DOCUMENTING GOOD PRACTICES
in Primary Health Care, KwaZulu-Natal

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DOCUMENTING GOOD PRACTICES
in Primary Health Care, KwaZulu-Natal

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral BCG (Bacille Calmette Guerin)
CCG	Community caregiver
CHC	Community Health Centre
CIMCI	Community Integrated Management of Childhood Illness
COPC	Community-oriented Primary Care
DHS	District Health System
DHIS	District Health Information System
DoE	Department of Education
DoH	Department of Health
DoSD	Department of Social Development
DOT	Directly Observed Treatment/Therapy
EDC	Educational Development Centre
EPWOP	Extended Public Works Programme
FOM	Friends of Mosvold
FPD	Foundation for Professional Development
HAST	HIV and AIDS, STI and TB
HCT	HIV counselling and testing
HCW	Healthcare worker
HIV	Human Immunodeficiency Virus
HODs	Heads of Department
HRH	Human Resources for Health
HST	Health Systems Trust
IDA	Initial Defined Area
IFCH	Institute for Family and Community Health
KZN	KwaZulu-Natal
M&E	Monitoring and evaluation
MDR-TB	Multidrug-resistant TB
MEC	Member of the Executive Council
MESAB	Medical Education for South African Blacks
MMC	Medical male circumcision
NGO	Non-governmental organisation
NHI	National Health Insurance
NIMART	Nurse-initiated Management of Antiretroviral Therapy
NSFAS	National Student Financial Aid Scheme
OPD	Outpatients Department
OSS	Operation Sukuma Sakhe
OVC	Orphaned and vulnerable children
PCA	Provincial Council on HIV and AIDS
PCR	Polymerase chain reaction
PHC	Primary health care
PIMD	Provincial Indices of Multiple Deprivation
PMTCT	Prevention of mother-to-child transmission (of HIV)
RTHC	Road to Health Card
RuDASA	Rural Doctors Association of South Africa
STI	Sexually transmitted infection
TB	Tuberculosis
UKZN	University of KwaZulu-Natal
UNICEF	United Nations Children's Fund
URC	University Research Corporation
VCT	Voluntary counselling and testing
WHO	World Health Organization
WOP	War on Poverty Programme
YDF	Youth Development Foundation
XDR-TB	Extensively drug-resistant tuberculosis
ZUMAT	Zululand Mission Air Transport

PREFACE

This booklet was originally ready for publication in January 2013 but, unfortunately, became enmeshed in the bureaucratic maze and never saw the light of day. However, its value in terms of knowledge-generation and motivational potential has not diminished – leading to a revival of interest in having it published, with the blessing of Dr ST Mtshali, KwaZulu-Natal Department of Health's Head of Department.

The booklet grew out of a Health Systems Trust project in KwaZulu-Natal Province in South Africa funded by The Atlantic Philanthropies. Recognising the presence of noteworthy health service interventions in the province depicting good practice and their capacity to stimulate innovation and empower healthcare workers on the ground, a decision was made to capture a selection of these and analyse them for themes that appear to contribute to their success. Such lessons could well serve to enhance the Minister of Health's current scaling-up of HIV and TB outputs in terms of the newly initiated UNAIDS 90-90-90 programme.

Readers should be aware that the long delay between this booklet being print-ready and being printed has some implications. None of the material has been updated for publication since its collation in 2012, meaning that some information could be dated. Some of the organisations behind the seven reported good practices might even have ceased to exist – and this would make for an interesting investigation on sustainability. The printed chapter will, nevertheless, serve as a permanent record of an inspiring story of good practice.

One of the original chapters – dealing with Operation Sukuma Sakhe (OSS) – has been removed prior to publishing this volume. When originally compiled in 2012, OSS was in its infancy and facing teething problems, but is now a completely different entity warranting its own story. The original chapter did not do justice to the rich tapestry of activities and benefits emanating from the current project. Just one example of this change is having leaders from other provinces making benchmarking visits to KwaZulu-Natal in preparation for setting up similar structures in their own provinces. Our aim is to capture and write up the OSS work in the field separately and, if the proposal is accepted by the Office of the Premier, to have the story ready by the end of 2016.

Health Systems Trust hopes that this collection of good practice stories will reach a wide and varied readership and encourage many to do greater things in providing health services to the people of our country.

Ms Ronel Visser
Director: Health Systems Strengthening
Health Systems Trust
March 2016

EXECUTIVE SUMMARY

The documentation and sharing of good practice has, on a global basis, been shown to stimulate and improve programme design and delivery. Without rigorous documentation of practices that work, despite the myriad challenges faced by implementers, there is little room for sharing experiences. The dissemination of such documentation serves as a springboard for diverse implementing bodies to replicate interventions that have proven effective elsewhere.

This study aimed to identify and document good practices within primary health care in KwaZulu-Natal Province, South Africa. The intention was not an evaluation of the selected good practices, but rather a process to document and share knowledge. The selection of the good practices was done in conjunction with the KwaZulu-Natal Department of Health. World Health Organization criteria were used as the basis for their identification.

Seven good practices were selected, as follows:

- Pholela Community Health Centre, Sisonke District
- Edzimkulu Community-oriented Primary Care, Sisonke District
- Mpilonhle Health and Education Programmes, uMkhanyakude District
- Sundumbili Community Health Centre, Ilembe District
- Mseleni Hospital PHC Outreach, uMkhanyakude District
- uMthombo Youth Development Foundation, uMkhanyakude District
- The Valley Trust Community Participation in Health, eThekwini District.

This current study employed a mixed-method approach, including a review of relevant policies and documents, interviews with relevant key stakeholders and programme staff, as well as observations of the selected practices. Qualitative and quantitative data analysis was employed in the generation of this report.

Common themes that emerged included: moving towards community engagement; individuals as champions of projects; the use of reflective practice; replicability and sustainability; the value of partnerships, and data monitoring and evaluation.

The project has highlighted several creative and constructive initiatives by people and organisations in the health sector in KwaZulu-Natal that have, and are still, contributing to improving health outcomes. Sharing knowledge widely can assist in replicating successful initiatives elsewhere without “reinventing the wheel”, in gleaning lessons to improve performance, and to avoid the mistakes of others.

BACKGROUND

THE NEED TO DOCUMENT GOOD PRACTICE

According to the World Health Organization (WHO) one of the significant barriers to knowledge-sharing and the re-application of experience is the limited culture of documenting and sharing information and knowledge. Although relevant knowledge may exist in people's minds, it is not always possible to tap it, or the knowledge may exist in a format that hampers people's ability to know it or find it. Decision-makers, health professionals and communities need to be able to find, use and share knowledge on experiences of what works and the lessons learnt.[1]

Documentation and sharing good practice has, on a global basis, been shown to stimulate and improve programme design and delivery and, based on lessons learnt, sustainability and outreach to a larger pool of beneficiaries, using the limited available resources.[2] In the past decade there has been an increased demand for the sharing of good practice in HIV and AIDS programming in the southern African region, including programmes addressing prevention, care, support, treatment and impact mitigation. Despite this, documentation of good practices and extensive sharing of these practices remains limited in the region.[2]

Whilst there is little doubt that successful programmes or models of practice exist within primary health care (PHC) in KwaZulu-Natal (KZN), these successes exist as islands of excellence in different parts of the province. Without rigorous documentation of practices that work, achieved despite the myriad challenges faced by implementers, there is little room for sharing experiences — thereby risking the loss of valuable experience gained through overcoming these challenges. The dissemination of such documentation would serve as a springboard for diverse implementing bodies to replicate interventions that have proven effective, or use aspects applicable to their own contexts.

DEFINING GOOD PRACTICE

According to Aidsnet, at its most basic, good practice suggests a simple maxim: Don't reinvent the wheel, but learn in order to improve it and adapt it to your terrain to make it work better.[3]

WHO, in the context of health programmes and services, offers a practical definition of a good practice as knowledge about what works in specific situations and contexts, without using inordinate resources to achieve the desired results, and which can be used to develop and implement solutions adapted to similar health problems in other situations and contexts.[3]

Over the past few years there has been debate over the choice between the terms "best practice" and "good practice". "Best" is difficult to define, especially when projects or programmes are implemented in different countries and contexts, with different objectives, different population groups, different opportunities and involving widely varying challenges in the cultural, political, socio-economic and resource environments. Many organisations have chosen to adopt the term "good" instead of "best" practice, thereby taking into consideration that one practice, while highly successful within one context, may not be replicable or successful in a different context.[2]

WHO, on the other hand, suggests that the use of the word "best" should not be considered in the superlative sense – the term "best practice" is not about "perfection" or the "gold standard".[1] Results can be partial and may be related to only one or more components of the practice being considered. As WHO states, documenting lessons learned on what does not work and why it does not work is also an integral part of "best practice" so that the same types of mistakes can be avoided by other programmes and projects.

In this study the term "good practice" was selected over "best practice", as the successes in PHC documented in this report have not been benchmarked against other practices attempting to achieve the same outputs or outcomes.

It is against this background that Health Systems Trust (HST) undertook a study of good practices in PHC in KZN. The study aimed to identify and document these good practices – benchmarking them would be the basis of separate study. Good practice in PHC is defined as activities that have enabled programme implementers to reach or surpass national targets in a particular area or for a specific health indicator, or that has enabled the health service to improve markedly on previous values for a specific health indicator. Since many weaknesses are still evident in areas where clear guidelines exist, a good practice did not have to be a novel one but could include marked success with the implementation of standard processes as prescribed in provincial or national policy.

HST hopes that this "good practice" report will highlight positive strides made in PHC delivery in KZN.

WHAT IS PRIMARY HEALTH CARE?

According to the Alma-Ata Declaration of 1978, PHC is defined as essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of development in the spirit of self-reliance and self-determination. PHC forms an integral part of a country's health system, of which it is the central function and main focus, and the overall social and economic development of the community. PHC is the first level of contact of individuals, the family and community with the national health system, bringing health care as close to where people live and work as possible, and constitutes the first element of a continuing healthcare process.[4]

The Department of Health[viii] (DoH) has adopted the PHC approach as the guiding principle for transformation of the health system in South Africa, along with the district health system (DHS) as the structural mechanism for transformation. The five pillars of PHC are:

- Equitable distribution of resources
- Community participation in decision-making
- A focus on preventive and promotive health services
- Appropriate (not necessarily low-cost) technology
- A multi-sectoral approach.[4]

RE-ENGINEERING PRIMARY HEALTH CARE

Despite relatively high levels of inputs (such as finances and human resources), health outcomes in South Africa remain below par[5]. In support of the health sector's contribution to the overall government strategy of *"A Long and Healthy Life for All South Africans"* the Minister of Health has a signed a performance agreement — the Negotiated Service Delivery Agreement — with the President wherein he commits himself and the nine provincial Members of the Executive Councils (MECs) to four main outputs:

- Increasing life expectancy
- Decreasing maternal and child mortality
- Combating HIV and AIDS and decreasing the burden of disease from tuberculosis (TB)
- Strengthening health system effectiveness.[6]

Following a ministerial and MEC visit to Brazil in May 2010, the Minister returned with a vision for the re-engineering of PHC and established a small team to develop a South African model to strengthen PHC. This team's narrative document was adopted by the National Health Council in November 2010, with the caveat that the South African model be based on the ward system as had been started in KZN.[7]

After debate in the National Health Council and in discussion with the Minister, a three-stream approach to PHC re-engineering was adopted by the DoH. The three streams are: deployment of a ward-based PHC outreach team for each electoral ward; strengthening school health services; and deployment of district-based clinical specialist teams with an initial focus on improving maternal and child health.[7] The re-engineering process does not detract from the need to strengthen the DHS, which remains the institutional vehicle for the delivery of PHC and district hospital services in the country. Pillay and Barron recognise that these re-engineering interventions must take place within the context of strengthening the DHS, which includes: strengthening planning and budgeting at district level; strengthening community participation; strengthening inter-sectoral collaboration; strengthening the functionality of district hospitals; strengthening the district management teams and their ability to plan; and support implementation, through among other things supportive supervision at all levels, as well as monitoring outcomes.[8]

viii In this report the Department of Health is the national body established in terms of the National Health Act, while the nine provincial health departments are identified by prefixing the Department of Health with the province's name (e.g. KwaZulu-Natal Department of Health)

KWAZULU-NATAL PROFILE

According to Statistics South Africa the population estimates for mid-year 2011 are as follows:

Population	Approximately 10.8 million
Percentage share of the total population in SA	21.4%
Area	92 100 km^2
Life expectancy at birth for males	48.4 years
Life expectancy at birth for females	52.8 years
Population <15 years	34%
Population 15-64 years	62%
Population ≥60 years	7%

KwaZulu-Natal's current population of 10.8 million people[9] represents the second-highest population and population density in South Africa. KZN also has the highest population under one year with nearly a quarter of all infants living in South Africa.[10]

Approximately 54% of the population live in rural areas, while approximately 10% of the urban population live in under-developed informal settlements. As a result of under-development and non-availability of essential resources (necessary to maintain health) these areas experience significant health and service delivery implications.[9] The province is divided into 50 municipalities, a metropolitan district and 10 health districts as represented in the Figure 1.1.

Socio-economic profile

According to the *District Health Barometer: 2010-2011* the 10 most deprived districts in South Africa fell within three provinces, namely KwaZulu-Natal, Eastern Cape and Limpopo, with households living on less than R800 per month ranging between 63% and 82% in 2006.[10]

Disease profile

Preliminary results of the KZN Burden of Disease study[9] indicate that the province has the highest disease burden related to hypertension (12.4%), followed by TB (9.9%), respiratory illnesses (9.4%), upper respiratory tract illnesses (5.4%) and HIV (5.0%). In 2009 the HIV and syphilis prevalence survey revealed that KwaZulu-Natal has had the highest HIV prevalence in the country of 39.5%.[10] KZN had the highest number of TB cases of all provinces for a number of years with 27 913 new smear-positive cases in 2001 and a high incidence of multidrug-resistant and extensively drug-resistant TB.[10] Together, TB and HIV account for the greatest burden of disease in KZN at 33.3% of years of life lost.[10] Nine of KZN's 11 districts have both the highest incidence of TB and the highest proportion of patients, both screened and diagnosed for HIV, in the country.[10]

Primary health care expenditure

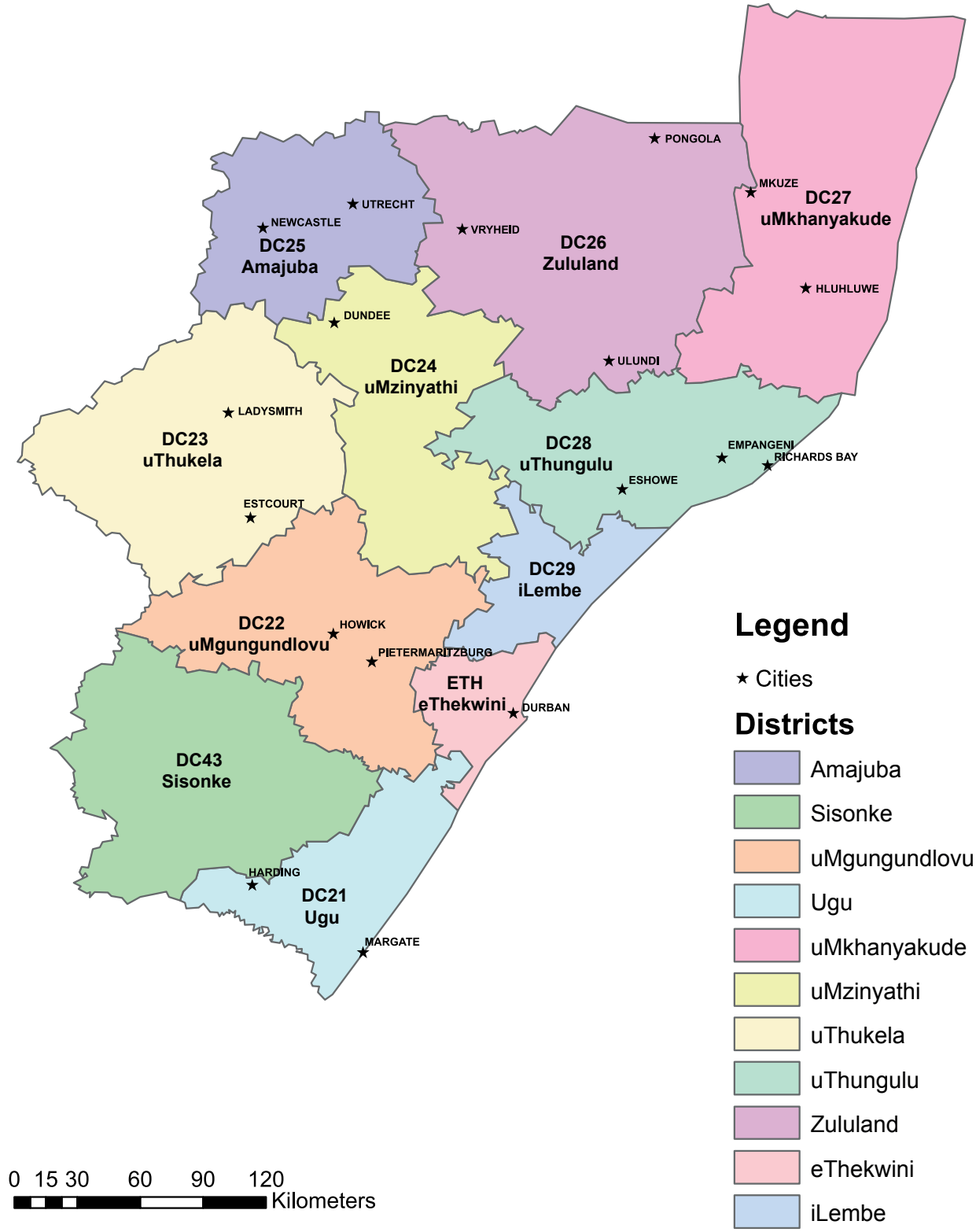
According to the *2010/11 District Health Barometer*, KZN's PHC expenditure per capita of R1 140 places the province fourth-lowest in relation to other provinces in the country. PHC facility utilisation rate in KwaZulu-Natal is currently 2.4 visits per person per year in 2010/11 – above the national average of 2.3.[10]

Provincial health priorities

The KZN health department's Strategic Goals for the next five years take cognisance of the DoH 10-Point Plan, the Medium-term Strategic Focus priorities and the province-specific health needs. They include:

- Overhauling the provincial health services, including rationalisation of health services, revitalisation of PHC, improving governance, strengthening management capacity, eliminating bureaucracy and decentralising delegations and accountability
- Improving the efficiency and quality of health services, including implementing the National Core Standards for Quality towards health facility accreditation, improving patient care, satisfaction and safety, and beginning to prepare facilities for the forthcoming National Health Insurance (NHI)
- Reducing morbidity and mortality due to communicable diseases and non-communicable conditions and illnesses and implementing an appropriate response to the burden of disease
- Improving infrastructure development which lags behind other provinces, with a little over 70% of the population having access to piped water.[11]

Figure 1.1: KwaZulu-Natal Health Districts



Source: Municipal Demarcation Board. Date created: 29 June 2016

AIMS AND OBJECTIVES OF THE STUDY

The Good Practice project aimed to identify and document good practices within primary health care in KwaZulu-Natal.

The specific objectives of the project were to:

- Identify current good practices within PHC in KwaZulu-Natal
- Identify successes achieved by the practices
- Identify the implementation challenges of the practice and local solutions in response to these challenges
- Identify lessons learnt from these practices that can be replicated in other settings.

The current study did not evaluate the selected good practices, but rather facilitated the process of documenting and sharing knowledge.

METHODOLOGY

HST conducted the study with funding from The Atlantic Philanthropies and with support from the KZN DoH. The project began in December 2011 and was completed in November 2012. The KZN DoH PHC task team was consulted at various stages in the study, and the KZN DoH Provincial Co-ordinators were integrally involved in the identification of the good practice sites and instrumental in facilitating the process of documentation in the various KZN health districts.

In general the study methodology has included:

High-level consultation meetings: HST participated in two stakeholder meetings with key executives at the KZN DoH in November and December 2011 where the scope of the project was refined.

Literature reviews: The research team reviewed (i) relevant PHC re-engineering policies and documents to ascertain the policy mandate, and (ii) reports and documents detailing current methodologies in identifying good practices.

Identification and selection of good practices: Good practices were selected in conjunction with the KZN DoH PHC task team. The task team consisted of representatives from the University of KwaZulu-Natal (UKZN) School of Public Health and Medicine and Centre for Rural Health, as well as district managers, who were commissioned by the Department to develop a framework for the implementation of the PHC Re-engineering Strategy. Through these discussions, extended by snowball methods and web-searches, the researchers identified a diverse range of PHC practices in the province.

The following documents were chosen to develop a framework and set of criteria for the selection of PHC good practices:

- WHO Guide for Documenting and Sharing "Best Practices" in Health Programmes. Brazzaville, 2008
- SAfAIDS. HIV and AIDS Documentation and Communication Skills: A Focus on Best Practices - A Course Handbook 2008

For the purpose of this study, the WHO criteria outlined in Table 3.1 were used to guide the final selection of PHC good practices. According to WHO, a best practice need not meet all the criteria but can be anything that works to produce results without using inordinate resources, in full or in part, and that can be useful in providing lessons learnt. For a practice to be included in the current study, it had to fulfil the first four criteria (effectiveness, efficiency, relevance and sustainability), together with one or more of the other criteria.

Table 3.1: Criteria used for selecting good practices for this study

Criteria	Definition
1. Effectiveness	The practice must work towards and achieve results that are measurable.
2. Efficiency	The practice must produce results using a reasonable level of resources and time.
3. Relevance	The proposed practice must address one or more priority health problems as identified by the provincial Department of Health.
4. Sustainability	The proposed practice must have been implemented over a long period of time (two or more years) without the injection of additional resources.
5. Ethical soundness	The practice must respect the rules of ethics for dealing with human populations and data, information and resource management.
6. Possibility of duplication	The practice must have the potential to be replicated elsewhere in the country.
7. Involvement of partnerships/ multi-sectoral collaboration	The practice could involve a satisfactory collaboration between several stakeholders, different government departments, civil society and private organisations.
8. Community involvement	Where relevant, the practice must involve participation of the affected communities.
9. Political commitment	The practice must have the support of provincial Department of Health as well as other relevant regulatory bodies/task teams.

Fieldwork: Researchers selected seven projects using the above criteria and conducted fieldwork in each to determine their structural and functional characteristics and to gather details of their history. A semi-structured questionnaire was

developed to systematically interrogate organisational features of each project in terms of the WHO Building Blocks, thus allowing the researchers to document salient organisational features contributing to each project's success.

Mixed data collection methods were used during fieldwork, including a review of relevant policies and documents, interviews with relevant key stakeholders and programme staff, as well as observations of the selected practices. Both qualitative and quantitative data were collected for the documentation process.

Analysis: A qualitative, thematic analysis of the data was undertaken. The emergent themes were supported by quantitative data and literature, thus validating the results through triangulation. To ensure data accuracy and relevance, the profiles of each practice were validated by healthcare professionals external to HST who demonstrated experience in the relevant fields.

Reporting: Each selected good practice was documented using mainly the descriptive information collected from interviews and direct observations of the practices.

Profiles on each of the seven selected PHC good practices follow this introductory chapter, arranged in the following order:

- Pholela Community Health Centre, Sisonke District
- Edzimkulu Community-oriented Primary Care, Sisonke District
- Mpilonhle Health and Education Programmes, uMkhanyakude District
- Sundumbili Community Health Centre, Ilembe District
- PHC Outreach, uMkhanyakude District
- uMthombo Youth Development Foundation, uMkhanyakude District
- Community Participation in Health, eThekwini District.

REFERENCES

1. World Health Organization. Guide for Documenting and Sharing "Best Practices" in Health Programmes. Brazzaville: 2008. Available from: http://afrolib.afro.who.int/documents/2009/en/GuideBestPractice.pdf [Accessed 18 March 2012].
2. SAfAIDS. HIV and AIDS Documentation and Communication Skills: A Focus on Best Practices - A Course Handbook. May 2008. Available from: http://safaids.net/files/u1/HIV_AIDSBestPracticeGuidebook.pdf [Accessed 18 March 2012].
3. Aidsnet. Manual on Best Practices - HIV/AIDS Programming with Children and Young People. 2007. Available from: http://aidsnet-en.ngoforum.dk/index.php?option=com_content&view=article&id=235&Itemid=217 [Accessed 18 March 2012].
4. Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. Available from:http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf [Accessed 18 March 2012].
5. Pillay Y. PHC re-engineering in South Africa: are we making progress? PHASA Newsletter [serial on the Internet] 2012; February 2012. Available from: http://www.phasa.org.za/articles/phc-re-engineering-in-south-africa-are-we-making-progress.html [Accessed 18 March 2012].
6. Office of the President. Republic of South Africa. Delivery Agreement for Output 2: A Long and Healthy Life for All South Africans. Available from: http://www.thepresidency.gov.za/MediaLib/Downloads/Home/Ministries/DepartmentofPerformanceMonitoringandEvaluation3/TheOutcomesApproach/Health%20Sector%20NSDA.pdf [Accessed 18 March 2012].
7. Barron P, Shasha W, Schneider H, Naledi T, Subedar H. Re-engineering Primary Health Care in South Africa: Discussion document. 2010. Available from http://www.phasa.org.za/wp-content/uploads/2011/11/Pillay-The-implementation-of-PHC.pdf [Accessed 23 August 2012].
8. Pillay Y, Baron P. The implementation of PHC re-engineering in South Africa. PHASA Newsletter [serial on the Internet]. November 15 2011. Available from: http://www.phasa.org.za/articles/the-implementation-of-phc-re-engineering-in-south-africa.html [Accessed 23 August 2012].
9. Statistics South Africa. Mid-year population estimates 2011: Pretoria: 2011 Available from: http://www.statssa.gov.za/publications/P0302/P03022011.pdf [Accessed 23 August 2012].
10. Day C, Barron P, Massyn N, Padarath A, English R, editors. District Health Barometer 2011. Chapter 4: Outcome Indicators. pg 85-100. Health Systems Trust; Durban: 2011.
11. Department of Health. The National Strategic Plan on HIV, STIs and TB 2012-2016. 2011. Available from: http://www.doh.gov.za/docs/stratdocs/2012/NSPfull.pdf [Accessed 31 May 2012].

SISONKE DISTRICT

PHOLELA COMMUNITY HEALTH CENTRE

The Pholela Community Health Centre was the birthplace of the community-oriented primary care approach. Pholela developed from the pioneering work of Sidney and Emily Kark. In this model, primary health care services to the community were informed by defining and characterising the community, describing healthcare problems and modifying programmes to address priority needs, and supported by effective monitoring of all activities. Although the Pholela Community Health Centre no longer shows evidence of the original activities, this model has become a foundation for primary health care worldwide.

DESCRIPTION

Drs Sidney and Emily Kark
Source: Social Medicine: http://www.socialmedicine.info/index.php/socialmedicine/issue/view/3

The Pholela Health Centre, in the Sisonke District, was set up in April 1940 by Sidney and Emily Kark. The Pholela Health Centre model was the forerunner to community-oriented primary care (COPC) and helped define and inform the concept of primary health care (PHC).[1]

The Pholela Health Centre (at the time named the Pholela Health Unit) was set up by the Ministry of Health to function independently of any existing government health service. As the first centre of its kind, it enjoyed considerable freedom of operation, with little need to conform to any district or regional health authority. The original task of the unit was to combine curative and preventive services into a comprehensive community-based package. Pholela utilised population-based investigations to inform the provision of health services and incorporated health education and health promotion as essential elements of the health delivery system.[2]

The unit worked in collaboration with local authorities, including agriculture and education. The Karks were joined by a trained medical aide graduate (a form of health auxiliary), Edward Jali, and a nurse, Amelia Jali, and later four health assistants. Training of the assistants focused on basic subject matter and supervised field experience. Training covered a range of subjects, including physiology, infectious diseases, nutrition, family health and health promotion. The importance of understanding local concepts of health and disease was stressed, along with methods of health education.

In 1942, Dr Sidney Kark was appointed technical advisor to the then newly established National Health Services Commission. The Commission, led by Dr Henry Gluckman, was tasked with advising on the establishment of a National Health Service capable of providing adequate health services to all sections of the South African population. Gluckman envisaged a countrywide National Health Service funded through taxation and available to all sections of the people of South Africa. The envisaged national health system would be based on a network of PHC centres adapted from the Pholela model. The Commission sought to establish a comprehensive health service, with the health centre serving as the primary unit in the delivery of integrated health care. By 1949, 44 affiliated health centres were established throughout South Africa. Medical officers and other staff appointed to the newly created health centres were first sent to Pholela to gain experience in health centre practice and to study the methods that evolved there. In 1946 Dr Sidney Kark established the Institute of Family and Community Health to teach and conduct research in community health practices. The institute became part of the Department of Social, Preventive and Family Medicine at the University of Natal a few years later.

In 1948 the National Party came to power in South Africa. State funding was withdrawn and all 44 centres were closed or converted to provincial outpatient clinics over the next 10 years, often without warning or consultation with the local community. The Karks left South Africa in 1959 to develop COPC further in Israel, also establishing a training centre for COPC in Israel. At Alma-Ata (in 1978) WHO and UNICEF endorsed a

policy of COPC and in the 1980s renewed interest arose in South Africa. In 2001 the then national Minister of Health, Dr Nkosazana Dlamini-Zuma, oversaw the launch of the new Pholela Health Centre. The new Pholela Community Health Centre (CHC) was built with the assistance of international donors, and officially opened on 21 April 2001. The Pholela CHC serves the people of KwaHlanganani and surrounding areas, up to Donnybrook, with a catchment population of about 18 000. Two mobile teams visit about 20 points monthly. Pholela CHC abides by the Patients' Rights Charter and the Batho Pele Principles.[3]

Objectives of COPC as developed at Pholela

Vision and mission

Pholela CHC's vision is to be a leading provider of optimal community-orientated primary health care in KwaHlanganani. This vision is supported by the CHC's mission, which is to provide an effective, efficient and integrated primary health care service for the community of KwaHlanganani through a community-orientated primary health care system.

Community-oriented Primary Health Care (COPC)

The main contribution of the Pholela Health Centre was the development of the COPC model. The elements of COPC as originally developed by Kark include:

COPC is a community, family and personal practice:

- This necessitated the definition of "community", which was initially "households bounded geographically". Second, practice is not only **in** a community and **for** a community, but **with** a community.

COPC requires multidisciplinary and team practice:

- As community needs cannot be met by a single profession, teams included a health educator, doctors, nurses, social workers, laboratory technicians and others, who all had to learn new disciplines including sociology, psychology, epidemiology and public health.

COPC on effective monitoring, evaluation and research:

- A census enabled the establishment of records that linked family and persons to health facilities. This provided baseline data for outcomes measurement and allowed the design of customised research studies. Monitoring and evaluation were continuous processes informing the programme strategy and activities.[4]

In 1982, the Institute of Medicine conference defined COPC operationally as:

- A primary care practice providing accessible, comprehensive, co-ordinated, continuous and accountable healthcare services
- A defined community including geographical or social communities, groups in the workplace, church or school or persons enrolled in a common health plan (but excluding active patients in a practice)
- A process with the following four steps:
  - Defining and characterising the community (including a community health assessment survey that measures health status, demographic, behavioural and environmental characteristics)
  - Describing the community's health problems
  - Modifying the healthcare programme to address high-priority health needs
  - Monitoring the effectiveness of the programme.[5]

Currently, the modern COPC concepts include:

- Comprehensive primary care within a defined community
- Community health needs assessments
- Systematic approach to health problems
- Recording results
- Multidisciplinary teams.[5]

The definition of a community in the COPC model has been debated over time. However, in general and in the Pholela context, it refers to a geographically defined community.

Structural features

Pholela is acknowledged internationally as the site where the COPC concept was successfully initiated and put into practice. The late Dr Sydney Kark introduced the COPC approach to deal with the health needs of the community. In this approach the community's health needs became known to the healthcare workers through community surveys that included mapping of areas; understanding the culture, beliefs and habits of the community; and determining socio-economic status as well as prevalent conditions. Through COPC, communities started taking care of their own health. The health workers conducted home visits and gave health education to families and the community.

Service delivery

Service delivery initially and currently is based on "community diagnosis" and focuses on all social and environmental aspects, rather than just health issues.[6]

Services provided by the original Pholela Health Centre

Initial activities of the centre included:

Above (left to right): Mobile clinic services; consultation with a Sister; home garden planted by a person who is disabled; a facilitator giving a health talk to the community

- Meetings with community leaders such as chiefs, elders and teachers to explain the purpose of the proposed work
- Establishment of a general clinic, open to all, in a disused farm building
- Control of infectious disease outbreaks notified by the magistrate or district surgeon (including smallpox, typhoid and typhus fevers) and family diseases (such as tuberculosis and leprosy)
- Health and nutrition surveys of school children in consultation with their teachers
- Immunisation programmes
- A maternal and child health programme
- Development of sub-centres in the Pholela District
- Community surveys of health-relevant activities with detailed feedback to the health team.

Initially, five community caregivers (CCGs) worked on communicable disease control and community health education. Each CCG was responsible for 4 000 to 5 000 people. During weekly staff meetings it became evident that more information regarding the home circumstances of community members was needed. Two innovations were introduced:

An initial defined area (IDA) was established. This comprised 130 households (900 individuals) for intensive study and service.

A household health census was done by the CCGs.

After a year, a review of findings clearly demonstrated improved health status in the IDA. Each year the IDA was extended until it covered 30% of the total population. This expansion also provided the opportunity to compare areas with different periods of service provision. Family health records (index cards) were designed to correlate clinic and field data.

Current services

The original Pholela Health Centre currently functions as a health clinic with additional projects that follow the COPC principles, including a tuberculosis (TB) project, micro-lending schemes, and projects focusing on people with disabilities, children and the elderly. It does not, however, currently serve as a model for COPC in the manner in which it was initially established.

↳ Tuberculosis

During 2006 it was noted that the defaulter rate was very high and the Department of Health responded by initiating Directly Observed Therapy (DOT) support. Pholela wanted to *"meet them half-way, by going to their homes"* and initiated the use of CCGs in the community.

Services currently offered by the Pholela Centre include TB education and screening. The CCG and TB community health workers mobilise people to test. Awareness-raising includes campaigns, door-to-door and home visits, and events at the clinic. Primary care is linked to treatment. During outreach events, TB education is provided (including information on signs and symptoms of TB), specimens are collected for testing and patients are informed on when the results will be available. Follow-up is done after the results are received. All TB activities are linked to HIV testing and education, or with TB education and testing done with HIV treatment. Other TB services provided at the clinic are Bacille Calmette Guerin (BCG) immunisation of children and TB education for traditional health practitioners.

TB health workers (tracers) conduct home visits to assess hygiene, encourage home vegetable gardens and enhance adherence to medication. Patients are

> *"There was health promotion; preventing and promotion.... At the clinic there was this thing that we did that was called animal husbandry. We had a fridge for vaccines for cows, because a person would come to you, and you would be asking how they are doing and they would tell you about their unwell cow. So you must cater for that before you can even talk about anything else. Addressing need was one thing that was important at that time; that is I cannot teach you anything before fixing the need that is bothering at the time - then we can agree on something else."*
>
> *(Former Pholela Health Centre Facility Manager)*

encouraged to network with CCGs, who will then provide DOT support for the person and regularly check for side effects. CCGs can also recruit and educate a household or community member to provide DOT support.

↳ Early Childhood Education and Crèche

The Early Childhood Education project started in 1994. A crèche was established in that year and continued unfunded until 2010 when it obtained funding from the Department of Social Development. It is now functioning with two teachers, an assistant teacher and a gardener. The crèche was started after an incident where a child was injured by a stray donkey, which raised concerns about the safety of children left at home when their mothers go to work in the fields. Older persons visit the crèche and narrate stories.

Education on issues such as HIV transmission is provided to the children and they are monitored (although informally) for growth. Feedback is given informally to the parents.

↳ Protective Workshop for the Disabled

The Practical Protective Workshop for the Disabled started in 2000. People with various disabilities are included in this project, including physical and mental disability and disabilities emanating from illnesses such as HIV. There are five home-based care workers taking care of 25 people. Income-generating projects (including weaving and making door-stoppers) have been initiated, as well as gardening and social events during which the people participating in the projects discuss challenges that they face on a day-to-day basis.

Resource use

Apart from the clinic staff, the TB project employs professional nurses, staff nurses and counsellors. There are five home carers working with the people with disabilities and a CCG working with the elderly. There are also two teachers, an assistant teacher and a gardener.

A clinic committee provides the link between the community and the clinic. The clinic committee discusses challenges and achievements in the meetings and with support staff (including accommodation).

Health information management

One of the principles of the original Pholela COPC system was to carry out social, behavioural and epidemiological investigations. Ongoing measurement and evaluation of programmes allowed for measurement of changes in community behaviour and health status. A records system was essential for this task. The health information system included demographic information (population, pregnancies, deaths and migrations), determinants of health (social structure, work and social activities, seasonal dietary surveys, housing and environment, and utilisation of health services) and health and morbidity data.

Currently the monitoring efforts include notebook entries by the CCGs that are consolidated monthly into a report. Community surveys are conducted, but the content is less structured and informative than in the early days of Pholela. True community diagnosis, as done during the early days, is missing. The Road to Health cards (RTHC) are interpreted by the CCGs but they are not able to record data on the cards as they do not have the equipment to do measurements, such as weight. They do, however, encourage immunisation if they notice that this is not up-to-date and they refer patients to the clinic (with a written referral note) when suspicious symptoms are observed.

Funding and partnerships

Funding

When it started in 1940, the Pholela Health Unit was funded from government sources. The current Pholela CHC is also government-funded.

The Department of Social Development (DoSD) funds the Protective Workshop for the Disabled project and the Crèche. The Department of Agriculture supplies the project with seedlings and gardening tools.

Partnerships

As in the original model, partnerships are still considered key to COPC. As a government clinic, the Pholela Health Centre is closely linked with the KZN DoH. Other state departments involved include the Departments of Social Development and Agriculture. A collaboration is planned with the Medical School of the University of KwaZulu-Natal. Other partnerships include TB Care and a working relationship with Edzimkulu, an NGO using the COPC approach successfully to provide services to the community. The Catholic Medical Mission Board assists with medical male circumcisions (MMC) and the Turntable Trust provides a venue for the CCGs to meet.

Community participation is encouraged through imbizos.

↘ Sustainability and possibility of replication

Pholela's key strength lies in the adaptability of the model for different contexts. The original Pholela model and the COPC approach has been adapted and developed by practitioners elsewhere, especially in Israel, the USA, Canada, several countries in Africa, Asia and Latin America, as well as in Spain and the UK. Although the model is time- and labour-intensive, its global recognition suggests that the investment necessary to partner with the community, using healthcare workers to support the community involvement, is both realistic and desirable.

The historical events at Pholela, subsequent local and international developments, and the adaptability of the model demonstrate that the Pholela site demonstrates a good practice model that can inform and contribute meaningfully to the current re-engineering of PHC.

SUCCESSES

- ✓ Pholela Health Centre, through the many health practitioners who worked there, has set an example of health centre practice that combines primary medical care with community outreach. This approach, later termed COPC, was regarded by senior administrators of the National Department of Health as the model to be followed in the future development of South Africa's health services. In 1945 the original Health Centre Advisory Committee, following the government's acceptance of the National Health Service Commission's recommendations on the development of health centres, decided to establish the Institute of Family and Community Health (IFCH) in Durban. In 1954 the IFCH was affiliated to the Natal University Medical School and IFCH staff members constituted a newly established Department of Social, Preventive and Family Medicine. Medical students were required to do clinical clerkships in the IFCH centres, along with systematic courses in family and community health, epidemiology and health education. This illustrated the successes in training local healthcare workers and of collaborating with academic institutions that offered practical training for students. Unfortunately, by 1960, the Department of Social, Preventive and Family Medicine of Natal University Medical School had been closed.

COMMUNITY IMBIZO

> *"A mini imbizo was called in October to hear from the community what had happened and all the services were marketed to the community. The community had a chance to say what they were not happy about and our side is addressed at the same time; people were encouraged to come back. There is a difference in stats now that we had the imbizo, so we can say that going out to the community has made a difference."*
>
> *(Pholela Clinic Representative)*

- ✓ Through the 1960s and 1970s, the strengths of COPC were recognised and the work at Pholela contributed significantly to the international body of experience that was formalised in 1978 in the Alma-Ata Declaration on Primary Health Care. The National Health Plan (presented in 1994) drew much of its inspiration from the country's early COPC experiences.[7]
- ✓ One of the key elements of the Pholela model is the use of data for continuous monitoring and evaluation. Early evidence of success includes the following examples:
  - A decline in syphilis incidence of 60% (from 5.8% to 2.3%) between 1945 and 1949
  - Scabies among schoolchildren declined from 82% (1942) to 7.8% (1950)
  - Between 1941 and 1950 not only did the number of households cultivating vegetables increase, but also the variety of vegetables
  - Pregnant mothers who attended nutritional education classes increased from only a few in 1942 to 90% of all pregnant women in 1950
  - During 1941/42, 10 to 15 cases of kwashiorkor (malnutrition) were reported per week while during 1950, 15 cases were seen during the whole year
  - The crude mortality rate per 1 000 declined from 38.3 in 1942 to 13.6 in 1950
  - Infant mortality declined from 275 per 1 000 (1942) to 101 per 1 000 (1950), this in a larger area, and to 86 per 1 000 in 1956.

CHALLENGES

➘ Challenges in establishing the original Health Centre

When the original Pholela Health Centre was established, some suspicion and resentment arose among chiefs, indunas and the local people, as they felt that they were not consulted about the purchase of the land and the appointment of outsiders as community workers. There was also objection to what they felt was "spying" by health assistants who visited homes, rather than allowing the community the choice to access health care when they wanted to.

The Centre embraced these challenges as a learning experience and responded by appointing local community members at the clinic (including CHWs, an administration clerk and a health recorder). Frequent meetings were held with representatives from different groups (teachers, women's groups and community elders). The appointment of Mrs Margaret Shembe (a prominent community figure) led to the establishment of "preschool child centres" which served as nutritional, education and feeding centres.

Challenges in maintaining the original Centre

The political situation in South Africa influenced the development of PHC and specifically the developing network of health centres during the 1940s. External funding (as with all COPC models) was a critical factor. In the social-political context of the apartheid era, both funding and political goodwill were withdrawn from this highly successful model.

The need to train professionals in a well-established COPC environment was recognised as necessary, but this proved difficult to incorporate into conventional medical training. Training in the original Pholela Clinic included two distinct modes:

- Multi-disciplinary teams of healthcare providers were formally trained in non-traditional, non-clinical subjects (e.g. epidemiology, survey methods, health promotion, nutrition) in university centres
- On-site training of non-professional community members and professionals from a variety of professions.

It seems that Pholela is currently functioning as a conventional clinic with some projects and aspects related to the original COPC approach practised at the CHC.

LESSONS LEARNT

The key lesson learnt from the COPC model is that the traditional separation of curative and preventative/ promotive services is inappropriate. Furthermore, the focus of PHC should be on the health status of the community, rather than of the individual.

A key learning from the original Pholela Health Centre was the importance of holding weekly team conferences ("epidemiology-in-practice" sessions) that allowed for exchange of information by all team members. These meetings provided an opportunity for reflective discussion and adaptation of practice.

Certain key concepts, arising from Pholela and refined by later experience, have emerged as central to COPC practice – aspects that should be revisited for future developments towards establishing ward-based PHC outreach teams. Briefly, these are:

- The link between diagnosis and treatment of individual patients and an approach that views the community as the 'patient'
- Recognising that several conditions may be interrelated and geographically clustered among the practice community led to the concept of a "community syndrome".

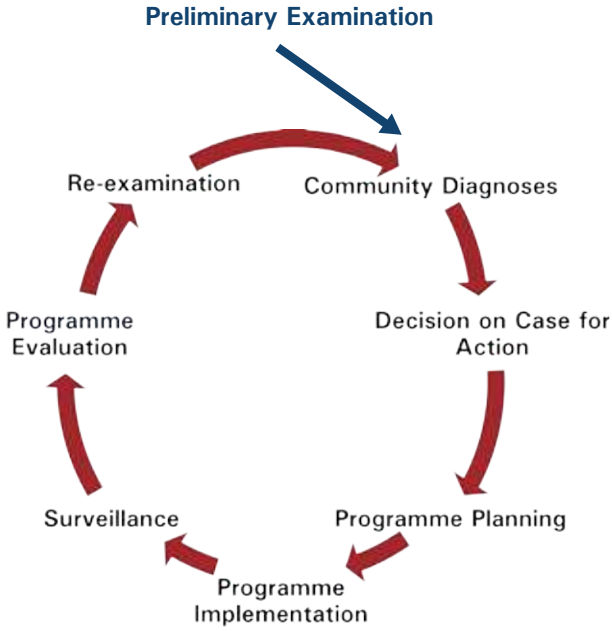
The development of COPC is a cyclical process (see Figure 4.1), similar to the planning cycle, in which "activities are continuously influenced by a feedback of epidemiological and other information".

Knowing the community well (through household registration and surveys) allowed the practice to plan services appropriately.

The COPC framework is widely adaptable. Suitably modified, COPC has been introduced with encouraging results to communities of widely differing social, cultural and economic status.

The importance of individual champions is clearly illustrated by the development of Pholela and the COPC model. These individuals do, however, leave a gap that is difficult to fill when they leave. Individuals with innovative ideas, passion and experience should be nurtured and a clear succession plan developed, including full documentation of relevant practices. This will prevent projects and programmes deteriorating when champions are no longer available to lead the projects.

Figure 4.1: Diagrammatic representation of COPC's cyclical process[1]



The COPC model as practised in Pholela in the 1950s has valuable lessons for current strategies. The use of multi-disciplinary teams, household registrations (and updated census information) and other activities could assist in the development of activities throughout KZN. The COPC model has specific applications in the re-engineering strategy. For example, the three streams of the PHC Re-engineering Strategy are all included in the Pholela COPC practice, namely: a ward-based PHC

outreach team; strengthening school health services; and district-based clinical specialist teams with a focus on maternal and child health.

AWARDS AND RECOGNITION

In 2007 and 2008, Pholela CHC won the Departmental Service Excellence Silver Award where the facility was recognised for its commitment to service delivery and excellence in line with Good Governance and Batho Pele Principles, in realisation of the Department's vision, mission, core values and standards of care.

Departmental Service Excellence Silver Award (Photo by researcher during fieldwork)

Izandla Eziphephile (Safe Hands) Award (Photo by researcher during fieldwork)

In November 2010 the maternity section of Pholela CHC was presented with the Izandla Eziphephile (Safe Hands) award for being competent and safe in rendering maternal and child care.

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REFERENCES

1. Tollman S.M. The Pholela Health Centre - the origins of community-oriented primary health care (COPC): An appreciation of the work of Sidney and Emily Kark. South African Medical Journal. 1994(84):653-8.

2. Kautzky K, Tollman S.M. A perspective on Primary Health Care in South Africa: Primary Health Care in context. South African Health Review. 2008:17-30.

3. Business Plan for the COPHC project at Pholela Community Health Centre in Bulwer 2011-2013.

4. Susser M. Pioneering community-oriented primary care. Bulletin of the World Health Organization. 1999;77(5):436-8.

5. Longlett S.K, Kruse M.S, Wesley R.M. Community-oriented primary care: historical perspective. Family Practice and the Health Care System. 2001;14(1):54-63.

6. Kark S.L, Cassel J. The Pholela Health Centre: a progress report. South African Medical Journal. 1952(26):101-36.

7. World Health Organization. Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, U.S.S.R, 6-12 September 1978. Geneva: 1978.

SISONKE DISTRICT

EDZIMKULU COMMUNITY-ORIENTED PRIMARY CARE

Edzimkulu is a non-governmental organisation working at Ndawana, uMzimkhulu Local Municipality, in the Sisonke District in southern KwaZulu-Natal. Edzimkulu uses a community-oriented primary care approach that involves the community at all levels of health care. Community mapping and surveying allow for tailor-made services and interventions. Their work is aligned with the PHC Re-engineering Strategy and the Community Caregiver Framework for Home-based Community Care.

DESCRIPTION

Established in May 2003, Edzimkulu is both a Canadian charity and registered South African NPO dedicated to providing support to children and adults impacted by HIV and AIDS in the Underberg area of KwaZulu-Natal (KZN). While Edzimkulu's clinic in Ndawana remains the focal point of their healthcare efforts, their work has expanded to a much larger area. The name Edzimkulu is a combination of the names Edmonton - the home city of the organisation's founders, Chris and Jim Newton - and uMzimkhulu, a major South African river in the catchment of which Ndawana is located. One of Edzimkulu's principal goals was to forge a long-term relationship between the greater Edmonton community and the communities where Edzimkulu works. The name signifies this connection.

When considering its establishment, the Edzimkulu founders recognised that access to patient-centred tuberculosis (TB) and HIV care in rural communities in South Africa was problematic because:

- the health system was not an integral part of the community;
- community caregivers (CCGs) were not recruited from local communities;
- training and supervision of CCGs was inadequate;
- linkages between clinic and community was poor;
- transport to hospital for extremely ill people was lacking; and
- systems to monitor and evaluate the CCGs work were poor.

When Edzimkulu began its work, Ndawana was a community of approximately 4 000 people. Health care was restricted to a mobile clinic that visited occasionally,

with the nearest clinic 50 km away and the nearest hospital 100 km away. Edzimkulu's vision for Ndawana was a community where the reality of HIV and AIDS is accepted and dealt with in an open, compassionate and non-stigmatised way, with healthy children and adults, an economic base enhanced by accessibility to government programmes, a strong system of education and many partners, including government agencies.

SERVICE DELIVERY

Objectives

A community-oriented primary care (COPC) framework for the delivery of primary health care (PHC) is based on the healthcare problems of the community that the practice serves. Edzimkulu's objective was to develop a COPC model in Ndawana using local solutions to address the challenges of integration, poverty and lack of basic service delivery.

Edzimkulu's philosophy dictated that a strong relationship be developed with local government agencies since

the organisation aimed to work itself out of a job within 10 years, leaving the community in a more sustainable situation than when the organisation arrived.

Strategies to achieve objectives

Edzimkulu's major strategies to build an integrated community/facility service included community consultation, developing community solutions, up-skilling CCGs to provide local services, retention of CCGs through offering remuneration, and provision of transport to the hospital for extremely ill people.

Edzimkulu began its work with the construction of a 450 m^2 four-building clinic and community centre built entirely with Ndawana labour and materials, with the exception of cement and hardware. Concurrently, the community was mapped and a community census was conducted to profile the community.

Community members were involved not only in the design of the project, but also as trainees and employees (including team members, construction labourers and CCGs). Initially, six community members were elected to act as the management team for the project.

Edzimkulu introduced a number of health initiatives, along with programmes in orphan support, education, food security and skills development. The health initiatives included transport to the closest hospital (a distance of 100 km), workshops in healthy lifestyles, and training of CCGs. All CCGs were trained in voluntary counselling and testing. In early 2008 Edzimkulu introduced Community Integrated Management of Childhood Illness (CIMCI), while community growth monitoring was implemented in March 2009.

Community gardens were established in 2006 to provide a fenced space with access to water for people interested in gardens. Seeds and seedlings were distributed to village people who had fencing and water at their homes. The gardens at the community centre continue to be used by approximately 20 families as well as staff members who garden to provide food for support groups and meetings at the centre. Uptake of home-based food gardening has increased to more than 60% of all households.

➘ Links to policy

Community-oriented primary care is a concept pioneered in 1940 by Dr Sidney Kark at KZN's Pholela Health Centre. In 1978, at a conference at Alma-Ata, Kazakhstan, WHO and UNICEF together endorsed the policy of community-oriented primary health care.[1]

In 2009 the DoH and the DoSD revised the Community Caregiver Framework for Home-based Community Care.[2] Edzimkulu's activities are aligned with this revised framework.

Edzimkulu's work also aligns with the government's strategy to re-engineer PHC. One of the three streams of PHC re-engineering – ward-based PHC outreach teams – recognises that the provision of home and community-based health services and their links with the fixed PHC facilities, in particular, are critical to good health outcomes, especially child health outcomes. This stream recognises the need for better training, support and monitoring of CCGs and the need for better links between the community-based services and services offered by fixed health facilities. This stream aims to make CCGs a key part of the ward-based PHC outreach teams and to ensure that they are well trained, supported and supervised - with a clear mandate in terms of what they are expected to do and the catchment population for whom they are responsible.

RESOURCE USE

At the time of this Good Practices study, Edzimkulu employed 21 people, including one professional nurse, one enrolled nursing assistant and a data capturer. The KZN Department of Health paid 18 of the staff members (one professional nurse, one staff nurse and sixteen community caregivers) and the South African non-profit organisation, TB/HIV Care, paid the other five. Ndawana Clinic is now an official government-funded clinic with a KZN Department of Health operating budget. All clinic staff are now Department of Health employees.

➘ Health information management

Monitoring and evaluation systems in place

Edzimkulu assigns every client who has ongoing health needs (such as HIV, TB, chronic illness, disability) to a CCG. Each CCG is provided with a monthly pre-printed assignment register – which includes not only names of clients but also what tasks are required during the month, for example weighing of children, monitoring breastfeeding or screening for TB. Blank lines allow for capturing new clients who are then added to the register for the next month.

The CCGs use various tools for capturing data, including household registration forms, mortality audit forms and child beneficiary registration forms. Edzimkulu has ensured that all tools are easy to use, clear and helpful to the CCGs. Data gathered by the CCGs are submitted monthly, entered into a central database and validated. A follow-up register is generated for use by the CCGs' supervisor. Analysing the data locally enables learning and planning the way forward for the project.

FUNDING AND PARTNERSHIPS

Funding

Edzimkulu's first five years of funding was provided almost entirely by individual donors and small family foundations in Canada's Edmonton area. Edzimkulu has now shifted from being 100% Canadian-funded to being about 30% Canadian-funded, and most of that funding is now used for reconstruction of the community centre, which will include a learning centre focused on COPC. Day-to-day operations are now funded locally by the KZN Department of Health and by TB/HIV Care.

Partnerships

Edzimkulu's philosophy was always to develop a strong relationship with local government agencies in order to facilitate the organisation's withdrawal from the community by 2013. Edzimkulu began working directly with the KZN Department of Health in 2004 and developed a partnership with the Department. The main stakeholders in the partnership are the Department of Health, Edzimkulu and the Ndawana community. Entry and exit strategies were agreed upfront and there has been an emphasis on skills sharing and constant, clear communication.

SUSTAINABILITY AND POSSIBILITY OF REPLICATION

Sustainability has always been Edzimkulu's goal and the project is now in the final stages of ensuring that its programmes and services are sustainable. The intention is to transfer their healthcare programmes and clinic operations to the KZN Department of Health and their training programmes to the non-profit organisation, TB/HIV Care, 10 years after establishment.

The Ndawana Health Centre

Edzimkulu has already reached their goal of sustainability in the following areas:

- The Department of Health and TB/HIV Care have absorbed the majority of Edzimkulu's employees.
- Ndawana Clinic is now an official government clinic with an operating budget.
- Large-scale gender, justice and HIV education, counselling and treatment programmes are in place, enabling positive attitudes and practices to continue to grow in the community.
- The community's financial sustainability has been improved through Edzimkulu's documentation programme, which assisted community members to apply for birth certificates and identity documents that would allow them to access grants.
- Edzimkulu's preschool continues to provide early education and nutritious meals to local children. The Department of Education is now funding the teachers' salaries and providing food to the children. Progress is being made towards formalising the site as a satellite Grade R programme.

Community gardens

Edzimkulu's founders, Jim and Chris Newton, intend to continue being a part-time presence in South Africa, thereby helping to ensure their sustainability goals.

With regard to replicability, the Department of Health is so impressed with the work of Edzimkulu that they have requested Edzimkulu's management to assist them in developing the healthcare model in Sisonke as part of the PHC re-engineering strategy. The involvement of the Department of Health is a critical factor for replication.

SUCCESSES

Successes to date

Some of the successes reported by Edzimkulu include:

- ✓ Ndawana Clinic was approved by the provincial HIV and AIDS / STI / TB (HAST) team as the first down-referral site in the Sisonke District (January 2007).
- ✓ Edzimkulu provided funding for a park home at Underberg Clinic to enable accreditation of the site as a down-referral site (2007).
- ✓ Ndawana was approved as an initiation site using the roving doctor concept (January 2008).

- ✓ CCGs underwent in-depth training in 2009 on community growth monitoring, nutrition counselling and early intervention for children with HIV, including training to administer polymerase chain reaction (PCR) tests. Province also gave permission for CCGs to plot and write on the Road-to-Health Cards. As a result, weighing coverage went from 17% to over 80%, many children were identified as HIV-positive and entered into treatment, and immunisation coverage increased.
- ✓ Improved HIV testing coverage:
  - As of September 2011, 73% of the Ndawana catchment population had been tested for HIV (excluding women tested in antenatal programmes),
  - People testing positive had entered into care.
  - Ndawana has a higher prevention of mother-to-child transmission (PMTCT) coverage rate than the rest of the Sisonke District, even without the benefit of linkages with antenatal programmes or any effective down-referral from hospital. PMTCT coverage is entirely reliant on community information. All children tested positive have successfully started on treatment. Edzimkulu's CCG model allowed for immediate response to the government's new infant feeding/nevirapine guidelines.
  - In Ndawana there were more children per capita on antiretroviral therapy (ART) than any other site in the Sisonke District (see Figure 5.1).
- ✓ Through what is called "Edzimkulu 2", Edzimkulu now supports people in seven other villages with provision of HIV-related health care. Most of these people are in the village of Mangeni, 25 km from Ndawana.
- ✓ Until December 2011, 310 children were enrolled on CIMCI – 206 in the Ndawana Sub-district and 104 in the Mangeni Sub-district.

CHALLENGES

Past challenges

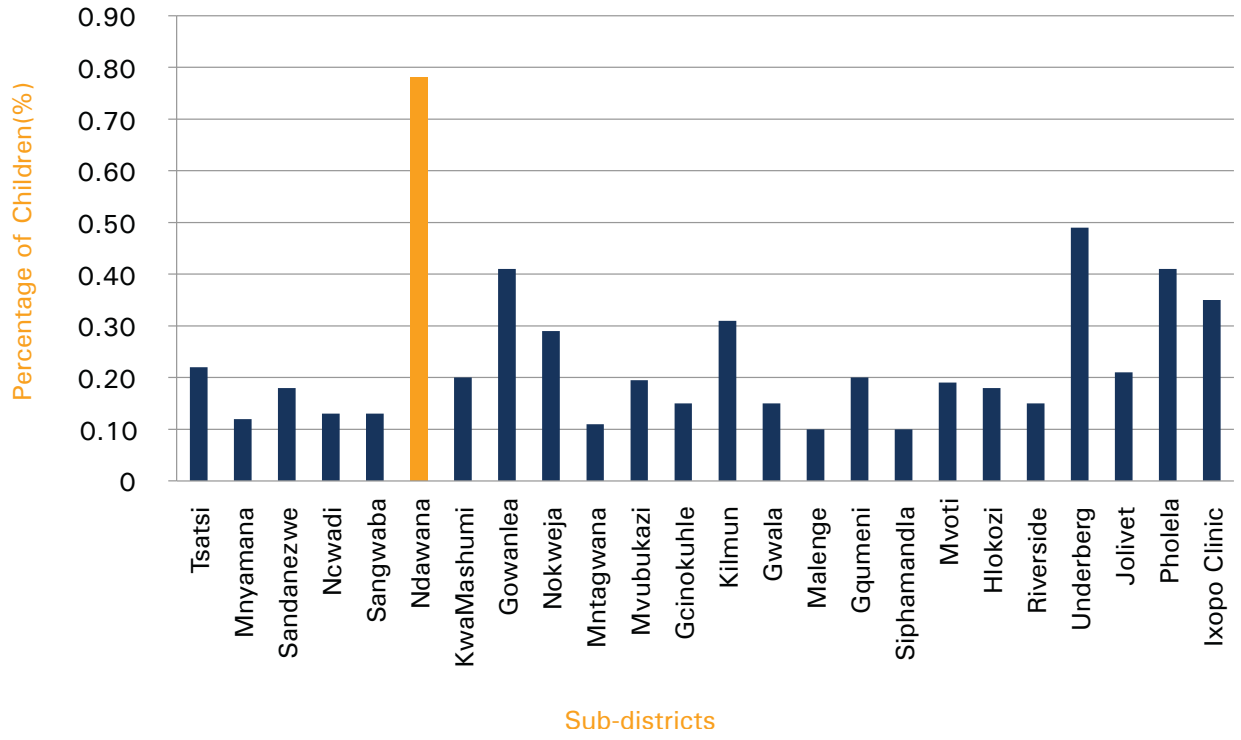
Edzimkulu's past challenges included a high burden of disease, and limited services and resources in Ndawana (no electricity, transport and medical services). In 2009 a fire seriously damaged the community centre built by Edzimkulu, but temporary buildings were erected soon after.

Current challenges

Currently, Ndawana does not provide antenatal care at its clinic, which means that pregnant mothers have to visit the Underberg Clinic to enter the system. Due to the distance, many mothers do not travel to Underberg for antenatal care and, as a result, recording of pregnancies,

Ndawana staff members

Figure 5.1: Children on ART in the Sisonke District, January 2011



deliveries and infant health is lacking.

Although Edzimkulu's TB and HIV case-finding and coverage is high, retaining clients and adherence is problematic. A high number of children on treatment live in less stable environments (many are orphans) which impacts negatively on their adherence. Adherence has been addressed for children by monthly support groups. The seasonal labour force also presents adherence challenges, as employers are reluctant to give workers time off to attend the clinic. The lack of transport further inhibits adherence. One solution has been to provide three months, instead of the customary one month, of treatment for selected clients who are then monitored closely by the CCGs.

LESSONS LEARNT

The Edzimkulu project has provided a number of valuable lessons whilst developing its community-oriented primary care model. These include:

- The need for community ownership, rather than merely community mobilisation. The health system must be an integral part of the community, and programmes must be designed by the people if they are to be embraced by the people.
- The need to use local resources: CCGs and community health facilitators must be from the community or the model will not work
- The need to recruit the right people: ensure geographical coverage and employ people with a likely commitment to the community
- The need for adequate remuneration for CCGs, especially if they need to take on a number of roles
- The need to train CCGs and provide dedicated supervision
- The need to integrate, not merely link, the clinic with the community: CCGs should, from time to time, work in the clinic and facility-based staff should do home visits. Clinic infrastructure should also be used for community purposes beyond only health. This can be realised by, for example, having multipurpose meeting rooms.
- The need for organised, community-located transport for tracking, supervision and patient referrals
- The need for a strong relationship and shared vision between the three stakeholders (community, Department of Health and Edzimkulu)
- The need for a well-defined exit strategy agreed on early in the project.

AWARDS AND RECOGNITION

In 2009, Edzimkulu was recognised for the following best-practice achievements:

- Best-practice model for community-based HIV work: Edzimkulu was recognised by Khomanani Caring Together, a national government social mobilisation campaign focusing on the impact of HIV and AIDS, as the best-practice model for community-based HIV work in KwaZulu-Natal.

- Best-practice model for Community Mobilisation for PMTCT of HIV: The University of Western Cape and Medical Research Council, in conjunction with the National Department of Health, recognised Edzimkulu as the country's best-practice model for PMTCT of HIV.
- Best-practice model for implementation of Community Integrated Management of Childhood Illness: In a study conducted by Masazi Consulting for UNICEF and the National Department of Health, Edzimkulu was found to be the best-practice site in South Africa for their work in PMTCT, home-based growth monitoring for children 0-2 years of age, and early intervention for children who are HIV-positive.
- In 2010, Edzimkulu's stigma DVD was selected for presentation at the International AIDS Conference in Vienna.

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REFERENCES

1. Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. Available from:http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf [Accessed 18 March 2012].
2. Republic of South Africa. Community Care Workers Management Policy Framework. Department of Health, 2009. Available from: http://www.doh.gov.za or http://www.dsd.gov.za [Accessed 15 March 2012].

UMKHANYAKUDE DISTRICT

MPILONHLE HEALTH AND EDUCATION PROGRAMME

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Mpilonhle is a non-governmental organisation dedicated to helping the youth in one of South Africa's poorest communities living in the uMkhanyakude District in northern KwaZulu-Natal. Mpilonhle focuses on health promotion and social development of youth, sponsoring mobile health units that visit rural schools and their communities to provide health education and HIV prevention services, HIV testing, curative services and computer training.

DESCRIPTION

Mpilonhle, which in Zulu means "a good life", is a non-governmental organisation (NGO) dedicated to helping one of South Africa's poorest communities living in the uMkhanyakude District in northern KwaZulu-Natal (KZN). Mpilonhle, based in Mtubatuba, was founded by Michael Bennish and JP Sevilla and has been active since October 2007.

Mpilonhle's mission is to improve the health and social development of adolescents and young adults in rural KZN, with a focus on HIV prevention. The vision of Mpilonhle is to have youth in uMkhanyakude District free of HIV and leading productive and fulfilling adult lives.

Principles that guide their work are:

- A healthy life is the foundation of a good life
- Prevention of HIV is vital for the community
- Adolescents can assume responsibility for their own future given the right skills and information
- Innovative strategies are needed to effectively serve rural populations.

Links to policy

Mpilonhle's work aligns with the Children's Act (38 of 2005)[1] which states that those aged 12 years and older should have access to HIV testing, contraceptives and reproductive health information. The project is also aligned with the government's strategy to re-engineer primary health care (PHC) by addressing one of the three main streams of PHC re-engineering, namely school health services. School health services focus on health promotion, screening and referral to health services among schoolgoing children, as well as addressing contraceptive health rights, teenage pregnancy, HIV and AIDS, and issues of drugs and alcohol in schools.

The Department of Health, in collaboration with the Department of Basic Education, revised the National School Health Policy in 2011. The new Integrated School Health Policy recognises that most children spend up to 13 of their formative years in a classroom environment. The policy states that this provides an ideal opportunity for health education and interventions that aim to address the many health and socio-economic factors that affect children in South Africa. The new Integrated School Health Policy also calls for the establishment of effective partnerships between government, trade unions, private sector, academic institutions, civil society and NGOs to assist in the formulation, implementation, monitoring and evaluation of priority areas for school health. Mpilonhle has capitalised on the opportunity created by the revised policy.

Mpilonhle aligns directly with the following specific objectives of the Integrated School Health Programme:

- To provide preventive and promotive services that address the health needs of schoolgoing children
- To facilitate referral to health and other services where required.

With the exception of environmental assessments, Mpilonhle also offers four of the five components of the Integrated School Health Programme's package of services, namely:

- Health promotion/education
- Individual learner assessment
- On-site health service provision
- Referral and follow-up.

OBJECTIVES

Mpilonhle's main objective is to promote the development

of youth through integrated, innovative health and education programmes to prevent HIV, promote general health and develop the computer-based skills and knowledge necessary for young adults to succeed economically.

Mpilonhle works in partnership with schools, government and other non-profit organisations.

Determining objectives

Mpilonhle's objectives were determined through a process of consultation. The organisation consulted with government departments where it was agreed that the school health programme was not functioning optimally in schools. Mpilonhle also spoke to educators and learners about the services they needed.

> *"We especially spoke with the life skills teachers. We met all the life skills teachers and they said we have a difficult time teaching this curriculum because we have no training in how to teach this."*
> *(Executive Director, Mpilonhle)*

STRUCTURAL FEATURES

Service delivery

As in most of KZN's rural areas, people in uMkhanyakude live in scattered homesteads. Since schools are often the only location in which youth congregate in numbers, Mpilonhle decided to target schools. The programme uses mobile units because schools lack space and the cost of having full-time staff at each school would be prohibitive. By using mobile units, Mpilonhle can also provide services to a greater number of students and community members. Three mobile units take services directly to 30 key schools in the uMkhanyakude District. Mpilonhle stays at each school (primary and high school) for a week, returning four to five times a year. During school holidays, the project runs intensive one-week sports and health camps at other schools in the region.

Mpilonhle offers the following services and programmes:

Health education

Each mobile unit has one trained health educator. Interactive sessions are conducted with groups of 20 learners - either four sessions per school year during school hours, or four sessions in a one-week sports and health camp. Learners discuss basic facts about HIV and how it is contracted and spread; the use of antiretroviral therapy; general health issues, including nutrition; life-style issues and family planning. Sessions also address reducing the stigma associated with HIV and living with HIV if infected. Sessions are adapted to the age of the students.

Health screening

Each mobile unit has four health counsellors and each year every student is offered a one-hour health screening. The annual screening includes voluntary counselling and testing for HIV with appropriate support and referral for those who are infected; screening and care for other sexually transmitted infections; and

Mpilonhle Mobile Unit (Source: Mpilonhle website, http://www.mpilonhle.org/mobile-units)

4x4 vehicles moving Mpilonhle Mobile Units

screening, counselling and referral to the mobile unit nurse as required for tuberculosis, pregnancy care, asthma, substance abuse and mental health problems. Students also receive counselling on family planning, nutrition, exercise and mental health, with referral to a social worker if required.

Medical referral and treatment

Each mobile unit has one primary health care nurse. When one or more problems are identified during a health screening, including testing positive for HIV, the student is referred to the Mpilonhle nurse assigned to the unit, who will further evaluate the student's condition. The nurse provides treatment and counselling as appropriate and works closely with the KZN Department of Health to refer to local clinics those students with more complex or difficult problems, including provision of antiretroviral therapy if required.

Social and psychology services

Each mobile unit has a social worker or psychologist who is responsible for, among other things, identification, referral and support for those eligible for social grants; counselling those who are HIV-positive; rape and domestic violence counselling; counselling for depression; and orphan support and placement.

Partnership for adolescent support programme (PALS)

Mpilonhle provides training to both students and teachers to create a peer team to support at-risk adolescents, particularly pregnant learners and those who are victims of violence or abuse. The trained teachers are available as an on-site resource for the peer counsellors.

Computer training

Each mobile unit has an IT educator and is equipped with 24 individual computers that are available to students during the day, after hours, on weekends and during school holidays. The students receive structured computer training, which includes guidance about how to use the computer, as well as basic software, email and Internet skills. Students can also access educational health material, including information on HIV and AIDS and self-tests for knowledge of HIV and other health issues from the Internet.

Career counselling

Career counselling is provided to learners in Grades 10, 11 and 12 and out-of-school youth during camps. This programme includes workshops, presentations and group and individual counselling.

Grassroot Soccer "Skillz" Programme

This programme uses a set of games developed by Grassroot Soccer, based on sports such as football and netball, to educate students about HIV and its prevention.

Home-based care programme

Twenty-four home-based care workers provide care to households of learners that are affected by HIV and AIDS. Support includes evaluation of health and social problems, psychosocial support and referral to Mpilonhle or other community services where appropriate.

Garden project

Mpilonhle is training teachers, community members and learners in sustainable gardening methods - permaculture and organic gardening – in line with the government's One Home, One Garden initiative.[2] This garden project aims to establish food gardens at each of the target schools; to empower people with the skills to live healthier lives; and to provide food for learners who need extra nutritional support.

Food parcel project

The Mpilonhle social worker identifies orphaned and vulnerable children in need of food parcels. They are generally learners who are orphans, with both parents deceased, but who do not qualify for a foster care grant because they are too old or lack documentation, or learners who are suffering from extreme poverty and food insecurity due to illness or injury of the head of the household.

Students who are eligible for a government grant are assisted to apply for the grant. After receiving a grant, food parcels are discontinued to that student so that another family in need can be supported.

Sports fields, water and sanitation

The sports fields, water and sanitation project aims to build soccer fields at selected schools along with a borehole to irrigate the field and to provide potable water to the school and community. The project also builds a laundry facility for the community and environmentally friendly toilets that use a minimum amount of water. The sports fields serve as the base for rejuvenating school sports' leagues and the fields are also accessible to the community when school is not in session.

Teacher training

Mpilonhle offers one-week teacher training sessions, two to three times per year. The training focuses on HIV education and testing and computer training, and creates a forum for shared experiences.

Mpilonhle educator Mpi Sepuhulo leading a computer class in the Mpilonhle mobile computer laboratory

Circumcision programme

A number of the male learners with whom Mpilonhle works request medical circumcision. Mpilonhle started by assisting at Department of Health circumcision camps. Mpilonhle now co-ordinates with the Department and runs camps at schools, offering medical circumcision to those learners who want the procedure.

Vision services

Mpilonhle facilitates eye clinics for schools and the community from their mobile units in partnership with OneSight, a charitable organisation that provides free eye care and new eyewear to those in need. Optometrists and technicians provide free prescription glasses on site and expedite referral and management of cases of cataracts or other eye problems through the Department of Health.

Shoe programme

Mpilonhle distributes annually to school learners more than 100 000 pairs of shoes donated by TOMS, an American shoe company that gives one pair of shoes to children in need around the world for every pair bought by its customers.

Resource use

According to the Executive Director, Dr Michael Bennish, Mpilonhle has 60 internal staff for its core programmes and tries to keep the office staff small. Each mobile unit is staffed by a professional nurse, a social worker, four health counsellors, one health educator, one IT trainer and a driver who doubles as a security guard. Mpilonhle currently has 24 home-based carers.

The most important resource, beside the staff, is the mobile units that cost, according to the Executive Director, approximately R225 000 for each caravan (each mobile unit has two caravans). Each mobile unit also carries 24 computers. The computers were specifically designed to function in the rural settings where Mpilonhle works and have very low power consumption, energy-saving LCD screens and a solid-state design (fanless and driveless) to improve durability. Mpilonhle asks schools to provide a room for the computer training, but provides all other services from the mobile unit. One of the primary schools mentioned that Mpilonhle uses the school kitchen when they are training community members, so that Mpilonhle can provide the participants with lunch.

Health information management

Monitoring and evaluation systems in place

Mpilonhle has developed an innovative data collection system, in which they record every contact with a student in real time using iPods connected wirelessly to a local area network in the mobile unit. This allows them, at any time, to know how many people have received services and have a complete and secure electronic medical record for every student they care for. The data collection system also allows Mpilonhle management to judge how each mobile unit and counsellor is performing.

> *"Having an electronic database gives us the information that we need to report on different things - individual staff performance, as well as overall organisation performance."*
>
> *(Executive Director, Mpilonhle).*

> *"We need to treat the time we spend at a school usefully - every minute of it. Working with an electronic system saves time… Paper wastes time. With the electronic system most of the things are tick-boxes, you don't need to focus on the paper. Writing on paper disrupts your engagement with the client. You don't provide your client with sufficient time to interact with you, because you are doing two things at the same time. With the iPod device, you can talk to the client and click at the same time; you can work quite fast."*
>
> *(Mpilonhle Co-ordinator: IT Education)*

Mpilonhle's monitoring and evaluation (M&E) staff are responsible for quality control of the data. The number of participants seen by project staff is also recorded on a board and M&E staff check that this tallies with the electronic data. An electronic questionnaire is structured to avoid errors common in a paper-based system. The system keeps track of who captured the data, to enable follow-up if there are any problems in the data. Data are backed up on a daily basis and stored off-site.

Mpilonhle also monitors their referrals to Department of Health clinics, to determine whether people actually do present at the clinic after referral and what the outcome of the referral is. Mpilonhle makes use of a referral letter. The nurses at the respective clinics write feedback on the letter and put it in a box provided by Mpilonhle. On a monthly basis, the referral letters are collected and given to Mpilonhle's M&E staff.

M&E staff prepare reports for Mpilonhle's Executive Director, their funders, the Provincial Department of Health, the District Office for Health and the various municipalities with which Mpilonhle works. They also prepare a weekly report for Hlabisa Hospital on numbers screened for HIV, TB and pneumonia, as Hlabisa Hospital provides Mpilonhle with test kits.

Mpilonhle monitors a number of key indicators, including the number of health education sessions provided, the number of learners counselled, the acceptance rate of testing for learners and the HIV positivity rate.

Funding and partnerships

Funding

Mpilonhle's funding has come from both private and public sources including: PEPFAR and USAID, Charlize Theron Africa Outreach Project, Oprah's Angel Network, IPAS, National Lottery Distribution Trust Fund, OneSight, South African Sugar Association, Iqraa Trust, Discovery Foundation, Old Mutual Foundation and Los Angeles Futbol Club – Chelsea Foundation.

The Charlize Theron Africa Outreach Project and Oprah's Angel Network provided funds for all of the start-up costs of Mpilonhle – including programme and curriculum design, and design and purchase of the original mobile unit. PEPFAR has provided funding to Mpilonhle since October 2007. From 2008 to 2011, PEPFAR was the largest financial supporter of the programme, providing funds for the operations of Mpilonhle's three mobile units, and for much of the central administrative structure of the organisation.

Partnerships

Collaboration is very important to Mpilonhle and it therefore works closely with government departments and other not-for-profit organisations.

KZN Department of Health

Mpilonhle works closely with the KZN Department of Health. Mpilonhle staff refer patients to Department of Health clinics and Departmental staff assist with Mpilonhle special projects, such as the vision clinic. According to the Operational Manager of a Departmental clinic to which Mpilonhle refers clients, there is a "very good" working relationship with the nurses from Mpilonhle. She felt that working with Mpilonhle helps her clinic by decreasing the clinic's patient load.

A key informant from the NDoH expressed what Mpilonhle brings to the partnership as follows:

> *"What I like most about Mpilonhle is their multi-disciplinary team approach…You can see that their team is comprehensive; it covers those aspects that we cannot cover as the Department… The services that we provide to schools are not as comprehensive as we want them to be… What I like about Mpilonhle in schools is that they stay long at a school and it's unlike us - we only visit the school for one day. For us it is just a hit and run because we are pushing the coverage and all those things. Mpilonhle camps in schools, so if a child has a problem it is easy for them to go and talk to them."*
>
> *(Key informant, Department of Health)*

KZN Department of Education

Mpilonhle works closely with the Department of Education, as the majority of Mpilonhle's activities take place in Department of Education facilities.

A key informant said the following about the importance of such partnerships:

> *"We have a high number of orphans due to HIV-related deaths and there are a lot of child-headed families, and this escalation of HIV/AIDS itself needed some sort of collaboration with other stakeholders. We could not do everything as Department of Education alone, we needed people like Mpilonhle to come in and give us some skills so that we can stop this pandemic."*
>
> *(Key informant, Department of Education)*

KZN Department of Social Development

Mpilonhle refers clients eligible for government grants or protective services to the local offices of the KZN Department of Social Development. Staff at the Department then assist learners or other community members to obtain their identification documents or process applications for grants.

South African Catholic Bishops' Conference (SACBC)

Mpilonhle works closely with South African Catholic Bishops' Conference (SACBC) to provide antiretroviral therapy to persons, including students, identified by Mpilonhle as HIV-positive. SACBC works throughout the district, using churches and parish houses to hold clinics. The SACBC Toga lab also provides laboratory testing, free of charge to Mpilonhle clients, for those in need of antiretroviral therapy.

Education Development Center (EDC)

The Education Development Center (EDC) was an original partner in the Mpilonhle programme and has played an essential role in helping design the curricula that Mpilonhle uses, especially helping to adapt existing materials on health education and HIV prevention to the context of Mpilonhle's work.

Grassroot Soccer

Mpilonhle has built a strong partnership with Grassroot Soccer to implement an innovative peer-based mentorship and health education programme in partner schools. A key component of this programme is the utilisation of the Grassroot Soccer's "Skillz" curriculum. This approach helps young people engage in relevant and important discussions about life, take small steps to achieve their goals, be resilient when faced with challenges, and protect themselves and others from HIV and AIDS.

Schools and communities

Mpilonhle makes every effort to build a strong partnership with the schools in which they work. The principals, teachers and learners who were interviewed clearly felt that they are part of the Mpilonhle programme and

that their views and inputs were considered from the inception of the programme.

> *"I remember when they came to introduce the project and as the teachers, we had our inputs as to what we thought the programme could cover."*
>
> *(Principal, High School 1)*

Principals were naturally concerned about losing teaching and learning time, so Mpilonhle negotiated this with each school.

> *"They told us what they wanted to do and we looked at the feasibility and availability of time and space."*
>
> *(Principal, High School 1)*

Mpilonhle also involved parents, school governing bodies and the community in consultations about the programme:

> *"Mpilonhle didn't just come and operate at the school. The community was called first and was told about Mpilonhle. According to my opinion, the proper channels were used to introduce Mpilonhle."*
>
> *(School Governing Body Chair, High School 1)*

Principals and teachers clearly felt that they are part of the programme and play a role in it as depicted below:

> *"We accommodate them into the school – we allocate time for them, we give them permission, access to the learners and we let them into the school premises."*
>
> *(Principal, Primary School 1)*

> *"My role as principal is to create space and time for this project in the school by creating a conducive environment and being able to make the staff see the need of having such a project in our school.... I ensure that our partners Mpilonhle get all the help that they need when they are in our school."*
>
> *(Principal, High School 1)*

SUSTAINABILITY AND POSSIBILITY OF REPLICATION

Mpilonhle has been active in the area for four-and-a-half years. Regarding its financial sustainability, by its very nature as a grant-supported programme, the future of Mpilonhle is precarious. This is a situation shared by many other NGOs and projects. PEPFAR funding is being scaled back significantly by the US government in the next five years and with PEPFAR being one of Mpilonhle's main funders, it is encouraging that the organisation has diverse sources of funding and a loyal core of financial supporters. The project could possibly supplement its income by charging for certain of its services. For example, Mpilonhle could charge community members a nominal fee for attending computer classes, although this may be a barrier to access and utilisation of the service.

A project's sustainability is also affected by the range and relevance of the services it provides and the efficiency with which these are provided. To survive, NGOs must provide goods or services that consistently meet the needs, priorities and expectations of their client communities. The appropriateness of the products and the efficiency with which these are delivered influence their clients' perceptions – in this case school communities and government – of the organisation. Feedback received indicates that Mpilonhle has fared well on all these aspects. It has also used media coverage strategically to enhance its position, and thus its sustainability.

Sustainability is dependent on local support for the programme's day-to-day operations. Through forging strong relationships with its schools, Mpilonhle has enjoyed excellent co-operation from them, as illustrated by their providing a space for the mobile units and allowing their students time to take part in project activities. The project's sustainability is further enhanced by training teachers and peer educators, thereby ensuring that Mpilonhle's work continues long after the mobile units have left. One of the learners commented that Mpilonhle's work could also be kept alive by learners teaching other learners:

> *"We should not be quiet with all the knowledge that Mpilonhle has given us, but teach others."*
>
> *(Learner, Primary School 2)*

With regard to replicability, Mpilonhle has developed a viable model of providing computer and health services support to isolated rural schools. In the long term, however, sustainability of their model will depend on government integrating the programme into the school health package of services and replicating the programme in other districts and even other provinces.

SUCCESSES

Successes to date

A number of key informants and beneficiaries commented on what they saw as the benefits of Mpilonhle's work. These included:

- ✓ **Decrease in high-risk behaviour:** A Department of Education key informant felt that there is a behaviour change among adolescents in the areas that Mpilonhle serves. He felt that adolescents now engage less in risky behaviours and *"the impact is visible"*.
- ✓ **Lower teenage pregnancy rate:** A Department of Health key informant reported that the teenage

pregnancy rate is lower in areas where Mpilonhle works:

> *We assume that it is due to Mpilonhle's assistance because they are able to spend some time with the learners, and if there are problems they are able to help them, compared to us.*
>
> *(Key informant, Department of Health)*

- A high school principal and his teachers also reported that they had observed a decrease in teenage pregnancies at their school:

> *Their coming to school made our work easy and the rate of pregnancy decreased.*
>
> *(Teacher, High School 1)*

- **Improvement in knowledge of HIV and AIDS:** A high school teacher and a DoSD key informant felt that a major benefit was that learners' knowledge of HIV and AIDS had improved, and that learners go for testing because of the knowledge they have.
- **Improved access to diverse services:** The Chairman of a high school Governing Body felt that the biggest benefit was that learners now have convenient access to services. The school's Resource Educator felt that the school had really benefited from the diverse services offered by Mpilonhle. A number of people mentioned the value of Mpilonhle providing shoes to learners and food parcels to vulnerable children:

> *We do not go hungry anymore.*
>
> *(Food Parcel Recipient, High School 1)*

- **Help for learners with problems:** Teachers and principals felt that Mpilonhle's assistance to children with problems, including learning difficulties and vision problems, was hugely beneficial.
- **Assistance for teachers:** Teachers acknowledged that they themselves have acquired knowledge of health issues, computer skills and assistance with teaching sensitive topics.
- **New communication channels:** Peer educators and learners felt that the strategy of using peer educators is successful:

> *The child is able to go to the person of the same age, discuss the problem that she or he is facing. It is difficult to go and tell the adult person and we [peer educators] are able to transfer that child to the adult person.*
>
> *(Peer Educator, High School 2)*

- **The community benefits:** A number of people mentioned how the communities where Mpilonhle works benefit from health education, testing, learning about permaculture, and computer classes. The community also benefits from the vision services Mpilonhle offers:

> *The grannies that could not see now have glasses.*
>
> *(Learner, Primary School 2)*

- According to a recent presentation on *"Mpilonhle – Four Years of Accomplishments"* Mpilonhle has reported the following in terms of programme coverage for the period October 2007 to December 2011:
  - A total of 50 852 Grade 8 to Grade 11 learners and camp participants attended health education sessions, as illustrated in Figure 6.1.
  - 27 191 Grade 8 to Grade 11 learners and camp participants received HIV counselling, as depicted in Figure 6.2. The acceptance rate of testing was 75% in 2010. From October

BENEFITS TO THE LEARNERS:

- "They have helped me to be open and communicate with others better." (Learner, High School 1)
- "They teach us not to be afraid of saying some names, so that if you happen to have a problem and want to talk to someone, you would be able to say what is bothering without a problem." (Learner, High School 1)
- "Some of us used to be very shy and had low self-esteem, but Mpilonhle has helped us; we are more confident." (Learner, High School 1)
- "We are able to speak up if we are facing some challenges in our lives." (Learner, High School 1)
- "They are happy to have Mpilonhle in their lives because that is where they are able to open up." (Principal, High School 1)
- "The health education that is passed on to the children has enabled them to ask some of the things that are difficult to ask." (Principal, Primary School 2)
- "I can say that after they started working here, I noticed that the learners have been able to speak out openly about some issues." (Teacher, Primary School 2)
- "It is this issue of learners being able to talk freely; it helps a lot."(Teacher, Primary School 2)

to December 2011, Mpilonhle did not test for HIV as per a request of the Department of Education, which impacted negatively on the acceptance rate of testing for 2011. From October 2007 to July 2011, the acceptance rate of testing averaged 82%.

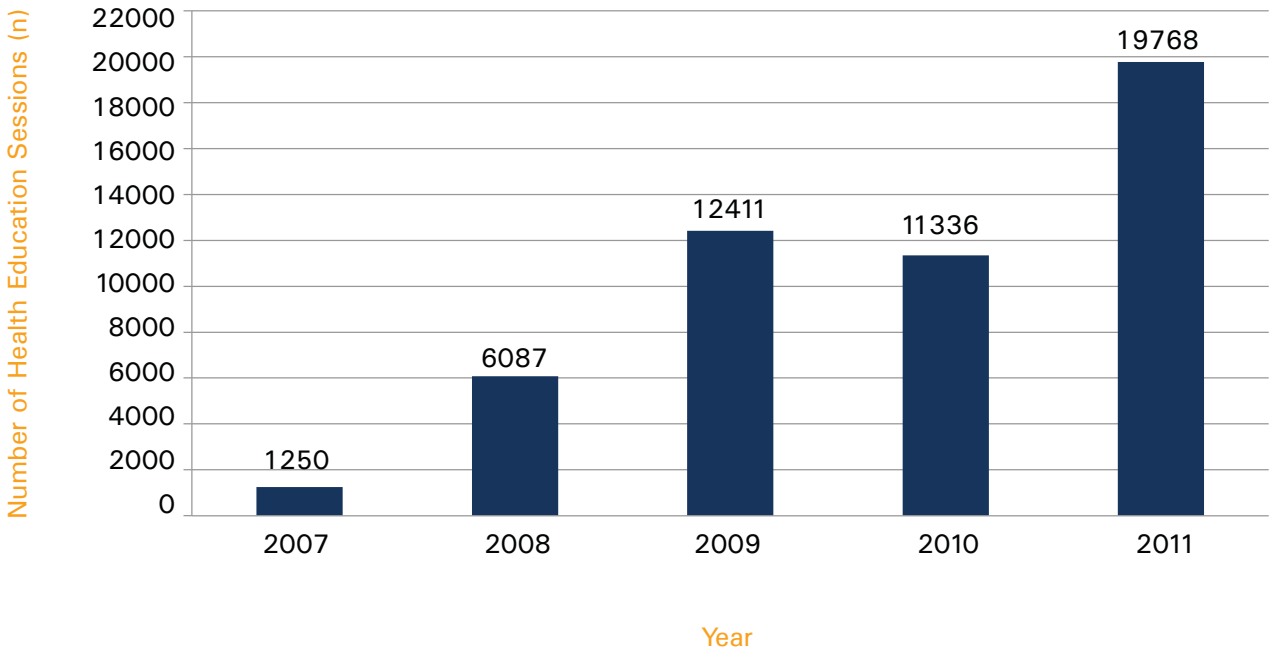
- 15 854 learners were seen by the Mpilonhle PHC nurses for, mainly, STI treatment, family planning, HIV second test and HIV care and support (October 2007 to May 2011).
- 3 242 students received social and psychology services, including identification, referral and support for those eligible for grants, counselling of HIV-positive learners, and counselling for sexual or physical abuse (October 2007 to July 2011).
- 30 849 learners from Grade 8 to Grade 11 and camp participants received computer training.
- Since September 2010, 400 learners received individual career counselling and a further 382 received career counselling through workshops.
- Since 2009 approximately 20 000 adolescents have completed eight or more one-hour sessions of Grassroot Soccer Skillz training.
- Four grassed soccer fields with water supply and ablutions are under construction.
- Food gardens were established at 15 of Mpilonhle's target schools.
- Food parcel distribution started in 2008 with 40 families and increased to 60 families in February 2011.
- Approximately 50 teachers attended a one-week teacher training session.
- Vision screening was provided to 19 225 persons and corrective lenses and glasses to 9 950.
- 50 000 learners receive two pairs of shoes per year.
- 23 632 community members received counselling and the acceptance rate of testing was 64%.
- 24 829 community members received health education and 3 659 received computer education (October 2007 to May 2011).

To what does Mpilonhle owe its success?

Mpilonhle project staff felt that the following factors contribute to their success:

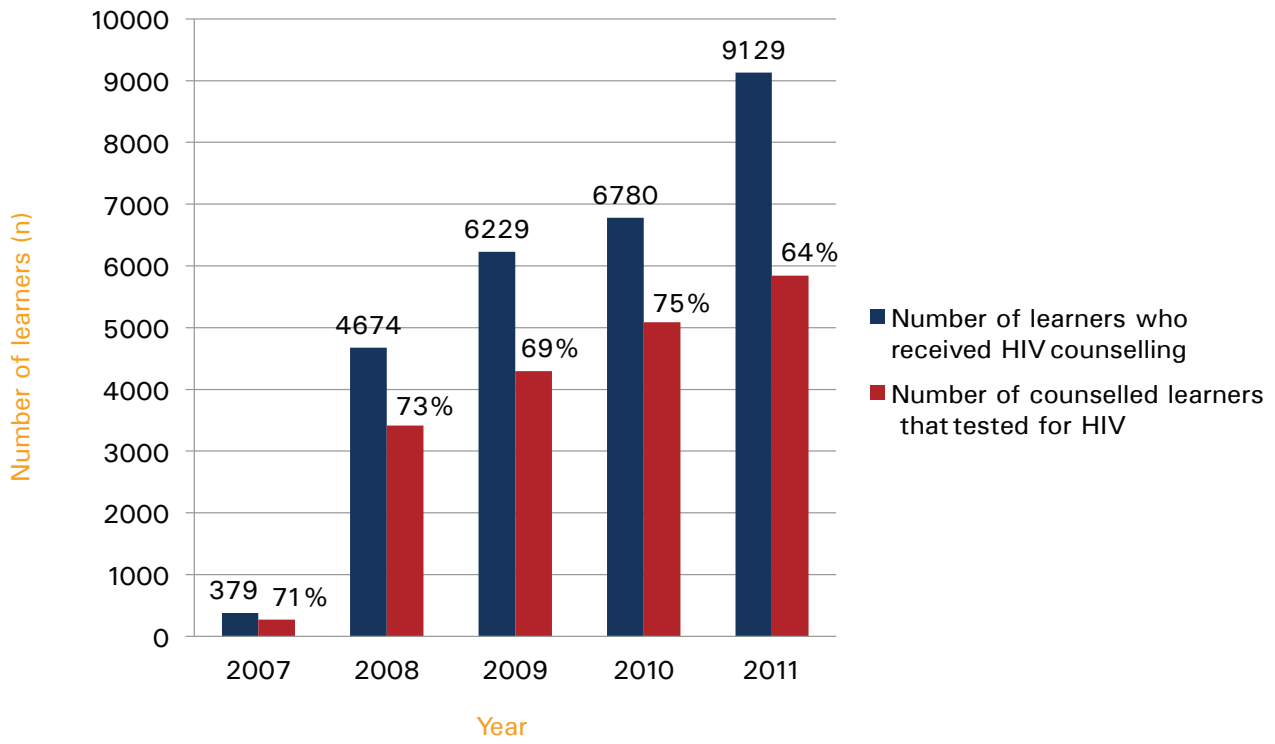
- ✓ A multidisciplinary approach
- ✓ Good management
- ✓ Working directly with stakeholders, thus reducing bureaucracy
- ✓ Using electronic systems to gather information
- ✓ Knowledgeable, motivated and dedicated staff who support each other
- ✓ Staff being able to see the effect of what they do

Figure 6.1: Number of Health Education sessions conducted, October 2007 to December 2011



(Note: Between October 2011 and December 2011 Mpilonhle did not test for HIV in schools as per request of the Department of Education. As of January 2012 Mpilonhle received permission to resume testing for HIV in schools.)

Figure 6.2: Number of counselled learners, per annum, and proportion of counselled learners that accept testing



- ✓ The support of school governing bodies, teachers and the community
- ✓ Counsellors being friendly, approachable and able to provide information
- ✓ Staff protecting the confidentiality of what beneficiaries tell them.

A Department of Health key informant felt that Mpilonhle's success is due to having the necessary resources, as well as good planning and organisation.

CHALLENGES

Past challenges

Mpilonhle faced a number of challenges in the past. Among these was deciding on the package of services to offer:

> *"Our sense was if we went to schools with only an HIV and AIDS programme it will face a lot of stigma and a lot of rejection."*
>
> *(Executive Director, Mpilonhle)*

The solution to this challenge was deciding to offer complementary and integrated services.

Mpilonhle also had to decide which schools to service:

> *"Do you go to the best-performing schools? If you go to the best-performing schools, you always look better, because things are better. And the best-performing schools are always the ones with good leadership, you know. If there is a good strong principal in the school, the school functions better."*
>
> *(Executive Director, Mpilonhle)*

The solution was to *"mix some of the best-performing schools and some of the worst-performing schools". (Executive Director, Mpilonhle)*

Co-ordinating project activities with school schedules was also a challenge, as schools have exams and holidays. Mpilonhle addressed this by servicing the community during the holidays.

A further challenge was that Mpilonhle deals with a range of learners in terms of age:

> *"When we designed health services for secondary schools this has to be recognised. You know we are not dealing with kids from 12 to 18, but we are often dealing with kids from 12 to 22 or 23, right. We have the whole range of kids."*
>
> *(Executive Director, Mpilonhle)*

They also had to realise that all schools are different and require a different approach.

> *"We work so much better with the schools now than we did four years ago because we learnt that every school is different. What is done in*

WHAT MAKES MPILONHLE SUCCESSFUL: VIEWS FROM THEIR BENEFICIARIES

- "It is the partnership between the teachers, learners and the community with Mpilonhle." (Learner, High School 1)
- "I would say that it is the dedication of Mpilonhle staff – they love their work, they are hard workers and they are always willing to assist… And the co-operation between Mpilonhle and us as the school." (Principal, High School 1)
- "It's co-operation." (Teacher, High School 1)
- "Their team dedicate themselves in their work. So they do have the dream and the vision of where they want to be in few years' time to come." (Principal, High School 2)
- "The other thing that I have learnt when attending Mpilonhle workshops, I gained a lot of skill about counselling learners that had a lot of problems. I have learnt that as a teacher, I'm everything to the child. I'm a mother, a nurse… I support the child in all the situations that she might be facing. I have also learnt that when the child has a problem I must not shout at him in front of other children because that degrades him, and it makes him to have a low self-esteem. One can end up dropping out of school because he knows that the teacher is going to say this and that to me. I have to get closer to the child, hear his problem and treat that problem. If I see that the problem is more than I can handle I pass it on." (Teacher, High School 1)

> *one school is not done in the other school. So the scheduling and the preparation is different… Every school has a different approach as to what time you need to bring services and which grades you need to go to. There is a lot of negotiation beforehand and before we come to the school. We have really become quite efficient about working with each school separately. You know, we treat them all very differently.* "

(Executive Director, Mpilonhle)

In the past, it was a challenge to refer learners to the local clinic or to the Department of Social Development.

> *They don't go because they don't have money for transport. Even if there is money, they cannot go during school hours; maybe they are writing exams.* "

(Programme Coordinator, Mpilonhle)

The solution has been for Mpilonhle staff to negotiate with the class teachers and to take the learner to the clinic or the DoSD themselves.

Current challenges

Mpilonhle faces a number of current challenges. Their major challenge, according to the Executive Director, is funding and the *"consistency of funding"*.

The project also needs:

> *more transport for our individual staff; the social worker has to make home visits or a nurse needs to make a home visit to follow up in terms of the CD4 count.* "

(Executive Director, Mpilonhle)

Geographical distance and transport also hamper Mpilonhle's desire to expand their footprint:

> *We would like to move to the north to Ingwavuma, but there are transport issues.* "

Such a move would require Mpilonhle to have a satellite office. They would also

> *like to have a satellite office in Jozini, because then we can reach Manguzi.* "

(Executive Director, Mpilonhle)

The great distances that project staff have to travel is also a challenge:

> *In town you have the density of population that makes it easy to be reached. In rural areas it is difficult to reach out.* "

(Executive Director, Mpilonhle)

It remains a challenge for Mpilonhle *"that the age group that is in secondary schools in the rural areas is much older than the age groups in urban areas". (Executive Director, Mpilonhle)*

Grassroot Soccer coaches find it challenging to deal with learners who are almost the same age as them:

> *You find that he will say he doesn't want to be trained by someone who is of the same age as him.* "

(Grassroot Soccer Coach)

A further challenge is to keep schools informed about the project because of changes in staff:

> *We can sit down with all the teachers at the beginning of the year and explain to everybody, but*

> *by mid-year you might have five new educators in that school.*

(Executive Director, Mpilonhle)

On a project level, programme co-ordinators felt they are short-staffed and, if any of the mobile unit staff is off sick, they do not achieve the numbers they need to. Peer educators felt it is a challenge to deal with the demands of their schoolwork and counselling other learners. It is also a challenge not having a private room where the peer educator can counsel the learner:

> *Even using a class during the break, you [the peer educator] get really disturbed, because there are people who are really rude. When they go past they comment by saying, "They think that they are clever; why are they sitting with this one?" You will find others standing by the window.*

(Peer Educator, High School 2)

A high school principal felt that a major challenge for Mpilonhle is the high number of learners in his school.

LESSONS LEARNT

Mpilonhle has learnt to strive continuously for improvement.

> *I always feel you go three steps forward and two steps back, but you must always go three steps forward...I think that we have to keep going.*

(Head: Finance and Administration)

Mpilonhle's Head of Finance and Administration felt that NGOs bring innovation to the system. She felt that *"government can learn from the NGOs [about] what works"*.

The key informants interviewed mentioned lessons they had learnt from working with Mpilonhle. A key informant felt that Mpilonhle had taught them the value of integration:

> *We have learnt more about integration, because when you see Mpilonhle, you do not think of only one department, you will meet Department of Social Development, Department of Health and Department of Education, and you will even meet other organisations.*

(Key informant: Department of Education)

A Department of Health key informant expressed that Mpilonhle had shown them how important a team approach is, as well as "superb" planning and organisation. A DoSD key informant felt there is a lot to learn from Mpilonhle's commitment and their dedication to their work.

A number of beneficiaries mentioned valuable lessons that they had learnt from Mpilonhle. A high school principal felt that Mpilonhle had taught him how important good planning is:

> *It is difficult to do something that is not planned. We get a structure from planning and we can integrate programmes if they are well planned and structured.*

(Principal, High School 1)

A number of learners were able to reflect and shared that Mpilonhle has taught them how to behave appropriately in class, the importance of respect and how to remain goal-orientated in order to persevere.

AWARDS AND RECOGNITION

Mpilonhle has, surprisingly, received no awards. It has, however, achieved a lot of media recognition, particularly because of the high profile of its original philanthropists, Oprah Winfrey and Charlize Theron. No fewer than nine videos about or mentioning Mpilonhle can be found on the YouTube video-sharing website. Mpilonhle has been featured on or in the following:

- Oprah Winfrey's Angel Network website (April 2008)
- *The Mercury* (September 2008)
- In a segment on Charlize Theron on the popular TV series E! True Hollywood Story (September 2008)
- The Media Club South Africa's website – a website dedicated to bringing South African accomplishments to the attention of world media (December 2008)
- The SAFM radio programme, "Otherwise" (January 2009)
- *The Sowetan* newspaper (September 2009)
- *Isolezwe* newspaper (September 2009)
- SABC News International's Health Issues programme which is broadcast in Washington DC and across Africa (19 June 2009)
- An article written by the actor Matt Damon for the American magazine, *Parade* (October 2009)
- In a blog post by Charlize Theron on *Huffington Post* (May 2010)
- *The Zululand Fever* newspaper (June 2010)
- *Hello* magazine's website (July 2010)
- *Le Monde* newspaper's website (Feb 2011)
- An international article by AFP news agency (March 2011)

- Radio France Internationale (June 2011)
- *O Magazine* (June 2011).

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REFERENCES

1. Republic of South Africa. Government Gazette Vol. 492:The Children's Act (38 of 2005) No. 610. The Presidency; Cape Town: 19 June 2006. No. 28944. Available from: http://www.info.gov.za/view/DownloadFileAction?id=67892 [Accessed 10 April 2012].
2. South African Government Information. Speech by MEC for Agriculture, Environmental Affairs and Rural Development, Mrs L Johnson, during the One Home One Garden campaign launch, Nseleni. 2010. Available from: http://www.info.gov.za/speeches/2010/10030411051001.htm [Accessed 10 April 2012].

WHAT I HAVE LEARNED FROM MPILONHLE – THE LEARNERS' VIEWS

- "Mpilonhle taught me that you go to school to better yourself, not to do negative things."
- "What I learnt is that you should know why you are here in school, not focus on things like friends and boyfriends or girlfriends. Focus on what you have come to do and forget about anything else."
- "Mpilonhle has taught me to focus on my studies and not on things that will not take me anywhere in life."
- "I was very noisy in class. Mpilonhle taught us to listen to the teacher and to respect others as well. Mpilonhle helped me to stop making all that noise and focus on my future."
- "I learnt you should not listen to bad friends who influence you negatively."
- "I learnt you should make your own choices."
- "I learnt you should never discriminate against someone who is HIV-positive because it might happen to you too."
- "I learnt to respect everybody around me."
- "Mpilonhle taught me how a girl should handle herself."
- "Mpilonhle taught me how I should behave as a boy…a boy should behave himself as such, not like he is a grown man."
- "They taught us to be patient…to be patient through all situations until you succeed."

ILEMBE DISTRICT

SUNDUMBILI COMMUNITY HEALTH CENTRE

Sundumbili Community Health Centre, situated at Sundumbili Township in the Ilembe Health District, was identified in 2009 as one of the High Transmission Areas for both HIV and AIDS and TB. The Community Health Centre's active fight against TB has been recognised as a good practice. Sundumbili's efforts to combat TB include outreach to the community, innovative Directly Observed Treatment support, concerted efforts to reduce the number of defaulters, and the use of local data to inform the Centre's activities.

DESCRIPTION

South Africa remains in the grip of concurrent HIV and tuberculosis (TB) epidemics. Despite the focus on TB and HIV programmes and increased expenditure on primary health care (PHC) services, together with investments in infrastructure and human resources, the health services have not yet had a meaningful impact on the extent of the epidemics. South Africa ranks fourth among all countries for TB incidence, and the high incidence of both multidrug-resistant TB (MDR-TB) and extensively drug-resistant TB (XDR-TB) is due, in part, to the limited performance of the TB control programme.[1]

With one of the highest TB incidence rates in the world, the South African situation needs careful analysis. The incidence rates vary across the provinces, with the highest rate of 1 142 per 100 000 in KwaZulu-Natal (KZN). Of the country's 12 districts with the highest incidence rates, nine are in KZN.[2] This is partially due to the high HIV infection rates in the province. According to the Tuberculosis Strategic Plan for South Africa, 2007 to 2011, from 2004 to 2007 KwaZulu-Natal had the highest number of MDR-TB and XDR-TB cases.[3]

Sundumbili Community Health Centre (CHC) is situated in Sundumbili Township in the Ilembe Health District. The CHC operates 24 hours a day and has a total of 27 beds. Sundumbili CHC's vision is to achieve optimal comprehensive health care for over 142 000 people residing in Mandeni Sub-district, while their mission is to provide sustainable, co-ordinated, integrated and comprehensive health care based on the PHC approach through the district health system.

Sundumbili CHC has always been active in the fight against TB and has supported campaigns such as the Hlolamanje TB campaign. This campaign was initiated in 2008 by the KZN Member of Executive Council (MEC) for Health as an initiative against the spread of TB and HIV. The campaign ran from 28 July until 1 August 2008 and its main aims of the campaign were, firstly, to bring health services to the community, especially those who live far away and who find it difficult to reach health facilities and, secondly, to facilitate early identification of TB and HIV and AIDS. Sites in the communities of Mazitapele, Vutha and Hlomendlini were visited by TB and HIV and AIDS campaigners from Ilembe Health District and Sundumbili CHC. On-site testing of sputa was provided, information was disseminated through health talks and pamphlets and condoms were distributed. Door-to-door community outreach, including testing of sputa, was also conducted to reach those who did not come to the pre-announced campaign sites. In addition to the Hlolamanje campaign, the TB BLITZ campaign and a number of TB awareness events were undertaken during 2010.

In 2009 Ilembe District was identified as one of the High Transmission Areas for both HIV and AIDS and TB. As a result, the Health District joined hands with the University Research Corporation (URC) to fight the spread of TB and HIV through engaging with the community – this through broadening community members' understanding of TB and encouraging the community to undergo voluntary HIV testing and, when positive, to take their medication as required. In the same year, in an attempt to counter the high TB and HIV transmission rates, Sundumbili CHC extended its services by establishing a satellite clinic in a container at Sundumbili Plaza, near the taxi ranks, to provide selected TB and HIV services. The main aim of the initiative was to bring health services to clients, such as taxi drivers, who find it difficult to reach health facilities. Schoolchildren are also making use of the service. The services rendered from this site include a number of community-based services such as voluntary counselling and testing (VCT), treatment adherence and TB Directly Observed Treatment

(DOT) support, issuing male and female condoms, and distributing pamphlets. These services are rendered by trained HIV and AIDS counsellors.

CURRENT OBJECTIVES

Determining objectives

As a starting point to determining current objectives, the CHC staff mapped their TB operations and analysed how the clients interact with these services. From this they identified gaps in service delivery and used this information to improve their performance based on key TB indicators.

Objectives identified include:

- Intensified case-finding
- Fast-tracking patients who are co-infected with TB and HIV
- Increasing the screening of household contacts, especially children under five years of age
- Improving treatment adherence/minimising the defaulter rate.

> *"We needed to intensify our case-findings, ensuring that all those diagnosed with TB should start treatment as soon as possible without infecting more people."*
>
> *(Staff member, Sundumbili CHC TB Unit)*

Links to policy

The National Strategic Plan on HIV, STIs and TB 2012-2016 is a framework to guide the activities of all partners whose work is relevant to HIV, STIs and TB in South Africa. The National Strategic Plan aims to achieve the following five goals by 2016:

- Halving the number of new HIV infections
- Ensuring that at least 80% of people who are eligible for HIV treatment are receiving it (at least 70% should be alive and still on treatment after five years)
- Halving the number of new TB infections and deaths from TB
- Ensuring that the rights of people living with HIV are protected.

The Tuberculosis Strategic Plan for South Africa, 2007-2011, had the following strategic objectives for the same period:

- To strengthen the implementation of the DOT strategy
- To address TB and HIV, MDR-TB and XDR-TB
- To contribute to health systems strengthening
- To work collaboratively with all care providers
- To empower people with TB, as well as communities
- To co-ordinate and implement TB research
- To strengthen infection control.

The South African government has prioritised addressing HIV and AIDS and TB in an integrated manner. The Department of Health launched the National HIV and AIDS Counselling and Testing (HCT) Campaign in 2010. The HCT campaign is used as a base for implementing key TB control, treatment and management activities, including active case-finding and contact tracing. The campaign activities are coupled with a strong focus on social mobilisation involving internal and external government partners.

In strengthening its oversight, the Department will proactively intervene in poorly performing districts through enhanced supervision by national TB Control and Management partners.

The Department will have to scale up support and follow-up for all patients on TB and antiretroviral (ARV) treatment in order to reduce the number of patients defaulting on their treatment plans. Defaulting contributes to the development of drug resistance and poor patient outcomes.

STRUCTURAL FEATURES

Service delivery

Sundumbili CHC's activities include integrated management of TB and HIV; decentralised TB management with a focus on TB treatment adherence; TB tracing teams using community caregivers (CCGs); a Streptomycin team doing community visits; intensified TB case-finding; contact tracing and infection control.

The CHC's TB Unit offers the following services to the community:

- TB testing for patients who have coughed for two or more weeks
- Evaluation and treatment of TB contacts
- Health education on TB, including signs and symptoms
- Education on the transmission of TB
- Education on nutrition and hygiene
- Education on adhering to TB treatment.

The strategy to intensify case-finding includes the introduction of TB screening in every department at the CHC.

> *"At the CHC we have different departments. There is a general department where we are seeing minor illness, chronics and everybody.*

We have the maternity side, we have the TB section, and we have the VCT/ARV section. We have implemented that those patients who are TB suspects or who are TB contacts get screened in those departments – each now has their own suspect register. Once they are found to be positive they are sent to the TB unit for initiation of treatment… It worked for us.

(Staff member, Sundumbili CHC TB Unit)

The CHC also undertakes contact tracing to identify individuals with TB who require treatment and follow-up care to reduce transmission and to prevent morbidity and mortality in newly infected individuals. Staff mentioned that if a schoolchild is diagnosed with TB, the TB team goes to that particular school and screens all the learners and teachers. They are also very concerned with the screening of contacts under five years of age.

If we have diagnosed a patient with TB, we ask them if they have under-5 children at home. If they say yes, then the tracing team will go to that particular household for screening and checking.

(Staff member, Sundumbili CHC TB Unit)

The CHC also makes proactive use of their local data to guide their interventions. They analyse the data in the TB register and if they see that there are many TB patients from a particular geographical area, they will conduct a campaign in that area, including TB screening and HIV screening. HIV screening of TB patients includes health promotion on HIV and AIDS and TB, pre-test counselling, offering HIV tests, post-test counselling and ongoing counselling. Patients who are co-infected with TB and HIV are fast-tracked into treatment and care. Although the number of TB patients who have tested for HIV still falls below the target of 100%, it has steadily increased from 77% in 2010 to 80% in 2012.

The CHC uses an innovative approach to TB adherence support, adopted from the ARV programme, called the "treatment buddy" strategy for TB DOT support. Buddies are family members or relatives who are trained to act as DOT supporters. Two factors influenced the adoption of the strategy – an insufficient number of CCGs to service all the areas where TB patients reside, and the CCGs having too great a workload with approximately 60 families per CCG. Although CCGs serve as a valuable resource for educating households about TB, about proper techniques for infection control, and for reminding TB patients to go to the clinic, it is physically not possible for them to be with every patient at treatment time to monitor adherence.

Another thing … the community caregivers are not always with the patient; it's better with the relatives because they are always with the patient. A family member is there to see whether the patient has taken the treatment.

(Staff member, Sundumbili CHC TB Unit)

As part of decentralised TB management, which addresses socio-structural barriers to accessing TB treatment and care, the CHC also has a roving Streptomycin team doing community visits. The team administers Streptomycin injections to patients who are unable to come to the clinic due to physical disability or because they do not have money for transport.

Resources

The TB Unit's human resources include a professional nurse to prescribe treatment and manage minor ailments. She is responsible for holistic treatment of the patient.

We treat a person holistically. We don't just look at TB because she or he has come there for TB, but we also look physically, psychologically and all the aspects of the patient. So the professional nurse is there for that.

(Staff member, Sundumbili CHC TB Unit)

An enrolled nurse assists with vital signs, administering injections and screening of contacts. In addition to the decentralised mobile teams, the tracer teams include CCGs, health promoters and Streptomycin injection teams. The clinic-based team includes an HCT counsellor for initial and ongoing counselling, while a data capturer deals with the TB register and the capturing of data.

Health information management

On a daily basis, TB data are captured on the patient's green card, which the patient carries, and the blue card which remains at the CHC. Routine data are captured in the suspect register and TB register. The TB Unit have monthly and quarterly meetings to discuss their data and review their performance. Important indicators include new cases, smear conversion rate, cure rate, treatment completion rate and defaulter rate.

If they are converting, then it tells us that their adherence is good, as well as the education we gave them, and their DOT supporter is effective.

(Staff member, Sundumbili CHC TB Unit)

The TB Unit has a system of recording patients' return dates and monitoring whether they actually present for their appointments. Patients' names are entered in a diary on the day they are expected. Every afternoon the data capturer monitors whether the expected patients were seen on that day.

It helps to know for every day how many patients are coming in and also look at their return dates. So, if the patient didn't come in for that particular day that's when we start phoning and tracing the patients.

(Staff member, Sundumbili CHC TB Unit)

> *We give them an allowance of a day or two. If those days elapse we call them. This helps us a lot.*
>
> *(Staff member, Sundumbili CHC TB Unit)*

Funding and partnerships

Sundumbili CHC is government funded. The CHC's staff view the CCGs, the non-governmental organisations in the area and key figures in the community as important partners in their efforts.

URC, a global company dedicated to improving the quality of health care, social services and health education worldwide, was involved with Sundumbili from 2006 until early in 2008. URC assisted Sundumbili by conducting support visits, conducting training and supporting the CHC with the TB programme's data management.

POSSIBILITY OF REPLICATION

Sundumbili CHC has implemented TB and HIV integrated treatment and care, ensuring TB services are available across all departments. In addition, the TB outreach programme extends the package of TB care and support to the community. By increasing patient access to care, Sundumbili CHC provides a useful model of how existing clinics can move towards a "one-stop" shop for universal access to treatment and care with a focus on reducing the burden of TB in areas that have a high transmission of TB and HIV. The decentralisation of care to communities using CCGs and other roving teams provides a model by which the PHC outreach teams, currently being piloted by the Department of Health, may be employed to strengthen TB programme interventions.

A number of factors, such as the successful implementation of the TB contact tracing and intensified case-finding across departments, provide a model that can be replicated and scaled up in other healthcare facilities that experience a high TB burden of disease. The Sundumbili CHC provides healthcare professionals and service providers with a useful model in which the components of TB treatment and care, such as case management, early identification of TB suspects through contact tracing and intensified case-finding, and regular education for adherence support and infection control, create synergy and form a comprehensive TB management service. Although this model is nothing more than what is set out in the TB guidelines, it is the way that Sundumbili CHC has implemented the systems to manage TB patients and deliver functioning services that is noteworthy and can be adopted in other clinics and healthcare settings.

The lack of the necessary human resources and the CCGs' current limited scope of practice may pose a challenge for other healthcare facilities wishing to replicate Sundumbili's TB services in the community. Patients' acceptance of decentralised TB treatment may pose a further challenge. The associated social stigma can, however, be reduced through community outreach campaigns, issuing pamphlets, and educating the community members.

SUCCESSES

The following successes, linked to key indicators, were reported by the clinic staff:

- ✓ Low defaulter rate
- ✓ Improved cure rate
- ✓ Increased highly-active ARV therapy (HAART) initiation for HIV-positive TB patients.

Figure 7.1 suggests that the new smear-positive conversion rate for the Sundumbili CHC shows an upward trend. When the baseline is already close to the target, it is difficult to show big increases as the programme is already running fairly efficiently; however, the results are above the target of 85%.

Although the new smear-positive cure rate shown in Figure 7.2 is still below the national target of 85%, there is a steady increase in trend.

Figure 7.3 illustrates a decrease in the defaulter rate since 2010. This is a very encouraging result as the national target is <5%, highlighting that Sundumbili CHC is certainly making good progress towards improving treatment outcomes.

Expanding on these areas of success, staff reported that having a Streptomycin team visiting patients' homes has increased the number of patients completing their treatment successfully.

The laboratory turnaround time for sputum results has also decreased, resulting in quicker time to treatment initiation. Previously, sputum specimens were only collected on certain days, but now a courier collects specimens every day.

Staff members believe that their health education activities have contributed to the improved cure rate. In addition to the health education that a patient receives when initiated on treatment, the CHC offers health education to their clients on TB treatment and their DOT supporters every second Friday.

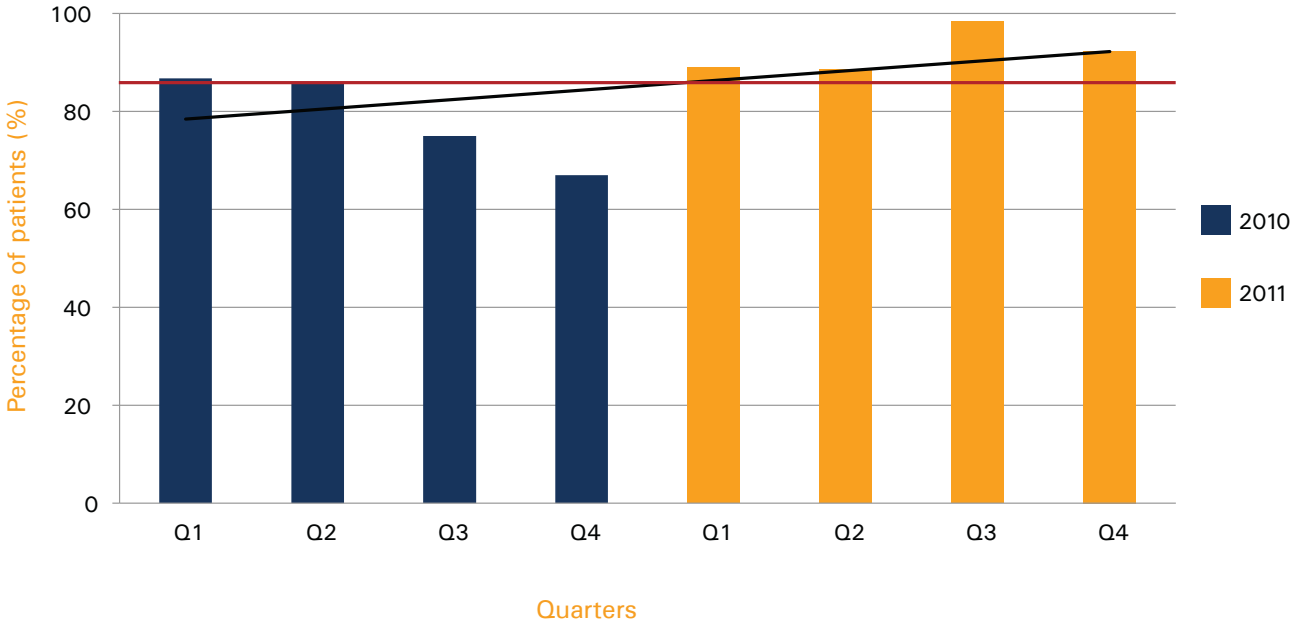
> *So they [the patient and their DOT supporter] are in line; they know what is expected from each of them. Making them work together has helped us a lot. Because they know when the person is supposed to finish treatment, and what is expected of them to do. So with that system it has worked some wonders.*
>
> *(Staff member, Sundumbili CHC TB Unit)*

The CHC's health education activities respond to the Tuberculosis Strategic Plan for South Africa, 2007-2011 of empowering people with TB as well as communities.

Patient tracing and follow-up visits are critical for improvement of TB outcomes. The system of diarising when patients should return to the CHC is also hailed as a success. The CHC also ensures they have a phone number for each client:

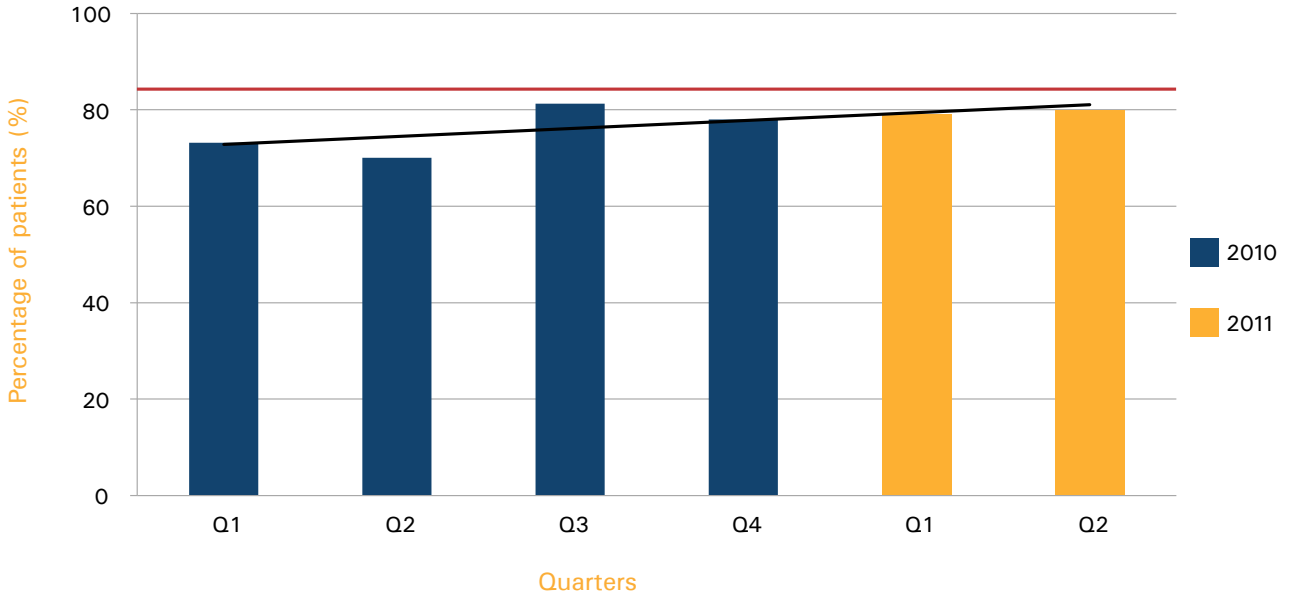
> *"When we are starting the treatment with the patient, and when we are taking the specimen for the patients, we do ask them for their phone numbers. We keep on phoning the patient. If the patient didn't come, we phone him and find out why he didn't come."*
>
> *(Staff member, Sundumbili CHC TB Unit)*

Figure 7.1: New smear-positive conversion rate at Sundumbili CHC, 2010 and 2011



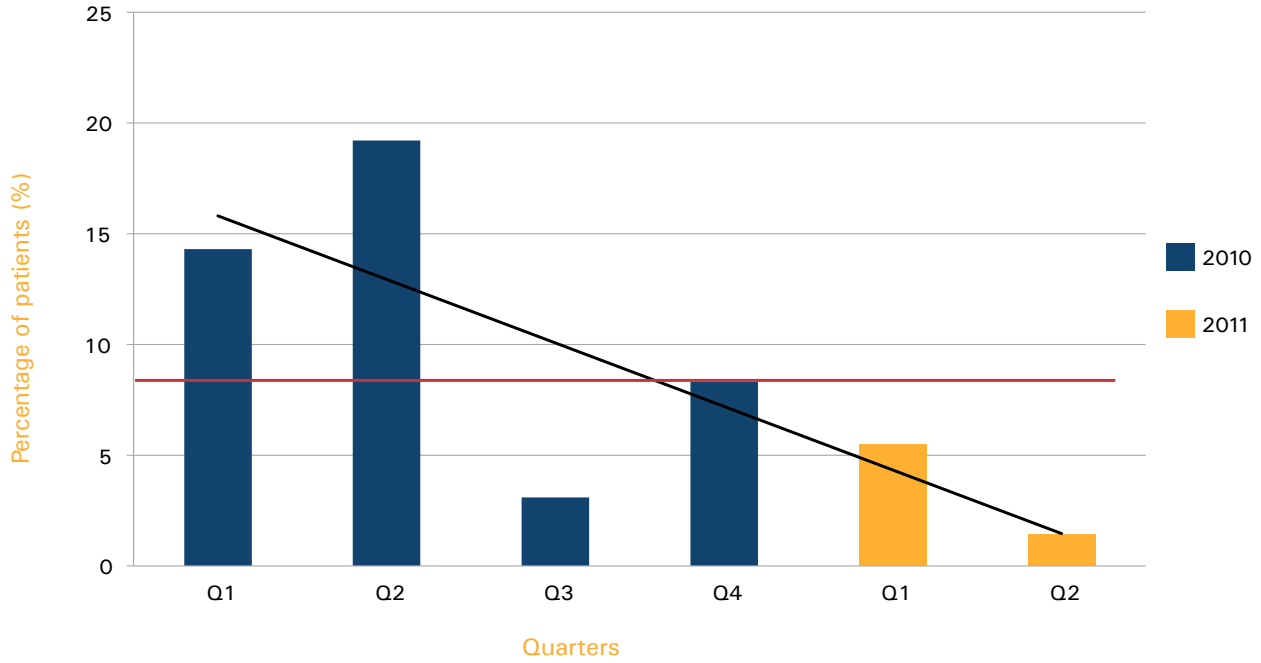
Note: Red line represents the national target cure rate for global TB control and black line indicates the linear trend

Figure 7.2: New smear-positive cure rate at Sundumbili CHC, 2010 and 2011



Note: Red line represents the national target cure rate for global TB control and black line indicates the linear trend

Figure 7.3: New smear-positive defaulter rate at Sundumbili CHC, 2010 and 2011.



Note: Red line represents the national target defaulter rate for global TB control and black line indicates the linear trend

CHALLENGES

The CHC previously experienced problems with tracing defaulters. They now have two tracer teams for Sundumbili and its clinics. Furthermore, the CHC has enlisted the CCGs and the Streptomycin team to assist with tracing defaulters.

The TB Unit's infrastructure is problematic – for instance, an isolation room is required for highly infectious patient like MDR patients:

> *"We need a building with proper fans, not air-conditioning, and windows to properly implement the open window system. "Before they [the patients] are taken to King George they must be seen or kept somewhere; we don't have that specific room."*
>
> *(Staff member, Sundumbili CHC TB Unit)*

Insufficient staff numbers impact negatively on service delivery. The two tracer teams are unable to deal with the high number of defaulters, while inadequate staffing in the TB Unit itself creates a problem:

> *"You will find that instead of having four to five persons, you have two persons."*
>
> *(Staff member, Sundumbili CHC TB Unit)*

Another challenge is that the CHC does not have a clinic committee, which is important to ensure that the health service is responsive to the needs of the community, thereby enhancing community participation and strengthening governance.

LESSONS LEARNT

Sundumbili CHC has expanded their normally clinic-based services to the community by providing TB treatment, support, care and education through community outreach. Community-based services enable all patients to have access to TB treatment, care, education and adherence support. The decentralisation of TB services addresses socio-structural barriers such as poverty and the lack of transport and infrastructure that contribute to patient loss to follow-up and negatively affects treatment adherence.

Sundumbili CHC has mobilised resources to address the health service needs of the community. By extending health services to communities, access to health care is improved. Sundumbili CHC has formed relationships with CCGs, community leaders and all relevant stakeholders who now actively support the programme.

According to the TB Unit staff, the most important lesson they have learnt is the need to have all stakeholders on board – no matter what programme is being run:

> *"For each and every programme you can't run it on your own; you need other stakeholders for it to be successful… Community leaders, all the relevant stakeholders, they need to be on board. So whenever you experience challenges you are able to go back to them for support."*
>
> *(Staff member, Sundumbili CHC TB Unit)*

Evidence-informed planning is a prerequisite to efficient service delivery and Sundumbili CHC demonstrates the successful use of their health data. An analysis of the TB register informs the decision on where to undertake a TB and HIV screening campaign. A daily diary is used to monitor patients' missed visits. Failure to keep an appointment triggers telephonic follow-up, followed if necessary by a tracer team visit. Careful collection of patients' contact details has facilitated this follow-up process.

A lesson mentioned was the need to learn what one can from outside partners and implement it for the programme.

> *"You can't just relax because there is a partner that is assisting you. You must learn from them and sustain it and make use of the information and skills that they are giving you. Otherwise you will find that when they leave you will go back to your old ways. The lesson is that you use the new information, accept it, make changes and move on and implement."*
>
> *(Staff member, Sundumbili CHC TB Unit)*

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REFERENCES

1. World Health Organization. Multidrug and extensively drug-resistant TB (M/XDR-TB): 2010 Global Report on Surveillance and Response. Geneva, Switzerland: 2010. Available from: http://whqlibdoc.who.int/publications/2010/9789241599191_eng.pdf [Accessed 10 April 2012].

2. Day C, Barron P, Massyn N, Padarath A, English R, editors. District Health Barometer 2011. Chapter 4: Outcome Indicators. pg 85-100. Health Systems Trust; Durban: 2011.

3. Department of Health. Tuberculosis Strategic Plan for South Africa, 2007-2011. Undated. Available from: http://www.gov.za/files/tbstratplan_0.pdf [Accessed 10 April 2012].

4. Department of Health. The National Strategic Plan on HIV, STIs and TB 2012-2016. 2011. Available from: http://www.doh.gov.za/docs/stratdocs/2012/NSPfull.pdf [Accessed 10 April 2012].

UMKHANYAKUDE DISTRICT

MSELENI HOSPITAL PRIMARY HEALTH CARE OUTREACH

At Mseleni Hospital in the uMkhanyakude District in north-eastern KwaZulu-Natal, healthcare workers are attempting to increase the coverage of their services through outreach activities. The remoteness and inaccessibility of parts of the district hamper community members' access to healthcare services at the hospitals. Through the hospital's support to the network of clinics and the mobile teams that service the visiting points, delivery of healthcare services in the communities is enhanced. Taking services to the community frees up services at the hospital, which then become available for those most in need, while also facilitating early detection of disease and illness.

DESCRIPTION

Much of the morbidity and mortality in South Africa is attributable to potentially preventable diseases.[1] Reducing morbidity and mortality thus implies improving the quality of health services, which is one of the 10 points in the Department of Health's 10-Point Plan for the health sector for 2009-2014. In the same vein, the World Bank contends that excess suffering and premature death can be reduced, at relatively low cost, through primary care interventions, increased outreach activities by preventative programmes, and improved access to basic medical care.[2] Successfully implementing these initiatives is the challenge that is faced by any healthcare service.[3] In post-1994 South Africa, the establishment of a district-based system contributed to substantial improvements in terms of access, rationalisation of health management and more equitable health expenditure. Shortcomings persist, however, and include insufficient control and prevention of epidemics, persistently skewed allocation of resources between the private and public health sector, and weaknesses in health systems management.[4] In rural areas, access to medical services is compromised by patients having to travel long distances to access health care at district hospitals. High numbers of patients arriving at the hospitals and the lack of human resources to service their needs places a burden on the healthcare system and limits the effective provision of quality services by the hospitals.

The uMkhanyakude District has been identified by the national Department of Health as one of 18 priority districts and uMhlabuyalingana was identified as the sub-district within uMkhanyakude with the highest deprivation index. Mseleni is one of four district hospitals in uMhlabuyalingana. Mseleni Hospital has made efforts to improve outreach by having medical teams travel to remote and inaccessible areas.

Mseleni Hospital

Mseleni Hospital is located in a remote part of north-eastern KwaZulu-Natal around 60 km from the Mozambique border. Originally it was a mission hospital that developed from a clinic service. The hospital currently provides primary health care (PHC) services for some 90 000 rural people.

The hospital has 184 beds, split into six wards (namely labour, male and female surgical, paediatrics, male and female medical, and isolation). Facilities include a therapy unit (with occupational, physiology and speech therapists), a radiography department with X-ray and ultrasound machines, a pharmacy and a laboratory. The hospital has resident dentists, dieticians and social workers. The hospital manages eight clinics situated in its catchment area of approximately 100 km by 30 km (some 3 000 km^2). Some patients present directly to the hospital, while others are referred by local general practitioners or from the eight hospital-managed clinics.

Mseleni Hospital is well integrated into the local community. The hospital site also houses the Mseleni Children's Home, which runs an AIDS orphan care project called Lulisandla Kumntwana. A community development project, Vuka Mabaso, runs a computer centre, a library, a hall used for community events, a small business centre, and a tutorial maths and science programme.

Clinics managed by Mseleni Hospital

Mseleni's eight clinics are spread throughout the hospital's designated catchment area. The closer and more accessible clinics (such as Mbazwana and Tshongwe) can

be reached using a passenger vehicle, but others involve a long and arduous journey requiring 4x4, rough-terrain vehicles. Over the last year the Mabibi and Nibela clinics have used the Zululand Mission Air Transport (ZUMAT) to transport healthcare workers (HCWs) from the hospital to the clinics in the furthest and least accessible areas in order to minimise doctor down-time and alleviate the strenuous nature of the travel.

Although Mseleni Hospital co-ordinates and macro-manages the clinics, day-to-day management is provided by a nursing operational manager living at or near the clinics. In addition to delivering the prescribed health services, the nurses are responsible for administrative tasks such as ordering drugs, collating monthly statistics, keeping and organising records, and notification of TB cases. Seven of the eight clinics are open for emergencies seven days a week, 24 hours a day. The other is open from 7am until 4pm. Two PHC supervisors, one for mobile clinics and one for the fixed clinics, oversee the operation.

A hospital-based doctor visits each clinic at least once a week, as does the team of therapists. A dentist visits the clinics once every two weeks. Patients are referred for specialised attention by the fixed or mobile clinic nurses. Where possible, patients are treated at the clinic, but more serious cases are referred to the hospital.

Clinic utilisation varies according to the size of the surrounding population and other sociological factors, such as the health status of the community and their perception of the services. Mbazwana Clinic averages the highest monthly headcount while Mabibi Clinic's headcount is the lowest.

To extend the PHC service coverage, three mobile teams serve 35 visiting points in the hospital's catchment area. These points are visited on a weekly or bi-weekly cycle and offer the standard health services linked to mobile clinics.

Links to policy

Elements of the national Human Resources for Health (HRH) Strategy for the Health Sector (2012/13–2016/17) are evident in the hospital's strategies. A strong link exists between the availability of adequately trained health workers and good health outcomes. Similarly, the availability of adequately trained health workers is a critical factor for the success of the planned National Health Insurance scheme. The HRH strategy document identifies three main challenges:

- Supply and distribution of health workers: There is an absolute shortage of health professionals and those that are available are unevenly distributed between rural and urban areas and between the public and private health sectors.
- Education and training: Education and training in the health sector has not kept pace with the country's health needs and health system requirements.
- Health workers' working environment: Issues that adversely affect health worker motivation include job design, performance management, remuneration, employment relationships, physical work environment, workplace cultures, facility workforce planning and lack of career paths.

Mseleni's efforts to increase PHC outreach contribute to addressing the inequitable distribution of HCWs and the

Entrance to Mseleni Hospital

strategic priority of access to healthcare professionals in rural and, especially, remote areas. These efforts also focus on having specialised medical teams visit different sites (fixed clinics and mobile visiting points) on a weekly basis.

OBJECTIVES

Mseleni's objective in initiating outreach to clinics is not formally stated, but staff clearly work towards the common goal of increasing PHC coverage and, as part of these efforts, to include more prevention opportunities.

> *"It's basically to bring health to the people, not to let the people come to the health services. It's basically a merciful approach to try and help people access health care more easily."*
>
> *(Medical doctor, Mseleni Hospital)*

> *"The intention in trying to decentralise is to get more people to work more effectively at a preventative level."*
>
> *(Medical doctor, Mseleni Hospital)*

The philosophy of the programme can be described as providing outreach in order to improve the delivery of primary care to the community.

> *"If you tend to draw all your diseases to the hospital you are merely managing problems as they are, you are beyond the preventative stage, you are in the curing stage … If you strengthen your role in clinics you are actually on the forefront of where you can prevent problems … If you manage them at a clinic level you use your resources much better, you deliver much better service, you are much more at a level where you can catch things before they happen – kind of at a screening level, not so much at a curative level."*
>
> *(Medical doctor, Mseleni Hospital)*

STRUCTURAL FEATURES

Service delivery

Although providing outreach medical services to the clinics is not new, in this case the approach and outreach activities are different. The current services include visits by medical teams to the clinics and visiting points. The main features of service delivery include:

- Early reporting of illness for patients who seek treatment early
- Differentiating levels of urgency in treatment (including using triaging of patients who need care)
- Initiating outreach programmes to satellite clinics and mobile sites (visiting points)
- Establishing a referral system that allows specialist care and primary health care at appropriate venues.

The aspects that are important in this service provision, related to the increase in outreach, include:

- Composition of the team: The inclusion of different medical professionals not only widens the scope of services but also contributes to a multidisciplinary approach and holistic care of patients. Preventative work (e.g. a dietician providing nutritional information) widens the scope to more than curative care and includes promotional health care. The presence of a medical doctor is, unfortunately, still critical for the client's perceived value of his/her visit. Even the nurses are caught up in this paradigm.

  > *"They [the nurses] feel more confident if the doctors are around at the clinic and that had an impact of a great improvement and great support."*
  >
  > *(Nursing manager)*

- Availability of comprehensive services during medical team visits: The team members do not deliver fixed services on specific days (e.g. ARV on Mondays, child health on Tuesdays) but instead provide integrated healthcare services in response to presenting conditions of patients. This encourages patients to access services and to not feel excluded because only certain services are provided at specific times.
- Use of the triage to classify and treat patients according to priority level.

  > *"Primary health care nurses have been trained to see patients at first contact and to categorise patients into mild, moderate and severe and then to refer those that they believe are ill or critically ill, especially if they are problem patients."*
  >
  > *(Key informant, University of KwaZulu-Natal)*

- An established referral system that facilitates specialist care and primary health care at the patients' convenience.
- Inclusion of social aspects of health: Having four social workers in the team helps with issues such as applying for and accessing child grants. Addressing socio-economic conditions is critical in successfully addressing adverse environmental factors contributing to poor health status.
- Specific programmes such as:
  - Phila Phaqa Pikinini that focuses on under-5 mortality rates through the establishment of children's health focus groups at the clinics that aim to involve community members such as pastors, teachers or parents
  - Providing medical male circumcision at clinics.

Resources

The Mseleni Hospital Outpatient Department serves as a doctors' waiting room during the day and also a 24-hour emergency department. There are usually between eight and 16 doctors employed by the hospital, this including community service doctors. The hospital employs 550 people in total and has more than 100 community caregivers. Mseleni pharmacy is responsible for the provision and management of drugs at the clinics and mobiles. The hospital runs a fleet of 30 assorted vehicles that can be accessed for providing outreach services thereby increasing PHC coverage. With these resources, the hospital currently serves 90 000 people, with 200 000 patient contacts and 8 000 admissions per year. Annually, 1 500 operations are performed and 2 300 babies delivered.

The mobile clinics are an integral resource in the initiative. ZUMAT, an air charter and flying doctor service based in Hluhluwe, northern KwaZulu-Natal, was used to increase the PHC initiative by some clinics. The flights make possible PHC outreach activities to inaccessible and remote areas that are difficult to reach by land transport.

> *"By flying the healthcare workers to the outlying clinics, [as] opposed to having them drive by vehicle, means a drastic reduction in time travelled. This allows the doctors and other health professionals to spend more time at each clinic, while also not being subjected to the often forgotten effect of fatigue induced by driving on these roads. By spending more quality time at the outlying clinics they consult more patients, this in turn reduces the number of referrals to the hospitals, lightening the load on the already short-staffed hospitals."*
>
> *(ZUMAT CEO)*

Health information management

Demographic information about the community informs decisions on needs to be addressed. The Hospital Information Officer is responsible for health information, including the clinics' routine data collection and initial analysis and the maintenance of the semi-permanent data, such as the clinic's catchment area, size and population. The doctors compile clinic reports every quarter on the healthcare activities and these reports are used internally for planning.

There is a monthly data review meeting and a weekly HCT and circumcision data review (nerve centre meeting). Reflection and case discussions are done informally during ward rounds.

Funding and partnerships

Funding

Mseleni Hospital is Department of Health-funded. The hospital reports having adequate staff to enable their outreach activities. Funding and support is also received from Africa Centre at Mtubatuba and PEPFAR through USAID. For example, Africa Centre recently assisted with the training of nurses on Nurse-Initiated Management of Antiretroviral Therapy (NIMART).

The HeliClinics programme, which uses helicopters for the hospital-clinics transfers, is currently funded entirely by ZUMATs own fundraising efforts, with a proposal to expand their services by enlisting financial assistance from the KZN Department of Health. This has not, however, yet been achieved.

Partnerships

Mseleni Hospital works closely with tribal leadership structures and communities. There are clinic committees and a hospital board, although they currently do not function optimally. Initially, the clinic committees worked on different levels and provided an important link to the community.

> *"Community involvement, there were committees at the clinics and those committees have to be kept updated about what is going to happen. Then the committees within the sub-district have a meeting once a month. All committees of the sub-district, by clinic, they will go to the hospital and meet with the hospital management and the hospital will give reports as to what is happening in the sub-district in terms of services."*
>
> *(Former district manager)*

Through the previously described partnership with ZUMAT, doctors are transported to the clinics that are furthest away from the hospital and least accessible.

Water projects that had been started before the advent of local government municipalities have been handed over to the authorities and a good relationship with the municipality is fostered to maintain the provision of water, which impacts on the curbing of diseases such as diarrhoea.

A partnership with the Department of Family Medicine (University of KwaZulu-Natal) provides students with practical learning opportunities. Mseleni also benefits from the Umthombo Youth Development Foundation funding local (rural) undergraduates to study in different health sciences. The students then return to the area to practise their professions.

SUSTAINABILITY AND POSSIBILITY OF REPLICATION

The replication of the services at Mseleni Hospital is largely dependent on a number of factors, namely:

- Community participation: Communities need to be kept informed of when medical teams will arrive and this depends largely on active clinic committees who serve as an essential communication link between those co-ordinating medical services and the community.
- Availability of resources: The use of mobile services appears to be a viable option for most hospitals dealing with populations in remote locations. The cost of introducing air transport for easier access to remote facilities, although innovative and effective, may prove prohibitive for others to replicate.
- Enthusiasm of staff is needed to adopt a proactive patient-centred approach to provide preventive and promotive services instead of waiting for patients to seek curative care in hospitals.

It would not be difficult to replicate the service delivery if both the resources described and the will to do outreach activities are present.

SUCCESSES

The outreach activities serve a gatekeeping function by enabling community members to access lower levels of care at primary care facilities, thereby reducing the numbers of patients seeking hospital services. The outreach activities also lead to improved early case detection and identification of risk factors before patients present with advanced disease, thus freeing up resources to further promote prevention activities. Increasing PHC coverage thus had a positive impact by reducing the work-load at the hospital.

An increased utilisation rate at Mseleni's clinics is the ultimate indicator of success of the outreach efforts:

> *"If it [the utilisation rate of clinics] is good, I would be saying that my services are being utilised maximally… When I compare the OPD count at the hospital with PHC, there should be a difference. One should be seeing people at the hospital who need the next level of care; I must not be seeing people that should have been managed at a local level… People should be treated in a known environment without travelling and coming to the hospital. All services, like social workers, physiotherapy and all other services that you can find at a hospital, must be taken to people at a primary health care level. One must not see a scenario where a person needing care from a dietician is having to travel."*
>
> *(District manager)*

Some of the self-reported successes include:

- ✓ Obtaining CD4 counts for HIV-positive patients is standard practice:

  > *"Everyone has CD4 counts in their file."*
  >
  > *(Medical doctor, Mseleni Hospital)*

- ✓ Maternal mortality has decreased due to ARV initiation.
- ✓ ARV initiation is not only done at the hospital, but also at clinic level:

  > *"So at the beginning of the ARV rollout nationally we said this is not something to be done just in hospital, but it has to be done at primary health care level."*
  >
  > *(Medical manager, Mseleni Hospital)*

CHALLENGES

Various challenges were reported, including:

- Staff retention: The hospital recruits and appoints sufficient numbers of staff, but staff turnover is high. Foreign doctors perform important duties and Mseleni provides an important learning opportunity for interns and student placements during electives. There is a fear that new legislation will make it more difficult to recruit foreign doctors. Inadequate numbers of local graduates willing to return to the area also frustrate the hospital management.

  > *"If we had our local kids coming back to work as doctors here we wouldn't be so dependent on foreign doctors."*
  >
  > *(Medical doctor)*

- Inadequate staff accommodation: Residential accommodation is a serious problem in recruiting and retaining experienced staff. Those who have worked for a number of years need better accommodation than the park homes that are available.
- Insufficient PHC training and education: Many junior doctors are more interested in specialising and do not consider PHC a specialist area.
- The lack of resources to sustain the use of ZUMAT to transport specialists into the community poses a challenge to PHC outreach and the health status of patients who reside in remote areas.
- Data management: Respondents reported data management as problematic, with inconsistent data quality.

LESSONS LEARNT

Learnings reported by the various stakeholders included:

- Community buy-in is important for a project to succeed. Obtaining such buy-in is easier if the community knows what services are available.
- Personal passion and commitment can make a difference:

> *"I must be honest…you remember the 2009 strike; you won't believe that Mseleni continued to do the clinical visits. People were here, but did not want to work, and the doctor would get into his car and go and work at the clinics, the far ones … patients did not know anything about the strike."*
>
> *(District manager)*

- Team work and a team approach are important, especially when it is a multi-disciplinary team.
- Reaching out to communities can improve service delivery, allows for patients to be treated early, and alleviates congestion at the hospital.
- Hospitals can support clinics and co-ordinate and manage outreach activities on a local level.

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REFERENCES

1. McIntyre D, Baba L, B M. Equity in Public Sector Health Care Financing and Expenditure in South Africa: An Analysis of Trends between 1995/96 to 2000/01. Durban: Health Systems Trust; 1999.
2. World Bank. World Development Report 1993: Investing in Health. New York: Oxford University Press for The World Bank; 1993.
3. World Bank. Better Health in Africa: Experience and Lessons Learned. Washington, D.C:The World Bank 4;1994.
4. Harrison D. An Overview of Health and Health care in South Africa 1994 – 2010: Priorities, Progress and Prospects for New Gains. A Discussion Document Commissioned by the Henry J. Kaiser Family Foundation to Help Inform the National Health Leaders' Retreat, Muldersdrift. 2009; January 24-26 2010.

UMKHANYAKUDE DISTRICT

UMTHOMBO YOUTH DEVELOPMENT FOUNDATION

Umthombo Youth Development Foundation originated as the Friends of Mosvold, a good practice that assists local rural youth to study towards degrees in health sciences. Through the preparation and encouragement of learners, and support and mentorship to students, graduates are encouraged to return to rural areas to serve their community of origin. This is an excellent example of addressing local needs by using local solutions and has become a long-term solution to address rural healthcare shortages. This approach has been replicated throughout uMkhanyakude and the surrounding districts.

DESCRIPTION

The Friends of Mosvold (FoM) Trust was established in 1995 by Dr Andrew Ross to facilitate health development in the uMkhanyakude District. Over the years the Trust raised money for Mosvold Hospital to purchase vehicles, improve accommodation, provide fencing for residential clinics, develop an HIV and AIDS education programme and implement a large-scale sanitation programme. Mosvold Hospital, situated in the remote district of Ingwavuma, KwaZulu-Natal, provides health care to over 200 000 people and is one of the five district hospitals in the uMkhanyakude District.

In 1998 the serious shortages of professional staff at the hospitals in the district, along with the belief that youth from the area, in spite of many financial, social and educational obstacles, have the potential to become health professionals, led the Trust to establish a scholarship scheme.

The Trust formed an agreement with the Medical Education for South African Blacks organisation (MESAB) to contribute half of the university costs (which amounted to approximately one third of the total costs involved).This agreement unfortunately ended in 2007 due to changes in MESAB itself.

A comprehensive programme was set up at the district hospitals and in local schools to promote careers in health sciences, to inspire learners to dream about what seemed impossible, and to raise awareness about HIV and AIDS. The Trust initiated career guidance days ("Open Days") at the district's hospitals twice a year to expose school learners to health science careers. It was realised that, for the approach to succeed, students accepted at university to study health science courses should not only be funded, but should also be mentored and supported whilst studying. On their return the graduates should then be helped to integrate into the hospitals in the district and, in so doing, be retained in the areas from whence they came.

Until 2008 the entire scheme was managed by a small group of highly committed trustees. Dr Ross was responsible for fundraising and mentoring students and

THE POWER OF AN INDIVIDUAL'S VISION

> *"Dr Ross (a medical superintendent at Mosvold hospital) said that we have got all these youth that have no opportunities, what about investing in them to become the future health care professionals that this hospital needs. A lot of people thought it was impossible for the rural youth to succeed; the schooling is bad and they will never get into university, and if they do they will fail, and if they happen to pass they will never go back [to the rural areas]. That is how it started - with no money, just the concept."*
>
> *(Director, Umthombo Youth Development Foundation)*

> *"He [Dr Ross] had a problem and he looked forward. He said we need to find a strategy of developing people who can be able to assist permanently rather than the doctors who come temporarily."*
>
> *(CEO, Hlabisa Hospital)*

Mrs Nsimbini managed the holiday work placements. In 2008 a Director, Dr Gavin MacGregor, was employed to develop the scheme further. In 2009 the scheme was expanded to three hospitals in the adjacent district and in 2010 expanded to two more hospitals. In March 2010, to coincide with the spread of the scheme to other districts, the name was changed from the Friends of Mosvold Scholarship Scheme to the Umthombo Youth Development Food Foundation (YDF).

CONTEXT

Residents of the uMkhanyakude District live in under-resourced conditions with little infrastructure. The communities are poor, unemployment is high and job opportunities are scarce. Schools are overcrowded and the standard of education is poor. The major health problems affecting people in this district include malaria, TB, HIV and AIDS and gastroenteritis.

All the district hospitals in uMkhanyakude have struggled to retain professional staff, which compromises the quality of service provided. To alleviate this problem, health professionals have been recruited to the hospitals from other countries, but few of these professionals remain in rural South Africa for long periods. Attempts have been made to encourage South African graduates to work in the district. For young people who have grown up in a city, however, a rural lifestyle has little to offer. A very small number of learners from uMkhanyakude District go on to tertiary education. Apart from nurses, few of the health professionals working in the district hospitals actually come from, or grew up in, the district. This is, in part, due to the poor standard of local education, the high cost of tertiary education for students from an area with a high level of unemployment, and the lack of appropriate role models. It is in the context of these rural challenges that Umthombo YDF is operating and changing lives.

LINKS TO POLICY

The National Human Resources for Health Strategy for the Health Sector (2012/13-2016/17) was launched on 11 October 2011.[1] Research has shown a strong link between the availability of adequately trained health workers and good health outcomes. Strengthening human resources for health (HRH) is thus one of the priorities identified in the government's 10-point Plan. Improving HRH is essential if other healthcare initiatives, such as the re-engineering of primary health care and the National Health Insurance scheme, are to succeed.

The HRH strategy identifies three main challenges:

- The supply and distribution of health workers: An absolute shortage of health professionals is exacerbated by the existing professionals being unevenly distributed between rural and urban areas and between the public and private health sectors.
- Education and training: Education and training in the health sector has not grown sufficiently to meet the country's health needs and health system requirements.
- The health workers' working environment: Health worker motivation is adversely affected by poor job design, performance management, remuneration, employment relationships, physical work environment, workplace culture, and facility workforce planning, as well as a lack of career paths. The HRH strategy addresses eight strategic priorities:

    1. Provide proactive leadership to achieve the objectives of the strategy
    2. Provide health worker information to support planning for HRH
    3. Provide a workforce for planned new services
    4. Upscale and revitalise education, training and research
    5. Strengthen academic health complexes and nursing colleges
    6. Effectively manage the health workforce
    7. Develop a workforce that delivers quality services with care and compassion
    8. Promote access to health care professionals in rural and remote areas.

The Umthombo YDF activities address the challenges identified in the HRH strategic document, particularly the supply and distribution of healthcare workers in rural areas. The Foundation's activities further address the retention of those workers in rural hospitals. Umthombo YDF's impact has more than increased numbers of health workers; it has advanced primary health care and community participation.

OBJECTIVES

Umthombo YDF seeks to address the shortage of qualified healthcare professionals at rural hospitals. It aims to improve healthcare delivery to rural communities through the identification, training and support of rural youth who have an interest in and the ability to become qualified healthcare workers and who will, on graduation, return to work at their local, rural hospital. This is achieved by:

- Outreach to rural schools to make pupils aware of the health sciences as career opportunities
- Identifying and selecting rural school-leavers who have the potential to become healthcare professionals and who have obtained a place at university
- Providing comprehensive financial support for the selected students
- Providing academic and social mentorship support

to all at Umthombo YDF

- Working with the local hospitals and the Department of Health to ensure all graduates obtain posts on completion of their studies
- Ensuring that graduates honour their work-back contracts by returning to work at a rural hospital
- Supporting graduates in their integration into the hospital working environment and in their professional development
- Establishing and maintaining relationships with funding agencies
- Expanding the programme to other rural hospitals and other provinces
- Researching rural health recruitment and retention and using this to inform and improve activities.

Although the goals of the organisation remained unchanged, new systems were developed and existing systems strengthened after 2010:

> *"In 2010, we spent time determining what the critical aspects of success are. Having identified them we are intentional about allocating the necessary resources to ensure they are implemented."*
>
> *(Director, Umthombo Youth Development Foundation)*

STRUCTURAL FEATURES

The healthcare system struggles to retain rural staff, especially those from urban areas who prefer a city lifestyle. Global research has guided Umthombo YDF to focus on educating local rural youth. Research has indicated that health sciences graduates of rural origin are more likely to work and live in rural areas than their counterparts from urban areas. Instead of waiting for government to address the problem, Umthombo YDF is proactively building qualified teams at rural hospitals.

Service delivery

Approach

The approach used by the Umthombo YDF is more than a simple bursary 'hand-out'. Rather, it is proving to be one of the few long-term solutions to the challenge of recruiting and retaining quality healthcare professionals for South Africa's rural areas. Research has shown that health professionals are more likely to choose to work in a rural hospital if they originate from a rural area themselves, or if they are exposed to the realities of rural healthcare delivery during their university training.

However, in the context of the uMkhanyakude District and the realities of poverty and rural marginalisation, more is needed and that is where the Umthombo YDF has stepped in. It offers a carefully considered approach, tested over 10 years, that:

- provides an incentive for rural high school learners to work hard to achieve the grades that are needed to be accepted to study a health science course at a university or University of Technology;
- offers a beacon of hope for local learners and stimulates local youth development *"It is possible to come from a rural area and become a health professional!" (Learner 1);*
- stimulates community development and co-operation, as hospital working groups help select the students for scholarships;
- offers students comprehensive support, allowing students to concentrate on their studies so they can pass, despite most rural families facing financial barriers to higher education;
- provides academic and social mentoring support to ensure rural youth have the best opportunity to succeed;
- enables students to gain practical exposure to complement their theory as they are mentored by hospital staff whilst participating in holiday work at their local hospital;
- improves the quality of healthcare delivery, because the young health professionals come from the area and, therefore, understand the language and the culture of the local people;
- positions graduates to become role models to the youth, which builds hope and prosperity within rural communities; and
- offers what is probably one of the most sustainable solutions for the long-term supply of professional health staff for rural areas.

Services

The Umthombo YDF identifies, trains and supports rural youth who demonstrate the potential to become qualified healthcare professionals, in order to address the human resource shortages in rural hospitals, thereby improving health care to the impoverished rural population of northern KwaZulu-Natal, South Africa. The Foundation provides financial and mentoring support for youth to study a health sciences degree at university. The graduates are expected to work at a rural hospital for the same number of years for which they were supported. The main services that enable Umthombo YDF to function optimally include financial, mentoring and alumni support.

Financial support

Financial support provided by Umthombo YDF is comprehensive in order to ensure that the students are

able to concentrate on their studies and pass. They are assisted with tuition fees, accommodation, a monthly food allowance, books, stationery and equipment. The Foundation also provides payment for holiday work.

Mentoring support

Mentoring support helps students to address academic, social and personal issues - a critical component to their success. Rural students face many challenges at university, including poor language skills, peer pressure, the fast pace of the academic programme, requests from home and expectations from the community. Initially, mentoring was provided by a single student mentor in the form of monthly contact with students through telephone, sms or e-mail communication and at least two face-to-face visits per year at the university and one during the student's holiday work.

> *Dumisani, the organisation's Student & Operations Manager, came from Domonia (Ingwavuma). He knows what it is like; he has been through the system ...and so he speaks passionately about the need to succeed and the need to overcome.*
>
> *(Founder, Umthombo YDF)*

Students are also encouraged to meet with each other:

> *They create a mechanism in which we have to help each other; the one in upper level helps the one in lower level, because you come from the same background.*
>
> *(Mosvold Therapist and Umthombo YDF beneficiary).*

A referral system is in place for those students who need help with more serious problems. The mentoring enables the students to be accountable and make good choices. From the inception of the organisation's activities, teaching the beneficiaries problem-solving skills and the need to take responsibility were seen as important.

With the expansion of the scheme, the main mentor, who was one of the first graduates of the Foundation and is now working as the Student and Operations Manager, cannot physically mentor all students. In 2010 a network of mentors was set up with a number of people who are overseeing the students on Umthombo YDF's behalf. The mentors make use of an assessment form that includes aspects such as: how are you doing academically; how are you doing socially; what are some of the family problems you have; are you coping in general; and how are you managing your money? Students meet with their mentor once a month; the mentor completes the assessment form and sends it to the Student and Operations Manager.

Some students who receive bursaries from the KZN Department of Health are also included in the mentorship programme provided to rural students.

Holiday work

Students work at hospitals in the district during their June and December holidays, which not only provides them with the opportunity to get practical experience in their field of study but also prepares them for work after graduation. They are mentored during the holiday work to maintain an interest in rural work:

> *Holiday work is important for us - practising, connecting with others, having a relationship with management.*
>
> *(Founder, Umthombo YDF)*

> *I like to have them shadow me and talk about the patient and give them some academic research journals. We do case discussions and, being the district hospital, we also talk about resource development and what we do for our patients in the community. So we are developing things and also it is nice to learn from them (the students) as well because they are coming from a fresh environment.*
>
> *(Hlabisa Therapist)*

Annual student Imbizo: mentoring support

The purpose of the Imbizo is to gather and talk about what was worthwhile in the year to date, what should be changed in the following year, and to inform participants about policies or procedures (e.g. what allowances they will be getting after the annual review). The real value of the Imbizo lies in the discussions around topics such as relationships, HIV and AIDS, managing yourself, motivation, values and work ethic. For the Umthombo YDF staff it's a valuable time to meet with the students as a family. Even though some of the students come from the same area, they are all at different universities and so they too enjoy coming together. Umthombo YDF aims to have graduates who are well-rounded individuals who will be able to solve problems in under-resourced hospital settings.

> *If you are learning to make good decisions about studying, you also need to make good decisions about sexual behaviour. We talk a lot about money management - that's very important. We say you have to go back for at least three reasons. One, we need workers at rural hospitals. We need workers for the lady next door. Two, our funding depends upon you going back. It is important that you go back, for the people who will follow behind you. Three, you must go back because you signed the contract.*
>
> *(Founder, Umthombo Youth Development Foundation)*

Alumni forum

On graduation, participants are assisted to integrate into the hospital working environment and become

MENTORING: MAKING THE DIFFERENCE

> *The key success of the scheme is around mentoring; it helps us to be successful in terms of passing. Mentoring also helps us in retention.*
>
> *(First beneficiary and current mentor)*

> *Mentoring is the backbone of this thing. Without these youth being mentored they would not be successful at university. They go to university at a huge disadvantage academically but also socially - a lot of family problems, going there knowing their siblings at home need food, and so on. So the mentoring programme was one of the first things that was established.*
>
> *(Director, Umthombo YDF)*

> *"We want you to have contact with some sort of mentor at least once a month." We really emphasised that they are good students - "You were good enough to get to the university so if you fail a test, it means that there is a problem and if you are clever you must find a way to fix the problem."*
>
> *(Founder, Umthombo YDF)*

> *Dr Andrew Ross played the role of a father in my life .. .just to know that there is someone behind you who is watching over you and how you are progressing.*
>
> *(First beneficiary, current mentoring coordinator)*

professional healthcare workers. The Umthombo YDF alumni become role models in their communities and encourage the rural youth to work hard and stay focused in order to achieve their dreams. The alumni are involved in open days at the hospitals and in visits to schools in the district to motivate learners to work hard and to expose them to careers in health sciences.

> *He (the graduate) will announce [at church] that he wants to meet with those who are in Grade 10. He calls for a meeting with them and has a talk with them, and he gives them forms to apply and encourages them.*
>
> *(Parent of beneficiary)*

> *The other thing which is important is to go back to your local school - to say I came from this school; if I can make it to university and if I can pass, you can pass too. I am here, you can touch me, I am real; I have gone to this very same school, that's my house down the road. It is real, possible; we want to help people to create a dream that is a reality.*
>
> *(Founder, Umthombo Youth Development Foundation)*

Selection

The recruitment of youth with potential is structured in a specific manner. It begins with outreach to schools to explain health science careers (especially those less known to learners), the criteria for selection into university programmes (e.g. required subjects and grades) and application procedures. The top learners are then invited to attend open days at the hospitals in the district. During these open days graduates (alumni) share their own stories and journeys with learners to encourage them. The learners are also exposed to the various departments in the hospital through visits and explanations of the various job roles. The scholarship scheme is then marketed to those who are interested. For youth to be eligible for consideration for an Umthombo YDF scholarship, they must come from a rural area in northern KwaZulu-Natal where the organisation is working; have done at least one week of voluntary work at their local hospital; have been accepted to study an approved health science degree or diploma; demonstrate financial need; be willing to sign a year-for-year work-back contract and, finally, be interviewed, and accepted, by a local selection committee.

Resource use

The Foundation used to be run by a small group of volunteer trustees, but since 2008 it has been employing full-time staff, including Dr Gavin MacGregor as the Director. There are five employees at this not-for-profit organisation managing an annual budget of R10 million.

Through the Foundation, funding was also sourced to equip various units at hospitals. For example, Umthombo YDF acquired funding from a private Trust to equip the audiology unit and optometry clinic at Hlabisa Hospital.

Monitoring and evaluation

The students' progress is monitored monthly through the mentoring system. The mentors assess test and examination results and help students to address their challenges. Assessment forms are completed by the

mentors and submitted to the mentoring co-ordinator. Individual students have to report (in writing) to their mentor on steps taken to address challenges (e.g. notes on meetings with lecturers). Overall pass rates are calculated every year and ways to improve the results are discussed and put into place. The ultimate goal of the Foundation is to increase the number of rural health professionals. Graduates are monitored during their internship, their community service placement, their time working back their commitment and even afterwards to determine who remains in a rural placement.

Graduates are from the community and give direct feedback to the community on the progress of the programme. Through the establishment of the Alumni body, graduates network and support one another, and discuss how they can support Umthombo YDF.

Funding and partnerships

Funding

Comprehensive financial support is provided to all students. The support covers tuition, accommodation, books and stationery, a monthly food allowance, payment for holiday work and any other incidental expense such as equipment needed (e.g. stethoscopes and dissection kits). In addition, all students receive comprehensive mentoring support, covering academic and social issues.

The estimated average cost per student per year in 2011 was approximately R55 000 and 184 students were supported in that year - a total of R7 920 000 for 2011. The Umthombo YDF then had four staff- a Director, the Student Mentor, an Office Administrator and an Office Assistant. Organisational expenses for 2011 represented 17% of the total budget and included salaries, office rental, travel, telephone, fax and internet expenses. Mentoring support to students includes the cost of the annual Student Imbizo, in addition to the Student Mentor's salary and his travel and accommodation, as well as stipends paid to local mentors. The total budget for 2011 was R10 960 872.

The first funding drive entailed asking various stakeholders to contribute - previous British contract doctors were asked to contribute £1 000, tribal authority members and community health workers were asked to each contribute R1, which raised a total of R15 000.

> *"The tribal leaders were involved. They knew that people are needy and the people were really taken by this initiative, because they were sitting with their kids at home - kids who have got Grade 12. So they were very much interested."*
>
> *(Trustee)*

The first four students were supported through donations by individuals (including overseas doctors who had worked at Mosvold Hospital) and South African companies. The Discovery Foundation's Award for Excellence received in 2007 allowed for the employment of full-time staff. Funding is now obtained from South African companies (mainly their corporate social investment budgets), a number of South African Trusts, and a few international Foundations, as well as individuals.

Partnerships

One of the most important reasons for the Foundation's success is the close partnership formed with the local community. This was already evident during the establishment of the organisation when the local community (linked to Mosvold Hospital) contributed R15 000. Rural residents also appoint representatives to sit on the interview committee that selects students for the bursaries. The selection committee plays an important role in the selection process, especially in confirming that applicants are local residents and have a clear commitment to their studies:

> *"The other thing that made the success of this scheme is the participation of the community - community participation, community buying into the programme."*
>
> *(Trustee)*

Parents of the participating students are also encouraged to motivate their children:

> *"He (Dr Ross) kept on encouraging us that we must assist our children."*
>
> *(Parent of beneficiary)*

The Department of Health is an important partner in a number of ways:

- Umthombo Youth Development Foundation works in partnership with local hospitals that contribute by committing time and resources, including staff being involved in holding Open Days for local school learners.
- Hospitals allow students to do holiday work at their institutions.
- The alumni (graduates) working at the hospitals provide ongoing support to students.
- The provincial Department of Health provides bursaries to students.

The Department of Education co-operates with schools and universities, and the local circuit inspector is on the selection committee of Umthombo YDF. The Foundation also partners with the Centre for Rural Health of the University of KwaZulu-Natal that works with the public health system, community networks and the university to improve the health care offered to underserved communities in rural areas.

Individual and organisational donors contribute financially to the activities and operational costs of the Foundation. The trustees are also key partners.

Umthombo YDF is part of South Africa's Rural Health Network and enjoys contact with a range of other organisations working on similar challenges, such as Africa Health Placements, Health-e News Agency, Rural Doctors Association of South Africa (RuDASA) and the Foundation for Professional Development (FPD).

Currently there are very strong relationships with all five hospitals in the uMkhanyakude District: Mosvold, Mseleni, Hlabisa, Manguzi and Bethesda, as well as Benedictine, Nkonjeni and Itshelejuba Hospitals (Zululand District); Nkandla and Ekombe Hospitals (uThungulu District); Christ the King (Sisonke District) and Emmaus Hospital (uThukela District).

SUSTAINABILITY AND POSSIBILITY OF REPLICATION

Umthombo YDF has been sustainable because it is rooted in the local context and focused on the beneficiaries giving back to the local community. Students are assisted to study, but in return they have to work at rural hospitals. These youth are immediately employable, which influences the alleviation of poverty. Not only do the graduates provide services to the community by working at the hospitals, but they are also role models for the local youth. The fields of study of the graduates include scarce skills that are in high demand. A number of graduates become mentors for the new students, and this too contributes to sustainability.

The diversity of Umthombo YDF's funding base contributes to its financial sustainability. The Umthombo YDF has started an Endowment Fund to ensure continued support for rural youth to become qualified healthcare professionals and so improve healthcare delivery to rural communities in the future. The establishment of an Endowment Fund is a significant step for the future sustainability of Umthombo YDF.

Recently National Student Financial Aid Scheme (NSFAS) loans are also used to lessen the risk to Umthombo YDF. The beneficiaries of the Umthombo YDF are given a NSFAS loan for their studies and Umthombo YDF pays back the loan equivalent to the number of years the student works in a rural area. The student remains accountable for the balance if they leave rural employment before the loan is repaid fully.

The work of Umthombo YDF is highly replicable and should be considered for replication in other parts of the country. It is a long-term model for staffing in all rural hospitals in South Africa. A similar programme is currently being established in the Eastern Cape Province in partnership with the Eastern Cape Department of Health.

The model is also replicable in other sectors, e.g. education, by providing the same support services for rural learners who can study to become professionals and alleviate resource shortages in education.

SUCCESSES TO DATE

Scope of support to date

Through Umthombo YDF, the quality of care has improved significantly in the rural hospitals included in the organisation's activities. Having locally recruited students working back their time in these rural areas means there are healthcare workers who truly understand the community and their context and who care about their welfare. The range of health disciplines supported by Umthombo YDF also means access to a variety of new services in some rural areas. The support of rural students has grown exponentially. Table 9.1 demonstrates the growth in support and the academic success of the beneficiaries.

Table 9.1: Intake of students

Year	Number of students supported	Pass rate
1999	4	Data not available
2007	54	87%
2008	65 (45 full bursaries)	82%
2009	84	85%
2010	110	89%
2011	150	88%
2012	183	Data not available

A breakdown of the health science disciplines in which the students are enrolled is presented in Figure 9.1. From this it is clear that students are supported across a wide range of health science disciplines (16 different disciplines). As a result, the Foundation-linked rural hospitals are able to provide new services because they now have the trained staff available. Previously patients needed to be referred to other hospitals for these services. In 2011, 77 of the 183 students were studying medicine. Umthombo YDF currently boasts 37 qualified medical doctors.

Successes

Umthombo YDF has established a highly successful student mentoring system that provides academic and social mentoring support to all students to optimise their chances of succeeding in their studies. The impact of the mentoring programme has been consistently high with pass rates of over 80% (88% in 2011) and highly committed graduates.

The Foundation has maintained regular training of students in life skills (particularly HIV and AIDS prevention) and supported them to make prudent academic and life decisions.

The FoM Scholarship Scheme started in 1999 supporting four students. As of 2012, Umthombo YDF is supporting 184 students and has produced 116 graduates in a wide range of health science disciplines - Medicine, Physiotherapy, Pharmacy, Occupational Therapy, Nutrition, Biomedical Technology, Social Work, Optometry, Dental Therapy, Dentistry, Environmental Health, Speech Therapy, Social Work, Nursing, Radiography and Psychology. All of the health science disciplines are important in offering patients comprehensive health care. New services such as Optometry, Occupational Therapy, Speech Therapy and Psychology have been introduced to some rural hospitals through Umthombo YDF's work. The Foundation's achievements are all the more remarkable when one considers the previously-held perception that rural students do not have the ability to succeed at university.

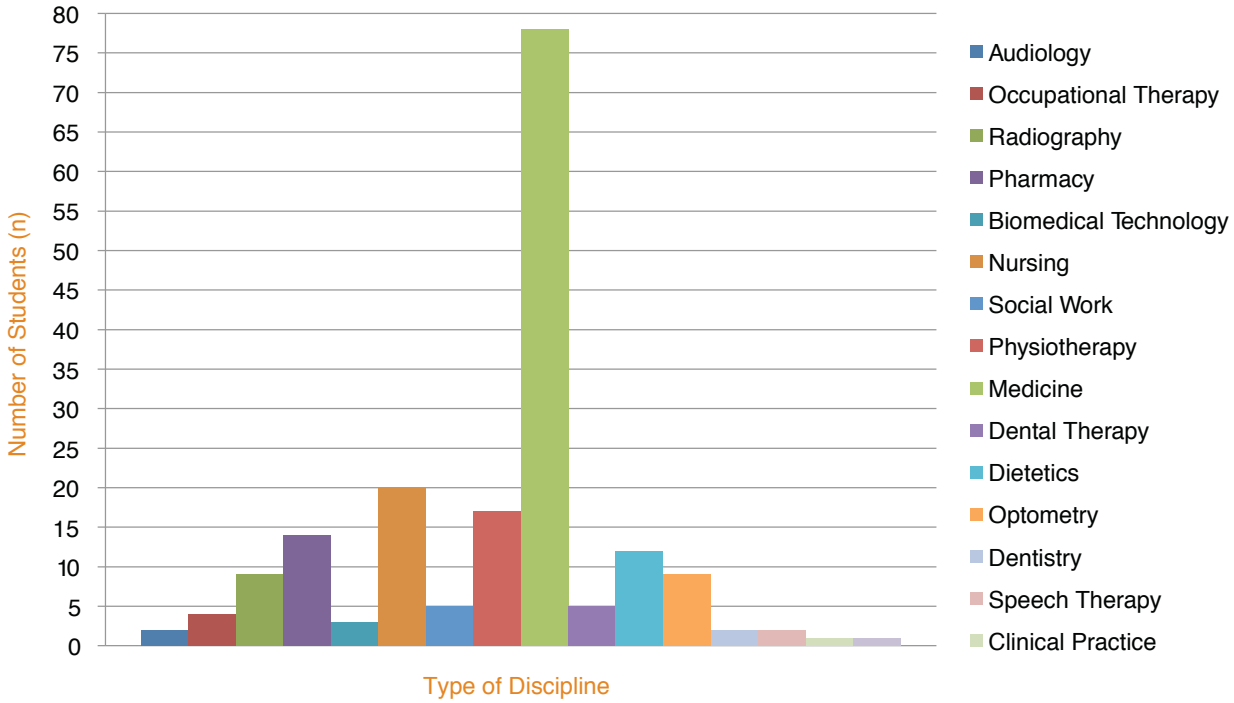
The majority of the graduates are working at a rural hospital, as intended. Of the 116 graduates:

- 66 are working at a rural hospital;
- four are working for rural NGOs;
- three are working in the private sector after having completed their work-back contracts;
- five are working at an urban public hospital;
- four are in the process of buying themselves out to pursue new opportunities (three of the four are still working in the public healthcare sector);
- 28 are currently busy with their internship training;
- five are studying further; and
- one graduate has unfortunately died.

The number of graduates produced annually is increasing, leading to a significant impact at participating hospitals when compared to the severe shortages of qualified medical staff at most rural hospitals. At certain hospitals, graduates are active in the day-to-day running of the programme at hospital level. Alumni are active in the mentorship and support of students doing their holiday work at the hospital. They are also involved in school outreach to highlight the opportunities available and motivate students to work hard to achieve good grades.

Umthombo YDF has been cited as one of the few sustainable solutions to health professional recruitment and retention in rural South Africa. The impact at community level includes the increased reach of hospitals, since more healthcare professionals employed at the hospital means more healthcare professionals who can travel to clinics and make essential services available to the community (especially for vulnerable groups such as people with disabilities). In many cases, a wider variety of services has become available to the community, including audiology and speech therapy. This also reduces the need to travel to bigger centres to access such services.

Figure 9.1: Numbers of Umthombo YDF-supported students in various health sciences disciplines for 2012 (n=184)



Source: Umthombo YDF website: http://www.umthomboyouth.org.za/page.asp?Id=19 (accessed 8 May 2012)

> *We did not have an optometrist ever at Mosvold; in fact in the whole district…people were being transferred or referred to other big institutions. We did not have a speech therapist in the whole district, but now we have our own.*
>
> *(Trustee)*

CRITICAL ASPECTS OF THE UMTHOMBO YDF MODEL

The following have been identified as "critical aspects" of the Umthombo Youth Development Foundation Model:

1. Identifying sufficient youth with potential
2. Providing academic and social mentoring support to all students
3. Providing comprehensive financial support to students
4. Providing graduates with employment at rural (participating) hospitals and honouring their work-back contracts
5. Providing support to graduates in the workplace as part of a retention strategy
6. Funding partnerships to ensure sufficient financial resources to increase student numbers annually and support the above initiatives.

CHALLENGES

The current economic crisis influences not-for-profit organisations such as Umthombo YDF. The organisation is vulnerable as it relies on funding from donors, and the downturn in the current global economic situation has threatened the commitment of funds from donors. The establishment of an Endowment Fund aims to overcome, to some extent, this vulnerability. In addition, the partnership Umthombo YDF has developed with NSFAS reduces the amount of funding needed to be raised for student support.

Another challenge is the current education system, which impacts on the language ability of students from rural areas. This becomes evident in the challenge of coping with the first year of study.

> *We learnt English in Zulu, which is 'Zunglish'.*
>
> *(Beneficiary)*

There are students from the rural areas who have bursaries from the Department of Health who, although funded by the Department (and not Umthombo YDF), are included in the Umthombo YDF mentoring programme. Other students are initially funded by Umthombo YDF and are in later years of study funded by the Department (freeing up Umthombo YDF scholarships for new students). The Department favours students who are already studying, while Umthombo YDF provides the initial funding as the rural students have financial difficulties starting their

THE IMPACT OF INDIVIDUALS GIVING BACK – STORIES FROM UMTHOMBO YOUTH DEVELOPMENT FOUNDATION GRADUATES

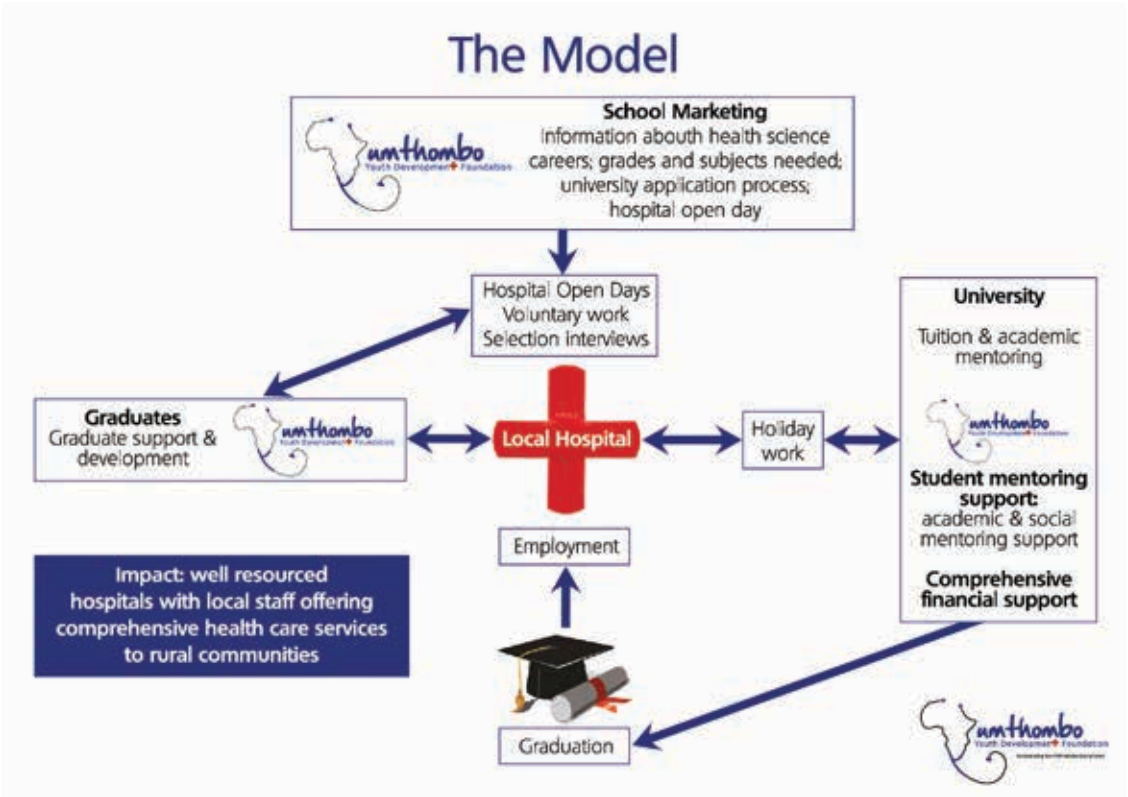
Zotha Myeni is a biomedical scientist, working in the laboratory at Hlabisa Hospital. Since Zotha arrived at Hlabisa Hospital, the laboratory has been able to offer three additional tests which previously had to be sent to other laboratories. Zotha is currently busy with post graduate studies, which will further increase the services available at Hlabisa Hospital.

France Nxumalo set up a provincial optometric service. Although he is no longer working in a rural hospital, his work still influences rural communities and health service delivery directly and his influence is now even wider than when employed at a rural hospital.

Through the efforts of Dumisani Gumede a rehabilitation unit was set up at Hlabisa Hospital consisting of physiotherapy, occupational therapy, audiology and speech therapy services.

> *When Dumisani came, it became even easier because he started to recruit staff and he is a young person who is active and he brought many people with skills to the area. The rehab was a small little room which was run by an assistant occupational therapist and a physiotherapist would work together with them, and they would maybe stay for a year or six months because they came from the UK, and then they would go. But now we have a permanent physiotherapist and permanent OTs.*
>
> *(CEO, Hlabisa Hospital)*

Figure 9.2: The Umthombo Youth Development Foundation Model



studies. These students also continue their mentorship with Umthombo YDF, regardless of the source of funding. Although this agreement works financially, the work-back conditions are unclear or are sometimes taken advantage of by graduates.

Although the provincial Department of Health bursary conditions also require a year-for-year work-back, enforcing of the bursary conditions has not been as strict as it should be. If all graduates' work-back conditions were enforced and managed properly, the number of graduates working in the rural areas would be greatly enhanced. All students who receive mentoring (regardless of funder) are required by Umthombo YDF to work back at a hospital in a rural area.

Another problem faced occasionally by Umthombo YDF is that some graduates cannot find posts at any of the rural hospitals after graduating, since these are specific health science disciplines. The availability of posts to absorb staff should be addressed.

A further challenge is that some graduates want to specialise. Especially in the case of medical doctors, certain specialities are seen as more prestigious yet do not benefit the rural communities as such. The current debate is around when specialisation should be allowed (how soon after graduation) and in which fields. Currently distance education, where possible, is preferred for those who want to specialise.

University policies regarding selection and subsidies do not currently include a rating system for rural students (as they do for black students and female students). If this is included, universities might be more motivated to take in more students of rural origin.

LESSONS LEARNT

Experience has shown that the working partnership between a hospital and the Umthombo YDF is most effective in reaching its aims, when the following factors are in place:

- Strong support for the project and a passion for long-term recruitment by the hospital management, particularly the Medical Manager, Hospital Manager, Finance Manager and HR Manager
- An established hospital Working Group with a key person to liaise with the Umthombo YDF
- A hospital Working Group that prioritises and organises a minimum of four weeks of holiday work for students per year in the hospital
- Arrangements for pre-selection voluntary work by applicants to the programme
- Two hospital representatives serving on the scholarships' selection committee
- Timeous advertising of hospital posts so that graduates can apply to work back their contract at the hospital

- Clearly communicated scholarship scheme policies and procedures, and regular meetings between the hospital Working Group and the Umthombo YDF
- Processes to update Hospital Managers regularly on the progress of the Umthombo YDF.

Valuable lessons can be learnt from the aspects that make Umthombo YDF successful:

- It addressed a need for recruiting and retaining healthcare professionals in rural areas that was previously unmet, by motivating local learners and funding and mentoring students from local communities to attend university. It proved that rural students have the potential to succeed if provided with the necessary support.
- It enabled a situation where graduates return to work in rural areas, thereby enabling retention of healthcare workers.
- The approach has been rolled out across the district and in surrounding districts with great success. It will be easy to replicate in other rural areas in KZN and South Africa, and even in other disciplines such as education.
- It is based on local, community-level partnerships and accountability between residents and leaders in the area, the hospitals and scholarship students.
- The approach provides a local solution to a local problem, but in a manner that can address similar challenges internationally.
- It provides academic support and personal mentoring on an ongoing basis, ensuring opportunities to succeed.
- The project demonstrates sustainability as graduates become mentors of students and they are able to provide appropriate and effective support. The graduates are role models and encourage and motivate school learners. Rural communities now have positive role models to emulate.
- The fund provides more than money. It intervenes throughout the process from when the student is selected to graduation and through completion of contractual obligations (and beyond).

A key learning is the benefit of searching for information to guide the design of strategy and activities. For Umthombo YDF, this included looking at research conducted (e.g. the Australian experience in rural health) and having conversations with other organisations offering bursaries and support to students (for example Anglo American).

Another key lesson was the value of continual reflection. This was evident from the beginning of the project when various avenues were tried to recruit and retain doctors at Mosvold Hospital (including advertising nationally and then internationally; recruiting "working holiday" health professionals from other countries; and trying various marketing strategies to attract interns, such as pamphlets and videos shown at all universities) and throughout the organisation's development. A final learning is the importance of teamwork and good leadership to any programme's achieve long-term results.

PUBLIC RECOGNITION AND AWARDS

The Umthombo Youth Development Foundation was one of the first organisational recipients of the Discovery Foundation Award for Excellence in 2007. This award allowed the trustees to explore alternatives in terms of the future of the scheme.

Andrew Ross receiving Impumelelo award (Source: Umthombo YDF website: http://www.umthomboyouth.org. za/page.asp?Id=12)

The Umthombo YDF won the highest award granted by Impumelelo Innovations Trust in recognition of innovative public-private partnerships that led to better service delivery to the public. This entailed an extensive evaluation of the scheme by external specialists contracted by the Impumelelo Trust.

In 2008 the Umthombo YDF was the second Runner-up in the Centre for Public Service Innovation Awards in the category *"Public Innovator of the Year"* and the first Runner-up in the All Africa Public Sector Innovation Awards in the category *"Innovative Service Delivery"*.

Umthombo YDF was the winner in the Investing in Life category of the Mail & Guardian Investing in the Future Awards in 2011. The judges were unanimous in their selection of Umthombo YDF as winner of this category and praised the project's youth focus, local content, sustainability and mentorship.

In 2011, Dr Gavin MacGregor received a certificate of appreciation on behalf of the organisation from the KZN Premier and KZN MEC for Health in recognition of Umthombo YDF's support for improving the lives of youth in KwaZulu-Natal.

Certificate of appreciation KZN Department of Health (Photo by researcher during fieldwork)

Mail & Guardian Investing in the Future Award (Photo by researcher during fieldwork)

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REFERENCES

1. Republic of South Africa. Human Resource Strategy for the Health Sector: 2012/13 - 2016/17. Department of Health; 2011. Available from: http://www.info.gov.za/view/DownloadFileAction?id=152486 [Accessed 8 May 2012].

ETHEKWINI DISTRICT

THE VALLEY TRUST COMMUNITY PARTICIPATION IN HEALTH

Community participation is a movement in the public health field that respects the rights and responsibility of community members to diagnose the causes of community problems and to actively engage in designing, implementing, and evaluating strategies to address the problem. Community participation in health in the Valley of a Thousand Hills originated from the work of Dr Halley Stott in the early 1950s and is still alive and well today.

DESCRIPTION

Community participation in health in the picturesque Valley of a Thousand Hills in KwaZulu-Natal (KZN) originated from the work of Dr Halley Stott and, subsequently, The Valley Trust in the 1950s. Dr Stott observed that patients from rural areas were frequently admitted to hospital with illnesses related to poor nutrition. They would spend time in hospital and apparently be cured, only to be re-admitted after some time with the same symptoms. He recognised that unless the root causes of ill-health were addressed there would be no significant change in people's health status. Dr Stott identified a nearby rural area of some 250 square kilometres in what was then known as a "Native Reserve", with an estimated population of 100 000 people, and proceeded to establish a multi-disciplinary programme focused on health promotion, primarily through improved nutrition, with a strong emphasis on self-help.

The Botha's Hill Health Centre, now known as the Halley Stott Clinic, was established in 1951 and served as the base from where the project was spearheaded. The Centre enabled Dr Stott to establish a relationship with the local community and to give nutritional advice to patients, especially the mothers of young children. Qualified nursing sisters conducted home visits to ensure that medication was being taken correctly and to identify and address factors in the home environment that contributed to poor health.

The Valley Trust, a non-profit welfare organisation, was established in 1953 to complement the work of the Health Centre. Various projects were established, such as a demonstration vegetable garden, a food preparation unit to encourage correct cooking practices, a home produce market, a maize grinding mill and recreational facilities, all designed to address the lifestyle deficiencies at the root of many diseases. The projects also acted as a referral system whereby patients from the clinic were referred to The Valley Trust for agricultural and nutritional advice and assistance. This rapidly led to outreach activities into the Reserve to assist with the establishment of home vegetable gardens and other basic amenities.

In the early 1980s, The Valley Trust, with the total support and backing of the tribal authority, established Development Committees in the Valley of a Thousand Hills area, including one at KwaNgcolosi. The idea behind the Development Committees was that they would serve all of the community's developmental needs, including health, education, agriculture, trade, sport and recreation. Each Development Committee created subcommittees for each of these aspects and the subcommittees collaborated to address development holistically. The traditional authority and the Development Committees also work together. Development committee members were elected democratically.

LINKS TO POLICY

Community participation is a social process whereby specific groups with shared needs, living in a defined geographical area, actively pursue identification of their needs, take decisions and establish mechanisms to meet these needs.[1] In the context of primary health care (PHC), this process is one which focuses on the ability of these groups to improve their health care and, by exercising effective decisions, to force the shift in resources with a view to achieving equity.[1]

The active involvement of community members in healthcare decisions was formally endorsed as a principle in the Alma-Ata Declaration on Primary Health Care in 1978. The Alma-Ata Declaration requires and promotes maximum community participation in the planning, organisation, operation and control of primary health care.

According to the White Paper for the Transformation of the Health System in South Africa[2], one of the goals and

objectives of the health sector is to foster community participation across the health sector. This entails:

- involving communities in various aspects of the planning and provision of health services;
- establishing mechanisms to improve public accountability and promote dialogue and feedback between the public and health providers, and;
- encouraging communities to take greater responsibility for their own health promotion and care.

The African National Congress (ANC) National Health Plan[3] (African National Congress, 1994) aimed to reduce inequalities in access to health services, especially in the rural areas and deprived communities. The ANC is committed to the promotion of health through prevention and education, using the PHC approach as the underlying philosophy for restructuring the health system. The PHC approach embodies the concept of community development where full community participation in the planning, provision, control and monitoring of services is central. According to the ANC National Health Plan,[3] effective community participation as envisaged in the PHC approach means that democratically elected community structures, integrated with representatives of the different sectors and stakeholders involved in health and community development, have the power to decide on health issues.

The ANC National Health Plan also calls for the establishment of intersectoral Community Development Committees, as well as Community Health Committees, in all communities. In this context, "community" is defined as those people living in the geographical area served by a Community Health Centre.

The government's re-engineered PHC approach also reconceptualises the interaction between the health services and the users of the health service. In the re-engineered approach there is greater emphasis on interaction with communities to get their support for participation in maintaining and improving their own health.[4]

The KZN Department of Health (DoH) Annual Performance Plan: Medium Term Economic Framework 2011/12–2013/14 calls for the development of communities (through integrated community-based programmes) to promote self-reliance in personal and community health and well-being.[5] According to the plan, a development paradigm where community involvement is lacking is unsustainable and ineffective. The plan states that an alternative paradigm that instils community self-reliance, builds on indigenous and traditional coping mechanisms, and acknowledges and respects the close interconnectedness between people, is critical to improve buy-in to programmes and involvement. There is thus a real challenge and opportunity for the Province to adjust service delivery and mechanisms for the development of communities through active engagement.

OBJECTIVES

Determining objectives

The Valley Trust profiled the five tribal authorities in the Valley of a Thousand Hills and the findings were shared with the community. The development committees' objectives were determined through a process of community meetings:

> *"So it was done through the process of many community meetings, not one community meeting. And there was no magic tool; it was done through discussions, debate and dialogue over years, not just once."*
>
> *(Former Valley Trust employee)*

Meetings were held with the community at least monthly on a Sunday:

> *"We would get together and work through the issues. There would be minutes and people would be mandated to do things – the community would do things, service providers would do things."*
>
> *(Former Valley Trust employee)*

Initially the major issues identified were the supply and quality of water, sanitation, roads, access to clinics, food security and housing issues. The Development Committees then prioritised the issues and started to work through them. Plans were developed, some annual and some spanning as long as three years. From these plans, programmes of action were drawn up and funding was sought.

> *"You draw up a programme of action, take it for funding, get it funded and implement it, have meetings all the way through as it is being implemented, and obviously evaluate what you are doing."*
>
> *(Former Valley Trust employee)*

STRUCTURAL FEATURES

Initial service delivery

The first priority in which The Valley Trust was involved was improving the water supply through initiatives such as a spring protection programme and putting in water reticulation systems with stand pipes. The next priority focused on the building of pit latrines.

The Health Committees from each area also began to prioritise the needs of their communities. KwaNgcolosi's

Health Committee prioritised access to a health facility as their community was far from the then Botha's Hill Health Centre and the KwaDabeka Community Health Centre. Monthly mobile service visits were also considered insufficient to serve the health needs of the community. A decision was taken to establish a health post at Bhekisisa where community caregivers could provide some elementary services and the mobile clinic could also use the post. The health post also served as a teaching centre and demonstrations were conducted on vegetable gardening and water and sanitation. The post was also used for other courses and literacy training, so it served a developmental need rather than merely a health need.

Service delivery today

Today KwaNgcolosi and Halley Stott are both official KZN DoH clinics, under the KwaDabeka Community Health Centre. KwaNgcolosi Clinic serves a population of 10 527. Halley Stott Clinic serves a population of 28 312 and the two Halley Stott Mobiles together service 19 290 people. The mobile clinic continues to visit the Bhekisisa health post once a month.

A number of different stakeholders operate in the KwaNgcolosi area today, all of whom see a definite role for themselves.

KwaNgcolosi community caregivers

Community caregivers (CCGs) mentioned a number of functions that they fulfil within the KwaNgcolosi community, including educating the community about disease prevention, encouraging people to eat healthily and maintain vegetable gardens, ensuring that patients adhere to tuberculosis (TB) and antiretroviral (ARV) medication regimes, linking community members with the relevant people to obtain grants, referring patients to the clinic and following up on the outcome of the referral, checking when children are due for immunisation and reminding the mother to take the child to the clinic, monitoring the weight of children, advising on home remedies such as oral rehydration and, finally, informing the community about health campaigns.

The CCGs meet at the clinic once a month during the first week of the month.

KwaNgcolosi Health Committee

The KwaNgcolosi Health Committee was established in the early 1980s as a subcommittee of the KwaNgcolosi Development Committee. From the community meetings it became clear that the mobile clinic was not an adequate option for providing health services *"because it only visited once a month and the community was not satisfied by the service". (Member, KwaNgcolosi Health Committee)* The Health Committee then became involved in raising funds to build the KwaNgcolosi Clinic.

The Health Committee also built the Phakama Care Centre to take care of orphaned and vulnerable children (OVCs). The objective of the Care Centre is to identify and assist destitute families in the KwaNgcolosi area by providing a free sanctuary where children can be safe, enjoy two healthy meals a day and become school-ready under the watchful eye of volunteer staff. The centre also provides day-care services for the elderly in the community.

The Health Committee sees itself as the representative of the community and the community can report any health service delivery problems to the committee. The committee is also there to support the clinic. The KwaNgcolosi CCG team leader reported that the Health Committee had been instrumental in dealing with a situation where CCGs were not being paid. The Health Committee took the issue to the District Health Office where *"they handled that matter very well". (CCG Team leader)*

KwaNgcolosi Clinic Committee

The KwaNgcolosi Clinic Committee is part of the KwaNgcolosi Health Committee. The role of the Clinic Committee is to work hand-in-hand with the KwaNgcolosi Clinic:

> *"When there are campaigns, we mobilise and organise the community. We work together, so that the clinic does not work on its own and we do not work on our own."*
>
> *(Member, KwaNgcolosi Clinic Committee)*

The Clinic Committee is a vital link between the clinic and the community. If the clinic staff experience problems with a community member, such as harassment of nurses, the Clinic Committee comes in to solve the problem. If the community is not satisfied with the services they receive at the clinic they can approach the Clinic Committee who will then raise the issue with the clinic: *"We are able to deal with such matters, we sit and talk about it"*. *(Member, KwaNgcolosi Clinic Committee)*

The Clinic Committee monitors whether the community members are being visited by CCGs and are happy with the work of the CCGs. The committee is also there to listen to the CCGs and see if they can assist with problems.

The Clinic Committee and the clinic staff have regular meetings where the Operational Manager tables the facility reports. The Clinic Committee is always involved in decisions around any corrective measures that might need to be introduced.

Non-governmental organisations

A number of non-governmental organisations (NGOs) are active in the KwaNgcolosi area. The Sethani Centre currently provides services to orphans and vulnerable

children through an after-care programme, as well as a crèche – Bongimpilo Crèche – which caters for around 70 pre-school children.

> *Children come through to the aftercare after school and they will be stimulated through a whole array of programmes - from homework supervision to computer literacy, choir music, dance and drama, colouring, puzzles and sports. So there is a whole array of very nice, diverse activities that happen after school.*
>
> *(Sethani Director)*

Orphan outreach also takes the form of food parcels, school uniforms, stationery and counselling services. Sethani refers children to resources such as the local clinic, the South African Police Service and social workers. They provide support with social grant and birth certificate registrations.

Sethani's latest initiative is a Kids Club which will cater for around 100 children on Saturdays.

> *There will be jumping castles, face painting, sporting activities, games, lots of fun. Our after-care programme from Monday till Friday has a very strong academic component, so we would like Saturday to be a fun day for the children.*
>
> *(Sethani Director)*

The Sethani Centre itself is also used as a community centre. The centre has a library and computers, as well as a hall that can be used for activities and training. The community has free use of the computers and the library. There is a small charge for photocopying and faxing. Sethani would like the community to see the Centre as *"the first port of call for all services to be rendered"*. *(Sethani Director)*

Amakhosi Club and Bhekisisa Crèche

The Amakhosi Club consists of approximately 20 sangomas and spiritual healers living in the area. The Amakhosi Club built a crèche (Bhekisisa Crèche) in KwaNgcolosi, as well as an Amakhosi house near the crèche. The members have started a garden to provide food for the children at the crèche and they plant medicinal herbs in the garden. The Amakhosi Club encourages members of the community to plant their own gardens and they promote healthy living.

> *It's not that they just concentrate only on healing; they are able to see that their patients should be healthy.*
>
> *(PHC Supervisor, KwaNgcolosi area)*

The Bhekisisa Crèche was founded by the Amakhosi Club. The crèche has five staff members, including a cook, and looks after children from two to five years old. Educational activities are provided for the children. Parents pay for their child's care if they can afford it. Parents can also contribute by working in the crèche garden.

Department of Public Works

As part of the Expanded Public Works Programme (EPWP) the Department of Public Works has placed a paralegal assistant and an agricultural advisor in KwaNgcolosi. The agricultural advisor advises community members on gardening and also teaches learners in schools about agriculture. The paralegal assistant advises community members on issues such as pensions.

> *You see how much they have to pay for transport. So the paralegal is there to assist in the community.*
>
> *(Paralegal Assistant, KwaNgcolosi community)*

Health information management

District Health Information System (DHIS) data are collected and submitted by the clinics. The clinics want to see an increase in the PHC headcount, as they want community members to be using the clinic for prevention rather than coming to the clinic only when they are sick. The clinic staff want to see an improvement in indicators such as immunisation coverage, vitamin A supplementation and cervical cancer screening.

The CCGs make use of exercise books for their own record-keeping. They record the number of households they visit and relevant health information such as the weight of any children. At the end of each month each CCG submits a written report to the clinic sister.

FUNDING AND PARTNERSHIPS

Funding

The Halley Stott and KwaNgcolosi Clinics are government funded. Bhekisisa Crèche gets some funding from the Department of Social Development, but funding is a major problem for them and there is often not enough money to pay the teachers. NGOs active in the area raise their own funds. Sethani, for example, has obtained funding from the Starfish Foundation to provide orphaned children with school uniforms.

Partnerships

Partnerships emerged as key to community participation in health.

> *You work hand-in-hand and collaborate with other stakeholders with the purpose of promoting health.*
>
> *(Operational Manager, KwaNgcolosi Clinic)*

A number of different partnerships were noted during the study, including:

Clinic and community

Staff at both the Halley Stott and KwaNgcolosi clinics spoke of the importance of a strong partnership with the community:

> *We must work hand-in-hand with the community because we cannot stand on our own. We need the community and community involvement.*
>
> *(Staff member, Halley Stott Clinic)*

Clinic and clinic committee

The KwaNgcolosi Clinic Committee has regular monthly meetings with the KwaNgcolosi Clinic staff and CCGs and, sometimes, representatives from the District Health Office. The committee members also communicate with the clinic between meetings:

> *It is easy to just pick up the phone and say, sister I have this situation; there is good communication.*
>
> *(Member, KwaNgcolosi Clinic Committee)*

One of the nurses at KwaNgcolosi confirmed the strength of the partnership between the clinic and the Clinic Committee, saying,

> *We do everything together; no one does things on their own.*
>
> *(Staff member, KwaNgcolosi Clinic)*

Clinic and CCGs

KwaNgcolosi Clinic staff and CCGs have a mutually beneficial relationship. The clinic staff and CCGs have regular, monthly meetings:

> *We link very well because they [CCGs] come once a month. They share the problems that they encounter in the field.*
>
> *(Operational Manager, KwaNgcolosi Clinic)*

The clinic provides training for the CCGs:

> *They conduct workshops and they educate us. Where we see that we are lacking we are able to request a workshop.*
>
> *(KwaNgcolosi CCG)*

The clinic staff also speak to community members about the important role that CCGs fulfil, so that community members are not suspicious or uncomfortable about CCGs visiting them in their homes.

The CCG's role in the partnership is to follow up on patients for the clinic and to refer patients to the clinic. KwaNgcolosi CCGs commented on how good their relationship is with the clinic staff:

> *We feel welcome. We work well with the clinic.*
>
> *(KwaNgcolosi CCG)*

Clinic and the Amakhosi Club

The KwaNgcolosi Clinic staff provide the Amakhosi Club with information on various medical conditions. They also encourage the Amakhosi Club to refer patients to the clinic:

> *We encourage them [Amakhosi Club] to refer clients to the clinic. We don't discourage clients if they believe they should go and consult with the traditional healer.*
>
> *(Operational Manager, KwaNgcolosi Clinic)*

The Amakhosi Club members feel free to refer patients:

> *You are able to send the people that you see to the clinic if they need medical help.*
>
> *(Member, Amakhosi Club)*

Clinic and NGOs

The NGOs in the KwaNgcolosi area work hand-in-hand with the clinics around health initiatives:

> *We have got NGOs that we work with, like Valley Trust and Hillcrest AIDS Centre. We work together when there are events in the community; we plan together and work hand-in-hand.*
>
> *(Staff member, Halley Stott Clinic)*

Clinic and churches

KwaNgcolosi Clinic has enlisted the aid of local churches to mobilise the community. When there are campaigns, the churches help to publicise them and encourage community members to get involved.

Clinic and schools

Schools in the areas are involved in marketing clinic services and providing information about health promotion initiatives. It is a mutually beneficial relationship, as the teachers can also call on the clinic for assistance:

> *What I have noticed as well is that if the school nurse is not available, the teachers are able to phone us when they have identified a problem and they ask us to attend to that.*
>
> *(Staff member, Halley Stott Clinic)*

CCGs and clinic committee

The KwaNgcolosi Clinic Committee and CCGs have a good partnership. The Clinic Committee attends the CCG meetings at the clinic and assists by following up on

households with problems. For example, a CCG identified a paralysed person in the community who was in need of a wheelchair. The Clinic Committee then approached Rotary for assistance. The Clinic Committee also identifies households that need assistance from the CCGs and together they develop a plan of action to service these households.

CCGs, schools and an NGO

KwaNgcolosi CCGs, teachers from the local schools and Sethani NGO meet regularly to discuss OVCs and their needs. The CCGs report to Sethani if there are orphans in need of school uniforms, shoes, stationery and/or food parcels.

CCGs and Inkosi

The KwaNgcolosi CCGs have a good working relationship with the local Inkosi (Chief):

> *"We are working very well with our Inkosi."*
>
> *(KwaNgcolosi CCG Team Leader)*

The CCGs let the Inkosi know when they are having campaigns in the community. He provides catering, encourages the community to attend and he attends and addresses the community. Because of his support the campaigns are well attended.

CCGs and Department of Public Works

The paralegal assistant from the Expanded Public Works Programme works in partnership with the KwaNgcolosi CCGs:

> *"We work with the CCGs because they are the ones that work in the households and encounter the problems that I can intervene in; they refer those people here."*
>
> *(Paralegal Assistant, EPWP eThekwini Municipality)*

Health Committee and Department of Social Development

The KwaNgcolosi Health Committee wants to expand the services offered by the Phakama Care Centre to include the elderly. The Committee is writing a proposal for these expanded services and the members are working hand-in-hand with the Department of Social Development.

NGOs and community

NGOs clearly recognise the need to work alongside the community and let the community make decisions about the services they require:

> *"Communities and people need to make a decision about these services; you can't do it for them. We tend to think we make the decisions. We take it as a right that as the providers we decide what people are going to have… Communities are amazing, provided you pay them that honour of dialoguing with them and then working through things with them. And don't presume that they can't do stuff."*
>
> *(Former Valley Trust employee)*

NGO and church

The Sethani NGO has formed a partnership with the Hillcrest Presbyterian Church so that they can start a Kids Club.

Bhekisisa Crèche and community

The crèche is supported by a committee of people from the community. They oversee the progress of the crèche and assist with fundraising.

SUSTAINABILITY AND POSSIBILITY OF REPLICATION

Sustaining community participation in health requires concerted action to engage communities and to identify and involve the relevant stakeholders. Involving communities in their own health care is time-consuming and any efforts to replicate the practice must be prepared to invest time into the practice.

Sustainability is a concern for those stakeholders who are not government-funded. Sethani, for example, has now prioritised broadening their funding base:

> *"We need more funds because the more resources we have, the more we are able to reach out to the community."*
>
> *(Sethani Director)*

Sethani is also exploring other avenues of income generation, such as scaling up their gardening project to ensure it can feed the children at the crèche. Currently they provide breakfast and lunch for the children. Children who are not orphaned or vulnerable will also be allowed to make use of the crèche and aftercare, and will be charged R50 per month.

Sustainability is very important for the NGOs operating in the KwaNgcolosi area as the community relies on them to provide certain services that the community needs and accepts. With regard to replicability, community participation in health is not only desirable in all communities but vital. Community involvement is an essential aspect of poverty alleviation and the attainment of health. Excellence in local government means involving citizens in government affairs to help define and plan the services that are critical to the community.[6]

SUCCESSES

One of the major successes in the KwaNgcolosi area is the building of the KwaNgcolosi Clinic. The community initiated and lobbied for the building of the clinic, the KwaNgcolosi Health Committee looked for funding, and the KZN DoH built the clinic, with the community participating in the building operations. On completion of the building, the clinic was handed over to the KZN DoH.

Among the successes reported when The Valley Trust first became involved in the area were fewer deaths among children caused by diarrhoeal disease, a decrease in infant mortality and better management of chronic conditions. Due to the efforts of the Development Committees and their work with Eskom and Umgeni Water, the whole population of the Valley of a Thousand Hills has benefited. The whole area now has electricity and Umgeni Water took over the water supply.

KwaNgcolosi CCGs reported that their constant follow-ups have impacted on the TB cure rate and their work with orphans has resulted in child-headed households getting the necessary assistance. The KwaNgcolosi Clinic Operational Manager reported increased ARV initiations since starting with Nurse-initiated Management of Antiretroviral Therapy (NIMART) at the clinic: *"Since we have started with initiation, people are now flooding in."*

The clinic has also assigned a sister to do NIMART in the community to cater for those people who cannot afford to travel.

A further success has been KwaNgcolosi Clinic having its first medical male circumcision camp this year. Males from 15 to 49 years were targeted and 150 circumcisions were performed. The clinic staff believe the campaign was successful because the clinic worked together with a number of stakeholders, including the Department of Education, eThekwini Municipality, the Ngcolosi Traditional Council, Chief Bengu of KwaNgcolosi, the Ward Councillor and NGOs, including The Valley Trust, Soul City, loveLife, and Brothers for Life.

Other successes evident from this example of good practice are:

- ✓ The community was involved in determining local health needs.
- ✓ Health services appropriate to the community's needs were provided.
- ✓ An appropriate system was developed to enable local people to participate, including the Development Committee and the Health Committee.
- ✓ The capacity and skills of local people were developed so that they could make informed decisions about health programmes.
- ✓ A relationship of trust and empathy has developed between healthcare providers and the community
- ✓ A sense of responsibility and ownership has grown among members of the community because of participatory decision-making.
- ✓ Community members are prepared to commit labour, time and money in support of health programmes.
- ✓ Healthcare workers and managers have a strong sense of accountability to the community they serve.

CHALLENGES

A number of the challenges reported by the Development Committees are also encountered in other areas of the province. Community health facilitators are usually nursing assistants or CCGs who have been promoted and should be responsible for approximately 10 to 20 CCGs. However, the ratio of CCGs to community health facilitator is much higher, which impacts on supervision. Community health facilitators also experience difficulties in keeping regular contact with all their CCGs:

> *"She must have a vehicle, but those vehicles are just not there."*
>
> *(Former Valley Trust employee)*

A further reported challenge is that CCGs often have to do time-consuming home-based care work, making it difficult to reach their target number of households:

> *"When you get to a household, you find a person who is too sick. You bath him, wash dishes and leave the house clean; this means that the number of households I visit has decreased. I have to cook, clean and feed the person, and only end up visiting two households."*
>
> *(KwaNgcolosi CCG)*

The CCGs reported the challenge of community members not wanting to disclose their TB or HIV status:

> *"Some people are still stubborn. It is the same with HIV. People still hide it and it is only a few people that are disclosing their TB status, because of the stigma associated with TB. The clinic gives us the details of the patients that we need follow up. When I go to that house and ask for a green card, they ask me what card I am talking about. Then I explain that I need their TB card. They then ask who told you I am taking medication."*
>
> *(KwaNgcolosi CCG team leader)*

The KwaNgcolosi Clinic Committee find it challenging that they cannot always solve community complaints because of factors beyond their control:

> *"Another challenge is that we as the committee get complaints from the community that when they come to the clinic they do not get enough*

help because of the shortage of the staff. The major issue is that there are no doctors.

(Member, KwaNgcolosi Clinic Committee)

The stakeholders who are not government-funded reported funding to be a major challenge. A teacher at Bhekisisa Crèche stated:

> *Our challenge is finance. We do not have enough equipment for the children and we have got few toys.*

The Director of Sethani reported:

> *I think a challenge facing every NGO at this point is the reduced funding, and working around those constraints while still meeting needs in the community. I think that will be a challenge for 2012 as well.*

Challenges for community participation programmes in general include:

- A common understanding of "community participation" is necessary among all those involved, otherwise effective participation will be compromised.
- Participation is not easy to achieve and requires an intensive commitment of time.
- Maintaining the participation of community sub-groups also requires a lot of effort.
- Care is necessary to ensure that there is sufficient participation by all age, gender, ethnicity and social status groupings and that no particular group dominates project activities.

LESSONS LEARNT

A number of lessons were reported by the various stakeholders, which should be considered in planning for effective community participation for PHC re-engineering. These include:

- True community participation requires community ownership over decision-making and resources.
- Community participation requires democratically elected, community-based structures that account to the community:

  > *And committees must report back regularly. They must report back to the community once a quarter. They must listen to the community for the priorities next year.*

  (Former Valley Trust employee)

- Community members must be capacitated to enable them to make informed decisions about their own health. The capacity of community decision-makers should be addressed at the meetings held with these decision-makers:

  > *You have regular meetings. You build up the capacity during those meetings. You need to make sure they are empowered to make decisions – that they have all the knowledge they need.*

  (Former Valley Trust employee)

- Promoting good health requires far more than improving medical services or improving access to health services. An intersectoral approach is needed to attain the ideal of health for all. Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Social welfare, therefore, has a major role to play in improving health status.
- The opinions of all stakeholders must be respected:

  > *I have learnt to respect everybody's opinion. I have learnt to counsel and not to impose if I want to gain the co-operation of these people. If you impose, you get a negative response.*

  (Operational Manager, KwaNgcolosi Clinic)

PUBLIC RECOGNITION AND AWARD

In August 2004, the management and staff of KwaNgcolosi Clinic were awarded a certificate of commendation by the Minister of Health for their commitment to service delivery and excellence in line with the Batho Pele Principles and Good Governance, in realisation of the Department's vision, mission and core values.

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REFERENCES

1. Rifkin SB, Muller F, Bichmann W. Primary Health Care: on measuring participation. Social Science Medicine. 1988(26):931-40.
2. Ministry of Health. White Paper for the Transformation of the Health System in South Africa.1997. Available from: http://www.info.gov.za/whitepapers/1997/health.htm [Accessed 12 May 2012].
3. African National Congress. A national health plan for South Africa. 1994. Available from: http://www.imsa.org.za/files/Library/NHI/Policy%20Brief%207/ANC%20HEALTH%20PLAN%201994.pdf [Accessed 12 May 2012].

4. Barron P, Shasha W, Schneider H, Naledi T, Subedar H. Re-engineering Primary Health Care in South Africa: Discussion document. 2010. Available from http://www.phasa.org.za/wp-content/uploads/2011/11/Pillay-The-implementation-of-PHC.pdf [Accessed on 12 May 2012].

5. Department of Health KwaZulu-Natal. Annual Performance Plan: MTEF 2011/12 – 2013/14. 2011. Available from: www.kznhealth.gov.za/app2011-14.pdf [Accessed 12 May 2012].

6. Gonzalez JL. Development sustainability through community participation: mixed results from the Philippine health sector. England: Ashgate; 1998.

DISCUSSION

This Good Practices project has revealed several creative and constructive initiatives by people and organisations working in the PHC sector that have contributed to more effective service delivery and improved health outcomes. Documenting and sharing good practice enables individuals and organisations to avoid reinventing the wheel, to improve performance through the application of lessons learnt, and to avoid the mistakes of others.[1] Documented and shared good practice offers access to the lessons learnt, thereby encouraging improvements to local strategies and activities that can, in turn, lead to larger-scale, more sustainable and more effective interventions.

This chapter identifies and reflects on the following themes that emerged during the study:

- Moving towards community engagement
- Individuals as champions of projects
- The use of reflective practice
- Replicability and sustainability
- The value of partnerships
- Data monitoring and evaluation.

COMMON THEMES ACROSS PRIMARY HEALTH CARE PRACTICES

Moving towards community engagement

KwaZulu-Natal's 2010/11 Annual Report[2], in assessing the province's health performance, acknowledges the paradigm shift from facility to community-based services. This shift away from the fragmented and curative-based health system to more decentralised, community-based and cost-effective health services was intended to improve equity, along with access to and availability of PHC. Aligned with this shift in service delivery is the need to empower communities to actively participate in the improvement of their own health. This approach was adopted in the 1978 Alma-Ata Declaration of Primary Health Care and subsequently reinforced by international experience that acknowledged that the "top-down" approach to community participation in health is not effective. This project shows, however, that various levels of community participation do exist and can be found across most of the good practices selected in KZN. These levels of community participation range from high community involvement, in which the community has control over decision-making, to low, in which the community has none.

Community participation evident across the practices involved aspects such as outreach into the community, profiling the needs of the community, involving community members in needs assessment, and involving community members in project planning and implementation. Effectiveness studies show increasing evidence that community participation can improve health outcomes, lead to more responsive care, facilitate people's involvement in treatment decisions, and improve quality and safety.[3]

The original Pholela Clinic initiated the concept of seeing the community, rather than the individual, as the patient. Part of the early Pholela COPC model involved defining and characterising the community. This principle highlighted the need for a community health assessment survey that measured health status, demographics, behavioural and environmental characteristics to obtain a clear understanding of the community's health problems. The current Pholela CHC encourages community participation through forums with the community members, called imbizos. Through meetings with community leaders, Pholela CHC has engaged community members and sensitised them to the value and importance of participating in determining their health status and health outcomes.

Edzimkulu COPC project in Sisonke District delivers PHC based on the healthcare problems of the community it serves, identified through a process of community engagement. This entails community consultation, community mapping and developing community solutions. The community is also involved in the design of project activities. The management at Edzimkulu felt strongly that programmes must be designed by the people if they are to be embraced by the people. The Edzimkulu project advocates for the integration of the community with the clinic. The project staff believe that CCGs should spend some time working in the clinic and that facility-based staff should also do home visits. They believe that the clinic infrastructure can also be used by the community for purposes beyond health – such as by holding community meetings at the clinic.

Mpilonhle Health and Education programme in uMkhanyakude District has extended its services beyond the learners at

the schools it visits, thus engaging the broader community. The Mpilonhle mobile units remain operational during school holidays to ensure that services are accessible to parents and other community members as well. Parents, community members and school staff access services similar to those that are provided to learners, including HIV testing and education, health screening and computer education. Sundumbili CHC in Ilembe District strives to get its services into the community, especially for those who live far away and who find it difficult to reach health facilities. Their efforts include door-to-door community outreach and establishing a satellite clinic near a taxi rank. Mseleni Hospital in uMkhanyakude District also extends its services by having medical teams travel to the community in remote and inaccessible parts of its catchment area.

One of the Umthombo YDF's most important partnerships is with the local community. In addition, community members contributed financially to the establishment of the organisation. As part of the scholarship programme, community members sit on the interview committee involved in selecting students for the bursaries. This participatory process encourages the community members to themselves become involved in youth development.

The chapter on community participation in health and the work of The Valley Trust describes a novel approach to addressing a wider range of the community's developmental needs. The project leaders realised the need to empower and capacitate community members to take decisions about their health. The community was intimately involved in prioritising their needs and determining the development objectives. Instituting a Development Committee and a Health Committee empowered the local community to participate in decision-making processes regarding their health status. These structures provided a mechanism for communication between the Trust and the community and enabled regular reports back to the community.

Conventional public health planning does not generally enable meaningful community participation. It tends to be top-down and centralised, which effectively precludes community members' active participation. When planning, it is important to utilise the community-held repository of local knowledge so as to not impose external beliefs and predetermined agendas. Members of a community are a rich source of energy and commitment to that community and can often mobilise resources that may not otherwise have been available. Community members cannot, however, be asked to contribute their time and energy if they do not have the sense of ownership that grows out of being involved in all stages of a programme. If community members play an active part in identifying needs, planning, implementing and evaluating activities, they will take ownership of both the problem and the solutions, which will improve programme success and sustainability. Getting the community involved in programme design and implementation ensures that strategies are appropriate for and acceptable to the community. Strategies that are owned by the community and are sensitive to their needs are more likely to be adopted by community members and sustained.

Policy documents such as the White Paper for the Transformation of the Health System in South Africa,[4] the Negotiated Service Delivery Agreement for Health[5] and the KwaZulu-Natal Department of Health Annual Performance Plan MTEF 2011/12–2013/14[6] all highlight the need for community involvement and social mobilisation at a local level. The KZN Premier's Sukuma Sakhe flagship project is a call for communities to take responsibility for their own development, rather than relying on government. A comprehensive representation of stakeholders in the community are invited to work with the government to achieve the envisaged provincial outcomes.

The South African Department of Health, through the National Health Act and subsequent Regulations, has made provision for community participation and governance structures in health – such as clinic committees and hospital boards. The National Progressive Primary Healthcare Network[7] points out, however, that difficulties arise when community members are simply nominated to participate in the management of the health system without proper preparation and training. Community representatives may lack adequate information and skills to make informed decisions about community-wide health issues. Programmes may need to build local capacity so that community members can make informed decisions about the best strategies to meet their needs.

Healthcare workers should create an enabling environment for community participation. If health workers display patriarchal and patronising attitudes and do not value the input of communities, community participation will fail. Community members must be respected as experts who are knowledgeable about the community's culture, resources and constraints. It is equally important that community members maintain realistic expectations about the Government's role and ability to service their health needs and improve their health status.

Individuals as champions of projects

Many of the practices reported in this study were the brainchild of an individual or a couple, such as Sidney and Emily Kark at the Pholela Clinic near Bulwer in the 1940's. The individuals listed below who were or are all leaders of NGOs, together with the Karks who worked in a State clinic, are referred to as 'champions' in this study:

- **Chris and Jim Newton** – Edzimkulu community-orientated primary care project
- **Halley Stott** – The Valley Trust community participation in health project
- **Andrew Ross** – Umthombo Youth Development Foundation
- **Mike Bennish** – Mpilonhle health and education programmes.

NGOs have played a significant role in PHC in South Africa. They often have the capacity to create innovative services which do not fit into conventional health service provision, while also having the potential to increase the efficiency of service delivery. NGO leaders face challenges distinct from those faced by governments or the for-profit sector. NGOs have a social change mission and specifically work with vulnerable people and marginalised groups who have often been overlooked by government services. NGOs are intermediary organisations bridging donors and beneficiaries and, therefore, have to constantly respond to multiple stakeholders. These types of organisations often work with limited resources and must respond to a rapidly changing environment.

Champions influence healthcare programmes and projects by using their creative visioning and widely informed perspective to influence methods of service delivery. They demonstrate drive, commitment and a remarkable ability to mobilise people and resources. Such individuals should be nurtured and supported to develop feasible ideas and be supported to implement new innovations.

A champion's ability to network with local structures has a positive influence on the success of the project. Networking promotes buy-in of innovative methods and builds local capacity to sustain the projects and programmes. The downside, however, is that a vacuum often remains when champions leave an organisation that they have pioneered. A noteworthy yet unfortunate vacuum was created in the apartheid era when South Africa lost talented public health professionals. During such a period of adherence to political ideology and lack of political will, the Karks, who founded the Pholela Clinic, left South Africa to continue their work in Israel. State support for the early Pholela Clinic was withdrawn and its initial gains could not be sustained.[8]

Political will and commitment achieved through strong collaboration and partnerships with NGOs, the government and communities necessitates planning for project sustainability. Projects that have not been adequately planned and managed to ensure skills transfer and adequate financial and human resource capacity run the risk of closing down as they become unsustainable – an issue that will be discussed further in the section on partnerships and sustainability. CIVICUS[9] has referred to the rapid attrition of NGO staff in leadership positions into business and government and the difficulty that NGOs experience in replacing them. These champions must incorporate a succession plan in their pioneering efforts, thereby making themselves dispensable - they need to ensure that a new generation of NGO leaders is developed. Umthombo YDF put this principle into practice with Dumisane Gumede, the first recipient of a bursary at Umthombo YDF, now playing a leadership role of the foundation. Ideally, NGO leaders should strive to make themselves obsolete by building the NGO to a point where it can function independently of their leadership or, alternatively, to prepare the context for their leaving from the beginning, as did Chris and Jim Newton in the Edzimkulu project.

The use of reflective practice

A number of the exemplars in this study engage in reflective practice. Reflective practice in its iterative sense refers to an integral cycle of bringing about learning, action and change. This cycle helps individuals or groups to reflect on their current work situation and the problems they face; plan changes to mitigate a problem; implement those changes; reflect on the results, i.e. review whether they actually address the problem; adapt or adopt the changes; document the lessons learnt and then start the reflection process again. Adopting the process of reflective practice is one of the defining characteristics of professional practice and is beneficial to healthcare workers/providers who have to constantly update their knowledge according to the changing context of health care and the continual growth of medical knowledge.[2]

The reflective practice cycle can be repeated a number of times as organisations try different options, learn from each experience and adjust interventions accordingly. At the early Pholela Clinic, continuous reflection informed the programme strategy and activities. The healthcare programme was continually modified to address high-priority health needs. Reflecting on the current work situation includes researching alternative solutions to emerging challenges. One of Umthombo YDF's stated objectives is to research rural health recruitment and retention and use this to inform and improve the Foundation's practice.

Reflection needs its own space and tools. There is a need to step back from day-to-day activities in order to figure out and reflect on the bigger picture. Usually people engaged in time-bound project activities are too busy acting and claim not to have time to step back and reflect. Even if something is seen to be not working, no time is given to consider the reasons for it.

Diverse stakeholders also require space for reflective dialogue. Reflection should be a collective effort between the different stakeholders – NGOs, government officials and community members. Umthombo YDF successfully creates space for reflection and involves its various stakeholders. At its annual student imbizo where students and staff gather to talk about what was worthwhile in the year, they also reflect on what should be changed in the following year.

To engage in reflective practice requires a willingness to be flexible and the ability to continuously adjust projects in the course of implementation based on that reflection. This may involve addition, deletion or redeployment of resources; changing expectations; developing new approaches and strategies; involving new partners, and more. It requires seeing a project not as a "once-off" but as a learning activity contributing to better projects in the future. This willingness to be flexible and continuously adjust is evident in a number of the practices studied. The early efforts at Pholela relied on ongoing measurement and evaluation of programmes. There was continuous reflection on what was being achieved so as to guide programme strategies and activities. Sundumbili CHC staff's reflections led to the treatment buddy strategy for TB DOT (Tuberculosis Directly Observed Therapy) support – a strategy already operational in their ARV programme that they adopted into their TB programme. Sundumbili staff also proactively use their local data to guide intervention efforts. Mpilonhle project has shown a willingness to adapt its programme to address the needs of a wider target group. Umthombo YDF consciously spends time reflecting on the critical aspects that make the project a success and management displayed a willingness to change activities as the context changed. For example, once the bursary scheme expanded, the mentoring system had to change. A network of mentors was then put in place.

In developing countries where funding for health care and, more specifically, for continuing professional development is becoming scarce, reflective practice is extremely important to facilitate capacity development in existing human resources. In addition to continuing professional development benefits, reflective practice offers opportunities for feedback to management and other healthcare workers to enhance cross-pollination of lessons learnt from experience. Managers that adopt reflective practice are likely to make better decisions, while practitioners who adopt reflective practice are likely to deliver better, more humane care.[10] In order to improve the quality of service delivery, managers and leaders of these and other practices are urged to encourage a culture of reflective practice in which healthcare providers share their experiences, thereby empowering the group to find solutions to daily service delivery problems or merely to continually strive to improve their practice.

Replicability and sustainability

Replicability of projects for scaling-up service delivery

The replicability of a model reflects the ease with which it can be introduced in other areas or other sectors, by the same or another organisation. Easily replicable practices facilitate expansion and broadening of good practice in PHC service delivery. Scalability is the ability of a system, network or process to handle a growing amount of work effectively, or its ability to expand in order to accommodate that growth.[11] This term is used to articulate that service delivery activities of all the reported PHC good practices were scaled-up and have the potential to be replicated by other healthcare providers.

Many of the reported practices lend themselves to replication. For example, the education sector could use Umthombo YDF's model by providing the same services for rural learners to become mathematics or science teachers. The possibility of replicating a model is apparent from the original Pholela Clinic at which the COPC approach emerged and is currently being adapted and developed by practitioners elsewhere is the world. Sukuma Sakhe's efforts have been noted by other provinces interested in initiating a similar project.

Both replicating and scaling up good practices have enormous resource implications. Replication usually requires the creation of new organisational and physical infrastructure, while scaling up usually benefits from improved economies of scale. The Mpilonhle project would like to extend its services into other geographical areas, but this has implications such as the need for a satellite office and more vehicles.

For some practices, scalability focused on increased geographical coverage. Mpilonhle has successfully expanded its service to a number of other schools locally. Umthombo Youth Development Foundation started at Mosvold Hospital but later included other hospitals in the district and then other rural districts. Scalability for some practices involved expanding services to other target groups. For example, Mpilonhle originally targeted learners, but expanded to offer services to community members around the target schools as well. The Umthombo YDF started with medical students and has expanded to all health science students.

In some cases, the initial focus of a practice was on one area but once successfully implemented, it was cascaded to other service areas. For example, Edzimkulu uses progressive skill attainment for CCGs that sees them master one skill before moving on to the next. CCGs start with basic home-based care and then move on to areas such as VCT, DOT support and CIMCI. Mseleni's PHC outreach efforts have also involved consciously scaling up services by expanding their

package of care to increase coverage and providing both curative and preventative care. Introducing a multidisciplinary team for outreach, rather than providing only doctors' medical services, means that patients have access to a number of specialised healthcare providers. This enables delivery of a more comprehensive package of services.

Sustainability of project for implementation

In many cases, NGO services have filled a void created by neglect of the healthcare needs of underserved populations. Some provide healthcare services in areas where little or none existed. Umthombo YDF, for example, works to increase the number of health professionals serving in rural areas, while Mpilonhle project services the rural uMkhanyakude District. In many instances NGOs have paved the way for the development of sustainable healthcare services at community level by adopting service delivery models that align with government priorities and policies. This creates a context that supports the smooth continuation of health services should NGO services cease in a given area. The clinic built by Edzimkulu project at Ndawana, for example, has been easily taken over by KZN DoH, thereby assuring its future in a sustainable way.

Having a strong public image and being in good standing with government can aid an NGO's sustainability. As previously highlighted, this can be achieved by networking and planning with government, other civil service organisations and with the healthcare workers at the coal-face of service delivery. Partnerships defined by strong commitment and political will allow for government to recognise the NGO as a partner in both service delivery and policy-making. Having a strong public image implies a need to cultivate positive media coverage. Mpilonhle project does this particularly well and has received numerous awards in recognition of its work.

Becoming obsolete should be the fundamental goal of all NGOs. The long-term goal of any NGO should be to assist in solving a healthcare problem and, thereby, becoming redundant. As noted this can only be done if sufficient human resources, capacity-building and skills transfer are in place to sustain a practice. For example, Edzimkulu planned and achieved the transfer of their staff and services to the Department of Health (DoH), which was made easier by formulating clear entry and exit strategies at the inception of the project. Building in redundancy also requires an emphasis on skills transfer to existing healthcare workers; the attitude and willingness to accept, learn, adopt and practice the skills; and the ability to transfer skills to fellow health workers. Umthombo YDF, for example, sustains its service as graduates of the scheme, at the completion of their education, are equipped to return to the workplace to mentor current students.

Resource implications can stand in the way of sustainability. At Mseleni Hospital the PHC outreach efforts would be limited without the availability of vehicles and a flying doctor service. Financial viability remains the Achilles heel of most NGOs. Overall, funding for South African NGOs has declined due to the global economic recession. As the funding situation grows even more difficult, NGOs will need to find creative ways of generating further funding, including adopting income- generating activities such as charging a nominal fee for some of their services. This is, however, difficult for NGOs that work with very poor people and when people are accustomed to getting the NGO's services for free. The Umthombo YDF recently established an endowment fund – a significant step towards the scheme's future sustainability. Projects such as Umthombo YDF and Mpilonhle have also strengthened their sustainability by diversifying their funding base.

The value of partnerships

A number of these selected good practices make use of partnerships to achieve their objectives. Edzimkulu project represents a novel partnership between a community in Canada and the rural Ndawana community, and wider, in KZN. The project uses the COPC framework that advocates for a strong partnership between NGO, government agencies and community. The Edzimkulu founders' vision of handing over all services also relied on a strong relationship with local government agencies. Similarly, Mpilonhle project works in partnership with schools, communities, government departments and other NPOs. Although not given in-depth coverage, University Research Co., LLC (URC), a global company providing assistance to improve the quality of health care, was involved with Sundumbili CHC from 2006 to early 2008. It is likely that their support assisted the CHC to reach its noteworthy achievements. Mseleni Hospital works closely with tribal leadership structures and communities. Umthombo YDF's work relies on partnerships with the community, staff at district hospitals, the DoH, the DoE and individual and organisational donors. The Valley Trust's profile on community participation in health shows partnerships in action between the clinic staff, CCGs, health committee, clinic committee, NGOs, leaders in the community, traditional healers and government departments working together to achieve the objectives of this practice.

What are the factors that influence the success of partnerships in PHC? For a partnership to work, there should be a well-articulated, shared vision of what is to be accomplished.[12] The vision has to be broad and inspiring enough to engage the interests of multiple organisations and yet be realistic in terms of motivating action toward achievement.[12]

The vision must also be greater than what can be achieved by an individual or group working alone.[13]

Any partnership in PHC should conduct a realistic assessment of the community's needs, so that efforts can be focused on the community's problems. If that focus is missing, only random successes are likely with relatively little community-wide impact. For example, a partnership might successfully increase childhood immunisations when substance abuse is actually a more prevalent and serious problem in a community. Without conducting an assessment of the community's health problems, the partnership will be unable to prioritise the allocation of resources across identified problems or develop a strategy for dealing with these problems. A realistic assessment of the partnership's capability and resources relative to the identified need is also necessary.[14] The partnership must be realistic about what can be accomplished in the short- and long-term. If different partners need to take the lead on different parts of the problem, they must be given the necessary resources and recognition for their efforts.

Partnerships in PHC will ideally include a diversity of individuals and groups who represent the issue, the geographic area and the population.[15] This diversity necessitates effective management of the partnership. Stakeholders should not underestimate the difficulty in convincing diverse groups to work together and in dealing with the inevitable interorganisational relationship issues. Each of the organisations that make up the partnership will have its own culture, mission, values, strategies and history of successes and failures. The goals, mission, vision and activities of the partnership must, therefore, be sufficiently important to the individual organisation's strategic agenda to induce commitment. Perceived benefits must also be seen to outweigh perceived costs. Managing the partnership will require regular reporting and feedback to all the partners.

Data monitoring and evaluation

All practices in this study collect data related to their activities. CHCs such as Sundumbili collect large amounts of routine data. The need to keep funders informed of progress ensures that the NGOs in this study routinely collect data on their outputs. Funding is often dependent on evaluation of practices to confirm that outputs and project outcomes have been achieved. Monitoring and evaluation contributes to learning, adjusting interventions and giving feedback to the community. NGOs often come up with various ways of capturing data and making it available for reporting purposes – from paper-based systems such as TB registers in Sundumbili CHC to more novel methods such as Mpilonhle's use of iPods to capture data.

However, there is very little evidence that any of the data collected from these strategies focus sufficiently on PHC-related health outcomes. Umthombo YDF reports on the number of students that have graduated and where they are now working. Mpilonhle project reports on aspects such as the number of health education sessions conducted and the number of VCT clients counselled. Sundumbili CHC is very focused on lowering its TB defaulter rate. But what are the actual impacts of their efforts on the health outcomes of the communities they serve?

According to the PHC re-engineering discussion document, insufficient attention has been given to the improvement and the measurement of health outcomes in PHC.[14] A key informant from the KZN Department of Health supports this observation when saying:

> *"I think the other thing that we don't do is probably the real failure. We talk about it like this: M&E – monitoring and evaluation. We do monitoring, we do very little evaluation. And I always say I want you to take a breath between the two words. Even our indicators; we say our mother-to-child transmission rate at six weeks is something like 2.7 or 2.8, or whatever it is. Wonderful! Great! Tell me what it is at six months. Twelve months? We don't know that. We don't do that kind of evaluation."*

Achieving good patient health outcomes is the fundamental purpose of health care. There is a need to measure, report and compare outcomes so that decisions can be made about where money and other resources are most needed.[16] Outcomes are the true measures of quality in health care, not the volume of services delivered, nor the process of care used. Providers tend to measure only what they directly control in a particular intervention and what is easily measured, rather than what matters for outcomes.[16] An analysis of the collected data can indicate the number of education sessions provided on teenage pregnancy in the community, but has that number of educational activities translated into fewer teenage pregnancies in that community?

Some aspects that have been identified as important for a re-engineered PHC such as community participation are, admittedly, difficult to evaluate. In particular, what outcomes should be evaluated – health outcomes, participation levels, improved capacities, or some combination of these – and how should they be evaluated? It will be important to identify and measure outcome indicators of community participation. Whether planners want to measure changes in community self-efficacy or changes in local capacity to identify and solve problems, it is important to define these objectives clearly, to develop accurate tools for monitoring progress towards the objectives and to ensure that the data collected translate into health outcome statistics.

REFERENCES

1. World Health Organization. Guide for Documenting and Sharing "Best Practices" in Health Programmes. Brazzaville: 2008. Available from: http://afrolib.afro.who.int/documents/2009/en/GuideBestPractice.pdf [Accessed 18 March 2012].

2. KwaZulu-Natal Department of Health. Annual Report 2010/2011. Durban 2011.Available from http://www.kznhealth.gov.za/1011report/partA.pdf. [Accessed 1 October 2012]

3. Australian Institute of Health Policy Studies. Engaging Consumers in Health Policy: Assessing Models and Outcomes. 2006. Roundtable Monograph Nov 2006.

4. Ministry of Health. White Paper for the Transformation of the Health System in South Africa.1997. Available from: http://www.info.gov.za/whitepapers/1997/health.htm [Accessed 12 May 2012].

5. Office of the President. Republic of South Africa. Delivery Agreement for Output 2: A Long and Healthy Life for All South Africans. Available from: http://www.thepresidency.gov.za/MediaLib/Downloads/Home/Ministries/DepartmentofPerformanceMonitoringandEvaluation3/TheOutcomesApproach/Health%20Sector%20NSDA.pdf [Accessed 18 March 2012].

6. Department of Health KwaZulu-Natal. Annual Performance Plan: MTEF 2011/12 – 2013/14. 2011. Available from: www.kznhealth.gov.za/app2011-14.pdf [Accessed 13 September 2012].

7. National Progressive Primary Health Care Network. Braamfontein: National Progressive Primary Health Care Network; 1995:1-22.

8. Radebe G, Thomson L. Action for health in Impendle / Pholela / Underberg: ISDS Technical Report 2d 1997/8. Available from: http://www.hst.org.za/sites/default/files/techrep2d.pdf [Accessed 13 September 2012].

9. CIVICUS. Connecting Civil Society Worldwide. 2002. Newsletter No 175 August, Johannesburg.

10. Oelofsen N. The importance of reflective practices. A whole systems approach to developing reflective practice across healthcare organisations. 2012. Available from: http://www.hsj.co.uk/resource-centre/best-practice/flexible-working-and-skills-resources/the-importance-of-reflective-practices/5048994.article [Accessed 13 September 2012].

11. Bondi AB. Characteristics of scalability and their impact on performance. Proceedings of the 2nd international workshop on Software and performance. 2000. New York: ACM; pages 195-203. Available from: http://dl.acm.org/citation.cfm?id=350391.350432 [Accessed 13 September 2012].

12. Shortell S, Zukosi A, Alexander J, Bazzoli G, Conrad D, Hasnain-Wynia R, et al. Evaluating partnerships for community health improvement: tracking the footprints. Journal of Health Politics, Policy and Law. 2002(27):1.

13. Mitchell S, Shortell S. The governance and management of effective community health partnerships: A typology for research, policy and practice. Milbank Quarterly. 2000;78(2):241-89.

14. Barron P, Shasha W, Schneider H, Naledi T, Subedar H. Re-engineering Primary Health Care in South Africa: Discussion document, 2010. Available from http://www.phasa.org.za/wp-content/uploads/2011/11/Pillay-The-implementation-of-PHC.pdf [Accessed 23 August 2012].

15. Roussos S, Fawcett S. A review of collaborative partnerships as a strategy for improving community health. Annual Review Public Health. 2000(21):369-402.

16. Porter M. What Is Value in Health Care? New England Journal of Medicine. 2010;363(26):2477-81.

CONCLUSION

Re-engineering primary health care in South Africa represents a plan of action towards more co-ordinated and strategic initiatives that will improve access to and strengthen PHC services across the country. Identifying and recording PHC good practices in KwaZulu-Natal presents an opportunity for the province to explore effective models of PHC and to share lessons learnt, along with details of successful programmes.

The Good Practices project identified and documented good practices within the primary health care sector in KwaZulu-Natal. This study was not intended as an evaluation of the selected practices but rather facilitated the process of documenting and sharing knowledge.

Several challenges were experienced in the course of the study, including logistical challenges such as difficulty in securing dates for fieldwork. Despite being provincially recognised good practices, some of the initiatives lacked adequate quantitative data to illustrate the magnitude of their success. While recognising that good practice is both motivational and inspirational, this study has shown that the process of identifying and selecting good practices in PHC could be improved – possibly by having well-publicised selection criteria and facilitating a process of self-identification by those implementing good practices. Readers of this report may rightly feel that there are other good practices in KwaZulu-Natal worthy of inclusion in this report. This is, however, not a negative in that it could inspire such practices to disseminate their own successes and lessons learnt.

The study uncovered several themes that may prove beneficial for future planning:

Community engagement emerged as a key factor in the successful implementation of any PHC-related programme. The greater the level of community involvement in needs assessments, planning and project activities, the larger the impact.

A strong association was noted between **leadership**, in the form of practice champions, and successful programmes. Such champions are cautioned, however, to avoid a total reliance on themselves for programme expansion and future development. These champions must incorporate a succession plan in their efforts, thereby developing a new generation of leaders to sustain the practice so that it can function independently of their leadership. Ideally, the context for their leaving should be prepared from the beginning,

Creating an environment that supports and reinforces the practice of **critical reflection** and continuous learning contributes to improved quality of care and strengthened health systems. The need for continuously adjusting existing processes is based on the observation that the realities of achieving an identified goal are complex and cannot be captured by means of mechanical techniques. Focusing on health outcomes is vital when determining the best use of scarce resources.

Strong **partnerships**, linkages and collaboration between public, private and non-government agencies is a pre-requisite for sustainable practices that promote good health outcomes across sectors and across professional and lay boundaries. While strategic partnerships are important, a reliance on NGOs for the provision of essential health services comes with some risk to the health sector. NGOs must prioritise skills transfer to the DoH to ensure effective long-term sustained service delivery. In addition, commitment and political will in support of the objectives and implementation of the good practices can impact positively on the broader determinants of health and well-being in populations and the promotion of individual health-related behaviour change.

Ongoing **monitoring and evaluation** is crucial to improving practice towards enhanced health outcomes and is an integral part of critical reflection and continuous learning. Monitoring and evaluation is not possible without routine collection of high-quality, indicator-related health information, an integral part of good practice. There is, however, very little evidence that any of the data collected from these good practices focus sufficiently on health outcomes. Not only is there evidence of inadequate data collection but, according to the PHC re-engineering discussion document, insufficient attention has been given to the improvement and the measurement of health outcomes in PHC.

The documentation of PHC good practices is a vital step for increasing momentum towards improved healthcare. Knowledge gleaned through this process is highly relevant for all those working at the coalface of service delivery. Along with efforts to improve the quality of service delivery in the PHC sector, there is a need to create a culture of documenting and sharing information and knowledge. Decision-makers, health professionals and communities must be able to access information on good practices and the lessons learnt in order to improve the quality of PHC in KwaZulu-Natal. This implies a need to document PHC good practices routinely, but also to create platforms where such documentation can

be shared. The main rationale for documenting and sharing PHC good practice is to enable individuals and organisations working in the health sector to avoid reinventing the wheel, to improve performance through the application of lessons learnt, and to avoid the mistakes of others. Without scaling up the process of documenting good practices, this goal will remain elusive.

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