



Médecins Sans Frontières Khayelitsha

ART/TB/PMTCT INITIATION

PATIENT EDUCATION AND COUNSELLING MODEL

REPORT AND TOOLKIT



1. RATIONALE:

Patient education and counselling in preparation for anti-retroviral treatment (ART) initiation is considered a key determinant of treatment adherence^{1,2}. Yet, delays between establishing a person's eligibility for ART and starting a person on ART has been shown to result in high losses to care, increasing the risk of morbidity and mortality. A recent systematic review exploring losses during this pre-ART stage in sub-Saharan Africa, estimated such losses at 34% (ranging from 14-59%)³.

In 2012, the South African National Department of Health released a circular recommending fast tracking patients onto ART without unnecessary delay. It further recommended that patients with CD4 counts under 200 and pregnant women be started on the same day as ART eligibility is ascertained. In practice, there are wide ranging approaches to patient ART preparation within the public sector. Some facilities now provide minimal ART initiation counselling due to prioritizing fast-tracking (especially for pregnant women) and others continue to require attendance of 3 (and sometime more when TB co-infected) sessions causing ART initiation delays and losses to care.

MSF along with collaborating partners (see acknowledgements) developed a revised approach to treatment initiation counselling. It supports fast-tracking ART initiation without failing to adequately prepare and support a patient, including those that are co-infected with TB or pregnant at the time of ART initiation.

The overall aim of the revised approach is to reduce the loss of patients prior to ART start without increasing losses post ART start.



OUR EXPERIENCE OF THE CURRENT SHORTFALLS IN ART INITIATION COUNSELLING PRACTICE

CHALLENGE/BARRIER	DESCRIPTION OF CHALLENGE	CONSEQUENCES
Multiple sessions prior to initiation	Clients are required to complete a number of sessions prior to ART initiation. There is frequently no fixed structure to the timing of these sessions.	Delay and losses to care between eligibility and initiation.
No formal fast tracking procedure (with necessary adaptations required for pregnant women)	Lay counsellors are often left to determine an appropriate way to adapt the counselling approach they have been trained to deliver to shorter sessions and fewer sessions.	Lack of sufficient support for fast-tracked patients who often need it the most. Risk of increased losses to care shortly after starting ART (or after delivery for pregnant women).
HIV and TB counselling session plans not HIV/TB integrated	While progress has been made to ensure the same counsellor provides both HIV and TB counselling, sessions remained separate often leading to the duplication of sessions and concepts (for example adherence).	Multiple additional sessions resulting in additional visits to clinic, and increased losses to care prior to ART initiation.
Focus on information giving rather than examining and planning around barriers to adherence	Multiple counselling sessions often result in repeated treatment literacy during such sessions. Limited attention is paid to practical support for a patient as they integrate treatment into their lives.	Good literacy but limited skills to deal with adherence challenges as encountered/experienced.
Limited opportunity for patients to express their readiness to initiate ART early	Patients were not provided with the choice to initiate ART immediately after their first ART initiation counselling session if they felt ready to do so.	Potential patient frustration, unnecessary financial costs for the patients, unnecessary delay in starting ART and possible losses to care prior to ART start.
Limited focus on the goal of an undetectable viral load	Treatment literacy prior to initiating ART focuses on CD4 count eligibility with limited/if any explanation of a patient's viral load.	Patients are not empowered to ask about their viral load and continue to focus on their CD4 count.
Not integrated with approach for managing patients who later risk failing ART	The counselling approach does not provide a platform for counsellors or clinicians to build on when a patient later struggles/ fails to suppress their viral load.	By not tackling common barriers to adherence when patients start ART there is an increased risk of patients not suppressing their viral load and developing resistance. Common adherence barriers are often new concepts which need to be addressed when a patient is identified to be failing treatment.
No formal session plans for counsellors to follow	Lay counsellors are often trained to cover a number of education and adherence support topics in a counselling session without a detailed formal session plan for each session on how to practically do so.	Counselling reverts to an information giving and often didactic style.
Limited supportive counselling stationary and registers	Counselling stationary frequently does not guide the creation of a recorded adherence plan. Counselling registers were not set up to track a patient through the counselling process.	Counsellors/Clinicians are not supported to understand the adherence plan identified. Patients which do not return to initiate ART cannot easily be tracked for follow-up.
No formal supervision for counsellors	Ongoing training, supervision and quality control are not standard practice.	Unable to report on the quality of counselling within a facility, unable to identify support needs for additional mentorship, quality of counselling is inconsistent.

2. OVERVIEW OF THE REVISED APPROACH:

The revised approach aims to address these challenges by using a more patient-centered counselling model with limited but clear take-home messages. Patients are supported to practice integrating treatment adherence into their lives, by addressing the most common barriers to adherence with all patients started ART, including those co-infected with TB or pregnant.

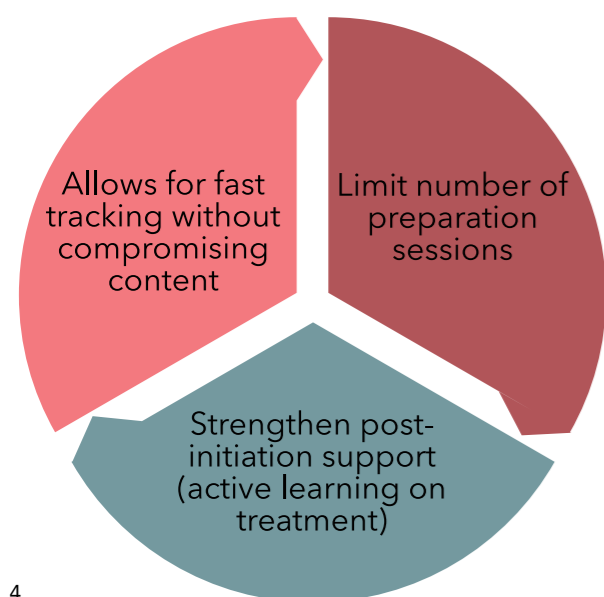
The sessions are conceived as a dialogue between the provider and the patient instead of only a one-directional transfer of information, from the provider to the patient. A patient should go through the complete cycle, receiving guidance both pre- and post- ART initiation.

Sessions have been designed and are presented in a step wise manner so they can be carried out by a lay counselor, expert patient or trained nurse, depending on the context and availability of staff. An adherence plan is completed through the counselling sessions with a copy included in the patient's file to allow follow-up of specific issues in future counselling sessions. The counselling sessions should be organized so that they coincide with the patients routine clinical visits.

The proposed approach can be broken down into 5 key components:



1/STRUCTURE



3 - 4 counselling sessions remain necessary.

- Limiting pre-initiation preparation to 1 session on the day ART eligibility is established.
- 1 session on the day of ART initiation.
- Strengthening post-initiation support. Ideally 2 sessions are provided but these can be consolidated into 1 session. This encourages active learning, while the patient is integrating treatment into their life.

Where the patient indicates at the end of the 1st session that they are not ready to start, an extra session is scheduled which specifically aims to work through patient identified barriers to initiating ART.

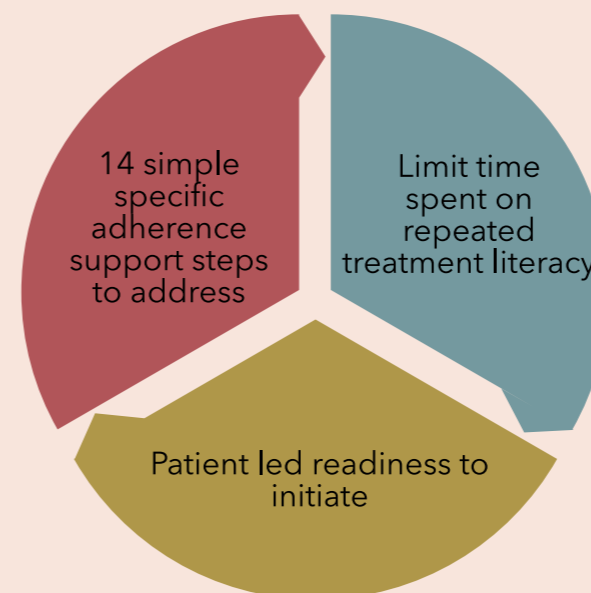
MSF implementation learning:

Certain MSF projects have added 1 session on the day that the patient receives their first viral load result. The session sets out the journey ahead for the patient. Where a patient has an undetectable viral load the patient can continue treatment through ART adherence clubs or Community ART groups. Alternatively where this is not the case, the patient immediately receives enhanced adherence or is referred to the high viral load support group.

Where it is appropriate to initiate ART on the day that ART eligibility is assessed, it is possible to carry out the first 2 sessions on the same day. This will require significantly more time for one long counselling session. Alternatively, a more patient friendly approach would be to carry out the first session prior to the nurse initiating ART and the second thereafter, prior to attending the pharmacy to have the first script filled.

See content and timing of sessions sections below.

2/APPROACH



Treatment literacy is limited to essential information to initiate ART and each session uses a goal-barriers-plan strategy to build adherence skills. See example on the next page. The 14 most common challenges to adherence are addressed with all patients. These were identified from both the Life Steps approach to HIV medication adherence⁴ and MSF's experience through its work with patients attending a second line failure clinic^{5,6}.

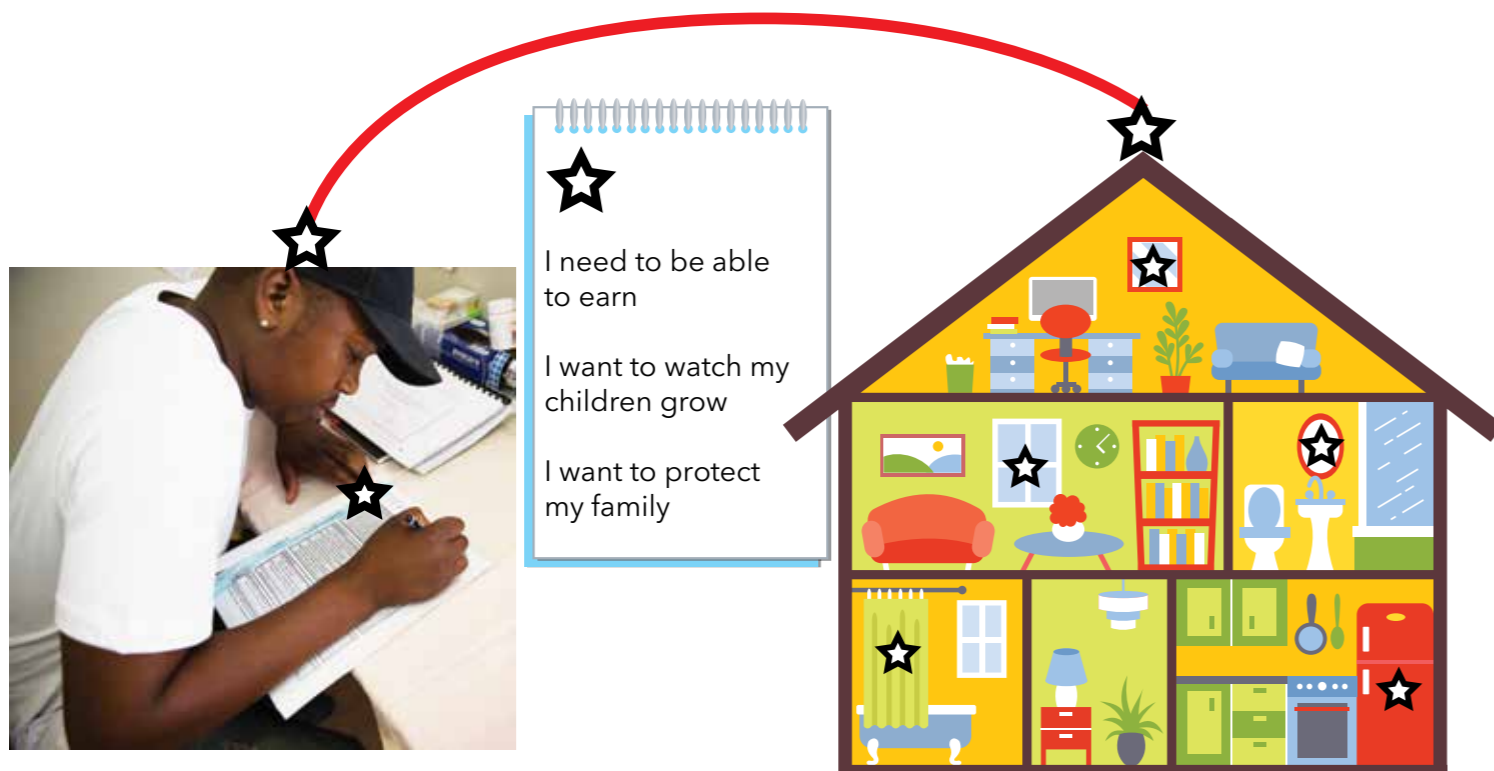
14 Adherence Steps:

- Step 1:** Understanding HIV (and TB)
- Step 2:** Identify support system
- Step 3:** Planning future appointments
- Step 4:** Readiness to start treatment
- Step 5:** Creation of a medication schedule
- Step 6:** Managing missed doses
- Step 7:** Reminder strategies
- Step 8:** Storing medication and extra doses
- Step 9:** Dealing with side-effects
- Step 10:** Planning trips
- Step 11:** Dealing with substance use
- Step 12:** Communication with treatment team
- Step 13:** Learning from mistakes
- Step 14:** Making goals: suppressed viral load (and TB continuation phase)

ADHERENCE STEP 8 - STORING MEDICATION AND EXTRA DOSES

Review adherence goal	"It is important to identify a convenient place to store medication so that you have easy access and are easily reminded"
Identify barriers	"Where could you keep your medication at home?" "How could you carry your medication when you go out?"
Make a concrete plan	Identify safe and convenient place to store drugs at home or at place where patient usually takes his/her drugs. Identify a place to carry extra doses of drugs, what to keep them in - in case patient does not make it in time to usual storage place (e.g. envelope in pocket of woman's bag, plastic bag in man's backpack or jacket he usually wears).
Complete adherence plan	Patient to complete storage places identified at home on patient's personal adherence plan (can be assisted by counsellor)

The approach also focuses on creating a patient oriented motivation for committing to lifelong treatment. At the onset the patient is asked to consider and identify three reasons why they are making a decision to invest in leading a long healthy life. Simplified cognitive-behavioural methodology has been incorporated here where small stickers are taught to be associated to these three reasons. The stickers are placed in familiar places in the patient's environment and the patient is encouraged to recall these three reasons for committing to stay healthy whenever they come across them and remember to take their ART.



MSF Lesson:
We encourage counsellors to read from or refer to the session plan until they are able to provide it without forgetting any part. Initially counsellors feel they are being rude or may appear not to know their role. Mentoring can overcome these concerns.

3/TOOLS

Tools have been developed that support the approach (see annexures). These consist of:

- **Session guide** - sets out the detailed guidance to the structured approach to be taken in counselling sessions. Once proficient in the session structure, it can be used just as a reference point to ensure all topics are covered (Annexure 1).
- **Adherence plan** - completed in the session by the patient with their counsellor. Each adherence step has a plan agreed with the patient and recorded (Annexure 2).
One copy remains with the patient and the duplicate in the patients folder for counsellor/clinician reference especially if the patient is later identified to be struggling with their adherence.
- **Stickers** - part of reminder strategy positively associating taking treatment with reasons for staying healthy and living a long life.
Can also use pieces of cloth/magazine etc in resource limited settings.
- **HIV/ART, TB flipchart, PMTCT flipchart** - to be used during counselling sessions as required (Annexure 3&4).
Can reference appropriate pages in existing flipcharts.
- **HIV/ART, TB treatment and PMTCT literacy pamphlets** - provides a patient with all essential treatment literacy which can be revisited by the patient in their own time at home should they have missed anything or have further questions (Annexure 5&6).
Can use existing treatment literacy print materials
- **Counselling register** - tracks each counsellor's patients through their counselling journey, supports follow-up of missed sessions and provides the counsellor supervisor with overview (Annexure 7).

Supervision tools:

- Routine observation tool - provides a guide to the counsellor supervisor for session observation. The areas observed include counselling approach, content and correct use of tools (Annexure 8).
- Monthly report template - covers qualitative and quantitative descriptions of the outcomes of ART initiation adherence counselling conducted in the month (Annexure 9).



4/TRAINING

Training

Training is provided over 3.5-5 days.

- 3 days for all counsellors and counsellor supervisors on ART/TB ART initiation counselling approach
- 1.5 days for all counsellors and counsellor supervisors on PMTCT initiation counselling adaption
- 0.5 day for only counsellor supervisors on approach to supervision built into the model.

Training has taken into consideration adult learning principles. It is interactive and experiential to ensure that the counsellors have engaged with the theory and practice.

MSF has developed a training module which can be used to deliver this training (**Annexure 11**).

Mentoring

Training is supported by a number of mentoring sessions with the each counsellor and their counsellor supervisor to support competency development subsequent to training.

MSF Experience:

NPO partners have consolidated training to 3 days in total, providing separate supervision training to the counsellor supervisor. While this is possible if necessary, it does cut necessary time for role playing and practice of the model.

5/SUPERVISION

Counsellor supervision is regarded as key to the approach to manage the quality of the execution of the approach and ensure facility accountability for the quality of counselling provided. The counsellors' supervisor is trained and mentored to carry out qualitative assessments of each counsellor's session execution, provide feedback and compile a monthly report which is submitted to the facility manager. This ensures that facility managers are empowered to understand and action counselling delivery issues.

MSF Lesson:

We noted feedback to counsellors was not standard practice. As a result it had negative connotations amongst the counsellors. Supervisors were also not used to providing feedback in a constructive manner. We mentored counsellor supervisors and counsellor to give and receive feedback by focusing on what went well and what could be improved as part of counselling development.

3. OVERVIEW OF THE COUNSELLING SESSION CONTENT

For patients initiating ART only - the following sessions apply

SESSION	OBJECTIVE	CONTENT
Session 1		
1A (group/individual)	For Session 1A <ul style="list-style-type: none"> • Understand basic principles of HIV and ART 	For Session 1A <ul style="list-style-type: none"> • HIV/ART education
1B (individual)	For Session 1B <ul style="list-style-type: none"> • Start preparing patient's individual adherence plan (2 copies - 1 copy to go home with patient, the other to stay in the patient's clinic file) • Define life goals and motivation for treatment 	For Session 1B <ul style="list-style-type: none"> • Reasons to lead long healthy life • Identify support system • Planning future appointments • Combining TB Treatment and ART (only if co-infected) • Readiness to start treatment • Agreement with the patient on an adherence plan
1C (group/individual - patients not ready to start ART)	For Session 1C <ul style="list-style-type: none"> • Provide additional support and encouragement for patients eligible for ART who do not feel ready to start treatment 	For Session 1C <ul style="list-style-type: none"> • Investigation of the reasons of non-readiness to start ART, testimony of expert patients, identification of barriers to start treatment and strategies to overcome these
Session 2 (individual)	<ul style="list-style-type: none"> • Prepare patients eligible for ART on day of initiation • Continue preparing patient's adherence plan 	<ul style="list-style-type: none"> • Creation of a medication schedule • Managing missed doses • Reminder strategies • Storing medication and extra doses • Dealing with side-effects • Adapt patients adherence plan
Session 3 (individual)	<ul style="list-style-type: none"> • Support patients on ART at first clinic visit after initiation • Continue preparing patient's adherence plan 	<ul style="list-style-type: none"> • Review adherence plan • Planning trips • Dealing with substance use • Communication with treatment team • Adapt patients adherence plan
Session 4 (individual)	<ul style="list-style-type: none"> • Support patients on ART at second clinic visit after initiation • Review adherence plan • Troubleshoot any adherence obstacles thus far 	<ul style="list-style-type: none"> • Review adherence plan • Learning from mistakes • Education on viral load monitoring • Discuss further support • Adapt patient's adherence plan

For patients co-infected with HIV and TB - the following sessions apply (in addition to sessions 2, 3 and 4 in above table)

SESSION	OBJECTIVE	CONTENT
Session 1 + (group/individual)	<ul style="list-style-type: none"> Understand basic principles of TB and TB treatment 	<ul style="list-style-type: none"> TB education
Session 2 + (individual)	<ul style="list-style-type: none"> TB treatment initiation preparation Prepare individual adherence plan (this is not repeated but reviewed when patient initiates ART) Define life goals and motivation for treatment 	<ul style="list-style-type: none"> Reasons to lead long healthy life Identify support system Planning future appointments Creation of a medical schedule Managing missed doses Reminder strategies Storing medication and extra doses Dealing with side effects
Session 4	<ul style="list-style-type: none"> Same as above 	<ul style="list-style-type: none"> Add: Education on reaching TB continuation phase

For patients initiating ART during pregnancy or while breastfeeding - the following sessions apply

SESSION	OBJECTIVE	CONTENT
ANC 1 ART Initiation session	<ul style="list-style-type: none"> Understand very basic principles of HIV and ART Emphasis on starting treatment for PMTCT, being able to take ART correctly and developing strategies for good adherence Start preparing patient's individual adherence plan Define life goals and motivation for treatment 	<ul style="list-style-type: none"> HIV Education in a nutshell My motivation to start treatment Identify support system Planning for future appointments Creation of a medication schedule Reminder strategies Managing missed doses Storing medication at home and keeping extra doses Dealing with side-effects
ANC 2 PMTCT and ART education session	<ul style="list-style-type: none"> More in depth understanding of HIV and PMTCT Understanding the way the virus works, the immune system, the action of ART and the benefits of lifelong treatment for the mother Planning for delivery, breastfeeding and treatment of the baby 	<ul style="list-style-type: none"> Expanded HIV Education Delivery plan Breastfeeding Treatment for the baby Testing of the baby
ANC 3 Planning for birth session	<ul style="list-style-type: none"> Revision of adherence plan Making a plan for delivery, infant feeding, PEP for baby and communication with ART/obstetric team as required 	<ul style="list-style-type: none"> Revision of adherence plan My delivery plan Feeding the baby Treatment for the baby Communication with medical team
ANC 4 Revision of adherence plan session	<ul style="list-style-type: none"> Revision of adherence plan Troubleshooting any adherence obstacles thus far 	<ul style="list-style-type: none"> Revision of adherence plan Learning from mistakes

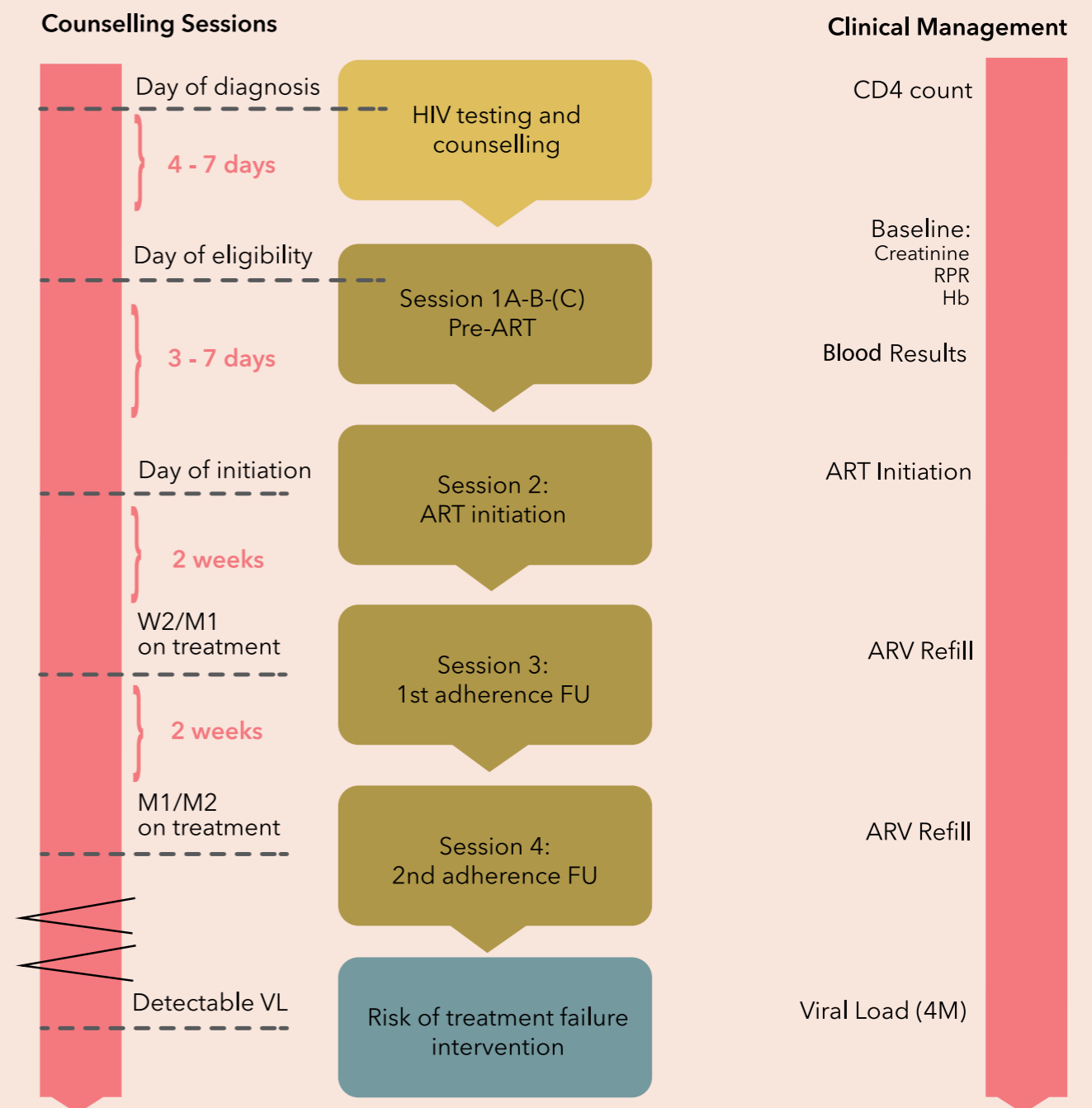
MSF Experience:

Adherence to treatment is complicated by extensive patient mobility. Assisting all patients to plan their travel (step 10) helps prevent treatment interruptions. MSF has designed posters and pamphlets to create awareness around planning for travel (Annexure 10).

4. TIMING OF SESSIONS

These three flow diagrams reflect optimal timing of sessions which can be adapted to the context.

Patients initiating ART only



Where primary healthcare provides community care workers (CCW) to perform supportive home visits to new patients initiating ART and the patient consents to such support, CCWs should ideally carry out their home visit between session 1 and 2. However if this is not possible, the CCW home visit should not delay ART initiation and can take place after ART initiation.

OPTIONS FOR COMPLETION OF THE SESSIONS

1. Standard track

- Initiation within 14 days of HCT
- Session 1 and 2 are not completed on the same day.
- Remember that session 3 and 4 can be consolidated and provided at 1 month ART refill date.

2. Fast track

- ART initiation takes place on the same day that ART eligibility is determined.
- Where CD4 is sent away to a lab this means within 1 week of HCT. Alternatively, where point-of-care CD4 is available at the facility, this is possible on the same day as HCT.
- Session 1 and 2 are both completed on the same day.

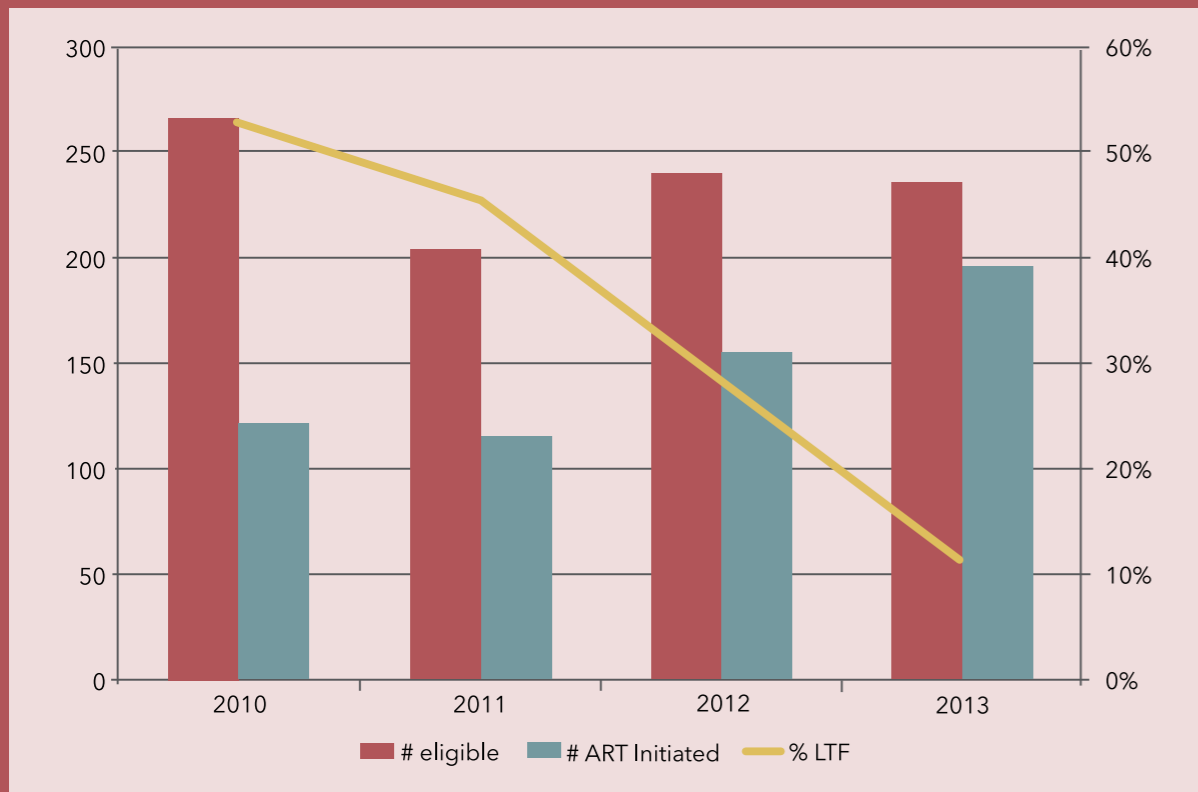
Note:

The same content is used in the counselling sessions for both the standard and fast track options. Only the duration between each session differs. This ensures that all patients receive the same adherence messages.

A patient is only 'fast tracked' if he/she feels ready or there is a clinical need. The extent to which a patient can be fast tracked will depend on practical arrangements/resources at clinic level (e.g. availability of Point of Care CD4, referral system for ART initiation, ordering/availability of treatment).

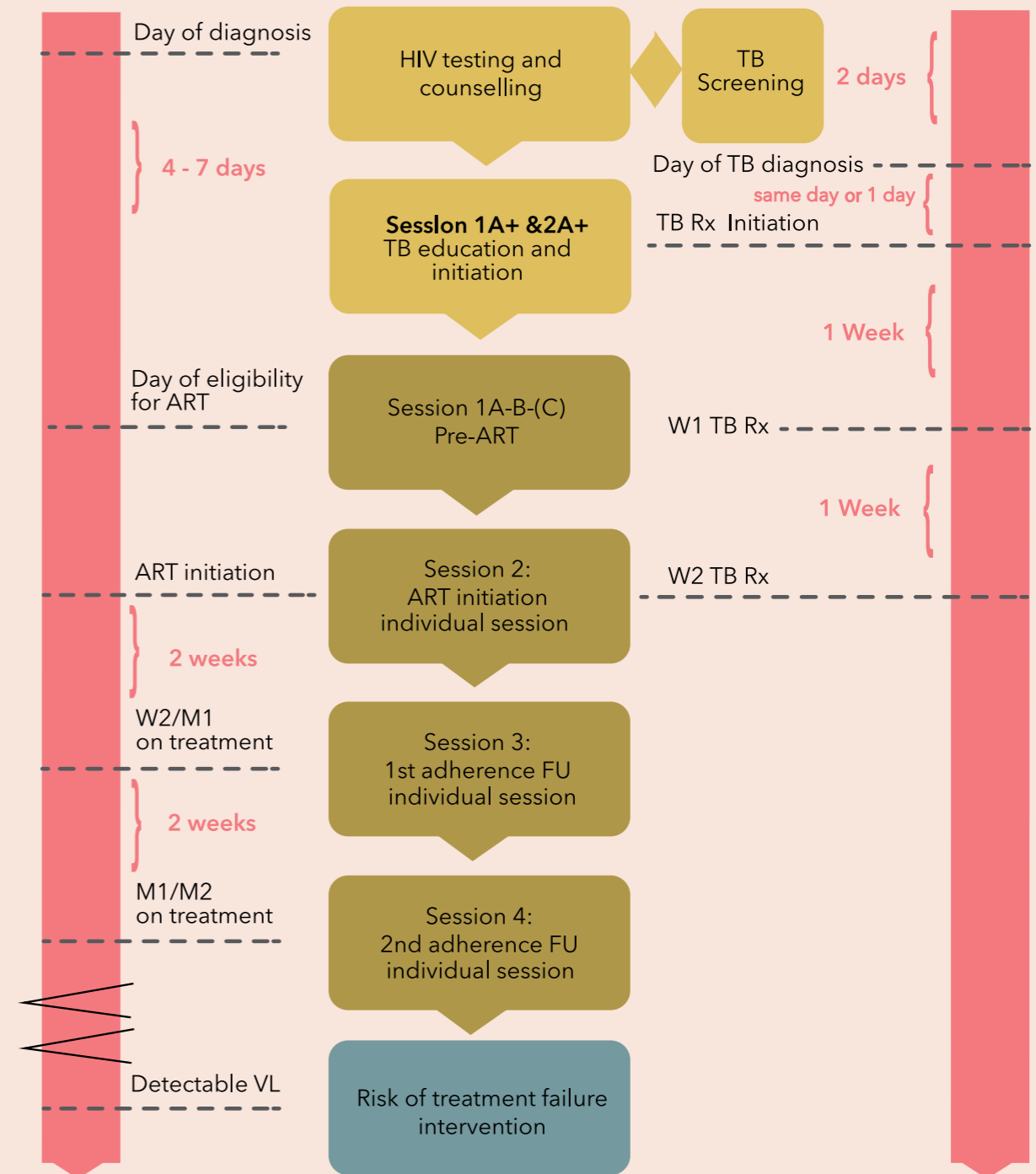
MSF implementation experience in a youth clinic:

Pre-ART losses to care are higher in youth. MSF partnered with the City of Cape Town Health Department to implement a number of strategies to improve retention throughout the cascade in a youth clinic in Khayelitsha. CD4 counts are taken on the day of HCT using a point-of-care CD4 count machine at the clinic. If the young person is eligible to start ART, they receive session 1 on



the same day. They are given a return date for session 2 and ART initiation 3-5 days later (by which time their other baseline blood results are back from the lab). MSF has observed significant decreases in losses prior to ART initiation.

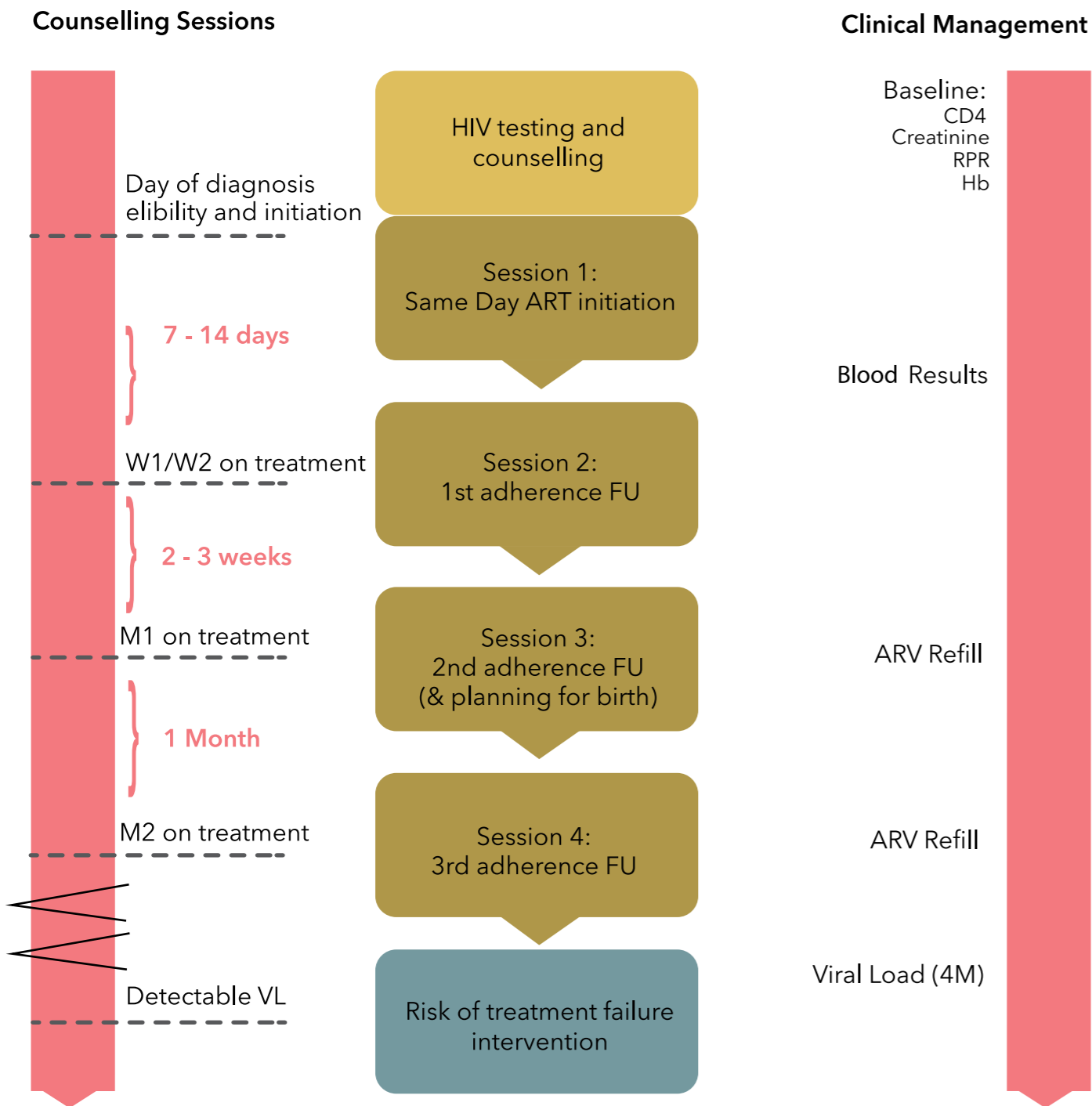
PATIENTS INITIATING TB TREATMENT AND ART



NDOH 2013 HIV guidelines indicate that ART should be initiated in patients co-infected with TB as soon as the patient is tolerating TB treatment, usually within 2-4 weeks but by no later than 8 weeks and as soon as possible for patients with CD4 counts less than 50 cells/mm³.

The session timing is based on starting ART 2 weeks after TB treatment. Optimal timing of starting ART from a clinical perspective needs to be balanced against the risk of losing a co-infected patient to care. Delayed ART initiation has been shown to increase both the risk of TB co-infected patients being lost from care⁷ and patient costs.⁸

PATIENTS INITIATING ART DURING PREGNANCY OR WHILE BREASTFEEDING



MSF Experience:

Losses to care after delivery may indicate a requirement to add an extra adherence plan review session after delivery or the cessation of breastfeeding.

5. FACILITY IMPLEMENTATION

For this approach to work, ART preparation counselling needs to be prioritized within the facility structure. The following should be considered:

Obtain buy-in from all key stakeholders

- Consider all stakeholders who will be in contact with the model, including Facility Manager, Operational Managers of services, all reception/registry clerks, all clinical staff (both TB and HIV), pharmacy, counsellor organizations and counselling staff.
- Build a case for revising the counselling approach by discussing current problems the team may be experiencing. This will build good platform from which to introduce the revised approach.
- Provide short overview presentation of the approach to stakeholders and obtain buy-in for implementation.

Commence with a review of the patient flow within the facility

- A review of the facility's patient flow aims to understand the standard route followed by a patient at their ART eligibility, ART initiation and first two ART refill visits to the facility.
- Understand who refers a patient for their ART initiation counselling sessions and when (before or after clinician visit, pharmacy visit, registry visit?)
- Consider that counselling should be prioritized to ensure that post-initiation counselling sessions 3 and 4 occur before the patient sees their clinician (it is difficult to ensure patients attend a counselling session after they have seen their clinician and received their ART refill).

Consider changes to patient-flow to ensure counselling attendance is prioritized

- Develop options for changes to patient flow See examples overleaf.
- Test the flow-changes within the facility to ensure they are effective and a good fit.
- Support the facility manager to change the patient flow as tested.

Train counselling team (including counsellor supervisor).

- Repeat short overview presentation of the approach to all members of facility team (clinicians, pharmacy, reception/registry) so they understand the key components of the model and their role in ensuring counselling sessions are attended.
- 3-4.5 day practical training for counsellors, providing an understanding of the theory behind the approach, practical engagement with the sessions and facility implementation considerations.
- The counsellor supervisor attends the full training, and an additional half-day to cover training on the supervision approach, tools and reporting responsibilities.

Set up a facility-based working group

- Working group members should include key implementation drivers including: the HAST programme manager for the sub-district, the facility manager, the operational manager for HIV/TB, the counsellor supervisor (if NPO managed, the supervisor's manager), representation from the pharmacy and reception/registry, and the community care worker supervisor.
- The meeting should be held monthly and

ideally be continued for the first six months of implementation of the new approach.

- The primary objective is to ensure continual engagement with the model, specifically patient flow in the facility to ensure counselling sessions are attended. It also provides an opportunity for the team to review the monthly report circulated by the counsellor supervisor, respond to any

challenges immediately with the full team present, and to celebrate successes!

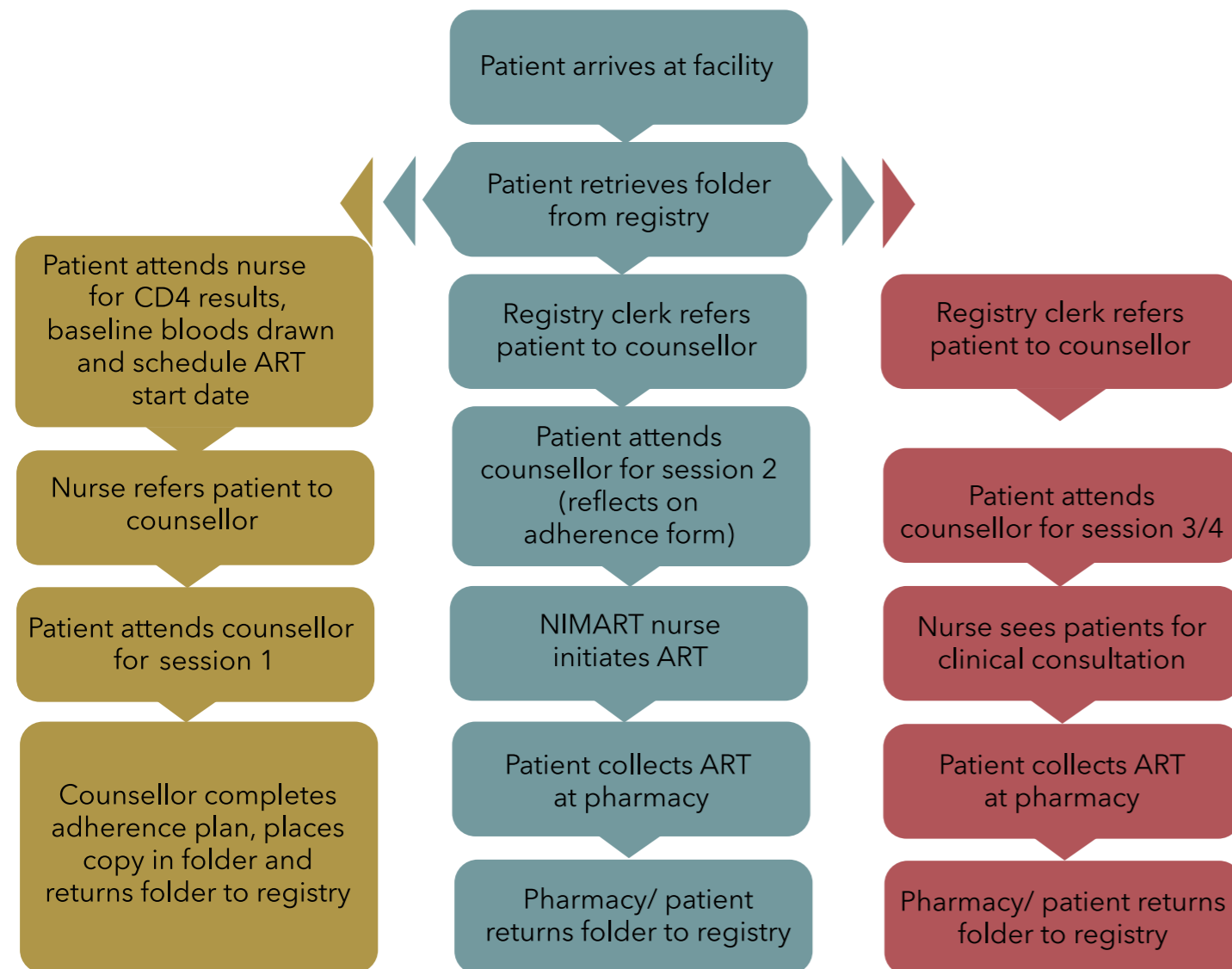
- Communicating routine outcomes to the team is a beneficial way of acknowledging the team and ensuring that everyone is aware of implementation progress/challenges within the facility.

EXAMPLES OF PATIENT FLOW PLANNING

SESSION 1

SESSION 2

SESSION 3+4



On-site mentoring support

On-site mentoring support is given for an agreed-upon period. This support includes:

Patient-flow

- Observing patient flow.
- Engaging with the facility manager, clinicians, pharmacy, registry and counsellors to ensure effective patient flow.

Counsellor mentoring

- Observing counselling sessions and the completion of all tools (adherence plan, register)
- Providing feedback after observations to the counsellor.

Counsellor supervisor mentoring

- Observing the counsellor supervisor carrying out a session observation, completing observation tool and providing feedback to the counsellor.
- Observing counsellor supervisor complete monthly report.
- Supporting the counsellor supervisor to set up a follow-up strategy for patients who have missed their session. Routine weekly tracing of these patients ensures that there is no backlog of incomplete counselling, potentially reducing loss to follow-up or identifying patients who are struggling early in their treatment journey.

Refresher training

- Offering refresher training on topics / areas that require clarity.

MSF pilot implementation outcomes in Kuyasa clinic, Khayelitsha: utilizing existing facility counsellors

From 23 July 2012 - 31 April 2013, 449 patients attended sessions 1 (mostly on the day of being informed of ART eligibility), only 3.6% did not return to the clinic to initiate ART. 96.8% of those initiating ART were retained in short term care at their first ART refill post ART initiation. 86.6% were retained at 6 months, of which 80.2% had a viral load taken within these 6 months and 95.4% achieving a suppressed viral load.

Preliminary results of this pilot indicate that limiting the pre-initiation counselling and strengthening the support after commencing ART has the potential to reduce pre-ART attrition, without increasing short-term losses to care. Educating and motivating patients to achieve an undetectable viral load is possible and this should be part of all ART adherence counselling models.

See **Annexure 12** (further outcomes expected early 2015)

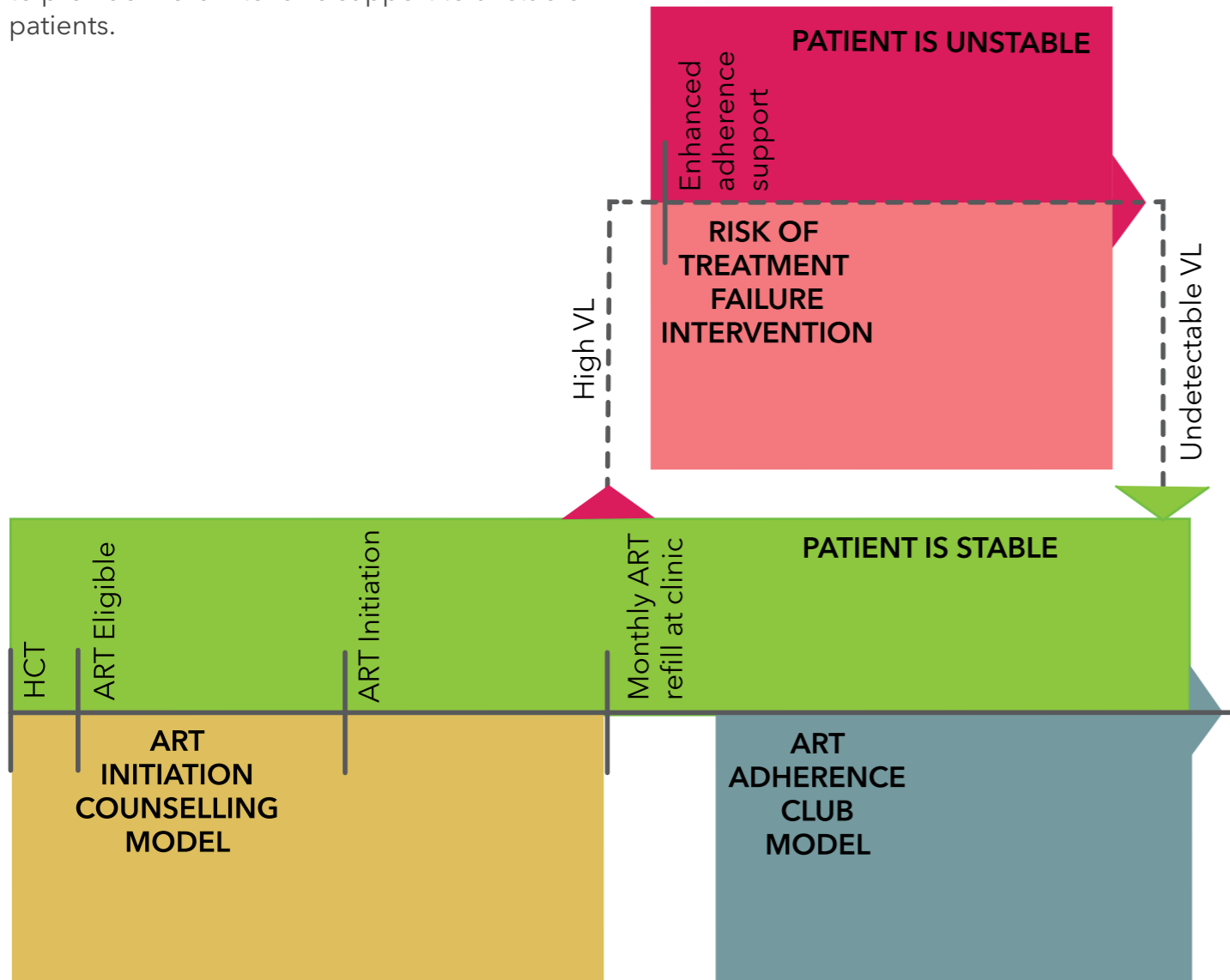
City of Cape Town Health's experience with the model during the pilot at Kuyasa clinic led to implementation of the model at all of their primary healthcare facilities in Khayelitsha, including the youth and male focused clinics.



6. Adherence and retention strategies after ART initiation implementation

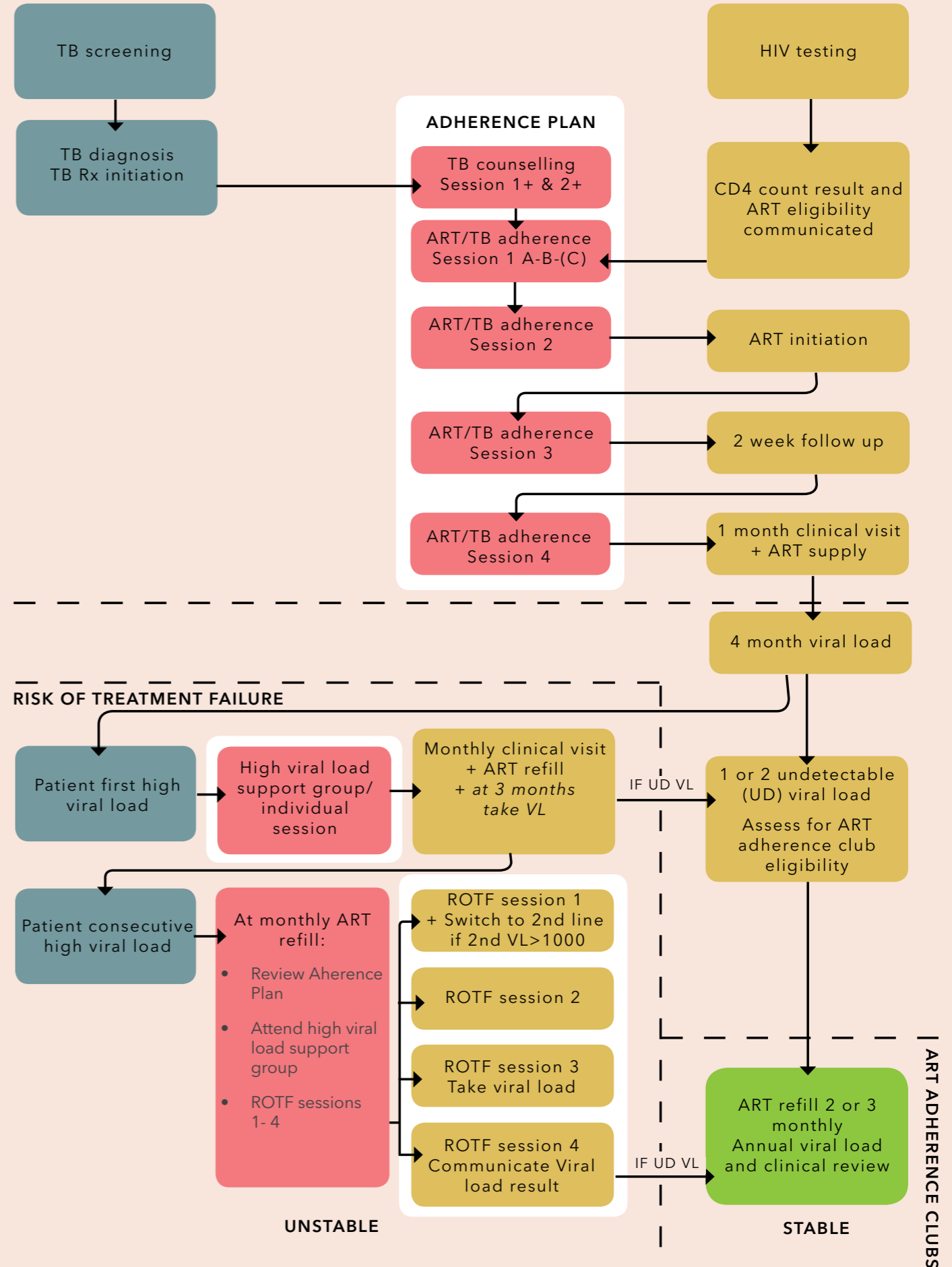
OVERVIEW

This diagram illustrates how patients after ART initiation require different models of care. The majority of patients will be adherent (suppress their viral load) and will benefit from community models of care limiting the need for interaction with their clinic, creating capacity at clinic level to provide more intensive support to unstable patients.



DETAILED PROCESS MAP

ART/TB INITIATION COUNSELLING APPROACH



This detailed process map shows that the ART initiation counselling and risk of treatment failure interventions are two parts of the same approach.

7. Managing stable patients through community models of care

When a patient suppresses their 1st viral load after ART initiation, the patient should be congratulated and encouraged to stay adherent to their treatment with the aim for meeting eligibility criteria for a community model of care such as ART adherence clubs which will make it easier to continue long-term care.

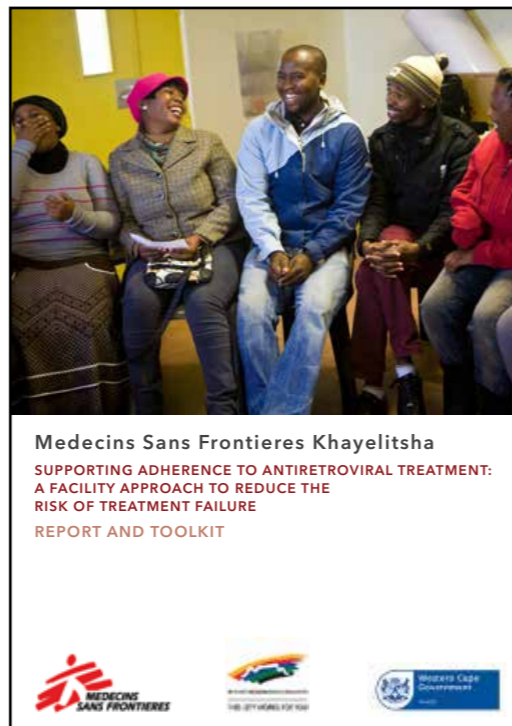
For further information on the model see: <http://samumfsf.org/download/art-adherence-club-report-and-toolkit-khayelitsha/>



8. Managing a high viral load after using this approach to ART initiation counselling

When a patient does not suppress their viral load at their 1st viral load after ART initiation or does suppress but later develops a high viral load, the adherence steps together with the adherence plan are re-examined in the risk of treatment failure intervention also developed by MSF. This intervention integrates adherence support into appropriate clinical management of a high viral load.

For further information on the model see: <https://www.msf.org.za/msf-publications/supporting-adherence-to-antiretroviral-treatment>



9. Annexures:

1. ART/TB Initiation Patient Education & Counseling Guide
2. Adherence plan
3. HIV/ART Flipchart
4. PMTCT Flipchart
5. HIV/ART and TB treatment literacy pamphlet
6. PMTCT treatment literacy postcard
7. Counselling register
8. Counselling observation tool
9. Monthly report template
- 10: Travel/migration support posters and pamphlets
11. Training module
12. Abstract for Western Cape Health Department research day

10. Acknowledgements

The structured adherence support sessions were adapted from a counselling approach known as "Life Steps", developed by Steven Safren (Massachusetts General Hospital, Harvard Medical School, and Fenway Community Health), Michael Otto and Jonathan Worth (Massachusetts General Hospital and Harvard Medical School)⁴.

MSF acknowledges and thanks City of Cape Town Health and Western Cape Department of Health for their partnership in piloting this intervention at Kuyasa and Nolungile clinics.



11. References

¹ Thompson MA, Mugavero MJ, Amico KR, Cargill VA, Chang LW, Gross R, et al. Guidelines for improving entry into and retention in care and antiretroviral adherence for persons with HIV: evidence-based recommendations from an International Association of Physicians in AIDS Care panel. *Annals of internal medicine*. 2012;156(11):817-33

² Chaiyachati KH, Ogbuoji O, Price M, Suthar AB, Negussie EK, Barnighausen T. Interventions to improve adherence to antiretroviral therapy: a rapid systematic review. *Aids*. 2014;28 Suppl 2:S187-204

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