Retention in care of ART patients through community-based adherence clubs (ACs)

**Theme 1:** Community Health Worker Programs that Support the Uptake of HIV Prevention and Treatment Services

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Background
USAID-funded CaSIPO Project develops the capacity of organizations and individuals at community level to improve retention and reintegration of patients in care.

Community Systems Strengthening

Community-based ACs offering adherence support, health education, nutritional assessments, STI and TB screenings and referral

Tracing patients Lost to Follow Up
Data Methods
From Blended Technical Assistance

<table>
<thead>
<tr>
<th>1. Targeted training</th>
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<tr>
<td>2. Intensified Technical Assistance</td>
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<tr>
<td>3. Mentoring</td>
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CaSIPO develops CHWs and supervisors’ skills and knowledge for improved quality services at community levels

<table>
<thead>
<tr>
<th>Establishment of adherence clubs (incl. cohorting)</th>
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<tr>
<td>Facilitation of adherence clubs (incl. referrals)</td>
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<tr>
<td>Provision of Universal Care Interventions (UCI) (NACS, STI and TB screenings)</td>
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<tr>
<td>Supervision of adherence clubs (AC Facilitation Audits)</td>
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<tr>
<td>Record keeping and monitoring data quality (AC and UCI Registers Audits)</td>
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**CHWs**: Community Health Workers  
**NACS**: Nutritional Assessment Counselling and Support  
**STI**: Sexually Transmitted Infection  
**TB**: Tuberculosis
To Establishment and Maintenance of Community-Based ACs

- Patients Files (paper-based)
- AC Registers (paper-based)
- UCI Registers (paper-based)

Tier.net

Facility and CBO Community Tool

Facility level Cohorting Report

District level Cohorting Report

District level Decanting Reporting Tool

National level Decanting Reporting Tool
Key Results
Retention in care

Patients decanted and retained in community ACs between October 2016 and March 2018

- 129,058 patients decanted to community ACs
- 123,935 patients retained in community ACs
- 5,123 HIV patients exited the clubs

96% retention in care
129,058 HIV stable patients decanted from 330 clinics to 4,971 community-based adherence clubs across 15 Districts.

5,123 patients exited the clubs

<table>
<thead>
<tr>
<th>Category</th>
<th>LTFU</th>
<th>RIP</th>
<th>Unstable &amp; BTC</th>
<th>T/O</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTFU</td>
<td>517</td>
<td>41</td>
<td>450</td>
<td>3,075</td>
<td>1,040</td>
</tr>
</tbody>
</table>

- **LTFU**: 60%
- **RIP**: 10%
- **Unstable & back to clinic (BTC)**: 20%
- **Transfer out (T/O)**: 9%
- **Other**: 1%
Impact of cohorting on viral load (VL) completion

Cohorting of patients resulted in:

- orderly services to ART patients in clubs;
- increased rates of viral load completion for the cohorts of ART patients in clubs.

By 31 March 2018, CaSIPO supported 51 facilities in Johannesburg Health District (JHD) to cohort 20,439 ART patients.
### Conclusions and Recommendations (1)

<table>
<thead>
<tr>
<th>CBOs not funded by DoH</th>
<th>CBOs funded by DoH</th>
<th>WBPHCOTs</th>
<th>Direct Service Delivery</th>
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<tbody>
<tr>
<td>• Facilitation of the ACs done by CHW employed by CBO</td>
<td>• Facilitation of the ACs done by CHW employed by CBO</td>
<td>• Facilitation of the ACs done by WBPHCOT’s OTL or CHW</td>
<td>• Facilitation of the ACs done by Project’s staff</td>
</tr>
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</table>

The establishment and facilitation of ACs by CHWs or CBOs funded by the DoH is a scalable and sustainable model.

The ownership of the AGL by the Districts is a key success factor in the implementation of the decanting process and the establishment of community-based ACs.

The use of CHWs or CBOs funded by the DoH for the facilitation of the ACs strengthens the linkages with the decanting clinics and facilitates a two-way referral pathway.
Conclusions and Recommendations (2)

WBPHCOTs Model: Role players

- Facility Data Capturer
- Adherence Club Champion (Professional Nurse)
- Community Health Worker
- Outreach Team Lead
- Club Facilitation
- Club Supervision
- Overall oversight

Capturing AC register in Tier.net
ACs not structured per cohort result in a disorganized provision of HIV services, with patients in one group receiving different services on the day of the club.

Quarterly cohorting ensures that all patients from the AC are due for their yearly clinical blood tests and clinical examination at the same time. The AC Facilitator can remind the group about scheduled HIV services and monitor their compliance with these appointments.

In JHD, the development of the SOP For Cohorting for Repeat Prescription Collection Strategies (RPCS): Adherence Clubs (AC), Spaced Fast Lane Appointments (SFLA) and CCMDD External Pick-up-Points (PuPs) played a key role in standardizing and fast-tracking the cohorting process.

Appropriate cohorting will enable patients on lifelong ART to move seamlessly from one RPCS option to another depending on their needs and circumstances.
Summary of Key Points
1. The use of CHWs or CBOs funded by the DoH for the facilitation of the ACs is a scalable and sustainable model which strengthens the linkages with the decanting clinics and facilitates a two-way referral pathway.

2. The key role players within the WBPHCOTs Model are the AC Champion at the facility who provides overall oversight on the program, the OTL who supervise and monitor the quality of the facilitation, the CHW who facilitate the clubs and the facility Data Capturer who ensures that the AC register is capture in Tier.net.

3. Quarterly cohorting ensures that all patients from the club are due for their yearly clinical blood tests and clinical examination at the same time. It facilitates monitoring of HIV services and enables patients on lifelong ART to move seamlessly from one RPCS option to another depending on their needs and circumstances.
Thank you,