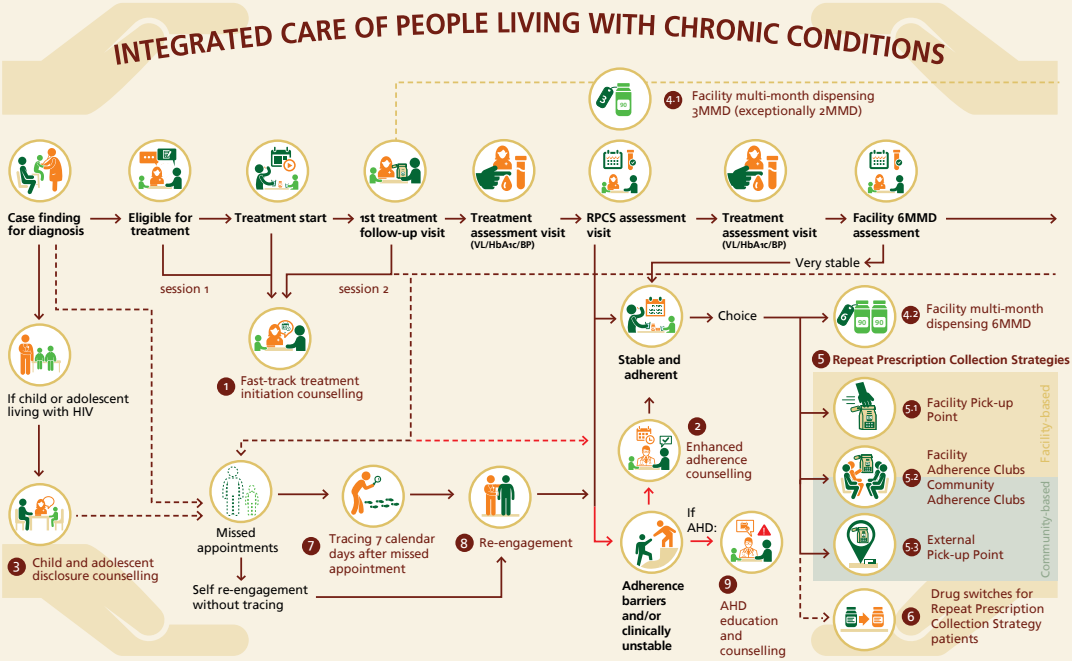
# DIFFERENTIATED MODELS OF CARE STANDARD OPERATING PROCEDURES

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

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## SOPS



## ANNEXURES

# FOREWORD

A differentiated approach to care aims to strengthen linkage, adherence and retention using a patient-centred approach throughout the treatment cascade. This is globally known as Differentiated Service Delivery (DSD) while in South Africa is termed **Differentiated Models of Care (DMOC)**.

The "minimum DMOC package" to be implemented in all facilities in South Africa recognises that based on a patient's specific population (e.g. adolescent), clinical characteristics (e.g. stable or established on ART) and context (e.g. urban), their short and long term adherence and retention will benefit from differentiating service provision into less and more intensive models of care and integrating chronic care.

The 2025 Differentiated Models of Care Standard Operating Procedures (DMOC SOPs) for the **"Minimum DMOC package to support linkage to care, adherence and retention in care"** included in this booklet, have revised the 2023 SOPs to align with the 2025 National consolidated guidelines for the management of HIV in adults, adolescents, children and infants and prevention of vertical transmission and the 2023 Adult Primary Care Guide. The aim of the DMOC SOPs is to enable delivery of effective differentiated care to chronic care patients within the health care system.

The minimum DMOC package is reflected in the continuum of care flow diagram on page 9 and is summarized below.

- **Integrated care for patients with chronic conditions**
- **Standardised education sessions and counselling approach** for i) treatment initiation, ii) patients struggling with adherence (while in care or when re-engaging in care) and iii) supporting child and adolescent disclosure
  - Fast track initiation counselling including adaptation for rapid initiation and post-initiation counselling aligned with treatment supply return date (SOP 1)
  - Enhanced adherence counselling for patients struggling with adherence (SOP 2)
  - Child and adolescent disclosure counselling (SOP 3)
  - Advanced HIV disease education and counselling (SOP 9)
- **Longer treatment supply to reduce patient burden and support continued engagement in care**
  - Multi-month treatment supply by the facility - Facility 3MMD (exceptionally 2MMD) (SOP 4.1)

- **Differentiated models of care for stable patients on chronic treatment**
  - Multi-month treatment supply by the facility - Facility 6MMD (SOP 4.2)
  - Repeat Prescription Collection strategies (RPCs) after the first normal assessment including multi-month dispensing (SOP 5):
    - Facility pick-up point = health facility-based individual RPCs (SOP 5.1)
    - Adherence Club = health facility or community-based group RPCs (SOP 5.2)
    - External pick-up point = out-of-facility individual RPCs (SOP 5.3)

    Treatment to RPCs is pre-dispensed by the Central Chronic Medicine Dispensing and Distribution program (CCMDD) or a Central Dispensing Unit (CDU) or the facility pharmacy. **CCMDD is a centralized treatment pre-dispensing and distribution mechanism which enables all of the RPCs.**
  - Switching to newly endorsed drugs for stable patients utilizing a RPCs (SOP 6)
- **Patient tracing and re-engagement**
  - Tracing and recall missed appointments in order of priority (SOP 7)
  - Re-engagement in care involves assessing clinical condition and time since missed scheduled appointment and differentiating follow-up management including accelerated access to MMD and RPCs (SOP 8)

This booklet is produced in pocket format so that healthcare 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 DMOC SOPs booklet should be used in conjunction with the Adherence Education flip file, adherence pamphlet and integrated treatment literacy toolkit and guide as reference.

Support from the facility managers, supporting NGOs and partners to implement the DMOC 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 our practice and make a positive contribution to ensure effective patient care and a strong, supportive, adherent and healthy community.

**This revision to the DMOC SOPs makes the following important changes:**

1. **Enables a reduction in health facility visits** in the first year on treatment to support continued engagement in care.
2. **Shifts the first treatment assessment** (clinical + VL/ BP/HbA1c) from 6 to 3 months from the start of treatment *(from after 6 to after 3 consecutive dispensing cycles)*.
3. **Shifts the review of the first assessment** results from 7 to 4 months from the start of treatment *(from after 7 to after 4 consecutive dispensing cycles)*.
4. **Facilitates earlier identification** of patients requiring adherence support for action.
5. **Removes time on treatment RPCs eligibility criteria**, enabling access as soon as the treatment assessment result/s are reviewed as normal and other eligibility criteria are met (from 4 months after the start of treatment).
6. **Prioritizes a reduction in total visits once enrolled in RPCs** with a maximum of 2 visits (1 facility +1 RPCs) per scripting cycle.
7. **Guides multi-month dispensing** (MMD) by the facility, including 6MMD for very stable patients.
8. **Revises** the differentiated approach to **patient management on re-engagement.**
9. **Guides education and counselling** support to patients diagnosed with **advanced HIV disease (AHD).**

# ACKNOWLEDGEMENTS

The 2023 revision and 2025 updates of the DMOC SOPs for the minimum DMOC package to support linkage to care, adherence, and retention in care; 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 drafts, and more importantly engaging in robust discussions.

A special thanks to the Differentiated Models of Care Technical Working Group especially Lynne Wilkinson from the International AIDS Society (IAS) for leading the write up and the officials and representatives of the Treatment, Care and Support Directorate for their coordination, technical input and for their involvement and commitment to the SOP revision process. A further thanks to Dr Jeannette Wessels and the HIV Clinical Advisory Technical Working Group who considered the DMOC SOP revisions to ensure integration and alignment with the 2025 National consolidated guidelines for the management of HIV in adults, adolescents, children and infants and prevention of vertical transmission.

The collaboration and involvement of the National and Provincial Departments of Health representatives, support partner organizations, and technical experts have ensured a valuable resource to implement an effective adherence programme. The finalization of the 2025 revised standard operating procedures booklet was co-ordinated by Dr. Musa Manganye, Director HIV/AIDS Treatment, Care & Support and Mrs Gugu Shabangu Chief Director HIV/AIDS & STI Cluster.

# ACRONYMS

| | |
|---|---|
| **2MMD:** | 2-months treatment dispensing |
| **3MMD:** | 3-months treatment dispensing |
| **4MMD:** | 4-months treatment dispensing |
| **6MMD:** | 6-months treatment dispensing |
| **AC:** | Adherence Club |
| **AGL:** | Adherence Guidelines for Chronic Diseases (HIV, TB and NCDs) |
| **AHD:** | Advanced HIV Disease |
| **ANC:** | Antenatal Care |
| **ART:** | Antiretroviral Therapy |
| **BANC:** | Basic Antenatal Care |
| **BMI:** | Body Mass Index |
| **BP:** | Blood pressure |
| **CADC:** | Child and Adolescent Disclosure Counselling |
| **CBO:** | Community Based Organization |
| **CCMDD:** | Central Chronic Medicine Dispensing and Distribution |
| **CDU:** | Central Dispensing Unit |
| **CHW:** | Community Health Worker |
| **DMOC:** | Differentiated Models of Care |
| **EAC:** | Enhanced Adherence Counselling |
| **EPI:** | Expanded Program on Immunization |
| **EX-PUP:** | External Pick-up Point |
| **FAC-PUP:** | Facility Pick-up Point |
| **FBO:** | Faith Based Organization |
| **FP** | Family planning |
| **FTIC:** | Fast Track Initiation Counselling |
| **HbA1c:** | Haemoglobin Adult type 1c |
| **HBC:** | Home Based Care |
| **HIV:** | Human Immunodeficiency Virus |
| **HTS:** | HIV Testing Services |
| **I-ACT:** | Integrated Access to Care and Treatment |
| **IEC:** | Information, Education and Communication |
| **MNCWH:** | Maternal, Newborn, Child and Women's Health |
| **MDR:** | Multi-Drug Resistant |
| **MMD:** | Multi-month dispensing |
| **NCDs:** | Non Communicable Diseases |
| **NGO:** | Non-Governmental Organisation |
| **PCR:** | Polymerase Chain Reaction |

**PDoH:** Provincial Department of Health

**PHC:** Primary Health Care

**PMP:** Patient Medicine Parcel

**PN:** Professional Nurse

**RPCs:** Repeat Prescription Collection Strategies

**SOP:** Standard Operating Procedures

**TB:** Tuberculosis

**TIER.Net:** TB/HIV information system application

**TLD:** Fixed-dose combination: tenofovir (TDF) 300 mg + lamivudine (3TC) 300 mg + DTG 50 mg

**TPT:** TB Preventative Therapy

**VL:** Viral Load

**VTP:** Vertical transmission prevention

**WBPHCOT:** Ward-based Primary Health Care Outreach Team

**XDR:** Extensively Drug Resistant

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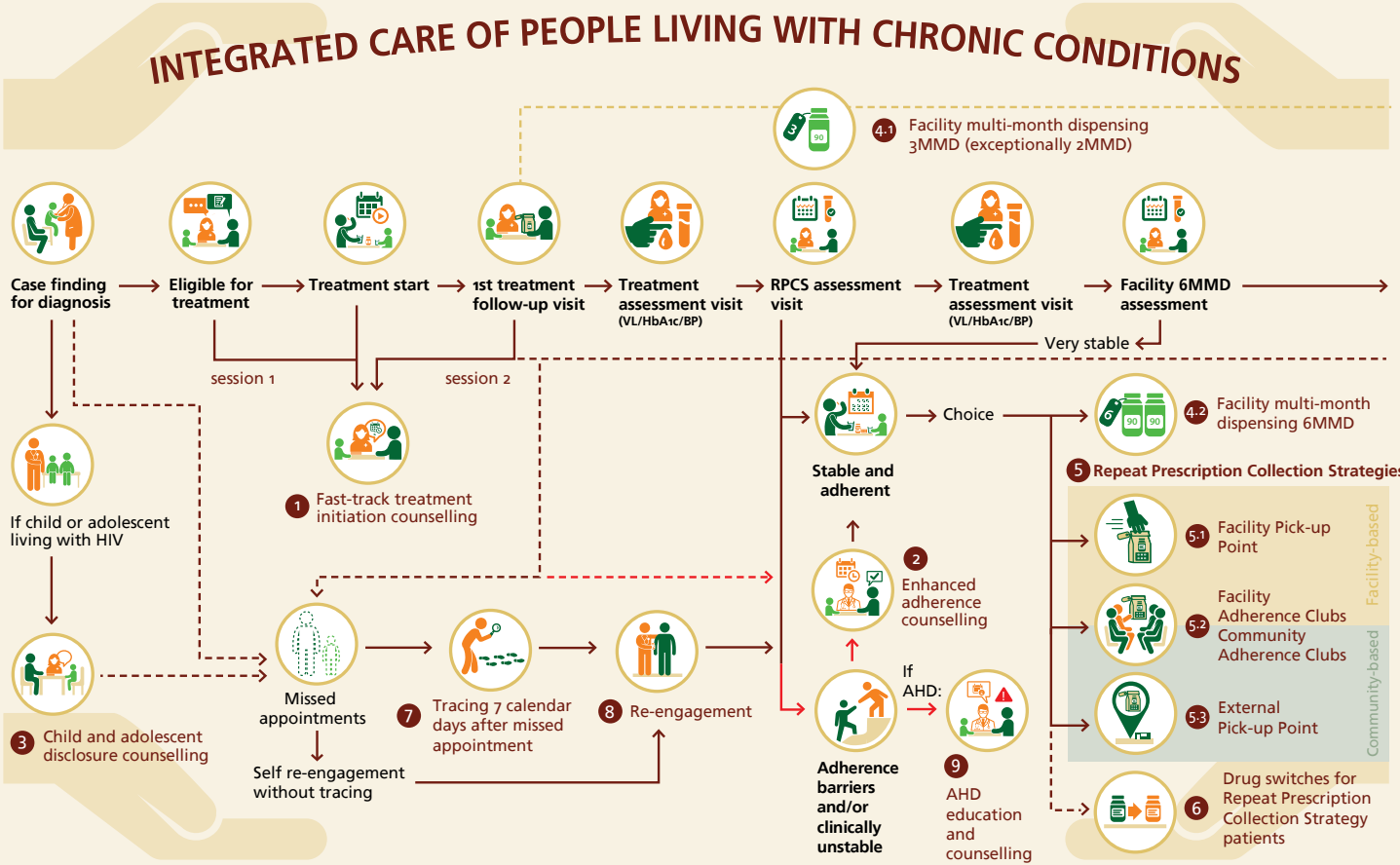

# DMOC DIAGRAM

| DIFFERENTIATED MODELS OF CARE (DMOC) | | | |
|---|---|---|---|
| **Clinically unstable** | **Not yet stable** | **Stable** | **Very stable*** ** |
| Symptomatic acute/sick<br><6 months old<br>Pregnant<br>AHD | New on ART<br>OI on treatment<br>6m to 5yrs old<br>Newly re-engaged<br>Post-natal <12 months<br>Elevated VL | 1 x VL<50 copies/ml<br>1 x HbA1c ≤8%<br>2 x BP <140/90 | 12 months on ART<br>2 x VLs <50 copies/ml<br>2 x HbA1c ≤8%<br>2 x BP <140/90 |
| More intensive service delivery | Standard service delivery | Less-intensive service delivery | |
| Monthly** clinical reviews and script | 3-monthly* clinical reviews<br>+ 3 month script (**3MMS***) | 6-monthly clinical review<br>+ 6 month script (**6MMS**) | |
| Facility **monthly**** dispensing | Facility **3MMD*** | RPCs: EX-PUP, FAC-PUP or AC **3MMD (or 2+4MMD)** | Facility **6MMD***** |

*2-monthly if on TB Rx, new on ART at month 1 visit, at delivery (see 2025 VTP guidelines tables) or necessary to align with required follow-up clinical management in 2 months time.
**Monthly can be adjusted: for pregnant women to integrate into BANC Plus visits; for AHD clients 2-weekly or monthly applies in the first 3 months; thereafter, adjust as clinically indicated for AHD and symptomatic/sick clients (can extend to 2- or 3-monthly; do not increase frequency unless clinically required).
***Limited to ART TLD regimen only until national medicine stock availability is confirmed for other ART regimens and hypertension and diabetic treatment.

# KEY TERMS

**Differentiated models of care (DMOC):** all service delivery models of care that are differentiated either by the patient's clinical characteristics (e.g. suppressed viral load or symptomatic) and/or their population (e.g. child under 5 years old).

**Facility provided service delivery:** the patient is managed at the facility by a clinician who prescribes treatment during clinical review which is dispensed by the clinician or the clinic pharmacy.

**Repeat Prescription Collection strategies (RPCs):** models of care where the patient collects their repeat pre-packed treatment collection (also called treatment refills) from an external pick-up point, facility pick-up point or an adherence club.

**Multi-month scripting (MMS):** Prescriptions of more than one month
- 3MMS = 3-month prescription covering the 3-month period between clinical reviews
- 6MMS = 6-month prescription covering the 6-month period between clinical reviews

**Multi-month dispensing (MMD):** Treatment supply of more than one month dispensed for one collection
- 3MMD = 3-months of treatment supplied for one collection
- 6MMD = 6-months of treatment supplied for one collection

**Standard service delivery:** The default model of care for all clients, provided at a health facility by a clinician, with clinical contacts at the recommended frequency.

**More intensive service delivery:** A model of care with a higher frequency of clinical contacts for clients requiring closer clinical management. This approach is more resource-intensive and less convenient for both clients and the health system but is necessary when increased clinical follow-up is needed.

**Less intensive service delivery:** A model of care with a lower frequency of clinical contacts for clinically stable clients. This approach allows for longer treatment supply either covering the full period between clinical contacts or treatment collection outside of clinical contacts at one-stop pick-up points or support groups at or outside a health facility and from other providers.

# FAST TRACK INITIATION COUNSELLING (FTIC)

## SOP 1

**TITLE: STANDARD OPERATING PROCEDURE FOR FAST TRACK INITIATION COUNSELLING (FTIC)**

**INSTITUTION: NATIONAL DEPARTMENT OF HEALTH**

**REFERENCE NUMBER: AGL: FTIC (1)** | **EFFECTIVE DATE: AUGUST 2025**

## PURPOSE

The purpose of this document is to outline the process for healthcare workers and lay counsellors to provide adherence related education and counselling support to patients without delaying treatment initiation and assist patients to develop their own adherence plan.

## PERSONS AFFECTED

- Patient living with HIV and/or a NCD and/or diagnosed with TB
- Healthcare worker
- Health promoters
- Counsellors (could include social workers, psychologist or lay counselors) and community health workers

## APPLICABLE POLICY REFERENCE

For HIV: 2025 National consolidated guidelines for the management of HIV in adults, adolescents, children and infants and prevention of vertical transmission
For NCDs: 2023 Adult Primary Care Guide
For TB: 2023 National guidelines for the management of TB infection;
2017 Community TB Care SOPs

## CRITERIA FOR FAST TRACK INITIATION COUNSELLING

- All patients eligible for ART on the same day as HTS (same day initiation) or within 7 days of HTS (rapid initiation)
  - Adolescents from 12 years of age after the completion of the HIV disclosure process
  - Caregivers of children under 12 years old or mental health patients (if benefiting from caregiver support)
- Patients co-infected with TB
- Pregnant women initiated on ART on the same day after HTS
- Hypertensive and Diabetic patients who need treatment initiation

## GUIDING PRINCIPLES

- Treatment education and adherence support to patients initiating treatment is critical.
- Treatment initiation can be sped up without compromising adherence.
- Treatment education and adherence support should be provided to a patient without delaying initiation on treatment.
- Post-initiation support is important as the first few months of treatment can be challenging. Patients may need extra support (for example mental health screening and promotion) to ensure they do not disengage early in their treatment journey.
- Treatment education should be provided using the Adherence flipchart for HIV, TB Hypertension and Diabetes.
- A problem-solving approach is required around the most common barriers to adherence, including the need for support, alcohol and substance use issues and clearing up misperceptions.
- Patients should be assisted to develop an individualized adherence plan and set clear treatment milestones.
- The completed adherence plan should be placed in the patient folder and updated with sessions provided.
- **For same day initiation: Session 1 steps 1-10 to be delivered in one counselling session on day of treatment start**
  **For rapid initiation: Steps 1-5 to be delivered at day of linkage to care and steps 6-10 on day of treatment start**
  **Session 2 to be delivered at return visit one month after treatment start**
  **Sessions content can be delivered individually or as a group.**
  Where group approach already exists (e.g. I-ACT), sessions content must be integrated into existing group discussion content.

| ROLES AND RESPONSIBILITIES FOR FAST TRACK INITIATION COUNSELLING | | |
|---|---|---|
| **Clinician's role** | **Counsellor's role** | **Patient's role:** |
| a. Screen and provide treatment based on clinical guidelines<br>b. Screen for mental health and substance use disorders (can delegate to trained counsellor for screening and support) and manage accordingly.<br>c. Emphasize importance of treatment continuation<br>d. Emphasize the importance of maintaining a healthy lifestyle<br>e. Invite the patient to express concerns regarding side effects or support with treatment, if appropriate<br>f. Start treatment if patient agrees<br>g. Provide next appointment as recommended per guidelines in consultation with patient considering his/her availability<br>h. Inform the patient about tracing system | a. Educate on diagnosis, treatment, adherence, **treatment pathway ahead,** risks associated with non-adherence, including illness<br>b. **Create an adherence plan and place in patient folder**<br>c. Continue the adherence plan at every visit to:<br>• Identify a support system<br>• Create a medication schedule<br>• Deal with missed doses<br>• Identify reminders<br>• Identify where to store medication<br>• Deal with side effects<br>• Explain treatment pathway ahead if adherent – longer treatment supply/easier collection<br>• Know what to do in case of travelling<br>• Take treatment in case of substance, alcohol or traditional medicine use<br>• Educate on the future steps on treatment such as VL or HbA1c or BP or sputum assessment.<br>d. Set goals with the patient as recommended per condition guidelines<br>e. Inform the patient about tracing system | a. Understand the importance of starting and continuing to take treatment<br>b. Identify a support system<br>c. Take the decision to start treatment<br>d. Voice concerns and ask questions<br>e. Agree on goals and care plan with provider<br>f. Elaborate an adherence plan with the counsellor to identify the best time to take treatment, reminders and place to store medication<br>g. Understand the treatment pathway ahead if adherent<br>h. Give input on availability on next proposed appointment date and time<br>i. Come for next appointment and inform the staff of any changes of contact number or address or if travelling.<br>j. Take treatment to reach goals.<br>k. Understand tracing system |

## PROCEDURE

### BEFORE EVERY SESSION

**Ensure you have all the tools you need:**

- Patient folder
- Patient Adherence Plan sheet **(stays in the patient's folder for follow-up and further completion)**
- FTIC register (if any)
- Adherence education flip chart
- Adherence treatment pamphlet
- Mental health assessment tool (to check the emotional state of all patients, not necessary for mentally ill patients)
- List of supporting organisations such as CBOs and FBOs to assist with psychosocial support.
- Pen

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

### DURING EACH SESSION (can be provided individually or as a group)

- The attitude of the counsellor or healthcare worker providing counseling is extremely important in supporting adherence.
- Each counseling session should start with an introduction.
- The counsellor or healthcare worker providing counseling should use their counseling skills to build trust with the patient and ensure that the patient is comfortable.
- Create a warm environment and promote patient's openness by establishing language preference and informing about their right to confidentiality.
- Show your appreciation to the patient for attending scheduled appointment at facility.
- Assist the patient to fill in the patient adherence plan.
- Ask questions to help understand the patient's situation and make time to listen carefully to their answer and discuss misunderstandings regarding 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.

## AT THE END OF THE VISIT

- Provide encouraging messages explaining the next steps on treatment at the end of the session.
- Discuss any further questions or concerns that the patient may have.
- Schedule a follow-up visit for a date and time the patient is available (aligned with next clinical or treatment supply visit date).
- Write the date of the follow-up visit in the patient's diary or appointment card and in the clinic 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. Confirm the patient's contact details.
- Provide IEC materials to the patient after making sure that the patient understands the information in the IEC material in their language.
- Provide helpline and health facility telephone numbers for patient to contact if necessary.
- Ensure completed adherence plan recording FTIC counselling session (including date of session) is filed in patient folder for future follow-up and completion and update facility FTIC register (if any).

## OVERVIEW OF FAST TRACK INITIATION COUNSELLING SESSIONS

There are two sessions:

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

**Where treatment is started at a follow-up visit (rapid initiation): Steps 1-5 to be delivered on day of linkage to care and steps 6-10 on day of treatment start**

**Session 2:** First treatment follow-up visit (1 month after treatment start) - finalize the last steps of the adherence plan, educate on assessment, restate goals and treatment pathway ahead if assessment result is normal

## SESSION 1: DAY OF LINKAGE TO CARE AND TREATMENT START

### 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 individualized adherence plan to help them take their treatment correctly.

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

- Provide education on illness and treatment for patient's condition using the Adherence flip chart.
- 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 their future.
- Ask them to identify 3 specific 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, go to school or work or taking care of my family or very specific to the person.

### 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 be visited at home or contacted by phone?*
- *Please confirm the telephone number where we can reach you. We will not disclose the reason for our call if someone else answers.*
- *Who will help you to keep track of your next appointment?*

**For mothers with babies or toddlers or children ask:** *If you are unable to bring your child to the clinic, 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 today?*
- 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 judgments.
- For patients who are reluctant to start treatment, suggest they 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 identified life goals with the patient and encourage and motivate the patient by making reference where possible to positive motivating role models.
- Positive role models can help a patient realize that starting treatment will be the way to achieve their goals.
- Encourage the patient to choose a moment to think about their life goals every day, for example when waking up or waiting for transport.
- **If patient is eligible and feels ready to start treatment, congratulate and continue with step 6 or confirm remainder of this counselling session (steps 6-10) will take place on appointment date for treatment start.**

**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 a doctor or nurse advised patient not to take treatment immediately.

**STEP 8: ADHERENCE STRATEGIES**

**Ask the patient the following:**

- *What reminder strategy will you have in place to avoid forgetting treatment?*

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

**STEP 9: STORING MEDICATION AND EXTRA MEDICATION DOSES**

**Ask the patient the following:**

- *Who are you worried may 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**

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

**Reassure and support patient to make a plan explaining that:**

- Severe side effects are rare.
- 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 the patient vomits up to one hour after taking the medication, the patient should take it again.
- If the patient feels unwell, it is important to continue taking treatment and come in to the nearest facility to get support.

## SESSION 2: FIRST TREATMENT FOLLOW-UP VISIT (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.
- Check the patient's understanding of their prescription (drug/s dosing and timing of doses).
- Encourage and motivate.

### STEP 11: EXPLAIN TREATMENT PATHWAY AHEAD

**Explain to the patient that if they take their treatment well, they will be eligible for longer treatment supply and easier collection systems**

- *You and your clinician will decide how regularly you need to come for the first few months on treatment. Depending on your health today and how you have been coping with taking your new treatment, you may together decide to return for your next clinical consultation in one or two months with enough treatment supply until your next appointment date.*
- *When you have been on treatment for three months (for HIV/NCDs)/seven weeks (for TB), you will have an assessment done (we will discuss this in more detail later in this session). It will measure how well you are taking your treatment and whether it is working.*
- *If your treatment is working well, you will be eligible to:*
  - *receive longer treatment supply to reduce the number of visits to the clinic*
  - *simpler ways to collect your treatment supply (explain FAC-PUP (fast track collection system at the clinic)/adherence club (support group where you collect your treatment)/EX-PUP (collection point outside of the facility))* depending on options available at your facility.

### STEP 12: PLAN FOR TRAVELS

**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?*

**Inform patients that:**

- *Things can happen suddenly, try to remember the best approach would be to come to the facility before travelling to inform them of your travel location and length of time away so that you can receive a referral letter and sufficient treatment supply.*

- *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 to carry evidence of your condition and evidence of the treatment you are taking.*
- *While referral/transfer letters make it easier for the staff at the new facility, it is important to know that the new facility may not require you to obtain a referral/ transfer letter before providing treatment to you. Treatment should be provided on the day you present at the new facility to ensure you do not interrupt treatment.*

**STEP 13: DEALING WITH SUBSTANCE AND TRADITIONAL MEDICINE USE**

**Explain that:**

- *Ideally, it is better to moderate alcohol or substance consumption when you are on treatment. 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.*

**Ask the patient:**

- *In case you are going to drink alcohol or use drugs, what could you do to make sure you remember to take your treatment?*

**Support** the patient to make a plan by assessing if someone could help 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.

- If the patient is planning to use alcohol or drug, it might be more appropriate to take the treatment before as this decreases the risk to forget to take it.
- If the patient recognizes that they have a substance abuse disorder, propose referral to a specific support structure (refer to list of organizations who could assist with mental health and psychosocial support). Bear in mind that passing judgment is not helpful. It is important to adopt a supportive attitude.

**Explain** to patient that it is better not to use traditional medicines that could interfere with the treatment. If the patient takes traditional medicine, they should make a plan with the clinician to still take their treatment.

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

## ASSESSMENT EDUCATION, TREATMENT GOALS AND PATHWAY AHEAD

**Provide explanation or information on the 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.*
- *A viral load of below 50 copies/ml means your treatment is working.*
- *When your treatment is working there are many benefits. You can vastly reduce the chance of transmitting HIV to other people and your CD4 count can recover helping you to stay well without illness.*
- Agree on a goal with the patient to get and keep their viral load below 50 copies/ml.
- *The first viral load is taken when you have been on treatment for three months. If your treatment is working and your viral load is below 50 copies/ml, it will be taken again at 10 months on treatment and then once a year thereafter.*
- Explain that most people who take their treatment as prescribed will have a viral load below 50 copies/ml by three months on ART.
- *Where a person has a viral load of more than 50 copies/ml, it usually means the person is struggling with taking their treatment and may require some assistance. But not always. For a few people who had a very high viral load at treatment start, it may take their viral load a little longer to come down to below 50 copies/ml.*
- *For any patient with a viral load more than 50 copies/ml, you will be provided with three more months of treatment to take correctly. Then another viral load will be taken to check again.*
- *If you are well and as soon as your viral load is below 50 copies/ml you can ask and the clinician should offer longer treatment supply and easier collection systems as we have already discussed.*
- Explain the importance of EPI schedule and return date for the child immunization and PCR for pregnant patients. *Your treatment supply should be provided to align with your infants immunization schedule to ensure you don't need to visit the facility separately for both. You can remind your clinician to align these dates for you.*

**b. For TB:**

- Check the patient folder for type of TB and treatment duration and explain to the patient.
- For drug sensitive TB with 6 months treatment duration explain:
  - *You will be taking four drugs in combination for the first two months (intensive phase) and if the treatment is working change to two drugs in combination (continuation phase) for the remaining four months of treatment.*
  - *A follow-up sputum test called a smear microscopy will be done at seven weeks on treatment.*
  - *If the smear microscopy is negative and you are well, it means the treatment is working and you can change from intensive to continuation phase of TB treatment. You can ask and your clinician should offer longer treatment supply to reduce the number of follow-up visits to the clinic.*
  - *Another follow-up sputum test will be taken at 23 weeks on treatment and reviewed a week later. If again negative, you have successfully completed TB treatment and it can be stopped.*
  - *If the smear microscopy is positive, further tests will be done and dependent on the results, you may require changes to the TB drugs prescribed. Your clinician will provide more detailed information in this regard.*
- Explain the importance of continuing and adhering to treatment until completing the course of treatment.
- Advise TB patients on how to prevent infecting other people by opening windows and covering their mouth when coughing.
- Agree on a goal with the patient to complete the TB treatment and be 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.
- Explain how a patient will know if their treatment is working:
  <u>For hypertension:</u>
  - *To know if your treatment is working, your blood pressure will be taken at each visit.*
  - *A blood pressure below 140/90 means your healthy eating, exercise and treatment are working. This can take time and effort to achieve.*
  - Agree on a goal with the patient to get and keep their BP below 140/90.

For Diabetes:

- *To know if your treatment is working, a blood test called a HbA1c will be done. This measures your blood sugar over the last 2-3 months.*
- *The first HbA1c is taken when you have been on treatment for 3 months.*
- *A HbA1c of 8% or less means your healthy eating, exercise and treatment are working. This can take time and effort to achieve.*

- *When your BP is consecutively less than 140/90 or the HbA1c is 8% or less, this means you are controlling the hypertension or diabetes well. You can ask and the clinician should offer a longer treatment supply and easier collection systems as we have already discussed.*
- Agree on a goal with the patient to have Blood Pressure <140/90 or keeping the blood glucose at HbA1c ≤8%.

**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 conditions, 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
4. Manage stress
5. Get enough rest

**For VTP:**
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
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.
- If the child is more than 5 years old, a plan needs to be made with the caregiver to start the disclosure process (see disclosure counselling SOP 3)
- Explain the importance of EPI schedule and return date for the remaining immunizations.
- Steps should be taken to support the caregiver to plan:

1. EPI visits
2. Give treatment appropriately
3. Follow up ART visits linked to EPI visits
4. Follow up ART visits linked to caregiver's ART follow-up visits (preferably in school holidays for school going children)

- At session 2: At script understanding check-in, ask the caregiver to demonstrate the volume of liquid/number of tablets and how these are dissolved.

## MENTAL HEALTH ASSESSMENT AND SUPPORT

Patients should be assessed for mental health and where concerns are identified, supported using the Mental Health Assessment tool in Annexure II either by a clinician or a delegated trained counsellor with referral back to the clinician for clinical management and any necessary referrals.

## TRACING, RECALL AND RE-ENGAGEMENT

**If chronic care patients do not arrive at facility for scheduled appointment within 7 calendar 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 WBPHCOT, CHWs, HBCs or other suitable means.
- Where a chronic care patient returns to the facility of their own accord or after tracing within 28 days of their missed scheduled appointment, the patient will be managed as a routine patient. If more than 28 days late, refer to Re-engagement SOP 8.
- For further details on tracing refer Tracing and Recall SOP 7.

| SOP AUTHORISED BY | | | |
|---|---|---|---|
| **DATE** | **INITIALS & SURNAME** | **DESIGNATION** | **SIGNATURE** |
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**Annexures:**

I. Patient Adherence Plan

II. Mental Health Assessment tool

# ENHANCED ADHERENCE COUNSELLING (EAC)

## SOP 2

**TITLE: STANDARD OPERATING PROCEDURE FOR ENHANCED ADHERENCE COUNSELLING FOR PATIENTS STRUGGLING WITH ADHERENCE (EAC)**

**INSTITUTION: NATIONAL DEPARTMENT OF HEALTH**

| **REFERENCE NUMBER: AGL: EAC (2)** | **EFFECTIVE DATE: AUGUST 2025** |
|---|---|

## PURPOSE

The purpose of this document is to outline the process for healthcare workers and lay counsellors to enhance adherence monitoring, provide enhanced adherence counselling and support to patients struggling with adherence (while in care or at re-engagement).

## PERSONS AFFECTED

- Patient living with HIV and/or a NCD and/or on TB treatment
- Healthcare workers
- Counsellors (includes social worker, psychologist or lay counsellors)

## APPLICABLE POLICY REFERENCE

For HIV: 2025 National consolidated guidelines for the management of HIV in adults, adolescents, children and infants and prevention of vertical transmission
For NCDs: 2023 Adult Primary Care Guide
For TB: 2023 National guidelines for the management of TB infection;
2017 Community TB Care SOPs

## CRITERIA FOR ENHANCED ADHERENCE COUNSELLING (EAC)

- **HIV:** Patients with a viral load (VL) more than 50 copies/ml on ART after the A-E elevated VL assessment by a clinician ascertains there may be an adherence problem which could benefit from enhanced adherence counselling (see 2025 HIV consolidated guidelines)
- **Hypertension:** Patients with persistent high blood pressure on treatment more than 140/90
- **Diabetes:** Patients with blood sugar level on treatment with HbA1c more than 8%
- **TB:** Co-infected patients with positive smear on treatment for 2 months
- **Mental health condition:** Patients with a positive mental health screen who would benefit from additional adherence support in conjunction with mental health support/referral.
- Patients re-engaging in care where the clinician ascertains there may be an adherence problem which could benefit from enhanced adherence counselling

## GUIDING PRINCIPLES

- Patients who are struggling with taking treatment as prescribed NOT due to side effects (to be discussed with clinician) or difficulties with collecting treatment (MMD and RPCs to be considered) should be prioritized.
- Patients with mental health conditions should receive prioritized mental health support (see Annexure II), alongside appropriate clinical management and, where necessary, referral. Enhanced adherence counselling (EAC) does not replace mental health support but complements it by focusing specifically on supporting adherence challenges when living with a mental mental health condition.
- Facilities should establish a system to identify and recall patients with abnormal results. The EAC identification system can consist of coloured stickers or note on the file or pulling out the files in a separate folder. A prioritised file should trigger A-E elevated VL assessment by a clinician for possible referral to the counsellor for EAC (if trained counsellor at facility) or provided by the clinician as soon as the patient comes back to the facility.
- Healthcare workers must provide patients with information on their latest assessment results.
- Healthcare workers and/or counsellors should assess and address the barriers to adherence (if any) and discuss effective strategies to overcome these barriers.
- Assistance should be provided to patients to set new treatment goals according to the next treatment steps.
- Additional individual support is needed in the case of switching to another regimen or treatment.
- Referral for appropriate additional care and support services should be considered and undertaken.
- Where possible, the facility manager shall identify counsellors with experience in counselling patients with adherence issues.

| ROLES AND RESPONSIBILITIES | | |
|---|---|---|
| **Clinician's role** | **Counsellor's role** | **Patient's role:** |
| a. Screen patients as recommended in the clinical guidelines to monitor adherence to treatment including review results from previous assessment.<br>b. Explain abnormal result to the patient.<br>c. Determine if abnormal result is likely to be adherence related not side effects or difficulties and if so, refer for EAC.<br>d. Screen for mental health and substance use disorders (can delegate to trained counsellor for screening and support) and manage accordingly.<br>e. Assess and manage side effects swiftly.<br>f. Screen and provide treatment based on clinical guidelines.<br>g. Consider switching to alternate regimen as per clinical guidelines.<br>h. Emphasize importance of treatment continuation.<br>i. Consider and offer MMD to support next scheduled appointment attendance if patient is clinically well.<br>j. Ensure communication between facilities when the patient is referred to another facility. | a. Educate on abnormal result and that adherence challenges are the common cause.<br>b. Check that patient is taking treatment regimen correctly (no misunderstandings).<br>c. Assess and address barriers to adherence.<br>d. Assess misconceptions and beliefs about treatment.<br>e. *If delegated,* screen for mental health and substance abuse disorders, provide mental health support.<br>f. Provide support strategies to overcome barriers such as taking treatment when struggling with mental health or using substances including alcohol.<br>g. Set new goals for next assessment such as having undetectable VL (<50 copies/ml), BP <140/90, HbA1c ≤8% or negative sputum (or revised thresholds in updated clinical guidelines).<br>h. Encourage excellent adherence to influence next result. | a. Express barriers to adherence (if any) and potential reason for treatment failure.<br>b. Review and adapt adherence plan with counsellor.<br>c. Set new treatment goals.<br>d. Adhere to treatment.<br>e. Come for 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:**

- Patient folder
- Patient Adherence Plan sheet **(stays in the patient's folder for follow-up and further completion)**
- EAC register (if any)
- 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, establish language preference and explain confidentiality.
- Show your appreciation to the patient for coming back to facility.
- Give the patient time to consider the abnormal results and help patient cope with emotions arising.
- Explain that achieving our treatment goals can be challenging and take longer for some of us.
- 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.
- Provide additional referrals for mental health and substance use disorder related support services.
- Update the adherence plan in the patient's folder (can attach a new plan if extensive revisions) and reflect EAC session visit date.

### AT THE END OF THE VISIT

- Discuss any further questions or concerns that the patient may have.
- Inform the patient that they will be traced if they miss appointments and obtain consent for patient to be visited at home. Confirm patient's contact details.
- 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.
- Ensure updated adherence plan recording EAC counselling session is filed in patient folder and update facility EAC register (if any).

## ENHANCED ADHERENCE COUNSELLING SESSIONS

**There are two sessions:**

**Session 1:** Initial enhanced adherence counselling for patients struggling with adherence.

**Session 2:** Enhanced adherence counselling for persistent non-adherent patients.

## SESSION 1

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

- Determine possible reasons for abnormal assessment results.
- Assess and address any reported barriers to adherence, including mental health related and discuss effective strategies to overcome.
- Update or develop an adherence plan with the patient (use Annexure 1: Patient Adherence Plan).

**2. Education on the assessment result**

- Ensure the patient's mental health has been assessed using the Mental Health Assessment tool in Annexure II.
- Find out what treatment education the patient has received.
- Find out what the patient knows about the treatment they are taking and check the treatment regimen has been understood correctly ie. the correct dose and when each medicine is taken. For children, ask the caregiver to demonstrate understanding of the volume of liquid/number of tablets and how these are dissolved.
- Explain in a supportive way that the most common reason for such result is a problem with taking medication correctly.
- Find out if the patient received education on the assessment to check adherence and effective treatment( VL/BP/HbA1c) and its meaning. If not, provide in SOP 1: FTIC session 2.

**3. Flexibility on treatment**

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

**4. Patient's experiences**

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

**5. Identify strategies to ensure good adherence**

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

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

- Treatment buddy to remind the patient to take treatment
- Setting phone alarm
- Support by a family member
- Pill counts
- Marking a calendar or using a pill box
- Linking medication to meal times
- Modified Direct Observed Therapy by a treatment supporter/buddy (this is also applicable to children)

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

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

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

**6. Inform the patient about pathway ahead**

- Explain the timing of follow-up assessments (tests) to check adherence and effective treatment as per disease specific guidelines (for HIV: another viral load will be taken in 3 months, for hypertension: a BP will be taken at every visit for the next 3 months, for diabetes: a further HbA1c test will be done in 3 months)
- Explain that if the next assessment is normal, it will become easier to collect treatment. The patient can ask and the clinician should offer the patient simpler treatment supply collection with longer treatment supply (FAC-PUP/Adherence Club/EX-PUP).
- Consider with the patient whether providing MMD today will support continued engagement in care until the follow-up assessment visit (see MMD SOP 4).

## SESSION 2

Patients are referred for session 2 only if they continue to have abnormal results after EAC session 1 (For HIV: patients with a second viral load >50 copies/ml, for Hypertension: patients with repeated BPs >140/90, for Diabetes: patients with a second HbA1c > 8%)

**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 the patient to explain what the patient understands to be the cause/reason for the abnormal result.

**3. Education on resistance and treatment changes**

- Explain to the patient what resistance means and treatment changes as appropriate for condition.
- For those switching single drugs or treatment regimens - provide explanation on treatment changes, how to take it (dosing schedule) and explain that the treatment is very effective if taken correctly.

**4. Support the patient to make a personalized adherence plan**

- Revise the steps of the adherence plan or create one if never done or major revisions (use Annexure 1: Patient Adherence Plan).
- Support the patient in identifying a peer support system and link them to a HBC, CHW, support group or access to government support programs where food insecurity is an issue.
- Support the patient to make a plan in case of mental health condition or substance use and encourage the patient to be linked to a specialized service.

**5. Explain the way forward:**

- Emphasize importance of adherence and general well-being.
- Explain monitoring, when any further assessments (tests) shall be taken.
- Explain possible side effects of treatment (only if switched). Reassure that it is important not to stop treatment and to report as soon as possible to the nearest facility to see the healthcare worker if it happens.
- Encourage the patient to share his concerns with someone the patient 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 (Diabetes/ Hypertension: and lifestyle changes).
- Assure client 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 trust.

## MENTAL HEALTH ASSESSMENT AND SUPPORT

Patients should be assessed for mental health and where concerns are identified, supported using the Mental Health Assessment tool in Annexure II either by a clinician or a delegated trained counsellor with referral back to the clinician for clinical management and any necessary referrals.

## TRACING, RECALL AND RE-ENGAGEMENT

**If chronic care patients do not arrive at facility within 7 calendar days from scheduled appointment:**

- Contact patients through reminder call or sms to return to the facility for scheduled appointment.
- If unsuccessful, facility initiates patient tracing using WBPHCOT, CHWs, HBCs or other suitable means.
- Where a chronic care patient returns to the facility of their own accord or after tracing within 28 days of their missed scheduled appointment, the patient will be managed as a routine patient. If more than 28 days late, refer to Re-engagement SOP 8.
- For further details on tracing refer Tracing and Recall SOP 7.

## SOP AUTHORISED BY

| DATE | INITIALS & SURNAME | DESIGNATION | SIGNATURE |
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**Annexures:**

I. Patient Adherence Plan

II. Mental Health Assessment tool

# CHILD AND ADOLESCENT DISCLOSURE COUNSELLING (CADC)

## SOP 3

**TITLE: STANDARD OPERATING PROCEDURE FOR CHILD AND ADOLESCENT DISCLOSURE COUNSELLING (CADC)**

**INSTITUTION: NATIONAL DEPARTMENT OF HEALTH**

| **REFERENCE NUMBER: AGL: CADC (3)** | **EFFECTIVE DATE: AUGUST 2025** |
|---|---|

## PURPOSE

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

## PERSONS AFFECTED

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

## APPLICABLE POLICY REFERENCE

For HIV: 2025 National consolidated guidelines for the management of HIV in adults, adolescents, children and infants and prevention of vertical transmission
2023 updated Disclosure Guidelines for Children and Adolescents

## CRITERIA FOR DISCLOSURE IN CHILDREN AND ADOLESCENTS

- Caregivers and all children with a chronic disease from 5 years old should start being prepared for partial disclosure.
- Disclosure criteria is as follows:
  - **Non-disclosure (<5 years)**
  - **Partial disclosure (5-9 years)**
  - **Full disclosure (>10 years)**
- Age criteria are intended as a guide. Certain children may want or be able to start disclosure before the indicated age parameters.

## GUIDING PRINCIPLES

- It is important that disclosure follows a planned process and 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.
- The healthcare worker or counselor prepares and supports the caregiver to disclose to the child. The counsellor's role is to facilitate the disclosure process not to do the actual disclosure.
- 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 require.
- Use age-appropriate language in line with education and emotional readiness.
- Use images or drawings to help children understand the explanations during counselling sessions.
- Anticipate possible responses from 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 refer to other psychosocial services as necessary.

**Caregiver's role:** Caregiver supported by the counsellor discloses to and supports the child.

## PROCEDURE

### BEFORE EVERY SESSION

**Ensure you have all the tools you need:**

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

## DURING EACH SESSION

- Prepare a warm friendly and conducive environment to conduct a disclosure session, establish language preference and assure caregiver and child of confidentiality.
- 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 the child if they have any questions or concerns.
- Ensure ongoing assessment of the child's wellbeing.
- Refer for psychosocial support such as social worker, psychologist, support group for both child and caregiver.
- Schedule and confirm the follow up visit after determining a suitable date and time with the caregiver (ideally align with treatment supply appointment dates).
- Document sessions in the disclosure records.
- Write the date of the follow-up visit in the 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

**Session 2:** Full disclosure

## SESSION 1: PARTIAL DICSLOSURE FOR 5-9 YEAR OLDS

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

1. Ask what the caregiver has told the child so far about the reason for coming to the clinic and taking treatment.
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 treatment the child is taking.*
- *From 5 years old, partial disclosure is recommended for the child to learn about health, immunity, having a 'sleeping' germ and treatment.*
- *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:**

- *Usually, children who know their status take their medicine better because they understand why they have to go to the clinic and take treatment.*
- *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 5 years old and tell them about their HIV status when they are between 10 and 12 year old.*

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 suggest providing 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 clinic**

- Ask the child: *What do you do when you come to the clinic?*
- Help the child to talk about clinical check-ups, fetching treatment 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 the 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 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 body soldiers 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 body soldiers. If it keeps on killing our soldiers, we will not have enough soldiers to fight off other germs. Then we get sick very easily. Refer annexure 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 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 follow 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 image 4 (treatment to fight the sleeping germ)

**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 take the medication every day to prevent the sleeping germs from waking up again because they could beat the body soldiers and make the child sick.
- Remind the child that in case they forget to take medication, they should take it as soon as they remember.

**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 Medicine" is 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 FOR 10 -12 YEARS OLD:**
**If the child is asking question and seems ready, the full disclosure can happen before 10 years old. By the age of 12, all children living with HIV should be fully disclosed**

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

**1. Introduction and assessment of readiness for full disclosure**

- *How is the child doing since the last session?*
- *Did the child ask questions?*
- *Did you disclose to the child's 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 caregiver expresses 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 of the child, 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.

**3. Discuss disclosure and secrecy**

- Using the hand of safety, ask with whom the child could speak about HIV (refer to 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 stigmatized by family members.

**4. Assess barriers to disclosure:**

- *What are your fears about disclosing the HIV status to the child?*

**5.** Reassure about the benefits of disclosure and propose to support the caregivers in disclosing to the child.

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

**1. Assess what the child remembers from the previous session on partial disclosure**

- *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 the medicines kill the sleeping germ? [no, it makes them sleep]*
- Complete the child answers explaining the importance of taking treatment every day to keep the sleeping germ asleep and make the soldiers of the body stronger

**2. If the caregiver is ready to disclose to the child, 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.
- Ask the child: *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.

**It is important that the disclosure be done by the Caregiver, the role of the healthcare worker or counsellor is to support this process. If the caregiver really cannot do it, then the clinician/counsellor can help to do it in the presence of the caregiver.**
**A child 12 years and older should at least be fully disclosed to at that age through the disclosure stepwise process.**

**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 this news?*
- *It is normal to experience such feelings and you can express whatever you want.*
- Refer to the disclosure toolkit on how to assess and express feelings (feelings faces).

**4. Ways of transmission**

- Explain 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 medication every day, 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, teacher or the nurse.
- Do the Hand of Safety activity with the child if they have not yet done one (refer to Disclosure talk toolkit).

**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 individualized adherence plan and set clear treatment milestones such as school holidays.
- Provide comprehensive support for HIV positive adolescents who are pregnant and breastfeeding on ART or co-infected with TB.

**TRACING, RECALL AND RE-ENGAGEMENT**

- Set regular follow-up dates to assess the child's levels of disclosure every time you see them (aligned with treatment supply appointment dates).
- Suggest to the caregiver and the child to enroll into a support group.
- Remind the caregiver and child to attend treatment supply collection and clinical follow-up visits as scheduled.

**If chronic care patients do not arrive at facility for scheduled appointment within 7 calendar 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 WBPHCOTs, CHWs or HBCs or other suitable means. For further details refer to Tracing and Recall SOP 7.
- Where a chronic care patient returns to the facility of their own accord or after tracing within 28 days of their missed scheduled appointment, the patient will be managed as a routine patient. If more than 28 days late, refer to Re-engagement SOP 8.

**SOP AUTHORISED BY:**

| Date | Initials and Surname | Designation | Signature |
|---|---|---|---|
| | | | |
| | | | |

**Annexures:**

III. Child and adolescent disclosure counselling images

# FACILITY PROVIDED MULTI-MONTH DISPENSING (FACILITY MMD)

## SOP 4

**TITLE: STANDARD OPERATING PROCEDURE: FACILTY PROVIDED MULTI-MONTH DISPENSING (FACILITY MMD)**

**INSTITUTION: NATIONAL DEPARTMENT OF HEALTH**

**REFERENCE NUMBER: FACILITY MMD** | **EFFECTIVE DATE: AUGUST 2025**

## PURPOSE

The purpose of this document is to outline access to and the process for facility provided multi-month dispensing (Facility MMD) of various treatment supply lengths for utilization by clinicians between patient clinical reviews (**for MMD within RPCs care – see SOP 5**):

- 2-month treatment supply = 2MMD
- 3-month treatment supply = 3MMD

SOP 4.1: 3MMD (exceptionally 2MMD)

- 6-month treatment supply = 6MMD

SOP 4.2: 6MMD

## PERSONS AFFECTED

- Patient living with HIV and/or a NCD and/or on TB treatment
- Healthcare worker
- Pharmacist or pharmacy assistant
- Non-clinicians (could include lay counsellors, CHWs, HBCs, nursing assistants or equivalent)

## APPLICABLE POLICY REFERENCE

For HIV: 2025 National consolidated guidelines for the management of HIV in adults, adolescents, children and infants and prevention of vertical transmission
For NCDs: 2023 Adult Primary Care Guide
For TB: 2023 National guidelines for the management of TB infection;
2017 Community TB Care SOPs

## FACILITY MMD CRITERIA

- See Facility 3MMD (or 2MMD) criteria in SOP 4.1 and Facility 6MMD criteria in SOP 4.2

## GUIDING PRINCIPLES FOR ALL FACILITY MMD

- Requiring monthly clinical consultations can be very costly for patients and can lead to disengagement from care.
- Clinicians should consider appropriate longer scripting (multi-month scripting (MMS)) and treatment supply (multi-month dispensing (MMD)) to offer a patient to support continued engagement in care and associated treatment adherence between necessary clinical reviews.

- **MMS and MMD is not only for clinically stable patients or patients enrolled in RPCs (see SOP 5) and should be considered for all patients for whom monthly clinical consultations are not indicated.** The clinician should determine an appropriate balance between clinical safety and supporting patient's continued engagement in care and adherence to treatment by reducing clinical review frequency. See DMOC diagram on page 10.
- When a clinician provides Facility MMD outside of RPCs, a return date for the next clinical consultation, the prescription length (MMS) and treatment supply (MMD) must be for the same period. For example, where the clinician gives a return date for a clinical consultation in 3 months time, the prescription period should cover the 3-month period (3MMS) with a 3-month supply of medicine dispensed (3MMD). There should be no repeat medicine collections.
- MMD outside of RPCs is dispensed by the facility to the patient either by the clinician or by the facility pharmacy.
- Facility for purposes of SOP 4 includes mobile services from a facility i.e. facility mobile outreach.
- **All patients who opt for a longer treatment supply should be encouraged to come to the facility to see a clinician at any other time should they feel unwell or experience any challenges which require support.**
- All processes must be documented.

**ROLE AND RESPONSIBILITIES FOR FACILITY MMD**

Clinician's role:

a. Consider:
   I. Whether it is clinically safe to only clinically review the patient in 2 or 3 or 6 months time including alignment of investigations or treatment completion visits mandated in clinical guidelines
   2. Whether a patient may benefit from MMD to support treatment adherence

b. Assess eligibility and offer MMD with appropriate patient information.

c. Write a prescription covering the time period until the client's next clinical review with the same treatment supply.

Facility pharmacy/clinicians role: Dispense treatment supply for the entire period of the prescription for one collection only.

## TRACING, RECALL AND RE-ENGAGEMENT FOR PATIENTS ON FACILITY MMD

**If chronic care patients do not arrive at facility within 7 calendar days from scheduled appointment:**

- Contact patients through reminder call or sms to return to the facility for scheduled appointment.
- If unsuccessful, facility initiates patient tracing using WBPHCOT, CHWs, HBCs or other suitable means.

**Management of patients who miss a scheduled appointment:**

- If the patient returns within 28 days (on their own or after tracing)
  - Manage as a routine patient in the same DMOC.
  - If not already in a less-intensive DMOC, assess eligibility and consider enrolment.
- If the patient is more than 28 days late: Follow the Re-engagement SOP 8.

For further details on tracing refer Tracing and Recall SOP 7.

**SOP AUTHORISED BY:**

| Date | Initials and Surname | Designation | Signature |
|---|---|---|---|
| | | | |
| | | | |

**Annexures:**

V. Facility MMD eligibility & visit schedules

# FACILITY 3MMD (EXCEPTIONALLY 2MMD)

## SOP 4.1

**TITLE: STANDARD OPERATING PROCEDURE: FACILTY PROVIDED MULTI-MONTH DISPENSING – 3MMD (EXCEPTIONALLY 2MMD)**

**INSTITUTION: NATIONAL DEPARTMENT OF HEALTH**

**REFERENCE NUMBER: FACILITY 3MMD** | **EFFECTIVE DATE: AUGUST 2025**

## PURPOSE

The purpose of this document is to outline access to and the process for facility provided 3-month supply of treatment (3MMD) and exceptionally 2-month supply of treatment (2MMD) for utilization by clinicians between 3-monthly (or 2-monthly) clinical reviews.

## CRITERIA FOR FACILITY PROVIDED 3MMD

- Above 6 months old
- On treatment for at least 3 months
- Patient (or patient caregiver) wants longer treatment supply to support continued engagement in care
- Clinician confirms patient is sufficiently clinically stable not to require clinical follow-up more regularly than in 3 months time.

## WHO WOULD BENEFIT FROM FACILITY PROVIDED 3MMD

- Facility 3MMD should be considered to reduce the burden of returning to the facility unnecessarily frequently for all patients who are not acutely unwell requiring more frequent clinical reviews for intensive management.
- It is also appropriate for all patients who are not eligible or do not take up the offer of a RPCs or facility 6MMD (see SOP 4.2) and includes:
  - children 6 months–5 years old on ART
  - after receiving an abnormal assessment result and an enhanced adherence counselling session (if indicated by clinician) to align with their next assessment date (for HIV: VL)
  - re-engaging in care (see SOP 8)
  - travelling
  - post-natal women to align with their next infant EPI visit
  - to facilitate alignment with a guideline mandated clinical review or follow-up assessment (test) or assessment result review date in 3 months time.

## CRITERIA FOR FACILITY PROVIDED 2MMD

- Above 6 months old
- On treatment for at least 1 month (TB treatment for at least 2 months)
- Patient (or patient caregiver) wants longer treatment supply to support continued engagement in care.
- Clinician confirms patient is sufficiently clinically stable not to require clinical follow-up more regularly than in 2 months time.
- **Not eligible for RPCs**

## WHO WOULD BENEFIT FROM FACILITY PROVIDED 2MMD

- 2MMD should be considered to reduce the burden to the patient of returning to the facility unnecessarily frequently **in the first few months of treatment.** Thereafter 3MMD is more appropriate.
- It will most commonly be appropriate for a patient:
  - one month after treatment start (at month 1 visit) to supply sufficient treatment to return for the assessment visit (e.g. VL or HBA1c at month 3).
  - completing continuation phase DS-TB treatment
  - at delivery to support adherence while transferring to MCH follow-up services and first infant EPI visit
  - to facilitate alignment with a guideline mandated clinical review or follow-up assessment (test) or assessment result review date in 2 months time.

## OVERVIEW OF PROCEDURE FOR 3MMD (AND EXCEPTIONALLY 2MMD)

| | **Combined clinical consultation + treatment supply** |
|---|---|
| WHEN (service frequency) | 3-monthly (or 2MMD) |
| WHERE (service location) | Health facility |
| WHO (service provider) | Clinician (dispensed by clinician or facility pharmacy) |
| WHAT (service package) | Clinical review<br>Adherence check<br>Prescription 3MMS (or 2MMS)<br>Treatment supply 3MMD (or 2MMD) |

**See Annexure V for Facility 3MMD visit schedule**

**INFORMATION TO BE PROVIDED TO THE PATIENT**

- Where a clinician considers that longer treatment supply may be beneficial to the patient, the clinician should explain:
  - the patient can choose to receive a longer treatment supply to enable less frequent visits to the facility.
  - the patient would need to come back to the facility to see the clinician at their next appointment date. Facility provided MMD (outside of RPCs) does not enable a fast track/one-stop visit only to collect treatment (see RPCs: FAC-PUP).
- If the patient accepts the MMD offer, the clinician should explain:
  - The length of treatment supply provided
  - If this length of treatment supply will continue or may change at the next visit and the reasons for any possible change (for example: if an assessment will be done at the next visit which will require a clinical review of the result the following month). **This is important to ensure the patient understands any possible changes to the length of treatment supply ahead.**
  - Explain to the patient when the next treatment assessment will take place and that if the result is normal, the patient will be offered simpler treatment collection options at the facility or outside the facility either individually or as part of a support group or longer supply from the facility.
  - Advise the patient that **in the case of any health problems or should the patient become pregnant, to come in immediately to see a clinician NOT to wait until the next scheduled appointment date.**
- The clinician should clearly prescribe the length of treatment supply (MMD).
- The clinician should prescribe all the patient's other medication for the same length of supply, including but not limited to other chronic, opportunistic infection related or preventative medication (e.g. contraception, TPT, cotrimoxazole) unless scheduling or cold chain prohibits.
- Write the date of the follow-up visit in patient's diary or appointment card.

**Annexures:**

V. Facility MMD eligibility & visit schedules

# FACILITY 6MMD
## SOP 4.2

**TITLE: STANDARD OPERATING PROCEDURE: FACILTY PROVIDED MULTI-MONTH DISPENSING – 6MMD**

**INSTITUTION: NATIONAL DEPARTMENT OF HEALTH**

**REFERENCE NUMBER: FACILITY 6MMD** | **EFFECTIVE DATE: AUGUST 2025**

## PURPOSE

The purpose of this document is to outline access to and the process for facility provided 6-month supply of treatment (6MMD) **for very stable patients** for utilization by clinicians between 6-monthly clinical reviews.

## CRITERIA FOR FACILITY PROVIDED 6MMD

**Summary: Same as RPCs (SOP 5) with an additional requirements of 12 months on treatment and two consecutive normal assessments**

- Above 5 years of age
- Not pregnant or post-natal within 12 months of delivery
- On treatment***** for at least 12 months
- Most recent **two assessment results** normal:
  - **For HIV:** Most recent two viral loads, including one in the last 12 months <50 copies/ml
  - **For Diabetes*:** Most recent two HbA1c, including one in the last 12 months ≤8%
  - **For Hypertension***: Two consecutive BP <140/90
- Clinically stable with no current TB, other opportunistic infection, malnutrition, new or uncontrolled mental health or chronic condition requiring clinical review more regularly than once every 6 months
- Clinician confirms the patient's eligibility
- Patient voluntarily opts for Facility 6MMD

**Children specific additional criteria:**

- No regimen or dosage change in the last 3 months
- Caregivers counselled on disclosure process where age appropriate disclosure not yet achieved (see SOP 3).
- Where patient <12 years, caregiver voluntarily opts for Facility 6MMD

**Stable family members should be encouraged to join the same DMOC with aligned collection location and date to support adherence. If a caregiver is eligible, Facility 6MMD can still be offered even if the child remains ineligible and on 3MMD, with aligned visits but the caregiver requiring care only every second visit.**

***Limited to ART TLD regimen only until national medicine stock availability is confirmed for other ART regimens and hypertension and diabetic treatment.**

**Note for pregnant and post-natal women:**

- Pregnant women should receive their ART care aligned and integrated into their BANC plus visits.
- New mothers should continue their ART care aligned with their infant EPI visit schedule (2MMD at birth and 3MMD from 6 week EPI visit) and preferably fully integrated into MNCWH services. At the Month 12 EPI visit, mothers may be assessed, offered and enrolled into RPCs of their choice or Facility 6MMD based on her previous VLs (see integration tables in 2025 VTP guidelines) provided she is seen at her facility every 6 months for her 6-monthly VL until cessation of breastfeeding.

## GUIDING PRINCIPLES SPECIFIC TO FACILITY 6MMD (in addition to those on page 49)

- **Facility 6MMD is intended for very stable clients only.**
- **Patient choice** of DMOC is key.
  - Where a patient is eligible for RPCs, RPCs options must always also be offered.
  - Where a patient wants to see a clinician more regularly than 6-monthly, they can decide not to take up the offer of RPCs or Facility 6MMD and rather opt for standard service delivery with 3-monthly clinical reviews, 3-month scripts and 3MMD. See DMOC summary table on page 10.
- Facility 6MMD can be considered for clients enrolled in RPCs option who would prefer Facility 6MMD to avoid repeat collections from external or facility pick-up points or adherence club locations (see SOP 5).
- Where treatment prescribed is available in **84-90 day pack sizes**, these should be dispensed as preferable for patients and less workload for clinician or clinic pharmacy to dispense.
- Clinicians must record enrolment/disenrolment in Facility 6MMD on clinical stationery, with clerks capturing in TIER.Net. Patients cannot be in Facility 6MMD and an RPCs simultaneously; if opting for Facility 6MMD, they must be disenrolled from RPCs.
- Women with contraceptive needs:
  - Re-explain contraceptive method options, with emphasis on how each impacts return visit frequency.
  - LARC: removes concerns about increased visit frequency or alignment.
  - Oral contraception and new self-injectable**: prescribe for 6 months and dispense full 6-month supply.
  - IM injectable (clinician-administered): explain that 2-4 additional facility visits per year will be required for injections. RPC options (see SOP 5): FAC-PUP or facility adherence club may be preferable.

** Available 1 October 2026 in all facilities - for more information see **www.depo2go.co.za**

## OVERVIEW OF ANNUAL FACILITY 6MMD PROCEDURE

| | **Combined clinical consultation + treatment supply** |
|---|---|
| WHEN (service frequency) | 6-monthly (**M6 & M12**) |
| WHERE (service location) | Health facility |
| WHO (service provider) | Clinician (dispensed by clinician or facility pharmacy) |
| WHAT (service package) | *Record in clinical stationery*<br>**M6 – Comprehensive clinical consultation visit**<br>Integrated chronic care clinical review (incl. FP review)<br>Routine investigations/exams according to guidelines (for HIV: VL)<br>6-month treatment script (6MMS) + 6-month treatment supply (6MMD)<br>**Add - For children:**<br>Dosage check and possible adjustment<br>Disclosure process review and check-in with caregiver<br>**Add - For adolescents:**<br>Mental health assessment<br>**M12 –Rescripting visit**<br>Brief integrated chronic care clinical check-up<br>6-month treatment script (6MMS) + 6-month treatment supply (6MMD)<br>**Add - For children:**<br>Dosage check and possible adjustment<br>**For breastfeeding mothers:**<br>VL |

**See Annexure V for Facility 6MMD visit schedule**

## INFORMATION TO BE PROVIDED TO THE PATIENT

**If patient meets criteria for Facility 6MMD, and chooses the Facility 6MMD over RPCs, the patient shall be informed about 6MMD as follows:**

- Facility 6MMD requires patients to see a clinician twice a year, once every 6 months. One comprehensive clinical consultation including routine investigations. One rescripting visit for a brief clinical check-up.
- At each visit, the patient will receive a 6-month prescription (6MMS) for their treatment.
- At each visit, the patient will be allowed to collect the full 6 months treatment supply.
- For women using contraception: If the women is using long-acting reversible contraception (LARC), there are no alignment concerns. If the women is using oral contraception or the new self-injectable**, her contraception will be included on the prescription and the full 6-month supply dispensed with treatment. Where a woman chooses to continue clinician administered short-acting intra-muscular (IM) injectable contraception, she will need attend the facility for 2-4 additional visits per year for her injections.
- Advise that medication should be stored in a cool, dry, safe place, away from sunlight and children. Pills should not be transferred out of the original containers into other containers. A few pills can be transferred into a weekly pill box or other small container for the day or week. The small packet inside the original pill container, called the desiccant, should be kept in the container as it absorbs unwanted moisture, keeping the pills dry. The pill bottles lids should be tightly closed after taking out medication.
- It is important for the patient to attend their two clinical consultations on the scheduled appointment dates.
- Patients should be reminded to take treatment every day to remain well and continue to qualify for Facility 6MMD. Patients will return to standard or more intensive DMOC and no longer qualify for Facility 6MMD if the patient requires more frequent clinical care or is more than 28 calendar days late for scheduled collection date.
- **Advise the patient that in the case of any health problems or should the patient become pregnant, to come in immediately to see a clinician NOT to wait until the next scheduled appointment date**
- A patient collection card with relevant scheduled return dates to the facility shall be issued to patient.

** Available 1 October 2026 in all facilities - for more information see **www.depo2go.co.za**

| ANNUAL VISIT SCHEDULE: FACILITY 6MMD | | | | |
|---|---|---|---|---|
| 6 MONTH* TREATMENT (TX) SUPPLY | | | | |
| MONTHS* IN 6MMD | LOCATION 6MMD VISIT | ACTIVITIES | SCRIPT TX SUPPLY NO. | |
| **6MMD M0** | Facility – Clinician | **Registration and Enrolment visit**<br>Facility 6MMD eligibility assessment + offer Facility 6MMD/RPCs options + record<br>Facility 6MMD enrolment in clinical stationery + 6MMS + 6MMD pick-up | 1 | |
| **6MMD M6** | Facility – Clinician | **Comprehensive clinical consultation visit**<br>Integrated chronic care clinical review (including FP review) + investigations + less intensive DMOC chosen still suitable + 6MMS[a] + record in clinical stationery + 6MMD pick-up | 1 | **2 visits per annum**<br>**Max 1 visit per 6-month script** |
| **6MMD M12** | Facility – Clinician | **Rescripting visit**<br>Brief integrated clinical care check-up + 6MMS + record in clinical stationery + 6MMD pick-up | 1 | |

**Cycle repeats from M6**

*** A month refers to a dispensing cycle (whether 28 or 30 days in length)**

a. After Facility 6MMD enrolment, patients should be rescripted at their 6-monthly clinical review dates. Patient should not be required to return for result review prior to rescripting. A small number of Facility 6MMD enrolled patients would receive an abnormal result and need to be recalled to the facility.

**See Annexure V for Facility 6MMD annual schedule diagram**

**CRITERIA FOR RETURN TO STANDARD OR MORE INTENSIVE DMOC**

- Patient did not return to the facility within 28 calendar days of their scheduled appointment date.
- Patient is assessed as clinically unstable requiring more frequent clinical management, including diagnosed with TB, other opportunistic infection, malnutrition, new or uncontrolled mental health or chronic condition.
- Other safety lab test results are abnormal:
  - **For HIV:** VL >1000 (where VL is 50-999 copies/ml, the patient must be recalled to the facility to see a clinician for A-E assessment (see ART guidelines), enhanced adherence counselling if indicated (SOP 2) and a follow-up VL 3 months later. A repeat 6MMS/6MMD prescription will only be provided once the second VL result is <50 copies/m. Low level viraemia must be managed).
  - **For Diabetes*:** HbA1c >8%
  - **For Hypertension*:** BP >140/90
- Facility 6MMD patient becomes pregnant and is referred to integrated MNCWH services.
- Clinicians determines that the patient is returning to the facility requiring a re-issue of treatment due to lost/stolen treatment supply repeatedly.

**All patients returned to standard or more intensive DMOC to ensure more frequent clinical care until they are stable again must be informed to ensure understanding. This is not punitive but supportive. Patients can return to an RPCs option after a single normal assessment result or Facility 6MMD after two consecutive normal assessment results and meeting other RPCs/Facility 6MMD criteria (also see Re-engagement SOP 8).**

**Annexures:**

V. Facility MMD eligibility & visit schedules

# REPEAT PRESCRIPTION COLLECTION STRATEGIES (RPCs)

## SOP 5

**TITLE: STANDARD OPERATING PROCEDURE FOR REPEAT PRESCRIPTION COLLECTION STRATEGIES**

**INSTITUTION: NATIONAL DEPARTMENT OF HEALTH**

**REFERENCE NUMBER: AGL: RPCS (5)** | **EFFECTIVE DATE: JUNE 2025**

## PURPOSE

The purpose of this document is to guide access to and the process for the three Repeat Prescription Collection Strategies options: Facility pick-up point (FAC-PUP); Adherence club (AC) and External pick-up (EX-PUP). Each RPCs provides MMD.

## PERSONS AFFECTED

- Chronic care patient living with HIV and/or a NCD or their nominee
- Healthcare worker, pharmacist or pharmacy assistant
- Lay counsellor or nursing assistant or CHW or NGO/CBO lay cadre (supporting facility)
- Administrative clerk
- Facility pharmacy or Central Chronic Medicine Dispensing and Distribution program (CCMDD) or Central Dispensing Unit (CDU)

## APPLICABLE POLICY REFERENCE

For HIV: 2025 National consolidated guidelines for the management of HIV in adults, adolescents, children and infants and prevention of vertical transmission
For NCDs: 2023 Adult Primary Care Guide

## CRITERIA FOR REPEAT PRESCRIPTION COLLECTION STRATEGIES

- Above 5 years of age
- Not pregnant or post-natal within 12 months of delivery
- Most recent assessment result normal:
  - **For HIV:** Most recent viral load taken in past 12 months <50 copies/ml
  - **For Diabetes:** Most recent HbA1c taken in past 12 months ≤8%
  - **For Hypertension:** Two consecutive BP <140/90
- Clinically stable with no current TB, other opportunistic infection, malnutrition, new or uncontrolled mental health or chronic condition requiring clinical review more regularly than once every 6 months (see SOP 4 Facility MMD to enable longer supply outside of RPCs)
- Clinician confirms the patient's eligibility for RPCs option
- Patient voluntarily opts for RPCs option

**Children specific additional criteria:**

- No regimen or dosage change in the last 3 months
- Caregivers counselled on disclosure process where age appropriate disclosure not yet achieved (see SOP 3).
- Where patient <12 years, caregiver voluntarily opts for Facility 6MMD

**Stable family members should be encouraged to join the less intensive DMOC with the same treatment supply collection location and appointment date to support family adherence.**

**Note for pregnant and post-natal women:**

- Pregnant women should receive their ART care aligned and integrated into their BANC plus visits.
- New mothers should continue their ART care aligned with their infant EPI visit schedule (2MMD at birth and 3MMD from week 6 EPI visit) and preferably fully integrated into MNCWH services. At the Month 12 EPI visit, mothers may be assessed, offered and enrolled into RPCs of their choice or Facility 6MMD (see integration tables in 2025 VTP guidelines) provided she is seen at her facility every 6 months for her 6-monthly VL until cessation of breastfeeding.

## GUIDING PRINCIPLES FOR ALL RPCs

- DMOC for stable patients provides for three different RPCs and Facility 6MMD (if eligible) depending on the patients needs and preferences.
- RPCs treatment supply can be pre-dispensed by CCMDD or a CDU or the facility pharmacy.
- Patients should be given a choice of RPCs options and Facility 6MMD (if eligible) to enroll in and not be forced into any one model. **Please note that CCMDD is not a RPCs, it is centralized treatment predispensing and distribution mechanism which enables all three RPCs.**
- A patient should be assessed for RPCs enrolment (external PUP, facility PUP or adherence club) at the first facility visit after clinical guideline mandated investigations (VL/HbA1c) are taken. **This enables RPCs assessment four dispensing cycles/Month 4 visit after treatment start.**
  **See Annexure IV for first year on treatment schedule**

- Women with contraceptive needs:
  - Re-explain contraceptive method options, with emphasis on how each impacts return visit location (at the facility or outside of the facility) and frequency.
  - LARC: removes concerns about increased visit frequency or alignment.
  - Oral contraception and new self-injectable*: prescribe for 6 months and dispense full 6-month supply on the scripting date or provide for refill collection through the same RPCs.
  - IM injectable (clinician-administered): explain that 2-4 additional facility visits per year will be required for injections. FAC-PUP or facility adherence club may be preferable.
- Clinicians should ensure that patients' enrolment/deregistration in the specific RPCs is reflected in their clinical stationery and administrative clerks should capture in TIER.Net.
- Patients should have **a maximum of two drug collections from a RPCs script**. The first from the facility aligned with the clinical review/scripting visit and the second from the RPCs location. At each drug collection the patients should collect multiple months treatment supply. The clinician should preferably script 2x3MMD. However if the facility is experiencing shortages for any scripted drug, the clinician can script 1x2MMD from the facility and 1x4MMD from RPCs. See RPCs annual schedule diagram.
- Routine investigations should only be done at the comprehensive clinical consultation visit not at the rescripting visit. For a patient already enrolled in RPCs, a new RPCs script is written and submitted at the comprehensive clinical consultation visit before laboratory results are back for review. **A RPCs patient should not be made to return for result review before a new RPCs script is submitted.** Small numbers of RPCs patients with abnormal assessment results should be recalled by the facility immediately on receipt of the abnormal result (see Tracing and Recall SOP 7).

* Available 1 October 2026 in all facilities - for more information see **www.depo2go.co.za**

- If RPCs patient screens positive for TB symptom/s at their RPCs clinical consultation visit, the clinician will rescript for RPCs.
  - If the facility has an effective result management and recall system in place, it will recall any patient with positive TB diagnosis.
  - If the facility does not have a reliable results management and/or recall system in place, it will require a patient with TB symptoms to return to the facility within 5-7 days for a combined review of their TB and assessment results.
  - If the patient is not diagnosed with TB (and their assessment result was normal), the patient will continue in RPCs.
  - If the patient is diagnosed with TB, the patient will be clinically managed more intensively and should be re-assessed for RPCs enrolment when TB treatment is completed. The patient should be considered for 2-monthly supply of ART and TB treatment during the continuation phase (refer to page 27 of the 2023 ART guideline and SOP 4.1 2MMD).
- **Patients feeling unwell can at any time go to the facility to see a clinician and should not wait for scheduled appointment date.**
- All processes must be documented.

**CRITERIA FOR RETURN TO STANDARD OR MORE INTENSIVE DMOC**

- RPCs patient did not return to the facility or RPCs within 28 calendar days of their scheduled RPCs appointment date.
- Patient is assessed as clinically unstable requiring more frequent clinical management, including diagnosed with TB, other opportunistic infection, malnutrition, new or uncontrolled mental health or chronic condition.
- Other safety lab test results are abnormal.
  - **For HIV:** VL >1000 copies/ml (where VL is 50-999 copies/ml the patient can choose to remain in RPCs but must be recalled to the facility to see a clinician for A-E assessment (see ART guidelines), enhanced adherence counselling if indicated (SOP 2) and a follow-up VL 3 months later). **Low level viraemia must be managed.**
  - **For Diabetes:** HbA1c >8%
  - **For Hypertension:** BP >140/90
- RPCs patient becomes pregnant and is referred to integrated MNCWH services.

**All patients returned to standard or more intensive service DMOC to ensure more frequent clinical care until they are stable again must be informed to ensure understanding. This is not punitive but supportive. Patients can return to their RPCs (or alternative preferred RPCs) after a single normal result and meeting other RPCs criteria (also see Re-engagement SOP 8).**

## TRACING, RECALL AND RE-ENGAGEMENT FOR RPCs PATIENTS

**If RPCs patients do not arrive at the facility or their RPCs location to pick-up their treatment supply within 7 calendar days from the last day they were allowed to collect their treatment supply from their RPCs:**

- Patients are contacted through SMS or reminder calls to return to the facility to collect medicine.
- If unsuccessful, patients are added to the facility tracing list which are traced according to their order of priority. For further details on tracing refer to Tracing and Recall SOP 7.

**Management of patients who miss a scheduled appointment:**

- If the patient returns within 28 days (on their own or after tracing)
  - Manage as a routine patient in the same RPCs.
  - If not already in a less-intensive DMOC, assess eligibility and consider enrolment.
- If the patient is more than 28 days late: Follow the Re-engagement SOP 8.

## DEREGISTRATION FROM RPCs

RPCs patients must be deregistered from their specific RPCs on TIER.Net if they change their DMOC including to Facility 6MMD or standard service delivery (Facility 3MMD (exceptionally 2MMD)) or more intensive service delivery.

**Annexures:**

IV. First year on treatment visit schedule
VI. RPCs eligbility & annual visit schedules
VII. RPCs algorithm

# RPCs
# FACILITY PICK-UP POINT (FAC-PUP)
## SOP 5.1

**TITLE: STANDARD OPERATING PROCEDURE FOR REPEAT PRESCRIPTION COLLECTION STRATEGY - FACILITY PICK-UP POINT (FAC-PUP)**

**INSTITUTION: NATIONAL DEPARTMENT OF HEALTH**

**REFERENCE NUMBER: AGL: FAC-PUP (5.1)** | **EFFECTIVE DATE: APRIL 2023**

## PURPOSE

The purpose of this document is to guide when a chronic care patient can be considered and the process for the Repeat Prescription Collection strategy (RPCs) option: **Facility pick-up point (FAC-PUP).**

## DESCRIPTION OF FAC-PUP

- A FAC-PUP can take various forms in a facility but all forms **must ensure fast (one stop only) treatment supply collection** and should not require a patient to attend registry, vital signs or see a clinician. **There is no need to add RPCs patients on facility headcount/utilization rate.** There are no financial implications if these patients do not set their feet in the facility.
- The following are examples of FAC-PUP models:
  - **Fast (one stop only)** ART treatment supply pick-up from *fast lane at facility pharmacy*
  - **Fast (one stop only)** ART treatment supply pick-up from *designated room/ area managed by lay cadre* at the facility
  - **Fast (one stop only)** ART treatment supply pick-up *after hours* from pharmacy/designated area at the facility
  - **Fast (one stop only)** ART treatment supply pick-up from a *mobile outreach point* (facility team will take pre-dispensed treatment supply to mobile outreach point for patient collection).
- **The treatment for the FAC-PUP can be pre-dispensed by the facility pharmacy or by a CDU or by CCMDD. CCMDD or CDU is preferred to reduce burden on the facility pharmacy.**

## ADDITIONAL GUIDING PRINCIPLES APPLICABLE TO FAC-PUP ONLY

- There must be a dedicated room/area at the facility or a fast lane at the facility pharmacy for a specified period decided by each facility (can be after hours to support working patients) to operate the FAC-PUP system.
- There is only one FAC-PUP at each facility. **There should not be multiple FAC PUPs at a facility driven by different treatment pre-dispensing systems.** The drug supply system should not impact the service delivery point to the patient.

- Patient medicine parcels (PMPs) must be prepared or delivered at least a day before to facilitate an effective FAC-PUP.
- **FAC-PUP patients must only attend one stop to ensure fast treatment collection. FAC-PUP patient are not required to attend registry, do not need to collect their patient folder, should not have their vital signs taken or see a clinician at each treatment supply visit. The patients should not be added to the facility headcount register.**

**FACILITY TEAM, ROLES AND RESPONSIBILITIES: FAC-PUP**

**RPCs Co-ordination Team** takes overall responsibility for the activities required to run a successful FAC-PUP system at the facility. A team of at least 2 people (nurse or pharmacist or pharmacy assistant) together with operational manager at the facility should be designated to take on this role. Duties include: ensuring this SOP is carried out, FAC-PUP distributors are designated to distribute PMPs at the times the FAC-PUP system operates at the facility (can include CBO supported cadre), FAC-PUP system set up and co-ordination at the facility including clinicians briefed on registration processes, FAC-PUP enrolment/deregistration is captured on TIER.Net, all FAC-PUP assessment results managed through ICSM lab results review approach (reviewed by clinician with recall of patients with abnormal results), visit attendance is captured in TIER.Net as outlined in Integrated TB/HIV data management SOP RPCs annexure.

**FAC-PUP Distributor** is the person designated to run the FAC-PUP on the day of the FAC-PUP (including after hours). FAC-PUP Distributors should be lay staff (lay counsellors, CHWs or supporting CBO). Their duties include: collecting PMPs, distributing PMPs, registering attendance in RPCs monitoring tool and following up patients who miss appointment dates.

**Pharmacist or Pharmacy Assistant** is responsible for pre-dispensing treatment for the FAC-PUP if supplied by facility pharmacy.

**Administrative clerk** is responsible for capturing patient's FAC-PUP enrolment/deregistration and attendance into TIER.Net as outlined in Integrated TB/HIV data management SOP RPCs annexure.

***Only the designated FAC-PUP Distributor needs to be present at the FAC-PUP pharmacy fast lane/designated area at the facility. A PN need not be present. FAC-PUP patients attend regular clinical care when due for clinical consultations.**

| OVERVIEW OF ANNUAL FAC-PUP PROCEDURE | | |
|---|---|---|
| | **Repeat collection** | **Clinical consultation** |
| **WHEN**<br>service frequency | 3-monthly<br>**(RPCs M3* & RPCs M9*)** | 6-monthly<br>**(RPCs M6 & RPCs M12)** |
| **WHERE**<br>service location | Health facility | Health facility |
| **WHO**<br>service provider | Lay cadre - lay counsellor/ CHW/supporting CBO lay cadre | Clinician |
| **WHAT**<br>service package | **Second treatment supply**<br>Adherence check<br>Check if patient unwell or wants to see a clinician – refer<br>Record patient visit in RPCs monitoring tool | *Record in clinical stationery*<br>**RPCs M6 – Comprehensive clinical consultation visit**<br>Integrated chronic care clinical review (incl. FP+TPT review)<br>Routine investigations/exams according to the HIV, hypertension and diabetes guidelines including VL/BP/HbA1c<br>Treatment script + **first supply**<br>**Add:**<br>**For children:**<br>Dosage check and possible adjustment<br>Disclosure process review and check-in with caregiver<br>**For adolescents:**<br>Mental health assessment<br>**RPCs M12 – Rescripting visit**<br>Brief integrated chronic care clinical check-up<br>Treatment script + **first supply**<br>**Add:**<br>**For children:**<br>Dosage check and possible adjustment<br>**For breastfeeding mothers:**<br>VL |

***** Where a facility is experiencing drug shortages, the treatment supply only visits to the RPCs location can be changed to RPCs M2 & RPCs M8. This will support a first supply of 2 months (2MMD) from the facility and a second supply of 4 months (4MMD) from RPCs. **Every effort should be made not to provide a shorter supply from the facility/RPCs to ensure a maximum of 2 patient visits per 6-month script.**

**FAC-PUP PROCEDURE - SEE RPCS ALGORITHM (ANNEXURE V)**

**INFORMATION TO BE PROVIDED TO FAC-PUP PATIENT**

**If patient complies with criteria for RPCs, and chooses the FAC-PUP option, the patient shall be informed about the FAC-PUP as follows:**

- In a FAC-PUP, clinically stable patients (meeting RPCs criteria) are required to see a clinician once a year for a comprehensive clinical consultation and routine investigations. At the clinician's discretion, they can be required to see a clinician at their rescripting visit for a brief clinical check-up.
- Patients receive a 6 month repeat prescription for their treatment at a time.
- Each time the FAC-PUP patient visits the facility, the patient should be allowed to collect multiple months treatment supply.
- At visits where a FAC-PUP patient does not need to see a clinician for a clinical consultation, FAC-PUP patients should be allowed to go through a fast lane, meaning only one stop at the pharmacy or designated room/area at the facility managed by a lay cadre without having to attend registry, collecting their patient folder, having their vital signs taken or seeing a clinician.
- It is important to attend the FAC-PUP on the scheduled collection date. If this is not possible, FAC-PUP patients can nominate a person to attend on their behalf but not twice in a row or at a clinical consultation visit. If this happens, the nominee will be told to tell the patient to come in themselves. If it was impossible to attend or send a nominee, the patient can continue to collect their treatment up to 28 days after their scheduled appointment date.
- For women using contraception: If the women is using long-acting reversible contraception (LARC), there are no alignment concerns. If the women is using oral contraception or the new self-injectable, her contraception will be included on the prescription and the full 6-month supply dispensed alternatively refill collection through her FAC-PUP. Where a woman chooses to continue clinician administered short-acting intra-muscular (IM) injectable contraception, she will need attend the facility for 2-4 additional visits per year for her injections.
- A FAC-PUP patient will return to regular care at the facility and no longer attend the FAC-PUP if the patient requires more frequent clinical care or is more than 28 calendar days late for scheduled FAC-PUP collection date. If the patient becomes pregnant, she should inform the FAC-PUP Distributor who will support linkage to integrated MNCWH services.
- **In case of health problems, patients must be advised to attend the facility to see a clinician and should not wait for scheduled appointment date.**
- A patient collection card with relevant scheduled collection and return dates to the facility shall be issued to patient.

| ANNUAL VISIT SCHEDULE: FAC-PUP | | | | |
|---|---|---|---|---|
| 3 MONTH* TREATMENT (TX) SUPPLY | | | | |
| MONTHS* IN RPCS | LOCATION FAC-PUP VISIT | ACTIVITIES | SCRIPT TX SUPPLY NO. | |
| **RPCs M0** | Facility – Clinician | **Registration and Enrolment visit**[a]<br>RPCs eligibility assessment + offer RPCs options + complete RPCs registration form + record FAC-PUP enrolment in clinical stationery + 6MMS + 3MMD** pick-up | 1 | |
| **RPCs M3**** | Facility - pharmacy fast lane/FAC-PUP designated area/ room | **Repeat collection**<br>3MMD** pick-up | 2 | **4 visits per annum**<br>**Max 2 visits per 6-month script** |
| **RPCs M6** | Facility – Clinician | **Comprehensive clinical consultation visit**<br>Integrated chronic care clinical review (including FP and TPT review) + investigations + check RPCs option chosen still suitable[b] + 6MMS[c] + record in clinical stationery + 3MMD** pick-up | 1 | |
| **RPCs M9**** | Facility - pharmacy fast lane/FAC-PUP designated area/ room | **Repeat collection**<br>3MMD** pick-up | 2 | |
| **RPCs M12** | Facility – Clinician | **Rescripting visit**[d]<br>Brief integrated clinical care check-up + 6MMS + record in clinical stationery + 3MMD** pick-up | 1 | |

**Cycle repeats from M3**

*** A month refers to a dispensing cycle (whether 28 or 30 days in length)**

**** RPCs treatment supply only visits can be 2 months after the clinician scripting date at M2 and M8 where the facility was experiencing drug shortages at date of scripting. The clinician can then specify 1x2MMD (first dispense from the facility at RPCs M0/M6/M12) and 1x4MMD (second dispense from RPCs location at RPCs M2/M8/M14).**

a. VL/HbA1c should not be done again at the registration visit.

b. If patient chooses to change RPCs option: Clinician to complete registration form indicating change and record change in clinical stationery for capturing

c. After RPCs enrolment, patients should be rescripted at their 6-monthly clinical review dates. Patient should not be required to return for result review prior to rescripting. A small number of RPCs enrolled patients would receive an abnormal result and need to be recalled to the facility.

d. To see clinician at clinician discretion

**See Annexure VI for RPCs annual schedule diagram**

**AT FACILITY PHARMACY FAST LANE/DESIGNATED FAC-PUP AREA/ROOM**

**The FAC-PUP Distributor shall:**

- Verify patient identity using approved means of identification. A nominated person collecting on behalf of the patient must produce patient's approved means of identification.
- Issue the multiple months treatment supply (PMP).
- Enquire whether the patient is doing well on current treatment and refer to a clinician if the patient reports feeling unwell or perceived to be unwell/unstable.
- Advise the patient when it is necessary at their next facility visit to see a clinician for a clinical review.
- Register the patient visit in the RPCs monitoring tool. For further detail refer to the Integrated TB/HIV data management SOP RPCs annexure.

**Annexures:**

IV. First year on treatment visit schedule
VI. RPCs annual schedules
VII. RPCs algorithm

# RPCs
# ADHERENCE CLUB (AC)
## SOP 5.2

**TITLE: STANDARD OPERATING PROCEDURE FOR REPEAT PRESCRIPTION COLLECTION STRATEGY - ADHERENCE CLUB (AC)**

**INSTITUTION: NATIONAL DEPARTMENT OF HEALTH**

**REFERENCE NUMBER: AGL: AC (5.2)** | **EFFECTIVE DATE: APRIL 2023**

## PURPOSE

The purpose of this document is to guide when a chronic care patient can be considered and the process for the Repeat Prescription Collection strategy (RPCs) option: **Facility or community adherence club**

## DESCRIPTION OF ADHERENCE CLUB

- Adherence clubs can be provided for any group of people, including from the same geographical area or a specific population of patients e.g. adolescents only or family units or men or members of a specific key population. They can take place in or outside of a facility. The Club Facilitator can work for a facility, for a CBO/NGO, private service provider or for a WBPHCOT team.
- An adherence club consists of a group of 10-30 patients (clubs can be smaller in rural contexts). Adherence club participation can be built up over a few months to reach this target group number.
- Adherence clubs provide a RPCs for stable patients who value continued psychosocial support and group engagement.
- Adherence clubs have a group format with patients meeting as a group and receiving their multi-month treatment supply. **Where patients come individually with no group format or group engagement, the RPCs is not an adherence club** (if at the facility = facility pick-up point (see SOP 5.1)/if outside of the facility = external pick up point (see SOP 5.3)).
- **The treatment for an adherence club can be pre-dispensed by the facility pharmacy or by a CDU or by CCMDD (CCMDD only for adherence clubs >10 patients). CCMDD or CDU is preferred to reduce burden on the facility pharmacy.**

## ADDITIONAL GUIDING PRINCIPLES APPLICABLE TO ADHERENCE CLUBS ONLY

- Health facilities can establish both facility-based and community-based adherence clubs with patients offered a choice.
- Patient medicine parcels (PMPs) must be prepared or delivered at least a day before to facilitate effective adherence clubs.
- **Adherence club patients are not required to attend registry, do not need to collect their patient folder, should not have their vital signs taken or see a clinician at each treatment supply. These patients do not need to be added to facility headcount register.**

| FACILITY TEAM, ROLES AND RESPONSIBILITIES: ADHERENCE CLUBS |
| --- |
| **Clubs Manager** takes overall responsibility for the activities required to run successful adherence clubs. The facility manager designates a nurse to take on this role. The nurse will be part of the RPCS Co-ordination Team. Where the nurse is not at the facility on any given day, the operational manager leading the RPCS co-ordination team will be responsible for this role. Duties include: ensuring this SOP is carried out, adherence club team recruitment, scheduling adherence club visit dates, adherence club enrolment/deregistration is captured on TIER.Net, providing Club Facilitators with new treatment literacy information/materials, ensure all adherence club assessment results are managed through ICSM lab results review approach (reviewed by clinician with recall of patients with abnormal results) and adherence club visit attendance is captured in TIER.Net as outlined in Integrated TB/HIV data management SOP RPCs annexure. |
| **Club Facilitator** is responsible for establishing adherence clubs with the assistance of Clubs Manager and running the adherence club sessions. Their duties include: collecting pre-dispensed PMPs, registering members, facilitating the support group, checking on adherence and wellness of members, referring patients to Club PN if necessary, distributing PMPs, registering attendance in RPCs monitoring tool and following up patients who miss sessions. |
| **Club PN** is responsible for oversight of adherence clubs on the day of the club visit. Duties include: seeing symptomatic patients referred by the Club Facilitator, carrying out clinical consultations for adherence club patients and routine investigations. |
| **Pharmacist or Pharmacy Assistant** is responsible for pre-dispensing treatment for adherence clubs if supplied by facility pharmacy. |
| **Administrative Clerk** is responsible for capturing patient's adherence club enrolment/deregistration and attendance into TIER.Net as outlined in Integrated TB/HIV data management SOP RPCs annexure. |
| ***Only the Club Facilitator is always present at each club session. The Club PN need not be present at the club session but is available at the health facility during and after the session to see any referrals, provide clinical consultations or labs or rescripts required.** |

| OVERVIEW OF ANNUAL ADHERENCE CLUB PROCEDURE | | |
|---|---|---|
| | **Repeat collection** | **Clinical consultation** |
| **WHEN**<br>service frequency | 3-monthly<br>**(RPCs M3* & RPCs M9*)** | 6-monthly<br>**(RPCs M6 & RPCs M12)** |
| **WHERE**<br>service location | Health facility/Community venue | Health facility |
| **WHO**<br>service provider | Lay cadre - lay counsellor/ CHW/CBO or NGO lay cadre | Clinician |
| **WHAT**<br>service package | **Second treatment supply**<br>Adherence check<br>Check if patient unwell or wants to see a clinician – refer<br>Record patient visit in RPCs monitoring tool | *Record in clinical stationery*<br>**RPCs M6 – Comprehensive clinical consultation visit**<br>Integrated chronic care clinical review (incl. FP + TPT review)<br>Routine investigations/exams according to the HIV, hypertension and diabetes guidelines including VL/BP/HbA1c<br>Treatment script + **first supply**<br>**Add:**<br>**For children:**<br>Dosage check and possible adjustment<br>Disclosure process review and check-in with caregiver<br>**For adolescents:**<br>Mental health assessment<br>**RPCs M12 – Rescripting visit**<br>Brief integrated chronic care clinical check-up<br>Treatment script + **first supply**<br>**Add:**<br>**For children:**<br>Dosage check and possible adjustment<br>**For breastfeeding mothers:**<br>VL |

* Where a facility is experiencing drug shortages, the treatment supply only visits to the RPCs location can be changed to RPCs M2 & RPCs M8. This will support a first supply of 2 months (2MMD) from the facility and a second supply of 4 months (4MMD) from RPCs. **Every effort should be made not to provide a shorter supply from the facility/RPCs to ensure a maximum of 2 patient visits per 6-month script.**

## ADHERENCE CLUB PROCEDURE – SEE RPCS ALGORITHM (ANNEXURE V)

### Information to be provided to adherence club patient

**If patient complies with criteria for RPCs, and chooses the adherence club option, the patient shall be informed about the adherence club as follows:**

- In an adherence club, clinically stable patients (meeting RPCs criteria) meet as a group for 45 minutes to 1.5 hours. The group is facilitated by a Club Facilitator who supports group engagement, sharing and brings new information or answers about disease, treatment and RPCs model. The group members are encouraged to engage and share their experiences and challenges of living with a chronic condition and taking lifelong treatment.
- Adherence clubs consist of a group of 10-30 patients (clubs can be smaller in rural contexts) and can meet at the facility or outside the facility at a member's home or community venue at a time agreed by the members of the adherence club. Adherence clubs can start at the facility and later move their meeting to a community-based venue as members feel more comfortable.
- Multiple months treatment supply is distributed at each group meeting so there is no need to attend the clinic pharmacy to collect.
- Members are required to see a clinician once a year for a comprehensive clinical consultation and routine investigations.
- Patients receive a 6 month repeat prescription for their treatment at a time.
- It is important to attend the adherence club on the scheduled appointment date. If this is not possible, an adherence club member can nominate a person (buddy) to attend on their behalf but cannot do so twice in a row or at a clinical consultation visit. If this happens, the buddy will be told to tell the patient to come in themselves. If it was impossible to attend or send a buddy, the patient can go to the facility within 28 calendar days to collect their treatment supply.
- For women using contraception: If the women is using long-acting reversible contraception (LARC), there are no alignment concerns. If the women is using oral contraception or the new self-injectable, her contraception will be included on the prescription and the full 6-month supply dispensed alternatively refill collection through her adherence club. Where a woman chooses to continue clinician administered short-acting intra-muscular (IM) injectable contraception, she will need attend the facility for 2-4 additional visits per year for her injections and may prefer a facility-based AC or FAC-PUP.

- A patient will return to regular care at the facility and no longer attend the adherence club if the patient requires more frequent clinical care, or missed their scheduled adherence club appointment date by more than 28 days. If the patient becomes pregnant, she should inform the Club Facilitator and report back to the facility for integrated MNCWH services.
- **In case of health problems, patients must be advised to attend the facility to see a clinician and should not wait for scheduled appointment date.**
- A patient collection card with relevant scheduled collection and return dates to the facility shall be issued to patient.

| ANNUAL VISIT SCHEDULE: ADHERENCE CLUBS | | | | |
|---|---|---|---|---|
| **3-MONTH* TREATMENT (TX) SUPPLY** | | | | |
| **MONTHS* IN RPCS** | **LOCATION AC VISIT** | **ACTIVITIES** | **SCRIPT TX SUPPLY NO.** | |
| **RPCs M-1** | Facility<br>*(not an adherence club visit)* | **Registration visit**<br>RPCs eligibility assessment + offer RPCs options + complete RPCs registration form + script and align treatment supply to cover until first adherence club visit date + collect treatment supply at facility pharmacy | | |
| **RPCs M0** | Facility<br>*(meet as a group for the first time)* | **Enrolment visit**[a]<br>Enrolment in RPCs monitoring tool + record adherence club enrolment in clinical stationery + 6MMS + 3MMD** pick-up from facility pharmacy | 1 | |
| **RPCs M3**** | Adherence club venue | **Repeat collection**<br>3MMD** pick-up | 2 | **4 visits per annum**<br>**Max 2 visits per 6-month script** |
| **RPCs M6** | Facility/Adherence club venue[e] | **Comprehensive clinical consultation visit**<br>Integrated chronic care clinical review (incl. FP+TPT review) + investigations + check RPCs option chosen still suitable[b] + 6MMS[c] + record in clinical stationery + 3MMD** pick-up | 1 | |
| **RPCs M9**** | Adherence club venue | **Repeat collection**<br>3MMD** pick-up | 2 | |
| **RPCs M12** | Facility/Adherence club venue[e] | **Rescripting visit**[d]<br>Brief integrated chronic care clinical check-up + 6MMS + record in clinical stationery + 3MMD** pick-up | 1 | |

**Cycle repeats from M3**

*** A month refers to a dispensing cycle (whether 28 or 30 days in length)**

**** RPCs treatment supply only visits can be 2 months after the clinician scripting date at M2 and M8 where the facility was experiencing drug shortages at date of scripting. The clinician can then specify 1x2MMD (first dispense from the facility at RPCs M0/M6/M12) and 1x4MMD (second dispense from RPCs location at RPCs M2/M8/M14).**

a. VL/HbA1c should not be done again at the enrolment visit.

b. If patient chooses to change RPCs option: Clinician to complete registration form indicating change and record change in clinical stationery for capturing

c. After RPCs enrolment, patients should be rescripted at their 6-monthly clinical review dates. Patient should not be required to return for result review prior to rescripting. A small number of RPCs enrolled patients would receive an abnormal result and need to be recalled to the facility.

d. To see clinician at clinician discretion

e. Clinician can carry out clinical consultation at adherence club meeting venue

**See Annexure VI for RPCs annual schedule diagram**

## AT ADHERENCE CLUB VENUE

**The Club Facilitator shall:**

- Verify patient identity using approved means of identification. A nominated person collecting on behalf of the patient must produce patient's approved means of identification.
- Facilitate a group discussion and engagement.
- Issue the multiple months treatment supply (PMPs).
- Enquire whether the patient is doing well on current treatment and refer to the Club PN if the patient reports feeling unwell or perceived to be unwell/unstable.
- Register the patient visit in the RPCs monitoring tool. For further detail refer to the Integrated TB/HIV data management SOP RPCs annexure.

## TRACING, RECALL AND RE-ENGAGEMENT SPECIFIC TO ADHERENCE CLUB PATIENTS

- If Adherence Club patients arrive at the facility within 28 calendar days from the scheduled adherence club appointment date, the Clubs Manager will review the case, and where appropriate refer to the clinic pharmacy for issuing of treatment. If it was a clinical consultation/rescripting visit, the Clubs Manager shall ensure that appropriate action is taken for the specific visit.

**Annexures:**

IV. First year on treatment visit schedule
VI. RPCs annual schedules
VII. RPCs algorithm

# RPCs
# EXTERNAL PICK-UP POINT (EX-PUP)
## SOP 5.3

**TITLE: STANDARD OPERATING PROCEDURE FOR REPEAT PRESCRIPTION COLLECTION STRATEGY – EXTERNAL PICK-UP POINT**

**INSTITUTION: NATIONAL DEPARTMENT OF HEALTH**

**REFERENCE NUMBER: AGL: EX-PUP (5.3)** | **EFFECTIVE DATE: APRIL 2023**

## PURPOSE

The purpose of this document is to guide when a chronic care patient can be considered and the process for the Repeat Prescription Collection strategy (RPCs) option: **External pick-up point (EX-PUP)**

## DESCRIPTION OF EX-PUP

- EX-PUP can take various forms but all involve the patient collecting their treatment supply individually from an external service provider based at a pick-up point outside of the facility or from an automated system.
- The following are examples of EX-PUPs:
  - Treatment supply pick-up from a private pharmacy
  - Treatment supply pick-up from a designated community venue (not an adherence club)
  - Treatment supply pick-up from a post box/ATM or similar automated system located inside or outside of a facility
  - Treatment supply pick-up from a container operated by a private service provider located inside the grounds of or outside of a facility
- **The treatment for an EX-PUP is most commonly pre-dispensed by CCMDD. However it can also be pre-dispensed by a CDU or a facility pharmacy and transported to the EX-PUP location. CCMDD or CDU is preferred to reduce burden on the facility pharmacy.**

## ADDITIONAL GUIDING PRINCIPLES APPLICABLE TO EX-PUP ONLY

- **Patients should be provided with ALL possible EX-PUP locations to choose the most suitable.**
- Pre-dispensed treatment supply (PMPs) must be delivered to the EX-PUP service provider at least a day before to facilitate effective EX-PUPs.

| FACILITY TEAM, ROLES AND RESPONSIBILITIES: EX-PUP |
| --- |
| **RPCs Co-ordination Team** takes overall responsibility for the activities required to run a successful EX-PUP system from the facility perspective. A team of at least 2 people (nurse or pharmacist or pharmacy assistant) together with operational manager at the facility should be designated by the facility manager to take on this role. Duties include: ensuring this SOP is carried out, ensuring clinicians briefed on all EX-PUP locations and providers and registration processes, CCMDD liaison and co-ordination, EX-PUP enrolment/deregistration is captured on TIER.Net, all EX-PUP assessment results managed through ICSM lab results review approach (reviewed by clinician with recall of patients with abnormal results), EX-PUP visit attendance is captured in TIER.Net as outlined in the Integrated TB/HIV data management SOP RPCs annexure. |
| **Administrative clerk** is responsible for capturing patient's EX-PUP enrolment/ deregistration and attendance into TIER.Net as outlined in the Integrated TB/HIV data management SOP RPCs annexure. |
| **EX-PUP patients attend regular clinical care when due for clinical consultations.** |

| **OVERVIEW OF ANNUAL EX-PUP PROCEDURE**<br>This procedure applies **after** initial RPCs enrolment. RPCs enrolment visit = RPCs M0 | | |
|---|---|---|
| | **Repeat collection** | **Clinical consultation** |
| **WHEN**<br>service frequency | 3-monthly<br>**(RPCs M3* & RPCs M9*)** | 6-monthly<br>**(RPCs M6 and RPCs M12)** |
| **WHERE**<br>service location | EX-PUP | Health facility |
| **WHO**<br>service provider | EX-PUP service provider | Clinician |
| **WHAT**<br>service package | **Second treatment supply**<br>Adherence check<br>Check if patient unwell or wants to see a clinician – refer<br>Record patient visit in RPCs monitoring tool | *Record in clinical stationery*<br>**RPCs M6 – Comprehensive clinical consultation visit**<br>Integrated chronic care clinical review (incl. FP+TPT review)<br>Routine investigations/exams according to the HIV, hypertension and diabetes guidelines including VL/BP/HbA1c<br>Treatment script + **first supply**<br>**Add:**<br>**For children:**<br>Dosage check and possible adjustment<br>Disclosure process review and check-in with caregiver<br>**For adolescents:**<br>Mental health assessment<br>**RPCs M12 – Rescripting visit**<br>Brief integrated chronic care clinical check-up<br>Treatment script + **first supply**<br>**Add:**<br>**For children:**<br>Dosage check and possible adjustment<br>**For breastfeeding mothers:**<br>VL |

* Where a facility is experiencing drug shortages, the treatment supply only visits to the RPCs location can be changed to RPCs M2 & RPCs M8. This will support a first supply of 2 months (2MMD) from the facility and a second supply of 4 months (4MMD) from RPCs. **Every effort should be made not to provide a shorter supply from the facility/RPCs to ensure a maximum of 2 patient visits per 6-month script.**

## EX-PUP PROCEDURE - SEE RPCS ALGORITHM (ANNEXURE V)

### INFORMATION TO BE PROVIDED TO EX-PUP PATIENT

**If patient complies with criteria for RPCs, and chooses the EX-PUP option, the patient shall be informed about the EX-PUP as follows:**

- EX-PUP patients are required to return to the facility every 6 months.
- The patient is required to see a clinician once a year for a comprehensive clinical consultation and routine investigations. They are required to see a clinician at their rescripting visit for a brief clinical check-up.
- Patients receive a 6 month repeat prescription for their treatment at a time.
- There are a number of EX-PUP locations and providers to choose from. Provide the patient with the full list of options.
- Each time the patient visits the facility or EX-PUP, the patient should be allowed to collect multiple months treatment supply.
  - The patient will receive their scripted first treatment supply from the facility.
  - The second treatment supply will be collected from the EX-PUP.
  - The patient will be informed when their treatment supply (PMP) has been delivered to the EX-PUP for collection.
  - Should a patient not receive a SMS regarding the collection date, the patient should still go to their EX-PUP location to collect their PMP on the scheduled collection date.
- Request the patient to complete the registration and consent form including choice of EX-PUP nominee details.
- It is important to attend the EX-PUP on the scheduled collection date. If this is not possible, the EX-PUP patient can send a registered nominee. The treatment supply will only remain at the EX-PUP for 28 calendar days thereafter it is returned.
- For women using contraception: If the women is using long-acting reversible contraception (LARC), there are no alignment concerns. If the women is using oral contraception or the new self-injectable, her contraception will be included on the prescription and the full 6-month supply dispensed alternatively refill collection through her EX-PUP. Where a woman chooses to continue clinician administered short-acting intra-muscular (IM) injectable contraception, she will need attend the facility for 2-4 additional visits per year for her injections and may prefer FAC-PUP or facility AC.

- A patient will return to regular care at the facility and no longer attend the EX-PUP if the patient requires more frequent clinical care, or misses their scheduled EX-PUP collection date by more than 28 days. If the patient becomes pregnant, she should inform the adherence club facilitator and report back to the facility for integrated MNCWH services.
- **In case of health problems, patients must be advised to attend the facility to see a clinician and should not wait for scheduled appointment date.**
- A patient collection card with relevant scheduled collection and return dates to the facility shall be issued to patient.

**ANNUAL VISIT SCHEDULE: EX-PUP**

This procedure applies **after** initial RPCs enrolment. RPCs enrolment visit = RPCs M0

**3 MONTH* TREATMENT (TX) SUPPLY**

| MONTHS* IN RPCS | LOCATION OF EX-PUP VISIT | ACTIVITIES | SCRIPT TX SUPPLY NO. | |
|---|---|---|---|---|
| **RPCs M0** | Facility | **Registration and Enrolment visit**[a] RPCs eligibility assessment + offer RPCs options + complete RPCs registration form + record EX-PUP enrolment in clinical stationery + 6MMS script + 3MMD** pick-up | 1 | |
| **RPCs M3**** | EX-PUP location | **Treatment supply only visit** 3MMD** pick-up | 2 | **4 visits per annum** **Max 2 visits per 6-month script** |
| **RPCs M6** | Facility | **Comprehensive clinical consultation visit** Integrated chronic care clinical review (incl. FP+TPT review) + investigations + check RPCs option chosen still suitable[b] + 6MMS[c] + record in clinical stationery + 3MMD** pick-up | 1 | |
| **RPCs M9**** | EX-PUP location | **Treatment supply only visit** 3MMD** pick-up | 2 | |
| **RPCs M12** | Facility | **Rescripting visit** Brief integrated chronic care clinical check-up + 6MMS re-script + record in clinical stationery + 3MMD** pick-up | 1 | |

**Cycle repeats from M3**

*** A month refers to a dispensing cycle (whether 28 or 30 days in length)**

**** RPCs treatment supply only visits can be 2 months after the clinician scripting date at M2 and M8 where the facility was experiencing drug shortages at date of scripting. The clinician can then specify 1x2MMD (first dispense from the facility at RPCs M0/M6/M12) and 1x4MMD (second dispense from RPCs location at RPCs M2/M8/M14).**

a. VL/HbA1c should not be done again at the enrolment visit.

b. If patient chooses to change RPCs option: Clinician to complete registration form indicating change and record change in clinical stationery for capturing

c. After RPCs enrolment, patients should be rescripted at their 6-monthly clinical review dates. Patient should not be required to return for result review prior to rescripting. A small number of RPCs enrolled patients would receive an abnormal result and need to be recalled to the facility.

**See Annexure VI for RPCs annual schedule diagram**

## AT EX-PUP

**The EX-PUP service provider shall:**

- Verify patient identity using approved means of identification.
- A nominated person collecting on behalf of the patient must produce patient's approved means of identification.
- Enquire whether the patient is doing well on current treatment and refer to the facility if the patient reports feeling unwell or is perceived to be unwell/unstable.
- Advise the patient on collection of the last scripted treatment supply to return to the facility for their clinical consultation and new script.
- Register the patient visit in the RPCs monitoring tool. For further detail refer to the Integrated TB/HIV data management SOP RPCs annexure.

## TRACING, RECALL AND RE-ENGAGEMENT SPECIFIC TO EX-PUP PATIENTS

- The EX-PUP service provider shall notify CCMDD of all patients who did not collect their treatment supply (PMP) within 7 calendar days after the scheduled pick-up date.
- Patients who failed to collect 7 calendar days after scheduled collection date, will be contacted by EX-PUP service provider/CCMDD via SMS or telephone to remind them to pick up their treatment supply (PMP) at the EX-PUP by no later than 28 calendar days of their appointment date otherwise return to the facility to see a clinician for assessment.
- CCMDD shall notify health facilities of patients who failed to collect treatment from EX-PUP within 28 calendar days of the missed scheduled collection date.

**Annexures:**

IV. First year on treatment visit schedule
VI. RPCs annual schedules
VII. RPCs algorithm

# DRUG SWITCHES FOR RPCS PATIENTS

## SOP 6

**TITLE: STANDARD OPERATING PROCEDURE: SWITCHING FIRST LINE REGIMENS FOR STABLE PATIENTS UTILIZING A REPEAT PRESCRIPTION COLLECTION STRATEGY**

**INSTITUTION: NATIONAL DEPARTMENT OF HEALTH**

| REFERENCE NUMBER: | EFFECTIVE DATE: |
|---|---|
| RPCS DRUG SWITCH (6) | AUGUST 2025 |

## PURPOSE

The purpose of this document is to outline the process for managing stable patients on ART first line regimen drug switches when receiving treatment through a Repeat Prescription Collection strategy (RPCs) – Facility pick-up point (FAC-PUP)/Adherence Club/External pick up-point (EX-PUP)

## PERSONS AFFECTED

- Patients on ART in Repeat Prescription Collection strategies
- Healthcare worker
- Pharmacist or pharmacy assistant
- Non-clinicians (could include lay counsellors, CHWs, HBCs, nursing assistants or equivalent)

## APPLICABLE POLICY REFERENCE

For HIV: 2025 National consolidated guidelines for the management of HIV in adults, adolescents, children and infants and prevention of vertical transmission

## GUIDING PRINCIPLES

- Clinically stable patients on ART receiving their care through a RPCs should also be considered for new drugs.
- Clinicians should utilize scheduled clinical consultation visits for stable patients on ART in RPCs (FAC-PUP/Adherence clubs/EX-PUP) to assess eligibility for and offer new drug/drug regimens.
- Stable patients should not be removed unnecessarily from their RPCs.
- Additional visits to the facility for additional clinical reviews or investigation should be minimized as much as possible. Where absolutely necessary, the clinician should discuss these with the patient, reach consensus on feasibility and as far as possible align with the applicable RPCs visit schedule (see SOP 5.1–5.3).
- Where a patient opts to switch to a new drug, the clinician should ensure the new script submitted reflects the drug changes correctly.
- All processes must be documented.

## PROCEDURE

When new ART drugs are approved in clinical guidelines, all patients on ART in RPCs should be assessed for drug switch at their next clinical RPCs visit. A clinician should:

1. Offer the drug switch with the appropriate information as set out in ART guidelines, including explaining to the patient that they may stay in their RPCs if they choose to switch.
2. If the patient opts to switch their drug/s and stay in their RPCs, the clinician should NOT remove the client from their RPCs and should not require any additional visits to be made to the facility (in addition to their RPCs schedule).
3. The clinician will submit a new 6-month script reflecting the new drug regimen. If the patient's RPCs is an adherence club, ensure dispensing date alignment with adherence club visit schedule.
4. **In case of health problems, patients must be advised to come in immediately to see a clinician NOT to wait until their next scheduled appointment date.**

## SOP AUTHORISED BY

| DATE | INITIALS AND SURNAME | DESIGNATION | SIGNATURE |
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# TRACING AND RECALL
## SOP 7

**TITLE: STANDARD OPERATING PROCEDURE FOR TRACING AND RECALL**

**INSTITUTION: NATIONAL DEPARTMENT OF HEALTH**

**REFERENCE NUMBER: AGL: TRACING (7)** | **EFFECTIVE DATE: AUGUST 2025**

## PURPOSE

The purpose of this document is to outline the process for tracing and recall recommended for all healthcare facilities in South Africa and should be read in conjunction with the Re-engagement SOP 8.

## PERSONS AFFECTED

- Patient living with HIV and/or a NCD including if co-infected with TB
- Healthcare worker
- Lay counsellor
- Community Health Worker (CHW)
- Ward Based PHC Outreach Team (WBPHCOT) including WBPHCOT Team Lead
- Administrative clerk
- Central Chronic Medicine Dispensing and Distribution program (CCMDD)
- Facility Manager

## APPLICABLE POLICY REFERENCE

For HIV: 2025 National consolidated guidelines for the management of HIV in adults, adolescents, children and infants and prevention of vertical transmission
For NCDs: 2023 Adult Primary Care Guide
For TB: 2023 National guidelines for the management of TB infection; 2017 Community TB Care SOPs
For TB/HIV: Integrated TB/HIV Data Management SOP WBPHCOT framework Integrated Clinical Services Management (ICSM) Manual

## CRITERIA AND PRIORITISATION FOR TRACING AND RECALL

**Criteria for tracing and recall:**

1. Patients who have failed to return to facility within 7 calendar days of their scheduled appointment including:
   - Patients who did not return for their treatment start appointment.
   - HIV, Diabetic or Hypertensive patients who have missed their scheduled appointment by 7 calendar days.
   - Patients in a Repeat Prescription Collection strategy (RPCs) who did not collect their treatment supply within 7 calendar days after the last day on which they were still able to collect through their RPCs (See SOP 5)
2. Patients with abnormal results who, after initial recall attempt, have not returned to the facility within 7 calendar days.

**Prioritisation order for tracing and recall:**

Every effort should be made to trace all patients with missed appointments and/or abnormal results. However, tracing and recall should be prioritized for the following patients in the order set out below:

1. Patients started to restarted on treatment in the last 6 months with advanced HIV disease (AHD)
2. Patients with abnormal results (HIV: Serum CrAg+, PCR+ or viral load >50 copies/ml, diabetes: HbA1c >8%, hypertension: BP > 140/90, TB: positive GXP, Smear, Culture, Line Probe Assay (LPA))
3. Patients diagnosed but not started on treatment (failed linkage)
4. Patients overdue for their condition specific assessment and/or investigation (test)

## GUIDING PRINCIPLES

- Patients are traced and recalled through methods that they have consented to: SMS, WhatsApp, phone call and/or home visits.
- Recall attempts should first be telephonic and only if this fails, then via a home visit.
- The following activities should be integrated into adherence strategies in all health facilities to trace and recall patients:
  - Informing patients about tracing and recall processes.
  - Asking patients' consent to be traced and preferred methods of tracing in order of preference.
  - Updating the patient's contact details at each visit.
  - Ensuring patient confidentiality is always maintained.
  - Identifying patients with abnormal results or missed appointments through the TIER.Net line lists for HIV/TB patients or from the appointment register/book for other chronic patients.
- Missed appointments must first be verified using the patient folder/RPCs monitoring tools prior to contacting the patient.
- Facilities must receive CCMDD 28 calendar day non-collection report for RPCs patients registered on CCMDD system.
- Tracing processes should start 7 calendar days after patients have missed their scheduled appointment or after the last day on which they were still able to collect through their RPCs or have not returned to the facility after an immediate initial recall on receipt of an abnormal result by the facility.
- Where tracing and recall is successful, an active referral should be made back to the facility within the next 7 calendar days.
- All tracing processes must be documented in the patient's clinical stationery and in the relevant monitoring systems.

| FACILITY TEAM, ROLES AND RESPONSIBILITIES |
| --- |
| **Facility Manager:**<br>• Verifying and signing off Missed Appointment Lists and Tracing Registers.<br>• Coordinating and liaising with WBPHCOT Team Lead regarding tracing and recall activities.<br>• Signing off on relevant tracing and recall reports. |
| **Administrative Clerk:**<br>• Pre-retrieving patient folders for patients who are scheduled for an appointment 48-72 hours prior to an appointment.<br>• Updating patient visits on TIER.Net.<br>• Reviewing and updating patient contact details when capturing each patient visit.<br>• Identifying all chronic care patients who have not attended the facility using the pre-retrieved folders still not collected after 7 calendar days.<br>• Generating missed appointment lists using TIER.Net and pre-retrieved folders not collected after 7 days.<br>• Filing NHLS laboratory results within 24-48 hours after triaging by clinician.<br>• Timeous filing of patient folders. |
| **WBPHCOT Team Lead:**<br>• Consolidating all facility missed appointment lists.<br>• Liaising with facility manager or designated official to identify and report back on patients with missed appointments or abnormal results. |
| **Community Health Worker:**<br>• Verifying missed appointments prior to contacting patients.<br>• Protecting the confidentiality of a patient at all times when attempting to trace and recall.<br>• Documenting tracing and recall attempts in relevant registers.<br>• Sharing tracing and recall attempts with relevant facility staff. |
| **CCMDD:**<br>• Sending 28 calendar day non-collection report to the facilities. |

## MATERIALS AND SUPPLIES

For a successful tracing and recall system, all health facilities should have the following:

- For all chronic disease patients (HIV/TB/NCDs):
  - Facility appointment register
  - PHC register
  - Facility telephonic tracing register
  - WBPHCOT tracing register
  - Community health worker tracing register
  - List of missed appointment for all patients enrolled in a RPCs
  - TB Identification Register
  - Patient folder
- In addition to the above, the following tools are required for TB/HIV patients:
  - TB/HIV information system – TIER.Net
  - TIER.Net missed appointment list and unconfirmed LTF List
  - TIER.Net patient appointment list
- Telephone or mobile phone available for telephonic recall and tracing

## PROCEDURE

### INFORMING PATIENT OF TRACING AND RECALL PROCESSES

- Tracing and recall consent from the patient should be sought by all healthcare workers, including their preferred tracing methods. Patients should be assured of confidentiality during tracing and recall processes.
- Patients should be encouraged to update their contact details at every visit to ensure successful tracing and recall support.
- If patient agrees to be traced through home visits, the patient should be informed that a CHW or designate will come to visit them if they miss an appointment by more than 7 calendar days. **If the patient or nominee is not at home, no other person present will be informed of the reason for the visit.**
- Caregivers should be made aware that contact with the child's school may be made to effectively trace the child. Caregivers should also be informed that this process is supported by school health teams.

## IDENTIFICATION OF PATIENTS WHO MISSED APPOINTMENTS

- The facility manager should ensure that there is a functional appointment system and that patient folders are retrieved 48-72 hours prior to the appointment date.
- After 7 calendar days the WBPHCOT Team Lead or designated official will create a consolidated list of patients in order of priority, who require telephonic recall using:
  - Facility appointment register/book
  - Missed appointment list generated from TIER.Net
- Once the lists have been verified and confirmation of missed appointment is obtained, the names of those patients requiring tracing and recall should be transferred to the facility telephonic tracing register.

## TRACING AND RECALL OF PATIENTS BY PHONE

- Using the patient folders, the WBPHCOT Team Lead will extract the contact information (phone number, address, name of treatment supporter/buddy) from the patient's folder or RPCs monitoring tool and confirm their priority category on the facility telephonic tracing register.
- Using the facility telephonic tracing register, the CHW will contact the patient via telephone (phone calls, SMS, WhatsApp).
- For each tracing effort, the 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 21 days from the missed scheduled appointment date should be transferred to the community health worker tracing register/WBPHCOT tracing register.
  - Patient consent for home visits should be verified in patient's folder.
- TB/HIV patients who did not return will continue to appear on the missed appointment lists generated from TIER.Net, until they either return to the facility or are given an outcome.
  - An ART patient is confirmed as an LTF after 90 days of a missed appointment
  - A TB patient is confirmed as an LTF after 60 consecutive days

## TRACING OF PATIENTS THROUGH OUTREACH TO COMMUNITIES AND HOMES

- The WBPHCOT Team Lead should transfer the names of patients from the facility telephonic tracing register to the WBPHCOT tracing register.
  - Patients who have telephone numbers, but where the numbers could not be reached, should also be included in the list of patients to be traced by the WBPHCOT/CHWs.
- Using the WBPHCOT tracing register, the CHWs should transfer the names of patients they are assigned to recall to their CHW tracing register.
- CHWs are required to trace patients at home (provided consent was obtained) **in priority tracing order** and document results. Where the patient or nominee is not present at the tracing address, no other person should be informed of the reason for the tracing visit.
- CHW to conduct home tracing and recall visit, document results and provide feedback to the facilities.

## DOCUMENTATION OF TRACING AND RECALL RESULTS

- Information obtained from tracing and recall attempts (telephonic and/or home visits) should be updated in the patient's clinical stationery and relevant information systems accordingly.

## RE-INTEGRATING PATIENTS INTO CARE (SEE RE-ENGAGEMENT SOP 8)

If a chronic care patient returns to the facility after the scheduled appointment date, the patient should retrieve their patient folder at registry where the administration clerk will check:

- If patient self-identifies as well, not on TB treatment and 28 days or less late for scheduled appointment - direct to continue their routine visit (no changes to visit type).
- If patient self-identifies as unwell and/or on TB treatment and/or more than 28 days late - direct to a clinician for a re-engagement specific clinical assessment (see SOP 8).
- All processes to be documented

## SOP AUTHORISED BY

| DATE | INITIALS & SURNAME | DESIGNATION | SIGNATURE |
|---|---|---|---|
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# RE-ENGAGEMENT IN CARE
## SOP 8

| TITLE: STANDARD OPERATING PROCEDURE: RE-ENGAGEMENT IN CARE | |
|---|---|
| INSTITUTION: NATIONAL DEPARTMENT OF HEALTH | |
| REFERENCE NUMBER:<br>AGL: RE-ENGAGEMENT (8) | EFFECTIVE DATE:<br>AUGUST 2025 |

## PURPOSE

The purpose of this document is to outline the differentiated approach to clinical management, counselling attendance, visit schedule, access to MMD and RPCs for chronic care patients returning to care to facilitate sustained re-engagement.

## PERSONS AFFECTED

- Returning chronic care patient living with HIV and/or a NCD including if co-infected with TB
- Healthcare worker
- Pharmacist or pharmacy assistant
- Non-clinicians (could include lay counsellors, CHWs, HBC Carers, nursing assistants or equivalent)

## APPLICABLE POLICY REFERENCE

For HIV: 2025 National consolidated guidelines for the management of HIV in adults, adolescents, children and infants and prevention of vertical transmission
For NCDs: 2023 Adult Primary Care Guide
For TB: 2023 National guidelines for the management of TB infection; 2017 Community TB Care SOPs

## CRITERIA FOR RE-ENGAGEMENT

Any chronic care patient who returns to the facility either of their own accord or after tracing, self-identifying as unwell or co-infected with TB or more than **28 calendar days** after their scheduled appointment date including a missed Repeat Prescription Collection strategies (RPCs) scheduled appointment.

## GUIDING PRINCIPLES

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

## FACILITY TEAM, ROLES AND RESPONSIBILITIES

**All service providers are encouraged to be welcoming and supportive. No punitive actions may be taken.**

**Administrative clerk** is responsible for reducing the patient's waiting time on return after missing a scheduled visit by determining if the patient is a routine or re-engaging patient. Thereafter supporting navigation to routine care or to a clinician for a re-engagement clinical assessment.

**Clinician** is responsible for providing a re-engagement clinical assessment and determining whether enhanced adherence counselling will assist the patient, carrying out any required laboratory assessments (tests) and follow-up clinical reviews. Where there are no counsellors available at the facility, providing EAC session 1 if indicated.

**Counsellor** is responsible for providing EAC session 1 if indicated to be appropriate by the clinician.

## RE-ENGAGEMENT PROCEDURE

**See Re-engagement algorithm – Annexure VIII and detailed job aid at www.knowledgehub.health.gov.za**

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

1. Complete a re-engagement clinical assessment:

a. **If the patient presents clinically unwell and/or on TB treatment and/or their most recent assessment result was abnormal**
   - The clinician will follow the appropriate clinical guideline (for HIV: 2023 ART Clinical Guidelines including A-E elevated VL assessment)
   - **Continue/restart treatment immediately including any drug switch (for HIV: TEE to TLD)**
   - For patients with HIV: take a CD4 count
   - Decide follow-up clinical review frequency as clinically indicated (For HIV: CD4 count result review for providing advanced HIV disease (AHD) package). Remember not to require a patient to return for clinical review unless clinically necessary due to increased patient burden.
   - Explain to the patient that a BP will be taken at each clinical review and VL/HbA1c will be taken after 3 consecutive months/dispensing cycles on treatment to check adherence and that treatment is working. If the result is normal and the patient is clinically stable, the clinician will then offer the patient RPCs options available at the facility

- Where the clinician does not need to see the patient for clinical review monthly and it will assist the patient to remain engaged in care, offer the patient multi-month treatment supply from the facility (see SOP 4: MMD) until their next required clinical review appointment and script accordingly.
- Write the date of the follow-up visit in patient's diary or appointment card.

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

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

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

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

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

2. Decide if enhanced adherence counselling EAC could assist:
   - Are drug side effects impacting adherence? If yes and drug/s switched → no need for EAC
   - Is the patient experiencing difficulties getting to facility to collect treatment → no need for EAC (*focus on providing access to MMD and RPCs*)

– Is the patient experiencing challenges with taking treatment (for example: forgetting, poor understanding of treatment and/or adherence, lack of social support, experiencing internal or external stigma, disclosure concerns, HIV diagnosis acceptance or mental health difficulties) → provide EAC session 1 (see EAC SOP 2)

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

## MENTAL HEALTH ASSESSMENT AND SUPPORT

Patients should be assessed for mental health and supported using the Mental Health Assessment tool in Annex 4 of the 2025 HIV consolidated guidelines or Annexure II either by a clinician or a delegated trained counsellor with referral back to the clinician for clinical management and any necessary referrals.

## TRACING, RECALL AND RE-ENGAGEMENT

**If chronic care patients do not arrive at facility to pick-up medicines within 7 days of the scheduled collection appointment date:**

- Patients are contacted through SMS or reminder calls to return to collect medicine
- If unsuccessful, facility initiates patient tracing using Ward-Based Outreach Team, CHWs or HBC Carers or other suitable means
- Where a chronic care patient returns to the facility of their own accord or after tracing within 28 days of their missed scheduled appointment, the patient will be managed as a routine patient. If more than 28 days late, apply re-engagement process again.
- For further details on tracing refer tracing and recall SOP 7.

## SOP AUTHORISED BY:

| Date | Initials and Surname | Designation | Signature |
|---|---|---|---|
| | | | |
| | | | |

**Annexures:**

VIII. Re-engagement algorithm

Detailed job aid at **www.knowledgehub.health.gov.za**

# ADVANCED HIV DISEASE EDUCATION AND COUNSELLING (AHD-EC)

## SOP 9

**TITLE: STANDARD OPERATING PROCEDURE FOR ADVANCED HIV DISEASE (AHD) EDUCATION AND COUNSELLING (AHD-EC)**

**INSTITUTION: NATIONAL DEPARTMENT OF HEALTH**

| REFERENCE NUMBER: | EFFECTIVE DATE: |
|---|---|
| AGL: AHD-EC (1) | AUGUST 2025 |

## PURPOSE

The purpose of this document is to outline the process for healthcare workers and counsellors to provide Advance HIV Disease (AHD) education and counselling.

## PERSONS AFFECTED

- Patient diagnosed with AHD
- Healthcare workers
- Counsellors (includes social worker, psychologist, lay counsellors and dietician/ nutritionist providing support to PLWHIV)
- Support system (family member, friend, community health worker and community-based support organisations)

## APPLICABLE POLICY REFERENCE

For HIV: 2025 National consolidated guidelines for the management of HIV in adults, adolescents, children and infants and prevention of vertical transmission
For TB: 2023 National guidelines for the management of TB infection; 2017 Community TB Care SOPs

## CRITERIA FOR AHD EDUCATION AND COUNSELLING

- Adults and adolescents living with HIV identified with:
  - CD4<200 cells/$mm^3$ or
  - WHO stage 3 or 4
- Caregivers of children:
  - **Under 5 years old** who are not on ART or on ART for less than a year or clinically unstable (has signs or symptoms of illness related to HIV or any other disease)
  - **Above 5 years old** with CD4 <200 or WHO stage 3 or 4

## GUIDING PRINCIPLES

- This AHD education and counselling session forms part of the AHD guideline adherence support plan to be developed by clinicians together with patients identified with AHD.
- This AHD education and counselling session should be provided along with:
  - **the Fast Track Initiation Counselling session two** (provided session one already completed on the day of diagnosis otherwise start with session one) (SOP 1: FTIC) for a patient initiating or
  - **the Enhanced Adherence Counselling session one** (SOP2: EAC) for a patient re-initiating or continuing ART.
- For patient's re-engaging in care, the re-engagement approach detailed in SOP 8 should also be followed.
- The AHD guideline adherence support plan is made up of the following components:
  - providing AHD treatment literacy
  - establishing and informing a home support network
  - appropriate adherence and disclosure counselling
  - mental health assessment and referral
  - documenting adherence barriers and plan (can be updated in existing Adherence Plan)
  - identifying the patient's preferred mechanisms for support
  - determining and documenting the follow-up visit schedule and format
  - tracing and recall consents and contact detail verification
- The clinician diagnosing a patient with AHD at clinic or hospital-level is responsible for providing this session. It can be delegated to a counsellor who is familiar with AHD (if available) provided the clinician retains responsibility for all components of the adherence support plan, including its documentation in the patient's record and any hospital discharge summary.
- The session should be provided to patients with AHD without delaying (re)initiation on ART and/or treatment for OIs.
- Use patient-centred communication to create a safe, non-judgmental space for your patient to discuss challenges.

- Where a patient with AHD has been discharged from a hospital to a Primary Health Care (PHC) facility:
  - the clinician at the PHC facility should take over the responsibility for the adherence support plan. Where this has not been fully developed by the hospital clinician or this session on AHD not provided to the patient, this should be done at the patient's first visit.
  - the discharging clinician should ensure the client has a transfer letter and discharge summary with active linkage to a designated primary care facility for continuity of care.

## ROLES AND RESPONSIBILITIES FOR AHD SUPPORT, EDUCATION AND COUNSELLING

### Clinician's role

- Screen for OIs and provide ART and OI treatment/prophylaxis in accordance with AHD guidelines, explaining indication, duration, timing, side effects and giving written pill schedule if helpful;
- Provide AHD education and counselling session;
- Provide mental health assessment and referral;
- Identify specific adherence barriers, create/update adherence plan (pill burden, side effects, costs of visits to the clinic and the need for support system) and keep it in the patient folder;
- Establish and inform the patient's home support network;
- Identify the patient's preferred mechanisms of support;
- Assess the patient's vulnerability to deterioration and circumstances, discuss and agree on intensity of visit schedule for the next 3 months and agree on next 3 appointment dates;
- Inform the patient about the importance of recall system, e.g. in case of test results requiring urgent action;
- Obtain consent and accurate information for recall for test results and missed appointments;
- Communicate with counsellors and CHW about phone or home check-ins agreed on with patient;
- Ensure continuity of care between hospital and primary care facility.

### Counsellor's role*

- Carry out the AHD education and counselling session if delegated by clinician;
- Provide FTIC or EAC counselling as appropriate;
- Create/update the Adherence Plan and keep it in the patient folder;
- Encourage the patient to identify a home support system;
- Carry-out telephonic check-in calls if delegated by clinician;
- Inform the patient about need to have accurate information for recall for test results or missed appointments;
- Check and update patient contact details at every patient interaction.

*Counsellors must have received an orientation on AHD and been designated by the clinician who maintains responsibility to ensure that patients received AHD education and counselling according to their needs.

**Patient's role**

- Understand AHD, individual diagnosis, treatment, importance of starting/ re-starting/ continuing ARVs and OI treatment/ prophylaxis, danger signs, side-effects and IRIS;
- Voice concerns and ask questions;
- Take the decision to start/ re-start/ continue/ adapt ART and OI treatment/s (increasing pill burden);
- Elaborate or adapt the Adherence Plan with the clinician/counsellor and be accountable for adherence within the AHD management plan in collaboration with healthcare team;
- Identify a home support network;
- Understand the treatment pathway ahead;
- Consider and provide consent and accurate contact details for recall for test results, missed appointments or check-ins, depending on needs;
- Give input on availability on next proposed appointment schedule and come for next appointment;
- Take treatment to reach goals;
- Choose a facility to continue care (in case of being discharged from a hospital or if moving/travelling to another area) and communicate this choice with the clinician.

**Support system's role** (with patient's consent)**

- Understand the treatment pathway ahead and accompany the patient on his/her treatment journey;
- Understand how ART and OI treatment must be taken;
- Support the patient in taking treatment daily, as advised by the clinician;
- Understand danger signs, side effects and IRIS. Contact the patient's clinician, counsellor or CHW and facilitate getting the patient back to the clinic or directly to hospital if needed;
- Support the patient in attending clinical visits and remind patient of next appointment;
- Remind the patient of their treatment goals and adherence steps when the patient is experiencing challenges;
- Encourage the patient to urgently re-engage in care or restart treatment in case of treatment interruption;
- Voice concerns and ask questions with the treatment team;
- Inform the treatment team if he/she can no longer be the support system for the patient (or must stop this role for a certain time for whatever reason).

**CBOs can also provide this and other support to the household such as food parcels, documentation support, supporting the family or friend support system

## PROCEDURE

### BEFORE THE SESSION

- Evaluate patient's ability to receive and understand the session. Check if the patient remembers recent events and if they have experienced any problems remembering, speaking, understanding or concentrating. If the patient shows signs of memory impairment, consider rescheduling the AHD education and counselling session until the patient feels better or when a support person can be present.
- Ensure you have all the tools you need:
  - Patient folder (including CD4 results, viral load, WHO stage, TB screening, TB NAAT and CrAg results;
  - Adherence education flip chart and/or any treatment adherence pamphlet
  - Patient Adherence Plan sheet (stays in the patient's folder for follow-up and further completion);
  - Mental health assessment;
  - Registers, depending on the conditions;
  - List of supporting organisations such as CBOs and FBOs to assist with psychosocial support and home visits;
  - Pen.

### DURING THE SESSION

- Build rapport with patient: Introduce yourself, ensure patient is comfortable, establish language preference and explain confidentiality.
- Show your appreciation to the patient for coming (back) to facility.
- Give the patient time to consider the AHD diagnosis and help the patient cope with emotions arising.
- Assess for any memory impairment and provide written information if remembering discussions from session may be an issue.
- Explain that achieving our treatment goals can be challenging and take longer for some of us.
- Explain AHD, any specific infections (including TB, Cryptococcal Meningitis and Serious Bacterial Infections) and treatment.
- Provide guidance regarding danger signs, medication side effects, and information about IRIS.
- Provide this session along with the initiation/continuation of FTIC, or with EAC depending on patients' needs.

- Check understanding, provide clarification as needed and allow time for the patient to ask questions.
- Discuss immediate concerns and help patient to identify a support person.
- Identify any barriers to adherence such as increased pill burden, drug side effects, memory impairment, unpalatable medicines and costs and time to attend clinic appointments and make a plan to address them.
- Make an active referral for a specific time and date to community structures for psychosocial, home visit and other care and support if needed.
- Provide additional referrals for mental health support and other services based on needs.
- Complete/Update the Adherence Plan in the patient's folder (and attach a new plan if extensive revisions), specifically addressing adherence issues related to AHD.

**AT THE END OF THE VISIT**

- Assess if patient remembers key information from the session (e.g. how to take medication, what to do in case of side effects, etc.). If the patient shows signs of memory impairment, provide written information to take home and consider repeating the AHD education and counselling session when the patient feels better or when a support person can be present.
- Discuss any further questions or concerns that the patient may have.
- Engage with the patient about their follow-up appointment schedule, record next 3 appointment dates, writing it down and setting up a phone reminder.
- Obtain consent and accurate information for recall for test results or missed appointments.
- Leave any 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.
- Ensure completed/updated Adherence Plan for FTIC, EAC and AHD education and counselling session additions is filed in patient folder and update appropriate facility registers accordingly (if any).

## OVERVIEW OF AHD EDUCATION AND COUNSELLING SESSION

- One session of education and counselling on AHD to be provided individually, or with a support person when possible:
  - **For ARV naïve patients:** Provide Fast Track Initiation Counselling (SOP 1: FTIC) and this session
  - **For patients who re-engage in care:** Follow the appropriate re-engagement approach (SOP 8: Re-engagement in care). Update Adherence Plan and provide Enhanced Adherence Counselling (SOP 2: EAC) if indicated in addition to this session.
  - **For patients on ART:** Address the potential reasons for AHD (update the Adherence Plan) and provide EAC if indicated, in addition to this session.
- If the patient is too weak and unable to understand, it is to clinician discretion to consider admission or home care, and delay or select the amount of information to be shared on the day of AHD diagnosis. Involve a support person (if possible), give written information and provide education and counselling on AHD as soon as the patient is well enough (before discharge, for those hospitalised).

## AHD EDUCATION AND COUNSELLING SESSION

**1. Explain the purpose of your session**

- To better understand AHD and any infections diagnosed
- To clarify that ARVs and infection treatment improve health and resolve AHD once the immune system recovers
- To understand tests that will be performed
- To educate on treatment, side effects, danger signs, additional clinical management and support
- To assess and address any reported barriers to adherence and discuss effective strategies to overcome them

**2. Explain the AHD diagnosis and why we are concerned**

- Use the adherence flipchart to provide explanations related to CD4 and OIs.
- **If AHD is due to low CD4 count (<200):**
  *Your CD4 count is* [insert CD4 count]. *Your CD4 cells, which are your immune system's soldiers, are low because they have been attacked and killed by the HIV in your body.*
- **If AHD is due to WHO Stage 3 or 4:**
  *You've been diagnosed with* [insert infection/s].
  *This infection* [name it] *is a common infection of HIV and while you have it, you are at risk of getting other infections that can make you very sick.*

- *While you have this* [infection/low CD4 count], *it is easier for you to get sick from infections like TB, meningitis (which is a serious infection in the brain), pneumonia (which is a serious infection in the lung), stomach infections, skin rashes, ear infections and viruses, such as flu or COVID. These infections can make you sicker than if your immune system was strong.*
- *We call this stage of HIV, advanced HIV disease. We need to work closely together to get you through this stage.*
- *Will you get better? Yes, I will explain how.*
- Be open and alert to any personal difficulties and struggles with aspects of the information.

**3. Educate on how to get better with appropriate treatment**

- Use the adherence flipchart to provide explanations related to ARVs.
- *ARVs will stop HIV killing more CD4 cells and over time, your CD4 count will go up, making your immune system stronger. By taking ARVs every day, you'll feel better, recover your health, and live a long life.*
- *If you have an infection, it is important to take the treatment for that too. Sometimes, we need to treat the infection(s) before starting ARVs. We will guide you on when to begin each treatment.*
- *Many people who were very sick with low CD4 counts and other infections like TB have recovered by taking their ARVs and other infection treatment as prescribed. Now, they have healthy CD4 counts and live full, healthy lives.*
- *Once your immune system is strong again and the infection(s) cleared, as long as you keep taking ARVs every day, you won't need extra clinical management or close support. You'll still be living with HIV, but not with advanced HIV disease that requires more frequent care and close monitoring.*

**4. Educate on IRIS**

- *What is IRIS?*
- *When your immune system begins to recover because you [started/re-started] ARVs, it might start fighting infections already in your body, which could make you feel worse before you get better. It is not the ARVs making you feel sick but your body trying to get rid of those infections. This is called IRIS, and it can be dangerous if not treated quickly.*
- *When should you come back to the clinic?*
- *If you start feeling worse or get any new symptoms—like getting a cough, fever, headache, or losing weight, skin changes or lumps —come to the clinic right away. The sooner we see you, the faster we can help. Don't stop your medications but come to the clinic or hospital immediately, even if it is not your scheduled appointment date.*
- *It is very rare to need to stop any treatments because of IRIS. We can support you through it.*

**5. Educate on danger signs**

- *Because your body is weak right now, your health can worsen quickly. It is important to recognise danger signs and act fast.*
- *Go to the hospital immediately if you experience any of the following: new seizures, weakness, confusion, headaches, new problems with vision, non-responsive to people around you, strange behaviour, unable to walk, coughing up blood, trouble breathing, shortness of breath, swollen lymph nodes, high fevers, severe diarrhoea or vomiting or any other severe symptoms.*
- *If you've recently been in the hospital and start feeling worse, go back immediately. Do remember to take your hospital records with you.*
- *Ask your support person at home to help you get to hospital if they see any of these danger signs.*

**6. Educate on tests performed (or to be performed) and possible results**

- *We are doing some tests to check for infections so we can treat them early.*
- **CrAg Test:**

  **If CD4 is below 100:**

  – *We've already tested for a germ called cryptococcus, which can cause a severe infection in the brain called meningitis. Your result was* [insert result].

  **If CD4 is between 100 and 200 and CrAg test sent in today:**

  – *We are testing for cryptococcus, a germ that can cause a severe brain infection called meningitis. If your test is positive, we will contact you immediately to plan the next urgent steps.*

  **If CrAg test is positive:**

  – *Your CrAg test is positive. This means the cryptococcus germ is in your body and can cause an infection around your brain called cryptococcal meningitis. We need to do a lumbar puncture, which is a procedure where we use a needle to take fluid from the spinal cord to check if the infection has reached the brain. This is a serious infection that need quick treatment to prevent you from getting very sick and dying. Only a doctor can do this lumbar puncture.*

  – Schedule appointment for lumbar puncture in consultation with the patient. Confirm place and date and time.

  – *The doctor will either ask you to stay for a few hours to get the result or give you a return date. It is important to go back for the results.*

  – *If the lumbar puncture result is positive, the doctor will give you the treatment needed to treat cryptococcal meningitis. You will need to stay in hospital for a few days.*

  – *If the lumbar puncture result is negative, you are still at risk of developing cryptococcal meningitis, the doctor will need to give you important medicine to prevent this.*

- **TB Test**:
  - *We are also testing for TB. The main symptoms of TB in adults are coughing, fever, night sweats and unplanned weight loss. When your CD4 cell count is very low, you may not have any symptoms but could still have TB, so we need to check thoroughly.*
  - *We will do a urine test (if available) and a sputum test.*

  **If patient has TB symptoms but the urine test is negative or only a sputum test is done:**
  - *You will need to come back in 2 days for your sputum results* (include in appointment schedule discussion below). *If the test is negative, your clinician will do more tests to find out why you are unwell.*

  **If patient does not have TB symptoms:**
  - *If your TB test is positive, we will contact you with the result. You will need to come to the health facility as soon as possible but no later than 3 days to start TB treatment.*
- **Next CD4 count:**
  - *You will have another CD4 count after 6 months.*

**7. Educate on prophylaxis**

- *What are the other medicines you're getting?*
- *We'll give you Bactrim (Cotrimoxazole) to help prevent serious infections like pneumonia and diarrhoea. You'll take this until your CD4 count rises above 200, which means your immune system is strong enough to fight infections on its own.*
- *If you don't have TB and are eligible, we'll also give you medicine to prevent TB. This is called TB Preventive Treatment (TPT).*
- Explain which TPT option is being provided:
  - INH taken once daily for twelve months
  - 3HP taken once weekly for 12 weeks
- *You can start Bactrim and TPT at the same time as your ARVs. It is important to take these medicines while your CD4 is low until it improves.*
- *It can feel overwhelming to have so many different medications, but each one is important for your health as your immune system recovers. If you're struggling to take all your pills every day, speak with your clinician so they can help you.*

**8. Educate on treatment adherence**

- *It's important to start (or restart) your ARVs as soon as soon as we advise and take them every day. This will help your CD4 cells recover and lower your risk of getting sick. Usually this will be on the day that you're diagnosed or return to care, but in a few cases, we will need to delay starting your ARVs to manage your infection first.* Explain if this is the case and when the client will be starting ART.
- Address only relevant co-infection(s):

  **If patient has TB:**

  – *Since you have TB, it's very important to take your TB medicine every day alongside your ARVs. TB can be cured, but only if you take all your tablets daily for the full course prescribed. Missing doses can make TB harder to treat.*

  – If patient is required to add ARV dose: *TB treatment can interact with your ARVs, making them less effective. You will need to take an extra dose of one of your ARVs until TB treatment is completed.*

  – *If your symptoms get worse or don't improve with treatment, please come back and don't wait for your next scheduled appointment date.*

  **If patient has cryptococcal meningitis:**

  – *Since you have cryptococcal meningitis, it is vital to take the treatment exactly as prescribed. Over the next few weeks, your clinician will adjust the number of tablets you need to take each day. The number will decrease over time, but you'll need to continue the treatment for a year or even longer, even if you start to feel better. Stopping too soon could allow the meningitis to come back. If you notice worsening symptoms, like headaches, a painful or stiff neck, confusion, sensitivity to light, come back to the clinic or hospital immediately.*

  **If patient has any other co-infection:**

  – Explain any other co-infection and treatment adherence

**9. Identifying a support person**

- *It's important to have someone in your family or friends who knows about your advanced HIV disease and can help monitor your health for any changes. This person can assist you getting to the clinic or hospital and help you take your medicines correctly every day, especially if you are having trouble remembering. Do you have someone who can support you? How can we contact this person?* (review FTIC SOP 1 adherence step 3)
- If a support person cannot be identified, plan for a counsellor or a CHW to provide follow-up calls or home visits to check-in.

**10. Identifying barriers**

- *We understand, taking ARVs can be challenging, we're here to support you. Please share any difficulties you face in collecting or taking your ARVs so we can help.*
- *Let's talk about any specific challenges you are having and work together to find solutions.*
- Discuss according to patient's specific situation:

  **If starting ARVs for the first time:**
  - *Since you are starting ARVs, we will create an adherence plan together. Taking several different treatments can make it more challenging to adhere, We'll address specific steps in your adherence plan related to increased pill burden, dealing with side effects and the number of clinic appointments.* Use FTIC session - SOP 1 and Adherence Plan.

  **If missed appointments:**
  - *It seems you've struggled with collecting or taking your ARVs. We'd like to understand why so we can support you better. Let's review your adherence plan to identify any steps that may be difficult for you and finds way to assist.*
  - Focus on the steps identified as problematic and review adherence steps - increased pill burden, dealing with side effects, attending clinic appointments, non-disclosure to people in the household, depression/anxiety/substance use.
  - Use Adherence Plan and the re-engagement approach set out in SOP 8.

  **If ongoing/new symptoms +/- unsuppressed VL +/- no CD4 count improvement:**
  - *You have been collecting your ARVs, but you are not getting better. We need to work out why your HIV has advanced instead of improving. It is likely you may not have been taking your medication correctly. Can you share what makes it difficult for you to take your medication? Have you received additional adherence counselling after you started ARVs? If not, let's do this together. If you have, we can check and update the information on it.*
  - Use EAC session - SOP 2 and Adherence Plan.
- Ask open-ended questions, provide support to find solutions and adapt the Adherence Plan accordingly:
  - *How do you feel about having to take more pills? When will you take the additional pills and how will you remember?* (Review adherence step 6-8)
  - *What will you do if you experience side effects?* (Review adherence step 10)
  - *How will you manage attending your clinic appointments. Do you anticipate needing to travel away from here in the next few months?* (Review adherence step 4 and 12)

**If patient is using alcohol or substances:**

- *How will you remember to take your treatments when you are using alcohol or other substances?*
- It's important not to tell someone they must stop drinking or using substances, as this could make them feel like they have to choose between their treatment and substance use due to possible negative interactions, leading to stopping treatment out of fear. Instead, work with a patient to find a time that works best for taking their medication, or identify someone who can help support them in taking their treatment(s), even if they use alcohol or other substances. (Review adherence step 13)
- *What will you do if you are feeling unwell, stressed or struggling with low mood? Remind of adherence goals and possibility to be referred for mental health support if needed.*

**11. Inform and plan follow-up appointment schedule**

- *We'll need to see you more often for the first 3 months to:* [insert: review test results/perform further test/manage any infections], *continue to check your health and ensure you are getting stronger.*
- *Once you are stronger, it'll get easier with fewer clinic appointments and longer ARV refills. Let's agree on a schedule that works for you.*
- Clinician to consider recent hospital admission, TB result return, any opportunistic infection requiring more frequent follow-up, mental health or lack of social support vulnerability, or treatment literacy concerns to recommend return every second week for the first month, then monthly; or alternatively, monthly for the first 3 months. (For further detail see Table 21: Factors to consider when determining an appointment schedule for clients with AHD in the AHD guidelines)
- *We propose that we set up these follow-up appointments* [insert frequency over the next 3 months]
- *How will attending this number of clinic appointments affect you? How will you manage additional transports costs, time to attend or missing days from work?*
- *If these number of appointments will be difficult for you, we can consider replacing some of these appointments with phone call or WhatsApp check-ins, or home visits. We can also check-in with your identified support person. Let us know how we can reduce the burden for you while managing your health?*
- Adjust proposed schedule as necessary – remember that if it is not feasible, the patient may interrupt treatment with worse outcomes.
- If missing days of work is a problem: explore sick leave availability, check if a sick note will assist.
- Confirm and record in the folder and for the patient the next 3 appointment dates.

**12. Explain importance of tracing and recall – obtain consent and valid contact details**

- Consent for communicating test results and recall to the facility: *We may need to reach you to inform you of your test results, it is important for us to be able to reach you or someone who supports you in taking your treatment. We will always respect your confidentiality and choice regarding the way you prefer to be contacted: phone call or SMS or WhatsApp message. When calling, we will not disclose your HIV status, and we won't share any other test results without confirming we are speaking to you or your selected support person. In messages, we will never mention your HIV status. We will ask you to return to the clinic for your test results.*
  - *Do you consent to us contacting you with your test results?*
  - *How would you prefer to be contacted: phone call/SMS/WhatsApp?*
  - *If we cannot reach you, can we contact your support person (without disclosing any result)?*
- Record in folder consents given
- Consent for health check-ins and recall to the facility if miss appointment: *If you miss your appointment, we will be worried about you and want to check that you are okay.*
  - *Do you consent to us contacting you to check that you are okay?*
  - *How would you prefer to be contacted: Phone call/SMS/WhatsApp?*
  - *If we cannot reach you, can we contact your support person to check if you are okay?*
  - *If we cannot reach you or your support person, can we come to your home to check you are okay and support you back to the clinic? The community health worker won't mention the reason for visiting to anyone else and will come back another time if you are not at home.* (Further tracing and recall information: SOP 7).
- Record in folder consents given
- Verify contact details: *Please provide your:*
  - *Phone or WhatsApp number*
  - *Phone or WhatsApp number for your support person*
  - *Your home address* (if consent given)
- Please make sure you let us know if your phone number changes or if you are not reachable on this number anymore

- *If you need to move to another clinic, please visit us first so we can give you a letter to help make the transfer smoother. If you switch clinics without telling us, we might worry about you, and the new clinic may not know your treatment plan. If planning ahead isn't possible, let the new clinic know you were with us and ask them to contact us for your information. It's helpful to keep a note or photo of your medications in case you move unexpectedly. Any clinic must provide you with medication, even without a letter, but having one will make the process easier.*
- Give the clinic phone number to the patient (save on their phone or write on a card).
- *If you ever realise that you will not be able to come on your appointment date, try to come to the clinic before that date to ensure that you don't run out of medication.*

**13. Additional Support (adapt to support services available)**

- *Would you like a WhatsApp number to contact a clinician for urgent advice?*
- *Would you or your family like to join a support group at our facility or virtually on WhasApp with others going through the same experience and an AHD trained clinician to answer questions?*
- *Offer any other support available* (for example a designated case manager if there is such a person at your facility).

## ADAPTATIONS

This AHD education and counselling SOP can be adapted depending on the condition(s) affecting the patient, the treatments or prophylaxis prescribed and according to whether a patient is initiating, re-initiating or continuing ART.

**Add for pregnant and breastfeeding women with AHD:**

- Add danger sign for return to clinic: *any coughing, repeated vomiting, failure to gain weight*
- Explain that having additional infections whilst pregnant makes the pregnancy high risk so more frequent follow-up will be necessary.
- Ensure Adherence Plan includes managing own medication and prophylaxis for infant
- Actively support continuity of care when patient has to move to different facilities (or departments within facilities) for antenatal care, delivery and post-natal care.
- **Prioritise integrated mother-infant pair care** (refer to: Visit schedule for Integrated Care for the mother living with HIV and her HIV exposed infant in Guideline for Family-centred Vertical Transmission Prevention of Communicable Infection Guidelines – page 31)
- Where available, enrol in post-natal club for ongoing support during breastfeeding

**Add for children:**

- **If the child is less than 5 years old,** provide the session with the caregiver only.
- **If the child is over 5 years old,** start or continue the child disclosure process using SOP 3 and adapt information on AHD to be provided to the caregiver and the child according to the disclosure status.
- Explain AHD diagnosis:

  **For children under 5 years:**

  – *Your child's is still very young. The CD4 cells, which are like soldiers in their immune system, are being attacked and killed by HIV in their body. This makes it easier for your child to get sick from infections like TB, meningitis (which is a serious infection in the brain), pneumonia (which is a serious infection in the lung), stomach infections, skin rashes, ear infections and viruses, such as flu or COVID. We need to provide extra clinical care and support until their immune system is stronger and can fight off these infections.*

  **For children over 5 years:**

  – Use the same explanation as above.
- **Educate on IMCI danger signs:** If you notice any of these danger signs, you should bring the child to the clinic immediately:
  – *Difficulty drinking, eating, or breastfeeding;*
  – *Vomiting everything;*
  – *Convulsions, unconsciousness, or extreme drowsiness;*
  – *Signs of shock (cold skin, less urine, breathing problems, weakness);*
  – *Trouble breathing, chest pulling in when breathing, or a whistling sound when breathing; or blue/grey colour around lips, tongue, gums, or fingernails;*
  – *Swollen feet, poor weight gain or growth;*
  – *Stiff neck, soft spot on the head that is bulging or sticking out, or constant irritability;*
  – *Pale palms, swollen tongue, unusual cravings (like dirt), or an enlarged belly (left side).*
- Provide education on what constitutes a balanced diet. Provide or refer for nutritional assessment and support.
- Educate on any additional tests to be performed.
- Identify specific barriers to adherence to create or adapt Adherence Plan.

## MENTAL HEALTH ASSESSMENT AND SUPPORT

Patients should be assessed for mental health and supported using the Mental Health Assessment tool in Annex 4 of the 2025 HIV consolidated guidelines or Annexure II either by a clinician or a delegated trained counsellor with referral back to the clinician for clinical management and any necessary referrals.

## TRACING RECALL AND RE-ENGAGEMENT

If patients diagnosed with AHD do not arrive at facility for a scheduled appointment, **prioritize for immediate tracing and recall:**

- Check consents obtained in the patient folder
- Depending on consents provided:
  - Contact patient/patient's support person by phone, WhatsApp or SMS to check on their current health, any assistance needed and encourage to return to the facility immediately.
  - If unsuccessful, the facility is expected to start patient tracing using WBPHCOT, CHWs, HBCs or other suitable means.
- Where patients diagnosed with AHD return to the facility of their own accord or after tracing within 28 days of their missed scheduled appointment, the patient will be managed as a routine patient **but must be seen by a clinician**. If more than 28 days late, refer to Re-engagement SOP 8.
- For further details on tracing refer to Tracing and Recall SOP 7.

**SOP AUTHORISED BY:**

| Date | Initials and Surname | Designation | Signature |
|---|---|---|---|
| | | | |
| | | | |

# ANNEXURES

# ANNEXURE I: PATIENT ADHERENCE PLAN

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

**Name and Surname:**

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

**Adherence step 1:** education on HIV ☐ TB ☐ Hypertension ☐ Diabetes ☐ Other ☐ …….....

**Adherence step 2:** Life goals:
My motivations to stay healthy are: (1)…….. (2)…….. (3)……..…..
I will maintain a healthy lifestyle by ☐ adopting healthy eating habits ☐ getting regular exercise ☐ managing my stress

**Adherence Step 3:** Patient Support system
Agree for home visit: Yes ☐ No ☐ Preferred means of contact: SMS ☐ WhatsAapp ☐ Phone call ☐ Other ☐ .....
Who can support me in my treatment: ☐ Family ☐ Friends ☐ Work ☐ School ☐ Church ☐ Other:

**Adherence Step 4:** Getting to appointments
I will come to my appointments by: ☐ walk ☐ public transport ☐ own transport
If I face a difficulty to come (money, transport, etc.), my alternative plan will be to ask for assistance from:
☐ family ☐ friends ☐ neighbour ☐ other ……
I will inform clinic I am unable to come to set appointment and request for an alternative appointment ☐

**Adherence step 5:** My readiness to start treatment
I feel ready and will start treatment:

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

☐ I do not feel ready and would like to discuss more with:
☐ peer ☐ family member ☐ other ……

**Adherence Step 6:** Medication schedule
The best time for me to take my treatment is: ☐ Morning ☐ Afternoon ☐ Evening

**Adherence step 7:** Managing missed doses
If I miss a dose, my plan is: (1) to take treatment as soon as I remember ☐

**Adherence Step 8:** Reminder strategies
To remind me to take medication I will use: ☐ watch ☐ cell phone alarm ☐ pill box ☐ buddy ☐ other ……..

**Adherence Step 9:** Storing medication and extra doses
I will store my medication in: ☐ Safe place: …… ☐ Far from reach of children
I will carry extra supply in: ☐ a bag ☐ pill box ☐ other:…..…….... I will keep it in my: ☐ handbag ☐ pocket ☐ other:…..…….....

**Adherence Step 10:** Dealing with side-effects
If I experience side effects, I will: Refer to treatment adherence pamphlet ☐
Inform clinic if side effects do not go away or are too worrying ☐

**FTIC Session 2 (date):**

**Adherence Step 11:** Understanding the treatment pathway ahead of me if I take my treatment well
☐ I understand the options for multi-month treatment supply and simplified collection available after one normal assessment result.

**Adherence Step 12:** Planning for trips
*If I have some trips planned, before going away I will:*
☐ Inform health facility before travelling to receive referral letter and treatment ☐ Get enough supply of treatment for trip
*In case I cannot come to the facility before going away:*
☐ I will report to the nearest health facility in the travel area as soon as I arrive to get access to treatment
☐ Carry evidence of my condition and evidence of the treatment I am taking

**Adherence Step 13:** Dealing with substance use
*My plan to make sure I take my medication if I used alcohol or drugs is:*
☐ To make sure I take treatment before starting to use drugs or alcohol
☐ Arrange for someone to remind me to take treatment in case I am intoxicated

**Education on assessment:** Viral load ☐ Sputum ☐ HbA1c ☐ BP ☐ Other: …….....☐
☐ I understand that I can access multi-month treatment supply and simplified collection if my results are normal

**Patients signature** …… **Date of signature** ……

**EAC Session 1 (date):**

**EAC Session 2 (date):**

# ANNEXURE II: MENTAL HEALTH ASSESSMENT

As mental health disorders can impact adherence negatively, it is recommended that screening is provided for mental health conditions while treating HIV, TB and NCDs. Any validated mental health screening tool can be used. A commonly used tool is included at the end of this Annexure. **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 condition 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 conditions.*

**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 cannot cope with work or daily activities.
- Their mind is controlled (such as by voices) or out of control.
- They need to use alcohol or drugs.

- 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.**

**Provide the patient with education on mental health and provide advice that can help overcome symptoms, such as:**

- 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.

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

**If a patient screens positive for any of the mental health conditions, please do the following:**

- Provide a mental health intervention if available and feasible (e.g. interpersonal counselling)
- Refer to clinician and assess for antidepressant prescription if appropriate
- Refer to mental health support specialists' services as needed
- Refer to other organizations for care and support
- Provide access to mental health materials and support services online **http://masiviwe.org.za/**

## Tool to screen patients for mental health conditions

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

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

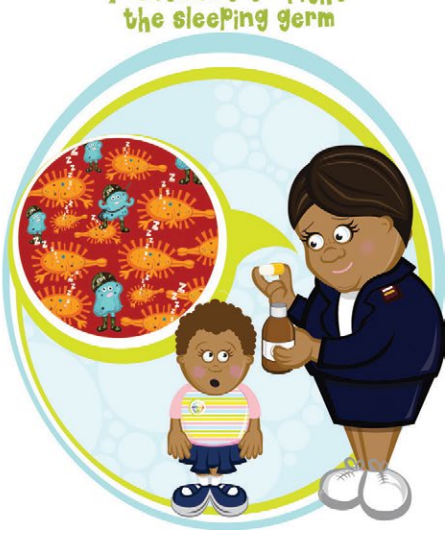
# ANNEXURE III: CHILD AND ADOLESCENT DISCLOSURE COUNSELLING IMAGES

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



# ANNEXURE IV: FIRST YEAR ON TREATMENT VISIT SCHEDULE

**MONTH (M) = dispensing cycle**

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

## 0 months on treament

**START ON TREATMENT VISIT**

- Baseline clinical and lab assessment as outlined in clinical guidelines
- Start treatment
- Session 1 fast track initiation counselling
- 1 month treatment supply

**AGL SOP:**

1 Fast-track treatment initiation counselling

## 1 month on treament

**1ST TREATMENT FOLLOW-UP VISIT**

- Repeat BP, clinical assessment and baseline result/s review and action
- Session 2 fast track initiation counselling including planning for travel and assessment education (VL/BP/HBA1c)
- *If clinically stable:* 2 months treatment supply (2MMD)

**AGL SOP:**

1 Fast-track treatment initiation counselling

4 Multi-month dispensing (MMD)

## 3 months on treament

**TREATMENT ASSESSMENT VISIT**

- Repeat BP, clinical assessment and first follow-up laboratory assessment (VL/HbA1c)
- 1 month treatment supply to enable result review and action the following month

## 4 months on treament = RPCs M0

**RPCS ASSESSMENT VISIT**

- Repeat BP, clinical assessment, and review of result/s (VL/ consecutive BPs/HbA1c and any other monitoring results)
- Assess eligibility for repeat prescription collection strategies (RPCs)
- *If RPCs criteria met:*
  - offer and enrol in RPCs of choice, script for next 6 months, with first treatment supply issued today from the facility
  - *if RPCs offer refused or not eligible <u>but well</u>:* offer facility 3MMD

**AGL SOP:**

5.1 Facility Pick-up Point

5.2 Facility Adherence Clubs Community Adherence Clubs

5.3 External Pick-up Point

4 Multi-month dispensing (MMD)

## 7* months on treament = RPCs M3

**RPCS TREATMENT COLLECTION ONLY VISIT**

- Collect treatment from RPCs

## 10 months on treament = RPCs M6

**RPCS COMPREHENSIVE CLINICAL CONSULTATION**

- Clinical assessment, BP and second follow-up laboratory assessment (VL/HBA1c)
- Renew script for next 6 months

*(Do not require patients to return to the facility for result review a month later. Recall to the facility few RPCs patients with elevated VLs)*

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

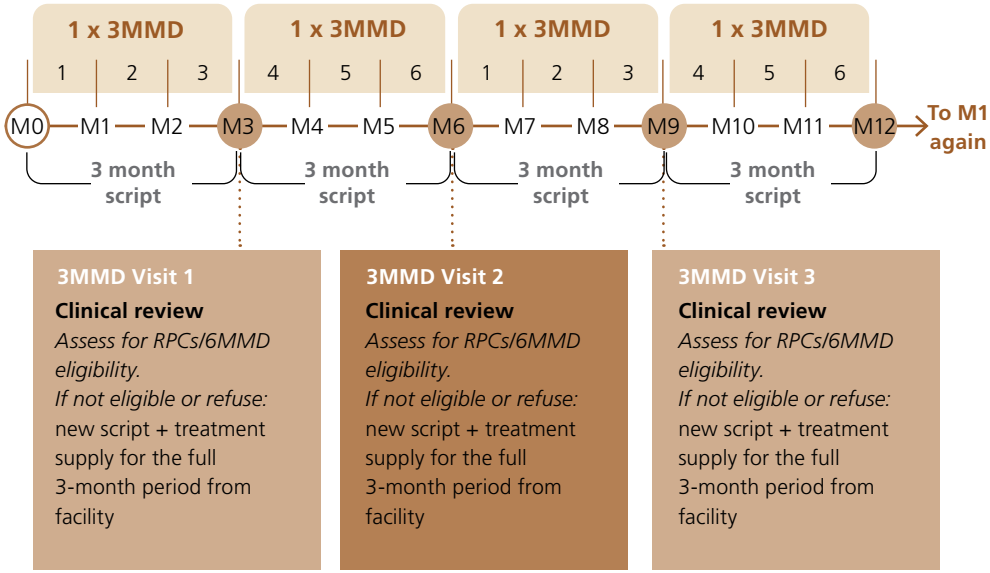
* Where a facility is experiencing drug shortages, a clinician can prescribe a first supply of 2 months (2MMD) from the facility and a second supply of 4 months (4MMD) from the RPCs. This would only change the RPCs treatment supply collection visit to 6 months on treatment (RPCs M2). Every effort should be made not to provide shorter supplies from the facility or RPCs to ensure a maximum of 2 patient visits per 6-month script.

# ANNEXURE V: FACILITY PROVIDED MMD ELIGIBILITY & VISIT SCHEDULES

**Facility provided 3MMD**

**FACILITY PROVIDED 3MMD ELIGIBILITY CRITERIA:**

- Not acutely unwell
- On ART for 3 months or more
- Not eligible for RPCs/Facility 6MMD or declines RPCs/Facility 6MMD
- Enables alignment with clinical review dates including: 6 months – 5 years old; re-engaging; abnormal assessment (e.g. elevated VL) after EAC; travelling; post-natal to align with EPI schedule



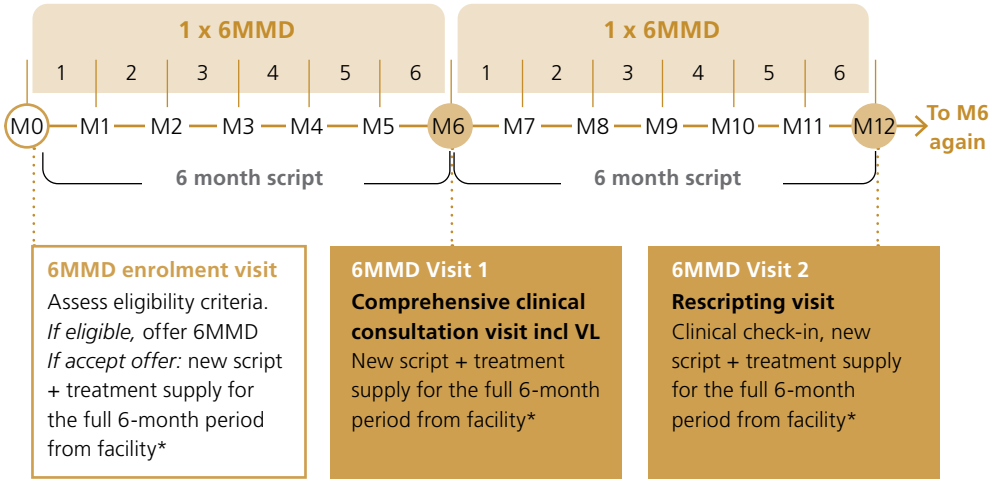
## Facility provided 6MMD

**FACILITY PROVIDED 6MMD ELIGIBILITY CRITERIA:**

- On ART TLD only* for 12 months
- Most recent two VLs <50 copies/ml
- Meet **all** other eligibility criteria for RPCs (see SOP 5), including above 5 years old, not pregnant or post-natal within 12 months of delivery and clinically stable with no current TB, other opportunistic infection, malnutrition, new or uncontrolled mental health or chronic condition requiring clinical review more regularly than once every 6 months.
- Clinician confirms eligibility and client voluntarily opts for Facility 6MMD

**Children and adolescents additional:**

- No regimen/dosage change in last 3 months
- Caregivers counselled on disclosure process




**6MMD enrolment visit**
Assess eligibility criteria.
*If eligible,* offer 6MMD
*If accept offer:* new script + treatment supply for the full 6-month period from facility*

**6MMD Visit 1**
**Comprehensive clinical consultation visit incl VL**
New script + treatment supply for the full 6-month period from facility*

**6MMD Visit 2**
**Rescripting visit**
Clinical check-in, new script + treatment supply for the full 6-month period from facility*

**Consider supplying 84-90 day pack sizes to reduce the number of containers for the client to take home and for dispensing by the clinician/ clinic pharmacy.**

* Limited to TLD regimen only until national medicine stock availability is confirmed for other ART regimens and hypertension and diabetic treatment.

# ANNEXURE VI: RPCs ANNUAL SCHEDULES

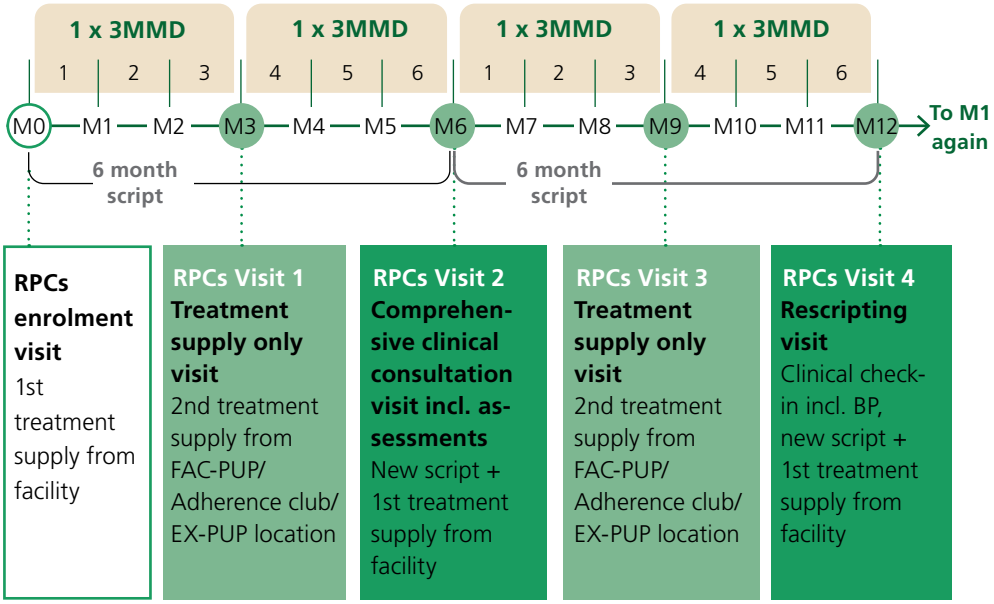
**RPCS provided 3MMD**

**RPCS ELIGIBILITY CRITERIA:**

- Above 5 years
- Not pregnant or post-natal within 12m of delivery
- **HIV:** Most recent VL <12m old and <50 copies/ml
- **Diabetes:** Most recent HbA1c <12m old and ≤8%
- **Hypertension:** 2 consecutive BP <140/90
- No TB/other OI/new or uncontrolled mental health/chronic condition requiring clinical review more frequently than 6-monthly
- Clinician confirms eligibility
- Patient/caregiver voluntarily opts for RPCs option

**Children and adolescents additional:**

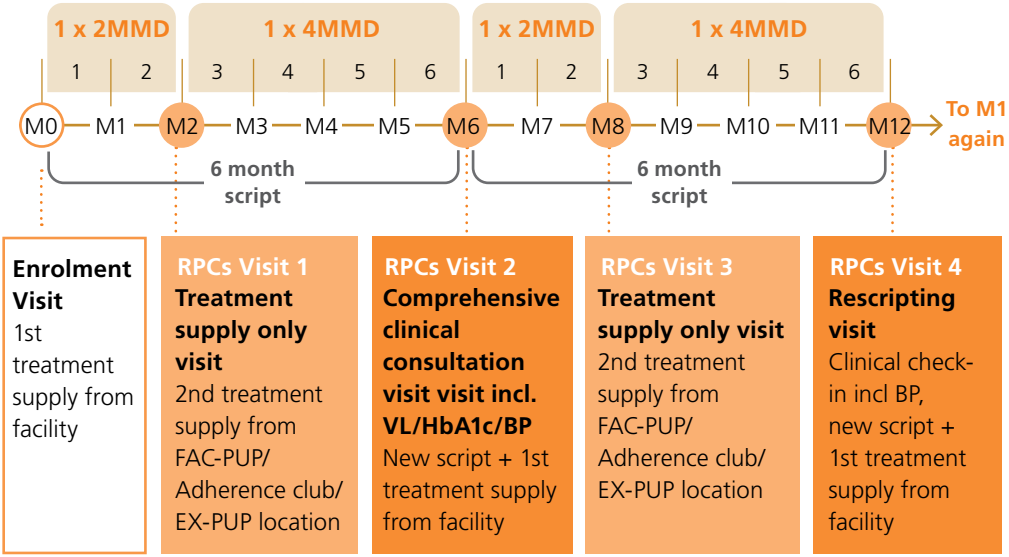
- No regimen/dosage change in last 3 months
- Caregivers counselled on disclosure process



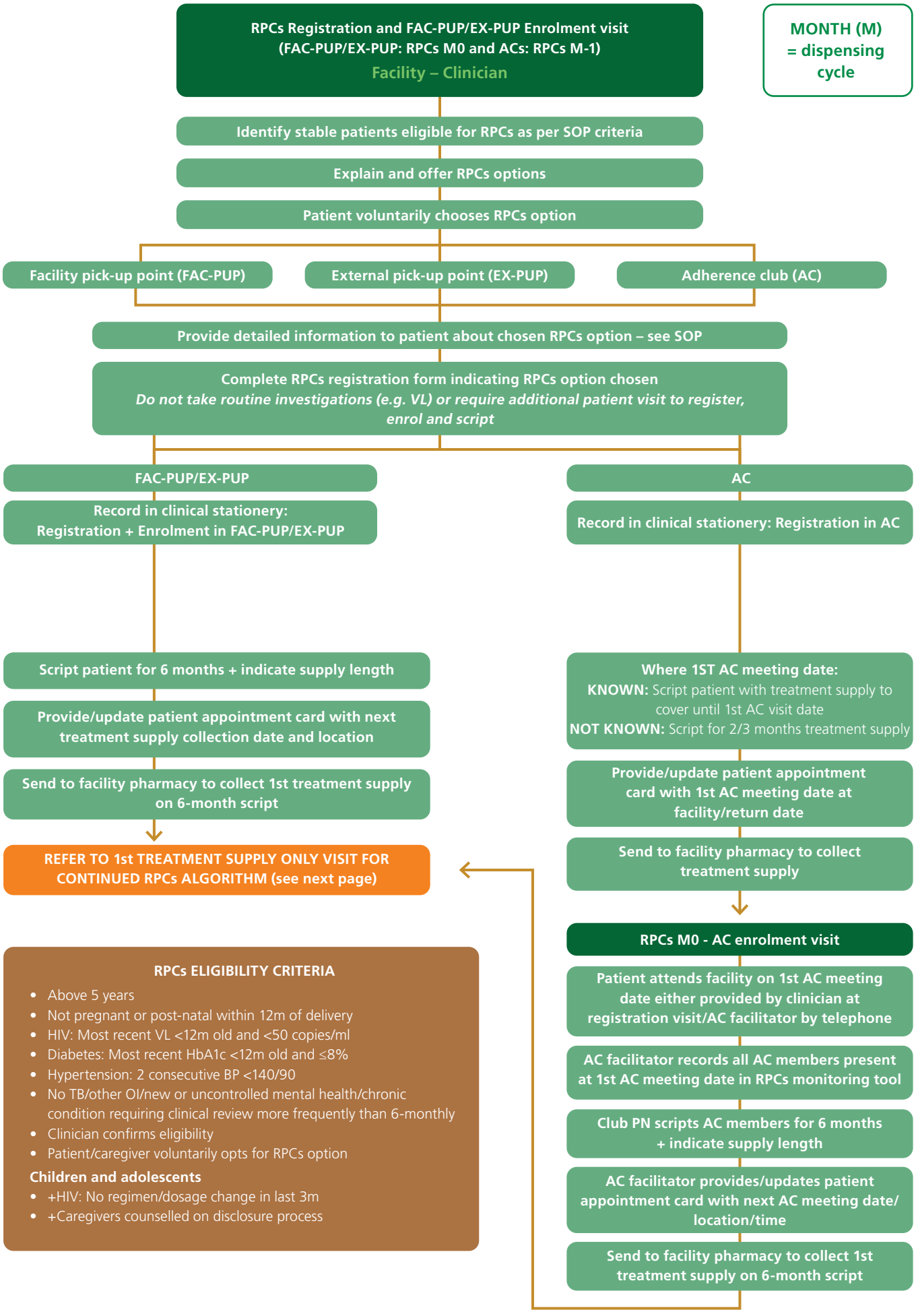

* Where a facility is experiencing drug shortages, the RPCs annual schedule can be changed as reflected below.

## FACILITY MEDICINE STOCK SHORTAGES

**RPCs provided 2/4MMD**



# ANNEXURE VII: REPEAT PRESCRIPTION COLLECTION STRATEGIES ALGORITHM



# RPCs ALGORITHM FROM 1st TREATMENT SUPPLY ONLY VISIT

**RPCs M3: Treatment supply only visit**
FAC-PUP: Facility pharmacy fast lane/designated area – FAC-PUP Distributor
EX-PUP: EXP-PUP location – EX-PUP service provider
AC: AC venue – Club Facilitator

- Verifies patient identity
- *Only AC:* Facilitates group discussion
- Patient reports unwell/looks unwell – refer to facility clinician/Club PN
- Distribute pre-dispensed treatment supply (PMP) - 2nd treatment supply from 6m script
- Record in RPCs monitoring tool
- Remind patient next visit to:
  **FAC-PUP:** see clinician
  **EX-PUP:** return to facility to see clinician
  **AC**: attend facility/AC venue for clinical consultation depending on Club PN location

**RPCs M6: Comprehensive clinical consultation visit**
FAC-PUP/EX-PUP: Facility – Clinician
AC: Facility/AC Venue – Club PN

- Integrated chronic care clinical review (incl. TPT review)
  *For adolescents:* annual mental health assessment
  *For children:* dosage + disclosure check
- Routine investigations (*For AC:* align all AC members)
- Check with patient that current RPCs option chosen still suitable
- Script patient for 6 months + indicate supply length
- Record in clinical stationery
- Remind patient next visit: Back to FAC-PUP/AC/EX-PUP location
- Update appointment card with next treatment supply date/location
- Collect 1st treatment supply from new 6m script at facility pharmacy/AC location

**MONTH (M) = dispensing cycle**

**RPCs M9: Treatment supply only visit**
FAC-PUP: acility Pharmacy fast lane/FAC-PUP designated area in facility – FAC-PUP Distributor
EX-PUP: EXP-PUP location – EX-PUP service provider
AC: AC venue – Club facilitator

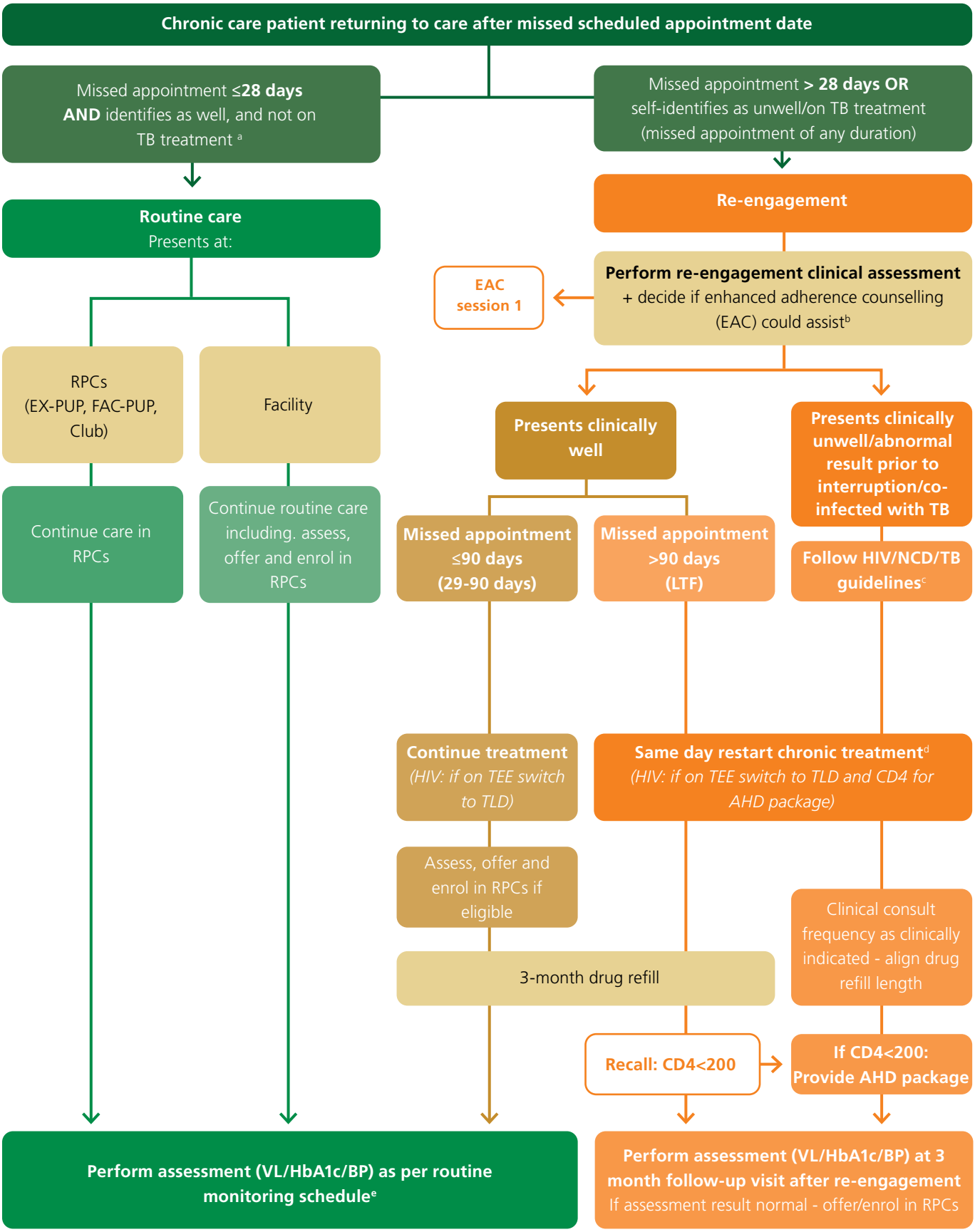
- Verifies patient identity
- *Only AC*: Facilitates group discussion
- Patient reports unwell/looks unwell – refer to facility clinician/Club PN
- Distribute pre-dispensed treatment supply (PMP) - 2nd treatment supply from 6m script
- Record in RPCs monitoring tool
- Remind patient next visit to:
  **FAC-PUP:** see clinician
  **EX-PUP:** return to facility to see clinician
  AC: attend facility/AC venue for clinical consultation depending on Club PN location

**RPCs M12: Rescripting visit***
FAC-PUP/EX-PUP: Facility – Clinician
AC: Facility/AC Venue – Club PN

- Brief integrated chronic care clinical check-up
  *For children:* dosage check
  *For breastfeeding women:* VL
- Script patient for 6 months + indicate supply length
- Record in clinical stationery
- Remind patient next visit: Back to FAC-PUP/AC/EX-PUP location
- Update appointment card with next treatment supply date/location
- Collect 1st treatment supply from new 6m script at facility pharmacy/AC location

*Clinician's discretion whether rescripting visit requires clinician to see patient but if required must complete integrated clinical check-up (see SOPs 5.1-5.3)

# ANNEXURE VIII: RE-ENGAGEMENT ALGORITHM




**a. If repeated, it is not appropriate to provide EAC or reclassify as re-engagement. Despite difficulties with attending as scheduled, the patient is not disengaging from care. If not in RPCs, assess eligibility and enrol. Alternatively, provide MMD from the facility.**

**b. Clinician considerations for providing EAC session 1:**

1. Drug side effects impacting adherence? If yes and drug/s switched → no need for EAC
2. Difficulty getting to facility to collect treatment → no need for EAC
3. Challenges with taking treatment as required → provide EAC (see EAC SOP 2)

**c. 2014 TB Guidelines managing interruption on page 60-61**

**d. Unless clinical indication exists to defer treatment restart**

**e. Where the patient is overdue for their routine assessment at return, only perform the assessment once the patient has taken treatment for 3 months (or if in RPCs, the closest clinical review date thereafter).**

Detailed job aid at **www.knowledgehub.co.za**

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