

Effectiveness of patient adherence groups as a model of care for stable patients on antiretroviral in eThekweni

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Background

Sustainable Innovative models of care are required to cope with the ever-increasing number of patients on antiretroviral therapy (ART) in the most affected countries, including South Africa. The eThekweni Municipality evaluated the effectiveness of a group-based model of care run predominantly by non-clinical staff in retaining patients in care and maintaining adherence.

Primary Objective

Compare the effectiveness of community versus clinic-based adherence clubs on retention in care and viral suppression.

Inclusion/Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Age \geq 18 years	Currently on D4T containing regimen
No change in ART regimen in previous year	Currently pregnant or intending to become in \leq 6 mos
Virally suppressed for \geq 12 months (confirmed at baseline)	Current comorbidity or chronic illness (diabetes, epilepsy, active TB, cancer, mental illness, etc)
	Uncontrolled hypertension or treatment with $>$ 1 drug
	Attending clinic with HIV infected child
	Currently experiencing ART side effects

Method



THINK began with 77 facilities supporting 780 adherence clubs. The ART adherence clubs provided patient-friendly access to ART for clinically stable patients. It reduces the burden that stable patients place on healthcare facilities, increasing clinical human resources for new patients, and those clinically unstable and at risk of failing treatment. In the model, 30 patients are allocated to an ART club. The group meets either at a facility or community venue for less than an hour every 2 months. Group meetings are facilitated by a lay club facilitator who provides a quick clinical assessment, referral where necessary, and dispenses pre-packed ART. The club model was adapted both during and after the completion of the initial pilot in Nquthu northern KwaZulu-Natal and implemented in Khayelitsha and now observed under Global Fund for Fight AIDS, Tuberculosis and Malaria in the eThekweni Municipality. At first, clubs allowed membership in excess of 30 patients, but lay club facilitators struggled to manage club sessions and it was felt that smaller groups would improve peer support among members. Eligibility criteria were also amended from >18 months on ART to >12 months on ART, at the time when routine viral load testing changed from every 6 months to annually after the first year of ART.

Action step	Description
Cohorting using the ART start date of the patients.	<ul style="list-style-type: none"> • For ease of management, it is recommended that cohorts are set up in yearly quarters: Jan- March; April – June; July – September; and October – December. • In this sequence, all patients who were initiated on treatment between Jan-Mar will be in one cohort, Apr-Jun in one cohort, Jul-Sept in one cohort and Oct-Dec in one cohort. • All patients in that cohort will be allocated same dates for all their normal visits, clinical visit and blood visits. • This is meant to then maximize time and effort for patient and staff that provides services, but also to ensure that patients are properly managed.
Allocation of Dates for each club	<ul style="list-style-type: none"> • The dates are allocated according to the start point of the day of the visit and then calculating the two months' supply (56 days / 8 weeks)

Community Models of Care

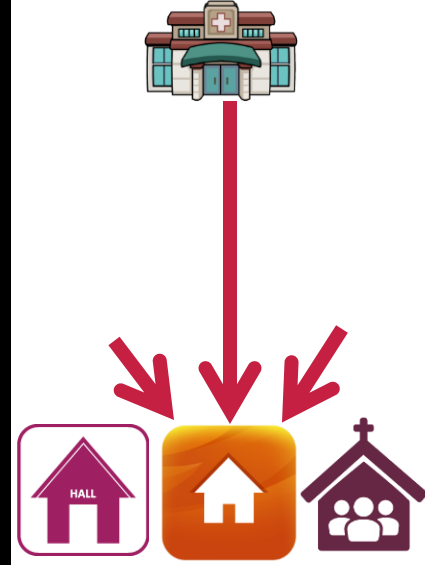
Facility



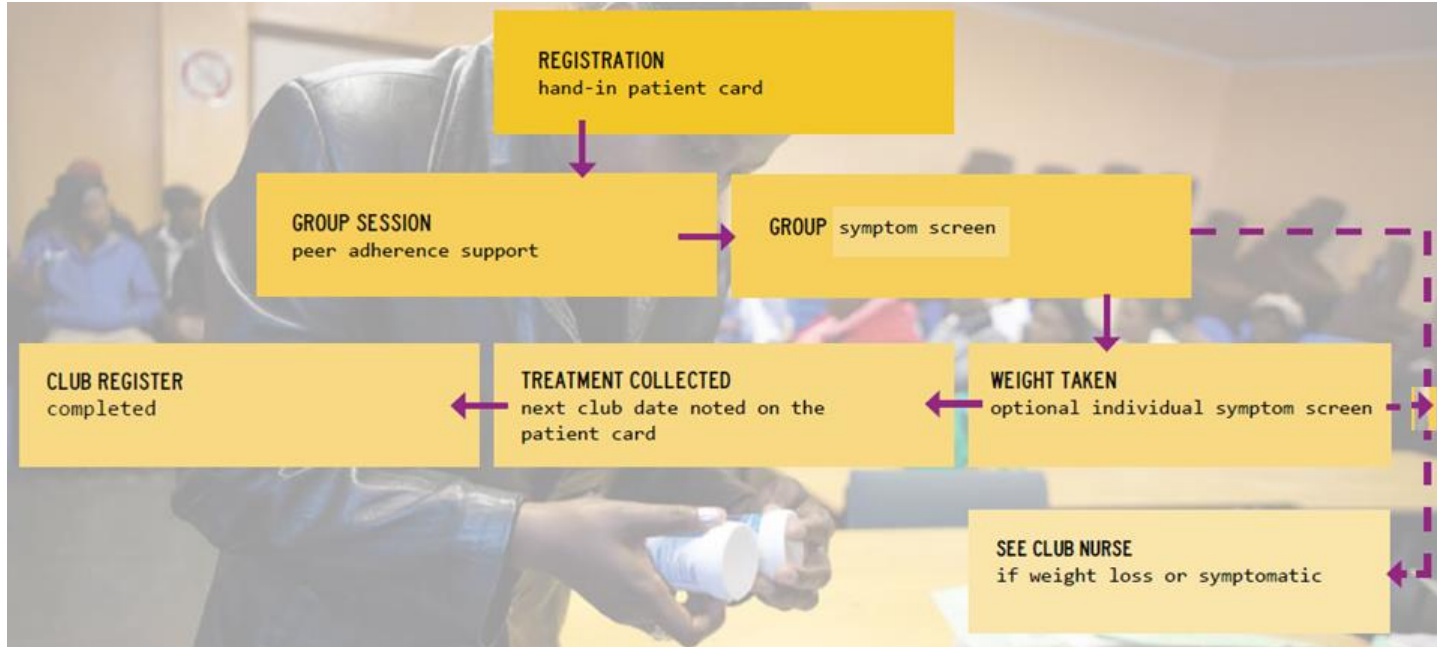
Community venue - close to facility



Community venue close to / in patient home



Club session

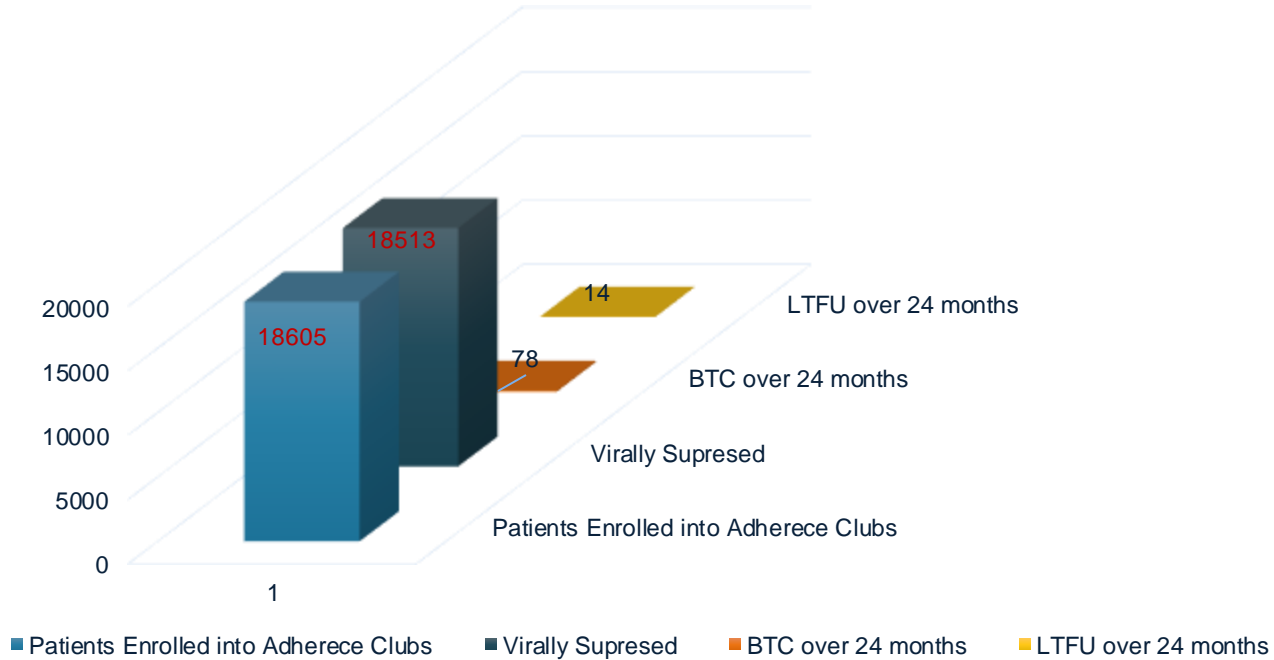


Results



A retrospective observational evaluation found that retention in clinic care after 40 months was **97%** for club patients compared with **85%** among those who qualified for clubs but continued to be managed outside of the club model. Club participants were also less likely to experience virologic rebound, indicating better adherence in clubs than in mainstream care. The program output of interest based on the agreed deliverable is the number of individuals that was provided with adherence support. THINK was provided with project term targets as well as quarterly targets. The total target for the project term was 97,655 (In club and Out of Club) with 18,600 patients on Adherence Clubs, patients after the targets were revised within 3 sub-districts to 2 sub-districts. In Year 2 of the project implementation, THINK reached an unduplicated 105,369 individuals with adherence support, which represents a performance rate of 118% exceeding the annual target by 18%. Overall, THINK met the project target of 97,655 by 94% with 92,192 patients RIC with total of 136,210 patients ever reached with Adherence Support.

Adherence Club Results over 24 Months



Reasons for Club Discontinuation at 24 months

Reason	Community club
Missing club visit and ART pick-up	41
Pregnancy	4
Viral rebound	5
2 consecutive late ART pick-ups	7
Voluntarily return to clinic	6
2 buddy pickups in a row	6
Developed comorbidity	2
Transferred out to another Club	7
LTF	14

Conclusion

The ART adherence club model improves adherence and long-term retention in care among clinically stable patients on ART patients, while optimizing health resources to manage new ART patients and patients at risk of failing treatment. The extensive and quick rollout in the eThekweni Municipality demonstrates active buy-in from patients and facility staff by addressing the obvious need for quick, patient-friendly access to care and treatment for clinically stable ART patients. The eThekweni Municipality needs more community-based adherence clubs to ensure that we reach the UNAIDS 90-90-90 targets, with a special focus on the last 90.

References

- www.msf.org
- www.nationalhealth.gov.za