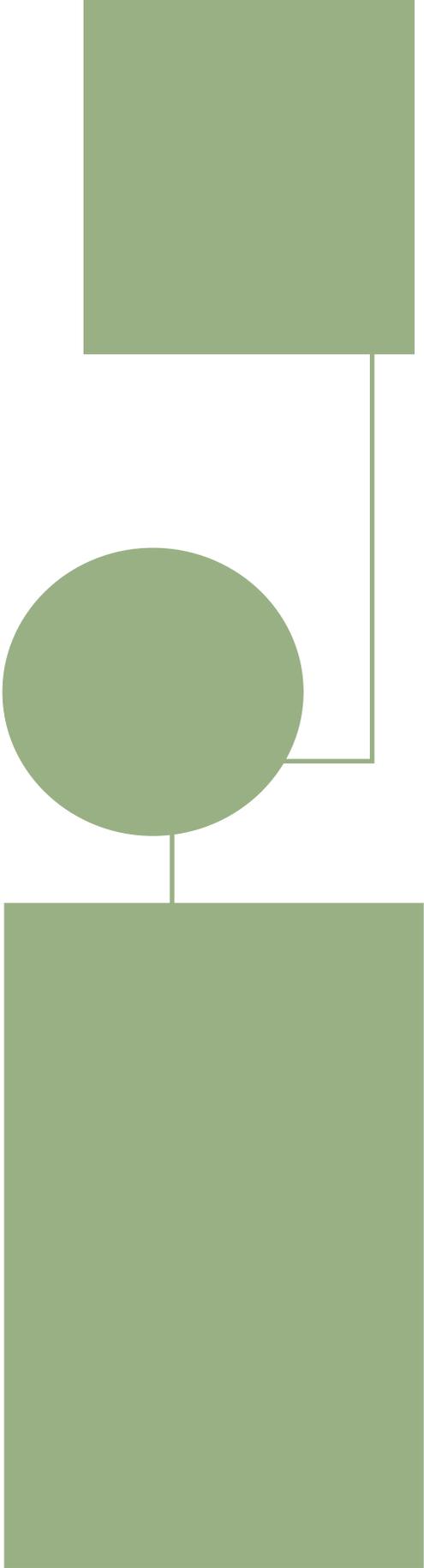


Strengthening community participation in health promotion and primary health care clinics

Ideas from the Eastern Cape



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The assistance of the supervisors from King D Sabata and Senqu Health Districts is also acknowledged. Carol Booth typed the many workshop reports and Cathleen Fourie typed the document.

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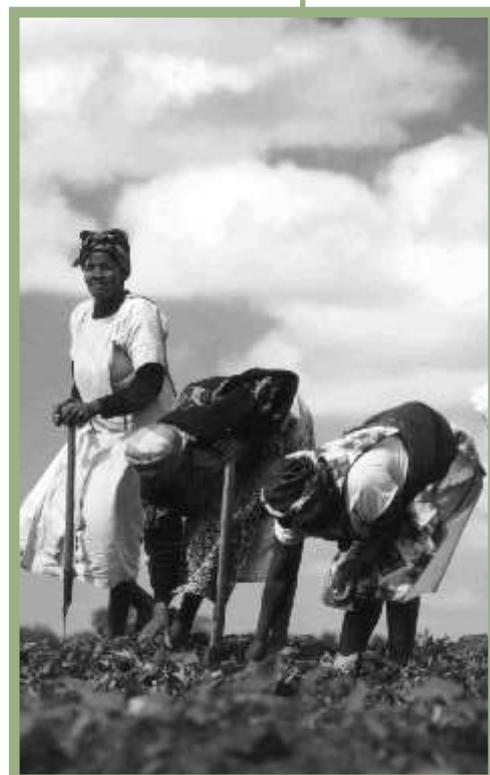
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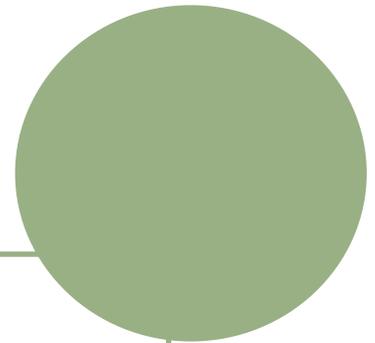


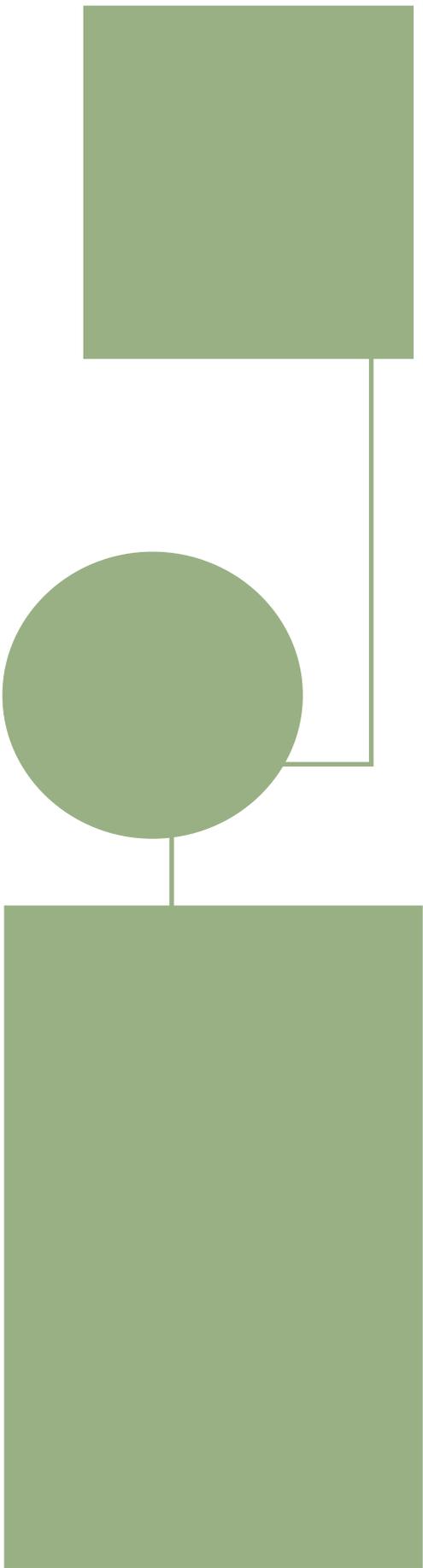
A note to the reader

This case study is about the Eastern Cape Province and the clinics (not the hospitals or health centres) and the community health committees (CHC) which represent the community and help to link the community and the clinic in order to improve the health of the population in the clinic catchment areas. The target readers are those workers in, and members of the districts and health committees where there is not yet a sustained and health promoting interaction between clinic, health committee and communities. The workshops which introduced the use of the tools attached as an annex are described in detail so that they can be replicated and improved where needed. The detail in this document provides insight into difficulties and areas needing emphasis.

Contents

- 3 Introduction
- 4 Background
- 10 Primary Health Care with and by the people
- 12 The Eastern Cape Provincial Health Act
- 15 Roles and functions of Community Health Committees
- 16 Community Health Committees and the clinic Health Information System
- 17 What aspects of the clinic should Community Health Committees consider in assessing the quality of care provided
- 19 Processes for increasing community involvement in health
- 21 Mapping as a tool for community involvement
- 23 The primary health care package and community/clinic participation
- 24 Community-based treatment of tuberculosis: DOTS
- 26 A review of community DOTS in the Eastern Cape Province
- 28 Home-based Care
- 30 The role of clinic supervisors in strengthening community involvement
- 32 Tools for increasing a Community Health Committee contributions to primary health care
- 34 Lessons learnt from previous workshops
- 37 Points from workshops that used checklists
- 39 Vision, Mission, Constitution
- 41 Model agenda for Community Health Committee
- 42 Conclusion
- 43 References
- 44 Annexure 1: Extracts from the *Eastern Cape Provincial Health Act*
- 45 Annexure 2: The outcome of the workshop: follow-up in the Nelson Mandela Metro
- 48 Annexure 3: Preamble to workshops to increase the involvement of communities in their own health care
- 50 Checklist 1: The role and activities of the Community Health Committee
- 53 Checklist 2: For rapid situation analysis by the Community Health Committee
- 58 Checklist 3: To assess community-based health care for different life stages in the community
- 63 Checklist 4: Adolescent-friendly Clinic Checklist





Abbreviations Used

AIDS	Acquired Immune Deficiency Syndrome
ANC	antenatal care
CBD	community-based distribution (of contraceptives)
CBHC	community-based health centre
CBO	community-based organization
CHC	community health committee
CHW	community health worker
CINDI	Care and support for children in distress
DOTS	Directly Observed Treatment Shortcourse
EHO	Environmental Health Officer
HIV	Human Immunodeficiency Virus
DHMT	District Health Management Team
IGA	Income-generating activities
KM	kilometre
MEC	Member of Executive Council
NGO	non-governmental organization
PHC	primary health care
SANCO	South African National Civic Organization
SANTA	South African National Tuberculosis Association
STI	sexually transmitted diseases
TB	tuberculosis
TLC	Transitional Local Council
UPE	University of Port Elizabeth

Introduction

Community involvement in health care is an essential component of primary health care (PHC) and of the transformation of the health system in South Africa.

Community involvement requires a partnership between the structures of the community and the health service structures of which the clinic is the most accessible in both urban and rural areas. The clinic might be a static one with outreach activities and small community-based satellite clinics or it might be a mobile clinic with its base in an urban centre, health centre or hospital. The community structures could include a CHC, or a larger urban or district health forum, or community-based organisations (CBO) such as women's self help groups, or non-governmental organisations (NGO) which have health and training activities.

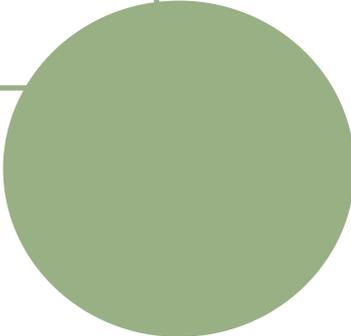
Neither a CHC nor the clinic is in control of the health of the community. Community health needs are best met where there is a common vision, achieved by a pooling of resources, the biggest of which is the energy and wisdom of all the people in the community. The clinic might have the technical expertise in health but the community understands better its own behaviour and how this might be modified to improve health. The clinic's resources are often more finite but those of the community can be developed. Participation for partnership is a learning process requiring an eagerness to learn from each other.

Basic to interaction between clinics and communities is the training which nurses have received. Previously nurses were trained in hospitals and the orientation was to sick persons in bed. PHC however, requires nurses who understand that they must consider all in their community – community-oriented PHC – and this requires training in clinics and in the communities they serve. One example of this was a process of community-based training pioneered in the province by the Border Institute of Primary Health Care. This was an NGO which was involved in training communities, community health workers (CHW) and nurses together in community-based health care. They worked in partnership with nursing training institutions (Frere Hospital) and community fieldwork areas (Newlands) to gain direct experience, and to prepare *Guidelines on Participatory Development for Health and Welfare Personnel at the Local and District Level* (3). Only with training, which also alters attitudes to be more aware of the influence of behaviour and family life on health, is it possible to motivate clinic staff to become facilitators who will increase community health action through the medium of health committees.

Avenues for participation

Communities are able to make an impact on their own health through two modes which are:

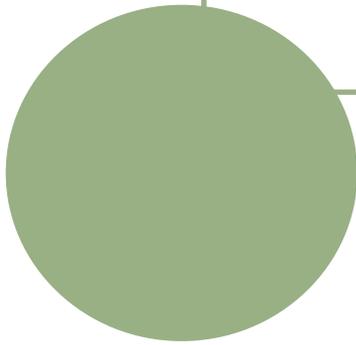
- Participation in health activities within the community such as community-based health care.
- Representation on structures which deal with health such as:
 - ◆ A health forum which is accountable to the community and which is part of the governance of the district health system.
 - ◆ A community health committee accountable to the community and which is part of the governance of the clinic.
 - ◆ A hospital board which is accountable to the communities served by the hospital and which is part of a system of governance of the district hospital.



Community involvement in health care is an essential component of PHC and of the transformation of the health system in South Africa.

Four basic conditions for community participation

- Political commitment to support community participation in service delivery programmes and community-based development programmes.
- Reorientation and retraining of health and welfare personnel in terms of attitudes and skills in interactions with communities.
- Support for community-based activities in the form of effective decentralization of services, logistical support and intersectoral coordination.
- Empowering communities to enhance their participation in health and welfare planning and development. This includes provision of information including that on health and welfare issues and assessing and accessing resources within the community.



➔ Guidelines on Participatory Development for Health and Welfare Personnel at the Local and District Level

Background

The earliest global awareness of community participation as an essential pillar of PHC dates from the Alma Ata Conference in 1978 (ref) and its Declaration – but South Africa was at that time not included in the World Health Organization. The former government policy of apartheid effectively denied the bulk of the population any real participation in planning, managing and evaluating their health services and it was the Reconstruction and Development Programme (ref) of the new government which adopted the PHC approach and placed community involvement and participation in health as essential for improving the health status of all communities.

Since then there have been numerous documents, white papers, bills and acts which have developed this theme that communities must not only participate actively in services provided for them. They must also become involved in improving health themselves whether on an individual, family or community basis. Both community participation and involvement really implies participation to varying extents in planning, in organizing, in managing and monitoring and evaluating health activities whether they be promotion, prevention, early diagnosis, treatment, or rehabilitation. Most of the documents produced nationally and provincially have been building up a picture of the necessary structure, committees or groups which need to facilitate community participation. The health services themselves can also strengthen these activities and so some of these structures are based on health facilities but with community membership. CHC usually function in relation to a clinic and are sometimes even called “clinic” committees. Hospital boards have their membership derived from the communities served by the hospital. Health fora bring together representatives from a very wide group of communities. All of these organs are aimed at meeting the peoples’ needs through a complex process of governance and accountability.

The following brief outline of some of these important documents forms a background to the joint activities of communities and their committees and health facilities such as clinics in ensuring that the health of communities in their catchment areas is enhanced.

In the 1995 policy document for the *Development of a District Health System for South Africa* (1), there is a section on community participation in governance. It states: “it is a fundamental principle of the PHC Approach that there be maximal possible community participation in the planning, provision, control and monitoring of health services”.

Governance structures at the community level as described in this document are listed as CHCs and Community Health Forums. Users of a service need to be organized into a structure that will relate to the health system.

The document goes on to recommend that committees and their forum should be statutorily defined by provincial legislation. They would meet quarterly and report to the forum, be part of the governance structures of the health facility and participate in needs analysis, planning, implementation and education of PHC in the area and might also elect or nominate representatives to the District Health Council and District Hospital Board.

This 1995 concept of the CHC seems to have been a proposal that has been superseded by what local communities and health services have created. In much of the Eastern Cape Province there are small CHCs related to clinics and representing the communities in the catchment area. Only the communities in the catchment area of the clinic should elect their committee members.

A 1998 document on *The District Health System (2)* states that “health services will be offered in response to community needs as expressed through health/clinic committees”.

The Municipal Structures Act (No 177 of 1998) (5), describes how internal municipal structures and functionaries relate to community structures in ways that would increase community participation in the work of municipalities in general. For example, the functions and powers of the executive committees include identifying the needs of the municipality, annually reporting on the involvement of committees and community *organisations* in the affairs of the municipality, and ensuring that regard is given to public views. Certain metropolitan and local municipalities may have ward committees which have as an objective the enhancement of participatory democracy in local government. Ward committees have certain features which might serve as a model for the size and composition of smaller committees, such as CHCs: they are to be no larger than 10 persons, not including the chairperson; membership needs to take into account the need for women and for a diversity of interests to be represented; and there to be specifications about circumstances under which members must vacate office and the frequency of meetings.

The *Municipality Systems Bill* also puts in place a mechanism for the country's vision of a developmental local government which, together with other organs of state, assists in the progressive realization of the fundamental rights concerning housing, health care, water, food, social security, and the environment. In the integrated planning process, the municipal council will consult communities, residents and other stakeholders on their development needs and priorities, and provide for their participation in the drafting and review of the integrated development plan. Urban clinics and their catchment population have the same role in community participation as rural clinics.



Meeting of a CHC

Objectives of community involvement

- Involve communities in various aspects of the planning and provision of health services.
- Establish mechanisms to improve public accountability and promote dialogue and feedback between the public and health provider.
- Encourage communities to take greater responsibility for their own health promotion and care.
- Build capacity at provincial, district, local and community level to develop plans based on priority issues and ensure appropriate and cost-effective intervention.



Numeracy and literacy classes increase people's capacity to participate in community health care.

The National Department of Health White Paper for the transformation of the health system in South Africa listed as one of the functions of a health district "the provision for community participation in health promotion and health service provision".

In the 1999 *Department of Health Sector Strategic 1999-2004 Framework* (6), there are several sections which have an immediate bearing on community involvement. The first is the mission statement, which includes "a focus on working in partnership with other stakeholders to improve the quality of care of all levels of the health system, especially preventive and promotive health and to improve the overall efficiency of the health care delivery system". The Framework's 10-point plan to strengthen implementation of efficient, effective, and high quality health services includes a goal of "improving communication and consultation within the health system and the communities we serve".

The objective for improving quality of care included:

- The establishment of boards and committees in all health facilities through which committees and users can change the way in which health services are provided in the public sector.
- The development of mechanisms to regularly ascertain the views and expectations of the users of health services.
- Introduction of programmes to enhance users awareness of their rights and obligations.

In this document's section on Primary Health Care and the District Health System, there were also sections on the Comprehensive PHC Package. In particular it stated that:

- All PHC facilities must run community outreach programmes aimed at galvanizing the energies of communities so that they actively participate in health programmes especially the preventative and promotive aspects of the health service.
- Each facility must have a visibly displayed statement of agreement between the providers and users on their mutual expectations. Well-functioning community committees should be established for all facilities to ensure that the users' voices are heard and acted upon by management.

This case study

This study in the Eastern Cape Province attempts to show what government has done to meet most of the basic conditions for participation by communities in their health.

The case study also raises a series of questions that aim to strengthen community involvement.

In addition, this case study provides three tools and describes their use in bringing clinics and communities into a closer working relationship. The tools were developed from policy documents and legislation. They were then tested in different districts and further refined.

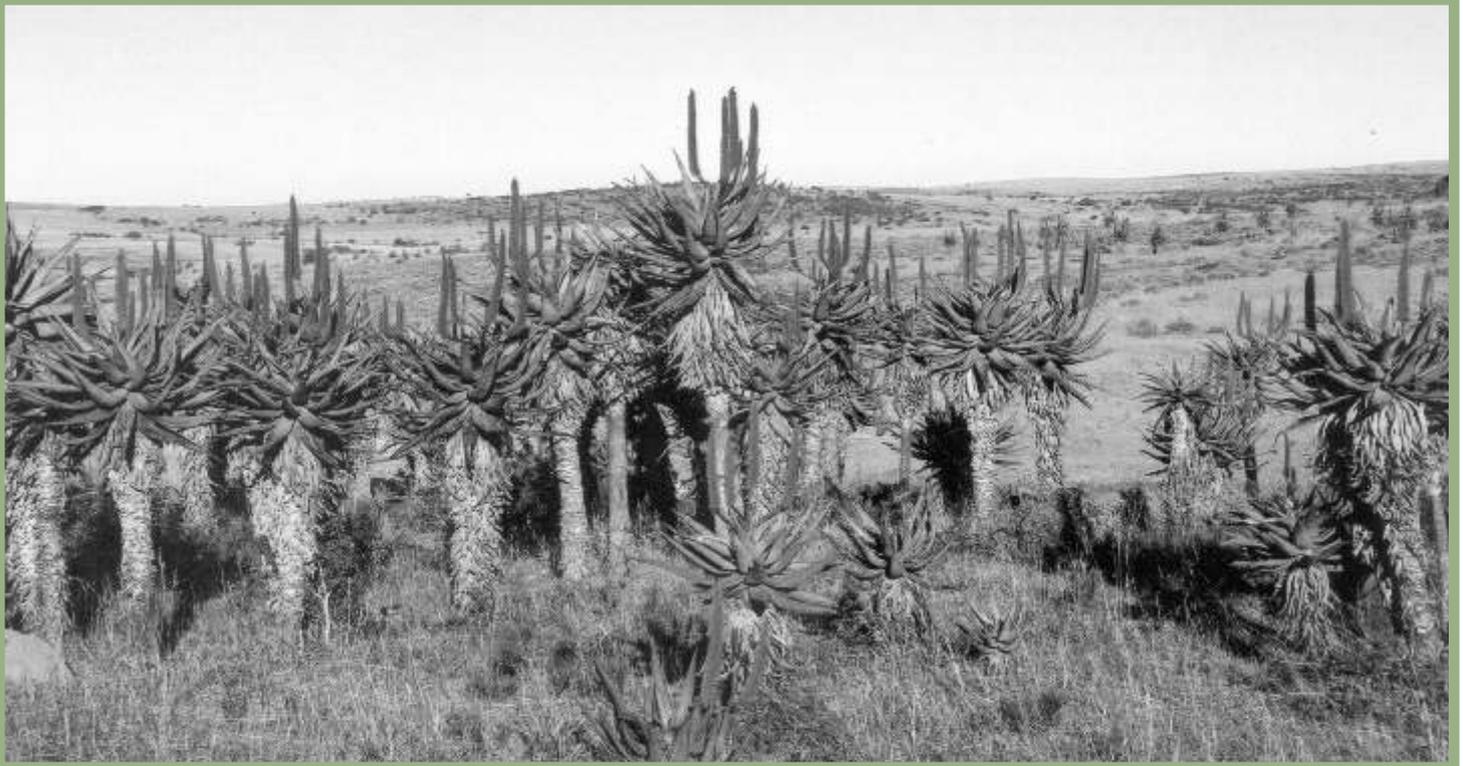
The National Department of Health White Paper for the Transformation of the Health System in South Africa lists as one of the functions of a health district “the provision for community participation in health promotion and health service provision”. (See also Annexure 2).

Under the section “Involving the Community”, two especially relevant principles are highlighted:

- All South Africans should be equipped with the information and the means to identify behavioural change conducive to the improvement of their health.
- People should be afforded the opportunity of participating actively in various aspects of the planning and provision of health services.

The following implementation strategies are listed:

- The Department of Health should work in close collaboration with all social groups especially women's and youth groups to support the acceptance of and response to messages related to healthy behaviour.
- Clinic, health centre, hospital, and community health committees should be provided with the required technical support and motivation to become advocates of positive behavioural change in the communities they represent.
- People should be afforded the opportunity of participating actively in various aspects of the planning and provision of health services.
- The essential PHC package is to be negotiated between providers and communities.
- The catchment area of facilities will be clearly defined and known to all partners.
- Representatives of communities are to identify underserved groups and establish strategies to reach them in partnership with the primary health team.
- Community-based information systems should be developed.
- Women should be enabled and supported in playing a major role in local health committees.



Aloe ferox which
flowers in August
(eyeKhala)

In Xhosa the months are named after the plants which flower in that month. Aloe ferox is used in traditional human and livestock medicines.

Key strategic interventions to decrease morbidity and mortality will be provided in partnership with relevant stakeholders especially communities, CBOs, and NGOs. The “Batho Pele” (People First) initiative attempts to “kick-start” transformation of service delivery by consultation between a service and the people as the first of its eight principles. A poster shown in many health facilities states “*You can tell us what you want from us*”.

This and “*openness and transparency*”, “*access*” and “*information*” are all principles which every community health committee will be working to have applied in their local health units.

Examples of special relevance include social mobilisation of communities for Human Immunodeficiency Virus (HIV)/Acquired Immuno Deficiency Syndrome (AIDS), sexually transmitted infections (STI) and tuberculosis (TB) and increasing the use of community and home-based care and promoting community-based growth monitoring.

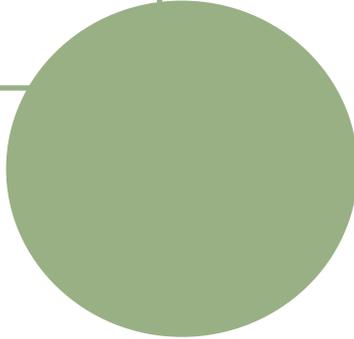
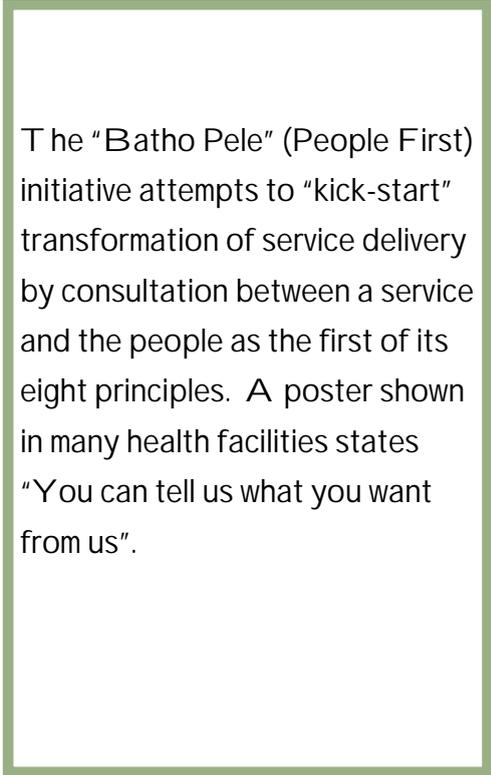
There are CHC in existence in many areas but they were formed in a variety of ways and many have problems in defining their role and activities. In some cases, clinic staff did not understand the partnership and may have been authoritarian in trying to select committee members and in proposing how the committee should function. It is clear that some efforts are needed to reorient management levels

to become more familiar with working with community membership outside of the health facility network and to reorient the service providers also to become partners with activities for health which stem from the villages and communities in the clinic catchment area.

Annex 1 summarises the relevant sections of the *Eastern Cape Provincial Health Act 1999* that addresses community participation.

“Community participation from provincial residents and health service users shall be encouraged through established forums and procedures for participation in the development and implementation of health services through transparent provincial governmental processes”.

The “Batho Pele” (People First) initiative attempts to “kick-start” transformation of service delivery by consultation between a service and the people as the first of its eight principles. A poster shown in many health facilities states “You can tell us what you want from us”.





Busi, one of the many CHWs in the field of health improvement

Primary health care with and by the people

South Africa has seen a tremendous surge in community-based health care due to many factors. These can be listed but not quantified with respect to their influence. They include:

- Decentralisation of health care.
- The creation of district and lower level municipalities.
- Enabling legislation which has set in place community powered structures or organisations.
- The continued flow of donor support for NGOs and CBOs.
- The increase in communication and information technology.
- Rising levels of education.
- Democratization and the recognition of rights; with an outstanding national constitution.

What have the above changes actually facilitated?

- There are now many CHWs in the field of health improvement. Many are volunteers, many hope to be paid and some are paid through many channels including NGO, CBO and government. They include:
 - CHW
 - Directly Observed Treatment Shortcourse (DOTS) supporters
 - Home-based carers
 - Community-based contraceptive distributors
 - Peer educators
 - Child-to-child educators
- Organisations/Committees which link communities with government sectors or institutions; have been created by legislation and by training often through NGO's; include for example:
 - Community Health or Clinic Committees
 - Hospital Boards
 - School Governing bodies and health promoting schools
 - Health Fora eg, District or City Health Forum

- NGOs and CBOs also are concerned with health - now with increasing numbers due to realization that major problems are related to the complex problem of HIV, AIDS, STI, TB, unemployment, poverty, alcohol abuse and drug addiction. These might include specific ones such as:

- Love Life
- FAMSA
- Youth for Christ
- Bambisanani
- NGOs dealing with TB such as SANTA
- Nutrition and income generating groups
- Youth clubs
- Women self-help income-generating groups
- Rotary and business affiliated groups

- There are also now the interlocking broad civic, traditional, political, and religious organisations which usually have “health desks” and sub-committees especially concerned with health matters and the mobilization of communities. They include:

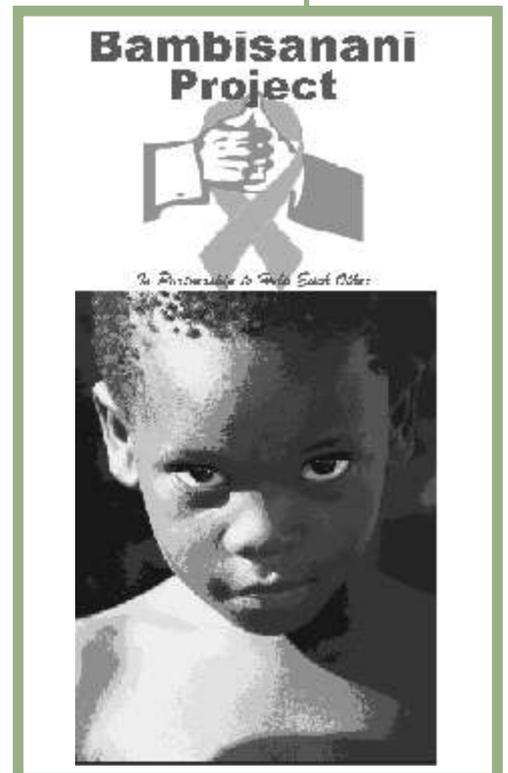
- Political parties
- SANCO
- Trade Unions
- Religious organisations
- District and Municipal councils
- Chieftainships

With such a wide range of possible partners in community involvement it is clear why particular staff are trained in outreach to these groups and organisations to mobilize around specific problems eg, HIV/AIDS and TB.



Acacia karoo
(Umnga). The Xhosa
name for December is
eyoMnga.

The bark, leaves and gum
are used in traditional
medicines.



The Eastern Cape Provincial Health Act

The *Eastern Cape Provincial Health Act* provides a good basis for a workshop as it covers almost all participants' expectations, from information on health services, district health systems, the rights and obligations of providers and users, to details of the health committees, forums and boards.

The sections which have been of most interest are:

- **Chapter IV - Provincial Health Policy**

This includes reference to upholding section 27 of the Constitution and national and provincial health policy to provide optimal, effective and cost efficient service delivery for health service users in the province. It also mentions municipalities and local government and community participation.

- **Chapter V - Principles Governing Provincial Health Policy**

This section is very dense with ideas; rights to have access to health care services, equitable opportunities for health care and redress of past inequalities, working within available financial and human resources to ensure no person is denied access, an integrated and comprehensive approach, planning and co-ordination and monitoring, broad participation, cost-effective use of resources and sustainable implementation, and co-operation between national, provincial and local governments on health.

- **Chapter XI - Health Service User Rights and Obligations**

Right of access to comprehensive health care services. Confidentiality, informed consent, user fees, complaints procedures, community participation, and obligation of users, are some of the important subheadings in this chapter.

PLE DGE OF SERVICE

Patients Rights Charter PHC Package

THE EASTERN CAPE PROVINCIAL
DEPARTMENT OF HEALTH
IS COMMITTED TO QUALITY HEALTH
CARE

- ☑ We pledge to treat all with respect to your rights; - to dignity; - to confidentiality; - to continuity of care.
- ☑ We will treat all - at every stage of life from the youngest to the most elderly with services which are integrated and accessible - for you and your family.
- ☑ We will always keep our knowledge and skills to levels which ensure the best quality of service.
- ☑ We will provide services at all levels of care and will strive to meet your expectations and provide satisfaction.
- ☑ Although restricted by financial limitations we pledge to ensure that the best use is made of finances to achieve the greatest possible benefit for you, the public.

- **Chapter XII - Health Care Provider Obligations and Rights**

The chapter deals with both obligations and rights of staff. The three obligations of health providers which are mentioned are treating all service users with dignity and respect, providing effective service and care as needed and informing health service users of every aspect of their treatment so they can make informed choices. Amongst the rights of health care providers there is mention of the hospital minimizing risk of injury or transmission of disease to workers, the right of providers to respect for human dignity and freedom from unfair discrimination on account of health status.

- **Chapter XIII - Integrated Provincial Health System**

This chapter deals with topics such as rationalisation, equitable distribution of resources, a single health information system, the levels of care and a comprehensive and integrated service as well as standards to be maintained.

- **Chapter XIV - District Health System**

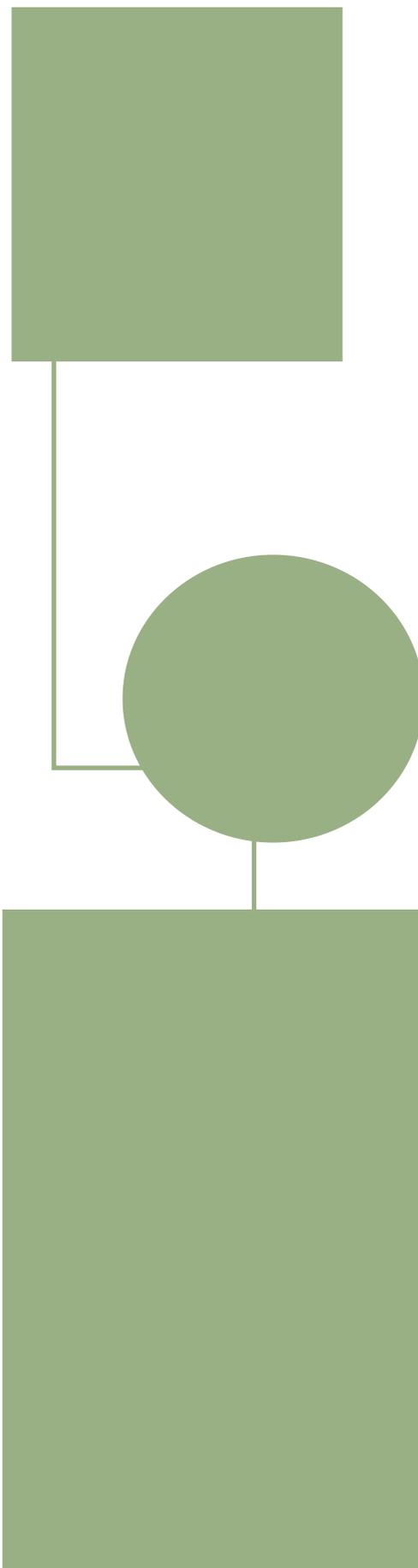
The demarcation and establishment of health districts and the management of district health authorities are covered in this chapter. Each district is to establish a district health council with equal numbers of representatives from organised local government and community representatives from each municipality represented within the health district.

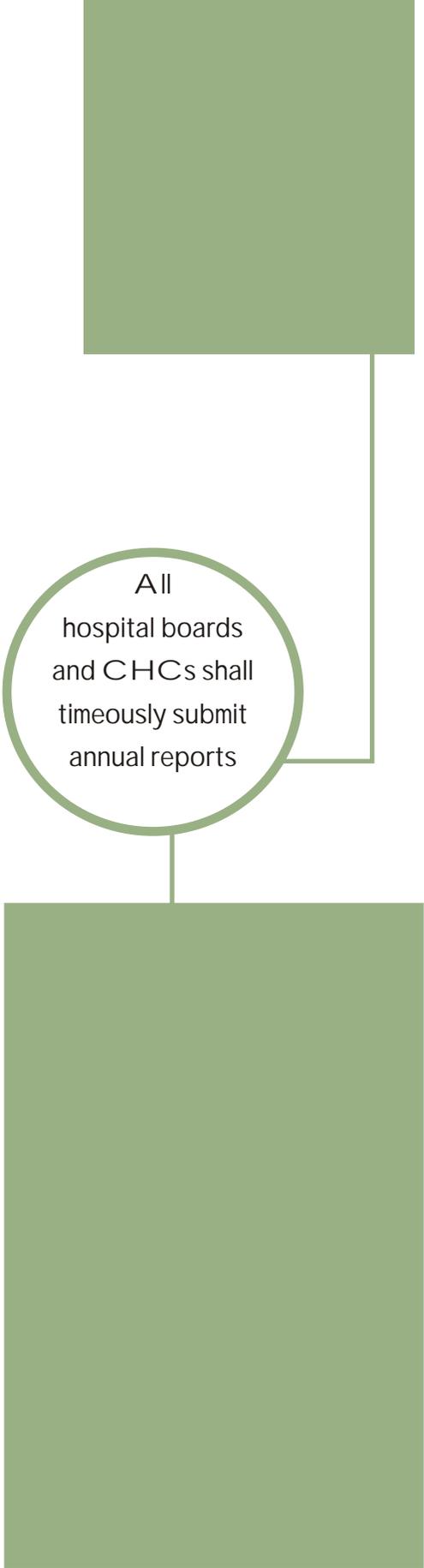
- **Chapter XVII - District Health Councils, CHCs, Hospital Boards, Advisory Committees and Forums**

The chapter covers the establishment of these structures, appointment of the board, the duration of appointment (two years), the publication by the Member of the Executive Council (MEC) of terms of reference and remuneration (entitled only to remuneration for expenses and no other remuneration as membership is a voluntary community service) and mandatory declaration of interests and conflict of interests.

Several sections of this chapter have been topics of much discussion by committee members who should go through the whole section very carefully. Some sections are listed here briefly.

- 34 (1) The MEC shall establish and determine terms of reference which will be published in the Gazette.
- (3) (a) Membership of all district health councils, community health committees and hospital boards shall be representative of the local community with appointment practices and selection procedures based on the needs of the committee, forum or board; individual ability, objectivity and fairness,





All
hospital boards
and CHCs shall
timeously submit
annual reports

and the need to redress the imbalances of the past with broad representation.

- ⦿ (b) All appointments for two years in duration made in terms of paragraphs (a) shall be made on a staggered basis to ensure continuity.
- ⦿ (8) All hospital boards and CHCs shall timeously submit annual reports including an accounting of all activities and expenditures during the prior financial year to the MEC or designee, on the last day of April. Each report to state goals and objectives and their achievement, or unforeseen circumstances which prevented their achievement.
- ⦿ (9) Failure to submit annual reports can result in disciplinary action – a reprimand or even termination of existence if no explanation is given for failure to submit reports.
- ⦿ (36) Duly appointed committee and board members are entitled to remuneration for expenses at the standard rate agreed by the MEC and the MEC for Finance. If there is no agreement on a standard rate for remuneration for expenses board members shall be entitled to reimbursement at the rate used for provincial employees.
- ⦿ (37) (1) No member of any advisory committee or board appointed by the MEC may use his or her appointed position to promote any special financial or other interest.
- ⦿ (2) All members of advisory committees and boards appointed by the MEC shall be required within 30 days of their appointment to submit a written declaration of any and all financial or other interests which are, or could be, related to, or in conflict with such appointment.

Roles and functions of Community Health Committees

- Liaison between clinic management and community.
- Ensure security and safety of clinic premises and staff.
- Monitor regular activities and,
 - ensure quality of care is maintained
 - ensure opening and closing of clinic is punctual
 - ensure adequate stock levels of drugs and other materials are maintained.
- Provide support for Village Health Workers.
- Oversee maintenance of clinic building and grounds.
- Communicate with district hospital - preferably by having a committee member serve on the hospital board.
- Encourage community projects - eg, a community garden at the clinic or protection of a spring or establishing a community-safe water supply.
- Assist in health campaigns, eg, measles and polio immunisation.
- Meet monthly with clinic staff and invite clinic supervisors to meetings.
- Keep good minutes of all meetings as well as a record of community health projects.
- Raise funds on behalf of the clinic when necessary eg, for minor repairs.
- Strengthen ownership and support of the clinic amongst local communities.
- Ensure patients rights are upheld and that "Batho Pele" is in evidence.

This list of functions has many similarities to that of a hospital board or forum in that it shows how communities are empowered to take a more active role in health work. This is part of the overall process of decentralisation of decision making and planning in health services.

Water is a universal need and establishing a community-safe water supply is important.



Community Health Committees and the clinic Health Information System

The CHC should make a point of requesting that clinic management keep them informed about the clinic health information system indicators which are compiled monthly.

The information is expressed in figures or graphs and no names are included so there is no problem with personal confidentiality.

Information is available on:

- drug availability
- immunization
- TB care and sputa sent for examination
- STI
- malnutrition
- facility assessment
- family planning
- number of patients seen per nurse
- supervisory visits
- antenatal care
- referrals
- utilization by under five years
- Vitamin A

The joint discussion of this information by clinic nurse and committee members can lead to feedback to the community for their action eg, to improve full immunization by one year of age, to help if possible with maintenance of the clinic, to stimulate earlier antenatal visits by pregnant women, to ensure condom availability at community distribution points.

Group discussing clinic information



What aspects of the clinic should a Community Health Committee consider in assessing the quality of care provided?

- **Process of clinical care**
 - The timeliness of receiving treatment.
 - Correct use of drugs.
 - Continuity of care (especially for chronic diseases, immunization, family planning, maternal care and growth monitoring and promotion).
 - Follow-up.
- **Interpersonal care process**
 - Good communication between provider and service user.
 - Health education provided at every consultation.
 - Patients rights always emphasised.
- **Outcome of health status**
 - Patients get better as shown by data (eg, for TB).
 - Vital events - births and deaths reported.
 - Clinic keeps information system up to date so can give output and outcome statistics.
- **User evaluation**
 - Complaint/suggestion box available.
 - Complaints are seen to be dealt with rapidly.
 - Patients feel rights and dignity are upheld.
- **Physical structure and resources**
 - Buildings well maintained.
 - Management good.
 - Clinic times kept.
 - Expected range of services available.
 - Drugs available.



Entertainment breaks can enliven a workshop as shown here with children from the community performing a song and dance routine about health.



A CHC should consider the efficient use of funds, for example a mobile clinic as shown here.



- **Staff characteristics**
 - Friendly.
 - Good teamwork with community and committee.
- **Community coverage**
 - All communities have access.
 - Efficient use of funds eg, for mobile/transport.
 - Available at suitable times.

Processes for increasing community involvement in health

Several processes have been used in the Eastern Cape Province to enhance teamwork between clinics and communities in order to improve health and well-being. Flexibility in approach is needed to accommodate local realities – communities in Camdeboo or Kouga are very different in many ways (environment, language, culture, agriculture, etc) when compared with Umzimkulu or Nyandeni.

Many NGOs eg, the Border Institute of Primary Health oriented communities and trained their community health workers (CHW) and the nurses in the related clinics.

A second example was the process of orientation of clinic staff to help them recognize the communities in their catchment area as their population and partners for health and not merely to be concerned with the patients who come through the clinic doors. This process developed and tried by the EQUITY Project included mapping of catchment areas as an activity jointly conducted between clinic staff, community health committees, and the environmental health officer. This process was documented in a publication called *Mapping for Primary Health Care* (8).

A third process was to conduct workshops to review an Eastern Cape Province Package of PHC, which was developed by the EQUITY Project as a checklist for different levels of care including the community and the clinic. This checklist has possible community health activities for different life stages (pregnancy, delivery, first year of life, pre-school age, school age, adolescence, adults, elderly) and it was suggested that the checklist could guide CHCs to define their roles (9).

The fourth process involved developing a community-based TB treatment programme where the clinic trains and supervises volunteer supporters of DOTS the modern home or community-based treatment of TB. Treatment is thereby more effective and convenient for patients and entire communities can have TB controlled.

A fifth process to strengthen the relationship between clinic and CHCs is the supervisory process for clinics from district or sub-district management teams. For example, in the supervisory support checklist being used throughout the province, there is a section with questions on the existence of a CHC, the frequency of its meetings, whether the

Several processes have been tried in the Eastern Cape Province to enhance teamwork between clinics and the communities they serve. One lesson learned through all experiences is that flexibility in approach is essential to accommodate local realities.

Community growth monitoring and promotion.



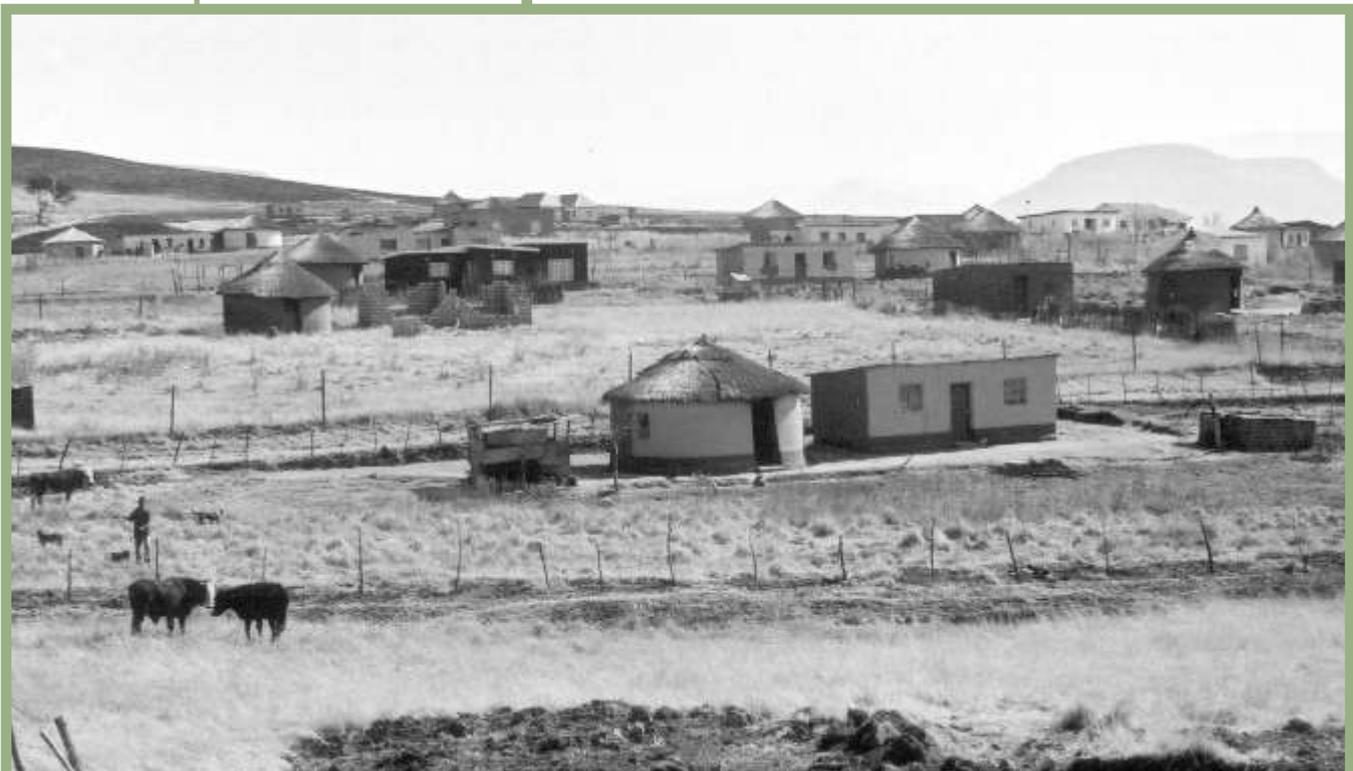
The sixth process was the elaboration and refinement by the EQUITY Project of three tools, described in this report, for existing CHCs to develop their role in partnership with the clinic to improve health in the catchment population.

A village in the Maluti district.

supervisor met the community, whether there are CHW, and the number of sites where condoms are available in the community. This information is also relevant for one indicator of the set of Goals, Objectives and Indicators: proportion of facilities that have functioning community participation structures.

The sixth process was the elaboration and refinement by the EQUITY Project of three tools, described in this report, for existing CHCs to develop their role in partnership with the clinic to improve health in the catchment population. The first tool is a checklist on the role of the CHC, the second on a rapid situation analysis, and the third on possible community health activities for each life stage.

Experiences of all these processes will be described, followed by a section detailing workshops held for using the three tools and the lessons learned. These workshops resulted in many anecdotes and insights of a qualitative nature, ideas on the way committees are set up, the composition of committees, the major problems encountered, and the establishment of health fora. Lastly, comments about the checklist are listed so that a final set of modified checklists could be provided as an annex for use in other districts.



Mapping as a tool for community involvement

Mapping as a joint activity between the CHC and the clinic is a process with great potential for bringing the two together as a force for promoting health and preventing disease and ensuring early and effective case management. Clear guidelines are given in *Mapping for Primary Health Care* (8) available from the EQUITY Project.

In this book (8), there are descriptions of training for mapping in all the five regions of the Eastern Cape Province. All the training was done jointly with clinic, district health staff and CHCs. In many instances, the committee members knew more about the clinic catchment area than the nurses and had to assist the clinic to become more aware of and more integrated into the community.

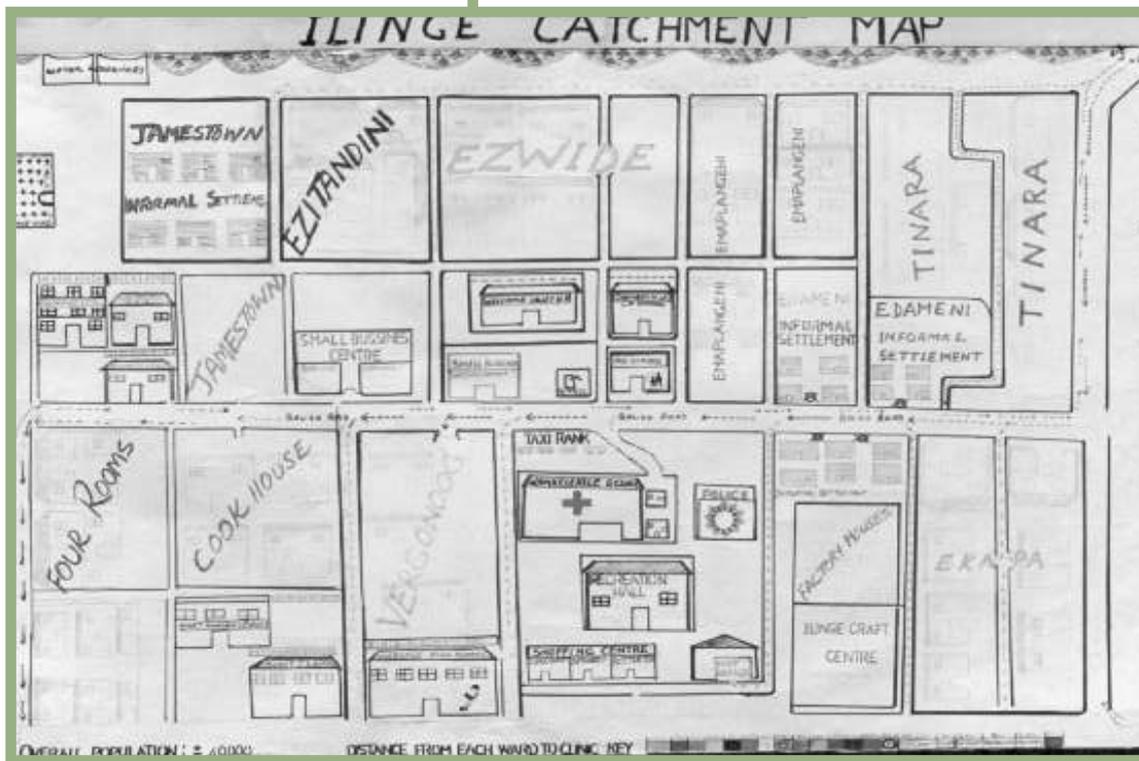


Mapping is a useful activity because.....

- *"We learned about real communication between clinic and community."*
- *"We now understand the relationship of the CHC, and the communities and the clinic."*
- *"It has changed attitudes."*
- *"Here we have seen community participation practised."*
- *"We have seen the linkage between committee and clinic and their pride of ownership of the clinic as their clinic."*
- *"For us committee members it has been like a dream working together and we are closer now with the clinic."*

In many instances, the committee members knew more about the clinic catchment area than the nurses and had to assist the clinic to become more aware of and more integrated into the community.

Clinic staff and CHC members drawing a catchment area map.



The mapping exercise in Sterkspruit as described in (8), for example, was community-oriented, starting with prayers and punctuated by singing and dancing. The community provided a meal and members of the committee accompanied all the groups doing the mapping they had suggested, including mapping of water supplies, gardens, and adolescents. The last mentioned was a compromise on their initial desire to map teenage pregnancy. The findings confirmed a very high density of teenagers home from school holidays and without adequate recreation facilities. This finding also brought out the potential problem of HIV/STI transmission and the need for community-based condom distribution.

Mapping as a joint activity between the CHC and the clinic is a process with great potential for bringing the two together as a force for promoting health and preventing disease and ensuring early and effective case management.

The primary health care package and community/clinic participation

The PHC checklist (9) developed in the Eastern Cape Province sets out activities needed at each level of health care (community, mobile clinic, clinic, community health centre, and community district (or sub-district) hospital). It also indicates the resources (staff, equipment, supplies, and facilities) required at each level. In all health regions of the province, workshops were conducted to assist participants from District Health Management Teams (DHMT) to see more clearly what comprehensive accessible PHC requires. The checklist with its life stage approach effectively combines health promotion, disease prevention, curative care and rehabilitation and also integrates previously vertical services such as family planning, school health, and mental health. With its detailed section on the community level of care, it provoked many comments from the nurses and managers.

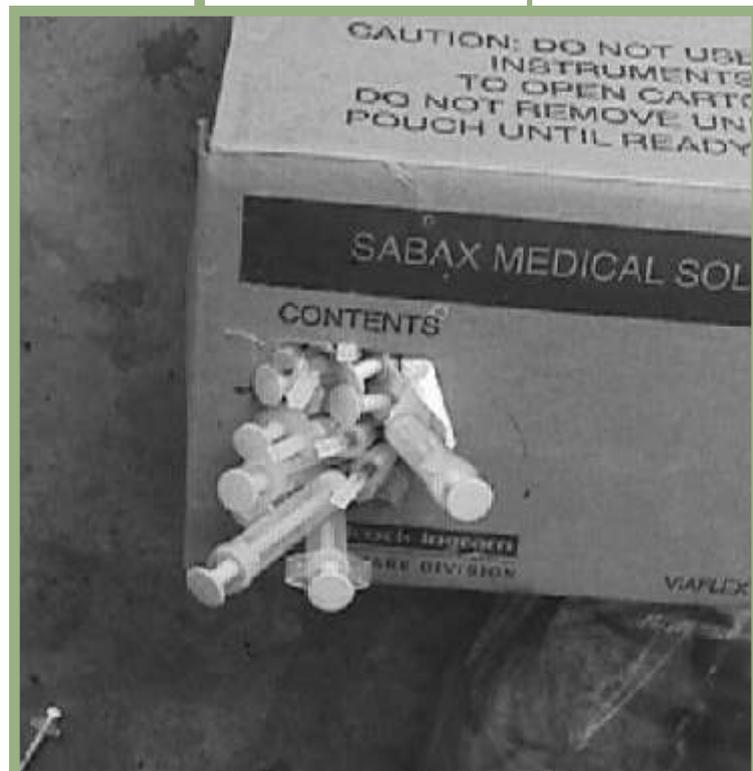
Community involvement has not been given enough attention in the past. And now, with the increase of patients due to free services, clinics are swamped and have become more curative oriented.

- There is a problem with waste disposal in communities and clinics could help committees to think out solutions – not just getting school children to spend time collecting rubbish.
- Communities must be enabled to take more responsibilities.
- Many minor ailments could be managed in the community and never need fill the queues in clinics.
- *“Nurses are very possessive”* – they do not want to relinquish activities such as DOTS or contraceptives distribution to community members even if they are trained.

The community level of care from the PHC package was later adapted as one of the checklists to be used by CHCs.

The PHC checklist sets out activities needed at each level of health care. It also indicates the resources (staff, equipment, supplies, and facilities) required at each level.

There is a problem with waste disposal in communities and clinics could help committees to think out solutions.



Community-based treatment of tuberculosis: DOTS



A DOTS supporter visits a patient at home to observe treatment.

DOTS for TB has been carried out for several years in some clinics in the Eastern Cape Province. However, with increasing numbers of patients, improved drug supply and the policy of free treatment, there has been a realization that the community will have to help.

DOTS for TB has been carried out for several years in some clinics in the Eastern Cape Province. However, with increasing numbers of patients, improved drug supply and the policy of free treatment, there has been a realization that the community will have to help. Community-based volunteers are now being trained to support TB patients by observing them taking their tablets daily for five days a week for the full six months required for cure. These volunteers might be relatives of the patient, teachers, employers, priests, shopkeepers, traditional healers, or ex-patients. They are trained by either an NGO or by the clinic nurses. DOTS is regarded as a priority province-wide. It cures the sputum-positive cases and prevents transmission a particularly important objective in the presence of the HIV/AIDS epidemic which makes many more people susceptible to active TB. One example of community involvement in the DOTS programme occurred in Joubertina District in Region A (Kouga). Some of the CHW were already working as community-based distributors (CBD) of contraceptives. Forty-three participants including regional, district and clinic health staff, a manager from an NGO, and 29 volunteers and CHWs (Nompilo) from the district were represented. Speakers covered the problem of TB and its treatment, and emphasized the need for training in the community's language. For example, DOTS can be remembered in Afrikaans as "*Daar Om Te Steun*". The discussion also emphasized the similarity between family planning, formerly only at clinics with specially trained staff and now offered through community-based distribution and TB formerly treated by doctors in special hospitals and now treated through DOTS in the community. There was also now a more patient-centred approach with an awareness of the need for patients to be treated nearer home and not to have to walk daily to a clinic.

The discussion was then taken over by the volunteers who mentioned people who could become supporters and what possible problems could be encountered (eg, alcohol abuse and seasonal migrant labour). The community participants divided into groups to discuss how the programme could be managed. One possibility suggested was that the clinic nurse might bring the drugs to the DOTS supporters, check record cards periodically, and ensure that sputa were taken for examination at the correct periods. The groups mentioned links with other community sectors such as the agricultural officer, the teacher and the police. In fact, the latter two sectors were represented in the meeting. The

workshop ended with decisions on follow-up to community committees and identification of more volunteers for training.

After training volunteers their location can be marked on the clinic catchment areas map so that they can be contacted for assistance as new cases arise. DOTS support might well prove to be the most vital service that committees and volunteers can do to improve health in their communities.



CHWs trained as DOTS supporters gather to receive their certificates.

Sustaining motivation

In the nine villages 40 kilometres from East London there were fourteen CHWs who volunteered their services as DOTS supporters in addition to other community health work. They had established that villagers needed kerosene for lighting and cooking but that it was not locally available. The EQUITY Project assisted them in writing a proposal to an oil company, which subsequently sponsored two 2000 litre kerosene tanks filled to start this income-generating project. The volunteer CHWs now have a small income from the kerosene sale and this will ensure sustainability of DOTS support. This is the basis for a strategy whereby volunteer health workers trained for DOTS support will be linked to income-generating projects to sustain their motivation.

A review of community DOTS in the Eastern Cape Province

The Eastern Cape Provincial Department of Health and the EQUITY Project in 2001 commissioned “*an exploration of Community DOTS models in the Eastern Cape Province*” by TADSA, which subcontracted the Community Development Unit of University of Port Elizabeth to assist in management, fieldwork and writing up the research.

The sites of this work were in Amatola Districts, Ukahlamba District, OR Tambo District and Alfred Nzo District. Some very important concepts were highlighted in the resulting document.

A continuum of control

- In some areas the first two months of treatment are in the hospital where there is a process of DOTS by the staff. This is direct control which might in some cases be followed by similar direct control by a nurse in the clinic where patients living nearby come daily.
- Then there are models of control which are indirect control where a CHW or a community volunteer observes treatment.
- There is in some cases family control where family members, friends or neighbours observe treatment.
- Finally there can be self control where the patient takes treatment without direct observation.

A systems-based process

This concept outlines two sub-systems:

- The support system which includes government commitment, supervision, district level management, drug supply and laboratory services.
- This supports the implementation system which includes diagnosis based on sputum smears, clinical care, management of DOTS supporters, a reliable record system, training, and incentives.

A DOTS supporter in a community prepares to observe the TB patient swallowing the drugs.



- The third system is a Community System which includes all the beliefs, traditions, access to care, community leadership, structures and where DOTS supporters come from and where DOTS actually takes place. It would also include NGOs and CBOs.

These three systems interlock and have different emphasis in urban areas and in rural areas.

Reward systems

This has many possibilities which include:

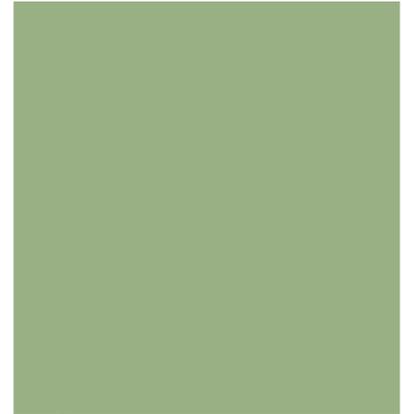
- Recognition and public acknowledgement eg, at a chief's meeting.
- Appreciation for effort and feedback from the client's family and health services – gifts, a certificate, an apron.
- Compensation – possible paying of costs eg, of transport – collection from the community, or from an NGO.
- Incentives – personal benefit for a measurable outcome – a small payment for a cured case.

Resource system issues

The constant availability of resources such as drugs, transport for sputum specimens, telephone, proved to be essential for a DOTS process to succeed.

Dedicated or combined use of transport, use of other sources such as motorcycles, and taxis are all options which have to be explored and maintained.

Some areas showed that being resourceful is critical for the success of a DOTS programme.



Using a motorbike and cell phone to transport T B sputa and results to and from remote clinics has revolutionised T B treatment in rural areas.



Home-based care



Shown here is a community group using clinic premises for IGA.

Booklet 3

Assessment of income generating activities in Region E, Eastern Cape

BAMBISANANI



A well-documented project for home-based care is the Bambisanani Project which began in April 2000 in Umzimkulu, Bizana and Lusikisiki areas. It was developed to assist communities to respond to the rapidly increasing problems of persons with HIV/AIDS needing care and support.

The project consisted of five elements. Community capacity building, home-base care, support groups, Income-generating activities (IGAs) and Care and Support for Children in Distress (CINDI). There are many partners working together in this project including the Eastern Cape Department of Health with EQUITY, and several non-government organisations as well as commercial organisations such as Gold Fields and TEBA. The community capacity building started with meetings and workshops for community leaders, women's and youth groups, traditional healers and community health committees. Home-based care was initiated by trained care supporters who provide support to people with terminal conditions in their homes.

The home-based care supporters role is one which must be differentiated from the family-based carer and also from the clinic's role, and the NGOs which pay and train the carer.

The clinic nurse's role in home-based care

- The nurse is responsible for a situation analysis and determines the type of patients needing care and how many there are in different localities. This is done by analysis of records and from reports eg, the number of AIDS, strokes.
- She identifies, enlists and coordinates support of NGOs and other resources.
- She distributes kits to carers and ensures supplies.
- Monitors and evaluates the clinical care.
- Gets reports from carers and ensures they are keeping their record books.
- Identifies the number needed, assigns cases to carers.

The home-based carer role

- The carer trains the family-based carers who provide the ongoing daily care.
- The carer assesses the family situation and also is able to elicit community or neighbours support.
- Provides feedback to clinic and employing NGO on state of patients, needs for drugs.



“ I feel good because I am helping my community. I use my teaching skills every day when I educate about HIV and T B.”

Nonkazimlo Mgojeni
Home care supporter,
Lusikisiki

The role of clinic supervisors in strengthening community involvement

Supervisors realize that community involvement in health is an essential element of PHC and that the interaction between a CHC and a clinic must be stimulated and monitored.

Cala Community Health Centre, Sub-district Hospital

Supervisors realize that community involvement in health is an essential element of PHC and that the interaction between a CHC and a clinic must be stimulated and monitored. The *Eastern Cape Supervisory Checklist*, developed in collaboration with the EQUITY Project, encourages supervisors to review clinic-community interaction each month. The existence, composition, and activities of committees are discussed and supervisors are encouraged to meet with the committee periodically.

After EQUITY Project facilitators held focus group discussions with supervisors in Elliot (Sengu) and Umtata Health (King D Sabata) Districts, supervisors were asked to write down what they thought to be the ten most important aspects to supervise in each programme area. One of the areas noted was community health work.

In Umtata Health District, there was a similar process of discussion with supervisors and it became clear that linkages of clinic with community differ between urban and rural areas. In urban Umtata there is a clear link between health services and the community through the clinic committee or the CHC - as they are called in some areas. All communication passes through the clinic committees to the community and vice versa. This committee has extensive powers, and will even veto new staff appointments.

Health staff in rural clinic areas have links to their communities via two mechanisms: through the clinic committee and through participation in community meetings. The clinic committee in the rural areas receives guidance from and through traditional leaders. Supervisors will from time to time be expected to attend and give input to both clinic committees and community meetings initiated by traditional leaders.

Suggested areas to be covered in supervisory visits

- Are health committees established and meeting regularly with staff? Are relevant stakeholders involved? Are records kept of meetings?



- Are CHWs used appropriately and do they receive in-service training?
- Is the community aware of the availability of health services?
- Support and encouragement of projects involving communities and clinic staff. Are clinic staff involved in these?
- Is the community involved in the organization of, preparation for and participation in Health Days by, for example, preparing community drama on AIDS?
- Are there open lines of communication between clinic staff and communities, eg, by attending community-based meetings and ensuring the clinic has a complaints box.
- Is there a response to problems identified from the community with regards to health services in general and the clinic services in particular?
- Are notices of important events appropriately advertised?
- Is the community invited to participate in the mapping process?
- Are youth groups involved in HIV/AIDS awareness creating campaigns?
- Are communities developing insights into new health issues such as HIV/AIDS or cholera? Do these committees have a chance to learn about the conditions, discuss them openly, and do they influence health messages?
- Are the objectives of the committee feasible and relevant and does the committee need support?
- Is there a system for the CHW to report to clinic nurses? What is the relationship between CHWs and the committee and do they cooperate?
- Are there community development projects in which nurses are involved and have the nurses arranged training for those involved and is this training done locally?
- Is the community aware of other disciplines and departments involved in health, such as Department of Water Affairs and Forestry, Social Welfare and Development, and Housing?
- Are support services provided by communities to clinics, such as the supply of water, assistance with transport, or providing watchmen for clinics?
- Are changes in clinic services or new policies shared and explained to the community?
- Are new staff introduced to the community?



Supervisors will need suitable transport to be able to reach clinics situated in remote mountainous areas.



Tools for increasing community health committees contribution to primary health care

Checklist 1

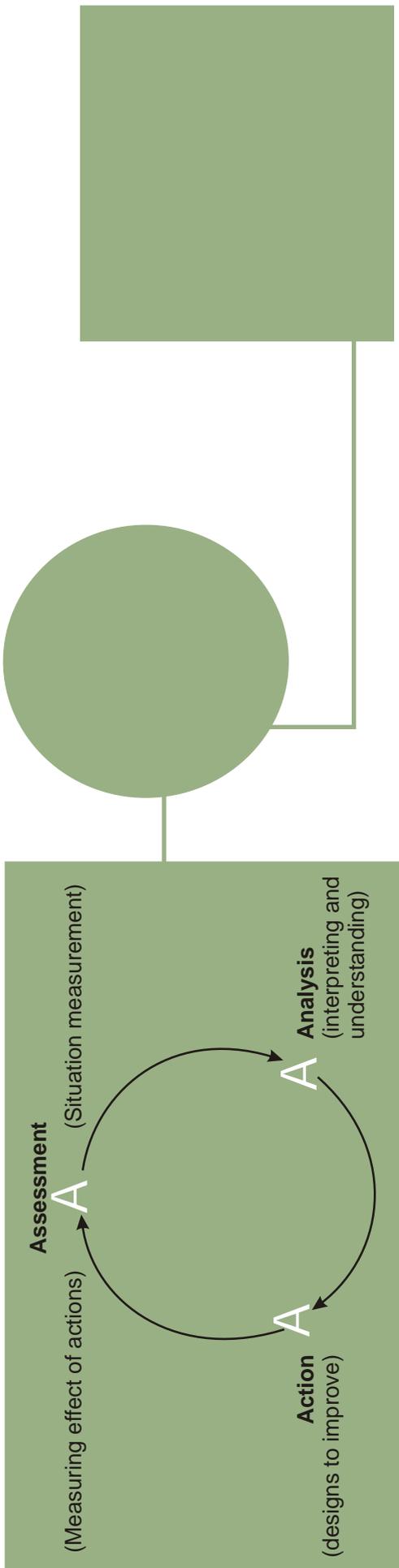
Roles and activities of CHCs

In meetings held with existing CHCs, committee members expressed a desire for guidance on their role and so a checklist for this was designed. The checklist includes the following key points: discussion of each point with the clinic as a partner; indication of roles accepted by the committee; and which ones should be considered for the future. Comments should also be included for future reference. After completing the exercise, the committee should inform the community members of the roles they have accepted. The tool is shown in the Annex.

Checklist 2

Rapid situation assessment by CHC

This checklist is intended for use in discussions between the community and the clinic staff leading to community action to address identified problems. The checklist answers should form the basis for further discussion. These discussions should include an analysis of what was found, the reasons for the finding followed by the development of a plan of action to improve matters. (This is the “Triple A Cycle” of assessment, analysis, and action). Periodic review of the key issues identified will also serve to document progress and identify further action for joint work and improvement.



Checklist 3

CHC assessment of community-based health care for different life stages

At each stage of life, critical aspects of health determine present and future well-being. This checklist identifies important aspects of health in the community at each life stage: pregnancy, delivery, infancy, preschool, school, adolescent, adult and elderly. This tool is long. Committees using it need to understand the importance of life stages and how each can strengthen or weaken an individual for subsequent stages. For example, it is easy to understand that what happens in utero during pregnancy and what happens during delivery are two critical stages that can lead to a healthy or a damaged infant. Discussion of the stages of life can establish connections. For example, unsafe sex in adolescence can lead to infection with HIV and death from AIDS as an adult, or passing the infection to the next generation during child birth. As the checklist is so long, it is suggested that one or two stages be covered in each meeting. Also it is suggested that in each life stage only one or two items be prioritised for CHC action. Prioritisation should be based on urgency of problem, number of people affected, the serious consequences for health if the problem is not addressed, the committee's ability to tackle the problem with existing resources, and sustainability of action.

Checklist 4

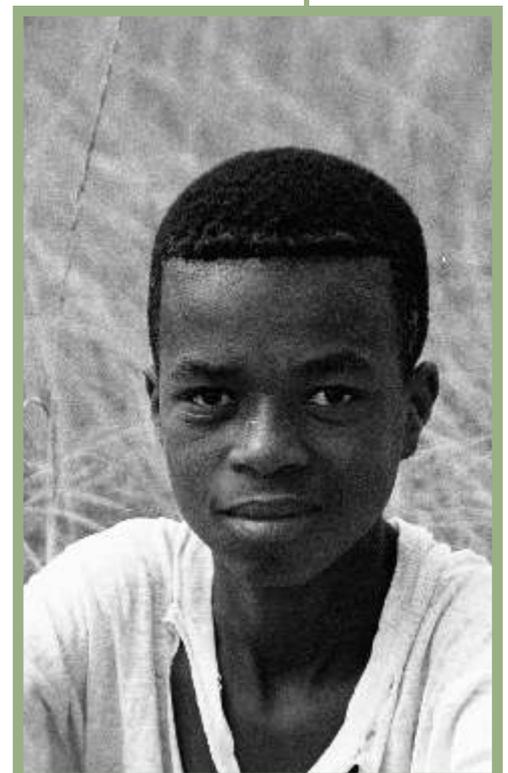
Adolescent-friendly clinic assessment

Adolescence is one of the life stages which has become filled with risks for serious illnesses in the next life stages of adulthood. This is because HIV-infection and other STIs due to risky sexual behaviour are often acquired in this age group. This then leads to AIDS and death in early adulthood just when economic activity and family should be at their most productive. The clinic related to the CHC might already have been involved with the National Adolescent-friendly Clinic Initiative but if it has not been accredited then the committee could use Checklist 4.

This to be done together with clinic staff in the spirit of trying to assure that services for adolescents will be inviting, confidential, convenient and effective.



HIV-infection and other STIs or risky sexual behaviour are often acquired in adolescence.



Lessons learnt from previous workshops

Ground rules for meetings

- A shared vision and commitment to working for health, patience and tolerance, punctuality and no wandering in and out of the meeting were all accepted.
- Mutual respect between community committee members and clinic staff. They must help each other.
- Discussion of issues and not of persons and maintenance of a friendly atmosphere.
- To remain apolitical.
- Not to mention patient's names.
- Team work.
- Avoid interference in running the clinic – rather discuss issues to achieve change.
- Work towards partnership.
- In Nelson Mandela Metro the norms of behaviour listed included being allowed to speak in one's own language.
- Meetings should have a purpose and an agenda.

Workshop leadership needed from the chairperson

- Assure all are heard even if shy or not articulate.
- Avoid being taken over by agenda of a few vocal interests.
- Direct the discussion to topics that can be solved by joint action and divert discussion from impossible issues (“*we want a full hospital in our village*”) or unrealistic expectations (“*all volunteers shall be given a government salary*”).
- Ensure continuity by written minutes that capture the spirit of all opinions.

Singing and dancing, which can help to relieve tensions and unite people, was part of this workshop in the Eastern Cape.



- Notify or send reminders to all members to attend meetings.
- Write up proposals emerging from committee discussion to seek resources.

Conclusions and lessons learned about the size of health committees

- Committees usually have about 10-16 members.
- Communities should now realize the importance of having youth on the committee.
- Different community structure eg, women, youth, civic (SANCO), church, and schools are usually represented.
- There are usually more women than men on a committee because so many health problems are related to children, child-bearing, and running the home.
- Health committees are large (up to 25 members) if the clinic serves very many villages or areas as each has to be represented.
- Urban committees can be quite small as there are many clinics but each committee can be represented on a larger forum.
- Urban committees might have more members from different sectors and CBOs.



A CHC should have young people, elders and perhaps more adult women than men represented.

Lessons learned in the Chris Hani District Council area

- Use all the language of an area – it takes longer but all can contribute fully.
- Establish ground rules for meetings, establish an agenda and keep minutes.
- Remember to evaluate activities and determine how this will be done.
- Review the committee's role periodically.
- Try posters or pictures as discussion starters.

Lessons learned about the initiation and role of committees

- There are many differing initiatives to form community health committees, no standardized approach is essential.



At any large community function women participate in preparing meals for participants.

- Most committees are called “*clinic health committees*” because they consist of representatives from the catchment area of clinics and form a link between the community and the clinic, but they are really CHCs.
- CHCs are of great benefit in assisting the clinic to be more responsive to community needs.
- In the former Ciskei and Transkei areas committees were elected at meetings called by the chief.
- Committee members are chosen by the community and usually have representatives from different community structures.

Lessons learned in Cacadu and Alfred Nzo District Council area

- Workshops for CHCs should bring together committee members, clinic staff and leadership: the district PHC co-ordinator, important traditional leaders, and traditional healers.
- Community-based DOTS and community-based home care should be placed on the agenda of meetings as important topics.
- Youth (age 18-25) must be brought into the committees, and community structures must be represented.
- Urban communities have to deal with very different problems which seem very difficult but there are more NGOs, church groups, youth and women's organisations to assist.
- In rural areas the traditional leaders play an important role in health and development.
- Traditional protocol must always be observed: start meetings with a prayer from any religion present.



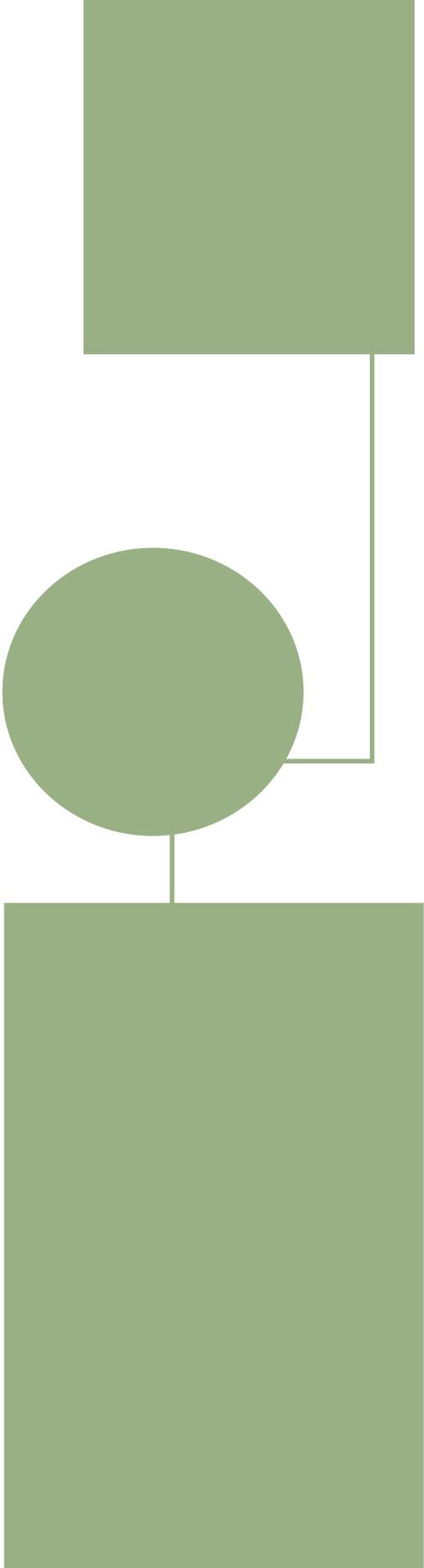
Points from workshops which used checklists

Checklist 1

- It is a useful tool to get committees to discuss their role and make it practical.
- As a link between community and clinic the committee has a role in ensuring satisfaction of the users.
- The committee can look after the continued maintenance of the clinic and ensure the nurses' welfare.
- Committees can better inform the community of their problems.
- The committees role is a supportive one – not a policing one.
- Advocacy is important to pressurize authorities to improve certain areas eg, transport.
- Members of the community can help improve compliance of clinic users who are not using their medicines properly eg, mentally-ill persons, epileptics, TB patients.
- Can identify persons who are not getting their pensions and inform clinic to arrange a social worker visit.
- The committee has an arbitration role between clinic and community when there are disputes or tensions.
- It is the clinic's role to keep registers of disabled persons – not the committees.
- Environmental clean-up days are important, as there is much pollution with plastic and rubbish.
- It's a good idea to have occasional joint meetings with the whole of the clinic staff and not just a few representatives of clinic management.
- Sometimes it is nurses who do not want to tackle sensitive issues such as alcohol and drug use and STIs and HIV/AIDS. But in a conservative community is there anything that a committee could do? Some areas agreed the committee must act and discuss these issues at meetings with health staff.

Breaks in the workshops allow nurses and community members to have casual and informative discussions.



- 
- In religious groups who do not want to take medicine, at least diarrhoea can be managed with water, salt and sugar solutions.
 - Domestic violence involving wives and children is a problem which needs help from social workers and even the police.
 - There are many “high-risk” families – where there is an ill woman and many small children, where parents have died from AIDS and left children with an old grandmother.
 - Home-based care supporters can help with these high-risk families with illness.

Checklist 2

- After going through the list of services, if a service is not available, then the committee must discuss how to get access to it.
- Some clinics had very few or no CHWs.
- To complete the checklist it is necessary for the committee to work with the clinic staff.
- In discussing staff attitudes it is good to review “Batho Pele” and the “Patients Rights Charter”.

Checklist 3

- Each life stage is important because if there are problems of health or development then the next stage or stages will be affected.
- Most committees chose to only discuss adolescence and pregnancy, as there was no time to do the whole checklist.
- The reason for discussing adolescence was because many committees and their communities did not know enough about the health problems of adolescence eg, STIs and HIV/AIDS, family planning and abortion, dangers of smoking and alcohol, the reasons for death after circumcision.
- In one area peer educators had been trained by an NGO to hold workshops for youth on sexuality, STI, AIDS and reproduction.

Vision, Mission and Constitution

Each committee should develop its own:

- Vision
- Mission Statement
- Constitution

These documents are the guidelines for the work of the committees and are the results of participatory work and consensus.

They should be forwarded yearly to the District Health Office (and onwards to the Provincial Health Department and MEC).

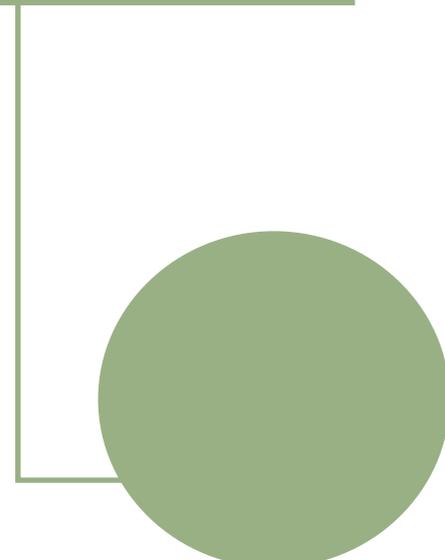
Every committee must display their Vision, Mission Statements and Constitution.

VISION

For the CHC to elaborate its vision statement it is necessary that they understand the implications of the word vision. The dictionary gives many meanings:

- ☐ *“All that comes into view when the eyes are turned in some direction”. The direction of the board's eyes would be the future.*
- ☐ *“A prophetic apparition”. This is what the committee must do - it must prophesy and conjure up an image: what they will see - the clinic, the patients, the staff, the community, the district - as a result of their successful activities.*
- ☐ *“Foresight, wisdom in planning”. The committee's vision is to do with planning - it is the situation to which they wish to move, and will influence their mission and strategic plan.*

The statement should be short. It might envisage harmony, health, well-being and for whom. It might include words such as accessible, efficient, cost-effective. As with the mission statement it is not cast in stone and can be revisited and reworded.



Each committee should develop and display the following:

- Vision
- Mission Statement
- Constitution

MISSION STATEMENT

A mission statement is about what an organisation does, for whom, and for what reasons. If the committee already has a mission statement, this should be studied. Is the mission what the committee considers to be correct for the communities and their needs – as the committee members know them? This should be the first consideration.

Next, members should work out a short half page statement that sums up:

- What they want to do, to achieve and for whom? For the community, for the patients, for the clinic?*
- Who will their efforts affect and how will they ensure getting the correct effect?*
- Is their organisation going to change and what are the directions of change they want to initiate?*
- Do they recognise obstacles which they will aim to overcome?*
- Who are their partners in the communities, the staff, the management?*
- Are they going to change things, to strengthen things, to initiate new things? If so, what things?*
- Remember the vision statement. The mission is to do the right things, in the right way to reach the vision. Clarity should not be obstructed by putting in short term objectives.*
- Revisit the mission statement after six months and change it as necessary.*

CONSTITUTION

The Draft Constitution given in the Department of Welfare's model documents lists the following headings.

- Name*
- Organisation's principal and secondary objectives*
- Income and property*
- Membership*
- Management*
- Finances*
- Changes to the constitution*
- Closing the organisation down*

The following details can also be added:

- Membership and ending membership*
- Office bearers*
- Duties of office bearers (chairperson, vice-chairperson, treasurer, secretary)*
- Meetings and procedures of committees*
- Annual general meeting*

Model agenda for a Community Health Committee

- Welcome and opening with faith observance.
- Apologies.
- Any additions to agenda.
- Approval of minutes of previous meeting.
- Matters arising from previous meeting.
- Management report (would include maintenance and staff changes).
- District manager's report (if available).
- Reports of sub-committees (eg, security, quality, training - with report annexed to minutes of last meeting).
- Report of any visit by a committee member.
- Financial report.
- Expenditure to date (clinic financial report).
- Additions (as requested at beginning of meeting).
- Date next meeting.

(Committees usually meet monthly - perhaps on a designated day in the month eg, last Thursday starting at 16h00. They must meet at least quarterly. All minutes must be kept and an annual report must be submitted.)



Conclusion

The involvement of provincial, municipal council and district council health facilities in work with communities has been accelerating recently.

The existence and role of traditional authorities in some district council areas has come out very clearly. Committees are elected at meetings called at the chief's place and these traditional leaders also take an active part in the discussions. The urban areas are different and urban municipal fora often play an important role and help to ensure that representatives from relevant communities are on the committees related to each clinic.

The three checklists whilst being used in training workshops for committees should also be used by committee members when they return to their own community or village.

More work is needed to stimulate the function of sustainable committees with a clear understanding of their role. They need imagination to start and stimulate their communities to do more for their own health – for example to improve water and sanitation, to use services correctly to have conditions such as TB diagnosed early, to use condoms to protect against STI and HIV, to monitor and promote growth of children, to have all children fully immunized. If PHC in its true sense is to develop rapidly in the Eastern Cape Province then many avenues to increase community involvement must be explored.



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Annexure 1

Extracts from the Eastern Cape Provincial Health Act

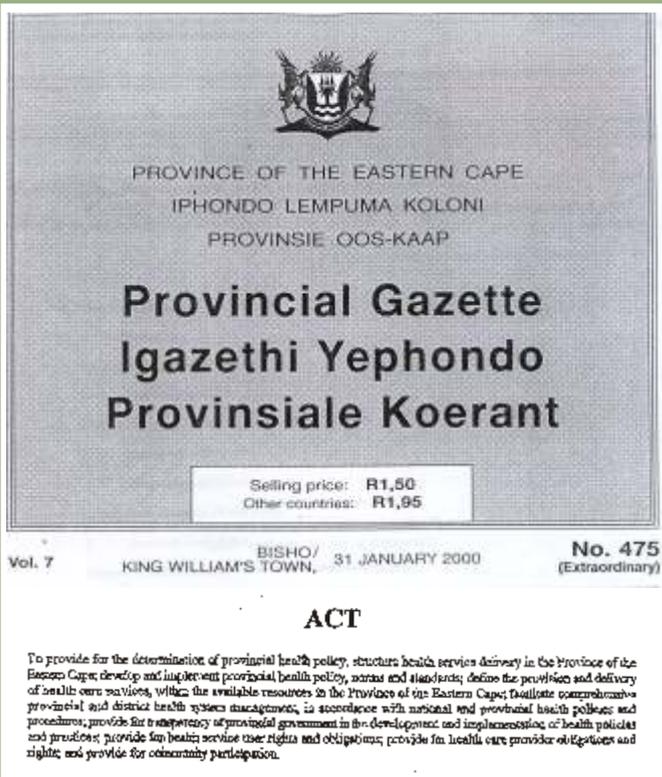
The Eastern Cape Provincial Health Act 1999(7) gives effect to the health care provision of the Constitution of the Republic of South Africa. In Chapter IV on “Provincial Health Policy and Principles”, it states:

“Community participation from provincial residents and health service users shall be encouraged through established forums and procedures for participation in the development and implementation of health services through transparent provincial governmental processes”.

“The MEC shall determine intersectoral co-operation between the Department and communities served by the Department. He is also responsible for establishing boards, forums and advisory committees and any other entity to address health matters including the establishment of terms of reference and conditions of appointment and to make such appointments as may be necessary”. (Chapter V)

One of the principles governing Provincial Health Policy is directed towards ensuring broad participation in the development of provincial health policy. Health service user rights and obligations are listed as well as rights of access to comprehensive Provincial health care services and access to information and confidentially. Complaints procedures are also listed. These sections of the Act should be made known to all residents and to committees. Similarly the detailed health care provider obligations and provider rights should be known.

Chapter XVII deals with the District Health Councils, CHCs, Hospital Boards, Advisory Committees and Forums which the MEC shall establish and for which she/he will determine terms of reference which will be published in the Gazette. Membership of all these bodies shall be representative of local community and selection will be based on needs, ability, fairness and will redress the imbalances of the past. Unless otherwise stated, the duration of a publicly created body shall be no more than one year. Minutes must be kept and annual reports submitted. Members of any of these bodies shall be remunerated for expenses incurred in travelling to and attending meetings but shall not be otherwise remunerated, as membership is voluntary.



Annexure 2

The outcome of the workshop: follow-up in the Nelson Mandela Metro

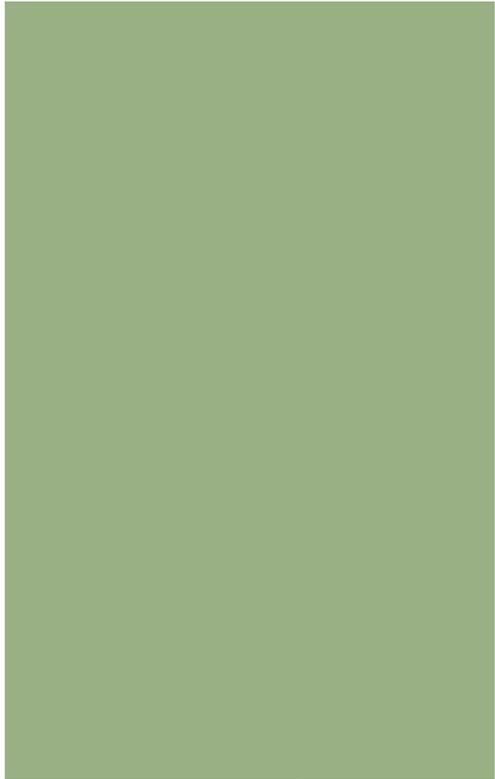
In the Nelson Mandela Metro, five health district committees (Chatty, Soweto, Zingisa, Kwazakhele and Day Hospital) filled in three checklists at subsequent meetings when they had all the committee members present. These were returned to the facilitating team about a month after the workshop.

The role and activities checklists showed that the Chatty and Soweto committees were already fulfilling most of the roles listed: facilitating working together with CBOs, guiding them on how to be more accessible and meet community needs, initiating health projects with community participation, providing a channel for information from the clinic, being advocates for positive behaviour change, identifying high risk families, organizing health days, working with other sectors to improve environment, and contributing to DOTS. On the whole, the Soweto committee felt they could accept a wider role than Chatty.

The Chatty said “No” to keeping a register of disabled children or people needing home visits, liaising with other committees, providing guard services, or supervising CHWs. They said “*it could be possible*” to notifying appropriate authorities of outbreaks of disease and improving the grounds of the clinic.

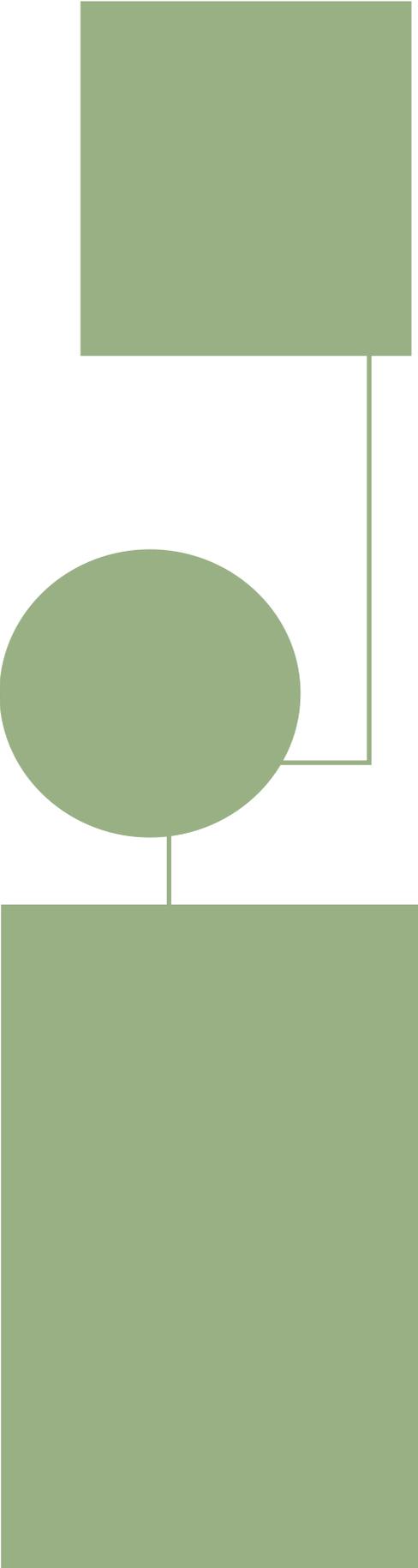
Zingisa, Kwazakhele and Day Hospital all said they did not include identifying felt needs for more health, nutrition and environmental activities nor did they provide a grassroots component for planning community health services. More training and having easier access to health and welfare under one roof were mentioned and there were comments on the size of the area and need for more mobile services.

High-risk families identified were the unemployed, TB and AIDS sufferers, and the malnourished. Health days committees participated in, were, breastfeeding, AIDS, diabetes, aged, eye care, and TB and there was a suggestion that they should be informed in advance and that the clinic post the dates of International Health Days.



A lively workshop in Lusikisiki.





The Checklists for Rapid situation Analysis

These were very carefully completed. Transport problems were mentioned by Zingisa and Kwazakhele as well as the problem of not enough DOTS volunteers.

The comments on attitudes of Clinic Staff were interesting:

Soweto

“Sometimes are not friendly. Decisions are taken without the committee. We don't have statistics on anything since we started.”

Chatty

“May have rude staff members at times, probably due to pressure of work.”

Zingisa

“Not very bad because of transformation between patients and staff plus clinic committee.”

Some of the comments which displayed attitudes of community members towards clinic were:

Soweto

“Community members are taking care of the clinic (security). Bad manners from community members are too much hence some nurses leave before time”.

Chatty

“Misuse of free medications selling pills, stealing articles and break into clinic. Do not co-operate and are rude to staff and do not keep clinic hours.”

Zingisa

“Very good attitude because we communicate very well with each other.”

Zingisa and Kwazakhele both had sports projects and Zingisa had one sewing and knitting project.

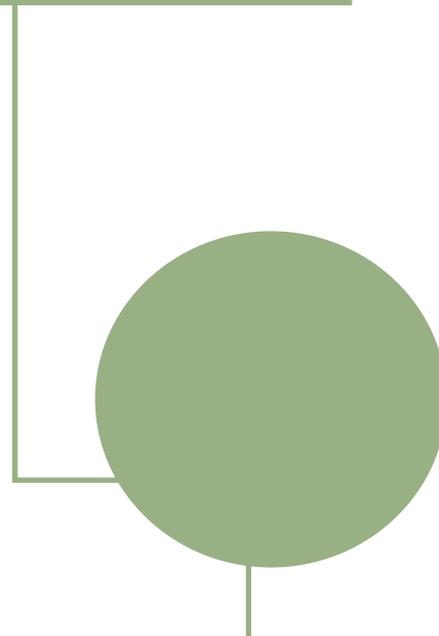
Soweto-on-Sea also mentioned services needed but not provided, such as wound stitching, baby delivering, district surgery, blood-testing, welfare desk, an old age and disabled program. Zingisa needed post natal services and chronic medication and the Day Hospital needed a labour ward.

This checklist provided a great deal of information which would be useful for the clinic indicating that this exercise should be done jointly by the committee and the clinic staff.

Subsequent follow-up in Nelson Mandela Metro Mandela Metro

Of the 64 items listed in the eight life stages, Soweto provided 31, Chatty 34, Zingisa 28, Kwazakhele 27, and Day Hospital 25. There were differences in the committees for example Chatty could provide fewer activities for pregnant women whereas Soweto said delivery could be started. Soweto could start more activities for school children which Chatty was already doing. Both Soweto and Chatty had many things they could organize for Adolescents and Adults. Zingisa, Kwazakhele and Day Hospital all thought they could start more activities for the elderly.

Soweto, in a summary at the end of this checklist added notes on the need for telephones, environmental gardens projects with Environmental Health Officers (EHO) and more programmes for the aged and disabled and in particular the need for a hospice for HIV-infected people. Day Hospital and Zingisa both mentioned they want to be part and parcel of management planning.



Community attitudes and clinics staff attitudes can often be improved after discussions.

Annexure 3

Preamble to workshops to increase the involvement of communities in their own health care

Introduction

In the White Paper for Transformation of the Health System in South Africa (Towards a National Health System) published in the Government Gazette Vol 382 No 17910 of 16th April 1997 (Notice 667 of 1997) there are the following objectives and statements relevant to community involvement as stated in Chapter 1 page 16.

- Involve communities in various aspects of the planning and provision of health services.
- Establish mechanisms to improve public accountability and promote dialogue and feedback between the public and health provider.
- Encourage communities to take greater responsibility for their own health promotion and care.
- Build capacity at provincial, district, local and community level to develop plans based on priority issues and ensure appropriate and cost-effective intervention.
- In section 2.5 Involving the Community (pages 34 and 35) the following relevant statements appear:
- Clinic, health centre, hospital and CHCs should be provided with the required technical support and motivation to become advocates of positive behavioural change in the communities they represent.
- People should be afforded the opportunity of participating actively in various aspects of the planning and provision of health services.

Shown here is the Sunduza Clinic nurses home which was built by the community.



- The essential PHC package is to be negotiated between providers and communities.
- The catchment area of facilities will be clearly known.
- Representatives of communities are to identify under- served groups.
- Community-based information systems should be developed.

Motivation

From the above extracts from the White Paper it is clear that community involvement in health care is an essential element in the transformation of the health system. CHCs need to be motivated and supported so that they can increase community involvement in improving their own health status. To start this process community health committees could reflect on their role and the development of appropriate activities to improve health.

Objective

To increase the effectiveness of CHCs in working with their neighbourhood health care facilities and in improving the health of their community.

Method

Bring CHC members, clinic staff and district co-ordinators together in a workshop so they can reach consensus on the role, tasks and purpose of the CHC (or health forum).

There are four checklists that can be introduced:

- The role and activities of the clinic/CHC.
- Checklist for rapid situation analysis of community-clinic relationship.
- Checklist to assess Community-based Health Care for different life stages.
- Adolescent-friendly clinic checklist.



A school garden
at Ntyatyambo Primary
School.

A large section of a community
are in school.

How well does the hospital
serve them when
necessary?

CHECKLIST 1

The role and activities of the Community Health Committee

Health Committee: _____ District: _____ Date: _____

Tick ✓ if already included, if not included, or if it could be included and add comments as appropriate

ROLE AND ACTIVITIES OF THE COMMITTEE

1. To facilitate working together of existing community based health activities (eg, NGO, CBO, Health, other Sectors such as Education, and private enterprise). Yes No Could be

Comments:

2. To identify felt needs for more health/work such as recruiting volunteers for DOTS. Yes No Could be

Comments:

3. Guiding the clinic on how to be more accessible and meet more of community felt needs, eg, possible changes in clinic hours. Yes No Could be

Comments:

4. Initiate health and environment related projects and activities with community participation eg, periodic collection of rubbish and plastic bags, or water/sanitation project. Yes No Could be

Comments:

5. Attend periodic meetings with health staff to discuss mutual concerns. Yes No Could be

Comments:

6. Initiate and support nutrition projects (eg, for schools and old people). Yes No Could be

Comments:

7. Provide a channel for a flow of health information from the clinic to the community. Yes No Could be

Comments:

8. Assist by providing “grassroots” information on needs for planning the health services for the community. Yes No Could be

Comments:

9. To be advocates for positive behaviour change to improve health in the community even on sensitive issues eg, not drinking alcohol during pregnancy, giving up smoking, safe sex and use of condoms. Yes No Could be

Comments:

10. Identify under served groups in the community and areas which have difficult access to the clinic services. Yes No Could be

Comments:

11. Identify high risk families in the community eg, unemployed widows with small children. Yes No Could be

Comments:

12. Organize health days relevant for community and participate in them. Yes No Could be

Comments:

13. Keep register of disabled children or people needing periodic home visits by CHWs (Nompilo) or nurses. Yes No Could be

Comments:

14. Liaise with health groups, NGO and other committees, eg, District council, Hospital board, District health forum. Yes No Could be

Comments:

15. Notify outbreaks of disease or unusual conditions (eg, Dysentery). Yes No Could be

Comments:

16. Work with other government sectors to improve the environment eg, Department of Water and Forestry, Agriculture. Yes No Could be

Comments:

17. Provide certain types of non-professional support to local clinics:

Cleaning service Yes No Could be

Guard service Yes No Could be

Ground improvement eg, garden Yes No Could be

Manage minor repairs and maintenance Yes No Could be

Manage or supervise CHW (administrative supervision). Yes No Could be

Contribute to DOTS for TB, follow-up of chronic cases. Yes No Could be

18. Does the committee know about the National Patients Rights Charter and does it help to see that it is observed? Yes No Could be

(There should be a poster and pamphlet about this charter in every Clinic)

Comments:

CHECKLIST 2

For rapid situation analysis by the Community Health Committee

Note: This rapid situation analysis should be participatory with all members of the committee taking on active part assisted where necessary by the clinic staff. This checklist is only an indication of the possible questions and investigations and it should be altered and expanded as necessary by the committee.

Community name: _____

Clinic name: _____ **District:** _____ **Date:** _____

Number and names of villages served by clinic: _____
(add distance in Km and/or minutes walking and also population estimate)

Committee helped clinic construct map Yes No

Usual opening time of clinic: _____

Usual closing time of clinic: _____

Variations within week on times open: _____

Problems in reaching clinic: _____

The Clinic Provides Daily

Health education Yes No

Child prevention and promotive care (immunization, nutrition) Yes No

Child curative care Yes No

Adult curative care Yes No

Antenatal care Yes No

Maternity care/delivery Yes No

Family planning Yes No

Mental health Yes No

Oral health Yes No

Chronic disease care Yes No

A good supply of health information pamphlets and posters in Xhosa is always available Yes No

Other (*specify*) _____

Attitude of clinic staff (*give example*) _____

Attitude of community members to health care facility and the staff (*give examples*):

Comment on cleanliness of clinic: _____

The Clinic Provides Daily (continued)

Can condoms be easily obtained without embarrassment at this clinic? Yes No

The committee is always informed about staff changes at the clinic Yes No

Are nurses always there during clinic hours? Yes No

Are nurses always there after clinic hours?
(if staff quarters available) Yes No

Can a patient see the same nurse each visit? Yes No

Waiting time before being attended to: _____

Total time usually spent on one visit: _____

Time taken for ambulance to be called in an emergency: _____

Services needed but not offered at clinic: _____

The clinic is practising "Batho Pele" Yes No

There is a complaints box at the clinic Yes No

Complaints are dealt with promptly Yes No

Is there a poster or are pamphlets available on the National Patients Rights Charter? Yes No

Does the clinic provide a healthy and safe environment? Yes No

Are the health care providers known by their names? Yes No

Are patient-held records in use? Yes No

Is counselling available on reproductive health and HIV/AIDS? Yes No

Are patients treated with dignity and respect? Yes No

The Clinic Health Committee

AGE	MEN	WOMEN
16- 25	_____	_____
26 45	_____	_____
46 65	_____	_____
66+	_____	_____
Chairperson	_____	_____

Community structures represented: _____

Frequency of meetings: _____

Do clinic staff attend meetings? Yes No

Major Community-based Activities in which the Committee Participates

- Work with clinic staff on measles/polio campaigns Yes No
- AIDS/STD/Sexuality education Yes No
- Community mobilization for DOTS Yes No
- Dealing with conflict/violence/rape/child abuse/
substance abuse Yes No
- Community initiated water and sanitation projects Yes No
- Growth monitoring and promotion Yes No
- Community gardens Yes No
- Environmental cleaning Yes No
- Poultry Yes No
- Drainage and tree planting Yes No
- Pig keeping Yes No
- Youth health projects Yes No

If there are Community Health Workers (Nompilo) complete this section

Name each village and give number of CHWs in each: _____

Trained by: _____

Selected by community Yes No

Acceptance by community (*describe*) _____

Consultation with CHW after hours possible Yes No

Remuneration through community Yes No

Details of remuneration or incentives: _____

Clinic staff regularly support to CHW includes following: _____

Major activities and achievements of CHW: _____

CHECKLIST 3

To assess community-based health care for different life stages in the community

Community name: _____ District: _____ Date: _____

Tick ✓ relevant column

Pregnant Women

- Are pregnant women provided with information on warning signs of serious complications (headache, bleeding)? Yes No Could be
- Are they provided with education on breast feeding and foods needed in pregnancy? Yes No Could be
- Do CHW refer pregnant women to the clinic and keep a list of expected births? Yes No Could be
- Do traditional healers and traditional birth attendants refer pregnant women to the clinic for a blood test and injections (tetanus toxoid)? Yes No Could be
- Does the community have arrangements for emergency transport of women in labour and about to deliver? Yes No Could be

Delivery

- Do traditional leaders, traditional healers, CHW and mothers report home deliveries to the nearest clinic? Yes No Could be
- Are women who delivered at home visited by a health worker? Yes No Could be
- Are traditional birth attendants able to get training at the clinic if they have been delivering many babies? Yes No Could be
- Is there a breast feeding support group in the community? Yes No Could be
- Are still births or deaths of baby shortly after delivery reported to the clinic? Yes No Could be
- If any abnormal babies are born are they recognized quickly and referred to the clinic? Yes No Could be

Infancy

- Are immunization campaigns done with community involvement and well publicized? Yes No Could be
- Have health surveys on nutrition or other health matters been done with community involvement? Yes No Could be
- Do the health committee or CHW check immunization cards of infants in village/area and refers those not up to date to one clinic? Yes No Could be
- Has the community been educated about polio, measles and neonatal tetanus and the need for reporting and immunization? Yes No Could be
- Does a nurse from the clinic visit homes of mothers with newly born twins or very small newborn babies? Yes No Could be
- Is there some system for care of orphans or fostering children from families where parents died? Yes No Could be
- Has the clinic arranged some training for mothers with disabled children? Yes No Could be
- Does a team from the clinic, health centre or hospital visit the families with disabled children? Yes No Could be
- Does the community collect mother and infants under two every month for weighing and promoting good growth? Yes No Could be

Pre-School Age

- Do the health committee and environmental health officer or clinic nurse inspect preschools? Yes No Could be
- Are homes where orphans live visited periodically? Yes No Could be
- Are there community feeding projects in preschools and for preschool age children? Yes No Could be
- In the last year has there been a round of immunization for measles and polio? Yes No Could be
- Are all disabled children referred periodically to the clinic for review? Yes No Could be
- Do all preschools have community parents committees which consider health aspects? Yes No Could be

School Age

Does the community or some group encourage packed lunches for schools in order to improve nutrition and school performance or are there school feeding programmes? Yes No Could be

Are school inspections of environment (eg, toilets, water) done by the community committee with nurse and environmental health officer? Yes No Could be

Do school nurses screen school children and discuss with parents? Yes No Could be

Do the teachers in this community attend health workshops? Yes No Could be

Do the EHOs check buildings and grounds of schools and report to the committee? Yes No Could be

Are there adequate sports facilities and coaching for both boys and girls of school age to decrease sports injuries? Yes No Could be

Does the committee discuss the problems of children in the street and living in the street? Yes No Could be

Has life skills teaching been introduced in all schools? Yes No Could be

Adolescent

Has the community arranged for mature approachable women or women teachers to act as someone to whom sexually harassed school girls can go to for help and support? Yes No Could be

Are there peer group health educators for schools and out of school youth? Yes No Could be

Can contraceptives and condoms be obtained by adolescents in the community easily at the clinic? Yes No Could be

Are there youth group activities for recreation and health for male and female youth? Yes No Could be

Is there available to youth: health education on smoking, drugs, alcohol and safe sex and dangers of HIV/AIDS/STI Yes No Could be

Do adolescents (girls and boys) receive nutritional guidance from nutrition workers? Yes No Could be

Does the EHO check on sport and play facilities to ensure safety? Yes No Could be

Is there a community-based mental health programme? Yes No Could be

Has circumcision been made a safe procedure in the community? Yes No Could be

Adults

Has there been health worker participation in community-based planning eg, water points, toilets, siting of clinics, telephones?

Yes No Could be

Does the community have members trained in early TB diagnosis and daily DOTS?

Yes No Could be

Does the community have group work for men and women related to health?

Yes No Could be

Are there NGO or CBO activities for health and welfare in the community?

Yes No Could be

Do nurses help with the reintegration of mentally ill into their families after discharge from mental hospitals?

Yes No Could be

Have the committee and community members done their own health surveys?

Yes No Could be

Has the committee participated with health staff investigating outbreaks of disease eg, dysentery or cholera?

Yes No Could be

Is there a committee concerned with violence/dispute/conflict resolution?

Yes No Could be

Is health monitored in occupational situations eg, factories, plantations, workshops, bus/taxi ranks, bars/hotels?

Yes No Could be

Has there been community education for adults on TB, HIV, AIDS, STIs and condom use?

Yes No Could be

Does the community arrange for rapid emergency transport in cases of accidents, violence or for maternity emergencies?

Yes No Could be

Does the EHO check new buildings, rubbish collection and toilets in the village?

Yes No Could be

Does EHO also advise on keeping pigs and on inspection of home slaughtered animals?

Yes No Could be

Can an adult who is HIV-positive get confidential counselling from the clinic or lay counsellor?

Yes No Could be

Has the committee taken steps to decrease the stigma of mental illness, epilepsy, AIDS and TB?

Yes No Could be

CHECKLIST 4

A adolescent-friendly Clinic Checklist

Community name: _____ District: _____ Date: _____

Tick ✓ relevant column

<p style="text-align: center;"><u>Staff trained</u> who/ when/ where</p>	<p>Family planning Adolescent-friendly clinic initiative STI Counselling for VCT and confidentiality Rapid testing for HIV Rapid testing for rapid plasma reagents How to get continuity?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p style="text-align: center;"><u>Counselling areas</u> and times</p>	<p>Private/confidential area available at all times Clinic times available for adolescents for FP and STI Fast track 12h00 - 14h00 16h00 - 16h30 16h30 - 17h00 Saturday am</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p style="text-align: center;"><u>Available</u> Drugs/Equipment</p>	<p>All contraceptives ( condoms), emergency contraceptives Poster on "choice" with indicator/contraindications All drugs for STI. Condocan in correct site Specula - lab - swabs/jars/slides Rapid tests - HIV/syphilis</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p style="text-align: center;">Records</p>	<p>A method of ensuring confidentiality and continuity</p> <ul style="list-style-type: none"> ● Registers - clinic morbidity/tick register ● Family planning ● VCT ● Laboratory 	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Health learning materials

- Correct languages
- Family planning
 - Emergency contraceptives - pamphlets
 - STI
 - VCT

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Linkage

- Does clinic know schools in catchment area?
When visited - ? Talks given
Given supply condoms
Established link with:
- Social worker
 - Police
 - School Governing Bodies

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Protocols

- Is there a rape procedure protocol?
Are all protocols available:
- Adolescent-friendly clinic initiative
 - VCT/STI/family planning

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

