Healthcare providers go beyond their call of duty in an ART programme in rural KwaZulu-Natal

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Introduction

Expansion of antiretroviral therapy (ART) programmes has increased demands on the South African health system for accessible and quality healthcare services, with further challenges likely to emerge with the new WHO guidelines recommending treatment initiation for all HIV positive individuals(WHO, 2013a; 2015). Nurses and counsellors are crucial for healthcare delivery, including ART scale-up; and they are a major building block in the WHO health system framework (WHO., 2010).

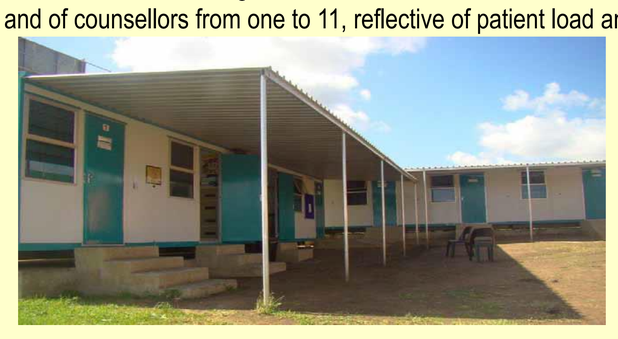
This study sought to understand healthcare providers' perspectives regarding patient care and provision of quality care in the context of an expanding ART programme in a high HIV prevalence rural setting. The study employed interviews structured around results relating to patient satisfaction from an earlier study in the same area, and examined whether such interviews enabled heath care providers to identify potentially modifiable problem areas that could influence quality of care.

Methods

Study setting

The study was situated in the Hlabisa sub-district, uMkhanyakude, northern KwaZulu-Natal, South Africa. Since 2004, the SA Department of Health (DoH) has delivered HIV treatment and care in the sub-district through a decentralised, primary healthcare programme in 17 primary healthcare (PHC) clinics and one district hospital. Between 2005 and 2012, the DoH programme was partially supported by the Africa Centre for Population Health (Africa Centre) through funding from the President's Emergency Plan for AIDS Relief (PEPFAR) via the United States Agency for International Development (USAID) (Houlihan et al., 2011).

The patient load per clinic at the end of 2012 ranged from 409 to 9056. The number of nurses per clinic ranged from none to four and of counsellors from one to 11, reflective of patient load and size of clinic.



Data collection

A qualitative study with nurses and counsellors was carried out in eight (of 17) randomly-selected primary healthcare (PHC) clinics in the rural sub-district in 2012. Twenty-five (25) ART healthcare providers directly involved in providing HIV care (16 nurses – including senior nurses in-charge of the clinic - and 9 counsellors) were engaged in discussion about challenges they and their patients faced and perceived factors affecting provision of quality care.

Discussions were based around aspects of satisfaction reported by patients in a previous survey in the same setting and broader issues affecting provision of quality care. Seven of 13 patient satisfaction findings (including aspects of overall satisfaction, communication, contact time, respect, privacy, cleanliness, and waiting times) from the 2009 users' survey (Chimbindi, Barnighausen, & Newell, 2014) were selected to structure the interviews. Discussions were recorded and transcribed, and all data were managed using Nvivo 10. Thematic analysis was used to identify emerging themes and patterns.

Discussion and conclusion

- We found that the use of results from a patient exit survey to engage nurses and counsellors in the same setting was an effective strategy for facilitating open discussion about patient satisfaction.
- Healthcare providers' responses show a commitment to providing quality care and to their profession. There is a need to strengthen the health systems in terms of human resources and availability of drugs. These concerns become even more urgent in light of the new WHO ART initiation guidelines (WHO, 2015), which will likely increase numbers of HIV positive people on treatment and thus further increase the burden on healthcare providers.
- Most clinics in our study were rural and patient load relative to the staff complement was high. Some healthcare providers felt their engagements with patients was sometimes out of their control and due to deeper structural and systemic problems within the healthcare system, indicating a limited capacity to bring about change. However, in line with other studies, we found that healthcare providers also showed resilience and endurance and developed effective coping mechanisms to provide quality care to patients within limited resources (Eyles, Harris, Fried, Govender, & Munyewende, 2015). For instance, providers described using their personal cars to collect ART from the district hospital pharmacy or borrowing resources from neighbouring clinics when their stocks were low.
- The issues raised are salient in HIV programmes, potentially affecting patients' engagement in care. Engaging healthcare providers in regular discussions may also empower staff to be active agents of change and help them to deal with the reality of constraints within a quality improvement framework.

Results

Two broad theoretical constructs emerged:

1. Healthcare providers' empathy and responsiveness to individual patient's challenges; and
2. Feelings of helplessness and inability to address structural barriers within the system.

Three key lessons learnt included:

1. Healthcare providers felt unable to respond effectively to patient concerns related to staff attitude, perceived respect and the long waiting times for individuals, within a system where many logistical challenges to delivering high quality care existed
2. Healthcare providers felt they had limited capacity to bring about change in the quality of the care they provided because of limited resources
3. Lessons on resilience emerged as healthcare providers described their adopted solutions to deal with these issues, including working longer hours and using personal resources to support patient needs

Emerging sub-themes:

Understaffing and increased workload - "We sacrifice our lunch breaks"

In response to patients' comments about long queues, poor contact time and lack of respect, healthcare providers pointed out that they were short-staffed, overworked, fatigued and emotionally and mentally tired most of the time.

"…we are short-staffed, sometimes when you are seeing more patients and you are tired physically and mentally you end up taking it to the client and the client won't understand that you are tired and overworked." (Clinic Nurse)

Healthcare providers reported sacrificing lunch breaks until they finished working through patient queues. While they were not happy with the situation, they felt "there was no alternative"

Drug stock-outs - "I use my own transport to go fetch drugs"

Healthcare providers indicated that working in a resource-limited setting (during the study time there were temporary ART shortages) was frustrating, and sometimes made them feel helpless. In response to drug shortages, some healthcare providers 'borrowed' treatment from other clinics and sometimes used their own cars to collect patients' treatment.

"I leave the patients and go to other clinic and ask for it and I have to use my own transport…It is because I want to assist the patients, so that the patient does not have to stay without treatment" (Clinic Nurse)

Working patients' dilemmas - "We prioritise patients that need to go back to work"

Healthcare providers reported that working patients had specific challenges accessing treatment. Employers particularly farmers, were reluctant to give time off to workers for initiation sessions and picking up treatment, resulting in some people being lost to follow-up before they could even start treatment.

Some healthcare providers were sympathetic to these concerns ("my conscience would haunt me," one described) and developed strategies to try to help these patients, for instance delivering treatment disguised as take-away foods to patients' workplaces within town or leaving treatment in the clinic for collection after work. In other clinics priority was given to working patients and they were allowed to send their relatives to pick-up their treatment, although sometimes patients needed to be seen and assessed in person.

Equipment and Infrastructure - "I motivate for equipment but no one is helping me"

Lack of essential equipment such as HIV testing kits, haemoglobin meter strips, domestic fridges for nurses, and filing space for patient records was reported. Healthcare providers motivated for repairs and equipment to the district hospital but there was no response.

"We always write letters and they say they are coming and help us with cupboards. We do not have medicine trolleys…we wait for them to come and help us…we don't have wheelchairs, and our stretcher is broken." (Clinic manager)

Cleanliness and hygiene - "We will clean it ourselves"

In response to patient comments on facilities' cleanliness, healthcare providers reported water shortages, old buildings, portable toilets or pit latrines rather than flush toilets as major challenges in their efforts to keep the facilities clean and hygienic.

"…really the toilets here are not enough. Gents and ladies use one toilet. These toilets are dirty and there is no water at all." (Clinic Nurse)

In one clinic, community women helped with cleaning; while in other clinics healthcare providers opted to clean themselves. Some clinics were making the effort to provide clean drinking water in the waiting area and for washing hands after toilet use

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