Eswatini adopted the 95-95-95 strategy as part of the National Multisectoral HIV and AIDS Strategic Framework (NSF) 2018 – 2023 which calls for: identifying 95% of people living with HIV (PLHIV) knowing their HIV status; 95% of PLHIV who know their HIV status initiating and retaining on antiretroviral therapy (ART); and 95% of ART clients viral suppressed. Also, according to the Eswatini HIV incidence measurement survey 2 (SHIMS 2), the country has reduced new HIV infections by 44%. HIV testing has been scaled up in all entry point with 84.7% Emaswati knowing their HIV status. However, linkage to care and HIV prevention amongst key populations, children, adolescent girls and young women, pregnant women and men remain a challenge in the country. Few PLHIV diagnosed receive antiretroviral therapy (ART) within 7 days of diagnosis (rapid ART) in accordance with World Health Organization recommendations and not all people diagnosed HIV negative have access to prevention services. If the country is to achieve the 2nd and 3rd 95 as well as zero new HIV infections, linkage to HIV prevention including care and treatment of PLHIV testing HIV positive and those identified to have dis-engaged must be prioritized especially amongst the priority groups.

In recent years, evidence has shown that linkage case management is associated with an increase in ART initiation and increase in uptake of HIV prevention services. To achieve epidemic control of human immunodeficiency virus (HIV) infection, sub-Saharan African countries are striving to diagnose, link relevantly all clients diagnosed either HIV negative or HIV positive and ensure they are kept HIV negative and virally suppressed respectively. To improve HIV prevention and rapid ART for clients diagnosed in both facility and community settings in Eswatini, the MoH is implementing Linkage Case Management to ensure that majority of the people are linked into prevention and care services. This document will provide guidance to improve HIV linkages from community to facility, facility to community and from facility to facility which amongst other health outcomes will improve early ART initiation and retention as well as prevention of new infections.

I would like to take this opportunity to express gratitude for the technical and financial support from PEPFAR through CDC and WHO, and everyone who contributed to the development of this SOP. This will improve linkages both from facility and community.

Dr S.V. Magagula

DIRECTOR OF HEALTH SERVICES
FOREWORD
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ACKNOWLEDGEMENTS 5
ABBREVIATIONS AND ACRONYMS 6
KEY DEFINITIONS 8
BACKGROUND 10
RATIONALE FOR LINKAGE CASE MANAGEMENT 10
OBJECTIVE OF LINKAGE CASE MANAGEMENT STANDARD OPERATING PROCEDURE 11
BARRIERS TO ART INITIATION 111
LINKAGE CASE MANAGEMENT MODEL 12
GUIDING PRINCIPLES FOR LINKAGE CASE MANAGEMENT
Error! Bookmark not defined.

ELIGIBILITY CRITERIA FOR LINKAGE CASE MANAGEMENT 14
ROLES AND RESPONSIBILITIES OF A LINKAGE CASE MANAGEMENT OFFICER 14
CRITERIA FOR DISCHARGING CLIENTS FROM LINKAGE CASE MANAGEMENT 15
INTRA-FACILITY LINKAGE CASE MANAGEMENT – WITHIN THE SAME HEALTH FACILITY 16
DIFFERENT SCENARIOS FOR ART INITIATION - LINKAGE CASE MANAGEMENT 16

FACILITY LINKAGE CASE MANAGEMENT MODEL 18
CLIENT DELAYING ART INITIATION 20
  HTS Provider 20
  Expert Client/Mentor Mother 20
  Doctor/Nurse 20
INTER-FACILITY LINKAGE CASE MANAGEMENT – FROM ONE HEALTH FACILITY TO ANOTHER 27

COMMUNITY TO HEALTH FACILITY LINKAGE CASE MANAGEMENT 31
COMMUNITY LINKAGES CASE MANAGEMENT MODEL 31
RESPONSIBILITIES AT COMMUNITY LINKAGE CASE MANAGEMENT 32
  Strategy 1: Community outreach HIV testing (not initiating ART) 33
STRATEGIES FOR PRIORITY POPULATIONS LINKAGES CASE MANAGEMENT 35
  Children 36
  Adolescents 36
  Key populations 36
  Men 36
LINKAGE FOR THE HIV NEGATIVE CLIENTS 37

HIV negative client 37

MONITORING AND EVALUATION 38

ANNEXES 39

Annex 1- Barriers to ART Initiation 39
Annex 2- Scenario 1 40
Annex 3- Scenario 2 41
Annex 4- Scenario 3 42
Annex 5- scenario 4 43

REFERENCES 44
The HIV linkages case management SOP was developed by the linkages working group chaired by ENAP Referral and linkages coordinator and consisting of representatives from MoH and Supporting partners. The linkage working group is comprised representatives from the following organizations:

MOH - Eswatini National AIDS Program (ENAP) and SRH, President’s Emergency Plan for AIDS Relief (PEPFAR), World Health Organization, Joint United Nations Programme on HIV/AIDS(UNAIDS), Population Services International (PSI), University Research Co.LLC (URC), Elizabeth Glazer Pediatric AIDS Foundation (EGPAF), International Centre for AIDS Care & Treatment Program (ICAP), Swaziland Business Coalition on Health and AIDS (SWABCHA), NERCHA, MSF,

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| 18. Thabo Motsa, | 38. Mbongeni Magagula, SWABCHA |
| 20. John Myeni, | |
| M&amp;E unit | |
| SRH | |
| RHM | |</p>
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune-Deficiency Syndrome</td>
</tr>
<tr>
<td>ALHIV</td>
<td>Adolescents Living with HIV</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Treatment</td>
</tr>
<tr>
<td>CCF</td>
<td>Chronic Care File</td>
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<tr>
<td>CHW</td>
<td>Community Health Care Worker</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<tr>
<td>CEC</td>
<td>Community Expert Client</td>
</tr>
<tr>
<td>CMIS</td>
<td>Client Management Information System</td>
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<tr>
<td>CMM</td>
<td>Community Mentor Mother</td>
</tr>
<tr>
<td>EC</td>
<td>Expert client</td>
</tr>
<tr>
<td>ENAP</td>
<td>Eswatini National AIDS Program</td>
</tr>
<tr>
<td>HCW</td>
<td>Health Care Workers</td>
</tr>
<tr>
<td>HF</td>
<td>Health Facility</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immune Virus</td>
</tr>
<tr>
<td>HTS</td>
<td>HIV Testing Services</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>LCM</td>
<td>Linkages case Management</td>
</tr>
<tr>
<td>KP</td>
<td>Key Populations</td>
</tr>
<tr>
<td>MDT</td>
<td>Multi-Disciplinary Team</td>
</tr>
<tr>
<td>MM</td>
<td>Mentor mother</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NSF</td>
<td>National Multi-sectoral HIV and AIDS Strategic Framework</td>
</tr>
<tr>
<td>OPD</td>
<td>Out Patient Department</td>
</tr>
<tr>
<td>OIs</td>
<td>Opportunistic Infections</td>
</tr>
<tr>
<td>PEP</td>
<td>Post Exposure Prophylaxis</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>The President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PFA’s</td>
<td>Partner, Family and Associates</td>
</tr>
</tbody>
</table>
PIHTC   Provider Initiated HIV Testing and Counselling
PLHIV   People Living with HIV
PrEP    Pre -Exposure Prophylaxis
PLHIV   People Living with HIV
RHM     Rural Health Motivator
RHMT    Regional Health Management team
SHIMS   Swaziland HIV Incidence Measurement Survey
SOP     Standard Operation Procedure
STI     Sexually Transmitted Infection
TFO     Transfer out
UNAIDS  Joint United Nations Programme on HIV/AIDS
WHO     World Health Organization
VCT     Voluntary Counselling and Testing
WHO     World Health Organization
VMMC    Voluntary Medical Male Circumcision.
**KEY DEFINITIONS**

**Adolescents**: Refers to people aged 10-19 years

**Associate**: This refers to an approach led by HIV positive peer workers, who are trained to create and manage a “referral chain network.” The peer outreach workers (e.g. KP members), who is trained to engage new KP members in HIV testing and to identify other KP members to serve as “peer mobilizers.” Peer mobilizers, have undergone HIV testing (and, if HIV positive, are enrolled in treatment); they pass referral slips for HIV testing to members of their social or sexual networks.

**Children**: Refers to people aged 0-9 years

**Community referral**: This is a referral of a client made at community level by Community Health care worker (Rural Health Motivators/Community Expert Client /Community Mentor Mother) to the nearest health facility (clinic, health center, hospital)

**Facility referral**: This is a referral of a client made at health facility level by facility and health care workers within the same facility (Intra-facility) or to another health facility (inter facility) for care they do not have the capacity to provide.

**Intra Facility**: This is a referral made within different departments in the same facility.

**Inter facility**: This is referral made from one health facility to another health facility.

**HIV index case**: This is an individual diagnosed with HIV infection who draws attention to his/her sexual partner/injecting drug users, biological children below 15 years and associates for linkage to services.

**Index contact**: People who have had contact with the index case in a way which is associated with HIV transmission. It includes biological child(ren) <15 with an unknown status, partners and associates.

**Index case testing**: This refers to an approach focused on testing individuals in the social or sexual networks of index case, including children below the age of 15 years, sexual partners, needle-sharing partners, and other high-risk contacts. Index case testing describes the process of tracing and offering HIV testing services to the children, and partner(s) of both newly identified HIV infected individuals and those of already known HIV positive status; with a goal to identify those infected with HIV but are not aware of their infection or those with known HIV positive status not currently in HIV care.

**Linkage to Care and Treatment**: Is the process when the client has reached the facility and provided with care and treatment services he/she needs. The referring facility verify if client have arrived and was provided with services or the receiving facility gives feedback to the referring facility.
**Linkages case management:** Linkage case management (LCM) comprises the package of linkage services including; Individualized case management; treatment navigation and Index testing.

**Linkages Facilitator:** This is a Health Care Worker (Doctor, Nurse, HTS counsellor, Expert client, Mentor mother, Peer and Peer navigator) that is responsible for providing the package of evidence-based LCM services, enrolling HIV diagnosed client into ART care, and ensuring clients are retained on ART through their 2nd ART refill and ensure linkage to prevention services for clients that have tested negative.

**National Referral form:** This is a tool that is filled by health care workers (HCW) or community health care (CHW) worker when referring a client to another level of care to obtain care that is not provided at the initial level where help was sought.

**Referral:** This is the process of forwarding a client/patient to another service delivery point within the same health facility but different departments or to another health facility to get the possible care for that condition he/she has.

- **Active Referral:** An active referral begins with assessment and prioritization of a client’s immediate needs for medical and/or risk-reduction services. In an active referral, a client is provided with assistance in accessing referral services, such as setting up an appointment, escorting or being given transportation.

- **Passive Referral:** In a passive referral, a client is provided with information, such as agency name and location, about one or more referral services. It is then up to the client to make decisions about whether and which services to access and how to access them.

**Peer:** Person who belongs to the same age group or social group as someone else.

**Sexual partner:** A person with whom someone has had sex with. In the context of index testing, it refers to partner(s) one has had sexual contact with within the past 12 months.

**Stable clients:** Clients that have tested HIV positive without opportunistic infection.
Eswatini has a mature and generalized HIV epidemic primarily driven by heterosexual sex. According to the Eswatini HIV Impact Assessment Survey (SHIMS) of 2016/17, HIV prevalence among adults 15 years and older is 27.0%. However, women, with a prevalence of 32.5%, are disproportionately affected by HIV than men (20.4%). Prevalence among children is estimated at 2.8% (2.6% among females and 3.0% among males.

The Kingdom of Eswatini adopted the 95-95-95 strategy as part of the National Multi-sectoral HIV and AIDS Strategic framework to end HIV and AIDS by 2022 which calls for: Identifying 95% of people living with HIV (PLHIV) to know their HIV status. To achieve the second 95, the linking of PLHIV to ART and those testing negative for prevention package is important to improve linkages and hence reduce mortality.

According to NSF 2018-2023 there is sub-optimal linkage rates as not all PLHIV are effectively linked to treatment. About 84.7% of people living with HIV know their HIV status, however, 87.4% of those diagnosed with HIV are on ART. Linkages case management (LCM) is a strategy recommended for the improvement of linkages to treatment for identified HIV positive clients based on evidence that enrollment into HIV care was >90% of approximately 5,400 clients diagnosed in facility and community settings within a few days of diagnosis, and when operating under Test & Start policy, initiated ART.

Based on the evidence, This Standard Operating Procedure (SOP) presents critical scenarios for effectively linking clients to ART which are Intra, Inter facilities and from community to facility. The implementation of Linkage Case Management approach is crucial in reaching the 2nd 95. All LCM services included in this SOP are evidence-based linkage services recommended by the United States Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO).

Rationale for Linkage Case Management

Although HIV testing and treatment programs have increased access to ART remarkably, many People Living with HIV (PLHIV) still initiate ART late particularly those amongst young adult males and people diagnosed in the community. In Eswatini, less than one third of all persons who test positive in community settings enroll in HIV care within 6 months of diagnosis after receiving standard referral services. According to NSF 2018-2023 there is sub-optimal linkage rates as not all PLHIV are effectively linked to treatment especially those testing for HIV through community based models. Individuals testing positive at community level take time to seek services and when they do, they seek services in distant health facilities for privacy. There is also loss of newly diagnosed PLHIV referred from one service point to another or from one facility to another. ART initiation is not the same amongst PLHIV as indicated in the 2017 MoH HIV Programs report; key populations (sex workers and men having sex with men) only 8% (207/2576), pregnant women-93% which was a decline from 95% for 2016, children (0-14 years)-75% and above 15 was 86%. Provision of LCM has been seen to be
effective in Tanzania where it was being implemented and again in Eswatini where it was being piloted by PSI in community testing, in both countries more than 90% of PLHIV were linked into care\(^2,3,5\).

This LCM SOP was developed based on two successful combination prevention evaluations conducted in Eswatini and Tanzania during 2014 - 2018\(^2,3\).

**Objective of Linkage Case Management Standard Operating Procedure**

The objective of the linkage case management (LCM) SOP is to provide a set of nationally accepted procedures to improve rates of linkage to and retention in ART care.

- To ensure more than 95% of clients testing HIV positive are initiated on ART and retained through second ARV refill visit.
- To ensure more than 90% clients have disclosed to a partner, family member or associate.
- To ensure more than 50% of clients have at least one sexual partner or biologic child tested for HIV.
- To establish an M&E system to monitor and track the above LCM outcomes.
- To scale up linkages of HIV negative clients at substantive risk for HIV acquisition to HIV preventative services.
- To create a welcoming environment for patients who miss appointment and or interrupt treatment (defaulters, missed appointment and lost to follow up).

**Barriers to ART Initiation**

It is important to understand some factors recognized as barriers that affect linkages at facility level which include; Individual, Community and system factors\(^1,8,9\).
Linkages case management provides the package of CDC/WHO recommended evidence-based linkage services adapted to the local Eswatini context for new and previously HIV diagnosed PLHIV who are out of HIV care. PLHIV who enrolled into LCM (clients) are paired either with a peer navigator, expert client (EC), HTS counsellor, or mentor mother (Linkages Facilitator) from HIV diagnosis through the client’s 2nd ARV refill. Linkages facilitator provide the package of recommended services for up to 45-60 days for most clients. Linkage Case management services Package includes: Individualized case management, treatment navigation and Index testing

**Individualized Case Management Services**

- Minimum of three face-to-face structured counseling sessions between clients and their assigned linkages facilitator at pre-determined intervals
- Providing psychosocial support and informational & motivational counseling on the benefits of early enrollment in HIV care and initiating ART
- Regular telephone follow-up for appointment reminders, and psychosocial and informational support
- Encouraging and supporting disclosure of HIV status and testing of partners & biologic children (when appropriate)
- Assessing and resolving barriers to enrolling and remaining in HIV care
- Conducting high-priority defaulter tracing for clients that have missed their visit and provide intensified counselling

**Treatment Navigation Services**

The purpose of escort and treatment navigation is to facilitate same-day enrollment in care and ART initiation, and improve ART retention by making clients more knowledgeable and comfortable about ART care. Escorting of clients is not about policing the client however it should be explained to the client that it is to assist him/her to reach the next service point without experiencing challenges. Escorting is done during the first visit as per need

- Stay with and support the client throughout their entire first ART visit (depending on the client)
- Inform clients about the physical layout and all stations of care
- Introduce clients to key staff, including facility-based ECs if client is a referral from community
- Help clients understand what services to expect during their ART visits
- Answer questions about ART care, and prevent or mitigate negative experiences
• Inform clients about what to do and services to expect at their next visit
• Assist staff in providing adherence counseling
• Complete patient registers

**Index Client Testing**

Index testing is routinely offered as an extension of the case management session dedicated to discussing disclosure, partner & family testing. The expect Client is guided by program forms and documents. The Linkages facilitator assists clients with:

• Disclosure of HIV status  
• Eliciting for availability of spouses, other partners, family, and associates in need of testing and listing them  
• Acceptance of Index testing  
• Indicate outcomes of index testing

**Summary of Linkage case management services**
The Linkage Case Management approach in the kingdom of Eswatini is guided by three guiding principles of LCM which are:

1. All HIV-positive patients should be screened for eligibility and offered LCM if eligible
2. LCM is voluntary; all eligible patients are free to enroll and discontinue services
3. Ensuring that partners, family members, and associates of LCM clients are appropriately HIV diagnosed and linked to ART care
4. Focus on the patient concerns and priorities.
5. Team work is a key among clinicians, peers, lay staff, community workers, families and the patients themselves
6. Good communication at all stages of LCM implementation

Eligibility Criteria include;

Eligibility Criteria include;

All HIV-positive clients diagnosed in the facility, who are referred for Linkage Care Management services. These maybe HIV positive clients;

1. Newly diagnosed,
2. Previously HIV diagnosed, but have not received HIV care in the past 90 days
3. Who have defaulted and are returning to care as new clients.

Special attention must be focused on catering for priority groups which are infants, children below 15 years, adolescents, men, pregnant women, Patients with advanced disease and key populations.

The Linkages facilitator is responsible for providing linkage case management through the following activities.

- Establishes rapport and explains program services and duration
- Conduct initial pre-screening of clients to Determine client eligibility to receive LCM
- Verifies previous HIV testing history and prior enrollment in ART care
- Explains case management processes
- Develop LCM management plan with the client
- Exchanges and verifies phone numbers
- Documents detailed physical address
- Explores and establishes convenient days and times for follow-up calls and document preference
- Provides and documents all LCM linkage services in accordance with this SOP
- Inform the client that if they miss a visit or defaulted that another health care worker will track them.

**NB:** Where possible the linkage Facilitator must have the same characteristics (age, sex, gender) with the client and allocation of clients to linkages facilitator must be balanced between stable and unstable clients.

### Criteria for Discharging Clients from Linkage Case

Client will be discharged if all of the following have been completed and documented in the chronic care file (CCF)/Client management information system (CMIS) CCF/CMIS. Otherwise LCM can continue with supervisory approval:

- Client has been initiated on ART and received their 1\textsuperscript{st} and 2\textsuperscript{nd} ARV refills on time
- Client has disclosed status to a partner, family member, or associate.
- Client is 100\% adherent to treatment and has been on time for scheduled appointments, and is not at high risk for defaulting from ART care
This is referral made within different departments in the same facility. A client testing positive in any testing entry points should be enrolled into Facility based Linkage Case Management and a client testing HIV negative should be actively referred for HIV prevention services. There are different scenarios for ART initiation and health facilities should choose what is relevant to their situation depending on the availability of the different personnel cadres in the facility. There are different scenarios in facilities as outlined below:

### Different Scenarios for ART initiation in intra-facility LCM

1. **Initiating ART in the same consulting room as the HIV diagnosis (Annex 2)**
   - HIV testing is done by Nurse and clients testing HIV positive is initiated by the Nurse/Doctor.
   - After ART initiation, the nurse assigns client to a linkages facilitator who then assist the client with
     - Psychosocial counselling
     - Address barriers to adherence
     - Discuss importance of disclosure including index testing
     - Navigate treatment including refills.
   - In health facilities with multiple HTS entry points, ART initiation to be done by Nurse/Doctor in the respective units.

2. **Initiating ART in the different consultation room within Outpatient Department (Annex 3)**
   - HIV testing is done by HTS counsellor, who opens chronic care file for the client that is HIV positive.
   - HTS counsellor hand over client to linkages facilitator, an EC’s if available who then assist the client with
     - Psychosocial counselling
     - Address barriers to adherence
     - Discuss importance of disclosure including index testing
     - Navigate treatment including refills.
   - After assisting client, the EC escort HIV Positive client to ART initiation room.
   - The client is initiated by the nurse or doctor, after ART initiation the nurse assigns client to linkages facilitator
3. Initiating ART at a co-located ART Clinic/VCT. (Annex 4)

- HIV testing done by HTS counsellor who opens chronic care file for client testing HIV positive
- HTS counsellor/Nurse refer client to EC who escort HIV positive client to co-located ART/VCT unit for ART initiation.
- On Arrival at co-located ART clinic, client is fast tracked into the consultation room for ART initiation.
- After ART initiation the nurse or doctor then assign client to linkages facilitator who then assist the client with
  - Psychosocial counselling
  - Address barriers to adherence
  - Discuss importance of disclosure including index testing
  - Navigate treatment including refills

4. Initiating ART at the Inpatient Department (Annex 5)

- HIV testing is done by the nurse /HTS counsellor who opens the chronic care file for the patient who test HIV positive
- The nurse/HTS counsellor refers client testing positive to the Nurse/Doctor who initiates patient on ART.
- The client is discharged via the ART/VCT unit to be assigned a Linkages facilitator who then assist the client with
  - Psychosocial counselling
  - Address barriers to adherence
  - Discuss importance of disclosure including index testing
  - Navigate treatment including refills

Facility based Linkage Case Management division of labor

Overall, the nursing manager and or focal person is responsible for ensuring that linkages case management is done in the health facility. There are different scenarios in the facilities and the approach is outlined below

NB:

Facilities with Nurse only: The nurse will be the linkages facilitator

Facilities with HTS counsellor & Nurse: The HTS counsellor will be the Linkages Facilitator

Facilities with nurse and EC’s: Linkage Facilitator will be the EC

Facilities with both EC and mentor mother and nurse: Both EC and mentor mother will be linkages facilitator; the EC will be responsible for general population while the mentor mother will be responsible for pregnant and lactating women and under-fives through their caregivers/parents.
Linkage Case Management is implemented for 60 – 90 days. It begins with the 1st health care visits for the newly diagnosed or the day the dis-engaged client returning to care is identified. The linkage case Management process is outlined in detail below.
Day Zero (HIV-diagnosis & first clinic visit (ART initiation))

**Personnel:** Doctor, Nurse, HTS provider, Expert client.

**Location:** HIV counseling room, HIV treatment room, Adherence Counselling room

**When:** During post-test session (Nurse/HTS counselor), at ART initiation (Doctor/Nurse), at adherence room (expect Client)

**Tools:** Linkages Case Management logbook, Index testing logbook, Chronic Care Files (hard copy/electronic in the Client Management Information System), National Referral book, Index Invitation Slip, , Appointment book, Monthly reporting forms (may be modified to report on LCM services).

All Clients testing HIV positive including those eligible for advanced disease package must be referred to clinician regardless of readiness to initiate ART. Clients initiating ART must be fast tracked in day zero to reduce waiting time

**Day Zero responsibilities**

### Clients initiation

<table>
<thead>
<tr>
<th>HTS Provider</th>
<th>Expert Client/Mentor Mother</th>
<th>Doctor/Nurse</th>
<th>Client</th>
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</thead>
<tbody>
<tr>
<td>o Assess coping with HIV diagnosis, and explain importance of linkage to ART</td>
<td>o Escort client to ART clinic and facilitate registration for ART care.</td>
<td>o Conduct HIV retesting for verification according to the national guidelines</td>
<td>o To ensure s/he understands whole process</td>
</tr>
<tr>
<td>o Document detailed client contact information both cellphone number and physical address in the Chronic Care Files/CMIS</td>
<td>o Provide face-to-face counseling sessions on the benefits of early enrollment in care and ART, disclosure and testing of PFAs/index testing.</td>
<td>o Review for ART initiation barriers</td>
<td>o Client should present their concerns, if any (maybe medical or social)</td>
</tr>
<tr>
<td>o Provide motivational counseling and information including the benefits of early ART initiation</td>
<td>o Provide motivational and informational counseling, including personal testimonials</td>
<td>o Same day initiation for patients who are eligible</td>
<td>o Return for follow-up/management</td>
</tr>
<tr>
<td>o Provide counseling on disclosure and testing of Partner, Family and Associates (PFAs).</td>
<td>o Conduct ART readiness assessment using the standardized tool and document.</td>
<td>o Explain treatment to patient</td>
<td>o Report any symptoms, side effects etc</td>
</tr>
<tr>
<td>o Ask about and list all PFAs that are available and who would benefit from testing (i.e. live within the catchment area of the facility or will visit the area before case closure)</td>
<td>o Open chronic care file and document eligibly all fields</td>
<td>o Document client in ART register/enter client in CMIS/APMR</td>
<td>o Call linkages facilitator if they will not be able to attend the scheduled appointment for rescheduling</td>
</tr>
<tr>
<td></td>
<td>o Navigate client across services (e.g. triage, clinical consultation, laboratory, etc.).</td>
<td>o Appoint client to be reviewed in 14 days</td>
<td>o Contact your health care provider right away if you experience or observe anything you familiar with</td>
</tr>
<tr>
<td></td>
<td>o Document the assigned case in the case management logbook</td>
<td>o Assign and introduce Linkage facilitator for all client</td>
<td></td>
</tr>
</tbody>
</table>
- Offer partner notification services for testing as per HTS guidelines
- Document the client in the linkage logbook/CMIS
- Introduce client to the ECs/MM/Nurse.
- Follow up with the client’s outcome and document ART number in the HTS register and linkages logbook/CMIS

<table>
<thead>
<tr>
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<th>Expert Client/Mentor Mother</th>
<th>Doctor/Nurse</th>
<th>Client</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Document detailed client contact information both cellphone number and physical address in the Chronic Care Files/CMIS</td>
<td>o Document detailed client contact information both cellphone number and physical address in the Chronic Care Files/CMIS</td>
<td>o Review and resolve identified ART initiation barriers reported by expert client</td>
<td>o To ensure s/he understands whole process</td>
</tr>
<tr>
<td>o Provide motivational counseling and information including the benefits of early ART initiation</td>
<td>o Provide motivational counseling and information including the benefits of early ART initiation</td>
<td>o Emphasize on the benefits of ART and early enrolment to treatment</td>
<td>o Client should present their concerns, if any (maybe medical or social)</td>
</tr>
<tr>
<td>o Document the client in the linkage logbook/CMIS</td>
<td>o Document the client in the linkage logbook/CMIS</td>
<td>o Document the client in the PRE-ART register/CMIS and appoint in the appointment register which is 14 days</td>
<td>o Return for follow-up/management</td>
</tr>
<tr>
<td>o Escort client to the nurse/doctor.</td>
<td>o Escort client to the nurse/doctor.</td>
<td>o Assign and introduce a Linkage facilitator for follow up of client</td>
<td></td>
</tr>
<tr>
<td>o Refer client to be reviewed by nurse or doctor and provide intensified counselling</td>
<td>o Refer client to be reviewed by nurse or doctor and provide intensified counselling</td>
<td>o Adolescent Delaying ART must be referred to peer for further counselling (where applicable)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Refer client to be reviewed by nurse or doctor and provide intensified counselling</td>
<td>o Children denied care by parents/guardian, refer client to social worker</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Appoint client in the appointment register for follow up calls and further</td>
<td>o If client is still hesitant the client must be booked for another session of further counselling</td>
<td></td>
</tr>
</tbody>
</table>
Clients refusing to be escorted give clear directions and complete the intra facility referral form. Give the name of receiving health care worker.

counselling sessions

---

**DAY 3-5: FIRST TELEPHONIC CALL**

*Personnel:* Linkages Facilitator (Expert client, HTS provider, Nurse)

*Location:* Adherence room, HIV treatment, Counseling Room,

*Application of Linkage Case Management:* Follow up session after initial HIV clinical visit

*Tools:* Chronic Care Files/ CMIS, Cell phone, Call logs, Case management logbook

**NB:** During the phone call First ascertain if it is the right client and convenient time, if yes proceed and if no reschedule

*During telephone call:*

<table>
<thead>
<tr>
<th>Linkages Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clients initiated on ART</strong></td>
</tr>
<tr>
<td>o Assess coping with ART treatment</td>
</tr>
<tr>
<td>o Ask if client is having someone providing support</td>
</tr>
<tr>
<td>o Ask if they have any challenges they are experiencing with regards to treatment and assist them if possible</td>
</tr>
<tr>
<td>o Provide motivational and informational counseling, including personal testimonials.</td>
</tr>
<tr>
<td>o Remind client of their next review date</td>
</tr>
<tr>
<td>o Record the call in the call log as needed and update in the chronic care file.</td>
</tr>
</tbody>
</table>
DAY 10 - 12: SECOND TELEPHONIC CALL

**Personnel:** Linkages Facilitator (Expert client, HTS provider, Nurse)

**Location:** Adherence room, Counseling Room, HIV treatment

**Application of Linkage Case Management:** Follow up session after initial HIV clinical visit

**Tools:** Chronic Care Files/CMIS, Cell phone, Call logs, Case management logbook, appointment register

**NB:** During the phone call, first ascertain if it is the right client and convenient time, if yes proceed and if no reschedule. Linkage Client Management officer to inform their clients to request for the Linkages Facilitator at the first visit.

**During telephone call:**

<table>
<thead>
<tr>
<th>Linkages Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clients initiated on ART</strong></td>
</tr>
<tr>
<td>- Assess coping with treatment and side effects</td>
</tr>
<tr>
<td>- Remind clients to bring index contacts for testing</td>
</tr>
<tr>
<td>- Provide motivational and informational counseling, including personal testimonials</td>
</tr>
<tr>
<td>- Allow the client to ask questions</td>
</tr>
<tr>
<td>- Remind client about next appointment date.</td>
</tr>
<tr>
<td>- Ask the client if they have any specific topic to discuss in the next appointment</td>
</tr>
<tr>
<td>- Record the call in the call log as needed and update in the chronic care file.</td>
</tr>
</tbody>
</table>
DAY 14: FIRST CLINIC VISIT (1st ARV REFILL)

**Personnel:** Expert client, Nurse, Doctor

**Location:** HIV treatment consultation room, Adherence room

**When:** During 1st ARV Refill visit, follow-up visit for those clients not on ART

**Tools:** Chronic Care Files/ CMIS, appointment book, Case management logbook, index logbook

On the day of the client’s first ARV refill (First refill clients must be fast tracked in the facility for the first refill visit). Congratulate and appreciate client for honoring appointment

**NB:** The goal for clients delaying ART initiation is to be initiated within 14 days (except those delaying due to OIs such as cryptococcal meningitis and TB)

**NB:** For clients who have not missed appointment:
- Congratulate and appreciate client for honoring appointment
- Fast track client in the facility for the first refill and inform client that during other visits they will join the queue.

**NB:** For Clients who missed appointment:
- Follow guidance on the management of missed appointment as stipulated in the appointment register (add steps)
- On return congratulate client for coming back and discuss the importance of honoring appointments and provide intensified counselling
- Assess challenges they are experiencing and assist them to resolve them
- Discuss the importance of honoring appointments

**Day 14 responsibilities**

**Client initiated on ART**

<table>
<thead>
<tr>
<th>Expert Client/Mentor Mother</th>
<th>Doctor/Nurse</th>
<th>Client</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Retrieve clients chronic care file</td>
<td>o Review baseline results</td>
<td>o To ensure s/he understands whole process</td>
</tr>
<tr>
<td>o Review disclosure progress (and as needed continue with counseling)</td>
<td>o Assess for side effects and adherence and document accordingly</td>
<td>o Client should present their concerns, if any (maybe medical or social)</td>
</tr>
<tr>
<td>o Follow up on eliciting new Index contacts</td>
<td>o Emphasize the importance of index testing Partners, biological children and associates.</td>
<td>o Return for follow-up/management</td>
</tr>
<tr>
<td>o Conduct pill count and document in CCF</td>
<td>o Emphasize the importance of treatment adherence and honoring appointments the importance of viral load monitoring and TB Prevention Therapy</td>
<td>o Report any symptoms, side effects etc. they experience</td>
</tr>
<tr>
<td>o Assess barriers to ART adherence</td>
<td>o Emphasize HIV prevention core messages and link to other health care services</td>
<td>o Call linkages facilitator if they will not be able to attend the scheduled appointment for rescheduling</td>
</tr>
<tr>
<td>o Address any concerns raised by the client</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Review and conduct HIV prevention counselling and positive living
List contacts for index and submit list to HTS for follow up
Provide motivational and informational counseling as needed, including personal testimonials on benefits of treatment adherence
Appoint client in the appointment register

Document in CCF, CMIS/APMR
Refill and give appointment date which is 2 weeks
Once the client has refilled, Reappoint client in the appointment register/CMIS

Clients delaying initiation on ART

<table>
<thead>
<tr>
<th>Expect Client/Mentor Mother</th>
<th>Doctor/Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Continue assessing and resolving barriers to ART initiation</td>
<td>o Conduct client’s readiness assessment</td>
</tr>
<tr>
<td>o Refer client to be reviewed by nurse or doctor and provide intensified counselling</td>
<td>o Address client’s immediate concerns and questions</td>
</tr>
<tr>
<td>o Update contacts for patients both physical and cellphone number</td>
<td>o Review and resolve previously identified barriers</td>
</tr>
<tr>
<td>o Update documentation in the linkages form</td>
<td>o Provide the PRE-ART service package</td>
</tr>
<tr>
<td>o Appoint client in the appointment register for follow up calls and further counselling sessions</td>
<td>o Emphasize on the benefits of ART and early enrolment to treatment</td>
</tr>
<tr>
<td>o Continue to counsel clients on the benefits of ART initiation</td>
<td>o Discuss and explain HIV disease progression with the client</td>
</tr>
<tr>
<td></td>
<td>o Document the client in the PRE-ART register and in the appointment register</td>
</tr>
<tr>
<td></td>
<td>o Clients still refusing ART initiation, should be referred to another colleague or to Social worker or Psychologist</td>
</tr>
<tr>
<td></td>
<td>o In case of adolescents refer for peer to peer counselling where possible</td>
</tr>
</tbody>
</table>

Day 21-29: Third telephonic call

**Personnel:** Linkages Facilitator. (Expert client, HTS provider Nurse)

**Location:** Counseling Room, HIV treatment, Adherence room

**When:** During Follow up session after initial HIV clinical visit

**Tools:** Chronic Care Files/ CMIS, Cell phone, Call logs, Case management logbook

**NB:** During the phone call First ascertain if it is the right client and convenient time, if yes proceed and if no reschedule

**During telephone call:**

<table>
<thead>
<tr>
<th>Linkages Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients initiated on ART</td>
</tr>
<tr>
<td>o Assess coping with ART treatment</td>
</tr>
<tr>
<td>o Review disclosure plans and assess progress</td>
</tr>
</tbody>
</table>
Trouble shoot immediate concerns regarding disclosure
Review testing plans and schedule testing for index testing
Provide motivational and informational counseling, including personal testimonials.
Assess coping and adherence, assess disclosure plans/outcomes, and testing of index; troubleshoot concerns and barriers to care
Record the call in the call log as needed and update in the chronic care file.

Troubleshoot concerns and barriers to care
Provide motivational and informational counseling, including personal testimonials on importance of early ART initiation.
Record the call in the call log as needed and update in the chronic care file.

DAY 30-45: SECOND CLINIC VISIT (2nd ARV REFILL)

**Personnel:** Doctor, Nurse, Expert client (Linkages Facilitator).
**Location:** HIV treatment consultation room, Adherence room
**When:** During 2nd ARV Refill visit, follow up visit for those clients not on ART
**Tools:** Chronic Care Files/ CMIS, appointment book, Case management logbook, index logbook

**Clients initiated on ART**

<table>
<thead>
<tr>
<th>Expert Client/Mentor Mother</th>
<th>Doctor/Nurse</th>
<th>Client</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Retrieve clients chronic care file</td>
<td>o Assess for side effects and adherence and document accordingly</td>
<td>o To ensure s/he understands whole process</td>
</tr>
<tr>
<td>o Review disclosure progress (and as needed continue with counseling)</td>
<td>o Emphasize the importance of Index testing</td>
<td>o Client should present their concerns, if any (maybe medical or social)</td>
</tr>
<tr>
<td>o Follow up on eliciting index contacts</td>
<td>o Emphasize the importance of treatment adherence and honoring appointments including the importance of viral load monitoring and TB Preventive Therapy</td>
<td>o Return for follow-up/management</td>
</tr>
<tr>
<td>o Conduct pill count and document in Chronic Care File (CCF)</td>
<td>o Refill and give appointment date which is 30 days</td>
<td>o Report any symptoms, side effects etc</td>
</tr>
<tr>
<td>o Assess barriers to ART adherence</td>
<td>o Once the client has refilled, Reappoint client in the appointment register/CMIS</td>
<td>o Call linkages facilitator if they will not be able to attend the scheduled appointment for rescheduling</td>
</tr>
<tr>
<td>o Address any concerns raised by the client</td>
<td></td>
<td>o Contact your health care provider right away if you experience or observe anything you familiar with</td>
</tr>
</tbody>
</table>
Clients delaying initiation on ART

<table>
<thead>
<tr>
<th>Expect Client/Mentor Mother</th>
<th>Doctor/Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Assess barriers to ART initiation</td>
<td>o Discuss lab results and disease progression</td>
</tr>
<tr>
<td>o Refer client to be reviewed by nurse or doctor and provide intensified counselling</td>
<td>o conduct client’s readiness assessment</td>
</tr>
<tr>
<td>o update contacts for patients both physical and cellphone number</td>
<td>o address client’s immediate concerns and questions</td>
</tr>
<tr>
<td>o Update documentation in the linkages form</td>
<td>o Review and resolve previously identified barriers</td>
</tr>
<tr>
<td>o Appoint client in the appointment register for follow up calls and further counselling sessions</td>
<td>o Provide the PRE-ART service package</td>
</tr>
<tr>
<td>o If still client has missed/defaulted visit they should be referred to CEC/CMM/RHM for follow up</td>
<td>o Emphasize on the benefits of ART and early enrolment to treatment</td>
</tr>
<tr>
<td>o Continue to discuss the benefits of ART initiation</td>
<td>o Document the client in the PRE-ART register and in the appointment register</td>
</tr>
<tr>
<td></td>
<td>o Clients still refusing ART initiation, should be referred to another colleague or to Social worker or Psychologist</td>
</tr>
</tbody>
</table>

Day 44 - 60: Fourth telephonic call

**Personnel:** Nurse, HTS provider, Expert client (Linkages Facilitator).

**Location:** Counseling Room, HIV treatment, Adherence room

**When:** During Follow up session after initial HIV clinical visit

**Tools:** Chronic Care Files/ CMIS, Cell phone, Call logs, Case management logbook

**NB:** During the phone call First ascertain if it is the right client and convenient time, if yes proceed and if no reschedule

**During telephone call:**

<table>
<thead>
<tr>
<th>Linkage Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clients initiated on ART</strong></td>
</tr>
<tr>
<td>o Assess coping with ART treatment</td>
</tr>
<tr>
<td>o Review disclosure plans and assess progress</td>
</tr>
<tr>
<td>o Troubleshoot immediate concerns regarding disclosure</td>
</tr>
<tr>
<td>o Review testing of plans and schedule testing for index testing</td>
</tr>
<tr>
<td>o Provide motivational and informational counseling, including personal testimonials.</td>
</tr>
<tr>
<td>o Assess coping and adherence, assess disclosure plans/outcomes, and elicit new index contacts; troubleshoot concerns and barriers to care</td>
</tr>
<tr>
<td>o Record the call in the call log as needed and update in the chronic care file.</td>
</tr>
</tbody>
</table>
**Personnel:** Doctor, Nurse, Expert client (Linkages facilitator).
**Location:** HIV treatment consultation room, Adherence room
**When:** During 2nd ARV Refill visit and those clients not on ART
**Tools:** Chronic Care Files/ CMIS, appointment book, Case management logbook, index logbook

<table>
<thead>
<tr>
<th>Expect Client/Mentor Mother</th>
<th>Doctor/Nurse</th>
<th>Client</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Assess disclosure and testing of index contacts</td>
<td>o Assess for side effects and adherence</td>
<td>o To ensure s/he understands whole process</td>
</tr>
<tr>
<td>o Follow up on eliciting index contacts</td>
<td>o Review disclosure status and testing of index contacts</td>
<td>o Client should present their concerns, if any (maybe medical or social)</td>
</tr>
<tr>
<td>o Conduct pill count and assess for ART adherence.</td>
<td>o Update status of index contacts</td>
<td>o Return for follow-up/management</td>
</tr>
<tr>
<td>o Provide motivational and informational counseling, including personal testimonials.</td>
<td>o Document all findings in the CCF</td>
<td>o Report any symptoms, side effects etc</td>
</tr>
<tr>
<td>o Update contacts for patients both physical and cellphone number</td>
<td>o Refill for client and give appointment date which is 30 days</td>
<td>o Call linkages facilitator if they will not be able to attend the scheduled appointment for rescheduling</td>
</tr>
<tr>
<td>o Call and document outcome in the linkage’s logbook and update in the chronic care file.</td>
<td></td>
<td>o Contact your health care provider right away if you experience or observe anything you familiar with</td>
</tr>
<tr>
<td>o Graduate client from linkages and case management program if not at high risk for defaulting from ART care and 100% adherent.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Congratulate client on achievement and confirm availability to discuss and help the client if they have challenges in the future</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Inter-facility linkage case management – from one health facility to another**

This is referral made from one health facility to another health facility. HIV testing is done by HTS provider who opens chronic care file/ CMIS for client testing HIV positive and then refer client to nurse or doctor who initiate client on ART, complete referral form for client and give completed form to client. After ART initiation the nurse or doctor then assign client to a Linkages facilitator who then assist the client with psychosocial counselling, navigate treatment including refills, address barriers to adherence, discuss importance of disclosure, index testing and set up appointment for client in the preferred health facility. Clients testing HIV negative must be actively referred to HIV prevention services.

**NB:** The Linkages facilitator must ensure that the client is linked to care and then hand over the follow up of the client to the facility to which the client is referred to. After hand over of client, the Linkages facilitator must complete linkage form and HTS register or update linkage outcomes in Client Management Information System.

Inter – facility Linkage Case Management is implemented on day zero before the client is transferred out (TFO) of the health facility where the newly diagnosed HIV positive client or PLHIV client who has dis-
engaged are identified. The subsequent linkage case management processes including clinical visit, follow-up calls and other follow-ups are undertaken by the linkages facilitator in the facility where the client is referred to.

**Day zero: Referral to another facility**

**Personnel:** Doctor, nurse, linkages facilitator  
**Location:** HIV treatment consultation room  
**Application of Linkage Case Management:** Same day referral for clients who have initiated or want to be initiated in another facility  
**Tools:** Chronic Care Files/CMIS, appointment book, Case management logbook, index logbook, National Referral book

**Key considerations before referring a client from one health facility to another**

1. ART initiation should happen before referral for clients who agree to be initiated.  
2. Patient should be referred to their preferred facility after the first clinical visit (14 days).  
3. Patient unwilling to initiate ART in the health facility where they were diagnosed HIV positive should be directly referred by the HTS provider to a nurse or doctor for further intensified counselling. If client still not ready to initiate ART, client should be referred to facility of their choice for ART initiation.  
4. Document outcomes in the HTS register and linkage form or update linkage outcomes in Client Management Information System  
5. Obtain contacts for patients both physical address and cellphone number  
6. Complete referral form including date patient was tested or identified as dis-engaged and status of client  
7. Obtain date when client will visit facility to which s/he is referred.  
8. Call the facility to set up appointment for the client  
9. Make a follow up call to the facility to which the client is referred to ensure if the client has reached facility and document outcome in the HTS/linkages logbook  
10. Client must be informed that if they have not honored the appointment, they will be reminded on their cell phone and if they continue not honoring appointment a home visit will be done  
11. If client has missed their appointment, client should be called on their cellphone numbers and or that of their treatment supporter in the event the client is not reachable.  
12. If still client has not reached facility to which s/he was referred within 14 days of their appointment, the client should be referred to Community Expert Client/Community Mentor Mother/Rural Health Motivator for follow up.

**Responsibility of referring facility**
**NB:** Health facility referring client must understand the needs of the client and ascertain if services are available at the facility where the client is being referred to. Set appointment for the client so that the receiving facility is made aware when they should expect the client. Comprehensively document services provided for the client in the National Referral form. Explain to the client the importance of linkage.

---

**For clients referred after the first clinical visit**

<table>
<thead>
<tr>
<th>Linkages facilitator (Nurse/Expect Client/Mentor Mother )</th>
<th>Doctor/Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Assess disclosure and testing of index contacts</td>
<td>o Collect history and conduct physical assessment</td>
</tr>
<tr>
<td>o Follow up on eliciting index contacts</td>
<td>o Review pending lab results</td>
</tr>
<tr>
<td>o Assess and troubleshoot barriers to care.</td>
<td>Assess for side effects and adherence</td>
</tr>
<tr>
<td>o Conduct pill count and assess for ART adherence.</td>
<td>o Review disclosure status and testing of index contacts</td>
</tr>
<tr>
<td>o Provide motivational and informational counseling, including personal testimonials.</td>
<td>o Update status of index testing</td>
</tr>
<tr>
<td>o Update contacts for patients both physical and cellphone number</td>
<td>o Document all findings in the CCF / CMIS</td>
</tr>
<tr>
<td>o Discuss with their client their preferred facility for transfer and agree on a date the patient will visit the preferred facility</td>
<td>o Refill for client</td>
</tr>
<tr>
<td>o Make a follow up call to the client 3 days prior to the agreed date for visiting the preferred facility to remind client of the appointment</td>
<td>o Fill out referral form and set up an appointment with the preferred facility after agreeing on the date the patient will visit the preferred facility</td>
</tr>
<tr>
<td>o Call the preferred facility a day after the agreed date to ensure the client honored the appointment and document outcome in the linkage’s logbook and update in the chronic care file.</td>
<td></td>
</tr>
</tbody>
</table>
Responsibilities at receiving facility

NB: All facilities receiving referred clients should call the referring facility to give feedback and document in the feedback slip. Clients should be allocated a linkages facilitator who continue to assist the client with psychosocial counselling, navigate treatment including refills, address barriers to adherence, discuss importance of disclosure, index testing and subsequent linkage case management activities which are as follows; follow up calls on days 3-5, 10 – 12, 21-2930, 44 – 60 and clinical visit on days 14, 30-45 and 60-75.

**EC/MM/ Health Care Worker who receives the client should provide APS package. Receiving health facility should provide feedback to the referring facility on clients either initiated at referring facility and not initiated.**

<table>
<thead>
<tr>
<th>EC/MM/Nurse/Doctor</th>
<th>Clients initiated ART at referring health facility</th>
<th>Clients not initiated at referring facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Congratulate client for honoring visit/appointment</td>
<td>○ Conduct HIV retesting for verification according to the national guidelines</td>
<td></td>
</tr>
<tr>
<td>○ Assess for side effects and adherence and document accordingly</td>
<td>○ Congratulate client for honoring visit</td>
<td></td>
</tr>
<tr>
<td>○ Introduce the importance of viral load monitoring and TB Preveative Therapy</td>
<td>○ Review and resolve previously identified barriers</td>
<td></td>
</tr>
<tr>
<td>○ Review and resolve previously identified barriers</td>
<td>○ Emphasize on the benefits of ART and early enrolment to treatment</td>
<td></td>
</tr>
<tr>
<td>○ Follow up on eliciting index contacts</td>
<td>○ Document client in the appointment register</td>
<td></td>
</tr>
<tr>
<td>○ Document client in ART register CMIS</td>
<td>○ Assign and introduce a Linkages facilitator for all client</td>
<td></td>
</tr>
<tr>
<td>○ Document client in the appointment register</td>
<td>○ Document the client in the, CMIS and in the appointment register</td>
<td></td>
</tr>
<tr>
<td>○ Assign and introduce a Linkages facilitator for all client</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
This is a referral of a client testing HIV positive at community level by Community Health care worker (HTS counsellor/CEC/peer navigator/CMM/ RHM) or outreach service to the nearest health facility (clinic, health center, hospital). PLHIV are paired/assigned with a community peer expert client (EC) or counselor (Linkages facilitator) from HIV diagnosis through the client’s 2nd ARV refill or second clinical visit. Linkages facilitator provide the package of recommended services for approximately 45-60 days for most clients (Figure2). The length of LCM and package of linkage services for community clients are the same as that for facility clients. Linkages facilitator must inform the client that if they miss the visit they will be called on their mobile phone or call next of kin/treatment supporter however if not available, home visit will be done by the community health care worker. Client testing HIV negative should be actively referred to HIV prevention services.

Community to Health Facility Linkage case management is implemented in in two strategies which are:
1) HIV testing only without community ART initiation
2) HIV testing with community ART initiation

NB: The Linkages facilitator must ensure that the client is linked to care and then hand over the follow up of the client to the facility to which the client is referred to. The community Case Management model is detailed in the figure 2 below
Community Linkage Case Management is implemented on day zero for the newly diagnosed HIV positive and PLHIV who have dis-engaged are identified. Client is referred to the nearest or preferred health facility where the subsequent linkage case management processes including clinical visit, follow-up calls and other follow ups are undertaken.

Day zero; referral of HIV positive client

**Personnel:** HTS provider, Nurse, Peer Navigators, Community Expert client (Linkages facilitator).

**Location:** HTS service point, consultation points

**When:** During HTS posttest session, Same day referral for clients who have initiated or referred for initiation or during outreach clinic at ART consultation point

**Tools:** Referral and linkages logbook, Index testing logbook, Chronic Care Files/ CMIS, National Referral book, Cell phone, Call logs, Index Invitation forms, Case management logbook, appointment book, Case management monthly summary sheet, Quarterly outcome report

NB: The outreach team works in collaboration with a health facility which is not physically on site at the time of testing. The outreach clinic or community testing partner will offer HIV testing and refer both reactive and non-reactive clients to a health facility of client’s choice for HIV prevention, care and treatment services

Clients testing HIV positive must be linked on the same day or within 7 days of diagnosis. Client whether initiated or not initiated should be seen at health facility within 7 days of testing HIV positive. Clients initiated in an outreach must be referred to their preferred facility. Clients testing negative must be linked for HIV prevention services, e.g. condom, PrEP/PEP and VMMC if male.

### Responsibilities at community Linkage Case Management

<table>
<thead>
<tr>
<th>Community Linkages facilitator / health care worker</th>
<th>Client</th>
<th>Receiving health facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Must be aware of available referral services (both clinical services and community resources) at the preferred facility</td>
<td>• Client to link to care on the same day or within 7 days if same day is not possible.</td>
<td>• Health care worker receives the client and verifies information in CMIS if facility is on CMIS.</td>
</tr>
<tr>
<td>• Must understand the services needed by the client</td>
<td>• Provide the list for all sexual/injecting partners, biological children below 15 years and associates.</td>
<td>• If not already on ART conduct retesting for verification.</td>
</tr>
<tr>
<td>• Document referral form which include date client tested and HIV status or the services the client is being referred for.</td>
<td>• Client should disclose to significant others,</td>
<td>• Facility to call community health care worker (if client was not escorted) to update on client referral.</td>
</tr>
<tr>
<td>• Agree on appointment date and the client preferred facility.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Call the facility you are referring the client to make an appointment for client.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Escort or meet client at facilities and provide treatment navigation services for at least the first facility visit.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Document referral form and transport it to ensure client is booked.
- Do follow up with receiving facility to confirm linkage of referred client.
- Conduct at least two follow-up support calls before ART initiation (if not on the day of diagnosis), and two follow-up support calls before the first and second ARV refills.
- Conduct one follow-up face-to-face counseling sessions or through phone.
- For Community partners implementing Community ART, clients must be initiated before referred out.
- Discuss with client about importance of index testing and disclosure.

<table>
<thead>
<tr>
<th>Clients willing to Initiate ART</th>
<th>Clients not willing to initiate ART</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Review and resolve identified barriers</td>
<td></td>
</tr>
<tr>
<td>- Emphasize on the benefits of ART and early enrolment to treatment</td>
<td></td>
</tr>
<tr>
<td>- All clients refusing to be initiated on ART must be discharged via the nurse for further counselling</td>
<td></td>
</tr>
<tr>
<td>- Assign and introduce a Linkages facilitator</td>
<td></td>
</tr>
<tr>
<td>- Obtain contacts both cellphone and physical address</td>
<td></td>
</tr>
<tr>
<td>- Make follow up calls as per the facility LCM SOP to find out how the client is coping with the diagnosis</td>
<td></td>
</tr>
<tr>
<td>- Inform client of the available support</td>
<td></td>
</tr>
<tr>
<td>- Appoint client in the appointment register for follow up calls and further counselling sessions</td>
<td></td>
</tr>
<tr>
<td>- Client is followed up through community health care workers and document outcome in the call log systems</td>
<td></td>
</tr>
</tbody>
</table>

**Strategy 1: Community outreach HIV testing (not ART initiation)**

In this strategy clients are tested for HIV, but are not initiated on ART in the outreach. The outreach team offer HIV testing and ideally works in collaboration with a nearby health facility. All clients testing HIV positive or identified as dis-engaged from treatment are referred to a nearby or preferred health facility by the community HIV testing partner for ART initiation. Clients at substantive risk testing HIV negative should be referred for HIV Combination prevention package.

**Responsibilities for HIV testing and not initiating ART at Community level**
Strategy 2: Community outreach HIV testing and ART initiation

In this strategy, the outreach clinic/community testing partner will offer HIV testing and initiate ART for HIV Positive clients and refer to clients preferred health facility for continuity of care. Files and ART numbers will be obtained from health facility that’s linked to the catchment area in which services will be provided. Those willing to be initiated on ART will be initiated and issued an ART number (issued prior by health facility) and all relevant files will be transferred to the health facility within seven days of service provision. If mobile outreach occurs outside of MoH clinic hours all files will be stored at a partner’s safe storage M&E lockable filing cabinet awaiting delivery to the health facilities within seven days. For those who opt to initiate ART outside health facility geographical catchment area, a National referral form/transfer out to the mother clinic/facility of choice is written. Outreach team should follow up if client have reached the facility she/he was referred too, if not they should have tracked clients.

Those clients who decline and choose to initiate ART elsewhere will be linked to the client preferred health facility of their choice (following procedures outlined in Strategy 1). Tracking of client’s adherence to treatment, or linkage to treatment, will be conducted through health facilities where client was referred using call log tracking systems to link clients to ART and navigating positive living through trained peer navigator’s/expert client.

Responsibilities for HIV testing and initiating ART at Community level

<table>
<thead>
<tr>
<th>Linkage facilitator</th>
<th>Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Client is introduced by HTS Counselor to the expert client or outreach/ mobile nurse.</td>
<td>o Conduct retesting for verification by the outreach nurse.</td>
</tr>
<tr>
<td>o Assess client readiness for ART</td>
<td>o Outreach nurse will assess client readiness for ART Initiation</td>
</tr>
<tr>
<td>o Client receives counselling and benefits of early ART, importance of long-term</td>
<td>o Initiate client on ART</td>
</tr>
<tr>
<td>o Open chronic care file and complete psychosocial information</td>
<td>o Assign linkages facilitator</td>
</tr>
<tr>
<td>o Enroll client in the LCM</td>
<td></td>
</tr>
<tr>
<td>o Document next appointment date on appointment register.</td>
<td></td>
</tr>
<tr>
<td>o Call client or visit (Expert client, peer, peer navigation to find out how is the client coping with treatment as per LCM SOP</td>
<td></td>
</tr>
<tr>
<td>o Assist and support with disclosure</td>
<td></td>
</tr>
<tr>
<td>o Discuss index testing with client</td>
<td></td>
</tr>
</tbody>
</table>

Clients not initiating ART

<table>
<thead>
<tr>
<th>Linkage facilitator</th>
<th>Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Assess coping with the HIV diagnosis</td>
<td>o Review and resolve identified barriers for ART initiation</td>
</tr>
<tr>
<td>o Review and resolve identified barriers for ART initiation</td>
<td>o Emphasize on the benefits of ART and</td>
</tr>
<tr>
<td>o Emphasize on the benefits of ART and early enrolment to treatment</td>
<td></td>
</tr>
<tr>
<td>o Reassure client on available support for coping with diagnosis and treatment</td>
<td></td>
</tr>
<tr>
<td>o Reassure client on available support for coping with diagnosis and treatment</td>
<td></td>
</tr>
</tbody>
</table>
Provide motivational and informational counseling, including personal testimonials on importance of early ART initiation.

- All clients refusing to be initiated on ART must be discharged via the nurse for further counseling.
- Client is followed up through community health care workers if client has consented, and document outcome in the call log systems.
- Appoint client in the appointment register for follow up calls and further counseling sessions.

**Strategies for priority populations - Linkages Case Management**

The priority groups have different challenges in relation to ART initiation. The priority groups are children, adolescents, men, key populations, and clients who have missed appointment or have disengaged in care.

For children, the challenge is that they cannot consent for themselves; they rely on their parent’s/caregivers’ guidance for either ART initiation or adherence to treatment. HCW’s must continuously conduct an assessment for the primary care giver. If there is a new care giver, HCW’s must provide counseling support and health education for continued quality of care and support.

The challenge with Adolescents is that they do not come to health facilities and are not comfortable about the attitude of health care workers towards them. Psychosocial Support for adolescents is crucial if we want to improve linkages and retention as they are confronted by a host of problems that require emotional and/or practical support. Anxiety about life commitment, stigma/discrimination, interruption of education, financial problems, the physical effects of illness, disease progression, and loss of relationships.

The challenge with key populations is stigma and discrimination and not comfortable with the negative attitude of health care workers. Peer navigators are individuals who assist individual patients to navigate through the continuum of care, ensuring that barriers to care and treatment are resolved and that each stage of care is as seamless as possible. It is essential that navigators build the trust of their beneficiaries without judgment or prejudice. To do so, navigators and facility-based staff must work together to present themselves to beneficiaries as part of one team. A navigator can be a friend, sounding board, health educator, health care facilitator, guide, coach, advocate, and community resource. Navigators are not medical experts, substance use counselors, mental health specialists, or social workers. They may walk beneficiaries through the initial registration at a service site. They have extensive knowledge of the health, psychosocial, and other support services available in their area and beyond. Navigators ensure that service beneficiaries are aware of nutrition, peer support, legal aid, psychological, GBV, and case management services and receive the necessary support to access these services.
Clients who have missed or dis-engaged in care
For Clients who missed appointment or dis-engage in care due to various reason it is important to welcome the client back and identify the challenges that made them to default. Explore with the client on how to resolve the challenge

The major challenge with men is that they do not come to our facilities, lack of knowledge of HIV and ART, they have long working hours and they are deterred by the long queue in health facilities. Health care workers need to develop strategies to improve ART initiation amongst men

<table>
<thead>
<tr>
<th>Children</th>
<th>Adolescents</th>
<th>Key populations</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>For children below 5 years Provide ART using family approach</td>
<td>Establishing or reestablishing a peer support network (teen clubs) to provide physical and emotional care</td>
<td>Provide outreach services that offer comprehensive HIV services</td>
<td>Provide IEC material on the benefits of early ART initiation</td>
</tr>
<tr>
<td>For all children, the primary care giver/guardian is fully responsible for ensuring linkage and retention of the child</td>
<td>Above 12 years they can link to all health care services with the help of parents, care giver or treatment supporter of their own choice</td>
<td>Health care workers to work in close collaboration with peer navigators</td>
<td>Provide outreach services to male dominated industries that offer comprehensive HIV services</td>
</tr>
<tr>
<td>Children depend on their Parents/Care giver for linkages hence the importance and benefits of ART should be continuously emphasized on the parent/care giver</td>
<td>Emphasize on the importance and benefits of disclosure</td>
<td>Refer clients who are delaying ART initiation, missed appointment and those who defaulted to peer navigators to build social cohesion and participation</td>
<td>If possible, assign male linkages facilitator</td>
</tr>
<tr>
<td>In situations where the child is denied care by the parent or care giver the involvement of Social workers is obligatory</td>
<td>Provide Psychosocial support as per the need of the adolescent</td>
<td>Implementing index testing for sexual and/or drug injecting partners</td>
<td>Provide man health days/male friendly clinics (Provide extended hours or weekends for ART initiation, allowing clients to select preferred facility if there are issues of stigma</td>
</tr>
<tr>
<td>Educate parents on the importance of age appropriate disclosure</td>
<td>Provision of youth friendly service package (fast tracking adolescents in uniform, extension of hours, school holidays consideration)</td>
<td>If the HIV-positive client agrees, offers these partner(s) HIV testing services (HTS). Partner notification is provided using passive or assisted approaches.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assess ART readiness and address barriers to ART initiation, and discuss benefits of ART, adherence and retention</td>
<td>Educate client on consistent use of condoms and lubricants with sexual partners</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discuss importance of family planning for adolescents that are sexually active</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discuss safer sex and risk reduction</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Promote the correct and consistent use of condoms among those who are sexually active, and increase the uptake of STI screening and family planning services</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Maintain privacy and confidentiality to reduce stigma and discrimination</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Utilization of peer to peer counselling to share their personal experiences with anxiety, guilt, fear, shame, rejection, depression, and feelings of hopelessness for newly HIV diagnosed adolescents where applicable</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If the country is to achieve the zero new infections clients testing HIV negative must not be neglected. A negative test presents an opportunity for linkage to HIV prevention services to ensure they remain negative and reduce the chances of them getting infected with HIV. Priority must be given to adolescents, young women, men and key populations

**HIV negative client**

All clients testing HIV negative must be actively referred for Comprehensive prevention packages. Priority focus must be on identifying HIV negative clients at substantive risk for HIV acquisition and linking then to their preferred preventive services.

**Responsibility of Health Care Worker for the HIV Negative client**

- Do risk assessment
- Determine next retesting date
- Offer Core Package for Combination HIV prevention
- Discuss and link client to preferred facility for the preventive services
- Document in the national referral tool prevention services referred for.
- For VMMC and PrEP clients, Call the preferred health facility within seven days to make an appointment

**Quality Improvement**

Quality improvement services are aimed at ensuring that there is continuous provision of quality of services for clients which include; clinical visits, initiation of ART, linkage to prevention services and appointment keeping.

**Facility**

- Facilities will be trained on LCM SOP and tools will be made available in all facilities implementing LCM for guidance.
- Facilities will conduct linkages data review during MDT’s meetings
- Facilities will conduct quality improvement projects on LCM
- Implementing partners will conduct monthly mentorship to strengthen LCM implementation (documentation in all LCM tools and reporting
- Clinic supervisor to conduct sit ins to monitor quality
Regional

- Regional Health Management team will be oriented on LCM and will be responsible to include LCM in the regional plans
- Include Linkages indicators in Regional Health Semi Annual Review(ReHSAR) meetings
- Tracking of LCM reports by regional Strategic Information Department(SID)

National

- Development of LCM SOP
- Standardization of LCM logbooks
- National coordinator will conduct quarterly supportive supervision visit in conjunction with the Quality, HTS and ART team
- Conduct quarterly review meeting to monitor progress of LCM implementation
- Include Linkages indicators in National Health Semi Annual Review(NaHSAR) meetings
- Review and adapt LCM tools as per the need

Monitoring and Evaluation

Currently referral and linkage template is available in the CMIS version 2.0. However, indicators for LCM are partially covered. Currently there is no official register for linkages in Health facilities. LCM register is to be utilized by the linkage facilitators (EC’s/HTS counsellors) to record all LCM related activities. Each linkage facilitator should submit a summary to the facility focal person for consolidation. The consolidated summary sheet should be submitted to the region by facilities.

Reporting – Monthly

1. Number of clients identified as HIV positive by age and sex
2. Number of clients enrolled on LCM from facility
3. Number of clients transferred in from Community or other facilities
4. Number of HIV positive clients linked for ART initiation by age and sex
5. Number of clients enrolled from facility who received the first call
6. Number of index cases with contact tested for HIV
7. Number of client’s who have disclosed HIV status to at-least one person
8. Number of clients with a final LCM outcome
## Annex 1- Barriers to ART Initiation

<table>
<thead>
<tr>
<th>Individual</th>
<th>Community</th>
<th>Health Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Perceived good health</td>
<td>1. Distance from community to facility</td>
<td>1. Health care worker’s attitude towards clients</td>
</tr>
<tr>
<td>2. Patient not ready to initiate</td>
<td>2. Transportation cost</td>
<td>2. Lack of monitoring tools including the unique identifier</td>
</tr>
<tr>
<td>3. Unwilling to disclose due to fear of lack of support, violence, or separation from spouse, partner, or family members</td>
<td>3. Stigma and discrimination</td>
<td>3. Facility Operational hours not conducive to clients</td>
</tr>
<tr>
<td>4. Emotional process of accepting status (Denial)</td>
<td>4. Ability to get time off work</td>
<td>4. Long queues at facilities</td>
</tr>
<tr>
<td>5. Fear of loss of confidentiality and stigma</td>
<td></td>
<td>5. Limited coverage of HIV prevention services</td>
</tr>
<tr>
<td>6. Fear to disclose</td>
<td></td>
<td>6. Perceived poor quality of HIV care services</td>
</tr>
<tr>
<td>7. Parents or caregivers who refuse care for their children</td>
<td></td>
<td>7.</td>
</tr>
<tr>
<td>8. Self-stigma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Socio-economic challenges</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Annex 2 - Scenario 1

Testing and ART initiation occurring in same consultation Room

**Group Giving Information**
- HIV Screening
- Conduct HIV Test

**Post-Test Counselling**
- Simple and clear communication of test results.
- Check Client's understanding of the results.
- Opportunities for the client to ask questions.
- Development of a coping strategy for the client.
- Assessment of referral needs for other services.
- Discussion of disclosure of Test results.
- Discussion of partner and family referral for HIV Testing.
- Clarify misconceptions and myths about HIV transmission and risks.
- Referrals for relevant services.

**HIV Positive**
- Support the emotions arising from Test result.
- Explore any immediate concerns.
- Inform individual of available ART services.
- Inform Client about benefits of Test and Start.
- Provide information on prevention HIV transmission.
- Discuss positive living.
- Discuss assisted partner notification, disclosure and follow up.

**HIV Negative**
- Explain about the window period and recommend when to reTest based on their risk profile.
- Discuss Partner Testing.
- Offer prevention package (PrEP, PEP, VMMC, condom, STI/FP).
- Discuss Client preferred facility.
- Complete referral form.
- Call facility to make appointment.
- Call client to make efollow ups if they have reached the facility.

**ART initiation**
- Retesting for verification.
- Open chronic care file.
- Discuss disclosure.
- Discuss index testing.
- Trouble shoot ART initiation barriers.
- Enroll client into LCM.
- Appoint client in appointment register.
- Register Client in ART register/ CMIS.

**Delay**
- Review and resolve identified barriers.
- Provide pre ART package.
- Emphasize importance of early ART initiation.
- Assign linkage case officer.
- Children denied ART must be referred to social workers.
- Client delaying ART must be discharged via Nurse/ Doctor.

**Follow up calls**
- Assess coping with treatment.
- Ask if they are experiencing any side effects.
- Remind about next appointment.

**Follow up calls**
- Assess coping with diagnosis.
- Reassure client on available support for coping with diagnosis.
- Remind about next appointment.
- Trouble shoot concerns and barriers to care.
- Provide motivational and informational counselling.

**Missed Appointment**
- Follow up according to guidance in register.
- On return congratulate client for coming back and identify reasons for missing appointments.
- Provide intensified counselling.

**Prevention Package**
- Pre-exposure prophylaxis (PrEP).
- Post-exposure prophylaxis (PEP).
- VMMC.
- STI Treatment.
Annex 3- Scenario 2

**ART initiation done in another consultation room within OPD**

**Group Giving Information**

**HIV Screening**

**Conduct HIV Test**

**Post-Test Counselling**
- Simple and clear communication of test results.
- Check Client's understanding of the results.
- Opportunities for the client to ask questions.
- Development of a coping strategy for the client.
- Assessment of referral needs for other services.
- Discussion of disclosure of test results.
- Discussion of partner and family referral for HIV Testing.
- Clarify misconceptions and myths about HIV transmission and risks.
- Referrals for relevant services.

**HIV Positive**
- Explore any immediate concerns.
- Inform individual of available ART services.
- Inform Client about benefits of Test and Start.
- Provide information on prevention of HIV transmission.
- Discuss positive living.
- Discuss assisted partner notification, disclosure and follow-up.
- Escort.

**Negative**
- Collect blood sample and send for DNA PCR to the National Reference Laboratory.
- Mark the form a urgent and document and the reason for Test should be confirmatory Test.
- Advise client to come after two weeks for results.

**HIV Negative**
- Explain about the window period and recommend when to reTest based on their risk profile.
- Discuss Partner Testing.
- Offer prevention package (PrEP, PEP, VMMC, condom, STI/FP).
- Discuss Client preferred facility.
- Complete referral form.
- Call facility to make appointment.
- Call client to make follow up if they have reached the facility.

**Nurse**
- Testing for verification

**Prevention Package**
- Male condoms
- Female condoms
- VMMC
- STI/FP
- PrEP/PEP

**Positive**
- Conduct physical assessment.
- Initiate Client on ART.
- Explain benefits of treatment to Client.
- Document Client in ART register/CMIS/APMR.
- Give next appointment date.
- Assign linkage case management Officer.

**EC**
- ART readiness assessment.
- Discuss importance of early ART initiation.
- Discuss importance of disclosure.
- Trouble shoot on ART adherence barriers.
- Assist Client to navigate treatment.
- Introduce Client to Nurse for ART initiation.
Annex 4 - Scenario 3

Interfacility Linkages

**Group Giving Information**

**HIV Screening**

**Conduct HIV Test**

**Post-Test Counselling**
- Simple and clear communication of test results.
- Check clients understanding of the results.
- Opportunities for the client to ask questions
- Development of a coping strategy for the client
- Assessment of referral needs for other services
- Discussion of disclosure of test results.
- Discussion of partner and family referral for HIV Testing
- Clarify misconceptions and myths about HIV transmission and risks
- Referrals for relevant services.

**HIV Positive**
- Explore any immediate concerns.
- Inform individual of available ART services.
- Inform client about benefits of Test and Start.
- Provide information on prevention HIV transmission.
- Discuss positive living.
- Discuss assisted partner notification, disclosure and follow up.
- Call facility and setup appointment.
- Document in the National referral tool.

**HIV Negative**
- Explain about the window period and recommend when to re-test based on their risk profile.
- Discuss partner testing.
- Offer prevention package (PrEP, PEP, VMMC, condom, STI/FP).
- Discuss client preferred facility.
- Complete referral form.
- Call facility to make appointment.
- Call client to make follow-up visits if they have reached the facility.

**Prevention Package**
- Make condoms
- Female condoms
- VMMC
- ARV Treatment
- PEP/PrEP

**ART Initiation**
- Initiation happen before referral
- Obtain contacts (physical and cellphone)
- Discuss preferred facility.
- Discuss index testing.
- Call set up appointment.

**Initiate same day**
- Conduct HIV retesting according to national guidelines.
- Review and resolve previously identified barriers.
- Same day initiation for patients in stage 1 and 2. NB if attended by a nurse for clients in stage 3 and 4, provide advanced disease package then refer to the doctor.
- Document ART number in HTS register.

**Delay**
- Review and resolve identified barriers.
- Provide pre ART package.
- Emphasize importance of ART.
- Assign linkage case officer.
- Children denied ART must be referred to social workers.
- Client delaying ART must be discharged via doctor.

**Follow up calls**
- Assess coping with treatment.
- Ask if they are experiencing any side effects.
- Remind about next appointment.
Annex 5 - scenario 4
References