

**DURBAN UNIVERSITY OF TECHNOLOGY**



**Management of an HIV/AIDS wellness programme: A Case Study of the HIV  
Your life programme**

**by**

**Shayhana Ganesh**

**Student No. 21451823**

**A thesis submitted in fulfilment of the requirements for the degree of**

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**In the**

**School of Public Management and Economics**

**Faculty of Management Sciences**

**Supervisor: Professor Renitha Rampersad**

**Co-Supervisor: Professor Nirmala Dorasamy**

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## **Abstract**

HIV-AIDS has infected more than 37 million individuals globally and has resulted in approximately 35 million HIV-AIDS related deaths globally since its discovery 35 years ago. HIV-AIDS remains a global and local health crisis as, despite innovative and accessible HIV-AIDS prevention efforts, the disease continues to spread. UNAIDS estimated over 2 million new HIV-AIDS infections with 700 000 of these infections occurring in young African women in 2015, revealing that the burden of HIV-AIDS is far from over (UNAIDS, 2016). As more individuals become infected with HIV-AIDS, more infected individuals are living longer, productive lives due to the international rollout and scale-up of life-saving antiretroviral (ARV) therapy aimed at halting disease progression. In 16 years, the world has initiated over 16 million HIV-infected individuals onto ARV programmes across the world aimed at preserving first line drug effectiveness of treatment, less resistance and lower mortality and morbidity rates (UNAIDS, 2016). This number is set to double as countries across the globe take bold steps to provide ARV treatment for all, based on latest WHO guideline changes. The initiative of ARV roll out for all HIV-positive individuals globally, brings with it the challenges and complexities of infrastructure support, resource allocation, uninterrupted drug supply, global access and clinical training requirements for HIV-AIDS programmes across the globe. Quality management systems with monitoring and evaluation frameworks in particular play a pivotal role in planning, allocating and utilising resources for optimal health benefits. This research study reviews available data on the prevalence of quality management systems in HIV-AIDS healthcare and identifies gaps and smart practises towards recommendations for comprehensive global HIV-AIDS standards development. This research study aims to propose a conceptual monitoring and evaluation framework derived from quality management systems for management of HIV-AIDS private sector programmes that can be used in both public and private healthcare sectors through analysis of current conceptual frameworks in the HIV-AIDS healthcare and the HIV-AIDS programmes within the South African context of HIV-AIDS healthcare provision.

## **Declaration**

I hereby declare that the work (described) in this thesis is my original work, and has not previously been submitted either in part or in its entirety, for a degree at any other university. I also further declare that this work does not in any way infringe or violate the rights of others, as all the sources cited or quoted by me are indicated and acknowledged by means of a comprehensive list of references.

## **Dedication**

This study is dedicated to my Dad whose unwavering faith, support and encouragement allowed me to remain positive, committed and dedicated to my goal realisation.

Love you always, Dad.

## Acknowledgments

*"The mediocre teacher tells. The good teacher explains. The superior teacher demonstrates. The great teacher inspires."* William Arthur Ward

My sincere appreciation is expressed to my two supervisors who, through their patience, teaching and tolerance *inspired* the culmination of this dissertation. Their sage advice, insightful criticisms, and patient encouragement guided the writing of this dissertation: Thank you very much!

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## List of abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CAPRISA	Centre for the AIDS Programme of Research in South Africa
HIV	Human Immunodeficiency virus
HSRC	Human Sciences Research council
KZN	Kwa Zulu Natal
M&E	Monitoring and Evaluation
NDoH	National Department of Health
MDGs	Millennium Development goals
NGO	Non-governmental organisation
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother to child transmission of HIV
SOP	Standard Operating procedure
Stats SA	Statistics South Africa
SAMRC	South African Medical Research Council
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
USAID	US Agency for International Development
WHO	World Health Organisation

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# **CHAPTER ONE**

## **INTRODUCTION**

### **CHAPTER 1**

#### **INTRODUCTION**

#### **1.1 Rationale for the study**

This study analyses an HIV-AIDS wellness programme within the South African HIV-AIDS healthcare context. South Africa hosts the largest HIV-AIDS programmes globally (UNAIDS, 2013:18). The appropriate management of HIV-AIDS treatment and wellness programmes is vital to ensure operational efficiency and cost effectiveness, hence ensuring optimal patient management. This research study aims to explore and evaluate the Your Life Programme as an HIV-AIDS treatment and wellness provider. The purpose of this framework will be to assess the current outcomes of the HIV-AIDS programme as well as to assess the operational outputs of the programme with a view to enhancing patient care with maximal public health benefits.

#### **1.2 Contextualisation**

The treatment and management of HIV-AIDS is a continually changing process informed by state of the art international randomised controlled trials, and global operational programme dynamics set against global, national and local ethical as well as regulatory requirements. It is imperative that HIV-AIDS wellness providers re-engineer their service delivery in order to adapt industry standards. The HIV Your life Programme is a new HIV-AIDS wellness provider in the managed healthcare industry and this research aims to improve the clinical efficacy of this programme. The current goals of this HIV-AIDS service provider are:

- The early initiation of Anti-retroviral therapy (ART) for adults and children;
- The removal of HIV-AIDS amongst children;
- The reduction of tuberculosis deaths; and

- The reduction of transmission of HIV-AIDS amongst individuals that are at risk;

### **1.3 Problem description**

HIV -AIDS places a significant burden of disease on HIV-AIDS service providers in South Africa due to the increasing HIV prevalence and incidence in the region. The HIV Your Life Programme is a young healthcare provider which offers a unique opportunity for research because there is currently a lack of similar studies available in this sector. Data acquired from this study will be used to inform the HIV-AIDS field and enhance the body of knowledge for HIV-AIDS. It will be used to collaborate the public sector facilities and non-governmental organisations to ensure that HIV-AIDS treatment and wellness programmes are optimally managed to allow for greater public health impact.

The research study will assess the Your Life Programme as a national HIV treatment and wellness provider with a view to developing a conceptual monitoring and evaluation framework for such programmes in order to enhance service delivery and patient care.

### **1.4 Contribution to the field of research**

The results of this study are applicable to HIV-AIDS management programmes locally and globally. Furthermore, research of this nature will be beneficial and valuable to the HIV-AIDS programme on which this case study is modelled. It will provide direct support of management services with a view to the continuous improvement of content and processes. This shows that the outcome of this research study can be rolled out in the private, public and non-governmental healthcare sectors in the spirit of collaborative learning and development.

#### **Specific contributions:**

- This research project aims to produce research papers on the development of a monitoring and evaluation conceptual HIV-AIDS framework as a model of practice for an HIV-AIDS programme;

- This study aims to develop training manuals for healthcare professionals to implement monitoring and evaluation tools in the healthcare sector;
- Outcomes of this research will be presented to local, regional and provincial Department of Health officials for roll out across other clinics; and
- This research project aims to produce International and National conference presentation materials.

## **1.5 Research objectives**

The central objective of this study is:

To propose a conceptual monitoring and evaluation framework derived from quality management systems for the management of HIV-AIDS private sector programmes through the analysis of current conceptual frameworks in HIV-AIDS healthcare and HIV-AIDS programmes within the South African context of HIV-AIDS healthcare provision.

Specific objectives

This research will make a significant contribution by:

- Developing clear monitoring and evaluation processes;
- Defining core indicators for the HIV-AIDS epidemic
- Describing the HIV-AIDS related operational research
- Describing critical data sources
- HIV-AIDS role description of stakeholder

## **Method of investigation**

This study adopts an exploratory and descriptive paradigm together with a developmental component and will be conducted using both qualitative and quantitative approaches. The descriptive component surveys study participants which classifies their roles and responsibilities at the HIV Your Life Programme and contextualises the environment in which they function. A qualitative and quantitative

approach was undertaken with questionnaire administration and interview completion in order to ensure a comprehensive data collection and analysis. A detailed discussion of the research methods is found in Chapter Six.

## **1.6 Literature study**

The literature review for this study comprises four chapters. Core concepts of the HIV-AIDS epidemic is analysed in each chapter. After presenting a global and then local perspective of HIV-AIDS; the researcher delves into quality management in healthcare.

## **1.7 Overview of the study**

### **Chapter two: global perspective of the HIV-AIDS epidemic**

Issues analysed include HIV-AIDS related stigma, discrimination and disclosure in vulnerable populations. Global HIV-AIDS programmes are discussed, with an emphasis on programme target goals, challenges and the integration of service delivery for optimal HIV-AIDS wellness and care. This chapter concludes with a multidisciplinary approach to past, present and future HIV-AIDS bio-psycho-social approaches to HIV-AIDS prevention, with lessons learnt

### **Chapter three: HIV-AIDS epidemic: a South African perspective**

This chapter explores the HIV-AIDS epidemic in South Africa. It analyses HIV-AIDS statistics in South Africa and reviews the social, political and behavioural aspects of the disease in South African context. Discussion points in this chapter focus on HIV-AIDS counselling and testing in South Africa; HIV-AIDS education in South Africa; clinical management and treatment of HIV-AIDS in South Africa; and concludes with the potential future of HIV-AIDS in the South African context.

### **Chapter four: an analysis of HIV-AIDS monitoring and evaluation frameworks: a component of quality management in healthcare**

This chapter provides a discussion of the concepts of quality management, its relevance to healthcare and discusses the ISO 9001 2015 as an integral quality



management tool in the healthcare arena. The chapter highlights discussions on monitoring and evaluation of health programmes.

#### **Chapter five: monitoring and evaluation of HIV-AIDS programmes in South Africa**

Exemplars of HIV-AIDS programmes from the various SWOT analysis of their internal (micro) operating environments and through a PEST analysis of their external (macro) environments in an attempt to identify their efficiencies, deficiencies and core capabilities towards smart practices.

#### **Chapter six: research methodology related to the problem under investigation**

This chapter reiterates the research problem and describes the research design that comprised a mixed methodology, using a case study approach. In addition, the data collection methods are outlined and the research instrument explored. The data analysis and statistical techniques are also explained.

#### **Chapter seven: presentation of findings and interpretation of results**

Results and its findings of this research study together with the interpretation of results utilising graphic representations and discussions.

#### **Chapter eight: conclusions and recommendations**

This final chapter culminates in a discussion on the conclusions and recommendations of this research study, based on the research study objectives.

### **1.8 Conclusion**

It is anticipated that this research study will generate data towards the development of a framework for the management of HIV-AIDS programmes in the private, public and NGO sectors with a view to enhancing patient care with maximal public health benefit. The literature review spanning Chapters Two, Three, Four and Five is presented hereafter.

**CHAPTER TWO**

**GLOBAL PERSPECTIVE OF THE HIV-AIDS EPIDEMIC**

## **CHAPTER TWO**

### **GLOBAL PERSPECTIVE OF THE HIV-AIDS EPIDEMIC**

#### **2.1 Introduction**

The routes of HIV transmission, with factors facilitating its spread, will be examined together with determinants of the disease resulting in its high incidence in developed and developing countries. HIV-AIDS global statistics will be shared, detailing differences between developed and developing countries and reasons for such disparity. This chapter also analyses HIV-AIDS- related stigma, discrimination and disclosure in vulnerable populations. Global HIV-AIDS programmes are discussed with an emphasis on programme target goals, challenges and the integration of service delivery for optimal HIV-AIDS wellness and care. This chapter concludes with a multi-disciplinary approach to past, present and future HIV-AIDS bio-psycho-social approaches to HIV-AIDS prevention.

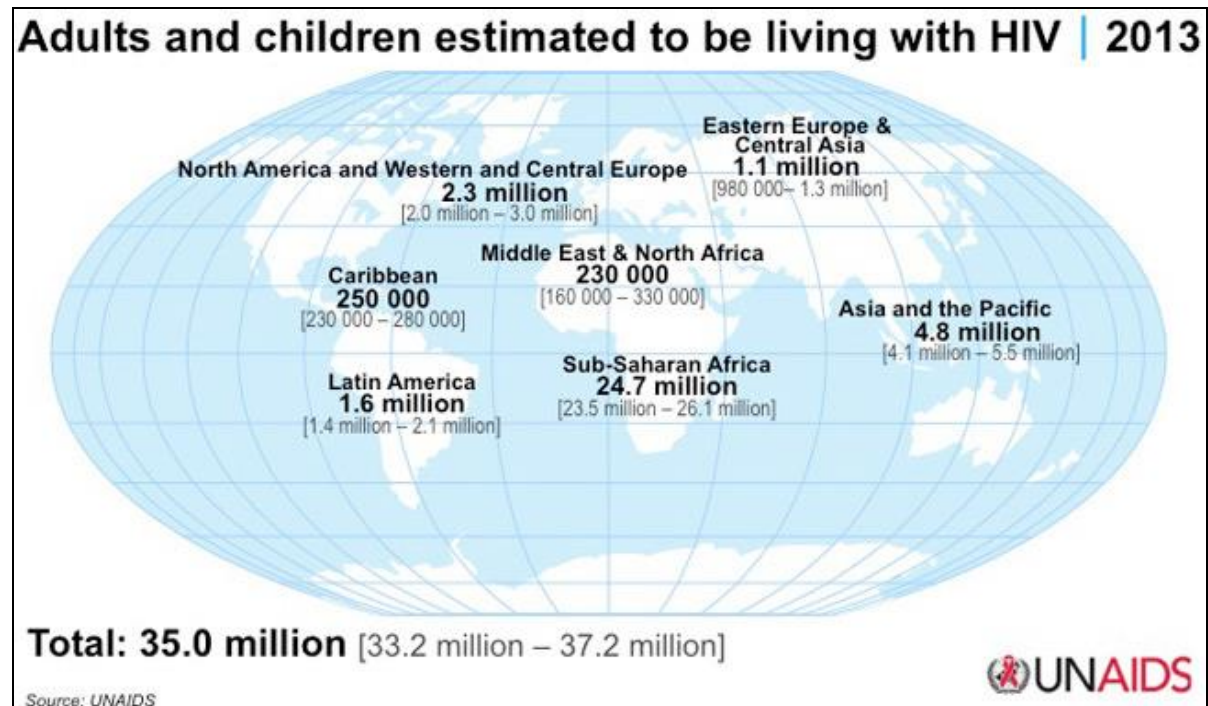
#### **2.2 Origin of HIV-AIDS**

Transmission routes of HIV-AIDS have been well documented and include transmission through sexual intercourse, intravenous drug usage of contaminated syringes and infected blood and blood products ( Hillier and McGowan 2009:34). HIV-AIDS transmission routes differ between populations and countries, necessitating a thorough analysis of HIV-AIDS epidemics in affected areas in order to ultimately understand reasons for differences in global HIV-AIDS statistics which is discussed below.

## 2.3 Global HIV-AIDS statistics

HIV-AIDS is a global phenomenon. Figure 2.1 provides this data.

**Figure 2.1 Adults and Children estimated to be living with HIV (2013)**



**Source: UNAIDS (2013:9)**

Figure 2.1 demonstrates the estimated global HIV-AIDS prevalence. In 2013, an estimated 35 million people were living with HIV-AIDS – a global HIV prevalence of 0.8%.

A concentrated epidemic is clearly located in Sub-Saharan Africa as developing countries bear the global brunt of this disease. In comparison, developed nations are minimally affected by the disease and the modes of transmissions are different. Sub-Saharan Africa has an abundance of heterosexual transmission, whereas the epidemics in the developed regions are primarily through homosexuals and drug users (Morrison 2014:7). This herald's important information for policy makers and implementers in trying to provide tailor- made HIV-AIDS prevention efforts to curb the epidemic (Mills 2014:10).

The response to HIV-AIDS in developing nations has been a fragmented one for some of the following reasons amongst others for : lack of healthcare resources; poor healthcare infrastructure coupled with poor healthcare service delivery resulting in sub-optimal HIV clinical management across the country; and inadequate HIV-AIDS counselling and testing resulting in poor uptake of life saving antiretroviral therapy. These factors have fuelled the epidemic and have contributed to the increasing HIV-AIDS prevalence rate for the sub-continent.

## **2.4 Global determinants of HIV-AIDS**

### **2.4.1 Community and societal characteristics**

Community and society has long been considered a social determinant of health (Bärnighausen, Hosegood, Timaeuss and Newell 2007:12). Data was analysed in terms of household income, type of lifestyle and risky sexual behaviour. Higher income earners were more likely to indulge in promiscuity and risky sexual behaviour. This longitudinal study provided evidence about the causal effect of relative wealth on the risk of HIV-AIDS acquisition.

### **2.4.2 Education**

An education has been identified as a major determinate for acquisition of HIV-AIDS.

### **2.4.3 Stigma**

Several themes emerged of “fear of HIV-AIDS infection”, which was identified as the most common cause of HIV-AIDS stigma. Public discrimination, workplace discrimination, prejudice and stereotypical behaviours were key findings revealed as important factors contributing to HIV-related stigma.

### **2.4.4 Behavioural**

The identification of factors driving the HIV-AIDS epidemic is only half the question answered. Coupled with this is exploring key innovative and targeted responses to reduce the epidemic. Responding to key driving factors of the HIV-AIDS epidemic is crucial to turning the epidemic around and can be achieved through interventions empowering people and building a stronger society.

### **2.4.5 Actions to address global determinants of HIV-AIDS**

Satcher (2010:4) identifies five areas of the public health system that should be leveraged for maximum public health benefit in order to address global determinants of HIV-AIDS:

- i) Emphasis on stronger health policies to directly control the HIV-AIDS epidemic. This is an important driver driver requiring government and political support to drive health policies for implementation at ground level.
- ii) A human rights approach bearing themes of beneficence and justice are key elements that underpin equity in developing key innovative implementations to address the components of the determinants of HIV-AIDS globally.
- iii) Expanding resources to address HIV-AIDS determinants of health. Distribution of health re allocated and re-budgeted to meet the growing need of HIV-AIDS related services.
- iv) Health care workers require HIV-AIDS programmes to encompass a diverse portfolio of individual and community-level interventions to HIV-AIDS prevention and control (Fox 2010:11).

### **2.6. UNAIDS goals for revised HIV-AIDS management targets: The (90%-90%-90% report)**

The UNAIDS goals for reaching HIV-AIDS targets for HIV-AIDS treatment, prevention and care have been revised to include the 90-90-90 goals. This means that: *“By 2020, 90% of all people living with HIV will know their HIV status. By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression”*.

Implementation of the UNAIDS revised HIV-AIDS management targets will require affordable HIV-AIDS diagnostics; better tolerated and more cost effective antiretrovirals and strong political will with strengthened health systems (UNAIDS Global Report 2014:15). Coupled with this are implementation and development of adaptable and contextually relevant monitoring and evaluation frameworks. Revised HIV-AIDS management targets have become the guiding principle for managing global HIV-AIDS programmes discussed below.

## **2.7 Global HIV-AIDS programmes**

Given the global burden of HIV-AIDS disease, governments and non-governmental organisations have set up in-country and global HIV-AIDS programmes in order to combat the devastating effect of rising HIV transmission rates both in the private and public healthcare sectors. Global HIV-AIDS programmes form innovative partnerships. Mobilizing political, technical, scientific and financial resources are pivotal to well-managed global HIV-AIDS Programmes.

Given recent changes and updates in the WHO ARV Initiation Guidelines and Clinical Management (WHO 2015:54), sector appropriate monitoring and evaluation efforts become crucial to track and guide responses to key programmatic challenges, some of which are discussed next.

### **2.7.1 Challenges facing global HIV-AIDS programmes**

A major challenge facing global HIV-AIDS programmes is that funding HIV-AIDS programmes. As the HIV-AIDS epidemic develops, countries across the globe will need to assess how to allocate what are currently limited resources across various HIV-AIDS programmes in order to reach the most vulnerable populations most in need of clinical interventions. Fundamental challenges to be overcome as described below:

- **Staff shortages:**

Staff shortages, the isolation of medical staff with few mentoring facilities, together with a lack of standardised training facilities pose significant programmatic issues. Equipped with properly formulated and relevant tools, healthcare workers can make

the necessary and sustainable impact on the health of the populations for which they are responsible (Meyers, Moultrie, Naidoo, Cotton, and Sherman 2007:85).

- **Lack of integration of health services:**

Epping-Jordan, Pruitt, Bengoa and Wagner (2004:246) identify a lack of integration of HIV-AIDS services with primary healthcare services as a key challenge to global HIV-AIDS programmes allowing vertical programmes that independently manage separate disease entities with a duplication of resources and efforts. Creative solutions are necessary to address the escalating healthcare demands of an ailing population. One such solution is the Integration of health services into global HIV-AIDS programmes (South Africa 2015:11).

## **2.8 Global efforts for HIV Prevention**

Global efforts to end HIV-AIDS have spanned since almost 20 years and still any form of a cure or effective HIV prevention modality remains at large. The newly coined term of HIV-AIDS combination prevention approaches have been shown to systematically and consistently increase HIV-AIDS programme effectiveness (Winscott, Taylor and Kenney 2010:51). These combination prevention packages utilise a variety of prevention mechanisms to best suit the patient and the community concerned, in order to develop a tailor made intervention approach to curb the HIV incidence in that particular community. HIV prevention approaches are discussed hereafter.

### **2.8.1 Behaviours to change HIV-AIDS**

HIV-AIDS education and awareness and the “ABC” approach is a key step to behaviour change.

#### **2.8.1.2 “ABC” approach**

Stopping the spread of HIV-AIDS can be done through abstinence (James, Shelton, Halperin, Nantulya, Potts, Gayle, and Holmes 2004:891). Most discussions surrounding HIV-AIDS is covering condom utilisation.



## **2.8.2 Biomedical prevention innovations**

Biomedical innovations are identified as the wave of the future. Several of these approaches are discussed below:

### **2.8.2.1 Condom Promotion**

It is important to realise to date condoms remain as the most important step in the fight against HIV. It is a barrier mechanism and hence prevents the physical spread of the disease. Condoms are available freely throughout all health facilities throughout the nation. More expensive ones can be purchased without a prescription.

### **2.8.2.2 Microbicides**

A microbicide is a vaginal device, gel or tablet that may be inserted into the vagina during times of sexual activity in order to decrease the risk of HIV acquisition (Hillier, McGowan and Riddler 2005:6, Moore and Rogers 2002:12). These microbicides are often impregnated with medication which exhibit anti-HIV activity.

### **2.8.2.6 Pre-exposure prophylaxis (PrEP)**

There is new hope in HIV prevention: Several studies have now shown that antiretroviral drugs prevent HIV infection. Treatment for prevention in particular provides huge hope as a promising new HIV prevention technology that can empower women to protect themselves from HIV-AIDS (Abdool Karrim 2013:9). The new anti-retroviral drug, Tenofovir, alone or in combination with 200 mg of Emtricitabine can decrease the chances by 50% or more among persons with high adherence to the regimen, with demonstrated efficacy in men who have sex with men, heterosexuals, and injection-drug users (Marrazzo, Ramjee and Richardson 2015 :509).

### **2.8.2.7 Perinatal HIV-AIDS prevention**

Perinatal transmission was a leading cause of HIV infection early in the epidemic and remains a significant concern in many countries in the world. However, advances in research, HIV-AIDS treatment, and care have greatly lowered the

chances of a mother passing HIV onto her unborn child to as low as 1 in 100 (Short 2014:2).

### **2.9.3 The future of HIV-AIDS prevention: Lessons learnt**

Behavioural, biomedical, and structural interventions are needed to prevent HIV-AIDS. Behavioural interventions have been successful, but suffer from low uptake, and few have been designed to accompany the biomedical innovations on the horizon.

Although Sub-Saharan Africa is leading the global HIV-AIDS response in the right direction, there is still a lot to be done. In some countries such as Lesotho, Uganda, United Republic of Tanzania, HIV-AIDS incidence has been stagnating or even increasing raising an alarm for the need to urgently step up prevention efforts (UNIADS 2013:12). Sub-Saharan HIV-AIDS prevention and treatment efforts are still plagued by the following challenges:

- We need progress in many community approaches to halting the spread of the disease.
- Considerable research efforts are necessary to obtain information about the disease and its spread and a possible cure (Weiss, Wasserheit, Barnabas, Hayes and Abu-Raddad 2008:508).
- The answer to assisting is in collaboration between the various healthcare sectors to ensure that a cure is gained (Potts, Halperin, Kirby, Swidler, Marseille and Klausner 2008:749).

## **2.10 Conclusion**

This chapter explored the global HIV-AIDS epidemic and discussed HIV-AIDS in developed and developing countries together with forces driving the epidemic. This chapter reviewed HIV-related stigma and discrimination and also reviewed HIV prevention efforts and analysed global HIV programmes. The next chapter will delve into the South African HIV-AIDS epidemic.



## **CHAPTER THREE**

### **HIV-AIDS EPIDEMIC: A SOUTH AFRICAN PERSPECTIVE**

## **CHAPTER THREE**

### **HIV-AIDS EPIDEMIC: A SOUTH AFRICAN PERSPECTIVE**

#### **3.1 Introduction**

This chapter explores the epidemic in the country. It analyses the statistics in the country and reviews the social, political and behavioural aspects of the disease in the Southern context. As South Africa has the highest incidence and prevalence globally, this chapter focuses on and assesses important components of the national HIV-AIDS programme. Discussion points in this chapter also focus on HIV-AIDS counselling and testing; the clinical management and treatment of HIV-AIDS in South Africa.

#### **3.2 Historical background to HIV-AIDS in South Africa**

Strong themes of advocacy and denialism run through the 33 years since its discovery in South Africa (Abdool Karrim 2014:3). Key events that highlight milestones in the rich tapestry of the South African HIV-AIDS history are chronologically tabulated below.

**Table 3.1 Pivotal factors in South African HIV-AIDS**

2003-2008	Delay with ARV approval and roll-out in South Africa due to obstacles from the presiding South African President, Mbeki, and Minister of Health, Msimang.
2009-2013	Change in presidency and Department of Health Ministry PEPFAR/USAID provide strong economic support for ARV supply and roll out in South Africa
2013-2016	Extensive ARV roll-out with adoption of the fixed dose combination pill for adults

**Source: author's research**

The conference called for strong advocacy groups and international government support to commence plans and programmes to target high-risk individuals. In 1999, the first ever campaign preventing HIV-AIDS, called Love Life was founded and soon became advertised over radio, television and print media. The political leadership during this turbulent period was the Health Minister, Manto-Shabala Msimang and South African President Thabo Mbeki. They failed to recognise the HIV-AIDS crisis in the country and delayed in setting up systems for the acquisition and delivery of life- saving anti-retroviral therapy to the millions of South Africans who required it. President Mbeki received wide scale international criticism and harsh judgment for delays with HIV-AIDS service delivery in South Africa. The period 2003 until 2009 was a turbulent journey with denialism, misunderstanding and a lack of understanding of HIV-AIDS amongst South African politicians. This further delayed the commencement and initiation of ARVs for all South Africans. The period 2009-2013 saw a change in leadership in the South African presidency and a change in the health ministry in South Africa following national elections. The period 2013 until 2016 has seen the ARV roll-out programme grow and extend its reach to more infected and affected South Africans. Now the South African ARV programme can boast an extensive ARV roll out with adoption of the fixed dose combination pill for adults, aimed at better treatment and compliance (Abdool Karrim 2014:6).

On 7 March 2016, ex South African president Thabo Mbeki released an online publication defending his actions towards the management of HIV-AIDS during his tenure as South African president. The publication received global and local criticism and set social media ablaze with HIV-AIDS advocates criticising his comments. Upon review of the article, Mbeki commenced with his theory that HIV does not cause AIDS as infections cannot cause syndromes. Scientific evidence states that viruses can cause syndromes and HIV is one such virus that does lead to a syndrome (Karim 2016:2). Mbeki also analysed the global epidemic and questions why no explanations are evident for the different rates of spread between the various countries. Scientists have long since described the varied strains of the HI virus and the different preponderance of its subtypes in certain geographical regions together with routes of transmission and genetics that play a pivotal role in the spread of HIV-AIDS (Gail Bekker 2016:3). In his online publication, Mbeki aligns himself with the beliefs of Luc Montagnier, a veteran HIV-AIDS scientist and researcher who proposes that HIV-AIDS can be cured by good nutrition. However, Karim 2016:2 contends that no human has ever been cured of HIV-AIDS by eating healthy. The mainstay of HIV-AIDS treatment is ARV therapy with good adherence while the cornerstone of HIV-AIDS prevention is combination prevention packages based on an individual's HIV-AIDS risk exposure. In addition, Mbeki still defends his delay of introducing ARV therapy to South Africa by stating that ARVS were a ploy by large multinational pharmaceutical companies to increase sales and profiteering. It is disappointing to see publications of this nature in an era where people are seeing the beginning of the end of HIV-AIDS in South Africa. Today, the South African HIV-AIDS response is being led by SANAC, Minister of Health: who have made significant strides in leading the country toward an HIV-AIDS free generation. Key interventions based on clinical outcomes and evidence-based medicine to inform critical decision-making towards good implementation of HIV-AIDS programmes in South Africa (South Africa 2015).

### **3.3 The South African HIV-AIDS epidemic**

The current prevalence rate amongst adults aged 15 to 49 is 19.1% (UNAIDS 2014:11). Women in South Africa are disproportionately affected by the disease (UNAIDS 2014:11). Biologically the female genital tract is more vulnerable to HIV-

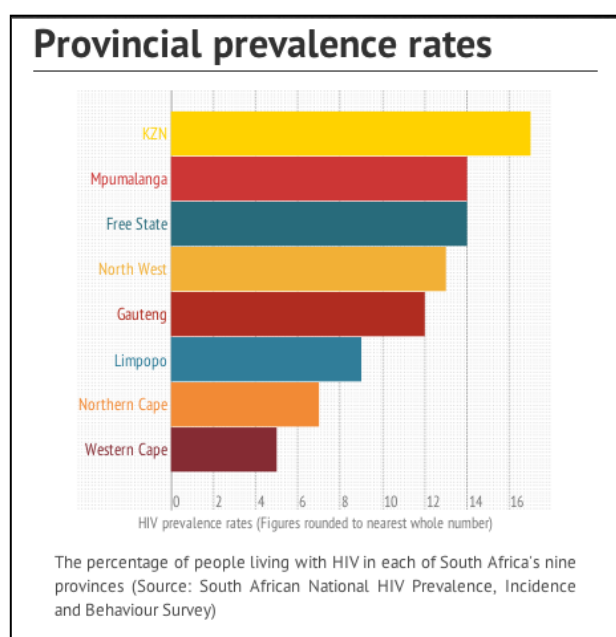
AIDS acquisition. In addition, younger females whose reproductive tracts are not fully developed are more prone to HIV-AIDS infection (International Partnerships for Microbicides 2015:1). In the South African context ,other issues such as culture and gender disparities may account for more females being infected with HIV-AIDS as opposed to males (International Partnerships for Microbicides 2015:2).

This data herald's important information for South African policy and programme developers .It reveals that the South African HIV-AIDS epidemic is still on the increase which implies that current HIV-AIDS education, awareness and advocacy work is failing to achieve necessary targets to reduce the transmission of HIV-AIDS in South Africa. This data highlights that Kwa-Zulu Natal (KZN) still remains the highest prevalent HIV-AIDS province in South Africa which beckons for a complete analysis of current prevention and treatment strategies in KZN to be reassessed and re-evaluated to identify the high areas of HIV-AIDS transmission rates and to inform research approaches with more intensified prevention interventions to curb the escalating rates of transmission.

Given that the Western Cape has the lowest rates of HIV-AIDS transmission, lessons learnt from the Western Cape local department of health HIV-AIDS programme should be shared in the spirit of collaboration with other provinces to help decrease the rate of new HIV-AIDS infections. Integral to these best practices are effective monitoring and evaluation processes which are key to assess whether HIV-AIDS programme realise desired goals and objectives.



**Figure 3.1 South African Provincial Prevalence Rates**



**Source: Adapted from the South African National HIV Prevalence, Incidence and Behaviour Survey (2014:10)**

HIV-AIDS in South Africa has been influenced by socio-behavioural, political, legal and biological components. This survey specifically interrogates key socio-behavioural areas such as socio-demographic characteristics, marital status of respondents, HIV-AIDS exposure risk, and serodiscordance between mother-child pairs and recognises these as integral drivers toward HIV-AIDS acquisition. Marrazzo and Chirenge (2015:11), found in a large HIV-AIDS microbicide prevention trial, that stable married women aged 25 to 50 in Zimbabwe showed less risk of HIV-AIDS acquisition and that this was an important factor in decreasing HIV-AIDS rates in that country. This was further iterated by Baeten and Palanee (2016:1056) when data from their most recent microbicide study (Aspire 2015) conducted predominantly in South Africa revealed that less than half of the women enrolled in the study were married and had the highest risk of HIV-AIDS acquisition, revealing once more that South African women bear a disproportionate burden of the global HIV-AIDS epidemic.

This data is reassuring in parts where attitudes toward people living with HIV-AIDS have improved, showing good successes with overcoming HIV-AIDS-related stigma

and discrimination in South Africa. However the data presented alarming statistics with early sexual debut and the lack of perceived risk of HIV-AIDS acquisition.

The response to HIV-AIDS in South Africa has been a multi-sectoral response with collaborative efforts being put forth from the state, parastatal and private health sectors. Significant funding from international donors and funders has helped alleviate the burden of disease within South Africa. HIV-AIDS prevention efforts appear to be yielding results (Simelela and Venter 2014: 249) such as aggressive approaches to treatment, expansion of Pre exposure prophylaxis, male medical circumcision, and continued condom provision. However, the determinants of HIV-AIDS still need to be addressed in order to assist individuals at risk of HIV-AIDS acquisition.

### **3.3.1 Determinants of HIV-AIDS disease in South Africa**

The HIV-AIDS epidemic is the greatest developmental health challenges that Sub-Saharan Africa faces (Bärnighausen, Hosegood, Timaeuss and Newell 2010:29). Understanding the key determinants propelling the spread of HIV-AIDS is crucial to ending the epidemic. The HIV-AIDS epidemic has four main determinants for its continued spread in Sub-Saharan Africa (National Institute of Health 2013:12). These are classified as: Biological, Behavioral, Structural and Socio-economic determinants.

#### **3.3.1.1 Biological determinants**

Biological determinants are other biomedical components that increase ones vulnerability to HIV-AIDS (tbTBfacts.org). Co-infection with tuberculosis (TB) is an important risk factor for the acquisition of HIV-AIDS (Pettifor, Rees, Klein-Schmidt, Steffenson, MacPhail and Hlongwa-Madikizela 2005:1525). TB is an aggressive bacterial infection most commonly affecting the lungs or throat or other parts of the body (tbTBfacts.org). Symptoms of TB include night sweats, coughing, fever and weight loss. TB can be cured with an intensified drug regimen containing four

antibiotics for two months (Intensive phase) and two antibiotics for four months (Continuation Phase). Adherence is compulsory for a complete cure. Any interruption from therapy can result in treatment resistance. TB is most common in individuals who are co-infected with HIV-AIDS due to a suppressed immunity (TBfacts.org). A significant 83% of HIV-AIDS sufferers are infected concurrently with TB in South Africa (TBfacts.org). Treatment of these individuals involves often more potent antibiotics for longer periods of treatment with better adherence models. Buve, Carael and Hayes (2001:27) contend that active case finding of TB has to be undertaken, treated and concomitant VCT testing undertaken in order to reach populations at risk of HIV-AIDS. HIV-AIDS increases vulnerability and susceptibility to HIV-AIDS Sexually transmitted infections (STI) in these groups should form part of prevention and intervention approaches as key modalities for addressing HIV-AIDS acquisition. Similar risk behaviours are associated with the acquisition of STI and HIV-AIDS. STIs heighten the acquisition risk of HIV-AIDS due to the underlying vulnerability of the genital tract, resulting in chronic inflammation and infection. This chronic inflammation allows susceptibility and entry of the HIV-AIDS virus directly into the genital tract especially if the chronic inflammation is ulcerative in nature. It is important to accurately identify STIs and provide the necessary treatment in the form of triple syndromic management (tbTBfacts.org). Partners should also be tested for STIs and can be treated prophylactically if necessary. Condom provision and secondary HIV-AIDS risk reduction is also required as part of risk reduction counselling for HIV-AIDS. In addressing the biological determinates of HIV-AIDS infection, it is important that a comprehensive biomedical HIV-AIDS prevention approach be undertaken, addressing risk reduction counselling and behaviour change interventions; condom distribution and promotion

### **3.3.1.2 Behavioural determinants**

Behavioural Determinants refer to patterns of behaviour regarding sex and sexual practises. According to Ramjee and Wand (2013:6), multiple partner relationships are powerful transmitters of HIV-AIDS. The authors state that having more than one sexual partner is an important driver for transmitting HIV-AIDS, especially if the sexual acts are unprotected.

In addition, it has been postulated that anal sex has a 13-fold increase in HIV-AIDS acquisition, as opposed to oral and vaginal sexual practices (Karrim and Ramjee 2009:12). Anal sexual practices are often taboo and are often stigmatised, which may be one of the key reasons why they are often not disclosed at times of counselling and risk reduction. Tailor-made HIV-AIDS prevention efforts are required to meet the needs of these key populations in a confidential and private enabling manner. Sexual decision making, condom negotiation and correct consistent condom use can be influenced by alcohol use and abuse, leading to violence and gender based violence. Chersich and Rees (2008:27) suggest that alcohol usage makes women more prone to violence and sexually related violent acts where STI acquisition and HIV-AIDS acquisition can occur.

Behaviorial determinants fuelling the HIV-AIDS epidemic in South Africa need to be addressed through the correct interventional approaches. Components of these interventions will include consistent condom use; safe sex counselling; voluntary counselling ; STI diagnosis; education and awareness on alcohol abuse and emphasise on monogamy and faithfulness (Chersich and Rees 2008:27). The challenge lies in providing a tailor made offering as part of the integration of healthcare services of the department of health in order to be most favourably rolled-out. This also heralds the need for integrated collaborative operational research to address the vacant areas of research needed in the arena of behavioural determinates of HIV-AIDS in order to inform the field.

### **3.3.1.3 Structural determinants**

Power and HIV-AIDS risk is an important driver for acquisition. Pettifor, Measham, Rees and Padian (2004:10) have revealed that the lack of sexual power in a relationship as is often the case in gender based relationships is the reason for forced sexual encounters, subservience for male partners to have concurrent partners and for inconsistent condom use. It is proposed that more operational research is required. Additional research is required to identify avenues for intervention.

Ramjee and Wand (2014:5) posit that migration has been identified as another structural determinant escalating the HIV-AIDS epidemic in South Africa. This

traditionally occurs as individuals migrate to seek employment or better employment and can also occur in areas of famine, war or political instability. Ramjee and Wand (2014:5) found that women are often driven to commercial sex work due to economic survival in a migratory setting arising from the lack of employment or better employment situations. They also found that mobile populations have higher rates of HIV-AIDS infections than that of non-mobile populations as a result of casual sexual encounters, unsafe sexual practices and inconsistent condom use.

Coupled with migration is the concept of urbanisation. Buvé, Bishikwabo-Nsarhaza and Mutangadura (2002: 359) state that urban HIV-AIDS prevalence is higher than rural populations and that it appears that urbanisation has fewer restrictions on marriage and sexual behaviour, leading to a loss of culture and stronger social networks related to alcohol abuse and risky sexual practices. These situations as such can disrupt social relationships and can contribute to concurrent multiple partner relationships resulting in sexual promiscuity with higher rates of HIV-AIDS spread. Scorgie, Chersich, Ntaganira, Gerbase, Lule and Lo (2012:4) posit that transactional sex work is yet another structural drive for HIV-AIDS infection. This is typically referred to as the transfer of goods or money in exchange for sexual activity. Issues such as limited income, multiple dependants, marital disruptions and low education have been characteristics identifying individuals most at risk for transactional sexual activity. Targeted integrated services with accessible coverage, taking into account behavioural and social vulnerabilities are urgently required to address the drivers of these determinates in HIV-AIDS infection rates (Scorgie et al 2012:4).

#### **3.3.1.4 Socio-economic determinants**

Socio-economic status has been identified as a powerful determinate in HIV acquisition. As such, poverty reduction is important (Buveet al 2002:2011). Poverty is a driving force in South Africa (Buvé, Bishikwabo-Nsarhaza and Mutangadura 2002:359). In a study conducted locally in KZN, researchers found that low economic status was associated with earlier sexual debut and with fewer reports of consistent condom usage (Ramjee and Wand 2014:11). This in itself is an example of risky sexual behaviour leaving young women vulnerable to the acquisition of HIV-AIDS.

Interventions aimed at addressing structural, behavioural, biological and socio-economic determinants of disease have been recognised as critical component of HIV-AIDS programmes, forming the backbone of HIV-AIDS prevention approaches. It is well-known that education and awareness campaigns can heighten an individual's knowledge and perception of HIV-AIDS risk acquisition. Together with behavioural change interventions and HIV-AIDS testing campaigns, good progress in decreasing HIV-AIDS infection rates has been shown in countries such as Kenya, Zambia and Uganda where intensive mass media education and awareness campaigns were undertaken to address the structural drivers of the HIV-AIDS pandemic (Ramjee and Wand 2014:12). Similar HIV-AIDS awareness programmes are required in South Africa to compliment the South African National HIV-AIDS Voluntary and Counselling Campaign in the country. A greater media advertising programme aimed at school learners, university students, and young adults is required to highlight the benefits of knowing ones HIV-AIDS status (Ramjee and Wand 2014:12). A programme of this nature should be based on revitalising the current government approach as well as being aimed at relating to issues experienced by school learners, university students and young adults. Recently social media has become an important communication tool with various platforms such as WhatsApp, Twitter, BBM and We chat which are popular with the younger generation. These platforms should be exploited as varied communication routes to attract and retain the attention of school learners, university students, and young adults. Interactive platforms like such can be used to provide important HIV-AIDS counselling messages, encourage safe sexual behaviours, promote correct and consistent condom use and also provide information for accessing the necessary healthcare when required. Novel innovative and technologically sound ways are now required to respond to the changing landscape of the HIV-AIDS epidemic. An acceptability study on social media as a means of content and information delivery of HIV-AIDS awareness and education material is an important research interest that can be further explored to highlight important information to inform the field.

### **3.3.2 Women and HIV-AIDS in South Africa**

Earlier in this chapter, the researcher focused on the high rates of HIV-AIDS in women in South Africa.

It is important to understand the gender and age distribution of the HIV-AIDS epidemic in South Africa is illustrated above. This information is required to identify the 'at risk' population groups by age, gender, sexual orientation and ethnicity in order to allocate sufficient resources, time and effort toward HIV-AIDS prevention, treatment and wellness. A "one size fits all" approach cannot be used to mitigate the risks associated with varied HIV-AIDS acquisition rates amongst different age groups and sexes in South Africa. What is required is a culturally acceptable, contextually relevant, cost efficient approach that is tailor made to curb the epidemic.

The study further confirmed that younger, unmarried women were most at risk for HIV-AIDS acquisition. This study has shown that being an older married female was protective against HIV-AIDS acquisition. Other factors that make women vulnerable to HIV-AIDS infections are structural, behavioural and biological risk factors (Marrazzo and Chirenge 2014:12).

The answer to ending the HIV-AIDS epidemic in South African women remains elusive. However, it is important that women are empowered to know more about the disease, to be educated and made aware of ways and means to protect themselves against it. The alarmingly high rates of disease in these groups' calls for more structured HIV-AIDS prevention interventions which must be discrete, female controlled and easily accessible to women.

### **3.3.3 Impact of HIV-AIDS in the South African context**

#### **3.3.3.1 Life expectancy**

Life expectancy is now estimated to be near normal at 62.5 years, several decades longer than previously (Losina and Freedberg 2011:343). In the pre-ARV era, the increased HIV-AIDS rate had resulted in a higher mortality rate, with more individuals being infected with chronic HIV-AIDS related opportunistic infections leading to higher rates of morbidity and mortality. The effect of this has been more adult deaths, leaving many orphaned children responsible for children headed households. In addition, during the long periods of chronic ill health, HIV-AIDS sufferers have been unable to be employed, with lower rates of productivity and income generation often leaving families with little or no source of food and other

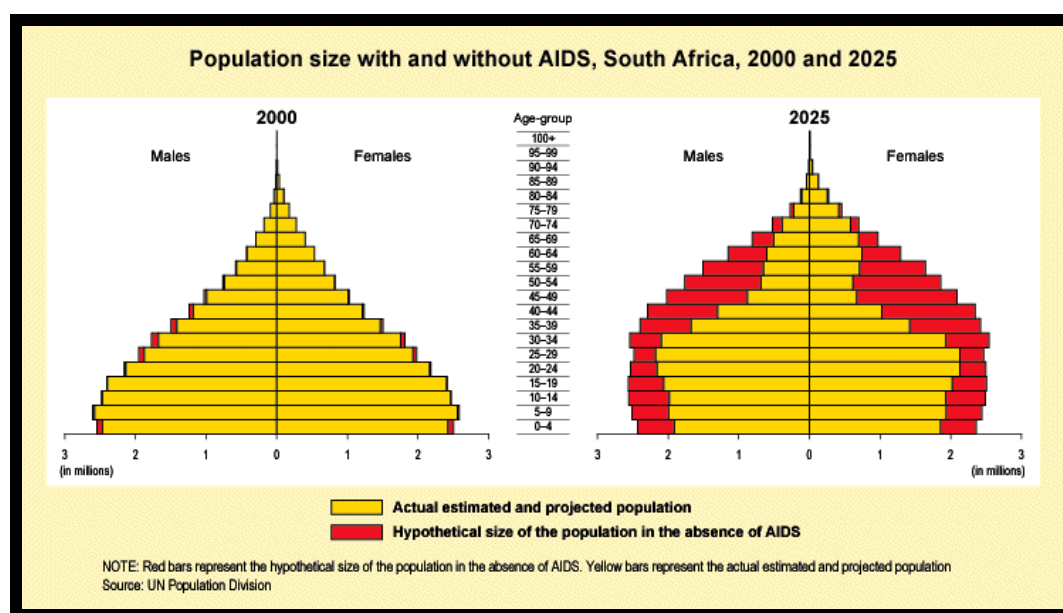
amenities. With the roll-out of ARVS ,more individuals have been able to access the necessary care and treatment and are now able to live longer, healthier ,productive lives of roughly the same life expectancy of their HIV-AIDS negative counterparts (Losina and Freedberg 2011:343).

### **3.3.3 Demographic changes on age and sex**

Dorrington, Johnson, Bradshaw and Daniel (2006:12) examined the impact of HIV-AIDS on demographic changes based on the high rates of HIV-AIDS prevalence in the middle-age group. They found that the young adults (less than 15 years) and old adults (greater than 55 years) population groups continue to grow, while the middle age groups do not grow at all (15-55 years). The greatest impact is seen in the middle age groups where these cohorts are smaller than they would have been. In the less than 15 years age group, it is assumed that more HIV-AIDS orphans exist; while in the older age population, it is thought that grandparents form the majority especially looking after grandchildren who have been affected by HIV-AIDS in their households.



**Figure 3.2 Population size with and without AIDS South Africa, 2000 and 2025**



**Source: Adapted from the United Nations Population Division (2010)**

Illustrated above, (Figure 3.2) demonstrates the projected population size with and without HIV- AIDS in South Africa for the period 2000 and 2025. This graph echoes the findings of Dorrington et al. (2006:12) above with similar areas of high infection rates in the middle-age population and lower rates of HIV-AIDS infectivity. The implication of this data is necessary and important in that it highlights the age groups of highest disease burden in an effort to alert HIV-AIDS policy makers and programme managers to develop interventions to address the greatest need.

### 3.3.3.3 Households and livelihoods

It is also important to take note of the physical, emotional, psychological and economic burden of looking after family members who are dead or dying from HIV- AIDS. Transmission of HIV-AIDS, although rare, can occur during improper protective gear use when caring for HIV-AIDS individuals, where contamination of blood and blood-related products can occur on the domestic front. Similar risks exist for occupational exposure to HIV-AIDS where a 0.23% chance in HIV-AIDS

acquisition rates has been postulated (Bell 1997:9). As the HIV-AIDS prevalence is highest in South Africa; the transmission rate is also high. This gives rise to an important topic of HIV-AIDS, that is Post Exposure Prophylaxis (PEP) which is the emergency treatment and investigation of an HIV-AIDS negative individual following high risk exposure of blood, blood products and/or fluids from HIV-AIDS infected individuals (South African HIV Clinicians Society, Guidelines for Post Exposure Prophylaxis 2008:34). It is important that medication in the form of ARVS is administered within 72 hours, the risk of seroconversion to HIV-AIDS. ARVS are a standard regimen of 3 drugs that must be adhered to daily for 28 days, despite side effects that may or may not occur. Interesting to note is that up until recently, in the wider state sector PEP has only been available to healthcare workers who have experienced an occupational hazard. PEP was never available to the general public for blood and blood-borne product contamination in instances such as condom rupture, violent assault with admixing of blood and admixing of blood during caregiving to name a few. The 2013 South African National Guidelines on ARV management in Adults now allows for PEP administration for any individual that meets the indications as specified. In contrast, the private health sector has no restrictions on PEP administration.

#### **3.3.3.4 Healthcare**

Great demands have been placed on these health systems to manage, treat and cure individuals infected with HIV-AIDS. The allocation of scarce resources in the public health sector to manage the greater burden of disease has created more reliance on the private and parastatal health sectors to jointly manage the disease. Adding HIV-AIDS services to healthcare will add to these challenges. Coupled with the above challenges is the need for training, development and upskilling of staff dealing with the clinical care and treatment of HIV-AIDS. Although HIV-AIDS has entered 35 years of existence, it has only been introduced into medical schools and nursing schools as core curriculum in the last ten years. This has created a skills gap and a void in knowledge which requires urgent clinical learning and development providers to assist with capacitation of all staff clinically managing the disease. Coupled with the clinical aspects of the disease, it is also important to take note of the emotional and psychological components of the disease which requires

extensive rigorous counselling with debriefing sessions for HIV-AIDS affected individuals, their families and their communities. Counselling and debriefing services for clinical staff is also warranted due to the high psychological burden in handling these cases dealing with death, grief and empathy. This may have also contributed to the “brain drain”, with more health professionals leaving the South African health care sector to access other employment opportunities with less psychological strain, better working conditions and fewer patients requiring the high level of care as required by the HIV-AIDS disease burden. It is also pertinent to mention that selected South African medical universities (e.g. University of the Witwatersrand, Johannesburg) and certain rural hospitals (e.g. Church of Scotland Hospital, Tugela Ferry, Kwa-Zulu Natal) have forged alliances with medical universities abroad for exchange programmes for medical students and young newly qualified doctors alike ([www.yale.com](http://www.yale.com)). These programmes allow medical students and newly qualified doctors from abroad to rotate through varied medical disciplines in order to gain first-hand experience of HIV-AIDS and to gain priceless hands on experience with the clinical management of HIV-AIDS. This has proved successful in selected rural and teaching hospitals in South Africa and is a concept that can be amplified across South Africa to ensure a continuous supply of medical staff to assist in areas of the country that are in short supply of HIV-AIDS skilled health professionals.

As HIV-AIDS enters its third decade, few could have imagined the impact it would have had. In the absence of a cure and with minimal progress being made in the field of therapeutic and preventative HIV-AIDS vaccinology, it is imperative that HIV-AIDS prevention efforts are stepped up to halt new infection rate. Effective HIV-AIDS prevention programmes need to be cognisant of key drivers. These include ensuring comprehensive HIV-AIDS prevention packages for the general public, tailor making various HIV-AIDS prevention options for women as they bear the brunt of the disease, supporting the current ARV programme and encouraging all South Africans to know their HIV-AIDS status.

### **3.4 South African response to the HIV-AIDS epidemic**

#### **3.4.1 The South African public health sector response**

The history of HIV-AIDS in South Africa is a long one due to the high prevalence of infection in the country, coupled with the delay in political response to advocacy and treatment. However, recently, with good gains being made with scaling up HIV-AIDS testing and with accessing HIV-AIDS treatment and care, South Africa has come a long way but still has a long way to go. Strong leadership and political commitment is required to drive and build on these successes. President Jacob Zuma stated the following regarding HIV-AIDS in South Africa:

“On the health front, the life expectancy of South Africans for both males and females has significantly improved and is currently 62 years across genders, which is an increase of eight and a half years since 2005. The HIV policy turnaround in 2009 led to a massive roll-out of HIV testing and treatment for 3, 2 million people living with the virus. This has contributed immensely to healthier and longer lives for those infected. We acknowledge the contribution of partners in the South African National AIDS Council, which is chaired by the Deputy President.

Our next step is to revive prevention campaigns especially amongst the youth. The Minister of Health will soon announce a major campaign in this regard. I am also happy to announce that the state-owned pharmaceutical company, Ketlaphela, has been established. The company will participate in the supply of anti-retroviral drug to the Department of Health from the 2016/17 financial year”.

These were important words shared by the South African president as it not only echoed the commitment of the SA government to HIV-AIDS in South Africa, but it recognised the severity of the health crisis in South Africa that is HIV-AIDS.

##### **3.4.1.1 HIV-AIDS policy and legislation**

The HIV-AIDS epidemic is a major focus of the National Health Act, given the national crisis regarding the high rates of infection and spread. Through the priorities

of the Act, the South African Department of Health has demonstrated its political will and commitment to effect change.

The National Health Insurance “seeks to transform the South African Healthcare system with emphasis on the promotion of health and the prevention of diseases. It also seeks to provide access to quality and affordable healthcare services for all South Africans based on their health needs irrespective of their socio-economic status” (Department of Health:2015). A strong collaborative component of the NHI will be the HIV-AIDS programme.

#### **3.4.1.2 The National strategic plan (NSP) on HIV, Sexually Transmitted**

##### **Infections (STIs) and Tuberculosis (TB) (2012 – 2016)**

The theme of the NSP launch was set against the following slogan, demonstrating powerful accountability by the South African Government for HIV-AIDS: “I am responsible. We are responsible. South Africa is taking responsibility”.

There is an urgent need to train more nurses and healthcare workers with innovative models of HIV-AIDS, which should be developed, adapted to local contexts, and rolled-out (Abbatt 2005:443). In addition, more resources need to be made available for operational research to support these programmes for productive outcomes. As ARV coverage increases amongst South African adults contributing to the overall largest ARV programme globally, it is imperative to ensure that clear monitoring and evaluation processes for success.

#### **3.4.2 The South African parastatal and NGO health sector response to HIV-AIDS**

The NGO Portal has grown from strength to strength with regard to HIV-AIDS instituted across the country. This has been in conjunction with the magnitude of the epidemic. This is testimony to how this sector has grown and developed in response to an ever-increasing HIV-AIDS epidemic in KZN and South Africa. This sector has grown increasingly important in its efforts to provide alleviation of the issues surrounding HIV-AIDS throughout KZN and South Africa in recent years (South Africa 2015). Organisations such as the AIDS Foundation of South Africa, Right to

Care, AIDS consortium, Médecins Sans Frontières (Doctors without borders), Centre for the AIDS Programme of Research in South Africa (CAPRISA), South Africa Medical Research Council (SAMRC) and the Treatment action Campaign pioneered the defining health response to HIV-AIDS in South Africa. These organisations were able to partner with significant global funders in order to leverage much needed resources to clinically manage the HIV-AIDS epidemic in South Africa at that time. The United States Agency for International Development (USAID), in conjunction with PEPFAR also provided extensive training, capacitation and clinical drug therapies to the South African public in the early response to the HIV-AIDS epidemic (PEPFAR 2015). Most of the economic and clinical relief was concentrated in Kwa-Zulu Natal as it historically and currently has the highest prevalence rates of HIV-AIDS infection. Circa 2003, the Ithembalabantu clinic situated in Umlazi, EThekweni South in Kwa-Zulu Natal, through the generous funding of the AIDS Foundation in South Africa was able to provide lifesaving anti-retroviral drug therapy to all HIV-AIDS sufferers. Co-incidentally there was no government roll-out of ARVS at the time or in sight and as such thousands of HIV-AIDS affected individuals flocked to the clinic. Having worked at the clinic during this period, the researcher vividly remember queues of HIV-AIDS sufferers waiting from dusk to dawn to commence the sought after therapy. Ithembalabantu loosely translated from Zulu, means “People’s hope and it was this hope that the clinic brought to many”. Today, the clinic still supplements the South African Department of Health ARV roll-out programme and plays a significant role at crucial times of drug stock outs and ARV drug non-deliveries.

### **3.4.3 The South African private managed healthcare sector response to HIV-AIDS**

South Africa's private healthcare sector comprises open and restricted medical aids. These private sector managed healthcare medical aids have tailor made disease management programmes equipped to deal with various disease entities. HIV-AIDS disease management programmes have received significant focus and attention. These disease management programmes are equipped with innovative state of the art approaches to HIV-AIDS screening, diagnosis and clinical management. These private sector clinical management programmes are often governed by international clinical care and treatment guidelines and hence are not restricted by funding and other challenges, as is the South African Department of Health ARV programme. As such the South African private sector began ARV roll-out and clinical HIV-AIDS management long before the public sector. Today there are several local players in this arena. Successful offerings of HIV-AIDS disease management include the Lifesense programme; AID for AIDS (AFA); Occupational Care of South Africa (OCSA); Prim cure programme; Universal; and the HIV Your Life Programme.

The corporate private business sector in South Africa has also recognised the impact and importance of HIV-AIDS on the working class in the country. The South African Business Coalition on HIV-AIDS (SABCOHA) is an organisation that has been developed to mitigate the risks of HIV-AIDS on the working population in South Africa(SABCOHA 2015).

In terms of the business sector in South Africa, the South African motor industry has also developed programmes for the expansion of the global HIV-AIDS response beyond the programmes of the past, by strategically positioning HIV-AIDS issues within a rapidly changing health and development agenda in South Africa.

HIV-AIDS has had an astounding effect on the people, communities and businesses from the various sectors they represent in South Africa (South Africa 2015). Each sector has had to respond to the HIV-AIDS epidemic in culturally relevant and financially appropriate ways (South Africa 2015). Bringing the specific efficiencies, discipline, focus and mind-sets of each of these varied sectors together is a concept

that is gaining momentum with the success and proliferation of public-private partnerships (PPPs) over the last 15 years. More resources though money, staff time, products, or other in-kind contributions are being valued together with expertise which is the core reason for the formation of PPPs. Leveraging capabilities and skill sets from the public, parastatal/NGO and private healthcare sector is urgently required to ensure free, fair and equitable access to HIV-AIDS -related care in South Africa. The South African public and private healthcare sectors have provided strategic interventions to address the South African HIV-AIDS epidemics as discussed below.

### **3.5 Strategic interventions to address the South African HIV-AIDS epidemic**

#### **3.5.1 HIV-AIDS counselling in South Africa**

Voluntary counselling should be provided to all individuals undergoing an HIV-AIDS test to allow them to make an informed decision. There are 3 key elements recommended for the HIV-AIDS counselling process comprising of comprehensive pre-test counselling, post-test counselling and on-going risk reduction counselling (South Africa 2015). Multiple guidelines exist for the various stakeholders involved in HIV-AIDS testing.

- Informed consent entails the patient providing written permission for an HIV test to be conducted and is still a legal requirement in South Africa.
- Confidentiality should and must be maintained throughout all stages of the HIV testing process.
- Counselling on the context of HIV encompasses HIV pre-test, and post-test counselling which emphasises the aspects of secondary prevention and HIV risk reduction counselling.



- Ensuring that the correct results are provided to the patient is a critical component of an ARV programme as future clinical decisions are based on this.
- Finally, linking the patient to proper referral, care and treatment is an important pillar of the HCT process. Monitoring and evaluation tools tracking the above indicators are vital in order to establish progress (World Health Organisation 2014:12).

The South African Department of Health has a structured approach to pre-test counselling and post-test counselling; which is being implemented in the public sector. Strong emphasis is placed on discussing what HIV-AIDS is, transmission routes, and perception of risk for HIV-AIDS acquisition and identification of any risk factors. The counselling process must ensure adequate discussion on the various HIV-AIDS rapid tests for diagnosis and confirmatory testing (South Africa 2015). The window period needs to be discussed and understood together with mechanisms and support structures, as well as accessing routes to care and wellness.

The South African private healthcare sector has pre-determined guidelines for pre-test counselling and post-test counselling. These guidelines are distributed through the South African HIV Clinicians Society. This society consists of healthcare workers across the country working the field of HIV-AIDS.

**Table 3.5 Private sector pre-test counselling**

Introduction and orientation
Outline the ground rules
Demographic data
Provide test results
Communication with partner
Risk Assessment
Risk reduction plan
Support systems

**Source: South African HIV Clinicians Society (2013)**

**Table 3.6 Private Sector Post-test counselling**

Assess readiness to receive results
Discuss Positive living
Risk Reduction Plan
Negotiating Disclosure
Sources of Support and Referral

**Source: South African HIV Clinicians Society (2013)**

From the table above, it is apparent that both approaches from the private and public healthcare sector essentially have the same core components when compared. However, subtle difference occurs. The context of HIV-AIDS counselling in the public sector is usually in a busy clinic setting with overworked nurses and counselling staff

having to deal with endless queues of people awaiting HIV-AIDS -related services. This may not always create an enabling environment for HIV-AIDS results disclosure and referral to care. In addition, during the researcher's tenure in state ARV clinics, it was a known fact that the department of health clinics often demarcate clinic patrons according to the services they require. Very often, HIV-AIDS positive individuals are queued separately from HIV-AIDS negative individuals based on their need for extra pathology blood draws or other pharmacy queues for ARV retrieval. This in itself may allude to the identification of HIV positive individuals who become non-adherent for fear of stigma and discrimination. In addition, it is very common for clinic patrons to attend clinics outside of their local drainage area. This is ideally to attend clinics where they are not known and where their HIV-AIDS status remains unknown, as opposed to visiting a local clinic often staffed by healthcare workers from their local neighbourhood. Although these personal reflections may appear anecdotal in nature, they are common findings which are pivotal in understanding the lack of uptake of counselling and testing in local clinics with poor disclosure to friends and family for support. Behavioral scientists need to tackle these issues tactfully in contextually relevant and culturally acceptably designed clinical trials to inform the field with best practices as next steps to enhancing the uptake of testing and counselling in these communities.

In contrast, HIV-AIDS counselling in the private health sector is often conducted by a general practitioner who shares a long history with the patient and his/her immediate and extended family, which spans generations. Almost immediately patients are relaxed and more comfortable with HIV-AIDS testing and disclosure due to familiarity with their doctor and are more willing to seek referrals to escalated care. Not surprisingly very minimal data exists on the uptake of HIV-AIDS testing and counselling in the private healthcare sector, which identifies another priority area for research. It is important for stronger collaboration between private and public health care sectors to share best practises and dialogue about lessons learnt to best increase HIV-AIDS counselling and testing across both sectors.

### **3.5.2. HIV-AIDS self-testing in South Africa**

On 15 February 2016, the HIV-AIDS self-test kit was approved for use in South Africa. It is available for sale solely through retail pharmacies throughout the country and available at a cost of between R35,00 to R70,00 each. This news comes amidst mixed reactions from the medical fraternity. While the South African HIV Clinicians society has applauded the move in the hope that this will encourage more individuals to test privately in their own comfort, there has been concern raised by the South African Medical Association (SAMA) about the role of pre- and post-test counselling in this setting (South African Medical Association 2016). SAMA also raised the concern of referrals to care and questions whether following the self-test procedure; individuals will seek the required care and treatment. It has long been discussed that HIV-AIDS self-testing was meant to be an adjunct to the national HIV-AIDS testing campaign to compliment and assist the UNAIDS 90-90-90 goals. The UNAIDS 90-90-90 fast track goals is an ambitious target aimed at HIV testing and treatment delivery focused on innovation and cost efficiency (UNAIDS 2015:2). The implementation of the 90-90-90 goals for South Africa is based on 6.4 million people living with HIV-AIDS. The first 90 % goal states that 5.7 million people living with HIV-AIDS should know their HIV status. The second 90 % goal states that 4.1 million people living with HIV-AIDS who know their status should be commenced on treatment and the third 90 % goal states that the 3.7 million people living with HIV-AIDS should be on treatment with suppressed viral loads (UNAIDS 2015:3).

The current HIV voluntary testing and counselling national programme cannot reach these desired targets thereby creating an urgent need for HIV self-testing in South Africa (Sabapathy, Van den Bergh, Fiddler, Hayes and Ford 2012:1351). HIV self-testing is an approach to delivering wide-scale HIV-AIDS testing. This enables individuals to perform some, or all aspects of an HIV test in a location chosen by them (Ganguli, Bassett, Dong and Walensky 2009: 217). Therefore the mandate for the scale up of HIV self-testing in South Africa is strong, and the next step is to ensure that appropriate measures are put in place to maximize the benefits of timely linkage.

Throughout the African continent, self-test HIV testing models are being recommended as a cheap and effective mode of HIV testing. However, there is a data void in South Africa regarding the acceptability of HIV self-testing. More research needs to be undertaken to assess the uptake of referrals following self-testing, as well as to assess the acceptability of this mode of testing, which will provide the necessary information to guide if the test should be more widely available

### **3.5.3 HIV-AIDS education in South Africa**

The national target is 0% rate of mother to child transmission rate thereby eliminating HIV-AIDS transmission to children and improving maternal and neonatal health. This is an innovative approach to communication and engagement of pregnant women in the public sector. The content provides specific information on antenatal procedures, medications and HIV-AIDS risk exposure. Mom connect is a good example of a public-private-partnership (PPP) collaboration between the SA Department of Health, US pharmaceutical company Johnson and Johnson and cell phone operators including Vodacom, MTN, Cell C and Telkom. This initiative is the first e-Health initiative from the Department of Health and heralds the DoH need to innovate with technology and other interfaces to tackle the major healthy burdens in the country.

PMTCT in the South African private healthcare sector is managed through a streamlined cohesive process. Clinical management ensures the all pregnant HIV-AIDS infected women deliver via caesarean section. Caesarean section has been known to reduce mtct of HIV-AIDS by approximately 60 % (International Perinatal HIV Group 1999:977). In addition, all newly born infants receive ARV prophylaxis for up to six months to decrease HIV-AIDS transmission rates in the puerperium period of MTCT. The HIV Your Life programme had a 0% MTCT transmission rate in 2015 ([www.mhg.co.za](http://www.mhg.co.za)).

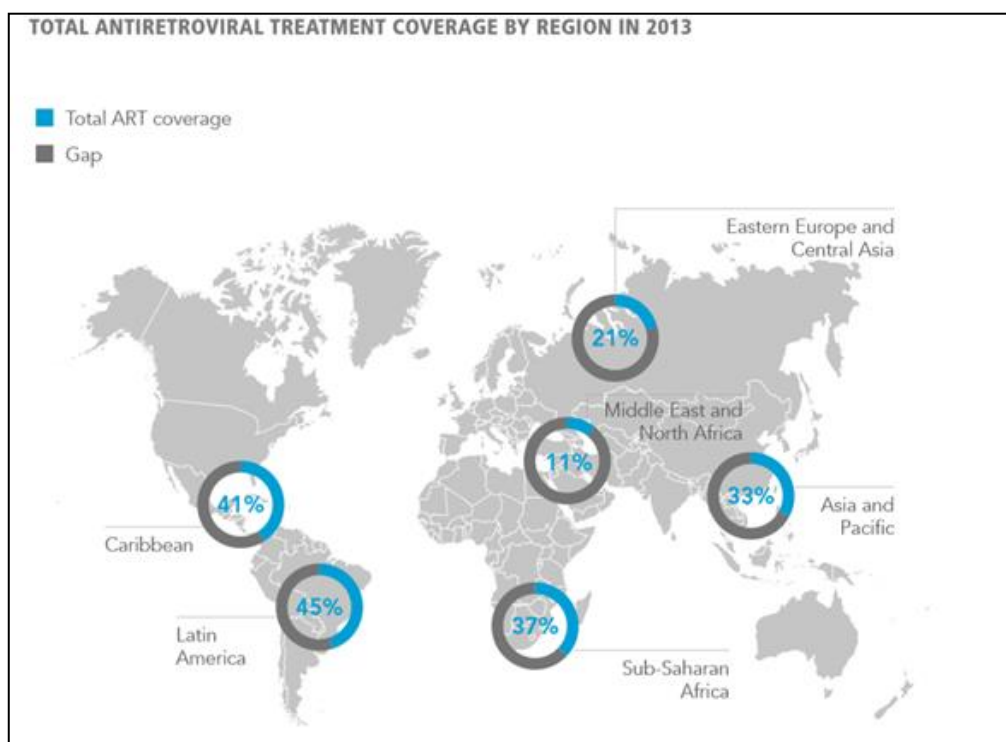
The prevention of MTCT is a priority for improving child survival in South Africa. Necessary protocols governing PMTCT HIV management have been developed and are reviewed annually or on an ad hoc basis based on new research studies in order to ensure South African clinical governance is appropriately and effectively implemented. Coupled with this process is the urgent need to develop monitoring

and evaluation tools to track progress and deficiencies in the MTCT programmes in South Africa which form integral components of the clinical management of HIV-AIDS in South Africa.

### 3.5. The Anti-retroviral (ARV) programme in South Africa

South Africa has both the most people with HIV-AIDS in the world and the largest ARV programme. During the first 3 years of the ARV roll-out, although ARV uptake averaged around 40% of those in need (Chanda, Hamainza, Moonga, Chalwe and Pagnoni 2011 : 11).

**Figure 3.3 Total antiretroviral treatment coverage by region in 2013**



**Source: UNAIDS 90-90-90 Global Report (2015:6)**

Although the South Africa ARV programme is the largest in the world, it is important to contextualise the total ART coverage in South Africa versus the rest of the world. Figure 3.3 above shows the total antiretroviral treatment coverage by region in 2013.

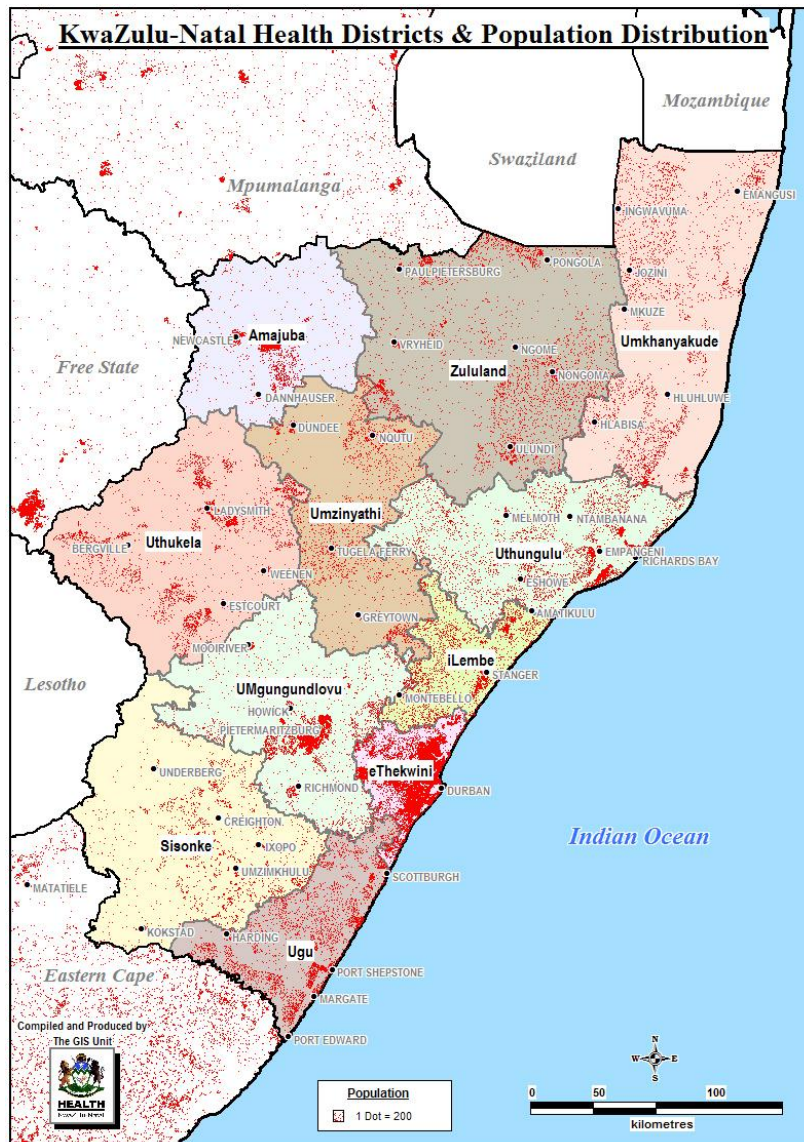
Latin America has the highest rate of ART coverage of 45 % followed by Caribbean of 41 %. South Africa include in Sub-Saharan Africa was found to have 37% coverage which is markedly low and needs to rapidly scale up ARV initiation.

The South African ARV programme is based on the clinical goals below (South Africa 2010:8):

- I. To reduce the HIV viral load to undetectable levels. This implies that the actual amount of virus in the blood is almost negligible.
- II. To assure the immunological goal is met
- III. To enhance the Therapeutic goal, where the risk of clinical manifestations of infections is reduced or almost undetectable.
- IV. To reduce the impact of HIV transmission in the community. This is expressed as the Epidemiological goal. Ultimately, the impact of HIV on an individual is also weighed on the combined impact at the community level, where every individuals HIV result cumutivley adds up to the outcome of the community at large.

The ARV programme in Kwa-Zulu Natal is the largest in South Africa. The map demonstrates the vast nature of KZN, with the large districts spanning majority rural and semi-rural areas with minimal health facilities. Of the 618 health facilities, 545 are primary health care (PHC) facilities and services are mainly nurse driven. On 1 November 2015, a total of 100 000 patients commenced receiving ARVs from 618 facilities in the province (personal communication: Dr Sunpath).

**Figure 3.4 Map of Kwa Zulu Natal Health Districts and Population Distribution**



**Source: Division of Medicine, University of Kwa Zulu Natal (2015)**

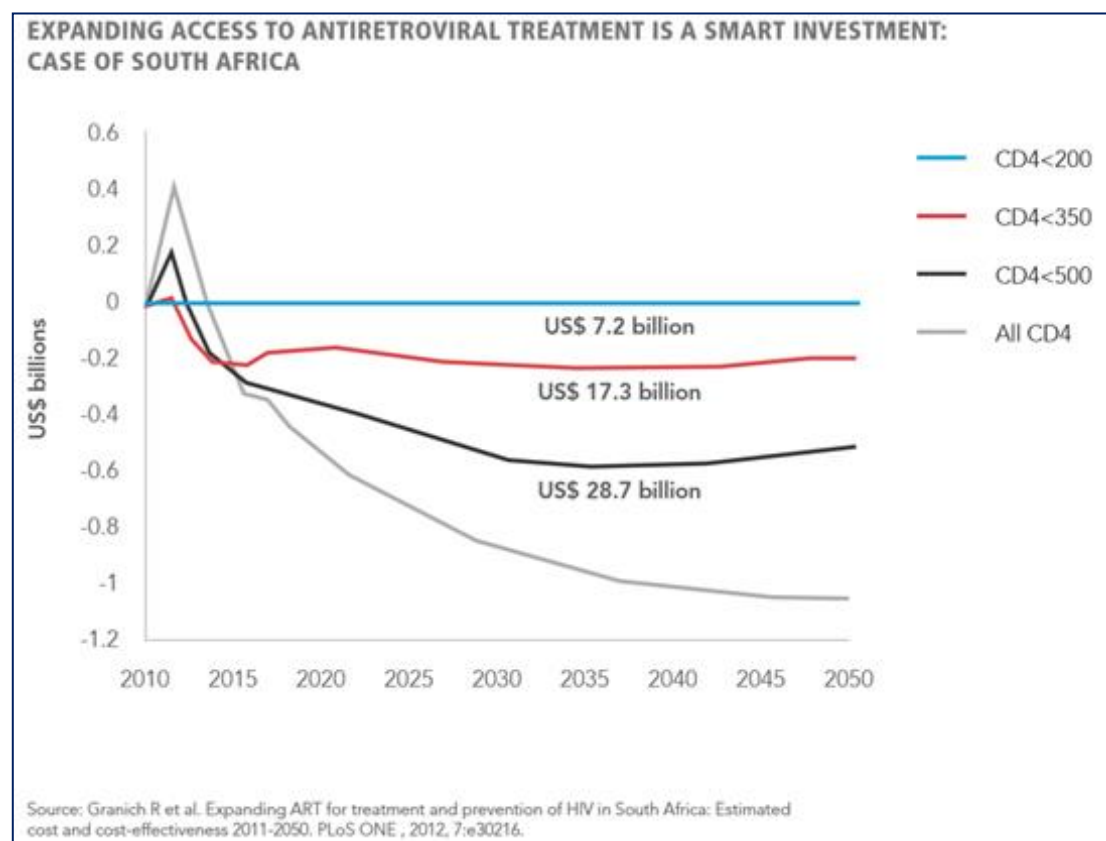
The KZN ARV programme clearly demonstrates the commitment to fighting HIV-AIDS vigorously and meeting the local and provincial targets in this regard. The programme, in keeping with other municipal programmes, offers a comprehensive package of care and treatment. The current ARV programme in South Africa is analysing the implementation of the “Test and Treat” option, which was released



worldwide in July 2015 by the World Health Organisation. This option allows any HIV-AIDS infected individual to access ARV irrespective of the CD4 count (previously only accessible to HIV-AIDS infected individuals with a CD4 count of less than 500). The financial implication of this new guideline is phenomenal as it would imply that the current ARV numbers will double. A study conducted by Granich, Kahn, Bennet and Holmes 92012:1307 explored the cost and cost effectiveness of ARV roll-out to all HIV-AIDS infected individuals, irrespective of CD4 count. Figure 3.5 below shows the amount required to fund ARVS in people with CD4 less than 200; 350 and 500; which amounts to a costing of USD 7.2 bn, USD 17.3 bn and USD 28.7bn respectively.

**Figure 3.5 Expanding access to anti-retroviral treatment is a smart investment:**

### Case of South Africa



**Source: UNAIDS 90-90-90 Report (2015:14)**

The current issue in South Africa is how to ensure the majority of the population are able to attain and gain significant treatment in order to remain healthy (Granich,

Kahn, Bennet and Holmes 2012:1307). This may be attained through various funding mechanisms which need to be assessed and verified for long term sustainability. Lessons should be learnt from other countries on funding models that can be used here in South Africa.

### **3.5.1 Strengths, weaknesses, opportunities and threat (SWOT) analysis of the ARV programme in South Africa**

The ARV programme commenced 12 years ago in KZN in 2004. It is important to assess the programme and perform a SWOT analysis to assess the areas of improvement and the areas where further development is required. By the same token, it is important to enhance the best practices from the programme so that these can be emphasized for success. Table 3.6 below summarizes the strengths, weaknesses, opportunities and threats of the ARV programme in South Africa.

**Table 3.7 Strengths, weaknesses, opportunities and threat analysis of the ARV programme in South Africa.**

<b>Strengths</b>	<b>Weaknesses</b>
Use multidisciplinary teams and more holistic approaches.  Large patient base.	decreasing budgets  Poor economic climate  Dwindling donarship
<b>Opportunities</b>	<b>Threats</b>
Training programmes  Improved efficiency.  Collaboration  Public private partnering	Brain Drain.  ARV cost.  Exchange rate.

**Source: authors research 2016**

One of the greatest strengths of the programme is that it has a large patient base and patients are handled through a holistic approach to medicine via a multi-disciplinary team including, clinicians, nurses, counsellors, physiotherapists, dieticians and occupational therapists. Through these strengths, the programme has leveraged the following opportunities: in-house training, given the large patient base and quick turnaround time to get patients on the programme, good collaborative training has taken place especially with better collaboration and efficiency through the various departments.

The programme has also faced several weakness and threats. The greatest adversity has been the exchange rate, with the declining rand dollar exchange rate impacting on import of ARVS and other medication. Coupled with this, is the weakening economic situation drawing international investors and donors away from South Africa against the back drop of poor budgetary spending by the health ministries. Trained, skilled and experienced clinicians and healthcare workers are also leaving the country as well as the programme for better working conditions and other incentives, resulting in further challenges is discussed below.

### **3.5. 2 Challenges facing the ARV programme in South Africa**

#### **3.5.2.1 Anti-retroviral drug supply**

The mechanism of action of anti-retrovirals exhibits a very intricate pattern for use. This implies that these drugs are complicated in their mode of use which is often the reason for the many side effects that may be warranted with this therapy. Given the complicated drug therapy required to combat the HI virus, it is no surprise the price tag these drugs come with. Ethical developments of these drugs range from 300 to 2000 ZAR per month (Aspen Pharmacare 2015:3). Cost has become an important factor in managing this disease as the disease is worst in South Africa and hence significant funding is required to sustain and maintain drug delivery and supply to all areas in the country. Monitoring and evaluation of good manufacturing practice, ARV drug delivery and ARV drug supply is crucial toward building successful ARV programmes on the country.

The national scale up of the ARV programme in South Africa has been undertaken with no specific consideration of the infrastructure requirements, the human resource need and the up skilling of HIV-AIDS healthcare workers. Coupled with this has been the unintended lack of oversight of the ARV drug distribution process in South Africa, leading to drug stock outs and poor patient adherence.

The supply of ARVs to the South African Department of Health is through a tender process which has been fraught with much controversy over the previous two tenders that have already been awarded in the country. The tender process has

been riddled with controversy surrounding pricing and price collusion with companies wishing to out price each other based on tender share. Companies tendering for participation should meet the legal and regulatory requirements together with quality and quantity aspects of the bid. Training of pharmacy personnel to implement inventory management practices; improved packaging to support inventory control; From 2013 to 2015, South Africa has seen the most number of ARV drug shortages, with ARV suppliers unable to deliver on Department of Health tender requirements due to fiscal inconsistencies and delays (Venter and Conradie 2015:11).

### **3.5.2.2 ARV theft**

HIV-AIDS is treated with a combination of three drugs as routine first line therapy for all HIV-AIDS infected adult individuals. One of the drugs is called Efavirenz and is a highly potent anti-retro viral agent .The side effects of this drug are dizziness, insomnia, agitation, vivid dreams, abnormal thoughts and impaired concentration (South African Medicines Formulary 2015:111). When this drug is ingested by HIV-AIDS negative individuals it may produce a euphoric state with the above mentioned side effects allowing this drug induced euphoria to be abused. Efavirenz has widely been included in local street cocktail of banned substances and is termed “whoonga”, which is now freely available to be sold as drugs to recreational drug users. On 14 February 2016, the KZN Provincial Crime Intelligence Unit unearthed operations of an ARV antiretroviral (ARV) theft syndicate operating in Durban, KZN. A women was found with ARVs to the value of R300 000, 00 that was being stolen for preparation of whoonga distribution and it was found to be linked to stolen property from local health facilities. This highlights major challenges to the South African ARV programme with misuse of funds and medication for fraudulent purposes denying the end user of the desire lifesaving medication. This directly speaks to the need for HIV-AIDS programmes to have appropriate monitoring and evaluation tools in place to adequately assess for discrepancies and institute corrective and preventative actions to assist with drug theft.

### **3.5.2.3 Adherence and support on the ARV programme**

The South African Department of Health (2014:12) defines adherence as “taking treatment as explained, keeping to appointments for test results, referrals and further investigation”). ARVs need to be taken daily for maximal benefit in order to prevent HIV resistance and decrease HIV-AIDS-related morbidity and mortality.

Adherence to treatment is required in all clinical management programmes globally and locally. The South African National TB programme features the popular DOTS adherence programme, which was adapted by the WHO. This programme ensures that the patient is watched by a treatment supporter whilst swallowing the anti-TB medication daily. The treatment supporter can be a friend, family, neighbour any individual interested in assisting the patient. Similar adherence programmes were initially proposed for the ARV programme but were not well received. Issues of stigma, discrimination, disclosure and the sheer volume of patients requiring this approach deemed this as not viable.

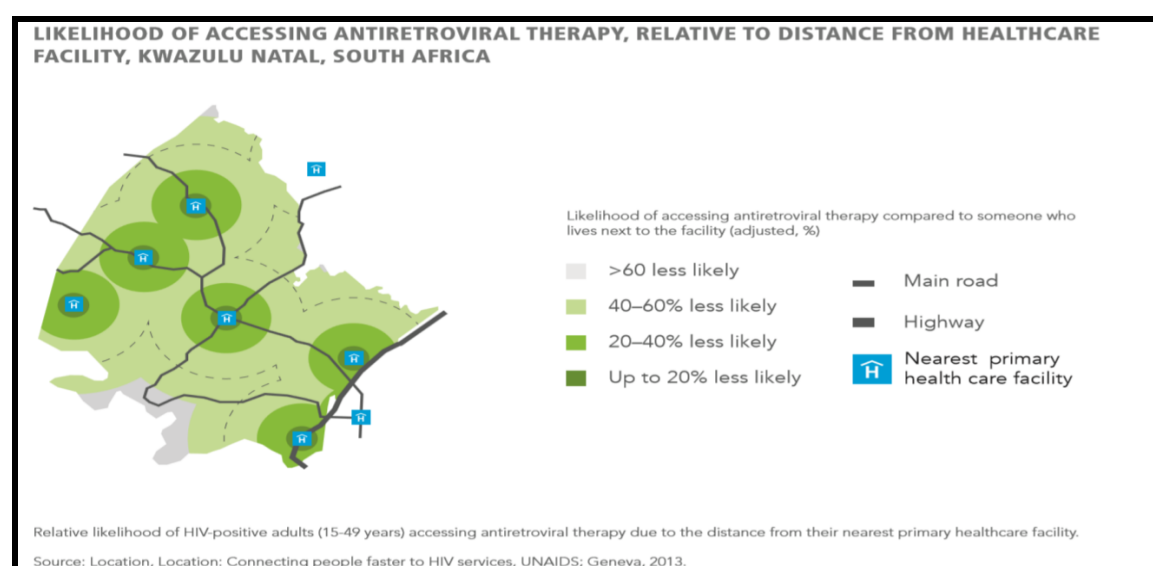
Consequences of noncompliance to ARVS are many and include treatment failure and HIV resistance. Barriers to ARV adherence have been identified as important constraints to HIV viral load suppression. Hardona, Akuru, Comoroc, Ekezie, Irundee, Gerritsa, Kglatwanef, Kinsmana, Kwasag, Maridadih, Morokai, Moyo, Nakiyembak, Nsimbal, Ogenyim, Oyabbak, Temun and Laingo (2007: 658) report that transport expenditures, registration and user fees at health facilities, and lost wages due to long waiting times feature as main obstacles to optimal adherence. Side effects and hunger in the initial treatment phase are an added concern (Christopher, Hamer, Davidson, Jonathon, Donald and Sabin 2005: 1243). Strategies to promote adherence include procedures to ensure quality adherence counselling. During adherence counselling, the patient should be educated about possible drug interactions, and possible consequences of mixing unknown substances and concomitant medication usage. (Orrel 2014:2) contends that ARV adherence counselling should empower patients to take responsibility for their illness and take necessary steps to manage HIV-AIDS as any other chronic illness. Adherence counselling and ensuring optimal adherence to therapy is one of the pillars of maintaining and sustaining a successful ARV programme. However, human

resources and staff up skilling may be seen as a stumbling block to achieving this. Task shifting (discussed in detail below) is a useful and cost effective implementation tool to realise the adherence goals of an ARV programme. A monitoring and evaluation plan for this component is therefore required to track and measure clinical outcomes of care (South African Department of Health ARV Guidelines 2014:11).

### 3.5.2.4 Access to care

Figure 3.6 below shows data from a KZN study, that assessed connecting people to HIV-AIDS service, the below graphically demonstrates the likelihood of accessing ARV therapy relative to distance from healthcare facility.

**Figure 3.6 accessing antiretroviral therapy, relative to distance from healthcare facility, Kwa-Zulu Natal, South Africa**



**Source: UNAIDS 90-90-90 Report (2015:17)**

The figure reveals that the further away an individual is from a health facility, the less likely he/she is to access care and treatment. The likelihood ranged from 20 to 60 % less likely to access care, which heralds an important barrier to treatment that is physical access to the ARV site. Very often, due to a lack of transport, incimate weather conditions, the lack of transport money and far distances form the ARV clinics, patients may fail to attend their necessary appointment dates. Hence, they will become non-compliant to ARV medication. Early in the inception of the South

African ARV programme, food hampers were distributed to patients attending ARV clinics which contained a months' worth of subsistence groceries. Patients became reliant on this monthly hamper and it was a method to ensure that both them and their families were fed. Unfortunately due to hampers being sold and stolen by clinic staff members, these hampers were discontinued.

Meintjes (2015:12) explored barriers to accessing HIV-AIDS-related care at ARV clinics in the Western Cape. The study team found that chronic ill health, lack of family support, poor economic situation and a lack of transport were found to delay access of patients to care. It is not uncommon in South African townships to see relatives pushing ill and weak patients in a wheelbarrow to ARV clinics as it are the only means of transport for the patients. In addition, HIV-AIDS infected individuals are often the breadwinners in the family and their chronic ill health prevents them from working and gaining economic stability, which results in the lack of finances to purchase food and nutritional supplements, ultimately delaying health recovery and perpetuating the disease.

### **3.6.2.5 Public health facility shortfalls**

Task shifting is “a process of delegation whereby tasks are moved, where appropriate, to less specialized health workers. By reorganizing the workforce in this way, task shifting can make more efficient use of the human resources currently available”. (Fox, Sanne, Conradie, Zeinecker, Orrell, Ive, Rassool, Dehlinger, Van der Horst, Charles, McIntyre and Wood 2011:5). Management controls in the form of monitoring and evaluation tools become important mechanisms for medication forecasting and evaluation in ensuring proper ARV distribution for HIV programmes in the South African context. More resources need to be made available for operational research to support the South African ART programme and to harness the successes learnt from the ARV private sector towards the development of monitoring and evaluation toolkits aimed at operational success and efficiency of these ARV programmes as discussed below.



### **3.7 Clinical management of HIV-AIDS infection in South Africa**

In South Africa, ARV treatment has become available in many hospitals and clinics. In addition, internationally funded donors have allowed for ARV access through local NGOs and faith-based organisations complemented by similar practices in the private sector. Coupled with the growth of the HIV-AIDS incidence in South Africa, there has been the need for scaling up access and linkages to HIV-AIDS-related care; up skilling of healthcare workers to meet the clinical demands of the disease and facilitating integration of HIV-AIDS services into the current state offerings of primary healthcare. Karim and Karim (2014:12) state that HIV-AIDS management is a complex challenge. It is integral to plan interventions (Karim and Karim 2014:12). Maartens (2014:4) reckons that partnerships are pivotal.

The HIV-AIDS epidemic is a complex mix of diverse epidemics (Berkman 2001:1348). From its discovery in South Africa, healthcare care clinicians and nurses struggled with little HIV-AIDS resources, few HIV-AIDS trainings, minimal clinical guidance, and poor health ministerial support while the epidemic continued to grow and destroy South African families and communities. Now, a good 20 years later, ARVs are available and treatment guidelines are clear and precise devised on evidence based HIV-AIDS medicine and clinical research. Significant gains in HIV-AIDS medicine have now revealed that the incidence of HIV-AIDS is slowly declining; life expectancy has increased; and fewer babies are infected with HIV-AIDS (Moorhouse 2014:2).

The field of HIV-AIDS is an ever-evolving one with a dynamic landscape shaped by data outcomes of many large clinical trials being conducted locally and abroad. Much information that governs the clinical management of HIV-AIDS in South Africa is provided from data and research with significant findings often shared and local, national and international conferences. South Africa is proud to be home to major international conferences which alternate annually; namely the South African AIDS conference and the South African Tuberculosis conference. Historically these conferences are earmarked to be based at the epicentre of the pandemic in Durban, Kwa-Zulu Natal. Previous conference themes have focused on “Building on Successes: Integrating Systems” (SA AIDS 2013) and “Reflection, Refocus and

Renewal” (SA AIDS 2015). These conferences have become important platforms for information sharing and information gathering, with learning and development toward capacity development of all health workers working with in the field of HIV-AIDS. These conferences form important components of continuous professional development highlighting important breakthroughs and ground breaking clinical data to better informs management of clinical situations. These conferences or learning opportunities are important for cross pollination of clinical silos, for networking and other opportunities. The only potential downside is the large cost of these conference often subsidised by external donors with time spent away from clinics. To ensure the most effectiveness of transfer of learning procedures from these conferences, potential pre-conference tests and post-conference tests should be carried out to highlight areas of improvement which can better enhance the conference experience and also allow better learning outcomes toward better patient management.

Today, the South African healthcare sector has shifted from simply providing ARV treatment to providing treatment that is easier to take in terms of toxicity as well as convenience. The aim is now, no longer to just save lives but also to aim for better quality of life as well as longevity as patients grow older and as HIV-AIDS becomes yet another manageable chronic disease (Maartens and Goemaere 2014:7). Currently the aim in clinical management in HIV-AIDS infection is trying to attain zero new infections, zero deaths and zero stigmas related to HIV-AIDS (Kaplan, Orrell, Lawn, Bekker and Wood 2014:35). Significant strides have been made towards achieving what twenty years ago seemed impossible.

### **3.8 Clinical management of HIV-AIDS and Tuberculosis: The South**

#### **African syndemic**

The WHO defines a syndemic as: “the aggregation of two or more diseases in a population in which there is some level of positive biological interaction that exacerbates the negative health effects of any or all of the diseases” (WHO 2015). It is also known as the twin epidemics. Globally, South Africa is disproportionately affected by the epidemics of tuberculosis and HIV-AIDS (Meintjes 2014:2).

The key to successful management of these diseases is screening for TB and HIV-AIDS at the same visit in order to detect the diseases timeously, early initiation of ARVs, co-management of drug toxicities common to both, consideration of drug interactions and initiation of universal preventions.

This once again demonstrates the need for adequate monitoring and evaluation tools with necessary protocols for management of HIV-AIDS and TB diagnosis which is integral to HIV-AIDS programmes to ensure adequate optimization and allocation of resources.

### **3.9 The HIV Your Life Programme: A case study**

The HIV Your Life Programme is a managed healthcare provider. It is currently the largest disease management programme dealing with HIV-AIDS and TB in South Africa. The programme is uniquely positioned in the private managed healthcare sector and has a national footprint with regional offices nationwide. There is also planned and current expansion into Africa, Asia, India and other international destinations. The core offering of the HIV Your Life Programme is a disease management programme dealing with the treatment and prevention of HIV-AIDS. The offering is seen as a tool to assist service providers such as doctors, nurses and other allied medical healthcare providers situated in the private healthcare sector to manage and deal with individuals, their families and communities affected and infected by HIV-AIDS.

The vision of the programme is to lead healthcare solutions in South Africa and beyond. The promise of the organisation is to provide comprehensive HIV-AIDS

related care to those infected and affected by HIV-AIDS. The HIV Your life Programme is a new HIV-AIDS wellness provider in the managed healthcare industry and this research aims to improve the clinical efficacy of this programme. The current goals of this HIV-AIDS service provider are:

- Early initiation of Anti-retroviral therapy (ART) for adults and children.
- Eliminating new HIV-AIDS infections among children.
- Integration of HIV-AIDS-related services, in order to strengthen the AIDS response in global health and development efforts.

The programme prides itself on three key objectives:

- Operational Excellence: Based on the annual review, the HIV Your Life Programme is mandated to track annual operational parameters on members, clients and service providers in order to gauge their level of satisfaction and dissatisfaction with operating practises of the programme.
- Compliance to the ISO 9001:2008 standard: In June 2011, the HIV Your Life Programme became the first disease management programme in the country to be certified to ISO 9001:2008. As an ISO 9001:2008 certificate holder, the HIV Your Life Programme must comply with clause 8.2.1 (Customer Satisfaction) and 8.4 (Analysis of Data). The company is in the process of transitioning to the ISO 9001:2015 certification process as this is now the industry standard.

The HIV Your Life Programme is staffed by clinicians, nurses, counsellors, lay counsellor pharmacists, Pharmacy assistant ,administrative staff, disease manager, health care worker, all with expertise, skill and experience in the management of HIV-AIDS. The job descriptions of each of these are unique with no overlap to ensure clear definition of roles and responsibilities in managing their deliverables. Core functions of each staff category are tabulated below

**Table 3.8. Core functions of HIV Your Life Programme staff**

<b>Staff category</b>	<b>Core function</b>
Doctors	Responsible for the clinical management of patients on the programme in accordance with industry standards and guidelines to ensure clinically appropriate methodology for use.
Nurses	Responsible for clinical management and wellness of the patients on the programme
Counsellors	Responsible for pre, post and risk reduction counselling in the context of HIV-AIDS and TB.
Pharmacists	Responsible for assessing accuracy of medication, dosage, side effects pricing and courier pharmacy delivery.
Administrative staff	Assist with daily office administrative duties
Disease managers	Responsible for clinical authorisation of medication and pathology in line with programme benefits.
Health care workers	Assist clinical team with ad hoc responsibilities based on programme requirements
Pharmacy assistants	Assist pharmacists with pharmacy responsibilities as per programme

	requirements
Lay counsellors	Assist counsellors with counselling responsibilities as per programme requirements

All business processes are managed and revised in accordance with South African Department of Health, SA HIV Clinicians Society and selected aspects of British HIV Association and United States National Institutes of Health guidelines. The HIV Your Life Programmes produces its own HIV Treatment Guidelines. This sixth edition presents the latest trends and developments in HIV medicine and clinical care. New inclusions in the current 2016 edition:

- New indications for initiation of HAART
- Updates to HIV salvage therapy
- Pre-exposure prophylaxis (PrEP)
- Updates to HIV-resistance testing
- Inclusions of new drugs (Maraviroc, Dolutegravir, Elvitegravir)
- ICD coding and descriptions for HIV-related conditions

The programme announced the release of a digitised version of their HIV treatment guidelines in June 2015. The HIV Clinical Guide is a free mobile app that provides easy access to the latest HIV clinical guidelines and clinical calculators via any smart device. In September 2014, the second version of the app was released in partnership with the UCT Medicines Information Centre, and now includes a drug interaction checker and a comprehensive HIV drug formulary for easy reference of information such as contra-indications and pharmacokinetics. The app was endorsed for use by UNAIDS, the Southern African HIV Clinicians Society and the South African National AIDS Council (SANAC). In keeping with the South African AIDS Conference theme of reflection, refocus and renewal, this app heralds important

public-private partnering aimed at enhancing innovative technological approaches to ensure optimal HIV-AIDS clinical management and holistic patient care.

The above are some of the key initiatives implemented by the Programme, including the innovative HIV-AIDS Treatment App for healthcare professionals, the annually updated HIV-AIDS Clinical Guidelines, and the comprehensive and extensive HIV-AIDS Provider networks. Offerings such as these (among others) have firmly placed the HIV Your Life Programme on the roadmap to becoming the best HIV-AIDS disease management programme in Southern Africa. However, the HIV Your Life Programme has developed selected strengths and weaknesses which are summarised below. Its strengths and opportunities are:

- The HIV Your Life programme is the largest HIV-AIDS disease management programme in the South African managed healthcare environment.
- The HIV Your Life programme holds the largest market share in terms of managed healthcare clients.
- The HIV Your Life programme has a strong innovative and technological focus with advancements shown in the smartphone and mobile applications arena
- HIV Your Life programme has partnered with the Department of Health as the preferred managed healthcare partner.
- The programme is ISO 9001:2008 accredited

The HIV Your Life programmes strongest weaknesses and threats are:

- The HIV Your Life programme does not have an M & E system to track and trace its progress
- The HIV Your Life programme is a large programme and is growing daily and can easily lose track of the core deliverables
- Training and development is a void of the programme with minimal undertakings done annually

The research conducted for the programme will make a significant contribution to the HIV Your Life Programme in the following areas as it directly addresses the programmes weaknesses and will serve to enhance its strengths:

- Develop clear M&E processes that will enable systematic collection, collation, processing, analysis, and interpretation of data.
- Define a list of core indicators that will enable tracking of progress in the most critical areas in the response to HIV-AIDS.
- Describe the key data sources to be used to gather necessary M&E data; establish clear data flow channels between the different stakeholders in the response to HIV-AIDS.
- Clearly describe the role of each of the stakeholders in the monitoring and evaluation of this HIV-AIDS programme.
- Develop a plan for strengthening the capacity of all partners involved in the monitoring and evaluation of the HIV Your Life Programme

### **3.9 The future of HIV-AIDS in South Africa**

As HIV-AIDS continues to grow as one of the largest chronic health disease burdens in South African, efforts now need to be focused on building sustainable monitoring and evaluation tools to track the South African epidemic, building on previous lessons learnt towards establishing efficient and cost effective operating systems. Today, a diagnosis of HIV-AIDS is no longer a death sentence; instead, the treatment of HIV-AIDS has become a chronic, manageable condition allowing HIV-infected people to experience long and productive lives. 35 years into the disease, we now know the answer to the world's longest HIV-AIDS debate on when to start anti-retrovirals and now HIV-AIDS infected individuals can be offered ARVs at any time when they are ready to commence treatment. Recent treatment regimens have become safer to use with fewer side effects and less toxic adverse events with a hope of moving toward single drug therapy with better adherence modalities. Remarkably, by the year 2016, more than half of people living with HIV-AIDS will be able to live to 62 years or older (Baeten 2014:56). However, HIV-AIDS is still at



catastrophic levels. As the dynamics of living with HIV-AIDS has changed, HIV-AIDS research priorities have shifted to address the challenges of the changing demographics and push the frontiers of the evolving scientific landscape. There is still a long road ahead inspired by the progress of the past and motivated by the belief that through collaboration and integration, a cure will someday be possible.

### **3.10 Conclusion**

This chapter analysed the country's HIV-AIDS epidemic and presented an overview of the determinants of HIV-AIDS disease and its impact in the country. It explored the components of the ARV programme in South Africa and discussed the clinical course of HIV-AIDS and its management culminating in discussion of the future of HIV-AIDS in South Africa. South Africa has reached a crucial moment in the history of HIV-AIDS, and now has an unprecedented opportunity to alter its course. As South Africa is the epicentre of the HIV epidemic, the country runs the largest HIV management programmes globally aimed at HIV-AIDS treatment, diagnosis, wellness and care. It is therefore, integral that these programmes have excellent controls in place for adequate monitoring and evaluation efforts to ensure optimal management efficiency in ensuring necessary treatment outcomes.



## **CHAPTER FOUR**

### **AN ANALYSIS OF HIV-AIDS MONITORING AND EVALUATION FRAMEWORKS: A COMPONENT OF QUALITY MANAGEMENT IN HEALTHCARE**

# **CHAPTER FOUR**

## **AN ANALYSIS OF HIV-AIDS MONITORING AND EVALUATION FRAMEWORKS: A COMPONENT OF QUALITY MANAGEMENT IN HEALTHCARE**

### **4.1 Introduction**

Quality management, through its components of monitoring and evaluation, is one of the cornerstones of a country's response to HIV-AIDS. It provides the information required to make evidence-based decisions for programme management, quality improvement, policy formulation, patient advocacy and also generates good quality data to satisfy programme accountability requirements. This chapter provides a discussion of the concepts of quality management, its relevance to healthcare and discusses ISO 9001 2015 as an integral quality management tool in the healthcare arena. The chapter highlights discussions on the monitoring and evaluation of health programmes as critical interventions of quality management systems through an analysis of existing HIV-AIDS monitoring and evaluation frameworks and culminates in a SWOT analysis of local and global HIV-AIDS monitoring and evaluation frameworks.

### **4.2 Quality management in healthcare**

Quality management ensures that an organization, product or service is consistent and is delivered with superior levels of quality (Sarkissian 2010:1). In recent years, quality management has become significant in the global and South African healthcare sector as a means to improve the effectiveness of treatment and increase patient satisfaction within health service delivery. Quality management in healthcare focuses on the oversight of programmes that improve patient care and safety, resource utilization and ancillary services (Centre for Disease Control 2014).

Healthcare organisations are increasingly becoming committed to the provision of quality healthcare for all. Quality and commitment to quality is a core value and key

business strategy for most private healthcare facilities (Life Healthcare 2016). Most South African private healthcare facilities have committed to clinical excellence, quality service, respect and empathy for their patients in order to ensure that patients receive world class clinical care, as well as to ensure that the patient experience addresses the needs of patients and their families (Life Healthcare 2016). In South Africa, although this proactive change is seen more in the private healthcare sector, similar efforts are being made in the public healthcare sector in South Africa. With the planned 14-year roll-out of the National Health Insurance in South Africa, the National Health Insurance White Paper delineates stronger focus on patients and patients' health in both private and public healthcare sectors (Capazorio 2015:11).

In the South African private health sector, quality health and safety is an integral part of an organisations' service delivery. Private sector employees play an integral role in creating and developing the quality culture in private hospitals and contribute to the sustainability of the quality management system. Enhancing the customer experience and the working environment for all private sector health employees supports the purpose of making life better in these health environments (Life Healthcare 2016). Quality management deals with delivering consistent quality which, in turn, requires reliable processes. Reliability requires strong leadership commitment with the existence of performance goals, risk reduction procedures, quality improvement policies, quality measurement systems and reward mechanisms (Life Healthcare 2016).

#### **4.2.1 Components of quality management**

These dimensions require that healthcare be:

- Effective: delivering health-care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need;
- Efficient: delivering health-care in a manner which maximizes resource use and avoids waste;

- Accessible: delivering health-care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need;
- Basic concepts of patient-centred care: delivering health care which takes into account the preferences and aspirations of individual service users and the cultures of their communities;
- Equitable: delivering healthcare which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socio-economic status; and
- Safe: delivering healthcare which minimizes risks and harm to service users (World Health Organization 2006:35).

With specific relevance to healthcare, quality management encompasses the following key aspects as illustrated in Table 4.1.

**Table 4.1 Components of Quality Management**

<b>Components of Quality Management</b>		
<b>Quality Planning</b>	<b>Quality Control and Quality Assurance</b>	<b>Quality Improvement</b>

**Source: Adapted from Juran, Joseph and Joseph (1999)**

#### **4.2.1.1 Quality planning**

Rapid changes in the global and local regulatory health environment have exerted significant pressures on healthcare providers to reassess their strategies on quality planning. In 2015, The South African National Department of Health established the Office of Health Standards Compliance (OHSC). In line with this office, quality planning should be clearly aligned to the healthcare strategic plan; tied to a quality healthcare framework; have measurable goals, including targets; be based on the resources available and be evaluated on an annual basis (Office of Health Standards Compliance 2015). A key objective of quality planning is to facilitate the development

of a culture of quality and safety for the healthcare organization (Life Healthcare 2016).

Quality planning in the management of HIV-AIDS programmes is of paramount importance. It is an important strategy to improve systems and reduce variation in the delivery of care and services so that patients receive the correct care at every visit. Quality planning has become a fundamental component of HIV-AIDS service delivery systems globally with emphasis being driven on the continual improvement of HIV-AIDS-related service delivery. However, its uptake in the South African healthcare sector has been minimal and slow. A key objective of this research study is to develop clear monitoring and evaluation processes that will enable the systematic collection, collation, processing, analysis and interpretation of data that will lead to quality planning and improvement in the HIV-AIDS healthcare sectors.

#### **4.2.1.2 Quality control and quality assurance**

The importance of establishing quality control in the South African private and public healthcare sectors was the necessity to standardize the medical treatment protocols to compare its usefulness in everyday practice doctors, medical teams and medical institutions (Board of Healthcare Funders 2015). Quality and safety are important factors shaping the future of the healthcare industry for hospitals and medical care providers. Quality control is integral to healthcare as metrics shape the medical practices and processes in place at the facilities in which they practice. Quality control defines both success and failure for healthcare workers and health facilities who lead in the healthcare industry (Buttell, Hendler and Daley 2007: 611). Quality control is a key component of healthcare but more so in HIV-AIDS related programmes, given the high burden of disease both globally and locally.

Given the high HIV-AIDS incidence and prevalence in the South African setting, it is both crucial and a priority that correct and accurate HIV test results are provided to the correct person being tested in order to prevent mis-diagnosis of HIV status and suboptimal testing in certain areas. The South African HIV Counselling and Testing campaign launched in 2009, has documented over 18 million South Africans who have been HIV tested to date (PEPFAR 2016). Stringent QA/QC procedures have been enhanced at all major testing centres as quality assurance and quality control

implemented through a quality management system is essential for any HIV testing. It is important that all laboratories performing HIV testing include promoting the use of standardized logbooks or registers for data collection verification, monitoring and evaluation of results along with the implementation of corrective action with key preventative actions. These key activities should be systematically planned and implemented in order to maximize their impact on the accuracy of HIV testing.

The turbulence faced and that continues to be faced in the management of HIV-AIDS serves as a reminder of the continued need for management to develop to a higher and more effective level of management to allow for the appropriate and efficient means of curbing the spread of HIV-AIDS. Quality assurance in HIV-AIDS programmes is critical for developing standards of consistency for clinical management; for the application of these standards across the programme; and for assessing its effectiveness in achieving the programme goals and objectives. This research study will define a list of core indicators that will enable tracking of progress in the most critical areas in the response to HIV-AIDS in these clinical programmes, and that will be used as markers for effectiveness and the evaluation of standards for consistency.

#### **4.2.1.3 Quality improvement**

The five principles are illustrated in the following discussion (Pyke 2008:47):

- I. *Quality improvement is the science of process management:* Healthcare is complex and is made up of interlinked processes that result in a very complex system. If focus is placed on the processes of care one at a time, fundamental challenges facing healthcare can be resolved and changes implemented. This principle is embodied in a key objective of this research study, where the researcher will attempt to develop clear monitoring and evaluation processes that will enable the systematic collection, collation, processing, analysis and interpretation of data. This will result in enhanced HIV-AIDS programme management with the improved delivery of HIV-AIDS-related care.
- II. *If you cannot measure it...you cannot improve it:* Deming (1986:12) understood the importance of data. Meaningful quality improvement must be



data-driven. This is particularly true in healthcare. Deming (1986:12) said: “*In God we trust...and all others must bring data.*” This implies that data is critical for it to have a meaningful impact in healthcare. This principle is of particular relevance to this research study’s objective, where the researcher will describe the key data sources to be used to gather necessary monitoring and evaluation data and establish clear data flow channels between the different stakeholders in the response to HIV-AIDS. This objective emphasises the need for accurate and consistent data collection and data monitoring systems in HIV-AIDS management programmes in order to guide effective decision making processes.

- III. *Managed care means managing the processes of care, not managing physicians and nurses:* Managing care means managing the processes of care. In order for continuous improvement to work, healthcare organisations need to engage clinicians in the process because they understand the care delivery process and they are best equipped to improve the process of care over time. This principle speaks to the research study objective of engagement of stakeholders involved in the management of HIV-AIDS clinical management programmes. The research study seeks to clearly describe the role of each of the stakeholders in the monitoring and evaluation of HIV-AIDS programmes in an attempt to improve clinical process flows of HIV-AIDS treatment and care.
- IV. *The right data in the right format at the right time in the right hands:* Deming proposed that clinicians need the right data delivered in the right format at the right time and in the right place in order to make empowering decisions for continual improvement in the health sector. This principle is the core focus of two objectives of this research study. Firstly, this principle is of particular relevance to this research study’s objective where the researcher will describe the key data sources to be used to gather necessary monitoring and evaluation data and establish clear data flow channels between the different stakeholders in the response to HIV-AIDS. Secondly this principle speaks to the objective to describe the role that HIV-AIDS-related operational research plays in the overall monitoring and evaluation of the national response to HIV-AIDS. It is critical to mention that operational research with the generation of

key data will be pivotal to develop new HIV-AIDS programmes as the disease enters its fourth decade and remains elusive to a cure.

- V. *Engaging the “smart cogs” of healthcare:* Deming referred to clinicians as healthcare’s so-called “smart cogs.” They are the frontline workers who understand and own the processes of care. Deming believed it was imperative to engage these clinicians in process improvement and challenge resolution in order to make meaningful and beneficial reforms to healthcare. Deming’s fifth principle forms the core of another objective of this research study, where a plan for strengthening the capacity of all partners involved in the monitoring and evaluation of the HIV-AIDS programme will be developed based on stakeholder engagement to overcome clinical challenges in the fight against HIV-AIDS (Pyke 2008:47).

Continual quality improvement in healthcare is mandatory as medical and allied health disciplines have to continually adapt to the changing healthcare landscape. Medico-legally, continuous improvement is a prerequisite, especially in an industry where medical litigation and malpractices are rife. The timeless quality improvement principles of Deming remain relevant and appropriate in this research study, firmly entrenched in the study’s core objectives devised to generate innovative data to develop a proposed conceptual framework for the management of HIV-AIDS programmes that can be used in the public, NGO and private healthcare sectors.

#### **4.2.2 Quality management systems**

A quality management system can be defined as “*a set of co-ordinated activities to direct and control an organisation in order to continually improve the effectiveness and efficiency of its performance*” (South Africa 2013:5). Quality management systems set direction to meet stakeholder expectations by improving process control, with wastage reduction and lowering of costs (Pyzdek 2003:11). These systems are a vehicle to facilitate training by involving staff participation and by raising employee morale. A fully implemented quality management system serves to establish a vision for the organisations employees through goal setting, motivation building and helping to direct corporate culture.

Meeting customer and organisational requirements in quality management is indicative of management commitment that the organisation will meet stakeholder needs and requirements in order to ensure total client satisfaction. The emphasis in quality management systems is placed on continuous improvement. A quality management system sees the integration of an organisation, its culture and environment in pursuit of continued quality improvement. A correctly implemented quality management system should be people-orientated and participative and assumes that a quality culture is an integral part of an organisation and encourages all staff to be involved in its implementation and monitoring. Employee buy-in and participation in quality management systems in healthcare is a critical success measure, more so in the field of HIV-AIDS given the high prevalence of the disease.

#### **4.2.2.1 The ISO 9001 standard**

The ISO 9001 standard is one of the most versatile, well known and commonly applied quality management systems. ISO 9001 standards, launched in 1987, is a generic management system standard. ISO 9001 is a standard that sets out the principles for a quality management system and has been implemented across various industries globally (International Organization for Standardization 2015). In recent years there has been much emphasis on the adaptation of ISO standards into the healthcare arena. This has been of particular importance due to the ISO standard promoting global harmonization of medical practices by supporting the efficient exchange of information and the protection of data towards ultimately protecting the health and safety of patients and healthcare providers and improving the quality of care (International Organization for Standardization 2015). A new version of the standard, ISO 9001:2015, has replaced the previous version (ISO 9001:2008) and allows implementing organisations to work in more efficient ways with process alignment which increases productivity and efficiency, bringing internal costs down (International Organization for Standardization 2015).

The ISO 9001 standard has seven principles which are embodied in the principles of quality management systems, namely:

- a) *Customer focus*: Meeting and exceeding customer needs is the focus of quality management, by understanding the present and future needs of customers.

With relevance to HIV-AIDS healthcare sector, this implies understanding the customer or patient, understanding the nature of their disease burden and developing HIV-AID interventions to mitigate the impact on them and their communities.

b) *Leadership*: The ISO standard dictates strong qualities for leaders to establish purpose and direction in management of healthcare programmes. This is crucial in ensuring that HIV-AIDS programmes meet necessary goals and objectives.

c) *Engagement of people*: This ISO quality management principle aims to encourage the involvement of people at all levels in all stages of programme development and this also bears relevance to the objectives of this research study dealing with stakeholder management and capacitation.

d) *Process approach*: This principle is based on the premise that organisations are more efficient and effective when they utilise a process approach to manage activities and related resources towards optimal goal realisation. This is pivotal in the backdrop of HIV-AIDS clinical management, where consistent and standardised healthcare is required.

e) *Improvement*: The ISO standard proposes that continual improvement should be a permanent objective of an organisation or facility. Given the dynamic changes occurring globally driven by international HIV-AIDS research and literature, it is imperative that HIV-AIDS programmes continually evolve to include best clinical practices towards optimising patient care.

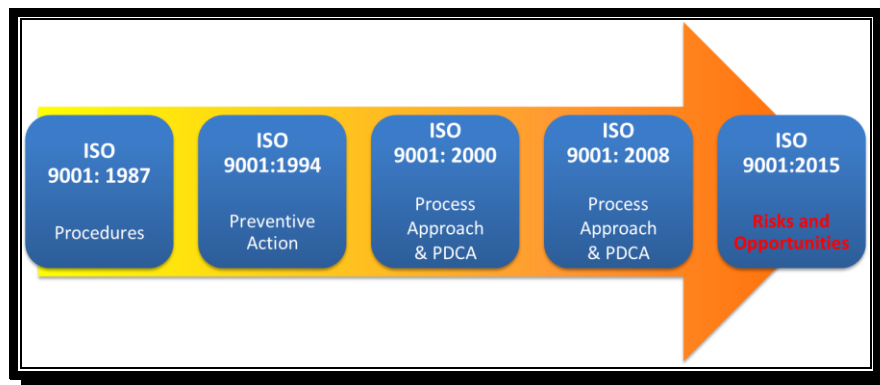
f) *Evidence based decision making*: The ISO standard suggests the use of factual data related to important current evidence bases to conclude management decisions on. This standard, when applied to HIV-AIDS programmes implies the ad hoc and continuous updating of clinical guidelines to steer evidence-based decision making.

g) *Relationship management*: The ISO standard bases its recommendation on the fact that all stakeholders and partners in organisations/facilities are interdependent and mutually beneficial relationships enhance the ability for value creation. As with all programmes in health-care, HIV-AIDS programmes call for

harmonised relationship management with all stakeholders as is echoed in this research study's objective to describe the role and capacitate all stakeholders involved in HIV-AIDS programme management.

The ISO 9001 standard has undergone several revisions since its inception, as reflected in Figure 4.1

**Figure 4.1 Revisions in ISO 9001 Standards**



**Source: Adapted from International Organization for Standardization (2015:2)**

- Revision 1 (ISO 9001:1987): Was influenced by existing U.S. defence standards and was pertinent to the manufacturing industry. Emphasis was placed on conformance with procedures rather than the overall process of management.
- Revision 2 (ISO 9001:1994): Emphasized quality assurance and emphasised key attention on preventive actions and how to document such.
- Revision 3 (ISO 9001: 2000): This revision integrates quality into the business system and aims to improve effectiveness via process performance metrics.

The ISO standards of quality management are being given increasing scrutiny by various institutions for its application to the diverse global healthcare industry. The ISO standard allows organisations to meet the necessary statutory and regulatory requirements and to identify and address the risks associated with the applicable organisation by instituting better management control, increased stakeholder satisfaction and investor attractiveness. The ISO standards have been widely adopted as a quality management system for improving competitiveness around the world (Tsuang Kuo, Tsun-Jin Chang, Kuei-chung Hung and Ming-yuan Lina 2009:1321).

The implementation of ISO standards provides organisations with a level of comfort by creating a more efficient, effective operation and by increasing customer satisfaction and retention. The standard provides a common tool for standardization and improves employee motivation and awareness towards achieving excellence (International Organization for Standardization 2015).

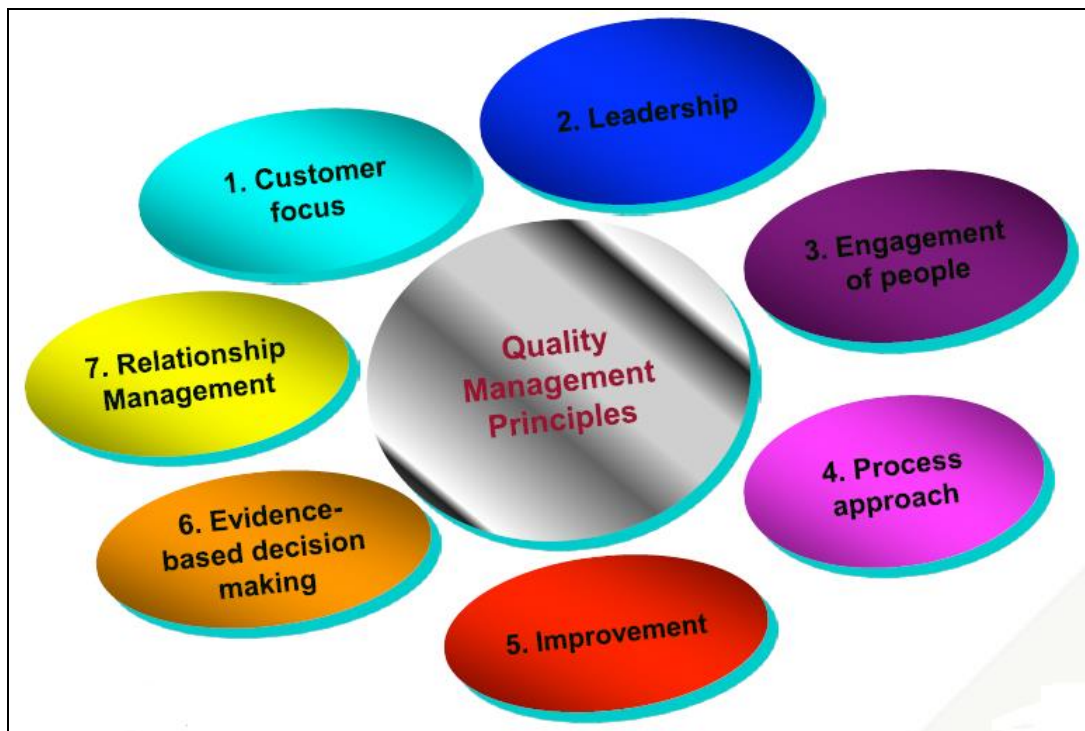
#### **4.2.2.2 The International Organization for Standardization (ISO) for Health**

In 2013 the International Organization for Standardization released their first ISO standard for health aimed at the health industry, health regulators and health consumers globally. Standardization in the field of health covered a variety of sectors including dentistry; optics; infusions and injections; medical devices; surgery; sterilization of healthcare products; health informatics and traditional Chinese medicine (International Organization for Standardization 2015). ISO standards increase healthcare efficiency and allow healthcare organisations to strive for operational effectiveness. An ISO standard measuring and evaluating HIV-AIDS programmes appears to be identified as a potential void in the existing array of standards. Given the local and global prevalence of HIV-AIDS, it would be beneficial for the development of an ISO standard for HIV-AIDS programmes.

#### 4.2.2.3 Applications of principles of quality management for health

Quality management systems are grounded on seven key principles which are discussed below, with specific reference to the healthcare environment. These are demonstrated in Figure 4.2 below.

**Figure 4.2 Principles of Quality Management**



**Source: Adapted from the International Organization for Standardization (2015:2)**

##### 4.2.2.3.1 Customer Focus

Selected hospitals have developed hotel-like amenities to create a comfortable environment to allow patients a safe and pleasurable stay in hospital. The recently opened Maternity Unit at the Alberlito Hospital in Ballito, Kwa-Zulu Natal, places a strong emphasis on creating a consumer specific state of the art experience for newly delivered parents by the provision of ante natal classes; 4D photographic scan; and special pamper packages that sets this healthcare facility apart from the rest. This specific focus on customer needs and requirements has set this facility as the leading facility in its field. However, these changes have come at a cost. The

price of private healthcare in South Africa has increased by 300% in the last 10 years, moving from R42bn in 2002 to R142bn in 2014 (Ngoepe 2014:2). It is estimated that 16 % of the South African population are included in the private sector, which begs the question of why the country is spending R142bn (almost half a trillion ZAR) for 16% of the population?

The healthcare sector in recent years has begun to take strides toward development of a “*client centric*” healthcare model of service delivery (Wilton and Broeckaert 2013:9). This model of care focuses on meeting client needs, expectations and satisfaction. Customer satisfaction in HIV-AIDS care implies overcoming poor access to services together with overcoming HIV-AIDS-related stigma and discrimination. This research study in line with customer focus on HIV-AIDS-related care and service delivery aims to develop a plan for strengthening the capacity of all partners, including customers and patients involved in HIV-AIDS programmes in an attempt to meet this urgent need.

#### **4.2.2.3.2. Leadership**

This research study aims to provide inclusion of stakeholder engagement as a key component of a proposed monitoring and evaluation framework aimed at enhancing quality management systems in HIV-AIDS programmes which is integral to developing and capacitating good leadership of HIV-AIDS programmes.

#### **4.2.2.3.3. Engagement of people**

Designated resources are also critical in supporting the engagement of people. This quality management principle is a core focus of this research study and is in line with the study objective to clearly describe the role of each of the stakeholders in the monitoring and evaluation of HIV-AIDS programme through engagement. Communities, donors, patients, programme management, politicians and healthcare workers are all key stakeholders who are integral to HIV-AIDS programme development and implementation for realisation of goals.



#### **4.2.2.3.4 Process approach**

Certain clinicians focus on Good clinical practice (GCP), which is an international quality standard that is provided by ICH, an international body that defines regulatory and clinical standards of care (Good Clinical Practice 2004). The South African version of GCP is clinically adapted for the rules and regulations within which the medical healthcare environment exists in South Africa. This approach allows management to focus on objectives to maximize effectiveness and efficiency. Process training, initial training and refresher training are important concepts in assessing employee achievement against learning outcomes and evaluating the training.

The process approach is also a core component in ensuring consistent and standardised HIV-AIDS healthcare service delivery. This is an important objective of this research study objective which will attempt to develop clear monitoring and evaluation processes that will enable the systematic collection, collation, processing, analysis and interpretation of data to ensure optimal HIV-AIDS programme management.

#### **4.2.2.3.5 Improvement**

Continuous improvement in HIV-AIDS programmes requires effective leadership development, a sustained commitment of resources, mentorship and on-going programme monitoring and evaluation. This research study seeks to explore HIV-AIDS programmes and monitoring and evaluation frameworks to define a list of core indicators that will enable the tracking of progress in the most critical areas in the response to HIV-AIDS towards the development of improvements in these areas.

#### **4.2.2.3.6 Evidence based decision making**

The field of HIV-AIDS is an ever-evolving and dynamic one, continually changing due to the level of HIV-AIDS research being undertaken globally in the areas of prevention, treatment and socio-behavioural changes affecting the continuum of HIV-AIDS care. HIV-AIDS operational research is explored as an objective of this research study in the context of HIV-AIDS programme delivery as a means for the

provision of evidence-based decision making to guide HIV-AIDS programme development, healthcare delivery and implementation.

#### **4.2.2.3.7 Relationship management**

Relationship management with partner networks is often of particular importance. It is important to establish a mutually beneficial client relationships; such a relationship creates value for both parties. A successful implementation of relationship management requires an understanding of the expectations and needs of stockholders involved at the healthcare facility (Gbadeyan 2010:168). Health workers need to be trained on addressing the human aspect of relationship management and how it can be successfully implemented in a healthcare facility (Gbadeyan 2010:168). Identification of barriers to care and enabling factors promoting linkage to healthcare facilities are especially important in the field of HIV-AIDS given the need for daily ARV treatment and monthly follow ups at healthcare facilities with strict adherence to HIV-AIDS programmes. The management of relationships between all stakeholders including healthcare workers and patients and other allied health professionals are important to ensure a warm and caring environment to allow patients/client to return to a health facility. This research study will focus efforts on attempting to identify the roles of these stakeholders and explore means to strengthen these stakeholder relationships the capacity of all partners towards best practices in HIV-AIDS care and service delivery.

#### **4.2.3 Need for quality management systems in healthcare**

Quality of care concepts have evolved from quality assessment to quality assurance and recently to quality management (World Health Organization 2006:34). Quality management systems in healthcare are required to identify best practices and to improve ineffective interventions (Padian, Holmes, McCoy, Lyster, Bouey, Paul and Goosby 2011:199).

Given the burden of disease that HIV-AIDS presents globally and locally, the need for quality management systems in HIV-AIDS programmes is critical. Quality management systems in this context will assess the extent to which HIV-AIDS health services are consistent with guidelines for the treatment of HIV-AIDS disease and

related opportunistic infections. HIV-AIDS programmes with quality management systems can also develop strategies for ensuring that service delivery is consistent with improvement in the access to and quality of HIV-AIDS services.

In 2013, new data emerged from the South African Department of Health on the high rates of medical healthcare malpractice and litigation, which were estimated to be over Three billion ZAR (Department of Health 2013). This raised new concerns regarding the policies, practices and procedures being conducted in healthcare facilities across South Africa and questioned the need for the implementation of quality management systems in the South African healthcare arena. This also heralded the need for more careful consideration of quality assurance in healthcare and set the way forward for more engagement on monitoring and evaluation frameworks as key interventions for implementation to track the progress of all health programmes in South Africa. Given the large spotlight firmly focused on the HIV-AIDS disease burden in South Africa by foreign donor countries, it became necessary to implement a component of quality management namely a monitoring and evaluation conceptual framework for the multisectorial HIV-AIDS programmes in South Africa.

#### **4.2.4 Quality management systems in the South African healthcare**

##### **Environment**

The South African Department of Health has an overall responsibility for healthcare in the country, with a specific responsibility for public-sector healthcare. The department's priority is to improve the health status of the entire population and to realise its vision of a long and healthy life for all South Africans (South Africa 2015:3). To accomplish this, the Department of Health has identified four strategic outputs (South Africa 2015:3), namely:

##### *a) Increasing life expectancy*

The South African Medical Research Council (SAMRC) conducts a Rapid Mortality Surveillance Report annually to assess the trend in life expectancy amongst South Africans.

### *b) Decreasing maternal and child mortality*

Accelerated progress is required to achieve the United Nations goals for decreasing maternal and child mortality (UNICEF 2015:22). It is widely recognised that reducing maternal and child mortality and morbidity rates in South Africa is a multifaceted approach that may be achieved by strengthening health systems, integration of health service delivery and continually improving maternal and child health interventions at primary health care level (Health Systems Trust 2015).

### *c) Combating HIV-AIDS and TB*

South Africa has launched a multipronged approach to combatting HIV-AIDS and TB through the National Strategic Plan and the HIV-AIDS monitoring and evaluation framework for national, provincial and local health facilities across the country. Although the national response to HIV-AIDS started out as a slow one burdened by issues of lack of political will and support, poor technical guidance and lack of funding, the country has made great strides towards righting the wrongs of the past and has gained momentum in bringing about the beginning of the end of HIV-AIDS.

### *d) Strengthening health-system effectiveness through quality management systems*

Health system strengthening has been recognised as a core component of healthcare service delivery. Since the launch of the government's Green Paper on National Health Insurance, various reforms and initiatives are underway to improve health systems strengthening in the country through the initiation of quality management systems. Operation Phakisa, also known as, The Ideal Clinic programme, is an initiative that was started in July 2013 as a way of systematically improving the quality management systems and healthcare provided in primary health care facilities throughout South Africa (Department of Health 2015).

The programme ultimately will need to be funded through local sustainable sources. Currently, a third of state hospitals and clinics are functional enough to qualify for NHI funding as there are too few doctors, poor health infrastructure, drug stock outs and poor stock control mechanisms, which are required for a successful NHI implementation (Mail and Guardian 2013). This prompts the question of whether the South African Department of Health should be investing external donor funds on

building new expensive ideal clinics with Operation Phakisa or should this money be more efficiently utilised toward building stronger health systems, better infrastructure, investing in healthcare worker capacitation, retaining suitably qualified healthcare staff and revitalising current knowledge potential.

The Batho Pele Principles are a strong component of the existing current knowledge potential of the South African public health sector and is a key example of quality management systems in the public health sector.

#### **4.2.4.1 The Batho Pele principles**

The South African Public health sector, under the Department of Health embodies the elements of quality management with the Batho Pele Principles, which are summarised below (South African Department of Health 2009):

##### **4.2.4.1.1 Consultation**

This principle ensures that patients are made aware of their disease and illness and allowed to make decisions to the best of their ability with their consulting doctors. This principle allows that patients increase their level of education, awareness and advocacy of the nature of their diseases. It is questionable if this goal is being reached in the state and public sector health systems. Do doctors and healthcare workers have enough time to educate and enlighten patients on their illness and allow them to make decisions about their medical treatments and interventions? In the public sector, this is far from a reality with long queues of patients, heavy volumes of medico-legal paperwork, long work hours and often the language barrier that prevents the realisation of this goal. In the South African private health sector, the level of advocacy and education is often reached as patients are spoilt for choice of healthcare facility and choice of health care providers. Consultations are longer and more time is available for the discussion of treatment of the disease and medication options through various modes and referrals. This service comes at a cost with high consultation rates being charged at various medical aid rates. The South African Department of Health as the custodian of health in the country needs

to review these mechanisms in order to bridge the divide between healthcare in the private and public sectors.

#### **4.2.4.1.2 Service standards**

This goal states that patients should be informed of what level or standard of care they can expect in a specific health facility. This is seldom the case in a state sector healthcare facility. Patients have to attend with a referral letter or access to the institution is denied. The referral letter dictates the level of care that the patient requires. Patients are seldom engaged about the quality of care expected. The nursing staff are responsible for triaging the patients into different queues for different levels of intervention—given the long work hours and high patient burden, these staff often do not engage patients unless absolutely necessary. The private sector is the total opposite –patients receive a care plan and treatment plan for the year and are informed of what level of service is to be expected in terms of cost, medications and consultations. The National Health Insurance plans to address the inconsistencies amongst the private and public health sector by tackling issues like this one.

#### **4.2.4.1.3 Access**

Healthcare is a human right. Patients should not be denied access to free and equitable healthcare. Social media and print media has been ablaze in the last few years as several cases have flared up with patients being denied healthcare at several public hospitals. This is never the case in private hospitals as patients are to be stabilised at these facilities and should be refereed after being assessed as stable if they are unable to pay the hospital rates. There appears to be various facilitators and barriers to access of care in the private and public healthcare sectors which need to be further explored to ultimately benefit the patient.

#### **4.2.4.1.4 Courtesy**

This goal addresses the notion that all patients should be treated with respect, courtesy and dignity. However, this has not been the case recently when the Mail

and Guardian (2010) reported on the “sick state of affairs” at Kwa-Zulu Natal provincial hospitals where a pregnant woman was tasked to deliver in an undignified manner on a hospital stretcher at a local hospital. The staff and management of the hospital had cited the staff shortages, the overcrowding of patients and few healthcare resources as reasons for this. At other hospitals, patients are placed on waiting lists for 8 to 12 months for procedures and not offered any reasons as a common courtesy should the procedure not occur. Issues such as this one, need to be addressed. On 10 March 2015, the Minister of Health Dr Aaron Motsoaledi indicated that a medical ombudsman would be appointed to address the challenges in both private and public healthcare (South African Department of Health 2015). It is hoped that this avenue will address complaints raised due to poor hospital infrastructure and poor working conditions amongst others.

#### **4.2.4.1.5 Information**

In addition, new innovative tools like social media networks and internet platforms such as “Google” provide patients with relevant information about their disease entities. The challenge has been and continues to be the provision of relevant, ethically sound and culturally appropriate medical information to patients both in the private and public sector. This process is often facilitated through healthcare workers, nursing sisters and clinical technologist in the private sector, while the barrier to information delivery in the public health sector remains staff shortages, fewer allied medical disciplines and language barriers.

#### **4.2.4.1.6 Openness and transparency**

This principle explores the right that patients can exercise to witness the transparency regarding budgets and healthcare expenditure. This has become evident with publications of the national healthcare budgets and hospital allocations. Syphoning off scarce resources, fraud and corruption appear to be rife across both private and public healthcare sectors. In the private sector, multiple modes of corruption exist through medical aid fraud, fraudulent claims and hospital cash back claims. Given the continued poor fiscal management in state facilities, more intensive efforts are required to address fraud and corruption in the healthcare sector.

#### **4.2.4.1.7 Redress**

This principle is based on the fact that if patients receive a sub-optimal level of standard of care, the patient is entitled to re-assess the issue with the treating team and is subject to an apology and can lay complaints of medical negligence, In the private sector several litigations and acts of medical negligence have been raised to civil law suits. Modes for mitigation of this medic-legal risk will be published in the National Health Insurance.

#### **4.2.4.1.8 Value for money**

This principle talks to the fact that all patients should be provided healthcare economically and efficiently in order to give citizens the best possible value for money. This is being conducted in the public healthcare sector especially in areas of high disease prevalence and incidence e.g. HIV-AIDS. The Department of Health has appointed a central procurement authority through which anti-retroviral medication has been procured with massive reduction in the prices of antiretroviral drugs which resulted in the 53, 1% reduction in the cost of the total 2014 tender which translated to a R4.7 billion savings (Department of Health 2014). This is an important and significant step toward cost savings and value for money in the health care system.

#### **4.2.4.1.9 Encouraging innovation and rewarding excellence**

This deals with rewarding healthcare employees that go the extra mile in making the difference in patients' lives. From time immemorial The Nightingale Awards for Excellence in nursing programme, has been successfully run across all public sector hospitals to be a collaborative effort to celebrate outstanding nurses and elevate the nursing profession. More awards and recognition programmes like this are required to inspire, encourage and motivate healthcare workers to perform at their best at all times.



#### **4.2.4.1.10 Customer impact**

Focusing on internal and external customer satisfaction is a core element of Batho Pele and more efforts are required to create better channels to communicate satisfaction or dissatisfaction from all stakeholders. The Department of Health has created several telephone lines that provide 24-hour access to all South Africans to report matters of concern, complaints and queries through the National Health System Ethics Line. In order to facilitate this process better, the department should consider the development of whistleblowing fraud hotlines via phone and web access for the various provincial hospitals and healthcare facilities. This will allow for real-time assessment of queries and resolutions in order to enhance patient satisfaction.

#### **4.2.4.1.11 Leadership and strategic direction**

Good leadership is one of the most critical components for successful healthcare facilities. In order to build good leadership, the Department of Health has committed to investing in training middle and top management layers in the health facilities as part of the readiness of the national health insurance implementation plan in the South African public health sector.

The Batho Pele Principles have set historical goals in the public healthcare sector in order to attain key elements of quality management systems. This needs to be revitalised and reviewed in order to be successfully implemented with the changing dynamics of healthcare trends locally. Strongly embedded within healthcare quality management systems is the critical aspect of monitoring and evaluation of health programmes and healthcare facilities.

### **4.3 Monitoring and evaluation of health programmes**

The monitoring and evaluation of health programmes is designed to improve health and promote efficient programme development (Kawonga, Blaauw and Fonn 2012:10). Surveillance and monitoring and evaluation all play a role in providing information to help determine the links between programme efforts, resources and

achievable programme goals. Countries affected by HIV-AIDS require information about their specific epidemic in order to combat its spread. Surveillance data provides information about trends in the spread of HIV-AIDS together with transmission patterns specific to disease areas and countries. HIV-AIDS programme developers and policy makers utilise surveillance data to devise monitoring and evaluation frameworks adapted for the community and patients. The rapid scale up monitoring and evaluation activities of global health programmes has been accompanied by an increasing emphasis on measurable indicators and provision of significant results. Integral to monitoring and evaluation activities has been the development of several monitoring and evaluation frameworks, data collection plans and data reporting tools which have been developed across NGOs, NPOs, civil and advocacy groups and the public health sector.

To date, the World Health Organisation has focused efforts on monitoring and evaluation on the global health sector. A major part of the interventions and programmes in the health sector concentrate on the development of guidelines and tools for monitoring health interventions and facilitating the collection of data on specific indicators of the health sector response at the country level. Given the high rate of HIV-AIDS prevalence, monitoring and evaluation of national HIV-AIDS programmes in the public and private healthcare sectors have evolved based on the country's epidemiological need. This has firmly focused the spotlight on monitoring and evaluation of HIV-AIDS programmes both globally and locally.

#### **4.3.1 Monitoring and evaluation of HIV-AIDS programmes**

Many different countries and institutions have contributed to the current understanding of how best to monitor and evaluate HIV-AIDS programmes. Monitoring and evaluation of HIV-AIDS programmes commenced in early 2000 and was developed as a result of consultation with programme staff, donor representatives and evaluation specialists from institutions all over the world (Centre for Disease Control 2015). This complex field has grown since then and will continue to grow to match the disease trends of the epidemic.

South African Health Minister, Dr Aaron Motsoaledi was present at the UNAIDS meeting and also pledged South Africa's commitment set of targets to fast-track progress efforts towards combating HIV-AIDS by 2030. The fast track goals include the realisation of UNAIDS' 90-90-90 goals and to identify gaps and barriers toward implementation (UNAIDS 2016). Meaningful engagement of and partnerships with communities and civil society are vital to the success of the on-going sustainability of management of HIV-AIDS monitoring and evaluation programmes for all populations (UNAIDS 2016:10). In recent years, progress has been made in monitoring and evaluation with the publication of national HIV-AIDS programme frameworks for monitoring and evaluation aimed at monitoring and evaluating HIV-AIDS activities through a set of indicators for prevention and mitigation at the level of national programmes (Microbicides Trial Network 2013:15). These include the UNAIDS and USAID/Global Fund monitoring and evaluation frameworks globally and the South African National HIV-AIDS monitoring and evaluation framework locally, which are discussed in section 4.4.

#### **4.3.1 Benefits of monitoring and evaluation of HIV-AIDS programmes**

- a) Monitoring and evaluation of healthcare programmes help programme implementers to reduce the spread of HIV-AIDS. This can be achieved by careful consideration of how HIV-AIDS programmes are monitored with regards to resources, healthcare workers and service delivery aimed at the reduction of new HIV-AIDS infections (UNAIDS 2013:13).
- b) To improve care for those infected, this can be achieved by the monitoring and evaluation of HIV-AIDS programmes aimed at managing HIV-AIDS - related service delivery such as ARV provision, pathology utilisation and healthcare consultations (UNAIDS 2013:13).
- c) To minimise the social and economic impact on affected families and communities, managing HIV-AIDS at an individual level ultimately impacts those affected by HIV-AIDS, including families and communities (UNAIDS 2013:13). Monitoring the community wide impact of the disease is key to developing substantial HIV-AIDS responses to stop the epidemic.

- d) The number of people in the world living with HIV-AIDS is increasing as HIV-AIDS-related mortality has declined but the annual number of people newly infected with HIV-AIDS has not (Beck, Santas and DeLay 2008:75). Based on this information, middle and lower-income countries that are scaling up HIV-AIDS services need access to robust and contemporary strategic information to develop and implement these services, and monitor and evaluate them once they are established.

To date, there is no established gold standard for the monitoring and evaluation of large HIV-AIDS programs in Sub-Saharan Africa where these programmes are being scaled up (Nachega, Hislop, Dowdy, Lo, Omer, Regensburg, Chaisson and Maartens 2006:43). The field of care and support is constantly evolving, and hence guidelines need to be revised periodically to ensure that content remains relevant and appropriate to the sector it functions in. Comprehensive monitoring and evaluation guides should exhibit specific indicators for the additional aspects of care and support programmes, such as the quality of care, health worker capacity, psychosocial issues and legal issues (Benatar 2004: 91). Piot (2006:526) states that monitoring and evaluation frameworks should contain the following basic components for efficient and cost effective functioning. These are a well devised monitoring and evaluation plan, including budgetary requirements with funding secured for its implementation; monitoring and evaluation staff to coordinate activities and an electronic data management system to manage and access data efficiently. A functional HIV-AIDS monitoring and evaluation system provides essential data for monitoring the epidemic and improving the response, ultimately ensuring accountability to those affected by HIV-AIDS.

The UNAIDS Guide to Monitoring and Evaluation of National HIV-AIDS Programmes distinguishes four concepts which form the basis on which HIV-AIDS programmes have been developed. A discussion of key components follows (UNAIDS 2013:13):

#### **4.3.1.2 Monitoring**

Monitoring is *“the routine tracking of priority information about a programme (at national or project level) and its intended outcomes. It includes monitoring of inputs and outputs through record-keeping and regular reporting systems, as well as health*

*observation and client surveys. It can be called programme, process or output monitoring*” (UNAIDS 2013:13). Guided by the United Nations global call to end HIV-AIDS by 2030 monitoring activities are crucial and essential to guide the planning, coordination and implementation of the HIV-AIDS response; assess the effectiveness of the HIV-AIDS response; and identify areas for programme improvement.

#### **4.3.1.2 Evaluation**

The context in which HIV-AIDS programs operate has become more complex; given the fiscal, socioeconomic, demographic, interpersonal and inter-organizational settings in which they function. Evaluation of activities plays a huge role in the HIV-AIDS setting as accountability from policymakers and stakeholders have increased.

#### **4.3.1.3 Surveillance**

Public health surveillance is a tool to estimate the health status and behaviour of the populations. The purpose of surveillance is to empower decision makers to manage the detection of secular disease trends and patterns. As the world enters the thirty fifth year of the global HIV-AIDS epidemic, integrated surveillance data analysis becomes inherently necessary to map global disease trends by describing emergent disease routes of transmission, patterns of resistance and barriers to cure therapy, which may be harnessed to end the epidemic.

#### **4.3.1.4 Indicators**

Indicators should be usable, effective, appropriate, durable, useful, coherent, measurable and meaningful. Different indicators work best for different situations, whether internal or external, or at a particular level of an organisation or process. Indicators gain strength when used as part of a basket of indicators - a structure that links multiple indicators together within a broader monitoring and evaluation framework (Health Systems Trust, Health Systems Review 2012:11).

The World Health Organisation dictates that indicators for health programmes should be **SMART** (World Health Organisation: 2011):

**Specific:** The indicator has to be specific. This is of relevance to HIV-AIDS programmes where interventions targeted at specific age groups should be emphasised. For example, a specific indicator will be the number of HIV tests conducted on females aged 12-18 years of age. This is specific to this age group and hence will allow data collection to develop interventions tailor made for this population subset.

**Measurable:** The indicator should be measurable. An example of a measurable indicator in HIV-AIDS programmes is the number of viral load blood tests conducted in the past 12 months. This will allow the actual number of blood tests conducted to be counted and will be used to monitor response to the HIV-AIDS epidemic in the last 12 months.

**Attainable:** The indicator is achievable if the performance target accurately specifies the amount or level of what is to be measured in order to meet the outcome. An example of this in HIV-AIDS programmes will be to assess the number of HIV-AID patients that drop-out from care in a 12-month period. This is important as it assesses the number of patients that no longer attend at the clinic concerned and hence should be counted as lost to follow-up. This sub-set should be removed from other data sets as inclusion may skew data making other related variable unattainable.

**Relevant:** An indicator must be relevant. This is the most versatile criteria of indicators in HIV-AIDS programmes as it allows the programme to adapt and contextualise indicators for use in a specific age group or demographic area. This is pivotal when inclusion of key populations are explored and to ensure that data collection is accurate and contextually relevant.

**Time bound:** All indicators should have a time frame for which they are being analysed and collected. This is important to assess for trends and impact analyses.

Recently, criticism has been leveraged at existing indicators as being too limiting and no longer relevant to the changing and dynamic needs of health infrastructures. Historical indicators have been criticised as being insensitive to changing trends. In

addition, current indicators tend to assess negative health impacts and not positive trends in data.

The ultimate goal is to continually improve and review indicators periodically to assess their relevance and appropriateness until a comprehensive description of the total range of indicators for the total determinants of health are achieved.

#### **4.4. HIV-AIDS monitoring and evaluation frameworks**

Several monitoring and evaluation frameworks across the various sectors have evolved in response to the HIV-AIDS epidemic. The global HIV-AIDS field utilises the Joint United Nations Programme on HIV-AIDS (UNAIDS) and United States Agency for International Development (USAID) monitoring and evaluation frameworks for HIV-AIDS programmes based on their versatility and relevance to the civil healthcare sector, public healthcare sector and para statal healthcare sector. The South African Department of Health has developed a South African National monitoring and evaluation HIV-AIDS Framework for use nationally in South Africa. The UNAIDS and USAID/Global Fund frameworks are the most widely used and accepted HIV-AIDS monitoring and evaluation frameworks globally and hence were chosen to be reviewed. These frameworks track important global milestones in the global battle against HIV-AIDS. The UNAIDS and USAID HIV-AIDS monitoring and evaluation frameworks recognise the need for a broader-based, expanded response to the epidemic in sectors ranging from health to economic development and the need to provide leadership and better-coordinated streamlined service delivery. These global frameworks offer support to countries regarding HIV-AIDS-related global activities, programme development and coordination global HIV-AIDS surveillance and resource mobilization. The South African National monitoring and evaluation HIV-AIDS Framework builds on the above and is relevant to the South African HIV-AIDS epidemic.

Currently, monitoring and evaluation frameworks assessing HIV-AIDS programmes have been developed for sector-specific responses and span different national and international arenas. The South African private managed healthcare sector manages HIV-AIDS specific programmes offering comprehensive HIV-AIDS treatment, wellness and care to selected patients on medical insurance. There is a current lack

of a contextually relevant, sector appropriate monitoring and evaluation HIV-AIDS framework for this sector, heralding an urgent need for development of such a framework.

Key differentiating factors and commonalities exist among the commonly used monitoring and evaluation frameworks which are discussed below.

#### **4.4.1 UNAIDS monitoring and evaluation HIV-AIDS framework**

UNAIDS and World Health Organisation (WHO) have developed a guidance document for use amongst non-governmental organisations, non-profit organisations, faith based organisations and civil society organisations designed primarily for programme managers and others involved in planning with implementing monitoring and evaluation of HIV-AIDS programmes and projects for community and district-based healthcare providers. However, these guidance documents may not solely be applicable to the South African context of HIV-AIDS programme management given the burden of disease in this area which heralds the need for collaborative efforts to ensure the recommendation of a culturally acceptable and socially relevant conceptual framework for public, private and non-governmental sectors alike in South Africa (UNAIDS 2013:12).

As the burden of disease in various countries across the globe changes due to the various routes of transmission and the varied HIV-AIDS programmes in response to disease incidence and prevalence, it has become necessary for a sector wide plan to develop a thorough understanding of each of the above components of the UNAIDS HIV-AIDS monitoring and evaluation and to firmly entrench these for optimal results. Unfortunately, most South African tertiary institutes do not offer a formal education programme aimed specifically at monitoring and evaluation modules and to date, there are none that are specifically aimed at monitoring and evaluation in the healthcare sector. This demonstrates paucity to build capacity for future generations to learn and research further in this very important and game changing field.

The UNAIDS monitoring and evaluation framework was reviewed to ensure the indicators contained were as applicable as possible to diverse settings, but local adaptation is necessary, depending both on the HIV-AIDS characteristics of the



country such as high or low prevalence and special populations affected and the agencies involved in planning, design, implementation, monitoring or evaluation (UNAIDS 2013:30).

The lists of indicators exhibited in the UNAIDS framework are not comprehensive or exhaustive. These indicators allow national, district and local HIV-AIDS programme monitoring and evaluation in order to track the epidemic and the response over time. However, many countries and organisations are struggling to establish routine data collection mechanisms. Some of the challenges they face include selecting the most appropriate indicators from the wide array of HIV-related indicators that have been developed over the years as well as ensuring data quality.

These are some issues resulting in measurement challenges that need to be addressed as new frameworks are devised for varied settings. The framework requires adaptation where necessary, especially with relevance to the South African epidemic to ensure that the indicators are relevant to the programme and meaningful to stakeholders for maximal benefit of the organisation being evaluated.

The HIV-AIDS epidemic continues to evolve with initial attention being focused on HIV-AIDS prevention but now as the HIV epidemic turns into the AIDS epidemic in various countries, HIV-AIDS treatment; care of chronically ill patients and social support to those infected and affected by the disease have become the focus point of programme delivery. Monitoring of key HIV-AIDS programmes and their implementation as well as evaluating their impact will be important in ensuring that the best possible HIV-AIDS related services are delivered.

## 4.4.2 USAID/GLOBAL fund monitoring and evaluation HIV-AIDS framework

USAID and the Global Fund have long worked with national governments and donors to fight many diseases, including HIV-AIDS, Tuberculosis and Malaria, as well as to make improvements in a number of health areas across the globe (USAID 2012:41).

More specifically, the M&E framework has been designed for (USAID 2012:41):

- *Assessment of the M&E programme:* This assessment is undertaken to carefully review capacities of the programmes implementing entities to ensure that they are in line with the programme objective and to assess if available resources are on hand for realisation of these goals. It is important to understand that monitoring and evaluation of a programme is a dynamic process which can take place periodically based on the management of the programme. Historically assessments of M&E programmes take place quarterly with biannual report submission to donor organisations and stakeholders however monthly assessments should be considered as an opportunity to amend programme areas of concern in real time rather than waiting for a periodic review.
- *Evaluation of the M & E programme:* This deals with how the M&E activities of programmes are linked and integrated within the National M&E System and how data is utilised across these systems for an integrated national response to HIV-AIDS.
- *Development of M & E Plan:* This is a pivotal plan required to help to develop a costed action plan to strengthen M&E systems. The M&E Plan is a document that describes a system which links strategic information obtained from various data collection systems to decisions that will improve health programmes. Given the high burden of disease of HIV-AIDS locally and abroad, it is critical that M and E plans be developed with key operational research inputs for maximal impacts and outcomes. The completion of the

M&E framework and the development of an action plan should (USAID 2012:41):

- Identify gaps and strengths: It is important that M and E plans are feasible and accurate based on practical information needs of intended users. These plans should reveal and convey technically accurate information guide investments in M&E to better inform the development of a M&E budget
- Strengthen HIV-AIDS national systems: M and e assists to measure the extent to which changes in desired health outcomes are attributable to a program's interventions. Jinabhai (2010:2) states that three primary uses of evaluation findings to strengthen HIV-AIDS national systems can be achieved by rendering judgements programme deliverables, facilitating improvements to core service delivery offering and through knowledge generation.

The USAID framework looks at the goals and objectives of HIV-AIDS programmes and how they relate to a country's national strategy and M&E framework. The framework also looks at data dissemination and transparency, as well as the confidentiality of sensitive data. Finally, the framework assesses the budget amount allocated to M&E (USAID 2012:41) in order to assist stakeholders conclude whether HIV-AIDS programme service delivery is a success or not.

#### **4.4.3 South African national HIV-AIDS monitoring and evaluation framework**

It is important to realise that HIV-AIDS programmes span across various healthcare sectors in South Africa and the varied sectors have mounted a response in proportion to the burden of disease that has been experienced. The multi-sector HIV-AIDS response has been implemented through programmatic changes and awareness campaigns supported by health legislature and policy amendments. It is therefore inherent that progress on these responses across the sectors are reviewed in tandem with data available for the areas they serve in order to accurately estimate the extent of HIV-AIDS disease burden across the country. Data generated from M & E frameworks assist with the collation of data towards an internal environment review of HIV-AIDS programmes through SWOT analysis. This analysis is able to

pinpoint weaknesses and threats to reform service delivery in meeting the goals and objectives of the HIV-AIDS programme concerned. Strengths and opportunities from HIV-AIDS programmes can also support clinical management of the patients and improve effectiveness of treatment implementation. Finally the objectives of the M&E framework are to prioritize, allocate and manage resources in order to monitor the impact of HIV -AIDS on health care systems and communities

**Table 4.2 Monitoring and Evaluation Framework Core indicators**

<b>INDICATORS</b>	<b>INPUTS</b>	<b>PROCESS</b>	<b>OUTPUTS</b>	<b>OUTCOME</b>	<b>IMPACT</b>
	Budget Human resources Expenditure	Drug expenditure Laboratory services Equipment	Number of ARVS dispensed Number of HIV tests utilised Number of CD4 tests conducted	Pharmacovigilance	Behavioural changes Survival Quality of life indicators HIV-AIDS Incidence HIV-AIDS prevalence

**Source; Adapted from Monitoring and Evaluation Framework: Comprehensive HIV and AIDS Care, Management and Treatment Plan for South Africa (2004:6)**

Indicators adapted from the HIV-AIDS Monitoring and Evaluation Framework is diagrammatically presented in Table 4.2. These indicators form the core of the HIV-AIDS Monitoring and Evaluation Framework and have been separated into input, process and output which deal with budget and expenditure; human resources and training; drug procurement and laboratory services. Patient outcome and impact indicators deal with prevention, care and treatment and pharmacovigilance. The framework has exhibited challenges to ensuring appropriately adequate human resources, finance and infrastructure, narrowing the gap in resource availability between provinces and timely reporting. This framework exhibits indicators relevant to the public and NGO HIV-AIDS healthcare sectors in South Africa. Currently there is a paucity of core HIV-AIDS private sector indicators within a relevant private sector HIV-AIDS monitoring and evaluation framework. The core objective of this research study is to develop an HIV-AIDS conceptual framework for the management of HIV-AIDS private sector programmes that can be used in both public and private healthcare sectors.

Comprehensive and timely monitoring and evaluation data is crucial to guide the optimal use of limited resources and to ensure effective HIV-AIDS programs. The effective implementation of one national HIV-AIDS M&E approach still has some ways to go. Efficient use of resources is imperative, all the more so in the context of the global economic recession (Peersman, Rugg, Erkkola, Kiwango and Math 2009:87). Long-term sustainability of monitoring and evaluation funding is also a concern. If monitoring and evaluation is to fulfil its role as required, monitoring and evaluation system strengthening over the next five years it should focus on prioritizing data use, addressing important data gaps, drawing on available donor funding for monitoring and evaluation and increasing the share of domestic funding sources over time and implementing a systematic evidence-based approach to human capacity-building at all levels (Izazola-Licea, Wigelmann and Ara 2009: 119).

The last decade of monitoring and evaluation of HIV-AIDS in South Africa has been challenging as HIV-AIDS prevention and ARV services were introduced against weak health information systems, coupled with limited health infrastructure and diverse service providers with various reporting requirements. Although elements of the UNIAD/USAID/Global Fund frameworks were deployed for use locally, relevance

and appropriateness of indicators for monitoring and evaluation have been challenging. A SWOT analysis was undertaken among the three monitoring and evaluation networks with a view to highlight commonalities, share disparities and identify best practices across them.

#### **4.5. Strengths, weaknesses, opportunities, threat (SWOT) analysis of monitoring and evaluation frameworks**

The UNAIDS, USAID/Global Fund and South African National HIV-AIDS Monitoring and Evaluation Frameworks are examples of frameworks most commonly used in the South African NGO sector and the South African public healthcare arena. The implementation of these frameworks in the South African public and NGO sector share some common challenges and benefits. The discussion that follows is based on a SWOT analysis conducted on each of these frameworks and highlights their strengths, weakness, opportunities and threats relevant to the South African NGO and public HIV-AIDS healthcare sector

##### **4.5.1 A SWOT analysis of UNAIDS' monitoring and evaluation framework**

###### **4.5.1 Strengths**

###### **A) Availability of monitoring and evaluation reference materials is a special strength**

Monitoring and evaluation activities should be proportional to programme resources. Monitoring and evaluation is needed at all levels and is most useful if performed in a logical sequence: first assessing data on input, process and output; then examining behavioural or immediate outcome; and finally assessing disease and social effects (Schwartlaender, Stover, Walker, Bollinger, Gutierrez, McGreevy, Opuni, and Forsythe 2009:11). Existing HIV-AIDS indicators and instruments for data collection and analysis should be built upon but should always be locally adapted. Monitoring and evaluation indicators should measure population-based, biological, behavioural, facility-based and programme data to determine the collective effectiveness of

consolidated programmes, and these efforts should be supplemented with good contextual data (Sumartojo, Holtgrave, Gayle, Merson and Michael 2000:10).

To increase the utilization of evaluation results, the design, planning, analysis and reporting of monitoring and evaluation should actively involve key stakeholders such as district and national programme managers, policy-makers, community members and programme participants (World Health Organisation 2005:12). Early lessons learnt from the initial monitoring and evaluation of the Department of Health HIV-AIDS frameworks found that an appropriate strategic objective had to be devised toward identifying intermediate results. This had to be further clarified by defining causal linkages between results. One of the shortfalls of the initial Department of Health monitoring and evaluation plans was failure to identify critical assumptions and emphasise key principles. The USAID/Global Fund monitoring and evaluation reports focus sufficient narrative on critical assumptions towards highlighting verifiable achievements.

#### **b) Effective use of monitoring and evaluation partners in national processes**

As evident from the discussion on the national South African monitoring and evaluation framework, the UNAIDS monitoring and evaluation framework and the USAID monitoring and evaluation framework, well-coordinated, strategic monitoring and evaluation activities are essential to minimize the burden of data collection on organisations while maximizing the usefulness of monitoring and evaluation data for decision-making (USAID 2012:41). National HIV-AIDS programmes, ministries of health and other sectors can jointly contribute to enhancing HIV-AIDS monitoring and evaluation efforts and must commit to identifying sustainable resources if monitoring and evaluation is to be a routine programme function (McKee 2001:296).

## **4.5.2 Weaknesses**

### **a) Funding**

The distribution of health funding in the South African health system is a controversial topic that always receives much attention. Health outcomes and access are not equitable between rich and poor. There are 7, 5 million lives on medical aids in the private healthcare sector amounting to just about 16% of the South African population. However, it is estimated that healthcare spend is almost six times the price of the public healthcare sector (KPMG 2015:11). These figures show stark disparities and highlight the differences in the public private divide. South African HIV-AIDS funding from time immemorial has often been provided by global benefactors like the Global Fund, PEPFAR and Bill and Melinda Gate's Foundation. However, domestic funding for the monitoring of health services will be the key to the long-term sustainability of implementation of the HIV-AIDS monitoring and evaluation plan and has been identified as a key challenge (Mugavero, Amico, Horn and Thompson 2013:1164).

The number of people in the world living with HIV-AIDs is increasing as HIV-related mortality has declined but the annual number of people newly infected with HIV-AIDS has not, hence efforts and substantial financial resources have gone toward strengthening national monitoring and evaluation systems for HIV-AIDS programmes (Rees 2014:3). There has been a significant shift in culture around HIV-AIDS monitoring and evaluation in the past 10 years, associated with the great infusion of financial support through PEPFAR and the Global Fund into South Africa (PEPFAR 2014). Building national monitoring and evaluation systems requires sustained efforts over long periods of time with local leadership, commitment, and extensive stakeholder engagement together with self-sustainable funding models. With maturing HIV-AIDS care and treatment programmes, the measurement of key outcomes on the same patients over time is important for patient management and programme monitoring. By focusing on the key evidence-based interventions needed to achieve an AIDS-free generation and the capacities needed to monitor and evaluate those interventions, the multisectorial health facilities in close collaboration with its global and national partners, are well positioned to transform the successes



and challenges associated with early rapid scale-up into future opportunities for sustainable, cost-effective, country-owned programmes and systems (Porter, Bouey, Curtis, Hochgesang, Idele, Jefferson, Lemma, Myrick, Nuwagaba-Biribonwoha, Prybylski, Souteyran and Tulli 2012:3).

## **b) Quality**

The greatest challenge encountered is to better understand the content and quality of care for people living with HIV-AIDS (Foster and Niederhausen 2000:11). As HIV-AIDS is an ever evolving field, it becomes more difficult to quantify and qualify markers of quality standards and consistency (Foster and Niederhausen 2000:11). The achievement of high and equitable coverage of integrated primary HIV-AIDS care services requires consistent political and financial commitment; incremental implementation based on local epidemiology; the use of data to direct priorities and assesses progress, especially at district level, and effective linkages with communities and non-health sectors (Lawn, Rohde, Rifkin, Were, Paul and Chopra 2008:917). The quality of data informing these processes are paramount to successful planning and implementation of monitoring and evaluation frameworks for HIV-AIDS.

Rapidly evolving science requires the ability to translate evidence to practice and to modify guidelines, services and systems in order to ensure best practices are being implemented. This can be a challenge in rural areas of South Africa with the lack of access to laboratory and health related machinery and equipment preventing state of the art technological equipment from being used for optimum efficiency. Another example of a local challenge to quality is the decentralisation of health services in EThekweni municipality. The current allocation of authority for medical management in the district confers 60% authority to the Department of Health and 40 % to the local municipality thereby conferring a combined-joint management system. Currently, HIV-AIDS data is collected from 11 health districts in Kwa-Zulu Natal from over 16 provincial hospitals, over 8 community health clinics and approximately 250 local clinics. A challenge to data quality is often seen when different information technology systems are being used at various facilities together with differing health policies, plans and priorities as this provides inconsistent data collection across the

board and makes the collation of data difficult and incorrect. Alignment to a single national policy, plan and priority for health is required for a consistent and standardised approach to data collection and data collation.

In 2000, the District Health Information System (DHIS) was adopted as the official South African routine health information system for managing aggregated routine health service-based information. However, the lack of proper training and guidance on the system left many centres unable to operate and utilise. This once again calls for integrated system development with proper co-ordination and planning structures to ensure timely data collection and collation.

### **4.5.3 Opportunities**

#### **a) Involve stakeholders in the development of the monitoring and evaluation plan**

Monitoring and evaluation stakeholders are those people who have a stake in the programme. They are persons who take decisions using the monitoring and evaluation data and findings and typically include donors, funders, communities, programme managers and programme staff. Aube (1999:11) describes clear advantages for stakeholder participation which include self-reliance in overall programme management, promotion of efficient allocation of resources and contribution to improved communication and collaboration. In South Africa especially in Kwa-Zulu Natal it is important to ensure participation from all communal leaders including tribal authorities which have existed and worked hand in hand with governments in South Africa. Their participation will ensure inclusion of locally relevant and contextually appropriate information, assuring more communal buy in and accountability.

#### **b) Monitoring and evaluation advocacy workshop**

Stakeholder advocacy is a novel way to build on an organisation's existing management and advocacy, while encouraging leadership for a community-led HIV-AIDS response. Strengthening advocacy increases stakeholder knowledge and understanding on the monitoring and evaluation project and its supporting processes. Advocacy workshops increase stakeholder understanding of monitoring

and evaluation planning and provide stakeholders with the competencies to be able to apply concepts of monitoring and evaluation. There is a paucity of organisations equipped to handle HIV-AIDS monitoring and evaluation advocacy workshops in South Africa and these organisations are almost non-existent in Kwa-Zulu Natal. This is ironic as Kwa-Zulu Natal bears the brunt of the national HIV-AIDS epidemic and one would assume that HIV-AIDS efforts at strengthening advocacy and communication in the province would be heightened. The South African HIV-AIDS activist group, Treatment Action Campaign does provide advocacy workshops nationally but does not cover the content of HIV-AIDS monitoring and evaluation. The Foundation for Professional Development (FPD) is a South African private institution of higher education that offers a wealth of HIV-AIDS training development programmes incorporating aspects of quality management, monitoring, evaluation and advocacy. Unfortunately, these courses are expensive limiting equitable access for all. This creates a void in the public and civil society sector in terms of advocacy training and capacitation.

### **c) Monitoring and evaluation audits**

Performance audits are an independent assurance service that provides assurance on the performance of projects, programs, activities and functions in terms of economy, efficiency and effectiveness but also in respect of environmental and equity aspects (Deloitte 2016). The aim of a performance audit is to provide recommendations about where and how improvements can be made and to identify the likely impact they may have. Currently, none of the monitoring and evaluation frameworks discussed above undergo any form of performance audits. Financially healthy and sustainable economic public policies and projects need to be based on a thorough understanding and consideration of how these impact communities. Performance audits provide effective and efficient means for measuring the impact of government authorities' efforts. Performance audits are a management tool just as internal audit; controlling and dashboards are and provides information for improvement.

#### **d) Technology**

Technological advancement has been identified as a novel approach to bridging the divide and to assist healthcare systems adapt to diverse settings. Bekker (2014) posits that great opportunities lie in the revolution in information technology and systems. Better harnessing of new opportunities in information and communication technology can lead to more accurate and timely communication of information across systems in resource-poor countries

While donor countries have provided funding and technical know how to set up and establish early HIV-AIDS monitoring and evaluation systems, it has become important for transfer of technology and information sharing to occur in order to ensure that South African health systems have been sufficiently nurtured to run and implement their own country specific frameworks which are contextually relevant and independently engineered. To date, partner nations have made progress to move away from partner-specific or donor-specific systems towards co-ordinated national ones, as longer term investments in national monitoring and evaluation systems begin to grow. A necessary stage in transition is the assessment of capacity for change. Accelerated transition to country-owned systems also focuses special attention on human resources for monitoring and evaluation systems.

#### **4.5.2 A SWOT analysis of USAID/Global Fund monitoring and evaluation framework**

##### **4.5.2.1 Strengths**

###### **a) Monitoring and evaluation champions**

A champion is a charismatic advocate of a belief, practice, program, policy and/or technology (USAID 2014). Champions create and communicate strategic meaning around the innovation, persistently promote the innovation, sell the idea to top management in order to secure resources, and involve and motivate others to support the innovation (Howell, Shea and Higgins 2005:646). In 2010, Family Health International (FHI), which is a non-profit human development organization dedicated

to improving lives in lasting ways by advancing integrated and locally driven solutions, commenced using public health champions as an advocacy strategy in the HIV-AIDS monitoring and evaluation arena. This approach may be particularly valuable for complex public health interventions that require sustained support. Public health champions are an invaluable resource to gain and sustain momentum for innovative programs and policies. There are three critical factors for the success of champions, namely: expressing enthusiasm and confidence about the success of the innovation, getting the right people involved and persisting under adversity (Howell, Shea and Higgins 2005: 647). A public health champion may be helpful in building consensus among stakeholders with diverse interests, or for garnering organizational support for significant changes to practice at the practitioner level. FHI has a local South African footprint and utilises its Champions Project to promote awareness and the use of technology and research through partnerships with health professionals, policy-makers and advocacy groups. This is an excellent collaborative tool for HIV-AIDS organisations to utilise. However, little knowledge and awareness exists of this project and the initiative. More education, awareness and exposure of this powerful initiative are required to ensure that all organisations can benefit from it.

#### **4.5.2.2 Weaknesses**

##### **a) Adapting for diverse settings**

Diversity of healthcare settings has been identified as another potential monitoring and evaluation challenge in the multi-sectoral response to HIV-AIDS. This implies the difference in settings across various geographical locations and across varied cultures. Adaptation should be encouraged when necessary to ensure that the data collected is relevant to the programme and meaningful to stakeholders. However, relevance must be balanced with rigorous adherence to methods to allow trends to be tracked over time, as well as comparability between sites (Beck, Santas and DeLaya 2008:72). Chopra, Lawn, Sanders, Barron, Abdool Karim, Bradshaw, Jewkes, Abdool Karim, Flisher, Mayosi, Tollman, Churchyard and Coovadia (2009:1023) state that in order to adapt to diverse settings a well-planned and sustained integrated multicultural approach include a genuine commitment to diversity from organizational leaders; includes policies and practices that promote

and support competence at all levels of the organization; and systematically conducts community needs assessments, collecting demographic data and language preference information to make decisions regarding appropriate interventions and healthcare services involvement. Health service integration has been defined as the “managerial or operational changes to health systems to bring together inputs, delivery, management and organisation of particular service functions”. Integration improves access and facilitates use of services, and addresses what has been referred to as the four ‘d’s’ – duplication, distortion, disruption and distraction (Western Cape Department of Health 2014). Scale up of integrated HIV-AIDS prevention, care, and treatment programs are important at addressing the response to diverse settings. Enhancements to routine HIV-AIDS monitoring systems are needed to better track individuals across services like testing, care and treatment and to assess retention and adherence to ART. At the same time, the decentralization of HIV-AIDS services to lower levels of the health system requires simplification of monitoring approaches and an integration of monitoring systems.

#### **4.5.2.3 Opportunities**

##### **a) Build capacity to develop research priorities and invest in operational research**

Operational research provides decision-makers with information to enable them to improve the performance of their programs. Operational research helps to identify solutions to problems that limit program quality, efficiency and effectiveness or to determine which alternative service delivery strategy would yield the best outcomes (Global Fund 2015:2). Operational research complements monitoring and evaluation programmes and provides the programme with solid information about which interventions and service delivery models work in the field of HIV-AIDS. Operational research helps build a program’s overall research capacity and ability to learn from data and implementation, effectively serving as an investment in future program efficiency and performance. Operational research activities strengthen health systems and provide program integration following the principles of the determining goals, objectives, and indicators. Currently there is joint funding for the South African public

HIV-AIDS programme with contributions from the South African National Department of Health, President's Emergency Plan for AIDS Relief (PEPFAR), The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM); The Bill and Melinda Gates Foundation; and the World Bank. To date, the largest component of funding allocation on the public sector HIV-AIDS programme is the purchase of life-saving ARV therapy. On May 11, 2016 South African Health Minister Aaron Motsoaledi announced that the CD4 eligibility criterion for ARV treatment will be removed from September 2016, in line with guidelines released by the World Health Organisation (WHO). This implies that all HIV-positive South Africans will now be eligible for ARV therapy under this test and treat regimen. This doubles the ARV budget, as an estimated 3.5 million South Africans will now join the ARV programme. The implication is that more of the health budget will be allocated to ARV procurement leaving minimal allocation for public health research including operational research. The massive global recession together with the mismanagement of funds by recipient countries has led to donor fatigue in many African and Sub-Saharan countries with several donors reducing funding for the new financial cycle. New funding sources have to be explored, including tackling the South African private sector for additional funding, especially for the highly sought after and very critical areas of operational research (South Africa 2015).

#### **4.5.2.4 Threats**

##### **a) Funding**

The procurement of suitable and sustainable budgets to fund HIV-AIDS monitoring and evaluation projects and frameworks will always be challenging given the context of the global recession and the erratic foreign exchange fluctuations. This calls for local leadership to build stakeholder co-ordination and sustainable partnerships and to facilitate strong collaborations to enhance working group relationships. Securing funding calls on national commitment to ensure HIV-AIDS monitoring and evaluation systems performance is sustained and human and institutional monitoring and evaluation capacity is strengthened at all levels to manage these projects efficiently and effectively. The South African private healthcare sector and the South African private business sector must be mobilized to enhance funding opportunities

pertaining to critical health needs and requirements. South African Business Coalition on Health and AIDS (SABCOHA) is an example of a private sector initiative involved in developing performance-based funding mechanisms for HIV-AIDS related projects of greatest needs aimed at attracting and sustaining collaborations with varied stakeholders. More organisations like this one are urgently required in South Africa.

## **b) Sustainability**

Sustainability can be defined as the ability of a project to maintain its operations, services and benefits during its projected life-time (Khan 2000:1). Sustainability is a major challenge in many developing countries in the field of HIV-AIDS (Khan 2000:1). A large number of healthcare projects implemented at huge costs often tend to experience difficulties with sustainability. This implies that sustainability concerns itself with the level of continuation of delivery of project services, changes stimulated by the project and new initiatives caused by the project (Bamberger and Cheema 1990:10).

The World Bank states that a sustainability strategy is a follow-up activity of sustainability analysis and is to indicate the way various elements of sustainability are to be identified, assessed and incorporated into a project or a programme, right at the design stage. The strategy is expected to specify various complements to sustainability and make provisions for their incorporation during the formulation, implementation, operation and maintenance stages of a project (The World Bank 2015). Sustainability of monitoring and evaluation programmes is at the centre of sound governance arrangements. They are necessary for the achievement of evidence-based policy making, budget decisions, management, and accountability, especially for HIV-AIDS given the high South African disease burden. Strong government support, political will, less reliance on donor funding together with novel ways for HIV-AIDS project income generation are required to continue funding existing projects and self-fund future projects



### **4.5.3 A SWOT analysis of the South African national HIV-AIDS monitoring and evaluation framework**

#### **4.5.3.1 Strengths**

##### **a) Emphasis on the national health insurance as a tool for harmonization**

South Africa has embarked on a bold and new direction with its National Health System following the publication of its green paper on the Policy on National Health Insurance on the 11 August 2011. The NHI intends to ensure that all South Africans have access to appropriate, efficient and quality health services. The NHI is intended to bring about reform that will improve service provision. The national health system has a number of challenges that need to overcome for the NHI to succeed. These include the worsening quadruple burden of disease, a shortage of key human resources and the present under-performance of public institutions (Naidoo 2015:149). The phased implementation over the 14 years is intended to deal with these challenges in a systematic and pragmatic way and allows for the piloting of the NHI and concomitant strengthening of the health-care system. These issues highlight country ownership and harmonization and advocate the use of existing in-country indicators, data systems and planned surveys in order to strengthen existing systems and existing tools for performance evaluation.

A key component of the NHI is the South African HIV-AIDS programme and the HIV-AIDS M&E framework. A monitoring and evaluation system built on this sound foundation will provide a roadmap to programme planning, monitoring and evaluation by delineating clear pathways to programme goals and objectives which should lead to sound implementation with emphasis on accountability.

##### **b) South African national HIV-AIDS monitoring and evaluation framework is SANAC endorsed**

The South African National AIDS Council (SANAC) brings together the NGO, public and private healthcare sectors to mount a multi-disciplinary response to HIV-AIDS in South Africa. SANAC bases its service delivery on objectives aimed at curbing the HIV-AIDS epidemic in the country. One of the core objectives is “*to ensure the*

*monitoring and evaluation of progress against the targets set in the NSP and ensure mid and end of term evaluations for the prevailing NSP (SANAC 2015)”. This objective aims to enhance the South African National HIV-AIDS Monitoring and Evaluation Framework as an important tool to quantify the South African response to HIV-AIDS and identify areas in need of improvement. SANAC endorsement of the South African National HIV-AIDS Monitoring and Evaluation Framework is an affirmation of the South African government’s commitment and strong political will to combat HIV-AIDS.*

#### **4.5.3.2 Weaknesses**

##### **a) Reliance on paper based data collection**

The South African Department of Health has relied on data collection to be undertaken on the clinic notes with which the patient is seen. There are several challenges with this system. Healthcare workers are the individuals tasked with updating the clinical chart notes, providing necessary indicators for monitoring and evaluation and finalising patient numbers on a daily, weekly and monthly basis. These statistics are collated at the local level, and then manually referred to district level clinics, followed by provincial clinics with final integration occurring at regional/national level. Staff shortages and fatigued healthcare workers are often reasons put forth for non-completion on local clinic statistics. In addition, lost patient information is a common finding at most Department of Health facilities where lost cards are the norm, resulting in new cards being opened at every clinic visit with the loss of previous clinical history and clinical notes.

The King Edward VIII Hospital in Durban, Kwa-Zulu Natal, issues almost 750 to 1100 new files a day due to the hospital experiencing challenges in locating cards as a result of misfiling, lost cards or in cases where patients leave the hospital with the cards (Daily News 2015). As part of the Department of Health HIV-AIDS Monitoring and Evaluation plan, all suspected and confirmed cases of Tuberculosis are to be recorded for the identification of active case findings and to ascertain the local, district and regional TB prevalence. Currently, this TB register is a single book which needs to be manually updated daily with all necessary patient details. The TB register is then sent manually on a monthly basis to district and regional offices for

collation. Having worked at the Prince Mshiyeni TB/Chest Clinic in Umlazi, Durban, the researcher recalls that the TB registers are never accurately completed. If the senior nurse in charge responsible for completion is not in, the registers were not completed. No other healthcare workers are trained as back up for completion. Furthermore, the information is not verified for precision and completeness before referring to the district offices. Also, there is always the risk of loss or damage to the register. Bearing in mind that the Prince Mshiyeni Memorial Hospital TB/Chest clinic is the largest TB Clinic in Kwa-Zulu Natal, accounting for the highest patient burden and responsible for the generation of the most TB statistics in KZN, can this data be trusted given the challenges experienced during data collection? This information, although anecdotal is important in signalling the data collection issues identified as weaknesses.

## **b) Human resources**

South Africa has low densities of the major health resources relative to its disease burden (World Health Organisation 2014:11). The World Health Organisation (2014:11) indicates that South Africa has 5.2 physicians per 1000 people, while Brazil has more than triple that, and Mexico five times this value. In order to address this issue, an increased training pipeline is essential. This can be achieved through the establishment of more nursing colleges and more medical schools. Furthermore, significant gains can be achieved through public private partnering to ensure access to more funding to initiate academic training and capacitation of medical professionals.

Many foreign nationals with medical and allied medical qualifications have entered South Africa and are keen to be employed in the public sector, but are denied employment due to immigration and certification bureaucracy which prevents many willing, foreign trained health professionals from working in SA. These laws need to be relaxed in order to enable these medical professionals access to assist in the overly burdened state facilities.

Task shifting (as discussed in chapter 2), enables the correct delegation of much care to the lowest appropriate level, e.g. primary care supervised by doctors, but run by nurses, can reduce the workload carried by scarce doctors. This is a key

intervention enabling wider supervision of healthcare facilities towards ensuring meeting healthcare goals and targets.

Contracting with private providers (GPs, specialists, hospitals, radiology and pathology providers) will enhance the ability of the public sector to deliver cost-effective healthcare to public sector patients. This will ensure the leveraging of capabilities and capacities enabling better efficient service delivery. In addition, it will manage inequalities in the distribution of skilled personnel between the public and private sectors. The relative lack of resources in the public sector needs to be relieved by making pay and working conditions more attractive to public sector clinicians, as well as through private sector contracting to fill in gaps.

HIV-AIDS monitoring and evaluation frameworks provide the basis for monitoring risk, related to achieving good patient outcomes and providing good clinical health practice. However, the implementation of this monitoring and evaluation framework has proven difficult in South Africa given the public healthcare challenges that the country faces. South Africa's health care system is two-pronged: a large, under-resourced and overused public sector and a small, well-funded and well-equipped private sector. While the public sector provides healthcare for 80 percent of the population, it accounted for only 47.9 percent of total healthcare spending in 2015, according to the World Health Organisation (WHO). Of the disproportionate private-sector spending, 81 percent comes from private medical aids. Private insurance is unaffordable for the majority of the population unless they are enrolled in a corporate health insurance plan made possible or subsidised by their employees.

### **c) Systems and management improvement**

It is critical that all levels in the public health sector improve the working of the basic financial, operational, procurement and logistical management systems and controls. This requires decentralisation of authority for staffing, financial management, procurement and disciplinary decisions to hospital level, accompanied by clear accountability at the same level, so that hospital managers are motivated to make choices that improve the operation of their facilities. Strong implementation of basic management processes includes improvement in planning, budgeting, clinical data collection, quality measurement and workforce incentivisation. Broad, appropriate

and consistent representation through amended structures, with increased accountability and responsibility at all levels of implementation and hence co-ordination is required for ensuring appropriate governance.

There are currently more than 400 public hospitals and around 215 private hospitals in South Africa. The government has acknowledged the need to significantly improve the quality of care in public hospitals. To improve standards, it views public–private partnerships as a way to fund improvements. In addition, private hospital groups have offered to support the public sector in areas such as training, patient administration and pharmacy management. The disparity in access to good health care between South Africa’s public and private sectors provides huge opportunities for innovative reforms that will increase access to wider sections of the population and generate additional value and revenue.

A key difference in health information management in the private sector is that there is greater emphasis on reimbursement and risk management than on support for patient care. This has directly been a result of the Council for Medical Schemes and the need for private sector accountability for risk mitigation in that environment. There is also standardisation of health information which reflects key issues in the private health care environment including diagnosis and procedure coding, pharmaceutical codes and standardised claim forms. In order for a similar model to be developed in the public sector, a dedicated national health information standards body needs to be established to take responsibility for the mammoth task of co-ordinating the public and private health information systems.

In 2013, the South African Office of Health Standards Compliance (OHSC) was created by the National Health Amendment Act of 2013 and, in terms of section 78 of the Act, the objectives of the Office are to protect and promote the health and safety of users of health services by (Office of Health Standards Compliance 2013):

- Monitoring and enforcing compliance by health establishments with norms and standards prescribed by the Minister of Health in relation to the national health system; and

- Ensuring consideration, investigation and disposal of complaints relating to non-compliance with prescribed norms and standards for health establishments in a procedurally fair, economical and expeditious manner.

The term health establishment refers to public and private healthcare services and facilities. It includes hospitals and primary healthcare clinics and extends to emergency medical services, hospices, private medical practices and institutions offering frail care.

The Office of Health Standards Compliance identifies and eliminates poor quality and unsafe practice by ensuring that core safety and quality standards set for each health facility are implemented, while accreditation standards establish systems and processes required in each of the facility's to deliver safe, quality care on a continuous basis. In this way, the Office of Health Standards Compliance requirements would be maintained and strengthened over time.

South Africa is a country in which both a massive HIV-AIDS epidemic and weak health system exist (Schneider, Blaauw, Gilson, Chabikuli and Goudge 2006:22). Without strengthened health systems, successful monitoring and evaluation HIV-AIDS frameworks cannot be implemented, maintained and sustained. System strengthening through technological platforms and innovative interfaces can be utilised to build effective information technology to sustain and maintain data collation in the public health sector.

#### **4.5.3.3 Opportunities**

##### **a) Electronic TB register**

Based on the weaknesses of monitoring and evaluation systems to capture accurate TB register information, an electronic tuberculosis register designed for TB-HIV surveillance program monitoring and evaluation was devised and is in the piloting stage for the use of data capture in South Africa. The system consists of a database which is accessed by the user via the user-friendly software interface, custom developed for the Microsoft Windows environment. This presents a novel opportunity for accurate and verifiable data collection across South Africa for precise TB reporting statistics.

## **b) National health laboratory services (NHLS) electronic database**

The National Health Laboratory Services (NHLS), which incorporates the laboratories of the South African Institute for Medical Research, the state-owned laboratories, the National Institute of Occupational Health and the National Institute of Communicable Diseases have a mandate to provide public health laboratory services throughout South Africa. In response to lost patient notes, clinical cards and missing laboratory data which has been described earlier as commonalities occurring at state-owned health facilities, the National TrakCare Lab LIS System has been implemented into all 322 laboratories throughout the nine provinces of the country. This system provides a more tailored reporting of results, and integration of results into electronic medical record (EMR) systems, which is accessible all across the country.

## **c) Electronic health record**

On 07 June 2016, the City of Johannesburg introduced an electronic health record, called e-Health@Joburg, at all its 81 public healthcare facilities (Daily News 2016:02). The core of the system is an electronic health record containing historic and current patient demographic details and clinical information. In addition, the record will contain treatment plans for all clinical conditions, customised to individual patients. The system will also send SMSes and e-mails to remind patients of their appointments. This is an excellent technological innovation that will negate the issues faced with lost cards and missing information's. The electronic health system transforms the city's health department, as it ensures that each person had one healthcare record. This is an example of an innovative data capturing tool that will possibly be rolled out among the other provinces so as to greatly assist in the collation of data for the HIV-AIDS monitoring and evaluation framework in South Africa.

### **4.5.3.4 Threats**

#### **a) Data integrity**

Accurate information and data collection is the cornerstone of HIV-AIDS monitoring and evaluation projects. This is critical to enable stakeholders to access relevant

data for policy formulation and programme management toward improvement. With relevance to the Department of Health HIV-AIDS framework and national strategic HIV-AIDS plan, upgrading of its information systems to web-enabled interfaces to facilitate ease of access to data is a necessary step. In addition relevant data from all stakeholder databases will need to be linked with the national HIV-AIDS database. Existing standard exchange formats should be used to facilitate data transfer between different databases. Data integrity can be assured by training all stakeholders and staff in data use for programme management and decision making. Database should be designed to respond to the decision-making and reporting needs of different stakeholders. In addition linkages between different relevant databases to ensure data consistency and to avoid duplication of effort should be undertaken resulting in a well-defined and managed national HIV-AIDS database to capture, verify, analyse, and present programme monitoring data from all levels and sectors.

## **4.8 Monitoring and evaluation frameworks: combined efficiencies and deficiencies**

The SWOT analysis conducted on the UNAIDS; USAID and GLOBAL FUND; and South African National HIV-AIDS monitoring and evaluation frameworks have revealed that there are similarities and differences dependant on the nature of the service delivered and the community treated.

### **4.8.1 Deficiencies**

#### **a) Funding**

Funding has been identified all frameworks both as a weakness and a threat as sustainable modes for continued attraction and retention of funds for HIV-AIDS programmes still remain elusive. With international acts of global terrorism on the



rise, global refugee crisis and political reforms such as Brexit, international sponsorships have had to reprioritise donor funding for continued HIV-AIDS programmes in South Africa and the other countries.

#### **b) Data integrity**

Continued efforts toward harmonization of data management issues remain a deficiency. The goal is to ultimately be able to create a digital interface integrated with all stakeholders to allow ease of information and data sharing. Coupled with that is the functionality to allow for real time data collation and report creation. HIV-AIDS programmes should also concur on line listings of common indicators and specialised indicators to allow for standard consistent monitoring of data while also to allow for comparison of data across programmes to assess how each programmes is rated in the local HIV-AIDS arena.

### **4.8.2 Efficiencies**

#### **a) Adaptability for diverse settings**

Adaptability for diverse settings of HIV-AIDS programmes to the local communities and structures is a key efficiency which can be leveraged for success. Making use of current systems and healthcare networks for HIV-AIDS service delivery is a pivotal step towards scaling up HIV-AIDS services to those that need them the most. Integration into existing healthcare structures through programme adaptability can be undertaken to attain patient value for attaining outcomes for HIV-AIDS programmes. Task shifting can also be undertaken to ensure multitasking across resource limited settings to fulfil key HIV-AIDS programme activities.

#### **b) Innovation through technology**

Innovation through technology has already entered the health sectors with useful healthcare worker applications designed to assist with HIV-AIDS learning and development. HIV-AIDS clinical management platforms have also been introduced into Social media platforms to enhance healthcare workers and patient's knowledge and awareness on HI-AIDS. Innovative technological advancements possibly remain as one of the key initiatives for data harmonisation across, awareness generation

and new knowledge creation in HIV-AIDS programmes which largely remains an untapped potential in South Africa.

This research study has set objectives to utilise findings from this study's literature review, from the quantitative and qualitative analysis of this study's data collection and from the triangulation of these processes. This will lead to the development of a proposed conceptual framework for management of HIV-AIDS private sector programmes that can be used in both public and private healthcare sectors thereby enhancing the efficiencies and improving deficiencies while leveraging core capabilities identified in the SWOT analysis of HIV-AIDS monitoring and evaluation frameworks.

## **4.9 Conclusion**

Strong leadership, political will, social mobilisation, adequate human and financial resources, and sustainable development of health-care services are needed for successful implementation of the monitoring and evaluation HIV-AIDS framework in South Africa (Abdool Karim, Churchyard, Abdool Karim and Lawn 2009: 921). "AIDS is far from over, over the next five years, we have a window of opportunity to radically change the trajectory of the epidemic and put an end to AIDS forever. Despite remarkable progress, if we do not act, there is a danger the epidemic will rebound in low- and middle-income countries" (UN Secretary-General Ban Ki-moon 2016). Decisive action is needed to implement evidence-based priorities for the control of the HIV-AIDS epidemic. While there are significant challenges facing the overall healthcare system, both public and private sector reforms as outlined above can start to address inequalities within the system, focusing on delivering accessible and high quality primary healthcare, making private healthcare more affordable to the general population, and linking the two into a sustainable, effective and integrated South African healthcare system.

The need for a monitoring and evaluation conceptual framework has various values and benefits in the HIV-AIDS managed healthcare private sector. Recognizing the need to build capacity within HIV-AIDS programmes, monitoring and evaluation frameworks have been designed to assist self-assessment and serve as a discussion guide in management of HIV-AIDS programmes. The robust process of

decision-making has to take into account sector specific factors such as current resourcing, cultural sensitivity, affordability, and sustainability– in determining which combination of quality interventions will deliver the best outcomes and benefits for that health sector. The private healthcare sector in South Africa is a favourable environment for implementation of an HIV-AIDS monitoring and evaluation framework due to strong financially viable budgets, established regulatory approvals and smaller patient volumes. Evidence-based information is needed to better understand trends for the generation of a monitoring and evaluation conceptual framework for the private managed healthcare HIV-AIDS sector to build on optimal use of scarce resources, client orientation, and sound planning toward improved quality of HIV-AIDS related services in the private healthcare sector.

**CHAPTER FIVE**

**MONITORING AND EVALUATION OF HIV-AIDS  
PROGRAMMES IN SOUTH AFRICA**

## **CHAPTER FIVE**

### **MONITORING AND EVALUATION OF HIV-AIDS PROGRAMMES IN SOUTH AFRICA**

#### **5.1 Introduction**

This chapter focuses on an in-depth analysis of key HIV-AIDS programmes from various South African health sectors. South Africa is a unique country in that it has aspects of both a developed and developing nation and as such has strong contributors to the HIV-AIDS national response from the public, private, civil and NGO sectors. Exemplars of HIV-AIDS programmes from each of these sectors are analysed through a SWOT analysis of their internal operating environments and through a PEST analysis of their external environments in an attempt to identify their efficiencies, deficiencies and core capabilities toward smart practices. This review is in line with the core objectives of this research study and will adopt the use of smart practices towards the development of a proposed conceptual framework for programmes that can be used in public, civil and private healthcare sectors.

#### **5.2 South African public sector HIV-AIDS programme**

Chapter two discussed the national perspective on HIV-AIDS and highlighted its impact and outcome in South Africa. South Africa's HIV-AIDS epidemic is the largest in the world, with 7 million people living with the disease resulting in an adult prevalence rate of 19, 2% with an estimated 380 000 new infections per annum (UNAIDS World Gap Report 2016:10).

## **5.2.1 Critical factors influencing the development of the HIV-AIDS programme in South Africa**

### **a) South African national aids council (SANAC) formation**

South Africa has the largest ARV programme globally, with 48 % of adults on the programme (UNAIDS World Gap Report 2016:10). South Africa's national public sector response to HIV-AIDS is spear headed by the South African National AIDS Council (SANAC), led by Deputy President Cyril Ramaphosa. The council has made and continues to make bold strides toward the prevention and ultimate elimination of HIV-AIDS in South Africa. SANAC's key initiative is the development of the South African National Strategic plan for HIV, TB and AIDS (NSP) which was discussed comprehensively in Chapter two of this research study. The plan addresses the key components of the HIV-AIDS and TB epidemics. This plan also explores key initiatives towards the improvement of service delivery through the various district levels within the country. The NSP 2012–2016 is driven by a long-term vision for the country with respect to the HIV-AIDS and TB epidemics. The South African Department of Health has adapted the three zeros proposed by UNAIDS to suit the local context (Department of Health 2012). The South African vision is : “ *zero new HIV-AIDS and TB infections; zero new infections due to vertical transmission; zero preventable deaths associated with HIV-AIDS and TB; and zero discrimination associated with HIV-AIDS, STIs and TB*” (National Strategic Plan for HIV, TB and AIDS, Department of Health South Africa 2011:2). These South African goals were in line with global goals towards HIV-AIDS prevention and elimination, but progress towards these was slow.

### **b) The United Nations 90-90-90 goals**

This was as a result of a lack of response to current national plans. In response, various multi-sector stakeholder consultations, including representations from key populations, were held in all regions of the world, which generated a new narrative on HIV-AIDS treatment and a new set of global targets the (90-90-90 goals) were set. The 90-90-90 strategy is an example of a global attempt to get the HIV-AIDS epidemic under control and is based on the principle of universal testing and treating of all individuals at risk of HIV-AIDS (UNAIDS 2013:11).

The UNAIDS 90-90-90 goals were the core focus of discussion at the 21<sup>st</sup> International AIDS Conference held between 18-22 July 2016 in Durban, South Africa. At this conference, Michel Sidibe the UNAIDS Executive Director co-chaired a session with the South African Deputy Director General for health, Dr Yogin Pillay, on charting a new course for the NSP 2017–2021. Integral discussion points ensued on the South African generalised epidemic, with the inclusion of access to testing, treatment and care for key populations. Key populations are recognised as often hard to treat populations and were identified in the South African context as males who have sex with males (MSM), intravenous drug users, adolescent girls and sex-workers. Activists called for emphasis to be placed on HIV-AIDS prevention implementation programmes, pre-exposure prophylaxis, gender-based violence, sexual and reproductive health, treatment, rights and justice. The plan is expected for release in December 2016 and will be launched by SANAC under the auspices of Deputy President Cyril Ramaphosa.

#### **c) Development of the national strategic plan for HIV, TB and AIDS (2011-2016).**

It is important to analyse the current NSP 2011-2016 as it has been the most comprehensive and visionary plan to date in South Africa. The NSP details the standard of HIV-AIDS care in South Africa. The current plan is aimed at five groups of South Africans. These include uninfected populations, exposed populations, people living with HIV-AIDS and the terminally ill (National Strategic Plan for HIV, TB and AIDS, Department of Health South Africa 2011:4). The range of care encompasses HIV-AIDS prevention efforts; HIV counselling and testing; post-exposure prophylaxis; treatment of opportunistic infections and antiretroviral therapy; prevention of mother to child transmission; palliative care; and psycho-social support. The South African HIV-AIDS programme boasts robust clinical guidelines for the clinical management of paediatric, adult and adolescent populations. The guidelines have been devised with input from the WHO, UNAIDS and CDC and is strategic in terms of its recommendations for drug usage and commencement of ARV.

### **5.3.2 Swot analysis of the South African national strategic plan for HIV, TB and aids governing the South African HIV-AIDS programme and the monitoring and evaluation framework for comprehensive HIV-AIDS care, management and treatment plan for South Africa**

A swot analysis of the South African National Department of Health's HIV-AIDS programme revealed the following:

#### **5.3.2.1 Strengths**

##### **a) Guidelines**

Given that the current HIV-AIDS programme is the largest in the world, it is gratifying to note the excellent quality of clinical guidelines and revisions that have taken place since its inception. It is important to acknowledge the comprehensive detail when providing clinical oversight for clinical ARV and opportunistic infection clinical management. The guidelines have echoed international changes as exhibited from changes in the WHO guidance documents and are an example of exemplary clinical guidance based on evidence-based medicine. The South African guidelines are also one of the very few countries that have adopted recent clinical trial evidence and data supporting the usage of pre-exposure prophylaxis for at risk key populations (Health e news, Gonzalez 2015). In addition, the South African Department of Health must be commended on its phenomenal strides to put all HIV positive South Africans on ARVS from 01 September 2016. This comes from evidenced-based data from the START trial which outlined the overwhelming benefits of commencing ARVS as soon as possible for all HIV-positive individuals ( NIAID 2015:22).

##### **b) Key populations**

In April 2016 pre-exposure-prophylaxis was rolled out to this high-risk population, demonstrating the need for urgent interventions to address the epidemic in hard to reach populations. South Africa has also made significant strides with the rollout of prevention modalities to Males who have sex with males (MSM) and Lesbian Gay Bisexual and Transgender (LGBT) communities. Internationally acclaimed singer



and Lesbian Gay Bisexual and Transgender (LGBT) activist Sir Elton John said at the 21st IAS conference: *“You leave no one behind in the human race. You include them all. If you don’t, this campaign to end HIV-AIDS will be a disaster”*. These words signalled important themes for the inclusion of all HIV-AIDS infected populations into HIV-AIDS prevention, treatment and care programmes globally towards HIV-AIDS elimination (Genendit 2016).

### **c) ARV access**

SANAC has taken great strides to increase access to ARV treatment for all South Africans. South Africa has the largest treatment programme globally with an estimated 3.5 million South Africans accessing the lifesaving therapy. South Africa recently adopted the WHO Guidelines for expanding access to universal access to ARVS for all HIV positive individuals through the application of the Test and Treat model which will be implemented 01 September 2016 at all ARV roll out facilities in South Africa. This bold and strategic move signals government’s commitment to acknowledge best practises toward optimal patient management. This step confirms the will to utilise universal treatment as an important step toward HIV-AIDS prevention. Access to ARV and appropriate clinical management thereof will also create a healthier workforce enabling South African to live longer and more productive lives.

### **d) Leadership**

The development of leaders amongst all sectors addressing HIV-AIDS is recognized as a critical factor as the HIV-AIDS epidemic moves into its fourth decade. Historically, the battle of HIV-AIDS in South Africa was a tragic one doomed for failure given weak political leadership, the strong HIV-AIDS denialism and delays in action for ARV treatment for all in need. Due to efforts from advocacy groups such as the Treatment Action Campaign and medico-legal battles demanding ARV access for the most vulnerable, the tide of change soon arrived on the shores of South Africa. The driving force behind the successful gains in the NSP has been from the leadership and governance of the current Minister of Health, SANAC and the Director General for Health and the Deputy Director Generals for health. Their commitment and dedication towards bringing about the end of HIV-AIDS in South

Africa has been commendable. South Africa stands poised on the brink of new national elections with changes in local governments and councils following local elections. It is hoped that newly elected ministry of health decision makers are suitably qualified and expertly skilled to continue with the level of leadership and management required to bring about the end of HIV-AIDS in South Africa. Failure to do so will negate the gains made thus far in trying to curb the South African HIV-AIDS epidemic.

#### **e) Adoption of the UNAIDS 90-90-90 goals**

Countries are making rapid progress in scaling up HIV-AIDS testing and treatment across several regions, with many close to or almost reaching the UNAIDS goals (UNAIDS World Gap Report 2016:11). Currently, the global target sits at 57 % - 81 % - 82 % i.e. 57 % of the global population know their HIV status; 81 % are receiving ARV care; and 82 % are virally suppressed on ARV therapy (UNAIDS World Gap Report 2016:11). The progress toward these goals has been uneven with some countries almost at attainment of these goals and others nowhere near them. To date Thailand, Botswana and Brazil are the closest to meeting these goals (UNAIDS World Gap Report 2016:11). Data on South Africa's progress towards attainment of the UNAIDS 90-90-90 goals presented by Dr Yogin Pillay, the Deputy Director General for Health for South Africa at the 21<sup>st</sup> IAS conference, revealed figures demonstrating South Africa's status of 56 % - 96 % - 84%. The aim is for South Africa, like all other countries, to attain the 90-90-90 goals (Pillay 2016). These statistics demonstrate that South Africa is on the right course towards the realisation of the 90-90-90 goals. In order to bring about the required achievement of these goals, South Africa needs strong political will to put in place conducive policies and environment. The UNAIDS GAP report released in July 2016 identified important gaps in the policy and environment to ensure full attainment of fast tracking goals for HIV-AIDS prevention and elimination. These gaps were aimed at significant programme inclusion and service delivery to young women, adolescent girls and their male partners and key populations with service offerings including continuous condom provision, medical male circumcision and pre-exposure prophylaxis. Adoption of the 90-90-90- goals globally will result in 28 million HIV infections prevented, 21 million AIDS-related deaths averted and over 24 billion USD saved

(President's Emergency Plan for AIDS Relief 2016:2). These statistics demonstrate that HIV-AIDS can be a thing of the past by 2030.

### **5.3.2.2 Weaknesses**

#### **a) Funding**

Ending the HIV-AIDS epidemic globally may only be achieved through sustainable financial investments. Historically, the global HIV-AIDS epidemic has been funded by the International Monetary Fund, World Bank, PEPFAR, USAID and The Global Fund. Lower and middle income countries have had more reliance on US funding, while higher income countries have become domestically funded. In South Africa, 21% of GDP is spent on HIV-AIDS programmes with a growing moral and fiscal obligation to maintain HIV-positive individuals on lifelong ARV therapy (Karim 2015:2). Sustainable funding is required to domestically fund the end of HIV-AIDS both globally and in South Africa. This can be done with improved economic growth, improved revenue generation, reprioritization of HIV-AIDS services and attaining innovative domestic and technical efficiency.

#### **b) Healthcare workers**

The WHO estimates a shortage of 140 000 health care workers by 2020 (Duncombe, Rosenbulm, Hellmann, Holmes and Wilkinson 2015:430). This is primarily due to the burden of disease in South Africa. In addition, there is a lack of specific expertise in HIV-AIDS care, with minimal opportunities for capacitation. There has also been a strong “brain drain” with a failure to retain the workforce in the public health sector. In addition, the Department of Health faces many challenges with a failure to attract and retain healthcare workers in rural areas for healthcare delivery with specific HIV-AIDS-related services (South Africa 2015). Finally, as alluded to in previous chapters, there is a lack of clinical trainers with specific HIV-AIDS-related skills and expertise to grow knowledge on HIV-AIDS amongst healthcare workers to efficiently work towards ending the epidemic.

### **c) Price of antiretrovirals**

Drug pricing for HIV-AIDS medication is a complex issue. It varies depending on the wealth status of countries, domestic funding and global trade agreements (Aspen Pharmacare 2015:22). It is also dependant on the magnitude of the disease burden and the standard of care, which is morally and ethically bound. Historically, ARV therapy has been very expensive with a traditional monthly supply of the required triple combination medication costing almost R1000, 00. With the advent of generic ARV medications that have now flooded the markets globally and locally, the same triple combination medication is now available to the public sector at R103,89 (Cipla 2016). Conversely, in the South African private sector, required triple combination medication is available at R1850 per month (Connolly 2016:5). Ways to bridge the divide between the private and public health sectors need to be explored in order to ensure that maximal benefit is derived for those who need it the most. The Department of Health implemented a policy to accelerate the registration of critical medicines thirteen years ago to fast track generic ARV medication. This has been a key initiative to drive the generic utilization of ARVs and to ensure equitable access for all HIV-positive individuals. Another consideration for both the public and the private South African pharmaceutical sector is the very expensive pricing of second and third line ARV therapy, where generics are eagerly awaited at cost-effective prices. Driving these prices down through industry competition will result in access of this lifesaving therapy to many South Africans in the public sector.

### **d) Drug stock outs**

A continual challenge faced by the National Department of Health is the shortages of HIV-AIDS and TB medication. The Stop Stock outs Project was formed to address the issues of unplanned ARV stockouts and to ensure seamless delivery to patients across all provinces (South African Clinicians Society 2015). The issue has become a national crisis, affecting districts in all nine provinces. Consequences of this imply costly delays with access to treatment and care for patients who require this. This issue requires urgent addressing by the South African ministry of health, as plans to increase ARV therapy to all South Africans commence on 01 September 2016.

### **e) Non-adherence and resistance**

With South Africa running the largest ARV rollout programme in the world and with plans for universal treatment for all later this year (2016), the South African ARV rollout programme will have almost 7, 5 million HIV-positive individuals on lifelong ARV therapy (South Africa 2015). Coupled with lifelong therapy comes the risk of non-adherence to treatment, resulting in ARV resistance and resultant HIV-AIDS-related mortality and morbidity. A study conducted at a local KZN-based ARV clinic found that ARV side-effects, lack of food, long distances to clinics, long waits in clinics and stigma with discrimination were key reasons for poor adherence (Coutsoudis and Spooner 2014:3). The lack of salvage regimens in the public sector, costly second line drugs in the public sector and poor adherence programmes are reasons why the programme falls short of comprehensive service delivery. This signals areas of weaknesses needing urgent action for successful healthcare service delivery.

### **5.3.2.3 Opportunities**

#### **a) Differentiated model of care**

The WHO has embarked on a strategy to support the scale up of differentiated models of ARV delivery (Duncombe, Rosenbulm, Hellmann, Holmes, Wilkinson and Biot 2015:430). The goal of the differentiated model of care is to optimize the delivery of ARV care both for the patient and the health system. Differentiated care models are envisioned to be implemented in communities and in healthcare facilities in order to be accessible to patients and families. This model of care is discussed later in this chapter.

### **5.3.2.4 Threats**

#### **a) Funding**

Funding is, was and always will be a looming threat as international donors have dwindled, with more sustainable funding requested domestically. The Global Fund to Fight AIDS, Tuberculosis and Malaria is widely considered to be one of the most

successful global health financing mechanisms of modern time. Since 2002, it has saved 17 million lives and helped drive progress against HIV/AIDS, TB and malaria – three diseases that seemed unstoppable at the turn of the century (The Global Fund 2015). A successful replenishment in 2016 will help the Global Fund invest in key and vulnerable populations, save 8 million lives and stimulate up to \$290 billion in economic growth (The Global Fund 2015). A global petition by the global HIV-AIDS fraternity was signed in July 2016 for a call to action for organisations, communities and individuals to fully fund The Global Fund to end AIDS, TB and Malaria for good. The Global Fund seeks to mobilize \$13 billion in resources for 2017-2019 and every \$100 million invested in the Global Fund will: save 60,000 lives; avert 2.3 million infections; secure \$300 million in domestic resource investment; and generate \$2.2 billion in long-term economic gains (The Global Fund 2016). A successful replenishment will dramatically accelerate progress by reducing deaths from the three diseases by more than one-third – from 2.5 million to 1.6 million. It will also help secure \$41 billion in health investments by developing countries (The Global Fund 2016).

#### **5.4. South African NGO sector HIV-AIDS programme**

The DTHF is making a substantial contribution to HIV-AIDS service delivery and public health policy in South Africa. The organisation has a core focus of activities leveraged at HIV-AIDS prevention, treatment wellness and care. The organisation also has a strong clinical trials unit, together with key community mobilisation projects to build communities and strengthen health systems. The NGO receives funding through various mechanisms ranging from the National Department of Health, PEPFAR, USAID, The Global Fund, Bill and Melinda Gates Foundation and several international private pharmaceutical organisations (Desmond Tutu HIV Foundation 2016). The organisation has hosted international delegates including President Barack Obama and Bill Clinton, together with Bill and Melinda Gates.

The organisation boasts several key initiatives. However, their key innovative concept is “The Tutu Tester”. The Tutu Tester is a mobile unit that provides a free comprehensive mobile health service. The aim is to improve the health of individuals in vulnerable communities and to normalise HIV testing. The project is in line with the

National Department of Health's Health Sector Strategic Framework that includes the accelerated implementation of the HIV & AIDS and Sexually Transmitted Infections National Strategic Plan 2012 – 2016 towards mass mobilisation for a healthier population.

#### **5.4.1 Monitoring and evaluation framework for the Desmond Tutu Foundation**

The Desmond Tutu Foundation is an example of a successful HIV-AIDS NGO functioning in South Africa, with various programmes funded by various funding sources and agencies. Most donors and funders prescribe their own organisational specific requirements for monitoring and evaluation efforts for their programmes. Hence, one NGO may have to utilise several to many monitoring and evaluation frameworks to meet stakeholder and donor requirements. This is a cumbersome process that may lead to confusion of details and poor time management. Other NGOs such as Ithembalabantu Clinic, AIDS Foundation for South Africa and Zoe Life allude to the same phenomena of having to provide stakeholder monitoring and evaluation framework details in various reporting formats to meet the needs and requirements of all concerned donors and stakeholders (Desmond Tutu HIV Foundation 2016). This signifies an urgent need to develop a proposed conceptual framework for the management of HIV-AIDS private sector programmes that can be used in both public, NGO and private healthcare sectors, which is a core objective of this research study.

#### **5.4.2 SWOT analysis of the Desmond Tutu HIV foundation's HIV-AIDS programme**

A swot analysis of the exemplar organisation The Desmond Tutu HIV Foundation revealed the following:

##### **5.4.2.1 Strengths**

###### **a) Diversification**

This NGO derives its strength in the market due to its innate ability to diversify its core business offering. Integral to this NGO's existence is combating HIV-AIDS in South Africa through community upliftment and community mobilisations projects.

The Desmond Tutu HIV Foundation has done this by the creation of various divisions in the Unit with various projects. These include a separate HIV-AIDS prevention division encompassing the CHAMPS youth Project; a clinical research facility enabling research for HIV-AIDS prevention modalities; an ARV treatment rollout site; mobile unit for treatment testers; and key counselling projects. There's a division for maternal and child health, a youth centre and also a men's health division. These projects demonstrate the multi-pronged approach towards combatting HIV-AIDS and highlight the organisation's reliance on multiple forms of income for sustainability and continuation.

#### **b) A strong commitment to the HIV-AIDS national response**

The commitment of this NGO's leadership to the fight against HIV-AIDS is one of the reasons for the present success of the Desmond Tutu HIV Foundation. From the government to religious and economic leaders, a common front has developed to stop control this disease and this has resulted in wide social mobilisation, which has been committed to by Archbishop Emeritus Desmond Tutu and the NGO's Directors Professor Robin Wood and Professor Linda Gail Bekker. The leadership and commitment shown in the fight against HIV-AIDS in South Arica has not gone unnoticed as Professor Linda Gail Bekker has been elected by the world renowned International AIDS Society as President for 2017. This presidency will be the first from South Africa and also the first woman, which echoes the need for urgent steps to be put in place to address the epidemic amongst the women in Africa, South Africa and Sub Saharan Africa as they bear the greatest brunt of this disease.

#### **c) Capacity building activities**

Given the overwhelming burden of TB and HIV-AIDS disease at community level, there needs to be a considerable level of training effort towards healthcare professionals with a significant task shifting to junior doctors and especially nurses, which must continue in order to reduce the morbidity and mortality associated with these diseases. Healthcare worker competency and adequacy largely determine programme quality and efficiency, particularly in TB programmes and ARV clinics. The Desmond Tutu HIV Foundation has a strong training team equipped to deliver training approaches for healthcare workers and communities to enhance their



understanding of HIV-AIDS and TB. These capacity building activities are delivered through face-to-face and online interfaces to reach a broader sector of the healthcare and general population.

#### **5.4.2.2 Weaknesses**

##### **a) Fragmentation of service delivery**

The Desmond Tutu HIV Foundation has many partnerships with corporate entities together with governmental organisations. The issue with multiple sources of funding is that they are often short-lived and as such, programme delivery for that source of funding often comes to a halt until alternate means of service delivery can be obtained. This leads to fragmentation of service delivery. A common yet fatal occurrence is when funding sources dry up for ARV service delivery and very often NGOS transfer patients to state facilities to continue attainment of their medication. This is a sub-optimal arrangement as patients often do not receive the same medication and this often leads to poor ARV adherence issues and the emergence of drug resistance, with further complications. Hence, fragmentation of service delivery is a seldom desired situation and has to be guarded against in order to ensure optimal treatment outcomes for end-users of HIV-AIDS-related care.

#### **5.4.2.3 Opportunities**

##### **a) Decentralisation of governmental services**

Decentralisation of HIV-AIDS and TB treatment offers the opportunity for more patients to access appropriate treatment for their disease (Loveday and Cox 2014:34). In the past, HIV-AIDS treatment has been provided through small local ARV programmes confined to local and district health facilities. This approach only reaches some of the patients some of the time when the patient loads are small. Decentralisation, treats larger volumes of patients through local facilities, with much less reliance on hospital and specialised care. Prior to 2011, national policy in South Africa mandated ARV initiation of HIV infected individuals only at state facilities with specialist level support. This resulted in long delays, on-going transmission and high mortality and morbidity. Recognising the deficiencies in the centralised system, decentralised care was piloted at a few sites, including some districts in KwaZulu-

Natal and Khayelitsha in the Western Cape, including the Desmond Tutu HIV Foundation. The ARV facility at the foundation has become a good example of the extension of access to care for those in need. The introduction of decentralisation into the South African healthcare system needs to be undertaken with care, through guideline development together with suitable training and capacitation of healthcare workers.

### **b) Strengthening the community response to HIV-AIDS**

HIV-AIDS has been described as one of the defining challenges of our time (Cameron 2014:10). Not only for the devastating impact on the HIV-positive infected individual but also due to the combined effects on communities and their constituents. The DTHF has community-based sites research, as well as community mobilization projects, conducted in close collaboration with other non-governmental organizations, the private and primary care health sector and community leaders and members. This exhibits an important example of community upliftment towards achieving HIV-AIDS treatment and operational goals.

#### **5.4.2.4 Threats**

##### **a) Funding**

Funding to sustain the HIV-AIDS response was highlighted at the recent International AIDS Conference in Durban in July 2016. Dr Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases (NIAID) and leading expert on HIV-AIDS globally, stated that South Africa is heavily dependent on foreign money, limiting its scope to set the research agenda. The National Institute of Health (NIH) provides about 60-million USD per year to HIV-AIDS scientists working independently or in collaboration with peers in the USA (NIAID 2016). Locally in 2015, the Medical Research Council channelled only about R60-million to HIV-AIDS research, while the Department of Science and Technology provided about R10 million in direct funding to research (SAMRC 2016). Dr Fauci concludes with the following comment on HIV-AIDS scientists based in South Africa: *“It would be a shame if they did not get the maximum funding to capitalise on their talent and the unique opportunity in SA. They have the opportunity to do transforming research”*

(Kahn, Financial Mail, 2016:2). Sourcing sustainable funding for the continued efforts at the Desmond Tutu HIV Foundation remains a challenge and may seriously impede beneficial efforts towards ending HIV-AIDS in South Africa.

## **5.5. South African private HIV-AIDS programme: AID FOR AIDS (AFA)**

The South African private healthcare sector has approximately ten managed healthcare companies that provide a dedicated HIV-AIDS programme. By far, the most well known and most successful programme to date has been Aid for AIDS (AFA) which has firmly established itself as a leader in HIV-AIDS private management and care. Aid for AIDS plays a leading role in collaborating and participating with government-led task teams in terms of challenging the epidemic. (Aid for AIDS 2015).

The AFA HIV-AIDS clinical management programme uses scientific evidence-based criteria in a cost-effective manner to interact with members and providers. The programme has a clinical advisory committee made up of highly respected leaders in the healthcare industry who have been recognised as global experts in HIV-AIDS management and have published and presented around the world (Aid for AIDS 2015). A core offering of this programme is HIV-AIDS education and training programmes which play a vital role in the comprehensive and holistic management of those infected and affected by HIV-AIDS. Education is therefore a key component of AFA's service offering and is strongly recommended as a minimum HIV/AIDS intervention. Aid for AIDS offers corporate clients a range of various HIV/AIDS training programmes to empower and equip them with the necessary skills to tackle the epidemic (Aid for AIDS 2015).

### **5.5.1 Monitoring and evaluation framework: AID FOR AIDS**

The programme data management team provides data analysis services to schemes through provision of disease trends and clinical management protocol development. The technical capabilities at AFA are of an international standard. This is equipped to offer their clients effective management and risk profiling functionalities together with

market-leading patient care technology. The biggest drawback is that the AFA HIV-AIDS programme does not have a dedicated monitoring and evaluation framework to accurately evaluate programme delivery on a monthly, quarterly and annual basis. This signals a need for a consistent and standardised reporting mechanism to allow optimal HIV-AIDS programme management towards optimal treatment outcomes. This signifies an urgent need to develop a proposed conceptual framework for the management of HIV-AIDS private sector programmes that can be used in public, NGO and private healthcare sectors, which is a core objective of this research study.

### **5.5.2 SWOT analysis for AID FOR AIDS**

A swot analysis for Aid for AIDS revealed the following:

#### **5.5.2.1 Strengths**

##### **a) Market leader**

It is obvious that AFA has firmly positioned itself as the market leader in the niche market of HIV-AIDS-related healthcare in the private sector. The programme boasts world-renowned clinical consultants against the backdrop of technological advancements to ensure a seamless service delivery to all their clients. The programme concentrates on client service delivery to corporate schemes and also provides exclusivity of client value proposition in the medical aid sector only.

#### **5.5.2.2 Weakness**

##### **a) Lack of collaboration**

*“Collaborative efforts in the workplace can lead to innovative approaches to projects, new processes to accomplish key tasks and shared ideas on varied responsibilities”* (Freed 2014). Collaboration and partnerships can move a company more effectively towards its goals. Collaborative efforts also allow companies to access skills and strengths towards efficiency. AFA does not utilise partnerships or collaboration and all those offerings are provided in house or after capacitation of their internal teams. Given that the HIV-AIDS clinical management programmes are dynamic and ever-changing, based on research-based evidence from all over the globe, collaborative approaches to synergistic benefits for healthcare providers and patients are required.

Although AFA may have functioned in solitude in the past, partnerships and collaborative efforts especially between NGO's, public and private organisations are now required to provide a unified and sustained response to bring about the end of HIV-AIDS.

### **5.5.2.3 Opportunities**

#### **a) Collaboration**

An African proverb with no known author states: *"If you want to go fast, go alone. If you want to go far, go together"*. This sums up the importance of collaborative partnerships towards combining skills, enhancing efficiencies and leveraging new innovations towards a symbiotic approach to problem solving, especially in the field of HIV-AIDS. Nelson Mandela said *"History will surely judge us harshly if we do not respond with all the energy and resources that we can bring to bear in the fight against HIV/AIDS"*. This in itself was a call to action, a call to collaborate and partner with organisations to combat HIV-AIDS. AFA has an opportunity to collaborate with other similar organisations in order to share strengths and overcome challenges. Given the rapid rate at which HIV-AIDS is spread, given its pandemic state and also its elusiveness to finding a cure now more than ever, organisations need to come together to develop a unified response to HIV-AIDS the world over.

#### **b) Education and training**

To date, AFA has been globally acknowledged for their useful education and training programmes, their knowledgeable clinical experts in the subject matter and their diverse clinical committees. AFA has embarked on several clinical and administrative education and training programmes. These are offered through distance, online and face-to-face training and are provided nationally. These trainings provide excellent beginner and experienced clinical training solutions to capacitate healthcare staff working in the field of HIV-AIDS. This clinical education and training platform may be seen as an important opportunity to capacitate healthcare providers across the private, public and NGO sectors towards skills enhancement and professional upliftment in the field of HIV-AIDS. If undertaken correctly, this initiative can be a vital

tool in the provision of the much needed HIV-AIDS-related skills required amongst healthcare professionals to optimally manage this disease.

#### **5.5.2.4 Threats**

##### **a) Private sector volatility**

These schemes have a total annual contribution flow of about R129.8 billion (Council for Medical Schemes 2016). In 2010, the CMS mandated that all schemes follow the tender procurement route for service delivery acquisition every five years. This introduced a great deal of uncertainty and insecurity for the industry, with the implication that all schemes could be lost due to the tender process. Smaller schemes also became vulnerable to mergers and acquisitions and poorly performing schemes may become vulnerable to curatorship under the CMS watchdog. These actions demonstrate the volatility of the South African private healthcare sector as a potential prominent threat for the longevity and sustainability of AFA.

#### **5.6 A PEST analysis of multisectorial HIV-AIDS programmes**

This chapter thus far examined the multi-sector response to HIV-AIDS and the strengths, weaknesses, opportunities and threats that each individual programme in the various sectors exhibited. A PEST analysis was then conducted on the multi-sector response to HIV-AIDS in order to generate a comprehensive macroscopic view of HIV-AIDS programmes within the sectors, which is presented in the discussion that follows. This approach was undertaken to identify efficiencies, deficiencies and core capabilities within HIV-AIDS programmes and their monitoring and evaluation mechanisms in order to develop best practices in line with the study objectives. This objective is to analyse smart practises and review current conceptual frameworks in the HIV-AIDS healthcare sector and to analyse the HIV-AIDS programme within South Africa towards the development of a proposed conceptual framework for the management of HIV-AID programmes that can be used in public, private and NGO healthcare sectors.

**Figure 5.1 PEST Analysis**



**Source: Adapted from Business Case Studies (2010:11)**

### **5.5.1 Political**

#### **a) South African national AIDS council (SANAC)**

The South African National AIDS Council (SANAC) is an association established by the national cabinet of the South African Government to drive an enhanced country response to HIV-AIDS and TB (SANAC 2013). SANAC has been instrumental in promoting the scale-up of treatment, prevention and human rights programmes for key populations since its inception.

Recently, there has been evidence of dysfunction in many SA National AIDS Council sectors. For example, in relation to medicine stock-outs and the on-going crisis in the Free State public healthcare system this is plagued by the shortage of healthcare workers, poor healthcare facilities and poor medical equipment (SA HIV Clinicians Society 2016). This has been criticised by the larger medical fraternity due to the lack of action from SANAC on these issues. Given the critical nature of continued ARV medication for all HIV-positive patients, continuous uninterrupted supply is imperative, resulting in fewer complications. However, there have been allegations of fraud and corruption with pharmaceutical companies and ARV theft by clinic staff, which have failed to be addressed by SANAC leadership and governance and local health authorities.

It has been suggested that a SANAC task force should be created which is answerable to the Minister of Health and the Deputy President, with representatives from private business, labour, healthcare worker groups and membership-based civil society organisations. This task force should be made up of appropriately qualified experts to consider technical scientific issues and to provide technical advice to the Minister and the Presidency and should play a pivotal role in the real-time management of these issues (Low, Health-e News Service, 2016).

## **b) National strategic plan**

December 2016 sees the release of the eagerly awaited new National Strategic Plan (NSP) for HIV, TB and STIs for the period 2017 - 2021. This plan is highly anticipated because it has been developed from consultancies with key population groups, technical experts and is proposed to be a realistic course that all of South Africa can get behind. The previous NSP has been criticised as being too ambitious, with little effectiveness in tracking progress towards agreed-upon targets and performance, as well as poor choice of indicators with little cultural appropriateness and relevance. This contributed to a lack of focus and direction. In order to provide for a more focused and effective NSP, the following should be considered for the NSP 2017 - 2021:

### *I. NSP targets*

Real-time monitoring of NSP targets in line with UNAIDS 90-90-90 goals need to be devised and tracked with regular frequency in order to ensure a structured and focused response in areas of the epidemic that require it the most. Indicators should be developed that are line with programme objectives and are regularly updated and shared with HIV-AIDS organisations and the public to assess progress towards goals.

### *II. Test and Treat*

The WHO guideline amendment to include treatment for all those infected with HIV-AIDS has become key guidance for inclusion in all HIV-AIDS management programmes the world over. The South African Department of Health has proactively recommended this for implementation from 01 September 2016 in South Africa.



Making a success of this programme will require an ambitious new test and treat campaign, together with a committed and dedicated team of healthcare professionals including community health workers and lay counsellors required for successful roll out and service delivery. In addition, the forthcoming NSP must have critical monitoring and evaluation targets to track and trace progress towards these goals.

### *III. TB target inclusion*

The new NSP should set South Africa on a course for dramatically scaled up TB contact tracing and active case-finding in an attempt to curtail new TB infections. The NSP should also demonstrate innovative ways toward addressing infection control, both in the public and private sectors in order to reduce TB transmission in schools, correctional facilities, taxis, hostels, shops, the mines and all other places where TB is transmitted. Linkage to care with MDR TB and XDR TB diagnosis, together with voluntary counselling and testing for HIV-AIDS are integral to TB elimination in South Africa.

### *IV. Inclusion of an evidence-based HIV-AIDS prevention plan*

The UNAIDS Gap Report 2016 reported South Africa to have a new HIV-AIDS infections rate of 380 000 new infections in the last year (UNAIDS Gap Report 2016:11). Women and girls aged 15 to 24 years of age represent 34% of newly-infected adults (UNICEF 2016). South African-born actress and UNAIDS HIV-AIDS Peace Ambassador Charlize Theron, during the IAS 2016 in Durban in July 2016, said *“young people will be the generation to end AIDS if they are included in conversations about the pandemic”*. This is a clear call for action to the Department of Health and the Department of Basic Education to strengthen HIV-AIDS education and awareness efforts in this age group in order to empower young vulnerable women to make educated choices about their sexuality and sexual risk behaviour.

PEPFAR, through the DREAMS grant, has launched a South African government based initiative of combination prevention efforts aimed at the young female group aged 10-24 years which exhibits almost 1000 new HIV infections per day (World Bank 2016:10). The DREAMS project invests almost half a billion US dollars into a

programme focused on HIV-AIDS risk reduction, mobilisation of communities and strengthening family structures. The DREAMS project has already shown in other Sub-Saharan countries that education reduces the risk of HIV-AIDS infection. A Zambian study showed that one additional year of high school education can reduce HIV infection by 50% (Beukes 2015:2). This is an important intervention in addressing the epidemic in key affected populations.

#### *V. Public-private partnerships*

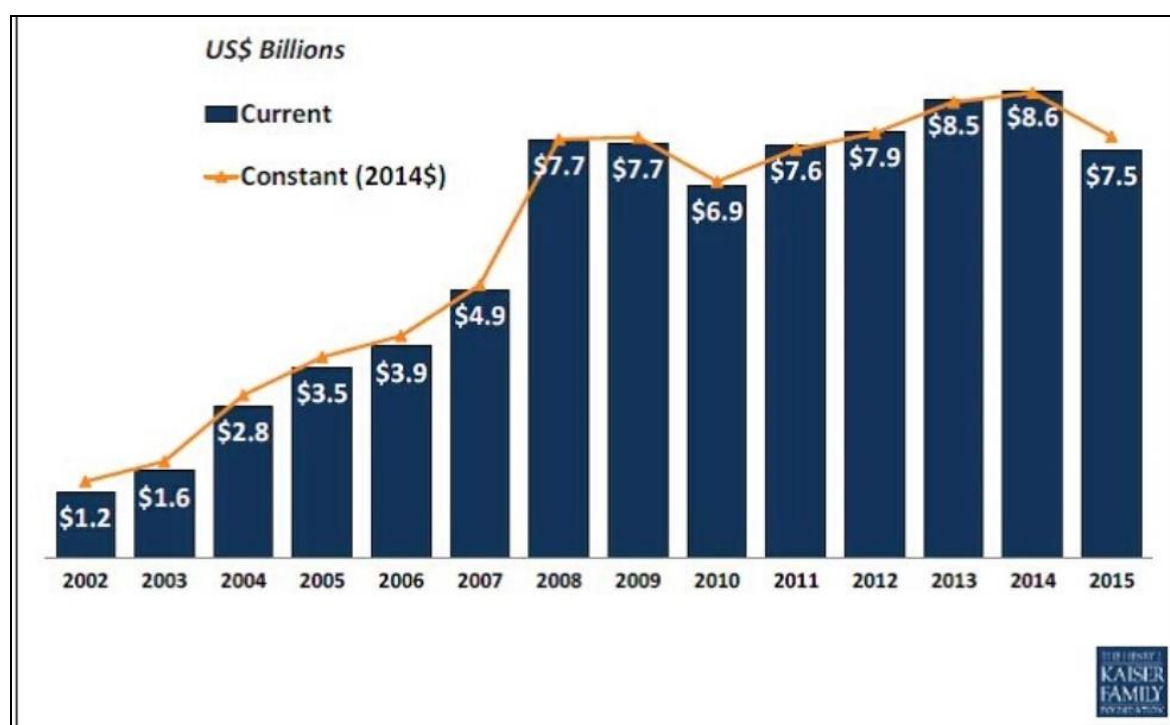
Ensuring a sustainable and continued response to the HIV-AIDS epidemic in South Africa is the backbone of the NSP as the country moves into the new generation of ending HIV-AIDS. Pivotal to this response is collaborations between various stakeholders who each have a role to play in promoting HIV-AIDS interventions in each of their sectors. This will create a shared responsibility toward a greater domestication strategy with less reliance on foreign donors to generate finance to re-focus and re-prioritise HIV-AIDS management efforts.

### **5.6.2 Economic**

#### **a) Funding**

As has been iterated, significant financial investments both locally and globally are required to sustain and maintain the HIV-AIDS response. The current question on most HIV-AIDS policy makers' minds for now is: Can the end of HIV-AIDS be financed?

**Figure 5.2 Internal HIV assistance from donor governments (2002-2015)**



**Source: Adapted from the Kaiser Family Trust (2015:22)**

Figure 5.2 (above) depicts the international HIV-AIDS assistance from donor governance for the period 2002 until 2015. It is interesting to see that funding peaked between 2008-2014, and is on the decline currently as many donors are holding back, promoting more reliance on domestically-funded approaches to HIV-AIDS. Currently, South Africa funds R 19,1 million annually with still another R 36 million required in realisation of the UNAIDS 90-90-90-goals (Remme 2015:12). With a growing moral and fiscal obligation to maintain people on lifelong ARV, the South Africa Department of Health is exploring other means to fund the epidemic. Traditional sources have been economic growth, improved revenue generation, re-prioritisation of HIV-AIDS issues and borrowing (Schwartlaender, Stover, Hallett, Atun, Avila, Gouws, Bartos, Ghys, Opuni, Barr, Alsallaq, Bollinger, de Freitas, Garnett, Holmes, Legins, Pillay, Stanciole, McClure, Hirnschall, Laga and Padian 2011: 231). Additional approaches being looked at include harnessing innovative domestic approaches and technical efficiencies (Schwartlaender, Stover, Hallett, Atun, Avila, Gouws, Bartos, Ghys, Opuni, Barr, Alsallaq, Bollinger, de Freitas,

Garnett, Holmes, Legins, Pillay, Stanciole, McClure, Hirnschall, Laga and Padian 2011: 231).

Stover, Bollinger, Izazola, Luiz Loures, DeLay and Ghys (2016:1371) propose that sustainable funding for HIV-AIDS programmes can come through savings and concessional borrowing through allocative efficiency; enhancing programme effectiveness; streamlining ARV treatment modalities; and integration of HIV-AIDS care into primary healthcare with stronger emphasis on community-based service delivery. Collaborations with advocacy groups are also required to rally the necessary support to guide governments through to the end of the epidemic. The “Keep the Promise” campaign is undertaken to call on world leaders to keep the promise to fund HIV-AIDS interventions. Keep the Promise 2016 is an empowering advocacy platform organized by the AIDS Healthcare Foundation to accelerate the fight against HIV/AIDS. Keep the Promise 2016 focuses on the need for a strong scale-up of global AIDS funding and calls on governments, global funding bodies and individuals to commit to ending the epidemic.

### **5.6.3 Social**

#### **a) Key populations**

Key populations are “*most-at-risk populations who inject drugs; gay men and other men who have sex with men (MSM); transgender persons; and sex workers*”. They are disproportionately infected with HIV-AIDS when compared to the general population (USAID 2016:2). As the country moves forward towards an HIV-AIDS-free generation, it is important that HIV-AIDS programmes develop combination prevention packages delivering comprehensive care to key populations. This can be delivered through empowering peer-led outreach efforts and community-based services which promote interventions to address gender-based violence. Provision of condoms and lubricant and linkage to clinical care and antiretroviral treatment should also be strongly emphasised. The commitment to ‘leave no one behind’ has been a key feature of all the discussions on ending HIV-AIDS led by the United Nations in the past few months. It takes into account the rights of key and vulnerable populations in the global response to decrease new HIV infections, while leaving no one behind in ending the HIV-AIDS epidemic.

## **b) Differentiated care**

The differentiated mode of care is a new term coined by the World Health Organisation, exploring HIV-AIDS care and service characterised by components of differentiation to meet the specific needs of communities and key populations. The World Health Organisation advocates that national and local HIV-AIDS programmes should offer safe, acceptable, appropriate clinical and non-clinical services aimed at improving health outcomes through the efficient and effective use of available resources.

## **c) The focus and objectives of operations research within HIV-AIDS programmes**

The rapid scale up of HIV-AIDS services in resource-limited countries is one of the most ambitious and complex undertakings in public health history. This has been in response to the global call to meet the UNAIDS 90-90-90 target to fast track the end of HIV-AIDS. However, the challenge of scale up is one of sustainability, efficiency and time constraints. Operations research has been defined as a method of mathematically-based analysis for providing a quantitative basis for management decisions (Fisher and Foreit 2002:3). Operations research is critical for inclusion in HIV-AIDS programmes to accomplish accelerated, large scale and sustainable delivery of HIV-AIDS treatment and prevention services (Fisher and Foreit 2002:3). It diagnoses, evaluates and compares one service delivery approach against another in terms of impact, cost-effectiveness, quality and acceptability (IAS 2016).

HIV-AIDS operations research is an often neglected component of HIV-AIDS programmes, yet it has integral functionality to enhance programme efficiencies. The much awaited South African NSP 2017-2021 will be the first NSP to date to include components of HIV-AIDS operations research, including developing the operations research agenda, expanding support for operations research and developing standardized tools and methodologies in operations research. This is in line with the objectives of this research study, which is to describe the role that HIV-AIDS operational research plays in the overall monitoring and evaluation of the national response to HIV-AIDS.

#### **d) Inclusion of women aged 15-24 years in HIV-AIDS programmes**

Young women and girls bear the brunt of HIV-AIDS globally, with 70% of new HIV infections occurring amongst adolescents in Sub-Saharan Africa. South Africa has a 3 times higher prevalence amongst young women and adolescent girls compared with their male counterparts. HIV-AIDS is the leading cause of death amongst adolescents in Africa. Only 15% of young women aged 15 to 24 in Sub-Saharan Africa is aware of their HIV status. Globally, 3 in 10 adolescent girls and young women have comprehensive and correct knowledge of HIV-AIDS. This data identifies adolescent females and women aged 15-24 years of age as a vulnerable population and as a key population to reduce new infections, gain access to ARV treatment and manage chronic HIV-AIDS opportunistic infections as a means to controlling the overall epidemic.

It is important to explore the reasons as to why this group as a sub-population is more prone to HIV-AIDS acquisition in order for policy makers and health ministries to tailor interventions suited to these causes. In most African and Asian countries, 15 million girls are married before the age of 18, bearing in mind that marrying before 18 may substantially increase the risk of HIV-AIDS acquisition due to child brides being younger and physically immature and also due to their limited power to negotiate safer sexual practices. Child brides also have increased risks for unprotected sexual intercourse with greater pressures for demonstration of their fertility and child reproducibility.

Most adolescents do not know their HIV status (Charlize Theron IAS: 2016). This is a rude awakening for advocacy groups and women's liberation movements across the globe to educate and empower women to make educated decisions regarding their sexuality and their HIV status. Female participation and leadership towards gender-based empowerment and knowledge-based decision-making is transformative for society. It shapes the institutions, markets and norms of a society.

Education confers higher knowledge about HIV-AIDS; sexuality and reproductive health; rights, and leads to better health outcomes for young women and adolescent girls. Nelson Mandela said: *"Education is the most powerful weapon which you can use to change the world"*. Education efforts and key strategies to keep girls in school

and offer comprehensive sexuality education are key to empowering these young minds. Empowering women will fast-track the end of the HIV-AIDS epidemic. The key to ending HIV-AIDS is to stop new HIV infections amongst young women and adolescent girls.

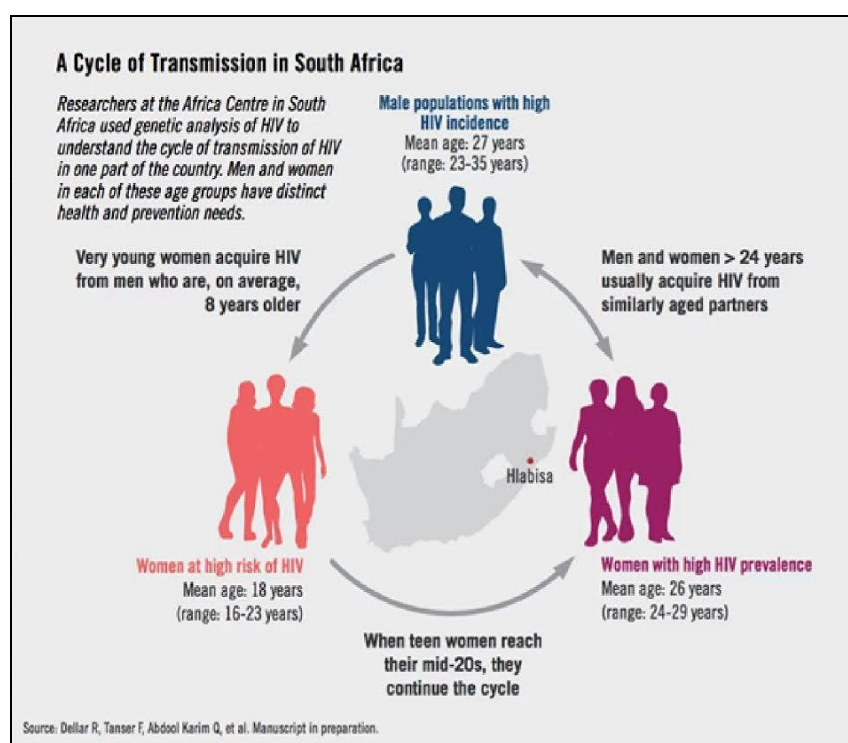
#### **e) Blessers**

In South Africa, 2016 has seen the rise of the phenomenon of “Blessers”. A Blesser is defined as an *“elderly gentleman that engages young women and adolescent girls between the ages of 14 to 24 for sexual favours in return for material goods”* (Adams 2016:1). The term “blesser” in South Africa has therefore become synonymous with someone who blesses a partner with money and gifts. The blesser is perhaps similar in many ways to the traditional sugar daddy. This new occurrence is taking South African social media platforms by storm with new Facebook pages and Twitter followers amassing virtual groups and followers daily. This phenomenon is occurring all over the country and now there are agents who engage interested parties to put these groups together.

In recent months, a new blesser application has been developed which puts young women in touch with older men based on the criteria required. The material wealth provided ranges from mobile phones to cars to overseas holidays and expensive real estate. This relationship is not new. It has long been known in the South African environment as the concept of “sugar daddies” and the Health ministry has conducted several campaigns in the media and online to discourage this behaviour, given the substantial risk of HIV-AIDS transmission from older males to younger females (South Africa 2014).

Researchers from the Africa Centre in South Africa examined the cycle of transmission of HIV-AIDS in the North of KZN, South Africa through genetic analysis as demonstrated in Figure 5.3. They found that males and females aged 24 years usually acquire HIV from similarly aged partners. This male population then infects very young women at high risk of acquisition between 16-23 years of age. This young group of teens then reach their mid-twenties and continue this cycle. The gentlemen referred to as Blessers are often males in this vicious cycle.

**Figure 5.3 A cycle of HIV transmission in South Africa**



**Source: Adapted from Dellar, Tanser, Abdool Karrim and Abdool Karrim (2016:02)**

HIV-AIDS programmes need to be tailored to meet the complex sociological needs of young women in age disparate relationships. Educating girls and empowering them toward financial independence is important. Men should also be targeted as part of male engagement programmes as part of larger HIV-AIDS programme efforts. Males should be made aware of the HIV-AIDS transmission risk associated with seeking out such potentially exploitative relationships. Men who are willing to speak out against such relationships should be identified and supported to be role models to other men in the community. Community leaders should also support community mobilisation efforts against age-disparate relationships and empower youth against them.



## **5.6.4 Technological**

### **a) Applications for healthcare professionals**

The use of mobile devices by health care professionals has transformed the health sector in many ways. Mobile devices have become commonplace in healthcare settings. These have become important innovative tools to reach healthcare workers across the various healthcare facilities as mechanisms to enhance learning and development in the rapidly evolving and dynamic field of HIV-AIDS.

### **b) Social media**

*“The potential of new technologies to re-energize the AIDS movement is clear. We need nothing less than an HIV prevention revolution, with social media and mobile technology at its core,”* said Michel Sidebé, Executive Director of UNAIDS (2011:11). These tools have the potential to deliver HIV-AIDS prevention programmes in a cost-effective way to young people through a media that they are already using. There are 500 million cellphones in Africa, and mobile health is increasingly recognized as an effective channel for HIV-AIDS programming (Wallace, Clark and White 2012:1088).

## **5.7 Conclusion**

The 21st International AIDS conference in Durban, South Africa, presented a troubling picture of the unrelenting HIV-AIDS epidemic as it fails to be prevented and eliminated from South Africa. The call to action from global HIV-AIDS stakeholders is clear: to enhance and promote HIV-AIDS programmes to heighten service delivery especially in South Africa. The opportunity to impede HIV-AIDS-related mortality, morbidity and transmission is now through committed leadership and evidence-based action. The need for this concerted effort has never been more critical.

# **CHAPTER SIX**

## **RESEARCH METHODOLOGY**

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### **6.1 Introduction**

The previous four chapters discussed the salient features of HIV-AIDS, quality management systems in healthcare and HIV-AIDS monitoring and evaluation frameworks both locally and globally. This chapter reiterates the research problem and discusses the research design that comprises a mixed methodology, using a case study approach. This study contributes empirically and theoretically to interdisciplinary knowledge on HIV-AIDS monitoring and evaluation conceptual frameworks based on quality management systems in the South African private healthcare sector.

### **6.2 Research problem**

HIV-AIDS in South Africa is a prominent health concern, as more people are living with the disease than in any other country in the world. As such, South Africa hosts the largest HIV-AIDS programmes globally, namely the South African Department of Health's HIV-AIDS programme in the public sector and Aid for AIDS (AFA) in the private health sector (UNAIDS 2013:18). The appropriate management of HIV-AIDS treatment and wellness programmes are vital to ensure operational efficiency and cost effectiveness, thereby ensuring optimal patient management. The HIV Your life Programme is a new HIV-AIDS wellness provider in the managed healthcare industry and this research assesses the clinical efficacy of this programme. The aim of this research study was to explore and evaluate the HIV Your Life Programme as a national HIV-AIDS treatment and wellness provider with a view to developing a conceptual monitoring and evaluation framework based on sound quality management systems for such programmes. The purpose of this framework is to assess the current outcomes of the HIV-AIDS programme, as well as to assess the operational outputs of the programme with a view to enhancing patient care with maximal public health benefits. Research of this nature will have beneficial value to this HIV-AIDS wellness provider in that it will provide direct support of management

services with a view to the continuous improvement of processes through the implementation of a monitoring and evaluation conceptual framework. This framework is a valuable contribution to the HIV-AIDS monitoring and evaluation field as it can be adapted for use in HIV-AIDS programmes in the Non-Governmental Organisation (NGO) and private health care sectors. Benefits of developing a monitoring and evaluation conceptual HIV-AIDS framework will streamline budgets, consolidate cost effectiveness and enhance patient care towards improved service delivery in HIV-AIDS healthcare.

### **6.3 Central objective**

The central objective of this study was:

To propose a conceptual monitoring and evaluation framework derived from quality management systems for the management of HIV-AIDS private sector programmes that can be used in both public and private healthcare sectors through the analysis of current conceptual frameworks in HIV-AIDS healthcare and HIV-AIDS programmes within the South African context of HIV-AIDS healthcare provision.

### **6.5 Research design**

Qualitative research reviews can help extend quantitative reviews of effectiveness by helping to formulate appropriate questions and identifying relevant outcome measures. This can also help in the interpretation of the results of quantitative reviews by offering insight into why actions/interventions are or are not effective in certain situations and with particular groups. Alternatively, systematic reviews of qualitative research can answer questions that are different from questions of effectiveness. By illuminating the needs of particular population groups, systematic reviews of qualitative research can point to new types of actions/interventions to meet these needs and highlight barriers and/or enablers to the implementation of interventions that have been shown to be effective in 'real life' (Popay and Mallinson 2010: 289).

The qualitative approach was selected as part of the mixed methodology component of this case study. This aspect was explored through interviews with the programme staff. This approach was undertaken in order to conduct an in-depth analysis of the

HIV Your Life programme to explore the programme management and implementation of the programme within the private healthcare sector. The qualitative approach was undertaken to complement the analysis of the quantitative component of this research study. Both the qualitative and quantitative aspects of this study are derived from the objectives of this study. The qualitative and quantitative aspects of this research study generated comprehensive and holistic information to better guide data analysis towards conclusions and recommendations of this study and future research opportunities.

The quantitative data collection component of this case study was achieved through the administration of a comprehensive questionnaire to the programme employees. The questionnaire items were based on relevant themes which emerged from the central and specific objectives of this case study.

This study adopted a descriptive paradigm together with a developmental component and was conducted within a qualitative and quantitative approach. The descriptive component surveyed study participants and classified their roles and responsibilities in the HIV Your Life Programme, as well as contextualised the environment in which they function. This research study explored current HIV-AIDS management approaches on part of the HIV-AIDS care providers and hence did not involve HIV-AIDS patients. Mixed methods research is both a method and methodology for conducting research that involves collecting, analyzing and integrating quantitative and qualitative research into a single study or a longitudinal program of inquiry (Creswell and Clark 2007:10). For the purpose of this study, a case study approach using a mixed methodology was adopted.

#### **6.5.1 Research methodology: Case study using mixed methodology**

Case studies emphasize a detailed contextual analysis of a limited number of events or conditions and hence provide a comprehensive analysis of results. This approach is valuable for public health research to develop theory, evaluate programmes and develops interventions because of its flexibility and rigor (Yin 2004: 23). Yin (2009: 187) states that in qualitative research “*a case study is an intensive investigation of a single unit and uses multiple variables*”. The qualitative methodology is also known widely as creative and interpretative (Denzin and Lincoln 2011: 14). A case study

approach was chosen to assist in the evaluation and analysis of the HIV/AIDS programme in this context, providing valuable recommendations to enhance treatment outcomes.

Case studies embrace several approaches and purposes. It is for this reason that this approach was considered for the current study. Data collection through multiple sources was undertaken, encompassing the qualitative and quantitative research methodologies in order to ensure that comprehensive data was collected from detailed questionnaires and complimented by data collection from the face-to-face interviews. Collation of all these data collection modalities was envisioned to provide the best critical analysis of the HIV-AIDS programme under review to yield smart practices to guide operational efficiency.

It is for this reason that this approach was used for this study. It allowed the researcher to be able to analyse this HIV-AIDS programme in its current real-life setting in order to understand and assess what the current real-life challenges and smart practices are. This information will then be utilised to assist the programme to improve on areas to enhance healthcare service delivery. It allowed the researcher the ability to interact with the HIV-AIDS programme employees in order to better comprehend their experiences with the HIV-AIDS programme to date in order to draw conclusions and make recommendations for streamlining practices.

Stake (2009: 18) best describes case studies as being used for adding to existing experience and humanistic understanding. Case studies are central to the comprehension of social problems. There are limitations and benefits to the use of the case study in research.

Clear **benefits** are:

- Case studies have the potential, when applied successfully, to 'retain more of the "noise" of real life than many other types of research' (Hodkinson and Hodkinson 2001: 3).
- Case studies simplify complex concepts ( Singh 2014:12)

- Case studies improve analytical thinking, communication and develop tolerance for different views on the same subject (Singh 2014:12).
- Case studies provide a good opportunity for innovation and are a good method to study rare phenomena (Singh 2014:12).
- Case studies are a good method to challenge theoretical assumptions and provide an alternative or complement to the group focus of psychology (Murphy 2014).

**Limitations** are:

- Case studies contain the perceptions and point of view of the researcher only.
- Case studies fail to draw definite cause-effect conclusions (Zainal 2007:36).
- Case studies pose possible biases in data collection and interpretation since a single person gathers and analyses the information (Zainal 2007:36).

A mixed method strategy was used in order to achieve the objectives of the study. This was achieved through a three-phased approach as follows:

- Phase 1-systematic and exhaustive review of the HIV-AIDS programme reports: a systematic reading and review of the HIV-AIDS programme reports were reviewed exclusively for this study.
- Phase 2-Quantitative study: a questionnaire was constructed in order to identify activities and objectives classified according to the HIV-AIDS programme.
- Phase 3-Qualitative study: a qualitative study was conducted in order to identify the experiences that employees in the HIV-AIDS programme had with HIV-AIDS monitoring and evaluation frameworks.

Given that the quantification of HIV-AIDS-related healthcare is difficult in the South African private healthcare sector due to the lack of a monitoring and evaluation conceptual framework, a case study approach was the ideal approach to provide a

contextually relevant, flexible and innovative solution towards this complex private sector healthcare challenge.

## **6.6 Description of the population and the target population**

According to Graziano and Raulin (1999), a population is the larger group of all the people of interest from which the sample is selected. White (2000:64) states that if the population is about 50 or less, the whole population must serve as the sample. The population for this research study was a large managed healthcare organisation with a national footprint with health interests in the field of insurance, medical aid, managed healthcare and financial wellness. The estimated current employee population ranks between 800-1000 employees. Due to ethical reasons and those of confidentiality, the researcher opted for the organisational name not to be disclosed. This managed healthcare organisation has a specific programme involved with HIV-AIDS treatment, wellness and care service delivery. Given that HIV-AIDS formed the focus of this research study, the target population for this study involved the staff of the HIV Your Life Programme only. A target population refers to the entire group of individuals or objects to which researchers are interested in generalizing the conclusions (Bhattacharjee 2012:38). Given that HIV-AIDS formed the focus of this research study, the target population for this study involved the staff of the HIV Your Life Programme only, which consisted of 90 employees

## **6.7 The sampling procedure**

Sampling involves the selection of a number of study units from a defined study population (Welman, Kruger and Mitchell 2005:55). A sample is the total collection of all units of analysis about which the researcher wishes to make specific conclusions. In order for results to be generalizable, the sample must be representative of the population as a whole (Welman, Kruger and Mitchell 2005:55). There are two major sampling designs: non-probability and probability.

This study utilised probability sampling.



## **6.8 Criteria for the selection of the sample**

All programme staff members employed at the HIV Your Life Programme were invited to participate in collecting data for this study. The sample size for the quantitative phase of this study comprised approximately 60 respondents. The sample size for the qualitative component of this study was 10 respondents. The sample size was representative as it had participation from all job descriptions currently employed in the programme.

- Inclusion Criteria:

All programme staff members employed at the HIV Your Life Programme were invited to participate in collecting data for this study. The programme staff members have a diverse composition in terms of gender, age, ethnicity and job descriptions. This research study was aimed at the HIV-AIDS programme staff only.

- Exclusion criteria

This research study did not include staff members not employed by the HIV Your Life Programme and also excluded HIV Your Life Programme Patients.

## **6.9 Sampling methods**

Given that the programme employees a multi-disciplinary team, this study utilised a randomised, stratified sampling approach. In this case study, the programme employees shared common attributes through their roles and responsibilities identified by their job descriptions. A random sample from each stratum was taken for both the qualitative and quantitative components of this research study. As such, the researcher ensured representation from all categories of employees, enabling comprehensive data collection and data analysis.

### 6.9.1 Sample size

The estimated current employee population for this organisation ranks between 800-1000 employees. The HIV Your life programme has 90 staff members. As such, a total of 90 staff members were invited to participate in this research study. Sixty employees participated in the quantitative component, comprising the questionnaire completion. This left 30 employees who were invited to participate in the qualitative component, involving the interview completion. Ten members of this 30 participated in the interviews. Employees participated in either the quantitative or the qualitative phase of this study through a process of random sampling. No employees participated in both components of this study (Tabulated below).

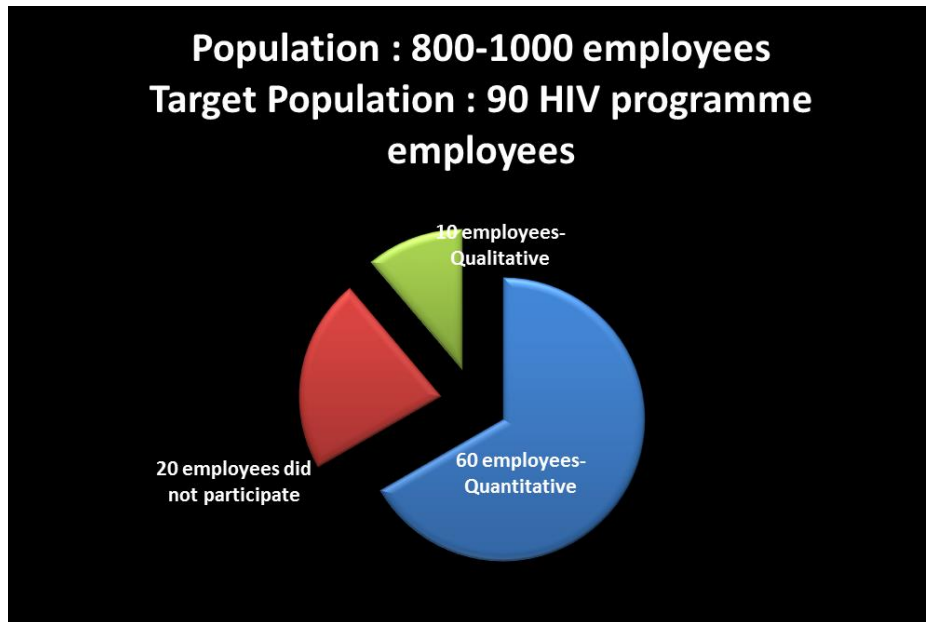
**Table 6.1 Sample Size tabulated**

Population : Approximately 800-1000 organisational employees				
Target Population: 90 HIV Your Life programme employees				
Sample size	Quantitive : 60 HIV Your Life programme employees		Qualitative : 10 HIV Your Life programme employees	
Sample Size breakdown per job description	Questionnaires (Quantitive component)		Face-to-face-Interviews (Qualitative component)	
	Actual	Sample	Actual	Sample
Clinicians	6	6	0	0

Counsellors	15	10	5	2
Lay counsellors	15	6	9	3
Health care workers	15	10	5	1
Administrative staff	9	9	0	0
Nurses	9	6	3	1
Disease managers	9	6	3	1
Pharmacist	3	1	2	1
Pharmacy assistant	9	6	3	1
TOTAL	90	60	30	10
Total quantitative study sample size		60		
Total qualitative study sample size				10
TOTAL STUDY SAMPLE SIZE	(60+10)=70			

**Source: Self-generated based on authors' viewpoints (2016)**

**Figure 6.1 Sample Size distributions**



**Source: Self-generated based on authors' viewpoints (2016)**

## **6.10 Data collection procedures**

### **6.10.1 Administration of questionnaires**

According to Saunders *et al.* (2009: 395), there are two types of questionnaire administration, namely self-administered and interviewer administered. Self-administered questionnaires have the following advantages (Saunders *et al.* 2009: 395):

- Respondents answer at their convenience;
- There is no need to set up interview appointments;
- No interviewer is present to inject bias in the way questions are asked; and
- The low cost-per-completion makes it an economical method of surveying large samples.

All employees at the HIV Your Life programme were informed of this research study and were invited to participate. Interested employees were then identified and appointments were requested based on their availability to complete questionnaires at the programme offices. Arrangements were made with programme management to allow the respondents time to complete the questionnaire. This was usually during the lunch break or prior to commencement of the work day. The questionnaires were personally administered by the researcher. The researcher has prior clinical trials experience and wished to have a hands-on approach with every aspect of this study. Upon completion of the questionnaire, the researcher ticked off the names of the respondents as the questionnaires were completed and returned. The questionnaires were assessed for completeness. All data was kept confidential.

### **6.10.2 Face-to-face interview schedule**

The primary advantage of face-to-face interviews is that they provide much more detailed information than what is available through other data collection methods.

There are however a few limitations and pitfalls (Thyer 2001: 308):

- Interviews are prone to bias;
- Interviews can be time-intensive;
- The interviewer must be appropriately trained in interviewing techniques; and
- Interviews are not generalizable.

The face-to-face interview is a widely used observation method in many types of qualitative studies and was selected for assessing comprehensive data collection. In-depth interviews were conducted both individually and as part of a group discussion. This mode of data collection was selected to allow employees to provide their opinions of the current programme. Face-to-face interviews were undertaken to ascertain unbiased views from all categories of employees. As implementers of the programme, they were identified as the most appropriate individuals to assess the strengths of the programme together with the gaps to isolate areas for continual improvement. These interviews allowed the researcher the opportunity to ascertain multiple employees' views about the programme and to assess their thoughts

towards enhancing programme service delivery. Face-to-face interviews were used because of their flexibility, response rate, non-verbal behaviour and control over the environment. Interested employees were identified and appointments were requested based on their availability to complete the interviews at the programme offices. Arrangements were made with the programme management to allow the respondents' time to complete the interviews. This was usually during the lunch break or prior to commencement of the work day. The researcher had prior research experience in clinical trial implementation and behavioural research and hence opted to personally conduct the interviews. The researcher wished to have extensive involvement at each stage of this research process.

## **6.11 Questionnaire design**

This study used a variety of data collection methods, including current and archival document analysis review, direct observation, structured questionnaire administration and semi-structured individual and group interviews.

### **6.11.1 Questionnaire items**

Each question was simply worded. The questionnaire was divided into sections. These sections generated themes based on the research objectives of this study. These themes were also developed in the face-to-face interview schedule for consistency and standardisation. The questionnaire was divided into sections as follows:

- Section A: Biographical Information. This section asked employees specifically for their age, gender and job descriptions in order to collect information on the baseline demographics of the programme employees. This data is important in that it sets the characteristics of the study population and describes the baseline demographics of the populations being studied.
- Theme 1: Section B: - Monitoring and evaluation processes. This section delved into the critical programmatic aspects of implementation activities of monitoring and evaluation within the programme.

- Theme 2: Section C: - Core indicators. This section asked employees specifically to provide their knowledge and input into the pivotal indicators that should be required in the management of HIV-AIDS programmes.
- Theme 3: Section D: - HIV-AIDS-related operational research activities. This section emphasised the new and ad hoc activities required for HIV-AIDS-related operational research within HIV-AIDS programmes.
- Theme 4: Section E: - Data management. Challenges and implemented solutions were focused on in this section on data management.
- Theme 5: Section F: - HIV-AIDS Programme Stakeholder management. Challenges with stakeholder management in HIV-AIDS programmes were examined in this section.
- Theme 6: Section G: Strengthening the capacity of all partners in HIV-AIDS programmes. Challenges with strengthening the capacity of all partners in HIV-AIDS programmes were examined in this section.
- Theme 7: Section H: Smart practices of HIV-AIDS monitoring and evaluation frameworks. Smart practices for HIV-AIDS programmes were probed in this section.
- Theme 8: Section I: Challenges of HIV-AIDS monitoring and evaluation frameworks. Challenges of HIV-AIDS monitoring and evaluation frameworks were explored in this section.

Each section contained questions based on the research study themes and sub-themes derived from the study objectives. The questionnaire comprised Likert-style questions. The nominal scale was used for the biographical profiles. The Likert scale of 1-5 was used for the other sections of the questionnaire. The Likert scale was used because it is easy and quick to construct. It provides a real picture of a well-defined sample group. It is also a popular summated scale to express either a favourable or unfavourable attitude towards the object of interest (Cooper and Schindler 2008:306).

## **6.12 Face-to-face interview questionnaire construction**

Based on the emergent themes from previous chapters and the research study objectives, the researcher developed a set of questions to appropriately illicit required information to answer the research question. The questions were open-ended, allowing for employees to provide comprehensive responses. The face to face interview questions were based on the following themes:

- Theme 1: Monitoring and evaluation processes. This section delved into the critical programmatic aspects of the implementation activities of monitoring and evaluation within the programme.
- Theme 2: Core indicators. This section asked employees specifically to provide their knowledge and input into the pivotal indicators that should be required in management of HIV-AIDS programmes.
- Theme 3: HIV-AIDS-related operational research activities. This section emphasised the new and ad hoc activities required for HIV-AIDS-related operational research within HIV-AIDS programmes.
- Theme 4: Data management. Challenges and implemented solutions were focused on in this section on data management.
- Theme 5: HIV-AIDS Programme Stakeholder management. Challenges with stakeholder management in HIV-AIDS programmes were examined in this section.
- Theme 6: Strengthening the capacity of all partners in HIV-AIDS programmes. Challenges with strengthening the capacity of all partners in HIV-AIDS programmes were examined in this section.
- Theme 7: Smart practices of HIV-AIDS monitoring and evaluation frameworks. Smart practices for HIV-AIDS programmes were probed in this section.
- Theme 8: Challenges of HIV-AIDS monitoring and evaluation frameworks. Challenges of HIV-AIDS monitoring and evaluation frameworks were explored in this section.



## **6.13 Validity and reliability**

### **6.13.1 Validity**

Face-to-face interviews and questionnaires are valid instruments of collecting data. The questions in the interview schedule to the programme staff and the questionnaire administered will be compared with the objectives of the study to ensure validity.

The pre-testing of the questionnaire increased the validity constructs for the study. The questionnaire was provided to three colleagues involved in HIV-AIDS research at the South African Medical Research Council, as well as the statistician for their review and guidance on the amendment of the questionnaire. These individuals were aware of this study's rationale, aims and objectives and were able to provide contextually-relevant comments and changes. This pre-testing process increased the validity of the questionnaire.

### **6.13.2 Reliability**

According to Piot, Bartos, Ghys Walker and Schwartlaender (2006:246), reliability refers to the ability, consistency or dependability of an instrument which is reliable to measure accurately and reflect the time score of the attributes under investigation. The inclusion of multiple sources of data collection in a research project is likely to increase the reliability of the observation. A content analysis will be conducted on the data gathered from the interviews and questionnaires (primary data) and the organisation's reports and other documents (secondary data). The findings will be validated through pre-testing. A health facility will be randomly selected for the pre-testing. Further to that, the use of data from the Provincial Department of Health, legislative and statutory frameworks, official reports, journals and books will ensure reliability and validity. Observation and unstructured interviews and a document search will also be used to ensure reliability.

Cronbach's Alpha is used to test reliability. The test length and dimensionality affects the Alpha. The reliability of a test can be increased by a longer test (Tavakol and Dennick 2011:53). This study used Cronbach's Alpha through SPSS to determine the reliability of the questionnaires.

The structure of the questionnaire and rigour of the pre-testing ensured the internal validity and reliability of the data collected. Data was assimilated with accuracy and consistency. In this study, questions were understood by the respondent in the way that the researcher intended and answers were decoded by the researcher in the way that the respondent had intended.

## **6.14 Pre-testing**

Pre-testing is a small experiment designed to test logistics and gather information prior to a larger study, in order to improve the latter's quality and efficiency (Cooper and Schindler 2003: 77). It is imperative to conduct a pilot study in order to identify any flaws in the data collection tools or the study design. A pilot study was carried out amongst healthcare workers at a private HIV-AIDS healthcare facility who were not part of the sample population.

## **6.15 Triangulation**

Bloor and Wood (2006:170) define Triangulation as *“the systematic comparison of findings on the same research topic generated by different research methods. Triangulation in qualitative research has come to mean a multimethod approach to data collection and data analysis”* (Rothbauer 2008:893). Lee and Lings (2008:239) maintain that triangulation is one way in which one can try to enhance validity. Therefore, the findings or data will be validated through triangulation with an intention to corroborate findings according to different approaches. Erlandson, Harris, Skipper and Allen (1993: 132) explain that *“triangulation lends credibility to the findings by incorporating multiple sources of data, methods, investigators or theories”*. Welman, Kruger and Mitchell (2005: 194) add that *“triangulation is used to corroborate findings according to at least three different approaches.”* Triangulation facilitates validation of data through cross verification from more than two sources.

HIV-AIDS is a dynamically evolving arena of healthcare due to the various global and local political, cultural, medico-legal and psychosocial influencing factors that shape the pattern of disease and its management. It is therefore integral that data from all these sources is contextualised through triangulation to ensure that decision making for recommendations and best practices are based on relevant, current and

evidence-based approaches. In order to triangulate data and draw necessary conclusions towards recommendations, the researcher reviewed data collection from the three phases of this research study. These phases were: Phase 1: HIV-AIDS and organisational document review; Phase 2: The Quantitative component; and Phase 3: The Qualitative component. Data was analysed and the emergent themes were reviewed and critically assessed to frame similarities and differences toward a comprehensive data conclusion.

This case study included only the HIV Your Life programme and was focused solely on the HIV-AIDS private healthcare sector in Kwa-Zulu Natal.

### **6.16 Limitations of the study**

A possible limitation of the study was that participants were drawn from only one division of this health organisation, namely the HIV Your Life Programme. A further possible limitation was that this study did not involve current patients of the programme, because this component is reserved as a further research study as a follow up to this one. As such, the results obtained may not be reflective of the organisation as a whole.

### **6.17 Elimination of bias**

Kumar (2005: 132) suggests that *“the form and wording of questions is extremely important in a research instrument as they have an effect on the type and quality of information obtained”*. This research remained objective through the use of gender-neutral words and people were not identified by race or ethnic group. There were minimal to none assumptions made. All participation was voluntary

### **6.18 Anonymity and confidentiality**

All details of participation were kept strictly confidential. There will be no disclosure of names or identity in the questionnaires and interviews. Data collected will be stored for five years and will be available to the researcher and supervisors for research purposes only.

## **6. 19 Ethical considerations**

All participants were asked to sign an informed consent form explaining the study aims and objectives. Participants could abstain from participation at any stage of the research process. Permission was gained from the HIV Your Life Programme Management and the study was conducted in accordance with the Durban University of Technology: Faculty Research Committee's ethical requirements. All participant information will be kept strictly anonymous and confidential.

### **6.20 Editing and coding of data**

The editing of data was conducted by the researcher in conjunction with the statistician and the statistical research assistant. The statistical research assistant is under the constant supervision of the statistician and has extensive prior experience in this field. The statistical research assistant undertook data capturing for this research study under supervision of the statistician. The questionnaires were printed on single pages to facilitate easy completion and easy data capturing. The researcher, in conjunction with the statistician, conducted the data analysis utilising selected statistical techniques, which are discussed next.

### **6.21 Statistical techniques and data analysis**

Data analysis is an integral part of research methodology and constitutes an essential stepping-stone towards both gathering data and linking one's findings with higher order concepts. Data collection should be systematic and meticulous and is a process of inspecting, cleaning, transforming and modelling data with the goal of discovering useful information, suggesting conclusions and supporting decision-making. The purpose of analysing data in a study is to describe the data in meaningful terms. Statistics help to answer important research questions and it is the answers to such questions that further understanding of the field. Both the quantitative and qualitative component of this research study utilise descriptive statistics and inferential statistics for the presentation and analysis of the empirical data with the Statistical Package for the Social Sciences (SPSS) Version 24.0 for Windows (Release August 2015).

## **6.22 Formulation of hypotheses**

The central objective of this study was to propose a conceptual monitoring and evaluation framework derived on quality management systems for the management of HIV-AIDS private sector programmes that can be used in both public and private healthcare sectors through the analysis of current conceptual frameworks in HIV-AIDS healthcare and HIV-AIDS programmes within the South African context of HIV-AIDS healthcare provision.

The empirical investigation also aimed to evaluate HIV-AIDS monitoring and evaluation processes; HIV-AIDS core indicators; HIV-AIDS operational research; HIV-AIDS data sources; and HIV-AIDS stakeholder management.

## **6.24 Conclusion**

In this chapter, the problem and study objectives were re-iterated. The target population and sampling method were explained. These components were discussed in relation to the research study under investigation. Statistical analyses and hypotheses generation were undertaken. The presentation of research findings and analysis of results is discussed in chapter seven.

# **CHAPTER SEVEN**

## **DATA ANALYSIS AND FINDINGS**

## **CHAPTER SEVEN**

### **DATA ANALYSIS AND FINDINGS**

#### **7. 1 Introduction**

Chapter six explored the research methodology for the study and described the approach to sampling and data collection.

This chapter presents the results and discusses the findings obtained from the quantitative and qualitative components of this study. For the quantitative component, the questionnaire was used to collect data from employees of the HIV Your Life programme. The data collected from the responses was analysed with Statistical Package for Social Sciences (SPSS version 24.0). The qualitative component utilised an interview schedule for individual interviews. Both study components analysed data according to significant themes. Theme one dealt with HIV-AIDS Quality management processes, which included sub themes such as leadership, customer focus and continual improvement. Theme two focused on the development of HIV-AIDS core indicators, while Theme three highlighted HIV-AIDS-related data management issues. Theme four discussed HIV-AIDS-related operational research activities. Theme five discussed HIV-AIDS Programme stakeholder management / strengthening the capacity of all partners in HIV-AIDS programmes.

## **7.2 Quantitative data analysis and findings**

According to Harwell (2007:147), “Quantitative research methods attempt to maximize the objectivity, replicability, and generalizability of findings”. Given that the researcher wished to remain objective while extracting accurate generalizable findings from this study, a quantitative approach as part of a mixed method study was utilised.

### **7.2.1 The sample**

The sample size is the number of observations that constitute it (Evans, Hastings, and Peacock 2000:16). For this study, 60 questionnaires were despatched and 60 were returned which gave a 100% response rate. The response rate is the number of people who answered the questionnaires divided by the number of people in the sample (Curtin, Presser and Singer 2000:413). The response rate needs to be at least 70% for analysis. Failure to attain a response rate greater than 70 % may result in bias, which may compromise data analysis.

### **7.2.2 The research instrument**

The research instrument consisted of 82 items, with a level of measurement at a nominal or an ordinal level. The questionnaire was divided into 9 sections as illustrated below:

- A Biographical data
- B Monitoring and evaluation processes
- C Core indicators
- D HIV-AIDS-related operational research activities
- E Data management
- F HIV-AIDS Programmes Stakeholder management
- G Strengthening the capacity of all partners in HIV-AIDS programmes
- H Smart practices



## I Challenges

### 7.2.3 Reliability statistics

The table below reflects the Cronbach's alpha score for all the items that constituted the questionnaire.

**Table 7.1 Cronbach's alpha score**

		Number of Items	Cronbach's Alpha
<b>B1</b>	Stakeholder/Relationship management	4 of 4	0.589
<b>B2</b>	Leadership	3 of 3	0.819
<b>B3</b>	Engagement of people	6 of 7	0.650
<b>B4</b>	Continual Improvement	4 of 4	0.790
<b>B5</b>	Evidence based decision making	3 of 3	0.895
<b>B6</b>	Process Approach	6 of 6	0.742
<b>B7</b>	Customer focus	3 of 3	0.866
<b>C</b>	Core indicators	10 of 10	0.950
<b>D</b>	HIV-AIDS-related operational research activities	6 of 6	0.720
<b>E</b>	Data management	10 of 10	0.857
<b>F</b>	HIV-AIDS Programmes Stakeholder management	5 of 5	0.743
<b>G</b>	Strengthening the capacity of all partners in HIV-AIDS programmes	5 of 5	0.658
<b>H</b>	Smart practices	5 of 5	0.812
<b>I</b>	Challenges	5 of 5	0.738

The reliability scores for all sections exceeded the recommended Cronbach's alpha value of 0.600. This indicates a degree of acceptable, consistent scoring for these sections of the research.

## 7.2.4 Factor analysis

Factor analysis is done only for the Likert scale items. Certain components divided into finer components. This is explained below in the rotated component matrix.

**Table 7.2 Kaiser-Meyer-Olkin and Bartlett's Test**

			Bartlett's Test of Sphericity		
			Approx. Chi-Square	df	Sig.
		<b>Kaiser-Meyer-Olkin Measure of Sampling Adequacy</b>			
B1	Stakeholder/Relationship management	0.563	36.997	6	0.000
B2	Leadership	0.693	68.969	3	0.000
B3	Engagement of people	0.641	249.626	21	0.000
B4	Continual Improvement	0.656	111.858	6	0.000
B5	Evidence-based decision making	0.716	111.016	3	0.000
B6	Process Approach	0.691	160.002	15	0.000
B7	Customer focus	0.652	109.340	3	0.000
C	Core indicators	0.874	548.957	45	0.000
D	HIV-AIDS-related operational research activities	0.610	84.929	15	0.000
E	Data management	0.775	236.178	45	0.000
F	HIV-AIDS Programmes Stakeholder management	0.556	99.721	10	0.000
G	Strengthening the capacity of all partners in HIV-AIDS programmes	0.531	57.077	10	0.000

H	Smart practices	0.612	120.570	10	0.000
I	Challenges	0.764	57.915	10	0.000

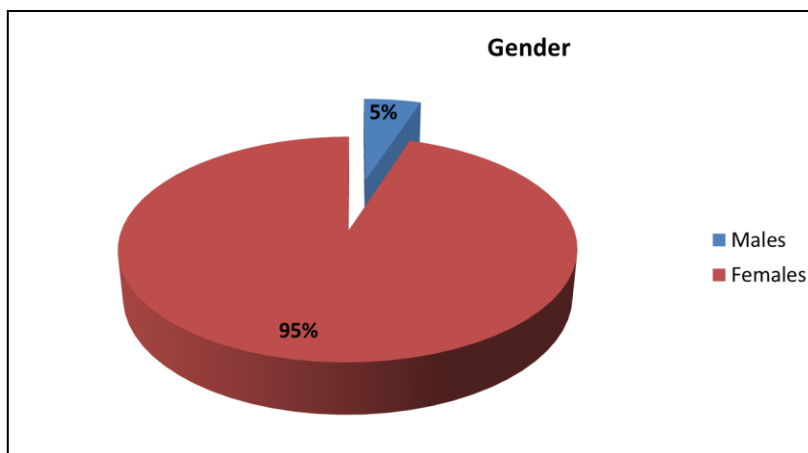
The Kaiser-Meyer-Olkin Measure of Sampling Adequacy value should be greater than 0.500 and the Bartlett's Test of Sphericity sig. value should be less than 0.05. All of the conditions are satisfied for factor analysis.

## 7.2.5 Analysis of the questionnaire

### 7.2.5.1 Section A: Biographical data

This section summarises the biographical characteristics of the respondents.

**Figure 7.1. Gender distribution**



Overall, the ratio of males to females is approximately 1:20 (5.0%: 95%). This ratio is in line with the general assumption that the healthcare industry has a preponderance of female employees. In general in the South African healthcare industry most nurses are female (Statistics South Africa 2015:37).

**Figure 7.2 Age distribution**

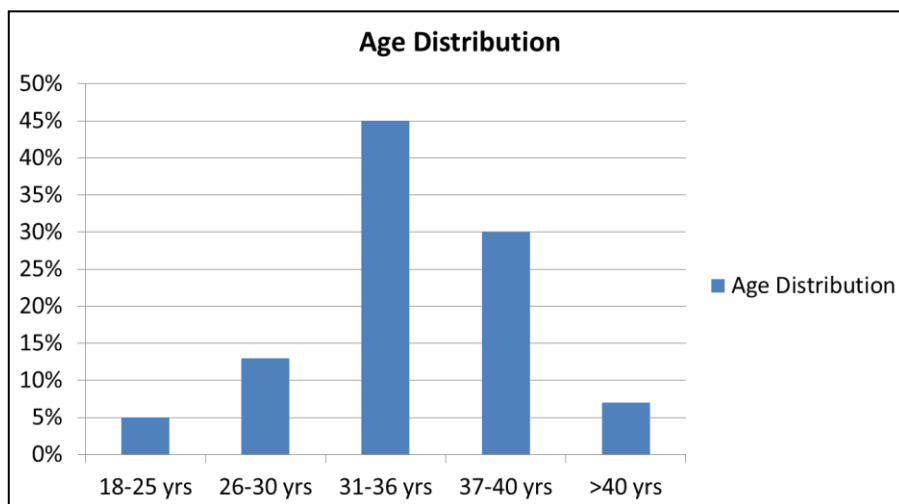
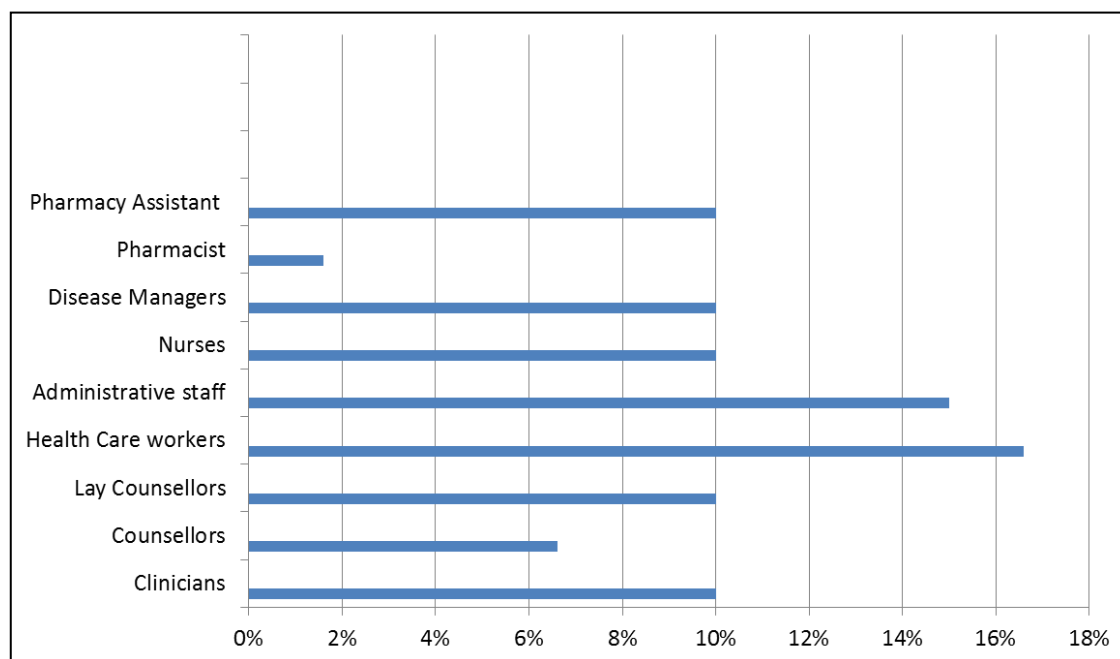


Figure 7.2 graphically represents the age distribution of the respondents. Almost 45 % of all respondents were between 31-36 years of age. Given that the programme under study deals specifically with HIV-AIDS management, all skilled employed staff must have previous HIV-AIDS skills, experience and training gained from another HIV-AIDS service provider. It is not uncommon to find that almost half of the respondents were between 31-36 years of age. This implies that this group of respondents have been employed elsewhere in the HIV-AIDS workforce and as such are expected to be in this age group and not straight out of tertiary education. Very few respondents were over 40 years of age and between 18-25 years of age. This is expected as 18-25 year respondents imply that respondents completed or are completing tertiary education. Attracting and retaining HIV-AIDS scarce skills in South Africa is difficult (South African HIV Clinicians Society 2016) and hence, it is expected to find few respondents over 40 years of age.

Figure 7.3 indicates the job descriptions of respondents. This spanned from clinicians to pharmacy assistants.

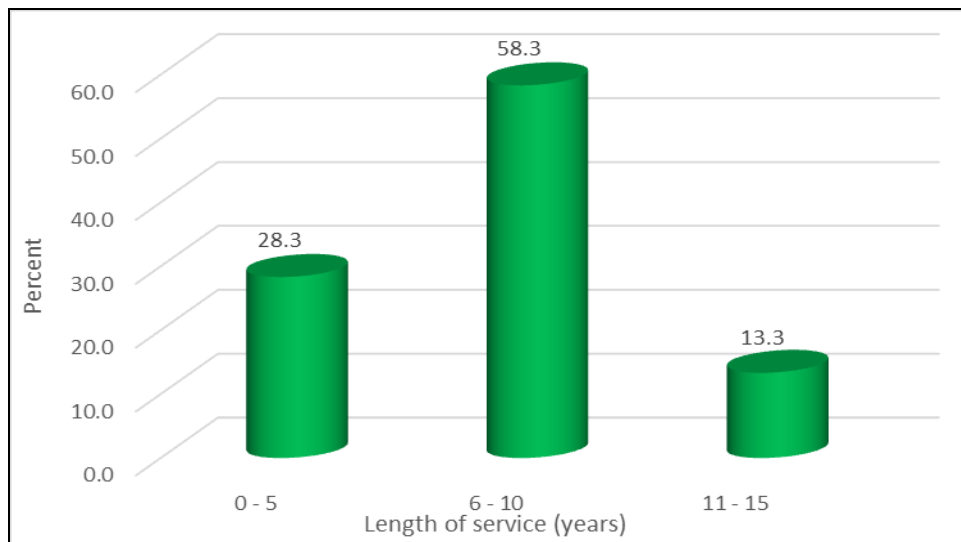
**Figure 7.3 Job descriptions**



There was representation from all job descriptions in the organisations. The majority of employees were in the administrative staff and healthcare worker category.

Figure 7.4 indicates the length of service of the respondents currently in the employ of this HIV-AIDS programme.

**Figure 7.4 Length of service of respondents**



Nearly three quarters of the respondents had been in employ for more than 5 years. This implies that respondents had been in employ for a while, which is also a useful fact as it indicates responses from experienced workers.

The racial composition of the sample is indicated in Table 7.5

**Table 7.5 racial composition**

	Frequency	Percent
Indian	15	25.0
Coloured	2	3.3
Black	42	70.0
White	1	1.7
Total	60	100.0

Seventy percent of this programme's employees are Black and represent the majority of study respondents. The minority of the respondent sample size was only 1.7% and represented the white group of employees. This is in proportion to the population and demonstrates similar characteristics to the larger organisational population.

#### **7.2.5.2 Section B: Monitoring and evaluation processes: quality management systems**

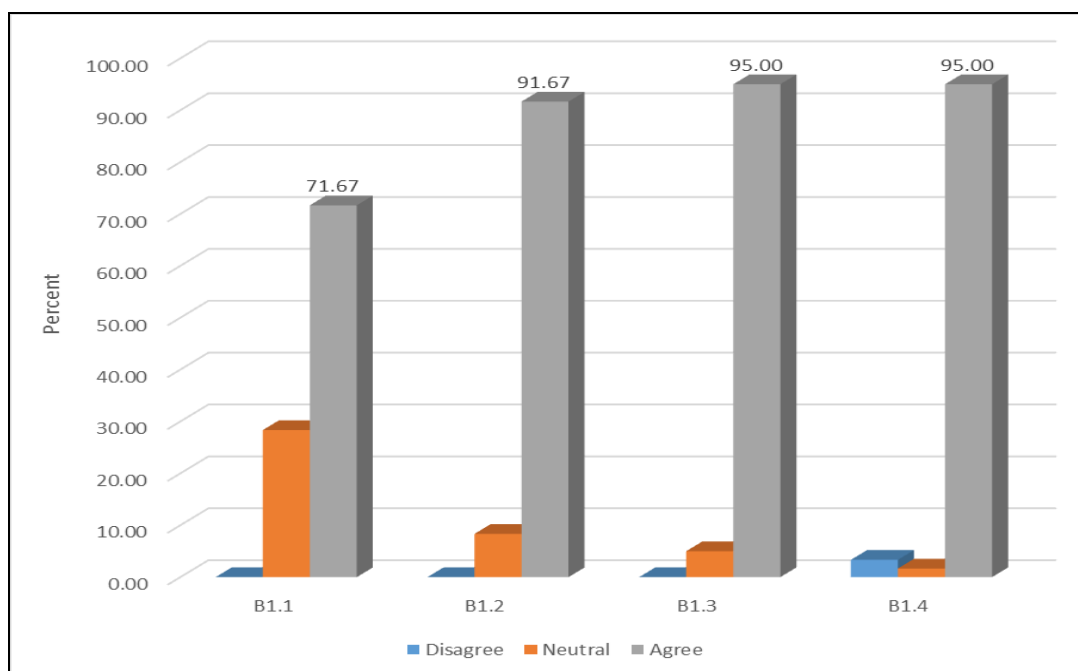
Quality management systems in HIV-AIDS programmes are a relatively new concept with little published data to date. While quality assurance and quality control

mechanisms have been described in HIV-AIDS programmes, very little data has been collated towards the implementation of quality management systems in HIV-AIDS programmes. This research study set out to make a significant contribution to developing clear monitoring and evaluation processes that will enable the systematic collection, collation, processing, analysis and interpretation of data in HIV-AIDS programmes in the private healthcare sector in South Africa. Section B of the research instrument explored the HIV-AIDS monitoring and evaluation process, with attention focused on quality management systems through various sub-sections.

#### 7.2.5.2.1 B1: Stakeholder-relationship management

The role of stakeholders was assessed in this section. Respondents were asked about their opinions of what value stakeholders leveraged in HIV-AIDS programmes. Figure 7.5 graphically demonstrates these responses.

**Figure 7.6 Stakeholder-relationship management**



Respondents were specifically asked to assess their level of agreement or disagreement with each of the following statements:

B1.1 The business understands the needs and requirements of their stakeholders (partners, patients, service providers). A significant 71.67% of respondents agreed



with this statement; 28.33% of respondents remained neutral with this statement and no respondents disagreed with this statement.

B1.2 Partnerships to plan coordinate and manage the monitoring and evaluation system need to be developed for a successful framework. An overwhelming 91.67% of respondents agreed with this statement, 8.33% of respondents remained neutral with this statement and no respondents disagreed with this statement.

**B1.3 A monitoring and evaluation plan should contain aspects dedicated to communication, advocacy and developing culture.** The majority of respondents agreed with this statement and 5% of respondents remained neutral, while no respondents disagreed with this statement.

**B1.4 An HIV-AIDS monitoring and evaluation plan should be developed in conjunction with all stakeholders and reviewed bi-annually.** The majority of respondents agreed with this statement and 1.67% remained neutral with this statement, while 3.33% disagreed with this statement.

The average level of agreement with the statements in this section is 88.33%. Some statements show (significantly) higher levels of agreement while other levels of agreement are lower. There are no statements with higher levels of disagreement. The statements B1.3 and B1.4 (shown in bold) showed the highest levels of agreements. This implies that respondents agreed that a monitoring and evaluation plan should encompass elements of communication, advocacy and developing culture and that this should be developed in conjunction with stakeholders.

Various stakeholders from health departments, community-based organizations and community planning groups were selected to be analysed in order to generate smart practices and highlight pertinent challenges. The emergent smart practices from the CDC study were to include stakeholders in planning, implementation, development of action plans and dissemination of key results from HIV-AIDS programmes. The greatest challenge from this context was the need for on-going communication and facilitation between all stakeholders and the HIV-AIDS programmes (Gilliam, Davis, Barrington, Lacson, Uhl and Phoenix (2002:11). Data from this research study concurred with the smart practices from the CDC study as the strongest areas of

agreement dealt with engaging HIV-AIDS programme stakeholders through communication, advocacy and culture development. Also, indications are to include HIV-AIDS stakeholders in HIV-AIDS monitoring and evaluation plan development for on-going and continual input.

To determine whether the scoring patterns per statement were significantly different per option, a chi-square test was conducted. These results are depicted in Table 7.7.

**Table 7.7 Chi-Square test scoring patterns for stakeholder-relationship management**

		Disagree		Neutral		Agree		Chi Square
		Count	Row N%	Count	Row N %	Count	Row N %	p-value

<b>The business understands the needs and requirements of their stakeholders (partners, patients, service providers)</b>	<b>B1.1</b>	<b>0</b>	<b>0.0%</b>	<b>17</b>	<b>28.3%</b>	<b>43</b>	<b>71.7%</b>	<b>0.001</b>
<b>Partnerships to plan coordinate and manage the monitoring and evaluation system need to be developed for a successful framework.</b>	<b>B1.2</b>	<b>0</b>	<b>0.0%</b>	<b>5</b>	<b>8.3%</b>	<b>55</b>	<b>91.7%</b>	<b>0.000</b>
<b>A monitoring and evaluation plan should contain aspects dedicated to communication, advocacy and developing culture</b>	<b>B1.3</b>	<b>0</b>	<b>0.0%</b>	<b>3</b>	<b>5.0%</b>	<b>57</b>	<b>95.0%</b>	<b>0.000</b>
<b>An HIV-AIDS monitoring and evaluation plan should be developed in conjunction with all stakeholders and reviewed bi-annually</b>	<b>B1.4</b>	<b>2</b>	<b>3.3%</b>	<b>1</b>	<b>1.7%</b>	<b>57</b>	<b>95.0%</b>	<b>0.000</b>

All p-values < 0.05 are significant. Statements that have a 100% response rate do not have a p-value because there is complete agreement. Data from this study revealed that all the statements were significant. In a multi-country study exploring the benefits of stakeholders in HIV-AIDS programmes, Cornu (2003:12) describes the engagement of stakeholders in HIV-AIDS programmes through involvement, inclusion and continuous participation. In conjunction with this study, the Global Advocacy for HIV prevention (AVAC) launched Good Participatory Practice (GPP) Guidelines (AVAC 2007). These guidelines describe how to effectively engage with all stakeholders in HIV-AIDS programmes. The Good Participatory Practice Guidelines (GPP) offers a wealth of information for global HIV-AIDS programmes.

Given that South Africa bears the brunt of HIV-AIDS in the world, the current GPP needs to be adapted for use in South Africa, together with supplementary contextually appropriate tools to best guide the implementation of these guidelines. This may be proposed for a further research study across the various healthcare sectors in South Africa.

Data from this sub-section was also analysed through the extraction method with the principal component analysis. A rotation method, Varimax with Kaiser Normalization, was utilised. Table 7.8 depicts the findings.

**Table 7.8 Rotated component matrix: Stakeholder-relationship management**

B1	Component	
	1	2
The business understands the needs and requirements of their stakeholders (partners, patients ,service providers)	0.018	0.844
Partnerships to plan coordinate and manage the monitoring and evaluation system need to be developed for a successful framework.	0.183	0.796
A monitoring and evaluation plan should contain aspects dedicated to communication, advocacy and developing culture	0.847	0.250

An HIV-AIDS monitoring and evaluation plan should be developed in conjunction with all stakeholders and reviewed bi-annually	0.904	-0.016
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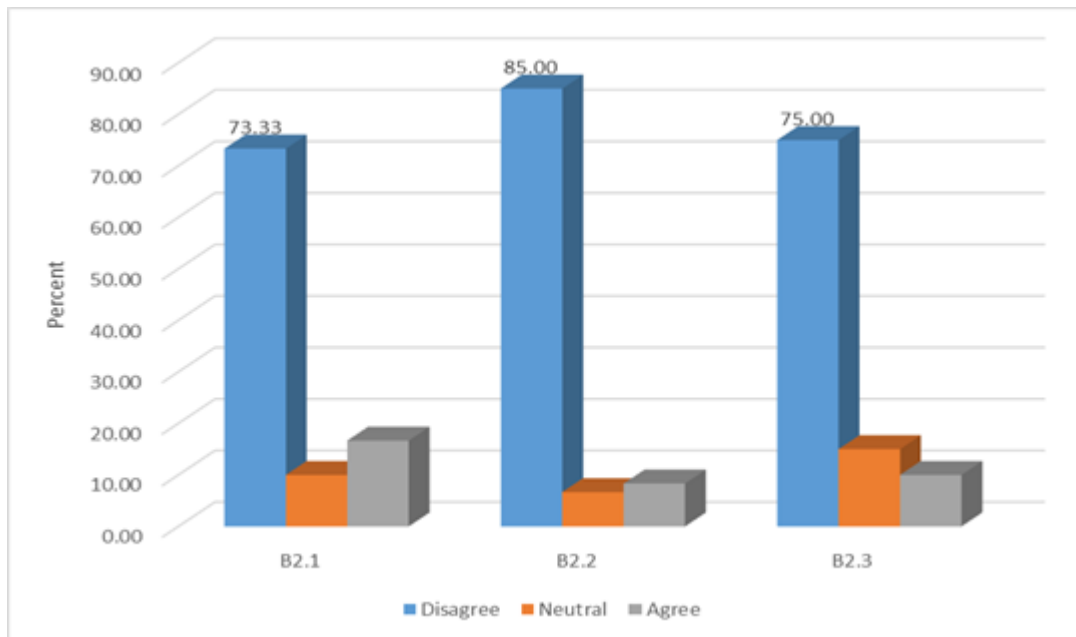
It is noted that the variables that constituted the remaining sections loaded along 2 or 3 components. This means that respondents identified different trends within the section. Respondents placed emphasis on building partnerships and on the business taking strides to understand the needs and requirements of their stakeholders. UNAIDS (2007:10) states that understanding stakeholders and their role in HIV-AIDS programmes is a key step to engagement. This engagement must be based on respect, mutual understanding, integrity, transparency and accountability. Building stakeholder autonomy through HIV-AIDS programme involvement is also pivotal to successful stakeholder relationship management. In order to develop clear monitoring and evaluation processes that will enable systematic collection, collation, processing, analysis and interpretation of data, managing stakeholder relationships play a valuable role in guiding and supporting HIV-AIDS programmes in the private, public and NGO healthcare sectors. Stakeholders play a pivotal role in community mobilisation efforts with communication and advocacy efforts. Stakeholders also contribute to organisational culture development in line with organisational and HIV-AIDS programmes mission, vision and goals. It is for these reasons that stakeholder relationships need to be managed and regular engagements need to occur at specified programmatic intervals to ensure appropriate and timely feedback and updates. Effective stakeholder management creates positive relationships through full engagement and great efforts to satisfy interested parties (Greenley and Foxall 2003: 259).

#### **7.2.5.2.2 B2: Leadership**

The International Organisation for Standardization (ISO) has always regarded the function of leadership as pivotal in the implementation of quality management systems in an organisation (International Organisation for Standardization 2011). All ISO standards strongly embody the requirements of top management support and leadership guidance as a key concept for the accreditation of organisations. The

same holds true for healthcare. It is the core job description of the leadership of organisations who have quality management systems implemented to ensure that appropriately skilled and suitably qualified staff is available to fulfil the quality management function. In addition, leadership should ensure that the necessary resources are made available to supplement and guide the implementation of quality management systems in the workplace. Leaders should also be trained in order to assist with query resolution and complaint escalation where necessary. These fundamental components were asked of respondents. Figure 7.6 graphically demonstrates these responses.

### **Figure 7.9 Leadership**



Respondents were specifically asked to assess their level of agreement or disagreement with each of the following statements:

B2.1 Leadership is proactive rather than reactive to changes in the field of HIV/AIDS. The majority of respondents disagreed with this statement and 10.00% of respondents remained neutral, while 16.67% agreed with this statement.

**B2.2 Escalation of complaints/compliments to leadership is clearly defined and easily accessible.** A significant 85.00% of respondents disagreed with this statement; 6.67% of respondents remained neutral, while 8.33 % agreed with this statement.

B2.3 Leaders receive HIV-AIDS training at regular intervals to ensure adequate knowledge generation. The majority of respondents disagreed with this statement and 15.00% of respondents remained neutral, while 10.00% agreed with this statement.

The average level of disagreement with the statements in this section is 77.76 %. Statements show (significantly) higher levels of disagreement. There are no statements with higher levels of agreement. Statement B2.2 (shown in bold) was the most disagreed with statement.

In order to further analyse this data, Chi-square testing was done. Table 7.10 demonstrates the chi-square data analysis for this sub-section.

**Table 7.10 Chi-Square test: scoring patterns**

		Disagree		Neutral		Agree		Chi Square
		Count	Row N %	Count	Row N %	Count	Row N %	p-value
<b>Leadership is proactive rather than reactive to changes in the field of HIV/AIDS</b>	<b>B2.1</b>	44	73.3%	6	10.0%	10	16.7%	0.000
<b>Escalation of complaints/compliments to leadership are clearly defined and easily accessible</b>	<b>B2.2</b>	51	85.0%	4	6.7%	5	8.3%	0.000
<b>Leaders receive HIV-AIDS training at regular intervals to ensure adequate knowledge generation</b>	<b>B2.3</b>	45	75.0%	9	15.0%	6	10.0%	0.000

The significance of the differences is tested and shown in the Table above. All p-values < 0.05 are significant. Statements that have a 100% response rate do not have a p-value because there is complete agreement. The highest level of disagreement was shown with the statement in bold dealing with the escalation of queries and resolutions. These results are a direct reflection of how leadership is viewed through the respondents' opinions. This clearly demonstrates voids in leadership and management, which require rectification.

The ability of organisations to deal with escalations and queries and how these are handled, demonstrate the true nature of organizational culture (Pereira 2014:11). An enabling environment allows leaders to respond, manage and deal with escalations of queries and complaints in an effective and appropriate manner. It is crucial that



leaders are trained to handle escalations from employees and to provide responses in a timely manner. A complaints escalation process should be developed to allow employees to be trained to escalate queries/complaints or compliments. An escalation policy will also streamline communication between employees and leadership, as both parties will be made aware of their responsibilities and actions ([www.discovery.com](http://www.discovery.com)). This will also ensure that the right people are alerted to selected issues at the right time.

Data from this sub-section was also analysed through the extraction method with the principal component analysis. A rotation method, Varimax with Kaiser normalization, was utilised. Table 7.11 depicts the findings.

**Table 7.11 Component Matrix: Leadership**

B2	Component
	1
Leadership is proactive rather than reactive to changes in the field of HIV/AIDS	0.804
Escalation of complaints/compliments to leadership are clearly defined and easily accessible	0.890
Leaders receive HIV-AIDS training at regular intervals to ensure adequate knowledge generation	0.891

This sub-section revealed an important action item for this HIV-AIDS programme to work on. Given that the greatest disagreement levels are seen with the statement on escalation, it is imperative for this programme to develop an escalation policy and process.

To date, the public healthcare sector in South Africa does not have established escalation processes. This is seen more in the private healthcare sectors, especially in the domain of private healthcare facilities. The Netcare Hospital Group provides practical information and assistance to their employees who manage complaints in health care services through an escalation matrix and handbook. This handbook allows for staff to have accessible processes and information to work towards a responsive resolution and closure ([www.netcare.com](http://www.netcare.com)). Similar initiatives specifically for HIV-AIDS programmes remain at large and are urgently required for

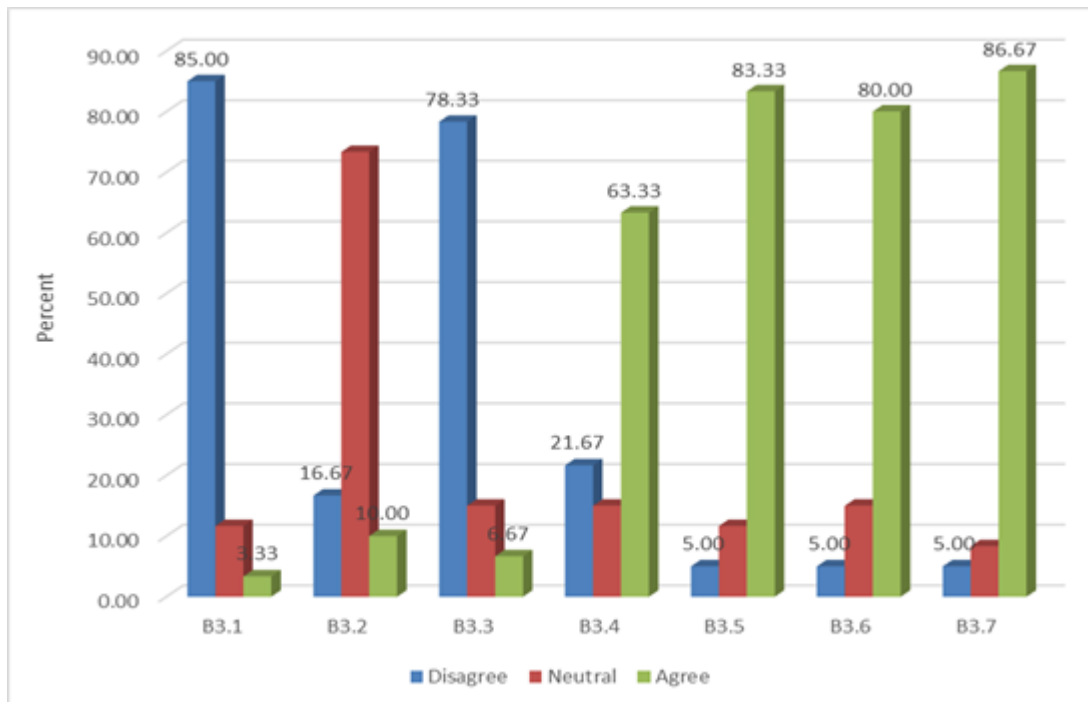
implementing better practices in HIV-AIDS programmes locally and abroad. The benefits of a proactive leadership governing HIV-AIDS programmes cannot be over-emphasised.

Knowledgeable, trustworthy and approachable leadership has been shown to have merits to ensure that employees and programmes reach desired goals. Employee needs analysis and training needs analysis are key elements for leadership to undertake to develop the capacity of employees in fulfilling their roles and responsibilities. Szekeres, Coates and Ehrhardt (2008:19) state that a number of initiatives that focus on leadership development in a variety of populations and settings exist for various contexts and business environments. Leaders need to embark on these recommendations in order to expand their scope and leadership development. These recommendations are primarily targeted towards developing leadership foundations and participation in leadership development programmes.

#### **7.2.5.2.3 B3: Engagement of people**

In order to create a successful quality management system in organisations, it is vitally important to engage and empower organisation's people or employees. "Engagement of people" is one of the stated quality management principles mentioned in the ISO 9001:2015. It is on the basis of this principle that respondents were asked to assess their organisation on the engagement of people and enhancing employee buy-in into quality management systems and processes. Figure 7.12 graphically demonstrates these responses.

**Figure 7.12 Engagement of people**



Respondents were specifically asked to assess their level of agreement or disagreement with each of the following statements.

**B3.1 Training and refresher training is conducted regularly as part of the programme.** A significant 85.00% of respondents disagreed with this statement and 11.67% of respondents remained neutral, while 3.33% agreed with this statement.

**B3.2 A reward and recognition programme is provided.** Only 16.67% of respondents disagreed with this statement and 73.33% of respondents remained neutral, while 10.00% agreed with this statement.

**B3.3 Communication is two-way between management and staff members.** A significant 78.33 % of respondents disagreed with this statement; 15.00% of respondents remained neutral, while 6.67 % agreed with this statement.

**B3.4 Ad hoc surveys should be sent off to monitoring and evaluation staff to assess how improvements can be made to the plan.** Only 21.67 % of respondents disagreed with this statement and 15.00% of respondents remained neutral, while 63.33 % agreed with this statement.

**B3.5 Human capacity for HIV-AIDS monitoring and evaluation frameworks needs to be planned and budgeted for.** A mere 5.00 % of respondents disagreed with this

statement; 11.67% of respondents remained neutral, while 83.33% agreed with this statement.

B3. 6 Management should motivate individuals to become monitoring and evaluation champions. Only 5.00 % of respondents disagreed with this statement; 15.00 % of respondents remained neutral and 80.00 % agreed with this statement.

**B.3 7 Supportive supervision and data auditing is warranted to build strong monitoring and evaluation frameworks.** Only 5.00 % of respondents disagreed with this statement; 8.33% of respondents remained neutral and 86.67 % agreed with this statement.

The average level of agreement with the statements in this section is 60.3 % for questions B3.4; B3.5; B3.6; and B3.7. Questions B3.1; B3.2 and B3.3 had a level of disagreement of 59.99 % — this highlights key voids in this programme aimed at two way communication of management, training, reward and recognition. Statement B3.1 regarding regular training and refresher training (shown in bold) scored the highest disagreement pattern, demonstrating that training does not occur regularly in this programme. In addition statement, B3.7 pertaining to supportive supervision and data auditing exhibited the highest level of agreement, revealing that respondents are aware that this is eagerly required within this programme. Chi-square testing was undertaken to further analyse data in this subsection. Table 7.13 below depicts the scoring patterns.

**Table 7.13 Scoring patterns: Engagement of people**

		Disagree		Neutral		Agree		Chi Square
		Count	Row N %	Count	Row N %	Count	Row N %	p-value
Training and refresher training is conducted regularly as part of the programme	B3.1	51	85.0%	7	11.7%	2	3.3%	0.000
A reward and recognition programme is provided	B3.2	10	16.7%	44	73.3%	6	10.0%	0.000
Communication is two-way between management and staff members	B3.3	47	78.3%	9	15.0%	4	6.7%	0.000
Ad hoc surveys should be sent off to monitoring and evaluation staff to assess how improvements can be enhanced to the plan	B3.4	13	21.7%	9	15.0%	38	63.3%	0.000
Human capacity for HIV-AIDS monitoring and evaluation frameworks needs to be planned and budgeted for.	B3.5	3	5.0%	7	11.7%	50	83.3%	0.000
Management should motivate individuals to become monitoring and evaluation champions	B3.6	3	5.0%	9	15.0%	48	80.0%	0.000
Supportive supervision and data auditing is warranted to build strong monitoring and evaluation frameworks	B3.7	3	5.0%	5	8.3%	52	86.7%	0.000

The significance of the differences is tested and shown in the table above. All p-

values < 0.05 are significant. Statements that have 100% response do not have a p-value because there is complete agreement. Data from this sub-section was also analysed through the extraction method with the principal component analysis. A rotation method: Varimax with Kaiser normalization was utilised. Table 7.14 depicts the findings.

**Table 7.14 Rotated component matrix: engagement of people**

B3	Component	
	1	2
Training and refresher training is conducted regularly as part of the programme	-0.236	0.719
A reward and recognition programme is provided	0.288	0.835
Communication is two-way between management and staff members	-0.265	0.752
Ad hoc surveys should be sent off to monitoring and evaluation staff to assess how improvements can be enhanced to the plan	0.552	-0.038
Human capacity for HIV-AIDS monitoring and evaluation frameworks needs to be planned and budgeted for.	0.923	-0.004
Management should motivate individuals to become monitoring and evaluation champions	0.903	-0.199
Supportive supervision and data auditing is warranted to build strong monitoring and evaluation frameworks	0.935	-0.129

When all three data analyses (bar graphs, chi-square analysis and rotated component matrix) are reviewed for this sub-section, two clearly emergent trends develop. Firstly, there is a strong level of disagreement regarding two-way communication, training and rewards and recognitions in this HIV-AIDS programme and secondly, there is a strong level of agreement for management motivation and supportive supervision through human capititation towards programme improvements and enhancements.

*“Extensive research has shown that no matter how knowledgeable a leader might be, if he or she is not able to open good communication with his/her employees, he or she may be of no help”* (Institute of Healthcare Communications 2011). This indicates that in order to build good manager/employee relationships, there should

be strong, positive relationships between a manager's communication skills and productive and empowered employees. The importance of clear, effective communication, especially in healthcare, cannot be over-emphasised. The need for providing great patient care and improving patient satisfaction remains key deliverables in the healthcare industry. According to O'Daniel and Rosenstein (2008:3), a lack of communication creates situations where medical errors can occur. Barriers to effective communication may be derived from personal values and expectations, hierarchy, culture, ethnicity and gender. It is important for health care organizations to assess areas of poor communication and proactively enhance collaboration (Berwick 1992:2).

Coupled with effective communication is the need for effective training and employee development. The creation of training and development programmes can increase employee retention, job satisfaction and productivity (Health Professions Council South Africa 2015). Training and development in the health care industry is an ongoing process. This is most relevant in the field of HIV-AIDS where continual research-related updates occur frequently and as such, healthcare professionals need to be kept abreast of the latest findings on this disease entity.

These reward and recognition programmes have benefits aimed at improving employee retention and recruitment, improving quality of care and encouraging specific collaborative behaviours. It is important that the HIV Your Life programme design, manage and deliver a rewards and recognition programme to their employees to foster better relationships and build a high-performing culture. High performing cultures can be attained through continuous people engagement, motivated managers and supportive supervision. The World Health Organisation (2016:2) states that: Employee engagement is about positive attitudes and behaviours leading to improved business outcomes. This must be built continually over time in order for managers to build trust and faith in their employees. However, this becomes difficult in healthcare sectors due to the healthcare brain drain. Cometto, Tulenk, Muula and Krech (2013:259) maintain that the challenge of the health workforce brain drain continues with the migration of health workers from low and middle-income countries to high-income countries. This is of relevance to the South African healthcare sector where it has become a challenge to meet the

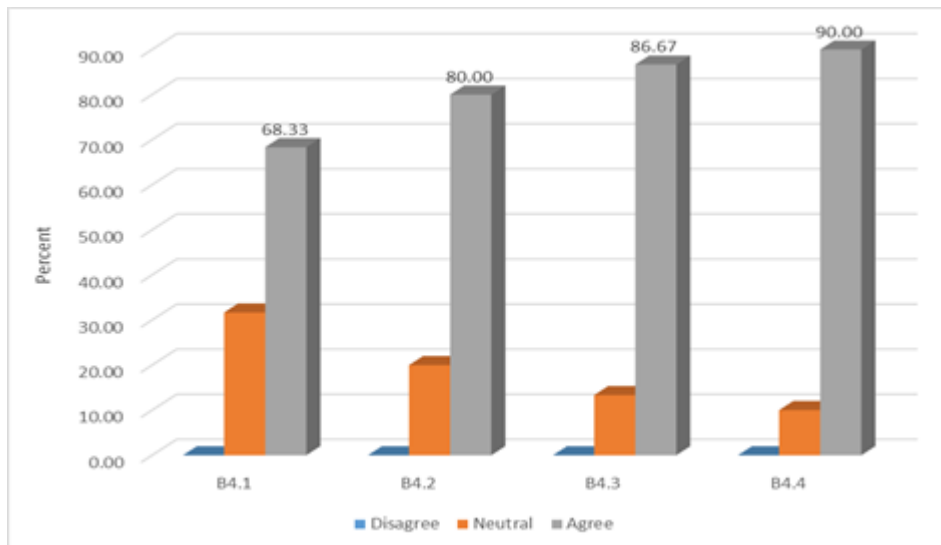
manpower needs in this sector. Coupled with long working hours, poor working conditions and the lack of appropriate remuneration, healthcare workers often leave the public South African health sector for better employment opportunities (Ike 2016:3). New and innovative solutions are required to attract and retain healthcare workers in the South African health sector through better remuneration, more training opportunities, flexible work hours, career development for advancement and more technological innovative automations to ease workloads. Clear, visible and transparent communication is pivotal to employee engagement. Facilitating discussions between leadership and employees is crucial to guiding and supporting HIV-AIDS programmes, together with monitoring and evaluation activities. Employee engagement may take the form of training and refresher training and reward and recognition programmes where high achieving employees are duly rewarded. Supportive supervision, together with leadership motivational activities, may help to build revitalised and energised employee teams. Ensuring adequate resources through budget allocations can create enabling work environments conducive for setting up HIV-AIDS monitoring and evaluation activities. In today's competitive and fast paced world, most organisations are beginning to recognise the true value of an engaged, reliable and accountable workforce. The Discovery Foundation states that their activities geared toward employee engagement in the workplace is a critical part of the organisation's competitive advantage and success in the markets in which they operate. It is important to cultivate employees' talent, vision and leadership to ensure value and quality products and services for clients ([www.discovery.com](http://www.discovery.com)).

#### **7.2.5.2.4 B 4: Continual improvement**

In order for organisations to continually evolve and improve their customer value proposition, questions on approaches to continual improvement were included to assess respondent's understanding on the need for this in the organisation. Figure 7.15 graphically demonstrates these responses.

#### **Figure 7.15 Continual improvement**





Respondents were specifically asked to assess their level of agreement or disagreement on each of the following statements:

**B4.1** Trust, openness, confidence and assertiveness is our approach for result oriented productivity of the programme. The majority of respondents agreed with this statement; 31.67% of respondents remained neutral with this statement; and no respondents disagreed with this statement.

**B4.2** Criteria of success are based upon target achievements by individuals. A significant 80.00 % of respondents agreed with this statement; 20.00% of respondents remained neutral with this statement; and no respondents disagreed with this statement.

**B4.3** Methods are consistently used to improve our work and gain advantage. A notable 86.67% of respondents agreed with this statement and 13.33 % of respondents remained neutral with this statement, while no respondents disagreed with this statement.

**B4.4 Competition, achievement and productivity are part of goal setting to improve performance.** A significant 90.00% of respondents agreed with this statement; 10.00 % of respondents remained neutral with this statement; and no respondents disagreed with this statement.

The average level of agreement with the statements in this section is 81.24 %. Some statements show (significantly) higher levels of agreement, whilst other levels of

agreement are lower (but still greater than the levels of disagreement). There are no statements with higher levels of disagreement. Statement B4.4, pertaining to competition, achievement and productivity scored the highest on agreement and exhibits that respondents are aware of what drives excellence in the programme.

Chi-square testing was undertaken to further analyse data in this sub-section. Table 7.16 depicts scoring patterns.

**Table 7.16 Scoring patterns: Continual improvement**

		Disagree		Neutral		Agree		Chi-Square
		Count	Row N %	Count	Row N %	Count	Row N %	p-value
Trust, openness, confidence and assertiveness is our approach for result oriented productivity of the programme	B4.1	0	0.0%	19	31.7%	41	68.3%	0.005

Criteria of success are based upon target achievements by individuals	B4.2	0	0.0%	12	20.0%	48	80.0%	0.000
Methods are consistently used to improve our work and gain advantage	B4.3	0	0.0%	8	13.3%	52	86.7%	0.000
Competition, achievement and productivity are part of goal setting to improve performance	B4.4	0	0.0%	6	10.0%	54	90.0%	0.000

The significance of the differences is tested and shown in the table above. All p-values < 0.05 are significant. Statements that have a 100% response rate do not have a p-value because there is complete agreement.

Data from this sub-section was also analysed through the extraction method with the principal component analysis. A rotation method, Varimax with Kaiser normalization, was utilised. Table 7.17 depicts the findings.

**Table 7.17 Component Matrix : Continual Improvement**

B4	Component
	1
Trust, openness, confidence and assertiveness is our approach for result oriented productivity of the programme	0.543
Criteria of success are based upon target achievements by individuals	0.888
Methods are consistently used to improve our work and gain advantage	0.870

Competition, achievement and productivity are part of goal setting to improve performance	0.839
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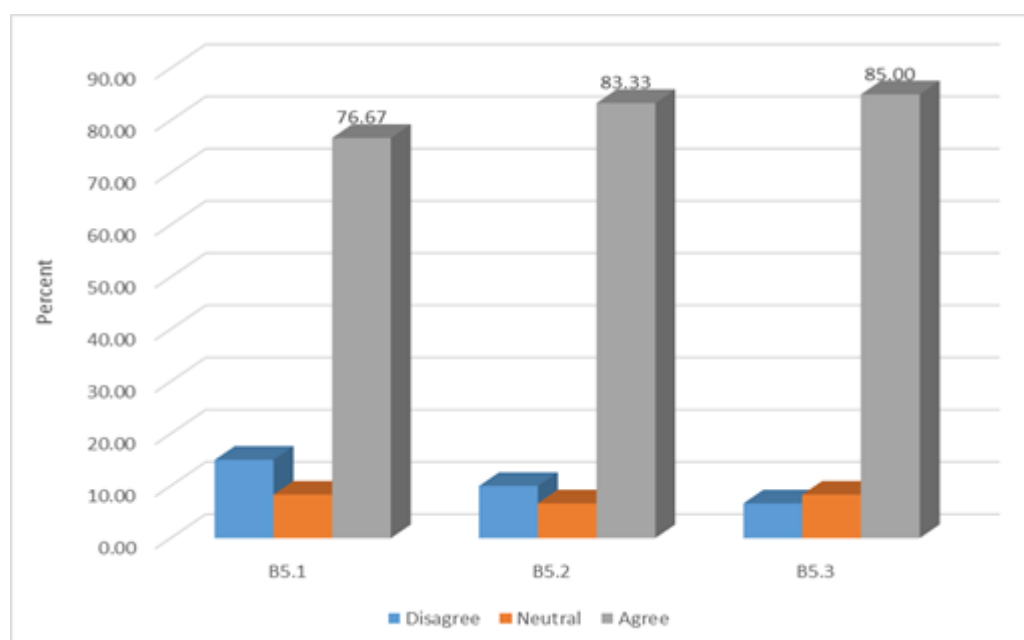
The statements that constituted these sections loaded perfectly along a single component. This implies that the statements that constituted these sections perfectly measured what it set out to measure. When all three data analyses (bar graphs, chi-square analysis and rotated component matrix) are reviewed for this sub-section, it is evident that a strong level of agreement exists for all statements. The themes of competition, achievement and productivity as performance enhancers emerge strongly. Johnson, Maruyama, Roger; Nelson and Skon (1989:41) maintain that interpersonal competition and individualistic efforts at the achievement of goals lead to co-operative goal realisation. Locke and Latham (2002:33) state that people perform better when they are committed to achieving certain goals. The more employees are motivated, the more they are stimulated and interested in accepting and meeting goals. The HIV Your life programme will need to keep employees continually engaged and motivated to ensure personal employee and programme goals are met.

Continual process and procedural review needs to be undertaken to monitor and evaluate HIV-AIDS programmes in order to evolve processes through smart practices and to overcome challenges. HIV-AIDS is a dynamic field where global research agendas are changing daily, based on the needs and changes of the epidemic. Integrating continual improvement in HIV-AIDS policy programmes and projects are paramount to ensuring best service delivery to patients for optimal treatment outcomes ([www.president's emergency fund for aids relief.com](http://www.president's emergency fund for aids relief.com)).

#### **7.2.5.2.5 B5: Evidence-based decision making**

A factual approach to decision making has now become increasingly important in the healthcare industry, especially in the field of HIV-AIDS, as a result of new data generation from local and global HIV-AIDS clinical trials that continually inform the field. The need for relevant, appropriate and acceptable data has never been more warranted than now. Respondents were probed on these issues. These are graphically represented in Figure 7.18 below.

**Figure 7.18 Evidence based decision making**



Respondents were specifically asked to assess their level of agreement or disagreement on each of the following statements:

**B5.1:** Decision making is based on objective guidelines and clinical protocols. The majority of respondents agreed with this statement, 8.33% of respondents remained neutral and 15.00% of respondents disagreed with this statement.

**B5.2:** Decisions for the clinical management of patients should be based on sound clinical discretion. Most of respondents agreed with this statement, 6.67% of respondents remained neutral with this statement and 10.00% of respondents disagreed with this statement.

**B5.3: Continuous professional development towards clinical learning and development in building clinical capacitation is key in HIV-AIDS programmes.** A significant 85.00 % of respondents agreed with this statement, 8.33 % of respondents remained neutral and 6.67 % of respondents disagreed with this statement.

The average level of agreement with the statements in this section is 81.6 %. Some statements show (significantly) higher levels of agreement, whilst other levels of agreement are lower (but still greater than levels of disagreement). There are no

statements with higher levels of disagreement. Statement B5.3 on continuous professional development scored the highest agreement which implies that employees are aware of the value and need for continuous professional development.

Chi-square testing was undertaken to further analyse data in this sub-section. Table 7.19 depicts scoring patterns.

**Table 7.19 Scoring patterns: evidence-based decision making**

		Disagree		Neutral		Agree		Chi-Square
		Count	Row N %	Count	Row N %	Count	Row N %	p-value
<b>Decision making is based on objective guidelines and clinical protocols</b>	<b>B5.1</b>	<b>9</b>	<b>15.0%</b>	<b>5</b>	<b>8.3%</b>	<b>46</b>	<b>76.7%</b>	<b>0.000</b>
<b>Decisions for clinical management of patients should be based on sound clinical discretion</b>	<b>B5.2</b>	<b>6</b>	<b>10.0%</b>	<b>4</b>	<b>6.7%</b>	<b>50</b>	<b>83.3%</b>	<b>0.000</b>

Continuous professional development toward clinical learning and development in building clinical capacitation is key in HIV-AIDS programmes	B5.3	4	6.7%	5	8.3%	51	85.0%	0.000
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The significance of the differences is tested and shown in table 7.13. All p-values < 0.05 are significant. Statements that have a 100% response rate do not have a p-value because there is complete agreement.

Data from this sub-section was also analysed through the extraction method with the principal component analysis. A rotation method; Varimax with Kaiser normalization, was utilised. Table 7.20 depicts the findings.

**Table 7.20 Component Matrix: Evidence-based decision making**

B5	Component
	1
Decision making is based on objective guidelines and clinical protocols	0.872
Decisions for clinical management of patients should be based on sound clinical discretion	0.940
Continuous professional development toward clinical learning and development in building clinical capacitation is key in HIV-AIDS programmes	0.916



The strongest level of agreement was exhibited on the statement of enhancing continuous professional development in HIV-AIDS programmes. The Health Professions Council of South Africa (HPCSA) defines continuous professional development (CPD) as “*a range of learning activities through which health and care professionals maintain and develop throughout their career to ensure that they retain their capacity to practice safely and effectively within their evolving scope of practice*” (Health Professions Council of South Africa 2014). South African health regulatory bodies have undertaken great strides to ensure that healthcare practitioners remain current in their knowledge and workloads in order to ensure optimal care to patients. Jehanzeb and Bashir (2013: 243) maintain that the benefits of continuous educational capacitation is building career competencies, enhancing employee satisfaction and optimising employee performance.

With specific relevance to HIV-AIDS, the Global Fund estimated that almost 431.9 million USD is spent on global HIV-AIDS research internationally in the field of HIV-AIDS treatment, prevention and wellness (Global Fund 2015). This implies that a large proportion of local USA and global funding is channelled into HIV-AIDS research which is often summarised in journal publications and articles for the HIV-AIDS healthcare fraternity to base clinical management on and guide clinical discussions. These publications provide a wealth of data for HIV-AIDS healthcare organisations to capacitate their employees to provide clinical decisions made on best practices and evidence-based learning. The HIV Your life programme should embark on Journal clubs and monthly meetings to ensure the continuity of clinical learning across its employees. The field of HIV-AIDS is constantly evolving, given the high importance attached to the global and local pursuit of a cure for this condition. Given its sustained high incidence and prevalence rates the world over, HIV-AIDS research remains a high priority. HIV-AIDS data is updated almost weekly and monthly with state of the art clinical trials providing evidenced-based HIV-AIDS research data governing new HIV-AIDS wellness, treatment and prevention

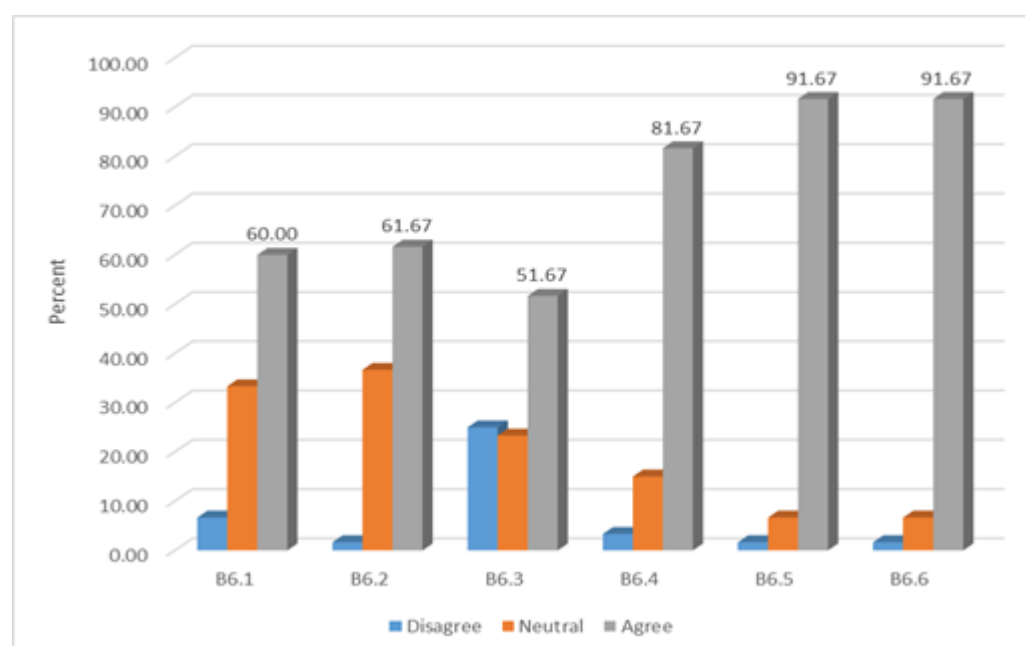


approaches. It is thus imperative to ensure that HIV-AIDS clinical management of programmes locally and abroad is based on sound clinical guidelines and clinical discretion. Continuous professional development towards clinical learning and development in building clinical capacitation is key in HIV-AIDS programmes.

#### 7.2.5.2.6 B6: Process approach

The International Organization for Standardization recognises a process as “*a set of interrelated or interacting activities that use inputs to deliver an intended result. Processes define interrelated activities and checks to deliver intended outputs*” (ISO 2015: 2). Organisational procedures are based on processes and these processes need to be understood in order to identify areas for enhancement and areas for improvement. It is for this reason that respondents were probed specifically on processes governing HIV-AIDS monitoring and evaluation activities. Responses are graphically demonstrated in Figure 7.21 below.

**Figure 7.21 Process approach**



Respondents were specifically asked to assess their level of agreement or disagreement on each of the following statements:

B6.1: Instructions and regulations are needed to govern every procedure of work. Sixty percent of respondents agreed with this statement, 33.33% of respondents remained neutral and 6.67% of respondents disagreed with this statement.

B6.2: Security, conformity and predictability define our work. Results show that 61.67% of respondents agreed with this statement, 36.67% of respondents remained neutral with this statement and 1.67% of respondents disagreed with this statement.

B6.3: Dissatisfaction is communicated without fear of information used at a later stage. Just over half of respondents agreed with this statement, 23.33 % of respondents remained neutral with this statement and 25.00% of respondents disagreed with this statement.

B6.4: Organizational structures with HIV-AIDS monitoring and evaluation functions are key to successful monitoring and evaluation frameworks. A significant 81.67 % of respondents agreed with this statement, 15.00 % of respondents remained neutral with this statement and 3.33 % of respondents disagreed with this statement.

**B6.5: Monitoring and evaluation frameworks will be a strategic component of the National Health Insurance plan.** An overwhelming 91.67 % of respondents agreed with this statement, 6.67% of respondents remained neutral with this statement and 3.33% of respondents disagreed with this statement.

**B6.6: A comprehensive budget should be allocated for monitoring and evaluation planning and implementation.** The majority of respondents agreed with this statement, 6.67% of respondents remained neutral and 3.33% of respondents disagreed with this statement.

The highest scoring statements were B6.5 and B6.6, which pertained to monitoring and evaluation frameworks forming an integral component of the National Health Insurance and having a comprehensive budget to execute it.

Chi-square testing was undertaken to further analyse data in this sub-section. Table 7.22 depicts scoring patterns.

**Table7.22 Scoring patterns: Process approach**

		Disagree		Neutral		Agree		Chi-Square
		Count	Row N %	Count	Row N %	Count	Row N %	p-value
Instructions and regulations are needed to govern every procedure of work	B6.1	4	6.7%	20	33.3%	36	60.0%	0.000
Security, conformity and predictability define our work	B6.2	1	1.7%	22	36.7%	37	61.7%	0.000
Dissatisfaction is communicated without fear of information used against at a later stage	B6.3	15	25.0%	14	23.3%	31	51.7%	0.011
Organizational structures with HIV-AIDS monitoring and evaluation functions are key to successful monitoring and evaluation frameworks.	B6.4	2	3.3%	9	15.0%	49	81.7%	0.000
Monitoring and evaluation frameworks will be a strategic component of the National Health Insurance plan	B6.5	1	1.7%	4	6.7%	55	91.7%	0.000

<b>A comprehensive budget should be allocated for monitoring and evaluation planning and implementation</b>	<b>B6.6</b>	<b>1</b>	<b>1.7%</b>	<b>4</b>	<b>6.7%</b>	<b>55</b>	<b>91.7%</b>	<b>0.000</b>
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The significance of the differences is tested and shown in Table 7.22. All p-values < 0.05 are significant. Statements that have a 100% response rate do not have a p-value because there is complete agreement. Data from this sub-section was also analysed through the extraction method with the principal component analysis. A rotation method, Varimax with Kaiser normalization, was utilised. Table 7.23 depicts the findings.

**Table 7.23 Rotated Component Matrix : Process Approach**

B6	Component	
	1	2
Instructions and regulations are needed to govern every procedure of work	0.865	0.199
Security, conformity and predictability define our work	0.887	0.197
Dissatisfaction is communicated without fear of information used against at a later stage	0.825	-0.089
Organizational structures with HIV-AIDS monitoring and evaluation functions are key to successful monitoring and evaluation frameworks.	0.383	0.744
Monitoring and evaluation frameworks will be a strategic component of the National Health Insurance plan	0.014	0.887
A comprehensive budget should be allocated for monitoring and evaluation planning and implementation	0.006	0.897

It is noted that the variables that constituted the remaining sections loaded along 2 or 3 components (sub-themes). This means that respondents identified different trends within the section. These trends are: capacity building of a comprehensive budget; monitoring and evaluation frameworks; and organizational structures with HIV-AIDS monitoring and evaluation functions, all in the context of the National Health Insurance (NHI).The white paper on the NHI clearly stipulates that the NHI will bring

about process control and standard operation procedures to monitor and evaluate all health facilities within South Africa. The South African government has estimated that the NHI will cost R256-billion by 2025 (Mkhwanazi, Cape Times, 2016:3).

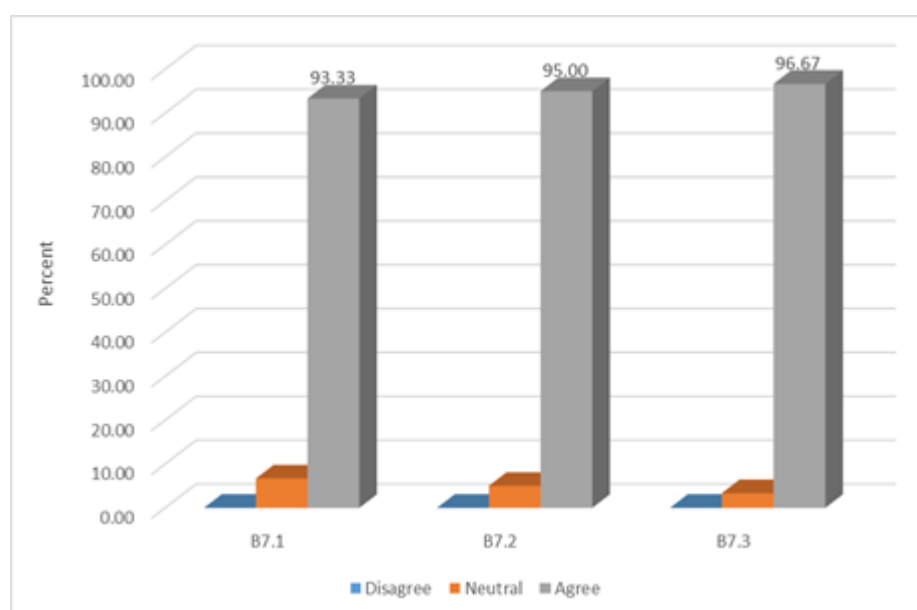
The South African Office of Health Standards Compliance (OHSC) has become the key player in the South African health industry in trying to attain the goals of the NHI implementation. The cornerstone of NHI implementation will be based on monitoring and evaluation processes and procedures that will be rolled out across all health facilities and in particular, in HIV-AIDS programmes across South Africa. In preparation for NHI implementation, audits were conducted across South African health facilities to assess their readiness for the NHI. Among the 1 427 facilities inspected between 2011-2015, 89 of them scored a pass mark of 70 percent or more. Facilities fell short on matters ranging from the availability of medicines to infection control to monitoring and evaluation. Improving the quality of the public health system is a vital part of the South African government's preparation for NHI (Kahn, Business Day 2016:7). However, data such as this reveals that the almost 4 000 South African public health facilities have a long way to go in order to reach accreditation for representation within the NHI. Innovative tools to assist with daily organisational and operational activities at these facilities are integral for their success. Organizational structures with HIV-AIDS monitoring and evaluation functions are key to successful monitoring and evaluation frameworks. Standard operating procedures and approaches need to govern daily work practices to allow employees to reach daily, weekly and monthly targets in achieving goals for HIV-AIDS monitoring and evaluation activities. A comprehensive budget should be allocated for monitoring and evaluation planning and implementation of activities paying special attention to bi-annual and ad hoc procedural changes. Given the imminent implementation of the National Health Insurance in South Africa, it is imperative that HIV-AIDS programmes finely tune and amend their HIV-AIDS monitoring and evaluation process and procedures to allow for a seamless merger of private, public and NGO healthcare sectors. It will be at that point that the true utility value of HIV-AIDS monitoring and evaluation resource sharing and tool sharing will be realised. The process approach to clinical management in the HIV-AIDS environment focuses on integrating, aligning and linking processes effectively to achieve planned goals and objectives

(International Organisation of Standards 2016).

#### 7.2.5.2.7 B7: Customer focus

Customer focus in the healthcare industry is fast becoming a concept for organisations to develop and enhance as it carries both big rewards and the risk of big penalties. Customer focus has been entrenched in the various healthcare sectors in different forms and as such, was included here to allow respondents to express their level of agreement or disagreement with the implementation of aspects of maintaining customer focus in private sector HIV-AIDS programmes. These responses are graphically represented in Figure 7.24 below.

**Figure 7.24 Customer focus**



Respondents were specifically asked to assess their level of agreement or disagreement with each of the following statements:

B7.1: Management should motivate individuals to enhance service provision towards customer satisfaction. A significant 93.33 % of respondents agreed with this

statement, 6.67% of respondents remained neutral with this statement and no respondents disagreed with this statement.

B7.2: Client-centricity should be the core focus of HIV-AIDS programmes. A significant 95.00 % of respondents agreed with this statement, 5.00% of respondents remained neutral with this statement and no respondents disagreed with this statement.

**B7.3: The Batho Pele principles can be adapted for use in non-government sector HIV-AIDS programmes.** An overwhelming 96.67 % of respondents agreed with this statement, 3.33% of respondents remained neutral and no respondents disagreed with this statement.

The highest scoring statement (B7.3) was shown in bold and pertained to the Batho Pele principles, which have long been established in the public sector and should start being rolled out in the NGO and private healthcare sectors as well.

Chi-square testing was undertaken to further analyse data in this sub-section. Table 7.25 depicts scoring patterns.

**Table 7.25 Scoring patterns: customer focus**

		Disagree		Neutral		Agree		Chi Square
		Count	Row N %	Count	Row N %	Count	Row N %	p-value
Management should motivate individuals to enhance service provision toward customer satisfaction.	B7.1	0	0.0%	4	6.7%	56	93.3%	0.000
Client -Centricity should be the core focus of HIV-AIDS programmes	B7.2	0	0.0%	3	5.0%	57	95.0%	0.000
The Batho Pele principles can be adapted for use in non-government sector HIV-AIDS programmes	B7.3	0	0.0%	2	3.3%	58	96.7%	0.000

The significance of the differences is tested and shown in table 7.25 above. All p-values < 0.05 are significant. Statements that have a 100% response rate do not have a p-value because there is complete agreement.

Data from this sub section was also analysed through the extraction method with the principal component analysis. A rotation method, Varimax with Kaiser normalisation, was utilised. Table 7.26 depicts the findings.

**Table 7.26 Component matrix: Customer focus**

B7	Component
	1
Management should motivate individuals to enhance service provision toward customer satisfaction.	0.797
Client -Centricity should be the core focus of HIV-AIDS programmes	0.945
The Batho Pele principles can be adapted for use in non-government sector HIV-AIDS programmes	0.919

These included enhancing service provision through customer satisfaction and client-centricity. The statement on the Batho Pele principles (discussed in Chapter Four) exhibited the highest level of agreement. Currently, these principles are implemented solely in the South African public health sector. Adopting these principles for use in the private sector would be an excellent example of public-private partnering. By leveraging the strengths from the public health sector regarding the use and experience of Batho Pele, the private sector can develop and grow the principles into a model that is applicable in the private sector.

The Batho Pele principles embody key elements of quality healthcare. Very few HIV-AIDS programmes have a clinical quality management plan including quality



principles which define a quality programme's strategic direction and provide a blueprint for upcoming improvement activities for the HIV-AIDS programme. The repercussions of managing an HIV-AIDS programme without an integral dedicated clinical quality plan can have several consequences. Failure to develop a clinical quality plan in an HIV-AIDS programme will leave the programme with a lack of clinical control and clinical processes, ultimately leading to unregulated HIV-AIDS care with sub-optimal treatment realisation for patients. This in turn may result in medico-legal consequences with a loss of staffing and loss of patients. This research study proposed to develop clear monitoring and evaluation processes to provide a continuum of care and support services that promotes optimal health, decreases HIV transmission, eliminates healthcare disparities and promotes consumer empowerment and self-determination.

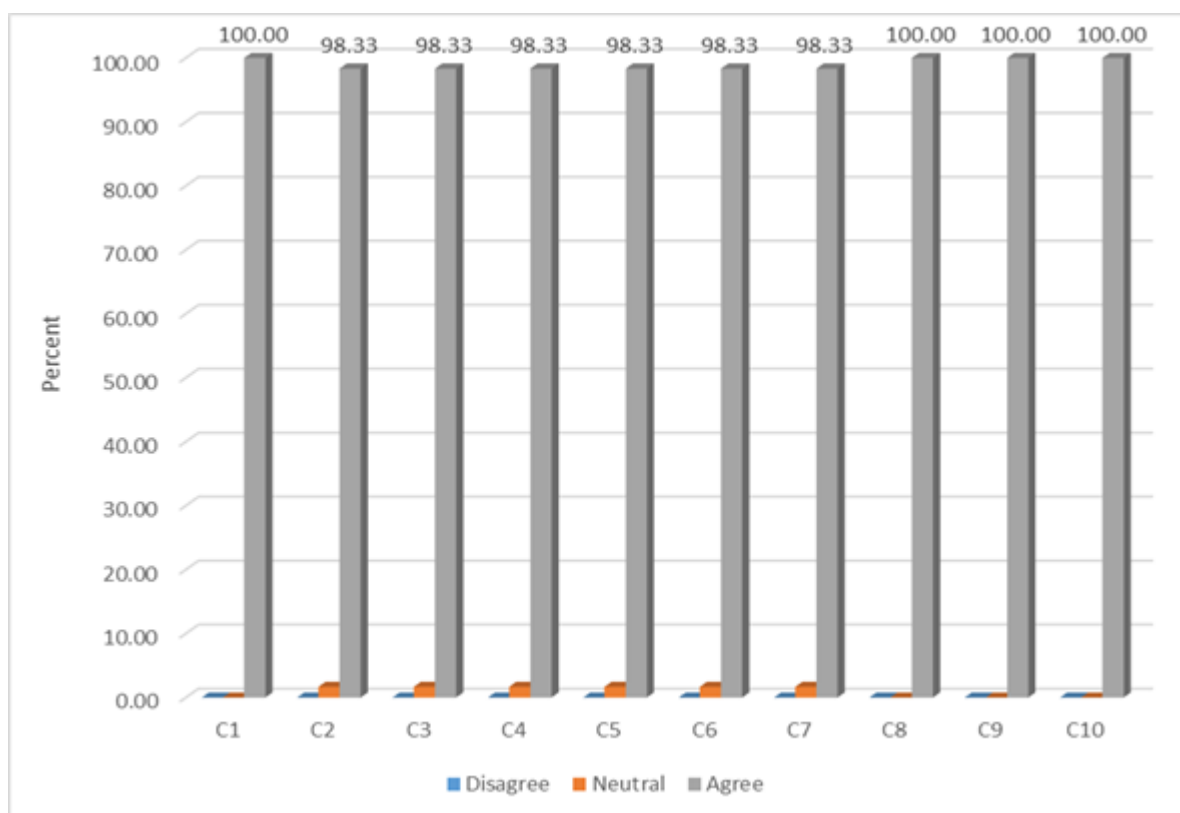
The concept of placing the client or customer at the centre of the business should be the core focus of HIV-AIDS programmes where employees need to be motivated to continually improve efforts in attaining customer satisfaction. The concept of client-centricity is placing customers at the core focus point of service delivery. This allows healthcare organisations to recognise opportunities for growth and to create a unique customer experience. In the private healthcare sector, this equates to more market share and larger profit margins ([www.momentum.co.za](http://www.momentum.co.za)). The concept of the Batho Pele principles, although solely practised in the public sector, needs to be revisited and revitalised and also re-engineered with components of the quality management systems frameworks, such as ISO accreditation for implementation across all healthcare sectors in the public, private and NGO sectors. Holistic client management and wellness is especially relevant in the HIV-AIDS arena and is highly recommended to ensure a seamless customer interaction.

#### **7.2.5.3 Section C: Core indicators**

This research study reviewed the use of HIV-AIDS indicators for impact and outcome in HIV-AIDS populations intended for use and signalled their importance as the core component of monitoring and evaluation frameworks. Given that an HIV-AIDS monitoring and evaluation framework for public sector HIV-AIDS programmes remains elusive, respondents were asked to guide the development of core indicators

for HIV-AIDS programmes in the private sector. These responses are shown in Figure 7.27 below.

**Figure 7.27 Core indicators**



Respondents were specifically asked to assess their level of agreement or disagreement on each of the following statements:

**C1: All monitoring and evaluation staff should review program documents with stated goals and objectives prior to programme indicator compilation.** All respondents agreed with this statement.

C2: Input indicators should cover resource allocations and human capital data. A significant 98.33 % of respondents agreed with this statement, 1.67% of respondents remained neutral and no respondents disagreed with this statement.

C3: Process indicators should cover quality of service and service statistics. The majority of respondents agreed with this statement, 1.67% of respondents remained neutral with this statement and no respondents disagreed with this statement.

C4: Output indicators should provide data on estimates of service coverage. A significant 98.33 % of respondents agreed with this statement, 1.67% of respondents remained neutral and no respondents disagreed with this statement.

C5: Outcome indicators should provide data on behaviour change/morbidity. An overwhelming 98.33 % of respondents agreed with this statement, 1.67% of respondents remained neutral and no respondents disagreed with this statement

C6: Impact evaluation should provide data on risk, prevention risks and population level impact. A significant 98.33 % of respondents agreed with this statement, 1.67% of respondents remained neutral and no respondents disagreed with this statement.

C7: Indicators should be devised and focused on what the programme should achieve. The majority of respondents agreed with this statement, 1.67% of respondents remained neutral and no respondents disagreed with this statement.

**C8: Indicators should be adaptive for diverse settings.** All respondents agreed with this statement.

**C9: Indicators should ensure that key factors that may influence program implementation and success are identified.** All respondents agreed with this statement.

**C10: Availability of monitoring and evaluation reference materials is a special strength.** All respondents agreed with this statement.

.The highest scoring statements (C1, C8, C9, and C10) pertained to indicators being developed on risk, prevention of risks and population level impact in line with programme goals and objectives that are achievable and should be adaptable to diverse settings. The highest scoring statements are shown in bold.

Chi-square testing was undertaken to further analyse data in this sub-section. Table 7.28 depicts scoring patterns.

**Table 7.28 scoring patterns: Core indicators**

		Disagree		Neutral		Agree	
		Count	Row N %	Count	Row N %	Count	Row N %
<b>All monitoring and evaluation staff should review program documents with stated goals and objectives prior to programme indicator compilation</b>	<b>C1</b>	<b>0</b>	<b>0.0%</b>	<b>0</b>	<b>0.0%</b>	<b>60</b>	<b>100.0%</b>
<b>Input indicators should cover resource allocations and human capital data</b>	<b>C2</b>	<b>0</b>	<b>0.0%</b>	<b>1</b>	<b>1.7%</b>	<b>59</b>	<b>98.3%</b>
<b>Process indicators should cover quality of service, and service statistics</b>	<b>C3</b>	<b>0</b>	<b>0.0%</b>	<b>1</b>	<b>1.7%</b>	<b>59</b>	<b>98.3%</b>
<b>Output indicators should provide data on estimates of service coverage</b>	<b>C4</b>	<b>0</b>	<b>0.0%</b>	<b>1</b>	<b>1.7%</b>	<b>59</b>	<b>98.3%</b>
<b>Outcome indicators should provide data on behaviour change/morbidity</b>	<b>C5</b>	<b>0</b>	<b>0.0%</b>	<b>1</b>	<b>1.7%</b>	<b>59</b>	<b>98.3%</b>

Impact evaluation should provide data on risk, prevention risks and population level impact	C6	0	0.0%	1	1.7%	59	98.3%
Indicators should be devised and focused on what the programme should achieve	C7	0	0.0%	1	1.7%	59	98.3%
Indicators should be adaptive for diverse settings	C8	0	0.0%	0	0.0%	59	100.0%
Indicators should ensure that key factors that may influence program implementation and success are identified	C9	0	0.0%	0	0.0%	60	100.0%
Availability of monitoring and evaluation reference materials is a special strength	C10	0	0.0%	0	0.0%	60	100.0%

All p-values < 0.05 are significant. Statements that have 100% response rate do not have a p-value because there is complete agreement. Data from this sub-section was also analysed through the extraction method with the principal component analysis. A rotation method, Varimax with Kaiser normalisation, was utilised. Table 7.29 depicts the findings.

Table 7.29 Component matrix: Core indicators

C	Component
	1
All monitoring and evaluation staff should review program documents with stated goals and objectives prior to programme indicator compilation	0.774
Input indicators should cover resource allocations and human capital data	0.851

Process indicators should cover quality of service, and service statistics	0.842
Output indicators should provide data on estimates of service coverage	0.841
Outcome indicators should provide data on behaviour change/morbidity	0.821
Impact evaluation should provide data on risk, prevention risks and population level impact	0.790
Indicators should be devised and focused on what the programme should achieve	0.851

The bold statements scored the highest and highlighted that HIV-AIDS programme indicators should be adapted for diverse settings, should be risk rated and should be well defined in order to reach the goals.

The major considerations for HIV-AIDS indicators development include the reduction of new HIV infections, improving access to and outcomes of HIV-AIDS care and reduction in HIV-AIDS-related health disparities. Appropriate indicators allow HIV-AIDS programmes to achieve more co-ordination, to promote equitable resource allocation and to allow for streamlined and standardized data collection. HIV-AIDS indicators need to be correctly identified in order to be useful to evaluate programmes and re-allocate resources for maximal impact (Forsythe 2011:2). This research study sought to promote and prioritize the strategic use of information to improve the quality and outcomes of HIV-AIDS programmes with regard to treatment, wellness and care. From a clinical operations point of view, a monitoring and evaluation HIV-AIDS framework should utilise cross-sectional indicators to quantify the number of people diagnosed, linked to care, retained in care, on ART and with a suppressed viral load, as a proportion of the estimated number of people that the HIV-AIDS programme provides service delivery to. Data from HIV-AIDS programme core indicators provide critical information on the viability of the HIV-AIDS programme together with the impact of the nature of the HIV-AIDS interventions that the programme offers. Contextually relevant and culturally appropriate indicators should be utilised in the development of HIV-AIDS monitoring and evaluation framework development. These indicators should be tailor made for the environment within the HIV-AIDS framework and adapted for the surroundings of

the intended monitoring and evaluation tasks or activities. This will allow for accurate data collection to ensure data integrity. These indicators should be adapted for the environments in which the HIV-AIDS programmes function. Burman, Aphane and Delobelle (2015:13) maintain that the HIV-AIDS arena provides a dynamic context, one that the HI virus is able to flourish in and suggests that a qualitative shift in the prevention, treatment and clinical management of HIV-AIDS adapt and change focus to contribute to reducing the overall burden of HIV-AIDS.

A comprehensive budget should be allocated for HIV-AIDS monitoring and evaluation planning and implementation. All monitoring and evaluation staff should review program documents with stated goals and objectives prior to programme indicator compilation. The availability of monitoring and evaluation reference materials is a special strength. The necessary intellectual and human capital resources should be sourced to ensure that requirements for core indicator development in HIV-AIDS monitoring and evaluation are met. Indicators should ensure that key factors that may influence program implementation and success are identified. The South African public healthcare HIV-AIDS sector provides a clear demonstration that there remains a large gap between healthcare need and healthcare resource availability. As the HIV-AIDS epidemic evolves into a chronic disease burden, more affected populations are beginning to live longer with the disease, placing more undue stress onto an already burdened healthcare system. Bautista-Arredondo, Gadsden, Harris and Bertozzi (2008:22) suggest that optimizing resource allocation for HIV-AIDS programmes requires management through an analytical framework consisting of constant funding and universal access to HIV-AIDS treatment and care.

In order to continually improve and evolve to meet HIV-AIDS monitoring and evaluation activities and programme goals, the quality of service needs to be evaluated at each step of the patient-client-customer interface. Quality of service should be embodied in all categories of indicators including input, process, output, outcome and impact. Furthermore, these need to be based on the environment in which the HIV-AIDS programmes function. Quality management systems have not been readily adopted in many healthcare organisations due to cost, lack of resources and lack of skills. The World Health Organisation (2016) has recently acknowledged

the importance of an organization-wide approach to quality management for implementation in healthcare and particularly in HIV-AIDS organisations. However, a contextually relevant and culturally appropriate quality management system for the management of HIV-AIDS programmes locally and globally remains at larger.

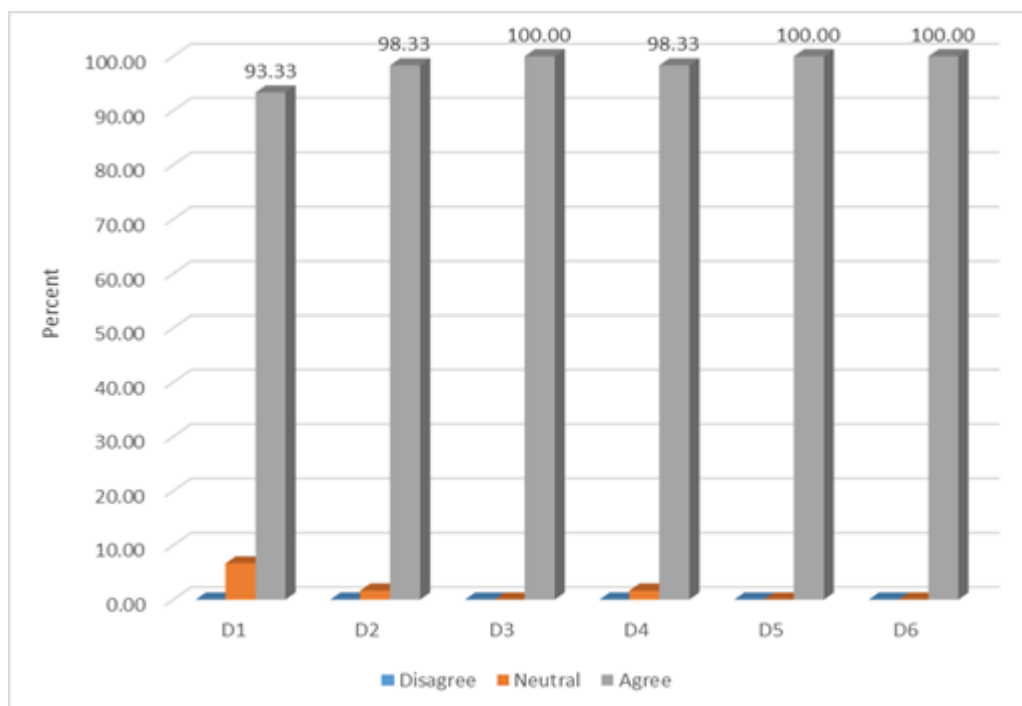
In order to attain appropriate data that is accurate and relevant, it is important to get daily, weekly, monthly and annual rates of the extent of reach or coverage of HIV-AIDS monitoring and evaluation indicators. This will allow for forecasting to ensure coverage areas are being appropriately addressed in relation to the burden of disease in those areas. HIV-AIDS incidence and prevalence data guides the amount of resources required in specific areas. High areas of HIV-AIDS prevalence and incidence signal areas of greater burden of disease, thus necessitating more resources to accurately quantify, analyse and profile the HIV-AIDS epidemic. Coverage once again plays a role to ensure that these areas of greater disease burden are subsequently identified and accurately detailed when HIV-AIDS monitoring and evaluation data indicator analysis occurs, in order to prevent issues of over estimation or under estimation of data. Family Health international (2015), as a key clinical research organisation in the global fight against HIV-AIDS, recognises the importance of encouraging the inclusion of key and vulnerable populations in indicator analysis to allow better and more representative sampling for data collection.

#### **7.2.5.4 Section D: HIV-AIDS-related operational research activities**

The benefits of HIV-AIDS-related operational research activities have only recently begun to come to the fore. Therefore, respondents were probed on current HIV-AIDS-related operational research activities with a view to future implementation of HIV-AIDS-related operational research activities for this organisation. These responses are graphically demonstrated in Figure 7.30 below.



**Figure 7.30 HIV-AIDS-related operational research activities**



Respondents were specifically asked to assess their level of agreement or disagreement on each of the following statements:

**D1:** Setting the research agenda is an important starting point for operational research activities. A significant 93.33 % of respondents agreed with this statement, 6.67% of respondents remained neutral and no respondents disagreed with this statement.

**D2:** Expanding support for operational research activities is key to successful clinical management treatments. An overwhelming 98.33 % of respondents agreed with this statement, 1.67% of respondents remained neutral and no respondents disagreed with this statement.

**D3: Developing common tools are imperative to operational research activities.** All respondents agreed with this statement.

D4: HIV-AIDS operational research requires a significant expansion of resources. The majority of respondents agreed with this statement, 1.67% of respondents remained neutral and no respondents disagreed with this statement.

**D5: HIV-AIDS-related operational research activities strengthen links to policy.** All respondents agreed with this statement.

**D6: HIV-AIDS-related operational research activities improve collaboration among health programmes.** All respondents agreed with this statement.

The highest scoring statements (D3, D5 and D6) pertained to HIV-AIDS-related operational research activities, which should be linked to policy with proper tools in order to improve collaboration among health programmes. These have been made bold for ease of identification

Chi-square testing was undertaken to further analyse data in this sub-section. Table 7.31 depicts scoring patterns.

**Table 7.31 Scoring patterns: HIV-AIDS related operational research activities**

		Disagree		Neutral		Agree		Chi Square
		Count	Row N %	Count	Row N %	Count	Row N %	p-value
Setting the research agenda is an important starting point for operational research activities	D1	0	0.0%	4	6.7%	56	93.3%	0.000
Expanding support for operational research activities is key to successful clinical operational management treatments	D2	0	0.0%	1	1.7%	59	98.3%	0.000
Developing common tools are imperative to research activities	D3	0	0.0%	0	0.0%	60	100.0%	
HIV-AIDS operational research requires significant expansion of resources.	D4	0	0.0%	1	1.7%	59	98.3%	0.000
HIV-AIDS related operational research activities strengthen links to policy	D5	0	0.0%	0	0.0%	60	100.0%	
HIV-AIDS related operational research activities improve collaboration among health programs	D6	0	0.0%	0	0.0%	60	100.0%	

All p-values < 0.05 are significant. Statements that have a 100% response rate do not have a p-value because there is complete agreement. Table 7.32 depicts the findings.

**Table 7.32 Rotated component matrix : HIV-AIDS-related operational research activities**

D	Component	
	1	2
Setting the research agenda is an important starting point for operational research activities	0.753	0.189
Expanding support for operational research activities is key to successful clinical management treatments	0.824	-0.069
Developing common tools are imperative to operational research activities	0.480	0.270
HIV-AIDS operational research requires significant expansion of resources.	0.692	0.211
HIV-AIDS related operational research activities strengthen links to policy	0.126	0.867
HIV-AIDS related operational research activities improve collaboration among health programs	0.180	0.898

Operations research is gaining increasing recognition in the management of global and local health programmes. This research provides research techniques which constantly guide healthcare programme implementation. Operational research modulates inputs and processes into the healthcare programme cycle to produce optimal gains in achieving programme targets and goals. Operations research in the HIV-AIDS healthcare paradigm helps programme managers to identify problems and troubleshoot ways and means to address these issues.

Operational research has been increasingly recognized as vital to the strengthening of health programmes. While the concept of operational research as an essential tool for health programmes is widely accepted, challenges to the successful implementation of comprehensive operational research activities are numerous (Naidoo, Smuts, Claassens, Rusen, Enarson and Beyers 2013:8). The concept of HIV-AIDS-related operational research is a relatively new but a rather important one, especially for South Africa where the disease burden of HIV-AIDS is the highest in

the world. It is to this end that HIV-AIDS programmes begin to amend HIV-AIDS programme monitoring and evaluation activities to include HIV-AIDS-related operational research on the research agenda. This research agenda needs to be adopted by top management and shared with HIV-AIDS programme employees to allow for the necessary buy-in, dedication and commitment. Given that HIV-AIDS has entered its third decade with little signs of recession, it has become important for the global health fraternity to reassess, re-engineer and re-organise how HIV-AIDS management has taken place in the past. HIV-AIDS-related operational research provides a robust body of evidence and high-quality patient services through the adoption of best practices. Ultimately, operational research in this context seeks to strengthen the capacity of HIV-AIDS organisations towards more effective and efficient patient management (Population Council 2016).

Expanding support for operational research activities is pivotal to successful clinical management treatments. HIV-AIDS operational research requires a significant expansion of resources. HIV-AIDS-related operational research activities strengthen links to policy. HIV-AIDS-related operational research activities improve collaboration among health programmes. With an HIV-AIDS disease burden that is so high in South Africa, collaborations between multi sector stakeholders are welcomed and valued as vital building blocks to develop HIV-AIDS-related operational monitoring and evaluation activities. The World Health Organisation (2016) has recently embraced efforts to support HIV-AIDS-related operational research activities to strengthen HIV-AIDS programmes globally. However, translation of these high level strategic documents towards implementation guidelines and frameworks still needs to be under per country and per healthcare sector.

Developing common tools are imperative to HIV-AIDS operational research activities to streamline work activities and to attain the best results possible from HIV-AIDS programmes. South Africa has a well-established multi sectoral response to HIV-AIDS with various public, private and NGO programmes dedicated to the on-going prevention, treatment and wellness of HIV-AIDS. The issue is the lack of integration and collaboration between these programmes. Enhanced communication and collaborative efforts will allow for more resource sharing (e.g. tools) and intellectual capital sharing, in turn allowing for a more homogenised response to HIV-AIDS in

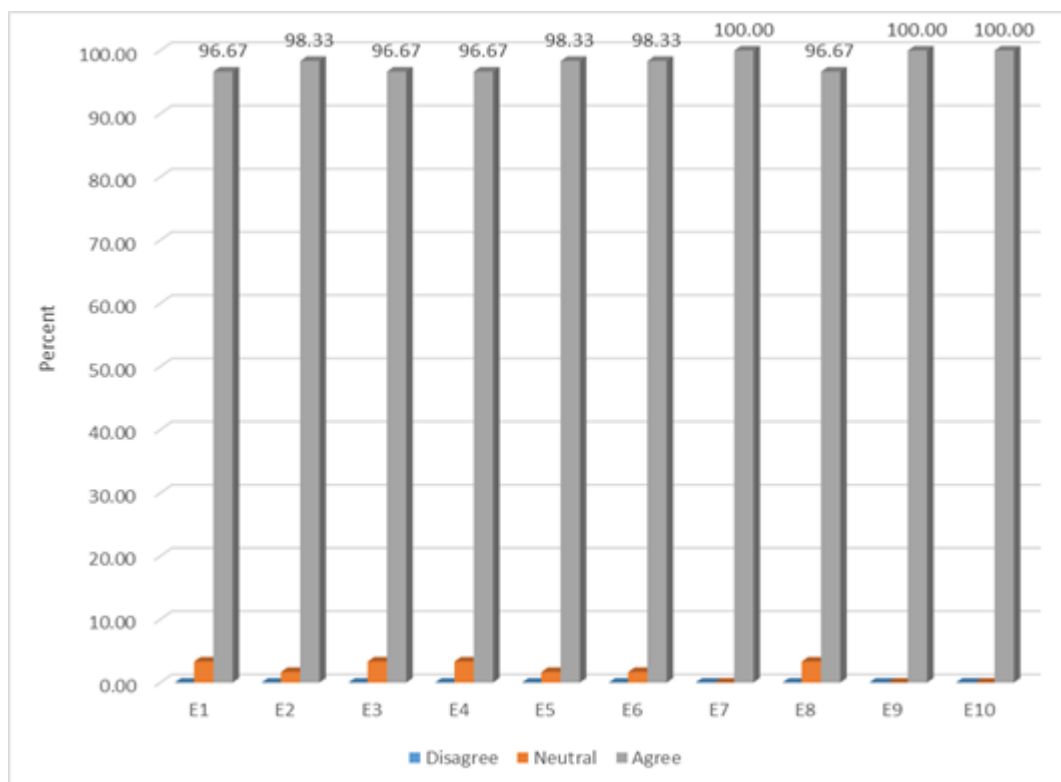
South Africa. Although HIV-AIDS operational research activities have become recognised as important developments to assist in HIV-AIDS programme management, the tools, guidelines and supportive materials have failed to be devised to assist programme management. These tools need to be appropriate and relevant in achieving the true value that is aimed for, which include:

- Developing common tools which are imperative to operational research activities;
- HIV-AIDS-related operational research activities strengthen links to policy; and
- HIV-AIDS-related operational research activities improve collaboration amongst health programs.

#### **7.2.5.5 Section E: Data management**

Data management is a key concept of an HIV-AIDS monitoring and evaluation frameworks development and implementation. Respondents were queried in depth on these aspects in order to ascertain their level of involvement and needs analysis for successful data management incorporation into a proposed organisational HIV-AIDS monitoring and evaluation framework development and implementation. These are graphically represented in Figure 7.33 below.

**Figure 7.33 Data management**



Respondents were specifically asked to assess their level of agreement or disagreement on each of the following statements:

E1: Data dissemination utilizing monitoring and evaluation reports should determine methods by which data will be collected, analysed and reported. A significant 96.67

% of respondents agreed with this statement, 3.33% of respondents remained neutral and no respondents disagreed with this statement.

E2: Capacity for collecting and using data should be assessed prior to project start up. A significant 98.33 % of respondents agreed with this statement, 1.67% of respondents remained neutral and no respondents disagreed with this statement.

E3: Monitoring and evaluation data should inform research agendas. The majority of respondents agreed with this statement, 3.33% of respondents remained neutral and no respondents disagreed with this statement.

E4: Data management should assess procedures for processing, storing and managing monitoring and evaluation data. A significant 96.67 % of respondents agreed with this statement, 3.33% of respondents remained neutral no respondents disagreed with this statement.

E5: Data managers should understand program goals and objectives. A significant 98.33 % of respondents agreed with this statement, 1.67% of respondents remained neutral and no respondents disagreed with this statement.

E6: Monitoring and evaluation plans should move away from a reliance on paper based data collection. A significant 98.33 % of respondents agreed with this statement, 1.67% of respondents remained neutral and no respondents disagreed with this statement.

**E7: Data managers should identify user needs and perspectives.** All respondents agreed with this statement.

E8: System management improvement is a key aspect of building sound monitoring and evaluation plans. A significant 96.67 % of respondents agreed with this statement, 3.33% of respondents remained neutral and no respondents disagreed with this statement.

**E9: Technological innovation should revolutionise monitoring and evaluation data collection.** All 100 % of the respondents agreed with this statement.



**E10: Prior to implementing new data management techniques, data management should learn about existing data collection systems and quality.**

All 100 % of the respondents agreed with this statement.

The highest scoring statements, shown in bold (E7, E9 and E10) were that data managers should be trained and equipped and that key emphasis should be paid to technological advancements of data systems. Chi-square testing was undertaken to further analyse data in this sub-section. Table 7.34 depicts scoring patterns.

**Table 7.34 scoring patterns: Data management**

		Disagree		Neutral		Agree		Chi Square
		Count	Row N %	Count	Row N %	Count	Row N %	p-value
<b>Data dissemination utilizing monitoring and evaluation reports should determine methods by which data will be collected, analysed and reported</b>	<b>E1</b>	<b>0</b>	<b>0.0%</b>	<b>2</b>	<b>3.3%</b>	<b>58</b>	<b>96.7%</b>	<b>0.000</b>
<b>Capacity for collecting and using data should be assessed prior to project start up</b>	<b>E2</b>	<b>0</b>	<b>0.0%</b>	<b>1</b>	<b>1.7%</b>	<b>59</b>	<b>98.3%</b>	<b>0.000</b>
<b>Monitoring and evaluation data should inform research agendas</b>	<b>E3</b>	<b>0</b>	<b>0.0%</b>	<b>2</b>	<b>3.3%</b>	<b>58</b>	<b>96.7%</b>	<b>0.000</b>
<b>Data management should assess procedures for processing, storing and managing monitoring and evaluation data</b>	<b>E4</b>	<b>0</b>	<b>0.0%</b>	<b>2</b>	<b>3.3%</b>	<b>58</b>	<b>96.7%</b>	<b>0.000</b>
<b>Data managers should understand program goals and objectives</b>	<b>E5</b>	<b>0</b>	<b>0.0%</b>	<b>1</b>	<b>1.7%</b>	<b>59</b>	<b>98.3%</b>	<b>0.000</b>

<b>Monitoring and evaluation plans should move away from a reliance on paper based data collection</b>	<b>E6</b>	<b>0</b>	<b>0.0%</b>	<b>1</b>	<b>1.7%</b>	<b>59</b>	<b>98.3%</b>	<b>0.000</b>
<b>Data managers should identify user needs and perspectives</b>	<b>E7</b>	<b>0</b>	<b>0.0%</b>	<b>0</b>	<b>0.0%</b>	<b>60</b>	<b>100.0%</b>	
<b>System management improvement is a key aspect of building sound monitoring and evaluation plans</b>	<b>E8</b>	<b>0</b>	<b>0.0%</b>	<b>2</b>	<b>3.3%</b>	<b>58</b>	<b>96.7%</b>	<b>0.000</b>
<b>Technological innovation should revolutionise monitoring and evaluation data collection</b>	<b>E9</b>	<b>0</b>	<b>0.0%</b>	<b>0</b>	<b>0.0%</b>	<b>60</b>	<b>100.0%</b>	
<b>Prior to implementing new data management techniques data management should learn about existing data collection systems and quality</b>	<b>E10</b>	<b>0</b>	<b>0.0%</b>	<b>0</b>	<b>0.0%</b>	<b>60</b>	<b>100.0%</b>	

The significance of the differences is tested and shown in the table above. All p-values < 0.05 are significant. Statements that have a 100% response rate do not have a p-value because there is complete agreement.

Data from this sub section was also analysed through the extraction method with the principal component analysis. A rotation method, Varimax with Kaiser normalisation, was utilised. Table 7.35 depicts the findings.

**Table 7.35 Rotated component matrix : Data management**

E	Component		
	1	2	3
Data dissemination utilizing monitoring and evaluation reports should determine methods by which data will be collected, analysed and reported	0.598	0.397	0.356
Capacity for collecting and using data should be assessed prior to project start up	0.313	0.481	0.502
Monitoring and evaluation data should inform research agendas	0.493	0.177	0.560
Data management should assess procedures for processing, storing and managing monitoring and evaluation data	0.603	0.117	0.556
Data managers should understand program goals and objectives	0.773	0.028	0.174
Monitoring and evaluation plans should move away from a reliance on paper based data collection	0.734	0.371	-0.109
Data managers should identify user needs and perspectives	0.245	0.862	-0.130
System management improvement is a key aspect of building sound monitoring and evaluation plans	0.210	0.774	0.295
Technological innovation should revolutionise monitoring and evaluation data collection	-0.095	0.604	0.625
Prior to implementing new data management techniques data management should learn about existing data collection systems and quality	0.102	-0.022	0.796

These trends pertain to innovative approaches to data management, utilising key goals and objectives to inform data management plans and availing accurately trained resources to conduct data management activities in HIV-AIDS programmes. The World Health Organisation (WHO) has developed significant data training

manuals in an attempt to capacitate HIV-AIDS data managers locally and globally.. However, in reality, this never materialises due to the huge demand for assistance and minimal supply of assistance from in-country resources (World Health Organisation 2015). The World Health Organisation needs to urgently adopt a “train the trainer” approach. This method of information sharing will allow key personnel from key HIV-AIDS organisations within the various healthcare sectors to attain the necessary skills and then allow for the transfer of these skills to others in their organisations and other programmes. Key issues for data management transfer of skills include the provision of data management technical assistance, support development and collation of data management functions; and complete import, verification and validation of all available data (World Health Organisation 2015). In this manner, the learning continues across all HIV-AIDS programmes and the continuum of learning and development is ensured.

However all data management is not always effective. The South African public healthcare sector faces significant challenges with data management across HIV-AIDS programmes. The goal of HIV-AIDS data management in the South African HIV-AIDS programme is to provide deliberate, accurate data with minimal disparities and fluctuations in order to generate health outcomes to enhance HIV-AIDS-related patient care (South Africa 2015). Data management aims to achieve a more co-ordinated national response towards streamlining and standardizing data collection (Sebelius 2011:2). Data challenges relevant to the South African HIV-AIDS programme include the absence of common data types, limited financial resources and limited staff with minimal training and skill sets. Lessons need to be learnt from successful programmes across the world in order to leverage their successes The USA HIV-AIDS programme has built successful data management tools and processes to enhance their data collection, collation and data analyses (Centre for Disease Control 2015). These include the formation of strong public-private partnering to share resources and up-skill mandatory key personnel. This also includes the development of standardised tools with common definitions and data metrics to allow uniform data collection. This resulted in a standardized data collection procedure which is essential for successful quality improvement through a monitoring and evaluation HIV-AIDS framework. Data management should assess

procedures for processing, storing and managing monitoring and evaluation data. Data dissemination utilizing monitoring and evaluation reports should determine methods by which data will be collected, analysed and reported. Prior to implementing new data management techniques, data management should learn about existing data collection systems and quality. Systematic data collection, collation, processing, analysis and interpretation should form part of HIV-AIDS programme goals and objectives. Data managers should understand programme goals and objectives. Data managers should identify user needs and perspectives regarding data management and utilise this to enhance data management qualities in HIV-AIDS management programmes, with specific relevance to HIV-AIDS monitoring and evaluation activities.

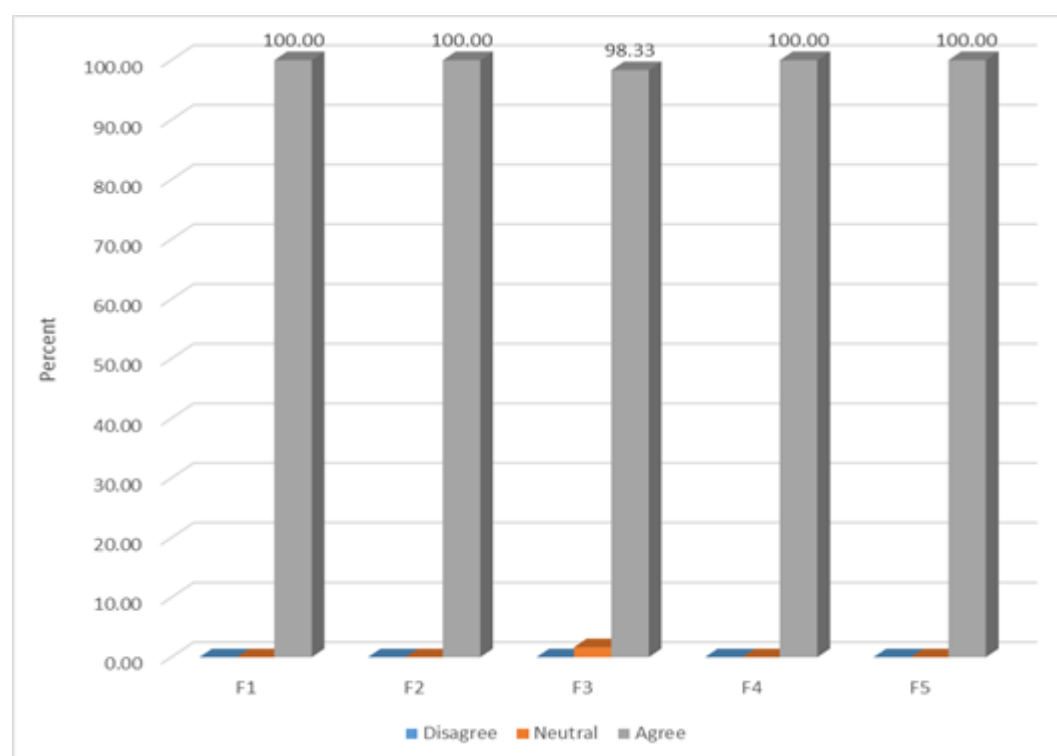
System management improvement is a key aspect of building sound monitoring and evaluation plans. Systems need to be analysed in order to identify strengths, weaknesses, opportunities and threats. System gap analysis needs to be undertaken to identify where the deficiencies are with regard to data management. Necessary data management processes must ensue to allow for deficiencies to be rectified. On-going maintenance of systems must be a sustainable process based on data management standard operating procedures to allow for efficacious attainment of data management goals in the field of HIV-AIDS monitoring and evaluation activities. The World Health Organisation (2016) defines integrated clinical service delivery as “the organization and management of health services so that people get the care they need, when they need it, in ways that are user friendly to achieve the desired results and provide value for money”. Technological innovation should revolutionise monitoring and evaluation data collection. The rapid pace at which technology is changing in today's world is indication enough that innovative technologies are urgently required to automate previously manual processes in order to work smarter. Digitally enhanced and technologically innovative efforts in healthcare is a relatively new concept but one that is fast becoming very popular. Digital interfaces allow for less reliance on paper based data, thus allowing for more effective and quicker analysis of real time data. Dr Margaret Chan, the Director-General of the World Health Organization, in her introductory remarks at the 2015 high-level meeting on HIV-AIDS, remarked on innovation and new technologies in the global fight against

HIV-AIDS. She stated: “Doing more of the same is not enough. We need innovation urgently. The world needs to accelerate the two-pronged innovation that has been the hallmark of the HIV-AIDS response: innovation to deliver existing interventions and innovation for new tools to do more behind this devastating epidemic” (Chan 2015).

#### 7.2.5.6 Section F: HIV-AIDS programmes’ stakeholder management

Stakeholder management is a critical component to the successful delivery of an HIV-AIDS programme. In this section, respondents were asked to provide their level of agreement or disagreement on approaches to stakeholder management for this organisation. These responses are shown in Figure 7.36 below.

**Figure 7.36 HIV-AIDS programmes’ stakeholder management**



Respondents were specifically asked to assess their level of agreement or disagreement on each of the following statements:

**F1: Taking stakeholder concerns and interests into account can improve organisational relationships.** All of the respondents agreed with this statement.

**F2: Stakeholder engagement can identify material risks and opportunities for HIV-AIDS programmes.** All of the respondents agreed with this statement.

F3: A concerted effort must be made to ensure that stakeholders are qualified to provide the right insight into key HIV-AIDS issues. A significant 98.33 % of respondents agreed with this statement, 1.67% of respondents remained neutral and no respondents disagreed with this statement.

**F4: Regular stakeholder engagement should be ensured so that a variety of opinions, insights, knowledge and collaboration can be obtained and feedback can be provided on actions taken based on specific stakeholder requirements and expectations.** All of the respondents agreed with this statement.

**F5: Good stakeholder management ultimately improves the quality and outcome of HIV-AIDS programmes.** All of the respondents agreed with this statement.

The statements shown in bold (F1, F2, F4 and F5) dealt with engaging and dealing with stakeholder concerns and interests and stakeholder engagement. Chi-square testing was undertaken to further analyse data in this subsection. Table 7.36 depicts scoring patterns.

**Table 7.36 Scoring patterns: HIV-AIDS programmes' stakeholder management**

		Disagree		Neutral		Agree		Chi Square
		Count	Row N %	Count	Row N %	Count	Row N %	p-value
Taking stakeholder concerns and interests into account can improve organisational relationships	F1	0	0.0%	0	0.0%	60	100.0%	

<b>Stakeholder engagement can identify material risks and opportunities for HIV-AIDS Programmes</b>	<b>F2</b>	<b>0</b>	<b>0.0%</b>	<b>0</b>	<b>0.0%</b>	<b>60</b>	<b>100.0%</b>	
<b>A concerted effort must be made to ensure that stakeholders are qualified to provide the right insight into key HIV-AIDS issues.</b>	<b>F3</b>	<b>0</b>	<b>0.0%</b>	<b>1</b>	<b>1.7%</b>	<b>59</b>	<b>98.3%</b>	<b>0.000</b>
<b>Regular stakeholder engagement should be ensured so that a variety of opinions, insights, knowledge and collaboration can be obtained and feedback can be provided on actions taken based on specific stakeholder requirements and expectations.</b>	<b>F4</b>	<b>0</b>	<b>0.0%</b>	<b>0</b>	<b>0.0%</b>	<b>60</b>	<b>100.0%</b>	
<b>Good stakeholder management ultimately improves the quality and outcome of HIV-AIDS programmes</b>	<b>F5</b>	<b>0</b>	<b>0.0%</b>	<b>0</b>	<b>0.0%</b>	<b>60</b>	<b>100.0%</b>	

The significance of the differences is tested and shown in the table above. All p-values < 0.05 are significant. Statements that have a 100% response rate do not have a p-value because there is complete agreement.

Data from this sub-section was also analysed through the extraction method with the principal component analysis. A rotation method, Varimax with Kaiser normalisation, was utilised. Table 7.37 depicts the findings.



**Table 7.37 Rotated component matrix : HIV-AIDS programmes' stakeholder management**

F	Component	
	1	2
Taking stakeholder concerns and interests into account can improve organisational relationships	0.896	0.090
Stakeholder engagement can identify material risks and opportunities for HIV-AIDS Programmes	0.900	0.103
A concerted effort must be made to ensure that stakeholders are qualified to provide the right insight into key HIV-AIDS issues.	0.711	0.336
Regular stakeholder engagement should be ensured so that a variety of opinions, insights, knowledge and collaboration can be obtained and feedback can be provided on actions taken based on specific stakeholder requirements and expectations.	0.108	0.852
Good stakeholder management ultimately improves the quality and outcome of HIV-AIDS programmes	0.176	0.767

It is noted that the variables that constituted the remaining sections loaded along 2 or 3 components (sub-themes). This means that respondents identified different trends within the section. These trends are capacity building of stakeholders, data management of

A Strengths-Weaknesses-Opportunities-Threat (SWOT) analysis and Political Economic-Social-Technological (PEST) analysis needs to be undertaken to assess the roles of relevant stakeholders in HIV-AIDS monitoring and evaluation activities. These analyses take into consideration the enablers and disablers leading to the identification of risks and opportunities governing stakeholders, their roles and relationships. Taking stakeholder concerns and interests into account can improve

organisational relationships. The International Organisation of Standards (ISO) maintains that monitoring, measuring, analysis and evaluation are accurate and frequent in order to identify stakeholder concerns and interests as a key step in building stronger HIV-AIDS programmes (International Organisation of Standards 2015).

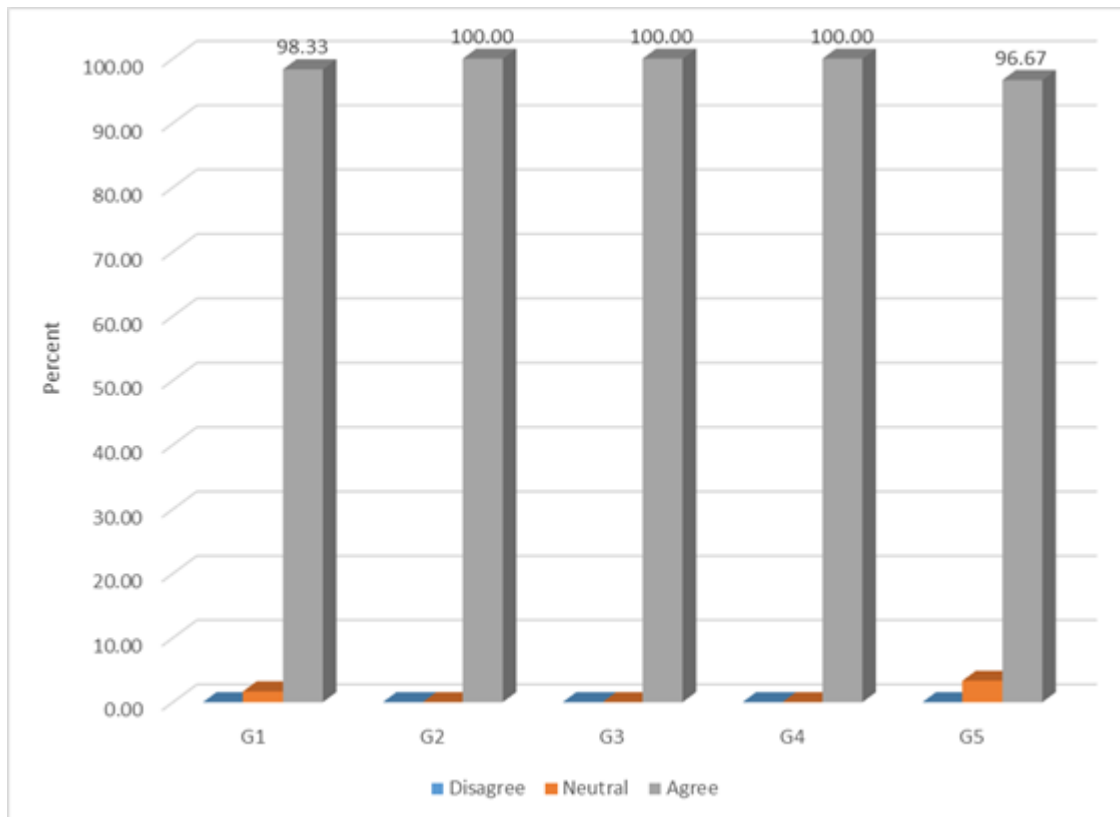
Good stakeholder management ultimately improves the quality and outcome of HIV-AIDS programmes. Building alliances and relationships allow healthcare organisations the opportunities to assess the differences and similarities and overlap them for best practices. This allows healthcare organisations to share risks and benefits to build stronger, effective and more efficient HIV-AIDS programmes.

It is also important to keep stakeholders capacitated along the HIV-AIDS monitoring and evaluation programme journey to ensure that stakeholders are updated with current learning and development in line with smart practices.

#### **7.2.5 7 Section G: Strengthening the capacity of all partners in HIV-AIDS programmes**

This section explored various avenues that this organisation can utilise to strengthen the capacity of the partners of the HIV-AIDS programmes. Questions were posed on communication, resources, tools and necessary skill development to strengthen capacity. These responses are graphically demonstrated in Figure 7.38 below.

#### **Figure 7.38 Strengthening the capacity of all partners in HIV-AIDS programmes**



Respondents were specifically asked to assess their level of agreement or disagreement on each of the following statements:

**G1:** Building strong health systems are a crucial step on the path towards universal access to comprehensive HIV-AIDS programmes. A significant 98.33 % of respondents agreed with this statement, 1.67% of respondents remained neutral and no respondents disagreed with this statement.

**G2:** Capacity building can occur though the identification of gaps in individual skills or organizational systems. All of the respondents agreed with this statement.

**G3:** Local resources, staff expertise and experience can be leveraged to provide assistance such as coaching and mentoring with compliance to donor regulations. All of the respondents agreed with this statement.

**G4:** Ensuring that new skills, tools and resources are successfully adapted into standard operating procedures is a key intervention for strengthening the

**capacity of all partners in HIV-AIDS programmes.** All of the respondents agreed with this statement.

G5: Clear and transparent communication efforts are integral to strengthening the capacity of all partners in HIV-AIDS programmes. A significant 96.67 % of respondents agreed with this statement, 3.33% of respondents remained neutral and no respondents disagreed with this statement.

There are no statements with higher levels of disagreement and 3 out 5 statements had a 100% response rate. These were shown in bold (G2, G3 and G4). These statements pertained to adequate capacity building, resource allocation and new skills and tool adaptation for effectiveness.

Chi-square testing was undertaken to further analyse data in this sub-section. Table 7.39 depicts scoring patterns.

**Table 7.39 Scoring patterns: Strengthening the capacity of all partners in HIV-AIDS programmes**

		Disagree		Neutral		Agree		Chi Square
		Count	Row N %	Count	Row N %	Count	Row N %	p-value
Building strong health systems is a crucial step on the path toward universal access to comprehensive HIV-AIDS programs	G1	0	0.0%	1	1.7%	59	98.3%	0.000
Capacity building can occur through identification of gaps in individual skills or organizational systems.	G2	0	0.0%	0	0.0%	60	100.0%	

Local resources, staff expertise and experience can be leveraged to provide assistance such as coaching and mentoring with compliance to donor regulations	G3	0	0.0%	0	0.0%	60	100.0%	
Ensuring that new skills, tools and resources are successfully adapted into standard operating procedures are key interventions at strengthening the capacity of all partners in HIV-AIDS programmes.	G4	0	0.0%	0	0.0%	60	100.0%	
Clear and transparent communication efforts is integral to strengthening the capacity of all partners in HIV-AIDS programmes	G5	0	0.0%	2	3.3%	58	96.7%	0.000

The significance of the differences is tested and shown in Table 7.39. All p-values < 0.05 are significant. Statements that have a 100% response rate do not have a p-value because there is complete agreement.

Data from this sub-section was also analysed through the extraction method with the principal component analysis. A rotation method, Varimax with Kaiser normalisation, was utilised. Table 7.40 depicts the findings.

**Table 7.40 Rotated component matrix : Strengthening the capacity of all partners in HIV/AIDS programmes**

---

G	Component	
	1	2

Building strong health systems is a crucial step on the path toward universal access to comprehensive HIV-AIDS programs	0.823	0.204
Capacity building can occur through identification of gaps in individual skills or organizational systems.	0.880	-0.025
Local resources, staff expertise and experience can be leveraged to provide assistance such as coaching and mentoring with compliance to donor regulations	0.485	0.364
Ensuring that new skills, tools and resources are successfully adapted into standard operating procedures are key interventions at strengthening the capacity of all partners in HIV-AIDS programmes.	0.115	0.737
Clear and transparent communication efforts is integral to strengthening the capacity of all partners in HIV-AIDS programmes	0.113	0.892

These trends are the adaptation of existing systems for effectiveness and enhancing communication.

The HIV-AIDS healthcare arena has a multitude of stakeholders with potentially competing interests and agendas. These stakeholders need to be managed and developed to encourage optimal benefits for HIV-AIDS programmes. This research study undertook to clearly describe the role of each of the stakeholders in the monitoring and evaluation of the HIV-AIDS programme concerned and also proposed to develop a plan for strengthening the capacity of all partners involved in the monitoring and evaluation of the HIV - AIDS programme. For a truly effective, comprehensive and wholly-owned response to the HIV/AIDS epidemic, HIV-AIDS programme managers need to play a leading role in shaping and driving HIV/AIDS policies within their programmes, making use of their stakeholders for implementing them.

In preparation for the National Health Insurance implementation in South Africa, it has become an imperative to ensure that strong flexible health systems are built, integrated for private public and private health sector utilisation. Given the expanse of HIV-AIDS programmes and the reach of the HIV-AIDS response in the country through the various healthcare sectors, HIV-AIDS forms the perfect vehicle to serve

as a conduit to building stronger resilient healthcare systems. Health and wellbeing depend upon strong health systems. It takes people, organizations and resources all functioning together to provide health services that are required. From human resources to better governance of the healthcare sector's public and private components, strengthening health systems by integrating services can be achieved. Overcoming barriers such as a lack of resources, poor skill sets, inadequate infrastructure and non-sustainable funding can lead to better, stronger health systems. South Africa has commenced this historic journey towards building the nation's health systems toward the national health insurance. HIV-AIDS programmes are central to this health offering (South Africa 2016).

Ineffective stakeholder management may lead to resource misuse and fraudulent behaviour. Buy-in from all stakeholders are key to successful monitoring and valuation framework implementation. Crisp, Swerissen and Duckett (2000:99) propose four healthcare capacity building interventions to assist organisations to help employees reach their true potential. These include a bottom-up organizational approach, which is the "development of technical expertise from employee level and is often considered to be essential for organizations so that they can plan, implement and evaluate appropriate health programs and measures" (Meissner 1992:16; Schwartz 1993:481). A top-down organizational approach is "building and sustaining capacity that requires organizational capacity, as well as the expertise of individuals" (Grisso 1995:12; Rist 1995:10). Partnerships include "the development of relationships between organizations or groups of people who might otherwise have little or no working relationship and can be viewed as another approach to building capacity" (Chavis 1995:235; Marty 1996:117). The community organizing approach is an approach "that capacity building aims to transform individuals from passive recipients of services to active participants in a process of community change" (Finn and Checkoway 1998:480).

Clear, precise and transparent communication is an integral success measure. Ineffective internal and external communication within an organisation is identified as a key challenge to successful monitoring and evaluation HIV-AIDS framework implementation. Communication is more than just exchanging information. It also

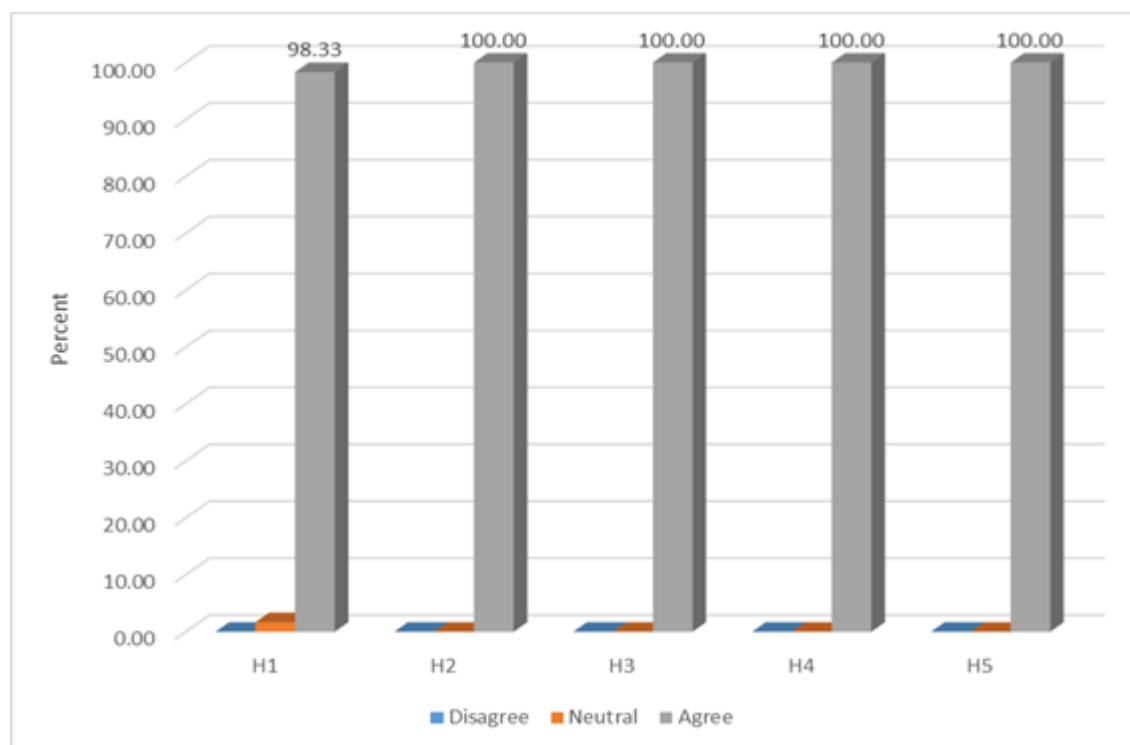
encompasses engaged listening. Communication skills need to be built with employees and teams to ensure building stronger relationships.

#### **7.2.5.8 Section H: Smart practises of HIV-AIDS monitoring and evaluation frameworks**

*“A smart practice is a method or technique that has been generally accepted as superior to any alternatives because it produces results that are superior to those achieved by other means or because it has become a standard way of doing things”* (Bardach 2011:11). Smart practices are being relied upon in recent years especially in the health industry to allow the sharing of successful ideas, processes and procedures as a means to reducing costs and unnecessary expenses. Successful HIV-AIDS monitoring and evaluation frameworks require a combination of smart practices from various other HIV-AIDS programmes in order to enhance operational efficiencies, drive process compliance and decrease costs. Respondents were probed on key smart practices encompassing communication, data collection and training and indicator collection to guide smart practice implementation in this organisation’s HIV-AIDS monitoring and evaluation framework. These responses are shown in Figure 7.41 below.



**Figure 7.41 Smart practises of HIV-AIDS monitoring and evaluation frameworks**



Respondents were specifically asked to indicate their level of agreement or disagreement on each of the following statements:

**H1: Adequate quality management system training of all staff members working in HIV-AIDS programmes is integral for successful outcomes.** The majority of respondents agreed with this statement, 1.67% of respondents remained neutral and no respondents disagreed with this statement

**H2: Buy-in from all stakeholders is key to successful monitoring and valuation framework implementation.** All of the respondents agreed with this statement.

**H3: Clear, precise and transparent communication is an integral success measure.** All of the respondents agreed with this statement.

**H4: Standardised contextually relevant indicators are an important component in HIV-AIDS monitoring and evaluation framework development.** All of the respondents agreed with this statement.

**H5: Real time data collection, data analysis and data collation are important steps to data integrity.** All of the respondents agreed with this statement.

The average level of agreement with the statements in this section is 99.6 %. This revealed that respondents clearly identified smart practices of HIV-AIDS monitoring and evaluation frameworks. Statements shown in bold H2, H3, H4 and H5 scored 100% agreement.

Chi-square testing was undertaken to further analyse data in this sub-section. Table 7.42 depicts scoring patterns.

**Table 7.42 Scoring Patterns: Smart practices of HIV-AIDS monitoring and evaluation frameworks**

		Disagree		Neutral		Agree		Chi Square
		Count	Row N %	Count	Row N %	Count	Row N %	p-value
<b>Adequate quality management system training of all staff members working in HIV-AIDS programmes is integral for successful outcomes.</b>	<b>H1</b>	<b>0</b>	<b>0.0%</b>	<b>1</b>	<b>1.7%</b>	<b>59</b>	<b>98.3%</b>	<b>0.000</b>
<b>Buy in from all stakeholders are key to successful monitoring and valuation</b>	<b>H2</b>	<b>0</b>	<b>0.0%</b>	<b>0</b>	<b>0.0%</b>	<b>60</b>	<b>100.0%</b>	

framework implementation								
Clear, precise and transparent communication is an integral success measure	H3	0	0.0%	0	0.0%	60	100.0%	
Standardised contextually relevant indicators are an important component in HIV-AIDS monitoring and evaluation framework development	H4	0	0.0%	0	0.0%	60	100.0%	
Real time data collection ,data analysis and data collation are important steps to data integrity	H5	0	0.0%	0	0.0%	60	100.0%	

The significance of the differences is tested and shown in Table 7.42. All p-values < 0.05 are significant. Statements that have a 100% response rate do not have a p-value because there is complete agreement.

Data from this sub-section was also analysed through the extraction method with the principal component analysis. A rotation method, Varimax with Kaiser normalisation, was utilised. Table 7.43 depicts the findings.

**Table 7.43 Component Matrix: Smart practices of HIV-AIDS monitoring and evaluation frameworks**

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H	Component
	1
Adequate quality management system training of all staff members working in HIV-AIDS programmes is integral for successful outcomes.	0.775
Buy in from all stakeholders are key to successful monitoring and valuation framework implementation	0.702
Clear, precise and transparent communication is an integral success measure	0.810
Standardised contextually relevant indicators are an important component in HIV-AIDS monitoring and evaluation framework development	0.763
Real time data collection ,data analysis and data collation are important steps to data integrity	0.732

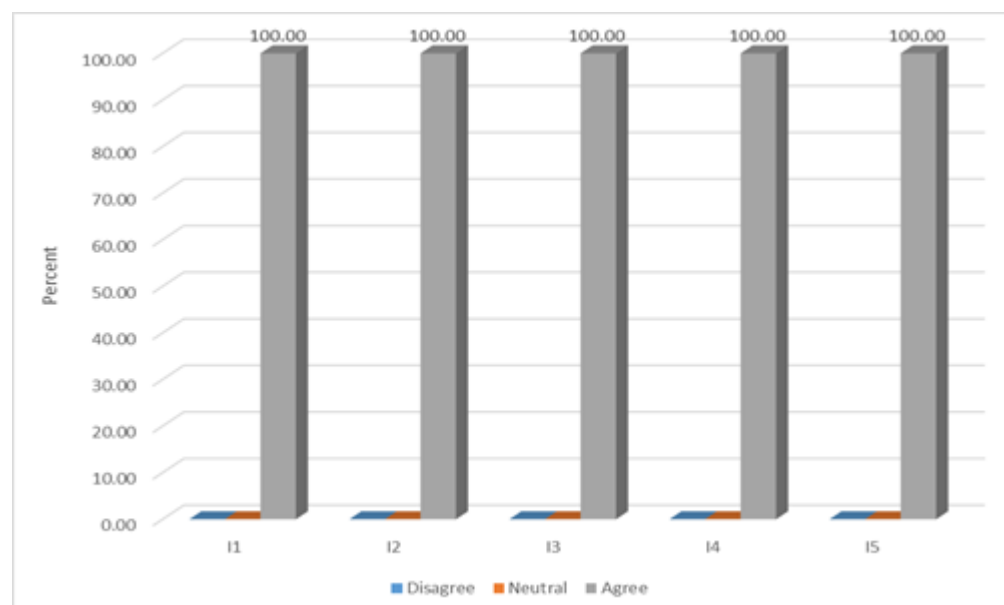
This implies that the statements that constituted these sections perfectly measured what they set out to measure

#### **7.2.5.9 Section I: Challenges of HIV-AIDS monitoring and evaluation frameworks**

Respondents were probed on what the existing challenges were with HIV-AIDS monitoring and evaluation frameworks. Questions spanned communication issues,

data collection issues, non-adaptive frameworks and reviewed training needs. These responses are graphically represented below in Figure 7.44 below.

**Figure 7.44 Challenges of HIV-AIDS monitoring and evaluation frameworks**



Respondents were specifically asked to assess their level of agreement or disagreement on each of the following statements:

**I1: Ineffective internal and external communication within an organisation is identified as a key challenge to successfully monitoring and evaluation HIV-AIDS framework implementation.** All of the respondents agreed with this statement.

**I2: Ineffective data collection mechanisms may impede data integrity.** All of the respondents agreed with this statement.

**I3: Monitoring and evaluation HIV-AIDS frameworks that are not adapted for use in diverse settings may not attain the desired outcomes.** All of the respondents agreed with this statement.

**I4: Ineffective stakeholder management may lead to resource misuse and fraudulent behaviour.** All of the respondents agreed with this statement.

**I5: Inconsistent and irregular staff training may be viewed as a critical impediment toward HIV-AIDS monitoring and evaluation implementation.** All of the respondents agreed with this statement.

The average level of agreement with the statements in this section was 100 %. This demonstrates that there was consensus amongst respondents regarding the key challenges pertaining to the issues of communication, data collection, stakeholder management, employee training and adaptability of HIV-AIDS frameworks. This provides integral data for this programme to build, learn and act on.

Chi-square testing was undertaken to further analyse data in this sub-section. Table 7.45 depicts scoring patterns

**Table 7.45 Scoring patterns: Challenges of HIV-AIDS monitoring and evaluation frameworks**

		Disagree		Neutral		Agree		Chi Square
		Count	Row N %	Count	Row N %	Count	Row N %	p-value
Ineffective internal and external communication within an organisation is identified as a key challenge to successful monitoring and evaluation HIV-AIDS framework implementation	I1	0	0.0%	0	0.0%	60	100.0%	
Ineffective data collection mechanisms may impede data integrity	I2	0	0.0%	0	0.0%	60	100.0%	
Monitoring and evaluation HIV-AIDS frameworks that are not adapted for use in diverse settings may not attain the desired outcomes.	I3	0	0.0%	0	0.0%	60	100.0%	
Ineffective stakeholder management may lead to resource misuse and fraudulent behaviour	I4	0	0.0%	0	0.0%	60	100.0%	
Inconsistent and irregular staff training may be viewed as a critical impediment toward HIV-AIDS monitoring and evaluation implementation.	I5	0	0.0%	0	0.0%	60	100.0%	

The significance of the differences is tested and shown in Table 7.45. Statements that have a 100% response rate do not have a p-value because there is complete agreement.

Data from this sub-section was also analysed through the extraction method with the principal component analysis. A rotation method, Varimax with Kaiser normalisation, was utilised. Table 7.46 depicts the findings.

**Table 7.46 Component Matrix : Challenges of HIV-AIDS monitoring and evaluation**

**Frameworks**

I	Component
	1
Ineffective internal and external communication within an organisation is identified as a key challenge to successful monitoring and evaluation HIV-AIDS framework implementation	0.787
Ineffective data collection mechanisms may impede data integrity	0.655
Monitoring and evaluation HIV-AIDS frameworks that are not adapted for use in diverse settings may not attain the desired outcomes.	0.774
Ineffective stakeholder management may lead to resource misuse and fraudulent behaviour	0.641
Inconsistent and irregular staff training may be viewed as a critical impediment toward HIV-AIDS monitoring and evaluation implementation.	0.624

The statements that constituted these sections loaded perfectly along a single component. This implies that the statements that constituted these sections perfectly measured what it set out to measure.



### 7.2.6 Hypothesis testing

These values are highlighted with a \*.

**Table 7.47 Hypothesis testing**

	Chi-Square	df	Asymp. Sig.
Qualification	1.75	4	0.782
Job description	11.818	3	0.008
Number of years employed in the organisation	18.9	2	0.000
Gender	48.6	1	0.000
Age	38.034	4	0.000
Ethnicity	72.933	3	0.000
The business understands the needs and requirements of their stakeholders (partners, patients ,service providers)	11.267	1	0.001
Partnerships to plan coordinate and manage the monitoring and evaluation system need to be developed for a successful framework	41.667	1	0.000
A monitoring and evaluation plan should contain aspects dedicated to	48.6	1	0.000

communication, advocacy and developing culture			
An HIV-AIDS monitoring and evaluation plan should be developed in conjunction with all stakeholders and reviewed bi-annually	102.7	2	0.000
Leadership is proactive rather than reactive to changes in the field of HIV/AIDS	43.6	2	0.000
Escalation of complaints/compliments to leadership are clearly defined and easily accessible	72.1	2	0.000
Leaders receive HIV-AIDS training at regular intervals to ensure adequate knowledge generation	47.1	2	0.000
Training and refresher training is conducted regularly as part of the programme	72.7	2	0.000
A reward and recognition programme is provided	43.6	2	0.000
Communication is two-way between management and staff members	55.3	2	0.000
Ad hoc surveys should be sent off to monitoring and evaluation staff to assess how improvements can be enhanced to the plan	24.7	2	0.000
Human capacity for HIV-AIDS monitoring and evaluation frameworks	67.9	2	0.000

needs to be planned and budgeted for.			
Management should motivate individuals to become monitoring and evaluation champions	59.7	2	0.000
Supportive supervision and data auditing is warranted to build strong monitoring and evaluation frameworks	76.9	2	0.000
Trust, openness, confidence and assertiveness is our approach for result oriented productivity of the programme	8.067	1	0.005
Criteria of success are based upon target achievements by individuals	21.6	1	0.000
Methods are consistently used to improve our work and gain advantage	32.267	1	0.000
Competition, achievement and productivity are part of goal setting to improve performance	38.4	1	0.000
Decision making is based on objective guidelines and clinical protocols	51.1	2	0.000
Decisions for clinical management of patients should be based on sound clinical discretion	67.6	2	0.000
Continuous professional development toward clinical learning and development in building clinical capacitation is key in HIV-AIDS	72.1	2	0.000

programmes			
Instructions and regulations are needed to govern every procedure of work	25.6	2	0.000
Security, conformity and predictability define our work	32.7	2	0.000
Dissatisfaction is communicated without fear of information used against at a later stage	9.1	2	0.011
Organizational structures with HIV-AIDS monitoring and evaluation functions are key to successful monitoring and evaluation frameworks	64.3	2	0.000
Monitoring and evaluation frameworks will be a strategic component of the National Health Insurance plan	92.1	2	0.000
A comprehensive budget should be allocated for monitoring and evaluation planning and implementation	92.1	2	0.000
Management should motivate individuals to enhance service provision toward customer satisfaction	45.067	1	0.000
Client-Centricity should be the core focus of HIV-AIDS programmes	48.6	1	0.000
The Batho Pele principles can be adapted for use in non-government sector HIV-AIDS programmes	52.267	1	0.000

Input indicators should cover resource allocations and human capital data	56.067	1	0.000
Process indicators should cover quality of service, and service statistics	56.067	1	0.000
Output indicators should provide data on estimates of service coverage	56.067	1	0.000
Outcome indicators should provide data on behaviour change/morbidity	56.067	1	0.000
Impact evaluation should provide data on risk, prevention risks and population level impact	56.067	1	0.000
Indicators should be devised and focused on what the programme should achieve	56.067	1	0.000
Setting the research agenda is an important starting point for operational research activities	45.067	1	0.000
Expanding support for operational research activities is key to successful clinical management treatments	56.067	1	0.000
HIV-AIDS operational research requires significant expansion of resources.	56.067	1	0.000
Data dissemination utilizing monitoring and evaluation reports should determine methods by which data will be collected, analysed and reported	52.267	1	0.000

Capacity for collecting and using data should be assessed prior to project start up	56.067	1	0.000
Monitoring and evaluation data should inform research agendas	52.267	1	0.000
Data management should assess procedures for processing, storing and managing monitoring and evaluation data	52.267	1	0.000
Data managers should understand program goals and objectives	56.067	1	0.000
Monitoring and evaluation plans should move away from a reliance on paper based data collection	56.067	1	0.000
System management improvement is a key aspect of building sound monitoring and evaluation plans	52.267	1	0.000
A concerted effort must be made to ensure that stakeholders are qualified to provide the right insight into key HIV-AIDS issues	56.067	1	0.000
Building strong health systems is a crucial step on the path toward universal access to comprehensive HIV-AIDS programs	56.067	1	0.000
Clear and transparent communication efforts is integral to strengthening the capacity of all partners in HIV-AIDS	52.267	1	0.000

programmes			
Adequate quality management system training of all staff members working in HIV-AIDS programmes is integral for successful outcomes	56.067	1	0.000

### 7.2.7 Pearson chi-square tests

A second Chi square test was performed to determine whether there was a statistically significant relationship between the variables (rows versus columns). The null hypothesis states that there is no association between the two. The alternate hypothesis indicates that there is an association. The p-value between “Ethnicity” and “Leadership is proactive rather than reactive to changes in the field of HIV/AIDS” is 0.008. This means that there is a significant relationship between the variables. This implies that the race of the respondent did play a significant role in terms of how respondents viewed the leadership approach. All values without an \* (or p-values more than 0.05) do not have a significant relationship.

**Table 7.48 Pearson chi-square tests**

Leadership is proactive rather than reactive to changes in the field of HIV/AIDS	Chi-square	11.780	8.483	5.368	1.199	22.578	26.878
	df	16	12	8	4	16	12
	Sig.	0.759	0.746	0.718	0.878	0.126	.008*
Escalation of complaints/compliments to leadership are clearly defined and easily accessible	Chi-square	10.825	9.044	9.496	1.131	9.178	18.647
	df	12	9	6	3	12	9
	Sig.	0.544	0.433	0.148	0.77	0.688	.028*
Leaders receive HIV-AIDS training at regular intervals to ensure adequate knowledge generation	Chi-square	21.205	13.644	5.809	1.189	12.336	40.622
	df	16	12	8	4	16	12
	Sig.	0.171	0.324	0.669	0.88	0.721	.000*
Training and refresher training is conducted regularly as part of the programme	Chi-square	9.629	7.028	7.257	4.421	13.233	17.274
	df	12	9	6	3	12	9
	Sig.	0.649	0.634	0.298	0.219	0.352	.045*

The Pearson Chi-Square Tests revealed a few trends of significance which the researcher wishes to highlight. There appears to be an association between the escalation of complaints/compliments to leadership and ethnicity, which scored a value of 0.028\*. There appears to be an association between leaders who receive HIV-AIDS training at regular intervals to ensure adequate knowledge generation and ethnicity, which scored 0.000\*. There also appears to be an association between

training and refresher training as part of the programme and ethnicity which scored 0.045\*. The underlying sub-theme here pertained to leadership and leadership activities and ethnicity. There is currently no data pertaining to this in this HIV-AIDS programme and environment and hence requires further exploration. This data will inform the leadership in this programme to better equip themselves and their employees for the ultimate success of the programme and organisation as a whole.

## **7.2.8 Cross tabulations**

### **7.2.8.1 Correlations**

Bivariate correlation was also performed on the (ordinal) data. The results indicate the following patterns:

Positive values indicate a directly proportional relationship between the variables and a negative value indicates an inverse relationship. All significant relationships are indicated by a \* or \*\*. For example, the correlation value between “The business understands the needs and requirements of their stakeholders (partners, patients, service providers)” and “Decision making is based on objective guidelines and clinical protocols” is 0.411. This is a directly related proportionality. Respondents indicate that the greater the understanding of the needs, the more decisions can be made regarding guidelines and objectives, and vice versa. Negative values imply an inverse relationship. That is, the variables have an opposite effect on each other. That is, as one increases, the other decreases.

#### **7.2.8.1.1 Emergent trends**

On data review, it became evident that certain patterns of significance began to emerge. These are highlighted below and the significance level is also provided.

##### **7.2.8.1.1.1 Leadership**

Escalation of complaints/compliments to leadership is clearly defined and easily accessible and leadership is proactive rather than reactive to changes in the field of HIV/AIDS scores 0.639\*\*. This implies that as escalation of complaints and compliments occur, leadership become more proactive rather than reactive to change.



Leaders receive HIV-AIDS training at regular intervals to ensure adequate knowledge generation and the business understands the needs and requirements of their stakeholders (partners, patients, service providers) scores 0.324\*. This implies that as training efforts increase among leaders, they are better able to understand the needs and requirements of their stakeholders.

Leaders receive HIV-AIDS training at regular intervals to ensure adequate knowledge generation and leadership is proactive rather than reactive to changes in the field of HIV/AIDS scores 0.553\*\*. This implies that as training efforts increase among leaders, leadership becomes more proactive rather than reactive to change.

Leaders receive HIV-AIDS training at regular intervals to ensure adequate knowledge generation and escalation of complaints/compliments to leadership are clearly defined and easily accessible scores 0.751\*\*. This implies that as training efforts increase amongst leaders, escalation of complaints and compliments become more clearly defined and easily accessible.

Communication is two-way between management and staff members and Training and refresher training is conducted regularly as part of the programme scores 0.459\*\*. This implies that as communication increases between management and staff members, regular training is conducted at the programme.

Supportive supervision and data auditing is warranted to build strong monitoring and evaluation frameworks and the business understands the needs and requirements of their stakeholders (partners, patients, service providers) scores 0.297\*. This implies that as supportive supervision and data auditing increase in the programme, the business understands the needs and requirements of their stakeholders better.

Supportive supervision and data auditing is warranted to build strong monitoring and evaluation frameworks and communication is two-way between management and staff members scores 0.439\*. This implies that as supportive supervision and data auditing increases in the programme, communication increases between management and staff members.

#### **7.2.8.1.1.2 Stakeholder relationship**

Partnerships to plan, coordinate and manage the monitoring and evaluation system need to be developed for a successful framework and the business understands the needs and requirements of their stakeholders (partners, patients, service providers) scores 0.357\*\*. As partnerships to plan coordinate and manage the monitoring and evaluation system of the programme increase, the business understands the needs and requirements of their stakeholders more.

An HIV-AIDS monitoring and evaluation plan should be developed in conjunction with all stakeholders and reviewed bi-annually and a monitoring and evaluation plan should contain aspects dedicated to communication, advocacy and developing culture scores 0.606\*\*. As HIV-AIDS monitoring and evaluation plan development increases, efforts dedicated to communication, advocacy and developing culture increases.

#### **7.2.8.1.1.3 HIV-AIDS-related operational research activities**

HIV-AIDS-related operational research activities strengthen links to policy and the business understands the needs and requirements of their stakeholders (partners, patients, service providers) scores 0.350\*\*. This implies that as HIV-AIDS-related operational research activities policy links strengthen, business understands the needs and requirements of their stakeholders more.

HIV-AIDS-related operational research activities strengthen links to policy and leaders receive HIV-AIDS training at regular intervals to ensure adequate knowledge generation scores 0.318\*. This implies that as HIV-AIDS-related operational research activities policy links strengthen, more training to ensure adequate knowledge generation is undertaken.

This data review has shown that the emergent themes revealed several associations between leadership and selected sub-themes, including training, communication and supportive supervision. Similar patterns were seen with stakeholder relationships and HIV-AIDS-related operational research activities. There is currently no data pertaining to these in this HIV-AIDS programme and it therefore requires further exploration. This data will inform the leadership in this programme to better equip

themselves and their employees for the ultimate success of the programme and organisation as a whole. This data may provide significant information that may inform the field of HIV-AIDS.

### **7.2.9 Summary of quantitative findings**

Key trends were observed throughout the quantitative data analysis process. These are integral findings that will be discussed next and will culminate in further discussion towards the conclusions and recommendations in the next chapter.

#### **7.2.9.1 Theme 1: HIV-AIDS quality management processes**

- A monitoring and evaluation plan should contain aspects dedicated to communication, advocacy and developing culture
- An HIV-AIDS monitoring and evaluation plan should be developed in conjunction with all stakeholders and reviewed bi-annually
- Escalation of complaints/compliments to leadership are clearly defined and easily accessible
- Training and refresher training is conducted regularly as part of the programme
- Supportive supervision and data auditing is warranted to build strong monitoring and evaluation frameworks
- Competition, achievement and productivity are part of goal setting to improve performance
- Continuous professional development toward clinical learning and development in building clinical capacitation is key in HIV-AIDS programmes
- Monitoring and evaluation frameworks will be a strategic component of the National Health Insurance plan
- A comprehensive budget should be allocated for monitoring and evaluation planning and implementation

- The Batho Pele principles can be adapted for use in non-government sector HIV-AIDS programmes
- All monitoring and evaluation staff should review program documents with stated goals and objectives prior to programme indicator compilation
- Inconsistent and irregular staff training may be viewed as a critical impediment toward HIV-AIDS monitoring and evaluation implementation.
- Capacity building can occur through identification of gaps in individual skills or organizational systems
- Local resources, staff expertise and experience can be leveraged to provide assistance such as coaching and mentoring with compliance to donor regulations
- Ensuring that new skills, tools and resources are successfully adapted into standard operating procedures are key interventions at strengthening the capacity of all partners in HIV-AIDS programmes.

#### **7.2.9.2 Theme 2: HIV-AIDS core indicators**

- Impact evaluation should provide data on risk, prevention risks and population level impact
- Indicators should be devised and focused on what the programme should achieve
- Indicators should be adaptive for diverse settings
- Standardised contextually relevant indicators are an important component in HIV-AIDS monitoring and evaluation framework development

#### **7.2.9.3 Theme 3: HIV-AIDS data management**

- Data managers should identify user needs and perspectives
- Technological innovation should revolutionise monitoring and evaluation data collection

- Prior to implementing new data management techniques data management should learn about existing data collection systems and quality
- Real time data collection ,data analysis and data collation are important steps to data integrity
- Ineffective data collection mechanisms may impede data integrity
- Monitoring and evaluation HIV-AIDS frameworks that are not adapted for use in diverse settings may not attain the desired outcomes

#### **7.2.9.4 Theme 4: HIV-AIDS operational research activities**

- Developing common tools are imperative to operational research activities
- HIV-AIDS-related operational research activities strengthen links to policy
- HIV-AIDS-related operational research activities improve collaboration among health programmes

#### **7.2.9.5 Theme 5: HIV-AIDS programmes stakeholder management/strengthening the capacity of all partners in HIV/AIDS programmes**

- Taking stakeholder concerns and interests into account can improve organisational relationships
- Stakeholder engagement can identify material risks and opportunities for HIV-AIDS Programmes
- Regular stakeholder engagement should be ensured so that a variety of opinions, insights, knowledge and collaboration can be obtained and feedback can be provided on actions taken based on specific stakeholder requirements and expectations
- Good stakeholder management ultimately improves the quality and outcome of HIV-AIDS programmes

- Buy in from all stakeholders are key to successful monitoring and valuation framework implementation
- Clear, precise and transparent communication is an integral success measure
- Ineffective internal and external communication within an organisation is identified as a key challenge to successful monitoring and evaluation HIV-AIDS framework implementation
- Ineffective stakeholder management may lead to resource misuse and fraudulent behaviour

### **7.3 Qualitative data analysis and findings**

The researcher undertook a component of qualitative research through the implementation of an individual interview schedule. The rationale for utilising this was to compliment the findings and data analysis of the quantitative component of this study in order to generate robust and comprehensive data for the programme under review to have access to in order to continually improve.

#### **7.3.1 The sample**

In total, 10 individual interviews were undertaken in a private and confidential environment to allow the respondents to feel comfortable and at ease through the interview process.

#### **7.3.2 The research instrument**

The interview schedule consisted of 20 questions and was divided into 9 sections as illustrated below:

- A HIV-AIDS Monitoring and Evaluation Processes
- B HIV-AIDS Core indicators
- C HIV-AIDS related operational research activities
- D Data management
- E HIV-AIDS Programmes Stakeholder management
- F Monitoring and evaluation HIV-AIDS Smart practices

##### **7.3.2.1 Section A: HIV-AIDS monitoring and evaluation processes**

In order to get a good understanding of the baseline level of education and awareness of HIV-AIDS quality management systems in their organisation, the first section of the interview schedule assessed respondents on their basic knowledge of quality management processes; their level of quality management awareness; their understanding of benefits of quality management systems; and also the prevalence of quality management systems in their organisations.

**Table7.49 Section A: HIV-AIDS monitoring and evaluation Processes**

1. Can you briefly describe what quality management is?
2. Can you briefly discuss what Monitoring and Evaluation activities you are aware of?
3. What do you think there are any benefits to Monitoring and Evaluation?
4. What does the Monitoring and Evaluation activities want to change and how?
5. What are the specific objectives to achieve this change?

Table7.49 provides the questions asked in this section. Programme employees were asked to describe what quality management meant. Most programme employees expressed that the HIV Your Life programme is ISO accredited and that it was similar to a quality management system. The remaining respondents concurred that quality management deals with:

Response 1: *“Maintaining quality in healthcare and is very important to ensure patient safety and wellness and good health toward continual improvement”.*

Response 2: *“This explores ways and means to ensure quality in healthcare.”*

Response 3: *“Looks at certain parameters to assess and evaluate quality. In our programme, we have the ISO standard which has been implemented as a quality management system”*

During the interviews, programme employees were asked to briefly discuss what monitoring and evaluation activities they were aware of and that were in existence at the programme. Most employees responded that there were no monitoring and evaluation activities being conducted at the programme. The remaining employees were aware of monitoring and evaluation activities in general and provided examples such as statistics, trend analysis and data collection for HIV-AIDS activities.

All programme employees displayed knowledge of the benefits of quality management systems when specifically probed on this question. When asked what



the monitoring and evaluation activities want to change and how, a programme employee aptly responded:

*“This deals with increasing patient satisfaction and programme efficiencies toward continual improvement”*. Unfortunately, no employees were able to provide the key objectives required to bring about change with quality management systems as the programmes does not have any current monitoring and evaluation activities and also very little knowledge and awareness for this exists. However, it is apparent that the respondents have a general knowledge of what quality management is but were unable to expand on the monitoring evaluation activities undertaken. Respondents understood the value of monitoring and evaluation activities and demonstrated clear benefits of monitoring and evaluation activities. Responses to these were:

Response 1: *“This is really important as it allows us to set and meet goals”*

Response 2: *“It allows an organisation to set and meet goals. Allows an organisation an approach to evaluate performance of the programme. Also to assess patient satisfaction with services and level of care”*

Response 3: *“It will provide better quality work, there will be fewer errors, and there will be higher standards of service delivery”*

Response 4: *“It enables us to set and meet goals, makes us more marketable, in order to reach more clients”*.

The responses from this aspect of the study demonstrate a strong need from this HIV-AIDS programme staff for policies, procedures and process development. Process and procedures provide programme staff with a routine for daily execution of service delivery and allows consistency and standardisation of HIV-AIDS treatment, prevention and care.

### 7.3.2.2 Section B: HIV-AIDS core indicators

**Table 7.50 Section B: HIV-AIDS core indicators**

1. Can you briefly discuss the HIV-AIDS programme indicators?
2. Can you briefly discuss data collection on HIV-AIDS indicators?
3. Can you briefly discuss if the programme delivers appropriate information on indicators?

Table 7.50 provides the questions asked in this section. This section explored in detail the level of employee knowledge on HIV-AIDS programme indicators and indicators relevant to the organisation being studied. Interviewees were unable to correctly identify programme indicators as these have never really been emphasised in the organisation. Interviewees were only able to provide core parameters such as Cd4 and viral load as examples of indicators that are used frequently in the realm of pathology. It was therefore concluded that the HIV-AIDS programme does not have clear indicators, does not have clear data collection methods for HIV-AIDS indicators and hence cannot provide appropriate information on HIV-AIDS indicators. Training was also never provided or recorded.

All programme employees unanimously agreed that they were unaware of the HIV-AIDS programme indicators for their HIV-AIDS programme and also were unable to comment on whether these were being reached or not. The majority of programme employees were able to identify the various types of monitoring and evaluation core indicators, although this is not being practised in this programme. The development of HIV-AIDS programme indicators has always been a difficult task as it is dependent on several factors including the budget, staffing, nature of the population servicing and predominant types of HIV-AIDS service delivery. The World Health Organisation (2015:2) maintains that HIV-AIDS programmes should adapt existing indicators for use within HIV-AIDS programmes. However, these indicators may not be readily applicable to South African HIV-AIDS programmes given the nature and extent of the disease in South Africa. As such, this remains a void in the South African HIV-AIDS

arena. This can be proposed for an area of further research, that is to develop locally relevant and culturally appropriate indicators for South African HIV-AIDS programmes.

### 7.3.2.3 Section c: HIV-AIDS-related operational research

#### activities

**Table7. 51 HIV-AIDS-related operational research activities**

1. In your opinion what are the current operational challenges with HIV-AIDS related operational research activities?
2. In your opinion, what do you think the strengths of this programme are?
3. In your opinion, what do you think the weaknesses of this programme are?

Table7.37 provides the questions asked in this section. This section explored HIV-AIDS-related operational research activities in detail to assess for operational challenges, strengths and weaknesses of the programme under review. Data revealed that the programme employees cannot recall any HIV-AIDS-related operational research activities being undertaken at the organisation or within the programme but are aware of the activities that should be incorporated into the organisation for better efficiencies and programme enhancements. All employees indicated that there were not any HIV-AIDS-related operational research activities in this HIV-AIDS programme. Employees could easily identify the strengths of the programme. This included the following:

Response 1: *“The programme strengths are the HIV Clinical Guidelines, the innovative HIV applications and the service provider networks”.*

Response 2: *“The programmes clinical skill and Intellectual property is also strength”.*

When employees were probed specifically on the challenges of the programme, they responded as follows:

Response 1: *“The programme lacks a structured quality assurance system and the lack of an HIV-AIDS monitoring and evaluation framework—this is a key weaknesses of the programme”.*

Response 2: *“There is a lack of training and on-going training. This is required as many developments in the HIV-AIDS field is fast paced.”*

Response 3: *“We do not have a monitoring and evaluation system or framework; we also do not have a system for this. We have never been trained on this .This will also need stuff like SOPS and specific processes. We need to grow”.*

Operational research refers to: *“the use of analytical techniques to define optimal processes of delivery, achieve better outcomes through evidence-based approaches, and provide more cost-effective care (WHO 2006)”*. The overall operational strategy seeks to address the longstanding challenge of linking research to policy in the emergency context of the HIV epidemic, as well as to provide rapid evidence to scale-up and improve programmes. Kumar (2003:10) suggests that the applications of operations research in HIV-AIDS research activities can enhance service delivery and program performance improvement. Considering the complexity of the HIV-AIDS epidemic, it is imperative to learn from operations research in scaling up HIV-AIDS treatment, prevention and wellness.

#### **7.3.2.4 Section D: Data management**

**Table7.52 Section D: Data management**

<b>1.</b> In your opinion, what do you think the data flow channels between the different stakeholders are?
<b>2.</b> What training needs do you think will be required to implement Monitoring and Evaluation in your environment?

Table7.52 provides the questions asked in this section. In this section of the interview, interviewees were probed on data management issues that they may have been facing in the programme. Interviewees responded that there was no data flow

channels between the different stakeholders and this is urgently required to ease information sharing. Employees also indicated that more electronic system development to ensure enhancement and development was required to allow better integration between the various stakeholders for a streamlined member experience. These employees identified the data flow channels between the different stakeholders as *“not streamlined and efficient currently—this needs to be done in a more transparent manner”*. The remaining employees were not aware of the role and responsibilities of data management and flow between stakeholders and agreed on a more transparent method to handle this. When queried on the training needs required for implementing monitoring and evaluation in this environment, all respondents provided data management training as an urgent need, together with specific HIV-AIDS-related data collection training.

Shivaji and Martins (2015:1) maintain that the demand for accurate information about HIV-AIDS epidemiology and status of the epidemic reporting is an on-going need for HIV-AIDS programmes globally and locally. Staff involvement, senior management support and momentum for change are key factors for successful implementation. Mauch (2009:14) suggests that programme processes and procedures need to be continually improved for inclusion of best practices to enhance and support optimal HIV-AIDS service delivery.

### **7.3.2.5 Section E: HIV-AIDS programmes’ stakeholder management**

**Table7.53 Section E: HIV-AIDS programmes’ stakeholder management**

1. In your opinion who do you think the HIV-AIDS programme stakeholders are?
2. In your opinion what do you think the challenges are with the programme stakeholders?
3. In your opinion how these challenges should be addressed?

Table7.53 provides the questions asked in this section. This section explored the interviewees’ knowledge on who the programme stakeholders were. Respondents agreed unanimously that stakeholders for this HIV-AIDS programme included

patients, treating doctors, pathology laboratories, medical aid schemes, medical insurance and hospitals. The regulatory bodies providing guidance for guidance and support include the Council for Medical Schemes and Board of Healthcare funders. When asked what the challenges with stakeholders for the HIV-AIDS programme are, the responses included fragmentation of service delivery and miscommunication as pivotal stumbling blocks to information gathering and sharing. Interviewees identified a lack of visibility and transparency of stakeholders as well. All employees agreed that clear, consistent communication with visibility and transparency are key elements to ensure good stakeholder-building relationships.

The responses were in keeping with the industry opinions on the value of building stakeholder relationships. Long-term stakeholder relationships help to build and sustain long-term partnerships with communities and groups where HIV-AIDS programmes are prevalent. According to the Global Advocacy for HIV Prevention (2011:16), meaningful stakeholder partnerships help to sustain trust and confidence in the management of HIV-AIDS programmes. It also adds value and merit to the HIV-AIDS programmes with interventions within the communities' to better utilise the services. According to Mugavero, Norton and Saag (2011:52), HIV-AIDS programmes should adopt an integrated health care system approach with equal importance given to programme management, trustees, stakeholders, patients and patrons. As per Cheever (2007:1400), the HIV-AIDS programmatic distribution of funds as per budgets should support HIV-AIDS testing, prevention, treatment, education and advocacy. Communication through continuous opportunities of regular engagement should bring about decisive and purposeful action to foster improved engagement in HIV-AIDS care.

### .7.3.2.6 Section F: monitoring and evaluation of HIV-AIDS smart practices

**Table7.54 Section F: Monitoring and evaluation HIV-AIDS smart practices**

1. In your opinion what monitoring and evaluation recommendations can be made to help or alleviate the burden of HIV-AIDS in South Africa?
2. Where do you think the gaps are with regards to service delivery of HIV-AIDS healthcare provision in South Africa?
3. How can these gaps be addressed?
4. What smart practises can be shared across all care providers for optimal patient treatment?

Table7.54 provides the questions asked in this section. This final section of the interview schedule was aimed at assessing what employee perceptions and opinions were regarding monitoring and evaluation HIV-AIDS smart practices Respondents concurred that they needed to be trained and also provided with resources dedicated to this. They agreed that clinical training (adhoc and on-going) has to be undertaken to ensure that all clinical employees are kept abreast with the latest knowledge governing this. The respondents identified data management issues as integral issues for the collection, collation and analysis of data. A single interviewee responded as follows: *“We need data integrity and data security, system integration and development to maintain and sustain data collection. Reports need to be generated and sent through to key personnel in order to guide policy development and objectives. In addition, budget allocations should be made taking in to account the needs of the project”*.

When asked what monitoring and evaluation recommendations can be made to help or alleviate the burden of HIV-AIDS in South Africa, a programme employee responded: *“that more training, awareness and education were required together a comprehensive single standard that speaks to all facets of HIV-AIDS management”*.

When probed on what the gaps are with regards to service delivery of HIV-AIDS healthcare provision in South Africa, a respondents stated : *“There are so many!—healthcare worker shortage, lack of HIV-AIDS specialised skill sets ,lack of resources, lack of free training and development., too many guidelines!—need to streamline processes”*.

When asked how to address the gaps, the interviewees responded as follows:

Response 1: *“We need training and communication, education and awareness. We need a single task group to compress procedures towards integration and alignment”*

Response 2: *“We need comprehensive system integration with public private partnering efforts towards sustainability”*.

Finally, a single programme employee summed up monitoring and evaluation HIV-AIDS smart practices as follows:

*“Quality management in HIV-AIDS is everyone’s business. We need to all take accountability and responsibility for our work and ensure it’s done to allow patient wellness and care”*

Smart practices are defined *“as those practices that, on rigorous evaluation, demonstrate success, have an impact, and can be replicated in other settings”* (Heffes 2002:5; UNESCO 2011). Maina, Mill, Chaw-Kant and Caine (2016:15) maintain that smart practices in HIV-AIDS care have the potential to improve patient outcomes and inform the HIV-AIDS field locally and globally. In their systematic review of smart practices in HIV-AIDS care, Maina, Mill, et al (2016:15) suggest that health practices, procedures and standards are helpful tools to communicate the innovations of practitioners and researchers who work in the field of HIV-AIDS treatment, prevention and care. Brink and Pienaar (2007:21) suggest that the greatest areas of need for HIV-AIDS care are in the arena of on-going training and development of healthcare workers given the constant need to up skill, cross skill and multi skill in healthcare environments. Charalambous, Grant, Day, Pemba, Chaisson, Kruger and Churchyard (2007:19) suggest that communication efforts and how to enhance these across HIV-AIDS programmes, vulnerable populations and stakeholders is a smart practice approach that needs to be shared with applicable



programmes in the HIV-AIDS field. Based on the literature reviewed, there was minimal data available from South African-based HIV-AIDS programmes. Given that South Africa hosts the largest HIV-AIDS programmes in the public and private sectors, a wealth of lessons can be shared locally and globally towards enhancing and optimising patient care. An urgent need exists to further explore these lessons and share them as smart practices with the greater HIV-AIDS fraternity.

### **7.3.3 Summary of qualitative findings**

Key trends were observed throughout the qualitative data analysis process. These are integral findings that will be discussed next and will culminate in a further discussion towards conclusions and recommendations in the next chapter.

#### **7. 3.3.1 Theme 1: HIV-AIDS quality management processes**

##### **7.3.3.1.1 Training needs**

The South African public healthcare HIV-AIDS sector provides clear demonstration that there remains a large gap between healthcare need and healthcare resource availability. As the HIV-AIDS epidemic grows to evolve into a chronic disease burden, more affected populations are beginning to live longer with the disease, placing more undue stress onto an already burdened healthcare system. Bautista-Arredondo, Gadsden, Harris and Bertozzi (2008:22) suggest that optimizing resource allocation for HIV-AIDS programmes requires management through an analytical framework consisting of constant funding and universal access to HIV-AIDS treatment and care. Integral to this is assessing and developing the training needs and capacity of healthcare employees.

##### **7.3.3.1.2 Quality management system development for HIV-AIDS**

###### **and quality management education and awareness**

Quality management systems have not been readily adapted in many healthcare organisations due to the cost, lack of resources and lack of skills. The World Health Organisation (2016) has recently acknowledged the importance of an organization-wide approach to quality management for implementation in healthcare and particularly in HIV-AIDS organisations. The quality assurance approach is related to

compliance with standards and can be applied to facilities, programmes, systems and sectors. However, a contextually relevant and culturally appropriate quality management system for the management for HIV-AIDS programmes locally and globally still remains exclusive.

### **7.3.3.2 Theme 2: HIV-AIDS core indicators**

All programme employees unanimously agreed that they were unaware of the HIV-AIDS programme indicators for their HIV-AIDS programme and were also unable to comment on whether or not these were being reached.

### **7.3.3.3 Theme 3: HIV-AIDS data management**

#### **7.3.3.3.1 Streamlined and efficient technological system enhancement**

The World Health Organisation( 2016) defines integrated clinical service delivery as *“the organization and management of health services so that people get the care they need, when they need it, in ways that are user friendly to achieve the desired results and provide value for money”*. System management improvement encompassing an integrated clinical service delivery approach can be viewed as a health system strengthening model. System management improvement builds on the strengths of HIV-AIDS programmes to deliver integrated care to patients with chronic diseases (Sunpath 2015:2). Coupled with this is technological system enhancement towards efficient and effective HIV-AIDS programme management.

### **7.3.3.4 Theme 4: HIV-AIDS operational research activities**

#### **7.3.3.4.1 Lack of operational research**

Given that HIV-AIDS has entered its third decade with little signs of recession, it has become important for the global health fraternity to re-assess, re-engineer and re-organise how HIV-AIDS management has taken place in the past. HIV-AIDS-related operational research provides a robust body of evidence and high-quality patient services through the adoption of best practices. Ultimately, operational research in this context seeks to strengthen the capacity of HIV-AIDS organisations towards more effective and efficient patient management (Population Council 2016).

### 7.3.3.5 Theme 5: HIV-AIDS stakeholder management

#### 7.3.3.5.1 Visible and transparent communication

Communication is more than just exchanging information. It also encompasses engaged listening. Communication skills need to be built with employees and teams in order to ensure building stronger relationships.

#### 7.3.3.5.2 Stakeholder relationships

Clear and transparent communication efforts are integral to strengthening the capacity of all partners in HIV-AIDS programmes.

### 7.4 Similarities and differences between qualitative and quantitative components of the research study

Table 7.55 presents, in a tabulated format, the emergent pivotal similarities and differences between the qualitative and quantitative phases of this research study. These will be discussed in more detail in Chapter Eight towards the conclusions and recommendations of this research study.

**Table 7.55 Similarities and differences between qualitative and quantitative**

#### **Components of the research study**

	Similarities between qualitative and quantitative components of research study	Differences between qualitative and quantitative components of research study
Theme 1: HIV-AIDS quality management processes	Training needs Quality management system development for HIV-AIDS and Quality management education and awareness	An HIV-AIDS monitoring and evaluation plan should be developed in conjunction with all stakeholders and reviewed bi-annually  Escalation of complaints/compliments to

		<p>leadership are clearly defined and easily accessible</p> <p>Training and refresher training is conducted regularly as part of the programme</p> <p>Supportive supervision and data auditing is warranted to build strong monitoring and evaluation frameworks</p> <p>Competition, achievement and productivity are part of goal setting to improve performance</p> <p>Continuous professional development toward clinical learning and development in building clinical capacitation is key in HIV-AIDS programmes</p> <p>Monitoring and evaluation frameworks will be a strategic component of the National Health Insurance plan</p> <p>A comprehensive budget should be allocated for monitoring and evaluation planning and implementation</p> <p>The Batho Pele principles can be adapted for use in non-government sector HIV-AIDS programmes</p>
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		<p>All monitoring and evaluation staff should review program documents with stated goals and objectives prior to programme indicator compilation</p> <p>Inconsistent and irregular staff training may be viewed as a critical impediment toward HIV-AIDS monitoring and evaluation implementation</p> <p>Capacity building can occur though identification of gaps in individual skills or organizational systems</p> <p>Local resources, staff expertise and experience can be leveraged to provide assistance such as coaching and mentoring with compliance to donor regulations</p> <p>Ensuring that new skills, tools and resources are successfully adapted into standard operating procedures are key interventions at strengthening the capacity of all partners in HIV-AIDS programmes</p>
Theme 2 : HIV-AIDS core indicators	Both aspects of this research study revealed that currently no HIV-AIDS Core Indicators	<p>Impact evaluation should provide data on risk, prevention risks and population level impact</p> <p>Indicators should be devised and focused on what the programme</p>

		<p>should achieve</p> <p>Indicators should be adaptive for diverse settings</p> <p>Standardised contextually relevant indicators are an important component in HIV-AIDS monitoring and evaluation framework development</p>
Theme 3 : HIV-AIDS data management	Streamlined and efficient Technological system enhancement	<p>Data managers should identify user needs and perspectives</p> <p>Technological innovation should revolutionise monitoring and evaluation data collection</p> <p>Prior to implementing new data management techniques data management should learn about existing data collection systems and quality</p> <p>Real time data collection ,data analysis and data collation are important steps to data integrity</p> <p>Ineffective data collection mechanisms may impede data integrity</p> <p>Monitoring and evaluation HIV-AIDS frameworks that are not adapted for use in diverse settings may not attain the desired</p>

		outcomes.
Theme 4: HIV-AIDS operational research activities	Both aspects of this research study revealed that currently no HIV-AIDS Operational Research Activities	<p>Developing common tools are imperative to operational research activities</p> <p>HIV-AIDS-related operational research activities strengthen links to policy</p> <p>HIV-AIDS-related operational research activities improve collaboration among health programs</p>
Theme 5: HIV-AIDS stakeholder management	Both aspects of this research study revealed that visible and transparent communication is needed.	Clear and transparent communication efforts are integral to strengthening the capacity of all partners in HIV-AIDS programmes.

## 7.5 Conclusion

This chapter presented the research findings and interpretation of results from the two components of this research study based on this research study's objectives. Both aspects of this research study revealed that currently no quality management system development for HIV-AIDS and quality management education and awareness exists in the programme under study. There is also an inherent need for HIV-AIDS operational research activities, with an urgent need for streamlined and efficient technological system enhancement. The data generated has provided significant critical information on which the conclusions and recommendations of this research study can be based. These conclusions and recommendations are presented in Chapter Eight.

## **CHAPTER EIGHT**

### **CONCLUSIONS AND RECOMMENDATIONS**



## **CHAPTER EIGHT**

### **CONCLUSIONS AND RECOMMENDATIONS**

#### **8.1 Introduction**

Conclusions and recommendations for this study are based on the study objectives and the pertinent literature review. Chapter one provided the introduction, problem description, objectives and rationale for the study.

Chapter two provided a global overview of the HIV-AIDS pandemic, including its epidemiology and origin. The routes of HIV transmission along with factors facilitating its spread will be examined, together with determinants of the disease resulting in its high incidence in developed and developing countries. This chapter concluded with a multidisciplinary approach to past, present and future bio-psycho-social approaches to HIV-AIDS prevention, with lessons learnt towards interventions that can reduce the spread of HIV-AIDS and alter the course of HIV-AIDS infection.

Chapter three explored the HIV-AIDS epidemic in South Africa. It analysed HIV-AIDS statistics in South Africa and reviewed the social, political and behavioural aspects of the disease in the South African context. Discussion points in this chapter focused on HIV-AIDS counselling and testing in South Africa; HIV-AIDS education in South Africa; the clinical management and treatment of HIV-AIDS in South Africa; and concluded with the potential future of HIV-AIDS in the South African context.

Chapter four explored quality management in healthcare, as this embodies one of the cornerstones of a country's response to HIV-AIDS. This chapter provided a discussion of the concepts of quality management and its relevance to healthcare and also discussed ISO 9001 2015 as an integral quality management tool in the healthcare arena. The chapter highlighted the discussions on the monitoring and evaluation of health programmes as critical interventions of quality management systems through analyses of existing HIV-AIDS monitoring and evaluation

frameworks. Chapter four culminated in a SWOT analysis of local and global HIV-AIDS monitoring and evaluation frameworks.

Chapter five reviewed exemplar HIV-AIDS management programmes in the South African public, private and parastatal sectors. This chapter provided a detailed SWOT analysis of each of these programmes and also presented a PEST analysis of the HIV-AIDS healthcare sector. These discussions were in line with the research study proposal in order to develop a conceptual monitoring and evaluation framework derived from quality management systems for the management of HIV-AIDS private sector programmes that can be used in both public and private healthcare sectors through the analysis of current conceptual frameworks in HIV-AIDS healthcare and HIV-AIDS programmes within the South African context of HIV-AIDS healthcare provision.

Chapter six reiterated the research problem and discussed the research design that comprised a mixed methodology, using a case study approach

Chapter seven provided an in-depth analysis of the results and an interpretation of the findings.

A culmination of research findings and reviewed literature based on this research study's objectives are presented in this chapter. This chapter presents conclusions of this research study per objective studied. General conclusions are presented per research objective explored. This chapter concludes with recommendations framed on the central objective of this research study towards the development of an HIV-AIDS conceptual monitoring and evaluation framework derived from quality management systems for the management of private sector HIV-AIDS programmes that can be used in both public and private healthcare sectors.

## 8.2 Conclusions

Findings from the three phases of this research study provided input towards the finalisation of the conclusions as graphically described in Figure 8.1.

**Figure 8.1 Conclusions and recommendations**



**Source: Self-generated based on authors' viewpoints (2016)**

General conclusions are presented as per the research objectives.

### **8.2.1 Objective 1: Develop clear monitoring and evaluation processes that will enable the systematic collection, collation, processing, analysis and interpretation of data**

This study concluded that an HIV-AIDS monitoring and evaluation plan should be developed in conjunction with all stakeholders and reviewed bi-annually. This plan should take into account local resources, staff expertise and experience. As such, a comprehensive budget should be allocated for HIV-AIDS monitoring and evaluation planning and implementation. Coupled with this process will be goal-setting for HIV-

AIDS programmes. Goal-setting is defined as: *“Motivational technique based on the concept that the practice of setting specific goals enhances performance and that setting difficult goals result in higher performance than setting easier goals”* (Kapur 2015:2). Competition, achievement and productivity are part of goal-setting to improve performance. Performance management is a comprehensive approach to planning and sustaining employee productivity. This allows employees to achieve pre-determined targets and encourages healthy competition amongst employees. In addition, goal-setting provides a competitive advantage to provide an edge over industry rivals.

The capacitation of employees to ensure necessary goal attainment becomes important in the goal-setting process. Capacity building can occur through the identification of gaps in individual skills or organizational systems while goal-setting. Continuous professional development towards clinical learning and development in building clinical capacitation is key in HIV-AIDS programmes during process and procedure development. Supportive supervision and data auditing is warranted as part of clinical capacitation to build strong monitoring and evaluation HIV-AIDS frameworks. Ensuring that new skills, tools and resources are successfully adapted into standard operating procedures are key interventions in strengthening the capacity of all partners in HIV-AIDS programmes.

#### **8.2.2 Objective 2: Define a list of core indicators that will enable the tracking of progress in the most critical areas in the response to HIV-AIDS**

This study concluded that HIV-AIDS indicators should be devised and focused on what the programme aims to achieve. Standardised contextually relevant indicators are an important component in HIV-AIDS monitoring and evaluation framework development. All stakeholders should provide input into the development of indicators for the programme. HIV-AIDS impact evaluation should provide data on risk, prevention risks and population level impact. In addition, HIV-AIDS indicators should be adaptive for diverse settings. This implies that HIV-AIDS indicators should be developed based on the needs of the programme and whether these exist in a rural community or urban community, as this will guide indicator development and selection. Financial and human capital resource allocations must be invested in and

committed to in the budget development in order to ensure that there is staff dedicated to indicator development and implementation. As indicators are developed, it is of paramount importance that quality checks, including quality control and assurance, are considered. In addition, HIV-AIDS indicators should be devised based on areas of coverage such as HIV-AIDS prevention, treatment and care. Given that the HIV Your Life programme functions within the private health risk management arena, it is vital that indicators are risk rated, implying that these should be rated low, medium or high based on the nature or intensity of the area covered.

### **8.2.3 Objective 3: Describe the role that HIV-AIDS-related operational research plays in the overall monitoring and evaluation of the national response to HIV-AIDS**

This study concluded that HIV-AIDS-related operational research is an important and vital component of an HIV-AIDS programme and one that should be enhanced to achieve the optimal benefit. The best approach to HIV-AIDS-related operational research is firstly to generate a research agenda based on the reach and capacity of the HIV-AIDS programme considered and which should cover the key pillars of HIV-AIDS including treatment, prevention and wellness. Secondly, there is need to ensure that the necessary support is gained financially and physically in order to reach the desired HIV-AIDS related operational research goals. Thirdly, HIV-AIDS programme management should ensure that the necessary tools are available to create an enabling environment for employees to implement smart practices in order to improve and enhance patient care and wellness. Fourthly, operational research specifically in the HIV-AIDS arena will ensure that key monitoring and evaluation deliverables are considered for HIV-AIDS programmes to allow streamlined processes and procedures.

**8.2.4 Objective 4: Describe the key data sources to be used to gather necessary monitoring and evaluation data and establish clear data flow channels between the different stakeholders in the response to HIV-AIDS**

This study concluded that prior to implementing new data management techniques, data management teams should learn about existing data collection systems and quality approaches. Data managers should identify user needs and perspectives as real-time data collection, data analysis and data collation is important steps to data integrity. Ineffective data collection mechanisms may impede data integrity. System management improvement with technological innovation should revolutionise monitoring and evaluation data collection as the industry moves to more reliance on a digital interface. Enhanced communication mechanisms should be embarked upon to embrace the various levels of involvement between all data management stakeholders. Standard operating procedures for data management specifically dealing with data collection, collation and analysis should be collaboratively developed for best results. Key HIV-AIDS data sources are HIV-AIDS test kit registers, clinic registers, pharmacy registers and data management registers. Monitoring and evaluation HIV-AIDS frameworks that do not adapt data management practices for use in diverse settings may not attain the desired outcomes.

**8.2.5 Objective 5: Clearly describe the role of each of the stakeholders in the monitoring and evaluation of HIV-AIDS programme**

This study concluded that taking stakeholder concerns and interests into account can vastly improve organisational relationships and HIV-AIDS programme management and outreach. Buy-in from all stakeholders is key to successful HIV-AIDS monitoring and valuation framework implementation. Stakeholder engagement can identify material risks and opportunities for HIV-AIDS programmes. Regular stakeholder engagement should be ensured so that a variety of opinions, insights, knowledge and collaborations can be obtained and feedback provided on actions

taken based on specific stakeholder requirements and expectations. Stakeholder role definition becomes important once stakeholders are identified per HIV-AIDS programme. Roles usually get assigned based on the nature, extent and outreach of the HIV-AIDS programme concerned. In addition, it is important that all stakeholders are provided with training and capacitation on what their roles entail within the context of the HIV-AIDS programme concerned. Good stakeholder management ultimately improves the quality and outcome of HIV-AIDS programmes. Ineffective internal and external communication within an HIV-AIDS programme is identified as a key challenge to successful monitoring and evaluation.

#### **8.2.6 Objective 6: Develop a plan for strengthening the capacity of all partners involved in the monitoring and evaluation of the HIV-AIDS programme**

This study concluded that it is important to build meaningful transparent and mutually beneficial partnerships with stakeholders and HIV-AIDS programmes. Successful stakeholder engagement requires the development of a stakeholder plan that explores risks, opportunities and collaborative efforts toward ultimate effective partnering in the field of HIV-AIDS monitoring and evaluation. All stakeholders should be provided adequate education and awareness of the HIV-AIDS programme context in order to optimise their value proposition. A broad and inclusive training and development learnership should be embarked upon the various facets of the HIV-AIDS programme in order to maximise training and capacitation.

### **8.3 Proposed monitoring and evaluation conceptual framework for the management of HIV-AIDS programmes**

The central objective of this study was: *“To propose a conceptual monitoring and evaluation framework derived from quality management systems for the management of HIV-AIDS private sector programmes that can be used in both public and private healthcare sectors through the analysis of current conceptual frameworks in HIV-AIDS healthcare and HIV-AIDS programmes within the South African context of HIV-AIDS healthcare provision”*. A narrative and diagrammatic representation follows and guides the discussions on an HIV-AIDS proposed monitoring and evaluation framework.

This research study explored smart practices, reviewed current conceptual frameworks in the HIV-AIDS healthcare sector and analysed HIV-AIDS programmes within the South African context of HIV-AIDS healthcare provision. Given the burden of disease that HIV-AIDS presents internationally and locally, discussed in Chapters 2 and 3, a significant need exists for efficient, cost effective and clinically appropriate HIV-AIDS service provision in the public, private and NGO sectors. Chapters 4 and 5 discussed how this can be achieved through the implementation of HIV-AIDS programmes with locally relevant and clinically appropriate HIV-AIDS monitoring and evaluation conceptual frameworks for accurate HIV-AIDS trend analysis and programme performance. The researcher presents a culmination of this research study whereby the core objective is presented as a proposed conceptual framework for the management of HIV-AIDS private sector programmes that can be used in both public and private healthcare sectors.

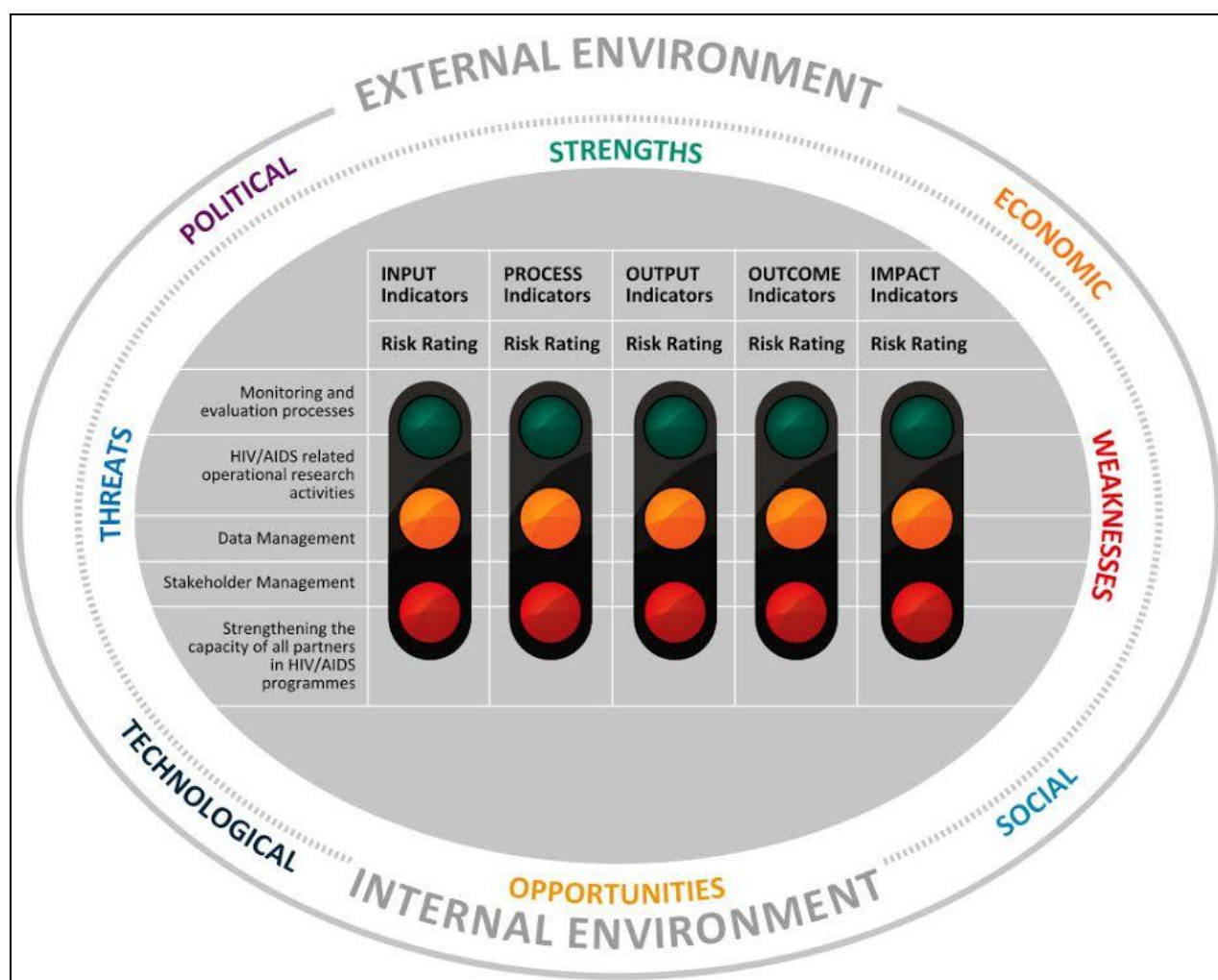
Based on the imminent themes that emerged from the data collection and analysis, the researcher recommends that monitoring and evaluation be viewed as pieces of a puzzle which need to be assembled to allow for the benefits of a cohesive whole. This research study was conducted in three phases. Phase 1 was a systematic review of HIV-AIDS reports of the HIV Your life Programme. Phase 2 was a transversal study through an ad-hoc questionnaire administered to HIV Your life Programme representatives and Phase 3 was a qualitative study with a phenomenological approach through focus groups, individual interviews and



observations. This monitoring framework is a synthesis of consensus-based international recommendations for monitoring HIV-AIDS treatment and care and is based on the research findings of this study. The purpose of this conceptual framework for the monitoring and evaluation of HIV-AIDS private sector programmes is to allow management to plan the programme initiatives, implement the service offering and measure patient and healthcare responses to the service provision through monitoring efforts. Through evaluation, it is aimed that the programme will be reviewed and reports generated for relevant stakeholders to then improve and adapt the programme based on patient needs and best treatment practices.

This proposed monitoring and evaluation system will be based on results as a powerful management tool in helping this healthcare organization demonstrate impacts and outcomes to their respective stakeholders. This programme will feature a results-based monitoring and evaluation system, emphasising outcomes and impacts of the programme while also examining programme implementation through programme inputs, activities and outputs. This monitoring and evaluation system will provide important feedback about the progress as well as the success or failure of the programme and will serve as an avenue for continuous learning, training and development. This is presented in Figure 8.2.

**Figure 8.2 Proposed monitoring and evaluation conceptual framework for the management of HIV-AIDS programmes**



**Source: Self-generated (2016) with authors' viewpoints**

The proposed conceptual monitoring and evaluation HIV-AIDS framework will be discussed according to the following components:

8.3.1 Programme mission

8.3.2 The HIV Your life programme's internal and external environment

8.3.3 The technical specifications of the Indicators

8.3.4 Digital automation

### 8.3.5 Mobile Application development

### 8.3.6 Dashboard

#### 8.3.1 Programme mission

The mission includes the healthcare programme's vision, goals and objectives. The key components of this proposed conceptual framework for the monitoring and evaluation of HIV-AIDS private sector programmes are graphically depicted below.

**Figure 8.3 Programme mission**

HIV-AIDS private healthcare programme	
Vision	To be the global leader in HIV-AIDS care provision
Goals	To decrease all HIV-AIDS-related mortality and morbidity  To maintain and sustain a PMTCT rate of 100%
Objectives	To offer strong clinical management guiding principles; fixed dose pill combinations; stronger adherence; better compliance; less ARV resistance; and first line drug regimen preservation
Research objectives	To implement HIV-AIDS-related operational research in order to enhance programme efficiencies

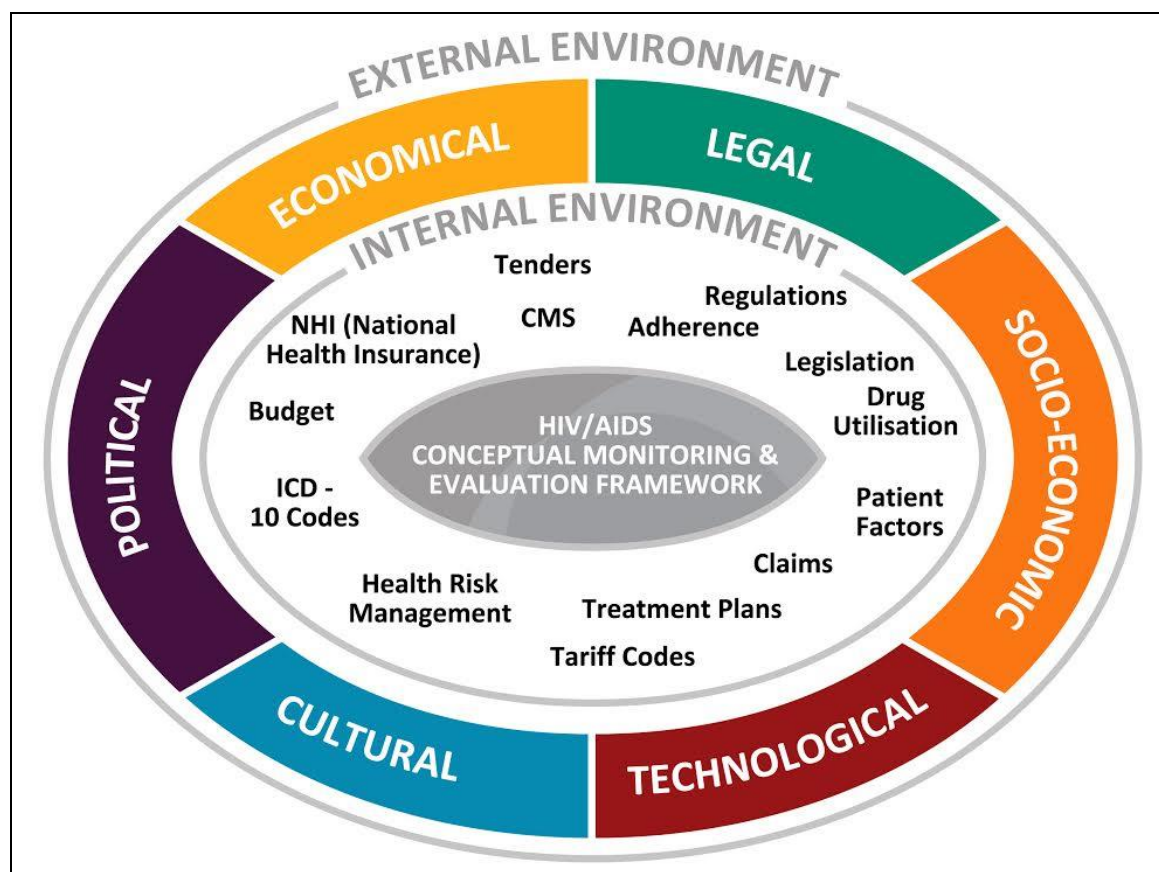
**Source: Self-generated (2016) with authors' viewpoints**

#### 8.3.2 The HIV your life programme's internal and external environment

The external environment explores the political, economic, socio-cultural, behavioural and technological factors impacting HIV-AIDS care in the private sector. There are several constraining and enhancing environmental factors that have been

identified as pivotal influencers in the internal environment. These are demonstrated in Figure 8.4.

**Figure 8.4 The HIV Your life programme's internal and external environments**



**Source: Self-generated (2016) with authors' viewpoints**

### 8.3.3 Technical specifications of the indicators

Indicators offer a consistent and standardised evaluation of effectiveness when adapted for use in HIV-AIDS healthcare programmes. With specific reference to the private healthcare sector, indicators need to have a tailor-made feature correlating with health risk in order to ensure appropriate mitigation and high organisational impact. For this proposed conceptual framework for monitoring and evaluation of HIV-AIDS, private sector programme indicators will be sensitive and provide an early warning thereby enabling proactive decision-making. Indicators will also provide a retrospective view on risk events, so lessons can be learned from the past.

Indicators will also provide a real-time actionable intelligence to decision makers and health risk managers.

The International Organisation for Standardisation (2015:01) defines Risk as *“the effect of uncertainty. Qualitative risk is proportional to both the expected losses which may be caused by an event and to the probability of the event. Greater loss and greater event likelihood result in a greater overall risk”*. Risk management is a structured approach to managing uncertainty related to a threat through a sequence of human activities, including risk assessment and strategy development to manage it. Risk management strategies may include transference of risk; avoidance of risk; reduction of risk; risk mitigation; and acceptance of risk. Healthcare risk management is a diverse profession in a dynamic and evolving healthcare industry (Moskowitz 2015:12).

Risk management in healthcare is potentially more important than in any other industry. A good healthcare risk management plan can reduce patient health risks as well as financial and liability risks (Yokota 2004:287). Risk rating of indicators is a key consideration for HIV-AIDS management. A proposed risk rated indicator matrix is tabulated below in Table 8.1

**Table 8.1 Indicator matrix**

<b>Process Measure</b>	<b>Indicator description</b>	<b>Source of Data</b>	<b>Data Collection frequency</b>
HIV-AIDS private healthcare programme input indicators (LOW RISK)	HIV-AIDS prevention services, HIV-AIDS promotion services; Condom distribution; number of STIs treated; Counselling and testing services; ARV prophylaxis to prevent MTCT; Counselling and	Programme weekly statistics  Medication summary  Drug utilisation report	Monthly, quarterly, annually

	support for safe infant feeding practices; and Family planning counselling or referral. Staff training and capacitation efforts, Training budgets, resources and infrastructure.	<p>Infant feeding practices</p> <p>Budget</p> <p>Staffing roster</p> <p>Training needs analysis</p> <p>Gap analysis</p>	
HIV-AIDS private healthcare programme process indicators (LOW RISK)	<p>Number of facilities conducting HIV-AIDS prevention/promotion services</p> <p>Number of facilities conducting HIV-AIDS Counselling and Testing services</p> <p>Number of HIV-AIDS individuals receiving ARVS</p>	<p>HIV testing kits utilisation</p> <p>ARV drug utilisation</p> <p>Marketing activities</p> <p>Outreach programme parameters</p>	Monthly,quarterly,annually
HIV-AIDS private healthcare programme output indicators (MEDIUM RISK)	<p>Number of HIV-AIDS individuals receiving TB treatment</p> <p>Number of HIV-AIDS individuals receiving PCP prophylaxis</p>	<p>TB drug utilisation</p> <p>PCP drug utilisation</p>	Monthly,quarterly,annually

HIV-AIDS private healthcare programme outcome indicators (HIGH RISK)	Number of infants tested by PCR at 6-14 weeks; Number of infants receiving an ARV prophylaxis; Number of HIV-infected pregnant women; Number of infants tested at 12 months; Adherence; viral load ; CD4 Marker; second line regimen, salvage regimen marker; co-morbidities	2 <sup>nd</sup> line drug regimen utilisation  PCR uptake report	Monthly,quarterly,annually
HIV-AIDS private healthcare programme impact indicators (HIGH RISK)	Behavioural changes; Survival; Quality of life indicators; Reduced incidence and prevalence of HIV –AIDS infection	Local, regional and national HIV prevalence	Monthly,quarterly,annually

**Source: Self-generated (2016) with authors' viewpoints**

Core indicators were selected according to the following criteria: (i) relevance of the indicator (ii) adequacy of the indicator in the HIV-AIDS context AND (iii) feasibility of obtaining the information needed to construct the indicator.

#### **8.3.4 Digital automation**

The researcher proposes that the conceptual framework be digitally automated to assist staff and management at the healthcare programme concerned. This can be easily achieved with programme developers and rigorous testing with application designers with integrating layout and analytics. New features can be updated based on alpha and beta testing. Considering the way in which mobile applications are continually changing the world with remarkable new applications being developed every day, this can be rolled out to monitoring and evaluation frameworks for HIV-AIDS. Health and hospital applications represent an area of incredible innovation, as healthcare workers are able to manoeuvre for education, learning and awareness. These apps can save time and provide useful information to the end-user.

A digitally automated conceptual framework will ease data collection as it will be automated; will allow for real time data trending; and provide daily, weekly and monthly reports on programme activities and programme targets. Access to data management will be controlled through managerial authorisations only in order to allow data integrity with minimal chance of data manipulation. Data reports can be generated based on the priority of indicators and can also be set up for alert functions to managers and programme decision makers. Functionality can also be set up to ensure snapshot dashboard and framework monitoring on smartphones and tablets at any time.

#### **8.3.5 Mobile application development**

A mobile app is a software application designed to run on mobile devices such as smartphones and tablet computers (Statistics South Africa 2015). Statistics South Africa (2015) estimated that people spend 52% of their time on digital media on mobile application usage. In addition, smartphone users spend approximately 89% of their phone time on mobile applications. In 2015 alone, the total number of iOS mobile application downloads was 25 billion and the total number of Android app downloads was 50 billion. Mobile applications are becoming very popular, spanning usage amongst all age groups and also across all sectors such as health, gaming, food, nutrition and fashion. Mobile applications also offer convenience and accessibility to all users and offer enhanced modes of mobile communication and



collaboration. Given that mobile applications are revolutionising the way people think, live and learn, the researcher proposes that an added advantage of a digitally automated HIV-AIDS conceptual framework will be to develop a mobile application for intended users. The application will be specific to the HIV Your Life programme but may be adapted for use amongst other HIV-AIDS programmes in the public, private and NGO sectors.

Haselmayr (2016:10) describes mobile application development in a few easy steps. Following the necessary research and goal development, a wireframe and storyboard is created. In this phase, ideas and features fuse into a clearer picture. Wire framing is the process of creating a prototype of the application. Following wire framing, prototype testing occurs. The development of back end and front end processes occur next. Back end processes encompass how the developer customizes the user's experience. Following this, access control and data control occur, with data storage then considered. Data integration which allows users to access from and publish data to third party users occurs next. Front end processes encompass storing data locally to speed up load time, thereby allowing for synchronisation which enables off-line usage. Finally, the user interface design and development process occurs, which leads to the testing process. Testing should be done with different groups of people over several time frames in order to ensure that all errors are excluded and data integrity assured.

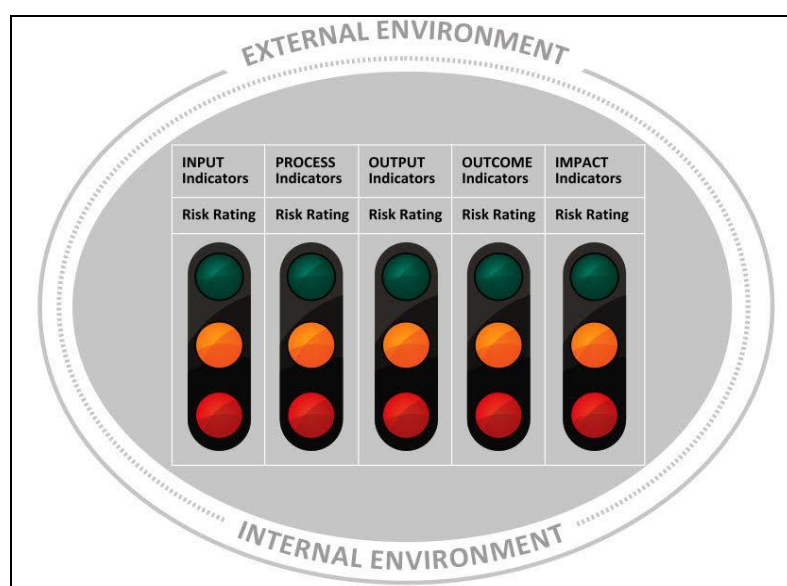
The development of a mobile application for the monitoring and evaluation an HIV-AIDS conceptual framework for the HIV Your Life programme will give this programme a competitive edge over other HIV-AIDS providers in the industry. A mobile application of this nature will allow for real-time data collection, collation and results provision. Data can be colour-coded and risk rated and provide a snapshot of whether the programme is in the red (danger) zone, yellow (caution) zone or green (good to go) zone. This will allow timeous interventions to be undertaken in real-time to address issues as they occur. Security measures can be installed to allow data integrity verification with all users, either getting read access or the ability to edit as well. Digital automation of this monitoring and evaluation HIV-AIDS conceptual framework for the HIV Your Life programme is an example of an innovative health

solution bridging the gap between HIV-AIDS healthcare and technological advancement.

### **8.3.6 Dashboard**

A dashboard is "*an easy to read, real-time user interface, showing a presentation of the current status and historical trends of an organization's performance indicators to enable instantaneous and informed decisions to be made at a glance*"(European System Risk Benefit: 2015). Dashboards often provide at-a-glance views of key performance indicators relevant to a particular programme or project. The researcher proposes the use of a dashboard as part of the proposed conceptual framework for the monitoring and evaluation of HIV-AIDS private sector programmes that can be used in both public and private healthcare sectors. Based on the literature review conducted for this research study, it is evident that no HIV-AIDS programmes in South Africa in the private sector are utilising dashboard functionality as part of the monitoring and evaluation conceptual framework to assess programme performance indicators. The researcher proposes the use of an HIV-AIDS dashboard structured according to a set of indicators based on risk stratification. Indicators can be triaged based on risk and programme outcome and mission. Triaging can be colour coded as red (severe); yellow (moderate); green (mild) and depending on the population of indicators, can be color coded to provide a visual measure of performance to gauge overall programme status as well as the problematic component.

**Figure: 8.5. Dashboard**



**Source: Self-generated (2016) with authors' viewpoints**

Depending on the information systems and information technology provider, the logic behind dashboard development can be decided by the programme manager. Most dashboards can also provide automatic alerts through sound or visual reminders to signal to managers in real-time when health components are deteriorating. For example, when a specific indicator changes from a green (mild) to a red (severe) status. From a healthcare worker point of view, in a busy clinic with multiple patients with multiple needs, a visible dashboard will be well received to assist with real-time HIV-AIDS programme target monitoring and evaluation. This dashboard has been developed through the realisation of objective 2 of this research study: *“To define a list of core indicators that will enable the tracking of progress in the most critical areas in the response to HIV-AIDS”*. Input and process indicators allow HIV-AIDS programmes the ability to devise the type of coverage the programme will have and the interventions that the programme will be responsible for. Output indicators give a clear picture of the service delivery coverage that the HIV-AIDS programme is able to reach within the designated drainage areas. Outcome and impact indicators provide data to assist HIV-AIDS programme managers with disease surveillance, incidence and prevalence rates.

This study revealed the importance of methodological combinations for a better understanding of results and the mechanisms of changes in the evaluation of HIV-AIDS private sector activities. Although the study had some limitations, the combination of quantitative and qualitative data provided the opportunity to construct HIV-AIDS monitoring and evaluation activities with corresponding indicators. This HIV-AIDS monitoring and evaluation framework could help to homogeneously assess HIV-AIDS prevention, treatment and wellness activities currently being implemented by HIV-AIDS programmes within South Africa. In addition, the indicator matrix could help healthcare workers improve their HIV-AIDS monitoring and evaluation activities. The indicator matrix enables the detection of gaps in intervention levels in order to generate strategies that may enhance HIV- AIDS programmes in the future. The above proposed digitally automated conceptual framework provides a clear roadmap to HIV-AIDS programme planning; monitoring and evaluation. It delineates clear pathways to programme goals and objectives and defines relationships between programme inputs, processes, outputs and outcomes. It describes how programme factors interact with external and internal environmental factors. The dashboard and automation functionality allows real-time assessment of programme measures in a novel, innovative and user-friendly manner. A proposed framework such as this is not only relevant to the private HIV-AIDS sector, but can be adapted for use in other sectors to ensure a multi-sectoral response to the HIV-AIDS epidemic. The innovative computerised technique allows this conceptual framework ease of use and offers a competitive edge over its counterparts.

#### **8.4 Recommendations from this research study**

- I. The gold standard for a homogenised national response to HIV-AIDS would be through the use of a single HIV-AIDS monitoring and evaluation conceptual framework for all sectors endorsed by the public, private and NGO healthcare sectors. This will result in a cost effective and collaborative approach to HIV-AIDS monitoring and evaluation conceptual framework for all sectors.
- II. A current void is that HIV-AIDS monitoring and evaluation efforts are not included in any formal undergraduate and postgraduate public health or

medical training in South Africa. It is recommended that given the local and national presence of this disease entity, HIV-AIDS monitoring and evaluation as part of the broader quality management aspect in healthcare should be included into the tertiary level curriculum.

- III. Due to the current HIV-AIDS prevalence globally and nationally, and due to the considerable efforts to mount a global response to bring about the end of HIV-AIDS, it is noted that several HIV-AIDS programmes have developed across the globe to combat this disease entity. In the absence of a dedicated HIV-AIDS quality management system inclusive of an HIV-AIDS monitoring and evaluation framework, it is proposed that for consistency and standardisation across all HIV-AIDS programmes, an ISO standard for HIV-AIDS programmes be developed and utilised for the quality management of such programmes. The researcher has proposed this to the ISO technical working group for health and is awaiting a response.
- IV. The development of an HIV-AIDS monitoring and evaluation framework in the form of a learning module aimed at healthcare workers to allow for implementation at ground level and to allow for more learning, development and training is also proposed. This is a tool for new knowledge generation.
- V. An online training and development module for the HIV-AIDS monitoring and evaluation framework is proposed for healthcare worker capacitation and new knowledge generation.

## **8.5 Pre-requisites for the successful management of the conceptual**

### **HIV-AIDS monitoring and evaluation framework**

In order for this conceptual HIV-AIDS monitoring and evaluation framework to be effectively implemented and utilised in HIV-AIDS programmes, all end-users need to be made aware of its functionality and be trained on its various aspects. Learning and development of this conceptual HIV-AIDS monitoring and evaluation framework has to be introductory and ad hoc in order to attain the best value. This study recommended the development of a learning module and an implementation model aimed at healthcare workers to allow for implementation at ground level and to allow

for more learning, development and training for this conceptual HIV-AIDS monitoring and evaluation framework. Specific human resources need to be allocated for training. Champions who are well trained on the aspects of the conceptual HIV-AIDS monitoring and evaluation framework should be identified and be used to train all employees on the floor to ensure employee buy-in, commitment and dedication to this project. Management support for this conceptual HIV-AIDS monitoring and evaluation framework should be visible and present to ensure that the pre-requisites for successful management of this framework are met.

## **8.6 Limitations**

The sample frame that was utilised within the scope and nature of this study included only the HIV Your life programme as it was a new programme exploring ways to continually improve and evolve. The sample did not allow for the inclusion of other HIV-AIDS programmes.

## **8.7 Recommendations for future areas of research**

- I. A feasibility analysis on the inclusion of HIV-AIDS monitoring and evaluation as part of quality management systems in healthcare in undergraduate and post graduate tertiary medical tuition in South Africa is needed. This will allow more capacitation and formal teaching, training and qualifications for healthcare professionals.
- II. A feasibility analysis for establishing an HIV-AIDS monitoring and evaluation council for oversight and governance of HIV-AIDS programmes in South Africa is warranted as this will enhance regulatory control, systems and processes of all HIV-AIDS programmes within South Africa.
- III. Devising a South African healthcare standard that is locally relevant and contextually appropriate is a necessity.
- IV. Exploring technological advancements towards a single data collection communication instrument across all HIV-AIDS healthcare sectors is suggested.

- V. Connected care and integrated care: developing a model for holistic HIV-AIDS care in the South African context is an area for future exploration.
- VI. This research study has shown that the emergent themes revealed several associations between leadership and selected sub-themes including training, communication and supportive supervision. Similar patterns were seen with stakeholder relationships and HIV-AIDS-related operational research activities. There is currently no data pertaining to this in the HIV-AIDS programme under study and therefore requires further exploration. This data will inform the leadership in this programme to better equip themselves and their employees for the ultimate success of the programme and organisation as a whole. This data may provide significant information that may inform the field of HIV-AIDS.
- VII. Based on the literature reviewed and data collected, there was minimal data available on South African smart practices in HIV-AIDS programmes. Given that South Africa hosts the largest HIV-AIDS programmes in the public and private sectors, a wealth of lessons can be shared locally and globally towards enhancing and optimising patient care. An urgent need exists to further explore these lessons and share them as smart practices with the greater HIV-AIDS fraternity.
- VIII. Global HIV-AIDS indicators may not be readily applicable to South African HIV-AIDS programmes given the nature and extent of the disease in South Africa. As such, this remains a void in the South African HIV-AIDS arena. This is proposed for an area of further research to develop locally relevant and culturally appropriate indicators for South African HIV-AIDS programmes through the development of a South African HIV-AIDS indicator registry.
- IX. The proposed HIV-AIDS conceptual monitoring and evaluation framework can be explored for use in other private HIV-AIDS programmes within South Africa.

- X. A SWOT analysis of the proposed HIV-AIDS conceptual monitoring and evaluation framework within the HIV-AIDS private sector can be undertaken to assess areas for improvement and success.
- XI. Given that South Africa has a well-established multi sectoral response to HIV-AIDS with various public, private and NGO programmes dedicated to the on-going prevention, treatment and wellness of HIV-AIDS. There is a need to develop common tools which are imperative to HIV-AIDS operational research activities to streamline work activities and to attain the best results possible from HIV-AIDS programmes.

## **8.8 Conclusion**

This research study comprised eight chapters taking the reader on a journey from the conceptualisation of this research study's aim in Chapter one to the realisation of the study's central objective in Chapter eight. Chapter one framed the context for this research study, explored objectives set against the study rationale and provided an outline based on the aim of this research.

Chapter two provided a global overview of the HIV-AIDS pandemic, including its epidemiology and origin. The routes of HIV transmission along with factors facilitating its spread were examined, together with determinants of the disease resulting in its high incidence in developed and developing countries.

Chapter three explored the HIV-AIDS epidemic in South Africa. It analysed HIV-AIDS statistics in South Africa and reviewed the social, political and behavioural aspects of the disease in the South African context.

Chapter four explored the components of quality management in healthcare of HIV-AIDS monitoring and evaluation, as one of the cornerstones of a country's response to HIV-AIDS.

Chapter five reviewed exemplar HIV-AIDS management programmes in the South African public, private and parastatal sectors.



Chapter six provided an overview of the research methodology undertaken for this study. It reminded the reader of the study population, sample size and methodologies undertaken for data collection and analysis.

Chapter seven presented the findings of this research study and provided elaborate discussion points on the interpretation of results.

Chapter eight culminated in the logical conclusion of this research study, framed on emergent themes from the research study's objectives, with recommendations based on the central objective of this study together with recommendations for future studies. This discussion was in line with the research study proposal to develop a conceptual monitoring and evaluation framework derived on quality management systems for the management of HIV-AIDS private sector programmes that can be used in both public and private healthcare sectors through an analysis of current conceptual frameworks in HIV-AIDS healthcare and HIV-AIDS programmes within the South African context of HIV-AIDS healthcare provision.

Huge challenges lie ahead in the battle against HIV-AIDS, where enormous gains but persistent challenges exist. More work remains to prevent and cure HIV-AIDS. Ending HIV-AIDS will require uninterrupted prevention, promotion and support of HIV-AIDS programmes across the globe. The cliché is true - *“what got us here, won't get us there”* (Sidebe 2016:23). *“The technology industry will take over medicine where anyone, anywhere can solve a problem or build a medical device that can cure diseases. Technology expanding footprints into health to develop healthcare solutions is necessary to fast track the end of HIV-AIDS”* (Wadhwa 2016). To put in place a comprehensive response to end the epidemic, concerted efforts and efficacious tools will be needed, such as the recommended automated conceptual framework to bring about the end of HIV-AIDS.

*“AIDS is not over, but it can be”.* (Michel Sidebe UNAIDS Executive Director 2016).



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## **ANNEXURES**

### **Annexure A**

#### **Permission letter**

15 August 2014

Dear Mr Adams

**Request for permission to conduct research**

I kindly request permission to allow staff members to participate in a research study by completing a questionnaire and participating in an interview. The information gathered will be treated as strictly confidential and will be anonymous. Staff participation in this research will be voluntary. Feedback from this study will be provided to all staff members at study completion.

Enclosed please find a copy of the questionnaire

Your support is highly appreciated in this regard.

Yours sincerely,

Shayhana Ganesh

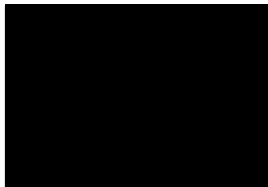
Permission granted

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Siraaj Adams

Executive Head

HIV Your Life Programme( MHG)



## **Annexure B Research Questionnaire; Letter of Information; Consent form**



## LETTER OF INFORMATION

**Title of the Research Study:** Management of a Private HIV/AIDS wellness programme: A Case Study of the HIV Your life programme

**Principal Investigator/s/researcher:** Dr. Shayhana Ganesh

**Supervisors:** Professor Renitha Rampersad/ Professor Nirmala Dorasamy

### **Introduction and Purpose of the Study:**

You are invited to participate in a research study currently being conducted for the HIV Programme .The nature and purpose of the research is to evaluate the HIV Your Life programme in order to enhance service delivery and patient care.

Participation in this study is voluntary and the responses will be treated in a confidential manner. In order to participate in this study an anonymous questionnaire will have to be completed.This will take about 10-20 mins. You are free to withdraw from the research at any time without any negative or undesired consequences to yourselves

**Risks or Discomforts to the Participant:** There are no risks or discomforts that may occur to you during study participation

**Benefits:** This research will assist in enhancing operational efficiency at your clinic and you will benefit from the enhanced service delivery.

**Reason/s why the Participant May Be Withdrawn from the Study:** You are free to withdraw from this study at any stage.

### **Remuneration:**

There is no remuneration for this study participation however you will be offered refreshments during the interview

### **Costs of the Study:**

There are no costs to you for this study participation.

### **Confidentiality:**

Your participation will remain confidential at all times and no information will be made available without your consent.

### **Research-related Injury: (Persons to Contact in the Event of Any Problems or Queries:**

Please contact the researcher (072 973 8652.), my supervisor (+27 31 373-6876/5277) or the Institutional Research Ethics administrator on 031 373 2900. Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031 373 2382 or [dvctip@dut.ac.za](mailto:dvctip@dut.ac.za).

Thank you for your time. Your co-operation is mostly appreciated.

Kind regards

---

Dr S Ganesh

Faculty of Management Sciences

Department of Public Management

031 574 3557 / 072 973 8652





## CONSENT

### Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Dr. Shayhana Ganesh, about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: \_\_\_\_\_,
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

_____	_____	_____	_____
<b>Full Name of Participant</b>	<b>Date</b>	<b>Time</b>	<b>Signature / Right Thumbprint</b>

I, Shayhana Ganesh herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

_____	_____	_____
<b>Full Name of Researcher</b>	<b>Date</b>	<b>Signature</b>

_____	_____	_____
<b>Full Name of Witness (If applicable)</b>	<b>Date</b>	<b>Signature</b>

_____	_____	_____
<b>Full name of Legal Guardian (If applicable)</b>	<b>Date</b>	<b>Signature</b>



**Faculty of Management Sciences**

**Department of Public Management**

**Date**

**Dear Participant**

**COVERING LETTER: RESEARCH QUESTIONNAIRE**

I am currently registered for the PhD degree in Public Management and Economics at the Durban University of Technology. The purpose of this study is to evaluate the HIV Your Life Programme in order to enhance service delivery and patient care. Please assist me in this study by completing the attached questionnaire. Please be advised that any information you provide on this questionnaire will remain completely confidential and you, as the participant, will remain completely anonymous. All data collected within this survey, will be treated with the utmost confidence, and will be housed on a secure server and will be used solely for the purpose of this study. Participating in this study is totally on a voluntary basis. You are not compelled to participate and can withdraw from this study without providing a reason, at any time you wish you wish to do so.

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If you have further questions, please do not hesitate to contact me on 031 574 3557/ 072 973 8652

Thank you for your time. Your co-operation is mostly appreciated.

Kind regards

---

Dr S Ganesh

Faculty of Management Sciences

Department of Public Management

## Research Questionnaire

Instruction(s): Please indicate your level of agreement with the opinion expressed in the statements below by marking the appropriate box with a (X)

### Section A: Biographical Information

1	Job description	Clinician	Counsellor	Lay counsellor	Health care worker	Pharmacy assistant
2		Administrative staff	Nurse	Disease manager	Pharmacist	
3	Number of years employed in the organisation	0-5 years	6-10 years	11-15years	16-20years	➤ than 20 years
4	Gender	Male		Female		
5	Age	18-25yrs	26-30yrs	31-36yrs	37-40yrs	>40yrs
6	Ethnicity	Indian	White	Coloured	Black	Other

### Section B: Monitoring and evaluation processes

#### 1.1 Quality Management Systems

		SD	D	N	A	SA
1.1.1	<b>Stakeholder/Relationship management</b>					
1	The business understands the needs and requirements of their stakeholders (partners, patients ,service providers)					
2.	Partnerships to plan coordinate and manage the monitoring and evaluation system need to be developed for a successful framework.					
3.	A monitoring and evaluation plan should contain aspects dedicated to communication, advocacy and developing culture					
4.	An HIV-AIDS monitoring and evaluation plan should be developed in conjunction with all stakeholders and reviewed bi-annually					
1.1.2	<b>Leadership</b>					

1.	Leadership is proactive rather than reactive to changes in the field of HIV/AIDS					
2.	Escalation of complaints/compliments to leadership are clearly defined and easily accessible					
3.	Leaders receive HIV-AIDS training at regular intervals to ensure adequate knowledge generation					
<b>1.1.3</b>	<b>Engagement of people</b>					
1	Training and refresher training is conducted regularly as part of the programme					
2.	A reward and recognition programme is provided					
3	Communication is two-way between management and staff members					
4	Ad hoc surveys should be sent off to monitoring and evaluation staff to assess how improvements can be enhanced to the plan					
5	Human capacity for HIV-AIDS monitoring and evaluation frameworks needs to be planned and budgeted for.					
6	Management should motivate individuals to become monitoring and evaluation champions					
7	Supportive supervision and data auditing is warranted to build strong monitoring and evaluation frameworks					
<b>1.1.4</b>	<b>Continual Improvement</b>					
1.	Trust, openness, confidence and assertiveness is our approach for result oriented productivity of the programme					
2	Criteria of success are based upon target achievements by individuals					
3	Methods are consistently used to improve our work and gain advantage					
4	Competition, achievement and productivity are part of goal setting to improve performance					

<b>1.1.5</b>	<b>Evidence based decision making</b>					
1	Decision making is based on objective guidelines and clinical protocols					
2	Decisions for clinical management of patients should be based on sound clinical discretion					
3	Continuous professional development toward clinical learning and development in building clinical capacitation is key in HIV-AIDS programmes					
<b>1.1.6</b>	<b>Process Approach</b>					
1	Instructions and regulations are needed to govern every procedure of work					
2	Security, conformity and predictability define our work					
3	Dissatisfaction is communicated without fear of information used against at a later stage					
4	Organizational structures with HIV-AIDS monitoring and evaluation functions are key to successful monitoring and evaluation frameworks.					
5	Monitoring and evaluation frameworks will be a strategic component of the National Health Insurance plan					
6	A comprehensive budget should be allocated for monitoring and evaluation planning and implementation					
<b>1.1.7</b>	<b>Customer focus</b>					
1.	Management should motivate individuals to enhance service provision toward customer satisfaction.					
2.	Client -Centricity should be the core focus of HIV-AIDS programmes					
3.	The Batho Pele principles can be adapted for use in non-government sector HIV-AIDS programmes					

### Section C: Core indicators

		SD	D	N	A	SA
1.	All monitoring and evaluation staff should review program documents with stated goals and objectives prior to programme indicator compilation					
2.	Input indicators should cover resource allocations and human capital data					
3.	Process indicators should cover quality of service, and service statistics					
4.	Output indicators should provide data on estimates of service coverage					
5.	Outcome indicators should provide data on behaviour change/morbidity					
6.	Impact evaluation should provide data on risk, prevention risks and population level impact					
7.	Indicators should be devised and focused on what the programme should achieve					
8.	Indicators should be adaptive for diverse settings					
9.	Indicators should ensure that key factors that may influence program implementation and success are identified					
10.	Availability of monitoring and evaluation reference materials is a special strength					

### Section D: HIV-AIDS related operational research activities

		SD	D	N	A	SA
1.	Setting the research agenda is an important starting point for operational research activities					
2.	Expanding support for operational research activities is key to successful clinical management treatments					
3.	Developing common tools are imperative to operational research activities					
4.	HIV-AIDS operational research requires significant					

	expansion of resources.					
5.	HIV-AIDS related operational research activities strengthen links to policy					
6.	HIV-AIDS related operational research activities improve collaboration among health programs					

#### Section E: Data management

		SD	D	N	A	SA
1.	Data dissemination utilizing monitoring and evaluation reports should determine methods by which data will be collected, analysed and reported					
2.	Capacity for collecting and using data should be assessed prior to project start up					
3.	Monitoring and evaluation data should inform research agendas					
4.	Data management should assess procedures for processing, storing and managing monitoring and evaluation data					
5.	Data managers should understand program goals and objectives					
6.	Monitoring and evaluation plans should move away from a reliance on paper based data collection					
7.	Data managers should identify user needs and perspectives					
8.	System management improvement is a key aspect of building sound monitoring and evaluation plans					
9.	Technological innovation should revolutionise monitoring and evaluation data collection					
10.	Prior to implementing new data management techniques data management should learn about existing data collection systems and quality					

### Section F: HIV-AIDS Programmes Stakeholder management

		SD	D	N	A	SA
1.	Taking stakeholder concerns and interests into account can improve organisational relationships					
2.	Stakeholder engagement can identify material risks and opportunities for HIV-AIDS Programmes					
3.	A concerted effort must be made to ensure that stakeholders are qualified to provide the right insight into key HIV-AIDS issues.					
4.	Regular stakeholder engagement should be ensured so that a variety of opinions, insights, knowledge and collaboration can be obtained and feedback can be provided on actions taken based on specific stakeholder requirements and expectations.					
5.	Good stakeholder management ultimately improves the quality and outcome of HIV-AIDS programmes					

### Section G: Strengthening the capacity of all partners in HIV-AIDS programmes

		SD	D	N	A	SA
1.	Building strong health systems is a crucial step on the path toward universal access to comprehensive HIV-AIDS programs					
2.	Capacity building can occur through identification of gaps in individual skills or organizational systems.					
3.	Local resources, staff expertise and experience can be leveraged to provide assistance such as coaching and mentoring with compliance to donor regulations					
4.	Ensuring that new skills, tools and resources are successfully adapted into standard operating procedures are key interventions at strengthening the capacity of all partners in HIV-AIDS programmes.					
5.	Clear and transparent communication efforts is integral to strengthening the capacity of all partners in HIV-AIDS programmes					



**Section H: Smart practises of HIV-AIDS monitoring and evaluation frameworks.**

		SD	D	N	A	SA
1.	Adequate quality management system training of all staff members working in HIV-AIDS programmes is integral for successful outcomes.					
2.	Buy in from all stakeholders are key to successful monitoring and valuation framework implementation					
3.	Clear, precise and transparent communication is an integral success measure					
4.	Standardised contextually relevant indicators are an important component in HIV-AIDS monitoring and evaluation framework development					
5.	Real time data collection ,data analysis and data collation are important steps to data integrity					

**Section I: Challenges of HIV-AIDS monitoring and evaluation frameworks.**

		SD	D	N	A	SA
1.	Ineffective internal and external communication within an organisation is identified as a key challenge to successful monitoring and evaluation HIV-AIDS framework implementation					
2.	Ineffective data collection mechanisms may impede data integrity					
3.	Monitoring and evaluation HIV-AIDS frameworks that are not adapted for use in diverse settings may not attain the desired outcomes.					
4.	Ineffective stakeholder management may lead to resource misuse and fraudulent behaviour					
5.	Inconsistent and irregular staff training may be viewed as a critical impediment toward HIV-AIDS monitoring and evaluation implementation.					

**Your assistance and cooperation is greatly appreciated. Thank you!**

**Annexure C Face to Face Interview Schedule; letter of information; consent form**



## LETTER OF INFORMATION

**Title of the Research Study:** Management of a Private HIV/AIDS wellness programme: A Case Study of the HIV Your life programme

**Principal Investigator/s/researcher:** Dr. Shayhana Ganesh

**Supervisors:** Professor Renitha Rampersad/ Professor Nirmala Dorasamy

### **Introduction and Purpose of the Study:**

You are invited to participate in a research study currently being conducted for the HIV Programme. The nature and purpose of the research is to evaluate the HIV Your Life programme in order to enhance service delivery and patient care.

Participation in this study is voluntary and the responses will be treated in a confidential manner. In order to participate in this study a face to face interview will be done. This will take about 10-20 mins. You are free to withdraw from the research at any time without any negative or undesired consequences to yourselves

**Risks or Discomforts to the Participant:** There are no risks or discomforts that may occur to you during study participation

**Benefits:** This research will assist in enhancing operational efficiency at your clinic and you will benefit from the enhanced service delivery.

**Reason/s why the Participant May Be Withdrawn from the Study:** You are free to withdraw from this study at any stage.

### **Remuneration:**

There is no remuneration for this study participation however you will be offered refreshments during the interview

### **Costs of the Study:**

There are no costs to you for this study participation.

### **Confidentiality:**

Your participation will remain confidential at all times and no information will be made available without your consent.

### **Research-related Injury: (Persons to Contact in the Event of Any Problems or Queries:**

Please contact the researcher (072 973 8652.), my supervisor (+27 31 373-6876/5277) or the Institutional Research Ethics administrator on 031 373 2900. Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031 373 2382 or [dvctip@dut.ac.za](mailto:dvctip@dut.ac.za).

Thank you for your time. Your co-operation is mostly appreciated.

Kind regards

---

Dr S Ganesh

Faculty of Management Sciences

Department of Public Management

031 574 3557 / 072 973 8652



## CONSENT

### Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Dr. Shayhana Ganesh, about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: \_\_\_\_\_,
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

_____	_____	_____	_____
<b>Full Name of Participant</b>	<b>Date</b>	<b>Time</b>	<b>Signature / Right Thumbprint</b>

I, Shayhana Ganesh herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

_____	_____	_____
<b>Full Name of Researcher</b>	<b>Date</b>	<b>Signature</b>

_____	_____	_____
<b>Full Name of Witness (If applicable)</b>	<b>Date</b>	<b>Signature</b>

_____	_____	_____
<b>Full name of Legal Guardian (If applicable)</b>	<b>Date</b>	<b>Signature</b>



**Faculty of Management Sciences**

**Department of Public Management**

**Date**

**Dear Participant**

**COVERING LETTER: FACE TO FACE INTERVIEW**

I am currently registered for the PhD degree in Public Management and Economics at the Durban University of Technology. The purpose of this study is to evaluate the HIV Your Life Programme in order to enhance service delivery and patient care. Please assist me in this study by participating in a face to face interview. Please be advised that any information you provide will remain completely confidential and you, as the participant, will remain completely anonymous. All data collected within this survey, will be treated with the utmost confidence, and will be housed on a secure server and will be used solely for the purpose of this study. Participating in this study is totally on a voluntary basis. You are not compelled to participate and can withdraw from this study without providing a reason, at any time you wish you wish to do so.

If you have further questions, please do not hesitate to contact me on 031 574 3557/ 072 973 8652

Thank you for your time. Your co-operation is mostly appreciated.

Kind regards

---

Dr S Ganesh

Faculty of Management Sciences

Department of Public Management

## **Section A: HIV-AIDS Monitoring and Evaluation Processes**

1. Can you briefly discuss what quality management is?
2. Can you briefly discuss what Monitoring and Evaluation activities you are aware of?
3. What do you think there are any benefits to Monitoring and Evaluation?
4. What does the Monitoring and Evaluation activities want to change and how?
5. What are the specific objectives to achieve this change?

## **Section B: HIV-AIDS Core Indicators**

1. Can you briefly discuss the HIV-AIDS programme indicators?
2. Can you briefly discuss data collection on HIV-AIDS indicators?
3. Can you briefly discuss if the programme delivers appropriate information on indicators?

## **Section C: HIV-AIDS related operational research activities**

1. In your opinion what are the current operational challenges with HIV-AIDS related operational research activities?
2. In your opinion, what do you think the strengths of this programme are?
3. In your opinion, what do you think the weaknesses of this programme are?

## **Section D: Data management**

1. In your opinion, what do you think the data flow channels between the different stakeholders are?
2. What training needs do you think will be required to implement Monitoring and Evaluation in your environment?

## **Section E: HIV-AIDS Programmes Stakeholder management**

1. In your opinion, who do you think the HIV-AIDS programme stakeholders are?
2. In your opinion, what do you think the challenges are with the programme stakeholders?
3. In your opinion, how should these challenges be addressed?

## **Section F: Monitoring and evaluation HIV-AIDS Smart practises**

1. In your opinion what monitoring and evaluation recommendations can be made to help or alleviate the burden of HIV-AIDS in South Africa?
2. Where do you think the gaps are with regards to service delivery of HIV-AIDS healthcare provision in South Africa?
3. How can these gaps be addressed?
4. What smart practises can be shared across all care providers for optimal patient treatment?