



..... ‘Assisted’

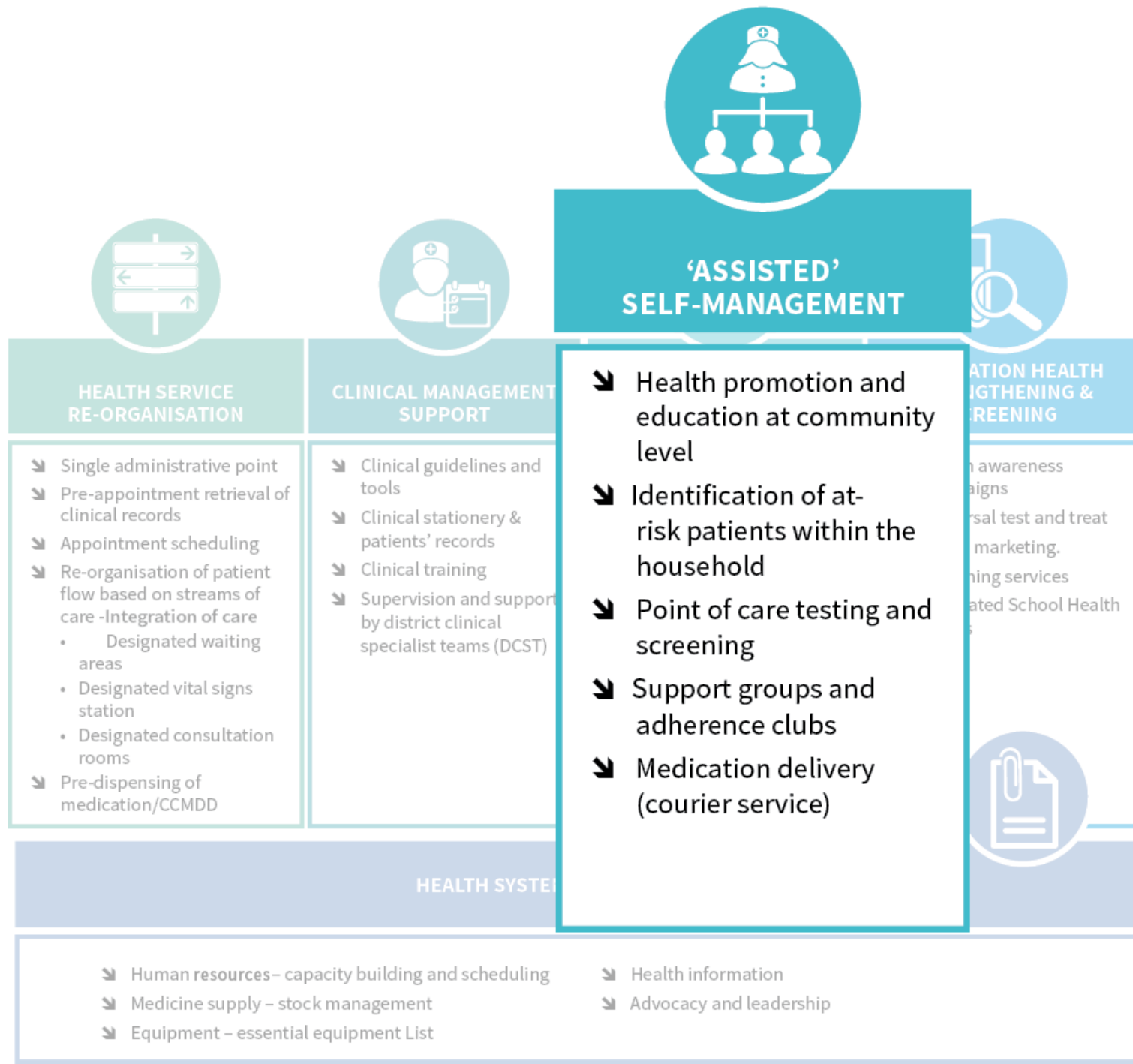
Self-management



health

Department:
Health
REPUBLIC OF SOUTH AFRICA

What is 'Assisted' Self-management?



'Assisted' Self-management



**'ASSISTED'
SELF- MANAGEMENT**

**COLLABORATION
WITH WARD BASED
OUTREACH TEAM**

HOUSEHOLD VISITS

**ADHERENCE CLUBS
AND SUPPORT
GROUPS**

What is self-management?



Refers to the taking of
responsibility for one's own
behaviour and **well-being**

'Assisted' Self-management



Utilise the **PHC Ward Based Outreach Team** to support and capacitate patients and communities to take **responsibility for their own health**

Principles/objectives



Activated and informed
patient that's takes
responsibility for their
own health

Role of the community health worker (CHW)



- The community health worker CHW is part of the Ward Based PHC Outreach Team (WBPHCOT)
- The CHW will serve as a link between the facility and the community
- The CHW will provide with respect to reducing the risk factors of chronic diseases as well as preventing complications. This will include but not be limited to:
 - ✓ Healthy eating habits
 - ✓ Active living through appropriate exercising
 - ✓ Reduction in tobacco and snuff use
 - ✓ Decrease in alcohol intake
 - ✓ Reduction in salt intake
- The CHW will offer for at risk clients during the home visits. This will include:
 - ✓ Household assessments – social services
 - ✓ Blood pressure measurements
 - ✓ Waist circumference measurement
 - ✓ Body mass index calculations
 - ✓ Blood sugar screening
 - ✓ Symptoms screening for tuberculosis
 - ✓ Voluntary counselling for HIV

Who should be referred to the Ward Based PHC Outreach Teams (WBPHCOT)?



- A patient who defaults his/her appointment
- A stable chronic patient for follow up, support and medication delivery if necessary

A patient is classified as stable if:

- Patient has been adherent to appointment schedules for 3 months
- All vital signs over the 3 months have been normal
- No evidence of deterioration in condition or complications

Central Chronic Medicines Dispensing and Distribution (CCMDD)

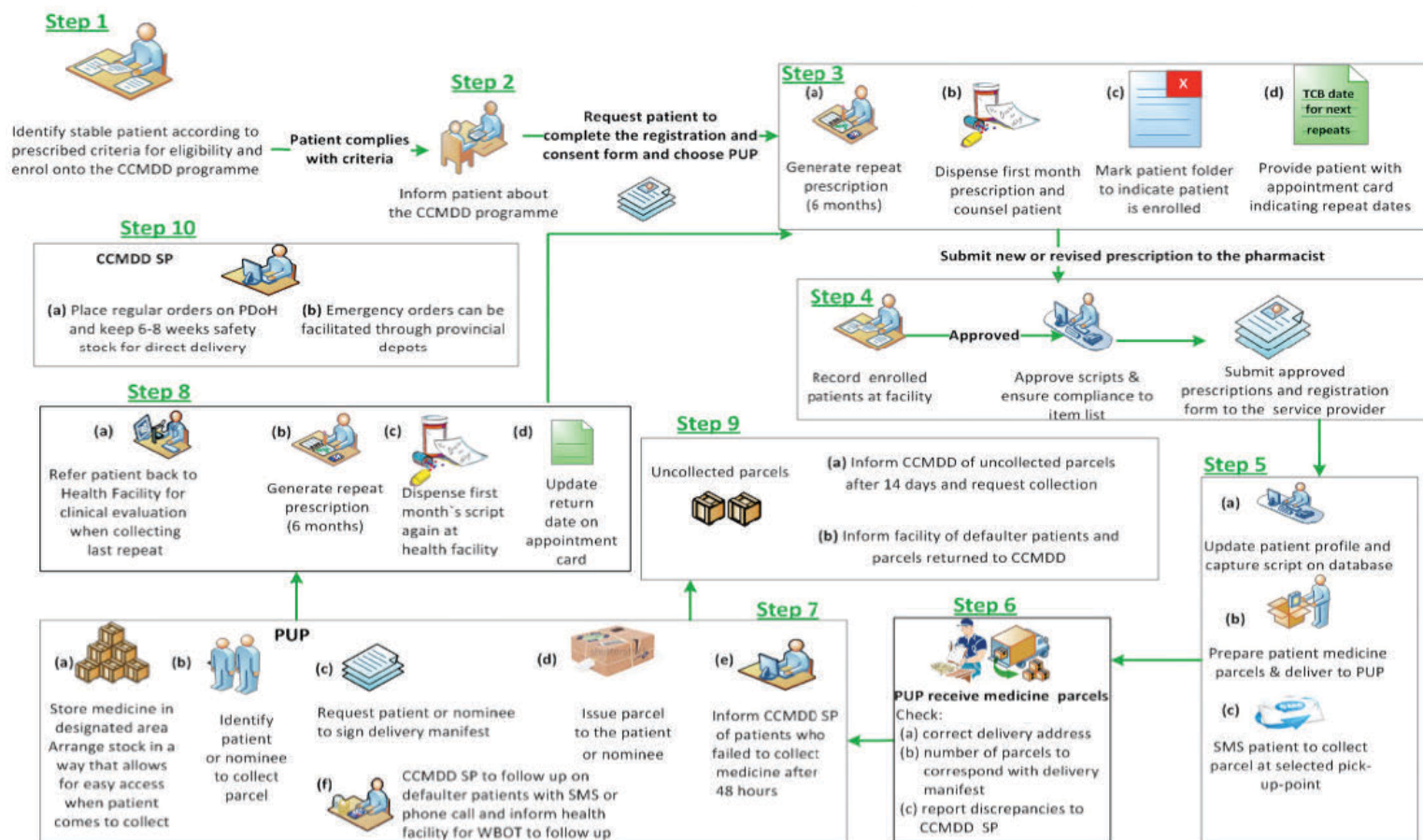


- The CCMDD programme has been implemented to **improve patient access to required medicines for chronic conditions** as well as to assist in decongesting public clinics
- This means that facilities are not inundated with chronic stable conditions
- The programme has two components i.e. the actual central dispensing where this occurs **off-site at a central location by a service provider and Pick-Up Points (PuPs)** which may include the facility or be in communities.

Central Chronic Medicines Dispensing and Distribution (CCMDD)



The diagram below highlights **the process** from identification of patients to the distribution and collection of medication.



Adherence clubs



Facility and community based Chronic Adherence Clubs.

- **Membership:** An adherence Club consists of a group of no more than 30 clients who are judged to be adherent to and stable on treatment
- **Timing:** Club members meet every 3 month as a group.
- The Club visit lasts approximately 1-1/2 hours.
- Each Club should consider an appropriate time for the adherence club considering accessibility for working clients (early morning or after work).
- At facilities, off peak, low client load periods could be considered with less pressure on space and human resources.

The Process

- **Process:** At each club visit, club members are clinically assessed (by weight and symptom screening), participate in a group support/education activity issue with 3 months pre-dispensed medication in the club venue.
- Annually, monitoring blood tests are taken in the Club (E.g. for HIV: CD4, viral load).
- At the following visit, all club members have an individual clinician consultation.
- **Facility based Clubs:** Every 3 months, clients meet as a group at clinic facilities, where facility space is limited, community venues close to the facility that don't require additional logistical support can be utilised.
 - Facilities can also make use of extended hours by establishing evening Clubs.

The Adherence club

- Community based Clubs: Every 3 months, club sessions are hosted in one of the client's homes or community venues near their home (e.g. NGO, church).
- Their pre-packed treatment is brought to them by the club facilitator.
- They are still clients at the main referral clinic but are only required to attend the facility for annual blood taking and clinical consultation.

Team, role and responsibilities:

- Each clinic should have a designated Clubs Manager who takes overall responsibility for the activities required to run successful clubs.
- This manager should be a nurse.
- Their duties include: ensuring their clubs team is in place, the club SOP is being carried out, scheduling annual return dates for club visits, ensuring the 6 monthly scripts are being coordinated and completed by the team.
- The clubs manager needs to have a good overview of the club outcomes and is responsible for completing monthly club stats for submission to the facility manager.

Adherence clubs



- Each club is assigned a **Club Facilitator** (a counsellor, peer educator, community health worker or equivalent) and a Club PN (Professional Nurse).
- Other possible team members could include a data capture/clerk and pharmacy assistant.
- The Club Facilitator (counsellor, peer educator, community health worker or equivalent) is responsible for preparing the clubs, running the club session, and their duties include:
 - Collecting pre-packed treatment dispensed from pharmacy, registering members, conducting the support group conducting symptom screening, referring clients to Club PN if necessary, issuing pre-packed treatments, completing club registers and following up clients who miss sessions.
- The Club PN is responsible for clinical oversight of a Club on the day of the club visit. His/her duties also include:
 - Seeing symptomatic clients referred by the Club Facilitator, drawing bloods for club clients on the annual blood visit and providing clinical consultation of club clients at their annual clinical review.
- Pharmacist or Pharmacy Assistant is responsible for pre-packing ART for clubs.
- Data Capturer is responsible for capturing the club client's visit from club register into the facility register after a grace period.
- Note: Only the Club Facilitator is always present at each club session. The Club PN is not present at the club session but available during and after the session to see symptomatic clients, take bloods and conduct annual consultation as necessary.

Club Organogram

- A club organogram is useful to clarify each team member's role in managing and supporting facility clubs.
- Clear roles and responsibilities for each team member improves staff participation in the model.
- The clubs manager requires authority (from facility manager) to ensure implementation and effective running of the clubs.
- Daily rotation of the club nurse function within the facility enables collective responsibility for the club clients' management.

Clinical Care and Counselling:

- Club members with symptoms/weight loss/other clinical problems are referred by Club facilitator and receive an individual consultation with the Club PN on the same day.
- Annually, monitoring blood tests are taken in the Club.
- At the following visit, all club members have an individual consultation with a clinician.
- Club members are re-scripted for ARV drug supply purposes every six months.

Club Records:

- Each Club has a club file that contains the scripts of the club members and a Club register which records attendance, weight, results of symptom screening and blood results.

Clients file are only drawn at re-scripting visits, at annual clinical consultation or if a Club member receives a consultation during a routine Club visit



Functioning of adherence clubs



DETAILED OUTLINE/FUNCTIONING OF CLUBS

Eligibility Criteria for Club membership

A client may qualify to join a club if (s) he meets the following criteria:

- Adult > 18 years
- On the same regimen for at least 6 months (regimen 1 or 2). However, in the case of a single drug substitution, clinician to determine when eligible.
- Stable on treatment (to be determined clinically according to the guidelines). E.g., for HIV, most recent viral load undetectable; the most recent of these taken in past 6 months (thus minimum of 6 months on treatment).
- OR client stable on second line Regimen
- Pregnant women and women on PMTCT follow-up can join or remain in the club granted that they do the ANC/PMTCT follow-up separately.
- No current TB in the intensive phase
- No medical condition requiring regular clinical consultations

Doctors or nurses determine and confirm the clients' eligibility for Club membership.

- Membership of a Club is voluntary
- Allocating clients to a Club designated for a specific feeder area makes it easier to move clubs into the community later on (easiest to start with facility-based clubs).
- Club members may be excluded from the Club based on a number of clinical and adherence criteria but may return to club at discretion of clinician.

Club attendance requirements

- a. Club members may send a buddy to collect medication for them on their Club visit day except:
 - on date of first attendance at the club
 - on a blood day
 - on a clinical consultation day
- b. Where the Club member sends a buddy on the blood day or the clinical consultation day, the buddy will be asked to inform the Club member that they need to come to the clinic to see the Clubs Manager within 5 working days of the club visit date.
- c. If a Club member sends a buddy to collect medication, 'buddy' is recorded in the register in the place of the weight. The buddy is informed that the Club member must attend the next visit.
- d. Should the Club member present within 1 week (5 working days), the Clubs manager reviews the case and, where appropriate, refers to pharmacy for issuing the treatment. This will be recorded in the Club register as a visit. If a blood, clinical or scripting visit the Clubs Manager will ensure that appropriate action taken for the specific visit.
- e. However, should a Club member not attend personally or send a buddy to collect meds within 1 week (5 working days) of the club day, the Club member will be regarded as a non-attender of the Club.

He/she will be recorded as a DNA (Did Not Attend) in the Club register.

- f. In the case of using an electronic register, the client must be recorded as DNA (not defaulter) as the client has not defaulted from the clinic.
- g. Non-attender members will be recalled through the contact details recorded in the register and the client will be required to return to mainstream care once they attend the clinic again.

Clinical management of Clubs

- At each visit, Club Facilitator is responsible for ensuring that:
 - The Club member is weighed, and weight recorded in register.
 - The Club member is asked – individually / in group / both – re the following, and results of the screening are entered into register:
 - TB symptoms (cough, weight loss, night sweats, fatigue)
 - Late onset treatment side effects
 - Pregnancy
 - Any other symptoms of concern
- Where the Club member is identified with any of the above symptoms, the Club member is referred to the Club PN for an individual consultation with their folder.
- The Club facilitator should also review the weights in the register to determine whether a client has lost weight. If this is the case, this client should be referred to the Club PN.
 - The Club PN consults these identified Club members.
 - The clinician(s) decide whether Club members referred from Club should remain in the Club or return to mainstream care

Pharmacy

- At enrolment visit Treatments will either be pre-packed by clinic pharmacy or each newly enrolled Club Member will attend the pharmacy after enrolment club visit for collection of medication.
- At facility a standard **facility script** is in use:
- The Clubs Manager must ensure that Club members are re-scripted 6 monthly at M6 by clinician at clinical consultation visit and at M12 and every 6 months thereafter.
- It should be clear on the club schedule when 6 monthly, re-scripting should be completed
- The Club file will be taken to the pharmacy at least 3 days prior to the club visit for pre-packing, and then be returned by the clinic pharmacy to the Clubs Manager.
- Pre-dispensed treatments to be issued at Club visit.
- It is recommended that the Club PN on duty for the club visit be responsible for its re-scripting.

Monitoring and evaluation of adherence clubs



Monitoring and Evaluation of adherence club

- Each club has a Club file, which contains a copy of the Club member's script (standard/CDU script). The file should also contain patient stickers.
- The Club File should be kept with the Club register (including the Club Tally sheet)
- Club register to be used every visit. The club tally sheet at the back of the register should also be completed at every visit.
- The Club register should be regularly reviewed by Clubs Manager.
- 5 days after the club visit, relevant information in the Club register must be transferred to the facility chronic register (paper or electronic) by the clinic data capture/clerk.
- Once monthly the Clubs Manager be responsible for providing the monthly club attendance data to the operational manager who will collate data together with other facility indicators and submit to the sub-structure co-ordinator
- At Facility level: club enrolment, club attendance, return to mainstream care (i.e. exited club), BP, weight, CD4 and Viral Load
- At Sub-district level: only enrolment, attendance at clubs and returns to mainstream care.

4.3.3 Fast/Spaced Appointments

Allowing a reduced frequency of clinical appointment and longer supply of drugs for healthy and stable patients on treatment can help reduce the burden on health workers and patients.

- In the spaced appointment system, clinically stable patients are requested to attend the clinic once a year for clinical assessment and drawing of blood (instead of every 1 or 2 months)
- Patients receive 6 months' prescription for their medication
- Each time they visit the health facility, stable patients should be allowed to collect at least 3 months' treatment
- Patients should be allowed to go through a fast lane system, meaning direct and quick access to the pharmacy
- In case of health problems or pregnancy, patients return to regular clinical care.



Population Health Awareness & Screening



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Department:
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REPUBLIC OF SOUTH AFRICA

Population Health Awareness and Screening



**POPULATION HEALTH
AWARENESS &
SCREENING**

HEALTH
AWARENESS DAYS

UNIVERSAL TEST
AND TREAT

INTEGRATED SCHOOL
HEALTH TEAM

WARD BASED
OUTREACH TEAMS



Population health promotion



- The Ward Based Primary Health Care Outreach Teams (WBPHCOT) should play a critical role in raising the level **of awareness of healthy lifestyles and good health** at a population level
- Primary prevention is most successful if it is conducted at a **population level** to increase awareness about the **social determinants of health** and their direct impact on the development of chronic diseases
- This can only be achieved through the participation of the WBPHCOTs in **awareness campaigns** that may be organised to coincide with specific events within the health calendar.
- **Social marketing** should be used at sports and religious events to raise awareness about chronic conditions
- **Screening services** should be provided during special events or at strategic points to identify asymptomatic patients or to identify at risk individuals and refer them appropriately
- Integrated School Health Teams will primarily conduct **health education and awareness campaigns at school level** and provide screening services to assist with the early detection of chronic diseases and the appropriate referral of these high-risk patients



Population health promotion

MONTH	HEALTH AWARENESS DAYS (SELECTED)
January	Finding of clinical audit and discussions with staff, facility manager and PHC supervisor.
February	<i>Healthy lifestyles Awareness Month</i> 15 Healthy Lifestyles Awareness Day 10-16 Pregnancy/STI/Condom week
March	24 World TB Day
April	7 World Health Day
May	<i>Anti-tobacco Campaign Month</i> 12 International Nurses Day 17 World Hypertension 12 World no Tobacco Day
June	17-23 June National Epilepsy Week 21 National Epilepsy Day
July	<i>Mental Illness Awareness Month</i>
August	<i>National Woman's Month</i> 9 National Woman's Day
September	<i>National Heart Awareness Month</i> <i>Cervical Cancer Awareness Month</i> 29 World Heart Day
October	10 World Mental Health Day 28-3 Nov World Stroke Week 29 World Stroke Day
November	14 World Diabetes Day
December	1 World AIDS Day



Universal Test and Treat (UTT)



Universal Test and Treat (UTT) is a strategy in which **all HIV infected individuals receive treatment** whether in need or not.

Overall goal

- To **reduce the incidence of HIV infection** in South Africa through the provision of expanded prevention and treatment options
- **All HIV positive children, adolescents and adults** regardless of CD4 count will be **offered ART treatment**, prioritizing those with $CD4 \leq 350$.
- Patients in the pre-ART and wellness programme shall be considered for UTT.

Integrated School Health Team



The Integrated School Health Team will provide **preventive** and **promotive** services for all learners at school and refer the learners for further investigation and management should the need arise

- Roles and responsibilities
- Referral loops
- Linkages with community health workers

Roles and responsibilities



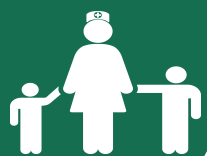
- The **DOH** is responsible for **provision of the package of school health services**
- The **DBE** plays a key role in creating an **enabling environment** for the provision of the ISHP. This includes planning, managing and monitoring of the programme, facilitating access to schools and services, and liaising with other role-players at all levels of the system



Services at school



Schooling Phases	Learner Assessments: Health Screening	On-site Services	Health Education
Foundation phase (Gr R-3) GRADE 1	<ul style="list-style-type: none"> Nutritional assessment Physical assessment (Gross & fine motor) Vision Oral health Hearing Speech Chronic Illnesses (Long term health conditions) TB screen Psychosocial Support Mental Health 	<ul style="list-style-type: none"> Deworming (incl bilharzia and malaria control where appropriate) Immunisation Td Oral health (where available) Minor ailments 	<ul style="list-style-type: none"> Hand washing Personal & environmental hygiene Nutrition Tuberculosis Road safety Poisoning Know your body Abuse (sexual, physical and emotional abuse)
Intermediate phase (Gr 4-6) GRADE 4	<ul style="list-style-type: none"> Nutritional assessment Physical assessment (Gross & fine motor) Vision Oral health Hearing Speech Chronic Illnesses (LTHC) TB screen Psychosocial Support Mental Health 	<ul style="list-style-type: none"> Deworming Minor ailments Counselling and referral for sexual and reproductive health as needed 	<ul style="list-style-type: none"> Personal & environmental hygiene Nutrition Tuberculosis Medical and Traditional Male circumcision Abuse (sexual, physical and emotional abuse including bullying, violence) Puberty (e.g., physical and emotional changes, menstruation & teenage pregnancy) Drug & substance abuse



Services at school



Schooling Phases	Learner Assessments: Health Screening	On-site Services	Health Education
Senior phase (Gr 7-9) GRADE 8	<ul style="list-style-type: none"> Nutritional assessment Vision Oral health Ear examination (Hearing) (Speech) Chronic Illnesses (LTHC) TB screen Anaemia screen Psychosocial Support Mental Health Physical assessment (including anaemia) 	<ul style="list-style-type: none"> Immunisation (Td) Minor ailments Counselling and referral for sexual and reproductive health as needed 	<ul style="list-style-type: none"> Nutrition Personal & environmental hygiene Tuberculosis Abuse (sexual, physical and emotional abuse, incl bullying and violence) Sexual & reproductive health <ul style="list-style-type: none"> Menstruation Contraception STIs incl. HIV MMC & Traditional Teenage pregnancy, CTOP, PMTCT HCT & stigma mitigation Drug and substance abuse Suicide
FET (Gr 10-12) GRADE 10	<ul style="list-style-type: none"> Nutritional assessment Vision Oral health Ear examination (Hearing) (Speech) Chronic Illnesses (LTHC) TB screen Anaemia screen Psychosocial Support Mental Health Physical assessment (including anaemia) 	<ul style="list-style-type: none"> Minor ailments Counselling and referral for sexual and reproductive health as needed 	<ul style="list-style-type: none"> Personal & environmental hygiene Nutrition Tuberculosis Abuse (sexual, physical and emotional abuse including bullying, violence) Sexual & reproductive health <ul style="list-style-type: none"> Menstruation Contraception STIs incl. HIV MMC & Traditional Teenage pregnancy, CTOP, PMTCT HCT & stigma mitigation Drug and substance abuse Suicide

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