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Standard Operating Procedure on Treatment Preparation, Adherence Monitoring and Support	
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Background

The cornerstone to good treatment outcomes for people living with HIV is high level of adherence to ART (Anti-Retroviral Therapy) and the subsequent follow up plans and medical advice from healthcare professionals. NASCOP recommends initiating adherence enhancing strategies from HIV diagnosis – during post-test counseling and linkage – and throughout the follow up sessions for ART. Its important to maintain clients on a first line regimen and prevent treatment failure, which can only be achieved by anticipating common individual barriers to good adherence and developing a plan to support clients to address these barriers. This guide is intended to provide healthcare providers a structured process of providing adherence support and monitoring for all clients on ART and follow up. This doesn't supersede National ART guidelines.

NB: Adherence preparation, monitoring and support for each patient should be customized based on their level of adherence, stage of ART initiation and the characteristics of the patient (NASCOP 2022). In cases where possible its recommended to have the same clinician and counsellor follow up newly enrolled patients at each visit, at least for the first 6 months on care.

Steps

At enrolment: Newly identified patients should be taken through counseling that includes:

a) Counseling on importance of starting ART treatment immediately, and the importance of good adherence for a long and productive life.
b) HIV education (**NASCOP guidelines page 5-10, Table 5.2**) and adherence preparation see **Annex 8 NASCOP ART guidelines 2022 (pg. 13-8 to 13-15)**
c) Enrolment in care (use the TPS checklists for treatment preparation)
d) Assessment for ART readiness using the ART readiness assessment tool **(attached).**
e) Conducting clinical assessment which includes screening for OI's and baseline lab tests on enrolment
f) **Preparing the patient and obtaining consent for possible home visits within the first 6 months**

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2nd Visit (2 weeks post diagnosis): Newly identified patients are high risk for poor adherence since they are still adjusting to lifelong treatment, dealing with medication side effects and challenges that come with disclosure. At this stage intense close follow-up is key for good adherence. The following should be done:

1) Adherence counselling (**NASCOP guidelines page 5-7, Table 5.1**), if possible, have the same health care provider who enrolled the patient to conduct the adherence counselling session, and engage the HTS counselor who tested them to take part in the session.
2) If not yet on ART (assess ART readiness), initiate and emphasize on medication counselling and possible side effects. If on ART assess for any side effects and administer **Morisky 4** to assess adherence and barriers. Develop an adherence plan with the patient (**Table 5.1, pg. 5-8 NASCOP 2022 ART guidelines**).
3) Conduct psychosocial assessments using the relevant tools (**See below table**) these results will form part of the adherence plan, any diagnosis of mental issues refer to relevant health care providers.
4) Conduct a comprehensive treatment preparation session depending on the type of patient (Adolescents, Children or Adult) using the **TPS checklists.**
5) Introduce the care team to the patient that includes his/her case manager, peers (adolescents and adult educators)
6) During this visit attach the patient to the **PSSG for newly enrolled clients** for further ART literacy classes, group counselling sessions and support through experience sharing.
7) **Prepare the patient and obtain consent for possible home visits within the first 6 months if not done at enrolment**

3rd Visits (At month 1): During this visit the objective is to reinforce the patient's adherence to ART, elicit any barriers to the same and develop a plan jointly with the patient to address any of the identified barriers.

a) Review the adherence plan from the previous visit and administer the **MMAS-4**. In case of identified/suspected poor adherence administer **MMAS-8** and develop a plan to address identified issues.
b) At this visit ensure to perform pill counts (**Pg. 5-25, Table 5.13**) and calculate adherence rate for a specified plan of action. Remember to ask the patent to carry any remaining drugs during the next return date.
c) Introduce U=U messages.
d) **Prepare the patient and obtain consent for possible home visits within the first 6 months if not already done**

4th Visit (Month 2): During this visit repeat everything as at visit 3, in addition to assessing if the patient might require a home visit in cases where barriers to adherence are persistent. This also allows for the provider to understand better the living situation and might reveal more than what the patient reports during clinic appointments.

5th and 6th Visit (Month 3 and 4)

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a) Prepare the patient for baseline viral load and educate on the possible outcomes of the viral load results
b) Review TPT status, Cervical cancer screening (women of reproductive age)
c) Strengthen adherence counselling sessions
d) Educate on DSD models and categorization criteria.
e) Ensure **U=U** Messages are fully shared with the client
f) Review the VL results and manage appropriately (Refer to the VL algorithm)-**6th visit**

List of assessment tools used during enrolment and subsequent visits assessments include:

1. **ART readiness assessment checklist**
2. **MMAS 4 – Morisky Medication Adherence Assessment Scale (Pg. 5-23, Table 5.11)**
3. **MMAS 8 – Morisky Medication Adherence Assessment Scale (Pg. 5-24, Table 5.12)**
4. **Adherence counselling checklist (Pg. 5-26, Table 5.14)**
5. **Barriers to adherence assessment guide (Pg. 5-27, Table 5.15)**
6. **HIV education checklist (Annex 8)**
7. **PHQ 9 – Patient health Questionnaire (Pg. 4-26, Table 4.15)**
8. **GAD -7 – General Anxiety Disorder (Pg. 4-32, Figure 4.2)**
9. **CAGE/CRAFT (Adult/Adolescents)**
10. **TPS Checklist**
11. **DSD Categorization Criteria**
12. **U=U checklist.**
13. **AHD checklist.**

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