

# Management Tract

## HEALTH CENTRE<sup>1</sup> MANAGEMENT STRATEGIES TO ADDRESS THE CHALLENGE OF ARV ADHERENCE

### Timetable

0800-0815	Introduction: The importance of adherence Introduction to group work session 1
0815-0900	Group work session 1: Obstacles to adherence
0900-0945	Feedback from group work, discussion
0945-1015	Tea
1015-1030	Explanation of group work session 2
1030-1130	Group work session 2: Overcoming obstacles to adherence
1130-1200	Report back and discussion: Group 1
1200-1230	Report back and discussion: Group 2
1230-1315	Lunch
1315-1345	Report back and discussion: Group 3
1345-1415	Report back and discussion: Group 4
1415-1445	Report back and discussion: Group 5
1445-1500	Tea
1500-1530	Report back and discussion: Group 6
1530-1600	Report back and discussion: Group 7

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<sup>1</sup> The term health centre is used to refer to the service point for AIDS care. This could be an out-patient clinic in a hospital, a health centre or a specialised or general primary care clinic.

## 1. Introduction: The importance of adherence

Over the past 9 days of training you have learnt about all the different ingredients that go into the successful provision of anti-retroviral therapy – correct clinical care, accurate prescribing, addressing stigma and many others. At the core of ARV care are three basic steps:

1. Clients presenting for care
2. Appropriate care and prescribing
3. Lifelong adherence to care

All these steps have challenges and are interlinked and become ever more difficult as the scale up provision of care from a few patients to the large numbers of people who could benefit.

The third step, adherence, is particularly difficult. Adherence (or as it is sometimes called, compliance) refers to the client following the advice given / treatment regimen prescribed by the health service. Adherence poses real challenges for the client – whether they are rich or poor, literate or illiterate, as is evident from experience with adherence for other chronic diseases. In HIV there is the added risk of rapid emergence of drug resistant strains of HIV in the face of poor adherence. However, there is much that we as health care providers can do to improve patient adherence. That is what we will be exploring today.

## 2. Group work session 1: Obstacles to adherence

*You are the nurse in charge of a health centre that is providing / about to add anti-retroviral care to its services. You are committed to providing good quality care to your patients and to ensuring that your clients attend regularly and adhere to their care regimen. You recognise that achieving this is going to be quite a challenge.*

Please break up into 7 groups and answer the question:

**# What are the obstacles that could prevent you from achieving success?**

Please write your answers onto flipchart paper. The first group to give feedback will go through their full list. The groups that follow will only add NEW points that have not been mentioned before. By the time the last group has presented we will have a complete list that includes all the obstacles identified by all 8 groups. (You have 45 minutes to do your group work)

## 3. Group work session 2: Overcoming obstacles to adherence

You can see that we have categorised the obstacles to adherence that you identified in group work session 1 into 7 clusters of obstacles. Please break up again into your 7 groups and answer the question:

**# How would you as a health centre manager overcome these obstacles?**

(You have 60 minutes for your group work and then each group will have 15 minutes to present their answer, to be followed by 15 minutes of facilitator led comment / discussion)

## **Note to learners**

Educational research has shown that a problem based learning approach is the most effective pedagogy for learning about the management challenges of providing effective HIV care. As you will identify problems based on (and your group's) experience and the real situation you face, and then find concrete, "real world" solutions to them, you will leave with a practical set of innovative ideas on how you can overcome these challenges. As opposed to a set of lectures, where the learning is easily forgotten, learning is internalised and retained over time and more readily applied to your work situation.

Back up reading material (post-readings) will also be provided to you at the end of the day and the presentations of the groups will be written up and circulated.

Evaluation of this module is based on ascribing a mark to each of the presentations in part 2 of the class i.e. "How will you as the health centre manager overcome these obstacles?"

## **3. HEALTH CENTRE MANAGEMENT STRATEGIES TO ADDRESS THE CHALLENGE OF ARV ADHERENCE**

In your group work you will have identified many obstacles to adherence to HIV care and identified many ways in which you can improve management, quality, motivation and community involvement to improve adherence. We will be providing you with a handout of your group presentations. To help to guide you further in providing successful long-term care for your clients, we have prepared some notes (below) based on experience of improving adherence in chronic disease care generally and for AIDS care specifically. To be successful in improving adherence you will need to:

- 1. Create a client-centred, stigma free clinic environment**
- 2. Treat patients as partners in their own care**
- 3. Provide comprehensive care**
- 4. Address factors at home that prevent clients coming regularly for care**
- 5. Link clients to community resources and care supporters**
- 6. Ensure that your supply and logistics systems work constantly**
- 7. Achieve a motivated and patient centred staff**
- 8. Monitor your progress and use the information to improve the service**

### **1. Creating a client-centred, stigma free clinic environment**

If you go to a shop to buy something and feel you are treated badly, you will not easily go back to that shop and rather go to another one that welcomes you and treats you with respect. In ARV care clients don't often have a choice of easily going to another clinic. If your clients feel uncomfortable or embarrassed they may simply not come back (drop out) or come back on and off (irregular attenders). Even patients who have been regular attenders may drop out if they get to feel stigmatised. That is why we need to create a client-centred, stigma free environment.

Patients need to feel welcome. How we greet them is important. Do they feel that you are pleased to see them and interested in their wellbeing or that they are another "burden in the

days load”? When you are consulting what is your tone of voice and what does your body language say? Is your response neutral to information on behaviours that you may disagree with or do you show your displeasure or annoyance. This is not to say that you should not advise clients, rather to emphasise that this must be done in a positive respectful way.

An important part of a stigma free clinic environment is privacy. Firstly, patients need to feel confident that your staff will respect their privacy. Some and even many will not have disclosed their status and others may have disclosed to selective friends or family or to other PLWAs or community based carers, but don't want their status to be information in the public domain. The question for you is how to make sure that there is not disclosure of the patients status without there wanting it to be so. One way we may do this inadvertently is by having a sign saying HIV clinic and publicly saying to patients within earshot of other (general) patients “the HIV clinic is over there”. Some people feel that the solution is to treat ARV patients as part of the general queue, while others feel that this will not ensure the specialised care and quality standards required. You will need to assess your own clinic situation to decide how to balance this out. A big sign is often inappropriate.

One difficulty with privacy is that we can end up giving our clients a mixed message. On the one hand we are saying that AIDS is just like any other disease and that there is no shame and we encourage disclosure; on the other hand we are recommending respect for privacy as a strategy for compliance. We need to continue to do both and offer privacy as a routine part of our service, without clients feeling that we have gone to special lengths to do so.

We do need to discuss disclosure as you have learnt earlier in the course, but ensure that this only happens when the client is comfortable and ready to do so. Forcing the issue may alienate the client and lose them to care.

Amongst the clients most sensitive to how they are treated are adolescents. They don't want to be parented or patronised by “adult” staff, while at the same time needing to feel that their clinic is adolescent friendly. Because of the long latent period in HIV you may not have many adolescents on ARV, but you should be aware that they are amongst the easiest patients to lose to follow up.

## **2. Have patients as partners in their own care**

Very often in health care we manage patients as passive recipients of care. We tell them what they need to do and expect them to follow our advice – sometimes, even unconsciously we behave a bit as if we were adults relating to children and talk down to and patronise our patients. The reality is that this doesn't work in chronic disease care and leads to poor adherence. Patients need to become informed adult partners in their own care. The starting point is that they need to understand their own disease well and how the treatment will help. There is lots of evidence that patient's being well informed is a sine qua non for good adherence, without it you cannot get this end product.

They need to understand the necessity of taking their tablets daily as a responsibility to themselves and to the community. Patients as partners in their own care, means that their management plan should be a participatory plan that they have helped develop. You have got a checklist of all the steps that need to be taken and they should decide with you when and how it should be done, although the clinical judgements remain with the health professional. At the same time, patients should know the important side effects of their treatment and that they do not simply have to suffer these if they occur – they need to know that there are treatments that can overcome many of the symptoms.

A motivated patient is also critical to adherence. This has been explored quite a bit earlier in our training, so it isn't repeated here. One point to re-emphasise is that criticism must be done in a positive, encouraging way, as doing it through fear and threats is usually counter-productive. The patient should feel that the carer behaves as would a close friend they have turned to for help, not as a "policeman" who is trying to catch them out for doing something wrong. How we ask questions to find out about adherence should reflect this friendly approach – the patient should feel that you are asking information in order to determine how you can help them. Then, if things are not going according to plan, you should say something like this to the client: "We need to try and work out how we can overcome this difficulty – have you got any ideas". In short, you should apply the counselling skills that were covered earlier in the course.

The bond that gets established between the client and their carers (nurse, counsellor) is one of the strongest factors affecting adherence. If they see a different carer each time then there is no ongoing relationship. There is the discomfort of someone new instead of "you are looking much better than last month – do you feel better?" or "how are things going at home now?" It also provides the ideal foundation for another critical contributor to adherence – one on one counselling and will also shorten consultation times for quality care, as the carer gets to know her/his clients. There will be times when the person's carer is not there, such as when they are on leave, and then of course someone else will need to step in. There will be times when a patient would like to change carers and this should be respected. Not doing so may lose them to care.

Pill counts are an interesting subject. Most ARV texts will tell you that you should count the left over pills to see if patients have been taking their medicine. The problem is that once you have done this once, patients may know the routine and if they feel uncomfortable or inspected, they will simply discard those that should have been taken and then you get wrong information. You need to judge each situation and decide what is best to do.

### **3. Provide comprehensive care**

In South Africa, we don't talk about ARV roll-out, we rather speak about comprehensive HIV and AIDS care, management and treatment. The difference between the two is important for adherence. ARV care is part of comprehensive care. If we are simply ARV pill providers we will not facilitate compliance, firstly because the patient may have other health problems that need attention. So, if the patient has other complications, such as TB or opportunistic infections and these remain untreated, then the patient will not feel well, your treatment becomes discredited and he/she may then decide to seek care elsewhere.

Another aspect of comprehensive care is ensuring that the patients' basic needs such as for nutrition are met. This is often very difficult in poor communities where there is already high unemployment, limited subsistence agriculture and little social welfare. In South Africa we are fortunate that our clients are entitled to a welfare grant. The problem is that many do not actually get one. Part of your job at the clinic is to link your client to those who can process the grant, and if possible to have a social worker as part of your clinic team. Also, if there are income generating groups in your area, you should, with the clients permission, link them to the group. Advice on the most cost-effective and socially acceptable nutrition options should also be part of your service. Some services offer food supplements as part of addressing this. One challenge is that in poor households this food will tend to get shared with others, even if you intend it for the patient only. We should not be too critical of this and understand why it happens.

Meeting psycho-social needs of patients can add a lot of time to the consultation, especially early on in treatment. Clients will have many concerns, and even though they might get better on ARVs they may still fear the worst early on in their treatment. They may have

understandable fears, there may be job related issues and if they are a breadwinner or parent they will surely be worrying about their family. In this course you have learnt about one on one counselling and group counselling, and about counselling by health professionals and by lay counsellors. You will have to judge your own situation and establish what works best. One thing is for sure, you cannot leave out the psycho-social aspect of care if you want to achieve adherence to ARV treatment. At the same time we need to do this in a way that it doesn't "lock up" too much of the health professionals time, as the aim is to increase the numbers of people who are able to access ARV care.

How we deal with disclosure can also affect adherence. If we push the patient too hard on this before they are ready we may chase them away. However, by not exploring disclosure at all we might be avoiding dealing with something that might lead to poor adherence later. For example, when the patient is much better, the family may ask "Why do you need to keep going back to the clinic now that you are better?"

#### **4. Address factors at home that prevent clients adhering to care**

A lot has been written about evaluation at the home before starting ARV care. We need to recognise that the purpose of this evaluation is not to deny people, especially poor people, their right to care because their circumstances are not suitable. Rather, the purpose is to better understand the home situation in order to effectively address those factors that could block adherence. The best way to do this is indeed to visit the home, but make sure that there are no blunders made, such as inadvertently disclosing in the home.

Because we have relatively few treatment sites at the moment, patients may have to travel far for care. This is because we want to ensure high quality care at accredited sites. This may be good for quality and for adherence of this living near the accredited site. But, it is not good for equity of access for those further away and for their regular attendance for care (attendance adherence) as getting to the accredited clinic takes time and money that poor people may not have. The aim over time must be to bring ARV care within easy reach of all South Africans. For now, your care plan that you work out jointly with the patient should include a plan on how he/she will manage to attend regularly – transport, time off work etc. Some people have even suggested that we should refund bus fares to patients who come for care, but this will raise questions of why we are not doing it for other patients and also problems of accounting for the funds. However, we must be responsive to the difficulties. For example, for patients coming from far away there may be limited options to get home and if they finish at the clinic too late, they may not make the last train / taxi home and they may be left to try and find a place to sleep. This will not encourage them to come regularly. Next time they may feel that they can't come because they haven't got money to pay to sleep or to buy cooked food.

#### **5. Link clients to community resources and care supporters**

Linking clients to community resources and care supporters improves adherence in a number of ways. It helps to reduce the sense of isolation and feelings of stigma and offers moral and other support as well as enabling patients to remember and attend for their clinic appointments. However, although there may be good relations between them, there are often poor referral links between the clinic and community structures. This needs to be established and a simple effective means of referral established so that when the client consents, the link is made and the chain of care is not broken. All clinics should have a list of community services and contacts in their area of service.

There is often discussion about which PWA group/NGO/CBO/FBO<sup>2</sup> it is best to refer the patient to. Often there isn't a choice as some areas have a lack of community structures. An established PWA group does have some unique advantages over other groups, but the two most important factors are patient choice and that the organisation functions honestly and effectively. Therefore you need to get to know the organisations in your community, so that you are aware of their strengths and weaknesses and can advise your client on the best match for them. The important thing is that your clients are not left feeling isolated.

You need to make sure that the connection is made. It is not enough to give a letter of referral and hope it happens. In busy clinics community organisations sometimes have someone based at the clinic for this purpose and some of your VCT volunteers may also be active in one of the community structures. You can also, with the clients permission, give their contact details to the community organisation. This must always, again with permission, include whether or not the client has disclosed lest there is an indiscretion when they visit the home.

Where there is a lack of active community structures some clinics have established their own ART support groups. In other areas HCC and VCT organisations have extended their services to include ARV support. This is a logical development of their community work and should be encouraged if they have the capacity to do it properly. If not, you should consider assisting them to establish it.

Whoever is providing the care support there are certain critical features of their contribution. Amongst these are that they need to be reliable and dependable, and that they are a supportive friend, not an inspector. Many people misunderstand the role of care supporters, be they DOTS supervisors or ARV supporters. The misconception is that the care supporter is inherently reliable and that the patient is unreliable. What really makes care support work is the bond that is established between the two. The care supporter knows the patient is waiting for him/her and the patient knows the care supporter is expecting him/her. Fulfilling this mutual expectation is what creates the effectiveness. It is therefore important that all care supporters are adequately trained and understand the nature of the social relationship that they are building and practise it. Much of what was said under "*point 2: Patients as partners in their own care*" applies as much to care supervisors as much as it does to health professionals.

If you do not have community organisations in your area to work with you should explore the possibility of helping to establish one. This may be through a respected person in the community who has shown interest or through approaching an established organisation to start a branch in your area or both. If you have organisations that are not that successful right now, and if they are "clean" (i.e. not corrupt) then you should see if there is a way to help them develop themselves. The details of how to do this are beyond the scope of this training.

## **6. Ensure that your logistics and supply systems work constantly**

Logistics is how you organise things – and how these work – queues, records, drugs and laboratory tests are amongst the most important. These have to work constantly, because any lapses can damage adherence.

In some communities time queuing is one of the most important influences on adherence. Certainly if someone loses pay for the time they are not at work, this can be a big problem. In

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<sup>2</sup> PWA = Persons living with HIV/AIDS, NGO = Non-governmental organisation, CBO = Community-based organisation, FBO = Faith-based organisation

your situation you have to assess if there are clients who will be lost to care if they end up in long queues. The best option is then to try and give them an appointment at a fixed time, preferably in the afternoon when the clinic is quieter and your other clients won't feel poorly done by when they see what they might perceive as favouritism for some patients. If you can give appointment times to other clients this is always helpful, but not always achievable in reality.

There are however ways of shortening long waiting times, but you need to be careful that this is not done at the expense of quality care. One option is to have a quick queue for patients who have been on care for a while, are regular attenders and are well. A problem to watch out for is that the patient says they don't have any problems so as to access the fast queue and things – especially on the psycho-social side get missed and not attended to. Another strategy is to review your patient flows and find out where the bottlenecks are occurring and see if there are ways in which you can address these. At the same time we need to recognise that good care does require time with each patient. Therefore, another strategy that has been used to reduce queues is to divide your patients up into 3 groups, depending on their condition, how long they have been on regular care and other factors. The first group are those that are in a more serious condition and need to be seen weekly or fortnightly, the second the regular group, who need to come back monthly for care and the third the well-established group who have community support. They may be best managed by giving them a 3 months supply of drugs. This means less visits for them, but also allows shorter queues and more time for those patients that really need more intensive care, which leads to better adherence for them. Patients can be moved from one group to the other depending on their situation i.e. from the weekly to the monthly to the 3 monthly group or vice-versa.

Good patient records play an important part in treatment adherence. So, you need to be confident with your record system. First clients must be sure about confidentiality. Then, the records should not be lost, so you need an effective record numbering and filing system. Systems where patients get a sequential number in order of attendance e.g. 4507/04 tend not to work well. Maybe the best is to use and file by the ID number. Other places prefer to file by when the patient is next due. This is helpful to identify patients who have missed appointments, but often makes it difficult to find when the patient doesn't come on that day. Most important is to be able to find the record and to identify missed appointments. Many clinics keep an attendance book for each day with a list of patients who attended on that day. This is not very helpful, although it does allow for easy calculation of the number of attenders. Some clinics now use a system similar to the one used for TB, which allows for monitoring TB adherence.

One option is to have a reference list of patients with their due dates for their next attendance. Then, if a week has passed and they have not attended, you can put in place your defaulter tracing system through your clinic staff, volunteers or community organisations. If you use a book, you can use a different page for each letter of the alphabet and extra pages for M (Ma-d, Me-h, Mi-m, Mn-z). The attendance reference list might look something like this – there are different ways of doing it – the important thing is to be able to identify people missing appointments. (Of course, if you have a computerised record system there are other ways of doing this.) If you were reviewing this record on the 20 November, you could see that John and Thandi have been regular attenders, that Anathi has missed his appointment and you will need to follow-up if he does not come in the next 3 days, that Desiree missed an appointment but did return, that tracing Terrence should already be in place, and that Thoko is a well-established regular attending patient who is well and on 3 monthly visits.

Surname	First name	ID 1 <sup>st</sup> 6	September				October				November				December			
Mabunda	John	550218		11			09				07			06				
Makole	Thandi	771129			14			17				16				15		
Matteo	Desiree	810416	04				05				03			02				
Mbenge	Anathi	790105	04	11	18	25	02	09		23	05		17					
McKay	Terrence	640815	07				06					04						
Mdluli	Thoko	720524				25											23	

In general you should also have a patient-kept record that has the most essential information on it, especially their ARV regimen. The problem is that some clients may not feel comfortable with this in case someone who they don't want to see it comes across it. However, for patients who are mobile, and may seek to continue their care at another service point – public, private or work, either temporarily or permanently, such information is invaluable.

One of the most devastating blows to both patients and health staff is when drugs go out of stock. Every effort has to be made to ensure that this especially does not happen in ARV care. The best method is prevention, rather than racing around for drugs because you have run out. At the clinic level this means that you must make sure that your ordering is properly planned. On the one hand you do not want to over order, on the other you want to be safe. A simple method to decide how much to order is to reach double your usual order-supply time usage if you order less than a week before your new order, or triple your usual order-supply time usage if you order a month before your new order will arrive. This will mean that you always have enough supply in stock for failure of one ordering cycle.

So, if you receive your supplies monthly and your average monthly use is 88 pre-packs, you round this up to 100 and if you order a week before the supply is due to arrive, you multiply by 2 to get your stock level i.e. 200. Then, if you have 60 in stock you order 140. If you are ordering a month before you should have a stock level of 300 and order 240. If your number of patients is increasing, remember to increase your baseline stock level.

The care protocol requires quite sophisticated laboratory tests and this may cause delays in receiving results and loss of patients. Because they are not on your list of patients on treatment, you may not even pick up that they are lost to care. Patients not coming back for their HIV test results is a problem that has largely been solved by rapid HIV testing. But what if a patient has a CD4 count <200 and has not returned for their result? Should we follow them up? But, what if they do return for their result and it has been delayed? Do you delay the start of care until it is there, realising that the patient may lose confidence and may not come back to start care. The author's opinion is that the benefits of not losing patients and their confidence in your care and hence future likelihood of adherence means that it would be better to start care if the clinical situation warrants it i.e. has clinical features indicative of a low CD4 count. In fact, the same may apply if the costs of laboratory tests in the guidelines exceeds what is available on the budget e.g. for viral load testing.

## 7. Achieve a motivated and patient centred staff

When we add AIDS care to the responsibilities of clinic staff, especially if there is no extra staff, we are asking a lot of them. This means that staff need to be well prepared and motivated and see the value of their efforts and that their contribution is valued, so that they feel motivated to make the extra effort. Without this patients will not get the quality of care and caring and attention to detail that is needed for successful adherence.

One of the reasons for poor adherence is a lack of AIDS expertise and understanding amongst staff – this course should have overcome this barrier, as well as the barrier of a judgemental attitude - but in itself this is not enough. Some of the things that need to be done, such as improved conditions of service and more staff may be beyond what you can do yourselves, but there is much that can be done, including:

- Build a common purpose and commitment amongst your team – build your staff into a mutually supportive team. Communicate well and keep staff informed.
- Live the values that you encourage – staff will take their cue from what they see you do, not what you say. Show caring and quality in your own patient care. Also build your expertise so that your authority comes more from the respect that staff have for your expertise and management ability and not simply from your line authority. Staff should experience you as their mentor.
- Involve your staff in planning your services and in identifying problems that you face and in proposing solutions to them – remember the value of regular team meetings but don't make them unnecessarily long and bureaucratic.
- Make sure you have a plan for the development of your services, but not one that is so complicated that it serves no practical value and sits on a shelf gathering dust. Your plan should be the centre of your management. Each month you should take stock of where you are making progress and where you have problems. When staff see that you are committed to the plan, they become more committed.
- Staff should feel that you recognise their individual contributions and their accomplishments.
- Show respect for your staff and the effort that they put in by the way you relate to them and provide supportive supervision –you are there to help them solve their difficulties and not just find faults. If there is a problem deal with it in a way that builds the staff member's commitment to addressing it and to the team and its goals, not one that makes them feel humiliated and alienated.
- Ensure that your logistics systems (e.g. drugs, laboratory, welfare grants) and hospital and community referral networks are working. It is really very difficult to maintain a positive work climate if your staff can't give their patients their medicine, if they can't get help for them. Also, staff need to be able to refer patients promptly if the care they require is beyond what the clinic can offer and receive feedback on referred cases - something that happens too seldom. If you have expert / doctor visits make sure that this is a learning opportunity for your staff.

A very useful question that helps you identify what is really of concern to staff is to ask them: If you were the district manager, what two things would you do first to improve staff morale at this clinic? And what if you were the clinic manager?

Always remember that volunteers are part of your team and in effect part of your staff and need much the same and even more of the leadership from you that was described above.

## 8. Monitor your progress and use the information to improve the service

Many clinics do not have an effective monitoring and evaluation system and many managers do not know where to start. There is also often a lack of information for planning and statistics are kept “for head office” and not used much locally for management purposes and the information collected does not always give practical ideas on how to improve services. There is also often a lack of feedback to staff on progress, other than anecdotal information.

The starting point of any monitoring system is to ask yourself what you are trying to achieve, how can you see if you are getting there and where there are weaknesses, what information would help you to address them. If your goal is an increasing number of patients on ARV treatment who are adhering to their care, then the following are examples of useful information that can be tracked over time to see if your results are improving.

- The total number of patients on care and the month on month increase.
- The percentage of patients who return for their laboratory test results.
- The percentage of patients who have attended for care for each of the first six months after starting care
- The percentage of patients on care who attend each month
- The number of non-adherers followed up and the percentage successfully returned to care
- The percentage of clients linked to community organisations and receiving care support
- The average number of days to receive laboratory test results (Is this reducing)
- The number of days the clinic is without one of the drugs used in AIDS care

In addition to this kind of data, you may find it useful to do some small studies to assist give you more information. You can do:

- Focus group discussions with staff, patients and / or community leaders on aspects of the services and how to advance them to improve adherence.
- Patient interviews or questionnaires to establish their knowledge about their condition and care, their experience of the clinic and its staff and how to improve it. If you do this always get patients informed consent and assure them of anonymity, otherwise you will get what is known as obsequious answers. This means that clients feel a bit threatened by it and give you the answers they think you want to hear. Patient exit interviews are used quite often, but these are not very accurate. The reason is that staff will know that you are asking about the care received and so will naturally make extra sure that they “do everything by the book”. This is called the Hawthorne effect. It is therefore better to ask patients before today’s care about their knowledge and about the care they received the last time they attended.
- Observation of patient care can help you assess whether staff can do something correctly, but cannot be used to assess what they actually do under routine circumstances, again because of the Hawthorne effect.

- Staff questionnaires to test the organisational climate in the clinic – to ask about how motivated they are (or are not) and about the various factors that influence morale and motivation.
- Review of patient records, for example to establish if the correct drugs are being prescribed in the correct dosage and if appropriate return dates are being booked. One problem with record reviews in busy clinics is that things are sometimes done but not written down, unless there is a specially developed easy to use ticksheet or similar record. The opposite can also happen - something is done poorly, but is recorded.

All methods of monitoring – routing data, patient care observation, record reviews, interviews, questionnaires and focus groups have their advantages and disadvantages, but as long as one is aware of the limitations of each and use them sensibly you can really become an informed, evidence based manager.

## 5. Further reading

For those who would like to read more about improving adherence the following further reading is provided:

- Ministerial Task Team chaired by Mbewu A. Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa. Pretoria: Department of Health, 19 November 2003.
- Department of Health, South Africa. HIV/AIDS & STD: Strategic Plan for South Africa: 2000-2005. Completed January 2000.
- Management Sciences for Health. Creating a Climate that Motivates Staff and Improves Performance. *The Manager* (Boston) 2002; 11(3): 1-22.
- Management Sciences for Health. Achieving Functional HIV/AIDS Services through Strong Community and Management Support. *The Manager* (Boston) 2002; 11(3): 1-28.
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## 6. Addenda