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# GUIDELINES FOR ART CLUBS

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# ACRONYM GLOSSARY

| | |
|---|---|
| ABN | Symptoms abnormal |
| ARV | Antiretroviral |
| B | Buddy |
| BTC | Exiting the club and re-entering routine patient care in the same facility. |
| CDU | Chronic Dispensing Unit |
| CD4 | Cluster of Differentiation 4 |
| CM | Club Manager |
| DNA | Not coming back to the health facility within the grace period. |
| FM | Facility Manager |
| N | Symptoms normal |
| NIMART | Nurse initiated and Management of Antiretroviral Treatment |
| PN | Professional Nurse |
| RIC | Remaining in care |
| RIP | Died whilst in the club |
| TFO | Transfer out to another facility |
| TFOC | Transfer out to another club |
| TFIC | Transfer in from another club |
| VL | Viral load |

# INTRODUCTION

The Western Cape Government, Health Department is in the process of formalizing its Integrated Adherence Guidelines for Chronic Diseases. The department acknowledges that disease management strategies are similar across most chronic conditions therefore; common services should be designed to be generalisable across chronic diseases to achieve both health system efficiencies and meet the needs of people living with a range of chronic conditions, inclusive of HIV.

The Integrated Adherence Guidelines for Chronic Diseases document will put forward a strategy and an implementation guide that will strengthen linkages to care, retention in care and adherence to treatment for patients with chronic diseases in the Western Cape. Before the integrated guidelines can be finalised, it is important to look at how the integration can be implemented across both PHC and CBS platforms and making best use of the available resources as well as ensuring resource equity for the minimum package of interventions for each platform. This guideline for ART Clubs will form part of the integrated policy document on its completion, but whilst work is being done on the integrated guidelines, the ART guidelines will be regarded as the first step towards this integration. ART clubs were implemented as part of an innovation to try and decant the PHC facilities and to reduce waiting times and there is a need to standardise and document this practice as a standard operating procedure which can be built on for further integration.

# PURPOSE OF THE SOP:

This guideline is intended to be used as a tool to support sites in establishing ART Adherence Clubs for stable patients on ART. With the limited resources available it is imperative that facilities optimise efficient ways of managing the growing number of ART patients. These efficiencies need to ensure that the patient experience of care is streamlined and that the programme still maintains a quality clinical service with intact M&E systems. To maintain these standards of care, the logistics around running clubs need to be well understood and properly implemented.

# OBJECTIVES OF CLUBS:

1. **Decongestion of health facilities**: To more efficiently manage stable patients on life-long ART whilst not compromising the quality of patient care
2. **Improving patient adherence**: To maintain good long-term adherence in patients on ART treatment by creating an environment within the health facility for more convenient clinical visits that is conducive to the patients' lifestyle needs.

3. **Task shifting:** To decongest the health facility through the use of group sessions that are facilitated by trained staff enabling clinicians to initiate new patients and manage more complex patients within the health facility.

## OVERVIEW OF CLUBS:

1. ART Chronic clubs consists of a group of patients who are deemed to be adherent to treatment and stable on ART. Optimal club size should be about 30 patients.
2. Club members meet every 2 months as a group. A club session usually lasts no more than an hour.
3. A club is usually facilitated by a lay person – a counsellor, community care worker or peer educator – under the clinical oversight of a clinician, generally a professional nurse (PN). The professional nurse is not present in the club, but available if needed.
4. At each club visit, patients are assessed by the facilitator (weight and a symptom screen – see 9) participate in a group support/education activity and are issued with 2 months' pre-dispensed medication in the club room
5. Patients may be seen by a counsellor on an individual basis if they request this.
6. Patients with symptoms / clinical problems receive an individual consultation with the club PN on the same day. If indicated, the client will be referred by the club PN to the club doctor (see 4).
7. Annually, monitoring and safety bloods are taken during the club visit prior to annual clinical consultation.
8. A mandatory yearly full clinical consultation takes place with the clinician, not the club facilitator, in the visit following the drawing of bloods to discuss the patients' management care plan
9. The blood taking and clinical visit sessions will take longer and patients should be notified of this when these appointment dates are given.
10. Each health facility should have a clubs team that ideally consist of a clubs manager, a medical officer, professional nurses (Club PNs), adherence counsellors, data clerk(s), a pharmacist or pharmacy assistant and peer educator(s).
11. There should be a designated club manager who takes overall responsibility for the successful management of the clubs (see 12). This manager is usually initially a doctor or nurse. With time other categories of staff could assume this role after appropriate mentoring
12. The facility manager needs to be appraised of all activities of the club team to ensure that s/he can provide adequate support to the programme.
13. Club registers record attendance, weight, symptom screening and blood results.
14. Folders only need to be drawn when the annual clinical consultation occurs, or when a client receives a consultation outside a routine club visit.
15. The contents of the club register are captured into the paper/electronic register directly.
16. Venue constraints or small facilities may choose to limit club size, and large facilities may choose to increase club size before adding more clubs once they reach 40 clubs (one club per day).
17. Grace period is the five days a club member has to collect their medication following the date of the club.

18. A buddy is the person who is collecting the member's medication on their behalf as a once off collection only.
19. Club members may be excluded from the club based on a number of clinical and adherence criteria.
20. Each club should have a file which includes the scripts and stickers of all members of that club. This should be easily available at club visits or when re-scripting is needed
21. The Club register must be used for every club visit (See register and guidelines for its use).
22. The register is to be reviewed at least monthly by the club manager / club nurse and signed and dated, after review.
23. One week after the club the relevant information in the club register must be captured into the electronic monitoring system (TIER.Net, eKapa or Prehmis); the data-clerk should report any incomplete register data to the club manager who is responsible for ensuring correct completion of the registers.

## ORGANISATION OF CLUB SYSTEMS:

### ANNUAL VISIT SCHEDULE:

Club visits are as follows:

1. Month 0 – Introductory / enrolment visit
2. Month 2 – Standard session
3. Month 4- Blood visit
4. Month 6 – Clinical consultation
5. Months 8, 10, 12, 14 – Standard sessions
6. Month 16 – Blood visit (cycle repeats from Month 4)

## THE CLUB TEAM – ROLES AND RESPONSIBILITIES

### FACILITY MANAGER (FM):

The facility manager takes ultimate responsibility for the performance of the various programmes in the facility, and this must include the ARV Club programme. For this reason the facility manager must be kept up-to-date with all club activities so that adequate support can be provided when the club team needs it and must review registers and sign.

### CLUB MANAGER (CM):

1. Ensures facility clubs team are in place

2. Ensures SOP being carried out in terms of: Recruitment, club preparation, club sessions, clinical governance, club follow-up, club patients returning to mainstream care.
3. Schedules annual return dates for club visits
4. Ensures 6 monthly scripting of club takes place
5. Overview of clubs outcomes – new clubs, new enrolments, RIC
6. Clinical oversight of clubs – review of VLs/CD4s/symptom checks
7. Responsible for ensuring that the club data is systematically captured into the electronic register after every club visit
8. Keeps the facility manager updated on clubs progress.
9. Review register for completeness, accuracy and general data quality.

### MEDICAL OFFICER (MO):

1. Maintains Clinical oversight for the club.
2. Responsible for the six monthly re –scripting of club patients (along with NIMART nurses).

## CLUB NURSE (CN):

1. Responsible for clinical oversight of a club with the support of the club medical officer.
2. Management of clients with symptoms / clinical issues
3. Takes the annual safety and monitoring bloods
4. Ensures that the blood results are entered into the register before the next visit
5. Prepares the folders and conducts the annual clinical visits
6. Ensures that club members are re-scripted 6 monthly by a medical officer / NIMART nurse at enrolment and during the prescribed scripting periods each year.
7. Checks that the register has been correctly completed at the end of each club session
8. May be tasked with keeping the register for the prescribed grace period for patients who attend late

## CLUB FACILITATOR

1. The club facilitator is usually an Adherence Counsellor (part of their job-description), but all club nurses should feel competent in this role and should get experience in facilitating clubs when they start with the service.
2. Ensures the venue, register and medication are ready for the club session at the right time.
3. Conducts the club support/ group education
4. Checks the weight and does a symptom screen on each patient
5. Records visits in the register
6. Issues the patients (or their buddy) with pre-dispensed medication.

7. May be tasked with keeping the register for the prescribed grace period for patients who attend late

### DATA CLERK

1. Draws folders for the first club visit and then subsequent annual clinical visits and ensures that the blood results are filed in the folders
2. Captures the paper club registers into the electronic ARV register when the grace period has expired (After each page has been captured completely), the data clerk signs off at the bottom of the corresponding column to indicate that all patients' club visits have been captured. When all patients of the current visit are entered, the data clerk signs off at the cover page Next to the current session date)
3. May be asked to assist with administrative tasks related to the logistics of running clubs
4. The capturing of club registers should NOT be assigned to one clerk only; it should be the responsibility of all clerks in the registry department to ensure the timeous capturing of club visits.

### PHARMACIST / PHARMACY ASSISTANT:

1. Pre-packs medication for patients for the enrolment visit
2. Ensures that doctors / NIMART nurses are aware of clubs that need scripting
3. Ensures that all CDU scripts are correctly completed and sends scripts to CDU timeously
4. Checks the manifest to ensure that medication has been packed for all club patients when the pre-dispensed parcels arrive
5. Takes responsibility for planning where medication is kept during the grace period
6. Returns all medication packets that were not given out by the end of the grace period to CDU

## CLUB RECRUITMENT:

### ELIGIBILITY CRITERIA FOR CLUB MEMBERSHIP

#### SUGGESTED CRITERIA FOR CLUB ELIGIBILITY:

1. Adult > 18 years
2. On the same ART regimen for at least 6 months (regimen 1 or 2). However, in the case of a single drug substitution, clinician to determine when eligible
3. Most recent viral load (taken in the past the 6 months) undetectable
4. No current TB
5. The patient agrees to receive care through the club system

## ADDITIONAL CLUB ELIGIBILITY INFORMATION:

1. The club criteria and model can be modified to meet certain special needs:

    a. I.e. family clubs, youth clubs, club for patients with other chronic conditions, clubs at small facilities that provide ART without extra staff etc.
2. A clinician (Medical Officer / NIMART Nurse) confirms the client's eligibility for club membership.

## RECRUITING CLUB PATIENTS

1. The whole ARV team and all categories of staff should be involved in identifying patients who are eligible for being recruited into clubs. However, the overall decision regarding a patient's membership of a club rests with a clinician (Medical officer or NIMART nurse)
2. Patients can be informed about the club program as they begin their ART work-up so that they can work towards club enrolment.
3. Waiting room talks can include information on clubs so that patients know that the club system exists
4. Posters about clubs and the eligibility criteria help to keep patients informed about the club system
5. Patients already in clubs are often very good advocates for the club system and spread the word about clubs
6. You know that your systems are working when patients start to ask to be put into clubs
7. It is essential that facilities understand that if they wish to decongest the facilities they need to move more patients into clubs each month than the monthly growth at the facility (i.e. new starts plus TFI and restart patients minus exiting patients (TFO, LTF, RIP)).
8. Patients may join existing clubs if club numbers are lower than the ideal for that facility.

## LOGISTICS OF MOVING PATIENTS INTO CLUBS

1. When a patient is identified as eligible for a club they need to be allocated to a club.
2. The club manager is responsible for identifying dates for new clubs to start, or existing clubs that can take new members (keeping in mind the blood-taking date for the group and ensuring that the patient entering the club will not go for more than 12 months after their last blood was taken); the logistics of allocation can however be delegated to another staff member if appropriate.
3. The recruited patient should be given the club number, date, time and venue that the club meets. This should all be clearly written on the patient held card and the patient informed to go straight to the club room without first queuing for a folder. The fact that the patient has been recruited into a club (with the club number and date of visit) should also be clearly recorded in the patient folder.

4. The clinician needs to ensure that the patient has enough medication until the next club visit, and a script to cover the first pre-packed dispensing of medication. This first pack is usually pre-packed at the facility pharmacy and a CDU script completed once the patient is enrolled in the club.
5. A list of recruited patients, patient scripts and patient stickers should be kept to ensure the medication can be pre-packed before the club meets, and a CDU script can be completed for the patient after the club session.
6. The patient is only enrolled into that club and entered into the club register when they arrive at their first club visit. The entry into the club should also be recorded in the folder of the patient, and this folder is then filed in the registry until the next clinical visit or other interim visits (if needed).

## LOGISTICS OF CLUB PREPARATION:

BEFORE A ROUTINE CLUB VISIT:

| Action | Person Responsible |
|---|---|
| Ensure pre-packed medication is available the morning before the club visit | Pharmacist / pharmacy assistant |
| Check that the club room is available and set up the day before | Club facilitator |
| Collect the club register from where it is safely stored before the session | Club facilitator. |
| Collect the pre-packed medication from the pharmacy before the session and take it to the club venue for dispensing - | Club facilitator |

BEFORE A BLOOD TAKING DAY:

The process is streamlined if the club register is correctly completed with the regimen the patient is on, in the regimen column so that any safety bloods needed, can easily be identified.

| Action | Person Responsible |
|---|---|
| Complete lab forms for VL and any other safety bloods that need to be taken | Club PN (facilitators can assist with the standard parts of the form – e.g. filling in the dates and the club number in the 'ward' field) |
| Ensure that there are patient stickers in the club file for putting onto the blood tubes | Clerk, club facilitator |
| Collect stock of necessary blood tubes, needles, syringes, webcols etc. – | Club PN |
| remind club PN that the upcoming club needs bloods taken the day before the club meets | Facilitator / club manager |

BEFORE A CLINICAL VISIT DAY:

| Action | Person Responsible |
|---|---|
| Remind the clerk that there is a clinical visit coming up | Club Facilitator / Club Manager |
| Folders to be drawn a few days before the club meets ensuring that all results are filed in the folders | Clerk(s) |
| All results to be entered into the club register | Club PN (clinical oversight by medical officer / club manager) |
| Folder to be prepared before the club meets:<br>• Write 'Club # - clinical visit' above the next free column<br>• Write that the patient has been attending all club session from the last visit<br>• Enter the blood results and date – highlight any abnormal results<br>• Check for other routine follow-up that may be needed – e.g. PAP due etc. | Clinician (Medical Officer/NIMART nurse) |

## LOGISTICS OF A CLUB SESSION:

### SETTING UP THE CLUB VENUE (AT FACILITY OR OFF SITE) ROOM:

1. Locate a place that is conducive to people sitting in an open yet private environment, free of interruption and noise. The venue should be either at the facility or in the community at a central meeting place. The identification of a venue must be completed by the facility management prior to introducing clubs to the facility.
2. The Club environment needs to provide a space that is conducive for people in the club to chat to each other, as part of the aim of the club system is to foster bonding between patients so that they can support each other in the ongoing need for adherence.
3. At the same time, it is essential that patients are able to have a degree of privacy within this setting so that problems can be brought to the attention of the facilitator.
4. The suggested set-up for the club space for a routine visit is to have the club members sitting in a circle, with the facilitator outside the circle at a table large enough to easily hold the register and the pre-packed medication. Patients can then be seen in relative privacy at the table where their weight and symptoms are checked and medication issued.

### CONDUCTING THE SESSION

1. The job of the facilitator is to see the patients, and to provide an environment where patients are comfortable speaking to other patients. When a club is newly constituted, club members are often not known to each other, and the facilitator can set the tone by asking them questions such as:
    a. Who lives closest to / furthest from the health facility
    b. Who has been on medication the longest etc. whilst she/he then sees each person individually?
2. At the enrolment visit, the facilitator should try and ensure that all patients arrive at the start of the club session and that the purpose and guidelines for being involved in a club are discussed with the whole group (see enrolment discussion guidelines in annexure 3.
3. Each club session should have a support group/education component. These sessions, including the screening, documentation and drug distribution, should take no more than one hour depending on the size of the club.
4. For blood-taking and clinical visits the club session is usually longer, and greater congestion can be expected, so patients need to be informed at the previous visit to potentially plan for more time.

5. Some facilities allocate two facilitators to a club group, one to work with the group aspect of the session and one to deal with the patients individually. This is particularly useful for the first few sessions that a club meets when club members are not yet known to each other.

### Clinical screening and indications for individual consultation

1. If a patient has any of the following, please refer to a clinician (NIMART Nurse or Doctor).
    a. TB symptoms (cough, weight loss, night sweats, fatigue)
    b. Late onset ARV side effects (lipo-dystrophy)
    c. Pregnancy
    d. Any other symptoms of concern
2. Clients who are in need of a consultation can be seen by the club PN at the end of the session and referred if necessary.
3. The clinician(s) decide whether clients referred from a club should remain in the Club or return to mainstream care

### Clinical Consultation day:

1. Clients are seen individually with their folders by a clinician (NIMART nurse or Doctor) in a private consultation area. All information regarding the consultation must be documented in the patients' folder.
2. After the consultation the club register is also completed and medication is issued by the facilitator.
3. Capturing into the club register is NOT in lieu of the clinician documenting in the patient folder.
4. Documenting in the patient folder is a requirement for the clinical consultation session.

## After a club session:

### Grace period and DNA (Did Not Attend):

1. If a client has missed their club session there is a defined grace period during which the client can still collect their medication or send a buddy, and still remain in the club.
2. At the end of the session the Club PN needs to check the register and arrange to recall those:
    a. Who have sent a buddy on a blood day, or on a clinical consultation day
    b. Who have sent a buddy twice in succession
    c. Who did not attend the club personally or send a buddy to collect ARVs (it is useful to do this before the grace period is up)
3. Unissued medication needs to be returned to the pharmacy, formally handing these over to one of the pharmacy staff. (Club PN / facilitator)

4. The register should be returned to a designated place for the grace period
5. Should the client / buddy present within the grace period, the club manager or designated team member (facilitator or club PN) sees the patient, records the visit in the club register (along with the fact that the patient came late), and patient goes to pharmacy to pick up pre-packed medication..
6. It is important that the rules of the grace period and the person to whom the club member should present him/herself are known to all club patients and all staff.
7. Should a client not attend personally or do not send a buddy to collect medication within the grace period, the client will be marked in the register as DNA, and will be removed from the club (and medication returned to CDU).
8. Any patients captured as DNA will appear on the early LTF list if they have not been captured into the monitoring system (TIER.Net & eKapa). After three months they will appear on the late LTF list. This should be dealt with according to the routine systems for defaulters at the facility.
    a. NOTE: if clients are issued medication in the grace period but not captured into the register, the information will then not be captured into the electronic M&E system; the patient will then be considered a DNA. It is essential that the register is completed for all late patients where medication is issued.
    b. At the end of the grace period the club manager / club PN / pharmacist should check the uncollected medication parcels against the register and clearly mark DNA in the blocks where medication was not issued. All unissued medication needs to be returned to CDU.
    c. Once this has been checked the paper register is given to the data-clerk to capture the register into the M&E system.
9. A patient who has missed the grace period will need to have their clinical folder pulled and be seen as a 'regular' patient for that specific visit.
10. A DNA client can only re-enter the club system if a clinician has reviewed the patient and decided that the client is eligible for re-entry.

## CRITERIA FOR RETURN TO MAINSTREAM CARE

1. Client is classified as DNA (Did Not Attend)
2. Raised viral load requiring closer monitoring. (Viral load of 400 copies/ml and more)
3. Safety blood results requiring closer monitoring
4. Client develops any clinical conditions that requires closer clinical monitoring by the ART team
5. Other indications assessed in individual clinical consultation.
6. Patient requests to return to mainstream care

### RESULTS

1. All club results (VL, and safety bloods) should be reviewed by a Medical officer or NIMART Nurse.
2. Patients with results needing action should be recalled as indicated by the clinician who reviews the results.
3. All blood results must be recorded on the HIV Stationery, and then filed in the patient's folder.

## CLUB REPORTING & DATA MANAGEMENT:

### LOGISTICS

(NB – see club register for example of how the register is to be completed in conjunction with the instructions below)

1. For the 1st club session, the selected patient's folder is pulled by the clerk and given to the club facilitator
2. The clerk should ensure that all the latest blood results are filed in the folder.
3. When the patient attends s/he is enrolled into the club: the nurse/facilitator overseeing the club enters the patient information into the club register, enters 'entered into club' in the continuation sheet in the patient's folder and writes the number / name of the club onto the front of the patient folder.
    a. That folder will be re-filed until the next clinical visit.
    b. For patients who are entered into a club all information will be captured on the club register and then subsequently captured into the electronic register.
4. Data recording into the club register is done by the club facilitator. All the patients present at the session must have the following information captured into the club-Register:
    a. Patient sticker; (if patient sticker not available: name, date of birth, sex and patient folder number) (Note – if the sticker is too large for the box ensure that the sticker is trimmed so that it still shows the bar code, patient name and patient folder number)
    b. ART Regimen at date of ART initiation and at the date of enrolment in the club
    c. Cell phone number of the patient and whether it is a private or shared phone
    d. Date of the session and the month of the session (M0, M2 etc.)
    e. Weight
    f. Symptoms: Normal (N); Abnormal (ABN)
    g. VL and safety bloods after blood visits
5. The front of the club register should be completed to reflect at least the rest of the dates for the current year and the first date of the next year.

6. For people who send a treatment supporter to collect the drugs, "B" or "BUDDY" is entered in the club register in the place of the weight and no symptoms are recorded in the symptom block.
7. Patients enrolled in the club after the initial enrolment visit should be entered in the column corresponding to the club visit for the whole club and have NEW written sideways in the block where they start along with their weight and symptoms. Prior blocks should be crossed out to avoid confusion. If the patient has been transferred in from another club, TFIC# should be recorded instead of NEW.
8. In case of the patient exiting the club, the outcomes below should be entered into the club register in the block where the weight would be recorded
    a. (If the outcome is combined with a club visit (e.g. requests TFO whilst attending the club) then both the weight and the outcome should be recorded in the weight block.

| Outcome Event | Note in the club-Register |
|---|---|
| Not coming back to the health facility within the grace period | DNA |
| Exiting the club and re-entering routine patient care in the same facility | BTC |
| Transferred out to another club in the same facility | TFOC# |
| Transferred out to another facility | TFO |
| Died whilst in the club system | RIP |

9. For patients not attending the club and not sending a treatment supporter, a grace period is allowed before determining an outcome.

10. If a patient arrives during this grace period (not more than 5 days) their weight and symptoms should be recorded in the club register. A note should be made (written side-ways in the block) as to the time (same day as club day but late) or date (another day during the grace period) that the patient attended.

11. If the patient does not present within 5 days, then "DNA" is noted in the weight block after the register has been checked against the uncollected medication packages to verify that medication has not been collected.

12. If the patient is known to have died, then RIP is entered in the weight block of the first missed visit along with the date of death.

13. At the end of the defined grace period for that club, the club register is brought by a dedicated person (as determined by the club manager) from the club team to the data clerk for capturing.
14. The data clerk enters the club number/name and all other required information (registration date for first time/ transferred in patients, current club visit date, next club visit date, VL, CD4, patient outcome) from the last club visit into the electronic register (TIER.net or eKapa)
15. After completion of capturing each page, the data clerk signs off at the bottom of the corresponding column to indicate that all patient club visits have been captured. When all patients of the current visit are entered, the data clerk signs off at the cover page next to the current session date.
16. Once completed, the data clerk places the register in the designated box entitled ("*Clubs captured*").
17. The club facilitators collect the registers from the designated box and checks if the data clerk has signed off on the corresponding visit. If it was not signed off, the Club facilitator will return the register to the data clerk for capturing.
18. Monthly and quarterly reports generated by TIER.net for routine monitoring (not club patient specific) are sent to the sub-district/sub-structure HAST team, and printed for the facility manager to sign off.

## PHARMACY ISSUES :( SEE ANNEXURE 4)

### LOGISTICS

1. Patients receive 2 months' supply of medication at each visit; where possible, 4 months' supply of medication is issued over the 'Festive season'.
2. Scripting occurs at least twice per year (see 'I'); each script stipulates 'repeat x 5'.
3. It is highly recommended that medications are ordered through the Central Dispensing Unit (CDU). In the absence of this facility, medication must be pre-packed by the facility pharmacy for issuing in the club.
4. Preparing for Clubs scripting: Each club should have a club file in which the current scripts (prescription sheets/CDU scripts) for the patients in that club are kept. Other contents of the file could be patient stickers, blank scripts (CDU scripts/prescription sheets) and laboratory forms.
5. At recruitment: The recruiting clinician should ensure that the patient has enough medication to last until the club enrolment visit (M0), as well as a 2 month script that will be pre-dispensed for issuing to the patient at the enrolment visit.

6. Pharmacy staff should prepack medication for the club patients for the enrolment visit.

### CLUB ENROLMENT DAY:

The Club manager/delegated team member should fetch the pre-dispensed medication from the pharmacy. The Club facilitator should issue the medication to the patients who present for enrolment to the club. Should any recruited patient not arrive for enrolment, their medication should be returned to the pharmacy, and their script removed from the Club File and returned to the patient's folder.

### CENTRAL DISPENSING UNIT (CDU):

1. Ideally all clubs should receive their medication through a CDU. (Pharmacy staff : See latest CDU policy in appendix)
2. CDU scripts need to be submitted by the pharmacy to the CDU within 5 days of the last club visit. In order to fulfil this requirement, Club scripts need to be prepared as soon after the club visit as possible.
3. The CDU script should be written (in duplicate) and signed by an authorised clinician (doctor or NIMART-authorised professional nurse).
4. The scripts should be filed in the Club file, and delivered to the pharmacy.
5. The facility pharmacist/s must ensure that the prescription adheres to the latest prescribing circular of the WC province (see annexure 6), ensuring the following is clearly reflected on each CDU script:
    a. The number of the club
    b. Prescriber's name and signature
    c. Prescribing date (date script is written, preferably day of club visit)
    d. 2 month dispensing period
    e. Next medicine collection date (next club visit date) in special instruction section on script
6. The facility pharmacist submits the original CDU script to the CDU within 5 days of the club visit. The duplicate script remains in the Club file, which will then be returned by the pharmacy staff to the Club Manager
7. If it is not possible to use a CDU, the clinician should write a 6-month repeat script for the Club Patients on standard prescription sheets, and file these in the Club file. As for the enrolment visit, this file should be delivered to the facility pharmacy two days before a clubs visit, to be pre-dispensed by the pharmacy staff and collected on the morning of the Club visit.

## CLUB VISIT DAYS:

1. The Club manager/delegated team member should collect the medication (CDU/pharmacy pre-dispensed) on the morning of the Club.
2. The Club facilitator issues the medication to those attending the club or their delegated Buddy.
3. The facilitator completes the Club register: if the attendance by the patient or their buddy is recorded in the register, this indicates that medication has been collected.
4. At the end of the club, the facilitator returns any uncollected medication to the pharmacy.

## GRACE PERIOD:

1. If a club patient/patient buddy arrive to collect medication within the defined grace period, the club manage/delegated team member should arrange for the patient to receive their medication from the pharmacy, and ensure that the register is completed to record that the medication was collected.
2. If there still be uncollected medication at the end of the grace period, the pharmacist along with the club manager / designated person checks the uncollected medication against the club register and ensures that DNA is recorded in the weight block for each patient where there is remaining medication.
3. The medications are then returned to the CDU (or to the pharmacy shelve if CDU is not being used).

**Re scripting:**

1. To make provision for Club patients to receive a 4 months' supply of medication over the 'Festive season' (October/November-Jan/February/March), all clubs need to have 6-months' medication re-scripted during two predetermined 'scripting cycles'.
2. Half of the clubs will need to be re-scripted a third time. An example of the scripting cycle for 2014/15 follows (see annexure 7 for scripting cycles to 2018):

| Scripting cycles 2014 | | | | | |
|---|---|---|---|---|---|
| first | | second | | extra | |
| 27 Jan | 21 March | 14 July | 5 Sep | 8 Sep | 3 Oct |
| Christmas Jump | | | | | |
| 01 December 2014 | | 23 January 2015 | | | |

Examples:

- The patients of Club 10 return from their 4-month 'festive season' break on March 7 2014. They receive the last 2 months of medication from their 2013 script. A new 6 month CDU script is written for the club members; they will receive these medications on their club visits on May 2, June 27 and August 22. A new 6 month script is written for them on August 22. At their next club visit, on October 17th, they will receive 4 months of medication, which will last them until their next visit on February 4th 2015. At that visit, they will receive the last 2 months of medication from the script written for them on August 22nd 2014. A new 6 month script will be written following the February 4th visit.
- The patients of Club 1 will be scripted on 27 January, and receive their medication at visits on March 24, May 19 and July 14. The 6 month rescript written on July 14th would provide medication for their visit of Sep 8th; the Club patients could receive 4 months medication from the same script at their last 2014 visit on November 3rd. However, that would mean that all 6 months of the July 14 script would have been issued: this would mean that a re-scripting would be needed before their first visit of 2015. As this would be difficult to manage, the guidelines propose that this club is re-scripted on September 8th: this script overwrites the script of July 14th, and provides enough medication for 4 months from November 3rd, and a remaining 2 months for issuing at the first visit of 2015. For any enquiries, please contact the Provincial ARV pharmacist Jackie Voget on **021 483 0893.**

## ANNEXURE 1 – FACILITATOR GUIDE:

### ART ADHERENCE CLUB SESSION FOR NEW CLUBS:

TIME ALLOCATION: 15 minutes

1. Introduce yourself, and your role as Club Facilitator
2. Tell the group about the Club Team
    a. Club Manager
    b. Club Nurse
    c. Club Pharmacist
    d. Data Capturer
    e. Clerks (scan cards)

3. Give an overview of the Club Rules:
    a. Attendance

    b. Start and end time of the club
    c. Duration of the club:
    d. The session will last for 45 minutes
    e. Buddy:
        i. What a buddy is
        ii. Who should be a buddy
        iii. Sending a Buddy if patient unable to attend
        iv. Explain that a buddy cannot be sent for 2 consecutive visits.
        v. A buddy cannot be sent on Blood visits and Clinical visits
4. Explain what the patients can and should do when attending a club session:
    a. Enter the club venue
    b. Put your card on the table
    c. Sit in a group and join the club talk (15min)
    d. The club facilitator will take your weights and check your symptoms
    e. Make sure the club facilitator writes this information in the register
    f. You will receive your pre-packed medication, you must check your medication pack yourself
    g. You will receive your next appointment date on your card
    h. Feel free to ask your club facilitator any questions
    i. Always make sure you take your green health facility card with you

j. Make sure you have your health facility's phone number on your phone with your folder number
k. Once a year you will have your bloods taken (CD4, viral load)
l. Once a year you will have a clinical visit for full check up
m. Both of these visit are longer – you will need to make a plan for work (remember this is only once a year).
n. The Club Nurse/Club Facilitator can arrange a doctors certificate to excuse you from work
o. There is always a Club Nurse available on your club visit to see you if you are unwell.
p. This is your club, we are happy to be with you, please feel free to talk and ask any questions.

5. Close the session
    a. Suggested Closing comment(s):
        i. There is a lot of power in the club – it is about getting to know other stable patients and sharing experiences, frustrations and questions
        ii. We all need a little support, if we can give it to others, we can also rely on their kindness and support.

## ANNEXURE 2 – ART ADHERENCE CLUB SESSION BEFORE FESTIVE SEASON

15 minutes club discussion by club facilitator

FOR ALL CLUBS

1. It is important to plan your adherence to your ARVs when you travel
    a. Where will you pack your ARVs when you travel and where you stay?
    b. Take all of your ARVs as you may unexpectedly have to stay longer,
    c. make sure you take patient held green health facility card with you
    d. make sure you have your health facility's phone number on your phone with your patient number
2. You will be receiving a 4 month supply
    a. This is special privilege to make it easier to travel during the holidays,
    b. Even if you have left over ARVs when you come back, please make sure you come back to your club on the date given to you,
    c. If you don't, this privilege could be taken away and it will not be possible to get 4 months next year,
    d. Please let's all work together to make this work for all club members' benefit
3. Tips for ARV drug storage
    a. Keep your ARVs out of reach of children
    b. Keep your ARVs in safe cool place out of direct sunlight
    c. Open one month supply of ARVs at the time
    d. Do not share your ARVs with others
4. What to do if you run out for any reason...
    a. Go to local health facility, give them your green card
    b. Ask the facility to phone your health facility and give your patient number to confirm your ARV treatment so that they can give you a supply until you return.
    c. If you do not know what facility to go to, dial this number from your home *130*448# and choose ARV treatment. You will get an sms with your closest health facility with ARVs (*120*448# for Vodacom users)

# ANNEXURE 3 - ISONIAZID PREVENTIVE THERAPY (IPT)

## PATIENT INFORMATION

### WHAT IS TB?

1. TB is a disease caused by a germ called Mycobacterium tuberculosis. It mainly affects the lungs, but can affect any part of the body.
2. TB germs are spread by someone with TB disease. When they cough, spit, or sneeze, the TB germs get into the air. The germs can stay in the air for a long time if there is no fresh air flowing through. Anyone who is in this space will breathe in the TB germs.

### WHAT HAPPENS WHEN YOU BREATHE IN TB GERMS?

1. When you breathe in TB germs, the germs go into your lungs. Your body's immune system can usually stop it from spreading further. The TB germs stay in the body, but do not cause symptoms. This is called TB infection. People with TB infection cannot spread TB germs.
2. In some people, the TB germs escape the body's immune system, spread through the lungs, and cause TB symptoms. This is called TB disease. People with TB disease can spread TB germs.

### HOW CAN PEOPLE LIVING WITH HIV PREVENT TB DISEASE?

1. Because HIV weakens the immune system, people living with HIV are much more likely to suffer from TB disease.
2. The best thing you can do to prevent TB disease is to take your **ARVs** well, which allows your immune system to get stronger again.
3. You can also take treatment (called Isoniazid or INH) to kill the TB germ before it has the chance to make you sick. This treatment is called Isoniazid Preventive Therapy, or IPT
4. Part of being assessed for IPT involves having a **TB skin test**. Your nurse will inject a small drop of liquid under the skin of your arm.
5. **You will need to come back in 2-3 days, when the nurse will look at your arm to read the result**. Swelling at the injection site means the test is positive, and indicates TB infection. If you do not come back to the health facility in 2-3 days the test will need to be done again.

### HOW LONG IS IPT TAKEN FOR?

1. IPT is taken every day, for at least 12 months. Depending on your skin test result, you may benefit from taking IPT for longer. Your nurse will tell you exactly how long. You will be provided with one or two month's supply.

2. **It is very important that you take your IPT every day**, for as long as your nurse advises you to. This will give you the best chance of preventing TB disease. If you stop your IPT early or take the treatment poorly, you are more likely to develop TB disease.

## ARE THERE ANY SIDE EFFECTS OF IPT?

1. Most people do not get side effects.
2. Mild side effects include:

    a. **aches or tingling** in your hands and feet
    b. skin rash
3. Mild side effects can be treated and you should be able to continue with your IPT
    a. Serious side effects are very uncommon. If you think you are experiencing a side effect, please let your nurse know.
    b. Serious side effects can include:
        - hepatitis ( inflammation of the liver) which may cause nausea and vomiting, jaundice (yellow skin or eyes) and stomach pains
        - If you get a serious side effect your IPT may be stopped
5. What can I do to prevent these side effects?
    a. You will be given a vitamin called pyridoxine to help prevent aches and tingling in your hands and feet
    b. You should avoid drinking alcohol while you are taking IPT to prevent inflammation of your liver.
6. You may not be able to take IPT if:
    a. You have symptoms of TB
    b. You have liver disease
    c. You drink excessive amounts of alcohol regularly
    d. You have painful or burning feet
7. It is safe to take IPT while you are pregnant.
8. It is safe to take IPT while you are on ARVs.
9. Can I still get TB if I am taking IPT?
    a. Yes you can. Taking IPT reduces your chances of TB disease, however it is still possible.
    b. If you develop any symptoms of TB while you are taking IPT, come back to the health facility as soon as you can and tell your nurse. You will need to have a sputum test done to check for TB disease.
    c. Remember, the symptoms of TB disease include:
        - Cough

- Fever
- Sweating too much at night
- Loss of weight

10. If you are HIV-infected, taking IPT can prevent TB.

# ANNEXURE 4 – CDU SCRIPTING REQUIREMENTS

Western Cape Government
Health

**PHARMACY SERVICES**

**REFERENCE: 3/1/R**
**ENQUIRES:** Tania Mathys

**CIRCULAR H** ..... 112 ..... **/ 2013**

**TO ALL:** **CHIEF DIRECTORS, DIRECTORS, EXECUTIVE DIRECTOR OF THE CITY OF CAPE TOWN**

**FOR ATTENTION:** **RESPONSIBLE PHARMACISTS,**

**PHARMACISTS,**

**PHARMACIST ASSISTANTS,**

**AUTHORISED PRESCRIBERS,**

**FACILITY MANAGERS**

**REQUIREMENTS FOR PRESCRIPTIONS SUBMITTED TO THE CDU**

This circular has been adapted from the Western Cape Government Health (WCGH) Circular H29/2006: REQUIREMENTS FOR THE ISSUING OF PRESCRIPTIONS FOR MEDICINE IN THE WESTERN CAPE DEPARTMENT OF HEALTH.

This circular does not replace circular H29/2006.

**Prescriptions that do not comply with the requirements below, will not be dispensed by the CDU, but will be returned to the dispenser.**

1. Medicines may only be prescribed by health professionals employed by WCGH, who are authorized to prescribe medicines in terms of the Medicines and Related Substances Act 101 of 1965 and or the Nursing Act 50 of 1968.
2. An authorized person may only prescribe in terms of Section 22A of the Medicines Act.

10th Floor, 4 Dorp Street, Cape Town, 8001 P O Box2060, Cape Town, 8000
tel: +27 21 483 8702 Fax: +27 21 483 6656 www.capegateway.gov.za

3. With regard to the choice of medicine prescribed, authorized prescribers must comply with the provincial coding policy.
4. A prescription must be written or typed on a WCGH Medicine Referral Prescription form. (See Annexure 1).
5. No Latin terminology may be used on the prescription.
6. Abbreviations of agents prescribed are not acceptable.
7. Monthly medicines must be prescribed for periods of 28 days.
8. The prescription must be submitted for dispensing to the CDU within five (5) days of the date of issue of the prescription if the next collection date is 28 days after first date of issue.
9. The prescription must be submitted for dispensing to the CDU within ten (10) days of the date of issue if the next collection date is 56 days after first date of issue.
10. The following particulars MUST appear on the prescription to avoid rejection (See Annexure 1)

**10.1. Facility Details**

Name of the Facility where the prescription originated from. Please do not use abbreviations. Facility stamps are allowed.

**10.2. Club number /Alternative site**

Alternative delivery site name or number (this may include clubs, old age homes or other outreach sites.)

Please ensure that the alternate site is registered before submitting prescriptions.

**10.3. Patient Details**

10.3.1 Patient Name and Surname

10.3.2 Folder Number

10.3.3 Identity number or date of birth

10.3.4 Gender

10.3.5 Patient address and contact number.

If the facility stickers are being used, please ensure that all details on the sticker are legible, including the barcode.

**10.4. Diagnosis**

Patient diagnoses must be clear (Please ensure that what has been prescribed corresponds with the patient diagnosis. Items that do not have a corresponding diagnosis will not be dispensed at the CDU).

**ICD 10 Codes are preferred.**

**10.5. Repeats**

10.5.1. Medicine may be prescribed for a maximum period of six (6) months.

Please avoid sending in prescriptions with less than 3 repeats.

10.5.2. In the case that medicines fall in **Schedules 0-4** the number of times that a prescription may be dispensed must be indicated clearly in the allocated space. (e.g. X 5 or 6/12).

10.5.3. In the case of **Schedule 5**, the number of times that a prescription may be dispensed, as well as the intervals at which it may be dispensed, must be indicated clearly on the prescription.

10.5.4. A prescription for **Schedule 6** medicine cannot be repeated and therefore cannot be submitted to the CDU.

**10.6. Dispenser details**

10.6.1. Name of dispenser in capital block letters.

10.6.2. Signature of prescriber.

10.6.3. If medicines were dispensed at the facility, please indicate the **FIRST DISPENSED DATE.**

**10.7. Prescriber details**

10.7.1 Name of prescriber in capital block letter or name stamp.

10.7.2 Qualification of prescriber.

10.7.2 Signature of prescriber in his/her own handwriting.

10.7.3 Registration number (*Health Professions Council of South Africa [HPCSA] and South African Nursing Council [SANC]*).

The registration number is required for identification of prescriber.

10.7.4 Date when medicine was first prescribed.

**10.8. Please mark the required monthly supply option to be dispensed by CDU (i.e. one or two months' supply).**

**10.9. Medicine Prescribed**

Medicine prescribed as per Western Cape Government Provincial Code list must correspond with the diagnosis recorded:

10.9.1 Generic name (NO ABBREVIATIONS)

10.9.2 Strength, quantities and directions (frequency)

10.9.3 Route.

**10.10. Medicine dispensed**

- Indicate quantities and strengths issued by facility dispensary.

***PLEASE NOTE: If no medicine is issued at the facility, please DO NOT complete this section.***

**10.11. Special Instructions**

10.11.1 If no medicines were dispensed at the facility, please indicate the **next collection date here, e.g. NCD: 3 October 2013.**

1011.2 If there are any known drug-interactions, please indicate whether the patient is stable.

10.11.2 Indicate any other special instructions for the CDU. Please ensure that these instructions are clear.

**Please note: Any amendments made to the original prescription must be co-signed by the prescriber. If not, the prescription will be rejected.**

**MS H HAYES**

**ACTING DIRECTOR: PHARMACY SERVICES**

**DATE:** 4 July 2013

## ANNEXURE 5 – SCRIPTING CYCLES 2014 TO 2018

| Scripting cycles 2014 | | | | | |
|---|---|---|---|---|---|
| first | | second | | extra | |
| 27 Jan | 21 March | 14 July | 5 Sep | 8 Sep | 3 Oct |
| Festive Season Jump | | | | | |
| 01 December 2014 | | 23 January 2015 | | | |

| Scripting cycles 2015 | | | | | |
|---|---|---|---|---|---|
| first | | second | | extra | |
| 26 Jan | 20 Mar | 13 July | 4 Sep | 7 Sep | 2 Oct |
| Festive Season Jump | | | | | |
| 30 November 2015 | | 22 January 2016 | | | |

| Scripting cycles 2016 | | | | | |
|---|---|---|---|---|---|
| first | | second | | extra | |
| 25 Jan | 18 Mar | 11 July | 2 Sep | 5 Sep | 30 Sep |
| Festive Season Jump | | | | | |
| 28 November 2016 | | 20 January 2017 | | | |

| Scripting cycles 2017 | | | | | |
|---|---|---|---|---|---|
| first | | second | | extra | |
| 23 Jan | 17 Mar | 10 Jul | 1 Sep | 4 Sep | 29 Sep |
| Festive Season Jump | | | | | |
| 27 November 2017 | | 19 January 2018 | | | |

| Scripting cycles 2018 | | | | | |
|---|---|---|---|---|---|
| first | | second | | extra | |
| 22 Jan | 16 Mar | 9 Jul | 31 Aug | 3 Sep | 28 Sep |
| Festive Season Jump | | | | | |
| 26 November 2018 | | 18 January 2019 | | | |