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CROSS- SECTIONAL ANALYSIS OF POINT OF CARE AS DETERMINANT FACTOR IN THE IMPLEMENTATION OF HIV/AIDS INTEGRATION POLICY

Maureen Atieno Adoyo *	Post Graduate Student *Corresponding Author
George Ochieng' Otieno	(PhD) Lecturer
Charles Omondi Oyaya	(PhD) Executive Director

ABSTRACT Involvement of multiple actors in HIV/AIDS intervention programmes led to inefficiency and ineffectiveness in service delivery. Later, integration policy come to force although policy success seemed varied across regions. Therefore, this study aimed at establishing influence of point of care factors in the implementation of HIV services integration policy. A cross-sectional study adopted to allow rapid analysis of policy environment. Multi-stage sampling technique used to arrive at samples, semi-structured questionnaire utilised for data collection. A total of 33 health workers and 8 coordinating agencies responded. Results indicate 76% of the hospitals had functional organization structure for participatory decision-making, structured clinic days mostly 5 days a week and guided institutional practices .50% of the facilities had no routine maintenance schedule for medical equipment's. Hence study recommends for intensive focus on ensuring routine maintenance for continuity of service delivery and cross learning among Institutions

KEYWORDS : HIV/AIDS, Care, Integration, Policy.

Introduction

Before implementation of service integration policies and guidelines, HIV and TB care were for example, offered in vertical systems. Communication and interaction between the staff of different projects offering HIV/AIDS related services had limited capacity, patients who had co-infection of HIV and TB received clinical care at multiple points. (Owiti et al., 2015; Wu et al., 2011)

When efforts were made to ensure coordination in HIV/AIDs service delivery, differentials in the implementation of service integration were observed. The differentials were evident when facilities packaged and offered services. The challenges arose from the limitation of human resources, inadequacy in medical supplies and poor coordination in information management. The limitations in the different institutions had been cited as the major attribute of unacceptable levels of quality of care for HIV/AIDs patients leading crisis at patient; local organization and community level in controlling HIV/AIDS related complications. (Owiti et al., 2015) .

Previous study on integration Indicate that with weak Leadership fail to champion the development or implementation of services integration policy. This scenario was experienced in Southern and Central African Countries, in which the government failed to have a clear integration policy framework or had weaker services integration guideline to support successful implementation of policy. This therefore acted as a barrier at lower level, particularly point of care hindering successful implementation of desired health reforms unless, the individual institutions through its leadership had innovative ways of countering challenges imposed from national levels(African Institute for Development Policy & Gates, 2014).

Material and Methods

This study adopted cross- sectional study design given the need to perform rapid analysis of the different settings of points of care. Both quantitative and qualitative approach to data collection used for purposes of triangulation and information obtained in parallel situation converged for analysis and presentation.

Five (5) Counties within Kenya purposively selected to represent the unique profile in relation to HIV dynamics. The counties selected were either high burden, high population of key population, busy transport corridor, marginalized and rich culture community, and multicultural urban setup. The counties representing the above description were Homabay, Mombasa, Isiolo, Kajiado and Nairobi. Respondents were drawn from hospital with comprehensive care units, and all the staff dedicated for CCC services who were available during interview days were taken through consenting process then interviewed.

A semi structured interviewer administered questionnaire used for data collection. The research team adopted interactive process of disclosing information pertaining purposes of the study and voluntary participation without inducement or loss of benefits incase legible participants declined to participates in the study.

Results

Having clear structures of decision making that involved participation of staff at different levels in operation process under integrated services was found to be at a higher level of 56% compared to facilities which reported medium level of participation at 20% and others who did not have clear opinion and reported neutral position in their participation in organization operations was recorded at 24% see **figure 1**

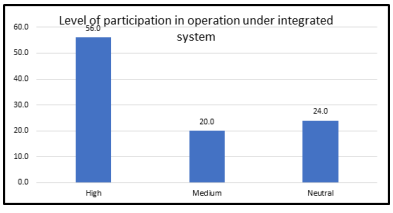

Figure 1: Level of staff participation in facility's operation

An assessment of organization functionality determined by established operation system and with focus on client appointment booking system revealed that in most of incidences (60%), facilities had a functional systems of booking clients' appointment and were available for verification, in other circumstances (23.3%) the system was reported to be in use although not available for verification and in rare circumstances (16.7%) client appointment booking systems was not available, see **figure 2**

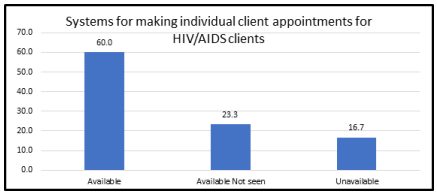

Figure 2. Systems for booking patient appointment

Robust and functional organization have scheduled maintenance of infrastructure to allow for uninterrupted services to its clients, the results in **figure 3** here in indicated more than half (50%)of the occurrences reported by health workers showed that facilities did not have routine infrastructure maintenance with only small portion (33.3%) reported to have routine maintenance, while others (16.7%) did not have idea whether there was routine maintenance or not.

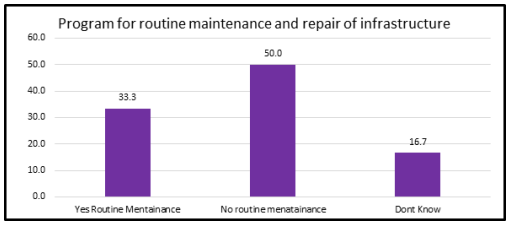

Figure 3 : Program for routine maintenance and infrastructure repairs

The mean, modal, and median number of days for clinics in the among study facilities was 5. The minimum number of clinic days per week was 3 while the maximum number of days was 5. Subsequently, the mean, modal, and median number of clinic days available in the Comprehensive Care Centres for TB clinics in those facilities reported at 5 days while the minimum number services available per week in the facilities were 3 while the maximum number of clinic days was 5. The mean number of days for the youth friendly services, community based services and family planning reported as one day each with the median and the modal number of days being 1 for each of the mentioned services. The minimum number of days for those services were zero while the maximum was 1. See **table 1**

	Clinic Days per week	TB clinics	Youth Friendly services	Community Based services(CBS)	Family planning
N	30	25	25	25	25
Mean	4.67	4.67	.76	.68	.88
Median	5.00	5.00	1.00	1.00	1.00
Mode	5	5	1	1	1
Minimum	3	3	0	0	0
Maximum	5	5	1	1	1

Table 1.Daily Services available in Comprehensive Care Centres

Under the universal integration policy in which all facilities required to operate, the study sought to find out ease and efficiency in which health workers could operate while delivering quality services. **Figure 4** below showed that majority 76% of health workers said there was a clear structure under integrated services for both CCC and Hospital, greater proportion 90% thought it was easy for them to work and communicate under the existing integration structures. Integration structures also called for routine meetings for reviewing managerial and administrative matters with high percentage of 93.3%. Further, most (73.3%) health workers reported co-location of HIV/AID services with greater margin of evidence on structured clinic days which was reported at 86.7%. Mechanism for linking counselling HIV testing and ART services was also high at 96.7%.

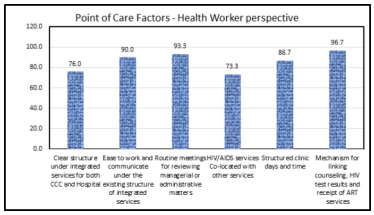

Figure 4: Point of care factors- Health worker perspective

Discussion

Functionality of organization defined by established structures and rules that shape decision making. Besides, mature, and well-established organization structures allow staff participation at different levels of operation. This study established that health facilities were at different levels in practicing participatory approach of management and administration. Majority, 56 percent reported high level participation of staff in operation since the beginning of implementation of integration policy while others reported medium and neutral level of participation with records of 20 and 24 percent respectively.

Operations systems described by client appointment booking system varied from facility to facility depending on intensity of pool of clients, level of care and healthworker or team initiative and/or innovations at point of care Nevertheless, 60 percent of the reporting facilities had a functional system for booking client appointment and available for verification, 23 percent reported to have a client appointment booking system however, they were not readily available for verification. Few facilities (17 percent) did not have defined or formal systems for booking clients appointment. The approach to booking clients appointment. This study supported evidence that indicate differentials in the implementation of services integration policies a fact that is attributable to limitations in resources, leadership and other institutional arrangements (African Institute for Development Policy & Gates, 2014; WHO, 2009).

Planning and scheduling of operations including routine maintenance of equipment and infrastructure ensures uninterrupted services provision to clients who need them. There were glaring differentials with half (50 percent) of the reporting facilities having no definite schedule for routine maintenance and only small proportion of 33 percent reported routine maintenance. Lack of routine maintenance of equipment surmounts to unavailability of diagnostic and treatment services leading to high number referral cases reported at an average of 92 percent for both health centres and sub county referral hospitals. The deficit in resource availability concurs with WHO (2007) observation that prompted the call for integration that would eventually aid Countries and facilities create synergies through resource sharing thereby making services available.

Organizational practices and culture particularly, daily services available at comprehensive care center were almost similar across the reporting facilities, most (99 percent) of the facilities had five (5) days clinic schedule excluding weekends. Available data showed a mean and mode of five (5) days a week. Other services for example TB were offered five (5) days a week in most (83 percent) of the facilities with a few reporting a minimum of three (3) days a week. Youth Friendly Services (YFS) for teenagers and young adults reported the least clinic days with an average of one (1) day a week while some facilities did not have YFS services at all. Similarly, Community Based Services (CBS) and FP clinics had an average of one (1) day a week. This scenario observed in clinic days with YFS, CBS and FP having least clinic days were evidently based on service utilization. The YFS CBS and FP services described in the study targeted critical groups in effort to reduce HIV/AIDS scourge however, they remain underutilized because possible stigmatization, lack of specialized personnel and less efforts made to create awareness on the available services by individual institutions, health workers and community gatekeepers. Thus,

missed opportunities in treatment & care spiralling to complications and eventually crisis at patient level especially for the vulnerable group ,an event decribed similarly in a study conducted by (Keugoung et al., 2014; Tran, Phuong, Nguyen, & Cameron, 2012). Overall, desired services organization evident through availability of clear organization structures and culture where joint review of managerial and administrative matters was a common practice, all together built an environment that influenced health worker capabilities. These capabilities reflected in the efficient and effective delivery of healthcare services. This study established that most (72 percent) had clear structures of which, 90 percent found existing structures effective while undertaking operations within the healthcare settings. Review meetings were binding frames for handling key administrative and management matters amicably, an indicator of noticeable commitment levels by all stakeholders in the implementation of integration policy. With the same background, approximately 73 percent of the facilities had their services co-located, 87 percent showed structured clinic days and 97 percent had proper mechanisms for linking counselling and ART services.

Point of care is determinant factor in policy environment and health system strengthening. Therefore, there is need to encourage cross learning among institutions, more so through identification of functional organization structures, practices, and culture for purposes of benchmarking and replication.

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