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A blueprint for ARV care?

by Julian Meldrum

Summary

A publication from the international development consultancy John Snow, Inc, offers a framework to assess the readiness of health care services at particular sites to provide antiretroviral (ARV) therapy.

This document deserves to be read critically because there could be a large amount of money for scaling up ARV provision in a number of countries relatively soon, if recent political promises lead on to real budgets.

The framework set out here is likely to be influential in how internationally funded services are planned and implemented (although so far this aspect of treatment provision has not received as much attention as it may deserve). It sets up criteria which could be used for choosing which services to fund, and what they should be funded to do.

This article invites readers to ask if there are dimensions which could and should be assessed, that have not been considered here? If a service that is currently providing treatment 'fails' to meet some of the criteria set for an advanced service here, is that a helpful pointer to problems that should be remedied, or could it be a distraction from the potentially more useful activity of identifying strengths and building on them?

REFERENCE:

Hirschhorn L et al. Tool to Assess Site Program Readiness for Initiating Antiretroviral Therapy (ART). Boston, Massachusetts: John Snow, Inc., for the US Agency for International Development, 2003.

This is a 20-page (101kB) publication in PDF format available [here](#)

The Idea of progress

The framework is concerned with capacity to implement treatment, and the level of development that has been reached, measured on a number of scales based on descriptions of aspects of services. Two or three scales are grouped into six 'domains' and these are then grouped again to give an overall score for a site.

Each five-point scale measures progress in a particular direction, against which providers could measure their own provision to see what they might (according to this model) be aiming for, and to check how this relates to their own priorities as they see them.

The idea is that when scores on a series of different measurements are combined, then services can be placed along a path as follows:

Stage 1: programme mobilisation sites that have no plans to provide ARVs, for reasons which may or may not be valid, but which have the potential to progress if given help.

Stage 2: service delivery planning sites with limited experience, perhaps in providing ARVs to prevent mother to child transmission, that are seeking to expand their services. These sites might provide follow-up for people on ARVs who begin treatment elsewhere, in advance of acquiring the capacity to start people on treatment.

Stage 3: preparation where there is a commitment to introduce ARVs and the potential to do so within 3 to 9 months if resources are made available to address particular needs.

Stage 4: action sites which are ready to provide access to ARVs, or may already have started doing so, as part of a wider pattern of HIV treatment and care.

Stage 5: support, maintenance, expansion and serving as a resource when service providers may have enough experience, and be sufficiently well organised, to be able to help others to move in the same direction.

The quality of leadership

The first 'domain' concerns leadership, with three scales, on 'leader', 'nullmodel of care' and 'ART protocols'.

The quality of leadership is measured on a scale from 1 to 5, where 1 is having 'no identified leadership or commitment at site or in community' and 5 is having a 'strong leader who is spearheading ARV program, and has experience or training in managing ARV programs'.

This does beg questions about 'strong' leadership. Questions such as how those using the tool are to value 'feminine' styles of management. Might 'effective' leadership have been a happier choice of phrase?

Model of care is on a range from having no particular model, through to having a detailed model of care and operating procedures set out and approved. Whether this is always the mark of a well-run service might be questioned. It is always going to depend on how appropriate and how genuinely endorsed such a model is or becomes.

Finally, in this section, ART protocols are assessed, with a bias for protocols that are carefully adapted to the particular setting in which services are being provided, and which provide for 'eligibility [criteria], screening criteria, regimens, initiation, clinical and lab monitoring and follow-up, adherence [assessment? support?], management of side effects, treatment interruption and [managing cases of?] failure.'

A strength is that it accepts that the detail will vary, appropriately, with levels of resources. Differing levels of provision are still valued rather than dismissed, with the implication that ARVs don't require everything that could possibly be put in place, before provision can begin to make a difference to people's lives.

How comprehensive do services need to be?

The second domain is 'services and clinical care'. Here there are two scales, one of which is specific to ARVs and is focussed on the level of experience of the clinical staff in using them. The other is a measure of the range of services available to patients.

The vision of the most comprehensive service is one that covers: "adherence, counselling, patient education, monitoring and managing of toxicities, and treatment failures. Has full scope of other services on-site or has coordinated linkages to these services (VCT, HIV primary care, OI prevention and treatment, STI management, PMTCT, TB management, counselling, nutritional counselling, linkage with inpatient care, access to assistance with concrete support (food, housing), home-based care, family planning, and positive/secondary prevention)."

Long though this list certainly is, there are still some important areas not clearly addressed.

For example, nutritional evaluation, diagnosis and treatment of parasitic diseases (from malaria to schistosomiasis), and paediatric care, including routine immunisations and developmental monitoring. Is palliative care included in 'home-based care' or should pain management and support for affected family members be specified?

In settings where injecting drug use is widespread and associated with HIV and hepatitis, which includes many Asian and Eastern European countries, the need for integration of drug-related

harm reduction and treatment programmes, including access to methadone and to clean needles, should surely be on the agenda too.

Management and evaluation

There are two scales in this domain. 'Health Management Information Systems' covers systems for individual patient records and 'Program Monitoring and Evaluation' covers the gathering and use of outcome results for the planning of services. These systems will obviously need to mean different things in practice depending on the scale of a service and the extent to which different services operate together.

Staffing and experience

This domain evaluates the extent to which a service has the staff it needs, how well trained and experienced the staff are in HIV care, and how well managed the whole operation may be.

Lab capacity

This domain has two separate scales one on capability, which is basically a measure of how well equipped and supplied the service is, and one on quality standards, which refers to the procedures used, ideally as part of a network of laboratories which operate a quality assurance scheme, to guarantee that results give reliable clinical information.

Drug management and procurement

This domain has three scales, for the supply chain, for pharmacy management, and financial resources for ARV and other drug procurement.

The first of these scales is focussed on aspects of the supply chain that might be susceptible to influence by the service providers, but it is not clear how much influence service providers will always have over it. The last is a little puzzling, and perhaps the one most easily altered by external funders!

Combining scales

It is suggested that every domain should be rated at 3 or above, taking an average of the different scales within it, before ARV provision begins. If the rating is lower, then action may be needed to correct this situation, including additional resources in many cases.

It is noticeable that there is a larger subjective element for some of these than there is for others.

Guidance on action planning

The first half of the document describes the scales, then the second half takes each 'stage' in turn and sets out likely scenarios for the kind of action that services may need to take to make progress. It would be interesting to know if any real services fit so neatly into their categories, that all of the recommendations set out for any one stage could be applied!

What might be missing?

It is noticeable that this does not deal with "infrastructure" in the strict sense of buildings and equipment, although some service providers have found, for example, that the provision of private space for counselling is essential for VCT to be acceptable and has not always been provided in healthcare facilities. Implicitly, too, the provision of laboratory facilities, inpatient care and even home care require buildings and equipment.

There are references to the need for patients to be educated and informed as well as being treated, but little on the potential for patients to help one another or to become involved in the development and running of services, for example by giving advice on how services can be improved.

In conclusion, could this be helpful in drawing the attention of international funders and national health care planners to what is involved in providing safe and effective treatment for HIV? Or would it cause more problems than it is worth, by suggesting that services need to develop along one particular line? Please let us - and John Snow, Inc - know.

about HATiP

A regular electronic newsletter for health care workers and community-based organisations on HIV treatment in resource-limited settings.

The newsletter is edited by Theo Smart (Cape Town) and Keith Alcorn, NAM's Senior Editor (London).

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