

EQUITY Project

Community Perceptions and Opinion of Primary Health Care Focus Group Discussions From the Training Needs Assessment Eastern Cape Province, South Africa 1997/98

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Eta E Banda, INTRAH/EQUITY Project PHC Clinical Training Advisor
Zoe Kati Provincial PHC Clinical Coordinator
Vuyie Yoli INTRAH/EQUITY Project PHC Clinical Training Manager
Jedida Wachira INTRAH Consultant
Pauline Muhuhu, INTRAH Regional Director
Rose Wahome INTRAH/EQUITY Coordinator

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ABBREVIATIONS

ANC	= Ante-natal Care
ECDOH	= Eastern Cape Department of Health
EPI	= Expanded Programme of Immunisation
FP	= Family Planning
INTRAH	= Programme for International Training in Health
PNC	= Post Natal Care
SDP	= Service Delivery Point
STD	= Sexually Transmitted Diseases
TNA	= Training Needs Assessment
TB	= Pulmonary Tuberculosis
USAID	= United States Agency for International Development
EQUITY	= a USAID-funded South African Project

EXECUTIVE SUMMARY

In the course of assessing the situation in primary health care facilities and the knowledge, attitude and skills of nursing staff working in these facilities Management Sciences for Health (MSH) in collaboration with the Programme for International Training in Health (INTRAH) and the Eastern Cape Department of Health (ECDOH) conducted a Training Needs Assessment (TNA) throughout the Eastern Cape Province. Seven questionnaires were designed to assess various aspects of primary health care facilities and services delivered and providers' knowledge and skills. Community perceptions of the available services was assessed through the focus group methodology. Nineteen focus groups of 15 to 20 community members from 14 of 21 districts throughout the Province were convened. Data was collected using an open-ended focus group guide which was developed and tested at a TNA Workshop in Port Alfred in June 1997. The focus group sessions lasted 1-2 hours with discussions guided by 3 trained nurses, one of whom guided the discussion, another recorded in writing, and the third one, a PHC trainer, served as the supervisor. The nurses were drawn from district supervisory staff and were not generally known by the communities they interviewed.

The district health management team approached the community leaders in villages or settlements served by health clinics. One focus group was randomly selected from the communities within the catchment area of a clinic also randomly selected to be part of the TNA study. The selection process did not permit the inclusion of clinics and/or communities from where the interviewing nurses worked and were known. Community leaders then arranged the venue for the focus group and invited adults, both male and female, to participate in the discussions. During this session it was emphasized that all responses would be confidential and that communities had the right to respond or not respond to any questions posed. Major points of the interviews were recorded in writing in order to extract information on common themes to better understand community perceptions and priorities.

Results or principal themes that emerged from the groups were client satisfaction issues (access, relationship and overall perception, waiting time, community concerns, non-availability of services, service integration), what clients liked best about clinic management, community participation and involvement issues (clinic committees, role of clinic committees, community contribution) and improvements needed.

Conclusions were 1) the majority of the groups expressed client satisfaction, 2) communities want to be involved in PHC activities, 3) communities expressed remarkable appreciation for staff efforts and patience with staff realizing the difficulties the staff experienced, 4) lack of regular drug supply was one of the main issues expressed as an area of concern in addition to waiting time, staff attitudes and work ethics, 5) communities identified areas that needed improvements, 6) need for training in clinic management and understanding and working with communities was a felt need.

Recommendations

- 1 Given the important role played by clinic committees and the fact that some clinics did not have committees it is recommended that clinic committees be formed in those clinics that did not have any in place
- 2 Training is required both for staff and communities on the roles of clinic committees, community ownership in relation to clinic property, utilization, and community participation
- 3 Training in clinic management skills (e g planning, staffing, organization of the clinic, time management , client/staff relationships, staggering of breaks, work ethics etc) is necessary
- 4 Training in drug management and distribution for clinic staff is required
- 5 PHC clinical training is required in attitudes and caring, client staff interaction and relationships
- 6 There is need for improving supervision in the clinics by the district management team

1 BACKGROUND AND RATIONALE FOR THE TRAINING NEEDS ASSESSMENT

In the course of assessing the situation in primary health care facilities, the knowledge, attitude and skills of nursing staff working in these facilities, Management Sciences for Health (MSH) in collaboration with the Programme for International Training in Health (INTRAH) and the Eastern Cape Department of Health (ECDOH) conducted a Training Needs Assessment throughout the Eastern Cape Province

In planning for a TNA the role of communities in patient care could not be ignored, hence the justification for assessment of community perceptions. The importance of incorporating clients' perception in health care programme planning has been documented by many client satisfaction writers (Sitzia & Woods, 1997, McIver, 1991a & DHSS, 1994). Most of these studies or models, however, have been based on management and professional views (Sitzia & Woods, 1997). In the Eastern Cape Province it was considered necessary that communities' perceptions be part of the basis for understanding training needs in the primary health care training programme development.

In preparation for such a study, three activities were planned and carried out: 1) a TNA Workshop held in Port Alfred Eastern Cape, for PHC clinical trainers and facilitators (Wachira, Banda, Yoli & Kati, 1997), 2) region-based briefing/consultative meetings for clinic supervisors, district managers, deputy regional directors for PHC and regional training coordinators to ensure support and cooperation at the facility level (Banda, Yoli & Kati, 1997), and 3) key community leaders were approached by the PHC clinical trainers and district management in each district seeking permission to hold focus group discussions and to recruit the group members.

2 PURPOSE AND OBJECTIVES THIS STUDY

The main objective of the study was to examine communities' perceptions of the quality and quantity of available services, current utilization of the services and the level of community participation in planning and implementing the current PHC services package.

The purpose of the focus group discussions was to explore the communities' perceptions of primary health care and their level of integration within the present services.

3 METHODOLOGY

The study design was descriptive using focus groups discussions for community and client perceptions of PHC. Nineteen focus groups consisting of 15 to 20 members were studied in 14 districts. The groups included community leaders, client/clinic users, both male and female who

were recruited by the community leaders. The focus group sessions lasted 1 to 2 hours. The districts that participated were in Region A: Port Elizabeth, Graaf Reinet, Region B: Cradock, Elliot, Queenstown, Region C: Butterworth, East London, Fort Beaufort, Region D: Libode, Mquanduli, Qumbu, Umtata and Region E, Mt. Frere(Kokstad), Bizana and Maluti. The settings were both rural and urban.

The instrument used was an open-ended focus group guide for communities. This tool was developed and pilot-tested in Port Alfred in June 1997 at a workshop facilitated by an INTRAH consultant and a team of MSH/EQUITY Project trainers, ECDOH EQUITY Coordinator, 21 PHC clinical training trainers, 5 co-facilitators and one MSH/EQUITY regional coordinator.

Data was collected from 14 districts by a team of 3 nurses: one facilitated or lead the discussion, another recorded the discussion and the third one, a PHC trainer, served as supervisor. The nurses were drawn from district supervisory staff and were not generally known by the communities they interviewed. The data collection teams were regionally trained in July and August, 1997.

The district health management team approached the community leaders in villages or settlements served by health clinics. Focus groups were selected randomly from the communities within the catchment area of a clinic that was also randomly selected. The selection process did not permit the inclusion of clinics and/or communities from where the interviewing nurses worked and were known. Community leaders arranged the venue for the focus group and invited adults, both male and female, to participate in the discussions. During this session it was emphasized that all responses would be confidential and that communities had the right to respond or not respond to any questions posed. Major points of the interviews were recorded in writing in order to extract information on common themes to better understand community perceptions and priorities.

4 RESULTS

4.1 Relationship to clinic and overall perception

Eighteen out of 19 focus groups stated general satisfaction with the relationship between clinic nurses and the community, often stating a strongly positive response. One focus group gave examples of how nurses are friendly, warm and helpful, even using their own transport to carry referred patients. Another group stated good interpersonal relationships and pleasant reception even when the clinic is extremely busy. The only focus group that indicated bad or negative relationships was convened in East London. Examples given by this group included staff arriving late for work, often at 10h00 when the clinic opens at 08h00, staff taking tea before doing any work, clinic closing at 14h00 when it should be open until 16h00, busy clinic waiting rooms, and medicines often not available. A number of communities wished for 24 hour service but acknowledge staff are available only from 08h00 to 16h00. In general satisfaction was expressed based largely on the attitudes and apparent work ethics of the nursing staff. Where nurses were prompt, pleasant and seen to be busy the communities expressed appreciation and understanding.

4.2 Access to clinic services

Transport to the clinics varied across every imaginable means walking bicycles taxi's, buses car hire, cross country hiking, and even horseback and wheelbarrow were mentioned. All focus groups indicated that transport was a major constraint to clinic utilisation, except in the case of 4 focus groups that were convened within easy walking distance of the clinic. Time to reach the clinic varied from 5 to 30 minutes for those who traveled by a vehicle while those walking indicated from 1 to 5 hours. Surely those willing to walk such a distance gave evidence of a strong felt need for the clinic services. Some even commented that patients had died due to the delay to reach health services. While improved transport would be most desirable, clearly alternative means of meeting the most inaccessible communities through community based health workers or mobile clinics or other outreach of health professionals would be most welcome.

Clinic schedule was an important determinant of access. Most clinics opened between 07h30 and 08h00 although one area indicated 09h00 was necessary due to lack of security at an earlier hour. Closing times varied from 16h00 to as late as 19h00 although security concerns again made the later hour unworkable in most situations. In only one area was it stated that a nurse remained on call at all hours for emergencies. In 5 focus groups (mostly rural) the times were felt not to be suitable while the others thought the opening times were reasonable. Those that indicated times were not suitable did not propose specific schedules.

Concerning the decision for clinic working hours one group identified the clinic committee as determining the clinic hours while a second group indicated that the hours were jointly decided between the community and clinic service providers. Six focus groups stated the government established clinic hours either provincially or by the municipality. Six groups had no idea who was responsible for the timings. One group said the decision was up to the sisters while another explicitly said the community had no involvement. Determining suitable hours for the clinic on the basis of consensus between community and service providers would be an important means of making services more accessible and giving communities the feeling that they had some control over their local facility.

4.3 Waiting time

Waiting times varied widely and perceptions were based more on nursing attitudes and behavior than on actual times waited. Nine groups said they were attended to "punctually", "promptly" "immediately" "as soon as possible" during the working hours although many noted that this changed when it was tea time or lunch time. At such times patients had to wait while nurses took a break even though many had already been waiting to be seen. A number pointed out that while the clinic opened at 08h00 clients were often attended to only from 09h00 or later. Such was a source of irritation. Eight focus groups described their wait as very long and associated this with tea and lunch breaks, integrated services taking more time, overcrowding and heavy workload, lack of privacy in the clinic, staff shortages, limited staff skills and lack of equipment and drugs. They also pointed out that if there was an emergency all else had to wait, a situation with which they were patient in

most circumstances. Most communities reported patients served on a “first come, first serve” basis with no effort to stagger appointment times or otherwise spread patients out throughout the day. One community reported attempting to help reduce waiting times by having community volunteers serve as clerks to take some of the recording load off nursing staff. In general, communities were understanding of long waiting times if the nurses were clearly busy with other patients. Long breaks and obvious disregard of waiting patients by nursing staff who were not busy were a broad source of irritation.

4.4 Service integration

Communities were asked about the availability of multiple services during a single visit. The majority (16 focus groups) stated that they could receive any care they required at the clinic on any day. They mentioned all PHC services, several services such as health education, family planning, chronic illness treatment, curative care, antenatal care, postnatal, breast feeding promotion, nutrition, minor ailments, and child health. Three focus groups, however, indicated that they would not be able to receive all the care they would require as services were scheduled in such a way that they could only take their child on a particular day assigned to childhood services which would not be available on days services were offered for adults. The new policy and approach to service integration is a welcome one in the eyes of the community.

4.5 Non-availability of services

Asked specifically about times when the clinic could not provide the service desired, 14 focus groups indicated that this had happened. Denied procedures included immunisations, family planning, deliveries, x-ray, blood tests, blood pressure check, injections, curative services, dressings, checking of blood sugar, intravenous fluid administration, care of incontinent patients and care of pre-term babies. The reasons for the inability to carry out a procedure or provide care included lack of adequate medicines or drugs, request for non-available services, particularly delivery after hours, lack of an x-ray department or laboratory, non-functional equipment such as sphygmomanometer, lack of gas for the refrigerator and, therefore, no vaccines, no equipment for giving intravenous fluids, no urine bags for urine incontinence, and no facilities to care for pre-term babies. Five groups felt they had never been denied a service. It appears that, in spite of a broad range of integrated services being available, these are dependent upon the timely delivery of adequate supplies, refrigeration, equipment maintenance and the availability of necessary support services such as x-ray and laboratory. While some of these may be unreasonable expectations of a small clinic, it is reasonable to anticipate that others can be improved with better developed management and logistic systems.

4.6 Major community concerns

The most pervasive complaint concerned non-availability of drugs. Virtually all focus groups identified drug supply as a major problem at their clinic. Reasons included lack of delivery in spite of nurses claiming that orders had been placed on schedule, lack of drugs for specific illnesses such as medications for worms or hypertension, being referred to a distant hospital to obtain medicine and, even worse, finding no medication even at the hospital meant that drugs were not available even

in the provincial headquarters. Groups attributed drug problems to the three existing health services that currently exist. Patients made frequent visits to each of them and described symptoms in order to obtain drugs which they then hoard at home for future use. Interestingly, the recent availability of free primary health care service was seen to have lowered the standard of health services and reduced medicine supplies. Clearly the expectation that drugs should be widely available and often are not was a major concern.

A second major concern cited was the problem of referrals and particularly the difficulties of transportation to the referral point. Public transport is expensive, costing 70 to 100 rands. In addition taxis, vans, private cars were not available and were costly. Ambulances often cannot be called due to the lack of telephone or delay is so long and unpredictable that ambulance services are widely seen as unreliable. Occasionally a government car may be used to transport patients. Often it was stated that transport was not available unless clients had money to pay. Improved patient referral and transport is a widely felt need necessary to link clinics to the higher levels of the health care system.

Other concerns expressed by the community related to overcrowding of the clinics, lack of privacy and individual examination space, perceived lack of skills in clinic staff and in some instances negative attitudes of staff towards their clientele. In general there was consensus on the range of issues that communities would like to see improved: available drugs, less waiting time, more polite reception from staff, privacy in both interviews and examination and facilitated referral.

4.7 Community participation

The existence of clinic committees was reported by 11 of 19 focus groups, one of which had two committees (one for the disabled and the other for the general clinic population). The role of these committees, actual or potential, was discussed in 17 focus groups and included:

- problem solving jointly with clinic staff
- assisting clinic in needs assessment of the community
- promotion of communication between clinic staff and the community
- better liaison between the community and nurses
- decision on money or other contributions to be made by community members
- collection of money and contributions from the community
- fetching or delivering medicines
- construction of toilets
- repairs, e.g. of windows, gutters, other parts of the building
- protection of clinic buildings and staff including fencing and help with security
- fund raising for the development and uplifting of the clinic
- doing the work of professionals and having "full powers" to work in the clinic as volunteers
- committees described having "hijacked" the organising of health days since when this was left to the nurses they did not really reach the "grassroots" which the community committee could do

4 8 Community empowerment through health education especially on TB environmental hygiene, health care and other lifestyle and behavioural health issues

Two urban focus groups indicated that the clinic committees had no management role and one group indicated that their committee was unhappy as it did not receive feedback on its work

When asked what contributions communities had actually made to the clinic the following were listed

- clinic improvement and assistance in such areas as water supply -fetching water from the river or boreholes, cleaners for the clinic surroundings, building of toilets, building a waiting area, construction of a waiting room for expectant mothers, clinic maintenance, clean-up, planting of scrubs and flowers and weeding of the garden for beautification
- security provision such as fencing, donation of bricks for a wall, security for the nurses and protection of the clinics doctor
- training of community volunteers for health promotion and home visits, e g training Nompilos and other health workers to do home visits and provide first aid and to give health talks on subjects provided by the nurses
- paying for transport by communities and making arranged to assure that patients in need can reach the hospital and attend OPD re-visits
- combating thievery from the clinic
- providing extra staff to help inside the clinic and cleaning of the waiting area, etc
- creating awareness and being involved in clinic matters, participating in decision making and planning
- encouraging and providing food gardens for TB patients, establishment of a soup kitchen so TB DOTs patients can have something to eat when they come to collect their medications
- involving traditional healers, encouraging them to send boys to the clinic for check-ups before circumcision and orienting traditional healers to sterile techniques
- loaning of TV and radios to clinics' waiting areas
- community volunteers can assist in the event of casualties, outbreaks and other health emergencies
- finally, a number of groups sited working as clerks giving out clinic patient cards and sending people away from the clinic if it was considered too full for the day
- Overall a wide range of contributions to needs at the clinic were cited

4 9 Community and client satisfaction

Groups were asked what they liked best about the service delivery point they attended The most common replies were as follows

- it was accessible to the community
- treatment was always given if drugs were available
- health education is available and relevant

- integration of services makes obtaining all needs at once convenient (citing family planning under 5 services, lab services, blood pressure taking, urine testing, weighing, like in a hospital)
- nurses tried to serve clients anytime even outside of clinical hours
 - positive attitude and simplicity of nurses in dealing with patients
 - the availability of electricity at the clinic
 - availability of telephone
 - co-operation of the staff
 - involvement of the community in clinic decisions
 - home visits by the nurses
 - 24-hour services and extension of service hours
 - sister in charge cited as very good and friendly
 - good communication between the staff and community and finally
 - beauty of the physical structure of the clinic

Only one focus group indicated that they could find nothing that they liked about their clinic

Groups were then asked what things they felt needed to be improved at the clinic with the following range of suggestions

- medicine for family planning
- water supply
- to be open on weekends
- to have trained security for night services
- to have fencing
- staffing, to have an increase in numbers
- doctors to be stationed at the clinic, doctor to visit the clinic at least weekly or more frequent
- finance for a bigger clinic or an extension of the building
- existence of toilets and having them cleaned regularly
- all services should be offered daily but this leads to overcrowding
- clients should be attended to quickly and should not have to wait in a queue for a long time
- electricity should be installed and paid for by the government
- telephone services are needed there should be televisions and magazines in the waiting room
- there should be air-conditioning in the waiting rooms
- need for transport for emergencies and maternity cases - ambulance services are needed where these are not presently available
- increase of drugs, equipment and other supplies
- need for a feeding scheme for clients
- clinic should not close when nurses go out in the communities home visiting, nurses should do more home visits
- services should be available 24 hours and on week-ends
- lawnmower needed for the garden
- improved hygiene and environment in the grounds around the clinic
- maternity beds are required
- high temperature in clinics in the summer need to provide ceiling for some clinics currently with bare roofs

- community health volunteers need to be paid
- clinic floors are dilapidated with no carpets
- clinics should set priorities for which patients to see based on illness severity not just on first come first serve basis
- the list of suggestions seemed long and reasonable

4 10 Conclusions from the focus groups

- 1 Client satisfaction was generally expressed widely by the majority of groups and their members and the relationship with clinic staff was considered positive
- 2 Communities wished to be involved in primary health care activities and have many suggestions for ways in which they can help
- 3 There was a remarkable appreciation for nursing staff efforts and communities were generally patient with staff realising the difficulties staff experience in their work
- 4 Lack of regular drug supply was the main, single issue expressed as an area of concern
- 5 Waiting time varied with clinics being attended to quickly most of the time although staff tea and lunch breaks increased client waiting time and were often an irritant to waiting patients
- 6 The attitude of staff was reported by most as being positive but the problem of work ethics, late reporting for work and brusque or impolite treatment by nurses was frequent enough to be a source of concern
- 7 There is a need for training of both staff as well as the communities on how to work better as partners in primary health care

5 RECOMMENDATIONS

- 1 Given the important role played by clinic committees and the fact that some clinics did not have committees these should be formed and guidelines should be provided to both staff and communities on the roles and responsibilities of such committees. A stronger sense of community ownership and responsibility for clinic property, correct utilisation and communities' role in health promotion should emerge
- 2 Clinic staff should be trained in management skills to enable them to respond more effectively to reasonable expectations of the community, for example, organisation of patient flow in the clinic, time management, client staff relations, staggering of breaks, encouragement of use of afternoon hours, adherence to proper work time and schedules, etc
- 3 Training in drug management and distribution for clinic staff and improvement in overall drug supply is required. There is a need for improving supervision in the clinics by the district management team to include attention to staff attitudes, interaction and relationships and team work in response perceived in real needs of the communities being served

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Appendix 1

PHC CLINICAL TNA/VALIDATION

FOCUS GROUP DISCUSSION FOR A GROUP OF COMMUNITY MEMBERS

Village Name

District

Region

Date of Focus Group Discussion

Composition of Community Group members

Name of nearest SDP which serves the community

Type of SDP

Questions

- 1 At which time does the clinic open?
- 2 At which time does the clinic close?
- 3 Is it suitable for the community needs?
- 4 Who makes the decision for clinic hours?
- 5 How long does it take you to get to the SDP?
- 6 How do you get there?
- 7 How easy is it to get there for most members of this community?
- 8 How well do you get on with the service providers in this clinic?
- 9 How soon you get served?
- 10 If you take your child to the clinic, what other services can you get for yourself?
- 11 Was there a stage where a procedure was not done because of equipment?
- 12 If yes, What procedure?
- 13 What was the problem with machine?
- 14 Is there any stage you could not get the necessary drugs prescribed to you?
- 15 If yes what was the reason given?
- 16 By what means do the referral clients get to the referral point?
- 17 Are there existing clinic committee?
- 18 What role does it play in terms of SDPs management?
- 19 What things do you like best about the way the SDP is managed?
- 20 What things do you feel need to be improved at the SDP?
- 21 In what areas do you think the community can contribute towards improving this SDP?

ECDOH/MSH/EQUITY PROJECT

MONTHLY REPORT FOR FEBRUARY 1998

Perhaps the most noteworthy accomplishment of the month was the orientation/training of more than 110 regional and district managers to the process of developing operational plans for 1998/99. Workshop participants included four of five regional directors and all 21 district managers/coordinators. Most these personnel, and in some regions additional personnel, were also briefed on the results of the clinic survey as part of the situational assessment process for plan formulation.

Other accomplishments during the month of February included

- 1 Condom week workshop identified "grab-a-condom" as the name for the condom cans. Forty Departmental and NGO personnel participated and 150 "grab-a-condom" cans were received and have been distributed. 1000 more are expected in order to have at least one in each health facility.
- 2 Department of Youth Affairs Workshop held for about 50 participants who developed action plans for education, prevention and referral related to HIV/AIDS/STDs & TB.
- 3 One-day EQUITY Project indicator workshop held with participants from the ECDOH, USAID and MSH. Baseline values were discussed, as well as possible life-of-project target values. A report was prepared and revised.
- 4 Approximately 220 thousand bin cards and one thousand sets preprinted requisition forms printed. These quantities correspond to a one-year supply. Related manual for stock management at clinic level drafted and will be validated when training begins in March.
- 5 National workshop to introduce the new PHC Essential Drug List and Standard Treatment Guidelines held in Eastern Cape. The workshop was jointly supported by the EQUITY Project and SADAP. All provinces and the national DOH were represented. Workshop participants reviewed and further developed needs estimation tools which were introduced in a similar workshop held in October. After the latter workshop every depot manager performed an ABC analysis of the drugs distributed from their depot.
- 6 ECDOH acquired direct access to MEDSAS and the ability to directly produce routine reports for the Umtata and Port Elizabeth Drug Depots. Formerly these reports were available only through the MEDSAS contractor.
- 7 National DOH developed and approved a plan for the "migration" or transfer of its data base on pharmaceutical procurement and distribution from the contractor's facility to an office within the DOH. EQUITY Project staff and consultants have supported the development of this plan and the initiation of its implementation.

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- 6 PHC clinical training (5 days) was held for 22 service providers in Alhwal North and for 30 service providers in Flagstaff. In addition, 10 service providers were trained in family planning services in Region B.
- 7 Meeting of the Technical Working Group (PHC clinical training curricula) held. Six task groups were formed as follows: 1) pregnancy, 2) infant and pre-school, 3) school age and adolescent, 4) adult, elderly and death, 5) curriculum coordination and 6) policy guidelines review.
- 8 Six Eastern Cape MPH students, including 4 district managers, initiated their program at the University of the Western Cape (UWC). In addition, 14 regional personnel attended several different 5-day courses at the UWC winter school.
- 9 Computer program to facilitate data entry and automate the calculation of indicators developed. This program will analyze the data provided on the new PHC service report which was distributed in December for initial use in January.
- 10 Final versions of Karen Quigley's Trip Report and Study Report produced and distributed. This report presents draft criteria and procedures for the identification and evaluation of opportunities for public/private partnerships that benefit both the public and private sectors.
- 11 Provincial meeting held to examine possible ways to assist traditional medical practitioners work more effectively with the public health system. Consensus was reached that they would assist on issues related to sexuality, STDs and HIV infection.
- 12 The President of MSH and Dr. Clarence Mini met with senior UNITRA faculty including Prof. Mazwai, Dean of the Faculty of Surgery, and Prof. Mfenyana, Director of the Department of Community Medicine, as well as the Director of the Department of Economics. Discussions focused on possible ways that EQUITY and MSH could support the strengthening of UNITRA.
- 13 EQUITY personnel participated in the National District Health Systems Committee meeting in Portoria.
- 14 Using funding criteria developed in December, NGO Funding Task Group of the HIV/AIDS/STD and TB Management Committee allocated R2,035 million to 26 NGOs. This action avoided possible loss of funds to the Eastern Cape.
- 15 Advocacy skills training workshop facilitated by EQUITY personnel. The 3-day workshop focused on HIV/AIDS issues and included 30 participants.