Policy barriers to improving infection prevention and control (IPC) in South African PHC facilities: failures of ownership, of evidence, of leadership, and of crisis-making in TB IPC

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Word count: 400/400

Introduction

The key principles and practices of infection prevention and control (IPC) for tuberculosis are widely known and accepted. Ideally, TB IPC guidelines and practices would be well integrated with broader IPC policies, with building design and equipment policies, with quality assurance mechanisms, with occupational health policies, with health education programming, and with the particular organisation of care within each individual health facility. In practice, however, we see that in many, and perhaps most settings, that TB IPC measures—though well understood and generally uncontroversial—are not put in practice, and are very poorly integrated with other crucial, related policy frameworks. This presentation presents the findings from a policy analysis of the successes and (mostly) failures of TB IPC policy development, implementation and enforcement at primary care clinics in South Africa.

Methods

We interviewed 15 policy actors at local, district, provincial, national and global levels from a range of sectors (university, government, NGOs) using semi-structured interviews. We also reviewed key existing policy documents related to TB IPC, and consulted with key informants in our Project Reference Group. We used an inductive thematic analysis approach to develop our findings.

Findings

Our analysis identified several critical barriers to effective TB IPC policy formulation and implementation. First, ownership and accountability for TB IPC as a policy problem is distributed across a highly fragmented institutional landscape, making coordinated policy development very difficult. Second, a failure to maintain a sense of crisis within TB along with a very weak TB activist sector weakens any provisional efforts to bring attention to IPC. Thirdly, a persistent lack of good evidence for what works, what works best and cheapest, and what works where for TB IPC, interacts with a sluggish demand for evidence among policy actors, and results in stagnation of TB IPC policy development. Fourthly, tensions between different disease programmes, between competing policy initiatives, between occupational health and patient safety advocates, and between primary and secondary level actors undermine the coherence of TB IPC policy approaches. Finally, the culture of medical and nursing training in South Africa tends to undercut key policy messages and clinical practices around TB IPC.

Conclusion

TB infection prevention and control should be seen as part of, and well integrated with a transversal set of health system concerns around patient and provider safety and epidemic control. Addressing this stubborn problem will require concerted effort in several of the areas identified in this study.