Acta Academica Supplementum 2006(1): 44-93

Dingie van Rensburg

The Free State's approach to implementing the *Comprehensive Plan*: notes by a participant outsider

This study reviews the first two years of implementation of the *Comprehensive Plan* in the Free State, within the national framework and amid external influences. The features and principles of the province's approach are analysed, in particular the phased, multi-model, PHC-centred nature and its emphasis on partnerships and inclusiveness. As implementation progresses, constraints and deficiencies are seen to emerge: a lack of leadership and support, a flawed national-provincial relationship, a lack of comprehensiveness, programme verticalisation, drug insecurity, chronic indecision and lack of action, a fixation on operational issues with concomitant neglect of strategic matters, and breakdowns in communication and co-ordination. Despite notable progress in implementation, it is necessary to rethink and redesign aspects of the approach. By identifying the major lessons to be learnt from the Free State's experience, this study attempts to inform such rethinking and redesigning, as well as highlighting lessons for application elsewhere.

Die Vrystaat se benadering tot implementering van die *Komprehensiewe Plan*: aantekeninge deur 'n deelnemende buitestaander

Die bydrae gee 'n oorsig van die implementering van die *Komprehensiewe Plan* gedurende die eerste twee jaar in die Vrystaat, binne die nasionale raamwerk en te midde van eksterne invloede. Die kenmerke en beginsels van die provinsie se benadering word ontleed, veral die gefaseerde, multimodel, PGS-gesentreerde aard en klem op vennootskappe en inklusiwiteit. Namate implementering vorder, ontwikkel stremminge en gebreke: 'n gebrek aan leierskap en ondersteuning, 'n defekte nasionale-provinsiale verhouding, gebrek aan omvattendheid, programvertikalisering, medisyne-onsekerheid, chroniese besluit- en handelingsverlamming, fiksering op operasionele probleme met verwaarlosing van strategiese sake, en breuke in kommunikasie en koördinasie. Ten spyte van merkwaardige vordering met programimplementering is dit nodig om aspekte van die benadering opnuut te bedink en te herontwerp. Deur lesse wat uit die Vrystaat se ervaring geleer is, wil hierdie bydrae sodanige heroorweging en herontwerp informeer, benewens om lesse vir wyer toepassing daaruit te abstraheer.

Prof H C J van Rensburg, Centre for Health Systems Research & Development, University of the Free State, P O Box 339, Bloemfontein 9300; E-mail: vrensh.hum-@mail.uovs.ac.za

The Free State's version of the *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa* (CCMT programme) was, like the national plan, introduced towards the end of 2003.[1] Since then implementation has proceeded through an initial preparation phase as well as a subsequent establishment phase, and is now entering its expansion phase.[2] It remains a programme of massive proportions posing immense challenges to policy implementers — indeed, Chapman (2005) described it as "one of the most significant public health interventions" and went on to say "I believe it will become the most difficult public health intervention to sustain". The challenge becomes even more demanding as service delivery has to be reorientated from acute to chronic disease care to ensure uninterrupted, life-long treatment and high levels of adherence to multi-drug regimens over many years. These requirements make HIV care (including ART)[3] a technically and managerially complex and labour-intensive health intervention (Schneider *et al* 2004).

This contribution gives an overview of the implementation of the ART programme in the Free State province of South Africa. It records the provincial roll-out during the first two years (October 2003 to October 2005) describing the main features and principles of the Free State's approach and recording notable innovations and achievements, as well as flaws and failures which emerged during the implementation process. Although the focus is primarily on the Free State, many of the elements

1 The Free State's Plan for ART is explained in two documents from August-September 2003, namely the *Proposed Plan for the Free State Department of Health roll-out of the Antiretroviral Treatment (ARV) programme* (FSDoH 2003a) and the *Proposed Plan for the implementation of ARVs in the Free State Province* (FSDoH 2003b).

2 The preparation phase lasts from the end of August 2003 until the activation of the first service site in each district. The establishment phase covers the period during which the first five ART sites were activated in sequence. The expansion phase involves planning, preparing and establishing the next series of ART sites. Each of these phases follows its own time-bound course, and also poses its own challenges in each of the five districts and in the province at large; hence, they inevitably overlap.

3 Schneider *et al* (2004: 3, 8) prefer the use of "HIV treatment" — to "ART" — in order to emphasise the broader scope of the intervention at stake, and thus to escape the narrow approach to ARV treatment and, at the same time, to promote the more comprehensive approach of which ART is but a single dimension which needs to form part of an integrated package of HIV prevention and care.

decribed and issues raised are not unique to this province. Several other studies in different contexts convey similar messages.

The first section, "Methodology", clarifies the strategy and methodology followed in the research and specifies the main sources of information used. The second section outlines the broader context — the enabling and constraining circumstances within which ART was introduced in South Africa — highlights the aims and principles of the *Comprehensive Plan*, and summarises its merits and demerits. The third section articulates the Free State's approach in implementing the *Comprehensive Plan* by describing the distinctive principles and features of the organisational and managerial models developed and used in delivering ART services in the province. It shows how the original "1x3" model was modified to suit the province's circumstances, practicalities and needs. Much attention is paid to assessing the shortfalls, flaws and failures in policy implementation and programme management, especially in respect of the principles and guidelines stipulated in the *Comprehensive Plan*. Section four reviews the external influences which have shaped — or misshaped — the implementation of ART in the province. Specific reference is made to the incongruency between the national plan and provincial implementation, the lack of national leadership, direction and support, and the flawed national/provincial relationship. Section five draws conclusions from the Free State's initial experience of programme implementation. These lessons might serve as a basis for rethinking and redesigning the province's approach in order to deal with the identified challenges, shortfalls, flaws and failures. At the same time, they might be more broadly applicable to policy and programme implementation elsewhere.

1. Methodology

This study is based on various sources of information gathered over the period under discussion. These include a review of the relevant literature and documents on the topic; observation of the proceedings of the various standing and *ad hoc* committees that develop, guide, and implement the ART plan in the province and the districts as well as facilities; interviews with governmental and non-governmental role-players involved in programme planning and implementation at the national, provincial, district and facility levels, and the contextualisation and inter-

pretation of emerging materials against the backdrop of the ever-changing South African health care system and the perilous HIV/AIDS epidemic raging in the country.

The multi-disciplinary provincial Task Team — as the main body steering and facilitating ART implementation in the Free State, through its members, subcommittees and weekly meetings, decisions and actions — is a major source of information for this study. Extensive use is made of excerpts and direct citations from the discussions, minutes, status reports and other documents tabled within this context, as well as from interviews, to illustrate, demonstrate, highlight and substantiate claims, as well as to give a sense of people's views, approaches and attitudes to what is happening in ART implementation in the Free State and further afield.[4] This strong focus on the provincial Task Team, its members and its proceedings may tend to portray the Free State as leaning towards a top-down (higher-level managers') perspective on the ART programme and its implementation, as it selectively concentrates on the upper layers of policy implementation.[5] The view from the bottom and of peripheral implementers remains rather fragmentary and certainly under-represented in this particular study.[6]

4 Due to the confidential nature of the interviews and discussions, citations are not directly linked to their origin. The sources are listed by name and position in the Bibliography, but not by date. However, to maintain the correct chronology the dates of interviews and meetings are indicated in-text. The materials generated in interviews with high-ranking managers of the NDoH and FSDoH involved in the programme, with medical specialists serving in the programme, and with representatives of NGOs are referred to as: NDoH official, FSDoH official, FSDoH clinician, TAC representative, etc, followed by the interview date. Statements or remarks made during meetings of the Task Team (or other relevant meetings) are similarly referenced. These interviews and meetings took place over the entire reporting period.

5 According to Walker & Gilson (2004: 1251) top-down approaches see policy implementation as a "rational process that can be pre-planned and controlled by the central planners responsible for developing policies". This implies hierarchical decision-making procedures which often crowd out local-level problem-solving and bottom-up approaches to service delivery (LG&HC 2004: 11).

6 Other studies in this volume do reflect dimensions of the bottom-up approach as they record the views and experiences of front-line implementers (cf especially the contributions by Du Plooy, Hlophe and Janse van Rensburg-Bonthuyzen in this volume).

This is a descriptive and explanatory analysis of the Free State's approach to ART provisioning in the public sector. It is intended to be a narrative and analytical account of a particular case rather than an analysis based on existing theory or aimed at generalisation. However, various studies on policy implementation, though in different contexts, tell similar stories and indeed substantiate the argumentation in this study; thus, messages and lessons are more generalisable and susceptible of wider application. In respect of ART, in particular, there is ample evidence that the experiences and messages noted do indeed have wider application (Stewart & Loveday 2005).

The ultimate aim of this study is to remind policy-makers and managers (in the Free State and elsewhere) of the limitations and deficiencies in approaches to policy implementation and to spur them on to rethink and adjust their approaches constantly, so as to deal constructively with emerging challenges in order to improve the system and service delivery. It calls on the Free State to thoroughly reconsider important elements of its approach to implementing the *Comprehensive Plan*, especially against the backdrop of the decreasing availability of all categories of professional staff for the programme, as well as the slow pace of the roll-out against the large and growing number of eligible patients for whom ART remains inaccessible.

2. The broader framework of ART in South Africa: the *Comprehensive Plan* of 2003

2.1 Facilitators and inhibitors of ART initiation in South Africa: the broader context

Antiretroviral treatment for the AIDS-afflicted who are dependent on public health services commenced with the announcement by Cabinet on 19 November 2003 of the *Comprehensive Plan* (NDoH 2003). This five-year strategic *Plan* predicates a multifaceted, integrated and intersectoral response of prevention, treatment and care, and envisions, firstly, the provision of comprehensive care, treatment and support for people infected and affected by HIV and AIDS and, secondly, the strengthening of the national health system as a whole (NDoH 2003, Kalombo 2005). Several reasons were given to explain why it became possible, after a

protracted refusal, to provide ART in the public sector: a fall in drug prices and successful negotiations with pharmaceutical companies; new medicines and experience in managing the use of ARVs; a growing appreciation of the role of nutrition in enhancing people's health and the efficacy of medicines; a critical mass of health workers and scientists with the skills and understanding to manage HIV and AIDS, and the availability of fiscal resources (Cabinet Statement 2003, also NDoH 2003). There were also external forces that paved the way for ART in the public sector, especially the Clinton Foundation (NDoH official interviews 13.06.05, 14.02.05).

However, there were (and still are) other and less defensible reasons for the indecision and lack of action before ART was made available. On the one hand, the past delay in providing public ART could be explained by protracted political, scientific and racial controversies; a lack of political commitment, resulting in wavering and confusing government direction and decision-making on matters related to HIV and AIDS (Fassin & Schneider 2003, Johnson 2004, Schneider & Fassin 2002); people treating HIV/AIDS as an "emotional disease" and constantly "mingling it with politics" (FSDoH clinician Joint Centre of Excellence-CIDA officials meeting 27.09.04),[7] and, more specifically, denialism.[8] The announcement on ART also came on the eve of the 2004 national elections, so political considerations could have played a role in the decision to provide ART at that particular time, as was surmised by many.[9] South Africa is by no means alone in having such a slow res-

7 Such deficiencies are a continuation of the protracted legacy which has crippled South Africa's response to the HIV/AIDS epidemic since its very onset. The crux of these deficits is recorded by Cameron 2005, Johnson 2004, Pelser *et al* 2004, Schneider & Fassin 2002, Van Rensburg *et al* 2002.

8 "Denialism" frequently crops up in different guises, as do reluctance and the withholding of treatment motivated on the grounds of HIV and AIDS being unconnected, socio-economic conditions being the main cause of HIV/AIDS, poverty as the instigator of immune deficiency, the toxicity of ARVs, the acclaimed nutritional and healing powers of traditional practices and remedies, and the questioning of mortality data and thus the magnitude of the HIV epidemic, and so forth. For descriptions of AIDS denialism see Cameron (2005: 65) and Schneider & Fassin (2002: S46).

9 In all fairness, one should bear in mind that the preparation of an ART strategy (the treatment, care and support component) was envisaged as early as 2000 in the *Strategic Plan*, and that preparations to provide ART in the public sector had

ponse to an imminent epidemic, whether in the guise of silence, indifference, indecision, negligence, denial or inaction.[10] However, South Africa's leaders remained in denial for much longer, resulting in major confusion. External pressures therefore increasingly accumulated against the government's inaction, specifically from the Treatment Action Campaign (TAC) and the AIDS Law Project. The years of delay in public ART provisioning have created unmanageable backlogs of patients eligible for ART — a situation which certainly diminishes the degree of success of the current CCMT programme.

2.2 The merits and demerits of the *Comprehensive Plan*

The *Comprehensive Plan* articulates the framework for ARV treatment both for the country as a whole and for the individual provinces. It complements the *Strategic Plan for HIV, AIDS and STIs 2000-2005* (NDoH 2000), and, in particular, elaborates on the treatment, care and support of people living with HIV/AIDS (PLWHA) in the public health domain — a dimension which remained underdeveloped in the original strategy: "So, for me, it now adds that missing link in a comprehensive plan" (FSDoH official interview 30.01.04). The *Comprehensive Plan* further urges balance and comprehensiveness: "The delivery of ARVs is not just about the delivery of ARV services, is not just about drugs. [...] It is more than a simple programmatic implementation plan. It is about strengthening the entire health system" (NDoH official interview 14.02.05). Prevention and the promotion of healthy lifestyles are repeatedly emphasised as cornerstones of the country's response, while much is made of purposefully strengthening other equally important health care priorities and programmes outside the ART programme (NDoH 2003: 18-21). The *National antiretroviral treatment guidelines* (NDoH 2004: 2) convey similar sentiments: "The approach adopted is that of a continuum of care, with a holistic patient focus in an integrated health system [...] The focus is at the primary level within the context of the district health system".

already commenced in July 2002 with the Joint Health and Treasury Task Team (NDoH 2003: 12-3).

10 Thailand initially experienced similar setbacks, with official silence, apathy, inertia, denial, and the absence of a coherent anti-AIDS strategy (D'Agnes 2001), as did Botswana and Kenya. In sharp contrast stand the successes resulting from the strong political commitment and leadership shown from the onset by Uganda and Senegal.

In the Free State, the positive effects of the *Comprehensive Plan* were widely acclaimed. High-level managers anticipated benefits for the health system: "It is like a new opportunity; it's a new breath of fresh air that gets pumped into the system" (FSDoH official interview 22.01.04); for health care workers: "It seems like it's giving them a lot of hope that the public sector can get its act together [...] it has rejuvenated the morale of some of the staff members" (NDoH official interview 04.02.04); and for PLWHA: "It will give back the quality of life" (FSDoH official interview 30.01.04). Nurses in PHC facilities welcomed the CCMT programme "as an opportunity to impact significantly on high levels of HIV-related morbidity and mortality in their communities". However, there was also a degree of ambivalence and some reservations. Among other things, there were fears about flooding of facilities and escalating workloads; doubts relating to the reliability of drug supplies, the existing co-ordination of inter-clinic and clinic-hospital referrals and feedback practices, and the capacity to transport patients between facilities; and concerns about community awareness, the stigmatisation of patients and the tracing of ARV defaulters (Louwagie *et al* 2004, Janse van Rensburg-Bonthuyzen 2004).

Besides its many potential merits and long overdue justification, the *Comprehensive Plan* also spelled failure and disenchantment, as expressed in wrong assumptions, far-fetched structural objectives, unrealistic time-frames, unattainable norms, standards and requirements, as well as impossible agendas for activities, amid insurmountable limitations and shortfalls in resources. "The comprehensiveness of the *Operational Plan* is a major strength," Stewart & Loveday (2005: 226) write,

> ... but it may be that some of the standards and targets set are too high and therefore probably unattainable [...] South Africa does not have and is unlikely to have the required personnel to meet the stated intention of universal treatment.

These fault-lines foreshadow mismatches between an idealistic plan and its implementation in practice: "In hindsight it [the *Comprehensive Plan*] was too ambitious ... to have a million people on treatment within five years is very, very ambitious" (NDoH official interview 14.02.05). As a result, the feasibility of the *Comprehensive Plan* has been in question

from the very start.[11] The implementation of the public ART programme in the first two years — nationally and in the province — thus revealed the huge gap between the ambitious plans and the reality of their practical execution, which led to a noticeable degree of implementation failure.[12] Overly ambitious targets, poor planning and overhasty policy implementation can also result in a variety of undesirable consequences which can compromise the quality and sustainability of care and undermine the access to care.[13]

11 The targets and time-frames set by the province itself in the Free State's ARV Plan (FSDoH 2003a; 2003b) are a mere continuation and extension of the lack of realism introduced by the NDoH in the *Comprehensive Plan*. Most of the Free State's tasks and targets for establising operational plans, appointing staff, implementing information system, providing infrastructure, training staff, communicating with stakeholders, and so forth, failed to materialise during the set period (1 October 2003-30 January 2004). Likewise, the number of ART service sites envisaged for 2004-2006 (a total of 28 hospitals and 116 PHC facilities) did not materialise and are unlikely to do so: towards the end of 2005, only 40 sites (eight treatment sites, one satellite treatment site, 21 assessment sites, and ten combined sites) had been established, some still not operational. As far as patients are concerned, the *Comprehensive Plan*'s targets for the Free State of 2 127 patients on ART by the end of 2003/04 and 11 883 by the end of 2004/05 (NDoH 2003: 248) were obviously way beyond reach, even when these were later summarily made the targets for 2004/05 and 2005/06, respectively. The province also set its own overly ambitious targets: 5 000 for 2004/05, which was later adjusted to 2 660. By the end of March 2005 a mere 48% of this target (1 288 patients) had been realised. A similar shortfall on the set target for 2005/06 realised: the original target of 12 000 patients was later halved to 6 000. By the end of October 2006 (seven months into the year) only 3 322 patients (including the 1 288 of 2004/05) were on treatment, a realisation rate of only 55%.

12 Such constraining effects are quite common in the implementation of plans and policies. They may be compared to what Gilson *et al* (2003, cf also Walker & Gilson 2004) call "unexpected impacts" (sometimes "unwanted impacts") which explain why initial plans or goals are often not implemented or achieved, or change in unexpected ways through the process of implementation. Such impacts are shaped by the "experience of implementation" or the recreation of policy "through the process of implementation" over which national elites (in this case also provincial elites) have limited influence. More specifically, the authors indicate that front-line health workers, mid-level managers and the public may exert important influences over policy implementation and its impacts, or even derail implementation. This emphasises the importance of communication and consultation with these actors in the implementation of policies and plans.

13 McCoy *et al* (2005: 19) point to the dangers when ART programmes strive to attain ambitious coverage targets. Among other things, this may lead to insufficient

Furthermore, the magnitude of the HIV/AIDS scourge, the long-time controversies surrounding the problem, its ensuing politicisation, and the systematic mobilisation of civil society's demands converged to put and keep the epidemic in the limelight. These factors unduly elevated HIV and AIDS to a position of priority in the broader health scene in comparison with contending issues. From the start, the ART programme was glorified as it attracted attention and resources out of all proportion to other health programmes. Several months into the roll-out of the ART programme in the Free State it was striking how much time, resources and energy were being invested in the programme and process, and how ART-focused everything became. Efforts on its behalf were so overwhelming that the perception was created that everything in health care was happening in support of and subject to the ART programme. In reality this was precisely the effect, as other programmes (and their staff) were (and still are) justified in thinking that they were being neglected and reduced to secondary importance. It remains to be seen whether this extraordinary focus on ART will divert attention and resources from other essential programmes and priorities, leading to neglect, as envisaged by a number of authors (Barron 2003a, 2003b, 2003c, McCoy 2005, Ssemakula 2004), or whether it will achieve the official aim of strengthening the entire health system through the programme.[14] Recent observations still convey concern: "[T]he current vertical approach to ART combined with what appears to be a re-distribution of resources away from existing programmes is a cause of concern" (Doherty *et al* 2005: 21) and: "[B]ecause of the sheer scale of the epidemic,

community and patient preparation, erratic and unsustainable drug supplies, inadequate training and support of health care providers, low levels of treatment adherence and an increased threat of drug resistance, thus compromising the quality and sustainability of care. In turn, Schneider *et al* (2004: 21) note that poorly planned and overhasty introduction of new drug regimens such as ART may entrench perverse incentives and informal economies of drug use that undermine access and accelerate the development of drug resistance.

14 In the context of the CCMT programme the much used phrase "strengthening the health system" implies more than merely adding extra resources and infrastructure for the purposes of establishing the ART programme. A precondition of strengthening such systems is the integration of ART provisioning into existing facilities, programmes and service delivery with the aim of benefiting all and strengthening the whole at the same time. Neglecting to integrate such a programme militates against such broader benefits.

in the short term the demand on scarce resources may be undermining the very systems that the *Operational Plan* seeks to build and strengthen" (Stewart & Loveday 2005: 224). Moreover, it still remains to be seen to what extent the stakeholders can "take the *Comprehensive Plan* in a comprehensive way", attending to more than just its ART elements (NDoH official interview 08.07.05).

3. The Free State's approach: distinctive principles and features, emerging flaws and failures

Though not necessarily unique to the province, several features and principles characterise the Free State's implementation of its public ART programme. Some of these were set well before commencement, while others emerged during the roll-out process. In the discussion that follows, the distinctive and commendable features and principles will be reconstructed. However, the province's approach is not above criticism; it also carries its flaws and failures. Several of these are very Free State-specific and can be ascribed to the general and health circumstances prevailing in the province, or to the province's approach to managing the programme and neglect of the principles advocated in the *Comprehensive Plan*, especially the principles of the district-based PHC system. Other features and flaws have resulted from external conditions and limitations.

3.1 A phased approach: district-by-district, month-by-month

From the beginning, the approach of the Free State was that implementation would take place in a phased or staggered manner, and as resources and experience became available (FSDoH official interview 10.02.04):

> Let's actually roll it out and start well … and not go for a big approach of implementing in many sites ... we are going to start step by step to implement it, and as we learn we will actually do better, much faster with later implementation.

This is in contrast to those who opted for the "big bang" approach, often accompanied by poor planning (FSDoH official Joint FSDoH-World Bank officials meeting 27.10.04). The approach was motivated by the "smaller scale pilot idea" and "learning of lessons" for the future.

It bore fruit during the early phases, especially in preparing systems and building experience for training, drug procurement and distribution, laboratory services and information systems; in fact, for the entire service platform that was to be established.

The stepwise, month-by-month sequencing of the programme per district was determined early in the preparation phase (January/February 2004). Lejweleputswa started first, in May 2004, following many deviations from the schedule as a result of frequent delays and postponements in refurbishing and accrediting the selected ART facilities, approving staff establishments, and appointing and training staff for ART. The other districts thus also became operational later than had originally been planned: Motheo in July 2004, Thabo Mofutsanyana in August 2004, Xhariep in September 2004 and Fezile Dabi in December 2004. By the end of 2004 the establishment phase of the roll-out had thus been completed. The programme was operational in all five districts and in six of the 20 local municipality areas. It was modelled as four treatment sites, three combined treatment-assessment sites, and 13 assessment sites (cf Map in Preface).

In March 2005 the first announcements on expanding the programme to a next round of sites also cast the further roll-out in this staggered district-by-district, month-by-month mould (FSDoH official Stakeholder Workshop 2005b). However, the province soon changed this strategy, because there was no reason why implementation could not start simultaneously in more than one district and during the same month. Internal factors also provided an impetus for discarding the sequencing by district and by month; in particular, personnel shortages and resignations amid increasing patient loads put pressure on meagre ART staff establishments at some of the existing ART sites. Patient loads had to be shifted to additional ART sites in order to cope with and speed up implementation. This aim was soon frustrated by the protracted preparation processes involved in selecting, refurbishing and accrediting the second-round sites, approving the establishment of posts, appointing and training staff, and so forth. Delays and postponements frequently derailed the schedule, which ultimately extended far beyond the original target dates. For example, the first site in the second round of the roll-out was intended to become operational in October 2005, but this happened only towards the end of November.

Whereas the sequencing was initially deemed an advantage, in time this approach became an impediment to effectiveness. It was increasingly criticised — both internally and externally — for hampering the pace of implementation and limiting access and coverage — in essence for the slow growth in the number of patients on ART, in relation to other provinces. The Free State turned out to be "overcautious, frightened of [drug] resistance, and [offering] poor access". Some managers even entertained the belief that slow pace equated with high quality (FSDoH official TT meeting 08.06.05). Others complained that the pace of the roll-out was too slow: "We should get our processes to move, or go for new processes" (FSDoH clinician TT meeting 08.06.05). A fruitless debate on access versus quality ensued, leaving the impression that they are mutually exclusive. At the time an official of the NDoH (interview 13.06.05) pointed out that there was no evidence (no single indicator) to prove that the Free State was faring any better on quality than any other province. On the other hand, there was abundant evidence that the Free State was definitely among the less well performing provinces on the quantitative side: "There is not one of the Free State districts coming up anywhere near the top ten". Moreover, the Free State's programme appeared to be far more costly than the national average, when accounting for the required budget in relation to the number of patients on ART. Certain Free State sites were staffed beyond justification. For example, despite the full establishment of approved posts at ART sites in Xhariep (many of which remained unfilled) it took the district several months to get started, and even longer to have any significant number of patients on treatment.

The selection of ART sites in the Free State tended, on the one hand, to "pick the low-hanging fruit first", opting for "the easy to do, the easiest to do quickly", while striving, on the other, to apply maximum rather than minimum standards, rendering its ART facilities unnecessarily well-equipped, thus clearly at the cost of putting more patients on treatment more quickly. A high-ranking official of the NDoH observed (interview 14.02.05, cf also McCoy *et al* 2005):

> Sometimes we are trying to be too sophisticated; we expect everything to be in place before things can happen. Sometimes you have to start before things are a hundred percent perfect ... And there is a very good logic for doing the 'low-hanging fruit' first, but if you keep on doing the easy things only, you are never going to achieve

> the level of scale-up you need. You also need to choose the difficult sites to learn lessons from them, because lessons from the easy ones are not always replicable in the difficult ones.

3.2 A multi-model approach: the "1x3" service delivery model and modifications

Initially the Free State adopted what could best be described as the "1x3" organisational-managerial model to deliver the ART programme — a predominantly doctor-driven treatment site fed by three nurse-driven assessment sites within the same referral chain.[15] In the beginning this model was considered "critical [to] success, because it helps to reduce the workload ... so the load can basically be dealt with quite adequately at the periphery [at clinics]" (FSDoH official interview 22.01.04). The first-round ART sites in four districts were thus fashioned along these lines — Lejweleputswa, Motheo, Thabo Mofutsanyana and Fezile Dabi. However, it was realised that in Xhariep a single service-delivery model was not suitable for the rural and small-town areas, with their sparse populations, few patients, vast distances, primary staff shortages, minimal health facilities, and major transport difficulties. To adapt to these area-specific circumstances several service-delivery models came into practice in addition to the aforementioned combined treatment-

15 In the Free State an ART site was originally defined as "a hospital (treatment site) and three referring clinics (assessment sites)" (Chapman 2005). An assessment site is a specially-equipped, nurse-driven PHC facility (a CHC or fixed clinic) which serves as an entry point into the public ART programme. Here patients are first screened and staged by ART-trained professional nurses, and eligible patients referred to the treatment site for follow-up tests. After a doctor has certified the patient eligible for ARVs, the assessment site also becomes the point of drug-readiness training, monthly drug issuing, and primary care delivery. The treatment site is, as a rule, a referral hospital (a regional or district hospital, or a CHC that serves the same function) to which the patient is referred in order to undergo more advanced diagnostic procedures, on the grounds of which the ART-trained doctor certifies the patient for ARV medication and prescribes the appropriate regimen. At set intervals the ART patient has to return to the treatment site for follow-up screening. The service at the treatment site is thus primarily doctor-driven, but to a significant extent also pharmacist-driven. Assessment sites may also function as treatment sites by shifting the doctor function to the PHC facilities. In this manner a number of combined treatment-assessment sites came into being in order to meet the special needs of the more rural and small-town areas in the province.

assessment sites. For areas with poor human resources, further models were implemented: a "driving social worker", a "shared dietician", a "shared pharmacist" for part of the district or for the entire facility, and "telephonic specialist support". Later, the plight of rural patients and the immense need for care raised possibilities of "mobile assessment sites" for farm workers and families, as well as "family-centred care" to train family members to care for people living with AIDS in their own or other families (FSDoH officials TT meeting 16.02.05, Stakeholder Workshop 2005b). After a year of implementation (May 2005) the search for new models became a frequent point of discussion as patient loads started reaching saturation levels at certain sites in relation to the available professional staff and floor space. The "satellite treatment sites" model was thus created, the first being approved at the Heidedal CHC (August 2005) to lighten the patient load on the National Hospital treatment site.

3.3 A PHC-centred approach: the verticalisation of ART

These models suggest that the Free State — like some other provinces and in accordance with the directives of the *Comprehensive Plan* — opted for a strong PHC orientation. This means that the programme was to be developed at the PHC level, utilising the existing referral systems, and to be delivered in a decentralised manner, integrated into other PHC programmes, and depending heavily on professional nurses. The main consideration was how to cope with the expected patient numbers (FSDoH official TT meeting 08.12.03, Chapman 2005). This close link to PHC meant that the Free State's implementation strategy was often typified as a nurse-driven initiative, more specifically one driven by nurses in PHC settings — the assessment sites. However, as doctors still played a central role in the referral chain, it was only partly correct to speak of a "nurse-centred" programme. Doctors certify patients, prescribe drug regimens, monitor disease progression, and attend to abnormalities (cf Patient Walk Through models).[16] It would

16 Patient Walk Through models depict the various service and support components in the logical flow of the ARV patient through the care system, including the movement within the service/care platform, *i e* local clinic → assessment site → treatment site → community care, and within the loop of nurse → doctor → counsellor → community carer/supporter. Originally the model was presented in matrix

thus be more appropriate to typify the ART programme as a "team approach" or a "team-driven service", in which both nurses and doctors play indispensable parts, but are essentially also complemented by the pharmacists, dieticians, social workers and community health workers (FSDoH official Stakeholder Workshop 2005b).

It was never the intention of the Comprehensive Plan that the ART programme would be offered in a vertical manner. On the contrary: "The integration of HIV and AIDS care and treatment within existing efforts and interventions will avert the development of vertical systems of care, and will reinforce the national strategy emphasising primary health care" (NDoH 2003: 55). In the Free State, there were strong voices against verticalisation and in favour of integration (FSDoH official interview 30.01.04):

> So, my feeling is that we would like to integrate it … it must benefit other programmes ... it must not be dedicated staff only to this programme ... out there they must try to link with other staff … that will then strengthen.

At various times, managers were well aware of the risk of ART evolving into a vertical programme. Their directive was that it would not run as a separate programme, but rather be integrated with other programmes. Rumours that the remuneration of ART staff would be elevated above that of other staff categories were nipped in the bud (FSDoH official Stakeholder Workshop 2004d).[17] At a much later stage a high-ranking official re-emphasised this principle in slightly different terms, saying that ART "should not become a silo … ARV is much more than

form, with the axes representing time (weekly and monthly phasing) and level-of-care (community, clinic, district hospital, regional hospital, centre of excellence) (FSDoH 2003b). In due course, this model was clarified and a final, more detailed operational model was presented at the stakeholder workshop of 31 March 2004 (FSDoH Stakeholder Workshop 2004d). However, two years into the implementation of the programme the Walk Through model was questioned on the grounds of efficiency and appropriateness: "Is this model appropriate?"; "Is it serving our needs?"; "Do we apply it?"; "How far can the model address the bottle-necks?"; "Is it addressing the staff shortages?". In particular, the model was depicted as too cumbersome: "The time span for patients to progress through it — eight weeks — is too stretched out" (Tshabalala 2005).

17 Other spokespeople were strongly in favour of such elevation, among other things, to attract committed people to the programme (FSDoH officials discussion 23.01.04).

that; look at ARV treatment comprehensively" (FSDoH official Joint FSDoH-CIDA officials meeting 27.09.04).

Despite all this, the urgency and priority assigned to the ART programme in the national and provincial agendas laid the groundwork for ART to be verticalised. There are various explanations for this. The early orientation programme apparently confirmed and strengthened such verticalisation: nurses reported that they were informed that dedicated staff would be appointed to run the programme, and that the programme would be verticalised in its operation within clinics, despite their desire for integration into existing PHC services (Louwagie *et al* 2004). Several other explanations for verticalisation were also noted (FSDoH official interview 30.01.04):

> [Firstly] Often when a vertical programme comes, it tends to dominate, because the resources are only looking for a vertical programme. The rest must just wait for it to go … [Secondly] I'm having a sense that sometimes the emphasis is still vertical from Health Support from where it is driven. [Thirdly] Also from National [Department of Health], because now they are prioritising it in such a way that they want to make sure that they can see it from the window of Pretoria when they go there.

At the national level there was also ample justification for initial or interim verticalisation (NDoH officials interviews 13.06.05, 14.02.05, 08.07.05). In subsequent implementation ART indeed emerged as a vertical programme *par excellence*, separately and centrally financed, run by separate ARV personnel mainly or exclusively assigned to the task, conducted in physically separate areas or sections in facilities, and with segregated filing, registering, and recording systems.[18]

18 At an early stage there was a concerted effort to combat verticalisation and to secure the supposedly comprehensive nature and intent of the programme by rectifying the prevalent semantics. It was requested that people refrain from using terminology referring to "ARV service sites", and rather use "HIV/AIDS comprehensive management centres/sites", because ARV treatment is only one aspect of the larger HIV/AIDS plan and the more comprehensive package, which also embraces prevention, VCCT and PMTCT (TT meeting 11.02.04). Despite this call, the parlance has not really changed: "ARV service sites" are still commonly referred to in conversations, meetings and documents, as well as in designating official structures and procedures such as "the ARV Task Team", "ARV meetings", "ARV Status Reports", and "Weekly ARV reports".

Towards the end of the establishment phase (January 2005) a greater degree of realism set in, with renewed pleas for a comprehensive and integrated approach against the backdrop of human resources shortages:

> We don't have enough manpower … If we want to survive in the long term, we have to integrate our services, and not reserve ARV staff for the ARV programme, and vice versa … walk away from ARV sites, rather integrate sites (FSDoH official TT meeting 05.01.05).

In March 2005 a stakeholder workshop on integrating services as a strategy to cope with imminent staff shortages specifically urged a return to the comprehensive approach and the abandonment of verticalisation. This would have required integrated staff establishments, training and budgets (FSDoH official Stakeholder Workshop 2005b).[19]

The conclusion, however, still holds: from its inception, the programme was elevated above all other health activities — even glorified. It was introduced as a programme with "its own staff, own money, own everything". On the one hand, staff servicing the programme perceived it as a separate, independent programme (FSDoH official Joint provincial Task Team-district ART programme co-ordinators/CEOs meeting 29.06.05):

> ... people appointed in ARV posts thought they [were] working for ARV sites, not for the hospital [...] functional people (e.g. a pharmacist) didn't see themselves as part of the hospital, [or] even report to hospital management.

On the other hand, managers of facilities and other programmes saw the ART programme as "a foreign thing invading their space", and believed that "the ARV people [were] getting everything, while the rest of the clinic [got] nothing" (FSDoH clinician and members of TT addressing crises at the Bongani and National Hospitals 30.05.05). This created the negative attitudes towards the programme, such as "[we] do not feel responsible" (NDoH official interview 13.06.05) and "we have nothing to do with ARVs" — a situation described as "creating

19 In August 2005, the opening of cost centres at treatment sites was announced (TT meeting 31.08.05). As from September 2005 the district ART budgets were thus devolved, henceforth to be managed by CEOs of institutions in the districts (TT meeting 07.09.05). However, the ring-fenced conditional grant for ART continued to favour the programme within facilities, and evoked feelings of relative deprivation among non-ART personnel.

chaos" (FSDoH official TT meeting 13.07.05). This clearly bred managerial apathy, which often manifested itself in paralysis in decision-making and action-taking.

All in all, the integrated, comprehensive nature of ART propagated in the *Comprehensive Plan* has found rather fragmentary expression in the Free State, if any. Too many elements of the programme are vertically implemented, in isolation from other PHC programmes (NDoH official interview 13.06.05). Moreover, many of the core principles of comprehensive PHC have not been achieved in the Free State's approach. This is demonstrated by weaknesses in intradepartmental, interdepartmental and intersectoral collaboration in the management of the programme, the absence of key roleplayers and stakeholders from policy-making structures, and little or no involvement on the part of civil society in its everyday running. These flaws and failures will be more clearly outlined in subsequent paragraphs.

3.4 Collaboration, partnerships and inclusiveness: narrow focus on health, limited involvement

In many respects the Free State's approach could be depicted as "collaborative", "inclusive" or "accommodative" due to the FSDoH's openness and receptiveness to all partners that could contribute to the provincial ART programme. "We've tried to involve as many role-players as possible … I think that our chances are better, because more people are involved" (FSDoH official interview 22.01.04) and, "it is only through partnerships that we will be able to resolve the challenges that lie ahead" (Chapman 2005). To this end, a number of civil and private organisations, non-health government departments and research institutions became involved in the Free State's programme, mainly with a view to strengthening and expanding the service in the province. As Doherty *et al* (2005: 5) observed, "This level of inclusion and transparency is almost unprecedented within public health sector structures, especially within the domain of HIV and AIDS."

This inclusiveness is both internal and external. Internal inclusiveness relates to the range of divisions within the Department of Health which could contribute to the implementation of the ART programme. In this respect nutrition, physical planning, corporate communications, HR management, HR development, community mobilisation, mar-

keting, information systems and IT, social work, and others (all divisions within the Health Support Cluster) became directly involved in planning, structuring and implementing the programme. The Clinical Health Cluster did so too, by way of hospital and district health services. External inclusiveness was initiated with government-sector partners outside the Department of Health (especially the Department of Correctional Services) and with civil society and private-sector partners, in particular the Catholic Relief Services, HIVCare (a company of NetCare) and the privately-run Mangaung Maximum Security Prison. Apart from approving these initiatives and affording the partners seats on the provincial Task Team, the province also offered material and non-material support — in the accreditation of sites; the training of staff; the use of training materials, treatment and nutritional guidelines, patient forms, and reporting systems devised by the province; the provision of dietician services and medication, both nutritional supplements and ARV drugs. In turn, these partners agreed to synchronise important aspects of their programmes with the Free State's policy and programme, especially in respect of the standardisation of staff training, treatment guidelines, patient forms, reporting systems, and drug regimes.

Notwithstanding this wider engagement — and somewhat in contradiction to the general approach — interdepartmental and intersectoral collaboration remained minimal, selective, fragmented and largely unexplored. Despite the rhetoric which saw broad-based collaboration as necessary for a comprehensive strategy, the ART programme in the provincial Department of Health embarked on a solitary course, devoid of engagement or collaboration with the government departments most relevant to ART, and reminiscent of the general approach to HIV/AIDS in the national context as a narrow health issue.[20] The programme is conceived and driven, rather, as a predominantly health-focused programme, and operates in a narrow health silo.[21] In spirit and practice it

20 Contrary to numerous policy directions and structures intended to attain a comprehensive or inclusive approach to HIV/AIDS and the strategies dealing with it, the entire record of engagement with the disease in this country testifies to this tendency of making its implementation mainly or exclusively the domain and responsibility of the national and provincial Departments of Health (Van Rensburg *et al* 2002, Pelser *et al* 2004).

21 For McCoy *et al* (2005: 19) the current focus on ART in the health care sector could overmedicalise the response to HIV/AIDS, thereby distracting attention

certainly misses what the *Comprehensive Plan* envisioned, namely that it would be implemented in a manner that would promote and strengthen co-operation among government departments and all spheres of government (NDoH 2003: 24). It is particularly disturbing that there is no serious engagement with the Departments of Social Development, Education or Agriculture,[22] despite the programme's obvious ramifications in terms of socio-economics, welfare, food security and education, and the desired emphasis on prevention and healthy lifestyles. These areas of neglect are indicative of how elusive success has been in implementing the district health system, and especially in integrating the ART programme within the broader policy and service framework and honouring the underlying principles (cf McCoy *et al* 2005).

Collaboration initiatives with the private sector have remained limited to supporting the Mangaung Maximum Security Prison in establishing an ART site; sporadic discussions with HIVCare to open a private ART site, and informing private practitioners about the ART programme. There has been no systematic exploration of the private-public dimension of intersectoral collaboration. Likewise, engagement with civil society has remained limited, and certainly not systematically developed, maintained or sustained. This narrow involvement is also reflected in the absence or irregular participation of district structures in the provincial Task Team. At the periphery, the collaboration and partnerships are even fewer or entirely lacking at least in terms of the composition and functioning of the district task teams.[23]

It is therefore justified to conclude that interdepartmental and intersectoral collaboration — which are key principles of comprehensive PHC and essential elements of the CCMT programme — did not (and still

from the underlying political, social, and economic determinants of the disease. To counteract this trend, these authors argue that a broad, multisectoral response to HIV/AIDS (including ART) is imperative.

22 The first time that the Department of Agriculture was mentioned in the Task Team as a possible partner in the Free State's ART programme was on 20 July 2005.

23 In any case, the partnerships deemed appropriate at the central level are not necessarily suitable as partnerships at the periphery. Schneider *et al* (2004: 24) observe that "the choice of partnerships — whether with NGOs, traditional healers, private practitioners or workplaces — can only be decided on the basis of local knowledge of what is possible and who is trustworthy."

do not) materialise to any arguable extent in the planning, structuring and implementation of the ART programme in the Free State.

3.5 Civil society's role in ART: neglect of an important partner

The public health system on its own is not able to deal with the challenges posed by the HIV/AIDS epidemic, or with the agenda stipulated in the *Comprehensive Plan*. The *Plan* envisions the organisations of civil society (CSOs = NGOs/CBOs/FBOs) as occupying a special place in the programme, especially in respect of counselling, adherence support groups, community mobilisation efforts to reduce stigma and discrimination, patient transport, home- and community-based care and, when necessary, palliative care (NDoH 2003: 20, 28). In view of the escalating demands and the limited public resources, the FSDoH recognises the indispensable role of CSOs as "part of our plan" whose involvement extends the "reach of provincial services" in rendering "one continuous service" (FSDoH official FSDoH-CIDA officials meeting 27.09.04). This recognition is demonstrated by tangible government support of NGOs through the Consortium of NGOs (which is responsible to the FSDoH). NGOs are formally contracted by the FSDoH to supplement and extend crucial services by providing, training and monitoring community health workers (CHWs). Certain reputable NGOs (Hospice, CANSA, NPPHCNetwork and LAMP) have a stipend-paying (and previously also a co-ordinating) function, while other NGOs in local areas are accredited to conduct the 59-day comprehensive training of CHWs on behalf of the province.

Despite this foundation, however, important elements of community-based care are missing or failing. Although lay counsellors and home-based carers are being widely used, their roles and links to facility management are not always clear or optimally explored. Often their involvement is loose and lacking in control. The situation is aggravated by the contamination of an essentially voluntary system by a semi-paid system, with resultant harm to volunteering and family support. Pessimism frequently surfaces in comments that home-based care has "fallen apart" and is "failing us", or that "the notion of a treatment buddy is not happening in practice" (FSDoH clinicians TT meetings 08.09.04, 03.11.04, 15.11.04, also FSDoH 2004b).

However, the issue is more profound. Key stakeholders in civil society which the *Comprehensive Plan* intended to involve (NAPWA, TAC and other NGOs) were never involved in planning or implementing the provincial programme, and still have no voice in the provincial and district task teams and other forums. Some are not even present or active in the province. By not involving, not inviting, and not supporting these key CSOs — which work at the coal face of HIV/AIDS and have made ART their core business — the programme is destined to remain a centralised, top-down and unilaterally government-run initiative. By not tapping the resources of civil society for ART, the programme is missing out on opportunities and thus forfeiting the proven benefits of community involvement and participation. In interviews, representatives of NGOs involved in HIV/AIDS and ART (TAC 16.02.04, NAPWA 17.02.04, Naledi Hospice 13.02.04) extensively articulated the contributions they could make: ensuring that prevention strategies are intensified and that communities become "HIV-competent"; encouraging people to be tested for HIV before they become sick; educating people not to remain in denial; inculcating "the importance of coming out and being open … saying 'I'm HIV-positive, I'm taking treatment, I'm healthy, I'm fine'"; making communities aware of the ART service and assisting them to access it; allaying confusion where people expect miracles when they are taking treatment; mobilising and organising PLWHA, communities and a variety of NGOs; training people who live with HIV and AIDS to understand their illness and in how to take ARVs; strengthening adherence, fighting complacency in patients, and informing them about the side-effects they might encounter; engaging site managers and encouraging ART clinics to establish support groups for patients, and pressurising government for a faster roll-out where it is "indirectly delaying the roll-out". A universal truth underscores the NGO philosophy (TAC representative interview 16.02.04):

> Around communities there are strong people, prominent individuals, stronger than other people. We need to bring them along to be a constant reminder to people that you need to know your status [and] you need to understand your CD4 count if you are HIV-positive. If you have those strong people talking about ARVs, talking about HIV status, and many different things related to HIV and treatment, then it becomes easy for people to understand it and to relate.

In these respects, the public ART programme in the Free State is the poorer because it lacks a mutually supportive relationship with civil society.[24]

3.6 Openness and receptiveness to research

The receptiveness to initiatives and contributions from outside the provincial government sphere also extends to research institutions. It implies an openness and eagerness on the side of policy-makers and managers to be informed and supported in their planning and decision-making by research. Engagement in such a research-to-policy-to-practice loop has been a key characteristic of the FSDoH's approach since the early 1990s. Although in the past it was mainly health systems research — collaborative research with a view to improving systems and services — that was involved, the recent widespread research interest in ART (along with the *Comprehensive Plan*'s call for multidisciplinary research in this domain) has led to an increrase in such government-researcher collaboration and in the number of research partners. With this has come new variations of research (controlled clinical trials, randomised control trials, epidemiological and virological studies, and so on) aimed at benefiting the programme, the personnel driving it, and the affected patients and communities.

The rationale for this receptiveness to research (especially research on the ART programme) has often been articulated by high-ranking provincial officials, specifically emphasising reciprocity (FSDoH official Joint FSDoH-research partners meeting 07.06.04):

> We are also excited about this project, and the way it's done. It meant to us assistance in strengthening the way we run our services […] Over the past ten years we implemented various projects, and only learned later that [they were] not working. So, [in] this one, as we implement we already research. I think we also have the opportunity to influence the researchers; to say exactly what we want, whereas normally the researchers will go out there and just do their research, and

24 In the broader national context, Johnson (2004: 123) explains the soured relationships between government and non-governmental groups and the resultant move away from consultative policy practices, both generally and in the HIV/AIDS sphere. As she puts it: "[I]ts unwillingness or inability to harness other energies and expertise outside of government became an important factor inhibiting an effective response to the AIDS epidemic".

> go. So that the research findings will also be implemented and inform service delivery, and also how to enhance the system section [...] it is an opportunity not only to research, but also [...] to strengthen the service delivery.

Chapman (2005) articulates the question "Why researchers on the team?" under seven heads: assessing the outcomes and impact of the programme; monitoring the implementation process; ensuring the collection of quality information, either routinely or with surveys; documenting the implementation process; developing local guidelines based on national guidelines; creating a framework for involving other interested researchers (including post-graduate students), and raising funds from interested donor agencies. As a visiting representative of a donor agency observed, "[T]he experimentation with the roll-out in the Free State holds important lessons for Southern and East Africa" (IDRC representative Joint FSDoH–CIDA-IDRC officials meeting 17.08.05).

Unfortunately, the flourishing of research in the ART domain also has its disadvantages. For one thing, the influx of researchers to the few ART facilities tends to overburden staff at these facilities, and the same might happen to patients. Furthermore, the research "tends to be more on the ART arm, while it should be across the entire [HIV/AIDS] programme, and also cover other dimensions of the larger programme" and it needs to take a "holistic approach" (FSDoH officials Joint FSDoH-CIDA-IDRC officials meeting 17.08.05). Finally, there are important conditions that need to be met in such a collaborative government-research undertaking, as Doherty *et al* (2005: 9) rightly point out: "On the one hand, researchers must be careful not to slow down the implementation process; on the other, policy-makers and implementers must be prepared to be open to constructive criticism".

3.7 Communication and co-ordination: breakdowns in synergising system components

Ever since the initiation of the Free State's ART programme, a high priority has been assigned to maintaining clear and open communication in order to ensure transparency, to keep staff informed, to solve problems as they emerge, and to prevent the destructive effects of miscommunication and misunderstanding. The motto has become: "keep it as open as possible"; "talk to one another so that we can resolve problems". In

attempts to address conflicts and constraints the phrases "have a cup of tea" and "have a bilateral" were coined and often used (FSDoH official TT meetings 15.12.03, 08.12.04, Chapman 2005).

Guided by these principles, the FSDoH developed an elaborate communication and information system for the ART programme, in many cases extending already well-established information and IT systems, to convey information to both personnel and the public. For the ART programme specifically, innumerable strategies and media were developed to keep the wide spectrum of stakeholders and role-players informed — and to support personnel in ART delivery. Among these were a portal for the ART programme on the existing website of the FSDoH,[25] weekly reports and monthly press releases, regular status reports, internet links to ART facilities via the iCAM satellite network, and broadcasting to personal computers in health facilities. In addition, public launches, radio broadcasts, information campaigns and road shows took place, and pamphlets and posters targeting ART patients and communities were distributed.

Despite generally good communication and co-ordination between components and levels of the programme, there nevertheless were often breakdowns between various levels, resulting in inadequate synchronisation among main components.[26] Especially crucial were (and remain), firstly, breakdowns in the communication and co-ordination between the province (the provincial Task Team) and the districts (district and facility managements) and, secondly, between the Health Support Cluster and the Clinical Health Cluster (both part of the provincial health bureaucracy). The ART programme became a process which was mainly centrally planned and directed by the provincial Task Team, and thus almost exclusively by senior managers in the Health Support Cluster, *i e* an inwardly focused process seriously neglecting any consultation or involvement of essential partners within and beyond the FSDoH.[27]

25 <http://healthweb.ofs.gov.za/othersites.html>

26 Such failures appear to have far wider application. The Local Government and Health Consortium (LG&HC 2004: 6-10) refers to the obstacles of a "hierarchical and rigid bureaucratic culture" and an accompanying "reluctance on the part of provincial governments and health departments to decentralise authority to lower managerial levels". As a result, "little decision-making power lies at facility and district management levels". In the end effective co-ordination is undermined.

27 In a different context (the introduction of free care in the mid-1990s in South Africa) Walker & Gilson (2004) also record the undesirable effects of a centrally driven,

Both community organisations and staff blamed the Department for failing to systematically and adequately inform, involve and communicate with communities. In respect of the ART programme the selection of certain sites and exclusion of others, the inception dates, the postponement of such dates, and so on testified to such failures in communication and information flow. During the set-up stages the reproach was heard: "There is a tendency in South Africa … we come with things, but we don't get people ready, psychologically and otherwise, to deal with those issues" (NAPWA representative interview 17.02.04). A much later comment was (FSDoH official Joint FSDoH-research partners meeting 07.06.04):

> We need to go out to communities and make sure that they are properly informed, take them on board. Not just expect, because you have announced that there are ARV drugs in your clinic and your hospital, they will just automatically respond. You have got to tell them.

Apparently the assumption was that all role-players would automatically be on board and remain on board. This did not prove to be the case. The effect, unfortunately, was that the roll-out was one-sidedly planned and implemented.

3.8 Structural divides within the health bureaucracy: constrained co-ordination

The reference to the structural divide within the FSDoH deserves further clarification, because of its constraining effects on essential co-ordination between programme components. As already mentioned, the divide is between the Health Support Cluster, within which the programme is situated, and the Clinical Health Cluster, under whose aegis the health facilities implementing the ART programme in practice belong. Once, in the earliest stages of the roll-out, there was a clear hint of the constraints caused by this divide, and an expression of the need for joint ownership and partnership in implementation (FSDoH official interview 30.01.04):

> top-down approach and the accompanying "bad communication" with and "inadequate consultation" of front-line providers (professional nurses) in planning for implementation on the eventual implementation of the policy. Likewise, the Local Government and Health Consortium (LG&HC 2004: 9) points to the deficiencies of centralised management approaches, so acutely experienced in the Free State's roll-out: "the need to wait for decisions approval 'from above' and poor communication".

> The fact that it [the ART programme] is driven from [Health] Support from whom it can be constrained, because we from the Clinical Cluster, from where it's going to be implemented … we are seen as just a platform ... receiving something … We must be co-partners in it. ... it must be done collectively, joined, so that we can also own it .[28]

This divide was more explicitly recognised at a much later stage: "How best can we improve relationships between the ART programme and CEOs of institutions?" And suggestions were made: "The institutions should be responsible for the ART programme in their domains. There should be consultation with the management, not just ... commands [from the] province, from outside the institution, from the Task Team" and "integration of ART staff" into the overall hospital establishment" (FSDoH official Joint Provincial Task Team-district ART programme co-ordinators/CEOs meeting 29.06.05).

Similar breakdowns in co-ordination also occurred quite frequently between various management and service structures, as reported in Task Team meetings: "Communication channels are not in place and [this] makes things impossible to run"; "Who is reporting to whom? [Without] clarity, the organogram becomes confused. Who co-ordinates whom?" (FSDoH clinicians TT meeting 23.02.05), and "If CEOs [of institutions] learn down the line about decisions and plans, it causes not such a nice feeling" (FSDoH official TT meeting 08.06.05). Recently, there was again the criticism from the ranks of district managers that the Task Team and the responsible provincial officials do not con-

28 During a meeting on 30.05.05, convened to address the ART staff crises at the Bongani and National Hospitals, it transpired that the Health Support Cluster was experiencing difficulties in implementing the ART programme because it was perceived as "its" programme, not that of the Clinical Health Cluster. The former thus had to solve its own problems (in this case, staffing), albeit within facilities under the aegis of the latter. The managements of the facilities under question (the Bongani and National Hospitals) clearly refrained from making problems at ART facilities their problem. This divide between the two clusters was again revealed when nursing posts advertised for ART sites were pitched at higher levels than those of certain existing nursing staff in the same facility, which meant that nursing staff might be drained from other programmes to the ART programme — with accompanying discontent (TT meeting 31.08.05). The issue was also expressed in "us-they" language ("They [the Clinical Cluster] hijack us [the Support Cluster]"), with reference to ART resources being used for non-ART purposes in facilities (FSDoH official TT meeting 07.09.05).

sider the inputs of district managers and do not properly consult them on the new staff establishments in their institutions. The result of such a non-consultative approach is managerial apathy, manifesting in "No manager is taking responsibility", "No ownership is taken by managers" and "No-one buys into the process" — "So nothing is happening" (FSDoH officials TT meeting 17.08.05).

In attempts to address these problems, many "cups of tea" and "bilaterals" were held, district ARV programme co-ordinators were appointed, and two joint provincial-district meetings (26.01.05 & 29.06.05) were convened with a view to opening channels for communication, exchange and support, and removing blockages. Unfortunately, too few such joint meetings materialised, and then only at the height of problems. However, in order to build on this essential and obviously effective co-ordination mechanism — from province to district and *vice versa* — the initiative was taken in mid-July 2005 to convene monthly joint meetings of district co-ordinators of the ART programme and joint provincial-district meetings (provincial Task Team and district managers/co-ordinators/CEOs of institutions) on a quarterly basis (FSDoH official TT meeting 28.07.05).

3.9 ART and drugs: preoccupation with drugs and disruption of drug supplies

From the inception of the programme, at least in the Free State, a narrow drug-driven approach prevailed, with an almost obsessive focus on drug supplies, as opposed to other components of the programme. During the roll-out the impression was often created at provincial Task Team meetings that medicines were the only problem which needed to be addressed. The general scarcity of pharmacists and pharmacy assistants in the public domain, as well as the sporadic delays and breakdowns in drug delivery exacerbated this fixation. It also became evident in the accreditation of ART sites, where the furnishing and refurbishing of pharmacies with sufficient space and equipment were frequently the top priority. At the same time, the Task Team's often rigid interpretation of the stipulations of the Pharmacy Act and the requirements of the Pharmacy Board created obstacles to implementation, literally delaying every step (FSDoH official TT meeting 18.05.05).

From the outset, drugs were repeatedly identified as a key factor which might jeopardise the programme, with concerns expressed about the "timely availability and delivery" of such medicines and the "obtainability and sufficient supply of all the required ARV regimens". Later, variations on the drug theme frequently entered the scene as "wild cards", creating insecurity and disruptions in the programme. As early as January 2004 delays were foreseen as a result of the NDoH's protracted international tendering process for drug procurement. The flow of ARV drugs into the country was indeed inconsistent (FSDoH official TT meeting 12.01.04). As the April and May delivery targets were not met, insecurity grew (FSDoH official TT meeting 02.06.04). Then came the large-scale withdrawal of several prescribed antiretroviral medicines from the international market in October-November 2004 by Ranbaxy (SA) (Thembalami Products) (e-drug 2004, PSSA 26.10.04, FSDoH 2004c, WHO Press Release 2004) and the consequent interruption of supply in the Free State for more than two months. At the time, the situation was varyiously depicted as "dire straits" and "a huge disaster looming", with the foreboding that the programme was becoming "a dismal failure" (TT meetings 10.11.04; 05.01.05).

The disruption indeed derailed the implementation, and at a stage when it had been rolling smoothly. Thus, increased insecurity about sustainability set in, even before the roll-out had reached all the districts. The disruption also had ramifications beyond mere drug provision: it left managers disempowered, health care workers demotivated, and prospective patients disappointed as waiting lists for drugs built up.[29] It also led to animosity between personnel and clients who had completed the treatment readiness programme, and raised concerns in relation to implications for drug resistance (TT meetings 10.11.04, 26.01.05). In January 2005 a treatment site manager remarked (TT meeting 05.01.05):

> This stopping, going, stopping, and accelerating cause havoc. We tell patients to wait two weeks, two months, three months [...] It will have a severe fallout. Patients were trained two months ago; we have to retrain them [...] we have bookings up to September 2005.

29 On 3 January 2005, at the ARV sites in operation in four districts, 448 patients had completed their drug readiness programme and were awaiting their first batch of medicines (FSDoH 2005a: 3).

In fact drug stocks continued to be a "wild card", creating a stop-start-stop-start pattern, while insecurity and loss of confidence in the programme set in. Kellerman (2005) describes the pattern of ART implementation in the Free State during the first nine months in a comical manner: "hurry up; slow, slow, slow; no, go, go, go".

Although the disruption was relatively short-lived — from 11 November 2004 to 17 January 2005 — it nevertheless demonstrated the fragility and vulnerability of the programme, especially when exposed to disruptive external forces.

3.10 Neglect of strategic matters

From the initial planning, throughout the establishment phase, and also during the expansion of the programme thus far, the proceedings of the provincial Task Team and its portfolio managers tended to focus on devising short-term operational responses to problems in implementation (infrastructure and programmatic matters). The week-to-week focus fell (and still falls) narrowly on ART provisioning, with little, if any, attention being afforded to pursuing the broader intent and core principles of the *Comprehensive Plan*. There is no emphasis on "prevention" (except in respect of those reporting for the ART service at facilities), or on deliberately "promoting healthy lifestyles" (except in respect of those accessing the programme at facilities) as the mainstays of the response to HIV/AIDS, or on efforts to "purposefully strengthen other equally important health care priorities and programmes" outside the ART programme (cf NDoH 2003: 18-21). The Task Team never comtemplated these essential cornerstones in relation to ART. An illustration of the approach is that the narrow "ARV-qualified" designations in use since the introduction of the *Comprehensive Plan* have remained the jargon throughout.

Linked to the narrow focus on operational issues and treatment only, has been a paralysis in both decision-making and action-taking on the part of the Task Team.[30] Chronic delays and procrastination, at times

30 Much of the inability to decide and to act resides in the composition of the provincial Task Team. In the beginning meetings were characterised by a clear division of labour with the tasking of specific functionaries, scheduled follow-up on performance and progress, and a vibrant commitment to and excitement about the new challenge. The functioning of the Task Team boiled down to weekly meetings

combined with *laissez-faire* attitudes, have signalled a lack of strategic planning and a neglect of strategic matters. As events often ran into bottle-necks, there has been a tendency to deal with emerging issues in an indecisive, postponing manner, framed as "Let's see what will happen with the roll-out" or "We [shall] adopt a wait-and-see attitude" (FSDoH official TT meeting 26.05.04). This has led to undue dragging of feet, "passing the buck", and blaming the system, which has often ended in missed delivery targets and target dates. Amid the too-easily blamed bureaucratic environment and sluggishness elsewhere in the organisation, such poor performance should also be attributed to personal inertia on the part of participants in the programme.[31] The fact is that the programme was (and still is) often characterised by an inability to implement or deliver on set targets, timeframes and activities, and in delays and procrastination in execution, or non-execution, of decisions and tasks. Part of the problem has been the failure to communicate decisions effectively to the operational levels of the district, sub-district and facility. In the end, this paralysis resulted in huge underspending of the con-

where a To-do-list-for-ARVs (sequenced in the format: task → what needs to be done → responsible person → date) guided the agenda and monitored progress and problems. The constant involvement and commitment of high-level officials of the Department of Health and academics to direct, advise and drive the process has always seemed the most positive element of the preparation phase. Their presence not only reflected the importance of the task at hand, but also enabled decisions to be taken swiftly, means and measures to be put in place immediately, and emerging issues to be dealt with on the spot, without any need for referral up the line for approval. This approach boosted the effectiveness and productivity of the Task Team and thus facilitated the process tremendously. However, this crisp dynamism and precision gradually waned as previously allocated tasks remained unaccomplished week after week, delayed and postponed on the To-do-list. As time went on, indecision and inaction set in. In fact, the To-do-list disappeared altogether, and inexcusable delays followed. This loss of thrust and direction can be attributed to the changing composition of the Task Team, the turnover among members, the frequent absence of key members, the discontinuity in chairing meetings, and the unwillingness of managers to take decisions or to act without higher-level approval.

31 Cf also the observation by Doherty *et al* (2005: 8): "Many aspects of the programme experience constraints within the bureaucracy. Implementers feel caught up between policy directives to increase coverage of ART programmes and what is perceived as bureaucratic inertia."

ditional grant allocated to the programme during the 2004/05 financial year and will probably also do so for the 2005/6 financial year.[32]

Obviously these conditions have caused frustration and despair among many role-players, as varyingly expressed in the Task Team itself: "Nothing happens with the ideas … Please, convey the message: we are frustrated, because our ideas end up [only] on paper" (FSDoH official TT meeting 18.05.05). Later, this ongoing paralysis in decision-making and action-taking in the Task Team was described, with irritation, as "Talk, talk, talk, but nothing happens" (FSDoH official TT meeting 13.07.05).

4. External influences on the implementation of the *Comprehensive Plan* in the Free State

4.1 External constraints on implementing the provincial programme

The broader framework of ART in South Africa as embodied in the *Comprehensive Plan*, its merits and demerits, and how these have affected the roll-out in the Free State have already been discussed. But more aspects of this external environment need to be considered when reviewing the implementation of ART in the province. This environment comprises a conglomerate of national role-players and stakeholders (the NDoH and the Treasury), pharmaceutical companies, civil society, AIDS-focused NGOs (the TAC and the AIDS Law Project), and the Joint Civil Society Monitoring Forum (JCSMF). In several respects these forces have left clear marks on the provincial domain.

More specifically, considering the obviously lack of resources, especially human resources, the external environment and its actors had, in the first place, set unrealistic timeframes and output targets for the programme. Secondly, there was by no means full delivery on the support initially promised. As a result, the programme was from the start tainted with disillusion: "But we were let down by the financial people

32 Johnson (2004: 112, 119) alludes to the underlying reasons for underspending on HIV/AIDS programmes, among others, "the restrictions of government expenditure according to the new macroeconomic framework", the "fiscal austerity" of the national government, and "the lack of capacity at the provincial level to manage and administer large projects".

... We kept on getting the message: 'put forward a plan and we will fund it — money is not a problem'. But when the Plan was approved money was, in fact, a problem" (NDoH official interview 14.02.05). Thirdly, the initial tender process for ARV drugs evoked "absolute abomination", undue delays and insecurity, while the interruptions in the supply of such medicines at times bordered on total derailment of the programme, described at the time as "a mess, a total mess" (FSDoH official TT meeting 02.12.04). Fourthly, during the establishment phase undue pressure was put on provinces to put patients more speedily on ART.

4.2 Discordance between the national plan and provincial implementation

Of necessity, the implementation of the CCMT programme in the Free State has remained a close operationalisation of the *Comprehensive Plan* at the provincial level, as is indeed reflected in the Free State's Plan. There is, thus, noticeable concordance and coherence within this larger national-provincial continuum. However, the national-provincial relation has also generated two important negative implications. On the one hand, it has meant that the deficient elements in the national plan (as mentioned above), in particular, transposed themselves onto the provincial plans, especially the overambitious targets and unrealistic timelines. Soon after the roll-out commenced, the failure to convert plans into practice became evident. With the need for speedy implementation, scarcity in human resources, lean management capacity and the timely availability of drugs, the goals of strengthening the health system and increasing the number of patients on ART came under pressure.[33]

On the other hand, and as a result of the gap between the aims of the policy (as portrayed in the *Comprehensive Plan*) and its execution in reality (at the provincial and district levels), the Free State's *Plan* also deviates from the national plan in order to meet the conditions, practi-

33 Cf Gilson *et al* (2003: 36) and Walker & Gilson (2004), who refer to the "problems of speedy implementation" of policies (illustrated in their case studies on the introduction of free primary care in South Africa and user fees in Zambia). They show how political momentum (often ignited by "politically symbolic gestures") often outstrips the technocratic requirements for the implementation of the policy, and can generate unexpected negative impacts on a wide front.

calities, needs and resources of the province and its districts. Such provincial variation has been manifested in strategising, prioritising and structuring the ART programme; in devising and implementing training curricula, manuals and schedules, and developing treatment guidelines, patient information systems, and so on. The inevitability of such provincial variance has also been acknowledged by the NDoH: "The reality of each province is different … we had to adhere to standards, but realities are different ... standards cannot be rigid" (NDoH officials Joint NDoH-FSDoH officials meeting 24.05.05).

4.3 Lack of national leadership, direction and support

In the initial stages, the main external influence was the NDoHs lack of the necessary capacity, support and leadership to guide and drive the implementation to the extent envisaged. "The NDoH needs to play a coordinating role, but they haven't been playing that role … 'Hey, guys, you are confused, and you are confusing us'" (FSDoH official interview 30.01.04). As a result, the Department did not deliver on crucial aspects of the programme, including training and training manuals, adult and paediatric treatment guidelines, an adequate monitoring and evaluation system, and timely approval of the FSDoH business plans. In the early stages this might have been understandable, because the NDoH was also affected by the rush to achieve roll-out. Moreover, key people leading the implementation of the *Comprehensive Plan* were, at the time, new in their posts, while others left the Department during critical phases (NDoH officials interviews 14.02.05, 13.06.05). It is less excusable that the lack of leadership and support persisted. After a year the JCSMF was still referring to the "lack of systematic national management and oversight" (JCSMF 2004a: 4), and after two years the NDoH was expressly blamed for changing the rules all the time (FSDoH clinician TT meeting 10.08.05).

However, there is another side to this issue. Although observers recorded strong, visible political will and support, as well as effective leadership and stewardship[34] on the part of the executive managers of the pro-

34 Schneider *et al* (2004: 4-5) deem stewardship crucial for the scaling up of ART. It implies "overall oversight, setting the rules of the game, regulating resource use, collating and collecting information". Stewardship comprises recognising existing opportunities and capacity within the system and building on these, whilst simultaneously addressing structural weaknesses.

gramme in the Free State (Doherty *et al* 2005), high-ranking officials of the NDoH reported a lack of managerial competence at the middle-management level in some provinces (including the Free State) leading to an inability to produce timeously on key deliverables, for instance an acceptable business plan and budget for the province. Inadequacies also appeared in the Free State's line of management, constraining the provincial-national continuum — in particular, "a gap, a complete gap" between the province's HIV management group and its top management, the former "had no authority, and obviously no competence in terms of deciding" at national meetings (NDoH official interview 13.06.05).

4.4 A flawed national-provincial relationship

At times, the conditions described above engender short-circuits in the national-provincial continuum, despite the regular national-provincial meetings convened to share experiences and to address issues relating to the implementation of the *Comprehensive Plan* (Kalombo 2005). From the earlier stages of the provincial roll-out there was a sense that the NDoH was out of step with developments on the ground: "What National wants, is not always practical … does not always make sense" (FSDoH official TT meeting 16.02.05). Later, the doings and non-doings of the NDoH were often criticised in loaded comments: "If we have to wait for the NDoH, we will get it in ten years' time" (FSDoH official TT meeting 15.09.04), while more recently its role was still typified as "lacking and lagging behind ... they don't know where they are leading us; they just respond to initiatives taken in the provinces" (FSDoH official discussion 07.03.05). At times frustration was aired: "The NDoH ... goes from disorganisation to paranoia" (FSDoH official Joint FSDoH-CIDA officials meeting 27.09.04). The JCSMF (2004b: 3-4) more tactfully records this flawed relationship as manifesting in "gaps in communication and information-sharing" between the national and provincial health departments.

The unilateral decision-making and action that flow from the troubled national-provincial relationship is a more serious issue. High-level officials in the Free State repeatedly hinted at the incongruency: "We [the Free State] have not the same plans that the NDoH has for us"; "We decide what is best for the Free State" (FSDoH officials TT meetings 02.06.04; 06.10.04, Joint FSDoH-CIDA officials meeting 27.09.04).

Although such stances should be welcomed, as they reflect initiative and autonomy on the provincial side, they also harbour a possibly destructive element. Too much independence in decision-making and unilateral action by provinces (in a federalist mode) undermines central, uniform direction and disempowers central leadership and authority.[35] To bridge this gap, more is needed than the unwelcome "very directive, even prescriptive" style on the national side or the indifferent pursuit of courses of action in an autonomous manner on the provincial side (FSDoH official Joint NDoH-FSDoH officials meeting 13.10.04).

5. How to proceed? Lessons from the Free State's experience

5.1 Achievements and strengths to build on, flaws and failures to attend to

There was significant progress and innovation in the implementation of the *Comprehensive Plan* in the Free State during the first two years. Among the main strengths and achievements are the following:

- establishing 20 functioning ART sites during 2004 (four treatment, 13 assessment and three combined sites) to make the service available in six of the province's 20 local municipalities;
- doubling this number of sites during the 2005 expansion phase by adding 20 new sites (four treatment, one satellite treatment, eight assessment and seven combined sites) and providing the service in 14 local municipalities, thereby putting the Free State well ahead of the *Comprehensive Plan*'s objective of having an ART site in each local municipality of the country by 2008 (cf Map in Preface);
- modelling ART services in quite a flexible manner according to a variety of organisational and managerial models to suit local circumstances, resources and needs in the districts, so that from the original "1x3" model, combined treatment-assessment sites, a satellite treat-

35 In a different context, but quite in line with this experience, the Local Government and Health Consortium (LG&HC 2004: 1) cautions about the possible effects of decentralisation to lower levels of government: "fragmentation and weakened strategic direction, national co-ordination and cohesion".

ment site, non-site-bound staff travelling between sites or serving an entire district, and other variations have emerged;

- instituting an active provincial ART Task Team as well as five equally active district ART task teams to advise and steer the implementation of the *Comprehensive Plan* in the province, districts and ART-rendering facilities;
- devising the province's own adult treatment guidelines for doctors and nurses on how to manage patients on ARVs;
- developing a core start-up training programme for ART staff, and later adapting it to offer decentralised implementation as well as maintenance training to staff at 38 health facilities across the province via a sophisticated broadcasting system (iCAM), and also phasing in a strong component of practical training;
- training a substantial number of staff in all the necessary professional categories (and including some lay people) for the programme (321 in 2004 and 438 in 2005),[36] and in the process also building a growing body of reserve staff at ART and other facilities;
- extending advice, support, services and means to several organisations in other sectors (state, faith-based and private), including accrediting their sites and providing them with training and training materials, treatment and nutritional guidelines, patient forms, reporting systems, dietetic services, nutrition supplements and ARV drugs — generally assisting them to establish their ART programmes;
- collaborating with these partners to strengthen and expand the province's delivery of ART by synchronising their programmes with the province's policy and programme, especially in terms of standardising training, treatment guidelines, patient forms, reporting systems and drug regimes, and in increasing the number of patients accessing ART;
- aligning the already existing CHW system (NGOs, home-based carers and lay counsellors) with the ART programme and expanding it to serve the needs of the programme more effectively;

36 Cf Steyn *et al* in this volume.

- developing a tailor-made drug readiness training programme, manual and guidelines to prepare patients entering the ART programme and to strengthen adherence to treatment regimens;
- installing and expanding an electronic network, information technology and IT systems to support the roll-out — including a site-based electronic patient IT network for capturing patients' details at all levels of care — and establishing essential monitoring, evaluation and reporting mechanisms to monitor and support patients and to secure adherence to treatment;
- devising a plethora of means, materials and media (pamphlets, road shows, radio talks, media releases, education-information videos and a portal for ARV roll-out on the website) for communicating messages so as to keep the wide spectrum of stakeholders, role-players and others affected by the ART programme informed;
- introducing an array of mechanisms to facilitate programme implementation and resolve emerging problems, *inter alia* joint meetings of the provincial and district task teams, the appointment of a programme manager and district ARV programme co-ordinators, and regular joint meetings of these co-ordinators, and
- screening sizable numbers of potential patients for the programme, expanding VCT, certifying sizable and growing numbers of patients for ART (3 322 patients by the end of October 2005) and putting and keeping them on treatment.

Despite these achievements and progress, not all aspects of the provincial programme ran, or run smoothly: "Just when we see the end of the tunnel, we hit another ceiling" (FSDoH official TT meeting 16.03.05). As has been discussed at great length, a variety of programme constraints and deficiencies have emerged during the implementation process, posing serious challenges to the programme and preventing its smooth implementation. Among these are the following:

- overambitious targets and timelines, combined with unhealthy haste;
- a lack of national leadership and delivery;
- chronic indecision and inaction;
- recurrent delays and disruptions, with resultant insecurity in drug supply in the early stages;

- a growing shortage of staff in most professional categories and a neglect of staffing issues;
- inappropriate glorification and verticalisation of the programme;
- communication breakdowns and inadequate co-ordination among the components and levels of the programme; and
- an undue fixation on operational issues, with negligible attention, being paid to strategic matters.

As the number of patients on ART have increased and additional sites have been opened, these mistakes have become magnified in the various dimensions of the programme and at almost every point in the service delivery chain. It is also true that "the high prevalence of HIV combined with a lower-than-hoped-for staff capacity has resulted in early saturation of sites" (Doherty *et al* 2005: 20).

5.2 Lessons for wider application and pointers for possible intervention

In devising and implementing its plan, the FSDoH instituted structures and processes which in hindsight — although well intended and often quite innovative — have become constraints or barriers to programme implementation over which policy-makers and high-level managers have little control. These "Achilles' heels" in the Free State's approach and strategy require rethinking and re-design, and may serve as lessons for other initiatives in similar settings. In fact, similar conclusions have been drawn by many researchers reporting on comparable policy and implementation endeavours. Among the core observations (and accompanying lessons) springing from the Free State's case are the following:

- The unbecoming haste in forcing the implementation of the *Comprehensive Plan*, linked to the urgency of the political agenda, overrode the need for adequate planning and proper preparation for implementation. Capacity at the implementation levels thus lagged far behind. This problem was complicated by years of political delay and denial, which created insurmountable backlogs and capacity shortfalls in care for the infected.
- The setting of overambitious targets, unrealistic timeframes, and unattainable agendas for implementation and delivery — for both the *Comprehensive Plan* and the Free State plan — had undesirable

effects on the implementation of the programme. These created unbridgeable policy-implementation gaps in the face of inadequate managerial capacity and human resources for efficient implementation of the policy and plans. Such targets, timelines and agendas may also have been counter-productive in discouraging programme implementers at the middle and lower levels, ultimately compromising the quality and sustainability of care. The problem was aggravated by the introduction of the programme without proper monitoring and evaluation systems. Only numbers of patients were available; there were no indicators against which to measure progress and quality, and upon which to act in case of failure.

- A flawed relationship between the NDoH and the provincial Departments of Health constrained the smooth implementation of the *Comprehensive Plan*. To a large extent this was the result of a hurried planning, inadequate preparation, and ultimately overhasty implementation agendas. This manifested itself particularly in the non-delivery of essential components of the programme, as well as necessary groundwork not being done and responsibility not being devolved to the provinces. The same overhasty pattern and similar inadequacies repeated themselves in the provincial domain when the Free State's plans reached the districts, facilities and staff, with an insistence on instantly converting overambitious plans and time-strapped schedules into practice.
- From the outset, the way the ART programme was planned, structured and implemented in the Free State was divorced from the comprehensive thrust of the *Comprehensive Plan*. Implementation thus also fell into the trap which is now so familiar in the HIV/AIDS sphere, namely of offering a narrow "health" initiative which is primarily (if not exclusively) the domain and responsibility of departments of health. No serious efforts were made to open the programme to the desired interdepartmental and intersectoral collaboration and involvement. This left untapped the huge potential which relevant "other" state departments, and especially civic society, could have contributed to supplementing, strengthening and sustaining the programme.
- Up to this point the ART programme in the Free State was managed in a highly centralised, top-down manner, predominantly by the provincial Task Team and its portfolio managers. One of the results

of this was non-involvement and even apathy at the lower and peripheral levels of management, which had constraining effects on the implementation process. One could expect that, as the programme expands, its management will move more and more to the district and institution levels and that, in time, the provincial Task Team may become redundant.

- Much of the initial flexibility with which this novel and challenging programme was initially planned, structured and implemented, as well as the initial enthusiasm and dedication of the implementers, was steadily paralysed by and lost in bureaucratic red-tape, rigidity and tardiness. This caused undue delays, postponements, indecision, inaction and a failure to meet targets and timelines. These entailed a loss of strategic focus and urgency. At the same time these deficiencies in implementation emphasise the need for strong leadership, stewardship and managerial capacity, especially in the introduction of new programmes, in order to hold the process, as well as the programme implementers and operators along the entire line, to the set targets and schedules, and thus to preclude the chronic problems of managerial indecision, inaction and apathy. Unfortunately the urgency and undue haste that accompanied the *Comprehensive Plan* did not sufficiently and appropriately allow for these implementation prerequisites.
- The experience of the Free State shows how underdeveloped, one-way and blocked communication channels can cripple information flow and reciprocal involvement, resulting in failures of co-ordination and collaboration. Breakdowns in co-ordination between the essential components and levels of the ART service and its management did and still do occur, causing problems for programme implementation. Foremost among these is the divide that developed between the Support Cluster and the Clinical Cluster within the provincial health bureaucracy due to ineffective communication and inadequate involvement of the latter in the planning and establishment phases. Equally important are the short-circuits in communication and involvement which developed between the central Task Team (and the programme's head office) and the peripheral managements operating in the districts and health facilities where it is implemented. The simple lesson is that, if significant implementers at

the centre and the periphery are not properly involved in every step, especially in the initial phases of a new programme, incongruencies between policy and implementation are bound to develop. At the same time, as the Free State's case at times also demonstrates, the free flow of communication, proper consultation and adequate involvement of managers in the districts and at peripheral institutions can surely counteract managerial apathy and inaction at the implementation levels.

- In the Free State, at least in the beginning, the ART programme was introduced as a vertical or stand-alone programme. This tendency is perhaps understandable when a new programme of this nature and scale is introduced and has to be fast-tracked. However, such verticalisation has gone too far in many facilities with a tendency to solidify in terms of separate authority over it and in separate staffing, financing and service delivery. Strict verticalisation of the programme in many facilities has largely stripped it of its original comprehensive aim of prevention and the promotion of healthy lifestyles, and of its intention to strengthen the broader health care system, in this case strengthening the mother facility within which the programme is embedded. Later, admittedly, note was taken of the deficiencies of verticalisation, and attempts to integrate the ART programme within related PHC programmes and services in health care facilities were systematically stepped up. It should also be recognised that some PHC facilities (and managers) followed an explicitly integrative approach from the start.
- Thus far, the tempo of programme implementation in the Free State has been relatively slow in terms of patients on treatment and, as has been indicated, this slow pace is not necessarily related to better quality, efficiency or effectiveness of service delivery. Unnecessarily high and expensive standards have been set for the programme, especially in resource-constrained areas. As has been pointed out, the "gold standards" used in the accreditation of sites led to intolerable delays in implementation. In addition, there has been a focus, thus far, on "picking the low-hanging fruit first", while little experience has been gained in opening sites in more demanding, resource-poor settings.

6. Conclusion

The Free State needs to concentrate more, and more continuously, on strategic matters in deploying and rendering the programme; to shift strategic challenges to centre-stage, and to pursue these systematically. Among these strategic matters and challenges are the following:

- first, pursuing the core ideals envisioned in the *Comprehensive Plan*, especially in terms of rendering the programme truly "comprehensive", catering for more than treatment and drug distribution, and focusing more strongly on prevention and healthy life styles;
- secondly, attending to the long-term challenges facing the programme, especially strategies to secure adequate human resources and skills mixes, and the well-being of the workforce;
- thirdly, integrating ART into related PHC programmes to ensure that its provision does indeed benefit and strengthen the entire health system, and vice versa;
- fourthly, dealing with the backlogs in the provision of public ART as well as with the growing discontent in communities and among patients which has resulted from the inacessibility, rationing and exclusivity of the programme.

These challenges demand that policy-makers and managers seriously rethink and redesign crucial aspects of the Free State's approach and strategy in order to stop the gaps and eliminate the flaws which have developed in the course of the past two years. In so doing, there is also the proud record of strengths, achievements and progress to build upon, especially if one acknowledges the youth of the programme and its prospects for evolution and maturation in years to come.

Bibliography

BARRON P

2003a. Scaling up the use of antiretrovirals in the public sector: what are the challenges? Unpubl presentation at ART seminar, School of Public Health and Perinatal HIV Research Unit, University of the Witwatersrand. Johannesburg, 1 August 2003.

2003b. No ARV roll-out is better than a bad ARV roll-out. Paper. <http://www.afroaidsinfo.org/content/home/arvrollout.htm>

2003c. Scaling up the use of antiretrovirals in the public sector: what are the challenges? *Independent Newspapers* August 2003. <http://news.hst.org.za/view.php3?id=20030808>

BUVÉ A

2005. Human resources for health and ART roll-out: a deepening crisis. Unpubl presentation at the conference on Implementing the Comprehensive Care and Treatment Programme for HIV/AIDS patients in the Free State: sharing experiences. Bloemfontein, 30 March-1 April 2005.

CABINET OF THE REPUBLIC OF SOUTH AFRICA

2003. Cabinet statement on comprehensive treatment plan for HIV & AIDS in South Africa. Issued by: Government Communications (GCIS). 19 November 2003.

CAMERON E

2005. *Witness to AIDS*. Cape Town: Tafelberg.

CHAPMAN R

2005. Managerial approach to establishing ARV sites: Free State experience. Unpubl presentation at the conference on Implementing the Comprehensive Care and Treatment Programme for HIV/AIDS patients in the Free State: sharing experiences. Bloemfontein, 30 March-1 April 2005.

D'AGNES T

2001. *From condoms to cabbages. An authorized biography of Mechai Viravaidya*. Bangkok: Post Books. [Chapter 9: AIDS in Thailand: 317-360].

DOHERTY J, M LOVEDAY, R STEWART & L THOMAS

2005. *Conference report: Implementing the Comprehensive Care and Treatment Programme for HIV and AIDS patients in the Free State: sharing experiences*. Durban: Health Systems Trust.

E-DRUG

2004. Ranbaxy withdraws all generic ARVs from WHO prequalification, 9 November 2004. <e-drug@healthnet.org>

FASSIN D & H SCHNEIDER

2003. The politics of AIDS in South Africa: beyond the controversies. *British Medical Journal* 326: 495-7.

FREE STATE PHARMACEUTICAL SERVICES

2005. Weekly report of the Free State Pharmaceutical Services: 22.06.05; 06.04.05.

FREE STATE DEPARTMENT OF HEALTH (FSDoH)

2003a. *Proposed plan for the Free State Department of Health roll-out of the Antiretroviral Treatment (ARV) programme*. Bloemfontein: Department of Health.

2003b. *Proposed plan for the implementation of ARVs in the Free State Province*. Bloemfontein: Department of Health.

2004a. Adult antiretroviral treatment guidelines (Version 1, April 2004).

2004b. ARV weekly report. Bloemfontein 29.09.04.

2004c. ARV weekly report. Bloemfontein 03.11.04.

2004d. Stock-taking of implementation of the ART programme and filling of gaps in areas that need to be addressed. Stakeholder workshop. Bloemfontein, 31 March 2004.

2005a. ARV status report. Bloemfontein 01.05.

2005b. Summary report of workshop on Provision of human resources to ensure sustainability of the *Comprehensive Plan*. Bloemfontein, Department of Health, 2 March 2005.

GILSON L, J DOHERTY, S LAKE, D MCINTYRE, C MWIKISA & S THOMAS

2003. The SAZA study: implementing health financing reform in South Africa and Zambia. *Health Policy and Planning* 18(1): 31-46.

HEALTH SYSTEMS TRUST

2005. *South African Health Review*. Durban: Health Systems Trust.

JANSE VAN RENSBURG-BONTHUYZEN E

2004. Report on ARV training workshop for assessment site personnel held in the Motheo District, July 2004. Bloemfontein: Centre for Health Systems Research & Development.

JOINT CIVIL SOCIETY MONITORING AND EVALUATION FORUM OF THE OPERATIONAL PLAN FOR COMPREHENSIVE HIV AND AIDS CARE, MANAGEMENT AND TREATMENT FOR SOUTH AFRICA (JCSMF)

2004a. Summary of discussion and resolutions. Inaugural launch of the Forum. Polokwane, 7 September 2004.

2004b. Minutes of the 2nd national meeting. Bloemfontein, 19 November 2004.

2005. Minutes of the 3rd national meeting on paediatric access to ARV treatment and developing a human resource plan for the health sector. Durban, 18 February 2005.

JOHNSON K
2004. The politics of AIDS policy development and implementation in post-apartheid South Africa. *Africa Today* 51(2): 106-28.

KALOMBO D
2005. Comprehensive HIV & AIDS care, management and treatment plan. CCMT progress report. Unpubl presentation at DCF: HIV&AIDS meeting. Pretoria, 6 July 2005.

KELLERMAN T
2005. Trying to 'roll it': pains, victories and challenges at an ART treatment site level. Unpubl presentation at the Conference on Implementing the Comprehensive Care and Treatment Programme for HIV/AIDS patients in the Free State: sharing experiences. Bloemfontein, 30 March-1 April 2005.

KOBER K & W VAN DAMME
2004. Scaling up access to anti-retroviral treatment in southern Africa: who will do the job? *Lancet* 364: 103-107: 105.

LOCAL GOVERNMENT AND HEALTH CONSORTIUM (LG&HC)
2004. *Decentralising health services in South Africa: constraints and opportunities*. Durban: Health Systems Trust.

LOUWAGIE G, L FAIRALL & Z MATEBESI
2004. *Barriers to the introduction of the public sector anti-retroviral treatment programme. A first report of structural barriers identified in focus group discussions with primary care nursing practitioners*. Cape Town: UCT Lung Institute.

MCCOY D, M CHOPRA, R LOEWENSTEIN, J-M AITKEN, T NGULUBE, A MUULA, S RAY, T KUREYI, P IJUMBA & M ROWSON
2005. Expanding access to anti-retroviral therapy in sub-Saharan Africa: avoiding the pittfalls and dangers, capitalizing on the opportunities. *American Journal of Public Health* 95(1): 18-22.

MRC & UCT LUNG INSTITUTE
2005a. *Implementation of the comprehensive care, managment and treatment of HIV and AIDS patients — outcomes of the first year, 2004*. Cape Town: MRC & UCT Lung Institute.

2005b. *Implementation of the comprehensive care, managment and treatment of HIV and AIDS programme — 2005 first quarter report*. Cape Town: MRC & UCT Lung Institute.

NATIONAL DEPARTMENT OF HEALTH (NDOH)
2000. *Strategic Plan for HIV, AIDS and STIs*. Pretoria. Department of Health.

2003. *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa*. Pretoria: Department of Health.

2004. *National antiretroviral treatment guidelines*. Pretoria: Department of Health.

NETCARE-FSDOH
2004. Proposal for PEPFAR funding, June 2004.

PELSER A J, C G NGWENA & J V SUMMERTON
2004. The HIV/AIDS epidemic in South Africa: trends, impacts and policy responses. Van Rensburg (ed) 2004: 275-314.

PHARMACEUTICAL SOCIETY OF SOUTH AFRICA (PSSA)
2004. Medicine recall/substitution. *Newsletter* 119/2004. 26 October 2004.

SCHNEIDER H, D BLAAUW, L GILSON, N CHABIKULI & J GOUDGE
2004. *Health systems strengthening and ART scaling-up: challenges and opportunities*. Johannesburg: Centre for Health Policy.

SCHNEIDER H & D FASSIN
2002. Denial and defiance: a socio-political analysis of AIDS in South Africa. *AIDS* 16 (suppl 4): S45-S51.

SSEMAKULA J K
2004. Through a glass darkly — the prism of AIDS. <http://medilinkz.org/Features/Articles/july2004/aidsdarkly.asp>

STEWART R & M LOVEDAY
2005. Operational plan: implementation of the antiretroviral therapy component. *Health Systems Trust* 2005: 224-46.

TABANE L
2005. *Minutes of the 3rd national meeting on paediatric access to ARV treatment and developing a human resource plan for the health sector*. Durban: JCSMF 18.02.05: 6.

TSHABALALA M
2005. Time to reflect: implementation of the *Comprehensive Plan*. Unpubl presentation at the FSDoH Stakeholder Workshop. Bloemfontein, 14 September 2005.

VAN RENSBURG D, I FRIEDMAN, C NGWENA, A PELSER, F STEYN, F BOOYSEN & E ADENDORFF
2002. *Strengthening local government and civic responses to the HIV/AIDS epidemic in South Africa*. Bloemfontein: Centre for Health Systems Research & Development.

VAN RENSBURG H C J
2005. *Staff at ARV service sites in the Free State per districts — November 2004*. Bloemfontein: Centre for Health Systems Research & Development.

VAN RENSBURG H C J (ed)
2004. *Health and health care in South Africa*. Pretoria: Van Schaik.

WALKER L & L GILSON
2004. 'We are bitter but we are satisfied': nurses as street-level bureaucrats in South Africa. *Social Science & Medicine* 59: 1251-61.

WORLD HEALTH ORGANIZATION (WHO)
2004. Ranbaxy withdraws all its antiretroviral medicines from WHO prequalification. <http://www.who.int/mediacentre/news/releases/2004/pr79/en/>

Meetings attended at which information was gathered

Statements or remarks made during meetings of the provincial Task Team — or in other official meetings related to the ART programme — are anonymously referred to as: FSDoH official, FSDoH clinician TT meeting (or other specific meeting), with the date of the statement or remark.

Accreditation feedback sessions. Bloemfontein (23.01.04) and Welkom (04.02.04).

Joint Centre of Excellence-CIDA officials meeting. Bloemfontein. 27.09.04.

Joint FSDOH-CIDA officials meeting. Bloemfontein. 27.09.04.

Joint FSDOH-CIDA-IDRC officials meeting. Bloemfontein. 17.08.05.

Joint FSDOH-Research partners meeting. Bloemfontein. 07.06.04.

Joint FSDOH-World Bank officials meeting. Bloemfontein. 27.10.04.

Joint NDOH-FSDOH officials meeting. Bloemfontein. 13.10.04.

Joint NDOH-FSDOH officials meeting. Bloemfontein. 24.05.05.

Joint Provincial-District task teams meeting. Bloemfontein. 26.01.05.

Joint task team members-District ART Programme Co-ordinators/ CEOS meeting. Bloemfontein. 29.06.05.

Interviews with stakeholders and role-players

The questions and content of the interviews were adapted at each occasion depending on the interviewee's affiliations and the time of the interview. In the main, the interviews focused on the nature of the programme in the province; the organisation's role in the provincial ART programme; its strengths, limitations and weaknesses in progress made in implementation in the province and in the districts; constraints encountered; the main positive and negative opinions on the ART programme, and the remaining challenges. For the sake of confidentiality the interviewees are cited anonymously.

High-ranking officials of the National Department of Health (all anonymously cited as NDoH official interview, with the date of the interview): Dr L Claassens (Director: Quality Assurance); Dr C Hamelmannn (Technical Advisor for the HIV/AIDS Programme); Dr D Kalombo (Manager of the CCMT Programme); Dr Y Pillay (Chief Director: Stra-

tegic Planning); Dr C Serenata (former Technical Advisor for the HIV/AIDS Programme).

High-ranking, mid-level officials and politicians of the Free State Department of Health (all anonymously cited as FSDoH official interview, discussion or statement, with the date of the interview or meeting, discussion or statement): the Honourable Mr S Belot, MEC for Health; Dr V Lithlakhanyane (former Head of Health); Mr M Shuping (Executive Manager: Clinical Heath Cluster, and acting Head of Health); Dr R Chapman (Executive Manager: Heath Support Cluster); Me N Jolingana (former Director: HIV/AIDS/TB/STIs and Communicable Disease Control); Ms P Shai-Mhatu (Director: HIV/AIDS/TB/STIs and Communicable Disease Control); Dr M Tshabalala (Manager: CCMT programme); Mr G Meyer (Chief Pharmacist: ART programme); Mr M Hoosen (Chief Pharmacist of Logistics, Medical Depot); Ms R Booi (Chief Professional Nurse: CCMT programme); Mr L Loffstadt (Senior Human Resource Adviser); Ms M Linstrom (Information and Research); Mr P Noe (Chairperson of the Boards of the Manapo and Elizabeth Ross Hospitals); Mr B Oliphant (CEO: Monapo Hospital); Ms R Marumo (acting district ARV programme co-ordinator, Lejweleputswa; Ms E Bolofo (district ART programme co-ordinator, Thabo Mofutsanyana).

Medical specialists serving in the Task Team and/or the Centre of Excellence or managing ART sites (all anonymously cited as FSDoH clinician, with the date of the interview): Drs D Steyn and C van Vuuren (Internal Medicine and Centre of Excellence); Dr L Tabane (Pediatrics and Centre of Excellence); Dr T Kellerman (Manager of treatment site at the National Hospital); Dr R Nhiwatiwa (Manager of treatment site at Bongani Hospital).

Representatives of NGOs (all anonymously cited as NGO representative, with the date of the interview): Naledi Hospice, 13 February 2004; TAC, 16 February 2004; NAPWA, 17 February 2004.