The EQUITY Project

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A project of the Department of Health supported by US Agency for International Development (USAID)/South Africa through : Management Sciences for Health

GUIDELINES

to strengthen community involvement in district hospitals and to make hospitals more district friendly

January 2001

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MSH

St Lucy's Hospital

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St Lucy's Hospital

CONTENTS

ACRONYMS

BCG	Bacille Calmette-Guérin
CBO	Community -Based Organisations
DENOSA	Democratic Nursing Organisation of South Africa
DOTS	Directly Observed Treatment Short Course
EHO	Environmental Health Officer
HOSPERSA	Hospital Personnel Association of South Africa
IEC	Information, Education and Communication
MDR	Multiple Drug Resistance
MEC	Member of Executive Council
NEHAWU	National Health and Allied Workers Union
NGO	Non-Government Organisation
PHA	Public Health Administration
PHC	Primary Health Care
SANCO	South African National Civic Association
STI	Sexually Transmitted Infections

Greenville Hospital, Bizana

INTRODUCTION

These guidelines are intended to guide to Managers, District Health Training Officers and Non-Government Organisations when conducting workshops for hospital boards. They could be useful for District Managers who are concerned that community involvement has not yet influenced the management of hospitals. They are derived from existing published material on hospital boards. Experiences in workshops and hospital board meetings with ten hospitals in Regions A, B and C in the Eastern Cape Province have shown the value of the material collected in these brief guidelines.

Cala Community Health Centre, Sub-District Hospital

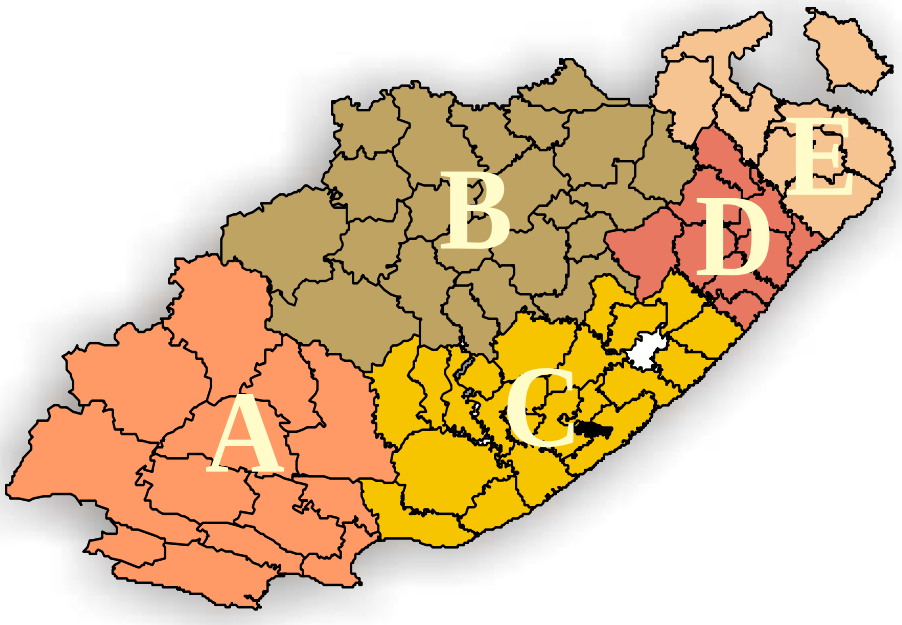
BACKGROUND

Many hospital boards were established when provinces were larger and there were so-called “independent states”. Primary health care (PHC) was not comprehensive and integrated within a district health service, and boards were not always representative of the population of the catchment area of the hospital. Modes of operation were established and board members often served for long periods. Numerous changes have occurred in the last eight years with new attitudes to patient rights, new more decentralised management and a more precise concept of PHC and the services which should be rendered at different levels of care. There is thus a need to assist these changes.

Interest in hospital boards now centres around developing their role in community involvement in health and also in their role in participatory governance of the district hospital and improvement of quality of care. These three elements are basic to the development of PHC within a district health system where the district hospital is an important component.

Hospital boards enable community involvement and participation. The government's aim of achieving involvement of communities is for them to become partners in developing their own health services. This is shown in the formation of a board consisting largely of representatives of community organisations. The emphasis on community participation is, however, seen in the contribution in time, labour and governance of members serving on the board. Community members serving on a voluntary basis are now able to foster activities together with hospital management, which meet community needs. At the same time many of the board members are also actively involved in their community organisation’s activities.

Map of the
Eastern Cape Province



THE NEED FOR COMMUNITY REPRESENTATION ON A HOSPITAL BOARD

Community members are needed to be advocates for the needs and feelings of the communities. They must be involved in the hospital strategies and policies and guide the management on decisions which affect the health and welfare of their communities. It is through community representation on hospital boards and their guidance that new policies can be formulated which reflect community needs.

The functions of community representatives on a board are to:

- advocate for community needs and interests
- ensure quality of service
- participate in the strategic planning process of the hospital
- consult with communities and provide feedback on progress
- monitor income and expenditure and seek funds where and when this is indicated
- assist in the resolution of problems and complaints of either the public or the staff.

Their role is thus advisory and supportive and, as assistants to the hospital board, makes them one element of governance of the hospital.

Community Interests

Hospital board community representatives might work towards meeting what the communities would like from the hospital. The following community expectations were gathered from discussions in four districts and were expressed by community representatives.

- *A quick and efficient service especially for seriously ill outpatients and cases referred by vehicle.*
- *Good quality care.*
- *Services which are convenient for family needs such as visiting hours, help with arrangements for delivery of bodies of deceased relatives, convenient time of discharge after childbirth with baby on breast.*
- *Assurance public money is well spent.*
- *Satisfaction with treatment, food, cleanliness.*
- *A happy service and environment.*
- *Reports sent back to the clinic, which referred the patients.*
- *Second opinion and further referral if needed.*
- *Safe – no theft, danger, other infections.*
- *Public and patients are kept informed on health matters.*
- *No problems of getting back home if referred on to another hospital.*
- *Community is encouraged to help, eg, playing with children in ward, helping with fund raising.*
- *Patients are discharged when well and not just to be readmitted again after a few days.*
- *Family members have somewhere to sit while watching over someone critically ill.*
- *There are facilities for children's play and for schooling (preschool type) for long-term children (eg, tuberculous meningitis).*
- *The hospital can occasionally provide small petty cash assistance for emergencies eg, getting a body home, or missed bus.*
- *Not to have patient transport (Metro) overbooked so patients are omitted and told to try again next week.*
- *The hospital board will report health issues back to the community.*
- *The hospital will not deteriorate in services, in buildings and equipment.*
- *The hospital board will help to raise funds to keep things moving.*

From the above list of interests it is clear the following six components are the most important:

- The conditions prevailing in the hospital.
  - The atmosphere of happiness (which is probably related to staff morale)
  - Safety for themselves or family
  - Openness of hospital for relatives visits; participation in care of children
  - Food, cleanliness, the environment and hospital grounds.
- The quality of care so that patients really get better.
- The link with the clinic and referral to hospital and back referral of information.
- Finance: is the money allocated well spent and can the hospital raise more money?
- Concern about critical times such as admission, discharge and deaths.
- The ability of the hospital to inform communities about health.

These are then the areas where hospital boards could help management by providing support and advice.

Barkley East Hospital grounds: "Large grounds can pose a problem"

APPOINTMENT TO THE HOSPITAL BOARD

Membership of the Board will be representative of the local community with appointment methods and selection based on the needs of the board, individual ability, objectivity and fairness and the need to redress imbalances of the past with broad representation. Appointments will be for 2 years and will be staggered to ensure continuity.

Individual nomination by different forums or committees will be submitted to the MEC for consideration for appointment. A letter from the community organisation which nominates a member, should be sent to the MEC for ratification of appointment. Nomination will be by existing forums eg, Community Development Forum, Community Health Committees, Community-Based Organisations, Non-Government Organisations or Civics. Technical experts will be nominated by the public, Provincial Health Administration (PHA) and National Professional Associations.

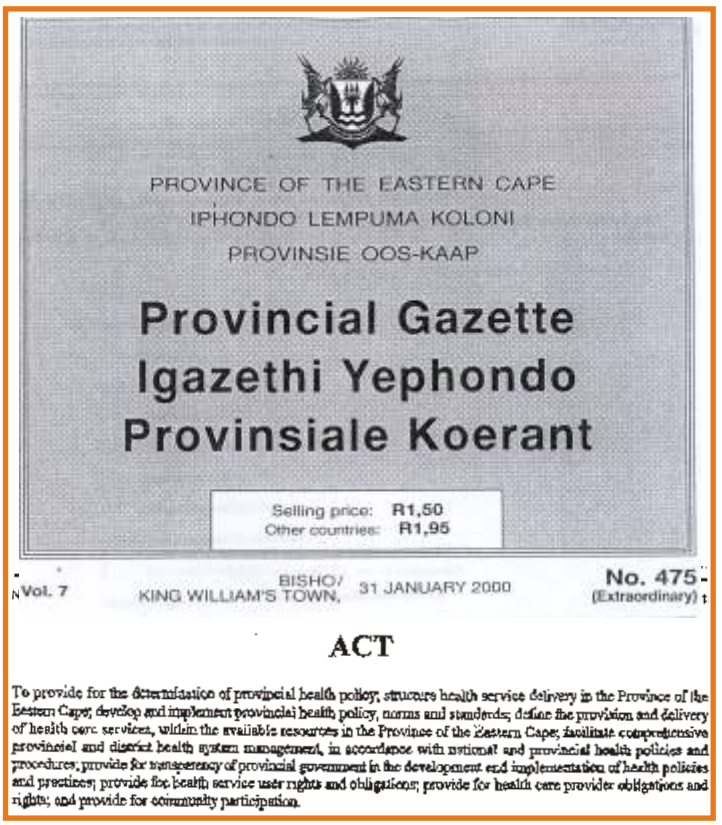
Local councillors or members of legislature will be nominated by local council or provincial cabinet. Ex-officio (non voting) members will be nominated by the PHA or Hospital management or Hospital staff. The chairperson will be appointed by the MEC after nomination by board members.

Members will be nominated from the districts served by the hospital through its referral system.

Duly appointed board members will only be entitled to remuneration for expenses for example travel at standard rates. All members of boards will submit within 30 days of appointment a written declaration of any or all financial or other interests, which are or could be related to, or in conflict with, such appointment.

These last two points must be made very clear to any prospective member of a board.

(See Chapter XVII of Eastern Cape Provincial Health Act 1999).



PROVINCE OF THE EASTERN CAPE
IPHONDO LEMPUMA KOLONI
PROVINSIE OOS-KAAP

Provincial Gazette
Igazethi Yephondo
Provinsiale Koerant

Selling price: R1,50
Other countries: R1,95

Vol. 7 BISHO/ KING WILLIAM'S TOWN, 31 JANUARY 2000 No. 475 (Extraordinary)

ACT

To provide for the decentralisation of provincial health policy; structure health service delivery in the Province of the Eastern Cape; develop and implement provincial health policy, norms and standards; define the provision and delivery of health care services, within the available resources in the Province of the Eastern Cape; facilitate comprehensive provincial and district health system management, in accordance with national and provincial health policies and procedures; provide for transparency of provincial government in the development and implementation of health policies and practices; provide for health service user rights and obligations; provide for health care provider obligations and rights; and provide for community participation.

COMPOSITION AND SIZE OF BOARDS

Size: 12- 20 probably on average 15 but depending on size of hospital and district.

Representatives to be selected from stakeholders

- Community Based Organisations
- Non-Government Organisations (eg, development, welfare, disability and health)
- Civic Organisation
- Community Health Committees (or "community/clinic committees")
- Youth Structures
- Religion Based Committees
- Local Councillors
- Locally based members of the Provincial Legislation
- Legal/financial/business/welfare technical experts
- Hospital Management (ex officio non-voting)
- School Governing Bodies
- Unions such as NEHAWU, DENOSA, HOSPERSA, etc. (ex officio if on hospital staff)

Sub-committees can be formed eg, on research, finance, evaluation or training etc.

At least 50% of the board members must be representatives drawn from the communities in the catchment area of the hospital. Members are not to represent political parties; they are selected for service to community interests.

An executive consisting of the Chairperson (who must represent the community) vice chair, secretary, vice-secretary and treasurer should be elected from the board.

(The members and executive of the board will be agreed upon by the MEC.)

Certain non-voting members can be co-opted for specific purposes (eg, security/police person, a health promotion Information, Education and Communication (IEC) specialist and infection control nurse).

Part of a hospitals catchment area (Makana)

THE PROBLEMS WHICH HAVE TO BE OVERCOME IN OBTAINING SUITABLE COMMUNITY REPRESENTATIVES

These were described as early as 1996 by the National Progressive Primary Health Care Network in a paper on community involvement in hospitals for the Hospital Strategy Project.

Lack of information and hence lack of interest on part of communities

Lack of information regarding hospitals is still present but is being improved due to a steady flow of revelations in the press on the problems and management in hospitals. Communities are aware of community health committees in relation to clinics and of health fora in some towns and districts but there is less knowledge of hospital boards or of the role they could play.

This has been observed where existing hospital boards with predominantly white membership claim that numerous requests for nominations have not been heeded. Perhaps this has occurred because the board's role has not been explained except for emphasising that there is no remuneration. Also the prospects of initiating change in an ageing board, which has become set in its ways and membership, might not be inviting. The meetings, which take place at the hospital in a formerly white area far from the black communities, are not easy to attend.

Recommendations include:

- Discussions on need for community representatives on hospital board in isiXhosa (or any local national language) at SANCO, Health Forum, Chiefs' meetings and other community gatherings by isiXhosa speaking board members or community health committee member or HOSPERSA, DENOSA or other union members (or use Afrikaans/isiXhosa in coloured communities).
- Alternating the venues of hospital board meetings from hospital to community or church hall.
- Using local press or radio in isiXhosa, Afrikaans, S.Sotho, and English to build public awareness.

Hospital staff through professional training have or are developing a social distance from the communities

Some staff might not be perceived as belonging to the communities which they serve and, if on the management of the hospital, they are not necessarily seen as being community oriented. This could put the hospital and its board at a distance (social as well as geographic) from the communities and consequently the district.

Recommendations

- Reorientation of staff board members and community through more open days, joint community/health staff activities such as World Health days (AIDS, Diabetes, Hypertension, etc).
- Discussions with staff, board and community members of district maps, population distribution, community based organisations,

district health information, movement patterns, and visits to different communities (shack areas, farms, villages). Opportunities to meet community leaders, women and youth. Board and hospital staff to go on mobile clinic tours.

Over politicisation and unionisation of attempts to get good board representation and over representation on board

Recommendations

- Political representatives eg, councillors and politicians make good board members if they wear their community hats and not their political hats. They should not be a majority.
- Hospital staff who are union members can be ex officio non-voting members of the board. A union member from elsewhere within the catchment area of the hospital eg, from COSATU or NEHAWU from a clinic could be on a board.
- Within a hospital there are many unions so there would be an imbalance if all were on the board; an overall union should select a small number of ex officio representatives.

Hospital boards have meetings which combine community and management representatives and either element might dominate proceedings

Their relationship is often not understood. This is especially true where there are language in educational and socio-economic differences between the two.

Recommendations

- There should be a training programme in a suitable language for all to develop the same view of the board's functional role especially in relation to a community and district needs.
- Team building should be one of the objectives of any training programme.
- The Chair of the hospital board must be from the community and should ensure there is no marginalisation of members from the community.
- Printed materials should be translated if not understood by several members.

Communities might not have strong organisations/structures which can nominate suitable representatives for the hospital board

Recommendation

- To ensure adequate representation of age, sex and ethnic groups attempts must be made to involve civic, council, community based organisations, different sectors, youth organisations, women's organisations and faith-based organisations.

Densely populated informal settlements might not have representatives from the same economic level as the majority

Recommendations

- Members of the board volunteer their services and do not get paid; reimbursement of expenditure on travel should be available for those using taxis.

- Hospital transport can often be made available to fetch members coming for meetings from outlying areas.
- Hours of meetings and venue should be considered so that those coming from disadvantaged areas are able to participate regularly.

Hospital board members usually have very different backgrounds and levels of awareness of the health services of a district. This is only to be expected if there is adequate representation of all communities and groups. Several languages might have to be used in a board meeting to ensure that all members have the same grasp of any issue discussed. Membership might include for example a university professor, a staff nurse from a clinic representing a union, a councillor, a police officer, a member of a youth club, the chairperson of a wome's development group.

Hospital Management Team

HOSPITAL BOARD MEMBERS' EXPECTATIONS FROM TRAINING WORKSHOPS

Besides practically setting the objectives of workshops, the usual workshop introductory session on expectations shows what board members need to make them more effective. The following list indicates the expectations:

- *To gain knowledge and thus empowerment.*
- *To be able to meet the needs of the community and the country.*
- *Enable us to become change agents towards better health.*
- *Be able to educate the community about health.*
- *Enable us to network with Non-Government Organisations (NGO) and Community Based Organisations (CBO)and have joint action for health.*
- *Find out methods to improve conditions and health care at the hospital.*
- *Work hand in hand with community and hospital board to improve the hospital.*
- *We expect hospital to have all equipment and machines to help the staff but want to know how to get things which are missing or not working.*
- *Expect to be able to get better staff (doctors).*
- *We will learn from each other for the benefit of patients and communities – share ideas.*
- *Expect to learn what role the hospital board will play.*
- *Help a district hospital to become "district friendly".*
- *Learn what is expected from a board – its functions.*
- *Find out how far to get involved within the hospital.*
- *Understand the involvement of hospital board with management.*
- *Find out method of operating as a board.*
- *The hospitals role in the district and the way to take this forward.*
- *What the shift to local government and new district boundaries mean.*
- *Will learn about finances and about staffing.*
- *Find out who are involved in the hospital board.*
- *What are the ordinances and regulations under which boards act – is there now an executive function?*
- *What is the relationship between chief executive officer, medical superintendent and board?*
- *What are the terms of reference for members and the board?*
- *Who should be represented and serve on board and how many?*
- *What is the part of the unions – where do they fit in?*
- *Expect training for board and management together.*
- *To understand new government policy on health matters.*
- *How can board contribute to running of the hospital?*
- *To understand why hospitals must have a board.*
- *What are the powers of the board?*
- *Learn boundaries of a board where it can work and where not.*
- *Duration of the hospital board.*
- *How hospital boards relate to each other in a health district or region.*
- *How do all these new participatory structures relate to each other?*
- *How is the catchment area of a hospital determined?*
- *How are referral routes between clinics and different level hospitals determined?*

Although many of these expectations are broadly similar, each has a particular slant. Together however, they show an interest in contributing to the health of communities and the district whilst at the same time defining their own role within the hospital, as well as defining the role of the hospital in the health services of the district.

To summarise, these expectations fall into eight areas which any workshop would have to address. These are:

- Knowledge which will lead to empowerment and the ability to become an agent for change.
- Discussion of community needs and how to provide education in relation to these needs.
- Networking with NGO and CBO and other sections eg, school governing bodies, welfare agencies, safety and security.
- Methods of improving hospital care, equipment and even staff.
- The board's role in work with hospital management and its accountability to the community.
- Details of roles and functions and activities usually required of boards.
- The district health system and the role of a district hospital.
- Legislation which governs the creation and work of hospital boards.

A hospital board training workshop (Cala)

EASTERN CAPE PROVINCIAL HEALTH ACT 1999

The 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 X1 - 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.

- **Chapter XII - Health Care Provider Obligations and Rights**
  The chapter deals with both obligations and rights of staff.

- **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.

- **Chapter XVII - District Health Councils, Community Health Committees, 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 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.

USE OF THE PROVINCIAL HEALTH ACT IN ORIENTATION OF HOSPITAL BOARDS

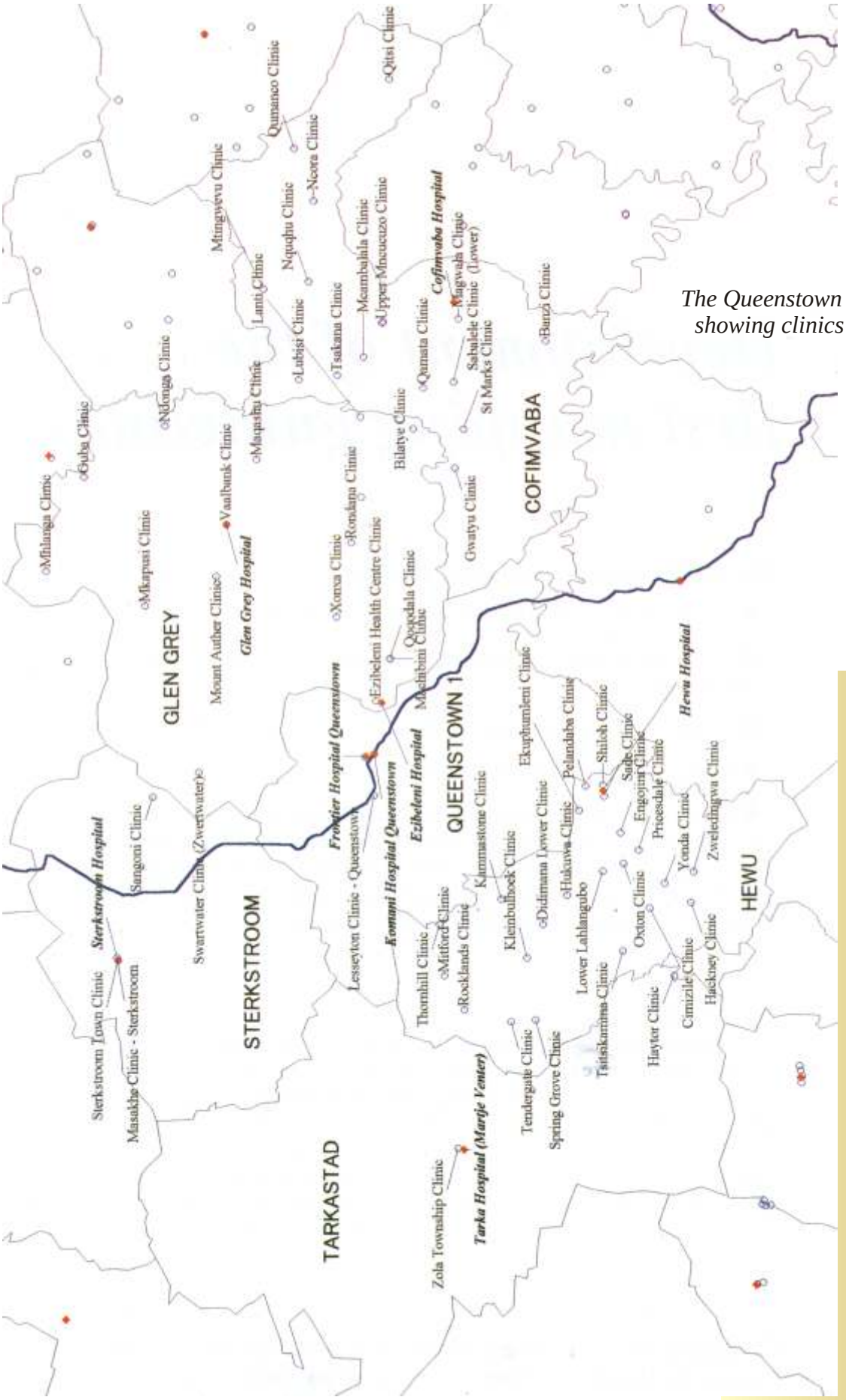
The content of the Provincial Health Act is broad and without detail . Each section can be used to give authority for more understandable descriptions supplemented by handouts, which could be translated into the languages used by board members (isiXhosa, English, Afrikaans, South Sotho). See annexures for ones covering the features of a district health system, a well functioning district hospital and various tools for assessing services. Copies of the National Patients Rights Charter are distributed (see list of handouts) and are easier to follow than Chapters XI and XII of the Act.

A chart or model of a Region and District Health service with levels of care and referral (and back referral) routes is useful. This should be supplemented by actual district and regional maps (and maps of the new demarcations) with all health facilities clinic, community health centres, district hospitals, regional hospitals, private hospitals and aided hospitals indicated. District and Regional Health Offices should also be shown. Words such as “integrated” and “comprehensive” health services have to be explained as it is largely the ex officio board members of the staff of a hospital who will already have knowledge of the changes in organisation and orientation of services which have occurred in the last few years. Previously preventive and curative services were separate but now they are integrated and a comprehensive service is provided.

Although the sequence of the Acts chapters is logical and provides a good background to the context of the hospital board, some members might not feel their demands for learning of their roles and power are being addressed. For this reason the Act has to be supplemented with more focussed discussion on terms of reference, governance, composition of board meetings, accountability and activities.

As much of what has been developed on these aspects is available in longer documents such as the Hospital Strategy Projects volumes and the NPPHCN document on community involvement in hospitals, it is necessary to extract ideas from these for shorter handouts for discussions. (See annexures).

Leadership in a community can be harnessed for health



The Queenstown Health District showing clinics and hospitals

THE DISTRICT HEALTH SYSTEM

Gilson, Balfour and Goosen in 1997 (Ref) gave a very clear picture of a well-functioning health district in South Africa.

"In the South African context a well-functioning health district is one that contributes to sustained health status improvements through the provision of equitable efficient technically good quality, acceptable, appropriate and affordable health care".

They list necessary inputs, processes and outputs to achieve this. These are given in full in a handout but those of special relevance to hospital boards are as follows :

Inputs

- Governance structures
- Clear legislative framework
- A clear understanding of District Health Systems and Primary Health Care concepts

Process

- Community participation in critical aspects of district planning and management
- Intersectoral collaboration in addressing district health problems

Outputs

- Hospital services oriented towards the support of the primary health care network
- Effective referral system
- Services co-ordinated with those of private providers
- A range of services that meets the districts health needs

Tombo TRC, TEBC
Clinic Complex, Port St Johns District

THE ROLE OF THE DISTRICT HOSPITAL

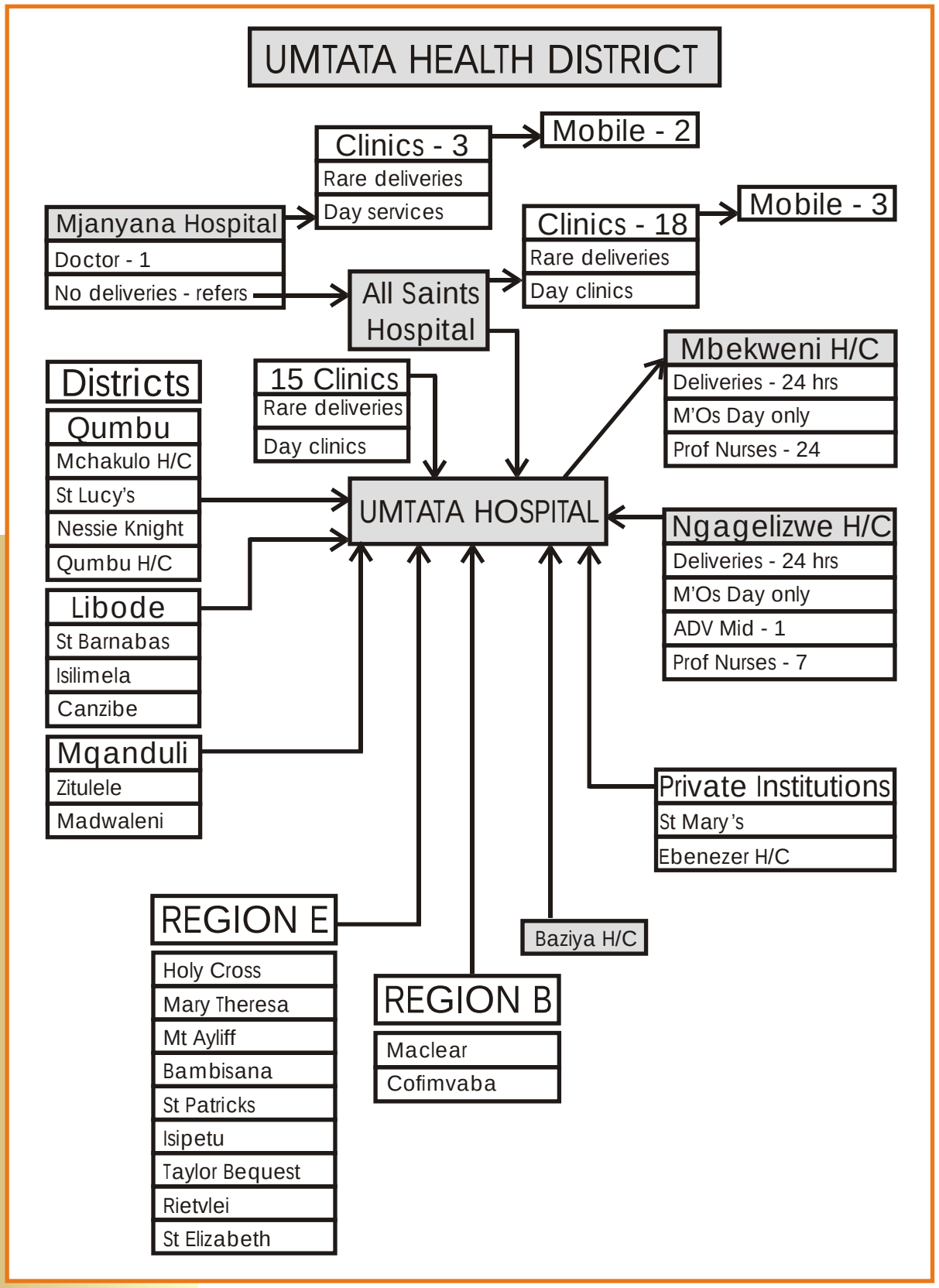
A handout on the features of a well-functioning district hospital (derived from the Initiative for Sub-District Support 1998) lists the following:

- *It must function as and consolidate an essential component of the health district.*
- *It must provide certain Level 1 hospital services that cannot be delivered at a clinic or community health centre.*
- *It will have the following clinical departments: emergency care, medicine, surgery, obstetrics, paediatrics, psychiatry and out patient services.*
- *It will provide a 24 hour service and will have more than 30 beds.*
- *It will provide in-service training and support to PHC services and facilities in the district.*
- *It will ensure the maintenance of good clinical standards in the district.*
- *It will be an integral part of all district health programmes.*
- *It will be staffed by general doctors who receive support from secondary and tertiary level hospitals.*
- *It will render primary level services to the surroundings population such as immunisation, growth monitoring and sexually transmitted infections (STI) treatment preferably through a separate PHC centre or outpatients department within the grounds of the hospital.*
- *It must have the capacity to interact with the community and with other sectors.*

The use of maps showing the centrality of the hospital in the referral system which is an essential element of the PHC approach will lead on to consideration of how to make the hospital a more interactive and friendly component of the district health systems. One of the problems here is that the system can become "hospicentric" as in some areas in the recent past. Clinics and health centres are distinct district levels of care, just as the hospital, but the three facilities must interact in many ways. To assist this concept a tool has been developed which the hospital board could complete with the hospital management (see 'A Tool Box for Hospital Boards',page 35 and Annex 1, 2 and 3). Annex 1 tool looks at elements within the hospital which can support district activities. There are also additional tools, Annex 2 and Annex 3, to evaluate the degree to which a district hospital provides support to the HIV/AIDS/STI, tuberculosis and maternal child and women's health district programmes.

Rietvlei Hospital ("Hospitaal")

Example of a map showing the centrality of the Umzimkulu District in the referral system



A TOUR OF THE HOSPITAL

At the end of the first day of the workshops for hospital boards it is useful to plan with management for a quick tour of the hospital the next morning with groups of 3-4 board members visiting different areas (wards, outpatients, casualty, maternity, domestic services, technical services, environment and incinerator) with a staff member as a guide. The purpose of this is to simulate in a small way a “visitors” inspection, which is one of the tasks for a board member between each meeting. The board members use their eyes, ears, and nose, and talk informally with staff and patients. They observe what is written on walls and in what languages and they see things for example, safety, security, fire prevention, and discuss issues as a group as they tour.

Done rapidly a tour could take 30 minutes and then members describe the notable findings in another 15 - 20 minutes. This will provide perhaps 10 issues, which need to be considered at subsequent board meetings. Examples have been lack of regularly checked fire extinguishers, no periodic fire drill, no hose for hydrants, smoking in the toilets; posters and instructions all in English only; lack of security; stores with no good locks and no inventory or records of contents; incinerator not working (for lack of a spare part) and medical waste just sent to local dumps; no patients rights charter poster and no complaints or suggestion box.

These issues immediately return the discussion to governance, and fund raising; what is the power of the board members to insist on a good complaints procedure?, how can funds be found for paying the security people who used to be there but now cannot be paid? If any funds are raised there is then the issue of accountability. The exercise has also brought into focus quality of care - so a tool which looks at how quality can be assessed by examining inputs, process and outcomes (Annex 1), was developed.

Similarly other tools have been evolved for patients to assess services on discharge by completing a form (similar to the one provided by many hotels) and for the board to help with the assessment of satisfaction (see “A Tool Box for Hospital Boards”, page 35).

GOVERNANCE AND ACCOUNTABILITY

These two terms are not always clear to board members. Workshops or training have to define them.

Governance

Oxford Dictionary	(noun) act, manner, fact, function of governing, sway, control
Groot Woordeboek	beheer, leiding, bestuur, gedrag
Xhosa Dictionary	(only govern) ulawulo
Fowler Modern English Usage	(archaism) now use government or control except in rhetorical or solemn context

The definition from Chapter 4 Final Report ofthe Hospital Strategy Project 1996, volume 3 is:

> *"Governance refers to the way in which control is exercised over hospitals and other health services, and the powers vested in the governing body, in this case the health authorities and district, provincial and national level, to exercise such control".*

These powers comprise:

- setting overall health policy;
- setting public health strategy;
- setting targets for and overseeing the performance of hospitals; and
- allocating funds to hospitals in return for a specified level of health service.

The governing authority takes final responsibility and has final authority for the health of the population under its jurisdiction.

Other bodies such as Hospital Boards or Community Health Committees (CHC) may have power to influence hospitals and other health services through recommendations and submissions. Hospital Boards and CHC, with the health authority, together comprise the total system of governance for health services in a particular area.

District Health Office, Humansdorp

The objectives of this system of governance over the public health services are to:

- promote effective provision of health services by providers;
- ensure public funds are used well;
- ensure services are consistent with national policy and promote equity of access;
- ensure health service providers meet targets of range and standards of service; and
- ensure services provided meet needs and priorities of communities.

Accountability

Oxford Dictionary	Accountable, bound to give account, responsible (for things, to persons)
Groot Woordeboek	Accountability, verantwoodelikheid, toerekensbaarheid
Xhosa	Accountability - unxulumelwano

The definition of the Final Report Hospital Strategy Report is: Accountability refers to the obligations of all tiers of the publically funded health system to account to the public for their actions and performance and for the actions of those bodies which fall under their governance.

A system of accountability is converse to the system of governance and has a two way flow:

- upwards from the lower levels of the health system to health authorities at District, Provincial and National levels and through them to elected representatives at each level; and
- latterly through Hospital Boards and other community representative committees to the communities who make use of the health services.

The objectives of an effective system of accountability are to:

- ensure those bodies who provide certain health services meet undertakings;
- ensure recipients of funds can account for use of funds;
- prevent risk of misallocation, squandering or misappropriation of funds; and
- ensure public health bodies are answerable not just to the health authority which allocated public funds but to public either indirectly through its elected representatives or directly through community accountability.

A District Health Management Team Meeting

FUNCTIONS OR TERMS OF REFERENCE OF HOSPITAL BOARDS

At workshops for hospital boards there are often requests for terms of reference of hospital boards "What do we actually do?" is the question. The Hospital Strategy Project (1996) Ref page 30, suggested that hospital boards be the statutory bodies which they now are. It outlined three primary objectives:

- "to support hospital management in meeting the greater burden of responsibility attached to increased delegated powers;
- to ensure that hospital management meets its obligations in terms of its performance agreement with the province; and
- to ensure that hospital management is responsive to community needs and views".

The functions listed in the above publication suggested, legislation to include;

- providing advice and support to the hospital management; management to manage and the board not to undermine its authority;
- provide guidance on management decisions that affect communities;
- provide a channel for complaints not adequately addressed by management and community. This includes regular inspections (see toolbox);
- review the budget and expenditure of the hospital on either a monthly or a quarterly basis;
- raise funds for the improvement of services or for hospital or community needs (see 'A Tool Box for Hospital Boards', page 35);
- act as an advocate for the hospital and its services (toolbox) both within the communities and with other stakeholders; and
- hold regular meetings with community to gather mandates and account back to them.

St Patrick's Hospital

As requests about functions often extend to more detailed information about “powers and functions” of hospital boards, the relevant section, 4.4.5 of Chapter 4, Governance and Accountability of the Hospital Strategy Project document is given as a handout. It is included as an example of training material (Annexe 1).

Besides the functions listed before, some hospital boards have included other activities. These include holding “open days” at the hospital, and taking part in campaigns (eg, World AIDS day or other programmes eg, for hypertension). Hospital boards might also be involved in negotiations on Public/Private Partnerships or on privatisation of certain hospital services such as security, grounds upkeep, laundry, and kitchen this latter being a sensitive issue which will require amicable working relations with the unions.

Hospital management is legally obliged to respond to requests, suggestions and advice of the board. In case of disputes, the district health manager or head of the hospital services in the Provincial Department of Health (or in the last recourse the MEC for Health) may be called on to resolve the dispute.

Hospital Boards must be concerned about health of children

THE FUNCTIONS OF OTHER COMMITTEES WHICH FACILITATE COMMUNITY INVOLVEMENT IN HEALTH

The Eastern Cape Provincial Health Act in Chapter XVII lists 5 types of committees and forums: District Health Councils, Community Health Committees, Hospital Boards, Advisory Committees and Forums.

Hospital Board members should know about these other committees as many of the roles and functions are similar. For this purpose the roles and functions of Community Health Committees often called "Clinic Health Committees" are described (box).

Community Group - local crafts as income generating project. (Imizizi Clinic)

Roles, functions and Activities of Community Health Committee:

- *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*
  - *ensuring opening and closing of clinic is punctual*
  - *ensuring 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 meeting.*
- *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.

ADDITIONAL ACTIVITIES OF HOSPITAL BOARDS

Each hospital board should develop its own:

- Vision
- Mission Statement
- Strategic Plan
- Operational Plan
- Constitution (toolbox)

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?

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

VISION

For the hospital board 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 is some direction". The direction of the board's eyes would be the future.*
- *"A prophetic apparition". This is what the board must do – it must prophesy and conjure up an image: what they will see – the hospital, the patients, the staff, the community, the district – as a result of their successful activities.*
- *"Foresight, wisdom in planning". The board's vision is to do with planning – it is the situation to which they wish to move.*

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.

MISSION STATEMENT

There might be some difficulty in first identifying whether the mission statement is to be that of the hospital board or of the hospital and its board.

A mission statement is about what an organisation does, for whom, and for what reasons. If the hospital already has a mission statement, this should be studied. Is the hospital mission what the board considers to be correct for the communities and their needs – as the board members know them? This should be a 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 hospital?*
- *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 6 months and change it as necessary.*

CONSTITUTION

The Draft Constitution given in the Department of Welfare's model documents (toolbox) 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*

Growth monitoring and promotion in the community clinic.

Community growth monitoring and promotion - to prevent cases of severe malnutrition from ever getting to a hospital.

FINANCES

Hospital boards need to have some members who are more skilled in financial matters eg, an accountant. There are also periodic needs for an auditor. In the best of cases the services may be free but possible changes have to be considered.

There are two different funds: hospital board's fund and hospital funds. The former are usually derived from various fund raising activities of the board. Hospital funds are provided by the tax payer via the provincial department of health. Both types of funds require auditing and accountability to the public or other sources from which they are derived, eg, a bequest.

At board meetings management usually provides a review of the hospitals monthly expenditure by each category for which there is a fixed budget. The board's responsibility is to scrutinise and, if needed, question the figures. Problems arise when, for example, there are no funds left for repair of the boiler. Is this a government responsibility or should the board try to raise funds for the needed spare part? A board will constantly have to work out its own policy and methods for dealing with problems. Another issue is rapid reimbursement of taxi fares to members attending a meeting. These funds, as stated in the Act, should be provided by Government.

Maintenance is a problem.

SUBCOMMITTEES

Hospital boards often have subcommittees which can be either of long duration or short-term for specific problems. Examples are:

- Quality assurance
- Training
- Fund raising
- Ethics
- Community campaigns
- Advocacy/public relations/information
- Conflict resolution/crisis management/complaints

ADDITIONAL TRAINING

Hospitals often have a need for additional training on, for example:

- Team building
- District health systems and new district and municipal health services
- Fund raising (toolbox)
- Effective meeting procedures
- Strategic and operational planning
- Comprehensive Primary Health Care
- Specific community health problems eg HIV/AIDS and TB

These training activities can often be arranged through the District Training co-ordinator. Occasional meeting between various hospital boards in a district could facilitate arrangements for joint workshops.

MODEL AGENDA FOR HOSPITAL BOARD MEETING

- Welcome and opening with faith observance
- Apologies
- Approval of minutes of previous meeting
- Matters arising from previous meeting
- Management report
- District manager's report
- Additions to agenda
- Board of survey report
- Official visitors report
- Staff changes to date
- Boards financial report
- Expenditure to date (hospital financial report)
- Additions
- Annexure
- Date next meeting
- Variable
  - Security report
  - Training report
  - Reports of subcommittees

Panorama of Hankey

TRAINING MATERIAL

Handouts used in workshops

1. 2 Day workshop programme

2. Eastern Cape Provincial Health Act 1999

3. A simple guide for hospital boards to assess quality of care (inputs, process, outcome/output)

4. Features of a well-functioning district hospital

5. Governance, a brief description of what it means in various languages and examples

6. Accountability, a brief description of what it means in various languages and examples.

7. Draft proposals for the governance of hospitals (preamble, functions or terms of reference, appointment and dissolution of hospital boards, composition, meetings, duration, accountability, remuneration of board members, references)

8. Appointment to the hospital board and composition of boards

9. District friendly hospital checklist

10. Relationships between Hospital and District Primary Health Programmes (Checklist)

11. The goal for DHS development (from Gilson, Balfour and Goosen)

12. National Development of Health:
National Patients Rights Charter
Your Right to Dignity
Patients Rights (Private Bag X828 Pretoria 0001)
Pamphlet for Patients (Specify Language)

13. Powers and Functions of Hospital Boards (Section 4.5 for Chapter 4 Governance and Accountability from Hospital Strategy Report (See Annexe 1).

THE USE OF REFERENCES IN TRAINING

These can often be arranged through the District Training co-ordinator. Occasional meeting between various hospital boards in a district could facilitate arrangements for joint workshops.

There are many references useful for training workshops. The problem with these references is that board members are seldom able to wade through hundreds of papers of dense and often technical material. A facilitator should digest the material beforehand and then weave a distillate into discussion sessions.

It appears that boards in fact work out their own directions and interests and that every hospital board functions within its own realities.

The reference list which follows suggests documents that has proved useful on occasion. The Hospital Strategy document is often the document previously issued by the Provincial Department of Health to Hospitals for guidance. Section of this report on Powers and Functions of Hospital Boards is included as Annexe 1.

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- *Municipal Demarcation Act*
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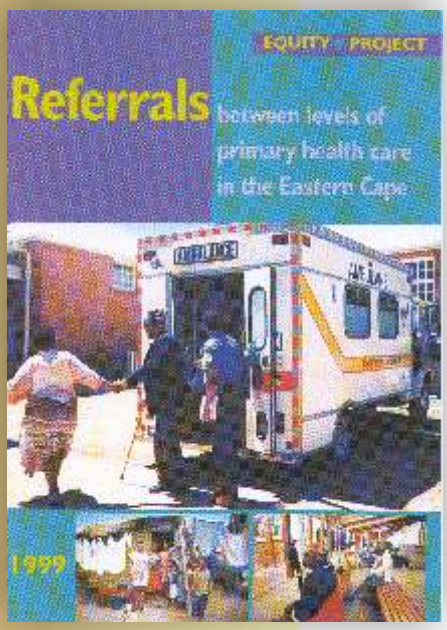

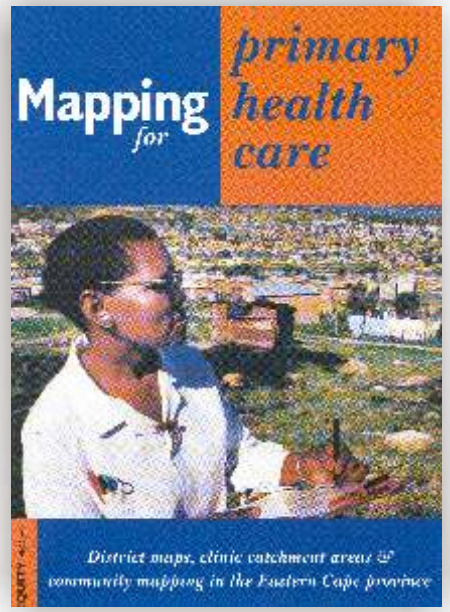

DEVELOPMENT AND USE OF TOOLS

Checklists have been developed for some aspects of hospital work and are attached.

A TOOL BOX FOR HOSPITAL BOARDS

1. A model constitution model documents and codes of good practice series No. 1 (Non-profit Organisations Act 1997).

2. Fundraising in Southern Africa Help yourself by Jill Ritchie and Owen Kinahan. 2nd Printing 1995 Papillon Press. PO Box 50676, Waterfront, 8002, Western Cape.

3. WHO/UNICEF Hospital Self Appraisal Tool for the WHO/UNICEF Baby Friendly Hospital Initiative. WHO/UNICEF August 1992

4. Department of National Health Directorate of Quality Assurance Core package of PHC Services for Metropolitan Councils.

5. Objective Assessment of High Priority Management and Clinical Functions for District Hospitals. Department of Health Eastern Cape Province 10/July/2000

6. ISDS and Health Systems Trust: Client Satisfaction Tool

7. EQUITY Project: District Friendly Hospital Checklist with sections on: HIV/AIDS, Tuberculosis, Maternal Child and Women's Health. November 2000 see Annex 1 and 2.

8. Council for Health Service Accreditation of Southern Africa Accreditation Programme. Standards for Hospitals. Sixth Edition 2000

9. John Hopkins School of Public Health Population Communication Services. "A" Frame for Advocacy. (Supplement to Population Reports No 49 Volume XVII No 2 July 1999

10. Provincial Draft Document: Complaints Procedure

11. Province Eastern Cape Provincial Gazette. Eastern Cape Provincial Health Act 1999 No 10 of 1999

12. EQUITY Pharmacy Checklist

POWERS AND FUNCTIONS OF HOSPITAL BOARDS

(From Chapter 4 Government and Accountability from Hospital Strategy Report)

In order to enable Boards to meet their objectives of advising hospital management, ensuring responsiveness to communities served, and overseeing hospital performance, the following powers and functions will be delegated to the Boards by the MEC in a staged process, according to the capacity of the Board to increase the scope of involvement:

Policy and Strategy

Assisting hospital management in:

- setting hospital policy appropriate for local application of provincial policy guidelines;
- ensuring equitable access to services for all community members;
- formulating strategy and drawing up plans for the hospital within the constraints of the hospital budget.

Advisory and Technical Support Roles

- provide expert advice and input to hospital management as requested;
- provide a visible presence at the hospital on a regular basis to build relations with the staff and gain an understanding of hospital working conditions;
- involvement in negotiating the performance agreement between hospital management and the PHA.

Oversight

- exercise the right of access to any information which may be required for the Board to exercise appropriate oversight of hospital performance;
- receive regular management reports on progress in meeting objectives;
- conduct regular inspection visits at the hospital;
- oversee the general service standards of the hospital;
- monitor decisions on the allocation of resources to ensure that they are used productively;
- monitor whether hospital management has acted on decisions taken at previous Board meetings.

Financial Review

- review financial statements on a monthly basis to ensure financial efficiency and probity;
- arrange for independent auditing of hospital financial statements on an annual basis, where feasible;
- submit regular financial statements and present an annual financial report to the PHA;
- approve the hospital budget prepared by the hospital management; and
- make recommendations to the MEC on financial matters.

Authorisation of Expenditure

Assist hospital management in:

- making recommendations to the province regarding hospital building and maintenance programmes;
- approving architectural plans for submission to the province;
- approving purchases of expensive equipment for submission to provincial tender procedures, where appropriate.

Staffing and Personnel Issues

- make recommendations to the MEC on the appointment of senior managers and clinicians after consultation with senior managers, staff representatives and other stakeholders;
- review hospital staffing practices to ensure fairness;
- assist the PHA in determining senior managers' performance bonuses
- assist hospital management and the PHA in conducting disciplinary proceedings and resolving disputes, were appropriate;
- assist hospital management in creating career development pathways for staff members;
- improve working conditions at the hospital through sponsorship of recreation facilities;
- recommend outstanding staff members for particular commendation by the MEC.

Community participation

- provide a channel for community views to be aired, in addition to those directly represented on the Board *inter alia* by means of open Board meetings; community media and focus groups, and surveys;
- ensure regular report-back meetings and the dissemination of information to the community through meetings and wide dissemination of annual reports;
- monitor the effectiveness of routine channels of communication between hospital management and the community;
- provide a forum to hear grievances of patients and the public at large;
- monitor the investigation and resolution of complaints;
- take an active interest in the welfare of patients and the development of an ethos of caring at all levels in the hospital;
- improve patient facilities, for example through sponsorship of TVs and libraries and advising management on the establishment of shops and other patient facilities.

Advocacy and Fundraising

- act as an advocate of hospital interests to the province and the public at large;
- build support for the hospital by fostering partnerships in the wider community;
- raise additional funds for the hospital;
- assist management in deploying these funds appropriately.

The powers and functions of Hospital Boards will be set out in clear terms of reference which also specify the reporting requirements of hospital management to Board and Board to MEC. In addition, the terms of reference will clarify the scope of Board interventions to ensure that the Board does not intervene unduly in the detailed day-to-day running of the hospital. The terms of reference will be agreed between the PHA and the Board in a memorandum of agreement, and require the endorsement of the MEC.

In order to function effectively, Board members will need to undergo specific training and induction programmes covering provincial health policy; local health priorities; the structures and functions of the hospital and the relationship between the hospital and other local or regional health services.

The functions listed above will apply to all Hospital Boards. However, specialist hospitals such as Psychiatric Hospitals may require additional functions on the part of the Board to meet specific needs.

DISTRICT FRIENDLY HOSPITAL CHECKLIST

Please tick [✓] appropriate box

1. COMMUNITY SERVICES

		YES	NO
1.1	Hospital knows its catchment area and catchment population		
1.2	Hospital has access to District Health Information Systems of clinics in area		
1.3	Members of community health committees are on hospital board		
1.4	Hospital interacts with all NGOs/CBO related to health		
1.5	Training of clinic staff continued and areas for training identified		
1.6	Arranges community outreach to workplace, schools, youth for peer education training and support		
1.7	Doctors visit clinics having determined which need most support		
1.8	Rehabilitation, physiotherapy, appliance support and outreach		
1.9	Hospital staff involved in campaigns in community		
1.10	Hospital data is analysed by age, sex, place, occupation and used in directing District Health Management Team's (DHMT) Programmes		
1.11	Some health education programmes develop and emanate from hospital		
1.12	Works with other sectors (eg police, welfare, education) in pinpointing areas of concern (eg, traffic accident, rape, malnourished children, HIV, Poverty)		
1.13	Liaison with DHMT through joint meetings		
1.14	Open days for women's groups, traditional healers		
1.15	Runs mobile to underserved areas		
1.16	Refresher course for private practitioners		
1.17	Mental health outreach service to clinics		
1.18	Oral health outreach service to clinics		
1.19	Participates in writing the annual district report with DHMT		
1.20	Responds to requests for seminars, workshops, visits by community leaders		
1.21	Estimates the percentage of its budget that is spent on PHC/Community		

2. TECHNICAL/MEDICAL SUPPORT SERVICES

		YES	NO
2.1	X-ray and laboratory results sent to clinics with good turnaround time		
2.2	Telephone information support availablefor staff at clinics		
2.3	Drug emergency supply available to assist clinic shortfall		
2.4	Assists in training of home-based carers in terminal care		
2.5	Provides waste disposal facilities by incineration for those accessible clinics		
2.6	Pharmacy can prepare bulk supply of drugs for clinics		
2.7	Participates in community health surveys and provides limited laboratory support		
2.8	Provide technical support for health installations, refrigerators and maintenance of small equipment (eg, sphygmomanometers)		
2.9	Can provide limited administrative and technical support to health centres and sub district hospitals.		
2.10	Responds to requests for research assistance from DHMT		

3. HOSPITAL SERVICES

		YES	NO
3.1	Referrals dealt with promptly especially the “third” delay concern for maternity emergencies		
3.2	Back referrals always sent with good detail and followed up by phone when indicated		
3.3	TB transfers done correctly with prior arrangement with clinic and DOTS support and follow-up by phone		
3.4	Children and women immunised in hospital with no missed opportunities		
3.5	Birth and death certificates recorded and analysed for DHMT		
3.6	Health education for all patients		
3.7	Arranges with home-based care services for transfer of AIDS patients back to their families		
3.8	Arranges visits from specialists from tertiary hospitals to obviate unnecessary out of district referrals		
3.9	Has spare accommodation for waiting pregnant mothers from district inaccessible villages		
3.10	Has arrangements for breastfeeding mothers to be with their babies		

RELATIONSHIPS BETWEEN HOSPITAL AND DISTRICT PRIORITY HEALTH PROGRAMMES

Although the District Friendly Hospital Checklist has a section on Hospital Services, it is useful to determine the relationship between the hospital and three priority health programmes which are:

- HIV/AIDS
- Tuberculosis
- Maternal Child and Women's Health

For each of these a more detailed checklist has been constructed. The District Hospital Board, which is accountable to the communities served by the hospital, should be aware of the importance of these three health programmes to their communities. As part of their governance function they could thus use the 3 checklists to supplement the District-Friendly checklist in reviewing the hospitals role in the district health PHC programme.

HIV/AIDS
THE HOSPITAL CONTRIBUTION TO THE CONTROL PROGRAMME

A hospital which contributes to the management and control of HIV/AIDS within its catchment area as the following characteristics and activities.

Please tick [✓] appropriate box

1. PREVENTATIVE ACTIVITIES

		YES	NO
Prevention of mother to child transmission of HIV			
1.1	There is a policy on voluntary testing and counselling (and on the preventive use of antiretroviral drugs) and on breastfeeding		
1.2	In the counselling for any testing done in the hospital preventive aspects are emphasised		
Information, Education and Communication for behaviour change			
1.3	Staff are willing and able to discuss life skills, sexuality and behaviour change with adolescents in OPD or wards		
1.4	Condoms and pamphlets on their use and on STI are available in outpatient departments and in all wards (even for visitors)		
1.5	A video programme on HIV/AIDS/STI/TB is available (Business organisation can be approached for funds) in outpatient departments waiting areas and for use for group discussions for patients		
1.6	The hospital staff participate in AIDS day activities and in Condom promotion week in the nearby towns		
1.7	There is a specific education programme on HIV/AIDS/STI in the women's ward, maternity ward and men's ward. If any NGOs dealing with HIV/AIDS are available they are requested to participate in such programmes		
1.8	Any doctors or nurses who visit clinics talk to young patients they see about behaviour change to prevent HIV		
Correct Management of STI			
1.9	Treatment and management of STI in outpatients, or inpatients is		
1.9.1	Done according to the syndromic management protocol		
1.9.2	Contact slips		
1.9.3	Condoms are always provided		
1.9.4	Staff are friendly to all and especially to adolescents and sex workers		
1.9.5	Have had training in values clarification		
Prevention of transmission by needle stick and contact with blood and body fluids			
1.10	The infection control nurse checks		
1.10.1	Injection technique and disposal of sharps		
1.10.2	Use of protective clothing and gloves during procedures such as childbirth		
1.10.3	Staff disposing of material use hazard labelled bags		
1.10.4	Domestic staff are given training by the infection control nurse and are issued with necessary protective clothing and gloves		
Prevention of transmission by transfusion			
1.11	The hospital will get its blood from the transfusion service which takes as much precaution as is possible to prevent transmission of HIV and hepatitis. However there is still always a window period of ± 8 days with the newer and existing tests. This implies that the hospital must take all possible steps to limit transfusion		
1.11.1	Which must be reviewed by senior staff monthly.		
1.11.2	The hospital has a policy document on blood transfusion		
1.11.3	Preparations for auto transfusion cold cases on waiting lists		

HIV/AIDS
THE HOSPITAL CONTRIBUTION TO THE CONTROL PROGRAMME

A hospital which contributes to the management and control of HIV/AIDS within its catchment area has the following characteristics and activities.

Please tick [✓] appropriate box

2. CARE AND MANAGEMENT OF HIV/AIDS

		YES	NO
	The hospital is particularly concerned about		
2.1	Confidentiality of information on tests and clinical findings, diagnoses and patient records		
2.2	All staff are reminded of human rights and of the legal repercussions of breaches of confidentiality		
2.3	Patients are also aware of their rights to confidentiality		
	Staff receive periodic training on		
2.4	Attitudes, body language		
2.5	The dignity of patients		
2.6	Terminal care		
	HIV positive patients (known or suspected) are treated		
2.7	Holistically with attention to their social, physical, emotional and spiritual needs		
2.8	The hospital welcomes visitors who contribute to this but is firm with those who disturb patients		
	There is a policy on who should be in the hospital with HIV/AIDS and for how long		
2.9	Minor complaints can be treated as outpatients		
2.10	Terminal patients can be transferred to home-based care so that the hospital does not become a terminal care hospice		
	Transfer to home-based care		
2.11	Patients are encouraged to die at home but the necessary arrangements are made with home carers.		
2.12	Staff are assigned to the role of home-care supporters that is they assist and support the family-based carers.		
	Linkage with social workers and NGOs		
2.13	The hospital becomes a node in the network of care in the district. It has links with		
2.13.1	Social workers		
2.13.2	NGOs that assist the patient and the family in meeting the challenges of disablement, death and changes in economic status.		
	Meetings with District Health Management Team		
2.14	The infection control nurse of the hospital participates in District meetings (eg, "HAST") to ensure the hospital is a part of the District HIV/AIDS control programme		
	Management of patients living with HIV		
2.15	Known patients who are HIV positive or those suspected of being so need advice on health living and the hospital also does this routinely for all		
2.15.1	Pregnant women		
2.15.2	TB		
2.15.3	STI patients		
2.16	Opportunistic infections causing neurological symptoms or neoplasms or other serious infections in HIV positive patients are		
2.16.1	Referred to higher level hospitals		
2.16.2	With due attention to confidentiality		

HIV/AIDS
THE HOSPITAL CONTRIBUTION TO THE CONTROL PROGRAMME

A hospital which contributes to the management and control of HIV/AIDS within its catchment area has the following characteristics and activities.

Please tick [✓] appropriate box

CARE AND MANAGEMENT OF HIV/AIDS - continued

		YES	NO
2.1	There is a hospital policy on		
2.1.1	Management of HIV positive pregnant women		
2.1.2	and HIV positive infants and children for example on prophylactic cotrimoxazole		
2.2	Guidelines on management of HIV in children are available in		
2.2.1	Outpatient department		
2.2.2	Maternal and children wards		
2.3	Infants who are born to HIV positive mothers are immunised after birth for		
2.3.1	Polio		
2.3.2	TB		
2.4	Infants in wards have their immunisation		
2.4.1	Checked and are given any immunisations needed		
2.4.2	Except for BGG to children with AIDS		

Policy on HIV infected staff

2.5	The AIDS and Employment Legislation is prominently listed and confidentiality enforced.		
2.5.1	The needle stick injuries are dealt with according to a protocol which is known to all staff		
2.5.2	All data are recorded in case of claims for workmen compensation		
2.6	Hospital staff transferred to clinics are given the same support if they become HIV positive		

TUBERCULOSIS
EFFICIENT HOSPITAL

A hospital which contributes efficiently to the management and control of Tuberculosis (TB) has the following characteristics:

Please tick [✓] appropriate box

		YES	NO
1.	The hospital is part of the tuberculosis control programme of the Province and the district		
1.1	The hospital realises the priority given to tuberculosis control in the Province and ensures that its management of patients with tuberculosis links them into the Provincial control programme		
1.2	Consequently the National TB programme protocols for tuberculosis are all available in the hospital and are used by all staff. These include: Year 2000 Standard Treatment Guidelines, Tuberculosis Management, Eastern Cape Drug Formularies, MDR guidelines		
2.	National Tuberculosis Control Programme Diagnostic and Management Guidelines are followed		
2.1	The diagnosis of Tuberculosis is made essentially on the identification of the M.tuberculosis bacillus whether this be by sputum smear or culture of by identification elsewhere		
2.2	X-rays and clinical findings and tuberculosis skin tests are seldom the sole basis for diagnosis. Staff are aware of the diagnostic problems now associated with concurrent HIV infection		
2.3	Diagnosis of TB in the absence of identifying the M.tuberculosis is preferably done by consensus, discussion between several doctors and is not the result of a clinical treatment trial		
2.4	The hospital has a clear policy on 7 day treatment regimes for adult TB and on 5 or 7 day treatment for children		
3.	All TB cases are notified		
3.1	All cases are notified using the notification form and this is sent with copies to the District Health Manager and TB co-ordinator, to the local authority		
4.	There is full involvement with the local TB Control Team		
	Linkages are established with the		
4.1	District TB coordinator		
4.2	Other hospitals (especially SANTA) and the District Health Manager		
4.3	Local authority staff concerned with follow up of patients in clinics and communities. These include periodic meetings, phone and fax communication		
4.4	If there is a District HAST committee the hospital sends a representative, usually the Infection Control Nurse		
5.	A referral protocol for TB patients has been developed and is used consistently		
5.1	There is a protocol for referral/transfer which is adhered to strictly		
5.2	All the correct forms are filled in completely		
5.3	Clinics to which a patient is transferred are notified through the form and by phone and by post as well if needed		
5.4	Arrangement prior to discharge are made through the clinic for a DOTS supporter		
5.5	Patients are discharged with drug treatment in a quantity which has been arranged with the clinic		
5.6	Patients will be aware where their sputum will be next examined and all results will be entered in the clinic register		
5.7	All transfers/referrals are notified to the District TB coordinator who thus has a duty to ensure the patient continues drug treatment and is not lost		

TUBERCULOSIS
EFFICIENT HOSPITAL

A hospital which contributes efficiently to the management and control of Tuberculosis (TB) has the following characteristics:

Please tick [✓] appropriate box

		YES	NO
5.8	It must be made clear who is responsible for the patients' treatment monitoring and care after discharge the gateway clinic or the community clinic		
6.	The Hospital Board is concerned about TB and its consequences for the communities		
6.1	The Hospital Board has as one of its special concerns the welfare and efficient management of TB patients		
6.2	Reviews every 6 months the outcome of all those admitted		
7.	Other facilities and key workers in the district and sub-districts are supported		
7.1	The hospital consolidates its interest in the TB programme by maintaining a buffer supply of TB drugs and sputum jars and TB examination lab material to supply clinics which run short		
7.2	Use is made of clinic information system to confirm this problem		
7.3	Transport under the hospitals control is used judiciously to support the priority TB programme when there are transport problems. Eg patients are taken to clinics on termination of the hospital stage of treatment, drugs are delivered to clinics when needed urgently and supervisors who have to supervise TB in clinics are helped if they have no transport		
8.	The Hospital TB Management is monitored		
8.1	Every month the District TB coordinator visits the hospital to check on the correctness of the treatment regimes and to hold discussions with doctors especially any new doctors. The coordinator also enquires about how patients are admitted who refers, how, why, with what forms, lab and x-ray reports etc		
8.2	Problems revealed by this check are followed through to prevent their future repetition (eg from private practitioners)		
9.	Arrangements are made for contact tracing		
9.1	All cases treated in hospital have contacts and children under 5 reviewed		
9.2	This being done either through the clinics and their community health committees or through visiting relatives, or by home visits by local authority staff or EHO		
10.	The Hospital ensures that TB patients are treated at the correct facility level		
10.1	The infection control nurse of the hospital maintains a Hospital TB register which besides the usual indicators will specify the reasons for being treated in hospital and not at clinic or community level. EG staff member on outpatient department DOTS, too ill and needs hospital bed, retreatment case unable to visit clinic daily for streptomycin injection, or chronic recurrent defaulter.		
11.	All hospital TB patients receive social support when warranted		
11.1	The hospital works with the local social worker to ensure that those patients with severe disability, as certified by the doctor, obtain a disability grant		
12.	Nosocomial TB infection is minimized for staff and patients		
12.1	The hospital has a clear policy on the provision of preventive treatment for staff and patients		
12.2	Staff who are HIV pos and shown not to be active TB are provided with preventive INH and cotrimoxazole and are not allowed to work in wards with sputum positive TB cases		
12.3	Cases with multiple drug resistant (MDR) bacilli are transferred to designated MDR wards or hospitals		
12.4	Laboratory staff are supervised regularly to ensure their work does not cause transmission		
12.5	The infection control nurse has done a course on Tuberculosis		

1. OUTPATIENT CARE

Please tick [✓] appropriate box

		YES	NO
	The outpatient MCWH activities under PHC include:		
1.1	Routine antenatal care (by professional nurse midwife)		
1.2	Routine young child preventive and promotive care (growth monitoring and promotion of growth, immunisation, vitamin A and deworming)		
1.3	Routine integrated management of childhood illness		
1.4	Routine postnatal care		
1.5	Routine family planning service		
1.6	Screening and referral to doctors		
1.7	All of these services are provided at a "gateway clinic" which might be outside the hospital building or inside but managed by professional nurses		
1.8	These gateway activities should be comprehensive eg family planning clients should get management of STI if needed		
1.9	Pregnant women should be immunised and have blood taken for:		
1.9.1	RPR tests		
1.9.2	Haemoglobin		
1.9.3	Voluntary rapid HIV testing be available with counselling		
1.10	These PHC components of hospital OPD MCWH should be models of PHC for clinics		

2. REFERRED MCWH OUTPATIENTS

2.1	Patients are referred by professional nurses or doctors in clinics to doctors and to specialists if available and are seen free of charge		
2.2	If they by-pass a professional nurse (at a clinic or in a gateway) they pay		
2.3	All MCWH patients seen by doctors in the hospital outpatients are charged if not referred by a professional nurse (or by a doctor at a clinic)		
2.4	Doctors in outpatients use the Standard Treatment Guidelines and drugs for Adults and Children		
2.5	Back referral letters are written to the clinics referring and these letters explain in detail the findings, special investigations, treatment and follow-up required		

3. ADMISSIONS FROM HOSPITAL OUTPATIENTS

3.1	Information on admission is relayed back to referring clinics. This is done either by a letter sent with an accompanying relative or carer or by telephone if possible		
3.2	On discharge information is sent to the referring clinic either as a		
3.2.1	Back referral letter or		
3.2.2	As detailed notes in the patient held card and can be		
3.2.3	Followed by a phone call		
3.3	Infants with severe malnutrition are fast tracked to the ward for the essential steps		
3.4	The ward have the protocol on management of severe malnutrition		
3.5	All children under 5 admitted have weights plotted on admission and discharge		
3.6	Births or deaths are notified and		
3.7	Copied to the District Health Management Team		

4. EMERGENCY ADMISSIONS

4.1	The third delay is minimised, that is, the time from arrival to the time of receiving treatment		
4.2	Times are noted on the record		
4.3	Women in labour have a fast tracked entrance to the labour suite		
4.4	Domestic violence is managed by a team including a social worker, and counsellor (and police if needed)		
4.5	Rape is managed according to the National Health Department protocol		

MATERNAL CHILD AND WOMEN'S HEALTH

The hospitals contribution to the MCWH programme

Please tick [✓] appropriate box

5. THE HOSPITAL ROLE IN COMMUNITY EDUCATION

Within all the hospital areas outpatient and inpatient an effort is made to educate every woman or mother on:

		YES	NO
5.1	The need for women 30 years and over and with 5 or more children to know and use contraceptives		
5.2	The need for HIV positive women to know and use contraceptives including condoms		
5.3	The warning/danger signs in pregnancy		
5.4	The mode of referral		
5.5	The need for regular attendance at antenatal clinics, and young child clinics		
5.6	The importance of immunisation and growth monitoring and promotion		
5.7	The confidentiality of HIV testing and counselling		
5.8	All staff visiting clinics should also review the amount of education given to patients and communities		
5.9	The hospital board checks occasionally to ensure IEC materials are in appropriate language for their communities