really ugly-looking germ! And what a strong looking soldier cell that is.*

- L: Yes he is. (Adds to the drawing)*
- C: And do you know, there are lots and lots of different germs. Ones that make you get colds, coughs, measles... Some are called viruses. Agnes told you that you have a virus called HIV in your body.*

- L: Yes, I have HIV.*
- C: And can you tell me what you know about HIV?*

- L: It can make me sick.*
- C: Well, what HIV does is to kill the germ fighters – the CD4 cells – one by one ... until there are hardly any germ – fighters left. This makes it easy for other germs to come in and make you sick. (Drawing of HIV added to illustration) See how it attacks the germ fighters? (Smudging*

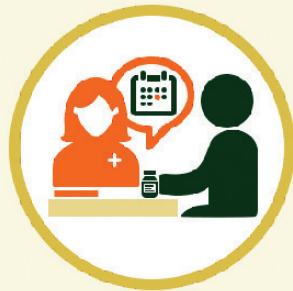
the CD4 germ fighter cell) That means you can get sick easily. That was probably why you got TB. But now, after taking drugs, you are getting better and your body is strong enough to be able to use stronger medicine to kill the HIV virus in your body. Then the germ-fighting soldiers can grow strong again-like the one in your drawing – and you won't get sick so easily.

- L: How did I get this HIV? Was I bad?*
- C: No, Lucky, you were not bad. You were born with HIV – it passed from your mommy's blood to yours before you were born.*

- A: Iesha, people don't understand about HIV. People have much shame.*
- C: Not everyone understands about HIV. HIV is nothing to be ashamed of, but having HIV sometimes has to be something you don't have to tell other people if you don't want to. Maybe we should keep this with you, Lucky and the teacher for now. Maybe later we can decide if you want to tell other people.*







Repeat Prescription Collection Strategies (RPCs) models

Learning objectives

- Know what RPCs options models are.
- Know what patients qualify for RPCs models.
- Know what patients are returned to regular care from RPCs.
- Understand how to implement each RPCs model.
- Understand the role of non-clinicians to support each RPCs model.

What are repeat prescription collection strategies models?

Repeat Prescription Collection Strategies models are one of the minimum package intervention models mainly for adult clients **who are stable and adherent on treatment**.

Repeat prescription collection strategies should be proposed to all stable adult patients to decrease waiting time and transport costs associated with facility visits.

These can reduce the load on clinical services while increasing convenience and thus lowering likelihood of defaulting treatment.

Repeat Prescription Collection Strategies focus on:

- Rewarding adherent and stable clients with a **faster service** and **flexibility** to choose their preferred medication collection service (client-centered focus).

Table 7: What patients qualify for the Repeat Prescription Collection Strategies options model?

| Adults | Children |
|---|---|
| <ul style="list-style-type: none"> • Above 18 years. | <ul style="list-style-type: none"> • 5 to 18 years old. |
| <ul style="list-style-type: none"> • On treatment for at least 6 months. | <ul style="list-style-type: none"> • On ART for at least 6 months with no regimen or dosage changes in the last 3 months. |
| <p>Most recent assessment results normal:</p> <ul style="list-style-type: none"> • Most recent viral load (VL) taken in past 6months < 50 copies/ml for HIV. • Most recent HbA1c taken in past 6 months \leq 7% for Diabetes. • 2 consecutive BP < 140/90 for Hypertension. | <ul style="list-style-type: none"> • Most recent VL taken in past 6 months <50 copies/ml. • Caregivers counselled on the disclosure process where age-appropriate disclosure is not yet achieved (see CADC 3). |
| <ul style="list-style-type: none"> • Clinician confirms the patient's eligibility for RPCs option. | |
| <ul style="list-style-type: none"> • The patient (>12 years/caregiver if patient <12years) voluntarily opts for the RPCs option. | |
| <ul style="list-style-type: none"> • No current TB or medical condition requiring regular clinical consultations. | |





Note: Stable family members should be encouraged to join the same RPCs option with the same treatment supply collection location and the appointment date to support family adherence.

Three Options:

- (4) Facility Pick Up Point (FAC-PUP)
- (5) Adherence Club (AC)
- (6) External Pick Up Point (EX-PUP)

Note: Clients enrolling for RPCs options shall be scheduled in a group according to the month that they were initiated on treatment, so that their clinical consul-

tations and lab monitoring can be done at the same time.

All patients must be advised that they are being returned to regular care to ensure more frequent clinical care until they are stable again. Patients can return to RPCs after a single normal result and meeting other RPCs criteria in the future (see Re-engagement 9).

The following section will describe each RPCs option in detail.

What patients are returned to regular care from RPCs

- FAC-PUP, AC or EX-PUP who did not return their RPCs collection point within 7 calendar days of their missed scheduled collection date.
- RPCs patient screens positive for TB.

Other safety lab test results are abnormal:

- For HIV: VL > 1000 copies/ml (where VL is 50 -1000 copies/ml: the patient can remain in the RPCs but must see a clinician 3 months after the date of elevated VL for further VL assessment.
- For diabetes: HbA1c >7%
- For Hypertension: BP > 140/90
- Other indications assessed on individual clinical consultation.
- RPCs patient becomes pregnant and should be referred to integrated Maternal, Neonatal, Child and Women Health services (MNCWH).

IV. RPCs Option: Facility Pick Up Point (FAC-PUP 4)

Learning objectives

- Understand Facility Pick up Point 4.
- Understand the role of non-clinician to support FAC-PUP 4

What is Facility Pick up Point (FAC-PUP) model?

- Facility Pick up Point (FAC-PUP4) model is one of the RPCs options that allows direct and quick access to the pharmacy for healthy and stable clients on treatment.
- A Facility Pick up Point can take various forms in a facility but all forms do not require a patient to attend registry, vital signs, or see a clinician.
- The treatment for the FAC-PUP can be pre-dispensed by the facility pharmacy or by a Central Dispensing Unit (CDU) or by the Centralised Chronic Medicines Dispensing and Distribution (CCMDD).

What tools are needed to implement the FAC-PUP 4 model?

- Minimum package SOPs for Facility Pick – up Point.

How is the FAC-PUP model implemented?

For FAC-PUP 4 to be implemented, the following should be available:

- There must be a dedicated fast lane pick up point at the pharmacy for each facility for a specified period decided by each facility.
- Patient files and pre-packaging of medicines, where possible, must be prepared or delivered at least a day before to facilitate an effective FAC-PUP.
- FAC-PUP do not need to collect their patient folder and should not have their vital signs taken.

The following activities form part of FAC-PUP 4

- If the patient complies with criteria for the RPCs option and chooses the Facility Pick up Point option, the non-clinician will inform the patient about Facility Pick up Point.

- In a FAC-PUP, clinically stable patients (meeting RPCs criteria) are required to see a clinician once a year for a comprehensive clinical consultation and routine investigations. At the clinician's discretion, they can be required to see a clinician at their rescripting visit for a brief clinical check-up.
- Patients receive a 6-month repeat prescription for their treatment at a time.
- Each time the FAC-PUP patient visits the facility, the patient should be allowed to collect multiple months of treatment supply.
- FAC-PUP patients should be allowed to go through a fast lane, meaning direct and quick access to the pharmacy or designated room/area at the facility managed by a lay cadre without having to attend registry, collecting their patient folder, having their vital signs taken or seeing a clinician.
- In case of health problems or pregnancy, patients return to regular care.
- Trace patients if they miss a scheduled appointment.

What is your role as a non-clinician to support FAC-PUP4 model?

- a) If patient complies with criteria for RPCs option, and chooses to collect medicine at the facility,

the non-clinician will inform the patient about FAC-PUP option.

- b) Inform the patient about tracing and retention in care system.
- c) Document all processes appropriately.



Role Play Activity

- Divide into groups of 3.
- Each group member to assume one of the following roles: Counsellor, Client, and Observer.
- Role-play the following scenario:
A newly diagnosed client has come for counselling and tells you that he has seen his relative go straight to the pharmacy to collect medications without queuing for hours during the consultations. The client now would like to also collect medications at pharmacy? What would you tell client about FAC-PUP model? How did the relative qualify for the FAC-PUP option? What can the client do to graduate to that option of fast and quick pharmacy access medication collection?



V. RPCs option: Adherence Club (AC 5) model

Learning objectives

- Understand Adherence Club model (AC 5).
- Understand the role of non-clinician to support AC 5.

What is the Adherence Club (AC 5) model?

The adherence club model is one of the RPCs option that allows stable patients to be grouped together voluntarily for routine check-ups and repeat prescription collections managed by a non-clinician.

Adherence clubs can take place at the health facility or in the community to save patients time and money. Adherence clubs are not a one size fit all strategy.

The adherence club can focus on one main condition (e.g. HIV or hypertension, Tuberculosis and Diabetes) but club facilitators should provide treatment for different treatment in case some clients are co-infected with other chronic conditions.

In circumstances where gathering together as an adherence club is not possible, Adherence clubs can also serve as an external pick up point for individual medicine pick up and (not for groups).

The treatment for an adherence club can be pre-dispensed by the facility pharmacy or by a Central Dispensing Unit (CDU) or by the Centralised Chronic Medicines Dispensing and Distribution (CCMDD).

What tools are needed to implement AC 5 model?

- Minimum package SOPs for Adherence Club.
 - Adherence Club register
 - Pre-packed medicine collection card
 - Repeat Prescription Collection Strategies enrolment and consent form

How is AC 5 model implemented?

- Health facilities can establish facility-based or community-based adherence clubs.
- Facility manager will nominate a club manager and facilitator.
- A club facilitator can be a non-clinician such as a HBCarer, CHW, peer educator or equivalent.

- Patients are allowed to bring nominee only on medicine collection adherence club visit days.

The following activities form part of AC 5:

- If a patient complies with criteria for RPCs, patient will be informed about RPCs option:

Adherence club as follows:

- An adherence Club consists of a group of no more than 10 – 30 patients who are judged to be adherent to and stable on treatment (clubs can be smaller in rural contexts).
- Timing: Club members meet every 2 months as a group. The Club visit lasts approximately 1 to 1.5 hours.

Facility-based Clubs:

- Every 2 months, patients meet as a group at facility and are issued with 2-3 months pre-packed medication in the club venue.
- Where health facility space is limited, community venues close to the facility that do not require additional logistical support can be used.
- Health facilities can also make use of extended hours by establishing evening Clubs.

Community-based Clubs:





- Every 2 months, club sessions are hosted in one of the patient’s homes or community venues near their home such as NGO or church.
- The club facilitator brings their pre-packed treatment to them.
- They are still patients at the main referral health facility but are only required to attend the facility for annual lab tests and clinical consultations.
- If the patient chooses, Adherence Club option, the patient will be requested to complete the adherence club registration form.
- During enrolment, club members will be issued with a repeat prescription for 6 months.
- The patient will be provided with an annual schedule to attend adherence club and appointments.
- The patient will receive pre-packed medications at the adherence club.
- Patients will be traced if they miss scheduled appointments at the club.

What is your role as a non-clinician to support AC 5 model?

This includes both non-clinicians at health facility and community level.

- Promote Adherence Clubs.

- Screen and recruit patients for adherence club.
- If the patient complies with criteria for RPCs option, and chooses Adherence Club option, inform the patient about Adherence Club.
- Understand the roles and responsibilities of each person involved in adherence club.
- Facilitate adherence club.

Key responsibilities as club facilitator include:

- promoting Adherence Clubs,
- establishing clubs with the assistance of clubs manager,
- responsible for running the club sessions,
- collecting pre-packed treatment dispensed from pharmacy,
- registering members,
- conducting symptom screening,
- referring patients to Club PN if necessary,
- issuing pre-packed treatments,
- completing Adherence Club registers and following up on patients who miss sessions.
- Understand the dynamics of running an adherence club model.
- Understand events and basic symptoms and side effects that need referral to the clinic.
- Understand referral systems within the health

facility and community as relevant to adherence club.

- Inform the patient about tracing and retention in care system.
- Document all processes appropriately.



Role Play Activity

- Divide into groups of 3.
- Each group member to assume one of the following roles: Counsellor, Client, and Observer.
- Role play the following scenario:
One of the non-clinicians is off sick and you have been asked to fill in to run the adherence club.
Who will you contact for guidance and planning for the next adherence club session? Where would you get pre-packed medications? What do you do when clients come to the adherence club? What do you need to record in the register? What would you do if a client complains of experiencing side effects? What would you do if clients do not come to the adherence club on the scheduled day?



VI. External Pick up Point (EX-PUP 6)



Learning objectives

- Understand External Pick-up Point (EX-PUP 6).
- Know how EX-PUP is implemented.
- Understand the role of a non-clinician to support EX-PUP.

What is the External Pick – up Point (EX-PUP) model?

- EX-PUP is one of the RPCs models. EX-PUP can take various forms but all involve the patient collecting their treatment supply individually from

an external service provider based at a pick-up point outside of the facility or from an automated system.

- Examples of EX-PUPs:
 - Treatment supply pick-up from a private pharmacy.
 - Treatment supply pick-up from a designated community venue.
 - Treatment supply pick-up from a post box/ATM or similar automated system located inside or outside of a facility.
 - EX-PUP treatment is pre-dispensed to the EX-PUP service provider by the Centralised Chronic Medicines Dispensing and Distribution (CCMDD).

What tools are needed to implement EX-PUP 6?

Reference tools:

- Minimum Package of SOPs for External Pick up Point (EX-PUP6).
- Minimum package SOPs for Central Chronic Medicine Dispensing and Distribution programme (CCMDD).

How is EX-PUP implemented?

Clients are enrolled in the Central Chronic Medicine Dispensing and Distribution (CCMDD), which is the distribution center for all patient medicine parcels (PMP), which is then pre-dispensed to the EX-PUP service provider. The EX-PUP service provider can be a pharmacy or a designated community venue. Clients can collect their treatment on a 1 to 2 monthly basis.

All patients enrolled on CCMDD receiving their medicine parcel through EX-PUP must be entered into the TIER.Net system.

The EX-PUP service provider will inform the patient when their medicine parcel has been delivered to the pick-up point for the collection.

Should a patient not receive an SMS regarding the collection of repeat medicine parcels, the patient should still collect their repeat medicine parcel at the EX-PUP on scheduled collection dates.

Patients will be informed that if they experience side effects or are not feeling well they can at any time go to the facility for assessment even if they still have repeat prescriptions on the CCMDD database.

Patients will be traced if they do not pick up their medicine at the selected EX-PUP.

What is your role as a non-clinician to support the EX-PUP model?

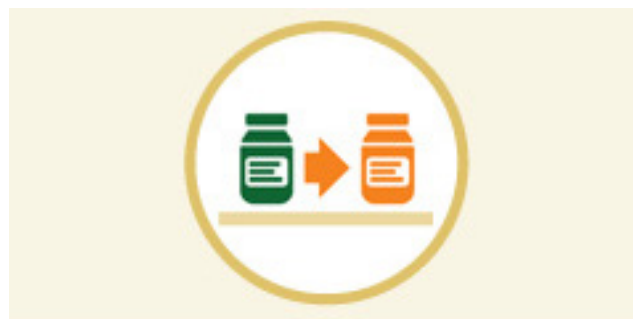
If a patient qualifies for RPCS and chooses EX-PUP, inform the patient about the EX –PUP model. Inform the patient about tracing and retention in the care system. Document all processes appropriately.



Role Play Activity

- Divide into groups of 3.
- Each group member to assume one of the following roles: Counsellor, Client, and Observer.
- Role-play the following scenario:

A client has heard about other clients collecting their medications closer at private pharmacies? Inform the client about the RPCS options and who qualifies for them. Also tell client about how the EX-PUP works.



VII. Drug Switches for RPCs Patients - 7

Learning objectives

- Understand Drug Switches for RPCs Patients - 7.
- Know what patients qualify for Drug Switch.
- Know how Drug Switches for RPCs Patients - 7 is implemented.
- Understand the role of a non-clinician to support Drug Switches for RPCs Patients - 7.

What is the Drug Switches for RPCs Patients - 7 model?

In this model, stable patients who are already receiving their treatment through a Repeat Collection Strategy are supported in switching to new regimens whilst remaining in their RPCs.

What tools are needed to implement Drug Switches for RPCs Patients - 7?

Reference tools:

- Minimum Package of SOPs for RPCs Drug Switches for RPCs Patients - 7.

How is Drug Switches for Patients - 7 implemented?

Stable patients attend their scheduled clinical consultation visit. The patients who opt for drug switch and meet the criteria are switched and they remain in their RPC model. The clinician issues a new prescription reflecting the new first-line drug regimen.

What patient qualifies for Drug Switch?

- The patient is enrolled on Repeat Collection Strategies.
- Recent viral load (VL) result (not older than 6 months).
- The patient is stable with VL<50 copies/ml OR second VL assessment between 50-1000 copies/ml.
- Not likely to be in 1st trimester of pregnancy.

NB: The clinician's assessment is crucial to determine if the patient qualifies for Drug Switch



What is your role as a non-clinician to support the Drug Switches for RPCs Patients model model?

If a patient is on RPCs and needs to know about Drug Switch, you inform the patient about the model including what is needed for a patient to qualify for drug switch.

It is also important to inform the patient about tracing and retention in the care system. Document all processes appropriately.



VIII. Tracing and Recall – 8

Learning objectives

- Know what Tracing and Recall model is.
- Know when patients qualify for the Tracing and Recall model.
- Understand how to implement the Tracing and Recall model.
- Understand the role of non-clinician to support the Tracing and Recall model.

What is the Tracing and Recall model?

Tracing and Recall model is one of the minimum package intervention models that focus mainly on early tracing and preventing loss to follow-up throughout the continuum of care.



Role Play Activity

- Divide into groups of 3. Each group member to assume one of the following roles: Counsellor, Client, and Observer.
- Role-play the following scenario: A client heard other clients talking about a new drug that works more effectively. The client is a woman and wants to know if she can get the new drug. Inform the client about the Drug Switches for RPCs Patients model, and who qualifies.



What patients qualify for the Tracing and Recall model?

All patients will be traced if they miss their scheduled appointment in all minimum package intervention models.

The following patients will be traced:

Table 8: What patients qualify for the Tracing and Recall model?

| Facility | Repeat Collection Strategies (FAC-PUP, AC, EX-PUP) |
|--|--|
| <ul style="list-style-type: none">Patients who have failed to return to the facility within 7 calendar days of their scheduled appointment.<ul style="list-style-type: none">Patients who did not return for their treatment initiation appointment.HIV, TB, Diabetic or Hypertensive patients who have missed their scheduled appointment by 7 calendar days | <ul style="list-style-type: none">Patients in an RPCs who did not collect their treatment supply within 7 calendar days after the last day on which they were still able to collect through their RPCs (See SOPs 4-6). |
| <ul style="list-style-type: none">Patients with abnormal results, who, after initial attempt, have not returned to the facility within 7 calendar days. | <ul style="list-style-type: none">Patients with abnormal results, who, after initial attempt, have not returned to the facility within 7 calendar days. |

- Patients are traced through contact by phones, SMS, home visits depending on what tracing method they have consented for.
- Recall attempts should first be telephonic and only if this fails, then via a home visit.

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What tools are needed to implement the Tracing and Recall model?

- Minimum package SOPs for Tracing and Recall.
- Minimum package SOPs (FTIC 1, EAC2, CADC 3, FAC-PUP 4, AC 5, EX-PUP 6, Re-engagement 9).

How is the Tracing and Recall model implemented?

- Patients are traced throughout the care cascade at different times depending on the adherence minimum package intervention model.

Prioritization order for tracing and recall:

Tracing and recall are prioritized for the following patients in the order set out below:

- Patients initiated on treatment in the last 6 months with advanced HIV disease (AHD).
- Patients with abnormal results (HIV: viral load >50 copies/ml, for diabetes: HbA1c >7%, for hypertension: BP > 140/90, TB: positive GXP, Smear, Culture, Line Probe Assay (LPA), Mantoux)
- Patients not initiated on treatment.
- Patients overdue for their condition-specific assessment and/or investigation (test).

The following activities form part of the Tracing and Recall model:

- Patient registration at enrolment.
- Update the patient's contact details at every visit.
- Inform the patient about tracing and recall process.
- Ask the patient's consent to be traced and the preferred methods of tracing in order of preference.
- Always ensure that patient confidentiality is maintained.
- Schedule an appointment for the next visit.
- Document the patient's appointment in a relevant register.
- Keep the appointment register up to date.
- Identify patients who miss their appointments as per minimum package of interventions.
- Generate missed appointment list of interrupted treatment.
- Facilities must receive CCMDD 7 calendar day non-collection report for RPCs patients registered on the CCMDD system.
- Tracing processes should start 7 calendar days after patients have missed their scheduled appointment or have not returned to the facility after an immediate initial recall on receipt of an abnormal result by the facility.
- Initiate tracing of patients who have missed appointments.
- Trace patients by phone or SMS.
- Trace patients through outreach to communities and homes.
- Where tracing and recall is successful, an active referral to integrated care services should be made back to the facility within the next 7 calendar days.

What is your role as a non-clinician to support the Tracing and Recall model?

1. Inform the patient about tracing and retention in care system in all the minimum package intervention.
2. Confirm the patient's contact details at every visit
3. Enrol all patients into specific appointment registers.
4. If referring patient, actively refer patients by contacting the referral site and provide the name of patient/s who are supposed to be linked to care to ensure they are linked to the health facility or community.
 - Ensure the patient knows where the facility is and what date and time the appointment is.
5. Document patient's appointment in facility or CBO appointment register.
6. Identify patients to be traced.
7. Trace patients by phone or SMS.
8. Trace patients through outreach to communities and homes.
9. Refer patients to facility or community after tracing for reintegration into care services.
10. Document all processes appropriately.



Role Play Activity

- Divide into groups of 3.
- Each group member to assume one of the following roles: Counsellor, Client, and Observer.
- Role play the following scenario:

A new client has been referred to you. Counsel the client about the tracing and recall system in your facility.

Get consent from the client on the best method to be traced if the client misses a scheduled appointment.





IX. Re-engagement 9

Learning objectives

- Know what the Re-engagement model is.
- Know what patients qualify for the Re-engagement model.
- Understand how to implement the Re-engagement model.
- Understand the role of non-clinician to support the Re-engagement model.

What is the Re-engagement model?

Re-engagement model ensures that the patients who re-engage in care after tracing or self re-engagement, receive appropriate support to improve retention in care.

What patients qualify for the Re-engagement model?

- Patients who return to the facility on their own.
- Patients who return to the facility after tracing more than 7 calendar days after their missed appointment date.
- Patients in Repeat Prescription Collection strategies (RPCs), who returns to the facility after tracing more than 7 calendar days after the last day the patient could collect their treatment supply from their RPCs.

What tools are needed to implement the Re-engagement model?

- Minimum package SOPs for Re-engagement.
- Minimum package SOPs (FTIC 1, EAC2, CADC 3, FAC-PUP 4, AC 5, EX-PUP 6, Tracing, and Recall).
- Welcome Back Campaign Flow-Chart.

How is the Re-engagement model implemented?

- If a patient returns to the facility more than 7 calendar days after their missed appointment or the date on which they were still able to collect treatment through their RPCs, a clinician will see the patient and do the following activities:



SECTION 4: ADDITIONAL RECOMMENDED ADHERENCE INTERVENTIONS

Overview

Minimum package of interventions to support linkage to care, adherence and retention in care are recommended to be implemented in all facilities and communities across South Africa.

The following recommended additional adherence interventions can be implemented in the health facilities and communities depending on the context, the specificity of the population and the available resources.

Learning objectives:

- Know different peer support and education models.
- Identify where peer support and education interventions would be applicable.
- Know about mHealth models.
- Know about CAGs.
- Know adaptation of services to specific populations and contexts.

Table 9: Additional interventions to support adherence and RIC

| | |
|--|---|
| Peer support and education | <ul style="list-style-type: none">– Integrated Access to Care and Treatment (I-ACT).– Support groups– Youth clubs– Buddy systems– Collaboration with traditional authorities. |
| mHealth | <ul style="list-style-type: none">– SMS encouraging adherence and appointment reminders. |
| CAGs | <ul style="list-style-type: none">– Community Adherence (ART) groups to be adapted for other chronic conditions. |
| Adaptation of services to specific populations and contexts | <ul style="list-style-type: none">– Outreach services (WBCHOT and CHW).– After hours services and MSM, LGBTI and sex worker-friendly clinics. |

Peer support and education

It is important to encourage patients to identify a support system within or (if not possible) outside the household.

The following models can be used to offer peer support and education to patients who are willing to join such a group.

Education by peer educators



The Integrated Access to Care and Treatment (iACT) is a programme that aims to empower PLHIV and others who are otherwise affected by HIV to confidently lead healthy lives. The programme is designed to follow well-defined steps covering topics such as education on illness and treatment, acceptance of status, healthy living principles and planning for the future.

- Educational sessions are offered in locations where people might need help, including the waiting rooms of local clinics, churches, taxi and bus ranks, and community centres.
- Closed support groups are exclusive to PLHIV. After the first session, no new participants are allowed to join. Closed support group participants commit to attend six sessions, not only to cover the complete programme content, but also to foster personal support networks.
- Open support groups cover the same six content areas but serve both PLHIV and others who are

impacted by HIV. 'Open' groups allow people to drop in for the sessions they are most interested in; there is no obligation to attend all sessions. This format helps participants address gaps in knowledge and learn about specific areas within the curriculum. Importantly, open groups do not require disclosure of status.



Support Groups

Support groups have been in existence for many years around the world as a mechanism for bringing individuals together to provide group support, to share life experiences and support each other collectively.

Support groups should create opportunities to form adherence clubs and reduce the burden on patients by providing medication to clinically stable members.

Youth-focused strategies

This programme proposes a structured support group for HIV-infected adolescents.

It consists of three structured support group sessions of 2 hours, which are held once a week and are facilitated by a counsellor or non-clinician.

The 3 main themes are:

- coping and support (session 1),
- HIV health (session 2); and
- Positive prevention (session 3).

Each session opens with a role play and is followed by group reflection on the issues raised and relaxation exercises. At the end of each session, participants set achievable goals related to the topic discussed, such as getting one's VL, disclosing status etc.

Other youth clubs group pre-ART, newly initiated and stable youth on ART. Youth-specific topics are discussed during the club sessions such as safe sex and unwanted youth pregnancy.

mHealth youth strategies such as B-WISE aims to assist youth make informed decisions about their health.



Buddy systems

Self-identified buddy:

Clinicians and non-clinicians can encourage the patient to identify someone living in the same household or area to support them in taking treatment and coming to the facility. Choosing a buddy is an individual choice and should not be imposed as a condition to initiate treatment.

Buddy facilitated by the health facility:

Clinicians can provide options to patients. The buddy could be a CHW, an expert patient or a peer from a support group who has been on treatment for some time. Peer mentors can significantly improve outcomes in patients with NCDs. Patient Advocates can also support linkage to care and accompany patients who has been newly diagnosed, such as newly diagnosed HIV positive patients.

Buddy systems can help patients to remember the time to take their treatment, remind them when they have to come for follow up and/or accompany them to the facility. Once the patient is stable on treatment, the buddy can collect medication for the patient at the health facility or in the club, as long as the patient comes when due for a clinical visit or according to repeat collection prescription strategy requirements.

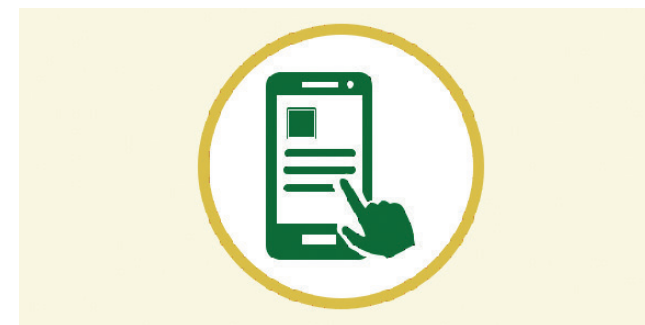
Collaboration with traditional authorities

Traditional healers and leaders should be involved and empowered to identify and refer patients for HCT, TB and NCDs screening and testing. The Health sector should explore measures to use them to support treatment adherence practices during consultations and provide them with appropriate training.

mHealth

In addition to the use of mobile phones to trace patients, interventions can also involve sending text messages before the person's appointment to remind them about their appointments or requesting them to report at facilities for follow ups. MomConnect is the first national public mHealth service to link pregnant women and

new mothers to health services. B-WISE is an mHealth App that aims to assist youth make informed decisions about their health.



WhatsApp adherence support 'chatrooms' can be established for newly diagnosed and stable patients who opt for repeat prescription collection strategies such as facility pick up points, adherence clubs and external pick up points. WhatsApp adherence support has a potential to support patients in their treatment journey and to keep patients connected to clinicians, non-clinicians and peer support.

Community Adherence (ART) Groups (CAGs)

CAGs currently exist for HIV but can be created for different chronic disease programmes. CAGs are





self-formed groups of patients who take turns attending clinical assessment and monitoring tests at the health facility, whilst collecting drugs for themselves and the other members of the group. The CAG provides a means of accessing ART for the group members and a source of social support. CAGs are particularly useful in rural areas where there are significant distances to clinics.

Adaptation of services to specific populations

Outreach services (WBCHOT and CHW)

To face a growing population on ART, TB and NCD medications, decentralising access to testing, treatment and counselling activities can reduce and have already

reduced the burden on health workers and patients and improves retention in care. Community-based services that involve the use of Ward Based Outreach (WBCHOT) teams, CHWs and Home based carers can take services to communities and decongest health facilities. This model supports the principles of a Primary Health Care and and patient-focused approach.

Outreach strategies could also involve the support of monitoring adherence strategies by CHWs for stable patients. Decentralising a comprehensive package of care (including treatment) can be an effective way to ensure that highly stigmatised populations such as sex workers can access care. At the same time, clubs mixing stable and less stable patients for vulnerable groups, such as youth clubs can enhance peer dynamics and retention.

After hours services and MSM, transgender and sex worker-friendly clinics

Offering health care out of working hours allows patients (often men) who are busy during the day and/or who prefer to visit health services out of working hours to access prevention, care and treatment services. Training staff through specialised organisation to

deal with MSM, Transgender and Sex Workers in a respectful way can also help to decrease stigma and fear amongst these vulnerable populations to access health services.



Role Play Activity

- Divide into groups of 3.
- Each group member to assume one of the following roles: Counsellor, Client, and Observer.
- Role play the following scenario:

A client is not doing well with medications. Where would you advise client about peer support and education options.

The client is also a sex worker, what advice would you give the client about services at facilities.





SECTION 5: MONITORING, EVALUATION AND REPORTING (MER)

Learning objectives

- Know basics of Monitoring Evaluation and Reporting.
- Understand importance of documenting all processes in Adherence Guidelines interventions.
- Understand role of non-clinician in supporting Adherence Guidelines interventions monitoring and reporting.

What is Monitoring, Evaluation and Reporting?

Monitoring involves collecting, analysing, and reporting data on activities and processes in a way that supports effective management.

Evaluation is assessing the design, efficiency, effectiveness and impact of current or work already done to inform future planning. The key question in evaluation is 'are we making a difference in what we are doing over a period of time?'

Reporting and usage refers to a compilation of descriptive information, presenting data and information as useful knowledge.

A data collection tool refers to the instrument used to collect or record information.

- Examples of activities for data collection for adherence interventions include completing:
 - facility attendance register;
 - adherence plan;
 - adherence club register; and
 - providing feedback on tracing outcomes.

MER team including data capturers or data assistants' role is to ensure that everyone in a facility or CBO records data collected correctly in appropriate registers. They also make sure that data collected is used by analysing it and providing feedback to teams in facilities or CBOs.

Monitoring and reporting provides information on progress, problems, difficulties encountered, successes

and lessons learnt during implementation.

This information or data should always be used for quality improvement.

What is your role as a non-clinician in supporting MER for Adherence Guidelines interventions?

- Understand your role in supporting adherence interventions models monitoring and reporting.
- Recording and collecting data during all minimum package interventions as relevant.
 - Fast Track Initiation Counselling.
 - Enhanced Adherence Counselling.
 - Child and Adolescent Disclosure Counselling.
 - Tracing and Retention in Care.
 - Adherence Club.
 - Peer support and education such as IACT and support groups.



SECTION 6: QUALITY PLANNING FOR IMPLEMENTATION

Learning objectives

- Know basics of quality cycle.
- Understand why ensuring quality is important in Adherence Guidelines interventions.
- Understand role of non-clinician in supporting quality implementation in Adherence Guidelines.

The National Department of Health defines quality as getting the best results possible within the available resources.

Cycle of Quality



Standards

What is a standard? A standard is a statement of an expected level of quality delivery, for example the Adherence Guidelines interventions tools and standardised education and counselling sessions.

Quality assurance is the maintenance of a desired level of quality especially by means of attention to every stage of the process delivery.

Quality Improvement is combined and unceasing efforts of everyone – clinicians, non-clinicians, patients and their families, to make the changes that will lead to better patient outcomes, better health care system performance and better professional development.

National Core Standards

National Department of Health developed the National Core Standards as a basis for quality.

National Core Standards Domains



Six priorities identified for patient-centered care:

- Values and attitudes of our staff both clinicians, non-clinicians and managers.
- Cleanliness of our facilities.
- Waiting times- queues and delays.



- Patient (and staff) safety and security.
- Infection prevention and control.
- Availability of medicines and supplies.

Standards, Quality Assurance and Quality Improvement can assist us in reaching our goals and providing quality care to patients:



Quality Improvement

Quality improvement needs to be an integrated part of our work.

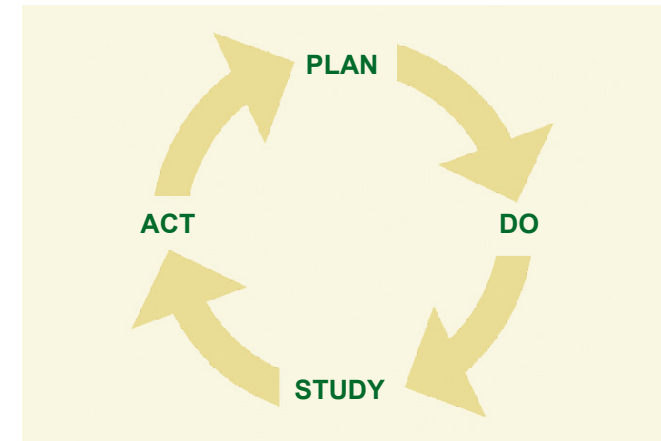
Quality Improvement is viewed as a journey in learning, rather than a method for quick fixes. It should be integrated in all we do.

It is a way to look at our current system, decide if we are getting the results we want and find ways to improve the way things are done.

What are some of the questions that we can ask for quality improvement?

- What are we trying to accomplish?
- How will we know that a change led to improvement?
- What changes can we make that will result in improvement?

There are many quality improvement tools. One of the tools used in quality improvement is called: PDSA. PDSA stands for Plan, Do, Study, Act.



Why is quality improvement important in the Adherence Guidelines implementation?

- Adherence Guidelines interventions will be implemented by a team in a facility or community setting. Teams depending on context can be made of clinicians, non-clinicians and managers. All members of the team will play an important role in implementing Adherence Guidelines interventions.
- Adherence Guidelines interventions implementation will require a lot of planning to identify Who, What, Where, When and How and then carrying out the plan and monitoring to ensure that what is being proposed actually works.





What is a non-clinician’s role in ensuring quality?

- Know the National Core Standards as they relate to everyday practice.
 - Of relevance is priority 1, which relates to all staff who work with patients.
- Use the Adherence Guidelines support tools so that patients can receive standardised education, counselling and support.
 - The tools include Patient adherence plan, Adherence Education flip file, and Standard Operation Procedures for minimum package interventions.
- Understand why quality improvement is important as we plan for and establish Adherence Guidelines interventions. The Adherence Guidelines interventions are to be implemented to improve systems in facilities and communities and improve patient’s linkage to care, adherence to treatment and retention in care.
- Understand that standardisation of adherence interventions should be done consistently to ensure that we deliver the right things, in the right

places to the right people along the care cascade.

- Work closely with facility or community in identifying any challenges with adherence interventions, bring them forward for improvement so that patients can have better clinical outcomes and be retained in care.



Role Play Activity

- Divide into groups of 3.
- Each group member to assume one of the following roles: Counsellor, Client, and Observer.
- Role play the following scenario: Another non-clinician is shouting at a client and not providing the right education and counselling to a client? What are the National Core Standards patient’s rights? What tools should the non-clinician use to counsel client? Why is it important for the non-clinician to use standardised tools for counselling?







REFERENCES

National Department of Health, 2020. *Adherence Guidelines for HIV, TB and NCDs*.

DISCLAIMER

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