

# The CQUIN Learning Network

## Annual Meeting

### Scaling up Adherence Clubs in Cape Town

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**HIV LEARNING NETWORK**  
The CQUIN Project for Differentiated Service Delivery





HAVE YOU BEEN TAKING  
ARVS FOR MORE  
THAN 1 YEAR?

IS YOUR HIV VIRAL LOAD  
UNDETECTABLE?

ARE YOU TIRED OF  
WAITING IN LONG QUEUES  
EVERY MONTH?

FAST...

FRIENDLY...

2 MONTHS SUPPLY OF ARVS...

ARV adherence clubs are your answer!

ASK YOUR NURSE TO REFER YOU  
TO AN ARV CLUB TODAY



# Overview

- 2001: HIV positive patients officially started on ART (Cape Town)
- Health facilities in high prevalence areas quickly overburdened with HIV positive patients. Led to:
  - Congestion
  - Concerns about poor quality of care
  - Defaulting
  - Patients being lost to follow up and succumbing to the disease
- Did all patients needed the same level of care?
- Response: 2007 Médecins Sans Frontières (MSF) piloted (Ubuntu Clinic, Khayelitsha, Cape Town) model of care to identify and support a category of 'stable' patients from amongst those who were on antiretroviral therapy (ART).

# Overview

- Adherence Clubs designed to provide ART support to:
  - groups of approximately 30 stable patients
  - meet every 8 weeks
  - Initially facility based
  - managed by lay counsellors
  - received pre-packed ART (initially from facility pharmacies and later from a centralised distribution unit).
- The model is about:
  - Decentralising care
  - Task shifting
  - Decongesting increasingly overburdened clinics of stable HIV patients
  - Providing a more flexible and convenient service for stable patients.

# Evaluation

- Epidemiological analysis focussing on retention-in-care (RIC) and viral load (VL) suppression conducted to check the quality of care in the CHW-managed adherence clubs.
- Qualitative study focused on factors influencing implementation of this model.
  - Management, staff and clients in a sample of 15 clinics were interviewed and observed.

## Impact/outcomes – service related: AC model

- End of March 2016, approx. 32% of 142,000 ART patients (42,600 patients) were in an AC (Cape Metro health district)
- Total patients on ART in ACs in facilities ranged from 10% to 60%
- Of the 3,216 adults sampled cumulative retention, LTFU and Transfer Out (TFO) were 83.7% (95% CI 81.5-85.6), 5.1% (95% CI 4.0-6.5) and 11.6% (95% CI 10.0-13.5) 24 months after AC enrolment.
- After 12 and 24 months in an AC, 95% (95% CI 96-98) and 96% (95% CI 94.8-96.8) were virally suppressed, respectively, with viral load completion in 87% and 84% of patients.

# Factors affecting roll out and scale up of the AC model

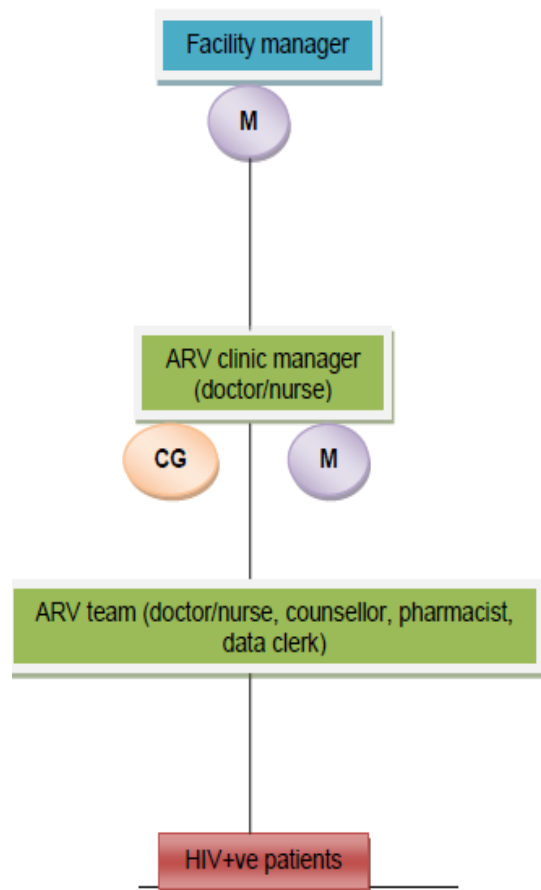
- Development of a differentiated care model (clinic, ACs, QPUP, specialised ACs, ROTF)
- Task shifting to CHWs (both lay counsellors and community care workers)
- Innovations – pharmacy (pre-packaging), information (registers, data systems)
- Transference to other NCDs: Co-morbidity clubs and other chronic diseases

## The evolving complex system

"A complex system is a large network of relatively simple components with no central control."

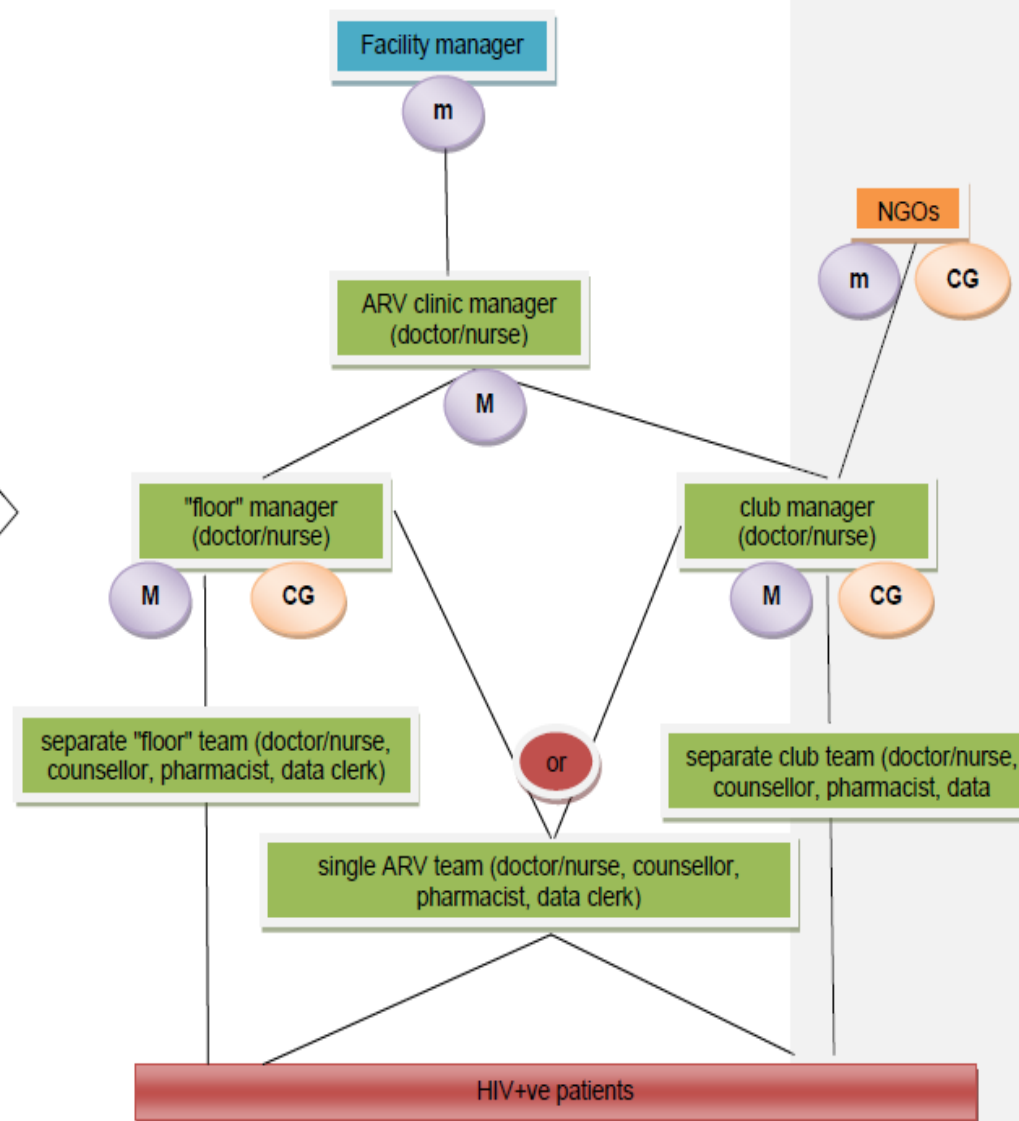
Key:  $M/m^{31}$  = Management; CG = clinical governance

Phase 1 (unitary system)



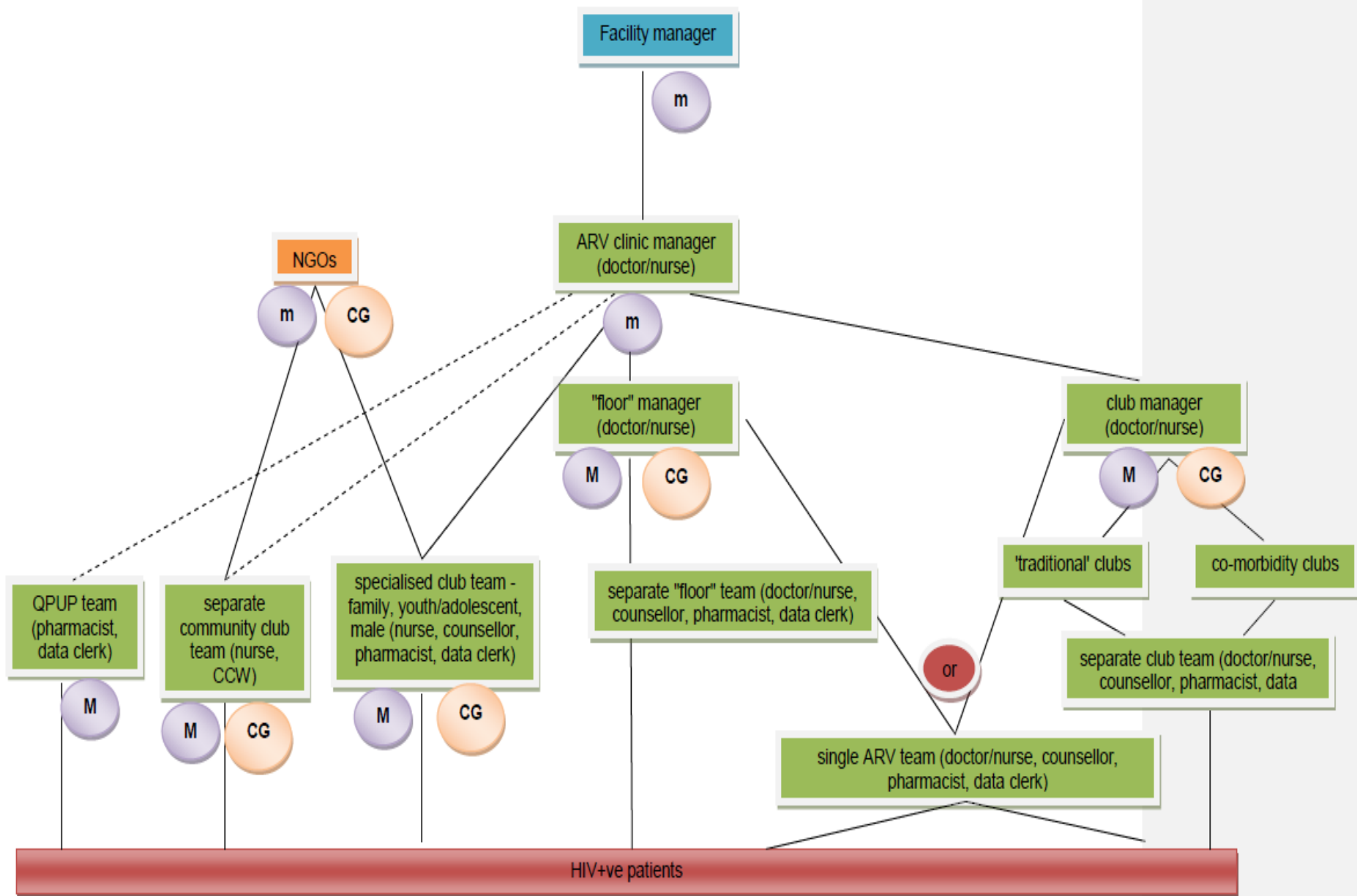
<sup>31</sup> M/m indicates level of importance of management

Phase 2 ("floor" and club)





Phase 3 (multiple options)





# Task shifting to CHWs

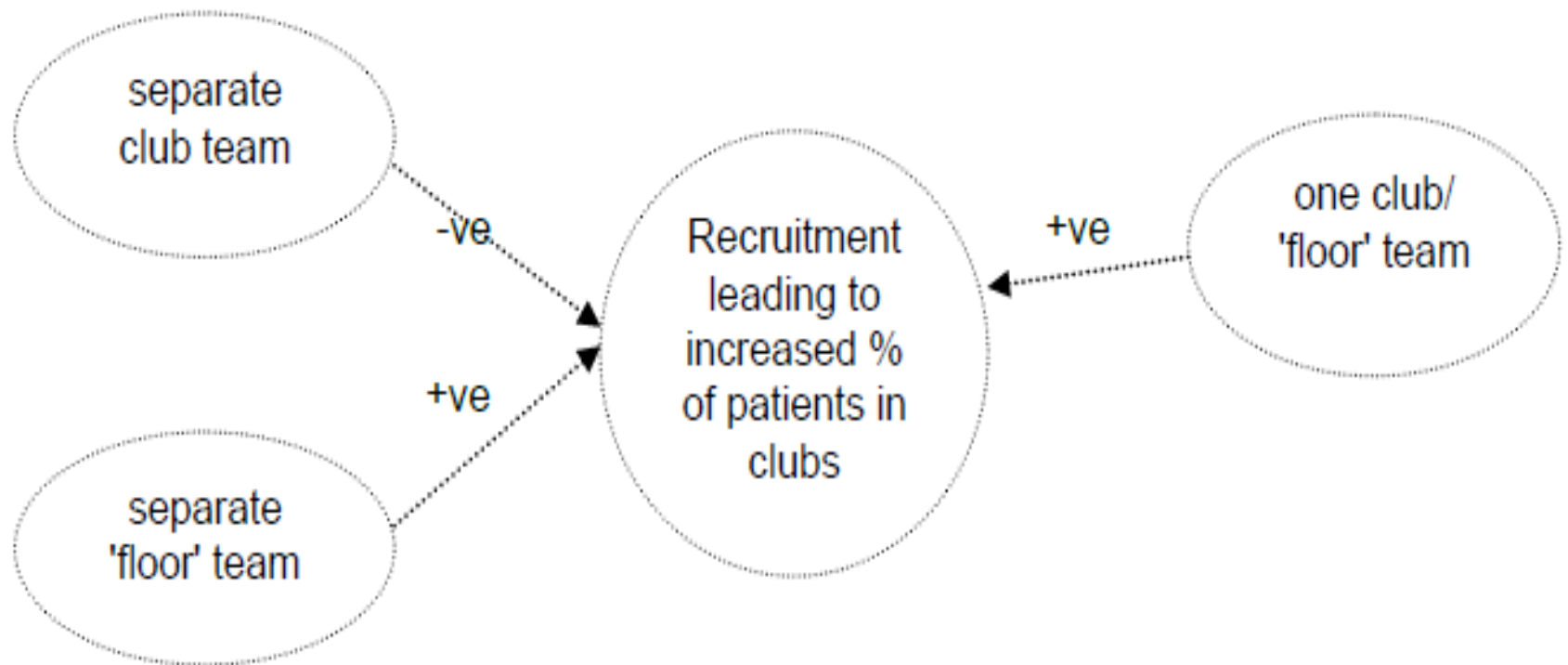
- Run most clinic-based ACs:
  - Prepare for club day
  - Check pre-packaged medicines
  - See patients
  - Check weight and S&S
  - Refer if necessary
  - Dispense medicines
  - Complete registers
  - Do tracking and tracing
- Run community-based ACs
  - Liaise with community structures in addition
- Psychosocial support



# Challenges to scale up

- Motivation/drive diminished
- Reduction of external support, less mentoring, less meetings
- Changing role of the steering committee
- Push for managers to focus on integrated NCDs
- Decongestion slow to appear
- Clubs 'added' to the workload
- Wholistic view or separate
- Burn out of counsellors, especially
- Focus on starting clubs but not scale up within a facility
- 40 club hurdle
- More complex pharmaceutical system – more breakdowns
- Limited infrastructure

# Outcomes of different approaches





# Understanding the 40 club hurdle

- Forty club hurdle as a tipping point
- One club per day over a 8 week cycle = 40 clubs
- Requires seamless logistical preparation and functioning - an error in one component was likely to have a domino effect across the whole club system:
  - Drug supply problems
  - Quality of care
  - Scheduling problems
- One holistic management system worked best

# Conclusion

- Quantitative results: significant ↑ numbers in ACs
- Quantitative results: equivalent RIC and VL suppression data
- Qualitative results highlighted the importance of a number of success factors including:
  - Piloting
  - Steering committee
  - Mentoring
  - Training
  - Innovations.
- Also found that
  - Role of NGOs key
  - CHWs key in rolling out and scaling up the model

# Conclusion

- The AC programme (from 2007) developed a model that worked and then advocated to change the way the health system served chronic stable HIV+ve patients. NGOs then supported the Western Cape Government (WCG) in implementing and further developing the AC model.
- Remarkable journey that is still going on

# Thank you