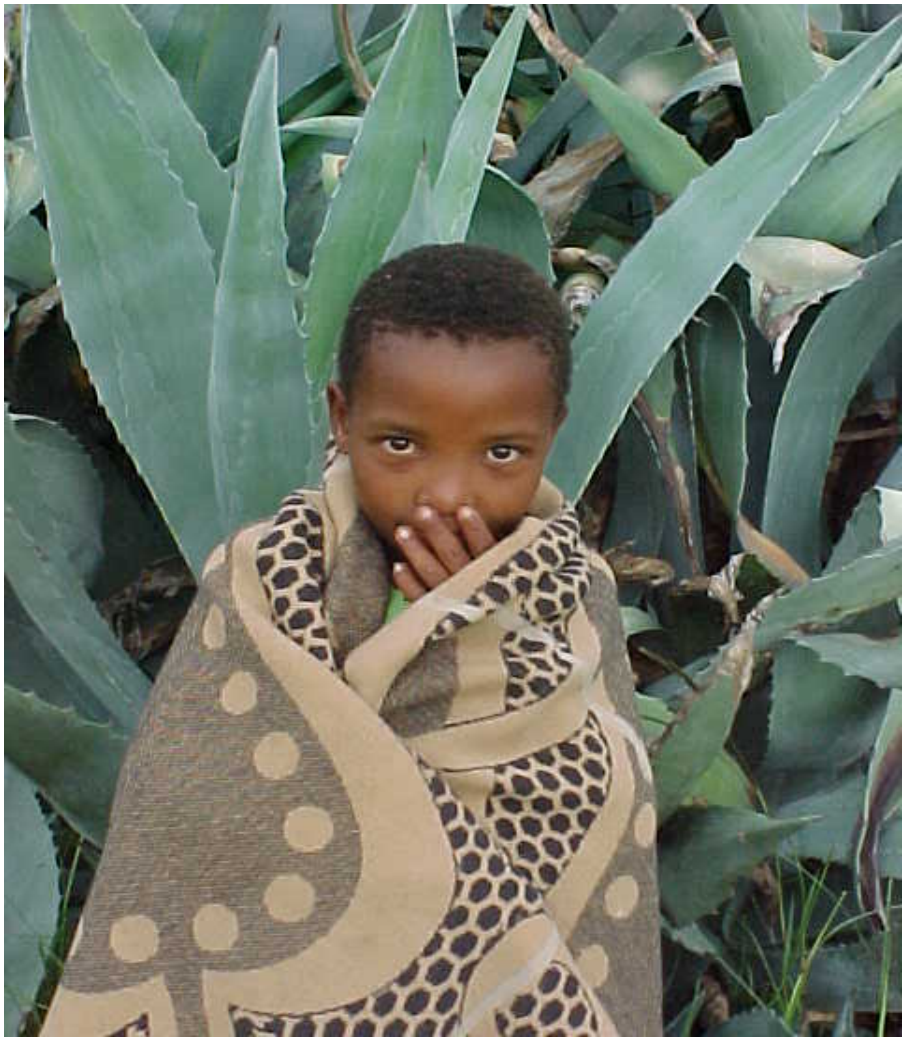
# HEALTH SYSTEMS TRUST
# INITIATIVE FOR SUB-DISTRICT (ISDS)

# EXIT REPORT FOR THABO MOFUTSANYANA DISTRICT MUNICIPALITY (DC 19), THE FREE STATE PROVINCE

**FEBRUARY 2002 – SEPTEMBER 2004**



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**FEBRUARY 2002 – SEPTEMBER 2004**

**This report was compiled by:**
**Dr Abdul G Elgoni, ISDS-facilitator**

**September 2004**

This Publication will also be available on the Internet
www.hst.org.za

This is an end of project report on the Health Systems Trust's commissioned role to facilitate the Rural District Health Systems Project (RDHSP) as per the European Union tender (Tender RT 1397 GP).

# CONTENT

# ACKNOWLEDGEMENTS

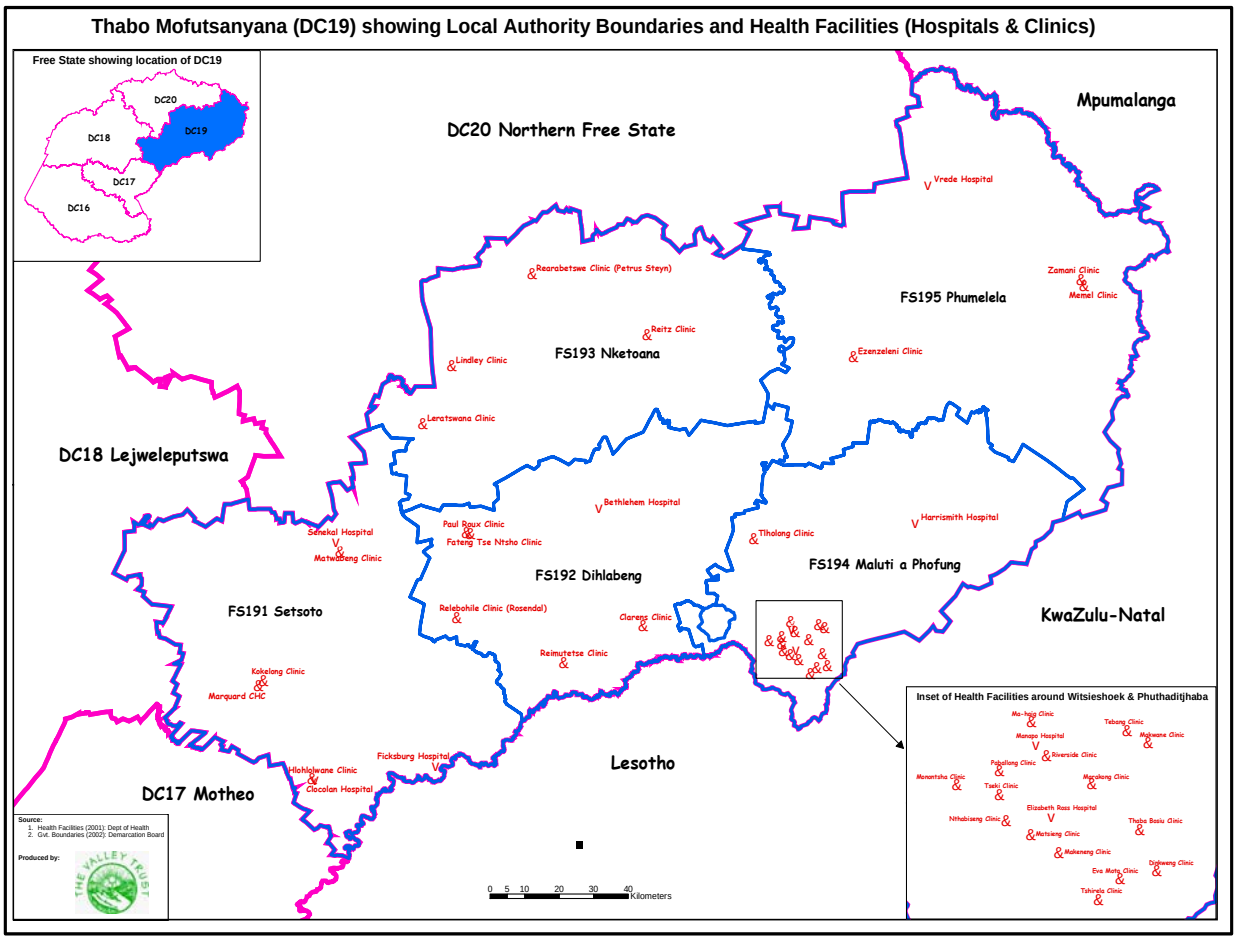
The facilitator wishes to acknowledge with appreciation, the co-operation with the Rural District Health Systems Project in Thabo Mofutsanyana District Municipality, of managers and personnel on all levels, from facility to Local Areas and district level. The cooperation of the Local Government health councillors, the community structures, and the QWAQWA AIDS consortium of NGOs and of the University of QwaQwa is also highly appreciated.

The support and guidance from the Free State Provincial Department and of Eastern Free State Region Chief Executive Officer as well as from the National Department of Health is also greatly appreciated.

# ACRONYMS AND DEFINITIONS

| | |
|---|---|
| CHC | Community Health Centre |
| DHER | District Health Expenditure Review |
| DHP | District Health Plans |
| DHIS | District Health Expenditure Review |
| DISCA | District STI |
| DOH | Department of Health |
| HISP | Health Information Systems Project |
| HST | Health Systems Trust |
| IDP | Integrated Development Plan |
| ISDS | Initiative for Sub-District Support |
| ISRDP | Integrated Sustainable Rural Development Programme |
| LSA | Local Service Area |
| RDHSP | Rural District Heath Systems Project |
| DHMT | District Health management Team |
| TMDM | Thabo Mofutsanyana District Municipality |
| LG | Local government |
| NGOs | Non-Governmental Organizations |
| PHC | Primary health care |
| HIV | Human immunodeficiency virus |
| AIDS | Acquired immunodeficiency syndrome |
| ANC | Antenatal care |
| DOTS | Direct observed treatment short course |
| EFS | Eastern Free State |
| FS | Free State |
| STI | Sexually transmitted infections |
| TB | Tuberculosis |
| EMS | Emergency medical services |
| VCCT | Voluntary confidential counselling and testing |

# DISTRICT SITE MAP



# EXECUTIVE SUMMARY

The Rural District Health Systems Project was part of a broader presidential initiative to support development in the 13 poorest rural nodes of the country, through the Integrated Sustainable Rural Development programme (ISRDP). Thabo Mofutsanyana District Municipality (TMDM) was chosen as the rural site in the Free State (FS), due to its levels of poverty and high burden of disease. Maluti-A-Phofung local municipality has the smallest area, but has the densest population and was selected as the focus of the interventions. The majority of the population in Thabo Mofutsanyana are between the age group of 5-19 years. This necessitates some focus on young children and adolescents' issues especially in relation to HIV/AIDS. Respiratory tract infections including TB are the leading cause of death in the District in all age groups. The very cold winter where people need to burn animal dung, wood or gas for heating in overcrowded rooms, maybe a reason for the high respiratory tract infection. Poverty and AIDS are clear culprits in this regard. The second leading cause is cardio-vascular disease and this may be an indication that affluent diseases are in the rise.

The project implemented a number of activities in a process to strengthen the District Health System and improve the quality of PHC services. There is no duplication as all facilities provide comprehensive PHC services within the capacity of their staffing and equipment. Health services are integrated and there is one plan for all health services. As an outcome of the improvements, TMDM won the prize of the best supported health district in South Africa in 2003. Some of the activities include:

- ✓ Completed a situation analysis with full participation of health stakeholders. It revealed inequity and health information quality problems. The situation analysis information was used to prioritise district interventions e.g. STI and TB evaluations, assigning two LAM to Maluti a Phofung, using Maluti a Phofung as focal municipality for interventions etc.
- ✓ District Health Management team strengthened to meet monthly with participation from Local Government.
- ✓ Organized training for the health councillors from all five local municipalities aimed at improving their knowledge around health issues. The workshops discussed the Free State Health Act, PHC and DHS concepts, the PHC package, role of governance structures versus management etc.
- ✓ Formal evaluation of TB using the improved Provincial TB evaluation tool. Three training workshops organized with attendance of TB coordinators from all five local municipalities, HIV/AIDS coordinators and NGOs. Main challenges identified are the need to training on TB management; improve records, training of doctors and involvement of trained DOTS supporters.
- ✓ Use of the DISCA tool to evaluate STI services with an action plan mapped out and interventions implemented, improving different indicators in STI management.
- ✓ Organized Thabo Mofutsanyana two annual DHS conferences (preceding the Provincial DHS conference and preparing for it) sharing information on all surveys done including DISCA, TB, Clinic client satisfaction and DHER, discussing successes and challenges.
- ✓ On identifying the problems faced by clinics to actively involve community in health issues, the training for more than one hundred clinic committee members solved part of the problem.
- ✓ Training on use of Clinic supervisors' manual and using its tools regularly and reporting on improvements and challenges during quarterly PHC review meetings.

- ✓ Organized DHER through training TMDM managers on computer skills to enter data, analyse it and produce DHER reports with support from the Valley Trust consultant. The produced document was used to guide the district planning.
- ✓ The ISDS facilitator organized a training workshop on the use of the national District planning guidelines at Provincial level.
- ✓ Developed and used a clinic client satisfaction tool that was adopted by the FS Province to be used in all clinics.

Lessons learnt

- *It is important that managers be supported to stay in the post at least for two years to be able to implement activities and see achievement through.*
- *A champion is needed to keep stakeholders focused on achieving.*
- *A lot of patience, understanding, mentoring and support is needed to create and sustain a team spirit through this participatory process and allow people to acknowledge and understand their health system's strengths and weaknesses.*
- *The joint collective inclusive process is important to sustain the functional integration efforts.*
- *The attendance of the MEC Health and Provincial directors at some of the participatory meetings was very helpful in solidifying the team spirit as they stressed functional integration.*
- *Regular use of the tools to like DISCA to evaluate services with an action plan mapped out and interventions implemented, improved different indicators in PHC programmes management.*
- *The anonymous clinic client satisfaction questionnaire to* measure client satisfaction with different aspects of clinic services assisted clinic staff to improve the services in the eyes of their clients.
- The training on and use of the Clinic Supervisors manual for a quarterly review of services sustained the improvements made in quality of health services.
- *Sustained supervision, mentoring and support is needed to ensure nurses are using the taught knowledge and skills*

# CHAPTER ONE

# OVERVIEW OF THABO MOFUTSANYANA DISTRICT MUNICIPALITY

## A: Introduction

In February 2002, the Health Systems Trust was chosen to implement the Rural District Health Systems Project (RDHSP). The project was part of a broader presidential initiative to support development in the 13 poorest rural nodes of the country, through the Integrated Sustainable Rural Development programme (ISRDP). Funding was provided through a European Union grant, via the National Department of Health. There are eight project objectives with the major goals being to support district health systems development and improving quality of care at primary care level.

Thabo Mofutsanyana District Municipality (TMDM) was chosen as the rural site in the Free State (FS), due to its levels of poverty and high burden of disease. The project duration was from February 2002 to September 2004, approximately two and a half years. The Health Information Systems Project (HISP) from the University of Western Cape (UWC) was responsible for developing the health information system. The HST site facilitator is Dr Abdul-Karim G Elgoni and the HISP facilitator Marius Gouws.

**Aim of the report**

The aim of this report is to record some of the achievements of the project and highlight some of the challenges. It is also to inform the District, Provincial and National Departments of Health (DOH) of the activities and progress of Health Systems Trust/Initiative for Sub-District Support (HST/ISDS) in the Rural District Health Systems Project (RDHSP). The report will reflect on enabling factors that made TMDM wins as the best supported health District in South Africa and discuss the factors constraining the delivery of the key objectives and highlight the lessons learnt.

**Sources of information**

This report was compiled based on the situation analysis done at the beginning of the project and from the monthly and quarterly project reports. A written client assessment was also undertaken to elicit the views of the key TMDM personnel who were involved in this project.

TMDM is one of five district municipalities of the FS. As seen from the attached area map, Lesotho, Kwazulu Natal and Gauteng border the District municipality. It contains five local service areas (LSA) or sub-districts. These are Setsoto (FS 191), Dihlabeng (FS 192), Nketoana (FS 193), Maluti a Phofung (FS 194) and Phumelela (FS 195)

**THABO MOFUTSANYANA DISTRICT POPULATION**

**TABLE 1: The area and population of all Local Municipalities in the District.**

| | FS 191 Setsoto | FS 192 Dihlabeng | FS 193 Nketoana | FS 194 Maluti a Phofung | FS 195 Phumelela | Thabo Mofutsanyana |
|---|---|---|---|---|---|---|
| Area as % of DC | 21% | 17% | 20% | 15% | 27% | 100% |
| Population | 117 430 | 114 655 | 68 769 | 377 901 | 48 452 | 727 207 |

Maluti-A-Phofung has the smallest area, but has the densest population. This has an implication on health, because more resources are needed for a small area and it may prove a challenge for one Local Area Manager to manage. Phumelela, on the other hand is a very remote and big area that is sparsely populated.

**TABLE 2: The fixed clinics in TMDM**

| | FS 191 Setsoto | FS 192 Dihlabeng | FS 193 Nketoana | FS 194 Maluti a Phofung | FS 195 Phumelela | **Thabo Mofutsanyana** |
|---|---|---|---|---|---|---|
| Professional Nurses | 35 | 29 | 13 | 122 | 9 | 207 |
| PN/Pop ratio: | 1/3355 | 1/3954 | 1/5290 | 1/3098 | 1/5384 | 1/3513 |
| Average number of patients per PN per day (workload) | 38 | 46 | 39 | 34 | 27 | 37 |
| Doctor/Pop ratio | 1/19572 | 1/57326 | 1/17192 | 1/47200 | 1/24226 | 1/33054 |
| Clinic/pop ratio | 1/9786 | 1/12740 | 1/11462 | 1/11452 | 1/6922 | 1/10854 |

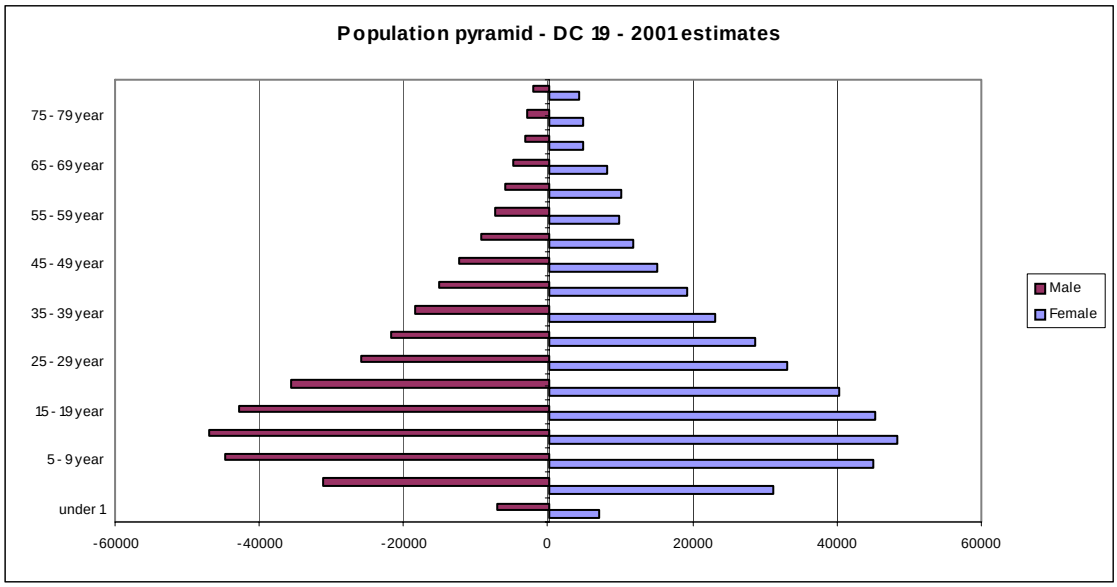
There are enough nurses per population except in Phumelela, although the workload on its nurses is the lowest in the District. The workload per nurse is reasonable except for Dihlabeng. The Community Service Doctors divide their time between the District Hospitals and the different PHC clinics. Though they visit some of the clinics to attend to patients, they do not visit all the clinics every day, as there are not enough doctors. A shortage of nursing assistants is experienced throughout the clinics, due to the unavailability of trained personnel. The clinic / population ratio according to the World Health Organization (WHO) norms is 1:10 000 population. Only Local Areas Setsoto and Phumelela are within this norm.

***Utilisation of PHC Services***

This indicator highlights the average use of facilities by the population it serves. *But due to many reasons the utilization of clinics is below the national average, which is 3.5 visits per person per year*. It is very low especially in Nketoana and Phumelela local municipalities.

| Facility | Utilization |
|---|---|
| Setsoto Local Area | 2.7 |
| Dihlabeng Local Area | 3.1 |
| Nketoana Local Area | 2.1 |
| Maluti-A-Phofung Local Area | 3.4 |
| Phumelela Local Area | 2.4 |

**GRAPH 1: The population pyramid for Thabo Mofutsanyana**




It is clear form the graph that the majority of the population in Thabo Mofutsanyana are between the age group of 5-19 years. This necessitates some focus on young children and adolescents' issues especially in relation to HIV/AIDS.

**TABLE 3: The main causes of death in Thabo Mofutsanyana 2001**

| | Setsoto | Dihlabeng | Nketoana | Maluti a Phofung | Phumelela | TM |
|---|---|---|---|---|---|---|
| ARI/Pneumonia | 279 | 172 | 150 | 1600 | 240 | 2441 |
| Cardio vascular | 31 | 56 | 69 | 791 | 42 | 989 |
| Tuberculosis | 112 | 125 | 52 | 497 | 50 | 836 |
| AIDS | 24 | 139 | 50 | 336 | 45 | 594 |
| Diarrhoea | 22 | 61 | 19 | 194 | 102 | 398 |
| Malnutrition | 17 | 22 | 6 | 117 | 77 | 239 |
| Pre-term delivery | 11 | 50 | 8 | 123 | 10 | 202 |
| Violence | 7 | 26 | 6 | 140 | 3 | 182 |
| Complications of Pregnancy and birth | 4 | 42 | 8 | 115 | 11 | 180 |
| Cancer | 2 | 1 | 6 | 162 | 2 | 173 |
| Motor Vehicle | 2 | 1 | 0 | 26 | 3 | 32 |
| **Total** | **511** | **695** | **374** | **4 101** | **585** | **6 266** |

It is very clear that respiratory tract infections including TB are the leading cause of death in the District in all age groups. The very cold winter where people need to burn animal dung, wood or gas for heating in overcrowded rooms, maybe a reason for the high respiratory tract infection. Poverty and AIDS are clear culprits in this regard. The second leading cause is

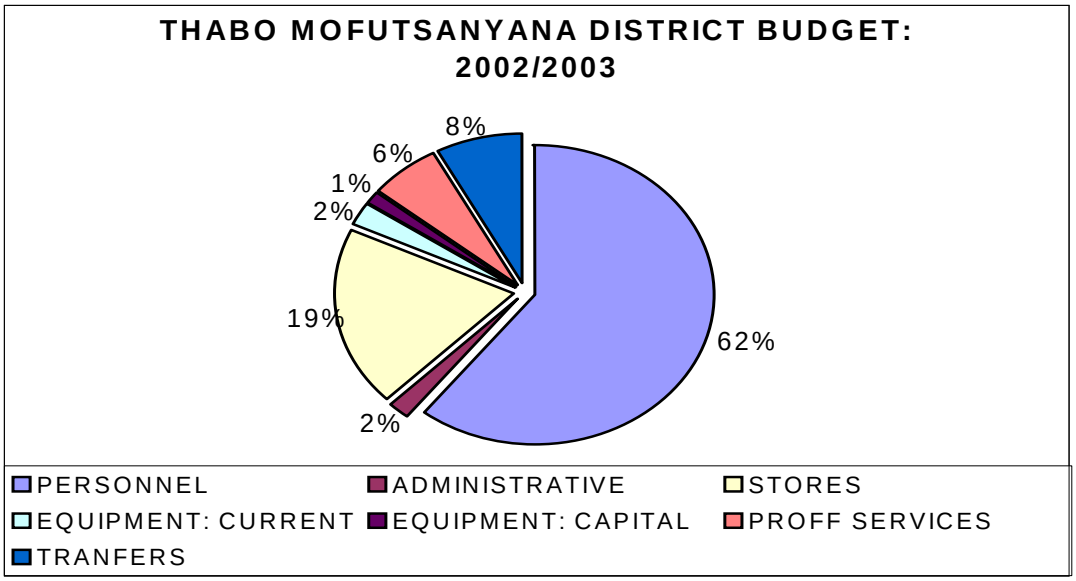
cardio-vascular disease. Although the district is a rural district, this may be an indication that affluent diseases may be in the rise. A concern is that not all death reasons are recorded correctly as many are just recorded as “natural causes” with no specific diagnosis.

Diarrhoea and Malnutrition figures are unacceptably high and the reasons need further investigation. HIV infection may be part of the problem as well as poverty, being a rural district. There are high death rates in the less than 1-year group; mostly this is due to complications of pregnancy and Pre-term delivery. The antenatal visits before 20 weeks rate is only 39% and perhaps this is one of the reasons behind the high complications of pregnancy and birth.

With the HIV/AIDS epidemic the anticipation is that there is a high number of deaths due to AIDS related illnesses, although they do not appear in the statistics. Due to the relationship between HIV/AIDS and TB, these figures may be linked together giving a truer picture of the impact of the epidemic.

As a rural district there is always difficulty to attract professionals, although the bulk of the District budget goes to personnel.

**GRAPH 2: The Budget broken down for Thabo Mofutsanyana District Municipality**



# CHAPTER TWO

# DISTRICT HEALTH SYSTEMS AND

# HEALTH MANAGEMENT DEVELOPMENT

**1. Objectives**

The following objectives were addressed in this section (see EU Goals for details)
A1: Build capacity to manage PHC and DHS;
A2: Build knowledge and capacity of councillors
A3: Support Local Government involvement in DHS
A4: Develop appropriate strategic plans for PHC & integrate into LG integrated development plan (IDP).
A5: Do capacity development through needs assessments and training.

**2. Planned activities and outcomes**

| Activities (& objective) | Level | Outcome |
|---|---|---|
| **1. Compiling a situational analysis (A1)** | District & Local Area (sub-district) | Completed with full participation of Local Area Task Teams. Revealed inequity and health information quality problems. Feedback information sharing and consensus building workshops were very lively with discussion.<br><br>Situation Analysis information used to prioritise district interventions e.g. priortizing DISCA and TB evaluations, assigning two LAM to Maluti a Phofung, using Maluti a Phofung as focal municipality for interventions etc. |
| **2. Completing a PHC staff training audit (A5)** | District & Local Area (sub-district) | Completed by Technical Advisor with participation of District Training officer.<br><br>Information shared with all stakeholders and used in DHP |
| **3. Establishing a District health management team (A1 & A3)** | District | District Health Management team (DHMT) strengthened. It is meeting monthly with participation from Local Government. However the turnover of leadership (three District managers and three acting, during the project period) weakened the flow of activities.<br><br>Organized two workshops for the District AIDS Council members focusing on their role and HIV/AIDS issues. This strengthened the District AIDS council. The regular follow up meetings with stakeholders ended in developing a District strategic and an annual HIV/AIDS plan and improved functional integration.<br><br>The facilitator organized three training workshop for all the health councillors from all five local municipalities aimed at improving the knowledge of councillors around health issues. Workshops discussed the Free State Health Act, PHC and DHS concepts, the PHC package, role of governance structures versus management, functional integration and participation of community in health issues.<br><br>All District managers' emails connected with the HST managed LG-District email discussion list and other specialized lists. Many managers are actively participating in the LG-DHS list discussions.<br><br>Organized Thabo Mofutsanyana annual DHS conference in August 2002 and September 2003 (preceding the Provincial DHS conference and preparing for it) sharing information on all surveys done including DISCA, TB, Clinic client satisfaction and DHER, discussing successes and challenges. Attendance 120 and 150 people (20-40 from each of the five local municipality) with participation from other Districts in Province and Provincial management.<br>Facilitated attendance of TMDM stakeholders at the Provincial annual DHS conference at Bloemfontein in |

| | | |
|---|---|---|
| | | September 2002, October 2003 sharing experiences, successes, challenges and lessons learnt. Attendances from each local municipality, with Power Point presentations from the District on achievements on implementing the DHS.<br><br>The PHC package, HST and EQUITY tools and publications and many others distributed to TMDM health stakeholders and used before the different workshops and consultation meetings<br><br>The Provincial priorities (HIV/AIDS/STD and TB) were the focus of integration efforts including NGOs/CBOs |
| **4. Promoting Local government councillor's health awareness (A2)** | District & Local Area (sub-district) | LG Councillor health awareness survey completed.<br><br>Training of health councillors from the five local areas on PHC, DHS and priority health programs including mother and child health, STIs including HIV/AIDS and TB. Health portfolio councillor is represented in the DHMT<br><br>On identifying the problems faced by clinic to actively involve community in health issues, the ISDS facilitator planned training for more than one hundred clinic committee members. Maluti a Phofung local municipality manager and liaison (community development) officers organized the training. It focused on the roles and responsibilities of clinic committees, governance versus management roles at clinic level, involvement of Ward Councillors in supporting clinic committees. |
| **5. IDP collaboration (A4)** | District & Local Area (sub-district) | Linked the DHP with the IDP planning process.<br><br>Joint participatory planning in IDP process for health projects |
| **6. District Management Training** | District & Local Area (sub-district) | A two-day report writing training for all district managers. Key managers not always available to attend. Positive course evaluation. |
| **7. District Health Plan (A4)** | District | Completed April 2004 using national planning guidelines. Annual DHP planning cycle established.<br><br>Training on use of Clinic supervisors' manual.<br><br>TMDM is the first District in the Free State Province to implement selected tools systematically since 2003 |
| **8. District health expenditure review (DHER)** | District | Organized DHER through training TMDM managers on computer skills to enter data, analyse it and produce DHER reports with support from the Valley Trust consultant. The produced document was used to guide the district planning |

## 3. Discussion

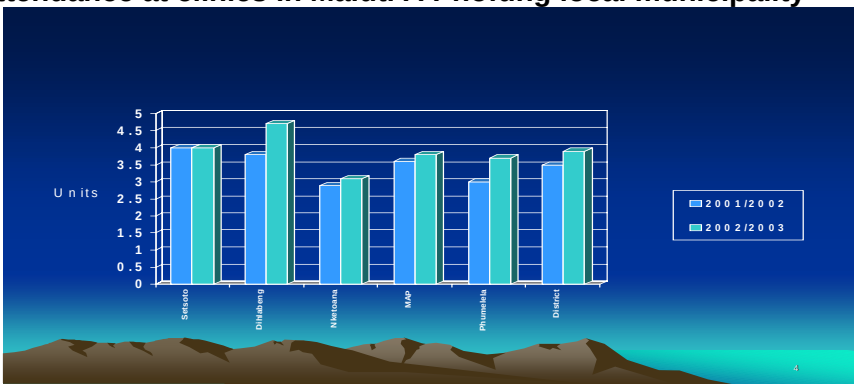
***Situational Analysis*:**
*The project kicked off with a participatory situation analysis for the five local municipalities. The process was as important as the document itself. All district health stakeholders attended a workshop discussing the draft situation analysis document in groups each tackling part of the document. Attendance included health service providers, PHC supervisors, health managers, Councillors, university of QwaQwa (UNIQWA) NGOs, Social welfare and other sector representatives. The process was an opportunity to strengthen the integration between local government and provincial department of health, NGOs and community structures, the university of QwaQwa and other stakeholders. The process of the exercise sustained the stakeholders' commitment to use the information to monitor services and improve quality. " It is very helpful in fact it was an eye opener for our service delivery in our district" as one manager commented on the questionnaire.*

The District health manager formed a Task Team to work on the situation analysis for the District. It was formed of members of the situation analysis task teams in the five local municipalities. They also used the documents and the maps, which the facilitator provided.

In the process of compiling the situational analysis, it became clear that health information systems and management is a priority area for improvement. The HISP facilitator tackled this task, guided by the objectives of part B of the EU tender. The ISDS facilitator followed up the implementation of HISP training at clinic and local area levels. The information was put to use in planning and made the district health expenditure review (DHER) process easy and more understandable to stakeholders. The situation analysis information was later used in the district health planning (DHP). It showed the importance of the health data for planning. The participatory process of the situation analysis was very useful in creating team spirit, educating LG councillors and other stakeholders being involved hands on in health issues for first time.

The situation analysis process and the focus on PHC and role of clinics as an entry point to the health system opened the discussions on utilization of clinics. The improved quality of PHC services also improved attendance at clinics. The active and enthusiastic community participation in health issues, especially involvement of councillors, sustained the change of mindset of community in relation to more reliance on clinics than seeking treatment at hospitals. There is increased utilization of clinics as seen from the headcounts, participation in health days etc.

**GRAPH 3: Attendance at clinics in Maluti A Phofung local municipality**



***District Management Training:***
The technical advisor undertook an audit of District management training needs. She also organized training workshops to reduce gaps in management training.

The ISDS facilitator organized writing skills training workshops to improve regular reporting by District managers. This is to improve the amount and quality of reporting on health activities and their impact and encourage the use of written materials to influence management decisions. All TMDM managers attended the course.

The relationships appears strained between the health councillors and health management as the councillors get involved in management issues and this appears to irritate health service providers in the facilities as well as the health supervisors and managers.

The facilitator used four formal meetings and two informal meetings to discuss management and governance issues and how they complement each other but also how they are misunderstood in practice creating conflict and resentment. The training of health councillors also discussed thoroughly issues of management and governance.

***District Health Management Team:***
The district health management team (DHMT) was formed and meets monthly with participation of Local government health councillors. The main achievements of the DHMT have been co-ordination and monitoring of the District Health plan, prompt action to solve problems and meet challenges. The DHMT is now well placed to guide and oversee the action plans in the DHP and to focus more on health indicators and quality of care monitoring.

A main hurdle in health administration in a rural district like Thabo Mofutsanyana is the ever-changing district leadership. The Provincial Department of Health appointed the fourth District manager, since the facilitator joined HST three years ago, all moving to posts at provincial level.

The facilitator met the last district manager formally to discuss progress of the remaining objectives. Discussed the support to implementation activities of the clinic supervisor's manual, using the DHER results to improve planning and to use the national DHS planning guidelines more appropriately to guide planning and resource allocation.

Communication, positive personal relationships and rapport are important in oiling stiff joints of the bureaucratic public sector. The ISDS facilitator worked a regular program to formally meet with the major stakeholders in the District to keep them informed and seek their commitment and support for implementing the project activities. The regular meetings included the District manager, the local area managers, the District health councillor and the QwaQwa AIDS consortium of NGOs.

Many stakeholders reiterated the positive role of external facilitation by HST in focusing efforts on improving the quality of care, strengthening team spirit and developing the DHS, despite the continuous change in District management leadership.

***Common comprehensive, integrated district and sub-district plans shared by Province and LG***

There is no duplication as all facilities provide comprehensive PHC services within the capacity of their staffing and equipment.

Health services are integrated and there is one plan for all health services. However there are only PN from local government participating in their capacity as service providers and

one LG clinic supervisor. Health is almost solely a Provincial function, and there is insufficient participation from Local government officials, managers or councillors.

Through these project activities the facilitator managed to bring together Municipal managers with the Health manager in meetings and workshops to discuss project activities or during DHS workshops. The project conducted two health information-sharing workshops to discuss health issues attended by LG officials and councillors as well as the District Health management. All program co-ordinators attended to share info about their programs.

The District health Manager agreed to take with him Municipal managers, Health councillors and LG Community Services Directors (handle health issues) to visit health facilities to see and feel the services and meet with service providers and users in the facilities. This is in the hope that it will improve rapport between LG and Health department and create more interest about health in LG officials and councillors.

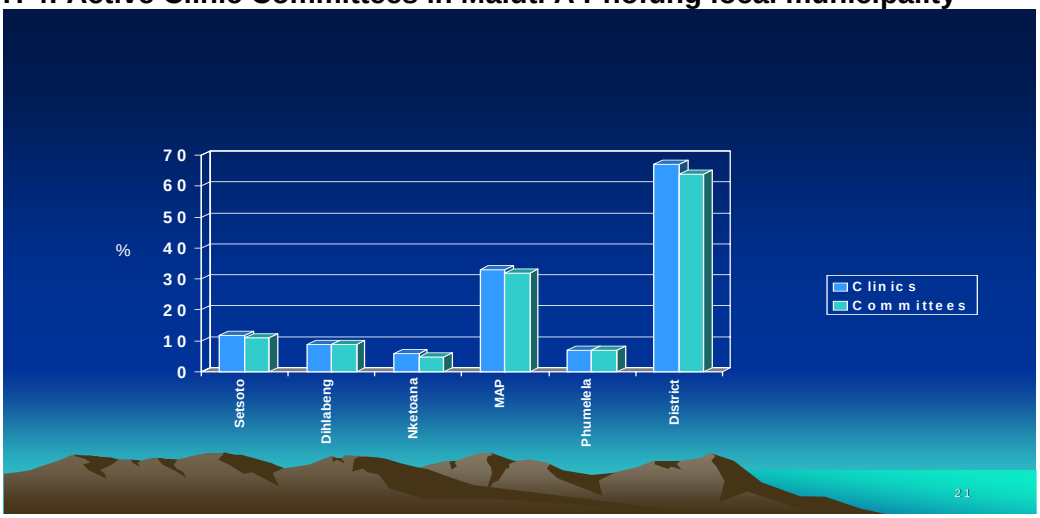
Provincial health is the main planner and provider of services. The health services are integrated and there is one plan for all District health services. The ISDS facilitator organized a workshop attended by all Thabo Mofutsanyana District manager and core staff and other Districts managers and provincial managers to align the District Business Planning process to the national guidelines. This will enhance uniformity and allow clarity of indicators for monitoring.

***Promoting Local government councillor's health awareness:***
Health Councillors from the five local municipalities attended training through three interactive workshops organized to inform and create better understanding of PHC, DHS, the Free State Health Act and priority health programs in the District. The District health program coordinators co-facilitated the workshops with the ISDS facilitator to present their programs and answer queries from the councillors.

The Free State Health Act stipulates that the LG head health councillor is the chairman of the District health council. ISDS facilitator met regularly with the District Health Councillor to discuss the project and to encourage more active involvement of Ward Councillors in enhancing efforts of HIV/AIDS awareness and home based care activities as well as strengthening the clinic committees especially the possibility of Ward councillor's actively endorsing and supporting Clinic Committees in QwaQwa.

On identifying the problems faced by clinics to actively involve community in health issues, the ISDS facilitator planned training for more than one hundred clinic committee members. Maluti a Phofung local municipality manager and liaison (community development) officers organized the training. The training was delayed three times at the eleventh hour by the District health management. The training focused on the roles and responsibilities of clinic committees, governance versus management roles at clinic level, involvement of Ward Councillors in supporting clinic committees and the support of clinic management to the committee members and including basic information on PHC services.

**GRAPH 4: Active Clinic Committees in Maluti A Phofung local municipality**




***IDP collaboration:***

The TMDM LG contracted a consultant firm to produce the IDP document for Maluti a Phofung local municipality and for the District. This did not help the participatory collective working objective of the IDP, especially for the health projects. At the same time health is mainly a provincial function since services were integrated and mainly funded by Province. Hence there was not so much LG enthusiasm about it.

The ISDS facilitator used the HST document "Fitting Functionality into Boundaries" in a workshop to inform the Local government integrated development process discussions of the Health component. This was followed in the meetings, as he is a member of the health and social development task team. Hence the health projects are well entrenched in the LG IDP documents.

***District Health Plan:***

The ISDS facilitator organized a training workshop on the use of the national District planning guidelines at Provincial level. Then working with District Management, he used the guidelines in developing the Thabo Mofutsanyana District service plan. *"HST came with skills and was helping with finances for the skills training in the district. The HST faciliatators were knowledgeable regarding DHS/PHC issues."*

The FS DOH developed its strategic plan that is guiding the annual district planning process, providing a platform for a comprehensive district plan for service delivery.

*Regular joint LG and Provincial Management meetings*

As mentioned above the meetings are not consistent and participation and involvement of local Government officials and councillors appears inadequate. In order to create interest and involvement in health issues the facilitator contacted local government officials, Municipal managers and Mayors of the Setsoto and Maluti a Phofung local Municipalities and Thabo Mofutsanyana District municipally with regard to these issues. There appears to be a general reluctance to take heath seriously by LG officials, as their plates are full. Councillors in Health Portfolios are interested to participate but Health is also reluctant to invite councillors, they prefer officials. Some councillors are interested to participate and we hope that this situation will change when letters of invitation will officially go to the Municipal managers to attend the monthly health meetings, where they may delegate that to councillors.

## 4. Client perspective (based on client survey/questionnaire)

The ISDS facilitator distributed a questionnaire to more than twenty of the TMDM health stakeholders including district managers, program managers, LAMs, clinic managers, councillors and NGOs. A list of the questions and responses to them follows.

### When HST started in the district did you think HST could be of any assistance to the District?

Many managers had high expectations of HST involvement in the district. Maybe they view any additional support an added value or maybe they know the good work HST has done in other Provinces. *"That they can assist the Health services to be structured, as their facilitators are knowledgeable, persons with a vision to better our district"*

HST came with skills and was helping with finances for the projects and activity in the district. *"following their involvement at Hlanganani area, I saw progress re integrated services."*

### How do you feel about HST now?

Many TMDM stakeholders are very positive about HST contribution to health development in the District. *"HST is dynamic – it must continue with its support in the District." "They build capacity strengthen the relations and services in the District, assist in prioritising needs & addressing problems."*

Service providers are specifically happy about seeing more of managers and councillors in their clinics. *"Managers who hardly has any idea of how things are happening in clinics, their involvement has taught them a lot. Taking them out of offices to the clinics has made them understand a lot of problems in the clinics.*" The service providers are happy with the work. *"Very confident about HST because our standard of services rendering in our respective Clinics is very excellent as compared to previous time that is before HST started."* Some went further reiterating that "*HST is the body that brings hope + positive attitude to the ground workers."*

### Did you think HST has built capacity to plan and manage PHC services and the District health system (DHS)?

The introduction of program evaluation tools and the implementation of the clinic supervision manual created a formal opportunity to improve and follow up improvements. *"The implementation of supervisory tools: standard tools could be used in the whole district and quality of services improved as gaps were rectified."*

*"Managers were exposed to different training with the help of HST. This assisted to improve on the capacity of the managers to better manage the PHC services, even though there are a lot of problems (e.g. shortage of personnel).*"

The training stressed alignment to provincial strategic plan and where possible use the plans to guide the work at different levels. *"In the past there was no strategic plan even though it was there it was not utilized but through HST there is supervisory visit manual clinics are evaluated on monthly basis – clinic managers are involved in PHC that is capacity building and thorough management of clinics."*

Sometimes more credit is given to HST than it deserves. *"Through HST 98% of Maluti a Phofung clinics have clinic committees. Clinic committee training has been given to 50% of clinic committee members. There are factual records indicting performance of clinics relating to specific PHC programmes."*

**Do you think that HST has contributed to build up the knowledge, skills and capacity of local government councilors?**

The major interventions HST undertook in TMDM are to improve the quality of services through bridging the gap in knowledge and skills of managers and service providers. *"I believe so, as there is better understanding and involvement of local communities in PHC matters. Health councillors are enlightened about Health issues."*

The collective work is meant encourage people to be self reliant as the FS provincial mission states. *"At least presently we realize our strength & weaknesses and HST is ready to support."*

The training included all not only managers but all health staff and their supportive community structures. "Now they have knowledge of what is happening in our Clinics because they were part of workshop held based or HST and they now have skills and capacity through workshops." The turnover is high not only in health staff but also in the support staff. "*The re – shuffle and changing of health councillors made is very difficult to walk the road*". This collective inclusive approach to change through personal interaction, distribution of reference materials, training workshop, and feedback workshop discussions improved *"integration, and intersectoral collaboration."*

**Do you think HST has contributed to build the DHS by helping managers to develop appropriate strategic and operational plans for PHC service delivery, and to build these into the Integrated Development Plans (IDPs) of local government?**

The District plan is in place and reflects on critical aspects of the IDPs. HST also facilitated the process of functional integration in Thabo Mofutsanyana. *"The training helped develop managers to use appropriate operational plans for better service delivery. Even the councillors (Local government) were involved in the HST facilitated meetings". The follow up activities were the most useful. " Until to date, task team that deals with IDP is still meeting."*

**Do you think HST has contributed to build the DHS by arranging or providing in service training to build capacity in financial planning and management?**

The managers really benefited for the process of the DHER. *"Our district developed the district expenditure review document with the help of HST. This process assisted to better re-allocate the resources and this resulted in us winning the fist price as the best rural district with support in South Africa."* All staff were included in DHER training to establish a pool of professionals to sustain it. *"LAM can utilize finances according to priorities as directors and Chief Professional Nurses (under local government) did attend these helpful workshops".* However not all the recommendations of DHER were implemented. *"HST encouraged the district to identify 2 clinics per local area to pilot cost centre management."*

**Do you feel that the expertise brought by HST has contributed to development in the Health District in general?**

Many people sing the praises of HST as a facilitator of positive change. It made people in TMDM see themselves as pioneers who benefit the other districts in the Free State who follow in their footsteps. *"The views of HST as well as input given could be taken to heart and were very valuable: (Supervisory tools could be shared with rest of the Free State. The workshop on report writing contributed to development of clinic managers."*

Managers see the input as professional. *"They are specialists in improvement of services & and implementation of PHC package"*. The mentoring and support assisted managers to do their work better. *"Managers and personnel feel confident about handling issues under their responsibility. Plans can be developed to deal with specific problems, even at clinic level personal know where to go."* Some managers even go to extreme saying, *"It has been a dark tunnel at the end a light is seen."*

Many give credit to HST for part of their achievements. *"This district has managed to be the best model in the entire Province. This is an indication that as far as development is concerned HST has contributed."*

The presence of HST facilitators in the District and their field visits to clinics and discussion of successes, problems and challenges on site in comparison to other Districts in South Africa *"exposed the managers in the district to what is happening or how things are done in other district and provinces."*

Many valued the follow up mentoring after training of different categories of health staff and support. *"Training of staff on DISCA, training of clinics committee members, implementation of clinic supervisory Manual and follow up support after workshops benefited managers at Maluti a Phofung."*

## 5. Lessons learnt

1. *It is important that managers be supported to stay in the post at least for two years to be able to implement activities and see achievement through. The ISDS facilitator District counterpart expressed that the new Thabo Mofutsanyana health district manager is stressing his full involvement in all decisions for activities in the District. Although he is a committed able manager, but unfortunately he is not always available. He is also overwhelmed by demands locally at the district level and from province. This created delays and frustration in implementing a number of planned activities including the District service plan, the clinic committee members training, the visit to Limpopo by the HIV/AIDS coordinator and NGOs to share and learn about management of HIV/AIDS and STIs in the trucking.*

2. *A champion is needed to keep stakeholders focused on achieving. There are demands for action on many aspects of health care delivery in a rural district and managers cannot stop "fire-fighting" practices. The champion will handle the priority activity, bring stakeholders together and see activities through. When there is will and sustained support and championing from Province plans are implemented. Integration between Province and LG in health services is almost complete due to sustained provincial commitment and demands.*

3. *Although not every non-health Situation Analysis Task Team member was happy at the beginning, they all praised the process at the end of it especially the councillors. A lot of patience, understanding, mentoring and support was needed to create a team spirit through this participatory process and allow people to acknowledge and understand their health system's strengths and weaknesses.*

4. *Satisfying the interest of community members and councillors in health issues and to support clinics is difficult. The spirit for free voluntary work is very poor and weakened further by the payment of stipend for the home based carers. The clinic committee members are requesting incentives for their services as home based carers are getting a R500 stipend for their work.*

5. *The joint collective inclusive process is important to sustain the functional integration efforts. Sustaining the presence of LG in the monthly regular district management meetings and the District manager in LG cluster meetings is the challenge. It may be easier since now we know the direction of LG health services.*

6. *The District AIDS plan did not receive the commitment for implementation support it needed. Unfortunately there seems to be juggling for positions and opportunities since there is a lot of funding for AIDS activities in Maluti a Phofung as a nodal point. There is more focus is on who gets what than what can be done.*

7. *Although all stakeholders in TMDM are committed to working together, the LG is still reluctant to enter with full force. This should ease with clarity of the uncertainties about ownership of health services and the interpretation of municipal health services.*

8. The open discussions allowed management to take their down line and councillors more seriously as a lot of wisdom came from them. At the same time councillors and NGOs found partners to work with.

9. The attendance of the MEC Health and Provincial directors at some of the participatory meetings was very helpful in solidifying the team spirit as they stressed functional integration. This vocal political support was an important recipe for success.

10. The presence of chief professional nurses (CPN) on different levels of management (e.g. clinic manager, program coordinator, supervisor) affects their commitment to working together, especially when their appointment is not done in writing but communicated verbally in meetings. Effective management by such CPN depends on the formal written authority.

# CHAPTER THREE

# HEALTH PROGRAMMES AND QUALITY OF CARE

**1. Objectives**
A3: Support Local Government involvement in DHS
A5: Do capacity development through needs assessments and training
A 6: Develop strategies to deliver comprehensive and quality PHC

**2. Planned activities and outcomes**

| Activities | Level | Outcome |
|---|---|---|
| **To complete a DISCA evaluation of STI services in Maluti a Phofung local municipality** | Clinic level in Maluti a Phofung local municipality | DISCA tool used in November 2002 to evaluate STI services, STI action plan mapped out and interventions implemented.<br><br>The data for second DISCA evaluation collected in November 2003.<br><br>Formal assessment with participation of STI program manager, District health information officer, local area managers and clinic managers. Main challenges identified are the need to training on syndromic STI management, additional equipment; improve records and use of equipment. |
| **Strengthen involvement of councillors in health issues** | Clinic level in Maluti a Phofung local municipality | Used a questionnaire to identify training needs of health councillors. Organized three workshops to train all health councillors in TMDM. Strengthened clinic committees and commitment of lay educators and home based carers. |
| **Complete a TB evaluation** | Clinic level in Maluti a Phofung local municipality | Formal evaluation in September 2003 using the improved Provincial TB evaluation tool. Tool pre-tested and improved in collaboration with Provincial TB coordinator. The evaluation in Maluti a Phofung done with participation of TB program manager, District health information officer, local area managers and clinic managers and NGOs.<br><br>Three training workshops organized with attendance of TB coordinators from all five local municipalities, HIV/AIDS coordinators and NGOs. The focus was the nodal point (Maluti a Phofung), the action plan mapped out with interventions.<br><br>Main challenges identified are the need to training on TB management; improve records, training of doctors and involvement of trained DOTS supporters. |
| **Compile a PHC package audit** | District and sub-district (Local area) | Facilitated the PHC audit with Technical advisor, gaps identified per local municipality. Each local municipality produced their Action Plan with interventions to reduce the gaps. |

| | | |
|---|---|---|
| | | Rapid audit completed as part of the DHER. Some gaps addressed in the DHP.<br><br>Developed and used an anonymous clinic client satisfaction questionnaire to measure client satisfaction with different aspects of clinic services. It showed a very high satisfaction. Some clinics used it quarterly to measure their client satisfaction levels and improve. |
| **Improving the supervision system-communication** | District and (Local area) sub-district | A workshop on use the Clinic Supervisors manual done and manual used. Quarterly Review meeting occurred regularly to present progress and work out solutions to challenges. |
| **Planned study tour to Lejweleputswa to discuss the DHER issues,** | District | Failed twice due to district management involvement in other issues during the agreed upon dates |
| **Planned study tour for STI manager and NGO staff to Trucking HIV/AIDS project in Limpopo** | District | Failed twice due to district management involvement in other issues during the agreed upon dates |

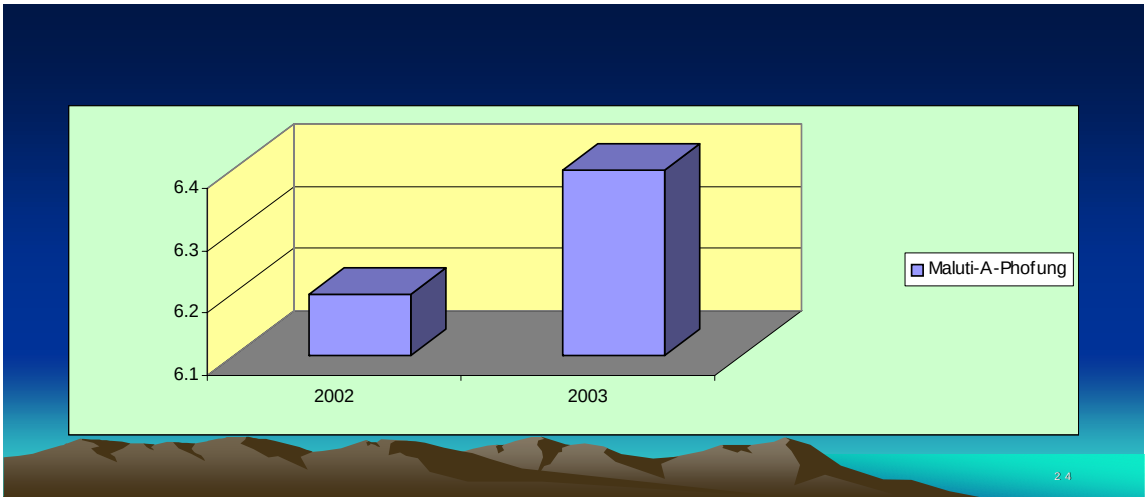
**3. Discussion**

**DISCA evaluation of sexually transmitted infections in Maluti a Phofung**
The Task Team monitoring the implementation of DISCA report recommendations for Maluti a Phofung had a measured positive progress of STI management at clinic level as many improvements has been observed by the Task teams monitoring STI management.

- ✓ More than 70% of the professional nurses in Maluti a Phofung attended three days training on syndromic management of STIs.
- ✓ The District purchased new vaginal specula and distributed them to all needy clinics.
- ✓ More clinics are using the specula in diagnosing STIs
- ✓ Partner notification sheets were printed in Sotho and Zulu for use in all clinics
- ✓ The professional nurses are capturing more data about each case they see
- ✓ The correct treatment of cases is almost 100% according to Syndromic management, when monitored in June.
- ✓ Active case finding has improved.

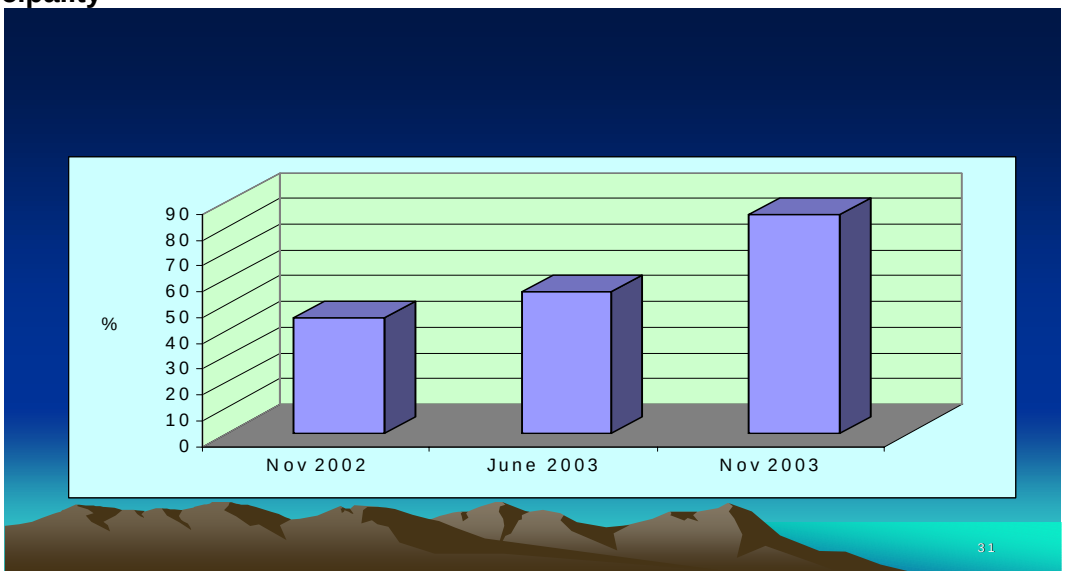
The ISDS facilitator worked with the Local area managers in the remaining four Local municipalities for DISCA evaluation of their services. This is knock-on effect of the same process in Maluti a Phofung when representatives from local municipalities attended the training. The District Information officer and selected Maluti a Phofung Task team members are assisting the Local Area managers to analyse their data and plan improvements.

**GRAPH 5: STI incidence rate in Maluti A Phofung local municipality**



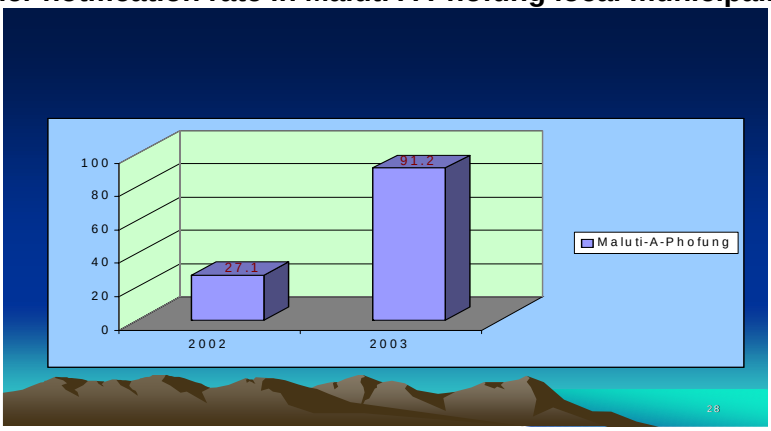

The training of the professional nurses improved active case finding as well as the recording of data. Hence there was a clear increase in the incidence rate. This was a clear indication that STI management is improving.

**GRAPH 6: Comparison of outcomes of STI treatment in Maluti A Phofung local municipality**



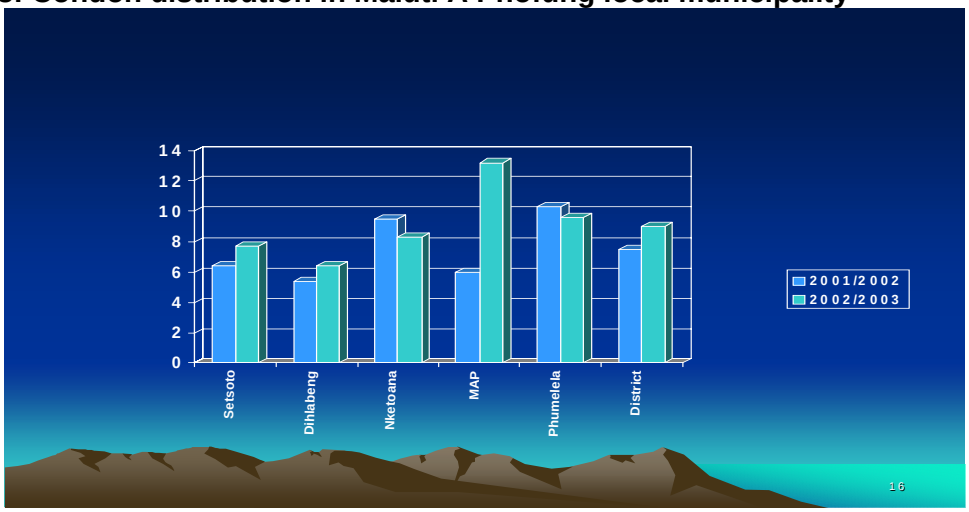

After the November 2002 DISCA evaluation and the training of nurses, the STI task team members visited the clinics every six months looking at the last ten STI cases treated in the clinic. It is clear that the training made a difference in correctness of treatment especially after all nurses were trained. The challenge now is to keep this momentum, through continuous on the job training and regular follow up of the daily register.

**GRAPH 7: Partner notification rate in Maluti A Phofung local municipality**




The feedback information on the quality of STI services and the training of nurses that followed improved a number of aspects of STI management. One of the clear positive changes is the improvement in partner notification and the improvement in condom distribution especially in Maluti a Phofung, which is the focal municipality for the project interventions in TMDM.

**GRAPH 8: Condon distribution in Maluti A Phofung local municipality**




**TB Evaluation**

Forty-five clinical staff and mangers were informed of the outcome of the TB evaluation, the strengths and weaknesses of TB services in Maluti a Phofung (MaP) at a two-days TB training workshop organized in October 2003. The participants included TB coordinators, clinic managers and PHC practitioners.

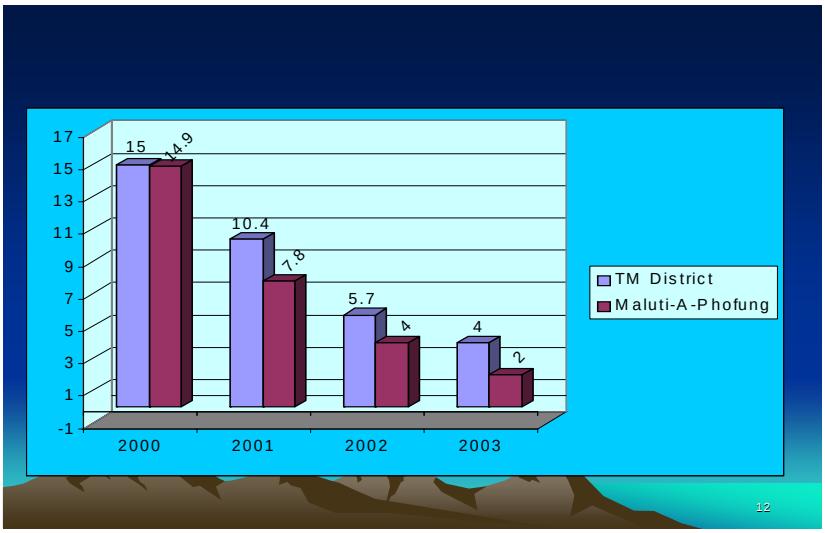
*Unfortunately no doctors attended the workshop. The issue of training doctors on the TB national guidelines is problematic. The Provincial TB Coordinator agreed to handle the training from Province, as she will link that with the national TB program. At the same time national has identified the Free State as one with good TB program and have not prioritised it in their training.*

The Provincial TB coordinator attended the second day of the TB workshop, where she trained the participants on TB management definitions and hands on TB register management. The participants brought their TB registers where quarterly reports were worked out. A number of case studies were used to facilitate a better understanding of TB management, data recording and reporting.

Selected TB coordinators from the other four local municipalities attended the training at MaP so as to conduct the same in their local areas, with support from the District TB manager and the ISDS facilitator.

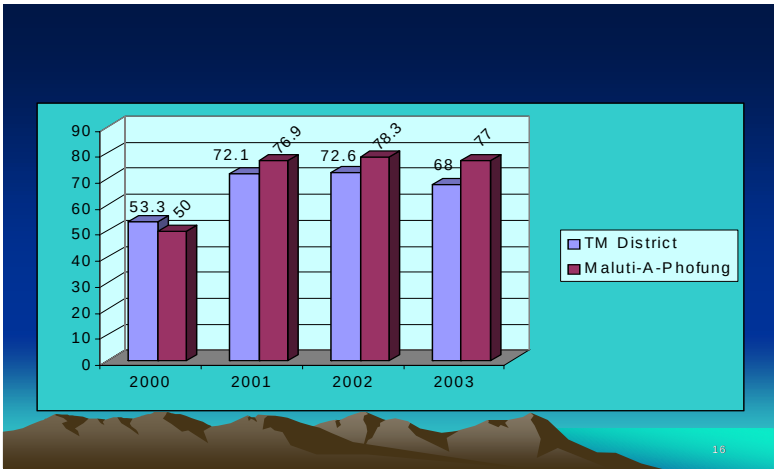
The TB task team members distributed the draft report of TB management in MaP to stakeholders for their information and comments. The report contained tables and graphs comparing the different clinics and shows areas where intervention was needed. The TB task team members worked out a plan to improve the TB management in MaP with training and regular monitoring of TB services to ensure improved quality of TB services.

**GRAPH 9: TB treatment interruption rate in Maluti A Phofung local municipality**



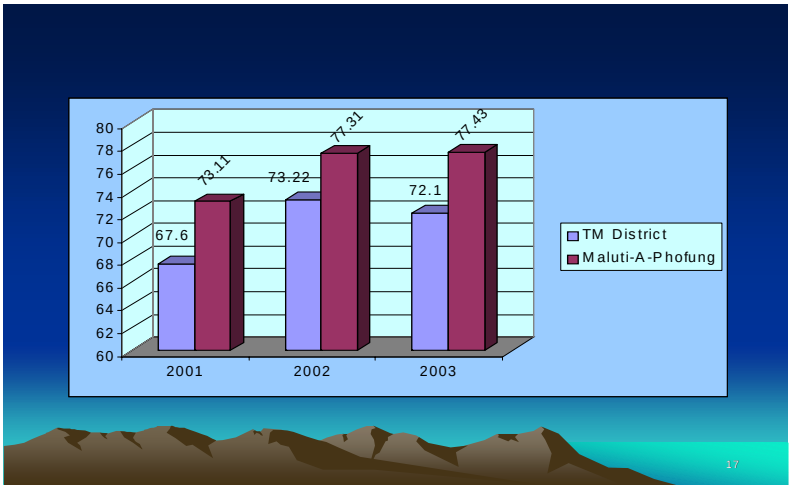

It is very clear that the training and interventions are having a positive impact of outcome of TB management in Maluti a Phofung. There is continuous and sustained reduction in treatment interruption rate. The rate is also less than the District average. The improved low interruption rate is an indication that the DOT supporters are doing good work.

**GRAPH 10: TB cure rate in Maluti A Phofung local municipality**




The TB cure rate has not improved the district as well as in Maluti a Phofung where, but at least the improvement after the interventions in 200 were sustained. The program stayed without a dedicated coordinator who moved to greener pastures in the neighbouring Kwazulu Natal.

**GRAPH 11: TB smear conversion rate in Maluti A Phofung local municipality**




The smear conversion tallies well with the cure rate in Maluti a Phofung. It is sustained improvement, although it is below the 80% required by Province.

**The quarterly clinic supervisors manual workshops**

The workshops are regular quarterly activity that looks at the Red Flag and Monthly PHC tools that are used in the monthly supervision support visits to clinics. Every quarter one in-depth tool is used to look at one program in the local municipality to identify strengths, weaknesses and challenges and to discuss the most appropriate and feasible solutions to improve service delivery.

- ✓ Improvement of existing methods of supervision is clear as supervisors present what was expected in last quarter and the challenges for the next one.
- ✓ Structured evaluation / supervision tool standardized and clinics are now easily compared.
- ✓ Knowledge of PHC package strengthened through the focus on implementation of the package, which included community participation at clinic level, the DOT supporters and home based carers.
- ✓ The discussions during the workshops clarified the role of local area managers (who are in posts of CPN) in relation to other chief professional nurses in the municipality. It also discussed the role of Local coordinators and District Coordinators.
- ✓ Enabled the managers to focus on implementing the PHC package and priority (strategic) programmes.
- ✓ Clinic management focus on patient care and not management?
- ✓ It enforced uniformity of reporting structure.

**4. Client perspective (based on client survey/questionnaire, where this will be done)**

The ISDS facilitator distributed a questionnaire to more than twenty of the TMDM health stakeholders including district managers, program managers, LAMs, clinic managers, councillors and NGOs.

**Did you think that HST has contributed to strengthen, expand and improve PHC?**

The project focused on improving the quality PHC services through evaluation to identify the gaps in service provision and planning to reduce these gaps. *"HST it give guidance i.e. objectives, how to overcome obstacles and to get focused on PHC."* This is done partly through the audit of the PHC package and through in-depth reviews of certain programs. *"HST assisted with the PHC package implementation gaps were identified and action plan developed to deal with this problems."* "*Now managers (LAM) have seen problems and they can now really support the implementers. They now understand how things have been happening and they can help in the change to better services."*
Many managers are proud of their achievements that are recognized provincially and nationally *"HST has strengthened our PHC services hence our district was considered the best and it has won in the last year in the Provincial and National health Districts competition"*. This did not stop some from criticizing some managers and service providers. *"They got all the information but because of staff shortage or just lack of interest or dedication the work is not implemented in most facilities."*

**5. Lessons learnt**

1. *Although the managers try hard to implement the district plan most of the work is fire fighting as Province priorities always supersede the District planned activities and there are many Province priorities that the District knows about in the eleventh hour. Many meetings are postponed in the eleventh hour by provincial demands or persons who are crucial for success of a meeting apologize from attending the meeting due to*

*priority provincial meeting at the same time. There is need for Province to support decentralization policies and allow the District a breathing space and not make provincial emergencies an added priority for District management.*

2. *The implementation of the quarterly review meetings using the supervisor's manual helped supervisors and clinic managers to improve clinic functioning address problems of transport and drug availability. Unfortunately this activity is supported externally and when it stops, TB and STI and other programs may be negatively affected. Province and District need to make resources available to keep this quarterly reporting and interaction between service providers, users and managers.*

3. *The structured process of supervision visit, reporting and action plan showed both clinic managers and supervisors that there is a lot to be done to improve the services within the available resources at clinic level, without the need for District and Provincial resources. It improved the morale through creating an understanding and supportive environment, the use of equipment such as specula, improved data recording and timeliness of reporting and to go the extra mile to satisfy clinic clients.*

4. *The work to better structure clinic supervision in TMDM, clarify the roles, responsibilities and expectations made supervision successful. At the same time the presence of the District manager at all the quarterly reviews gave him better insight into the services delivery problems.*

5. *The DISCA tool was very useful in identifying challenges that face providing quality STI services, identifying current quality issues in clinics and assisting in a planned action to improve and monitor the quality of STI management. This also assisted positively the quality of other services.*

6. *Lack of supervision and regular visits to the clinics is a main culprit in non-availability and utilization of equipment such as dildos and specula in STI management as well as active utilization of syndromic management protocols. Regular visits raised awareness among both service providers and supervisors on importance of using equipment and protocol on all cases.*

7. *Although all professional nurses received ample TB management training, the resignation of the TB coordinator affected their work negatively. Sustained supervision, mentoring and support is needed to ensure nurses are using the taught knowledge and skills. When comparing the training received by the same nurses on TB and STI, the impact on improving STI management is far better and the main factor is the responsive proactive STI program coordinator.*

# CHAPTER FOUR

# HEALTH SERVICE SUPPORT SYSTEMS

## 1. Objectives

- ✓ Compile a District Health Expenditure Review
- ✓ Health information: Accessing mortality data
- ✓ Health services support systems integral to DHP
- ✓ Use The national guidelines to guide the development of the Thabo Mofutsanyana District service plan

## 2. Planned activities and outcomes

| Activities | Level | Outcome |
|---|---|---|
| **Complete a district health expenditure review** | District | DHER done collectively with training of district managers. A pool of District staff trained in DHER data collection, entry and analysis using EXCEL. HR, Admin staff, local area managers, HISP and some LG officers all involved in the process.<br><br>The feedback workshop attended by health staff, LG managers, councillors, NGOs and university of QwaQwa. Main issues in the DHER shared with all District stakeholders during the DHS conference in September 2003.<br><br>DHER highlighted problems including Health information gaps in the PHC package, utilisation and workload distribution, cost centre development and mobile services.<br><br>Document informed decisions in the district health planning process |
| **Health information: Accessing mortality data** | District & sub-district (Local area) | As part of Analysis and DHP, the lack of mortality data was evident. The district has now established their own system for collating annual mortality data. |
| **Health services support systems integral to DHP** | District & sub-district (Local area) | Support Services is one of the 5 interrelated plans in the District Health Plan |
| **Use The national guidelines to guide the development of the Thabo Mofutsanyana District service plan** | District & sub-district (Local area) | Two workshops and follow up meeting took place. The District plan is developed and is monitored quarterly during the quarterly CSM review workshops |

## 3. Discussion

**District Health Expenditure Review (DHER)**

Process of compiling it took longer as it required knowledge and skills about the computerized formats, data entry and analysis. Task Team members attended two training sessions outside the District to gain that. The exercise also required bringing province and

LG operational and financial managers together to learn about each other's financial systems. DHER information only became useful once it was used in the District Health Plan. This required that managers look initially to internal efficiency gain, rather than requesting greater funding.

The total recurrent expenditure for the district was R 254,836,601.78 and was made up as follows showing how the system is still hospicentric as PHC receives only 19% of the TMDM budget.

| Programme | Expenditure amount | % |
|---|---|---|
| District Office | R 41,219,258.27 | 16.17% |
| Primary Health Care | R 49,625,607.69 | 19.47% |
| District Hospitals | R 72,206,949.19 | 28.33% |
| Regional Hospitals | R 91,784,786.63 | 36.02% |
| TOTAL | R 254,836,601.78 | 100% |

The DHER process was as important as the final document itself. The participatory work of different stakeholders helped in understanding the cost drivers, prioritisation within limited resources and opportunities for alternative resourcing through tapping private sector, NGOs etc.

**Guidelines for District Planning**

There is a pool of District managers who attended the training and are able to sustain use of the national guidelines to guide planning as required.

The ISDS facilitator worked with the District managers to use the quarterly CSM review meeting to follow up the District plan and report about achievements, failures and challenges. The quarterly reports produced can then be used to produce the annual District report that can be used to guide the annual planning for the district health services.

**4. Client perspective**

**Stakeholders were asked whether HST has contributed to build the DHS by arranging or providing in service training to build capacity in financial planning and management. Their responses were positive.**

As discussed the participatory process was useful. *"Our district developed the district expenditure review document with the help of HST. This process assisted to better re-allocate the resources and this resulted in us winning the first prize as the best rural district with support in South Africa."* Some managers benefited from the DHER more than others. *"As a LAM I can utilize finances according to priorities".* But "*there is still a need for financial planning and management training."*

Unfortunately due to shortage of financial skills not all recommendations were implemented. *"HST encouraged the district to identify 2 clinics per local area to pilot cost centre management."*

# CHAPTER FIVE

# OTHER ACTIVITIES

## 1. Objectives

- ✓ AIDS NGOs support and sharing of experiences
- ✓ Health services innovation recording and sharing
- ✓ The District Health Services conferences for sharing of experiences and lessons Learnt
- ✓ Rural Health Conference

### 2. Planned activities and outcomes

| Activities | Level | Outcome |
|---|---|---|
| **Support NGOs to assist with community based health interventions** | Maluti a Phofung local municipality | Organized two workshops for information sharing between QwaQwa AIDS Consortium members (twenty-two NGOs and CBOs). Each participant CBO organized oral and poster presentations. Many produced very informative posters. They networked and shared challenges and successful interventions.<br><br>Facilitator connected the QwaQwa Consortium management with networks of AIDS donors and activists in the Province, Gauteng and Kwazulu Natal, sharing with them.<br><br>The Consortium has its agreements with Social Development. The only service level agreement in the district is between the Province and SANTA to coordinate training and payment of NGOs participating in home based care. |
| Health services innovation recording and sharing | Provincial | Many innovations in HIV/AIDS awareness, community participation in health, strengthening clinic support groups were recorded and shared. |
| The District Health Services conferences for sharing of experiences and lessons Learnt | National | The District manager presented the achievements, constrains and challenges. |

### 3. Discussion

There are no signed agreements between TMDM health department and NGOs except for the agreement between the Provincial Department of Health and SANTA to coordinate the home based care financial aspects in the District. There are good relationships between NGOs and the AIDS program as they receive the training and accreditation from them. All NGOs and CBOs are registered with the Department of

Social Development. The QwaQwa Consortium of NGOs is a collection of organizations providing mainly home based care and are supported by both the Department of health and that of social development. The interaction with them assisted in improving the skills of some of the NGOs staff in relation to program management and fundraising. The project also facilitated information sharing workshops to allow exchange of ideas and networking.

## 4. Client perspective

The ISDS facilitator distributed a questionnaire to more than twenty of the TMDM health stakeholders including district managers, program managers, LAMs, clinic managers, councillors and NGOs. A list of the questions and responses to them follows.

The major interventions HST undertook in TMDM are to improve the quality of services through bridging the gap in knowledge and skills of managers and service providers. *"I believe so, as there is better understanding and involvement of local communities in PHC matters. Health councillors are enlightened about Health issues."*

## 5. Lessons Learnt/Way forward

There are a number of NGOs working in the same area but opted not to join the consortium. There are a lot of internal politics between NGOs and their leaders, especially with so much funding for a poor district like Maluti a Phofung.

1. *The NGO workers and volunteers are energetic and enthusiastic youth, who with a little support can provide a lot of support to PHC services at community level.*
2. *Clinic managers are overwhelmed with work at clinics and supervising and supporting NGOs and CBOs falls in the fringes of their priorities. There is a need for a concerted effort to keep the linkages between the NGOs and clinics nearest to them so as to ascertain the quality of services they provide in home based care.*

# CHAPTER SIX

# CONCLUSION AND RECOMMENDATIONS

1. *There is need for Province to really support decentralization policies and allow the District a breathing space and not make provincial emergencies an added priority for District management.*

2. *Province and District need to make resources available to keep the quarterly review meetings using the supervisor's manual with reporting and interaction between service providers, users and managers.*

3. *The District manager and his District staff need to prioritise the quarterly review meetings as the presence of the District manager at all the quarterly reviews gave him better insight into the services delivery problems and stakeholders an assurance that quality of services is what the District is working for.*

4. *The Program in depth evaluation tools needs to be used annually as the DISCA tool was very useful in identifying challenges that face providing quality STI services, identifying current quality issues in clinics and assisting in a planned action to improve and monitor the quality of STI management.*

5. *The District needs to allocate resources especially transport and time to allow monthly supervision visits to take place. Lack of supervision and regular visits to the clinics is a main culprit in non-availability and utilization of equipment such as dildos and specula in STI management as well as active utilization of syndromic management protocols. Regular visits raised awareness among both service providers and supervisors on importance of using equipment and protocol on all cases.*

6. *Sustained supervision, mentoring and support is needed to ensure nurses are using the taught knowledge and skills. When comparing the training received by the same nurses on TB and STI, the impact on improving STI management is far better and the main factor is the responsive proactive STI program coordinator.*

7. *It is important that managers be supported to stay in the post at least for two years to be able to implement activities and see achievement through.*

8. *A champion is needed to keep stakeholders focused on achieving. There are demands for action on many aspects of health care delivery in a rural district and managers cannot stop "fire-fighting" practices. The champion will handle the priority activity, bring stakeholders together and see activities through.*

9. *It is important to sustain the thrust of the commitment of province as when there is will and sustained support and championing from Province plans are implemented. Integration between Province and LG in health services is almost complete due to sustained provincial commitment and demands.*

10. *A lot of patience, understanding, mentoring and support was needed to create a team spirit through participatory processes and to allow people to acknowledge and understand their health system's strengths and weaknesses.*

11. *The spirit for free voluntary work is very poor and weakened further by the payment of stipend for the home based carers, that the clinic committee members are requesting incentives for their services. There is a need to look for alternative ways to incentives.*

12. *The joint collective inclusive process is important to sustain the functional integration efforts. Sustaining the presence of LG in the monthly regular district management meetings and the District manager in LG cluster meetings is important.*

13. *The HIV/AIDS is a priority program and there is need to ensure it is not a vertical program. District AIDS Plan did not receive the commitment for implementation support it needed.*

14. The attendance of the MEC Health and Provincial directors at some of the participatory meetings was very helpful in solidifying the team spirit as they stressed functional integration. This vocal political support was an important recipe for success.

15. The presence of chief professional nurses (CPN) on different levels of management (e.g. clinic manager, program coordinator, supervisor) affects their commitment to working together, especially when their appointment is not done in writing but communicated verbally in meetings. Effective management by such CPN depends on the formal written authority.

16. Clinic managers are overwhelmed with work at clinics and supervising and supporting NGOs and CBOs falls in the fringes of their priorities. There is a need for a concerted effort to keep the linkages between the NGOs and clinics nearest to them so as to ascertain the quality of services they provide in home based care.