The ART-adherence club model described here provides patient-friendly access to antiretroviral therapy (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. From January 2011 to December 2012, after adoption for phased rollout by the Western Cape Government, more than 600 ART clubs were established in Cape Town, providing ART care to over 16 000 patients. This extensive, rapid rollout demonstrates active buy-in from patients and facility staff. South Africa should consider a similar model for national rollout.
Plus clinic attendance in the clinic’s electronic database by the clinic data capturer. ART clubs are considered part of the ART service at a facility and are managed by a facility-based nurse (called the ‘clubs manager’) who is responsible for the scheduling of club dates, the smooth running of clubs, clinical governance and club reporting requirements.

Pilot: Experience from Khayelitsha

MSF began with a pilot project of 20 clubs at the Ubuntu clinic, Site B, Khayelitsha in 2007. 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 67% less likely to experience virological rebound, indicating better adherence in clubs than in mainstream care.[5]

The club model was adapted both during and after the completion of the initial pilot. At first, clubs allowed membership in excess of 50 patients, but this was later limited to 30 patients after 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 3 months on ART, at the time when routine viral load testing changed from every 6 months to >12 months on ART.

Overall, there has been widespread buy-in and participation by clinic staff and patients in the ART clubs in Khayelitsha. There is a continued, high demand for more ART clubs in facilities where club rollout has slowed or stopped.

Further detail on how to establish clubs, the ART club staff organogram, lessons learnt through the Khayelitsha implementation experience and tools utilised in the ART club model, are available online (http://www.msf.org.za/publication/art-club-toolkit).

Implementation beyond the pilot

In early 2011, the ART club model was adopted by the Western Cape Government (WCG) Department of Health (DoH) for phased rollout initially in the Cape Town Metro. A partnership was formed between the WCG DoH, City Health (City of Cape Town), MSF and the Institute for Health Improvement (IHI), to support implementation.[6]

Fig. 1 illustrates the implementation strategy adopted by the partnership. First, a steering committee with representatives from each partner was formed and HIV/AIDS, sexually transmitted infections (STIs) and tuberculosis (TB) (HAST) managers or facility-based doctors were identified to become club mentors. The club mentors were trained on the ART club model and were tasked with supporting the implementation of ART clubs in 1 - 3 pilot facilities. Facilities with the highest patient load were prioritised. The next phase was to invite 10 - 12 facility club teams (including the clubs manager, clinic nurse, club facilitator(s), clinic pharmacist and clinic data capturer) to attend a learning session where they were trained by the steering committee and club mentors and supported in making an implementation plan. The facility club mentor supported the team at the facility intensively at first and with routine support visits thereafter. Six months later, the same facility club teams attended a second learning session where they reported back on progress. Any challenges experienced were discussed with other facilities and the steering committee allowed for the sharing of possible solutions. Where club implementation at these pilot facilities continued to face obstacles, a third learning session could be convened. In general, for this process to be successful, it is important to have buy-in and active support from facility management and sub-district management throughout the implementation process.
By 31 December 2012, the Cape Town Metro had implemented over 600 clubs with more than 16 000 stable ART patients receiving care and treatment accordingly. This amounts to approximately 15% of ART patients in care in Cape Town. The partnership won a 2012 Platinum Award from the prestigious Impumelelo Social Innovations Centre for adopting and implementing this innovative approach to managing large numbers of patients receiving ART.

Resources to operate adherence clubs

Each facility running ART clubs requires a club team. The role of the clubs manager is part time, but does require sufficient time to carry out club-management responsibilities. At least one full-time lay club facilitator is required per 40 ART clubs. In addition, a facility nurse needs to be allocated as the club nurse on the clinic roster for each day on which a club session takes places. The nurse can usually continue to see clinic patients as he/she is infrequently required to see a club patient after a club session, other than the annual blood investigation and annual clinical consultation sessions.

In the Cape Town Metro, club facilitation has been included in the job profile of facility counsellors. Additional counsellor posts have been allocated to facilities – one for facilities with more than 15 clubs and two for facilities with more than 40 clubs. Where clubs are run in the community, community-care workers could serve as club facilitators.

In addition, resources may be spared by adapting the ART club-visit schedule and associated ART supply from 2- to 3-monthly.

Pharmacy-related bottlenecks to club rollout can be pre-empted by allocating an additional pharmacy assistant where the number of facility clubs exceeds 15, or alternatively, by utilising a central dispensing model and is the MSF representative on the WCG DoH ART club steering committee.

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Conflict of interest. The author contributed to the development of the club model and is the MSF representative on the WCG DoH ART club steering committee.

References