Counseling Support for Persons with Rifampicin–Resistant TB Receiving Bedaquiline: A Successful Model from Khayelitsha, South Africa
Abstract 229
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Background

- Population ~ 500,000
- 50% live in informal dwellings
- ~200 rifampicin-resistant TB (RR-TB) cases diagnosed each year (75% HIV infected)
- 90% initiate treatment
- High seasonal migration area
Why is patient support Imperative?

Injectable phase

Continuation phase

2 year journey
The Traditional khayelitsha model

MDR Treatment start

Session 1
Facility Counselor

<1 week later

Session 2
Facility Counselor

<1 month later

Session 3/ Home Visit
District DR TB Counselor

2nd line DST result

XDR session
MSF DR TB Counselor

End of Intensive phase

Specialized Palliative Care Support
MSF DR-TB counselor

Session 4
District/ MSF DR-TB counselor

Self-administered of treatment

Adherance session
MSF DR-TB counselor

Newly Diagnosed HIV infection

ART Counseling
To start in 2 weeks

Injectable phase

Continuation phase

General palliative care, Psychosocial support, Monthly clinical monitoring and management

Treatment interruption > 2 weeks at any point through treatment

Treatment interruption session
MSF DR TB Counselor

Treatment interruption follow up
MSF DR TB Counselor/TB Nurse
Support process with new regimens

Regimen inadequate

- Resistance profile
- Adverse events
- Side effects

New strengthen regimens may include:
- Linezolid
- Bedaquiline
- Delamanid
Support process

Breaking News
- Break News
- Treatment literacy

Consent

Support
Results of patients started on BDQ

6 month interim outcomes

- Still on treatment: 66
- Loss from Treatment: 1
- Died: 2
- Transferred: 1

Number of RR-TB patients
Recommendation

• A comprehensive patient support approach with the introduction of new medications is essential to enhance adherence

• Adequate patient centered support requires adequate and appropriate human resources that speaks to the local context and patient needs
Acknowledgements

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