Author's response to reviews

Title: Assessment of service quality of public antiretroviral treatment (ART) clinics in South Africa: a cross-sectional study

Authors:

Hans F Kinkel (hfkinkel@foundation.co.za)
Adeboye M Adelekan (adelekanA@sa.cdc.gov)
Tessa S Marcus (marcute@gmail.com)
Gustaaf Wolvaardt (gustaafw@foundation.co.za)

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Author's response to reviews: see over
Dear Simon Harold,

Thank you for your response and for considering our paper for publication in your journal.

We appreciate the suggestions and comments made by the reviewers. Below, you will find our responses and changes. The page and line numbers refer to the revised manuscript.

Reviewer: Eddy Beck

Reviewer's report:

1. Is the question posed original, important and well defined? Yes
2. Are the data sound and well controlled? Yes – see below
3. Is the interpretation (discussion and conclusion) well balanced and supported by the data? Yes but improvements can be made presentation – see below
4. Are the methods appropriate and well described, and are sufficient details provided to allow others to evaluate and/or replicate the work? Yes – see below
5. What are the strengths and weaknesses of the methods? See below
6. Can the writing, organization, tables and figures be improved? Yes – see below.
7. When revisions are requested. I think the paper can be improved – see comments below.
8. Are there any ethical or competing interests issues you would like to raise? Unaware of any.

Thank you for asking me to review this interesting paper. I am sympathetic with the aim of the authors, i.e. to ascertain the quality of HIV services provided in and around- Pretoria, South Africa.

General comments:

This is an interesting study that tries to quantify some of the qualitative aspects of HIV services provision. However the paper as it stands can be improved and sharpened so the main points of their findings can be highlighted. For this reviewer, the main finding pertains to the findings when seeing the
clinicians and HIV counselors. Some of the findings here are indeed worrying and the paper should be recast to highlight these deficiencies more.

We agree, that the findings regarding clinicians and HIV counsellors are one of the main findings and have made changes in the abstract (p. 2), the result section (p. 10-11) and the discussion (p. 12-13) in order to accentuate these findings.

One assumes that the 16 clinics that were visited by the participant observers had given approval for this but that they were unaware who the actual participant observers were? Please elaborate.

USAID/PEPFAR contributed significantly to building up the public sector ART programme in South Africa (see also reference 23). The funds are distributed through local NGO which assist the government in establishing and managing the public ART programme. The Foundation for Professional Development’s (FPD) is one such national NGO which receives USAID/PEPFAR funds and which was given the mandate by provincial and local governments amongst others in Gauteng/Pretoria, Limpopo, Mpumalanga and North West Province to assist in establishing and managing public ART services. This mandate includes among many others areas quality assurance (QA) of ART services. Until 2010 all public ART providing clinics in greater Pretoria were supported by FPD. All FPD supported clinics have given approval of being monitored and assessed for QA and quality improvement purposes, which includes monthly reporting on basic performance and outcome indicators, regular inspection visits, occasional file audits, patient satisfaction surveys, and evaluations by participant observers. The clinics were informed, and agreed that an evaluation based on participant observers would happen in the coming months and that they would be unaware when exactly the assessments would happen and who the actual participant observers were.

A sentence was added regarding clinic approval and that the clinics were unaware who the actual participant observers were (p. 8)

Specific comments:

Abstract: result section very confusing – suggest mean reception area 76.5% (range ); clinician’s consultation 64.5% (range....) etc. I would bring the clinician and HIV counseling forward as they are the worse and one could argue one of the most important.

We agree and have revised the abstract. The results of the clinicians and HIV counsellors have been brought forward as suggested (p.2)

Background: need a reference for the is the study referred to at the bottom of page 3 in Free State.

The reference was added (p.4).

Methods: Table 3 is referred to first in this paper – in most journal this should be labeled ‘Table 1’.

The labelling of the tables was changed according to the order of their reference in the text.

I am not sure that I can accept 60-69% as ‘acceptable’ (p6) – I find this unacceptably low, especially given that the clinician and HIV counseling session were primarily affected.

We agree that results may be perceived differently by different analysts. The rating scale referred to in our paper reflects the perception of the results considering the local context (Please keep in mind that the ART services that were evaluated here have been built up in only
3-5 years from nothing). The development of the rating scale (p. 8-p.9) was guided by the experience how the results were perceived on the various occasions the results were presented in South Africa to the various partners (local authorities, FPD, USAID) and on various levels (staff, management, funders).

Results: while means are provided for the various clinics, little or no reference is made to the ranges with many ranges falling well below 50%.

We have revised the results section accordingly (p. 10).
(Regarding the presentation of median instead of mean, please see below our response to comment 7 of reviewer 2)

While I appreciate that the authors want to follow the path that patients take, the main problems encountered were with clinicians and HIV counseling. These should be highlighted.

We agree. We have revised the text and made changes on several occasions to accentuate the results of the clinicians and HIV counsellors (p.2, p.10-11, p.12-13, p.17).

P9 What is a ‘mean median’ time?

We have fully revised this section and do not use “mean median” anymore.
(Regarding the use of median instead of mean, please see below our response to comment 7 of reviewer 2)

Authors have a heading of ‘correlations’ but do not actually discuss results. They, however, come back to this in the discussion – need to move the discussion of page 14 into the results section.

We agree and have revised this aspect accordingly (p.9, p. 11, p.15).
(Please see also below our response to comment 8 of reviewer 2 regarding “correlations”)

Discussion: Need to start with summarizing main findings – that can be followed by limitations. Currently the other way around and authors miss the impact of highlighting their findings. Findings reported on page 12/13 should be brought forward
Suggest – Request authors to focus the paper in terms stated above and review new draft.

We agree and have recast the discussion as suggested.
(Please see also below our comments to the suggestions of reviewer 2 regarding the discussion)

Reviewer: Ralf Weigel

Reviewer's report:

The authors survey service quality against set performance standards in a sample of ART clinics in urban South Africa, using feedback from trained evaluator patients. In their results they report on waiting and contact time and achieved performance measured against the standards by service provider station and by clinic. Investigations of ART service quality are important as their results may inform clinicians, clinic managers and policy makers and may enable them to identify and resolve bottlenecks, improve patient outcomes and satisfaction of both, patients and providers. The way methods, results and discussion are presented raise several questions which have to be clarified.
Major compulsory revisions

Methods:

1. Were the applied performance standards discussed with the providers prior to the survey? Where providers trained according to the standards?

   Because providers were familiar with the PS, the PS have not been discussed with the providers again for this study. The concept of the PS was not new to the providers when the evaluation took place. A hardly different previous version of PS was available when the ART programme started and was used to train providers on, and the updated version was distributed to all (FPD supported) clinics very soon after being launched.
   We have added an explanation in methods (p.6, p.8), see also an addition in the discussion regarding this question (p.15).

2. The use of evaluator patients is interesting. Were the providers aware that their services will be assessed by evaluator patients?

   Yes. Please see above response to reviewer 1.
   An addition was made in the methods section regarding this question (p.8)

Has this method been tested elsewhere?

   Participant observation is a method which is mainly used in anthropology. Participant observers in ethnography remain “recognisable” to the scenery but more in the background, just observing the scenery. In our approach the participant observers were “unrecognisable” to the environment as they acted as if they were “real” patients, while they were actually assessing the scenery. We are not aware the approach we used in this study has been applied for quality assessment in the health sector.
   Please be referred to the following publication that summarizes the (ethnographic way) of participant observation method for research in health care:

Did you do a pilot prior to your study to see if the tools work and evaluator patients record meaningful information?

   Yes we did and tested the method two times prior to the evaluation.
   An addition to the method section was made (p. 7).

3. According to what criteria did you select your clinic sample?

   We selected the clinic according to the geographic location and accessibility.
   We have revised the section accordingly (p. 5).

4. Can you give more detailed information about the selected clinics and cadres involved, e.g are these clinics run by the government or by NGOs or are they research clinics? Counsellors: are they lay counsellors, expert patients, nurses? Clinicians: medical doctors, specialist nurses, clinical officers?

   More detailed information was added in the methods part on the type of clinic (governmental or NGO (p.5) and regarding the qualification of staff (p.6)
5. In these clinics I assume not all providers are working full time 5 days a week. You may want to introduce the concept of full time equivalent (FTE) to describe workload per cadre to improve comparability between the sites.

   Yes, that is right not all staff works full time. The revised table 2 now also shows available workforce per clinic per month. However, only clinic 10 shows the employment of part-time staff. A reference to the concept of FTE is now made in methods section (p. 8).

6. Patient load and headcount are better described as either number of patient visits or number of patients visited per month.

   We agree. We have revised the method section regarding this definition (p. 8)

The same patient may visit several times in a month and it is likely that an initial visit takes longer and requires more and different procedures for a clinician than a regular follow up visit or unscheduled visit for acute illness.

   Yes, that’s right. Different visits require different time and differ regarding the scope. That is why we chose to assess first time appointments (assessing treatment readiness) which are pretty standardised and hence better comparable, especially regarding the clinicians consultation.

The same may apply to counsellors: are these all counselling and testing visits?

   We evaluated what is referred to as ART counselling, because this was the type of counselling a patient is supposed to get at this stage. This differs from a counselling & testing visit (a counselling & testing visit includes pre-test counselling, testing, post-test counselling). We have clarified this in the text (p. 6)

Or are adherence counselling visits included? Is there a standard protocol for pre and post test counselling across clinics or is pre test counselling done in groups? Is couple counselling included? It would be important to have more detailed information for these core HIV/ART services.

   See also response to the previous question.

   Similarly to the clinicians there are different types of counselling sessions. For each type of visit specific performance standards are outlined. Counselling can be done individually and in groups (including couples). Similarly as with clinicians counsellors are trained for and supposed to provide all kind of counselling.

   We agree that a more detailed analysis taking the type of visits (clinicians and counsellors) into consideration would have been useful for a better understanding of the workload. Unfortunately this information was not reliably available from the clinic registers. As each cadre may see a more or less similar mix of patients for different visits we believe that the analyses utilizing the crude number of patients per cadre is still meaningful to get an idea of the workload per cadre.

   We have added information regarding the type of visits and type of counselling that is reflected by the crude number of patients seen per cadre (p. 6 and p.8)

7. Why did you decide to present summary statistics as mean and range, rather than either mean and standard deviation or median and interquartile range?
Thank you for indicating this. After consultation with our biostatistician about the use of mean and median, we agreed to use the median and interquartile range consistently. This has resulted in slight changes regarding the values of the data presented. The graphs 2 and 3 and table 1 (p.25) have been revised accordingly. Consequently, we have also revised the method how to calculate the Clinic Performance Score (CPF). We have changed the paragraph referring to the CPS accordingly (p. 8) and have revised table 2 (p. 31). The meaning of the data and the interpretation thereof, however, remains unaffected.

8. In the description of the correlation analysis in the paragraph before ethical approval, can you clarify what you correlate, using the terms in table 4? Can you also please clarify what the Correlation coefficient R² means? A graph, showing the correlation between the variables would be more informative than a table.

The section referring to “correlations” was fully revised and changes have been made in the methods section (p. 9, an explanation of the correlation coefficient and how it is interpreted is included), the results (p. 11, we have added a new graph (graph 4) as suggested that shows the correlations as scatter graphs, which to our opinion visualises nicely the correlation between workload and duration of the visit time, and between the duration of the visit and the performance) and in the discussion (p.15).

Results:

9. Under services accessed you talk about general availability and availability that day. However, also the observer patients might have only selective need for services. For example, is it plausible that the patients would have a counselling session, ART visit, social workers visit all at the same day- or were they told to access and assess all services available at the site under all circumstances?

We assessed what is called: “Treatment readiness in Adults”. That includes Reception, Front station, clinical assessment by a clinician, the counsellor assessing patient knowledge, providing general and specific information about ART and discussing prevention strategies, a social worker assessing the patient and a dietician providing nutritional assessments and pharmacy handing out prophylaxis. We have revised the respective section in the methods part (p. 6)

According to the operations guideline at the clinics, patients are supposed to complete these visits on one occasion (one reason is to keep efforts and cost for transport to the patient low; some patients come from far and cost for transport is an access barrier). So yes, participant observers were supposed to see all the services “automatically” and not on request or their personal needs. We have revised the respective section in the methods part (p. 7)

Regarding the need for service by the participant observers: The participant observers acted, for the purpose of this research as if they were real patients who needed to start ART. During their evaluation visit at the clinic they did not “demand” any services as private person. In real life, the participant observers are patients at another ART clinic. We have revised this section in the methods part (p. 7).

10. Generally, information is mainly repeated what is already visible in the tables, especially in the quality of services section. The text in the results section of the paper should highlight key results and point the reader to expected and unexpected findings, which are later discussed.

We agree, and have revised the section in order to avoid repetitions.
The last paragraph on correlations is not helpful.

The paragraph was fully revised (see above)

Discussion:

11. The first paragraph should summarize the main findings, and highlight why they are important and what they add to the knowledge base. The following paragraphs go into more detail describing the results, but the meaning of the findings in the context of other research in this area is largely missing. Limitations should be discussed towards the end of the discussion.

   We have recast the discussion as suggested. (See also response to reviewer 1). Paragraphs addressing the meaning of the findings in the context of other research in the area have been added on several occasions (p. 14, p.15, p.16)

12. Was feedback of the survey results given to the clinics? What were their responses? Did the study result in any changes of procedures? Information about these aspects would make the discussion more relevant.

   Feedback of the survey was given to the clinics through the FPD clinic coordinators and FPD area managers in order to address the issues identified as challenges in the clinic. The outcome however has not yet been assessed - A re-assessment is in planning. We hence cannot comment meaningfully on any changes yet.

Minor essential revisions

13. You use several terms for the same thing: trained participant observers, evaluator patients, assessors- please stick to one term.

   We agree. We decided to stick to the term participant observers and have made changes accordingly.

14. You mention several times the Foundation of Professional Development. What is the mandate of this organisation? Is it an NGO? Is it linked to the Ministry of Health? Is it linked to a professional council, such as the Medical council or medical board? A generic explanation would be more helpful than the actual name of the organisation.

   We agree and refer to FPD just once in a more generic way as a national academic institution (p.6). Changes were made in the abstract (p.2).

   For more information about the role of FPD please see above our response to reviewer 1. Although FPD and other USAID/PEPFAR funded NGOs play a crucial role in the South African health sector, we believe that a more detailed explanation of the role of FPD is not necessary in the paper. However FPD as well as USAID/PEPFAR are mentioned in the acknowledgment section.

15. How long was the training for evaluator patients?

   The evaluator patients were trained for about 3-4 hours. An addition was made in the text (p. 7)
16. In the abstract you conclude that the overall service quality was good. However, if core HIV services provided by clinicians and counsellors on average only achieve acceptable (60-69%) scores, I don’t think one can say that overall it was good- it is actually an issue of major concern (only 41% of visits with clinical exam, little TB screening: 56% ask for night sweats).

We agree. The word “good” has been exchanged for “acceptable” (p. 3).
Please see above response to the comment of reviewer 1, which is connected to this comment.

17. Did the authors think about use of qualitative methods, such as focus group discussions with providers and patients, observation, in depth interviews to evaluate service quality further?

Thank you very much for this suggestion. We are definitively considering qualitative methods.

18. In Conclusions, first sentence:.....describes a mixed picture of services. Or did you want to say: ....a mixed picture of adherence to performance standards? Kind regards

Thank you for this comment. It should say correctly: “...a mixed picture of the quality of services” (p. 17). Our understanding of the quality of services is not only based on the adherence to performance standards, but also on general availability and accessibility of the services.

Additionally to the responses to the reviewers, we needed to make the following corrections:

Regarding the time during which the assessment took place. It says now correctly: “...between June and November 2009.” (p. 2 [Abstract], p. 5 [Methods, first sentence], p. 11 [discussion])

Regarding the number of participant observers. It says now correctly: “Eleven patients...” (p.5 [Methods, fourth sentence])

Yours sincerely

Dr. Hans-Friedemann Kinkel