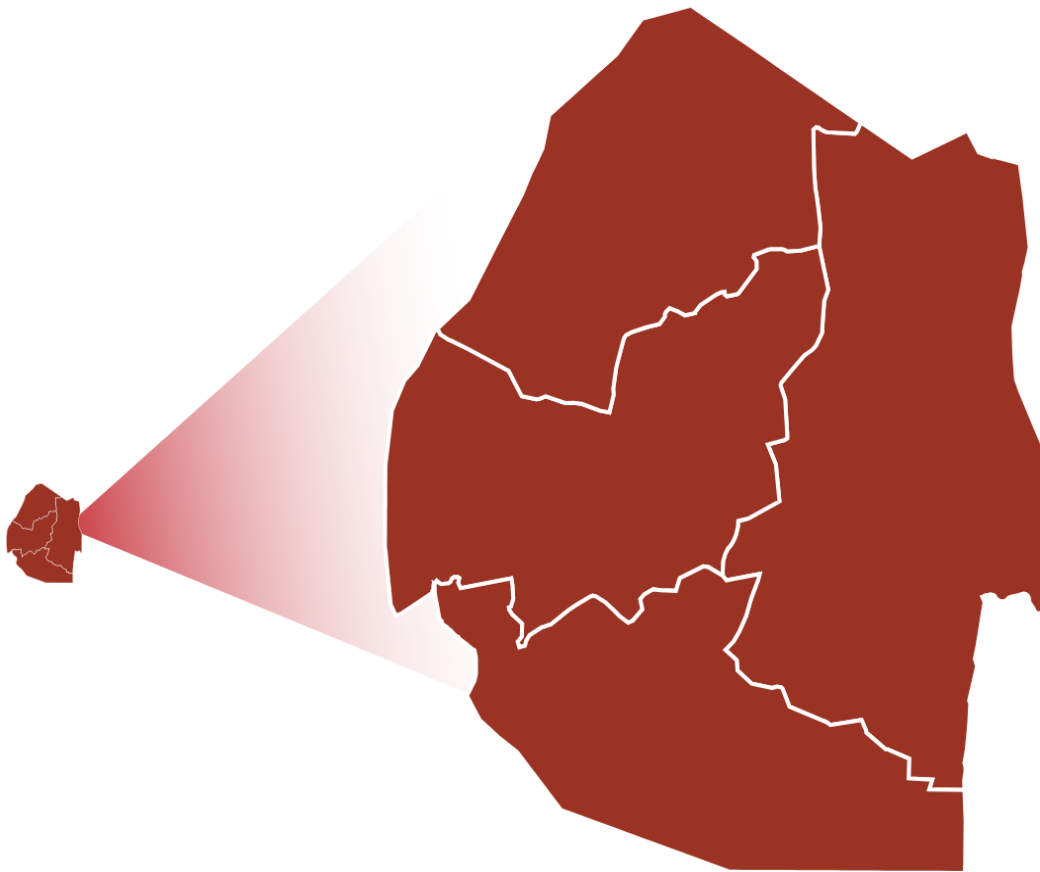




KINGDOM of ESWATINI
Ministry of Health

ESWATINI RE-ENGAGEMENT & RETENTION STANDARD OPERATING PROCEDURE



STOP AIDS, STAY HEALTHY  → 



2024

Foreword

Eswatini has sustained positive progress towards the achievement of the ambitious 95-95-95 UNAIDS targets by 2030. According to SHIMS 3, the country's progress at the national level in adults 15+ years is at 94-97-96. However, all sub and minority populations, including children, must achieve 95-95-95 targets if the country is to sustain the gains and achieve epidemic control. To reduce new HIV infections, AIDS-related mortality, and drug -resistance, all PLHIV on ART must adhere to long-life treatment and remain in care.

Literature has shown that recipients of care engage and disengage from care multiple times during their treatment journey. Hence, there is a need to develop a re-engagement and retention framework that will guide healthcare workers in identifying and managing clients who have disengaged from care.

The re-engagement and retention framework aims to support the re-engagement and retention of PLHIV who were diagnosed but never initiated on ART and those who were initiated on treatment and interrupted ART. This document complements the enhanced linkages case management SOP, patient follow-up job aid, and the Integrated HIV management guidelines. These strategies use a client-centred approach, identifying leakages in the HIV treatment cascade and providing a package of care according to the duration of treatment interruption. The framework will help the country to achieve and reach the goals set in the National Multisectoral HIV and AIDS framework.

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Acronyms and Abbreviations

AHD	Advanced HIV Disease
ART	Antiretroviral Therapy
eLCM	Enhanced linkages case management
CD4	Cluster of Differentiation 4
EC	Expert client
EAC	Enhanced Adherence Counselling
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
HTS	HIV testing services
IAS	International AIDS Society
IIT	Interruption in Treatment
LTFU	Lost to follow-up
MMD	Multi-month dispensing
NCDs	Non-communicable diseases
OHW	Outreach Health Worker
OI's	Opportunistic infections
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	Person Living with HIV
PTVL	Pretreatment viral load
PWD	People Living with Disability
RoC	Recipient of Care
RTT	Return to treatment
SHIMS	Swaziland HIV incidence measurement survey
SOP	Standard Operating Procedure
SNAP	Swaziland National AIDS Program
SUAC	Step-up adherence Counselling
TPT	Tuberculosis Preventive Therapy
UNAIDS	Joint United Nations Programme on HIV and AIDS
VL	Viral load
WHO	World Health Organization

Key Definitions

Interruption in treatment: An interruption in HIV treatment is when a person stops taking their antiretroviral therapy (ART).

Lost to follow-up: Clients who have not been seen at the facility/community service delivery site for 28 days or more since the last missed appointment (including missed antiretroviral [drug] refills in either facility or community settings).

Missed visit is a missed appointment either for an antiretroviral refill or a clinical visit. WHO suggested criteria for initiating tracing and recall interventions include missing an appointment or visit by more than seven days.

Reengagement: Refers to individuals returning to HIV services after a 28-day interruption (after missing a scheduled visit or visit and not receiving treatment

Silent transfers: A self-transfer in a health facility is when a patient moves to a new facility without proper referral documentation. This can happen when a patient moves to a new area within or outside of a city and transfers to a nearby health facility.

Table of Contents

Foreword.....	2
Acknowledgements	3
Acronyms and Abbreviations	4
Key Definitions	5
Table of Contents	6
1.0 INTRODUCTION.....	8
1.1 Goal of the SOP	9
1.2 Objectives of the framework	9
1.3 Target audience for the SOP	9
1.4 Rationale for this framework	10
2.0 REASONS FOR INTERRUPTING CARE.....	10
2.1 Consideration for Specific populations.....	11
2.1.1 Children and young people	12
2.1.2 People with Disabilities.....	12
2.1.3 Mental Health Clients	13
2.1.4 Key populations	13
2.1.5 Older People.....	13
3.0 UNDERSTANDING THE LEVELS OF LEAKAGES & RE-ENGAGEMENT WITHIN THE CASCADE OF CARE	14
4.0 LINKAGES, ADHERENCE, RETENTION AND RE-ENGAGEMENT ENABLING PACKAGES.	15
4.1 Differentiated service delivery (DSD)	15
4.2 Client-Centred Care Planning	15
4.3 Training for Health care workers-Competent Care	16
4.4 Client friendly HIV Literacy Materials	16
4.5 Integration of services	16
4.6 Community systems strengthening	17
4.7 Strong Strategic Information Systems	17
4.8 Empowering Caregivers and Family Members	17
5.0 MANAGEMENT OF CLIENT RE-ENGAGING TO CARE BY HCW.....	17
5.1 Clinical assessment	19
5.2 Psychosocial support	21
6.0 MONITORING AND EVALUATION	22
6.1 M&E INDICATORS.....	23
7.0 REFERENCES.....	14
8.0 ANNEXURES.....	15

Annex 1: Re-engagement flow chart	15
Annex 2 Interventions for factors associated with disengagement.	16
Annex 2.1 Individual factors	16
Annex 2.2 Interpersonal factors.....	21
Annex 2.3 Community system factors	23
Annex 2.4 Health system factors	24

1.0 INTRODUCTION

In 2020, Eswatini became the first African country to achieve the Joint United Nations Programme on HIV/AIDS (UNAIDS) 95-95-95 HIV treatment targets. These targets stipulate that 95% of people living with HIV are aware of their status, 95% of those who know they are living with HIV are receiving antiretroviral treatment (ART), and 95% of individuals on ART are virally suppressed (UNAIDS,2023).Disengagement and re-engagement into care among people living with HIV is a critical issue that affects both individual health outcomes and public health goals globally, (World Health Organization [WHO], 2024). Eswatini, like many other countries, the challenge of maintaining continuous engagement in HIV care is significant. According to WHO disengagement can occur for various reasons, including stigma, discrimination, socio-economic factors, and health system barriers Ware et al. (2013). Re-engagement efforts are essential to ensure that individuals return to care and continue their treatment, which is crucial for achieving viral suppression and preventing further transmission of the virus.

Globally, the cyclical nature of disengagement and re-engagement highlights the need for robust, person-centred interventions that address the underlying causes of disengagement and provide support for individuals to re-engage in care. Effective strategies include community-based tracing, tailored support services, and policy frameworks that protect the rights of people living with HIV (WHO, 2024). By focusing on these approaches, both Eswatini and the global community can work towards reducing HIV-related morbidity and mortality, ultimately moving closer to ending the HIV epidemic.

Disengagement from HIV care and treatment refers to individuals who were diagnosed with HIV, initiated on ART and subsequently interrupted treatment, (WHO, 2024). It is noted that the highest leakages and re-engagement occur between three to six months or above six months, with a high proportion of females as compared to their male counterparts. Additionally, there is a substantive number of clients (11%) that the system is not able to capture relevantly. Eswatini may have achieved most of the easy wins; however, it is going to take something extra to reach the last mile (Grimsrud 2020). Despite the progress made by the country about the 2nd 95, some clients still disengage from care for various reasons, and it remains a challenge to understand the reasons that make the clients disengage from care. For example, 13% of men who know their HIV-positive status are not initiated on ART (SHIMS3, 2021). According to Eswatini's national HIV/AIDS report for 2021, 3% of clients had interrupted treatment for various reasons. Disengaging from care and treatment poses a several risks to the client's wellbeing including progression to advanced HIV diseases, increased mortality and increased drug resistance and increased risk of onward transmission as the result of the viral rebound.

The SOP aims at assisting health care workers at all levels to improve understanding of the various challenges of clients reengaging to care. It prioritises meaningful client involvement

in decision-making processes and promotes mutual respect between healthcare workers and persons living with HIV (PLHIV). It also highlights guidance on how to manage clients according to the period they have interrupted treatment using the person-centred approach that address the reason the client interrupted treatment.

Successful re-engagement involves a combination of strategies, such as electronic medical record tracing, telephone calls, home visits, and providing additional support services like food, housing, and transportation assistance.

The application of this framework will be tailored to meet the specific needs of subpopulations that have disengaged from care and provide a client-centred package of services. It will also ensure that PLHIV who are returning to care are received with respect and are supported clinically and psychosocially. PLHIV re-engaging and struggling with adherence should not be mistreated. Clients returning to treatment should receive a package of care according to the category of treatment interruption and their clinical and psychosocial status. The document insists that clients who return through any entry point should not be turned away and should not be documented as new but be linked back to care following the HTS verification process.

1.1 Goal of the SOP

To sustain 95% ART initiation and retention of PLHIV in HIV care in Eswatini by 2030, which ultimately promotes retention in care and reduces morbidity and mortality.

1.2 Objectives of the framework

- To provide systematic guidance and support to healthcare workers to manage clients who have interrupted ARV treatment effectively.
- To provide re-engagement packages (strategies) according to the category of interruption and disengagement, including clients who have delayed treatment.
- To guide the capacity building of healthcare workers on the implementation of re-engagement packages and processes (training, supportive supervision, and routine mentorship).
- To support optimised client-centred clinical management of PLHIV re-engaging in care whether virally suppressed, detectable viral load or Advanced HIV Disease (AHD).

1.3 Target audience for the SOP

- Doctors
- Nurses
- Clinic supervisors
- Social Workers
- Psychologist
- Nonclinical health care workers (Expert clients, HTS counsellors & mentor mothers)
- Community healthcare workers

1.4 Rationale for this framework

In 2016, the World Health Organization (WHO) recommended that all individuals diagnosed with HIV should initiate antiretroviral therapy (ART) on the same day, irrespective of their CD4 count, with the aim of enhancing the quality of life for people living with HIV (PLHIV). Eswatini has effectively implemented this "test and start" strategy; however, challenges persist, including clients interrupting their treatment and some individuals delaying the initiation of ART, often presenting late with stage 3 or 4 conditions. In Eswatini, 98% of clients who test positive for HIV begin ART within one month, and 90% of new ART initiations remain active on treatment six months after commencement. Approximately 86% of clients who experience interruptions in treatment return to care within 90 days. Data suggests that many of these interruptions are not indicative of true disengagement but rather stem from documentation gaps. Additionally, about 3% of ART initiations involve clients who are restarting treatment but present themselves as new clients at the HIV testing services (HTS) entry point.

The standard operating procedures (SOP) are designed to assist healthcare workers in recognizing that disengagement can occur and that it is essential for healthcare providers to ensure that clients who reengage in care receive the necessary support, experience a welcoming environment, and are managed according to the results of their clinical assessments.

For a long time, we have thought about the HIV treatment cascade as a linear pathway through which people pass. As cohorts have grown and been on ART for longer, it is becoming clear that this linear cascade is not the reality. PLHIV are dis-engaging and re-engaging with the cascade at multiple points in their treatment journey. According to the 2023 HIV programs report, 7,875 clients (3%) disengaged from care. See the diagram below.

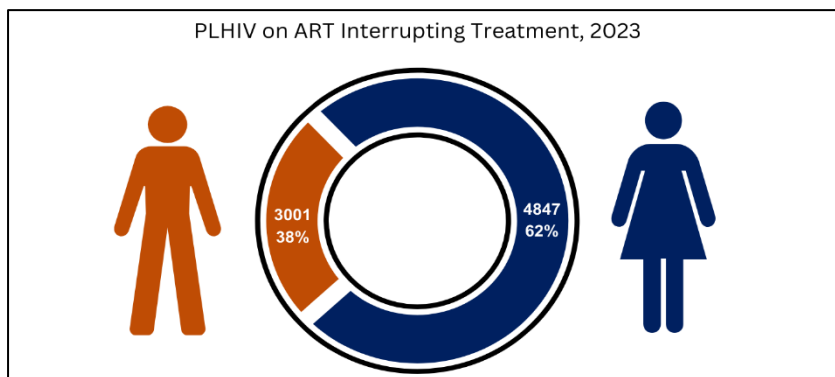


Figure 1: Number of ART clients interrupting treatment in 2023 by sex in Eswatini

A systematic review using data from sub-Saharan Africa reported that approximately 20-50% of clients presenting for ART initiation were treatment experienced. ((WHO, 2024).

2.0 REASONS FOR INTERRUPTING CARE

Understanding the effects of barriers to ART uptake and retention is important in the development of differentiated packages according to client's needs. The reasons for interrupting ART care are categorised into four categories illustrated below: individual factors,

interpersonal factors, community-related factors, and health system factors as shown in Figure 2 below.



Figure 2: Factors affecting retention in care

TREATMENT INTERRUPTOR

Any individual who fails to honour their appointment for >28 days. Includes clients classified as being lost to follow up (missed >90 days)

2.1 Consideration for Specific populations.

There are various factors associated with disengagement in special populations. According to World Health Organization [WHO], 2024, the different sub populations have different factors that contribute to disengagement. Clients can be identified at various entry points; they can present themselves as new clients that want to be tested or they can come back through the outpatient unit. This process of identifying clients should start from the time of HIV testing during pre/post-test counselling and continue through ART initiation formalities, clinical refills, adherence counselling sessions and re-engagement consultations. In addition, the interventions should be continued during community interventions like home visits, community campaigns, outreach sessions and any other contact with the client.

All HCWs should be trained on the proposed interventions either at community or facility levels. To improve management of clients returning to care, health care workers should acknowledge it is normal to miss appointments for clients on chronic care. Health care workers should not always require for transfer documents but should reinitiate the client and verify with previous facility. The health care worker should develop a differentiated follow-up plan on re-engagement depending on client needs and preferences. Each sub population

faces unique challenges to remain in care. It is important to understand their challenges as indicated below.

2.1.1 Children and young people

Children that have identified as having interrupted treatment should be reinitiated on the same day, involvement of the care giver is crucial as they are dependent on them. The points below are critical when reinitiating children and adolescents. Children depend on caregivers and the caregivers may change time and again, and that the children do not understand their own HIV status. Adolescents and young people may engage in care without fully having known or understood their HIV status. They might be having challenges to come to the facility due to school attendance. The young people may be afraid to disclose their HIV status to their partners as there are issues of stigma and discrimination.

- Determine if the child is well or unwell.
- If the child is below 5 years, manage the child as having AHD.
- Clinical symptoms in children may be slightly different from adults, so a thorough history taking, and physical examination as recommended in the national HIV guidelines is recommended.
- Clinical and psychosocial support should focus on the child/young person's support system because reasons for disengaging may be related to the support system. Refer to the Caregiver manual on how to engage caregivers.
- Provide appropriate antiretroviral drug formulations and decentralized paediatric care to improve access to services.
- Refer to the HIV management guidelines on the basic care package for children and adolescents.
- Check if the caregiver has disclosed to the client and initiate the disclosure process, if not assist the care giver to disclose
- Schedule appointments to accommodate school hours and holidays.
- Refer teenagers to teen clubs and link with peer supporters.
- Facilitate transition to adult ART services and adult delivery models when they age out of adolescent support group.

2.1.2 People with Disabilities

Just like in children, people with disabilities may need caregiver support to access and stay in care because of their disability. Healthcare workers should note the following challenges faced by people living with disabilities and work with relevant organisations and community supporters to support re-engagement and retention in care. The below are the challenges for people living with disability as they have an impact on adherence and being retained in care for the client living with disability:

- Communication barriers.
- Transport barriers including accessibility and finances.

- Inadequate HCW capacity to provide differentiated services.
- Inadequate caregiver support to handle the needs of people with disability.
- Caregiver fatigue.
- Changing treatment supporters.
- Disability needs such as cognitive, physical and sensory disability.
- Stigma and discrimination.

Health facilities should capacitate HCWs to provide effective care to different clients with disabilities. The active involvement of caregivers, together with psychosocial support for the families, also ensures that clients are retained in care. Despite their disability, involving clients in their care plan development fosters a sense of ownership and improves treatment adherence.

2.1.3 Mental Health Clients

Clients with mental health conditions are faced with a lot of barriers to continuity in care, including the ones highlighted below.

Challenges	Recommendations
<ul style="list-style-type: none"> •Lack of insight •Fluctuating mental health status •Highly mobile •Lack of social support to stay on treatment •Stigma and discrimination deterring them from seeking care •Complex regimens and drug to drug interactions •Lack of finances to access care •Limited mental health knowledge among HCWs 	<ul style="list-style-type: none"> •Use MDT approach and involve the family and community in treatment plan •Integration and decentralisation of services •Involve client and their community in stigma reduction strategies •Simplify regimens and collaborate with psychiatrist in formulating ART regimens •Train HCWs on the needs of people with mental health and be non judgemental when providing care

Table 1

2.1.4 Key populations

Key populations face legal and social issues such as stigma and discrimination, lack of tailored services, lack of privacy and confidentiality in the process of staying on treatment. There are specialised clinics where they receive care, but in the future, all health facilities should be able to provide KP-friendly services. Criminalisation of KPs, stigma and inadequate capacity of HCWs are some of the major issues affecting them. The HIV program has developed a KP manual of care for HCWs and should be used whenever they encounter them.

2.1.5 Older People

Older people have other comorbidities which result in clients experiencing polypharmacy and have drug interactions hence the health care worker should check for potential drug to drug interactions. AS the client are ageing there is cognitive decline which results to being forgetful hence there is need to conduct regular cognitive assessments and engage family to

possible assist client with taking of medications. Also, an older client has psychosocial issues such as depression, lack of family support which can result in poor adherence. There is need to improve adherence support and align appointment ART with other comorbidities and simplify regimen to reduce pill burden.

3.0 UNDERSTANDING THE LEVELS OF LEAKAGES & RE-ENGAGEMENT WITHIN THE CASCADE OF CARE

Client treatment interruption may happen at any stage along the HIV treatment cascade, from the time when they test HIV positive and don't initiate ART to initiating treatment being lost through the care continuum. The HIV cascade is not linear, many clients engage and disengage from care for a variety of reasons. Hence, it is imperative to support the clients aware of their HIV positive status but not actively engaged in care and treatment. According to WHO, there are various levels of treatment interruption, which are as follows:

- **Treatment naïve interruption:** disengagement from care after testing HIV positive before ART initiation
 - **Immediate interruption:** disengagement from care ≤ 28 days post ART initiation
 - **Early interruption:** Disengagement from care >28 days to <6 months post ART initiation and,
 - **Late interrupters:** Disengagement from care after being on ART for at least six months.
- Each of the stages of treatment interruption or disengagement from care is illustrated in the figure below, as adapted from the WHO guideline.

Stages of treatment interruption and re-engagement

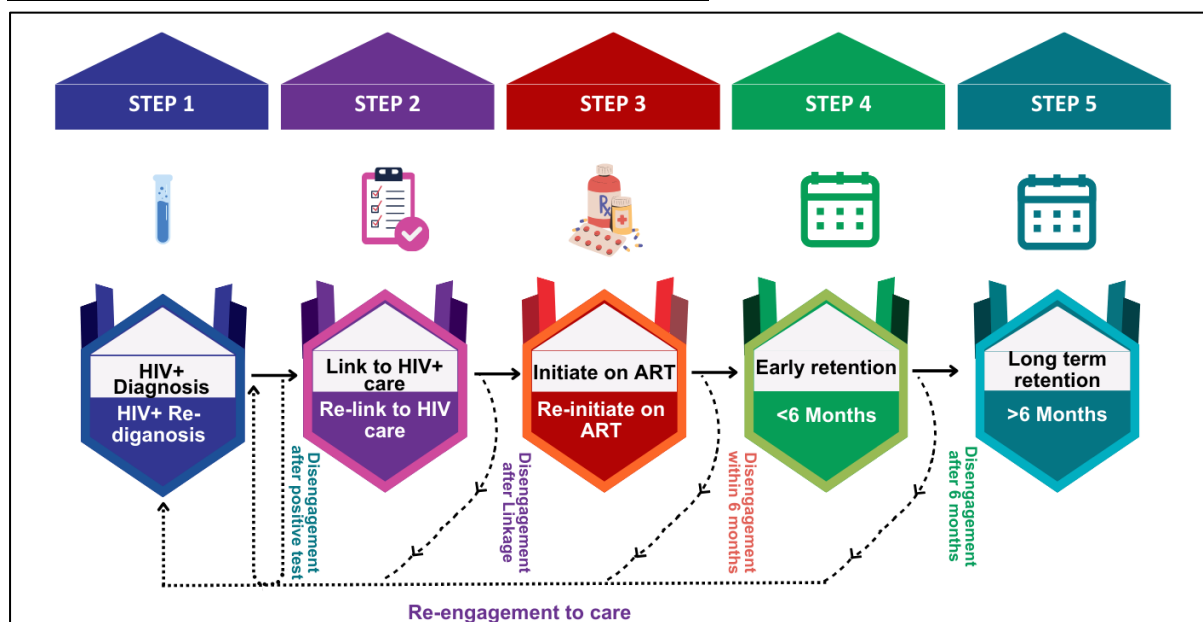


Figure 3: Illustration of client interruption and re-engagement flow at all levels.

At each level of disengagement and re-engagement within the cascade of care, the reasons are congruent to the factors identified in Figure 2. Clients who re-engage may do so at any

entry point, such as at HIV testing, in-patient or ART units. Therefore, healthcare workers at all entry points should ensure that the re-engagement package is implemented using a client-centred differentiated service delivery approach to address client-specific issues.

4.0 LINKAGES, ADHERENCE, RETENTION AND RE-ENGAGEMENT ENABLING PACKAGES.

4.1 Differentiated service delivery (DSD)

Clients reengaging to care have different needs and some may be well while others might be sick, hence the need of differentiated care. To create an enabling welcoming environment health care workers should implement flexi-hours (extended opening hours, such as early morning, evening, or weekend), Govindasamy et al., (2014) to enable those who are having school or work commitment. Fast-tracking newly diagnosed include expedited initiation of ART on the same day as diagnosis or initiation. Effective ART retention strategies also include:

1. Providing comprehensive education to clients regarding their treatment and the importance of adherence.
2. On-going individualized counselling and person-centred care to cater to the unique needs and preferences of each client.
3. Utilizing peer counselling and support networks to foster a sense of community and promote mutual understanding among clients.
4. Implementing a reduced frequency of clinical visits to minimize disruptions to clients' daily lives and facilitate long-term treatment adherence.
5. Provide adherence support through digital platforms.
6. Prompt Tracing of clients who have disengaged from care and provide support.

To ensure retention in care, HCWs should conduct ART readiness assessment to identify potential barriers to continuity in treatment and to proactively identify clients at risk of disengaging. For clients with disability or children ensuring a consistent caregiver is important in assisting the client to take medications. Where applicable, escalation to the psychiatric hospital may be needed. It is also important to ensure that drug-drug interactions with ART are considered to decrease the probability of either treatment failing. Below are the enabling packages that can be provided for clients to promote retention in care.

4.2 Client-Centred Care Planning



Rationale: Involving clients in their care plan development fosters a sense of ownership and improves treatment adherence.

Action: Healthcare workers should use population specific communication methods (e.g., sign language interpreters, assistive listening devices) to ensure clear communication with PWDs. They will actively solicit the client's needs, preferences, and concerns regarding their care plan.

4.3 Training for Health care workers-Competent Care



Rationale: Healthcare workers equipped with knowledge and skills to provide population friendly services e.g., disability, youth, key population and male-competent care can better address clients' specific needs. Promote friendly healthcare workers who refrain from punitive actions towards clients with treatment continuity challenges. Ensuring a welcoming, non-stigmatising environment and equitable access to services.



Action: The Ministry of Health will develop and implement training programs for healthcare workers on providing competent care to PLHIV from different priority or marginalised populations. These trainings will cover topics such as accessible communication strategies, reengagement package according to being well or not well, addressing physical and cognitive limitations, and creating an inclusive clinic environment.

4.4 Client friendly HIV Literacy Materials



Rationale: Providing HIV treatment information in accessible formats empowers recipients of care to make informed decisions about their health.



Action: Healthcare facilities should stock a variety of HIV literacy materials in accessible hard and soft copies distributed through traditional and digital platforms. Materials should be both in English and SiSwati versions, large print brochures, digital platforms, video demonstrations with sign language interpretation, or audio recordings with clear descriptions. Workers should be trained to identify appropriate resources based on the client's needs. Promote treatment literacy among recipients of care and communities to reduce stigma and discrimination and improve retention in care.

4.5 Integration of services



Rationale: Minimising the number of appointments and service points reduces travel burden and improves care access. Use point-of-care laboratory platforms to allow clients to get results on time. Integration of other comorbidities should be strengthened to promote adherence and thus reducing the number of visits the client must make to the facility.



Action: Healthcare facilities should integrate HIV and NCD services so that clients access essential services like laboratory testing, medication refills, and psychosocial support within the same location or on the same day.

By implementing these action plans, healthcare workers can create a more welcoming and accessible environment for key and priority populations re-engaging in ART treatment, ultimately promoting successful re-engagement and improved health outcomes.

4.6 Community systems strengthening



Strengthen collaboration between the health facility and community health systems to improve the tracing of interrupters, tracking and provision of ongoing peer and psychosocial support.

4.7 Strong Strategic Information Systems



Develop a system to identify clients at risk of disengaging and institute preventive methods to improve retention in care.

- Use electronic medical record system to allow clients to access healthcare from anywhere in the country.
- Establish a clear appointment and follow-up system to help identify clients delaying ART or interrupting treatment.
- Apply a standardised approach to enhance the verification of true new positives across all health facilities.

4.8 Empowering Caregivers and Family Members



Rationale: Strong peer and caregiver support is crucial in adhering to ART treatment. Caregivers of children, adolescents, mental health clients and people with disabilities need to be empowered to provide care to their clients.



Action: Healthcare workers should actively engage peers, caregivers and family members during client visits. Workers can also offer guidance and support to caregivers on how to best assist the client with medication adherence and appointments.

5.0 MANAGEMENT OF CLIENT RE-ENGAGING TO CARE BY HCW

There are multiple ways to re-engage at different points in the cascade within the same facility or between facilities. Individuals may return to their ART program, silently transfer to a new facility or more often, present for HIV testing services as new clients. Healthcare workers should provide a differentiated client-centred approach that considers the duration of treatment interruption and the clinical and psychosocial assessment of the client at the time of re-engagement. Healthcare professionals should ensure that PLHIV who re-engage in care are treated with respect, given the necessary clinical attention, and receive quality psychosocial support. Patients with adherence issues should be appointed according to their needs to ensure higher continuity in treatment. Time since last appointment is very important as those who have a short disengagement are much less likely to have clinical needs, limited risk of mortality and may actually benefit from making access to ART easier by returning back to their less intense DSD model when they re-engage. Those with a longer disengagements will have more clinical needs, possibly require more intensive psychosocial

support and should be screened for advanced HIV disease. Other important factors that must be considered for a differentiated approach to re-engagement are the clinical presentation and psychosocial needs of the client but identifying the duration of disengagement is a major step. It is critical that clients returning to care receive high quality clinical and support services that are also part of the key factors that ensures differentiated re-engagement support pathways. The differentiated pathways include:

- Clinical Assessment and Rapid ART Reinitiation.
- support clients overcome barriers, by providing psychosocial and Adherence support.
- Tailoring pathways according to individual clinical needs, and not as a punitive measure.
- Address the unique challenges of different population groups according to their needs.

Using the patient follow-up SOP, health facilities should identify clients who have interrupted treatment, i.e., did not honour their last appointment by more than 28 days, (Eswatini Ministry of Health, 2022). After unsuccessful follow-up, clients are classified as having been lost to follow-up if they miss their previous appointment by more than 90 days. **Re-engagement, therefore, focuses on clients who return to care after being classified as IIT or LTFU.** Figure 4 below show the categories of clients who have missed appointment. The categories in important as it assist in client's management.

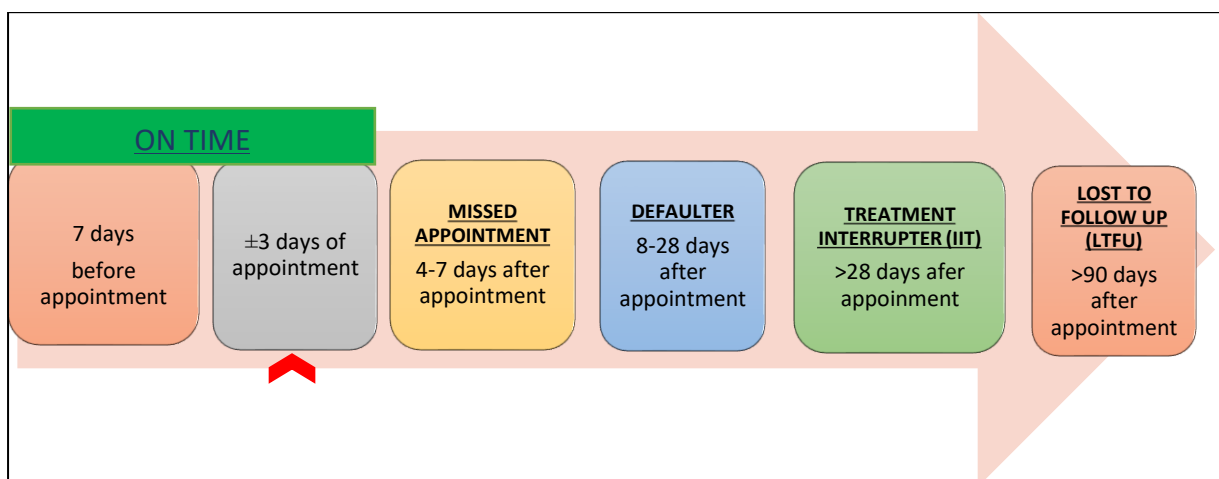


Figure 4: Patient follow-up definitions

The package of care is differentiated based on the duration of treatment interruption and clinical/psychosocial status.

Refer to annex 1 for reengagement algorithm

5.1 Clinical assessment

STEP 1: Confirm if the client is a true IIT/LTFU and the circumstances surrounding them not honouring their appointment. Provide complete clinical assessment on re-engagement in care to determine the clinical stability of the client.

STEP 2: Manage based on findings from step 1.

For all clients who fail to honour appointments, ascertain reasons for failing to come to the facility.

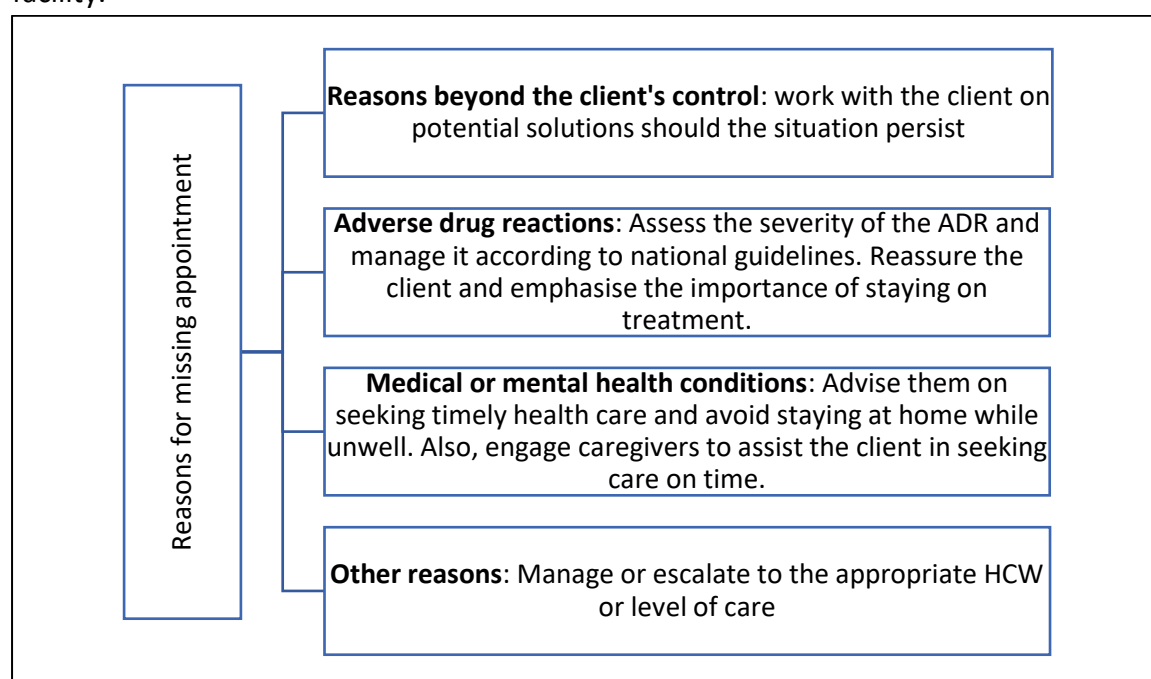


Figure 5: Client management based on reasons for of honouring appointment.

5.1.1 The client did not interrupt treatment but missed 3 – 28 days.

- Correct data or documentation errors in all medical records
- Provide enhanced counselling according to the Patient Follow-up SOP
- Enrol client into eLCM if less 6 months in treatment and not already enrolled.
- Review recent VL results.
 - VL > 200 copies/ml and clinical well:
 - Offer DSD if not already enrolled.
 - Provide routine follow-up services.
 - 3 - 6 MMD based on eligibility
 - Provide the basic HIV care package.
 - VL < 200 copies/ml or clinically unwell.

- Manage unsuppressed viral load according to Addendum to the 2022 Integrated HIV Management Guidelines.
- Treat the presenting illness according to national guidelines.
- Collect a sample for CD4 monitoring and manage accordingly.
- Follow up within a month or earlier if indicated.
- Provide 1 month ART refill.
- Provide the basic HIV care package.
- Provide AHD package as indicated in the Integrated HIV management guidelines 2022
- No recent VL result
 - Collect blood for routine VL monitoring.
 - Provide the basic HIV care package.
 - Provide one month refill to allow the client to come for VL results.

NB: For Advanced HIV Disease, please refer to Integrated HIV Management Guidelines

5.1.2 Client interrupted treatment (missed >28 days)

- Welcome the client for returning to the facility.
- Update and document the client's contact details, treatment supporters, and family members.
- Allow the client to feel comfortable and let them know that this is a routine check-up for all clients documented to have interrupted treatment.
- To classify if they are clinically well/unwell, review clinical records and laboratory investigations.
- Please enquire about the client's general health on that day and what made them decide to come to the health facility.
- Enquire when the client last took their medication.

5.1.3 Never took ART.

5.2 Understand reasons for delaying ART.

5.3 Manage as ART naïve client according to national guidelines.

5.4 Escalate client for further counselling and support according to the reason identified.

5.1.4 Last took ART 28-90 days ago:

Clinically well	Clinically unwell
<ul style="list-style-type: none"> • No Active opportunistic Infections (OI) • Previous VL <200 copies/ml • Controlled commobidities • No active Adverse Drug Reaction • Able to walk unaided • Normal vital signs 	<ul style="list-style-type: none"> • Respiratory rate >30 per minute • Temperature > 39°C • Heart rate >120 beats per minute • Ambulatory or Bed ridden • Active Opportunistic Infection • Uncontrolled commobid condition • Poor mental health status • Children < 5 years

If clinically well,

Manage as above (**VL <200 and clinically well**) and restart on the same ART regimen and provide psychosocial counselling. Collect CD4 if eligible as per the HIV management guidelines.

If clinically unwell,

- Collect CD4 and manage based on CD4 count result and presenting illness, for clients with AHD see the annexure 2 on Advance AHD
- Restart the previous ART regimen unless contraindicated by the current clinical condition.
- Manage presenting illness according to national guidelines.
- Conduct VL testing at the scheduled time.

5.1.5 Last took ART >90 days ago.

- Please enquire about the client's general health on that day and what made them decide to come to the health facility.
- Ask the client if they have ever interrupted treatment before and why. Also, check the client's medical records for confirmation.
- Conduct a psychosocial assessment and document findings. Escalate to social worker, psychologist, psychiatrist or community health workers as appropriate.
- Review the client's recent (previous 3-6 months) laboratory results (VL, Blood sugar, Kidney function, etc), vital signs, including BP, and adherence.
- If the client has abnormal results, manage accordingly.

All clients who interrupt treatment for at **least 90 days** should collect a sample for CD4 count monitoring

- CD4 count < 200 copies/mm³ → Provide AHD package and restart ART accordingly.
- CD4 count >200 copies/mm³ → Restart ART on the same day
- Provide 1 month refill or earlier if needed.
- Discuss whether the client will be able to continue follow-up at the health facility or needs a referral to another facility. The client should know that they are free to come back for follow-up at any time during their lifetime.
- Follow up according to the national guidelines.

5.2 Psychosocial support

All clients re-engaging back into care should receive a baseline psychosocial assessment every year after that. Clients who need close follow-up should be managed according to national guidelines. Refer to the ***Addendum to the 2022 guidelines and the Psychological First Aid manual*** for psychosocial assessment. Psychosocial assessment should cover the following areas and more:

- Conduct readiness assessment according to the 2022 Integrated HIV Management Guidelines.

- Assessing their mental health status
- Discuss peer-to-peer support for adolescents and other populations.
- Use of visual aids tools for counselling to improve counselling outcomes.
- Refer to social worker or psychologist for further support and management

AT EACH CLINICAL ENGAGEMENT WITH THE CLIENT:

- Document the outcome of the client engagement.
- Did the client interrupt treatment, default, miss an appointment or wrongfully classified?
- What is the duration of treatment interruption?
- Is the client clinically stable or not? Document the diagnosis made on that date.
- Are there psychosocial issues that need escalation to the psychiatrist, psychologist, social worker or community healthcare worker?

According to national guidelines, VL testing should be done 3 months post ART (re)initiation so all clients returning to care should have a VL test 3 months post ART reinitiation. HCWs should manage the client according to the clinical condition and the VL results. See addendum of the 2022 Integrated HIV management guidelines. All clients with a VL < 200 copies/ml should be assessed for eligibility for DSD or 3MMD.

6.0 MONITORING AND EVALUATION

The main objectives of monitoring and evaluation are:

- To provide accountability to all stakeholders
- To provide program performance against set targets, to identify successes and areas of improvement.
- To provide evidence-based informed decisions for programming and policy planning.

The re-engagement SOP has developed indicators to measure the program's progress towards the set targets. The indicators will be collected at national, regional, facility, and community levels through electronic and non-electronic data sources, from assessments, and other nationally approved registers. The table below provides a list of indicators that will be used to track progress for the re-engagement SOP.

6.1 M&E INDICATORS

No.	Indicator	Calculation	Disaggregation
1	Percentage of clients who interrupted treatment returning to care restarted on ART and remained in care during the reporting period.	Numerator: Number of clients returning to care Denominator: Total clients interrupted treatment	Age, Sex, Region, Facility, duration of interruption
2	Number of PLHIV interrupting care during the reporting period	N/A	Age, Sex, Region, Facility, ART status (on ART, PreART)
3	Number of PLHIV on ART who interrupted treatment who restarted ART in the reporting period.		Age, Sex, Region, Facility, Duration of IIT
4	Percentage of PLHIV on ART who interrupted treatment who restarted ART in the reporting period.	Numerator: Number of clients returning to care in the reporting period. Denominator: Total client interruption treatment	Age, Sex, Region, Facility, Duration of IIT

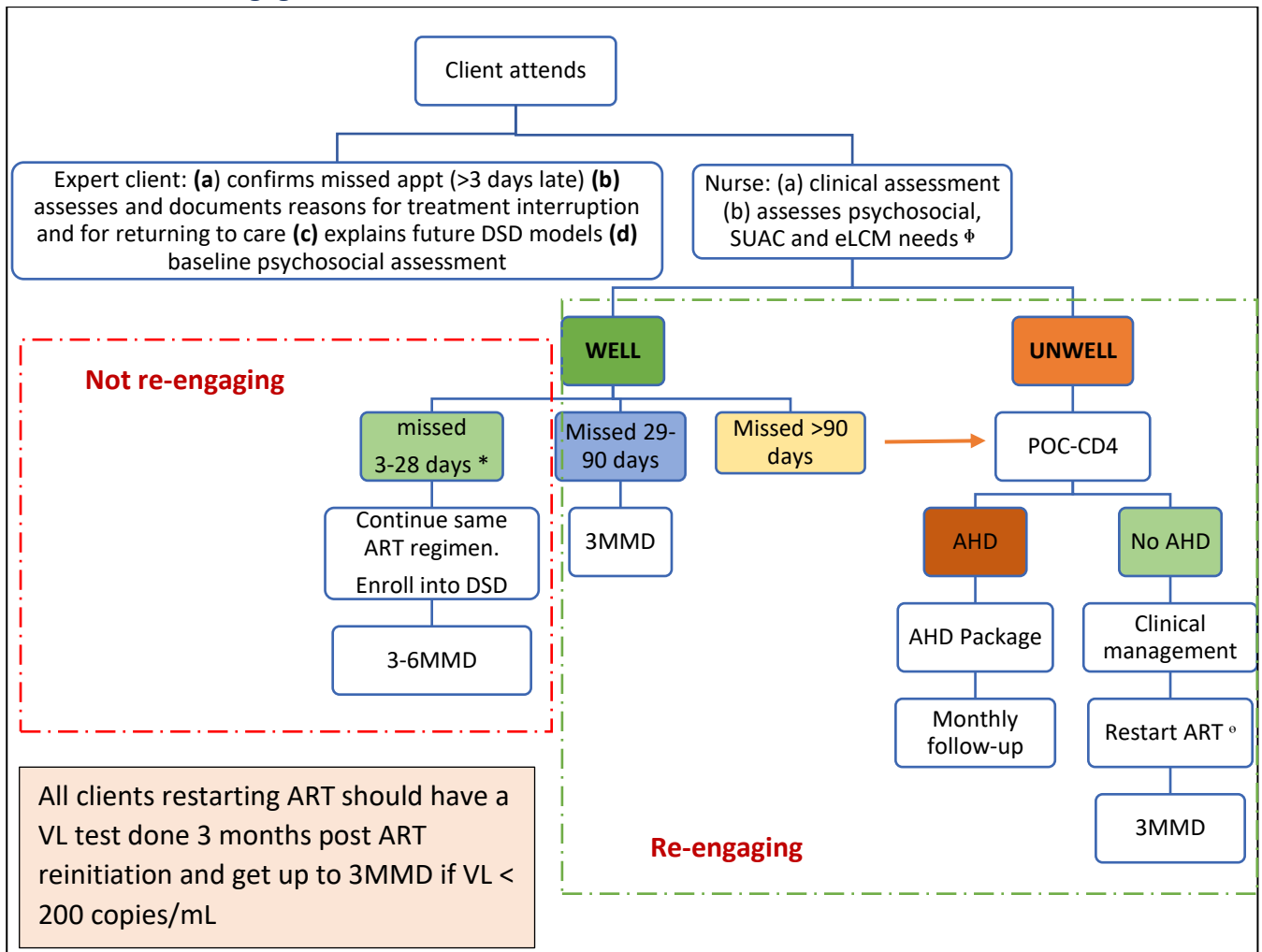
All data should come from the HMIS and be monitored quarterly. Additional indicators should be monitored as part of routine programming. SNAP, the Strategic Information Department, Supporting Partners are responsible for data monitoring.

7.0 REFERENCES

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8.0 ANNEXURES

Annex 1: Re-engagement flow chart



Φ SUAC/eLCM not indicated if (a) <28 days late (b) reasons for missing appointment are beyond client’s control (c) ART sourced elsewhere/client had buffer stock

* Client who is 3-28 days late NOT considered to be “re-engaging”. If unwell, the client is offered the same package of care as any unwell client.

° ART should be restarted same day without any delays unless clinical guidelines specify delay

Annex 2 AHD algorithm

Annex 3 Interventions for factors associated with disengagement.

The following tables show factors associated with disengagement in special populations and the differentiated care that may be provided according to the different subpopulations; what, who, where, and when. The healthcare worker should respond according to the issue identified during counselling. In all the identified factors, all HCWs should be included in the proposed interventions either at community or facility levels. This process should start from the time of HIV testing during pre/post-test counselling and continue through ART initiation formalities, clinical refills, adherence counselling sessions and re-engagement consultations. In addition, the interventions should be continued during community interventions like home visits, community campaigns, outreach sessions and at any other contact with the client.

Annex 3.1 Individual factors

Key issue identified	Affected population	Proposed intervention (What)
Adolescents not willing to be transitioned to adult clinics through care models	<ul style="list-style-type: none"> Adolescents and young people 	<ul style="list-style-type: none"> Empower client from an early stage of treatment about transitioning to adult care. Assess readiness for transitioning. Discuss transitioning barriers with the client. Provide an enabling and conducive environment for transitioning. Enrol into DSD for young people and provide MMD or ARVs.
Poor knowledge of HIV	<ul style="list-style-type: none"> ALL 	<ul style="list-style-type: none"> Empowerment through health education to increase knowledge and understanding about HIV. Use visual aids to aid understanding amongst men to improve early ART uptake, adherence, and viral suppression. Targeted IEC material for men especially in male-dominated workplaces to capacitate them on HIV issues. Engage peer educators to empower men and assist in the development of tailor-made interventions targeting specific populations. Champions will also influence other clients to make proper decisions about their sexual lifestyle and treatment continuity. Provide a comprehensive package including HIV, NCDs, Sexual and reproductive health, etc to entice men to come for services.

Key issue identified	Affected population	Proposed intervention (What)
Caregiver dependence	<ul style="list-style-type: none"> ● Children ● Mental health patients ● People with disabilities 	<ul style="list-style-type: none"> ● Educate caregiver on adherence, proper dosing, drug storage and taking care of HIV positive child taking into consideration the age of child. ● Provide appropriate antiretroviral drug formulation for children and align schedule for children with the mothers ART schedule ● Educate care caregivers on Providing treatment literacy to caregivers continually. ● Update contact details of client as per the guidance in the HIV management guidelines. ● Ensure confidentiality and privacy.
Work/Business engagements (issues of prioritising income)	<ul style="list-style-type: none"> ● Young people ● Men 	<ul style="list-style-type: none"> ● Refer to social and psychologist as per the need. ● Provision of Health talks to encourage men to prioritise their health. ● Use pretreatment VL, CD4 count and the visual aids to motivate clients to start/continue and re-engage in care. ● Identify treatment supporters to always support and encourage clients not to miss appointments. ● Virtual and physical support to clients on keeping their ART appointments.
Pill burden	<ul style="list-style-type: none"> ● Elderly ● Mental health clients ● Clients with comorbid conditions 	<ul style="list-style-type: none"> ● Provide fixed dose for where possible. ● Educate caregivers and provide continuous motivational counselling to ensure adherence. ● Monitor drug to drug interaction. ● Provide client centred counselling to address fears about medication. ● Educate client on the importance of adherence to treatment. ● Engage family or caregiver to assist with medication
Side effects	<ul style="list-style-type: none"> ● ALL 	<ul style="list-style-type: none"> ● Educate caregiver on possible side effects and what to do when child experience them. ● Encourage them to contact the facility and report if experiencing side effects. ● Determine the level of side effects and manage accordingly. If Grade 3 or 4 stop medication and refer to the doctor if the client was seen by the nurse.
Stigma and	<ul style="list-style-type: none"> ● ALL 	<ul style="list-style-type: none"> ● Education and motivational counselling to

Key issue identified	Affected population	Proposed intervention (What)
denial		<p>empower client to be able to cope with self-stigma.</p> <ul style="list-style-type: none"> ● ART readiness to identify barrier. ● Continuous Psychosocial support. ● Testimonials from peer-to-peer support through support groups. ● Provide a warm and welcoming environment. ● Motivational counselling to improve men's coping mechanisms to deal with stigma and discrimination. ● Intrinsic stimulation to activate positive sensation and personal drive. ● Link men to the Community PLHIV network to promote experience sharing with other PLHIV to facilitate the support system. ● Empowerment through health talk understanding that HIV is a condition like any other condition like HTN, DM.
Self-Discovery	<ul style="list-style-type: none"> ● Adolescents 	<ul style="list-style-type: none"> ● Educate on adolescent awareness's (Contraceptives, dating, disclosure in dating. ● Educate on the benefits of adhering to treatment. ● Provide motivational counselling.
Substance abuse	<ul style="list-style-type: none"> ● Adolescents ● Young people ● People with mental health issues 	<ul style="list-style-type: none"> ● Enhanced adherence counselling. ● Educate clients on effect of substances while on treatment. ● Implement a specific escalation plan for counselling against substance use and ARVs efficacy. ● Refer to mental health nurse or psychologist for further counselling to assess reasons for substance use and support client as they try to stop substance abuse. ● Enhanced adherence counselling to identify factors influencing behaviour and how it affects treatment adherence. Furthermore, provide client-centered approaches to address them. ● Refer for rehabilitation where available. ● Refer to the support group for ongoing support.

Key issue identified	Affected population	Proposed intervention (What)
Financial challenges	<ul style="list-style-type: none"> ● ALL 	<ul style="list-style-type: none"> ● Inform client about available DSD models. ● Educate on income generating projects. ● Refer appropriately to community support groups(OVC support). ● Refer to DREAMS if available within the client's catchment area.
Mental health issues	<ul style="list-style-type: none"> ● Mental health clients ● Young people especial OVCs ● People with disabilities 	<ul style="list-style-type: none"> ● Use DSM5 checklist to assess for mental health issues. ● Provide counselling and manage the condition identified. ● Refer to psychiatric hospital if at clinic level. ● Schedule psychologist in teen clubs to address mental health issues . ● Provide ongoing support.
Religious & traditional barriers	<ul style="list-style-type: none"> ● ALL 	<ul style="list-style-type: none"> ● Counsel client on the disease progression and ART benefits. ● Build capacity for HCWs to address clients holding different traditional and religious beliefs. Equip HCWs on being culture/ religious sensitive. ● Sensitise the community on health education targeting men using community gatherings (soccer tournaments, traditional events). ● Refer and link according to escalation plan to address religious beliefs. ● Engage religious leaders on HIV literacy. ● Implement Faith and Community Initiatives (bringing comprehensive health services to churches using outreach sites).
High mobility due to work, school and other social reasons	<ul style="list-style-type: none"> ● Adolescents ● Young people ● Men 	<ul style="list-style-type: none"> ● Empower client to own their health, if client is not able honour the appointment, they should contact facility to request rescheduling. ● Educate and empower the client on refilling at another facility. ● Inform client about MMD and DSD. ● Provide a supportive and welcoming environment for visitors and silent transfers. ● Provide post-test counselling and ART readiness assessment before ART initiation on adherence to treatment and taking your treatment.

Key issue identified	Affected population	Proposed intervention (What)
		<ul style="list-style-type: none"> ● Educate clients to always carry their medication whenever you are traveling. ● Encourage clients to know their CMIS/ID number or have a photo of green book demographics and the last refill page to be able to refill in a close by the facility.
Fear of HIV Disclosure in new relationships	<ul style="list-style-type: none"> ● Women 	<ul style="list-style-type: none"> ● Empowerment through health talk about issues of re-infection, the importance of knowing the HIV status of your partner. ● Conduct motivational counselling and intrinsic stimulation to empower the client, stimulate positive living, and improve self-efficacy. ● Utilise index testing effectively to improve HIV disclosure and promote support from the other partner. ● Community PLHIV network linkage to CAGs to facilitate disclosure and find peers. ● Encourage HIV disclosure to closer relatives. ● Provide IEC messages for further reading to assist clients in understanding testing, and the importance of disclosure, and facilitate re-engagement in HIV care.
Fear of the loss of privacy (accidental disclosure)	<ul style="list-style-type: none"> ● Young people ● Women ● Men 	<ul style="list-style-type: none"> ● Utilise the supermarket approach to service delivery inform client that once they are established there are DSD models such as Lula meds where they can get their refills. ● Self-management empowerment to enable the client to cope with stigma and live positive lives. ● Motivational counselling for a positive outlook on life.

Annex 3.2 Interpersonal factors

Key issue identified	Affected population	Proposed intervention
Lack of disclosure	<ul style="list-style-type: none"> ● Children and adolescents ● Women 	<ul style="list-style-type: none"> ● Discuss importance and benefits of disclosure during counselling with caregiver. ● Facilitate disclosure by educating caregiver on how to disclose according to age of the child. ● Provide training on positive living and self-acceptance. ● Invite the partner/family and assist the client in disclosing to them. ● Where there is a need provide assisted disclosure counselling. ● Inform the client of available support.
Enacted Stigma	<ul style="list-style-type: none"> ● ALL 	<ul style="list-style-type: none"> ● Conduct health education sessions on the benefits of taking ART and being supportive to HIV positive clients. ● Implement client centred approaches to provide services guided by client's needs. ● Educate community including schools and teachers on benefits of taking ART. ● Educate community on being supportive. ● Testimonials through peer-to-peer support. ● Avoid discriminating the child by always pointing out HIV as the main issue. ● Refer the client to a social worker for further management and engagement of the family.
Caregiver attitude	<ul style="list-style-type: none"> ● Children & adolescents ● People with disabilities ● Mental health clients 	<ul style="list-style-type: none"> ● Caregiver treatment literacy empowerment and involvement. ● Always protect the child and prioritise the child's treatment and adherence . ● Refer the caregiver to a social worker or psychologist for counselling and support.
Gender based violence	<ul style="list-style-type: none"> ● Women ● Children and adolescents ● Clients with disability 	<ul style="list-style-type: none"> ● Sensitise family members on GBV. ● Encourage anonymous reporting. ● Conduct active follow-up/regular check-ins with the client at the home or place of safety to prevent repeated violations and re-disengagement to ART. ● Implement escalation plan for suspected cases. Involve a social worker or social welfare for assessment and intervention at the

Key issue identified	Affected population	Proposed intervention
		<p>home/community.</p> <ul style="list-style-type: none"> Refer clients to GBV services for further support.
Treatment Fatigue	<ul style="list-style-type: none"> Adolescents Young people Elderly 	<ul style="list-style-type: none"> Acknowledge that having treatment fatigue may happen if you are on chronic medication. Testimonial counselling and support through peer. Provide fixed dose combinations or transition to simplified regimens according to national guidelines. Educate on benefits of treatment continuity including U=U Escalate to psychologist where applicable.
Wrong contact details	<ul style="list-style-type: none"> ALL 	<ul style="list-style-type: none"> Verify contact details once a year for all clients. For clients who fail to honour appointments, verify contact details on return to the health facility.
Inaccurate Perception of HIV by Client	<ul style="list-style-type: none"> ALL 	<ul style="list-style-type: none"> Educate the client on the disease progression. Educate clients on treatment . Counsel client using the visual aids such as B-OK beads to promote understanding.
Contradicting Religious Beliefs	<ul style="list-style-type: none"> ALL 	<ul style="list-style-type: none"> Educate clients on the HIV disease progression. Provide IEC material for further reading. Educate community members on disease progression and the benefits of ART. Provide treatment literacy on benefits of ART.
Changing of caregivers	<ul style="list-style-type: none"> Children and adolescents People with disabilities Mental health clients 	<ul style="list-style-type: none"> Continuously educate the caregivers on how to care for the child. Use the caregiver manual. Educate caregivers on their responsibility as treatment supporters (reporting when the client changes caregivers, expires, transfers, etc). Support disclosure and self-management. Motivate the client & family to identify constant treatment supporter. Engage community health workers to support family in treatment continuity. Empower the AYP to manage treatment independently.
Poor relationship issues with healthcare	<ul style="list-style-type: none"> ALL 	<ul style="list-style-type: none"> Empower the clients to report (NONO, Suggestion box, Nurse managers, peer educators, etc.) negative attitudes received from healthcare workers.

Key issue identified	Affected population	Proposed intervention
provider		<ul style="list-style-type: none"> ● Educate HCWs to provide client specific services e.g., adolescent/KP friendly services. ● Encourage CSOs to give feedback to facilities on CLM results.
Lack of support system	<ul style="list-style-type: none"> ● Mental health clients ● Young people especially OVCs ● People with disabilities 	<ul style="list-style-type: none"> ● Intrinsic motivation assessment and provide motivational counselling. ● Enrol client into ELCM. ● Engage client to identify key family members for support. ● Refer client to community support groups for continuous support. ● Refer client using facility specific escalation plan. ● Engage caregivers and community health workers and educate on the importance of continuous support. ● Refer the client to a social worker for further support.
Caregiver literacy	<ul style="list-style-type: none"> ● Children ● Mental health patients ● People with disabilities 	<ul style="list-style-type: none"> ● Use ART readiness tool to provide counselling. ● Identify challenges and barriers provide one on one education sessions . ● Use of visual aids during counselling to improve understanding of the benefits of early ART, adherence, and suppression.

Annex 3.3 Community system factors

Key issue identified	Affected population	Proposed intervention (What)
Stigma and discrimination	<ul style="list-style-type: none"> ● ALL 	<ul style="list-style-type: none"> ● Raise awareness about stigmatising and discriminatory behaviours and their effects. ● Educate and inform community and family members on ART to support the elimination of stigma and discrimination. ● Provide targeted caregiver engagements.
Accidental Disclosure	<ul style="list-style-type: none"> ● ALL 	<ul style="list-style-type: none"> ● Educate HCWs (facility and community on good ethical practice). ● Encourage CHWs on procedures that promote confidentiality e.g., consent for home visits, using non branded cars for community commodity distribution, integration. ● Educate the client on the benefits of ART.

Annex 3.4 Health system factors

Key issue identified	Affected population	Proposed intervention (What)
Inflexible working hours of the facility	<ul style="list-style-type: none"> ● Adolescents ● Young people ● Men 	<ul style="list-style-type: none"> ● Have flexi hours for refills for AYPs (Early bird, late refills). ● Strengthen facilities' operating hours to 8-5 pm on operating days. ● Discuss and agree on the suitable DSD model preferred by the client. ● Optimise Automated Dispensing Machines in strategic areas. Where clients can be able to access their medication anytime.
Long waiting periods at the facility	<ul style="list-style-type: none"> ● Men ● Adolescents and young people 	<ul style="list-style-type: none"> ● Optimise patient flow to suit ART clients especially those re-engaging. ● Fast-tracking of clients that are in a hurry or going to school. ● Use the standardised triaging tool to enable Triaging and fast-tracking re-engaging clients. ● Escorting clients to the next service to ensure they are not lost in the process. ● Customer care (engaging the client whilst queuing, utilisation of sports and men's health magazines, TVs in waiting areas to entertain males (soccer, action movies)). ● Supermarket approach to test, initiate, and dispense in the same room or department in primary care facilities. ● Integrate HIV services with NCDs.
Transport (Poverty)	<ul style="list-style-type: none"> ● ALL 	<ul style="list-style-type: none"> ● Enrol more clients on other DSD models. ● Link client to community programs e.g., DREAMs program where possible. ● Empower clients to attend clinic visits closer to home.
Lack of population-friendly services	<ul style="list-style-type: none"> ● Men ● KPs ● Mental Health clients ● Children and adolescents ● Elderly 	<ul style="list-style-type: none"> ● Optimise Automated Dispensing Machines in strategic areas. Where clients can be able to access their medication anytime. ● Mobile clinics in strategic areas with flexible operating hours.

Key issue identified	Affected population	Proposed intervention (What)
Healthcare worker attitudes	<ul style="list-style-type: none"> ● ALL 	<ul style="list-style-type: none"> ● Ensure that exit interviews are well conducted for every tenth clients (depending on the client volume). ● Provide customer care trainings to HCWs frequently. ● Strengthen the use of suggestion boxes, to gather feedback from the recipients of care.
Excess pills	<ul style="list-style-type: none"> ● ALL 	<ul style="list-style-type: none"> ● Ensuring proper pill count to track adherence and pinpoint risks of disengagement. ● Encourage clients to come with the remaining medication/pills for effective pill count. ● Promote client self-management support for clients to do their pill count, which is verified during clinical visits randomly. ● Encourage clients to utilise tools like pill boxes to effectively track adherence to avoid the possibility of disengagement. ● Use digital platforms to remotely monitor adherence to identify clients struggling with adherence. ● Using CMIS to accurately calculate pill count and appointment date according to the pills the client has. ● Using standardised and proper guidelines for MMD to those who qualify.
Lack of standardised tools to aid smooth re-engagement	<ul style="list-style-type: none"> ● ALL 	<ul style="list-style-type: none"> ● Develop triaging tool to aid fast tracking of men and other priority populations. ● Develop standardised customer care training for HCW to equip them on how to engage men effectively. ● Develop standardised comprehensive counselling of PLHIV training manual that includes motivational counselling, enhanced adherence counselling, SUAC, intrinsic stimulation, self-management training manuals etc to empower men and promote autonomy.