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Reinitiating Patients on ART Who Were Lost/Re-engaging

Dr Lesego Mawela

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Outline

1. Purpose
2. Initiating and Managing Patients on ART
3. Interventions to Support Adherence
4. Optimizing the patient journery
5. Adherence SOPs
6. Quality Improvement

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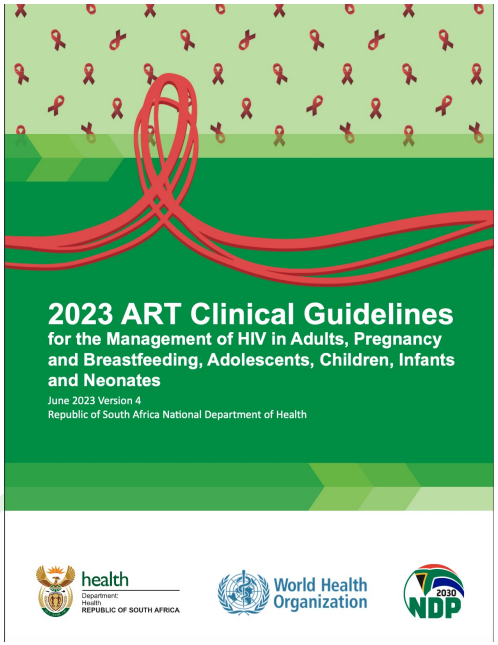
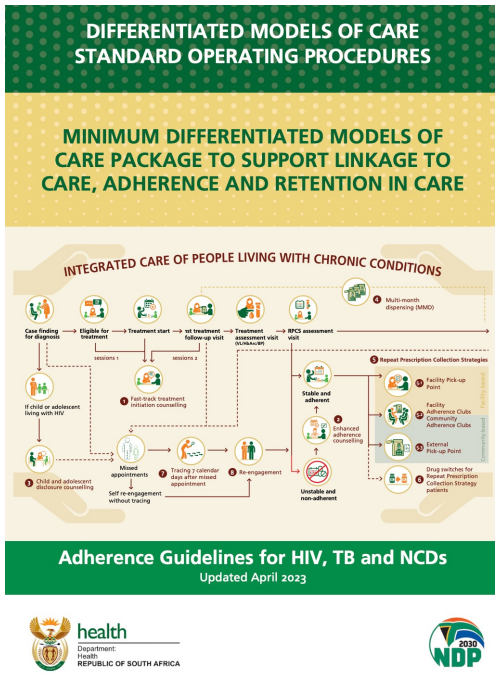
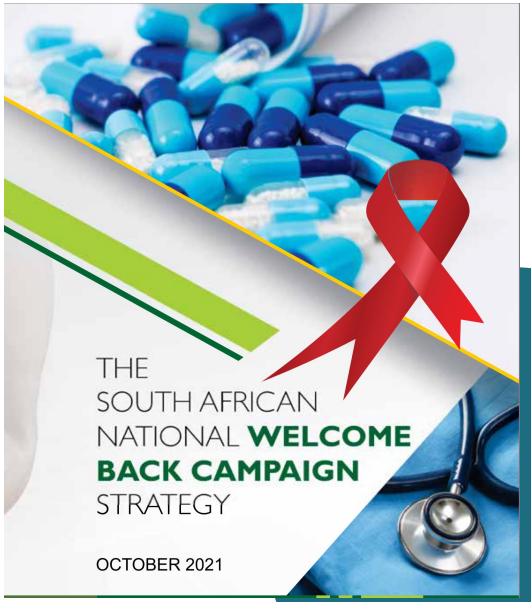
References

- 2023 ART Clinical Guidelines for the Management of HIV in Adults, Pregnancy and Breastfeeding, Adolescents, Children, Infants and Neonates June 2023 Version 4. SA NDOH.
- Adherence Guidelines for HIV, TB and NCDs, Updated April 2023. SA NDOH.

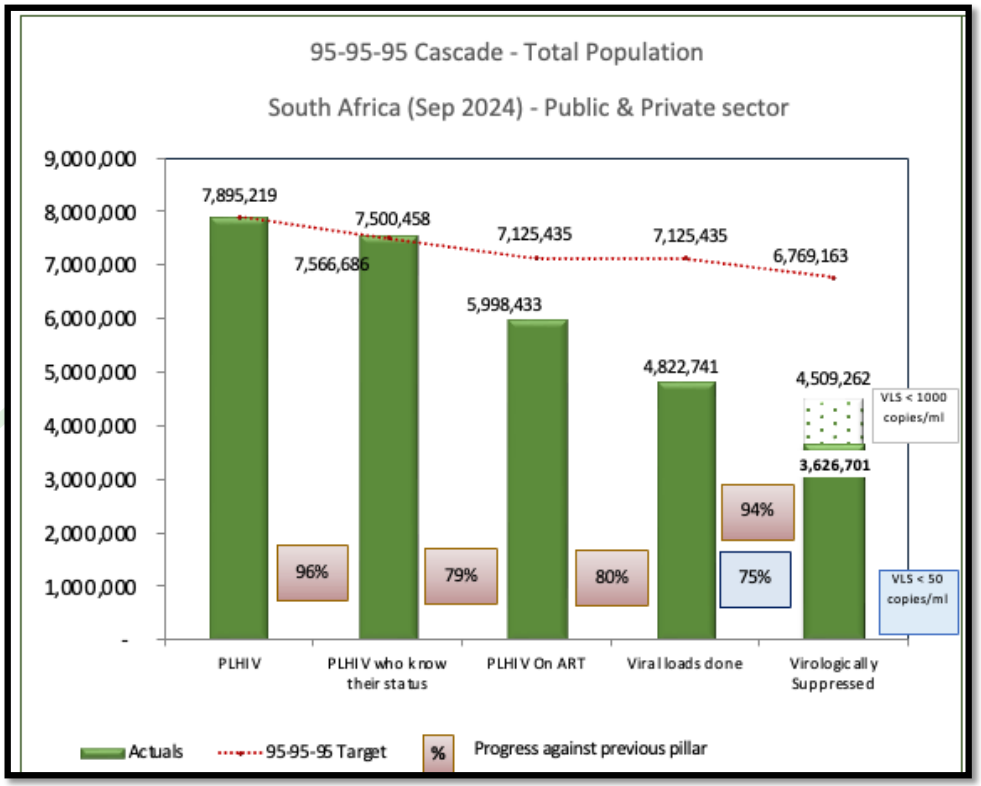






Purpose

- We have a goal to **FIND** and **RETAIN** 1.1 Million PLHIV on ART by end of December 2025



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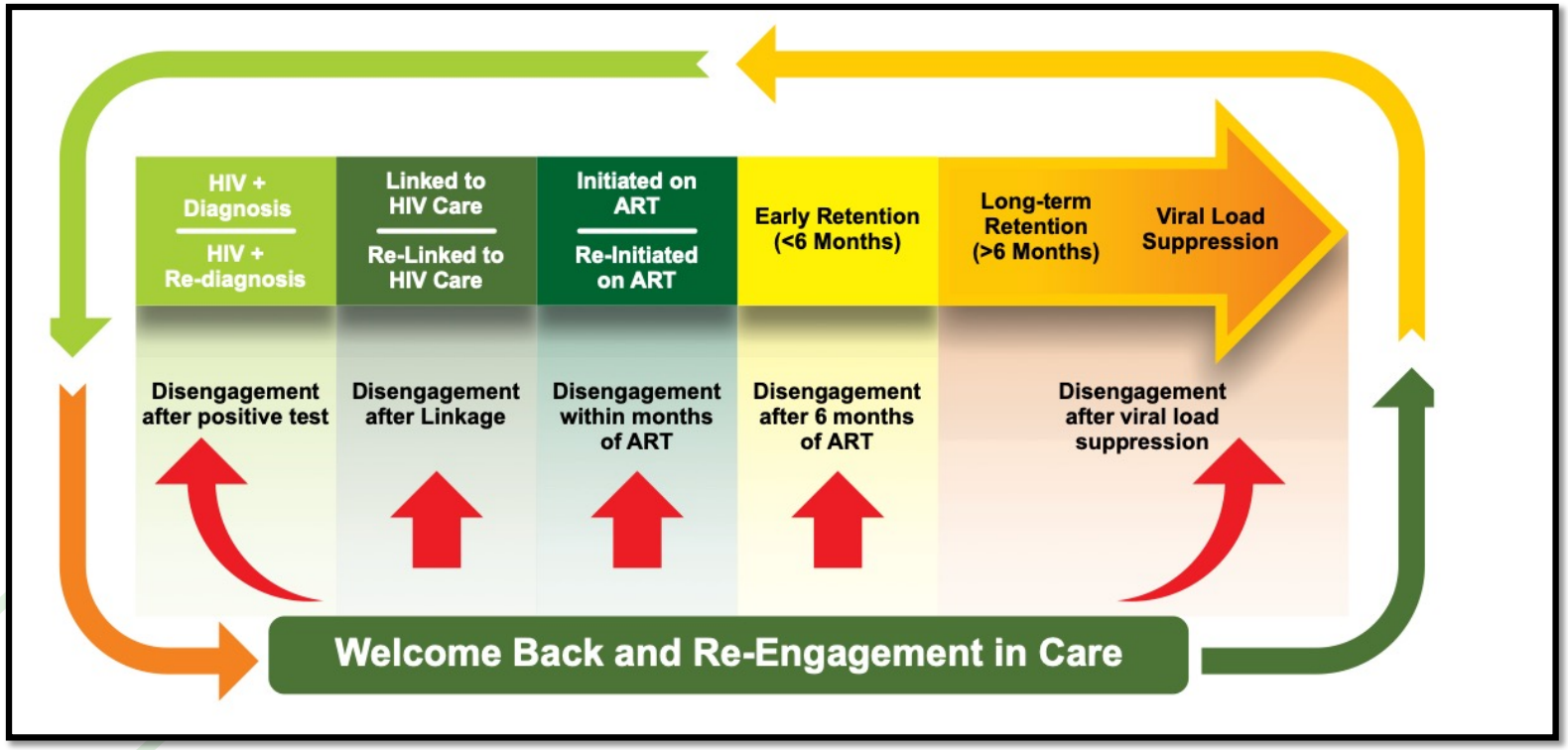
Identifying leakage in the HIV care cascade- where is the problem?



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Why this Presentation is important

- Disengagement from antiretroviral therapy (ART) care is an important reason why people living with HIV do not achieve viral load suppression become unwell.

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Why Clients Disengage

JIAS JOURNAL OF THE INTERNATIONAL AIDS SOCIETY Open Access

J Int AIDS Soc. 2024 Mar 17;27(3):e26230. doi: 10.1002/jia2.26230

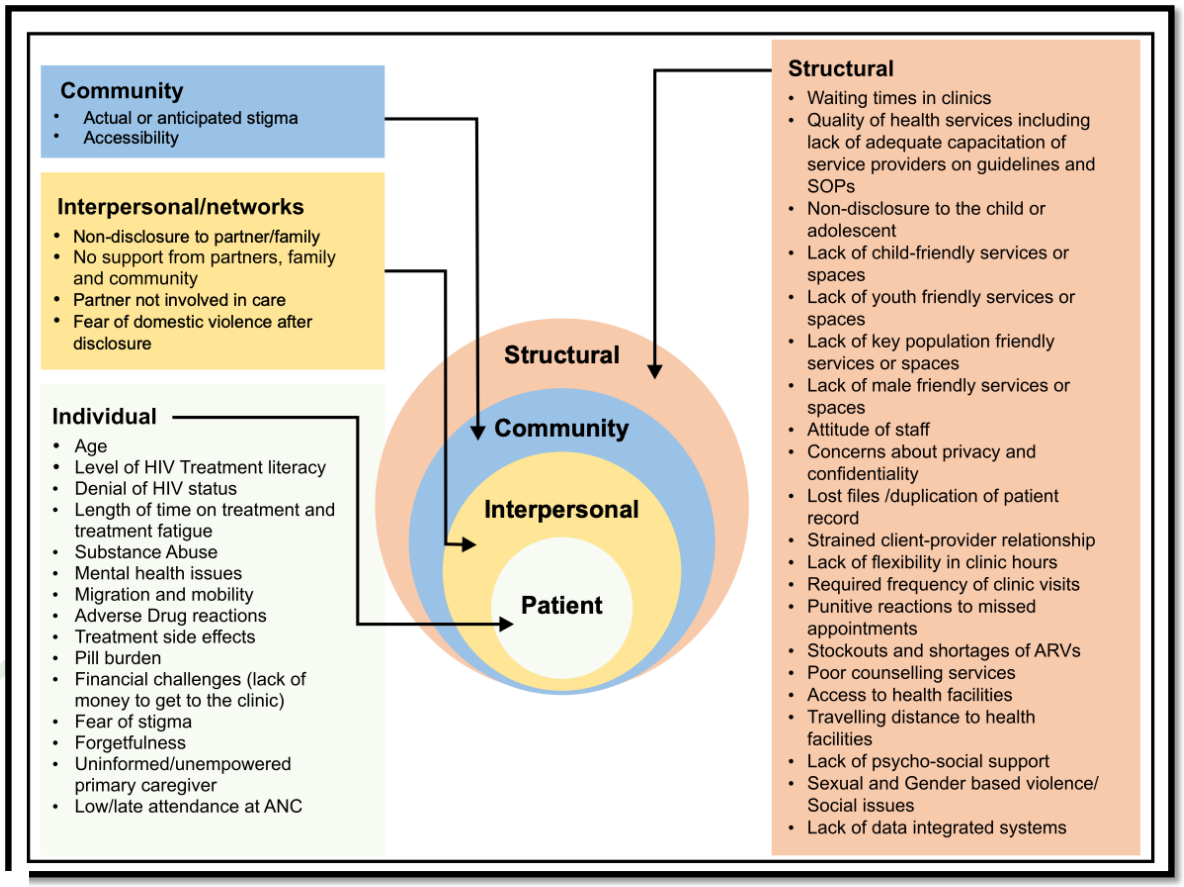
Reasons for disengagement from antiretroviral care in the era of "Treat All" in low- or middle-income countries: a systematic review

Rachael M Burke [1,2], Hannah M Rickman [1,2], Clarice Pinto [3], Peter Ehrenkranz [4], Augustine Choko [2,5], Nathan Ford [3,6,✉]

The most common reasons for disengagement were **unexpected events**, **socio-economic** reasons, ART **side effects** or **lack of perceived benefit of ART**.

Conceptually, studies described underlying vulnerability factors (**individual, interpersonal, structural and healthcare**) but that often unexpected proximal events (e.g. **unanticipated mobility**) acted as the trigger for disengagement to occur.

Barriers to ART initiation, adherence, and retention in care.



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Key Message

We must focus on ways to encourage clients to engage with care by making ART services **welcoming**, **person-centred** and more **flexible** alongside offering **adherence interventions**, such as counselling and peer support.

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Batho Pele Principles

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EIGHT BATHO PELE PRINCIPLES TO KICKSTART THE TRANSFORMATION OF SERVICE DELIVERY

The Public Service will put the following "People First" principles into practice without delay.
And we will step up implementation to arrive at acceptable service levels and quality as soon as possible.

1 CONSULTATION

You can tell us what you want from us.

You will be asked for your views on existing public services and may also tell us what new basic services you would like. All levels of society will be consulted and your feelings will be conveyed to Ministers, MECs and legislators.

THE PRINCIPLE: *You should be consulted about the level and quality of the public services you receive and, wherever possible, should be given a choice about the services that are offered.*

2 SERVICE STANDARDS

Insist that our promises are kept.

All national and provincial government departments will be required to publish service standards for existing and new services. Standards may not be lowered! They will be monitored at least once a year and be raised progressively.

THE PRINCIPLE: *You should be told what level and quality of public services you will receive so that you are aware of what to expect.*

3 ACCESS

One and all should get their fair share.

Departments will have to set targets for extending access to public servants and public services. They should implement special programmes for improved service delivery to physically, socially and culturally disadvantaged persons.

THE PRINCIPLE: *You and all citizens should have equal access to the services to which you are entitled.*

4 COURTESY

Don't accept insensitive treatment.

All departments must set standards for the treatment of the public and incorporate these into their Codes of Conduct, values and training programmes. Staff performance will be regularly monitored, and discourtesy will not be tolerated.

THE PRINCIPLE: *You should be treated with courtesy and consideration.*

5 INFORMATION

You're entitled to full particulars.

You will get full, accurate and up-to-date facts about services you are entitled to. Information should be provided at service points and in local media and languages. Contact numbers and names should appear in all departmental communications.

THE PRINCIPLE: *You should be given full, accurate information about the public services you are entitled to receive.*

6 OPENNESS AND TRANSPARENCY

Administration must be an open book.

You'll have the right to know. Departmental staff numbers, particulars of senior officials, expenditure and performance against standards will not be secret. Reports to citizens will be widely published and submitted to legislatures.

THE PRINCIPLE: *You should be told how national and provincial departments are run, how much they cost, and who is in charge.*

7 REDRESS

Your complaints must spark positive action.

Mechanisms for recording any public dissatisfaction will be established and all staff will be trained to handle your complaints fast and efficiently. You will receive regular feedback on the outcomes.

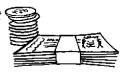
THE PRINCIPLE: *If the promised standard of service is not delivered, you should be offered an apology, a full explanation and a speedy and effective remedy. When complaints are made, you should receive a sympathetic, positive response.*

8 VALUE FOR MONEY

Your money should be employed wisely.

You pay income, VAT and other taxes to finance the administration of the country. You have the right to insist that your money should be used properly. Departments owe you proof that efficiency savings and improved service delivery are on the agenda.

THE PRINCIPLE: *Public services should be provided economically and efficiently in order to give you the best possible value for money.*



Designed and issued by the Department of Public Service and Administration.

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THE PATIENTS' RIGHTS CHARTER

For many decades the vast majority of the South African population has experienced either a denial or violation of fundamental human rights, including rights to health care services. To ensure the realization of the right of access to health care services as guaranteed in the Constitution of the Republic of South Africa (Act No 108 of 1996), the Department of Health is committed to upholding, promoting and protecting this right and therefore proclaims this *PATIENTS' RIGHTS CHARTER* as a common standard for achieving the realization of this right.

This Charter is subject to the provisions of any law operating within the Republic of South Africa and to the financial means of the country.

A HEALTHY AND SAFE ENVIRONMENT

Everyone has the right to a healthy and safe environment that will ensure their physical and mental health or well-being, including adequate water supply, sanitation and waste disposal as well as protection from all forms of environmental danger, such as pollution, ecological degradation or infection.

PARTICIPATION IN DECISION-MAKING

Every citizen has the right to participate in the development of health policies and everyone has the right to participate in decision-making on matters affecting one's health

ACCESS TO HEALTHCARE

Everyone has the right of access to health care services that include:

i. receiving timely emergency care at any health care facility that is open regardless of one's ability to pay;

ii. treatment and rehabilitation that must be made known to the patient to enable the patient to understand such treatment or rehabilitation and the consequences thereof;

iii. provision for special needs in the case of newborn infants, children, pregnant women, the aged, disabled persons, patients in pain, person living with HIV or AIDS patients;

iv. counselling without discrimination, coercion or violence on matters such as reproductive health, cancer or HIV/AIDS;

v. palliative care that is affordable and effective in cases of incurable or terminal illness;

vi. a positive disposition displayed by health care providers that demonstrate courtesy, human dignity, patience, empathy and tolerance; and

vii. health information that includes the availability of health services and how best to use such services and such information shall be in the language understood by the patient.

KNOWLEDGE OF ONE'S HEALTH INSURANCE/MEDICAL AID SCHEME

A member of a health insurance or medical aid scheme is entitled to information about that insurance or medical aid scheme and to challenge, where necessary, the decisions of such health insurance or medical aid scheme relating to the member.

CHOICE OF HEALTH SERVICES

Everyone has the right to choose a particular health care provider for services or a particular health facility for treatment provided that such choice shall not be contrary to the ethical standards applicable to such health care providers or facilities, and the choice of facilities in line with prescribed service delivery guide lines.

BE TREATED BY A NAMED HEALTH CARE PROVIDER

Everyone has the right to know the person that is providing health care and therefore must be attended to by clearly identified health care providers.

CONFIDENTIALITY AND PRIVACY

Information concerning one's health, including information concerning treatment may only be disclosed with informed consent, except when required in terms of any law or an order of the court.

INFORMED CONSENT

Everyone has the right to be given full and accurate information about the nature of one's illnesses, diagnostic procedures, the proposed treatment and the costs involved, for one to make a decision that affects anyone of these elements.

REFUSAL OF TREATMENT

A person may refuse treatment and such refusal shall be verbal or in writing provided that such refusal does not endanger the health of others.

BE REFERRED FOR A SECOND OPINION

Everyone has the right to be referred for a second opinion on request to a health provider of one's choice.

CONTINUITY OF CARE

No one shall be abandoned by a health care professional worker or a health facility which initially took responsibility for one's health.

COMPLAIN ABOUT HEALTH SERVICES

Everyone has the right to complain about health care services and to have such complaints investigated and to receive a full response on such investigation.

EVERY PATIENT OR CLIENT HAS THE FOLLOWING RESPONSIBILITIES:

- Advise the health care providers on his or her wishes with regard to his or her death.
- Comply with the prescribed treatment or rehabilitation procedures.
- Enquire about the related costs of treatment and/or rehabilitation and to arrange for payment.
- Take care of health records in his or her possession.
- Take care of his or her health.
- Care for and protect the environment.
- Respect the rights of other patients and health providers.
- Utilise the health care system properly and not abuse it.
- Know his or her local health services and what they offer.
- Provide health care providers with the relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes.

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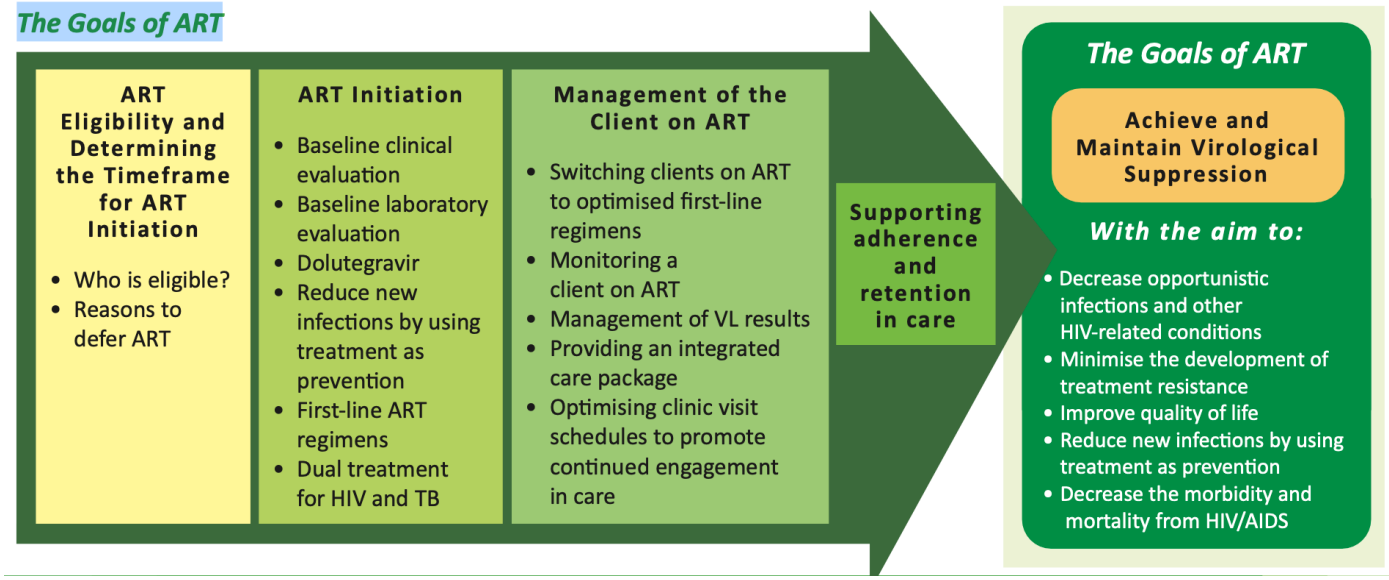
The Goals of ART



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Medical Indications to Defer ART

Medical Indications to Defer ART	
Indication	**Action**
TB symptoms (cough, night sweats, fever, recent weight loss)	Investigate symptomatic clients for TB before initiating ART. If TB is excluded, proceed with ART initiation and TB preventive therapy (after excluding contra-indications to TPT). If TB is diagnosed, initiate TB treatment and defer ART. The timing of ART initiation will be determined by the site of TB infection and the client's CD4 cell count
Diagnosis of drug-sensitive (DS) TB at a non-neurological site (e.g. pulmonary TB, abdominal TB, or TB lymphadenitis)	Defer ART initiation as follows: • If CD4 < 50 cells/µL – initiate ART within 2 weeks of starting TB treatment, when the client's symptoms are improving, and TB treatment is tolerated • If CD4 ≥ 50 cells/µL – initiate ART 8 weeks after starting TB treatment • In pregnant and breastfeeding women (PBFW) initiate ART within 2 weeks of starting TB treatment, when the client's symptoms are improving, and TB treatment is tolerated. Defer ART for 4-6 weeks if symptoms of meningitis are present. For further details, refer to the Family-Centered Transmission Prevention Guideline 2023
Diagnosis of drug-resistant (DR) TB at a non-neurological site (e.g. pulmonary TB, abdominal TB, or TB lymphadenitis)	Initiate ART after 2 weeks of TB treatment, when the client's symptoms are improving, and TB treatment is tolerated
Diagnosis of DS-TB or DR-TB at a neurological site (e.g. TB meningitis or tuberculoma)	Defer ART until 4-8 weeks after start of TB treatment
Signs and symptoms of meningitis	Investigate for meningitis before starting ART
Cryptococcal antigen (CrAg) positive in the absence of symptoms or signs of meningitis and if lumbar puncture is (LP) negative for cryptococcal meningitis (CM)	No need to delay ART. ART can be started immediately.
Confirmed cryptococcal meningitis	Defer ART until 4-6 weeks of antifungal treatment has been completed
Other acute illnesses e.g. *Pneumocystis jirovecii* pneumonia (PJP) or bacterial pneumonia	Defer ART for 1-2 weeks after commencing treatment for the infection
Clinical symptoms or signs of liver disease	Confirm liver injury using ALT and total bilirubin levels. ALT elevations > 120 IU/L with symptoms of hepatitis, and/or total serum bilirubin concentrations > 40 µmol/L are significant. Investigate and manage possible causes including TB, hepatitis B, drug-induced liver injury (DILI), or alcohol abuse

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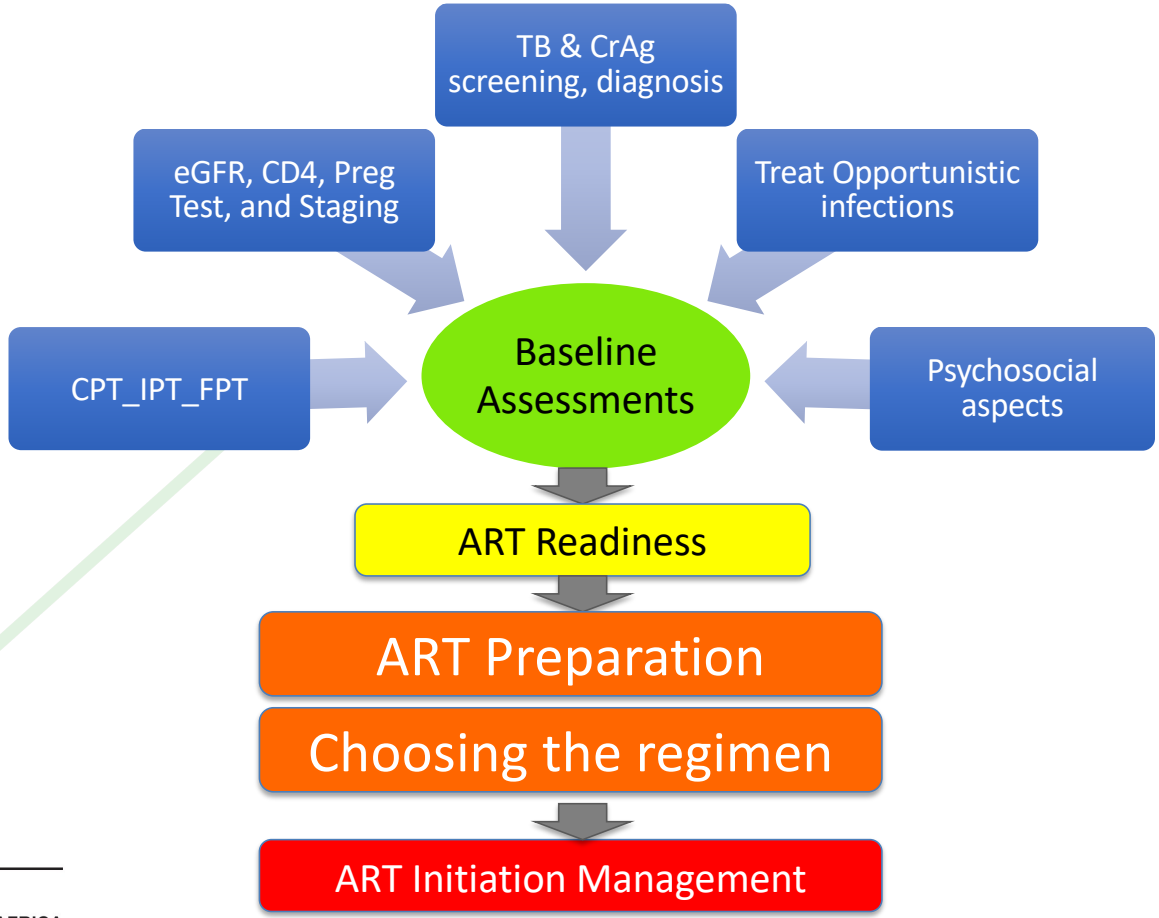
Preparation for ART Initiation



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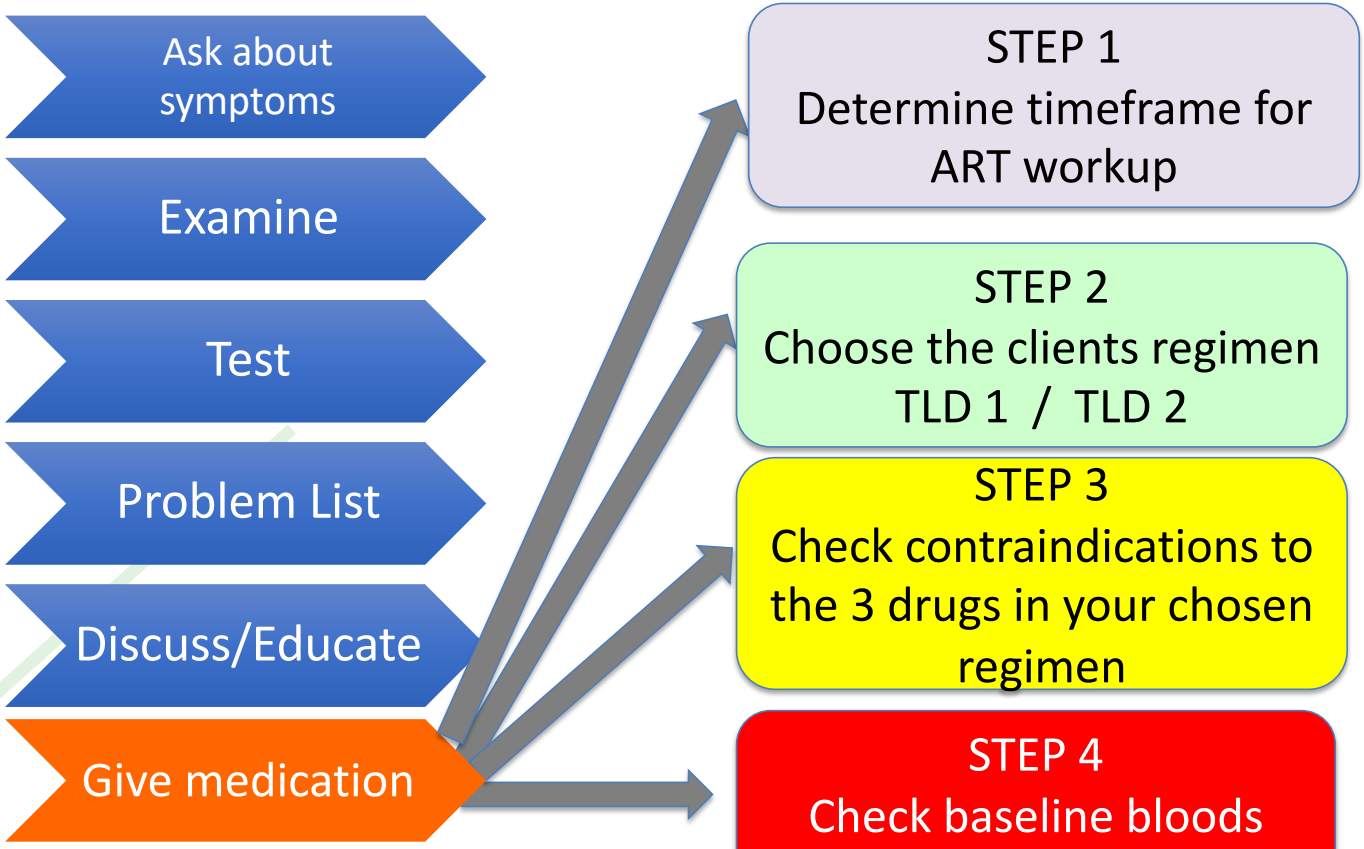
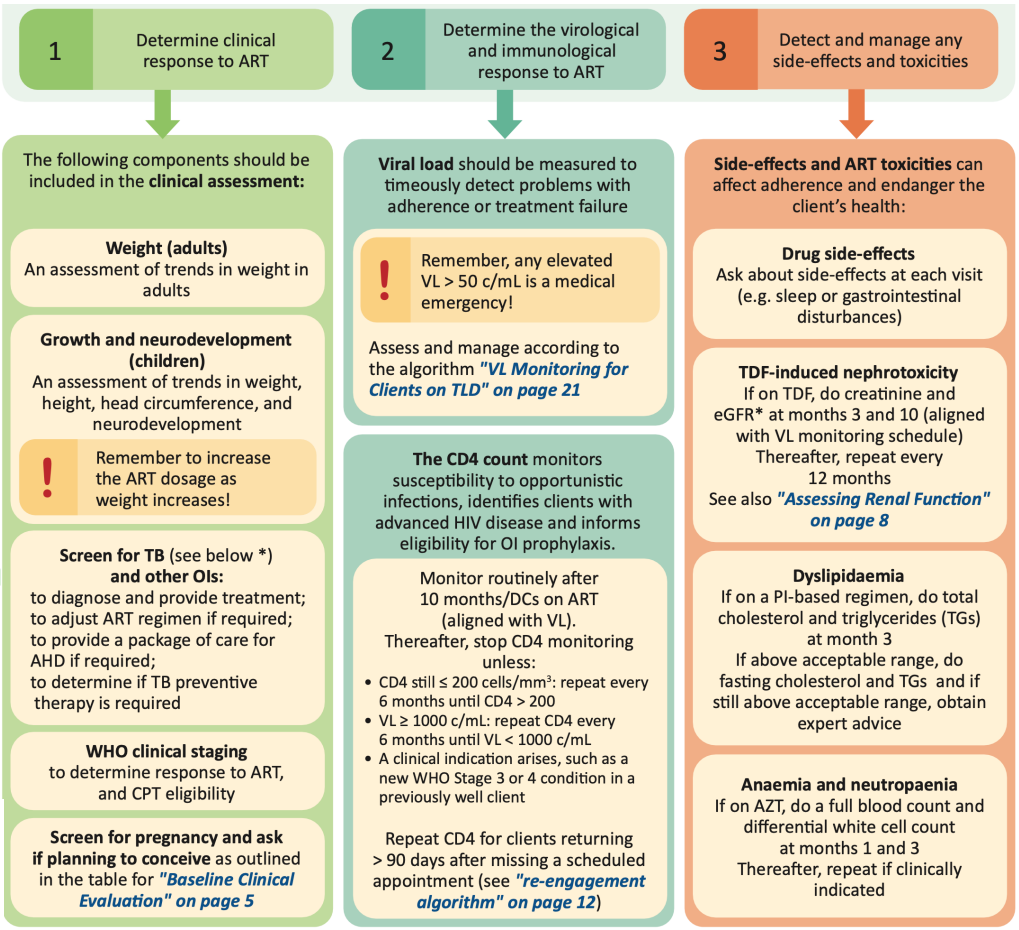
Choosing the client's ART regimen



Monitoring Patients on ART



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Baseline: Mental Health Screening

- Screen for active depression, other mental health issue or substance abuse
- Mental health conditions and substance use can affect adherence and the client's quality of life.

Mental Health Assessment

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As mental health disorders can impact adherence negatively, it is recommended that screening is provided for mental health disorders while treating HIV, TB and NCDs.

Basic screening should assess:

1. What is the patient's appearance?

- Is he/she clean and looking after him or herself
- Does the person look worried or sad?
- Does the person seem agitated?
- Does he/she seem suspicious, nervous or hostile?

2. Assess the patient's mood, asking:

- How have you been feeling over the last week?
- Have you been feeling mostly normal, or sad or happy, or worried?
- How do you feel today?
- What are your feelings about the future?

3. Assess the patient's thoughts:

- Are you having negative thoughts?
- Are you having strange thoughts?
- Any unusual fears (such as being followed, spied on)?
- Have you had any strange experiences (such as hearing voices/seeing visions other people cannot hear or see) or special abilities?

Negative thoughts can suggest depression, other strange thoughts or experiences could raise suspicion of psychosis.

4. Assess patient's cognition:

- Does thinking seem slow?
- Is the person able to concentrate?
- Does the memory seem impaired?

If you suspect a mental health disorder while asking the previous questions, try to answer the following questions:

- What is the main problem?
- How long has it been present?
- Does it affect the patient's daily functioning?
- Can this be managed at this clinic?

If further assessment and treatment cannot be provided at the clinic, refer to a psychiatric nurse or service. Tools such as SRQ 20 recommended by the WHO can help to identify mental health disorder.

Provide the patient with education on mental health and provide them with advice that can help them overcome symptoms. Explain to the patient that the following signs could mean that they may need support to improve their mental health condition:

If they feel:

- constantly angry or very worried
- very sad for a very long time
- they are losing interest in things they used to enjoy doing
- they can not cope with work or daily activities
- their mind is controlled (such as by voices) or out of control
- they need to use alcohol or drugs
- Obsessively do things such as repeat washing hands, non-stop sport activity, eating too much, obsessive diet or other obsessive behaviours.
- Hurt themselves or other people or destroy things.
- Do irresponsible things that could harm them or others.
- 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.

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Respond to Socio-Economic Impacts on Patients

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Social Risk Screening and Social Scripts

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Interventions to support adherence to ART

- All clients, and caregivers of paediatric clients, must receive counselling on how to administer medication, monitor side-effects and deal with challenges to adherence.

- ART literacy education and fast-track initiation counselling (FTIC) empower clients to adhere to treatment, and positively influence clinical outcomes.

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Interventions to support adherence to ART

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Adherence counselling at ART initiation and first

follow-up visit should focus on:

- providing the client with an understanding of HIV, ART, and the importance of VL suppression
- Providing the client with practical skills to adhere to ART
- Identifying any potential risk factors for adherence in the future
- An individualized adherence plan should be developed with clear treatment milestones, including an undetectable viral load

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Eligibility criteria for DMOC

1) having a suppressed VL,
2) being clinically well with no opportunistic infections (OIs),
3) not having any other uncontrolled chronic conditions that require clinical review more frequently than 6-monthly, and
4) not being pregnant.

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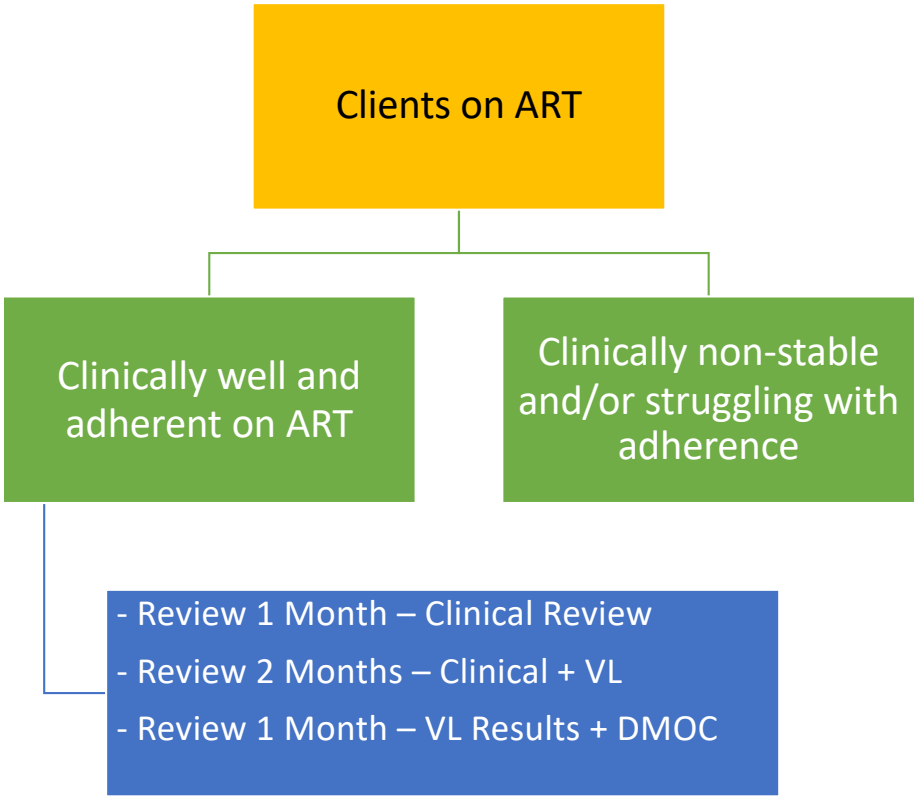
Care Continuum for Clients 5 years of age and older on ART



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Visit Schedule for Adults, Adolescents and Children 5 Years and Older on ART

DC/ Months* on ART	Routine monitoring tests	Overview of Management
0	**Baseline clinical and lab assessment as outlined on pages 4 to 6 ART initiation and session 1 of fast track initiation counselling**	
1	**Review test results**	• Session 2 of fast track initiation counselling including planning for travel and VL education • Clinical assessment and routine monitoring as outlined on page 19 • Integrated services for family planning and NCDs • **2 months ART dispensed (2MMD) - DMOC SOP 4**
3	**3-month* VL sCR and eGFR**	• Clinical assessment including VL and any other routine monitoring bloods as outlined on page 19 • Integrated services for family planning and NCDs

4	**Review test results**	• Clinical assessment and review of VL and any other monitoring results
		• Integrated services for family planning and NCDs
		• Assess eligibility for Repeat Prescription Collection strategies (RPCs) (South Africa's differentiated models of care for stable patients)
		  • VL < 50 c/mL
		  • Clinically well
		  • No OIs, including TB
		  • Not pregnant
		Repeat Prescription Collection strategies (DMOC for stable patients)
		Facility Pick-up Point (FAC-PUP) (DMOC SOP 5.1) / Adherence Clubs (AC) Facility or community-based support groups (DMOC SOP 5.2) / External Pick-up point (EX-PUP) (DMOC SOP 5.3)
		• Renew prescription for next 6 months, with first 3 month's supply issued today from the facility
		• If not eligible for RPCs or refused RPCs: Assess eligibility for facility provided multi-month dispensing (MMD) – DMOC SOP 4

7		• Collect medication from preferred RPCs
10	**10-month* VL sCR and eGFR CD4 count**	• Clinical assessment including VL and any other monitoring bloods as per *"Monitoring on ART" on page 19* • Integrated services for family planning and NCDs • Check TPT eligibility • Renew prescription for next 6 months • Do not require clients to return to the facility in 1 month to review the VL results, unless other clinical indications exist that require review. Rather, recall to the facility only those clients with elevated VLs
11+		• 12-monthly clinical assessment and family planning review as per *"Monitoring on ART" on page 19* • 12-monthly routine monitoring of VL, sCR and eGFR • Check that chosen RPCs option is still suitable • Collect medication from preferred RPCs

Non-stable clients

If at any stage the client becomes clinically non-stable and /or non-adherent i.e. a client who has:

- missed a scheduled appointment by more than 28 days (including in an RPCs) (see also *"Re-engagement algorithm" on page 12*)
- a VL ≥ 50 c/ml
- possible signs or symptoms of clinical failure, e.g. if the client is acutely unwell, or develops a new OI such as TB

A clinician should:

- If in an RPCs, return the client to regular care to ensure more frequent clinical follow-up until they are stable again.
- Provide appropriate clinical management
- If clinically well and struggling with visit frequency: provide multi-month dispensing (DMOC SOP 4)
- If experiencing side effects or the child cannot tolerate their medication: switch drugs/formulation
- If struggling to take ART as prescribed: enhanced adherence counselling (See Annexure 3)

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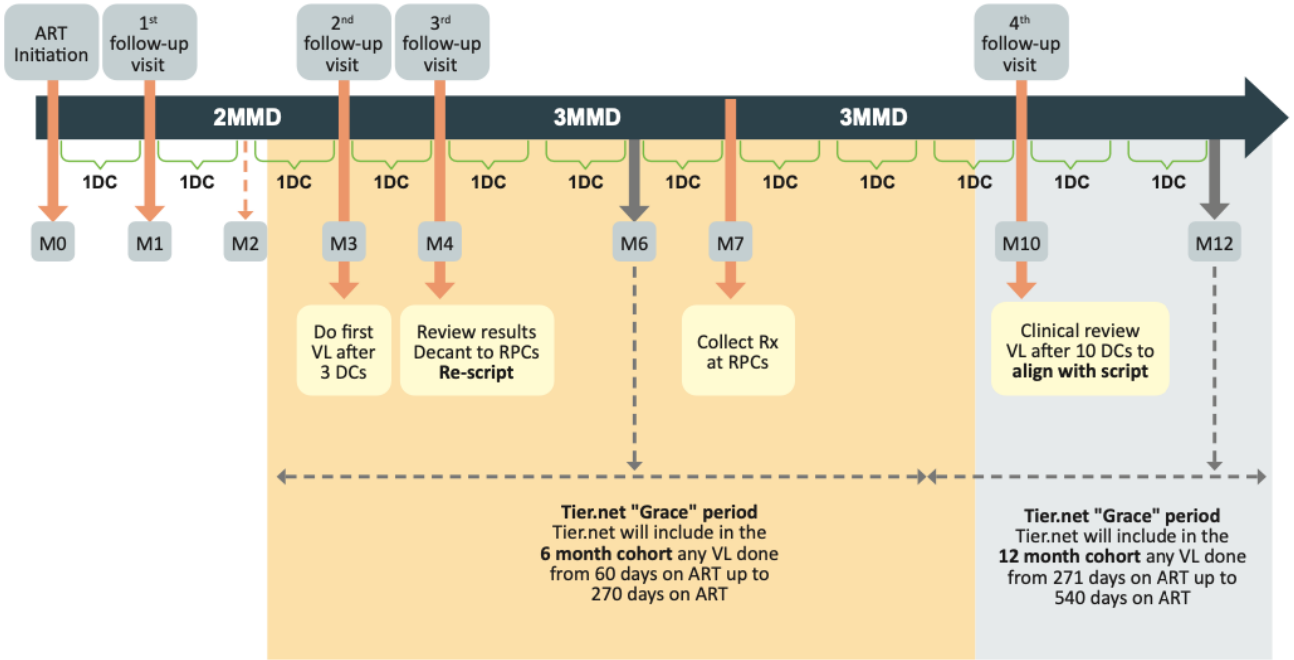
Visit Schedule for Adults, Adolescents and Children 5 Years and Older on ART



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Make it Easy for Women on Contraception

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Women with contraceptive needs should have contraceptive method options explained, specifically how each method impacts all required return visits' location (facility or outside of the facility) and visit frequency:

- Long-acting reversible contraception (LARC) removes any increased visit frequency or alignment concerns.
- The combined oral contraceptive pill (COCP) can be repeated 3-monthly, aligns well with ART and well-baby visit schedules (if applicable), and can be scripted through her preferred RPCs.
- The DMPA 3-monthly injection must be administered by a clinician but aligns with ART and well-baby visit schedules
- The NET-EN 2-monthly injection also needs to be administered by a clinician, but will require additional visits by the mother.
- Where a woman chooses to continue clinician administered short-acting injectable contraception (e.g., DMPA or NET-EN), a facility-based pick-up point (FAC-PUP) or facility-based adherence club may be the preferred option provided visit alignment can be ensured.

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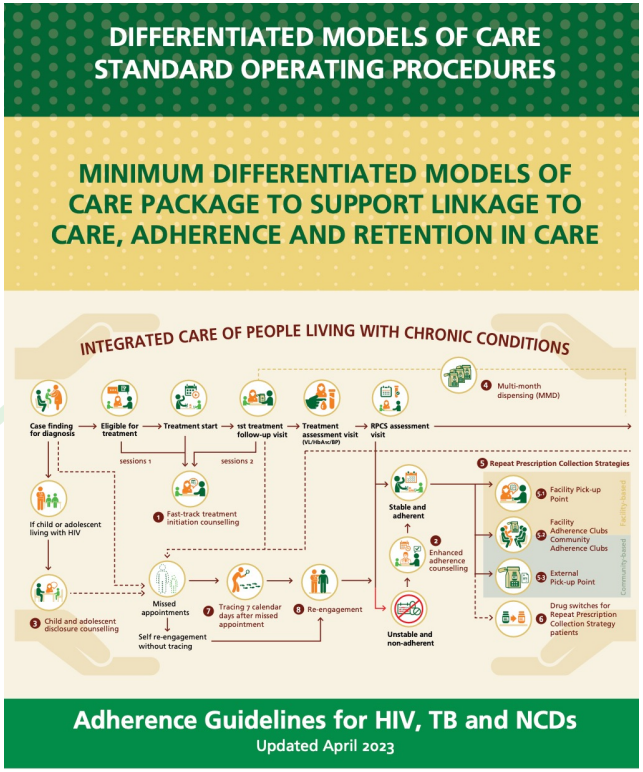
Know Your Adherence Guideline



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MINIMUM DIFFERENTIATED MODELS OF CARE PACKAGE TO SUPPORT LINKAGE TO CARE, ADHERENCE AND RETENTION IN CARE

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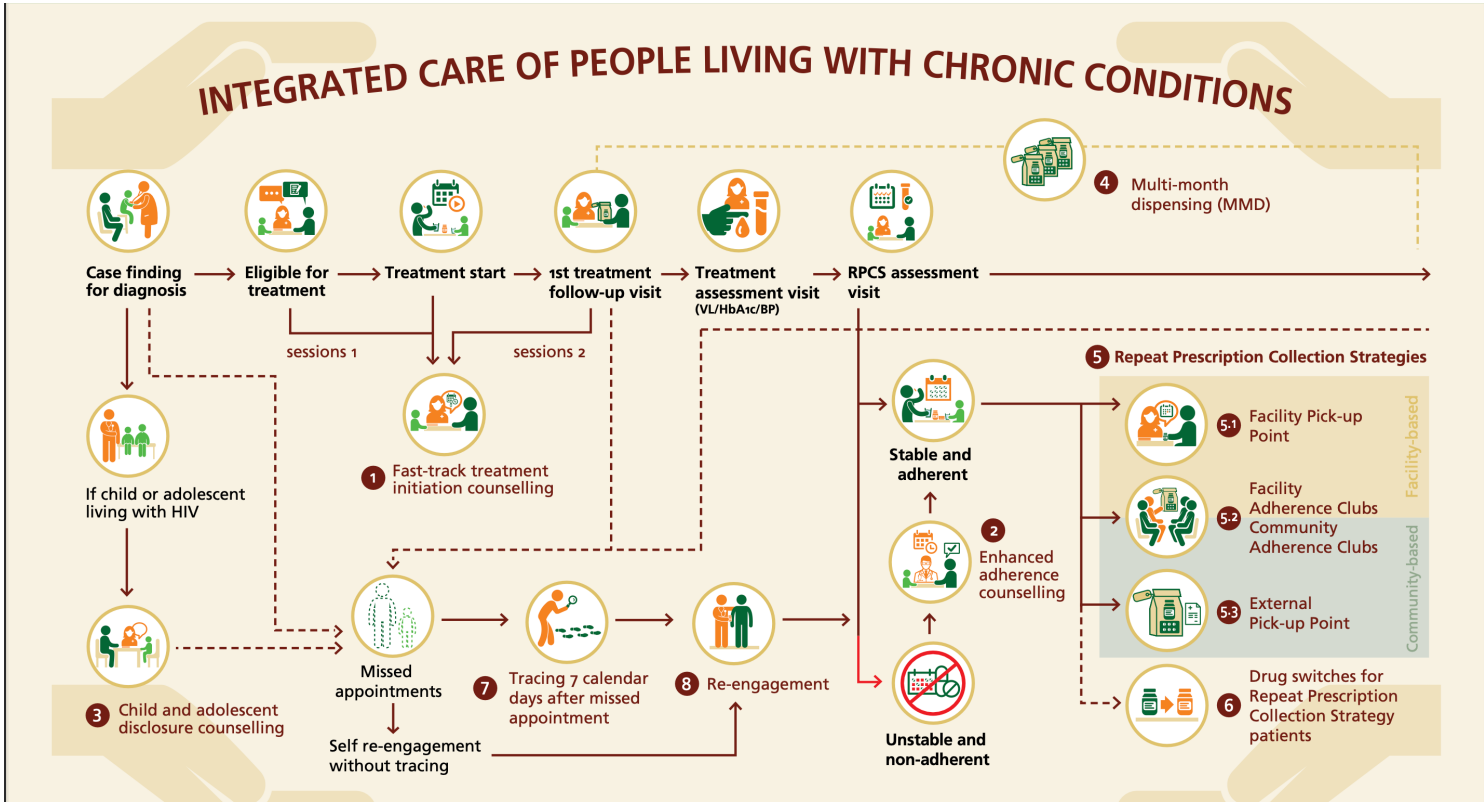

Know Your Adherence Guideline/ DMOC SOPs

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FAST TRACK INITIATION COUNSELLING (FTIC)
SOP 1

ENHANCED ADHERENCE COUNSELLING (EAC)
SOP 2

CHILD AND ADOLESCENT DISCLOSURE COUNSELLING (CADC)
SOP 3

MULTI-MONTH DISPENSING (MMD)
SOP 4

Enhanced Adherence Counselling

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ENHANCED ADHERENCE COUNSELLING SESSIONS

There are two sessions:
Session 1: Initial enhanced adherence counselling for patients struggling with adherence.
Session 2: Enhanced adherence counselling for persistent non-adherent patients (covered in DMOC SOP 2).

SESSION 1

Benefits of Viral Suppression:

- Undetectable VL means the virus is untransmittable to HIV negative partners
- CD4/immune function recovery
- Less chance of illness
- Reduced visits to clinic through access to MMD/RPC

1. Explain the purpose of your session, define terms:

- Determine possible reasons for abnormal assessment results.
- Assess and address any reported barriers to adherence and discuss effective strategies to overcome.
- Update or develop an adherence plan with the patient.

2. Education on the assessment result

- Assess patient for mental health using the Mental Health Assessment tool in Annexure II.
- Find out what treatment education the patient has received. Recap the benefits of VL suppression as outlined in the box above.
- Find out what the patient knows about the treatment they are taking and check the treatment regimen has been understood correctly i.e. when each medicine is taken.
- Explain in a supportive way that the most common reason for such result is a problem with taking medication correctly.
- Find out if the patient received education on the assessment to check adherence and effective treatment(VL/BP/HbA1c) and its meaning. If not, provide this information (see SOP 1: FTIC session 2).

3. Flexibility on treatment

- Clear any myths and misconceptions around taking treatment and explain that there is some flexibility.
- Emphasize the importance of patients choosing their own suitable time for taking medication as prescribed.
- Explain what to do with late or missed doses depending on the treatment.
- Explain what to do in case of alcohol use while on treatment. If patient cannot control their use of alcohol, they should make sure that they take their treatment anyway.
- Explain to patient that it is better not to use traditional medicines that could interfere with the treatment. If they take traditional medicine, they should make a plan with the clinician to still take their treatment.

4. Patient's experiences

Ask: What makes it difficult for you to take the treatment sometimes? Encourage the patient to be honest about personal issues that may affect their adherence and help them to address issues such as alcohol or other substance intake as they can lead to forgetting medication.

- Explain that medication should be taken even without food and what they can do if food insecurity is an issue. Inform and assist patient on how to access government support programmes, if necessary.
- Consider patient's religious and traditional beliefs that may contribute to non-adherence to treatment.

5. Identify strategies to ensure good adherence

Ask: What could help you to remember to take the treatment?

Discuss treatment reminders and adherence options including the advantages and disadvantages of each for the specific patient:

- Treatment buddy to remind the patient to take treatment
- Setting phone alarm
- Support by a family member
- Pill counts
- Marking a calendar or using a pill box
- Linking medication to meals times or other daily routine such a brushing teeth
- Storing medication somewhere accessible if unable to disclose to others in the home
- Carrying/keeping spare medication to take at work in case dosing at home was forgotten or client late returning home
- Modified Direct Observed Therapy such as treatment supporter (this is also applicable to children)

Ask: Who could support you to take the treatment every day?

Discuss sources of social support for the client. Emphasise the importance of support structures in coping and adherence such as family, friends, peer support groups, faith-based group and work-based support.

- Encourage sharing of feelings and emotions regarding the illness.
- Empower the patient in making a plan that is adapted to the barriers expressed. Be aware not to create dependency, but to find their own solutions, with the help of the healthcare worker or lay counsellor.

6. Inform the patient about pathway ahead

- Explain further assessments (tests) to check adherence and effective treatment as per disease specific guidelines (for HIV: a further viral load will be taken in 3 months, for hypertension: a BP will be taken at every visit for the next 3 months, for diabetes: a further HbA1c test will be done in 3 months)
- Explain that if the next assessment is normal, it will become easier to collect treatment. The patient can ask and the clinician should offer and enroll the patient into a simpler treatment supply collection system of their choice with longer treatment supply based on what is available at the facility (FAC-PUP/Adherence Club/EX-PUP).

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Child and Adolescent Disclosure Counselling for Children Living with HIV

- Disclosure should ideally be a gradual process over many years, advancing from partial disclosure to full disclosure, post-disclosure, and ongoing support.
- Ideally full disclosure should take place between 10 and 14 years old if the child is of normal cognition and maturity, making sure that it is done before sexual debut.
- The parent or caregiver (PCG) should be prepared for disclosure and supported through each step by the healthcare worker (HCW). PCGs should decide what role the HCW should play.
- The HCW/PCG should make sure to use age-appropriate language, pictures where possible, excellent counselling skills, be aware of emotions, use a private space, and refer to psychologists and social workers when necessary.

Failure of full disclosure by early teenage years can lead to:

- Poor adherence
- Emotional difficulties
- Poor school performance
- HIV transmission if sexually active
- The adolescent finding out their HIV status through other mechanisms
- Psychological issues if disclosure is not sensitively done

No disclosure yet (0 — 4 Years)

- Conduct the consultation with the child present (but do not mention the word HIV if the child can understand the conversation)
- The child is too young for direct information about HIV but explanations to the caregiver about how HIV can affect the child remain important.
- Provide ideas to help the caregiver support the child taking medicine. Congratulate the child on taking their medicines well.
- Address the caregiver's anxieties and inform them that in time you will support them through the partial and full disclosure process as outlined below.
- Provide a safe and welcoming clinic and build a relationship with the child through play/singing.
- Warn the PCG that when the child starts asking questions about why they must take medicine, they should give the information described under partial disclosure below. They should try not to lie and name other illnesses as the reason for needing medication.

Partial Disclosure (5-9 years)

- The child needs to learn about illness and why they must take medicine but not HIV by name yet.
- Introduce the concepts of good and bad health. Talk about how good health can be promoted by eating healthy food, keeping clean, exercising, looking after teeth etc. Explain that medicines help to keep a body healthy and strong.
- Introduce infections as 'germs' that can damage the body/make you sick and (white) blood cells as the part of the body that look for and kill germs.
- Explain that some germs hide, and you need to take medicines to help fight the germs or explain that they were born without enough white blood cells so they need to take medicine every day to make their white blood cells increase so that they can stay healthy and are able to fight the germs
- Advise PCG that they can start teaching their child about HIV and other illnesses without telling them that they have HIV, so that the child learns correct information about HIV and not the negative myths (see the 5 points in the red box below)

Before Full Disclosure:

- Assess the adolescent's cognitive and emotional maturity (if they are passing school at the appropriate level for their age, they can be assumed to be of normal cognitive maturity)
- Prepare the PCG for full disclosure
- Get consent to disclose the adolescent's (and PCG's) HIV status. It is preferable to disclose the PCG's status as well, but not essential if the PCG requests not to.
- Find out what the adolescent knows about HIV already before disclosing to them.
- Educate them about HIV and dispel the negative myths:

Children and adolescents living with HIV (C/ALWH) often learn negative myths about HIV from their community, their friends and school, such as "HIV kills", "people with HIV are promiscuous or bad" and "people with HIV can't live a normal life". It is therefore extremely important to educate C/ALWH and dispel all of these myths before you tell them they have HIV. Different ways of educating them include teaching them about a few different illnesses, holding education sessions in the clinic or telling their parents to teach them about HIV at home from a young age. Five important things for them to understand include:

1. These days we have very good treatment for HIV, so people living with HIV (PLHIV) can remain perfectly healthy and never get AIDS.
2. PLHIV can live as long as people without HIV if they take their treatment every day.
3. Anyone can have HIV and it does not make them different/bad. Many people around you have HIV and you do not know because they are just as healthy as those without HIV.
4. PLHIV can have relationships and have children, and if they are taking their treatment and have a suppressed viral load, they will not transmit HIV to their sexual partner or children.
5. Living with HIV does not prevent people from living a completely normal life and following any career they want.

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Know your Adherence Guideline/ DMOC SOPs

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REPEAT PRESCRIPTION COLLECTION STRATEGIES (RPCs)
SOP 5

DIFFERENTIATED MODELS OF CARE FOR PEOPLE STABLE ON TREATMENT

DRUG SWITCHES FOR RPCS PATIENTS
SOP 6

TRACING AND RECALL
SOP 7

RE-ENGAGEMENT IN CARE
SOP 8

Transform Your Mind and Systems

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! If a patient comes from a different facility, it is critical that the patient be provided with treatment on the day of presentation to limit any further treatment interruption and its impact on viral suppression. While referral letters are helpful, a patient cannot be required to leave the facility without treatment to first obtain a referral/transfer letter.

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Re-Engagement in Care

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GUIDING PRINCIPLES

- All staff in the facility are welcoming, acknowledge it is normal to miss appointments and/or have treatment interruptions, support and empower patients to sustain their re-engagement effort.
- If a patient comes from a different facility, it is critical that the patient be provided with treatment on day of presentation to limit any further treatment interruption and for patients living with HIV, reduce time to viral suppression.
- While referral letters are helpful, a patient cannot be required to leave the facility without treatment to first obtain a referral/transfer letter (HIV: for further guidance refer to 2023 ART clinical guidelines)
- **Returning or re-engaging patients should not be made to wait until last to see any service provider but should join the patient queue on the same basis as all other patients. No punitive actions may be taken by facility staff.**
- Patients who return to care self-identifying as well, not on TB treatment and 28 days or less after a missed schedule appointment will return to routine care. This means there will be no change to patient management. Where the patient was in an RPCs, the patient will continue in their RPCs.
- Adherence counselling should not be mandated for all patients who re-engage in care. Follow the procedure below to determine who to provide with adherence counselling.
- Patients may have missed a scheduled appointment because of time, cost or mobility constraints. Sustained re-engagement may be best supported by reducing the required frequency of attendance by providing longer treatment supply and identifying more convenient locations or service hours for collection of treatment supply. *Increasing the intensity of service provision may not be supportive.*
- Re-engaging patients should be considered for multiple-month treatment supply and/or enrolling or re-enrolling into a repeat prescription collection strategy (RPCs) if eligible.
- Chronic care patients returning repeatedly 28 days or less late for their scheduled visits do not require enhanced adherence counselling and should not be reclassified as re-engaging. Despite difficulty with attending as scheduled, the patient is not disengaging from care. If not already enrolled in RPCs, the patient should be urgently assessed for and offered RPCs (otherwise at least facility provided MMD).
- All processes must be documented.

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FACILITY TEAM, ROLES AND RESPONSIBILITIES

All service providers are encouraged to be welcoming and supportive. No punitive actions may be taken.
Administrative clerk is responsible for reducing the patient's waiting time on return after missing a scheduled visit by determining if the patient is a routine or re-engaging patient. Thereafter supporting navigation to routine care or to a clinician for a re-engagement clinical assessment.
Clinician is responsible for providing a re-engagement clinical assessment and determining whether enhanced adherence counselling will assist the patient, carrying out any required laboratory assessments (tests) and follow-up clinical reviews. Where there are no counsellors available at the facility, providing EAC session 1 if indicated.
Counsellor is responsible for providing EAC session 1 if indicated to be appropriate by the clinician.

RE-ENGAGEMENT PROCEDURE

See Re-engagement algorithm – Annexure VII

If a chronic care patient returns to the facility self-identifying as unwell and/or on TB treatment and/or more than 28 days after their scheduled appointment date, a clinician will see the patient to:

1. Complete a re-engagement clinical assessment:

a. **If the patient presents clinically unwell and/or on TB treatment and/or their most recent assessment result was abnormal**
   - The clinician will follow the appropriate clinical guideline (for HIV: 2023 ART Clinical Guidelines including A-E elevated VL assessment)
   - **Continue/restart treatment immediately including any drug switch (for HIV: TEE to TLD)**
   - For patients with HIV: take a CD4 count
   - Decide follow-up clinical review frequency as clinically indicated (For HIV: CD4 count result review for providing advanced HIV disease (AHD) package). Remember not to require a patient to return for clinical review unless clinically necessary due to increased patient burden.
   - Explain to the patient that a BP will be taken at each clinical review and VL/ HbA1c will be taken after 3 consecutive months/dispensing cycles on treatment to check adherence and that treatment is working. If the result is normal and the patient is clinically stable, the clinician will then offer the patient RPCs options available at the facility
   - Where the clinician does not need to see the patient for clinical review monthly and it will assist the patient to remain engaged in care, offer the patient multi-month treatment supply from the facility (see SOP 4: MMD) until their next required clinical review appointment and script accordingly.
   - Write the date of the follow-up visit in patient's diary or appointment card.

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b. **If the patient presents clinically well, not on TB treatment and missed their scheduled appointment by:**

<u>90 days or less (29-90 days late)</u>

- Continue treatment immediately including any drug switch (for HIV: TEE to TLD)
- Assess for RPCs and if the patient meets eligibility criteria, offer RPCs. If the patient consents, enrol/re-enrol in preferred RPCs option.
- If the patient does not meet RPCs eligibility criteria or refuses RPCs, offer three-month treatment supply from the facility (see SOP 4: MMD) until their next required clinical review appointment and script accordingly.
- There is no need for additional assessments, perform assessment/s as per the patient's routine monitoring schedule (VL, BP, HbA1c). If at re-engagement, the patient is overdue for their VL/HbA1c assessment, only perform the assessment once the patient has taken treatment for 3 consecutive months/dispensing cycles.

<u>More than 90 days (>90 days late)</u>

- Restart treatment immediately including any drug switch (for HIV: TEE to TLD)
- For patients with HIV: take a CD4 count
- Explain to the patient that a BP will be taken at each clinical review and VL/ HbA1c will be taken after 3 consecutive months/dispensing cycles on treatment to check adherence and that treatment is working. If the result is normal, the clinician will then offer the patient RPCs options available at the facility.
- Offer the patient three-month treatment supply from the facility (see SOP 4: MMD) until their next required clinical review appointment and script accordingly.
- For HIV: recall any patient with a CD4 count<200 to provide the advanced HIV disease (AHD) package.
- Write the date of the follow-up visit in patient's diary or appointment card.

2. Decide if enhanced adherence counselling EAC could assist:
   - Are drug side effects impacting adherence? If yes and drug/s switched → no need for EAC
   - Is the patient experiencing difficulties getting to facility to collect treatment → no need for EAC (*focus on providing access to MMD and RPCs*)
   - Is the patient experiencing challenges with taking treatment (for example: forgetting, poor understanding of treatment and/or adherence, lack of social support, experiencing internal or external stigma, disclosure concerns, HIV diagnosis acceptance or mental health difficulties) → provide EAC session 1 (see EAC SOP 2)

In case of health problems, patients must be advised to come in immediately to see a clinician NOT to wait until their next scheduled appointment date.

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Re-Engagement in Care

TRACING, RECALL AND RE-ENGAGEMENT
If chronic care patients do not arrive at facility to pick-up medicines within 7 days of the scheduled collection appointment date: • Patients are contacted through SMS or reminder calls to return to collect medicine • If unsuccessful, facility initiates patient tracing using Ward-Based Outreach Team, CHWs or HBC Carers or other suitable means • Where a chronic care patient returns to the facility of their own accord or after tracing within 28 days of their missed scheduled appointment, the patient will be managed as a routine patient. If more than 28 days late, apply re-engagement process again. • For further details on tracing refer tracing and recall SOP 7.

SOP AUTHORISED BY:			
Date	**Initials and Surname**	**Designation**	**Signature**

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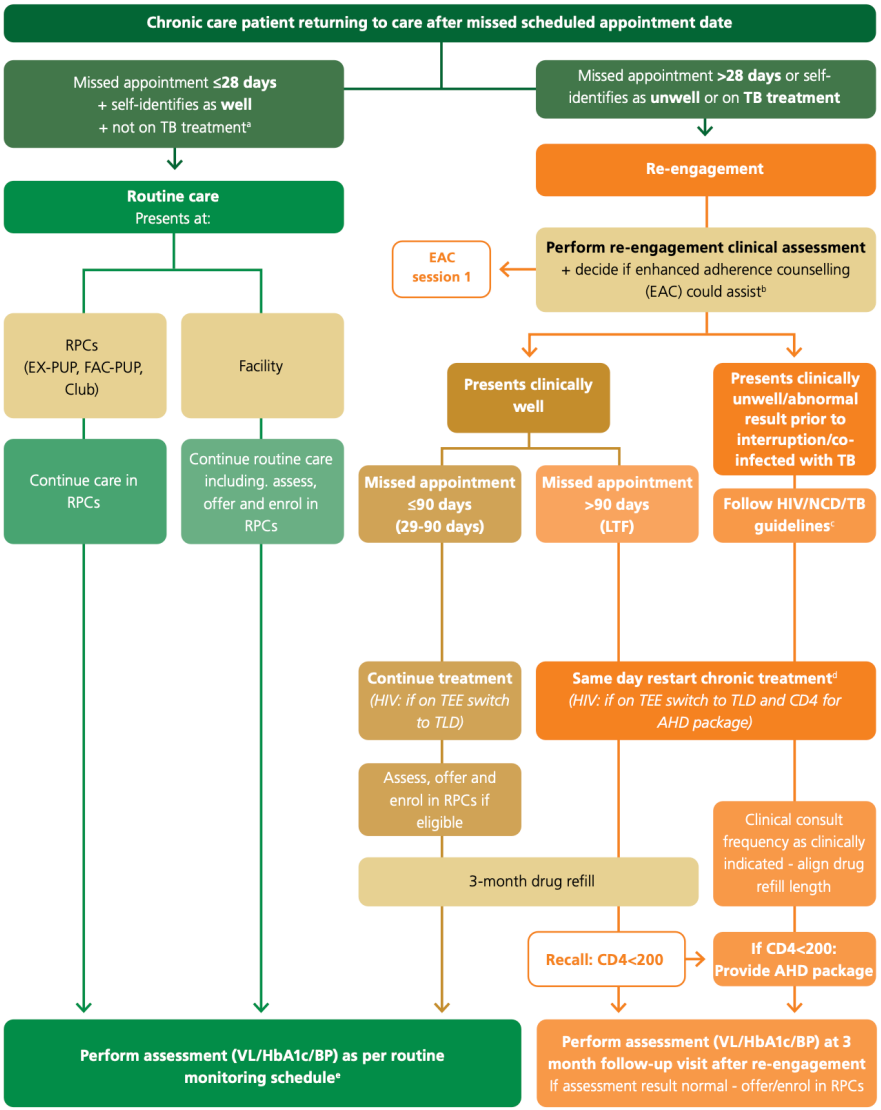
The Algorithm



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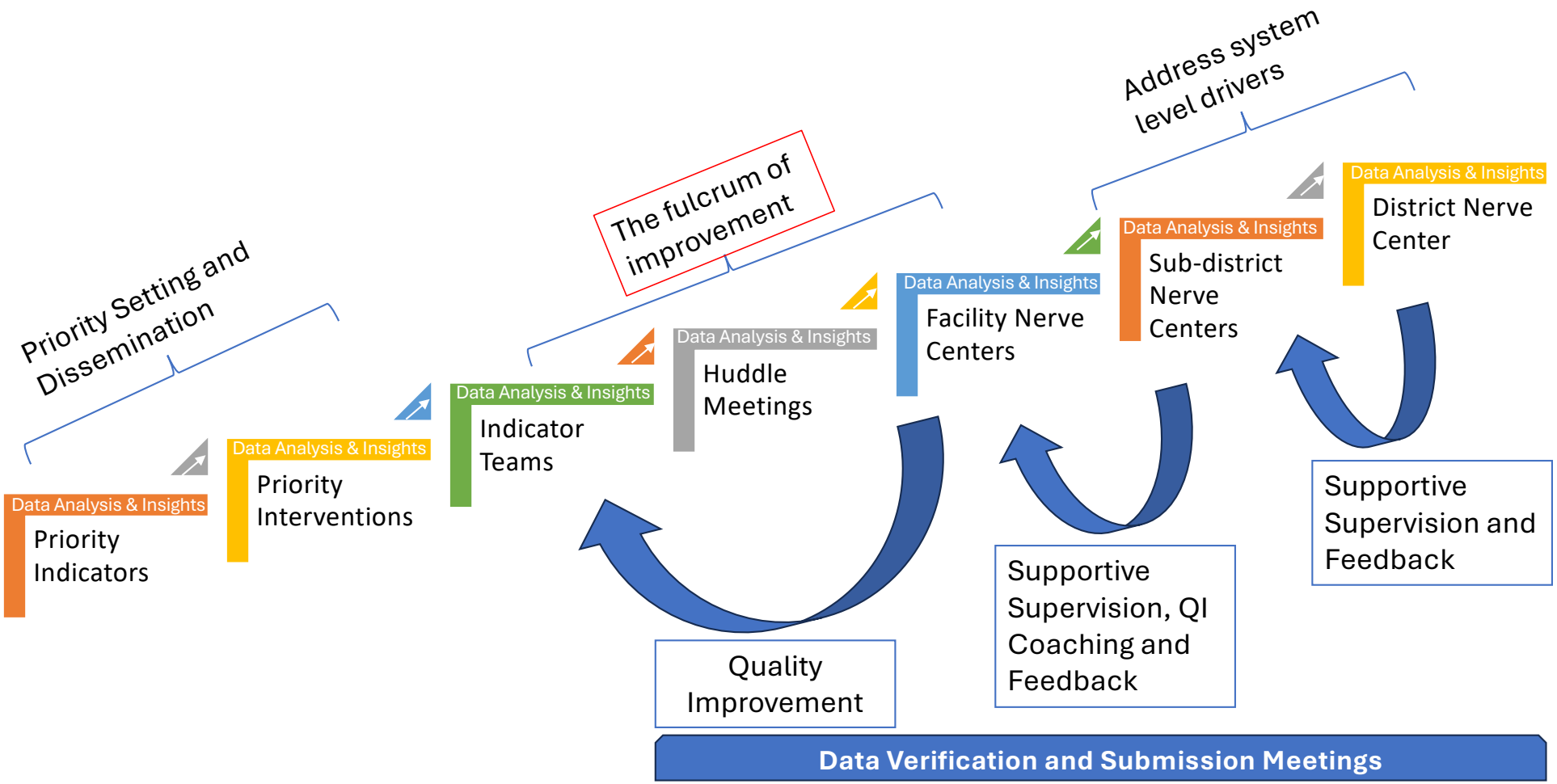
Data Analysis and Continuous Improvement



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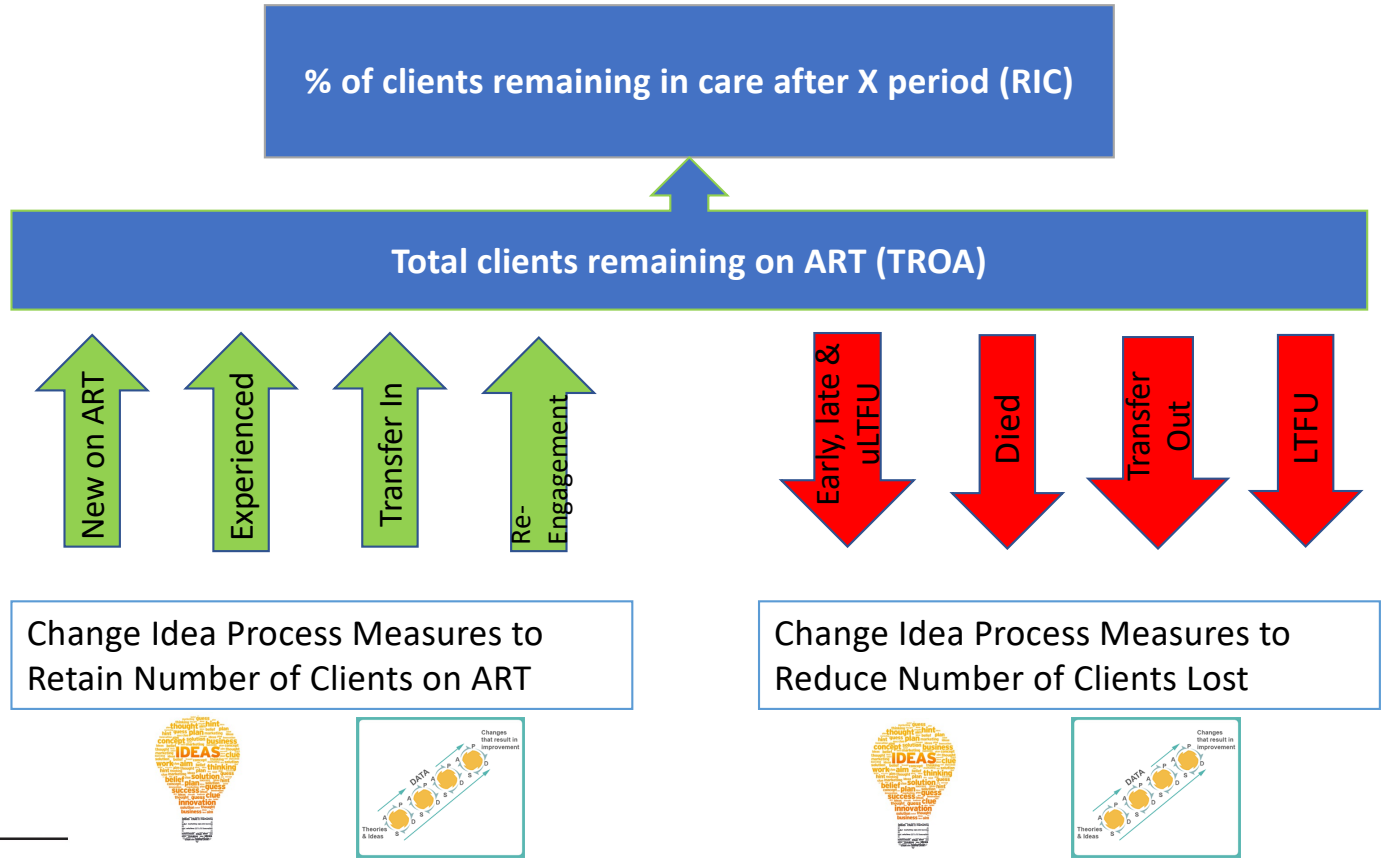

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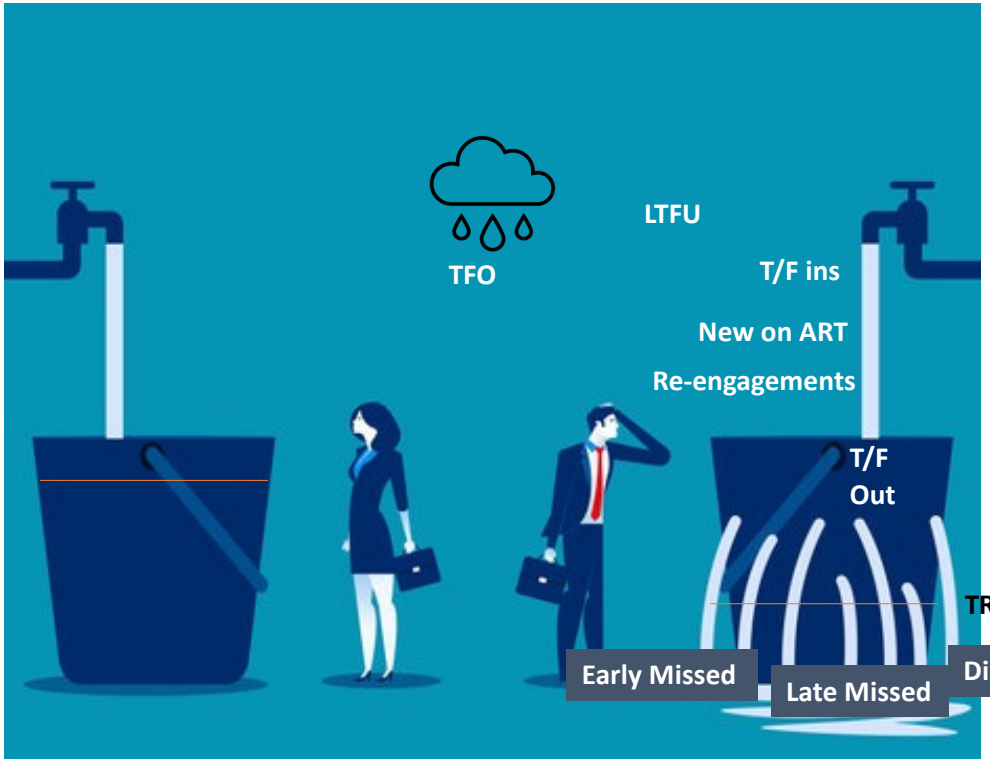
TROA and Leaky Bucket

TROA = Water Level in Bucket



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In Summary

To keep patients on Care:

1. Smile and provide respectful HIV/TB services
2. We must improve treatment literacy and Support
3. Conduct mental health screening and support
4. Link patients to social support services
5. Optimize clinical care as per guidelines
6. Optimize ART regimens
7. Minimize unnecessary clinical visits
8. Know Your Guidelines and Improve on QI skills

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THANK YOU

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