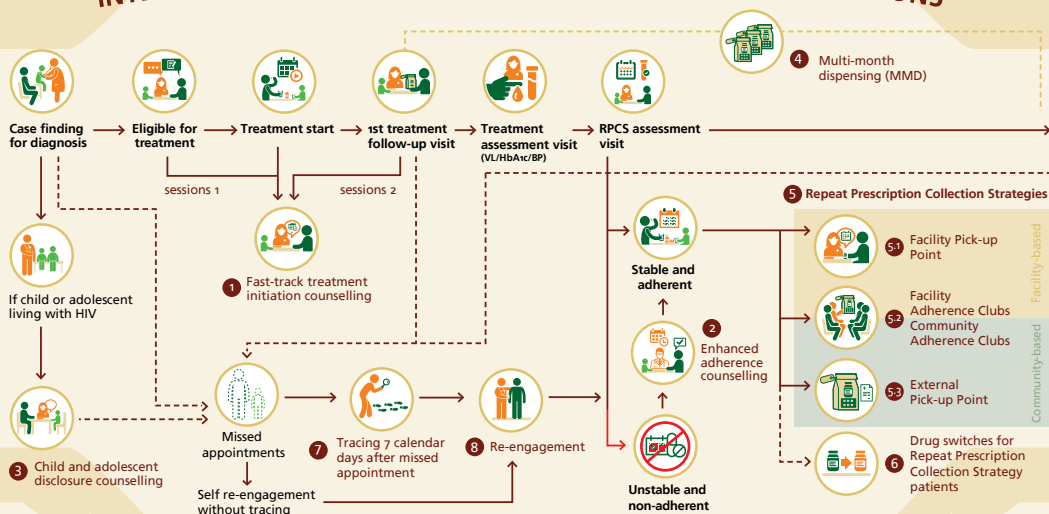


DIFFERENTIATED MODELS OF CARE STANDARD OPERATING PROCEDURES

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

INTEGRATED CARE OF PEOPLE LIVING WITH CHRONIC CONDITIONS



Adherence Guidelines for HIV, TB and NCDs

Updated April 2023



health

Department:
Health
REPUBLIC OF SOUTH AFRICA



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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 2023 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 2020 SOPs to align with the 2023 ART Clinical Guidelines for the Management of HIV in Adults, Pregnancy and Breastfeeding, Adolescents, Children, Infants and Neonates and the 2019/2020 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)
- **Longer treatment supply to reduce patient burden and support continued engagement in care**
 - Multi-month dispensing (SOP 4)

- **Differentiated models of care for stable patients on chronic treatment**

- Repeat Prescription Collection strategies (RPCs) after the first normal assessment including multi-month dispensing (SOP 5):
 - o Facility pick-up point = health facility-based individual RPCs (SOP 5.1)
 - o Adherence Club = health facility or community-based group RPCs (SOP 5.2)
 - o External pick-up point = out-of-facility individual RPCs (SOP 5.3)

Treatment to RPCs is supplied by the Central Chronic Medicine Dispensing and Distribution program (CCMDD) or a Central Dispensing Unit (CDU) or the facility pharmacy. **CCMDD is a supply chain mechanism not a model of care.**

- 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 participant 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 once operational capacity and stock availability is confirmed.
8. **Revises** the differentiated approach to **patient management on re-engagement**.

ACKNOWLEDGEMENTS

The 2023 revision 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, including the United States Centers for Disease Control and Prevention (CDC) and the United States Agency for International Development (USAID). 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 2023 ART Clinical Guidelines.

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 this standard operating procedures booklet was coordinated by Dr Thato Chidarikire the Acting Chief Director for the HIV/AIDS & STI Cluster and Director: HIV Prevention Strategies, National Department of Health.

ACRONYMS

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

RPCs: Repeat Prescription
Collection Strategies

SOP: Standard Operating
Procedures

TB: Tuberculosis

TIER.Net: TB/HIV information system
application

TPT: TB Preventative Therapy

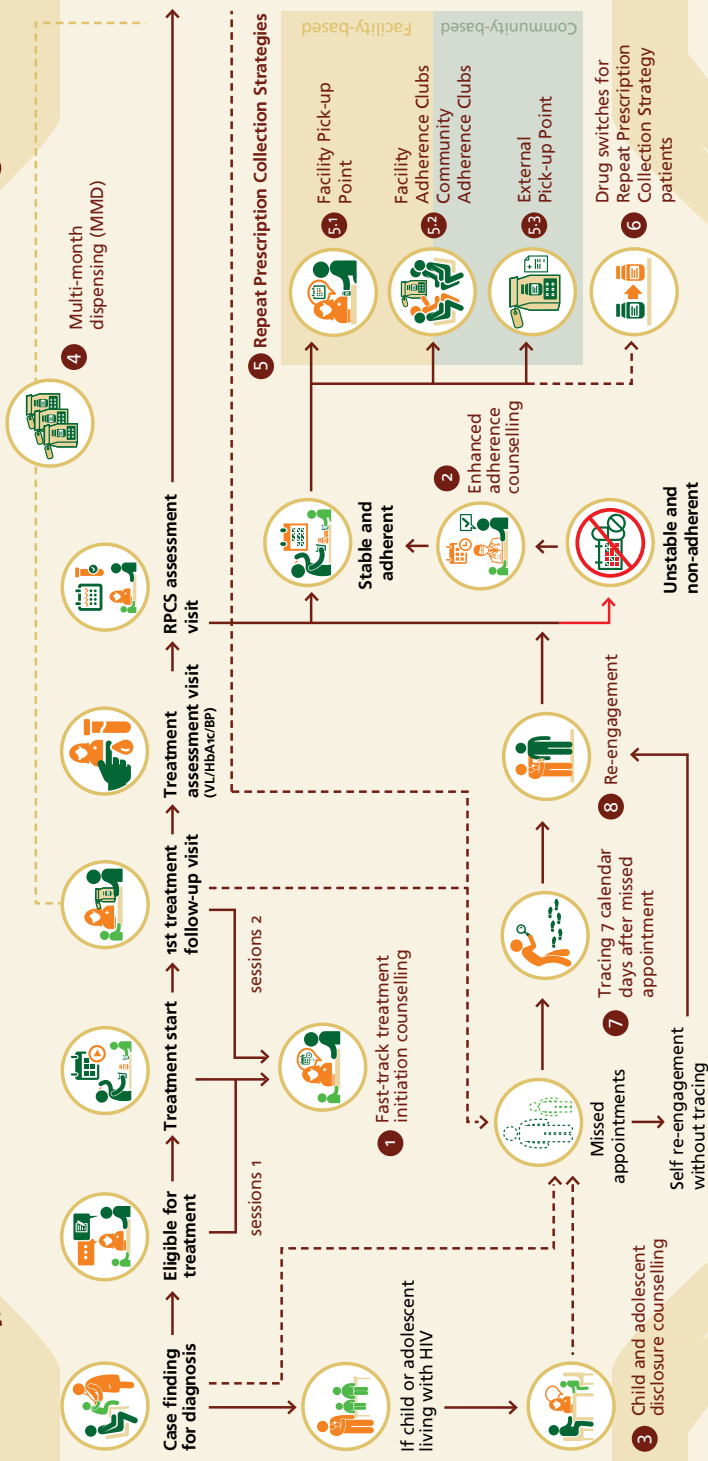
VL: Viral Load

WBPHCOT: Ward-based Primary Health
Care Outreach Team

XDR: Extensively Drug Resistant

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

INTEGRATED CARE OF PEOPLE LIVING WITH CHRONIC CONDITIONS



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: APRIL 2023

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: 2023 ART Clinical Guidelines for the Management of HIV in Adults, Pregnancy and Breastfeeding, Adolescents, Children, Infants and Neonates

For NCDs: 2019/2020 Adult Primary Care Guide

For TB: 2014 National TB Management Guidelines; 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 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:
<ul style="list-style-type: none"> a. Screen and provide treatment based on clinical guidelines b. Screen for mental health and substance use disorders c. Emphasize importance of treatment continuation d. Emphasize the importance of maintaining a healthy lifestyle e. Invite the patient to express concerns regarding side effects or support with treatment, if appropriate f. Start treatment if patient agrees g. Provide next appointment as recommended per guidelines in consultation with patient considering his/her availability h. Inform the patient about tracing system 	<ul style="list-style-type: none"> a. Educate on diagnosis, treatment, adherence, treatment pathway ahead, risks associated with non-adherence, including illness b. Create an adherence plan and place in patient folder c. Continue the adherence plan at every visit to: <ul style="list-style-type: none"> • Identify a support system • Create a medication schedule • Deal with missed doses • Identify reminders • Identify where to store medication • Deal with side effects • Explain treatment pathway ahead if adherent – longer treatment supply/easier collection • Know what to do in case of travelling • Take treatment in case of substance, alcohol or traditional medicine use • Educate on the future steps on treatment such as VL or HbA1c or BP or sputum assessment. d. Set goals with the patient as recommended per condition guidelines e. Inform the patient about tracing system 	<ul style="list-style-type: none"> a. Understand the importance of starting and continuing to take treatment b. Identify a support system c. Take the decision to start treatment d. Voice concerns and ask questions e. Agree on goals and care plan with provider f. Elaborate an adherence plan with the counsellor to identify the best time to take treatment, reminders and place to store medication g. Understand the treatment pathway ahead if adherent h. Give input on availability on next proposed appointment date and time i. Come for next appointment and inform the staff of any changes of contact number or address or if travelling. j. Take treatment to reach goals. 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 3 months (for HIV/INCDs)/7 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 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 3 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 3 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 3 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 PMTCT patients.*

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 4 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 4 months of treatment.*
 - *A follow-up sputum test called a smear microscopy will be done at 7 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:
For hypertension:
 - *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 PMTCT:

Steps should be added to support the pregnant and breastfeeding women to make a plan to:

1. Deliver at the facility
2. Choose a feeding option
3. Give the treatment to the baby
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 child immunization.
- 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

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

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

Annexures:

- I. Patient Adherence Plan ([click here](#))
- II. Mental Health Assessment tool ([click here](#))

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: APRIL 2023

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: 2023 ART Clinical Guidelines for the Management of HIV in Adults, Pregnancy and Breastfeeding, Adolescents, Children, Infants and Neonates

For NCDs: 2019/2020 Adult Primary Care Guide

For TB: 2014 National TB Management Guidelines; 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 2023 ART Clinical 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
- 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.
- 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:
<ul style="list-style-type: none"> a. Screen patients as recommended in the clinical guidelines to monitor adherence to treatment including review results from previous assessment. b. Explain abnormal result to the patient. c. Determine if abnormal result is likely to be adherence related not side effects or difficulties and if so, refer for EAC. d. Assess and manage side effects swiftly. e. Screen and provide treatment based on clinical guidelines. f. Consider switching to alternate regimen as per clinical guidelines. g. Emphasize importance of treatment continuation. h. Consider and offer MMD to support next scheduled appointment attendance if patient is clinically well. i. Ensure communication between facilities when the patient is referred to another facility. 	<ul style="list-style-type: none"> a. Educate on abnormal result and that adherence challenges are the common cause. b. Check that patient is taking treatment regimen correctly (no misunderstandings). c. Assess and address barriers to adherence. d. Assess misconceptions and beliefs about treatment. e. Provide support strategies to overcome barriers such as taking treatment even if drinking alcohol. f. 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). g. Encourage excellent adherence to influence next result. 	<ul style="list-style-type: none"> a. Express barriers to adherence (if any) and potential reason for treatment failure. b. Review and adapt adherence plan with counsellor. c. Set new treatment goals. d. Adhere to treatment. 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 prevention, counselling, support and other 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 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

- Assess patient for mental health 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 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 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.

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

Annexures:

I. Patient Adherence Plan ([click here](#))

II. Mental Health Assessment tool ([click here](#))

CHILD AND ADOLESCENT DISCLOSURE COUNSELLING (CADAC) 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: APRIL 2023

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: 2023 ART Clinical Guidelines for the Management of HIV in Adults, Pregnancy and Breastfeeding, Adolescents, Children, Infants and Neonates, 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 DISCLOSURE FOR 6-9 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 6 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 6 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

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 ([click here](#))

MULTI-MONTH DISPENSING (MMD)

SOP 4



TITLE: STANDARD OPERATING PROCEDURE: MULTI-MONTH DISPENSING (MMD)

INSTITUTION: NATIONAL DEPARTMENT OF HEALTH

REFERENCE NUMBER: AGL: MMD

EFFECTIVE DATE: APRIL 2023

PURPOSE

The purpose of this document is to outline access to and the process for multi-month dispensing (MMD) of various treatment supply lengths for utilization by facilities for patients receiving regular facility-based clinician managed care (for MMD within RPCs care - see SOP 5):

- 2-month treatment supply = 2MMD
- 3-month treatment supply = 3MMD
- 6-month treatment supply = 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: 2023 ART Clinical Guidelines for the Management of HIV in Adults, Pregnancy and Breastfeeding, Adolescents, Children, Infants and Neonates

For NCDs: 2019/2020 Adult Primary Care Guide

For TB: 2014 National TB Management Guidelines; 2017 Community TB Care SOPs

GUIDING PRINCIPLES

- Requiring monthly clinical consultations can be very costly for patients and can lead to disengagement from care.
- Clinicians should consider appropriate length of treatment supply (multi-month dispensing (MMD)) to offer a patient to support continued engagement in care and associated treatment adherence, not only for patients enrolled or being considered for RPCs enrolment.
- **Where a patient is eligible for RPCs, RPCs options must always be offered first. Only a patient who wants to see a clinician more regularly or for whom none of the RPCs options available at the facility are appropriate, may be offered MMD outside of RPCs.**

* 6MMD dependent on confirmed operational capacity and stock availability

- MMD can be considered for patients co-infected with a non-chronic condition (for example TB). The clinician should determine an appropriate balance between clinical safety and supporting patient’s continued engagement in care and adherence to treatment (reducing clinical review frequency).
- When a clinician provides MMD outside of RPCs, a return date for a further clinical consultation and rescript must be aligned with the length of treatment supply given. For example, where the clinician provides 3MMD, the patient will be given a return date for a clinical consultation in 3 months time with a 3-month script.
- 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.
- All processes must be documented.

3MMD USE AND ELIGIBILITY

3MMD USE

- 3MMD should be considered to reduce the burden to the patient of returning to the facility unnecessarily frequently.
- It will most commonly be appropriate for a patient:
 - 1. Who does not qualify for RPCs** but is struggling to attend frequent facility visits and is not acutely unwell:
 - completing continuation phase TB treatment
 - re-engaging in care (see SOP 8)
 - HIV virally suppressed children 6 months–5 years old
 - 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)
 - travelling
 - post-natal women to align with next EPI visit
 - 2. Who does qualify for RPCs and who has been offered RPCs** but prefers to attend regular clinician managed care at the facility or for whom none of the RPCs options available at the facility are appropriate.

3MMD ELIGIBILITY CRITERIA

- Above 6 months old
- On treatment for at least 3 months (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 3 months time.

2MMD USE AND ELIGIBILITY

2MMD USE

- 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 TB treatment
 - at child birth to support adherence while transferring to MCH follow-up services
 - post-natal women to align with next 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.
- **It should not be used for patients in RPCs other than for exceptional reasons.**

2MMD ELIGIBILITY CRITERIA

- Above 6 months old
- On treatment for at least 1 month (TB treatment for at least 2 months)
- Patient 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

6MMD* USE AND ELIGIBILITY

6MMD* USE

- 6MMD* can be considered for patients **who are eligible for RPCs** who will benefit from a further reduction in visit burden. 6MMD will remove the RPCs treatment collection-only visit between facility visits for clinical review.
- It will most commonly be appropriate for a patient temporarily travelling away from their permanent residence.

6MMD* ELIGIBILITY CRITERIA

- Above 5 years old
- Two consecutive normal assessment results
- Meet all other eligibility criteria for RPCs (see SOP 5)

* 6MMD dependent on confirmed operational capacity and stock availability

ROLE AND RESPONSIBILITIES FOR MMD

Clinician's role:

- a. Consider:
 1. Whether it is clinically safe to only clinically review the patient in 2 or 3 or 6 months time including timing 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.

OVERVIEW OF PROCEDURE

FACILITY MMD

Dispensed by facility pharmacy

3MMD or 2MMD or 6MMD*

	Combined clinical consultation + treatment supply**
WHEN (service frequency)	3-monthly/2-monthly/6-monthly
WHERE (service location)	Health facility
WHO (service provider)	Clinician (and pharmacy)
WHAT (service package)	Clinical review Adherence check Rescript Treatment supply (3MMD or 2MMD or 6MMD*)

* 6MMD dependent on confirmed operational capacity and stock availability

** Please note below how the procedure differs to RPCs (see further detail in SOP 5).

There is no separation of clinical consultation and treatment supply visits - these are always combined and provided by the facility (not an RPCs).

	Treatment supply only	Clinical consultation
WHEN (service frequency)	3-monthly	6-monthly
WHERE (service location)	FAC-PUP/adherence club/ EX-PUP	Health facility
WHO (service provider)	RPCs service provider	Clinician
WHAT (service package)	Second treatment supply (3MMD)	Clinical review Adherence check Rescript for 6 months First treatment supply (3MMD)

INFORMATION TO BE PROVIDED TO THE PATIENT

Only for MMD outside of RPCs. For MMD within RPCs see SOP 5

- 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 no longer be required to see the clinician at every visit and will be offered simpler treatment collection options at the facility or outside the facility either individually or as part of a support group
 - 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 write a multi-month script aligned with multi-month dispensing. All of the patient's medication must be prescribed for the same length of supply, including but not limited to other chronic, opportunistic infection related or preventative medication (e.g. contraception, TPT, cotrimoxazole).
- Write the date of the follow-up visit in patient's diary or appointment card.

TRACING, RECALL AND RE-ENGAGEMENT FOR PATIENTS ON 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.
- 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 and Surname	Designation	Signature

REPEAT PRESCRIPTION COLLECTION STRATEGIES (RPCs) SOP 5



DIFFERENTIATED MODELS OF CARE
FOR PEOPLE STABLE ON TREATMENT

TITLE: STANDARD OPERATING PROCEDURE FOR REPEAT PRESCRIPTION COLLECTION STRATEGIES (DMOC FOR STABLE PATIENTS)

INSTITUTION: NATIONAL DEPARTMENT OF HEALTH

REFERENCE NUMBER: AGL: RPCS (5)

EFFECTIVE DATE: APRIL 2023

PURPOSE

The purpose of this document is to guide access to **differentiated models of care for stable patients** 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: 2023 ART Clinical Guidelines for the Management of HIV in Adults, Pregnancy and Breastfeeding, Adolescents, Children, Infants and Neonates
For NCDs: 2019/2020 Adult Primary Care Guide

CRITERIA FOR REPEAT PRESCRIPTION COLLECTION STRATEGIES*

For adults:

- Above 18 years
- Most recent assessment results normal:
 - Most recent viral load (VL) taken in past 12 months <50 copies/ml for HIV
 - Most recent HbA1c taken in past 12 months ≤8% for Diabetes
 - 2 consecutive BP <140/90 for Hypertension
- Clinically stable with no current TB or other opportunistic infection/condition requiring clinical review more regularly than once every 6 months (see MMD SOP 4 to enable longer treatment supply outside of RPCs).
- Clinician confirms the patient's eligibility for RPCs option
- Patient voluntarily opts for the RPCs option

* Initial assessment for RPCs enrolment should be done at the visit following the first treatment assessment visit (VL/BP/HbA1c). The RPCs assessment should not be unnecessarily delayed and can be undertaken 4 months from treatment start when investigation result/s are available to complete RPCs criteria assessment.

See Annexure IV for first year on treatment schedule ([click here](#))

Pregnant and post-partum women:

- Women already on ART who become pregnant should be managed within ante-natal services with their ART and VL monitoring at ANC (aligned with their BANC plus visits) and are not eligible for enrolment in a RPCs.
- New mothers should continue to receive their ART through MNCWH services until 6 weeks after cessation of breastfeeding if they are receiving integrated care with their infant (preferred option). Where a mother is not receiving integrated care, she may be considered for a RPCs provided she is seen at her facility every 6 months for her 6-monthly VL until cessation of breastfeeding.

For children and adolescents:

- 5 to 18 years old
- No regimen or dosage changes in last 3 months
- Most recent VL taken in past 12 months <50 copies/ml
- Caregivers counselled on disclosure process where age appropriate disclosure not yet achieved (see SOP 3).
- Clinician confirms the patient's eligibility for RPCs option
- Patient (>12 years/caregiver if patient <12 years) voluntarily opts for the RPCs option
- Clinically stable with no current TB, malnutrition, mental health disorder, other opportunistic infection/condition requiring clinical review more regularly than once every 6 months (see MMD SOP 4 to enable longer treatment supply outside of RPCs).

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

GUIDING PRINCIPLES FOR ALL RPCs

- DMOC for stable patients provides for 3 different RPCs depending on the patients needs and preferences. RPCs treatment supply can be prepacked by either CCMDD or a CDU or the facility pharmacy. Patients should be given a choice of RPCs to enroll in and not be forced into any one model. **Please note that CCMDD is not a differentiated model of care but a drug supply chain mechanism enabling the RPCs.**
- A patient should be assessed for RPCs enrolment at the first facility visit after clinical guideline mandated investigations (VL/HbA1c) are taken. **This enables RPCs assessment 4 dispensing cycles/months after treatment start.**

- Women with contraceptive needs should have contraceptive method options re-explained, specifically how each method impacts all required return visits' location (facility or outside of the facility) and frequency. Long-acting reversible contraception (LARC) removes increased visit frequency/alignment concerns. Oral contraception should be scripted through preferred RPCs. Where a woman chooses to continue clinician administered short-acting injectable contraception, FAC-PUP or facility adherence club may be the preferred option provided visit alignment can be ensured.
- 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 ([click here](#))
- **All chronic treatment and any preventative therapy** (including but not limited to oral contraception, TB preventative therapy (TPT), cotrimoxazole) **should be prescribed with ART on the RPCs script**.
- 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.** 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).
- 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 and/or abnormal assessment result (VL>50 copies/ml or HbA1C>8%).
 - 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 and/or their assessment result is abnormal, the patient will return to regular clinician-managed care and should be re-assessed for RPCs enrolment when TB treatment is completed and/or the patient receives a normal assessment (VL<50 copies/ml/HbA1c ≤8%/2 consecutive BPs <140/90).
- **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 REGULAR CARE

- RPCs patient did not return to the facility or RPCs within 28 calendar days of their scheduled RPCs appointment date.
- RPCs patient is assessed as clinically unstable requiring more frequent clinical management, including diagnosed with TB or any other opportunistic infection or any other opportunistic infection.
- Other safety lab test results are abnormal.
 - For HIV: VL ≥50 copies/ml (unless clinician confirms persistent viraemia)
 - For Diabetes: HbA1c >8%
 - For Hypertension: BP >140/90
- RPCs patient becomes pregnant and is referred to integrated MNCWH services.

All patients must be advised that they are being returned to regular care to ensure more frequent clinical care until they are stable again. Patients can return to their RPCs (or alternative preferred RPCs) after a single normal result and meeting other RPCs criteria (also see Re-engagement SOP 10).

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.
- Where a patient returns to the RPCs or facility of their own accord or after tracing **within** 28 days of their RPCs scheduled appointment, the patient can continue to be managed in their RPCs. If more than 28 days late, refer to re-engagement (see SOP 8).

DEREGISTRATION FROM RPCs

RPCs patients must be deregistered from their specific RPCs on TIER.Net if they meet the criteria for return to regular care. For further detail see Integrated TB/HIV data management SOP RPCs annexure.

Annexures:

- IV. First year on treatment visit schedule ([click here](#))
- V. RPCs algorithm ([click here](#))
- VI. RPCs annual schedule diagram ([click here](#))

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

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

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

* 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.**

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.
- 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

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

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 RPCs eligibility assessment + offer RPCs options + complete RPCs registration form + record FAC-PUP enrolment in clinical stationery + 6m script + 3m** treatment supply pick-up	1	
RPCs M3**	Facility - pharmacy fast lane/FAC-PUP designated area/ room	Treatment supply only visit 3m** treatment supply pick-up	2	4 visits per annum Max 2 visits per 6-month script
RPCs M6	Facility – Clinician	Comprehensive clinical consultation visit Integrated chronic care clinical review (including FP and TPT review) + investigations + check RPCs option chosen still suitable ^b + 6m re-script ^c + record in clinical stationery + 3m** treatment supply pick-up	1	
RPCs M9**	Facility - pharmacy fast lane/FAC-PUP designated area/ room	Treatment supply only visit 3m** treatment supply pick-up	2	
RPCs M12	Facility – Clinician	Rescripting visit^d Brief integrated clinical care check-up + 6m re-script + record in clinical stationery + 3m** treatment supply 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. The minority of RPCs enrolled patients receiving an abnormal result should be recalled to the facility.

d. To see clinician at clinician discretion

See Annexure VI for RPCs annual schedule diagram ([click here](#))

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 ([click here](#))
- V. RPCs algorithm ([click here](#))
- VI. RPCs annual schedule diagram ([click here](#))

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

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

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

* 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.**

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.
- 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

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

3-MONTH* TREATMENT (TX) SUPPLY

MONTHS* IN RPCS	LOCATION AC VISIT	ACTIVITIES	SCRIPT TX SUPPLY NO.	
RPCs M-1	Facility <i>(not an adherence club visit)</i>	Registration visit 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 <i>(meet as a group for the first time)</i>	Enrolment visit^a Enrolment in RPCs monitoring tool + record adherence club enrolment in clinical stationery + 6m script + 3m** treatment supply pick-up from facility pharmacy	1	
RPCs M3**	Adherence club venue	Treatment supply only visit 3m** treatment supply pick-up	2	4 visits per annum Max 2 visits per 6-month script
RPCs M6	Facility/Adherence club venue ^e	Comprehensive clinical consultation visit Integrated chronic care clinical review (incl. FP+TPT review) + investigations + check RPCs option chosen still suitable ^b + 6m re-script ^c + record in clinical stationery + 3m** treatment supply pick-up	1	
RPCs M9**	Adherence club venue	Treatment supply only visit 3m** treatment supply pick-up	2	
RPCs M12	Facility/Adherence club venue ^e	Rescripting visit^d Brief integrated chronic care clinical check-up + 6m re-script + record in clinical stationery + 3m** treatment supply 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. The minority of RPCs enrolled patients receiving an abnormal result should 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 ([click here](#))

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 ([click here](#))

V. RPCs algorithm ([click here](#))

VI. RPCs annual schedule diagram ([click here](#))

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

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

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

* 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.**

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.
- 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 + 6m script + 3m** treatment supply pick-up	1	
RPCs M3**	EX-PUP location	Treatment supply only visit 3m** treatment supply 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 + 6m re-script ^c + record in clinical stationery + 3m** treatment supply pick-up	1	
RPCs M9**	EX-PUP location	Treatment supply only visit 3m** treatment supply pick-up	2	
RPCs M12	Facility	Rescripting visit Brief integrated chronic care clinical check-up + 6m re-script + record in clinical stationery + 3m** treatment supply 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. The minority of RPCs enrolled patients receiving an abnormal result should be recalled to the facility.

See Annexure VI for RPCs annual schedule diagram ([click here](#))

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 ([click here](#))
- V. RPCs algorithm ([click here](#))
- VI. RPCs annual schedule diagram ([click here](#))

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:
RPCS DRUG SWITCH (6)**

**EFFECTIVE DATE:
APRIL 2023**

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: 2023 ART Clinical Guidelines for the Management of HIV in Adults, Pregnancy and Breastfeeding, Adolescents, Children, Infants and Neonates

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

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: APRIL 2023

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: 2023 ART Clinical Guidelines for the Management of HIV in Adults, Pregnancy and Breastfeeding, Adolescents, Children, Infants and Neonates

For NCDs: 2019/2020 Adult Primary Care Guide

For TB: National TB Management Guidelines, 2014; 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:

- Verifying and signing off Missed Appointment Lists and Tracing Registers.
- Coordinating and liaising with WBPHCOT Team Lead regarding tracing and recall activities.
- Signing off on relevant tracing and recall reports.

Administrative Clerk:

- Pre-retrieving patient folders for patients who are scheduled for an appointment 48-72 hours prior to an appointment.
- Updating patient visits on TIER.Net.
- Reviewing and updating patient contact details when capturing each patient visit.
- Identifying all chronic care patients who have not attended the facility using the pre-retrieved folders still not collected after 7 calendar days.
- Generating missed appointment lists using TIER.Net and pre-retrieved folders not collected after 7 days.
- Filing NHLS laboratory results within 24-48 hours after triaging by clinician.
- Timeous filing of patient folders.

WBPHCOT Team Lead:

- Consolidating all facility missed appointment lists.
- Liaising with facility manager or designated official to identify and report back on patients with missed appointments or abnormal results.

Community Health Worker:

- Verifying missed appointments prior to contacting patients.
- Protecting the confidentiality of a patient at all times when attempting to trace and recall.
- Documenting tracing and recall attempts in relevant registers.
- Sharing tracing and recall attempts with relevant facility staff.

CCMDD:

- 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

RE-ENGAGEMENT IN CARE

SOP 8



TITLE: STANDARD OPERATING PROCEDURE: RE-ENGAGEMENT IN CARE

INSTITUTION: NATIONAL DEPARTMENT OF HEALTH

**REFERENCE NUMBER:
AGL: RE-ENGAGEMENT (8)**

**EFFECTIVE DATE:
APRIL 2023**

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: 2023 ART Clinical Guidelines for the Management of HIV in Adults, Pregnancy and Breastfeeding, Adolescents, Children, Infants and Neonates

For NCDs: 2019/2020 Adult Primary Care Guide

For TB: 2014 National TB Management Guidelines; 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. Sustained re-engagement may be best supported by reducing the required frequency of attendance by providing longer treatment supply and identifying more convenient locations or service hours for collection of treatment supply. *Increasing the intensity of service provision may not be supportive.*
- Re-engaging patients should be considered for multiple-month treatment supply and/or enrolling or re-enrolling into a repeat prescription collection strategy (RPCs) if eligible.
- Chronic care patients returning repeatedly 28 days or less late for their scheduled visits do not require enhanced adherence counselling and should not be reclassified as re-engaging. Despite difficulty with attending as scheduled, the patient is not disengaging from care. If not already enrolled in RPCs, the patient should be urgently assessed for and offered RPCs (otherwise at least facility provided MMD).
- All processes must be documented.

FACILITY TEAM, ROLES AND RESPONSIBILITIES

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

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

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

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

RE-ENGAGEMENT PROCEDURE

See Re-engagement algorithm – Annexure VII

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

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

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

90 days or less (29-90 days late)

- 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.

More than 90 days (>90 days late)

- 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.

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:

VII. Re-engagement algorithm ([click here](#))

ANNEXURES



ANNEXURE I: PATIENT ADHERENCE PLAN

Name and Surname:

FTIC Session 1 after chronic disease education session (date):
Adherence step 1: education on HIV <input type="checkbox"/> TB <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Other <input type="checkbox"/>
Adherence step 2: Life goals: My motivations to stay healthy are: (1)..... (2)..... (3)..... I will maintain a healthy lifestyle by <input type="checkbox"/> adopting healthy eating habits <input type="checkbox"/> getting regular exercise <input type="checkbox"/> managing my stress
Adherence Step 3: Patient Support system Agree for home visit: Yes <input type="checkbox"/> No <input type="checkbox"/> Preferred means of contact: SMS <input type="checkbox"/> WhatsApp <input type="checkbox"/> Phone call <input type="checkbox"/> Other <input type="checkbox"/> Who can support me in my treatment: <input type="checkbox"/> Family <input type="checkbox"/> Friends <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Church <input type="checkbox"/> Other:
Adherence Step 4: Getting to appointments I will come to my appointments by: <input type="checkbox"/> walk <input type="checkbox"/> public transport <input type="checkbox"/> own transport If I face a difficulty to come (money, transport, etc.), my alternative plan will be to ask for assistance from: <input type="checkbox"/> family <input type="checkbox"/> friends <input type="checkbox"/> neighbour <input type="checkbox"/> other I will inform clinic I am unable to come to set appointment and request for an alternative appointment <input type="checkbox"/>
Adherence step 5: My readiness to start treatment I feel ready and will start treatment: <input type="checkbox"/> Yes <input type="checkbox"/> I do not feel ready and would like to discuss more with: I am ready today <input type="checkbox"/> Yes <input type="checkbox"/> No but will be on..... (insert date) <input type="checkbox"/> peer <input type="checkbox"/> family member <input type="checkbox"/> other
Adherence Step 6: Medication schedule The best time for me to take my treatment is: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening
Adherence step 7: Managing missed doses If I miss a dose, my plan is: (1) to take treatment as soon as I remember <input type="checkbox"/>

Adherence Step 8: Reminder strategies To remind me to take medication I will use: <input type="checkbox"/> watch <input type="checkbox"/> cell phone alarm <input type="checkbox"/> pill box <input type="checkbox"/> buddy <input type="checkbox"/> other
Adherence Step 9: Storing medication and extra doses I will store my medication in: <input type="checkbox"/> Safe place: <input type="checkbox"/> Far from reach of children I will carry extra supply in: <input type="checkbox"/> a bag <input type="checkbox"/> pill box <input type="checkbox"/> other:..... I will keep it in my: <input type="checkbox"/> handbag <input type="checkbox"/> pocket <input type="checkbox"/> other:.....
Adherence Step 10: Dealing with side-effects If I experience side effects, I will: Refer to treatment adherence pamphlet <input type="checkbox"/> Inform clinic if side effects do not go away or are too worrying <input type="checkbox"/>
FTIC Session 2 (date):
Adherence Step 11: Understanding the treatment pathway ahead of me if I take my treatment well <input type="checkbox"/> I understand the options for multi-month treatment supply and simplified collection available after one normal assessment result.
Adherence Step 12: Planning for trips <i>If I have some trips planned, before going away I will:</i> <input type="checkbox"/> Inform health facility before travelling to receive referral letter and treatment <input type="checkbox"/> Get enough supply of treatment for trip <i>In case I cannot come to the facility before going away:</i> <input type="checkbox"/> I will report to the nearest health facility in the travel area as soon as I arrive to get access to treatment <input type="checkbox"/> Carry evidence of my condition and evidence of the treatment I am taking
Adherence Step 13: Dealing with substance use <i>My plan to make sure I take my medication if I used alcohol or drugs is:</i> <input type="checkbox"/> To make sure I take treatment before starting to use drugs or alcohol <input type="checkbox"/> Arrange for someone to remind me to take treatment in case I am intoxicated
Education on assessment: Viral load <input type="checkbox"/> Sputum <input type="checkbox"/> HbA1c <input type="checkbox"/> BP <input type="checkbox"/> Other: <input type="checkbox"/> <input type="checkbox"/> 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 disorders while treating HIV, TB and NCDs.

Basic screening should assess:

1. What is the patient's appearance?

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

2. Assess the patient's mood, asking:

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

3. Assess the patient's thoughts:

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

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

4. Assess patient's cognition:

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

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

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

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

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

If they feel:

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

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

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

- Share your feelings and spend time with other people you trust.
- Get back to daily routine as much as possible (such as work, school, housework).
- Participate in religious or spiritual activities.
- Play sports or get regular exercise.
- Eat regular meals.
- Get adequate rest.
- Take a break and relax.

- Participate in enjoyable activities (such as singing, dancing, reading), even if at the moment it may be hard for you to enjoy them.
- Help other people talk about how they feel, but also respect if they choose not to talk about it.

Recommend that they avoid:

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

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

ANNEXURE III: CHILD AND ADOLESCENT DISCLOSURE COUNSELLING IMAGES

Image 1
Different types of germs



Image 2
Soldiers inside the blood
The immune system



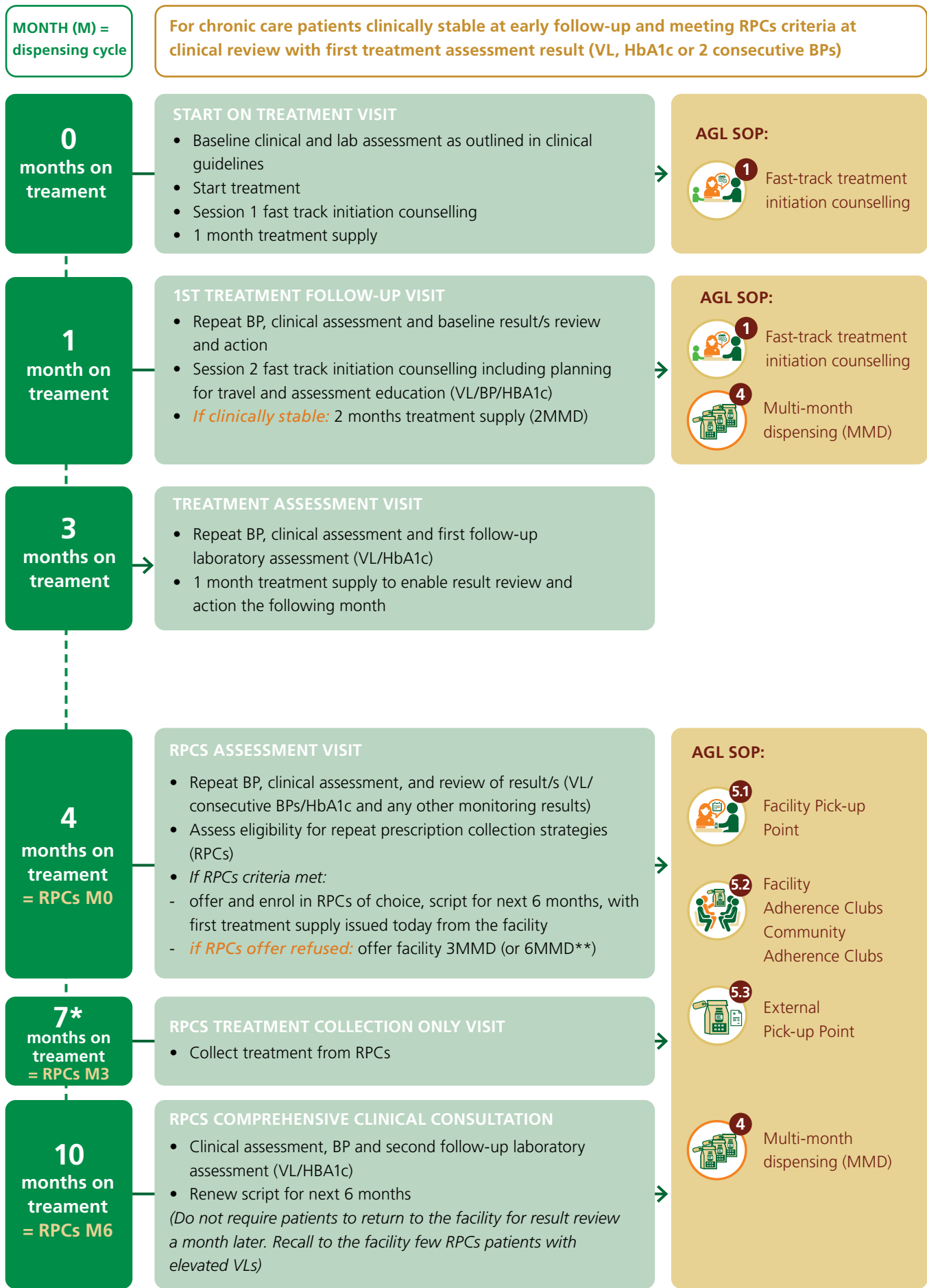
Image 3
The sleeping germ



Image 4
Treatment to fight
the sleeping germ



ANNEXURE IV: FIRST YEAR ON TREATMENT VISIT SCHEDULE



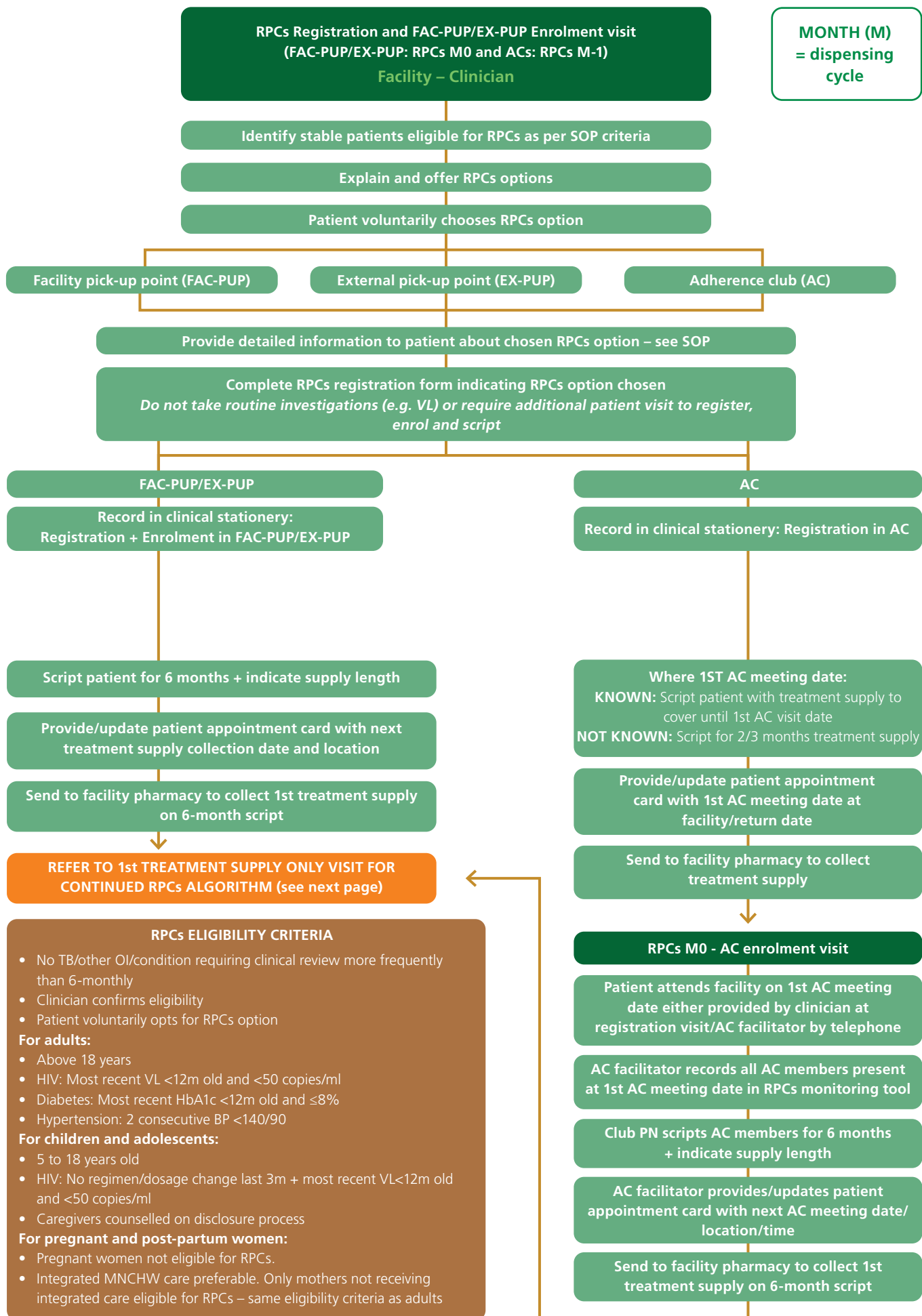
Year 1 starting chronic treatment: 5 facility visits and 1 RPCs visit = 6 visits

* 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.

** 6MMD dependent on confirmed operational capacity and stock availability

ANNEXURE V: REPEAT PRESCRIPTION COLLECTION STRATEGIES ALGORITHM

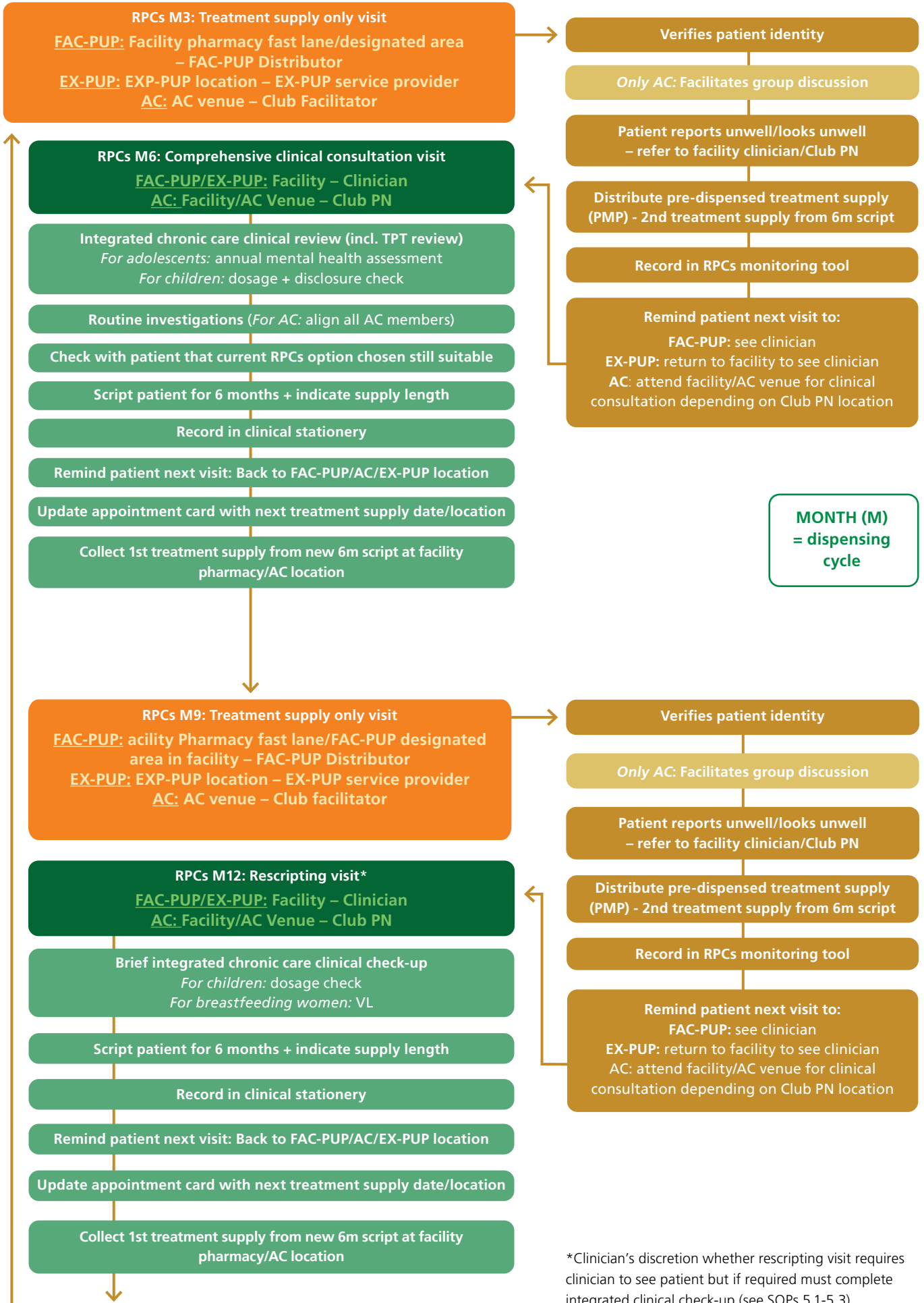
**MONTH (M)
= dispensing
cycle**



RPCs ELIGIBILITY CRITERIA

- No TB/other OI/condition requiring clinical review more frequently than 6-monthly
 - Clinician confirms eligibility
 - Patient voluntarily opts for RPCs option
- For adults:**
- Above 18 years
 - HIV: Most recent VL <12m old and <50 copies/ml
 - Diabetes: Most recent HbA1c <12m old and ≤8%
 - Hypertension: 2 consecutive BP <140/90
- For children and adolescents:**
- 5 to 18 years old
 - HIV: No regimen/dosage change last 3m + most recent VL <12m old and <50 copies/ml
 - Caregivers counselled on disclosure process
- For pregnant and post-partum women:**
- Pregnant women not eligible for RPCs.
 - Integrated MNCHW care preferable. Only mothers not receiving integrated care eligible for RPCs – same eligibility criteria as adults

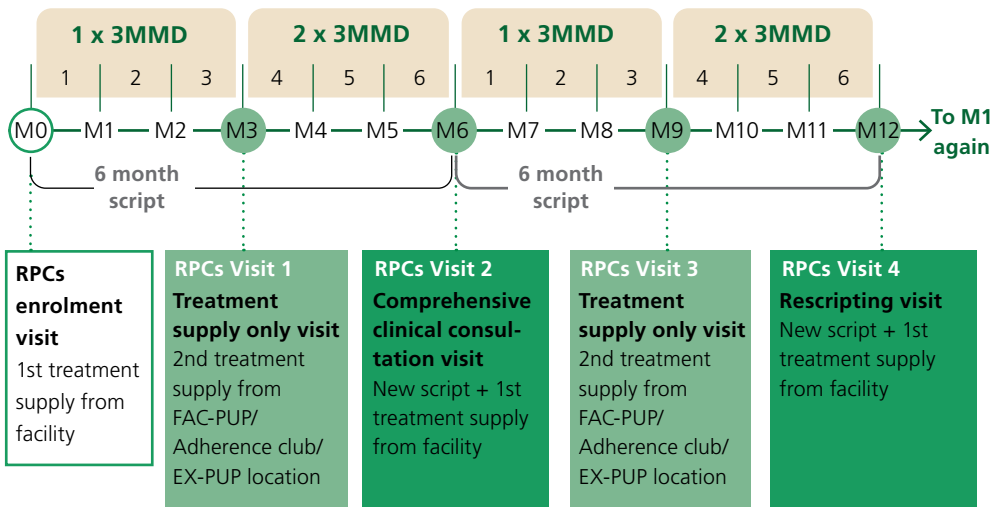
RPCs ALGORITHM FROM 1st TREATMENT SUPPLY ONLY VISIT



*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)

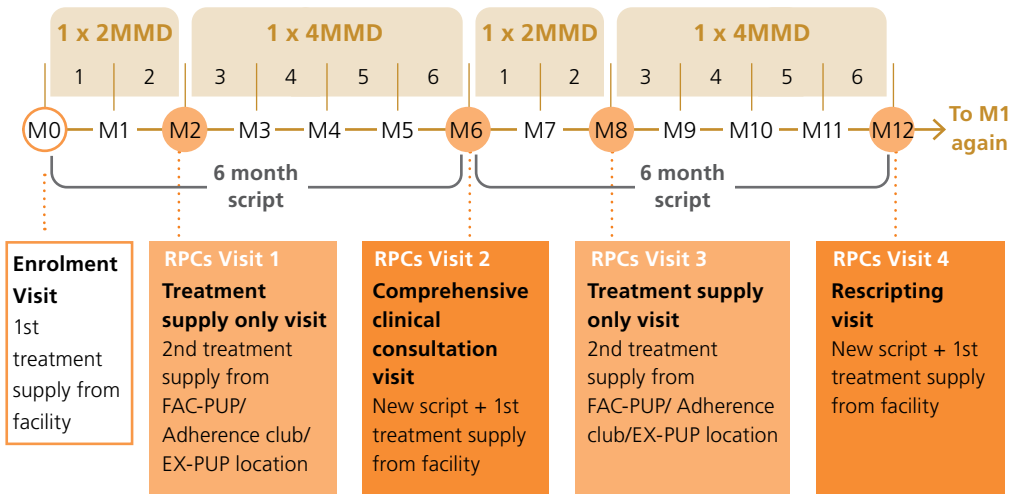
ANNEXURE VI: RPCs ANNUAL SCHEDULE DIAGRAM

3-monthly supply (3MMD)*

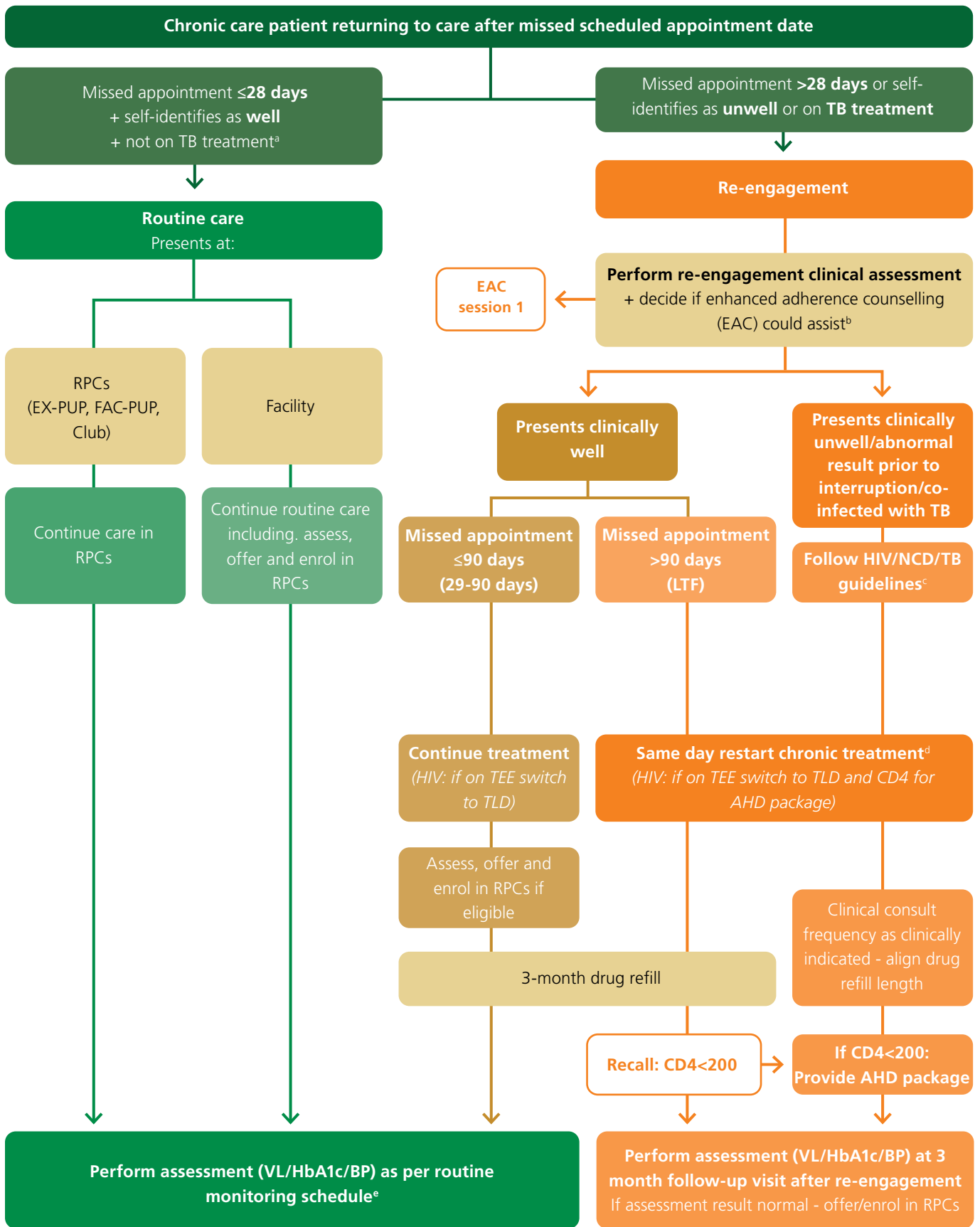


* Where a facility is experiencing drug shortages, the RPCs annual schedule can be changed as reflected below.

2/4 month supply (2MMD/4MMD)



ANNEXURE VII: 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).

**MONTH (M)
= dispensing
cycle**

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