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This training manual was developed based on qualitative research in phase I of the Shikamana study; input from KEMRI research staff, local LGBT groups, and the co-investigators listed above; and material adapted from Next Step Counselling, an approach developed by Amico et al for the iPrEx Study ("Iniciativa Profilaxis Pre-Exposición"), a phase III clinical trial to determine whether the antiretroviral medication emtricitabine/tenofovir disoproxil fumarate (commercially known as Truvada®) could safely and effectively prevent HIV acquisition through sex in men who have sex with men (1). We have adapted the material in this intervention to fit the Kenyan context, by streamlining procedures to enhance feasibility in a care environment in which task-shifting is required.
Introduction to Shikamana

Antiretroviral therapy (ART) has greatly decreased morbidity and mortality due to HIV-1 infection and the acquired immunodeficiency syndrome (AIDS) worldwide. However, successful virologic suppression during ART requires good adherence and the avoidance of treatment interruptions, which can lead to drug-resistance mutations. Marginalized patients may have problems with treatment support from providers, family, and friends, and often need additional assistance. Men who have sex with men (MSM) are marginalized and even criminalized in African settings, and many have problems with social isolation, depression, substance abuse, and stigma. The Shikamana project is a new intervention to enhance antiretroviral adherence among MSM in African settings. Shikamana has been developed and is being tested as part of a 3-year developmental research study funded by the U.S. National Institutes of Mental Health (R34MH099946, PI Graham) and carried out by Kenya Medical Research Institute (KEMRI) researchers and colleagues in coastal Kenya.

The Shikamana intervention tests the relative efficacy of patient-centred care and a modified version of Next Step Counselling implemented by counsellors, combined with support from a peer navigator (“Mshikaji” in Kiswahili; “Washikaji” is the plural form) assigned to each patient, versus the standard of care in Kenya. Clinicians contribute to the intervention by reinforcing counselling messages and supporting peer navigators. The intervention is practical, relatively inexpensive, does not require extensive training, and has the potential for easy and widespread dissemination. The Shikamana intervention is conceptually based in the social support literature and social cognitive theory, and is supported by findings from qualitative interviews with MSM in coastal Kenya and focus groups with their providers. This qualitative research led to the development of an access-information-motivation-behavioural skills model situated on multiple levels (intrapersonal, interpersonal, institutional or community, and sociocultural or policy) that influence men’s adherence.

Peer navigators (Washikaji) are HIV-positive MSM who have experience taking ART and are judged to be good role models for others. Washikaji can provide “experiential expertise” regarding the daily realities for MSM living with HIV and taking ART. They often are able to develop relationships with patients that are more candid and comfortable than those with the treatment team professionals. The aim is that the insight and care the peers provide will enhance a patient’s ability to understand, cope with, and adhere to their medication regimen. In addition, Washikaji can serve as role models for general life coping skills (or resiliencies) that are especially important for men living in a highly stigmatizing environment.

After selection, Washikaji undergo two days of training in how to provide information, empathy, and encouragement to MSM, targeting key mediators known to affect adherence: ART knowledge, motivation, self-efficacy, negative affective states, and substance abuse. Washikaji provide social support to 2-6 assigned patients each, in accordance with a protocol explained and rehearsed in their training. Washikaji meet weekly for their first month of work, and then have monthly meetings with the clinic team. The purpose of these meetings is to provide Washikaji with regular supervision, hold joint discussions about patients’ progress, and reinforce Washikaji training as needed.
Introduction to Provider Training Manual

This manual was designed as part of a research project on enhancing antiretroviral adherence among Kenyan MSM. The premise of the study is that combined support from providers and from peer navigators (Washikaji) can help men engage in care, manage problems as they arise, and adhere to treatment. Because MSM often experience stigma, discrimination, and other difficulties, providers need to spend time getting to know men’s situation and their individual facilitators and barriers to engagement in care. For this reason, we have incorporated patient-centred care and aspects of motivational interviewing (both well-established methods to improve care and support adherence) into provider training for the Shikamana intervention. The aim is that providers learn to involve patients in their care and start working through adherence barriers as a team, in order to enhance a patient’s knowledge, motivation, and skills to adhere to their medication regimen.

We decided to train both counsellors and clinicians in the Next Step Counselling intervention developed for Shikamana. This was done so that clinicians, many of whom are significant sources of patient information and counselling, can support and reinforce discussions with counsellors after reviewing brief counselling notes. We feel strongly that the patient-centred approach used in Next Step Counselling should be reflected in the care provided by both counselling and clinical staff. Performance objectives developed for the providers participating in Shikamana can be found in Appendix A. In general, our objectives for the provider training manual are:

1. To increase providers’ knowledge and skills related to promoting ART adherence for MSM patients;
2. To increase providers’ theoretical knowledge regarding the rationale for our provider and peer intervention developed for the Shikamana study;
3. To increase providers’ knowledge and skills in supporting, communicating with, and collaborating with peer navigators (Washikaji); and
4. To increase the capacity of the provider and Washikaji team for participatory program management related to Shikamana activities.
BACKGROUND

HIV Infection in African MSM

According to the 2013 UNAIDS report on the global AIDS epidemic, the epidemic continues to disproportionately affect sub-Saharan Africa, which was home to 70% of all new HIV infections in 2012 (2). However, since 2001, the annual number of new HIV infections among adults in sub-Saharan Africa has declined by 34% overall, due at least in part to increases in knowledge about HIV, reductions in sexual risk behaviour, and the scale-up of antiretroviral therapy (ART) (2). Unfortunately, there are no data on trends in HIV transmission risk for men who have sex with men (MSM) in this region, despite the disproportional toll of HIV and AIDS in this group since HIV-1 was first identified in the early 1980s (3). Reporting on HIV-1 infection among African MSM has been non-existent until recently. Most national HIV programs are now struggling to develop policy and programs to reduce HIV acquisition in this group and ensure that men’s HIV care and prevention needs are met (3).

HIV transmission risk for MSM

There are a number of reasons why MSM are at higher risk for acquiring HIV infection than other men:

1. The risk of acquiring HIV-1 through unprotected receptive anal intercourse is thought to be 18-fold to 35-fold higher than the risk of unprotected heterosexual sex (4).
2. Because a man can act as either an insertive or a receptive partner in male-male sex, men who acquire HIV infection through unprotected receptive anal intercourse can easily infect their receptive partners when taking the insertive role (5). This is especially true during acute HIV infection when men are very infectious and usually do not know their HIV status.
3. Because MSM often have relatively small sexual networks including partners who are also MSM and therefore at high risk of HIV acquisition, their risk of acquiring infection from any given partner is higher than for persons from lower risk groups (6).

For these reasons, and due to the poor access African MSM have had to tailored health information, including information on HIV risk, many MSM are living with HIV infection. These men need prompt diagnosis, linkage to care, and appropriate HIV care, including ART, to protect their health and prevent ongoing transmission to others. Transgender women are at very high risk as well, primarily due to unprotected receptive anal intercourse and high-risk sexual networks.

Disease progression and prognosis

Immediately after HIV acquisition, CD4 cell counts decline abruptly due to acute infection (see Figure 1). CD4 counts usually rebound as viremia is controlled, but then slowly decrease over time. HIV infection is therefore a progressive disease that leads to constitutional symptoms, opportunistic infections, and eventually death due to worsening immunosuppression. The average time until symptomatic disease (AIDS) is about 10 years. Early diagnosis, linkage to care, and treatment are essential for all infected individuals, in order to prevent disease progression and suppress plasma virus levels, or viral load. Of note, disease progression and prognosis should be no different for MSM than for other adult patients. However, engagement in care and adherence may be more problematic for African MSM due to stigma and discrimination, leading to increased morbidity and mortality in this group.
Reflection. Take a moment to think about what you know about HIV infection. Why might MSM have difficulties with access to care?

Consider each of the following points in the care cascade:

- HIV counselling and testing
- Linkage to care
- Entry into HIV care
- HIV disease staging
- Counselling around ART initiation
- ART initiation
- Retention in care
ART prevents morbidity, mortality, and transmission
Current WHO guidelines recommend ART initiation for adults and adolescents when their CD4 count falls below 500 cells/μL (7). In addition, ART should be started in all adults with severe or advanced disease (WHO stage 3 or 4), active tuberculosis, chronic liver disease due to co-infection with hepatitis B, or a seronegative sex partner. In general, recent recommendations for ART initiation have emphasized starting treatment early for a number of reasons:

1. Early ART leads to higher CD4 counts and a reduced burden of infection (i.e., viral reservoir), preventing irreversible immune system damage (8).
2. Early ART decreases the risk of opportunistic infections, such as tuberculosis, pneumocystis jirovecii pneumonia, malaria, and bacterial infections (9).
3. Early ART likely also decreases the risk of other conditions associated with HIV infection, including cardiovascular, renal, and liver disease; and malignancies (9).
4. Finally and importantly, decreased viral load greatly lowers the risk of HIV-1 infection, by up to 96% in a study of mostly heterosexual couples (10). Evidence suggests a substantial prevention benefit for MSM taking ART as well (11), although the true extent of protection is unknown. However, ART clearly provides benefit to patients and their sex partners by significantly reducing the risk of sexual transmission.

African MSM need support to engage successfully in care
Support for patients taking ART is an important component of treatment success (12). In resource-limited settings, social capital, defined as “the use of relationships to obtain benefits and achieve desired ends” is an important way that patients obtain resources such as transportation to appointments and funds for needed medication or food (13). Unfortunately, stigma and discrimination related to male-male sex, as well as social isolation due to fear of rejection, may seriously undermine the ability of MSM living in Africa use social capital to their advantage (14). Stress, internalized stigma, lack of social support, and lack of disclosure have been found to influence linkage to and retention in HIV care (15). Especially in areas where stigma can be powerful, issues of culture, population density, isolation, and lack of access to health care services present different challenges for the design and dissemination of interventions targeting MSM (16). Available evidence suggests that African MSM suffer from lack of knowledge about and poor access to prevention services, fear of health-care seeking, denial of care, and even blackmail (17-21). Human rights abuses including rape, police discrimination, harassment, and beatings may be common in areas with a low acceptance of male-male sex (22).

Data from our early work with MSM patients taking ART in Kenya suggests that MSM may have lower adherence and poor clinical outcomes compared to less stigmatized groups (23). In addition, we have found that most health care providers are poorly equipped to address the needs of MSM and need additional training in order to provide adequate care (24, 25). While recently formed advocacy groups for lesbian, gay, bisexual, and transgendered (LGBT) individuals are contributing importantly to health care gains in sub-Saharan Africa, projects like Shikamana are needed. The goal of the Shikamana project is to engage and retain HIV-positive African MSM in care, motivate their adherence to treatment, and provide services that meet their needs. By training providers and MSM peers to promote adherence and support engagement in care, we hope to better address the barriers to access and successful
engagement in care currently faced by African MSM. We believe that the Shikamana project has the potential to improve outcomes and to serve as a model for innovative care delivery to MSM in sub-Saharan Africa.

**Reflection.** Take a moment to think about what you know about facilitators and barriers to ART adherence. Why might MSM have difficulties with ART adherence?

Consider the following facilitators and barriers, and how they might affect MSM patients:

<table>
<thead>
<tr>
<th>Facilitators</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV knowledge and information</td>
<td>Lack of knowledge about HIV infection</td>
</tr>
<tr>
<td>ART knowledge and information</td>
<td>Belief in traditional medicine or healing</td>
</tr>
<tr>
<td>Motivation to achieve goals</td>
<td>Poor motivation</td>
</tr>
<tr>
<td>Social support</td>
<td>Social isolation</td>
</tr>
<tr>
<td>Desire to be healthy</td>
<td>Mental health</td>
</tr>
<tr>
<td>Desire to avoid signs of illness</td>
<td>Substance abuse</td>
</tr>
<tr>
<td>Skills for navigating care</td>
<td>Lack of skills to navigate care</td>
</tr>
<tr>
<td>Skills for taking medicine</td>
<td>No routine for medicine-taking</td>
</tr>
</tbody>
</table>

**Positive living for MSM**

While ART may be the key to preventing both disease progression and HIV transmission to sex partners, there are many other aspects of “positive living” that are important for MSM living with HIV/AIDS. We would be remiss if we didn’t mention these and stress their importance as adjuncts to ART.

1. **Accepting the diagnosis.** Men who accept their HIV diagnosis experience less stress and are better able to obtain needed services and social support. Counsellors and clinicians need to work with recently diagnosed men to provide emotional support, information, and other care as needed in order to help men accept their HIV diagnosis.

2. **Co-trimoxazole (or septrin) prophylaxis.** WHO recommends co-trimoxazole prophylaxis for all HIV-infected individuals in African settings (7). This intervention reduces the risk of pneumocystis jirovecii pneumonia, toxoplasmosis, bacterial infections and malaria. MSM should have access to this important preventive intervention, which is usually started before ART initiation and continued indefinitely in areas with a high prevalence of malaria and bacterial infections.

3. **Nutrition and self-care.** Many patients need education about healthy eating, which can help prevent weight loss, boost immunity, and improve quality of life. MSM who are homeless or have unstable housing, in particular, may benefit from education and counselling on nutrition and self-care, with referrals to additional support as needed.

4. **Psychosocial support.** Support from friends and family is important for patients who need help with transportation, finances, or personal care (for example, if bedbound or hospitalized) (13). Disclosure to select individuals is recommended for this reason, and is discussed later in this training guide. In addition, men may benefit from support groups for people living with HIV,
whether specifically for MSM or for the general population. Some men may need access to more intensive counselling support, including substance abuse or mental health treatment. Although resources for addressing such problems in African settings are limited, training and programming are both increasing and should eventually allow greater access for MSM patients in need of substance abuse treatment or mental health interventions. Providers should work to identify local resources for mental health referrals and other services.

5. **Sexual risk reduction.** All HIV-infected individuals need information about routes of HIV transmission and information about reducing the risk of transmitting HIV to others. Several programs targeting sexual risk reduction for MSM are in development, and a provider training developed by the KEMRI-Wellcome Trust Research Programme and the Desmond Tutu HIV Foundation is available online at [www.marps-africa.org](http://www.marps-africa.org). Because such materials are available, while adherence interventions targeting this group are currently lacking, we have not focused on general sexual risk reduction as a major focus of the Shikamana project. In our experience, many providers have difficulty addressing both sexual risk reduction and ART adherence in the same visit with MSM patients. In Shikamana, we stress that ART adherence is a key component of HIV prevention, by suppressing viral load and reducing transmission risk. Both providers and peers in Shikamana will also distribute condoms and lubricants, advising their use to prevent transmission of HIV and other sexually transmitted infections (STI).
Adherence to Antiretroviral Therapy

Improved HIV prevention services targeting MSM, including condoms and lubricants, community-based behavioural interventions, and increased access to ART, could make a significant impact on preventing new infections, not only among MSM but also in the general population (26, 27). However, while ART effectively reduces HIV transmission risk (28), its impact depends critically on adherence and retention in care (29). One of the foremost concerns of ART programs is the ability of people living with HIV/AIDS to maintain near-perfect adherence over the long term.

ART adherence is the strongest predictor of genital HIV-1 shedding, a proxy measure for HIV-1 infectivity (30). Improvement in clinical outcomes is also contingent on adequate levels of adherence (31-34). While only moderate adherence (i.e., 70%-90%) may be needed for virologic suppression on the NNRTI-based, first-line treatment regimens used in African settings (35, 36), lower levels of adherence lead to unsuppressed plasma viral load and an increased risk of progression to AIDS (35-40). In addition, non-adherence generates drug resistance mutations (41, 42), increasing the risk of treatment failure and transmission of drug-resistant variants (43, 44).

Adherence is defined as a patient’s ability to follow a treatment plan, take medicine at prescribed times and frequencies, and follow restrictions regarding food and other medications. Both patients and health care providers face significant challenges with respect to adherence to ART. Adherence is similar to any behaviour that is either adopted or avoided, such as a healthy diet or smoking cessation. Once initiated, ART is a life-long treatment that must be taken as prescribed, following dietary or other instructions if need be. These medications also have side effects, some of which may be temporary, while others may be more permanent and require a change of treatment.

ART barriers and facilitators for African MSM

Our research in coastal Kenya helped identify specific barriers and facilitators faced by HIV-positive Kenyan MSM. In this area, 20% of total HIV infections occur among MSM, who are highly stigmatized and face many barriers to care engagement and ART adherence. We conducted 30 individual in-depth interviews (IDI) with HIV-positive MSM recruited through purposive sampling, and 4 focus group discussions (FGD) with their health care providers. Semi-structured, open-ended topic guides used an approach based on an access-information-motivation-behavioural skills (access-IMB) model of adherence, with additional focus on trust in providers, stigma, and discrimination. After translation into English, detailed interviewer notes and transcriptions were reviewed to identify common factors influencing ART adherence.

In general, conformity was observed between individual-level adherence factors proposed by the access-IMB conceptual framework and those identified in the study. Barriers included limited access due to poverty and poor availability of MSM-friendly health information and services; inadequate knowledge of HIV and ART; and decreased motivation due to lack of psychosocial support, non-disclosure of HIV status, medication side effects, mental health challenges (often referred to by patients as “stress”), and substance abuse. Facilitators included economic empowerment, more comprehensive HIV and ART knowledge, peer support, disclosure to select individuals, and self-acceptance. Standard adherence skills such as medicine-taking reminders and appointment-keeping were important. In addition, resiliency
emerged as an important protective factor against stigma and discrimination that was not included in the original model. Examples of resiliencies that facilitated adherence were having life goals to motivate one-self, belonging to a support group or having some role in the community, and a desire to protect loved ones or help others avoid HIV infection.

Adherence occurs in a specific context, in which specific facilitators and barriers help or hinder adherence in both general and specific situations (1). In developing the Shikamana intervention, our guiding conceptual model for understanding what “drives” adherence over time was based on the Information, Motivation, Behavioural Skills (IMB) model of adherence (45), modified to include access as a prerequisite, according to cross-cultural work done by Fredriksen et al (46). While our qualitative results confirmed the importance of this model for MSM, we also determined that a situated or context-specific approach to understanding MSM’s adherence is also important, including factors on the individual or intrapersonal, inter-personal, institutional or community, and policy or cultural levels. We therefore adapted and refined our thinking on MSM’s adherence to develop the Shikamana Conceptual Model, which is pictured below.

Figure 2. The Shikamana Conceptual Model

**COMBINED ACCESS-IMB SKILLS AND SOCIOECOLOGICAL MODEL**
SHIKAMANA INTERVENTION

The Shikamana Team Model
The Shikamana project combines provider training in patient-centred care and motivational interviewing skills with peer training on how to provide support and give patients helpful reminders. All peers have experience taking ART, and are selected for their character and ability to serve as a role model. After training, each peer works with his assigned patients in close collaboration with the providers. Trained peers work with 2-6 patients each, arranging meetings in person or by telephone and encouraging patients to take their medication every day as prescribed.

Peers are asked to keep logs of all patient contacts and are invited to monthly clinic meetings to discuss patient progress. Providers and peers work together to problem-solve patients’ specific adherence barriers, using a case management model. For example, peers or providers could work together to send text reminders to a patient who has problems remembering clinic appointments or specific doses of his or her ART. The patient is a critical part of this team, as his or her input is needed to develop the optimal plan. Working as a team, the patient, peer, and provider can form a bond (Shikamana) to promote good health and prevent HIV transmission.

Roles on the provider team
In general, HIV care in sub-Saharan Africa is provided by teams of individuals including clinicians (usually clinical officers or nurses), counsellors, and pharmacists (who are often the same as clinicians). In the Shikamana project, the following roles were assigned to each of these three groups in order to support the patients and peers:

1. **Clinicians** are assigned the role of evaluating the patient clinically, staging the patient’s disease, ensuring eligibility for ART, reinforcing teaching on ART and the importance of adherence, and managing side effects. Clinicians are responsible for seeing patients at baseline, twice during month 1 (to monitor for side effects and clinical response), at month 3, and then quarterly thereafter. In addition, clinicians see and evaluate patients who have any symptoms or other complaints.

2. **Counsellors** are assigned the role of engaging patients in education about ART and its risks and benefits, drawing blood when needed for clinical monitoring, and counselling patients at baseline and monthly refills visits to promote ART adherence and engagement in care. The Next Step counselling approach outlined in this training manual will be delivered by counsellors, supported by clinicians when possible.
3. **Pharmacists** are assigned the role of collecting patient monitoring devices (MEMS caps will be used in the Shikamana pilot and RCT), capturing additional adherence data (through a questionnaire and a brief audio computer-assisted self-interview), and refilling medications. Education concerning use of MEMS as well as medication storage or other relevant issues is provided as needed. We ask pharmacists to be neutral in their interactions with patients to the extent possible, so as not to bias the adherence data collected in the pharmacy. This strategy, called “Neutral Assessment” was used in the iPrEx trial in conjunction with Next Step Counselling (1).

Providers at our clinic meet weekly to review the clinic work-load, discuss complicated cases, and plan for the next week’s activities. A clinical Section Head oversees these meetings and is responsible for the oversight and supervision of clinic activities. The section head plays an important role in ensuring the smooth running of the intervention, providing ongoing training reinforcement and refreshers, and helping to integrate peer navigators to the health team. Working with peer navigators, or Washikaji, is discussed in more detail at the end of this training guide.
Counselling MSM on ART Adherence

Patient-centred care
Patient-centred care is an approach to the provider-patient relationship in which providers contract with patients about the purpose, scope, and goals of care at each visit. As part of this process, the provider puts forward a list of goals for the visit. The provider also asks the patient to contribute to the agenda by listing any active problems that need to be addressed, as well as patient goals for the specific session. These goals could be learning more about HIV infection, getting help with medication refill problems, or discussing the difficulties of disclosing to a sex partner. Patients will of course also have other needs related to acute illness (e.g., urethritis, upper respiratory infections), chronic health problems (e.g., haemorrhoids, diabetes), and other challenges in their lives (e.g., financial worries, housing problems). Providers should always be open and receptive, listen to patient concerns, and do their best to address problems that are important to the patient, no matter how important they may seem to the provider.

Communicating about patient needs
“Reasonable” appearing patients may have rational and irrational reasons why they don’t adhere to medication. Never assume that patients:
- Fully understand (have the knowledge needed)
- Want to and intend to take medicine as prescribed (have the motivation needed to adhere)
- Can adhere (have the skills needed to take medication in a variety of situations)

To understand your patient’s point of view, you need to learn more about him or her. As you get to know the patient during clinic visits, discuss what HIV means to him or her and how it has affected his or her life plans. Ask what he or she thinks about taking medicine to treat HIV. Examples of areas to explore and questions to ask include the following:
- Beliefs about HIV
  - What does it mean to have HIV?
  - How serious is it compared to other problems in your life?
- Beliefs about ART
  - What will happen if you take ART? If you don’t take ART?
  - Will ART help you? If so, how? If not, why?
- Relationships with providers (whether clinicians or counsellors)
  - Is there one or more provider with whom you feel comfortable?
  - Do you feel uncomfortable with certain providers? If so, why?
  - Do you believe your provider understands your needs?
  - Are you confident you can communicate your needs to your providers?
- Practical barriers to adherence
  - Do you understand how to take the medicine?
  - Do you need reminders for dose times?
  - Do you need reminders for refills?
  - Do you have privacy?
  - Do you have somewhere to store your medicine?
  - Can you carry medicine when you are away from home?
• **Risk factors for non-adherence**
  o **History of non-adherence to medications**
  o **Substance abuse**
  o **Mental illness, stress, or cognitive impairment**
  o **Inadequate financial and social support**
  o **Food insecurity**
  o **Side effects**
Motivating patients to adhere: Next Step Counselling

We identified Next Step Counselling as an evidence-based approach to motivate patients to adhere. The following sections are adapted, with permission, from the Next Step Counselling approach developed for the iPrEx Study of pre-exposure prophylaxis by Amico et al (1). The Next Step Counselling approach was developed to promote the development of accurate information, enhanced motivation, and increased behavioural skills necessary for daily medicine-taking, while minimizing burden in one’s daily life. Next Step Counselling is a patient-centred approach to promoting medicine-taking. The adapted Shikamana version of this intervention is delivered in six steps, as outlined below:

### Shikamana Next Step Counselling in Six Steps

**STEP 1:** INTRODUCE the counselling session.
*I would like to spend a little time talking about how things are going with trying to take your medication on time every day. That can be a real challenge for a lot of people. Is it OK for us to talk about that together?*

**STEP 2:** REVIEW the patient’s experiences and progress.
*Please share with me what, if anything, has helped you with medication-taking since we last met? Are there things that make it a little easier? What about things that make it difficult or more challenging? Any times, situations, or things that have made it hard for you?*

**STEP 3:** EXPLORE the patient’s context (facilitators and barriers) and motivation.
*If I am hearing you right, the main things that help are...and the main things that get in the way are… Is that right?*

**STEP 4:** IDENTIFY the next step (WHAT).
*What do you feel would need to happen in order for…*
  - Taking the medicine on time every day to be just a little easier? More manageable?
  - Taking ART in that situation you just described to feel a little easier? Less difficult?
  - Your current confidence in taking your ART to stay strong?
*Can you see anything that would make it easier for you?*

**STEP 5:** STRATEGIZE (HOW) and AGREE ON a plan.
*So it sounds like having more privacy when you take medicine would make it a lot easier for you, especially at home. How might that happen? How could you have more privacy?*

*You mentioned a few different things that might get you privacy. Is there one of those you might be willing to try before we meet again?*

**STEP 6:** RECORD the plan and document the visit.
Promoting comfortable discussions about medicine-taking
To work with patients to explore important feelings, thoughts, beliefs, and skills, Next Step Counselling draws from a number of counselling approaches, including motivational interviewing and other client-centred models. Motivational interviewing (MI) is a technique that seeks to elicit a patient’s own thoughts on what makes it harder or easier to adhere to therapy. MI uses several strategies to promote the mobilization of motivation, commitment to the change process, and sustaining health-promoting behaviour. It assumes that patients know their own circumstances better than anyone else, and are much more likely to come up with realistic plans and solutions that fit their needs.

The Next Step Counselling approach includes core elements that are:

- **Patient-centred.** The patient is the expert on his or her life and behaviours.
- **Context-driven.** The counselling session explores the context in which medicine-taking occurs or does not occur.
- **Individualized.** Counselling for ART adherence is individually tailored to the levels of engagement and medicine-taking behaviours of a given patient at a given point in time.
- **Comprehensive (Multi-targeted).** Providing accurate information is necessary but insufficient to produce behaviour change or promote patient engagement in discussions about medicine-taking. Motivation (personal and social) and skills are also critical to help produce change.
- **Neutral (In Stance).** The counsellor maintains a supportive but neutral stance throughout the session to convey acceptance of both the patient and his or her disclosures of positive and negative aspects of medicine-taking.
- **Realistic.** The counsellor recognizes that their impact is in the immediate session and that they cannot “make” patients do anything. They can, however, ensure that a safe environment for patients to openly discuss medicine-taking is consistently provided.

**STEP 1: INTRODUCE the counselling session**

**Introduction and Permission**
The aims of this step are to establish a safe environment to discuss medicine-taking, reinforce that the goal of counselling is to explore difficulties with medicine-taking, and establish a collaborative, patient-centred approach. You should provide patients with a sense of what you are interested in (i.e., ART adherence) and why it’s important to discuss. Specifically ask their permission to engage in the conversation. Attending in some way to each of the critical elements below will help patients to feel more engaged in the process.

**Critical Elements to Address in Framing the Session**

1. **FRAMING:** Frame the interaction as an occasion to discuss the patient’s experience with ART, recognizing that taking medicine every day can be difficult for many people. Request permission from the patient to have a discussion about this.
   
   “I would like to learn a little bit about how things are going with trying to take your medicine on time every day. That can be a real challenge for a lot of people. Is it OK for us to talk about that together?”
2. **NORMALIZE**: What is the ideal and what is reality, based on what we have learned about adherence to date? Full compliance, which is to take ART correctly every day, is the goal. However, the reality is that medicine-taking every day is difficult. Many patients have a lot of trouble with medicine-taking; some are not able to take medicine at all. Many patients are also uncomfortable sharing that information with clinicians or counsellors.

3. **INTRODUCE NEXT STEP COUNSELING**. We are changing the way we interact with patients about their medicine-taking. We hope that patients will trust that we very much want to help make medicine-taking easier in their life and, just as importantly, make it easier for them to talk about the challenges of medicine-taking. With our new counselling approach, we will spend 10-15 minutes at each visit discussing medicine-taking and its challenges. This will happen for all patients, no matter how much or how little they take their ART.

4. **FOSTER ENGAGEMENT IN THIS APPROACH**: Will you join us in working together on the difficulties surrounding medicine-taking?

Here is an example of how a counsellor might introduce the new Next Step Counselling approach:

> “Taking ART every day can be really challenging and not always possible. In the past, you may have talked about medicine-taking with a nurse or counsellor, but might not have felt able to talk about times when it is really hard to take ART. To encourage people to feel more comfortable, we have separated out the discussion about medicine-taking from the actual measurement of the number of medicine taken or missed. That way, we can talk together about times when it is easy or hard to take ART without worrying about your adherence reports. Reporting will be done in the pharmacy as you get your refill, and will take place on a computer questionnaire, after we get a chance to talk. I hope we can explore today how your experiences have been so far with ART, and if there might be some ways to make medicine-taking as manageable as possible given the demands you your daily life. Would it be OK if we spent a few minutes talking about that?”

**Follow-up Sessions at Return Visits**

For follow-up sessions, it is still important to let the patient know what you would like to discuss and seek permission. For example:

> “I would like to check in with you again about what makes it easier or harder for you when it comes to taking or trying to take your ART. Would that be OK?”

> “It has been a while since we last met and something may have changed. I’d like to check in with you about how it’s been going with your ART. OK?”

**STEP 2: REVIEW the patient’s experiences and progress**

**Initial Sessions**

The aims of this step are to establish rapport and set the stage for open discussion. Ask the patient about thoughts, feelings, and experiences he or she has had with medicine-taking in the past, and/or what it is or might be like for him or her to take ART. Listen for:
• Situations
• Feelings (including fear and anxiety)
• Motivation
• Thoughts
• Influences from others
• Skills

...that will contribute to his or her commitment to taking ART or to his or her engagement in care in general. For example:

“I am curious about what your experiences with ART have been so far. What has it been like for you to take medicine every day? What is going well? What is more difficult?”

Follow-up Sessions
For follow-up sessions, ask the patient about his or her thoughts and feelings about previous sessions. Ask about goal progress and provide reinforcement. For example:

“After you left last time, what did you think about the discussions you had with me (or other counsellor’s name) and the goal you set?”

“When you were here last, you had agreed to try __________; how did that go?”

Counsellor skills required for this step include using open-ended questions, reflective listening, “ventilation and validation,” reframing, summarizing, process comments, and elicit-provide-elicit (see Appendix B for examples).

STEP 3: EXPLORE the patient’s context (facilitators and barriers) and motivation
The aims of this step are to explore patient experiences, identify facilitators, use a strengths-based approach to identify barriers, and elicit information to adapt the approach according to the patient’s level of motivation. To explore the context, the following are recommended activities:

• Contextualize medicine-taking with facilitators, then barriers. First elicit facilitators (what makes it easy), then barriers (what makes it hard), then summarize for the patient.
• Do not ask the patient if he or she has missed medicine or linger on reports of missed medicine.
• Do ask about what seems to make it easier and what seems to make it harder to take the medicine.

Counsellor skills required for this step include using open-ended questions, reflective listening, elicit-provide-elicit, summarizing, and process comments (see Appendix B for examples).

Exploring Facilitators
Ask the patient about times when taking ART was or is “easy” or “easier” for him or her. Listen for:

• Situations
• Feelings
• Motivation
• Thoughts
• Influences from others
• Skills

For example:

“What are the times, situations, ways you feel, ways you think, ways others think, or things you hear from others that help you to take ART more easily?”

“Has there been a time when you felt that taking ART was less difficult for you?”

Exploring Barriers
Ask the patient about times when taking ART was or is “hard” or “harder” for him or her. Listen for:

• Situations
• Feelings
• Motivation
• Thoughts
• Influences from others
• Lack of skills

For example:

“What would you say are the main barriers, reasons, or things that make it difficult to you’re your ART?”

“Are there certain times or ways you feel that make taking your ART really difficult?”

“Tell me about the times when taking your ART seemed most difficult for you, no matter what actually happened or whether or not you took ART — just when did it feel difficult?”

<table>
<thead>
<tr>
<th>Common Facilitators</th>
<th>Common Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptance of HIV status</td>
<td>Misunderstanding of how or when to take ART</td>
</tr>
<tr>
<td>Belief that ART works</td>
<td>Schedule changes or travel</td>
</tr>
<tr>
<td>Partner/friend/family support</td>
<td>Lack of partner/friend/family support</td>
</tr>
<tr>
<td>Trust in providers</td>
<td>Belief that ART does not work</td>
</tr>
<tr>
<td>Feelings of commitment to providers</td>
<td>Feeling that taking ART is a burden</td>
</tr>
<tr>
<td>Predictability of schedule/weekday</td>
<td>Fear of unintended disclosure</td>
</tr>
<tr>
<td>Use of reminders (e.g., alarm on cell phone)</td>
<td>Unintentional forgetting, not having medicine</td>
</tr>
<tr>
<td></td>
<td>Feeling ART is too inconvenient</td>
</tr>
<tr>
<td></td>
<td>Substance abuse or depression</td>
</tr>
</tbody>
</table>
**Summarize**

Provide a supportive summary of the situations, feelings, thoughts, and influences that have made taking ART easier or harder to work into the patient’s life. For example:

“If I am hearing you right, the main things that help are…. and the main things that get in the way are …. Is that right?”

“Let me check in to make sure I understand. Medicine-taking seems easier when.....and seems more difficult when..... Are you comfortable with that summary?”

**Follow-up Sessions**

For follow-up sessions, you want to "refresh" the context. Because things can change quite a bit over time and since the last session, a new assessment of facilitators and barriers is needed, especially if the patient has tried a new strategy or experienced some kind of major change since the last visit. For example:

“I would like to revisit your experiences with ART. What are the times or things now that seem to make taking ART easier? What are the times or things now that seem to make it harder?"

“Sometimes a lot of things can change and things that influence how medicine-taking has worked into your life can change, even over a brief period. When you think about everything that is going on now in your life, what are the things that make medicine-taking easier? And what are the things now that seem to make it harder?"

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**WHEN PATIENTS JUST DON'T WANT TO TALK**

NO, it’s not OK to explore or push further! Some patients may not be ready, may be unwilling, or may feel that discussing ways to make medicine-taking easier for them is not something they need to discuss or address.

DON’T RESIST RESISTANCE!

If a patient is not interested or is unwilling to move forward, or is just not into the discussion now, honour that information. Use reflection to check your impressions and simply let him or her know that you’ll be checking in again next time.

“I am feeling that this is not something you want to explore right now. Is that how you are feeling?... Thank you for sharing that with me. I’ll check with you again next time you come in. Maybe you’ll have some different experiences between now and then that we could explore further. Thank you for taking the time to work though some of this with me today.”
THE QUESTION ANSWER TRAP — STAY NEUTRAL!!
Some patients may expect you to react negatively to non-adherence and so want to present an overly positive picture of their medicine-taking. For example, they may provide lots of examples of times when it is easy and no examples of times when it is difficult. Be careful in providing too much praise for good adherence. Counsellors can fall into a trap where the agenda (promoting adherence) dominates the discussion, so when a patient presents a picture that is consistent with that agenda, exploration is cut short, the patient is reinforced for presenting a short and positive picture, and what is actually happening in the patient’s life and their experiences with ART remain un-explored.

Many patients learn to report certain things, in order to make the experience with the counsellor as “painless” for everyone as possible.

Remain positive but also open and neutral in discussions. You are a guide on an exploration and that means you need to be aware of your agenda, work hard to accept an agenda that is different from what you have been doing so far (change from promoting adherence to working on easing adherence), and watch for wanting to cut the exploration short when you hear what you “want” to hear.

I DON’T HAVE TROUBLE
Some patients will simply not be willing or able to explore barriers, or may insist there are no barriers and that they have no trouble taking ART. In any of these scenarios you have some options.

When a patient reports only facilitators and says they have a strategy already in place that works, you can ask about any times when that strategy is difficult to do or maintain; you can ask the patient if he or she can share with you what he or she does to keep that strategy going over time or in different situations, because so many patients do struggle with medicine-taking. Let patients know you are eager to learn of ways people can approach medicine-taking that seem to be effective.

Should a patient feel unable to explore further, you can always reflect to the patient in a neutral way that you hear them saying there are no barriers that they can think of right now. Ask them if they would be willing to pay close attention to this in the next few weeks, before you meet again, to see if maybe there are some important things going on that are only noticed under close observation.

RIGHTING REFLEX
For patients who are not taking their ART, be open-minded. Instead of focusing on and arguing for CHANGE (in this case adherence) join the patient in their exploration of non-adherence. It is hard to do! Spend some focused attention on agreeing with patients when they admit to having difficulty. By joining the patient in discussing the negatives of adherence and the positives of non-adherence, you are building credibility and trust, and provide the patient with the opportunity to ultimately be more open in exploring pathways to medicine-taking.
Assess the patient’s engagement
One important aim of this step is to adjust discussions to match the patient’s level of engagement and position on the continuum of medicine-taking. Before moving on to Step 4, take a moment and make sure you are being responsive to this patient’s context and his or her engagement in the session with you. Counsellor skills required for this step include adjusting the focus of discussions ( tailoring), consensus building, active listening, and process comments (see Appendix B for examples).

ONE SIZE DOES NOT FIT ALL: One way of taking medicine, one barrier, one strategy to promote ease of taking medicine does NOT speak to all patients. This is the basis for adopting a flexible discussion approach to supporting medicine-taking, versus a modulized one where all counsellors cover certain content and skills with all patients. The discussion needs to be responsive to the patient, his or her context, and his or her willingness and ability to work with you right now on exploring medicine-taking.

Before moving on to Step 4, where you will identify a next step forward towards medicine-taking (essentially, WHAT would need to happen for progress to be made), the kind of progress you and the patient are working on needs to be defined. The session needs to be tailored to the patient’s level of engagement in the counselling process and what he or she has shared with you so far in terms of how medicine-taking fits and does not fit into his or her life (explored context).

As a counsellor with experience, many times you gauge where a conversation should go based on your own gut feeling. You have a sense of what would be most productive to explore and what would likely get you nowhere with a patient, or worse, would shut a patient down. For this counselling approach, you will not only take a moment to check-in with yourself to make sure you are being responsive to this patient’s needs and context, but also to be conscious about what you think this patient’s level of engagement is in the counselling session. This brief “check-in” will help you to decide how to move forward. This process actually is taking place from the time you first start interacting with the patient.

OBSERVE THE PATIENT’S NON-VERBAL BEHAVIOUR AND ALSO BE AWARE OF YOUR OWN!

Engaged
- Posture is relaxed
- Eye contact maintained
- Forward lean
- Emotions are consistent with what you are saying

Closed
- Arms crossed across the body
- Tight posture
- Protective posture
- Minimal eye contact
- Emotions appear inconsistent with content of discussions
- Protective, reactive, or defensive tone
- Patient ‘feels’ distant, not ‘into’ the discussion
- Patient does not ‘warm up’ as discussions continue

In most cultures, direct sustained eye contact and finger pointing are considered aggressive.
**Tailoring**
Several pieces of data are available to you to help tailor the session, including consistency of presentation, body language, avoidance of topics, and capacity to explore. Keep in mind that you are not trying to get to a certain “truth.” You are taking your best, most educated, and informed guess about what direction the session should take from here. The choice in direction is to move forward, focusing on increasing ease of medicine-taking generally, increasing ease of medicine-taking in specific situations, promoting continued use of a strategy perceived by the patient to be effective, increasing ease of maintaining a strategy in potentially difficult situations, or encouraging the patient to continue exploring their facilitators and barriers to medicine-taking and remain open to discussing them at the next visit.

**DON’T MISS MESSAGES**
- Watch and listen closely
- Listen for the patient’s
  - Information and knowledge level
  - Beliefs about ART and HIV care
  - Attitudes about ART and HIV care
  - Support from family, friends, providers, and others
  - Sets of skills
  - Ability to cope with difficulties
- Think about how you can help the patient to explore solutions
- What approach matches this patient best?

**STEP 4: IDENTIFY the next step (WHAT)**
The aim of this step is to identify WHAT needs to happen to make progress towards increasing the ease of medicine-taking. Counsellor skills needed include the Next Step Identification Activities (see Appendix C), and promotion of patient identification of what would be the next step towards progress.

Using one or more of the Next Step activities, work collaboratively with the patient to identify what the most effective and reasonable “next step” is for him, based on your tailoring in Step 3. Essentially, the activities are designed to provide a toolbox of ways to get at "WHAT would need to happen" or "WHAT would need to be different" for the patient to increase the ease of medicine-taking. The activity will naturally lead to HOW he or she might be able to accomplish that "WHAT" (which is Step 5). The "WHAT" (Step 4) identifies the next step for the patient and the "HOW" (Step 5) generates a list of potential strategies that could be used to make progress towards the next step.

- Select one of the next step identification activities.
- Introduce the selected activity. Share with the patient what you would like to work on with him.
- With the patient’s agreement, implement the selected activity.
Why identify the next step, when the goal is taking ART every day?

The goal of taking ART every day is ideal. BUT there are many ways to get to that goal and we need to be sensitive to how far away that ultimate goal is for different people. If taking ART every day is very far away from the patient’s current approach, it can be very frustrating to just be “told” what the ideal is. All that does is give the patient information about what is ideal. It does not help to make that goal manageable.

Imagine being told you “need” to lose weight or quit smoking or spend less money or drink less or eat healthier. You know what you “need” to do, but may not know if you really want to do it, or how to approach it in smaller steps, or how to make the journey more manageable. How would it feel to you to be told frequently that you “must” accomplish the goal but almost never asked about what you feel the next step is? How might it feel if someone did stop and recognize the smaller steps you are accomplishing on the way?

Counselling on the next step is about helping people to see the smaller steps towards a larger goal, promoting the experience of progress and success towards some ultimate outcome, and empowering people to recognize smaller steps as large accomplishments. Even though the goal is taking ART every day, Next Step Counseling works with people where they are NOW, focusing on small steps that make medicine-taking a little more manageable in their lives.

REMEMBER TO STAY NEUTRAL!!

As the saying goes, be careful what you wish for! Be careful not to be overly pleased with reports of perfect medicine-taking. Good performance should be reinforced, but with an overall neutral and exploratory stance, and not with excessive praise or personal thanks. Remember to maintain a neutral stance and limited role. Reports of never having barriers or trouble taking medicine will not actually be accurate for many people, but this will be exactly what they think you want to hear.

If you are too effusive and complementary about reports of no troubles, nothing but success, or spontaneous reports of perfect medicine-taking, you risk creating an environment where patients want to please you and feel unable to report troubles, difficulties, or struggles with taking the medicine.

Balance supportive reinforcement with recognition that you don't want to set up unrealistic expectations — you want the expectation to be that you are supportive of the patient, no matter what they report. Aim for open discussion about the ease and burdens of taking ART. In this way, you will meet your goal, no matter what the patient’s behaviour is.
**Small Accomplishable Steps**
When you help patients identify a next step, think of where they may be in the change process. Try to encourage them to focus on the next step that represents a CHANGE from their current approach, but is also a small, manageable, realistic, and accomplishable step forward.

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**STEP 5: STRATEGIZE (HOW) and AGREE ON a plan**
When the patient has identified WHAT would need to happen for progress to be made (a next step that appears realistic, accomplishable, and relevant — something that would be possible to try and is generated by the patient, or appears well accepted by the patient), ask the patient **HOW** this might be accomplished or approached.

WAIT for the patient to think about this. The tendency for counsellors is to jump in and offer strategies. Offering strategies may be appropriate and needed, but only after the patient has been given ample opportunity to come up with his or her OWN approach. Counsellors can help patients to generate
potential strategies for HOW to make process towards the next step, but should avoid prescribing strategies (“you need to try this or that”).

BEFORE offering any strategies, counsellors should seek permission to provide some ideas that have worked for others, might help, or seem appropriate. The AIM of this step is to generate a list of possible strategies the patient could consider using to make some progress towards the next step in increasing ease of medicine-taking.

ASK... How could the patient make progress towards the next step identified?

WAIT... Give the patient the opportunity to explore possible strategies and wait for him or her to provide possible solutions. Keep asking "What else might help" until strategies that are realistic, accomplishable, and likely to lead to an experience of success are offered.

OFFER... Ask the patient if you can share some things that have worked for others that may be helpful for him or her as well. Provide strategies to consider ONLY after the patient has been given sufficient opportunity to offer his or her own strategies.

For example:

“So it sounds like having more privacy when you take the medicine would make it a lot easier for you, especially at home in the morning. How might that be accomplished? How could you have more privacy?”

“How can you do that?”

“What are some ideas for how you could approach that?”

“I have some ideas that might help. Can I share those with you?”

**Develop an ACTION PLAN (if needed)**

The aim of step 5 is to set a specific goal that supports progress towards the identified next step. The general direction of progress towards taking ART consistently was identified in Step 4, and Step 5 moves discussions towards discrete behaviours or “things you can do” to move in the desired direction. To complete Step 5, it is important to finalize the discussion by agreeing on a specific action the patient will try out. The discussion has moved from general to very specific. The counselling skill needed for this process is consensus building.
**Agree on a Strategy to Try**
Ask the patient which of the strategies he or she identified (OR you offered) he or she would be willing to try between now and the next time you meet. Avoid strategies that are unrealistic or not likely to be accomplished.

Offer guidance for patients struggling to identify a strategy they are willing to try. Because it can be important for the patient have success, especially early on, consider whether or not the best strategy may simply be to meet with you again at that next visit. When patients select a strategy that appears highly unlikely to lead to success, suggest an alternative with greater odds of being accomplished.

**Characteristics of a Good Strategy to Select**
- REALISTIC
- ACCOMPLISHABLE
- MEANINGFUL
- BUILDS TRUST IN THE PROCESS
- BUILDS RELATIONSHIPS
- HAS A VERY GOOD CHANCE OF BEING COMPLETED

For Example:

"Of these strategies, is there one you would be willing to try between now and the next time we meet?"

"We explored some things that may eventually make taking ART a little easier. We discussed a few different things you could try for that. Would you be willing to try one of them before we meet again and let me know how it goes? Which can you try?"

"Seems like you felt that using a pill carrier when you go out with a client would make taking ART less difficult; are you willing to try that between now and the next time we meet?"

Consider how the next step identified can best be supported. What strategies can the patient use, what resources might be available that could help? This action plan, if implemented, should result in progress towards the next step identified.

- The actions or preparations needed to successfully accomplish the next step goal, including possible resources needed, make up the action plan.
- An action plan should be developed collaboratively, and could include resources that you know about that may be helpful.

For example:

"Now that we have worked on a next step that makes sense for you, there may be a few things we need to make that happen. What are your thoughts about that? What kind of support do you feel would be needed?"
“That next step seems like a good fit for you. I have some ideas for some specific things you could do to get there, but first I’m curious about what you think would be most important.”

“We talked about trying to keep water in your bedroom and taking ART with the door closed. Are you willing to try that before we meet again? There are a few steps to it. You would need to (1) put a water bottle in your room at night like you are drinking it during the night, (2) make it a reminder for you, (3) make sure the medicine is hidden in your room, and (4) try taking your ART with the door closed. If I write out the steps, can you take the sheet with you or would you rather not have it written out?”

**STEP 6: RECORD**

Record the results of the counselling session on the Shikamana counselling record, found in Appendix D. Be sure to document barriers and facilitators identified, and the next step that is identified to support the patient’s adherence. The agreed-upon strategy and action plan should be indicated on the completed form. Initial and date the completed form.
Follow-up Sessions

Prepare: BEFORE meeting with the patient, review the Adherence Counselling Record from the last session. Look over the facilitators, barriers, level of engagement, and selected strategy. GET a new Adherence Counselling Record and COMPLETE the parts you can from the last session. Then implement slightly modified steps of the counselling guide, as below.

STEP 1: INTRODUCE the counselling session

Follow-up sessions — Recognize that the patient has now been through this process one or a number of times. Move quickly into asking patients about any thoughts, feelings, or reactions they may have had about taking ART since the last visit. For example:

"It's been a while since we last met and something may have changed. I'd like to check in with you about how it's been going with your ART. Would that be OK?"

STEP 2: REVIEW the patient's experiences and progress

Follow-up sessions — In addition to reviewing experiences or thoughts since last visit, specifically assess progress made on the strategy selected at the last session.

REINFORCING PROGRESS MADE

The patient may have done anything from completely accomplishing the strategy selected to not even remembering what the strategy was. In early sessions, part of asking about progress is letting patients know that you are interested in their efforts and that you will follow up with them. The important part is that you are asking. Listen reflectively to what patients report. Appreciate difficulties reported and avoid judging.

<table>
<thead>
<tr>
<th>Patient report</th>
<th>Counsellor response</th>
</tr>
</thead>
<tbody>
<tr>
<td>I did it!</td>
<td>Reinforce accomplishment appropriately, with recognition of success.</td>
</tr>
<tr>
<td>I did some of it.</td>
<td>Reinforce the patient’s efforts.</td>
</tr>
<tr>
<td>I tried but could not.</td>
<td>Reinforce the patient’s efforts; note that the strategy may not have been realistic.</td>
</tr>
<tr>
<td>I did not want to do it.</td>
<td>Reinforce honesty and recognize that the strategy may not have been realistic.</td>
</tr>
<tr>
<td>What goal?</td>
<td>Recognize that it is understandable that the strategy is not remembered and that picking a more meaningful, realistic strategy today could help.</td>
</tr>
</tbody>
</table>

TRANSITION

Keeping the patient's next step progress in mind, move into exploration of how taking ART is going for him or her now.

STEP 3: EXPLORE the patient's context (facilitators and barriers) and motivation

Follow-up sessions — as for the initial visit, the purpose of the exploration step is to learn about how the patient manages, or cannot manage, medicine-taking in his or her current life circumstances. In follow-up sessions, this exploration is linked back to earlier discoveries and emphasizes that things can change. This allows patients who had previously reported “perfect” medicine-taking or “no barriers” to now disclose having missed medicine or otherwise had trouble if needed. For example:
“A lot may have changed since you were last here. I know we talked about taking ART the last time you were here, but I would really like to know how you feel about it now. Can you tell me about what kind of things make it feel easy or possible for you to take the medicine, and the things that make it harder for you?”

As with initial visits, listen closely for how engaged the patient appears to be in discussions with you and what the current context is for medicine-taking. Based on those impressions, move forward with identification of the next step, focusing on increasing the ease of medicine-taking in a way that is most responsive to the patient’s context and level of engagement.

**STEP 4: IDENTIFY the next step (WHAT)**

_Follow-up sessions_ — This step remains largely unchanged for the first several sessions, but should be prefaced during these subsequent sessions with an acknowledgment that the patient is gaining experience in being able to identify next steps. For example:

“As you know, there are many ways to explore what the next step might be in our work together. You may have looked at things this way before, but I think mapping out things with a Decisional Matrix would help. Is this something you've done before? Can we try this?”

“You probably worked with your counsellor last time on identifying what would be a good next step towards feeling more comfortable with the idea of taking your ART. Do you recall what you did? Was the approach you took useful? Can we work together today with the new things you shared in the same way?”

After several follow-up sessions — After repeated exposures to counselling sessions, it may become reasonable to simply ask him or her “What do you think our next step is?” This, however, should only be considered an appropriate approach when the patient is well-experienced in the approach. For example:

“By now you have probably explored medicine-taking in a number of different ways. Can you recall different strategies you have tried with your counsellors? Was there an approach that worked really well for you?”

“We've worked together for a few months now. You've made a lot of progress towards taking ART consistently, and by now you have a better idea than I do about how to identify your next step. So, what, given all you have accomplished and experienced so far, is your next step?”

**STEP 5: STRATEGIZE (HOW) and AGREE ON a plan**

_Follow-up sessions_ — This step remains largely unchanged. When possible, and if accurate, provide the patient with a history of strategies identified and accomplished to provide an overall picture of progress and foster motivation. If the patient is "recycling" a previous next step strategy, exploration of what worked and what did not would be important.

**STEP 6: RECORD**

_Follow-up sessions_ — On the Shikamana Counselling Record, mark the session as a follow-up session and note the patient’s reported progress on the previously selected strategy. Complete the remainder of the
form, noting "None identified" where appropriate. All patients except for those refusing the counselling or refusing to agree to try a strategy should have a strategy selected for the next session.
## Lexicon for Shikamana Next Step Counselling: Steps 1 through 5

<table>
<thead>
<tr>
<th>Step</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| **Step 1: Introduce the counselling session** | • Explain what you’re going to talk about and why.  
• Get permission to proceed.  

> Taking your ARVs on time every day can be very difficult and at times frustrating. My role is to work with you to explore what this experience is like for you. By exploring this, we can work towards making it as easy as possible or at least as manageable as possible in the context of your daily life. Would it be OK to just take a few minutes to discuss this?  

*(Follow-up) I’d like to check in with you again about what makes it easier and harder for you when it comes to your ART. Would that be OK?* |
| **Step 2: Review experiences and progress** | • Ask about the individual’s experiences thus far with the clinic and their ART. Establish/reinforce rapport.  
• At initial visit(s), provide the ‘tool kit’ - strategies that have been useful for other patients with associated tools available (e.g., medicine carrier, SMS reminders)  
• For follow-up, ask about progress on the strategy selected at the last session. Reinforce efforts in a neutral but supportive manner.  

> Thank you. Can you please share with me a little about your experiences at this clinic and with taking ART?  

> As part of your participation in this program, we are providing all individuals with this tool kit. Here you have...(explain tool kit)  

*(Follow-up) Last time you were here you agreed to try _____. How did that go?* |
| **Step 3: Explore the context and motivation** | • Use open-ended questions to explore factors or situations that help or make on-time medicine-taking a little easier; and those that make it harder, or a little more difficult.  
• For follow-up, frame questions to allow patients to explore current facilitators and barriers; these may be different from what was previously reported.  
• Before moving forward, ensure that you understand the factors that influence this patient's adherence and that you have a feeling for their level of engagement in the counselling session.  
• Use this information to tailor the question you ask in Step 4 to the context of this patient's experiences.  

> Can you tell me what you do that makes it a little easier to take your ART on time each day?  

> Are there times when taking your medicine feels easy or easier for you?  

> What makes it harder to take your doses?  

> When is it that taking doses feels a little more difficult?  

*(Follow-up) What are the times or things now that seem to make taking doses easier? What are the times or things now that seem to make it harder?* |
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| **Step 4**: Identify the next step (WHAT) | • Use an activity or open-ended question to help the patient identify WHAT would need to happen to make progress towards increasing the ease of medicine-taking, on time every day.  
  What would need to happen to ... feel better about taking doses, or make it generally a little easier or less frustrating?  
  What would need to happen for it to feel easier to take the dose that is often difficult, or in the situation where it feels frustrating?  
  What would help to support your current practices...keep up with strategies that work well...make sticking with current strategies more likely in different situations...stay motivated and engaged in current approach?  
  (Just-Ask Strategy presented. See Appendix C for other strategies.) |
| **Step 5**: Strategize (HOW) and AGREE ON a plan | • Work with patient to identify viable strategies for HOW to accomplish the identified next step.  
  • Emphasize strategies that are realistic for this patient.  
  • When agreeing on a strategy, support the selection of one that appears particularly realistic for this patient.  
  • For some patients, remaining open to exploring adherence or continuing successful strategies already in place may be appropriate.  
  • If there are steps needed to prepare for the next step chosen, define these and the associated resources in an action plan.  
  How might that be accomplished or approached?  
  How can you do that? How could that happen?  
  What are some ideas for how you could approach that?  
  I have some ideas that might help. Can I share those with you?  
  Of the strategies we have talked about, which might you be willing to try between now and the next time we meet?  
  For that strategy, are there some things you need to do or get to prepare for it? When will you do that? (Action plan) |

Appendix E contains several examples of Next Step Counselling visits.
Safe Disclosure for HIV-Positive MSM
(This material was adapted from (48))

*Imagining Disclosure for HIV-positive MSM*

Imagine you are HIV positive. You've only just learned about your status. OR you've known about it for some time. Whether it's still fresh news that you are beginning to absorb or it's something you have been living with for a while, there are bound to be many situations in your life in which you will be faced with the decision of whether or not to disclose your HIV status – to tell others that you are infected with HIV. In a number of circumstances you will find yourself trying to balance honesty with protecting your right to privacy.

Now imagine you are a man who has sex with other men, either occasionally or frequently. You are already aware that society disapproves of male-male sex, and you may have tried to keep your family, friends, or others from knowing about your sex life. You may have only a small group of people who know you have male sex partners. With your HIV diagnosis, your life has been made more complicated. You may feel guilty because your sex life has led to a chronic infection. You may be reluctant to tell people about your HIV status, due to doubled stigma or fear of losing support from those who accept you as an MSM. If you are someone who relies on selling sex for income, fear of losing customers could make you reluctant to disclose your HIV status.

Whom would you need to tell about your HIV status? Is there someone you would want to tell, but wouldn't be sure what or how much to say? Is there anyone you feel that you would have to tell like a spouse, a partner, or perhaps someone whom you've been dating? What about informing any recent sex partners? Sex work clients?

Perhaps you need surgery or you're going to see a dentist. Would you have to advise these or other healthcare providers that you're HIV positive? Do they have a legal right to ask you about HIV status or to deny you care if you are HIV positive? Are there any circumstances when you're legally required to disclose that you're HIV positive?

Along with the many thoughts and feelings you might experience while coming to terms with your HIV infection, these are some of the questions and concerns that would may arise with respect to disclosing your HIV status. As with so many of the issues about HIV, or many important life decisions, there are no absolute answers that are right for everyone.
How and when to disclose

HIV disclosure is a lifelong process. Reasons for disclosing or not disclosing change constantly, and many individuals have their own personal strategies and reasons for disclosing which are carefully planned to elicit positive outcomes. Common facilitators and reasons for disclosing include:

- trust in the recipient of disclosure
- positive experiences with previous disclosure
- existence of strong social support
- to gain social support
- to obtain relief from the stress of withholding a secret
- obligation and duty to inform
- self-acceptance of HIV-positive identity
- sharing knowledge
- controlling disclosure (i.e., disclosing before someone else exposes you)

Common barriers to disclosing include:

- negative experiences with previous disclosures
- fear of discrimination, stigma and rejection
- lack of a strong social network
- feelings of shame and guilt regarding one’s status
- struggle with being HIV positive
- cultural factors (i.e., homophobia) within one’s community
- lack of HIV education and inability to cope with the outcome of the disclosure
- concerns about harming or burdening others

The impacts and outcomes of HIV status disclosure are wide-ranging. Negative outcomes include rejection, abuse, violence, stigma and discrimination. However, positive outcomes include increased social support, stronger family cohesion and relationships, reductions in anxiety and depression, and improvements in physical health. Most studies of disclosure have found more positive outcomes than negative ones, particularly over the long term. Furthermore, the majority of disclosures have reported little to no regret after disclosing. However, little is known about how disclosure works for HIV-positive MSM and transgender individuals living in highly stigmatized environments. Our research suggests that some patients have disclosed to select individuals (i.e., close friends and supportive family members) safely.

It takes time to adjust to being HIV positive. With that in mind, it’s a good idea to not rush patients into disclosing their HIV status without first giving it some thought. Wanting to share this knowledge with someone else may be a perfectly natural reaction, especially when the diagnosis is new and the patient is feeling overwhelmed, vulnerable, and uncertain about his or her life and future. The reality is that people with HIV need to be selective about disclosing. **They need to be selective about who they tell and when they tell them.** This process of selection often involves uncertainty and can sometimes be an anguishing experience.
That old fashioned maxim, "easy does it" is a good approach to consider when thinking about disclosure. Even if a patient has been living with HIV for a while, he or she will likely find situations continuously arising in which he or she may be forced to think about having to disclose. Wanting patients to tell family members and friends is very natural. However, the truth of the matter is that it can also create problems. Over the course of the HIV epidemic, there have been some significant improvements in the general public's awareness about and understanding of HIV issues. Unfortunately, stigma is still attached to the whole subject of HIV and to those who have it. In Kenya and other settings that criminalize male-male sex, stigma attached to HIV-positive MSM can be even stronger and may present dangers to patients who disclose.

**General disclosure tips for patients**

- You don't have to tell everyone. The choice is yours about whom to tell. Be selective.
- Be sure to consider the five "W's" when thinking about disclosure: who, what, when, where and why. Who do you need to tell? What do you want to tell them about your HIV infection, and what are you expecting from the person you are disclosing your HIV status to? When should you tell them? Where is the best place to have this conversation? Why are you telling them?
- Easy does it. In most situations, you can take your time to consider who to tell and how to tell them.
- Consider whether there is a real purpose for you to tell this person or if you are simply feeling anxious and want to "dump" your feelings.
- Telling people indiscriminately may affect your life in ways you haven't considered.
- Having feelings of uncertainty about disclosing is a very common reaction in this situation.
- You have a virus. That doesn't mean you've done anything wrong. You don't have anything to apologize for simply because you are HIV positive.
- Keep it simple. You don't have to tell the story of your life or disclose your status as an MSM if you don't want to do that.
- Avoid isolating yourself about your status. If you are still not able to tell close friends, family members or other loved ones about your HIV status, allow yourself to draw upon the support and experience available to you, through organized support groups, community LGBT groups, and clinics providing HIV care.
- There's no perfect roadmap for how to disclose. Trust your instinct, but use caution.
- Whatever the response you receive in a specific situation, and even if it doesn't go the way you'd hoped, you're going to survive it and your life will go on.
- Millions of others have dealt with this experience and have found their way through it. You will get through it too.
- Choosing whom to tell or not tell is your personal decision. It's your choice and your right.
Maintaining ART Access

Missed doses and the “half-time rule”

Missed doses are unfortunate, but they happen to all patients from time to time. Sometimes, patients can think that if they miss their scheduled dose, they have “ruined” their adherence for the entire day. It is important to dispel this myth, and to encourage patients to follow the half-time rule. This rule can be explained as follows:

1. If less than half the interval until the next dose has passed, take the medication.
2. If more than half the interval until the next dose has passed, wait until the next scheduled dose.

For example, if a patient takes one combination ART tablet every day at 6 am (i.e., every 24 hours) and misses this dose for some reason, he or she should still take this dose if able to do so before 6 pm (i.e., within 12 hours, or half the scheduled interval). If he or she is unable to take the missed dose until after 6 pm (i.e., over 12 hours have passed), he or she should wait for the next dose.

Similarly, if a patient takes one medicine twice daily (every 12 hours) and misses a dose, he or she should still take the missed dose if less than 6 hours have passed since the scheduled time. If over 6 hours have passed, he or she should wait until the next scheduled dose time.

Ideally, a patient would miss no doses at all, but it is unrealistic to expect this over the patient’s lifetime. It is better to take a dose a few hours late than to miss it altogether. Similarly, although reducing alcohol or drug use is an important goal, patients need to take their medication regularly even if they have a drink or use drugs on the same day.

Remember, a missed dose is a learning opportunity. Patients should ask themselves what happened to make them miss ART and what might be needed to ensure that it doesn’t happen again. Providers should review missed doses and identify WHAT next step could help avoid similar situations, as well as HOW to accomplish that next step.

Planned travel and emergency refills

At each refill visit, providers should enquire about whether patients have any travel plans. The usual refill interval in Kenya is one month, although longer refill intervals (up to 2 or 3 months) are possible at patient request. We suggest that this be discussed at each visit, and the refill date be adjusted if need be, as follows:

1. If the patient will be away for longer than 1 month, postpone the refill date and issue enough extra supply of drugs to last until the new date
2. Up to a maximum of 3-month supply can be issued. If a longer period is needed, consider transfer of care.

All patients should be counselled about what to do if they run out of drugs while away from the clinic. It is critical to maintain a supply of ART at all times, as treatment interruptions are a very strong risk factor for drug resistance. We suggest the following recommendations for patients who have travelled or are otherwise unable to come to their “home” clinic for a refill as scheduled:
1. Before the drugs are completely finished, visit the nearest health facility where ART is provided.
2. Explain to the provider in charge the reason you need an emergency supply of drugs, and for how many days you need this (e.g., for the return trip home, plus 2-3 days extra to ensure you can get to the clinic).
3. Show the doctor the remaining drugs you have, plus your clinic appointment card so that he or she can tell which drugs to give you.
4. Most health facilities will issue a maximum emergency supply of 2 weeks.
5. Call the clinic immediately if you need a longer supply or if the outside clinic provider asks for more information. You should carry a clinic card with a contact number to call in case of emergency.
6. Come for a refill immediately after you return home.

For all patients who come late for their scheduled refill, ask whether an emergency refill was obtained and record the details in the patient chart.

**ART access in prison or jail**

Some MSM patients participate in sex work or other activities that could potentially lead to an arrest. Because ART is very important and it is hard to predict who will have this problem, all patients should be counselled on what to do if they are arrested or sentenced to jail:

1. Always carry your appointment card with you
2. If you get arrested for more than a night, request the prison warden to allow you to call your doctor.
3. Call the clinic number and explain your situation. The clinic staff will advise you what to do, which will usually be one of three options:
   a. Ask a relative or friend to bring you the medicine
   b. The clinic will bring you emergency doses
   c. The prison can give you emergency doses

If the prison stay will be longer than a month, transfer of care to the prison facility is recommended.

**Transfer of care**

Adult patients, particularly men, move frequently in Kenya, and MSM are no exception. If a patient needs to be away from his or her “home” clinic for more than 3 months, consider a transfer of care. To do this, the following steps are needed:

1. Ask the volunteer if they have a preferred ART site near their new residence.
2. Complete an ART transfer form and ask the volunteer to present it to the new ART site as soon as they arrive.
3. Provide the patient with a copy of his or her blue clinic card (MOH257) to complete the transfer at the new clinic site and ensure that important medical history is not lost.
Advocating for MSM Patients

In 2011, the WHO published guidelines on the “Prevention and Treatment of HIV and Other Sexually Transmitted Infections among Men Who Have Sex with Men and Transgender People: Recommendations for a Public Health Approach” (3). The overarching principle of these guidelines is stated as “respect for and protection of human rights.” This document makes the following recommendations:

1. Legislators and other government authorities should establish antidiscrimination and protective laws, derived from international human rights standards, in order to eliminate discrimination and violence faced by MSM and transgender people, and reduce their vulnerability to infection with HIV, and the impacts of HIV and AIDS.

2. Health services should be made inclusive of MSM and transgender people, based on the principles of medical ethics and the right to health.

As you work to provide HIV care to MSM patients, you will have opportunities both to adhere to principles of medical ethics and to protect the right to health. Relationships of trust and respect between MSM and their care providers form the basis for lasting engagement in care. It is our hope that the Shikamana project will equip providers with the knowledge, motivation, and skills to provide the highest quality of care to their MSM patients and to be advocates for a rights-based approach to health care provision, regardless of the setting.
Working with Peer Navigators

In our experience, Kenyan MSM can be socially isolated or lack support. To fill this gap, the Shikamana project will recruit MSM peers with ART experience and train these peers to help fellow MSM patients with issues of access and motivation. These peer navigators, called “Washikaji,” will be identified among MSM working in our outreach network, with assistance from local LGBT groups. Each peer will be selected on the basis of his maturity, professionalism, and motivation. Peers will be trained on the basics of HIV and ART, on what we have learned about barriers and facilitators to adherence among MSM, and on how to provide support to patients in a professional and confidential manner.

During the Shikamana project, each Mshikaji will be assigned to 2-6 patients. The Mshikaji will meet with each patient as he or she initiates ART, and then will provide support in person or by telephone weekly during the first month of ART, and then monthly thereafter. At each contact, peers will provide social support and advocacy, as well as basic information on HIV transmission and safe sex. Washikaji will be specifically instructed not to give medical advice and instead defer to clinic staff. The main focus of peer support for ART adherence will be psychosocial. Washikaji will also give tips on adherence strategies to help incorporate medication taking into daily routines. Washikaji will receive ongoing support through monthly meetings with the clinical staff, at which patient progress and overall challenges will be discussed.

Peer support interventions to improve ART adherence are considered by the US Centers for Diseases Control and Prevention to have good evidence (49). In our qualitative research, MSM patients chose an experienced peer as the intervention component most likely to be of help to them. We believe this intervention has a very good chance of helping MSM patients adhere. However, in order for the Washikaji to be helpful to patients, they need to be:

- Well trained and knowledgeable about HIV and ART
- Motivated to take their own medicine and use their experience to help others
- Extremely careful to maintain patient confidentiality at all costs
- Professional and responsible in the role that they have
- Aware of their limits – they are not clinicians nor are they therapists
- Supervised and supported by clinical staff

Reflection: Working with Washikaji

Now that you have learned about and discussed the roles, responsibilities, and qualifications of a peer navigator (or Mshikaji) and the importance of this role, consider what you think would be optimal for peer navigators working with MSM in the community, in terms of:

- Personal characteristics
- Qualifications and skills
- Other attributes

Do you think Washikaji can serve as a role model to MSM patients? How do you think Washikaji should be supported, in order to perform this work successfully?
References


5. Goodreau SM, Golden MR. Biological and demographic causes of high HIV and sexually transmitted disease prevalence in men who have sex with men. Sex Transm Infect. 2007;83:458-462. PMID: 17855487; PMCID: PMC2598698.


18. Lane T, Mogale T, Struthers H, McIntyre J, Kegeles SM. "They see you as a different thing": the experiences of men who have sex with men with healthcare workers in South African township communities. Sex Transm Infect. 2008;84:430-433. PMID: 19028941; PMCID: PMC2780345.


APPENDICES

Appendix A – Performance Objectives

Performance objectives were developed for providers based on the intervention mapping approach of Bartholomew et al (50). This process involves first conducting a needs assessment, which we did through our interviews with HIV-positive MSM, focus groups with their providers, and input from community LGBT groups. Second, we identified expected outcomes that were desired, and analysed what would be needed to achieve each specific outcome. This process resulted in specific performance objectives for providers caring for HIV-positive MSM. The mapping process was then used to map performance objectives to the information, motivation, and skills or self-efficacy that providers would need to achieve these objectives, as well as perceived social norms and outcome expectations integral to the Shikamana intervention.

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<th>Performance Objectives for Providers</th>
<th>Information</th>
<th>Motivation</th>
<th>Skill/Self-Efficacy</th>
<th>Perceived Social Norms</th>
<th>Outcome Expectations</th>
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<tr>
<td>Teach MSM about HIV, what the virus does to the body, and how this impacts health</td>
<td>Understand what it means to be HIV infected</td>
<td>Endorse the importance of alleviating fear surrounding HIV and AIDS</td>
<td>Instil confidence in talking about HIV</td>
<td>Recognize that ignorance leads to alienation and social isolation</td>
<td>Providers can convey information about HIV and its impact on health in a way that MSM patients can understand</td>
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<td>Understand available management plans such as ART</td>
<td>Endorse acceptance of HIV status</td>
<td>Instil confidence in promoting secondary risk reduction</td>
<td>Recognize that knowledge is needed for understanding and acceptance</td>
<td>Providers can convey information on HIV transmission risk, including risk from male-male sex, and motivate risk reduction</td>
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<td>Understand disease progression and prognosis</td>
<td>Promote a positive outlook (“living positively”)</td>
<td>Instil confidence in providing MSM with tailored information on reducing transmission risk</td>
<td>Endorse the need for MSM to have tailored information in order to understand risk</td>
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<td>Understand how HIV is transmitted from an infected person, including through male-male sex</td>
<td>Endorse the need to stop transmission by reducing risky behaviour</td>
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<td>Teach MSM about ART, how it works, and its benefits</td>
<td>Know current recommendations for ART, and their rationale</td>
<td>Endorse the importance of ART and its benefits</td>
<td>Express confidence in teaching patients about ART</td>
<td>Recognize that patients who take ART can have healthy, productive lives and decrease their risk of transmitting HIV to their sex partners</td>
<td>• Providers can teach patients about ART and promote optimal adherence</td>
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<td>Understand how ART adherence works (maintaining drug levels)</td>
<td>Endorse the need to maintain an adequate drug level</td>
<td>Express confidence in teaching patients about maintaining adequate drug levels</td>
<td>Recognize that MSM may have specific additional challenges for accessing care and adhering to ART</td>
<td>• Providers can teach patients about the importance of maintaining adequate drug levels</td>
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<td>Describe the benefits of ART to infected individuals and to their sex partners</td>
<td>Promote treatment as prevention</td>
<td>Express confidence in assessing patients’ adherence needs</td>
<td>• Providers will endorse the personal and public health benefits of ART for MSM</td>
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<td>Know recommendations regarding Septrin prophylaxis and describe how its use and benefits differ from those of ART</td>
<td>Promote Septrin prophylaxis as an adjunct to ART</td>
<td>Instil confidence in promoting ART as a critical intervention</td>
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<td>Understand that certain barriers and facilitators may be more important for MSM patients</td>
<td>Endorse the importance of understanding each patient’s barriers and facilitators</td>
<td>Instil confidence in assessing MSM’s specific adherence counselling needs</td>
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<td>• Providers can teach patients about ART and promote optimal adherence</td>
<td>• Providers can teach patients about the importance of maintaining adequate drug levels</td>
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<td>• Providers can teach patients about ART and promote optimal adherence</td>
<td>• Providers can use Next Step counselling to motivate MSM patients to adhere</td>
<td>• Providers can screen for and address (through counselling or referrals) problems such as mental illness and substance abuse</td>
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<td>Interact effectively with MSM patients at visits</td>
<td>Understand the importance of a strong healthy link between the peers and patients to ensure program success</td>
<td>Endorse honesty and trust as key to working with MSM patients</td>
<td>Express confidence in ability to listen and communicate with patients about their needs</td>
<td>Recognize that individual MSM may have different priorities and needs</td>
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<td>• Providers can communicate effectively with MSM patients in a patient-centred manner</td>
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<td>• Providers can use Next Step counselling to motivate MSM patients to adhere</td>
<td>Express confidence in being able to help link patients to services outside the scope of Shikamana</td>
<td>Recognize that the program cannot cater for all needs, but will do its best to link men to needed support when available</td>
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<td>Promote safe disclosure to the MSM peer and to family and friends who can provide support</td>
<td>Understand that support is necessary when learning to take ART and maintaining adherence over time</td>
<td>Describe having social support as positive</td>
<td>Express confidence in ability to counsel patients about safely disclosing HIV status and enlisting support for ART adherence from trained peer</td>
<td>Recognize that you are a role model to patients and an important supporter</td>
<td>• Providers can engage patients in a discussion about safe disclosure to the Mshikaji and to others, if desired</td>
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<td>Teach MSM patients and peers about Kenyan HIV care points and clinic policies pertinent to travel, moves, or prison/jail time</td>
<td>Describe the availability of ART in Kenya and how patients can access care when traveling or moving, or in prison/jail</td>
<td>Promote maintenance of adequate drug levels in all situations</td>
<td>Express confidence in increasing patient knowledge about obtaining care when traveling/moving or in prison/jail</td>
<td>Recognize that refills are available in government facilities because uninterrupted medicine-taking is a priority</td>
<td>• Providers can advise MSM patients on how to access care in the event of travel, moving, or incarceration</td>
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<td>Discuss the HIV prevention and care needs of MSM with community leaders</td>
<td>Know basic information about HIV risk and clinical outcomes among MSM in Kenya</td>
<td>Know about basic human rights, including access to health care</td>
<td>Endorse the importance of community engagement for work with MSM</td>
<td>Express confidence in discussing why access to good HIV prevention and care services is vital for Kenyan MSM</td>
<td>Recognize the authoritative role a health care provider plays in fostering community support and acceptance, and addressing concerns</td>
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<td>Support the peer in providing advice on regular medicine-taking and keeping appointments</td>
<td>Explain the importance of medicine timing</td>
<td>Reinforce the importance of making ART a priority</td>
<td>Express confidence in discussing regular medicine taking and use of an alarm device with peers and patients</td>
<td>Recognize that peers are a valuable extension of the healthcare system and need ongoing support</td>
<td>• Providers can collaborate with peers to promote regular medicine-taking behaviour and engagement in care</td>
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<td>Explain what to do if a dose is missed</td>
<td>Ensure that the peer is knowledgeable about ART and problem management</td>
<td>Express confidence in helping peers and patients understand what to do if a dose is missed or a refill is needed</td>
<td>Recognize that education and counselling by peers needs reinforcement and review by providers</td>
<td>• Providers can effectively counsel patients on how to take a Next Step towards improving adherence</td>
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<td>Explain why on-time refills are critical for good adherence</td>
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<td>Express confidence in helping patients help patients manage appointments and refills, with text messaging to aid if helpful</td>
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<td>• Providers can improve patient planning skills for on-time appointments and refills</td>
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<td>Explain how missed doses can lead to drug resistance</td>
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<td>Express confidence in discussing planning ahead and carrying medicine when traveling</td>
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<td>• Providers can teach patients to cope with unexpected events and missed doses</td>
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<td>Explain common and uncommon side effects and need to report</td>
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<td>Express confidence in helping patients report persistent or bothersome side effects</td>
<td></td>
<td>• Providers can help patients who are having side effects</td>
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<td></td>
<td>List three strategies to cope with minor side effects like nausea or drowsiness</td>
<td></td>
<td>Express confidence in discussing the importance of taking medicine despite substance use and in reducing substance use when possible</td>
<td></td>
<td>• Providers can initiate discussions on reducing the impact of alcohol and other substance use on ART adherence</td>
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<td></td>
<td>Explain why adherence is still important even when using alcohol and other substances</td>
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<tr>
<td>Interact effectively with MSM peers as part of the care team</td>
<td>Understand the value of a peer, and the importance of a collaboration between the peer and providers to ensure program success</td>
<td>Endorse trust in MSM peers’ abilities</td>
<td>Express confidence in communicating with peers about patient needs and problems identified</td>
<td>Recognize that peers want to help patients succeed</td>
<td>• Providers can interact effectively with and support trained peer navigators</td>
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Appendix B – Counsellor Skills

Basic Skills

Active listening. Active Listening (or Attending) refers to the counsellor’s ability to communicate listening through frequent and varied eye contact, facial expressions, and other forms of non-verbal communication. This includes sitting in a relaxed posture, leaning forward occasionally, and using natural hand and arm movements that are responsive and encouraging. Counsellors need also to be aware of non-verbal communications in the patient’s demeanour, since non-verbal cues are important forms of communication.

Open, collaborative approach. The entire spirit of the counselling session is one of openness (inviting patients to share their experiences and supporting their efforts and honesty) and collaboration (recognizing that the patient is the resident expert on medicine-taking and what it is like for him or her, as well as what works and what does not work for him or her in that regard). Patients are not pushed towards immediately complying 100% with an ideal medicine-taking consistency but are supported in the small steps in that direction. The many strategies included in the overall counselling guide seek to establish common ground and move forward as a team.

Open-ended questions. Open-ended questions are those questions which are not easily answered with a one-word response (“yes” or “no”) and do not assert the counsellor’s values or objectives. Counsellors should use them when they are seeking information about the context in which medicine-taking occurs or when exploring attitude, culture, economic and/or social factors which may play a role in medicine-taking. Open-ended questions invite further disclosure and help to build rapport and trust. What the counsellor asks and how it is asked can also demonstrate positive regard for the patient and a genuine interest in knowing how the patient feels.

Paraphrasing. Paraphrasing refers to rewording the content of what the patient has said in similar but fewer words. This can help the counsellor clarify the basic message expressed in the verbal content of the patient’s communication. Paraphrasing neither expands nor builds on the topic, but is a way to help the patient feel heard and build rapport.

Pausing. Pausing provides opportunities for patients and counsellors to digest material and to make room for feelings or thoughts to emerge. Giving the patient time to “experience the moment” by allowing silence to happen is a sign of respect for the power of the patient’s thoughts and feelings. Sometimes counsellor’s discomfort with silence can interrupt the patient’s process. Remember: Silence is also a form of communication.

Reflective listening. Reflection refers to restating the patient’s comments and feelings, perhaps with some of the patient’s words and some other words. Reflecting statements are validating statements and, by allowing the patient to hear his or her words in another person’s voice, may help to clarify patient feelings.

Summarizing. Summarizing refers to the technique of highlighting for the patient the most important aspects of the session that have been discussed.
More Advanced Skills

Elicit-Provide-Elicit. Elicit-Provide-Elicit is a strategy from Motivational Interviewing that involves asking the client to explore some aspect of a feeling, experience, or behaviour (eliciting information from the client); providing the client with relevant information about what he or she has shared (the counsellor shares knowledge or expertise he or she has on the issue in a supportive manner); and then again asking the client to share what he or she makes of the information (given what the counsellor has shared, what does the client make of that information, how does it fit or not fit with the client’s sense of things). This is a marked difference from simply giving the client information and then moving on to some other topic area. The elicit-provide-elicit approach offers greater opportunity to build consensus and keep the session client-centred.

Genuine transparency. The notion of genuine transparency is that if the counsellor can remain open and transparent about his or her experiences with the client, while maintaining respect and client-centeredness, the counsellor can model how openness can be functional, respectful, and productive. Counsellors can share confusion over something the client has said, note an inconsistency in report, or share concern in a manner that is honest and sincere and collaborative. Because a key message for counselling about medicine-taking is to be open and build comfort in sharing experiences or feelings, counsellors may want to model how to share negative experiences or feelings in a manner that is not negative. To be transparent, genuine, and sincere, counsellors “own” the confusion or concern and seek collaborative help from clients with statements such as “I am confused about something, can you help me to work this through?” and “I am concerned about something you said, and feel I should discuss this with you. I am hearing you say this……but am also hearing that you feel this way…. How does that feel to you?” The goal is not to create discomfort or to catch patients in a “lie.” On the contrary, the goal is to bring counsellor experiences to the forefront as things that could be valuable to explore.

Process comments. Process comments are counselling techniques that are useful when sessions seem “stuck” in some way. A comment is made about what is going on in the session, rather than the content of the discussion. A process comment may help move the session along if the counsellor has a sense that the patient is not fully present or distracted for a reason unknown to the counsellor. The result may be that the patient will reveal more about the original issue and what makes it difficult to move on.

Reframing. Reframing refers to offering an alternative way of looking at something that the patient has just said, usually one that is more constructive and positive.

Third-personing. When counsellors are able to reflect upon the patient’s experience (as a way to try to understand more fully what the patient is feeling) by referring to someone outside the session, they are using third-personing techniques. Third person statements often include the words “s/he,” “they,” or “other patients,” as in “Many other patients have shared similar concerns with me.”

Ventilation and Validation. Ventilation refers to ‘getting something off your chest’. When someone has complaints about something or someone, it can be helpful at times and when used constructively to ‘vent’ or verbalize feelings and frustration. Validation is when the client’s frustration is recognized by the counsellor as valid, understandable, and well within reason. By allowing the frustration to be legitimate
and a reasonable understandable response, the pressure and discomfort in the experience of the frustration can be reduced. In this regard it is most important for the counsellor to validate feelings and not the content or specifics of the events attributed to causing the frustration.

**Motivational Interviewing (MI)**
(This material was adapted from the Options project (51, 52))

**Motivational Interviewing as a Tool for Change**
Motivational Interviewing (MI) consists of a set of proven interpersonal communication techniques designed to produce rapid changes in health-related behaviours. It is a client-centred approach to increasing individuals’ **motivation** to change, and one of its main underlying principles is that **people cannot be forced to change their behaviour if they are not ready to change their behaviour**.

Giving advice and telling the client what to do is the typical strategy that is used in healthcare settings to encourage clients to engage in healthier behaviour, but this strategy has been found to be effective with in only 5% to 20% of clients. It is effective only with clients who are already ready and motivated to change. Arguing with clients who are unsure about why they should change their behaviour typically results in resistance and arguments from clients about why they cannot change. Thus it is critical to work collaboratively with clients in a supportive and non-judgmental way to help them explore, understand and resolve their ambivalence to change by identifying and addressing barriers to change that are important to them. There are costs and benefits to changing and not changing, and to work effectively with a client to increase their motivation to change, it is important to understand what the costs and benefits are for that particular person.

Equally important, MI recognizes that each individual client is the best source of information about the particular barriers that they may face to consistently practicing healthy behaviour. MI uses the clients’ insight on these barriers as the basis for a collaborative discussion between the counsellor and the client in which individually-tailored strategies for behaviour change (or maintaining healthy behaviour) are developed.

**Collaboration between Counsellor and Client**
Motivational Interviewing techniques can be used to deliver information on the information, motivation, and behavioural skills needed for ART adherence in a way that maximizes client “buy-in,” minimizes resistance and has a proven likelihood of changing behaviour. Rather than taking on an authoritarian role and acting as an expert in prescribing change, the counsellor leaves the responsibility for change with the client. This does not mean that the counsellor is not directive. On the contrary, the counsellor has a clear goal in mind, which is to increase ARV adherence, and they use various MI strategies to achieve that goal. Specifically, the counsellor:

1. assesses the client’s behaviour in a non-judgmental manner,
2. identifies the client’s informational, motivational, behavioural skills, and other barriers to consistently practicing adherent behaviour,
3. learns from the client “what would have to happen” for them to overcome these barriers and take each dose correctly, and
negotiates a behaviour change goal or action plan with the client.

Because the client is viewed as the “expert” in their own individual and unique life situation, it is the client who defines the problem and identifies the solution, with the counsellor serving as the facilitator of this process. In the case where the client is unable to identify any solutions or strategies, the counsellor takes a more active role and offers a menu of intervention strategies from which the client can choose. The client is intimately involved in every step of the process, especially in the selection of the goals. The relationship between the client and the counsellor is thus a collaboration—one in which the client and counsellor work together to negotiate an individualized plan for positive change.

**Key Components of Motivational Interviewing**

- **Acknowledge personal choice.** It is the individual’s personal responsibility and choice whether or not to improve their adherence. A common assumption made by counsellors is that the client wants to change. Assessing how much the person wants to change is crucial to the success of the counsellor-client interaction. Expressing one’s views about change in a relatively neutral and non-judgmental way and emphasizing the client’s freedom to choose, can help one avoid isolating the client or making them defensive.

- **Respect the client as an expert.** The client is the expert on how they themselves can change. Each client is unique in what motivates them to change, and it is assumed that the client has important insight and ideas for how to solve their own problems.

- **Ask simple open-ended questions** (instead of close-ended, or yes-no questions) to encourage exploration and decision-making.

- **Use reflective listening.** Reflective listening involves the counsellor briefly summarizing what the client is saying in order to show that the counsellor is listening to the client and understands the meaning of what they are saying. It provides the counsellor with the opportunity to check their understanding of the client’s perspective, and it helps build rapport with the client. It is only by careful listening that the counsellor can learn what it will take for the client to improve his or her adherence.

- **Create and heighten, in the client’s mind, any differences between present adherence (where they are now) and broader goals (where they want to be).** Most clients who are missing medicine are not malicious and do not want to harm others. And most clients want to prolong their lives and do not want to compromise their health. Consequently, if clients can come to understand that their medicine-taking behaviour is at odds with these goals, it is likely that they will be more motivated to change.

- **Embrace ambivalence/uncertainty.** Many clients are unsure about change, and they have very good reasons for not changing their behaviour. It is important for the counsellor to understand
those reasons. Allowing the client to discuss the benefits they get from the behaviour that is causing them to miss doses can serve as a catalyst for positive behaviour change.

- **Avoid arguing, confronting, and pressuring the client into action.** This can lead to the client taking a defensive and rigid stance, and thus not being open to making any changes.

- **Support a client’s right to choose.** Approaches that support the client’s freedom are more effective in helping a client change than coercive measures are. Clients are more likely to adopt healthy behaviours if they “want to” than if they “should” or “have to.” Adopting a controlling and paternalistic approach does not support the client’s autonomy and personal choice. Clients are more likely to make healthy choices if the counsellor acknowledges and supports their right to choose than if the counsellor behaves as if they can make the client change.

- **Work at the client’s pace.** It is important to work at a pace that is sensitive to the client’s needs and their readiness to change. If the counsellor pushes the client ahead of where they are ready to be, the counsellor is likely to encounter resistance on the part of the client.

- **“Roll with resistance” to change.** Any statement made by the client can be rephrased or reframed to create movement toward change. Resistance (e.g., denial, arguing, objecting, refusing to engage in conversation) is influenced by the way in which the counsellor interacts with the client. It is a function of the interpersonal interaction between the client and the counsellor, and it can either be made worse or lessened depending on the counsellor’s response to it. Resistance is a signal that the counsellor and client are not in the same place. Further exploration or shifting focus may help “melt” the resistance.

- **Avoid being judgmental.** It is critical to provide non-judgmental feedback and information to maximize the client’s motivation to engage in safe sexual and drug use practices. The role of the counsellor is to understand the client’s feelings and perspectives without judging, criticizing, or blaming.

- **Adopt an attitude of acceptance and respect.** By showing respect for the client, the client’s self-esteem is supported, which frees them to change. Acceptance refers to “understanding” the client’s perspective. It does not mean approving of or endorsing their behaviour.

- **Support and increase the client’s self-efficacy and their ability to cope with obstacles and succeed at change.** Self-efficacy refers to a person’s confidence in their ability to make a specific change in behaviour. It is important to help the client believe that healthy outcomes are possible.

- **Negotiate action plans that are realistic and attainable.** It is critical that the client be successful in their efforts to reach their goals so that their self-efficacy and their motivation to change
increases. Therefore, it is important that realistic action plans be made. This may mean choosing smaller interim steps at which the client can succeed rather than ambitious goals at which they will fail.
Appendix C – Activities To Use in Step 4: Identify the Next Step (WHAT)

- RATE IT
- JUST ASK
- IMAGINE IF
- STAIRCASE
- DECISIONAL MATRIX
- MAINTAIN IT
RATE IT
You can use this approach when the patient tells you about a specific time or situation when medicine is missed or when he or she appears open to working more generally on increasing adherence. Appendix D contains a visual aid for the Rate It Scale.

6 GENERAL STEPS

1. CONTEXTUALIZE MEDICINE-TAKING. Give the patient permission to report negative aspects of medicine-taking by recognizing that it is not likely the priority in one's life or daily routine. Here are some examples:
   “Given everything going on in your life…”
   “Given how hectic you said your days can be....”
   “With all the demands you juggle each day....”
   “When you think about everything else you have to do....”
   “At this point in life, when you are not always in the same place every day....”

2. RATE IMPORTANCE OF TAKING ART (each day, a certain number of times a week, in a certain situation). For example:
   “If you think about the different things going on in your life, on a scale from 0 to 10, how important would you say it generally is to you to take ART in that situation (e.g., the day after you go out partying)? 0 means it is the least important thing in your life and 10 means it is the absolute most important thing in your daily routine.”

3. RATE CONFIDENCE IN TAKING ART (each day, a certain number of times a week, in a certain situation). For example:
   “OK. Same scale, different questions. Let’s focus on ‘confidence’ – how confident are you that you could actually take ART if you really wanted to in that situation (e.g., the day after partying)? How confident are you in your ability to take ART, on a scale from 0 to 10 where 0 is absolutely NOT confident at all and 10 is positively certain you can do it?”

4. FOCUS ON IMPORTANCE OR CONFIDENCE. SUGGEST which to focus on.... importance OR confidence.

   IMPORTANCE: If the patient rates importance as very low, below 6 or 7, consider suggesting that importance be the focus of continued discussion. For example:
   “You said that importance for you right now is a 5. How important something is often plays a big role in decisions about whether or not to do it. I think we could learn a lot from exploring that a little further and saving discussions about confidence for another time. Is that OK?”

   CONFIDENCE: If the patient rates importance as 8 or higher, and confidence is less than 10, consider suggesting that confidence be the focus of continued discussion. For example:
   “You said that taking ART feels important, and your confidence is 5. How confident someone is in actually doing something can be a strong influence on whether or not they do it, even if they really want to or intend to do it. I think we could learn a lot from exploring this idea further. Is that OK?”
5. ELICIT STRENGTHS. Use the rating for the selected focus (importance or confidence) to ask why the patient did not rate it LOWER on the scale. Do this for all ratings that are higher than zero. If the patient said ‘0’ skip this step and move to number 6. For example:

“You said rated importance as a 3, but not a 2 or a 1. What is it that makes it that high for you? Why not lower? What makes it that important?”

EXTREME SCORES
FOR SCORES OF 0
Because it does not make sense to ask why the score is not lower, skip asking why the score was not lower and go directly to asking what it would take to move up a point.

FOR SCORES OF 10
If both importance and confidence are rated at 10, you can still explore why each is not lower, but will not be able to explore how to increase them. Consider moving forward with the exploration of facilitators, providing appropriate reinforcement for accomplishments but also conveying that the same amount of exploration goes on in the counselling session for “perfect” scores as would go on for lower scores. For example:

“It’s wonderful that you feel so strongly and positively about taking ART. So many other patients tell us it’s very hard to take ART every single day. Can you tell me what it is you’re doing so that I might be able to share your experiences and strategies with others?”

6. IDENTIFY WHAT THE NEXT STEP IS. Use the rating for the selected focus (importance or confidence) to ask what it would take to move the rating up one to two points.

Focus on the small parts of barriers. For example, if the patient reports “not liking” to take any medicine, see if he or she can discuss the smaller pieces of that – what about taking medicine does he or she not care for? Is it the taste? Having to remember it? Having to carry it around? The size of the tablets? Swallowing ART? Small pieces can be addressed with small steps, but very large issues are very difficult to address.

Think about what you learned about the patient’s
- Information or knowledge
- Beliefs
- Attitudes
- Motivation
- Social support
- Set of skills
These might be avenues and opportunities for managing medicine-taking. For example:

“What do you think it would take to move your rating from a 3 to say a 4 or a 5? What would be different? What would need to happen?”

MOVE INTO STEP 5 (MOVING FROM WHAT WOULD NEED TO HAPPEN TO HOW THAT COULD HAPPEN).
For example:
“You said that learning more about ART and what side effects might come from the medicine would help to make taking ART the day after you are out late partying a little more important. Let’s think about HOW (Step 6) that could be accomplished.”

“You mentioned that you struggle with confidence in your ability to take ART consistently, and said that it would help if you figured out a way to keep your medicine on hand, no matter where you are. Let’s think about things you could try to make sure ART is always handy (Step 6).”
JUST ASK

This exercise can be used in any tailoring situation. There are three steps:

1. ASK. Several questions can be used to help patients to identify their next step in regard to medicine-taking. Generally, the questions should be very transparent (no “trick questions”) and seek information about the patient’s:
   - experiences with medicine-taking so far
   - motivation towards medicine-taking
   - general interest in medicine-taking
   - understanding and conceptualization of the role of medicine-taking in his or her life.

   EXAMPLES:
   “What would need to happen for you to....”
   “What would need to have been different for you to have....”
   “What are some things that would make you feel more....”
   “What would need to happen or be different for medicine-taking to feel just a little easier for you?”

2. LISTEN. Only ask direct questions if you are ready, able, and willing to listen carefully, openly, and with neutrality to the answer. Use Reflective Listening to move the patient from a simple response to further exploration.

   There are several barriers to being a skilled listener. When you have asked someone to share their story or struggles or the why and how of change, let silence take the place of:
   - Disagreeing
   - Instructing
   - Questioning
   - Warning
   - Reasoning
   - Sympathizing
   - Arguing
   - Suggesting
   - Analysing
   - Persuading
   - Approving
   - Shaming
   - Reassuring

   Being a skilled listener involves quieting the “inner chatter.” If you are busy thinking about ways to persuade someone, you won’t be able to pay attention or be present. The patient is the expert in his or her life and he or she is giving you a window of opportunity to learn from him or her. Listen for emerging themes, but try to be as open as possible to learning new things.

   Make your goal to be engaged in the process and NOT to make someone change.

   REFLECTIVE listening involves offering some reflections of what you hear the patient saying. It is NOT repeating what you just heard OR asking a question; it is a statement of what you are hearing and experiencing as the main theme. Reflect on:
   - Feelings behind what is being said
• Struggles that make a theme (i.e., procrastination or fear of stigma)
• Beliefs, perceived consequences, and worries
• Specific words the patient has used that reflect feelings, emotions, or beliefs.

For example:
Patient: “When I try to remember, it seems I forget even more. I know it's important but my life is pretty crazy right now.”
Counsellor: “It feels chaotic...”
Patient: “Yes. And when I think of everything else I have to do, I kind of get annoyed by taking the ART...like it is one more thing other people are asking me to do.”
Counsellor: “It feels annoying .... and like it is something you have to do for others, not yourself.”

3. IDENTIFY WHAT THE NEXT STEP IS. When the patient shares a viable next step in their reflections and explorations, move forward with that next step.

DO NOT move forward until a viable next step is identified. Patients may identify a number of “things” that could make medicine-taking easier or ensure success in a certain situation — but they may not be “next steps.” Things that could help that are unattainable, impossible (or highly unlikely), a great distance from current Behaviour or resources, or not likely to lead to a successful experience are NOT next steps. Things that are realistic, accomplishable, proximal to current behaviour or resources, and likely to lead to a successful experience are good next steps.

SILENCE is essential in promoting self-exploration and the patient's own identification of what a good next step might be.
• If several minutes go by and the exploration still does not reveal viable next steps, ask the patient if you can share some ideas that have been helpful for others, if you do indeed have these ideas.
• In sessions where you also are struggling to identify a next step, consider making a process comment about this.

For example:
“This is a difficult situation. I too am struggling to see a way clear to what might be able to help most effectively. I think the best next step in this situation is to make an agreement to spend the next few weeks, until we meet again, really looking out for new clues and ideas about what could help. I too will keep thinking about it. Would you be willing to do this?” (This approach will close the session – completing Steps 4 and 5).

Another example (continued from above):
Patient: “Really annoying. I can't think of the last time I did something just for me.”
Counsellor: “If I am hearing you correctly, it feels like life can be chaotic and there seems to be so much to juggle each day and there doesn't seem to be a time when you get to do something for you. Yes?”
Patient: “That's pretty much how it is. ”
Counsellor: “Slowing things down would help, but you shared that you don't see a way to do that. Let's think of how that juggling could feel a little different. I wonder....maybe
if you truly felt that taking ART was in fact something you were doing for yourself or the things you believe in, if it would feel any different. What do you think about that?”

Patient: “That might help.”

Counsellor: “I also wonder if there is a way we could work out a deal where you get to do special things for yourself when you meet some goal. Say you try for a week to take ART every day and if you meet that goal you do something just for you. We would need to make a list of what those special things might be, but I do know that other people have used this kind of deal with themselves as a way to recognize their accomplishments. What do you think of that?”

MOVE INTO STEP 5 (MOVING FROM WHAT WOULD NEED TO HAPPEN TO HOW THAT COULD HAPPEN)
**IMAGINE IF**

*This exercise can be used in any tailoring situation.* There are three steps:

1. **SET THE SCENE**
   Set the scene for the patient by clearly explaining a “desired” situation, experience, or event.
   Start with....
   - Imagine yourself.....
   - I am going to describe an imagined situation to you.....

   Add in a description of the desired behaviour
   - You just took the last dose of the week. Every day, you managed to take ART.
   - You are out with friends and excuse yourself to take ART in privacy.
   - You take ART and it feels easy....it feels good...like you just accomplished something important.

2. **EXPLORE THE SCENE**
   Explore several aspects of the scene
   - What is going on around you?
   - How do you feel?
   - How did you manage to take ART?
   - If we could rewind the film, what happened to get you here?

3. **IDENTIFY WHAT THE NEXT STEP IS**
   Highlight
   - What information was important?
   - What seemed to motivate the patient?
   - What skills were implemented?
   - What feelings were important?
   - What preparatory steps did the patient need to get there?

   Identify
   - The small steps that went into creating the scene where the behaviour was accomplished.
   - Ask the patient if there is some part of what was explored that he or she may be willing to consider as a good next step.

   For example:
   "To get to that place where you felt really good about having taken ART, you mentioned that you needed to stop and reflect on how important your actions were...and how you always feel good about setting a goal and accomplishing it. I’m wondering if maybe a good next step for you in taking ART would be to figure out a way to help you to stop and reflect on how this is meaningful to you. You should stop and feel good about that. Let’s think about different things that could help with that. Would that be a good approach for now?"

**MOVE INTO STEP 5 (MOVING FROM WHAT WOULD NEED TO HAPPEN TO HOW THAT COULD HAPPEN)**
**STAIRCASE**

*This exercise can be used in any tailoring situation.*

Behaviour change is in many ways a process where you may go up a step towards some goal or towards consistently adopting a behaviour, back a step, and up and down for some time before you reach the landing where the behaviour has been adopted (for good or for a long time).

When considering a difficult behaviour, or one that is not very exciting or is not intrinsically motivating, you may feel like you are standing at the bottom of 10 flights of stairs looking up at where you want to be. If you can break the journey up into one step at a time, the focus is then on the next step, and not on whether you have reached the top step. Focusing on small steps forward can be much easier and much more rewarding for many.

Many people need help in figuring out what the smaller steps are. They may see the last step (in this case taking ART each day) but the pathway to make it there might seem like the side of a very tall building and not like a series of steps. Counsellors can help patients to see medicine-taking as a process and a journey, where there are steps toward making it to consistent medicine-taking, and each step is important to consider. Moreover, making it to the next step, while not at the top, is still very important to celebrate and learn from.

Using the STAIRCASE metaphor can help patients to see that all the steps along the way are important, and counsellors and patients can work together to identify the next step for a patient and work out strategies to get there.

**3 STEPS**

1. PROVIDE THE METAPHOR
   
   You can use any number of “journey” metaphors: steps, a map, a path, traveling somewhere specific, or even a point on a line. We use the staircase metaphor here because it reflects that (1) there are steps available, (2) climbing long sets of stairs is generally viewed as difficult, and (3) difficult work should be celebrated when accomplished. Other metaphors that can offer the same kinds of features or that are more meaningful to a given patient can be used as well.

   For example:

   "I appreciate all you just shared about when it’s easy and when it’s hard to take ART. It sounds like things just get in the way sometimes. I wonder if we can look at taking ART each day as the top of a staircase. We are looking up at the top wondering how to get there. Now, based on what you just told me, you are not starting on the bottom step, let’s say you are half way up. Let’s just look at the very next step. What would be the next step to take to get you not to the top of the stairs, just one step closer?"

2. EXPLORE

   Explore....

   - How did the patient get to the step he or she is currently on? What worked in the past?
   - Where is the next step? Is it too big a step?
   - What characterizes the next step in terms of medicine-taking-related thoughts, feelings, or behaviours?
   - What needs to happen to get to the next step?
3. IDENTIFY WHAT THE NEXT STEP IS
From the discussions and explorations that have occurred, share with the patient what you heard him or her say the next closest step was — and what characterized it.

• What was characterized as the next step (e.g., taking ART, thinking about taking ART, feeling good about taking ART, etc.)?

Summarize any comments or thoughts about how to get to that next step. For example:
“So the next step for you is pretty clearly just getting comfortable with the idea of taking ART. You have concerns about what is in ART and are curious about why you have to take it if you are using condoms anyway. Those are very real concerns. To get to the very top of the stairway seems too far to travel, but let's just focus on the first step, which sounds like would be to explore a little more about ART. Get information. Gain knowledge from reliable knowledgeable people and places. Would you be open to looking at some specific things you could do to get to that next step....to feel more comfortable about taking ART?”

MOVE INTO STEP 5 (FROM WHAT WOULD NEED TO HAPPEN TO HOW THAT COULD HAPPEN)
DECISIONAL MATRIX

You can use this approach when the patient tells you about a specific time or situation when medicine is missed or when he or she appears open to working more generally on increasing rates of medicine-taking. Appendix D contains a blank Decisional Matrix that can be used for this exercise.

A motivational interviewing strategy that can be very helpful in gaining an understanding of the push and pull of behaviour change is to use a Decisional Matrix (Matrix). The Matrix has patients list the pros and cons of adopting a new (health-promoting or desired) behaviour and the pros and cons of not adopting the new behaviour (keeping the old behaviour). Although detailed here in terms of adopting a new behaviour, the same approach can be applied to maintaining behaviour over time or in different situations.

The various cells of the Matrix can be used as a way to identify what a good next step would be — what thoughts, feelings, facilitators, or barriers would help the patient to take the medicine or feel good about taking them.

Pay special attention to what the benefits of not changing are.....these can often tell you a lot about the underlying forces that keep the status quo going.

3 STEPS

1. INTRODUCE THE BEHAVIOUR THAT WILL BE DISCUSSED

   Based on what you learned in exploring barriers and facilitators, offer one or several possible behaviours to consider evaluating. Think about where the person is on the continuum of medicine-taking behaviour and what behaviour he or she will likely be able to manage. If someone is probably not taking any medicine, evaluate whether he or she is taking at least some doses. If the patient is taking all of the medicine, think about framing this as relapse prevention or exploration of how it is that he or she maintains consistent medicine-taking over time and across different situations. Or, work with a behaviour that is anywhere in between.

   After mentioning the behaviour, or negotiating an appropriate one when there are several to consider, introduce the general idea behind a decisional matrix: there are always two sides in deciding to do or not to do a behaviour and all sides are very important. For example:

   “I appreciate all you just shared about when it is easy and hard to take ART. I would like to explore what your thoughts and feelings are about, say, taking the medicine at least a few days a week. As you know, there are always reasons for doing something and for not doing it. Only by understanding each side can you really understand what medicine-taking is like. Can we explore that?”

   “I can hear that you have mixed feelings at times about taking the medicine. I would like to learn more about that. Sometimes it can be helpful to list out the reasons or pros and cons of adopting a behaviour and the pros and cons of not doing it. We can think about medicine-taking in general, but I wonder if exploring these things with something concrete, like taking ART this Saturday or taking at least four doses on time next week would be more useful to you. What do you think would be a medicine-taking behaviour that would be most realistic to consider? “
2. **COMPLETE THE MATRIX**

Use the Matrix to work with the patient to explore and fill out each cell. Start with the pros of (positives of or reasons to) maintain one’s current behaviour and move through the other cells of the Matrix.

<table>
<thead>
<tr>
<th>New Behaviour (what medicine-taking related behaviour the patient is considering adopting)</th>
<th>OLD BEHAVIOUR</th>
<th>NEW BEHAVIOUR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pros (positives)</strong></td>
<td>What are the benefits or positive things about NOT changing or doing the behaviour?</td>
<td>What are the benefits or positive things about changing or adopting the behaviour?</td>
</tr>
<tr>
<td><strong>Cons (negatives)</strong></td>
<td>What are the negative things about NOT changing or doing the behaviour?</td>
<td>What are the negative things about changing or adopting the behaviour?</td>
</tr>
</tbody>
</table>

3. **REVIEW THE MATRIX**

Go over each of the completed cells. Point out that usually, people emphasize reasons to adopt the behaviour and cons for not adopting it but in reality there are also good reasons NOT to change and negative things about changing.

Ask patient what they see in the matrix. Did the exploration reveal anything new to them? Look for cells that have a lot of reasons and compare to those that have few. Does this mean something to the patient?

4. **IDENTIFY WHAT THE NEXT STEP IS**

Ask patient to look over everything that was written down and see which of those things listed could be changed in some way to move towards the medicine-taking behaviour.

Behaviour is supported by decreasing the positives of non-adoption and the negatives of adoption; also by increasing the positives of adoption and negatives of non-adoption.
Ask the patient what would need to change in the Matrix for him or her to feel better able to adopt the behaviour listed. It does not have to be everything that would be needed to adopt the behaviour, just some small steps towards adopting the behaviour.

This small step will become the next step that can then be explored in terms of how to actually get there (Step 5). For example:

“So, making it more positive to take ART might be particularly helpful, and so would making it a lot less negative to take ART. Either is important but trying to tackle it all at the same time might be overwhelming. How about we focus on making it less negative? I have some ideas for that, but I would like to know from you what you think would be helpful in making it a little less negative to take ART (on Saturday, a few times this week, so on).”

SAMPLE COMPLETED MATRIX
Because what drives a behaviour for a given individual at a given time is quite unique to him or her and his or her life situation, don't fill in the matrix for the patient. Let the patient decide what belongs where.

<table>
<thead>
<tr>
<th>BEHAVIOUR: Taking ART each day of the weekend</th>
<th>OLD BEHAVIOUR</th>
<th>NEW BEHAVIOUR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NOT taking ART each day of the weekend</td>
<td>Taking ART each day of the weekend</td>
</tr>
<tr>
<td>Pros (positives)</td>
<td>Easier</td>
<td>I said I would do it—honour my commitments</td>
</tr>
<tr>
<td></td>
<td>can get ready and go out more quickly</td>
<td>do something good for my community</td>
</tr>
<tr>
<td></td>
<td>No worries about someone seeing it</td>
<td>do something to fight HIV</td>
</tr>
<tr>
<td>Cons (negatives)</td>
<td>Feel bad about not taking it</td>
<td>Worried about what is in it—could make me sick</td>
</tr>
<tr>
<td></td>
<td>guilty feeling over not doing</td>
<td>Someone might find it and think I am HIV positive</td>
</tr>
<tr>
<td></td>
<td>what I said I would do</td>
<td>Can’t be free to stay out or do what I want</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Have to plan around it</td>
</tr>
</tbody>
</table>

MOVE INTO STEP 5 (MOVING FROM WHAT WOULD NEED TO HAPPEN TO HOW THAT COULD HAPPEN)
MAINTAIN IT

This approach is good for working on progress towards easing medicine-taking burden when “perfect” medicine-taking is reported.

Maintenance of a behaviour has to do with time and experience with the adopted behaviour. A common model of ART adherence suggests that information about HIV and ART, motivation to take medicine, and behavioural skills are all needed for good adherence. From this “IMB” model perspective, the better informed you are, motivated you feel, and skilled you are, the better the odds of maintaining adherence over time and across different situations.

From a relapse prevention approach, the more knowledgeable you are about your “triggers,” or situations and events that would promote letting go of the adopted behaviour and going back to an older, less desirable one; and the more skills you have at avoiding, coping with, or managing these triggers; the better the odds of maintaining the desired behaviour.

From just about any perspective, once you adopt a behaviour, the key to maintaining it is a combination of time and experience with the new behaviour, the related development of skills to maintain that behaviour, continued reinforcement for the behaviour, and the relative decrease in attractiveness of the old behaviour.

So, how do you help someone maintain consistent medicine-taking?

- **Promote reflection** on what exactly the patient does and how he or she manages to do it
- **Explore** if there are times when it is particularly difficult (are there triggers?)
- **Identify** a maintenance appropriate next step
  - Sharing success story
  - Taking active role in research project (i.e., becoming a role model or Mshikaji)
  - Develop a plan for continued reinforcement of the behaviour
  - Gain an understanding of “slips” – it can be normal to miss medicine from time to time – what will the patient do with those slips?
- **Reinforce a neutral and open environment**
- Strongly reinforce that while taking ART each day is wonderful, you are equally interested in gaining an understanding of when it can be particularly difficult
- Strongly reinforce that occasionally missing a medicine may happen and if it does, please pay close attention to what is going on at the time
- Strongly reinforce long-term investment in the process – tell the patient that you or another counsellor will check in with him or her at each visit
For example:

“It’s wonderful that you have been able to take the medicine every day . . . and so consistently. So many other patients tell us it’s very hard to do that. Can you tell me what it is you’re doing that I might be able to share with others.”

MOVE INTO STEP 5 (MOVING FROM WHAT WOULD NEED TO HAPPEN TO HOW THAT COULD HAPPEN)
Appendix D – Tools and Forms

- RATE IT SCALE
- DECISIONAL MATRIX
- SHIKAMANA COUNSELING VISIT RECORD
RATE IT SCALE

ON A SCALE FROM 0 TO 10
### DECISIONAL MATRIX

**NEW (TARGET) BEHAVIOUR:** (what ART-related behaviour the patient is considering adopting)

**OLD BEHAVIOUR:** (what behaviour would this new one replace?)

<table>
<thead>
<tr>
<th>Pros (positives)</th>
<th>OLD BEHAVIOUR (DON'T CHANGE)</th>
<th>NEW BEHAVIOUR (CHANGE)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>What are the benefits or positive things about NOT changing or doing the behaviour?</em></td>
<td><em>What are the benefits or positive things about changing or adopting the behaviour?</em></td>
</tr>
<tr>
<td>Cons (negatives)</td>
<td><em>What are the negative things about NOT changing or doing the behaviour?</em></td>
<td><em>What are the negative things about changing or adopting the behaviour?</em></td>
</tr>
</tbody>
</table>
### SHIKAMANA NEXT-STEP COUNSELING RECORD

**STEP 1: FRAME** - In Shikamana, we discuss adherence with all men who are working with peers, because adherence is very important and is difficult for many people.

**STEP 2: REVIEW PROGRESS (if follow-up session)**
Strategy selected at last visit:

- [ ] Strategy was accomplished completely
- [ ] Strategy was partly accomplished
- [ ] Strategy was not accomplished

Comments:

<table>
<thead>
<tr>
<th>DATE: ___ / ___ / ___</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID: __________________</td>
</tr>
</tbody>
</table>

Start Time: ___ : ___
(24-hr clock)

**Session Data**
- [ ] Session (Month 1)
- [ ] Follow-up Session
- [ ] Patient REFUSED counseling

**STEP 3: EXPLORE Facilitators (summarize) and Barriers (summarize) to taking ART**

**Facilitators**
*What are the times, situations, feelings, thoughts, or people that help you?*

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

**Barriers**
*What are the times, situations, feelings, thoughts, or people that make it hard?*

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

**STEP 4: IDENTIFY WHAT would need to happen to increase ease of taking medication(s)?**
Use Rate It, Just Ask, Imagine If, Staircase, Decisional Matrix, or Maintain It to help with this.

**Next Step:**

**STEP 5: STRATEGIZE HOW could that happen...what is the first plan? Is there a back-up plan?**

**Strategies:**
1. 
2. 

**STEP 6: RECORD. DO NOT LEAVE ANY STEP BLANK.**

Stop Time: ___ : ___ (24-hr clock)  Initials: __________
Appendix E – Examples of Next Step Counselling Approach

CASE ONE: Context, Next Steps, and Strategies
A 27-year-old MSM taking ART for 1.5 years reports that things that make it easier for him include feeling good about his health, having a regular partner who knows about his diagnosis and is supportive of treatment, and not feeling any "ill effects" from the medicine. Things that make it harder for him include an irregular work schedule (he is a sex worker) that makes life a little hectic and hard to plan out.

When asked what would need to happen for it to be just a little easier to manage his ART given his hectic schedule, he said (1) quit working; (2) keep some medicine with me; and (3) feel more relaxed when I take ART. Because quitting sex work is not a reasonable or desirable option (he has no other income), the counsellor asked him about feeling more relaxed: "How could you see being more relaxed when you take your ART?" The patient explained that trying to take ART in the morning when he may have been out all night and may feel hung-over is stressful. When asked about times that were less stressful, he said mid-day because he always took time to eat some small thing (beans or a banana) for lunch, and it was a time when he felt relaxed and not rushing around. When asked if taking ART around noon would be a good way to feel more relaxed, the patient agreed. The counsellor asked the patient if he would be willing to try this different dose time out before he came in for his next visit, and he agreed. The counsellor and patient discussed whether or not any preparations needed to be made for him to have ART with him around noon. The patient said he already had that worked out because he does keep a dose in a pill holder in his purse and could just use that when he is away from home. At home he keeps his medicine container in a locked suitcase under his bed.

NOTES:
- The counsellor did not ask the patient if he missed medicine. They still came up with a next step that would help the patient given the context of his current daily life.
- Note that the barriers reported are different from what the patient identified as a good next step towards making progress.
- Even though the situation and structural barriers to medicine-taking are not possible to change (e.g., his unpredictable sex work schedule) promoting consideration of strategies that could be helpful specifically in the context of those "unchangeable" barriers was possible.

Please complete the counselling visit record on the next page.
**SHIKAMANA COUNSELING VISIT RECORD FOR CASE ONE**

**SHIKAMANA NEXT-STEP COUNSELING RECORD**

**STEP 1: FRAME.** In Shikamana, we discuss adherence with all men who are working with peers, because adherence is very important and is difficult for many people.

**STEP 2: REVIEW PROGRESS (If follow-up session)**

Strategy selected at last visit:

- [ ] Strategy was accomplished completely
- [ ] Strategy was partly accomplished
- [ ] Strategy was not accomplished

**Comments:**

**STEP 3: EXPLORE Facilitators (summarize) and Barriers (summarize) to taking ART**

**Facilitators**

*What are the times, situations, feelings, thoughts, or people that help you?*

<table>
<thead>
<tr>
<th>Facilitators</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Barriers**

*What are the times, situations, feelings, thoughts, or people that make it hard?*

<table>
<thead>
<tr>
<th>Barriers</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**STEP 4: IDENTIFY WHAT would need to happen to increase ease of taking medication(s)?**

Use Rate It, Just Ask, Imagine If, Staircase, Decisional Matrix, or Maintain It to help with this.

**Next Step:**

<table>
<thead>
<tr>
<th>Next Step</th>
<th></th>
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<tbody>
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</tbody>
</table>

**STEP 5: STRATEGIZE HOW could that happen...what is the first plan? Is there a back-up plan?**

**Strategies:**

1. 

2. 

**STEP 6: RECORD. DO NOT LEAVE ANY STEP BLANK.**

**Stop Time:** ____ : ____ (24-hr clock)  Initials: __________

**DATE:** ____ / ____ / ____

**ID:** ______________________

**Start Time:** ____ : ____

(24-hr clock)

**Session Data**

- [ ] Session (Month 1)
- [ ] Follow-up Session
- [ ] Patient REFUSED counseling
CASE TWO: When patients report no barriers, just one "effective" strategy

A 24-year-old trans works at a salon and has been taking ART for almost a year. She is open to discussing medicine-taking but throughout the session insisted on several occasions that she takes ART a day every day "no matter what" and has never missed ART. The counsellor explained that he appreciated her sharing this, but was really interested in talking about things that make it easier and harder to take her ART, regardless as to whether or not she actually did or did not take it. He explained that even when people do take ART every day, he would still like to explore with her to see if that can be made any easier or if there is anything they could work on together to help her to continue with her efforts, because many patients find it hard to do at times. The counsellor felt that there were moments when she considered this, but quickly she would insist that there are no times that are difficult. The counsellor felt she was engaged in the conversation but also felt that he was not really hearing the full story.

When asked what makes it easier for her to take her ART the patient said that she has a strategy that works all the time...she takes ART in the morning with a cup of tea, before her boyfriend (who is supporting her financially) gets up. When asked if anything else seems to make it easier for her, she said she could not think of anything else. The counsellor asked if there were times when it was hard for her, and she said that there were no difficulties at all. He then asked if there were times when her strategy was difficult to implement or stay motivated to use. She said that her strategy has never failed and she could not foresee it not working. Later in the discussion she mentioned that at times she skips her morning tea. Because she mentioned this as happening only every couple months, the counsellor decided to work with maintaining the strategy instead of focusing on what the patient is reporting as very infrequent "lapses" in the strategy's effectiveness.

The counsellor asked how the patient could foresee continuing the strategy: "How could you continue to use this strategy that you say works for you most if not all the time?" The patient replied that she would just keep taking ART with her morning tea. The counsellor asked if she would be willing to agree to keep using this strategy between now and the next visit and the patient agreed. Before closing the counselling advised the patient that he or another counsellor would be checking in again with her at the next visit to see how thing went for her and if there are other ways they might be able to help her in managing medicine taking so that it is as least burdensome as possible for her.

The counsellor notes that he or the next counsellor that meets with her should reassess the strategy because he is not sure that the patient felt comfortable enough to talk about difficulties or admit to times when it is hard to take her ART.

NOTES:

- The counsellor decided to primarily focus on increasing the patient's trust and engagement.
- The counsellor sought to support the use of a strategy the patient reported as effective but also left the door open for changing this report at the next session by not simply reinforcing an "effective" strategy- he explored the strategy with the 8-step approach and reinforced the idea that it is OK to also report times when it is difficult.

Please complete the counselling visit record on the next page.
SHIKAMANA COUNSELING VISIT RECORD FOR CASE TWO

SHIKAMANA NEXT-STEP COUNSELING RECORD

STEP 1: FRAME - In Shikamana, we discuss adherence with all men who are working with peers, because adherence is very important and is difficult for many people.

STEP 2: REVIEW PROGRESS (if follow-up session)
Strategy selected at last visit:

- [ ] Strategy was accomplished completely
- [ ] Strategy was partly accomplished
- [ ] Strategy was not accomplished

Comments:


STEP 3: EXPLORE Facilitators (summarize) and Barriers (summarize) to taking ART
Facilitators
What are the times, situations, feelings, thoughts, or people that help you?


Barriers
What are the times, situations, feelings, thoughts, or people that make it hard?


STEP 4: IDENTIFY WHAT would need to happen to increase ease of taking medication(s)?
Use Rate It, Just Ask, Imagine If, Staircase, Decisional Matrix, or Maintain It to help with this.

Next Step:


STEP 5: STRATEGIZE HOW could that happen...what is the first plan? Is there a back-up plan?

Strategies:
1.
2.


STEP 6: RECORD. DO NOT LEAVE ANY STEP BLANK.
Stop Time: __ __ : __ __ (24-hr clock)    Initials: __________

DATE: ___ / ___ / ___
ID: ___________________
Start Time: __ __ : __ __
(24-hr clock)
Session Data
- [ ] Session (Month 1)
- [ ] Follow-up Session
- [ ] Patient REFUSED counseling

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CASE THREE: Next steps are not necessarily a reported barrier

A 30-year-old MSM lives at home with his mother and two brothers, and has been taking ART for almost 2 years. His family does not know about his diagnosis. At his last session he said he would try to go out partying less often to avoid getting hung-over, which is when he has difficulty with medicine-taking. He tried this for one week but decided it was not a good strategy for him. The counsellor assured the patient that sometimes a strategy that seems possible at first starts to be hard once he leaves the session. He tells the patient that today they might be able to come up with a strategy for making medicine-taking a little easier that is a better fit with him and his life.

The counsellor tells the patient that because things change all the time, he would like to take a few moments to explore how the patient has been feeling about taking his ART now. He asks the patient about things that seem to make medicine-taking a bit easier, and what things seem to get in the way. The patient says that it is pretty much the same as last time. The counsellor asks the patient to please help him understand the context of medicine-taking better, by taking just a few moments to explore what makes it easier or harder. The patient reports that feeling supported by his provider helps a lot, and also he has a good way to remember when he is supposed to take his medicine — he has a programmed alarm in his cell phone. He says what gets in the way still is going out drinking with friends, feeling hung-over, and just feeling so tired that taking ART becomes a real chore.

The counsellor decides to ask the patient about what might make it a little less of a chore, a little easier to do, even when feeling tired or hung-over. The patient shared that what might help would be if his ART was right with him, so that if he was away from home and his alarm went off he could take it right there. Having ART right with him would make it easier than having to go through his closet to get the bottle of medicine when his family is around. When asked how he could see having ART with him being possible, he says that he is not sure. The counsellor asks if he could share some strategies that other patients have found helpful for him to consider. He tells him that some people use medicine boxes and keep those with them. Some have a small pill holder on a key chain, that they use to conceal the pills, and some keep ART bottle in their backpack or bag. The counsellor asks if one of those might be helpful. The patient says he likes the idea of a key chain pill holder, that he would keep in his pocket and put in his closet when he is home.

The counsellor asks if he would be willing to try this before he comes in for his next visit, and the patient agrees. The counsellor explores the need for an action plan and lets the patient know that key chain pill holders are available from the Shikamana program. The patient says he feels able to implement the strategy. The counsellor makes sure that the patient understands that if other people open the pill holder and think the medication is some kind of candy that it could be dangerous. The patient says he will be able to make sure only he has access to the container. The counsellor lets the patient know that he or the counsellor he meets with for his next session will check in with him to see how it went.

NOTES:
- The counsellor waited to get a good feel for the context before moving with the patient towards action (a next step) which turned out to be something quite different from the barriers reported.
• The counsellor helped the patient by offering a set of strategies to consider and asking permission to share these.

Please complete the counselling visit record on the next page.
SHIKAMANA COUNSELING VISIT RECORD FOR CASE THREE

SHIKAMANA NEXT-STEP COUNSELING RECORD

STEP 1: FRAME - In Shikamana, we discuss adherence with all men who are working with peers, because adherence is very important and is difficult for many people.

STEP 2: REVIEW PROGRESS (if follow-up session)
Strategy selected at last visit:

☐ Strategy was accomplished completely
☐ Strategy was partly accomplished
☐ Strategy was not accomplished

Comments:

STEP 3: EXPLORE Facilitators (summarize) and Barriers (summarize) to taking ART
Facilitators

What are the times, situations, feelings, thoughts, or people that help you?

Barriers

What are the times, situations, feelings, thoughts, or people that make it hard?

STEP 4: IDENTIFY WHAT would need to happen to increase ease of taking medication(s)?
Use Rate It, Just Ask, Imagine If, Staircase, Decisional Matrix, or Maintain It to help with this.

Next Step:

STEP 5: STRATEGIZE HOW could that happen...what is the first plan? Is there a back-up plan?

Strategies:
1.
2.

STEP 6: RECORD. DO NOT LEAVE ANY STEP BLANK.
Stop Time: ___ : ___ (24-hr clock) Initials: ______________

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