Feature

Patient Responses on Quality of Care and Satisfaction with Staff After Integrated HIV Care in South African Primary Health Care Clinics

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HIV care integrated into primary health care (PHC) encourages reorganized service delivery but could increase workload. In 2012-2013, we surveyed 910 patients and caregivers at two time points after integration in four clinics in Free State, South Africa. Likert surveys measured quality of care (QoC) and satisfaction with staff (SwS). QoC scores were lower for females, those older than 56 years, those visiting clinics every 3 months, and child health participants. Regression estimates showed QoC scores higher for ages 36-45 versus 18-25 years, and lower for those attending clinics for more than 10 years versus 6-12 months. Overall, SwS scores were lower for child health attendees and higher for tuberculosis attendees compared to chronic disease care attendees. Research is needed to understand determinants of disparities in QoC and SwS, especially for child health, diabetes, and hypertension attendees, to ensure high-quality care experiences for all patients attending PHC clinics with integrated HIV care.

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Improved access to antiretroviral therapy (ART) for people living with HIV (PLWH) has resulted in 11.7 million people on treatment in Eastern and Southern Africa (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2017). Although this represents 60% of those in need of treatment in this region, 8 million PLWH are not accessing treatment. A key strategy to expand access to ART includes the provision of ART through integrated or decentralized care at the primary health care (PHC) level, emphasizing the need for high-quality health care (UNAIDS, 2014a; World Health Organization, 2013). This is

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especially important in high HIV burdened contexts with weak health systems.

While successful HIV integration in PHC settings can decrease HIV-related mortality, reduce referrals within the health system, improve access to treatment, and improve the quality of HIV care (Uebel, Lombard, et al., 2013), unintended negative consequences could result. Some have highlighted concerns of increased patient wait times, reduced quality of care due to increased HIV-related workloads, less focus on non-HIV conditions, reduced access to specialists, compromised patient confidentiality, and increased HIV-related stigma (Yu, Souteyrand, Banda, Kaufman, & Perriëns, 2008). Successes achieved by Nurse Initiation and Management of ART (NIMART) have also led to challenges of increased stress on staff as well as on infrastructure, both of which may compromise the quality of care (QoC) provided at PHC clinics, especially in countries where health systems are under-resourced (Gray et al., 2015). In a study from HIV-integrated PHC clinics in South Africa, nurses felt that high workloads from integrated HIV care reduced the QoC provided, and PLWH expressed concerns of long wait times and poor treatment from the staff (Mathibe, Hendricks, & Bergh, 2015). Although that study included both clinician and PLWH perspectives, those seeking care for non-HIV conditions were not included. A study in Zambia of patient perceptions of integrated care found that stand-alone models were potentially stigmatizing but allowed patients to network and support one another, while integrated models increased equity between patients with and without HIV but did not adequately protect confidentiality (Topp et al., 2012). In a study in South Africa, PLWH who had been referred to PHC clinics once stable, reported reduced transport time and cost, but also a lack of specialized care, poor services, mistreatment by the staff, stigma, and inadequate confidentiality at clinics (Mukora, Charalambous, Dahab, Hamilton, & Karstaedt, 2011). A study in Swaziland of PLWH perspectives of integrated HIV and sexual/reproductive health services found satisfaction was highest in stand-alone models compared to partially integrated or fully integrated service delivery systems (Church et al., 2012). While much of the current evidence has focused on PLWH experiences and clinical outcomes or the perspectives of health care workers, the QoC received by PHC clients (both with and without HIV) in HIV-integrated PHC settings has not been well researched (Crowley & Stellenberg, 2014), especially during the implementation of integrated care.

Patient satisfaction and QoC, critical aspects of well-functioning health care systems, can influence health service utilization, adherence, and patient–provider relationships (Odeny et al., 2013; Osborn & Obermeyer, 2016; Schneider, Blaauw, Gilson, Chabikuli, & Goudge, 2006; Wouters, Heunis, van Rensburg, & Meulemans, 2008). Patient confidence and trust in a health system is largely determined by interactions with staff and perceived quality of services received (McCoy, Chopra, & Loewenson, 2005; Schneider et al., 2006). While expanded ART coverage will result in millions of patients in need of life-long treatment receiving services in PHC contexts, these patients will have increasingly complex care needs as aging and HIV necessitate treating co-morbidities and multi-morbidities (Rabkin & El-Sadr, 2011). Therefore, high QoC for all patients attending PHC clinics must be understood and prioritized in the HIV response, especially in countries with high HIV burdens, such as South Africa.

In South Africa, a country with the largest ART program in the world, nearly 3.4 million people accessed ART in 2015, representing 48% of those eligible (UNAIDS, 2015). South Africa's public sector PHC-based health system provides care for 80% of the population (Van Rensburg & Ataguba, 2012). A lack of availability and inequitable distribution of physicians has been one of the major challenges to expanding access to ART (Schneider et al., 2006). The ART program began via a vertical system in 2004 where patients accessed testing, treatment, and care in separate HIV-specific facilities (Van Rensburg, 2006). A national policy (Colvin et al., 2010) supporting the integration of HIV care through NIMART in PHC facilities was implemented in April 2010 in South Africa (Uebel, Guise, Georgeu, Colvin, & Lewin, 2013). In many clinics, the addition of staff (e.g., pharmacy assistants, data entry staff) and training of professional nurses in comprehensive management of PLWH via the Practical Approach to Lung Health in South Africa guidelines (Zwarenstein et al., 2011) preceded integration into PHC clinics. In practice, integration in the clinic setting has been revealed to be diverse, ranging from disease-specific nurses and consultation rooms in the same clinics