ADHERENCE GUIDELINES FOR HIV, TB AND NCDS: TRAINING COURSE FOR HEALTH CARE WORKERS

A Skills Building Program for Clinicians and Non-Clinicians

APRIL 2021

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Introductions

- ❑ Registrations
- ❑ Welcome & Introductions
- ❑ Ground Rules
- ❑ Course expectations
- ❑ Discuss training logistics and agenda
- ❑ Pre-test Assessment
- ❑ Purpose of the training

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Purpose Of Training

What is the purpose of Adherence Guidelines Training?

- To introduce the **minimum package of interventions**
  - **to support linkage to care, adherence and retention in care**;
  - to be implemented in both facility and community based structures

- To provide non-clinicians with the **skills required** to support linkage to care, adherence and retention in care services for chronic conditions (HIV, TB and non-communicable diseases)

- To r**e-orientate** non-clinicians in their role of **strengthening** the implementation of linkage to care, adherence and retention in care programmes and interventions

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Training Outline

There are six sections on this training guide

Day 1	Day 2	Day 3	Day 4
• **Section 1**: Overview of the Adherence Guideline for HIV, TB, NCDs	• **Section 2**: Education on Illness and Treatment	• **Section 3**: Minimum Package of Interventions to Support Linkage to Care, Adherence and Retention in Care • **Section 4**: Additional Adherence Interventions	• **Section 5**: Monitoring, Evaluation and Reporting • **Section 6**: Quality Planning for implementation

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DAY ONE

SECTION 1:
Overview of The Adherence Guidelines for HIV, TB, NCDs

Section 1: Learning Objectives

- ❑ Know the background to Adherence Guidelines
- ❑ Know the stepwise approach in strengthening adherence across care cascade
- ❑ Know the overview of <u>key</u> adherence strategies
- ❑ Understand roles and responsibilities of non-clinicians to support adherence guidelines

Group Reflection – Adherence

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Background

- Adherence to treatment is both a national and international priority
- Effective implementation of the minimum package of interventions to support
  - linkage to care,
  - adherence and
  - retention in care

Is essential in reducing the burden or strain in health facilities.

- Linkage to care, adherence, and retention in care interventions can be linked to key indicators to evaluate programmes performance
- The Covid-19 Pandemic, which is a global concern, has created challenges on the continuum of care of patients within the healthcare system,
  - Including people living with HIV, TB and NCDs.
- Raises on the concerns about access to quality treatment, care and support including access to medication refills.

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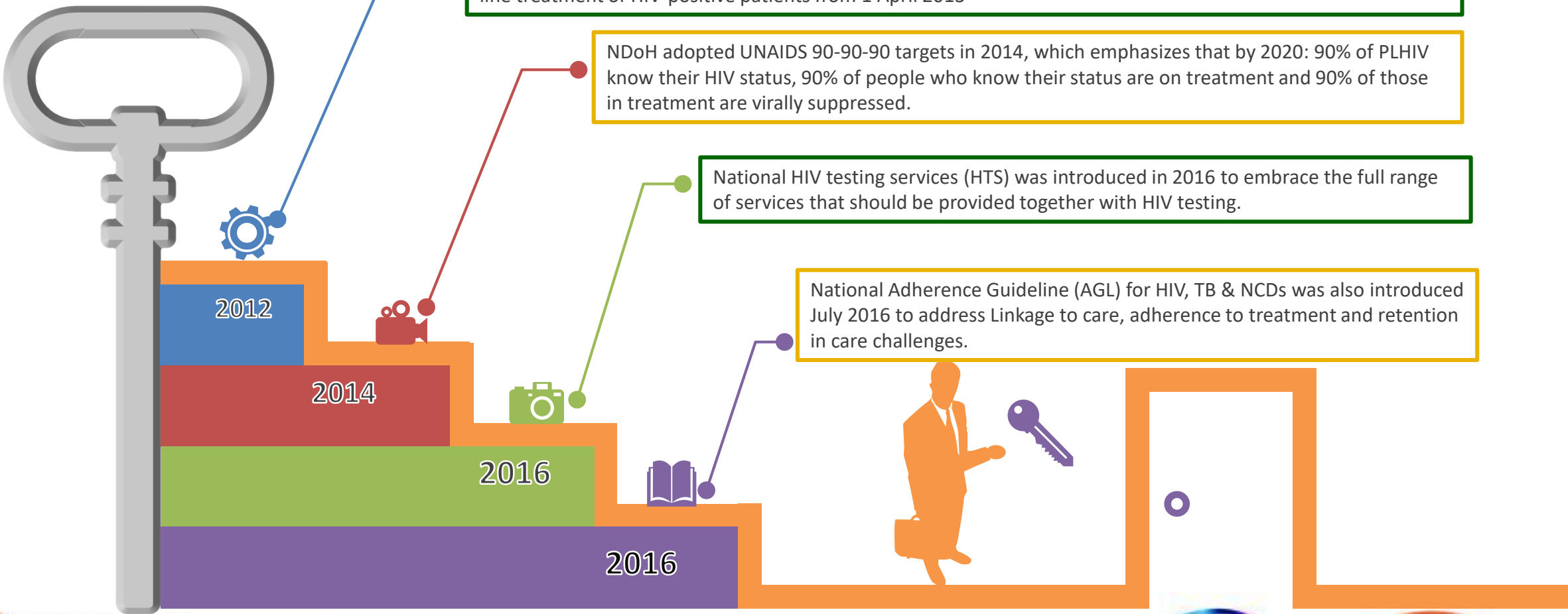
Reflections

Minister of health introduced fixed dose combination (FDC) antiretroviral drugs (ARVs) will be used in the first line treatment of HIV-positive patients from 1 April 2013

NDoH adopted UNAIDS 90-90-90 targets in 2014, which emphasizes that by 2020: 90% of PLHIV know their HIV status, 90% of people who know their status are on treatment and 90% of those in treatment are virally suppressed.

National HIV testing services (HTS) was introduced in 2016 to embrace the full range of services that should be provided together with HIV testing.

National Adherence Guideline (AGL) for HIV, TB & NCDs was also introduced July 2016 to address Linkage to care, adherence to treatment and retention in care challenges.



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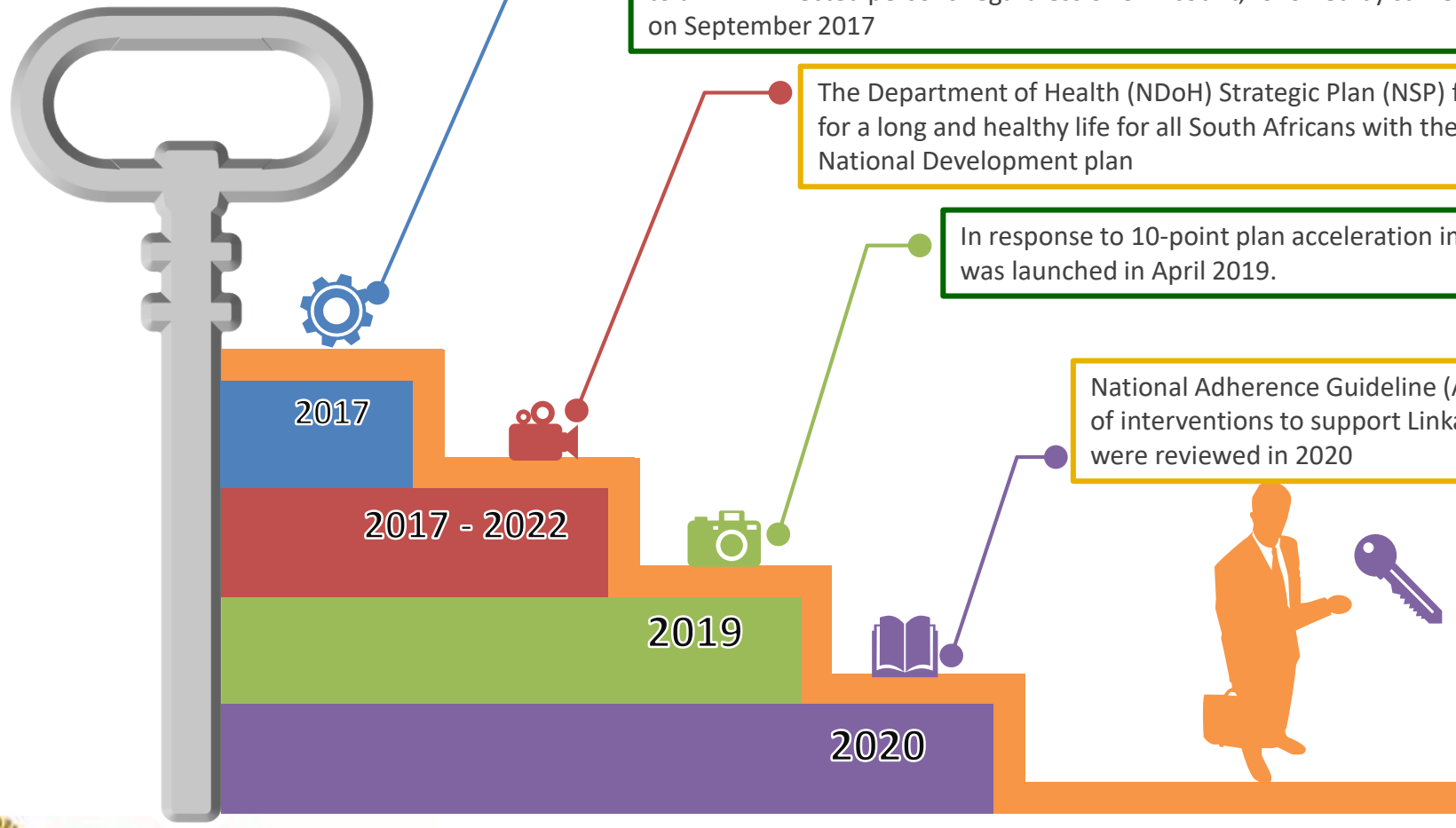
Reflections

A policy of universal test and treat (UTT) was introduced on September 2016, to fast-track treatment initiation to all HIV- infected persons regardless of CD4 count, followed by same-day initiation (SDI) which came into effect on September 2017

The Department of Health (NDoH) Strategic Plan (NSP) for HIV, TB and STIs 2017-2022 purposes for a long and healthy life for all South Africans with the objective to attain vision 2030 of the National Development plan

In response to 10-point plan acceleration implementation plan operation Phuthuma was launched in April 2019.

National Adherence Guideline (AGL) for HIV, TB & NCDs minimum package of interventions to support Linkage to care, adherence and retention in care were reviewed in 2020



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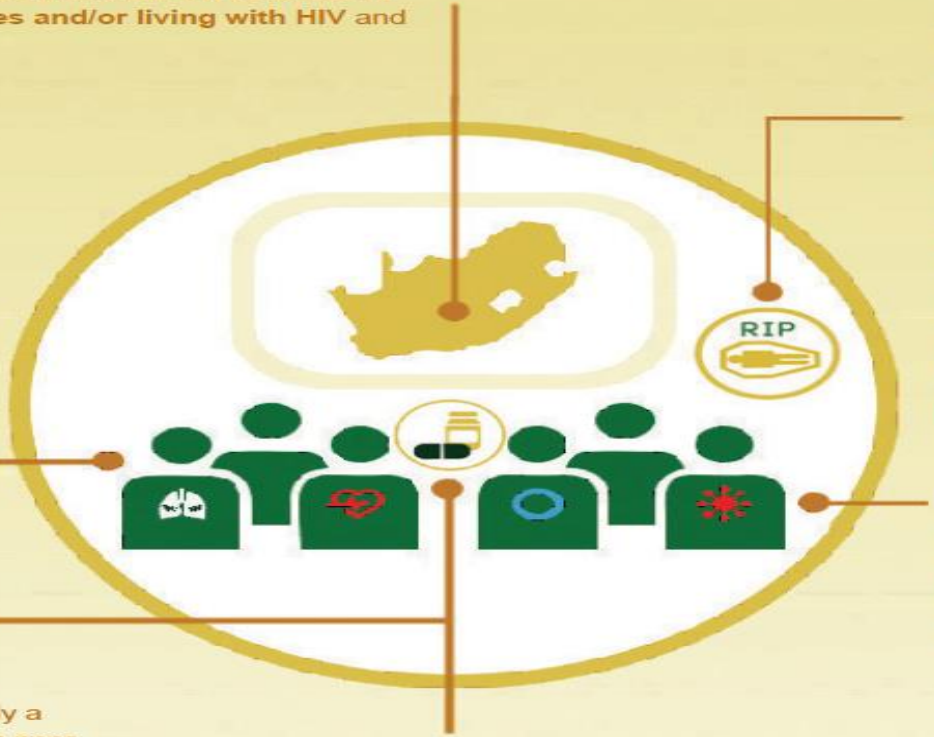
Current Challenges

Epidemic Profile and Rationale for Adherence

There are currently 7, 5million PLHIV, and 5million on Antiretroviral treatment – which is the largest ART programme in the world. It is estimated that there will be a total of 12.3 million **people being treated for chronic diseases and/or living with HIV** and receiving antiretroviral treatment (ART) by 2025.

Globally, South Africa is among the high **TB burden** countries ranked six after India, Indonesia, China, Nigeria and Pakistan. South Africa's TB problem is complicated by the elevated caseload of DR-TB. According to the NHLS data, 4% of all TB is MDR-TB. Although Tuberculosis (TB) Tuberculosis remains the leading cause of death amongst communicable diseases, mortality due to tuberculosis has reduced in the past few years by about 25% (39 695 in 2014 to 29 513 in 2016). TB case notifications have also declined significantly in the last decade, which due to improvement in Antiretroviral Treatment coverage and TB preventative care offered in the country for those people living with HIV.



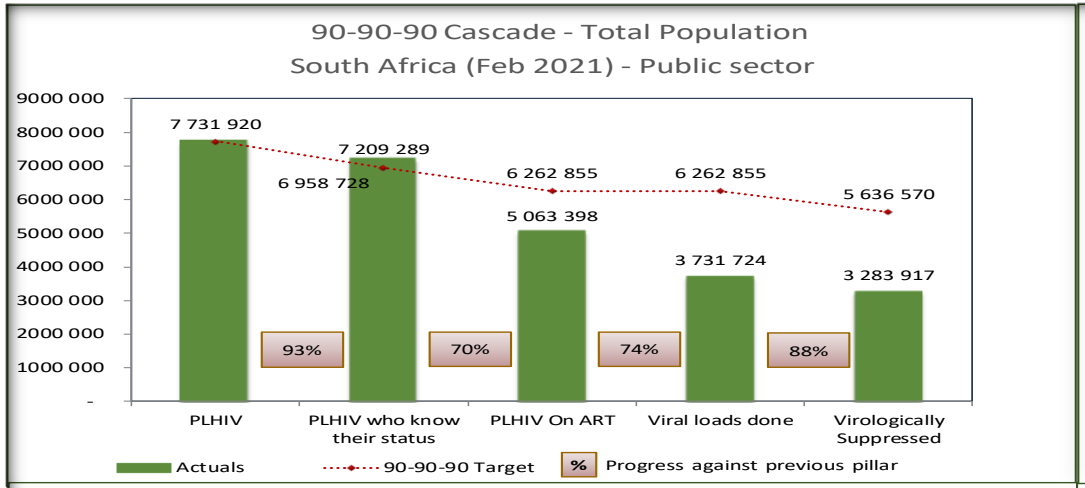
The number of deaths due to HIV reduced significantly from 214 365 in 2009 (accounting for 35.4% of deaths), to 115 167 in 2018 (22% of total deaths). HIV interventions have resulted in a steady decline in HIV incidence. Premature mortality has been observed between the ages of 30 and 70, due to selected NCDs including cardiovascular disease, cancer, diabetes, and chronic respiratory diseases, which is 34% for males and 24% for females – total 29%. According to Stats – SA, NCDs contribute 57.4% of all deaths, of which 60% are premature (under 70 years of age). The leading single cause of death from NCDs is cardiovascular disease, followed by cancer, diabetes, and chronic respiratory disease. Many of these deaths are preventable through health promotive/preventive and control measures.

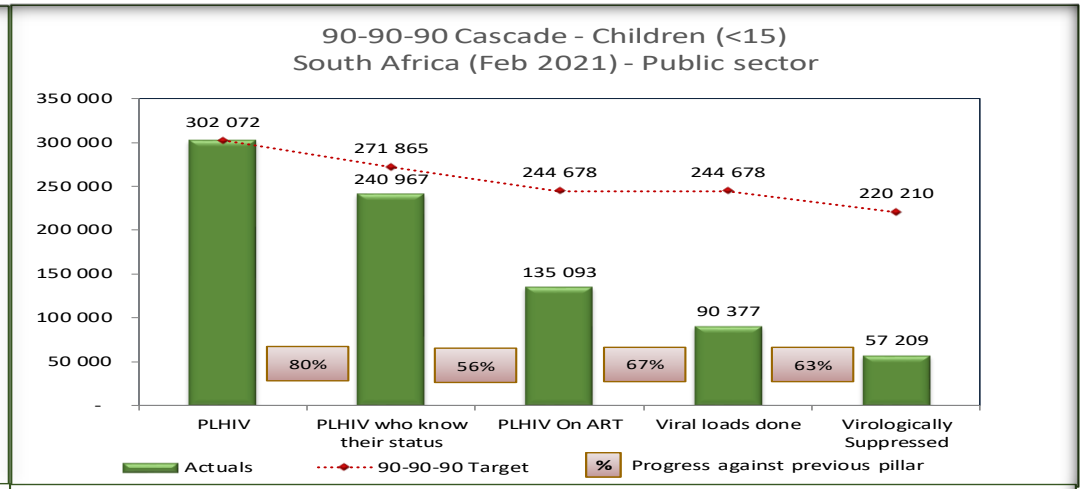
The Covid-19 Pandemic, which is a global concern, has created challenges on the continuum of care of patients within the healthcare system, including people living with HIV, TB and NCDs. Thus, raising concerns about access to quality treatment, care and support including access to medication refills.

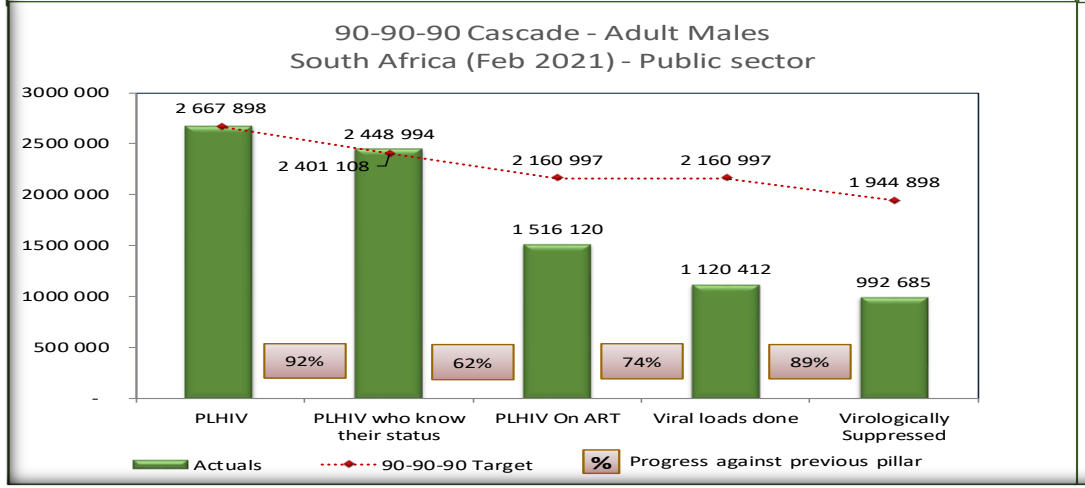
Adherence to HIV, TB and NCD treatment is increasingly a challenge. Non-adherence to longterm therapies results in poor health outcomes and increases overall health care costs. However, effective implementation of the minimum package of interventions to support linkage to care adherence to treatment and retention in care is essential in reducing the burden or strain in health facilities

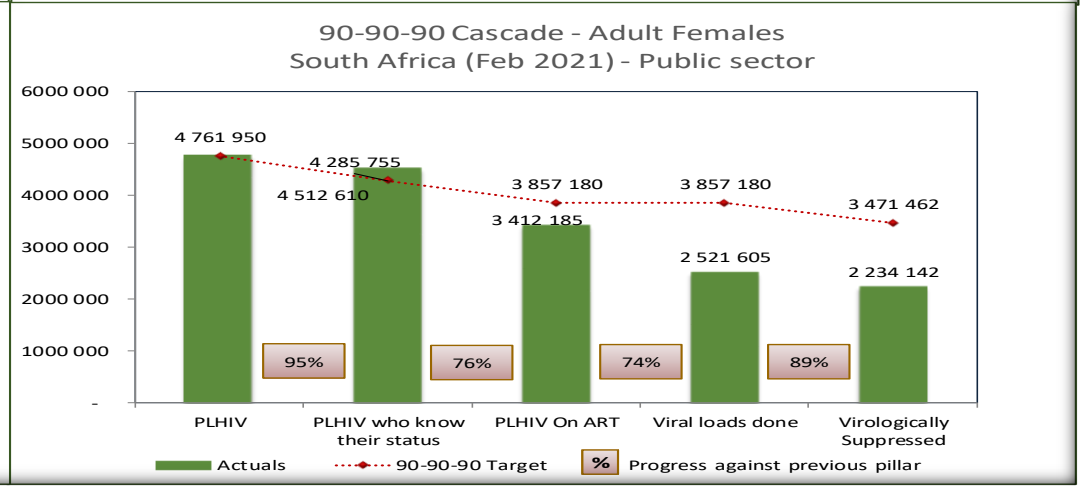
The quadruple burden of diseases in South Africa, with HIV/AIDS, TB, Hypertension, and Diabetes on the lead and the massive expansion of the ART programme put a considerable strain, put considerable strain on health care services, which presents challenges of maintaining high-quality public services.

National HIV Care Cascade









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Challenges to Non-adherence

- Patient-related barriers to linkage, adherence and retention in care
- Provider-related and structural barriers to linkage to care, adherence and retention in care

Group Reflection – Barriers to Adherence

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Patient-Related Barriers to Linkage, Adherence and Retention in Care

Cognitive	Poor knowledge and understanding of results, disease and treatment options.
Affective	Depression, anxiety, denial, lack of motivation, stigma and fear of violence.
Behavioural	Forgetfulness, alcohol and drug consumption, missed appointments.
Medical	Pill burden and regimen complexity, treatment adverse effects, medication toxicity, medication palatability.
Family/social support	Lack of social support, lack of community involvement and dependency on partner.
Socio-demographic	Age, sex, socio-economic status, level of education, stigma, and non-disclosure of status.

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Provider-Related and Structural Barriers to Linkage to Care, Adherence and Retention in Care

Provider-related

Communication	Poor client – provider communication, Inadequate health education, lack of assessment and understanding of the clients reasons for non-adherence, weakness in measuring adherence.
Behavioural	Attitude of health care providers towards clients, level of engagement and empathy towards the client.
Training	Inadequate training of staff in breaking bad news, educating and supporting clients in adhering to treatment, limited capacity to screen and identify mental health issues.

Structural

Organisational	• Distance to the clinic. • Long waiting time. • Lack of integration and coordination between services. • Medicine shortages and stockouts. • Inflexible clinic hours.
Intervention quality	• Lack of tools to guide health care workers on ways to support client's adherence. • Lack of confidentiality. • Inconvenient linkage to care. • Delayed treatment initiation. • Inadequate assessment of treatment adaption needed. • Poor tracing system. • Inadequate resources and laboratory services. • Poor management and support of health care workers.

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Objectives of the National Adherence Strategy

- To strengthen access to appropriate services and interventions in order to improve clinical outcomes
- To assist service providers to ensure that people with chronic diseases are linked to care, retained in care and supported in adhering to treatment
- To address client and service-provider barriers

Adherence Strategy is for HIV, TB, NCDs such as diabetes and hypertension

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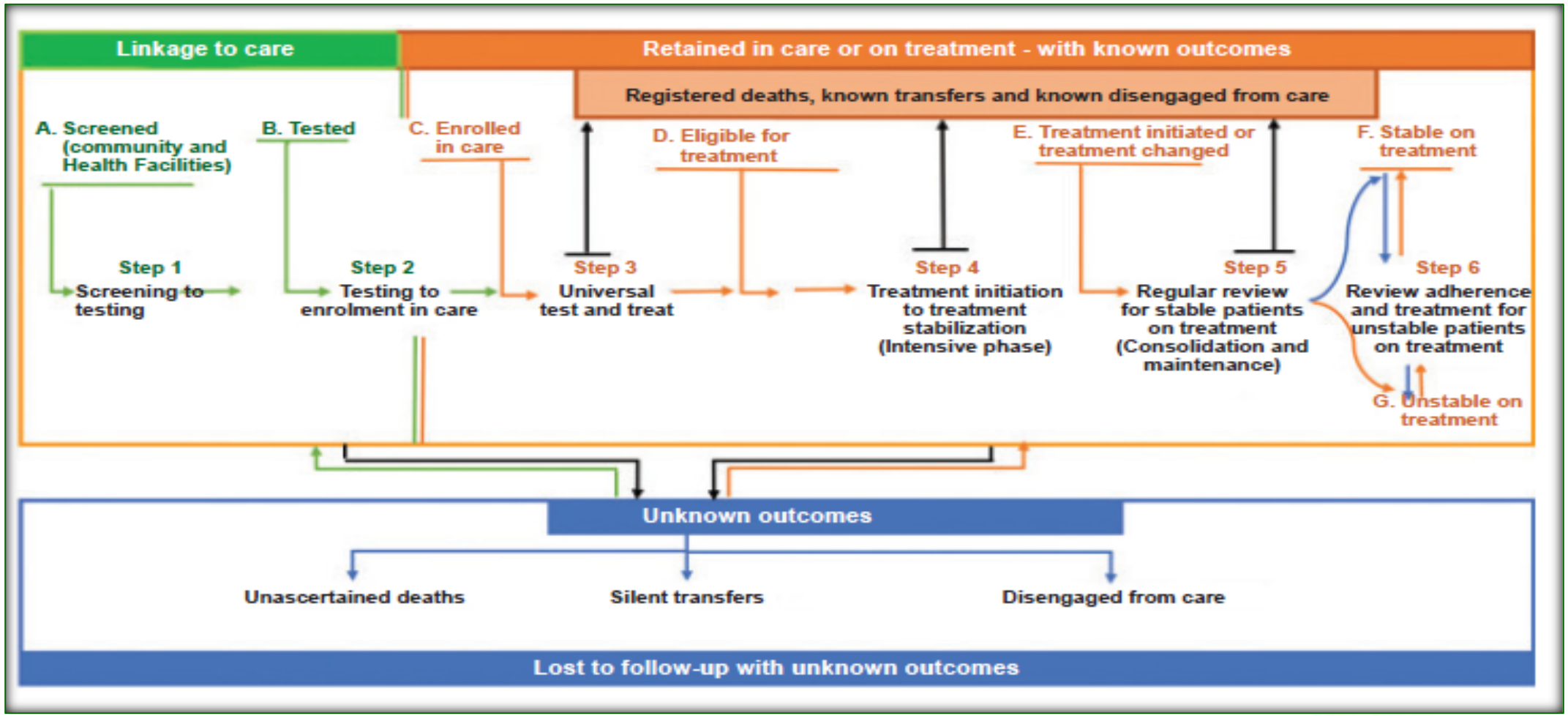
AGL Focus: Patient –Centred Approach

- Patients' self-assisted monitoring and a more patient-centred approach through..
  - Empowering chronic care patients
  - Improving their health care experience and
  - Providing information that enables them to make informed decisions about their own health.

The Stepwise Approach for Strengthening Adherence Across the Care Cascade



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Minimum Package of Interventions to Support Linkage, Adherence and Retention In Care

- Integrated care for patients with chronic conditions.

- Standardized education sessions and counselling approach for:

  i) Treatment initiation – Fast Track Initiation and Counselling (FTIC1)

  ii) Patients struggling with adherence (while in care or when re-engaging in care) – Enhanced Adherence Counselling (EAC2).

  iii) Supporting child and adolescent disclosure – Child and Adolescent Disclosure (CADAC3)

- Differentiated models of care (DMoC) for stable patients on treatment:

  i) Repeat Prescription Collection strategies (RPCs) after 6 months on treatment.
  - Facility Pick-up Point (FAC-PUP4)
  - Adherence Club (AC5)
  - External Pick-up Point (EX-PUP6)

  ii) Switching first-line regimens for stable patients utilizing an RPCs – Drug Switch 7

- Patient tracing and re-engagement.
  - Tracing and Recall 8
  - Re-engagement 9

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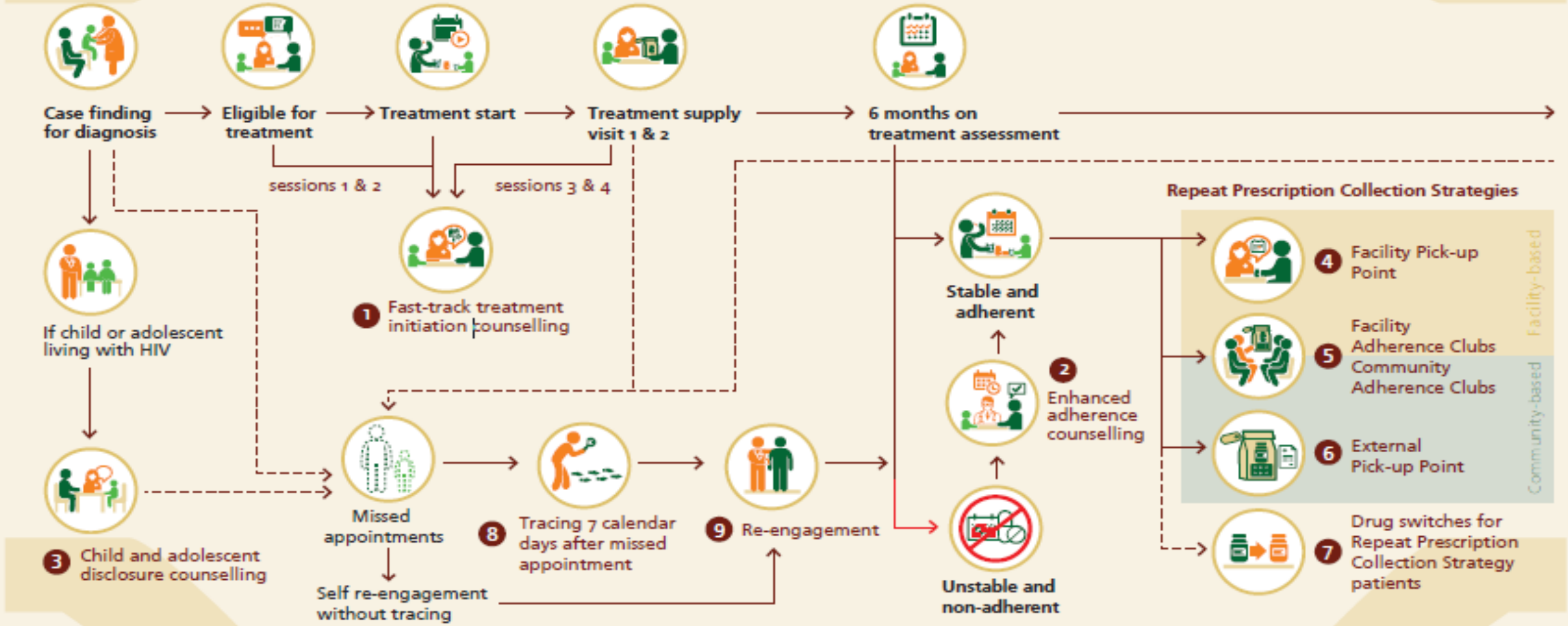
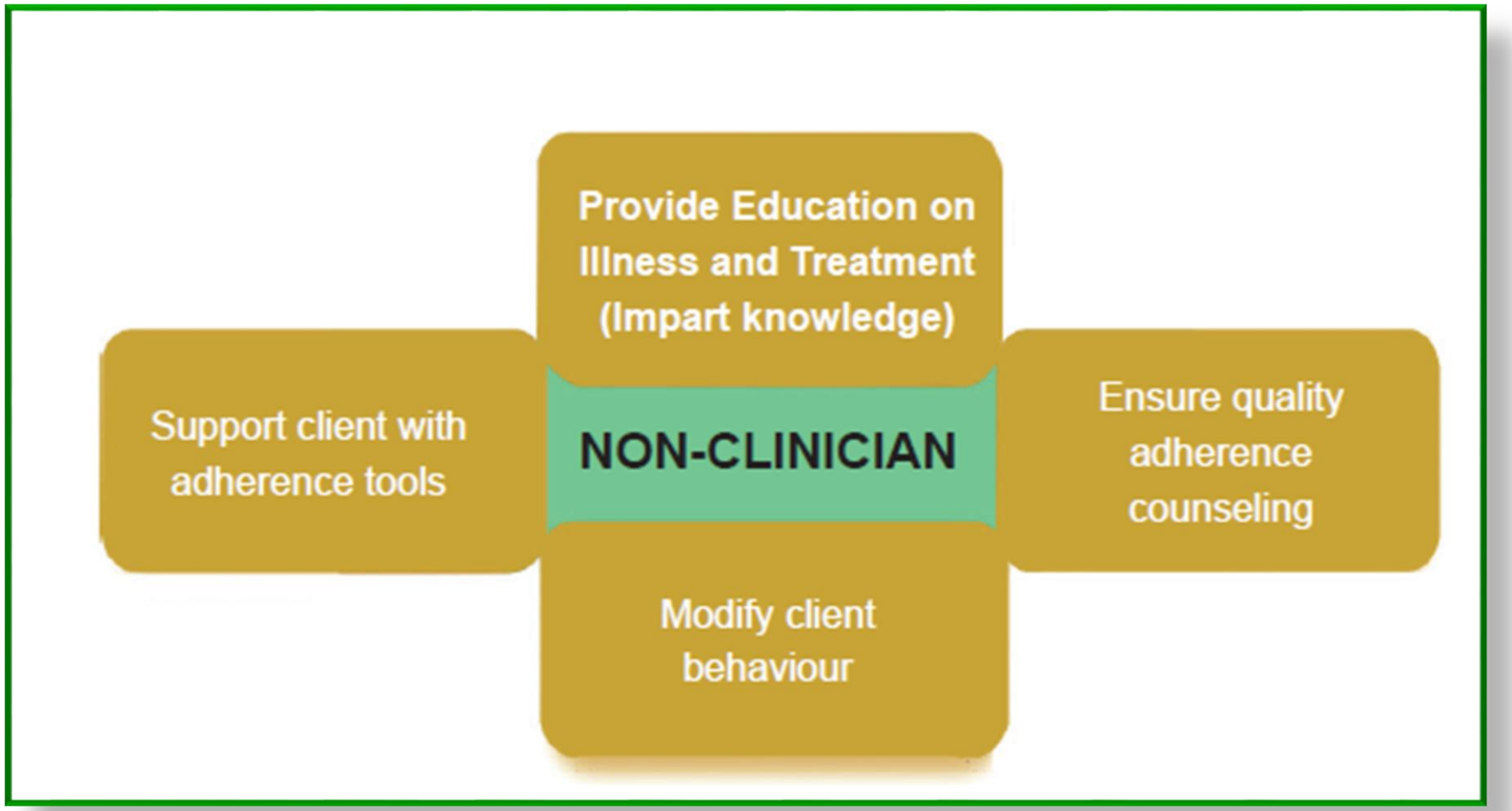
INTEGRATED CARE OF PATIENTS WITH CHRONIC CONDITIONS



Core roles and Responsibilities for Non-Clinicians



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Core roles and Responsibilities for Non-Clinicians

Core Responsibilities	Key Activities
Impart knowledge	• Improve understanding: clients often have limited knowledge and understanding about why they must take chronic medication, how it works, and how it benefits them. • Focus on client-provider shared decision-making. • Involve the client's family or caregiver wherever possible. • Advice on how to cope with medication costs. • Provide prescription instructions. • Reinforce all discussions often. • Provide pre-treatment information and education as per the visit schedule.
Ensure quality adherence counselling	• Spend time with the client and explain the disease, the goals of therapy, and the need for adherence. • Discuss the role of treatment in the management of chronic condition. • Negotiate a treatment adherence plan that the client can understand and commit to. • Explain to clients how to avoid adverse drug-drug interactions. • Assist clients to understand the possible consequences of mixing other prescribed or recreational drugs and substances.
Modify client behaviour	• Empower clients to manage their condition. • Ensure clients understand the risk of not taking their medication. • Address fears and concerns regarding treatment and adherence. • Provide encouragement and recognition for adherence. • Encourage attendance and participation in a support group.
Support clients with adherence tools	• Encourage self-reporting on adherence. • Reinforce use of pillboxes or a daily dosing diary. • Encourage treatment buddy. • Introduce client or caregiver to the therapeutic counsellor and client advocate, if available.

AGL Implementation Supporting Tools: Standard Operating Procedures (SOPs) Booklet

- ❑ SOPs for 9 minimum package interventions.
- ❑ Each SOP details
  - Purpose
  - Person's affected
  - Criteria
  - Guiding principles and
  - Procedure on how to implement
- ❑ Tracing and retention in care cuts across in all SOPs
- ❑ Applicable at facility and community settings

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AGL Implementation Tools: Training Manual and Mentorship Guide

- ❑ Comprises of 6 sections,
- ❑ Includes 2 unique sections included:
  - MER for non-clinicians
  - Quality planning for implementation
- ❑ A mentorship guide to support non-clinicians during implementation.

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AGL Implementation Supporting Tools: Adherence Flip File

- **Guides and assists** health care service providers during counselling sessions to provide **standardised adherence education**
  - TB, HIV, Hypertension, Diabetes, Healthy living and Mental health.
- Can be used by:
  - Health care workers
  - Enrolled nursing assistants
  - Health promoters
  - Lay counsellors
  - Home based carers
  - Community health workers
  - WBPHCOT leaders
  - Support group facilitators

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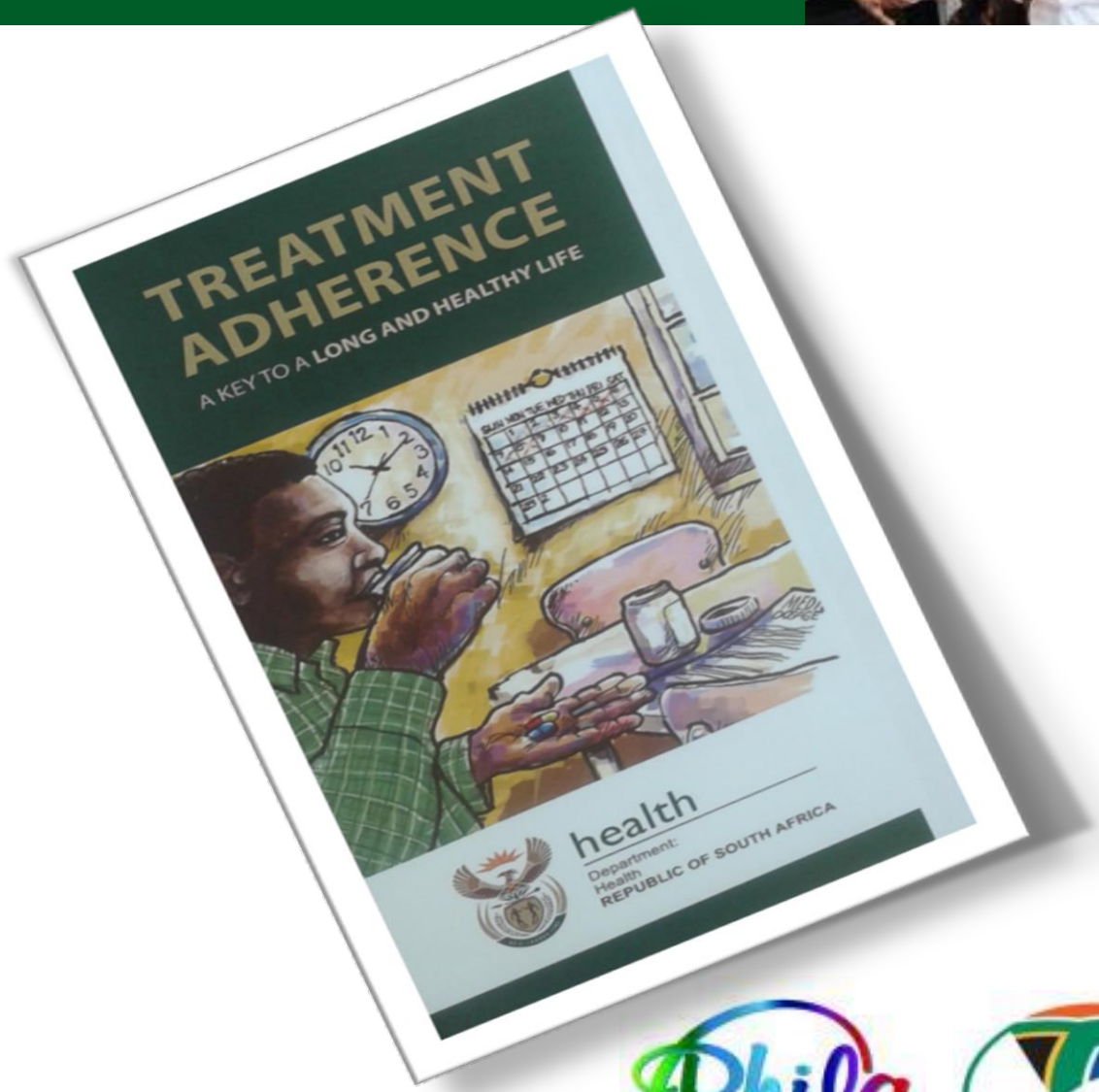
AGL Implementation Supporting Tools: Patient Treatment Adherence Pamphlet

- Adapted in **11** languages
- **Provides** patients with treatment adherence reference material to refer to when they get home.
- **Informs patients of:**
  - Importance of treatment adherence
  - Dealing with side effects
  - Benefits of disclosure
  - Healthy life style
  - Contacts details for more information



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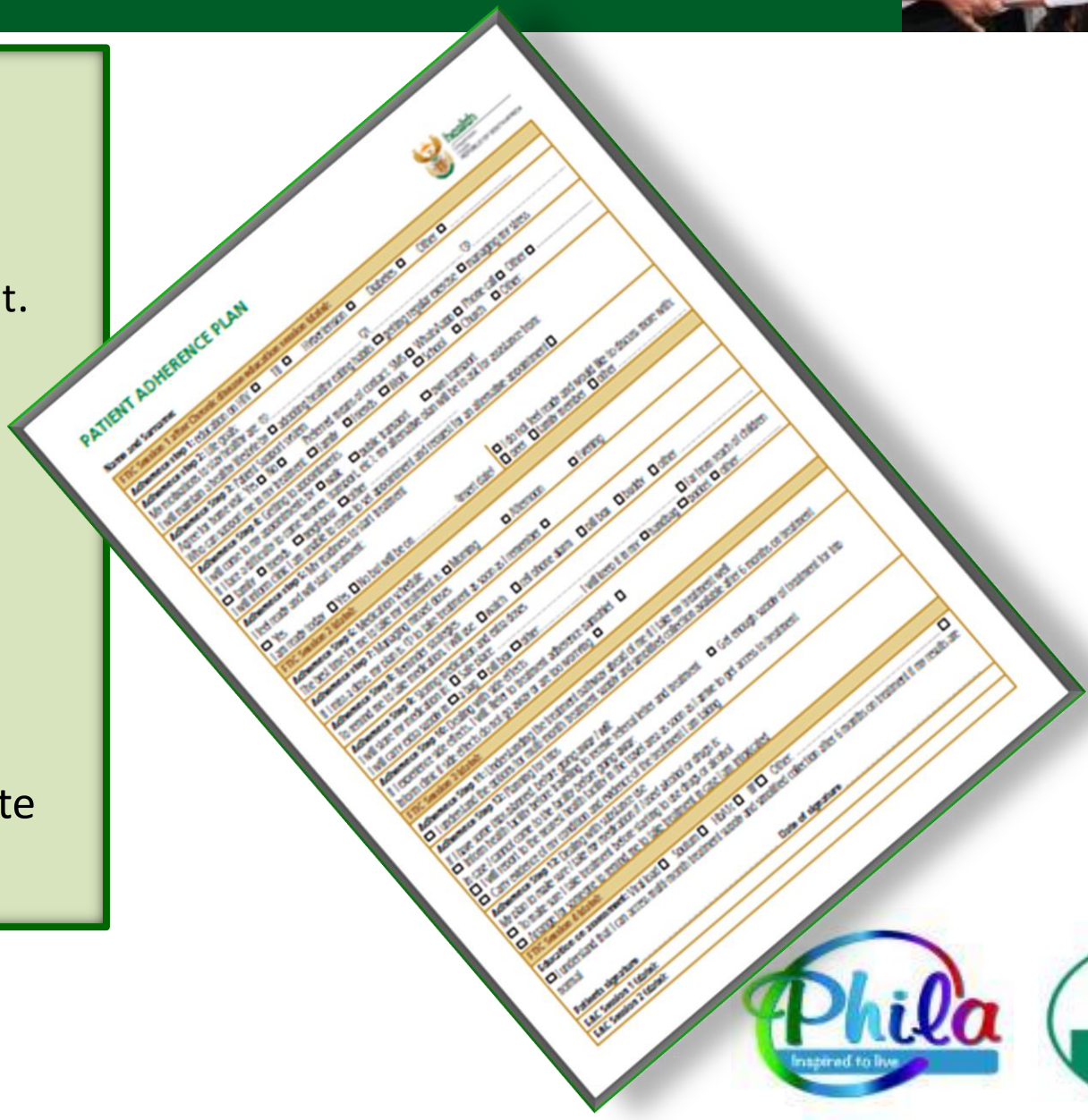
AGL Implementation Supporting Tools: Patient Adherence Plan

- Assist patients to
  - Make **their own** commitment during counselling sessions
  - Be accountable for adherence of treatment.
- Retrieved at every visit to review patient's commitment
- Used during counselling sessions
  - Fast Track Initiation Counselling
  - Enhanced Adherence counselling
- Non clinicians to assist patients to complete adherence plan



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Group Activity

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DAY TWO

SECTION 2:

Education on Illness

Section 2 :Learning Objectives

- Demonstrate the ability to provide education and counselling for the following chronic conditions so as to ensure adherence to treatment:
  - TB
  - HIV
  - Hypertension
  - Diabetes
- Discuss impact of poor or non-adherence on these chronic conditions.
- Understand mental health issues, substance abuse and healthy living as they relate to adherence education.

Group Reflection- Chronic Conditions

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Education and Counselling on Tuberculosis

Learning Objectives

- ❑ Describe what TB is.
- ❑ Discuss how TB is spread.
- ❑ Describe the results of poor adherence to TB treatment.
- ❑ Explain the link between
  - Poor adherence to TB treatment
  - and the spread of TB.
- ❑ Provide education on TB on the day of TB screening, diagnosis, treatment initiation or throughout consultations in a group or individual session.

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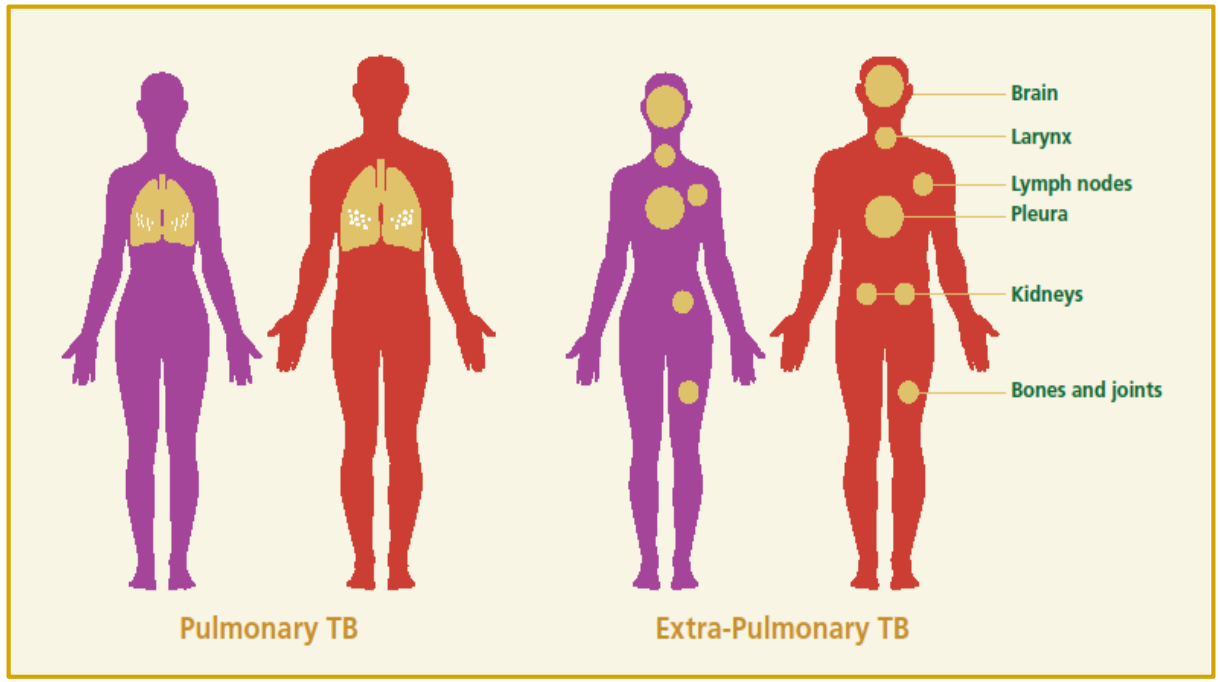
Education and Counselling on Tuberculosis..

- TB is an **infectious** disease
- TB is caused by a **bacteria Mycobacterium TB** that is breathed in
- TB mainly damages the lungs by growing and causing local destruction
  - This form is called **pulmonary TB** and is infectious to others
- TB can also occur in some parts of the body outside the lungs
  - This form is called **Extra-Pulmonary TB**



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Education and Counselling on Tuberculosis: Topics to be Presented

- What is TB?
- How is it spread?
- Who is at the risk of getting TB?
- How can you prevent passing TB on to others?
- What is the link between TB and HIV?
- What is the link between TB and diabetes?

- How should TB treatment be taken?
- How does TB become medicine (drug) resistant?
- How does treatment for DR-TB medication work?
- What are the side effects of TB treatment?
- TB medicine and contraceptives.
- TB treatment and alcohol.

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Education and Counselling on Tuberculosis: Small Group Activity

Discuss the following case study:

- As a non-clinician you are visiting Thandi, who has
- TB and has been taking medication for over 4 months.
    - She tells you that:
    - She is feeling better and
    - she has stopped taking her medication.
    - She does not like to swallow pills as they make her dizzy.

(a) What will you educate this client on?

(b) How will you educate this client?

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Education and Counselling on HIV

Group Reflection – Experience on HIV

Learning Objectives

- ❑ Describe what is HIV
- ❑ Discuss how HIV is spread
- ❑ Explain the relationship between poor adherence to HIV treatment and spread of HIV
- ❑ Describe the results of poor adherence to HIV treatment.
- ❑ Provide education to clients on HIV and
- ❑ ART from the day of HIV screening, diagnosis, treatment initiation or throughout consultations in a group or individual session.

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Education and Counselling on HIV: Topics to be Presented

- What is HIV?
- What are CD4 cells?
- How is HIV spread?
- How is HIV treated?

- When should Antiretroviral (ARV) treatment started?
- How is ARV treatment taken?
- Do ARVs have side effects?
- What are the risks of poor adherence?

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Education and Counselling on HIV: Small Group Activity

Discuss the following case Scenario:

- Thomas is a 45-year-old male who came to your facility/CBO and has been diagnosed with HIV.
- As a non-clinician what would you educate Thomas on about HIV?

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Role Play

Education and Counselling on High Blood Pressure

Group Reflection – Experience on High Blood Pressure

Learning Objectives

- ❑ Discuss what High Blood Pressure is
- ❑ Describe the results of poor adherence to High Blood Pressure treatment
- ❑ Provide education to clients on Hypertension from the day of
  - Hypertension screening,
  - diagnosis, treatment initiation,
  - or throughout consultations in a group or individual session.

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Education and Counselling on High Blood Pressure: Topics to be Presented

- How does our heart and blood work?
- What causes High Blood Pressure?
- Who is more at risk for High Blood Pressure?
- How is Blood Pressure measured?
- What can you do to lower your High Blood Pressure?
- What happens if you do not lower your High Blood Pressure?
- Can medicines control High Blood Pressure?
- What are some of the side effects of High Blood Pressure medicines?
- How often should I go to the clinic for my High Blood Pressure check-up?

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Education and Counselling on Diabetes

Group Reflection – Experience on Diabetes

Learning Objectives

- ❑ Discuss what diabetes is
- ❑ Describe results of poor adherence to diabetes treatment
- ❑ Provide education to clients on diabetes
  - from the day of diabetes screening,
  - diagnosis, treatment initiation, or
  - throughout consultations in a group or individual session.

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Education and Counselling on Diabetes: Topics to be Presented

- What is diabetes?
- What are the types of diabetes?
- What are the signs and symptoms of diabetes?
- How is diabetes prevented?
- Who is at risk of getting diabetes?

- What should you do to manage your diabetes?
- How is diabetes treated?
- Why is it important to keep blood sugar controlled?
- What are the side effects of diabetes treatment?
- What is the link between diabetes and TB?

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Education and Counselling on High Blood Pressure and Diabetes: Role Play

Role Play

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Education and Counselling on Healthy Living

Learning Objectives

At the end of this session participants should be able to:

- ❑ Make recommendations on leading a healthy lifestyle
- ❑ Explain what a basic, healthy diet is made of
- ❑ Provide education to clients on healthy Lifestyles
  - from the day of screening,
  - diagnosis, treatment initiation
  - and throughout consultations in a group or individual session

Topics to be Presented:

- ❑ Healthy lifestyle.
- ❑ What is a basic healthy diet made of?
- ❑ Healthy living and water.
- ❑ Safe food preparation.

NB: The same method which has been used in a role play to educate a client on HIV, TB, Diabetes and High Blood Pressure should also be used to educate clients on healthy lifestyles

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Education and Counselling on Mental Health

Learning Objectives

At the end of this session participants should be able to:

- ❑ To provide counselling and support for clients with mental health issues.
- ❑ To refer clients with mental health issues.
- ❑ Provide education to clients on mental health issues from the day of
  - screening,
  - diagnosis, treatment initiation and
  - throughout consultations in a group or individual session.

Topics to be Presented

- ❑ What is mental health?
- ❑ When do you need help with mental health?
- ❑ What are the signs and symptoms of mental health issues?
- ❑ What can I do for myself in case I have some of these signs and symptoms of mental health issues?
- ❑ What are specific issues people with mental health issues are faced with?
- ❑ Mental health treatment and adherence
- ❑ How and when mental health treatment should be taken?
- ❑ What are the side effects of mental health treatment?

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Education and Counselling on Mental Health: Role Play

Role Play

Education and Counselling on Substance Abuse

Learning Objectives

At the end of this session participants should be able to:

- ❑ To provide education and counselling support for clients who abuse substances.
- ❑ To refer clients who abuse substances

Topics to be Presented:

- ❑ What is substance abuse.
- ❑ What does it mean if someone is dependent on substances?
- ❑ Adherence to treatment and substance use.

NB: The same method which has been used in a role play to educate a client on HIV, TB, Diabetes and High Blood Pressure should also be used to educate clients on healthy lifestyles

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Role Play

DAY THREE

SECTION 3:
Minimum Package of Interventions to support Linkage to care, Adherence and Retention in Care

Section 3: Learning Objectives

At the end of the session participants should be able to:

- ❑ Explain the minimum package of 9 interventions.
- ❑ Explain the role of non-clinicians to support minimum package of adherence and retention interventions.
- ❑ Apply the minimum package of interventions in promoting adherence and linkage in care.

Group Reflection- ways which can improve adherence and retain clients in care

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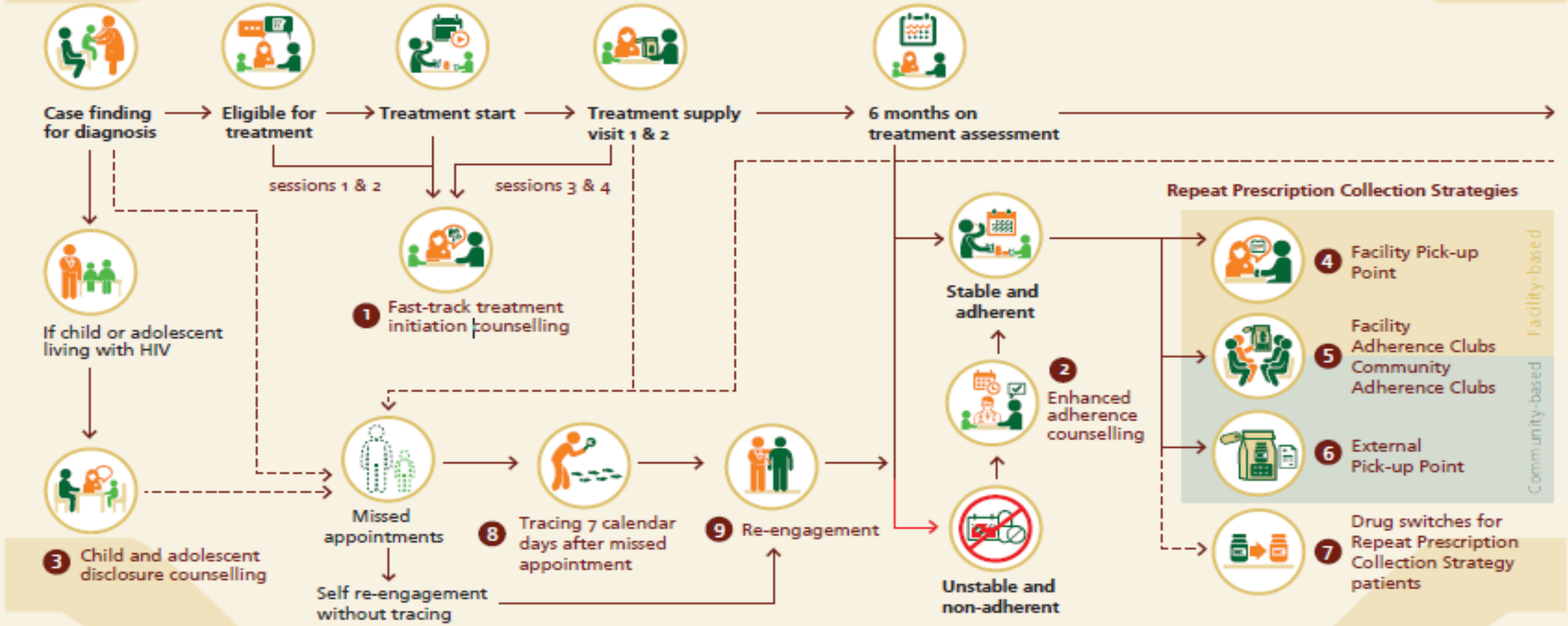
INTEGRATED CARE OF PATIENTS WITH CHRONIC CONDITIONS



Minimum Package of Interventions

Interventions	SOP #	SOP Label
Standardised Education Sessions and Counselling approach for: • Treatment Initiation • Patients struggling with adherence (while in care or when re-engaging in care) • Supporting child and adolescent disclosure	**SOP 1**	Fast Track Initiation and Counselling (FTIC)
	SOP 2	Enhanced Adherence Counselling (EAC)
	SOP 3	Child and Adolescent Disclosure Counselling (CADC)
Differentiated Models of care (DMoC) for stable patients on treatment • Repeat Prescription Collection strategies (RPCs) after 6 months on treatment: • SOP4-6 (Patients decanted at 6months) • Switching first line regiments for stable patients utilizing RPCs – SOP7	**SOP4**	Facility Pick – up Point (FAC-PUP)
	SOP 5	Adherence Club (AC)
	SOP6	External Pick – up Point (EX – PUP)
	SOP7	Switching first line regiment for stable patients utilizing RPCs (DRUG SWITCH)

Interventions	SOP #	SOP Label
Patient tracing and re-engagement	**SOP8**	Tracing and Recall (TRACING)
	SOP9	Re-engagement in care (RE – ENGAGEMENT)

SOP 1: Fast Track Initiation Counselling (FTIC)

Learning Objectives

At the end of the session participants should be able to explain

- ❑ What is Fast Track Initiation counselling?
- ❑ What clients qualify for fast track initiation counselling?
- ❑ What tools are needed to implement FTIC 1 and discuss each tool?
- ❑ How is FTIC 1 implemented?
- ❑ What are the activities that form part of FTIC 1?
- ❑ What is your role as a non-clinician to support FTIC 1?

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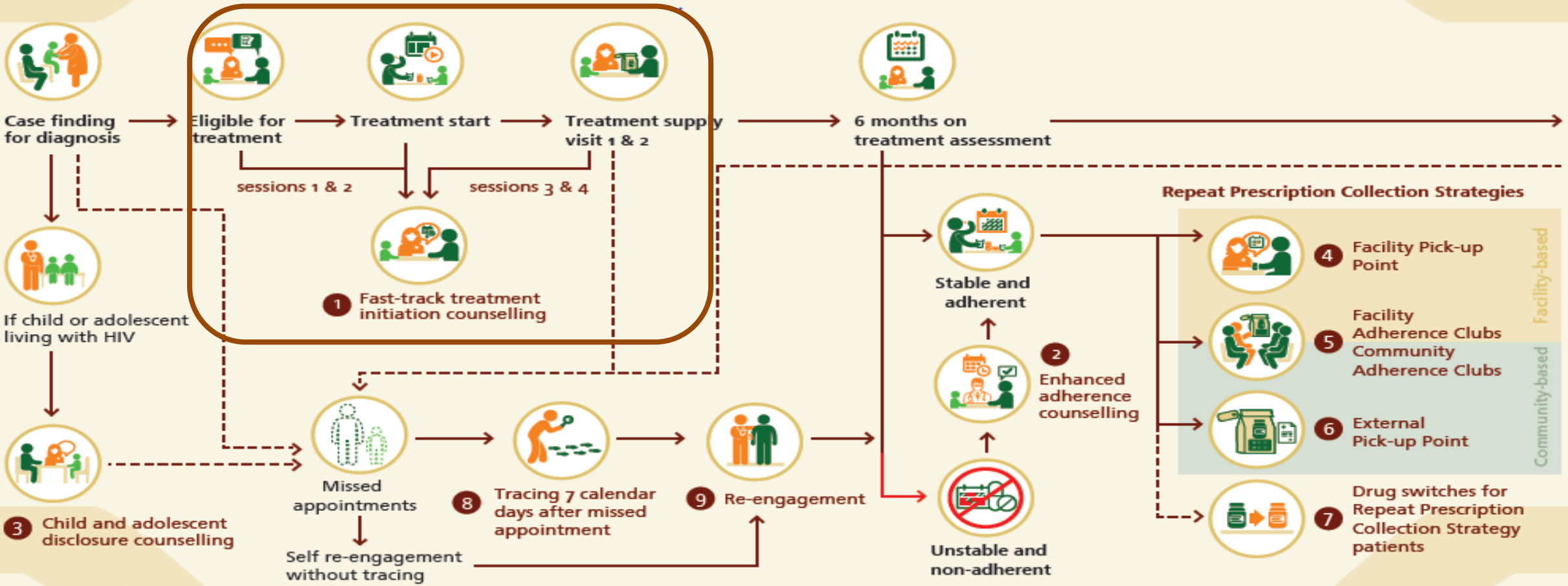

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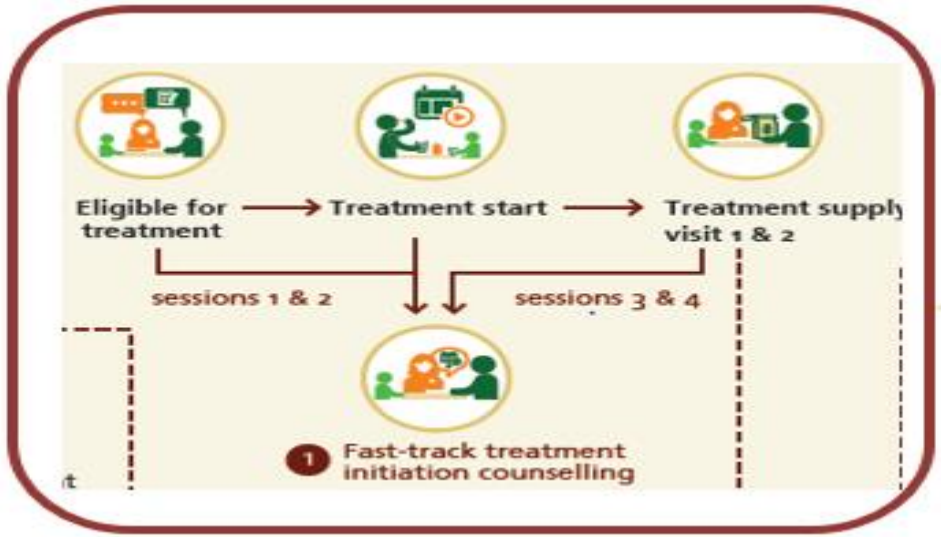
What is Fast Track Initiation Counselling (FTIC)

- FTIC 1 model is one of the minimum package intervention models that focuses on
  - Providing education
  - and counselling mainly for newly diagnosed clients.
- Providing education and support to patients without delaying initiation of treatment.
- Assist the patient to develop an individualised adherence plan and set clear treatment milestones.
- Provide standardised education and counselling:
  - using Adherence Education flip file for HIV, TB, Hypertension and Diabetes.



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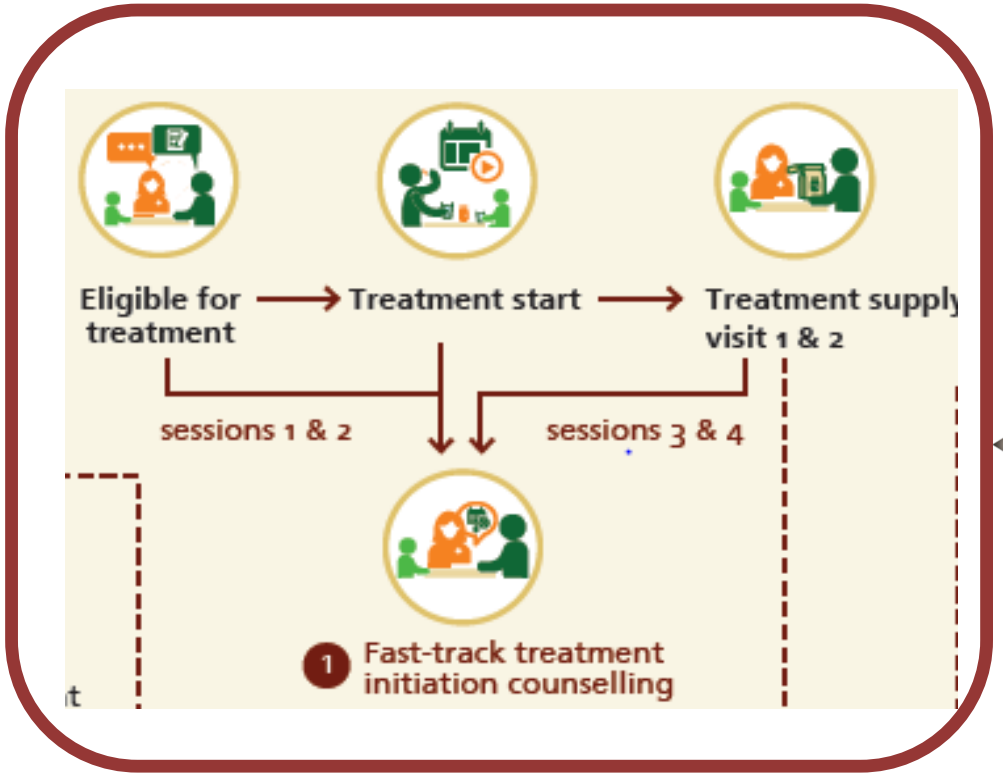
SOP 1: Fast Track Initiation Counselling (FTIC) ...



- Increasing LTFU immediately after treatment start, highlights a need to focus attention on providing session 3 and 4 at 1st and 2nd treatment refill visit (individually or as group)
- Add focus on explaining the service delivery options on treatment pathway ahead – if assessment normal at 6 months patient opts for easier collection options
- Only 1 adherence plan in client folder revised to include indication of same day readiness and treatment pathway ahead + EAC session dates

SOP 1: Fast Track Initiation Counselling (FTIC)…

What patients qualify for Fast Track Initiation Counselling (FTIC 1) model?

- ❑ All newly diagnosed patients who are pre-treatment and treatment patients.
- ❑ Patients co-infected with TB who need to initiate ART shortly after TB treatment.
- ❑ Pregnant women who initiate on the same day as HTS.

What tools are needed to implement FTIC 1 model?

- ❑ Minimum package SOPs for Fast Track Initiation Counselling.
- ❑ Patient Adherence Plan sheet.
- ❑ Adherence education flip file.
- ❑ Mental Health assessment tool.
- ❑ Adherence treatment pamphlet.
- ❑ List of supporting organisations (CBOs, FBOs) to assist with referral to psychosocial support.

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SOP 1: Fast Track Initiation Counselling (FTIC)…

How is the FTIC 1 model implemented?

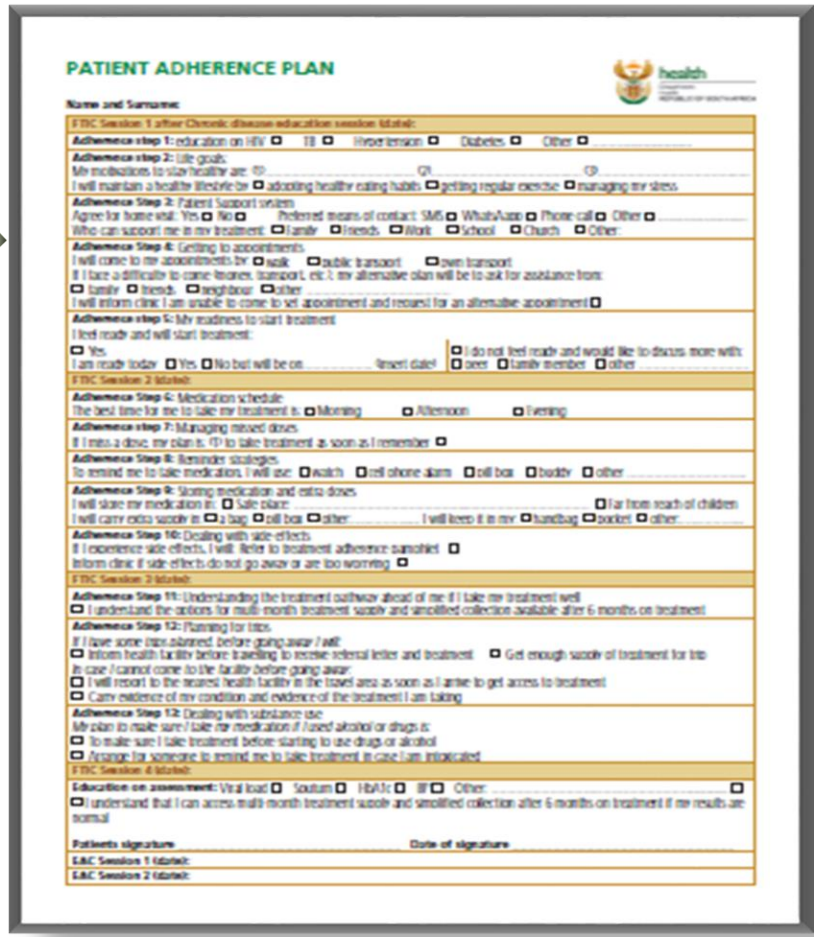
- ❑ All newly diagnosed patients who are pre-treatment and treatment patients are referred for education counselling and to start their adherence plan.

- ❑ There are four sessions in the adherence plan:

Session 1: Day of linkage into care
  - provide education on the health condition and start an adherence plan.

Session 2: Day of initiation
  - continue with the adherence plan. Session 1 and 2 must be combined if same day initiation.

❑ Adherence Plan has been revised to include additional **step 11** on the treatment pathway ahead.



PATIENT ADHERENCE PLAN

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Name and Surname:

FTIC Session 1 after Chronic disease education session (date):

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

Adherence step 2: Life goals

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

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

Adherence Step 3: Patient Support system

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

Who can support me in my treatment: ☐ family ☐ friends ☐ Work ☐ School ☐ Church ☐ Other

Adherence Step 4: Getting to appointments

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

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

☐ family ☐ friends ☐ neighbour ☐ other

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

Adherence step 5: My readiness to start treatment

I feel ready and will start treatment:

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

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

FTIC Session 2 (date):

Adherence Step 6: Medication schedule

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

Adherence step 7: Managing missed doses

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

Adherence Step 8: Reminder strategies

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

Adherence Step 9: Storing medication and extra doses

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

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

Adherence Step 10: Dealing with side effects

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

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

FTIC Session 3 (date):

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

☐ I understand the options for multi-month treatment supply and simplified collection available after 6 months on treatment

Adherence Step 12: Planning for trips

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

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

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

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

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

Adherence Step 13: Dealing with substance use

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

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

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

FTIC Session 4 (date):

Education on assessment: Viral load ☐ Sputum ☐ HbA1c ☐ IP ☐ Other ☐

☐ I understand that I can access multi-month treatment supply and simplified collection after 6 months on treatment if my results are normal

Patients signature Date of signature

EAC Session 1 (date):

EAC Session 2 (date):

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SOP 1: Fast Track Initiation Counselling (FTIC)…

Session 3: First treatment refill
(1 month from treatment start)

- finalise the last steps of the adherence plan and outline the treatment pathway ahead if adherent.

Session 4: Second treatment refill
(2 months from treatment)

- Educate on assessment,
- Restate goals and treatment pathway ahead if assessment results are normal.

Remind Patients of their Adherence Plan Treatment Goals as follows:

- ❑ **Hypertension goal**: The goal is to attain Blood Pressure less than 140/90.
- ❑ **Diabetes goal**: blood glucose at HbA1c ≤7%. HbA1c is a longer-term measurement that is able to show your average blood sugar over the three months.
- ❑ **ARV goal**: The goal is to attain VL< 50 copies /ml according the revised SOPs.
- ❑ **TB goal** have completed 6 months TB treatment and I am cured of TB!

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SOP 1: Fast Track Initiation Counselling (FTIC) Group Activities

Group Activity – Adherence Plan

Group Reflection- Barriers to Adherence

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SOP 2: Enhanced Adherence Counselling (EAC)

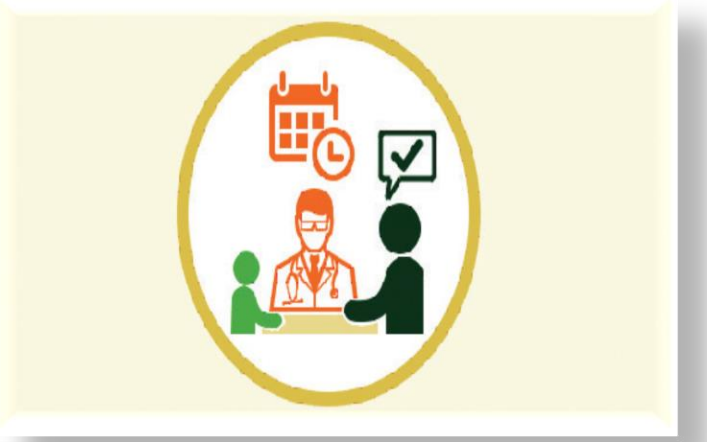
Learning Objectives

At the end of the session participants should be able to explain

- ❑ What is Enhanced Adherence Counselling?
- ❑ What clients qualify for EAC 2?
- ❑ How is EAC 2 model implemented?
- ❑ Activities which form part of supporting EAC 2
- ❑ What is your role as a non-clinician to support EAC 2?

What is Enhanced Adherence Counselling (EAC 2) model?

- ❑ The EAC 2 model is one of the minimum package intervention models that focuses on providing education and counselling to clients who are non-adherent.



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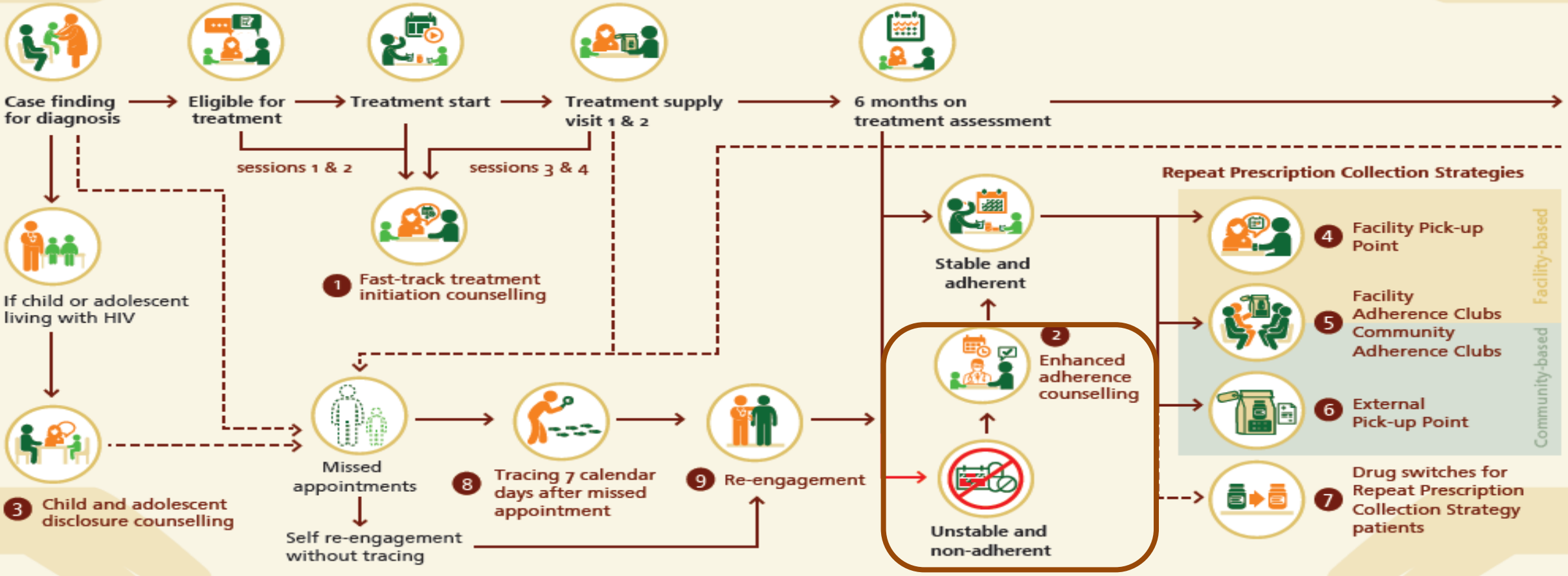

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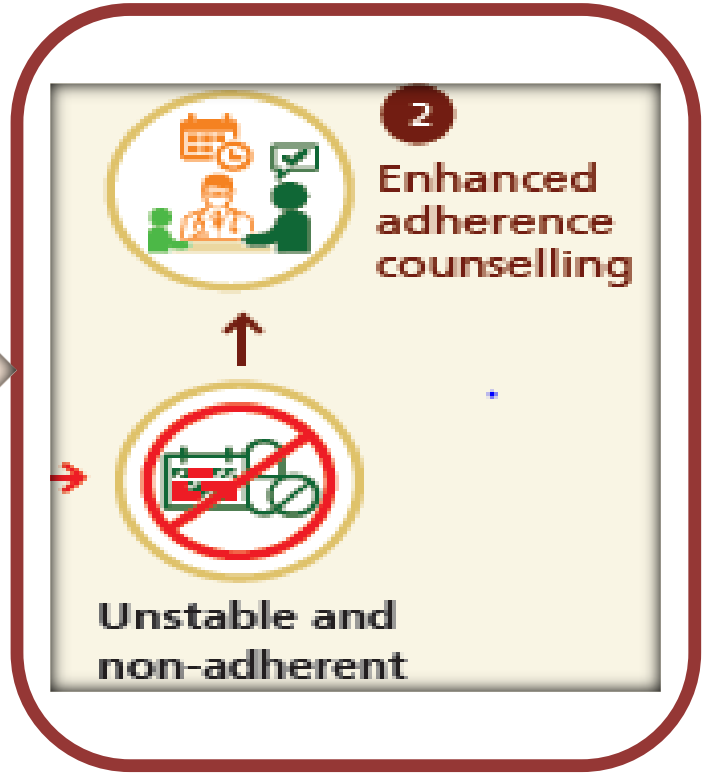
SOP 2: Enhanced Adherence Counselling…

- Aligns with new ART clinical guidelines: Clients with VL>50 copies/ml can be referred for EAC by clinician after assessing possible adherence issue **after A - E clinician's assessment** (Page 39 ART Consolidated Guidelines) See next slide

- All Diabetes Mellitus (DM) patients with HbA1c > 7% referred for EAC

- Also adds explanation to client on easier pick up options if suppressed <50 copies/ml, HbA1c ≤ 7%



A-E Assessment

A thorough assessment is essential for any patient with a viral load measuring ≥ 50 c/ml

A Adherence	Is adherence to medication poor? Ask about factors that may influence adherence e.g. • Medication side-effects, • Depression, • Alcohol or substance abuse, • Poor social support or • Non-disclosure. Pregnant women may experience nausea, heartburn, and constipation. Assess the need for symptomatic treatment with an anti-emetic, anti-diarrhea agent, or fiber supplement.	**Tips** Ask open ended questions e.g. "What makes it difficult for you to take your treatment?", and "How many doses have you missed this week?" Be non-judgemental. Statements like "we all miss a dose now and then" can encourage a client to be more open.
B Bugs (Infections)	Check for symptoms and signs of infection. Do a TB and STI screen.	Remember that immune compromised and pregnant clients may not exhibit overt symptoms of TB. If in doubt, do a TB GXP.
C Correct Dose	Is the client on the correct dose for her weight? This is especially applicable to young or malnourished girls who may have recently gained weight, or clients with previous renal impairment.	
D Drug Interactions	Are there any potential drug interactions? Consider: • Other prescribed treatment e.g. rifampicin, anti-epilepsy drugs • Over the counter treatment e.g. antacids • Supplements and herbal/traditional medications e.g. St John's wort	If in any doubt, call the **HIV Hotline** **0800 212 506**
E RE-sistance	Consider HIV drug resistance if other causes of virological failure have been excluded and the client is adherent to their medication. The need for 2nd-line ART is determined by her current regimen and how long she has been on ART.	Refer to the 2019 Consolidated ART Guideline for further management

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SOP 2: Enhanced Adherence Counselling (EAC)…

What patients qualify for the Enhanced Adherence Counselling (EAC 2) model?

- ❑ Patients ascertained by the clinician as having adherence problems.
  - Clinicians would have assessed them on Adherence, Bugs (Infections), correct dose, drug interactions, Resistance.
- ❑ Patients with abnormal results on treatment:
  - Hypertension: persistent high BP (> 140/90).
  - Diabetes: patients with blood sugar level on treatment with HbA1c more than 7%.
  - TB: positive smear on treatment for 2 months.
  - HIV: high HIV viral load on ART. Viral load of more than 50 copies/ml.
- ❑ Patients with adherence problems to prescribed chronic medication.

What tools are needed to implement EAC 2 model?

- ❑ Minimum package SOPs for Fast Track Initiation Counselling.
- ❑ Patient Adherence Plan sheet.
- ❑ Mental Health assessment tool.
- ❑ List of supporting organisations (CBOs, FBOs) to assist with referral to psychosocial support.

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SOP 2: Enhanced Adherence Counselling (EAC)…

How is EAC 2 model implemented?

- ❑ The facility shall establish a system to identify all files

of unstable patients.

  - The EAC identification system can consist of coloured stickers or note on the file or in pulling out the files in a separate folder.
  - A prioritised file should trigger referral for enhanced adherence counselling as soon as the patient comes back to the facility.

There are two sessions for Enhanced Adherence Counselling (Refer SOPs EAC 2)

- ❑ **Session 1:**

Initial enhanced adherence counselling for unstable patients.

- ❑ **Session 2**:

Enhanced adherence counselling for persistent
unstable patient..

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SOP 2: Enhanced Adherence Counselling (EAC)…

The Role of a Non-clinician to support EAC 2 model?

- ❑ Provide education on abnormal results and common cause for treatment failure.
- ❑ Assess and address barriers to adherence.
- ❑ Assess misconceptions and beliefs about treatment.
- ❑ Provide support to elaborate strategies to overcome barriers such as taking treatment even if drinking alcohol.

The Role of a Non-clinician to support EAC 2 model?

- ❑ Assist patients to set new goals for next test or appointment such as
  - having undetectable VL, less than 50 copies per/ml,
  - blood pressure less than 140/90, blood glucose with HbA1c less than 7%
  - or negative sputum.
- ❑ Encourage adherence to influence next result.

SOP 2: Enhanced Adherence Counselling (EAC) Group Activity

Group Activity – Skills needed conducting Enhanced Adherence Counselling

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SOP 3:Child and Adolescent Disclosure Counselling (CADC 3)

Learning Objectives

At the end of the session participants should be able to:

- ❑ What is child and adolescent disclosure counselling?
- ❑ What clients qualify for child and adolescent disclosure counselling?
- ❑ What tools are needed to implement CADC 3?
- ❑ How is CADC 3 model implemented?
- ❑ What is your role as a non-clinician to support CADC 3?

Group Reflection- The Importance for Children and Adolescents to Know About their HIV Status

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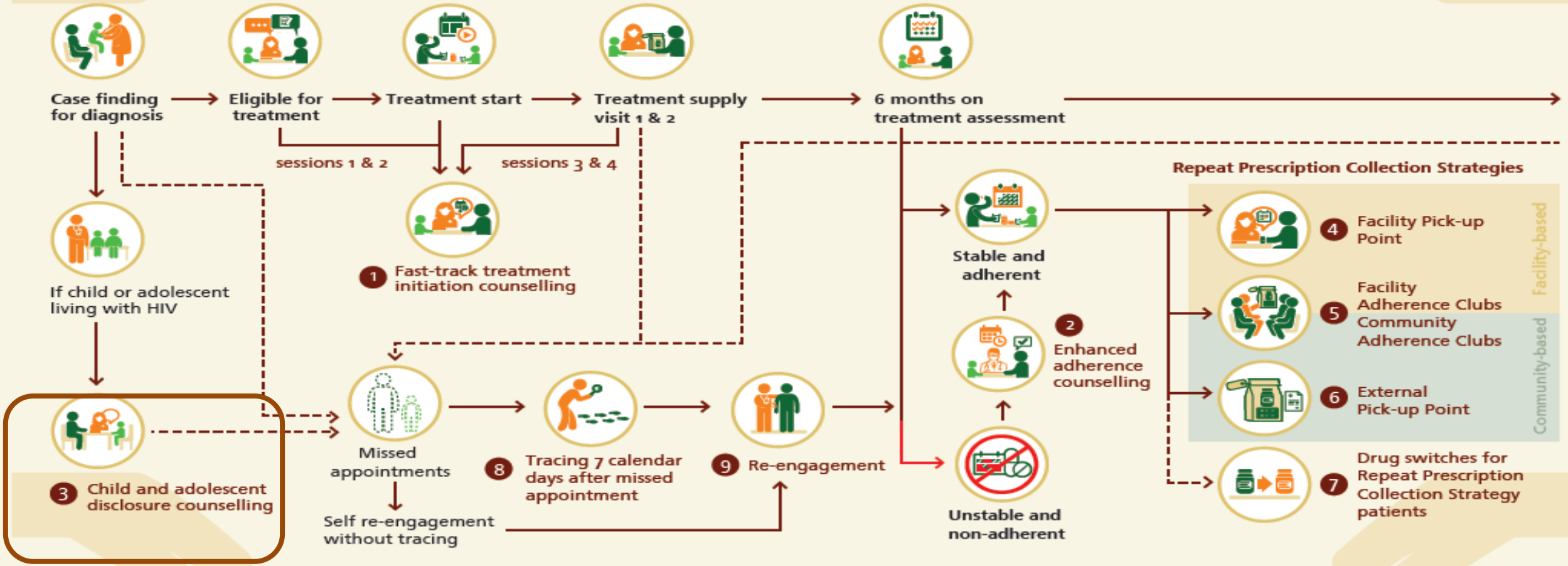

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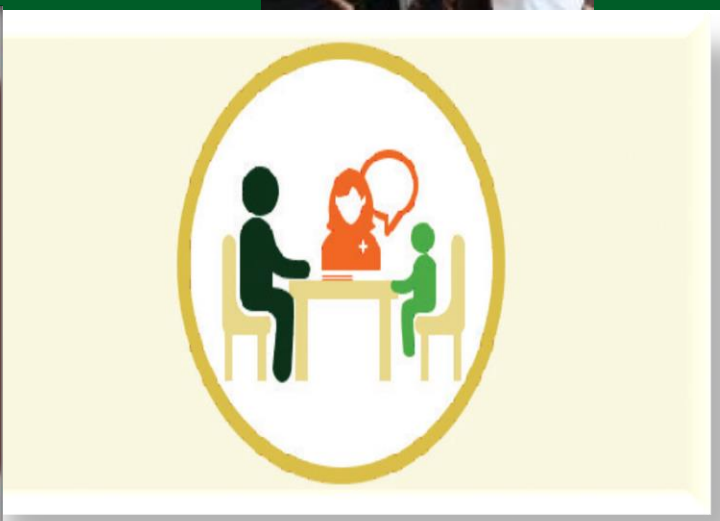
SOP 3:Child and Adolescent Disclosure Counselling (CADC 3)…

What is Child and Adolescent Disclosure Counselling (CADC 3) Model?

- Child and Adolescent Disclosure Counselling (CADC 3) model is one of the minimum package intervention models providing education and counselling mainly for children and adolescents living with HIV and their caregivers.
- The health care worker or non-clinician prepares and supports the caregiver to disclose to the child or adolescent.
- Providing step-by-step, incremental, and standardized approaches to HIV disclosure counselling in children and adolescents



What patients qualify for child and adolescent disclosure counselling (CADC) model?

- Caregivers and all children from 3 years old should start being prepared for partial disclosure.
- Disclosure criteria are as follows:
  - Non- Disclosure (3 – 5 yrs)
  - Partial Disclosure (6 – 9 yrs)
  - Full disclosure (10 – 12 yrs)

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SOP 3:Child and Adolescent Disclosure Counselling (CADC 3)…

What tools are needed to implement CADC model?

- ❑ Minimum package SOPs for Child and adolescent disclosure counselling.
- ❑ Disclosure talk tool.
- ❑ Disclosure plan.
- ❑ Disclosure IEC material.

How is CADC 3 model implemented?

- ❑ It is important to ensure that the caregiver is the primary caregiver who lives with the child or adolescent.
- ❑ There are two sessions:
  - **Session 1**: Partial disclosure.
  - **Session 2**: Full disclosure.
- ❑ For each session, the caregiver is prepared separately to support the child during the disclosure session.

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Repeat Collection Strategies (RPCs): SOP 4 (FAC-PUP), SOP 5 (AC), SOP 6 (EX-PUP)

Learning Objectives

At the end of the session participants should be able to explain:

- ❑ What are Repeat Prescription Collection Strategies (RPCs)?
- ❑ What clients qualify for Repeat Prescription Collection Strategies?
- ❑ What RPCs clients qualify for drug-switch?

Group Reflection- Rewards

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Repeat Prescription Collection Strategies (RPCs)

Facility Pick-up Point: FAC-PUP (SOP 4)

Adherence clubs: AC (SOP 5)

External Pick-up Point: EX-PUP (SOP 6)

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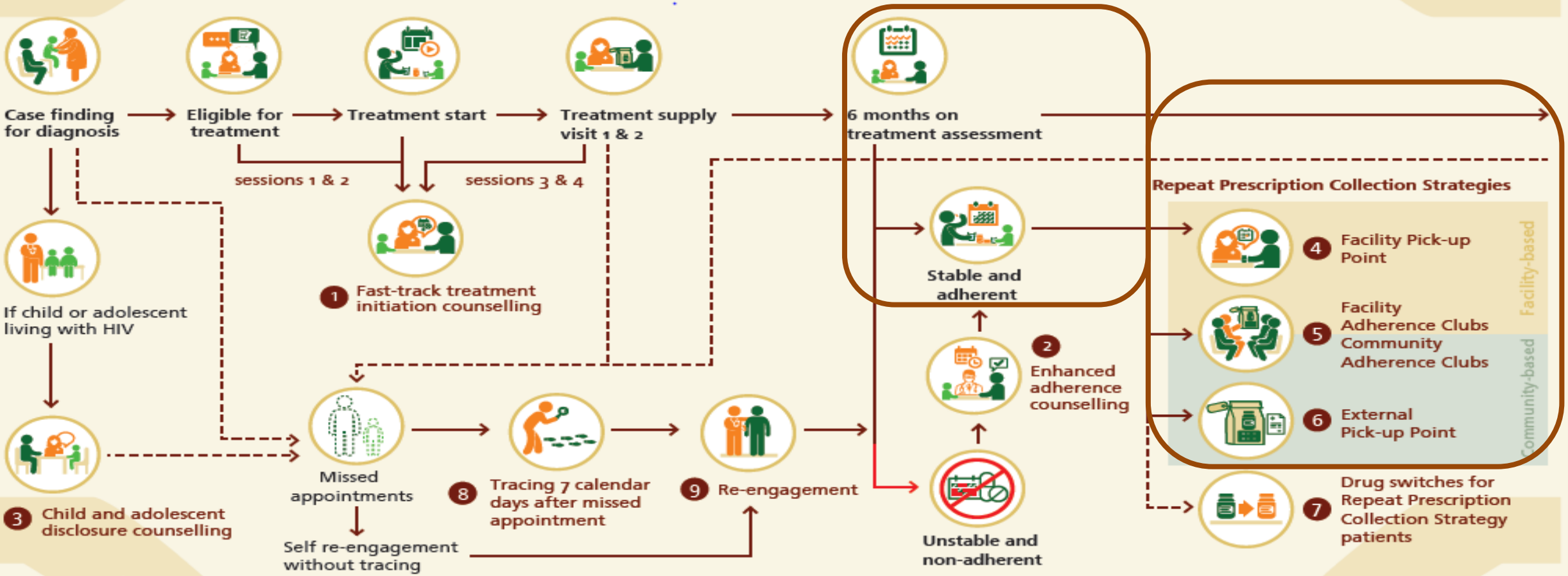

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Repeat Collection Strategies (RPCs): SOP 4 (FAC-PUP), SOP 5 (AC), SOP 6 (EX-PUP)

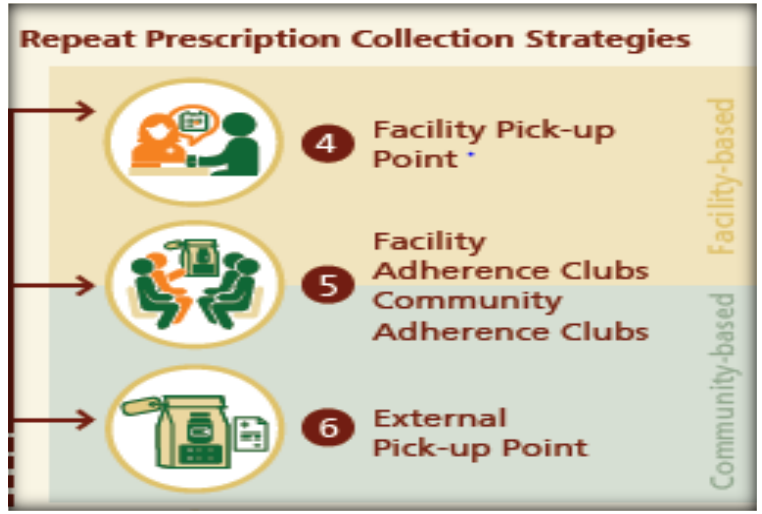
What is New

- ❑ Decanting of stable patients at 6 months (New criteria)
- ❑ Eligibility criteria for all RPCs revised

- ❑ CCMDD now recognised as supply system for ALL Repeat Prescription Collection strategy (RPCs).
- ❑ FAC - PuP and Adherence Clubs can also be pre-packed by facility/central dispensing unit (CDU).

- ❑ SOP 6 now called External Pick-up Point (EX-PUP)

- ❑ RPCs benefit from multi-month supply with annual visit schedule includes 2 and 3-month treatment supply annual schedules
- ❑ Same criteria for return to regular care across all RPCs



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A comprehensive Algorithm and Annual Visit Schedule for all RPCs is included

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Repeat Collection Strategies (RPCs): SOP 4 (FAC-PUP), SOP 5 (AC), SOP 6 (EX-PUP): Eligibility Criteria

What patients qualify for Repeat Prescription Collection Strategies?

✓ No current TB/Medical condition requiring regular clinical consultations
✓ Clinician confirms eligibility
✓ Patient voluntarily opts for RPCs option

For Adults

- ❑ Above 18 years
- ❑ On treatment for at least 6 months
- ❑ Most recent assessment results normal:
  - Most recent viral load (VL) taken in past 6months < 50 copies/ml for HIV
  - Most recent HbA1c taken in past 6 months ≤ 7% for Diabetes
  - 2 consecutive BP < 140/90 for Hypertension

For Children and Adolescents

- ❑ 5-18 years
- ❑ On ART for at least 6 months with no regimen or dosage change in the last 3 months
- ❑ Most recent VL taken in past 6 months < 50 copies/ml
- ❑ Care givers counselled on disclosure process
- ❑ Patient (>12 years/caregiver if patient<12 years) voluntarily opts for the RPCs option

Repeat Collection Strategies (RPCs): SOP 4 (FAC-PUP)

What is Facility Pick-up Point (FAC-PUP)?

- ❑ A FAC-PuP can take various forms in a facility, but all forms do 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.
- ❑ There is only one FAC –PuP in each facility, there should not be multiple FAC –PuPs at a facility driven by treatment dispensing systems
- ❑ The treatment for the FAC-PuP can be pre-dispensed by the facility pharmacy or by a Central Dispensing Unit (CDU) or Centralised Chronic Medicines Dispensing and Distribution (CCMDD).

What is your role as a non-clinician to support FAC-PUP model?

- ❑ If patient complies with criteria for RPCs option, and chooses Facility Pick-up Point option,
  - the non-clinician will inform the patient about FAC-PUP option.
  - Inform the patient about tracing and retention in care system.
  - Document all processes appropriately.

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Repeat Collection Strategies (RPCs): SOP 5 (AC)

What is Adherence Club (AC) model?

- ❑ Adherence clubs can be provided for any group of people, including from the same geographical area or a specific population of patients
- ❑ They can take place in or outside of a facility.

- ❑ Adherence clubs provide a RPCs for stable patients who value continued psychosocial support and group engagement.

- ❑ Adherence clubs can serve as external pick up point for individual medicine pick up and (not for groups)
- ❑ The treatment for an adherence club can be pre-dispensed by the facility pharmacy or by a Central Dispensing Unit (CDU) or by the Centralised Chronic Medicines Dispensing and Distribution (CCMDD).

How is AC 5 model implemented?

- ❑ Health facilities can establish facility-based or community-based adherence clubs.
- ❑ Facility manager will nominate a club manager and facilitator.
- ❑ A club facilitator can be a non-clinician such as a HB-Carer, CHW, peer educator or equivalent.
- ❑ Patients are allowed to bring nominee only on medicine collection adherence club visit days.

Repeat Collection Strategies (RPCs): SOP 6 (EX-PUP)

What is an External Pick-up Point (EX-PUP) model?

- EX-PuP can take various forms, but all involve the patient collecting their treatment supply individually from pick-up point outside of the facility or from an automated system.

- Examples of EX-PuPs:
  - Treatment supply pick-up from a private pharmacy
  - Treatment supply pick-up from a designated community venue (which can also be AC)
  - Treatment supply pick-up from a post box/ATM or similar automated system located inside or outside of a facility

- EX-PuP treatment is pre-dispensed to the EX-PuP service provider by the Centralised Chronic Medicines Dispensing and Distribution (CCMDD)

How is EX-PUP implemented?

- Clients are enrolled in the (CCMDD), which is the distribution center for all patient medicine parcels (PMP), which is then pre-dispensed to the EX-PUP service provider.
- The EX-PUP service provider can be a pharmacy or a designated community venue.
- Clients can collect their treatment on a 1 to 2 monthly basis.
- All patients enrolled on CCMDD receiving their medicine parcel through EX-PUP must be entered into the TIER. Net system.
- The EX-PUP service provider will inform the patient when their medicine parcel has been delivered to the pick-up point for the collection.

Criteria For Return To Regular Care for RPCs

What is the Criteria for Return to Regular Care for clients who are on RPCs

- ❑ FAC – PuP, AC or EX-PuP clients did not return to their RPCs collection point within 7 calendar days of their missed scheduled collection date
- ❑ RPCs patient screens positive for TB
- ❑ Other safety lab test results are abnormal:
  - For HIV: VL > 1000 copies/ml (where VL is 50 -1000 copies/ml: the patient can remain in the RPCs but must see a clinician 3 months after the date of elevated VL for further VL assessment
  - For diabetes: HbA1c >7%
  - For Hypertension: BP > 140/90
- ❑ Other indications assessed on individual clinical consultation
- ❑ RPCs patient becomes pregnant and should be referred to integrated Maternal, Neonatal, Child and Women Health services (MNCWH)
- ❑ 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 RPCs after a single normal result and meeting other RPCs criteria in the future (see Re-engagement SOP 9)

Repeat Collection Strategies (RPCs): SOP 4 (FAC-PUP)
Role Play

Role Play

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NEW SOP 7: RPCs Drug Switching SOP

Learning Objectives

At the end of the session participants should be able to explain

- ❑ What is Drug Switches for Repeat Collection Strategies Patients ?
- ❑ What clients qualify for Drug Switch?
- ❑ How is Drug Switches for Repeat Collection Strategies Patients implemented?
- ❑ What is your role as non-clinician to support Drug Switches for Repeat Collection Strategies Patients

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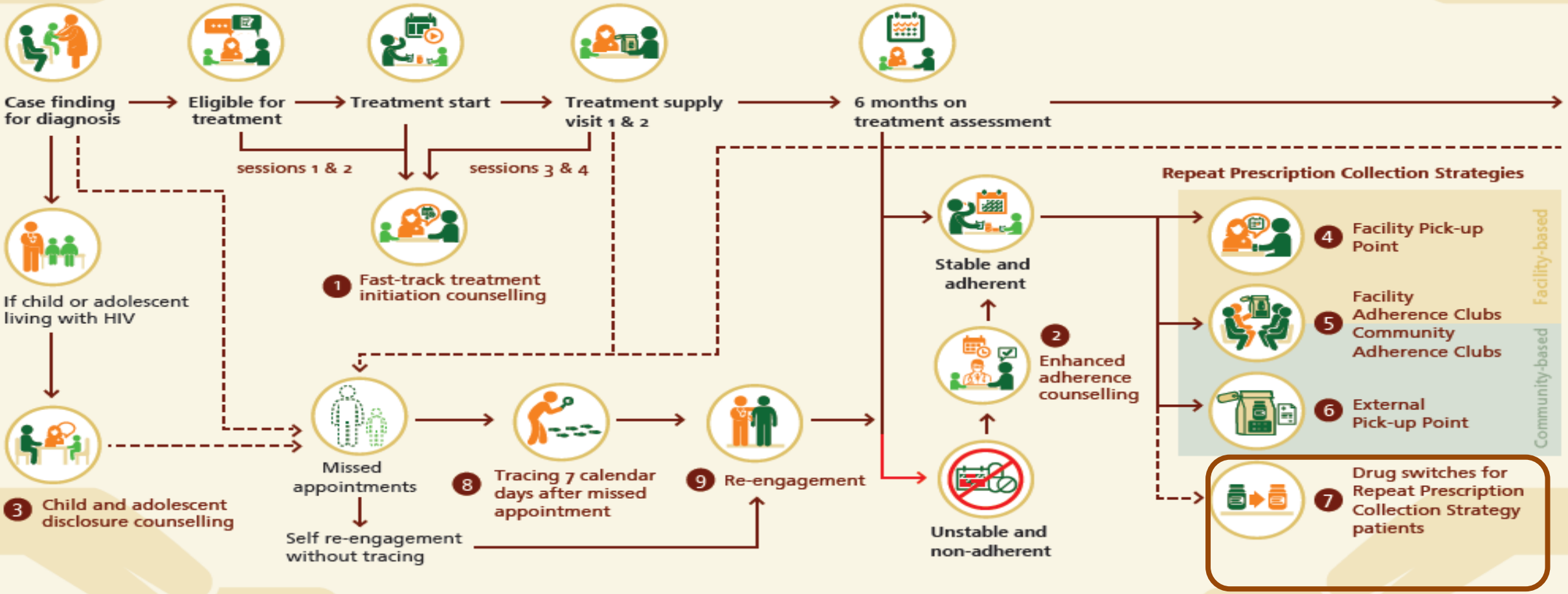
NEW SOP 7: RPCs Drug Switching SOP

- NEW SOP – supporting access for stable clients in RPCs to new regimens while remaining in their RPCs
- SOP refrains from referring to specific regimen so that it can be used for future regimens beyond DTG.
- **Overview of the Drug Switching procedure**
  Review the patient's recent viral load result (not older than 6 months)
  - Assess the stability of the patient:
    - Either VL<50 copies/ml
    - OR second VL assessment between 50-1000 copies/ml
  - Remember the A - E Assessment

INTEGRATED CARE OF PATIENTS WITH CHRONIC CONDITIONS



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SOP 8: Tracing and Recall

Learning Objectives

At the end of the session participants should be able to explain

- ❑ What is Tracing and Recall?
- ❑ What clients qualify for Tracing and Recall?
- ❑ What tools are needed to implement Tracing and Recall ?
- ❑ How is Tracing and Recall model implemented?
- ❑ What are the activities which from part of Tracing and Recall ?
- ❑ What is your role as a non-clinician to support Tracing and Recall ?

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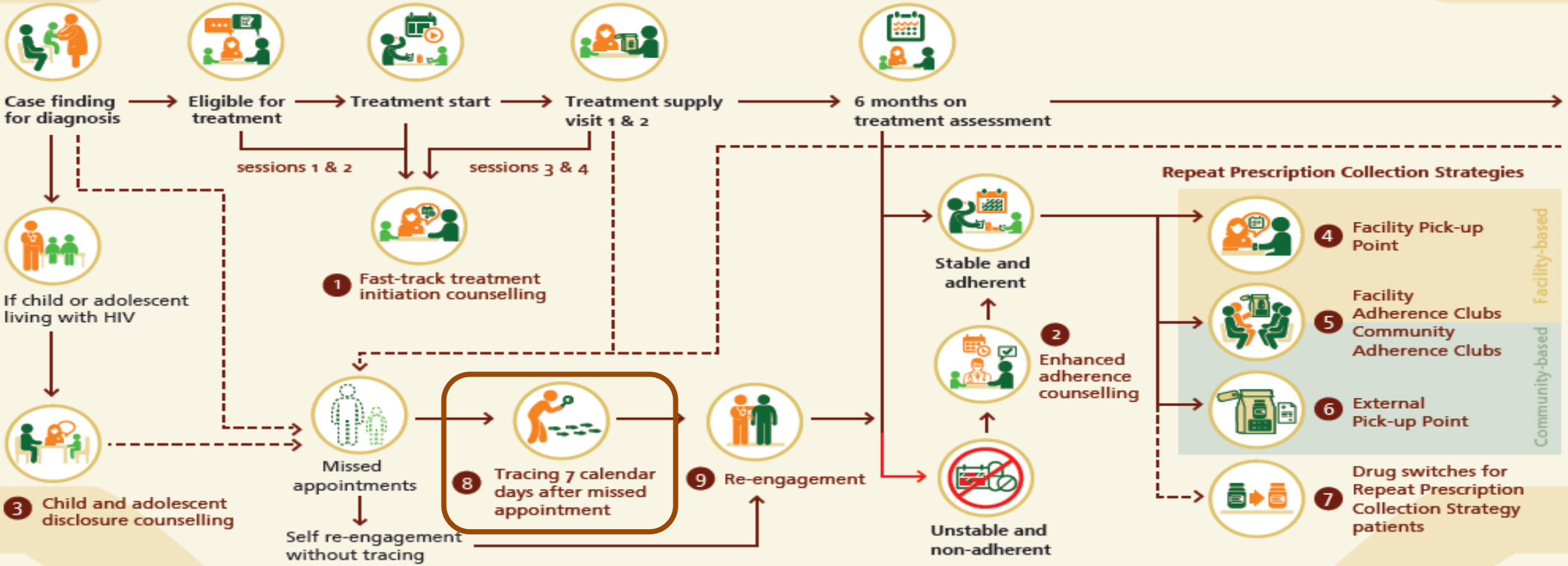

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SOP 8: Tracing and Recall…

Group Reflection - The current practice regarding tracing and retention of clients in care.

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SOP 8: Tracing and Recall…Group Activity

Group Activity – What clients qualify for Tracing and Recall?

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SOP 8: Tracing and Recall…

What patients qualify for Tracing and Recall?

Facility	Repeat Collection Strategies (FAC-PUP, AC, EX-PUP)
• Patients who have failed to return to the facility within 7 calendar days of their scheduled appointment. – Patients who did not return for their treatment initiation appointment. – HIV, TB, Diabetic or Hypertensive patients who have missed their scheduled appointment by 7 calendar days	• Patients in an 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 SOPs 4-6).
• Patients wit abnormal results, who, after initial attempt, have not returned to the facility within 7 calender days.	• Patients with abnormal results, who, after initial attempt, have not returned to the facility within 7 calendar days.

Refrains from using the term **defaulter** instead – patient who **missed an appointment**

How is Tracing and Recall model implemented?

- ❑ Patients are traced throughout the care cascade at different times depending on the adherence minimum package intervention model.
- ❑ Patients are traced through contact by
  - phones, SMS,
  - home visits
  - depending on what tracing method they have consented for.
- ❑ Recall attempts should first be telephonic and only
- ❑ If this fails, then via a home visit.

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SOP 8: Tracing and Recall Prioritization Order

Prioritization order for tracing and recall:

Tracing and recall are prioritized for the following patients in the order set out below:

- Patients initiated on treatment in the last 6 months with advanced HIV disease (AHD).
- Patients with abnormal results (HIV: viral load >50 copies/ml, for diabetes: HbA1c >7%, for hypertension: BP > 140/90, TB: positive GXP, Smear, Culture, Line Probe Assay (LPA), Mantoux)
- Patients not initiated on treatment.
- Patients overdue for their condition-specific assessment and/or investigation (test).

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SOP 8: Tracing and Recall…

What is your role as a non-clinician to support the Tracing and Recall model?

- ❑ Inform the patient about tracing and retention in care system in all the minimum package intervention.
- ❑ Confirm the patient's contact details at every visit
- ❑ Enrol all patients into specific appointment registers.
- ❑ If referring patient,
  - Actively refer patients by contacting the referral site and
  - provide the name of patient/s who are supposed to be linked to care to ensure they are linked to the health facility or community.
  - Ensure the patient knows where the facility is and what date and time the appointment is.

How is Tracing and Recall model implemented?

- ❑ Document patient's appointment in facility or CBO appointment register.
- ❑ Identify patients to be traced.
- ❑ Trace patients by phone or SMS.
- ❑ Trace patients through outreach to communities and homes.
- ❑ Refer patients to facility or community after tracing for reintegration into care services.
- ❑ Document all processes appropriately.

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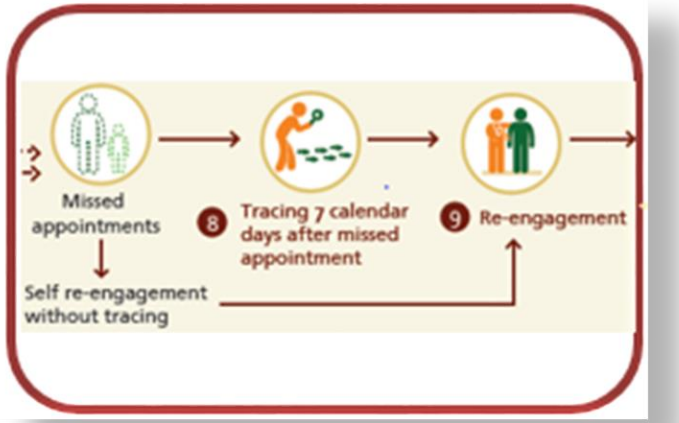
NEW SOP 9: Re-engagement

Learning Objectives

At the end of the session participants should be able to explain

- ❑ What is Re-engagement model?
- ❑ What patients qualify for the Re-engagement model
- ❑ How is Re-engagement model implemented?
- ❑ What is your role as a non-clinician to support the Re-engagement model.



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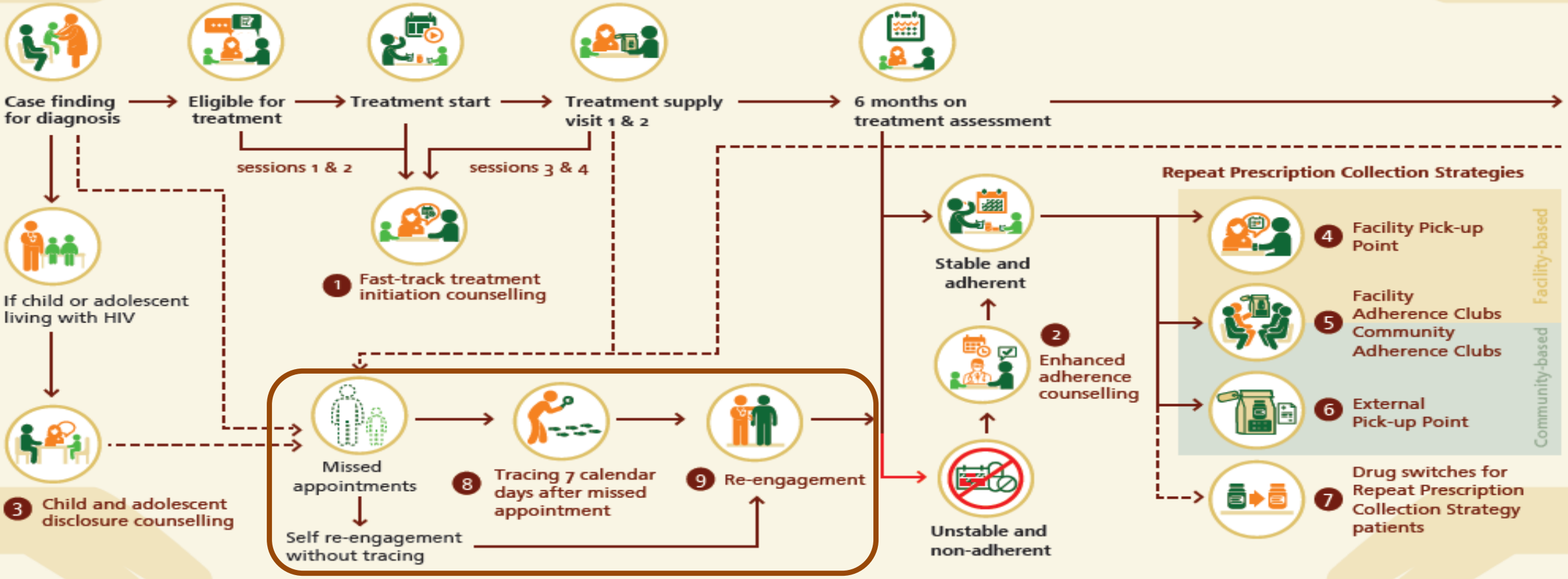

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NEW SOP 9: Re-engagement …

Group Reflection - Why is it important to welcome patients back to care even if they might have missed their appointment for a while.

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NEW SOP 9: Re-engagement …

What is the Re-engagement model?

- ❑ Re-engagement model ensures that the patients who re-engage in care after tracing or self re-engagement, receive appropriate support to improve retention in care.

The following is required from the facility staff:

- ❑ All staff in the facility should be welcoming.
- ❑ Facility staff also acknowledge it is normal to miss appointments or have treatment interruptions.
- ❑ Provide support and empower patients to improve retention after re-engagement.

What patients qualify for the Reengagement model?

- ❑ Patients who return to the facility on their own.
- ❑ Patients who return to the facility after tracing more than 7 calendar days after their missed appointment date.
- ❑ Patients in Repeat Prescription Collection strategies (RPCs), who returns to the facility
  - after tracing more than 7 calendar days after the last day the patient could collect their treatment supply from their RPCs.

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Group Activities on the Minimum Package of Interventions to support Linkage to Care, Adherence and Retention in Care

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SECTION 4:
Additional Adherence Interventions

Additional Adherence Interventions

Group Reflection – Ways in which facilities, communities or CBOs are to support people who are on treatment to adhere to their treatment.

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Additional Adherence Interventions..

Learning Objectives

- ❑ Describe different peer support and education Intervention models.
- ❑ Explain mHealth models.
- ❑ Community Adherence (ART) groups (CAGs)
- ❑ Adaptation of services to specific populations and contexts

Additional interventions to support adherence and Retention In Care

Peer support and education	– Integrated Access to Care and Treatment (I-ACT). – Support groups – Youth clubs – Buddy systems – Collaboration with traditional authorities.
mHealth	– SMS encouraging adherence and appointment reminders.
CAGs	– Community Adherence (ART) groups to be adapted for other chronic conditions.
Adaptation of services to specific populations and contexts	– Outreach services (WBCHOT and CHW). – After hours services and MSM, LGBTI and sex worker-friendly clinics.

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Peer Support and Education Intervention Models.

iACT

Integrated Access to Care and Treatment

- Aims to empower **PLHIV** and others who are otherwise affected **by HIV to confidently lead healthy lives.**
  - Closed and Open support groups
  - 6 sessions
    - education on illness and treatment
    - acceptance of status
    - healthy living principles and planning for the future.

Support Groups

- Brings individuals together
  - to provide group support,
  - to share life experiences
  - to support each other collectively
- Opportunities to form adherence clubs
- Support groups for children, adolescent, youth, adults and key populations (sex workers and MSM)

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Peer Support and Education Intervention Models…

Youth-focused strategies

- ❑ structured support group for HIV-infected adolescents.
- ❑ Held once a week, by a non clinician
- ❑ The 3 main themes are:
  - Coping and support (session 1),
  - HIV health (session 2); and
  - Positive prevention (session 3).
- ❑ Youth-specific topics
  - safe sex
  - unwanted youth pregnancy

Self-identified buddy or Buddy facilitated by the health facility

- ❑ Individual choice
- ❑ Support them in taking treatment and coming to the facility
- ❑ Reminds patients to remember the time to take their treatment
- ❑ buddy can collect medications at clinic or adherence club if patient stable (RPCs)

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Collaboration with Traditional Authorities

- Traditional healers and traditional leaders involvement
- empowered to identify and refer patients for HTS, TB and NCDs screening and testing.

- Health sector to explore measures to use them to support treatment adherence practices during consultations

**Provide Traditional healers and traditional leaders with appropriate training

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m-Health Models

- In addition to the use of mobile phones to trace patients interventions can also involve sending text messages before the person's appointment to remind them about their appointments or requesting them to report at facilities for follow ups.

- **MomConnect**

first national public mHealth service
links pregnant women and new mothers to health services.

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Community Adherence (ART) Groups (CAGs)

- **Self-formed groups** of patients who take turns attending clinical assessment and monitoring tests at the health facility, whilst **collecting drugs for themselves and the other members of the group.**
  - ART access for group members
  - Source of social support.

- Useful in **rural areas** where there are significant **distances to clinics**

Additional Adherence Interventions. Group Activity

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DAY FOUR

SECTION 5:
Monitoring, Evaluation and Reporting (MER) Interventions

Monitoring, Evaluation and Reporting

Learning Objectives

- ❑ Know basics of Monitoring Evaluation and reporting
- ❑ Understand importance of documenting all processes in Adherence guidelines interventions
- ❑ Understand role of non-clinician in supporting Adherence Guidelines monitoring and reporting

What is Monitoring, Evaluation and Reporting?

Monitoring

- ❑ Involves collecting, analysing, and reporting data on activities and processes in a way that supports effective management.

Evaluation

- ❑ Assessing the design, efficiency, effectiveness and impact of current or work already done to inform future planning
- ❑ The key question in evaluation is **'are we making a difference in what we are doing over a period of time?**

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Monitoring, Evaluation and Reporting…

Reporting and usage:

- ❑ Compilation of descriptive information, presenting data and information as useful knowledge
- ❑ **A data collection tool** refers to the instrument used to collect or record information
- ❑ **Examples of activities for data collection for adherence interventions include completing**:
  - facility attendance register;
  - adherence plan;
  - reports; and
  - providing feedback on tracing outcomes.

Role of MER Team

- ❑ Ensure that everyone in a facility or CBO records data collected correctly in appropriate registers
- ❑ Ensure that data collected is used by analysing it and providing feedback to teams in facilities or CBOs.
- ❑ Monitoring and reporting provides information on progress, problems, difficulties encountered, successes and lessons learnt during implementation.
- ❑ This information or data should always be used for quality improvement.

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Monitoring, Evaluation and Reporting…

What is your role as a non-clinician in supporting MER for Adherence Guidelines interventions?

- ❑ Understand your role in supporting adherence interventions models monitoring and reporting
- ❑ Record data collection during all adherence interventions as relevant.
  - Fast Track Initiation Counselling
  - Enhanced Adherence Counselling
  - Child and Adolescent Disclosure Counselling
  - Tracing and Retention in Care
  - Adherence Club
  - Peer support and education such as IACT and support groups

Non-Clinician's role continues

- ❑ Know important documentations for non-clinicians:
  - Adherence plan
  - Differentiated Model of Care register
  - Pre-packed medicine collection card
- ❑ Completing facility registers as relevant
- ❑ Reporting back on outcomes of tracing
- ❑ Providing summary reports to facility manager as relevant
- ❑ Understand importance of documenting all processes and completing records

'If it wasn't recorded then it wasn't done!"

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Monitoring, Evaluation and Reporting Group Activity

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SECTION 6:
Quality Planning for Implementation

Quality Planning for Implementation

Learning Objectives

- ❑ Know basics of quality cycle
- ❑ Understand why ensuring quality is important in adherence guidelines interventions
- ❑ Understand role of non-clinician in supporting quality implementation in adherence guidelines

The Cycle of Quality

The National Department of Health defines quality as **getting the best results possible within the available resources.**

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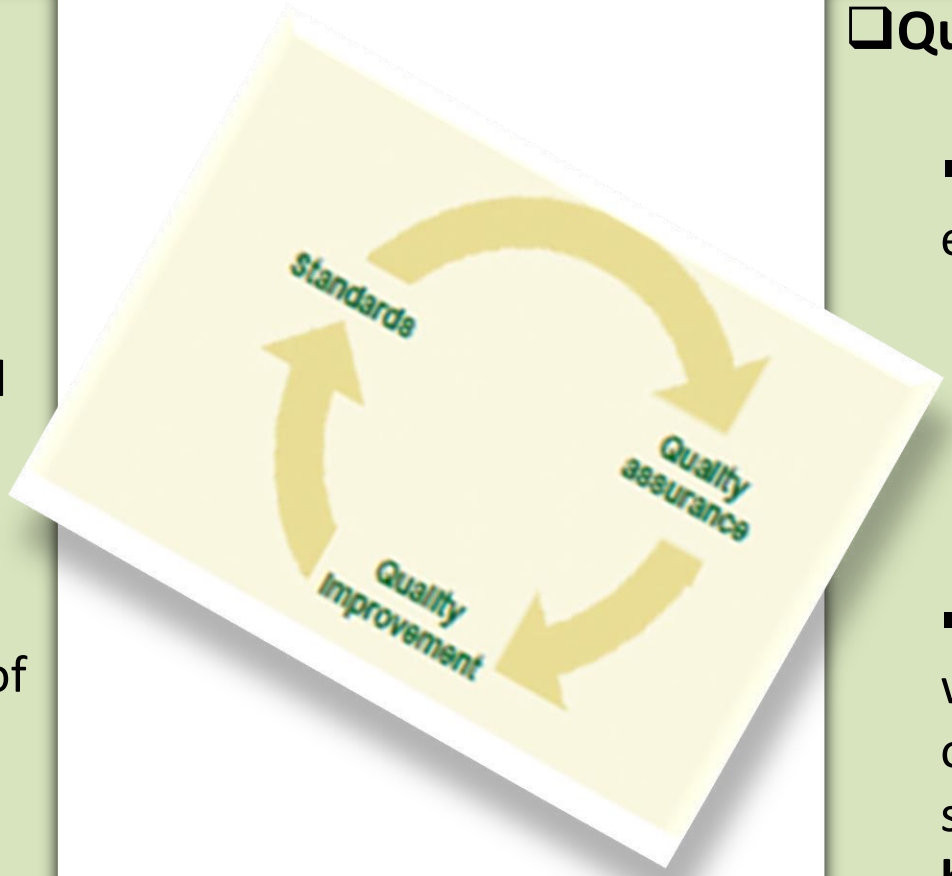
Quality Planning for Implementation: What is the Cycle of Quality Made of?

❑ Standards

- statement of an expected level of quality delivery
  - e.g. adherence guidelines interventions tools and standardised education and counselling sessions.

❑ Quality assurance

- maintenance of a desired level of quality especially by means of attention to every stage of the process delivery.



❑Quality Improvement

- combined and unceasing efforts of everyone
  - clinicians
  - non-clinicians
  - patients and their families

- Aims to make changes that will lead to **better** patient outcomes, **better** health care system performance and **better** professional development

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National Core Standards

National Core Standards

1. Patient Rights
2. Patient Safety, Clinical Governance & Care
3. Clinical Support Services
4. Public Health
5. Leadership & Corporate Governance
6. Operational Management
7. Facilities & Infrastructure

Six priorities identified for patient-centred care

- ❑ **Values and attitudes of our staff both clinicians, non-clinicians and managers**
- ❑ Cleanliness of our facilities
- ❑ **Waiting times- queues and delays**
- ❑ Patient (and staff) safety and security
- ❑ Infection prevention and control
- ❑ **Availability of medicines and supplies**

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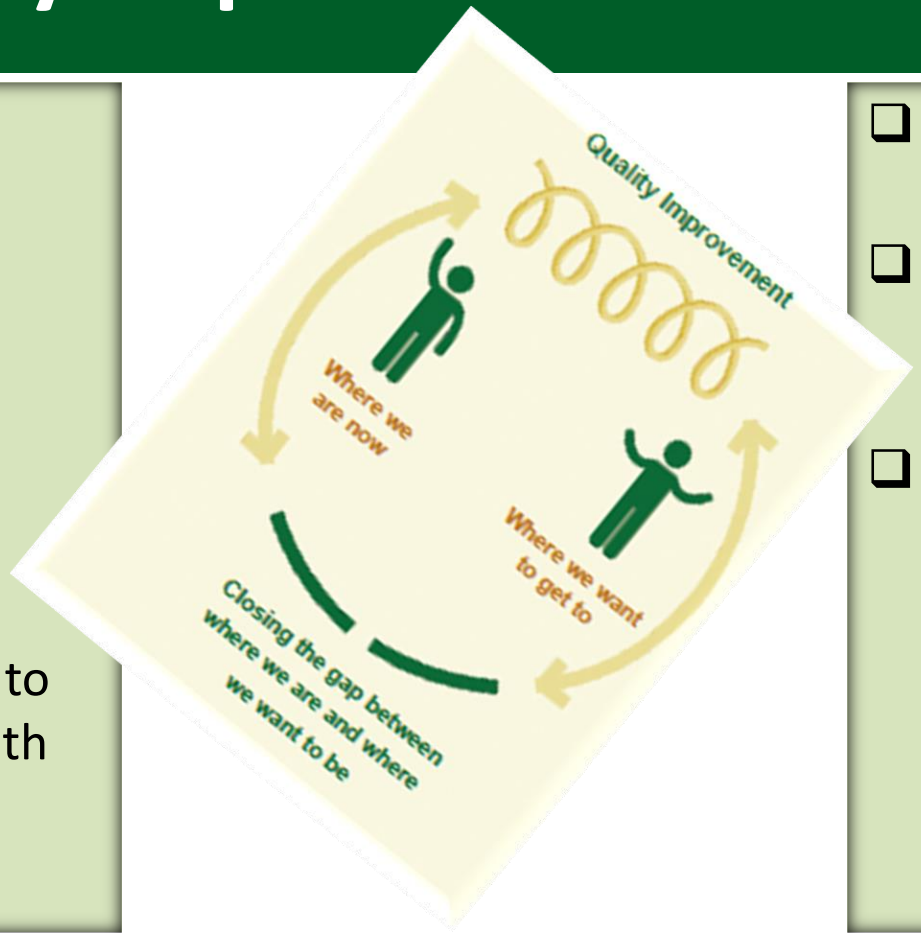
Quality Improvement

Quality Improvement

- Combined and unceasing efforts of everyone
  - clinicians
  - non-clinicians
  - patients and their families

- Aims to make changes that will lead to **better** patient outcomes, **better** health care system performance and **better** professional development



- needs to be an integrated part of our work.
- viewed as a journey in learning, rather than a method for quick fixes
- It is a way to **look** at our current system, **decide** if we are getting the results we want and **find** ways to improve the way things are done.

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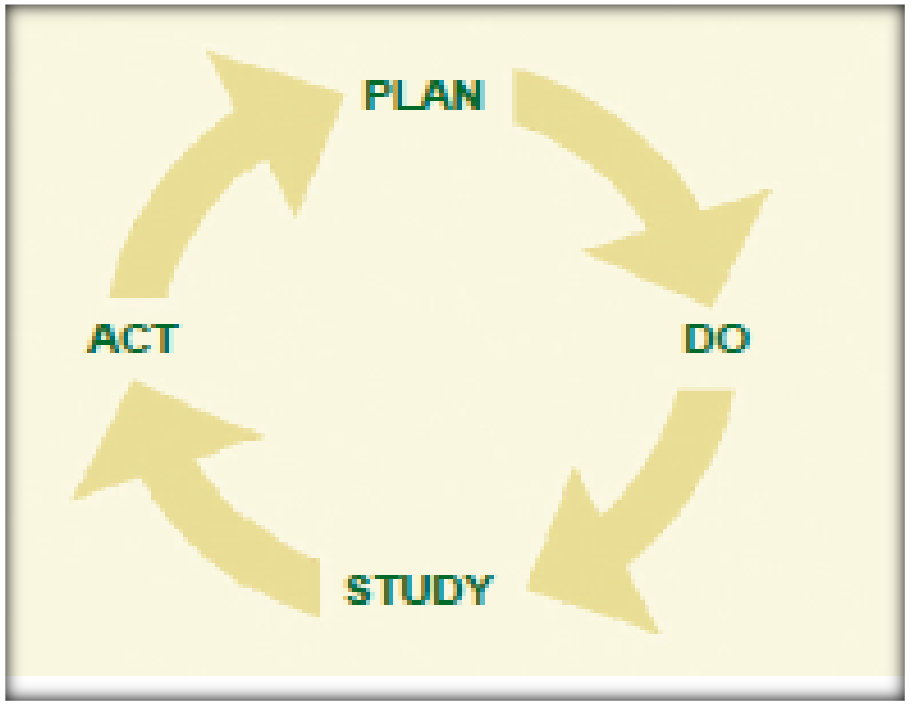
Quality Improvement …..

What are some of the questions that we can ask for quality improvement?

- What are we trying to accomplish?
- How will we know that a change led to improvement?
- What changes can we make that will result in improvement?

PDSA Model for Quality Improvement



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Quality Improvement …..

Why is quality improvement important in the Adherence guidelines implementation?

- ❑ Implementation by teams in a facility or community setting.
  - clinicians, non-clinicians and managers.
  - All members of the team play an **important** role
- ❑ Requires a lot of planning to identify **Who**, **What**, **Where**, **When** and **How** and then carrying out the plan and monitoring to ensure that what is being proposed actually works.

What is a non-clinician's role in ensuring quality?

- ❑ Know the National Core Standards everyday practice.
  - priority 1 for all staff who work with patients -Staff attitudes
- ❑ Use the Adherence Guidelines support tools standardised education, counselling and support.
- ❑ Understand why quality improvement is important as we plan for and establish adherence guidelines intervention models
- ❑ Understand that standardisation of adherence interventions should be done consistently
- ❑ Work closely with facility or community in identifying any challenges with adherence interventions, bring them forward for improvement

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Conclusion

- **Linkage to care, adherence and retention in care**
  - is key for better clinical outcomes hence the proposed innovative adherence guidelines interventions.

- **Linkage to care is everyone's responsibility:**
  - Patients
  - Clinicians
  - Non-clinicians
  - Communities
  - Traditional authorities
  - Implementing partners
  - Civil Society Organizations

- **Standardization of adherence interventions**
  - should be done consistently to ensure that
    - we deliver the right things,
    - in the right places
    - to the right people along the care cascade.

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