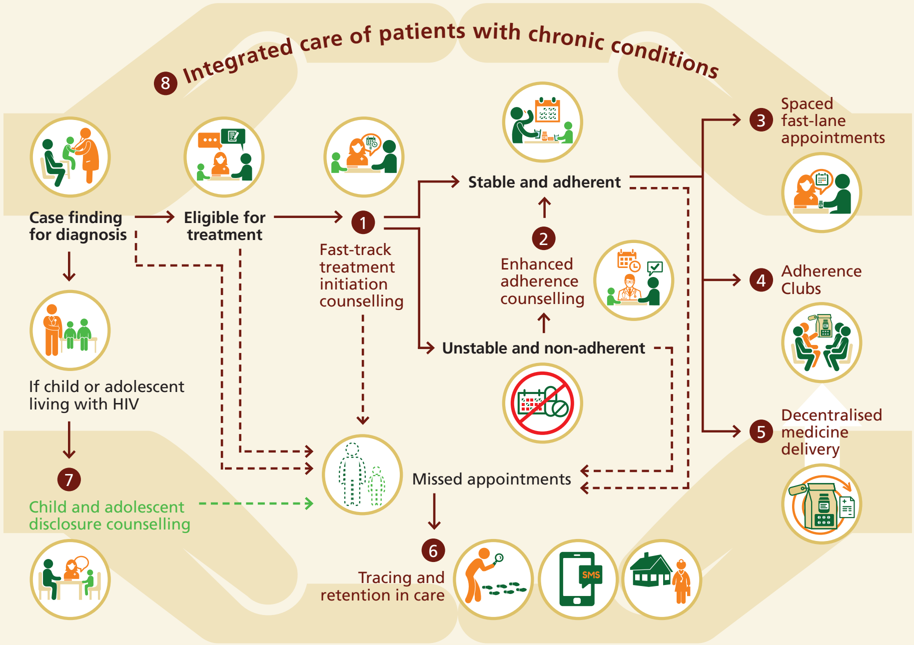
STANDARD OPERATING PROCEDURES

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



8 Integrated care of patients with chronic conditions

Case finding for diagnosis

Eligible for treatment

1 Fast-track treatment initiation counselling

Stable and adherent

2 Enhanced adherence counselling

Unstable and non-adherent

3 Spaced fast-lane appointments

4 Adherence Clubs

5 Decentralised medicine delivery

If child or adolescent living with HIV

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health

Department:
Health
REPUBLIC OF SOUTH AFRICA

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FOREWORD

The Standard Operating Procedures (SOPs) for minimum package of interventions to support linkage, adherence and retention in care included in this booklet support implementation of the 'Adherence Guidelines for Chronic Diseases (HIV, TB and NCDs)'. The aim of the SOPs is to enable the delivery of effective care to clients within the healthcare system in a sequential manner.

The 'minimum package' includes:

- Standardised, updated education and counselling approach for:
  - Fast track initiation counselling
  - Enhanced adherence counselling for unstable patients
  - Child and adolescent disclosure counselling
- Repeat Prescription Collection strategies for stable patients based on context:
  - Spaced and fast lane appointment system
  - Adherence clubs
  - Decentralised medication delivery
- Patient tracing and retention in care system for early tracing of all missed appointments.
- Integrated care of patients with chronic conditions.

This booklet is produced in pocket format so that health care workers and non-clinicians can refer to it as and when they need to, to ensure all necessary procedures and steps are followed to encourage linkage to care, adherence to treatment and retention in care of patients with chronic conditions.

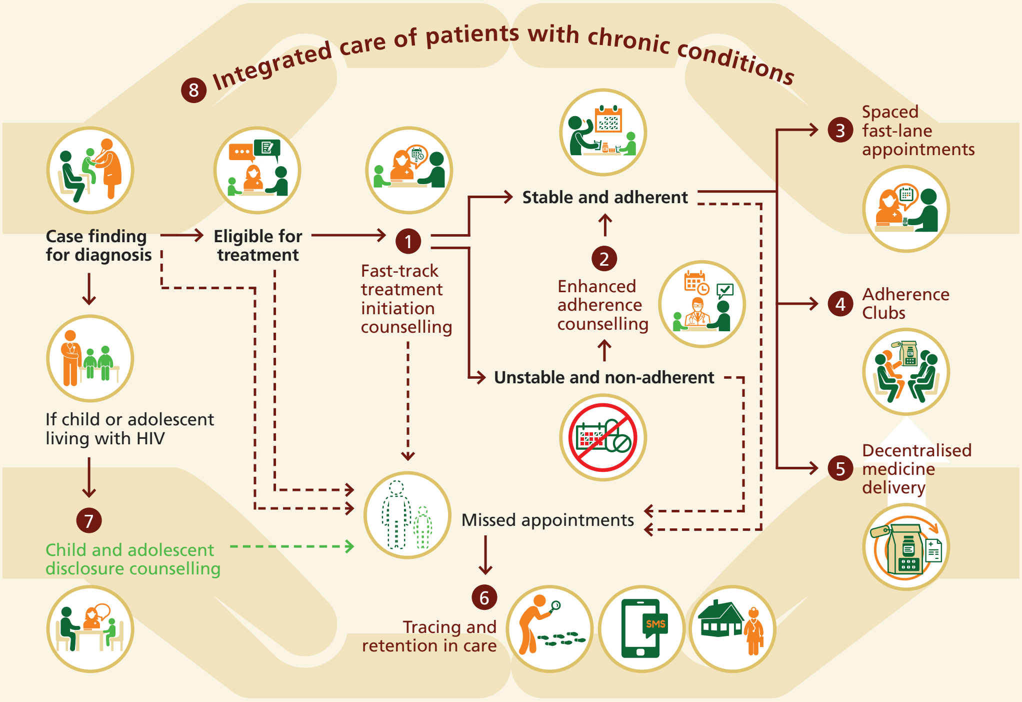
The SOPs booklet should be used in conjunction with the Adherence Education flip file, adherence pamphlet, participant guide and Adherence Guidelines for HIV, TB, NCDs as reference.

Support from the facility managers, supporting NGOs and partners to implement the SOPs effectively will enable the National Department of Health to realise the vision of a "better life for all" in South Africa.

The use of this booklet is recommended to inform your practice and make a positive contribution to ensure effective client care and a strong, supportive, adherent and healthy community.

Ms M P MATSOSO
DIRECTOR-GENERAL FOR HEALTH

MINIMUM PACKAGE OF INTERVENTIONS TO SUPPORT LINKAGE TO CARE, ADHERENCE TO TREATMENT AND RETENTION IN CARE



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ACKNOWLEDGEMENTS

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

Development of this standard operating procedures booklet was co-ordinated by Ms M Phokojoe, Director, Care and Support, National Department of Health.

FAST TRACK INITIATION COUNSELLING (FTIC 1)

TITLE: Standard Operating Procedure for Fast Tracking Initiation Counselling (FTIC)

INSTITUTION: National Department of Health

REFERENCE NUMBER: AGL: FTIC (1)

EFFECTIVE DATE: OCTOBER 2015

PURPOSE

The purpose of this document is to outline the process for health care workers and non-clinicians to provide standardised education, counselling and support to patient on adherence without delaying treatment initiation and to assist the patient to develop their own adherence plan.

PERSONS AFFECTED

- Patient
- Health care worker
- Non-clinicians (could include lay counsellors, community health workers, home based carers, nursing assistants or equivalent)

APPLICABLE POLICY REFERENCE

- Adherence Strategy and Guidelines for HIV,TB, NCDs
  - Minimum package interventions to support linkage, adherence and retention in care.

ABBREVIATIONS

- **AGL:** Adherence Guidelines for HIV, TB, NCDs
- **BMI:** Body Mass Index
- **BP:** Blood Pressure
- **CHW:** Community Health Worker
- **CBO:** Community Based Organisation
- **EPI:** Expanded Program for Immunisations
- **FBO:** Faith Based Organisation
- **FPG:** Fasting Plasma Glucose
- **FTIC:** Fast Track Initiation Counselling
- **HbA1c:** Haemoglobin Adult type 1c
- **HCT:** HIV Testing and Counselling
- **IEC:** Information Education and Communication
- **MDR:** Multiple Drug Resistance
- **PCR:** Polymerase Chain Reaction
- **PMTCT:** Prevention of Mother to Child Transmission
- **SRQ 20:** Self-Reporting Questionnaire 20
- **WBOT:** Ward-based outreach team
- **XDR:** Extensively Drug Resistance

CRITERIA FOR FAST TRACK INITIATION COUNSELLING

The criteria for Fast Track Initiation Counselling is as follows:

- Newly diagnosed HIV, TB, Hypertension and Diabetes patients eligible for ART including patients initiated on ART on the same visit.
- Adolescents from 12 year old after the HIV disclosure process.
- Caregivers of children with HIV, TB or NCDs under 12 years.
- Patients co-infected with TB who need to be initiated on ART shortly after TB treatment.
- Pregnant women initiated on ART on the same day after HIV Counselling and Testing.
- Mental health patients who need to be initiated on ART, TB and other chronic diseases.
- Hypertension and Diabetes patients who need treatment initiation.

Newly diagnosed HIV, Hypertension and Diabetes patients can benefit from Ist session even if they are not yet eligible or ready for treatment.

GUIDING PRINCIPLES

This SOP is designed to help health care workers and non-clinicians to:

- Provide pre- and post-initiation support to newly diagnosed patients with particular focus on adherence support.
- Speed up treatment initiation without compromising adherence.
- Provid education and support to the patient without delaying initiation on treatment.
- Standardised education and counselling approach using the Adherence education flip file for HIV, TB Hypertension and Diabetes.
- Problem solving around the most common barriers to adherence including the need for support, alcohol and substance use issues and clearing misperceptions.
- Assist the patient to develop an individualised adherence plan and set clear treatment milestones.
- Referral and comprehensive support for pregnant or lactating women on any chronic treatment such as ART or HIV/TB, TB/diabetes co-infected patients or hypertensive patients.

It is important to note that:

Session 1: Day of linkage to care applies to all patients regardless of their eligibility to treatment: specifically:

- **Steps 1- 4** applies to all patients who are newly diagnosed and linked to care even if they are not eligible for ART.
- in HIV: patients referred from HCT or wellness clinic who are not yet eligible for ART.
- **Steps 1-12** applies to all patients who are eligible for treatment.

ROLES AND RESPONSIBILITIES FOR FAST TRACK INITIATION COUNSELLING

Clinician's role	Non-clinician's role	Patient's role:
a) Screen and provide treatment based on clinical guidelines. b) Screen for mental health and substance use disorders. c) Emphasise importance of treatment continuation. d) Emphasise the importance of maintaining a healthy lifestyle. e) Invite the patient to express side effects or other concerns and support with treatment, if appropriate. f) Provide next appointment as recommended per guidelines. g) Inform the patient about tracing and retention in care system.	a) Education on illness, treatment, adherence, side effects and risk of non-adherence. b) Creation of an adherence plan. c) Continuation of the adherence plan at every visit to: • Identify a support system • Create a medication schedule • Deal with missed doses • Identify reminders • Identify where to store medication • Deal with side effects • Know what to do in case travelling • Take medication in case of substance or alcohol use • Educate on the future steps on treatment such as VL, sputum, or HbA1c. d) Set goals with the patient as recommended per condition guidelines. e) Inform the patient about tracing and retention in care system.	a) Understand the importance of starting and continuing to take treatment. b) Identify a support system. c) Take the decision to start treatment. d) Voice concerns and ask questions. e) Agree on goals and care plan with health care worker. f) Elaborate an adherence plan with the counsellor to identify the best time to take treatment, reminders and place to store medication. g) Understand need to adhere in case of alcohol or substance use problems. h) Return for appointments i) Take treatment to reach goals. j) Understand tracing and retention in care system.

PROCEDURE

BEFORE EVERY SESSION

a) **Ensure you have all the tools you need:**
  - Facility register
  - Patient Adherence Plan sheet
  - Adherence education flip file
  - Adherence treatment pamphlet
  - Mental assessment tool: to check the emotional state of all patients, not necessarily for mentally ill patients
  - List of supporting organisations such as CBOs or FBOs to assist with referral to psychosocial support
  - Pen

b) **Take a minute to be ready to receive the next person with a warm welcome and open approach.**

DURING EACH SESSION

- The attitude of the official providing counseling is extremely important in supporting adherence.
- Each counseling session should start with an introduction.
- The counsellor or health care worker providing counseling should use their counselling skills to build trust with the patient and ensure that the patient is comfortable.
- Create a warm environment and promote patient's openness by informing them about their right to confidentiality.
- Show your appreciation to the patient for attending scheduled appointment at facility.
- Assist the patient to fill in patient adherence plan sheet.
- Ask questions to help understand the patient's situation and make time to listen carefully to their answer and discuss misunderstandings with regard to treatment.
- Encourage and provide time for the patient to ask questions and discuss their concerns.
- Discuss immediate concerns and help patient decide who in their social network may be available to provide immediate support.
- Make an active referral for a specific time and date to community structures for psychosocial and other care and support services.
- Provide additional referrals for prevention, counselling support and other services as appropriate such as mental health user services, family planning, ANC, dietician or TB screening.
- Record the information about the adherence plan in the patient file.

AT THE END OF THE VISIT

- Encouraging messages explaining the next steps on treatment should be given at the end of the session.
- Discuss any further questions or concerns that the patient may have.
- Schedule follow up visit, including confirming time and date to ensure that the patient is available.
- Write the date of the follow-up visit in the patient's diary or appointment card and in the facility appointment register.
- Encourage patient to adhere to treatment and return to facility as scheduled.
- Inform the patient that they will be traced if they miss appointments and obtain consent for patient to be visited at home or to be called on a cell phone number, if necessary: reassure the patient of your support.
- Provide IEC materials with the patient after making sure that the patient understands information in IEC material in their language.
- Provide helpline numbers and facility number for patient to contact facility if necessary.
- Update facility register or records.

FAST TRACK INITIATION COUNSELLING SESSIONS

There are four sessions, mainly:

Session 1: Day of linkage to care – provide education on the health condition and start an adherence plan

Session 2: Day of initiation – continue with the adherence plan

Session 3: First refill: 1 month of treatment – finalise the last steps of adherence plan

Session 4: Second refill: 2 months on treatment – Education and goals

It is important to note that not all patients will follow the steps sequentially.

SESSION 1:DAY OF LINKAGE TO CARE

START AN ADHERENCE PLAN

Explain the purpose of your session:

- Acknowledge that as facility staff you are there to support patients in this process.
- Explain that the first step of the adherence plan is to receive education on illness and treatment.
- Explain to patients that you will assist them by discussing together any barriers they or those close to them may have and to assist them in creating an individualised adherence plan to help them take their treatment correctly.

STEP 1: Education on illness and treatment: individual or group

- Provide standardised education on illness and treatment for patient's condition using the Adherence education flip file.
- Be open and alert to any personal difficulties and struggles with aspects of the information.
- Ask questions to assess understanding

STEP 2: Identify life goals

Explain the reason for discussing life goals:

- Ask patient to think about things that make them want to stay healthy and to live fully.
- Ask them to think about the important people in their lives, what projects or goals they have in the future.
- Ask them to think about 3 things such as things they really want that others may not even know about. It may be goals common to many of us for example, getting married, going to school or work or taking care of my family.

STEP 3: Identify Support system

Assist the patient to identify support system by asking the following questions:

- Who could support you in taking your treatment?
- Do you have access to other support structures such as church, school and friends?
- How important do you think it is to disclose your health status?
- Would you be willing to have a WBOT, CHW, and HBCarer visiting you at home or to be contacted by phone?
- Who will help you to keep track of your next appointment?

For mothers with new born babies or toddlers or children ask: If you are not able to bring your child to the facility, who will you allow to give consent for any medical investigations which may be necessary?

STEP 4: Plan for future appointments

Assist the patient to plan for future appointments by asking the following questions:

- How will you travel to your appointments?
- What will you do if something prevents you from coming to your appointment such as no money for transport, raining when you usually walk, taxi strike or a sick child or any other reason?

STEP 5: Assess the readiness of the patient to start treatment

Ask the patient the following questions to assess readiness:

- Do you feel ready to start treatment as soon as possible?
- If patient answer no, stay supportive and explore the reasons by probing.
- Assist the patient to find ways of addressing barriers to start treatment.
- Refer the patient for psychosocial intervention, if stigma, disclosure or family challenges exist.
- Invite patient to express beliefs or concerns that may interfere with the initiation of their treatment.
- Provide patient with information that will help them correct the misconceptions or myths about treatment.
- Be willing to acknowledge common barriers that other patients have experienced to make the space safe and avoid judgements.
- For patients who are reluctant to start treatment, propose for them to meet a peer from a support group or a peer educator to talk things over and to hear about their experience on treatment.
- Repeat the life goals with the patient and encourage and motivate them by making reference where possible to positive motivating role models.
- Positive role models will help them realise that starting treatment will be the way to achieve their goals.
- Encourage them to choose a moment to think about the goals every day if they can, for example when waking up or waiting for transport.

If the patient is eligible and feels ready to start treatment, congratulate them and offer further support.

SESSION 2: DAY OF INITIATION

CONTINUE THE ADHERENCE PLAN

STEP 6: Medication schedule

Ask the patient the following:

- According to your schedule, what would be the best time for you to take your treatment?

STEP 7: Managing missed dose

- Ask the patient the following:
  - What will you do in case you forget to take a dose?
- **Advise patient to take the treatment as soon as they remember** unless if a doctor or nurse advised patient not to take treatment immediately.

STEP 8: Adherence reminder strategies

a. Ask the patient the following:
   - What reminder strategy will you have in place to avoid forgetting treatment?

b. Advise on setting watch, cellphone alarm, using pill box or ask someone to remind them to take treatment.

STEP 9: Storing medication and extra medication doses

Ask the patient the following:

- Who might you worry about if they see you taking treatment? Offer possibilities such as maybe your children or a neighbor. Invite them to share why this is so?
- What safe place could you identify to store your treatment?
- In case you do not have access to your treatment at the time you are supposed to take it, how can you always carry 1 or 2 doses with you?

STEP 10: Dealing with side effects

a) Remind the patient side effects can occur and are a normal part of adjusting to treatment

b) Ask patient:
   - Do you know about possible side effects
   - What will you do if you are experiencing side effects?
   - Who can you contact for advice?

c) Reassure and support patient to make a plan explaining that:
   - Side effects such as dizziness, vomiting, nausea, headache or diarrhea can happen when starting treatment.
   - Most side effects go away after a few weeks.
   - If you vomit up to one hour after taking the medication, take your treatment again.
   - Severe side effects are rare.
   - If you do not feel well, it is important that you do not stop your treatment and come to the nearest facility to be able to get some support.

SESSION 3: FIRST REFILL 1 MONTH ON TREATMENT

THE LAST STEPS OF THE ADHERENCE PLAN

- Assess how the first weeks on treatment were and if the patient managed to apply the adherence steps agreed upon last time.
- Encourage and motivate.

STEP 11: Plan for travels

a) Ask the patient the following:

- Do you plan to travel in the coming weeks or months?
- What would you do to make sure you can continue your treatment if you go away?
- What could you do in case you have an unplanned trip and cannot come to the facility?

b) Inform patients that:

- Things can happen suddenly but try and remember that the best approach would be to come to the facility before travelling to inform on how long or where you are going, to receive a referral letter and enough supply of treatment.
- If the trip is not planned and you cannot come to the facility, it is important to go to the nearest facility in the travel area as soon as you arrive to make sure you can access treatment there. It is important you carry evidence of your condition and evidence of the treatment you are taking.

STEP 12: Dealing with substance use

a) **Explain that:** Ideally, it is better to moderate alcohol or substance consumption when you are on treatment especially TB treatment, Hypertension and Diabetes. But if you have difficulties limiting your consumption to 1 or 2 drinks, it is still important to make sure that you do not forget to take your treatment.

b) **Ask the patient:** In case a patient is going to drink alcohol or use drugs, what could the patient do to make sure treatment is taken as advised by the clinician?

c) **Support** the patient to make a plan by assessing if someone could make sure they take their medication in case they use drugs or alcohol or if they should rather take it at another time when they are less likely to forget.

d) If the patient is planning to use alcohol or drug, it might be sometimes more appropriate to take treatment before so it decreases the risk to forget to take it.

e) If the patients recognise that they have a substance abuse disorder, propose to be referred to a specific support structure:refer to list of supporting organisations such as CBOs or FBOs to assisit with referral to psychosocial support. Bear in mind that passing judgement is not helpful. It is important to adopt a supportive attitude.

f) **Encourage** patients to think about their 3 reasons to stay healthy starting from the first session to re-motivate them when they experience difficulty in taking their treatment.

SESSION 4: SECOND REFILL 2 MONTHS ON TREATMENT

EDUCATION AND GOALS

Provide explanation or information on the further tests that will be performed:

a) For HIV:

- To know if your treatment is working, a viral load test will be done. This measures the amount of HIV virus in your blood. It is taken after 6 months on treatment, then at 12 months of treatment, then annually thereafter, unless viral load is more than 400 copies/mL.
- Explain the possible results and their meaning , explain to the patient what undetectable viral load vs high viral load mean, in terms of the amount of HIV detectable in the blood.
- Agree on a goal with the patient to have viral load below 400 copies/mL(adults) and 50 copies/mL(children).
- Explain the importance of EPI schedule and return date for the child immunisation and PCR for PMTCT patients.

b) For TB:

- Treatment will be for 6 months in drug sensitive TB.
- Treatment for patients with MDR, XDR and extra pulmonary TB is offered for more than 6 months.
- During the Initial phase, medicine will be taken for 2 months.
- Explain that a sputum test will be done at 7 weeks and another one will be done at 23 weeks during treatment.
- Explain the results of the sputum test and their meaning.
- Continuation phase is when medicine is taken for 4 months after the initial phase.
- Explain the importance of continuing and adhering to treatment till completing course of treatment.
- Advise TB patients on how to prevent infecting other people by opening windows and covering mouth when coughing.
- Agree on a goal with the patient to complete the TB treatment and being cured.

c) For Hypertension and Diabetes

- Treatment is for life.
- Maintaining a healthy lifestyle is part of the treatment.
- Explain the importance of routine tests and procedures such as blood glucose level, urine samples, BMI, BP, foot examination or eye examination.
- Explain the importance of continuing and adhering to treatment.
- Explain the link between chronic non-communicable and chronic communicable diseases for example TB and Diabetes.
- Agree on a goal with the patient to have Blood Pressure less than 140/90 or keeping the blood glucose within FPG 4-7 mmol/L.

ADAPTATIONS

- This fast track initiation counselling SOP can be adapted depending on the type of illness.
- The content of the educational session will vary depending on the condition affecting the patient.

SPECIFIC ADDITIONAL STEPS

Specific additional steps should be added for certain conditions:

- For all chronic illnesses, it is recommended to add a healthy lifestyle plan supporting the patient to:
  1) Adopt healthy eating habits;
  2) Get regular exercise;
  3) Cut down smoking; and
  4) Manage stress.

For PMTCT:

- Steps should be added to support the pregnant and breastfeeding women to make a plan to:
  1) Deliver at the facility;
  2) Choose a feeding option;
  3) Give the treatment to the baby and
  4) Bring the baby for PCR and rapid test.
  5) Identify and give a caregiver permission to consent for further medical investigations which may be necessary for the child.

For CHILDREN:

- For children who know their HIV status, the model can be adapted to their understanding.
- For children under 12 years, the education and the session will be facilitated with the caregiver.
  - Children who have not been disclosed should not be present during the sessions.
  - The goal for ART treatment in children is to have VL below 50 copies/mL.
- In addition, explain the importance of EPI schedule and return date for the child immunisation.
- Steps should be taken to support the caregiver to plan:
  1) EPI visits.
  2) Support the child and give treatment appropriately.
  3) Follow up ART visits linked to EPI visits.
  4) Follow up ART visits linked to Caregiver ART follow-up visits.

MENTAL HEALTH ASSESSMENT

- Patients should be assessed for mental health using the Mental Health Assessment tool in Annexure II.

TRACING AND RETENTION IN CARE

If patients do not arrive at facility for scheduled appointment within 14 days from their appointment date:

- Contact patients by offering them a reminder call or sms to return to the facility for scheduled appointments.
- If unsuccessful, facility is expected to initiate patient tracing using Ward Based Outreach Teams, Community health workers, Home Based Carers or other suitable means.
- Patients who arrive within 14 days of their scheduled appointment date should be assessed and referred as necessary.
- When patient returns to facility after tracing, patient should be actively referred for psychosocial support to either a Social worker, Psychologist, Peer support or Support group for adults and for both child and caregiver as applicable.
- For further details on tracing refer to Tracing and Retention in Care SOP.

SOP AUTHORISED BY

Date	Initials & surname	Designation	Signature

Annexures:

I. Patient Adherence Plan
II. Mental Health Assessment tool

ENHANCED ADHERENCE COUNSELLING (EAC)

TITLE: **Standard Operating Procedure for Enhanced Adherence Counselling (EAC)**

INSTITUTION: **National Department of Health**

REFERENCE NUMBER: **AGL: EAC (2)**

EFFECTIVE DATE: **OCTOBER 2015**

PURPOSE

The purpose of this document is to outline the process for health care workers and non-clinicians to enhance adherence monitoring and targeted interventions for unstable patients and refer them for support as soon as possible.

PERSONS AFFECTED

- Patient
- Health care worker
- Non-clinicians (could include experienced lay counsellors, community health workers, nursing assistants or equivalent)

APPLICABLE POLICY REFERENCE

- Adherence Strategy and Guidelines for HIV, TB, NCDs
  - Minimum package interventions to support linkage, adherence and retention in care.

ABBREVIATIONS

- **AGL:** Adherence Guidelines for HIV, TB, NCDs
- **CBOs:** Community Based Organisations
- **EAC:** Enhanced Adherence Counselling for Unstable Patients
- **FBO:** Faith Based Organisation
- **FPG:** Fasting Plasma Glucose
- **HbA1c:** Haemoglobin Adult type 1c
- **HBC:** Home Based Care
- **HCW:** Health Care Worker
- **IEC:** Information, Education and Communication
- **SRQ 20:** Self-Reporting Questionnaire 20
- **WBOT:** Ward-based outreach team

CRITERIA FOR ENHANCED ADHERENCE COUNSELLING (EAC)

The criteria for Enhanced Adherence Counselling is as follows:

- **HIV:** Patients with viral load more than 400 copies/mL on ART or children with VL below 50copies/mL.
- **Hypertension:** Patients with persistent high blood pressure on treatment more than 140/90.
- **Diabetes:** Patients with blood sugar level on treatment not within FPG 4.0-7.0 mmol/L
- **TB**: Patients with positive smear on treatment for 2 months.
- Patients with adherence problems to prescribed chronic medication.

GUIDING PRINCIPLES

This SOP is designed to help health care workers and non-clinicians to:

- Prioritise patients with less than optimal outcomes: The facility shall establish a system to identify all files of unstable patients. The EAC identification system can consist of coloured stickers or note on the file or in pulling out the files in a separate folder. A EAC identified file should trigger referral for EAC as soon as the patient comes back to the facility.
- Provide information to patients on their latest facility assessment outcome.
- Assess and address barriers to adherence and discuss effective strategies to overcome barriers to adherence.
- Assist patients to set new objectives according to the next treatment steps.
- Provide additional, individual support in case of switching to another regimen or treatment.
- Refer patients for appropriate additional care and support services.
- Where possible, the facility manager shall identify non-clinicians such as lay counsellors with experience in counselling unstable patients on adherence issues.

ROLES AND RESPONSIBILITIES

Clinician's role	Non-clinician's role	Patient's role
• Screen patients as recommended in the clinical guidelines to monitor adherence to treatment. • Explain abnormal result to the patient. • Careful review of patient's adherence history. • Assess and manage side effects swiftly. • Screen and provide treatment based on clinical guidelines. • Consider switching to alternate regimen as per treatment guidelines. • Emphasise importance of treatment continuation. • Ensure communication between facilities when the patient is referred to another facility.	• Education on abnormal result and common cause for treatment failure. • Assess and address barriers to adherence. • Assess misconceptions and beliefs about treatment. • Support patient to elaborate strategies to overcome barriers such as taking treatment even if drinking alcohol. • Set new goals for next test or appointment such as having VL less than 400 copies/mL, blood pressure less than 140/90, blood glucose within FPG 4-7mmol/L or negative sputum. • Encourage adherence to influence next result.	• Express barriers to adherence and potential reason for treatment failure. • Review and adapt adherence plan with non-clinician. • Set new objectives. • Adhere to treatment. • Come for the next appointment and inform the staff of any changes of contact number or address or if travelling.

PROCEDURE

BEFORE EVERY SESSION

Ensure you have all the tools you need:

- Facility register
- Patient Adherence Plan sheet
- Adherence treatment pamphlet
- List of supporting organisations such as CBOs and FBOs to assist with psychosocial support.
- Pen

DURING EACH SESSION

- Build rapport with patient: Introduce yourself, ensure patient is comfortable and explain confidentiality.
- Show your appreciation to the patient for coming back to facility.
- Confirm contact details for patient tracing and cover issues of shared confidentiality.
- Give the patient time to consider the abnormal results and help patient cope with emotions arising.
- Encourage and provide time for the patient to ask questions and discuss their concerns.
- Discuss immediate concerns and help patient decide who in their social network may be available to provide immediate support.
- Make an active referral for a specific time and date to community structures for psycho-social and other care and support.
- Provide additional referrals for prevention, counselling, support and other services as appropriate such as mental health user services, family planning, ANC, dietician and TB screening.

AT THE END OF THE VISIT

- Discuss any further questions or concerns that the patient may have.
- Schedule follow up visit, including confirming time and date to ensure that the patient is available.
- Write the date of the follow-up visit in patient’s diary or appointment card.
- Inform the patient that they shall be traced if they miss appointments and obtain consent for patient to be to be traced through phone or home visit.
- Leave IEC materials with the patient after making sure that the patient understands information in IEC material in their language.
- Provide hope and encouragement to the patient.
- Update facility register.

ENHANCED ADHERENCE COUNSELLING

There are two sessions:
1) **Session 1:** Initial enhanced adherence counselling for unstable patients.
2) **Session 2:** Enhanced adherence counselling for persistent unstable patients.

SESSION 1 (Initial enhanced adherence counselling for unstable patients)

1. Explain the purpose of your session
   - Determine the reason for abnormal results.
   - Discuss the new treatment regimen if a switch in regimen is required.
   - Assess and address the barriers to adherence and to discuss effective strategies to overcome barriers to adherence.
   - Update or develop an adherence plan with the patient.
2. Education on the result
   - Assess patient for mental health using the Mental Health Assessment tool in Annexure II.
   - Find out what advise on taking treatment the patient has been informed about
   - Find out what the patient knows about the treatment they are taking.
   - Explain in a supportive way that the most common reason for such result is a problem in taking medication correctly.
3. Flexibility on treatment
   - Clear any myths and misconceptions around taking treatment and explain that there is some flexibility.
   - Emphasise the importance of patients choosing their own suitable time for taking medication as prescribed.
   - Explain what to do with late or missed doses depending on the treatment.
   - Explain what to do in case of alcohol use while on treatment. If patient cannot control their use of alcohol, they should make sure that they take their treatment anyway.
   - Explain to patient that it is better not to use traditional medicines that could interfere with the treatment. If they take traditional medicine, they should make a plan with the clinician to still make sure they take their treatment.
4. Patient's experiences

   Ask: What makes it difficult for you to take the treatment sometimes?
   - Encourage the patient to be honest about personal issues that may affect their adherence and help them to address issues such as discussing about alcohol or other substances intake as they can lead to forgetting medication.
   - Explain that medication should be taken even without food and what they can do if food security is an issue. Inform and assist patient on how to access government support programmes, if necessary.
   - Consider patient's religious and traditional beliefs that may contribute to non-adherence to treatment.

5. Identify strategies to ensure good adherence

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

a) Discuss treatment reminders and adherence options such as:

- Treatment buddy to remind them of taking treatment,
- Setting phone alarm,
- Support by a family member,
- Pill counts,
- Marking a calendar or using a pill box,
- Linking medication to meal times, and
- Modified Direct Observed Therapy such as TB treatment supporter. This is also applicable to children.

Ask: Who could support you to take the treatment everyday?

b) Discuss sources of social support for the client

- Emphasise the importance of support structures in coping and adherence such as family, friends, peer support groups, faith based group and work based support.
- Encourage sharing of feelings and emotions regarding the illness
- Empower the patient in making a plan that is adapted to the barriers expressed. Be aware not to create dependency, but to find their own solutions, with the help of the health care worker or experienced non-clinician.
- Write the plan in the patient adherence plan and file in the patient file.

6. Inform the patient about further facility tests to check adherence and effective treatment as per disease specific guidelines.

SESSION 2

Patients are called for session 2, if they continue to have abnormal results after EAC session 1.

1. Explain the purpose of your session
   - To discuss the importance of adherence.
   - To remind and encourage patient to adhere to treatment.
2. Assessment of education session and reasons for 2nd abnormal result
   - Assess what the patient remembers from the 1st session.
   - Inform the patient of their abnormal results in a supportive way.
   - Ask if patient can explain why results are abnormal.
3. Education on resistance and 2nd line treatment
   - Explain to the patient what resistance means and available 2nd line treatment as appropriate for condition clinical guidelines.
   - Provide explanation on 2nd line treatment and explain that the treatment is very effective if it is taken correctly.

4. Support the patient to make a personalised adherence plan
    - Revise the steps of the adherence plan of the fast track initiation counselling or create one if never done.
    - Support the patient in identifying a peer support system and link them to a HBC, CHW, support group or access to government support programmes where food security is an issue.
    - Support the patient to make a plan in case of substance use and encourage the patient to be linked to a specialised service.
5. Explain the way forward:
    - Emphasise importance of adherence and general wellbeing.
    - Explain lab monitoring, if any laboratory tests shall be taken and when.
    - Explain possible side effects of treatment.
    - Reassure that it is important not to stop treatment and to report as soon as possible to the nearest facility to see the health care worker if it happens.
    - Encourage the patient to share his concerns with someone he trusts.
    - Link the patients with the services available in the community.
6. Assess patient questions and provide encouraging messages to adhere to treatment
    - Give encouraging messages for patients to have a positive outlook on life.
    - Remind the patient of the importance and benefits of adherence.
    - Assure patient that you are available to support them and provide them with information of where else they can access support.
    - Encourage the patient to share psychosocial issues with someone they trusts.

TRACING AND RETENTION IN CARE

If patients do not arrive at facility for scheduled appointment within 5 to 14 days:

- Contact patients through reminder call or sms to return to the facility for scheduled appointment.
- If unsuccessful, facility initiates patient tracing using WBOTs, CHWs, Home Based Carers or other suitable means.
- Patients who arrive within 14 days of their scheduled appointment date shall be assessed and referred as necessary.
- When a patient returns to facility after tracing, patient should be actively referred for psychosocial support to either a Social worker, Psychologist, Peer support or Support group for adults and for both child and caregiver as applicable.
- For further details on tracing refer Tracing and Retention in Care SOP.

SOP AUTHORISED BY			
Date	Initials & surname	Designation	Signature

Annexures:

I. Patient Adherence Plan

II. Mental Health Assessment

RPCS OPTION: SPACED AND FAST LANE APPOINTMENT (SFLA)

TITLE: Standard Operating Procedure for RPCS option: Spaced and Fast Lane Appointment (SFLA)

INSTITUTION: National Department of Health

REFERENCE NUMBER: AGL: SFLA (3) | **EFFECTIVE DATE: OCTOBER 2015**

PURPOSE

The purpose of this document is to outline the process of the RPCS option: Spaced and Fast lane appointment system.

PERSONS AFFECTED

- Patient
- Health care worker
- Pharmacist or pharmacy assistant
- Non-clinicians (could include lay counsellors, CHWs, HBCarers, nursing assistants or equivalent)

APPLICABLE POLICY REFERENCE

- Adherence Strategy and Guidelines for HIV, TB, NCDs
  - Minimum package interventions to support linkage, adherence and retention in care.

ABBREVIATIONS

- **AGL:** Adherence Guidelines for HIV, TB, NCDs
- **FPG:** Fasting Plasma Glucose
- **NCDs:** Non Communicable diseases
- **RPCS:** Repeat Prescription Collection Strategies
- **SFLA:** Spaced and Fast Lane Appointment System Option
- **WBOT:** Ward-based outreach team

CRITERIA FOR REPEAT PRESCRIPTION COLLECTION STRATEGIES OPTIONS

A patient may qualify for Repeat Prescription Collection Strategies (RPCS) option if patient meets the following criteria:

- Adult above 18 years
- On the same treatment regimen for at least 12 months
- Most recent 2 laboratory results normal:
  - Most recent VL taken in past 6 months
  - 2 consecutive viral loads undetectable thus a minimum of 12 months on ART
  - 2 consecutive normal FPG for Diabetes, and
  - 2 consecutive normal BP for Hypertension

- Clinician confirms the patient's eligibility for RPCS option.
- Patient voluntarily opts for the RPCS option.
- No current TB and No medical condition requiring regular clinical consultations.

Mothers or responsible caregivers with a child on ART should not be enrolled to the RPCS option especially if the child medication pick up point is different.

GUIDING PRINCIPLES

- Ensure that patients are registered in the facility list of patients in RPCS option: Spaced and Fast lane appointment system.
- Patients enrolling for SFLA shall be scheduled in a group according to the month that they were initiated on treatment, so that their clinical consultations and lab monitoring can be done at the same time.
- Patient files and pre-packaging of medicines, where possible, must be prepared at least a day before to facilitate the fast lane system.
- There must be a dedicated fast lane pick up point at the pharmacy for each facility with the spaced and fast lane system for a specified period decided by each facility.
- Patients shall be traced if they do not return to pick-up medicine within 5 days from the scheduled SFLA.
- Patients shall be de-registered from the spaced and fast lane option if untraceable after 30 days from missed appointment date and followed up closely at the facility regular care.
- All processes must be documented.

PROCEDURE

If patient complies with criteria for RPCS option, and chooses Spaced and Fast lane appointment system option, the patient shall be informed about Spaced and Fast lane appointment system as follows:

- In the Spaced and Fast lane appointment system, clinically stable and patients meeting RPCS criteria are requested to attend the clinic once a year for clinical assessment and laboratory testing.
- Patients receive 6 months' prescription for their medication.
- When the patients are coming for the 3rd 2 months refill, another prescription should be prepared in advance and handed over to them for the next refill.
- Each time a stable patient visits the facility, the patient should be allowed to collect at least 2 months treatment.
- Patients should be allowed to go through a fast lane system, meaning direct and quick access to the pharmacy.
- In case of health problems or pregnancy, patients must be advised to return to regular care.

TRACING AND RETENTION IN CARE FOR PATIENTS ON RPCS OPTION: SFLA

If patients do not arrive at facility to pick-up medicines within 5 to 14 days of the set collection appointment date:

- Patients are contacted through reminder calls or sms to return to collect medicine
- If unsuccessful, facility initiates patient tracing using Ward-Based Outreach Team, CHWs or Home Based Carers or other suitable means
- Medicines should be issued as soon as they come back to the heath facility and reason for missing the appointment date should be enquired.
- If, after 30 days the patient is not found after tracing, the patient is removed from the RPCS option: Spaced and Fast lane appointment system and followed closely at facility regular care.
- Patients can return to SFLA system if they meet the criteria for RPCS in the future.

For further details on tracing refer SOP to Tracing and Retention in Care SOP.

SOP AUTHORISED BY

Date	Initials and Surname	Designation	Signature

RPCS OPTION:
ADHERENCE CLUB (AC)

TITLE: Standard Operating Procedure for RPCS option: Adherence Club (AC)

INSTITUTION: National Department of Health

REFERENCE NUMBER: AGL: AC (4)	**EFFECTIVE DATE:** OCTOBER 2015

PURPOSE

The purpose of this document is to outline the process for RPCS option: Adherence Club.

PERSONS AFFECTED

- Patient or nominee
- Health care worker, pharmacist and pharmacy assistant
- Non-clinicians (could include lay counsellors, CHWs, HBCarers, nursing assistants or equivalent)
- Data capturer

APPLICABLE POLICY REFERENCE

- Adherence Strategy and Guidelines for HIV, TB, NCDs:
  - Minimum package of interventions to support linkage, adherence and retention in care.

ABBREVIATIONS

- **RPCS:** Repeat Prescription Collection Strategies
- **AGL:** Adherence Guidelines for HIV, TB, NCDs
- **AC:** Adherence Club
- **M:** Month e.g. M6: Month 6
- **PN:** Professional Nurse
- **Club:** refers to adherence club
- **ID:** valid Identity Document
- **FPG:** Fasting Plasma Glucose
- **BP:** Blood pressure
- **HbA1c:** Hemoglobin Adult type 1c

CRITERIA FOR REPEAT PRESCRIPTION COLLECTION STRATEGIES

A patient may qualify to Repeat Prescription Collection Strategies if patient meets the following criteria:

- Adult above 18 years
- On the same treatment regimen for at least 12 months
- Most recent 2 laboratory results normal:
  - Most recent VL taken in past 6 months thus a minimum of 12 months on ART
  - 2 consecutive viral loads undetectable
  - 2 consecutive FPG normal for Diabetes and
  - 2 consecutive BP normal for Hypertension

- Clinician confirms the patient's eligibility for RPCS option.
- Patient voluntarily opts for the RPCS option.
- No current TB and No medical condition requiring regular clinical consultations.

Mothers or responsible caregivers with a child on ART should not be enrolled to the RPCS options especially if the child medication pick up point is different.

GUIDING PRINCIPLES

- **Facility manager** shall nominate a clubs manager and facilitator.
- A clubs facilitator can be a lay counsellor, home based carer, community health worker, peer educator or equivalent.
- Ensure that patients are registered in the facility list of patients in adherence club.
- Patients enrolling for AC shall be scheduled in a group according to the month that they were initiated on treatment, so that their clinical consultations and lab monitoring can be done at the same time.
- Patients are allowed to bring nominee only on medicine collection adherence club visit days.
- Patients that do not return to pick-up medicine at the club shall be traced by the health facilities within 5 days.
- Health facilities can establish heath facility based or community based adherence clubs.
- All processes must be documented.

TEAM, ROLES AND RESPONSIBILITIES

- **Clubs Manager** takes overall responsibility for the activities required to run successful clubs. This manager is a nurse. Duties include: ensuring the Adherence club SOP is being *carried out, clubs team recruitment, assessment and allocation with the assistance of clubs facilitator, scheduling annual return dates for club visits and ensuring 6 monthly prescriptions are being coordinated* and completed by the team.

The clubs manager needs to have a good overview of the club outcomes and is responsible for completing monthly club data for submission to the facility manager.

- **Club Facilitator** is responsible for establishing adherence clubs with the assistance of clubs manager and also responsible for running the club sessions. Their duties include: Collecting pre-packed treatment dispensed from pharmacy, registering members, conducting adherence club sessions, basic symptom screening as necessary, referring patients to Club PN if necessary, issuing pre-packed treatment, completing club registers and following up patients who miss adherence club sessions.

- **Club PN** is responsible for facility oversight of an Adherence Club on the day of the club visit. Duties include: Seeing symptomatic patients referred by the Club Facilitator, drawing lab tests on the annual lab tests visit and clinical consultation of club patients at their annual clinical review.
- **Pharmacist or Pharmacy Assistant** is responsible for pre-dispensing treatment for clubs.
- **Data Capturer** is responsible for capturing the club patient's visit from Adherence Club register into the facility register after an agreed period.

Only the Club Facilitator is always present at each club session. The Adherence Club PN may not be present at the club session but available during and after the session to provide clinical consultations or labs as appropriate.

PROCEDURE

1. If a patient complies with criteria for RPCS option, patient shall be informed about RPCS option: Adherence Club as follows:

- An Adherence Club consists of a group of no more than 30 patients who are judged to be adherent to and stable on treatment
- **Timing:** Club members meet every 2 months as a group. The Club visit lasts approximately 1 to 1.5 hours.
- **Heath facility based Clubs:** Every 2 months, patients meet as a group at facility and are issued with 2 months pre-packed medication in the club venue. Where facility space is limited, community venues close to the facility that do not require additional logistical support can be used. Health facilities can also make use of extended hours by establishing evening Clubs.
- **Community facility based Clubs:** Every 2 months, club sessions are hosted in one of the patient's homes or community venues near their home such as NGO or church. The club facilitator brings their pre-packed treatment to them. They are still patients at the main referral facility but are only required to attend the facility for annual lab tests and clinical consultations.

2. If patient chooses, Adherence Club option, patient shall be requested to complete the adherence club registration form

3. During enrolment, club members shall be issued with a repeat prescription for 6 months

- The prescription used for the facility must be legally compliant
  - When patient is recruited for RPCS adherence club option, the clinician completes a script for the period until the first club visit and for the following 2 months.
  - These scripts are kept in club folder and the pharmacy can either pre-pack for the 1st club visit from these scripts or the patients can go to collect the medication at the pharmacy after first club visit.
  - At first club visit, M0 a prescriptions is completed for 6 months for each patient in the club ensuring supply for M2, M4, and M6.
  - The Clubs Manager must ensure that Club members are issued with a new repeat prescription 6 monthly.
  - It should be clear on the club schedule when 6 monthly repeat prescriptions should be obtained.
  - At M6, each club patient is re-scripted to cover M8, M10, and M12. This also means that scripting coincides with the clinical visit once a year.
  - The Club file shall be taken to the pharmacy at least 3 days prior to the club visit for pre-packing, and then be returned by the facility pharmacy to the Clubs Manager.
  - Pre-packed treatments are to be issued at Club visit.
- It is recommended that the Club PN on duty for the club visit be responsible for obtaining of the new repeat prescriptions that the newly enrolled club member collects the first month's supply at the facility pharmacy after the club visit.
- Provide patient with appointment card indicating repeat dates at the facility or community adherence club.

ANNUAL VISIT SCHEDULE

Visit no.	Type of club visit	Activities	Adherence club visit no.
Month -1		Recruitment	Attend pharmacy
Month 0	Enrolment visit	Scripting	Attend pharmacy; 2 m supply
Month 2	Routine visit		1
Month 4	Lab tests visit	Lab tests taken	2

ANNUAL VISIT SCHEDULE (Cont.)

Visit no.	Type of club visit	Activities	Adherence club visit no.
Month 6	Clinical visit; obtain lab tests results	Clinical consultation and Re-scripting	3
Month 8	Routine visit		1
Month 10	Routine visit		2
Month 12	Re-scripting visit	Re-scripting	3

Cycle repeats from M2.
Patient receives pre-packed medications at routine club visit.

ISSUING OF PRE-PACKED MEDICINES TO PATIENTS AT THE ADHERENCE CLUB

- Check the ID, passport or asylum permit.
- A nominated person collecting medicines on behalf of the patient must produce their own valid ID document, passport or asylum permit.
- Ask the patient or nominee to sign after collecting medicines.
- Enquire whether patient is doing well on current treatment, assess symptoms and refer to PN if needed.
- Notify the facility if the pre-packed medicine has not been picked up by the date that patient or nominee is expected to present for medication collection club visit.

MONITORING AND REPORTING

- Each club has a Club file, which contains a copy of the Club member's prescription and the club register.
- Club register is to be used every visit.
- 5 days after the club visit, relevant information in the Club register must be transferred to the facility treatment register or electronic register by the facility data capturer or clerk.
- Once monthly the Clubs Manager is responsible for providing the monthly club attendance data to the facility manager who shall collate data together with other facility indicators and submit to the district.
- At Facility level: club enrolment, club attendance, return to mainstream care, weight, Viral Load, Blood Pressure and FPG shall be reported.
- At district level: only enrolment, attendance at clubs and returns to mainstream care shall be reported.

TRACING AND RETENTION IN CARE FOR PATIENTS ON RPCS OPTION: ADHERENCE CLUB

Adherence Club attendance requirements and tracing

- Club members may send a buddy to collect medication for them on their Club visit day except:
  - on a date of first attendance at the club
  - on a lab tests day
  - on a clinical consultation day

If the club member did not attend personally on the previous club day, the buddy cannot attend twice in succession on behalf of the patient:

- Where the Club member sends a buddy on the lab test day or the clinical consultation day, the buddy shall be asked to inform the Club member that they need to come to the facility to see the Clubs Manager within 5 working days of the club visit scheduled date:
  - Should the patient not present during this time, they would be classified as a defaulter.
- If a Club member sends a buddy to collect medication, *'buddy' is recorded in the register in the place of the weight*. The buddy is informed that the Club member must attend the next visit.
- Should the Club member present within 5 working days from the club appointment date, after notification, the Clubs manager reviews the case, and where appropriate refers to pharmacy for issuing of treatment. This shall be recorded in the Club register as a visit. If it was a lab test, clinical or scripting visit the Clubs Manager shall ensure that appropriate action is taken for the specific visit.
- However, should a Club member not attend personally or send a buddy to collect medication within 5 working days of the club day, the Club member shall be regarded as a defaulter, and recorded as such in the Club register.
- Defaulting Club members shall be recalled through the contact details recorded in the register.
- Patients shall be shall be de-registered from the adherence club by the facility if untraceable after 30 days since the missed appointment or medication collection date and followed up closely at the facility.

Criteria to return to Mainstream Care

- Club member is classified as defaulter
- Club member screens positive for TB
- Other safety lab test results are significantly abnormal
  - For HIV : Viral load more than 400 copies/mL
  - For Diabetes: HbA1c≥ 6.6%
  - For Hypertension: BP>140/90
- Other indications assessed on individual clinical consultation.

Criteria for return to club

- The clinician shall use his or her discretion to assess patients for possible return to a club after returning to mainstream care and shall communicate this to the club manager. The patient is required to meet the initial criteria for club membership.

RESULTS AND RECALLS

- Clubs Manager is responsible for ensuring that:
  - All Club results such as VL and HbA1c and safety lab tests are reviewed by a clinician.
  - Patients are recalled as indicated by the clinician who reviews results.
  - Results are to be entered into the register, between club dates, before clinical visit club day.
  - Results should be filed in the patients folders before the clinical visit club day
- **Where a Club facilitator becomes aware of a detectable viral load (VL>400 copies/mL), HbA1c more than 6.6% or persistently high BP more than 140/90 entered in the Club register, the Club facilitator should contact the patient to come to the clinic and immediately refer the Club member to the Clubs Manager if the Club member has not been seen by a clinician already.**

SOP AUTHORISED BY

Date	Initials and surname	Designation	Signature

RPCS OPTION: CCMDD

TITLE: Standard Operating Procedure for RPCS option: CCMDD (CCMDD)

INSTITUTION: National Department of Health

REFERENCE NUMBER: AGL: CCMDD (5) | **EFFECTIVE DATE:** OCTOBER 2015

PURPOSE

The purpose of this document is to outline the process for RPCS option: Central Chronic Medicine Dispensing and Distribution (CCMDD) programme

PERSONS AFFECTED

- Patient or nominee
- Health care worker, pharmacist, pharmacy assistant
- Non-clinician (could include lay counsellors, CHWs, HBCarers, nursing assistants or equivalent)
- CCMDD dispensing service provider

APPLICABLE POLICY REFERENCE

- Adherence Strategy and Guidelines for HIV, TB, NCDs
  - Minimum package of interventions to support adherence and retention in care.
- SOP for capturing CCMDD patients on Tier.net

ABBREVIATIONS

- **AGL:** Adherence Guidelines for HIV, TB, NCDs
- **CCMDD** dispensing service provider:- such as pharmacies providing dispensing and distribution services
- **CCMDD:** Central Chronic Medicine Dispensing and Distribution programme
- **FPG:** Fasting Plasma Glucose
- **NCDs:** Non-Communicable Diseases
- **PDoH:** Provincial Department of Health
- **PuP:** Pick-up point
- **RPCS:** Repeat Prescription Collection Strategies
- **WBOT:** Ward-based outreach team

CRITERIA FOR REPEAT PRESCRIPTION COLLECTION STRATEGIES

A patients may qualify for Repeat Prescription Collection Strategies if patient meets the following criteria:

- Adult above 18 years
- On the same treatment regimen for at least 12 months

- Most recent 2 laboratory results normal:
  - Most recent VL taken in past 6 months thus a minimum of 12 months on HAART
  - 2 consecutive viral loads undetectable
  - 2 consecutive FPG normal for Diabetes and
  - 2 consecutive BP normal for Hypertension
- Clinician confirms the patient's eligibility for RPCS option.
- Patient voluntarily opts for the RPCS option.
- No current TB and No medical condition requiring regular clinical consultations.

Mothers or responsible caregivers with a child on ART should not be enrolled to the RPCS options especially if the child medication pick up point is different.

GUIDING PRINCIPLES

- When patients are registering with the CCMDD programme, they must present their valid ID or passport or asylum permit.
- Patients can choose a facility or external based PuP.
- All patients should complete and sign the registration and consent forms to enroll on the CCMDD programme at the facility.
- Patients enrolling for CCMDD shall be scheduled in a group according to the month that they were initiated on treatment, so that their clinical consultations and lab monitoring can be done at the same time.
- Patient should be able to collect 1 to 2 months of treatment through the PuP.
- Patient with side effects or not feeling well can at any time go to the facility for assessment even if they still have repeat prescriptions on the CCMDD database.
- Patients that do not pick up their medicine at the selected PuP shall be traced by the facilities within 2-14 days.
- Patient prescription should be cancelled on the system if the patient is no longer stable, needs active management or requires regimen change.
- All processes must be documented.

PROCEDURE

1. If patient complies with criteria for RPCS options, patient shall be informed about CCMDD programme as follows:

- Stable patients have to come for clinical assessments every 6 months.
- A 6-month repeat prescription is written up for stable patient during the clinical assessment visit.
- If patients choose RPCS option: CCMDD, they shall be requested to complete the registration and consent form and choose a PuP. A patient can also nominate a person to collect the medicine on their behalf by entering the information on the registration form.
- A doctor or nurse assessing the patient shall generate a repeat prescription for 6 months.

PROCEDURE (Cont.)

- A patient collection card with relevant scheduled collection and return dates to the facility shall be issued to patient.
- The patient can receive treatment for up to 2 months through the PuP.
- The patient shall receive their first supply of prescription from the facility and shall be counseled.
- Remaining repeat prescriptions shall be collected from PuP.
- Should a patient not receive a SMS regarding collection of repeat medicine parcel, the patient should still collect their repeat medicine parcel at the PuP on scheduled collection dates.
- The CCMDD service provider shall inform the patient when their medicine parcel has been delivered to the pick-up point for collection.

2. All CCMDD patients must be entered into the TIER.Net system as per the SOP for capturing CCMDD patients on TIER.Net at facility level.

3. All CCMDD patients must be entered into adherence club registers if enrolled in a club

At the external or facility based PuP chosen by patient, the person issuing the medicine parcel to the patient shall:

- Check the identity document, passport, asylum permit or other unique identifier such as facility number as approved by PDoH.
- A nominated person collecting on behalf of the patient must produce their ID or passport or asylum permit.
- Ask the patient or nominated person to sign the delivery manifest.
- Enquire whether patient is doing well on current treatment and request patient to return to their originating health facility if they are not feeling well or perceived unstable.
- Advise patient to log a call with service provider call center should patient have any questions regarding received medication.
- Advise patient on collection of last repeat medicine parcel to return to facility for assessment and new script.

TRACING AND RETENTION IN CARE FOR PATIENTS ON RPCS OPTION: CCMDD

- The PuP shall notify CCMDD service provider of all patients who did not collect their medicines within 2 days after the scheduled pick-up date.

- Patients who failed to collect repeat medicines after 2 days of collection date, will be contacted by the CCMDD service provider via sms or telephone to remind them to pick up their repeat medicine parcels.
- CCMDD service provider shall also notify health facilities of patients who failed to collect prescriptions from external PuPs on scheduled collection date.
- Facilities should activate tracing processes for patients who fail to collect their treatment within 5-14 days.
- PuP shall issue medicine parcels to patients who present within 14 days of their scheduled date of collection
- Patients can be de-activated from the CCMDD programme by facilities if untraceable after 30 days and can continue with CCMDD programme at a later stage if stable and meet RPCS criteria.
- Patient shall be de-registered on the system in case of death, or if the patient is a persistent defaulter on the programme or relocates to other area where CCMDD is not implemented.
- For further details on tracing refer to Tracing and Retention in Care SOP.

SOP AUTHORISED BY

Date	Initials and surname	Designation	Signature

TRACING AND RETENTION IN CARE (TRIC)

TITLE: **Standard Operating Procedure for Tracing and Retention in Care (TRIC)**

INSTITUTION: **National Department of Health**

REFERENCE NUMBER: **AGL: TRIC (6)**

EFFECTIVE DATE: **OCTOBER 2015**

PURPOSE

The purpose of this document is to outline the process of Tracing and Retention in care system recommended for all health care and community facilities in South Africa.

PERSONS AFFECTED

- Patients
- Health care worker
- Non-clinicians (could include lay counsellors, WBOT, CHWs, HBCarers, nursing assistants or equivalent)
- Data capturer or assistant

APPLICABLE POLICY REFERENCE

- Adherence Strategy and Guidelines for HIV,TB, NCDs
  - Minimum package interventions to support linkage, adherence and retention in care
- SOP for capturing CCMDD patients on Tier.net
- SOP for capturing data on Tier.net

ABBREVIATIONS

- **AGL:** Adherence Guidelines for HIV, TB, NCDs
- **ANC:** Antenatal Care
- **CBO:** Community Based Organisation
- **CCMDD:** Central Chronic Medicines Dispensing and Distribution Programme
- **CHW:** Community Health Worker
- **EAC:** Enhanced Adherence Counselling
- **FTIC:** Fast Track Initiation Counselling
- **HBC:** Home Based Care
- **HBCarers:** Home Based Carers linked to facility
- **HCT:** HIV Counselling and Testing
- **I ACT:** Integrated Access to Care and Treatment
- **RPCS:** Repeat Prescription Collection Strategies
- **TRIC:** Tracing and Retention In Care
- **WBOT:** Ward-Based Outreach Team

CRITERIA FOR TRACING AND RETENTION IN CARE

The criteria for Tracing and Retention in care is as follows:

1. **Facility:** Patients who have failed to return to facility for scheduled appointments at the facility are identified through facility data base or appointment register as follows:
   - TB patients who have missed scheduled appointment within 3 days.
   - Pre-treatment patient who have missed active referral to linkage to care services (including wellness clinic) for more than 5 days of set appointment date.
   - HIV, Diabetes and Hypertension:
     - Early missed appointment: refers to patients who did not go back to the facility within 5-14 days from their missed appointment date.
     - Late missed appointment: refers to patients who did not go back to the facility within 30 days from their missed appointment date.
     - Loss to follow-up: refers to patients who did not go back to the facility within 90 days from their missed appointment date.
2. **CCMDD programme:** Patients who have failed to attend CCMDD pick up point within 2 days following the set appointment date
3. **Adherence Club:** Club members who have failed to attend the facility for clinical monitoring, lab tests or medication collection within 5 days following the set Adherence club appointment date:
   - Adherence club member who sends a buddy on the lab day or clinical consultation day, and do not o present to Clubs manager within 5 working days
   - If a Club member sends a buddy twice in a row to collect medication.

GUIDING PRINCIPLES

1. Patients are traced throughout the care cascade at different times depending on the minimum package intervention.
2. Patients are traced through contact by phones, sms, home visits depending on what tracing method they have consented for.
3. The following activities should be integrated into adherence strategies in all facilities to trace and retain patients in care throughout the care cascade:
   - Informing patients about Tracing and Retention in care system.
   - Asking patient's consent to be traced.
   - Making an active referral for a specific time and date.
   - Scheduling a follow up visit, including confirming time and date to ensure that the patient is available.
   - Providing the list of names of patients and the date they are supposed to come for appointment to the referral service at the facility.

- Identifying patients who miss their appointments.
- Tracing of patients who have missed appointments.
- Reintegrating patients to care.
- Providing additional psychosocial support and active referral to integrated care services for patients who return to facility after tracing.
- All tracing and retention in care processes must be documented.

REQUIREMENTS FOR A SUCCESSFUL TRACING AND RETENTION IN CARE SYSTEM

I. PATIENT REGISTRATION AT ENROLLMENT AND FOLLOW-UP APPOINTMENTS

1. **The facility staff, data capturer or non-clinicians should enrol all patients into specific appointment registers during the patient's first visit to the facility.**
2. **If patients test HIV positive, counsellors testing patients should enroll patients into HCT appointment register.**
   - Non-clinicians or official referring patient to wellness clinic should actively refer patients by contacting referring site and provide the list of patients who are supposed to link to care to ensure is they are linked to the facility.
   - Patient should be actively referred from Pre-ART to wellness clinic to ensure the patient knows where the facility is and what date and time the appointment is.
3. **If patient comes for a follow-up visit: Check facility appointment register to confirm that patient is expected on that day.**
   a) If patient comes on the day, they were expected:
      - Congratulate patient for coming
      - Find date in appointment register and document that they came on time, then proceed with item 4 as below.
   b) If patient comes earlier than expected:
      - Congratulate patient for coming
      - Determine why patient came earlier than expected
      - Find date in appointment register on which they were expected and indicate that patient came early, then proceed with 4.
   c) If patient comes later than expected:
      - Congratulate patient for coming
      - Find date in appointment register on which they are expected and indicate that they came late
      - Determine why patient came later than expected and explore solutions with the patient to minimise recurrence then proceed with 4.

REQUIREMENTS FOR A SUCCESSFUL TRACING AND RETENTION IN CARE SYSTEM (Cont.)

4. Updating of patient's contact details

a) Update patient's and treatment supporter's contacts at every visit in the patient's file and relevant registers as follows:

- Full name of the patient and the name of the patient's treatment supporter or buddy.
- Telephone number of the patient: call the patient at this point to ensure that the number is functional.
- Alternative phone number such as the number of a relative or a treatment supporter: call the relative or treatment supporter at this point to ensure that the number is functional.
- Detailed address: house number and street name should be obtained where possible. Alternatively, detailed descriptions with well-known landmarks should be obtained for patients who do not have street address or those living in rural areas.
- For school going children, ensure that the patient details include the name of the school the child is attending. (Refer to Paediatric clinical stationary).

b) All healthcare workers or non-clinicians consulting with patients should ask for the address and contact number of the patient and reassess at each consultation if there are any changes regarding these.

c) Provide patient and treatment supporter with the facility's contact number to be used should they have need to contact the facility for information or assistance.

2. INTRODUCING PATIENT TO TRACING AND RETENTION IN CARE SYSTEM

The patient's consent should be sought by all HCWs or non-clinicians attending to the patient to allow tracing and agree on the best way to trace them such as through home visits, by phone or SMS if necessary;

- If patient agrees to be traced through home visits, a patient should be informed that someone, other than a facility staff will come to visit them if they disengage from care
- The person conducting home visits may be from a WBOTs, HBC or adherence club or CBO.
- Caregivers should be made aware that contact with the child's school are made in order to effectively trace the child. Caregivers should also be informed that this process is supported by School health teams.

3. SCHEDULING APPOINTMENTS FOR THE NEXT VISIT

If the patient is not yet enrolled to care, agree with the patient on the most appropriate facility and date to link to care. The appointment information related to patients not yet in care should be shared with the receiving facility identified with the patient.

For the patients already enrolled into care, after counselling the patient and dispensing the medication, the dispensing health worker or non-clinician must schedule the patient for their next appointment in agreement with the patient and fill out the next appointment date on the patient file, patient appointment card and on the corresponding relevant facility register.

It is recommended that caregivers on ART who also have children on ART should have their facility clinic visits scheduled on the same day and in the same service as their children.

The purpose of providing an appointment date to patients is to ensure that:

- Patients agree on the appointment date and are available or provide alternative return date.
- Patients not yet linked to care are supported to identify a convenient place to link to care.
- Patients in care know when they have to come back to the facility.

4. DOCUMENTING PATIENT'S APPOINTMENT IN FACILITY APPOINTMENT REGISTER

The healthcare worker or non-clinician or designated official will:

- Fill out the patient's name, patient's ID, passport or asylum permit number and mark the corresponding age, gender disaggregation with an "x" and enter the date reported for appointment on the **correct** appointment date page of the facility appointment register.

5. KEEPING FACILITY APPOINTMENT REGISTER UP TO DATE

- The data capturer or designated official will ensure that the facility appointment register is up to date by liaising with the health care worker or non-clinician in completing the 'over by one 5 days' column on the page of the facility appointment register corresponding to the facility day 5 days earlier.
- The data capturer or designated official will also liaise with the club facilitator and CCMDD service provider to capture patients who did not attend the club or CCMDD service point.

PROCEDURE

MATERIALS AND SUPPLIES

For a successful tracing and retention in care system, all health care and community care facilities should have the following:

- Facility appointment register or note book.
- Treatment registers such as ART, TB or PHC register as relevant.
- Patient contact tracing register adapted to facility stationary.
- Telephone or Mobile phone if available.

I. IDENTIFICATION OF PATIENTS TO BE TRACED

Specifically, patients to be traced are identified as follows:

a) **Facility:** The designated official such as a health care worker, lay counsellors , WBOT team leader, HCT mentor, HBCarer or other designated official reviews the facility register during the week to check patients who did not attend their appointment on the set appointment date
   - If a patient has not attended the facility within 5 working days to follow-up on pre-treatment scheduled appointment, collection of medications, clinical review or labs, the patient is classified as a defaulter and registered as such in the facility register to be traced.

b) **CCMDD:** Pick-up-point notifies the CCMDD service provider if patients fail to collect the package 2 days after the scheduled pick-up date, which will trigger a patient tracing process.

c) **Adherence Club:**
   - At the end of each club session the Club Facilitator checks register for names of those who:
     - did not either attend personally or send a buddy to collect medication, or
     - have sent a buddy on a lab day, or on a clinical consultation day, or
     - have sent a buddy twice in succession
   - If club members identified in the club register as above, do not arrive within 5 working days, the club facilitator includes the patient in the tracing list and informs the club manager.

d) If patients present
   - within 5 working days from the Club appointment date,
   - at a facility within 14 working days since the appointment date,
   - at CCMDD pick-up point within 5 working days since pick up day,

Depending on where the patient presents as above, clubs manager, health care worker, pharmacist or official dispensing medication respectively, the respective official will review the case to enquire:

- the reason for missing the facility, Club, CCMDD PuP appointment,
- if patient is doing well on current treatment,
- if there are any medication side effects or
- if there are any adherence barriers, and
- This is registered in the facility register, Club register or CCMDD register as a visit and patients should still be considered as being registered in the specific programme.

This is registered in the facility register, Club register or CCMDD register as a visit.

e) If patient on the RPCS option was scheduled for a lab, clinical or scripting visit the health care worker or clubs manager will ensure that appropriate action is taken for the specific visit and refer patient back to RPCS option such as SFLA, adherence club or CCMDD.

2. GENERATING DEFAULTERS' LIST

The facility manager should ensure that there is a functional appointment system in place whereby all folders for patients who are coming the following day are pulled out the day before. Folders of patients who did not attend should be kept aside for further action. A list of all patients who missed their appointments at facility, CCMDD service point, or adherence club should be generated every week and the list should be handed over to the facility manager for sign off.

a) **Paper based sites:** Every Friday, the designated official or data capturer will refer to the facility appointment register page corresponding to the facility visits to generate a defaulter list.

b) **Electronic based sites:** Data capturer or admin clerk can also generate defaulters list through facility database e.g.Tier.Net. (Refer to the Tier.net SOP)
   - The data capturer will include list of patients from the clubs or CCMDD service into the list, if not yet captured on database.
   - The data capturer will also use TB files and PHC files to compile defaulter list.

3. INITIATING TRACING

The list of patients who missed their appointments referred to as defaulters list is signed off by the facility manager and transferred to the person responsible for tracing patient such as WBOT lead, CHW or HBC linked to the facility as appropriate.

- If possible, a tracing and retention in care meeting is conducted to present the defaulters list.

3. INITIATING TRACING (Cont.)

- The meeting is attended by data capturer, relevant facility personnel, WBOT lead, HBCarers, tracers team such as in TB and or referral committee where available.
- Minutes of these meetings should be kept for management purposes.
- Patients are traced as soon as the defaulter list is signed off by facility manager.
- The facility manager or delegated official will delegate an individual to contact patients by phone.

4. TRACING OF PATIENTS BY PHONE OR SMS

- The delegated nominee will then extract the contact information most particularly addresses and telephone numbers of the defaulter and their treatment supporter/ buddy (in case they have one) from the patient's file or club register.
- The defaulter and treatment supporter/buddy's contact information is transferred into the facility tracing register adapted to facility clinical stationary.
- The facility telephone is used to contact patients.
- The delegated official will make telephone calls to all defaulters added to the facility tracing register that week.
- For each tracing effort, the facility tracing register should be marked, indicating the date the tracing was done and the tracing outcome, whether successful or unsuccessful and when the patient will return to the facility.
- First attempt is when the patient is first contacted. The names of patients whose telephone numbers cannot be reached after 3 attempts within 14 days since scheduled appointment date should be transferred to the list of those to be traced through outreach and home visit. Patient consent for home visits should be verified in patient's file.

5. TRACING OF PATIENTS THROUGH OUTREACH TO COMMUNITIES AND HOMES

a) After 3 unsuccessful attempts to contact patients by phone or sms, WBOT, CHWs, HBCarers linked to facilities are involved to trace patients when they cannot be reached by phone or do not come back to the facility within 2 weeks.

b) Patients who have telephone numbers, but the numbers could not be reached should also be included in the list of defaulters to be traced by the WBOT, CHW or HBCarers, if available in the facility.

c) If a home visit is conducted, details from the home visits including outcomes of the visit should be reported back to the Facility Manager.

  - For each outreach tracing effort, the facility tracing register should be marked, indicating the date the tracing was done and the tracing outcome, whether successful or unsuccessful and when the patient will return to the facility.

The following outreach services can be used to trace patients in the communities and homes:

a) Contact tracing through WBOTs and CHWs
  - The consent form should be reviewed to ensure patient consented for home visit through WBOTs and CHWs if patient disengages from care.

b) Contact tracing through HBCarers
  - Where facilities are linked to Home Based Care or Community based organisations, HBCarers will be engaged to trace patients.

c) Contact tracing through adherence club facilitator
  - Patients who miss appointments in adherence clubs, are traced by the club facilitator though telephone, sms or home visits as appropriate. (Refer to RPCS Adherence Club SOP).

d) Contact tracing through TB tracing teams
  - If available, TB tracing teams can also be engaged to trace TB patients in the communities.

e) Contact tracing of children through School health teams
  - In order to effectively trace children, children who miss scheduled appointments are traced through the support of School health teams.
  - WBOTs or CHWs may collaborate with the school health workers to trace children during school health visits.

6. TRACING OF PATIENTS NOT SEEN FOR 90 DAYS AND WITH NO STATUS UPDATE ON TREATMENT REGISTER

a) Registered treatment patients who have not reported to the treatment service point or treatment delivery service point for 90 days since their last visit and not known whether the patient has died, was transferred out or stopped treatment for documented medical or social reasons after 90 days of intensive contact tracing should be registered as: Loss to follow-up. (Ref SOP for capturing data on Tier.net).

b) Before this entry is made, one more attempt at phoning and or visiting patient should be made by the WBOTs, CHWs, HBCarers and outreach services.

7. RE-INTEGRATING PATIENTS INTO CARE

a) For each successful contact tracing attempt, where the patient agrees to continue treatment, the WBOT, CHW, HBCarer will inform the patient to report back to the facility. On return to the facility, the patient will be referred immediately to the non-clinician for additional support, exploring solutions to patient adherence barriers and actively referred to appropriate support services, as required.

7. RE-INTEGRATING PATIENTS INTO CARE (Cont.)

b) For patients who return after tracing, the health care worker, non-clinician or data capturer will enter the day the patient returns in the facility tracing register stating the date for missed refill or appointment and mark R to indicate 'return' in the date of return column.

c) A patient who agrees to return to care, should be supported through other additional psychosocial support and adherence interventions supporting peer support and education such as Wellness clinic, I ACT, support groups, youth clubs, buddy systems, mhealth, child disclosure and ANC.

d) All patients' clinical management should follow integrated care of patients with chronic conditions including prevention and screening, mental health screening, treatment of opportunistic infections, lifestyle modification, nutrition counselling and intensified psychosocial counselling and active referral to supportive services as appropriate.

8. REPORTS TO INFORM PROVINCE AND DISTRICT IMPLEMENTATION TEAMS

Some of the reports to be generated at facility level to inform province and district management on Tracing and Retention in Care (TRIC) implementation could include reports tracking defaulters such as:

a) Reports tracking defaulters:
- Report on patients supposed to link into care (appointment book/list)
    - Early Missed Appointment List.
    - Late Missed Appointment List.
- Loss to follow-up list.
- Report on tracing activities (number of patient traced and outcomes).
- Transfer Out Reports.

b) Reports that help with patient management:
- Sputum conversion report
- Viral Load report

SOP AUTHORISED BY

Date	Initials and Surname	Designation	Signature

CHILD AND ADOLESCENT DISCLOSURE COUNSELLING (CADC)

TITLE: **Standard Operating Procedure for Child and Adolescent Disclosure Counselling (CADC)**

INSTITUTION: **National Department of Health**

REFERENCE NUMBER: **AGL: CADC (7)** | **EFFECTIVE DATE:** **OCTOBER 2015**

PURPOSE

The purpose of this document is to outline the process for incremental and standardised approach to HIV disclosure counselling in children and adolescents.

PERSONS AFFECTED

- Caregiver
- Child and adolescent patients
- Health care workers
- School health nurse or team member
- Non-clinicians (could include laycounsellors, CHWs, HBCarers, nursing assistants or equivalent)

APPLICABLE POLICY REFERENCE

- Adherence Strategy and Guidelines for HIV, TB, NCDs
  - Minimum package interventions to support linkage, adherence and retention in care.

ABBREVIATIONS

- **AGL:** Adherence Guidelines for HIV, TB, NCDs
- **CADC:** Child and Adolescent Disclosure Counselling
- **IEC:** Information, Education and Communication
- **NCD:** Non Communicable Diseases
- **WBOT:** Ward-based outreach team

CRITERIA FOR DISCLOSURE IN CHILDREN AND ADOLECENTS

- Caregivers and all children from 3 years old should start being prepared for partial disclosure. Disclosure criteria is as follows:
  - Non-Disclosure (under 2 yrs.)
  - Partial Disclosure (3 – 9 yrs.)
  - Full disclosure (from 10 yrs.)

- It is important that disclosure follows a planned process and to understand that there are levels of disclosure over time.
- The process of disclosure is progressive and ongoing as new information or deeper levels of information are shared with the child.

GUIDING PRINCIPLES

- The health care worker or counsellor prepares and supports the caregiver to disclose to the child.
- Ensure that the caregiver is the primary caregiver who lives with the child.
- Be respectful of the child's needs and feelings.
- Be led by the child in terms of the amount of information they requires.
- Use age-appropriate language in line with education and emotional readiness.
- Use images or drawings to help children understand the explanations during child disclosure counselling sessions.
- Anticipate possible responses by the child and plan for the future.
- Be honest. If you do not know the answer to the child's questions, say so.
- Anticipate the impact of the disclosure on other family members, friends, the school and the community and plan for this.

ROLES AND RESPONSIBILITIES FOR CHILD AND ADOLESCENT DISCLOSURE

- **Clinician's role:** Assess and support the caregiver and child as recommended by the disclosure guidelines toolkit and refer to multidisciplinary team as necessary.
- **Counsellor's role:** Support caregiver and child with the process of disclosure as recommended and refers to other psychosocial services as necessary.
- **Patient's role:** Caregiver supported by the counsellor discloses and supports the child.

PROCEDURE

BEFORE EVERY SESSION

Ensure you have all the tools you need:

- Disclosure talk tool kit
- Disclosure assessment tool
- Disclosure plan
- Disclosure record
- Disclosure IEC material
- Patient's file or paediatric stationary
- Pen

DURING EACH SESSION

- Prepare a conducive environment to conduct a disclosure session and maintain privacy.
- Build rapport with caregiver and child by introducing yourself and ensure the child is comfortable.
- Listen and respond.
- Allow the child to express emotions.
- Discuss immediate concerns and help caregiver and child decide who in their social network may be available to provide immediate support.
- Provide information on care and support, adherence, treatment and prevention services.
- Document every process in the Disclosure record.
- Document disclosure plan with caregiver.
- Encourage and provide time for the caregiver and child to ask questions.

AT THE END OF THE VISIT

- Ask the caregiver and child if they have any questions or concerns.
- Ensure ongoing assessment of child well being.
- Refer for psychosocial support such as Social worker, Psychologist, Support group for both child and caregiver.
- Schedule a follow up visit, including confirming time and date to make sure that the caregiver and child are available.
- Document sessions on the disclosure records.
- Write the date of the follow-up visit on your facility appointment register.
- Leave IEC materials with the patient after making sure that the patient understands information on IEC material in their language.
- Provide hope and encouragement to caregiver and child.

DISCLOSURE TO CHILDREN AND ADOLESCENT SESSIONS

There are two sessions: Session 1: Partial disclosure and Session 2: Full disclosure

Session 1: Partial disclosure for 3 – 9 year olds

Session 1 consists of part 1: caregiver only and part 2: caregiver and child

PART 1: CONTENT TO BE COVERED WITH THE CAREGIVER AFTER INTRODUCTION

1. Ask what the caregivers has told the child so far about the reason to come to the clinic and or taking medicine.

2. Explain partial disclosure as follows:
    - The disclosure process is like a journey with many stops. At each stop, we will explain a little more to the child. At the end of the journey, when it is the right time for the child, the child will understand HIV and the medicine the child is taking.
    - From 3 years old, partial disclosure is recommended for the child to learn about health, immunity, having a 'sleeping' germ and medicines.
    - HIV will not be named at this stage.
    - Later, when the child is ready, HIV status will be disclosed to the child.
3. Explain the advantages of disclosure as follows:
    - Usually, children who know their status take their medicine better because they understand why they have to go to the clinic and take medicines.
    - Children often know that something is wrong. They may have fears that are worse than the real thing. Hearing about HIV from you rather than anyone else will help the child to accept the situation.
4. Explain the timing for disclosure:
    - Talking with your child about HIV is not going to happen on just one occasion. You can take opportunities to tell them part of the story, for example when they have to go to the clinic or have blood tests. The counsellor can help you with that.
    - It is good to follow the lead of the child. When children ask questions, find ways to respond with adapted explanations for their age without lying. It is recommended to do it progressively from 3 years old and tell them about their HIV status when they are 10 years and above.
5. Assess barriers to disclosure:
    - How do you feel about giving information to the child on their condition today without naming HIV?
    - What are your fears about disclosing child's status one day?
6. Reassure about the benefits of disclosure and propose to give explanations to the child about their health without naming HIV.
7. Repeat Part 1 with caregiver until caregiver is ready to bring the child for Partial disclosure: part 2.

PART 2: CONTENT TO BE FACILITATED WITH THE CHILD AND THE CAREGIVER

1. The visit to the facility or clinic

   Ask the child:

    - Ask what do you do when you come to the clinic?
    - Help the child to talk about clinical check-ups, fetching medicines and having blood test done.

2. The body and the blood system
   - Explain that we all have blood that travels all around inside the body. It circulates through little tubes called the veins. Draw the outline of a body and veins inside.
3. Soldiers inside the blood – the immune system
   - Explain that inside the blood we all have small soldiers that protect us from becoming sick. Draw little soldiers in the blood all around the body. The soldiers fight against different types of germs that try to enter the body and cause diseases. Usually soldiers are strong enough to fight germs that cause diseases. **Refer Annexure 3 image 1 (different types of germs) and image 2 (soldiers inside the body).**
4. A sleeping germ
   - Explain that sometimes a different type of germ enters the body. It is stronger and acts differently. The soldiers of the body are not strong enough to fight against the special germ.This germ cannot be killed by medicine, but it can be put to sleep. That is why we call it the 'sleeping' germ. This germ is a very difficult germ as it kills our soldiers and we will not have enough soldiers to fight off other germs. Then we get sick very easily. **Refer Annexure 3 image, 3 (sleeping germ).**
5. **When the sleeping germ multiplies, the soldiers will not be enough to fight disease anymore.**
   - Explain that the sleeping germs make more and more sleeping germs inside the body. If we do not fight the sleeping germ, the child will get sick and will not feel like playing anymore. If this goes on, the body will become very weak and more germs will enter the body and cause diseases. **Refer Annexure 3, image 3 (sleeping germ).**
6. Treatment to fight the sleeping germ
   - Explain that there is very good news. There is a medicine that contains special warriors. When the child takes this medicine, the warriors enter the child's blood and follows the sleeping germs. These warriors are very, very strong and they fight the sleeping germ and keep it asleep. The sleeping germ cannot be killed by medicine, but it can be put to sleep.
   - When the warriors fight and beat the sleeping germ, it makes the soldiers in the blood happy. They can then multiply and protect our body against other germs that cause diseases. Refer **Annexure 3 image 4** (treatment to fight the sleeping germ).
   - Remind the child that in case they forget to take medication, they should take it as soon as they remember.

7. The importance of taking treatment every day to keep the sleeping germs asleep
   - Explain that to make sure that the sleeping germs stay asleep and keep us well, the child must take their medicines called 'Good Night Medicine' every day around the same time They are called 'good night medicine' because they keep the 'sleeping' germ asleep. It is very important to prevent the sleeping germs from waking up again because they could beat the body soldiers and make the child sick.
8. Explain to the child that they have the sleeping germ and reassure them that they do not need to be afraid because the Good night Medicines are very good at keeping the germ asleep.
9. Repeat Part 2 steps at every visit to make sure the child understands.

SESSION 2: FULL DISCLOSURE from 10 – 12 years old:

From the age of 10, all children living with HIV should be fully disclosed

Session consists of part 1: caregiver only and part 2: caregiver and child

PART 1: CONTENT TO BE FACILITATED WITH THE CAREGIVER AFTER INTRODUCTION OR PRESENTATION

1. Introduction and assessment of readiness for full disclosure: Ask the following questions:
   - How is the child doing since the last session?
   - Did the child ask questions?
   - Did you disclose to the child his or her HIV status?
   - Explain that, if the caregiver has not disclosed and is willing to do so, we can help to talk about the child's HIV status to the child today
   - If the caregivers express reluctance to disclose, let them express their fears. Support them in finding solutions and remind them about the advantages of disclosure.
2. Propose specific help to the caregiver for disclosure:
   - Propose role plays to practice disclosure and discuss how to answer difficult questions.
   - Prepare the caregiver for the emotional response of the child such as crying or shouting
   - It is important for the caregiver to accept the reaction, whatever it is. It is normal for the child to be sad or angry.
   - Recommend the caregiver to be supportive to the child and respect their emotions.
   - Speak with the caregivers about the distinction between telling all and telling what is necessary for the child's understanding.

PART 1: CONTENT TO BE FACILITATED WITH THE CAREGIVER AFTER INTRODUCTION OR PRESENTATION (Cont.)

3. Discuss about the secrecy
    - Using the hand of safety, ask with whom the child could speak about HIV (refer disclosure talk tool).
    - Explain that disclosure inside the family can increase support to the child.
    - It is important that the child feels supported in taking treatment.
    - It is up to the caregiver and the child to decide whom it is good to tell. The caregiver should ensure that the child Is not stigmatised by family members.
4. Assess barriers to disclosure:
    - Ask caregiver: What are your fears about disclosing the status to the child?
5. Reassure about the benefits of disclosure and propose to support the caregivers in disclosing the status to the child.

PART 2: CONTENT TO BE FACILITATED WITH THE CHILD AND THE CAREGIVER: This is conducted after the child has completed session 1 and the caregiver has completed session 1 and session 2: part I; preparedness for caregiver to support child during child full disclosure

1. Assess what the child remembers from the previous session on partial disclosure
   Ask the child:
    - How can the body fight against diseases? [the soldiers of the body fight against diseases]
    - What does the sleeping germ do to the soldiers of the body? [it makes them weak or kills them]
    - What can we do to fight the sleeping germ? [take medicine correctly every day]
    - Can medicines kill the sleeping germ? [no, makes them sleep]

   Complete the child answers explaining the importance of taking medicines every day to keep the sleeping germ asleep and make the soldiers of the body stronger.
2. If the caregiver is ready for it, support disclosure to the child:
   Ask the child:
    - Do you know the name of the sleeping germ that you have in your body?

   Propose that the caregiver tells the child. If it is difficult, support the caregiver to tell the child that the sleeping germ is called HIV.

   NOTE: It is important to note that disclosure is done by the caregiver while the health care worker and non-clinician support the process. The HCW or non-clinician can assist with disclosure in the presence of the caregiver in case the caregiver is unable to disclose to the child.

A child 10 years and older should at least be fully disclosed to at that age through the disclosure stepwise proces.

Ask:

- What do you know about HIV? [Correct misconceptions and reassure]

Let the child talk and ask question and give the child time to absorb the new information.

3. Assess feelings and support
    - Some children may feel sad or angry; others will be shocked when they hear they have HIV.
        - How do you feel about these news?
    - It is normal to experience such feelings and you can express whatever you want.
    - Refer to the Disclosure talk tool on how to assess and express feelings. (*feelings faces*)
4. Ways of transmission
    - HIV can be transmitted when a mother who has HIV is pregnant and transmits the virus to her baby during pregnancy, giving birth or during breastfeeding. HIV can also be transmitted when people have sex without using a condom or by sharing sharp materials that were in contact with HIV infected blood.
        - Do you understand how HIV can be transmitted?
    - Do you know how you got HIV?
    - As you can see there are many ways a person can get infected with HIV; the important thing is that you know you have the virus in your body and you can take your medicine every day, at the same time, as the nurse or doctor told you, so that the HIV stays asleep and does not attack your soldiers and does not make you sick.
    - Some people have wrong ideas about the way HIV is transmitted. It cannot be transmitted by playing, hugging, kissing, sharing forks, glasses or taking a bath with someone who has HIV.
5. Who to tell:
    - Ask the child and the caregiver if there is anyone else that they can share their experiences with and get support from a close family member, a teacher or the nurse.
    - Do the Hand of Safety activity with the child if they have not yet done one. **(Refer to Talk Toolkit)**

PART 2: CONTENT TO BE FACILITATED WITH THE CHILD AND THE CAREGIVER: (Cont.)

6. Encourage adherence to keep HIV asleep in the body
    - Provide pre- and post-initiation support to newly diagnosed patients and or their caregiver with particular focus on adherence support.
    - Identify and address most common barriers to adherence.
    - Assist the child to develop an individualised adherence plan and set clear treatment milestones such as school holidays and visitations.
    - Provide comprehensive support for HIV positive adolescents who are pregnant and breastfeeding on ART or co-infected with TB.

TRACING AND RETENTION IN CARE

- Set regular follow-up dates to assess the child's levels of disclosure every time you see them.
- Propose to the caregiver and child to enrol into a support group.
- Remind them to come for medication and clinical follow-up visits as scheduled.
- Inform the caregiver and child that they will be traced if they do not return on set appointment dates.
- If the caregiver and child do not follow-up on set appointment within 5 to 14 days, the caregiver and child will be contacted through reminder call or SMS.
- If unsuccessful, the health care worker or non-clinician will notify facility manager.
- Patient tracing will be initiated using WBOTs, CHWs, Home Based Carers, School health teams or other suitable means.
- When patient returns to facility after tracing, patient will be actively referred for psychosocial support such as Social worker, Psychologist, Peer support or Support group for both child and caregiver as appropriate.
- For further details on tracing refer to Tracing and Retention in Care SOP.

SOP AUTHORISED BY

Date	Initials and Surname	Designation	Signature

ADDITIONAL ADHERENCE INTERVENTIONS: mHealth WhatsApp ADHERENCE SUPPORT

TITLE: Standard Operating Procedures for mHealth: WhatsApp adherence support

INSTITUTION: National Department of Health

REFERENCE NUMBER:

EFFECTIVE DATE: FEBRUARY 2016

PURPOSE

The purpose of this document is to outline the use of a mHealth tool: WhatsApp adherence support to increase patient's linkage to care, adherence to treatment and retention in care.

PERSONS AFFECTED

- Patient
- Patient nominee
- Non-clinicians (could include lay counsellors, CHWs, HBCarers, nursing assistants or equivalent)
- Health care worker

APPLICABLE POLICY REFERENCE

- Adherence Guidelines for HIV, TB, NCDs
- South Africa mHealth Strategy 2015-2019

ABBREVIATIONS

- **AGL:** Adherence Guidelines for HIV, TB, NCDs
- **App:** Application
- **HCW:** Health Care Worker
- **LTFU:** Lost to follow up
- **NCD:** Non-Communicable Diseases

ELIGIBILITY CRITERIA FOR WHATSAPP ADHERENCE SUPPORT

A patient may qualify for WhatsApp Adherence Support if the patient meets the following criteria:

- Adults aged 18 or above
- Adolescent aged 12-17 with parental or guardian consent
- Diagnosed with HIV, TB, Hypertension or Diabetes.
- Access to a WhatsApp compatible phone (Android, Windows, BlackBerry, iPhone) and

with WhatsApp Messenger app already installed and registered (WhatsApp profile set up).
- Patient voluntarily opts for registering with health facility's WhatsApp adherence support.

GUIDING PRINCIPLES

- The facility manager will nominate a "WhatsApp manager" for the health facility.
- Only patients who meet the criteria for the WhatsApp adherence support should be enrolled in the WhatsApp adherence support.
- Patients aged 12-17 years require a parent or guardian to give written consent for the patient to join the health facility's WhatsApp adherence support.
- Patients registering for the WhatsApp adherence support are informed about WhatsApp messenger not being **designed for confidential medical information, and encouraged to make use of password protection on their phone.**
- Patients joining a WhatsApp adherence support group chat or chatroom will be seen with the name that they registered with when they installed and activated WhatsApp, and this profile will be indicated in their chats. As patients with different conditions are signed up, their disease or treatment status is not revealed through this or through the WhatsApp Group invitation.

TEAM, ROLES AND RESPONSIBILITIES

The following persons can be part of the WhatsApp adherence support team:

WhatsApp Manager: takes overall responsibility for the coordination, oversight and activities required to run the WhatsApp adherence support. Duties include:

1. ensuring all HCWs and non-clinicians are aware of the WhatsApp tool for additional patient support
2. ensuring the SOP is adhered to by all HCWs and non-clinicians using WhatsApp adherence support, including the protection of patients' privacy in the WhatsApp communications (see section 3 of this SOP)
3. offering WhatsApp adherence support to eligible patients who are interested
4. encouraging other HCWs to use WhatsApp for patient support and starting chat rooms
5. helping with queries by HCWs, non-clinicians and patients on use of WhatsApp adherence support
6. supporting monitoring and evaluation activities on WhatsApp adherence support

TEAM, ROLES AND RESPONSIBILITIES (Cont.)

7. appointing or being a group chat administrator to establish chat groups, extend invitations, accept group member invitations or requests, monitor, participate and guide chat activity
8. provide or advise HCWs or non-clinicians of basic chatroom ground rules for use, chatroom etiquette and advise on consequences for inappropriate or offensive chats.

The WhatsApp manager has a good overview of the WhatsApp adherence support use in the facility and can provide the number of patients subscribed and the number of active chatrooms.

HCWs and non-clinicians using WhatsApp adherence support (such as lay counsellors, community health workers, home based carers or equivalent) are responsible for contributing to the reach of the WhatsApp adherence support. Duties include:

1. identifying patients who could benefit from WhatsApp adherence support and linking interested patients to the WhatsApp manager
2. running their own WhatsApp communications with patients and joining or establishing a WhatsApp group, upon agreement from the WhatsApp manager and based on the WhatsApp adherence support SOP
3. monitoring their group chatrooms and advise patients on privacy settings in WhatsApp (section 3).

PROCEDURE

1. IF A PATIENT IS ELIGIBLE FOR THE WHATSAPP ADHERENCE SUPPORT, PATIENT WILL BE ASKED WHETHER THEY ARE INTERESTED IN JOINING.

- WhatsApp adherence support is voluntary.
- If a 12-17 years old patient is interested, parent or guardian's consent is required.

a) WhatsApp adherence support can be used with the following patients:
   - Newly diagnosed patients who require long-term treatment.
   - Patients who are 'stable' on treatment and receiving medication through the Repeat prescription collection strategy options such as spaced and fast-lane appointments, adherence clubs and decentralised medication delivery.

- Patients who struggle to adhere to their long-term treatment.
- Patients who are at risk of missing appointments.

b) Patients can be given information about WhatsApp adherence support during regular clinic visits, at adherence clubs or at any other contact with the health system. Health care workers and non-clinicians can also send out **invites** to patients and invite them to be in touch via WhatsApp adherence support as they may already have mobile phone numbers of patients.

c) Patients sign up **voluntarily** for WhatsApp adherence support and will not need to commit to anything in return, and can opt out at any time.

d) Patients are encouraged to use the WhatsApp adherence support chatrooms to stay connected and to raise any concerns or questions they may have regarding linkage, adherence and retention in care – they can contact the HCWs and non-clinicians individually or share with the group, depending on the issue at hand and whether they are already part of a group chatroom.

2. HEALTH CARE FACILITY STAFF COMMUNICATION TO INDIVIDUAL PATIENTS

It is important for the HCWs and non-clinicians to plan and use standardised messages for WhatsApp adherence support.

WhatsApp adherence support is **not suited for secure communication of medical information** and is not HIPAA (Health Insurance Portability and Accountability Act) compliant. Given this context, messages and information provided need to be as neutral as possible in order to protect privacy and confidentiality of the patient.

- **Call any laboratory tests just "test"** – e.g. never use "CD4", "VL", or "sputum test",
- **Call the medication "medicine" or "pills"** – never use the term "ARVs", "TB drugs", Diabetes medicines or Hypertension medicines.
- **Refer any detailed health queries to health facility visit with HCW.**

Health care workers and non-clinicians and non-clinicians will send out simple messages like 'how are you?' one-to-two times per month (to group or individual) to give patients a feeling that they are being looked after (ask, don't tell approach).

3. GROUP CHATROOMS

a) HCWs and non-clinicians will group patients (establish group for each) by profile, for example:
   - adolescents or adults
   - patients in remote areas with difficult transport or access to clinic
   - stable patients or patients who have had adherence challenges
   - Patients with diabetes, hypertension, TB or HIV patients

   Such grouping will allow more meaningful support as patients will have some issues in common.

b) Create group chartroom names to help distinguish the group chatrooms. Group names should indicate whether it is a youth or adult group, and can indicate whether it is **men or women**.

   Group chatroom names should NOT IDENTIFY the diagnosis of the patients, their treatment types, or whether they are unstable or non-adherent patients.

   Then add/invite patient contacts as they register with you. **Note: Group administrators can invite participation (with contact number). The patient can accept or decline chatrooms or leave the chatroom at any point.**

c) Remind patients signing up to the chatroom that WhatsApp offers **'privacy settings'**. The usual /default setting is "Everybody", which means that others in the chatroom can see their WhatsApp profile which can include address, Facebook links, e-mail addresses and potentially other personal information (see WhatsApp – settings – account – privacy).

   Peer networks (chatrooms) can be encouraged as well, where patients can create their own group and ask questions to their peers without HCWs or non-clinicians involved. To avoid potential harmful actions, the peer WhatsApp adherence support chatroom can be led by an expert patient, who will have an opportunity to check in with WhatsApp manager and and relevant HCWs and non-clinicians regularly.

The peer network can also identify a 'monitor' who is following the communications and checks back with HCWs and non-clinicians if there is an indication for misleading information communicated through the platform.

Generally, all discussions should aim to positively enforce patients, to show **empathy and care** for them and give useful practical advice on linkage to care, adherence to treatment and how to be retained in care.

4. USING WHATSAPP ADHERENCE SUPPORT SPECIFICALLY FOR TRACING AND RETENTION IN CARE

Although WhatsApp adherence support is meant to support patients, it has a potential to be used as a Tracing and Retention in care tool for patients who miss their appointments.

WhatsApp adherence support can be a useful tool to:

- Reach harder-to-reach persons like adolescents, men and dispersed populations
- Provide a direct line to problem patients who struggle with treatment adherence due to personal challenges or life events
- Potentially prevent loss-to-follow-up and increase retention in care for patients.

5. MONITORING AND EVALUATION

In health facilities which are part of the mini roll-out of Adherence Guidelines for HIV,TB and NCDs (AGL)), the implementation and evaluation teams will seek to answer key questions on whether WhatsApp adherence support can be beneficial to treatment adherence for HIV, TB, Diabetes and Hypertension. The following questions will be posed:

- *Who are the patients who are likely to enroll to the WhatsApp adherence support service?*
- *Will WhatsApp adherence support reduce loss to follow-up and increase linkage to care, adherence and retention in care for HIV, TB, Diabetes and Hypertension patients?*
- *What is the experience of the patients in using WhatsApp adherence support to support their adherence and is this a tool that more patients should use?*

In other health facilities, there can be activities of joint review and learning, which include any feedback from patients, be it positive or negative.

SOP AUTHORISED BY			
Date	Initials and surname	Designation	Signature

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ANNEXURE I: PATIENT ADHERENCE PLAN

Name and Surname: ____

It is important to note that not all patients will follow the steps sequentially

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 stress ☐

Adherence Step 3 – Patient support system

Agree for home visit: Yes ☐ No ☐

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 facility 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 ☐ No ☐

I do not feel ready and would like to discuss more with: peer ☐ family member ☐
Community Health Worker ☐

Session 2 (*date*):

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 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 and keep it in: bag ☐ pill box ☐
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 facility if side effects do not go away or are too worrying ☐

Session 3 (*date*):

Adherence Step 11: Planning for trips

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

1) I will go to the nearest health facility in the travel access as soon as I arrive to get access to treatment ☐
2) Carry evidence of my condition and evidence of the treatment I am taking ☐

Adherence Step 12: 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 drug or alcohol
☐ Arrange for someone to remind me to take treatment in case I am intoxicated

Session 4 (*date*):

Education on follow up: Viral load ☐ Sputum ☐ HbA1c ☐
Other: ☐ ______________________

Patient's signature: Date:

TREATMENT GOALS:

- ARV goal: My first Viral Load will be suppressed! And thereafter remain below 400 copies/mL.
- TB goal: I have completed 6 months TB treatment and I am cured of TB.
- Hypertension goal: My Blood Pressure is less than 140/90.
- Diabetes goal: I monitor and keep my blood glucose within (FPG) 4-7 mmol/L.

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ANNEXURE II: MENTAL HEALTH ASSESSMENT

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

Basic screening should assess:

1) What is the patient's appearance?
    - Is he/she clean and looking after him or herself
    - Does the person look worried or sad?
    - Does the person seem agitated?
    - Does he/she seem suspicious, nervous or hostile?

2) Assess the patient's mood, asking:
    - How have you been feeling over the last week?
    - Have you been feeling mostly normal, or sad or happy, or worried?
    - How do you feel today?
    - What are your feelings about the future?

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

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

4) Assess patient's cognition:
    - Does thinking seem slow?
    - Is the person able to concentrate?
    - Does the memory seem impaired?

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

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

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

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

- constantly angry or very worried
- very sad for a very long time
- they are losing interest in things they use to enjoy doing
- they can not cope with work or daily activities
- their mind is controlled (such as by voices) or out of control
- they need to use alcohol or drugs
- Obsessively do things such as repeat washing hands, non-stop sport activity, eating too much, obsessive diet or other obsessive behaviours.
- Hurt themselves or other people or destroy things.
- Do irresponsible things that could harm them or others.
- Having problems sleeping or feeling tired and not having energy.
- Feeling anxious, looking or feeling 'jumpy' or upset, having panic attacks.
- Not wanting to spend time with people; spending too much time in bed.
- Hearing and seeing things that others do not see.
- Other differences in the way the person sees what is happening around them, for example believing that someone is trying to harm you, or laughing at you.

If the patients show signs of intense sadness, risk to harm themselves or others or hear or see things that other do not see they should directly be referred for psychiatric support.

If the patients experience some of the other symptoms, explain to them that they can identify some ways to help them cope with their situation by telling them that it might help to:

- Share your feelings and spend time with other people you trust.
- Get back to daily routine as much as possible (such as work, school, housework).
- Participate in religious or spiritual activities.
- Play sports or get regular exercise.
- Eat regular meals.
- Get adequate rest.
- Take a break and relax.
- Participate in enjoyable activities (such as singing, dancing, reading), even if at the moment it may be hard for you to enjoy them.
- Help other people talk about how they feel, but also respect if they choose not to talk about it.

Recommend that they avoid:

- Using alcohol or drugs to cope with the symptoms
- Withdrawing from family and friends
- Withdrawing from daily activities
- Overworking
- Blaming yourself or others
- Neglecting your health or self-care (such as sleep, hygiene, diet)

Explain that the patient, may need to seek help from a psychiatric nurse, social worker, psychologist or counsellor if they want to talk with someone outside of their family or circle of friends or if their symptoms do not improve with coping strategies.

ANNEXURE III: CHILD AND ADOLESCENT DISCLOSURE COUNSELLING IMAGES

Image 1
Different types of germs

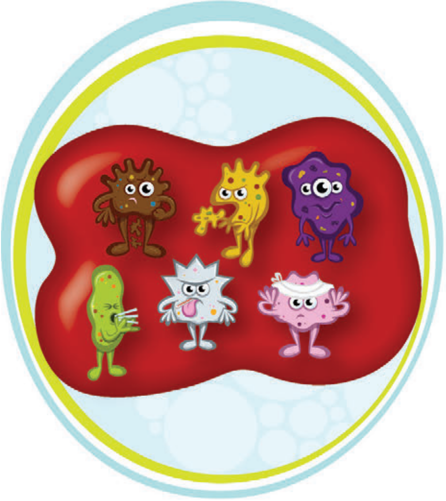

Image 2
Soldiers inside the blood
The immune system

Image 3
The sleeping germ

Image 4
Treatment to fight
the sleeping germ

Disclaimer

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