



The
EQUITY
1997 | 2003 **Project**



The EQUITY Project

Strengthening equitable access to quality health services for all South Africans

3rd Floor, South African Nursing Council Building
602 Pretorius Street
Arcadia 0007 Pretoria
South Africa
Telephone: +27 (0) 12 344 6118
Fax: +27 (0) 12 344 6115
Website: www.equityproject.co.za
Email: carmenu@equityproject.co.za

Acknowledgement and Disclaimer

The EQUITY Project was a project of the Department of Health funded by the United States Agency for International Development (USAID)/South Africa through Management Sciences for Health (MSH).

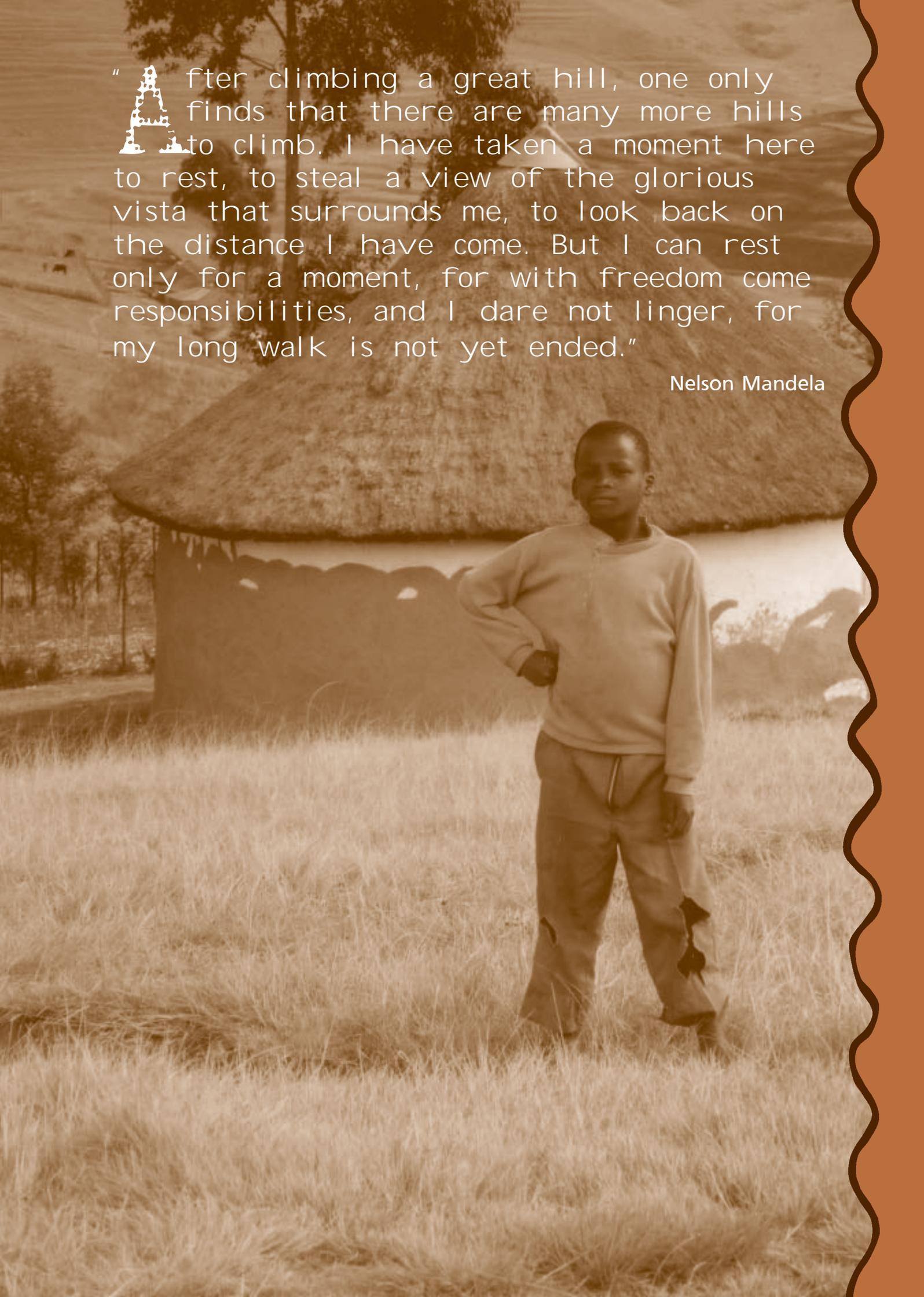
This report was made possible through support provided by USAID/South Africa under the terms of contract 674-0320-C-00-7010-00. The opinions expressed herein are those of the author and do not necessarily reflect the views of USAID or MSH.

Photos and text: Carmen Urdaneta

Design and Layout: ITL Communication and Design

Printing: Global Print

Symbols used throughout this publication come from: Heike Owusu, "Symbols of Africa", Sterling Publishing Co., Inc. New York, 1998

A young boy stands in a field of tall grass, looking towards the camera. Behind him is a traditional thatched hut. The background shows a hilly landscape under a clear sky. The entire image is overlaid with a semi-transparent brown filter. A decorative wavy black border runs along the right edge of the page.

" After climbing a great hill, one only finds that there are many more hills to climb. I have taken a moment here to rest, to steal a view of the glorious vista that surrounds me, to look back on the distance I have come. But I can rest only for a moment, for with freedom come responsibilities, and I dare not linger, for my long walk is not yet ended."

Nelson Mandela

Table of Contents

| | |
|----------------------------------------------------------------------------------|----|
| Letter from the Project Director | 2 |
| Context of 1994 South Africa | 4 |
| Introduction to the EQUITY Project | 6 |
| Highlights | 10 |
| Primary Health Care: Transforming a Health System | 15 |
| Moving from Isolation to Integration | 16 |
| Empowering the Next Generation of Nurses | 18 |
| Community Voices Chime in Tune on Hospital Boards and Clinic Committees | 20 |
| Supervision: The Foundation of Quality Health Care | 22 |
| A Healthier Horizon Dawns in Mpumalanga | 24 |
| Information for Action: Management Strategies for Improved Health | 27 |
| Making Sense of Health Information | 28 |
| District Teams on the Front Lines of Primary Care | 30 |
| Better Planning for Better Health | 32 |
| Prescriptions for a Developing Drug Management System | 34 |
| Priority Diseases: Confronting the Biggest Killers | 37 |
| Reinforcing the Basics to Improve TB Management | 38 |
| Taking the HIV Test | 40 |
| After the HIV Test | 42 |
| Remaining Challenges | 44 |



Letter from the Project Director

It was 1997 and South Africa was a country re-born. Just three years after the country's first democratic elections, the EQUITY Project – a United States Agency for International Development (USAID) – funded partnership between the Department of Health (DOH) and Boston-based Management Sciences for Health (MSH) – opened its first office in Bisho, capital of the newly-formed Eastern Cape Province.

It is seven years hence and time for the EQUITY Project to close its doors, reflecting on the lessons and achievements of the past seven years.

Where once we had 14 separate, fragmented health departments: today, we have one.

Where once we had health systems of hospital-based care for the privileged, largely white elite: today, we have one system that ensures preventive, promotive and integrated primary health care to its entire population.

Where once rural health providers functioned in solitude: today, supervisors in all nine provinces visit clinics more often, using the [Supervision Manual](#) to support those providers.

Where once community voices were purposely left out of the health system: today, hundreds of hospital boards and clinic committees in the Eastern Cape actively promote health and use of health services.

Where once the country's many health information systems collected thousands of data that often went un-used: today, we have one unified district health information system (DHIS) used nationwide and spreading around the world.

Where once nurses were ill-prepared to deliver primary care: today, they increasingly have both the management and clinical knowledge they need to deliver a comprehensive primary care package reflective of community needs.

Where once many local managers did not participate in health planning: today, they use [Guidelines for District Health Planning and Reporting](#) to link services, illness patterns and health needs with budgets and plans to ensure that community concerns are met.

Where once essential medicines were erratically available and management of drugs cumbersome and inefficient: today, well-managed drug systems ensure essential medicines are available when patients need them most.

Where once programmes like immunisation, family planning, ante-natal care and child curative services were separated from other health programmes: today, over 90% of Eastern Cape clinics offer these basic services five days/week.

Where once the means to learn about or test for HIV was available only in a handful of special centres in the Eastern Cape: today, 90% of clinics offer counselling five days/week and 55% can perform tests on-site and provide medicines to prevent mother-to-child transmission of HIV.

1997-2003



In each of these changes, three key themes emerge. Indeed, they are the areas the EQUITY Project was asked to support in 1997:

Primary Health Care: Transforming a Health System

Information for Action: Management Strategies for Improved Health

Priority Diseases: Confronting the Biggest Killers

The participation of our partners deserves special mention; this report is a reflection of the work, dedication and partnership that characterised the EQUITY Project from the onset.

We thank the Department of Health and South African Government: your struggle and faith in freedom made these first steps into a healthy and socially-just democracy a reality.

Thank you to USAID: your leadership and foresight to create a comprehensive project to help transform a health system offers South Africa a distinction unusual in a world of focused health projects.

Thank you to the many partners listed here. Without you, these results would not have been possible. Our partnerships have illustrated to the neglected citizens of the Eastern Cape Province and the entire country, that the commitment to improve health services for the under-served is, and will remain, strong.

As you read the features in this report, you will be reminded time and again of the needs that existed in 1997. While challenges and inequities will exist for years to come, we thank you for allowing us to join in the first steps to address them. We are proud to have been a part of the most striking transformation towards democracy in health the world has ever witnessed.

Partners

Afrox Health Care

Anglo Gold

Bristol-Myers Squibb Secure the Future Foundation

Council for Health Service Accreditation of Southern Africa (COHSASA)

East London AIDS Training, Information and Counselling Centre

Gold Fields

Harmony Gold

Health Systems Trust

Intrah Health

Joint United Nations Programme on HIV/AIDS (UNAIDS)

Kula Development Facilitators

Loveliflife

Medical Research Council

National Health Laboratory Service

Planned Parenthood Association of South Africa (PPASA)

Rhodes University

Society for Family Health

Soul City

South African National Tuberculosis Association (SANTA)

TB Alliance Directly Observed Treatment Short-course (DOTS) Support Association

The Employment Bureau of Africa

University of Fort Hare

University of the Free State: Centre for Health Systems Research and Development

University of North Carolina: MEASURE Evaluation Project

University of Port Elizabeth

University of Transkei

University of the Western Cape: Health Information Systems Programme (HISP)

University of Witwatersrand: Centre for Health Policy

University of Witwatersrand: Department of Community Health

University of Zimbabwe

University Research Corporation: Quality Assurance Project

World Health Organization (WHO)

Youth Academy

Zakhe Peace and Development Trust



Health Care in 1994:

The Basics

- 14 competing health authorities merged into one
- Curative, hospital-based care
- Duplicated and fragmented services
- Weak infrastructure for primary health care
- Isolation and separation along racial lines in training and service delivery
- Communities excluded from the health system
- Under-resourced clinics and entrenched inequities
- Weak systems for basic management

Context of 1994 South Africa

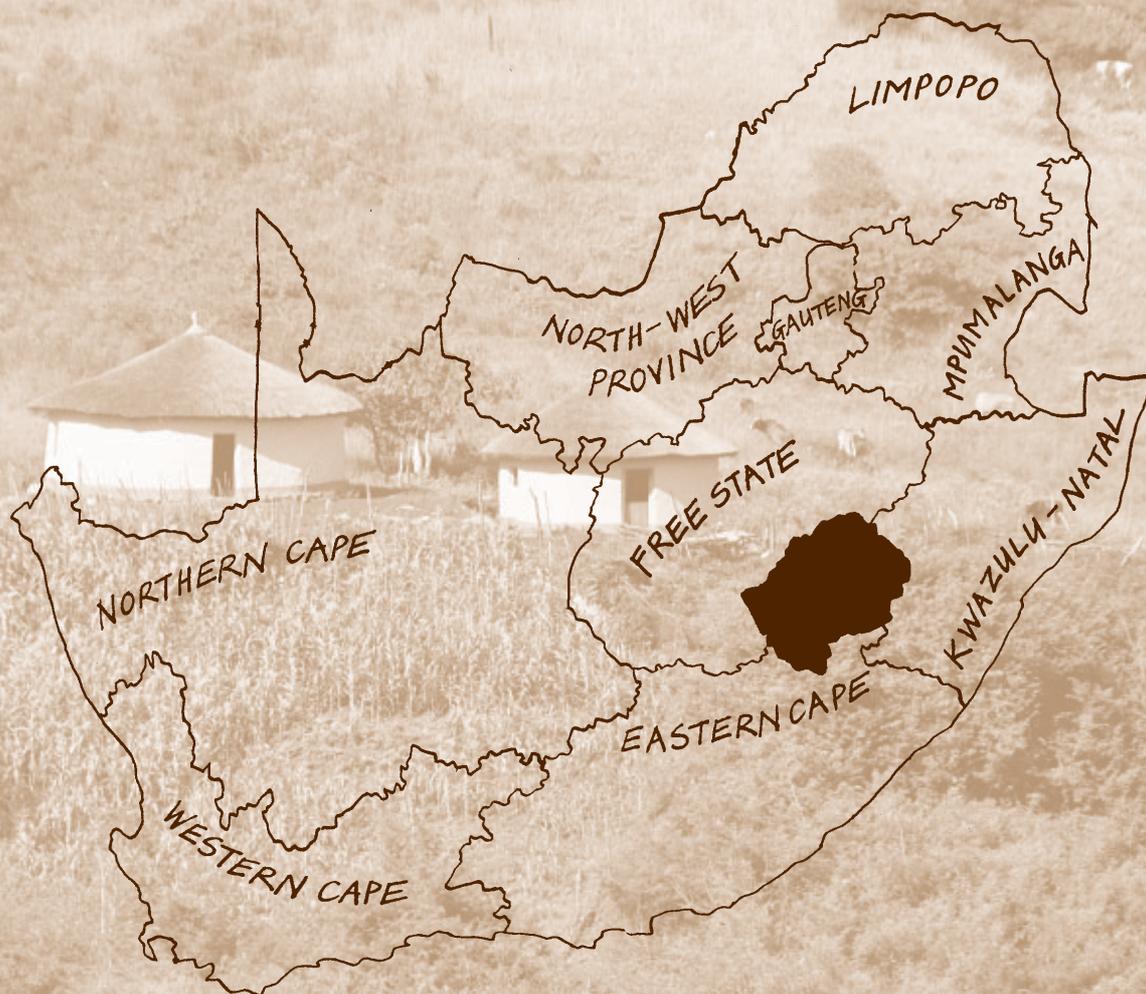
In 1994, South Africa became the last country in sub-Saharan Africa to achieve its independence. Unprecedented in the modern world, the country's social situation at this time set in motion the reconstruction, nation-building and democratisation needed to address 50 years of isolation and authoritative rule and 300 years of colonisation. This transformation into one, representative nation was at times tumultuous and at others exuberant. The highly-centralised and controlling apartheid government, working through a network of bureaucracies in white South Africa and ten black homelands, taught people to accept their racial position in society. Undoing entrenched systems and attitudes of oppression was the first challenge South Africa faced.

Behind the scenes, a transformation in health also began. Hierarchy dominated management of the country's 14 separate departments, with doctors at the pinnacle and nurses and other health workers at the bottom. All concepts of public health had been structured to exclude community involvement, concepts of equity, or social, political and economic determinants of health – carefully erasing all foundations of primary health care. As a result, South Africa's health care system spent over 75% of its budget on hospitals, most of which catered to the needs of the small white population and other elites, with lesser quality services available to most blacks. Even in the homelands and in facilities providing for the majority population, service planning was top-down. With concepts of population-based health care largely absent, separate clinics for TB, for sexually transmitted infections (STIs), for maternal and child health and family planning and for curative services predominated.

The new government elected in 1994 aimed to replace the fragmented, hospital-focused and centrally-controlled health system with **primary health care** – emphasising community participation, prevention, equity and decentralised management. This was a manifestation of the new South Africa's commitment to democracy, equality and community involvement.

Meanwhile, a new cadre of dedicated managers with limited training took over the health system. Information was difficult to access; there was no complete list of health facilities, no comprehensive knowledge of available equipment and limited understanding of people's health needs. Budgets were arbitrarily assigned following historical precedent, lacking cost accounting and providing no basis for decision-making. Facilities had limited understanding of the populations they served while training institutions clung to teaching methods and curriculum content based on outdated health concepts. The professional councils of South Africa, modelling themselves on Europe and North America, had established standards which were highly inappropriate for conditions in a largely developing country.





The few experienced managers, unreliable systems and lack of accountability about financial expenditures and personnel at the Eastern Cape Department of Health (ECDOH) made decision-making a challenge. By 1997, the provincial government controlled over 800 health facilities, although few managers knew exactly where they were. The new system absorbed over 35 000 employees, mostly based in hospitals, expecting them to take on a new set of job responsibilities. Meanwhile, administrative systems for thousands of employees, hundreds of clinics and dozens of hospitals merged. Unequal capacity and skills compromised this clear and decisive amalgamation. Further changes in senior appointments, demarcation of new health districts, hiring freezes and negative media coverage all plagued the Eastern Cape over the Project years, furthering cynicism that unification of the health system could succeed.

Despite post-1994 efforts to establish public health care and reasonable increases in some health indicators, recognition for the poor state of health in the Eastern Cape soon emerged. South Africa's inequities were among the most extreme in the world, and nowhere was this more evident than the impoverished Eastern Cape Province. The need to train new managers, update clinical skills and instil basic systems for drug, finance, personnel and information management became a national priority.

Introduction to the EQUITY Project

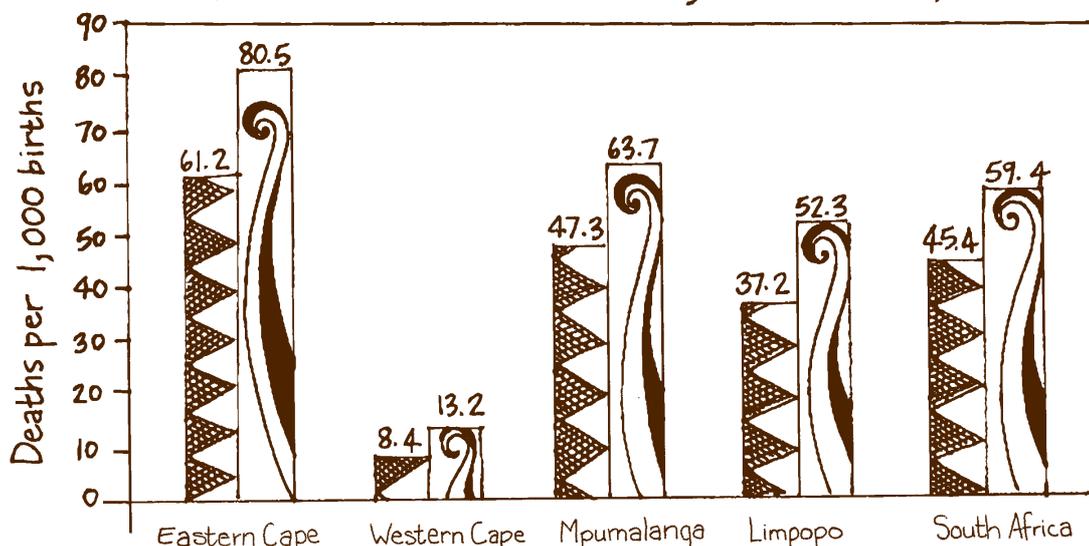
"To give up the task of reforming society is to give up one's responsibility as a free man."

Alan Paton

The challenges seemed insurmountable. As a result of the purposeful separation along racial lines, segmentation, fragmentation and duplication characterised each of 14 health systems. In 1994, these became one. Containing two of the largest homelands (Transkei and Ciskei), the Eastern Cape faced the most severe health challenges. Inter and intra-provincial inequities painted a dire picture of poor health for its 6.4 million citizens (see graph), amidst palpable pressure to ensure this merger would improve health for the most disadvantaged. Improving health services in the Eastern Cape would be a huge task, and one that could not fail.

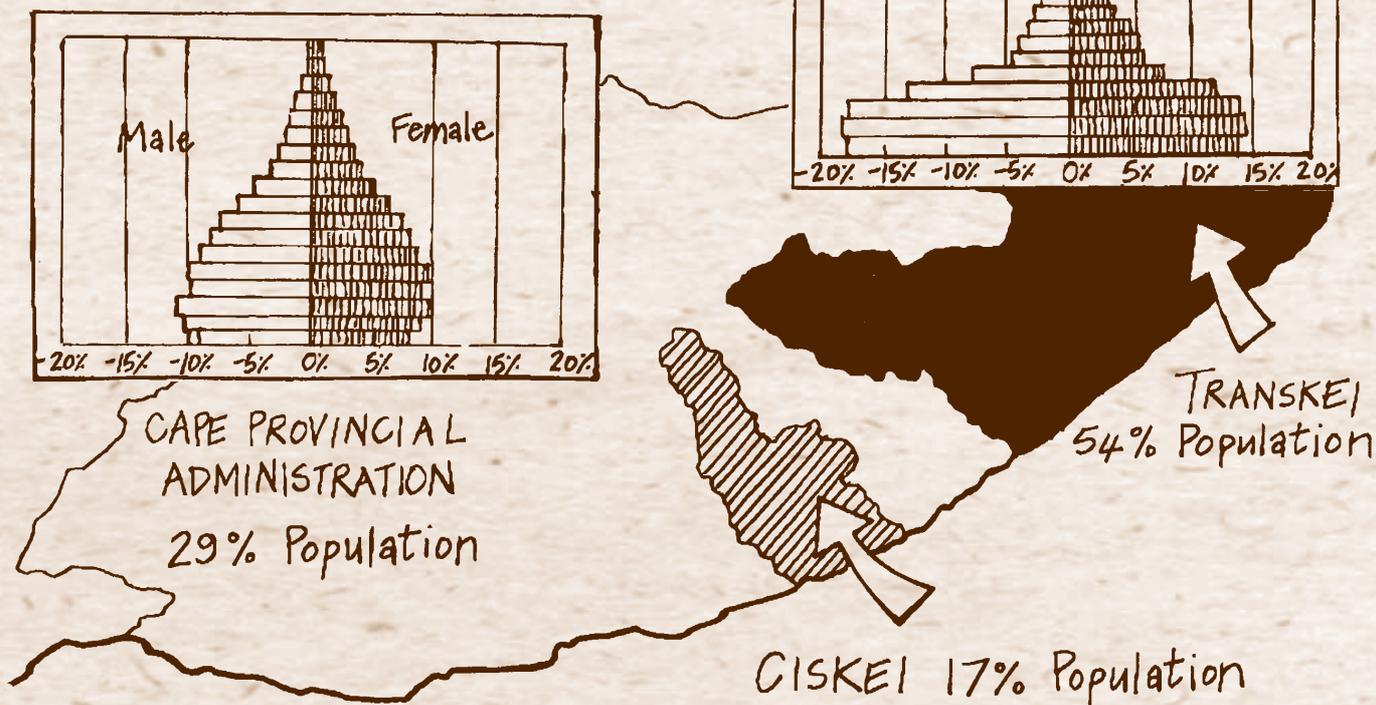
The EQUITY Project aimed to bring relevant international experience and assist the new DOH to implement **primary health care**, focusing its work on the Eastern Cape Province and later expanding to additional provinces. Conceived in a political context rarely encountered by USAID or its contractors, the Project supported establishment of new health districts, management decentralisation, empowerment of health workers and dismantling of vertical and centrally-controlled health programmes under the umbrella of "transformation". Amidst an environment rife with both promise and challenges, USAID and the DOH designed a complex project to address the basic health needs of the country's black majority. Aptly named the **EQUITY in Integrated Primary Health Care Project**, the initiative would strengthen management systems, thereby enabling the government to respond more effectively to the priority concerns of its population.

Infant and Under-5 Mortality in South Africa



▶ Infant Mortality Rate ◉ Under 5 Mortality

Eastern Cape Province Pre-1994



In 1997, the National DOH (NDOH) and USAID established five objectives to guide Project activities, implemented hand-in-hand with government counterparts:

- 1) provision of equitable, comprehensive primary health care for all citizens;
- 2) improved functioning of the referral system through all levels of hospitals;
- 3) improved management of resources allocated to health under the specific headings of planning, drug supply, finance, personnel and information systems;
- 4) improved training of all staff in clinical primary health care and emerging diseases, and management training with development of capable district management teams; and
- 5) effective attention to the emerging epidemics of STIs, TB and HIV and AIDS.



"A paradigm shift to comprehensive primary health care was perhaps the most difficult. We had to build this new primary care image, with its broader, holistic approach to the human being."

District Manager, Eastern Cape Province

1997-2003



For comprehensive monitoring, the Project identified a set of 36 key indicators, measured in annual surveys in the Eastern Cape. In 1998 and 2002, the surveys linked over 3 000 households with facilities to measure the impact of quality improvements on the health of communities. This data is used throughout this report to demonstrate changes. Meanwhile, the massive retraining of clinical and management staff provided new styles of education and content. This investment exposed more than 5 000 providers and managers to modern approaches of primary health care, preparing them to effectively manage the district health system and address priorities, such as TB, STIs and HIV and AIDS.

The EQUITY Project challenge was a new one for all partners: to instil an entirely new public health approach using personnel and procedures designed for a fundamentally different model. To meet expectations, this system would become capable of assessing the health needs of its entire population and provide accessible services, devoting resources in a planned, accountable way and measuring progress. This report provides evidence that such expectations were largely met. Building the capacity of South Africa's health system to respond to and manage the complexities of the HIV epidemic in a comprehensive manner and within primary health care is just one example that the investment in South Africa was a sound one. This was the desired outcome of the EQUITY Project and as the country mobilises to roll-out anti-retrovirals and scale up prevention, the initial groundwork has been laid through sound systems and improved skills to manage them.

Letter from a District Manager

As a newly appointed district manager in 1996, I recall the feeling of bewilderment at the thought of pioneering an entirely new health care concept in South Africa. Although intimidating, it also offered the opportunity to be as innovative and creative as we could, as it appeared that very few people really had a clear idea of what we were supposed to do.

This is where the EQUITY Project offered enormous support, from the very first training programme to the development of checklists to monitor our own performance as well as guiding us on critical focus areas. Coupled with various clinical and management training programmes and ultimately the District Health Management and Leadership Programme, district managers and their teams were enabled to evolve into confident managers to improve service delivery in our communities.

Highlights

1994

South Africa's first democratic elections establish Nelson Mandela as the country's first black president. Fourteen health systems merge into one, overseen by the NDOH.

1997

The government releases the **White Paper for the Transformation of the Health System**, detailing strategies to promote equity under one health system, focusing on health districts and primary care.

The EQUITY Project is established in the Eastern Cape Province. Partnership building and strategy identification dominate initial activities as counterpart relationships are forged. Baseline surveys identify the health needs and priorities of the province's population.

1998

The first South African Health and Demographic Survey results reveal severe inequities and a poor state of health services in the former homeland areas.

A primary health care package for health facilities is developed and a Project checklist improves understanding of appropriate services for each level of care.

Clinic catchment mapping is conducted with Eastern Cape communities to help facilities understand who they are serving.

The **Clinic Supervisory Checklist**, which becomes the **Supervision Manual**, begins to improve relationships between supervisors and clinic staff in the Eastern Cape. (See story, page 22)

Stock cards and order forms are introduced. For the first time, the Eastern Cape has standardised management tools to improve drug supply. (See story, page 34)

The first facility audit in the Eastern Cape covers more than 600 clinics and documents the realities of primary health care services.

The **Public Health Certificate Course** (which becomes the **District Health Management and Leadership [DHM&L] Programme**) is established between four Eastern Cape universities, the ECDOH, and the EQUITY Project. (See story, page 30)

The EQUITY Project shares its expertise in information systems with national counterparts.

1999

The Project refines, applies and finalises tools and strategies for improved primary health care, publishing and distributing publications more widely.

Eastern Cape districts are re-demarcated, creating new boundaries and new management appointments at all levels.

The Eastern Cape pilots a district assessment tool, the first of its kind, which is then applied nationally to determine the best performing health districts.

A study of non-governmental organisations and an inventory of community health workers in the Eastern Cape improve understanding of stakeholder roles in health care.

Assistance to the ECDOH in the formulation of the Provincial Health Bill influences discussions on health needs and priorities.

An assessment in Eastern Cape health districts results in development of a field guide to help clinic committees to form and function. (See story, page 20)

Training in the district health information system (DHIS) capacitates all provinces in its use.

A high STI/HIV transmission area project is established in the Eastern Cape and later replicated at another site. By training peer educators to conduct outreach campaigns in bars and truck stops, the projects increase condom use and improve HIV and AIDS information coverage.

2000

A new strategic framework aligns project goals with national and provincial initiatives, increasing emphasis on access to TB, STI and HIV and AIDS prevention and treatment within the primary care package.

The Eastern Cape's Maluti and Uitenhage Districts receive national recognition for district development.

The Project expands activities to North West, Mpumalanga and KwaZulu-Natal Provinces.

Every health district in South Africa collects and reports monthly health indicator data through the DHIS, a first for the country. The National Health Information System of South Africa confirms DHIS as the accepted system for collecting routine information from all facilities in the country. (See story, page 28)

Results from a costing study of primary health care services in the Eastern Cape are used to cost the primary health care package nationwide.

An in-depth evaluation documents DHM&L contributions to the district health system through new management skills and improved systems in drug, finance, personnel and other health programmes.

With public and private partners, the EQUITY Project establishes the Bambisanani Project, a model for home-based care, community mobilisation, orphan support and income-generation to address HIV and AIDS and other terminal illnesses in the former Transkei.

2001

Social marketing efforts conducted by the Society for Family Health since 1997 reach thousands of young people through condom road shows and radio programmes in the Eastern Cape. A five-fold increase in retail outlets boosts sales of socially-marketed Trust© and Lovers Plus© condoms to more than 6 million from less than 100 000 in 1997. Annual health diaries and calendars distributed to providers nationwide give crucial information on health days and treatment protocols.

The Eastern Cape's Craddock and Uitenhage Districts win NDOH awards for best performing districts in the country while the Port Elizabeth Nelson Mandela Metropole wins in the national metro category.

Assisting to develop user requirement specifications helps ensure basic system standards at provincial drug depots and hospitals nationwide.

The Project implements Photovoice, a community assessment methodology that gives cameras to 16 youth in an Eastern Cape township. The resulting 80 photographs document dire social conditions, particularly of the impact of HIV and AIDS, and are exhibited to advocate to local councillors for improvements.

Project support to disseminate Ubomi, a newspaper featuring photos and stories of HIV infected individuals, helps teach young people at 6 000 Eastern Cape schools how to prevent HIV.

Through EQUITY Project advocacy efforts and DHIS information, the ECDOH budget improves intra-provincial equity, reducing disparities that reached as high as 200%. Budgets are distributed according to demonstrated need, not on previous years' allocations.

2002

The Project launches a comprehensive website [www.equityproject.co.za] with full coverage of Project events, technical approaches and downloadable tools and publications. Monthly web hits increase from a low of 200 before the launch to more than 2 000.

EQUITY Project advisors help the NDOH to define norms and standards for drug procurement, distribution, inventory and financial management nationwide.

Former President Nelson Mandela meets with Bambisanani-supported communities from the former Transkei to encourage traditional leader involvement in the fight against AIDS.

Initiated in 1999, the Council for Health Service Accreditation Association of Southern Africa (COHSASA) programme for quality improvement is adopted by the ECDOH after all 18 participating hospitals make strides towards accreditation.

A TB costing model developed for the NDOH is applied in the North West Province.

The Zanempilo TB Project, which uses motorbikes to transport TB sputa from clinics to laboratories in the former Transkei, wins the Impumelelo Award, national recognition for service innovations. Expansion of the project results with government funding. (See story, page 38)

Community focus groups in the former Transkei describe facility deficiencies and community attitudes that influence use of reproductive health services.

2003

Beginning in 2001, support to the NDOH HIV and AIDS Programme coordinates the National Integrated Plan for women and children. Streamlined reporting and financing as well as training in gender and life skills enhance implementation of the plan, resulting in improved grant spending and higher budgets from National Treasury.

The ECDOH achieves rapid expansion of voluntary counselling and testing (VCT) and PMTCT services. (See story, page 40)

The Project shares tools and publications more widely. A survey of 200 publication users demonstrates that 87% find EQUITY tools very useful and relevant in their work.

Five presentations at the annual conference of the Global Health Council, the largest membership alliance for health in the world, communicate Project experiences to international audiences.

The NDOH requests Project assistance to conduct a nationwide impact study on the use of essential drugs.

The NDOH adopts [Guidelines for District Health Planning and Reporting](#) as the national guide for district planning linked to budgets and health priorities. (See story, page 32)

The ECDOH funds expansion of the Cofimvaba TB Project, which uses local taxis to transport sputa to laboratories in the former Transkei.

Already used in nine provinces, the NDOH adopts the [Supervision Manual](#) as the quality guide for supervision nationwide.

The ECDOH adopts and institutionalises curriculum changes for nursing colleges. (See story, page 18)

The ECDOH institutionalises the DHM&L by assuming its funding and management.

A public-private partnership between the ECDOH and a private consortium affiliated with Afrox Health Care is established at Humansdorp Hospital; sharing resources will upgrade the facility, helping to improve efficiency and quality.

After seven years, the EQUITY Project closes its doors in South Africa, having played a crucial role in helping to strengthen the health system of the Eastern Cape and across the country.



"Freedom for South Africa has brought the opportunity at last to address the basic needs of our people. It allows us not only to attend to immediate health needs, but also to begin to eradicate the legacy of poverty and inequity that is the greatest threat to our public health."

Nelson Mandela

1997-2003

PRIMARY HEALTH CARE:

Re-building a health system

Primary health care emphasises a patient's general health needs, reflecting community involvement and prevention of illness. Advancing this approach and establishing systems to enable a shift from hospital-based care to one of primary care was one of the main objectives of the EQUITY Project.

From integration at facility level and filling clinical training gaps to upgrading supervision and enhancing community involvement, management and systems interventions to establish primary care resulted in improved accessibility and quality of health services in the Eastern Cape and across the country.





Moving From Isolation to Integration

The Basics of Primary Care

Before:

Monday: minor ailments

Tuesday: ante-natal care

Wednesday: immunisation

Thursday: family planning and chronic care

Friday: emergencies

- Less than 20% of budgets directed to primary care
- 51% of EC clinics offer immunisation, family planning, ante-natal care and child curative services 5 days/week

In 2002:

- 92% of EC clinics offer immunisation, family planning, ante-natal care and child curative services 5 days/week
- 69% of EC children immunised, up from 58% in 1998
- 74% of EC clinics have at least one nurse trained in primary care, up from 45% in 1998
- 88% of patients in EC clinics satisfied with their care
- 93% of patients in EC clinics would recommend the facility to a friend

Source: EC Facility and Household Surveys

Mafukamile Zadantsa's tired smile illustrates a life of struggle. As she sits outside the Ntafufu Clinic, where she has accessed health services for more than 20 years, she describes a walk that begins at sunrise and gets her to the clinic just after 10:00. A 63-year-old mother of five and grandmother of two, she has visited the clinic with her family often over the years – whether for immunisations, treatment for diarrhoea or to refill her blood pressure medication. Ten years ago, she had to plan her trips according to what service was offered at the clinic that day and she often had to make more than one trip in a week. One of the Eastern Cape's more than 700 clinics, Ntafufu reaches an estimated 10 000 predominantly rural people. Ten years ago, its nurses struggled to manage patients with outdated training, little information to measure their progress and following the national mandate of health delivery – one type of care per day of the week (see box).

When people cannot access comprehensive health care, they risk not only their lives, but often those of their children. A missed immunisation, running out of TB medicines or an untreated STI – each potentially serious case contributes to the rise of preventable and treatable illness. Under a system dictating one clinic to offer family planning, another to treat STIs and another to treat TB, with prescriptions filled at yet another facility, South Africans like Mafukamile could not access health services when they needed them.

"We did not choose to inherit the situation that we did, but we became an umbrella for EQUITY and in the process, realised that functional integration is best. How? We are working as one family."

Maternal Health Manager, Eastern Cape Province

In 1997, the EQUITY Project began to support government goals to establish comprehensive, integrated primary health care through widespread training to update primary care skills and communicate new patient rights to communities. This strategy touched on all of the Project's technical areas, incorporating both management systems upgrades and clinical skills enhancements.

First, the Project helped to define services by life stages and at each level of health services – community, mobile/satellite, clinic, day hospital/community health centre, and sub-district/district hospital. A Project checklist guided health providers to offer all nine services comprising primary care: immunisation, ante-natal care, family planning, STI, TB, child curative, adult chronic, minor ailments and nutrition. Concurrently, mapping of clinic catchment areas enabled new managers and providers to tailor services to community needs. Further clinical and management training of thousands through various initiatives, such as the DHM&L Programme, clinical updates at nursing colleges and hundreds of tailored training events –

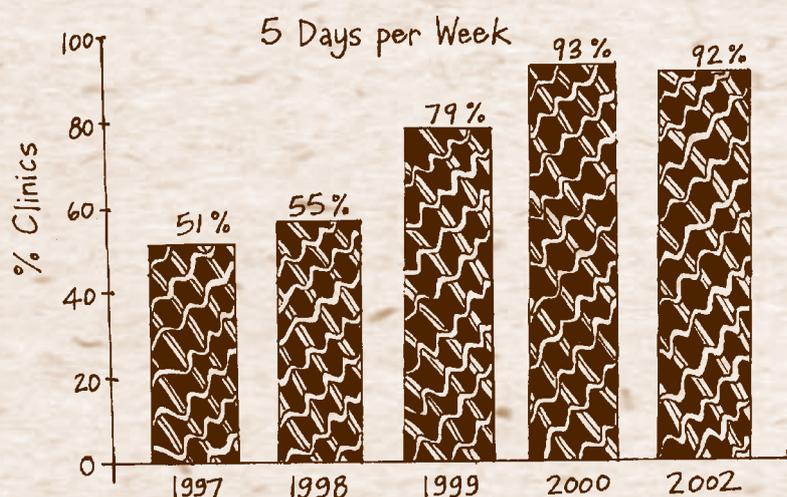


1997-2003



covered primary care, drug management, the DHIS, supervision, budgeting and planning and not least, priority diseases. The culmination of this far-reaching approach was integrated primary health care for all.

Provision of Basic Child Care Services



Includes: Ante-natal, Immunisation, Family Planning & Child Curative
Source: EC Facility Survey

Today, 92% of Eastern Cape clinics provide all basic child health care services five days/week (see graph). Further, 75% of clinics have catchment area maps posted, compared to 13% in 1997. Most importantly, integration has resulted in better health for the citizens of the Eastern Cape: 69% of children are now fully immunised, up from 58% in 1998. Meanwhile, provincial support has accompanied district and regional endorsement for integration: resources for primary health care now account for more than 50% of the provincial health budget, compared to less than 20% in 1997. By incorporating the systems improvements needed to effectively manage primary care, the EQUITY Project has helped to redress some of the inequities of the past. While more still needs to be done, patients like Mafukamile are better off than they were in 1997: "The nurses have changed. It is better now...now I get treatment. We are accepted daily, unlike before."

Needs

- Lack of tools or systems to facilitate primary health care integration and delivery
- Limited management skills to meet expectations of comprehensive primary care
- New model of primary health care introduced to a curative-focused system
- Segmentation, fragmentation and duplication of basic health services
- Hospital-based training and delivery of health care
- 75% of health budgets directed to hospital services

Interventions

- Conducted assessments and focus groups to understand health needs
- Facilitated mapping of clinic and facility catchment areas in the Eastern Cape
- Trained thousands of health workers in primary health care management
- Developed the Primary Health Care by Level of Delivery checklist to guide health workers through services at each level of health care
- Documented phases of integration in the Functional Integration publication
- Advocated for increased resource allocation dedicated to primary health care

Out comes

- Basic primary health care services available in all clinics
- Improved communication between all health system levels in the Eastern Cape
- Providers and district managers have guides to manage integrated primary health care
- More than half of the EC provincial budget is now allocated to primary health care



Eastern Cape

Clinical Training Impact

2001-2002

- 20% of nurse educators trained in HIV/AIDS/STI/TB (up from 12%)
- 30% in IMCI (up from 6%)
- 28% in VCT (up from 1%)
- 40% in patient rights (up from 9%)

Source: EQUITY Clinical Training
Assessment

- 70% of child diarrhoea treated with ORS, up from 43% in 1997
- 85% of respiratory tract infections treated according to protocol
- 85% of STI cases treated according to protocol, compared to 54% in 1997

Source: EC Facility Surveys

Empowering the Next Generation of Nurses

"Previously, we concentrated on diseases presented in overseas text books. We never looked at the health needs of our country. Now we are aware of them. We know the health priorities."

Nurse Educator, Eastern Cape Province

Virginia Henderson has never been to South Africa. If she had, she would know that managing TB in the United States is very different than managing TB in one of the worst-affected countries in the world. In standard text books used by South Africa's nursing colleges, Ms. Henderson's US-based advice was taught, learned and tested upon, despite its irrelevance to local circumstances. Nurses were ill-prepared to deliver primary care, to address the country's worsening epidemics of TB or HIV and AIDS, or to focus on community needs.

An expensive injection, an over-prescribed antibiotic or an un-needed cough syrup: outdated clinical training risked placing South Africa's health system in financial ruin and its patients in jeopardy. A 1999 EQUITY Project assessment documented inefficient and hospital-focused training at the Eastern Cape's 12 nursing schools: only 6% of nurse educators had received training in integrated management of childhood illness (IMCI), none had been trained in current TB strategies and only 1% in voluntary counselling and testing (VCT). Meanwhile, less than 10% of nurse educators had been exposed to concepts of patient rights. Nurse tutors lacked the skills to manage STIs and had difficulty understanding health information. Nurses in many rural areas functioned in isolated and neglected states, with limited access to clinical updates. In clinics where nurses have received up-to-date training in priority diseases, communities are more likely to use condoms and modern contraceptives and to immunise their children.

In partnership with Intrah Health, the EQUITY Project updated both management and clinical skills in primary health care by delivering a comprehensive orientation programme for nurse educators and providers across the Eastern Cape. Incorporating national health priorities and standard treatment guidelines into the curriculum of nursing schools, Project partners also created new workbooks, tutor guides and clinical checklists to supplement teaching of students, supervisors, rural providers and managers. In five pilot clinics, supervisors implemented a performance improvement approach with on-the-job training to address rural communities' priority concerns.

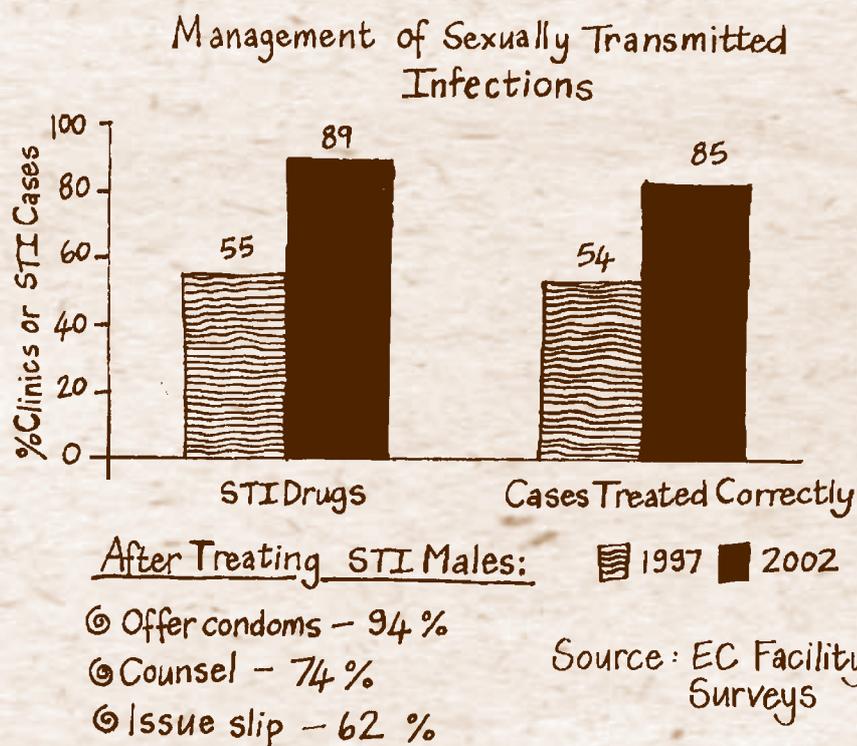


1997-2003

"I am proud of us as a [nursing] college. We can take risks, even with all the problems we face. If this means our contribution is now to communities and in partnership, then we will all go out in one voice, contributing to all the citizens of this country."

Nurse educator, Eastern Cape Province

These nurses improved diagnosis and treatment of TB patients and sick children and management of STIs – now 85% treated according to protocol (see graph). Updates in IMCI reached 30% of nurse educators, up from 6%. As a result, nurses have improved treatment of childhood diarrhoea in the Eastern Cape; 70% of cases are now treated correctly with oral rehydration solution (ORS), up from 43% in 1997. As one nurse described: "Today's treatment of diarrhoea is ORS done at home. Before, we would give a drip or antibiotics. [Nursing] students now teach community members what to do about a cough. In the old days, they gave a cough mixture or injections."



This all-embracing strategy contributed to the creation of holistic nurses – who listen and understand patient concerns, examine patients fully and whose confidence and training assures the correct diagnosis and treatment. Further, nurse educators' test scores in TB, STI management and VCT have more than doubled. Meanwhile, rural nurses and their supervisors in five pilot clinics also advanced national priorities: increasing family planning users and improving TB treatment completion and STIs treated according to protocol. With the EQUITY training approach now the model for the South African Nursing Council, the 15 million annual patient visits in the Eastern Cape can be reassured that they are in good hands.

Needs

A 1999 assessment documented lack of knowledge of health priorities at nursing institutions

Poor communication between nurse educators, communities and other health providers

Nurse graduates were ill-prepared to deliver primary health care

Nurse training emphasised knowledge and theory with limited practical application

Nurse education was outdated and hospital-focused

Interventions

Trained more than 5 000 providers and managers in primary primary health care

Developed infrastructure of trainers, facilitators and tutors on district clinical training teams

Introduced supervisor-facilitated on-the-job training province-wide, supported by checklists

Developed a clinical skills curriculum to integrate national health priorities in nurse training

Implemented performance improvement approaches to address priorities in five rural clinics

Developed Priorities in Child Health Booklets to guide providers to immunise and treat diarrhoea, malnutrition and acute respiratory infections appropriately

Shared clinical training approaches in Strengthening Clinic-Based Services in the Eastern Cape, a four-part series developed by Intra Health

Outcomes

The ECDOH adopted the EQUITY-designed nursing curriculum, which is also the model for the South African Nursing Council

Nurses have improved diagnosis and treatment of priority diseases

Nurse education better prepares nurses to provide primary care

Nurse educators' test scores more than doubled after completing TB, STI and VCT modules

Supervisors institutionalised use of Clinical Tips for diarrhoea, HIV and AIDS and counselling

Improved clinical management of STIs, TB and health priorities in five rural clinics



Community Impact: 2002

- 88% of EC clinics have patient complaint mechanisms, compared to 47% in 1998
- 79% of EC clinic health committees met in last 90 days, up from 56% in 1997
- 95% of EC patients in exit interviews said they would use the clinic again

Source: EC Facility and Household Surveys

Nono Motshani appreciates the help of a clinic committee member in caring for her paralysed husband.

Community Voices Chime in Tune on Hospital Boards and Clinic Committees

Mcingelwa Motshani lies motionless inside a small mud hut in a poor village of the rural Eastern Cape; his wife Nono sits nearby. Mcingelwa had a stroke last year and is now paralysed, unable to walk or use the toilet without assistance. The road in front of the Motshani's house is dirt and gravel and with no wheelchair, Mcingelwa cannot visit the health clinic. However, the Motshanis feel its support. Every day, Nobubele Fumana, a clinic health committee member and a home care worker trained by EQUITY, visits the Motshanis to relieve Mcingelwa's pain and Nono's burden: to carry him outside for some fresh air and to turn his fragile body so he does not develop bed sores. She is an extension of health services offered by the local clinic, a voice of health education when the nurses are not present and a crucial link between her community and primary health care.

Community representation in health was not encouraged under South Africa's previous government. Critical understanding of community needs comes from such representation, as does awareness of what a health clinic offers its community. Decentralisation and merging of health systems created new roles for providers and managers, placing new emphasis on community involvement. In 1997, hospital boards and clinic committees in the Eastern Cape Province were defunct, not representative of communities or functioning with little guidance or oversight. South Africa's new democracy needed to communicate everyone's right to health; the EQUITY Project participated in this effort by conducting mass training to develop, form and guide hospital boards and clinic health committees in the Eastern Cape Province.

The EQUITY Project province-wide training of hospital boards and clinic committees served to convey roles and structure and the importance of proper representation. Including community organisations, local leaders and facility managers, training also established standard criteria for membership, roles and responsibilities and basic ground rules for operation – such as appointment time limits. Reinforced by [Guidelines for Hospital Boards](#), workshops did more than provide an overview of basic policies and actions. Participants also learned their roles of financial oversight, resolving complaints, ensuring quality, fundraising and sharing community attitudes with facilities while observing important concepts of patient rights and quality first-hand during facility visits.





Following EQUITY training, St. Patrick's Hospital board member Wellington Ngubane helped advocate for more doctors and conducted health education to encourage women to seek ante-natal care.

Today, there are more than 600 hospital boards and clinic committees functioning in the Eastern Cape, with membership in the thousands. They not only meet regularly and abide by a basic constitution, but also further the premise of primary health care and community advocacy missing for so many years. For example, one year ago, St. Patrick Hospital's crumbling walls and chipped paint depicted a grim picture of health services for its patients. With hospital board fundraising, St. Patrick's painted and upgraded the facility, and is building a new maternity ward and outpatient department. When maternal deaths increased, the board conducted community outreach to motivate pregnant women to seek ante-natal care as early as possible. As the medical superintendent summarised: "The board plays an integrated role by solving problems when [we] are unable to do so. [For example], we had a doctor shortage. We realised services would be compromised and the community would not be cared for. We are fortunate our board was trained so well. They facilitated this problem and helped us get two more doctors."

Building alliances between facility managers and community members is not always easy, but the improved communication benefits patients, hospital managers and board members. Teamwork and a resolve to battle problems motivated many to go beyond their traditional roles on boards and committees: they have become DOTS supporters and home care workers, drug delivery men and women, fundraisers, proposal writers and policemen. As they help alleviate the burden of TB and HIV, ensure essential medicines, build new wards, hire security to protect a burglarised clinic and report abuse of ambulances, their voices have united with those of service providers. Relying on new skills and the trust of facility managers, board and committee members across the Eastern Cape have learned how to address their community's biggest health problems and in so doing, have become the grassroots leaders of primary health care: "We learned from EQUITY that if you do something, you must love it, own it and make it a part of your life. I am more committed than ever to making a difference in other people's lives."

Needs

Situation analysis in Eastern Cape documented performance of boards and committees:

Lack of community representation in health decision-making

Hundreds of defunct hospital boards and clinic committees

No accountability or standard structure for boards or committees

Hospital boards and clinic committees not representative of the populations served

Limited guidance or skills development for board and committee formation and functioning

Hospitals and clinics lacked understanding of community needs

Strained relations between community members and facility managers

Interventions

Developed wide-ranging curriculum and material to train boards and committees

Trained hospital board and clinic committee members how to form and function effectively

Developed Guidelines for Hospital Boards, a handbook for members before and after formation

Enhanced leadership and management skills of board and committee members

Highlighted successful community initiatives in Strengthening Community Participation in Health, which includes tools and checklists for improving community involvement

Trained all Eastern Cape clinics in patient rights

Outcomes

More than 600 hospital boards and clinic committees functioning in the Eastern Cape

Established renewed links between health needs of communities and health services

Advocacy for health from community-level is institutionalised in the Eastern Cape

Improved understanding of patient rights to health care

Improved the health of thousands by ensuring community voices influence health decisions



Supervision: The Foundation of Quality Health Care

Supervision Impact: 2002

- 44% of EC clinics have written supervisory report after last visit, up from 6% in 1997
- 45% of supervisors train staff during visits, up from 14% in 1997

Source: EC Facility Surveys

“There was a sick child with his mother in the clinic. [I observed] that the nurse only listened to the mother and did not examine the child. Maybe the child is sick, and the mother may only attribute it to the illness present. Nurses did not know that if a child had diarrhoea, they could still immunise them. Nurses would continually miss opportunities to immunise and meanwhile, they did not treat the child appropriately for his illness. ”

As a supervisor in the Eastern Cape Province, Noxolo Majozini recalled one of many problems she encountered during clinic supervision.

Few would argue against supporting immunisation programmes to save vulnerable children. However, without a comprehensive, well-managed health system that offers support and guidance to front-line health workers, such programmes will fail. Every aspect of public health – from ensuring medicine availability or proper STI treatment to immunising a child – depends on a health worker who has up-to-date clinical knowledge and motivation to offer quality services. Clinic supervision affords health providers a support system to address problems while offering continual learning opportunities that enhance quality.

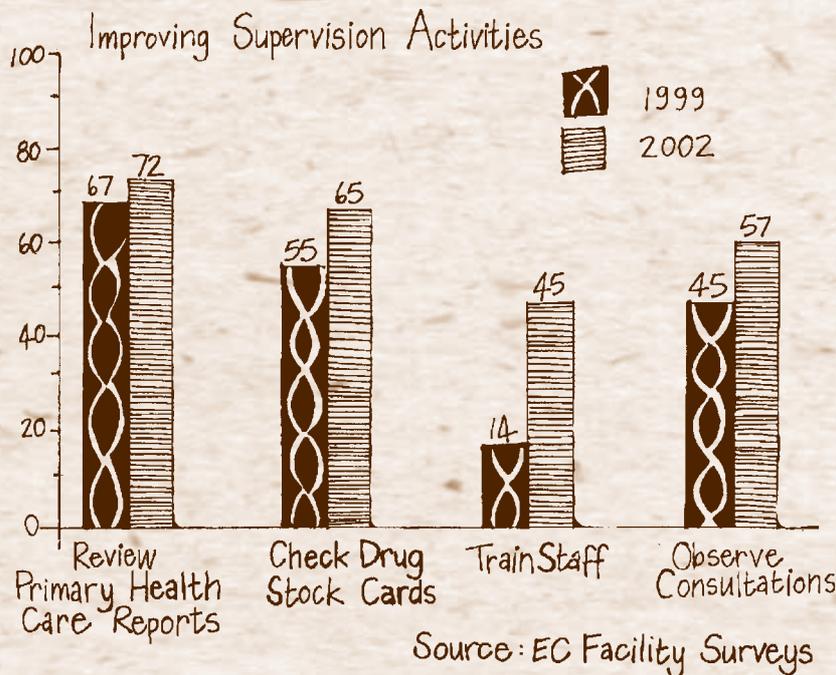
In 1997, South Africa did not have a uniform supervision system. A 1999 EQUITY assessment in the Eastern Cape revealed alarming gaps and confirmed that lack of uniformity and guidance in supervision compromised quality. The study also identified significant challenges impeding supervision, such as staff rotation, staff shortages, lack of tools to guide supervisors and lack of transport. These problems culminated in brief, unproductive and fault-finding visits that strained relationships between supervisors and clinic staff. Effective supervision was needed to help the collective speak a common language of primary care and broadcast its message to patients around the country.

First, the EQUITY Project donation of 22 all-terrain vehicles improved supervisors' access to rural clinics in the Eastern Cape. The Project then developed simple, user-friendly documents, offering tips such as how to organise visits and what to discuss and check. Piloted during training, including the DHM&L Human Resource Module, supervisors and clinic nurses welcomed these reinforcements as they felt a positive shift in mindsets. The Project also created in-depth programme checklists, giving supervisors an easy way to cover all aspects of priority diseases during visits. Supervision policies and job descriptions reinforced improvements and helped to clarify roles, responsibilities and reporting structures.



1997-2003

Meanwhile, supervisors trained in all nine provinces began adapting the Supervision Manual to suit local needs. Visits across the country became animated problem-solving sessions, as one Mpumalanga supervisor explained: "This is a tool that we use to evaluate services. We can see where we want to go and if a clinic isn't doing well. It helps us plan, identify gaps and address those gaps."



Today, the NDOH has a standardised supervision system that uses the Supervision Manual as its quality guide. Its contents – from organising visits and information system guidelines to national norms and in-depth programme reviews – cover every aspect of primary health care. All nine provinces use the manual, adapting and amending its contents while maintaining a basic structure and system. Clinic nurses feel motivated: "This manual gives the nurses confidence. If they have a problem, they have guidance to address it. Records of visits and training plans are now in place." A true reflection of its institutionalisation, supervisors are sharing their new skills outside their provinces; Mpumalanga supervisors trained by EQUITY recently travelled to the Northern Cape Province to train colleagues to use the manual.

Most importantly, quality of services improved: "I did not know I needed to initiate TB treatment – I thought a doctor had to first diagnose. Now we know we can do it at the clinic, on the spot," said one nurse in the Eastern Cape. Her colleague in Mpumalanga also explained: "We identified that some nurses were not giving correct treatment for STIs, so we organised training on proper STI management." The examples are too numerous to list and come from every province of the country. The comprehensive system has helped to integrate primary care and reinforced the importance of investing in support systems: "The tool is built on the primary health care package. As a department, it has enabled us to implement its norms and standards. We can now evaluate if nurses are progressing according to these guidelines. It helps us to uphold quality standards in all aspects of health care."

Deputy Director, Mpumalanga DOH

Needs

A 1999 supervisory assessment in the Eastern Cape documented:

No standardised criteria or model for conducting supervision

Supervision irregular, brief and unstructured

No written feedback on findings and no follow-up of problems encountered

Unclear roles and responsibilities for clinic supervisors

Transport challenges in rural areas impeding regular supervision

Strained relationships between clinic staff and supervisors

Interventions

Developed supervision policies to establish regular visits

Motivated for increased posts dedicated to clinic supervision

Donated 22 all-terrain vehicles to improve supervision in rural Eastern Cape

Developed checklists for clinic functions and field-tested each list

Developed one-page training tips to share new information at each visit

Culminated checklists and tips into comprehensive Supervision Manual

Trained hundreds of supervisors in all nine provinces to clarify purpose of supervision

Outcomes

One single, uniform supervision system promotes primary health care nationwide

The Supervision Manual is part of national policy for quality improvement

The Supervision Manual is used and adapted to local needs in all nine provinces

Improved supervision enhanced quality, particularly around priority disease management

Posts created for supervisors in rural Eastern Cape



A Healthier Horizon Dawns in Mpumalanga

Everyone greeted me as I walked into the hospital. I was anxious and tired and my baby was sick. The clerk was quick to take my details, her voice reassuring me that we would be attended well. I watched the nurses rush around me, my child finally asleep after a long night. The doctor passed through and offered us a smile. When the cleaner stopped, I wondered what was happening. He was kind; he told me how to help my baby eat properly. He said that breastfeeding would help him grow up strong and healthy. I knew about breastfeeding but I did not realise how important it was. I felt so relieved; it seems this hospital takes good care of its patients if even the cleaner knows such important information!

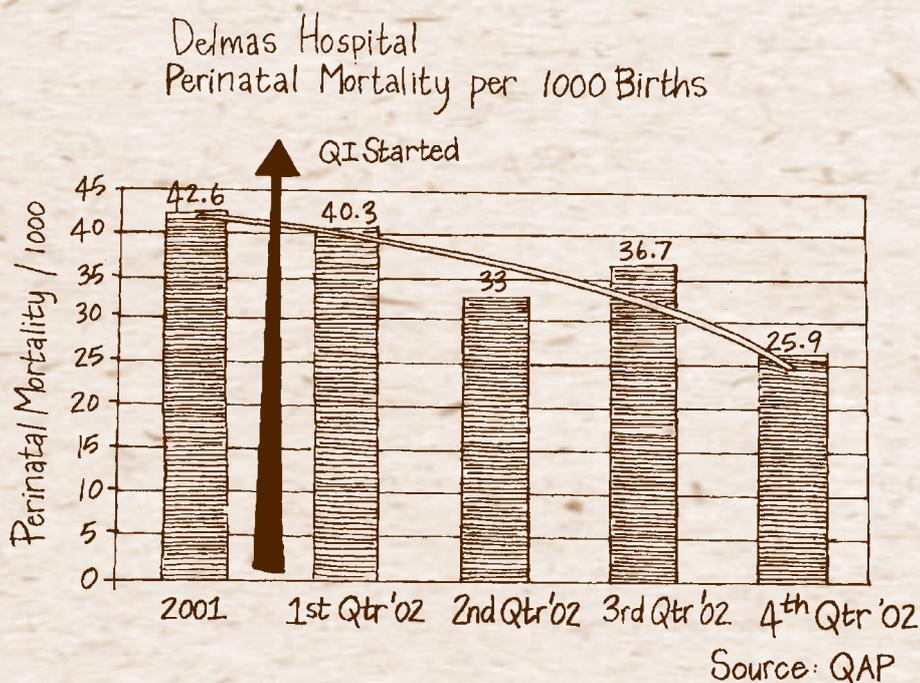
Two years ago, this woman's story would have been very different. She would have walked into Mpumalanga's Delmas Hospital and not been acknowledged by the staff. She would have waited, uncomfortable and anxious, wondering how long it would take to see a doctor. When she was finally called, she may – or may not – have been examined fully. A record of her visits may – or may not – have been available. For mothers and their children across Mpumalanga Province, visiting hospitals was not a pleasant experience. In 2001, a situation analysis in Mpumalanga's maternity wards revealed poor history-taking, ad hoc physical examinations, inconsistent vital signs monitoring and infrequent APGAR scoring of newborns (a critical assessment to determine heart rate, respiration, reflex, colour and muscle tone). In other health facilities, poor TB case finding and limited access to prevention of mother-to-child transmission (PMTCT) programmes added to the list of problems, further contributing to lack of knowledge about health problems and fear of visiting local facilities. As one district manager summarised: "People had forgotten quality."



Pride & greatness

With support from the Quality Assurance Project and in partnership with EQUITY, Delmas became one of 22 hospitals and 250 clinics in Mpumalanga to embark on a journey of teamwork in 2002 – its final destination: improved quality of care.

With few additional resources, the initiative targeted maternity wards across the province while also aiming to upgrade TB, voluntary counselling and testing (VCT) and PMTCT programmes. First, teams in all the facilities gathered to examine findings of situation analyses. Training in quality assurance enlisted multi-disciplinary groups to address content of care (standards, protocols and guidelines) and process of care (systems, attitudes and motivation) while emphasising the importance of measured outcomes and increased efficiency. Nurses, managers and other hospital staff applied a holistic approach, recognising that "quality assurance starts from the gate." The comprehensive interventions targeted all levels of health services: clinics re-vamped health education and promotion, supervisors visited facilities more regularly with the support of the Supervision Manual, hospital staff



posted health policies and protocols on facility walls and training sessions updated staff knowledge of key maternal and child health issues, TB protocols and PMTCT services. Everyone – from doctors and nurses to cleaners and security guards – now understood the importance of following standard guidelines.

Slowly, things began to change. At Delmas, nurses greeted everyone that walked into the hospital. Patients seemed happier. Client exit surveys became more positive. Data indicated improved patient management. At monthly meetings, staff discussed problems while basking in the glory of improvements coming to light. Graphs illustrating APGAR scoring, physical examinations of mothers and babies and vital signs monitoring blanketed the walls. The emerging data trends were startling: early neonatal mortality fell from 13.9/1000 in 2001 to 8/1000 in 2002 while perinatal mortality fell from 42.6/1000 in 2001 to 34/1000 in 2002 (see graph). Compliance with complete history taking increased from 47% in 2001 to 83% in 2002. Finally, compliance with complete physical examinations of mothers and APGAR scoring increased to levels unseen in the Delmas Hospital for many years. As Teresa Lukhozi, Senior Professional Nurse in the Maternity Ward said: "Since we started quality assurance, things have improved. We have guidelines on the wall to prompt exams...today, 90-95% of mothers are given physical exams and 100% APGAR scoring for babies."

In 2003, replication of lessons and successful interventions began in eight hospitals and 45 clinics in KwaZulu-Natal. With the proper knowledge and new results in hand, Mpumalanga's multi-disciplinary quality improvement teams are demonstrating that a focus on quality can make a difference. Most importantly, Mpumalanga's mothers and babies are increasingly assured of better quality care.



Needs

High maternal and perinatal mortality rates caused partially by:

Broken or unavailable equipment in hospital maternity wards

Staff shortages and wards filled to capacity

Poor history-taking and ad hoc physical examinations of mothers and children

Inconsistent and infrequent vital signs monitoring and APGAR scoring

Inconsistent HIV counselling of pregnant women

Interventions

Donated new equipment to maternity wards

Provided motivation, support and in-service training on quality improvement

Established monthly quality meetings in hospitals

Trained 90 providers in 3 districts, as well as 17 tutors, in PMTCT

Provided training in record-keeping and monitoring, including links to DHIS

Outcomes

Motivated hospital and clinic staff to make quality improvements themselves

Institutionalised meetings of multi-disciplinary teams to ensure quality in facilities

Improved consistency of HIV counselling of pregnant women

Improved monitoring and treatment of maternity patients

Decreased maternal and neonatal mortality rates in hospitals

"It is easy enough to shout slogans, to sign manifestos, but it is quite a different matter to also build, manage, command, spend days and nights, seeking solutions to problems."

Patrice Lumumba



1997-2003

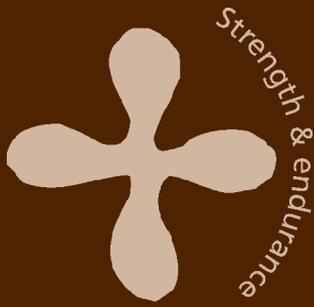
INFORMATION FOR ACTION:

Management strategies for improved health

Recognising the importance of building systems and enhancing use of information, the Eastern Cape became a laboratory for management development interventions in 1997, later spreading its lessons throughout the country.

Whether health information, management and leadership knowledge, planning and budgeting tools or drugs and logistics systems – each of these features demonstrates how using information to improve management results in a more effective primary health care system capable of meeting the needs of its population.





Information Impact: 2002

- 77% of EC clinics display data on walls, compared to 29% in 1997
- 75% of EC clinics have catchment maps posted on walls, compared to 13% in 1997

Source: EC Facility Surveys

Making Sense of Health Information

"We had to change. We were frustrated with the health system and we had no useful information to base management on. This had a radical impact on our inability to provide quality health services."

District Manager, Eastern Cape Province

What they remember most is the paper. Reams and reams of it, containing numbers and data that few could understand and no one read. That it took time away from helping patients was beside the point, because it was required and therefore collected, compiled and sent to someone in an office far from the clinics and hospitals its contents dealt with. Buried deep were probably one or two useful pieces of information – like TB cure rates or the percentage of fully immunised children – but if it was there, few managers used it.

In 1997, South Africa had hundreds of paper-based health information systems that were used in an ad hoc fashion and could not answer managers' most plugging concerns: *Are essential medicines available? Are all pregnant women visiting the clinic for ante-natal care? Are nurses really over-worked?* There was no list of the health facilities and few clinics knew their catchment population. Every authority used its own forms and requirements; it was hundreds of people speaking different languages. Without a user-friendly, comprehensive and unified health information system, the country could not integrate primary health care, improve quality or address the worsening TB and HIV and AIDS epidemics.

In one Eastern Cape district, managers took matters into their own hands: "We asked ourselves: *why are we collecting data?* First, we tried to create a data collection tool that would cut out the duplication. Then we reduced the set of indicators and stopped sending statistics that made no sense. Over time, another region bought into our process...and clinics started making graphs. EQUITY then evaluated what we did and adapted the basic concept and some of the indicators. The [district health information system] DHIS was born."

To assist in the development of the DHIS, the EQUITY Project questioned managers and providers at every level of the health system – facility, community, regional, provincial and national – to determine what essential information they needed to function effectively. These information needs were transformed into measured indicators, to be calculated from specific, uniform data elements devised to ensure that the majority would be useful at clinic level. If providers could not gain value from the data, it was dropped. Reporting structures warranted that as information



1997-2003

was reported up, its volume decreased. For example, a clinic needs to know if vaccines are available, while a national programme manager will be more interested in the percentage of fully immunised children. Beginning with a paper-based system encouraged clinics to make hand-drawn graphs before advancing to a computer programme that now includes internal validity checks, automatic indicator calculations and reports generated as tables, graphs or even maps. Uniformity makes the core system standard across nearly 6 000 health facilities in the public sector while also adaptable to local needs.



Needs

Hundreds of paper-based health information systems not systematically used or understood

No single unified system for collecting and reporting essential primary care indicators

No data on number of clinics, personnel, services, basic problems or populations served

Hundreds of primary care indicators not widely used

Limited understanding of the importance of health information

Interventions

Assessed information needs at all levels: facility, region, district, province and national

Developed and field-tested health information system covering all aspects of primary care

Reduced the basic set of primary health care indicators from hundreds to 25

Trained managers and providers in all nine provinces to use DHIS

Developed Mapping for Primary Health Care as a guide to community mapping

Developed Using Information for Action, a practical guide for data management

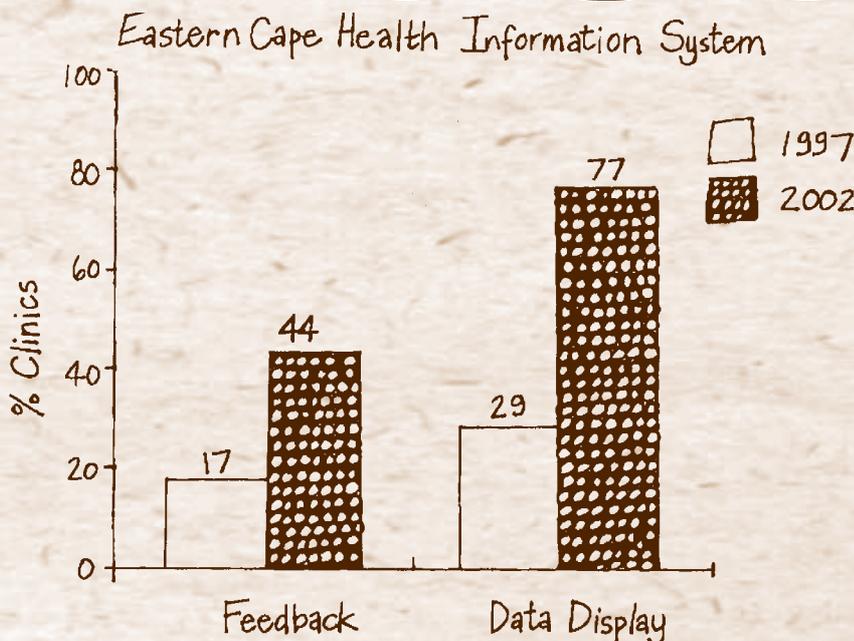
Out comes

The DHIS is the uniform, comprehensive information system adopted nationwide

Every district in South Africa uses DHIS to collect and report essential health data monthly

Providers and managers increasingly use the DHIS to inform plans, develop disease profiles, monitor progress and identify priorities

Eight countries worldwide use the DHIS as a model for their health information systems



Clinics Discuss Primary Health Care Indicators – 91%
Source: EC Facility Surveys

Today, the DHIS is the national system for health information and every facility in the country collects and reports data using it every month. Managers and providers across the country are also beginning to innovate and challenge the system to improve health services – from clinic supervisors monitoring performance to health coordinators allocating reduced TB budgets while still prioritising clinics with low cure rates. The DHIS has helped move previously vertical and isolated programmes into an integrated primary care continuum. Providing a tool to keep track of service indicators such as TB cure rates, children not gaining weight and number of STI cases treated, the DHIS is also a comprehensive management tool which includes data on out-of-stock medicines, allocated resources for various programmes, as well as a list of health facilities in every district of the country, to name a few. As one manager involved in its early development summarised: "Before EQUITY arrived, we didn't know what was going on...we now know how to manage clients, especially in primary health care. We are confronted with systems that were not there before and we have a logical mechanism to record patients. We have graphs on the walls, ask questions about statistics and develop disease profiles. We now know what is expected of us."

District Teams on the front lines of Primary Care

"My brother died of AIDS [and] he had some resources. What about the people with nothing? They are really suffering." Nomvulo Kosana sat in the Eastern Cape's Motherwell township clinic while outside, thousands of her patients lived in poverty. As coordinator of the voluntary counselling and testing (VCT) programme, she saw the need for additional HIV and AIDS services for the many infected and affected in her community.

Nomvulo addressed this need after taking the HIV/AIDS/STD/TB (HAST) Module of the District Health Management & Leadership (DHM&L) Programme: "The HAST course was a wonderful benefit. It gave me new knowledge and I was able to learn from people in different sectors. It inspired me to do more in my community to battle HIV and AIDS." First, she developed a tool to determine VCT coverage compared to the clinic catchment population. She then advocated for additional funding: "We started PMTCT soon after and then I helped form support groups for mothers. I also felt that VCT and PMTCT were not complete if I could not attend to the sick people, so I began a home-based care project." Nomvulo is now recognised as one of South Africa's best health workers. In 2003, she was the only finalist from the Eastern Cape for the national Khomanani Health Workers Excellence Award.

In 1997, Eastern Cape nurses and managers like Nomvulo had few options for improving their management skills, nor for effectively overseeing new appointments at all levels of the health system, decentralisation or a recently-introduced model of primary health care. These new managers needed additional skills to address transformation and bring primary care to front lines.



In 1998, the EQUITY Project partnered with the ECDOH and the University of Port Elizabeth, Fort Hare University, Rhodes University and University of Transkei, to develop a programme that could address

training needs of new district teams. The resulting DHM&L Programme offers both management courses (leadership, governance, human resource management, budgeting and finance and resource management) and service and programme courses (HAST, maternal and women's health, child health and mental health). The unique blend of talents in the partnerships complements not only the teaching curriculum, but also provides students a combination of academic and practical approaches to health management.

"The Finance Module empowered us, demystifying finances to instil a new sense of confidence. For example, when we compared the cost of drugs we realised one clinic was spending more than it should. We [now] have formalised monthly budget reviews."

Primary Health Care Manager, Eastern Cape Province

The DHM&L presented new styles of participatory, active learning and developed managers' skills in problem-solving and teamwork, requiring immediate application in community projects. For example, three students in the Child Health Module designed a project to address transport problems preventing rural mothers from taking their children to the health clinic for immunisations and routine growth monitoring. The result is a project that continues three years later, featuring monthly community baby-weighing and including community health workers, clinic nurses and community members, who work together to battle malnutrition and lack of growth,



as one of the students explained: "The Child Health Module made us able, as a team, to establish a culture of helping ourselves, even if we work far from the clinic. This project is helping bring health services to people at home. Where there is no clinic, they have established community weighing." In another community, students in the Governance Module conducted a situation analysis with TB patients to determine reasons for treatment interruption. The team then designed and implemented an advocacy project with mass education, role plays and community meetings, demonstrating how improved understanding of patients' experiences must be incorporated into health interventions.

Today, 30 students have completed the two-year diploma and 500 managers and providers have taken at least one course. The collective has renewed skills to manage the district health system; they assess services, use information to make decisions, apply quality improvement strategies to develop plans and solve problems, work in teams, consider costs and write and present reports – touching on all aspects of both primary care management and service delivery. As they manage their districts towards quality and equity, they do so as more knowledgeable and empowered individuals: "I have gained interpersonal skills and open-mindedness. No goal is too high if I take a step each day. I feel empowered from top to bottom. This [programme] has given me the courage to tackle anything. I have courage, strength, hope and a feeling of being capable."

Health Manager, Eastern Cape Province

Needs

- Decentralisation of services to district level placed new responsibilities on managers
- New appointments at all levels of the health system
- Limited knowledge or capacity to assume management of district health system
- Lack of a training programme to address management and clinical skills for primary care
- Vertical models for teaching and top-down approaches

Interventions

- Facilitated partnerships between universities and ECDOH to address training needs
- Developed wide-ranging curriculum covering primary care management and service delivery
- Developed academic and practical approaches to teaching primary health care skills
- Evaluated impact of DHM&L on district health system development

Outcomes

- The ECDOH has assumed full leadership and funding of the DHM&L
- The DHM&L is the main health management development programme in the province
- Strengthened concepts of district health system and primary health care
- 30 district managers completed the full DHM&L diploma
- 500 managers and providers have taken at least one course
- Created hundreds of innovative community projects and opportunities for advancement
- Created training and teaching example that is being modelled in other provinces

Better Planning for Better Health

"We need more 24-hour clinics there...primary health care is under-resourced, put that in...but what is the cost of keeping a patient in the hospital? Whether it's small or not, this cost tends to be overlooked...they need the same resources." They debate back and forth, a vision of the new South Africa hard at work in the North West Province, analysing health data from the past quarter, identifying progress and remaining gaps, and isolating their biggest cost



drivers. With TB, HIV and AIDS topping their list of concerns, the team is working together to decide where resources should be allocated. It was not always like this, says one manager: "Primary health care came with new challenges. Things were very centralised before; things happened 'up there'. Not all races were involved.

Now we work together and have improved communication...we involve all groups, all cultures...we know their needs better." Black and white, rural and urban - they have come together to develop a district health plan and budget that is equitable and that meets health needs.

Apartheid left a legacy of skewed health service distribution and an emphasis on hospitals. Beginning in 1997, EQUITY Project studies and analyses confirmed inequities in resource allocation between and within provinces; the poorest districts and provinces received less for basic health services than the richest. The difficulties of shifting resources for greater efficiency and equity, together with a lack of planning and management skills, resulted in poor quality, dilapidated buildings, broken equipment and shortages of staff, supplies and medicines, particularly in rural communities. Meanwhile, few health workers knew where resources went. For example, of the 95 hospitals in the Eastern Cape Province, only six were monitoring their costs in 1997. New legislation aimed to make managers more accountable for use of resources and ultimately achieve better health service performance. To focus resources on primary health care, district managers needed to gather service and financial information, analyse needs, set priorities and develop plans and budgets.

The EQUITY Project implemented a multi-pronged approach to help managers meet these challenges by developing systems and providing training to address deficiencies in budgeting, planning, performance analysis and reporting. This approach built on other Project initiatives, such as training in supervision, the DHIS and drug and logistics courses, as well as the DHM&L's Budget, Finance and Planning





Module, which offered specialised support for district health expenditure reviews. Widespread technical assistance and training in Mpumalanga, North West and Eastern Cape Provinces improved planning and budgeting skills. One-on-one assistance with Eastern Cape hospitals helped managers to use funds more efficiently and improve quality, thereby informing and enhancing health plans and their implementation. To encourage sharing between hospitals, the Project facilitated performance and expenditure reviews, putting forth a simple tool to track expenditure against budgets and to see if planned targets were met. The culmination of these efforts are featured in the **Guidelines for District Health Planning and Reporting**, a manual which advises managers how to develop three-year and annual plans and annual reports, based on long-term strategic plans. With instructions on conducting a situation analysis and building on existing data from the DHIS and expenditure and performance reviews, the **Guidelines** provide step-by-step instructions and illustrations, making them easy-to-use. The **Guidelines** are now mandated by the NDOH to be used by all health districts across the country.

The integrated approach to improved financial management and planning enhanced collaboration between sub-districts, districts and provinces, contributing to a more complete picture of health. Managers increasingly link health plans with resources, understanding the relationship between expenditures they authorise and the services that facilities produce. Further, advocacy efforts using this information are helping to address crucial needs, such as in North West: "The **Guidelines** helped us identify that we were under-resourced in human resources. As a result, all the sub-districts received funds to hire new personnel." In the Eastern Cape, 100% of districts developed annual plans using a standard format in 2002, up from 67% in 1997, as did all districts in North West and Mpumalanga. Facilities now see first-hand the inefficiencies that waste resources as they re-direct those resources to meet health needs throughout the country: "We have experienced this paradigm shift in rendering of health services, and it is no longer tunnel vision. We have a broad approach and we take community needs into consideration. This was not there before. Now, we've come to serve the province and our people. The way we have changed – it is night and day. We still have a long way to go, but so far, it is a much better world."

Health Manager, North West Province

Needs

Staff and supplies shortage
and inaccessible health
services partly due to:

Inequitable allocation of resources – less funds
to some areas than to others

Ineffective allocation of resources –
insufficient funds for primary care

Inefficient use of resources

Lack of service planning and weak links
between service planning and budgeting

Lack of systematic analysis and reporting on
use of health service expenditure

Interventions

Developed simple spreadsheet tool and
manual for performance and expenditure
reviews

Developed guidelines to facilitate
expenditure reviews and health planning and
reporting

Trained managers in three provinces to
improve budgeting, planning and reporting

Refined Service Level Agreement template to
better define relationships between
government levels

Developed a planning and budgeting format
to guide the NDOH and other African countries
in HIV and AIDS proposal development

Conducted an analysis of provincial health
spending which documented inequity

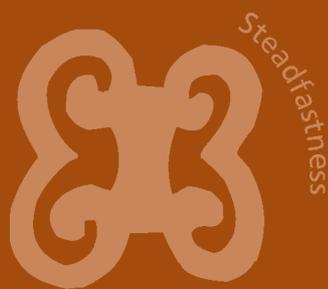
Outcomes

The NDOH adopted **Guidelines for District
Health Planning and Reporting** for use in all
districts nationwide

The NDOH adopted the **Service Level
Agreement** template for use in all districts
nationwide

All sub-district and district management teams
in North West and Mpumalanga produced
annual health reports and plans

All districts in the Eastern Cape produced
annual reports



Drug Impact: 2002

- 89% of EC clinics have STI drugs available, compared to 55% in 1997
- 70% of EC clinics follow standard treatment guidelines, compared to 43% in 1997
- 75% of EC clinics use bin cards to ensure availability of a key antibiotic, compared to 37% in 1998
- 92% of EC clinics have injectable contraceptives available

Source: EC Facility Surveys

- 220 new pharmacist positions created in EC, compared to 40 in 1997



Prescriptions for a Developing Drug Management System

Wednesdays used to be the worst days to pick up medicines in the Eastern Cape's Empilweni Community Health Centre. The pharmacy was closed as Sisanda Mtatambi, the only pharmacist, manually filled out long forms to place orders for the following week. On Wednesdays, the 50 000 people served by the health centre would have to risk their health and return another day. "Patients suffered as a result," said Sisanda. Whether clean gloves to examine a patient, polio drops to prevent life-threatening disease in a child or blood pressure medicine to prevent heart attacks – without an efficient drug management system that ensures availability of essential medicines, needless deaths can result.

Beginning in 1997, the EQUITY Project conducted comprehensive assessments to document the performance of the Eastern Cape's drug management system, illustrating breakdowns in distribution, procurement and drug depot management. A drug utilisation review also verified lack of rational prescribing and limited adherence to standard treatment guidelines and essential drug lists. Pharmacist shortages meant that nurses and other health workers had to dispense and order drugs, a responsibility few could handle. To address these pressing issues, Project partners aimed to fill vacant posts, update clinical knowledge, develop uniform systems and train staff in their use, thereby enhancing use of information and developing local capacity to manage drug supply.

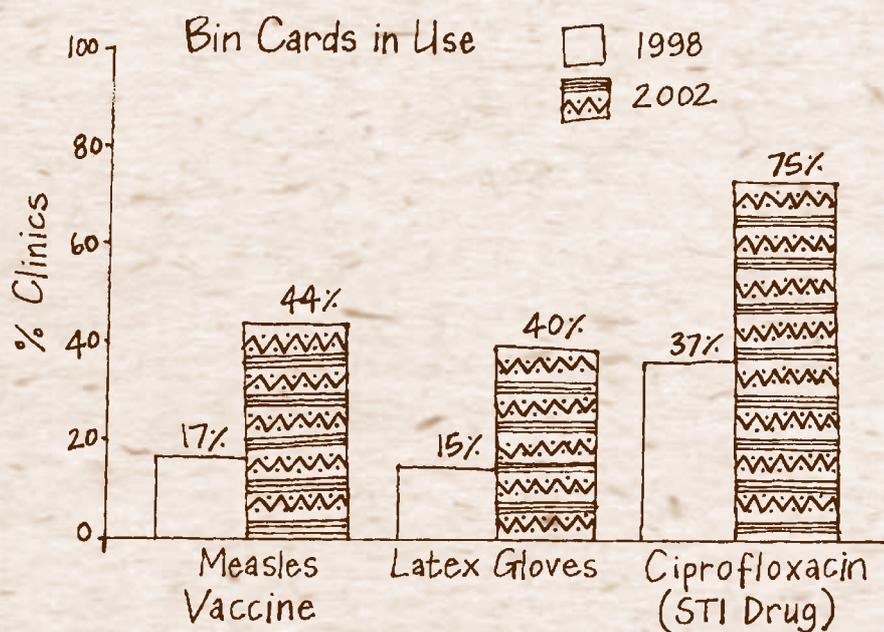
Working with the Eastern Cape Provincial Drug and Therapeutic Committee (DTC), the EQUITY Project enforced standard treatment guidelines and the National Essential Drug List through the **Eastern Cape Formulary**, which includes prescriber levels and prices for essential medicines. The first province with its own guide to determine dose and cost, the formulary is being replicated in other provinces. Training of hundreds of DTC members in all nine provinces further reinforced these guidelines by creating multi-disciplinary teams of pharmacists, doctors, nurses and other health workers to advise on and evaluate drug use and expenditure.

Development and implementation of bin cards and order forms in the more than 700 Eastern Cape clinics created a uniform system for managing drug supply at facility level. Guided by the EQUITY Project **Managing Drug Supply for Health Institutions** manual, providers and managers now had a simple process to ensure essential medicines. These important tools are now institutionalised in the ECDOH and have also been introduced in North West and Mpumalanga Provinces.

1997-2003

To address emerging needs for more advanced monitoring systems, the Project developed **RX Store**, a computerised inventory management information system that allows users to keep track of and cost all transactions, to print out specific management reports and to make decisions based on more accurate data. Because it is less labour-intensive than manual stock cards, pharmacists like Sisanda at the Empilweni Community Health Centre spend less time ordering and more time helping patients. At national level, the NDOH utilises the Pharmaceutical Information System (PharMIS), developed with EQUITY support, to monitor costs and usage trends in all provincial pharmaceutical depots.

New systems are only as good as their use to managers. The EQUITY Project trained hundreds of health workers in Mpumalanga, North West and Eastern Cape Provinces in the essentials of drug supply management. At the same time, creation of the Pharmacist Assistant Training Programme in the Eastern Cape placed 65 graduates in rural areas as 200 students learn the basics of pharmacy practice. Courses also exposed non-pharmacy personnel to basics in drug management: "The drug course opened my eyes! I wasn't aware that we should use rational drug use surveys. It improved the way we prescribe and we now use the stock card system."



Source: EC Facility Survey

The impact of these efforts is evidenced by improved availability of critical medicines; 89% of Eastern Cape clinics have STI drugs available, compared with just 55% in 1997 and 82% have TB drugs available, compared to 67% in 1997. Further, use of bin cards to ensure availability of essential medicines has improved significantly (see graph). Most importantly, patients visiting health clinics feel the impact, as Nozamile Konqana, waiting at a rural clinic in the Eastern Cape explained: "Sometimes they couldn't help me or my kids. It is better today... they have [medicines] available to help us."

Needs

- Lack of suitably qualified staff to manage drug supply
- Lack of a unified drug management system
- Few pharmacists in rural areas
- Expired drugs contributed to wasted resources
- Limited adherence to standard treatment guidelines or essential drug lists
- Tedious and time-consuming drug management

Interventions

- Implemented Pharmacist Assistant Programme to address staff shortages
- Trained 400 pharmacists in North West, Mpumalanga and Eastern Cape in drug supply management
- Trained DTC members in all nine provinces to clarify roles and responsibilities
- Implemented stock cards and trained staff in 700+ Eastern Cape clinics in their use
- Introduced stock cards to all districts in Mpumalanga and North West Provinces
- Developed Managing Drug Supply for Health Institutions to implement stock card use
- Implemented RX Store in 20 facilities in the Eastern Cape and one metro in Gauteng
- Developed PharMIS, a data warehouse to monitor drug distribution and costs nationwide
- Developed Eastern Cape Formulary to promote essential drug lists
- Assisted the ECDOH to develop a recruitment and retention strategy for pharmacists

Outcomes

- The ECDOH institutionalised funding and management of stock cards and order forms
- New posts for pharmacists improved capacity to sustain drug management improvements
- Information systems at national and facility levels standardised drug supply management
- 65 pharmacist assistants completed the programme and are serving in rural areas
- All nine provinces institutionalised DTCs, promoting implementation of essential drug lists and standard treatment guidelines



"The key to our success is our own collective effort. The time for rhetorical arguments and victim blaming has passed. Now is the time for action. Let us ensure that everybody understands that a successful fight against AIDS is not a success only for individuals, but for families, communities and indeed for our country as a whole."

Nelson Mandela

1997-2003

PRIORITY DISEASES: **Confronting the biggest killers**

Every day, more than 600 people die of AIDS-related illness in South Africa. Half of these die from TB.

Sound management systems – from information used to track disease patterns to clinical training that enhances quality – are crucial to effectively address TB, HIV and AIDS. Firmly entrenched within the primary health care system, the successes described here resulted from seven years of systems strengthening and increased attention on the country's biggest killers.





Reinforcing the Basics to Improve TB Management

TB Impact: 2002

- 82% of EC clinics have all TB drugs available, compared to 67% in 1997
- 85% of EC clinics take TB sputa, compared to 59% in 1998
- 100% of EC clinics using DOTS

Source: EC Facility Surveys

In motorbike communities (2002):

- more than doubled monthly average number of sputa collected at clinics
- reduced sputa collection turnaround time from weeks to less than 48 hours
- increased collection of sputa specimens by 88%

Vuyisile is determined to complete his TB treatment with the support of his DOTS supporter, who is also a traditional healer.

Fifty-three year old Vuyisile Makabeni is gaunt and haggard, tired and too ill to work. His cheeks cave in as he quietly describes his various experiences with TB. Each time, he begins treatment and when he improves, he stops. Like thousands of others in the Eastern Cape Province, Vuyisile has yet to complete the six-month course required for a cure and therefore contributes to the province's less than 50% cure rates. Since 1997, the EQUITY Project has aimed to help people like Vuyisile rid themselves of a disease that kills half of HIV infected South Africans and contributes further to the country's social ills of unemployment, poverty and poor health.

An assessment of the epidemic in the Eastern Cape documented that erratic drug supply, lack of clinical knowledge, poor record-keeping, inability to get sputum exams, poor patient education and transport difficulties contributed to inefficient case finding, high treatment interruption and low cure rates. Previously operating independently of other priority programmes, these reviews helped underscore the need to integrate TB management within primary health care. With the country's second worst TB epidemic, the Eastern Cape's vast distances and poor infrastructure made addressing its scourge a significant challenge. The EQUITY Project sought to provide needed clinical training, management support and systems innovations to address the epidemic while empowering communities to sustain its fight. Above all, this strategy intended to enable people like Vuyisile to access TB medicines, obtain informed information and advice and ensure that his progress – and hopefully his cure – was monitored and recorded.



Widespread clinical and management training of nurses, supervisors, programme managers and laboratory technicians ensued to improve understanding of how to diagnose and treat TB, supported by checklists in the *Supervision Manual*. Improved clinical knowledge increasingly shifted TB diagnosis and treatment from hospitals to clinics, where most patients get their care. Emphasis on DOTS helped to revive community support structures to treat patients, while training improved nurses' data collection capabilities by ensuring daily recording of patient information in registers (which feed into the DHIS). As one Eastern Cape lab technician described: "Before this project we were not using the TB register. There was no system...now we have started keeping records of every laboratory result and we know every patient that is on DOTS."

In many rural areas, testing sputum samples used to take as long as three weeks because of transport problems. As a result, patients rarely returned to receive their diagnosis. Working with both private companies and local government, the Project established two innovative initiatives using taxis and motorbikes to transport sputum samples from clinics to laboratories. These projects cut turn around times from several weeks to 24 – 48 hours. Serving rural, impoverished populations numbering more than 100 000, the projects were so successful that the ECDOH is funding expansion.

Training clinic health committee members and community health workers established sustainable support for DOTS – further uniting clinics with the people they serve. As Mrs. Boqwana, a nurse at Tombo Clinic recalls: "We didn't know about DOTS before we underwent training. We saw there was a need for people who cannot visit the clinic to be helped in their community, where they live." For evidence of the impact of these interventions, one need only look at this clinic's treatment register, which illustrates an 88% increase in the number of TB sputa processed, meaning more TB patients are identified and put on treatment. Even more impressive and a first for this area – the Tombo Clinic achieved an 85% cure rate of new TB clients in 2001, compared to 60% in 2000.

Despite worsening TB statistics in the Eastern Cape, the groundwork has been laid for effective management and replication of innovative initiatives. By ensuring TB management is linked with effective supervision and with community structures, the Project established basic systems to address a challenging epidemic. With such examples of innovation and improved clinical knowledge in place, TB patients like Vuyisile stand a better chance of being cured than ten years ago. His DOTS supporter, a traditional healer trained by EQUITY, motivates him to continue: "I am happy with my care. I am not going to stop this time. I am determined to finish my treatment."

Needs

- Assessment documented lack of systems, transport and poor record-keeping
- Frequent stock-outs of TB drugs, particularly in former homelands
- Fragmented approaches and numerous systems for TB management
- Lack of accurate TB information, cure rates unknown prior to 1995
- Limited clinic-based TB diagnosis or treatment
- Lack of understanding for scope of TB problem and outdated clinical knowledge
- Lack of widespread community treatment for TB

Interventions

- Improved understanding and communication about TB at provincial and local levels
- Developed tools and checklists to strengthen DOTS
- Trained supervisors, managers, laboratory staff, nurses and doctors in TB management
- Developed a simple TB recording register, integrated into primary health care reports and the DHIS
- Established motorbike and taxi projects to transport TB sputa to laboratories

Outcomes

- The ECDOH has assumed funding of training in TB management
- The ECDOH is expanding innovative projects using taxis and motorbikes
- Institutionalised TB updates through checklists in the *Supervision Manual*
- Community health workers and clinic committee members support patients through DOTS
- Improved record-keeping and data collection
- Improved capacity to diagnose and treat TB at clinic level



Taking the HIV Test

Lusanda stares ahead, wide-eyed and scared, like a small child whose mother cannot help her. She is 13, sitting alone as she listens to what the next 30 minutes will entail. She will first be given some basic information and asked a series of questions, repeating back what she has understood. Then she will sign her name on a form and take the test. Thirty minutes of anxiety will pass, and she will be given the results. Lusanda is not taking a test in school nor is she in a classroom with her friends. She is at her local health clinic, about to find out if she has HIV, the virus that causes AIDS.

More than half of South Africa's adults with HIV – the largest number in the world – were infected before the age of 25. A young woman like Lusanda, already sexually active, is at highest risk. Though the HIV epidemic does not discriminate, it does disproportionately affect the young and the poor, especially if they are women.

In 1997, people like Lusanda had few options available to get tested for HIV in the Eastern Cape. Quality data on the epidemic was not widely available, informational materials haphazardly distributed and testing services limited to specialised centres. So too

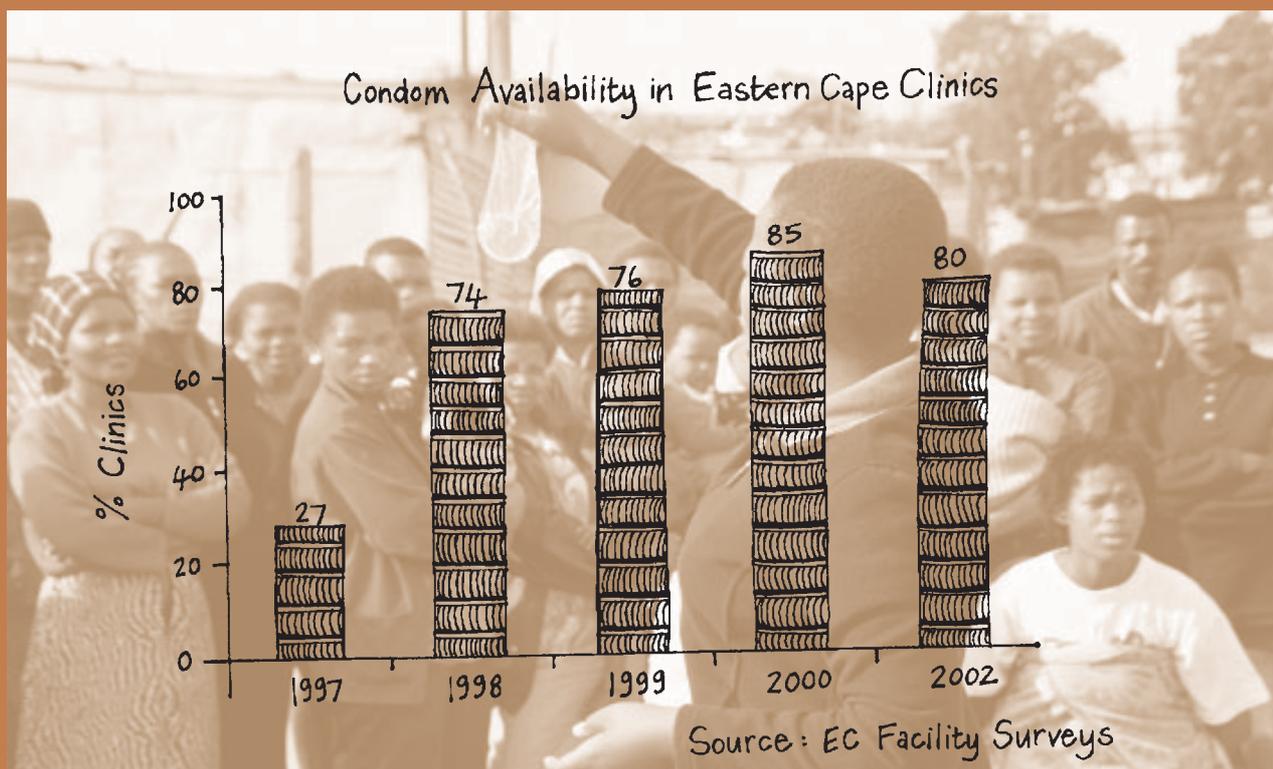


as the epidemic is complex and far-reaching, any strategy to successfully address its scourge would need to be comprehensive in scope. The EQUITY Project increasingly focused on the management and training challenges the worsening epidemic presented.

Widespread social marketing campaigns in the Eastern Cape from 1997-2001 created new demands for socially marketed condoms by helping young people better understand how to prevent HIV. For those who could not afford to purchase condoms, the Project improved promotion and supply of free condoms in the public sector, available in "condo cans" at 80% of Eastern Cape clinics in 2002, up from 27% in 1997 (see graph).

Building on efforts to improve integration in primary health care, the Project supported formation of multi-disciplinary HIV and AIDS/STI/TB (HAST) committees, now meeting regularly in the Eastern Cape to coordinate planning and implementation of priority activities.

In 2001, rapid expansion of voluntary counselling and testing (VCT) and prevention of mother-to-child transmission (PMTCT) sites became a national priority.





Needs

- Limited capacity in all provinces to train counsellors for VCT and PMTCT
- Inefficient data management systems
- Lack of relevant VCT training and educational materials
- Low coverage for VCT and PMTCT services
- Few nurses trained on HIV and AIDS management
- Lack of district structures to effectively address HIV and AIDS

Interventions

PMTCT programmes are helping thousands of mothers and their children in the Eastern Cape.

Through the NDOH HIV and AIDS Programme, the EQUITY Project supported widespread training of trainers and counsellors in nine provinces, aided by guidelines and coupled with distribution of pamphlets, posters and banners marketing VCT services. In the Eastern Cape, a comprehensive assessment of facility readiness documented that poor record-keeping and management gaps had to be addressed before new sites could be opened. Through technical assistance and training, the Project upgraded clinical and management skills of nurses to become counsellors, created a user-friendly monitoring guide and developed a tool to accredit facilities ready for testing. In 2003, 403 VCT and 157 PMTCT sites were operational, reaching 55% of the provincial population, compared to just 54 VCT and PMTCT sites in 2001.

By offering VCT and PMTCT within the primary health care package, patients can easily access ante-natal care, TB treatment, and family planning – each crucial to effectively mitigate the AIDS epidemic. The impact of this approach is best seen in experience of someone like Lusanda, today one of thousands seeking to know her HIV status. As Sindiswa, a clinic nurse, waits with Lusanda to determine her test results, she encourages the young woman to visit the family planning clinic, be faithful to her partner and use condoms each time she has sex, regardless of her outcome. Sindiswa and her colleagues see an average of 300 clients every month, mostly women, about half of whom test positive. This time and for today, Sindiswa's patient is negative. Lusanda's happiness is evident, and if she follows the nurse's advice, perhaps she will remain negative. As the grateful young woman leaves the room, Sindiswa's own words remind her of why she does this work:

"I like my job because I am helping my clients and their families. The other day, someone in town said to me: 'you helped me.' Being able to sit with someone who trusts you, relies on you, and accepts their [HIV] status...this is when I feel that I've accomplished something."

- Supported district-level interventions nationwide through Developing and Implementing an HIV and AIDS Plan at District Level publication
- Developed guidelines to support training of counsellors in all nine provinces
- Distributed thousands of VCT/PMTCT pamphlets, posters and banners nationwide
- Developed VCT indicators to be incorporated into the DHIS
- In the Eastern Cape:
 - Conducted baseline assessment of district capacity to implement VCT and PMTCT
 - Trained health workers on VCT and PMTCT and developed Toolkit for Integration of VCT to guide them
 - Established multi-disciplinary HAST committees at district-level
 - Developed tool to assess facility readiness to implement VCT and PMTCT
 - Developed tool to monitor quality of VCT and PMTCT services

Outcomes

- More than 1600 VCT sites are functioning nationwide
- Rapid expansion of VCT and PMTCT in Eastern Cape provides access to 55% of population, up from 7% in 2001
- The ECDOH institutionalised funding and management to train counsellors
- Managers are using EQUITY tools to monitor VCT and PMTCT service quality
- HAST committees capacitated to manage district-level HIV and AIDS services
- Guidelines for counsellors are being used to train additional health workers
- VCT promotional material is widely available nationwide

After the HIV Test

HIV Positive – blazoned in bold purple letters across Lungile Konongo's chest, the words are misleading on this outwardly healthy 32-year-old man. Lungile does not look like a stereotypical AIDS patient. He is not gaunt, wasted or bed-ridden. Statistically, there is no doubt that he will eventually die from the disease that kills more than 600 of his fellow South Africans every day. He tells his story from an Eastern Cape clinic serving more than 50 000 of South Africa's poorest, living in a sprawling township rife with poverty, unemployment and HIV. Here, clinic nurses reach out to their community with VCT, PMTCT and comprehensive follow-up and continued support for the many who test positive.

"Sometimes it is so hard. I had a 16-year-old, a teenager like my own child at home, who was chased away by her parents. Sometimes, you do 10 tests, and 8 are positive. You must give them some hope."

Nurse and Counsellor,
Eastern Cape Province

What happens after an HIV test is an often untold or forgotten story. This is when the real work – for providers and patients alike – begins. Stigma and lack of knowledge about the HIV continuum underscored the need to train nurses to manage opportunistic infections, which take advantage of immune-compromised



individuals, such as those with HIV. Meanwhile, positive individuals increasingly relied on community support structures to address feelings of alienation, fear, hopelessness and denial. In 1996, Lungile found out he was positive. Even after he was told he had five years to live, he could not accept his diagnosis: "I was so scared! I told myself no! I did not take it seriously."

Health care providers do more than administer VCT and PMTCT; they help patients break news to families, recommend condoms, offer dietary advice and provide referrals for TB treatment, support groups and home-based care. To address clinical gaps, the EQUITY Project supported the NDOH HIV and AIDS Programme to train more than 10 000 health workers in all nine provinces in clinical protocols for opportunistic infections.

Support groups for HIV infected individuals provide a crucial link between facilities and communities. For many, support groups afford the only safe environment where they can grapple with a range of emotions. Today, hundreds of support groups are active in the Eastern Cape. After joining a support group, Lungile became more dedicated than ever to educating others about HIV. Now trained as a counsellor, he recognises the important role he plays in what can be the most devastating moment of someone's life: "The patient must be free to accept. The first thing I do as a counsellor is refer the patient to a support group...this helps to fight discrimination. In the support group, you work together and motivate others." Emphasising this further, he recalls his own experience: "People will see [that] this is where they're supposed to be. After going, I became relieved. I had new friends. They have HIV. So I've become one too, and I'm a changed person."



1997-2003

Bambisanani Impact

Since 2001:

- Supported 950 HIV and AIDS, 850 TB, and 1300 terminally ill clients
- Registered 700 orphans for government support grants
- Trained 70 people in income-generation
- Assisted 175 support group members

The Need for Home-based Care

On October 25, 2002, 26-year old Zanele Mavana was dying slowly in her home in a rural village of the Eastern Cape Province. Her three children, ages 10, 8 and 4, watched in horror as their mother's bones became more visible. She no longer had the strength to get out of bed; her diarrhoea stained the sheets as she waited helplessly for someone to clean her. Her family refused to touch her or spend time in her small room, fearing they too would catch what is referred to here as the "disease with no name" – it is HIV and AIDS, and it is the harsh reality of life in many communities.

While HIV positive people can remain healthy for years, without anti-retrovirals, their bodies eventually succumb to illness. Hospitals can do little once patients reach the end stages of AIDS; the need for home-based care in communities around South Africa became increasingly urgent. Family members struggled to care for loved ones, ill-prepared to deal with both the physical and emotional toll of terminal disease.

In 2000, the EQUITY Project helped to establish Bambisanani, a unique public-private partnership between the ECDOH, Bristol-Myers Squibb, Goldfields, Anglo Gold, Harmony Goldmines, the Employment Bureau of Africa, and Transkei Hospice, to address the emerging needs for home-based care. With a focus on the former Transkei, the project has four main components: community mobilisation, home-based care, income-generation and support to vulnerable children. First enlisting community involvement, traditional leaders then nominate home care workers. Once nominated, these community members receive comprehensive training to care for terminally ill people. Every day, home care workers visit families and help make patients as comfortable as possible, using home care kits which contain aspirin, gloves, thermometers, bed pans, and calamine lotion, to name a few. To address the poverty-related issues, income-generating activities such as bread baking, candle making and gardening, help families deal with losing the main salary earners. Finally, identification and referral of vulnerable and orphaned children ensure they have access to social grants.

Recognising the needs of HIV infected individuals to be treated for opportunistic infections or referred to support groups and to home-based care, the voice of one of those who did not win the war, Zanele Mavana, emphasises the importance of community support structures:

"I only wish that people understand why they should care for us. We are still people. We may have AIDS, but we need your support."

Needs

- Ineffective management of opportunistic infections associated with HIV
- Lack of efficient dissemination of guidelines on HIV and AIDS policy at facility level
- Lack of integrated national training programme for HIV and AIDS and STI management
- Few home-based care initiatives in former Transkei of Eastern Cape Province
- Lack of support group structures in many communities

Interventions

- Supported training of 10 000 health workers to manage opportunistic infections in nine provinces
- Distributed clinical guidelines for opportunistic infection management to all provinces
- Developed palliative care guidelines to be distributed to all provinces
- Initiated mapping of home and community-based care nationwide
- Helped establish community and facility links for support groups and home-based care
- Helped establish public-private Bambisanani Project, documenting lessons in Bambisanani Booklets

Outcomes

- Guidelines for opportunistic infection management are being used in all nine provinces
- Capacitated thousands of health workers in all provinces to properly treat opportunistic infections
- 60% of Eastern Cape clinics offering rapid HIV tests have support groups

Remaining Challenges

South Africa remains one of the most inequitable countries in the world. While considerable progress has been made, the road to equity in health is a long, arduous journey.

Integrated, quality primary health care needs continued strengthening, particularly in rural areas.

Clinical education must address both primary care and priority diseases to ensure future health providers properly address patients' needs.

Hospital boards and clinic committees must be guided and established across all districts and provinces.

Access to transport and dedicated posts will prove crucial for the sustainability of clinic supervision.

The DHIS must be not only available, but managers and providers further trained to use its information for decision-making.

Management and leadership training must be accessible and ongoing to further build district teams' capacity to improve service quality and address community concerns.

District planning and budgeting tools must be rolled-out throughout the country, supported with technical assistance to ensure sound plans and equitable resource allocation in all settings.

Drug management systems need continued strengthening to ensure seamless selection, procurement, distribution and use of essential drug lists and adherence to protocols.

Finally, expanded prevention education and further management training, systems upgrading and improved community support structures are crucial to address the worsening TB, HIV and AIDS epidemics.

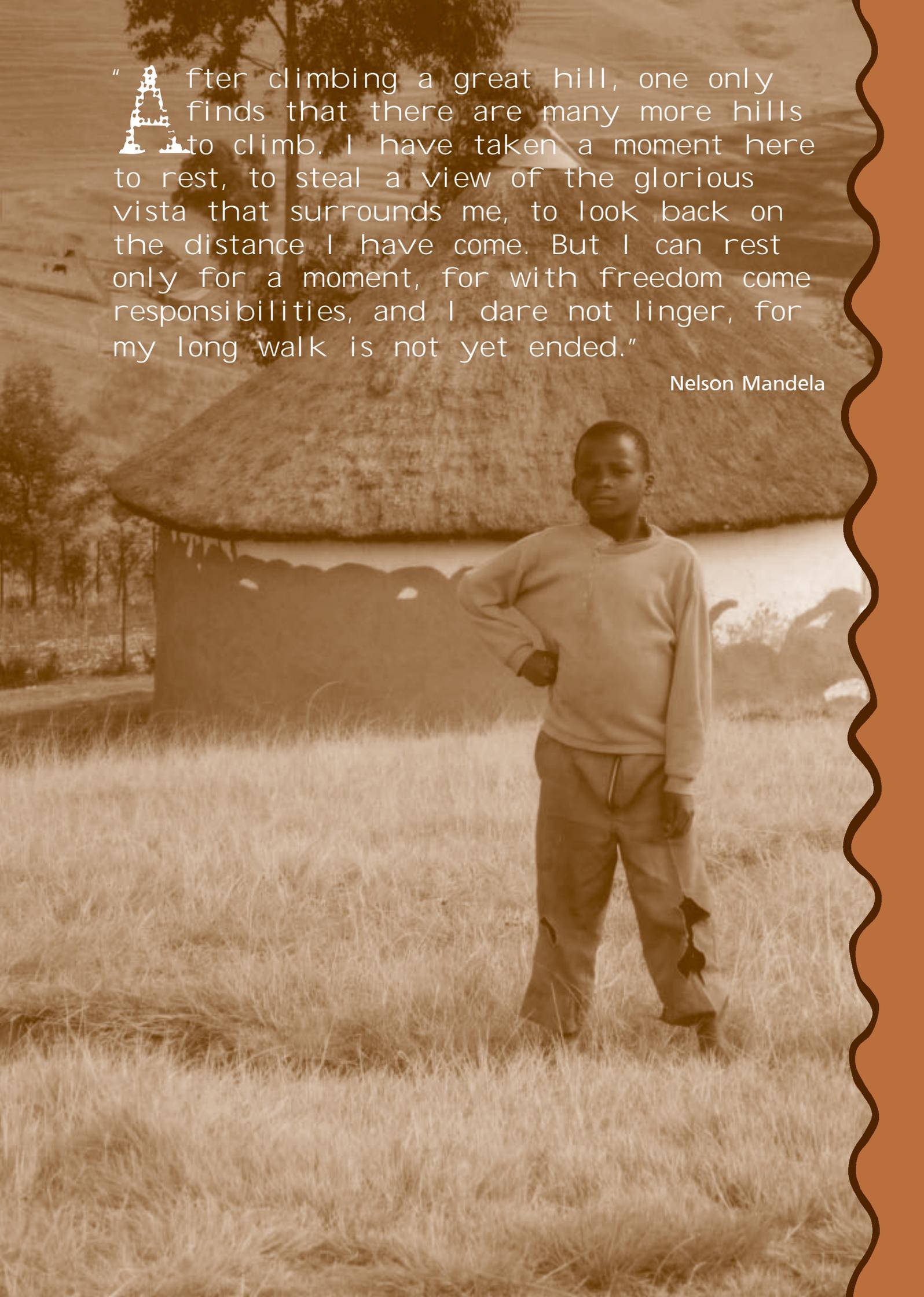
Travelled together, the final destination on the road to equity will be a better and brighter future for all South Africans:

"Half the battle shall have been won if indeed our efforts as leaders of our countries, parties and communities can at least inspire hope in our people for a better life.

The battle shall have been won if by 2099 our great great grandchildren shall be able to enjoy the benefits of a good education and decent housing.

The battle shall have been won if by the turn of the next century poverty, squalor, degradation and disease shall remain but a distant and fading memory."

Walter Sisulu (1912-2003)

A young boy stands in a field of tall grass, looking towards the camera. Behind him is a traditional thatched hut. The background shows a hilly landscape under a clear sky. The entire image is overlaid with a semi-transparent brown filter. A decorative wavy black border runs along the right edge of the page.

" After climbing a great hill, one only finds that there are many more hills to climb. I have taken a moment here to rest, to steal a view of the glorious vista that surrounds me, to look back on the distance I have come. But I can rest only for a moment, for with freedom come responsibilities, and I dare not linger, for my long walk is not yet ended."

Nelson Mandela

