



# **ART ADHERENCE** **CLUB REPORT AND TOOLKIT**



Updated October 2014





# 1.

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MSF acknowledges the following partnerships that contributed significantly to the ART adherence club model pilot:



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## ART ADHERENCE CLUBS: AN OVERVIEW





## 1.1 WHY ART ADHERENCE CLUBS?

South Africa's National Strategic Plan 2012-2016 targets:

- 80% of all patients eligible on ART by 2016:  
estimated at more than 3 million patients
- 70% retained in care 5 years after treatment initiation

By mid 2014, approximately 2.4 million patient were initiated on ART with retention in care estimated at 62% at 4 years.

### HEALTH SYSTEM PERSPECTIVE

“Ensuring patients get started on ARVs has motivated me to keep working in the public sector but the clinic I work in is stretched to capacity. My day is spent seeing many patients who are otherwise well and stable on treatment. My time would be more usefully spent focusing on starting new patients on ART and giving more time to my patients who are not doing well on their treatment”.

(Dr Musaed Abrahams – 2007 Ubuntu clinic, Khayelitsha)

South African health facilities have done an incredible job escalating ART initiation over the last 5 years but they do not have the necessary capacity to double their patient loads while managing an increasing number of patients at risk of failing their treatment. As the pressure on the health system increases, retention in care and adherence of patients on ART decreases.

### PATIENT PERSPECTIVE

“I started ART 8 years ago and each month I had to take a day off work to come to the clinic, to spend a few minutes with a nurse who tells me I am well and can collect my ART supply. My boss thinks I am making excuses and that I do not want to work. I am worried that he will find a reason to replace me with someone who comes to work every day, I don't know what to do, I want to take my ARV treatment but how?”

(Bonelwa Nukwa - on treatment since 2004, before joining a club in 2007)

Adherent stable patients need quick access to ART supply with access to clinical care if needed so that they can continue their lives while managing their HIV – working, supporting their families and achieving their goals.

Médecins Sans Frontières (MSF) has piloted various community models to bring long term models of care closer to patients' homes. These models differ in each context and include the ART adherence clubs piloted in Khayelitsha, South Africa and the Community ART Group model piloted in Tete, Mozambique. Outlines of these models are detailed in MSF 2013 report: Reaching Closer to Home: Progress implementing community-based and other adherence strategies supporting people on HIV treatment. Experiences from DRC, Lesotho, Malawi, Mozambique, South Africa & Zimbabwe (<https://www.msf.org.za/msf-publications/reaching-closer-to-home>)



## 1.2 ART ADHERENCE CLUBS IN A NUTSHELL

ART adherence clubs (ART clubs) are a long term retention model of care catering for stable ART patients. 30 stable patients meet and are facilitated by a lay healthcare worker who provides quick clinical assessment, referral where necessary, peer support and distribution of pre-packed ART every 2 months. Once a year, a clinician provides follow up clinical management.



### COUNSELLOR/ PEER EDUCATOR RUN

Every 2 months

1. Quick clinical assessment
2. Collection of 2 month ART supply
3. Quick optimized group support
4. Simplified monitoring

See ART club short film - Annexure 1.

### NURSE SUPPORTED

Once a year

1. Blood taken for CD4 and viral load
2. Clinical consultation with clinician

## 1.3 ART CLUB OUTCOMES

ART clubs were piloted by MSF with support from the Western Cape Department of Health (WCDOH) and the Treatment Action Campaign (TAC) in a large community health centre ART site in Khayelitsha, Cape Town. The pilot demonstrated that club participation was associated with sustained virological suppression and immunologic recovery. Over 40 months, 97% of club patients remained in care compared to 85% of those who qualified for clubs but remained in mainstream care. Club participants were also 67% less likely to experience virological rebound, indicating better adherence in clubs compared to mainstream care.



For details of outcome analysis see Annexure 2



## 1.4 BENEFITS OF ART CLUBS

### HEALTH FACILITY AND SYSTEM

1. Reduces patient load in mainstream care
2. Increases available capacity for clinicians to initiate new patients on ART and manage clinically unstable patients and patients at risk of failing ART
3. Can reduce pharmacy load by utilising central dispensing service for pre-packing

### PATIENT

1. Easier and quicker to access continued ART supply
2. Creates opportunity for establishing group dynamic and peer support
3. Empowers patient through self management
4. Provides community network for tracing patients not attending their club
5. Ensures continued access to clinical care and support through appropriate referral mechanism
6. Improves retention in care and virological outcomes

The club model further provides cost savings to both the health system and the patient by utilising non-clinical staff, reducing clinician time necessary to manage repeat ART follow up consultations and reducing frequency and time spent by patients at clinics.

## 1.5 FEASIBILITY OF SUB-DISTRICT LEVEL IMPLEMENTATION

The ART club model was adopted for phased roll out by WCDOH in the Cape Metro including throughout Khayelitsha. For description of implementation process see Annexure 3.

From January 2011 to end June 2014, 7694 (26.3%) and 27 800 (24%) of all ART patients retained in care in Khayelitsha and the entire Cape Metro respectively were receiving their care through ART clubs

The partnership of WCDOH, City Department of Health, MSF and the Institute for Health Improvement won a 2012 platinum Award from the prestigious Impumelelo Social Innovations Centre for the adopting and implementing this innovative approach to managing large numbers of HIV patients taking ART.



### INCREASING THE BENEFITS

Changing the club model to allow for 3 month rather than 2 months supply will further optimise benefits outlined above.

Since 2013, we have used Fixed Dose Combinations (FDCs) which has considerably reduced the burden placed on clinic pharmacies to pre-pack or check pre-packs from the central dispensing service.

Community clubs taking place in patients' homes and community venues close to home have increased members ownership of their club and mutual responsibility for each other's wellbeing. Such clubs also promote HIV awareness and contribute to de-stigmatization of HIV within communities (see pg 32).





# 2.

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- 2.1.2 Who is eligible to enter an ART club?
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# HOW TO IMPLEMENT ART CLUBS IN YOUR FACILITY: A PRACTICAL GUIDE

## 2.1 CLUB BASICS

### 2.1.1 CLUB ORGANOGRAM - ROLES & RESPONSIBILITIES



FACILITY MANAGER



CLUBS MANAGER (NURSE)



CLUBS FACILITATOR



CLUB PROFESSIONAL NURSE



PHARMACIST + DATA CAPTURER

#### CLUBS MANAGER

Nurse responsible for the activities required to run successful ART clubs.

The Clubs Manager is responsible for:

1. ensuring facility clubs team in place
2. ensuring Club Standard Operating Procedure (SOP – Annexure 4) is being carried out including recruitment, club preparation, club sessions, clinical governance, club follow up, club patients returning to mainstream care
3. scheduling annual return dates for club visits
4. ensuring 6 monthly scripting of club patients
5. overview of clubs outcomes – new clubs, new enrolments, retention in care
6. clinical oversight of clubs
7. responsible for completing monthly clubs stat sheet for submission to facility manager
8. keeps facility manager updated on clubs progress in the facility

**Not present at club sessions unless support has been specifically requested by club facilitator.**

**This is a part-time role, depending on the number of clubs could be undertaken by an existing nurse.**

#### CLUBS FACILITATOR

Counsellor/Peer Educator responsible for preparing and running the club sessions.

The Clubs Facilitator is responsible for:

1. preparing for the club session including ensuring ART pre-packs are ordered and ready for the club session
2. running session on club visit date:
  - registers members
  - conducts support/education group
  - conducts symptom screening including taking weight
  - refers patients to Club nurse – sick/ blood/ clinical visit
  - distributes ARV supply
  - completes registers
3. after club management: returning uncollected ART pre-packs to pharmacy and following up patients who missed session

**Always present as facilitating club sessions.**

#### CLUB PROFESSIONAL NURSE

The Club nurse is responsible for clinical oversight of a club on the day of the club session.

**Not present at club sessions but available during or after club session to see symptomatic patients, take bloods and conduct annual clinical consultation.**

#### FLEXIBILITY OF MODEL FOR DIFFERENT CONTEXTS

While in Khayelitsha - South Africa, nurses carry out the Clubs Manager role, management of the clubs is not complex and could feasibly be managed by more junior clinical staff, an administrative function or a local NPO.

#### PHARMACIST

Pharmacist/Pharmacy assistant is responsible for pre-packing ART for clubs

In case of using central dispensing service ensuring scripts are submitted and pre-packs received and correct.

**Not present at club sessions.**

#### DATA CAPTURER

Data Capturer is responsible for capturing club patient visits from club register into facility electronic register

**Not present at club sessions.**



## PLANNING SUFFICIENT POSTS TO CAPACITATE THE CLUB MODEL

The club model promotes efficiencies within the ART service. However, it is essential that a facility's ART cohort which is divested into the club model remain the responsibility of the ART service. This requires sufficient human resources to run clubs. Clinics cannot be expected to utilise current staffing in the long term with increasing club expansion.

From our experience in Khayelitsha, where a facility rolls out more than a few clubs, club preparation and facilitation becomes a substantial role. Utilising existing facility counsellors jeopardizes their responsibilities towards ART preparation counselling, counselling non-adherent patients and tracing defaulters. Similarly, increasing the number of patients requiring ART supply puts increasing pressure on pharmacy staff.

MSF strongly recommends that additional Clubs Facilitator and pharmacy assistant posts need to be created and funded either within the facility, primary healthcare team or NPO organograms based on the number of clubs run by the facility or within the feeder community.

### MSF RECOMMENDS:

**1.** Clubs Facilitator – Counsellor/Community health worker (CHW) level non medical staff

- 0 – 8 clubs: use current clinic staff
- 8 – 40 clubs: add 1 extra counsellor/CHW
- > 40 clubs: add 2 extra counsellors/CHW

**2.** Pharmacy assistant:

- 0 – 8 use current pharmacy staff
- > 8: add 1 extra pharmacy assistant

**3.** Additional Nurses and Data clerks according to facilities total patients retained in care including club patients.

## 2.1.2 WHO IS ELIGIBLE TO ENTER AN ART CLUB



The club model intends to benefit stable ART patients that are clinically well and adhering to their treatment. Clinicians determine whether a patient qualifies for clubs applying the following criteria:

- 1.** Adult patient (more than 40kgs – no longer requiring dosage change according to weight change).
- 2.** On the same ART regimen for at least 12 months (regimen 1 or 2).
- 3.** 2 most recent consecutive viral loads undetectable.
- 4.** No medical condition requiring regular clinical consultations.





## 2.1.3 CLUB SESSIONS PLANNING

Club sessions are structured to ensure that blood investigations, an annual clinical consultation and twice annual scriptings are aligned for all club patients. This optimises efficiency and allows the facility to plan when additional nurse support will be required.

Visit no.	Type of club visit	Activities	Script
Month -1		Recruitment + clinician scripting for 3 months	1 month supplied by pharmacy
Month 0	Enrolment visit	Scripting for 6 months	1 x 2m pre-packed
Month 2	Routine visit		1 x 2m pre-packed
Month 4	Blood visit	Bloods taken	2 x 2m pre-packed
Month 6	Clinical visit	Clinical consultation + Re-scripting for 6 months	3 x 2m pre-packed
Month 8	Routine visit		1 x 2m pre-packed
Month 10	Routine visit		2 x 2m pre-packed
Month 12	Re-scripting visit	Re-scripting for 6 months	3 x 2m pre-packed

See Annexure 5 for full 36 months and Annexure 6 for clubs with central dispensing service support.

## 2.2 CLUB PLANNING AND SET-UP IN YOUR FACILITY

### 2.2.1 ENSURE BUY-IN OF ALL FACILITY STAFF

ART club patients are still facility patients and all staff involved in routine ART patient care remain responsible for their care. Sustainable clubs in a facility are dependent on:

1. Facility manager taking ownership of the ART clubs as part of the facility's ART service. This is supported by the facility manager's responsibility for submission of monthly club indicators to the sub-district.
2. Clinicians continuing to see club patients who visit the clinic outside of the club session with health complaints just like any other facility patient.
3. Pharmacy continuing to take responsibility for providing club patients with their ART supply (even when utilising a central dispersing service).
4. Data capturers continuing to ensure that these patients' club attendance and clinical information is captured otherwise club patients are reflected as lost to follow up.

### LESSONS LEARNT

There is a risk that if not all facility staff buy into implementing clubs as part of the facility's ART service, the club patients will be regarded as the sole responsibility of the Clubs Facilitator and Clubs Manager.

"I am frustrated that my colleagues now refer every club patient with a problem to me. We all used to manage these patients when they queued at the clinic to see us, but now, because I led the set up of clubs in my facility, my colleagues see all these patients as my patients. I should emphasize that all these patients, are all of our patients. I like the idea of nurses rotating as the club professional nurse each day, this will help my colleagues to take ownership of clubs, so we all know what is happening and expected, and this will mean we can set up more clubs."

Sister Popi Faltein - Matthew Goniwe Clinic



## 2.2.2 CLUB MEETING SPACE

This varies from facility to facility depending on available infrastructure space.

### OPTIONS WITHIN FACILITIES:

1. Support group room
2. Outside courtyard or NPO structure on clinic premises
3. General waiting area if club meets before clinic officially opens or after clinic officially closes
4. Reducing size of club if no available space to accommodate 30 people

### OUT OF FACILITY OPTIONS:

Clinics have utilised public buildings close to the clinic which can still be supported by staff walking from the clinic. These include:

1. a room at the local public library
2. a church hall
3. a building used by clinic outreach teams

## LESSONS LEARNT

### UBUNTU COMMUNITY VENUE EXPERIENCE

Ubuntu – Site B CHC, Khayelitsha’s largest ART site, moved 23 of its clubs to a large room at the local library, 500m from the facility.

These clubs are run in the same way as the facility based clubs with the same staffing responsibilities as described. The drug supply is carried by the Clubs Facilitator from the facility pharmacy to the library in the morning and the unclaimed drugs are brought back after the club session. All club sessions take place in the community venue with completion of the club register. The club nurse takes the bloods at the blood visit at the library. The clinical visit club session is held at the facility annually as the patients are each seen for review by the club nurse. Where a patient is symptomatic at a routine club visit, the patient is referred to the club nurse who is available at the facility to see the club patients.

## 2.2.3 SCHEDULING OF CLUB DATES

When implementing clubs, the Clubs Manager needs to determine how many clubs will be implemented over a given period and schedule the first and subsequent club session dates accordingly. It makes it simpler for the Club staff if these dates are reflected both in a table format for the remainder of the year designating blood, clinical and scripting visits. Clubs Facilitators benefit from a simple monthly planner (see example in Annexure 7).

TUES	FRI	MON	FRI
Club 1	Club 2	Club 3	Club 4
2011/11/01	(B) 2011/12/09	2011/12/12	
2011/12/11			
2012/01/24	(C/S) 2012/02/03	2012/02/06	2012/02/10
(S) 2012/03/20	2012/03/30	(B) 2012/04/02	(S) 2010/04/13
2012/05/15	2012/05/25	(C/S) 2012/05/28	2012/06/08
(B) 2012/07/10	(S) 2012/07/20	2012/07/23	(B) 2012/08/03
(C/S) 2012/09/04	2012/09/14	2012/09/17	(C/S) 2012/09/28
2012/10/30	(B) 2012/11/09	(S) 2012/11/12	2012/11/23
2013/01/22	(C/S) 2013/02/01	2013/02/04	2013/02/15

B = blood visit  
C = clinical visit  
S = scripting visit

Remember that the more clubs the facility implements, the more complex this scheduling becomes and the risk for clubs coinciding in future months if not planned carefully, increases.



## LESSONS LEARNT

Try to space out your first clubs. If you put them all in a 2 week period, it means that going forward, those clubs will always have their blood visit, clinical visit and scripting visit in the same week or month.

“Try to space out your clubs over the weeks and months. What happened when we started clubs at one of our first large facilities is that we started four clubs in the first week, and then a further four clubs in the second week. This meant that months down the line, there were weeks when all club members needed their bloods taken, or all needed a clinical visit. Obviously this put a great amount of strain on the functioning of the rest of the clinic!

On the basis of this experience, we would advise that you spread out your first clubs over the weeks, and the months - depending on the number of clubs you need to have. A busy site might start one club each week for 8 weeks, before adding a second club per week. On the other hand, a smaller site might start a club in week 1 and week 5, followed by week 3 and 8 - thus spreading the clubs over the weeks, and the months.”

Dr Carol Cragg, HAST Medical Officer Khayelitsha



## 2.2.4 RECRUITMENT

### PATIENT EMPOWERMENT

Quick scale up of clubs relies on patients understanding the benefits of belonging to clubs. Patients will be then be empowered to request their clinician to consider his/her eligibility for clubs. Use peer educators or counsellors to create awareness of the clubs and their benefits amongst ART patients in the waiting room. Club posters and patient information pamphlets can also be used. See examples attached in Annexure 8 and 9.

### CLINICIAN ROLE

Clinicians are required to assess a patient's eligibility for clubs and if a patient meets the requirements, refer them to the appropriate person in the facility responsible for booking the patients into new clubs. Clinicians can support club set-up in the faculty by discussing with patients who meet the criteria.

### CLUB ALLOCATION

Each facility has a different approach to booking/allocating patients to a club during the recruitment process i.e. before the first club session. A facility has to determine the staff member responsible for this process depending on their daily availability for managing this process. Possible options are:

1. Clubs Facilitator (if at the clinic each day)
2. Facility clerk/counsellor
3. Clubs Manager (this is a nurse/doctor and this person may be busy with other patients)

The patient will be referred to the appropriate booking person who then requires an appropriate tool to allocate the patient to the club to monitor when the club is full. See example in Annexure 10.

## LESSONS LEARNT

High retention in care is attained where patients choose to manage their chronic HIV through the club system. It is not advisable for a facility to allocate patients to clubs based on the patient meeting the criteria .

This may mean slower initial enrolment but our experience in Khayelitsha shows patients very quickly see the benefit of clubs and a waiting list for clubs soon develops.



## 2.2.5 HOW TO RUN CLUBS

A detailed description of preparing for and running the clubs (including daily activities) is contained in the SOP attached as Annexure 4. A summary is set out below.

### 2.2.5.1 PREPARATION

#### PREPARATION FOR THE FIRST CLUB

1. All club patients' scripts are taken from the patient file and placed in the club file. The club file is then sent to the pharmacy for pre-packing the 2 months supply of ART. It is important to set the time period with the pharmacy that the pharmacy needs to pre-pack i.e. 1 - 3 days before the club session.
2. A blank club register is available
3. 30 clinic scripts are available for completion with patient stickers
4. All the patients' files are pulled for purposes of scripting

#### PREPARATION FOR ROUTINE, BLOOD AND CLINICAL CLUB VISITS

1. Club file goes to pharmacy in time for pre-packing.
2. Clubs Facilitator collects pre-packed ART from pharmacy on the morning of the club session.
3. The club register is ready for the club session.
4. Blood visit: appropriate blood forms have been completed by the club facilitator.
5. Clinical/Scripting visit: patient files are drawn for the clinician to see the patient and complete a further 6 month script. For the clinical visit, the blood results of the patient need to be included in the patient file for clinician review.

### 2.2.5.2 RUNNING THE CLUB





### ADDITIONAL ACTIVITIES FOR SCRIPTING, BLOOD AND CLINICAL VISITS

- 1. AT THE FIRST CLUB VISIT:** Club nurse scripts all the patients who attended the club using their patient files. These scripts then replace those in the club file. The Club facilitator clearly marks on the front of the patient's file that the patient is now a club patient reflecting the Club number on the front of the patient's file and on patient-held card.
- 2. AT BLOOD VISIT:** Club nurse takes all club patients' routine annual blood investigations, irrespective of how recently the routine bloods were taken in order to align all the club patients going forward.
- 3. AT CLINICAL VISIT:** Club nurse sees each patient with the patient's blood results for their annual clinical review (see Annexure 11 for annual clinical review SOP).
- 4. AT SCRIPTING VISIT:** Club nurse scripts the patients every 6 months. One out of the two annual scripting visits coincides with the clinical visit.

### 2.2.5.3 AFTER CLUB SESSION

- 1. Clubs Facilitator returns the unclaimed ART pre-packs to the pharmacy for those club patients that did not attend (or send a buddy) to the club session.**  
(In some facilities, the Clubs Facilitator/Clubs Managers keeps uncollected ART for the grace period in locked cupboard in Clubs Manager's consultation room or support group room)
- 2. GRACE PERIOD:** Each facility should determine the appropriate grace period to be given to club patients and whether the Clubs Manager or the Clubs Facilitator will manage the grace period. If the patient arrives during the grace period, the patient remains in the club and the register is completed by the person managing the grace period. The patient is sent to the pharmacy to collect their pre-packed ART supply.
- 3. AFTER THE GRACE PERIOD:** The Clubs Facilitator follows up the patients that did not come within the grace period using the register. When the patient comes to the clinic after the grace period, the patient is referred to the Clubs Manager who will return the patient to mainstream care.

### LESSONS LEARNT

In Khayelitsha, the grace period was initially set at five days. While patients were not routinely informed of the grace period, patients quickly learnt the flexibility and in certain facilities started abusing the club system. Where club patients come individually, the benefits of the club system for reducing the workload at the facilities is largely diminished. Facilities are now considering shortening the grace period and also removing patients from the clubs where a patient consistently abuses the grace period.

"We are going to meet as a club team and decide our grace period but we are also going to be stricter with our club patients to stop them coming each time after the club session. They will need to see the Clubs Manager when they are late. The club is a privilege and some patients are abusing it, this takes away a place in a club for a patient that will not abuse it."

Sister Langa - Nolungile CHC, Khayelitsha



## 2.2.5.4 CLUB ATTENDANCE

Club patients are allowed to send buddies to collect their treatment from the club if they are unable to make the club session. A buddy cannot be sent to the blood or clinical visits and should not be allowed at consecutive visits.

## 2.2.5.5 CLINICAL OVERSIGHT

### OVERVIEW

On each day that a club meets, a nurse at the facility needs to be rostered as the club nurse. On the day of a routine club session, he/she will continue to see clinic patients but will be available to see any sick club patient referral immediately after the club session. As the clubs are meant for stable patients there should be very few patients who need to see a clinician.

Where it is a blood, clinical or scripting visit, the allocated nurse will have an increased workload for the day and will need to plan his/her day accordingly. The patients will complete the club session and then see the nurse either for their bloods to be taken or for their clinical visit.

During the clinical visit, the nurse should ensure the prescription remains appropriate. The scripting process can be completed after the club session once the clinic quietens down.

### WHEN ARE CLUB PATIENTS REMOVED FROM THE CLUB TO RETURN TO MAINSTREAM CARE?

Clubs are a model of care for stable adherent ART patients. Where a patient is no longer stable or is missing club sessions, he/she no longer qualifies for clubs and should be removed from the club.

### CLUB MEMBER HAS DEFAULTED BY MISSING A CLUB SESSION:

Where a club patient has not sent a buddy to collect treatment and has not arrived at the facility within the grace period, the patient will be referred to the Clubs Manager. The Clubs Manager will inform the patient that the patient will return to mainstream care so that he/she can receive increased support and clinical attention.

### CLINICAL REASONS:

Club patients with significantly abnormal blood results including high viral loads should be followed up by the facility's routine red flagging and follow up system. Ideally a club patient is followed up prior to their clinical visit. At the very latest, 2 months after the bloods have been taken, the abnormal result should be acted upon by the club nurse at the annual clinical visit.

A club patient will no longer be eligible for the club if the club nurse or another facility clinician determines that the patient has:

- a viral load is above 400
- other safety blood results significantly abnormal
- developed TB
- a change of ART regimen for clinical reasons
- other indications assessed in individual annual clinical follow up.

The clinician will inform the patient that they can no longer be in the club until the patient has become clinically stable again. The clinician will give the patient an appropriate return date and will send the patient to inform the Clubs Manager/Facilitator that the patient has been removed from the club. This must clearly be indicated on the patient's file and patient card by crossing out the club number reflected.

The Clubs Facilitator will indicate in the club register that the patient is no longer a club member by reflecting 'BTC - Back to Clinic' in the club register.

### CLINICIAN DISCRETION TO RE-ENROL:

Where a patient has been returned to mainstream care for clinical reasons, any facility clinician can determine when a patient may re-enrol in the club system. The patient may not need to meet the eligibility criteria again. The patient will then be regarded as a new club patient from a monitoring and evaluation perspective.



## 2.2.5.6 MONITORING OF CLUB PATIENT AND CLUB OUTCOMES

Patient files are not drawn other than at the clinical or scripting visit. Each club has a club register which is completed by the Clubs Facilitator, in which a patient's club attendance is recorded for each club session

The club register template is attached as Annexure 12.

The register reflects limited patient indicators for each club session, namely:

1. Patient weight
2. Where patient is asymptomatic – reflect 'N – no symptoms'
3. Where patient is symptomatic – reflect 'RTC – refer to clinician'

Club : .....		Club manager: .....				Standard Session (Month 0)		Standard Session (Month 2)	
Sticker	Phone Number Private (PVT) or Shared (S)	Drug Regimen		Weight (W)	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome
Place Patient sticker here. Or write Folder number First Name, Last Name Gender, Date of Birth				Write patient's cell phone number	ART drugs	Weight (W)	Weight or outcome	Weight or outcome	Weight or outcome
				Write "PVT" or "S"	Date of ART start	Symptoms (S)	N or RTC	N or RTC	N or RTC
300005436 BIZIKALA TOLOMINTA Female, 01/05/1977	078195628	DYT, JTC, EFV	W	75	67				
	PVT	24/10/2005	S	N	RTC				

Where the patient sends a buddy, 'buddy is completed in the weight field'

Club : .....		Club manager: .....				Standard Session (Month 0)		Standard Session (Month 2)		Bloods taken (Month 4)		Results CD4 VL	
Sticker	Phone Number Private (PVT) or Shared (S)	Drug Regimen		Weight (W)	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Lab Results CD4 count	Viral Load
Place Patient sticker here. Or write Folder number First Name, Last Name Gender, Date of Birth				Write patient's cell phone number	ART drugs	Weight (W)	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Lab Results CD4 count	Viral Load
				Write "PVT" or "S"	Date of ART start	Symptoms (S)	N or RTC	N or RTC	N or RTC	N or RTC	N or RTC	Viral Load	
886669034 MURIKA FUJIZIKO Female, 11/11/1962	0825659076	TDF, JTC, EFV	W	81	BODDY	66	500						
	S	13/09/2008	S	N									

Where a patient does not come to the club session or within 5 days grace period, the register will be marked "DNA" for did not attend in the weight block.

Club : .....		Club manager: .....				Standard Session (Month 0)		Standard Session (Month 2)		Bloods taken (Month 4)		Results CD4 VL	
Sticker	Phone Number Private (PVT) or Shared (S)	Drug Regimen		Weight (W)	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Lab results CD4 count	Viral Load
Place Patient sticker here. Or write Folder number First Name, Last Name Gender, Date of Birth				Write patient's cell phone number	ART drugs	Weight (W)	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Lab results CD4 count	Viral Load
				Write "PVT" or "S"	Date of ART start	Symptoms (S)	N or RTC	N or RTC	N or RTC	N or RTC	N or RTC	Viral Load	
6866669034 MURIKA FUJIZIKO Female, 11/11/1962	0825659076	TDF, JTC, EFV	W	81	DNA	/	/						
	S	13/09/2008	S	N		/	/						

The Club Facilitators will also reflect where a patient has been removed from club care. It is important to note that the patient's removal from the club is only reflected at the club visit where the patient is no longer at the club.

In the example below in Month 8 the patient is Referred to Clinician (RTC), the clinician returns the patient to mainstream care, in Month 10 the patient is no longer attending the club and is reflected as Back to Clinic (BTC).

Club : .....		Club manager: .....				Standard Session (Month 0)		Standard Session (Month 2)		Bloods taken (Month 4)		Results CD4 VL		Clinical Consult (Month 6)		Standard Session (Month 8)		Standard Session (Month 10)			
Sticker	Phone Number Private (PVT) or Shared (S)	Drug Regimen		Weight (W)	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome		
Place Patient sticker here. Or write Folder number First Name, Last Name Gender, Date of Birth				Write patient's cell phone number	ART drugs	Weight (W)	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Weight or outcome	Lab Results CD4 count	Viral Load	N or RTC	N or RTC	N or RTC	N or RTC	N or RTC	N or RTC	N or RTC	
				Write "PVT" or "S"	Date of ART start	Symptoms (S)	N or RTC	N or RTC	N or RTC	N or RTC	N or RTC	N or RTC	N or RTC	N or RTC	N or RTC	N or RTC	N or RTC	N or RTC	N or RTC	N or RTC	
886669034 MURIKA FUJIZIKO Female, 11/11/1962	0825659076	TDF, JTC, EFV	W	81	BODDY	66	500	83	88											BTC	
	S	13/09/2008	S	N																	

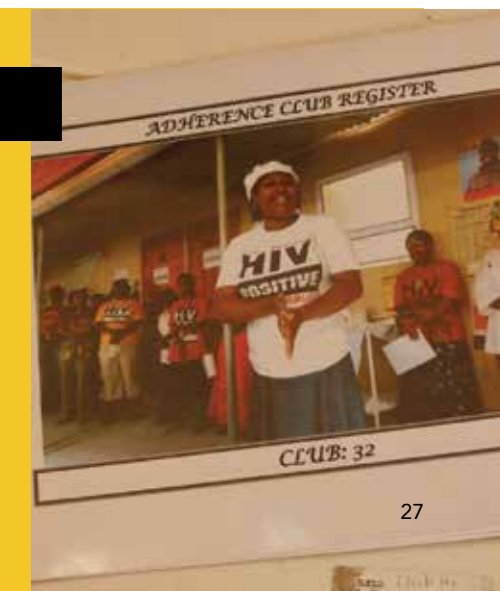
The club register is given to the facility data capturer after the completion of the grace period to capture into the clinic's regular ART register that the patient attended their ART repeat visit. The data capturer needs to sign at the bottom of the club session column that patients club visits have been captured.

The Clubs Manager should review the Club registers to ensure:

- ✓ they are completed correctly and completely
- ✓ patients with symptoms referred to club nurse
- ✓ VL/CD4 taken and completed in register
- ✓ annual clinical consult taken place and high VLs actioned by club nurse
- ✓ defaulters sent back to mainstream care
- ✓ register captured by data capturer

## LESSONS LEARNT

Ensure that the club registers reach the data capturers. Where the facility defaulter list suddenly increases with club patients or the facility retention in care numbers suddenly drop, check that the data capturer is timeously capturing the club registers.





## 2.2.5.7. CLUB OUTCOME INDICATORS

### FACILITY LEVEL

The appropriate club outcome monitoring process is dependent on whether the facility is utilising an electronic register or not and whether that electronic register has fields that can be adapted for capturing club attendance such as a sub-facility field.

Where the facility is using tier.net or eKapa, recent versions of both have the functionality to track club outcomes. The data capturer will be required to capture the patient's club at each visit.

The Clubs Facilitator and Clubs Manager could then be provided with a monthly report from the electronic register/database providing an overview of each of the facility clubs including number of patients that did not attend (DNA), referred back to clinic (BTC) care, patients who died or transferred out, new club enrolments, club retention in care.

Where a facility does not have an electronic register that is able to manage clubs and track club outcomes, a facility can utilise two paper based tracking tools:

1. Club tally sheet which provides an overview of the specific club
2. Facility clubs monthly report which provides an overview of all the facility clubs at month end

Templates are attached as Annexure 13 and 14.

### CLUB TALLY SHEET

The club tally sheet forms part of the club register and is completed by the Club's Facilitator after the end of the grace period so that those that did not attend can be noted.

The Clubs Manager should review the Club tally sheet when compiling the Clinic Clubs monthly report to ensure:

- ✓ completed by end of the month
- ✓ correctly completed
  - no recording of an event that occurred in previous month
  - RIC from previous month (+) new (-) club leavers
- ✓ check overall state of club
  - Is there a high number of DNAs/BTCs?
  - Does the club require further recruitment to fill?

### FACILITY CLUBS MONTHLY REPORT

The Clubs Manager completes the monthly report using the tally sheets at the back of each club register.

Important points to note when completing this report:

- ✓ RIC = RIC previous month (+) new (-) club leavers
- ✓ complete all clubs in the report irrespective of whether the club met in the current month or the previous month to ensure total RIC is correct
- ✓ where the club met in the previous month, only record RIC - no other indicators as these were recorded in the previous month

The Clubs Manager uses this report as a management tool to keep track of number of defaulters, patients referred back to mainstream care, patients who died or transferred out, new club enrolments, club retention in care. This tool also provides useful information to the clinic's management staff and should be reviewed monthly along with other monthly reporting of ART outcomes.

In Khayelitsha, we set the target of 30% of the total ART retained in care cohort across the facilities.

Clinics with ART clubs	RIC	Club RIC End Aug 2012	% of RIC
11	29208	7694	26.3%

### SUB-DISTRICT LEVEL

#### TARGETS AND INDICATORS

Where a sub-district rolls out clubs as part of their ART service, it should set a target for the number of its total ART cohort that it aims to enrol in the club model. It will require 2 indicators to track the achievement of this target and the quality of the model:

1. Number of patients enrolled in clubs in the facility
2. Number of patients retained in the facility clubs

Where the electronic registers have the required functionality to track clubs, this functionality can be utilised for sub-district reporting of club indicators.

Where there is no electronic register or it does not have requisite functionality, the Clubs Manager should submit the Facility Clubs monthly report to the Facility Manager at the end of each month and it should be submitted along with other reports to the sub-district.



## 2.3 OTHER TYPES OF CLUBS

### 2.3.1 FAMILY CLUBS

These clubs provide the same club service to all stable members of a family including a child. The club model is the same other than that child/adolescent ART supply cannot be pre-packed (under the weight of 40kg ART dosages need to be reassessed at each visit depending on weight).

The children/adolescent members of the club:

1. are weighed at the start of the club visit to determine the appropriate dosage
2. the Club nurse needs to prescribe the appropriate dosing
3. the scripts have to go to the pharmacy to pre-pack while the club session is being conducted
4. the Clubs Facilitator will collect the children/adolescent pre-packs to distribute with the adult pre-packs at the end of the club session

### 2.3.2 EVENING CLUBS

These clubs cater for the needs of working ART patients who cannot attend the clinic or clubs during the working day.

The clubs are run in the same way as the club described above. However, the following needs to be considered for after hours clubs:

1. Club Facilitator working extended hours
2. A clinician working extended hours at blood/clinical visit. At routine visits only for a short period after club session begins for any symptomatic patient.

### LESSONS LEARNT

Ubuntu after hour club

“Our patients really value our after hours clubs. We started these clubs in October 2011, and in 8 months, we already have 15 after hours clubs with many of our patients waiting for more of these clubs to be set up. We can’t keep up with the demand.”

Nompumelelo Mantangana – Facility Manager, Ubuntu ART site, Site B, Khayelitsha

### 2.3.3 YOUTH CLUBS

#### UTILISING CLUB MODEL FOR ART INELIGIBLE OR UNSTABLE PATIENTS

While the club model rolled out in Khayelitsha has focused on providing long term care to stable adherent patients, MSF is also piloting youth clubs for adolescents which include ART ineligible, newly ART initiated and stable ART patients within a single club. The newly initiated patients see the clinician immediately after the group for their ART supply and appropriate clinical follow up. ART ineligible patients benefit from learning from their peers on ART increasing the likelihood of linkage to treatment when required in the future. Family planning follow-up is integrated into the model.





## 2.3.4 COMMUNITY CLUBS

MSF with health authority buy-in started piloting fully decentralized community ART clubs in Khayelitsha. These clubs meet in patients homes or in community venues close to homes. The home club size is reduced to a total of 15 patients to be accommodated in small residences.

Once a year, the club session moves to the clinic for the clinical visit. At the visit before, club patients are given blood referral slips at their club meeting. They can attend the clinic at anytime within the following month to have their bloods taken at the clinic. The referral slip entitled the club patient to have their blood drawn immediately without queuing or having their file drawn.

When patients are recruited to clubs in the facility and they reside in the community club designated areas, they are provided with the option to join a facility based club or their community club close to home. The first community club meeting is held at the facility, where the group decides on an appropriate venue for their club meetings. Club members can volunteer to host the club in their home.

### LESSONS LEARNT SO FAR

1. There has been good uptake of the community club option
2. Patients who attend the club the first time often report knowing other people from the same area that attend the clinic for ARVs. They ask whether these people can also join the club. The Clubs Facilitator refers the person to a clinician to determine eligibility and then ensures allocation to the same community club.
3. It may therefore be appropriate not to recruit a full community club initially but start with a small number as this allows the club to form with some members already knowing each other, strengthening the peer support component.

### FACILITY CLUB PLANNING CONSIDERATIONS FOR FUTURE COMMUNITY CLUBS

Where clubs are first started in the facility, there are considerations that should be taken into account when setting up facility based clubs that will make it easier to later decentralise into the community. The most important of these is to designate a facility club with a specific feeder geographical area. All club members for that club have to reside in the specified geographical location. This will ensure that the entire club can be relocated to a community venue.



Different settings will need to take different considerations into account to determine a feasible model of care for community based ART clubs including:

- Oversight and management of the community clubs
- ART drug supply
- Club facilitation
- Appropriate monitoring
- Access to clinical care and clinical oversight

MSF has started working with Department of Health recognised community based organisations in Khayelitsha to scale out community clubs.

“I agreed to join the new club started near my home. It takes me only a few minutes to walk there from my house. We start the club early at 8am so that we can catch our transport to work after the club. The bus stop is near our club. This is making it much easier for me to collect my treatment. I know a few other people from my area that attend the clinic for ARVs. At the first club meeting, Fanelwa (Clubs Facilitator) helped me to get into the club. I am meeting people from my area also on ARVs in BM section. We are becoming friends and coming to the club together.”

Nomonde Tyutu, Club 1 at Andile’s house

“I think it is a good thing, a good idea for me to host the club in my house. It has been good for me, for the community and the people. Personally, I am well known in my area. Many people know me and so it is easier for them to come to my house. Most of them are also working, so they come to my house, we sit down, discuss and support each other and get our treatment, and then go to work. I don’t have any problems having it in my home. At least I feel like I am contributing to my community in some way. My wife is very supportive, even though she is not HIV positive, she agreed to have it in our home. One of my challenges that I have met is that some other people in my area want to join the club, they requesting all the time to have the same house club. Unfortunately, there is a procedure and I must explain that they cannot just join. This house club really is a good thing.”

Andile Madondile, hosts Club 1 at his house



## 2.4 OPTIONAL EXTRAS

### 2.4.1 UTILISATION OF CENTRAL DISPENSING SERVICE

The implementation of the ART club model is making a significant difference to the clinician's patient load at high burden ART sites and has also been shown to have significant benefits for long term retention in care of patients in the clubs, compared to those patients still seen in the clinic.

However, pre-packing for a group of 30 only has a small impact on the work load of the clinic pharmacy and its staff. Every ART patient whether in the clinic or in a club needs to have their ART supply packed and dispensed by the clinic pharmacy.

With one of the most scarce resources in the South African public sector healthcare being pharmacists, trained post basic and basic pharmacy

assistants, the roll out of the model will benefit from a feasible option to remove the pre-packing responsibility from the clinic pharmacy.

ART clubs only meet every 2 months (with a possibility for every 3 months) and club patients are the most likely patients to collect their pre-packed medication ensuring that pre-packing makes sense. By centralising the pre-packing for ART clubs, there are significant economies of scale benefits.

#### THE KHAYELITSHA EXPERIENCE

The Cape Metro (WCDOH) contracted the services of an external service provider to pre-pack and dispense the 2 monthly ART supply for ART adherence clubs. At the club scripting visits, scripts are completed for each member of the club, the club patients' scripts are submitted by the facility pharmacy to the Central Dispensing Unit (CDU) which then manages the pre-packing and timely delivery to the facility pharmacy of the pre-packed club ART supply.

#### LESSONS LEARNT

1. Utilisation of CDU function has the potential to significantly reduce facility pharmacy workload which allows scale up of club roll out and increased capacity for facility ART enrolment.
2. Optimal CDU service provision may take time to develop. This has improved significantly over time but it is important to note that implementation can initially require a time investment by the clinic pharmacy staff to check and correct incorrectly packed scripts.
3. Facility pharmacy staff may quickly become distrustful of the service and it may take some time to rebuild trust long after the service has improved. Consequently, it may be advisable to slowly phase in utilisation of CDU function by a facility pharmacy rather than scripting all facility clubs simultaneously.
4. Use of CDU function limits the flexibility of moving patients between clubs, changing club patients' drug regimens, removing patients from clubs or recruiting new patients to existing clubs as 6 monthly scripts are captured at CDU. Changes mid-script are difficult to manage.
5. In a large ART site in Khayelitsha, the club staff including the pharmacist have decided to only start utilising the CDU function for new clubs once the club membership has been established and stabilized. Coincide the first CDU scripting with scripting visit at month 6 or 12.







## ANNEXURES

- 1) Club movie
- 2) Luque-Fernandez Plos One (2013)
- 3) Wilkinson SAHJM (2013)
- 4) Club SOP
- 5) Annual visit alignment
- 6) Annual visit alignment with CDU
- 7) Example of Club monthly planner
- 8) Club marketing – clinic posters
- 9) Club marketing - patient pamphlets
- 10) Club allocation sheet
- 11) Clinical visit SOP
- 12) Club register template
- 13) Club tally sheet template
- 14) Club monthly stat sheet template with completed example



A blue-tinted photograph of a soccer field. In the foreground, a player is running towards the right. In the middle ground, several other players are scattered across the field. In the background, there are mountains and a tall stadium light pole. The text "JOIN THE CLUB" is overlaid in the center in a bold, white, sans-serif font, with horizontal lines above and below the text.

**JOIN THE  
CLUB**