Decentralising non-communicable disease care in Swaziland: successes, challenges and recommendations from a pilot study

POLICY BRIEF

Good Shepherd Hospital's Sister Sweetness screens a patient for diabetes and hypertension at a family health promotion day

Background

In 2014, in conjunction with the Swaziland Ministry of Health and other local stakeholders, COMDIS-HSD initiated the decentralisation of diabetes and hypertension care from Good Shepherd Hospital (GSH) to community clinics in Lubombo region, Swaziland.

This 2-year pilot involved 10 intervention clinics and 10 control clinics in Lubombo region. Our aim was to improve accessibility by providing high-quality NCD care across the region. Our pilot study also assessed the feasibility and effectiveness of decentralising diabetes and hypertension care across Swaziland.

> Following our effective pilot in clinics across the Lubombo region, we recommend that decentralisation should begin in other regions of Swaziland.

GOOD SHEPHERD MISSION HOSPITAL

5 recommendations for policy and practice

1. Decentralisation in other regions of Swaziland

Due to the effectiveness of our pilot in clinics across the Lubombo region, we recommend that decentralisation should begin in other regions of Swaziland. The deskguide, training manual and recording templates have been made available for this purpose.

2. Implement integrated regional outreach programmes for mentoring and monitoring of rural clinics

Continued mentoring can help address issues with medication stock outs or old, faulty equipment, as well as ensure consistent record-keeping. Several outreach programmes already exist at GSH for TB, HIV, and home-based care. With support, outreach programmes that include mentoring and monitoring of rural clinics can be expanded to include NCDs.

3. Allow community clinic nurses to undertake assessments of uncomplicated patients

We are confident that community clinic nurses are able to undertake baseline assessments for uncomplicated patients, as seen in the Lubombo pilot.

However, patients with complications should still be referred to a doctor-led service.

4. Revisit agreements between Central Medical Stores and rural clinics

Our pilot highlighted frequent medication stock-outs where clinics have been without certain medications for months. We recommend that the contract between Central Medical Stores and rural clinics be revisited to evaluate their medication needs and procedures on what to do in the event of stock-outs.

5. Encourage consistent record-keeping through wide use of patient-held and clinic-held treatment cards

We recommend that the clinic-held and patient-held treatment cards are used widely across all clinics undertaking diagnosis and treatment of diabetes and hypertension. This will ensure complete and consistent record-keeping, as well as providing prompts for appropriate care.

> "Several outreach programmes already exist at GSH for TB, HIV, and home-based care. With adequate support, outreach programmes that include mentoring and monitoring of rural clinics can be expanded to include NCDs."

TB counsellor, Tivelele Khoza (left) testing a patient for diabetes and hypertension as part of the screening programme in a TB clinic at GSH

7 successes of the NCD decentralisation pilot

1. Overall, decentralisation appears to have been undertaken successfully with intervention clinics diagnosing and treating patients with diabetes and hypertension.
2. The technical working group, developed as part of this programme, has been proactive in addressing issues with the pilot and service delivery in the rural clinics as they have arisen.
3. The national treatment guidelines for hypertension and Type II diabetes service delivery were well received during the pilot.
4. The clinic-held and patient-held treatment cards were accurately completed by clinics during the pilot, encouraging good recording as well as prompting clinicians to undertake appropriate care.
5. A comprehensive, culturally-specific training programme was developed as part of the pilot, consisting of 3.5 days of interactive training, including role-plays, lectures by expert clinicians and training evaluation.
6. The training programme and associated training manual were well received and found to be effective. Staff at control clinics involved in the pilot have now been trained to intervention standard, learning about the prevention, management and treatment of diabetes and hypertension.
7. An agreement was made between the National NCD lead, the Chief Pharmacist, and a representative from Central Medical Stores to provide previously unreleased medications for hypertension and Type II Diabetes to rural community clinics. Access to these drugs was essential to the care that the intervention clinics were able to provide during the pilot.

4 challenges to consider for the future

1. Availability of medication supplies

Despite the agreement to supply community clinics with appropriate medication, problems were experienced throughout the pilot with clinics regularly running out of certain medications (eg HCTZ) and being unable to restock for long periods.

Some clinics reported not having certain drugs for months. As such, they were required to send patients to hospitals or private pharmacies (if available) for routine drug refills.

Client access to medications locally was a key part of decentralisation, but was not always met. There was frequent 'rationing' of diabetes and hypertension medications; normally patients would receive a supply sufficient for one month, but were only given enough medication for shorter periods.

2. Lack of initial assessment by doctor

Initially it was intended that all patients with a new diagnosis should be seen by a doctor at GSH to obtain an initial assessment before receiving nurse-led continuing care in the community clinics. However, it quickly became apparent that GSH doctors did not have the capacity to undertake such a large number of assessments, and patients did not want to travel all the way to GSH to be assessed. However, nurses at the community clinics appear to have undertaken initial assessments of uncomplicated patients effectively without support from doctors.

3. Culture of record-keeping

In the control clinics, it was apparent that some diabetes/hypertension patients were being treated, but it was not possible to evaluate

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3. Culture of record-keeping continued....

whether the diagnosis and treatment provided was appropriate. This is because overall record-keeping was poor and there was no record-keeping for NCD treatment. In several clinics, nurses had only mobility registers distributed by the ministry, and in other clinics, nurses had only tables inside notebooks to record basic personal information, such as name, date, date of birth, complaint, and medications given to the patient.

This is part of a broader issue with poor record-keeping.

4. Geographical difficulties

Some of the clinics chosen for the pilot were located in areas where there is poor public transport, away from high- or moderate-quality roads. This makes mentoring and data collection difficult, and also makes it difficult for patients to access healthcare.

Figure 1: Map of the clinics involved in the pilot

Our methods

Each intervention clinic was given patient-held patient cards and clinic-held patient cards to record patient information, including demographics and vital signs (ie blood pressure, fasting blood glucose, random blood glucose).

These acted as both recording systems and prompts to healthcare workers to give appropriate care. Blood pressure cuffs, stethoscopes and blood glucose monitors were provided for clinics that needed them.

We developed a Swaziland diabetes/ hypertension deskguide and training manual, and conducted 3.5 days of training for a selection of nurses from the intervention clinics so that they would be able to undertake the intervention.

Through an agreement with the Ministry of Health and Central Medical Stores, the intervention clinic nurses were given the tools to give adequate and high-quality healthcare to patients with hypertension and/or diabetes.

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