

CASE MANAGEMENT JOB AIDS: A Supplement to the USAID/ICYD Graduation- based HIV- sensitive case management training manual

Keeping the End in Mind:
Delivering the *Right Services* > to the *Right People* > at the *Right Time*



This Phase I HIV-centered Case Management Job Aid Package is intended to complement the HIV-centered case management training. The aids are designed to help Social Workers, Linkage Facilitators and Parasocial Workers (PSWs) understand technical information concerning HIV, documentation, and their roles and responsibilities in coordinating, delivering, monitoring, and documenting clinical and social protection service delivery within a case management system and clinic-community referral networks. The aids, designed as simple reference packs, aim to help community and clinic-based cadres absorb, understand and apply information and skills to improve HIV treatment and resilience outcomes for vulnerable children, adolescents and their caregivers.

ACKNOWLEDGEMENTS

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CASE MANAGEMENT PRINCIPLES



WHY DO I NEED TO KNOW ABOUT CASE MANAGEMENT PRINCIPLES?

- Case management work can be sensitive and challenging. The following principles are important to keep in mind as you carry out your work with children, youth and families.
- These principles provide guidance needed for high-quality case management.

12 IMPORTANT PRINCIPLES OF CASE MANAGEMENT:

Principle	Definition	Practical Application
Do no harm	Thinking about the rights and best interests of the child/family, and making sure that actions maximize possible benefits and DO NOT expose them to any further harm.	Planning home visits in advance to ensure you are prepared to speak to the necessary people, in a sensitive manner, and are able to keep information confidential.
Best interest of the child	Putting the child's best interest first when it comes to well-being, rights, positive development, protection, and the child's own wishes.	Not inflicting any further harm or stress, not shaming or humiliating the child; you are confident that the caregiver will adhere to child protection principles.
Strengths-based approach	Consider each child and family's unique set of strengths and challenges, potential contribution, and existing resources they have available when determining needed support.	Engage the family as a partner in developing and implementing a case plan that is specific to their strengths and resources.
Child and family participation	Children and caregivers should both be involved in decisions that affect them. This helps build mutual respect and ensures services best address the child's/family's strengths and needs.	Ask families about the services they feel they need. Inform caregivers and children (12+) why you are requesting information,
Confidentiality	Keeping information about clients - such as names, locations, ages and personal information - private and secret, unless it is necessary to share with individuals authorized to have information about the child's situation.	Do not discuss cases at home, with friends and neighbors, or in places where others may overhear. Inform caregivers and children (12+) how information will be used and who you plan to share it with. Always get consent from caregivers and children (12+) to share information about their situation.

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COMMUNICATION FOR CASE MANAGEMENT

Principle	Definition	Practical Application
Consent	Giving permission for something to happen, such as participating in the case management process, or sharing confidential information.	Clearly explain what will happen throughout case management process, who will do what, and provide opportunity for the client to provide verbal or written consent. Children age 12+ can give consent for sharing confidential information, like HIV status.
Informed assent	Expressed willingness to participate in HIV treatment.	MOH guidance says that all children 12+ living with HIV should know their HIV status and assent to treatment. However, children should never be lied to.
Non-discrimination	Differences such as socioeconomic status, tribe, race, age, gender, religion or ability are acknowledged, respected, and treated equally.	Be aware of and respect local cultures and traditions, deliver case management services equitably, and appropriately engage clients with disabilities.
Accountability	Obligation of an individual or organization to report activities, accept responsibility for them, and disclose results in a transparent manner.	Documentation is an important way of carrying out this principle.
Professional boundaries	Lines we draw to help define our roles and interactions in relationships.	Mutually understood, practical physical and emotional limits that protect the space between your power and the client's vulnerability.
Professional ethics	Standards of personal and professional behavior, values and guiding principles.	Upholding confidentiality and informed consent are examples of professional ethics.
Release of information	A signed document, such as Consent Form, by caregivers and/or children that gives their consent to share information.	Caregivers and children can withdraw this at any time.

COMMUNICATION FOR CASE MANAGEMENT



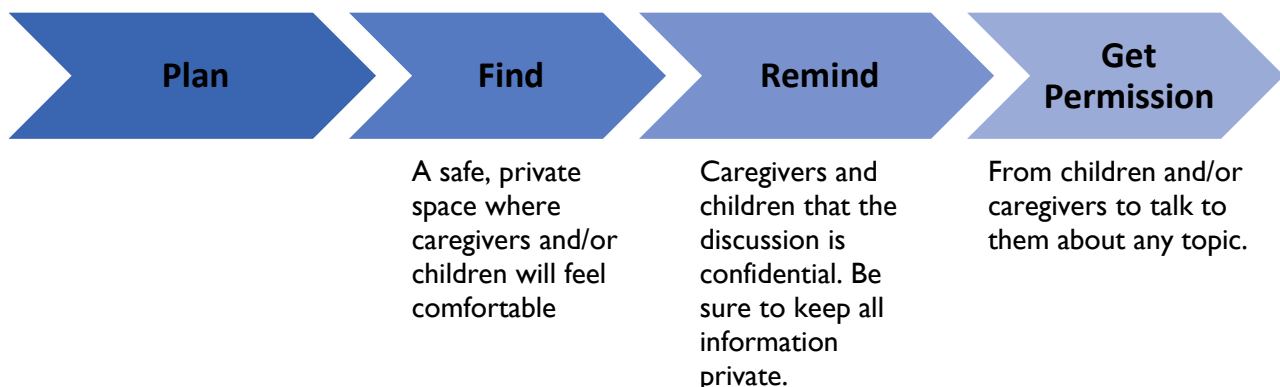
WHY DO I NEED TO KNOW ABOUT COMMUNICATION FOR CASE MANAGEMENT?

- Good communication skills will help me carry out case management functions at every stage.
- Good communication skills are especially important when talking about sensitive topics like HIV, child protection, death or inheritance
- Using good communication skills can help build trust with children and caregivers, and are necessary for providing the counseling and psychosocial support that families may need.

TIPS FOR GOOD COMMUNICATION

- Listen in respectful ways and make an effort to understand. Resist distractions, like your phone.
- Never assume you know how a person feels. Instead, acknowledge the feelings they share with you.
- Avoid disapproval, judgement or strong emotional responses.
- Maintain eye contact.
- Keep calm and maintain a friendly tone of voice.
- Try to see the world from the child/caregiver's point of view.
- Show understanding and provide information while also helping caregivers and children to find their own solutions.
- Be sensitive to social and cultural norms or stigmas.
- Be sensitive to non-verbal communication such as body language.

HOW CAN I PREPARE TO TALK WITH CHILDREN AND CAREGIVERS?



COMMUNICATION FOR CASE MANAGEMENT

HOW DO I TALK WITH CHILDREN AND CAREGIVERS?

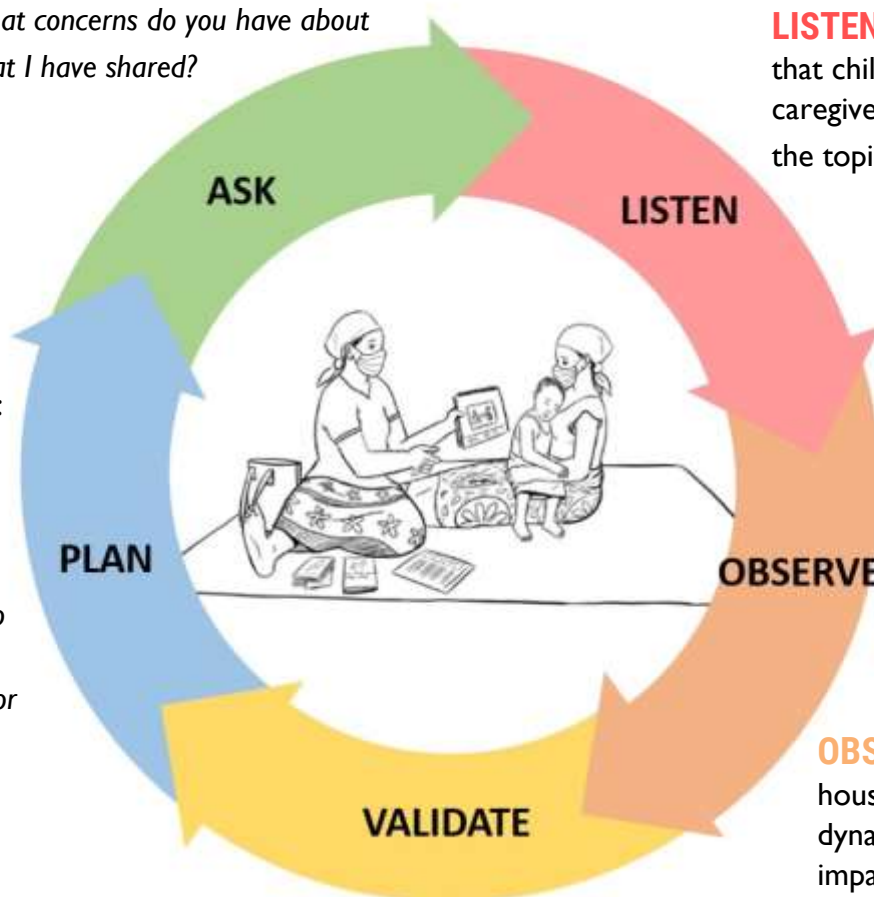
ASK children and/or caregivers:

- *How are you doing?*
- *What is going well for you?*
- *What are your challenges?*
- *What concerns do you have about what I have shared?*

LISTEN to concerns that children and/or caregivers have about the topic at hand

PLAN a course of action:

- *What actions can caregivers and children take to address concerns?*
- *What can you do to address concerns?*
- *When will you see or talk to them again?*

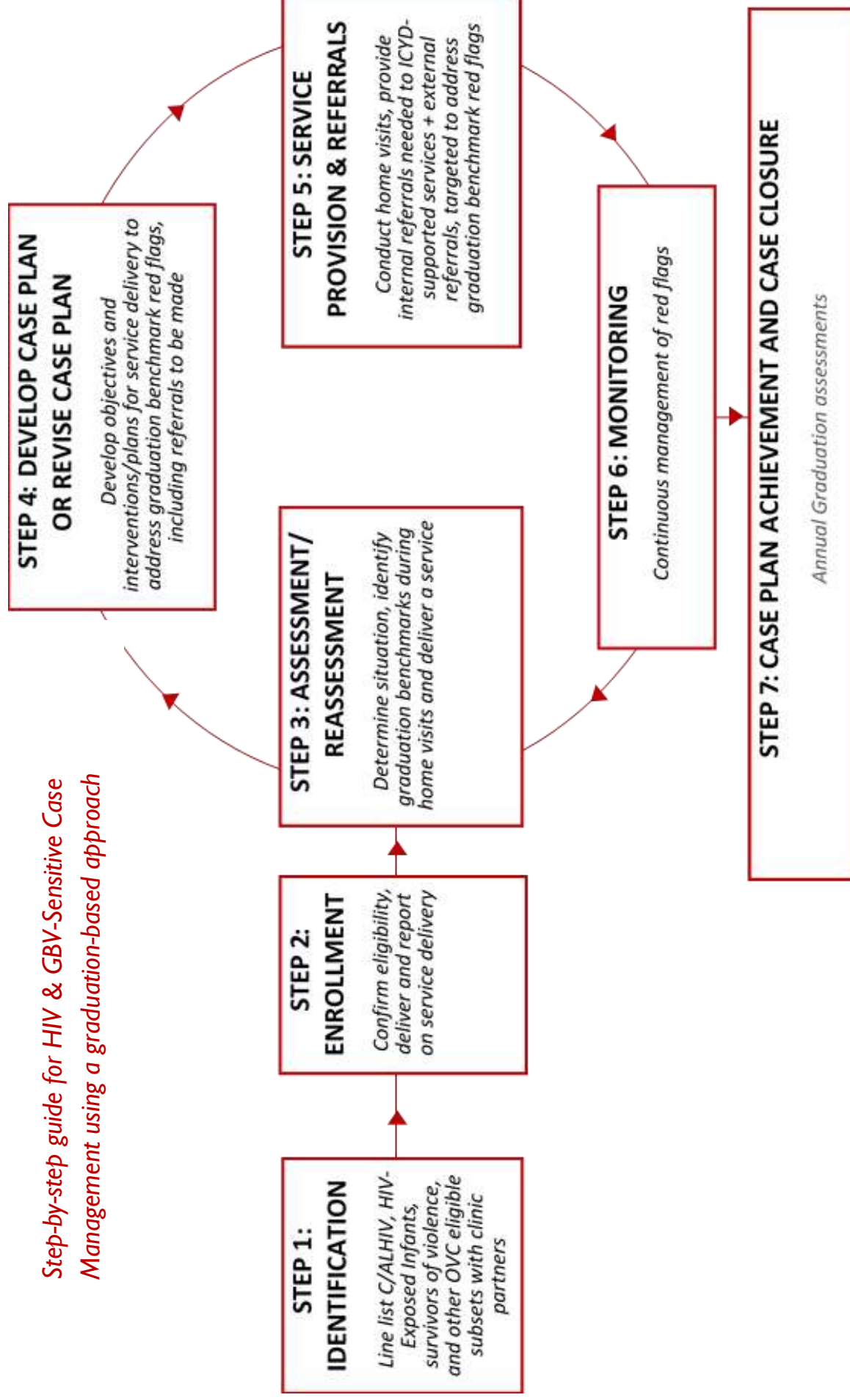


OBSERVE the household and family dynamics that may impact the child's health and wellbeing.

VALIDATE caregivers' and children's concerns. This means recognizing their feelings and showing you believe what they have shared. This helps build trust and shows you are listening and take seriously what they say.

7-STEP CASE MANAGEMENT CYCLE MATRIX

*Step-by-step guide for HIV & GBV-Sensitive Case
Management using a graduation-based approach*



HIV & VIOLENCE: HOW DO THEY RELATE?



WHY DO I NEED TO UNDERSTAND THE RELATIONSHIP BETWEEN HIV AND VIOLENCE AGAINST CHILDREN AND ADOLESCENTS (VAC)?

- Boys and girls in Uganda experience **high rates of violence and neglect** (VAC 2017).
- Youth who experience violence may be more likely to **make poor decisions that increase their risk to HIV and violence** now and in the future.
- By becoming more aware of the family dynamics of children/adolescents on my case load, I will be better able to **reinforce protective factors for preventing HIV and VAC** and to **mitigate VAC-related risks** that can contribute to **poor HIV treatment outcomes**.

WHAT ARE THE IMPORTANT FACTS ABOUT VAC IN UGANDA?

- Girls are especially vulnerable to sexual violence:** 1 in 3 girls in Uganda experiences sexual violence before she turns 18.
- Adolescent girls account for more than half (66.7%) of all new HIV infections** in Uganda (UNICEF, 2020).
- HIV prevalence among adolescent **girls and young women aged 15-24 is almost four times higher than in boys and men** of the same age group (MOH, 2017).

HOW CAN VAC LEAD TO HIV?



- Sexual violence can lead to direct transmission of HIV.
- Girls in early marriage and cross-generational sexual relationships have an **increased risk of HIV infection** due to having less negotiating power.
- Children exposed to violence are substantially more likely to engage in high-risk sexual behaviour, which increases HIV risk, especially for girls.

HIV & VIOLENCE: HOW DO THEY RELATE?

- Sexual abuse is **linked to drug use, living on the streets, sex work and higher rates of sexual exploitation**, which are factors that increase risk to HIV.

HOW CAN HIV LEAD TO VAC?



- **Highly vulnerable children and adolescents can experience elevated levels of stigma and discrimination** at home, in the community and in school. This can come in the form of **neglect and physical, sexual and/or emotional abuse at home**. Examples include lack of education, food, health or other basic supports, or bullying and teasing by peers in the community and in school.
- Children living with HIV may experience greater levels of **stigma and discrimination** due to their HIV status.
- Caregivers living with HIV may **struggle to provide protective and a caring environment** for their children.



WHAT IS MY ROLE AS A PSW RELATED TO HIV & VAC?

- One of the primary goals of your work is to **improve HIV treatment and social protection outcomes** for children and adolescents on your caseload.
- You play an important role in helping **children stay healthy, safe, stable and in school** by supporting families to access needed clinical and social protection services.
- These services may include: **economic support, positive parenting, early childhood services, HIV and violence prevention, psychosocial support, and HIV and health supports**.

HIV BASICS



WHY DO I NEED TO UNDERSTAND THE BASICS OF HIV?

- The majority of children, adolescents and caregivers on your caseload are living with HIV.
- A **primary goal of your work is to help children improve HIV treatment outcomes.**
- Your basic understanding of HIV—how it works in the blood, how it impacts the body, and how it impacts the physical and emotional health of children and adolescents—will help you support the children and families you serve.

WHAT IS HIV?

- HIV is a dangerous **virus**.
- The HIV virus is **an enemy** in our blood.
- HIV can attack the healthy parts of our **blood**.
- HIV is not curable, but if children, adolescents and adults living with HIV **take the right medicine, at the right time, every day, they can lead long and healthy lives!**
- Anyone living with HIV must take **HIV medicine** for the **rest of their life**.

HOW IS HIV TRANSMITTED?

- The most common ways that HIV is transmitted are through unprotected sex (vaginal, oral, anal) via contact with the blood, semen or vaginal fluids of an HIV positive person, or from mother-to-child during pregnancy, delivery and breastfeeding.

WHAT ARE CD4 CELLS?

- The part of our blood that fight diseases are called the **CD4 cells**.
- CD4 cells are the **‘warriors’** that fight the HIV virus **‘enemy’**.
- When people with HIV **do not take their medicine**, the ‘warriors’ (CD4 cells) in the blood become **fewer** and **cannot fight** the HIV virus ‘enemy’.

HIV BASICS

WHAT IS TREATMENT ADHERENCE?

- Treatment adherence is when C/ALHIV take the **right medicine, at the right time, every day**.

WHAT IS VIRAL LOAD?

- Without medicine, the virus can **make more of itself** by killing CD4 cells (warriors) which can make adults and children living with HIV very sick. The amount of virus in the blood is called viral load.
- The only way to **reduce viral load**—and stay healthy—is to take the **right medicine at the right time every day**.
- When there is **a lot of HIV virus in the blood**, children can get very sick. This is called **AIDS**.
- **AIDS can lead to death**. The right medicine taken at the **right time every day** can prevent **AIDS**.


WHAT IS MY ROLE AS A PSW IN HELPING CHILDREN UNDERSTAND HIV?

- As a PSW, you **directly interact with children, adolescents and caregivers** living with HIV.
- Living with HIV can be hard for children, adolescents and adults for many reasons. Your role is to **listen, validate their challenges, and help them access the clinical and social protection services they need** to improve their lives.
- Your trusted relationships with caregivers and children put you in a unique position to understand their HIV-related challenges and **work with them and your clinic counterparts to improve their treatment outcomes**.
- Home visits offer you a unique opportunity to discuss HIV issues with children and caregivers **without judgement** and in a **confidential, safe, and supportive manner**.
- See other HIV and GBV specific job aids in the reference pack for more detailed information about specific HIV topics including: ART, adherence, disclosure, nutrition, and viral load tracking, among others.

PSYCHOSOCIAL SUPPORT FOR CHILDREN & ADOLESCENTS LIVING WITH HIV & THEIR CAREGIVERS



WHY DO I NEED TO KNOW ABOUT PSYCHOSOCIAL SUPPORT (PSS) FOR CHILDREN & ADOLESCENTS LIVING WITH HIV (C/AHLIV) & THEIR CAREGIVERS?

- Diseases, such as HIV, can affect a child's thoughts, feelings, moods, self-esteem, ways of coping and relationships with family and friends as they grow into adults.
- Many C/AHLIV face tough life events like losing caregivers, rejection by friends or other peers due to stigma and discrimination, shock about their status, and not understanding the importance of treatment adherence.
- How adolescents cope with these emotional challenges can impact their health, physical, emotional and psychological wellbeing - and the decisions they make.
- PSWs can help by providing Psychosocial Support – or PSS – to help adolescents learn positive coping skills and build the emotional strength necessary to weather the emotional ups and downs that are a part of adolescence.

This job aid refers to PSS specifically for C/AHLIV and their caregivers. But, remember, offering CARING, NON-JUDGMENTAL and COMPASSIONATE PSS to all children and caregivers on your case load is an essential part of a PSW's role!

WHAT IS PSS FOR C/AHLIV & THEIR CAREGIVERS?

- PSS refers to the **actions that support a person's emotional, social, mental and spiritual needs.**
- For **people living with HIV, PSS includes support that helps a person cope with HIV infection and its related challenges.** This includes support with disclosure, adherence, treatment literacy, stigma and discrimination, and living positively with HIV.
- PSS helps people living with HIV to feel loved, supported, safe, and encouraged.
- PSS for C/AHLIV includes:
 - Support from trusting relationships with caregivers and/or other adults.
 - Basic counseling (which can be offered during home visits or clinic visits).
 - Support groups and mentorship programs.
 - Other social, cultural or spiritual activities that help children feel loved, supported, safe and encouraged.

WHAT ARE THE PSS NEEDS OF C/ALHIV?

- C/ALHIV often **experience low self-esteem, sadness and shame due to stigma and discrimination** from families, teachers, peers and others.

PSYCHOSOCIAL SUPPORT FOR HIV MANAGEMENT

- C/ALHIV are more likely to experience **emotional difficulties** such as anxiety, loss of hope, or low self-image, often linked to stigma and/or a lack of support.
- Stigma can **impact C/AHLIVs' willingness to take medication** (treatment adherence), wellbeing, education and/or relationships with caregivers and peers.
- Adolescents often harbor particular fears related to romantic relationships, **fearing no one will accept them** because of their HIV status, or that they will not be able to marry or have children.
- These feelings may lead adolescents into **risky coping behaviors** like drug and alcohol use or hanging around people who are not trustworthy.
- **Adolescent girls may be drawn into dangerous sexual relationships** to fill the void of love, affection and basic needs—putting them at further risk for pregnancy and violence.
- **Boys may be drawn to drugs or alcohol** to dull the emotional pain of stigma, lack of love, care, or support.

WHAT ARE THE PSS NEEDS OF CAREGIVERS?

- Caregivers also cope with the impact of their HIV status on their health, wellbeing, and relationships.
- Caregivers may not have disclosed the child's HIV status to them or disclosed their own HIV status to their children or spouse due to fears of blame, shame, stigma and abuse.
- Caregivers may have difficulty providing for children's basic needs due to economic hardship.
- Caregivers may need non-judgmental, compassionate support to help them build strong, trusting relationships with their children.



WHAT IS MY ROLE AS A PSW IN PROVIDING PSS TO C/AHLIV AND THEIR CAREGIVERS?

- Helping caregivers and their children cope positively with HIV—and other challenges—is a central role of PSWs in case management.
- Asking C/AHLIV and caregivers how they are doing, giving them a safe space to share, and listening to them without judgement is an important part of PSS.
- You can also observe their situation through home visits and work with them to identify other available supports, such as support groups or social, cultural or spiritual activities.



HOME VISIT CHECKLIST: PSYCHOSOCIAL SUPPORT FOR HIV MANAGEMENT

- ☐ Remind caregivers and children that all discussions are confidential and will only be shared with others with their consent.
- ☐ **Ask/Assess:** Ask caregivers and/or children to explain in their own words how they are doing in their daily lives. What are their primary concerns with respect to caring for the family? Themselves? What are their primary concerns about HIV management?
- ☐ **Listen:** Be attentive and give time for the caregivers and/or children to respond to your questions without interference or judgement. The information they provide will be important for making case plans that reflect their specific needs. They will also build trust if they feel you are listening and care what they say.
- ☐ **Observe:** You can learn a lot about how someone is coping by observing their **home environment** and their **interactions with each other and you**.
- ☐ **Validate:** An easy first step in the PSS communication cycle is to validate what the caregiver or child is saying to you. Some examples are: “Your life is not easy. I am so sorry you are dealing with this. I am sorry this has happened to you. I hope we can talk together to plan how we can make things better for you.”
- ☐ **Deliver support:** PSS support is the process of exploring the specific coping issues children and caregivers are dealing with—validating them—and then asking them what they think might help them cope better.



Questions to Identify Support Needs of Caregivers:

- | | |
|--|--|
| ✓ Does the caregiver easily open up with you about her concerns? | ✓ Do they seem fearful or frightened to discuss HIV or other child protection issues? How do they talk about her children? |
| ✓ Do they sound defensive? | |
| ✓ Are they willing to talk about certain issues? | ✓ What do these signs tell you about what the caregiver is struggling with? |
| ✓ Are they frustrated? Tired? Angry? Hopeful? | |

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HOME VISIT CHECKLIST: PSYCHOSOCIAL SUPPORT FOR HIV MANAGEMENT

Questions to Identify Support Needs of Children:

- ✓ Does the child easily open up to you?
 - ✓ Is s/he withdrawn, shy, uncertain, defensive?
 - ✓ Is s/he willing to openly talk about her concerns?
 - ✓ What do these signs tell you about what the child is struggling with?
-
- ☐ **Refer:** Based on the caregiver's or child's priorities, you may work with the caregiver to refer them to social protections, clinics, facility support groups for C/ALHIV, or other groups.
 - ☐ If you observe **neglect or abuse**, immediately consult with your supervisor and plan to report statutory cases to the district child protection officer and immediately refer and follow up.
 - ☐ **Care Plan: Record** information from your home visits and referrals in your **Home Visit form**. Your Linkage Facilitator or supervisor can help you fill out these forms.
 - ☐ **Follow up:** Plan your next visit or schedule a check in call with the caregiver and/or child to follow up on referrals and their coping progress.
 - ☐ **Encourage and Validate:** Always leave with an encouraging word to the family!

ANTIRETROVIRALS (ARVs) & REGIMEN OPTIMIZATION BASICS



WHY DO I NEED TO KNOW ABOUT ARVs?

- Your basic knowledge of ARVs will help you support positive treatment outcomes for children living with HIV on your caseload.
- Understanding ARV basics will help you to **identify signs** that children, adolescents or adults are not taking the right medication.
- Children, adolescents, and adults living with HIV **must take the right medication at the right time every day to stay healthy**. This is called **treatment adherence**.

WHAT ARE ARVs? WHAT IS A REGIMEN?

- ARVs—**antiretroviral drugs**—is the common name for HIV medicine.
- **ARVs are not one single type of drug.** There are many different types of ARVs.
- **A regimen** is a combination of drugs given together. HIV treatment (also called antiretroviral therapy or **ART**) begins with choosing an HIV regimen.
- Regimens usually include three ARVs for 1st and 2nd line treatment, but can include as many as six or more ARVs for 3rd line treatment. **This is why C/ALHIV must be supported to remain on 1st or 2nd line treatment.**
- **Formulation** refers to the different forms that medicine may come in.
- HIV medicine is **not the same for everyone**. Medicine may come in liquid, pellets or pill/**tablets** form depending on the child's age, weight and **ability to swallow**.
- The same drug may come in **liquid** (syrup), **pellet** or **pill** form.



WHEN SHOULD A CHILD START ART?

- All children and adolescents living with HIV should be started on ART as soon as they test positive for HIV. If that is not possible, children/adolescents and pregnant women should start **within 1 week**.
- Adults should be supported to start **within 1 month of testing HIV positive**.

ANTIRETROVIRALS (ARVs) & REGIMEN OPTIMIZATION BASICS

HOW DO I KNOW IF A CHILD IS TAKING THE RIGHT HIV MEDICINE (REGIMEN OPTIMIZATION)?

- For a variety of reasons, **children and adolescents often do not achieve the same rates of success on ART as adults**. Part of the reason for this—especially among younger children—has to do with challenges children face swallowing medicine, taking the right medicine and the **right dose**.
- Only a **qualified health care worker at the ART clinic** can decide what regimen to prescribe to a child, in accordance with national treatment guidelines.
- As children grow and gain weight, they may need to **adjust ARV medications**.
- If the child is not taking the right medication, the child may show signs of **infection**.
- Sometimes, a **particular drug regimen may not work for a child** due to “**drug resistance**.” Drug resistance may be the result of poor adherence, the drugs not being effective, or other reasons. That child may need to change to a different medicine.

**WHAT IS MY ROLE AS A PSW IN SUPPORTING REGIMEN OPTIMIZATION?**

- Only a qualified health care worker can prescribe HIV treatment and decide which specific regimen is right for each child and adult.
- As a PSW, you can help support clients to adhere to their HIV treatment during your home visit. This includes watching out for signs that children are not taking the right medication. Signs may include:
 - Children cannot or do not want to swallow pills
 - Children feel ill, dizzy, or unwell after taking their medication
- During your home visit, you should routinely ask adolescents and their caregivers about any challenges they are having taking their medication at the same time every day to identify signs that they may not be taking the right medication.
- You should consult and coordinate with your Linkage Facilitator and/or supervisor or other clinic counterparts if you observe signs that a client is having trouble with their current treatment regimen.



HOME VISIT CHECKLIST: ANTIRETROVIRALS (ARVs) & REGIMEN OPTIMIZATION BASICS

- ☐ Tell the caregiver and the child why you are asking them for this information.
- ☐ Remind them that the information is **confidential** and will only be shared with clinic or other team members with the caregivers or child's **consent**.
- ☐ Ask the caregiver or child to show you the name of the medicine s/he is taking.
- ☐ **Record** the information you receive—like the name of the medicine—in your **Home Visit form**. Work with your Linkage Facilitator, ART in charge and/or Supervisor to update the **Viral Load Tracker** with this information.
- ☐ Write down the child's age and approximate weight. *This information will help your clinic counterpart/ linkage facilitator assess if the child is on the right medication.*
- ☐ Ask the caregiver or child if s/he is having any trouble taking the medication. Does s/he:
 - ☐ Have any trouble swallowing the medicine? If so, what kind of trouble?
 - ☐ Have any side effects (feel bad) after taking the medicine?
 - ☐ Does s/he have any fever, sweats, other signs of sickness associated with the medicine?
- ☐ Consult with your clinic counterpart or supervisor if:
 - ☐ The child is experiencing health side effects from the medication
 - ☐ The caregiver or child does not know the name of the HIV medication
 - ☐ The child shows signs of infection or other illness
 - ☐ The child is of age and not disclosed to
 - ☐ Child has no recent viral load test
 - ☐ Child not taking drugs regularly
 - ☐ Child has signs of malnutrition
- ☐ Make a plan with the caregiver and child to access clinic services.
- ☐ Always make a date and time to follow up with caregiver and child to ensure they received referred services and to monitor and track progress on their treatment outcomes.

TREATMENT ADHERENCE



WHY DO I NEED TO KNOW ABOUT TREATMENT ADHERENCE?

- HIV medicine is called Antiretrovirals (ARVs)
- ARVs are like a good 'army' that fights the HIV 'enemy' by protecting the good parts of our blood (CD4 cells) from being attacked—they are the stronger 'warriors'
- All children and adults need the right medicine and the right dose for the 'army' to fight the virus 'enemy' and make the 'warriors' stronger. Warriors keep the level of virus enemies low in the blood—which keeps children healthy!

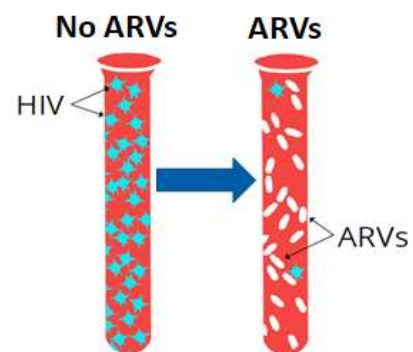


TREATMENT ADHERENCE MEANS:

Taking the right medicine
At the right dose
The right way
At the right time
Everyday!

WHAT IS TREATMENT ADHERENCE IMPORTANT?

- ARVs fight HIV and keep the amount of HIV in the blood low.
- Children living with HIV always need to have ARVs in their blood to keep the amount of HIV in their blood low.
- People living with HIV must take their ARVs every day at the same time.
- If a dose is missed, the amount of ARVs in the blood may be too low to stop HIV from making more copies of the virus.
- When the ARVs in the blood are too low, the virus can learn how to survive in the medicine by altering some parts of its body. This makes ARVs less effective.
- When the virus begins to fight the medicine, it makes it harder for the ARVs to keep the viral load low.



TREATMENT ADHERENCE

- There are many reasons that children struggle with taking the right medicine, at the right time every day. See the *Home Visit Checklist*.



WHAT IS MY ROLE AS A PSW IN SUPPORTING TREATMENT ADHERENCE?

- Your role in supporting treatment adherence depends on your knowledge of adherence and your relationship with the caregivers and children on your caseload.
- **Consult and coordinate all adherence support activities with your Linkage Facilitator and/or supervisor or other clinic counterparts.**
- If you— by yourself or with your clinic counterpart or supervisor—discuss adherence during home visits, this checklist can help you prepare for and document results from your visit in the Home Visit form and Viral Load tracker (with support from your Linkage Facilitator or supervisor).
- As part of treatment adherence, you can also support C/AHLIV to attend all scheduled clinical appointments, and work with clinic counterparts to follow up with C/AHLIV who have missed appointments.



HOME VISIT CHECKLIST: TREATMENT ADHERENCE

- ☐ Remind caregivers and children that the conversation is **confidential** and will only be shared with others with their **consent**.
- ☐ Always remember to be **compassionate, caring, and kind** when you talk to caregivers and children about adherence.
- ☐ Ask caregivers and/or children if you can talk with them about adherence.
- ☐ Ask caregivers/children to tell you what **guidance the doctor gave** about taking medication.
- ☐ Ask caregivers or children **what medicine** the child is taking and **how many times per day** the child is supposed to take the medicine.
- ☐ If children are not adhering to treatment, **record** reasons (see check list on back side) in your **Case Record Book**. Work with your Linkage Facilitator, ART in charge and/or Supervisor to also update the **Viral Load Tracker** with this information. This will help you and your clinic counterpart **develop a plan to improve treatment adherence**.
- ☐ Remind caregivers about the **importance of adherence**.
- ☐ Talk with caregivers—and/or children— about **situations that might interfere with adherence** and how adherence barriers might be addressed.
- ☐ Use your skills in psychosocial support to encourage the caregiver and the child with their challenges. Remember to: **Listen, Inquire, Validate, Enhance Safety, Plan and Follow up**.
- ☐ Refer the caregiver and/or child to clinical or social protection services that will help manage the barriers. You may need to arrange a clinic appointment with your clinic counterpart or go with the caregiver or child to the clinic.
- ☐ Follow up with caregivers and children to make sure the services were received.
- ☐ Continue to monitor and document adherence during home visits and provide the necessary support.



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HOME VISIT CHECKLIST: TREATMENT ADHERENCE

CHECK ALL THAT APPLY AND RECORD THESE IN YOUR VIRAL LOAD TRACKER AND CASE BOOK (with the help of your Linkage Facilitator or supervisor):

- ☐ The child has run out of medicine
- ☐ The family has no transport to go to the clinic to pick up medicine
- ☐ The child doesn't like the taste of the medicine
- ☐ The child doesn't have food to take with the medicine
- ☐ The caregiver has not disclosed to the child
- ☐ The child has not disclosed to her/his friends or teachers
- ☐ The child is neglected or abused
- ☐ The child is sad, lonely, in despair due to h/his HIV status or other psychosocial issues
- ☐ Other reasons:

Your work is important! Thank you for making a great difference in the lives of children and families!

NUTRITION, FOOD SECURITY & HIV



WHY DO I NEED TO KNOW ABOUT NUTRITION, FOOD SECURITY & HIV?

- The healthy growth and wellbeing of Children and Adolescents Living with HIV (C/ALHIV), like all children, depends on their **daily intake of nutritious food**.
- Ensuring caregivers and children have access to healthy, nutritious food is an important part of the case management care plan for C/ALHIV.
- This includes looking for **signs of malnutrition**—and **referring** malnourished children and caregivers to clinic counterparts for a full Nutritional Assessment Counseling and Support (NACs).

WHAT DO I NEED TO KNOW ABOUT NUTRITION, FOOD SECURITY & HIV?

- For **C/ALHIV**, eating nutritious food every day is very important because of the relationship between healthy nutrition and HIV treatment outcomes.
- For **pregnant women/new mothers living with HIV**, eating nutritious food is important for their own health, and that of their unborn and new babies who are exposed to HIV.
- **All persons living with HIV must take food with their HIV medicine.** A lack of food to take with their medicine is one of the primary reasons that people living with HIV do not take their medicine at the correct time every day.
- For C/ALHIV, **lack of food and nutrition is related to poor adherence**, reduced ability to fend off sickness and increased risk behaviors from adolescents (especially girls, who may opt to trade sex for food).
- **Healthy food and nutrition means that a child has the food s/he needs every day** to keep the body strong, give the body energy and help the body grow and develop. This is called a balanced diet.
- **A balanced diet** promotes body growth and protection against diseases. This is extra important for C/ALHIV to ensure they stay healthy.

In Uganda, nutritious foods include:

- **Foods that make bodies strong (*protein*):** Simsim, ground nuts, beans, cowpeas, silver fish, fish, rabbit, chicken, meat and milk from goats and cows.
- **Foods that give you energy (*carbohydrates*):** Cassava, matooke, sweet potatoes, millet, posho, yarms, etc.
- **Foods that help children grow and develop (*important vitamins*):** leafy vegetables, fruits, grains, etc.





WHAT IS MY ROLE AS A PSW IN HELPING C/ALHIV AND PREGNANT WOMEN/NEW MOTHERS LIVING WITH HIV MAINTAIN GOOD NUTRITION & FOOD SECURITY?

- I can **talk** to caregivers about her/his food concerns, learn where the family's food comes from, **observe** what food is available in the household, and help caregivers **assess and plan** how to overcome challenges they may face ensuring their children eat nutritious foods every day.
- **I can ensure that C/ALHIV and pregnant women/new mothers living with HIV have food to take with their medicine.**
- **I can help caregivers and children:**
 - **Understand** what a balanced diet is.
 - **Identify** locally available, inexpensive nutritious foods to grow in their garden.
 - **Recommend** nutritious and inexpensive foods available in their region.
 - **Refer** families to ICYD economic strengthening activities like saving schemes, kitchen gardens or food resources through other partners in the community.
 - **Refer** severely malnourished children to clinic counterparts for urgent support.



HOME VISIT CHECKLIST: NUTRITION, FOOD SECURITY & HIV

- ☐ **Assess:** Ask caregivers and children to tell you in their own words what concerns they have about food security and nutrition.
- ☐ **Check** for common signs of malnutrition in children: Short or small for age, underweight, low energy, lack of appetite or trouble eating.
- ☐ **Observe:** Is there good hygiene in the household? How can you support caregivers to improve hygiene?
- ☐ **Ask** caregivers and children in their own words what they eat and how often they eat every day. Are they able to eat each time they take their medicine? Explain why it is important to eat food with medicine.
- ☐ **Ask** caregivers what they know about nutrition and explain how important nutrition is to the health and wellbeing of them and their children.
- ☐ **Help** caregivers identify how they can improve their diet, keep food and water safe, and plan to ensure children have food every day and can take food with their medicine.
- ☐ **Arrange** a cooking demonstration if the family has issues regarding food preparation.
- ☐ **Refer** children with signs of malnutrition for assessment and nutritional rehabilitation with clinic counterparts.
- ☐ **Follow up** with caregivers and children referred by you to ensure they receive their necessary services.
- ☐ **Write** down what you learn in your VL tracker or care plan and continue to monitor the child and family through case management. Consult with your Linkage Facilitator or supervisor to help you fill out the home visit or care plan forms.

SUPPORTIVE DISCLOSURE



WHY DO I NEED TO KNOW ABOUT SUPPORTIVE DISCLOSURE?

- Disclosure is the process of sharing one's HIV status with someone else.
- Uganda's policy states that a child should be **informed of their HIV status by age 12** and should **never be lied to** about his/her HIV status.
- **Disclosure is important because it impacts ART adherence of children and adolescents.** One of the main barriers to ART adherence is a lack of disclosure. This means the child or adolescent living with HIV has not yet been told that they are HIV-positive by their caregiver.
- Disclosure is sometimes met with **anger, blame or even violence.**
- Helping caregivers and children prepare for disclosure requires support from **someone trained** in supportive disclosure.
- Depending on my level of training, I may be able to help support caregivers and/or children to disclose, or link them to a trained individual that can help.

WHAT IS SUPPORTIVE DISCLOSURE?

- Disclosure in OVC programs is primarily concerned with:
 - Caregiver disclosure of the child's HIV status to the child.
 - Children disclosing their HIV status to others—like friends, teachers and even some family members.



- Disclosure of HIV status for any child or adult can be emotionally difficult.
- **Supportive disclosure** is the process of helping caregivers prepare to disclose to children living with HIV (and sometimes their spouses or partners), as well as helping children disclose their HIV status to others.

WHAT DO I NEED TO KNOW ABOUT SUPPORTIVE DISCLOSURE?

- Disclosure to a child of their HIV status should be based on **their readiness and desire to know** (i.e., they begin asking questions about why they take medication).

SUPPORTIVE DISCLOSURE

- This is due to stigma and discrimination experienced by children—and adults—related to positive HIV status in Uganda.
- Helping caregivers and children prepare for disclosure requires support from **someone trained** in supportive disclosure.
- Many **factors influence when and how** a child's HIV status can be disclosed to them—and when they should disclose to others.
- Caregivers should be involved in disclosing to the child as much as possible.
- Most adolescents and caregivers need support with **planning disclosure, the actual disclosure conversation, and post-disclosure follow up.**

WHAT ARE THE BENEFITS OF DISCLOSURE?

- Disclosure allows children to receive the necessary support from family and community to accept their condition and take medications correctly.
- Disclosure relieves fear from stigma and anxiety, and opens up more social support from family and peers.
- Disclosure improves a child's sense of personal power and ability to manage his/her own health.
- Disclosure allows the child/adolescent to serve as a role model for others dealing with disclosure.



WHAT IS MY ROLE AS A PSW IN SUPPORTING DISCLOSURE?

- Your role depends on your knowledge of disclosure, your level of training in supportive disclosure, and your relationship with caregivers and children on your caseload.
- **You should consult with and coordinate all disclosure activities with your supervisor and clinic counterparts.**
- If you—by yourself or with your clinic counterpart, Linkage Facilitator or supervisor—discuss disclosure during home visits, use this checklist to prepare for your visit.
- **Record** what you learn in your **Home Visit form** and **Viral Load Tracker**. Your Linkage Facilitator and supervisor can help you fill out these forms.



HOME VISIT CHECKLIST: SUPPORTIVE DISCLOSURE

- ☐ Always open conversations about HIV with caregivers or children by reassuring them that the information is **confidential** and will only be shared after **consent** by the caregiver and/or child.
- ☐ Ask the caregiver and/or the child if it is OK for you to ask them some questions about their health. **Remember, disclosure issues should always be discussed in private!**
- ☐ If you do not know whether the caregiver has disclosed to the child, ask the caregiver if you can discuss this issue in private.
- ☐ If the caregiver *has* disclosed the child's HIV status to the child, ask the caregiver or child if the child has disclosed to his/her friends, teachers or other important people in their life. Remind the caregiver and child why disclosure is important.
- ☐ If the caregiver *has not* disclosed to the child, explore the challenges of disclosure for the caregiver or child. **Record** what you learn in the **Home Visit form**. Work with your Linkage Facilitator, ART in charge and/or Supervisor to update the **Viral Load Tracker** with this information.
- ☐ Offer to help the caregiver—or child—plan for disclosure. Reassure the caregiver and child that you will support them in every step of the way.
- ☐ Explain to the caregiver that you would like to set up an appointment with the caregiver (and/or the child) and someone **trained in the disclosure process** to support them during this process.
- ☐ Consult with your clinic counterparts or supervisor to set up a planned disclosure session.
- ☐ Follow up with the caregiver and child until the disclosure process has been **completed**.

VIRAL LOAD MONITORING

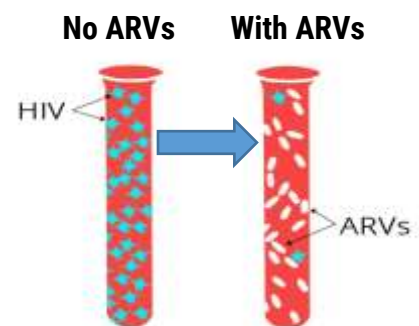


WHY DO I NEED TO KNOW ABOUT VIRAL LOAD?

- The primary goal for all children, adolescents and caregivers living with HIV is to stay healthy by having no detectable HIV in the blood—this is called *viral load suppression*.
- Viral suppression occurs when children and adults living with HIV are taking the right medication, at the right dose, the right way and at the right time, every day.
- Your understanding about viral load and the relationship between adherence, viral load testing and viral load suppression will enable you to:
 1. **Reinforce and promote** important information with children and caregivers.
 2. Help children, adolescents and caregivers **adhere to treatment, go for viral load testing, and receive viral load suppression support**, when needed.
 3. Help **identify non-suppression early** and work with clinic and social protection counterparts to address suppression issues.

WHAT IS A VIRAL LOAD?

- A viral load is a measure of how much HIV is in the blood.
- The viral load provides information about how well ARVs are working.
- ARVs stop HIV from making more copies of the virus.



WHAT IS A VIRAL LOAD TEST?

- A viral load test measures the amount of HIV virus in your blood.

WHEN SHOULD A CHILD TAKE A VIRAL LOAD TEST?

- **Six months** after initiation of ART regardless of age.
- A **child** should receive a **follow up viral load test every 6 months** if the previous viral load was suppressed.
- An **adult** should receive a **follow up viral load test once every year** if the previous viral load was suppressed.

VIRAL LOAD MONITORING

WHAT DOES A HIGH VIRAL LOAD MEAN?

- A high viral load means there is a lot of HIV in the blood (1,000 or more copies of HIV virus per millilitre of blood).
- **The most common reason for high viral load is poor treatment adherence** (See *Adherence Job Aid* to learn more about the many reasons for poor adherence).

WHAT IS VIRAL LOAD SUPPRESSION?

- Viral load suppression means that there is a **LOW viral load** in the blood—less than 1,000 copies/ml of blood. This means that ART is **working very well!**
- This **does not mean** that a child living with HIV can stop taking their medication.
- If children **stop taking their medication, the HIV will start multiplying again** and the viral load will increase!
- **Encourage children** to keep up the good work!

**WHAT IS MY ROLE AS A PSW IN SUPPORTING VIRAL LOAD MONITORING of C/AHLIV?**



- With basic knowledge about viral load, you can support children and caregivers to find out their viral load testing eligibility, schedule viral load tests, ensure they receive results, and talk to caregivers/children about addressing high viral loads.
- As PSW, you are a valuable resource to the family and clinical team. You can:
 - Assist C/ALHIV and their families to identify potential causes of high viral loads.
 - Support them to address social barriers, such as lack of transport and missed appointments, inadequate food, etc.
 - Work with clinical teams to plan holistic approaches for C/ALHIV with high viral loads.
- You should consult with and coordinate documentation and follow up of all viral load activities with your **Linkage Facilitator, ART clinic in-charge, supervisor or other clinic counterparts.**



HOME VISIT CHECKLIST: VIRAL LOAD MONITORING

- ☐ **Record** the child's facility name and ART number in your tracking tools.
- ☐ Verify the date child is eligible for viral load test. Work with your Linkage Facilitator, ART in charge or Supervisor to update the **Viral Load Tracker** with this information.
- ☐ Help arrange a date for a viral load test with the clinic, caregiver and child.
- ☐ Remind the caregiver and child a few days before the day of the viral load test by call, text, or home visit.
- ☐ Following the test, make sure the caregiver and child receive their results.
- ☐ If the test shows **low viral load** (viral suppression), it means the medication is working! Encourage the child and the caregiver!
- ☐ If the test shows **high viral load (non-suppressed viral load)**, it means the medication is not working, or the child is not swallowing ARVs well (adhering to the medication). Do the following:

HOW TO INTERPRET VIRAL LOAD TEST

<p>LOW VIRAL LOAD=</p> <p>Less than 1,000 copies/ml=</p> <p>Viral load suppressed</p> 	<p>HIGH VIRAL LOAD=</p> <p>More than 1,000 copies/ml</p> <p>Viral load not suppressed</p> 
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- ☐ **Ask** the caregiver—or child—if they understand the child's viral load results.
- ☐ **Discuss** with the caregiver and child **what a high viral load means**.
- ☐ **Identify** challenges the child/family have that may affect treatment adherence.
- ☐ **Help** the caregiver and child make a plan to improve adherence together.
- ☐ **Help arrange** a clinic visit to review results and better understand what is affecting the child from virally suppressing.
- ☐ **Document** the reason for non-suppression in your tracking tools. Work with your Linkage Facilitator, ART in charge or Supervisor to update **Viral Load Tracker** with this information.
- ☐ If needed and you are trained, **initiate intensive adherence counselling (IAC)** in consultation with the ART facility. Otherwise, refer the child for IAC sessions at the ART facility. Share identified adherence barriers with the clinical team and make plans to address them. With the child, caregivers and facility, ensure that the child receives 3 consecutive IAC sessions with a “good” adherence score before a repeat viral load test.

Continued on side 2

VIRAL LOAD MONITORING

- ☐ **Refer and follow up to monitor** caregivers and children until they have a viral load test that shows viral load suppression.
- ☐ **Refer children** who fail to suppress after good adherence to the clinic for assessment and further management.

Remember, children living with HIV need to be virally suppressed for a least one year before the family will be eligible for graduation!

Multi Month Dispensing (of Antiretrovirals)



WHY DO I NEED TO KNOW ABOUT MULTI-MONTH DISPENSING (MMD)?

- My caseload may include Children/Adolescents Living with HIV (C/ALHIV) who already use Multi-Month Dispensing (MMD), or are eligible for and would benefit from it.
- By understanding how MMD works, I can better support my C/ALHIV clients to adhere to their treatment, even when they are not attending the clinic as frequently.
- I can also provide information about MMD to eligible C/ALHIV so they can follow up with their health care provider about using MMD.
- I will know when to reach out to health care providers about clients on MMD.

WHAT IS MULTI-MONTH DISPENSING (MMD)?

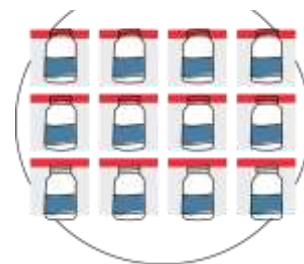
- MMD is when a person receiving HIV treatment receives 3 or more months' supply of Antiretrovirals (ARVs) at once.
- Clients usually receive a three to six-month supply of medication.
- Many clients like MMD because they do not need to go for clinic visits as often.
- MMD may help clients continue treatment. This is important for viral load suppression, which is key to controlling HIV.

HOW DOES MMD WORK?

- C/ALHIV using MMD receive exactly the same **type and dosage** of drugs as they would if they were receiving them one month at a time.
- ARVs are obtained from community-based distribution points or health centres.
- C/ALHIV clinic visits are timed with visits of HIV-positive caregivers to allow easy monitoring of both the child and caregiver.
- Caregivers are allowed to pick up their child's medication without bringing the child, unless the child is due for a clinic visit.

Monthly dispensing of ARV

1-month supply

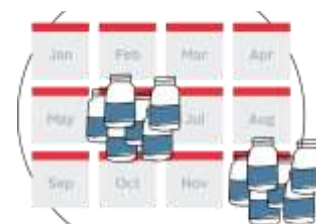


Multi-month dispensing of ARV

3-month supply



6-month supply



MULTI MONTH DISPENSING (OF ART)

- Health workers will assess C/AHLIV to decide if and when to start MMD and what is the appropriate duration for refills.
- MMD is the preferred mode of ART dispensing during the COVID-19 pandemic; stable clients should be encouraged to request it.

WHICH CHILDREN AND ADOLESCENTS ARE ELIGIBLE FOR MMD?

- Be above 2 years of age.
- Be on ART for at least 6 months.
- Have demonstrated good treatment adherence.
- Be virally suppressed in the past 6 months.
- Have a caregiver that has suppressed viral load.
- Is NOT on third (3rd) line treatment.
- Pregnant/breastfeeding women must have been on ART for more than 6 months.
- Has not switched or substituted regimen in the last 6 months.
- Have completed TB preventative treatment (INH prophylaxis).
- Other factors may also be considered (e.g., presence of TB, malnutrition or other opportunistic infections).

WHAT ARE THE BENEFITS OF MMD FOR CHILDREN AND ADOLESCENTS?

- Fewer trips to the clinic save time and money.
- Less crowded clinics mean shorter wait times. This may allow for more time with health providers and less exposure to diseases like COVID-19.
- In the event of movement restrictions due to disease outbreaks such as COVID-19, clients will have better access to ARV supplies.



WHAT IS MY ROLE AS A PSW IN SUPPORTING C/AHLIV ON MMD?

- As a PSW, I can support C/AHLIV and caregivers who are on MMD to make sure they are adhering to their treatment.
- I can discuss challenges related to using MMD and help identify solutions, in consultation with the **Linkage Facilitator, ART in-charge** and/or other clinic counterpart.
- I can also identify C/AHLIV that may be eligible for MMD and talk with them about the benefits. I should consult with or refer interested clients to the **Linkage Facilitator, ART in-charge or clinic** for more information.



HOME VISIT CHECKLIST: MULTI MONTH DISPENSING

- ☐ Find out if the C/ALHIV is on MMD by asking how many months of ARV prescriptions they receive at one time.
- ☐ Work with your Linkage Facilitator, ART in charge and/or Supervisor to update the **Viral Load Tracker** with information about the child's MMD status.
- ☐ Encourage the C/ALHIV or caregiver to talk to the health care provider about aligning MMD schedules if more than one person in the household is on MMD.
- ☐ Confirm dates and that there are plans in place for: refilling prescriptions, attending next clinic appointment, and going for viral load sample collection.
- ☐ Ask about any problems related to storing or administering ARVs, such as lack of cool or confidential storage space or child's difficulty to swallow pills, etc. Refer C/AHLIV with challenges back to the health facility for clinical review.
- ☐ Assess the C/ALHIV's adherence to their medications and clinical appointments. Provide support in identifying and overcoming related barriers.
- ☐ Make sure that drug sharing is not happening in the household.
- ☐ For C/ALHIV not using MMD, discuss its benefits and refer them to the treatment facility for assessment and decision on using MMD.



Image Source: Job Aid for providers, case workers, and other counsellors to discuss ARV multi month dispensing with adolescents living with HIV. USAID/PEPFAR ACHEIVE. 2021.

CASE MANAGEMENT OF HIV-EXPOSED INFANTS & MOTHERS



WHAT DO I NEED TO KNOW ABOUT CASE MANAGEMENT OF HIV-EXPOSED INFANTS AND MOTHERS?

- Infants exposed to HIV need special care to **stay free of HIV** during pregnancy and breastfeeding.
- HIV-exposed infants also need care to **ensure they start HIV treatment immediately if they become HIV-positive.**
- New mothers living with HIV also need care and support:
 - They may need support to **continue their HIV care and adhere to their HIV treatment.**
 - They may need support to **disclose their HIV status to their partner/baby's father**, if they have not done so already.
 - Mothers who have **newly tested positive for HIV** may also need support to cope with their HIV status, including overcoming self-stigma and self-rejection.
 - Like all new mothers, those living with HIV may also struggle to cope with **intense feelings of sadness, anxiety, or despair** after having a baby.

WHO IS AN HIV-EXPOSED INFANT?

- If a pregnant woman is HIV-positive, her baby is exposed to HIV during pregnancy, labour and delivery, or during breastfeeding.
- Infants must be tested for HIV to know if they are HIV-positive.
- Infants exposed to HIV – even if uninfected – may experience impacts on their health (growth, infectious diseases) and may also experience psychosocial and economic challenges due to living in a household with an HIV-positive caregiver.

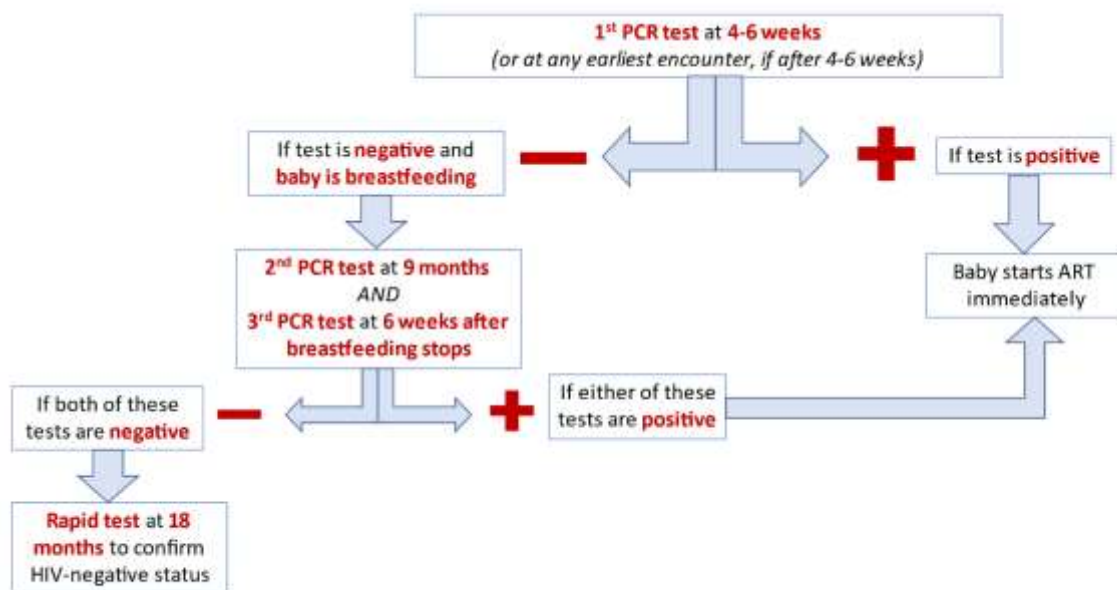
WHAT SPECIFIC HEALTH INTERVENTIONS DO HIV-EXPOSED INFANTS NEED?

- Care at mother-baby care points until the baby is 18 months of age, including clinical assessments.
- From birth to 6-12 weeks: a health worker prescribes a daily syrup to the baby called Nevirapine (or NVP) or other ARVs (depending on the mother's condition) to reduce risk of HIV infection.
- At 6 weeks of age to 18 months (or when breastfeeding stops): the baby should start Septrin to prevent common childhood diseases like diarrhea, pneumonia and malaria.

CASE MANAGEMENT OF HIV-EXPOSED INFANTS

- HIV-exposed infants should be immunized like other babies to protect against infectious disease. Immunizations occur at birth, 6 weeks, 10 weeks, 6 months and 9 months.
- Growth and development monitoring at mother-baby care points and nutrition assessment, education and good food handling practices when breastfeeding ends.
- HIV testing from 4-6 weeks (see below).

WHEN DO HIV-EXPOSED INFANTS NEED TO BE TESTED FOR HIV?



WHAT IS MY ROLE AS A PSW IN SUPPORTING HIV-EXPOSED INFANTS & MOTHERS?

- As a PSW, I can educate, encourage and support mothers living with HIV and other caregivers to seek the special care needed for both mother and baby to stay healthy.
- I should pay attention to the needs of **both** mother and baby.
- Getting to know each family's dynamics is necessary for providing the right support.
- I can link families to needed health and nutrition services, as well as ICYD economic strengthening and early childhood development services.



HOME VISIT CHECKLIST: CASE MANAGEMENT OF HIV-EXPOSED INFANTS



Source: Care of the HIV-Exposed Infant Flipchart. CDC. 2018.

During Pregnancy

- ☐ Encourage her to enroll in the EMTCT program and to deliver at a health facility.
- ☐ Get to know the family dynamics and what kind of support would be helpful.
- ☐ Let her know that even though her baby will be HIV-exposed, there are ways to keep her baby healthy and reduce the chance of her baby contracting HIV.
- ☐ Encourage her to take her ART every day, maintain good adherence and ensure viral load suppression: this helps reduce the risk of transmission to baby.
- ☐ Encourage her to do routine viral load testing, as guided by a health worker (every 6 months after an initial suppressed result).
- ☐ Assess whether she has disclosed her HIV status to her partner. Work with facility EMTCT staff to plan and support her in assisted disclosure. Encourage the male partner to be tested for HIV if his status is unknown.
- ☐ Encourage her to eat a balanced diet to support baby's growth and development.
- ☐ Encourage her male partner to support her (e.g., encourage facility delivery, escort her to facility, eat healthy foods, support use of treated bed net).



After Childbirth

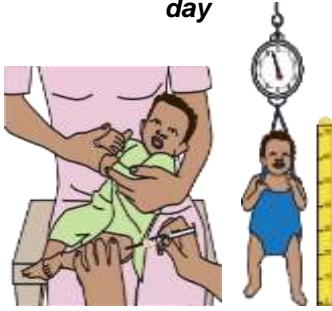
- ☐ Remind caregivers to get their baby tested for HIV at recommended intervals.
- ☐ Track/follow-up with caregivers who miss HIV testing for the baby and help resolve challenges related to accessing HIV testing.
- ☐ **Record** HIV testing results in the **Home Visit form** and share with your Social Worker/OVC team for updating of records.

Continued on Side 2

HOME VISIT CHECKLIST: CASE MANAGEMENT OF HIV-EXPOSED INFANTS



**Give your baby
medicine every
day**



**Take your baby for routine
immunizations and care**



**Breastfeed exclusively
for at least 6 months**

Images sourced from: Care of the HIV-Exposed Infant Flipchart. CDC. 2018.

- ☐ Remind mothers to continue taking their ART every day. If they have stopped, encourage them to return to their health provider to discuss options for restarting treatment.
- ☐ Discuss which medicines the health provider has recommended for the baby. **Record** this information in your **Home Visit form** and/or **Case Record Book**.
- ☐ Remind mothers to give their baby the appropriate medicine each day.
- ☐ Encourage mothers to give their baby only breast milk until 6 months of age.
- ☐ Educate caregivers on feeding options for babies 6 - 18 months.
- ☐ Encourage mothers to continue attending the mother-baby care point for their routine clinical assessments until after breastfeeding and final HIV diagnosis.
- ☐ Remind mothers to take her child for routine immunization (check on their immunization card to ensure they are on schedule).
- ☐ Promote good hygiene and sanitation practices.
- ☐ Counsel caregivers to seek care and treatment as soon as the baby has an infection or other illness.
- ☐ Listen to mothers, allow them to share their concerns or problems, and help them identify ways to address those challenges in a non-judgmental way.

Refer to the Treatment Adherence and Nutrition Assessment & Referral job aids for more information.

CASE MANAGEMENT FOR CHILD AND ADOLESCENT SURVIVORS OF SEXUAL ABUSE



WHY DO I NEED TO KNOW ABOUT CASE MANAGEMENT FOR CHILDREN AND ADOLESCENT SURVIVORS OF SEXUAL ABUSE?

- Rates of sexual abuse – especially among girls are high in Uganda: 1 in 3 girls experiences sexual violence before she turns 18.
- Yet, survivors rarely seek or receive services, including post-rape care.
- As a PSW, my case load includes children and adolescents who are sexual abuse survivors. Information about their specific support needs will help me better provide services for them without causing further harm.

WHAT ARE THE SIGNS OF SEXUAL ABUSE IN CHILDREN AND ADOLESCENTS?

Physical signs:

- Sexually transmitted infections (STIs)
- Signs of trauma to genital area (unexplained bleeding, bruising, or blood on sheets, underwear, or other clothing)

Emotional signs:

- Change in eating habits, mood, or personality
- Lower self-confidence
- Overly worried or fearful
- Increase in unexplained health problems
- Less interest in school, activities, and friends
- Nightmares/fear of being alone at night
- Self-harming behaviors

Behavioral signs:

- Too much talk about or knowledge of sexual topics
- Keep secrets and more quiet
- Don't want to be left alone with certain people/afraid to be away from primary caregivers
- Resume behaviors like thumb sucking or bedwetting
- Overly obedient behavior
- Sexual behavior that is inappropriate for the child's age
- Spend unusual amount of time alone
- Try to avoid removing clothing to change or bathe

WHAT 'FIRST LINE SUPPORT' SERVICES ARE NEEDED BY SEXUAL ABUSE SURVIVORS?

- **First Line Support** responds to a survivor's emotional, physical, safety and support needs, without intruding on their privacy. It is the **most** important type of support.
- It includes 5 key steps: Listen, Inquire, Validate, Ensure safety, and Support (LIVES).
- The five core concepts can be applied in any interaction with survivors – for post – care emotional support.

CASE MANAGEMENT OF HIV-EXPOSED INFANTS

- L** Listen closely with empathy, not judging
- I** Inquire about needs and concerns – emotion, physical, social and practical
- V** Validate by showing that you believe and understand the survivor
- E** Ensure **safety** by discussing how to protect the survivor from further harm
- S** Support - Help the survivor connect to services, social support

WHAT OTHER SERVICES DO SEXUAL ABUSE SURVIVORS NEED?

- It is mandatory to report a sexual abuse case to the Police and Probation Office. Always consult your supervisor to determine who will report the case.
- HIV Post Exposure Prophylaxis (also known as PEP) to reduce risk of HIV transmission (within 72 hours of rape incident) and adherence support.
- Wound care and Tetanus shot (if needed).
- Treatment/vaccines for other STIs, as available in Uganda.
- Emergency contraception for girls/women who present within 72 hours of the incident.
- Referral for legal services and support.
- Psychosocial support (PSS) and information about when to seek further help for emotional healing and recovery.



WHAT IS MY ROLE AS A PSW IN THE CASE MANAGEMENT OF CHILDREN AND ADOLESCENT SEXUAL ABUSE SURVIVORS?

- As a PSW, if any child, adolescent, or caregiver discloses sexual abuse or you suspect it has occurred, you must report it to the responsible authorities for investigation. Consult with your supervisor to determine who will file the report with the Police or Probation Office.
- You can First Line Support –listening, asking about needs and concerns), and validating their feelings. This includes reminding them that **1) you are sorry this happened 2) sexual abuse is not their fault 3) you are there to support them.**
- With your supervisor and Police, Probation Officer, you can work through the follow up plan, including how to ensure – and accompany, if needed, the survivor of recent sexual abuse (with 72 hours) to access medical treatment



HOME VISIT CHECKLIST: CASE MANAGEMENT FOR SURVIVORS OF SEXUAL ABUSE

This checklist is to support you to deliver some First Line Support services, in instances where a child, adolescent or caregiver discloses a sexual violence incident to you.

If someone discloses sexual abuse to you, or you suspect an incident has occurred, report it immediately to the responsible authorities.

Sexual violence incidents should be reported to one of the following:

1. Police
2. Probation
3. 116 child helpline

First line support:

- ☐ Ensure **privacy** in conversations with caregivers and/or children: no one else should **see or hear** the conversation, especially the suspected perpetrator.
- ☐ Maintain **client confidentiality** – do NOT discuss with anyone, apart from those to whom you are required to report. Inform child and/or caregiver of your mandate to report cases to the Police/Probation department.
- ☐ **Listen** respectfully to the child or adolescent and their caregiver(s). Allow them to talk freely.
- ☐ **Inquire** about the child's or adolescent's worries or concerns and needs in age-appropriate, friendly tone.
 - ✓ **Do answer questions.** If you do not have an answer, let them know you will try to find and share the information or link them to someone who can.
 - ✓ **Don't ask questions that force the child to relive painful events.**
 - ✓ **Don't ask them to analyze what happened or why OR pressure them to tell you their feelings and reactions**
- ☐ **Validate** or reassure the survivor that they are not to blame and that they have acted appropriately to share.
 - ✓ Do reassure them they are not in trouble.
 - ✓ Don't judge.
- ☐ **Provide emotional and practical support – this includes:**

Good **listening** means listening with your:



Eyes

giving your undivided attention



Ears

truly hear survivor's concerns



Heart

with caring and respect

HOME VISIT CHECKLIST: CASE MANAGEMENT OF HIV-EXPOSED INFANTS

- Encourage survivor and assist them to access medical care (this is especially important within the 72 hour window)
- Following referral of the case, you should work with Social Workers/Police/Probation Officers to follow-up with cases as needed.

Remember— sharing any information about a violence incident may pose serious and potentially life-threatening consequences for the survivor and for those helping them.

Share only essential information to responsible authorities on how service providers can get in touch with the survivor and important safety issues relating to the survivor's situation. Refer to Case Management Principles job aid for more information on safeguarding children and adolescent sexual abuse survivors.

What you can say to **inquire**:

- What would you like to talk about?
- How do you feel about that?
- You mentioned you feel very scared.
- It sounds as if you are feeling angry about that...
- You seem upset.
- Is there anything that you need?
- You seem to be saying...

Things you can say to **validate**:

- It's not your fault. You are not to blame.
- It's okay to talk.
- Help is available. [Say this only if it is true.]
- No one deserves to be abused.
- You are not alone. Unfortunately, many other children have faced this problem, too.
- What happened has no excuse.
- You are important.
- Everybody deserves to feel safe.

