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Hope is the pillar of the universe: Health-care providers' experiences of delivering anti-retroviral therapy in primary health-care clinics in the Free State province of South Africa

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Abstract

South Africa is experiencing one of the largest HIV/AIDS epidemics in the world. A national, publicly funded anti-retroviral therapy (ART) programme has recently been launched. This paper describes the findings from a qualitative study of the views of health-care professionals, especially nurses, regarding the ART roll-out in the Free State province of South Africa, where nurses are responsible for most of the care delivered to AIDS patients. The study highlights the hope provided by the new programme and the motivation it has engendered among nurses. Apart from long waiting lists for ART, these professionals saw the main programme challenge as the integration of a holistic model of patient-centred care, inclusive of psycho-social support, into an under-resourced primary health-care system. By comparison, neither the increasing clinical responsibilities borne by nurses, nor the ability of patients to adhere to ART, were seen as key problems. This study suggests that the ART programme has mobilised health workers to assume responsibility for providing high-quality care in an under-resourced setting.

Keywords: South Africa; Anti-retroviral therapy; HIV/AIDS; Patient-centred primary care; Nurses

Introduction

The extent of the HIV pandemic in South Africa is now common knowledge. National seroprevalence among women of reproductive age was reported at 29.5% in 2004 (South African Department of Health, 2005). Furthermore, the Actuarial Society of South Africa estimates that over 1000 people are infected daily and that over 300,000 people died of AIDS in South Africa in 2004 alone (Groenewald, Nannan, Bourne, Laubscher, & Bradshaw, 2005).

The slow pace of the anti-retroviral therapy (ART) programme roll-out has been criticised by those who point out that the ART programme was officially launched in November 2003, with a commitment to treating over 380,000 South Africans by April 2006. As of January 2006, however,

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preliminary estimates placed numbers on treatment at about 110,000 (Cullinan, 2004; Geffen, 2006). At least 85% (900,000) of South Africans requiring ART had not received this by mid-2005 (UNAIDS/WHO, 2005).

What is less well known, and certainly less well understood, are the challenges facing the South African public health-care sector in achieving a comprehensive national programme (Chopra, 2005). Because a roll-out on the scale currently being initiated in South Africa has not been attempted elsewhere, little is known regarding the impacts of this on health-care providers and the health system. In this paper, the experiences of health-care professionals (nurses, and to a lesser extent doctors) involved in the ART roll-out in the primary health-care clinics of dusty Free State province townships, often somewhat romantically referred to as the 'grassroots', will be elaborated. These experiences need firstly to be contextualised within the overall context of the HIV/AIDS pandemic and the public health-care system of South Africa.

While high drug prices have been highlighted as the primary constraint to large scale ART provision, the reality is that ART is now affordable in South Africa's publicly funded health sector. It is the shortage of skilled health professionals in the public sector that is arguably now the most serious constraint to comprehensive roll-out (Benatar, 2004; WHO, 2006a). One manifestation of under-resourcing has been the dearth of national leadership regarding HIV/AIDS within the Department of Health (Marais, 2005; Schneider & Stein, 1999). This has been attributed partly to the frustrations of working in a context where ART is still not actively endorsed by senior national government officials (Geffen, 2006; Sunday Times Editorial, 2005). This has been further compounded by the 'poaching' of highly qualified personnel by international aid and donor organisations (WHO, 2006a). During 2004–2005, the National AIDS Director, the Head of the National TB Directorate and the Registrar of the Medicines Control Council all left to join international agencies.

There are approximately 32,000 nursing positions vacant in the South African public health sector, partly as the result of an ongoing 'brain drain' to other countries (Kober & Van Damme, 2004; WHO, 2006a). This might lead one to expect nurses to be ambivalent about ART implementation, given the additional training and workload involved, not to mention the need to interact with stigmatised and very ill patients. Certainly, many previous initiatives to motivate nurses in South Africa to change their clinical practices, for example regarding TB diagnosis and care and mental health care, have met with limited success, in part due to the entrenched system of task-oriented care (Lewin, 2004; Lewin, Dick, Zwarenstein, & Lombard, 2005; Petersen, 1999).

ART roll-out in the Free State province

The Free State, one of nine provinces in South Africa, has the fourth highest prevalence of HIV infection in the country, with 29.5% of antenatal attendees testing positive (South African Department of Health, 2005). (This corresponds exactly to the national prevalence rate.) Estimates suggest that 100,000 of its 548,000 HIV-positive citizens are presently eligible for ART in line with the National AIDS Plan (Dorrington, Bradshaw, & Budlender, 2002). Better-resourced provinces started to implement ART from as early as 2001, regardless of a lack of national direction (Coetzee et al., 2004). Unfortunately, poorer and largely rural provinces such as the Free State have lacked the expertise and/or independent funding and political will to do so, and ART first became available in the Free State public health sector in May 2004. At the end of March 2005, 9527 HIV-positive adults had been assessed in programme facilities and 1165 of these commenced on treatment (UCT, MRC, & FSDoH, 2005).

From a health systems perspective, the Free State is characterised by a lack of skilled health workers, particularly doctors. Its ART programme is therefore primarily nurse-driven. At the time of study, patients who qualified for treatment (CD4 count $\leqslant$200 and/or AIDS as diagnosed by clinical staging) were referred to the nearest hospital for initial assessment by a doctor. Thereafter patients were referred back to the primary care clinic for 'drug readiness' training to facilitate adherence. After returning to the hospital-based doctor for review, ART was initiated if appropriate. Follow-up thereafter was based primarily at clinics, where nurses were responsible for issuing medication, clinical monitoring and adherence monitoring and promotion. A doctor reviewed progress periodically.

Hope and the provision of treatment to people living with AIDS

Studies from South Africa and elsewhere have described frontline health-care providers' feelings of