NATIONAL ADHERENCE GUIDELINES FOR HIV ,TB AND NON—COMMUNICABLE DISEASES

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Background I

- Adherence to treatment is both a national and international priority

- Retention in care and adherence to ART, TB and chronic medications underpins a successful treatment program

- The SAG drafted the adherence strategy to addresses breakdowns in the care cascade

Background II

The adherence strategy directly links to the the 90-90-90 targets

Targets for HIV	Targets for TB	Targets for NCDs
90% PLHIV tested	90% key populations screened	90% of all people living with a chronic disease should know their status
90% diagnosed and started on treatment	90% diagnosed and started on treatment	90% of all those with a positive diagnosis should be on treatment
90% virally suppressed	90% treatment success	90% of those on treatment are adherent with the desired clinical or infection benefits

Draft Adherence Strategy for HIV, TB and other chronic diseases

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- includes a **minimum package of interventions** to be **implemented by all facilities and key implementation partners to increase linkage to care, retention in care and adherence to treatment**

- **Strategic Document:** outlining a **stepwise approach model** to inform the **national and provincial level** about evidence based interventions that overcome barriers to linkage and retention in care, and enhance adherence to treatment for HIV, TB and NCDs

- **Implementation Guide:** providing recommendations to the **district and the facility managers** on the evidence-based interventions to be implemented throughout the care cascade

Demand side: **Client-related barriers**

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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
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

References:
1) CHAI (2014), Antiretroviral Adherence Support-Review of Effective Strategies
2) Scalon et al (2013), Current strategies for improving access and adherence to antiretroviral therapies in resource limited settings
3) Govindasami et al (2014). Interventions to improve or facilitate linkage to or retenteion in Pre-ART (HIV) care and initiation of ART in low and middle-income settings – a systematic review.

Supply side: **Provider related barriers**

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 **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 illness

References:

1) Nachega et al. HIV Treatment adherence Patient Health Literacy, and Health Care Provider-Patient communication
2) Kagee et al (2010). Barriers to adherence to antiretroviral Treatment, the perspectives of patient advocates.
3) Hodgson et al (2014). A systematic review of individual and contextual factors affecting ART initiation, adherence and retention for HIV-infected pregnant and postpartum women

Supply side: **Structural barriers**

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Organisational

- Distance to the clinic
- Long waiting time
- Lack of integration and coordination between services
- Medicine shortages and stock-outs
- Inflexible clinic hours

Intervention quality

- Lack of tools to guide the 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

References:

1) CHAI (2014), Antiretroviral Adherence Support-Review of Effective Strategies
2) Scalon et al (2013), Current strategies for improving access and adherence to antiretroviral therapies in resource limited settings
3) Govindasami et al (2014). Interventions to improve or facilitate linkage to or retenteion in Pre-ART (HIV) care and initiation of ART in low and middle-income settings – a systematic review.
4) Sticker et al (2014). Retention in care and adherence to ART are critical elements of HIV care interventions

Objectives of the Adherence Strategy

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- 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 like diabetes and hypertension

The **Stepwise Approach**

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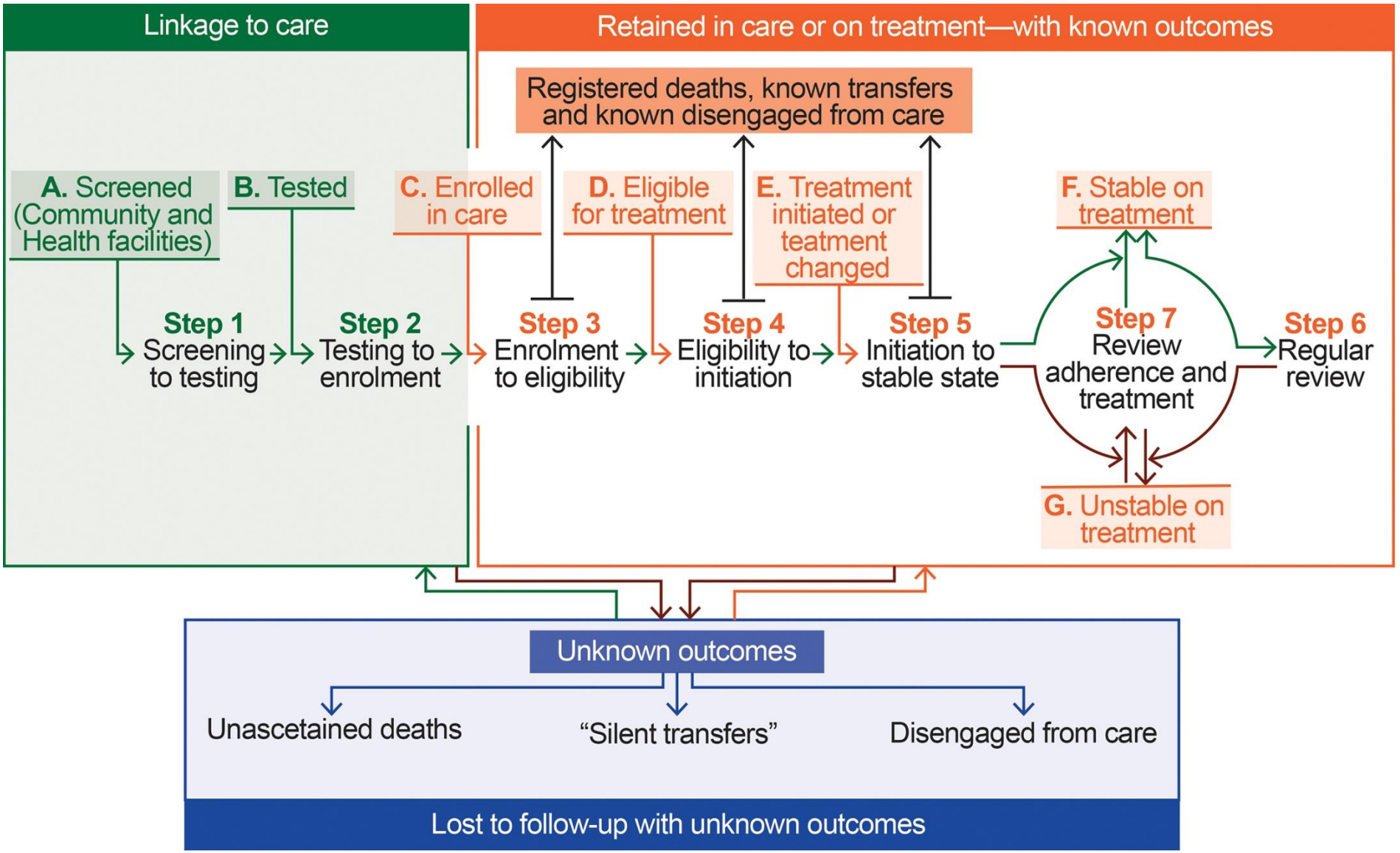

The Adherence Minimum Package

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Screening to testing | Testing to linkage to care | Enrollment in care eligibility | Eligibility to Initiation | Initiation to stabilisation | Stable on treatment | Unstable on treatment

Education and Counselling

Fast track initiation counselling

Enhanced adherence counselling

Child Disclosure Counselling for Children Living with HIV

Repeat Prescription Collection Strategies

Spaced and fast-lane appointments

Adherence Clubs

Decentralised medicine delivery

Tracing Strategies for Missed Appointments

Appointment / track linkage / unique identifier / trace early missed appointments

Integrated Care

Management of multiple chronic conditions in an integrated manner

Minimum Package of Adherence Interventions

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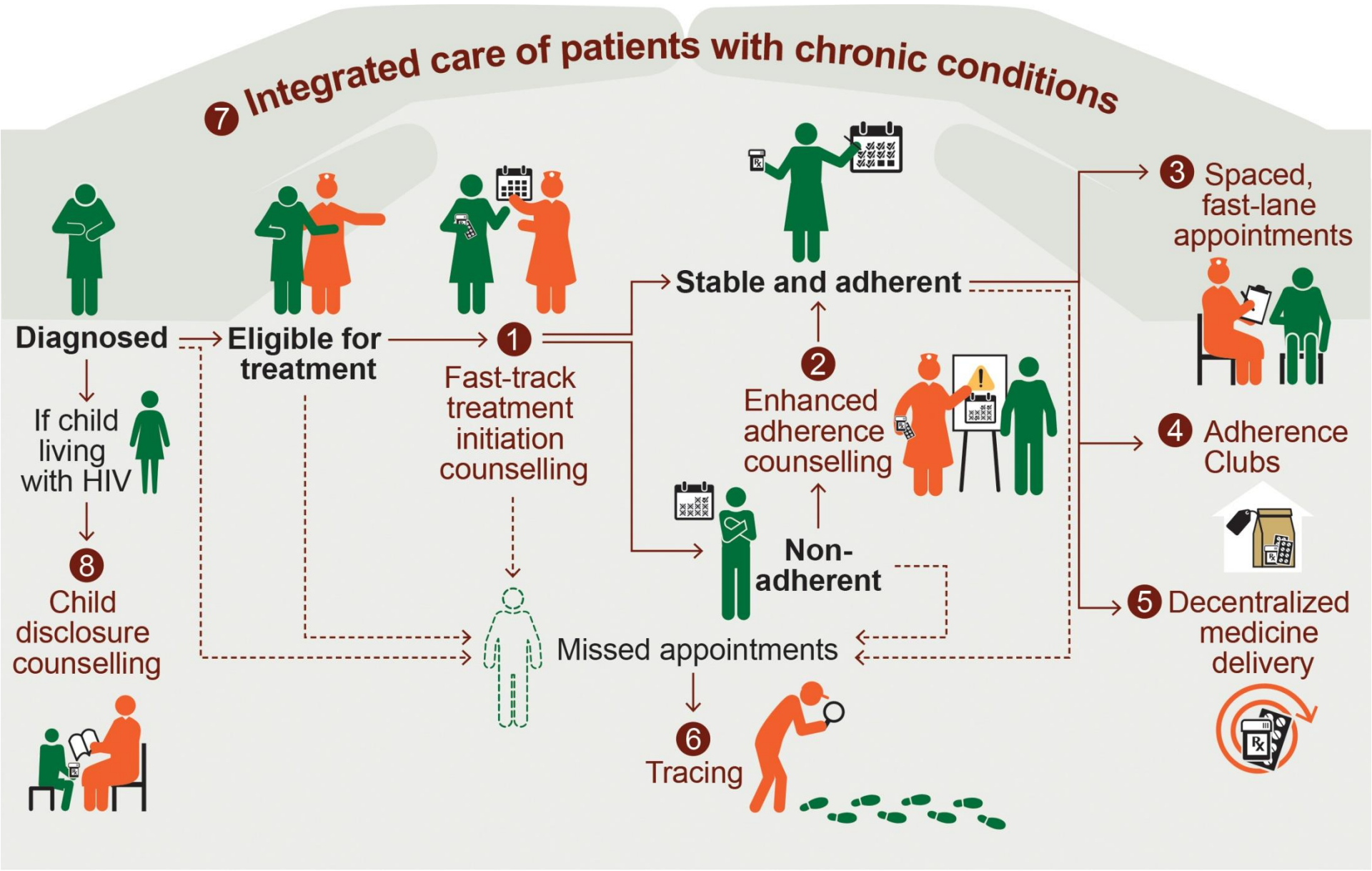

New clients starting treatment
Fast-track initiation counseling

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- **Standardized approach** using standardized tools for HIV, TB and NCDs (the flip-chart)
- **Tailored sessions for different groups** (HIV, TB and NCDs)
- **Client-centred focus** (assist client to make their own adherence plan)
- **Speed up treatment initiation** without compromising adherence

Adherence plan Sheet

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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)……
Adherence Step 3 - Patient Support system Agree for home visit: Yes ☐ No ☐ Who can support me in my treatment: …… ...
Adherence Step 4 - Getting to appointments I will come to my appointments by:…… If I face a difficulty to come (money, transport, etc.), my alternative plan will be:
Adherence step 5: My readiness to start treatment I do feel ready and will start treatment on (date): I don't feel ready and would like to discuss more with (peer, family member, Community Health Worker, etc……

Session 2 *(date):*
Adherence Step 6 - Medication schedule The best time for me to take my treatment is:
Adherence step 7: Managing missed doses If I miss a dose, my plan is……
Adherence Step 8 - Reminder strategies To remind me to take medication, I will use:
Adherence Step 9 - Storing medication and extra doses I will store my medication in: …… I will carry extra supply and keep it in:
Adherence Step 10 – Dealing with side-effects If I experience side effects, I will: ……

Session 3 *(date)*
Adherence Step 11 - Planning for trips If I have some trips planned, before going away I will: In case I cannot come to the health facility before going away, I will:
Adherence Step 12 - Dealing with substance use My plan to make sure I take my medication if I used alcohol or drugs is:

Session 4 *(date)*
Education on follow up: Viral load ☐ Continuation phase ☐ Other: …… ☐

If they are non-adherent…
Enhanced adherence counseling 2

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- Flagging clients **early**
- Providing clients with their **results**
- **Client-focused strategy—**assessing the barriers to adherence and discussing effective strategies that are aligned to the cause of non-adherence and acceptable to the client
- Setting **new objectives** according to the next step on treatment
- Providing additional **individual support** in case of switching to another regimen

If they are adherent…Graduate to repeat prescription collection strategies (RPCs)

Adherent and stable clients should be rewarded with a **faster service** and **flexibility** to choose their preferred medication collection service (**client-centered focus**)

Three client options

- Spaced and fast-lane appointments
- Adherence clubs
- Treatment delivery or collection closer to home (e.g., Central Chronic Medication Dispensing Distribution, CCMDD)

Option **Spaced and fast-lane appointments** 3

- **In a spaced appointment system:**
  - Clinically stable patients attend **annual clinic visits** for assessment and drawing blood.
  - **6-monthly prescriptions received**

- **Fast lane system:**
  - direct and quick access to the pharmacy)
  - dispensing of **1-2 months' medication**

In case of health problems or pregnancy, patients to return to regular care

Option Adherence Club 4

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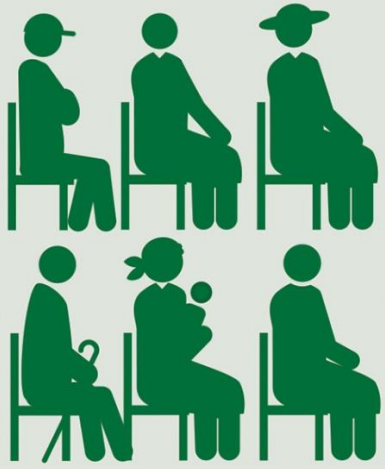
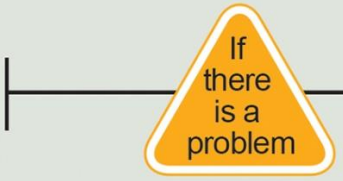
Every 2–3 Months — Facility, Community or a Home

Up to 30 members



Counsellor or CBO lay staff led

Quick clinical assessment



Refer to a nurse

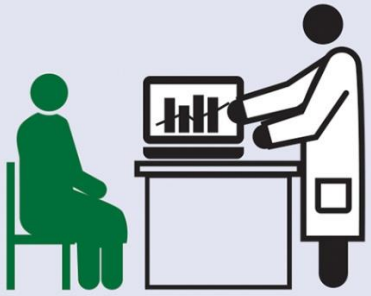
Group support/ educational activity

Pre-packaged meds (2–3 month supply)

Annually — At Facility

Laboratory monitoring

Clinical consultation with clinician



Option **Decentralized Medicine Delivery** 5

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- 6-monthly clinic visits
- 6-monthly prescriptions
- Monthly dispensing of treatment **BUT** 5/6 months medication can be picked up closer to home

Repeat prescription collection strategies (RPCs)

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Model	Clinical consultation	Prescription	Dispensing duration	Collection point
Spaced and fast-lane appointments	Annual	6-monthly	1–2 months	Facility pharmacy
Adherence club	Annual	6-monthly	2–3 months	Club
Decentralized medication delivery (e.g., Central Chronic Medication Dispensing Distribution)	Annual	6-monthly	1 month	Decentralized location (10 months) and facility pharmacy (2 months)

Preventing loss to follow-up—**core part of tracing strategy**

- Re-enforce the importance of follow-up care at every visit
- Give clients an **appointment**
- Verify contact details **at every visit**
- Issue a list of clients who have missed their appointments **early** (2 weeks)
- Trace clients **immediately** (as soon as this list is issued)
- Use **SMS/phone** and involve **WBOTs, CCGs and CHWs** to trace clients when needed
- Record the information about the clients to be traced and the outcomes **on standardized tracing forms**

Integrated care 7

- Implement **an integrated approach by** treating multiple diseases at once
- Integrate our models, services and our stationary
- Integrate the ICSM model as a **“one-stop shop”** approach for all chronic conditions
- Train clinical staff to offer **integrated consultations** to clients with co-morbidities
- Use an **integrated counselling** model adapted for different conditions

Disclosure to children 8

*"Problems arise when parents **don't disclose to the children**. They tell them they are taking medications for something else."*

- **Incremental and standardized approach** to disclosure, providing education on HIV and ART in **adapted language respecting the needs of the child (client-centred focus)**
- Start partial disclosure from the age of 6, ensure **full disclosure before the age of 12**

Adherence Interventions for Key Populations

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Key population	Recommended adherence interventions
Children and adolescents	Child disclosure counselling
Adolescent and youth	Youth clubs
Pregnant and lactating women	Mom- connect
Men who have sex with men	MSM-friendly services
Sex Workers	Outreach peer support interventions
Older persons	Include a family member or caregiver when providing information to older persons
Persons with disabilities	Ensure communication material is available in accessible formats such as Braille
Mental health disorders	Screening, management, and treatment for psychosocial stress, depression and other mental illnesses integrated into management of chronic diseases.
Substance use disorders	Screening for substance use and appropriate referral should be integrated into management of chronic conditions

Additional interventions to support Adherence and Retention In Care

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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 ART groups to be adapted for other chronic diseases
Adaptation of services to specific populations and contexts	• Outreach services (WBOTs and CHWs) • After hour services and MSM, LGBTI and sex worker friendly clinics

Monitoring and evaluation

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- Ensure integration of the adherence strategy into the 90-90-90 DIP plans
- Use existing data sources and indicators
- Strengthen systems to ensure Quality Assurance and Improvement
- Health Information Systems will underpin the following four critical functions:
  - ❑ Data generation
  - ❑ Data compilation
  - ❑ Data analysis and synthesis
  - ❑ Data sharing and usage

“If it wasn’t recorded then it wasn’t done!”

Financing of the Adherence Strategy

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- Cost sharing approach
- Conditional grant budget leverage
- Development partners support
- Continue to learn from the HIV and TB investment case and reprioritise accordingly

Roles and responsibilities: General Overview

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National Department of Health

- Develop, review, and disseminate the Adherence Strategy
- Develop supervision and monitoring tools
- Monitor and support the implementation of the Adherence Strategy
- Develop standardised certified training modules
- Roll out unique patient identifier nationwide

Provincial Department of Health

- Establish Adherence Steering Committees
- Disseminate Adherence Strategy
- Disseminate training modules
- Disseminate supervision and monitoring tools
- Allocate financial resources to districts to roll-out Adherence Strategy

District/ Sub-district Managers and Supervisors

- Support facilities in implementation of Adherence Strategy, including IEC material
- Establish clinical forums in each sub district (information sharing)
- Supervise the new implemented Adherence Strategy with appropriate supervision tools

Mobilise health workers for training

With technical support from development partners

Facility Managers

- Supervise the implementation of the adherence interventions
- Ensure all models of the Adherence Strategy are appropriately established
- Ensure all staff trained on the Adherence Strategy
- Disseminate support material
- Define staff responsibilities in the implementation of the Adherence Strategy

Adherence guidelines implementation tools

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Tools	Audience
Standard Operating Procedures (SOPs)	Health Care Workers, WBOTs, CCGs, CHW
Job aids	WBOTs, CCGs, CHW
IEC materials	Patients
Flip charts, patient booklets,	Patients and WBOTs, CCGs, CHW
Reorientation Training manual	WBOTs, CCGs, CHW
Mentoring and supportive supervision tools	WBOTs, CCGs, CHW
In- service training manuals	Health Care Workers

Regional Training Centre will be facilitating reorientation trainings

In Conclusion…..

- Linkage and retention is key for better clinical outcomes hence the proposed innovative adherence minimum package.
- Scaling up of the ‘new’ adherence program means that our facilities are going to get busier, and this will require multi-sectorial response from government, partners and civil society
- Standardization of adherence interventions is critical and should be done consistently to ensure that we deliver the right things, in the right places to the right people along the care cascade to meet the 90-90-90 targets.

Acknowledgements

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Strategy development oversight and coordination	NDOH Directorates valued inputs	Technical Working Group representation
DDG: HIV, TB, MCWH	HIV&AIDS & STIs	UNAIDS
NDOH: Care and Support Directorate	TB	USAID
	MCWH	WHO
	NCDs	World Bank
	Sector Wide Procurement	CDC
	Provinces	HPCA
		FHI360
		Right to Care
		Kheth'Impilo
		MSF
		Health Systems Trust
		SA Partners

Let us continue the Adherence programme scale-up dialogue

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Please send feedback, suggestions and recommendations by 18th June, 2015 to:

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