

**A RAPID APPRAISAL OF THE STATUS OF ROLL OUT OF THE
ANTIRETROVIRAL PROGRAMME IN FACILITIES WHERE
ROLL OUT HAS STARTED AND THOSE WHERE ROLL OUT IS
PLANNED IN GAUTENG PROVINCE – CENTRAL WITS
REGION**

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A research report submitted to the Faculty of Health Sciences, University
of the Witwatersrand, in partial fulfilment of the requirements
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of

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I, Lynette Nonhlanhla Nxumalo declare that this research report is my own work. It is being submitted in part fulfilment of the requirements for the degree Master in Public Health at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.

_____ day of _____ 2006

DEDICATION

This work is dedicated firstly to my family, who have constantly offered their nurturing love as a soft place to land on during those challenging times and secondly, to my best friend and partner, who has lent unrelenting support and motivation from the beginning of this journey.

ABSTRACT

When the South African government decided to implement the roll out of antiretrovirals (ARVs) in public health facilities, as part of its HIV/AIDS care and treatment plan, there was concern about the capacity of the country's health care system, to deliver the service efficiently and equitably. The study was deemed necessary, due to that the South African government requires information and feedback on the state of its health care system to provide ARVs in public health facilities. The study will add to the growing body of knowledge on the status of the ARV programme and therefore assist in the improvement of the efficiency and efficacy of the services.

The objective of this study was to conduct a rapid appraisal of the status of roll out of the ARVs in facilities that had begun offering the service and the readiness of facilities that were planning to roll out, in the Gauteng Province. Focus was on the capacity of these facilities to provide the ARV services, as outlined by the Provincial Department of Health.

It is a descriptive cross-sectional study, drawing on qualitative methods such as thematic analysis, document review and a facility checklist. A sample was determined by purposely selecting participants who were involved in the ARV programme. Participants included facility managers, doctors and nurses from the study facilities, regional managers and representatives from non-profit organisations. Perspectives about the roll out were drawn from in-depth interviews from 27 participants, including document reviews and a facility checklist.

The study highlighted the fact that the ARV programme is implemented within a health care system that is experiencing weaknesses and bottleneck problems in the following facets: human resources, training, referral systems, management and monitoring and evaluation systems.

Findings indicated that the core weaknesses and constraints in the implementation of ARVs are systemic and hence will require intervention at a systemic level. It is recommended that the Department of Health improve the recruitment and retaining of health professionals, improve training and training structures, improve communication channels and support systems, provide skills to local government, managers and improve monitoring and evaluation systems.

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LIST OF ACRONYMS

AIDS – Acquired Immuno Deficiency Syndrome

ARV – Antiretroviral

CHC – Community Health Centre

DoH – Department of Health

DOTS – Directly Observed Therapy Short-Course

HCW- Health care worker

HIV – Human Immunodeficiency Virus

HSRC- Human Sciences Research Council

KZN – Kwa-Zulu Natal

MTCT- Mother-to-child transmission

NGO – Non-Governmental Organisation

NHLS- National Health Laboratory Service

OPD- Outpatient department

PEP- Post-exposure prophylaxis

PMTCT- Prevention of mother-to-child transmission

STI- Sexually transmitted infection

TB- Tuberculosis

TOP- Termination of pregnancy

VCT- Voluntary counselling and testing

WHO – World Health Organisation

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CHAPTER 1

1. INTRODUCTION

1.1 BACKGROUND

After more than 20 years since the identification of HIV/AIDS, it has become an epidemic that has affected millions of people and has spread throughout the world, although in uneven proportions. UNAIDS (2004), reported that HIV/AIDS had affected over 38 million people by 2003, and 20 million had died from AIDS-related illnesses, since the first cases were identified in 1981. About five million people were infected with HIV in 2003, reportedly the highest number of infections in a single year on record (UNAIDS, 2004). Sub-Saharan Africa is a region known to be the hardest hit by HIV/AIDS, with an estimate of 25 million people living with the disease. This means that 71% of people with HIV/AIDS are concentrated in Sub-Saharan Africa. Added to this, 70% of new infections occurred in this region (Manning, 2002)

Within Sub-Saharan Africa HIV infection in adults in the ages 15-49 years is at more than 20% in seven countries. In four countries, Botswana, Lesotho, Swaziland and Zimbabwe, the prevalence stands at more than 30% in adults. The high level of infection renders this region with the greatest impact of HIV/AIDS. The impact will largely affect progress in the economic, social and demographic sphere of its society (Manning, 2002)

HIV/AIDS has resulted in a high mortality of prime-aged adults, which has led to an increasing number of children being left orphaned and the surviving family members, particularly elderly persons, as caregivers in households with few breadwinners as a source of support. There is greater impact if the deceased were the main source of this support (Hunter and Twine, 2005). According to UNAIDS (2004), the epidemic has also led to girls being forced to leave school, to care for their ailing parents or siblings.

It is reported that the existence of HIV/AIDS in a household results in and aggravates poverty, because it inhibits the capacity of family members to provide an income or any production. This is particularly due to the protracted period of illness and morbidity. Additionally, the increase in household health care expenditure is mainly towards AIDS-related health care expenses (Schatz and Ogunmefun, 2005)

Despite the fact that a cure remains a distant reality, the existence of HIV/AIDS has resulted in the improvements in the quality of care of people living with AIDS-related illnesses. An important development has been in the area of antiretroviral drug treatment (UNAIDS, 2004). Many countries, particularly in sub-Saharan Africa, are responding to the epidemic by providing antiretroviral treatment. This however, necessitates the scaling up of the programmes that provide this treatment. Major challenges still exist in this regard, not least of all the fact that despite increasing efforts and signs of progress, only 7% have access to antiretrovirals (ARVs) (UNAIDS, 2004).

The health sector has been reported to be bearing the most impact. The existence of HIV/AIDS, has created a demand for an efficient and flexible health care system. This is ironically; most needed in countries that already have a weakened health care system, where the need for health care surpasses the capacity.

1.2 LITERATURE REVIEW

1.2.1 HIV/AIDS treatment in developing countries

Uganda was one of the first countries in Africa to run a pilot antiretroviral programme in 1998 and offered one of the first learning tools for developing protocols and ARV implementation strategies. With the assistance of UNAIDS, the initiative developed national treatment guidelines and information material, and trained and educated health care workers (Weidle, Malamba, et al., 2002). Facilities accredited under the pilot project provided ARVs under prescribed requirements which included: trained medical staff, a laboratory, counselling services, secure and adequate drug storage systems and sufficient resources for the purchasing of the initial drugs (Weidle, Malamba, et al., 2002).

The outcome of the programme indicated that a successful ARV provision programme could be achieved by improving existing resources and implementing an efficient and effective system for drug distribution and procurement. It also indicated that effective training and capacity building are crucial for successful and sustainable implementation. Another component that proved to be important, was national commitment and human and financial investment (Weidle, Malamba, et al., 2002).

It should be kept in mind that pilot programmes often operate under the most ideal circumstances and replication of these programmes under normal conditions that prevail in many developing countries bring many unforeseen problems (van Teijlingen and Hundley, 2001) .

Countries such as Brazil and Argentina ensured the provision of ARVs as early as 1991. Experiences in this Brazil revealed that even with sufficient access and provision systems being in place, there were constraints that acted as barriers to treatment access. There were some fears that implementation would gradually increase the numbers of people being provided treatment, which would result in increasing costs. This was expected to eventually lead to drug supplies being compromised (Chequer, Cuchi, et al., 2002).

However, in terms of the general macro-economic effect of this endeavour, it was evident that there was an overall decrease in expenditure. This was due to the reduction in the number of people being hospitalised, less opportunistic infections, less sick leave, fewer people taking early retirement and proven reduction in loss of productivity (Chequer, et al. 2002).

Other concerns, in countries that have experienced implementation of ARVs, including South Africa, lie in issues of stigma. Studies conducted, have motivated the importance of establishing education interventions at community level in order to de-stigmatise HIV/AIDS (Schneider, 2003). Even with the raised concern of reduced adherence to treatment by various researchers, due to limited sustainable delivery

systems and poor case management, Brazil proved the contrary, as adherence was noted to be high, due to strong educational programmes (Chequer, Cuchi, et al., 2002). Concerns about inequitable access to services, arising from stigma and fear and also provider responses and attitudes, and the management infrastructure around providers, could manifest as barriers to services (Schneider, 2003).

1.2.2 HIV/AIDS in South Africa

South Africa's HIV prevalence is estimated to be more than 4,7 million based on surveillance statistics from antenatal clinics (Ncayiyana, 2001). Studies have shown that HIV/AIDS affects all race groups in South Africa, although prevalence differs, due to transmission risk being largely determined by social and behavioural factors. Findings from the Nelson Mandela/Human Sciences Research Council (HSRC) study on HIV/AIDS, 2001, indicated that prevalence was the highest among Africans, at 12,9%, followed by whites at 6,2%, coloureds at 6,1% and Indians at 1,6% (Shisana et al., 2001). Differences in prevalence also occur between males and females, and geographical area. 12,9% of women were reported to have tested HIV-positive, while among males the prevalence was 9,5%. A provincial breakdown of prevalence indicated that the Free State had the highest prevalence at 14,9%, with Gauteng with the second highest at 14,7%, Mpumalanga at 14,1% and KwaZulu Natal at 11,7%.

The HSRC data is population-based whereas the antenatal data is based on the sexually active population (above the age of 16 years), which influences the ability to compare the two sets of findings. However, the antenatal surveys have indicated KZN

to have the highest prevalence of HIV/AIDS. This may be due to the changing epidemic or the limitations of the different research methods. The highest prevalence within age groups was among the 25-29 age group (Shisana, et al., 2001).

The South African government has relied on antenatal surveys as a useful tool to follow the trends of the virus. This mechanism however has its limitations (Shisana and Simbayi, 2002) such as extrapolations which are based on prevalence among women only. Because of these factors the government is uncertain about how many of its people actually live with the virus.

1.2.3. The impact of HIV/AIDS

Despite these limitations, the reality of HIV/AIDS has manifested in most sectors.

There is agreement that the prevalence of HIV/AIDS in South Africa has caused harm to the key factors of the economic growth and it is anticipated that this will continue (Parker, et al., 2000). The increase in the death rate among members of the population who are economically active, will gradually lead to the reduction of human resources, hence negatively affecting productivity and profits in organisations. A study that assessed the effect of the epidemic in Kenya and Botswana indicated how the level of absenteeism and the increased burial costs, determined the increase in labour costs (Parker, et al., 2000). The effect of the epidemic is also likely to compromise other sectors, like education.

1.2.4. HIV/AIDS Treatment

A sector that appears to be prominently affected by the epidemic is public health. Health facilities throughout the country are reported to be inundated with high patient attendance with AIDS-related illnesses (Ncayiyana, 2001). In response to the predicted catastrophic effect of the epidemic, the South African Department of Health has released the *Operational Plan for Comprehensive HIV and AIDS Care Management and Treatment for South Africa*. The plan focuses on a multi-sectoral response, which includes the provision of ARVs. The aim is to provide comprehensive HIV/AIDS care and treatment in at least one service point in each of the 53 health districts of the country within a year of commencing implementation. The goal is to provide HIV/AIDS care to all South Africans who require it, within five years (Steward, Padarath, et al., 2004).

Inevitably, the implementation process is to be executed by integrating HIV-related services into primary health care services, as stipulated in the five-year Strategic Plan for HIV/AIDS, launched in 2000 (DoH, 2003).

Health services are reported to be already overwhelmed in efforts to provide standard services (Modiba, Schneider, et al., 2002). The call for additional services has placed enormous pressure on the processes involved in establishing a district health system toward a decentralised and integrated primary health care service. Primary health care is key to the delivery of ARVs and equitable access to services (Modiba, et al., 2003).

A variety of studies conducted in different locations, indicated how the integration of HIV/AIDS care and support services in primary health care is creating bottlenecks in service delivery (Buve, Kalibala and McIntyre, 2003). With some of the key areas of intervention being already in the process of implementation, such as the aspects of prevention, care, support and treatment, studies have indicated how some of the processes have not adequately fallen into place (Modiba, et al., 2002). One research study concluded that health care in South Africa is mainly provided by practitioners and nurses who are overworked and are having to function in sparsely resourced facilities and often in inaccessible locations (Ncayiyana, 2001). In a World Health Organisation Report for the year 2000, South Africa was ranked 57th in terms of availability of funding and resources and 175th when it came to efficiency of service provision (Parker, et al., 2000).

Despite the health systems problems, it has been strongly suggested that an important aspect in the treatment of people living with HIV/AIDS, is access to medication, specifically antiretroviral drugs (Chequer, et al., 2002). It appears that the South African government did not reach the decision to provide ARVs based on the recognition of the negative aspects that could manifest from the increase in morbidity and mortality rates caused by HIV/AIDS. It appears to have been due to the unrelenting pressure from the various forces both local and international.

The decision by the South African government, in 2000, not to provide ARVs triggered controversy and prompted advocacy initiatives from various sectors of society. The Treatment Action Campaign, which has been prominent in lobbying for

access to HIV/AIDS treatment in South Africa was one of the most consistent proponents of a systematic ARV roll out programme. Health professionals in one province, Western Cape, began delivering services to prevent the transmission of HIV to HIV-positive mothers in primary health care clinics and centres before the National Department of Health policy was changed (Parker, et al., 2000). The Western Cape had a different policy on HIV/AIDS that allowed for several pilot sites to deliver ARV services before the National Department of Health policy on ARV delivery changed in 2003.

The South African government's cautious and reluctant approach to providing ARVs is reported to have been due to its recognition that treatment requires more than the provision of drugs; it also involves testing, which requires adequate diagnostic testing tools, counselling and monitoring. A number of collaborative initiatives are required in order to establish a successful and sustainable ARV programme. There needs to be a workable interaction and easy access to the laboratory, so as to conduct tests for viral load, CD4 counts; and a reliable and secure supply channel for ARV drugs to ensure secure procurement and distribution. There needs to be a stable system of records for laboratory tests and the establishment of clinical monitoring systems.

There have been various proposals put forth on adopting a model for ARV provision. Provision is an important aspect in the ensuring of sustainability and adherence of those that are using the service (Liechty and Bangsberg, 2003). It is crucial for there to be a decision on how the drugs will be prescribed and administered in terms of

patient selection. Lack of critical support systems in this area may render the programme unsustainable.

The government had expressed concern about the administrative and technical capacity to roll out ARVs. It had also voiced some doubts about the safety and efficacy of ARVs. Significant pressure, manifesting in various forms, at both local and international level, resulted in the government launching a comprehensive ARV roll out programme in 2004. Without a doubt, the provision of ARV will affect the quality and duration of the lives of people living with HIV/AIDS. Provision of drugs will also have a pervasive effect on a number of sectors in the country, particularly the health sector. With impeccable systematic planning, there could be strengthening of service delivery in areas where problems currently exist and the allocation of resources to under-resourced areas (Schneider, 2003). The general view from those that are observing the process of the ARV programme is that, with adequate planning, the programme could bring new investments in the health system. These investments could have a positive influence on the entire health care system (Schneider, 2003).

With the decrease in local pricing of triple ARVs in 2001, the South African government has had to continue with the roll out of the drugs, despite its many concerns about capacity within the health care system (Orrell, et al., 2003). The effective implementation and administration of the ARV programme has been accompanied by various expectations and concerns, because it will require other procedures in addition to simply prescribing and handing out drugs. Many aspects of

design and implementation need to be adequate to ensure sustainability of the processes outlined in the policies that are already in place (Chequer, et al., 2002).

The provision of ARV drugs requires that the government address fundamental weaknesses in the health care system, many of which have existed for a number of years, due to the system being burdened with additional policies and programmes (Loewenson and Whiteside, 2004). Common issues and weaknesses that have been continuously identified are the lack of technical support and resources in primary health care facilities. This has manifested in the shortage of staff, lack of moral and motivation in the remaining staff, poor infrastructure and poor communication between the users, the community and the health system (Schneider, 2003)

Many studies have raised concerns about poor adherence, even though there has been no published material to substantiate the anticipation of poor adherence by people that reside in a resource-limited society (Orrell, et al., 2003). A study was conducted in 2000 on patients from the greater Cape Town area and from poor socio-economic circumstances. Results indicated that patients from poor circumstances could have successful outcomes in terms of adherence to treatment if there were no financial barriers (Orrell, et al., 2003).

In February 2000, Medecins Sans Frontieres (MSF) in collaboration with Department of Health of the Western Cape established a comprehensive HIV site in Khayelitsha, which became the first public health sector ARV service in South Africa. The ARV clinic became an example that it is possible for people living in impoverished and

disadvantaged circumstances to take ARV drugs consistently and in a sustainable manner. The aim of the project was to also demonstrate the effectiveness, acceptability and feasibility of providing ARV in a primary health care setting. In order to evaluate adherence to antiretroviral therapy (ART) the MSF conducted a prospective study which indicated that 90% of patients reported high levels of adherence. In May 2003 the Khayelitsha ARV programme celebrated its second anniversary and demonstrated that treatment is possible in resource-limited settings (Medecins Sans Frontieres, 2003)

Botswana is another country that has been implementing an ARV programme since 2002. Challenges identified included having to prioritise equitably and fairly in resource-constrained environments, staff shortages and limited training, patient fear to disclose, provider's reluctance to address HIV/AIDS aggressively and unwillingness to participate in programmes (Schneider, 2003).

1.2.5. The Health System in the Gauteng Province

In Gauteng, the implementation of ARV services will include all levels of health care facilities. These include fourteen level 1, 2 and 3 hospitals and nine community health centres and clinics, which will be the core of PHC provision. The most resourced hospitals will be designated in the initial phases of implementation. It is widely assumed that the Gauteng province is the most resourced and is reasonably well off in terms of general socio-economic indicators. However, it has been reported that there are vast socio-economic differences within the province itself that compromise the equity of health care provision. It has been suggested that providing ARVs only in

hospitals would increase this inequity because people living further from hospitals are unlikely to have equal access to services (Schneider, 2003). Designated service points for ARV roll out will initially be those that service the highest population and have the most resources, such as the major hospitals. These facilities have been designated to provide clinical and training support, but initially will be the first providers of ARV services. The designation of facilities will be determined by the presence of a number of conditions including a trained care team representing all the relevant professions for ARV programmes, access to 24-hour care at the service point, a staff recruitment, training and skills development plan in place, access to laboratory services, secure and adequate pharmacy storage, formal referral systems and links with other functions (wards, other clinics) and outside expertise, linkages with support organisations and NGOs, patient/treatment tracking system in place, maintenance systems of medical records and data transmission to central data collection system, links with the provincial HIV and AIDS Unit, amongst others (DoH, 2003).

Recognising the importance of primary health care, the Gauteng provincial government initiated and developed its strategic plan with a focus on primary health care services. Already, between 50% and 60% of Gauteng's clinics provided AIDS care, but the aim was to increase this to 90% by 2004/2005 (Modiba, et al., 2002). Such services would play a major role in the continuum of the HIV/AIDS strategy, such as and include counselling, testing and/or diagnosis, TB treatment, palliative care referral, support to home-based care, prevention of occupational exposure and post-exposure prophylaxis (Modiba, et al 2002).

The inclusion of these services into the general continuum of health care has reportedly increased the burden on health care facilities and its professionals. A study by Shisana, et al. (2001), indicated that there has been an increase in the demand for HIV/AIDS-related care in the public health sector. This has been reportedly led to an increase in the workload, particularly of health professionals. Despite the attempt by government to allocate more staff to deal with the epidemic, the study indicated that a high percentage of health facility managers felt that there was a need for more health personnel to be deployed, to cope with the increased need for care and treatment (Shisana, et, al., 2001).

All these factors and many more have emerged as concerns in implementing the ARV roll out programme. Specific aspects are required in the public health sector for adequate planning to take place. It is questionable as to whether these exist and where they do, whether they function adequately. These include staff support systems such as training, workload issues, drug supply, staff knowledge and training systems, networking relationships and the quality of services in care and support services, which affect user perceptions (Schneider, 2003).

1.3 STATEMENT OF THE PROBLEM

Despite the fact that the recent decrease in the pricing of ARV drugs may mean that access to treatment may increasingly be available in the public health system to the most poorly resourced South Africans who live with HIV/AIDS, there are still fundamental issues that need to be addressed in the health care system to ensure that

the process will function smoothly and adequately. Questions have been raised about the capacity of the present health system to cope with the additional services that will be rendered within poorly resourced clinics and hospitals.

An increasing body of literature indicates that the provision of ARVs in the South African public health sector will require a level of delivery that is higher than the current status of capacity. Core challenges, highlighted by a variety of studies, include decreasing staff establishments, weaknesses in management and distorted patterns of referrals due to the enormity of the problem and the demand for quality of care, resulting in the bypassing of health care referral systems.

1.4 JUSTIFICATION FOR THE STUDY

This study is pertinent, because it has been conducted at a stage in which the South African government is requiring information and feedback on the state of its health care system to initiate, develop and sustain the process of providing ARVs. The study itself will add to a repertoire of studies that have been and will be conducted to determine the status and potential effect of the interventions that have been outlined in the government's Operational Plan for Comprehensive HIV and AIDS care and Treatment (DoH, 2003).

There has been general concern about the fact that in Sub-Saharan the expansion and implementation of HIV/AIDS treatment is occurring in the absence of adequate

investment in strengthening the weaknesses in health systems. The increasing of funds towards the fight against the epidemic and to increase access to ARVs will not change the fact that there are inadequate resources in most of the region's health systems. To add to this, the structural programmes and health sector reforms imposed on developing countries by institutions such as the World Bank and the International Monetary Fund, has left many of these countries with fragmented and disorganised health systems (McCoy et al., 2005).

Experiences of ARV roll out and provision in the public sector in other African countries, such as Botswana, indicate that there can be challenges in a variety of areas, particularly, in the capacity of the health care system and the inadequate demand for services (Schneider, 2003). In Botswana, the treatment of HIV/AIDS further burdened an already ailing health system, technically and structurally and led to more deficiencies, as the demand for care increased. This was exacerbated by the shortage of health professionals and the lack of integration of programmes in their health system (Steward, et al., 2004).

South Africa is faced with similar pre-existing deficiencies in its health system, and a volume of literature highlights the need for the strengthening of its infrastructure and systems before the broader the provision of ARVs in the public sector can be successfully implemented. Documented experiences from the introduction of other programmes and other public health interventions have highlighted the need for adequate research and monitoring systems, during the process of implementation. It has been argued that if a similar health care environment exists in the process of ARV

provision, as existed at the introduction of TB, TOP and MTCT programmes, then the same challenges are likely to arise (Schneider, 2003). Core challenges include lack of resources, particularly, human resources, inequity in service provision, monitoring and evaluation systems, management systems and in infrastructure and support systems (Schneider, 2003).

All these aspects require adequate research, so as to assess and monitor the process of the implementation of the ARV programme. It has been suggested that there are shortcomings in literature and that areas pertinent to this topic require further research (Steward et, al., 2004). An introduction of a new public health programme cannot exist without robust data and information on ARV provision to critically assess the programme's progress.

The roll out of ARVs will be conducted in all the nine provinces of South Africa. However, this study will assess the roll out in a province that has been perceived to be better - resourced than others. This may highlight what other provinces are likely to experience.

The study will also attempt to describe the challenges that may lie ahead for the implementation of the ARV roll out plan and other aspects relevant to the provision of HIV/AIDS treatment. The data and information gathered from the study may assist in addressing the challenges in service provision that may be identified. This will assist in the improvement of the efficiency and efficacy of the services.

1.5 AIM OF THE STUDY

To conduct a rapid appraisal of the status of the roll out of the antiretroviral programme in Gauteng and the preparedness of the facilities in which roll out is yet to occur in the province.

1.6 OBJECTIVES OF THE STUDY

1. To describe the capacity of facilities to deliver services, specifically:
 - Human resources
 - Training
 - Referral mechanisms
 - Accreditation processes
 - Drug management systems
 - Laboratory management systems
 - Monitoring and evaluation mechanisms and systems
2. To compare the capacity of facilities in which roll out of the ARV programme is underway and those designated facilities in which roll out is planned
3. To identify and describe the selection criteria utilised for drug provision to patients
4. To identify and describe community-based education programmes that are envisaged and/or in place
5. To compare perspectives from inside and outside the system about the preparedness of health services.

6. To compare the preparedness of facilities for roll out of ARVs to the strategy and planning at provincial level and national level.
7. To identify whether contingency plans to address problems and barriers to the delivery of services are in place and to describe them.

CHAPTER 2

2. METHODOLOGY

2.1 Study design

The study has a descriptive cross-sectional design, drawing on qualitative methods such as the document review and a facility checklist.

2.2 Study sites

The selection of sites was conducted in collaboration with the Gauteng provincial department of health and its regional offices. The department felt that it should recommend sites in which to conduct the study, as not all facilities would be appropriate for study. Both offices did not indicate on which basis the sites were selected. The recommended list was confined primarily to Region A, Gauteng. The selected Region A is made up of the Central Wits Region and the West Rand. The study was confined to the Central Wits Region. This area is predominantly urban and peri-urban, and according to the 1996 census, comprises of a population of 2 507 260. Twenty-four percent of this population resides in informal settlements, while 76% live in formal residences (McDonough et al, 1999).

The initial goal was to conduct the study in three community health centres (CHCs) and/or clinics and two hospitals. However, due to the shortage of health care professionals in most of the identified facilities, the number of facilities studied

numbered four CHCs and three hospitals. All the selected facilities were situated in the Central Wits Region of Gauteng. Three facilities were located in Soweto.

All the facilities surveyed in this study that were already rolling out the ARV programme were hospitals and all facilities that were preparing to roll out were CHCs.

Table 1 describes the facilities that were selected for the study.

2.2.1 FACILITY DESCRIPTION

TABLE 1: COMMUNITY HEALTH CENTRES*

HILLBROW COMMUNITY HEALTH CENTRE
<p>A facility in the centre of Johannesburg. It is a primary health centre in the sub-District of the Central Wits Region, known as sub-District 8. In 2004, it had an annual patient headcount of 213 561*. The following HIV/AIDS-related services are rendered:</p> <ul style="list-style-type: none"> • HIV testing • VCT • STI treatment • TB treatment • PMTCT • PEP
ZOLA COMMUNITY HEALTH CENTRE
<p>A facility in Soweto, south of the Province. It is situated in sub-District 6. In 2004, it had an annual patient headcount of 160 098*. The following HIV/AIDS –related services are rendered:</p> <ul style="list-style-type: none"> • HIV testing • VCT • STI treatment • TB treatment • PMTCT • PEP
DISCOVERERS COMMUNITY HEALTH CENTRE
<p>A facility in the west of the Province. It is situated in sub-District 5. In 2004, it had an annual patient headcount of 151 217*. The following HIV/AIDS – related services are rendered:</p> <ul style="list-style-type: none"> • HIV testing • VCT • STI treatment • TB treatment • PMTCT • PEP

* Source: Department of Health – Regional office

LILLIAN NGOYI COMMUNITY HEALTH CENTRE
<p>A facility in Soweto. It is situated in sub-District 10. In 2004, it had an annual patient headcount of 198 659*. The following HIV/AIDS-related services are rendered:</p> <ul style="list-style-type: none"> • HIV testing • VCT • STI treatment • TB treatment • PMTCT • PEP

TABLE 2: HOSPITALS^Ψ

JOHANNESBURG HOSPITAL
<p>A national central hospital. It is also in the city centre of Johannesburg. Data from 2004: Total annual usable beds: 13 128 Total annual Inpatient days: 321 230 Total annual OPD headcount: 552 796 The following HIV/AIDS-related services are rendered:</p> <ul style="list-style-type: none"> • PEP (only cases of needle prick, not unprotected sex) • For all other services, the facility refers to the clinics
CHRIS HANI BARAGWANATH HOSPITAL
<p>A national central hospital. It is situated in Soweto, in the South of the Province. Data from 2004: Total annual usable beds: 30 824 Total annual Inpatient days: 760 593 Total annual OPD headcount: 180 575 The following HIV/AIDS-related services are rendered:</p> <ul style="list-style-type: none"> • VCT • STI treatment • TB treatment • PMTCT • PEP
HELEN JOSEPH HOSPITAL
<p>A regional hospital. It is situated in the west of the Johannesburg. Data from 2004: Total annual usable beds: 6 394 Total annual Inpatient days: 153 482 Total annual OPD headcount: 246 968 The following HIV/AIDS-related services are rendered:</p> <ul style="list-style-type: none"> • PEP (only in cases of needle prick, not unprotected sex) • For all other services, the facility refers to the clinics

^Ψ Source: Department of Health – Regional Office

2.3 Study population / study sample

The following people were interviewed: two regional managers of the HIV/AIDS programme, one facility manager; either the Chief Executive Officer (CEO), superintendent or manager of the ARV programme, one doctor and one nurse who were involved in ARV service provision at each facility and representatives from three key HIV/AIDS NGOs, active in Gauteng. One NGO was able to provide two representatives; one member, a provincial chairperson and the other, a regional representative. The other two organisations provided one representative each. A total of 25 participants were interviewed.

2.4 Data collection / Measurement

Identification of the participants commenced with the researcher contacting the managers of the study facilities, who provided information on the doctors and nurses who were working at the ARV clinics and recommended participants.

Participants from the NGOs were identified by the researcher after meeting with relevant representatives. By contacting the Gauteng department of health regional office, the researcher identified the regional managers as appropriate participants.

All fieldwork was conducted by the researcher who can communicate in five South African languages, including those most often spoken in Gauteng. While most interviews were conducted in English, some participants responded in the language

that they felt most comfortable speaking. Each facility was able to provide a private room in which the interviews were conducted. The researcher ensured that no one was able to overhear the responses. All interviews were, on average, one hour to one hour and-a-half long in duration.

Data collection for this study involved the following tools:

- Semi-structured interviews with the following key people:
 - Two provincial managers on training, laboratory services, drug supply services and on general district management.
 - One facility manager at each facility
 - One facility nurses who was delivering HIV/AIDS services
 - One facility doctor who was delivering HIV/AIDS services
 - One member each from three NGOs active in the province on their general view of the readiness of facilities to provide ARVs

- Record review of planning documents, training material, patient record-keeping material:

Facilities were requested to provide accreditation documents or documents that were guidelines on the implementation of the ARV programme. To view the content of the training that had taken place, the researcher requested to view any of the material that was utilised and/or received in the training. The patient information systems of all the facilities were also viewed, assessing whether electronic or hard copy material was utilised.

- Facility checklist for basic requirements of designated facilities:

A facility checklist was completed in each facility with the assistance of the facility manager. The checklist was explained to all the managers prior to the assessment. No problems or barriers were encountered during the process of completing the checklist in the facilities.

Questions in the semi-structured interviews covered the key areas of interest, including:

- Perspective on how roll out had progressed thus far
- Laboratory services
- Training
- Drug supply and distribution
- Information systems
- Monitoring and Evaluation
- Accreditation
- Clinical protocols/referrals
- Infrastructure
- Human resources

The facility checklist covered the key areas of interest including:

- Infrastructure
- Access
- Management of resources
- Patient and clinic environment
- Clinical protocols and guidelines
- Facility list for accreditation requirements
- HIV/AIDS service support systems

2.5. Data Processing Methods and Data Analysis

All interviews were tape-recorded and transcribed verbatim and a thematic analysis was carried out. The analysis extracted themes that emerged from the responses of the participants. The emergent themes were correlated to findings that emerged from the facility checklist and from the facility guidelines. It must be noted that facility guidelines were difficult to source, as most of the facilities did not have the required documentation, such as ARV guidelines and protocols. All facilities had hard copy patient information records

The data from the facility checklist was entered on Excel and a descriptive analysis was conducted. All aspects that emerged from the facility checklist were analysed on a collective basis, to assess the scope of the facilities with regards to the infrastructure, as recommended by the accreditation guidelines, detailed in the Operational Plan on Comprehensive Care and Treatment for HIV and AIDS (DoH, 2003).

Triangulation of the findings from the interviews and the checklist were carried out in the analysis. Analysis of all the sites was collective, hence none of the sites was assessed and/or analysed individually.

2.6 Study Limitations

The study has a cross-sectional design and because of the rapid development in this area the study is likely to have a short life span, as it will be an analysis of the status of service delivery at a particular time. It is possible however that the issues identified by the study will be useful in the planning of ongoing service delivery. The fact that the issue of ARV provision had been controversial may have led to there being heightened sensitivity to the issue, which, in turn may have affected responses from participants and the reluctance of some prospective interviewees to participate.

Some of the designated sites that were preparing for the roll out had not as yet allocated relevant staff members (particularly doctors) required for the study. Other designated facilities were subsequently selected, as recommended by the provincial and regional departments. The documentation (treatment guidelines/protocols and training material) required by the researcher, could not be provided as most facilities did not have the guidelines and most training materials were not kept on site. The absence of documents limited the scope of the document review.

2.7 Ethical Considerations

Informed consent to be interviewed was obtained from each participant. Each participant was given an information sheet that explained the purpose of the study as well as information on consent and who to contact if he/she had questions prior to the interview. Permission to tape record was requested separately. The Gauteng Department of Health was approached for written permission to undertake the study.

A letter of permission, once obtained, was provided to all facility managers and interviews were arranged subsequently. A room for interviews was selected where privacy was ensured. The study was explained in the language of choice. Contact details of the researcher were provided to the participants, in case further clarification was required. To ensure confidentiality and anonymity details of the participants were not recorded.

Participants were identified by their titles and not by their names, to ensure confidentiality. The interview was transcribed immediately to allow for the safekeeping of tapes. Tapes from the interviews were stored in a cabinet accessible only to the researcher. The tapes were destroyed after all the transcription was completed. All transcribed material was kept in a safe file for any further referral.

The proposal for the study was submitted for ethics approval to the University of the Witwatersrand's Human Research and Ethics Committee (see Appendix 15). Approval was granted, with a request to mention, in the data analysis section, that the sites would be analysed collectively.

2.8 Utilisation and dissemination of results

The outcome of the study will be provided to management of the facilities that were studied. The findings of the study will be held at the School of Public Health and the published of the research study will be held as a University library resource.

CHAPTER 3

3. FINDINGS

3.1 Demographic information: Participant description

The nineteen health care workers who participated in the study included seven doctors, seven professional nurses and five managers. All the facility managers were qualified professional nurses. Two of the health care workers in the studied facilities, were male.

Regional managers who participated in the study were both female. Of the four representatives from NGOs that participated in the study, there were two males and two females.

3.2 Facility Infrastructure

The following table reflects facility checklist and the guidelines/protocols viewed in the seven facilities. The content of the checklist focussed on areas that were specified in the Operational Plan on Comprehensive Care and Treatment for HIV and AIDS (DoH, 2003).

Table 3: HIV/AIDS- RELATED SERVICES

Item/Activity	N=7	Percentage
Operating Hours:		
24 hours	2	29%
8 hours	5	71%
Required repairs:		
Serious repairs	1	14%
Minor repairs	2	29%
No immediate repairs	4	57%
Available toilet facility:		
None		
1 ventilated		
Separate flush for patients and staff	7	100%
VCT services	7	100%
PMTCT services	6	86%
STI services	7	100%
TB services	7	100%
PEP services	7	100%
Patient information kept in:		
Register (book)		
Loose sheets	4	57%
Other	3	43%
	0	0%
Blood sample room storage area:		
Consulting room	0	0%
Allocated space for samples in facility	7	100%
Blood sample storage:		
Refrigerator	3	43%
Cupboard	1	14%
Other	3	43%
Adequate supply of HIV tests?:		
Yes	7	100%
No	0	0%
Problems with tests?:		
Yes	1	14%
No	6	86%

Table 4: ARV RELATED SERVICES

ITEM/ACTIVITY	N=7	Percentage
ARV service hours:		
Open on specific days	4	57%
Open office hours, 5 days/week	2	29%
24 hours, 5days/week	1	14%
ARV guidelines available in:		
VCT area	2	29%
Other parts of facility	5	71%
Charge office	0	0%
Filing cabinet	0	0%
Specified drawer	0	0%
Other	0	0%
HCWs have access to ARV guidelines:		
Yes	5	71%
No	2	29%
Patient information kept in:		
Register (book)	3	43%
Loose sheets	3	43%
Other	1	14%
ARV services delivered in:		
Closed off area(no walls and doors)	2	29%
Private room(4 walls and door)	3	43%
Other(new/designated clinic in facility)	2	29%
Multiple consulting rooms:		
Yes	6	86%
No	1	14%
Adequate supply of ARV drugs:		
Yes	4	57%
No	0	0%
N/A	3	43%
Experienced problems with drugs:		
Yes	4	57%
No	0	0%
N/A	3	43%

Table 5: STAFF/PATIENT RATIO

Facility A (rolling out)	16: +/-1000
Facility B (rolling out)	13: +/-1000
Facility C (rolling out)	8:1 200
Facility D (not yet rolling out)	13:500*
Facility E (not yet rolling out)	5:500*
Facility F (not yet rolling out)	12:? [#]
Facility G (not yet rolling out)	13:? [#]

- Staff / Patient ratio is the total number of staff in the ARV service to the total number of patients on ARV treatment. All figures were provided by the facilities

* These were booked patients, not yet attending treatment

These sites were unable to provide patient figure

What emerged from the facility checklist ultimately differentiated the status of the facilities that were rolling out and those that were preparing to roll out, in terms of the state of the roll out process and the state of preparedness for the roll out, respectively. The checklist revealed that the CHCs required some level of repair and/or extension of the areas to be utilised for the ARV service, while hospitals were not in need of any immediate repairs, even though it seemed that the increase in patient attendance would require some modifications of the facility or the area for ARV service.

According to the accreditation guidelines detailed in the Operational Plan on Comprehensive Care and Treatment for HIV and AIDS (DoH, 2003) the selected facility is required to provide 24- hour or to be close in vicinity of a facility that provides 24- hour care. Only two of the seven facilities surveyed provided 24- hour services. The remaining sites were open eight hours a day with most providing ARV services on specific days.

Two of the sites, which were not yet rolling out, had a challenge of space for the ARV clinic. Both had plans to close off a section of the facility, which would be utilised for ARV roll out. This had implications for privacy and confidentiality. Some of the hospitals had already made provisions for a separate clinic for ARV roll out. Two of the facilities, including one CHC, had a newly built separate area, away from all other facility functions, which would be utilised for the ARV clinic.

All facilities already rolling out had experienced a consistent supply of drugs.

The requested accreditation documents or protocols on the implementation of the ARV programme were not available in all the facilities. Neither was any training material. None of the facilities could provide these documents. It must be mentioned that this was reportedly due to that none of the participants kept their training material at the facility itself and it was not explained as to where the material was kept.

3.1.1. AN OVERVIEW OF THE ARV ROLL OUT

The following findings were drawn from the 25 semi-structured interviews conducted with HCWs, facility managers, representatives of NGOs and regional managers who were involved in the implementation of the roll out of the antiretroviral treatment programme. The interviews with HCWs focussed on the perspectives of those who were in facilities that had already started rolling out and those who were getting ready to roll out. The interviews also drew perspectives from those that were in managerial positions outside and inside the facilities and also from representatives that were external role-players, from relevant NGOs involved in the process of ARV treatment implementation.

The following themes emerged from the interviews:

3.1.1.1. Gauteng may be better resourced

Some of the participants were convinced that the Gauteng province was still in a better and privileged position than most of the other provinces for various reasons. Many felt that Gauteng was better resourced than other provinces, particularly financially and that there was a need for appropriate management skills to manage the finances to ensure sufficient coverage, which in their view was lacking. The perception was that there was enough money to afford all the health professionals that are needed for the implementation of the ARV programme. Strong sentiment was expressed that Gauteng had started running the programme before the other provinces and was ahead in the learning stages. Some were also of the view that Gauteng has strong training organisations; hence it should be more than capable of conducting the ARV roll out programme.

“Gauteng is far much advanced, firstly they started before government announced that it was going to roll out and secondly, they've got the money to back up the roll out programme...” (NGO)

There was also a general sense that a political willingness and a political commitment existed to implement the programme. This was enhanced by commitment of those tasked with implementing the policy. Interviews generally indicated that most of the HCWs improvised and worked with the resources at their disposal to ensure that there was adequate service delivery. Many displayed this commitment by developing their own initiatives to facilitate a system of service delivery and utilised existing staff members to roll out the new service. Participants felt that their strength lay in the fact

that they had some level of leadership from the HCWs themselves, who were informed by a strong sense of values and principles.

“ The thought was that we all had to make an extra effort or sacrifice if we wanted it to work , because if we had wait for additional staff, it may not start and working in this clinic on a daily basis, we do see the need for this kind of clinic (ARV clinic) because we have many patients that are positive, whose CD4 counts are dropping and who are in need of the drugs. So the need is obviously there and if we are to wait any further for staff to get appointed, it might take forever, we need to sacrifice.” (Doctor, facility not yet rolling out)

“We have a calibre of health care workers. Not everyone, but a leadership amongst health care workers. Where the programme is working, is where you have key individuals that are informed by principles around humanity, around what health care services should be providing, especially for the impoverished communities. So I'd say we (Gauteng) are an advantage in that sense.” (NGO).

3.1.1.2 General perception of the roll out

3.1.1.2.1 Perceptions about the status of roll out in facilities that are preparing to roll out ARVs

There were varying perceptions from participants on the status of roll out of ARVs . Many of the participants felt that capacity within facilities that were already in the process of implementation were burdened and in need of support at all levels. Many felt that there were varying degrees of progress, and much of it was reportedly due to the extent of management from the region and the province. This was an indication, according to participants, of the lack of prioritising. It seemed that those sites that needed most assistance in implementing the programme were not getting assistance.

“ As much as there is capacity in Gauteng, you can have a good programme running in Bara and Helen Joseph, but then you have got a mess at Natalspruit Hospital, Sebokeng, problems in hospitals in the Pretoria area and they are

trying. And then you have another level where you have nothing. Orange Farm for instance has to go to Bara.”
(NGO)

There was still a strong sense that some level of success was being experienced in the process of implementation. HCWs indicated that there were challenges, many of them familiar, but the roll out was in progress and they felt that they were saving lives already.

3.1.1.2.2 Perceptions on the status of readiness in facilities not yet rolling out ARVs

Similarly, most participants felt that there were varying degrees of readiness in facilities that were preparing to roll out the ARV programme. Participants who were essentially internal role-players in the implementation, primarily HCWs, were of the view that the lack of infrastructure rendered them not ready to roll out. Most indicated that physically, the sites were not designed to handle the anticipated increase in the number of patients. There was concern about the lack of human resources and the lack of experience of some of the staff. This view coincided with the fact that most felt that they were given little time to prepare, when considering the amount of adjustments that had to be made.

“ I don’t think we are ready, especially the time frame we have been given, because our clinic does not have proper furniture and neither do we have a pharmacy, as it was said we needed a pharmacy specifically for the programme and we only have two professional nurses working and that’s not going to be enough. Fortunately, there is a doctor working at the crisis centre who volunteered to help out. Basically, structurally, we are not ready.” (Nurse, facility not yet rolling out)

External role-players were of the opinion that there was a varying degree of readiness, but the strength was influenced by the capacity that had been built up over time in the process of preparing for the roll out. There was a general view that Gauteng had the resources in academia, the private sector and the public sector.

“ Gauteng has various degrees of readiness and we are the province with the largest teaching institutions and with a lot of research expertise that has been developed around the use of ARVs, both in the public and the private sector and academic sector. We have organisations like the Wits consortium. The research unit has built up considerable capacity skill prior to cabinet decision to start. With those programmes, that explains why this province has moved faster, apart from the Limpopo province, because the foundation and capacity was there.”
(NGO)

3.1.2 Factors affecting access to ARVs: The Social Context of ARV treatment

3.1.2.1 Poverty

One of the concerns that had emerged from the interviews was how poverty in the communities that are generally served by most public health services may have an impact on the implementation of the ARV programme. Many of the participants claimed that public health systems are still inadequate to the extent that they do not alleviate the effects of poverty on the people who were using the services. The general perspective drawn from the interviews, was that facilities in which ARVs are available are not necessarily close to where people reside and that transport costs to reach the services were a barrier to accessing the services.

Participants indicated how a person living in a particular area was expected to travel to a facility that required money to reach it, as that was the only site that provided the

service. The view was that many people with such experiences may not have the money to even get to the service. This was seen as a result of poverty and also the experience of many in our society that use public health services that do not cater for the circumstances of poverty.

“ For someone to come from Soweto to here costs them a lot of money and then you can’t send them around to another place where they’re going to be shoved around again, and that is the experience of most people with public health services.” (NGO)

The problem of poverty is a complex issue because it is intertwined with issues of unemployment and an inefficient health care system. People who are seeking ARV treatment are in need of more than the drugs themselves. This is where the need for co-ordination of other government departments was stated as necessary. Many of the HCWs cited how most of the patients came to the facilities in need of food and grants. Most were of the view that access to grants was still a problem for patients, thus there is a need for an efficient and systematic co-ordination between the Department of Welfare and the Department of Health.

“ One problem that I foresee with the patients that are on ARVs, especially here in this area, is unemployment. These patients need food, hence everybody that comes here wants a grant before they start on ARVs...that may interrupt the process...” (Nurse, facility not rolling out)

3.1.2.2 Stigma and Health Worker Attitudes towards Sexual Behaviour

Many of the participants indicated that there are various possible barriers to reaching people that need ARV treatment and one of them is the stigma that is still attached to HIV/AIDS. This sentiment was more importantly centred on health care professionals

themselves and how they viewed HIV/AIDS and issues around sexuality and how this could lead to negative views about the patients that are served. It was indicated that HCWs also carry their personal views, as they are products of society and therefore carry those social values into their work as implementers. This view supports the possibility that HCWs assert conservative views, especially in relation to sexuality. For instance, it is likely to find health professionals who question the dynamics of rape. Perceptions such as that, the manner in which a woman dresses tends to provoke or invite an incident of rape, may be likely to influence attitude towards patients. To emphasise this view, participants also highlighted pregnant women who are HIV positive and how ill-informed morality amongst HCWs may lead to the questioning of the choice of HIV-positive mothers to have children. It is these kind of perceptions that the participants said are likely to be carried over into the implementation of the ARV programme.

It must be noted that this concern was mainly raised by representatives from NGOs. None of the HCWs interviewed seemed to perceive stigma from this dimension.

“...there’s not much stigma associated with TB as there is with ARV and HIV and ultimately, sexuality...

You see someone with HIV and you immediately think this person is immoral...he or she has just had unsafe sex...not even unsafe sex...and deserves what they got.” (NGO)

“health care workers are the product of our society, so they have the same opinions about things and they carry that through in policy implementation.” (NGO)

These personal views, according to the NGO participants, lead people to judge and condemn those that carry the virus. This was perceived to be more evident amongst women in services directed at women. Women are judged for having children while

being HIV-positive. Women, therefore bear the brunt of attitudes from the public services they have to use because conservative views about women and women's rights prevail.

“You know, I think it would be interesting to focus in particular on pregnant mothers, who are HIV positive, because there, you find the same kind of ill-informed morality is what I call it, because it's, ‘ you are HIV positive. How can you have babies?’” (NGO)

3.1.2.3 Disclosure to the community, family and/or sexual partners

The prevention and control of HIV infection relies on the success of a variety of strategies, to prevent incidences of infections and to manage those who are already infected. One of the strategies that is utilised to achieve prevention and control of HIV-infection, is Voluntary Counselling and Testing (VCT). This tool, particularly in the public health sector, emphasises the importance of the disclosure of one's status. It is considered vital because it increases an individual's opportunity to receive social support and the ability to access and receive adequate treatment, such as ARVs, without any hindrance (WHO, 2003a). The failure to disclose one's status may ultimately lead to difficulty in using one's treatment adequately. For instance, if an individual has not disclosed his/her status to a sexual partner or to the family, he/she may find it difficult to establish a necessary routine in taking the treatment, due to fear of being identified. This may inhibit to the success of the ARV programme, if this is the experience of many users who are on treatment.

There was a general view amongst the participants that disclosure was not a simple process. Many of the patients are in circumstances that do not allow them the

privilege of disclosure and that in itself would presents a barrier. It was acknowledged that if an individual has not disclosed, adherence will be a problem. Many participants recognised the fact that many people, especially women, live in disempowering circumstances where disclosure may present as a threat to, rather than a facilitator of treatment.

“ I think that people should understand that disclosure is not the problem, but the stigma is. That’s why we have counsellors dealing with that. For instance, you have someone whose husband beats her twice a week. He will kill her if he finds out she is HIV positive, so that’s reason enough not to disclose. That’s a barrier.” (Doctor, facility rolling out)

3.1.2.4 Adherence

A strong sentiment about the nature of ARVs and about the treatment, was the challenge of changing the mindset of people towards the nature of treatment and the need to adhere to drug regimens. Most of the participants recognised the challenge of having to be on treatment for the rest of one’s life and how that poses a barrier to implementation. The implementation of the ARV programme was acknowledged to be different from most health policies, as it requires fundamental changes in people’s behaviour.

Most HCWs highlighted adherence as one of the problems they anticipated in the implementation of the HIV/AIDS policy. They reportedly have similar experiences with TB treatment, where people experience problems complying with treatment regimens. The commitment and lifestyle adjustments that coincide with the treatment were considered as difficult aspects of the regimen.

“ We expect problems with adherence. We see it with our diabetic patients and even on the chronic side, patients are not complying. They don’t keep their appointments. Obviously that is going to be a problem and there’s nothing you can do about it.”(Nurse, facility not yet rolling out)

Entrenching certain behaviours such as exercise and eating healthily) will facilitate the success of the treatment amongst individuals but may also interfere with adherence.

“ What is required to implement...is much in this case. It’s different to other policies that are on health care services, given that it’s changing people’s attitude, it goes to the core of individuals.” (NGO)

One doctor regarded the lifestyle changes that are expected from people on treatment as impractical. He felt that the expectations disregarded the emotional and social changes that people experience when they discover their status. He pointed out how many are probably overwhelmed by the prospect of taking medication for the rest of their lives, including possible experiences of depression and the loss of income.

“government says that you have HIV. To get ARVs, you must disclose, eat properly, practice safe sex, exercise and stop drinking. Government needs to understand that the latter is difficult to implement. You have to be a superhuman to implement that, even for an HIV negative person. Now this is even worse for the HIV positive person who is probably depressed and has to take drugs for the rest of his life and has probably lost their job, and then they have to do all that.” (Doctor, facility rolling out).

3.1.3. Factors affecting access to ARVs: The health system context

3.1.3.1 Selection Criteria: An “annoying necessity”

One of the core issues that participants identified as a barrier to providing a service and for people to access the service, was the issue of selection criteria. Some of the HCWs felt that the specifications for selection were too limiting. Many found that the selection criteria of below 200 created an ethical dilemma for nurses and had become an emotional burden, as many people with CD4 counts of, for instance 208 had to be turned away. Others stated that the criteria is simply annoying, since one has to make an individual with a CD4 count of 230 wait for a few months until it drops, before they can include him in the treatment programme. Generally, HCWs viewed the selection criteria of 200 as a way of simplifying things and often rely on the physical presentation of the patients.

“ I mean things like that get to be annoying. We have a specification in this site, where we start all our patients with a 230 CD4 count. I mean you can’t wait for 4 months until it drops! My sense is that the criteria poses as a barrier. The 200 is just to make it easier. But the system is not geared enough to take on complex issues.” (Doctor, facility rolling out)

“It creates a huge ethical dilemma as a nurse because I sometimes see a patient with a CD4 count of 208, her baby’s died of TB, she doesn’t have an Aids-defining condition, but I can’t put her on the programme because her CD4 count is 208. I think that emotionally, it really is a huge burden on health care professionals, because you have to say no to people...” (Nurse, facility rolling out)

Problems around the limitations offered by the selection criteria present in many ways. Participants said most of the patients that access the sites for treatment are people that are already in the advanced stages of HIV/AIDS and some already have full blown AIDS, which means that many of them are unable to be put onto the

programme as there are conditions attached to the treatment regimen. There was a concern that many people seek treatment when it is too late, so the ARV programme does not always reach those it was meant to.

“According to the programme, ARV is not supposed to be administered to extremely sick patients and most of them have TB. We are also anticipating problems with the treatment in terms of its success, because it was started late when the disease has advanced or the patients have full blown Aids.” (Nurse, facility no yet rolling out)

3.1.3.2 Inadequate communication and mechanisms for educating the public about the ARV programme

Many of the participants expressed their frustration with seemingly inadequate mechanisms for communicating general information about ARVs and treatment requirements to the public. There was the perception that the public was misinformed about the location of various treatment sites. Patients often ended up at sites that do not offer the service, and have to be turned away, requiring them to incur additional travel costs.

“ It’s a lot around information and access to information and I think that’s the biggest challenge, that there’s very basic things that communities don’t know, and that’s linked to access to services as well, information about what services are available and what good services are available because you’re dealing with poor communities.” (NGO)

Most health facility users were reportedly also misinformed about the actual process of being on ARV treatment. The general perception, said the participants, was that one enters an ARV site and receives treatment immediately, not knowing about the process of CD4 counts, counselling and other treatment regimens. This often

frustrated patients who end up not following through with treatment. Members of the public were also said to be highly misinformed about the selection criteria. HCWs indicated that patients are frustrated if they are not selected for the treatment. This perception also prevailed in the selection criteria for the ARV treatment itself and the receiving of food parcels when on the treatment.

“ There is also the problem of criteria and selection. Arguments from patients why they are not selected are very often. We were briefed about the criteria and I am happy with that. I just wish it would be communicated to the public that they must be aware that there is a criteria. You don't just come in and get the drugs. There should be more communication with the public on radio and TV. Patients need to know that if you get HIV, you can get the drugs, but there is a criteria. Satellite clinics are not dealing with these problems.” (Doctor, facility not yet rolling out)

It was therefore evident that community-based education and information mechanisms were not promoting the successful education of people who need the information. Many of the HCWs indicated that they relied on the volunteers from NGOs and the health promoters to establish a link between the facility and the community. Many cited that the community itself was the strongest driver of community awareness and education, particularly in light of the human resource shortage.

“ The role of civil society is to not only monitor, but to also provide solutions to the problems they (government) are facing, because NGOs have the capacity. They have volunteers who are willing to do things like treatment literacy, who are willing to do adherence counselling, are willing to communicate government information to the community, because people lack information. If government works with civil society a lot more, information can filter down to community level.” (NGO)

3.1.3.3 Lack of co-ordination of different services and sectors

Some of the participants cited that there was a lack of co-ordination between different government departments to facilitate the delivery of services in the various sites. The participants indicated that many of the designated sites required extensive repairs and the construction of extra rooms and/or partitions hence the participation of the Department of Public Works is essential. Some participants highlighted the delay in responses from various sectors, as contributing to delays in the process of commencing the roll out at many sites. This reportedly affected the quality of the services rendered in the process. Ineffective and inadequate systems were seen to lead to the abuse of the system.

“ One of the problems is really the buying in of departments like Public Works. They take their time, even if they are told that the facility needs to be ready by a certain time, they tell you about procedures.” (Regional Health Manager)

Inappropriate co-ordination of certain entities of the health care system was also evident in the facilities themselves, where some HCWs raised frustrations about the lack of co-ordination of clinics and functions within the facilities. Health care workers, particularly those working in the paediatric and ante-natal clinics expressed concern that there seemed to be no planning, by the facilities to include patients being serviced in different clinics to access services in the main ARV clinics. Some of the HCWs indicated how women from the ante-natal clinic, who needed to be on ARV treatment were not appropriately accommodated, and protocols to make access to ARV clinics easier post-delivery are lacking. Some of the participants said that the waiting times were inappropriate for pregnant women and some of the facilities were

forced to arrange for separate pharmacies to cater for them. This aspect was also, reportedly, evident in government ARV guidelines. Some HCWs saw them as impractical for pregnant patients and hence had to adjust them to suite the needs of the patients.

“ We had to open a separate little satellite clinic, to actually work with the pregnant women. But the problem there is that we got them onto the roll out got them onto the ARV drugs, but now there’s a hitch between when they deliver and when they go to the normal adult clinic away from the antenatal clinic. I suspect that quite a lot of our patients are having a break in their treatment once they get onto the system for general adults and it’s quite a concern.” (Nurse, facility rolling out)

“ The guidelines are great, but they are not practical. We were actually slower than the rest of the hospital because we had to develop guidelines, based on the national guidelines specifically for pregnant women. The government ones are very brief. I think they give about one page and it’s not implementable (sic) on a practical level, so we actually had to sit down and develop what was suitable and that took a long time.” (Nurse, facility rolling out)

3.1.4 Problems in the health care system

3.1.4.1 Human Resources

3.1.4.1.1 Staff Shortages

One of the key issues raised by HCWs and other participants outside of the facilities as pivotal to their experience of ARV implementation was the shortage of staff. A large proportion of the HCWs in facilities that were getting ready to roll out, expressed their concern about adequate staffing before the introduction of the ARV programme.

“I think it was premature of the Province to expect the clinics and CHCs to be ready even before all the identified hospitals were even ready to roll out. Now we have found that the process of having (to prepare) our facility has occurred, but certain processes have had to be frozen due to that not all the seven designated hospitals have started

rolling out. The lack of designated staff is also starting to be a concern” (Facility Manager, facility not yet rolling out)

3.1.4.1.2 Causes of staff shortages: Inadequate planning and recruitment systems

Various views were expressed as to why there was staff shortage and as to why it will continue to be an issue in health facilities. Most of the participants felt that the problem existed due to inefficient recruitment systems and lack of planning from the government side. However, some participants were ambivalent. They stated that the shortage of staff was not entirely due to inefficient government planning, but rather the fact that public health employment is not very attractive or lucrative. However, some felt that government structures are not innovative and do not attract people to apply. They felt that not much effort is applied to make potential employees understand what employment in government really can offer. Not much emphasis is placed on explaining the benefits and the opportunities that exist for the health professional in the public service. Many also felt that recruitment systems are either inefficient or not in place, hence the evident delay in the placement of some people that have already applied.

“Medical staff come in and want to do jobs for six months, but they (government) haven’t even fostered their career structure. They are going to recruit people but they recruit them on a medical officer structure. They haven’t even explained to you that if you do a year, your salary will go up. When and how you will get your benefits. Nobody tells you all that. Because that has to come centrally, it can’t come locally.” (Doctor, Facility rolling out)

“We were promised staff. It was a governmental responsibility to interview staff. A massive number of people applied and there was no mechanism in place to sort them out. But I think there were really problems to actually getting staff on board.” (Doctor, facility rolling out)

General views from most of the participants emphasised the fact that there seems to be little effort from those in authority to recognise the underlying issues around staff shortages in the public health sector. Participants indicated that there was little effort from other stakeholders including the media to promote a more positive image. Several participants bemoaned the fact that so little was publicised about the positive strides that have been made with respect to implementing the ARV programme. HCWs felt that if more positive aspects of the programme in public facilities are publicised, then more health professionals would be drawn to get involved in this programme. Others, such as NGOs felt that there needs to be an in-depth vision on how to deal with the issue of human resources, as it is not only about pay and financial benefits.

“The jobs are not attractive enough at the moment. And there haven’t been any reports in the papers about the roll out. What we’ve repeatedly suggested here, is why don’t we get some good news stories written about it and that will attract people.” (Doctor, facility rolling out)

“...presented in a positive way rather than in the negative way, it could draw people and draw money to the health system. There is an article from the public health sector in the Western Cape, which talks about the impact this programme has had at the health centre level. This has made people, health professionals positive and excited” (NGO)

“This is a sector where people are just leaving. There’s just no vision (from above) to say, what can we do to make this health care sector attractive for people to come in and work...it’s not just about pay.” (NGO)

Some of the HCWs expressed little hope in the ability of the system to attract and/or retain more staff. It was suggested that public health facilities should rely and invest in the health professionals who have opted to remain in the public sector by providing more training.

“ I don’t even know if we’ll even ever get extra staff. I think our long-term plan now is to train the professionals we have here. And I think that’s really the best we can do. I don’t think we can get much more and even if we do, it might be one person.” (Nurse, facility rolling out).

3.1.4.1.3 Consequences of staff shortages: Work overload, staff burnout and low staff morale

The majority of HCWs interviewed in facilities that were already rolling out felt strongly that the shortage of staff was having an effect on the health care workers, resulting in long working hours and in burnout.

“In terms of human resources, it’s really tough. We are under-resourced both in space and staff, staff members at all levels. Even in terms of support. Although there’s one or two doctors on ARV, in terms of numbers, they are the same number of doctors I had before the roll out. The fact is, in medical staff, we have none extra.

...so people in the job enjoy it, but there’s burnout and it’s really tough. I mean we can start at 8:30am but we can leave here at 6:45pm.” (Doctor, facility rolling out ARVs)

Concomitant factors that were a direct result of staff shortage appeared to be a source of frustration for all involved in the roll out. The majority of the HCWs felt that the lack of staff, leads to work overload. There was general consensus that the work overload was due to the lack of enough hands, hence patient overload. But it also emerged that the patient overload was perceived to be due to patients bypassing their areas and coming to Gauteng because they believe that are were better services in the province. This led to the staff being overburdened and the services being overloaded.

“The patient load has been frightening. It’s almost up to about a seven month waiting period now, for general adults on anti-retroviral treatment. The workload is huge and we just don’t have the staff to cope with it.” (Nurse, facility rolling out)

Many said that more clients arrived for treatment than planned for. Another factor that was cited was how this pressure led to low staff morale especially when the unfavourable working conditions, low salaries and low staff support are taken into consideration.

“If you look at the balance between the private and the public sector, it differs. It has implications for the salaries. That also has an impact. If you go to the private sector, doctors there are very willing mainly because of the money they are getting, but with the public sector, it’s problematic since they work under extreme pressure, they lose morale...” (NGO)

3.1.4.1.4 Sharing of health care professionals

In order to sustain the service, staff members were left with the option of sharing the responsibility and continuing their usual duties, while also accommodating the ARV services. Many of the HCWs were of the opinion that, getting more staff members is a challenge and they must therefore rely on the human resources at their present disposal.

“We definitely need more staff to be exclusively dedicated to the ARV programme, as there is a shortage of staff already. If unable to recruit more staff, it’s already arranged that the present staff, especially nurses to share the responsibility of running the clinic, especially those that are already involved in the HIV clinic and testing.”
(Nurse, facility not yet rolling out)

The sharing of health professionals extended to other hospitals. Some of the participants said they had to share some health professionals between facilities, so as to adhere to the model of core staffing requirements that is prescribed by the province, namely: one medical officer, two professional nurses, one pharmacist, one dietician /nutritionist, five social workers, five lay health counsellors, one administrative clerk

and one data capturer per service site to administer the ARV programme to 500 patients (DoH, 2003). Meeting these requirements ultimately became a strain for the staff involved.

“We do have problems with certain categories of the staff, for example the medical practitioners. In most of the clinics, we don’t have doctors and in others, we don’t have pharmacists and you find that waiting for these people delays the whole programme. We are having to resort to, for instance, one pharmacist catering for two sites, which is too much for one person.” (Health service manager)

3.1.4.2 Inadequate management and supervision

Inadequate management was perceived to manifest in the weak health care system that has always existed. The lack of proper reporting infrastructure meant that a lot of the data that should be reported was often either not reported or reported inaccurately. This was strongly viewed to result in the perpetuation of some of the weaknesses in the health care system. The sentiment around leadership also, reportedly, affected other elements, which were perceived to be crucial in the implementation of any programme in a health care facility, such as supervision. Many of the health care workers felt that there was a need for supervision particularly because ARV treatment was new to some professionals. Some participants also cited a strong need for the management of emotions and the disappointments that are associated with the programme itself. The deaths that result from the side effects are inevitable and HCWs are left to deal with that on their own.

“ I think health care professionals need to understand that a patient’s death is not their fault. This is such a terrible disease, but the benefits of the drugs are far greater than the deaths, which are often linked to the drugs. So by and

large, management is needed at many levels, but for one, I don't know what to call it, but some sort of disappointment management..." (Doctor, facility rolling out)

3.1.4.3 The added burdens to health care workers: unfavourable working conditions and bureaucracy

Frustrations experienced by HCWs extended to other factors that added to problems with human resources. The majority of participants cited unfavourable working conditions as a common stressor in public health facilities. Many cited bureaucracy as something that frustrates processes and the execution of certain responsibilities. The majority of the participants cited the general frustrations of HCWs having to go through long processes in order to provide a service.

"Everybody is saying, they are finding all health care workers that we speak to are saying, we're just finding it really hard to do what we want to do. There's too much bureaucracy. There's just difficulties with having to implement and the resources are not getting to where they should be." (NGO)

"There are doctors who want to do the programme, but because of the environment, it becomes difficult for them to order the equipment material or resources for the programme. It can also be an attitude problem from one specific person within the institution. This then becomes a hindrance to the whole programme itself." (NGO)

3.1.4.4 Administrative burden

Most of the participants generally felt that the issue of the staff in the facilities having to bear the burden of administrative workload was exacerbated by the bureaucracy within systems. Many HCWs felt that there were too few of them to handle the paperwork that is required by the department. Many felt that skills were being inappropriately utilised, as it is ultimately the HCWs that have to do the

administrative work. Many also commented that the organisation of public hospitals contributed to the problem because they do not utilise their resources efficiently. Most felt that there are enough volunteers in public facilities to do the minor duties which tend to be commonly done by nurses. Participants commented that health facilities need to start using their resources more efficiently if they are to survive the reality of the lack of personnel.

“ We don't have enough doctors, nurses and pharmacists, therefore we must look into ways of de-stressing those three professions. We have enough counsellors, we have a lot of community activism, a lot of community support for the clinic, so let's use those people. Why should a nurse pull a file when someone with a Standard 4 can do it? Some of the volunteers can do all that. They can read and write. So my sense is that we do need additional staff, that's true, but we aren't going to get any, so we should use the available staff more effectively.” (Doctor, facility rolling out).

3.1.4.5 Lack of uniformity in Training

According to the operational plan for comprehensive care and treatment of HIV/AIDS, a priority for the first phase of the implementation process is to execute a national training programme for all the HCWs (in all the pertinent categories) and support staff for the provision of HIV/AIDS treatment. Nurses, medical officers, pharmacists and lay counsellors, at functioning sites, would complete the training on a priority basis, with a wide geographical coverage (DoH, 2003).

A strong perception that was held by both HCWs and managers, focussed on the training of HCWs. There was general consensus that there has been a lack of uniformity with regards to the training coverage of HCWs involved in the implementation. It was evident that most of the sites that had started the roll out

already did not have the opportunity to send all involved HCWs on the provincial training course that is being offered. The plan is ultimately to send people in phases as not all staff members from each facility can attend at once. Many, however, felt that there was a lack of a systematic approach to ensure that everyone would have the opportunity to attend. The vast majority of HCWs said they had not attended the course because some of them found out only later that there is a course in progress during a particular month. Some of the facility managers commented on the lack of communication from the province, which resulted in staff members missing the training completely. Some of the HCWs commented that there were not enough staff members in their facility to afford others the opportunity to attend for a full five days training - the duration of some of the courses. HCWs in the facilities that had started rolling out earlier felt that they were eventually excluded, because the provincial department gave priority to the smaller clinics where reportedly, HCWs have less experience with ARVs. Therefore, some hospital staff had been left out.

“ Unfortunately, there isn’t a system. We submit names of the staff that need to go and they (province) sit on them until it’s too late for us to go to the training. I mean we’ve missed last week’s training already.” (Nurse, facility rolling out)

“ ...but it’s not a system really. Their priority is those that haven’t started rolling out, those that don’t know anything about ARVs. So because we sort of know as we started earlier, they’ve sort of left us in limbo.” (Programme/facility manager, facility rolling out).

The majority of the HCWs in the sites already rolling out indicated that their actual training was dependent on the experience they get on the job. Some of the doctors and managers said that they trained most of the staff on the job.

“ They haven’t been on the Gauteng training. The counsellors have, one or two nurses have gone, but not all. I trained on the job, but the extra meetings on Mondays and Tuesdays have come in handy. Some of the doctors have experience and they learn quickly, but I’m training them on the job. We are sort of training as we go.”
(Doctor, facility rolling out)

“ Our pharmacist has been on a two-day course, our dietician has also been and that’s been about it. We train by experience more than anything else. Our doctors most of our consultants come from the clinical trials unit, so it’s been really about experience.” (Programme/facility manager, facility rolling out)

There was however, deep concern about the training, which many felt was not reaching the HCWs that need it. Many felt that the nature of the ARV programme was different from other programmes. It is more complex, especially in terms of administering the drugs. Due to the rush of implementing the programme, many HCWs had to be trained in an emergency effort, which was a point of concern for many nurses.

One nurse said it was difficult to get people trained and acknowledged the difficulty of the ARV treatment itself. She said that the complexity of administering the drugs necessitates that all HCWs be adequately trained, however, the discrepancy in having to train all of them was hampering the process of the roll out. The nurse stated that the contingency plan of training people at a pace of urgency, does not aid the situation, as adequate training is needed to ensure sufficient understanding of the drug regimen.

“It’s actually been quite difficult. The reason being, most people have not been trained, most people don’t know the drugs, so we had to train people in an emergency to try and get them up to date with the drugs and try and implement the roll out as well.”...“ It’s not easy to be able to administer the drugs; it’s not easy to understand all the regimens, to understand all the protocols, signs and dangers, adherence, if you haven’t been trained. So we’re finding huge hiccups there.” (Nurse, facility rolling out)

There were varying reactions from most of the HCWs that attended the provincial training course. The majority were very satisfied with the quality of the provincial course and agreed that the training was comprehensive and broad in nature. However, there were a few participants who were concerned for those who have never had any experience with HIV/AIDS and/or ARVs. Some of them felt that one has to have prior experience to follow the course and extract content from it.

“ Well, when I went to the training, it was really a crash course...it was really a crash course. Not worthy for a person that has never had experience with ARVs. At least I've trained for three months, though I've never practiced that much. So I went there to hear what they were going to say, but for a person that has never. I don't think so!” (Nurse, not yet rolling out)

“ To me it wasn't new. To me it was short and not broad enough. It covered most of the areas, but it wasn't enough, it was not detailed. Without prior experience, it would have been difficult because it is a very detailed area. Issues like CD4 counts, cholesterol levels, and it also didn't cover the complications of the patients.” (Nurse, not yet rolling out)

The lack of training evidently manifested in various forms, as some of the participants, mostly external representatives, said that the lack of knowledge, was mostly due to the lack of training and this leads to inappropriate treatment of clients. It was generally thought that inadequate or lack of training results in inappropriate application of knowledge and skills.

“There seems to be lack of knowledge with the health care workers on the programme. For instance, when I go to the clinic looking as I am, wanting to know what my CD4 count, I will be turned away and told to come back when I am sick...” (NGO)

“It goes as far as the interpretation of results at a national health laboratory system. It's becoming a problem. People do things in a mechanical fashion and do not interrogate the results they get.” (NGO)

The vast majority of the HCWs viewed the training as adequate and broad, but felt that the process was rushed and that there had been inadequate coverage. Most of them were concerned that the HCWs who were already involved in the implementation stages had missed out on an aspect (training) that is crucial to the execution of the programme.

3.1.4.6 Informal Referral Systems

The general goal with regards to the referral system is to alleviate the workload of mainly hospitals, by following a system that allows for the distribution of public health users accordingly. Ideally, the referral system should act as a supportive structure. Clinics, being the first place of contact by users, are meant to execute the basic clinical functions, such as staging. Referral to a higher level of the health system should allow for more advanced functions to be carried out without the additional responsibility of executing basic functions (Modiba, Schneider, et al., 2002).

A vast majority of the participants commented that the referral systems were not adequate enough to support the implementation of the programme. Many felt that referral systems generally were ineffective, due to inadequate communication between facilities and internal clinics. The participants commented that referral sites referred patients without having conducted the required tests and assessment. This exacerbated the burden of workload because all procedures have to be redone and this delays the process for the HCWs and patients.

“ You get a referral of a CD4 that is 7. They don’t even think to write that the patient was diagnosed ten years ago and has these particular problems. Everything is from the beginning and because of the delay, we run a two-track system. Basically, the system is not supporting us and it’s also not supporting the patients. They end up being referred back to the small clinics and they get sent with an acute problem and with a low CD count.” (Doctor, facility rolling out)

Views also focused on the fact that many of the patients that access services in the Gauteng regions are from other provinces and even other countries. A majority of the participants felt that the hospitals were more affected by this phenomenon, because most people perceived that large hospitals offer better services.

“ We are hoping to improve the referral system between the primary clinics and ourselves, but it’s not so good. Some of our patients come from outside of Gauteng.” (Doctor, facility rolling out).

“ No strict system is being used really. We receive referrals from anywhere; it’s across the board. We receive from the rest of the hospital as well, from the doctors, the clinics, the antenatal department. The lack of a referral system may eventually lead to us not coping. I really feel that we need structures to be in place, some control structure.”
(Doctor, facility rolling out).

3.1.4.7 Laboratory services

The responsibility of facilitating laboratory services, so as to support the HIV/AIDS care and treatment programme, is executed by the National Health Laboratory Service (NHLS). The core responsibilities of the laboratories are to monitor the development of drug resistance, to diagnose opportunistic diseases, to carry out toxicity assessments, assessments of viral loads, assessments of CD4 counts and HIV diagnostic tests (DoH, 2003).

Despite the fact that the majority of the HCWs indicated that they had little insight into the activities of the laboratories, most commented that they felt that the laboratory services were coping better than the rest of the services. The common perception was that the laboratory had managed to sustain turn-around times and deliveries even after the implementation. A number of facilities were reported to be utilising a single laboratory, however most commented that the service remained efficient and that the distance between the sites and the laboratory did not affect the efficiency of communication. Many participants believed the courier system is working efficiently and that the ARV programme had no apparent effect on its capacity to deliver. The majority of participants said that there appeared to be no service interruptions.

“ The labs have been successfully staffed. They have everything in place and the maximum waiting time for a lab is five days. So far they have had capacity to handle whatever we bring on...” (Health regional manager)

“Capacity is pretty much established because the lab started small. I mean we had been doing baseline bloods before we even started the roll out. And we developed blood forms for the labs. Capacity has been built up over quite a long time.” (Programme/Facility manager)

“ Thus far, the lab people have a plan. They know how to budget. They are fine. There was an increase in machinery for CD4 counts and viral loads, the transfer of bloods, quality improvement issues. There are systems in place.” (Doctor, facility rolling out)

Some participants indicated that there has been an impact on the laboratory, as its infrastructure is now not enough for the patient load. Some indicated the increase in the numbers might require the laboratories to consider some infrastructural changes.

“ The clinic is expanding everyday and everyday we’re getting more and more patients. So the actual clinic, including the lab itself, is nowhere near big enough. Staff standing around with not much place to sit. There’s no place, it’s chaos.” (Nurse, facility rolling out)

3.1.4.8 The burden on pharmaceutical services

Pharmaceutical services are required to ensure efficient and secure distribution, storage and utilisation of antiretroviral medications. Additionally, there also needs to be management of the inventory, patient prescription information and some level of financial management. There needs to be secure storage, efficient packaging, necessary for control (DoH, 2003).

Participants had different perceptions about the services from the pharmacies. Even though the majority felt that the pharmacy was currently not experiencing problems due to drug stocks and ordering systems running well, many felt that the lack of pharmacists in the public sector may result in a significant burden on the service. Participants stated that one of the health professional categories that seemed most difficult to draw into the public health sector was the pharmacist category. It was also clear, as indicated earlier in the discussion; that many facilities had to resort to sharing pharmacists with other facilities.

This resulted in long queues of patients, said many participants. Many of the HCWs expressed their frustration with the lack of co-ordination of the different pharmacies for the different clinics within the facilities. Some indicated that women from the antenatal clinics were not appropriately catered for and were more often likely to join long queues, since they were not part of the main clinic yet. The lack of an effective

system meant that patients that were coming from different clinics and ultimately had to follow different queues to get the rest of their treatment.

“ The patients are getting their ARVs, let me put it that way, but they wait for a really long time, and the problem is that they get their ARVs from the ARV clinic, but they have to get their other drugs, like the Clotrimazole from the general pharmacy. So they’ll stand in one queue to get the one drug and they’ll stand in another queue to get the other drugs, which is very irritating for the patients. I normally say to my patients, if it’s your repeat day for your drugs, expect to stay here the whole day.” (Nurse, facility rolling out)

Most of the participants said the drug management systems were in place. The HCWs indicated that there had never been incidences of drug shortages, and drug stocks seemed to be adequate. A few of the HCWs felt that there were no concrete systems for drug procurement and it appeared that it was more guess work. Most of the HCWs in the facilities that were still getting ready to roll out, indicated that they did not know what to expect with regards to patient load, therefore, drug ordering was reliant on the assessment when roll out commenced. Some of the participants, however, felt that this non-systematic way of procuring drugs may lead to the shortage of other medications such as multivitamins which are required in the ARV guidelines.

“ With respect to drug stocks, we’ve never experienced an instant where a patient has been turned away because there wasn’t any medication. The only medication we don’t have, which is recommended in the guidelines, is multivitamins. We never see multivitamins and we never see iron supplements. So, we always seem to be out of stock with that, but certainly ARVs, we have.

Systems of ordering is guess work! That’s probably why we’re running out of so many drugs, well not ARVs, but things like Pregamols and multivitamins. But at the beginning, with ARVs, it was a huge concern that we would either over-order or under-order and patients wouldn’t get drugs, but now, it seems to be working.” (Nurse, facility rolling out).

3.1.4.9 Patient Information systems

Ideally, a patient information system is developed to be standardised, efficient and effective, so as to collect data, collate, monitor and provide feedback to a facility. This facilitates the implementation of any programme, including an ARV programme. At the time that the study was conducted, there still needed to be an integration of a new system into the existing data collection systems. This system still had to be standardised across all the facilities that are implementing the programme. The three sub-systems that exist, namely, a hospital information system, a district health information system and a disease notification system, are to be adapted for the ARV treatment programme. However, all of this is still to be fully achieved (DoH, 2004).

Participants indicated that patient information systems were mostly documented on hard copy records while other facilities were gradually capturing data on patient computers. A few considered the process of loading information onto computer as cumbersome and claimed that they did not have staff members to do so. Some indicated that they avoided creating differences between clinics and therefore they employed similar patient information record keeping methods as the general clinics. Others, however, had resorted to creating their own records, which were unique to the ARV clinic as they found that the forms designed by the department were not user-friendly and they struggled to understand them. It was indicated that the general challenge with the current system was that even with computers, there were not enough people to operate the computer system effectively.

“We don’t have any computers. We’ve got no form of IT system running and we’ve got no one to sit and load all the documents. We’ve got all the paperwork done, but no person has actually loaded all the data...” (Nurse, facility rolling out).

“ Keeping records is a disaster, that’s why we’re depending on the NGO. We don’t as yet have the government software, for the computers and so on. And that’s a problem, because if we could just feed them into a computer ...Now it’s lots and lots of forms and lots of forms means time for people to file.” (Programme/ facility manager).

HCWs said that the process of completing the various forms was tedious and time consuming. Most said the administrative burden was enormous. Others felt that the forms were not user-friendly and often required unnecessary information.

“ I mean, we know how important it is to keep data in a standardised fashion. We were trying to create something, then National government made data collection forms and they are not user-friendly. Some things don’t make sense. We really tried to follow those forms. I think we are the only site that tried to use them. Most of our patients had to have those forms filled in, it’s really not working. It’s like extra work and capacity, the capacity which we don’t have. I don’t know since there hasn’t been any follow ups. We are busy designing something that is user-friendly and we’re trying better ways to do that.” (Doctor, facility rolling out).

“ We actually now do our own forms and that is in itself a problem, because we do them ourselves. There is too much unnecessary stuff on the government forms. You find that the patients which we start on the programme have no side effects, so there is really no use for us to fill in those forms, because there is nothing to tick. What is important is filling in factors about vital signs, but it’s repetition every week, so it’s unnecessary and it’s things that we can write on the patient files. For example, symptoms which the patient has, because we fill in the form and write it on the file as well.” (Nurse, facility rolling out)

3.1.4.10 Community Mobilisation and Utilisation

The main objective of social and/or community mobilisation is to ascertain whether people living with HIV/AIDS have feasible access to care, treatment and support

systems in their communities. This can reportedly be achieved by establishing and utilising existing community structures and networks, which can be supportive networks for people who are on ARV treatment and their families (DoH, 2003)

Despite the varying sentiments, there was strong consensus amongst participants that there was significant effort from the government and health care facilities to engage and work with community-based organisations. Many of the participants, mostly NGOs, acknowledged the initiative that government had taken, at all levels, in an effort to engage with relevant organisations. However, there were participants who felt that there were clear parameters and limitations on what areas the government was willing to consult and engage on. However, the general sentiment amongst NGOs was that the government is confident to engage with community-based organisations and to utilise them as support systems.

“ I would say they really made a genuine effort, from all levels, from the MEC, right down to local government level. We’ve seen initiatives to engage with organisations that are doing something, irrespective of what stand they’ve taken. That has been fairly consistent.” (NGO)

However some participants felt somewhat differently:

“This province is better than all the other provinces, it could be better still. There are areas where we would benefit from consultation but on the other hand, we have easy access to the Department of Health.” (NGO)

“In terms of processes, we are trying to get government to work with us, but it has proven difficult getting them on board. This is evident in that though we invite them to our forums which we hold, they don’t come. We want to assist in monitoring the system.” (NGO)

As much as there was willingness by the government, to involve community structures, there was also the perception that community-based organisations lack efficient systems and organisation. There seemed to be no existing system that integrated community networks and health care facilities, to ensure a systematic and efficient working relationship. Most support networks appeared to be in isolation of health facilities, and were not integrated as a support element in the care and treatment of the patients.

As much as it was indicated that community-based organisations had enormous capacity to be effective support in the implementation of the ARV programme, it was also clear that there was a lack of capacity within their systems, and that discrepancies had resulted. Some participants cited the lack of concrete support systems and some level of mentorship for these organisations. This, they said, led to the ineffective facilitation of services and the inefficient use of funds. Many felt that the lack of training for people in community-based organisation often result in them being unsustainable.

“ There aren’t proper support systems to community-based organisations that systematically train these people so they can sustain these organisations and give them the kind of mentorship they need. You can see that, not necessarily at provincial level, although I am sure it’s their problem. In the recent Auditor’s General report on the national level, one of the criticisms was that a R110 million rand is not accounted for , that went to NGOs. That is because the NGOs don’t have the skill to do proper reporting.” (NGO)

Some participants even expressed their belief that some of the problems encountered result from the organisations themselves. Community-based organisations and/or NGOs tended to lack good governance and accountability and in this regard there was plenty of room for improvement.

“ There’s no recognition that there’s a whole sector of development that, like you treat business, that, needs to be respected for the role it can play. But then having said that, I must admit that the NGO sector or development sector hasn’t been rigorous in showing a standard of delivery. There is a large scope for NGOs, but there must be improvement in accountability and governance.” (NGO)

Not only was lack of capacity cited as the one of the problems with organisations that could pose as support systems for government, but there was also the perception that corruption was a problem. It was clear to the participants that some community-based organisations only seemed to be visible and active only when it was the time for the allocation of funds. Lack of proper monitoring systems for these organisations perpetuated this thinking.

“ there are organisations that are involved in this programme because they can generate funds from it. Most of these organisations don’t have a holistic approach. You find out that there are NGOs who are only visible when it’s time to allocate funding. They cease to operate and wait for another financial year. There is no system that monitors these NGOs to make sure they are active.” (NGO)

Despite the problems cited, participants perceived the presence of community-based organisations as more effective than not. People from the NGOs interviewed were well utilised by HCWs in the different sites. The majority of HCWs said that they extensively used volunteers and lay health counsellors for most of their community mobilisation and literacy activities. It was suggested that there is a need to consider some form of incentive, particularly for the counsellors, as they play an important role in the implementation of the ARV programme.

“...Simply because as a volunteer they can't dispense is not the point, because most of the volunteers are HIV positive themselves, so they help in identifying tablets which need to be taken at certain times, simply because they are familiar with the treatment as well. From a human resource capacity, there needs to be incentives and accreditation and perhaps even remuneration.” (NGO)

3.1.4.11 Monitoring and Evaluation

An efficient monitoring and evaluation system is designed to utilise the data collected by clinicians at all service points, and is aggregated at district level and be incorporated into the central databases (DoH, 2004). Monitoring and evaluation systems were reported to be mainly facilitated by the completion of manual registers from the relevant facilities. HCWs indicated that they did not fully understand how data is used by the provincial office or at the facilities for that matter. Participants commented that much of the data that was registered but not utilised by them. It was merely entered onto the relevant forms, but not analysed or utilised in any way.

“ In terms of monitoring and evaluation, we have all the information, but we're not loading it and analysing it. At the moment, the main way is that we fill in a register. Basically, all we're plotting on that register is how many patients we are seeing per day and that's about it. We haven't actually sat down and analysed that data.” (Nurse, facility rolling out)

Some of the managers indicated that the statistics accessed from the sites focused mainly on the number of patients attended to, the number of people on the treatment and the status of adherence. The information was then compared and analysed with that from other facilities. It was suggested that compiling statistics was just one of the methods utilised in the monitoring and evaluation process, but other methods included regular visits to the designated sites, particularly those that are preparing to roll out.

This also coincided with monthly meetings at all the sites in the region that are rolling out and those that are soon to commence.

“ Stats is one of the methods that are used to monitor the program, but we also visit the sites and find out what is happening. We also have monthly meetings with them, we invite people from facilities such as Zola, Bara, Lillian Ngoyi...” (Health regional manager)

There were participants that held different views about the process of monitoring and evaluation. They indicated that practically, the visits to the different sites were not as regular as claimed. Some thought that monitoring and evaluation of the programme mainly relied on statistics. The perception of participants, especially those from NGOs, was that the site visits were not regular enough to experience and understand some of the problems of implementation.

“ In practical terms, that doesn't happen because they rely on statistics provided by the service points and are not having direct information from the clients themselves or actually visit those sites and personally see what is happening.” (NGO)

Most participants however felt the methods used for monitoring were tedious and were a burden and an interference in the rest of their work. There was consensus that the documentation required a lot of time and was a burden because of staff shortage. HCWs ultimately end up doing the work.

“ The paperwork is totally unnecessary. We don't have to fill out all those forms in triplicate when you have to deal with patients that need a lot more care, a lot more counselling, a lot more supervision and you still need to fill out all these forms. It actually becomes a nightmare to get through all that. So there's a bit of negativity regarding the treatment of the patients because of all the documentation. I'd really like to recommend that all the

documentation. It needs to be shortened, simplified to really cut down on the workload. Already we're understaffed and we just can't cope with all that paperwork." (Nurse, facility rolling out)

3.1.4.12 Lack of leadership from the Department of Health

There was a general perception from most of the participants that prior to implementation of the ARV programme and even during the implementation, there has been minimal leadership from all spheres of the department of health. Participants voiced general concern about the lack of leadership and direction from national level, which manifested on all other levels, the most conspicuous, being management at local level. Participants are very concerned about the lack of communication about how the roll out should proceed. Many at local level had taken it upon themselves to run the programme as they saw fit, even if inappropriate. This caused delays in implementation of the programme at sites where there may have been a lack of understanding of the protocols and the guidelines proposed by the national office. One of the participants commented that:

"there is actually no guide from the top, hence there might be delays for the hospitals that are not certain about the criteria that National office has put in place. There are no guidelines from National in terms of creating sites. There is no proper information, so doctors are doing things in communication with the ARV managers, for the province."
(NGO C)

There was a general perception that many of the discrepancies that have occurred and continue to occur in public facilities, was due to the lack of communication between the sites and the leadership. Many felt that there was a lack of understanding on the part authorities of the extent of the state of preparedness at some of the sites that were expected to commence the programme in the proposed timeframe. Authorities appear

oblivious of the lack of capacity in some sites during the start-up stages and throughout the programme. There existed the perception that government was oblivious of the challenges within the existing health care system and merely expected health care facilities to roll out. One participant said:

“ There’s been no effort in my view, from the national government...on a kind of perspective on how we’re going to roll-out. You ask for ARVs, we’re rolling it out. Whether the doctors are ready or the nurses are ready...a lot of that is dependent at provincial level and they are coming up against huge obstacles of capacity and in the context of the health care system.” (NGO)

The lack of leadership was also seen to manifest through management at local level. There was a perception of management failures in the health care system, a problem which was considered to slow down delivery at the sites that were likely to do well in the implementation of the programme. The weaknesses in management led to the lack of systematic flow in implementation. There is a need for the appropriate management of areas according to particular context, taking into consideration the different needs in urban, peri-urban and informal settlements. Insufficient management skills, as identified by the participants, were the most likely explanation for the lack of contingency plans to address presenting problems, such as the long waiting lists in most designated facilities. This had led to overwhelming numbers of patients seeking care and treatment. A participant expressed an observation:

“ You know, if I had to put my finger on the main problem, it would be management, when you’re having a situation where...it depends on what informs the person in charge of various primary care services” (NGO)

A strong sentiment that emerged, particularly amongst the HCWs, was the lack of support at all levels. Most of the HCWs felt that there was no support during the

process of implementation and hasty implementation procedures had been at the expense of support systems, adding to the existing inefficiencies within most public health sites.

“ There was not enough support. There was not enough help in implementing the programme. It just almost felt as if it was dropped on us and it was a crisis to suddenly get it going before we could really win.” (Nurse, facility rolling out)

Some of the participants felt that there was bureaucracy that blocked channels of communication. There seemed to be no direct dialogue with the HCWs who are directly involved in implementing the ARV programme. There was a problem of isolation between the provincial levels and the HCWs levels, such that not much was known about the challenges.

“ I thought they would have at least visited us once. The other thing is that they communicate with management and not directly to us. I think there has been this view that they want the facility to run itself. If I want to speak to someone in Gauteng health, the message gets back to the executive and I am asked why I am bypassing channels, so I don't know how they would run a programme with limited sites treating and not have had direct communication. Two meetings in eight months in is not sensible.” (Doctor, facility rolling out)

CHAPTER 4

4. DISCUSSION

The findings of this study clearly indicate that the implementation of the ARV treatment programme in Gauteng is experiencing varying degrees of success. The introduction of this programme might bring large new investments, which might result in an improvement of the health care system and thus strengthen areas that are less resourced. The challenges arise within the context of a health system that has weakened capacity in areas such as the health care personnel, the low morale, flight of health care workers from the public sector and inequities in access to health care facilities, amongst many other shortfalls (Schneider, 2003). Most of the views voiced by the participants highlighted issues that generally emphasise the extent to which the health care system, with its existing functions, is able to implement a new health policy, specifically, the ARV programme. The results ultimately indicate that the process of implementing a health policy is highly dependent on the status of the health system within which the implementation occurs.

4.1 Health Systems

A number of discussions and articles have confirmed what is evident from the results (Loewenson and McCoy, 2004; WHO, 2003 (b)). The challenges experienced in the implementation of ARVs commonly coincide with weaknesses within the health care system. Much of what emerged from this study, particularly from the reports of the participants, was reflective of the documented experiences regarding the restructuring

of the health care sector and the rapid introduction of an array of policies. The effort to reform the health care sector, involving the integration of health services in South Africa, since 1994, has led to a situation in which the programmes that were formerly vertical programmes, such as the STD/HIV/AIDS programmes have had to be integrated into the comprehensive health services (McIntyre and Klugman, 2003). The process of this integration has had an effect on the health system, as evident from the results, particularly, in relation to human resources, capacity of management and communication frameworks.

Generally, most studies conducted on the implementation of the government's HIV/AIDS plan have reflected common difficulties with the policy. Most studies have found that the policy has been implemented in a health system that has inherited a weak public sector capacity, with different government actors, lacking any adequate cohesion and co-ordination (Schneider and Stein, 2001).

Widespread research has indicated that the strength and capacity of a health care system is reflected through the capacity of its structures. Results of this study have indicated some of the weaknesses that exist in the health system and those that in particular, present challenges to the implementation of the ARV programme. It is through these findings that we can reflect on the health sector that has undergone reform and how this process has affected the health system in general.

A system that is awash with weaknesses is more likely to have an effect on entities within the system that are performing well. This was the experience of one facility in the study, which began implementing the ARV programme before the official roll out,

and was a success story in terms of the initial delivery. However, due to the lack of uniformity in the roll out procedure in the province, this facility had to accommodate under-resourced facilities. This additional burden in that facility interfered with a system of service provision and to some extent compromised service delivery.

4.2 HUMAN RESOURCES: Staff shortages

It is evident that the implementation of any policy is dependent on the implementers. In a health care system, this involves human resources. One of the main problems highlighted in the research was the burden on human resources that results from the implementation of the ARV programme. The majority of participants described a malfunctioning human resource system within a burdened health system. Many were of the view that strengthening the human resource capacity of health care was given little priority and this concurred with other research findings in the area of health systems. These suggest that in the process of integrating the HIV/AIDS programme into the health system, HCWs were the ones bearing the brunt of the burden to health care. This sentiment is in accordance with the criticism raised that human resource planning in the South African health sector is fragmented (Lehmann and Sanders, 2004). One study cites that the low morale of HCWs is due to factors such as unfavourable working conditions, high patient load, lack of staff and low-income levels (Shisana, O. et, al., 2001). Research indicates that the effectiveness of health care providers in a health system is dependent on various factors, such as the work environment that is in turn facilitated by the capacity and effectiveness of management and support systems within the workplace.

The need to strengthen human resources in the South African health system has been an historical issue amongst all role-players. This study, though small in scale, reveals that the failure to gradually address existing weaknesses within health care will eventually hamper the implementation process of any policy. Many of the HCWs interviewed felt that the implementation of the ARV programme was merely an add-on to other health care activities and functions that have been implemented over the years, thus problems of staff shortages and the continuation of a reduction in skilled personnel remain ongoing problems. Comments from those in academic fields acknowledge this sentiment and cite that the expectation that implementation of the ARV programme by an already burdened workforce is unrealistic, particularly in light of the shortage of skilled professionals. The challenge of staff shortages has always been exacerbated by the difficulty of sourcing skilled personnel, as most are lost to the private sector and to other industrialised countries (EQUINET, 2004).

With regards to staff shortages, the evident staff establishment during the study indicated that the staff to patient ratio was 10.5 to 800-1000 patients. According to the guidelines specified in the Detailed Operational Plan for Comprehensive Care and Treatment of HIV and AIDS (DoH, 2003), the core staffing requirements per service site to treat 500 patients with ARV, is 12.5 staff members. From the findings, it appears that the ARV programme observed, carried staff establishments close to the national target. However, it emerged that most of the HCWs involved in the ARV programme were involved in the rendering of other services and most of the professionals, particularly the doctors and the pharmacists, were also servicing other facilities. The dissected profile revealed that the distribution of HCWs was far below the targets set by the national guidelines. Most of the core staff members for the ARV service, throughout all the studied facilities, comprised of professional nurses,

medical doctors and lay health counsellors. Four of the facilities were sharing pharmacists with other sites and only one ARV site had a dietician. One facility was still waiting for a doctor to be appointed. Lehmann and Sanders (2004), confirm that there is a maldistribution of health care professionals, by level of care, hence the regular feature of high workload, as expressed by the HCWs in the study. All of this echoes what has been discussed, through the years of health care reform research. The changes that have occurred through this process of reform revealed the core problem of a poorly functioning health system and the weakness in the health workforce (Travis et al, 2004). It is perhaps here that the documented problem of the maldistribution of health personnel, particularly between the public and private sector, is more glaring.

The concern about high workload can be explained by the evidence that emerged in all the ARV sites. Firstly, when considering the facility checklist, all the facilities used hardcopies for their patient information systems, hence the administrative burden. This responsibility was carried out by the health care workers themselves, rather than data captures and/or clerks. Perhaps this was due to the fact that none of these staff categories were specifically designated for the ARV service, even though this did not emerge in the study. The second concern that contributed to the workload was the fact that four of the seven ARV sites were conducting ARV clinics on specific days and directing other days to other clinical services. This aspect was exacerbated by the fact that all the sites that were still to roll out the ARV programme, were unable to consider running the clinic on other days, as they were not certain of what patient loads to anticipate. The third concern was the maldistribution of the core personnel. This resulted in clinical programmes, particularly in the CHCs and clinics,

not running simultaneously, since most of the sites did not have designated HCWs for the ARV service. There was uneven and varying distribution of HCWs in all the ARV sites.

The Detailed Operational Plan for Comprehensive Care and Treatment of HIV and AIDS (DoH, 2003), states that the HIV/AIDS programme will be interwoven into the overall public health system and will be supported by investing in human resources and training. The plan also envisages that new staff will provide some support in filling the gaps in other areas of health care. The added staff will be prioritised to district hospitals, CHCs and clinics. It is evident that this has not occurred, and the resulting situation is that personnel that run services constantly "fill the gaps in other areas", and now have to run the ARV programme as well.

This seems to draw HCWs from regular services towards the servicing of the ARV programme. This finding ultimately means that recruitment and retention of the core health professionals for the ARV service has resulted in a large gap in human resources and this requires alternative and efficient plans.

Many contributors to health policy and research have indicated that, investing in the improvement of human systems in health care can lead to the strengthening of the quality of health care provision and widen the scope of access (Schneider and Coetzee, 2003). However, it seems that the lack of strategic plans to address the challenge of poor working conditions, as viewed by the participants in the study, has led to staff migrations to other health sectors and a struggle to draw skilled personnel into the public health sector. Participants pointed out that one of the indicators of bad planning with regards to decreasing personnel was the lengthy time it takes between

the appointment of identified candidates and the actual filling of the posts. The inefficient recruitment systems and bureaucracy had led to long waiting periods for appointments (for employment), which then leads to HCWs migrating to the private sector and other countries. There has been failure to ensure that the sites that lack personnel had the necessary staff before commencement of the programme and most crucial of all, that the HCWs who are in primary health care sites have undergone the training. Improving staff and training quotas might assist the few personnel that exist in the system to deliver a quality service.

It was apparent from the study that the combination of varying levels of staff and training across the sites was having an influence on other areas of service provision. A participant from one of the facilities, also with some early experience of implementing the ARV programme, commented on how they were reluctant to refer some of their patients to the official referral clinics for fear of them being treated by unskilled HCWs and having their treatment interrupted. Yet again, this indicates how weaknesses in the system have had an adverse impact on areas that were performing better than other facilities.

Some research on the human resources in the health care indicates how the views and principles of HCWs, inform the implementation of a health policy (Walker, L., Gilson, L., 2004). Failure to address the needs of the service providers is likely to influence the status of implementation. Unfavourable working conditions cause HCWs to become demoralised and experience high stress levels (Schneider, 2003). This was evident from the interviews with HCWs, who felt that there was a lack of

commitment to address the issue of shortages and the introduction of a new health policy was unlikely to change that.

The reality was that HCWs were working in environments where there was lack of organisational and personnel resources. Studies dealing with the conduct of public servants working under difficult conditions, indicated how they tended to develop routines of practice, which helped them cope with the situation (Walker and Gilson, 2004). Facilities devised policies that were more practical and easy to apply. For example, in order to cope with the lack of integration of the antenatal clinic into the main ARV clinic, one facility developed treatment guidelines which, in their view, met with national guidelines, but had been reformulated so as to make implementation easier. With regards to the behaviour of public workers who deal with citizens on a direct level, Lipsky (1980) pointed out that these compensatory practices ultimately become public policy rather than the official goals of the documents and mandates formulated at central levels.

Studies have indicated that HCWs also deal with their unsupportive working environment in ways that manifest in negative attitudes towards those that suffer from HIV/AIDS. These negative attitudes are exacerbated by their perceptions of how patients are infected by the virus, thus distinguishing between those that contracted the virus through modes such as blood transfusion and patients that contracted the virus through modes such as practicing unsafe sex (Smit, 2003). Various studies that have focussed on HCW behaviour have indicated how this issue is a manifestation of the rapid structural changes that have occurred in the health sector since the first democratic elections in 1994 (Gilson, et. al, unpublished)

4.3 TRAINING

The lack of support from the health care sector was viewed by the HCWs, to result in training inadequacies. There was lack of uniformity in the manner in which training was rendered. This resulted in many inadequately skilled HCWs having to implement the ARV treatment programme. This ultimately has implications for the quality of service provision. Reinforcing the implications of the lack of human resources, literature indicated that the lack of uniformity in the distribution of personnel and the training of the different health professionals is likely to result in an increase in inequity in service provision as there can be varying concentrations of personnel equipped with varying skills in different areas (Schneider, 2003). The lack of efficiency in the provision of training to most HCWs involved in the ARV programme has had a negative impact on HCWs in all the sites that provide ARVs. Healthcare personnel in the tertiary training facilities that have better access to training institutions and to trained HCWs who can transfer the skills, were evidently more reluctant to refer patients to CHCs and clinics as they perceived them to have fewer trained or adequately trained personnel. Even though the initial plan set out to select lesser-resourced facilities (CHCs and clinics) as a priority for training, it seems that the lack of organisation and uniformity had left many HCWs (from clinics and hospitals) without ARV training. The implications for this shortfall have been widely documented and are a cause for concern in a health care system whose workforce is disillusioned and despondent. Studies indicate that lack of training pressure to undertake tasks that a health worker may not be equipped to conduct, may lead to a lack of confidence and feelings of powerlessness (Gilson, Khumalo, et al., 2004).

Inadequacy in training may not only have an impact on the HCWs, but also on the health managers, particularly at local levels. The pressure to adjust to an environment where policies are introduced at a rapid rate may require training that enables managers to manage the constant changes. It is reported in one study, that few managers receive appropriate training (Green and Collins, 2003). This aspect confirms the concern that emerged in the study about weak management and leadership.

Despite the fact that CHCs and clinics are given priority for training, they were often isolated and far removed from academic or teaching health institutions, where HCWs can access some information, particularly when there are no required health professionals available. It is also important to acknowledge that tertiary training hospitals more often have a diverse distribution of health professionals in different departments, thus allowing for easier access, as opposed to CHCs and clinics, which tend to have a narrower distribution of categories of HCWs. It is here that there is a greater need for training and provision of human resources. It is evident from the findings that the primary health centre facilities that were preparing to roll out were lagging behind in their efforts to get all the HCWs involved in the ARV programme, to attend training. This is obviously attributed to the burden of a low staff distribution and inadequate communication. It was difficult for staff members to attend the training, as this would leave an unattended facility. Furthermore, information details of the training courses were often received long after the training had taken place. The one feature that was evident in all the hospitals in the study, was that despite having missed the training, staff members still had the opportunity to learn and rely on the health professionals that acquired the skills and the knowledge, hence their confidence

to carry out the tasks, even without formal training. This was not apparent in primary health care facilities.

The issue of inadequate training unfortunately exists in other spheres of the public health sector. A study of nurses in a maternity section, also involved in the HIV/AIDS programme, showed that there were instances when staff members were unable to attend the training due to personnel shortages. It was also evident, similar to the findings of this study, that a lack of training can have an impact on staff morale (Penn- Kekana, et al., 2005).

4.4 AN INADEQUATE REFERRAL SYSTEM

The challenges for HCWs in the public health care sector seem familiar and simple and appear to lead to other complexities and difficulties, which ultimately hinder adequate implementation. A system where there is a reduction in health personnel means that responsibilities and functions are transferred to those sites that are willing to accommodate them, exacerbating a referral system that was already weak. Most of the participants indicated how the referral system continues to function in the way that it always had. There were apparently no plans to strength what should theoretically be a support system. It is clear from assessments conducted on the progress of the ARV programme, that there was a need to strengthen referral systems between departments (DoH, 2004). However, participants in this study indicated a need for further structural improvements in the referral systems between sites and clinics. A study by Modiba, et al., (2002), confirmed this need for improvement and highlighted the lack of formal relationships between hospitals and clinics and NGOs. Several difficulties

similar to the findings of this study included the lack of referral guidelines and the lack of knowledge of other service providers over and above those that have been utilised over the years. A poor referral system is primarily a reflection of bad planning and inefficient communication between health sites and between health professionals.

It was evident that in some of the facilities, the reality of insufficient training had a negative effect on the decisions to refer to primary health care sites. Distrust of other HCWs and their levels of training emerged. HCWs in hospitals seemed not to trust the capacity of HCWs in clinics to continue with appropriate management of patients once they had been referred. This distrust exacerbates an already inadequate referral system, and also results in the public's negative perception of primary health care services. It was highlighted, mostly by HCWs, that most public health service users preferred to bypass CHCs and clinics and go directly to hospitals, as they believed that services at clinics are inferior. An efficient referral system is generally meant to distribute and share responsibilities amongst the health care services within an area, so as to alleviate any pressure in any of the sites. In the case of the ARV programmes, the primary health care facilities are responsible for the basic aspects of the comprehensive HIV/AIDS care and treatment plans, such as HIV testing, CD4 counts, staging, etc. It is when such functions lag behind or are not performed that referrals become a burden to other facilities, such as hospitals, which are responsible for the advanced and further care and treatment procedures. These are the features that destabilise a system that is meant to alleviate the workload for health care workers and the waiting time for patients.

The obvious implication of a malfunctioning referral system is the effect it is likely to have on equity of access to service provision. Participants said that the lack of

structure in the health system had led to incidents in which people were referred to other sites, due to lack of relevant personnel. This has negative implications for patients who must travel from one site to another. This points to the continuing inequities in the health care system. In fact, Ntuli, et al., (2003) pointed out how the introduction of the ARV programme would accentuate existing health system inequalities, a phenomenon that is typical in the event of the introduction of any new intervention. The way in which a health system contributes to the access of those services is determined by whether there is an existence of barriers within the system. Participants in the study identified a number of aspects which, in their view, posed as barriers to ARV services. Literature (Hirschowitz and de Castro, 1995), indicates that one of the contributors to poor access to health care by users are social barriers such, as low or lack of income and/or poverty. This supports the findings in this study.

Many of the participants cited how the selection criteria for determining the patients who entered the programme created challenges. They felt that the official criteria was too rigid and excluded many from receiving treatment. This may be an indication that the lack of training leads to an inability to apply flexible measures to certain protocols. Some participants said they found some HCWs to be unable to question certain aspects that may require a practice of informed discretion. Lipsky (1980) pointed out that, in order to cope HCWs working in a stressful and unsupportive environment will normally exercise discretion, yet in this case, as indicated by the participants, they were not even able to adopt a similar approach.

4.5 LACK OF LEADERSHIP AND MANAGERIAL SUPPORT

Due to a period of health sector restructuring, where there has been decentralising of health services, the leadership component, particularly within management structures, and a shift in the state of management in the health sector has been weakened. The process of decentralisation in district health systems has in some case led to a situation of weakened and rudimentary systems in which managers are often unable to apply management and decision-making power due to a number of aspects. These include lack of uniformity in the structures of management, especially between province and national levels, lack of definite boundaries between lines of communication, which ultimately results in the loss of interest in performing the required duties (McIntyre and Klugman, 2003)

The lack of leadership and managerial support is an issue that emerged throughout the study. HCWs and external participants indicated that there was a pervasive lack of support of ground-level implementers by authorities, resulting in situations such as, long delays in obtaining necessary resources. Moreover, communication of apparent problems was hampered by bureaucracy, often resulting in no outcome. These scenarios have had reported implications. Facilities were left with no resources, hence certain functions ceased to operate. An example that emerged from the study, illustrates this aspect. The lack of computers in most sites resulted in the inefficient and often absent monitoring of the process of implementation because of the absence of data collections.

The lack of dialogue and communication leads to a situation where HCWs feel unheard and unimportant. Health professionals within this environment feel isolated from health authorities and the decision-making processes. Research on the influence of HCWs on policy change indicated that an environment where health implementers are far removed from the authorities results in them disregarding health policy and narrowly focussing on their duties (Walker and Gilson, 2004).

Participants, who ironically did not include any views from the managers, felt that more accessible leadership would provide the opportunity for them to provide suggestions on how to deal with the inadequacy in their sites. The support from leadership was viewed as most lacking at the national level. This was reflected in the lack of knowledge about the accreditation guidelines (which were not provided) of most of the health facility managers. Literature suggests that efficient leadership, made up of rigorous communication mechanisms, ensures the co-operation of all role-players in the implementation process (Schneider and Coetzee, 2003). HCWs who are more involved in the process of implementation are more likely to understand the processes, and hence apply functions according to the policy guidelines. The lack of information and knowledge, reflected by the facility managers indicated the extent of the limited consultation and communication of national and/or provincial leadership with site managers.

The lack of adequate human resources in the public health sector has had a direct influence on managerial structures, which ultimately affects health managers. The implementation of any policy and/or introduction of any change, financial or institutional, is assumed to have significant impact on the health staff, with health

managers being at the centre (Green and Collins, 2003). The concerns of the participants, with regards to the lack of managerial support and inadequate communication mechanisms with management, highlighted the challenges faced by health managers in the realms of a continuously changing environment, particularly the changing lines of responsibility and accountability in the process of decentralisation. The process of integrating the HIV/AIDS programme, a formerly vertical programme, into mainstream delivery, has exacerbated this lack of clarity about responsibilities and lines of accountability (McIntyre and Klugman, 2003). Somehow, the management structures for prior vertical programmes have remained the same. Efforts to move towards integration aside, vertical programme managers still remain at national and provincial levels (McIntyre and Klugman, 2003). The implications here are that the managers of vertical programmes, who have primarily managed programmes separately are now expected to manage and plan programmes such as HIV/AIDS in an integrated manner. This expectation is perhaps contributing to the reported management weaknesses. It also echoes the sentiment that health reform in the public sector often does not acknowledge the effect that change has on the health workforce, particularly with respect to human resource management structures. Managers in the public sector are “being required to manage the unmanageable” (Green and Collins, 2003, S71). The overall concern here is how, inefficiencies, result in all the facilities functional systems.

Ultimately, management skills and structures are weak, owing to the fact that managers are required to manage within a system that has questionable structures and mechanisms. Inadequate structures influence other facets that involve managers and HCWs. Comments from the findings highlighted the frustration about the lack of

communication, particularly on two levels. Firstly, communication between HCWs and management, whether at local, provincial and national level. Those who are expected to implement policy decisions tend to be the last to receive any information. This obviously affects local government managers, hence the concern of HCWs about the lack of communication through practical channels.

The other level at which communication could be considered lacking is as a support mechanism. Health care workers and other personnel that are involved in the implementation of the ARV programme should feel that there is an adequate and efficient manner of communicating with management, whether at local, provincial or national level. There should be some level of confidence that their concerns or queries can be communicated on a personal level. The findings, from the reports from the HCWs, indicated a chasm between the decision-makers and the implementers. HCWs felt that whatever occurred at local level never reached those who should be addressing their concerns. This discord has evidently been found to lead to feelings of disempowerment and a sense of being undervalued.

The general perspective on HCWs' experiences, with regard to management and support is confirmed by a study on HCW perception of public health care working conditions. It is described in this study how the style of management and the lack of communication can lead to a negative perspective of the workplace, by HCWs (Walker and Gilson, 2004). Human resource inefficiencies, as indicated in the findings, not only involve issues of staff shortages, but also difficulties in staff recruitment and retention of health personnel. The study indicated that the issue of inadequate staff establishments was exacerbated by the difficulty of recruiting staff

into the public health sector, a challenge that was apparent in the ARV programme. There were clearly not enough professionals, as evident from the staff ratios in the findings.

It is, however, important to acknowledge that difficulty in recruiting health personnel is a shortfall that pervades all other areas of the public health care sector. In a study by Penn-Kekana, Blauuw, et al., (2005), it is evident that most of the facility managers have little control over staff recruitment procedures and/or allocations. There seemed to be a lack of an appropriate system for staff allocations. At times, the allocation of posts was not sufficient for the workload of the facility (Penn-Kekana, et al., 2005).

In the midst of staff recruitment and retention problems, it is noted from the study that perhaps with efficient and strong management of responsibilities, most of the facilities, involved in the study, would be able to cope, to some extent, with the workload, even with uneven patient-to-core staff ratios. It is evident that workloads tended to fluctuate, with one week or month being heavier or lighter than the other. This may be due to the fact that staff numbers change at a rapid rate from month to month in the public sector. In fact, it is noted in one study, how the issue of high workload, may at times, be a perception that is reflected in the overall picture of human resource dynamics: high staff turnover and the long waiting periods for the filling of posts.

Even though it may be a fact that the workload in ARV services including other areas in the health sector is high, it has been suggested that this may also be a perception than a reality.

This observation emerged, particularly at one of the hospitals which had been conducting the ARV programme for a longer period than the other sites. It was clear that the facility had a stable flow of patients who had been booked systematically to attend the clinic at regular intervals, but on different days, alleviating a high patient flow. However, due to other clinical and administrative responsibilities, most of the staff complained of high workload. This phenomenon is considered to be exacerbated by the lack of planning and routine qualitative data collection, which would enable easier work strategies and staffing norms (Penn-Kekana, et al, 2005).

4.5.1 Insufficient communication mechanisms and channels

The perception about the lack of communication from authorities at higher and local levels was evident through all the facilities and is a feature that has been widely dealt with in the literature on public health. HCWs and those working in other areas of the health sector have consistently raised concern about the chasm between the implementers of policies and the decision-makers. Evidence from other studies has indicated how the lack of communication to managers and front-line workers can lead to low levels of motivation in implementing and delivering services (McIntyre and Klugman, 2003).

Findings from this study indicate and confirm how HCWs felt powerless in the implementation process. They are unable to facilitate any form of dialogue with authorities, with regards to the dynamics occurring in the ARV programme. It has been overlooked as to how a strengthened communication process between national, provincial and regional structures can strengthen and even assist with the process of

monitoring the programme. Studies that have dealt with issues of poor communication between personnel have highlighted that an improvement in this area is likely to ensure acceptance and successful implementation of a policy (McIntyre and Klugman, 2003).

A recent study (Modiba, et al., 2002) indicates that in certain circumstances, there is actually communication between the provincial HIV/AIDS programme and the regional HIV/AIDS co-ordinators. Yet, there is still a perception of poor communication due to laborious and outdated systems. The study revealed that any communication has to first go through the regional manager and contact with any facility has to be approved by the director's office at the regional office (Modiba, et al., 2002). Further findings in the study indicated that all communication is channelled through the regional HIV/AIDS co-ordinator. It is indicated that the individual in this capacity was often overloaded, thus he/she experienced difficulties in managing tasks. This is considered to be a bottleneck in the system (Modiba, et al., 2002).

Weakened communication resulted in HCWs lacking access to information, like guidelines on policy implementation. This is one of the aspects that emerged in the findings. Five of the seven facilities reported to having ARV guidelines in other parts of the facility, rather than in the ARV clinic itself. The varying access to the ARV treatment guidelines means that most of the HCWs that were involved in the programme did not know the content of the guidelines. This poses the question as to who should be responsible for the provision of the guidelines to every health care worker in an ARV service. It is perhaps in such areas that the effectiveness of management plays a role. Communication remains a concern, as a weak

communication structure evidently affects other channels of collaboration. HCWs in higher authority expressed frustration about working with other government sectors.

The lack of formal partnerships with other interested Departments was even more evident in the study. Facility managers often reported on the difficulties of meeting deadlines of activities, due to the lack of involvement and tardiness of other sectors, for example, the Department of Public Works. In the results, it appeared that other departments were not involved in the process of implementation. This may be a manifestation of the lack of preparation in the implementation of the ARV programme, a process which allows the appreciation of the activities that need to be co-ordinated within the different sectors. An author indicated that the establishment of a multi-sectoral framework shapes a national response to HIV/AIDS (Kelly, et al., 2002). However, the challenge to convince and encourage sectors, which would comprise of ministries external to health, to form effective links, was acknowledged (Kelly, et al., 2002), thus confirming the challenges that were indicated in the study. Effective communication could facilitate synergy through all the public sectors for an effective working culture. A weak culture of communication is thus likely to make inter-sectoral collaboration and liaisoning difficult.

4.5.2 Poor communication: The affected public

Just as an inefficient communication process has affected all spheres of the public sector, it has similarly affected the public at large. Participants expressed frustration of dealing with uninformed and even ill-informed users. There was the general notion that the communication mechanisms utilised to reach the public were having little

effect. Most of the participants said that they have had to deal with patients who were frustrated and angry at the prospect of not being considered for treatment. This stems from the fact that they were misinformed and unaware of the selection criteria and perhaps not even explained to about the purpose of the criteria. Inefficient communication mechanisms to the public resulted in many people living with HIV/AIDS not being informed or not being reached on time. The general concern amongst the participants was that, although a variety of mechanisms had been utilised to educate and communicate with the public, the system was unable to meet the challenge of those who are not reached.

It is worrying to note how HCWs in general, did not seem to perceive themselves as role-players in communicating to patients about the policy. This poses the question whether training emphasises the message that those involved in the implementation of the programme are the messengers of information. Attention needs to be paid, particularly in the training, to the need for all role-players involved in the ARV roll out, to relay and enforce information to improve public knowledge and make work easier for all practitioners. Perhaps it is also beneficial to recognise the role of NGOs and community-based organisations in the facilitation of information.

Facilities have clearly depended on the community-based organisations to be their link between the communities and the sites, but these links have resulted from desperate need, rather than formal links. This suggests that government had not taken full advantage of the strengths that community-based organisations could offer to the ARV programme. Russell and Schneider (2000) point out how these community-based organisations provide a closer link between health care and the community,

because they are more accessible to people than health facilities and are the organisations that provide interventions needed by people living with HIV/AIDS. They substantiate this by noting that the community organisation activities and responses may help to raise awareness of available services (Russell and Schneider, 2000), thus ensuring that people access the correct facilities.

Participants from the study said that the government had made great efforts to involve communities and engage them in the process of implementation. However, this was mostly through informal and convenient structures, rather than formal structures which may allow them to be integrated into the public health system of HIV/AIDS care and treatment. This is particularly important, because most communities lack the most basic resources. There is a need for government to establish a formal partnership with community-based organisations, to mobilise the community to take responsibility for its own health and to ensure its contribution to the strengthening of the implementation process of the ARV policy. This is an effort that particular authors say will require a paradigm shift by health professionals, from the pure health model to that of community mobilisation. They must acknowledge that ordinary communities are able to provide their own counselling and care, without necessarily needing highly developed scientific skills and knowledge (Russell and Schneider, 2000).

4.6 The lack of a continuum of HIV/AIDS care and treatment

A feature that emerged from the findings was the difficulty of the HIV/AIDS care and treatment programme to accommodate other areas such as the continuation of care to

patients that were too ill to be on ARV treatment. This may be due to the fact that the South African health system has been designed to treat acute patients who are provided with treatment and then sent home. The emergence of HIV/AIDS has revealed a weakness in the system, which does not accommodate chronic patients. Many of the participants expressed frustration at the lack of services to refer such patients. Discrepancies in the process of implementing the ARV treatment, such as poor record-keeping, referral systems and communication mechanisms, existed in addition to a lack of continuity of care for people that were too ill for ARV treatment. Necessary to the continuum of HIV/AIDS care and treatment is palliative care. The escalating incidence of HIV infection, coupled with the increase in the number of people ill with AIDS, has put a strain on hospitals and hospices. HCWs were concerned about the lack of external palliative care services to refer patients to. This situation had resulted in many patients ill with AIDS seeking care, being turned away due to institutions being full and households eventually having to carry the responsibility of managing ill people, often without the skills and resources to do so (Motsepe and Perry, 2000).

This is yet another area that requires extensive attention, as the care and treatment of HIV/AIDS is a continuum that goes beyond medicinal treatment. Failure to rethink methods of accommodating the continuation of care will have implications on the outcomes of the ARV programme. Most patients may need to return to facilities for regular treatment and this will have adverse implications for those who are too ill to reach facilities and this will lead one to consider aspects of socio-economic implications. Not all patients will be able to reach health facilities, whether it be due to reasons of affordability or illness.

This also highlights the need for the programme to accommodate patients with special care. The pattern that emerged in the study was how the programme seemed to have limited ability to accommodate pregnant women who may require special considerations because of differing treatment protocols. This requires an adaptation of the treatment system itself, because many candidates fall through the system.

4.7 A weak health system, thus, insufficient support: a question of adherence...a question of stigma.

The array of challenges outlined in this study coincide with the barriers that exacerbated a weakened health system and/or emerged due to the weaknesses. From a context of a health system that was unable to support its sub-systems, one would anticipate that it would be unable to offer support systems for its users. Despite the fact that the issue of adherence was not one that was a highlight in most of the sites in the study, it remained a concern. Most HCWs felt that it had not emerged as a problem because of the small number of patients and the fact that the programme was in its early stages. The sentiment was that the patient-health worker ratio will eventually be too wide and that HCWs will be unable to provide adequate support to ensure adherence. Literature indicates that there needs to be a framework of support and empowerment for patients, to facilitate adherence to treatment by the patients. Documented examples of pilot projects of ARV programmes indicate that a rate of adherence amongst patients can be achieved when there has been an establishment of support systems for the users. It is indicated that there needs to be an establishment of a relationship between the user and the health provider. There needs to be a process of

treatment literacy and community activities that promote the rights of people living with HIV/AIDS (Schneider and Coetzee, 2003).

From this study, it was evident that some level of treatment literacy was in process, facilitated by both the health promoters and community organisations. However, these parties operated on an independent basis rather than in partnership. This was likewise for community-based organisations, where it was reported by participants that community activity was not facilitated by any formal relationship between health providers and community members, but rather on the desperate need for communities to support themselves.

Relationships between service providers and patients are most likely to occur in an adequate health care system, where there has been a change in the culture of service provision. This culture has been primarily associated with an inherited traditional past, in which health providers expected patients to be passively obedient and take their medication while being observed. An example of this expectation is the DOTS programme for TB patients, a strategy that was utilised to achieve adherence (Schneider, Gilson and Blaauw, 2003/4).

The interaction between patient and HCW can operate efficiently when the human resource system is functioning adequately, and this study has indicated a context contrary to that. The lack of established components that contribute to successful implementation of the ARV programme, were indicated in the study and the emergent barriers were a clear manifestation of this weakness.

It also needs to be acknowledged that the implementation of any policy occurs within a context and in this case, it is one in which HIV/AIDS is immersed in stigma and fear and is a condition that occurs primarily within the context of sexuality. Clearly these aspects have contributed to the difficulty of implementing the programme. Most participants said the issue of stigma around HIV/AIDS was a component that interfered with the process of implementation. They said that disclosure to most of the patients was a difficult responsibility and even considered dangerous for other people, especially women, who may be placed in a vulnerable position if they are to disclose to their partners.

The existence of stigma in communities and even health facilities where health providers might have attitudes of their own, can present as a barrier to effective implementation, because patients feel inhibited to disclose. Being on treatment without having to disclose makes it extremely difficult for the patient to take drugs regularly and removes any possible source of support, for instance family and/or friends. Some health providers indicated that some patients already on ARV treatment could not adhere, simply because they had not disclosed. This confirms how the context in which the policy is being implemented, is highly influential. The fact that adherence rates are proven to be high in pilot projects, where the environment is controlled does not necessarily mean that the same will prevail in conditions associated with a large ARV roll out.

4.8 Monitoring and Evaluation: "...all that documentation...it needs to be shortened".

The need for adequate monitoring and evaluation processes is most essential, particularly in the context where there is a need to monitor patient usage of the service and adherence to treatment. The fact that this study indicated a lack of adequate systems to monitor the entire ARV programme might indicate that there will be areas of research which will emerge over time. It is clearly evident in the study that there were weaknesses in the monitoring and evaluation processes, with the participants specifically reporting on their uncertainty of the indicators and the inadequate reporting mechanisms and frameworks.

It was indicated by HCWs that the alternative option of collecting data through daunting paperwork had negative implications. Health professionals had more pressing duties and yet were forced to perform administrative duties as well. The lack of adequate reporting resources such as computers and standardised monitoring tools, merely added to the burden of HCWs. This resulted in HCWs not recording the necessary data.

It needs to be acknowledged that poor administration systems are again not due to the ARV programme itself but rather to a weak health information system, which has existed for many years. However, the failure to complete this process of data collection in the ARV treatment process ultimately means that the goals and objectives of the monitoring and evaluation process will not be achieved. It is this aspect that will gradually deepen the ineffective communication between health care

providers and other levels of leadership. This will be a barrier that will have implications for health service delivery and improvements.

CHAPTER 5

5.1 CONCLUSION

A wide range of literature has supports the sentiment that access to antiretroviral therapy can offer a significant change and improvement to the health and survival of millions of people living with HIV/AIDS (Dhaliwal and Ellman,2003; Steward, Padarath and Bamford, 2004). The provision of ARVs will have a positive influence on many other areas that have been reported to be affected by the epidemic, for example, human resources in business, education and the health sector.

The aim of the rapid appraisal of the status of roll out of the ARV programme was to assess how the implementation of this new policy will progress within a public health care system and to highlight the core factors that emerge during the preparation process and the implementation process.

The outcomes emerging from the study indicate that the core weaknesses and constraints in the implementation of ARVs are profoundly systemic and will require intervention on a systemic level. It is evident that even the successes that are highlighted in the study are due to interventions at facility level and therefore offer limited capacity to achieve similar success, if similar interventions were to be applied to the greater systemic constraints. It is evident, that there is a challenge to mobilise the existing health system infrastructure.

Core challenges included decreasing human resources, a problem that was exacerbated by the failure of government to recruit and retain health professionals. Concomitant factors included difficulty in the management and planning systems of referrals, patient information systems and inadequate communications systems, which affected communication links between national-provincial levels and local levels. This inefficiency resulted in ineffective and inefficient in facility level communication functions between clinical programmes and facilities. For instance, in some of the sites, the antenatal clinics were a completely separate entity to the main ARV clinic, such that the women from that clinic were not accommodated within the operating systems of the clinic.

Monitoring and evaluation systems appeared not to have fallen into place, with most health providers reporting frustrations with existing methods of collecting data. Interviews revealed that most of the HCWs were ultimately not completing the required recordings for the data and if they were, were not completing them sufficiently and/or consistently. This phenomenon, which had either been caused or worsened by a variety of factors, ultimately led to an inadequate monitoring and evaluation systems, which was evident at all levels. What emerged in the study was that the lack of communication systems at all levels has exacerbated this systemic weakness. Alienation between provincial and facility level has deepened the extent of monitoring and evaluation inefficiency and this may be proof of the extent to which managerial functions are inefficient.

Ultimately, the study highlights the fact that the implementation of the ARV programme requires significant preparation and planning. The preparation should take

into account that the programme is being facilitated within a health care system that already has weaknesses and bottleneck problems that need to be addressed time. The roll out of the ARV programme occurred against a background of social factors, such as stigma and fear and political dynamics and a health care system that is plagued by staff shortages, systemic incapacity and inequity. It is within this context that the challenges in this study have emerged.

Various literature and academics addressing the challenges suggest similar to conclusions in this study. It is evident from the various studies, that addressing the inherent weaknesses within the health care system could lead to improvement within the system (Schneider, 2003), such that the existing inefficiencies would cause less burden on other well-functioning areas. Addressing these weaknesses, however, requires significant planning prior to the roll out.

5.2 RECOMMENDATIONS

◆ Improve the recruitment system and retention of health professionals

- There should be strategies built into the system to enable new personnel to be appointed at a faster rate. Recruitment processes and decisions should be administered at local level, so as to reduce the bureaucratic process of advertising of posts and the subsequent appointment of staff.
- Establish short-term contracts that will allow continuity of the presence of health care professionals, despite the high staff

turnover. This will also ensure that vacant posts are filled on a reasonably regular basis.

- Since it is evident that health care professionals in the public sector do not stay for long periods, establish a variety of choices for the duration of stay. For instance, three, six, nine and twelve month contracts.
- It is evident from the study that staff establishment is unbalanced. Some categories are oversubscribed while others are lacking. It would be beneficial to establish a system of determining the categories of health professionals that are required in health facilities, so as to ensure an adequate and appropriate staff establishment. This is where public-private partnership might play an important role. Health professionals who are vastly scarce in the public sector, such as pharmacists and dieticians, can be sourced from the private sector. They can be of service to public facilities for a few hours a week, through some formal agreement with the DoH.
- The DoH should device innovative ways of retaining staff. Conducting a provincial and national survey of the needs of health professionals, focussing specifically the different options of incentives, would be an initial step to findings strategies of retaining health personnel.

◆ **Alleviate administrative responsibilities on health staff:**

Administrative duties can be delegated to non-professional staff

such as community workers and volunteers, so as to ensure adequate record keeping and data collection. It is evident from the study that the administrative inadequacies are located in the inefficient systems. Addressing the inefficiencies on a local level might alleviate the constraints, while plans are put into place at a national level.

◆ **Improve training and training structures** for adequate coverage of health workers:

- In light of the fact that ARV treatment has historically not been included in the undergraduate curriculum of health professionals and other primary health care training programmes, sufficient training in comprehensive clinical skills should be a priority, particularly in primary health care facilities. Practical schedules need to be devised, to ensure that all health care professionals involved in the ARV programme are catered for. This might require provision of training schedules to health facilities long before the training, so as to allow health workers in each facility to make contingency plans, particularly for those that have few personnel servicing the programme.
- Identify the problems that lead to a lack of uniformity in the coverage of health care workers that undergo training.

◆ **Improve communication channels and support systems:**

- Strong channels of communication between national, provincial and regional stakeholders need to be established, to reduce the sense of isolation by front-line workers. Communication within the ARV

facilities to regional levels should not require approval and should be practical. Health care workers should have access to management and feel that they are being heard, perhaps through a personal written acknowledgement from managers, of their requests and queries by managers.

- The regional manager of the HIV/AIDS programme should communicate all issues regularly, perhaps through monthly meetings with provincial authorities. Managers need to be empowered to provide support to front-line health workers, even if only to boost morale and motivation and to foster a sense of being heard.
 - In recognition of the fact that ARV treatment may not always be successful with each patient, provision of emotional support structures, in the form of a resident psychologist or counsellor should be considered. This will reduce stress and low morale amongst health care workers.
 - Implementers of the ARV programme should be utilised extensively by management, as tools for monitoring the roll out and as candidates for providing practical solutions to occurring problems.
- ◆ **Provide skills to local government managers** to alleviate the pressure of functioning in a health care system that is prone to rapid policy changes. Provide facility managers with resources that allow them to execute their functions effectively. For instance, provide computers for record keeping, regular information about changes or introduction of policies and access to resources such

as guidelines on ARV treatment, which should be distributed to all HCWs involved in the ARV programme.

- ◆ **Establish formal networks** with NGOs, Community-based organisations, the provincial DoH and health facilities. This will ensure a stable flow of information to communities. A formal relationship can be facilitated by providing community-based organisations with basic resources, such as pamphlets, posters or any material from the government that relates to the ARV programme. Health facilities should be able to refer patients outwards to community-based structures to ensure continuity of care.

- ◆ **Improve referral networks amongst health service institutions.** Extensive research needs to be done to identify barriers that have reportedly existed for many years in the referral system. Strategies to ensure a workable referral system upwards to hospitals, downwards to clinics and CHCs and outwards to community-based organisations and NGOs should be considered. Health facilities should be formally required to refer patients with adequate reports and primary health care facilities should conduct all the basic clinical requirements before referral. Telephonic communication with other referral facilities should be ensured, so as to allow alternative ways of retrieving patient information.

- ◆ **Improve monitoring and evaluation systems.** This may require the identification of barriers to the current system of monitoring and evaluation.
 - Establish more practical and feasible ways of collecting data, particularly for facilities where HCWs are required to carry out

additional administrative functions. It may be beneficial to discuss this with HCWs themselves

- Establish a more open channel of communication at national, provincial and regional government levels that can narrow the gaps between the three levels and ensure that higher-level authorities are aware of what is occurring at local level.
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- ◆ Establish a database of all active community-based organisations (including home-based care institutions) and NGOs, to formalise and strengthen the referral channels for patients seeking chronic and continued care.
 - Identify the needs of these institutions and identify ways in which they can be provided with resources to strengthen their interaction with public health facilities.

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