INTRODUCTION

The South African government has an impressive constitution and legislative framework that recognizes the right of its citizens to quality health care (Government of South Africa, 1996). In South Africa, approximately 80% of the population relies on state-provided health care. Health workers in the public health sector provide services at the formal health facilities and to the various outreach programs in the community (i.e., immunization drives). The effective management and delivery of these diverse services requires regular reporting of routine and exceptional information by health care workers. These workers spend a significant amount of time collecting, recording, storing, and transmitting data in various forms.

With the commencement of the Anti-Retroviral Treatment (ART) program in selected clinics throughout South Africa in 2003 (Department of Health, 2003), treating and supporting clients attending ART clinics places great pressure on the health staff, not only because of insufficient human resources and time, but also with the associated severe emotional strain. Pressure is escalating as the number of clients requesting ART is increasing daily (Stewart, Padarath & Bamford, 2004). An effective Information System (IS) is needed to manage this increase in clients as well as support a variety of reporting requirements.

A national survey in South Africa of health personnel, ambulatory and hospitalized patients, and health facilities substantiates that a weak patient IS (a) was an impediment to ensuring ongoing and correct treatment, (b) increased staff workloads, and (c) led to unnecessary duplication of effort and time. Additionally, Shisana, et al. (2002) argue that ensuring that a single electronic IS is in place to assist in treatment of patients is an essential yet often neglected aspect of the health system.

In 2005, the clinical director of the Batho Pele clinic in the Gauteng province in South Africa requested the assistance of the Department of Informatics at the University of Pretoria in addressing their IS issues. This request fitted the department’s research interests in health information systems (HIS), as well the broader research focus and commitment to provide outreach services to the community. Knowing the problems of commencing projects without having planned for sustainability and scalability, the HIS research group elected to use the “networks of action” concept to partner and collaborate with the various role players, institutions, and other ART entities. This process of developing interconnecting networks of human and nonhuman entities in South Africa and beyond its borders raised a number of opportunities, challenges, and tensions in initiating this project.

To provide a background to this process, the next section introduces the concept of “networks of action” and a brief description of the ART clinic. The following section develops the main focus of this chapter, which is the process of developing these networks. The last section suggests the necessity of developing networks of action as a future trend for sustainable IS.

BACKGROUND

Networks of Action

In addressing why so many action research efforts fail in the long term, Braa, Monteiro, and Sahay (2004) argue that the two major challenges in the development of a successful HIS are the interrelated factors of sustainability and scalability. Sustainability refers to making the IS work over time through the institutionalization of routines and the development of local learning processes. Scaling concerns the spreading of
The development of networks of action is pivotal to addressing the challenges of sustainability and scalability and is especially important to the project described in this chapter, the Anti-Retroviral Treatment Information System (ARTIS) Project.

**Background of ART Program**

The Batho Pele ART clinic was recently established (2006) and is housed in a district hospital in the province of Gauteng. The clinic is part of the government’s plan to improve the delivery of HIV/AIDS-related services (Department of Health, 2003).

Principally, there are three phases in processing a patient at this ART clinic:

- **Phase 1. Making an initial appointment.** This is based on the patient having a CD4 count <200 cells/mm3 or a WHO Stage IV disease (Department of Health, 2004). The patient has to be referred to the clinic from another clinic or medical practitioner.
- **Phase 2. Preprescription of ART.** Depending on the health and emotional status of the patient, acceptance for ART can occur, starting with the third visit or later.
- **Phase 3. ART prescription and follow-up.** Once accepted onto ART, there are regular return visits scheduled for pill counting, patient assessment, and prescription renewal.

Each visit requires the patient to check in with the ART administrator and register with the hospital administrator. Once registered, the patient is seen on each visit by nurses for tests (i.e., blood, weight, urine, blood pressure) and by the doctor, who reviews and analyzes the test results and prescribes the treatment regimen. The pharmacist dispenses the antiretroviral drugs. Consultations with the counselor, social worker, and dietician occur as the need arises (De Freitas, 2005).

Although there are official workflow processes for an ART clinic, these workflow processes are not adhered to stringently for a variety of reasons. Staff members are allocated to particular positions with clearly defined roles and duties, but due principally to shortages of staff, little segregation of duties occurs. When there is a shortage of staff or a staff member is experiencing a heavy workload, it is common for staff members to assist in completing the work tasks of their
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