

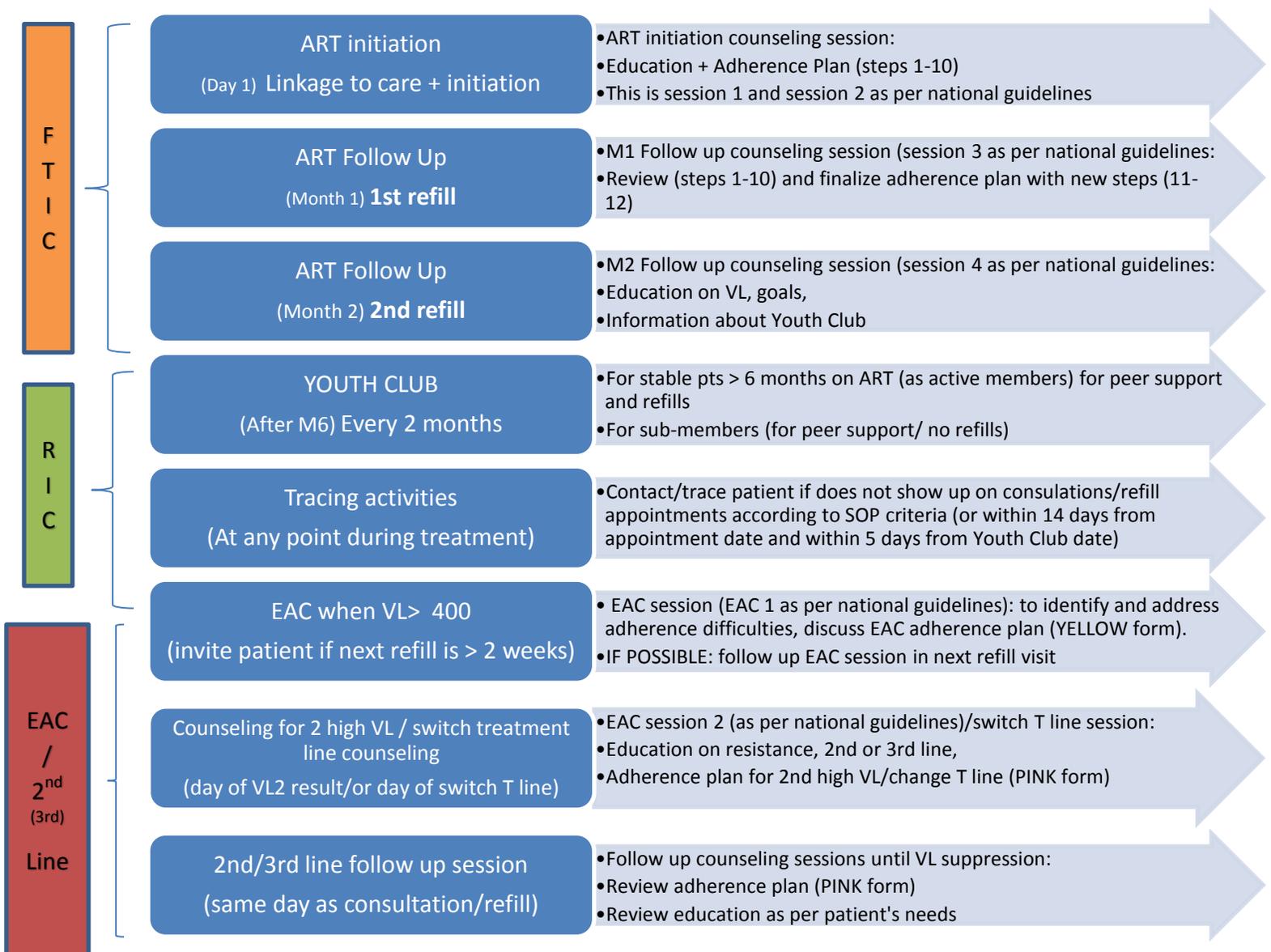
## Guidelines for Patient & Community Support activities to HIV infected adolescents/youth

### Introduction:

This document describes the “Patient & Community Support” (PCS) activities provided by the health care providers (more precisely by the counselors) to HIV infected adolescents, from the day they are linked to care and throughout their follow up at a Health Facility (or in the community, when this is applicable).

“Patient & Community Support (PCS)” for Youth refers to a package of services aiming at supporting HIV-infected adolescents to start ART and retain in care. Among others, PCS activities include: health and treatment education, counseling for ART initiation and counseling for ART follow up, specific interventions to enhance ART adherence (EAC), to facilitate Retention in Care (RIC) and to trace those who are missing their appointments/refills.

### Flowchart of PCS activities and counseling sessions:



## FTIC / ART counseling

When the adolescent is fully disclosed, conduct the sessions with the adolescent and his parent/caregiver if he is accompanied. If the adolescent has not yet been fully disclosed, conduct the session with the parent/caregiver and refer the patient for a disclosure session with parent's consent. (PLEASE SEE THE SECTION OF FULL DISCLOSURE TO CONDUCT THE DISCLOSURE SESSION WITH THE ADOLESCENT IF NOT YET DISCLOSED).

### 1. ART initiation counseling session:

**When:** Day 1 (day of linkage to care and day the patient is initiated on ART)

**What & How:** for details see SOP national guidelines, FTIC session 1 and session 2. For short version and key points of the session see below:

Discuss with the patient a personalized adherence plan as follows and fill out the steps 1-10 in the form (see annex 1).

- *Adherence step 1/ Education on HIV/ART:*  
Using the ART flipchart and the key messages in cards 1, 2 and 3, provide education and explain to patient about Immune system, HIV, Opportunistic Infections, ARVs and ART Adherence.
- *Adherence step 2/ Identify life goals:*  
Ask patient to think of his reasons to start the treatment
- *Adherence step 3/ Identify Support System:*  
Assist patient to identify a support system (buddy, person who can help to keep track on appointments/refills)
- *Adherence step 4/ Plan for future appointments:*  
Discuss with patient ways to ensure he will come to next appointments
- *Adherence step 5/ Assess readiness to start treatment:*  
Ask patient if he is ready to start ART. If yes, congratulate him and continue with the following steps in the adherence plan. If no, assess reasons why and without judging support the patient to clarify possible misconceptions or beliefs about ART and repeat life goals.

From this point onwards continue with patients who are ready to start the treatment today:

- *Adherence step 6/ Medication Schedule:*  
Discuss with patient convenient time(s) to take his ARVs.
- *Adherence step 7/ managing missed doses:*  
Ask and advice patient what to do in case he forgets to take a dose
- *Adherence step 8/ Adherence reminder strategies:*  
Discuss reminders that can help patient not to forget taking his medication
- *Adherence step 9/ Storing medication and extra medication doses:*  
Discuss with patient if disclosure of their HIV status to others members of household may be an issue; where they can store their medication in their house, and how they can always carry with them 1-2 doses of ARVs.
- *Adherence step 10/ Dealing with side-effects:*  
Discuss with patient how to deal with possible side-effects and ensure he understands that he should not stop the treatment but instead come to the clinic if he cannot tolerate a side effect.

## 2. ART Follow up counseling session at M1

**When:** 1 month after the day of treatment initiation / when the patient comes to the clinic for the 1<sup>st</sup> refill

**What & How:** for details see SOP national guidelines, FTIC session 3. For short version and key points of the session see below:

- Congratulate the patient for being already 1 month on treatment. Check his motivation and how he feels about it.
- Assess patient's adherence to treatment and whether or not he followed the steps in the adherence plan. Review adherence plan steps if/when necessary.

Examples of questions to assess patient's adherence:

*Can you explain me how have you been taking your pills?, Did you have any difficulties taking your pills? When was it more difficult for you to take your pills? How many pills did you forget/skip over the last week? etc.)*

- Continue with 2 more adherence steps to complete the adherence plan and fill out the adherence plan form:
- *Adherence Plan step 11/ Plan for travels:*  
Using the HIV/ART flipchart card 7, discuss with the patient how to ensure the continuation of his treatment in case he needs to travel (planned or unplanned trip).l
- *Adherence Plan step 12/ Dealing with substance abuse:*  
Discuss with the patient how to ensure taking his medication in case of alcohol/drug use. Explain that is better to avoid alcohol or other substance use so that he won't forget to take his treatment on time. If patient admits drug abuse, refer for specialized support. Encourage the patient to think of his reasons to stay healthy by adhering to his treatment.

## 3. ART Follow up counseling session at M2

**When:** 2 months after the initiation of treatment / when the patient comes to the clinic for the 2<sup>nd</sup> refill

**What & How:** for details see SOP national guidelines, FTIC session 4. For short version and key points of the session see below:

- Congratulate the patient for being already 2 months on treatment. Check how he feels about it. Observe and pay attention in possible signs of depression, sadness and inform a medical staff if you suspect a depressive mood of the patient.
- Assess patient's adherence and check application of adherence steps discussed in previous sessions. Review adherence plan steps if/when necessary.
- Using the HIV/ART flipchart and key messages in cards 4 and 5, provide education and explain to patient about Viral Load (VL) monitoring and VL results (detectable/undetectable) as well as risks of poor adherence.
- Inform the patient about his (1<sup>st</sup>, if not yet as baseline) VL test at M4 or M6 (depending on health facility) and motivate him to reach his goal: an undetectable VL < 50 copies (or at least VL < 400 copies).
- Using the HIV/ART flipchart card 8 explain to the patient the "treatment journey" and more precisely the option to participate in a Youth Club with other peers. Explain the criteria to be an active or social member of a Youth Club and motivate patient to reach his goals. Ask the patient if he wants to join a Youth Club (as social member at this stage) and invite him in the next available Youth Club session.

- Explain to patient that this is the last time you meet individually (unless his viral load results are worrying), but he is welcome to meet again if he has any questions or issues he would like to discuss individually. Encourage patient to always adhere to his treatment and join a Youth Club.

### Enhanced Adherence Counseling (EAC)

When the adolescent is fully disclosed, conduct the sessions with the adolescent and his parent/caregiver when patient is accompanied. If the adolescent has not yet been fully disclosed, conduct the session with the parent/caregiver and “urgently” refer the patient for a disclosure session with parent’s consent if possible.

#### *Criteria to provide EAC:*

Adolescents with VL > 400 at any point of their follow up. (But please remind patient the goal is to have a VL < 50).

#### *Planning EAC:*

- Request the list of patients with high VL every 2 weeks (even if the data can be retrieved later on).
- Call/invite the patient to come to the health facility if his next appointment is not within the following 2 weeks and communicate this information to all health care providers.
- Conduct the EAC session as follows:

#### EAC for high VL

**When:** day the patient comes to the clinic after invitation for EAC session.

#### **What & How:**

- Welcome the patient and explain the reasons why we invited him for this session (“to discuss about your last VL test results and ways to strengthen your treatment adherence; this way, your treatment will be effective against HIV”).
- Throughout the session pay attention on any possible signs of depression, sadness. Inform a medical staff if you suspect depression.
- Discuss the different steps in the “(EAC) adherence plan for clients with high VL” and encourage the patient to fill out the form (See annex 2):
  - Step 1: Evaluate patient’s understanding regarding ART goal and importance of adherence, VL and meaning of VL test results (“can you please explain what the goal of your treatment is? What is VL and what it measures?...”) Using the ART flipchart (card #4) provide/review education on these subjects and correct misunderstandings about adherence and VL -if any.
  - Step 2: Without criticising, explain that the most common reason of a high VL is a “poor” adherence (not taking medications every day/forgetting/skipping doses...) Ask if the patient knows the reasons of his high VL and check how he feels about it. Correct misconceptions about high VL –if any.  
If patient has difficulties to give his reasons for high VL, brainstorm on possible adherence barriers following the next steps in the adherence plan. At each step discuss possible strategies to improve adherence.
  - Step 3: Assess how the patient has been taking his medication that far and what were some possible problems with adherence. Ask what would be the most convenient time to take his pills from now onwards according to his daily schedule. Clarify misconceptions and explain flexibility about: time of medication, late/missed doses, pills intake on empty stomach, with traditional medicine, with alcohol/drug use.

- Step 4: Review storing medication and extra doses. Discuss with patient where he has been storing his medications, if the same place would be still convenient for him so as to remember taking his medication on time every day.  
Discuss with patient where/how he will keep an emergency supply with him so he won't miss a dose in case he is not at home to take his pills on time.
- Step 5: Review motivation to stay healthy and goals for the future. Assess if the patient believes ART can help him to reach his goals.
- Step 6: Review patients' support system. Who is aware of his HIV status and can support/encourage him to take his treatment, in difficult times etc.
- Step 7: Discuss strategies to overcome specific barriers (e.g. alcohol/drug use and forgetting taking pills, missing refill appointments and running out of pills, disclosure and have to hide to take medications, feeling tired of treatment etc.) and a plan to ensure medication intake from now onwards.
- Step 8: Review how the patient will be coming to future appointments and what will be his backup plan in case he can't come on his appointment dates.
- Step 9: Discuss the way forward: date of next VL test and goal to be reached/expected test results. Invite patient to have a follow up EAC session next time he visits the clinic for medication refills.
- Step 10: Referral to other health care providers/services according to the needs of patient. Invite patient to join a Youth Club as a sub-member for participation in group discussions with peers.

#### EAC Follow Up session (when possible)

**When:** if possible, conduct a follow up EAC session next time the patient visits the clinic for his medication refills and before he repeats the VL test.

#### What & How:

- Welcome the patient and congratulate him for coming to the clinic for his refills and the counseling follow up session.
- Step 1: Check if the patient has any questions regarding his treatment or his Viral Load test procedures. Assess adherence of patient since last visit and if he faced any challenges in implementing the EAC adherence plan.
- Step 2: Explain the way forward. Remind to patient the next date for his VL blood test (3 months after the last VL test) and what will happen depending on the VL results.

#### Counseling after 2<sup>nd</sup> high VL and/or switch treatment line

**When:** when VL test after EAC is still high (2 consecutive high VL test results indicating the need to switch treatment line) or after a genotype test or at any point the clinician decide to change a patient's regiment. On the day the patient comes to the clinic after invitation.

#### What & How:

- Welcome the patient and explain the reasons why we invited him in the clinic (e.g. "the VL test you repeated last time shows that your VL remains high/ you need to change treatment line").
- Throughout the session pay attention on any possible signs of depression, sadness. Inform a medical staff if you suspect depression.

- Discuss the different steps in the “adherence plan for clients with 2<sup>nd</sup> high VL/switch treatment line” and encourage the patient to fill out the form (See annex 3):
- Step 1: Review the education from previous EAC session (understanding of ART goal and VL).
- Step 2: Without being judgmental, assess patient’s reasons for 2 consecutive high VL test results.
- Step 3: Educate patient on resistance and 2<sup>nd</sup> (or 3<sup>rd</sup>) line treatment using the ART flipchart cards 5 and 6. Assess if patient needs more explanations about the disease and treatment in general; and review education on ART if needed.
- Step 4: Assess motivation to stay healthy and goals for the future. Evaluate if patient believes in reaching his goals by taking ART.  
Assess patient’s readiness to start a new treatment line
- Step 5: Explain to patient the new medication and discuss a new medication schedule based on patient’s needs and convenient timing.
- Step 6: Review with the patient how to manage possible missed doses. Advise to take the “forgotten” dose as soon as he remembers about it.
- Step 7: Discuss what reminder tools the patient can use to ensure medication intake on time.
- Step 8: Discuss with patient about his support system (who is aware of his HIV status and who can support him to take his medications?)
- Step 9: Review storage of medications and where to keep an emergency supply.
- Step 10: Explain possible side effects of new treatment and discuss how to deal with them
- Step 11: Discuss about what to do in case of short or long trips and how to ensure that he doesn’t run out of medications.
- Step 12: Discuss a plan to ensure that ARVs are taken in case of alcohol/drug abuse.
- Step 13: Review how the patient will be coming to the clinic for his appointments.
- Step 14: Explain to patient the next VL test after 3 months and way forward until suppression.
- Step 15: Proceed to referrals as per patient’s needs
- Invite the patient to join a Youth Club as sub-member, give appointment for next visit and conclude the session.

### Retention in Care: Youth Club and Tracing Activities

**Tracing activities** take place according to tracing criteria at any point of ART patient’s follow up. For details, please see below SOP for Tracing and RIC.

<b>TITLE</b>	<b>STANDARD OPERATING PROCEDURE FOR TRACING AND RETENTION IN CARE (TRIC)</b>		
<b>INSTITUTION</b>	<b>MSF-KZN “BENDING THE CURVE”</b>	<b>EFFECTIVE DATE</b>	<b>MAY 2016</b>
<b>PURPOSE</b>			
The purpose of this document is to outline the process of Tracing and Retention in care system recommended for all the MSF supported health care facilities, which is also based on the National Adherence Guideline.			
<b>PERSONS AFFECTED</b>			
<ul style="list-style-type: none"> <li>• Patients on ART</li> <li>• Counselors</li> <li>• Community Health Agents/ Community Care Giver</li> <li>• Data Capturer or assistant</li> <li>• Counseling Supervisor/ CHAP coordinator</li> </ul>			

## CRITERIA FOR TRACING AND RETENTION IN CARE

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

Patients on ART who have failed to return to facility for scheduled appointments at the facility are identified through facility data base or appointment register as follows:

- Definition of terminology (regardless of models of care):
  - Early missed appointment refer to patients who did not come back to the facility within 10 working days from their missed appointment date
  - Late missed appointment refer to patient who did not come back to the facility within 30 days from their missed appointment date
  - Loss to follow-up refer to patients who did not come back to the facility within 90 days from their missed appointment date

## GUIDING PRINCIPLES

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

## INTRODUCING PATIENT TO TRACING AND RETENTION IN CARE SYSTEM

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

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

## PROCEDURE

### 1.IDENTIFICATION OF PATIENTS TO BE TRACED/ GENERATING LIST OF MISSED APPOINTMENTS

- a) A data capturer will create a list of patients who have missed their appointments by extracting from Tier.net on every Monday. (Early missed appointments). The list should contain patients who missed appointment regardless of models of care patients attend. (Patients in this list didn't show up in the facilities or community clubs within 10 working days from their appointment date).
- b) The counselor will cross check the files to be sure and finalize the list.
- c) The list will be handed over to counselor on Tuesday.

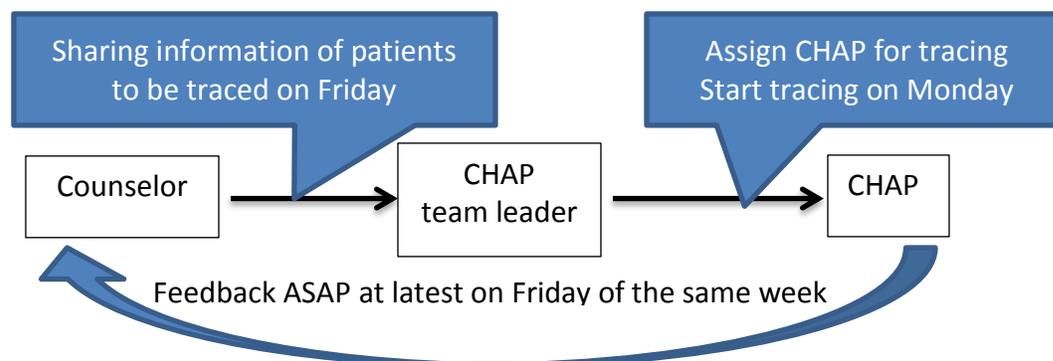
d) Counselor supervisor to ensure that list are printed and received by counselors weekly

## 2. INITIATING TRACING

- As soon as a counsellor receives a list of missed appointment, the counsellor starts tracing patients on phone.
- The facility telephone/ designated mobile phone is used to contact patients
- The counsellor should make at least 2 calls within the week (the 2<sup>nd</sup> call should be done when the 1<sup>st</sup> call was not successful).
- For each tracing effort, the facility tracing register should be marked, indicating the date the tracing was done and the tracing outcome, whether successful or unsuccessful.
- The names of patients whose telephone numbers cannot be reached after 2 attempts within the same week should be transferred to the list of those to be traced through outreach and home visit. Patient consent for home visits should be verified in patient's file.
- CHA referral form should be filled and forms from all the facilities are centralized in the counselling supervisor on Friday. The forms are handed over to CHAP coordinator.

## 3. TRACING OF PATIENTS THROUGH OUTREACH TO COMMUNITIES AND HOMES

- After 2 unsuccessful attempts to contact patients by phone, CHAs or CCG linked to facilities are involved to trace patients.
- Patients who have telephone numbers, but the numbers could not be reached should also be included in the list of patients to be traced by CHAs and CCG.
- If a home visit is conducted, details from the home visits, including outcomes of the visit should be reported back to the counselor as soon as possible.
  - For each outreach tracing effort, the facility tracing form 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. And the form will be collected by the counseling supervisor and CHAP coordinator to evaluate the tracing system and analyze the outcome.
  - The tracing system will be evaluated and fine-tuned by having a regular meeting between counselor's supervisor, CHAP coordinator, and M&E team.



## 4. TRACING FOR PATIENTS NOT SEEN FOR THREE MONTHS AND WITH NO STATUS UPDATE ON TREATMENT REGISTER

- Registered treatment patients who have not reported to the treatment service point or treatment delivery service point for 90 days since their last visit and not known whether the patient has died, was transferred out or stopped treatment for documented medical or social reasons after 90 days of intensive contact tracing should be registered as: Loss to follow-up. **(Ref SOP for capturing data on Tier.net)**
- Before this entry is made, one more attempt at phoning and or visiting patient should be made by counsellors and outreach services

## 5. RE-INTEGRATING PATIENTS INTO CARE

- For each successful contact tracing attempt, where the patient agrees to continue treatment, the counsellor, CHA, or CCG will inform the patient to report back to the facility. On return to the facility, the patient will be referred

immediately to the counsellor for additional support, exploring solutions to patient adherence barriers and actively referred to appropriate support services, as required.

- b) When a defaulted patient comes back to the facility, the counselor will record it in the list of missed appointment ("Returned", "R").

**Youth Clubs** are part of the PCS services to help the RIC of ART patients. For this, Youth Clubs are proposed to all patients on ART according to the Youth Club criteria, either as active or social members. For details, please see below SOP for Youth Club and RIC.

TITLE	STANDARD OPERATING PROCEDURE FOR YOUTH CLUB
<b>PURPOSE</b>	
The purpose of the SOP is to outline the process for Health Care Workers to conduct youth club where they provide comprehensive services to adolescents on ART	
<b>PERSONS AFFECTED</b>	
<ul style="list-style-type: none"> <li>• Patients; Adolescents on ART who are 13- 18 years old</li> <li>• Nurses</li> <li>• Doctors</li> <li>• Counselors</li> <li>• Data capturer</li> <li>• Pharmacist</li> <li>• Others (social workers, community health agent, community care giver) when necessary</li> </ul>	
<b>DEFINITION OF YOUTH CLUB</b>	
<p>A youth club consists of adolescents on ART for longer than 6 months (maximum 30 members per group) after they have attended all 4 treatment initiation counseling sessions. Club members meet 2 monthly.</p> <p>Adolescents between 13-18 years with VL &lt;1000 who are adherent to ART are eligible for enrolment. However adolescents with VL&gt;1000 who need peer support are also encouraged to participate in the club group discussions as sub-members (social members). The group is open and new adolescents can always join. During the club sessions, adolescents are provided with health education related to HIV, ART, and SRH, bi-yearly clinical assessment/consultation and pre-packed medications.</p>	
<b>OBJECTIVE OF YOUTH CLUB</b>	
<ul style="list-style-type: none"> <li>• To provide quality of comprehensive services to adolescents (HIV pediatric care and SRH)</li> <li>• To improve and maintain adherence through individual counseling according to adolescents' needs / ongoing group health education</li> <li>• To improve retention in care of adolescents on ART</li> <li>• To discuss with/ educate adolescents on issues related to sexual behaviors to minimize the chance of unwanted pregnancies, STI and HIV transmission to others</li> <li>• To ensure an adolescent understands that s/he is not the only one affected (peer support)</li> <li>• To provide a therapeutic environment in which adolescents who are infected by HIV/AIDS can develop social skills for the appropriate expression of feelings, problem-solving and decision-making skills and increase self-esteem.</li> <li>• To identify adolescents with social problems and refer them to social welfare service department</li> </ul>	
<b>CRITERIA FOR YOUTH CLUB</b>	
<ul style="list-style-type: none"> <li>• Adolescents (13-18 years old) on ART for longer than 6 months who have VL &lt;1000</li> <li>• Members who got high VL (&gt;1000 copies/ ml) will be immediately referred back to the regular clinic visits for medication refills/consultations but will be offered the opportunity to remain in the Youth Club as social members and to continue participating in the group discussions/activities with their peers.</li> </ul>	

- Adolescents fully disclosed
- No current TB treatment/ other severe OI
- Adolescents who have been confirmed by clinicians for the membership
- Participation is voluntary
- Adolescents can send buddy twice per year but can't send buddy to 2 consecutive clubs

**SUB MEMBERSHIP (SOCIAL MEMBER)**

- Adolescents with VL>1000 / and those who are newly initiated on ART and who need peer support are encouraged to participate in the club as sub member (social member)
- The sub members receive monthly clinical management and refill at the clinic individually

**ROLES AND RESPONSIBILITIES FOR YOUTH CLUB**

Doctor's role	Nurse's role	Counsellor's role:
<ul style="list-style-type: none"> <li>• Provide clinical consultation to referred adolescents</li> <li>• Ensure that adolescents with symptoms or abnormal lab results are managed accordingly</li> <li>• Report clinical issues to paediatric focal point</li> </ul>	<ul style="list-style-type: none"> <li>• Review clinical chart</li> <li>• Responsible for reviewing the weight and ensure dosing according to last recorded weight</li> <li>• Prepack medications for the session together with a pharmacist</li> <li>• Make sure buffer box is available to adjust dosage</li> <li>• Refer patients to other relevant health department when necessary</li> <li>• Invite the patient to express side effects or other concerns and support with treatment, if appropriate</li> <li>• Withdraw blood according to clinical guideline</li> <li>• Document every finding on clinical chart on the day of clinical visit</li> <li>• Provide family planning commodities upon request</li> <li>• Screen STI symptoms</li> </ul>	<ul style="list-style-type: none"> <li>• Planning of health education sessions in groups</li> <li>• Prepare clinical charts in collaboration with clinicians</li> <li>• Set up the meeting room</li> <li>• Prepare essential materials (IEC materials, snack, juice, etc.)</li> <li>• Prepare cold chain when necessary</li> <li>• Education on HIV, treatment, adherence, side effects, risk of non-adherence (how this is different from health education mentioned above?)</li> <li>• Discuss and educate on issues of SRH (STI, FP, SGBV, etc.)</li> <li>• Weight and TB screening according to TB symptom checklist</li> <li>• Fill the register</li> <li>• Organise and conduct individual EAC when necessary after the end of the group discussions/education</li> <li>• Refer patients to other relevant department such as social welfare</li> <li>• Provide next appointment of club</li> <li>• Take blood sample to laboratory when necessary (Saturday)</li> <li>• Inform the clinic staff of schedule of club</li> <li>• Document sessions done and finding on clinical chart</li> </ul>
Pharmacist	Paediatric focal nurse	Counselling supervisor

- |   |   |  |
|---|---|--|
| <ul style="list-style-type: none"> <li>• Ensure that enough medications are stocked including minor ailment medications/ STI/ FP</li> <li>• Prepare buffer box based on list coming from focal point nurse</li> <li>• Support nurses for pre-packing when requested according to “pink card”</li> <li>• Assist and communicate with DoH in case of stock out of medications for youth club</li> </ul> | <ul style="list-style-type: none"> <li>• Coordinate all the nursing activities related to youth clubs</li> <li>• Be sure that lab technicians are informed of blood taken</li> <li>• Ensure that clinical information is recorded in the register (VL results, etc.)</li> </ul> | <ul style="list-style-type: none"> <li>• Identify any organizational problems and report to PCS manager/ MAM</li> <li>• Be sure that at least 1 DoH nurse will be involved in running the group</li> </ul> |
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• PROCEDURE

**BEFORE EVERY VISIT (1 week before or at latest 2 days before)**

- A nurse reviews clinical charts, changes dosage when necessary, and indicate ‘due for FP’
- A nurse refers patients to doctors when relevant or notify doctors through MSF counselors
- A nurse pre-packs medications according to prescription with assist of a pharmacist
- A counselor prepares all the tools needed:
  - Facility register
  - Youth club registers
  - Education flip chart/ other materials for health education (HIV/ART, SRH or other)
  - Weigh scale
  - Cool box (where/when necessary)

**DURING EACH VISIT**

- Each Youth Club gathering OR group discussion? should start with an introduction (5-10 minutes)
- A counsellor conducts health education session/ group discussion (20 minutes) according to the plan
- A counsellor does weight scaling and TB screening (cough, weight loss, night sweats, fatigue, loss of appetite) and fill the register (1-2 minutes per patient)
- A nurse conducts clinical assessments (STI and FP), provides medications for minor ailment/FP commodities and records in each clinical chart when relevant
- When a nurse is not present on the club day
  - A counsellor will tell members due for FP to be back to the clinic on Monday when the club is held on Saturday
  - A counselor will do STI symptom screening according to the checklist individually
- A clinician provides clinical consultation (**every 6 months**)
- A counsellor provides pre-packed ART. Note; Drugs for adolescents who did not attend will be handed back to clinic
- A nurse performs blood taking **when indicated (standard: 2 times per year)**

**AT THE END OF THE VISIT**

- Write the date of the next visit in the patient’s appointment card and in club register
- Encourage patient to adhere to treatment and return to facility as scheduled

- Provide individual EAC to adolescents with VL >400 copies/ ml
- Update facility register or records and submit it to data capturer

#### 1 WEEK AFTER THE GROUP

- Check the clinical charts of club members who did not show up in the group
- Fill the register referring to the clinical charts with writing “LATE” in order to highlight that the members showed up later (but within 1 week)
- Write “NP” on the column of those who did not show up within 5 days

#### TRACING AND RETENTION IN CARE for youth club active members

- Check on the adolescents who do not show up within 5 working days, call them to make sure that they will come back to the clinic
- Adolescents who did not come on the club day are seen at the regular clinic , but they are encouraged to attend the next club
- If adolescents send buddy/ guardians to 2 consecutive groups, they will be asked to bring their guardians or CCG/CHAP/counsellor will conduct home visits
- When an adolescent gets VL >400, the patient needs to receive EAC immediately by asking them to come to the clinic on phone. When a data capturer finds a youth club member getting a result of VL >400, s/he will inform to counsellors immediately. EAC individual sessions can be organised after the Youth Club group discussion when the adolescent continues attending the Youth Club group discussions as sub-member.

#### Youth Club group discussion session

**When:** at each Youth Club day, after the registrations/vital signs/ clinical assessments.

**What & How:**

Introduction:

- Welcome participants in the group discussion. Explain the objectives of the group (for example “to learn and exchange with peers about health and other topics interesting to our age group”).
- As the groups are open and new members may be joining for the first time, invite participants to introduce themselves at the beginning of the session (this can be in a fun/creative way or combined with an energizer).

Educational component (optional or alternatively with adherence component):

- From a list of topics related to health/diseases/treatment/prevention, ask participants to vote for their topic of preference for today’s group education.
- The group education can be provided in various ways:
  - Directly from the facilitator, using some visual aid when possible (e.g. ART flipchart, FP leaflets etc.)
  - Or by the participants as a group work. This can be done by dividing participants into smaller groups of 5-6 persons to discuss their health topic of preference and note down on a paper some key messages that will be then presented in plenary. Visual aids can be also given to participants and ask them to be utilised during their presentations in plenary.

- Or by making a quiz with Correct/False answers on various health topics and by encouraging participants to explain their answers to the rest of the group.

Adherence component (optional or alternatively with educational component):

- During the group discussion, whenever is possible, highlight the importance and benefits of adherence to ART.
- Encourage a participant to share his experience regarding medication intake, in specific about his motivation to stay in good health. That should be on a volunteer basis. Alternatively, prepare in advance a couple of short case studies (for example cases of adolescents with adherence problems because of peer pressure, discrimination, treatment fatigue...); divide participants in smaller groups and give them the case studies; give them 10-15 minutes to discuss and note down their views about the case; then, let them present in plenary the outcomes of their small group discussions.

Adolescents' topics of discussion other than health-related:

- Invite participants to note down on an individual paper and anonymously a topic they would like to discuss with their peers. Collect the papers and if possible group them by categories; then choose the topic of discussion of the day after participants' votes.
- Alternatively, facilitator proposes a list of topics and participants vote what they would like to discuss in today's session.
- Invite the participants to guide the discussion and share their views/knowledge/opinions about the topic of discussion. When a view is expressed by a participant, ask if others share the same or if they have a different view/ additional information to share on the topic. Correct misconceptions when necessary without criticising.
- When possible organise debates or group works or invite participants to have role plays as to demonstrate their experiences from daily life.

Closing the group session:

- Thank adolescents for their participation and wrap up today's session.
- Ask participants to share one word or one key message they will take home from today's session.
- Give appointment for next Youth Club and proceed for individual counseling session for those who need individual follow up (e.g. EAC).

## PATIENT ADHERENCE PLAN

Name and Surname:

<b>Session 1 after Chronic disease education session (date):</b>
<b>Adherence step 1:</b> education on HIV <input type="checkbox"/> TB <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Other <input type="checkbox"/> .....
<b>Adherence step 2: Life goals:</b> 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 stress
<b>Adherence Step 3 - Patient Support system</b> Agree for home visit: Yes <input type="checkbox"/> No <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:
<b>Adherence Step 4 - Getting to appointments</b> 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"/>
<b>Adherence step 5: My readiness to start treatment</b> I feel ready and will start treatment Yes <input type="checkbox"/> No <input type="checkbox"/> I do not feel ready and would like to discuss more with: <input type="checkbox"/> peer <input type="checkbox"/> family member <input type="checkbox"/> Community Health Worker <input type="checkbox"/> other <input type="checkbox"/>
<b>Session 2 (date):</b>
<b>Adherence Step 6 - Medication schedule</b> The best time for me to take my treatment is: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening
<b>Adherence step 7: Managing missed doses</b> If I miss a dose, my plan is : to take treatment as soon as I remember <input type="checkbox"/>
<b>Adherence Step 8 - Reminder strategies</b> 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:.....
<b>Adherence Step 9 - Storing medication and extra doses</b> I will store my medication in: <input type="checkbox"/> Safe place:..... <input type="checkbox"/> Far from reach of children I will carry extra supply and keep it in: <input type="checkbox"/> 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:.....
<b>Adherence Step 10 – Dealing with side-effects</b> 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"/>
<b>Session 3 (date):</b>
<b>Adherence Step 11 - Planning for trips</b> <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 go to the nearest health facility in the travel access 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
<b>Adherence Step 12 - Dealing with substance use</b> My plan to make sure I take my medication if I used alcohol or drugs is: <input type="checkbox"/> To make sure I take treatment before starting to use drug or alcohol <input type="checkbox"/> Arrange for someone to remind me to take treatment in case I am intoxicated
<b>Session 4 (date):</b>
<b>Education on follow up:</b> Viral load <input type="checkbox"/> Sputum <input type="checkbox"/> HbA1c <input type="checkbox"/> Other: ..... <input type="checkbox"/> Patient's signature..... Date.....

**TREATMENT GOALS:**

**ARV goal:** My first Viral Load will be suppressed! And thereafter remain below 400 copies/mL

**TB goal:** I have completed 6 months TB treatment and I am cured of TB

ANNEX 2

**(EAC) Adherence plan for client with High VL (for patient and carbonated paper for patient's file)**

<p><b>Session 1 (date):</b></p> <p>Step 1: Review EDUCATION on ART goal &amp; adherence <input type="checkbox"/> Viral Load ( test that measures the amount of HIV in the blood) <input type="checkbox"/> VL test results <input type="checkbox"/></p> <p>Viral load is: _____</p> <p>High viral load is: _____</p> <p>Suppressed viral load is: _____</p>
<p>Step 2: ASSESS CLIENT'S REASONS FOR HIGH VL: (ask if the patient knows what make their VL is high and correct misconceptions)</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p>
<p>Step 3: REVIEW TIME MEDS TAKEN</p> <p>Problem with time: _____</p> <p>Agreed upon time: _____</p> <p>Late/missed doses: _____</p> <p>EXPLAIN FLEXIBILITY on: time to take the treatment, late/missed doses, empty stomach, traditional medicine, alcohol consumption/drug use</p>
<p>Step 4: REVIEW STORING MEDS/EXTRA DOSES</p> <p>Convenient storage place: _____</p> <p>Emergency supply will be carried in: _____</p>
<p>Step 5: ASSESS MOTIVATION TO STAY HEALTHY: Top 3 goals for the future: future projects or important people to take care of, etc.</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>Do you think your ARVs can help you achieve your goals for the future?</p>
<p>Step 6: REVIEW CLIENT'S SUPPORT SYSTEM</p> <p>Members of Client's support system: _____</p>
<p>Step 7: CLIENT'S STRATEGIES TO OVERCOME ADHERENCE BARRIERS (e.g. alcohol/drug use and forgetting taking pills, missing refill appointments, disclosure and have to hide to take medications, feeling tired of treatment etc.)</p> <p>Your plan to make sure you take your ARVs: _____</p>
<p>Step 8: GETTING TO APPOINTMENTS</p> <p>How you will get to the clinic: _____</p> <p>Your back up plan to get to the clinic: _____</p>
<p>Step 9: WAY FORWARD</p> <p>Your VL will be repeated in _____ (which month) and your VL must be _____</p> <p>Next visit date: _____</p>
<p>Step 10: Referral</p> <p>Referred to: _____</p> <p>Referred for: _____</p>
<p><b>IF POSSIBLE, conduct a follow-up EAC session next time the patient comes to clinic for refills/ before he repeats VL test (date):</b></p>
<p><b>Step 1: ASSESS ADHERENCE</b></p> <p>How did it go to take your treatment since last time?</p> <p>Did you face any situation in which it was difficult to take your treatment?</p> <p>Which steps discussed last time worked well for you and which ones need to be revised?</p> <p>Counsellors Assessment: Adherences has improved <input type="checkbox"/> / Adherence has not improved <input type="checkbox"/></p>
<p><b>Step 2: EXPLAIN WAY FORWARD</b></p> <p>Next time (3 months after last VL) you will get your blood drawn to check if your VL has decreased. Remind to patient what will happen after the results come in.</p> <p>Next visit date: _____</p>

ANNEX 3

**Adherence plan for client with 2<sup>nd</sup> High VL / Switch Treatment Line** *(for patient and carbonated paper for patient's file)*

<p><b>Session 1 after 2 High VL (date):</b></p> <p>Step 1: REVIEW EDUCATION FROM 1<sup>ST</sup> EAC SESSION          Viral load is: _____          High viral load is: _____          Suppressed viral load is: _____          ART goal is to have a VL _____</p> <p>Step 2: CLIENT'S REASONS FOR 2<sup>ND</sup> HIGH VL:          _____          _____</p> <p>Step 3: EDUCATE ON RESISTANCE AND 2<sup>ND</sup> /3<sup>RD</sup> LINE TREATMENT:          - Explain how HIV become resistant          - Provide literacy session for 2<sup>nd</sup> or 3<sup>rd</sup> line treatment</p> <p>Step 4: ASSESS MOTIVATION TO STAY HEALTHY: Top 3 goals for the future: future projects, dreams etc.          1. _____          2. _____          3. _____          Do you think your ARVs can help you achieve your goals for the future? Are you ready to start a new treatment line?</p> <p>Step 5: EXPLAIN MEDICATION SCHEDULE          I will take my medication at this time: _____</p> <p>Step 6: REVIEW HOW TO MANAGE MISSED DOSES          If I miss a dose, my plan is : to take treatment as soon as I remember <input type="checkbox"/></p> <p>Step 7: REVIEW REMINDERS:          To remind me to take medication, I will use: <input type="checkbox"/> watch <input type="checkbox"/> cell phone alarm <input type="checkbox"/> other _____</p> <p>Step 8: REVIEW CLIENT'S SUPPORT SYSTEM          Members of my support system: _____</p> <p>Step 9: REVIEW STORING MEDS/EXTRA DOSES          Convenient storage place: _____          Emergency supply will be carried in: _____</p> <p>Step 10: DISCUSS HOW TO DEAL WITH SIDE EFFECTS          If I experience side effects, I will: _____          Inform clinic if side effects do not go away or are too worrying <input type="checkbox"/></p> <p>Step 11: PLANNING FOR TRIPS  <b>If I have some trips planned, before going away I will:</b> <input type="checkbox"/> inform health facility before travelling to receive referral letter and treatment <input type="checkbox"/> Get enough supply of treatment for trip  <b>In case I cannot come to the facility before going away:</b>  <input type="checkbox"/> I will go to the nearest health facility in the travel access 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</p> <p>Step 12: PLANNING FOR SUBSTANCE USE          Your plan to make sure you take your ARVs if you use alcohol or drugs: _____</p> <p>Step 13: GETTING TO APPOINTMENTS          How do you get to clinic? _____          Back-up plan to get to clinic _____          Not able to come on date _____</p> <p>Step 14: HOMEWORK &amp; WAY FORWARD          Your VL will be repeated in _____ (which month)</p> <p>Step 15: Referral          Referred to: _____          Referred for: _____</p>
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