

NATIONAL INTEGRATED TREATMENT LITERACY TOOLKIT

A Guide for Healthcare Providers to Empower Patients
to Treatment Adherence





health

Department:
Health
REPUBLIC OF SOUTH AFRICA



CONTENTS

PAGE

ACRONYMS

iii

INTRODUCTION AND BACKGROUND

1

1

UNIT 1

Health Promotion

5

2

UNIT 2

Adherence to Treatment of Chronic Conditions

13

3

UNIT 3

Differentiated Models of Care for Clients on Chronic Treatment

25

4

UNIT 4

Your Journey to Health in the First 12 Months

33

5

UNIT 5

HIV/AIDS

37

6

UNIT 6

Non-Communicable Diseases

49

7

UNIT 7

Tailored Treatment Literacy for the Sub-Populations

65

8

UNIT 8

Community Engagement and Support in Treatment Literacy

81

ANNEXURES

83

ANNEX I Patient Adherence Plan

84

ANNEX II Mental Assessment

86

ANNEX III Child and Adolescent Disclosure Counselling (CADC) Images

88

ANNEX IV First Year Visit Schedule for Clinically Stable Clients

90

ACKNOWLEDGEMENTS

92

ACRONYMS

AGYW	Adolescent Girls and Young Women	HPV	Human Papillomavirus
AHD	Advanced HIV Disease	ICDM	Integrated Chronic Disease Management
AIDS	Acquired Immune Deficiency Syndrome	ICSM	Integrated Clinical Services Management
ANC	Antenatal Care	IEC	Information, Education, and Communication
APC	Adult Primary Care	ISHP	Integrated School Health Programme
ART	Antiretroviral Therapy	LLETZ	Large Loop Excision of the Transformation Zone
ARV	Antiretroviral	LTOT	Long-Term Oxygen Therapy
AYFHS	Adolescent and Youth-Friendly Health Services	MIP	Mother-Infant Pair
AYP	Adolescents and Young People	NCD	Non-Communicable Disease
CADC	Child and Adolescent Disclosure Counselling	NDOH	National Department of Health
CHW	Community Health Worker	NPO	Non Profit Organization
CLHIV	Children Living with HIV	PCP	Pneumocystis Pneumonia
COPD	Chronic Obstructive Pulmonary Disease	PCR	Polymerase Chain Reaction
COVID	Coronavirus Disease	PEP	Post-Exposure Prophylaxis
CWP	Coal Worker Pneumoconiosis	PHC	Primary Health Care
DMOC	Differentiated Models of Care	PLHIV	People Living with HIV
DPR	DMOC Performance Review	RPCS	Repeat Prescription Collection Strategy
DTG	Dolutegravir	SADAG	South African Depression and Anxiety Group
EAC	Enhanced Adherence Counselling	SOP	Standard Operating Procedure
EPI	Expanded Programme on Immunization	SRH	Sexual and Reproductive Health
FBO	Faith-Based Organization	TB	Tuberculosis
FDC	Fixed-Dose Combination	TDF	Tenofovir Disoproxil Fumarate
FTIC	Fast Track Initiation Counselling	TPT	Tuberculosis Preventive Therapy
GBMSM	Gay, Bisexual and other Men who have Sex Men	VL	Viral Load
HEI	HIV-Exposed Infant	WLHIV	Women Living with HIV
HIV	Human Immunodeficiency Virus		

INTRODUCTION AND BACKGROUND

1. The concept of Treatment Literacy – What is Treatment Literacy?

Treatment literacy refers to the ability and knowledge of individuals, communities, and organizations to obtain, interpret and understand basic disease prevention, testing, and care information, skills, and services and the competence to use such information, to prevent infection, further transmission, and related stigma and discrimination.

For patients to attain the level where they are treatment literate, they need to be provided with the necessary information, education, and communication (IEC) materials such that they are empowered in a way that they can relay the information to others. Furthermore, patients should be encouraged to own and be responsible for their own health.

The Department of Health emphasizes the importance of holistic management of patients and not managing the disease or condition exclusively. As such, a person-centered approach is a core element in the treatment literacy toolkit. This person-centered approach assumes a distinct care as emphasized in the Differentiated Models of Care (DMOC) guidance. This document will be referred to as the Treatment Literacy and not only HIV Literacy toolkit because it recognizes the essence of integrated treatment optimized information and education throughout the continuum of care of chronic health conditions.

Furthermore, the aging HIV epidemic, and the success of antiretroviral therapy (ART), people living with HIV (PLHIV) are living longer and growing older, similar to the general population. With increasing age, PLHIV are at risk of developing NCDs such as cardiovascular diseases, metabolic disorders (like diabetes), and cancers, similar to the non-HIV population.

Treatment Literacy, therefore, should cover most of the common non-communicable disease conditions and not only focus on HIV alone.

2. The importance of Treatment Literacy

The treatment literacy toolkit recognizes the importance of integrated care for clients who are living with chronic conditions such as HIV, Diabetes, Hypertension and other Non-communicable Diseases (NCDs) that often overlap in high burden communities. It equips clients and communities to manage multiple, overlapping health conditions more effectively, improves adherence, prevents complications, and ensures that care is people-centered, not disease-centered. The toolkit includes sections on:

- A. The Importance of treatment literacy in managing HIV/AIDS and TB
- B. Overview of target groups: children, caregivers, adolescents, young adults, men, pregnant women, and seniors (50+)
- C. Overview of NCDs
- D. Importance of treatment literacy in managing NCDs

3. Why develop a Treatment Literacy Toolkit?

South Africa — with over 8 million people living with HIV (PLHIV), persistently high HIV incidence, and frequent treatment interruptions — continues to face challenges in sustaining long-term adherence and retention in care. The growing burden of non-communicable diseases (NCDs) such as hypertension and diabetes further compounds these challenges, as many clients now require lifelong management of multiple chronic conditions. Despite significant progress in scaling up antiretroviral therapy (ART), gaps in health education, counseling, and provider–client communication remain evident across health facilities. These gaps limit clients' understanding of their treatment, weaken self-management capacity, and contribute to missed appointments or defaulting.

The DMOC Performance Reviews (DPR) conducted in nine (9) provinces, showed gaps on the implementation of the Fast Track Initiation Counselling (FTIC) which is Standard Operating Procedure (SOP1) of the Differentiated Models of Care (DMOC) care package of interventions to support linkage to care, adherence to treatment and retention in care. Whilst DMOC enables a differentiated approach to care, and client-centered care across the care cascade, FTIC enables effective client education and counselling regarding the condition which the client is diagnosed with and other related health conditions. It is therefore on this basis that the Department of Health developed a toolkit to help healthcare providers to empower clients throughout their treatment pathway by improving treatment literacy for chronic health conditions.

Treatment education and adherence support to clients initiating treatment is essential. One of the measures of effectiveness of FTIC, is completion of the Adherence Plan upon the initial counselling session with the client, as a tool to guide through the client's treatment readiness. The Adherence Plan provides a set of steps to guide healthcare providers in supporting clients who have chronic health conditions with treatment readiness. This plan should be put in the client's folder. However, the DPRs showed that the Adherence Plan was not in the client folder.

The DPR dissemination workshops provided a platform for the program managers as well as the healthcare providers to discuss gaps pertaining to effective implementation of FTIC, quality adherence counselling, completion of the Adherence Plan and provision Treatment Literacy. Users of healthcare services have identified significant gaps in the provision of health education and counseling, underscoring the need for improved communication and client support within healthcare settings. During the 20-year commemoration of ART provision workshop, PLHIV emphasized the importance of reinvigorating their meaningful participation in national health dialogues and the need to address persistent gaps in treatment adherence, counseling, and psychosocial support.

Strengthening treatment literacy interventions is therefore critical to empower clients with accurate information, improve adherence, and enhance shared decision-making between healthcare providers and clients.

4. What is the Treatment Literacy Toolkit?

The Treatment Literacy Toolkit assembles all the available treatment literacy materials and resources that are available in the public and private healthcare sectors. The purpose of the toolkit is to guide the healthcare providers on the significance of treatment literacy, and to guide them on empowering the patients to adhere to treatment. It will provide a seamless approach to conducting treatment literacy. It also provides guidance to tailored treatment literacy to address the unique needs of specific sub populations.

To attain this, mapping of the available treatment literacy materials has been undertaken. For example, the following are the resources from the Department of Health:

- ART Guidelines
- DMOC SOPs
- TB Guidelines
- TPT Guidelines
- Viral Hepatitis Guidelines
- Adherence Flip Chart
- Adult Primary Care (APC) Guidelines
- Health Promotion Guidelines (Clinician and Community Health Worker Guidelines)
- National Department of Health Undetectable Equals Untransmittable (U=U) Messaging Toolkit
- SANAC HIV Treatment – Messaging Toolkit
- Management of type 2 Diabetes in Adults at Primary Care Level
- National User Guide on The Prevention and Treatment of Hypertension at PHC
- National Integrated Men's Health Strategy
- Society of Endocrinology, Metabolism and Diabetes of South Africa
- The Undetectable and You App
- South Africa National AIDS Commission U=U Communication Guidelines

5. Who will utilise the Treatment Literacy Toolkit?

This toolkit is meant for the healthcare providers (Clinicians and Non-Clinicians) who will be providing treatment literacy. The toolkit is tailored to the end user who is the client through simplified and sub-population specific health messaging that enables individuals to take action for the good of their health, their families and community.

6. When will the Treatment Literacy Toolkit be utilised?

The Treatment Literacy Toolkit will be used at different time periods in the continuum of care:

- Upon diagnosis of the disease condition – to educate the client and provide support through the treatment journey.
- As a health education resource at the healthcare facility during the time for health talks to provide guidance on issues to be included in the health talk.
- During support group sessions.
- During the clinical review.
- During the adherence club sessions.

7. How will the Treatment Literacy Toolkit be utilised?

This toolkit will be used to communicate with a client at the time of preparing for treatment start, and throughout the treatment journey as an adherence support intervention, to ensure a seamless approach to empower clients regarding their health. It will also be used as a health education tool and provide different topics for presentations and discussion.

8. Where will the Treatment Literacy Toolkit be utilised?

The Treatment Literacy Toolkit will be utilised at a healthcare facility or in a community setting.

The content will be provided in the form of units with specific topics and the expected learning objectives in each unit will be provided.

THE TOOLKIT

UNIT 1: Health Promotion

UNIT 2: Adherence to Treatment of Chronic Conditions

UNIT 3: Roadmap to Treatment

UNIT 4: Differentiated Models of Care for Clients on Chronic Treatment

UNIT 5: HIV/AIDS

UNIT 6: Non-Communicable Diseases

UNIT 7: Tailored Treatment Literacy for Sub-populations

UNIT 8: Community Engagement and Support

UNIT 1

HEALTH PROMOTION



Unit 1 provides practical approaches to health promotion in the primary health care setting. It serves as an aid to healthcare providers to deliver accurate, simple and consistent health messages to promote good health.

Healthcare providers must assist clients to identify and mitigate lifestyle-related health risks that are important to control their existing chronic health conditions.

Suggested facilitator

- Clinician (enrolled nurse, professional nurse)
- Adherence counsellor
- Lay counsellors
- Peer educator

Target group

- PLHIV
- Clients taking medication for NCDs (Diabetes, hypertension)
- Clients on treatment for mental health conditions

Objectives

The objectives of health promotion are to inform, empower, prevent, support, and improve overall health and quality of life at both individual and community levels.

- Increase Awareness and Knowledge
 - Provide accurate information to assist clients to understand health issues, risk factors, and prevention.
- Encourage Healthy Behaviours
 - Motivate clients to adopt healthy lifestyles (e.g. balanced diet, physical activity, safer sex).
- Improve Treatment Literacy and Adherence
 - Empower patients to understand their conditions and follow treatment correctly (HIV, TB, diabetes, hypertension, etc).
- Prevent Disease and Complications
 - Reduce the risk of communicable diseases (HIV, TB, and non-communicable diseases such as, diabetes, and Hypertension).
- Improve Quality of Life

Unit sessions

This unit is comprised of five sessions:

- **Session 1.1** Know your condition
- **Session 1.2** Know your treatment
- **Session 1.3** Why adherence matters
- **Session 1.4** Healthy living
- **Session 1.5** Stay connected to care
- **Session 1.6** Risk assessment

Define key concepts

HEALTH PROMOTION	HEALTH EDUCATION	HEALTH LITERACY
The process of enabling people to increase control over their health and its determinants, and thereby improve their health.	Any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes and stimulating actions.	The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Health promotion must be client-centred taking into consideration the needs and aspirations of the client.

Healthcare providers must use effective communication, and deliver key messages in simple language that the clients and their families can understand.

Session 1.1

Know your condition

HIV, TB, high blood pressure, and diabetes are common in South Africa but can be managed with effective medication and lifestyle changes.

Understanding your illness helps you stay healthy and live a full life.

UNDERSTANDING CHRONIC CONDITION			
HIV	TB	Diabetes	Hypertension
- Know your CD4 result after you start treatment or restart treatment - Know your viral load and what it means - Know when to come for a viral load test - Keep your clinic appointments	- Know your TB test results (sputum, urine or blood) - Keep your clinic appointments - Inform those you live with to come to the clinic for screening - Cover your mouth when coughing (demonstrate)	- Know your blood sugar results - If you take insulin, understand how it works; ask your health provider - Come for regular checkups	- Know your blood pressure reading - Understand how your medicine works; ask your health provider - Come for regular checkups
What can make it worse or increase complications			
- Not taking your medication correctly - Not eating a healthy diet - Having multiple concurrent sexual partners - Other chronic conditions/diseases	- Not seeking care early - Not taking your Medication correctly - Not taking ART if you have HIV - Smoking/alcohol/drug use - Uncontrolled diabetes - Chronic lung disease	- Overweight or obesity - Not watching your diet - High blood pressure - High blood cholesterol/fats - Alcohol use - Uncontrolled HIV - Untreated TB	- Smoking/tobacco use - Alcohol abuse - Lack of physical activity - Stress - High blood cholesterol/fats - Uncontrolled Diabetes - Uncontrolled HIV
What makes it better or reduces complications			
- Taking your ART - Healthy eating - Treating other infections - The support of others - Keep using a condom when your VL is detectable	- Starting treatment immediately - Taking medication correctly - Treatment of HIV and other conditions - Healthy eating - Good ventilation	- Healthy eating - Taking medication correctly - Physical activity - Taking care of your feet and hands - Having your feet and eyes checked	- Taking medication daily - Physical activity - Healthy eating - Low salt diet - Stop smoking/tobacco use

Session 1.2

Know your treatment

Explain to the client that treatment for chronic conditions must be taken every day. Assist the client to learn the name of their pills and how to take them.

Don't worry if your medicine package looks different or has a new name — it's often just a different brand of the same medicine.

Discussion Points:

- Remind the client not to skip or stop treatment without speaking to a healthcare provider.
- Remind the client to immediately report any side effects to the healthcare provider – help is available at the clinic.

Session 1.3

Why adherence matters

Adherence to treatment is the active choice and extent to which a person follows health recommendations from a healthcare provider. This includes taking medication as prescribed, following dietary guidelines, making lifestyle changes and following appointments.

- Taking medicine every day keeps you healthy and prevents serious illness.
 - For HIV: adherence makes your viral load undetectable (U=U).
 - For TB: adherence cures TB and prevents drug resistance.
 - For diabetes and hypertension: adherence prevents stroke, kidney failure, heart disease, and blindness.

Session 1.4

Healthy living

Living with a chronic condition (like diabetes, hypertension, asthma, and HIV) can be challenging, but with the right habits, you can stay strong, active, and in control of your health.

- Eat healthy food (less salt, sugar, and fried foods).
- Exercise – walking, dancing, or sports.
- Avoid smoking and limit alcohol.
- Manage stress and get enough rest.

Session 1.5

Stay connected to care

- Keep your clinic appointments.
- Make use of Differentiated Models of Care (DMOC) like adherence clubs, external medicine pick-up points, or multi-month dispensing to make treatment easier.
- Join support groups or adherence clubs to share experiences and encouragement.
- Involve family or a treatment buddy to help remind you about your medicines.
- Speak up for your health – ask questions until you understand.

Session 1.6

Risk assessment

Risk assessment of clients on chronic medication is not only about identifying dangers but also about promoting health by linking risks to targeted health education, behavior change, and support systems. This ensures clients stay adherent, prevent complications, and enjoy a better quality of life.

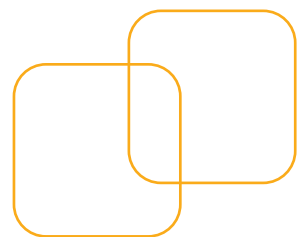
Explain to the client that on every visit the healthcare worker will conduct a risk assessment. The risk assessment will assist in identifying health issues early and to jointly develop solutions with the client and the health worker.

Assist the clients to understand the risk assessment based on their chronic condition.

Conduct risk assessment under the following five (5) areas and provide client centered health promotion response to support the client.

RISK ASSESSMENT AREA	ENQUIRE ABOUT THE FOLLOWING	HEALTH PROMOTION RESPONSE
Clinical Risks	• Poor adherence or missed doses. • Poorly controlled disease (e.g. high blood pressure, high blood sugar, detectable viral load). • Side effects of medication. • Co-morbidities (e.g. HIV and diabetes together). • Risk of drug resistance (especially in HIV and TB).	• Provide treatment literacy (importance of daily medication). • Educate on recognising and reporting side effects. • Reinforce the benefits of routine monitoring (BP checks, sugar levels, viral load).

Behavioural and Lifestyle Risks	• Unhealthy diet, smoking, alcohol, substance abuse. • Lack of physical activity. • Poor health-seeking behaviour (missing appointments). • Use of local/traditional medicine and herbs.	• Promote healthy eating (low salt, less sugar, affordable local foods). • Encourage exercise such as walking or community sports. • Educate about dangers of alcohol, smoking, and drug use. • Educate on complications of mixing herbs with treatment.
Psychosocial Risks	• Lack of family/community support. • Stigma including self-stigma (HIV, TB). • Depression, stress, or anxiety affecting adherence. • Poverty and unemployment.	• Link clients to support groups, adherence clubs, and treatment buddies. • Provide counselling and mental health referrals. • Strengthen community awareness to reduce stigma. • Connect clients to social support services (e.g. grants, food parcels).
Environmental Risks	• Overcrowding and poor ventilation (risk for TB). • Poor housing and sanitation. • Work conditions that interfere with treatment schedules.	• Educate on infection prevention (ventilation, hygiene). • Encourage workplace adjustments or disclosure (where safe). • Educate on RPC strategies and Multi-Month Dispensing. • Advocate for better living conditions and community-level interventions.



NOTES

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UNIT 2

ADHERENCE TO TREATMENT OF CHRONIC CONDITIONS

Unit 2 focuses on adherence to treatment of chronic health conditions. These include HIV, TB, and Non-communicable Diseases such as Diabetes, Hypertension, Cancers, Chronic Respiratory Diseases and Mental Health conditions.

Suggested facilitator

- Clinician (enrolled nurse, professional nurse)
- Adherence counsellor
- Lay counsellors
- Peer educator
- Community health care worker

Target group

- People living with HIV
- Clients taking medication for NCDs (Diabetes, Hypertension, Asthma and COPD)
- Clients on treatment for mental health conditions

Objectives

Providing sufficient education and support to clients is key to help them adhere to treatment, meet their treatment goals, and live a happy healthy life.

For clients on ART, the NDOH Undetectable=Untransmittable (U=U) Messaging Toolkit and the DMOC SOPs provide guidance for adherence, through the Fast Track Initiation Counselling (FTIC), the Enhanced Adherence Counselling (EAC) and the Child and Adolescent Disclosure (CADC) SOPs.

Unit sessions

This unit is comprised of five sessions:

- **Session 2.1** The Six Wise Words of Adherence
- **Session 2.2** Benefits of Adherence to Treatment
- **Session 2.3** The Adherence Plan
- **Session 2.4** Adherence Assessment
- **Session 2.5** Support Network

Session 2.1

The Six Wise Words of Adherence (WHAT, WHEN, WHO, WHY, WHERE and HOW)

Ask the client to tell you in their own words, their understanding of:

- **WHAT** adherence to treatment means
- **WHY** it is important to remain adherent to treatment
- Discuss **WHEN** the client must return for their appointment to treatment
- Discuss **WHO** must remain adherent to treatment
- **WHERE** the client can keep their medication
- Discuss **HOW** the client can find support for adherence to treatment

Remember!

Chronic conditions (like HIV, TB, diabetes, hypertension, asthma) require daily medication to keep the body healthy and prevent complications.

Educate clients who have chronic conditions that chronic medication is usually for life. Empower the client to commit to their treatment by discussing the approaches below.

- Understand Your Treatment**
 - Know the name and purpose of your medicine
 - What side effects may occur and what to do if you experience side effects
 - What to do if you miss a dose
- Build a Daily Routine**
 - Take medicine at the same time every day (link it to daily habits such brushing teeth, meals, bedtime)
 - Use reminders: phone alarms, or pill boxes
- Manage Challenges**
 - Travel/work – collect medication in advance or use a chronic medication pick-up point near you
 - Importance of long-term commitment
- Use Support Systems**
 - Family, friends, peers, or community health workers can encourage you
 - Adherence clubs and support groups provide shared experiences

Remind clients that taking their medicine every day, exactly as prescribed, helps them stay healthy, protect their family, save money, and prevent complications.

For PLHIV, taking your treatment daily at the same time can help achieve viral suppression leading to a long healthy life without transmitting the virus to your sexual partner.

Discussion Points:

- Discuss the effects of non-adherence to treatment.

Below are some of the complications that can arise when a client does not adhere to their treatment.

- **On Your Health**
 - Your illness may get worse instead of better.
 - You may develop drug resistance to your medicines, meaning stronger and more costly ones are needed.
 - Missing doses can cause serious complications, like heart attack, stroke, kidney problems, or infections.
- **On Your Family and Community**
 - If the illness is infectious (e.g. TB or HIV), poor adherence to treatment increases the risk of transmitting the infections to others. For example, if you are HIV-positive, your HIV viral load may be high, and HIV can be transmitted to your sexual partner or your baby (if pregnant/breastfeeding).
- **On Your Daily Life**
 - You may need more hospital visits and treatments. You might miss work or school, affecting income and family life.
 - Living with untreated illness can affect your confidence and emotional wellbeing.
- **On Costs**
 - Treating advanced illness is much more expensive than preventing it with regular treatment.
 - Your family and loved ones may face financial strain from hospital bills, transport, and you may not be able to continue your work.

Session 2.2

Benefits of Adherence to Treatment

In this session, clients must be empowered to understand and own the benefits of adhering to treatment of chronic health conditions.

Explain the benefits of adherence to the client and to the family, their loved ones and their community.

FOR CLIENTS ON HIV TREATMENT

1

Individual Health Benefits

- Taking ART as prescribed reduces the HIV viral load to undetectable levels, undetectable=untransmittable (U=U).
- Adherence to ART helps CD4 counts recover leading to stronger immune system: (less chances of developing infections like TB, pneumonia, or meningitis).
- Improved quality of life: With fewer illnesses, individuals can work, study, and care for their families.

2

Preventing Drug Resistance

- Poor adherence can lead to drug-resistant HIV strains.
- Good adherence ensures first-line ART remains effective, avoiding the need for more complex second- or third-line regimens.

3

Reducing HIV Transmission

- When viral load is undetectable, it means it is untransmittable and HIV cannot be sexually transmitted (U=U).
- Significantly reduces the risk of vertical transmission during pregnancy and breastfeeding.

4

Psychological and Social Benefits

- People with undetectable viral load feel more confident in relationships.
- Knowing HIV is a manageable chronic condition encourages positive life planning.

FOR CLIENTS ON DIABETES TREATMENT

1

Individual Health Benefits

- Taking treatment (Insulin or oral drugs) as prescribed keeps blood glucose within target ranges.
- Reduces dangerous swings of sugar levels (you can live near-normal lifestyle).

2

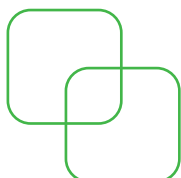
Preventing Complications

- Long-term uncontrolled diabetes can damage blood vessels and nerves. Good adherence reduces risk of:
 - Heart disease and stroke
 - Kidney failure
 - Vision loss (diabetic retinopathy)
 - Nerve damage (neuropathy)
 - Foot ulcers and amputations

3

Psychological and Social Benefits

- Greater peace of mind from knowing the condition is controlled.
- Reduced stress, anxiety, and fear about long-term complications.
- Improved confidence in social and family life.



FOR CLIENTS ON HYPERTENSION TREATMENT

1

Individual Health Benefits

- Taking blood pressure medication as prescribed keeps blood pressure within target ranges.

2

Preventing Complications

- Poorly controlled hypertension is known as the "silent killer" because it often has no symptoms but causes damage. Good adherence reduces risk of:
 - Stroke
 - Heart attack (myocardial infarction)
 - Heart failure
 - Kidney disease/kidney failure
 - Vision problems (hypertensive retinopathy)

3

Psychological and Social Benefits

- Greater peace of mind from knowing the condition is controlled.
- Reduced stress, anxiety, and fear about long-term complications.
- Improved confidence in social and family life.

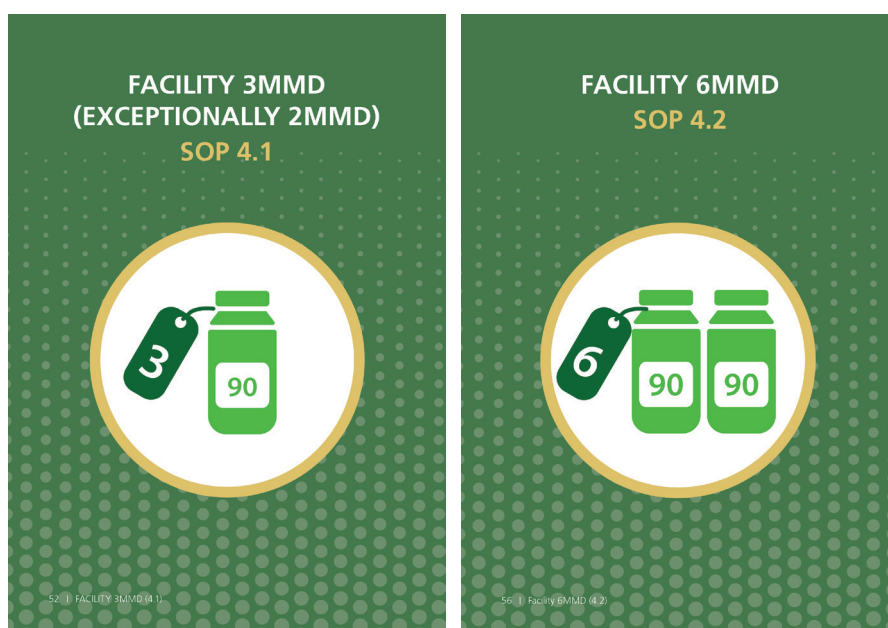
Remind the client about repeat prescription collection strategies (RPCs) and 6-months treatment supply which is available to them when their chronic condition is under control.

SOP 4.1: Offers the ability to collect 3 months of chronic medication.

SOP 4.2: Offers the options for 6 months supply of medication for PLHIV who are are adherent and very stable on chronic care.

SOP 5: RPCs offers 3 options for medication collection for clients who are adherent and stable on chronic care.

- SOP 5.1 – Facility pick points
- SOP 5.2 – Facility and community adherence clubs
- SOP 5.3 – External pick points



Session 2.3

The Adherence Plan

Using the DMOC SOP 1 (FTIC), assist the client to develop an individualized adherence plan and set clear treatment milestones to reach the goal of a happy healthy life.

The completed adherence plan should be placed in the client's folder and updated with sessions provided.

- For same-day initiation: Session 1. Step 1 – 10 to be delivered in one counselling session on the day of treatment initiation.
- For rapid initiation: Steps 1 – 5 to be delivered at day of linkage to care and steps 6 – 10 on day of treatment initiation.
- Session 2 to be delivered at return visit one month after treatment initiation.
- Where a group approach already exists (e.g. I-ACT), the session content must be integrated into existing group discussion content.

ANNEXURE I: PATIENT ADHERENCE PLAN



Name and Surname: _____

FTIC Session 1 after chronic disease education session (date): _____

Adherence step 1: education on HIV ☐ TB ☐ Hypertension ☐ Diabetes ☐ Other ☐ _____

Adherence step 2: Life goals:

My motivations to stay healthy are: (1)..... (2)..... (3).....

I will maintain a healthy lifestyle by: ☐ adopting healthy eating habits ☐ getting regular exercise ☐ managing my stress

Adherence Step 3: Patient Support system

Agree for home visit: Yes ☐ No ☐ Preferred means of contact: SMS ☐ WhatsApp ☐ Phone call ☐ Other ☐ _____

Who can support me in my treatment: ☐ Family ☐ Friends ☐ Work ☐ School ☐ Church ☐ Other: _____

Adherence Step 4: Getting to appointments

I will come to my appointments by: ☐ walk ☐ public transport ☐ own transport

If I face a difficulty to come (money, transport, etc.), my alternative plan will be to ask for assistance from:

☐ family ☐ friends ☐ neighbour ☐ other _____

I will inform clinic I am unable to come to set appointment and request for an alternative appointment ☐

Adherence step 5: My readiness to start treatment

I feel ready and will start treatment:

☐ Yes

I am ready today ☐ Yes ☐ No but will be on..... (insert date)

☐ I do not feel ready and would like to discuss more with:

☐ peer ☐ family member ☐ other _____

Adherence Step 6: Medication schedule

The best time for me to take my treatment is: ☐ Morning ☐ Afternoon ☐ Evening

Adherence step 7: Managing missed doses

If I miss a dose, my plan is: (1) to take treatment as soon as I remember ☐

Adherence Step 8: Reminder strategies

To remind me to take medication I will use: ☐ watch ☐ cell phone alarm ☐ pill box ☐ buddy ☐ other _____

Adherence Step 9: Storing medication and extra doses

I will store my medication in: ☐ Safe place: _____ ☐ Far from reach of children

I will carry extra supply in: ☐ a bag ☐ pill box ☐ other: _____ I will keep it in my: ☐ handbag ☐ pocket ☐ other: _____

Adherence Step 10: Dealing with side-effects

If I experience side effects, I will: Refer to treatment adherence pamphlet ☐

Inform clinic if side effects do not go away or are too worrying ☐

FTIC Session 2 (date): _____

Adherence Step 11: Understanding the treatment pathway ahead of me if I take my treatment well

☐ I understand the options for multi-month treatment supply and simplified collection available after one normal assessment result.

Adherence Step 12: Planning for trips

If I have some trips planned, before going away I will:

☐ Inform health facility before travelling to receive referral letter and treatment ☐ Get enough supply of treatment for trip

In case I cannot come to the facility before going away:

☐ I will report to the nearest health facility in the travel area as soon as I arrive to get access to treatment

☐ Carry evidence of my condition and evidence of the treatment I am taking

Adherence Step 13: Dealing with substance use

My plan to make sure I take my medication if I used alcohol or drugs is:

☐ To make sure I take treatment before starting to use drugs or alcohol

☐ Arrange for someone to remind me to take treatment in case I am intoxicated

Education on assessment: Viral load ☐ Sputum ☐ HbA1c ☐ BP ☐ Other: _____ ☐

☐ I understand that I can access multi-month treatment supply and simplified collection if my results are normal

Patients signature _____ Date of signature _____

EAC Session 1 (date): _____

EAC Session 2 (date): _____

Adapted from DMOC SOP 1 (FTIC sessions)

Session 2.4

Adherence Assessment

Assess adherence of every client to treatment plans during every encounter. Routine assessment of adherence to treatment helps to identify any challenges and empower the clients to address them.

ADHERENCE ASSESSMENT

- Self-report questionnaires
 - Example: "How many doses did you miss in the last 3 – 30 days?"
- Pill counts – checking remaining tablets during refill.
- Pharmacy refill records/TIER.Net system – monitors whether patients collect meds on time.
- Laboratory results:
 - For HIV – the target VL of < 50 copies/mL
 - For Blood Pressure – the target reading is < 140/90
 - For Diabetes – the target is HbA1c ≤ 8%

Discussion Points:

- Discuss with the client the importance of routine assessment during clinical appointments to ensure their treatment is working properly.

Empower clients to ask their healthcare provider about their laboratory results.

If laboratory test results results and other clinical measurements are not meeting treatment targets, healthcare providers should use the ABCDE to conduct a comprehensive evaluation and identify any challenges.



Adherence



**Bugs
(Infections)**



Correct Dose



**Drug
Interactions**



RE-sistance

A Adherence	• Ask about factors that may influence adherence e.g. – Medication side-effects – Mental health disorders – Alcohol or substance abuse – Non-disclosure
B Bugs (infections)	• Ask the client if he/she is not feeling well lately (Fever, weight loss, etc.) and if this is affecting the way he/she is taking medication
C Correct Dose	• Ask the client if he/she is using her medication according to the prescription. Explain (demonstrate if insulin) correct use of medication
D Drug interactions	• Ask the client if he/she is using other medication in addition to his/her treatment. Explain that some drugs may interfere with his/her treatment – Other prescribed treatment e.g. rifampicin, anti-epilepsy drugs – Over the counter treatment e.g. antacids – Supplements and herbal/traditional medications e.g. St John's Wort
E Resistance	• If client is on ART, consider HIV drug resistance if other causes of high VL have been excluded and the client is adherent to their medication

Session 2.5

Support Network

Use the DMOC SOP 1 (FTIC Step 3) to assist the client to identify the support system they need to support them with adherence to treatment.

All clients on chronic medication must be empowered to manage the many life changes associated with their treatment.

Discussion Points:

- Discuss the importance of having a strong support system to help clients adhere to treatment and make the right decisions about their health and life.
- Explain how a support network helps through some of the challenging times during the treatment journey. Assist the client to understand and avoid negative beliefs, shame or stereotypes about their condition.
- Emphasize the importance of accurate information from trained clinical and non-clinical healthcare providers that are available at the facility.

Empower the client to identify who can be a possible supporter by answering the following:

- Who could support you in taking your treatment?
- Do you have access to other support structures e.g. church, school, friends?
- How important do you think it is to disclose your status?
- Will you be willing to be visited at home or contacted by phone?
- Share your contact details and that of your next of kin.
- Who will help you track appointments?

For Step 3: Mothers with babies/toddlers or children

- Find out what she will do if she is unable to bring the child to clinic
- If she will give consent to medical investigations necessary

There are special people who will help and support you in different ways with your treatment for chronic conditions. Support networks can include:

- Family members
- Close friends
- Neighbours
- Peers
- Community group
- Community health workers (CHWs) and volunteers

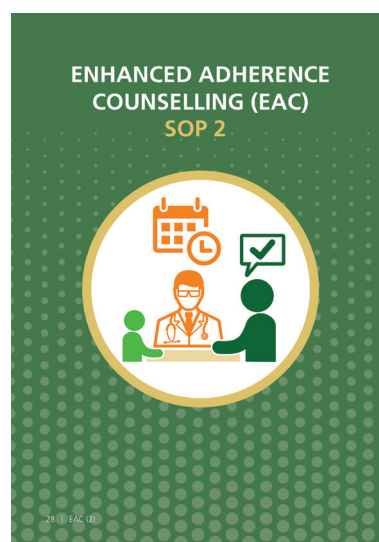
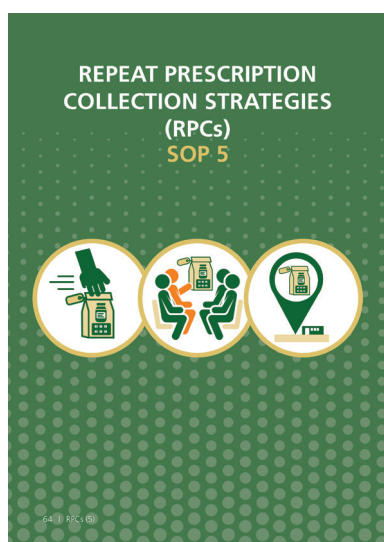
Explain to the client that these may be people in your family, among your friends, community, in our churches or mosques, and at school. These are also the people who you have chosen to tell that you are HIV-positive because you trust them.

Support groups help with the holistic management of the disease. It helps clients to access support from the government, disclosure, find treatment, manage relationships and safe sex, etc. A newly diagnosed client may feel overwhelmed and support groups can help him/her/they navigate the treatment journey.

Provide the client with a list of supporting organisations (CBOs, FBOs) to assist with referral for psychosocial support in your area.

At the end of this session, discuss treatment support options available for clients who are:

- Adherent and are stable on treatment
 - Repeat prescription collection strategies (SOP 5 – RPCs)
 - Facility provided multi-month dispensing (SOP 4.2)
- Struggling with adherence/not clinically stable (not established) on treatment
 - Enhanced adherence counselling (SOP 2 – EAC)



Adapted from DMOC SOPs 5, 6, & 7

At the end of this unit the provider must confirm that the client:

- Understands the importance of starting and continuing to take treatment
- Identifies a support system that is feasible
- Makes the decision to start and remain on treatment
- Voices any concerns and ask questions
- Agrees on goals and care plan with provider
- Elaborates on an adherence plan to identify the best time to take treatment, reminders and place to store medication
- Understands the treatment pathway ahead if adherent
- Commits to attend their next appointment at the facility

UNIT 3

DIFFERENTIATED MODELS OF CARE FOR CLIENTS ON CHRONIC TREATMENT



In unit 3 clients on chronic treatment will be empowered to understand treatment for HIV and other NCDs, through the Differentiated Models of Care approaches for all clients (stable and unstable or not established).

Suggested facilitator

- Adherence counsellor
- Peer educator
- Clinician (Clinical Officer or Nurse)
- Lay counsellor
- Community health worker

Objectives

By the end of this module, the client should be able:

- To understand client-centred approaches to support linkage and retention.

Unit sessions

This unit is comprised of five sessions:

- **Session 3.1** Differentiated Models of Care
- **Session 3.2** Benefits of tailoring care to individuals
- **Session 3.3** Community-based care initiatives

Session 3.1

Differentiated Models of Care

Differentiated Models of Care (DMOC) is where a client-centered approach to HIV/TB and NCDs services adapts the **where, when, who, and what** of service delivery to better meet the diverse needs of the client.



Session 3.2

Benefits of tailoring care to individual needs

Assist clients to understand the four broad categories of the DMOC package. Use the SOPs as reference guide and explain the benefits of each intervention for the client.

Category 1:

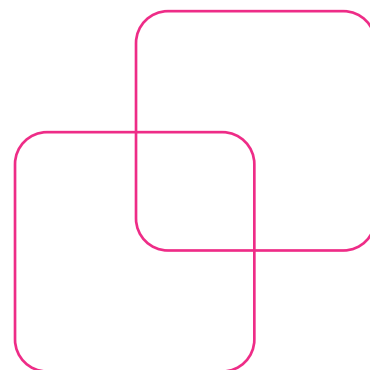
Standardised education sessions and counselling approach for treatment initiation and for clients who struggling with adherence or when re-engaging in care. Category 1 also includes Child and adolescent disclosure support.

DMOC SOPS FOR REFERENCE	BENEFITS FOR CLIENTS
• SOP 1 – Fast Track Initiation Counselling (FTIC) • SOP 2 – Enhanced Adherence Counselling (EAC) • SOP3 – Child and adolescent Disclosure Counselling (CADC)	• Everyone gets the same reliable information. • Sessions build confidence to manage treatment. • Reduces misunderstandings and myths. • Provides a safe space to ask questions. • Encourages peer support and shared learning.
Key messages for clients • Education helps you understand your treatment and stay healthy. • Counselling is your right — ask questions and share your challenges. • What you learn here will help you and your family.	

Category 2:

Dispensing more than one month (2, 3, or 6 months) of chronic medication supply from the facility for: (clients who are not eligible for RPCs OR are eligible but do not want RPCs OR no RPCs option available at the facility).

DMOC SOPS FOR REFERENCE	BENEFITS FOR CLIENTS
- SOP 4.1 – Facility 3MMD - SOP 4.2 – Facility 6MMD	- Fewer clinic visits: saves transport costs, time, and reduces waiting. - Convenience: easier to manage work, school, or family responsibilities. - Improved adherence: reduces the risk of missed doses because clients always have enough medication. - Better health outcomes. Staying on treatment leads to: - Viral suppression (for HIV) - Controlled blood pressure - Blood sugar stability
Key messages for clients - You may be given more than one month supply of your medication (MMD). - Collecting many months of medicine at once saves time. - MMD means fewer clinic visits in a year, but you must still take your treatment every day. - If you feel unwell, don't wait — go back to the clinic immediately.	



Category 3:

Care for clients who are stable on chronic medication.

Explain to client: If their next clinical assessment is normal, it will become easier to enrol in Repeat Prescription Collection Strategies (RPCs) of treatment. The healthcare provider will issue a 6-month repeat prescription for their medication. The client can collect the medication every 2–3 months from designated points without needing a full clinic consultation every time.

NOTE!

Refer to RPCs eligibility criteria and strategies for stable family members on chronic medication.

DMOC SOPS FOR REFERENCE	BENEFITS FOR CLIENTS
• SOP 4.2 – Facility 6MMD • SOP 5 – Repeat Prescription Collection strategies (RPCs) – SOP 5.1 – Facility pick-up point – SOP 5.2 – Adherence Club – SOP 5.3 – External pick-up point • SOP 6 – Drug Switch (Switching to new drugs for stable clients on RPCs)	• Less time at the clinic, more time for work, school, and family. • Medicines always available without monthly check-ups. • Privacy and convenience through several collection points. – Facility pick-up points, including pelexboxes – Community (Adherence clubs) – External Pick-up points – Clinic Fast Lane – Home delivery (where feasible) • Better health outcomes; Staying on treatment leads to: – Viral suppression (for HIV) – Controlled blood pressure – Blood sugar stability

Key messages for clients

- Repeat prescriptions are for clients who are doing well on treatment.
- You still need to come for your check-up when the clinic tells you.
- Never miss your collection date – medicines keep you healthy.
- If you feel sick or notice side effects, go back to the clinic immediately.

Category 4:

Delivering client-centred approaches to assist clients who missed appointments, medication pick-ups, or have been lost to follow-up.

INFORM clients about the follow-up support, tracing and retention in care system. Tracing effort will start immediately.

- Seven (7) calendar days after client has missed their scheduled appointment, or
- Seven (7) calendar days after the last day on which must have collected their medication, or
- Have not returned to the facility after an immediate initial recall on receipt of an abnormal result by the facility.

DMOC SOPS FOR REFERENCE	BENEFITS FOR CLIENTS
• SOP 7 – Tracing and Recall • SOP 8 – Re-engagement in care • SOP 9 – Advanced HIV Disease	• Reduces interruption in treatment • Supports viral suppression for HIV clients • Prevent complications for chronic illnesses (hypertension, diabetes, TB) • Strengthen trust between clients and the health system

Key messages for clients

- Updating your contact details at each visit.
- Your personal confidentiality is important.
 - You need to consent to be traced through your preferred methods.
- Missing treatment puts your health at risk — but we are here to help you come back safely.
- If you miss your medicine pick-up, return as soon as possible — you will be welcomed, not judged.

Session 3.3

Community-based care initiatives

Community-based initiatives bring services closer to the client, reduce the burden on clinics, and support continuity of care of chronic conditions.

Explain to the client the community-based initiatives available for them.

Community Adherence Clubs (CACs)

Facilitated by a Club Facilitator, this group consists of clients who are stable (20 – 30) and they may meet at a community venue (church, school, community hall).

- Activities: medication pick-up, peer support, and adherence education.
- Benefits: reduced clinic congestion, peer motivation, improved retention one on one support, sharing experiences with others.

Community Health Worker (CHW) Outreach

CHWs conduct home visits to link facility and community care, especially in rural and underserved areas. During home visits they may provide the following services:

- Monitor adherence on chronic medication
- Support tracing clients who miss appointments
- Provide health education
- Facilitate child and adolescent disclosure
- Index testing services

Remember!

- Stable clients who have hypertension or diabetes, whether or not co-infected with HIV, qualify for RPCs and should be offered and enrolled.
- If co-infected, these clients should receive their ART and NCD treatment through the same RPCs for the same refill length with integrated clinical reviews.

NOTES

UNIT 4

YOUR JOURNEY TO HEALTH IN THE FIRST 12 MONTHS



Unit 4 focuses on the journey to health in the first 12 months after starting or restarting treatment.

Suggested facilitator

- Adherence counsellor
- Peer educator
- Clinician (Clinical Officer or Nurse)
- Health promoter

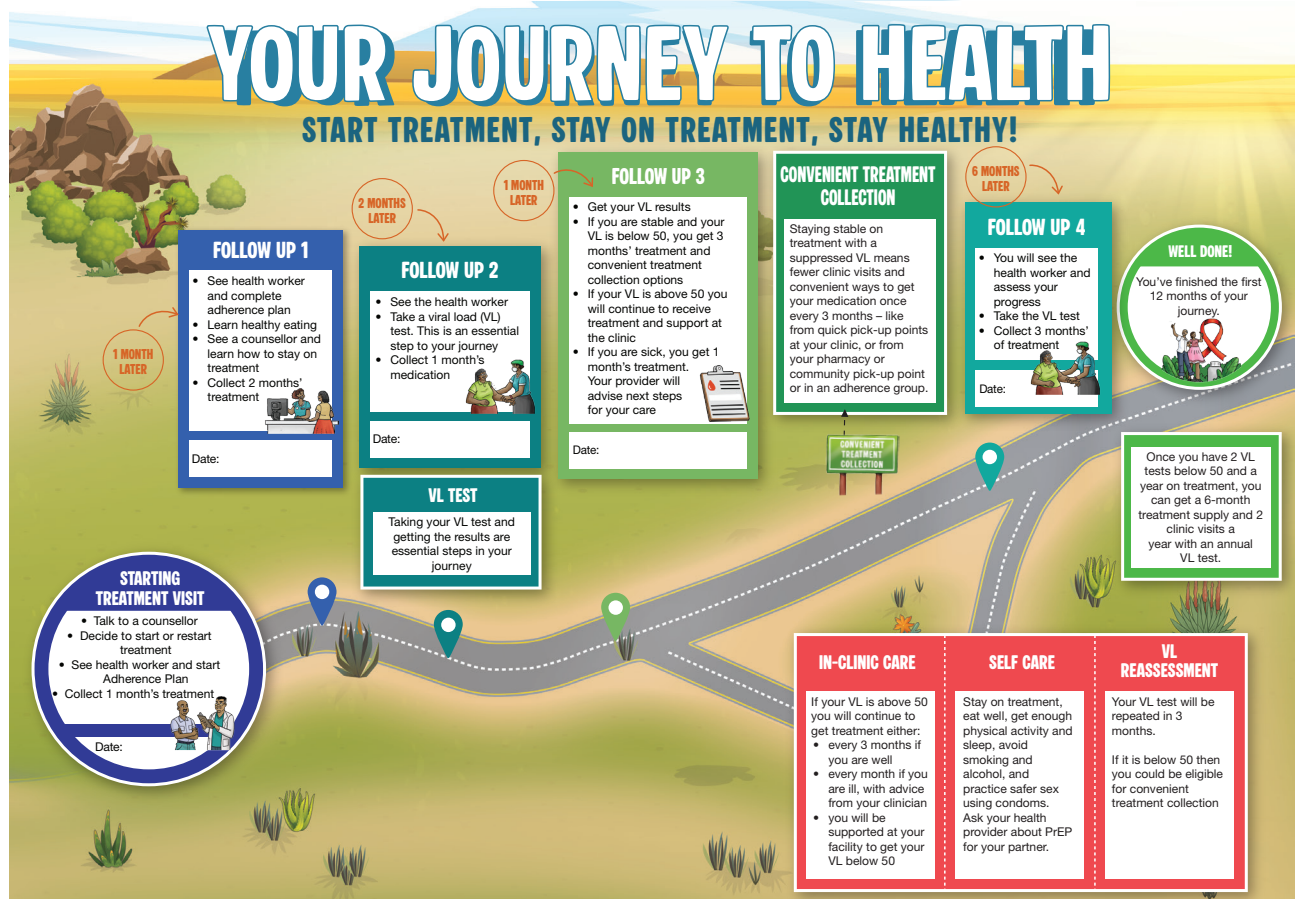
Objectives

By the end of this module, the client should be able:

- To understand the follow-up visit schedule that is required after starting treatment

Unit sessions

- Session 4.1 What is Your Journey to Health



Session 4.1

Your Journey to Health

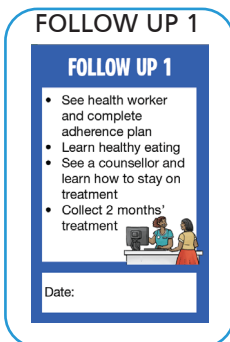
Explain to the client that most people who start ART are required to attend the facility three (3) times in the first six (6) months of treatment.



These visits are:

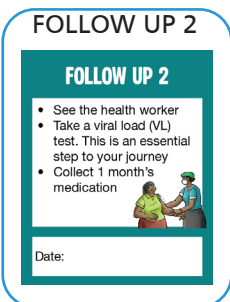
- To check if the treatment is working well
- To check if there are any complications
- To provide ongoing counselling support for the client about his/her condition

On the day of diagnosis and start or restarting treatment, the client will be given one month of treatment.



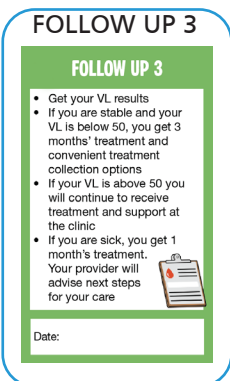
The first follow up visit will be after one (1) month on treatment. During this visit:

- The healthcare provider will assist the client to complete his/her adherence plan
- Client will learn healthy living and eating habits
- The client will receive additional counselling on adherence
- The client will receive 2 months of medication



The second follow up visit will be after three (3) months on treatment. During this visit:

- The healthcare provider will check for any complications
- The viral load of the client will be taken
- The client will receive one month of medication if eligible



The third follow up visit will be after four (4) months on treatment. During this visit:

- The client will receive his/her VL results
- If the VL is < 50, the client may be enrolled in any convenient treatment collection option available for him/her
- The client will receive a six (6 months) script of his/her medicine. He/she will only return for a repeat VL testing after 6 months

Explain to the client:

- If the VL is 50 or higher, the client will continue to return to the facility to collect his/her treatment and receive additional adherence support.
- After three months of additional adherence support the VL will be repeated. If the VL is undetectable, the client will be offered a convenient chronic medication collection option of their choice.

NOTES

UNIT 5

HIV AND AIDS



In unit 5 clients will be empowered to understand HIV and AIDS, ART, adherence to treatment and viral load. Clients will also understand other co-infections, disclosure and the importance of healthy living.

Suggested facilitator

- Adherence counsellor
- Peer educator
- Clinician (Clinical Officer or Nurse)

Objectives

By the end of this module, the client should be able:

- To understand HIV and AIDS
- To understand how HIV is transmitted/not transmitted

Unit sessions

This unit is comprised of five sessions:

- **Session 5.1** What is HIV and AIDS
- **Session 5.2** Antiretroviral Therapy (ART)
- **Session 5.3** Importance of Adherence to Treatment
- **Session 5.4** Viral Load Monitoring
- **Session 5.5** Co-infections and Comorbidities
- **Session 5.6** Advanced HIV disease
- **Session 5.7** Nutrition and HIV

Session 5.1

What is HIV and AIDS

Definition of HIV and how it differs from AIDS.

Discussion Points:

- Ask the client what they understand by the term HIV and what each letter stands for. Compare what their response with the answer below:

H

Human, meaning that only human beings get this virus. You cannot get infected from a pet or a mosquito.

I

Immunodeficiency, meaning the virus destroys your immune system and your ability to fight diseases.

V

Virus. HIV is caused by a virus.

A person develops AIDS when HIV damages the defence system so severely that the body is no longer able to fight diseases.

Discussion Points:

- Ask the client what they understand by the term AIDS and what each letter stands for. Compare what their response with the answer below:

A

Acquired (person gets it)

I

Immune (defence system)

D

Deficiency (lack of defence)

S

Syndrome (collection of diseases)

A person develops AIDS when HIV damages the defence system severely that the body is no longer able to fight diseases.

Session 5.2

Antiretroviral Therapy (ART)

Antiretroviral therapy is treatment of people living with HIV using antiretroviral medicine. The antiretroviral medicines are also called ARVs.

The goal:

The goal of ART is to achieve and maintain virological suppression with the aim to:

- Decrease opportunistic infections and other HIV-related conditions.
- Minimise the development of treatment resistance.
- Improve quality of life.
- Reduce the risk of new HIV infections by using treatment as prevention decrease the morbidity and mortality from HIV and AIDS.



Explain to the client

Standard ART consists of a combination of at least three medicines that stop HIV from multiplying or making more copies of virus inside a person's body. This reduces the amount of HIV virus in the blood, referred to as viral load (VL).

Three drugs are combined to form a fixed-dose combination (FDC) of one pill. This is done to reduce the likelihood of the virus developing resistance. The fixed dose combination makes it easier to take the drugs.

Most clients are eligible to start ART on the same day after receiving counselling and when they are ready. In rare instances, such as when you have TB, your healthcare provider will delay starting ART for a few days or weeks.

The following baseline laboratory investigations will be performed routinely before a client initiates ART.

Remind the client that they are not required to wait for the results of the baseline test before starting ART. The results will be assessed at the next clinical visit.

LABORATORY TEST	PURPOSE OF TEST
Confirm HIV test result	To confirm HIV status for those without documented HIV status
CD4 cell count	To identify eligibility for CPT
Creatinine and eGFR	To assess renal insufficiency
Haemoglobin	To identify and manage anaemia
GeneXpert	To diagnose TB
Cryptococcal antigen test	To identify asymptomatic clients who need pre-emptive fluconazole treatment
Cervical cancer screening	To identify women with cervical lesions and manage appropriately
HBsAg	To identify hepatitis B (HBV) co-infection

Discussion Points:

- Discuss with the client, the journey on ART for the first year.
- Remind the client that most people who start ART and remain adherent on treatment come to the clinic only **4 times** in the first year. After this you will only need to come to the clinic **2 times** every year.

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 Routine HIV VL Monitoring on ART on page 42 • Integrated services for family planning* and NCDs* • 2 months ART dispensed (2MMD) - DMOG SOP 4		
3	3-month* VL sCR and eGFR	• Clinical assessment including VL and any other routine monitoring bloods as outlined on Routine HIV VL Monitoring on ART on page 42 • 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 (DMOG for stable patients)		
		Facility Pick-up Point (FAC-PUP) (DMOG SOP 5.1)	Adherence Clubs (AC) Facility or community-based support groups (DMOG SOP 5.2)	External Pick-up point (EX-PUP) (DMOG 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) – DMOG 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 41 • 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		

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 34](#))
- 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 (DMOG 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)

Educate on side effects of ART.

Most clients tolerate ART very well.

Common side effects include (often improve within a few days to weeks):

- **Dolutegravir (DTG):** headache, dizziness, insomnia
- **Tenofovir (TDF):** nausea, diarrhoea, mild abdominal discomfort
- **Lamivudine (3TC):** mild nausea or tiredness

Long term (less common) side effects:

- **Tenofovir:** kidney problems, reduced bone mineral density.
- **Dolutegravir:** weight gain; rare mood changes or depression.

Key Literacy Messages:

- Do not stop ART because of mild side effects - the benefits of treatment are much greater.
- Keep taking your ART every day, and if you feel serious side effects, talk to a healthcare provider.
- Report new or serious symptoms to your clinic immediately.
- Join adherence clubs or community ART groups for support.
- Remember: U=U (Undetectable = Untransmittable) - staying on ARVs protects your health and your loved ones.



Session 5.3

Importance of Treatment Adherence

Explain the importance of adherence to the client in a simple way. Taking your medicine every day keeps you healthy and prevents serious illness.

- Consistent adherence to treatment significantly reduces the risk of HIV infection from mother to infant. During pregnancy and breastfeeding, the focus is strict adherence to treatment and have undetectable VL.
- Adherence prevents drug resistance: Skipping doses allows the virus to change shape and make your medicine less effective.
- Improves quality of life: being strong reduced illness and hospitalization and simplified medication collection.

Session 5.4

Viral load monitoring

Viral load (VL) monitoring is a blood test that measures the amount of HIV in the blood.

Why is it Important?

- Confirms if a client is taking treatment correctly (adherence).
- Detects treatment failure early, before a person becomes sick.
- Helps decide if a person should continue the same ART regimen or switch.
- Supports the goal of viral suppression and U=U (Undetectable = Untransmittable).

Explain to the client:

Blood will be drawn to test for viral load. At their next visit the healthcare provider will inform them about their viral load:

- Viral UNDETECTABLE (< 50 copies/mL)
- Viral DETECTABLE (≥ 50 c/mL)

Discussion Points:

Demonstrate to the client: Viral load is the most important tool to check if antiretroviral treatment (ART) is working.



Before ART



After starting
ART



With
continued
intake of ART

 Represent
HIV

 Represent
healthy cells

Explain to the Client:

The Viral Load monitoring schedule for the first year on treatment.

Key Literacy Messages

- Viral load shows if your ART is working to bring down the virus so low that it is undetectable in the blood.
- An undetectable viral load means you stay healthy and cannot pass HIV to your sexual partner (U=U).
- If your viral load is high, don't panic — it means we need to work together on adherence.
- Always come for your routine blood test, even if you feel well.

Congratulatory Message

- Always congratulate and affirm the client's success when he/she achieves VL < 50 copies/mL.
 - U=U: Having an undetectable viral load means you can take control of your life to stay strong, healthy and provide for your family.
 - When your VL remains undetectable, you can have a healthy sexual relationship without the fear of passing the virus to your partner.



Session 5.5

Co-infections and Comorbidities

Co-Infections (infections that occur together with HIV)

Assist the client to understand that because HIV weakens the immune system, people living with HIV are more likely to get other infections. In South Africa, the most common include:

- Tuberculosis (TB) – the leading cause of death among people with HIV.
 - HIV increases risk of active TB.
 - All HIV clients must be screened for TB at every visit.
- Hepatitis B – can damage the liver; important to check before starting ARVs.
- Sexually Transmitted Infections (STIs) – like syphilis, gonorrhoea, and chlamydia.
- Opportunistic infections – such as cryptococcal meningitis (CM), pneumocystis pneumonia (PCP), candidiasis (oral thrush).

Most of these co-infections occur when you are not taking your treatment. The body's immune system can get weak, and you may develop a condition called Advanced HIV Disease.

Session 5.6

Advanced HIV Disease (AHD)

Anyone living with HIV who is older than five years old has advanced HIV disease (AHD) if:

- Their CD4 cell count is less than 200 cells/ μ L.
- They have WHO clinical stage 3 or 4 event.

Remember!

All children living with HIV younger than five years should be considered as having AHD (regardless of CD4 % or clinical stage) unless they have been receiving ART for longer than one year and are clinically stable on ART.

Explain:

- One in five people living with HIV (PLHIV) in South Africa who start, or re-start treatment have Advanced HIV Disease (AHD).
- Advanced HIV Disease increase the risk of complication and death, even after starting ART.
- It is important to remain on treatment and attend all your clinic appointments.

Key Literacy Messages

Advanced HIV disease can be prevented through the following

- Starting ART early and adhering to treatment.
- Recognising warning signs of AHD (weight loss, fever, night sweats, persistent cough, headaches, oral thrush).
- Attending all clinic appointments.
- Regular viral load monitoring to check ART effectiveness and promote U=U.
 - If your VL is less than 50 because of good adherence, you can live a healthy life, and you cannot transmit HIV to your sexual partner.

Co-Morbidities (Other health conditions that occur with HIV)

Explain that as people live longer on ARVs, chronic diseases are becoming more common:

- Hypertension (High blood pressure)
- Diabetes mellitus (Blood sugar)
- Chronic kidney disease (can be due to HIV itself or ARV side effects)
- Liver disease (especially with Hepatitis B or alcohol use)
- Cancers (HIV increases risk of cervical cancer, Kaposi's sarcoma, lymphomas)
- Mental health conditions – depression, anxiety, substance use disorders

Why This Matters

Integrated care: Based on the Integrated Chronic Disease Management (ICDM) and the Integrated Clinical Services Manual (ICSM), The Department of Health promotes “one-stop shop” services where HIV, TB, hypertension, and diabetes are managed together.

Health Literacy Messages

- Integrated care means you get all the health services you need in one place - protecting you from HIV, TB, high blood pressure, diabetes, and more.
- Staying in care helps you live longer and healthier.

Session 5.7

Nutrition and HIV

Nutrition is part of Integrated Clinical Services Management (ICSM) and Integrated Chronic Disease Management (ICDM).

Nutrition plays a critical role in the management of HIV. Good nutrition helps the body fight infections, improves the effectiveness of antiretroviral therapy (ART), and enhances quality of life.

Ask the client if food intake is adequate: If inadequate, look for reason and provide support or referral:

- Nausea and vomiting
- Loss of appetite
- Stress or anxiety
- No money for food
- Sores in mouth/difficult in swallowing food

Discussion Points:

Explain why nutrition matters in HIV:

- Boosts immunity – supports the body in fighting infections.
- Maintains healthy weight – prevents malnutrition and wasting.
- Improves ART effectiveness – some ARVs work better when taken with food.
- Manages side effects – healthy food choices can reduce nausea and diarrhoea.
- Prevents co-morbidities – lowers risk of hypertension and diabetes, which are common in long-term HIV.

Health Literacy Messages

Eating well keeps you strong, helps your treatment work, and protects you from other illnesses.

- Eat a variety of foods every day – include maize, sorghum, beans, vegetables, fruit, dairy, and lean protein.
- Plenty of vegetables and fruits.
- Choose wholegrains – brown bread, oats, samp, and unrefined maize meal.
- Eat legumes regularly – beans, peas, lentils, and groundnuts.
- Limit sugar, salt, and fatty foods – to reduce risk of hypertension and diabetes.
- Drink plenty of safe, clean water.
- Practice food safety – wash hands, cook food thoroughly, store properly to prevent diarrhoea.
- Stay physically active – regular exercise helps manage weight and strengthens immunity.

NOTES

UNIT 6

NON-COMMUNICABLE DISEASES



In unit 6 clients will be empowered to understand non-communicable diseases (NCDs). Clients will also understand the importance of lifestyle changes and recognise complications.

Suggested facilitator

- Adherence counsellor
- Peer educator
- Clinician (Clinical officer, or nurse)
- Health promoter

Objectives

By the end of this module, the client should be able:

- To understand NCDs and its treatment and self-care
- To understand lifestyle changes necessary for a long healthy life
- To recognise complications

Treatment literacy package for NCDs must be integrated into ICDM and DMOC strategies, ensuring that education materials for clients are:

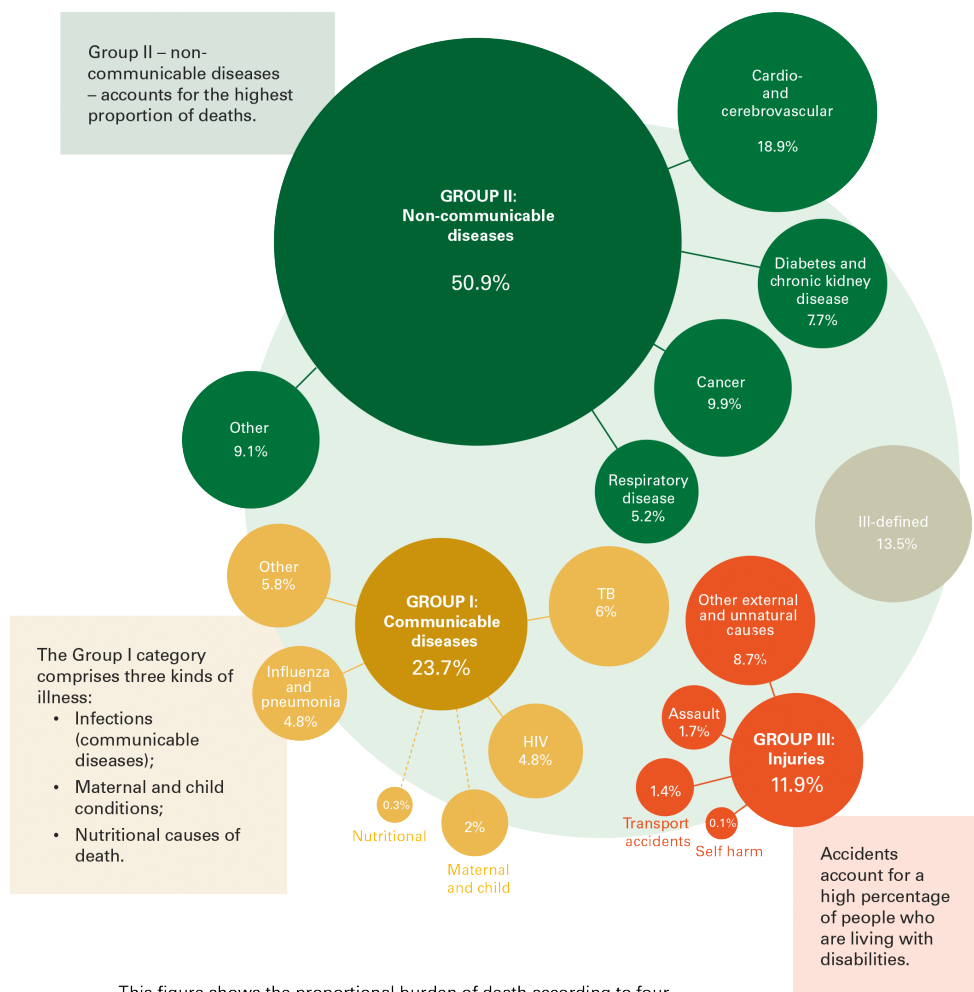
- Culturally relevant and in local languages.
- Simple and visual (posters, flip charts, SMS reminders).
- Delivered through group sessions, one-on-one counselling, and CHW outreach.

In South Africa the burden of NCDs is high with NCDs accounting for over 50% of deaths in the country. Urban populations, low-income households, and people already living with HIV/TB are vulnerable to NCDs.

Unit sessions

This unit is comprised of five sessions:

- **Session 6.1** Diabetes
- **Session 6.2** Hypertension
- **Session 6.3** Chronic Respiratory Disease
- **Session 6.4** Cancers
- **Session 6.5** Mental Health



This figure shows the proportional burden of death according to four major categories using the ICD-10 disease classification with data from the Statistics South Africa report, Mortality and causes of death in South Africa: Findings from death notification (2018).¹⁹

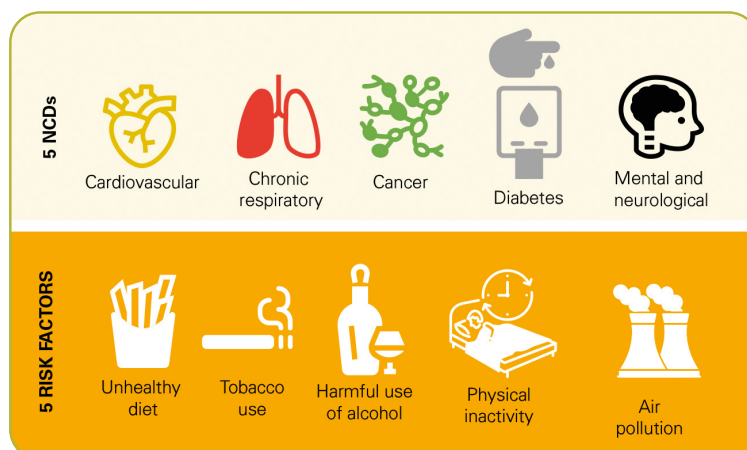
Mortality in South Africa by grouped disease category 2018 (Source: Statistics SA)

Remember!

The 5 by 5 strategy! (5 Diseases and 5 Risk factors)

NCDs are chronic diseases that are not passed from person to person. They include (Mention the five diseases)

Explain to the client the risk factor for NCDs (Mention five)



Session 6.1

Diabetes

Diabetes is a condition where there is an increased level of sugar in the blood.

When blood sugar is high, it will keep on going around, and this circulating sugar can destroy blood vessels and nerves to your legs, eyes, heart, and kidneys. This may result in complications such as blindness, kidney failure, heart disease, stroke, and limb amputations.

There are three types:

- Type 1: The body stops making insulin to control blood sugar.
- Type 2: The body does not make enough insulin or is unable to use insulin properly to control blood sugar.
- Type 3: Known as gestational diabetes. Occurs during pregnancy due to hormonal changes in the body and goes away after delivery.

Clients who have diabetes may experience the following symptoms:

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

In South Africa, Type 2 Diabetes is the most common form. This is linked to obesity, physical inactivity, and unhealthy diets.

Type 1 diabetes occurs because of a lack of insulin. The result is an increase in blood glucose concentration.

Medication Literacy

Explain importance of adherence to treatment. If difficulty with adherence, provide adherence support including linkage to community initiatives (SOP 2 – EAC).

- Discuss and educate about injection technique and injection sites (abdomen, thighs, arms) for clients who are on or starting insulin treatment.
 - Discuss how to store insulin in fridge/cool dark place
 - Disposal of sharps
 - Demonstrate injection technique and sites (abdomen, thighs, arms)
 - Storage of insulin in fridge/cool dark place
- Advise clients that if unwell and vomiting/not eating as usual: to increase fluid intake and check glucose 3 times a day if possible.
- Managing side effects and when to seek help.

Remember!

- The goal when taking blood sugar medicine is to have blood sugar test called **Hb1Ac less than 8%**. It is important to take blood sugar medicines as prescribed.
- Blood sugar medicines should not be taken **ONLY** when you feel sick but should be continued **EVEN IF** blood sugar is well controlled.
- Interrupting or stopping blood sugar medicines can be dangerous.

Monitoring and Self-Care

Assist clients to understand that diabetes is a chronic condition. Encourage the client to:

- Attend their clinic appointment and come for regular checkups.
- If available, use and keep records of home sugar monitoring tools (glucometers).
- Take good care of feet to prevent ulcers and amputation.
- Eat regular meals. If possible, carry a snack on you every time.

Lifestyle Modification Education

Lifestyle modification may be necessary to manage diabetes effectively and avoid complications. Encourage the client to

- Eat a healthy diet
 - Avoid white/brown sugar and honey, use artificial sweetener instead.
 - Cut down on starch (rice, noodles, bread, potato, sweet potato, butternut, mielies, pap, samp).
 - Eat more vegetables: spinach, cabbage and beans.
- Keep physically active (daily exercise tailored to ability/age).
- Reduce alcohol intake and stop smoking.
- Stress management and mental health awareness.

Crisis and Complication Awareness

Assist the client to understand warning signs and provide clear instructions on what to do and where to go in emergencies.

- Recognise and manage hypoglycaemia (shaking, sweating, palpitations, weakness, hunger):
 - Drink milk with sugar or eat a sweet
 - If possible, always carry something sweet or a snack on you
- Identify and manage the cause of hypoglycaemia:
 - Increased exercise
 - Missed meals
 - Inappropriate dosing of glucose-lowering medications
 - Alcohol consumption
 - Infections
- Educate on the risk of severe COVID-19 disease.

With good treatment, healthy eating, exercise, and regular check-ups, you can manage both HIV and diabetes successfully and live a long, healthy life.

Session 6.2

Hypertension

Blood pressure is the force of blood as it flows through your veins.

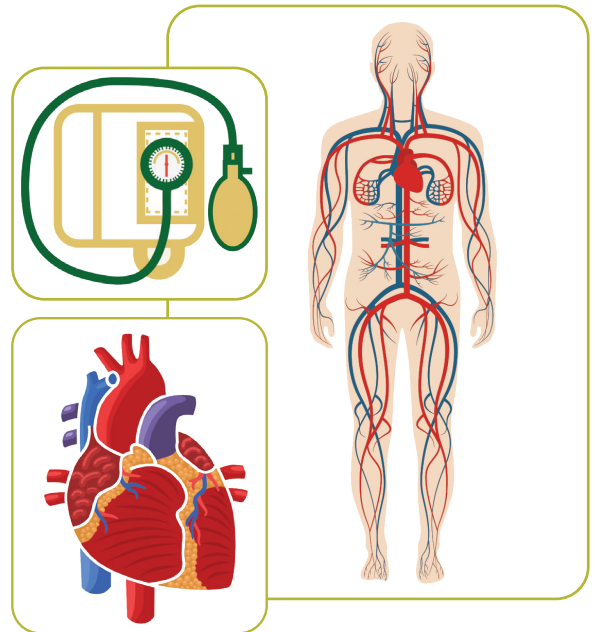
Explain to the client:

Our heart works like a pump to make blood circulate around the body. With every heartbeat blood is pushed through small blood vessels throughout the body to carry oxygen and nutrition.

High blood pressure is defined as blood pressure measurement which is greater than 140/90 mmHg or more.

People with any of the following are at risk for high blood pressure.

These factors should be managed through lifestyle changes.



Inherent risks	• Age. The risk of high blood pressure increases with age. • Ethnic group. High blood pressure is particularly common among people of African heritage. • Family history. High blood pressure tends to run in families.
Lifestyle risks	• Weight. Being overweight or obese. • Sedentary lifestyle. People who are inactive tend to have higher heart rates. • Using tobacco of any kind. This can cause the arteries to narrow and increase the risk of heart disease. • Too much salt (sodium) in the diet. • Excessive alcohol intake.
Other conditions	• Certain chronic conditions. Such as kidney disease, and diabetes. • Sometimes high blood pressure may occur during pregnancy.
External factors	• Stress

Remember!

- The goal when taking blood pressure medicine is to have blood pressure less than **140/90**. It is important to take blood pressure medicines as prescribed.
- Blood pressure medicines should not be taken **ONLY** when you feel sick but should be continued **EVEN IF** blood pressure is well controlled.
- Interrupting or stopping blood pressure medicines can be dangerous.

Medication Literacy

Explain importance of adherence to treatment. If difficulty with adherence, provide adherence support including linkage to community initiatives (SOP 2 – EAC).

- Explain the importance of adherence. Lifelong hypertension care is essential to prevent stroke, heart disease, eye disease and kidney disease.
 - Take your treatment on time every day
 - Do not miss a day
 - Use a pill box or reminder on your phone
 - Know the names of your medicines and ask for possible side effects

Monitoring and Self-Care

Assist clients to understand that hypertension is a chronic condition. Encourage the client to:

- Attend their clinic appointment and come for regular checkups.
- If available, use and keep records of home blood pressure monitoring tools.
- Limit exposure to sunlight and use sunscreen if using hydrochlorothiazide.

Lifestyle Modification Education

Lifestyle modification is important to manage hypertension effectively and avoid complications.

- Controlling high blood pressure means a lifelong change of eating and lifestyle. This means:
 - 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
 - Lose weight if overweight

Crisis and Complication Awareness

Assist the client to understand side effects and warning signs while taking blood pressure medicine.

- Headache
- Feeling tightness in the chest
- Dizziness
- Cough
- Swelling in the legs
- Sexual dysfunction
- Muscle cramps
- Educate on the risk of severe COVID-19 disease



Session 6.3

Chronic Respiratory Diseases

Chronic respiratory diseases (CRDs) are long-term conditions of the airways and the lungs that results in progressive (get worse over time) breathing difficulties.

The most common CRDs include asthma and chronic obstructive pulmonary disease (COPD).

CRDs are a major contributor to premature death and disability, alongside other NCDs.

COPD rates are rising due to tobacco use, indoor air pollution, mining/occupational exposure, and TB-related lung damage.

Chronic Obstructive Pulmonary Diseases (COPD) and Asthma

COPD and Asthma are different types of diseases, but both affect the airway and present with similar symptoms:

- Shortness of breath
- Coughing
- Wheezing
- Frequent chest infections

Medication Literacy

Explain importance of adherence to treatment. If difficulty with adherence, provide adherence support including linkage to community initiatives (SOP 2 – EAC).

- Advise client to use their inhaler properly.
- Practice the right way to use inhaler.
- Use rescue inhaler before exercise or when your chest gets tight.
- Always keep an inhaler on you.
- Ensure the clients understands medication:
 - Salbutamol relieves symptoms but does not control asthma. Inhaled corticosteroid prevents but does not relieve symptoms.
- Inhaled corticosteroids can cause oral candida: advise the client to rinse and gargle after each dose of inhaled corticosteroid.
- Educate on Long Term Domiciliary Oxygen Therapy/Use (LTOT) at home.

Monitoring and Self-Care

Assist clients to understand that CRDs are chronic conditions. Encourage the client to:

- Attend their clinic appointment and come for regular checkups.

Lifestyle Modification Education

Lifestyle modification is important to manage CRDs effectively and avoid complications.

- Advise to avoid triggers that may worsen asthma/COPD (e.g. animals, cigarette smoke, dust, chemicals, pollen, grass), and medication such as aspirin/ibuprofen).
- If the client smokes, encourage to stop.

Crisis and Complication Awareness

Assist the client to understand danger signs and avoid triggers of acute difficulty in breathing.

- Allergenic substances
- Cold air
- Certain chemicals
- Lung infection
- Certain medications
- Physical activity
- Anxiety or stress

Occupational Lung Diseases

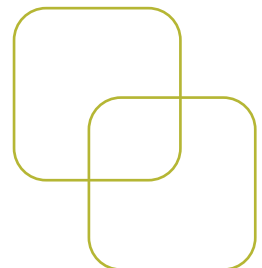
Coal worker pneumoconiosis (CWP) and Silicosis are chronic lung conditions that impact clients who work in mines, construction and quarry. Communities who live near these activities may be affected.

Coal Worker Pneumoconiosis (black lung) – is a lung disease caused by long-term inhalation of coal dust commonly found in coal mine, coal transport and dump sites.

Silicosis – is a condition caused by breathing in silica dust, commonly found in mining, construction, sandblasting, and quarrying.

Clients who have CWP or Silicosis may have the following signs:

- Persistent cough.
- Shortness of breath (initially with exertion, later at rest).
- Chest pain or tightness.
- Fatigue, weakness, weight loss.
- Increased risk of tuberculosis



Remember!

Educate clients that CWP and Silicosis are not curable, but they can be prevented.

Self-care and Community Support

- Quit smoking (worsens lung damage).
- Good nutrition to strengthen the immune system.
- Breathing exercises and light physical activity.
- Access to worker compensation and health benefits through department of labour.

Messages for Health Literacy

- Coal pneumoconiosis can be prevented but not cured.
- Miners must use protective gear and attend regular health check-ups.
- Families should be aware of symptoms and encourage early medical evaluation.

Session 6.4

Cancers

Cancer is the rapid growth of abnormal cells in the body and can spread to other organs. Cancer is a condition that can affect any part of the body.

Anyone can get cancer. People living with HIV are at higher risk for certain cancers, but early detection saves lives.

Common types of cancer and their risk factors in the epidemic of HIV:

CANCER TYPE	RISK FACTORS
Cervical cancer	Human papillomavirus (HPV) infection, weakened immunity, smoking, poor screening uptake.
Kaposi's sarcoma (KS)	Human herpesvirus-8, low CD4 counts, late ART initiation.
Non-Hodgkin lymphoma (NHL)	Epstein-Barr virus (EBV), immune suppression, uncontrolled HIV.
Anal cancer	HPV infection, receptive anal intercourse, smoking.
Liver cancer (Hepatocellular carcinoma)	Hepatitis B/C co-infection, alcohol, long-term liver inflammation.

Regular screening for cancers can help to detect the condition early and prevent complications.

Remember!

- Cervical cancer is a preventable disease and is curable if diagnosed and treated early. The most effective strategy available to primarily prevent cervical cancer is by vaccination against HPV.
- HPV vaccines are recommended for pre-pubertal girls and offer the most hope to stop the epidemic of cervical cancer in South Africa effectively.
- Women living with HIV (WLHIV) have a higher risk of pre-cancer and invasive cervical cancer. The risk and persistence of HPV infection increase with low CD4 count and high HIV viral load.
- Encourage all WLHIV to start and remain on their treatment for HIV.
- Cervical cancer screening leads to early detection of precancerous and cancerous cervical lesions. This can prevent serious morbidity and mortality.
- All women living with HIV should be screened for cervical cancer at diagnosis and subsequently every three years if the screening test is negative.
- If the cervical screening results suggest a possible abnormality, additional investigation and treatment (e.g. colposcopy and LLETZ procedure) will be conducted.

For men 50+ consider education and promotion of prostate cancer screening:

Medication Literacy

Explain that there are several types of treatment options available for. These are usually dependent on several factors such as the type of the cancer, the stage of the cancer and the state of the client. The main types of treatment include the following:

- Surgery – removing tumours.
- Chemotherapy – medicines to kill cancer cells.
- Radiation therapy – high-energy rays to destroy cancer cells.

Lifestyle Modification Education

Advise the client to do regular exercise, avoid smoking and alcohol use, and attend their routine medical check-ups to stay strong while living with prostate cancer.

Crisis and Complication Awareness

Educate the client to watch for serious warning signs such as inability to pass urine, severe back pain, blood in urine, or sudden shortness of breath. If any of these symptoms occur, seek medical care immediately.

Session 6.5

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 is able to contribute to his or her community.

Assist the client to understand and recognize the signs and symptoms of mental health conditions. 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.
- Less interested in things they used to enjoy doing.
- They cannot 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 all the time.
- They do things repetitively, such as repeated handwashing, eating too much, obsessive diet or other obsessive behaviours.
- They intentionally hurt themselves or other people.
- They have problems sleeping or feeling tired and not having energy.
- Anxious, looking or feeling 'jumpy' or upset, having panic attacks.
- They don't want to spend time with other people; spending too much time in bed.
- They are hearing and seeing things that others do not see.

Your mental health can affect your daily life, relationships and even your physical health.

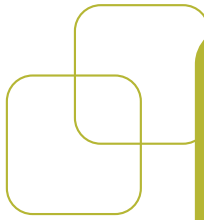
If you are sad or stressed, this can affect your adherence to treatment.

Use the DMOC SOP Mental Health Assessment tool to assess and recommend appropriate actions for clients who have mental health conditions.

PART 1 DEPRESSION AND ANXIETY SCREEN					
Question 1: Core features of depression			Question 2: Other features of depression		
	For the past two weeks have you...	Score		For the past two weeks have you...	Score
1	Felt depressed most of the day almost every day?		1	Experienced reduced concentration and attention?	
			2	Experienced reduced self esteem and self confidence?	
2	Lost interest or pleasure in activities those are normally pleasurable?		3	Had ideas of guilt and unworthiness?	
			4	Experienced that your view of the future is bleak and negative?	
3	Experienced decreased energy or increased fatigue?		5	Experienced ideas or acts of self harm or suicide?	
			6	Sleep been disturbed?	
			7	Your appetite decreased?	
Total score for Question 1			Total score for Question 2		
A score of 2 or more for Question 1 is a positive screening result Manage as per the APC Guidelines			A score of 3 or more for Question 2 is a positive screening result Manage as per the APC Guidelines		
Question 3: Anxiety					
1	Is the patient feeling tense/nervous and/or worrying a lot ?	Yes	No	A "Yes" answer for Question 3 is a positive screening result for anxiety. Manage as per the APC Guidelines	

Remember!

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



Remember!

The HIV virus may have direct effects on the brain. The stress of living with a chronic condition, stigma, and side effects from some medications can lead to a higher risk of mood disorders like anxiety and depression.

Medication Literacy

Mental health conditions may be treated in several ways. 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.

Explain to the client that 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 healthcare provider first.

If difficulty with adherence, provide adherence support including linkage to community initiatives (SOP 2 – EAC).

Monitoring and Self-Care

Assist clients to understand that mental health conditions are chronic and may require ongoing care. Encourage the client to:

- Attend their clinic appointment and come for regular checkups.

Lifestyle Modification Education

Lifestyle modification is important to manage mental health conditions effectively and avoid complications.



Get enough sleep



Spend time with supportive friends or family



Relax: Find creative or fun activity to do



Do relaxing breathing exercise each day



Get active: Regular exercise might help



Access support: Link client with helpline or support group

Crisis and Complication Awareness

Explain that thoughts of self-harm and suicide are common in mental health conditions.

- Advise the client that if s/he has these thoughts, s/he should not act, but,
 - tell a trusted person and return for help IMMEDIATELY
 - contact a dedicated helpline number.

Substance Abuse

Substance abuse is the harmful use of drugs or alcohol that can negatively impact health behaviour and social wellbeing.

Use the DMOC SOP Mental Health Assessment tool to assess and recommend appropriate actions for clients who have substance use disorder.

PART 2 SUBSTANCE USE DISORDER SCREEN							
Question 1	Score No=0 Yes=1	Question 2	Score No=0 Yes=1	Question 3	Score No=0 Yes=1	Question 4	Score No=0 Yes=1
Has your taking of drugs or alcohol caused serious problems for yourself, your family or the community		Did you have more than 5 drinks per session in the last week?		Have you ever experienced any of the following?		Have you used any illicit drugs or misused prescription drugs?	
		<i>If you are a man:</i> Do you have more than 21 drinks per week?		Felt that you should cut down on drinking?			
		<i>If you are a woman:</i> Do you have more than 14 drinks per week?		Felt annoyed if criticized by anyone about your drinking?			
		(1 drink = 1 tot of spirits or 1 small glass of wine or 1 can of beer)		Felt guilty about drinking?			
Total Score		Total Score		Total Score		Total Score	
A score of 1 is a positive screen and needs action		A score of 1 or more is a positive screen and needs action		A score of 2 or more is a positive screen and needs action		A score of 1 is a positive screen and needs action	

Ask clients about their pattern of using the following substances and educate clients on the dangers of using substances.

SUBSTANCES	EDUCATE ON DANGERS
- Alcohol - Tobacco - Dagga - Mandrax - Snuff - Cocaine - Nyaope	- Substance abuse may lead to physical health issues such as: - Liver disease - Increased risk of TB - Increased HIV infection risk - Substance abuse may lead to mental health conditions such as - Depression - Substance use may lead to social and legal problems - Homelessness - Arrests - Substance abuse may progress to addiction - You may forget your treatment or clinic appointment

Important!

Provide all clients who have mental health and substance abuse issues with contacts for additional information and support.

The South Africa Depression and Anxiety Group (SADAG) Helpline is open 24 hours, 7 days a week:

Substance Abuse – 0800 12 13 14 or SMS 32312

Suicide Crisis Line – 0800 567 567

NOTES

UNIT 7

TAILORED TREATMENT LITERACY FOR THE SUB-POPULATIONS



Unit 7 focuses on treatment literacy tailored to the needs of different sub-populations. It recognises that people receiving chronic treatment require different types of support depending on their age, gender, and lived realities.

Objectives

By the end of this unit each sub-population must be empowered to tackle age, gender or context-specific barriers (e.g. stigma, mobility, low literacy, side effects, disclosure challenges) to treatment of chronic conditions.

Unit sessions

This unit is comprised of five sessions:

- **Session 7.1** Pregnant and breastfeeding women and their children
- **Session 7.2** Children and adolescents aged 5 – 14 years
- **Session 7.3** Adolescents and young people aged 15 – 24 years
- **Session 7.4** Men
- **Session 7.5** Individuals 50 years and older
- **Session 7.6** Key populations

Session 7.1

Pregnant and breastfeeding women and their children

This session discusses integrated care for the mother living with HIV and her HIV exposed infant (HEI).

Target Group

- Pregnant and breastfeeding mothers living with HIV and or other chronic conditions.

Facilitator

- Clinician (enrolled nurse, professional nurse)
- Adherence counsellor
- Lay counsellors
- Peer educator

Managing the health of women living with HIV and preventing triple infections (i.e., HIV, Syphilis and Hepatitis) remains a critical intervention for both maternal survival and improved outcomes for their children in South Africa.

Importance of ART during pregnancy and breastfeeding

All pregnant women newly diagnosed with HIV are eligible for lifelong ART regardless of gestation, CD4 count, or WHO clinical stage. Taking ART protects the baby from getting HIV and keeps the mother healthy. Early antenatal care booking and strict adherence to medication are essential for optimal health outcomes for mother infant pair (MIP).

It is critical to use a family care approach to optimise index testing of the male partners and siblings.

Several factors: medical, mental health, cultural and socioeconomic may contribute to put a mother-infant-pair at risk of poorer outcome. Healthcare providers must assess for any risk factors at every encounter with the mother.

ANTENATAL RISK FACTORS	PERINATAL RISK FACTORS
Teenage pregnancy	Low birth weight baby (<2500 grams)
Primigravida	Delivery before 37 weeks (premature baby)
Lives in an informal settlement	Neonatal death or stillbirth
Single	Any neonatal problem: e.g. Low Apgar (<7); breast-feeding problems; suspected hypoxic ischaemic encephalopathy (HIE); congenital problems
Unemployed	Any maternal problem that arose during delivery or post-delivery: e.g. bleeding, tears, infection, re-tained placenta
Any medical problem (including HIV)	Any other relevant reason e.g. violence/abuse at home, lack of social support, food insecurity, being a refugee, recent bereavement, etc.
Any obstetric problem	
Any psychiatric problem	
Use of tobacco, drugs, or alcohol	
Any other relevant reason e.g. violence/abuse at home, lack of social support, food insecurity, being a refugee, recent bereavement, etc.	

Adapted from the National Consolidated Guidelines for the Management of HIV 2025

Remember!

Antacids can be taken with or without food, but must be separated from ART. Try and separate the time for taking antacids and iron supplements as much as possible to avoid drug-drug interaction.

Implications for maternal and neonatal health

Explain to the pregnant or breastfeeding woman that she will be deregistered from her chronic medication RPCS option until the baby is 24 months old. She will return to attend the clinic as part of integrated care where:

- Her clinic visit schedule will be aligned with her baby's immunisations. Explain the integrated care for the mother living with HIV and her HIV-exposed infant (HEI) or HIV-infected infant.
- Mother's treatment, VL monitoring and contraception visits will align with that of the child's immunisation, early infant diagnosis, infant's VL, mental health screening etc.
- Mother and baby will receive treatment at the same facility.
- Optimise the Road to Health booklet to ensure all HEI are getting tested until 18 months old.

All HIV-exposed infants will be tested at birth, 10 weeks, 6 months, 18 months and at any point six weeks after cessation of breastfeeding.

Discussion Points:

- Discuss the integrated care visit schedule with mother and address any concerns she may have that will affect her ability to come to the clinic.

Age group	Age of child	Routine visits as per RTHB	PrEP Dispensing cycle (DC)	PrEP Follow-up for mother	Immunisations	Feeding advice	Growth monitoring	Development	Head circumference	Vit A	Deworming	Oral Health	TB Screen	Mother's contraception
Delivery			1	• Provide 3 months* of PrEP (3MMD) which will last until 10 week PN visit		x								
Neonate	1st week of life	3-6 days postnatal (PN) visit for mother and baby		• Provide HIV test to mother (if not tested in labour) • Check PrEP supply. The mother should have been provided with 3 months* of PrEP at delivery which will last her until 10 week PN visit • PrEP adherence check-in for mother • Provide breastfeeding support and routine post natal care		x	x						x	x***
2 - 6 months	6 weeks	6 weeks	2*	• Postnatal clinical review • Provide breastfeeding support • PrEP adherence check-in	x	x	x						x	
	10 weeks	10 weeks	3	• Postnatal and PrEP clinical review and PrEP adherence check-in • Provide breastfeeding support. • Provide HIV test and STI screen to mother • Provide PrEP for 3 PrEP DCs (3MMD) for mother** • If mother received either DMPA (Depo Provera®) or NET-EN (Nur Isterate®) after delivery, give repeat injection at this visit****	x	x	x						x	x
	14 weeks	14 weeks	4	• Postnatal clinical review • Provide breastfeeding support • PrEP adherence check-in	x	x	x	x	x				x	
	18 weeks	4 months	5			x	x						x	
	22 weeks	5 months	6			x	x						x	
	26 weeks	6 months	7	• PrEP clinical review • Provide breastfeeding support. • HIV test and STI screen for mother • Script for and provide PrEP for 3DCs at a time (3MMD)	x	x	x	x		x			x	x

Adapted from the National Consolidated Guidelines for the Management of HIV 2025

Remember!

An elevated VL in a pregnant or breastfeeding mother is a **MEDICAL EMERGENCY!**

- Explain the role of viral load (VL) monitoring during pregnancy and breastfeeding. During this period viral loads will be monitored more frequently to ensure that her ART works properly.
- Advise mother to only take medications prescribed by nurse/doctor who knows she is pregnant. If she is unsure, advise her to check with healthcare provider.
- Educate on the dangers of smoking and drinking alcohol and advise to stop.
- Advise mother to identify a companion or support system during this critical period.

TB in pregnant and breastfeeding women is an important cause of maternal and infant mortality. The possibility of TB should be considered at every encounter during antenatal care (ANC), delivery, and in the postnatal period.

Emphasise the importance of screening and treatment for TB, syphilis, hepatitis B, and STIs. These infections can also harm your baby.

Importance of follow up until cessation of breastfeeding period

Discussion Points:

Infant feeding:

- Encourage exclusive breastfeeding for 6 months, regardless of HIV status: this means that baby gets only breast milk (no formula, water, cereal) and if HIV-exposed, dual infant prophylaxis. If mother is not virally suppressed at delivery, dual prophylaxis should be administered in accordance with national guidelines.
- If a mother decides to stop breastfeeding it should be done gradually over a period of a month. Abrupt cessation of breastfeeding is not recommended and may increase the VL in breastmilk.
- **EXPLAIN:** If subsequent intermittent breastfeeding should occur, the infant is at increased risk of becoming HIV infected if VL > 50 copies/mL.
- Clinician should conduct a 6-week post cessation of breastfeeding PCR test.

- Encourage mother to register on MomConnect (dial *134*550#) to receive messages to support her and her baby during pregnancy, childbirth and the baby's first year.
- Discuss safe sex. Advise mother to practice safe sex or (use condoms or PrEP if HIV negative).
- Educate mother on infant prophylaxis strategies, infant testing schedule, adherence to the infant prophylaxis and promote breastfeeding.

Remember!

- Your baby will receive medication to prevent HIV infection. The medication may **ONLY** be stopped by your healthcare provider if the risk of infection is low.

Management of the HIV-negative Mother-Infant Pair

- Offer HIV testing, Syphilis and Hepatitis for this population as well.
- Repeat HIV testing at each basic ANC visit or every 3 months during the post-natal care
- Offer Pre-Exposure Prophylaxis (PrEP)/Post Exposure Prophylaxis (PEP) as part of an integrated service to all HIV-negative pregnant and breastfeeding women.

PrEP is a safe and effective HIV prevention strategy for high risk pregnant and breastfeeding women. This is the time of heightened vulnerability to HIV infection due to biological and social factors. PrEP is safe with no significant adverse events reported during pregnancy and breastfeeding.

Session 7.2

Children and adolescents aged 5 – 14 years

This session focuses on treatment literacy for children and adolescents living with HIV and or other chronic conditions and who are aged 5 – 14 years.

Target Group

- Mothers/Caregiver of child
- Child and adolescent patients living with HIV
- Healthcare workers
- School health nurse or team member
- Counsellors (includes social workers, psychologists or lay counsellors)

Facilitator

- Peer educator/healthcare worker
- Health promoter

Special considerations in treatment for children

Caregivers and all children with chronic diseases from 5 years old should start being prepared for partial disclosure and full disclosure of their chronic condition. Use SOP 3 (CADC) to conduct age-appropriate disclosure for children and adolescents.

Disclosure must be conducted in two stepwise sessions:

- Partial disclosure (5 – 9 years)
- Full disclosure (> 10 years)

Explain to the caregiver that for children under 12 years, the education and the disclosure sessions will be facilitated with the caregiver.

The caregiver must be the primary caregiver who lives with the child.

Key issues in monitoring infants (weight monitoring and treatment adjustment)

Treatment dosage in young children is weight-based. Rapid growth means frequent dose adjustments. To empower caregivers with simple, practical knowledge so they can:

- Bring children for routine treatment follow visits linked to EPI visits.
- Understand script instructions and give treatment appropriately.
 - Ask the caregiver to demonstrate the volume of liquid/number of tablets and how these are dissolved.

- Ask the caregiver about how the child tolerates the medication e.g. does the child refuse to swallow or spit, or vomit the medicine out.
- Understand that the follow up visits of the child may be linked to caregiver's follow-up visits (preferably in school holidays for school going children).
- Know that when children reach 10 years old, their medication will change as they transition to adult type of medication. But this must still be taken daily without missing a dose.
- Where possible advocate for caregiver support groups.

Remember!

- Disclosure is important as it prepares children for youth club. Check that by the time the child is 15 years they know their HIV status.

Roles of caregivers in treatment adherence

Caregivers play critical role in the wellbeing and adherence of children living with chronic conditions.

- Caregivers, supported by the counsellor, discloses to and supports the child.
- Food & nutrition support (especially for malnourished children).

Care of the caregiver

Caregiver – parents, grandparents, relatives, or community health workers – play a critical role in supporting CLHIV and other chronic conditions.

However, caregiving can be physically, emotionally, and financially draining. Supporting caregivers ensures better health outcomes for both the children and the caregiver. Discuss the following caregivers and provide appropriate support:

- Address orphanhood and foster care issues and linkage to social grants.
- Psychosocial wellbeing and linkage peer support groups.
- Provide HIV treatment literacy education on ART adherence, nutrition, and child development.
- Encourage self-care: regular health check-ups, rest, nutrition, and exercise.
- Provide caregiver-friendly services (e.g. clinic fast-tracking and screening for hypertension, diabetes, depression).

Session 7.3

Adolescents and young people aged 15 – 24 years

This session focuses on living well with HIV and other NCDs for adolescents and youth.

Target Group

- Adolescents (12 – 24 years old) living with HIV and or other chronic conditions.
- Youth (20 – 24) living with HIV and or other chronic conditions.

Facilitator

- Peer educator/healthcare worker

Challenges specific to young people living with HIV

- Children and adolescents living with HIV (C/ALWH) often learn negative myths about HIV from their community, their friends and school.
- It is therefore extremely important to educate C/ALWH and dispel all myths before you tell them they have HIV. Five important things for them to understand include:

Remember!

- These days there is very good treatment for HIV, so PLHIV can remain perfectly healthy and never get AIDS.
- PLHIV can live as long as people without HIV if they take their treatment every day.
- 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.
- PLHIV can have relationships and have children and not transmit HIV to their sexual partner or children if they take their treatment and have a suppressed viral load.
- Living with HIV does not prevent people from living a completely normal life and following any career they want.

Support adolescents and young people to **first understand** these 5 points in the box above before you explain that:

- They were born with a germ/virus called HIV, which can kill their white blood cells so they can't protect their body from other germs.
- The medicine they receive works very well at making the HIV virus sleep so that it can't kill white blood cells. That way the body is well protected from other germs, and you won't get sick.

- If you don't take your medicines every day the HIV virus can get stronger and prevent the medicines from working.
- They need to understand their responsibility for not transmitting HIV e.g. safer sex, and family planning.
- Educate on safe conception in Sero-different couples.
- Partners can conceive through condomless sex provided the HIV-positive partner is virally undetectable and remains adherent to antiretroviral therapy. (Undetectable viral load is defined as VL less than 50 copies/mL).

Navigating the transition from childhood to adulthood can be challenging for adolescents who need to adhere to treatment of chronic medication. Assist adolescents to.

- Put appointment date in a diary or phone or mark it on a calendar so that you don't forget.
- To join B-WISE to get accurate information and make informed decisions about their health.
- Discuss any challenges s/he may have that may make it difficult to take medication (peer pressure, forgetfulness, stigma or side effects).
- Inform healthcare providers of any changes in their routine schedule that may interfere with clinic appointment or medication pick up. For example:
 - Going to school earlier than usual
 - Transition from day school to a boarding school
 - Moving away from home in search of work
 - Going to college

Address misconceptions about treatment for chronic conditions. Explain to adolescents and young people the habits that are not good and may make their condition worse.

- Stopping treatment for a day or many days (taking a "drug holiday").
- Missing scheduled clinical/laboratory appointments or failing to pick up your medication.
- Mixing alcohol and recreational drugs with ART or other medication for chronic conditions.
- Sharing medicine with other people.
- Taking some medications and leaving out some.
- Stopping your medications with a claim of miracle healing or a religious blessing.
- Using herbal medicines instead of the medicine given by your healthcare provider.

AGYW:

- AGYWs face a unique challenge and require additional consideration focusing on navigating sexual and reproductive health (SRH) needs.

- Empower AGYW to make informed decisions and contraceptive choices:
 - Educate on options available (pills, injectables, implants, IUDs, condoms).
 - Educate on dual protection to prevent pregnancy and HIV/ STIs.
- Educate AGYW on teenage pregnancy and maternal health.
 - If pregnant to book antenatal care early.
- Empower AGYW to recognise, prevent and respond to Gender and Sexual violence.
 - Educate on services that are available for survivors (PEP, emergency contraceptives and counselling).
- Promote HPV vaccination and screening.
- Educate on and promote screening for STIs.

Importance of Support Networks

Discuss sources of social support available for adolescents and young people. Emphasise the importance of support structures in coping and adherence. Encourage joining a teen club/youth adherence club.

- Offer peer mentor contact for support.
- Link with psychosocial services if needed.
- Encourage adolescents and youth to join B-Wise web App for ongoing Adolescent and Youth-Friendly Health Services (AYFHS) and information.

Session 7.4

Men

This session discusses key men's health strategies to empower and support all men to optimise their own and each other's health and wellbeing across all stages of the life course.

Target Group

- Men living with HIV and or other chronic conditions

Facilitator

- Peer educator/healthcare worker

Addressing stigma and discrimination

Stigma and discrimination are some of the biggest barriers for men in accessing HIV and other health services for chronic health conditions.

Assist men to identify the type of stigma they face and help offer the appropriate literacy to empower men on treatment.

TYPES OF STIGMA MEN FACE	TREATMENT LITERACY MESSAGES TO REDUCE STIGMA
• HIV stigma: – being labelled as weak, promiscuous, or "less of a man" if living with HIV. • Clinic stigma: – men seen as outsiders in "female-dominated" clinic spaces. • Self-stigma (internalised): – fear of being judged leads to not taking treatment. • Gender stigma: – belief that men must be strong, not seek help, or hide illness.	• Normalize HIV and treatment: – "HIV is a manageable condition — like high blood pressure or diabetes." • Frame treatment as strength: – "Real strength is protecting your health and your family." • Challenge myths: – "Taking treatment doesn't mean you are sick — it means you are smart." • Promote confidentiality and choice: – "Your health information is private — you choose who to tell."

- Remind men that the clinic offers integrated services: HIV services are combined with general men's health (blood pressure, diabetes, fitness checks).
- Men may request to be seen by a nurse healthcare provider of their choice.
- Educate about after-hours services if available and RPCS for chronic medication.

Importance of Support Networks

Encourage men to:

- Use peer role models in the community: This may include male champions (sports figures, community leaders, fathers) who openly talk about living with HIV or managing chronic conditions.
- Join community dialogues that bring men, and leaders together to talk about their health and challenge misconception.

Session 7.5

Individuals 50 years and older

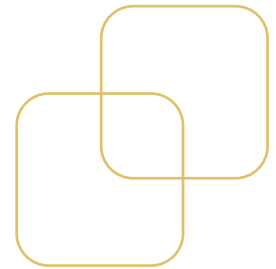
This session focuses on the unique health literacy needs for individuals who are 50 years and older and living with chronic conditions.

Target Group

- Men and women 50 years and older living with HIV and or other chronic conditions

Facilitator

- Peer educator/healthcare worker



Managing co-morbidities in older adults

Given the burden of HIV in South Africa many people living with HIV who take lifelong ART may be aging and at risk of NCDs. TB is common and dangerous among people who are living with HIV. Some NCDs such as type 2 diabetes triple the risk of TB infection.

Remember: Providing holistic and integrated treatment literacy is important to address co-morbidities among individuals 50+.

Support the client to improve their understanding of chronic conditions and develop skills for safe medication use and adherence (refer to units on HIV, and NCDs), arthritis, etc.).

Assess for barriers to treatment literacy and provide the appropriate support:

KEY ISSUES/BARRIERS

- Multiple chronic conditions
 - Ask and educate about drug interactions and pill burden.
- Declining memory & vision/hearing difficulties
 - Ask if s/he has challenges with remembering or reading medication instructions.
- Lower digital literacy
 - Ask if s/he has access to online health information.
- Cultural beliefs & stigma
 - Ask if s/he can openly discuss about HIV, mental health, or sexual health.
- Social isolation
 - Ask if s/he has support systems for adherence and follow-up at home or workplace.

- Low health literacy and language barriers between clients and healthcare providers may lead to difficulty in understanding complex medical information.
- Use language to communicate. Avoid jargons.

For men 50+:

For males discuss the essential annual check-up.

- He must screen for heart disease, diabetes, colon and prostate cancer.
- Don't forget mental health and lifestyle risk assessments (smoking, alcohol, diet and exercise).
- Emphasise sexual reproductive health.

For women 50+:

For females discuss the essential annual check-up.

- Screen for heart disease, diabetes, colon cancer and osteoporosis.
- Don't forget mental health and lifestyle risk assessments (smoking, alcohol, diet and exercise).
- Emphasise sexual reproductive health.
- Discuss the importance of regular screening for cervical cancer.

Mental health considerations

Empower individual 50+ to overcome cultural beliefs and stigma associated with chronic conditions. Encourage her/him to:

- Normalise conversations around HIV, NCDs including mental health, and aging.
- Join peer support groups.

Session 7.6

Key populations

Key populations include the following groups:

1. Gay, bisexual, and other men who have sex with men (GBMSM).
2. Sex workers (female, male, and transgender).
3. Transgender people.
4. People who inject or use drugs.
5. People in correctional centres and other closed settings.

Empower key populations community to locate, understand, and use health information and services effectively. This should ensure that key population individuals make informed decisions that improve health outcomes, while overcoming stigma and navigating barriers in health systems.

Key populations should benefit from all the treatment literacy approaches discussed in this toolkit, and IN ADDITION, these are additional considerations.

Rights and Access to Services

- All people in South Africa — including key populations — are guaranteed the right to access high-quality health services. This right is enshrined in Section 27 of the Constitution of the Republic of South Africa, which states that everyone has the right to have access to health care services, including reproductive health, and that the state must take reasonable measures to achieve the progressive realisation of this right.
- In addition, the Batho Pele (“People First”) principles guide public service delivery and require that all individuals be treated with dignity, courtesy, and respect when accessing services. These principles reinforce the obligation of the health system to provide equitable, responsive, and respectful care to all, without discrimination or stigma.

KEY POPULATIONS	EDUCATION
GBMSM	• Information on safer sex practices, chemsex, HPV vaccination, and anal health • GBMSM peer community outreach and social media platforms for support
Transgender Individuals	• Gender-affirming care, hormone therapy (this is available only in selected tertiary facilities) • Monitoring side effects and drug-drug interaction between hormones and ART
Sex Workers	• Sexual and reproductive health services, violence protection and legal rights
People who inject or use drugs	• Sterile injecting equipment, overdose and withdrawal management • Opioid agonist therapy (OAT) and harm reduction
People in prisons and other closed settings	• HIV/TB/NCD education, adherence, mental health, and linkage to facilities for ART continuation after release

UNIT 8

COMMUNITY ENGAGEMENT AND SUPPORT IN TREATMENT LITERACY



Managing chronic conditions can be demanding for clients and healthcare providers alike. Community-based initiatives bring services closer to the client, reduce the burden on clinics, and support continuity of care of chronic conditions.

Importance of community resources and support groups

Educate clients with chronic health conditions about the importance of community resources and encourage clients to use community resources to improve their knowledge, enhance adherence, find additional services such as social grants and nutritional support.

Discuss community resources that are available:

- **Ward-Based PHC Outreach Teams (WBPHCOTs):** These are community health teams delivering household-level services such as:
 - Enabling clients to access psychosocial care
 - Delivering chronic medications to elderly clients or clients who are not mobile
 - Disease screening (HIV, TB and NCD)
 - Assisting clients who have stopped taking their treatment to return to care
- **Integrated School Health Services (ISHP):** Offer health screening, education, and referrals for learners.
- **Adherence Clubs:** where clients can join peer groups that combine medicine pick-up with education and support.
- **Diabetes and Hypertension Support Groups:** where clients find additional support and learn healthy living.
- **Youth Peer Support (AYP programs):** where there are peer navigators dedicated to addressing the needs of youth through their life course with chronic health conditions.

Role of family members in supporting individuals with NCDs

Families play a vital role in care, motivation, and creating a supportive environment that improves health outcomes for people with HIV and other chronic conditions. If possible, encourage clients to remain connected to their families.

- Families encourage and support treatment adherence (medication reminders and administration, facilitate clinic visits).
- Families promote healthy lifestyle such as preparing balanced diet and supporting physical activity.
- Families provide emotional and psychosocial support to reduce stress and stigma.
- Families assist with daily care needs and monitoring of symptoms or complications.
- Families facilitate communication with healthcare providers and ensure follow-up.

ANNEXURES

ANNEX I

PATIENT ADHERENCE PLAN

FTIC Session 1 after chronic disease education session (date):	
Adherence step 1: education on HIV ☐ TB ☐ Hypertension ☐ Diabetes ☐ Other ☐	
Adherence step 2: Life goals: My motivations to stay healthy are: (1)..... (2)..... (3)..... I will maintain a healthy lifestyle by ☐ adopting healthy eating habits ☐ getting regular exercise ☐ managing my stress	
Adherence Step 3: Patient Support system Agree for home visit: Yes ☐ No ☐ Preferred means of contact: SMS ☐ WhatsApp ☐ Phone call ☐ Other ☐ Who can support me in my treatment: ☐ Family ☐ Friends ☐ Work ☐ School ☐ Church ☐ Other:	
Adherence Step 4: Getting to appointments I will come to my appointments by: ☐ walk ☐ public transport ☐ own transport If I face a difficulty to come (money, transport, etc.), my alternative plan will be to ask for assistance from: ☐ family ☐ friends ☐ neighbour ☐ other I will inform clinic I am unable to come to set appointment and request for an alternative appointment ☐	
Adherence step 5: My readiness to start treatment I feel ready and will start treatment: ☐ Yes ☐ I do not feel ready and would like to discuss more with: I am ready today ☐ Yes ☐ No but will be on..... (insert date) ☐ peer ☐ family member ☐ other	
Adherence Step 6: Medication schedule The best time for me to take my treatment is: ☐ Morning ☐ Afternoon ☐ Evening	
Adherence step 7: Managing missed doses If I miss a dose, my plan is: (1) to take treatment as soon as I remember ☐	
Adherence Step 8: Reminder strategies To remind me to take medication I will use: ☐ watch ☐ cell phone alarm ☐ pill box ☐ buddy ☐ other	
Adherence Step 9: Storing medication and extra doses I will store my medication in: ☐ Safe place: ☐ Far from reach of children I will carry extra supply in: ☐ a bag ☐ pill box ☐ other:..... I will keep it in my: ☐ handbag ☐ pocket ☐ other:.....	
Adherence Step 10: Dealing with side-effects If I experience side effects, I will: Refer to treatment adherence pamphlet ☐ Inform clinic if side effects do not go away or are too worrying ☐	
FTIC Session 2 (date):	
Adherence Step 11: Understanding the treatment pathway ahead of me if I take my treatment well ☐ I understand the options for multi-month treatment supply and simplified collection available after one normal assessment result.	
Adherence Step 12: Planning for trips <i>If I have some trips planned, before going away I will:</i> ☐ Inform health facility before travelling to receive referral letter and treatment ☐ Get enough supply of treatment for trip <i>In case I cannot come to the facility before going away:</i> ☐ I will report to the nearest health facility in the travel area as soon as I arrive to get access to treatment ☐ Carry evidence of my condition and evidence of the treatment I am taking	
Adherence Step 13: Dealing with substance use <i>My plan to make sure I take my medication if I used alcohol or drugs is:</i> ☐ To make sure I take treatment before starting to use drugs or alcohol ☐ Arrange for someone to remind me to take treatment in case I am intoxicated	
Education on assessment: Viral load ☐ Sputum ☐ HbA1c ☐ BP ☐ Other: ☐ ☐ I understand that I can access multi-month treatment supply and simplified collection if my results are normal	
Patients signature Date of signature	
EAC Session 1 (date):	
EAC Session 2 (date):	

ANNEX II

MENTAL ASSESSMENT

PART 1 DEPRESSION AND ANXIETY SCREEN

Question 1: Core features of depression				Question 2: Other features of depression			
For the past two weeks have you...			Score	For the past two weeks have you...			Score
1	Felt depressed most of the day almost every day?			1	Experienced reduced concentration and attention?		
				2	Experienced reduced self esteem and self confidence?		
2	Lost interest or pleasure in activities those are normally pleasurable?			3	Had ideas of guilt and unworthiness?		
				4	Experienced that your view of the future is bleak and negative?		
3	Experienced decreased energy or increased fatigue?			5	Experienced ideas or acts of self harm or suicide?		
				6	Sleep been disturbed?		
				7	Your appetite decreased?		
Total score for Question 1				Total score for Question 2			
A score of 2 or more for Question 1 is a positive screening result Manage as per the APC Guidelines				A score of 3 or more for Question 2 is a positive screening result Manage as per the APC Guidelines			
Question 3: Anxiety							
1	Is the patient feeling tense/nervous and/or worrying a lot ?	Yes		No		A "Yes" answer for Question 3 is a positive screening result for anxiety. Manage as per the APC Guidelines	

PART 2 SUBSTANCE USE DISORDER SCREEN

Question 1	Score No=0 Yes=1	Question 2	Score No=0 Yes=1	Question 3	Score No=0 Yes=1	Question 4	Score No=0 Yes=1
Has your taking of drugs or alcohol caused serious problems for yourself, your family or the community		Did you have more than 5 drinks per session in the last week?		Taken a drink to steady your nerves or treat a hangover?		Have you used any illicit drugs or misused prescription drugs?	
		<i>If you are a man:</i> Do you have more than 21 drinks per week?		Felt that you should cut down on drinking?			
		<i>If you are a woman:</i> Do you have more than 14 drinks per week?		Felt annoyed if criticized by anyone about your drinking?			
		(1 drink = 1 tot of spirits or 1 small glass of wine or 1 can of beer)		Felt guilty about drinking?			
Total Score		Total Score		Total Score		Total Score	
A score of 1 is a positive screen and needs action		A score of 1 or more is a positive screen and needs action		A score of 2 or more is a positive screen and needs action		A score of 1 is a positive screen and needs action	

ANNEX III

CHILD AND ADOLESCENT DISCLOSURE COUNSELLING (CADC) IMAGES

Image 1
Different types of germs

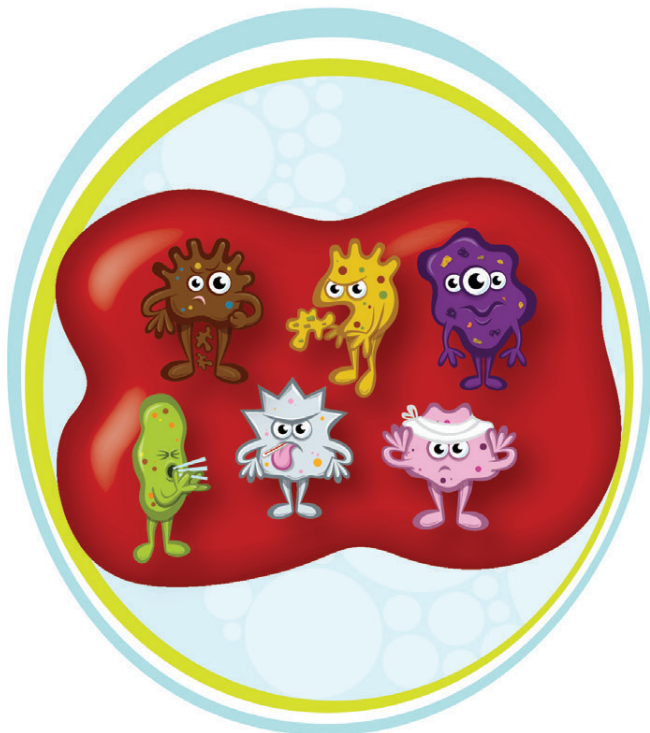


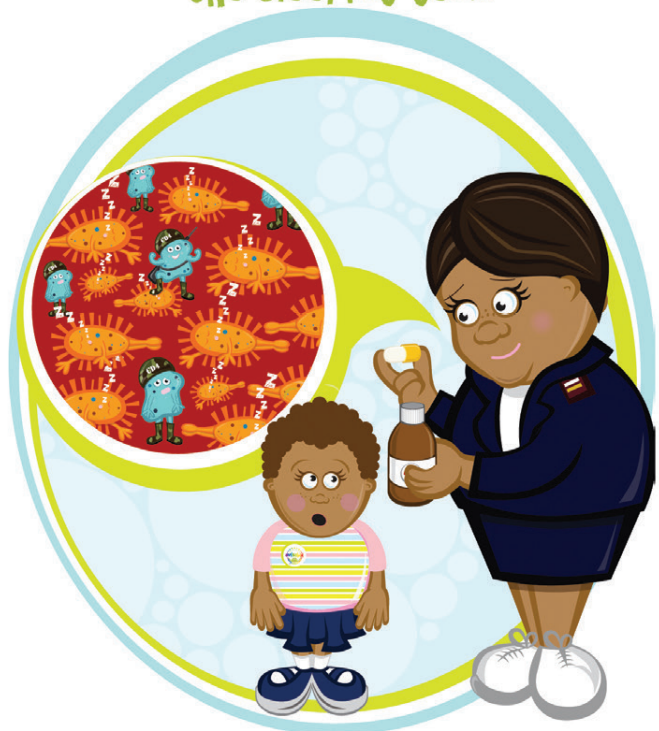
Image 2
Soldiers inside the blood
The immune system



Image 3
The sleeping germ



Image 4
Treatment to fight
the sleeping germ

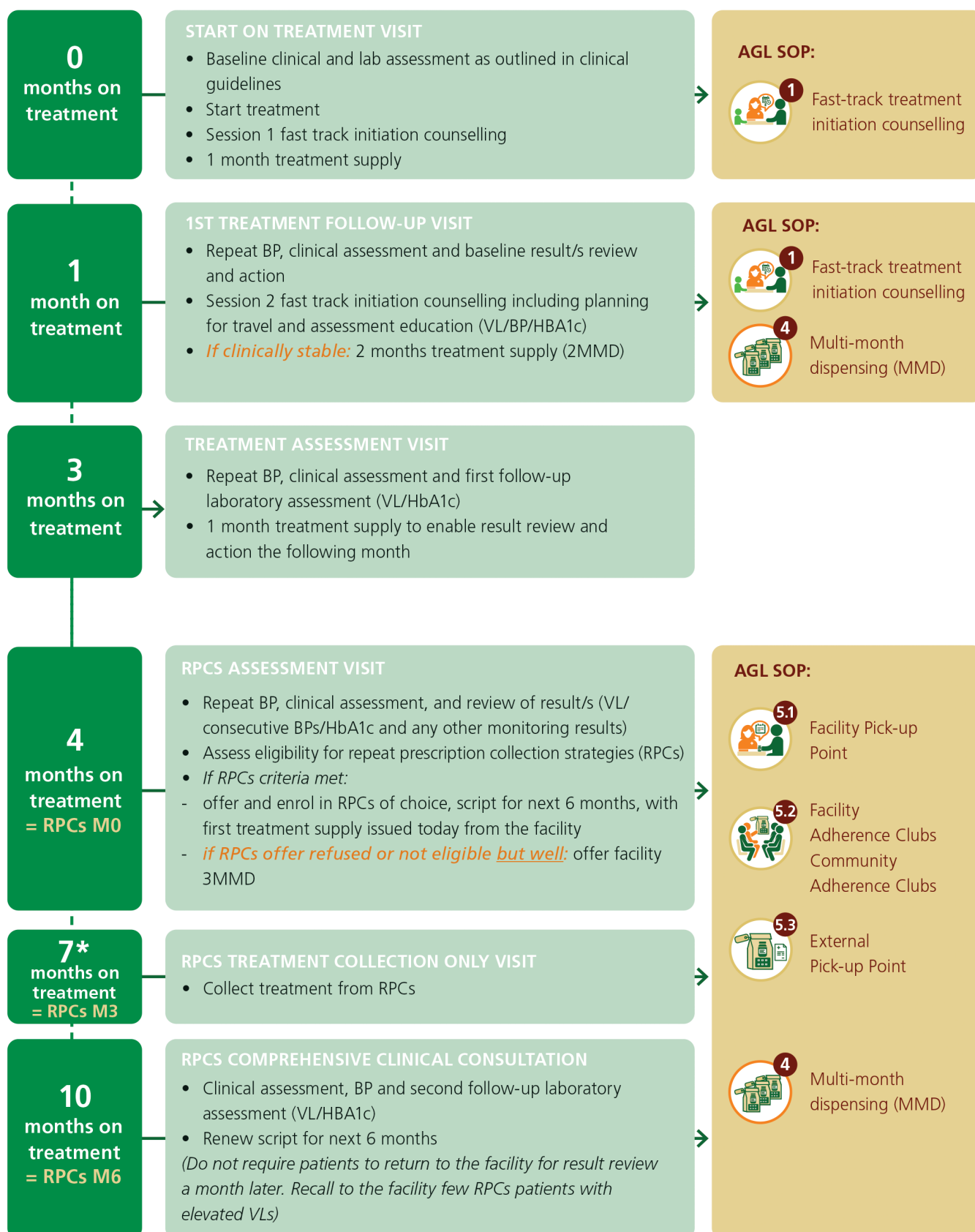


ANNEX IV

FIRST YEAR VISIT SCHEDULE FOR CLINICALLY STABLE CLIENTS

**MONTH (M) =
dispensing cycle**

For chronic care patients clinically stable at early follow-up and meeting RPCs criteria at clinical review with first treatment assessment result (VL, HbA1c or 2 consecutive BPs)



Year 1 starting chronic treatment: 5 facility visits and 1 RPCs visit = 6 visits

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