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EVALUATION OF THE INTEGRATION OF THE COMPREHENSIVE CARE MANAGEMENT AND TREATMENT PLAN FOR HIV and AIDS IN EKURHULENI AND SEDIBENG DISTRICT HEALTH SERVICES

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A research report submitted to the School of Public Health, University of the Witwatersrand in partial fulfillment of the requirements for the degree of Master of Public Health.

May 2015

DECLARATION

I, Thoko Mercy Maboe student no: 0516244A declare that this research report is my own work and has not been submitted before for any qualification, certificate or publication.

Signature…….

6 day of May 2015

DEDICATION

I would like to dedicate this dissertation to my husband Paul and my son Amos not forgetting my father Chrissie and my late mother Sophie. There is no doubt in my mind that without their continued support, encouragement, and understanding I could not have completed this study.

ABSTRACT

Introduction

HIV and AIDS in South Africa has a considerable disease burden which places an enormous strain on the health care system. The increased workloads brought about by testing and counseling, prevention, treatment, care and support services with a concomitant decrease in the supply of health care workers impacts negatively on the quality of services.

Health planners and managers need to implement approaches that enable maximum utilisation of available resources by integrating HIV and AIDS into the normal functioning of existing programmes to address increasing demands for HIV and AIDS services and to strengthen the health care system.

Aim and Objectives

The aim of the study was to describe the extent of integration of HIV and AIDS services at the different levels of care in the district health system.

Method

This is a descriptive cross sectional study that used structured pretested interview questionnaires, data review and a facility check list. A stratified random sample of five facilities that were accredited in the district from 2004 – 2007 was used. Fifty two interviews were conducted face to face with facility managers, doctors, nurses, dieticians, social workers, and lay counselors and seventeen self-administered questionnaires were completed by district programme managers. A total of 69 interviews were conducted.

Results

The study highlighted the fact that most of the facilities (96%) implemented the HIV and AIDS programme without a documented operational plan. Stakeholder participation on planning was limited at less than 30% across all levels of services within the district. Budgeting and resource

allocation operated independently from the district and facility financial systems resulting in parallel systems.

Technical support and programme reviews by the district and provincial managers were weak and irregular. Support of HIV and AIDS services was mainly given by facility management. The district`s monitoring and evaluation systems were not in place. The referral systems between the facilities and community structures were not well established. Lay counselors skills on PMTCT and nutrition was rated the lowest and compromised the implementation of an integrated approach. HIV and AIDS services were not implemented at well baby clinics.

Conclusions

The findings of this study suggests that the HIV and AIDS services have developed into separate vertical administrative and reporting systems operating differently from the mainstream services and not supporting the strengthening of the health care system and therefore not capable of achieving the intended goal of the programme.

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ABBREVIATIONS AND DEFINITIONS

ANC - Antenatal care

ART - Anti retroviral therapy

CCMT - Comprehensive Care Management and Treatment

CHC - Community Health Care Centre

DER - District Expenditure review

DHIS - District Health Information System

FHI - Family health International

FP - Family planning

GTAFM - Global fund to fight AIDS, TB and Malaria

GTT - Global Task Teams

HAST - HIV and AIDS Sexually transmitted infections and Tuberculosis

HCT - HIV Counseling and Testing

PEPFAR - United States President Emergency plan for AIDS Relief

PICT - Provider Initiated Counseling and Testing

PHC - Primary Health Care

PMTCT - Prevention of mother to child transmission of HIV and AIDS

SDR - Service Delivery Region

MAP - Multi country AIDS Programme

MOU - Maternity Obstetric Units

Mx - Management

NSP - National Strategic Plan

NSDA - Negotiated Service Delivery Agreement.

USAID - US Agency for international development

WHO - World Health Organisation

CHAPTER 1 INTRODUCTION

1.1 Background

The HIV and AIDS epidemic is outpacing government's initiatives to upscale health care services to the majority of its communities in need of care. Health care systems around the world are striving for the implementation of policies that will ensure the attainment of the highest possible level of health as indicated in the Alma Ata declaration and the Millennium Development Goal (MDG) targets (UNDP, 2010). Countries have adopted different approaches to address their own health needs with respect to policy, planning, financing, managing and monitoring services. Health system strengthening requires significant investments and the increasing donor funding for HIV and AIDS has potential to divert resources and experienced staff from mainstream health programmes (Heunis and Schneider, 2006). There is however evidence that if managed correctly, the AIDS response has a unique opportunity to strengthen the wider health sector (Marchal, Cavalli and Kegel, 2009).

According to the report of the World Health Organisation (2007), the global trend indicates that targets set by the international community to combat HIV and AIDS are not being reached and unnecessary deaths are still at a very high level because of the limited capacity to put more patients on antiretroviral (ARV) treatment in low and middle income countries (LMIC). ARV coverage in LMIC increased from 39% in 2009 to 47% in 2010 improving access to 6,65 million population infected with HIV/AIDS (WHO, 2013). The people infected with HIV in 2011 were estimated at 34 million and seven million who were eligible for treatment did not have access (UNAIDS, 2012). In Africa, with approximately 26 million HIV infected people, only 8% of the more than four million people eligible for services had access to ARVs (WHO, 2013). Historically, the approach of the international aid agencies in developing countries, as seen with smallpox, malaria, family

planning, sexual and reproductive health interventions, were disease centered. Targeted responses that functioned vertically within the existing health care system with their own lines of accountability and ring-fenced budgets were implemented (de Pinho, et al., 2005). Although this approach was able to deal effectively with some of these diseases, it does not address systems strengthening and sustainable development (Jeppsson and Okuonzi, 2000).

There is now worldwide commitment to health systems development to ensure that HIV and AIDS services become accessible to the majority of communities in need of the services (WHO, 2009a).The United Nations General Assembly special commission on HIV and AIDS convened in 2001 affirmed that a comprehensive (as opposed to a vertical or selective) approach is the most effective response to combat the epidemic and to strengthen health care systems (WHO, 2008).

Despite efforts and increased resources, health care systems in low and middle income countries have not experienced major improvements in their health systems and continue to experience high death rates, poor health indicators, suffering and poverty brought about by the HIV epidemic (WHO, 2006). Some countries are questioning whether investments have strengthened or weakened their already ailing health systems as increased resources are used to deal with a limited number of HIV and AIDS patients in a vertical manner at the expense of other equally important diseases confronting their communities and a large number of HIV and AIDS patients in need of health care (Marchal, Cavalli and Kegel, 2009).

The HIV and AIDS prevalence rate in South Africa is 11% and the total number of people living with HIV is estimated at 5,38 million in 2011 (Statistics South Africa, 2011). This figure is significantly higher than the rate in sub-Saharan Africa (5.0%) and globally (0.8%) (Kaiser Family Foundation, 2011). An

estimated 270 000 South Africans died in 2010 due to HIV/AIDS. This figure constitutes 42% all deaths (UNAIDS, 2012).

In South Africa the Comprehensive Care, Management and Treatment (CCMT) Plan for HIV and AIDS (DoH, 2003) is aimed at addressing universal coverage for HIV and AIDS services. This plan resulted in the accreditation of facilities to render antiretroviral treatment since 2004. The fundamental objective of this plan is to strengthen the health care system by ensuring that the services for HIV and AIDS are integrated into primary health care (DoH, 2003).

The comprehensive HIV and AIDS plan needs to be operationalised in the activities of the PHC services to ensure an integrated approach within the existing systems, address the root causes of the health system weakness and promote a sustained level of accessible, effective and quality HIV and AIDS services (Pfeiffer, et al., 2010).

The Ekurhuleni and Sedibeng Districts are located in the Eastern and Southern parts of Gauteng Province. They have a combined urban population of 3, 3 million (DoH, 2007). Services in these two districts are managed by a Regional office, and include nine hospitals (4 regional and 5 district) 12 Community Health Centers (CHCs) and 117 Primary Health Care (PHC) clinics (Annexure 4 and Annexure 5).

The antenatal HIV prevalence rate in Ekurhuleni and Sedibeng Health districts in 2007 was at 33% (DoH, 2010), and only 30% of the estimated coverage of eligible patients was on ARV treatment (DoH,2007a). The HIV and AIDS plan has been implemented in twelve dedicated “service points” spread throughout all the six sub districts of the two districts from April 2004 (DoH, 2007a). Of the 19385 people on ARVs PHC services in Ekurhuleni and Sedibeng districts were seeing

only 17% of the total consultations for HIV and AIDS in comparison to 46% at regional hospitals and 37% at district hospital (Figure 1). Fully 83% of consultations were happening in hospitals (DOH, 2007a).

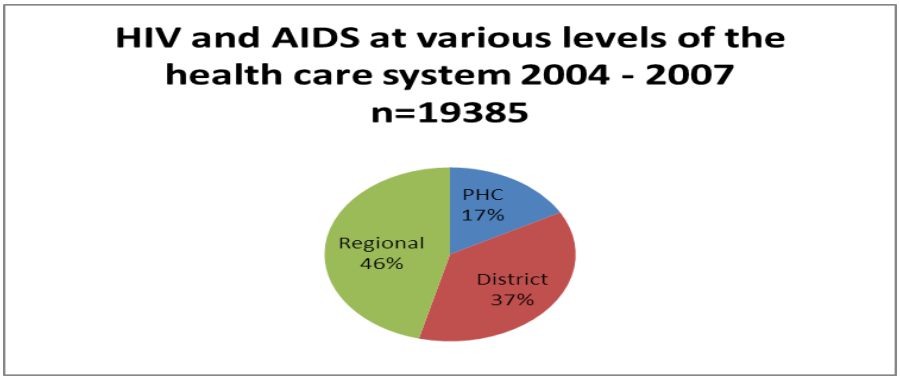

Fig 1: Proportion of HIV and AIDS consultations at the various facilities Ekurhuleni and Sedibeng districts 2004 -2007. (Source: Health Information Systems Gauteng January 2007 ART service Report).

By 2007 all of these sites had reached saturation points as seen by long waiting times and need for more resources (DoH 2007b). The researcher also identified that management and support of these sites was challenging, with expectations from donors, different programme managers and conflicting roles and responsibilities of stakeholders.

The preparation and support of these sites was given by both Provincial and National departments in line with international standards for strengthening the health care system by ensuring an integrated approach to existing services (DoH, 2003). However the extent to which the activities and processes of planning and financing, management and support and integrated service delivery within the HIV and AIDS programme has contributed to strengthening the overall institutional and district health care system is not clear.

1.2. Statement of the problem

The growing number of people in need of treatment care and support continue to outpace the capacity of health care services to respond effectively to the epidemic (WHO, 2007). There are still major gaps in the implementation of the HIV and AIDS services which are still running parallel at all levels of care in the health system and impacting negatively on the limited resources, access as well as the quality of the services (WHO, 2009 c). In the researcher's experience as a regional coordinator for the programme, she observed that HIV and AIDS management and decision making are to a large extent centralised and disabling responsiveness to the epidemic at local level.

1.3 Justification for the study

The researcher was appointed to establish ARV sites in Ekurhuleni and Sedibeng Districts (known as Region B) in 2004.Part of her management role was to monitor the programme`s compliance with the Comprehensive operational plan of 2003 as indicated by the National Department of Health (see attached copy Appointment letter).

The findings will assist health care planners and management at Ekurhuleni and Sedibeng health District to ensure that the HIV and AIDS plan is integrated into key health care system functions for PHC which is planning and financing, management support and service to ensure the desired output for the programme.

1.4 Aim and objectives

The aim of the research study was to establish the extent to which the comprehensive management of HIV and AIDS plan is integrated into the existing primary health care services at three key areas of the health care system namely:

planning and financing, monitoring and service delivery in Ekurhuleni and Sedibeng health services.

1. To describe how the planning and resource allocation for HIV and AIDS is integrated in PHC services of Ekurhuleni and Sedibeng Districts.
2. To describe how HIV and AIDS programme development and monitoring are integrated in Ekurhuleni and Sedibeng District health services.
3. To describe the extent to which HIV and AIDS services are integrated at entry points of PHC services within the HIV and AIDS facilities.
4. To identify the capacity of lay counselors in the comprehensive management of HIV and AIDS at service delivery level.

CHAPTER 2 - LITERATURE REVIEW

2.1 Development of HIV and AIDS programmes

The commitment to scale up HIV and AIDS treatment to people living in resource limited countries has gained substantial financial support from multilateral institutions and private donors e.g. Global fund to Fight AIDS, Tuberculosis and Malaria (GTAFM), the World Bank's Multi country AIDS programme, (MAP), the United States President Emergency plan for AIDS relief (PEPFAR) and private donors such as Bill and Melinda Gates Foundation (Global Task Team, 2005). Operational support has been given by the Joint United Nations Programme on HIV and AIDS (UNAIDS), World Health Organisation and UNICEF to address national leadership in areas of ownership, alignment and harmonisation of the response to the AIDS epidemic (WHO, 2007). Therefore reports and papers from these organisations have contributed to shaping the face of HIV and AIDS Implementation County wide (WHO, 2009c).

Literature reviewed in this research was mainly from peer reviewed papers, reports and case studies by the Global Task Teams (GTT) and multilateral institutions supporting HIV and AIDS services in low and middle resourced countries.

2.2 Integration of HIV and AIDS services

The definition of integration as used in this research is according to Heunis and Schneider (2006: 260). They state that "Integration is the process of bringing together different independent services and administrative structures, so as to achieve common goals. Integration can occur at three levels: at the patient level (integrated case management); at the level of service delivery (bringing together

different services into one delivery channel) and at the systems level (management and support functions)".

Integration is not a new concept and has been used to describe a range of phenomena. Integration in this research is mainly about the organisation of service delivery to enable clients to receive a continuum of preventable and curative services according to their needs across different levels of the health care system (de Pinho, et al., 2005). Integration can also play a role in promoting alignment and harmonisation with other priority programmes to eliminate unnecessary duplication and bureaucratic red tape that impedes cost effectiveness, equity, and patient and community participation (Farrell, 2007).

Integrated services do not necessary mean that services are offered in the same location within the facility or by the same service provider. Rather it implies that a seamless service structure for HIV and AIDS need to be in place to ensure that the organisation of services enables people to get the care they need at every point of contact within the primary health care system in a way that is acceptable and in a manner that promotes the achievement of the desired goals and intent of the national plans and policies (Foreit, 2002). Integration can be vertical (between the levels of care) or horizontal giving decision making power to the periphery (Kabatereine, et al., 2010). It is advocated that integration should include strategies that will have the greatest impact on the epidemic with limited resources and that progress should be measured in terms of sustainability of other programmes and not just HIV and AIDS. According to Pfeiffer (2010), integration should include ART services in existing units, retraining existing workers, strengthening of laboratories, testing and referral linkages, expanding testing, integrating HIV and antenatal services and improving district level management.

Evidence based reports of MDG goals assessments in thirty-four countries around the world supports health interventions that address multiple factors. These reports indicate that such approaches have resulted in overcoming many obstacles in low resourced countries towards the accomplishment of the MDG goals (United Nations, 2010). Best practices for success were in Kenya, Rwanda, Mali and Botswana who managed to improve the health of children by integrating obstetric care, immunisation, vitamin A supplementation and emphasis on community based health into primary health care services (United Nations, 2010).

Studies in Uganda, Rwanda, Mozambique and Cameroon have indicated that when efforts are harnessed to strengthen the health care system by integrating HIV and AIDS services in a primary health care setting, positive outcomes are experienced in HIV and AIDS as well as other priority health programmes (Ritzenthal, 2005). The integration approach in these countries enabled the PHC system to test more patients for HIV, initiate more patients on ART quickly and efficiently, reduce loss to follow up and improve geographic HIV care coverage. HIV resources have been used to improve infrastructure, supervision, human resource, and patient referral systems (UNAIDS, 2005).

An integrated health information system is a management tool that needs to address all facets of clinical care and health status, and inform management decisions for intervention and improvement of the quality of services rendered (Ritzenthaler, 2005).

Countries who managed to improve the integration process focused on their reporting tools for accuracy and reliability e.g. Uganda and Rwanda and Mozambique (Ritzenthal, 2005).

The Primary health care system is the entry points for HIV and AIDS management where patients access testing and present with symptoms. Integration of HIV management at this level of care mitigates stigma and loss to follow up where patients may not be able to afford the transport to go to a referral center for care or the complicated maneuvering and long waiting times within the facility. Strong health care systems are identified as key towards the improvement of health outcomes (Travis, et al., 2004) and studies across the countries has identified operational barriers to the integration of services (Farrel, 2007). In Kenya the following barriers were identified (Okundi, et al., 2009):

- Lack of national strategy / policy and guidelines on integration.
- Minimal national level supervision for integrated services.
- Different reporting formats and the absence of clear monitoring and evaluation indicators to measure progress.

Studies conducted in South Africa have indicated missed opportunities and gaps in the management of PMTCT. In Kwa Zulu Natal, though this province had the highest antenatal HIV prevalence at 40% in 2005, counseling and testing services were conducted to only a third of women visiting ANC services with only 42% of facilities offering testing and PMTCT services (Global Task Team, 2005). A National Evaluation study by the Department of Health in South Africa showed that antenatal mother to child transmission rates in pregnancy and intrapartum was

at 3.5% and early infant diagnosis of HIV and AIDS was at 35% pointing to missed opportunities in well baby services (Goga, et al.,2010).

The World Health Organisation advocates for a Public Health approach to the management of HIV and AIDS (WHO,2009a). This approach integrates chronic disease management as well as acute illnesses by simplifying protocols and decentralising the services to reach many people. The report also noted that sustainable systems need to be integrated at the point of service as well as at higher levels to ensure integrated policies to address issues of financing, coordination between government and donors and between public and private service providers (WHO, 2009a). This approach to integration of HIV and AIDS programmes across the entire health care system can minimise many of the barriers to the achievement of universal access and the improvement of the health care system to address the needs of the communities within affordable and sustainable means (WHO, 2006).

2.3 Decentralisation

An integrated approach requires a decentralised system to build capacity and ownership at the lower levels of services i.e. facilities and districts. According to

Brijlal (1988 :38) "Any decentralisation initiative can be clearly weakened by a lack of capacity, if tasks and responsibilities are transferred from central without the necessary capacity to perform these tasks" therefore it is important to build capacity at the lower levels to improve the responsiveness of services. The South African health policy is supportive of a decentralised health care system and gives the right for all citizens to have access to health care services. This places an obligation on the state to progressively realise socio economic rights including access to health care (Hassim,et al., 2007).

HIV and AIDS is now a maturing disease according to the global trends (WHO, 2009a) with improvements in prognosis. This is envisaged to increase numbers of patients visiting the facilities beyond the current status. A disease of this magnitude, calls for the utilisation of strategies that have been documented as yielding benefits especially in the face of limited resources. Treating patients at primary health level is highlighted as a means of improving access and accountability by lowering medical costs for poor communities (Tawfik and Kinoti, 2003). Building capacity and skills for monitoring and support of the programme at this level is therefore a prerequisite for a decentralised dispensation that promotes local decision making powers and accountability (Pillay, et al., 2001).

All countries are striving towards the achievement of the millennium development goals by 2015 which include halting and beginning to reverse the spread of HIV and AIDS (DoH, 2012). In achieving this goal the main objective is to ensure that key decision making powers for planning, budgeting, human resources monitoring and evaluation are decentralised to the lower levels of service delivery for maximum impact and for monitoring and reviewing of progress (WHO, 2000).

2.4 Global and National HIV and AIDS Targets

In 2003 the multinational agencies aimed to reach 3 million people in resource constrained countries with ARV's by 2005 (3x5 strategy) (WHO, 2006). Achievement of universal access to HIV and AIDS services was set out as the goal for all health systems with a high burden of HIV and AIDS. Even though this goal was not achieved, it influenced remarkable coverage and access to ARV's especially in low resourced countries (WHO, 2006). More than 1,3 million people in sub Saharan Africa received treatment by December 2006 representing 28% of

those in need as compared to 3% in 2003 (WHO,2006). The trend was still disappointing with only 11% of pregnant mothers having access to ARV's and HIV and testing remaining very low (WHO, 2006). The millennium development goals set out by the United Nations in 2000 include the targets for HIV in terms of the reduction of spread and universal access by 2015(United Nations , 2010). All nations are beginning to strive for strategies that will enable the accomplishment of this goal (Travis, et al., 2004).

The South African TB review conducted in 2009 indicated that more than 70% of TB patients were co - infected with TB and HIV and only 40% were tested for HIV since 2005 (WHO, 2009b). HIV counseling and testing and TB / HIV co management are two important entry points to HIV and AIDS management and the improvement of mortality rates from HIV infection. Countries with high prevalence of HIV need urgent strategies to accomplish the target of having TB cure rates of 85% to ensure that the spread of HIV and AIDS is reversed by 2015 (Fields,1998).

The health Policy in South Africa was revised in 2010 to greatly upscale treatment (DoH, 2010). The areas highlighted in the revised policy are: children under one year of age testing positive to initiate treatment irrespective of CD4 count as well as pregnant HIV positive women with CD4 count of 350 or less. Other HIV positive pregnant women with a CD4 count of more than 350 to be given dual therapy treatment (AZT and Nevirapine) at 14 weeks of pregnancy to protect the baby (DoH,2010). Massive HIV counseling and testing (HCT) campaigns were introduced as well as establishment of male medical circumcision sites (DoH, 2010).

The National HIV Strategic plan for 2012/2016 (Department of Health, 2012) is in line with the global trends for escalating HIV and AIDS outcomes. The strategy has five goals namely:

- Halving the number of new HIV infections
- Ensuring that at least 80% of people who are eligible for treatment for HIV are receiving it.
- Halving the number of new TB infections and deaths from TB.
- Ensuring that the rights of people living with HIV are protected.
- Halving the stigma related to HIV and TB.

This plan has identified that for implementation to be successful an integrated multisectoral approach at national, provincial and district level is key (DoH, 2012).

South Africa is faced with a quadruple burden of disease (DoH, 2010) which is HIV and AIDS and TB, High maternal and child mortality, non-communicable diseases, violence and injuries. The National government has agreed on key indicators to monitor performance, the negotiated service delivery agreement (NSDA) (DOH, 2010). This is an outcome based approach focusing on the following key deliverables:

- Increasing life expectancy.
- Reducing child and maternal mortality.
- Combating HIV and AIDS and tuberculosis.
- Improving health care systems effectiveness.

The South African health care system has been characterised as fragmented and inequitable and the approach to reengineering of Primary Health Care has been identified as the backbone in strengthening the Health care system (DoH,2010).

Priority areas that need to be addressed by this approach include: decentralisation of management, establishment of District health system, increasing access to services, strengthening disease prevention and health promotion for HIV and AIDS maternal and child mortality and budget reprioritisation (Pillay, McCoy and Asia, 2001).

It is therefore important that the District health systems in the face of limited resources review the strategies employed at this level to address capacity at all levels of the District health care services with emphasis on, Sub district, Facility level and community outreach (DoH, 2010). An integrated approach towards, planning and financing, management support and integrated service delivery will ensure that the health care system is strengthened not only to manage HIV and AIDS as a major contributor to high mortality rates but to agressively ensure that HIV and AIDS is an integral aspect of all strategies employed to decrease the quardruple burden of disease (DoH,2010).

2.5 HIV and AIDS and health system impacts and constraints.

Significant challenges in the delivery of HIV and AIDS services in low and middle resourced countries have been identified as: shortage of human resources, limited funding, weak procurement systems and unreliable information systems (Ritzenthal, 2005).

Measures taken to strengthen the health care system for the improvement of quality in HIV and AIDS services need to invest in these areas for a sustained approach (Shakow, 2005).

In Uganda the global health workforce alliance forum held in Kampala in 2008 identified that shortages of human resources for health contributes to a weak health care system and that massive scale up of community and midlevel health workers can positively contribute to the scaling up of HIV prevention, treatment care and support (UNAIDS, 2008).

A shortage of skilled health personnel has been observed in high HIV prevalence countries more often than in countries with low HIV prevalence. This is due to direct impact of HIV on the workforce (Veriava, et al., 2005). The World Bank has estimated that a country with prevalence rates of 30% would lose 3% to 7% of its health care workers (Marchal, DeBrouwere and Kegel, 2005).TB incidence increased fivefold in South Africa during 1991 and 1998 among health workers (WHO, 2009b).

A study conducted in Gauteng Province (Mathabathe and Kalete, 2004) has shown that up to 40% of all hospitalized patients have an HIV and AIDS related illness constituting 44, 6% of adult admissions and 48.5% child admissions. The overall mortality rate for hospitalized patients was the highest in Ekurhuleni/ Sedibeng Region at 17.2% compared to that of City of Johannesburg at 13.2% and Tshwane Metsweding at 9.9%. The hospital average length of stay ranged between 9 to 14 days for HIV/AIDS in comparison to 6.6 for other patients. This resulted in non HIV and AIDS patients being crowded out of regional and tertiary institutions

(Mathabathe and Kalete, 2004).

Mortality rates reflect poor outcomes of health care management and point directly to a need to improve the quality of services (United Nations, 2010).

Primary health care services are overstretched and lack the capacity and skills to deal with the changing demands of service delivery (DoH, 2007a). There has been a re-emergence of diseases which were previously managed well and showing a decline e.g. TB with the manifestation of MDR and XDR, malnutrition, diarrhea and pneumonia (DoH, 2009b). HIV and AIDS has increased the activities of clinicians during consultations with new services such as HCT, PMTCT and ART (DoH, 2007a). The demand for health care services has increased with the roll out of ARV`s causing new constraints to adequate provision of resources and quality of care (WHO, 2008).

Apart from the fact that health professionals could be infected, they have to deal with an increasing number of people who suffer from a fatal disease for which no cure has been found and emotional stress, poor performance, absenteeism and burnout are directly linked to high workloads and difficult working conditions brought about by high inpatient care and mortality rates (Marchal, et al., 2005). A study conducted in two public hospitals in Johannesburg (Veriava,et al., 2005) showed that 83% of nurses who left nursing had less than five years of service a factor contributing to loss of skilled workers in the health care system.

2.6 Funding for HIV and AIDS services

Governments and donor funding for HIV and AIDS has increased over the years however the funding in low and middle income countries have not kept pace with an increased demand for services (Global Task Team, 2005). The ring fencing of HIV and AIDS budgets by donor countries has resulted in poor absorptive capacity

and inability to implement country AIDS plans (UNAIDS, 2005). Increased government and donor allocations are not accompanied by improved capacity within countries to determine their own agenda to support the overall strengthening of the health care system (Marchal, Cavalli and Kegel, 2009). The provision of HIV and AIDS services depends on a sustainable health care system which is able to provide all services and not only HIV and AIDS. HIV and AIDS budgets should therefore be utilised to improve sustainability and overall effectiveness of the health care system (WHO, 2007).

The harmonisation and coordination of all procurement procedures within the health care system ensures that equipment and drug sustainability regardless of whether there are multiple drug procurement systems from donors or a single system within the country (Shakow, 2005) be managed effectively. The bulk of the HIV and AIDS budgets come from donor funds, therefore integration can be possible if the donors and country leadership contextualise programs to the individual country needs (WHO, 2009c).

In South Africa there has been a remarkable improvement in the budget allocated for HIV and AIDS by the government at a nominal growth of 98% from 2001 to 2003 financial year with donor funds increasing to 40% in 2003 as a share of total HIV and AIDS earmarked funds (Ndlovu, 2004) which shows a remarkable improvement in the prioritization of funds for HIV and AIDS by the Government. The increase of funds has created challenges of absorptive capacity mainly created by the fact that the budgets are ring fenced with strict conditions that do not accommodate the overall health care weaknesses (UNAIDS, 2005).

2.7 Strengthening of the health system

The HIV and AIDS epidemic contributed to the damage of health care systems that were already overstretched due to decades of neglect in developing countries (WHO, 2009a). According to Bossert (1998) decision making space at local level allowed by central government contributes to effective strentherning of the health care system and therefore the district, subdistrict and facility level managers need to make meaningful contributions in critical decisions of planning and financing health care systems to be reponsive to the needs of the community.

Human resources planning is critical and should be placed high on the agenda of all strategic plans for health delivery and not just producing the numbers and type of staff to match the services (Tawfic and Kinoti, 2003). Maintaining adequate levels of training and inflow and ensuring that adequate skill mix is retained in all categories (Marchal, DeBrouwere and Kegel, 2005). Human resources consume 60% to 70% of the health budget and strategies for retention, attraction, and health worker motivation should be sustained with appropriate planning, support and management for an improved response to the epidemic (WHO, 2006).

The World Health Organisation recommends task shifting to alleviate health care worker shortages and health system weakening. Task shifting involves the identification of tasks that could be performed by lower categories of health care workers as well as patients and lay community members (Callaghan and Schneider 2009). This system is yet to be implemented in South Africa. According to Simon (2009) the evolution of integrated and expanded health activities for community health care workers will deliver the desired output of a strengthened health care system as opposed to a ‘disease specific’ approach. Lessons learned in rural Mozambique have indicated that an integrated approach is more acceptable to the

communities and fosters accountability from service providers (Pfeifer, et al., 2010).

According to the World Health Report 2005, the purpose of integration is to tackle the need for complementing different independent services and administration structures so as to achieve common goals (WHO 2005:108). The report defines integration at three levels i.e. patient level, "case management", services delivery and systems level. HIV and AIDS patients have different need e.g. prevention of mother to child transmission (PMTCT), nutrition, treatment adherence, voluntary counselling and testing (VCT) and (PCR). Comprehensive management of these needs at patient level and service delivery level promotes holistic management and loss to follow up to patients referred to different services at the same time in the same of different services.

CHAPTER 3 – MATERIALS AND METHODS

3.1 Study Design

A descriptive cross-sectional study was conducted.

3.2 Study site

Ekurhuleni and Sedibeng health districts are two of the six health districts in Gauteng and together they command 37% of the entire population of Gauteng at 3.9 million. The total population of Ekurhuleni is estimated at 3, 1 million with 34% HIV prevalence while Sedibeng has an estimated population of 800,000 with 33% HIV prevalence (DoH, 2010).

The health care system is based on the district health system model with primary health care as the first line of contact with health care services.

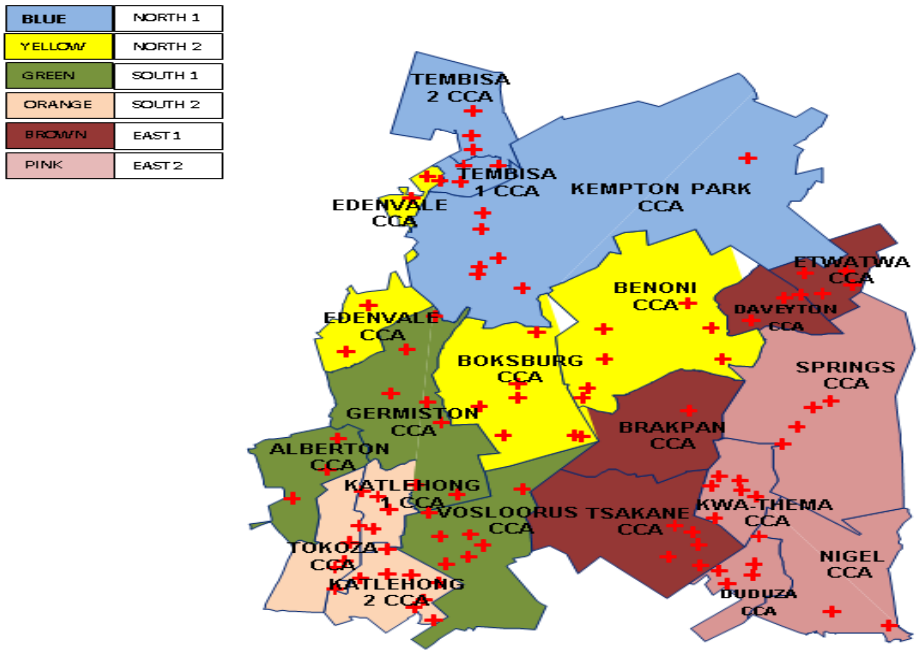

Fig: 2 Ekurhuleni District Map: District Health Plan (DHP) 2013.

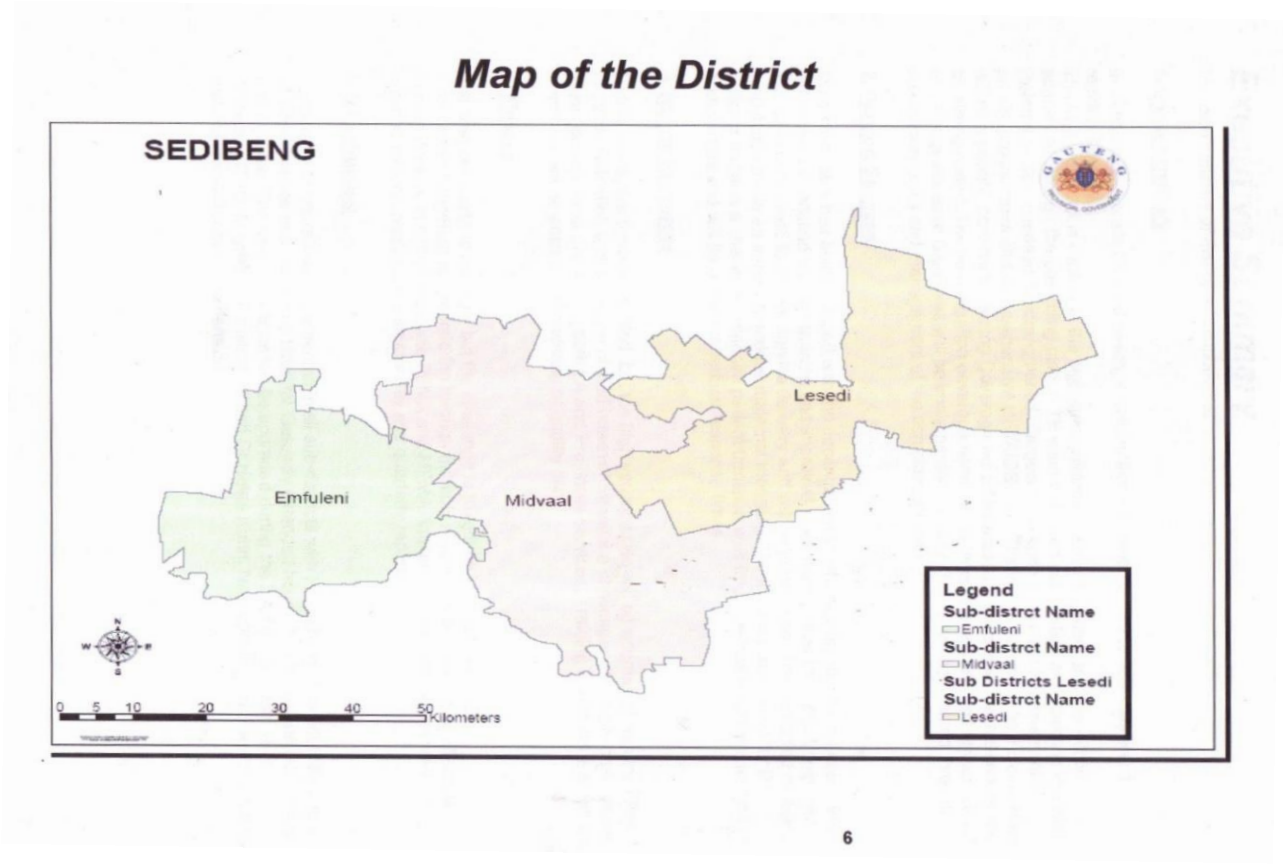

Fig: 3 Sedibeng District Map: District health plan (DHP) 2013.

3.3 Study Population

Ekurhuleni and Sedibeng health districts were implementing the Comprehensive management of HIV and AIDS plan (DoH,2003) from 2004 – 2007 in twelve of the fixed primary health care facilities. These facilities were given accreditation certificates by the National Department of Health. All accredited facilities were in operation for more than two years and had reached the 500 mark of new patients on ART. The Districts were selected for the study to evaluate the extent at which the HIV and AIDS services were integrated in PHC facilities according to the HIV and AIDS plan of 2003.

There are 12 accredited facilities consisting of nine hospitals and three community health care centers with a staff complement 180 health care personnel excluding allied staff (Administration officers and cleaners). Twenty three district and regional managers were responsible for the management of the programme in both districts from provincial and local government six Sedibeng, 14 Ekurhuleni and three Finance and procurement managers at the regional office supporting both Ekurhuleni and Sedibeng districts.

3.4 Study Sample

3.4.1 Facilities

A random stratified sampling of five health care facilities was done from the twelve accredited facilities. The stratified sample resulted in

- Two (2) District Hospital based health facility
- Two (2) Regional Hospital based health facility
- One (1) Clinic based health facility.

In addition, two District offices were included.

The five accredited facilities had a staff establishment of 63 health care professionals and a convenience sampling was used to recruit all personnel on duty during the interviews for the study. A total of 52 health care professionals were available to be interviewed. Face-to-face interviews were conducted as per schedule agreed upon with the facility head in order not to disrupt services.

3.4.2 Programme Management.

The HIV and AIDS programme was supported by 23 managers from provincial and local government who supported all facilities in both districts on programme coordination and development i.e. six for Sedibeng, fourteen for Ekurhuleni and three regional finance managers. All programme managers were purposively selected for the study and self-administered questionnaires were emailed to all of them.

3.4.3 Document validation.

A follow up facility visit for validation of responses was done using the checklist (Annexure 4) in all the health facilities where interviews took place. Supporting documentation available during the audit was reconciled.

3.4.4 Document review – patients files.

Integrated service delivery of HIV and AIDS into routine patient management was validated in key priority programmes namely: antenatal services, well baby clinic services and tuberculosis services. The average daily intake of patients under these categories over a period of one week ranged between 27 and50 in these facilities. A random sample of 30 patient files were selected from the reception desk (six per facility) to validate HIV and AIDS entry points in the routine management of patients presenting in these facilities. Facility auditing for integrated services delivery was done to assess access to counseling services and community participation within the facility. A checklist was used (Annexure 4).

3.5 Exclusion criteria

An exclusion criterion was used for all community health care workers doing Direct Observed Treatment for tuberculosis patients (DOT) supporters, cleaners, and administration staff who were on duty.

3.6 Questionnaire development

Integration of services is a complex phenomenon which is not interpreted the same everywhere and therefore data collection was standardised by means of a conceptual framework (Annexure 3) based on the three major objectives to guide the research process and to generate clear hypothesis and use of data in analysis.

The variables measured were categorized in terms of the integration ‘domains” which are:

- Integrated planning and financing
- Integrated management and support
- Integrated service delivery.

Detailed indicators for each domain were developed and formed the basis of the design of the interview schedule.

HIV and AIDS services in this context were defined according to the Comprehensive HIV and AIDS Care, Management and Treatment (CCMT) Operational Plan for South Africa which includes testing for HIV and AIDS, providing antiretroviral treatment, managing and supporting people infected and affected with HIV and AIDS. The plan addresses issues of access to treatment for HIV and AIDS in a comprehensive manner and its fundamental principle is the strengthening of the national health care system as a whole, to ensure the effective

delivery of HIV and AIDS services. The plan also requires that the programme should be integrated within the existing health care programmes across the board and not as a parallel system.

3.7 Data collection

3.7.1 Face to face interviews

Face to face interviews were carried out by means of a structured interview schedule (Annexure 2) which was administered by a trained fieldworker at the point of service. Time schedules for interviews as agreed with the facility heads were strictly adhered to. The interview sessions lasted for an average of thirty five minutes. Participants were informed that a follow up session will be done at a later stage. Interviews were performed to 52 respondents and a total of 11 personnel were not on duty.

3.7.2 Self-administered interviews

Structured interview schedules (Annexure 2) were used for self-administered interviews. Twenty three structured questionnaires were emailed to district and regional programme support managers for self-administration.

Twelve responses were received via email and five responses were deposited into the collection box. A total of seventeen positive responses were received.

3.7.3 Document reviews and facility audits.

Document reviews and facility audits were done according to the checklist (Annexure 4). Five facilities and two district offices were followed up on document validation total of seven. The session for document review and facility audit was done as a follow up to validate the responses from face to face as well as

self-administered interviews. Facility documents included plans and policies, budgets and procurements, management support and meetings.

3.7.4 Document reviews – Patient files.

Thirty patients were randomly selected from the reception desk of five facilities according to the following category: two from ANC, two from well babies and two TB patients. The patient files were audited for documented HIV interventions during the routine management of the patient. Facilities were audited to determine proximity and accessibility of counseling services by tracking referral points. This session lasted for six to seven hours on average.

3.8 Pilot study

Four field workers were trained by the researcher to collect data and to do facility observation and document reviews. Training was conducted for all the fieldworkers on data collection, facility observation and document reviews. The interviews, facility observation and document reviews were piloted at one of the CCMT site that was not part of the study. Self-administered questionnaires were distributed by email to five former MPH class colleagues who were working in primary health care services of South Africa. The study involved pre testing of the research tools and data collection methods to improve the design of the research. The pilot study led to the modification of the data collection materials and procedures for facility audits and was therefore not incorporated into the main study.

3.9 Data Analysis

3.9.1 Structured questionnaires (face to face and self-administered)

Open ended questions from structured questionnaires (face to face and self-administered) were categorised manually according to responses and coded. The data was captured on excel Microsoft spreadsheets and data cleaning was done by running all frequencies to identify missing and duplicate records as well as completeness.

Variables were categorised in terms of the study objectives and each data set was analysed separately. Microsoft excel analysis toolpak was used to analyse all data sets. Variables were measured for central tendencies and calculated to represent the average and spread of values of variables. Results were displayed in graphs and tables.

3.9.2 Checklists (Document validation /patient files/facility audit)

The checklists for document validation and patient file reviews (Annexure 4) were tabulated manually and captured on excel Microsoft spreadsheets. Microsoft excel analysis toolpak was used to analyse all data sets. Variables were measured for central tendencies and calculated to represent the average and spread of values of variables at 95% confidence interval. Results were displayed in graphs and tables.

3.10 Bias

Bias could be introduced by the researchers association with the programme as well as other HIV and AIDS health care workers as to how responses are interpreted. However it is also important to note that the development and improvement of the programme is one of the research team's key areas of

responsibility and the research will benefit output and functioning of services in the area of HIV and AIDS.

3.11 Ethical considerations

Participation in the research was voluntary and all participants were provided with consent information sheets which stated the purpose of the research.

Participants also signed a consent form. Respondents were given an opportunity to decline participation before or at any point of the study. Names of people or their facilities were not indicated on the data collection tools.

Approval for the study was given by the Committee on Human Research Ethics (Medical) University of the Witwatersrand (R14/49). (Annexure1)

Permission to conduct the research in the Districts was given by Ekurhuleni research committee.

CHAPTER 4 - RESULTS

4.1 Introduction

In this chapter the data is presented in tables and graphs following the order of the objectives. Standardised face-to-face interviews were conducted with 52 respondents and 17 positive responses were received from self-administered questionnaires. A total of 69 interviews were conducted which includes the following categories of health care workers: 34 professional nurses, six doctors, five dieticians, five social workers, six pharmacists, 11 lay counselors and two finance managers.

Documents were reviewed in a total of seven facilities i.e. five health care facilities and two district offices. Thirty patient files were audited to track HIV and AIDS services rendered to patients visiting the facility. A follow up facility audit was done to all the health care facilities under study and a random selection of six clients at the registration desk of each facility site was selected. Criteria used for selection of patients were: two ANC, two well-babies/ under 5 and two TB patients.

4.2. Professional profile and years of experience

Over two-thirds (71%) of all respondents had more than two years of experience with the largest proportion having two to three years of service (48%). The lay counselors mainly had experience of less than two years. The professional nurses constituted the largest proportion of all health care workers at 49%.

Table 1: Professional profile and years of experience. n = 69

Health care professionals	< 2yrs	2yrs - 3 yrs.	4yrs – 5yrs	5yrs+	Total	%
Prof. nurse	4	20	6	4	34	49%
Doctor	2	3	1	0	6	9%
Dietician	2	3	0	0	5	7%
Social work	0	3	2	0	5	7%
Pharmacist	3	2	1	0	6	9%
Lay counselor	8	2	1	0	11	16%
Finance	0	0	1	1	2	3%
Total	19	33	11	5	69	100%
Percentage	28%	48%	16%	7%	100%	

4.3 Planning and financing

Out of 49 health providers interviewed at the facilities 72% did not have a HIV and AIDS operational plan. Most of the managers interviewed at the District Offices (23) had access to the HIV and AIDS operational plans with 14% of managers not having access. Only the financial managers at the district offices had a costed operational plan. None of the operational plans at the facility level were costed.

4.4 Stakeholder participation in the development of operational plans.

Participation of management in the development of operational plans at CHCs (point of service) was 2%. Hospital management at regional level had the highest participation (78%) and the District management participation was at 8%. The regional hospitals were mainly supported by HIV and AIDS NGO partners.

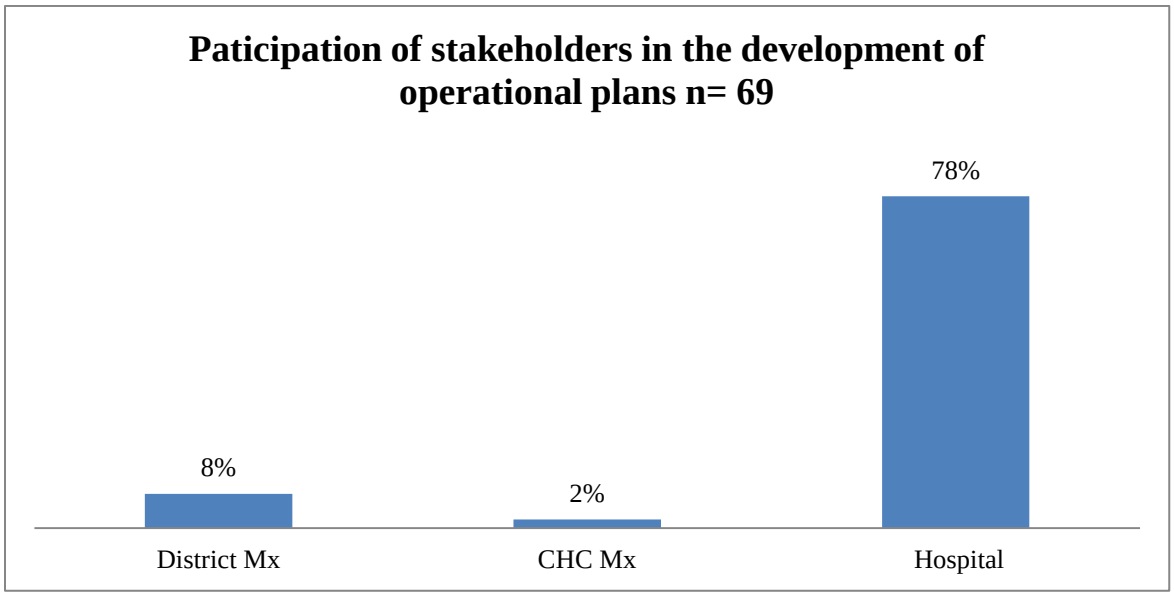

Fig 4: Participation of stakeholders in the development of operational plans.(Mx – management)

4.5 Awareness of National Department of Health operational plans

More than a third (35%) of respondents indicated that they were fully informed about the National Department of Health operational plan of 2003. Sixty five percent of personnel across all levels of care indicated that they were not informed about the DoH operational plan. Even though participation in operational planning was high at hospitals at 78% the awareness of the DoH plans was at 6%.

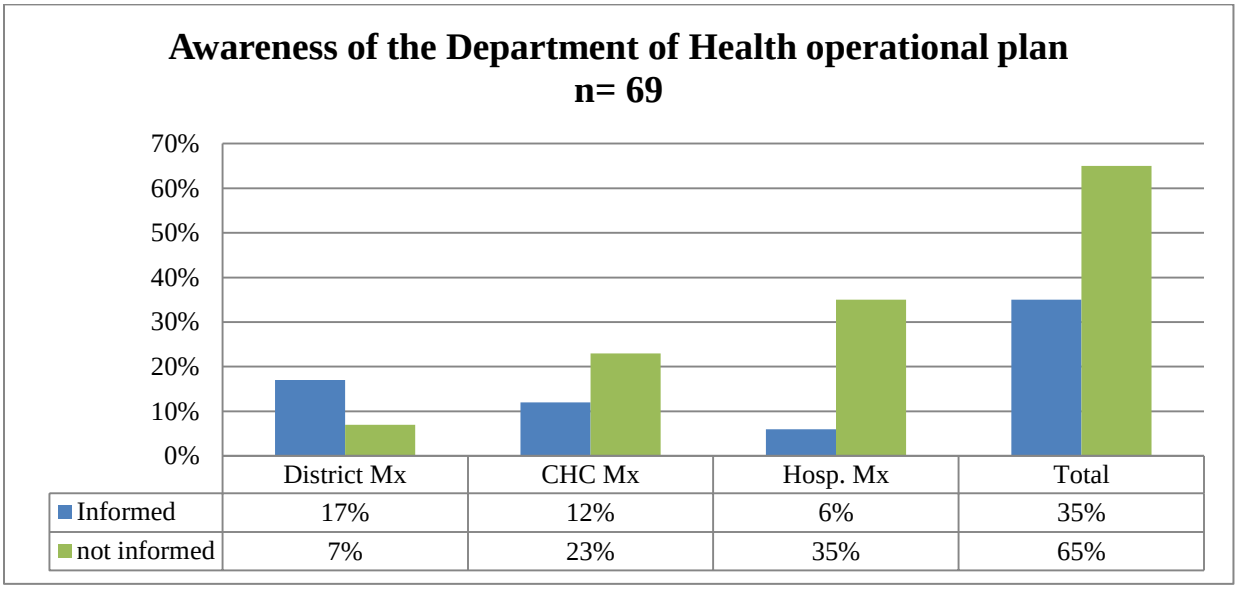

Fig 5: Awareness of the Department of Health operational plan.

4.6 Improvement strategies for implementation of operational plans

The most preferred strategy to improve the implementation of the operational plans was training suggested by 48% of the personnel across all health facilities and management. Workshops were the least preferred at 20%.

Table 2: Suggested improvement strategies for operational planning.

	Training	Meeting	Workshop
Facilities	17	13	11
Management	16	9	3
Total	33 (48%)	22 (32%)	14 (20%)

4.7 Procurement systems used within the HIV and AIDS facilities

A procurement policy and process exists within the districts and in facilities for the purchasing of new equipment. Twenty eight percent of procurement occurred using the existing District channels. Most (72%) providers reported that they went outside of the district channels and procured equipment through NGOs (private channels) and made requests directly to the Province.

Table 3: Procurement channels of equipment in HIV and AIDS services.

	Existing channels	Province /NGOs	Total
Facilities	13	33	46
Management	6	17	23
Total	19 (28%)	50 (72%)	69 (100%)

4.8 Human resource planning

More than three-quarters (78%) of respondents have personnel working in HIV and AIDS facilities at District level interviewed and appointed by Province rather than the District Office or the facilities.

Table 4: Responsibility for appointment of personnel in HIV and AIDS services.

	Province	District	Facility	Total
Appointments Districts and facility level	54	12	3	69
%	78.3%	17.3%	4.4%	100%

4.9 Frequency of support visits by management to HIV and AIDS facilities.

The District managers' support visits were reported to occur irregularly (58%). Forty-five percent of respondents reported that provincial support visits never took place. Within the facilities support was provided mainly by the institutional managers at 95%.

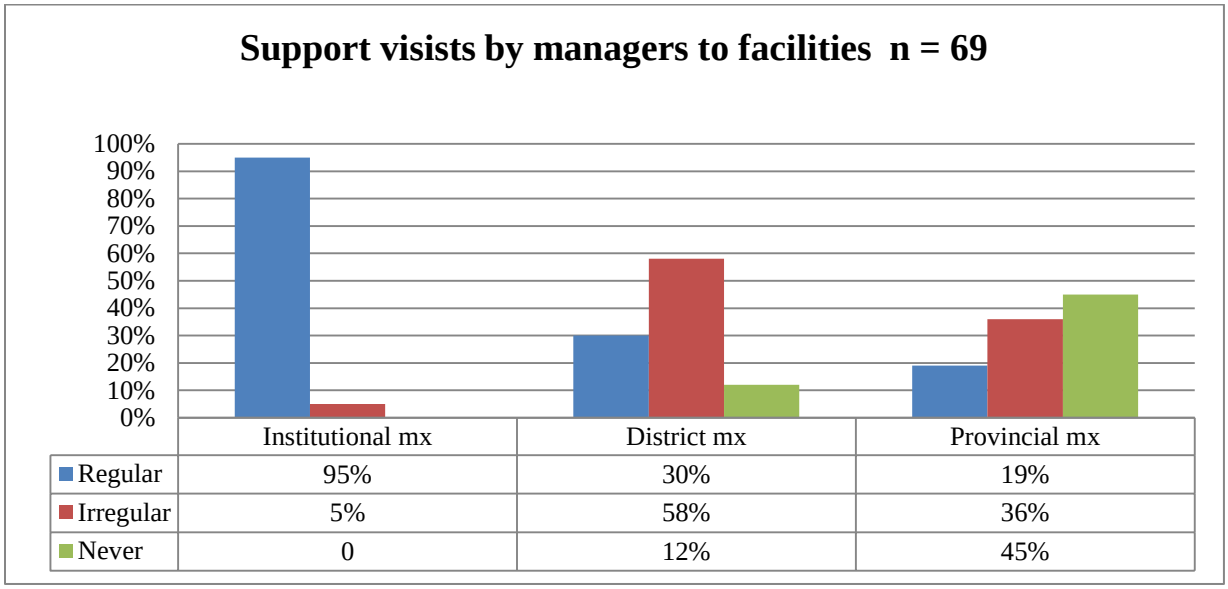

Fig 6: Support visits by management to HIV and AIDS facilities.

4.10 Programme development and monitoring

Only one (1) respondent at District health facility reported that the HIV and AIDS programme was reviewed for progress.

4.11 Integrated Service delivery

The lay counselors were reported as not having skills on PMTCT and PCR by 97% and 91% of respondents respectively. Their skills on VCT were however reported to be well informed by 96% of respondents.

Table 5: Clinical skills of lay counselors

	Not informed	Somewhat informed	Well informed	Total
PMTCT	67 (97%)	2 (3%)	0	69 (100%)
PCR	63 (91%)	4 (6%)	2 (3%)	69 (100%)
VCT	0	3 (4%)	66 (96%)	69 (100%)

4.12 HIV and AIDS entry points

HIV and AIDS services were mainly integrated in the TB services at 87% and ANC services were at 13%. HIV and AIDS services were not documented at well - baby clinics.

Table 6: HIV and AIDS entry points = n30

	Documented evidence	Not Documented	Total
ANC	4 (13%)	26 (87%)	30 (100%)
Well baby clinic	0	30 (100%)	30 (100%)
Tuberculosis	26 (87%)	4 (13%)	30 (100%)

4.13 Standidised referral systems within community structures.

Referral systems were well established within the district for home based care services (51%) and support groups (43%) and other services were at 6%.

Table 7: Referral systems within community structures.

	HBC	Support groups	Other/TAC, hospice
Referral systems	35	30	4
percentage	51%	43%	6%

4.14 Standidised referral systems within facilities.

Standardised referral systems were available in 14% of the District facilities (CHC`s and District hospital).The availability in regional hospitals was at 20%.

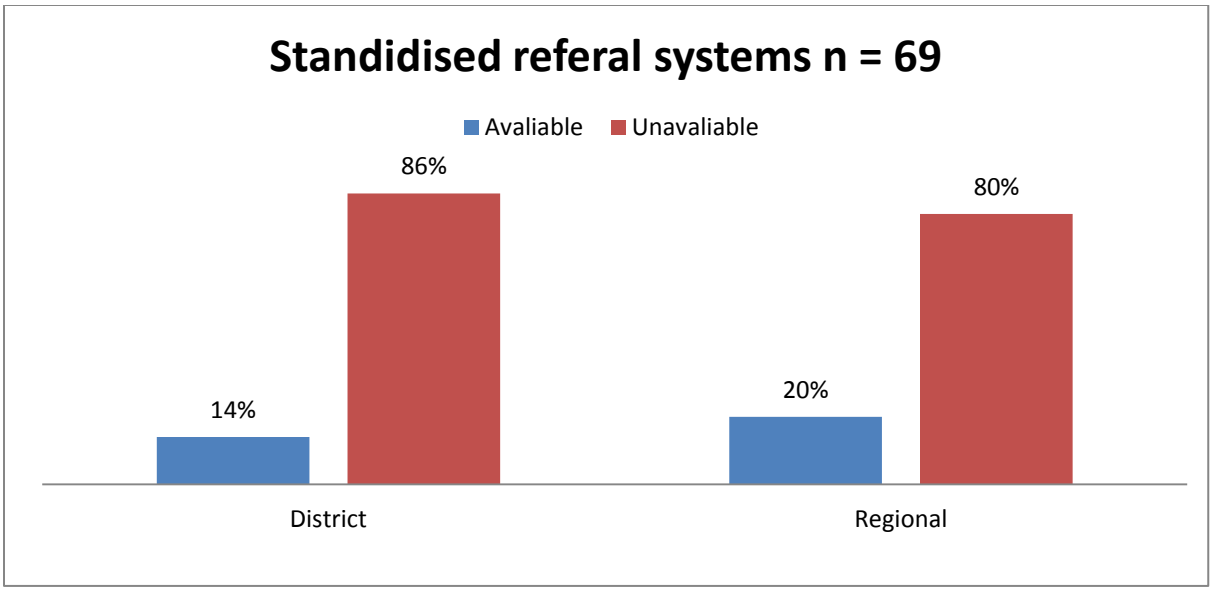

Fig 7: Standardised referral system. (District = CHC and District hospitals, Regional = Regional hospitals)

4.15 Document validation through the facility checklist

Providers were asked about the availability and accessibility of various documents and referral systems through the self-administered questionnaire and the face to face interviews. We used a facility checklist to validate the availability of these documents. Although providers reported that there were district support visits, there was no documentation of these. Facility HIV and AIDS reports were not available on the DHIS information. However, monitoring forms were available and submitted directly to Province; however they were never captured on the DHIS. The facility visits revealed that 43% had an operational plan. However, these included operational plans that had been developed by NGOs and were aligned to DoH strategy and signed off by Province. Few (14%) of facilities had a database of NGOs in their catchment areas for referrals mainly for home-based care.

Twenty-nine percent (29%) of facilities had a copy of the HIV and AIDS budget for their facility.

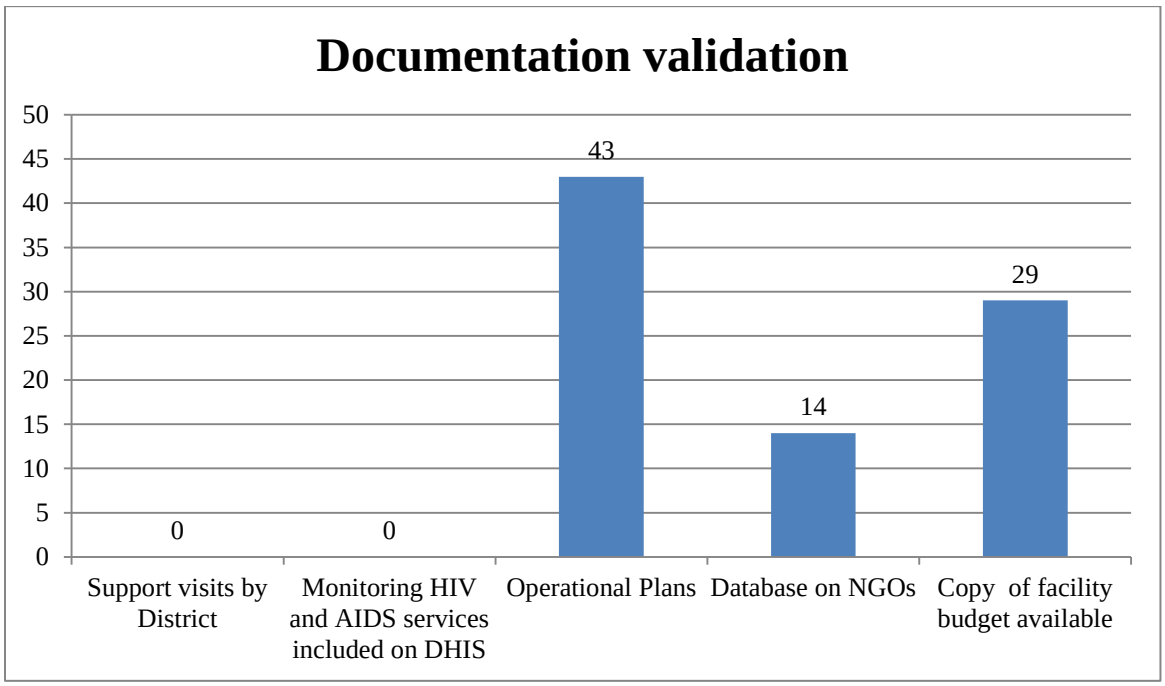

Fig 8: Document validation at facilities

HIV and AIDS documentation could not be found in any files in the well-baby clinics. Documentation was found in 23% of tuberculosis patient files and 13% of patient files in the antenatal services.

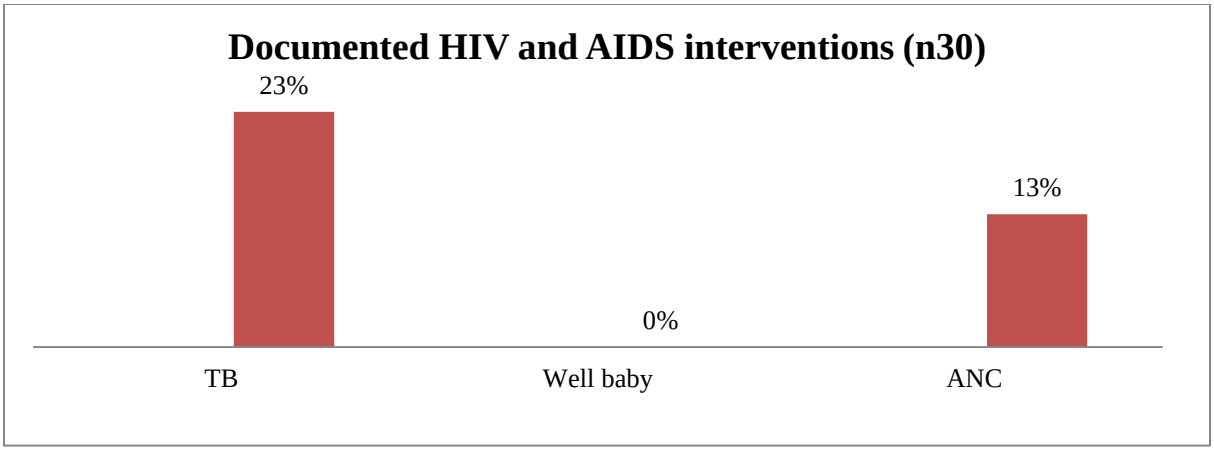

Fig 9: Document validation – patients file

HIV and AIDS counseling was done within all the facilities visited and the counseling rooms were accessible to the patients. Forty percent of facilities (40%) had support groups run by NGOs.

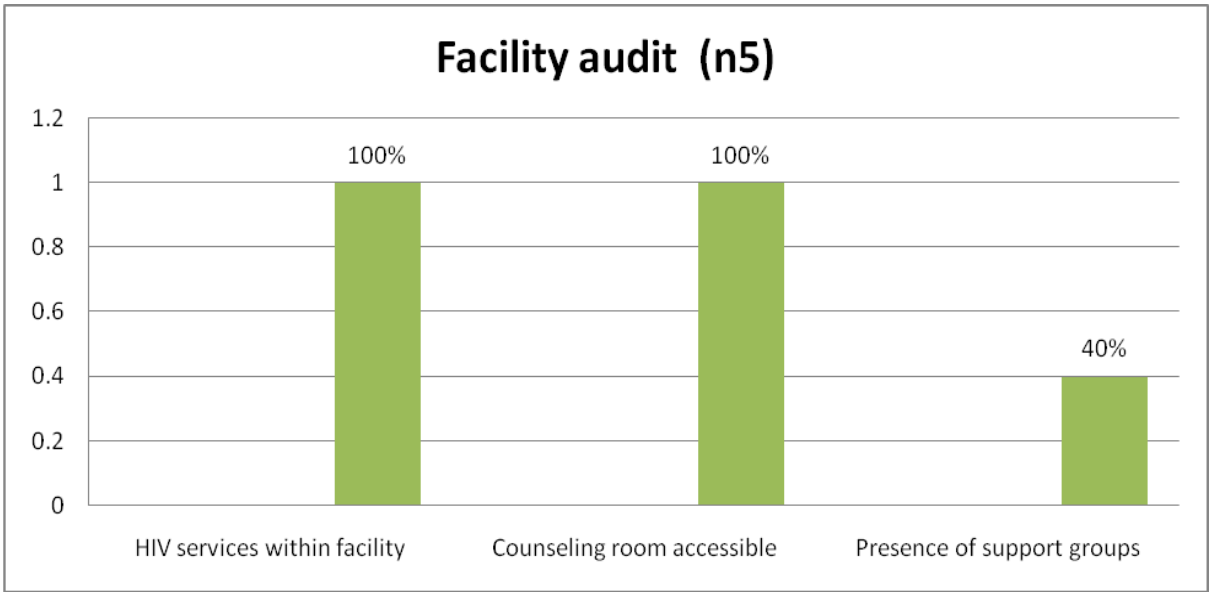

Fig 10: Accessibility of HIV testing and counseling and the presence of HIV and AIDS support groups.

CHAPTER 5 – DISCUSSION

5.1 Introduction

The government of South Africa has established a comprehensive policy and programmes to guide the country's response to HIV and AIDS epidemic (DoH, 2003) as well as integrating HIV and AIDS into Primary Health Services as indicated in the re-engineering of PHC document (DoH, 2010) The main objective of these policies is to integrate HIV and AIDS into the mainstream of Primary health care services.

The findings of this study show that integration of HIV and AIDS services is very limited. This was found at all the different levels of care CHCs, District hospitals and Regional hospitals as well as at the District offices. Non-integration of services has been found to be mainly caused by lack of ownership and decision making space (Bossert,1998) at facility, district management and community level. The district and facility managers were not able to take decisions on the implementation of the programme. The HIV and AIDS programme was not treated at the same level as other programmes in terms of appointments, procurement and monitoring. The decision making relied heavily on partner NGOs and Provincial managers.

5.2. Planning and financing of HIV and AIDS services

Adequate planning with costed operational plans is essential if HIV and AIDS service targets, such as initiation of new patients on antiretroviral treatment, are to be met. This research showed that the HIV and AIDS services were functioning without a costed operational plan that was informed by the Department of Health strategic plans. The absence of a plan used for guiding implementation resulted in

the development of parallel and duplicate systems from donors, district and provincial management for the, allocation of resources and procurement. Parallel systems have been found to undermine local decision making and create imbalances in resource allocation and utilisation within the health care services (Marchal et al., 2009). A parallel procurement system was found in this study where many facilities approached NGOs to procure equipment mostly as a result of limited awareness of their own facility budget.

The financing of the HIV and AIDS programme relied heavily on the additional funding at District level from the conditional grant which had special accounting requirements. According to Ndlovu (2004) significant resources allocations mainly from the government and in the form of international aid have been committed in South Africa. These additional funds have not translated into strengthening internal planning and financing processes and absorption capacity has become an increasing issue for HIV and AIDS spending. In this study finance managers at District were responsible for budget expenditure of the conditional grant but all other programme managers were not aware of the budget available for running the programme at district and facility level.

Decentralisation of financing, procurement and resource allocation to the lower levels of care has been found to address the needs of the programme where it matters and improves the responsiveness of services (Brijlal et al.,1988). In this study systems for procurement, recruitment, and resource allocation were at a different level than the service delivery level resulting in a mismatch between where the money was most needed and where it was actually spent. Evidence for this was found in limited procurement of resources using existing systems at

district and facility level. There was also evidence in the recruitment of new staff where most personnel were appointed from provincial level.

Stakeholder participation in the development of operational plans was limited and most of the personnel were not aware of the HIV and AIDS operational plans. Research in low resource countries has shown that building capacity at district level involves the institution having a clear vision which is accepted and understood by stakeholders, and internal structures that have autonomy and are able to advocate for additional resources as well as being accountable for the resources received in terms of the desired outcomes (WHO, 2000).

5.3 HIV and AIDS programme development – stakeholder involvement

The international Global Fund to fight HIV and AIDS advocates for improved coordination and cooperation between donors and governments at all levels to ensure maximal utilisation of resources for addressing existing health inequities (UNAIDS, 2005). Stakeholder participation is essential if coordination and cooperation is to be achieved.

The research showed that stakeholder participation at district level in planning and monitoring was low and depended on other levels (donors and provincial level) for direction and guidance for programme improvement. This finding contradicts the National HIV and AIDS strategic plan which identified stakeholder participation as important in setting objectives, planning and monitoring of services as well as communication and regular feedback to communities to ensure the success of community participation and outreach (DoH, 2010).

5.4 Integrated management Support – Monitoring HIV and AIDS services

The DHIS is a management tool that enables managers to make informed decisions on policy implementation, priority setting, and allocation of resources and identification of gaps in service delivery DoH (2011). This research showed that DHIS did not have information on HIV and AIDS routinely captured as data was reported directly to Province. The absence of data at the District level affected management decisions and resulted in requests for reports from facilities using a different format from that required by Province. This created duplication and additional burden on providers at the facilities.

The study show that the HIV and AIDS services are mainly supported by institutional managers with District support visits reported as irregular and no support visits from Provincial managers reported. According to Kawonga, Fonn &Blaauw (2013) District and facility managers are responsible for the collection of HIV data as well as technical support however they have limited capacity on the use and monitoring and evaluation knowledge.

Placing ART services in existing PHC services and improving district management support is critical (Pfeiffer at al., 2010) to minimize the costs, increase coverage and to strengthen the health care system. Lessons learned from Ghana, Kenya and Rwanda in the delivery of antiretroviral therapy indicate that standardised health information systems across programmes that are consistent with existing data requirements supports data flow and enable more efficient reporting (Ritzenthaler, 2005).

5.5 Integrated Service Delivery

The Comprehensive Care, Management and Treatment Plan for HIV and AIDS has two fundamental goals which is" To provide comprehensive care and treatment for people living with HIV and AIDS and to help strengthen the countries health system" DoH (2004). The pressures on rapidly increasing patient numbers leads to the emergence of vertical HIV programme at the expense of PHC system. The main concern is how to implement HIV and AIDS programmes without exacerbating existing health care systems weaknesses and inequities (DoH, 2003).

The poor integration of HIV and AIDS services in the well-baby and ANC clinics in this research is evident in the National evaluation study on the effectiveness of the National Prevention strategy of mother-to-child transmission (Goga et al., 2010) which indicates that early infant diagnosis in PMTCT is poor.

5.6 Lay counseling services and community outreach

Counseling services for HIV and AIDS and the targets set for HCT in the country relies heavily on a strengthened community outreach which forms an integral aspect of Primary Health Care services. Primary Health care facilities lack the capacity to test large numbers as only a limited number of people present themselves in public health facilities and in most cases only visits the facilities at an advanced stage of HIV and AIDS. Therefore the skills of lay counselors are critical to enable integrated services at community level.

The research indicated that the clinical skills of lay counselors specifically in PMTCT and PCR need to be improved to facilitate an integrated approach to HIV and AIDS counseling. Key to this is ensuring that counseling and voluntary testing are universally accessible, routinely offered in all appropriate clinical settings

(Simon et al., 2009). The research indicated that children are the most neglected in this intervention in well baby clinic and under five clinics. This compromise the identification of children exposed to HIV and AIDS as well as their prompt initiation on ARVs.

Lessons learned in Haiti (WHO, 2008) indicated that stigma is a motivating force for integration. The fact that PLWA were experiencing discrimination from mainstream health programmes resulted in the need to integrate HIV services into PHC health programmes. This approach is critical for" CCMT sites "to evolve from managing HIV only to an integrated system that manages a PHC package of services that ensures strengthening of the health System as well as scaling up of ARV`s.

5.7 Study Limitations

In considering the findings of this study it is important to bear in mind the following limitations:

Lay counselor skills were reported on by providers and there was no direct observation of skills. Copies of reports of support visits did not have comments by supervisors to indicate what support given to facilities. This meant that there was no additional data on the quality of lay counselling to support or refute what was reported by the providers.

The study collected data from facilities that were implementing comprehensive care management and treatment services. This limited the number of providers who participated in the study. The small numbers of responses meant that the results presented are descriptive in nature.

CHAPTER 6 – CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

In conclusion the findings of this study suggests that the HIV and AIDS services are not integrated into the PHC system as indicated in the comprehensive management of HIV and AIDS plan for South Africa (DoH, 2003). Services for HIV and AIDS have developed into separate vertical administrative and reporting systems operating differently from the mainstream services. Similarities were observed in terms of constraints in the study that impedes integration.

These included:

- Parallel processes and implementation of operational plans within the district for HIV and AIDS (conditional grant) and the existing district plans with the exclusion of the main stakeholders at facility and community level.
- DHIS did not have information on HIV and AIDS routinely captured which affected management decisions at the District level, and resulted in requests for reports from facilities using a different format which created duplication and additional burden on providers at the facilities.
- Irregular and nonexistent programme reviews and programme support especially from District and Provincial level.
- Management capacity and decision space at district and facility level for resourcing the HIV and AIDS services was limited.

- Sustainable financing options for the HIV and AIDS programme is required in the face of limited or absence of donor funds at district and facility level.
- Integrated skilling of community health care workers to address multiple health care issues including PMTCT.

6.2 Recommendations

6.2.1 Planning and Financing.

- Districts should adopt an integrated strategy in planning that will be inclusive of HIV and AIDS (conditional grant).
- Monitoring and evaluation systems of key performance indicators for the Districts as indicated in the NSDA`s, Millennium development goals, National and Strategic plans should be built in the district management agenda.
- The conditional grant should be used to finance areas of weakness as identified in the district health plan to improve the overall PHC system and not only confined to HIV and AIDS services.
- Stakeholder participation needs to be broadened especially to facility and district management to improve the responsiveness of the programme to challenges faced at these levels.

6.2.2 Management support.

- Regular programme reviews at facility and District level should be implemented to improve feedback and performance monitoring.
- Implementation of an integrated health information system and data flow that addresses accountability at every level of data generation.
- Regular Provincial and district support visits and documented feedback.

6.2.3 Service Delivery

- Linking of HIV and AIDS services to other programmes and identification of entry points in all programmes at PHC level.
- Integrated training and multiskilling of community health care workers.
- Implementation of standardised referral systems within and between facilities and community based structures to prevent loss to follow up of patients.

6.2.4 Further study.

Further research is recommended in the following areas identified in this study as needing further understanding to maximise the integration of HIV and AIDS in PHC services.

- The quality of lay counselors services on the HIV and AIDS programme.
- District health system planning, financing and monitoring.
- Integration of community based services (PHC outreach programmes).

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ANNEXURE 1

ANNEXURE 2

DATA COLLECTION TOOL FOR FACE TO FACE AND SELF-ADMINISTERED INTERVIEWS

Section1 (Tick appropriate column)

Current Employment	CCMT Site	District management
1.Years of employment in present post	0-1 year	1-2 years
	2-3 years	3- 4years
	4-5years	5 and above
1.1 Professional qualification	Professional nurse	Doctor
	Dietician	Social worker
	Pharmacist	Lay counselor
	Finance manager	Other (indicate)
If you are a lay counselor go straight to Question 11		
Section 2: Integrated planning and financing		

Answer yes or no in the following questions	yes	no
2. Does the facility / District Have an HIV and AIDS operational plan	yes	no

2.2. Is the operational plan costed?	yes	no
2.3. Indicate the stakeholders who participated in the development of the Operational plan.	Hospital management	District management
	Facility management	Provincial management

3**.** Please rate how well informed are you regarding the operational plan- use appropriate section. (**HIV and AIDS Operational plan of 2003**). (Tick in the appropriate column).		
Not informed	Somewhat informed	Well informed
3.1 How can the operational planning for HIV and AIDS be improved in this facility/District?		
Answer yes or no in the following questions		

4. Does the HIV and AIDS budget form part of the Medium Term Framework expenditure proposal for the institution/district?	yes	no
4.1. Are expenditure requests for the facility / district processed through the existing procurement channels of the institution/ district?	yes	no
5. If not how do you process requests for HIV and AIDS? (explain)		
6. Who is responsible for human resource planning? (explain)		
7. Do you think that you have the capacity to make decisions over the allocation and use of resources to improve the quality of care in the institution/district?	yes	no

Section 3: Integrated management and support.(**TICK appropriate column**)			
8. To whom does the HIV and AIDS facility manager /District coordinator report to?	Institutional Manager	District Manager	Provincial Manager

9. Could you indicate how regular the support visits to the HIV and AIDS facility are from: (tick appropriate column)

	Regular	Irregular	never	Date of last visit
Institutional manager				
District manager				
Provincial manager.				

10. How is the programme reviewed for progress?		
10.1 Does HIV and AIDS information form part of the institutions/ district health information system?	yes	no
10.2. Is there a training / in-service programme for HIV and AIDS for the institution and district for health personnel?	yes	no

Section 4: Integrated service delivery:

(If you are a lay counselor answer only this section)

11. Please indicate how well informed are the lay counselors in the following Programmes.

	Not informed	Somewhat informed	Well informed
PMTCT			
Nutrition			
Treatment and adherence			
VCT			
PCR			

12. HIV testing and staging is available at the following entry points: **(tick appropriate answer)**		
ANC clinic	Under five/ well baby clinic	TB Clinic/ TB focal point

13. Is there a standardised referral system within the facility?	yes	no
13.1 Is there a standardised referral system within the district?	yes	no

If yes indicate the stakeholders in the community who participate in this communication (exclude health care facilities).

THANK YOU FOR YOUR PARTICIPATION.

ANNEXURE 3

CONCEPTUAL FRAMEWORK (INTEGRATION DOMAINS)

Domain	Indicator/ variable	Source document
		Available expenditure reports /facility/district/province
Integrated Planning	Capital equipment and maintenance	Acquisition plans Maintenance budgets. Equipment and maintenance plans available at facility and district with a dedicated budget.
	Decision space	Changes developments made by the facility.
Integrated management and support	Management Support and reporting lines	Support visits reports
	Integrated HIV Reports	HIV reports forms part of facility Reporting procedures (Copies of DHIS reports)

	Training and development	Available schedules for workshops, training and in-service with attendance registers.
Integrated service delivery	Lay counselors knowledge base (horizontal integration)	Documented counseling interventions following a counseling session on register/ patient files.
	HIV entry points	Logistics and facility arrangement (HIV services within the facility are they easy to reach.) HIV and AIDS services available at the following entry points: ANC, TB, well baby clinic.
	HIV and AIDS referrals	Standidised referral forms
	Monitoring and evaluation of community based NGO`s	M&E tool. Database of NGOs in catchment area. Support groups in the facility.

ANNEXURE 4

FACILITY CHECKLIST - DOCUMENT REVIEW

Variable code	Variables	Responses	Code
1(a)	Availability of operational plans	Available	1
		Not available	0
1(b)	Costed	Yes	1
		No	0
2.	Available minutes of stakeholder meetings and attendance registers.	Yes N o	1 2
3.	Copy of budget allocated to facility	Yes No	1 2
4.	Medium term expenditure frameworks plans (MTEF)	Yes No	1 0
5	Available expenditure reports	Yes No	1 0

6	Copies of facility reports.	Yes No	1 0
7.	Copy of DHIS HIV included	Yes No	1 0
8	Copies of support visit reports/ recommendations	Yes No	1 0
9.	In-service schedules and attendance registers	Yes No	1 0
10	Monitoring and evaluation tool for NGOs	Yes no	1 0
11	Database of NGOs in catchment area	Yes no	1 0
12	Standidised referral forms	Yes No	1 0
13	HIV entry points Documented counseling interventions		
13 (a)	ANC	Yes	1

		No	0
13(b)	Well baby	Yes no	1 0
13(c)	TB	Yes no	1 0
14	HIV Counseling within facility	Yes no	1 0
14.1	Counseling room accessible to patients	Yes no	
15	Presence of support groups in the facility	Yes no	1 0

ANNEXURE 5

CONSENT FOR FACE TO FACE INTERVIEWS HEALTH CARE WORKERS

I have been given and read the information sheet on the research on "Evaluation of the Integration of the Comprehensive Care Treatment Plan for HIV and AIDS into Ekurhuleni and Sedibeng health region." I understand the information sheet and have any questions that I had satisfactory answered.

I understand that the researchers will make every effort to ensure confidentiality that my name will not be used in the study, and that comments or views that I make will not be reported back to anybody within the Department of Health.

I understand that I do not have to consent to this interview, and that they will not be any negative consequences if I do not participate. I also understand that I do not have to answer any questions in the interview that I do not wish to answer, and I can stop the interview at any time with no consequences for myself.

I give consent to be interviewed.

Interviewee's signature: Date:

Interviewer's signature: Date:

Interviewer's name (please print) Date:

RESEARCH CLEARANCE CERTIFICATE

Research Project Title: EVALUATION OF THE INTEGRATION OF THE COMPREHENSIVE CARE MANAGEMENT AND TREATMENT PLAN FOR HIV AND AIDS INTO EKURHULENI/ SEDIBENG HEALTH SERVICES.

Research Project Number: 01/2008/0516244A

Name of Researcher(s): Ms Thoko Mercy Maboe

Division/Institution/Company: Gauteng Department of Health

Qualification(s) of Researcher(s): -

DECISION TAKEN BY THE EKURHULENI HEALTH DISTRICT ETHICS PANEL (EHDEP)

- *THIS DOCUMENT CERTIFIES THAT THE APPLICANT'S RESEARCH PROPOSAL HAS BEEN SCRUTINISED BY THE EHDEP AND HAS RECEIVED FULL APPROVAL.*

Dr J. Sepuya

CHAIRPERSON: EKURHULENI HEALTH DISTRICT ETHICS PANEL
Dated: 07 / 02 / 2008

Mr B. Matthysen

RESEARCH COORDINATOR: EKURHULENI METROPOLITAN MUNICIPALITY
Dated: 07 / 02 / 2008

Dr A. Govender

RESEARCH COORDINATOR: GAUTENG DEPARTMENT OF HEALTH (REGION B)
Dated: 07 / 02 / 2008

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Maboe

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER M070836**
PROJECT	Evaluation of the Integration of the Comprehensive Care Management and Treatment (CCMT) for Plan for HIV and AIDS...
INVESTIGATORS	Ms T Maboe
DEPARTMENT	School of Public Health
DATE CONSIDERED	07.08.31
DECISION OF THE COMMITTEE*	APPROVED UNCONDITIONALLY

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 07.11.26 **CHAIRPERSON** .....
(Professors PE Cleaton-Jones, A Dhai, M Vorster, C Feldman, A Woodiwiss)

*Guidelines for written 'informed consent' attached where applicable

cc: Supervisor : Prof H Schneider

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10005, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Faculty of Health Sciences
Medical School, 7 York Road, Parktown, 2193
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Reference: Ms Tania Van Leeve
E-mail: tania.vanleeve@wits.ac.za
03 December 2007
Person No: 0516244A
PAG

Ms T Maboe
28 Smythe Str
Vanderbijlpark
1911
South Africa

Dear Ms Maboe

Master of Public Health (Health Policy and Management): Approval of Title

We have pleasure in advising that your proposal entitled "*Evaluation of the integration of the comprehensive care management and treatment plan for HIV and AIDS into Ekurhuleni / Sedibeng health services*" has been approved. Please note that any amendments to this title have to be endorsed by the Faculty's higher degrees committee and formally approved.

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences