

Patient & Community Support for Advanced HIV Disease

Annexes

Annex 1: example of AHD counseling session from Khayelitsha, South Africa

| Advanced HIV counseling session | |
|--|---|
| Target group | Advanced HIV patients and their caregiver (if possible) |
| Timing | 3 days after Visit 1 (before medical consultation) |
| Objectives | Explain concepts related to advanced HIV and patient's health condition Discuss treatment(s), goals and expectations |
| Duration | 45 min |
| Mode | Individual |
| <p>1. Introduction:</p> <ul style="list-style-type: none"> • Give a warm welcome to the patient and the caregiver (if available) • Congratulate for coming in today and explain the objectives of the session <p>2. Assess patient's feelings:</p> <ul style="list-style-type: none"> • Discuss how the patient is feeling and how has been processing the information about their condition since the last visit: <i>"How have you been feeling since last time we met?"</i>, <i>"What do you think about what we discussed last time regarding your health condition?"</i> <p>3. Evaluate patient's understanding on their condition and explain about Advanced HIV</p> <p>HIV/ART:</p> <ul style="list-style-type: none"> • First ensure that patient understands well how HIV functions in the body and how ARVs work against HIV (<i>"Let's review some key information about HIV and treatment. Can you please tell me what does HIV do in your body?"</i>, <i>"How ARVs work and what is the benefit of ARV treatment?"</i>) <p>Advanced HIV:</p> <ul style="list-style-type: none"> • Review information about advanced HIV: <i>"Do you remember what we discussed last time about advanced HIV? Can you please tell me what and how do you understand your health condition? Can you tell me what we discussed last time about your CD4? What are the risks of having a CD4<200?"</i> • If necessary, and without any criticism explain the correct information to the patient: <i>"Advanced HIV is the stage where the CD4 has dropped below 200 copies and/or when clinicians see there have been already some serious infections (such as TB) in your body. Low levels of CD4 are very risky for your health; it means your immune system is weak and cannot protect from viruses and infections that put your life at risk if medical care is not provided on time"</i> • Explain why and when this happens: <i>"Do you remember your CD4 when you took ARVs in the past? We see now that your CD4 has dropped to risky levels; that's because HIV has been multiplying in the body and have been destroying the CD4 cells and damaging your immunity. This happens when the treatment has been interrupted or when treatment has not been taken regularly"</i> • Take the opportunity to congratulate again the patient for returning to care where all the team will take good care of them. <i>"But remember we are here to support you to have your CD4 back to good levels. When your CD4 is at least 200 copies and above, then your health will be more stable and your immunity can protect you against germs and infections"</i> <p>4. Link Advanced HIV to Opportunistic Infections/symptoms:</p> <ul style="list-style-type: none"> • Assess first what the patient knows about OIs: <i>"We are now going to talk about Opportunistic Infections or OIs. Do you know what an OI is or do you know any OI?"</i> • Explain: <i>"There are different infections that take the opportunity to make patients sick:</i> <ul style="list-style-type: none"> ○ <i>There are infections that can affect the lungs and make it difficult to breath, and/or give us fever, make us short of breath</i> | |

- *There are other infections that can affect the brain and give us headaches or make us confused*
 - *There is chronic diarrhea*
 - *TB is the most common infection we can get; this affects the lungs or other parts of the body, such as the brain*
 - *If there are any changes in the body (lumps, changes in the skin, bleeding between the periods) let the clinician or nurse know next time you come to the clinic"*
 - Explain that at this stage of Advanced HIV, it is highly possible that they already have or may experience one or more of these OIs
 - Inform that for most OIs there is treatment and prevention. Clinicians will prescribe the necessary medication to treat or cure them
- 5. Explain danger signs:**
- *"Can you please tell me what you recall from what we discussed last time on danger signs?"* If necessary, discuss again the definition of danger signs
 - Go through the following danger signs with the patient and the caregiver:
 - 1) *Unable to walk unaided or stay in bed all day*
 - 2) *Changes in behavior or confusion or being very sleepy*
 - 3) *Shortness of breath*
 - 4) *Fever*
 - 5) *Vomiting or diarrhea or you don't want to eat or drink*
 - 6) *Strong headache that doesn't go away with medication (panado or grandpa...)*
 - 7) *The white part of your eyes turns yellow*
 - If possible, link with a specific danger sign the patient may have noticed recently on themselves
 - Explain that if the patient experiences any (one or more) of the danger signs, they need to seek for medical care ASAP (with no delays!) - even if that is earlier than their next appointment in the clinic
- 6. Other precautions/ information the patient need to know :**
- Let the patient (and caregiver) know that as their immune system is weak, they can still get an OI; or an existing OI (such as TB) may get worse when they first start taking ARVs
 - Advice: *"For that we will need your attention and collaboration: anytime you see a change in your body or you feel unwell, you need to come in the clinic – even if this is earlier than your next appointment- and report it to your clinician. This way we will be able to take care of you"*
- 7. Treatment management and way forward:**
- Inform about the different type of treatments the patient need to take (adapt accordingly):
 - Medications to fight HIV and to boost their immunity (ARVs) that need to be taken for life and
 - Medications (TB treatment, fluconazole...) for a specific period of time (defined by the clinician) to cure or treat existing opportunistic infections (TB, crypto...). Explain that when there is TB, they will first start with TB treatment and later on (in a couple of weeks or months depending on their CD4) they will start ART as well or
 - Prophylaxis (IPT, Cotrimoxazole, Fluconazole...) to prevent TB, diarrhea or other OIs - if such OI does not already exist.
 - Bactrim/Cotrimoxazole is the most common prophylaxis to prevent from lots of different infections like pneumonia for example; this you take it until your CD4 is higher than 200;
 - Fluconazole is another prophylaxis to prevent from Cryptococcal meningitis that needs to be taken based on your CD4 and other blood tests;

- IPT is to prevent from TB and will be taken for 12 months if the clinician makes sure you don't have TB
- All these medications can prevent from getting an OI. If an OI already is presented in your body, then the clinician will prescribe you treatment. Ensure the patient understands the importance of taking the medications as prescribed to them. Review the adherence plan steps discussed in last counseling session and ask if the patient has any question about when and how to take the different pills
- Acknowledge there may be lots of pills to take for some time, but this is only until their OIs are treated/cured and until their immune system recovers/gets strong again
- Discuss about follow up appointments in the clinic:
 - The first 4 months the visits will be scheduled on a monthly basis
 - Need to come yourself (don't send a buddy – we need to see you and check everything is alright)
 - From month 5, if patient's health gets better, the appointments could be spaced (every 2 months) and they could be offered the option to join a Club
- At month 3 they will have Viral load test and after a year a CD4 test
- The most important is to come back in every appointment so clinicians/nurses can check patient's health progress

8. Motivation and targets

- Discuss patient's goals:
 - 1) To have a suppressed VL < 400 (checked at month 3 and again after another 3 months if it is high)
 - 2) To have their next CD4 count above 200 copies or at least increased
 - 3) To come to clinic as soon as possible if they experience any danger sign
 - 4) To cure their TB or other existing OIs or to prevent them by taking prophylaxis
 - 5) To take their ARVs for life
- Discuss which targets can be reached faster than others and encourage by saying that they are all achievable. Check patient's motivation to take their treatment (discussed in last visit together with the adherence plan)

9. Closure of the session:

- Summarize key points of today's session
- Ask if the patient (and caregiver) have any other questions
- Thank them and encourage to come in the next appointment at M1

Annex 2: example of danger signs leaflet from Nsanje, Malawi

If you have one or more danger signs
DO NOT WAIT
Go to the clinic and seek for help



Don't miss your medical appointments, medication refills and lab tests in the clinic



Take your medications as prescribed



Health Self-check



&
Self-referral to the clinic



Danger signs



Not able to walk without aid or staying in bed all day



Vomiting or Diarrhea that doesn't get better /doesn't stop



Difficulties breathing



Headache or Confusion



Fever



Loss of weight

Yellow eyes



Annex 3: example of adherence history assessment and form from KZN, South Africa

| Assessment of ART & adherence history for advanced HIV patients | |
|--|---|
| Target group | Patients with advanced HIV disease starting any treatment (ART/TB/Crypto/prophylaxis...); non-naïve patients in particular |
| Timing | During the first adherence session at treatment (re)initiation or after defaulting |
| Objectives | To assess reasons for possible treatment interruptions/adherence problems in the past or reasons for not coming earlier to the clinic |
| Duration | 20 minutes |
| Tools | Assessment form |
| <p>➔ NOTE for the counselor:</p> <p>Patients with advanced HIV are ART “naïve” or more frequently (here) ART “non-naïve”. In either case, all staff should be welcoming when these patients come/return to the clinic; or else we risk to discourage patients from continuing their treatment.</p> <p>For ART non-naïve patients: counselors need to explore more about patient’s treatment history: possible adherence difficulties, reasons of defaulting or treatment interruptions in the past. Some of these reasons may be still valid for the patient at present time, risking their adherence and continuation of new treatment in the future. For ART naïve patient: counselors can focus on whether the patient have been tested positive before and what possibly made them not to come to the clinic earlier.</p> <p>➔ Before going through the standardized steps in 1st adherence session at treatment (re)initiation or before the steps in counseling session for defaulters, please discuss the following questions with the patient:</p> <ol style="list-style-type: none"> 1. Start by assessing patient’s experience with HIV test(s) and HIV positive results: <ul style="list-style-type: none"> – “When did you first take an HIV test/how many HIV tests have you done? When did you get a (+) result?” – “What happened after? Were you linked to a clinic? Did you get any treatment? Where was that?” – “What made it difficult for you to come to this clinic and start treatment earlier?” 2. “Have you ever had TB? If yes, did you take a treatment and for how long? when/where was that?” 3. “Have you ever been hospitalized in the past? For what reason?” 4. “Have you ever taken any ARVs before? When and where was that? For how long?” 5. “Did you have any difficulties taking ARVs in the past? How easy was it to take ARVs every day?” 6. “Have you ever stopped taking treatment for a short or longer period of time? How many times did that happen and for how long? What made it difficult for you to continue taking ART?” 7. Check if any of the following factors affected the adherence/continuation of the treatment in the past: <ul style="list-style-type: none"> – Alcohol/Substance abuse – Distance from the clinic – Traveling in a different region/looking for job – Fear of discrimination/ No disclosure of HIV status – Side effects of medication – Tired of taking medication – Lack of information on why/how to take treatment – Other traditional beliefs or healing methods – Any other reasons that made you stopped your treatment? 8. Ask the patient if any of the above can prevent them from taking their new treatment every day and from coming to the clinic. If the answer is yes, discuss a plan in order to overcome the issue and ensure adherence 9. Continue with the adherence plan, as per session guide, starting from motivation to take treatment(s) | |

Assessment form for ART history/adherence for advanced HIV patients

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|--|--------------|
| Patient's code: | Date: |
| Previous HTS experience: (how many HIV tests? when and where? When was the first positive result? Was the patient linked to care?) | |
| Health Facility where patient has been previously followed up for ART treatment: TB treatment: Hospitalizations in the past (after HIV diagnosis): | |
| Previous treatment interruptions (temporary or long term). Please note all, if more than once: When and for how long ART and/or TB treatment was disrupted in the past? | |
| Reasons for treatment interruption(s) in the past: | |
| <input type="checkbox"/> Alcohol/substance abuse, explain: | |
| <input type="checkbox"/> Distance of home from the clinic, explain: | |
| <input type="checkbox"/> Traveling/looking for job, explain: | |
| <input type="checkbox"/> Lack of disclosure/fear of discrimination, explain: | |
| <input type="checkbox"/> Side effects of medication, explain: | |
| <input type="checkbox"/> Tired of taking medication, explain: | |
| <input type="checkbox"/> Lack of Treatment literacy/ understanding why or how to take medication, explain: | |
| <input type="checkbox"/> Other traditional beliefs/ healing methods, explain: | |
| <input type="checkbox"/> Other reasons; please precise and explain: | |
| Which of the above can be still a barrier for current treatment adherence? | |
| Have any of the above or other factors made it difficult for the patient to come to clinic earlier? <i>(Please assess without judging or criticizing. And add your comments below :)</i> | |

Annex 4: Example from Nsanje, Malawi : counseling session for patient who missed appointment

| | | | | |
|--|--|---------------------|----------|---------------|
| Target Group | Patients who missed appointment(s) | | | |
| When | At day of consultation when issue is identified | | | |
| Method | <u>Individual session</u> | | | |
| Tools | ART flipchart | | | |
| Objective | To help a patient identify appropriate solutions to challenges he/she is facing with appointment dates and drug adherence | | | |
| <p>1. Welcome the patient and explain purpose of the session.</p> <p>Note: <i>it is important to adopt a patient-centered approach and to always welcome the patient</i></p> <p>FOR ALL</p> | <p>“Good morning, I’m ... and you...?” “How are you feeling today?”</p> <p>“First of all, thank you for coming today at ART clinic day. Do you know why the nurse/clinician sent you to our counseling room?”</p> <p>➔ Let the patient answer first ➔ Give explanation: “you have been sent to the counseling room because you were supposed to come on XXX date, meaning earlier than today. Thus we would like to hear from you the reasons why you couldn’t make it earlier.</p> | | | |
| <p>2. Assess reasons for missing appointment and evaluate patient’s adherence.</p> <p>FOR ALL</p> | <ul style="list-style-type: none"> • Check on MasterCard if the patient was coming on his/her appointment dates in the previous months • Acknowledge the difficulties related to lifelong treatment (treatment fatigue, forgetting doses, side-effects which makes patients stop, transport cost to facility, etc.) by explaining that a lot of patients are facing those challenges. • Assess the reasons behind the missing appointment by asking the patient what challenges he/she has for not managing to come on the expected appointment date. <p>Important:</p> <ul style="list-style-type: none"> • Evaluate patient’s adherence and get specific information about missed doses <p>Check whether the patient had previous problems of adherence and/or missed appointments.</p> <p>Check adherence since last visit: Start with open questions and asking the patient to describe you how they have been taking their medications Then, use the Morisky questions below: If the patient answers yes to at least one question, adherence is not good and the issue needs to be explored:</p> <ul style="list-style-type: none"> • In what situations were doses missed? • Explore the reason for missed doses (forgot, misunderstanding on how to take medication, fell asleep, ran out of pills, difficulty with medication schedule, etc.). | | | |
| Self-report/Morisky questions | 1.Mumaiwala kumwa mankhwala ngakhale kamodzi? | | | Result |
| | 2.Mumanyalanyaza kumwa mankhwala anu nthawi zina? | | | |
| | 3.Mukakhala kuti mukupeza bwino mthupi, mumasiya kumwa mankhwala nthawi zina? | | | |
| | 4.Ngati simukumwa bwino mthupi pamene mukumwa | No to all questions | 2 | |
| | | Yes to one | 1 | |

| | | | | |
|---|--|-------------------------------|---|--|
| | mankhwala, mumawasiya kumwa? | Yes to more than one question | 0 | |
| <p>4. Assess patient’s knowledge on ART adherence</p> <p>FOR ALL</p> | <p>Assess the knowledge of the patient about the link between “missed appointment” and adherence to treatment by asking this question: “<i>could you explain me why it is very important to come on time in ART clinic and not to miss appointment?</i>”</p> <ul style="list-style-type: none"> ➔ Let patient answer first. ➔ Give information about adherence challenges if ARVs are not taken every day and if doses are missed. ➔ Discuss importance of adherence ➔ use ARV flipchart Cards 4, 9, 10 and 11 or the Man Chart. | | | |
| <p>5. Discuss ARV resistance and treatment failure</p> <p>FOR ALL</p> | <ul style="list-style-type: none"> • Use ARV flipchart Card 19 and 24 • Link missed appointments and missed doses with possibility of resistance | | | |
| <p>6. Review behavioral aspects and identify factors that may affect missing doses/appointments.</p> <p>If available: use adherence plan.</p> <p><u>TO BE COVERED IF ADHERENCE IS NOT GOOD</u> (Based on section 3 above).</p> | <ul style="list-style-type: none"> • How does the current medication schedule fit the daily routines of the patient? In which situations does he find it most difficult to take his medication? • What are the reminder strategies put in place? (<i>e.g.: calendar, reminders, assistance from family members or friends</i>). • How does the patient plan for trips? (<i>e.g.: asking a longer ART refill, getting medication at nearest ARV treatment clinic at travel destination, need for a transfer to another clinic...</i>). • Where are extra doses of medication kept, to take when away from home? • How does the patient deal with side effects he may be experiencing? • How does the patient manage missed doses? <p>Support identifying strategies to overcome challenges identified through the questions above.</p> | | | |
| <p>7. Explore other factors that may affect missing doses and try to help identify adapted strategies to improve adherence.</p> <p><u>TO BE COVERED IF ADHERENCE IS NOT GOOD</u> (Based on section 4 above).</p> | <ul style="list-style-type: none"> • Explore cognitive component: motivation to take ARV/TB medication, expectations about benefit of ARV/TB medication, degree of knowledge on HIV and ART. • Assess emotion/mental status: level of stress related to medication and related to life events, feelings of loneliness, self-blame, poor self-esteem, depressed mood, hopelessness, substance use, etc. • Assess socio-economic status: transportation problems, social stigma, financial concerns, HIV status disclosure, social support, occupational/educational challenges. <p>Support identifying strategies to overcome challenges identified through the questions above.</p> | | | |

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| <p>8. Danger signs education</p> | <p>Upon every encounter, highlight to the patients the importance of returning to HC if one experiences any of the following “danger signs” (= alerting signs of serious infections):</p> <ul style="list-style-type: none"> • Not able to walk unaided or bedridden • Fever • Headache • Confusion • Difficulty breathing • Vomiting or diarrhea that doesn’t get better/doesn’t stop • Loss of weight • For patients taking TB treatment: Yellow eyes (the white part of your eyes turns yellow)/Jaundice |
| <p>9. Assess any need for referral back to clinician</p> <p><u>TO BE COVERED IF ADHRENCE ISSUE IS RELATED TO SIDE EFFECTS</u></p> | <ul style="list-style-type: none"> • In case of adherence challenges due to side-effects, refer the patient back to clinician |
| <p>10. Conclusion</p> <p>FOR ALL</p> | <ul style="list-style-type: none"> • Summarize the session by reviewing strategies for patient. • Thank the patient for the time and his/her collaboration. • Ask if the patient has further question before closing the session. |

Annex 5: Psychosocial support strategy for AHD in PHC Beira, Mozambique

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| <p>PHASE 0:</p> <p>For all HIV patients</p> | <ul style="list-style-type: none"> - <u>FOR ALL HIV PATIENTS REFERRED FOR COUNSELING:</u> Counselors include “danger signs” education and “welcome back” message in all ART initiation counseling sessions, ART Follow Up counseling, EAC, 2nd line counseling etc. - <u>FOR ALL PATIENTS IN WAITING AREAS:</u> Raise awareness on danger signs and welcome back message during health talks/theatre at waiting bays |
| <p>PHASE 1:</p> <p>For AHD patients at Day 1 (day patient is presented at OPD with AHD or catch up for those already FU by consultant)</p> | <ul style="list-style-type: none"> • <u>FOR ART NAIVE PATIENTS:</u> <ul style="list-style-type: none"> - ART initiation counseling : HIV/ART education (with flipchart), explain different medications/prophylaxis, discuss side effects and importance of good adherence - Explain AHD; link AHD with patient’s CD4 and possible OIs; explain patient’s health condition is critical but there is treatment to improve it; motivation; goal: to increase CD4 and have undetectable Viral Load - Danger signs education (use visual aid: leaflet or poster) • <u>FOR ART NON-NAIVE PATIENTS:</u> <ul style="list-style-type: none"> - ART counseling (reinitiation or switch to 2nd line)with ART flipchart: education, explain different medications/ prophylaxis and importance of good adherence - Adherence history assessment and counseling to enhance adherence - Explain AHD; link AHD with patient’s CD4 and possible OIs; explain patient’s health condition is critical but there is treatment to improve it; motivation; goal: to increase CD4 and have undetectable Viral Load - Danger signs education (use visual aid: leaflet or poster) • <u>In addition, for patients discharged from from Beira Central Hospital:</u> <ul style="list-style-type: none"> - Congratulate for coming to Manhava for treatment continuation and follow up - Assess patient’s understanding on treatment(s) and prophylaxis, AHD, danger signs; review info if needed - Assess and support adherence post-discharge • <u>In addition for AHD/TB coinfectd patients:</u> TB Counseling combined with AHD and ART counseling as described above |
| <p>PHASE 2:</p> <p>For AHD patients in Follow Up (throughout 3 months)</p> | <ul style="list-style-type: none"> - Assess and support adherence to treatment(s) and prophylaxis - Counseling to enhance adherence or switch to 2nd line counseling (if needed) - Review danger signs education - Propose Index testing and family planning |



Annex 6: example from Nsanje, Malawi on adherence history assessment at IPD level

NDH – Adherence assessment for non-naïve patients

| | |
|---|--------------|
| Patient's code: | Date: |
| Previous HTC discussed: Health Facility where patient has been previously followed up for ART treatment: TB treatment: Other hospitalizations in the past (after HIV diagnosis): Viral load test: Date of last VL:, VL <1000 <input type="checkbox"/> or VL >1000 <input type="checkbox"/> <input type="checkbox"/> No VL test done before, explain: | |
| <p>Previous treatment discontinuation, temporary or long term interruptions (please note all, if more than one): When and for how long ART and/or TB treatment was disrupted in the past? </p> | |
| <p>Reasons for treatment interruption(s) or adherence barriers in the past: <i>(please note which of the factors below refer to treatment interruptions and which ones to adherence barriers)</i></p> <input type="checkbox"/> Disclosure to partner, explain: <input type="checkbox"/> Alcohol/substance abuse, explain: <input type="checkbox"/> Side effects of medication, explain: <input type="checkbox"/> Distance/ Transport to Health Facility, explain: <input type="checkbox"/> Work / Income, explain: <input type="checkbox"/> Signs of depression, explain: <input type="checkbox"/> Lack of Treatment literacy/ understanding, explain: <input type="checkbox"/> Other (e.g. mobility/traveling, fear of stigma/discrimination, treatment fatigue, Health staff attitude etc.), explain: | |
| Which of the above are still present (and could affect treatment adherence)? | |
| Have any of the above or other factors made it difficult for the patient to come to HF earlier (before getting too sick)? <i>(Please assess without judging or criticizing. And add your comments below :)</i> | |
| Action plan to improve adherence: | Date: |
| Assessment outcome: | |
| Action plan:..... | |

.....
Action done (if any):.....
.....

Note: please record this information on the adherence plan!

Annex 7: Example from Nsanje, Malawi about counseling session prior to discharge and checklist

| Pre-discharge counselling session | |
|---|--|
| Target group | NDH Patients on ART/TB treatment before discharge |
| Duration | 30 min |
| Mode | Individual session with patient AND guardian if available |
| Tools | Discharge checklist, NDH PS Register, ART flipchart, TB flipchart, Danger signs visual aid |
| <p>1. Introduction:</p> <ul style="list-style-type: none"> – Greet the patient and guardian & explain the objective of the session – Ensure the contact numbers & address details of patient (and caregiver when possible) in patient's file are correct – Assess and support adherence in the usual way <p>2. Explain post-discharge follow up (PDFU) process:</p> <ul style="list-style-type: none"> – Explain to patient and caregiver the (counter-) referral process from NDH to a community HC – Ensure the referral HC is convenient to the patient – Indicate in health passport the next appointment day at NDH or other HC after 2 weeks (if appointment day is not known: go and ask the clinician in person) – Ensure the patient /guardian knows about the next appointment day at HC – Explain to patient the importance of going to HC every time clinician advises it to: <ul style="list-style-type: none"> • Ensure medical HIV/TB check-ups and for ART/TB (and other) medication refills • Make sure he/she is recovering well – Emphasize the importance of attending regular appointments at HC for life and that after patient's condition is stable, the appointments can be spaced and patient will be able to take longer ART refills – Inform the patient (and the caregiver) about PDFU through phone contacts (or potential home visits by a community health worker in case patient is not reachable by phone) AND seek consent to do so. Explain NDH counsellor will call them at Week 2, AND at Month 1, M2, and M3 post-discharge – Discuss Week 2 post-discharge day: whether or not patient can come at NDH or other HC – Ask if patient (and caregiver) have any concerns about the NDH PDFU and address them accordingly <p>➔ Use the flipchart card # 23 and educate about regular ART follow up visits at HC CARD 23 – ZONWE TINGAYEMBEKEZERE TIKAPITA KUCHIPATALA CHA MA ARV</p> <p><u>What should you expect when you go for your ARV collection in Health Centres?</u></p> | |

- Height and weight
- See clinician (side effects, pill count and screening for tuberculosis infection)
- Refill medication
- Viral load testing (some appointments)

What should you bring to your Health Centre appointment or during hospital admission?

- Health passport book
- ARV and CPT bottles and other medications you were prescribed
- Your guardian is most welcome to accompany, especially for first six months on ART.

Remember:

- Go to all scheduled appointments.
- Bring **same** health passport book to all clinic visits
- If you are stable and your health in good shape (for example: low viral load, no serious infections) you can be prescribed with longer refills (ARVs for 3 months or sometimes for 6 months when you take DTG). This means you will no need to come to HC every month to take your ARVs

3. Review key information on treatment(s) and post-discharge care using discharge checklist (see annex):

- ART, TB (and other) treatment:

Ensure the following are well understood by the patient/caregiver:

- When/ what/ how each medication (ARV and/or TB or other drugs) needs to be taken and for how long
- Benefits of treatment(s) and risks of non-adherence
- Infection control measures at home/community for TB, if applicable

- Danger signs and returning to care:

Use danger signs visual aid and explain that besides scheduled appointments at HC, it's very important to return to HC if the patient experiences any of the following danger signs (= alerting signs of serious Infections):

- Not able to walk unaided or bedridden
- Fever
- Headache
- Confusion
- Difficulty breathing
- Vomiting or diarrhoea that doesn't get better or doesn't stop
- Loss of weight
- Yellow eyes (the white part of your eyes becomes yellow) - for patients on TB treatment

- Adherence plan

- Ensure the plan of action to address adherence issues in the past (prior to hospitalization) is set

and put in place

- Review all steps in the adherence plan (refer to patient’s personal adherence plan). Ensure the new adherence plan is applicable during post-discharge phase and for life
- Encourage patient to continue taking daily ART medication for life (and TB or treatment for other OIs accordingly). Emphasize their health condition is still not stable but with the treatments/prophylaxis and good adherence they will get better

4. Emotional Support

- *How do you feel about continuing treatment at home?*
- *How will you stay motivated to continue treatment when you feel better or in case you get tired of taking medication every day?*
- Review the 3 main reasons to remain healthy and continue treatment

5. Closure of the session

- Ask if the patient has any questions and if so, take time to answer it
- Summarize the short term goals and the 3 month post-discharge plan
- Reinforce and provide motivation: *“You have come this far and I know that you can do this. I am looking forward to hearing from you how things are going on the phone”* AND thank patient

Discharge counselling Checklist Date:

ART number: Health Facility (to be referred):

First name: Last name:

Contact Number:...../.....

Tick (v) the below statements during consultation

| Information / Counselling | Yes | No | Comments (Include feedback given by patients) |
|--|------------|-----------|---|
| Patient is aware of HIV/TB (and other)diagnosis | | | |
| Patient is aware of the treatment <ul style="list-style-type: none"> • Medications& side effects • Ancillary medicines: Cotrimoxazole, Fluconazole... • Appointment (refills) • Diagnostics/lab tests eg: Viral Load, CD4 & Sputum | | | |
| <i>For Co-infected cases:</i> Patient is aware of pill burden but motivated to take treatment | | | |

| | | | |
|--|--|--|--|
| Review of Adherence Plan (<i>with the tool in hand</i>) and if any changes, specify it. | | | |
| Patient understands the importance of adherence in ART/TB treatment & has identified ways to improve adherence. | | | |
| TB patient is aware of Infection Control measures to be practiced at home/community. | | | |
| Patient has identified a Treatment supporter (Specify) (but is not obliged to) | | | |
| Index testing proposed/ offered during hospitalization (Results specify) | | | |
| Family Planning proposed/ offered during hospitalization (Specify which measures) | | | |
| Patient has been informed about: importance of (re)linkage and post-discharge follow up at HC; about phone contact at W2, M1, M2, M3 and about possible tracing Patient is aware of Week 2 appointment date at NDH/other HC | | | |
| Patient understands ART follow up/refills by HC providers are on-going/ for life Approx. date of HC app a/c pill count | | | |
| Patient (and caregiver if possible) is aware of "danger signs" and when/where to seek for medical care, need be | | | |

**If possible, include patient's family during this session*

Action Plan (e.g. when/how to go to HC, possibility to attend W2 post-discharge FU at NDH or other HF, danger signs/return to care...):

.....
.....
.....

Annex 8: example from Nsanje, Malawi on post-discharge follow up calls

Patient's name: MSF ID:

Age: Gender: male / female Nationality:

Address:

Patient's telephone number: Alternative telephone number:

Discharge date: ____/____/____ Health Center patient is referred:

Call 0 (reminder) – due 2 weeks post discharge (____/____/____)

Was patient reached and reminded on his appointment in the Health Center within one month post discharge:

Yes / No, explain: _____

Call 1 – due 4 weeks post discharge (____/____/____)

Date call was made: ____/____/____

1. Has patient been reviewed by a clinician/nurse at HF after discharge? Yes / No
2. How is patient feeling? Healthier than in hospital / sicker than in hospital* / no changes since discharge*
3. Has the patient been readmitted to hospital? Yes / No
4. Vital status: dead / alive
5. Informed by: patient / family member / HF worker / other
6. Self-reported adherence to treatment(s): good – moderate** – poor**

Remarks:

Call 2 – due 8 weeks post discharge (____/____/____)

Date call was made: ____/____/____

1. Has patient been reviewed by a clinician/nurse at HF? Yes / No
2. How is patient feeling? Healthier than in hospital / sicker than in hospital* / no changes since discharge*
3. Has the patient been readmitted to hospital? Yes / No
4. Vital status: dead / alive
5. Informed by: patient / family member / HF worker / other
6. Self-reported adherence to treatment(s): good – moderate** – poor**

Remarks:

Call 3 – due 12 weeks post discharge (____/____/____)

Date call was made: ____/____/____

1. Has patient been reviewed by a clinician/nurse at HF? Yes / No
2. How is patient feeling? Healthier than in hospital / sicker than in hospital* / no changes since discharge*
3. Has the patient been readmitted to hospital? Yes / No
4. Vital status: dead / alive
5. Informed by: patient / family member / HF worker / other
6. Self-reported adherence to treatment(s): good – moderate** – poor**

Remarks:

* Please refer patient to be seen by a HCW. Inform health centre

** If adherence is not good, please explain further in remarks. (What is the issue, what action was taken i.e. refer to HCW, home visit...?)