EMERGING IMPLEMENTATION SCIENCE IN SOUTH AFRICA

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TODAY’S SEMINAR

- share the South African context for scale up of mental health interventions in primary care
- outline challenges and opportunities for researchers in this emerging field in South Africa
- describe some ongoing implementation initiatives in 4 South African provinces
SOUTH AFRICA – THE RAINBOW NATION

• Transition to democratic government post-apartheid (1994)
• The dream of the ‘rainbow nation’
• Liberal constitution (1996) crafted by struggle activists
  • human rights principles
  • promotes equality
  • progressive on, gender, sexuality, civil partnership
  • Legislative authority devolved to the 9 provinces
• Strong culture of social activism and nation building
• Strong civil society organisations (e.g. Section 27)
• History of social activism on health – Treatment Action Campaign – activists moved to health system
South Africa world’s most unequal society - report

SOUTH AFRICA: 28 MARCH 2018, 07:17 AM / SWINE FEEKETHA
About 40% of South Africans lived below the lower bound poverty line in 2015, up from 36.4% in 2011.
Racial inequality declines to its lowest levels yet

The income gap between race groups is the lowest it has ever been.

Using a monthly income per capita threshold of R4100, research shows SA’s black middle class has grown.

Black South Africans now represent the largest share of the middle class.

The constraints of apartheid are gradually being lifted.

Racial integration and social cohesion may emerge with a substantial lag...

But, life chances of South African children remain tragically unequal...

Black affluence can be interpreted that...

Society may be becoming fairer with opportunities.

Economics and Political Science departments Stellenbosch University (SU)
The corruption of South Africa

• R27 Billion loss annually
HEALTH SYSTEM CONTEXT

- Efforts to turn around the racialized provision of health care
- 1990s onset of HIV epidemic
- Mbeki era AIDS denialism
- Manto 2006 Toronto AIDS conference
- Current ARV programme globally recognized
  - More than 3 million people on treatment since 2004
  - We CAN do scale up, but little use of frameworks to research and improve implementation
Dr. Beetroot

AIDS treatment? Don't get me started on that 'years of scientific research' nonsense.

Vegetable Garden
HEALTH SYSTEM CONTEXT

- Huge spending on voluntary health insurance (not only the wealthy)
- National Health Insurance bill
- Health insurance (compulsory)
- Centralised purchasing of health services from public and private providers (standards of care and regulation)
- Economies of scale
SPENDING ON PRIVATE HEALTH CARE UN可持续

- Private hospitals (3 hospitals, listed on the Johannesburg Stock Exchange) – rapidly increasing profits
- Competition Commission - Health market enquiry – unfair monopoly
- Similar picture of quality and spending for primary healthcare
PRIVATE VS PUBLIC
IMPLEMENTATION SCIENCE IN SOUTH AFRICA

- General acceptance of the concept of evidence-based practice
- Less widespread understanding that effectiveness data is not enough
- Department of Health quality improvement cycles/efforts e.g. ideal clinic
- We need South Africa specific research on processes, barriers, facilitators, implementation strategies
- Acceptability, appropriateness, feasibility, adoption, fidelity, costs, sustainability
- Few researchers working with the established implementation frameworks, but growing interest
POTENTIAL

- Great potential to benefit from reducing the implementation gap for evidence-based practices in primary care.
- Momentum and political will around health system strengthening with build up to NHI bill.
- Progressive and public health minded minister of health understanding that we cannot afford the 17 year effectiveness to implementation gap.
STRENGTHS: NATIONAL DEPARTMENT OF HEALTH QUALITY IMPROVEMENT

• National Department of Health recognizes primary care as the backbone of the public health system

• Quality improvement efforts – the IDEAL clinic

• Response to the growing burden of chronic diseases in South Africa

• Adequate infrastructure, adequate staff, adequate medicine and supplies, good administrative processes, applicable clinical policies, protocols and guidelines

• Collaboration with other government departments, the private sector and non-
IMPROVING PRIMARY CARE: PACK IMPLEMENTATION

Dr Lara Fairall and colleagues
Evolved from guidelines developed to address widespread TB and multidrug resistant TB crucial challenge in Western Cape Province
The Practical Approach to Care Kit (PACK) - a health systems improvement programme for primary care workers in underserved communities (doctors, nurses, midwives, health officers, community health practitioners)
Challenges with training, supervision and mentoring of health staff
PACP provides simple treatment algorithms/guidelines for common presentations in primary care
Nationwide training and use
Widely used and liked by nursing staff (particularly the younger staff)
Adaptation and transfer to Brazil, Nigeria, Ethiopia, Botswana, Malawi
ONGOING IMPLEMENTATION RESEARCH

- Prof Inge Petersen, Dr Lara Fairall
- CDC Funded – scale-up of counselling for depression in patients with HIV
- Effectiveness trials – COBALT, PRIME-South Africa
- 3 Provinces (KwaZulu Natal, Mpumalanga, Limpopo)
- Using the Re-AIM framework

- Martin Prince – Kings; South African PI Crick Lund
- 5 African countries. (Uganda, SA, Ethiopia, Malawi, Zimbabwe)
- South Africa – scale up of routine screening for CMD in midwife obstetric units in Cape Town Screening for CMD and violence using PACK tool Referral to lay counsellor (trained) employed in MOU by NGO
PROJECT MIND

• PI – Bronwyn Myers: Chief Specialist Scientist, SAMRC
• Longstanding relationship with Department of Health – interest in future implementation studies
• Quadruple burden of chronic communicable disease, non-communicable diseases, injury and mental disorders.
• Untreated common mental disorders:
  • poor adherence to chronic disease treatment
    • more rapid disease progression
    • treatment failure
• Screening (depression, substance use) and brief intervention
• PROJECT MIND: Chronic disease clients (diabetes, HIV), comorbid depression (CES-D) OR risky alcohol use (AUDIT)
FACILITY MANAGERS SUB-STUDY

• Key to integration of the intervention, and any change in the service

• Responding to crises, staff management, clinical work, management and administration

• Challenges: Community contexts, resources, interpersonal and hierarchical relationships, change fatigue

• Aim: Investigated experiences of implementing service changes, current challenges

• In-depth interviews, 20 PHC facility managers Western Cape (urban and rural)
BUILDING CONTEXTUAL UNDERSTANDING

• Majority reflected on lack of capability to address social determinants:
  • Poverty
  • Young mothers
  • Violence (gang-related)

‘Violence in our communities is also a constriction because people can’t get through here to come to the clinic to get their treatment…If there’s an outbreak, we can’t go in certain areas to get the children measles…The gangsters is very prominent and the violence is there every day. They’re still killing people’

‘It’s different now. I think the mothers is getting the babies very young, of poverty. I think in the olden days the oumas have played a bigger part and they will bring the children to the clinic but now the oumas is very young. They don’t have that responsibility to bring in the children’
HEALTH SYSTEM CHALLENGES

• Majority cited
  • Increasing patient burden
  • Budget constraints (staff shortage, inadequate infrastructure)
  • Managing staff performance issues
  • Union involvement
  • Patient lack of responsibility for their own health

‘The people who come up with this wonderful cost containment plan, they are safe out of the water. You’re going to cut on treatment which means it’s going to take longer to stabilize your patient. What’s the sense in all of this?’
EMERGENT RESPONSES

- Responses
  - All described strong problem solving skills to cope with these challenges – crisis management
  - Emotional support for overburdened staff
  - Commitment to community and patients

‘Sometimes I must be a manager I must push them a bit; but sometimes I will tell them; "Guys, I see. It's a hard work, this is what is expected of us. I know sometimes we feel... overwhelmed. I'm a human being, I feel like that. But this is what we signed up for. Remember these are our people, they depend upon us’
MENTAL HEALTH BURDEN

• Overwhelmed by burden of care extending to patients and in particular their staff

• Disillusionment with the system and wider context

‘At times you are stretched to that point where you don’t know am I coming or am I going and you don’t know where do I latch on now for support. Even if you’ve got less resources but you keep on trying. Patients must not suffer because of that.’

‘I enjoy being a nurse and I enjoy being a manager, and I think I can strategize very well but for the years working for the department it seems as if it’s just getting worse and worse and I’m at that point where I can’t take it anymore.’
WORK-RELATED STRESS

- Two substantial causes of stress
  - seeing first-hand the adverse impact of resource constraints on patients
  - personal accountability for health outcomes and facility statistics in this challenging environment

‘...you want to help people, that's how we were brought up and how we were trained, and now you must send people home because you can't help them, ja that's very degrading’

‘And it’s not as if your communities are getting smaller. They are growing and growing and you can’t tell them no, I can’t give you service because we don’t have money, and what is the patient going to do? The patient is going to lodge a complaint with who? With the minister. And then who must give the answer? I must give the answer.’
Workload inducing resistance to change

‘Because we have a shortage of staff it’s not always easy to implement something new... because we are under a lot of pressure, seeing a lot of people you tend to try to work faster but now you can imagine that one sister doing two people’s work is not enough.’

Staff’s lack of understanding of an innovation and its potential benefits

‘.. I think what we need to do is give them [staff] a bigger insight into a public health output and actually if you spend more time doing the community work you should have less burden in your facility.’

Staff personalities, attitudes, and behaviours lead to resistance to change

‘I try to understand people’s personality... identify the ring-leaders, the strong people, the... people with influence... and then try to work with those people.’
Suboptimal communication through DOH structures

‘.. sometimes the managers go to meetings and say “Yes, it will benefit our facility” But then the people [staff] actually don’t know about it they just see it as extra work and they don’t do it.’

Hierarchy of health system limits managers decision-making on innovations

‘It is simply said there is a budget and this is the staff you are given, so you must just cope. Then they [subdistrict] say you must work ‘smarter’. I don’t know how to work smarter to get through more people’

Frequency and pace of change is overwhelming

‘Last year the the TB policies changed about four times, HIV about six times and people were overwhelmed with all the changes’
Figure 1: Framework of managerial competencies supporting innovation adoption and health system resilience.
IMPLICATIONS FOR FUTURE MIND IMPLEMENTATION

- All but one of these managers remained positive of their ability to address ongoing challenges with a pragmatic approach
- Commitment of primary care facility managers positions them as a lever influencing public health outcomes
- AVOID eroding this vital human resource
- Strong support from Western Cape Department of Health for implementation study
- 2019 co-development with managers - intervention for management capabilities promoting innovation adoption
THANK YOU, ENKNOSI, DANKIE