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Organisational capacity of public sector ART provision in Gauteng Province and its impact on patient adherence : Case studies of two facilities

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Executive Summary

In November 2003, the Department of Health launched the Operational Plan for Comprehensive Care, Management and Treatment (CCMT) for South Africa. This policy has as its central goal universal access to antiretroviral therapy to 1 million people living with HIV by the end of 2007. National implementation of the operational plan began in April 2004 and as at the end of October 2006, South Africa had initiated 213 828 people onto ART through the Plan, making it the biggest programme in the world. Of these, 55 580 people had been placed on treatment in Gauteng Province.

Despite these early achievements, there are concerns as to whether the South African public health sector can rise to the challenge of universal access while achieving good clinical outcomes and programme performance. As Venter (2006: 298) states, "the health sector is buckling under the current load, and currently does not have the capacity to do anymore than dent the numbers needed to treat, unless a radical restructuring of health services occurs." A crucial factor in providing a comprehensive approach to HIV/AIDS is the reorientation of service delivery from acute to chronic disease care. In addition to the shift in focus to chronic disease management of HIV/AIDS, health system constraints need to be addressed. These include inadequate health system infrastructure and human resources.

This study aimed to comprehensively assess organisational capacity to provide antiretroviral therapy (ART) in two public sector CCMT sites in Gauteng Province and the influence of these organisational factors on follow-up and adherence to ART, with the view to understanding whether public sector CCMT sites are able to deal with new challenges posed by the Plan. The objectives were to assess: (1) levels of follow-up and adherence in patients registered at the CCMT site, (2) dimensions of organisational capacity, drawing on internationally recognised chronic disease care frameworks, namely the Wagner Chronic Care Model (CCM) and Innovative Care for Chronic

Conditions (ICCC). These dimensions were: presence of motivated and adequately staffed teams; delivery systems design; the quality of support systems; and facility information systems. 3) the similarities and differences between the two sites with respect to organisational capacity, follow-up and adherence.

The two sites were selected through a stratified (CHC and hospital) random sample of CCMT sites in Region A of the province, excluding the long–standing and well-established academic hospital CCMT sites in the sampling frame. The two sites, located in a District Hospital in the West Rand and a Community Health Centre (CHC) in Central Witwatersrand, were visited between May and July 2006. They had initiated 540 and 1001 patients on ART respectively since October 2004. A multi-method health service evaluation of capacity in the HIV related services (ART/Wellness, VCT, PMTCT, and TB) was conducted. This consisted of 11 semi-structured interviews with facility and programme managers; review of registers and routine facility data; an observation checklist and mapping to assess the physical infrastructure of the facility, presence of management and health information systems; 35 self administered questionnaires to assess the levels of motivation of nursing staff at each site. Data on self-reported adherence and viral loads were obtained from a separate study involving exit interviews with 356 patients who had been attending the services for at least four months in the two sites.[1]

Of the 540 and 1001 patients enrolled in the two services, 69.8% and 69.3% were still in the service after 18 months at the hospital and CHC, respectively. The monthly drop-out rate at the hospital had risen fairly sharply towards the end of the 18 month period, attributed by the staff to growing difficulties in access to the site by new enrolments. Nevertheless, based on self-reports (3-day recall period), viral load measures, and loss to follow-up, adherence levels at both sites appeared to be in line with national and international best practice. The percentage of patients with

[1] Also part of a separate MPH study report.

undetectable virus was 76.2% and 74.4% at the hospital and CHC, respectively.

Staffing of the CCMT sites matched the pre-requisites outlined by the National Department of Health for a 'core' health care team treating 500 patients. The CHC CCMT site, however, had more than 500 patients on ART and moreover was providing two services within one unit, i.e. ART/Wellness and VCT thus increasing the patient load. Sites were reaching saturation and this was due to the lack of sufficient space coupled with the high volumes of patients, shortage of certain scarce skills (in particular pharmacy staff), and the multiple responsibilities of nursing staff. In general, the staffing situation at the hospital appeared better. More staff had joined than left the hospital over the year prior to March 2006, and clinical workloads both in the ambulatory services and the CCMT site were less than at the CHC. Vacancy rates were low, at 13.8% and 4.8% for the hospital and CHC, respectively.

Strong leadership of CCMT sites by motivated ART programme managers was displayed; site managers were highly respected and revered by staff. Based on ratings in a self-administered questionnaire, overall levels of motivation and organisational commitment at both sites appeared good, although, worryingly, a sizeable proportion of respondents in both sites agreed with statement "I intend to leave this hospital/clinic." Lack of external support (from the HIV/AIDS, STI, TB Programme) and debriefing systems for programme managers and nursing staff was identified as weaknesses.

With some exceptions, both sites showed evidence of strong 'horizontal' mechanisms of referral and coordination between HIV and AIDS related services within sites; however the PMTCT programme at the hospital was less co-ordinated and networked with other services. In addition, ART and PMTCT programme managers at the hospital indicated that the relationship between hospital services and surrounding clinics was poor.

Apart from the lack of space at the CHC CCMT site, support systems were adequate. There were no reported drug stock outs and supply of drugs and general supplies was good at both sites. Both sites were able to offer a range of routine and HIV specific tests.

A combination of paper and electronic based information systems were used at both sites, however, the hospital CCMT site used a mixture of standard and locally designed data collection forms compared to the CHC which mainly used standard Department of Health forms. The information systems were adequate in monitoring and evaluating patients and programme performance; however, the study highlighted the absence of a clear patient register for individual and programme monitoring and only cross sectional patient data was reported. There was also considerable duplication at the hospital in collecting and compiling patient information.

The findings of the study suggest that the two sites, located in the 'routine' public sector environment of Gauteng Province have demonstrated ability to build organisational capacity for ART provision, through a degree of systems integration and design, decision support systems, generation and local use of information and motivated local champions. Through these elements of organisational capacity, both sites have achieved good adherence rates. The key factors to achieving this good programme performance were motivated local champions who drove programmes forward and good working relationships between the CCMT and other players.

In light of the weaknesses identified, the following key recommendations are proposed:

- Review sites to identify the reasons for the high-drop out rate and address these issues
- Due to evidence of early saturation at the CHC, it is suggested that additional roll-out sites be established, or alternatively increase staffing and space at the CHC to meet the needs of the high patient load. In addition, well patients should be decanted to lower level services e.g. community based care organisations, thus reducing the burden on the site

- Pay attention to the physical infrastructure needs of clinic based sites, especially as they become saturated
- Foremost, the current Employee Assistance Programme (EAP) implemented in Gauteng Province should be strengthened and marketed so that staff members are more aware of the service and make use of it accordingly. Alternatively, a culture of "caring for the caregivers" should be cultivated, through for example, specialist assistance, debriefing sessions, and better external programme support from HIV/AIDS, STI, TB (HAST) managers
- Improve support and supervision of ART programmes by facilitating greater communication and feedback between sites and district, national and provincial levels of government.
- Adopt a strategy of "task shifting", through better use of lay workers, counsellors, and mid level workers such as pharmacy assistants.
- Facilitate greater integration and coordination between the PMTCT programmes and other services, including the provision of VCT and training of staff. In addition, it is imperative that there is good integration between services provided by local and provincial Departments of Health
- Simplify and standardise information systems, particularly the development of clear patient registers to allow for cohort analysis.