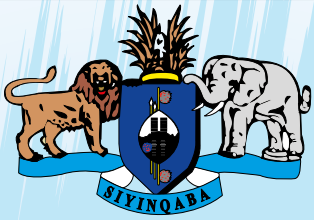


Ministry of Health
Kingdom of Eswatini

HIV LINKAGE CASE MANAGEMENT

STANDARD OPERATING PROCEDURES (SOP)

MAY 2019

PEPFAR

MOH HIV/AIDS SNAP

World Health Organization

FOREWORD

Eswatini adopted the 95-95-95 strategy as part of the National Multisectoral HIV and AIDS Strategic Framework (NSF) 2018-2023 which calls for: identifying 95% of people living with HIV (PLHIV) knowing their HIV status; 95% of PLHIV who their status initiating and retaining on antiretoviral theraryp (ART); and 95% of ART clients viral supressed. Also, according to the Eswatini HIV incidence measurement survery 2 (SHIMS 2), the country has reduced new HIV infections by 44%[1] HIV testing has been scaled up in all entry point with 84.7% Emaswati knowing their HIV status. However, linkage to care and HIV prevention amongst key populations, children, adolescent girls and young women, pregnant women and men remain a challenge in the country. Few PLHIV diagnosed receive antiretrovial therapy (ART) within 7 days of diagnosis (rapid ART) in accordance with World Health Organization recommendations and not all people diagnosed HIV negative have access to prevention services. If the country is to achieve the 2nd and 3rd 95 as well as zero new HIV infections. Linkages to HIV prevention services is critical for those testing HIV negative and treatment of PLHIV and those identified to have dis-engaged must be prioritized especially amongst the priority groups.

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

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

Dr S.V. Magagula
DIRECTOR OF HEALTH SERVICES

DOCUMENT CHANGE HISTORY

Document No.	Effective Date	Significant Changes	Previous Document No.
ENAP ACT 015	May 2019	Initial release	N/A

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

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

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

The following individuals are acknowledged for tirelessly and meticulously developing this SOP:

1. Muhle Dlamini	SNAP	21. Mbuso Mabuza,	NERCHA
2. Harriet Mamba	SNAP	22. Violet Bulima,	MoH
3. Rudo Kuwengwa,	SNAP	23. Nomthandazo Lukhele	WHO
4. Lenhle Dube,	SNAP	24. Phumzile Mndzebele,	CDC PEPFAR
5. Ntombi Ginindza,	SNAP	25. Daniel Williams,	CDC Atlanta
6. Nompilo Dlamini,	SNAP	26. Duncan Mackellar,	CDC Atlanta
7. Nompilo Gwebu,	SNAP	27. Thembisile Dlamini,	UNAIDS
8. Nhlanhla Magagula,	SNAP	28. Lindiwe Mkhatshwa,	URC
9. Sindy Shongwe,	SNAP	29. Batsabile Simelane	URC
10. Ayanda Sikhondze,	SNAP	30. Thando Mabila,	URC
11. Nkanyiso Gambu,	SNAP	31. Khulekani Simelane	URC
12. Promise Dlamini,	SNAP	32. Arlerta Ndlela,	ICAP
13. Nonhlanhla Dlamini,	SNAP	33. Nokuthula Mdluli Kuhlase,	PSI
14. Bongani Masango,	SNAP	34. Simangele Mthethwa-Hleta,	EGPAF
15. Nobuhle Mthethwa	SNAP	35. Dr.Kikanda Kindandi,	EGPAF
16. Khanyi Lukhele,	SNAP	36. Pholile Dlamini,	M2M
17. Thabo Motsa,	M&E unit	37. Muzi Nzima,	MSF
18. Ntombikayise Dlamini,	SRH	38. Mbongeni Magagula,	SWABCHA
19. John Myeni,	RHM	39. Bonginkosi Zwane,	SWABCHA

ABBREVIATIONS AND ACRONYMS

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
EC	Expert client
ENAP	Eswatini National AIDS Programme
HCW	Health Care Workers
HF	Health Facility
HIV	Human Immuno deficiency Virus
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	Out Patient 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

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.

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 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 facility.

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

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

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

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

Linkage to Care and Treatment: Is the process when the client has reached the facility and provided with care and treatment services he/she needs. The referring facility verifies if the client has arrived and was provided with services or the receiving facility gives feedback to the referring facility**.**

Linkages case management: Linkage case management (LCM) comprises the package of linkage services including; individualized case management; treatment navigation and index testing.

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

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

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

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

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

Stable clients: Clients that have tested HIV positive without opportunistic infection.

Background

Eswatini has a mature and generalized HIV epidemic primarily driven by heterosexual sex. According to 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).

The Kingdom of Eswatini adopted the 95-95-95 strategy as part of the National Multi-sectoral HIV and AIDS Strategic framework to end HIV and AIDS by 2022. This strategy calls for: Identifying 95% of people living with HIV (PLHIV) and ensure they know their HIV status, the second 95% is ensuring that 95% of PLHIV must be initiated on ART while the third 95% refers to that 95% PLHIV initiated on ART must be virally suppressed. To achieve the 1st and 2nd 95, linking of PLHIV to ART and those testing negative for prevention package is important to improve outcomes and hence reduce mortality.

According to the NSF 2018-2023 the linkage rates is sub-optimal as not all PLHIV are effectively linked to treatment. About 84.7% of people living with HIV know their HIV status, however, 87.4% of those diagnosed with HIV are on ART. Linkages case management (LCM) is a strategy recommended for the improvement of linkages to treatment for identified HIV positive clients based on evidence 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[1,2]. Based on the evidence, This Standard Operating Procedure (SOP) presents critical scenarios for effectively linking clients to ART which are Intra, Inter facilities and from community to facility. The implementation of Linkage Case Management approach is crucial in reaching the 2nd 95. All LCM services included in this SOP are evidence-based linkage services recommended by the United States Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO)[2,3].

Rationale for Linkage Case Management

Although HIV testing and treatment programs have increased access to ART remarkably, many People Living with HIV (PLHIV) still initiate ART late particularly those amongst young adult males and people diagnosed in the community[2-4]. 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[2]. According to the NSF 2018-2023 there is 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 privacy[2, 5, 6]. There is also loss of newly diagnosed PLHIV referred

from one service point to another or from one facility to another. ART initiation is not the same amongst PLHIV as indicated in the 2017 MoH HIV Programs report; key populations (sex workers and men having sex with men) only 8% (207/2576), pregnant women-93% which was a decline from 95% for 2016, children (0-14 years)-75% and above 15 was 86%[7]. Provision of LCM has been seen to be effective in Tanzania where it was being implemented and again in Eswatini where it was being piloted by PSI in community testing, in both countries more than 90% of PLHIV were linked into care [2, 3, 5].

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

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

Objective of Linkage Case Management Standard Operating Procedures

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

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

Barriers to ART Initiation

It is important to understand some factors recognized as barriers that affect linkages at facility level which include; Individual, Community and system factors [1, 8, 9]. See annex 1

Linkage Case Management Model

Linkage case management provides the package of CDC/WHO recommended evidence-based linkage services adapted to the local Eswatini context for new and previously HIV diagnosed PLHIV who are out of HIV care [5, 4]. PLHIV who enrolled into LCM (clients) are paired either with a peer navigator, expert client (EC), HTS counsellor, mentor mother (Linkages Facilitator) from HIV diagnosis through to the client's 2nd ARV refill. Linkages facilitator provide the package of recommended services for up to 45-60 days for most clients. Linkage Case management services Package includes: Individualized case management, treatment navigation and Index testing.

Individualized Case Management Services

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

Treatment Navigation Services

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

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

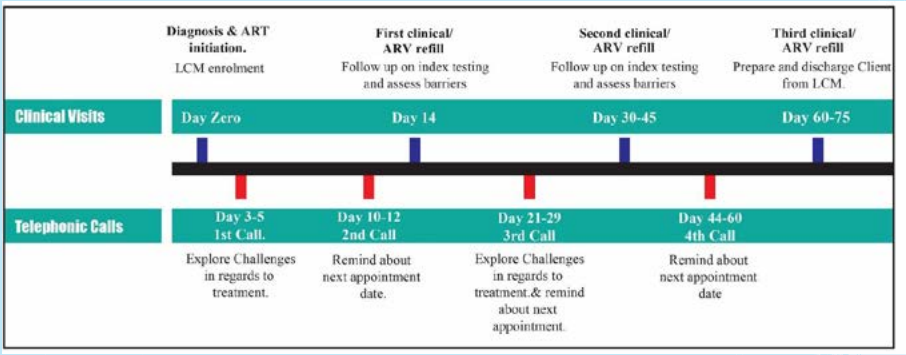
- Assist staff in providing adherence counseling.

Index Client Testing

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

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

Summary of Linkage case management services



Guiding Principles for Linkage Case Management

The Linkage Case Management approach in the kingdom of Eswatini is guided by six guiding principles of LCM which are:

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

Eligibility Criteria for Linkage Case Management

Eligibility Criteria include:
All HIV-positive clients diagnosed in the Facility/Community, who are referred for Linkage Care Management services. These maybe HIV positive clients;

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

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

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

NB: *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.*

Criteria for Discharging Clients from Linkage Case Management

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

- Client has been initiated on ART and received their 1st and 2nd ARV refills on time
- Client has disclosed status to a partner, family member, or associate.
- Client is 100% adherent to treatment and has been on time for scheduled appointments, and is not at high risk for defaulting from ART care

Intra-facility Linkage Case management – Within the same Health Facility

This is referral made 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 personnel cadres in the facility. There are different scenarios in facilities as outlined below:

Different Scenarios for ART initiation in intra-facility LCM

1. *Initiating ART in the same consulting room as the HIV diagnosis (Annex 2)*

- HIV testing is done by a Nurse and the client testing HIV positive is initiated by the Nurse/Doctor.
- After ART initiation, the nurse assigns the client to a linkages facilitator who then assist the client with
    - Psychosocial counselling
    - Addressing barriers to adherence
    - Discussing importance of disclosure including index testing
    - Navigate treatment including refills.
- In health facilities with multiple HTS entry points, ART initiation is to be done by the Nurse/Doctor in the respective units.

2. *Initiating ART in the different consultation rooms within Outpatient Department (Annex 3)*

- HIV testing is done by the HTS counsellor, who opens a chronic care file for the client that is HIV positive.
- The HTS counsellor hands over the client to a linkages facilitator or an EC's if available who then assist the client with
    - Psychosocial counselling
    - Addressing barriers to adherence
    - Discussing importance of disclosure including index testing
    - Navigate treatment including refills.
- After assisting the client, the EC escorts the HIV Positive client to ART initiation room.
- The client is initiated by the nurse or doctor, after ART initiation the nurse assigns client to a linkages facilitator.

3. *Initiating ART at a co- located ART Clinic/VCT. (Annex 4)*

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

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

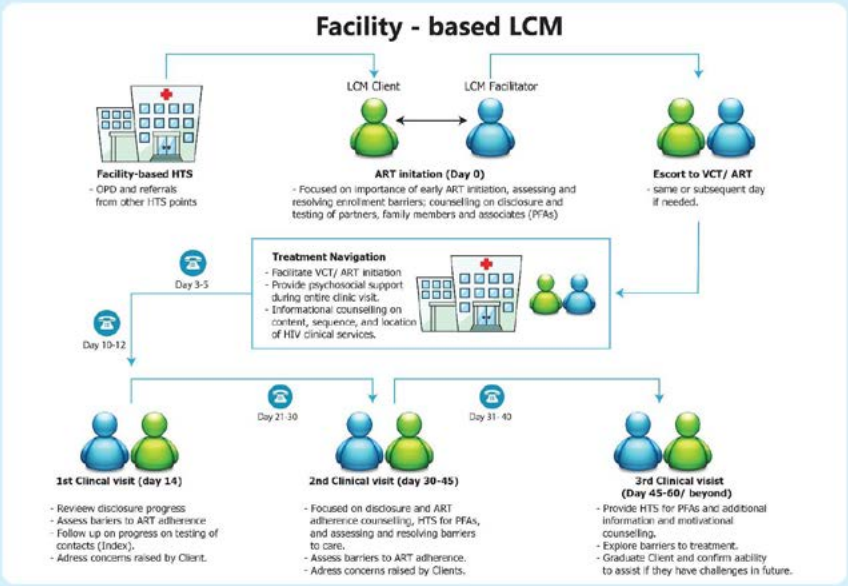
- HIV testing is done by the nurse /HTS counsellor who opens the chronic care file for the patient who test HIV positive
- The nurse/HTS counsellor refers client testing positive to the Nurse/ Doctor who initiates patient on ART.
- The client is discharged via the ART/VCT unit to be assigned a Linkages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

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

NB: Facilities with Nurse only: *The nurse will be the linkages facilitator*
Facilities with HTS counsellor & Nurse: *The HTS counsellor will be the Linkages Facilitator*
Facilities with nurse and EC's: *Linkage Facilitator will be the EC*
Facilities with both EC and mentor mother and nurse: *Both EC and mentor mother will be linkages facilitator; the EC will be responsible for general population while the mentor mother will be responsible for pregnant and lactating women and under-fives through their caregivers/parents.*

Facility Linkage Case Management Model



Linkage Case Management is implemented for 60 – 90 days. It begins with the 1st health care visits for the newly diagnosed or the day the dis-engaged client returning to care is identified. The linkage case Management process is outlined in detail below.

DAY ZERO (HIV-DIAGNOSIS & FIRST CLINIC VISIT (ART INITIATION)

***Personnel**: Doctor, Nurse, HTS provider, Expert client.*
***Location:** HIV counseling room, HIV treatment room, Adherence Counselling* room
***When:** During post-test session (Nurse/HTS counselor), at ART initiation (Doctor/ Nurse), at adherence room (expect Client)*
***Tools:** Linkages Case Management logbook, Index testing logbook, Chronic Care Files (hard copy/electronic in the Client Management Information System), National Referral book, Index Invitation Slip, , Appointment book, Monthly reporting forms (may be modified to report on LCM services).*

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

Day Zero responsibilities

Clients initiation

HTS Provider	Expert Client/Mentor Mother	Doctor/Nurse	Client
○ Assess coping with HIV diagnosis, and explain importance of linkage to ART ○ Document detailed client contact information both cellphone number and physical address in the Chronic Care Files or CMIS ○ Provide motivational counseling and information including the benefits of early ART initiation ○ 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 ○ Introduce client to the ECs/ MM/ Nurse. ○ Follow up with the client's outcome and document ART number in the HTS register and linkages logbook/ CMIS	○ Escort client to ART clinic 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. ○ Provide motivational and informational counseling, including personal testimonials ○ Conduct ART readiness assessment using the standardized tool and document. ○ Open chronic care file and document eligibly all fields ○ Assist client to navigate across services (e.g. triage, clinical consultation, laboratory, etc.). ○ Document the assigned case in the linkages management logbook ○ Assess and resolve real and perceived barriers to care ○ Provide counseling on disclosure and testing of partners, family members, and associates ○ Schedule sessions 2 and 3 on expected dates of the clients first and second ARV refills ○ Complete appropriate sections of LCM log book ○ Appoint client in the ART appointment register.	○ Conduct HIV retesting for verification according to the national guidelines ○ Review for ART initiation barriers ○ Initiate clients who are in stage 1 or 2 on the same day ○ Explain treatment to patient ○ Document client in ART register/enter client in CMIS/APMR ○ Assign and introduce Linkage facilitator for all client ○ Inform clients that if they experience any side effects they should come back to the facility	○ 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 anything you familiar with

Client delaying ART initiation

NB: For clients delaying ART initiation the is for them to be initiated within 14 days

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

DAY 3-5: FIRST TELEPHONIC CALL

Personnel: *Linkages Facilitator (Expert client, HTS provider, Nurse)*
Location: *Adherence room, HIV treatment, Counseling Room,*
Application of Linkage Case Management: *Follow up session after initial HIV clinical visit*
Tools: *Chronic Care Files/ CMIS, Cell phone, Call logs, Case management logbook*

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

During telephone call:

Linkages Facilitator	
Clients initiated on ART	Clients delaying ART initiation
○ Assess coping with ART treatment ○ Ask if client is having someone providing support ○ Ask if they have any challenges they are experiencing with regards to treatment and assist them if possible ○ Provide motivational and informational counseling, including personal testimonials. ○ Remind client of their next review date ○ Record the call in the call log as needed and update in the chronic care file.	○ Assess coping with HIV diagnosis ○ Reassure client on available support for treatment ○ Troubleshoot concerns and barriers to treatment ○ Provide motivational and informational counseling, including personal testimonials focusing on benefits of early ART ○ Remind client of their appointment visit ○ Record the call in the call log as needed and update in the chronic care file

DAY 10 - 12: SECOND TELEPHONIC CALL

Personnel: *Linkages Facilitator (Expert client, HTS provider, Nurse)*
Location: *Adherence room, Counseling Room, HIV treatment*
Application of Linkage Case Management: *Follow up session after initial HIV clinical visit*
Tools: *Chronic Care Files/ CMIS, Cell phone, Call logs, Case management logbook, appointment register*

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

During telephone call:

Linkages Facilitator	
Clients initiated on ART	Clients delaying ART initiation
○ 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 client about next appointment date. ○ Ask the client if they have any specific topic to discuss in the next appointment ○ Record the call in the call log as needed and update in the chronic care file.	○ Assess 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 client about next appointment date. ○ Record the call in the call log as needed and update in the chronic care file

DAY 14: FIRST CLINIC VISIT (1st ARV REFILL)

Personnel: *Expert client, Nurse, Doctor*
Location: **HIV treatment consultation room, Adherence room**
When: *During 1st ARV Refill visit, follow-up visit for those clients not on ART*
Tools: *Chronic Care Files/ CMIS, appointment book, Case management logbook, index logbook*

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

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

For clients who have not missed appointment:

- Congratulate and appreciate client for honoring appointment
- Fast track client in the facility for the first refill and inform client that during other visits they will join the queue.

For Clients who missed appointment;

- Follow guidance on the management of missed appointment as stipulated in the appointment register (add steps)

- On return congratulate client for coming back and discuss the importance of honoring appointments and provide intensified counselling
- Assess challenges they are experiencing and assist them to resolve them
- Discuss the importance of honoring appointments

Day 14 responsibilities

Client initiated on ART

Expert Client/Mentor Mother	Doctor/Nurse	Client
○ Retrieve clients chronic care file ○ Review disclosure progress (and as needed continue with counseling) ○ Follow up on eliciting new index contacts ○ Conduct pill count and document in CCF ○ Assess barriers to ART adherence ○ Address any concerns raised by the client ○ Review and conduct HIV prevention counselling and positive living ○ List contacts for index and submit list to HTS for follow up ○ Provide motivational and informational counseling as needed, including personal testimonials on benefits of treatment adherence ○ Appoint client in the appointment register	○ Review baseline results ○ Assess for side effects and adherence and document accordingly ○ Emphasize the importance of index testing for Partners, biological children and associates. ○ Emphasize the importance of treatment adherence and honoring appointments the importance of viral load monitoring and TB Prevention Therapy ○ Emphasize HIV prevention core messages and link to other health care services ○ Document in CCF, CMIS / APMR ○ Refill and give appointment date as schedule by nurse or doctor ○ Once the client has refilled, Reappoint client in the appointment register/CMIS	○ 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 if they will not be able to attend the scheduled appointment for rescheduling

Clients delaying initiation on ART

Expect Client/Mentor Mother	Doctor/Nurse
○ Continue assessing and resolving barriers to ART initiation ○ 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 form ○ Appoint client in the appointment register for follow up calls and further counselling sessions ○ Continue to counsel clients on the benefits of ART initiation	○ Conduct client's readiness assessment ○ 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 ○ Discuss and explain HIV disease progression with the client ○ Document the client in the Pre-ART register and in the appointment register ○ Clients still refusing ART initiation, should be referred to another colleague or to Social worker or Psychologist ○ In case of adolescents refer for peer to peer counselling where possible

DAY 21-29: THIRD TELEPHONIC CALL

Personnel: *Linkages Facilitator. (Expert client, HTS provider Nurse)*
Location: *Counseling Room, HIV treatment, Adherence room*
When: *During Follow up session after initial HIV clinical visit*
Tools: *Chronic Care Files/ CMIS, Cell phone, Call logs, Case management logbook*

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

During telephone call:

Linkages Facilitator	
Clients initiated on ART	Clients delaying ART initiation
○ Assess coping with ART treatment ○ Review disclosure plans and assess progress ○ Trouble shoot immediate concerns regarding disclosure ○ Review testing plans and schedule testing for index testing ○ Provide motivational and informational counseling, including personal testimonials.	○ Assess coping with HIV diagnosis ○ Reassure client on available support for coping with diagnosis and treatment ○ Troubleshoot concerns and barriers to care ○ Provide motivational and informational counseling, including personal testimonials on importance of early ART

○ Assess coping and adherence, assess disclosure plans/outcomes, and testing of index; troubleshoot concerns and barriers to care ○ Record the call in the call log as needed and update in the chronic care file.	initiation. ○ Record the call in the call log as needed and update in the chronic care file.

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

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

Clients initiated on ART

Expert Client/Mentor Mother	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 (CCF) ○ Assess barriers to ART adherence ○ Address any concerns raised by the client ○ Review and conduct HIV prevention counselling and positive living ○ Provide motivational and informational counseling as needed, including personal testimonials on benefits of treatment adherence	○ Assess for side effects and adherence and document accordingly ○ Emphasize the importance of index testing ○ Emphasize the importance of treatment adherence and honoring appointments including the importance of viral load monitoring and TB Preventive Therapy ○ Refill and give appointment date which is 30 days ○ 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

○ Document next appointment in the appointment register		○ Contact your health care provider right away if you experience or observe unfamiliar symptoms

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 ○ update contacts for patients both physical and cellphone number ○ Update documentation in the linkages form ○ 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 ○ conduct client's readiness assessment ○ 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 PRE-ART 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

DAY 44 - 60: FOURTH TELEPHONIC CALL

Personnel: *Nurse, HTS provider, Expert client (Linkages Facilitator).*
Location: *Counseling Room, HIV treatment, Adherence room*
When: *During Follow up session after initial HIV clinical visit*
Tools: *Chronic Care Files/ CMIS, Cell phone, Call logs, Case management logbook*

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

During telephone call:

Linkage Facilitator	
Clients initiated on ART	Clients delaying ART initiation
○ Assess coping with ART treatment ○ Review disclosure plans and assess progress ○ Trouble shoot 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 ○ 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 chronic care file.

DAYS 60-75: THIRD 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 and those clients not on ART*
Tools: *Chronic Care Files/ CMIS, appointment book, Case management logbook, index logbook*

Clients initiated on ART

Expect Client/Mentor Mother	Doctor/Nurse	Client
○ Assess disclosure and testing of index contacts ○ Follow up on eliciting index contacts ○ Explore barriers to treatment. ○ Conduct pill count and assess for ART adherence. ○ Provide motivational and informational counseling, including personal testimonials. ○ Update contacts for patients both physical and cellphone number	○ Assess for side effects and adherence ○ Review disclosure status and testing of index contacts ○ Update status of index contacts	○ To ensure s/he understands whole process ○ Call linkages facilitator if they will not be able to attend the scheduled appointment for rescheduling

○ 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 challenges in the future	○ Document all findings in the CCF ○ Refill for client and give appointment date which is 30 days	○ Contact your health care provider right away if you experience or observe anything you familiar with

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

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

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

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

DAY ZERO: REFERRAL TO ANOTHER FACILITY

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

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

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

RESPONSIBILITY OF REFERRING FACILITY

NB: 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 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	
Linkages facilitator (Nurse/Expect Client/ Mentor Mother)	**Doctor/Nurse**
○ Assess disclosure and testing of index contacts ○ Follow up on eliciting index contacts ○ Assess and troubleshoot barriers to care. ○ Conduct pill count and assess for ART adherence. ○ Provide motivational and informational counseling, including personal testimonials. ○ 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 ○ 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. ○ Make follow up call to confirm linkages with the facility and call the client to get feedback	○ Collect history and conduct physical assessment ○ Review pending laboratory results Assess for side effects and adherence ○ Review disclosure status and testing of index contacts ○ Update status of index testing ○ Document all findings in the CCF / CMIS ○ Refill for client ○ Fill out referral form and set up an appointment with the preferred facility after agreeing on the date the patient will visit the preferred facility

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 continue to assist the client with psychosocial counselling, navigate treatment including refills, address barriers to adherence, discuss importance of disclosure, index testing and sub-sequent linkage case management activities which are as follows; follow up calls on days 3-5, 10 – 12, 21-2930, 44 – 60 and

clinical visit on days 14, 30-45 and 60-75.

The EC/MM/ Health Care Worker who receives the client should provide Psycho Social Services. The receiving health facility should provide feedback to the referring facility on clients either initiated at 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	○ Conduct HIV retesting for verification according to the national guidelines ○ Congratulate client for honoring visit ○ 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

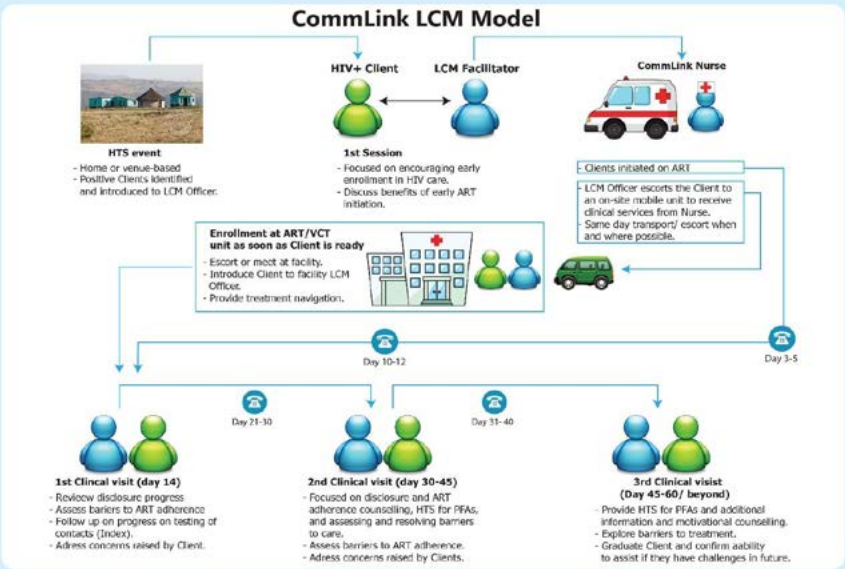
Community Linkages Case Management Model

Community to Health Facility Linkage Case management

This is a referral of a client testing HIV positive at community level by Community Health care worker (HTS counsellor/CEC/peer navigator/CMM/ RHM) or outreach service to the nearest health facility (clinic, health center, hospital). PLHIV are paired/assigned with a community peer expert client (EC) or counselor (Linkages facilitator) from HIV diagnosis through the client's 2nd ARV refill or second clinical visit. The Linkage facilitator provide the package of recommended services for approximately 45-60 days for most clients (Figure2). The length of LCM and package of linkage services for community clients are the same as that for facility clients**.** Linkage facilitator **must** inform the client that if they miss the visit they will be called on their mobile phone or call next of kin/treatment supporter however if not available, home visit will be done by the community health care worker. Clients testing HIV negative should be actively referred to HIV prevention services.

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

NB: The Linkages facilitator must ensure that the client is linked to care and then hand over the follow up of the client to the facility to which the client is referred to. The community Case Management model is detailed in the figure 2 below



Community Linkage Case Management is implemented on day zero for the newly diagnosed HIV positive and PLHIV who have dis-engaged are identified. Client is referred to the nearest or preferred health facility where the subsequent linkage case management processes including clinical visit, follow-up calls and other follow ups are undertaken.

DAY ZERO; REFERRAL OF HIV POSITIVE CLIENT

Personnel: *HTS provider, Nurse, Peer Navigators, Community Expert client (Linkages facilitator).*
Location: *HTS service point, consultation points*
When: *During HTS posttest session, Same day referral for clients who have initiated or referred for initiation or during outreach clinic at ART consultation point*
Tools: *Referral and linkages logbook, Index testing logbook, Chronic Care Files/ CMIS, National Referral book, Cell phone, Call logs, Index Invitation forms, Case management logbook, appointment book, Case management monthly summary sheet, Quarterly outcome report*

NB: The outreach team works in collaboration with a health facility which is not physically on site at the time of testing. The outreach clinic or community testing partner will offer HIV testing and refer both reactive and non-reactive clients to a health facility of client's choice for HIV prevention, care and treatment services
Clients testing HIV positive must be linked on the same day or within 7 days of diagnosis. Client whether initiated or not initiated should be seen at health facility within 7 days of testing HIV positive. Clients initiated in an outreach must be referred to their preferred facility. Clients testing negative must be linked for HIV prevention services, e.g. condom, PrEP/PEP and VMMC if male.

Responsibilities at community Linkages

Community Linkages facilitator / health care worker	Client	Receiving health facility
• 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 • Document referral form which include date client tested and HIV status or the services the client is being referred for. • Agree on appointment date and the client preferred facility. • Call the facility you are referring the client to make an appointment for client. • Escort or meet client at facilities and provide treatment navigation services for at least the first facility visit. • Document in the referral form and transport it to ensure client is booked. • Do follow up with receiving facility to confirm linkage of referred client • Conduct at least two follow-up support calls before ART initiation (if not on the day of diagnosis), and two follow-up support calls before the first and second ARV refills. • Conduct one follow-up face-to-face counseling sessions or through phone. • For Community partners implementing Community ART, clients must be initiated before being referred out. • Discuss with the client the importance of index testing and disclosure.	• Client to link to care on the same day or within 7 days if same day 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 receives the client and verifies information in CMIS if facility is on CMIS. • If not already on ART conduct retesting for verification. • Facility to call 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 worker.

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

Linkages 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) ▪ Document referral form which include date client tested and HIV status or the services the client is being referred for. ▪ Agree on appointment date and the client preferred facility. ▪ Call the facility you are referring the client to make an appointment for client. ▪ Escort or meet client at facilities and provide treatment navigation services for at least the first facility visit. ▪ Document referral and transport pink form to facility to ensure client is booked. ▪ Conduct at least two follow-up support calls before ART initiation (if not on the day of diagnosis), and two follow-up support calls before the first and second ARV refills. ▪ Conduct one follow-up face-to-face counseling session or through phone call. ▪ For Community partners implementing Community ART, clients must be initiated before being referred out. ▪ Discuss with client about importance of index testing and disclosure	• Review and resolve identified barriers • Emphasize on the benefits of ART and early enrolment to treatment • All clients refusing to be initiated on ART must be discharged via the nurse for further counselling • 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

Strategy 2: Community outreach HIV testing and ART initiation

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

Responsibilities for HIV testing and initiating ART at Community level

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 ○ 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

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 ○ Reassure client on available support for coping with diagnosis ○ Provide motivational and informational counseling, including personal testimonials on importance of early ART initiation. ○ All clients refusing to be initiated on ART must be discharged via the nurse for further counselling ○ 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 ○ Emphasize on the benefits of ART and early enrollment to treatment ○ Assign and introduce a Linkages facilitator for all clients

Strategies 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 appointment or have disengaged in care.

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 care giver. If there is a new care giver HCW's must provide counselling support and health education for continued quality of care and support.

The challenge with Adolescents is that they do not come to health facilities and are not comfortable with the attitude of health care workers towards them and the vertical provision of ART services. Psychosocial Support for adolescent 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

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 who have Missed or Dis-engaged in Care

For Clients who missed appointment or dis-engage in care due to various reason it is important to welcome the client back and identify the challenges that made them to default. Explore with the client on how to resolve the challenge

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

Children	Adolescents	Key populations	Men
○ For children below 5 years provide ART using family approach ○ For all children, the primary care giver/ guardian is fully responsible for ensuring linkage and retention of the child ○ Children depend on their parent's/ care giver for linkages hence the importance and benefits of ART should be continuously emphasized on the parent/care giver ○ In situations where the child is denied care by the parent or care giver the involvement of Social workers is obligatory ○ Educate parents on the importance of age appropriate disclosure	○ 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, care giver 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 ○ 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 ○ 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 HIV diagnosed adolescents where applicable	○ Provide outreach services that offer comprehensive HIV services ○ Health care workers to work in close collaboration with peer navigators ○ Refer clients who are delaying ART initiation, missed appointment and those who defaulted to peer navigators to build social cohesion and participation ○ Implementing index testing for sexual and/or drug injecting partners. ○ If the HIV-positive client agrees, offer HIVST for `secondary distribution. ○ Educate client on consistent use of condoms and lubricants with sexual 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 ○ Provide man health days/ male friendly clinics (Provide extended hours or weekends for ART initiation, allowing clients to select preferred facility if there are issues of stigma

Linkage for the HIV negative Clients

If the country is to achieve the zero new infections clients testing HIV negative must not be neglected. A negative test presents an opportunity for linkage to HIV prevention services to ensure they remain negative and reduce the chances of them getting infected with HIV. Priority must be given to adolescents, young women, men and key populations

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

RESPONSIBILITY OF HEALTH CARE WORKER FOR THE HIV NEGATIVE CLIENT

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

Quality Improvement

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

Facility

- Facilities will be trained on 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

Regional

- The Regional Health Management Team will be oriented on LCM and will be

responsible for include 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)

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

Monitoring and Evaluation

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

Reporting – Monthly

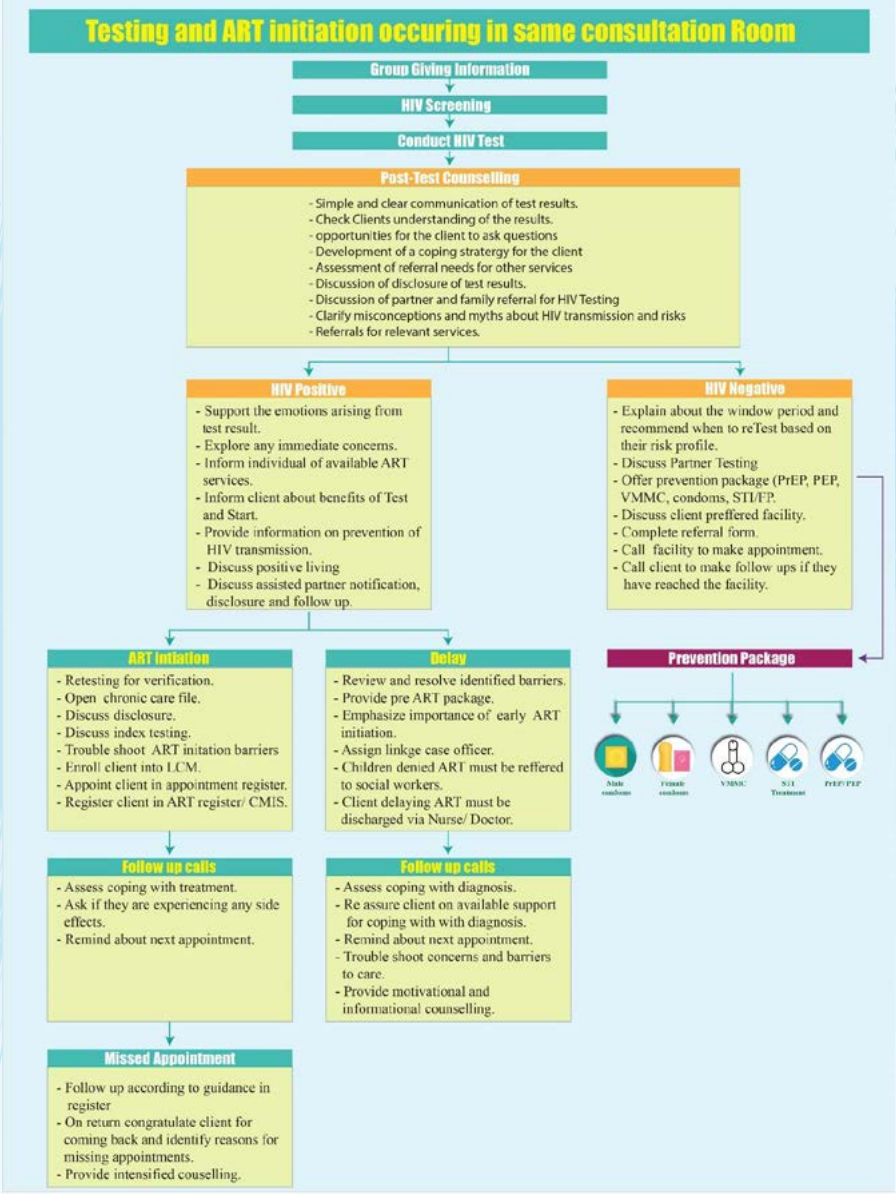
1. Number of clients identified as HIV positive by age and sex
2. Number of clients enrolled on LCM from facility
3. Number of clients transferred in from community or other facilities
4. Number of HIV positive clients linked for ART initiation by age and sex
5. Number of clients enrolled from facility who received the first call
6. Number of clients who came for 14-day visit (both facility and transfer in)
7. Number of index cases with contact tested for HIV
8. Number of client's who have disclosed HIV status to atleast one person
9. Number of clients with a final LCM outcome

ANNEXES

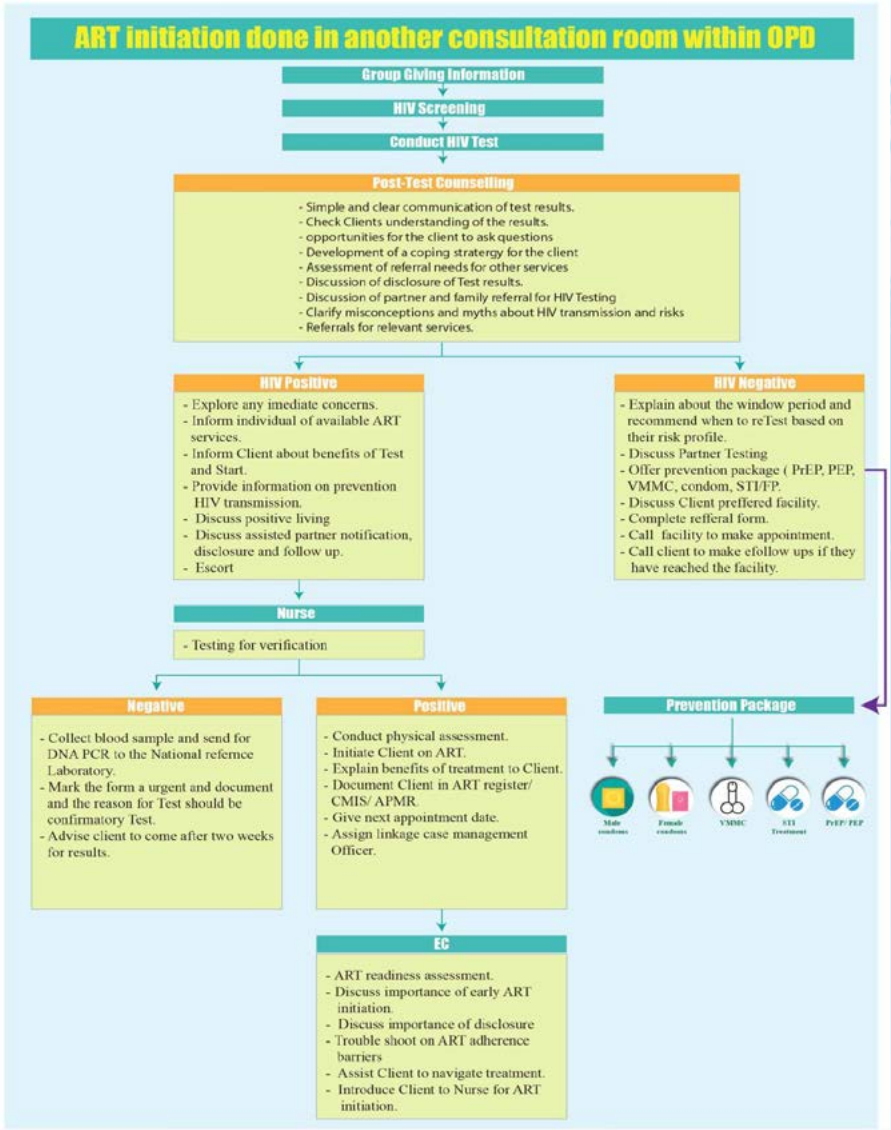
Annex 1- Barriers to ART Initiation

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

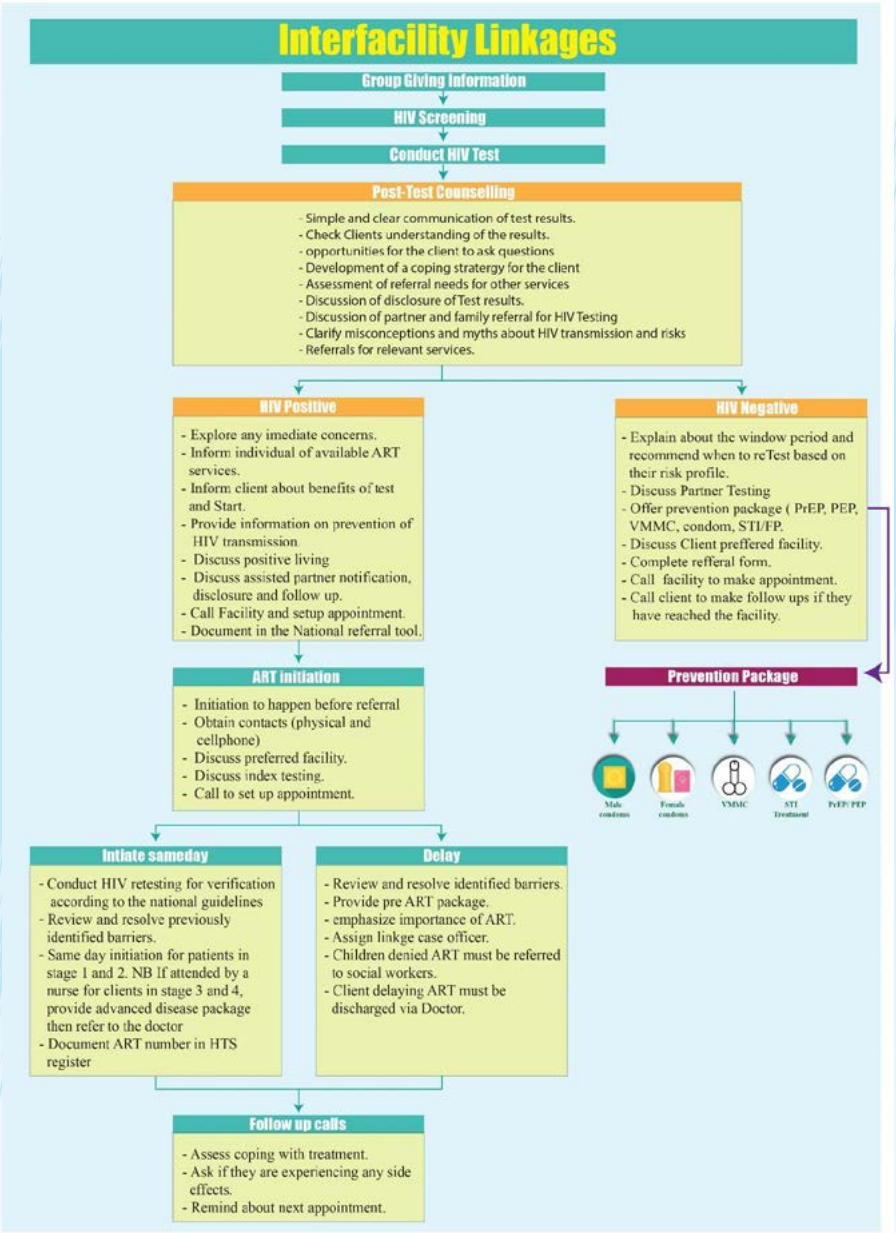
Annex 2 - Scenario 1 - ART initiation occurring in same consultation room



Annex 3- Scenario 2 - ART initiation in another consultation room within OPD



Annex 4 - Scenario 3 - Interfacility Linkages



Annex 5 - Scenario 4 - Community to Facility

References

1. AIDS NERCHA. National Multisectoral HIV And AIDS Strategic Framework 2018-2023. June 2018.
2. MacKellar D, Williams D, Bhembe B, et al. Peer-Delivered Linkage Case Management and Same-Day ART Initiation for Men and Young Persons with HIV Infection - Eswatini, 2015-2017. *MMWR Morbidity and mortality weekly report*. 2018; 67: 663-7.
3. MacKellar D, Maruyama H, Rwabiyago OE, et al. Implementing the package of CDC and WHO recommended linkage services: Methods, outcomes, and costs of the Bukoba Tanzania Combination Prevention Evaluation peer-delivered, linkage case management program, 2014-2017. *PLOS ONE*. 2018; 13: e0208919.
4. World Health Organization. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infections. Recommendation for Public health approach. 2016.
5. Centers for Disease Control and Prevention, National Institutes of Health, American Academy of HIV Medicine, Association of Nurses in AIDS Care, International Association of Providers of AIDS Care, National Minority AIDS Council, and Urban Coalition for HIV/AIDS Prevention Services. Recommendations for HIV Prevention with Adults and Adolescents with HIV in the United States: Summary for Clinical Providers, 2014.
6. Platform. PS. United States President's Emergency Plan for AIDS Relief (PEPFAR). Washington DC, United States. 2018.
7. Health MO. HIV Programs Report. 2017.
8. Gourlay A, Birdthistle I, Mburu G, Iorpenda K and Wringe A. Barriers and facilitating factors to the uptake of antiretroviral drugs for prevention of mother-to-child transmission of HIV in sub-Saharan Africa: a systematic review. *Journal of the International AIDS Society*. 2013; 16.
9. Buregyeya E, Naigino R, Mukose A, et al. Facilitators and barriers to uptake and adherence to lifelong antiretroviral therapy among HIV infected pregnant women in Uganda: a qualitative study. *BMC Pregnancy and Childbirth*. 2017; 17: 94.

Notes

Notes