The Kingdom of Eswatini

ENHANCED LINKAGES CASE MANAGEMENT SOP

SEPTEMBER 2021

UNAIDS

SWAZIS AND AMERICANS IN PARTNERSHIPS TO FIGHT HIV/AIDS
PEPFAR

MOH HIV/AIDS SNAP

World Health Organization

The Kingdom of Eswatini

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FOREWORD

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.

Eswatini adopted the 95-95-95 strategy as part of the National Strategic Plan to end HIV and AIDS as a public health threat. This calls for: identifying 95% of people living with HIV (PLHIV); initiating and retaining on antiretroviral therapy (ART) 95% of PLHIV identified; and achieving 95% viral load suppression for ART patients. HIV testing has been scaled up in all entry point however linkage to care amongst key populations, children and adolescent, pregnant women and men remain a challenge especially if they are tested at community level. Few PLHIV diagnosed in community settings receive antiretroviral therapy within 7 days of diagnosis (rapid ART) in accordance with World Health Organization recommendations. If the country is to achieve the 2nd and 3rd 95 Linkages must be prioritized especially amongst the priority groups and particularly those tested in the Community

In recent years, evidence have shown that linkage case management is associated with an increase in ART initiation. To achieve epidemic control of human immunodeficiency virus (HIV) infection, sub-Saharan African countries are striving to diagnose, link all clients diagnose with HIV and ensure that their viral load is suppressed. To improve rapid ART for clients diagnosed in both facility and community settings in Eswatini, the Ministry of Health is implementing Linkage Case Management which ensures that majority of people who test HIV positive are linked into care and those who test HIV negative are linked to HIV prevention services.

This document is a guide for HIV linkages from community to facility and from facility to facility towards improving early ART initiation, re-initiation of those who have defaulted and provision of HIV prevention services.

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Abbreviations And Acronyms

AGYW	Adolescent Girls and young Women
AIDS	Acquired Immune -Deficiency Syndrome
ALHIV	Adolescents Living with HIV
ART	Antiretroviral Treatment
CCF	Chronic Care File
CHW	Community Health Care Worker
CDC	Centers for Disease Control and Prevention
CEC	Community Expert Client
CMIS	Client Management Information System
CMM	Community Mentor Mother
FEC	Facility Expert client
SNAP	Eswatini National AIDS Programme
HCW	Health Care Workers
HF	Health Facility
HIV	Human Immunodeficiency Virus
HIVST	HIV Self-testing
HTS	HIV Testing Services
IEC	Information, Education and Communication
LCM	Linkages case Management
KP	Key Populations
MDT	Multi-Disciplinary Team
MM	Mentor mother
MOH	Ministry of Health
NSF	National Multi-sectoral HIV and AIDS Strategic Framework
OPD	Outpatient Department
OIs	Opportunistic Infections
PEP	Post Exposure Prophylaxis
PEPFAR	The United States President's Emergency Plan for AIDS Relief
PFA's	Partner, Family and Associates
PIHTC	Provider Initiated HIV Testing and Counselling
PLHIV	People Living with HIV

PrEP	Pre -Exposure Prophylaxis
RHM	Rural Health Motivator
RHMT	Regional Health Management team
SHIMS	Swaziland HIV Incidence Measurement Survey
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
TFO	Transfer out
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
VMMC	Voluntary Medical Male Circumcision.

Key Definitions

Term	Definition
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". 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, sexual or drug networks.
Bidirectional referral	System considers both the information going from the health care system to the referred community program or resource
Children	Refers to people aged 0-9 years.
Community referral	This is a referral of a client made at community level by a 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 health facility (Intra-facility) or to another health facility (inter facility) for care that the health care workers do not have the capacity to provide.
Intra Facility	This is a referral made within different departments in the same health facility.
Inter facility	This is a 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(s)/injecting drug users, biological children below 15 years and associates for HIV testing services.

HIV Self-testing	This is a process where an individual collects his or her specimen, performs a test and the results, often in a private setting, either alone or with someone he or she trusts.
Index contact	These are 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 cases, 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	This is a process in which the client has reached the facility and provided with care and treatment services he/she needs. The referring facility verifies if the client has arrived and was provided with services, or the receiving facility gives feedback to the referring facility.
Linkage case management	Linkage case management (LCM) comprises the package of linkage services including individualized case management; treatment navigation and index testing.
Linkages Facilitator/ Linkage case management officer	This is a Health Care Worker who includes (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 workers (CHW) 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, being escorted or given transportation cost/fee. *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 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.
Prevention package	Effective prevention interventions have been proven to reduce HIV transmission. Prevention packages include PREP, PEP, VMMC, Condom, HIVST, FP, STI
Stable clients	Clients that have tested HIV positive without opportunistic infections
Returning to Care	Any client that was once enrolled in ART returning after 28 days of treatment interruption
Delayed initiation	Clients not initiated on ART within 14 days of testing HIV positive

1 Background

The HIV testing and treatment pathway remains a challenge with patients being lost soon after testing, or after initiating ART. ART initiation may be difficult for healthy clients in the context of Test-and-Start. Hence there is need to utilize specific strategies to improve referral from HIV testing to HIV treatment services, to support Rapid ART initiation among those diagnosed HIV positive. In addition, to improve retention of clients in care and viral suppression rates there is a growing need to facilitate client's re-engagement in care following treatment interruptions. To improve linkages, ART initiation and retention in care, Eswatini adopted the linkages case management strategy which include provision of targeted support, for clients, community sensitization on the benefits of early ART initiation, community ART initiation and multi-month scripting.

Eswatini has a mature and generalized HIV epidemic primarily driven by heterosexual sex [1]. According to the Swaziland HIV Incidence Measurement 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).

Linkages case management (LCM) is a strategy recommended for the improvement of linkages to treatment for identified HIV positive clients. Evidence by Commlink study done in Eswatini which demonstrated 90% linkages for clients that were enrolled into LCM. Client's enrollment into HIV care was >90%. Clients diagnosed in community settings were linked within a few days of diagnosis [3]. 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 LCM approach is crucial in reaching the second 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) [4,6]. In 2019, Eswatini started implementing LCM and linkages rates increased from 64% in 2018 to 92.2% in 2019 according to HIV programs report 2019.

2 Rationale For The SOP

Although HIV testing and treatment programs have increased access to ART remarkably, many (PLHIV still initiate ART late, particularly those amongst young adult males and people diagnosed in the community [1,3]. 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 [3]. According to the NSF 2018-2023 there is a sub-optimal linkage rate 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 the purposes of privacy [1,3,4,].

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) 8% (207/2576), pregnant women-93% which was a decline from 95% for 2016, children (0-14 years)-75% and above 15 was 86% [7]. Provision of LCM has been seen to be effective in Eswatini where linkages improved from 64.7% in 2018 to 92,2% [8]. However, despite the positive gains, clients are seen to disengage from care and treatment after 3 months. This is shown by the drop in retention from 92,2% at 3months to 88.5% at 6 months. Eswatini is committed to maintain the achievement of greater than 95% treatment target for all sub populations by 2030.

3 Objective of HIV Referral and Linkages SOP

Goal

The overall goal of the HIV referral and linkages SOP is to provide a set of nationally accepted procedures to improve rates of linkage to HIV Prevention Treatment and care services.

Objectives

- To provide a set of nationally accepted mechanism to improve rates of linkages to HIV prevention, treatment, and care
- To define a series of minimum procedures which are efficient, sustainable, and ensuring retention of clients in treatment and care.
- To guide motivation for clients to disclose
- To provide a set of indicators for monitoring and tracking the LCM outcomes
- To provide guidance on ensuring clients that have two or more index contact listed, e.g., sexual partner or biologic child tested for HIV.
- To provide guidance on how to handle clients that have disengaged from treatment and care.
- To provide guidance on bidirectional referral and linkages between community and facility

4 Barriers to Art Initiation

It is important to understand some factors recognized as barriers that affect linkages at facility level which is categorized to Individual, community, and system factors [10,11]. See Annex 1

5 Linkage to Treatment and Care

Linkages case management provide the package recommended by CDC/WHO to Eswatini context for newly and previously HIV diagnosed who are not in HIV care [3,4,8]. PLHIV who enrolled into LCM (clients) are paired either with a peer navigator, expert client (EC), HIV Testing Services (HTS) counsellor, mentor mother (Linkages Facilitator) from HIV diagnosis until clients have reached six months post ART initiation. Linkage's facilitator provides the package of recommended services for up to 180 days for clients. LCM services package includes Individualized case management, treatment navigation and Index testing.

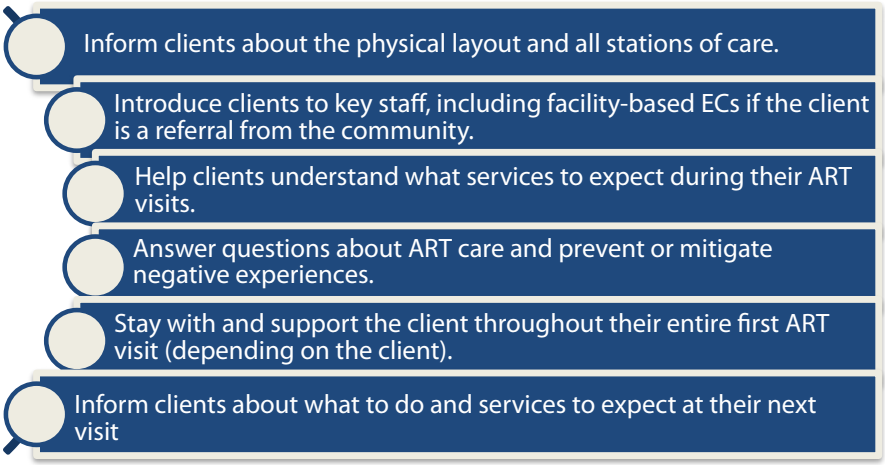
Health care workers must Screen all clients testing HIV positive for mental health and substance abuse and refer according to the facility referral system.

5.1 Individualized Case Management Services

- Minimum of five face-to-face structured counseling sessions between clients and their assigned linkages facilitator at predetermined intervals.
- Providing psychosocial support, informational & motivational counseling on the benefits of early enrollment in HIV care and initiating ART.
- Telephone follow-up for appointment reminders, psychosocial and informational support according to the LCM timelines
- Encouraging and supporting disclosure of HIV status and testing of partners & biological children (when appropriate).
- Assessing and resolving barriers to enrolling and remaining in HIV care.
- Conducting defaulter tracing and intensified counselling for clients that have missed their appointments.

5.2 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 locations of ART services. Escorting clients is not about policing the client, but it should assist him/her to reach the next service point without experiencing challenges. Escorting is done during the first visit as per the need.



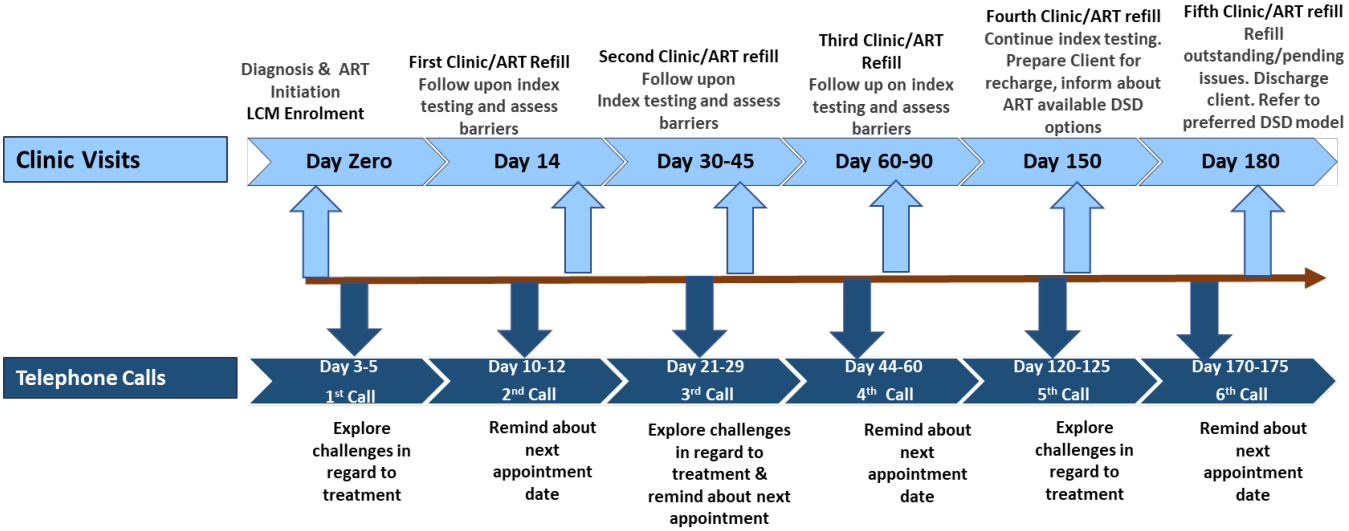
Treatment navigation should follow the steps below:

5.3 Index Client Testing

Index testing is routinely offered as an extension of the case management session that is dedicated to discussing testing needs. The Linkages facilitator assists clients with:

- Eliciting further index contacts, e.g., partners, or family members, or associates in need of HIV testing.
- Providing outcomes of index testing.

5.4 Summary of Linkage case management services



Guiding Principles for Linkage Case Management

1. LCM is voluntary; all eligible patients are free to enroll or discontinue services.
2. Quality and Inclusiveness; LCM should ensure that partners, family members, and associates of LCM clients are appropriately HIV diagnosed and linked to ART care.
3. Client centered: LCM should focus on the patient's client's concerns and priorities or must focus on problem solving approach to address concerns
4. Teamwork: Providers of LCM including clinicians, peers, lay staff, community workers, families, and the clients themselves should strive to always work together.
5. Transparency: Providers of LCM should ensure good communication at all stages of LCM implementation.

6 Eligibility Criteria for LCM

Clients who are eligible for LCM are;

All HIV-positive clients diagnosed in the facility or community, and they are:

- Newly HIV diagnosed
- have defaulted or disengaged from ART and are returning to care as new patients
- Clients initiated on ART from community then referred to facility
- Previously HIV diagnosed but have not received HIV care in the past 90 days.

Special attention paid to infants, children below 15 years since they depend on caregivers, adolescents and young women, men, pregnant and lactating women, **Patients with advanced disease** and key populations.

7 Roles And Responsibilities of a Linkages Facilitator

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

- Establishes rapport and explains program services and duration.
- Verifies previous HIV testing history and prior enrollment in ART care.
- Explains case management processes.
- Develops LCM management plan with the client. Exchange and verify phone numbers.
- Document detailed physical address (for both current and home)
- 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 default, the facility will track them to provide support.

Where possible the linkages 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.

8 Criteria for Discharging Clients from Linkage Case Management

Clients will be discharged if the following have been completed and documented in the chronic care file (CCF)/Client management information system (CMIS)/CMIS.

- Client has been initiated on ART and retained on ART until 6 months.
- Client has disclosed status to at least one person (partner, family member, or associate)
- For clients who are children, the caregiver should be taken through the disclosure process in the pediatric disclosure guidelines.
- Client is adherent to treatment plan Client had at least two eligible contacts (partner, child, or associate) tested for HIV.

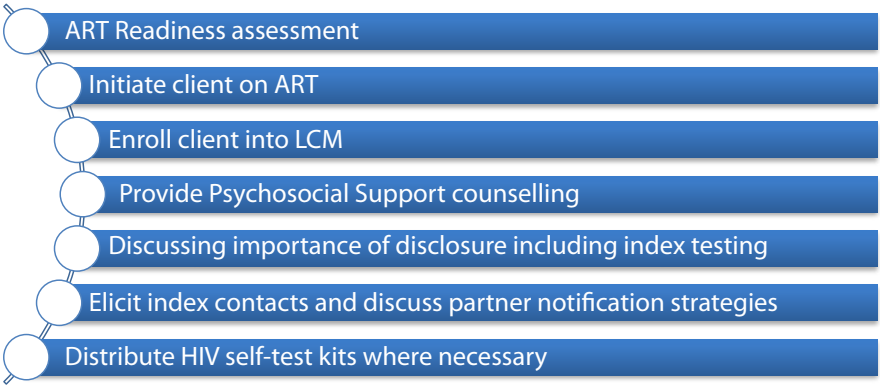
Clients tested and initiated on ART in the community should be discharged from the community as soon as they are linked at the facility for further LCM implementation.

9 Intra-Facility Linkage Case Management

Linkages that happen within different departments in the same facility. A client testing positive in any testing entry point 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 cadres in the facility. These different scenarios are as follows:

9.1 Initiating ART on client testing positive HIV diagnosis (Annex 2)

HIV testing is done by clinicians, the client testing HIV positive shall be provided with the following by the clinician.



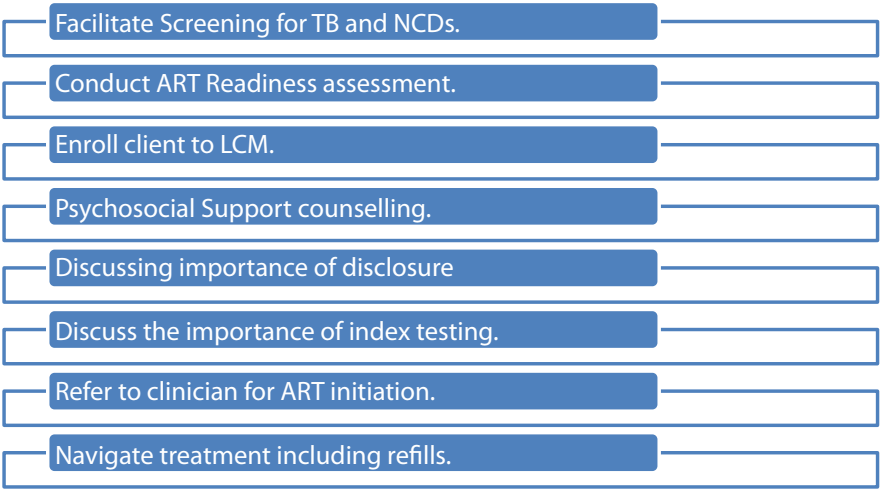
In health facilities with multiple HTS entry points, ART initiation is to be done by the Clinicians in the respective units.

9.2 Initiating ART in facility (Annex 2)

- HIV testing is done by the HTS counsellor, who opens a chronic care file for the client that is HIV positive.
- Elicit index contacts and discuss partner notification strategies.
- Distribute HIV self-test kits where necessary.

- The HTS counsellor shall ensure linkage of clients according to the facility linkage strategy (buzzing/ calling site or escorting).

9.2.1 The EC will provide the following:



The client is initiated by the nurse or doctor, after ART initiation the nurse assigns the client to a linkage's facilitator. While clients delaying ART should be referred for escalation counselling according to the facility plan

9.3 Initiating ART at a co-located ART Clinic/VCT (Annex 1)

Client on arrival at co-located ART clinic
∞ The client is fast tracked into the consultation room for ART initiation.
∞ Retesting for verification of clients by healthcare worker.
∞ Opens a chronic care file for the client that is HIV positive.
∞ Ascertain if contacts have been elicited.
∞ Provide HIV self-test kits where necessary.
∞ ART Readiness Assessment.
∞ Enroll client to LCM.
∞ Provide psychosocial Support counselling.
∞ Discussing importance of disclosure
∞ Discuss the importance of index testing.
∞ Refer to clinician for ART initiation.
∞ Navigate treatment including refills.

9.4 Initiating ART at the Inpatient Department (Annex 1)

Client on arrival at co-located ART clinic
∞ Retesting for verification of clients by healthcare worker.
∞ Opens a chronic care file for the client that is HIV positive.
∞ ART Readiness Assessment.
∞ Enroll client to LCM.
∞ Provide Psychosocial Support counselling.
∞ Discuss importance of disclosure.
∞ Discuss the importance of index testing.
∞ Clinician shall initiate client on ART.
∞ On discharge, the client shall be navigated to the ART department.
∞ The inpatient department shall communicate with the ART department to ensure linkage after discharge from the inpatient. unit.

9.5 Initiating ART at the community (Annex 1)

Client referred after initiation	
On Arrival at clinic	**The health care worker**
∞ The client submits referral form to health care worker and thus should be fast tracked into the adherence room.	∞ Congratulates client for honoring appointment. ∞ Review referral form to determine the service client was referred for. ∞ Determine if there has been challenges with treatment. ∞ Follow up on index contacts. ∞ Enroll client into LCM. ∞ Discuss and agree with client of the next appointment date

10 Client referred without ART initiation.

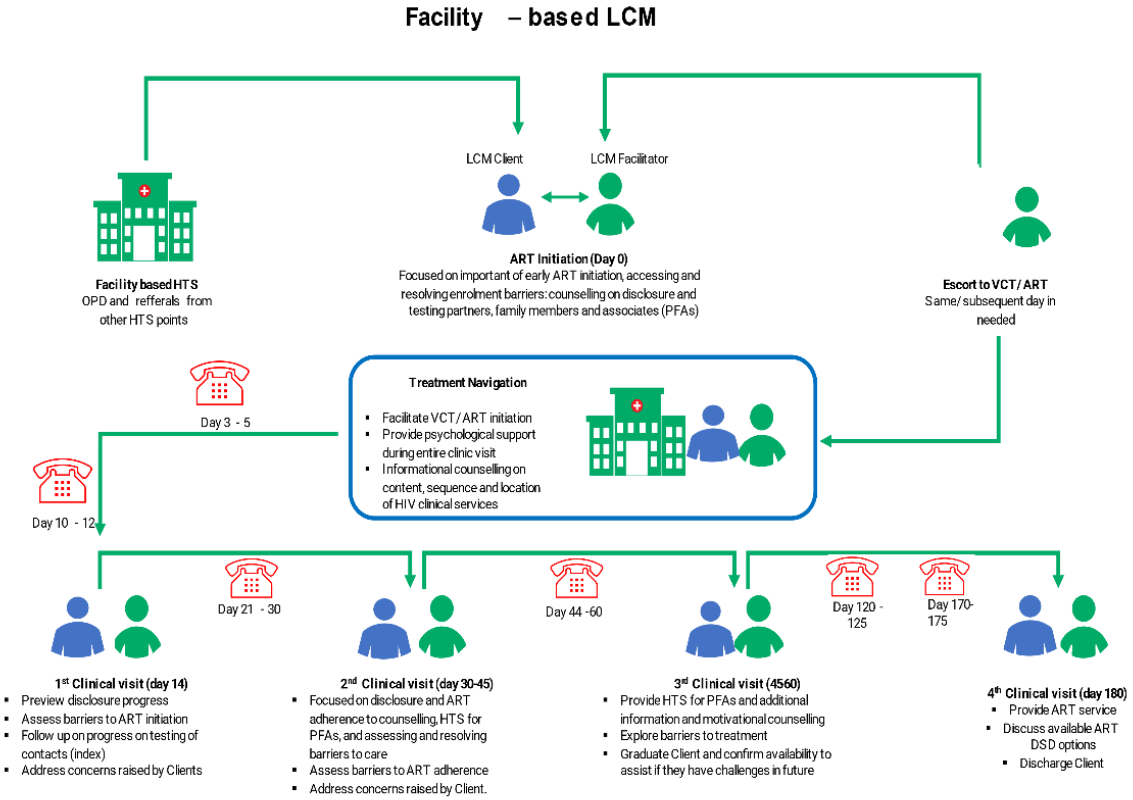
The health care worker
∞ Congratulate client for honoring visit.
∞ Re-test client for verification of positive HIV status
∞ Opens a chronic care file for the client.
∞ Discuss the importance of index testing and ascertain if contacts have been elicited. If not, elicit index client's contacts
∞ Provide HIV self-test kits where necessary.
∞ Conduct ART Readiness Assessment.
∞ Provide Psychosocial Support counselling.
∞ Discuss importance of disclosure.
∞ Discuss the importance of index testing and ascertain if contacts have been elicited.
∞ Refer to clinician for ART initiation.
∞ Enroll client to LCM.
∞ Assist the client with treatment navigation including refills.

11 Facility based Linkage Case Management division of labor.

Overall, the facility 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.

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: *The Linkage EC will be the Linkages Facilitator.*
Facilities with both EC and mentor mother and nurse: *Both EC and mentor mother will be linkages facilitator; the EC will be responsible for the general population while the mentor mother will be responsible for pregnant and lactating women and under- fives through their caregivers/parents.*
To ensure smooth implementation, facilities should develop site specific SOP adapted from the national LCM SOP.
Facilities need to develop client escalation plan for clients delaying ART.

12 FACILITY BASED LINKAGE'S CASE MANAGEMENT MODEL.



12.1 Facility linkage case management model

Linkage Case Management is implemented for 180 days. It begins with the 1st health care visit for the newly diagnosed, delayed or the returning to care client. The purpose of facility LCM is to outline the process for healthcare workers to provide adherence related education and counselling support to patients without delaying treatment initiation. The linkage case Management process is outlined in detail below.

12.2 Day zero- [HIV diagnosis & first clinic visit (art initiation)]

***Personnel**: Doctor, Nurse, HTS provider, Expert client.*
***Location:** HIV counseling room, Consultation room, Adherence Counselling* room
***When:** During post-test session (Nurse/HTS counselor), at ART initiation (Doctor/ Nurse), in 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 on day zero to reduce waiting time. The attitude of the healthcare worker providing counseling is extremely important in supporting ART initiation and retention. It is important to introduce yourself and create a warm environment to promote patient's openness by establishing language preference and informing about their right to confidentiality. Inform the client that the purpose of this process is to support the client through the process. Inform the client that they will be assisted through the journey of HIV discussing the treatment package, challenge and concerns the client might have in regards treatment based on the needs

12.3 Day Zero responsibilities

Clients initiating ART.

HTS Provider	Linkage's facilitator	Nurse/Doctor	Client
○ Verify in CMIS client details and background. ○ Assess coping with HIV diagnosis, and explain importance of linkage to ART. ○ Document detailed client contact information both cell phone number and physical address in the Chronic Care Files or CMIS. ○ Provide motivational counseling and information including the benefits of early ART initiation.	○ Escort clients to ART clinics and facilitate registration for ART care. ○ Provide face-to-face counseling sessions on the benefits of early enrollment in care and ART, disclosure, and testing of PFAs/index testing. ○ Conduct ART readiness assessment using the standardized tool and document. ○ Screen for NCDs	○ Conduct HIV retesting for verification according to the national guidelines. ○ Review for ART initiation barriers (psychosocial /clinical barriers) ○ Emphasize the importance of maintaining a healthy lifestyle. ○ Explain treatment to patient.	○ To ensure s/he understands whole process. ○ Client should present their concerns, if any (maybe medical or social) ○ Take the decision to start treatment. ○ Elaborate an adherence plan with the HCW and to identify the best time for taking treatment, reminders, and place to store medication.

○ Provide counseling on disclosure and testing of Partner, Family and Associates (PFAs). ○ 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) ○ Offer partner notification services for testing as per HTS guidelines. ○ Document the client in the linkage logbook/CMIS.	○ Provide motivational and informational counseling, including personal testimonials. ○ Open chronic care file and document adherence session provided to client assist clients to navigate across services (e.g., triage, clinical consultation, laboratory, etc.). ○ Document the assigned case in the linkage's management logbook. ○ Assess and resolve real and perceived barriers to care.	○ Document client in ART register/enter client in CMIS/APMR. ○ Assign and introduce Linkage facilitator for all clients. ○ Inform clients that if they experience any side effects, they should report to the facility. ○ Screen for NCD	○ Return for follow-up/ management. ○ Call the facility if they will not be able to attend the scheduled appointment for rescheduling. ○ Contact the health care provider right away if they experience or observe unfamiliar symptoms. ○ Identifying a support System.

○ Introduce clients to the ECs/ MM/ Nurse. ○ Follow up with the client's outcome and document ART number in the HTS register and linkages logbook/ CMIS. ○ For clients delaying initiation, the HTS provider will initiate escalated referral for higher level intervention. ○ Escort client to ART clinic and facilitate registration for ART care	○ Provide counseling on disclosure. ○ Facilitate testing of partners, family members, and associates (PFAs). ○ Inform clients that there will be on going face to face sessions for the next 6 months. ○ Complete appropriate sections of LCM register/ CMIS	○ Screen and initiate TPT ○ Inform the patient about tracing system. ○ Discuss with client on the next appointment as recommended per guidelines.	

	○ Appoint the client in the ART appointment register/ CMIS. ○ For clients delaying initiation, the EC/ Mentor Mother/ adherence officer will initiate escalated referral for higher level intervention. ○ Give facility contacts to clients so that clients can call if experiencing challenges. ○ Document facility's contact details on client health card upon initiation		

	○ For children and adolescents, educate caregiver(s) on treatment plan. ○ Provide IEC materials to the patient to assist with further understanding. ○ Refer to community- facility Linkage section. **For clients returning to care** ○ Welcome the client back to care. ○ Enhanced adherence counselling		

Client delaying ART initiation.

For clients delaying ART initiation, the goal is to initiate within 14 days

HTS Provider	Linkage's facilitator	Nurse/Doctor	Client
○ Verify in CMIS client details and background. ○ Document detailed client contact information both cell phone number and detailed physical address in the Chronic Care Files/ CMIS ○ Verify contact details provided by client. ○ Document the client in the linkage register / CMIS.	○ Document detailed client contact information both cell phone number and physical address in the Chronic Care Files/ CMIS/LCM register ○ Provide motivational counseling and information including the benefits of early ART initiation. ○ Prepare client for Pretreatment viral load. ○ Document the client in the linkage register/CMIS. ○ Screen for NCDs ○ Refer clients delaying ART initiation using facility escalation counseling plan.	○ Review and resolve identified ART initiation barriers reported by expert client. ○ Emphasize on the benefits of ART and early enrolment to treatment. ○ For children and adolescents, inform caregivers on disease progression. ○ Discuss and agree with the client t for the next appointment date. ○ Adolescent Delaying ART must be referred to peer supporters for further counselling.	○ To ensure s/he understands whole process. ○ Client should present their concerns, if any (maybe medical or social) ○ Return for follow-up/ management.

○ Refer clients delaying ART initiation using facility escalation counseling plan. ○ Elicitation of PFA ○ Clients refusing to be escorted should be given clear directions and complete the intra facility referral form.	○ Refer client to be reviewed by nurse or doctor and provide intensified counselling. ○ Appoint client in the appointment register for follow up calls and further counselling sessions. ○ For children and adolescents, educate caregiver(s) on treatment plan. ○ Inform client of follow up contacts to be conducted by facility	○ Children denied care by parents/guardian, refer client to social worker. ○ If client is still hesitant the client must be booked for another session of further counselling ○ Refer clients delaying ART initiation using facility escalation counseling plan. ○ Screen for NCDs ○ Screen and initiate TPT	○ Contact the health care provider right away if they experience or observe unfamiliar symptoms. ○ Client should present their concerns, if any (maybe medical or social) ○ Take the decision to start treatment.

12.4 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*

Objective of telephonic contact:

If ART initiated – Find out how the client is coping with medication.

If delaying ART- Assess readiness and provide support If returning to care and treatment-Bring back clients to care and treatment and retain them for lifelong treatment.

During the phone call first ascertain if it is the right client and convenient time, if yes proceed and if no reschedule

12.5 During telephone call:

Linkages Facilitator (EC/Adherence officer/Counselor)	
Clients initiated on ART	Clients delaying ART initiation
○ Introduce yourself and facility, ascertain if it is the right client. ○ Ascertain convenience of having call, if no, find out appropriate time ○ Establish rapport. ○ Assess coping with treatment. ○ Ask if they have any challenges they are experiencing with regards to treatment and assist them if possible ○ Ask if the client is having someone providing support. ○ Remind the client of the next call. ○ Record the call in the call log as needed and update in the chronic Care fil and the LCM register/CCF	○ Before the call, check ART barriers from the LCM register and CCF. ○ Call client: introduce yourself and facility, ascertain if it is the right client. ○ Ascertain convenience of having call, if no, find out appropriate time ○ Establish rapport. ○ Tailor-make conversation based on barriers ascertained. ○ Assess if the client is coping with HIV diagnosis. ○ Reassure client on available sup- port for treatment and explore readiness for initiation. ○ Agree with the client on the appointment at a facility or home visit. ○ inform client on the next call. ○ Record the call in the call log as needed and update in the chronic care file

12.6 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*

Objective of Telephonic contact

To remind client *of the next appointment and remind them to come with their contacts if possible.*

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:

Linkages Facilitator	
Clients initiated on ART	Clients delaying ART initiation
○ Introduce yourself and facility, ascertain if it is the right client. ○ Ascertain convenience of having call, if no, find out appropriate time ○ Establish rapport. ○ Assess coping with treatment and side effects. ○ Remind clients to bring index contacts for testing. ○ Provide motivational and informational counseling, including personal testimonials. ○ Allow the client to ask questions. ○ Remind the client about the next appointment date. ○ Address any questions from the client. ○ Record the call in the call log as needed and update in the chronic care file.	○ Before the call, check ART barriers from the LCM register. ○ Call client: introduce yourself and facility, ascertain if it is the right client. ○ Ascertain convenience of having call, if no, find out appropriate time ○ Assess if the client is coping with the diagnosis. ○ Explore possible support for them to cope with diagnosis. ○ Reinforce the benefits of early initiation, assess their barriers to treatment and try to allay any concerns. ○ Reassure client on available support for treatment. ○ Remind the client about the next appointment date. ○ Record the call in the call log as needed and update in the chronic care file

12.7 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*

Objective of the visit

If ART i*nitiated – To conduct clinical review and find out any challenges with medication.*

If delaying ART-Assess readiness and provide support

If returning to care and treatment- Bring back clients to care and treatment and retain them for lifelong treatment

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

The goal for clients that have initiated on ART is to encourage and motivate client to be retained in treatment and care through early identification of challenges and promptly address those challenges. 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)

For clients who have not missed appointment	For Clients who missed appointment
∞ Congratulate and appreciate client for honoring appointment. ∞ Fast track client in the facility for the first refill and inform the client that during other visits they will join the queue.	∞ Follow guidance on the management of missed appointment as stipulated in the appointment register (add steps) ∞ Upon return, congratulate the client for coming back and discuss the importance of honoring appointments and providing intensified counselling. ∞ Assess challenges they are experiencing and assist them to resolve them

12.8 Day 14 responsibilities

Client initiated on ART.

Linkage's facilitator	Doctor/Nurse	Client
○ Retrieve clients chronic care file. ○ Review disclosure progress (and as needed continue with counseling) ○ Conduct pill count and document in CCF/CMIS. ○ Ask client what reminder strategy they have in place to avoid forgetting taking treatment? . ○ Ask client what they do in case they had forgotten to take their medication. ○ Ask client what will they do if they experience side effects? ○ Address any concerns raised by the client. ○ If client came with index contacts escort them to the testing unit Appoint client in the appointment register	○ Review baseline results ○ conduct active pharmacovigilance to monitor for side effects and adherence and document accordingly. ○ Emphasize the importance of treatment adherence , honoring appointments the importance of viral. load monitoring and TB Prevention Therapy ○ Emphasize HIV prevention core messages and link to other health care services for index contacts. ○ Refill ARV's and other prophylaxis for client and agree on the next appointment date Once the client has refilled, document next appointment date in the CCF/ CMIS and green booklet.	○ To ensure s/he understands the whole process. ○ Client should present their concerns, if any (maybe medical or social) ○ Return for follow- up/ management. ○ Report any symptoms, side effects etc. they experience. ○ Call linkages facilitator/EC if they will not be able to attend the scheduled. appointment for rescheduling

12.9 Clients delaying initiation on ART

Linkage's facilitator	Doctor/Nurse
○ Before the call, check ART barriers from the LCM from the LCM register and CCF. ○ Call client: introduce yourself and facility, ascertain if it is the right client. ○ Ascertain convenience of having call, if no, find out appropriate time ○ Establish rapport. ○ Tailor-make conversation based on barriers ascertained. ○ Assess if the client is coping with HIV diagnosis. ○ Reassure client on available sup- port for treatment and explore readiness for initiation. ○ Continue to conduct ART readiness assessment. ○ Refer client to be reviewed by nurse or doctor and provide intensified counselling. ○ Update contacts for patients both physical and cellphone number. ○ Update documentation in the linkages case management register. ○ Appoint client in the appointment register for follow up calls and further counselling sessions.	○ Conduct client's readiness assessment. ○ Address client's immediate concerns and questions ○ Review and resolve previously identified barriers. ○ Provide the Pre-ART service package for clients delaying ART initiation. ○ Discuss and explain HIV disease progression with the client. ○ Agree with the client on the next appointment date. ○ Clients still refusing ART initiation, should be referred to the next level of escalation counselling according to the facility plan. ○ In case of adolescents refer for peer to peer counselling where possible

12.10 Day 21-29: Third Telephonic Call

Personnel: *Linkages Facilitator. (Expert client, HTS provider Nurse, Mentor mother)*
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*
Objective of Telephonic contact
To remind client *of the next appointment and remind them to come with their contacts if possible and check if client is experiencing any challenges.*

During the phone call first ascertain if it is the right client and convenient time, if yes proceed and if no reschedule

12.11 During telephone call:

Linkages Facilitator	
Clients initiated on ART	**Clients delaying ART initiation**
○ Introduce yourself and facility, ascertain if it is the right client. ○ Ascertain convenience of having call, if no, find out appropriate time ○ Assess how client is coping with ART treatment, check if there are any challenges. ○ Remind client of the next appointment date. ○ Check if clients have questions and give relevant responses. ○ Record the call in the call log as needed and update in the chronic care file.	○ Before the call, check ART barriers from the LCM from LCM register and CCF. ○ Call client: introduce yourself and facility, ascertain if it is the right client. ○ Ascertain convenience of having call, if no, find out appropriate time. ○ Tailor-make conversation based on barriers ascertained. ○ Assess how the client is coping with HIV diagnosis. ○ Reassure client on available sup- port for treatment and explore readiness for initiation. ○ Record the call in the call log as needed and update in the chronic care file.

12.12 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*

Objective of the visit

If ART initiated – To conduct clinical review and find out any challenges with medication.

If Delaying ART-Assess readiness and provide support

12.13 Clients initiated on ART.

Linkage's facilitator	Doctor/Nurse	Client
○ Retrieve clients chronic care file. ○ Review disclosure progress (and as needed continue with counseling) ○ Follow up on eliciting index contacts. ○ Conduct pill count and document in Chronic Care File ○ Assess barriers to ART adherence. ○ Address any concerns raised by the client. ○ Review and conduct HIV prevention counselling and positive living ○ Emphasize the importance of treatment adherence and honoring appointments including the importance of viral load monitoring and TB Preventive Therapy ○ Document next appointment in the appointment register	○ Conduct active pharmacovigilance to monitor side effects and adherence active pharmacovigilance to monitoring. ○ Provision of prophylaxis including TPT. ○ Refill ARVs for the client and agree on the next appointment date. ○ Once the client has refilled, Reappoint client in the appointment register/ CMIS	○ To ensure s/ ○ he understands whole process. ○ Client should present their concerns, if any (maybe medical or social) ○ Return for follow- up/management. ○ Report any symptoms, side effects etc. ○ Call linkages facilitator if they will not be able to attend the scheduled appointment for rescheduling. ○ Contact your health care provider right away if you experience or observe unfamiliar symptoms

12.14 Clients delaying initiation on ART.

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

12.15 Day 44 - 60: Fourth Telephonic Call

Personnel: *Nurse, HTS provider, Expert client, Mentor mother (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*

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:

Linkage Facilitator	
Clients initiated on ART	**Clients delaying ART initiation**
○ Assess coping with ART treatment. ○ Review disclosure plans and assess progress. ○ Troubleshoot immediate concerns regarding disclosure. ○ Review testing of plans and schedule for index partner testing ○ Provide motivational and informational counseling, including personal testimonials. ○ Assess coping and adherence, assess disclosure plans/outcomes, and elicit new index contacts; troubleshoot concerns and barriers to care. Record the call in the call log as needed and update in the chronic care file.	○ Assess coping with the HIV diagnosis. ○ Reassure client on available support for coping with diagnosis and treatment. ○ Check if client has been visited by a community health volunteer on behalf of the facility. ○ 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 the chronic care file.

12.16 DAYS 60-90: THIRD CLINIC VISIT (3rd ARV REFILL)

Personnel: *Doctor, Nurse, Expert client, Mentor mother (Linkage's facilitator).* ***Location****: HIV treatment consultation room, Adherence room* ***When:*** *During 3rd ARV Refill visit and those clients not on ART*

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

The main goal of this visit is to encourage adherence and retention to treatment and care. Explain to the client that at 6 months, an assessment will be done that will measure how well you are taking your treatment and whether it is working to suppress the HIV virus; If the virus is suppressed, you will be eligible to:

-Receive longer treatment supply to reduce the number of visits to the clinic. Inform the client of available DSD models the client might be enrolled if suppressed, as this will help them to think about the preferred model. Provide treatment literacy on different DSD model for further reading.

Clients initiated on ART.

Linkage's facilitator (Expert Client/Mentor Mother)	Doctor/Nurse	Client
○ Assess disclosure and testing of index contacts. ○ Follow up on eliciting index contacts. ○ Explore challenges with treatment. ○ Conduct pill count and assess for ART adherence. ○ Update contacts for patients both physical and cellphone number ○ inform the client that the next visit will be after 2 months. ○ document client in the appointment register ○ Call and document outcome in the linkage's logbook and update in the chronic care file. ○ Graduate client from linkages and case management program if not at high risk for defaulting from ART care and 100% adherent. ○ Congratulate client on achievement and confirm availability to discuss and help the client if they have	○ Assess for side effects and report. ○ Refill treatment and agree with the client on the next appointment date. ○ Refer client to psychologist/social worker if necessary. ○ Document all findings in the CCF. ○ Refill ARV's and other prophylaxis for client and give next appointment date	○ To ensure s/he understands whole process. ○ Call linkages facilitator if they will not be able to attend the scheduled. ○ appointment for setting another appointment date Contact your health care provider right away if you experience or observe anything you familiar with

12.17 Day 120-125: Fifth Telephonic Call

Personnel: Nurse, HTS provider, Expert client, Mentor mother (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

Objective of telephonic contact:

If ART initiated – Find out how the client is coping with medication.

If delaying ART- Assess readiness and provide support If returning to care and treatment-Bring back clients to care and treatment and retain them for lifelong treatment.

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:

Linkage Facilitator	
Clients initiated on ART	**Clients delaying ART initiation**
○ Introduce yourself and facility, ascertain if it is the right client. ○ Ascertain convenience of having call, if no, find out appropriate time ○ Establish rapport. ○ Assess coping with treatment. ○ Ask if they have any challenges they are experiencing with regards to treatment and assist them if possible ○ Remind the client of the next clinical visit. ○ Record the call in the call log	○ Introduce yourself and facility, ascertain if it is the right client. ○ Ascertain convenience of having call, if no, find out appropriate time ○ Establish rapport. ○ Assess coping with the HIV diagnosis ○ Reassure client on available support for coping with diagnosis ○ Encourage client to come to the facility to be assisted ○ Highlight benefits of early ART initiation ○ Record the call in the call log as needed and update the chronic care file.

12.18 DAY 150: FIFTH CLINIC VISIT (5th ARV REFILL)

Personnel: Doctor, Nurse, Expert client (Linkages Facilitator).
Location: HIV treatment consultation room, Adherence room
When: During 5th ARV Refill visit, follow up visit for those clients not on ART
Tools: Chronic Care Files/ CMIS, appointment book, Case management logbook, index logbook

Objective of the visit
If ART initiated – To conduct clinical review and find out any challenges with medication.
If Delaying ART - Assess readiness and provide support

Linkage Facilitator	
Clients initiated on ART	**Clients delaying ART initiation**
○ Check any pending issues in the client chronic care file ○ Check if they have managed to disclose ○ Check if their contacts have been tested ○ Ask client if they have any challenges with treatment and assist with treatment. ○ Inform client about availability of DSD options if their viral load is undetectable ○ Remind the client of the next clinical visit.	○ Inform client of the available support should they change their mind ○ Check if escalation counselling was done ○ Inform client that there is no need to test again, should they decide that they want to be initiated on ART ○ Discharge client from the LCM and document outcome

12.19 DAY 170-175: SIXTH TELEPHONIC CALL

Personnel: Nurse, HTS provider, Expert client, Mentor mother (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

Objective of telephonic contact:

If ART initiated – Find out how the client is coping with medication.

During the phone call first ascertain if it is the right client and convenient time, if yes proceed and if no reschedule

Clients initiated on ART	Clients delaying ART initiation
○ Introduce yourself and facility, ascertain if it is the right client. ○ Ascertain convenience of having call, if no, find out appropriate time ○ Establish rapport. ○ Assess coping with treatment. ○ Ask if they have any challenges they are experiencing with regards to treatment and assist them if possible ○ Remind the client of the next clinical visit. ○ Record the call in the call log	○ Introduce yourself and facility, ascertain if it is the right client. ○ Ascertain convenience of having call, if no, find out appropriate time ○ Establish rapport. ○ Assess coping with the HIV diagnosis ○ Reassure client on available support for coping with diagnosis ○ Encourage client to come to the facility to be assisted ○ Highlight benefits of early ART initiation ○ Record the call in the call log as needed and update the chronic care file.

12.20 Day 180 SIXTH CLINICAL (6th ARV REFILL)

The sixth visit is the last visit in the LCM.

Linkage Facilitator	
Clients initiated on ART	**Clients delaying ART initiation**
○ Check any pending issues in the client chronic care file to be finalized ○ Inform the client that this is the last visit. ○ Ask client if they have any issues, they want to discuss ○ Remind the client that today they will be taken V/L and they will be called once the results are back. If the V/L is undetectable they will be enrolled into more intense DSD model. If the second one is still undetectable, they will then be transitioned into less intensive model ○ Congratulate the client for being adherent and inform if they have any issues they can always contact you or the facility ○ Document outcome in the LCM register/CMIS	○ Inform client of the available support should they change their mind ○ Inform client that there is no need to test again, should they decide that they want to be initiated on ART ○ Discharge client from the LCM and document outcome

12.21 Inter-Facility LCM – From One Health Facility to Another

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

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 handing over the client, the Linkages facilitator must complete the linkage form and HTS register or update linkage outcomes in the 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 linkage's facilitator in the facility where the client is referred to.

12.22 **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. Patients should be referred to their preferred facility after the first clinical visit (14 days).
3. Patients 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 the client is still not ready to initiate ART, the client should be referred to the 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 disengaged and status of client.
7. Obtain a date when the client will visit the 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 a client has missed their appointment, the 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 the client has not reached the 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.

12.23 Responsibility Of Referring Facility

The 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 an 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		
Linkage's facilitator (Nurse/Expect Client/ Mentor Mother)	**Doctor/Nurse**	**Patient**
○ Conduct ART readiness assessment and highlight identified gaps that must be addressed during next visit ○ Assess and troubleshoot barriers to care. ○ Assess disclosure and testing of index contacts. ○ Follow up on eliciting index contacts ○ Provide motivational and informational counseling. ○ Update contacts for patients both physical and cellphone number ○ Discuss with their client their preferred facility for transfer and agree on a date the patient will visit the preferred facility.	○ Collect physical history and conduct physical assessment. ○ Review pending laboratory results Assess for side effects and adherence. ○ Document all findings in the CCF / CMIS. ○ Initiate client on ART for client ○ Fill out referral form with detailed information and set up an appointment	○ To ensure s/he understand the process of referral and linkages ○ Client should Facility if they will not be able to honor their appointment. ○ Client must understand that it is their responsibility to ensure they are linked for treatment

○ 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. ○ 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. ○ Give the client the contact number of the facility they are referred too ○ Make follow up call to confirm linkages with the facility and call the client to get feedback		○ Inform client that if they are not linked, clients will be referred to community health care worker.

12.24 Responsibilities At Receiving Facility

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 continues 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 as indicated in the LCM follow up schedule. The EC/MM/ Health Care Worker who receives the client should provide Psychosocial Services. The receiving health facility should provide feedback to the referring facility on clients either initiated at the referring facility or not initiated.

EC/MM/Nurse/Doctor	
Clients initiating ART at referring health facility	**Clients not initiated at referring facility**
○ Congratulate client for honoring visit/appointment. ○ Assess for side effects and adherence and document accordingly. ○ Introduce the importance of viral load monitoring and TB Preventive Therapy ○ Review and resolve previously identified barriers. ○ Follow up on eliciting index contacts. ○ Document client in ART register/ CMIS ○ Document client in the appointment register ○ Assign and introduce a linkages facilitator for all clients	○ Congratulate client for honoring visit/appointment. ○ Ensure HIV retesting for verification according to the national guidelines. ○ Review and resolve previously identified barriers. ○ Emphasize on the benefits of ART and early enrolment to treatment. ○ Document client in the appointment register ○ Assign and introduce a linkages facilitator for all clients. ○ Document the client in the, CMIS and in the appointment register

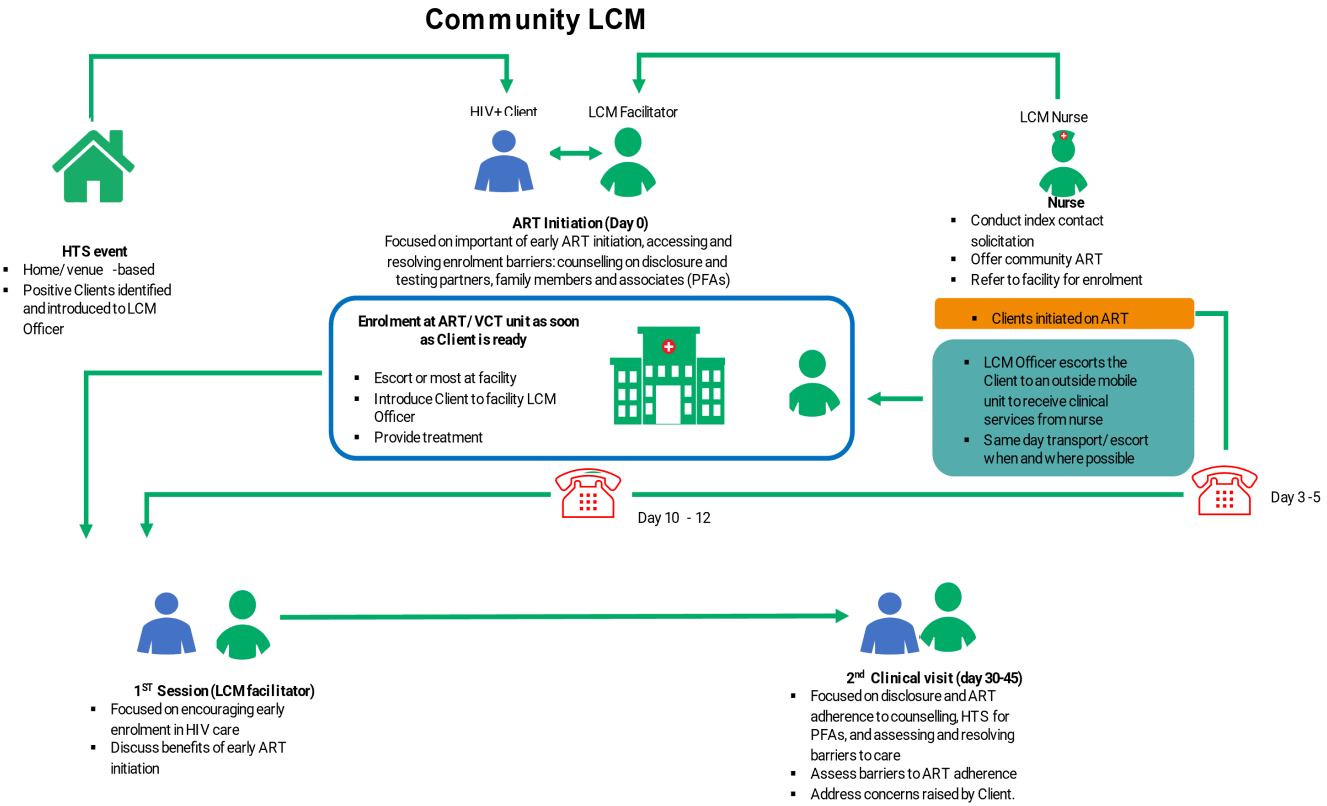
12.25 Community LCM Model

This is a referral of a client testing HIV positive at community level by a Community Health care worker (HTS counsellor/CEC/peer navigator/CMM/ RHM) or outreach service to the nearest health facility (clinic, health center, hospital). Where possible PLHIV are paired/assigned with a community peer expert client (EC) or counselor (Linkage facilitator) from HIV diagnosis until the client reaches 6 months (180 days) clinical visit. The length of LCM and package of linkage services for community clients are the same as that for facility clients**.** Linkage facilitators 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. Clients initiated on ART at community level must reach the facility within day 14. Clients testing HIV negative should be actively referred to HIV prevention services. Once client has been linked to the facility, the community partner should stop following the client, the facility will now provide the expected follow up according to LCM. In a situation where the community wants the outcome of the client they should communicate with the facility.

12.26 Community to Health Facility Linkage case management Strategies:

1) HIV testing only without community ART initiation.
2) HIV testing with community ART initiation.

Community 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. However, the community partner and facility will communicate updates on client's retention. The community Case Management model is detailed in the figure 2 below.


Community LCM
HIV+ Client
LCM Facilitator
LCM Nurse
Nurse
HTS event
Home/ venue -based
Positive Clients identified and introduced to LCM Officer
ART Initiation (Day 0)
Focused on important of early ART initiation, accessing and resolving enrolment barriers: counselling on disclosure and testing partners, family members and associates (PFAs)
Conduct index contact solicitation
Offer community ART
Refer to facility for enrolment
Clients initiated on ART
Enrolment at ART/ VCT unit as soon as Client is ready
Escort or most at facility
Introduce Client to facility LCM Officer
Provide treatment
LCM Officer escorts the Client to an outside mobile unit to receive clinical services from nurse
Same day transport/ escort when and where possible
Day 3 -5
Day 10 - 12
1ST Session (LCM facilitator)
Focused on encouraging early enrolment in HIV care
Discuss benefits of early ART initiation
2nd Clinical visit (day 30-45)
Focused on disclosure and ART adherence to counselling, HTS for PFAs, and assessing and resolving barriers to care
Assess barriers to ART adherence
Address concerns raised by Client.

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.

12.27 DAY ZERO; REFERRAL OF HIV POSITIVE CLIENT

Personnel: *HTS provider, Nurse, Peer Navigators, Community Expert client (Linkage's 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*
***Objective**: Ensure that clients referred to facility are linked to the facility*

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. Clients whether initiated or not initiated should be seen at a 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 Linkages

Community Linkages facilitator / health care worker	Client	Receiving health facility
○ Conduct ART readiness assessment and highlight identified gaps in the CCF and in the referral form ○ Must be aware of available referral services (both clinical services and community resources) at the preferred facility. ○ Must understand the services needed by the client. ○ Initiate client on ART, give client two weeks supply ○ Document referral form which include detailed physical address date client tested and HIV status or the services the client is being referred for. ○ Agree on the appointment date and the client's preferred facility. ○ Call the facility the client is being referred to make an appointment.	○ Client to link to care on the same day or within 7 days if same day initiation is not possible. ○ Provide the list for all sexual/ injecting partners, biological children below 15 years and associates. ○ Client should disclose to significant others, family, and partner when appropriate. ○ Client to honor appointments and adhere to treatment if initiated on ART	○ Health care worker who receives the client and verifies information in CMIS if the facility is on CMIS. ○ If not already on ART conduct retesting for verification. ○ The facility must call the community health care worker (if client was not escorted) to update on client referral. ○ Document update in the referral form and file the referral slip. ○ Complete and return bottom referral slip to client to give to community health care workers.

○ Complete the referral form comprehensively and ensure the client is booked at the referred facility ○ Escort or meet clients at facilities and provide treatment navigation services for at least the first facility visit as per the need of the client. ○ Do follow up with receiving facility to confirm linkage of referred client. ○ Conduct at least one follow-up support calls before ART initiation (if not on the day of diagnosis), and two follow-up support call. ○ For Community partners implementing Community ART, clients must be initiated before being referred out. ○ Discuss with the client the importance of index testing and disclosure.		

12.28 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 offers HIV testing and ideally works in collaboration with a nearby health facility. All clients testing HIV positive or identified as disengaged 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

Facilitator	
Clients willing to initiate ART	**Clients not willing to initiate ART**
○ Must be aware of available referral services (both clinical services and community resources) ○ Conduct ART readiness assessment and document in the referral form ○ Document a detailed referral form which include date client tested and HIV status, regimen client was initiated on or any other services the client was provided. Agree on appointment date and the client preferred facility. ○ Call the facility you are referring to make an appointment for a client. ○ Escort or meet clients at facilities and assist with treatment navigation services for at least the first facility visit. ○ Document referral and transport pink form to the facility to ensure the client is booked. ○ Conduct one follow-up face-to-face counseling session or through phone call once the client has been linked to the facility. ○ For Community partners implementing Community ART, clients must be initiated before being referred out. ○ Discuss with client about importance of index testing and disclosure	○ Highlight the barriers that cause the client not to initiate ○ Emphasize on the benefits of ART and early enrolment to treatment. ○ All clients refusing to be initiated on ART must be referred according to the counselling escalation plan. ○ Assign and introduce a Linkages facilitator. ○ Obtain contacts both cellphone and physical address ○ Make follow up calls as per the facility LCM SOP to find out how the client is coping with the diagnosis. ○ Inform client of the available support. ○ Appoint client in the appointment register for follow up calls and further counselling sessions. ○ Client is followed up through community health care workers and outcome must be documented in the call log systems

12.29 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 facilities for continuity of care. Files and ART numbers will be obtained from the health facility that is 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 the 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 the health facility geographical catchment area, a national referral form/transfer out to the mother clinic/facility of choice is written. The Outreach team should follow up if the client has reached the facility. if not, they should track the client.

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 the client was referred using call log tracking systems to link clients to ART and navigating positive living through trained peer navigator's/expert clients.

12.30 Responsibilities for HIV testing and initiating ART at Community level

Linkage facilitator	Nurse
○ Client is introduced by HTS Counselor to the expert client or outreach/ mobile nurse. ○ Assess client readiness for ART. ○ Client receives counselling and benefits of early ART. ○ Open chronic care file and complete psychosocial information ○ Enroll client in the LCM register/CMIS. ○ Document next appointment date on appointment register. ○ Call client or visit (Expert client, peer, peer navigation to find out how the client is coping with treatment as per LCM SOP ○ Assist and support with disclosure. ○ Discuss index testing with client	○ Conduct retesting for verification by the outreach nurse. ○ Outreach nurse will assess client readiness for ART Initiation. ○ Initiate client on ART ○ Assign linkages facilitator ○ Inform the client that it is their responsibility to ensure they are linked within the agreed upon time ○ Inform client that if they experience any unfamiliar symptoms, they should contact the linkages facilitator ○ Document the number for the facility where the client has been referred and the linkages facilitator

Clients not initiating ART	
Linkage facilitator	**Nurse**
○ Assess coping with the HIV diagnosis. ○ Review and resolve identified barriers for ART initiation. ○ Emphasize on the benefits of early ART enrollment to treatment. ○ Reassure client on available support for coping with diagnosis and treatment. ○ Provide motivational and informational counseling, including personal testimonials on importance of early ART initiation. ○ All clients refusing to be initiated on ART must be referred according to the escalation counselling plan. ○ 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 counselling sessions	○ Review and resolve identified barriers for ART initiation and address client's immediate concerns and questions. ○ Emphasize on the benefits of ART and early enrollment to treatment. ○ Discuss and explain HIV disease progression with the client. ○ Provide the Pre-ART service package for package for clients delaying ART initiation. ○ Assign and introduce a linkages facilitator for all clients. ○ Clients still refusing ART initiation, should be referred to the next level of escalation counselling according to the facility plan. ○ In case of adolescents refer for peer to peer counselling where possible

12.31 Differentiated Service Delivery for Priority Populations Linkages

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 appointments or have engaged in care.

1. ***Children***

   For children, the challenge is that they cannot consent for themselves; they rely on their parent's/care givers/guidance for either ART initiation or adherence to treatment. HCW's to continuously conduct an assessment for the primary caregiver. If there is a new caregiver HCW's must provide

counselling support and health education for continued quality of care and support.

2. ***Adolescents***

The challenge with Adolescents is that they do not come to health facilities and are not comfortable with the attitude of health care workers towards them and the vertical provision of ART services, hence there is need of friendly comprehensive services to cater for adolescent and reduce stigma. 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 of treatment, stigma/discrimination interruption of education, financial problems, the physical effects of illness, disease progression and loss of relationships.

3. ***Men***

According to Plazy M, Perriat D, Gumede D, et al., an Implementing universal HIV treatment in a high HIV prevalence and rural South showed that linkage to treatment is challenging, in the period of test and start because, PLHIV are asymptomatic hence they do not see the need to be initiated on ART thus causing them to have high viral load and this will result in fueling HIV epidemic at population level. The major challenge with men is that they do not visit health facilities, lack 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.

Data has shown that men are lagging for ART initiations as indicated in the; Eswatini HIV Incidence Measurement Survey (SHIMS) 2016-17 which showed that only 77.7% of newly diagnosed PLHIV were initiated on ART. Due to the lower uptake of ART there is need to provide male friendly services which include Provision of integrated and broader package of services at once to all men that come to the health facility or community HIV services. This will attract men and reduce stigma attached to HIV services thus leading

to an increase in ART initiations amongst men. The service provision should be flexible operational hours, friendly, and comprehensive. To scale up ART initiation amongst men the following strategies must be implemented. Placement of male counsellors in man friendly department, flexible facility operational hours, comprehensive and friendly services are necessary to scaling up linkages to ART initiation among men.

4. ***Key population***

The challenge with key populations is stigma and discrimination and they are 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 counsellors, 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 that have tested in the community can be initiated on ART at community level by community partners in collaboration with health facilities or client can be escorted to nearby facilities by expert client or peer navigator if the community partner do not offer ART initiation service

Children	Adolescents	Key populations	Men
○ For children below 5 years provide ART using family approach ○ For all children, the primary caregiver/ guardian is fully responsible for ensuring linkage and retention of the child. ○ Children depend on their parent's/ caregiver for linkages hence the importance and benefits of ART should be continuously. Emphasized on the parent/caregiver.	○ Establishing or reestablishing a peer support network (teen clubs) to provide physical and emotional care. ○ Above 12 years they can link to all health care services with the help of parents, caregiver, or treatment supporter of their own choice. ○ Emphasize on the importance and benefits of disclosure. ○ Provide Psychosocial support as per the need of the adolescent.	○ Provide outreach services that offer comprehensive HIV services. ○ Refer clients who are delaying ART initiation, missed appointment and those who disengaged from treatment to peer navigators to build social cohesion and participation. ○ Implementing index testing for sexual and/or drug injecting partners.	○ Provide IEC material on the benefits of early ART initiation. ○ Provide outreach services to male dominated industries that offer comprehensive HIV services. ○ If possible, assign male linkages facilitator who will provide empathetic guidance and support based on personnel experience as men diagnosed with HIV feels they alone.

○ In situations where the child is denied care by the parent or caregiver the involvement of social workers is obligatory. ○ Educate parents/ caregivers on the importance of age-appropriate disclosure ○ Use age-appropriate language in line with education and emotional readiness. ○ Use images or drawings to help children understand the explanations during counselling sessions. ○ Be honest. If you do not know the answer to the child's questions, say so.	○ Provision of youth friendly service package (fast tracking adolescents in uniform, extension of hours, school holidays consideration and provision of comprehensive services) ○ Assess ART readiness and address barriers to ART initiation, and discuss benefits of ART, adherence, and retention. ○ Discuss importance of family planning for adolescents that are sexually active. ○ Discuss safer sex and risk reduction.	○ If the HIV-positive client agrees, offer HIVST for `secondary distribution. ○ Educate client on consistent use of condoms and lubricants with sexual partners. ○ Refer clients not ready to initiate according to the escalation plan.	○ Provide men 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. ○ Enroll men into adherence club for men to support each other ○ STI screening at every visit and provide treatment if needed. ○ Offer VMMC if client is eligible. ○ Routine NCD screening ○ Assessment of risk factors for erectile dysfunction and premature ejaculation. ○ Diabetes and anti-hypertensive drug refills

○ Anticipate the impact of the disclosure on other family members, friends, the ○ school and the community and plan for this.	○ 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. ○ Maintain privacy and confidentiality to reduce stigma and discrimination. ○ Utilization of peer-to-peer counselling to share their personal experiences with anxiety, guilt, fear, shame, rejection, depression, and feelings of hopelessness for newly diagnosed adolescents. ○ STI screening at every visit and provide treatment in necessary.		○ Provision of curative services ○ Discuss with the client what to do in case of travelling

	○ Provision family planning to prevent unintended pregnancy. ○ Screen for breast and cervical cancer and link accordingly ○ For adolescent who have economic challenges refer them to community partners that can assist with economic empowerment		

13 Clients Who Interrupted Treatment Have (Lost To Follow Up).

This session focus on any client who returns to the facility either of their own accord or after tracing more than 28 calendar days after their missed appointment fall under the category of returning to care. For clients to continue to benefit from ART, they must not disengage from care, however, there is challenge of clients that disengage from care. Ensuring long-term retention in care and treatment for HIV/AIDS has observed to be difficult in countries with limited resources [12]. Previous studies done in other countries indicate that 20%-80% of have disengaged from care [12].

Implementing return to care approach (rather than prevention of missed visits) would be to bring a harm reduction approach to the retention problem, and to recognize that, while not optimal, absences will be unavoidable over a lifetime of treatment and reasons are complex and can change over time. A harm reduction approach would seek to reduce barriers to re-engagement. The process through which unintentional and intentional missed visits evolve into a weakened sense of connectedness, reluctance to return, and, ultimately, disengagement from care points to an underlying exchange-based relationship between health care providers and HIV/AIDS patients receiving care and ART.

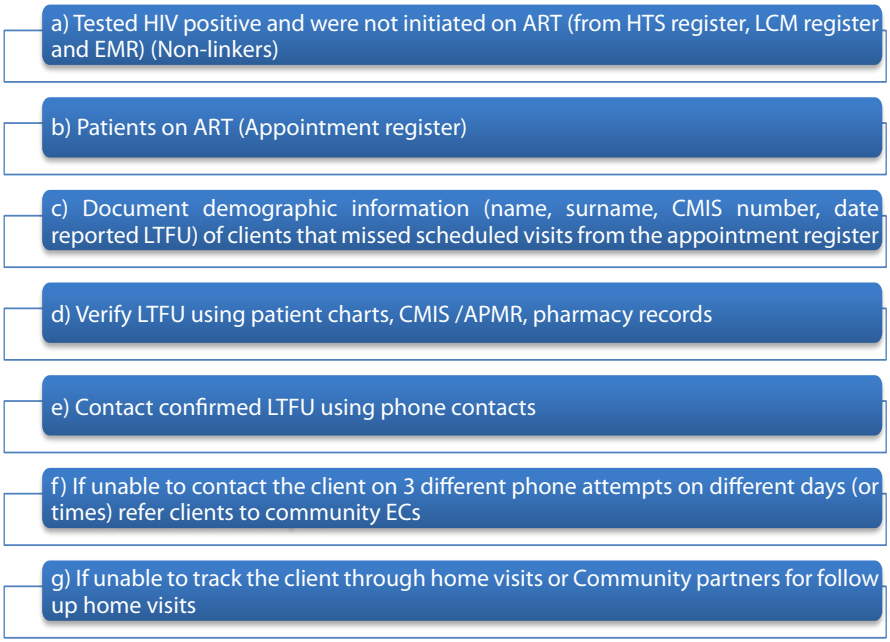
The aim of this document is to outline the process of determining the most appropriate support for patients who re-engage in care to help improved retention. Re-engagement in care involves assessing treatment interruption and adherence challenges, including reviewing documented suppressed viral loads for clients. There are various reasons why clients miss or disengage from care. These factors include individual, health system and interpersonal factors [12]. The Clients who missed appointments or dis-engaged in care must be followed up according to the patient follow up SOP. If client returns to care welcome and congratulating them for coming back and identifying the challenges that made them default. Discuss with the client on how to resolve the challenges and develop an action plan together with the client.

There are three types of clients that disengage from treatment and care, there are **immediate interrupters** (those who do not return after ART initiation)) and **early interrupters** (those who interrupt in the first six months on ART), late interrupters(those who stop treatment after 6 months post initiation)**.**

To identify clients that have missed, defaulted or loss to follow-up health care workers must use the process listed in the loss to follow up SOP.

Process to identify client that have disengaged from care include the following activities

1. Identify the clients that missed scheduled visits from the appointment register for > 28 days (LTFU). This should include:



a) who tested HIV positive and were not initiated on ART (from HTS register, LCM register and EMR) (Non -linkers)
b) Patients on ART (Appointment register)

c) Document demographic information (name, surname, CMIS number, date reported LTFU etc.) of clients that missed scheduled visits from the appointment register
d) Verify LTFU using patient charts, CMIS /APMR, pharmacy records
e) Contact confirmed LTFU using phone contacts
f) If unable to contact the client on 3 different phone attempts on different days (or times) refer clients to community ECs
g) If unable to track the client through home visits or Community partners for follow up home visits

13.1 Steps for Patient re-engaging to treatment

Re-engagement in treatment and care involves the following steps:

- Warm welcoming of clients which include congratulating the client for coming back (Avoid scolding or being judgmental)
- Pledge support that as facility staff you are here to support the client through the journey of ART.
- Identifying the reason, the client interrupted treatment interruption and adherence.
- Ascertain which drugs the patient was taking, and for how long, the reasons for stopping treatment, check if they had any side-effects.
- Reviewing chronic care/ green booklet to check last regimen and check viral documented suppressed viral loads. Patient should be referred for escalation counselling.
- Refer client for further escalation counselling at facility or community according to the type of barrier identified.
- Manage according to HIV guidelines.

13.2 Immediate interrupters (those who do not return after ART initiation

1. First session

These are clients that do not honor their first clinical review. Below are the activities to be done to the client who are reengaging to care after welcoming

and congratulating the client.

- Explain to the client that there will be various counselling session to assist client through their journey which will include treatment and support services.
- Where possible for men assign a male expert client who will serve as a mentor as men feel they are alone in this journey, or they have failed their families
- For adolescents where possible assign peer to provide further counselling
- Inform client that you will assist them to develop individualized adherence plan to help them take their treatment correctly.
- Identify what made the client to disengage.
- Create an adherence plan together with the client to identify the support system, develop reminder, and to communicate with facility in-case they will not be able to visit the facility.
- Education client on the disease progression and treatment
- Inform clients of other treatment options once they are suppressed.
- Discuss what to do in case client will be travelling.
- If reason for interrupting treatment is beyond EC, refer according to facility counselling plan
- Find out from the client if they will be willing to contacted by phone or home visit.
- Enroll them into LCM.
- Refer to clinician to be reinitiated same regimen.

2. **Second session:**

The main objective is to follow up on the previous agreed upon plan and identify any challenges the client experienced while they were taking treatment at home and review action plan if there is a need. Allow the client to share what they have managed to implement and the challenges they experienced. The client will be called to be reminded of their next appointment visit as per the guide in the extended LCM.

Activities to be implemented during second visit.

- Congratulate the client for coming back and the minor milestones they have achieved in relation to adherence

- Review action items together with the client, including side effects.
- Motivate and encourage the client to continue with treatment.
- Find out from the client if they think it is important to disclose your health status?
- If the client is positive about disclosing, take them through the process of disclosure.

3. **Third Session**: **Plan for future appointments and adherence plan**

This session is to prepare the client to be fully responsible for taking treatment.

Activities to be implemented during third visit.

- How will you keep track of your next appointment?
- What will you do if something prevents you from coming to your appointment, such as no money for transport, raining when you usually walk, taxi strike or a sick child or any other reason?
- What reminder strategy do you have in place to avoid forgetting treatment or keeping appointments?

Early interrupters (those who interrupt in the first six months on ART ***Activities to be implemented.***

On top of the above activities, clients that have stopped treatment after 6 months the following need to be considered.

- Check if they were done viral load, if yes were they suppressed.
- Reinitiate on the same regime they were on
- If not done take blood samples to check viral load
- Call client once results are back.
- Enroll client into LCM.
- Provide Psychosocial support according to the challenges that resulted in the client disengaging from care

Late interrupters (those who interrupt in the after six months post ART initiation ART ***Activities to be implemented.***

On top of the above activities, implement the following activities :

- Conduct ART readiness assessment
- Determine what made client to stop treatment
- Provide step up adherence counselling according to enhanced counselling guide
- Build client resilience to cope with previous, current, and potential barriers or challenges

13.3 Linkages For HIV Negative Clients

If the country is to achieve 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. Clients that are testing HIV negative yet are at risk of getting infected with HIV must be provided with an HIV prevention package according to the client's selected and preferred method of HIV prevention. These may include at least the following: VMMC, PrEP, PEP, condoms, STI screening and treatment, HIVST, and family planning. The following groups must be prioritized for HIV prevention package; AGYW, men, children, key populations, pregnant and lactating women since recency data has shown that new infections are high amongst this sub populations. Clients must not be pressured in accepting prevention services, however they must be educated on the benefits of each prevention method and assured of support if they change their mind and want to be given prevention package. All clients testing HIV negative must be actively referred for comprehensive prevention packages.

13.4 Responsibility Of Health Care Worker For The Hiv Negative Client

- Determine next retesting date.
- Offer Core Package for Combination HIV prevention.
- Refer 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.

13.5 Strategies To Improve Bidirectional Linkage

If facilities are to improve linkages between community and facilities, there should be systems that promote clear communication between facilities and the community. Community health care workers should partake in facility multi-disciplinary meetings.

- Mapping of community partners
- Monthly / Quarterly Collaborative meeting regional level
- Identification of focal linkages focal persons in facilities and communities
- Participate in facility MDTs to develop a collaborative work-plan with the key objectives (Return to care and linkages to treatment pathways)

1. Quality Improvement

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

2. Facility

- Facilities will be trained on the LCM SOP and tools will be made available in all facilities implementing LCM for guidance.
- Facilities will conduct linkages data review during MDT 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.
- Tracking of linkages on weekly basis
- To hold collaboration meetings with community testing partners

3. Regional

- The Regional Health Management Team will be oriented on LCM and will be responsible for including LCM in the regional plans.
- Inclusion of linkages indicators in Regional Health Semi Annual Review (ReHSAR) meetings
- Tracking of linkages bi-weekly

- Tracking of LCM reports by regional Strategic Information Department (SID)

4. 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.
- Inclusion of linkages indicators in National Health Semi Annual Review (NaHSAR) meetings
- Review and adapt LCM tools as per the need.

13.6 Monitoring And Evaluation

The purpose of this section is to provide guidance to HCW/ Linkage Facilitator on the different methods used for monitoring, evaluation and reporting of HIV linkages. It will also sensitize HCW/ Linkage Facilitator on how to document and report data/information as per National reporting guidance.

13.7 Linkages Data Collection Tools

The LCM program currently uses two data collection systems concurrently, as the referral and linkage indicators for LCM are partially covered on electronic system. These two systems are the electronic system known as Client Management Information System (CMIS) and the paper- based tools. The electronic CMIS LCM variables are integrated within the different HIV modules.

For paper- based the following reporting tools are used.

Name of tool	Description	Responsible	Frequency of Use
Appointment register	Captures all next appointments/ visit for all PLHIV	Linkage Facilitator	Daily
LCM register	Captures all newly identified HIV positives and return to care clients for a period of 3 to 6 months to monitor linkage and adherence.	Linkage Facilitators	Daily
LCM monthly summary	Collates all verified LCM activities for the months, the source being the LCM register.	Linkage Facilitator and Nurse	Monthly

13.8 Linkages Case Management Data Flow and Reporting

The diagram below shows the flow of linkages case management data from service delivery to the Health Management Information System (HMIS).

LCM Data Flow

- Each Linkage Facilitator should submit the monthly summary report to the facility focal person for consolidation and verification.
- The reviewed and verified summary form must then be submitted to the regional SI (HMIS) by the 07th of every new month.
- Upon verification by the HMIS personnel information is captured on the HMIS portal.
- M&E personnel will then have access to the data, to produce reports for program and stakeholders.

LCM Indicators

- The table below shows the list of key LCM indicators as identified by the program based on Stakeholder recommendations include WHO, the Country HIV Program and other related monitoring, evaluation and reporting structures
- Disaggregation can be by age, sex, region and adults/ children.

13.9 List of LCM Reporting Indicators

Indicator	Description	Calculation	Data Collection tools
Proportion of PLHIV enrolled onto LCM	Percentage of adults and children enrolled into linkages case management	**Numerator:** Number of PLHIV enrolled into Linkages case management **Denominator:** Total number of HIV diagnosed clients in the reporting period	LCM register LCM register
Number of clients identified as HIV positive	Total number of clients that had a HIV positive result during the reporting period.	n/a	HTS register HTS summary Index testing register HIVST register CMIS
Number of clients enrolled on LCM.	Indicator measures the HIV positive clients the consented to enrolled onto LCM.	n/a	LCM register LCM summary
Number of clients transferred in from community and other facilities	Total number of transfer-ins	n/a	LCM register

Number of HIV positive clients linked for ART initiation	Total HIV positive clients that were initiated on ART during the reporting period.	n/a	LCM register LCM summary CMIS HIV module Chronic Care File
Number of clients transferred out after initiation.	Total clients that wanted to be to transferred to another facility after being initiated on ART.	n/a	CMIS HIV module LCM register Chronic Care File LCM summary
Number of clients enrolled from facility who received first call.	Clients that were called within 3-5 days LCM enrollment	n/a	LCM register LCM summary
Number of clients who received the second call.	Clients that were called or followed-up after 10-12 days of bring enrolled on LCM	n/a	LCM register LCM summary
Number of clients who came for 14-day visit.	Clients that attended their 14 days clinical visit	n/a	LCM register LCM summary Appointment register CMIS appointments
Number of index cases with contact tested for HIV.	Total index cases wit contacts that were tested for HIV	n/a	LCM register Index register CMIS

Number of clients who have disclosed HIV status to at least one person	Total clients enrolled on LCM that have disclosed their HIV status	n/a	LCM register
Proportion of clients enrolled on LCM initiated on ART	Percentage of LCM clients (adults and children) that were started on ART during the reporting period.	**Numerator**: Number of PLHIV enrolled on LCM newly initiated on ART **Denominator:** Total number of people tested HIV positive enrolled on LCM	LCM register
Proportion of LCM clients retained and virally suppressed in care at 6 months.	Percentage of clients enrolled on LCM with a virally suppressed 6 months after initiation (cohort indicator)	**Numerator**: Total number of LCM clients on ART that were virally suppressed. **Denominator**: Total number of eligible clients enrolled on LCM that has VL taken	LCM register LIS CMIS APMR

Proportion of clients with a LCM outcome by type	Percentage of clients enrolled on LCM that reported an outcome after completion at 6 months (cohort indicator).	Numerator: Total number of clients that had an outcome (completed, transferred out, LTFU, died or did not imitate) after completion **Numerator:** Total number of clients enrolled on LCM that were eligible for completion	LCM register

14 Annex

Barriers to ART Initiation

Assess and resolve (if applicable) enrollment barriers for all clients and before case closure, be sure all Barriers have been resolved. If not, clients should be referred according to the facility escalation plan.

Objective:

To assist clients overcome ART initiation barriers and retain them in care using LCM strategy

Enrollment Barrier	Clients Perception for not starting treatment	Possible intervention
Individual factors		
1. Feeling healthy/well Some men are unaware that early treatment can mean a longer and healthier life. Some know but find it too	*Client does not believe he/she needs to start treatment because of perceived good health.* *Patient argues that with high CD4 count, there is no need to start ART.*	• Explain that the earlier an individual starts ART the longer they can live without acquiring AIDS. • Explain the goal of ART is to improve quality of life. • Refer client to clinician for escalated counselling according to facility adapted plan. • Clinician Explain HIV progression using Pretreatment viral load. • Inform client that treatment guidelines have changed and now nearly all clients can start ART on the day of diagnosis Explain the previous threshold for starting ART (200-350-500)

2. No time; too busy with work, school, or other responsibilities.	*Client believes he/she does not have time to initiate or come for refills*	• Enroll client on LCM. • Explore the clients' time commitments, underlying reasons. • Provide Motivational counselling • Develop a treatment plan that will address adjusting refill dates and time to suit the client. • Appoint client for counselling session based on the agreed time and date · • Inform client about the DSD model once client is on treatment and have undetectable viral load. • Refer client to clinician for escalated counselling

3. Denies being HIV infected.	*Client believes he/she is not infected with HIV.*	• Inform client that before being initiated on ART they will be retested for verification by another health care worker. • Clinician Explain HIV progression using Pretreatment viral load. • Provide motivational counselling. • Enroll client on LCM. • Explore why the client does not want others to know.
4. Loss of confidentiality and stigma.	*Client does not want others to know and fears stigmatization if identified at the ART clinic.*	• Share benefits of disclosure and implications of not disclosing. • Be cautious and explore the potential of partner violence. • Explain disclosure process. • Inform client that ART services are now integrated to service points.
5.Substance abuse.	*Client has been drinking too much and/ or using other drugs.*	• Explain effects of substance abuse on adherence and possible interactions. • Refer client to clinician.

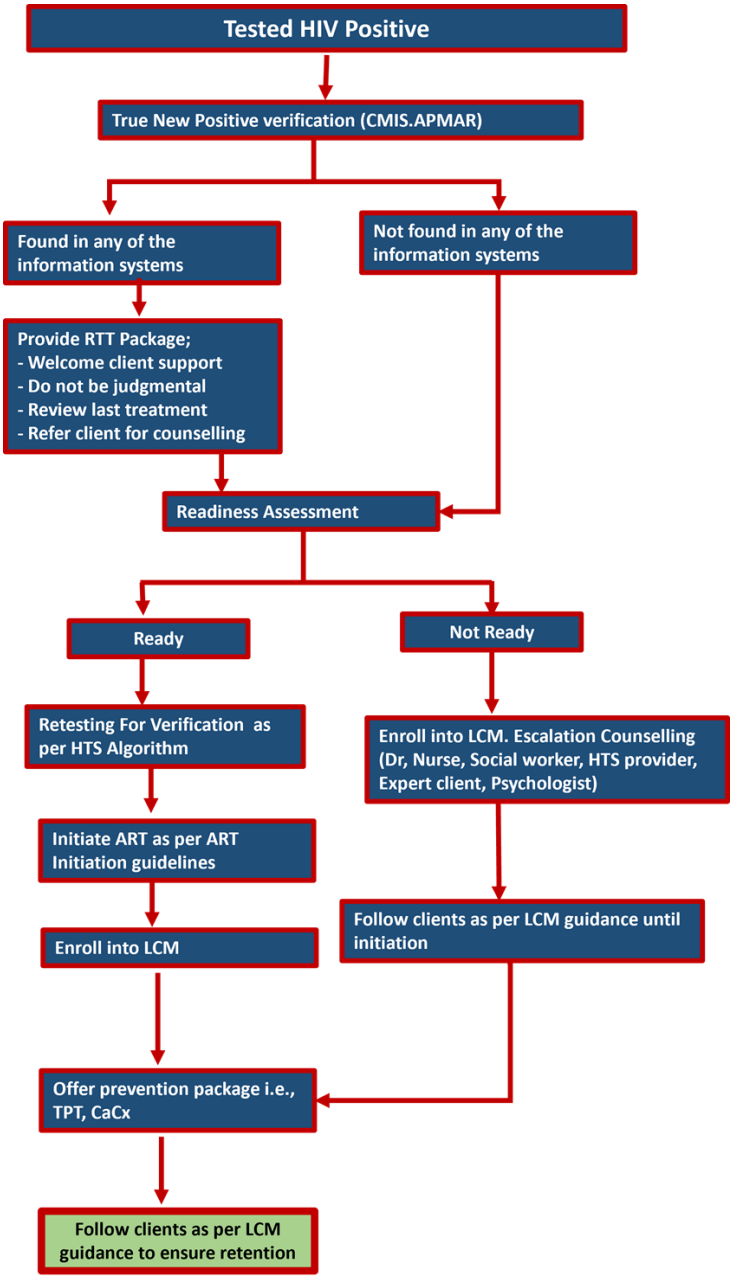
6. Denial that client has HIV, Want Confirmation in another facility	*Clients want second opinion.*	• Clinician to refer client to psychologist/mental health nurse. •
7. Concerned about lifelong commitment	*Client is worried that he/she might not be able to adhere to treatment.*	• complete referral form and empower client to produce referral form to site wherever he/she test. • Inform client that before being initiated on ART they will be retested for verification by another health care worker within or in another facility of his/her choosing. • Demystify ART (explain what is, how it works and potential side effects). • Enroll client on LCM · • Yes, ART is a lifelong treatment, and it is not just the only one, there are other conditions that you must take treatment for the rest of your life, e.g., diabetes, hypertension etc.

8. Fear of side effects	*Clients is concerned about side effects*	• Inform the client that there are simpler, less toxic combinations. • The health care worker should inform clients about possible side effects and advise clients to report to nurse or doctor as soon as possible. • Encourage treatment ownership and report new or unfamiliar symptoms at each visit. • • Explain about the continuous monitoring of side effects by clinician during refills which has scaled up early identification of side effects.
Interpersonal factors		
1. Fear's lack of support, violence, or separation from spouse/partner or partners disapproval.	*Client fears might not get support from close family members, partner(s), Peers, and associates.*	• Educate client on the disclosure process (who, why, when, and how) • Explain benefits of disclosing status. • refer client to social worker for further counseling and support. • Encourage client to join support group for peer support

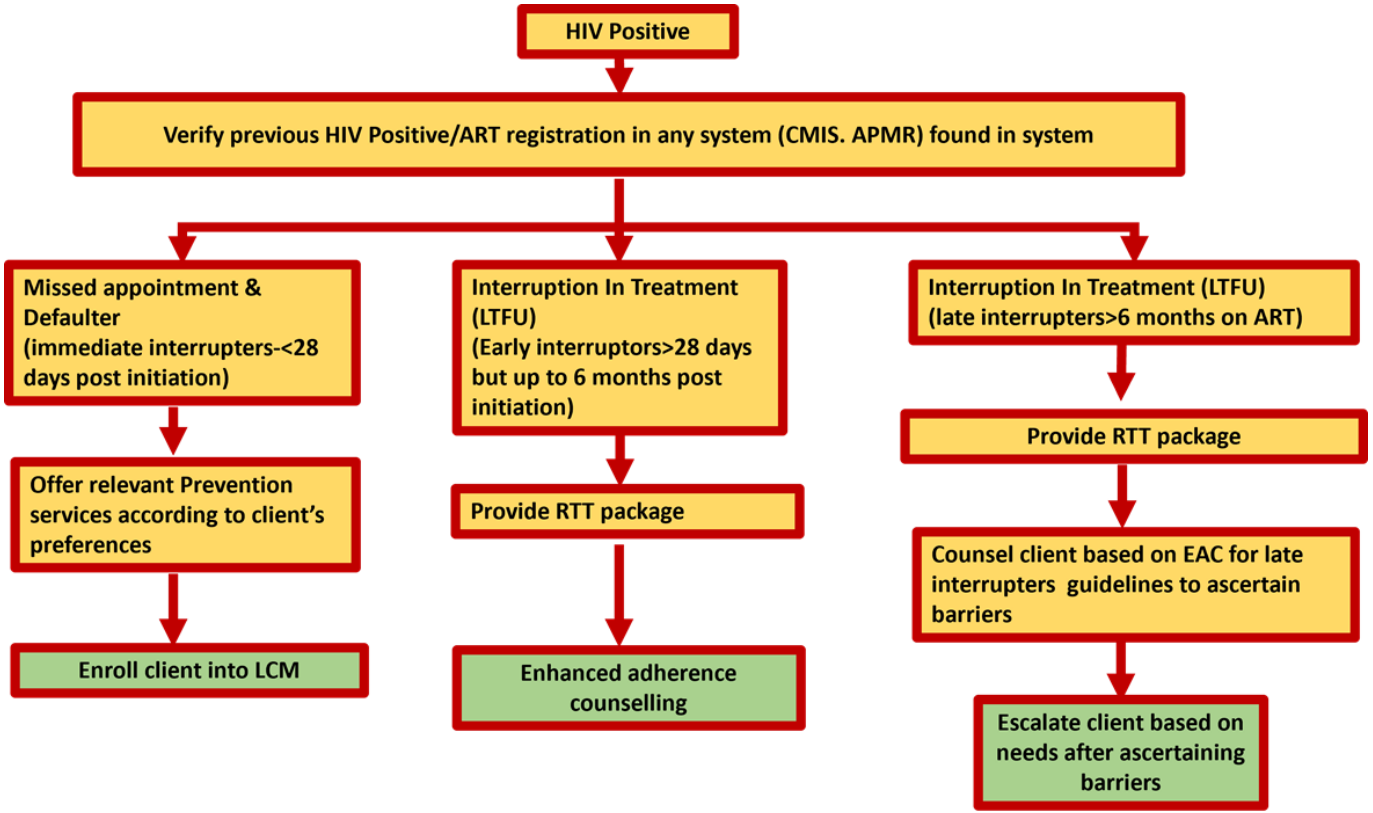
2. Want to disclose to partner first	*Fear reaction of their partners if they start treatment.* *Perceived lack of support from spouse if he/she starts ART* *Lack skills to disclose*	• Educate client on the disclosure process (who, why, when, and how) • Explore the reasons why client wants to disclose to partner before initiation. • refer client to social worker/ mental health nurse/ psychologist for further counseling and support • Refer 101 counselling job aid
3. Believes in traditional medicine.	*Client believes that traditional medicine cures HIV or AIDS.*	• *Explain the basic facts about HIV.* • *Inform client of possible drug interaction with traditional medicine.* • *refer for further counseling as per escalation plan*
4. Has strong religious beliefs.	*Client believes that prayer will cure HIV or AIDS.*	• *Explain the basic facts about HIV.* • *refer for further counseling as per escalation plan.*
Health system factors		
1. Quality or delivery of HIV care is poor	*Client believes treatment offered is sub-standard*	Ascertain why the client thinks services offered is sub-standard. • Inform clients that there are standard trainings for all HCWs in country· • Document referral to preferred site and set appointment. • Enroll into LCM for follow up

2.Operational hours not conducive to clients	*Facility Operating hours*	• Explore possible time for initiation. • Inform client about DSD models offered by facility that can suit his/her situation. • Facility should develop plan on how to manage clients that are unable to attend during normal operating hours.
3. Vertical ART services	*Clients feel vertical ART services will lead to incidental disclosure*	• Inform client that ART services are now integrated to service points
4. Health care worker's attitude towards clients	*Clients feel they have been mistreated*	• Inform clients on procedures of how report if mistreated. • Assure the client that the facility will support and has best intention for all clients. • Explain that the earlier an individual starts ART the longer they can live without acquiring AIDS
5. Use of unique identifier	*Clients perceive that there would be breach of confidentiality*	• Explain why it is necessary to use unique identifier.
6. Long queues at facilities	*client thinks he/she does not have enough time to wait in line*	• Inform client about the DSD model once client is on treatment and have undetectable viral load.
7.Long distance to health facility	*Client believes that you can only initiate ART certain health facility*	• Initiating ART at community level • Assure the client that ART has been decentralized to most health facilities in country

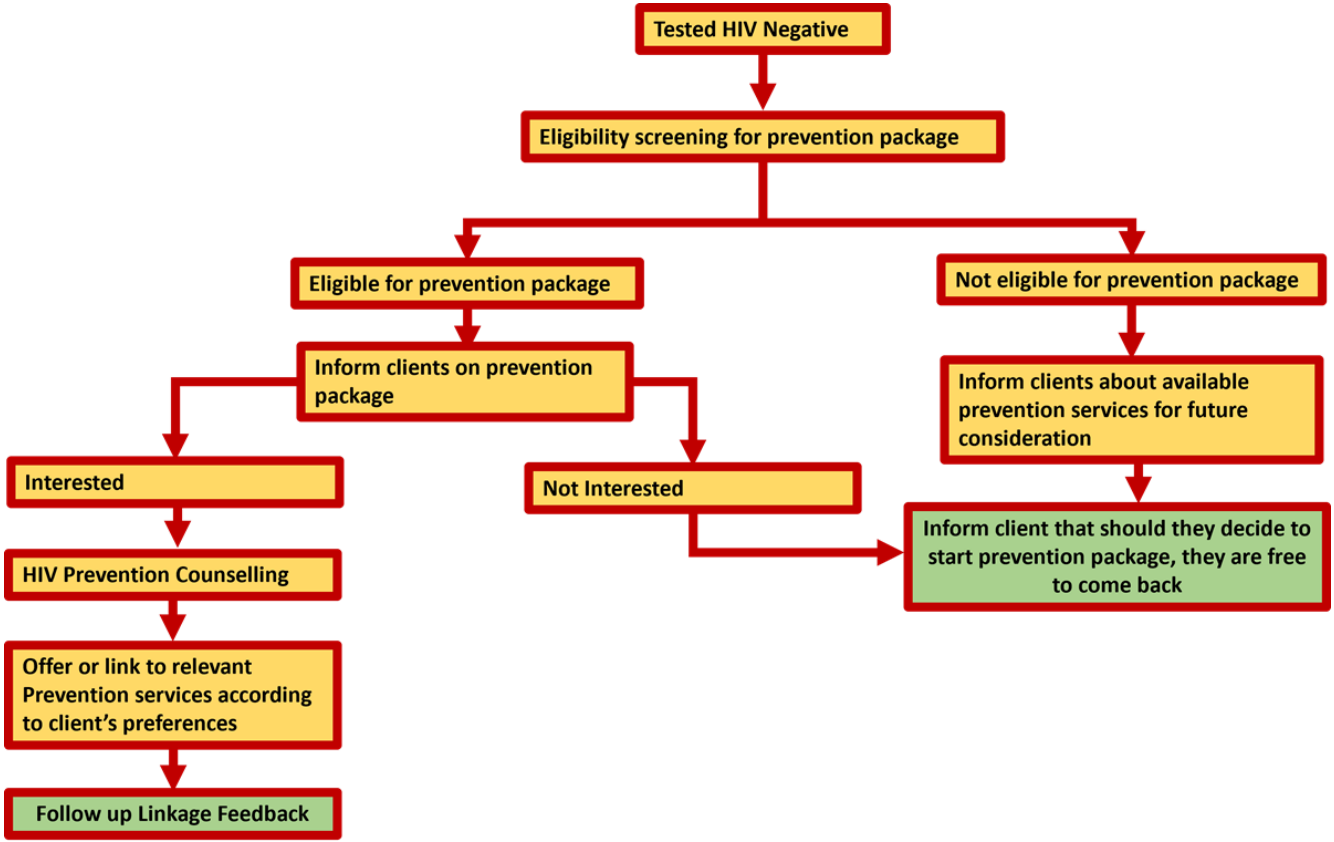
14.1 Annexure 1 Linkages for Client Testing Positive in the Facility



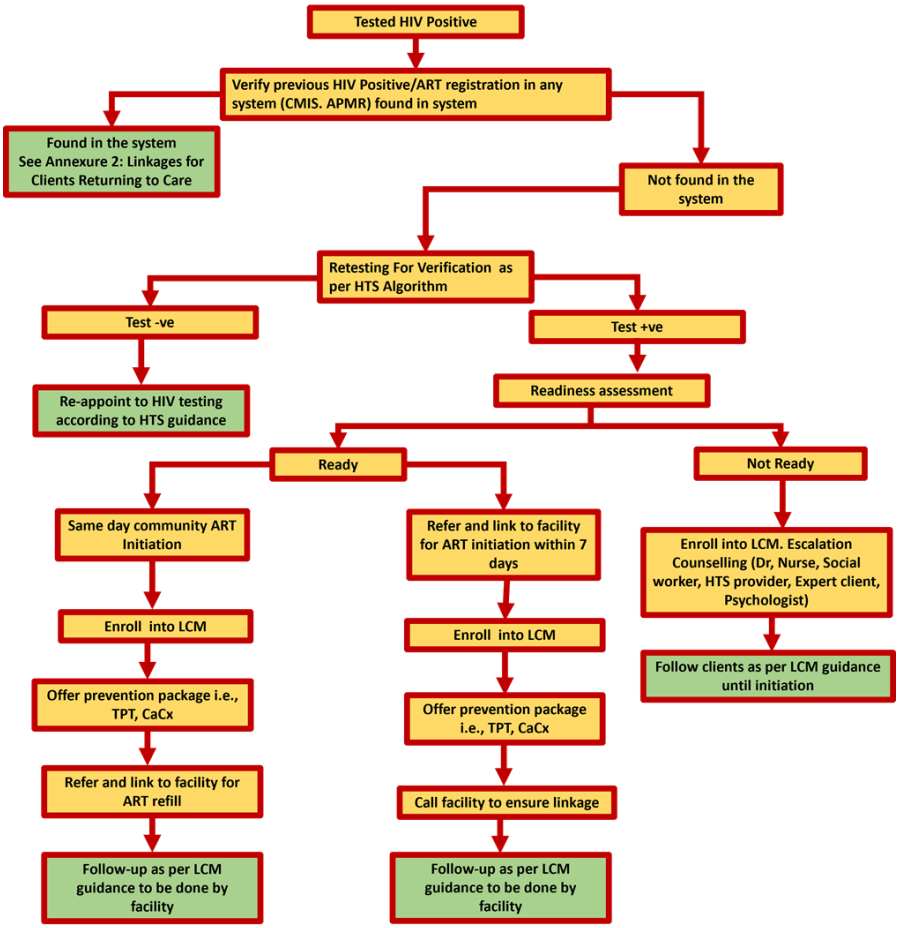
14.2 Annexure 2 Linkages for Client Returning to Care



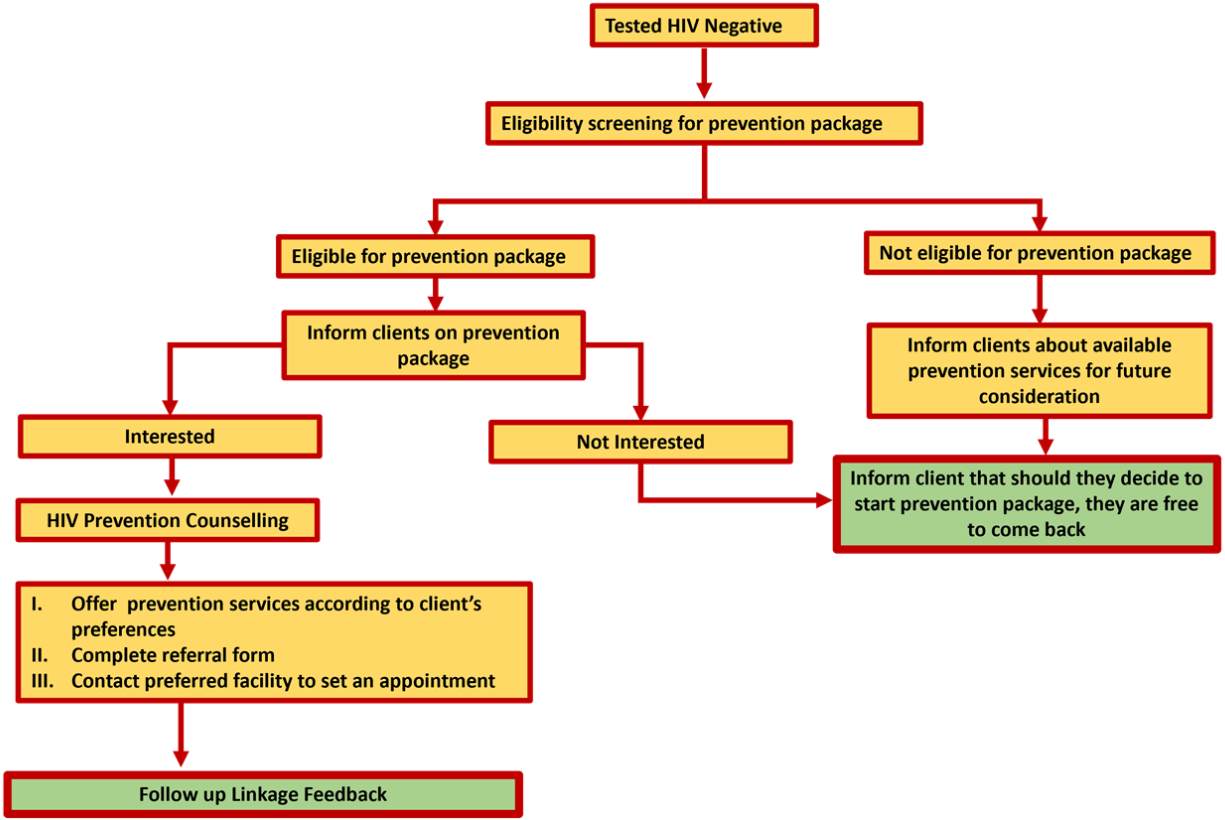
14.3 Annexure 3 Linkages for Client Testing Negative in the Facility



14.4 Annexure 4 Linkages for Client Testing Positive in the Community



14.5 Annexure 5 Linkages for Client Testing Negative in the Community



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