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RESEARCH QUESTION

The research was a comparative case study of the early management of ART scale up in three South African provinces (Western Cape, Gauteng and Free State), focusing on both operational and strategic dimensions (Brinkerhoff & Crosby, 2002). The three provinces represent the range of ART programme coverage, and therefore scale up success, in South Africa: from lowest (Free State) to highest (Western Cape) and average (Gauteng) coverage rates (see Figure 1).

INTRODUCTION

South Africa's antiretroviral programme is governed by defined national plans, establishing treatment targets and providing funding through ring-fenced conditional grants. In constitutional terms, however, provincial governments bear the main responsibility for provision of health care, and have a certain amount of autonomy and therefore choice in the way their HIV/AIDS programmes are implemented.

Despite the presence of ring-fenced funding and specific national policy, one of the striking features of ART scale up in South Africa has been the level of provincial variation in outcomes: in 2008, ART coverage rates (using national criteria of need) ranged from 26% (Free State) to 72% (Western Cape) (Adam & Johnson, 2009).

What accounts for this variation between provinces? Many argue that financing and human resource capacity explain the variation. While these factors are relevant to understanding variation, they do not sufficiently explain it. This brief focuses on the role of provincial programme implementation, as a set of political and managerial choices further influencing programme scale up.

KEY FINDINGS

DIFFERENCES IN OPERATIONAL MANAGEMENT

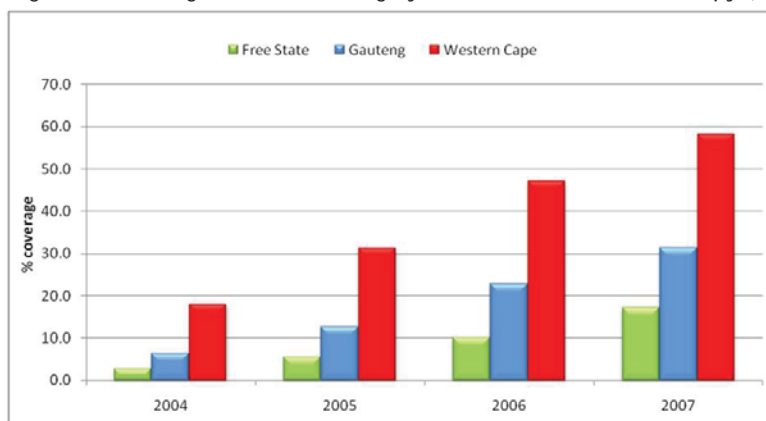
Availability of ART sites, medical personnel and drugs

The Western Cape had a higher ratio of ART sites per population and availability of medical personnel than the other two provinces. Gauteng and Free State had similar human resource profiles, although the latter had higher ratios of public sector nursing personnel than Gauteng. Both Gauteng and Western Cape had procured antiretroviral drugs prior to the finalisation of the national drug tenders (in 2004) using their own resources, in contrast to the Free State programme, which relied on a delayed and initially erratic national process of procurement. The inception of the programme in the Free State was thus characterised by hesitancy and disrupted availability of drug supplies.

Programme monitoring

Poor information, especially regarding programme outcomes, has been regarded as a key weakness of South Africa's ART programme nationally. However, a distinctive feature of the Western Cape was its high quality ART information system. This provided the basis for programme review and accountability.

Figure 1: Coverage of adults on Highly Active Antiretroviral Therapy (HAART), 2004-2007



Source: Personal communication, Leigh Johnson, 2009

STRIKING DIFFERENCES IN STRATEGIC MANAGEMENT

Political backing

Amidst national political scepticism towards ART programmes, some provinces benefited from strong and open political backing:

- In the Western Cape, key ANC-aligned officials within the bureaucracy were willing to push policies that went against national recommendations, ensuring early implementation of the programme.
- In Gauteng, political support came from an ANC-aligned provincial premier who had sufficient political capital within the ruling party to chart an independent course on AIDS in the province.

The Free State did not benefit from such high level backing:

- Officials in the Free State operated within a more constrained environment, dictated by national policy and funding. While seeking to express their own unique approach to the programme, their power to mobilise and influence other actors within the province was patchy.

Programme design

Provinces adopted different approaches to programme design:

Fixed approach (Free State)

- The programme in the Free State was designed with external experts to ensure a carefully planned and monitored roll-out process; it was referred to as the “3X1 patient-walk-through” model (where patients moved between one of three “assessment” sites and a “treatment” site at particular points in the care pathway).
- This design inadvertently created a programme style of rigidity and excessive caution, whether related to accreditation of new sites or the decision to initiate treatment in individual patients. It did not encourage new ideas and learning from experience or promote ownership of the programme on the part of front-line providers or district health services.

Partnership approach (Western Cape)

- The Western Cape’s programme was defined by the idea of creating partnerships between government, NGOs and academics. Governance relied on the considerable chemistry between a few “leading men” in the policy community.
- Through these processes, programme rules evolved, such as the standardisation of the information system for the province. However, individual sites were also encouraged to experiment with different approaches or modify them as services evolved and problems were confronted.

Laissez faire approach (Gauteng)

- There was a fair degree of variation between sites evaluated in this province with respect to adherence, information and other systems, and some autonomy for local/district players to develop their own approaches to service delivery.
- This programme did not have a particular design beyond the templates provided by national plans; it did not specifically encourage but neither precluded partnerships with other actors, which did emerge around specific foci of activity, such as training.
- In particular, the programme implicitly drew on the experience, support and training of several large, well established and donor-funded (particularly PEPFAR-partner) ART sites based in academic centres.

POLICY IMPLICATIONS

- Sub-national programme processes and the influence of factors other than financing or human resource capacity are critical in understanding intervention scale up.
- Strategic management plays a central role in scale up, at the heart of which is the capacity to engage flexibly with multiple actors and interests to align them to programme goals, whilst taking account of the constraints and possibilities of the implementation environment. This capability is required at both national and sub-national levels, particularly in decentralised health systems.
- Operational research on appropriate programme choices and on how to build managerial capacity, particularly in decentralised health systems, could play an important role in supporting scale up processes in policy environments.

References

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