

**AN ASSESSMENT OF THE EFFECTIVENESS OF PRIMARY HEALTH
CARE SERVICES IN ADDRESSING HIV/AIDS BY PROVIDING ANTI-
RETROVIRAL TREATMENT – THE CASE OF DU NOON CLINIC IN
THE WESTERN HEALTH SUB-DISTRICT OF THE CITY OF CAPE
TOWN**

by

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**Thesis presented in partial fulfilment of the requirements for the degree Master
in Public Administration at Stellenbosch University**

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December 2010

DECLARATION

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ABSTRACT

The accessibility of anti-retroviral drugs to patients and families affected by HIV and AIDS, and the affordability of these drugs, have been challenges to the Du Noon community in the Cape Peninsula. The aim of the study was to assess the effectiveness of primary health care services in addressing HIV/AIDS in the light of these challenges.

The focus was on patients registered on the ARV programme and who were receiving treatment at Du Noon Clinic. Interviews were conducted with 15 groups of 10 patients each using a patient questionnaire. During these interviews qualitative and quantitative data were gathered and secondary data was used for quantitative analysis. The results that the data analysis yielded are in keeping with the hypothesis that the HIV/AIDS programme is effective in meeting the needs of the HIV/AIDS patients of Du Noon.

After content analysis of qualitative data, two themes related to patient satisfaction emerged: positive and negative feelings that were categorised as satisfied and not satisfied with the service. Most often noted was the feeling of satisfaction with the services rendered at the clinic and that the staff were helpful. The staff rendering the service were also satisfied with the kind of service offered to the patients, but were dissatisfied with the allocation of resources. An increase in enrolment figures of patients was noted in the statistical analysis for the period 2004-2008 with 1,018 patients registered. The statistics illustrate the linear tendency in the enrolment of patients, which indicated the accessibility and affordability of the service.

OPSOMMING

Geredelike toegang tot en die bekostigbaarheid van anti-retrivore middels (ARM's) vir pasiënte en families wat deur MIV en VIGS aangetas is, is 'n uitdaging vir die Du Noon-gemeenskap in die Kaapse Skiereiland. Die doel van die studie was om die doeltreffendheid van primêre gesondheidsorgdienste te bepaal wanneer MIV/VIGS aangespreek word.

Die fokus is op geregistreerde pasiënte wat die ARM-program volg en behandeling by die Du Noon Kliniek ontvang. Met behulp van 'n pasiëntevraelys was onderhoude met 15 groepe van 10 pasiënte elk gevoer. Tydens hierdie onderhoude is kwalitatiewe data versamel en vir kwantitatiewe analise was sekondêre data aangewend. Die resultate wat uit die data analise verkry was, strook met die hipotese dat die MIV/VIGS-program doeltreffend is om die behoeftes van die pasiënte en die gemeenskap van Du Noon aan te spreek.

Nadat 'n inhoudsanalise van die kwalitatiewe data onderneem was, het twee temas rakende positiewe en negatiewe gevoelens – gekategoriseer as tevrede en nie tevrede nie – ten opsigte van die gelewerde diens na vore getree. Veral die gevoel van tevredenheid teenoor die diens gelewer by die kliniek en die personeel as behulpzaam, is opgemerk. Die personeel wat die diens lewer, was ook tevrede met die diens wat aan die pasiënte gelewer word, maar was ontevrede oor die toekenning van hulpbronne. By die statistiese analise is 'n toename in die inskrywingsgetalle deur pasiënte waargeneem. Toename in inskrywingsgetalle deur pasiënte is gemerk in statistiese analise van 2004 - 2008, met 1,018 pasiënte geregistreer. Die statistiek het die lineêre tendens toegelig ten aansien van die inskrywing van pasiënte wat die toeganklikheid en bekostigbaarheid van die diens uitbeeld.

ACKNOWLEDGEMENTS

Firstly, I want to thank my Lord, Jesus Christ, for granting me the strength, wisdom and courage to complete this work successfully. I also thank Prof. Muller for advising me not to give up and to join the 2008 class.

Secondly, my family, especially my children (Cuma, Lwazi and Mazizi), for their support, motivation and tolerance as well as their enthusiasm evident during the entire course of my studies.

Thirdly, my study leader, Mr Francois Theron, whose support, guidance, patience and inspiration, and his trust in my abilities and motivation, were invaluable in this academic achievement.

Also, Ms Rose Richards and Ms Jennifer Saunders, who have been pillars of strength; they played an important role in refining this work grammatically and linguistically, together with Mr Werner Scholtz and Dr Edwin Hees.

To Prof. Martin Kidd and Ms Anne-Mari Lackay for their guidance in the construction of the questionnaires.

To Mr Cobus Snyman and the team for their assistance in the translation of the questionnaires into IsiXhosa.

To Ms Ivona Contardo and Liezl Jonker for their guidance in the scientific analysis of the qualitative and quantitative data.

To Dr Ansie Loots for her guidance and support in compiling the research report and Ms Judy Williams for her assistance and support in searching for information in the library.

To the staff of City of Cape Town, in particular Dr Karen Jennings, Ms Lynn Adams, Mr Russel Piquer and Mr Nazeem Adams, as well as the clinic manager and staff of Du Noon Clinic for their support during this research project.

Lastly, and fundamental to this study, to the community of Du Noon, with special reference to the patients infected with HIV and enrolled on the ARV programme who were eager to participate in this study voluntarily.

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RESEARCH FRAMEWORK

Du Noon
Community

City of Cape Town
Western Sub-
District Context

Introduction to
PHC Principles

HIV/AIDS in the
context of PHC

Patient
Participation

HIV/AIDS programme at Du Noon
Clinic – an assessment of the
programme's effectiveness in
addressing HIV/AIDS
in the context of PHC

Patient
Empowerment

Conclusion and Recommendations

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List of Acronyms and Abbreviations

ABC	Abstain, Be faithful, Condomise
AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
ARV	Anti-retroviral
ARK	Absolute Return for Kids
BANC	Basic Ante-Natal Care
CBOs	Community-Based Organisations
CHCs	Community Health Centres
CCT	City of Cape Town
CHWs	Community Health Workers
CMRA	Centre for Municipal Research and Advice
CNP	Clinical Nurse Practitioner
DHS	District Health System
DHT	District Health Team
DoH	Department of Health
DOT	Directly Observed Treatment
DPLG	Department of Provincial and Local Government
ENAs	Enrolled Nursing Assistants
ENs	Enrolled Nurses
HAART	Highly Active Anti-Retroviral Treatment
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
IDP	Integrated Development Plan
IMCI	Integrated Management of Childhood Illnesses
MDHS	Metro District Health Services
MRC	Medical Research Council
MSF	Médecins sans Frontières
MSATs	Multi-Sectoral Action Teams
NDoH	National Department of Health
NGO	Non-Governmental Organisation
PDoH	Provincial Department of Health

PDR	Plan, Do, Review
PEP	Pre-Exposure Prophylaxis
PFM	Participatory Forest Management
PG	Provincial Government
PGWC	Provincial Government of the Western Cape
PHC	Primary Health Care
pMTCT	prevention of Mother To Child Transmission
PN	Professional Nurse
PPP	Public-Private Partnerships
PQ	Patient Questionnaire
RDP	Reconstruction and Development Programme
RMR	Routine Monthly Record
SAMC	South African Medical Research Council
STIs	Sexually Transmitted Infections
TAC	Treatment Action Campaign
TB	Tuberculosis
VCT	Voluntary Counselling and Testing
WHO	WorldHealthOrganisation

CHAPTER 1

GENERAL INTRODUCTION

1. 1 INTRODUCTION TO THE STUDY

The aim of the study is to assess the effectiveness of primary health care (PHC) services and in particular the HIV/AIDS programme in providing anti-retroviral treatment at the Du Noon Clinic in the Western Health Sub-District of the City of Cape Town (CCT). The concept of PHC indicates the need for a comprehensive health strategy that addresses the underlying social, economic and political causes of poor health (Alma Ata and the Institutionalization of Primary Health Care, 1978: 18). PHC emphasises the close link between health and the development of the poorer sector of the community. Since PHC is the key to attaining an acceptable level of health by all, its implementation will help people to contribute to their own social and economic development (Alma Ata and the Institutionalization of Primary Health Care, 1978: 19). The contribution of people to their health needs promotes community participation in decision making on health matters. The research framework (page x) shows the linkage of PHC to the community, the role of the community and the format of this research project.

The international conference on PHC held at Alma Ata in 1978 pledged to work toward meeting people's basic needs through a comprehensive and remarkably progressive approach called PHC (Alma Ata and the Institutionalization of Primary Health Care, 1978: 18). Twenty-five years later, however, there seemed to be little progress made in implementing the decisions taken at the conference. Tejada de Rivero (2003: 1) revisited the issues raised at Alma Ata to assess the goal "Health for all by the year 2000" in order to establish whether it had been understood by those who originally formulated the concept. The countries that participated in the conference in 1978 signed an ambitious commitment and South Africa responded to the call (Tejada de Rivero, 2003: 1). The conclusions drawn at this conference highlighted that "PHC is based on practical, scientifically sound and socially acceptable methods made universally accessible through peoples' full participation and at a cost that the community and country can afford" (Tejada de Rivero, 2003: 5). According to the Department of Health (DoH), "PHC is at the heart of the plans to

transform the health services in South Africa. It is an integrated package of essential PHC services available to the entire population to provide a solid foundation for a single, unified health system. It is the driving force in promoting equity in health care” (DoH, 2000: 3). As much as South Africa had heeded the call in principle, the researcher’s experience is that the Western Cape Province has not yet implemented the integrated health service package; hence the Cape Town Metropolitan Municipality is focusing on preventive, promotive and rehabilitation health care, whilst the Province is providing curative services, indicating that the services offered are still fragmented (Ceasar & Theron, 2008: 157). (The concepts of promotive, preventive and rehabilitation health care are defined under conceptualization below).

PHC as a package of health care services is provided in well-defined geographical areas, called Health Districts. The District Health System (DHS) is the vehicle for providing quality PHC in the district by bringing services closer to the people. Tapia, Brasington and Van Lith (2007: 3) state that “participation in health and development communication programmes can strengthen the voice of ordinary citizens and ensure their involvement in decisions that affect them, their families, and their communities”. The services should be accessible, acceptable and affordable. The PHC programmes include dealing with maternal and child health, nutrition, tuberculosis, sexually transmitted infections and HIV/AIDS (DoH, 2000: 14). The service is comprised of the promotion of good health, the prevention of disease and trauma, curing of illnesses, and rehabilitation and palliation when required.

In terms of the National Health Act 61 of 2003, provinces will develop DHS (Section 29 (1) and allow the further division of health districts into sub-districts (Section 30 (1) (a) to render PHC services. The Du Noon Clinic renders these services and included in this package is an HIV/AIDS programme delivered to the community. The clinic has brought PHC services to people in the informal settlements and low socio-economic groups living in so-called RDP (Reconstruction and Development) houses. At the time of writing this thesis the clinic had just been established and consequently no previous research that was conducted on the effectiveness of the programmes could be accessed. The HIV/AIDS programme was chosen because the clinic is providing anti-retroviral treatment (ARV) to HIV positive patients in the area. Previously the patients were referred to other clinics and or hospitals to enable

them to access ARV treatment. Not all clinics in the sub-district offer ARV, only testing and HIV wellness are provided. The City of Cape Town has an Integrated Development Plan (IDP) with a strategy for turning the tide against HIV/AIDS infections. It suffices, then, to assess the strategy at Du Noon to ascertain whether it has made a difference. What is not clear about the strategy is the level of participation of the beneficiaries and other stakeholders who might contribute positively to the programme. The consultation process with communities regarding the IDP does not necessarily mean that there is authentic participation by recipients of services.

1.2 RATIONALE

The Du Noon Clinic was chosen as the focus point for this study in order to gauge the effectiveness of PHC services in terms of the HIV/AIDS programme in providing ARV. The evaluation of the ARV programme will assist in determining the future needs of the programme as well as of the community. This clinic was selected because it is new and is serving people living in informal settlements and RDP houses. There has not been any health facility in the area in the past and the nearest clinic to this community is Table View Clinic. The people who live in Du Noon are very poor and many live in houses made from corrugated iron and wood; they use outside water and sanitation facilities and have to travel to access services. Male unemployment is rated at 33% and female unemployment at 67%, with 86% earning less than R1,600 per month (Statistics 2001). Getting to Table View is expensive, as the only transport available is taxis or buses; this in turn makes these services inaccessible and unaffordable for Du Noon residents, thus defeating the intentions of PHC.

Welford, Nelson and Viard (2008: 6) state that “enabling participation has an impact on the participants. Being connected to a group of people who have lived under similar conditions (and dissimilar situations) can bring empowerment and strength”. Through a process of community participation the residents identified a storage building in their area that was no longer utilised and they requested that the Blaauwberg Administration (Health Department) should provide health care services to them at this venue. Because of pressure applied by the community, this structure was made available to the community of Du Noon to accommodate health services.

This had the effect of strengthening community participation. According to Theron (2008: 15), participation means first “that the most important role-players in the development process should be its beneficiaries; second, that project participants should have a direct say in the outcome of a development intervention; and third, that they should own the process”. As the original structure did not satisfy health standards for rendering services, some renovations had to be made and the clinic subsequently became a satellite of the Table View Clinic, with services rendered twice a week. The outcome of engaging in partnership action led to the structure being made available to the community. This is an effective illustration of the bottom-up approach to development.

The initiative by the Du Noon community to acquire a clinic indicates a paradigm shift where the beneficiaries of development engage with the government for service delivery, rather than the Department of Health prescribing the kind of service needed by the community. This is in accordance with the view expressed by Theron (2008: 229) that the process of participation, social learning and empowerment are the building blocks of development. Participation is viewed as one of the cornerstones to sustainable development.

The increase in the numbers of patients seen at the Du Noon Clinic two days a week suggests that the service was no longer sufficient. The building became inadequate and the staff could not cope with the workload. The services therefore had to be spread throughout the week and Table View Clinic became a satellite of Du Noon Clinic as the number of patients treated at each facility was more or less the same. The staff numbers at the clinics also had to be increased. The voting-station built for the 2004 general elections had to be converted into additional consulting rooms because of the lack of space for nurses to deliver services and for patients to wait. A non-governmental organisation (NGO), Absolute Return for Kids (ARK), donated shipping containers that were joined together to build additional consulting rooms. This enabled the clinic to expand the services it provided, which then included the following: tuberculosis care, treatment of sexually transmitted infections, family planning, immunisation, voluntary counselling and testing (VCT), pap smears, ARV treatment and the prevention of mother to child transmission (pMTCT).

The numbers of patients attending the clinic continued to increase steadily to 61,992 in 2006, 75,833 in 2007 and 79,026 in 2008, and the number of HIV-positive patients

escalated, as shown in Figure 6. 1 (CCT, 2008/2009). The article by Health 24 (2006b: 1) states that, although there are other factors that can help to keep a person with HIV infection well for many years, eventually it becomes necessary to take antiretroviral drugs in order to lengthen a person's life. The nearest referral hospitals for this community are Vanguard Community Health Centre and New Somerset Hospital. Hence the need for the clinic to become an ARV health care centre was identified because of the distance the patients had to travel to seek health care elsewhere. Establishing a clinic would also address the issue of equity, which focuses on the equal distribution of resources and health care that need to be distributed according to need. Needless to say, Du Noon is indeed a community in need.

The focus on HIV programmes in this study, in particular the provision of ARV at the Du Noon Clinic, is to assess whether the implementation of the ARV programme is making a difference to the patients. The researcher wished to evaluate the effectiveness of the ARV programme from the perspective of the patients, the recipients of the service. In an article published in *Daily News* (2008) "Human cost of slow ARV roll-out calculated", the reporters stated that "access to appropriate health practice is often determined by a small number of politicians". Dr Pride Chigwedere (a researcher quoted in the article) felt that in the case of South Africa many persons died because of a failure to accept and start treatment in time, as the use of ARVs had already become available to prevent and treat HIV and AIDS. The specific issues about the programme that the researcher would want to investigate in this study are whether such treatment is accessible to, and affordable for people, as well as whether there is participation in decision making for enrolment in the programme and how effective it is. By undertaking this study the researcher will be in a position to take a more detailed look at the provision of ARV and to assess how effective and efficient these services are in meeting the needs of the community. Based on the information gathered, some conclusions will be drawn and recommendations will be developed to support the programme or suggest improvements in its implementation.

1.3 PROBLEM STATEMENT

The researcher aims to assess the effectiveness of the HIV/AIDS programme in providing ARV at the Du Noon Clinic. Welman and Kruger (2001:12) suggest that a

researcher needs to know what a problem is to be able to define it correctly. The researcher defines the research problem as “referring to some difficulty that the researcher experiences in the context of either a theoretical or practical situation and to which an individual wants to obtain a solution” (Welman & Kruger, 2001:12). Early in the process of the DHS development a decision was taken that monitoring and evaluation should form a vital part of the implementation process (DoH, 2001). In 1997 the Centre for Health Policy, with the support of the National Department of Health (NDoH), developed a manual entitled “Towards Well-Functioning Health Districts in South Africa” with a set of indicators to monitor inputs, processes and outputs. The indicators used have been institutionalised in the management processes to improve district operations. The provision of ARV in HIV/AIDS programmes is measured to assess whether the patients have access to, and have benefited from the programme. Theron (2008: 8) argues that “the desirable direction/focus of a development initiative should consider people’s own experience of their reality”. This includes beneficiary participation as one of the most important steps towards project planning, implementation and evaluation. Against the background described above, a number of questions need to be asked:

- As part of the PHC package, is the provision of ARV in the HIV/AIDS programme accessible to the community of Du Noon?
- Is this ARV programme measured for effectiveness? If yes, how?
- Are there standards and norms established to measure performance?
- How are patient satisfaction and benefits monitored?

1.4 RESEARCH HYPOTHESIS

Primary health care services with specific reference to the HIV/AIDS programme at Du Noon Clinic is effective in serving the needs of the patients in terms of accessibility to, and affordability of, the ARV services provided in the clinic.

1.5 RESEARCH OBJECTIVES

The aim of this study is to assess the effectiveness of the PHC services, specifically the HIV/AIDS programme in providing ARV in the Du Noon Clinic. ARV is offered to terminally ill patients at the clinic and not all clinics are afforded the opportunity to provide the service. The patients' experiences in participating in the ARV programme has a potential to influence further roll-out of the programme and to determine future

needs from lessons learnt. In striving to achieve this aim, the following objectives will be pursued:

- Outline the HIV/AIDS policy and strategy of the CCT as linked to the IDP;
- Analyse the ARV data for HIV/AIDS at Du Noon Clinic;
- Gauge the effectiveness of the HIV/AIDS programme, that is the contribution of ARV to the improved health of patients;
- Make recommendations on the basis of the outcome of the study.

1.6 RESEARCH METHODOLOGY

A qualitative and quantitative approach was used for this study. The questions asked seek to assess and evaluate the effectiveness of the HIV/AIDS programme as a component of a PHC package, specifically the provision of ARV.

Qualitative research emphasises the social understanding of the patients as beneficiaries of services and is the preferred approach where attitudes, perceptions and opinions need to be evaluated. Melville (1998:5) states that this approach enables researchers to obtain an in-depth measurement. A literature review was undertaken to assess the effectiveness of PHC services relating to the HIV/AIDS programme in the provision of ARV. The literature was organised around the key construct of HIV/AIDS ARV programme implementation internationally and nationally. Subsequently data were collected by conducting interviews with the respondents to assess their satisfaction with the provision of ARV service at the Du Noon Clinic. The focus group approach was used to obtain direct input and recommendations from focus group participants who had been interviewed in the language they understand. The respondents were drawn systematically from the groups that had been at the clinic on the days that were identified for the interviews. The questionnaires were drawn up to ask patients about their experiences regarding the accessibility, affordability, level of care, staff attitude, their feelings and emotions on enrolment and the effectiveness of the ARV programme. The advantage of the focus group interview is the opportunity to observe interaction on a topic in a limited period of time (Babbie & Mouton, 2001:292). The individual interviews were semi-structured to allow participants to be actively engaged and open in the discussions. This also allowed respondents to expand on the topic as they saw fit and to relate their own experiences (Bless, Higson-Smith & Kagee 2006:116). The interviewer

could also intervene to ask for clarification or further explanation (Bless *et al.*, 2006: 16). Individual interviews with the clinic manager and with other identified health professionals, who will be mentioned under the relevant instruments, were also conducted to obtain a service-provider perspective and evaluation of the ARV programme.

The quantitative research entailed the use of primary data from the questionnaire and secondary data collected in the clinic, referring to the number of patients who received services, the number of patients registered in the ARV programme and patients who have done the HIV test. The data were collected daily by means of the Routine Monthly Record (RMR), VCT register, pMTCT register, pap-smear register and ARV register. The community is continually growing in numbers as this is a mobile community emanating mostly from the Eastern Cape and other countries. Thus monitoring growth in numbers for the ARV programme becomes crucial to identify any defaulters and to determine the need for any extension of services.

1.6.1 Research design

The HIV/AIDS programme, specifically the provision of ARV at Du Noon Clinic, was studied to assess and evaluate the performance of the clinic and the effectiveness of this programme. Mouton (2004:158) refers to the “implementation (process) evaluation where assessment of a programme is done to check if the programme has been properly implemented or whether the target group has been adequately covered”. The intention of this study was to establish whether the ARV programme is reaching the intended community of Du Noon affected and infected by HIV/AIDS.

The number of focus groups used in this study was determined by the number of days spent at this facility. One focus group was interviewed per day, so that the researcher could reach as many patients as possible. The focus group participants were systematically drawn from the patients attending the ARV programme and semi-structured interviews were conducted with them. The researcher explained to the participants that participation is by choice and they are not compelled to be in the group if they feel uncomfortable. This ethical principle was used by the researcher to protect the respondents and to ensure that they could exercise their rights and refuse to participate. The issue of illiteracy was also taken into consideration, so interviews were conducted face to face in the language in which respondents were

comfortable. The groups were constituted of all HIV-positive patients on ARV who have disclosed their HIV status and do not feel uncomfortable discussing the enrolment in the programme in a group setting.

The researcher also used secondary data for the analysis of the effectiveness of the programmes. The quantitative data used consisted of the existing data captured daily in the clinic and compiled weekly. At the end of each month this information was collated and sent to the District Health Information Officer for capturing, collation and validation, before it was forwarded to the relevant managers and health departments.

1.6.2 Research instruments

The focus groups interviews were conducted with 10 to 12 patients in a group. The questionnaire focused on the HIV/AIDS programme with specific reference to the effectiveness of the various aspects of the ARV programme and assessed patient experience and satisfaction.

Certain health professionals from the clinic were also targeted for individual interviews on their contribution to the delivery of PHC in the HIV/AIDS programme. These health professionals were singled out because they contribute in different ways to the programme, as reflected in their job descriptions. Included in this group were the clinic manager, doctor, pharmacist, clinical nurse practitioner (CNP) and the data capturer. There are different categories of community health workers (CHWs) in different areas and programmes linked to the health services, such as home-based carers and TB Directly Observed Treatment (DOTs) supporters who work within the community, but they were not interviewed as they are not directly linked to the HIV/AIDS programme, but can be engaged with respect to the role they play in delivering PHC services.

1.7 CONCEPTUALISATION

Language usage often leads to problems of interpretation. It has thus been deemed necessary to define specific concepts in this study that may otherwise lead to ambiguity in the use of terminology. The following terms are relevant to this study: primary health care, accessibility, equity, effectiveness, comprehensive services, district health system, community, community health centre, clinics, preventive and

promotive, rehabilitation, community participation and community empowerment. Accessibility, equity and effectiveness are defined under PHC principles.

Primary health care: “The concept of PHC encompasses a political philosophy that addresses traditional health care services. It advocates an approach to health care based on principles that allow people to receive the care that enables them to lead socially and economically productive lives” (Dennill, King & Swanepoel, 1999:2). The Alma Ata definition of PHC formulated by the World Health Organization (WHO, 1978) is the one that forms the cornerstone of PHC. Primary health care is the first level of care brought closer to the people in their areas of residence.

Comprehensive services: This implies an integrated (promotion, preventive, curative and rehabilitative) and multi-disciplinary approach to health and health care provision services between the districts (Owen 1995:4). A comprehensive approach to service delivery is a strategy for the health development of a community. The emphasis of this approach is on preventing fragmentation of services.

District health system: Refers to the devolved organisation of health services within a geographically defined area, mirroring local authority boundaries, and which integrates community, primary, secondary and tertiary health care. It is linked to the wider developmental and intersectoral initiatives around water, sanitation, etc. It is thus “a strategy of organising health services which is development-directed, community-oriented and needs-based” (NCHE cited in Dennill *et al.*, 1999:106). The White Paper on the Transformation of the Health System in South Africa (1997:224) as quoted by Ceasar and Theron (2008:156) defines “a health district as a geographic area that is small enough to allow maximum participation of the community in meeting local health care needs”. Therefore the DHS is a vehicle for providing quality primary health care to everyone in a defined geographical area.

Community: A community is an entity comprising a diversity of groups with shared interests within a specific geographical boundary or neighbourhood that determines this social group (Gott & Warren, 1991:414; Dreyer, Hattingh & Lock 1993:111). It is a closely condensed unit within this boundary where the specific interests of value of individual members are shared cumulatively by the group and which are paramount for its continued existence. Swanepoel (1997:32) states that “a community is a unique, living entity and, like its people, it undergoes continuous physical and

psychological change. It also interacts with its own individuals, its environment and other communities". It is clear that in the community interaction takes place and the community does not exist in isolation.

Community health centre: This is a facility located inside the community, larger than the clinic, and it constitutes the district health service providing preventive, promotive, curative and rehabilitative care (Dennill *et al.*, 1999:49). In the Western Cape context the Metro District Health Services (MDHS) manage the 24-hour health service (or extended hours service) in conjunction with the Provincial Government of the Western Cape (PGWC),

Clinic: A clinic is also a facility located inside the community and is smaller than a community health centre. It provides similar services at a less specialised level (Dennill *et al.*, 1999:49). The operating hours for a clinic are from 07:30 in the morning until 17:00 in the afternoon. The clinics are managed by the local authority, that is, the municipality. PHC services in the clinics are rendered by nurses with the support of a doctor who visits the clinic to consult patients with complicated symptoms referred by nurses.

Prevention, promotion and rehabilitation: Prevention covers measures not only to prevent the occurrence of disease, such as risk-factor reduction, but also to arrest its progress and reduce its consequences once established. Health promotion is the process of enabling people to increase control over, and to improve, their health (WHO, 1994: 1-4). Health promotion represents a comprehensive social and political process, embraces actions directed at strengthening the skills and capabilities of individuals and also actions directed towards changing social, environmental and economic conditions to reduce their impact on public and individual health. It is a process of enabling people to increase control over the determinants of health and thereby improve their health. Participation is essential to sustain health promotion (WHO, 1994: 1-4). Tertiary prevention refers to keeping existing problems from becoming worse by providing the appropriate treatment and rehabilitation. Rehabilitation restores function (Rakowski, 1994: 2). Rehabilitation is also a strategy aimed at equalisation of opportunities and social integration of all people after hospital treatment.

Community participation: This may be described as the active participation of people who live together in some form of social organisation and cohesion, in planning, operation and control of primary health care, by using local, national and other resources (Dennill *et al.*, 1999:85). The Alma Ata definition, as quoted by Ceasar and Theron (2008:152) emerged as “the process by which individuals and families assume responsibility for their own health and welfare and for those of the community, and develop the capacity to contribute to their and the community’s development. They come to know their own situation better and are motivated to solve their common problems. These processes enable them to become agents of their own development instead of passive beneficiaries of development aid. They therefore need to realise that they are not obliged to accept conventional solutions that are unsuitable but can improvise and innovate to find solutions that are suitable” (WHO, 1978). Swanepoel (1997:4) sees participation as a way of ensuring equity. He claims that “often, the poorest of the poor do not get their fair share of the fruits of development. Therefore participation must include them”. Chambers (2005:93) as quoted in Theron and Ceasar (2008:105) states that participation means “.... more influence and resources to those who are already influential and better off, while those who are less influential and less well off benefit much less or do not benefit, or actually lose”. For the community to participate fully in its daily activities that affect their lives, it needs to be provided with an enabling environment that will make residents grow and be well developed so that they can make informed decisions.

Community empowerment: This is “the process where community members come together to share and discuss their problems and needs, prioritise them and find possible solutions which they plan, implement and assess through continuous monitoring, dialogue and evaluation based on their objectives” (Dennill *et al.*, 1999: 84). Swanepoel (1997:6) presents empowerment as a principle of community development and states that for communities to participate they must be empowered, that is, power must accompany participation. It is a democratic right for people to participate in decisions affecting their lives, which is the reason why they must be empowered to do so.

1.8 SCOPE AND LIMITATIONS OF THE STUDY

This study has been limited to the CCT, the Western Health Sub-District, Du Noon Clinic. The following limitations may be noted:

There is limited or no literature available with regard to the Du Noon Clinic, because it is a new facility in a new community. Du Noon was established as an informal settlement with no health services in the area. These were formerly accessed at the Table View Clinic. The data collected referred only to the Table View Clinic and no difference was made in relation to data collected for Du Noon Clinic. In 2003 the services were offered to this community twice a week and at that stage the data were still combined with those of the Table View Clinic; thus data applicable to Du Noon could not be divorced from the group which made the data inaccessible. As from 2004 Du Noon data were captured separately from the Table View Clinic data as the HIV/AIDS programme was introduced in August 2004. Available data are thus four years old. Because of this short time span the researcher is not in a position to undertake a lengthy historical (longitudinal) study or try to track trends.

1.9 CHAPTER OUTLINE

Chapter One contains the introduction and serves to introduce the topic of the study. The chapter outlines the specific aims and objectives in assessing the effectiveness of the HIV/AIDS programme at the Du Noon Clinic.

Chapter Two focuses on research methodology; this includes data collection, design, sampling and analysis. The data have been divided into primary and secondary data, as well as qualitative and quantitative data. The research design, methodology and limitations of the study are addressed.

Chapter Three focuses on PHC, examining an analytical framework for South Africa. Because there is such a large volume of literature available on PHC an attempt has been made to narrow the focus to institutional and regulatory frameworks, PHC in PGWC, and the PHC framework in the CCT.

Chapter Four deals with PHC as applied in the HIV/AIDS programme at the Du Noon Clinic. This is discussed in the context of the international and national approach to such programmes. The PGWC and CCT approach is discussed.

Chapter Five focuses on the HIV/AIDS programme in Du Noon. The chapter will deal with the history of the origins of this community and explore community participation and empowerment, structures formed (e.g. social, health, education), infrastructure and the nature of problems experienced.

Chapter Six focuses on data presentation and the interpretation of research results.

Chapter Seven provides a summary, recommendations and conclusions reached on the effectiveness of the HIV/AIDS programme. Finally, the chapter reflects on the relevant benefits of the programme to the community of Du Noon.

CHAPTER 2

RESEARCH METHODOLOGY

2.1 INTRODUCTION

This chapter describes the procedure used for identifying possible research participants, the criteria established for qualification to participate in the study and the technique applied in order to obtain the relevant information. The various inhibiting factors that could have influenced the final results will be highlighted.

2.2 THE RESEARCH PARTICIPANTS

The research participants consisted of patients, hereafter referred to as participants, who entered the Du Noon Clinic attending the ARV programme over a 15-day period. A group of 150 participants was selected, one group per day consisting of 10 members selected on the basis of following criteria:

- They should have been a patient, registered at the clinic on the ARV programme for more than three months (this is the critical time for defaulting);
- They should have the ability to participate in group discussions;
- They had to be willing and feel free to discuss issues related to their enrolment in the ARV programme;
- They must have visited the clinic themselves and not sent relatives to collect treatment for them.

Potential participants were identified systematically by selecting every 5th patient still waiting to be seen by the doctor and/or clinical nurse practitioner on that specific day; they were recruited and briefed as to the purpose of the study and the importance of their participation. Consent to participate was then obtained from them.

The one data capturer (clerk working in ARV programme) at the clinic was requested to assist in identifying the potential patients for the interview. The reason for this choice was that this data capturer was most familiar with the administration processes of this programme and had established trust relationships with most

patients. The researcher respected the decisions of those patients who were not able or willing to participate. Special prior arrangements were made with the clinic manager and the staff working in the ARV programme in order to facilitate the channelling of participants through to the interview room. This was done to allow for sufficient time for the group interview, which lasted 50–60 minutes per session. Another reason for this time span was to allow all participants to make a contribution in the group interview and not be passive participants. The interviews were conducted in an outside consulting room away from the main clinic so as to minimise disturbance. Arrangements were also made with relevant health workers who work with the programme to be interviewed at suitable times that would not hinder service delivery.

It is worth mentioning that research participants were only those patients attending the ARV programme and a new staff member (one month in the service), while those on leave were omitted. The patients who were very sick and those with hearing disability were excluded from the sample.

2. 3 SAMPLING

A systematic sampling technique was used to obtain a sample of 150 participants from the population of ± 750 participants registered in the ARV programme. The researcher was determined to ensure that no fewer than 150 participants in groups of ten were interviewed at the clinic. This was made possible by selecting every 5th patient to participate in the group discussions. The probability of this study's sample lies in the fact that any member of the population will be included in the sample to be interviewed. On average a total of 50 patients per day attend the ARV programme, so every fifth person represents 5% of the total population of 750 participants over the 15-day period. However, the method has constraints in that it depends on an available, completely unbiased population listing, which was not always possible in this study.

2. 4 Demographic profile of the sample

A sample of 150 participants was drawn from a total population of ± 750 patients. A systematic sampling technique was used. The demographic characteristics of the

sample (n=150) is as follows: in terms of gender, 32% of the sample were male (n=47) and 68% were female (n=103). The ages of participants ranged between 20 and 59. Of the 150 participants 35% (n=52) were between ages 20 and 29; 38% (n=57) were between ages of 30 and 39; 26% (n=36) were between ages 40 and 49; and 3% (n=5) were between 50 and 59. This indicates that the majority of infected participants were females falling into the highly productive age group.

Before putting the research questions to the participants, the researcher explained to the group that there was an interest in establishing their areas of residence, their educational level and employment status. This information was gathered to assist the researcher in explaining questions and take into account those who could not stay long because they had to go to work. Of the 150 participants interviewed, 97% (n=145) reside in the Du Noon area. The residential profile indicated that the majority of the people interviewed reside in the areas immediately around or closest to the clinic. The 3% (n=5) residing outside the area did not experience any problems accessing the service; this was because of the reliable transport system and the service was also found to be affordable to all participants.

Concerning the participants' educational level, it was ascertained that 74.9% (n=112) of them have no matric (Grade 12) qualification, but dropped out of school between Grades 8-12. A total of 25.1% (n=38) attended school up to Grade 7.

As far as employment is concerned, 13.1% (n=20) of the participants were economically active (working), while the remaining 86.9% (n=130) were not. Of the 103 women, 12% (n=13) were employed. Only 14% (n=7) of the 47 males were employed.

The income levels could not be established because there was uneasiness about disclosing such information in a group; however, it was evident that those who were working were doing domestic work. Of the 7 employed males, 57.1% (n=4) worked in factories and the remaining 42.8% (n=3) earned their living through piece work. Of the 13 employed women, 61.5% (n=8) were chars and the remaining 38.5% (n=7) were full-time domestic workers. The information above is additional to what had been reported under rationale.

2.5 MEASUREMENT PROCESS

A patient questionnaire (PQ) (see Annexure D) was constructed to measure patients' feelings and emotions about enrolment in the ARV programme at Du Noon Clinic. Also measured was accessibility, affordability, level of care, staff attitude and participation in decision making on their enrolment. Wilkin, Hallam and Doggett (1992: 283) state that multidimensional measures are likely to be of most general relevance in PHC, but such measurements are unlikely to include sufficient detail to evaluate the care of certain major chronic conditions, such as HIV/AIDS in this instance. Ascertaining how patients feel about a health service is a legitimate goal for medical care. Satisfaction is but one tool used to determine and evaluate the effectiveness of the ARV programme. It must be stressed that this PQ did not conclusively prove effectiveness and should be used in conjunction with other methods for a more complete determination.

The questions consisted of open-ended and closed questions to stimulate and allow inputs from the patients. The group interview was conducted in such a way that at the end participants were afforded the opportunity to add what they experienced/perceived would add value to the interview. The eight questions asked sought to probe participants' own experiences, feelings and views of health care in the ARV programme at the clinic and to ascertain their opinions about the quality of care they are afforded by the health workers. The participants' responses to interview questions would then be interpreted to make meaning of their experiences and feelings. The responses would then be classified and used as a scale of measurement.

2.6 QUESTIONNAIRE DESIGN CONSIDERATIONS

Wilkin *et al.* (1992: 30) state that an instrument is valid to the extent that it measures what it purports to measure. The questions were posed in as simple language as possible and in the mother tongue of respondents (IsiXhosa). The researcher structured the questions in such a way that participants were free to express their answers as they wish, make them as detailed and complex, as long or as short as they felt was appropriate. No restrictions, guidelines or suggestions for solutions were given.

In conjunction with the above procedures, control questions were set to assist in obtaining validity. The correlation with the control questions was important to ascertain reliability. A high correlation value is indicative of more consistent answers. Face validity was also measured by asking five independent experts in the construction of questionnaires to evaluate the questionnaire in terms of its simplicity, objectivity, reliability and validity. Experts in a language department of Stellenbosch University were requested to translate the questionnaire to IsiXhosa.

The instrument for measuring participant experiences and feelings consisted of eight questions probing their feelings, emotions, problems experienced, staff attitudes and professionalism, sharing of information by staff, helpfulness of the staff and the impact of the ARV programme. These questions were assessing accessibility, continuity of care, courtesy/humaneness, thoroughness and informativeness, and evaluated overall effectiveness of the programme. The participant groups' responses were all written down during the interview sessions. The group interview took long as indicated because of data collection by scribing. Participants were not comfortable with the use of a tape recorder when the researcher asked to be allowed to record the sessions. The researcher kept field notes during participation in the group.

The staff questionnaire consisted of 18 questions divided into four sections: technical proficiency, logistics, standards and norms, and evaluation. These questions were assessing proper planning, participation by relevant stakeholders, monitoring and evaluation of the ARV programme.

2.7 DATA COLLECTION

As described above, the researcher conducted interviews over a five-week period. One focus group per day was conducted three days per week. Prior arrangements were made with the clinic manager that would suit the clinics' operational times.

In addition to the 15 focus group interviews conducted, data were also collected by means of semi-structured interviews with the clinic manager, the doctor, the pharmacist, data capturer and clinical nurse practitioner working in the programme. These interviews took place at the clinic and lasted on average 45 minutes.

Appointments were made with each individual staff member at a suitable time to avoid any disruptions to clinic activities.

On completion of all interviews the focus group data would be collated separately from the individual staff data. The researcher studied each group's responses to make meaning of the data collected at the end of each day, so that all data could be filled in immediately in order not to lose valuable information. The responses to questions were captured as they were collected and the researcher had to translate them from IsiXhosa into English. All responses to questions from all groups were later grouped together. The responses were further grouped into categories/themes. These responses were categorised as 'satisfied' and 'dissatisfied' with enrolment on the ARV programme. Where group responses were similar, the researcher reflected the number of participants in the group who shared the same ideas and captured the information in numerical form. The researcher repeatedly worked through the data to extract the exact responses of participants, whilst the same was done with staff data. The group interview responses were grouped according to questions asked and transformed into the following themes: programme effectiveness – impact, emotions/feelings, continuity of care, accessibility, humaneness/courtesy and thoroughness/informativeness.

2. 8 DATA ANALYSIS

Analysis involves breaking up the data into manageable themes, patterns, trends and relationships. The aim of analysis is to understand the various constitutive elements of the data through an inspection of the relationships between concepts, constructs or variables to see if there are patterns or trends that can be identified or isolated.

2. 8. 1 Qualitative analysis

Qualitative analysis was performed on the data using content analysis. Content analysis is essentially a coding operation.

The study used manifest and latent coding to draw up a coding system to identify terms or actions that were located in the transcripts of the qualitative section of the interviews and to derive the implicit meaning in the text content. Babbie and Mouton

(2001: 388) state that manifest coding focuses on the visible, surface content, which has the advantage of ease and reliability, yet has the disadvantage of creating validity. As opposed to latent coding, that seems better designed for tapping the underlying meaning of communication, the advantage of manifest coding comes at a cost of reliability and specificity. Hence the authors suggest an integration of both methods. Both methods/approaches seemed appropriate to the present study as the researcher aimed to assess the effectiveness of the HIV/AIDS programme in the implementation of the ARV in the Du Noon Clinic. In the interviews and focus group discussion the effectiveness of the services and ARV programme was expressed both implicitly and at surface level.

In the first stage of coding the researcher undertook the first scan through the data to assign initial codes and search for themes. During the second scan through the data the researcher focused on the initial coded themes and examined whether categories should be added or collapsed to provide a complete coding system for the final analysis. The last scan through the data involved working through the previous codes and data to identify themes and contrasts in specific areas. The result after these stages was a coding system that could be used to identify frequency. Welman and Kruger (2001: 195) state that this involves the contents of sources being examined systematically to record the relative incidence (frequencies) of themes and of the ways in which these themes are portrayed. Frequency then means counting whether or not something occurs, and if something is found to occur, how often it does so (Babbie & Mouton, 2001: 492; Welman & Kruger, 2001: 116 & 168). With the coding system, it was possible to work through the data, record the number of times (how often) satisfied/dissatisfied in all the groups was expressed implicitly and at surface level, and tabulate results. In accordance with Ratcliff's "15 Methods of Data Analysis in Qualitative Research" citing Weber (1990), Ratcliff states that the standard rules of content analysis include how big a chunk of data is analysed and what are the units of meaning, the categories used whether and these must be inclusive or mutually exclusive, and data must be exhaustive. Each item applied to one category, and where various responses fitted into one category, the category was selected once.

The qualitative information was transcribed by the interviewer during the qualitative part of the interview and as far as possible the transcriptions were done word for word. Lee and Fielding (2004: 543) argue that what counts in establishing validity is the conduct /operation of the research community itself. Because of the nature of the subject of study, the criteria of validity will never be fully met in a way that will convince everyone.

2. 8. 2 Statistical analyses

Existing statistics were used to analyse and evaluate the accessibility of the ARV programme at the Du Noon Clinic by assessing the number of patients registered on the programme at the end of each month to indicate effectiveness of the programme. Neuman (2003: 37) states that existing statistics can be used for descriptive purposes in research. These statistics are used to test the relationship or examine the association between the effectiveness of the HIV/AIDS programme, which entails the provision of ARV and meeting the health care needs of the Du Noon community in terms of accessibility and affordability. This is done by monitoring patient attendance for treatment at no cost.

2. 9 ETHICAL CONSIDERATIONS

The researcher approached the clinic manager at the Du Noon Clinic about conducting the study in the facility.

Before being selected, potential participants were asked for their consent to participate. The participants were also assured of the confidentiality of the information supplied by them before the focus group interview could begin. The individual staff members interviewed were also assured about confidentiality.

CHAPTER 3
PRIMARY HEALTH CARE – AN ANALYTICAL FRAMEWORK
FOR SOUTH AFRICA

3.1 INTRODUCTION

This chapter discusses the public health system in South Africa before the current system of PHC came into effect. To be able to follow the evolution of the South African health system it is imperative to understand the events that led to the establishment of the PHC system that operates in a health district. The goal of the South African health system is to strive for "health for all", a principle that commits the government to seek an equitable and acceptable approach to attain a level of service for all people within its borders (Tejada de Rivero, 2003: 1; ANC, 1994:42–46). This approach allows for the possible participation, empowerment and commitment of communities and society.

Several events influenced the development of health services in South Africa. Epidemics that occurred at various stages in the country's history compelled the government to adopt a different stance in rendering health services (Gluckman Commission, 1944). In addition to the above, certain political, demographic and geographical factors also had a direct influence on how health services developed in South Africa. This led to the development of the present DHS, a vehicle for providing quality PHC to everyone within a defined geographical area (ANC, 1994:42-46). Thus after 1994 the South African public sector began to reorient the health services to achieve the goals of equity, accessibility, affordability, availability, effectiveness and efficiency (Dennill *et al.*, 1999: 6-7). The services would be comprehensive and an integrated approach to service delivery would be adopted. The effectiveness of these services would be measured to assess their impact on the patients, the recipients of services.

The researcher intends providing some background to the development of the South African health system and the reasons for changes, as well as examining the previous national health policies regarding PHC compared with provincial interpretations of these policies, with a particular focus in the western sub-district of the CCT.

3.2 BACKGROUND TO THE DEVELOPMENT OF PHC

Amongst other developments that played a significant role in shaping the development of the new South African health services were the creation of the World Health Organization (WHO) and the convening of the Alma Ata International Conference in 1978 (WHO, 1978). At this conference all countries were expected to adopt and adhere to the aims and objectives of the WHO. The following factors and events shaped the specific nature and development of the South African health care system (Van Rensburg, Fourie & Pretorius, 1992:8):

- European settlement since 1652 and during the colonial era influenced health services;
- The health legislation of 1807 paved the way for the introduction of formal health policies;
- The role played by overseas missionaries;
- The unification of South Africa in 1910 led to the formation of provincial health systems;
- The global flu epidemic of 1918 compelled re-prioritisation of strategies;
- The health legislation of 1919 was a milestone in shaping health services and changed focus to preventive, promotive and curative services.

The Gluckman Commission (1944) played a significant role in exposing the limitations and shortfalls of the health services of the period. The report revealed, amongst other things, the numerous socio-economically-related health problems from which especially the Black population suffered, linked to factors such as the desperate housing situation, overcrowding, illiteracy, unhygienic living conditions and widespread malnutrition during the 1930s and 1940s.

The Gluckman Commission (1944: 8) specifically revealed the following shortcomings:

1. Firstly, a lack of coordination. The Commission condemned the existing health services as “disjointed, haphazard, provincial and parochial.” As an example it cited eight role players responsible for the control and provision of health care, namely Local Authorities, Provincial Administrations, the Department of Public Health, the mines, missionary societies, charitable institutions, private hospitals and private practitioners.

2. Secondly, it cited the lack of services, which was acute in black areas in terms of both inadequate personnel provision and poor facilities and also the unsatisfactory quality of both.
3. Thirdly, the Commission's criticism was levelled at the curative orientation and profit motive of private practices, which brought about a situation in which care was not administered according to need, but according to the individual's ability to pay. Consequently doctors established themselves where the wealthy lived and not where the ill and needy lived, and as a result health services were not equally available and accessible to all sectors of the population.
4. Fourthly, the Commission also found that there was an excessive emphasis on curative services and institutional care, and not enough on either the prevention of disease or community-based care. In addition, the Commission criticised the inadequate environmental measures and the critical shortage of medical services needed for preventing illness (Gluckman Commission, 1944: 10). According to Van Rensburg *et al.* (1992: 61), the Gluckman Commission recognised this problem and called for a single national health department that would serve "all sections of the population, according to their need, and without regard to race, colour, means or station in life" (Dennill *et al.*, 1999: 34). The conditions of the Black population were made worse by a series of segregationist legislation and apartheid laws (before 1948 and after) which created "homeland" health policies that led to further fragmentation of the health services. The health services developed in a way that the segregation and inequity engendered by colonisation and racism manifested themselves in numerous discrepancies and inequalities. The 1977 health legislation conformed to the prevailing apartheid dispensation, according to which people were treated according to race and not need. This state of affairs continued during the 1980s, until the apartheid policies were abolished at the beginning of the 1990s.

It is unfortunate that the recommendations of the Gluckman Commission were never implemented at the time. It was only during the dawn of democracy that the African National Congress (ANC) proposed the introduction of a single health system from the level of national government that would link up with the three spheres of

government, i.e. including the provincial government and the local authority/municipality (ANC, 1994:43-45). Health policies would be developed by the national government for implementation at provincial and local levels of government. Thus PHC came about because of the failure of the previous dispensation of health care. The next sections will explore the development of the post-apartheid South African health system, divided into the National, Provincial and the Municipality health systems.

3.3 THE DEVELOPMENT OF THE POST-1994 SOUTH AFRICAN HEALTH SYSTEM

According to Van Rensburg *et al.* (1992:7), the “National Health Care systems do not execute isolated functions within closed vacuums. They are open systems, each component embedded in its environment and each in a constant input-output interaction with the environment”. The researcher examined the South African health system, in particular the national health policies regarding PHC as compared with provincial interpretations of these policies, with a particular focus on the western sub-district of the CCT. After apartheid was abolished in 1994, the government of the day discussed new policies to replace the old ones (ANC, 1994:43-45).

In 1991 the National Health Service Delivery Plan made clear the intention of delivering PHC to all South African citizens (Dennill *et al.*, 1999: 36). It stated that during 1990-95 an affordable, comprehensive health service should be developed, which would be planned according to the priorities identified by the communities themselves. As described by Van Rensburg *et al.* (1992: 81), the plan recommended:

- Reorganisation of health services to regional and local level, with the local authorities taking responsibility for most primary health care services;
- That health services be democratised and community participation be advocated;
- The right of admission of all population groups to public hospitals;
- The introduction of community-orientated training of health personnel;
- That the formula for health financing should make available more funds for PHC (Dennill *et al.*, 1999: 36).

The current budget allocation by the National Health Department is in line with what has been proposed above (Dennill *et al.*, 1999: 36). More resources are allocated for municipal health services as compared to secondary and tertiary levels of care. The system is addressing the equal distribution of services or distributing services according to need (Dennill *et al.*, 1999: 36).

Ceasar and Theron (2008:155) write that “two dominant strategies stand out as the linchpins of the new health care dispensation, namely a shift towards primary health care and the introduction of the district health system” (DHS) (Van Rensburg & Pelsler, 2004:132). The RDP document (ANC, 1994:45) suggested that the “National Health System must be driven by the PHC approach. This emphasised community participation and empowerment, inter-sectoral collaboration and cost-effective care, as well as integration of preventive, promotive, curative and rehabilitation services”. This approach to health care seeks to address the needs of the vulnerable groups, the children, the elderly, youths and the disabled. In the context of HIV/AIDS “vulnerability has been defined as the likelihood of the disease having negative impacts on individuals, households, organisations or entire societies. The degree to which individuals or groups are vulnerable to such negative impacts also tends to be related to a number of well-established factors, such as poverty, access to livelihood assets, access to social capital, household size and composition, and access to support from the state” (Isandla Institute, 2007:12). An article by Health 24 (2006a) ‘How is HIV treated?’ promotes the discussion of HIV status with partners so that they can also be tested and treated, if necessary. The idea is to protect partners by practising safer sex to remain healthy and maintain a strong immune system.

PHC is the first level of care in the community where people live. They will only visit secondary and tertiary care levels as a result of a referral system, as indicated by (Hall and Taylor 2003:4). The aim is for communities to take a lead in identifying their own health care needs (Hall & Taylor, 2003:3).

The Department of Health is the central force in public health and bears the responsibility for the health of the nation as set out in the National Health Act, 61 of 2003 [RSA, 2003]. The Department has fulfilled the task of developing guidelines, norms and standards to apply throughout the health system. It has been the intention of the national government to enable access to PHC for all South Africans. The intention of the PHC approach is to establish the DHS to place all health care

services within well-defined geographical areas under one single authority, known as the DHS. The National Health Act of 2003 gives effect to policies that pertain to developing a uniform health system for the country. The role of the DHS within the National Health System is legislated in the Health Act of 2003 and “in terms of the National Health Act, this level of the health care system should be responsible for the overall management and control of its health budget and the provision and/or purchase of a full range of comprehensive primary health care services” (Ceasar and Theron, 2008:155). The DHS has been established within the rules and regulations of the National Health Act (Act 61 of 2003) and has to operate as such (RSA, 2003). The monitoring systems are in place to assess the establishment and effectiveness of the DHS (DoH, 2000: 4).

In Chapter Four, when discussing the HIV/AIDS programme, the researcher will analyse whether PHC has been effective in delivering the service to the relevant community. Delivery of health care is regulated by the Acts, policies and regulations developed by the National Department of Health (NDoH) for implementation by provinces and municipalities. It now becomes necessary to discuss the regulatory framework and Acts guiding the implementation of health care services.

3.4 THE NATIONAL HEALTH ACT (Act No. 61 of 2003) AND REGULATORY FRAMEWORK

The objectives of the National Health Act, 2003 (2) are to regulate national health and to provide uniformity in respect of health services across the nation (RSA, 2003:16). It is the responsibility of the Minister of Health to promote, protect, improve and maintain the health of the population, to determine the policies and measures necessary to protect, promote, improve and maintain the health and well-being of the population (RSA, 2003: 18). The Minister also decides on eligibility for free health services in public health establishments.

(At this stage it should be mentioned that the specific contents of the chapters of the Act are not discussed in this study. In as far as the Act relates to the framework within which PHC is rendered, it should be borne in mind that arguments about PHC will be presented in the relevant sections of the study).

The NDoH has established regulations that govern the smooth running of PHC in the following areas:

- the fees to be paid to public health establishments for health services rendered;
- the norms and standards for specified types of protective clothing and the use, cleaning and disposal of such clothing;
- the development of an essential drugs list;
- human resource development;
- returns, registers, reports, records, documents and forms to be completed and kept;
- communicable diseases;
- health nuisances and medical waste;
- health research and other regulations (RSA, 2003: 88).

The National Health Act (RSA, 2003) and the regulations were developed as guiding principles on how health care must be delivered to the citizens of the country. The regulatory framework is meant to guard against the abuse of powers and abuse of beneficiaries of health care, and also to protect both providers and recipients of care. The regulations pertaining to health are not limited to the list above, because there are many health care providers whose professions are guided by their professional bodies to practise within the prescribed norms and standards (RSA, 2003:88-90).

Chapter 4 of the National Health Act (2003) is dedicated to the provision of health care services on the level of provincial government and in the next section the researcher will analyse PHC as provided by the PGWC.

3.5 PROVISION OF PHC IN THE PGWC

In line with the National Health Act the provincial government (PG) has to ensure the implementation of national health policies, norms and standards in the province (RSA, 2003 (l): 34). The NDoH granted the provinces the powers to develop health districts and guidelines. It is, therefore, the function of the PG to facilitate and promote the provision of comprehensive PHC and community hospital services in terms of the National Health Act (RSA, 2003 (2) (l): 34). The province will also consult with communities regarding health matters, and promote community participation in the planning, provision and evaluation of health services according to

the National Health Act, 2003 (2) (q) (t) (34). The role of the DHS within the National Health System is also legislated in the National Health Act (RSA, 2003).

Cesar and Theron (2008:157) state that “although legislation pertaining to the establishment of the DHS was promulgated in 2005, the actual DHS in provinces such as the Western Cape has not been implemented”. Because of insufficient capacity and infrastructure at the district level to take on independent responsibility for comprehensive health services in certain areas, the PGWC has retained full responsibility to render all health services (Zimba, 2002:22). The PGWC is still delivering fragmented health services, because the community health centres are rendering only curative services, whereas preventive, promotive and rehabilitative services are rendered by the local government clinics. Municipalities are funded by the PGWC to deliver comprehensive health care to the citizens of the Western Cape Province. In June 2008 the metropolitan district was divided into four sub-structures and four sub-structure managers were appointed. These appointments have, at the time of writing, not yet been tested for effectiveness. It is expected that power would be devolved to the districts and PHC would be implemented.

The Provincial Health Department is responsible for taking control of all health services in the province. The research aimed at PHC at local authority level will be discussed next.

3.6 PROVISION OF PHC IN THE CCT – FRAMEWORK FOR WESTERN HEALTH SUB-DISTRICT

The CCT’s Health Department is divided into eight sub-districts: Eastern, Khayelitsha, Klipfontein, Mitchell’s Plain, Northern, Southern, Tygerberg and Western. These sub-districts were established in 2005 and came into effect in January 2006. In terms of Section 30(1) (a) (2) of the National Health Act (RSA, 2003), a health district may be divided into sub-districts. The Health Department’s vision, mission, values and business plan captures the key performance indicators that are measured in accordance with the plan. The business plan is in line with the IDP, a document that captures inputs from communities and other stakeholders to develop strategies for implementation by the CCT. Theron and Cesar (2008:117) argue that the IDP as a development process is supposed to be controlled by the public, who are the intended beneficiaries.

The Western Health Sub-District renders PHC services to the citizens in its geographical area. PHC service is a service brought nearer to where people stay and is concerned with the health of all people in its area of jurisdiction. This service is brought to the people through the District Health System (DHS). The DHS is a key health sector reform strategy, which is based on the RDP (ANC, 1994). As noted by Ceasar and Theron (2008:156), the health system focuses on districts as the major locus for implementation of integrated comprehensive health services and emphasises the PHC approach. This approach to health care promotes community participation and empowerment, inter-sectoral collaboration and integration of services, and it encourages the training, use and support of community health workers (CHWs) (ANC, 1994:45).

The Western Health Sub-District has ten fixed clinics that render these services from Monday to Friday, eight hours per day. There are also four satellite clinics that are open two days a week and one mobile service that visits farming areas and informal settlements three days a week. The staff working in the facilities are required to be competent in all areas of work in rendering PHC. Training is offered to meet the challenges of the job and there is ongoing in-service training. CHWs are used in the implementation of PHC. Community participation is vital to the success of PHC with basic health services at grassroots level.

For all the services rendered, data are collected by all the staff in all the areas of work. By the end of each month the statistics are compiled by the clinic clerks together with their clinic managers and then sent to the Health Information Officer of the sub-district. Information at facility level is used by the staff to assess their performance in terms of reaching out to the patients and their impact. The Health Information Officers capture these data, collate them and validate them before sending them through to the Health Information Manager, who validates them as well before sending them over to the PDoH. The statistics for the clinics of the CCT are added to the statistics of the community health centres (CHC) that are run by the Provincial Department. Such data are interpreted and converted into indicators to measure performance against set targets and comparisons are made with previous months, quarters and previous years' statistics. Each sub-district has a sub-district manager who holds monthly Plan, Do, Review sessions (PDR) with the District Health Team (DHT), which includes Clinic Managers, Heads: Environmental Health

and Personal Primary Health and Programmes, Health Information Officers, Health Promotion Officers, Principal Environmental Health Officers, District Trainer and TB/HIV/AIDS Coordinators. At these sessions the indicators are discussed at length, looking at the performance of the clinics and environmental health offices. Action plans are discussed that will be adopted by the facilities that do not meet their targets and the support needed from the management is made available. The teams share their successes and best practices. The effectiveness of services is assessed through the use of these secondary data sources to measure performance.

At community level there are CHWs employed by non- governmental organisations (NGO), TB Care and Leadership South to support different programmes in the clinic, including provision of ARV in the HIV/AIDS programme. The CHW's role will be elaborated upon in Chapter Four when discussing the Du Noon Clinic specifically. The discussion to follow relates to the guiding framework and principles of PHC which will also be applied when testing the effectiveness of the programme to ascertain whether it is being implemented according to the stated principles.

3.7 GUIDING FRAMEWORK AND PRINCIPLES OF PHC

Both the City Health Department and the Western Sub-District are guided by the principles of PHC in the implementation of health programmes. PHC brings services closer to the people and in so doing the following principles apply: equity, accessibility, affordability, availability, effectiveness and efficiency. The services are measured for their impact on the community in terms of principles referred to above. The principles are discussed more fully below.

3.7.1 Equity

This principle is intended to ensure that all people will have equal access to health care. There will be no sub-groups with regard to health care. Services should be provided to every person in the community on the basis of need. Equity here refers to equal health, equal access and equal use related to equal need (Hunt and Backman, 2008:3). It also means equal opportunity to use the health service for equal needs. Equity implies the equal distribution of resources across the board, taking into consideration those communities who are less privileged and those people who need to benefit most, as explained in the Gluckman Commission Report. Equity promotes equal opportunity to use of resources without compromising their

use by other groups of people. Hunt and Backman (2008:3) state that if government fails to take effective steps to address race discrimination in a health system, it could be held to account and required to take remedial measures.

3.7.2 Accessibility

Services should be within reach of the people living in that community. This is measured in terms of the distance the patients travel to access the basic health care. The services should also be accessible in terms of finance and the language used by service providers. Accessibility of services is not only confined to the above matters, but the staff attitudes could also have negative implications for the patients, thus making services effectively inaccessible. The long waiting times before patients are served also contribute to dissatisfaction about service delivery and could also lead to services being inaccessible. Accessibility would then also imply that services comply with the expectations of the patients.

3.7.3 Affordability

This principle is intended to ensure that the level of care offered should be aligned to what the community can afford. The Bill of Rights, as part of the Constitution of South Africa (1996), states that no one should be denied health care because of an inability to pay (RSA, 1996: 13). Primary health care services are meant to reach the poorest of the poor as far as service delivery is concerned. Affordability should not be a stumbling block to access health care, irrespective of social status and race, since health care is a basic human right. It could be argued that this right is not equal to receiving the same (equal) level of health care, since there is a difference in monetary contribution to this care. The buying power of health care will always be unequal as a result of the different circumstances of people. This would warrant the benefits of a better health care deal on the basis of affordability, but not disadvantaging those individuals or groups of people who are not well off.

3.7.4 Availability

Health services should be sufficient and appropriate to meet the particular health needs of each community. It would not be serving the interests of the community to have a health care facility that does not meet its health care needs. The communities know their health care needs and would prefer to have services that meet these

needs. It would be inappropriate for providers of health care to offer services that are not in the interests of the community.

3.7.5 Effectiveness

The health services provided to the community should provide the quality of care they were intended to. The effectiveness of the service should be justifiable in terms of cost. The services must have an impact on the community, that is make a difference, and there should be an ability to measure the effectiveness of the service. Melville (1998:12) describes effectiveness as “the extent to which the organization responds to the needs and expectations of communities and those of their leaders”. He further defines effectiveness as the degree of achievement of desirable effects at individual or community level. Criteria for effectiveness are readily available if the activities under evaluation have well-defined pre-established goals. The extent to which these goals are attained, as a direct measure resulting from some activity, is a measure of effectiveness. Effective health care is, therefore, a measure in which the health system, its processes and programmes respond to the needs and expectations of the community, the health worker and management, and the extent to which the goals and objectives have been successfully met with what little resources are at its disposal (Melville, 1998:12).

3.7.6 Efficiency

Health services need to be as timely and streamlined as possible. The services have to be integrated to avoid working in silos and the waiting times in the clinic should not be too long, at least less than an hour. In addition to the above, PHC services should be friendly and courteous, that is service providers should serve the patients with the dignity and kindness they deserve. The service providers should be patient, reach out to the patients and have the ability to explain to them what they do not understand. Efficiency is about doing well more cheaply and/or doing better with the same resources. It is about maximising the ‘good’ with the resources available. The good that emanates from maximum utilisation is measured for effectiveness.

The effectiveness of the HIV/AIDS programme at Du Noon Clinic will be evaluated and assessed based on the objectives of the study and how it relates to PHC principles.

3.8 CONCLUSION

The above discussion has shown that the previous health system of South Africa had a different approach to the delivery of health services. The dawn of democracy brought about changes to health delivery by the introduction of DHS, which has been the vehicle for introducing PHC services. The NDoH functions within the framework and regulations of the National Health Act (RSA, 2003). The PGWC is guided by the National Health Department in implementing the policies of the government. From the PGWC these policies are cascaded down to the local authority level for implementation at community level. Community participation to empower and develop citizens in decision making has been discussed, but it seems to be lacking in practice. This retards the growth and development of the community, which in turn means that beneficiaries are not empowered. If patients do not actively participate, they do not have direct influence on the PHC process and cannot eventually own it. Finally, the guiding framework and principles of PHC were discussed.

In the next chapter the researcher will discuss the international, national and local approach of PHC in implementing the HIV/AIDS programme.

CHAPTER 4

APPLYING PRIMARY HEALTH CARE (PHC) IN HIV/AIDS PROGRAMMES

4.1 INTRODUCTION

This chapter will discuss the application of PHC to HIV/AIDS programmes. To obtain a clear picture of how the HIV/AIDS epidemic is dealt with in the world in general, and in South Africa and the Western Cape in particular, it will be necessary to discuss the PHC framework as it pertains to the international and national approach, and also to the approach of the PGWC and the CCT. It has been interesting to note that all these spheres of government are implementing similar strategies to turn the tide of HIV/AIDS. The focus internationally and nationally is on prevention, education and empowerment. Community participation, capacity building and sustainability of the HIV/AIDS programmes are promoted.

An integrated approach to HIV/AIDS prevention and treatment is essential if any intervention is to be effective. When targeting a specific group of people (people affected and infected with HIV), partnerships would lead to various ways of improving the efficiency of the services provided, including community participation of the beneficiaries. This community strategy would strengthen community groups, commission services that reflect local needs and support capacity building and empowerment. This approach is important because of the impact it can have on other aspects of social upliftment, taking into consideration the burden of chronic diseases.

Theron and Ceasar (2008: 106) have argued that it is unfortunate that most participatory intervention or engagements are introduced by outsiders through development change agents. The communities as participants are not equal partners and are not capacitated to perform to the level at which they can take ownership of the programmes. The integration of the HIV/AIDS programme with other programmes such as those for tuberculosis (TB), reproductive health and curative services, to mention a few, promotes a holistic approach to treatment and care in a “one-stop shop” service. Integrated services reduce the problem of fragmentation, which is costly and time consuming to the patients. WHO (2007) states that TB ravages HIV and AIDS patients and that each of the millions of TB deaths recorded in 2007 are thought to involve a HIV and AIDS patient. It further states that more

than one third of TB patients are not diagnosed, leaving many out of reach of treatment. This crucially increases the risk of spreading the contagious disease, according to WHO (2007). South Africa's fight against HIV/AIDS has also been compromised by statements from leadership that have caused confusion amongst people with low levels of education. This matter will be discussed further under the South African approach to HIV/AIDS.

At the end of the chapter the HIV/AIDS programme in the Western Health District will be discussed in order to provide background to the implementation of the PHC package in the HIV/AIDS programme at Du Noon clinic.

4.2 INTERNATIONAL APPROACH TO HIV/AIDS

Undoubtedly the best approach to HIV/AIDS is preventing the spread of the disease. The international approach to HIV/AIDS is to strengthen the prevention strategies against the disease and to treat the opportunistic infections, as there is no cure yet. The United Nations body in this field, UNAIDS, was requested in a meeting of its Programme Coordinating Board in June 2004 to develop a global strategy to intensify HIV prevention (UNAIDS, 2005b: 6).

The United Nations Programme Coordinating Board delivered a policy position paper that has as its primary goal to energise and mobilise an intensification of HIV prevention with the ultimate aim of providing universal access to HIV prevention and treatment. The policy position paper is directed at all those people who play a leadership role in HIV prevention, treatment and care. The focus is on intensifying prevention of the disease, because of the high rate in the spread of infections. In this regard it is useful to refer to the international initiative of recruiting influential local women to distribute condoms or to act as staff in community health programmes, which tap into local social organisations (Poku, Whiteside & Sandkjaer 2007: 153). This action is seen as an attempt to promote community participation with the ultimate aim of empowering communities to take ownership of their health needs. Theron and Ceasar (2008: 111) argue that "to narrow the gap between rhetoric and reality, beneficiaries – as local experts with indigenous knowledge systems – should be part of the process of planning and identifying appropriate participation strategies. This is fundamental to implementing grassroots participation programmes/processes such as IDP". In the context of human settlements, "mainstreaming HIV/AIDS in

slum upgrading should be ongoing and not a once-off intervention” (Isandla Institute, 2007: 8). The argument is that governments should deal with the direct and indirect causes that lead to vulnerability to HIV/AIDS, and this cannot be ‘business as usual’ as we are dealing with communities. There should be an effective internal focus and also an external response to HIV/AIDS.

The UNAIDS Policy Position Paper (2005a) claims that HIV prevention, if adequately resourced, can have a major impact on other national priority areas, including controlling the spread of sexually transmitted infections and tuberculosis, addressing gender inequality, promoting education, tackling drug and alcohol abuse, improving health services and mitigating the impact on children made orphans and vulnerable by AIDS (UNAIDS, 2005a: 12). It becomes critical, then, to argue for raising the level of participation by the beneficiaries and increasing their understanding of the roles they play as partners in service delivery. The extent of inclusion of communities in decision making would determine their participation, the influence they have and their buy-in into the project. If they feel alienated, they will withdraw and the implementers stand a risk of not being accepted in the community.

The worldwide challenge to HIV/AIDS care is ensuring the accessibility of health care services. The update on the Aids Epidemic (UNAIDS, 2005b: 6) shows that “less than one in five people at risk of becoming infected with HIV, has access to basic prevention services; and of people living with HIV only one in ten has been tested and knows that he or she is infected”. It is believed that to deal with the HIV/AIDS epidemic it should be recognised that HIV prevention efforts need to be intensified as part of a comprehensive response that expands access to treatment and care. The communities need to determine the extent of their participation in the implementation of the programme as partners in service delivery. The inclusion of beneficiaries in decision making strengthens relationships amongst stakeholders and promotes buy-in and ownership of programmes from the community.

The worldwide view on the epidemic is that “only through fundamental efforts coupled with increased global and national commitment will the world be able to achieve universal access, and truly begin to get ahead of AIDS” (UNAIDS, 2005b: 6). HIV/AIDS needs to be discussed and debated vigorously without fear and shame by all people of the world in order to educate those individuals with limited knowledge (UNAIDS, 2005b: 6). Efforts need to be made to develop intervention

prevention strategies with short-term horizons that would translate into long-term programmatic strategies (UNAIDS, 2005b: 6). The researcher is of the opinion that the people affected by, and infected with, HIV/AIDS are not asked about their limitations as far as knowledge is concerned. Instead more information is pumped into the system without participation. A typical example is the thousands of pamphlets that are produced and distributed, but which are afterwards seen in the dustbins without being read by people. In a community satisfaction survey done by the CCT, the results showed that people are making use of community newspapers as a preferred way of communication instead of pamphlets (CCT, 2009).

Ceasar and Theron (2008: 162) suggest that in order to address the HIV/AIDS and TB pandemic, “we need to stress the integrated nature of planning interventions and the participation of role-players/stakeholders”. They are of the opinion that “if local government acts as the level of government intervention ‘closest to the people’, then the relationship between municipalities and the public must be prioritised”. The public must be given a voice in addressing health issues. International practices recognise that HIV prevention and treatment are interlinked and that both should be accelerated simultaneously to ensure a comprehensive response to the infection which would culminate in a multidimensional approach, as stated by Theron (2008: 43).

An HIV/AIDS programme strategy involves cooperation between the government, non-governmental organisations and civil society. Implementation is through bilateral and multilateral projects cooperating and coordinating with other partners in public health and social wellbeing with other international actors (Barents, 2005:3). The aim is to reduce the spread of HIV through a multi-sectoral approach. The impact of HIV/AIDS on every sector of society means that all development programmes need to follow a multi-sectoral approach in order to achieve a concerted drive. Integration of TB and HIV programmes with the intention of increasing voluntary counselling testing (VCT) among TB patients has been another strategy. This approach intends to facilitate an integrated approach to the management of co-infected persons creating a "single" service and also increases service efficiency with a more rational staff deployment and increased staff motivation (WCDoH, 2005: 5). The approach led to increased enrolment figures of patients on ARVs, which in turn led to a decrease in viral load and increase in CD4 (blood cell count) count in Khayelitsha.

What is required for strengthening the health systems approach to ARV is realistic targets for ART coverage set in conjunction with realistic and appropriate targets for the delivery of other key essential health care services such as treatment of TB, malaria, maternal health care, sexually transmitted infections (STIs), integrated management of childhood illnesses (IMCI) and HIV prevention. This also needs explicit analysis and a rationale for the proposed mix of vertical and integrated ARV programmes, as well as a mix of public-private and NGO delivery agents (MRC, 2005: 23). There need also to be monitoring systems that emphasise ARV coverage and accessibility to other primary health care services and that incorporate performance indicators for broader health systems (MRC, 2005: 23). Médecins sans Frontières (MSF) has been successful in achieving a better compliance to ARV therapy compared to TB programmes because MSF has focused its energy on ARV and brought on board volunteers (community participation) visiting homes of those patients on treatment. Amongst those volunteers are HIV-positive patients who are also on treatment but have improved. They teach patients about side effects and the importance of compliance based on their personal experiences on treatment (MRC, 2005: 43).

To be effective in dealing with HIV/AIDS, it is suggested that HIV-prevention programmes should address the contexts in which people live their lives. "This should take into consideration the rights and status of women and young girls who are often victims to HIV infections because of poverty" (CMRA, 2009: 2). There is evidence suggesting that there are high levels of sexual violence against women and young girls by strangers and/or intimate partners, and that this form of abuse increases the likelihood of these women becoming infected with HIV. The HIV/AIDS epidemic could also be reversed if effective prevention measures are intensified in scale and scope; this is popularly explained as "ABC – Abstain, Be faithful to one partner and use Condoms (Condomise)".

The historical exclusion from participation in decision making and the inequality of women has resulted in women having lower levels of employment, income and education and hence fewer chances of upward mobility (Centre for Municipal Research and Advice CMRA, 2009: 2). Arguments by the CMRA (2009: 2) show that "poverty is perceived as a gender issue because women make up the majority of the poor and access to basic needs has also been influenced by unequal gender, race

and class relations". The inequality of power between women and men has inevitably led to unequal sharing of resources such as information, time and income. CMRA indicate that many studies show that gender roles and especially rigid notions of manhood contribute to gender-based violence and other forms of gender inequality, and also exacerbate the spread and impact of HIV/AIDS (CMRA, 2009: 2).

Women become so disempowered that they cannot negotiate sex with their partners (CMRA, 2009: 3). If a man objects to the use of family planning by his partner and does not want to use condoms, the woman has to tow the line, failing which she must decide how to rescue herself. The issue of power especially in those communities or race groups with low levels of education plays a big role in relationships as women have an inferior status to men. Women have much less bargaining power than men in the negotiation surrounding safe sex (Kauffman and Lindauer 2004: 22). This is common practice, more than being a cultural issue in Black African communities. To address this issue it would be ideal for communities to foster closer collaboration between women's advocacy organisations and organisations working with men to achieve gender equality. Also recommended is the creation of partnerships with stakeholders (CMRA, 2009: 3).

There have been calls on governments by citizens both internationally and nationally to show political commitment in dealing with HIV/AIDS (Kauffman and Lindauer 2004: 126 - 127). There has been some reluctance among politicians and international organisations to fund the programme because of fears of losing their mystique of expertise and the power that goes with the control they have over budgets and planning (Poku *et al.*, 2007: 169). However, when governments adopt the language of community participation, they do not have to relinquish that power, but rather treat community-level civil society organisations as valued partners and implementers of programmes (Poku *et al.*, 2007: 169). The Global Fund has made available funds to fight AIDS together with World Bank initiatives, including the Multicountry AIDS Programme and the United States President's Emergency Plan for AIDS Relief (UNAIDS, 2005a: 11).

The funding of programmes offers opportunities to those infected by the disease to be enrolled in the treatment programme, which is based on antiretroviral treatment. Providing opportunities for people infected with HIV to have access to treatment also

offers the means of preventing the spread of infections. Increased access to antiretroviral treatment provides the prospect for involving many new players in HIV prevention, including people living with HIV, treatment activists and health workers (UNAIDS, 2005a: 11). Community participation can be a learning experience helping to develop skills and analysis through participation. This helps develop the capacity of individuals and communities directly involved in the work. This effort of community participation takes into consideration the use of marginalised groups such as women, children and people living with HIV/AIDS (Project Cycle Management, 2006: 48).

The role of CHW in primary health care is instrumental in promoting community participation. To ensure the active participation of people in primary health care it is essential to make good health the real aim of people. The essence of authentic participation entails creating an enabling setting through which health beneficiaries can influence and direct planning. This means having a stake in the process, one which leads to project ownership by health beneficiaries. PHC, a global strategy to combat preventable diseases that undermine the health of vulnerable groups, has been implemented by most governments of developing nations, including South Africa. However, observation of “participatory planning” still indicates that participants (project beneficiaries) are often not capacitated or empowered through their “participation” (Theron, 2008: 61). Change agents as project partners of project beneficiaries should act as “enablers” or “facilitators” and not add to the confusion with regard to key concepts and approaches. Discussing planning in itself must be a participatory social learning process, one which is opposed in principle to a prescriptive and mechanical approach to ideas and the stages of planning. The ideal of a holistic approach to development planning and management is linked to a social learning partnership approach to planning. Theron (2008: 61, citing Brown 1997: 69) states that “a social systems approach to project planning and management entails a holistic view of a problem to be challenged through which the constituent parts of the whole are identified”. Such as holistic approach entails participation by project beneficiaries in development planning and project management.

“The UNAIDS Governing Board, comprised of member states, in endorsing its policy position paper for intensifying HIV prevention, included a compendium of proven programmes and actions that could be used to close the prevention gap and 12

essential policy actions that would be needed to ensure universal access” (UNAIDS, 2005a: 14). Providing greater access to HIV antiretroviral treatment reinforces HIV prevention through increased HIV testing.

The next section compares the South African national approach to HIV/AIDS with that of the international community. The focus will be on strengthening those strategies that seek to bring about change in the lives of all South Africans and learning from best practices of other countries.

4. 3 THE SOUTH AFRICAN (NATIONAL) APPROACH TO HIV/AIDS

South Africa’s approach to HIV/AIDS is to promote intervention strategies by creating awareness, educating communities on prevention, the distribution of condoms and providing HIV-positive patients with treatment (Kauffman and Lindauer 2004: 136). The researcher is of the opinion that people infected and affected by HIV/AIDS are not afforded the opportunity to contribute and/or participate in decision making about their state of readiness to resume treatment; hence enrolment to treatment is determined by the patient's CD4 count. South Africa is experiencing a HIV/AIDS epidemic of shattering dimensions. The main source of information about the epidemic is the antenatal clinic data from the maternal services according to the South African Medical Research Council (SAMC, 2001: 5).

The national approach to the treatment of HIV/AIDS in South Africa is in line with international standards and practice promoting the prevention of the spread of the disease, creating awareness by educating communities, allowing community participation and empowering communities. In June 1994 the National Coordinating Committee of South Africa met and drafted a comprehensive AIDS strategy that detailed the National Plan. The plan called for “the provision of free condoms and sexually transmitted infections (STI) treatment services” (Kauffman & Lindauer, 2004: 136). The plan was adopted and since then condoms were and are still distributed freely in public health facilities and in the treatment of STI. There have also been numerous calls in all the media (national television, print media and radio stations) for national leadership and political commitment in addressing the HIV/AIDS pandemic (Kauffman and Lindauer, 2004: 86).

The international community considers leadership to be crucial in curbing the spread of HIV. In a meeting held by the United Nations General Assembly to discuss the

HIV/AIDS epidemic “the emerging declaration stated that leadership by Governments in combating HIV/AIDS is essential and also pointed out that the efforts of Governments should be complemented by the full and active participation of civil society, the business community and the private sector” (Shisana & Simbayi, 2002: 89). To succeed in this approach public-private partnership needs to be strengthened so that communities are encouraged to participate in order for them to *influence, direct* and eventually take *ownership* of the project or programme at hand.

There has also been controversy both locally and internationally about the role of the South African government in its handling of HIV/AIDS issues, and particularly on its commitment to providing ARV treatment for people living with HIV/AIDS. The Nelson Mandela Study of HIV/AIDS shows that 15-year-olds are the most vulnerable group, because they are the least informed and most careless about sexual practices (Shisana & Simbayi 2002: 131).

“National leadership, ownership and commitment to HIV prevention constitute the prerequisite for implementation of a successful HIV prevention strategy” (UNAIDS, 2005a: 40). There is a strong belief that communities look up to their leaders for guidance to provide direction; this supports the widely held notion that leaders should take a lead in the fight against the disease (UNAIDS, 2005a: 40). The problem here, as far as the researcher is concerned, is that there is not sufficient emphasis on the fact that the people on the ground should take ownership of the programme, but the leaders still need to lead. This could be seen as a conflict of roles, because people expect to be led, but with regard to HIV/AIDS they have a responsibility to protect themselves. There is a need to spell out where the burden of responsibility lies with HIV/AIDS and how it should be shared. The view of the people sometimes amounts to a false perception that “Government will provide”.

Calls have been made by South African citizens for political commitment and buy-in to fighting the disease (Kauffman and Lindauer 2004: 86). The response of former President Thabo Mbeki was at the root of the problem. According to Kauffman and Lindauer (2004: 86), much of what has happened on the political front in South Africa’s AIDS epidemic has lead astray analysts, both locally and internationally. The former President became the subject of criticism with his refusal to address the issue of HIV and AIDS as he created confusion especially amongst people with low levels of education. This was interpreted as lack of political will.

Despite Mbeki's utterances and lack of pressure on the then Minister of Health Tshabalala-Msimang in his cabinet to tackle the problem head-on, the civil society organisation, Treatment Action Campaign (TAC), continued to put pressure on the government to provide treatment for HIV/AIDS and to strengthen the prevention strategies. The call by TAC was supported nationally and internationally and especially by the people infected and affected by the disease, because of the continuing increase in the mortality rate. Interactive communication approaches amongst community-based organisations were strengthened to create community awareness in order to encourage community participation. TAC's actions and responses to Mbeki's utterances led to increased ownership and community participation in the ARV programme in certain sectors of society (Kauffman and Lindauer (2004: 56 - 57).

International funds were made available to the NDoH to fund antiretroviral therapy, but the national government under Mbeki delayed the implementation of the programme (Heywood, 2004: 102). The pressure from NGOs led to the establishment of antiretroviral (ARV) treatment clinics as additional strategy in HIV-prevention programmes (Heywood, 2004: 103 - 106). The introduction of female condoms, microbicides, pre-exposure prophylaxis (PEP) along with promoting male circumcision are new prevention methods that have been made universally accessible. These programmes are additional to existing ones, such as voluntary counselling and testing (VCT), prevention of mother to child transmission (pMTCT), and extensive HIV/AIDS awareness and education campaigns. It is believed that educating the youth about their sexual conduct will benefit them in the long term. "Changes in sexual behaviour appear to have contributed to the declines in HIV prevalence in some countries like Zimbabwe" (UNAIDS, 2005b: 20). The significant decline in HIV prevalence among pregnant young women (15-24 years) has shown a decline from 29% to 20% in 2000 to 2004 (UNAIDS, 2005b: 20).

For some time it has been the belief of people, both in South Africa and internationally, that politics and not medicine holds the key to an effective response to HIV/AIDS (Poku *et al.*, 2007: 4). This assumption has been created by the understanding that politics has some influence on the global funding of programmes. To counter this view the United Nations General Assembly Special Session on AIDS called for "greater political leadership in the fight against the epidemic with the donor

community's acquiescence" (Poku *et al.*, 2007: 4). HIV/AIDS policies and programmes should reflect a coherent understanding of the epidemic as a development problem that needs to be addressed. The political leadership will influence funding of the HIV programmes and determining the price of drugs. It is evident, as discussed above, that the most effective strategy in addressing HIV/AIDS is prevention. Included in a care package are education and empowering of the youth, women and vulnerable groups, and encouraging community participation by communities to take ownership of the programmes.

Other key strategies used to control HIV/AIDS, as discussed in the survey conducted by Shisana, Rehle, Simbayi and Mbelle (2005: 6-13), are:

- "legislative responses which include rights to non-discrimination in workplace setting a number of emerging Bills which focus on gender disparities and the needs and environments of children;
- an expanding home-based care (HBC) programme;
- training of traditional healers as partners in health care;
- training of partners, notably in collaboration with labour unions;
- communication strategy through press release to mobilise community members to participate in activities/projects in their communities".

Most of these points favour increasing ownership and integration of role-players at all levels.

In addressing these challenges it defies belief that government and other policy makers and planners often do not realise that a second party – the beneficiaries of development programmes/projects – should be the major partner and participant in strategising towards alleviating development problems. Swanepoel's (1997) intention is to stress the importance of community participation in developmental efforts as the main role-player and owner of development efforts, while other role-players become supporting participants. The role of communities through participation would then become central and their participation a natural outflow and manifestation of ownership and empowerment (Theron, 2008a: 5). Project beneficiaries can have an impact to influence the direction and outcome of the project and eventually "own" the project/programme.

There is a need to bring about changes in HIV prevalence among young South Africans over time. If the decline occurs, it will likely be the result of the combined effect of many prevention efforts (Health Systems Trust, 2004: 63). Young people's awareness, their interaction with and participation in government's youth programmes would encourage commitment and buy-in from them. This approach promotes and encourages youths to be part of the solution to the problem of HIV/AIDS so that they take ownership of the youth programmes. The approach then becomes a bottom-up approach, directly influenced by stakeholders who understand their needs.

In the next section the researcher will discuss the approach of the provincial government in Western Cape Province in dealing with HIV/AIDS.

4.4 HIV/AIDS APPROACH IN THE PGWC

In this section the researcher will be discussing the implementation of Highly Active Anti Retroviral Treatment and HIV care in hospitals. The problems experienced by the patients and institutions of care will also be discussed. The role of NGOs and the forging of partnerships with private and public institutions will be analysed.

The implementation of an HIV/AIDS programme in the PGWC follows the government's strategy and policy plans because the Department of Health, in consultation with relevant stakeholders, sets up policies, that in turn are to be implemented by provinces and local authorities. The Western Cape's HIV/AIDS programme is housed in the Provincial Health Department under the guidance of a directorate. The role of the PGWC is described as follows: "The important role of provincial government is to build and maintain the strategic partnerships with private sector and NGOs. This approach requires political will, leadership and coordination, and to develop and sustain new partnerships and ways of working and so strengthen the capacity of all sectors to make an effective contribution" (Chirambo & Ceasar, 2003: 33). This statement promotes participation by all stakeholders who become equal partners in service delivery. This approach is inclusive of all participants, including the beneficiaries.

This partnership is demonstrated by PGWC through contracting NGOs to recruit CHWs to support clinics in the implementation of the programme. Ceasar and Theron (2008: 164) argue that "partnership building through participatory planning by

groups within a community (schools, faith-based organisations, the private sector) fosters collective action, maximises the use of resources, and builds consensus around strategic communication goals". General practitioners are also co-opted and encouraged to treat STIs free by providing medication. This encourages private-public partnerships (PPPs). The researcher supports the views of these authors, because partnerships would empower and capacitate communities whilst at the same time promote community participation.

The PGWC's multi-sectoral approach aims to link HIV/AIDS to poverty reduction strategies and improving the quality of life, as the government is doing. It recognises the central role in the response of people living with HIV/AIDS and promotes actions that seek to achieve specified goals like breaking the silence about HIV/AIDS, reducing discrimination and stigma, protecting the human rights of people living with the disease, and mobilising and making available resources for civil society organisations engaged in prevention and care.

The provincial health directorate, therefore, plays a leading role in dealing with HIV/AIDS. In partnership with local government, NGOs play an increasingly important role in health care as they contribute significantly to HIV/AIDS and tuberculosis programmes. They also participate in other programmes, such as those for cancer and disability. Protocols are developed in this department that are cascaded down to local authorities for implementation. There are many challenges faced by the health department in addressing this epidemic, because the disease burden cuts across directorates and departments. The tools for mainstreaming and analysing HIV/AIDS are established so as to understand the factors contributing to the spread of the disease, taking into consideration its impact and consequences for the public/private sector and the community at large.

Mainstreaming is about taking HIV/AIDS in account when planning and implementing in respect of issues or sectors that are not specifically about HIV and AIDS (CMRA, 2009: 4). It is an approach which requires municipalities and other stakeholders to analyse how HIV and AIDS impacts on them as organisations and on their core work, and to determine how they should respond.

The Western Cape Department of Health has been able to plan ahead with a comprehensive programme to tackle AIDS. This programme includes prevention,

care and treatment components, implying that all three components are needed to tackle the epidemic. The demographics of the province show a higher Human Development Index and a lower infant and child mortality rate than other parts of South Africa, but the Western Cape also has a higher prevalence of chronic diseases (Abdullah, 2004: 247). Be that as it may, HIV prevalence in the province is still lower when compared to other provinces and stands at about half of the national average (Abdullah, 2004: 247). HIV prevalence is determined by an antenatal survey, which does not represent the whole population, as it excludes males and females who are not in the child-bearing age bracket. The researcher is of the opinion that the HIV prevalence rate determined by the abovementioned measurement should be used with caution when publishing results.

Arguments by the Isandla Institute (2007: 18) on HIV prevalence reveal that data derived from antenatal surveys and extrapolated to general populations has obvious limitations in terms of how much detail the data can reveal about characteristics of the epidemic amongst different groups and sub-groups within society. In the case of Cape Town, for which data are drawn almost exclusively from antenatal sites, there is little, if any, reliable data available on HIV incidence and prevalence rates amongst different race groups, religious and ethnic groups, and the local gay community. The HSRC study of HIV/AIDS (Shisana & Simbayi, 2002: 1) supports the arguments cited above by stating that the antenatal survey does have limitations for estimating national prevalence levels in the general population, because only a select group (i.e. currently or recently sexually-active women, who are pregnant and thus of a limited age group range 15–49) are included in the survey. The fact that a sexually active group is being sampled makes it difficult to draw conclusions about proportions of the population who are not sexually active, particularly younger age groups where sexual debut may not yet have occurred. It makes sense to mention that individuals who have adopted key HIV-prevention practices such as condom use are considerably less likely to be represented in the antenatal sample, as it focuses only on the female component.

Having said this, the HIV epidemic constitutes the single largest health crisis facing the Western Cape at the present time. The situation is expected to worsen over the next number of years. It is estimated that a quarter of all admissions and visits to health facilities in the province will be related to HIV/AIDS infections. The province

implemented all the HIV-prevention programmes initiated by the NDoH. In 1999 the province moved ahead to initiate a pMTCT programme in Khayelitsha (Abdullah, 2004: 249). This relates to the administration of ARV therapy to pregnant women. In 2001 the so-called triple therapy was introduced as a joint effort involving the NGO called Médecins sans Frontières and the PGWC. The HAART programme was later rolled out to other facilities such as Groote Schuur, Somerset Hospitals, Khayelitsha, Gugulethu community health centres and Langa Clinic (Abdullah, 2004: 250). To open up the facilities for ARV programmes ground work needs to be done so that services are accessible to those in need; it must also be possible to sustain them.

Health workers need to be recruited and trained to render the services with the intention of empowering communities through health worker-community partnerships. The facilities need to meet the criteria set out by national government to be accredited to issue ARV treatment. The Province's strategic approach to HAART is that the ARV plan includes HIV care that is to be provided at all health facilities. It seems that the hospitals providing HAART experience lower adherence as patients have to travel long distances to get treatment, on top of which there is a lack of psycho-social support (Abdullah, 2004: 257). More ARV programmes are established at CHCs and local authority clinics.

The success of the HIV programme has been strengthened by the level of partnerships the DOH has entered into with different organisations such as Médecins sans Frontières in Khayelitsha, the Desmond Tutu HIV Centre in Gugulethu and Kidzpositive in Groote Schuur Hospital (Abdullah, 2004: 257). These partnerships were framed as operational research projects aimed at working out best practices in the provision of ARVs in the public sector (Abdullah, 2004: 258). Later in the course of the government-funded roll-out phase the DOH entered into a partnership with an NGO called Absolute Return for Kids (ARK) that aimed at speeding up the commencement of new ARV programmes in clinics and CHCs.

This programme is seen as ahead of the rest, innovative, responsive and all inclusive, attracting good-quality staff and better resources, and experiencing greater trust from the public and civil society (Abdullah, 2004: 258). ARK brings a team of health workers to initiate the programme and, once the department is able to recruit its own staff, ARK pulls out of the operation. ARK's withdrawal is based on the fact that the programme becomes fully funded from the Global Fund in partnership with

CCT. The City of Cape Town in partnership with PGWC assign tasks to NGOs that are funded by the province to participate in service delivery bringing the communities on board as partners in service delivery.

Next the implementation of the programme at the local authority clinics will be discussed. The researcher is assessing the effectiveness of the HIV/AIDS programme by monitoring the accessibility and affordability of the PHC service to its beneficiaries/recipients of health care. Included in the effectiveness of the programme is assessing the participation of beneficiaries in the decision making and implementation of the programme. This also takes into consideration measuring the performance of the programme in terms of whether it meets the needs of the beneficiaries.

4.5 HIV/AIDS APPROACH IN CCT

The White Paper on Local Government (1998) urges local government to focus on development outcomes, such as community empowerment and redistribution. The White Paper proposes developmental approaches that include working with citizens as partners. This approach represents a major paradigm shift in terms of how municipalities should democratise development and integrate development planning with community-based goals (DPLG, 2008-2011: 34). The CCT has developed its own strategy in line with NDoH and PGWC in the implementation of the HIV/AIDS programme. The CCT health department receives funds from the Global Fund and is supported by PGWC to implement the HIV/AIDS programme. The programme is managed by the project manager, who supports the districts in implementation. She is accountable for the funding and reports to the Executive Director and Global Fund. The programme is designed to be accessible to the communities the City serves.

The CCT adopts and implements policies and protocols of the National and Provincial Health Departments. Awareness campaigns are the order of the day in all City facilities. HIV/AIDS affects the workforce and this is why awareness is promoted across all directorates. The staff and community at large are educated about the disease in order to promote behavioural change. The CCT promotes the ABC principles to promote healthy life styles and strengthen prevention strategies. In line with the above, in terms of the Municipal Systems Act (Act 32 of 2000), the CCT is required to develop an IDP.

The IDP is “a key document in the life of a municipality, and all municipalities are required by law to draw up an IDP to direct all development in a municipal area” (Municipal Systems Act 32 of 2000). The City of Cape Town’s IDP document contains strategies developed to address all areas of work in the organisation. Linked to the IDP process the focus area and objective is health as well as social and community development, and the City health’s strategy specifically proposes building strong communities. The strategy addresses youth development, the impact of HIV/AIDS and TB and the way that the City is tackling the epidemic (CCT, 2008/2009).

Since the IDP is the overarching plan that is meant to guide all development activities within the municipal area, HIV/AIDS mainstreaming needs to be reflected in the plan (that is, a holistic approach to health care needs to be adopted). Preparation for the IDP review process must ensure that a participation mechanism is in place and sufficiently accessible to all within the municipal area. This is to ensure a proactive approach that will enable marginalised and vulnerable people, including people living with HIV/AIDS and people in informal settlements, to fully participate in the process (DPLG, 2007: 15-16).

The HIV/AIDS prevention programme is captured in the City Health’s Business Plan as indicator which is measured for performance (City of Cape Town, 2008/2009). The number of VCT sites and people accepting VCT are monitored. The number of condoms distributed and outreach prevention programmes are also monitored. Health education talks are given at schools and youth programmes (such as adolescent-friendly initiatives) are encouraged. There are multi-sectoral action teams consisting of NGOs and CBOs established in all sub-districts to address HIV/AIDS and TB issues in the communities. The establishing of multi-sectoral action teams is one of the capacity-building strategies aimed at empowering communities.

All City health facilities provide HIV care and in each sub-district there are ARV programmes (in one or two clinics) established to treat HIV-positive patients. In implementing the HIV programme the City Health Department has entered into partnerships with NGOs by signing contracts with these organisations. These organisations operate directly at grassroots level in the sub-districts where clinics and community health centres are located. An organogram of National Health, Provincial Health and CCT (Municipal Health) follows. The NDoH develops policies

that are cascaded to all provinces and, for this programme specifically, to PGWC. The HIV/AIDS programme is housed in the Department of Health. The PGWC health directorate has delegated some of the health programmes to City Health Department, including the HIV/AIDS programme. City health has eight sub-districts rendering this service in the clinics. These clinics work with NGOs and CBOs, which assist in driving the programmes contributing to HIV/AIDS prevention strategies in the form of MSATs. The structure below depicts how NDoH relates to other levels of government down to community level, where clinics deliver this service.

ORGANOGRAM FOR NATIONAL, PROVINCIAL AND LOCAL AUTHORITY

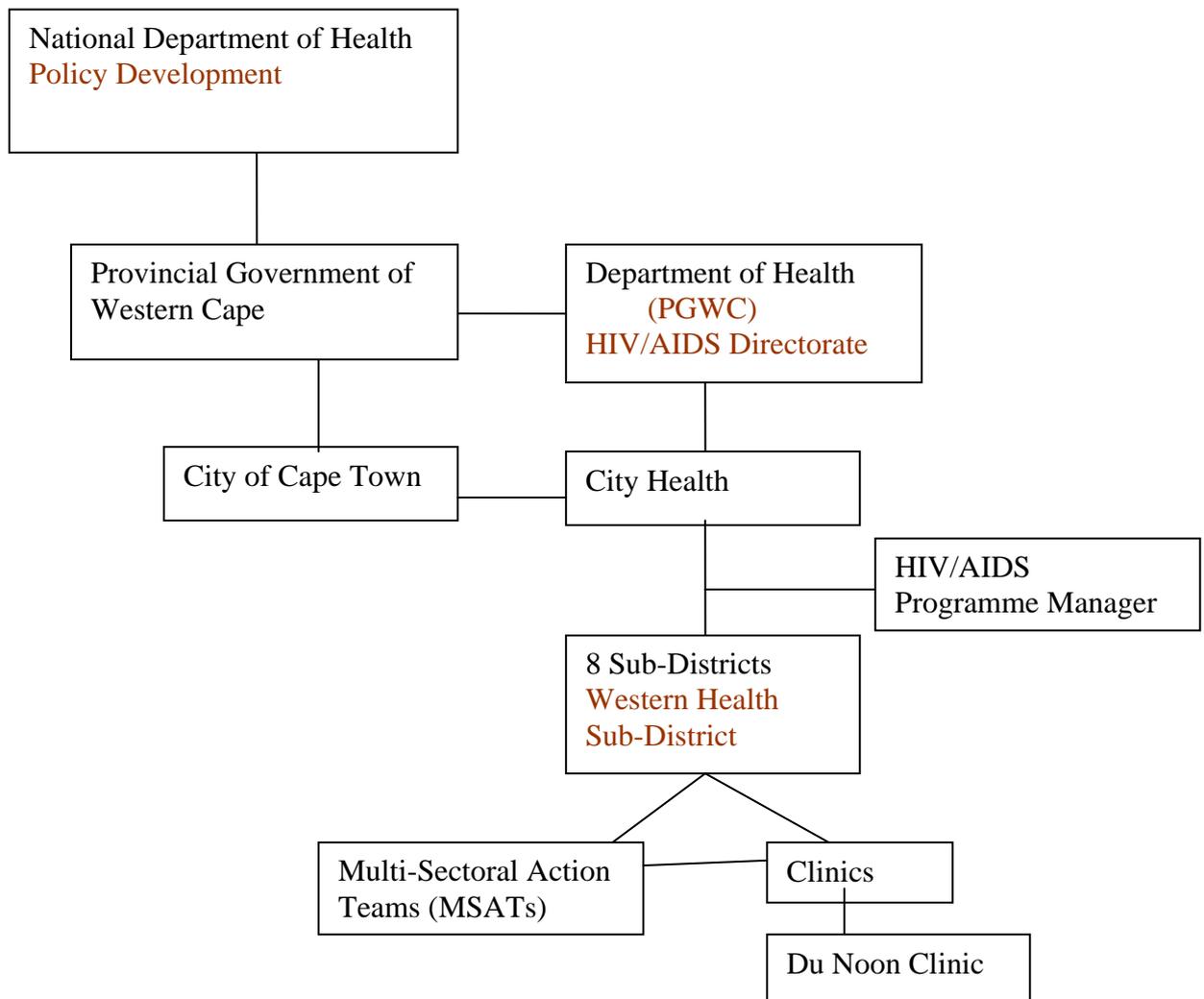


Figure 4.1: Organogram for National, Provincial and Local authority

The organogram also shows that NDoH and PGWC decentralize service delivery.

The next section will discuss the implementation of the PHC programme in the Western Health Sub-District and the role played by CBOs in the community.

4.6 HIV/AIDS APPROACH IN THE WESTERN HEALTH SUB-DISTRICT

The Western Health Sub-District is one of the eight sub-districts of the CCT. The sub-district does not carry the highest load of HIV-positive patients as it is at 9%. Khayelitsha carries the highest load at 22% followed by Eastern at 16% (CCT, 2008/2009). This sub-district consists mostly of middle and upper class income groups with pockets of low socio-economic groups (Statistics 2001). The low socio-

economic groups are thinly spread throughout the sub-district and live mostly in extremely adverse conditions that make them prone to diseases associated with poverty. The interest in studying the sub-district is to assess PHC services and the way in which the ARV programme is delivered to reach the intended communities.

The Western Health Sub-District implements the CCT's health policies in the HIV/AIDS programme. The sub-district has ten facilities that render PHC services from Monday to Friday, eight hours a day. There are also four satellite facilities that open two days a week and one mobile service that visits farming areas and informal settlements three days a week. All facilities provide HIV care. Condoms are distributed in clinics and communities. There are sites that have been established to render such a service and condom dispensers have been installed in public toilets and libraries. Other areas have been identified by staff such as taxi ranks and factories, where condoms are supplied.

Health care education is a continuous process at the health facilities and all facilities are accessible for such service. VCT lay counsellors are employed by NGOs to market and offer VCT in the facilities. There are also CHWs (also called DOTs supporters) who assist with the supervision of TB treatment. The adherence counsellors have been trained to work with the HIV-positive patients and assist in supporting and encouraging patients to comply. Tapia *et al.* (2007: 30) suggest that "representatives of the affected individuals and groups should be involved in the design of participatory evaluation activities". They claim that participation of those who were traditionally excluded in activities pertaining to their well-being will empower them to participate in and initiate health and development projects that are culturally appropriate and that respond to their needs. This view is supported by the researcher, because the inclusion of beneficiaries in decision-making and implementation of programmes will be viewed as a bottom-up approach that will lead to ownership of projects.

There is also a PMTCT programme that has been implemented at all the facilities. The staff working at the facilities are required to be competent in all areas of work. Training is offered to meet the challenges of the job and there is ongoing in-service training. Awareness campaigns and outreach programmes are rendered by the staff. Clinic managers and clinicians work jointly at the coal face of service delivery and have first-hand experience of the service (Abdullah, 2004: 259). The district so far

has established only three ARV programmes in clinics out of ten facilities assisted by ARK. Despite many good intentions and plans, not much has happened yet, because of a lack of resources (human and financial). It is a long process to establish these ARV programmes in clinics, because they require infrastructure and to have that in place is time consuming. It is the intention to have all facilities providing this service. Hence HIV care is provided in all facilities and the patients are referred to clinics that render ARV programmes to commence their treatment. The management model of the ARV programme has been hailed as an important factor in the success of the programme.

Figure 4.2 below shows the participation of NGOs, TB/HIV Care and Leadership South at clinic level. Each NGO is responsible for a certain category of CHW, as the organogram shows. Their role and functions have been discussed above. These CHW are supervised by the clinic manager and support the programmes in the clinic. The CHW are not working in isolation in the clinic. Chapter 5 will show a clinic staff organogram with NGOs and discuss interactions between clinic staff and CHW.

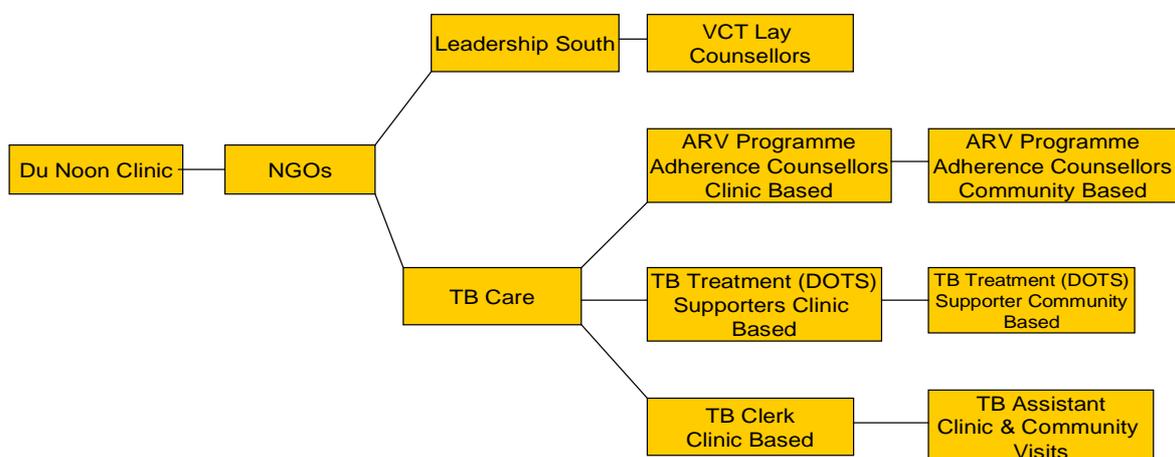


Figure 4.2: Organogram of NGO activities in Du Noon

The clinics are managed by clinic managers and there are professional nurses (PNs) who render PHC services with enrolled nurses (ENs) and enrolled nursing assistants (ENAs). The TB/HIV/AIDS coordinators and clerks support the programmes in the

sub-district. The ARV sites have the advantage of additional staff, namely a doctor, clinical nurse practitioner (CNP), pharmacist, pharmacy assistant and data capturers. For all the services rendered data are collected by all the staff in all the areas of work. By the end of the month the statistics are compiled by the clerks with the clinic manager and sent to the Health Information Officer of the sub-district for collation and validation. The organogram depicting staff at clinic level is presented in Chapter 5 (see Figure 5.2).

In its approach to HIV the programme appears to be the same internationally, nationally, provincially and at local authority level. The strategies have been planned by officials, politicians and interested groups for people infected and affected by the disease. There are, however, no obvious participatory forums internationally, nationally and locally where the beneficiaries of services or communities are requested to give an input about their wishes or needs. This is seen as a prescriptive process in which patients cannot exercise any choices when they wish to enrol for treatment. Their enrolment is determined by the staging process that informs the extent of the disease and in practice it is found that treatment usually commences at a late stage of the disease. This kind of "participation", as described by Theron and Ceasar (2008: 113), is based on the International Association for Public Participation's level 2 (IAP2), which is aimed at "consulting" the community, for example, during briefings. This is disempowering as patients are not given choices and obtaining treatment means disclosing one's status to a family member, even if one is not yet ready to do so. The quality of counselling to the patients is of a low level, because of the quality of training afforded to the lay counsellors, which may in turn be ascribed to their low level of education.

4.7 CONCLUSION

The approach to PHC internationally and nationally in the implementation of the HIV/AIDS programme is to strengthen prevention strategies in combating the spread of the disease, empower communities by providing awareness through education and encouraging community participation. The focus is more on prevention, because there is no cure for the disease and the spread of infections can be prevented. The spread is controlled by expanding and strengthening the prevention programmes, such as distributing condoms, providing free STI treatment, offering VCT in all facilities, awareness campaigns and presenting outreach programmes.

PPPs are encouraged by strengthening relationships with NGOs, the private sector and CBOs. The ABC principles are reinforced and condom distribution has been emphasised. The importance of pMTCT programmes and providing HIV care in all facilities has also been emphasised. The ARV clinics have been introduced through Médecins sans Frontières, ARK and other organisations where treatment is provided to HIV-positive patients who qualify to be treated. The ARK approach in initiating ARV programmes in clinics seems acceptable and the CCT has adopted the same approach in all its clinics that are rendering the service.

Government and NGOs, together with CBOs, seem to be doing more than in the past in creating awareness, educating the community and providing them with condoms to prevent the spread of infections. The question that needs some answers is what the community is doing to meet government halfway in preventing the spread of the disease? Little emanates from the community, because it is a fact that children are seen playing with condoms for making balloons. Secondly, boxes of condoms have been seen dumped with trash for disposal. It seems HIV/AIDS is not yet taken seriously by the African (Black) communities, hence there is still an increase in the number of new infections. There is no concrete evidence to support the above statement, but based on observation, a participatory action research strategy used to share information and testing precautionary measures with those around the researcher, there seems to be a lack of seriousness in implementing precautionary measures. Gardner (2004: 25 - 26) describes participatory action research as "removing the distance between the objective observer and subjective subject and includes the community being studied as an active participant in the research, with an end goal of empowering the community being studied".

Bearing in mind the international, national and local contexts described above, the next chapter will analyse the HIV/AIDS programme at Du Noon Clinic in Cape Town. This clinic has been chosen because of its history and its location in a low socio-economic area which makes its patients vulnerable to many of the challenges discussed in this chapter. Secondly, the researcher wishes to assess the effectiveness of the programme in preventing and treating HIV/AIDS.

CHAPTER 5

ADDRESSING THE HIV/AIDS PROGRAMME – THE CASE OF DU NOON CLINIC

5. 1 INTRODUCTION

The HIV/AIDS programme in the implementation of the PHC package at Du Noon Clinic, Table View, is the focus of this chapter. The researcher will analyse this facility in respect of its creation, the present infrastructure and the functioning of the health delivery system. The chapter will also reflect on the role played by community health workers in the clinic and at community level.

5. 2 BACKGROUND TO DU NOON CLINIC

Du Noon is a mixture of a formal and informal residential area situated along the N7 highway towards Malmesbury. It is five kilometres away from the Caltex refinery near Milnerton and on its western side is the middle- to upper-class area of Table View. The area itself previously consisted of informal settlements and government-provided RDP housing. To obtain information on this area the researcher visited the old Blaauwberg Administration offices to search for information that would provide clues about its establishment. There is a file in the archives of the Blaauwberg Administration (CCT, 2001) with the reference number B 33/2/1/1, which contains limited information about the facility. What has been captured relates to the squatter camp population of 9,990 for Table View, Milnerton, Marconi Beam, Du Noon and Joe Slovo, with an estimated growth rate of 9-11% per annum. The contents of this file mostly refer to the construction of new health facilities, consisting of private and public hospitals and clinics. It is thus safe to assume that the Du Noon Clinic would not be reflected in earlier statistics, as it is not an established clinic.

Previously the community of Du Noon attended the Table View Clinic to access health care. The majority of people in this area are unemployed and migrated to Du Noon mostly from the Eastern Cape to seek employment. To complicate the matter, there are no resources within close proximity. The storage building that was previously used by Power Construction to store building material was identified by the community as a suitable site for health services. After completion, the building was donated to the City Health Department. This happened after the community initiated the request that this building should be converted into a clinic. The community consulted the then Health District Manager for Blaauwberg

Administration to assist with the rendering of health services in what was basically a container. As the structure did not meet health standards to render services, renovations had to be made and the Planning and Commissioning Unit was tasked with making structural improvements to the building.

In 2003 Du Noon started to function as a satellite clinic of Table View (see Annexure A - Structure A). All services were rendered in this structure, but because of a lack of space, bad light, inadequate ventilation and the sheer volume of patients, it became impossible to perform pap smears and examine for STIs.

In due course there was a noticeable increase in the numbers of all categories of patients, especially those diagnosed with tuberculosis. It became evident that the majority of these patients were also HIV positive and had already commenced ARV therapy. An article in the *Cape Argus* (2009) 'SA ahead of its ARV treatment' stated that former Health Minister Barbara Hogan had said that the government was ahead of its target of providing antiretroviral treatment to people with HIV and AIDS. At that stage the nearest facilities to Du Noon which rendered such services were Somerset Hospital and Langa Clinic, both being far from the area. Dr P Naidoo, who was project manager then for TB/HIV/AIDS/STI in the CCT, through PGWC consulted with ARK to render HIV services at Du Noon Clinic (CCT, 2004). Figure 5.1 shows the figures of newly registered patients on the ARV programme per annum since its inception in 2004 according to gender and children enrolled on the programme. Figure 5.1 will be discussed in more detail in Chapter 6 under presentation of quantitative results.

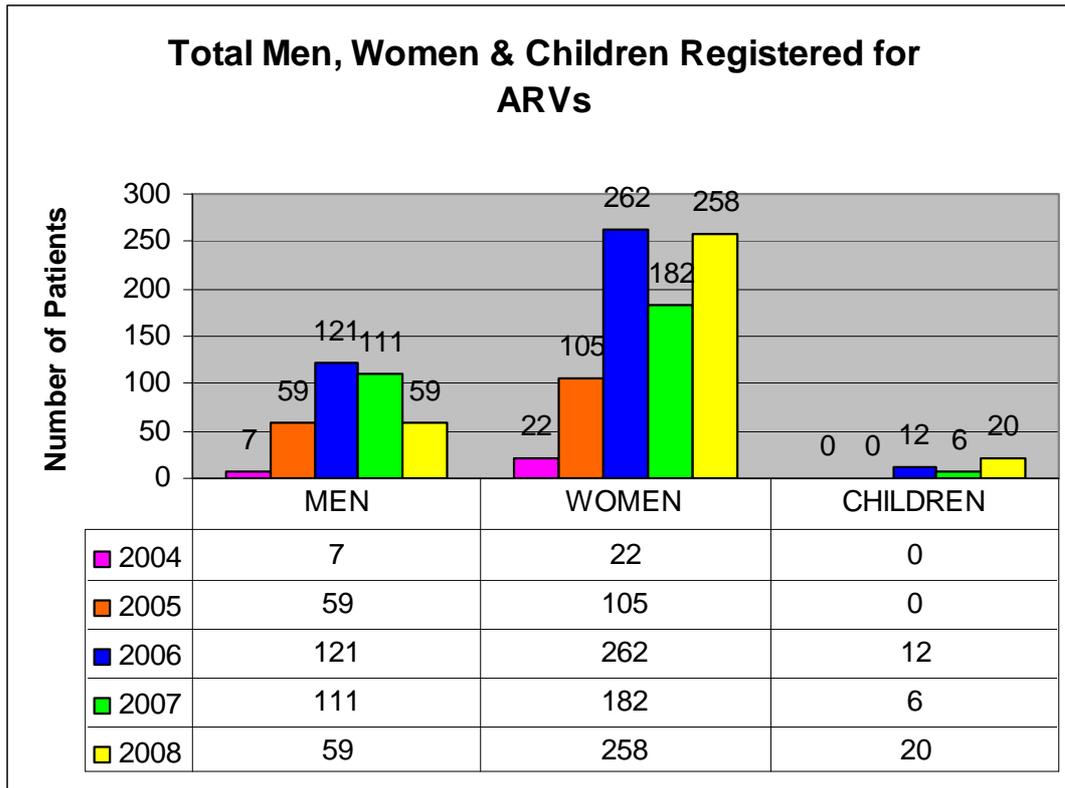


Figure 5.1: Total men, women and children registered for ARVs

Source: The Du Noon ARV Register.

In 2008 Dr Jennings, who is currently working for CCT as TB/HIV/AIDS/STI project manager (previously worked for ARK), stated that in August 2004 Dr Pienaar (her colleague) started ARV services with other ARK staff members at Du Noon. The clinic was soon bursting at its seams with all the programmes rendered in this small structure. The HIV programme was rendered every day; other programmes were rendered two days a week. In introducing the HIV/AIDS programme at this clinic the CCT was fulfilling its mandate, as discussed in a previous chapter, relating to the IDP.

In the next section the researcher will discuss PHC services in the implementation of the HIV/AIDS programme at Du Noon clinic.

5.3 PRIMARY HEALTH CARE SERVICES AT DU NOON

Despite the space problem at Du Noon, patient attendance continued to increase and a need for additional space was identified. The voting station that was used in the 2004 elections was handed over to the City Health Department in 2005. The Planning Commissioning Unit (CCT) was given the task of converting the container

into consulting rooms and a waiting area that would be used mainly for various mother-and-child programmes so that these patients did not need to wait in a single waiting area in structure A with poor ventilation. The STI patients would be examined in these consulting rooms so that pap smears could also be performed. The renovations to structure B (see Annexure B) were completed in 2006. As from that date all services were rendered every day at Du Noon Clinic and Table View Clinic became a satellite clinic as the numbers of daily attendants there dropped significantly. This is despite the fact that the latter clinic is built of bricks and bigger than Du Noon.

Even so, the two structures were not sufficient to cope with the daily activities and additional staff were employed to render the services. There was an increase in family planning patients; under-13 curative services, immunisation, STI treatments, tuberculosis and HIV-infected patients. A need was also identified to accommodate basic ante-natal care (BANC) for pregnant women, because there was no other ante-natal care available nearby. The lay counsellors did not have any space in which to work and, therefore, ARK donated some containers (see Annexure C) that would be used mostly by the relevant lay counsellors for voluntary counselling patients. The BANC programme and the doctors who visit the clinic once a week are also accommodated in this building. The programmes still rendered in structure A deal with TB and HIV/AIDS, but the structure also still serves as the clinic's main building, because the record room, phone system and fax machine, staff tea room, pharmacy and clinic manager's office are contained in this building.

5.3.1 HIV/AIDS PROGRAMME

“The HIV treatment programme presents extra challenges to the fragile public health system. The treatment protocols require skilled health workers with access to high-quality laboratory services both of which are scarce in many parts of the country” (Stein & Erasmus, 2005: 5). The provision of ARV treatment provides a great opportunity to save and improve the lives of many thousands of people. It also presents the challenge of developing a high-quality, equitable and sustainable delivery system (Stein & Erasmus, 2005: 8).

The HIV/AIDS programme, which relates to the provision of antiretroviral treatment, is funded through global funds in the CCT. All the staff employed in the programme

work on fixed-term contracts that are renewable. They are employed by CCT which claims their salaries from the Global Fund. The following staff members are employed in the programme: one doctor, one pharmacist, two clinical nurse practitioners and two data capturers. The patients seen in this programme are referred patients from hospitals, surrounding clinics and community health centres, as well as patients within the clinic from other programmes.

“Eligibility for ARV treatment in the programme is determined by criteria that combine an assessment of the clinical and social conditions of candidates, as well as of their anticipated ability to adhere to ARV treatment. Only people who attend the HIV clinic regularly and who stay in the area are considered for ARV treatment” (DoPH, 2003; DPH - UCT, 2003; PGWC, 2003; MSF, 2003: 3). These patients have to undergo a number of stages before they are registered in the ARV programme. In the enrolment process the candidates’ anonymous dossiers are presented to a committee of community members, people living with HIV/AIDS and clinicians, who make the final decision on enrolment based on clinical, social and adherence criteria. From the referral points they convey the necessary information to the staff in the programme who are then able to decide where and when to start with intervention (HIV staging). It is important to mention at this stage that the blood test results for viral load and CD4 count (blood-cell count) determine the admission of these patients on ARV programmes.

The VCT lay counsellors (CHWs) ensure that pre-test and post-test counselling is done and recorded with other matters that have been discussed. These include the need to provide patients with condoms and literature for those who can read, and they are also referred for family planning. These patients are afforded the opportunity to meet with adherence counsellors (CHW) to discuss the process of disclosure to the family or to one member who will be supporting him/her with treatment. This process takes a long time as it assesses the state of readiness of individuals and, when necessary, they are taught about medication. The adherence counsellor visits the patient at home for support and strengthening relationships within the family.

The position of the patients who are going to be admitted to the programme is then discussed by all the staff working in the programme, assessing their state of readiness. The patients are guided through all the stages of treatment, recording the treatment intake and all the side effects they might be experiencing. The patients are

encouraged to form and join support groups. The doctor and the clinical nurse practitioners see and examine these patients and prescribe the treatment according to the relevant protocol. The pharmacist dispenses the medication and captures these patients in his/her database. He/she also educates the patients about the importance of adhering to treatment times, while taking note of any side effects. The details of these patients are then captured in the manual register and on the computer by the data capturers. An average of 15 new patients is registered per month and they are seen together with monthly repeat medication patients. It must be mentioned that there are criteria used to register patients to the programme, and the patients do not choose when to be registered. They also do not choose to have adherence counsellors; this is part of the package of HIV care. There are two adherence counsellors who are clinic based and are employed by an NGO, namely 'Leadership South'. The other staff complement is shown in Figure 5.2. Once treatment commences, the patients are given monthly return dates and they are allocated to, and monitored by, adherence counsellors in the community – called CHWs – and who are employed by an NGO called TB/HIV Care. The patients are also monitored through monthly visits in the clinic.

At the end of each month the data capturers, together with the clinic manager, compile the monthly statistics and they send these to the Health Information Officer to collate and validate before sending these data to the Health Information Manager for consolidation and finally submission to PGWC. The pMTCT programme, VCT, education about the disease and provision of condoms are not confined to the ARV programme, but they form part of the HIV care plan in the clinic where other staff members are also involved. The programme at the moment is running as a vertical programme and it is driven by ARK. All other programmes in the facility are integrated and the majority of these patients are co-infected with both TB and HIV. It would be ideal for the researcher in assessing the effectiveness of the programme to argue the relevance of integrating services to meet this need.

In the next section the researcher will discuss the role of CHWs in the implementation of the HIV/AIDS programme.

5. 4 ROLE OF CHWs

The CHWs are community-based generalist health workers who combine competencies in health promotion, primary health care and health-resource networking and coordination (DoH, 2001). Welford *et al.* (2008: 14) argue that "at the start of any initiative regarding the fight against poverty, gather the input of people living in poverty". There is no evidence in the events leading up to the establishment of this facility that suggests community participation in decision making.

Communities are suppose to establish (or have) "Health Committees," a recognised structure that becomes a link between the clinic and the community. This body is the "eyes and ears" for both groups and is supposed to participate in all decision making activities that pertain to the community. The objective of community health committees/forums is to address the health needs and concerns of their respective communities. Members are recruited from all structures in the community to represent the interests and needs of the community. The clinic manager and one or two staff members serve as *ex-officio* members in community meetings (Jacobs, 2006: 7).

As stated by Ceasar and Theron (2008: 149), "the role of CHWs as community change agents should be understood in the broader context and challenge of development, participatory planning, development partnerships, and community capacity-building and empowerment." The CHWs' role is to enter communities and households in order to engage with community members to determine their health needs and other service requirements. CHWs are assigned different tasks and as such bear different names and/or designations. Within the scope of their competence they provide limited health services to community members. Ceasar and Theron (2008: 164) are of the opinion that "a new approach is necessary to counter the HIV/AIDS pandemic – we need a radical new way of thinking and a holistic health approach". This approach would entail forging a partnership between the municipality, the community and CHWs. The CHWs are employed by NGOs; some are clinic based whilst others work in the community (DoH, 2001).

In this community and clinic there are different categories of CHWs, some of whom are clinic based. Ceasar and Theron (2008: 149) acknowledge the variety of titles

under which the CHWs are known and suggest that partnerships between them and health care professionals should be prioritised. There are VCT lay counsellors employed by Leadership South working full time in the clinic. Their core function is to counsel all those patients who wish to be tested for HIV. They refer patients to the nurses for testing and would also do post-test counselling. The Adherence Counsellors are also clinic based and employed by Leadership South to prepare patients for ARV therapy and to give support in adherence to treatment. The community-based Adherence Counsellors – also known as CHWs – visit patients and their families in the community to give support and monitor adherence on ARV treatment. The TB treatment supporters are based in the community and visit the clinic weekly to collect the treatment supply of those patients they are supporting. They supervise the daily intake of TB treatment by these patients. There is a strong move towards converting TB treatment supporters into adherence counsellors to jointly supervise both ARV and TB treatments.

At the clinic there is also a TB clerk and a TB assistant. The clerk works full time in the TB room, opens folders for TB patients, enters data in the TB register and files the laboratory results in patient folders. The assistant follows up treatment defaulters and collects sputum for those patients who need to be followed up in the community. These other categories of CHWs are employed by TB/HIV care association.

The CHW initiative is a government strategy to strengthen communities' abilities to empower themselves to participate in all local activities (DoH, 2001). They play a significant role in supporting the provision of health care services, especially in view of the shortage of health care professionals. These CHWs meet with clinic staff and other role-players on a monthly basis to discuss progress and problems as a form of monitoring the programme. Ceasar and Theron (2008: 153) state that "linked to the appreciation that complex health care issues should be addressed within the larger holistic context of challenges was the acceptance that health care strategies should ideally be addressed by following interdisciplinary approaches". The employment of CHWs by different NGOs makes their management by the clinic manager difficult, because they have immediate line managers to whom they report in their organisations. In the facility the clinic manager is the line manager. There is usually a breakdown in communication, because the CCT has certain expectations of these workers which more often differ from those of their own institutions. Their

accountability is split between the two organisations. The links between the health committee, the CHWs and their NGOs and the clinic need to be clarified to establish better working relationships.

Based on the discussion above, it is clear that health professionals need the support of CHWs in the implementation of the HIV/AIDS programme. The CHWs help in identifying the patients in need of support and care and they also refer patients to home-based care in the community. CHWs are used both in TB and HIV programmes. In the clinic they consult with professional staff and are guided in their actions.

Figure 5.2 depicts the staff structure of Du Noon Clinic, also the areas of work and reporting lines and how CHWs fit into the clinic structure. This structure is meant to show the staff component of the clinic, how it is managed and who manages it. This is in line with the national requirements of a PHC approach, where a facility is managed by one person and everybody working in it reports to this manager. The clinic manager then reports to the sub-district, where the sub-district management is based. Decisions about services rendered in the facility are taken at sub-district level before being reported at head office.

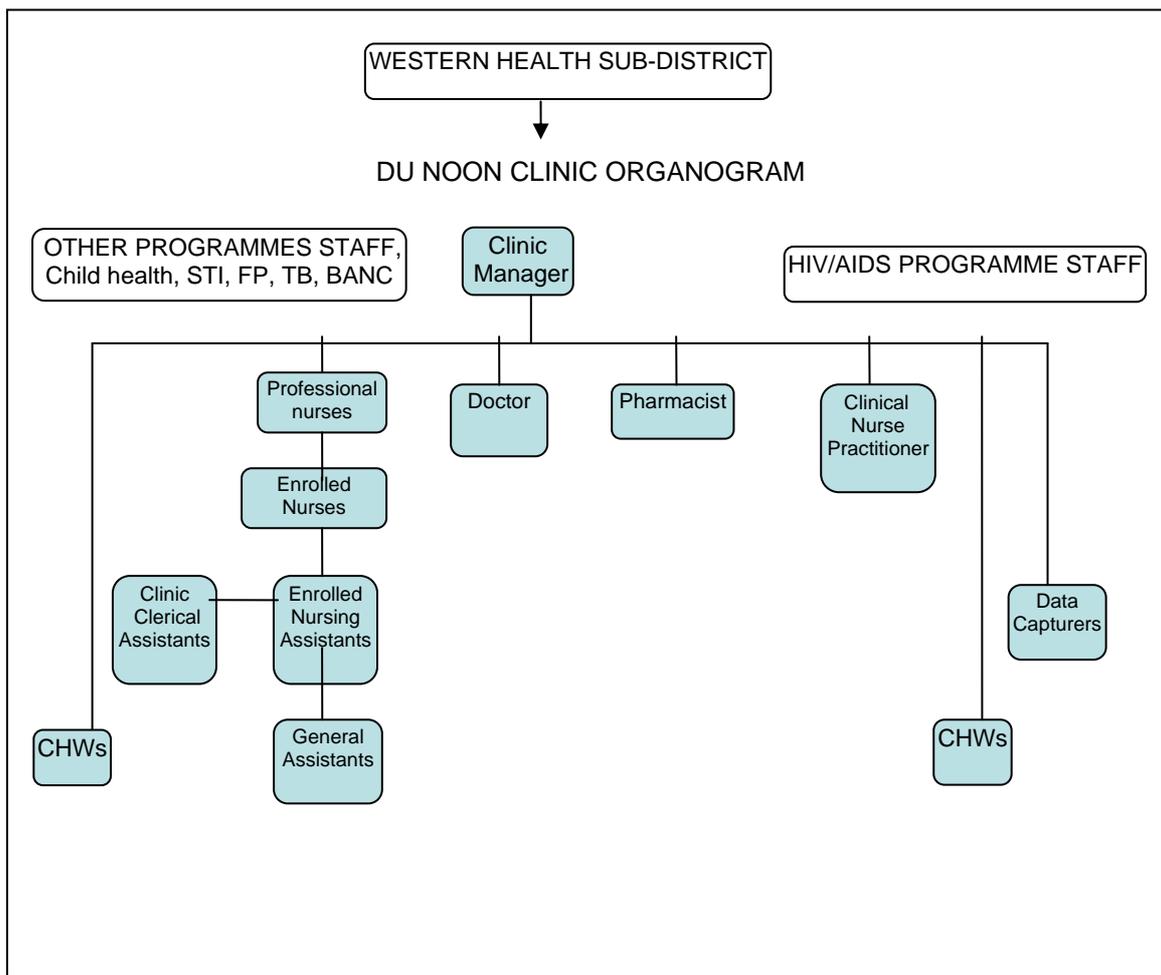


Figure 5.2: Western Health Sub-District/Du Noon Clinic organogram

5. 5 CONCLUSION

Faced by poverty and high unemployment, the Du Noon community took it upon themselves to request the establishment of Du Noon Clinic. They could not afford the costs of receiving health care at Table View Clinic. The current three structures were erected in stages to be used to serve this community. The implementation of the PHC package is inclusive of the HIV/AIDS programme and is in line with HIV/AIDS strategy as contained in the IDP of the CCT (CCT, 2008/2009). The implementation of the ARV programme was initiated by ARK, which later withdrew their staff from the services to allow CCT to take over management of the programme. CCT is delivering the HIV/AIDS programme in partnership with PGWC, NGOs and private organisations. The CHWs support the implementation of the programme in the clinic and at community level. The staff structure of the clinic is presented to show how the

programmes and staff interact in the clinic and how they relate to CHWs. There is lack of coordination between all these health workers and a need has been identified to link them with the health committee.

The lack of development and empowerment is a cause of concern in this community. There are different categories of CHW fulfilling different roles, but there does not seem to be a link between the clinic and the community. Do these CHW and their NGOs with CBOs serve the interests of this community? This question needs to be explored by health officials so that these organisations can work together for the benefit of Du Noon community.

In the next chapter the researcher will, present, interpret and discuss research results.

CHAPTER 6

PRESENTATION AND INTERPRETATION OF RESULTS

6.1 INTRODUCTION

The problem statement and research hypothesis examined the effectiveness of the ARV programme in meeting the needs of the Du Noon community. The objectives have been to monitor whether the programme is measured for effectiveness, if there are norms and standards established and if services are accessible to the community of Du Noon. Based on the information gathered, the researcher will analyse and interpret data collected to assess if the questions posed in the problem statement and hypothesis are answered.

Analysis of the questionnaires for both patients and staff revealed a number of factors that could be associated with effectiveness and affordability of the ARV programme. Certain themes like being satisfied and dissatisfied with the ARV programme emerged in the interviews and these will be discussed in the following sections. Statistical analysis (quantitative data) and results will be presented and interpreted first, followed by the presentation, analysis and interpretation of qualitative data.

6.2. PRESENTATION OF QUANTITATIVE RESULTS

The data have been gathered from the RMR and ARV register kept up to date by the data capturers. The information is subsequently submitted to the Health Information Officer for collation and validation. The ARV programme is quite a new programme that started to register patients in September 2004. It should be noted that for this year (2004) the statistics cover only four months. As expected, there were only a few patients, 32 in the first four months, but there was a significant increase from one month to the next.

In 2005 a steady increase was evident during the 12 months. Figures increased more than fivefold from January 2005 with only 39 patients and in December 2005 there were 211 patients enrolled. This might be associated with the fact that the community became aware of this service and patients had the courage to enrol on the programme. This could also be associated to the work of CHWs, who might have created awareness in the community to spread the news about the ARV clinic during their door-to-door visits.

During 2006 there was a steady increase in the number of patients registered for the programme, but not as high as 2004 and 2005. This steady increase could be

associated with the number of staff employed to render the ARV programme; however, no additional staff were employed. The doctor was working half day with one CNP employed full time. This would mean that there was an increase in staff workload and with these minimum levels of staff members they could register only minimum numbers of patients. Figure 6.1 indicates a linear tendency which confirms the steady increase in number of registered patients in the ARV programme.

From 2007 it is evident there is no longer a monotone and a linear tendency. During January to March 2007 the increase in patient registration continued, but dropped for the first time in April 2007 and May 2007. During this time a second CNP was employed to assist in the programme to reduce staff workload, but the researcher would find the decrease in numbers difficult to associate with a single reason. Because Du Noon is a mobile community, most of the residents come from the Eastern Cape and there are pockets of foreigners scattered in the area who return home from time to time. There was also a new ARV programme established in the Brooklyn Chest area (Albow Gardens Clinic). The patients might have assumed that it would offer better or different services from those at Du Noon.

The programme seemed to be in a stable phase with only small increases and decreases in the number of patients. This could also be associated with an aggressive approach by NGOs in educating patients about adherence to treatment and placing them under DOTS Supporters to monitor compliance. The clinic staff also continued to give health education and promote safer sexual practices, including distribution of condoms at the clinic and amongst the community. The mobility of the community would remain a challenge to the programme, because there were patients who became lost and whose whereabouts had to be followed up/traced.

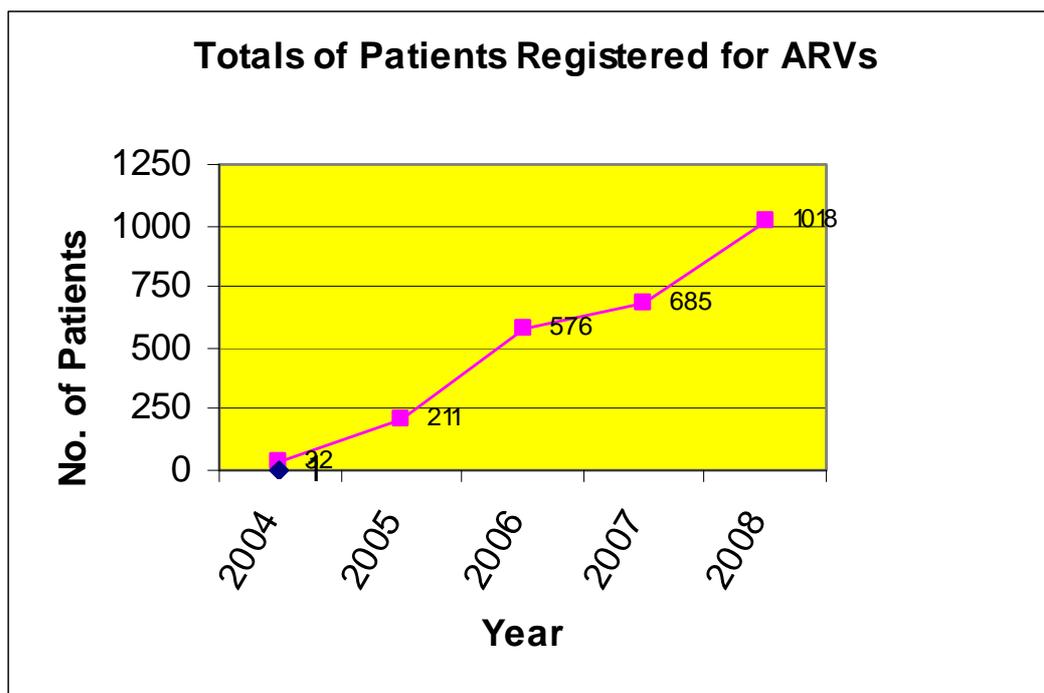


Figure 6.1: Totals of patients registered for ARVs 2004-2008

The number of patients registering for the programme (2004–2008) increased from 12 to 1,018. The reason for the increase can be associated with the number of new patients infected with HIV. Migration can also be associated with new patients registered on the programme. Despite the preventive measures that are in place – popularly explained as "ABC – Abstain, Be faithful to one partner and use Condoms (Condomise)" – people continue to be infected. The high rate of unemployment may be associated with an increase in the numbers of infected people as has been evident in the results of the group interviews. The researcher assumes that as a result of poverty and unemployment with more time at their disposal they indulge in too much alcohol that clouds their judgement and they end up engaging in unprotected sex.

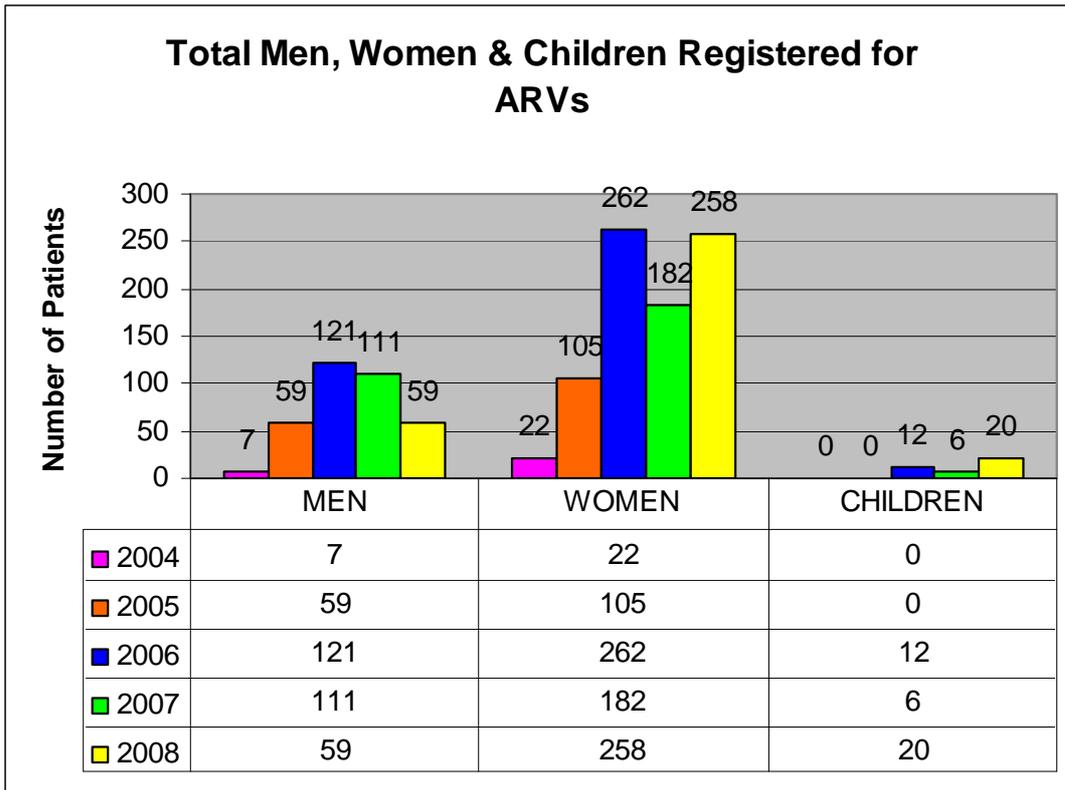


Figure 6.2: Total of men, women and children registered for ARVs 2004-2008

Figure 6.2 shows a comparison between men, women and children registered for the ARV programme at Du Noon Clinic from 2004–2008.

MEN

From 2004 to 2006 there was an increase in the number of registered male patients in the ARV programme. The increase from 2004 to 2005 was more than fivefold and from 2005 to 2006 was twofold. In 2007 there was a steady decrease of registered male patients, with 2008 seeing almost a 50% decrease in the number of registered patients.

WOMEN

Since 2004 there has been a rapid increase in the number of registered female patients. In 2005 the figure increased almost fivefold from 22 patients to 105 patients. In 2006 this figure doubled and 262 female patients were registered. There was a steady decline noticed in 2007, when 182 female patients were registered. The following year (2008) saw a steady growth in number of registered patients.

CHILDREN

Very few children have been registered for the ARV programme since 2004. In 2006 12 children were registered and in the following year the figure dropped by half and only six children were registered. In 2008 the figure increased more than three times the number of children registered for the programme.

COMPARISON OF MEN AND WOMEN

There was an increase in figures of registered female patients every year compared to the number of registered male patients. In the first three years of the implementation of the programme (2004-2006) both male and female patients registered in the ARV programme increased dramatically, but in 2007 there was a steady decrease in both male and female patients registered. In 2008 the figure of registered male patients decreased by almost half, as only 59 patients were registered compared to the sharp increase in the figure of 258 registered female patients.

The study has shown that there is a high unemployment rate in Du Noon among both males and females and so the majority of patients registered for the ARV programme are poor. As a mobile community the migrant factor might contribute in the spread of infections as a result of multiple partners. The low figures of children registered for the programme may be associated with the success of the pMTCT programme that was introduced from 1999 in the Western Cape. It is apparent that the provision of pMTCT has reduced mother to child HIV transmission from 30% to 5% in Khayelitsha; the pMTCT programme is provided in all districts (Isandla Institute, 2007: 31).

6.3 INTERPRETATION OF QUANTITATIVE RESULTS

It is evident from data presented above that there is a need for effective PHC services at Du Noon to enrol patients on the ARV programme. There has been a constant increase in the numbers of patients enrolled in the ARV programme. All the figures reveal the upward trend in new enrolments especially of women, but 2007–2008 saw a steady decline in the number of male patients being registered. This enables one to gauge the ARV programme's contribution to the improved health of patients. Because the clinic is new and not much data has been accumulated, it would be misleading to make conclusive deductions about the PHC services at Du Noon Clinic. Having said this, there has been a noticeable increase in condom distribution and the researcher assumes that males might be taking condom use

seriously, and hence there is a steady decline in their enrolment. The researcher does not want to lose sight of the fact that cultural beliefs are still entrenched in this community, consulting traditional healers is still practised, and the belief that the certain inhabitants are bewitched still prevails. This came up when some patients explained that they sought medical assistance late as they were using home remedies including traditional medication and herbs. There is a need for aggressive education, which could be provided by CHWs through door-to-door visits as an intervention strategy.

6.4 PRESENTATION OF QUALITATIVE AND QUANTITATIVE RESULTS

The questionnaire contained both qualitative and quantitative questions. Analysis of respondents' answers revealed themes that could be organised into two categories: positive and negative experiences brought about by enrolling in the ARV programme. These were classified as "satisfied and dissatisfied" by the service. The frequencies of the themes in all the groups were noted. The results are presented below.

PATIENT QUESTIONNAIRE

Question 1

Describe according to your experience the difference brought by the ARV programme on yourself.

Response:

All participants claimed that the programme has brought about changes in their lives. They reported that they have regained life and have developed a positive attitude about life. The participants felt that they have been given a second chance to live. These positive responses came frequently from all patients as they were expressing satisfaction about being afforded the opportunity to enrol on the ARV programme.

Question 2

How did you feel when you got enrolled in the ARV programme?

Response:

This aspect reflects how participants felt and the emotions they experienced on enrolment to the programme. All the participants interviewed felt good and relieved as they were anxious to be enrolled. They were longing for treatment and could not wait to commence. They were at last getting help, because their condition had deteriorated so much that they had no hope of getting their lives back. The

participants had accepted their condition and regard that the treatment is meant for any other chronic medical condition. The participants were of the opinion that even if they had been told that the treatment was poisonous, they would not be willing to stop it because they had improved. The feeling of satisfaction when they enrolled in the programme came up frequently as these patients commenced treatment when they were very sick.

There was dissatisfaction cited by some participants. They were not happy because they were not working and had fears about drinking medication on an empty stomach. They also cited painful experiences they went through during the initial stages of treatment that created the impression that they would not be able to stick to treatment times. There was also shock experienced because treatment is for life. There were participants who felt depressed and sad as a result of the side effects of medication. The side effects of the drugs are so bad that they could decide to stop medication; hence they have to be counselled extensively about not stopping their medication. These negative sentiments were not cited because of dissatisfaction about enrolment on the programme, but because the participants experienced fears. The frequency was low and these sentiments were expressed at the initial stages of treatment.

Question 3

As a patient participating in the ARV programme, what emotions have you experienced?

Response:

There were both happy and sad moments. The respondents were excited by participating in the ARV programme. They used words such as "there was joy, we felt good and happy, and we had hope for life and felt relieved". They expressed hope for a new life and this was felt and seen in their physical appearance. Those who experienced sadness after their enrolment were not aware of their HIV status until they underwent tests when pregnant and had to commence treatment. They had to learn to live with their condition and accept that it is for life. The sadness did not imply dissatisfaction with enrolment and did not come up frequently; it was expressing their emotions about their status.

Question 4

What experiences did you encounter while taking part in the ARV programme?

Response:

The problems raised by respondents ranged from poor accessibility, long waiting hours, staff shortages, and lack of privacy and confidentiality. The majority of participants expressed concern about the accessibility of the clinic in terms of time, not distance. They mentioned that they have to queue as early as 05:00 in the morning to be seen first. The gates are opened only at 07:30 and the result is that they wait a long time (more than three hours) before they are seen by the doctor and clinical nurse practitioners, and then they have to wait again at the dispensary. This dissatisfaction came up frequently as a concern in all the groups.

There were participants who raised the concern about shortage of treatment when it is counted on their return to recollect, yet they had not defaulted or lost treatment; there was also a complaint about record room staff to the effect that they delay in taking out the files and sometimes even lose them. The participants also complained about long waiting times. They expressed the wish to be separated from the mainstream clinic, because they understand each others' condition. The participants complained about lack of privacy because the two CNPs share a consulting room and there is only one waiting area for all patients. They expressed great concern about their privacy as they were unable to discuss personal matters pertaining to their health status. This dissatisfaction came up frequently (eight or nine times) from all the groups and almost from every participant.

There was a minority of participants who were concerned that they were referred to secondary hospitals or given prescriptions to get medication from the chemist when they raised complaints and they could not afford to buy the medication or travel to the hospital. All the participants felt that to be mixed with mainstream patients makes their HIV status known to the people whom they have not disclosed it to.

Question 5

Do you feel that the clinic is giving you the best treatment?

Response:

Of the 150 participants interviewed 88% (n=132) felt that the clinic gives the desired level of care and treatment every time it is visited. With every clinic visit they are monitored on compliance and continuity of treatment. They even claimed that "with every visit to the clinic we are asked frequently how we feel, we are never deferred and we are educated about our treatment". Furthermore they expressed agreement

and satisfaction with care compared to the small number of participants 12% (n=18) in partial to full agreement with continuity of care. This dissatisfied group was concerned about privacy in the consultation room used by the CNPs and stated that they would prefer to be treated by staff they can identify with (i.e. staff who are HIV positive) because they would sympathise and empathise with them. A concern was raised by 5.3% (n=8) participants about patients with dual infections who experience some difficulties with their treatment in the TB programme.

Question 6

Are the staff in the clinic helpful and considerate when they treat you?

Response:

Of the 150 participants interviewed 93% (n=141) indicated that they were pleased with the courtesy (attitude) of the staff. The level of satisfaction was measured by how often they expressed satisfaction (frequency) and cited practical assistance they receive from staff. Of this total percentage, 69% (n=98) felt that staff were treating them with dignity and respect and were very helpful. The remaining 24% (n=43) were neutral, associating their uncertainty with huge numbers of patients visiting the clinic and the number of staff seeing the patients. The majority of participants agreed with the statement that the clinic is providing humane care.

This aspect also reflects how well and with what expertise and knowledge the work is performed. It also indicates the learning experience from the patients' point of view. There was general agreement about the service being properly executed in that 74% (n=111) of respondents felt satisfied. Forty-seven percent (47%) (n=52) of this total percentage (74%) felt very strongly satisfied with the thoroughness and educational value of the programme. Therefore the majority of the participants (74%) were satisfied that the ARV programme was being thoroughly conducted and educational.

Question 7

Did the staff explain the ARV programme to you in full?

Response:

All respondents 100% (n=150) agreed that the ARV programme was explained in full by all health workers in different stations. They claimed that the staff made sure that they were ready for treatment before they could commence the programme. The respondents went so far as to report that the staff even assesses their own state of

their readiness as well as that of their treatment supporters, usually a family member brought along to the clinic. The emphasis was on the fact that patients are not registered for treatment if the staff are not certain that they are ready. They are taught about the consequences of defaulting and not sticking to treatment times. This response was frequently noted with almost every patient in all the groups.

Question 8

Do you have anything in addition to the above to state?

Response:

All respondents wished that they could be separated from the mainstream clinic, because they understand each other and looked forward to forming a support group. They expressed the wish to have their home conditions assessed when they commenced treatment. Since the majority of them are unemployed, they wished that there could be a way of providing financial assistance or food parcels. The participants also wanted clarity on the criteria used to qualify for disability grants and food parcels, also why these are discontinued after six months, yet the individual is not earning any income. Some of the participants enquired about what the word “defaulting” means and this was clarified immediately.

All of the participants felt that the government needs to build a new clinic because the existing clinic is overcrowded and does not look like a health care centre. They also requested clinic times to be extended, because there is no secondary hospital or emergency/trauma centre in the vicinity of Du Noon. There is also no maternal unit, whilst in cases of emergency they have to travel to Somerset Hospital or Vanguard Community Health Centre, so they need these services to be brought nearer to them.

6.5 INTERPRETATION OF QUALITATIVE AND QUANTITATIVE RESULTS

From the results of group interviews with patients conducted at Du Noon Clinic the following general findings are presented below.

6.5.1 Accessibility of clinic

The participants were generally satisfied with the accessibility of the clinic (for example, distance from homes, available transport and costs). The few patients using transport felt that there were enough alternative means of public transportation. The costs involved were reasonable, considering that they come for monthly visits only.

The presentability of the clinic itself, inside and out, evoked strong dissatisfaction. Dissatisfaction was strongly indicated about the three structures that did not have the proper appearance of a clinic. High dissatisfaction was also expressed about waiting times in the morning, because the gates are still locked. Most participants complained about the lack of privacy in consulting rooms. All patients in the group complained about the size of the waiting area and few complained about waiting for their records. These unsatisfactory conditions were the consequence of the vast growth in the numbers of patients over the previous years, numbers that were anticipated, but the pace of building the new clinic is very slow.

This also links directly with the dissatisfaction expressed about waiting times. The waiting time may be further reflection of staff shortages and an inefficient distribution of staff among different clinics, or it might be perpetuated by a lack of space for staff to work in, on top of which they also get deployed to other facilities. As much as these are perceived as problem areas, there is also an entrenched culture of visiting the clinic very early in the morning to be first in the queue. The clinic is not fully utilised in the afternoons, because the patients arrive in large numbers in the morning and as a result they have to wait and may only be seen in the afternoon. A change of mindset is necessary to educate the patients about flexible clinic times and an optimal utilisation of resources throughout the day. The CHW as change agents could be utilised in this instance to change the mindset of communities.

6.5.2 Continuity of care

There was general consensus about the continuity aspect of care as satisfactory. The participants felt very strongly about the quality and benefits of their return visits to the same staff, but the unfortunate part was that with the CNPs they had noticed that there had been some changes. It emerged that consulting the same doctor or nurse over a period of time had a positive influence on the satisfaction of the respondents. They had become familiar with the staff and had established a trust relationship.

From the patient perspective a relationship of trust develops between caregiver and the recipient of care when there is continuity of care. Disclosure and expression of feelings become difficult when a new CNP is sent from a nursing agency to relieve, as is sometimes the case. This sometimes compromises the patient's position and might result in non-compliance with treatment. The view and experience of the

researcher is that vulnerable groups tend to put their trust in health professionals, especially when a nurse/doctor-patient trust relationship has been established.

6.5.3 Courtesy/humaneness

There was strong agreement among participants about the courtesy of the service at Du Noon Clinic. They felt they were being treated with respect and dignity by the staff. The different categories of staff, professionals and support staff, were highly regarded as being helpful in running the programme. A small percentage of respondents showed dissatisfaction about the record-room process of admitting patients and taking out of folders.

The argument above creates the impression that the patients put their trust in health professionals. The caregivers apply the Batho Pele Principles in caring for their patients without creating dependence on staff. The patients are supported and monitored for compliance to avoid complications. It remains the patients' right to be treated with respect and dignity, despite race or creed and the health professionals have taken an oath to act accordingly.

6. 5. 4 Thoroughness and informativeness

There was a general satisfaction (average) among participants with respect to the thoroughness of execution of services at the clinic. Strong agreement was expressed about the service received from the doctor, CNPs and pharmacist. This might be due to their executing their job with skill and expertise and demonstrating the necessary knowledge in their respective fields. The majority of respondents indicated that their condition on enrolment was hopeless because of the disease, but with the help of the staff they feel they have been given a second chance to life.

The other aspect worth noting was the satisfaction with the amount of information that is shared with them on enrolment to the programme; most patients expressed satisfaction. They expressed their gratitude towards the staff who are patient in explaining the enrolment process and the difficulties they might encounter on treatment. The one aspect worth mentioning was the dissatisfaction – and at best neutrality – of patients about the number of staff going to tea and lunch at the same time, leaving the patients unattended. This might be a result of too few staff employed to render the service or staff numbers not growing in relation to the growing number of patients, because in these working stations there is only one health worker, except the CNPs, and during the period of the interviews the second

CNP was on maternity leave. However, on average the participants were satisfied with the quality of service they received from the clinic.

The patients enrolled for the ARV programme are mostly at the terminal stage of the disease. The high quality of care received from health care workers made them feel wanted and accepted; they felt a sense of belonging. The patients seem to have adopted an inferior status as recipients of care who do not have the ability to negotiate participation in the decision making about their treatment. Such an approach to health care could promote a culture of dependence on handouts instead of patients becoming proactive about their health care needs.

6.5.5 Overall effectiveness

The trend observed during the group discussions was almost unanimous satisfaction among participants about the ARV programme. On average this aspect of the service participants corroborated with the above statement that the service was effective in meeting their needs. Both men and women in the study shared the same sentiments. Another factor to consider was that fewer men participated in the group discussions – in fact, less than half the number of women – which shows that more women than men are enrolled in the programme in line with how the sample was drawn.

There appeared to be some concern about the waiting time before the clinic starts operating, as patients felt they spent too much time in the waiting area and at various points in the system. This dissatisfaction was expressed during all group interviews. This could have been expected because the Du Noon population has grown and the patient numbers are increasing steadily without a proportional growth in staff. The lack of staff expansion is directly related to the availability of space to accommodate additional staff (see Annexures A, B, C as clinic structures). Respondents expressed considerable dissatisfaction with congestion in the clinic with low temperatures in winter and high temperatures in summer, taking into consideration that old and young and infectious patients all wait in the same area. These clinic structures have poor ventilation.

A health outlet is traditionally regarded as a respectable place where one must take cognisance of the sick. However, it seemed that this had not been catered for at this clinic. The high temperatures are the result of structural defects as well as the large numbers of patients visiting the clinic and overcrowding, especially during peak time, and the consequent reduction of circulation of cool and fresh air. This situation is not

conducive to a health-enhancing environment. It may even increase health risks, because disease can spread more easily in the absence of proper ventilation.

6.5.6 Community participation

A service cannot be effective if no channels for participation are instituted and there is no interest among users in participating. During group interviews participants did not focus on the role they can play in assisting with problems they have identified. They were satisfied that help had come their way to alleviate their suffering. But a lack of knowledge about the nature of community participation was evident. This was tested with each group when they were asked for additional information and asked where they could lodge complaints if there was dissatisfaction with service delivery. The majority of patients did not know about patients' rights and responsibilities. They have also heard about the health committee, but none of them knew its role and function. This revealed a lack of a proper structure that enables patients to be involved in community development initiatives. There is a need to empower the Du Noon community to be proactive in issues that affect their health. A participatory process spearheaded by health professionals is necessary to create communication platform for communities.

6.6 Presentation of staff interviews

Five staff members were interviewed: the doctor, pharmacist, clinic manager, CNP and data capturer. The researcher must stress that these individual staff members were interviewed in their specific capacities and as such the results cannot be presented in percentages because the information would be misleading. Instead they will be reported as follows: technical proficiency, logistics, standards and norms and evaluation.

Technical Proficiency

Question 1

How did programme managers manage the ARV programme to ensure that it was effectively and efficiently implemented?

Response:

The staff generally felt that the programme managers did not do proper handing over of the programme. They all felt that the programme had been poorly managed once ARK had withdrawn with no proper feedback mechanisms.

Question 2

How did the programme managers according to your opinion address the integration aspects of the programme?

Response:

The doctor felt that attempts have been made to integrate the ARV programme with other programmes, but these had failed because of improper planning and resistance of staff to integrate; at the same time the atmosphere was not conducive to introducing changes. The clinic manager felt that integration was never addressed until problems surfaced amongst staff from all programmes. Apparently a meeting was then convened and there was no integration plan in place. The pharmacist indicated that a meeting was called with all role-players to discuss integration, but there was lack of participation and staff showed no interest. The CNP also indicated that integration was discussed, but there was lack of follow-up thereafter. The data capturer felt that the issue was properly dealt with.

Question 3

How did the programme managers according to your opinion address the uniformity aspect of the programme?

Response:

All the staff felt that the uniformity aspect of the programme was addressed through the development and setting up of guidelines and protocols. The programme managers trained staff on both ARV and TB programmes for a holistic view of the patient. The doctor, clinic manager and pharmacist felt that it was dealt with in a fair manner.

Question 4

Did the programme managers according to your opinion fulfil their obligation?

Response:

The staff was of the opinion that programme managers did not fulfil their obligations, because they did not pay attention to critical but avoidable problems that would have allowed the programme to run smoothly, such as shortage of staff. The doctor referred to times when there were no CNPs and there were still huge numbers of patients at 16:30 whom she had to defer. The doctor was also concerned about poor communication with staff about issues pertaining to the ARV programme. The clinic

manager felt that proper integration of the programme with other programmes would yield better results and that the ARV programme not be treated as a private entity but be part and parcel of other programmes. The clinic manager raised some concerns about programme managers who have not been visible in the clinic since the implementation of the programme.

Logistics

Question 1

What was the approach of PGWC in respect of the ARV programme to be rolled-out to your facility?

Response:

All the staff indicated that they do not know what the approach of PGWC was, since they were not working on the programme when it was implementation.

Question 2

For the roll-out of the ARV programme was this (Du Noon) the best site for the roll-out of the programme?

Response:

In responding to this question about the choice of the clinic the doctor, data capturer, clinic manager and pharmacist felt strongly that Du Noon Clinic was the best choice to implement ARV programme. Only the CNP felt that it was not the best choice mainly because of the size of the building. The explanation given was that initially, when the clinic was at Table View, it was far from the patients at Du Noon and they had to use transport.

Question 3

Were all staff employed in the programme properly trained?

Response:

The doctor and pharmacist indicated that when ARK initially implemented the programme all staff were trained. Since the programme was taken over by the Du Noon Clinic staff, not all of them were trained in that most of the time they use CNPs from nursing agencies. The clinic manager and CNP informed the researcher that the nurse had to be sent to another clinic for mentoring; otherwise she had to figure out herself how to run the programme.

Standards and Norms

Question 1

Did the programme management team have sufficient time to implement the ARV programme?

Response:

The doctor, pharmacist and data capturer were of the opinion that the programme management team had sufficient time to implement the ARV programme; the clinic manager was neutral on this point and the CNP felt that the team did not have sufficient time.

Question 2

Did the PGWC and CCT ensure that the implementation of the programme was properly dealt with?

Response:

When asked about the joint approach to the programme the doctor, clinic manager and CNP felt that PGWC and CCT did not ensure that the implementation of the programme was properly dealt with and the pharmacist and the data capturer felt that the two organisations dealt properly with the implementation of the programme.

Question 3

Do you think an outsider would regard the ARV programme as a process that was effectively and efficiently implemented?

Response:

When asked about the implementation process, the doctor and pharmacist felt that the programme would be regarded as a process that was effectively and efficiently implemented because the ARK team was properly trained. However, the clinic manager, CNP and data capturer felt that the programme was not effectively and efficiently implemented because not all staff were trained and there had been constant staff shortages. This apparently led to the use of staff from nursing agencies who were not familiar with processes and protocols of CCT.

Evaluation

Question 1

Do you think that the objectives of the ARV programme are well executed?

Response:

All staff felt strongly that the objectives of the ARV programme were well executed.

Question 2

Did the ARV project management ensure that all the objectives were correctly executed?

Response:

Four of the staff members, with the exception of the doctor, were of the opinion that the ARV project management team ensured that all objectives were correctly executed.

Question 3

Was the information and feedback regarding the ARV programme fully explained to the staff by management?

Response:

There was a strong feeling amongst all staff that information and feedback regarding the programme was not fully explained to the staff by management.

Question 4

Were any of the difficulties experienced by the ARV programme reviewed by management?

Response:

Three of the staff members – the doctor, data capturer and pharmacist – felt that the difficulties experienced by the ARV programme were reviewed by management, although no action was taken. The two staff members, clinic manager and CNP felt that no reviews were conducted. They indicated that auditing was conducted by the task team requested to do so where gaps were identified in the management of the programme. This resulted in realization by management that improvements were needed.

Question 5

Was the progress continuously monitored in respect of the ARV programme?

Response:

All staff agreed that the ARV programme is continuously monitored through auditing and feedback, monthly statistics, patient numbers, use of daily registers and tracking of defaulters.

Question 6

Do you think that sufficient resources were made available for the implementation of the ARV programme?

Response:

The doctor, pharmacist and data capturer agreed that sufficient resources were made available for the implementation of the programme; access to the programme was made available as was up-to-date information about clinical and drug issues. The clinic manager and CNP felt that resources were not sufficient because there was a lack of furniture and equipment, insufficient space and a shortage of staff.

Question 7

Did any of the staff and patients experience adaptation problems?

Response:

Three staff members – the clinic manager, data capturer and pharmacist – felt that both staff and patients experienced adaptation problems as a result of space constraints, but the doctor and CNP were uncertain.

Question 8

What were the most common problems experienced by management in the implementation of the programme?

Response:

When asked about problems experienced by management in the implementation of the programme, the doctor, pharmacist and clinic manager felt that management could not retain old and experienced staff for various reasons. There had also been resistance in integrating all other programmes with the ARV programme as well as a lack of consultation between staff and management. Staff felt that policies are imposed on them and this was seen as one of the problems hindering creativity on their part.

6.7 Interpretation of staff interviews

From the results of staff interviews conducted at Du Noon Clinic the following general findings are offered below.

6.7.1 Technical proficiency

The results reveal that staff working in the ARV programme were not knowledgeable as to how the programme was implemented. During the early stages of implementation the ARK staff initiated the programme but after that there was no

proper handing over of the programme. There had been no proper training of staff who took over the programme and training opportunities seemed limited because of a staff shortage. An impression was created that integrating the programme with other programmes was problematic as a result of staff resistance to change. Yet this could have been an ideal solution that would have addressed staff shortages and at the same time create a holistic approach to patient care because the majority of the patients are co-infected.

6.7.2 Logistics

All staff, except the CNP, shared the same sentiments that the service was mostly needed by residents because of the HIV/AIDS and TB pandemic in the community. These results show that ARV services had been taken to the community that needed them the most as a result of the low socio-economic status of the residents with a high unemployment rate. Travelling to Table View Clinic for patients to collect treatment would have been costly or even unaffordable. Establishing PHC services at Du Noon Clinic implies that patients' wellbeing and needs remain the CCT's priority by bringing health services nearer to the people in terms of accessibility. The area that remains a challenge is the use of agency staff to meet demand, since these staff members are not familiar with the protocols and guidelines of the Health Department of CCT.

6.7.3 Standards and norms

The staff response created the impression that the programme management team had applied their minds when implementing the programme. The joint effort by the CCT and PGWC to properly manage the implementation phase of the programme is sufficient to reflect the commitment of both organisations to render a service that seeks to benefit the community of Du Noon. The ARV programme attracted many patients for enrolment as well as NGOs to offer support to the patients in need. These factors confirm it was a process that was effectively and efficiently implemented. The number of enrolled patients per month and per annum is testimony to the effectiveness and efficiency of the programme.

6.7.4 Evaluation

There seemed to be agreement amongst all participants (staff) that there are systems in place to evaluate and monitor the progress of the programme. Evaluating and monitoring the programme did not necessarily mean that the programme was

not functioning well, nor that there was optimal utilisation of service. This was due to the fact that there was no consistent feedback about outcomes. This created the impression that the staff working with the ARV programme lack the understanding of how systems work in the programme. This could be associated with the fact that they inherited the programme and are unable to relate to the initial stages of the programme. There had been an understanding amongst staff members that evaluating the programme would assist programme managers in identifying additional resources required, such as staffing needs and treatment needs of patients, but this seemed not to be happening.

6. 8 CONCLUSION

After analysing the data, a number of issues pertaining to the effectiveness of the ARV programme emerged. Quality, accessibility, humaneness/courtesy, continuity of care, thoroughness, informativeness and affordability came up strongly as indications of patient satisfaction in terms of service delivery. There were areas of dissatisfaction highlighted by patients pertaining to the awarding of food parcels and disability grants on which they wanted clarity. The researcher obtained the impression that these patients assume that their HIV status automatically qualifies them for the grants. The doctor determines who qualifies for the grant, and the clinic manager and CNPs determine who qualifies for food parcels. Once they have improved on treatment, they are encouraged to seek employment; however, their level of education disadvantages them in that area.

The staff perspective indicated support for the continuity of the ARV programme and for the measures that have been put in place to monitor the programme; however, there is some need to improve the present systems. The staff feels that PGWC and programme managers do little to support them in the programme. There is never a shortage of drugs, but the space constraints and increasing numbers of registered patients make the programme unmanageable. The results of the audit are only communicated to the managers and not to the staff, so they cannot improve in the areas highlighted. Quantitatively the statistics reveal the steady increase in enrolment for patients in the ARV programme. The next chapter will contain the summary, recommendations and conclusions.

CHAPTER 7

SUMMARY, RECOMMENDATIONS AND CONCLUSIONS

7.1 Introduction

The aim of the study was to assess and evaluate the effectiveness of PHC services, that is the HIV/AIDS programme with a specific focus on the implementation of the ARV programme in the Du Noon Clinic. The summary, recommendations and conclusions are based on the hypothesis that HIV/AIDS programmes at Du Noon Clinic are effective in serving the needs of the community, and specifically those of the patients in terms of patient experiences, accessibility and affordability of the ARV services at the clinic. Linked to the hypothesis is the problem statement that seeks clarification on the accessibility of the service, the effectiveness of the programme, the standards and norms to measure performance; and the monitoring of patient satisfaction. In accordance with PHC literature, the PHC guiding principles, patient experiences, feelings and emotions were used as indicators to measure patient satisfaction in terms of their enrolment in the ARV programme. The findings were discussed in the summary of the previous chapter, and the conclusion and recommendations will be provided here.

7.2 Summary

According to patient experiences, and the accessibility and affordability of ARV programme, two themes emerged in the content analysis of the qualitative and quantitative data, namely *positive* and *negative* sentiments on the quality of service in the Du Noon Clinic, which would translate into *satisfaction* and/or *dissatisfaction*. These themes were later described as categories which defined the feelings of the patients and impact of the ARV programme. Esch, Marian, Busato and Heusser (2008: 4) argue that patient satisfaction is a multidimensional concept based on a relationship between experiences and expectations. The study conducted by these authors compared patient satisfaction with anthroposophic medicine and conventional medicine. In the study the term 'patient satisfaction' is used to mean positive emotional reaction to the consultation and the positive experience of the treatment in its various aspects. The results showed significantly high treatment satisfaction in particular with communication and relationships with health care providers. These sentiments were shared in the focus group when participants were

asked if the clinic was giving them the best care. The majority of the patients felt that the clinic was indeed giving them the best care.

Royse (2008: 301) associates the positive client feedback with instruments used that favour certain categories of clients and those dissatisfied with services often drop out early and may not participate in the studies. Royse further argues that clients are in a vulnerable position and may not want to risk something negative for fear that they might lose the use of services at a future point in time. The argument above holds as far as the researcher is concerned, because all the participants claimed that the programme has brought about significant changes to their lives and the majority felt that they have been given the second chance to life. This reveals a total dependence of patients on the clinic and they could not risk losing the care they receive. All study participants were at the terminal stage of their disease on registration to the programme and would not risk their lives. They stated that even if they would be told that the treatment is poisonous, they would not be willing to stop it. The criterion for enrolment on ARV programme is determined by the patients' blood results that define the stage of HIV infection. Only when the patients' CD4 count has dropped below 200 are they eligible for treatment and this is usually at the advanced stage of the disease.

The analysis of qualitative and quantitative data enabled the identification of the most commonly cited PHC principles like accessibility, affordability, effectiveness and efficiency. In terms of the CCT's IDP strategy of turning the tide against HIV/AIDS infections, the results show that the Health Department in partnership with NGOs and PGWC is implementing plans to curb the spread of the disease. Thiedke (2007: 1) looked at patients with chronic diseases and found some consistent patterns. This was in relation to types of chronic illnesses and the medication and the hassles the patients experienced. As a result of improved coordination and communication of care, the patients' perception of hassles decreased and satisfaction improved. Continuity of care seems to have played a big role. The patients who have been monitored by their physician for more than two years were most satisfied with their care. This aspect of care existed and was confirmed by research participants as the majority felt that their return visits to the same staff member had a positive influence on their satisfaction.

It is commonly acknowledged that patients' reports of their health and quality of life, and their satisfaction with the quality of care and services, are as important as many

clinical health measures (Bolus & Pitts 1999: 1). The Gluckman Commission – discussed in Chapter 2 – revealed a lack of proper health care that led to the recommendations to introduce PHC. The PHC package was planned according to the priorities identified by the communities themselves. The National Health Act, as indicated in Chapter 3, states that the Province will also consult with communities regarding health matters and promote community participation – an element that is lacking in the Du Noon community. The change in the system of health care delivery was meant to satisfy patients' needs. Bolus and Pitts (1999: 2) argue that without acceptable levels of patient satisfaction, health plans may not get full accreditation and will lack the competitive edge enjoyed by fully accredited plans.

7. 3 Positive Outcomes

Both qualitative and quantitative results reveal that the provision of ARV in the HIV/AIDS programme is making a difference to the Du Noon community. The service has been brought nearer to them; it is accessible and the patients do not travel to Table View Clinic to access health care services; it is also a free service, making it affordable. All respondents in group interviews agreed that the ARV programme had brought about change in their lives. The quantitative data, together with input from staff (qualitative data), reveal that the programme is measured for effectiveness by collecting monthly data, registering patients to monitor compliance, and conducting quarterly audits to monitor and evaluate the programme. There are tools and systems in place to measure the performance of the programme, as indicated above. The programme is registering more and more patients. The graphs in Chapter 6 depicted a steady increase and non-compliance by the patients was not identified as a major problem, which supports the notion that the patients are satisfied with the service.

7. 4 Negative Outcomes

The role played by CHWs in the implementation of the ARV programme seemed limited. They are not utilised as developmental change agents to facilitate community participation, as recommended by Ceasar and Theron (2008: 155). According to the authors, the effectiveness of CHWs in facilitating community participation revolves around their recognition of community needs; this is something that this community does not utilise. This supports the arguments proposed in Jacobs (2006: 7) about health committees, suggesting that they are the link between the health facilities and communities. Without such a structure the CHWs do not seem to be getting the

recognition they deserve as health workers on the ground, the level at which patients have to live. This results in lack of community participation, which in turn denies communities the right to influence decisions about their own health.

It has been evident in the study that the patients do not participate in their enrolment on the programme. One HIV-positive patient is quoted as saying: “Ask any HIV-positive person and they will tell you there is no better support than to talk to another HIV-positive person, who experiences the same as they do. We care from the heart! There is no substitute for that feeling of being understood...” (UNAIDS, 2003: 24). There is a general feeling that many more HIV-positive people should be working in the treatment programme (UNAIDS, 2003: 25). These people say that “We have experienced the problems the patients are going through – we’re the best people to help them”. These concerns were expressed during group interviews, when participants indicated their wish to be separated from the mainstream clinic because they understand each other and relate better to one another. They wished they could be cared for by people (staff) who are HIV positive, and who feel and understand how they themselves feel. Based on the information above, the following recommendations are put forward.

7. 5 Recommendations

The patients expressed dissatisfaction with the clinic structure, waiting times, lack of privacy, frequent changes of staff, one waiting room that is overcrowded, and fear of cross-infection. The researcher noticed a lack of knowledge among patients about issues pertaining to patients' rights and responsibilities. These will be addressed below under relevant headings. The staff expressed concerns about the resistance to integrate the programme with other programmes in the clinic, as well as the missed opportunities for staff training as a result of staff shortages and the use of staff from agencies who are not familiar with City protocols. Action on these matters will be captured below.

7. 5. 1 Accessibility of clinic

- It is evident that there is a need to extend the health service hours at Du Noon clinic because there are no immediate secondary referral institutions.
- The three structures serving this community have become inadequate as a result of the increase in the numbers of patients. This should motivate the building of a new clinic in the near future.

- The health and safety of health care workers becomes compromised and become prone to contracting infectious diseases.
- The patients are also at risk of infecting others, especially the vulnerable groups like children, who come for immunisations and the young people who come for family planning.
- The overcrowding might also lead to poor air flow in the facility, contribute to defaulting and spread of infectious diseases.
- The great need for a sufficient number of staff members should be addressed. Building a new clinic to accommodate the increasing number of patients and additional staff members would enhance service delivery and provide opportunities for privacy to be maintained.

7. 5. 2 Overall Effectiveness

- The responsiveness of staff towards the needs of the patients should be addressed. This applies to concerns raised about not having different waiting areas. This concern could be addressed by having open communication channels with the patients where they can air their views or make suggestions through community structures.
- Because of the size of the clinic with the limited number of consulting rooms and one waiting area, it becomes evident to all patients that some consulting rooms deal only with certain kind of patients. This frustrates HIV-positive patients as this means indirect disclosure of their HIV status to people whom they are not comfortable with. Consulting room does not need to be seen as specifically used for consulting HIV positive patients. Privacy of patients therefore needs to be addressed as a priority. This matter could have been resolved by extending the clinic to include more consulting rooms, but space constraints mean the clinic cannot be extended. The problem will only be resolved by constructing a new facility.
- Patients should be educated about clinic hours and their consultations should be spread evenly throughout the day. An appointment system could alleviate the huge volumes of patients reporting all at the same time at the clinic. Service delivery will be enhanced if an appointment system is introduced.

- The congestion in waiting areas and temperature problems inside the clinic in the interim could be partially addressed by ensuring that all ventilation devices are functional, and all windows and entrance/exit doors are open.

7. 5. 3 Participation

It is recommended that the clinic should establish a health committee that will be functional as the structure for patients and community at large. This body will be a link between the clinic and the community for interaction between all stakeholders. The community requires to be educated to participate in addressing their own health care needs. This will induce a greater sense of responsibility, belonging and comradeship with health staff and create cooperation among all stakeholders in the process – hence creating an environment conducive to effective service delivery. Recognition needs to be given to all patients – especially those infected and affected with HIV/AIDS yearning to contribute to development initiatives. These patients may present a different dimension to participation, which may be a driving force for the process. Meeting places on health issues should be scheduled for areas accessible to all people. By doing so greater representativeness on health delivery issues would be achieved. This would also create a platform for educating patients about their health rights and responsibilities and be informed about a patient charter.

7. 5. 4 Coordination of CHW

The employment of CHWs by different NGOs creates confusion about the role they play in supporting the ARV programme. Their roles overlap and some have different conditions of service, with the expectation that they are managed by the clinic manager. Coordination between all these health workers by one organization as partners in health would enhance service delivery. All stakeholders need to establish relationships of trust amongst each other as equal partners based on their interest of bringing health services to their communities. The health committee as a recognised structure would play a crucial role in bringing on board all stakeholders to participate in decision making pertaining to community needs. This process calls for networking and buy-in by all structures involved.

7. 5. 5 Integration of services

Concerns were raised by a few respondents about people with dual infections who need to attend a TB programme as well. An integrated approach to service delivery would be ideal, as it will save the patient's and the health worker's time and mean

treating the patient in a holistic way. Kotze and Kotze (2008: 78) define an integrated approach as the “empirical domain in which an attempt is made to take into consideration several issues or aspects at the same time”. The integration of services would de-stigmatise the patients treated in room 2 as HIV positive and all nurses will be capacitated to see all patients visiting the clinic.

The integration of programmes would also assist the staff from the nursing agency who are not familiar with City health protocols to integrate with CCT staff, as they will be working side by side. This would also create privilege for staff to attend training due to support received from staff working on other programmes. Resistance to integration is sometimes the result of fear of the unknown or salary issues, which will be addressed by the personnel department.

7. 6 Conclusions

This research was initiated on the hypothesis that the HIV/AIDS programme at Du Noon Clinic is effective in serving the needs of the community, specifically with regards to their experiences, accessibility and affordability of the ARV services in the clinic.

The aspects measured include the affordability, accessibility of and physical quality of the service, continuity of care, courtesy of staff, overall effectiveness, thoroughness and informativeness. The hypothesis was tested through an empirical measurement of these criteria by means of semi-structured interviews with the patients and staff. The research focused on the patients attending the ARV programme on those specific days. Generally the findings of the research were that the respondents were pleased with the provision of the ARV programme.

The broad recommendations included: motivation for a new clinic that would create more space for staff and allow privacy; clinic manager and staff to set up a health committee that would encompass greater collaboration; and promote participation from all stakeholders (staff and community).

The PHC service, focusing on the provision of the ARV programme, was evaluated and assessed for effectiveness, that is making a difference in the lives of HIV-positive patients against the background of increasing numbers of patients registering for the ARV programme. The average result of the research with its various criteria has indicated a generally satisfied community (participants), which is also corroborated by general agreement about the quality of service offered in the ARV programme.

The research therefore confirms the initial hypothesis that the HIV/AIDS programme at Du Noon Clinic is effective in serving the needs of a certain section of community, specifically those of the patients in terms of accessibility and affordability of the ARV services in the clinic.

REFERENCES

Abdullah, F. 2004. The Complexities of Implementing Antiretroviral Treatment in the Western Cape Province of South Africa. In M. Heywood. *From Disaster to Development – HIV and AIDS in Southern Africa. Development Update*, Cape Town: Interfund Partners.

African National Congress. 1994. *The Reconstruction and Development Programme A Policy Framework*. Johannesburg: Umanyano Publications.

Alma Ata and the Institutionalization of Primary Health Care. 1978. Available online at: http://www.healthwrights.org/books/qts/qts_ch03.pdf (Accessed 21 November 2008).

Babbie, E. & Mouton, J. 2001. *The Practice of Social Research*. Cape Town: Oxford University Press.

Barents. 2005. HIV/AIDS Programme – A Strategy Plan for a Better Future. Available online at http://idc.stakes.fi/NR/rdonlyres/5337C25B-1821-4D1A-BD08-A9DBF32F1B3/0/BarentsHIV_AIDS_english.pdf (Accessed 27 February 2009).

Bless, C., Higson–Smith, C. & Kagee, A. 2006. *Fundamentals of Social Research Methods – An African Perspective*. Cape Town: Juta.

Bolus, R. & Pitts, J. 1999. Patient Satisfaction: The Indispensable Outcome. Available online at: <http://www.managedcaremag.com/archives/9904/9904.patsatis.html> (Accessed 8 June 2009).

Brown, C. J. 1997. The societal dimension of project management. *Management Dynamics*, 6(3): 69-87.

Cape Argus. 2009. SA ahead of its ARV treatment targets – 29 January 2009. Available online at: <http://www.capeargus.co.za> (Accessed 20 October 2009).

Cesar, N. & Theron, F. 2008. Community health – the community health worker as change agent. In Theron, F (ed). *The development change agent – a micro-level approach to development*. Pretoria: Van Schaik.

Centre for Municipal Research & Advice (CMRA). 2009. *Benchmarking HIV & AIDS - Newsletter*. Issue 2 April 2009. Available online at www.cmra.org.za (04 June 2009).

Chambers, R. 2005. *Ideas for Development*. London: Earthscan.

Chirambo, K. & Caesar, M. 2003. AIDS and Governance in Southern Africa: Emerging Theories and Perspectives. A Report on the IDASA/UNDP Regional Governance and AIDS Forum April 2 – 4, 2003. Pretoria: Institute for Democracy in South Africa.

City of Cape Town. (CCT). 2001. Health Services, Facilities, Planning, Construction and Provision. All Facilities. February . File No. B 33/2/1/1. (Accessed at Milnerton Offices).

City of Cape Town. (CCT). 2004. City Health Department Annual Report. Cape Town.

City of Cape Town. (CCT). 2008/2009. City Health Business Plan - *linked to the Integrated Development Plan*. Cape Town.

City of Cape Town. (CCT) 2009. Community Satisfaction Survey. *Making use of community newspaper as a preferred way of communication*. Cape Town. tsn research surveys.

Daily News. 2008. Human cost of slow ARV roll-out calculated. Available online at: <http://www.iol.co.za> (Accessed 21 October 2009).

Dennill, K., King, L. & Swanepoel, T. 1999. *Aspects of Primary Health Care: Community Health Care in Southern Africa*. Cape Town: Oxford University Press.

Department of Health. 2000. *The Primary Health Care Package for South Africa – a set of norms and Standards*. March 2000. Pretoria: Department of Health.

Department of Health. 2001. *The District Health System in South Africa: Progress made and next steps*. July 2001. Pretoria. Available online at: <http://www.doh.gov.za/docs/policy/dhsystem.html> (Accessed 10 March 2009).

Department of Health. 2001. *Community Health Workers – Policy Framework Document*. Pretoria: Department of Health.

Department of Provincial Health. (DoPH), 2003. Department of Public Health (University of Cape Town), Provincial Government of Western Cape, Médecins sans Frontières South Africa. *Perspectives and practice in antiretroviral treatment. Antiretroviral therapy in primary health care: a case study*.

Department of Provincial and Local Government in Partnership with SALGA. 2008 – 2011. National Capacity Building Framework for Local Government - In Support of the Five Year Local Government Strategic Agenda. Available online at: <http://www.dplg.gov.za> (Accessed 04 June 2009).

Department of Provincial and Local Government (DPLG). 2007. *Framework for an Integrated Local Government Response to HIV and AIDS*. Available online at: <http://www.dplg.gov.za> (Accessed 04 June 2009).

Department of Provincial and Local Government (DPLG) 2008. Handbook for facilitating development and governance responses to HIV and AIDS. Available online at: www.mrc.ac.za/healthdevelop/hivpositionpaper.pdf (Accessed 04 June 2009).

Dreyer, M., Hattingh, S. & Lock, M. 1993. *Fundamental Aspects in Community Health Nursing*. Halfway House: Southern Book Publishers.

Esch, B. M., Marian, F., Busato, A. & Heusser, P. 2008. Patient Satisfaction with Primary Care: an observational study comparing anthroposophic and conventional care. Available online at <http://www.hqlo.com/content/6/1/74> (Accessed 30 October 2009).

Gardner, S. 2004. Participatory Action Research Helps Now. *The Hispanic Outlook in Higher Education*, 14: 25 - 26.

Gluckman Commission 1944. Report of the National Health Services Commission. Pretoria: Department of Health.

Gott, M. & Warren, G. 1991. Neighbourhood Health Forums: Local Democracy at Work. *World Health Forum*, 12. pp. 413-417.

Hall, J. J. & Taylor, R. 2003. *Health for all Beyond 2000: the demise of the Alma-Ata Declaration and primary health care in developing countries*. Available online at: http://www.mja.com.au/public/issues/178_01_060103/hal10723_fm.html (Accessed 21 November 2008).

Health 24. 2006a. How is HIV treated? Available online at: <http://www.health24.com/printarticle.htm> (Accessed 20 October 2009).

Health 24. 2006b. Antiretroviral treatment. Available online at: <http://www.health24.com/printarticle.htm> (Accessed 20 October 2009).

Health Systems Trust. 2004. *HIV and Sexual Behaviour Among Young South Africans: A National Survey of 15 – 24 year olds*. Cape Town: Health Systems Trust.

Heywood, M. 2004. The Price of Denial. In M. Heywood. *From Disaster to Development – HIV and AIDS in Southern Africa*. Development Update, Cape Town: Interfund Partners. pp 93 - 120.

Hunt, P. & Backman, G. 2008. *Health Systems and the Right to the Highest Attainable Standard of Health*, 10:1, Critical concepts pp 1 - 11. www.hhrjournal.org //.

Isandla Institute. 2007. *Mainstreaming Local Government Responses to HIV/AIDS – a Case study of the City of Cape Town's HIV/AIDS/TB Multi-Sectoral Strategy*. Pretoria: Isandla.

Isandla Institute and the South African Cities Network. 2007. 'Positive Spaces' Sustainable Settlements in the Context of HIV/AIDS. Report of the National Seminar and Learning Event. Johannesburg: Isandla.

Jacobs, A. 2006. *Basic Guiding Principles for Active Community Participation in Health* (A document self-compiled based on extracts from the following documents:

chapter 7 of the Constitution, The Development Facilitation Act, Local Government Transitional Act 2nd Amendment, White Paper on Local Government, Municipal Structures Act, Municipal Systems Bill, Provincial Health Plan, National Health Plan, Integrated Development Planning, Draft Strategic and Service Delivery Improvement Plan). Unpublished.

Kauffman, K. D. & Lindauer, D. L. 2004. *AIDS and South Africa: the Social Expression of a Pandemic*. United States: Palgrave Macmillan Ltd.

Korten, D. C. 1990. *Getting to the 21st Century: Voluntary action and the global agenda*. West Harford: Kumarian Press.

Kotzé, D. & Kotzé, P. 2008. Understanding communities and enabling people – a holistic approach. In Theron, F. (ed). *The development change agent – a micro-level approach to development*. Pretoria: Van Schaik.

Lee, R. M. & Fielding, N. G. 2004. Tools for Qualitative Data Analysis. In M. Hardy & A. Bryman (Eds). *Handbook of data analysis*. London: Sage.

Medical Research Council of South Africa, (MRC) 2005. *Aids Bulletin. March 2005 - an MRC Publication*. Available online at http://www.idrc.ca/uploads/user-S/11533358141AIDS_Bulletin-_march_2005_-_Final.pdf (Accessed 27 February 2009).

Melville, G. I. 1998. *Evaluation of Health Services at Belhar Community Health Centre*. Unpublished Master's thesis. University of Stellenbosch: US Printers.

Mouton, J. 2004. *How to Succeed in your Master's & Doctoral Studies: A South African Guide and Resource Book*. Pretoria: Van Schaik.

Neuman, L. 2003. *Social Research Methods: Qualitative and Quantitative Approaches*. (5th ed). Boston, MA: Allyn and Bacon.

Owen, C. P 1995. *A Policy for the Development of a District Health System for South Africa*. Compiled by the Health policy coordinating Unit on behalf of the national District Health System Committee. Pretoria: Department of Health.

Poku, N. K., Whiteside, A. & Sandkjaer, B. 2007. *AIDS and Governance*. Aldershot: Ashgate Publishing Limited.

Project Cycle Management. 2006. CBO Training Toolkit; Core Initiative – Communities Responding to the HIV/AIDS Epidemic. Available online at <http://www.coreinitiative.org/Resources/Publications/ProjectCycleManagementToolkit.pdf> (Accessed 20 March 2009).

Rakowski, W. 1994. The Definition and Measurement of Prevention, Preventive Healthcare, and Health Promotion. (Preventive Healthcare and Health Promotion for Older Adults). Available online <http://www.accessmylibrary.com/article-IGI-15188177/definition-and-measurement-pre...> (Accessed 30 July 2010).

Ratcliff, D. 1990. 15 Methods of Data Analysis in Qualitative Research. Available online <http://qualitativeresearch.ratcliffs.net/15methods.pdf> (Accessed 14 August 2009).

Republic of South Africa. (RSA). 1996. *The Constitution of the Republic of South Africa (Act 108 of 1996)*. Pretoria: Government Printers.

Republic of South Africa. (RSA). 1998. *The White Paper on Local Government*. Pretoria: Government Printers.

Republic of South Africa. (RSA). 2000. *Municipal Systems Act (Act 32 of 2000)*. Pretoria: Government Printers.

Republic of South Africa. (RSA). 2003. *The National Health Act (Act No. 61 of 2003)*. Pretoria: Government Printers.

Royse, D. 2008. *Research Methods in Social Work*. Belmont: Thomson Brooks/Cole.

Shisana, O., Rehle, T., Simbayi, L., & Mbelle, N., 2005. *South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005*. Nelson Mandela Foundation. Living the Legacy. Cape Town: Human Sciences Research Council.

Shisana, O. & Simbayi, L. 2002. *South African National HIV Prevalence, Behavioural Risks and Mass Media Household Survey 2002*. Nelson Mandela/HSRC Study of HIV/AIDS. Cape Town: Human Sciences Research Council.

South African Medical Research Council. 2001. The impact of HIV / AIDS on adult mortality in South Africa. Technical Report 2001. Tygerberg, South Africa: SAMC.

Statistics 2001 national census of Du Noon. Available online at: <http://www.capetown.gov.za/en/stats/2001census/Documents/Du%20Noon.htm> (Accessed 21 July 2010).

Stein, J. & Erasmus, A. 2005. The impact of antiretroviral provision on HIV/AIDS preventions. *AIDS Bulletin* 14:1, pp58-71. Available online at: http://www.idrc.ca/uploads/user-S/11533358141AIDS_Bulletin- March 2005 - _Final.pdf (Accessed 27 February 2009).

Swanepoel, H. 1997. *Community Development – Putting Plans into Actions*. Cape Town: Juta.

Tapia, M., Brasington, A., Van Lith, L. 2007. *Participation Guide – Involving Those Directly Affected in Health and Development Communication Programs*. International HIV/AIDS Alliance. Available online at: <http://www.eldis.org/cf/rdr/?doc=41174&em=140109c=partic> (Accessed 21 January 2009).

Tejada de Rivero, D. A. 2003. *Alma – Ata Revisited*. Perspectives in Health Magazine, 8:2. Available online at: http://www.paho.org/english/DD/PIN/Number17_article1_4.htm (Accessed 21 November 2008).

Thiedke, C. C. 2007. What Do We Know About Patient Satisfaction? Available online at <http://www.aafp.org/fpm/20070100/33what.html> (Accessed 30 October 2009).

Theron, F. (ed) 2008. *The Development Change Agent – a micro-level approach to development*. Pretoria: Van Schaik.

Theron, F. 2008. *The change agent-project beneficiary partnership in development planning - theoretical perspective*. Pretoria: Van Schaik.

Theron, F. 2008. Key themes, reflection and action for development change agents – a call for a change agent-beneficiary partnership. In Theron, F. (ed). *The development change agent – a micro-level approach to development*. Pretoria: Van Schaik.

Theron, F. & Ceasar, N. 2008. Participation – a grassroots strategy for development management. In Theron, F. (ed). *The development change agent – a micro-level approach to development*. Pretoria: Van Schaik.

UNAIDS. 2003 Stepping Back from the Edge: The Pursuit of Antiretroviral Therapy in Botswana, South Africa and Uganda. UNAIDS/03.46E. Geneva, Switzerland: UNAIDS.

UNAIDS. 2005a. Intensifying HIV prevention: a UNAIDS policy position paper. Geneva, Switzerland: UNAIDS.

UNAIDS. 2005b. AIDS epidemic update: December. “UNAIDS/05.19E”. Geneva, Switzerland: UNAIDS.

Van Rensburg, H. C. J., Fourie, A. & Pretorius, E. 1992. *Health in South Africa: Structure and Dynamics*. Pretoria: Van Schaik.

Van Rensburg, H. C. J. & Pelsler, A. J. 2004. The Transformation of the South African Health System. In Van Rensburg, H. C. J. (Ed). *Health and Health Care in South Africa*. Pretoria: J. L. van Schaik.

Weber, R. P. 1990. *Basic Content Analysis*. Newbury Park. Cal.: Sage.

Welford, S., Nelson, J., Viard, T. 2008. Turning Rhetoric into Action – Building effective partnerships to combat extreme poverty and exclusion. Available online at: <http://www.eldis.org/cf/rdr/?doc=40484&em=140109c=&partic> (Accessed 21 January 2009).

Welman, J. & Kruger, S. 2001. *Research Methodology for the business and administrative sciences*. 2nd ed. Cape Town: Oxford University Press.

Western Cape Department of Health. (WCDoH). 2005. Comprehensive HIV Service Development at Primary Care Clinics: The experience from Khayelitsha – Activity Update July 2005. Cape Town: Western Cape Department of Health: City of Cape Town Health Services.

Wilkin, D., Hallam, L. & Doggett, M. 1992. *Measures of Need and Outcome for Primary Health Care*. New York: Oxford University Press.

World Health Organization., (WHO) 1978. *The Alma-Ata Declaration*. International Conference on Primary Health Care, Alma-Ata. USSR, 6 - 12 September 1978. Available online
<http://www.righttohealthcare.org/Docs/DocumentsC.htm> (Accessed 27 February 2009).

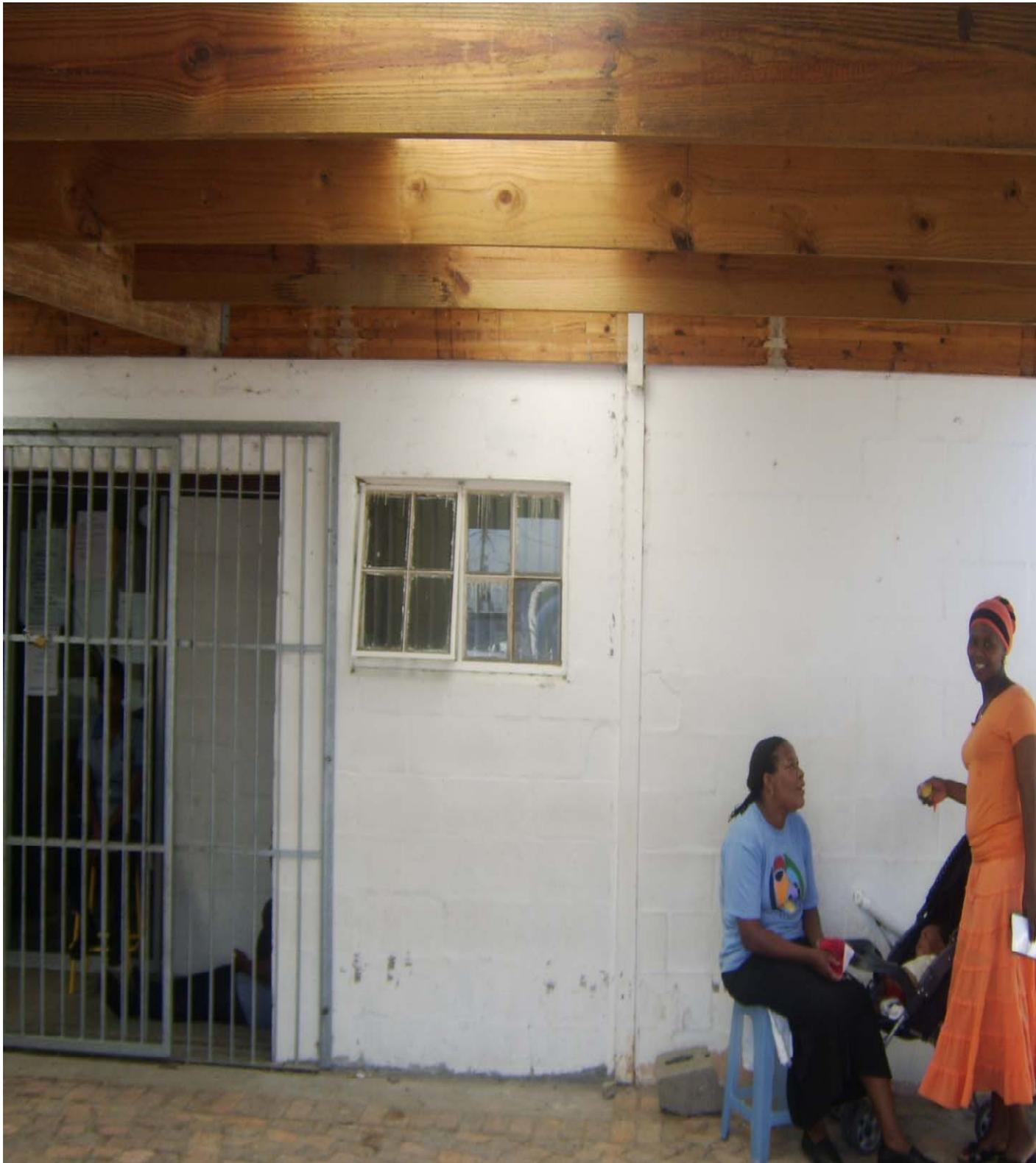
World Health Organization., (WHO) 1994. *Health Promotion Glossary*. Geneva. Available Online <http://www.who.ch/hep>.

World Health Organization. (WHO) 2003. *Antiretroviral Therapy in Primary Health Care: Experience of the Khayelitsha Programme in South Africa. Case Study*. Perspectives and practice in antiretroviral treatment. Available Online http://www.who.int/hiv/pub/prev_care/en/South_Africa_E.pdf (Accessed 27 February 2009).

World Health Organization. (WHO) 2007. *TB Ravages HIV and AIDS Patients. WHO Annual Report*. Geneva. Available online at: <http://www.iol.co.za> (Accessed 21 October 2009).

Zimba, A. 2002. A Descriptive Analysis of how Primary Health Care Services have Developed in the Cape Metropolitan Area from the period – pre 1994 to post 2000 elections. Unpublished Master's thesis. University of Stellenbosch: US Printers.

Annexure A - Structure A



Annexure B - Structure B



Annexure C - Structure C



QUESTIONNAIRE

INTRODUCTION.

I am currently registered at Stellenbosch University and I am doing a research project as part of my studies towards a qualification in Public Management. The reason that I am here today is to ask you some questions about the ARV programme. I want to find out if the clinic is meeting your needs as patients and if you are participating in decisions about your health needs.

The intention of the meeting with you is to ask you questions to assess the effectiveness of the programme in meeting your needs. The questions are semi-structured and there is no right and wrong answers. Confidentiality will be maintained and there will be no use of people's names. The information collected is intended to be used to strengthen the ARV programme and make it accessible to the community of Du Noon.

PARTICIPANT QUESTIONNAIRE

1. Describe according to your experience the difference brought by the ARV programme on yourself.

2. How did you feel when you got enrolled in the ARV programme?

3. As a patient participating in the ARV programme, what emotions have you experienced?

Explain:

4. What experiences did you encounter while taking part in the ARV programme?

5. Do you feel that the clinic is giving you the best treatment?

Explain why?

Yes	1
No	2

6. Are the staff in the clinic helpful and considerate when they treat you?

Yes	1
No	2

7. Did the staff explain the ARV programme to you in full?

Yes	1
No	2

8. Do you have anything in addition to the above to state?

STAFF QUESTIONNAIRE

TECHNICAL PROFICIENCY

1. How did programme managers manage the ARV programme to ensure that it was effectively and efficiently implemented?

2. How did the programme managers according to your opinion address the integration aspects of the programme?

3. How did the programme managers according to your opinion address the uniformity aspect of the programme?

4. Did the programme managers according to your opinion fulfil their obligation?

Yes	1
No	2

Explain:

LOGISTICS

1. What was the approach of PGWC in respect of the ARV programme to be rolled-out to your facility?

2. For the roll-out of the ARV programme was this (Du Noon) the best site for the roll-out of the programme?

Yes	1
No	2

Explain:

3. Were all staff employed in the programme properly trained?

Yes	1
No	2

Explain:

STANDARDS AND NORMS

1. Did the programme management team have sufficient time to implement the ARV programme?

Yes	1
No	2

2. Did the PGWC and CCT ensure that the implementation of the programme was properly dealt with?

Yes	1
No	2

3. Do you think an outsider would regard the ARV programme as a process that was effectively and efficiently implemented?

Yes	1
No	2

Explain:

EVALUATION

1. Do you think that the objectives of the ARV programme are well executed?

Yes	1
No	2

Explain:

2. Did the ARV project management ensure that all the objectives were correctly executed?

Yes	1
No	2

3. Was the information and feedback regarding the ARV programme fully explained to the staff by management?

Yes	1
No	2

4. Were any of the difficulties experienced by the ARV programme reviewed by management?

Yes	1
No	2

5. Was the progress continuously monitored in respect of the ARV programme?

Yes	1
No	2

Explain:

6. Do you think that sufficient resources were made available for the implementation of the ARV programme?

Yes	1
No	2

Explain:

7. Did any of the staff and patients experience adaptation problems?

Yes	1
No	2

Explain:

8. What were the most common problems experienced by management in the implementation of the programme?

IPHEPHA LEMIBUZO

INTSHAYELELO

Ngeli ixesha ndingobhalisiweyo kwiDyunivesithi yaseStellenbosch yaye ndixakekile yiprowujekhthi yophando njengenxalenye yezifundo zam ukuze ndifumane isiqinisekiso sempumelelo kwiPublic Management, oko kukuthi kuLawulo loLuntu. Isizathu sokuba ndibelapha namhlanje sesokuba mandikubuze imibuzo ethile ngenkqubo ye-ARV. Ndifuna ukwazi ukuba iiklinikhi iyahlangabezana na neemfuno zenu njengezigulana nokuba ingaba niyayithatha na inxaxheba ekwenzeni izigqibo malunga neemfuno zokunonophelwa kwempilo yenu.

Iinjongo zokudibana nani zezokunibuzwa imibuzo yokuqikelela ukuba le nkqubo iyasebenza ngokwaneleyo na ekuhlangabezeni iimfuno zenu. Akukho bungqongqo ekusekweni kwale mibuzo, kungekho zimpendulo zichanekileyo nezingachanekanga. Konke kuza kugcinwa kuyimfihlelo yaye akukho magama abantu aza kusetyenziswa. Iinkcukacha eziqokelelweyo kukho iinjongo zokuzisebenzisela ekomelezeni le nkqubo ye-ARV nokuyenza ukuba mayifikeleleke kubahlali baseDu Noon.

IPHEPHA LEMIBUZO YEQELA EMAKUGXILWE KULO

UKWANELISEKA KWESIGULANA

1. Khawuchaze ngokumalunga namava akho ngegalelo elibalulekileyo lenkqubo ye-ARV kuwe.

2. Waziva njani wakube ubhalisiwe kule nkqubo ye-ARV?

3. Njengesigulana esithatha inxaxheba kule nkqubo ye-ARV, loluphi uvakalelo okhe wanalo?

Chaza ukuba kutheni usitsho nje

4. Zeziphi iingxaki odibene nazo xa ubuthatha inxaxheba kwinkqubo ye-ARV?

5. Uziva ngathi iklinikhi ikunika unyango oluphucukileyo?

Ewe	1
Hayi	2

Chaza ukuba kutheni usitsho nje

6. Abantu abaphangela eklinikhi baluncedo na, bekwanayo ingqikelelo ephucukileyo xa bekunika unyango?

Ewe	1
Hayi	2

7. Abasebenzi basekliniki bakuchazele ngokupheleleyo ngale nkqubo ye-ARV?

Ewe	1
Hayi	2

8. Ikhona enye inkcazelo onokuyongeza kule ingentla?

IPHEPHA LEMIBUZO LABASEBENZI
UBUCHULE KWEZOBUGCISA

1. Abalawuli benkqubo bayilawula njani inkqubo ye-ARV ukuqinisekisa ukuba imiselwa ngokufanelekileyo nangobuchule?

2. Abalawuli benkqubo bayivelela njani ngokokubona kwakho imibono yokuhlenganisa le nkqubo

3. Abawuli benkqubo bayivelela njani ngokubona kwakho indima yokumiselwa ngokufanayo kwale nkqubo?

4. Ingaba abalawuli benkqubo ngokubona kwakho bayawufezekisa umsebenzi wabo?

Ewe	1
Hayi	2

Cacisa:

UCWANGCISO LOMSEBENZI

1. Ingaba uRhulumente wePhondo leNtshona Koloni usebenzise yiphi indlela ephathelene nokuqaliswa kwenkqubo ye-ARV kwindawo yakho?

2. Ukuqalwa kwenkqubo ye-ARV ingaba le ndawo (Du Noon) yeyona ndawo ikulungeleyo ukuqalwa kwale nkqubo?

Ewe	1
Hayi	2

Cacisa:

3. Ingaba bonke abasebenzi ababeqeshwe kwinkqubo babeqeqeshwe kakuhle?

Ewe	1
Hayi	2

Cacisa:

IMIMISELO NEMIGANGATHO

1. Ingaba iqela lolawulo lwenkqubo belinexesha elaneleyo ukumisela inkqubo ye-ARV?

Ewe	1
Hayi	2

2. Ingaba uRhulumente wePhondo leNtshona Koloni neSixeko saseKapa bakuqinisekisele ukuba ukumiselwa kwenkqubo kwenziwe ngendlela eyiyo?

Ewe	1
Hayi	2

3. Ucinga ukuba umntu wangaphandle angayibona inkqubo ye-ARV njengenkqubo emiselwe ngokufanelekileyo nangobuchule?

Ewe	1
Hayi	2

Cacisa:

UVAVANYO

1. Ucinga ukuba iinjongo zenkqubo ye-ARV zisefezekiswe kakuhle?

Ewe	1
Hayi	2

Cacisa:

2. Ingaba abalawuli beprojekthi ye-ARV baqinisekise ukuba iinjongo zayo ziphunyezwe ngendlela eyiyo?

Ewe	1
Hayi	2

3. Ingaba ulwazi nezimvo ngokuphathelene nenkqubo ye-ARV zicaciswe ngokupheleleyo kubasebenzi ngabalawuli?

Ewe	1
Hayi	2

4. Ingaba iingxaki ezifunyenwe yinkqubo ye-ARV ziphononongiwe ngabalawuli?

Ewe	1
Hayi	2

5. Ingaba inkqubela-phambili yenkqubo ye- ARV ibisoloko iphononongwa?

Ewe	1
Hayi	2

Cacisa:

6. Ucinga ukuba kwakukho imithombo eyoneleyo yokumiselwa kwenkqubo ye-ARV ?

Ewe	1
Hayi	2

Cacisa:

7. Ingaba abanye abasebenzi nezigulana babeneengxaki zokuzilungelelanisa?

Ewe	1
Hayi	2

Cacisa:

8. Zeziphi ezona ngxaki eziqhelekileyo ezafunyanwa ngabaphathi ekumiselweni kwale nkqubo?
