PHC delivery in the Galeshewe Urban Renewal Site, Northern Cape

Mapping gaps in the maternal health, IMCI, TB, STIs, HIV/AIDS and EDL programmes

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CHAPTER 1

THE URBAN RENEWAL STRATEGY AND THE PHC PACKAGE

1. The Urban Renewal Strategy

The *Urban Renewal Strategy* (URS[1]) (along with the Integrated Rural Development Strategy) was established in 1999 as a means for all three spheres of government to work together in a coordinated manner in addressing urban (and rural) poverty. The URS was envisaged to include investment in economic and social infrastructure, human resource development, enterprise development, the enhancement of the development capacity of local government, poverty alleviation and the strengthening of the criminal justice system.[2] Galeshewe in the Northern Cape is one of eight[3] urban renewal sites (*'URSs'*) identified for implementation of the URS by the presidency and the government. Delivery of the URS is meant to occur through the new structures of local government, and through support of provincial government departments. According to the Department of Health (2002: 60) the government's launch of the Integrated Sustainable Rural Development Programme (ISRDP) and the URS has enriched and complemented the district approach to PHC. Within the Department the Rural and Urban Development component focuses on ensuring that different sectors work closely together in the districts that have been prioritised as development nodes. It is a stated objective of the Department of Health (2002: 60) to use priority PHC programmes (TB, EPI, IMCI and HIV/AIDS) as pillars for building the district health system (DHS) and to prioritise PHC services as the health sector's contribution to the ISDRP and the URS.

2. The PHC Service Package[4]

In 1999 the Department of Health reported that the first five years after the democratisation of South Africa were focussed largely on increasing access to health care. Henceforth, as stated in its *Health Sector Strategic Framework 1999-2004,* the Department would accelerate quality health service delivery, amongst others through *'the speeding up of an essential package of services through the [DHS]'* (one of a ten-point plan) (Department of Health 1999: 4). A mechanism was needed to define parameters for service delivery, as well as to ensure comparability in the rendering of services. Having taken years to research (in partnership with the provinces) this mechanism realised in the form of the PHC Service Package during 2000 (Department of Health 2001e). The Package entails a standardised, comprehensive *'basket'* of services that are to be delivered at primary care level. Beginning in April 2000 the Package would be implemented incrementally in all provinces, with 2004[5] set as the target for

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[1] Also referred to as the Urban Renewal Programme (Department of Health 2002: 60).

[2] See MCA Urban and Environmental Planners (2001) for an overview of the *Urban Renewal Strategy*.

[3] The other URSs include Khayelitsha and Mitchell's Plain in the Western Cape, KwaMashu and Inanda in KwaZulu-Natal, Mdantsane and Motherwell in the Eastern Cape, and Alexandra Township in Gauteng.

[4] The service components described in the Package are expected to deal, as cost-effectively as possible, with the leading causes of mortality and morbidity in South Africa. It thus focuses in particular on the following (Department of Health, 2001b: 7): child health (in particular infectious diseases), STDs and HIV/AIDS, TB, reproductive health (ANC, family planning and maternity), mental health, chronic diseases (hypertension, diabetes and asthma), disabilities, trauma and injuries.

[5] While the Minister of Health in Department of Health (2001a: 2) targets 2004 for reaching *all* stated standards, Department of Health (2001b) targets respectively end of 2001, end of 2002 and end of 2005 for the provision of specified service components.

full provision and availability of the Package in *all* PHC facilities. The Department of Health (2001e: 40) viewed the development of the Package as a huge advance towards the standardisation of health care on an equitable basis.[6]

The *Primary Health Care Package* was (officially) published in 2001. Two documents were made available simultaneously: *The primary health care package for South Africa – A set of norms and standards* (Department of Health 2001a) and *A comprehensive primary health care service package for South Africa* (Department of Health 2001b). While, as its title denotes, the former is concerned with service norms and standards for respectively PHC clinics (Part 1) and for community-based, clinic-initiated services (Part 2), the latter lists service components and target dates for their implementation (date by when the component shall have been introduced and be in place) for district/community-based services, personal community-based services, and mobile/fixed clinics (distinguishing between services for adults, services as part of the 'fast queue' (repeats), and services offered by community health centres (CHCs). Because the two documents differ in terms of their internal structuring, their simultaneous and supposed complementary use is sometimes difficult, although the Department of Health (2001e) took a different view: "[The two Package documents] *spell out with absolute clarity what services should be provided, what the corresponding staffing requirements are, and even the necessary equipment and drugs. There is a protocol specified for each of the core services listed.*"

- **Core norms of the Package**

Central to the Package is the set of norms and standards that provide direction for the rendering of health services at acceptable levels. The following ten *core norms* are applicable to all public PHC facilities (Department of Health 2001a: 12):

- Through a one-stop approach, the facility provides comprehensive integrated PHC services for a minimum of eight hours per day, five days a week.
- Access, as determined by the number of health care recipients living within five kilometres of the facility, is improved.
- The facility receives a supervisor visit at least once a month to assist staff, identify and prioritise needs and shortcomings, and monitor the quality of services.
- The staff component includes at least one service provider who has successfully completed a recognised PHC training course.
- Medical officers and other specialists undertake periodic visits and are accessible for support, consultation and referral.
- Facility managers undergo training in facilitation skills and PHC management.
- An annual evaluation of the rendering of PHC services is undertaken to reduce the gap between service provision and needs by means of a situation analysis of the health needs of the community, as well as through consultation of routine health information that is gathered at facility-level.
- An annual PHC strategy, based on the evaluation, is planned.
- The facility has a method to monitor services and quality assurance, while an audit of services is conducted at least once a year.

[6] It was originally intended to audit all local authorities to identify the gap between existing PHC services and the target as specified by the Package (Department of Health 2001e: 40).

- The perceptions and views of the community are assessed at least biannually by means of patient interviews or anonymous patient questionnaires.

❑ **Core standards for PHC services**

The *core standards* for PHC service provision amount to the presence of the following (Department of Health, 2001a:12-14):

- *References, prints and educational materials*, including standard treatment guidelines, the EDL manual, a mini library, appropriate national and provincial health circulars and policy documents, copies of the Patients' Charter, and supplies of health learning materials in local languages.
- *Equipment*, amongst others, a diagnostic set, blood pressure apparatus, adult and infant scales, a reliable means of communication, oxygen, refrigeration facilities, condom dispensers, a sharps disposal system, equipment and containers for taking blood and other samples, a sluice room and an adequate number of consulting rooms with wash basins.
- *Medicines and supplies*, especially those pertaining to the EDL, with a mechanism in place for the ordering and control of supplies, as well as available electricity and cold and warm water.
- *Competencies of health care providers*, amongst others, the ability to organise and run the facility, setting up of a system for referrals and feedback on referrals, and caring for patients through existing management protocols and standard treatment guidelines.
- *Patient education* where service providers are able to address community-based health problems in collaboration with health committees and community civic organisations, and IEC materials are displayed and made available at the facility.
- *Records*, specifically related to an integrated standard health information system that facilitates the collecting and utilisation of data, as well as ensuring that notifiable medical conditions are reported according to protocol and that the facility has a filing system that allows continuity of health care.
- *Community and home-based activities* in the form of a functioning community health committee, as well as through linkages with civic organisations, workplaces, education facilities and home-based care initiatives.
- *Referral* of patients to the next level of care whenever appropriate, including referral to social services, and ensuring that referrals within and outside the facility are recorded in relevant registers.
- *Collaboration on an intersectoral basis* with officials and service providers from social welfare, assistance and health-oriented civic organisations and workplaces.

❑ **Mapping the gaps in PHC service provisioning in Galeshewe**

Full implementation of the Package in any particular PHC facility would mean that that facility is offering comprehensive PHC services. Indeed this is the expectation of the national Department of Health as the first of the above-mentioned core norms of the Package refers to *'the clinic'* '(it) *renders comprehensive integrated PHC services using a one-stop approach for at least eight hours a day, five days a week'*.[7] Nevertheless, it may be argued that in its entirety

[7] By 2002, seemingly, the Department of Health (2002: 9) was reconsidering the notion of full implementation of the package at all PHC facilities: *"We remain committed to implementing a comprehensive package of care across clinics and health centres in all districts by 2004. However, we believe that a focused approach to quality of care in specific programmes will produce advances where a diffuse approach may fail."*

the current Package perhaps does not emphasise the expectation that individual clinics should be offering *'one-stop PHC services'* - the full ambit of PHC services as described in the Package - strongly enough. In practice, and as illustrated by the current study, while the full Package might be offered by the health district as a whole, the full Package is very often not offered by all individual facilities. Thus, here we are dealing with gaps between the expectation of the Package (and the Department of Health) and the actual implementation of PHC programmes and services by districts and by individual facilities.

However, individual PHC facilities do not take decisions about the scope of the services they offer all on their own. Rather, they are guided in this by the policies and decisions of provincial and district health authorities and managers. Individual PHC facilities also face an array of constraints limiting their ability to offer the full Package. As will also be shown in this report, the infrastructure and equipment[8] available to facilities, as well as the support they receive from managers, and, particularly, their staffing situations (numbers and training), very often pose serious challenges to the implementation of the Package. It is the degree of success PHC facilities (and thus provincial and district health authorities and PHC managers and workers) have achieved in overcoming such constraints that this study set out to determine.

The research problem, therefore, is described as the need to *'map the gaps'* in PHC service provisioning in Galeshewe, i.e. to measure to what extent the full basket of PHC services associated with maternal health, IMCI, TB, STIs, HIV/AIDS and EDL are offered by PHC facilities. Measurement of such gaps were based on the Package norms and standards as and where applicable to the PHC programmes under study, and as described in the standards in the Package and other policy documents of the Department of Health[9].

3. Galeshewe as an Urban Renewal Node[10]

- **Galeshewe township**

- Amalgamated with the City Council of Kimberley
- One of the oldest townships in South Africa having been established in the 1870s and achieving municipal status even before Soweto.
- Population of some 120 000[11] people (1996).
- Developed as a labour reservoir for the diamond mining industry.
- 65% unemployment – the employed are mostly semi- and unskilled labourers.
- 70% of population younger than 20 years – this implies high susceptibility to HIV/AIDS.
- Education levels are very low – only 7% matriculated.
- Social problems include substance (alcohol) abuse.
- Heavily reliant on Kimberley for economic activity.

[8] It is a stated five-year objective of the Department of Health (2002: 59) to define an essential equipment package for PHC and to equip clinics accordingly – this would benefit future studies of the current type.
[9] See list of references.
[10] Extracted from Nodal Reports: *Galeshewe Urban Renewal Node July 2002*.
[11] Total catchment population for the five PHC facilities in Galeshewe is indicated as 95 368.

- **Galeshewe Urban Renewal Strategy**

The Galeshewe URS currently accommodates eight development projects, none of which is directly driven by the health authorities or expressly linked to PHC clinics. Respectively the projects relate to the installation of a purified effluent network, eradication of the bucket sanitation system, a car wash project, the Galeshewe Activity Corridor (including housing and storm water upgrading), a cultural village for SMMEs, development of public open spaces, and a compost yard and recycling center. The total cost of these projects exceed R20 million and involve players such as Consolidated Municipal Infrastructure Programme (CMIP), Social Policy Model (SPM), Departments of Housing and Local Government and Economic Affairs, and the Human Settlement Redevelopment Programme. The programme is championed at the local and provincial levels by the Executive Mayor, the MEC of Housing and Local Government, and the Premier. Relationships between the political and technical applications of the programme are not yet very clear. To some degree the programme remains in the domain of the Department of Housing and Local Government and has not yet received priority attention in other provincial government departments, including that for Health. Structures for community involvement in the URS have yet to be established to ensure sustainability. Dedicated capacity to implement the URS remains a problem with only three people (two in the provincial Department of Housing and Local Government and only one person at local level) allocated to drive the programme. There is little or no evidence of various departments, including the provincial Department of Health, committing special resources to Galeshewe[12].

4. Research strategy and methodology

The current study is concerned with implementation of the broad URS as applied to public health care provision, and key primary health care (PHC) programmes in particular. So commissioned by the National Health Department and the Centers for Disease Control and Prevention, the Centre for Health Systems Research & Development in November 2002 undertook an assessment of the following key PHC programmes in Galeshewe: maternal health, Integrated Management of Childhood Illnesses (IMCI), tuberculosis (TB), sexually transmitted infections (STIs), HIV/AIDS and Essential Drug List (EDL)[13]. The research was authorised by and conducted in collaboration with the Northern Cape Department of Health, the district health authority (Directorate: Community services) and the Sol Plaatjie District Municipality.

- **Aims and objectives**

The broad aims of the research is to measure to what extent the full basket of PHC services associated with maternal health, IMCI, TB, STIs, HIV/AIDS and EDL are offered by PHC facilities in Galeshewe and to gain understanding of the constraints inhibiting the implementation of the Package.

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[12] Take note that nine of the 13 rural nodes forming part of the ISRDP are supported by the HST in implementing the Package by the appointment of facilitators in each node and thus qualify for European Union funding for district development for the period 2001 to 2003. These nine nodes specifically agreed to treat the implementation of the Package as 'anchor' projects for the ISRDP (Department of Health 2002: 60). In Galeshewe, as far as could be ascertained, PHC did not receive any attention as a component of the URS. In fact, most health managers and workers participating in the study for the first time learnt that Galeshewe is, in fact, an URS site.

[13] The malaria programme, although included in the overall research framework is reported on only in cases where URSs are in areas where malaria constitutes a serious public health threat.

Specific objectives of the research are

- to identify possible PHC delivery gaps in respect of the seven key PHC programmes as presented at all PHC facilities in Galeshewe
- to provide local, provincial and health authorities and managers with a reliable measurement of the status of the implementation of the Package in Galeshewe, and, thereby, to endeavour to facilitate planning and decision-making towards well-focused, quality and comprehensive PHC services in line with the expectations of the Package
- to produce an instrument and a methodology that in future also may be adopted for self-assessment by URSs and health districts

❑ **Focal areas of analysis**

The following aspects PHC service delivery were applied as cross-cutting dimensions in the analyses of the key PHC programmes as well as the individual PHC facilities under study in Galeshewe:

- Facility staffing and programme target populations
- Programme management
- Scope and accessibility of services
- Facility equipment
- Tests
- Drugs and supplies
- Protocols, registers, forms and maps
- Facility- and patient held records
- Referral practice
- Information, education and communication (IEC) material
- Community involvement and patient rights
- Key outcome indicators

❑ **Research methodology**

Broadly, the project strategy amounted to a three-pronged task:

- Development of a standardised set of indicators for each of the prioritised programmes/services, the measurement and capturing of which is to be on a single, comprehensive and user-friendly data collection instrument.
- Fieldwork exercises in all URSs during which information pertaining to the specified programmes is collected, collated, supplemented and verified.
- Facilitation of planning to rectify gaps in PHC service provisioning together with local PHC managers and suatrict information officers.

Galeshewe represented the pilot study area after an intensive consultation process to develop a comprehensive assessment instrument. Concerned programme managers at the national and provincial Departments of Health and various technical experts were requested to comment on a draft instrument developed against the background of the Primary Health Care Package and a broad spectrum of national and provincial PHC programme policy guidelines.

Based on the practical experience gained during the Galeshewe pilot, the instrument has since then repeatedly been revised. It is hoped that the instrument may in future be of use to PHC managers and district information officers to conduct routine assessments of their own.

- **Data collection**

Data collection took place in November 2002. Researchers worked in teams of two persons and were assisted and supported by the DIO. Care was taken not to interrupt the clinical functioning of the facility. Much time was, however, required of the facility managers to obtain all the information. This was especially the case where the coordination of all the programmes rested directly with the facility manager. On average it took two days of fieldwork to complete the data collection for each facility. On completion of the data collection the researchers held a one-day debriefing session to systematically discuss each focal area of the analysis and to supplement the instrument data with qualitative observations. Tape recording of this session took place to enhance the analysis of the data.

All five the public health facilities (four fixed clinics and one CHC) in Galeshewe providing PHC services were targeted for assessment. No mobile clinics operate in the area. Data collection took place according to the directives contained in the instrument, which specifies four data collection methods to be applied respectively to collect different types of information, namely through:

- interviewing facility managers
- interviewing key programme coordinators
- conducting physical observations in the facility
- capturing information off the computerised DHIS

- **Research feedback workshop - 6 February 2003**

On 6 February 2003 successful research feedback workshop was convened in Kimberley with stakeholder groups in and around the URS in the Northern Cape. Especially two groups attended the workshop. Firstly, officials at various levels in the employ of both the Northern Cape Department of Health, the Sol Plaatjie local municipality and the Frances Baard district municipality. Secondly, various politicians attended and participated in the workshop, representing both the district and local councils in various portfolios. At the workshop the researchers gave an orientation to the URS and the PHC Package, and dealt in detail with the strategy and methodology of the research and the research process, and even more so with the findings on PHC in Galeshewe and the recommendations ensuing from the research. These were well received. A draft report was made available to all attendees, as well as to key stakeholders who could not attend. A date was set for comments on the draft report. The report indeed stimulated activity towards more complete (and equitable) implementation of the PHC Package – both PHC managers and local councillors took the initiative for driving the recommendations of the report forward.

At the end of the workshop the stakeholders also planned a follow-up strategy in order to give effect to the recommended measures for solving the many problems and constraints pertaining to health and health care in the Galeshewe URS. A week after our workshop (14 February 2003) the people of the Northern Cape convened their first meeting to address the

identified problems and constraints. Specific plans were conceived to address the many identified gaps in PHC delivery in Galeshewe. Amongst others, it was decided that an incremental approach should be followed in addressing the implementation of recommendations. More concretely it was decided that 80% of the PHC package should be implemented by 1 July 2003 by each clinic in Sol Plaatje municipal area, including Galeshewe CHC. Furthermore, the manager : personal health services was to submit an implementation plan of each clinic to Ms Thuntsi by 5 March 2003, while the supervisor of Galeshewe CHC was to submit such a plan by 5 March 2003. Gaps and weaknesses pertaining to the following (and as identified by the research) were specifically targeted for intervention: management/supervision/training, equipment, drugs, information and education, community involvement,

5. How to use the report

First and foremost, the report is meant to serve as baseline information on public PHC provisioning in Galeshewe. More specifically, it gives an indication of the implementation, or lack of implementation, of the selected PHC programmes, and for that matter of the application of the PHC Package, as in December 2002. From this baseline subsequent improvement or deterioration, progress or backsliding, in PHC service delivery could then be monitored and measured.

Furthermore, at the micro-level (i.e. at facility level), it is recommended that the facility managers and programme coordinators at each of the PHC facilities in the Galeshewe URS use this report as a manual or guide to address or solve one-by-one the operational gaps/deficiencies/constraints identified by the research within each of the PHC facilities. At the meso-level (i.e. at the URS or district levels), it is recommended that management structures of the Galeshewe Urban Renewal Node (if in existence), as well as the management and supervisory health structures in Galeshewe, and in the larger local and district municipal areas, use this report as a manual or guide to address or solve the identified gaps/deficiencies/constraints (operational and strategic) within the area.

CHAPTER 2

PHC SERVICE PROVISIONING IN GALESHEWE - RESEARCH FINDINGS

1. Staffing of PHC facilities in Galeshewe

PHC in Galeshewe is provided at the Betty Gaetsewe, Mapule Matsepane, Recreation, and Masakhane s and at the Galeshewe Day Hospital (GDH). In a sense it would seem that the provincial vs. local authority distinction between facilities is disappearing in Galeshewe. This was evident in some difference of opinion among respondents as to whether they thought that particular facilities might be classified as municipal (local authority) or provincial authorities. Assuming that such differentiation is still relevant and that it hinges mostly on the authority which pays most of the facility's staff, the following descriptions of the PHC facilities under study suggest that most of PHC services in Galeshewe are provided by staff employed by the provincial Department of Health. Thus, PHC services in Galeshewe retain a predominantly *'provincial'* character:

Betty Gaetsewe Clinic: a mostly *'provincial'* clinic with seven nurses (five professional nurses and two enrolled/assistant nurses) and two community health workers (HIV/AIDS counselors/nutrition advisors/health educators) employed by the provincial Department of Health and one professional nurse employed by the local authority.

Mapule Matsepane Clinic: a mostly *'provincial'* clinic with three nurses (two professional nurses and one enrolled/assistant nurse) employed by the provincial Department of Health and one professional nurse employed by the local authority.

Recreation Clinic: a mostly *'local authority' ('municipal')* clinic with three professional nurses employed by the local authority and two nurses (one professional nurse and one enrolled/assistant nurse) employed by the provincial Department of Health.

Masakhane Clinic: a *'provincial'* clinic with six nurses (five professional nurses and one enrolled/assistant nurse) and two community health workers (HIV/AIDS counselors/nutrition advisors/health educators) employed by the provincial Department of Health.

Galeshewe Day Hospital (GDH): locally variably referred to as a clinic, a CHC or a hospital it is a provincial facility in the process of being reformed to a local authority facility. All staff members are province-employed. The classification of the facility as a CHC or hospital might stem from its previous history of being part of the Kimberley hospital complex, its large staff contingent and/or from its staying open until 22:00. However, its current comparatively limited scope of key PHC services calls into question its classification as a CHC.

- **Facility staffing indicators and target population sizes**

The most prominent constraint reported by four of the five facilities (Betty Gaetsewe, Mapule Matsepane, Recreation and Masakhane) in managing the PHC programme at large, as well as for the priority PHC programmes under study (IMCI, maternal health, TB, STI, HIV/AIDS, EDL), is the shortage of nursing staff. This shortage reportedly compromises the quality of

PHC service provision and limits the provision of comprehensive PHC by a facility as per Package guidelines. In the absence of clear guidelines and policies regarding reasonable clinical workload, comparing nurse clinical workload between facilities, districts and provinces appears to be the next closest 'yardstick' to determine the number of nursing staff required to provide the full range of PHC services.

Other factors indicative of staffing requirements at facility level include doctor clinical workload, utilisation rate, child caseload under 5 years and curative caseload under 5 years. The latter two indicators are used to allocate resources and weigh workload figures between facilities and health districts, and to indicate the status of child health. This is important in so far as children being most vulnerable to illnesses and diseases, thus, the higher the percentage of curative services rendered, the less resources available for preventive and promotive health services (DHIS 2002). Table 1 indicates high rates of curative caseloads under-five years for Masakhane and especially GDH as compared to Betty Gaetsewe, Mapule Matsepane and Recreation. Seventy-seven percent of children under-five years who are seen at GDH are curative cases. This translates into increased resources spent on child curative health care at the expense of preventive and promotive health care that form an integral part of PHC.

The utilisation rates of all the clinics thus appear low regardless of the apparent high nurse clinical workload. Of note is that GDH has the lowest nurse clinical workload yet the highest utilisation rate of all the facilities. This could be attributed to GDH being a referral facility for certain PHC services such as PMTCT, oral health, eye care, etc.

The number of referrals to a doctor is a useful indicator for training or equipment needs. It is expected of nurses to address 90% or more of all clinical cases and to refer not more than 10% of clinic cases to a doctor. A high referral rate means that nurses are not utilised to their full potential or that they are not adequately trained or equipped (Heywood & Rhode 2002: 115). Less than 10% of patients are referred to a doctor at all of the PHC facilities in Galeshewe.

Professional nurses are required to work a total of 225 days per year (DHIS 2002). This figure takes into account weekends as well as official leave. Professional nurses at all the clinics in Galeshewe worked less than that in the year preceding the survey. The number of days not worked (excluding official leave days) range between 33 (Betty Gaetsewe and Recreation) and 81 (GDH) days per nurse per year.

Table 1: Facility staffing indicators*

Facility	Nurse clinical workload per day -***	Doctor clinical workload per day****	Patients referred to doctor(%)	Utilisation rate (%)*****	Child caseload under 5yrs (%)******	Curative caseload under 5yrs (%)*******	Expected professional nurse work days per year	Actual professional nurse work days per year
Betty Gaetsewe	39	37	3	16	21	24	225	192
Mapule Matsepane	32	18	6	11	17	34	225	180
Recreation	33	29	7	28	32	36	225	192
Masakhane	33	23	4	15	23	51	225	175
GDH**	24	33	8	47	12	77	225	144**

* Source: DHIS (January to October 2002)
** Missing data for six of the ten months - used average working days per month.
*** Nurse clinical workload per day = total PHC headcount/nurse clinical work days (i.e. professional nurse)
**** Doctor clinical workload per day = patients seen by doctor/doctor clinical work days
***** Utilisation rate = total PHC headcount/catchment population
****** Child caseload under 5yrs = child (0-5) PHC headcount/total PHC headcount
******* Curative caseload under 5 yrs = children under 5 yrs seen for curative purposes/PHC headcount under 5 yrs

Table 2: Programme target populations

Facility	Maternal Health		IMCI		TB		STIs and HIV/AIDS		Total catchment area population
	Women 15-49 years	Expected deliveries per month	<1 year	<5 years	<15 years	>=15 years	Males >15 years	Females >15 years	
Betty Gaetsewe	11 272	117	788	3 189	12 499	27 116	12 704	14 412	39 615
Mapule Matsepane	5 058	92	354	1 431	5 609	12 164	5 687	6 467	17 773
Recreation	2 674	17	187	756	2 967	6 430	3 012	3 418	9 397
Masakhane	5 641	87	394	1 595	6 255	13 568	6 355	7 213	19 823
GDH	2 491	18	174	705	2 764	5 996	2 810	3 186	8 760
Total	27 136	331	1 897	7 676	30 094	65 274	30 568	34 696	95 368

- **Nurses**

Discrepancies in the workload of nurses between the clinics in Galeshewe are clear. Table 1 indicates that the workloads range between 24 and 39 patients per nurse per day. At GDH each nurse sees an average of 24 patients per day - this facility has a total of 41 nursing staff and 8 CHWs. In comparison, at Mapule Matsepane nurses see an average of 32 patients per day, the clinic having a total of 4 nursing staff and only 3 CHWs. Similarly, at Betty Gaetsewe each nurse sees an average of 39 patients per day. This clinic has a total of 10 nursing staff and 18 CHWs.

The major discrepancy in nurse workload is between GDH and the other clinics. Although there is no national norm for a patient-nurse ratio, findings from studies conducted in the Free State have shown that 35 to 40 patients per nurse per day is the ideal workload.[14] This norm has seemingly been adopted in other provinces too. If this norm is applied to Galeshewe, the implications are that all of Betty Gaetsewe, Mapule Matsepane, Recreation and Masakhane are sufficiently staffed and GDH is over-staffed, However, in 2000, the national average nurse clinical workload at fixed clinics was 19.8 (Viljoen *et al.* 2000: 44). If the national average of patients consulted by a nurse per day is thus regarded as the norm,

[14] In one national survey, health managers reported between 20 and 35 patients per nurse per day as the ideal nurse clinical workload (Viljoen *et al.* 2000: 44).

then all the clinics in Galeshewe are under-staffed. Take note also that a previous study by Massyn *et al*. (2002: 18) called for the high workload of nurses in the Frances Baard district to be addressed.

Table 3: Nurse clinical workload, total number of staff and number of community health workers

Facility	Nurse clinical workload per day	Total no of nursing staff	No of community health workers
Betty Gaetsewe	39	10	18
Mapule Matsepane	32	4	3
Recreation	33	5	9
Masakhane	33	6	13
GDH	24	41	8

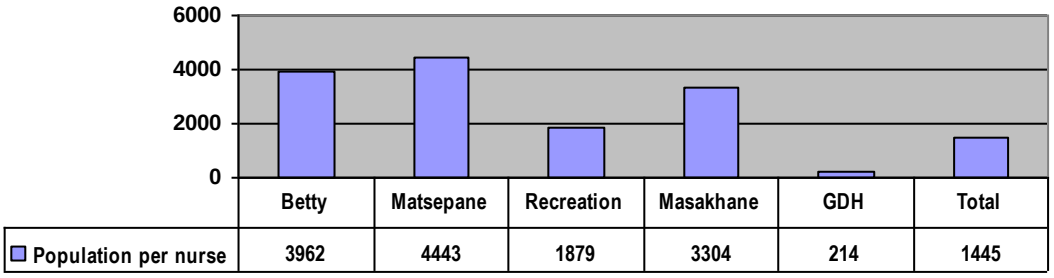
Table 4: Nursing staff establishment

Facility	Chief professional nurse		Senior professional nurse		Professional nurse		Enrolled nurse		Assistant nurse		Total	
	Normally	On day of visit	Normally	On day of visit	Normally	On day of visit	Normally	On day of visit	Normally	On day of visit	Normally	On day of visit
Betty Gaetsewe	2	1	4	3	0	0	1	0	3	3	**10**	**7**
Mapule Matsepane	1	0	2	1	0	0	0	0	1	1	**4**	**2**
Recreation	2	2	2	2	0	0	0	0	1	1	**5**	**5**
Masakhane	3	2	1	1	1	1	1	1	0	0	**6**	**5**
GDH	25	12	0	0	5	3	1	1	10	6	**41**	**22**
Total	**33**	**17**	**9**	**7**	**6**	**4**	**3**	**2**	**15**	**11**	**66**	**41**

Gap-attack!

Four in every ten (38%) nurses were absent on the day of the fieldwork. The situation was the worst at GDH and Mapule Matsepane with 46% and 50% of nurses absent respectively, and best at Recreation with all nurses present.

Figure 1: Population per nurse (all types) ratio



Gap-attack!

GDH compares unfavourably with other PHC facilities in terms of the population per nurse ratio. Why are there so many nurses at GDH? Are they serving a different population than noted on the DHIS? Is GDH providing unique services that justify the large nurse complement? This is clearly a distorted placement of nurses in the district and to the detriment of patients in the catchment areas of especially Masakhane and Betty Gaetsewe.

- **Community health workers**

There appears to be no national guidelines or policies regarding the number of CHWs required for a facility or per catchment population. However, the number of CHWs at Galeshewe clinics varied considerably from three at Mapule Matsepane to 18 at Betty Gaetsewe (Tables 3 and 5). If the difference in nurse clinical workload between Mapule Matsepane and Masakhane is one patient (32 and 33 respectively), why is there such a large discrepancy in the number of CHWs for these clinics (3 and 13 respectively)?

When one compares the number of CHWs at a clinic with the availability of other support staff, such as nutrition advisor, health educationist and AIDS counselor, it becomes clear that there is a correlation between the two. From the comments made by some of these support staff it is clear that they tend to take responsibility for recruiting and coordinating CHWs and their activities.

Table 5: Employed (paid) and unpaid[15] community health workers

Facility	Paid	Unpaid	Total no. of CHWs
Betty Gaetsewe	3	15	18
Mapule Matsepane	-*	-*	3
Recreation	0	9	9
Masakhane	2	11	13
GDH	8	0	8
Total	**13**	**35**	**51**

* The acting facility manager at Mapule Matsepane was uncertain whether CHWs are paid or not.

Gap-attack!

There is a dire need for specific guidelines on establishing the number of nursing staff and CHWs required for comprehensive PHC services for specific catchment populations in Galeshewe. There are only 13 employed (paid) CHWs serving a total catchment population of 95 368.

- **Doctors**

Table 6: Availability of doctors

Facility	Doctors		
	Full-time	Sessional	Total no of sessional hours per week
Betty Gaetsewe	✘	✓	11
Mapule Matsepane	✘	✓	7
Recreation	✘	✓	8
Masakhane	✘	✓	12.5
GDH	✓	✓	15

Gap-attack!

Why do sessional doctors at Mapule Matsepane and Recreation work less than the minimum required 10 hours per week? Is there enough justification for the placement of the full-time doctor at GDH?

[15] Reportedly home-based carers are not yet receiving payment, despite being told that they would be paid from 2000. It would seem that generally the home-based care system is not functioning well, although this issue requires further research.

2 PHC management - facility and programme management

The voices of health facility managers in South Africa have been recorded by Pillay (2001: 273-281):
What are their frustrations? *" …the facility manager having all these responsibilities, doesn't get incentives … the salary is the same as any other nurse … lack of incentives and promotion opportunities … lack of support and understanding and co-ordination of activities at provincial and national levels … lack of co-ordination between programmes and the support services and between the various programmes as well."*
Why do they do it? *"The base is the love of the work I do … money is not everything, we have a service to deliver, we have people looking towards us for help, hope and for survival and you have to be committed …"*

All of the above also feature in the management of PHC services in Galeshewe. To begin with the facility managers in the district are relatively inexperienced (in three of the five cases they have two or less years experience). This makes constant referral to lack of management support in the research findings all the more disturbing.

Table 7: Number of years facility managers have been in their posts

Facility	Years
Betty Gaetsewe	5
Mapule Matsepane	<1*
Recreation	<1
Masakhane	2
GDH	3

* Acting as facility manager for six months.

❑ Supervisor and district official visits

Table 8: Visits by supervisors and district officials in the last three years (2000-2002)*

Facility	District infection control official	Pharmacist	IMCI trainer	Laboratory technician	District coordinator/supervisor					
					PHC	Maternal health	IMCI	TB	STIs	HIV/AIDS
Betty Gaetsewe	No	Yes	Yes	No	No	No****	Yes	Yes	Yes	No
Mapule Matsepane	No	Yes	No	No	Yes**	N/A***	No	N/A	No	No
Recreation	No		Yes	No	No	N/A	Yes	Yes	No	No
Masakhane	No	Yes	No	No	No	No	No	N/A	No	No
GDH	Yes	Yes	Yes	Yes	Yes	*Missing data*	No	N/A	Yes	No

* Information as reported by clinics (interviews with facility and programme managers).
** Provincial supervisor has not visited in three years. Local municipality head of health usually visits the clinic once per year, but had not visited the clinic in the current year.
*** (Here and elsewhere in tables) N/A = Programme not offered at the facility - see par. 5.3.
****It was reported that concerned personnel rather go to the district office for meetings.

Gap-attack!

Generally, the impression from the data in regard to PHC management supervision in the district (i.e. PHC supervisors) is that visits to the clinics are a rare occurrence. When taking place such visits are usually in reaction to problems (e.g. *'staff concerns'*), rather than routine (pro-active). However, the pharmacist visits the clinics regularly.

Table 9: Written feedback on any one of the last three monthly PHC reports submitted to management*

Facility	PHC	Maternal health	IMCI	TB	STIs	HIV/AIDS
Betty Gaetsewe	No	No	No	Yes***	No	Yes
Mapule Matsepane	Yes	N/A	No	N/A	Yes	No
Recreation	No	N/A	No	Yes	No	No
Masakhane	No	No	No**	No****	*No report submitted by facility*	No
GDH	No	*Missing data*	*No report submitted by facility*	N/A	Yes	No

* Information as reported by clinics (interviews with facility and programme managers).
** Received feedback on vitamin A supplementation report only.
*** Feedback received from DIO.
**** Although this facility does not offer the full TB programme, *'DOTS reports'* had been submitted.

Gap-attack!

Written feedback to clinics on the reports they submit to PHC managers are lacking in most cases – this problem relates to PHC management in general and to all the key PHC programmes. This problem is least pronounced in the case of the TB programme.

Table 10: Date of last programme assessment performed

Facility	Date	
	STI	IMCI
Betty Gaetsewe	2002	2001
Mapule Matsepane	2001	Never
Recreation	2001	2002
Masakhane	*Missing data*	2002
GDH	2002	2002

Gap-attack!

Mapule Matsepane does not conduct annual assessments of IMCI services?

- **Constraints experienced in managing the PHC programme and suggestions for improvement**

Table 11: Self-reported management constraints and suggestions for improvement: PHC programme

Facility	Constraints	Suggestions
Betty Gaetsewe	▪ Severe staff shortage – only one nurse per programme/service - if this person is not there chaos occurs (e.g. children treated with adults, assistant has to run entire TB programme). ▪ There are times when nearly all seven professional nurses are on training or sick leave. ▪ Quality service cannot be provided without back-up personnel for programmes.	▪ Improve staffing ▪ Training of current staff is adequate ▪ Management support is required – managers need to visit clinics
Mapule Matsepane	▪ Drugs out of stock, drug orders sometimes placed too late ▪ Staff shortage results in the clinic being unable to provide a full TB service (only taking TB sputum) ▪ Too little space in clinic	▪ Improve staffing – five nurses needed – currently there are three nurses, but two are on leave ▪ Full TB service needs to be provided, to relieve pressure on *'TB clinics'* in the district ▪ Clinic space needs to be expanded
Recreation	▪ Staff shortage (nurses and nursing assistants) ▪ Cleaner is negative and often absent from work ▪ Temporary building ▪ Maintenance by the municipality is poor (e.g. slow response to requests for cupboard locks, the yard needs cleaning)	▪ Solutions should come from top management – *'everyone should be under one umbrella'* – the local authority can no longer employ people
Masakhane	▪ Staff shortage – the manager does not have time for her management duties ▪ Periodic drug shortages – especially chronic medicine, sometimes IMCI vaccines, Neristerate currently out of stock ▪ Certain nurses need PHC training ▪ Too little space in clinic	▪ Improve staffing ▪ PHC skills training ▪ Clinic space needs to be expanded
GDH	▪ Insufficient equipment, e.g. computers, photocopier, desks, medical equipment and fans. ▪ Budget inadequate	▪ Management support from senior managers ▪ Information about budgetary matters

Gap-attack!

Four of the five facilities in Galeshewe (Betty Gaetsewe, Mapule Matsepane, Recreation and Masakhane) view serious staff shortages as the main constraint experienced in managing the PHC programme. Additionally at least three facilities view lack of management support as the main problem.

- **Coordination of specific programmes**

Table 12: Whether a specific health worker coordinates the programme

Facility	Maternal health	IMCI	TB	STIs	HIV/AIDS	EDL
Betty Gaetsewe	✓	✓	✓	✓	✓	✓
Mapule Matsepane	N/A	×	N/A	×	×	×
Recreation	N/A	✓	✓	✓	✓	✓
Masakhane	✓	✓	✓	×	×	×
GDH	✓	✓	N/A	✓	✓	✓

Betty Gaetsewe and GDH have specific coordinators for all the key PHC programmes presented.

Gap-attack!

Specific responsibility for programme coordination is lacking at Mapule Matsepane for IMCI, STIs, HIV/AIDS and EDL. Specific responsibility for programme coordination is lacking at Masakhane for the STIs, HIV/AIDS and EDL programmes.

Table 13: Monthly staff discussions on PHC indicators, as indicated by the different programme coordinators

Facility	Facility manager	Maternal health	TB	IMCI	STIs	HIV/AIDS	EDL
Betty Gaetsewe	✓	✓	✓	✓	✓	✓	✓
Mapule Matsepane	✓	N/A	N/A	N/A	N/A	N/A	N/A
Recreation	✓	N/A	✓	✓	✓	✓	✓
Masakhane	✓	✓	✓	✓	N/A	N/A	✓
GDH	×	×	×	×	×	×	×

Gap-attack!

GDH does not have regular discussion on PHC indicators. It is operating according to the PHC approach? Does it see itself as a PHC facility or (still) as a hospital?

❑ Programme-specific management constraints

Table 14: Self-reported management constraints and suggestions for improvement: Maternal health programme

Facility	Constraints	Suggestions
Betty Gaetsewe	▪ Staff shortage – if professional nurse in charge of programme is on leave a staff nurse has to take over service ▪ Training insufficient ▪ ANC services not provided ▪ Shortage of consultation rooms	▪ Improve staffing ▪ Nurse in charge needs IUD and Pap smear and general family planning training ▪ There is a need to provide ANC services as well (to provide full PHC services) – the clinic was instructed by management to provide ANC services immediately but refuses to do so until staffing situation has been improved ▪ More consultation rooms needed
Mapule Matsepane	N/A	N/A
Recreation	N/A	N/A
Masakhane	▪ Equipment shortage ▪ Facility too small – no space for health talks, exercises ▪ Training insufficient (PEP)	▪ Plastic rather than metal fetal scopes needed, doptone rather than fetal scopes ▪ PEP training for all health workers ▪ Clinic space needs to be expanded
GDH	*Missing data*	*Missing data*

Gap-attack!

Facilities providing maternal health services in Galeshewe (i.e. Betty Gaetsewe and Masakhane) reported shortage of staff, equipment and limited clinic space as obstacles to providing comprehensive maternal health services. Mapule Matsepane and Recreation do not have a maternal health programme. Also, the staff at Betty Gaetsewe and Recreation need additional maternal health training.

Table 15: Self-reported management constraints and suggestions for improvement: IMCI programme

Facility	Constraints	Suggestions
Betty Gaetsewe	▪ Staff shortage	▪ Improve staffing
Mapule Matsepane	▪ No one coordinating programme	▪ Improve staffing
Recreation	▪ Staff shortage – when the clinic is full, children cannot be seen by the IMCI nurse and have to be seen by other nurses. ▪ Clinic infrastructure not suitable for IMCI activities, e.g. no space for oral rehydration. The building was not designed as a clinic. ▪ Drug supply (from the hospital) is now better (than when drugs were supplied from the local authority pharmacy), but the clinic still sometimes runs out of stock – the problem emanates from the hospital.	▪ Improve staffing ▪ Frequent evaluations from the IMCI supervisor are needed
Masakhane	▪ Responsible nurse experiences a feeling of stagnation, she has been doing IMCI for three years.	▪ Follow-up courses should take place, at least quarterly ▪ Rotate staff amongst facilities and programmes
GDH	▪ *'No constraints'*	▪ *'Community component'* needs to be established to complement programme ▪ The trained IMCI coordinator should be conducting follow-up and quarterly reports to enable monitoring and evaluation of the programme.

Gap-attack!

Shortage of staff is reiterated by three facilities (i.e. Betty Gaetsewe, Mapule Matsepane and Recreation). Limited clinic space, drug shortages and lack of sufficient supervision and monitoring by the district IMCI supervisor/coordinator also hamper the effective running of the IMCI programme.

❑ **Previous research findings on the management of TB services in the district**

Massyn *et al.* (2002: 18) reviewed TB control in the Francis Baard district. Their findings concentrate on the problems experienced in transferring TB patients from West End Hospital to Jan Kempdorp and Warrenton (where they are admitted for different lengths of stay. The review indicated that the training of nurses at these hospitals was insufficient and that their knowledge regarding the management of TB was very limited. The review further expressed concern about the lack of isolation of TB patients at Warrenton Hospital where TB patients were grouping of patients was according to gender and TB patients, although placed in separate rooms, were sharing bathroom and toilet facilities and feely mixed with children and maternity cases. Further of concern, was that no staff members at Warrenton Hospital were allocated to manage TB specifically. The review's recommendations focused on, firstly, the need to train hospital staff in TB control and on re-organising the admission of patients: male cases to Jan Kempdorp Hospital (30 beds) and female patients to Warrenton Hospital (eight beds); secondly, the isolation of patients at these hospitals; and, thirdly, the need for the hospital to use the prescribed register, *'blue'* cards and to submit TB quarterly reports. Additionally, the review made recommendations for the district as a whole, focusing on the need for the appointment of a district TB coordinator, for active involvement of the TB unit in TB issues in the district, for quarterly TB training sessions, for medical officers and environmental health officers to become involved in TB services, for a medical officer dedicated to the TB control programme to give support and advice with problem and MDRTB cases, for a proper referral system to be in place, for every clinic to have a well-

functioning DOT system, for every clinic to have a structured patient education programme in place, for the high workload of nurses to be addressed, for each clinic to have a supervisor who should have enough time to spend on in-service training and quality issues, for all clinics to have means of transport to use in tracing of contacts and defaulters and to do home visits, for TB services also to be rendered at Mapule Matsepane, Masakhane and GDH, and for quarterly TB meetings at district level. The current study is generally supportive of these recommendations. At the facility-level managers reported serious constraints with the management if the TB control programme.

Table 16: Self-reported management constraints and suggestions for improvement: TB control programme

Facility	Constraints	Suggestions
Betty Gaetsewe	▪ Kimberley Hospital refers very ill patients to the clinic – so ill that they cannot walk. This affects especially retreatment patients who have to receive daily streptomycin injections. ▪ Patients come from the hospital with no X-ray or sputum diagnostic results. ▪ It is very difficult to obtain, especially X-ray, results from the hospital. The radiology department is very disorganised (files lying around on the floor). X-rays sometimes have to be repeated because files cannot be found even if X-rays were done just a day or two before. ▪ Getting patients admitted to the hospital is very difficult. There is no admission without an X-ray and a sputum result: *"We wait forever for X-rays before patients can be admitted."* ▪ Hospital staff members do not use the referral form correctly, e.g. they do not fill in the X-ray number. ▪ There are a number of sputum-negative TB patients that have to be diagnosed by X-rays: *"The radiology department makes our job very difficult."*	▪ Improve radiology services at Kimberley Hospital. ▪ Keep very ill TB patients and patients on streptomycin in hospital longer.
Mapule Matsepane	N/A	N/A
Recreation	▪ Staff shortage – responsible nurse is handicapped by having to relieve in other programmes. ▪ High levels of treatment interruption on the part of patients. ▪ Sputum turn-around time is too long at 4-5 days. ▪ Doctors from Kimberley Hospital write vague referral letters. ▪ Social conditions in Galeshewe (unemployment and poverty) cause relapses of TB disease.	▪ Improve staffing ▪ Need visual aids to educate TB clients ▪ More training of DOT supporters at strategic points in the community.
Masakhane	▪ *'No training'*	▪ Training of a professional nurse dedicated to TB
GDH	N/A	N/A

Table 17: Self-reported management constraints and suggestions for improvement: STI programme

Facility	Constraints	Suggestions
Betty Gaetsewe	▪ Staff shortage ▪ No full-time coordinator ▪ Lack of in-service training of staff ▪ Poor follow-up on contacts ▪ Drug supply problems	▪ Allocate responsibility for full-time coordinator ▪ In-service training ▪ Improve drug supply
Mapule Matsepane	▪ Despite contact slips being provided to clients, contacts *'never'* come in.	▪ There is not much the clinic can do about contact tracing.
Recreation	▪ Contact tracing rendered difficult by patients *'lying'* about contacts. ▪ Recurrence of STIs – *'patients don't want to use condoms.'* ▪ On the other hand, shortages of condoms also occur and this upsets patients.	▪ Improve supply of condoms from depot ▪ Educate patients about condoms and the need to trace contacts
Masakhane	▪ Staff shortage ▪ Limited work space	▪ Improve clinic staffing ▪ Clinic space needs to be expanded
GDH	▪ Equipment shortage, e.g. speculum ▪ Lack of training	▪ Improve availability of equipment ▪ Provide training

Table 18: Self-reported management constraints and suggestions for improvement: HIV/AIDS programme

Facility	Constraints	Suggestions
Betty Gaetsewe	▪ Equipment shortage - ordering of rapid HIV tests problematic ▪ Staff shortage (for HIV testing) ▪ Lack of stationery, e.g. confidentiality files and forms ▪ Shortage of consultation rooms ▪ No debriefing sessions for staff doing VCCT	▪ Most important is the equipment (and the testing equipment especially)
Mapule Matsepane	▪ *"It is emotionally draining to counsel HIV/AIDS clients. We receive no support."*	*Missing data*
Recreation	▪ The HIV/AIDS counselor at Recreation has undergone training in VCT but cannot administer the HIV test due to her not being a qualified nurse. Not qualified to do so, she has to train the professional nurses to administer the rapid HIV tests. The current arrangement compromises confidentiality of HIV testing. She has been working as counselor since 1998, but she has no supervisor/mentor among the nurses. She has no one to report to or discuss problems with: *"I recently had a patient who was diagnosed HIV-positive and attempted suicide. I did not have a mentor to offer guidance and advice and had to rely on other clinic staff and the police."* ▪ Condom shortages emanating from the supplier	▪ Awareness campaigns and more health education generally ▪ A controversial suggestion: *"There is a need to train lay personnel working with the HIV programme to conduct certain medical procedures such as rapid testing and blood taking for HIV testing."* ▪ Allocate mentors to HIV/AIDS programme managers ▪ Counselors need to debriefed from time to time to enable them also to unload some of the emotional burden associated with HIV/AIDS ▪ Condom availability needs to be improved.
Masakhane	▪ Staff shortage ▪ No feedback from managers: *'only one provincial workshop'*	▪ Improve staffing: '*More time*'
GDH	*Missing data*	*Missing data*

Table 19: Self-reported management constraints and suggestions for improvement: EDL programme

Facility	Constraints	Suggestions
Betty Gaetsewe	▪ No specific problem, yet the programme is affected by staff shortage[16]	▪ *'It is still alright'*
Mapule Matsepane	▪ *"EDL is helpful but restricts one to certain medications, e.g. Nalidixic acid not on EDL, but the doctor asked us to order it for him. Some doctors are really frustrated with EDL – does not have the drugs they want to give.""*	▪ EDL should be reviewed by sessional doctors
Recreation	▪ Drug shortage at depot. Depot does not deliver drugs ordered in good time by clinic. Problems occur when the driver does not deliver order to the depot on time. ▪ Medicine needs to be *'packed'* at clinic and this is time consuming.	▪ Regular provision of drugs ▪ Appointment of a pharmacist ▪ Helpers to pack drugs ▪ Regular in-service training of staff
Masakhane	▪ Lack of cooperation and understanding in regard to EDL by the clients/community	▪ There should be massive publicity of the EDL programme in the community, including the issue of responsible use of drugs
GDH	Insufficient information system for drug management at the facility: *"There is a need for statistics to measure consumption, forecast and budget"*	▪ Information system required for stock management

Gap-attack!

Mapule Matsepane and GDH do not offer TB services. Mapule Matsepane merely takes sputum samples and then refers patients. The relationship between Kimberley Hospital and the two clinics providing TB services (i.e. Betty Gaetsewe and Recreation) regarding TB testing and the referral procedure contribute to problems in managing the TB programme at the clinics. Insufficient staff, training, equipment, drugs, clinic space and supervision, monitoring and evaluation are the most prominent constraints in the management of the PHC, Maternal Health, IMCI, TB, STI, HIV/AIDS and EDL programmes.

[16] The respondent did not mention the fact that no one in the clinic underwent EDL training as a problem.

3. Scope and accessibility of services

Table 20: Scope of PHC services offered

Services	Betty Gaetsewe	Mapule Matsepane	Recreation	Masakhane	GDH
Maternal health (complete)	✗	✗	✗	✗	✗
ANC	✗	✗	✗	✓	✓
Pap smears	✓	✗	✗	✓	✓
Family planning	✓	✓	✓	✓	✓
TOP	✗	✗	✗	✗	✗
IMCI	✓	✓	✓	✓	✓
Child health	✓	✓	✓	✓	✓
TB	✓	✗	✓	✗	✗
Walk-through DOTS	✓	✗	✓	*	✗
STIs	✓	✓	✓	✓	✓
VCT	✓	✓	✗	✓	✓
PMTCT	✗	✗	✗	✗	✓
Adult acute curative care	✓	✓	✓	✓	✓
Chronic disease management	✓	✓	✓	✓	✓
Mental health	✓	✗	✗	✗	✓
Nutrition	✓	✓	✓	✓	✓
Health education and promotion	✓	✓	✓	✓	✓
Home-based care	✗	✓	✓	✓	✗
Eye care services	✓	✓	✗	✗	✓
Oral health	✓	✗	✗	✗	✓
Repeat/fast queue	✓	✗	✓	✗	✓
Emergency care/casualty	✗	✓	✓	✗	✓
Violence/sexual abuse	✗	✓	✓	✗	✓
Rehabilitation	✗	✗	✗	✗	✓
Environmental health	✗	✗	✗	✗	✓
Occupational health	✗	✗	✗	✗	✓

* This clinic does not have a TB register. The patients are registered at the Betty Gaetsewe. However, if they live close to Masakhane, they receive their medication there. Masakhane staff members have received no DOTS training.

Gap-attack!

ANC: routine ANC services should have been be introduced and in place at PHC facilities (clinics, mobiles and CHCs) by the end of 2001 (Department of Health 2001b: 21, 30). Hence, Betty Gaetsewe, Mapule Matsepane and Recreation should be providing this service.

Pap smears: screening for cervical cancer should have been in place at CHCs by the end of 2001 and at clinics/mobiles by the end of 2002 (Department of Health 2001b: 22, 23, 31). GDH, the only CHC in Galeshewe, is already providing this service. Although only Masakhane is currently doing Pap smears, the remaining clinics had up until the end of 2002 to implement this service.

TOP: by the end of 2001 clinics should have had in place: medical terminations for pregnancies under 9 weeks; daily recall up to the actual abortion procedure; and referral if the abortion did not occur within one week. Twenty-four hour CHCs should be providing comprehensive TOP services by the end of 2002 (Department of Health 2001b: 23, 30). Despite these guidelines, no facility in Galeshewe is providing TOP services.

TB: all PHC facilities should have been diagnosing and treating TB patients by the end of 2001 (Department of Health 2001b: 25, 32). TB services should thus be available at Mapule Matsepane, Masakhane and GDH.

Walk through DOTS: in order to make the service more user-friendly, a walk through service for patients on DOTS should have been available from the end of 2001 (Department of Health 2001b: 28). This service is only available at the two clinics (Betty Gaetsewe and Recreation) providing TB services.

VCT: VCT should be available at all PHC facilities by the end of March 2003 (Elgoni 2003).
PMTCT: only selected facilities (e.g. GDH) provide PMTCT.
Mental health: by the end of 2001, mental health services should be available at all PHC facilities (Department of Health 2001b: 27, 28, 33). Hence, mental health services should be rendered at Mapule Matsepane; Recreation and Masakhane.
Environmental health: this entails, amongst others, information on environmental health services; information on waste management; information on water quality; and chemical and food safety. This service should have been in place at all PHC facilities by the end of 2001 (Department of Health 2001b: 26; 34; 35). Currently this service is only offered at the CHC (GDH) and not at any of the clinics in Galeshewe.
Occupational health: amongst others, occupational health entails rendering occupational health promotion services, sensitising workers to specific occupational health problems, and primary risk assessment of occupational health exposure. This service should be in place at CHCs by the end of 2002 (Department of Health 2001b: 16). No reference is made to the availability of this service at clinics. Occupational health is provided at GDH.
Home-based care: this service is organised into special needs; i.e. growth faltering, persons needing rehabilitation and palliative care. In general, home-based care should have been in place by the end of 2002. Home visits by auxiliary nurses should have been in place by 2001 (Department of Health 2001b: 15). Hence, Betty Gaetsewe and GDH should provide home-based care services.
Repeat/fast queue: this should have been implemented at PHC facilities by the end of 2001. This service is for patients who have been previously assessed, and is vital to minimise waiting time for patients (Department of Health 2001b: 27). This service should, therefore, be available at Mapule Matsepane and Masakhane.
Emergency care: casualty services should have been implemented at CHCs by the end of 2001 (Department of Health 2001b: 35). No reference is made to the availability of this service at clinics. This service is offered at GDH.
Violence/sexual abuse: this service should have been available at PHC facilities from the end of 2001 (Department of Health 2001b: 22, 23). Therefore, this service should be available at Betty Gaetsewe and Masakhane.
Rehabilitation: this includes, amongst others, screening and observations at clinics and home for early detection; and basic assessment, and should have been available from the end of 2001 at clinics and CHCs (Department of Health 2001b: 26; 33, 34). Only the CHC (GDH) offers this service currently, despite the fact that it should be offered by all PHC facilities.

Table 21: PHC facility open times

Facility	Days per week	Hours week days	Hours Saturdays	Hours Sundays	Total hours per week
Betty Gaetsewe	5	9	0	0	45
Mapule Matsepane	5	8.5	0	0	42.5
Recreation	5	8.5	0	0	42.5
Masakhane	5	8.75	0	0	43.75
GDH	5	15	0	0	75*

* GDH has a 24-hour maternal obstetrics unit.

Gap-attack!
No PHC services in Galeshewe over weekends? What about employed people who cannot attend during the week? Does GDH that stays open until 22h00 on weekdays accommodate their needs?

The goal in all provinces is for comprehensive and integrated PHC services to be delivered at district level. In reality, this goal has not been achieved as many clinics still offer certain

services on certain days (Harrison-Migochi 1998: 129). The situation in Galeshewe revealed that although certain services are available on certain days, should a patient present at a clinic on a day that that service is not provided, he/she would not automatically be turned away. More specifically:

Betty Gaetsewe Clinic: this clinic sets aside certain days of the week for immunisations, nutrition/growth monitoring, oral health, chronic diseases, and mental health. In all cases, these services are available on other days should a patient present with a complaint.

Mapule Matsepane Clinic: immunisation, family planning, nutrition/growth monitoring, eye care and VCT are offered on certain days of the week at this clinic. All of these services, except for eye care and VCT, are available on other days if a patient requires it. However, eye care and VCT require the services of persons not stationed at the clinic and are therefore only available on the selected days.

Recreation Clinic: fewer services are offered on specific days at this clinic – immunisation, child care and nutrition/growth monitoring. All of these services are available on other days should a patient request it.

Masakhane Clinic: this clinic has the most services offered on certain days of the week – immunisations, family planning, antenatal care, nutrition/growth monitoring, adult curative and chronic diseases. Of concern is that chronic disease and adult curative services are only available four days a week even if a patient presents on the day that that service is not available he/she is not seen to.

GDH: this CHC offers antenatal care, eye care and rehabilitation on certain days of the week. Eye care and rehabilitation services are only available on those days as persons providing these services are not permanently stationed at this facility. With regard to the services provided daily, GDH appears to be offering the most comprehensive PHC service amongst the five facilities under study (although it does not offer TB services). Also considering the large nursing component (41 nurses) and the size of the facility (19 consultation rooms), one would expect an even more comprehensive service to be provided by this CHC. It is clear that the facilities in Galeshewe have far to go in terms of providing the services as set out in the Package (Department of Health 2001a; 2001b).

Table 22: Number of days PHC services offered

Services	Betty Gaetsewe		Mapule Matsepane		Recreation		Masakhane		GDH	
	Days/ week	Other days if needed	Days/ week	Other days if needed	Days/ Week	Other days if needed	Days/ week	Other days if needed	Days/ week	Other days if needed
Antenatal care	N/A		N/A		N/A		4	✔	4	✔
Family planning (emergency contraception)	5		2	✔	5		1	✔	5	
TOP referral	5		5		5		5		5	
Immunisations	1	✔	1	✔	2	✔	1	✔	5	
Child care/curative	5		5		2	✔	5		5	
TB treatment	5		N/A		5		5*		N/A	
Clinic-based DOT	5		N/A		5		5		N/A	
STI treatment	5		5		5		5		5	
HIV clinic for opportunistic infections	5		5		5		5		5	
VCT	5		1	✕	N/A		5		5	
PMTCT counseling	N/A		N/A		N/A		*		5	
Delivery/maternity	N/A		N/A		N/A		N/A		7	
Nutrition/growth monitoring	1	✔	1	✔	1	✔	1	✔	5	
Eye care/refer	5		2	✕	5		5		1	
Basic oral health/referral	1	✔	5		N/A		5		5	
Rehabilitation for disability	N/A		N/A		N/A		N/A		1	✕
Home visits by facility staff	*		*		*		N/A		N/A	
Special hours for youth	N/A		N/A		N/A		*		N/A	
Adult curative	5		5		5		4	✕	5	
Chronic diseases	4	✔	5		5		4	✕	5	
Mental health/refer	1	✔	5		5		N/A		5	
Geriatric care	5		5		5		N/A		5	
Genetic counseling	N/A		N/A		N/A		N/A		N/A	

* Administration of community and clinic-based DOT.

Gap-attack!

Facilities in Galeshewe appear to be behind the national average in many instances when it comes to service provision on a daily basis (e.g. Family planning, ANC, immunisations, TB). Why does Masakhane only offer treatment for adult curative and chronic diseases four days a week? What happens to these patients if they visit the clinic on the day that these services are not offered? Eye care, rehabilitation services and VCT are only available at certain clinics on specific days, when trained persons are available to provide these services.

- **Comparing scope and frequency of PHC services in Galeshewe to national (1997, 1998 and 2000) and Eastern Cape (2000) situations**

The comparisons showed that in most instances, service provision on a daily basis in Galeshewe is below the average set in other provinces and nationally:

- Family planning services on a daily basis in the Eastern Cape increased from 87% in 1997 to 99% in 1999 and then decreased to 97% in 2000 (Mahlalela 2000: 63). Nationally 87.1% of fixed facilities offered family planning services on a daily basis in 2000 (Viljoen al. 2000: 13). The current study showed that in Galeshewe 60% of the facilities offered family planning on a daily basis - this is well below the national average of 87.1% set in 2000.

- ANC on a daily basis in the Eastern Cape increased from 51% in 1997 to 80% in 1999 and then decreased slightly to 78% in 2000 (Mahlalela 2000: 63). Nationally 59.3% of the fixed facilities offered ANC services on a daily basis in 2000 (Viljoen *et al.* 2000: 14). However, the current study showed that no facility offered ANC services on a daily basis in Galeshewe.
- EPI/immunisation on a daily basis in the Eastern Cape increased from 68% in 1997 to 88% in 1999 and 89% in 2000 (Mahlalela 2000: 63). Nationally, 73.7% of facilities were offering immunisation services on a daily basis in 2000 (Viljoen *et al.* 2000: 11). The current study indicates that no clinic offered immunisation services on a daily basis in Galeshewe, although GDH did note that this service was available when needed.
- Child care on a daily basis in the Eastern Cape, was available at 99% of the facilities in 1997 and 1999 and then decreased slightly to 97% in 2000 (Mahlalela 2000: 63). Nationally, child curative care was available on a daily basis at 92.2% of the fixed clinics (Viljoen *et al.* 2000: 20). In comparison, only 80% of the facilities in Galeshewe offered child care services on a daily basis in 2002.
- TB care was offered nationally on a daily basis in 2000 at 84.1% of the fixed facilities (Viljoen *et al.* 2000: 19). In Galeshewe TB care is only offered at 40% of the clinics, compared to the national average of 84.1% set in 2000.
- STI care was offered nationally on a daily basis in 2000 at 94.9% of the fixed facilities (Viljoen *et al.* 2000: 17). On a positive note, all facilities in Galeshewe offered STI care on a daily basis.
- HIV testing was offered nationally on a daily basis during 2000 at 56.2% of fixed clinics (Viljoen *et al.* 2000: 20). Sixty percent of the facilities in Galeshewe offered VCT in 2002.
- Adult curative care on a daily basis in the Eastern Cape improved from 96% in 1997 to 98% in 1999 and 2000 (Mahlalela 2000: 56). Nationally, adult curative services are available on a daily basis at 89.5% of the fixed clinics. Similarly, adult curative services were available at 80% of the facilities in Galeshewe on a daily basis.
- Chronic care on a daily basis in the Eastern Cape increased from 81% in 1997 to 91% in 1999 and 93% in 2000 (Mahlalela 2000: 56). At a far lower level of availability, chronic services were provided at 60% of facilities in Galeshewe on a daily basis.
- Mental health services on a daily basis in the Eastern Cape increased from 50% in 1997 to 70% in 1999 and 85% in 2000 (Mahlalela 2000: 56). Mental health services available at 60% of facilities in Galeshewe on a daily basis.

4. PHC facility equipment

❑ General PHC equipment

Table 23: General, diagnostic and clinical equipment*

Item	Betty Gaetsewe	Mapule Matsepane	Recreation	Masakhane	GDH
Adult scale	4(2)	2	4	2	5
Examination couch	11	3	4	7	12
Examination light	2	0(1)	1	6	6
Thermometer	Numerous	4	3	8(2 digital)	16(numerous)
Stethoscope	8(2)	3	4	5	14(4)
Blood pressure meter	10(1)	2(1)	5	7	?
Otoscope	5(3)	2	4	6	?
Glucometer	1(2)	0(1)	2(1)	1	?

* This table depicts the numbers of equipment items in working order. Numbers in brackets depict the number of items in need of repair.

To better interpret the data in Table 23, the number of consultation rooms at the five facilities need to be considered (Table 24).

Table 24: Number of consultation rooms per facility

Item	Betty Gaetsewe	Mapule Matsepane	Recreation	Masakhane	GDH
Number of consultation rooms	11	4	6	7	19

Adult scales: the respondent from Betty Gaetsewe indicated that there is, in addition to the four adult scales in working condition, two more such scales, but that they are in need of repair. Only four of the eleven consultation rooms at this clinic thus has an adult scale in working condition, which means that adult patients who need to be weighed in consultation rooms without scales, need to be accompanied to another room for this purpose. Although the Department of Health (2001a: 13) does not stipulate the number of adult scales needed per health clinic, it does make sense to equip most consultation rooms (except those used only for IMCI) with an adult scale for time-efficiency reasons. Mapule Matsepane and Recreation are in a better position with regard to adult scales, but Masakhane and especially GDH are in need of more adult scales. GDH had only five adult scales for 19 consultation rooms.

Examination couches: Betty Gaetsewe and Masakhane are in a comparably favourable position regarding examination couches, as every consultation room is equipped with an examination couch. With the exception of one consultation room at Betty Gaetsewe, all of the consultation rooms at these two clinics had audio and visual privacy. The situation in GDH is again unfavourable, with only 12 of their 19 consultation rooms having an examination couch. The question arises here whether all consultation rooms at GDH are utilised on a daily basis. Unfortunately, Department of Health (2001a: 13) does not set a standard for the number of examination couches needed in health clinics. However, it goes without saying that all, or at least most, consultation rooms need examination couches.

Examination lights: it is specifically stipulated by the Department of Health (2001a: 13) that every professional nurse and medical officer working on the same shift should be equipped with an examination light. However, as a rule, less than one third of consultation

rooms/professional nurses in the facilities under study had examination lights. Masakhane is the exception, having six examination lights for their seven consultation rooms[17]. Mapule Matsepane did not have any examination light in a working condition. All consultation rooms/professional nurses/medical officers should be equipped with examination lights.

Thermometers: only Recreation lacked thermometers. However, GDH indicated that they had numerous thermometers that are not in a working condition. Masakhane has more thermometers than consultation rooms, although two digital thermometers are out of order. Although the Department of Health (2001: 13) does not stipulate the number of thermometers per professional nurse/consultation room the need for thermometers in everyday screening of all types of patients goes without saying.

Stethoscopes: none of the clinics had stethoscopes in all their consultation rooms. This is disturbing as stethoscopes are needed in the routine screening of all patients attending PHC facilities.

Blood pressure meters and otoscopes: not all the consultation rooms in Galeshewe facilities were stocked with blood pressure meters or otoscopes. The need for blood pressure meters is clear as this is equipment used in the everyday screening of most patient categories (even though it is again not specifically stipulated by the Department of Health (2001a: 13). Arguably, otoscopes might be less important (not mentioned by the Package).

Glucometers: the Department of Health (2001a: 13) stipulates that all health clinics should have a glucometer. This was found not to be the case in Galeshewe. Glucometers are either not well maintained or prone to breaking, as Recreation, Mapule Matsepane and Betty Gaetsewe all reported some glucometers to be out of order. Betty Gaetsewe indicated that two of the three glucometers in the clinic have expired and Mapule Matsepane reported that glucometer was sent for repair but never returned. As glucometers are not used in the routine screening of all patients, it is not necessary for all consultation rooms to have them, however, it is recommended that all clinics have at least one in a working condition.

Equipment in need of repair: Table 23 indicates that more than twenty equipment items are in need of repair. Maintenance of equipment in Galeshewe facilities requires urgent attention. Reparation of existing equipment alone will greatly improve the capacity of the facilities to deliver quality PHC services. It is also recommended that, where possible, equipment should be relocated to facilities that are in urgent need thereof; e.g. Masakhane has more thermometers than consultation rooms and Recreation only has one thermometer for every two consultation rooms.

Gap-attack!

It is specifically stipulated by the Package (Department of Health 2001a: 13) that every professional nurse and medical officer working on the same shift should be equipped with an examination light. However, less than one third of consultation rooms/professional nurses in Galeshewe have examination lights. The Package further stipulates that all health clinics should have a glucometer. Not all the facilities in Galeshewe had a glucometer in working order. More than twenty items of equipment important to the rendering of PHC services were in need of repair.

[17] This clinic does need another examination light for the IMCI room.

- **Maternity programme equipment**

Table 25: Maternity programme-specific equipment and items

Item	Betty Gaetsewe	Mapule Matsepane	Recreation	Masakhane	GDH
Number of fetal scopes	1	0	0	3*	1
Delivery sets/sterile packs	Numerous	0	2	1	20
Neonatal resuscitation trolley	1	0	0	0	1
Ventouse	N/A	N/A	N/A	N/A	0
Forceps	N/A	N/A	N/A	N/A	0
Manual vacuum aspiration (MVA) syringe	N/A	N/A	N/A	N/A	0
Privacy during TOP	N/A	N/A	N/A	N/A	N/A
Private recovery space after TOP	N/A	N/A	N/A	N/A	N/A

* This clinic has five fetal scopes, of which two are in need of repair.

Of the five services visited in Galeshewe, only GDH is a designated PHC service that has a 24-hour maternal obstetrics unit (other services are provided only until 22h00). Yet there is no ventouse or forceps in this facility.

Fetal scopes: the fact that neither Mapule Matsepane nor Recreation has a fetal scope is problematic in the light of the fact that the Department of Health (2001a: 16) sets the standard that all health clinics should have at least one fetal scope in working order. Strangely, although Betty Gaetsewe and Masakhane do not offer maternity services, they do have fetal scopes.

Delivery sets/sterile packs: all the services except Mapule Matsepane have delivery sets/sterile packs. Mapule Matsepane should be equipped with either sterile packs or a delivery set - this is a standard set by the Package (Department of Health 2001a: 16).

Neonatal resuscitation trolleys: Betty Gaetsewe and GDH are the only facilities in Galeshewe that have a neonatal resuscitation trolley. The reason for Betty Gaetsewe having this piece of equipment is not clear as they do not offer ANC or maternity services. However, according to the Package (Department of Health 2001a: 21) all PHC facilities should be equipped to manage uncomplicated deliveries.

Gap-attack!

Mapule Matsepane and Recreation have no fetal scopes. Mapule Matsepane has no delivery sets and sterile packs. Three of the five facilities do not have neonatal resuscitation trolleys.

- **IMCI programme equipment**

Table 26: IMCI programme-specific equipment

Item	Betty Gaetsewe	Mapule Matsepane	Recreation	Masakhane	GDH
Infant scale	2	2	1	1(1*)	3
IMCI health education videos	0	0	0	0	3**
Emergency equipment for intravenous resuscitation of severely dehydrated children	✓	✓	✓	✓	✓
Oral re-hydration corner	✓	✘***	✓	✓	✓

* In need of repair.

** GDH has three sets of health education videos while none of the other clinics have any. These are reportedly used for training purposes and not for health education.

*** This is done in all consultation rooms, there is no area specifically allocated for this. It is, however, recommended in the Package (Department of Health 2001a: 19-20) that all clinics should have an oral rehydration corner.

In accordance with the Package (Department of Health 2001a: 13) all the facilities in Galeshewe has one or more infant scales. [18] Also in line with the Package all the facilities have emergency equipment for intravenous resuscitation of severely dehydrated children.

Gap-attack!

Mapule Matsepane did not have an oral re-hydration corner.

- **Equipment needed for cold chain maintenance**

A range of observations were carried out to determine the cold chain maintenance for vaccines (Table 27).

Table 27: Cold chain maintenance

Item	Betty Gaetsewe	Mapule Matsepane	Recreation	Masakhane	GDH
Refrigerator used exclusively for vaccines?	Yes	Yes	Yes	Yes	Yes
Temperature at the time of the visit	**10⁰C**	8⁰C	8⁰C	2⁰C	**9⁰C**
Temperature record card present	✘	✘	✓	✓	✓
Date of last recording of temperature	-	-	27/11/2002	28/11/2002	14/08/2002
Last recorded temperature	-	-	5⁰C	4⁰C	5⁰C
Cold packs in the refrigerator	✓	✓	✓	✓	✓
Cold boxes in the clinic	✓	✓	✓	✓	✘
Freezer compartment in refrigerator	✓	✓	✓	✓	✓
Number of days refrigerator out of order in the past month	0	0	0	0	0
Refrigerator thermometer in working condition	✓	✓	✓	✓	✓
Space for circulation between vaccines?	✓	✓	✓	✓	✘
Refrigerator located within 3 metres from a heater/air conditioner?	Yes	No	Yes	No	No
Is the refrigerator located against an inside wall (away from direct sunlight)?	No	Yes	Yes	Yes	Yes
Is the refrigerator located in an area where only clinic personnel have access to it?	Yes	Yes	Yes	Yes	Yes
Can the door to the room in which the refrigerator is located be locked?	Yes	Yes	Yes	Yes	Yes

[18] It is recommend that future studies record the number of consultation rooms offering IMCI and TB to enable calculation of the number of infant and adult scales respectively.

Maintenance of temperature: all the facilities had a refrigerator that they used exclusively for vaccines and ice packs. In fact, all the facilities had more than one refrigerator in a working condition, which is in line with the national standard, as stipulated in the Package (Department of Health 2001:13). Observations were conducted to determine the current temperatures in vaccine refrigerators: Two of the clinics' vaccine refrigerator temperatures (Betty Gaetsewe at 10^0C and GDH at 9^0C) were found to be too high. This is a serious problem as the EDL guidelines (Department of Health 1998: 87) stipulate that the cold chain temperature be maintained at between zero and eight degrees.

Monitoring and recording of temperature: both the Package and the EDL guidelines stipulate that all PHC facilities should have temperature cards in use that vaccine refrigerator temperatures should be regularly monitored and recorded (twice per day). Betty Gaetsewe and Mapule Matsepane did not have temperature record cards in use at all. The other three facilities did have temperature record cards in use, but only Recreation and Masakhane had recently recorded dates on these cards (the day before or the same day). GDH last recorded a date more than three months before the field visit.

Location of the refrigerator: the last four questions in Table 27 were derived from the EPI review instrument utilised in the EPI review conducted in the Free State during 2001. (The instrument was compiled by the National Review Coordinator: Assistant Director of EPI in South Africa.) It was found that in two of the facilities (Betty Gaetsewe and Recreation), the vaccination refrigerators were located within three metres from air conditioning equipment, which is unacceptable as this equipment mostly produces heat and could affect the temperatures in the refrigerator. Furthermore, in Betty Gaetsewe the refrigerator was located against an outside wall, which is also unacceptable for more or less the same reason as stated above, namely that outside walls absorb sunlight which could also cause unwanted heat close to the refrigerator. On the positive side, at all the facilities the vaccination refrigerators were located in an area where only clinic personnel had access. Also, the doors of the storage rooms in which they were located were lockable.

Ice packs, cooler bags and thermometers: all the clinics had ice packs in the refrigeration compartments of the vaccine refrigerators as well as cooler bags (GDH lacked one) in case of power failures and for maintaining the cold chain when vaccines need to be transported elsewhere, and working thermometers, as stipulated by the EDL guidelines (Department of Health 1998: 86). However, the vaccine refrigerator in GDH was too full and there was not enough space (5cm) between each tray of vaccines to allow cold air to move around, as is stipulated by the guidelines. When considering that this facility has a total of 19 working refrigerators to its avail, it is unacceptable to find this situation in their vaccination refrigerator.

It could be concluded that cold chain maintenance at especially Betty Gaetsewe need serious attention, but also at Mapule Matsepane, Recreation and GDH where, one or more aspects of their cold chain maintenance was not up to standard. Masakhane, it was found, experience no problem with the maintenance of the cold chain.

Gap-attack!

At Betty Gaetsewe (10^0C) and GDH (9^0C) the vaccine refrigerators' temperatures were found to be unacceptably high. Betty Gaetsewe and Mapule Matsepane did not have temperature record cards implemented at all. GDH had a temperature card, however, the last date recorded was more than three months before the field visit. In Betty Gaetsewe and Recreation the vaccination refrigerators were located within three metres from air conditioning equipment. In Betty Gaetsewe the refrigerator was located against an outside wall. The vaccine refrigerator in GDH was too full and there were not enough space (5cm) between each tray of vaccines to allow cold air to move around.

- **STI programme equipment**

Table 28: STI programme-specific equipment

Item	Betty Gaetsewe	Mapule Matsepane	Recreation	Masakhane	GDH
Number of screened examination couches in working condition	3	3	1	2	6
Number of sterile specula in working condition	1	**0(2)***	10	**Missing data**	**?**

*The number in brackets depicts the number of items in need of repair, should there be any out of order.

In accordance with the Package (Department of Health 2001a: 31), every clinic in Galeshewe has at least one screened examination couch in working condition. However not all clinics have sterile specula in working order. Mapule Matsepane does not have any specula in working condition[19]. All facilities have at least one condom dispenser in an accessible place (where patients do not have to ask for them – Department of Health 2001a: 31-33).

Gap-attack!

Mapule Matsepane does not have sterile specula in working order.

- **HIV/AIDS programme equipment**

Table 29: Availability of a lockable storage room

Item	Betty Gaetsewe	Mapule Matsepane	Recreation	Masakhane	GDH
Lockable storage room for HIV/AIDS information sources	✓	✓	✓	✓	✓

All the facilities had a lockable storage room for HIV/AIDS information sources to be locked up and kept confidential.[20]

- **Sterilisation equipment and practices**

Table 30: Sterilisation infrastructure per facility

Item	Betty Gaetsewe	Mapule Matsepane	Recreation	Masakhane	GDH
Steriliser	0(1)*	0	0	**0**	1

*The number in brackets depicts the number of items in need of repair.

[19] It is recommended that future studies record the number of consultation rooms offering the STI programme to enable calculation of the number of screened examination couches and specula required by the facility.

[20] It is recommended that future studies establish whether these rooms are actually used to this end.

It was found that, with few exceptions, equipment in need of sterilisation is sent to Kimberley Hospital. This situation needs to be re-evaluated and it should be considered whether it would not be more cost-effective to equip all facilities with sterilisation equipment. Also the Package (Department of Health 2001a: 31) stipulates that all health clinics should have a steriliser. GDH was the only facility with a working steriliser at the time of the survey.

Gap-attack!
Only one of the five facilities (GDH) has a steriliser in working order. The others send their equipment in need of sterilisation to Kimberley hospital.

- **Emergency equipment**

Table 31: Oxygen availability

Item	Betty Gaetsewe	Mapule Matsepane	Recreation	Masakhane	GDH
Oxygen cylinder with 0_2	**0(1)***	1	1	1	10
Oxygen mask	Numerous	4	1	5	Numerous

* Number in brackets depicts the number of items in need of repair.

As stipulated by the Package (Department of Health 2001a: 13), all health clinics need to be equipped with oxygen cylinders and masks. At the time of the survey, apart from Betty Gaetsewe, all the facilities had an Oxygen cylinder with oxygen. The respondent at Betty Gaetsewe indicated that they had to send away their cylinder to be filled with oxygen. Therefore at the time of the survey this clinic had no available oxygen for emergencies. All clinics had oxygen masks at the time of the survey. This finding implies that emergencies requiring oxygen can be managed by the PHC facilities in Galeshewe, except when they send cylinders away for refilling. GDH had large number of oxygen cylinders (10) probably because its outpatient department serves as an emergency unit. Seeing that it is the only facility staying open after 16:45 it is important for GDH to have sufficient supply of oxygen.[21] Additionally, GDH also provide a maternity service, for which these cylinders could also be needed. However, if some of GDHs' 10 oxygen cylinders are relocated to the four other clinics in Galeshewe, one to each, GDH will still have six oxygen cylinders and all the facilities will have a backup with oxygen should one their cylinders run out of oxygen. This way, all facilities could always have the infrastructure to manage oxygen-related emergencies. It is therefore recommended that district managers investigate the viability of relocating four of GDHs' oxygen cylinders to the other four facilities in Galeshewe.

Gap-attack!
Betty Gaetsewe did not have an oxygen cylinder with oxygen at the time of the survey.

[21] GDH is closer to the Galeshewe community than Kimberley Hospital rendering it more accessible in emergency situations.

- **Equipment for communication and health education**

Table 32: Equipment for communication and health education

Item	Betty Gaetsewe	Mapule Matsepane	Recreation	Masakhane	GDH
Telephone	3	2	2	6	14
Fax machine	0	0	0	0	0
Computer	1(1)*	2	1	0	1(1)*
Audiovisual set	0(1)*	0	0	0	3

* Number in need of repair.

As stipulated by the Package (Department of Health 2001a: 13), all facilities in Galeshewe have reliable means of communication – all had more than one telephone in working order at the time of the survey. This situation should facilitate smooth communication between the different facilities, between the services and the hospital, the supplying dispensary and the laboratory, and between health workers and their managers. None of the clinics, however, have fax machines and all rely on hand delivery of notices from the District and Provincial offices at the clinics. Four of the five facilities have computers. However, Betty Gaetsewe and GDH reported their computer had been out of order for months. Recreation admitted reported that they never use their computer. The question arises why some of the facilities have computers and others not, and why this equipment was bought in the first place if it is not utilised.[22]

GDH is the only facility with audiovisual equipment[23] (three sets) in working condition. However, even in this case, this equipment is reportedly only used for training health staff and not for patient health education. Betty Gaetsewe also has audiovisual equipment, but in need of repair. At Recreation the audiovisual equipment has been stolen. It is important for all facilities to be equipped with audiovisual sets and health education videos in a local language[24] of the area. Not only would this improve access to health education in facilities (especially where nurses are preoccupied with consultation and care), but it will also make waiting times more of a learning experience for patients (and keep them occupied!).

Gap-attack!

Galeshewe has not yet begun to fully exploit the advantages of computers in health facilities. Even the DIO does not have a computer in working order, rendering quick retrieval of DHIS information difficult. Audiovisual equipment is needed in the waiting rooms of all facilities, especially in the case of facilities where the providers have little time for health education.

- **Electricity supply**

In accordance with the Package (Department of Health 2001a: 13), all of the facilities enjoy reliable electricity supply. No interruptions were reported for the month preceding the survey.

[22] Take note that the DIO responsible for Galeshewe also does not have a computer in working order. This, as was also experienced by the research team, makes accessing updated DHIS information for Galeshewe difficult.

[23] [23] It is a stated five-year objective of the Department of Health (2002: 59) to use tele-education and telemedicine appropriately to support PHC.

[24] Local language in Galeshewe = Afrikaans and Tswana.

- **Self-reported equipment needs**

Betty Gaetsewe Clinic:

- A second oxygen cylinder
- A computer in working order is needed to reduce paper work in the clinic by slotting daily data straight into the computer.
- A fax machine – *'other districts have it'*.
- A photocopier – to photocopy record cards when out of stock. The clinic reports having to wait long times for records cards after ordering and that it frequently runs out of stock.[25]
- A mini-switchboard and connected telephones in all consultation rooms – the respondent indicated that at the moment, if they have to attend to a phone call, they have to leave the patient they are busy with and walk all the way to the front desk in the clinic to take the call. This practice is not time-efficient and if they have a switchboard and connected phones, they will be able to deal with calls in the consultation. (This may be beneficial for other large clinics in Galeshewe as well.)
- More consultation rooms – at this stage some of the programmes are sharing consultation rooms.
- More waiting areas – there are reportedly two waiting areas in the clinic and children/babies and adult curatives use the same waiting areas which is not a healthy situation as the children/babies might contract communicable diseases from adults.[26]

Mapule Matsepane Clinic:

- Audiovisual set
- Glucometer

Recreation Clinic:

- Audiovisual set

Masakhane Clinic:

- A computer – they want to use this for stock control and client information.
- Doptone[27].

GDH:

- Diagnostic sets
- HB meters
- Blood pressure meters
- Doppler
- Glucose meters (four needed)
- Stethoscopes (ten needed)
- Computers (three needed)

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[25] Although it is probably feasible to equip every facility with a photocopier, the management of record cards could be improved as this is clearly a management problem requiring the attention of the sub-district managers.

[26] It could also be considered to divide the waiting areas so that children/babies do not have contact with adult curative patients. This would be less costly than expanding the clinic by building another waiting area. The patient load, seemingly, is not such that all patients do not fit into the waiting areas, the situation is only problematic because children/babies and adult curative patients wait together.

[27] This is an electronic device item that makes it easier to listen to fetal heartbeat. It is recommended that all facilities that provide ANC service be equipped with this item.

- Fax machine
- Photocopier

The above-mentioned needs for equipment have to be weighed against both the patient load and the staffing establishments of the concerned facilities. The current catchment population and headcounts for GDH does not seem to justify expanded resourcing of this facility. On the contrary, it would seem that it is already over-resourced (at least in terms of staffing).

5. PHC diagnostic tests

Table 33 depicts whether important PHC diagnostic tests are offered, as well as the turn-around times of these tests.

Table 33: Diagnostic tests offered and turn-around times

Test item	Betty Gaetsewe		Mapule Matsepane		Recreation		Masakhane		GDH	
	Offered?	Turn-around time – days	Offered?	Turn-around time – days	Offered?	Turn-around time - days	Offered?	Turn-around time - days	Offered?	Turn-around time - days
HIV (laboratory)	Yes	7	Yes	7	Yes	3-4	Yes	5	Yes	3
Syphilis in pregnancy (RPR)	No	-	Yes	7	Yes	3-4	Yes	5	Yes	5
Screening for haemoglobin/blood group/RH (Rhesus test)	No	-	Yes	7	Yes	3-4	Yes	5	Yes	5
Pap smear	Yes	14	Yes	14	Yes	3-4	Yes	10	Yes	10
TB – AFB/smear	Yes	7	Yes	7	Yes	3-4	Yes	7	Yes	5

❑ PHC test practices

The respondent at Betty Gaetsewe reported that Rhesus tests and tests for syphilis in pregnancy were performed at the hospital, as the clinic did not offer ANC services. What is puzzling is the fact that the all the other facilities indicated that they do offer the two tests irrespective of whether or not they offer ANC services. The explanation for this difference may lie therein that Betty Gaetsewe refers all ANC and maternal patients to the hospital (or to other clinics offering these services), while Mapule Matsepane, for example, itself takes the blood samples for these tests and then send them to the laboratory. This difference should be verified by nursing managers in the area as this is a practice that probably best be standardised.

❑ Turn-around times for tests[28]

Reported test turn-around times differ substantially among the five facilities[29]. According to the Package (Department of Health 2001a: 25) HIV test turn-around times should be available within a week. All Galeshewe facilities' turn-around times for these tests were in line with this. The TB Control Programme guidelines (Department of Health 2000: 14) stipulate that AFB/smear tests for pulmonary TB be available within 48 hours, a standard that none of the five facilities accomplished. If Galeshewe was a rural area, this might have been

[28] As far as could be established national standards for RPR, Rhesus-tests and Pap-smears have not been laid down.

[29] Plausibly, the respondents were not all well informed about the turn-around times – verification of this data by district programme managers is recommended.

understandable, but seeing that there is a laboratory available within this urban area and sputum turn-around times are so far below the standard, the situation requires urgent district management attention. One option is to equip all clinics with fax machines so that results can be faxed through from the laboratory as soon as they become available.[30] This system is implemented in certain districts of the Free State and considerable reductions of sputum turn-around times have resulted.[31]

Gap-attack!

Betty Gaetsewe does not offer Rhesus tests and tests for syphilis in pregnancy. Sputum turn-around times were too long at all of the facilities. Why do the turn-around times for all the tests differ widely from facility to facility? Standardisation of best practices is recommended.

6. PHC drugs and supplies

According to the Package, all EDL drugs and supplies should be in stock at clinics and CHCs, stocks should not be kept after expiry and the principle of FEFO (first expiry, first out) should be followed when organising the drug store (Department of Health 2001a: 13-15; 2002). Where does Galeshewe stand in terms of implementing the Package in respect of the EDL programme?

❑ Stock control

As stipulated by the Package (Department of Health 2001a: 13), all health clinics need to be equipped with stock control cards and these should be kept up to date. However, none of the facilities in Galeshewe had stock-control cards in place at the time of the field visit. On the positive side all the facilities had secure lockable storage rooms or cupboards for drug stocks, which is in accordance with the Package.

Gap-attack!

Stock control cards are not implemented in any Galeshewe PHC facility.

[30] Concern, however, was also expressed in how this might compromise confidentiality.

[31] The provincial coordinator of laboratory services in the Free State could be of assistance with information in this regard.

❑ Maternal health[32] programme drugs and supplies

Table 34: Maternity programme drugs

Item	Betty Gaetsewe			Mapule Matsepane			Recreation			Masakhane			GDH		
	S*	FEFO**	NE***	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Injectable contraceptives	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Oral hormonal contraceptives	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓
Post-coital contraceptives (emergency pill)	✓	✓	✓	×	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓
Iron and folic acid combination tablets for pregnant women	×	-	-	×	-	-	✓	✓	✓	×	-	-	×	-	-
Iron tablets (Ferrous sulphate) for pregnant women	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓
Folic acid tablets	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓
Vitamin K injectables	✓	✓	✓	×	-	-	✓	✓	✓	×	-	-	✓	×	✓
Nevirapine tablets	×	-	-	×	-	-	×	-	-	×	-	-	✓	✓	✓
Nevirapine liquid/syrup	×	-	-	×	-	-	×	-	-	×	-	-	✓	×	✓
Misoprostil	×	-	-	×	-	-	×	-	-	×	-	-	✓	✓	✓

* ✓ = Stock available.
** ✓ = Stock organised according to the FEFO principle.
*** ✓ = No expired stock observed.

In accordance with the Package (Department of Health 2001a: 16), all facilities had a supply of oral and injectable hormonal contraceptives at the time of field visits, although some of the oral hormonal contraceptives at Mapule Matsepane had expired. Four out of the five facilities had a supply of emergency contraceptives. Mapule Matsepane did not have any in stock at the time of the survey.

In accordance with the EDL guidelines (Department of Health: 1998: 70), all antenatal patients should receive routine iron and folic acid supplementation as a preventative measure. All facilities had these tablets in stock, however, some of the iron tablets at Mapule Matsepane were expired.

The EDL guidelines (Department of Health 1998: 73) further specify that all babies should receive vitamin K IM 1mg immediately after birth to prevent hypoprothrombinaemia. Both Mapule Matsepane and Masakhane did not have this item in stock.

None of the facilities stocked nevirapine tablets or syrup. It is difficult to determine whether it is required for clinics to stock this item[33]. Even though it is not part of the essential drug list for clinics, the Package (Department of Health 2001a: 18, 33) does specify that post-exposure prophylaxis of occupationally acquired HIV exposure (e.g. needle stick injuries) should be stocked.

Mysoprostil was not available at any of the clinics as they did not provide TOP services. However it is stipulated by the Package (Department 2001b: 18, 23) that medical TOPs should be done, if the pregnancy has lasted 9 weeks or less?

[32] Here defined as ante- and postnatal care and family planning.
[33] PMTCT is currently being piloted only at GDH.

Table 35: Maternity programme supplies

Item	Betty Gaetsewe	Mapule Matsepane	Recreation	Masakhane	GDH
Pregnancy test kit	✓	×	✓	✓	✓
Rapid Rhesus tests	×	×	×	✓	✓
Glucostix	✓	✓	×	×	✓
Uristix	✓	✓	✓	✓	✓
Intrauterine contraceptive devices (IUCDs)	×	×	×	×	×

According to the Package (Department of Health 2001a: 13; 2001b: 22), all clinics should be able to screen for pregnancy when necessary and should have pregnancy tests. Mapule Matsepane did not have any pregnancy test kits. Only Masakhane and GDH stocked rapid Rhesus tests and only Betty Gaetsewe, Mapule Matsepane and GDH had glucostix in stock, but all clinics had uristix in stock. The Package (Department of Health 2001a: 16) stipulates that all health clinics should have intrauterine contraceptive devices. None of the clinics in Galeshewe had these devices in stock.

Gap-attack!

Mapule Matsepane did not have any emergency contraceptives or pregnancy test kits. Betty Gaetsewe, Mapule Matsepane and Recreation did not have rapid rhesus test kits. Both Recreation and Masakhane did not have any glucostix in stock. Both Mapule Matsepane and Masakhane did not have vitamin K injectables in stock. None of the facilities in Galeshewe had intrauterine contraceptive devices. None of the facilities had Misoprostil in stock. Some iron and folic acid tablets as well as oral hormonal contraceptives at Mapule Matsepane were expired. The nevirapine liquids and vitamin K injectables at GDH were not stored according to FEFO.

- **IMCI programme drugs and supplies**

For the IMCI programme it was necessary to include a wide variety of drugs and supplies for observation at the facilities, as an extensive array of drugs and supplies are needed at PHC facilities for carrying out the IMCI programme. All the drugs observed at the facilities are listed in the EDL guidelines (Department of Health**:** 1998).

Table 36: Drugs and supplies used for rehydration

Item	Betty Gaetsewe			Mapule Matsepane			Recreation			Masakhane			GDH		
	S*	FEFO**	NE***	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Salt and sugar	×	-	-	✓	-	-	×	-	-	×	-	-	×	-	-
Teaspoons/millimeter measures	✓	-	-	✓	-	-	✓	-	-	✓	-	-	✓	-	-
Litre measures	✓	-	-	✓	-	-	✓	-	-	✓	-	-	×	-	-
Cups	✓	-	-	✓	-	-	×	-	-	✓	-	-	×	-	-
ORS packets	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

* ✓ = Stock available.
** ✓ = Stock organised according to the FEFO principle.
*** ✓ = No expired stock observed.

The Package (Department of Health 2001a: 20) states that all health clinics should have litre and teaspoon/millimeter measures, cups for feeding, and sugar and salt available for children with diarrhoea who have not yet dehydrated. Only Mapule Matsepane met this standard. None of the other clinics had salt and sugar or cups for this purpose and GDH did not have any litre measures. All the facilities had ORS packets in stock for the rehydration of

dehydrated children and it would seem like ORS packets are used for children with diarrhoea whether they are dehydrated or not. These packets are more expensive than a homemade salt and sugar solution and it is recommended that that only the solution is used in cases not dehydrated.

Table 37: Drugs and supplies used in severely dehydrated children

Item	Betty Gaetsewe			Mapule Matsepane			Recreation			Masakhane			GDH		
	S*	FEFO**	NE***	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Ringer-lactate or Normal Saline (4 sets)	✓	✓	✓	✓	✓	×	✓	✓	×	✓	✓	✓	✓	✓	✓
Blankets (for babies in shock)	×	-	-	×	-	-	×	-	-	✓	-	-	✓	-	-

* ✓ = Stock available.
** ✓ = Stock organised according to the FEFO principle.
*** ✓ = No expired stock observed.

The Package (Department of Health 2001a: 62) specifies that all clinics should stock Ringer-lactate or normal Saline for use in children with severe dehydration. All the facilities did have at least one of these items in stock, however, some of the stock in both Mapule Matsepane and Recreation were found to be expired. Only GDH and Masakhane had blankets with which to keep babies/children in shock warm.

Table 38: Vaccines

Item	Betty Gaetsewe			Mapule Matsepane			Recreation			Masakhane			GDH		
	S*	FEFO**	NE***	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Oral polio vaccine	✓	✓	✓	×	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓
DPT (or DPT Hib) vaccine	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hepatitis B	×	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tetanus toxoid vaccine	×	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
BCG vaccine	×	-	-	×	-	-	×	-	-	×	-	-	✓	✓	✓

* ✓ = Stock available.
** ✓ = Stock organised according to the FEFO principle.
*** ✓ = No expired stock observed.

Vaccination is an important component of the IMCI strategy. The Package (Department of Health 2001a: 19) sets the standard that immunisation coverage in all districts should not be below 80%. It is imperative that all PHC facilities have all necessary vaccines in stock. Therefore it is of great concern that Betty Gaetsewe did not have any hepatitis B vaccine in stock, while Mapule Matsepane did not have any oral polio vaccine and that some of its DPT stock had expired.

Although Tetanus toxoid vaccine is not routinely used for all children, it is necessary for children to receive this if wounded in such a way that tetanus is a possibility. Betty Gaetsewe did not have any of this vaccine in stock and therefore could not protect children (or adults) against possible tetanus at the time of the survey.

Only GDH had BCG vaccines, as this is administered directly after birth to a baby and GDH is the only facility that renders a delivery service. However, if no visible scar appear after six

weeks of vaccination, it is necessary to repeat the vaccination. The question arises here whether all professional nurses screen babies for the BCG-scar after six weeks and administer it again if no scar develops, which would be impossible, as none of the other facilities stock this vaccine.

Table 39: Supplies for vaccination programme

Item	Betty Gaetsewe			Mapule Matsepane			Recreation			Masakhane			GDH		
	S*	FEFO**	NE***	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Sterile water for injection	✓	-	-	×	-	-	✓	-	-	✓	-	-	✓	-	-
Unused sealed syringes appropriate for vaccinations: Gauge needles with minimum length of 25 mm	✓	-	-	✓	-	-	✓	-	-	✓	-	-	✓	-	-
Unused sealed syringes appropriate for vaccinations: gauge needles with minimum length of 32 mm	×	-	-	✓	-	-	✓	-	-	✓	-	-	✓	-	-

* ✓ = Stock available.
** ✓ = Stock organised according to the FEFO principle.
*** ✓ = No expired stock observed.

It was found that Mapule Matsepane did not have sterile water for injection and Betty Gaetsewe did not have any sealed syringes with a minimum length of 32mm for intramuscular injections.

Table 40: Nutritional supplements

Item	Betty Gaetsewe			Mapule Matsepane			Recreation			Masakhane			GDH		
	S*	FEFO**	NE***	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Infant nutrition supplements: milk	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Infant nutrition supplements: porridge product	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Supply of iron supplementation for children	✓	✓	✓	×	-	-	✓	✓	×	✓	✓	✓	✓	✓	✓
Vitamin A capsules or solution	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Vitamin C for use in children	×	-	-	×	-	-	×	-	-	✓	✓	✓	✓	✓	✓
Vitamin B complex for use in children	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

* ✓ = Stock available.
** ✓ = Stock organised according to the FEFO principle.
*** ✓ = No expired stock observed.

All facilities in Galeshewe had both milk and porridge products in stock with which to compliment the feeding of malnourished children. However, not all clinics had all the micronutrients as listed in the EDL guidelines (Department of Health 1998: 112). Mapule Matsepane did not have any iron supplements for children in stock and some of the iron supplementation at Recreation had expired. Only Masakhane and GDH had vitamin C available for use in children. All facilities had vitamin A and B complex supplements, although the latter was not stored according to the FEFO principle.

Table 41: Antibiotics, drugs and supplies used in the management of ear, nose, throat and pulmonary and other conditions in children

Item	Betty Gaetsewe			Mapule Matsepane			Recreation			Masakhane			GDH		
	S*	FEFO**	NE***	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Cotrimoxazole syrup (combination of trimethoprim and sulfamethoxadole)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Benzylpenicillin	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prednisolone	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Salbutamol inhaler	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nebuliser/tubing masks	✓	-	-	✓	-	-	✓	-	-	✓	-	-	✓	-	-
Child spacer (for salbutomol inhaler)	✓	-	-	✓	-	-	✓	-	-	✓	-	-	✓	-	-

* ✓ = Stock available.
** ✓ = Stock organised according to the FEFO principle.
*** ✓ = No expired stock observed.

It is to the credit of the IMCI programme in Galeshewe that all facilities had all the drugs, supplies and equipment listed in the Table 41. Also all the drugs were stored according to the FEFO principle and none were expired.

Table 42: Drugs used for pain and fever

Item	Betty Gaetsewe			Mapule Matsepane			Recreation			Masakhane			GDH		
	S*	FEFO**	NE***	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Paracetamol	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

* ✓ = Stock available.
** ✓ = Stock organised according to the FEFO principle.
*** ✓ = No expired stock observed.

All clinics also had a supply of paracetamol for pain and fever and none were expired or incorrectly stored.

Table 43: Drugs used for worm infestation

Item	Betty Gaetsewe			Mapule Matsepane			Recreation			Masakhane			GDH		
	S*	FEFO**	NE***	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Mebendazole	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

* ✓ = Stock available.
** ✓ = Stock organised according to the FEFO principle.
*** ✓ = No expired stock observed.

All facilities also had a supply of mebendazole in stock. All the stocks were stored according to FEFO at all facilities and none were expired.

- **Drugs used in eye care**

Table 44: Drugs used in eye care

Item	Betty Gaetsewe			Mapule Matsepane			Recreation			Masakhane			GDH		
	S*	FEFO**	NE***	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Tetracycline eye ointment	✓	✓	✓	✓	✓	✓	×	-	-	×	-	-	×	-	-
Chloramphenicol eye ointment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

* ✓ = Stock available.
** ✓ = Stock organised according to the FEFO principle.
*** ✓ = No expired stock observed.

Three of the five facilities (Recreation, Masakhane and GDH) did not have tetracycline ophthalmic (eye) ointment in stock. This is quite serious, as it is a component in the treatment regimen for trachoma in children and adults and trachoma is a highly infectious notifiable eye condition. All facilities had chloramphenicol eye ointment in stock.

- **Antiseptics and oral health drugs**

Table 45: Antiseptics and oral health drugs

Item	Betty Gaetsewe			Mapule Matsepane			Recreation			Masakhane			GDH		
	S*	FEFO**	NE***	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Polyvidone iodine/chlorhexine	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gentian violet	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	×

* ✓ = Stock available.
** ✓ = Stock organised according to the FEFO principle.
*** ✓ = No expired stock observed.

All facilities had polyvidone iodine in stock, stored according to the FEFO principle and no stock was expired. Although all facilities had gentian violet in stock as well, some of the stock was expired in Mapule Matsepane and GDH.

Table 46: Emergency treatment supplies (anaphylactic shock, cardiac arrest and hypoglycaemic)

Item	Betty Gaetsewe			Mapule Matsepane			Recreation			Masakhane			GDH		
	S*	FEFO**	NE***	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Adrenalin	✓	✓	✓	×	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓
10% dextrose	✓	✓	✓	✓	✓	×	✓	✓	✓	×	-	-	✓	✓	✓

* ✓ = Stock available.
** ✓ = Stock organised according to the FEFO principle.
*** ✓ = No expired stock observed.

All health clinics should be able to handle emergencies like anaphylactic shock, cardiac arrest, and hypoglucaemic coma, as these conditions are often encountered in PHC facilities. Therefore, life saving emergency drugs like adrenalin and dextrose should always be in stock. Nevertheless, Mapule Matsepane did not have any adrenalin in stock at the time of the survey, while Masakhane did not have 10% dextrose.

Gap-attack!

Betty Gaetsewe, Recreation, Masakhane and GDH did not have salt and sugar or cups for children with diarrhoea (who are not dehydrated). GDH did not have any litre measures. Some of the Ringer-lactate stock in Mapule Matsepane and Recreation were found to have expired. Betty Gaetsewe, Mapule Matsepane and Recreation did not have blankets (to keep babies/children in shock warm). Betty Gaetsewe did not have any hepatitis B vaccine in stock. Mapule Matsepane did not have any oral polio vaccine. Some of the DPT vaccines in Mapule Matsepane had expired. Betty Gaetsewe did not have any Tetanus toxoid vaccine in stock. Only GDH had BCG vaccine. Mapule Matsepane did not have sterile water for injection. Betty Gaetsewe did not have any sealed syringes with a minimum length of 32mm for intramuscular injections. Mapule Matsepane did not have any iron supplements for children. Some of the iron supplementation in Recreation had expired. Only Masakhane and GDH had vitamin C available for use in children. The vitamin B complex supplements in Mapule Matsepane were not stored according to the FEFO principle. Three of the five facilities (Recreation, Masakhane and GDH) did not have tetracycline ophthalmic (eye) ointment in stock. Some gentian violet stock was expired in Mapule Matsepane and GDH. Mapule Matsepane did not have any adrenalin. Masakhane did not have 10% dextrose stock.

- **TB control programme drugs**

Table 47: TB drugs

Item	Betty Gaetsewe			Mapule Matsepane			Recreation			Masakhane			GDH		
	S*	FEFO**	NE***	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
RH (refinah) for adults and children	✓	✓	✓	×	-	-	✓	✓	✓	✓	✓	✓	×	-	-
RHZE (rifafour)	✓	✓	✓	×	-	-	✓	✓	✓	✓	✓	✓	×	-	-
H (isoniazid)	✓	✓	✓	×	-	-	✓	✓	×	✓	✓	✓	×	-	-
E (ethambutol)	✓	✓	✓	×	-	-	✓	✓	✓	✓	✓	✓	×	-	-

* ✓ = Stock available.
** ✓ = Stock organised according to the FEFO principle.
*** ✓ = No expired stock observed.

The reason why Mapule Matsepane and GDH did not have any TB medication in stock, is because they do not offer the TB programme. Masakhane does not offer a full TB service, but stocks the medication because it offers DOT for patients on the registers at Betty Gaetsewe and Recreation. In those clinics that did offer TB services or dispensed TB medication, little problems were encountered, except for the fact that some of the isoniazid stock in Recreation was expired.

Gap-attack!

Some isoniazid stock at Recreation was expired.

❑ STI/HIV/AIDS programme drugs and supplies

Table 48: Drugs and supplies required for the STI and HIV/AIDS programmes

Item	Betty Gaetsewe			Mapule Matsepane			Recreation			Masakhane			GDH		
	S*	FEFO**	NE***	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Ciprofloxacin (250 mg tabs)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Flagyl (2 g tabs)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Erythromycin (250 mg tabs)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Doxycycline (100 mg tabs)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Benzathine penicillin	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Condoms	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Latex gloves	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rapid HIV/AIDS test kits	✓	✓	✓	×	-	-	×	-	-	✓	✓	✓	✓	✓	✓
Sharps disposal containers	✓	-	-	✓	-	-	✓	-	-	✓	-	-	✓	-	-

* ✓ = Stock available.
** ✓ = Stock organised according to the FEFO principle.
*** ✓ = No expired stock observed.

To the credit of the EDL, STIs and HIV/AIDS programmes all the listed drugs and supplies were found to be in stock at all facilities. None was expired and everything was stocked according to FEFO. However, neither Mapule Matsepane nor Recreation had any rapid HIV/AIDS test kits in stock, which probably mean they have not yet been trained to use these tests.

Gap-attack!
Mapule Matsepane and Recreation had no rapid HIV/AIDS test kits in stock.

7. PHC maps, graphs and protocol documents

The Package only defines which services are required to provide a comprehensive PHC service to patients (Department of Health 2001a: 7). It therefore does not specify how specific services should be delivered. This *'how'* is left to the national, provincial and district health levels, who are responsible for the development of protocols for specific programmes. The Package (Department of Health 2001a: 12), however, does specify that facilities should have access to *"[a]ll relevant national and provincial health related circulars, policy documents, acts and protocols that impact on service delivery"*. Similarly, facilities should have a catchment area map that indicates all the activities that the facility undertakes in the community (Department of Health 2001a: 13, 16). Furthermore, monthly and annual data related to the facility should be graphed and displayed where staff and the community health committee have access to it.

❑ Maps

Table 49: Display of catchment area maps

Facility	Catchment map displayed on wall
Betty Gaetsewe	*Missing data*
Mapule Matsepane	Map available – catchment population not indicated
Recreation	No map
Masakhane	Map available – catchment population not indicated
GDH	No map

A GIS survey was undertaken recently, but maps and information has not yet been distributed to facilities.

❑ Graphs

Table 50: Display of graphs with recent information (past three months)

Facility	Maternal health	IMCI	TB	STIs	HIV/AIDS
Betty Gaetsewe	✓	✓	✓	✓	✓
Mapule Matsepane	N/A	×	N/A	×	×
Recreation	N/A	×	×	×	×
Masakhane	×	×	×	×	✓
GDH	✓	✓	N/A	×	×

In some cases, graphs were available, but were not displayed.

Gap-attack!
Of the five clinics only Betty Gaetsewe displays recent PHC graphs relating to all the key PHC programmes it offers.

❑ Protocols and stationery

Table 51: Availability of general PHC protocols and stationery

Facility	Betty Gaetsewe	Mapule Matsepane	Recreation	Masakhane	GDH
The primary health care package for South Africa – a set of norms and standards (Department of Health 2001a)/*A comprehensive primary health care package for South Africa* (Department of Health 2001b)	✓	✓	×	✓	✓
Death notification forms	✓	×	×	×	✓
Notifiable diseases reporting form	✓	×	✓	×	✓
Referral letter	✓	✓	✓	✓	✓

Although referral letters were universally available, it is of concern that Recreation did not have a copy of either of the two Package documents, that death notification forms were not available at Mapule Matsepane, Recreation and Masakhane, and that forms for reporting notifiable diseases were not available at Mapule Matsepane and Masakhane.

Gap-attack!
Recreation did not have a copy of either of the Package documents.

Table 52: Availability of family planning, women's and maternal health protocols and stationery[34]

Facility	Betty Gaetsewe	Mapule Matsepane	Recreation	Masakhane	GDH
Family planning register	✓	×	×	×	✓
National contraception guidelines (2002)	×	×	×	×	×
Midwifery protocol	N/A	N/A	N/A	✓	✓
Executive summary of saving mothers report (1998)	N/A	N/A	N/A	✓	✓
Saving babies report (2001)	N/A	N/A	N/A	×	×
Maternity register	N/A	N/A	N/A	N/A	✓
TOP register	N/A	N/A	N/A	N/A	N/A

[34] Not noted in the table is that of the five facilities, three (Betty Gaetsewe, Mapule Matsepane and Recreation Clinics) do not have a copy of either the 1998 Sterilisation Act or the 2001 *National guide for cervical screening*, while GDH does not have the *Sterilisation act* and Masakhane does not have the *National guide for cervical screening*. This is of concern, as the Package (Department of Health 2001b: 22) requires all PHC facilities to provide family planning services by the end of 2001, and at least one Pap smear to all women by the end of 2002.

Only Betty Gaetsewe and GDH had family planning registers. None of the facilities had a copy of the 2002 *National contraception guidelines*. The two facilities that offer maternal health services, i.e. Masakhane and GDH, have both the *Midwifery protocol* and the 1998 *Executive summary of saving mothers report* (the protocols relating to ante- and perinatal care), but neither have a copy of the 2001 *Saving babies report*. GDH is the only facility with a maternal obstetrics unit (MOU) and that has a *Maternity register*. None of the five facilities in Galeshewe have a TOP register (all TOPs are currently referred to Kimberley hospital).

Gap-attack!

Protocols related to family planning (FP) are not generally available, with Mapule Matsepane, Recreation and Masakhane not having FP registers, and none of the facilities having a copy of the *National contraception guidelines*. Neither of the two facilities that provide ANC services (Masakhane and GDH) have a copy of the 2001 *Saving babies report*.

Table 53: Availability of IMCI protocols, stationery and contact lists

Facility	Betty Gaetsewe	Mapule Matsepane	Recreation	Masakhane	GDH
Growth monitoring/*Road-to-health* charts	✓	✓	✓	✓	×
Protocol for managing and referring children with growth faltering and micronutrient deficiency and obesity	✓	×	×	×	×
Nutrition/child health register/book	×	×	×	✓	✓
Protein energy malnutrition (PEM) register/book	×	✓	✓	✓	✓
Protocol for management of children with HIV/AIDS	✓	*	✓	×	✓
Protocol for emergency referral	✓	*	×	×	×
IMCI chart booklet or enlarged wall chart	✓	✓	✓	✓	✓
Immunisation register/book	✓	×	×	✓	✓
Official national form for adverse effects of immunisation	✓	*	✓	×	×
EPI disease surveillance manual	✓	*	×	✓	✓
EPI vaccination manual	✓	✓	×	×	✓
EPI cold chain operations manual	✓	✓	×	×	✓
Written cold chain contingency plan for power interruptions/paraffin shortages/gas shortages	✓	*	×	×	×
Written cold chain contingency plan while defrosting refrigerator	✓	*	×	×	×
List of notifiable diseases	✓	×	✓	✓	×
Contact person/number list for emergencies	✓	✓	✓	×	✓
Poison centre contact numbers	✓	✓	×	×	✓
List of names of women in breastfeeding support groups	×	N/A	N/A	✓	×
Birth notification forms	N/A	×	✓	N/A	×

* The acting facility manager was not sure where to find all the documentation.

Of the two protocols needed to monitor nutrition and growth in children, GDH does not have a *Road-to-health chart*, while, with the exception of Betty Gaetsewe, none of the other facilities have the *Protocol for management and referring children with growth faltering and micronutrient deficiencies and obesity*. When it comes to nutrition registers, three facilities (Betty Gaetsewe, Mapule Matsepane, and Recreation) do not have a register for child health and nutrition, while Betty Gaetsewe also does not have a PEM register. Neither Mapule Matsepane nor Masakhane has the *Protocol for management of children with HIV/AIDS*, while only Betty Gaetsewe has the *Protocol for emergency referral*. All five facilities have a copy of either the IMCI chart booklet of an IMCI wall chart. However, Mapule Matsepane and Recreation do not have immunisation registers, while Mapule Matsepane, Masakhane and GDH do not have copies of the *Official national form for adverse effects of immunisation*. Recreation does not have any of the *EPI* documents, while Mapule Matsepane does not the *EPI disease*

surveillance manual, and Masakhane does not have either the *EPI vaccination manual* or the *EPI Cold chain Operations manual*. Only Betty Gaetsewe has cold chain contingency plans for power failures and defrosting the refrigerator, with none of the other facilities having any written protocol. Mapule Matsepane does not have a list of notifiable diseases, while Masakhane does not have an emergency contact list and Recreation and Masakhane do not have contact numbers for the Poison centre. Of the three facilities offering ANC services (Betty Gaetsewe, Masakhane and GDH) only Masakhane has a name list of a breastfeeding support group.

Gap-attack!

Mapule Matsepane, Recreation, Masakhane and GDH do not have the *Protocol for managing and referring children with growth faltering and micronutrient deficiency and obesity*, while Betty Gaetsewe, Mapule Matsepane and Recreation do not have nutrition or child health registers. Of concern is that only Betty Gaetsewe could produce an emergency referral protocol. Recreation did not have any of the EPI manuals. A further concern is that four of the facilities (Mapule Gaetsewe, Recreation, Masakhane and GDH) do not have cold chain contingency plans to handle power failures and defrosting of the refrigerator.

Table 54: Availability of TB protocols and stationery

Facility	Betty Gaetsewe	Mapule Matsepane	Recreation	Masakhane	GDH
The South African TB control programme practical guidelines (2000)	✓	N/A	✓	×	N/A
TB register manual	×	N/A	×	N/A	N/A
Tracking TB at work – guidelines from South Africa's national TB control programme	×	N/A	×	N/A	N/A
DOTS training manual	×	N/A	✓	×	N/A
Flow charts on TB diagnosis	×	N/A	✓	N/A	N/A

Currently TB services are provided only at Betty Gaetsewe and Recreation. What is of concern, however, is that neither Betty Gaetsewe, nor Recreation, have either a TB register manual or the protocol *Tracking TB at work*. In addition, Betty Gaetsewe does not have a *DOTS training manual* or the flow charts used for diagnosing TB, which inevitably will influence how effectively and accurately they are able to diagnose TB patients. Masakhane provides clinic and community-based DOT(S) for patients registered at Betty Gaetsewe. However, Masakhane has no TB protocols.

Gap-attack!

Both Betty Gaetsewe and Masakhane do not have the required protocols that would assist them in providing an appropriate and effective TB service.

Table 55: Availability of STI protocols and stationery

Facility	Betty Gaetsewe	Mapule Matsepane	Recreation	Masakhane	GDH
Training manual for the management of a person with a sexually transmitted disease (1999)	×	*	✓	×	✓
Syndromic case management of sexually transmitted diseases (or EDL booklet)	✓	✓	✓	✓	✓
The diagnosis and management of sexually transmitted diseases in South Africa	✓	✓	×	✓	×
Wall chart of the six protocols for STI management	✓	✓	✓	✓	✓

All five facilities have the protocol on the *Syndromic management of sexually transmitted diseases*, as well as the wall chart on STI management. However, Betty Gaetsewe, Mapule Matsepane and Masakhane do not have a copy of the *Training manual for the management of a person with a sexually transmitted disease*, while Recreation and GDH does not have a copy of *The diagnosis and management of sexually transmitted diseases in South Africa*.

Table 56: Availability of HIV/AIDS protocols and stationery

Facility	Betty Gaetsewe	Mapule Matsepane	Recreation	Masakhane	GDH
Protocol for managing of opportunistic infections of HIV	×	✓	×	×	✓
Protocol for HIV rapid test quality assurance	✓	*	×	✓	✓
Informed consent for HIV testing	×	✓	✓	×	✓
Resource list of HIV/AIDS services	×	*	×	×	×
Protocol on HIV rapid testing	×	✓	×	×	✓
Protocol on voluntary HIV confidential counseling and testing (VCCT)	×	✓	×	×	✓
HIV strategic plan for South Africa 2000-2005	×	*	×	×	×
Summary results of the last national HIV serological survey on women attending public health services in South Africa	×	*	×	×	✓
Management of occupational exposure to HIV	×	✓	×	×	✓
Paediatric HIV/AIDS guidelines	×	*	×	×	✓
HIV/AIDS guidelines for home-based care	×	×	✓	×	×
Policy guidelines and recommendations for feeding infants of HIV positive mothers	×	✓	×	×	✓
PMTCT guidelines	N/A	N/A	N/A	N/A	✓

It is disconcerting that Betty Gaetsewe and Masakhane have only the *Protocol for HIV rapid test quality assurance*, and none of the other protocols and documents on HIV/AIDS. This means that they also do not have copies of the informed consent form for HIV testing. Recreation only has the informed consent form and *HIV/AIDS guidelines for home-based care*. None of the facilities could produce a list of HIV/AIDS service providers in their area, which implies that they are not able to refer patients to other organisations for support. Betty Gaetsewe, Recreation and Masakhane do not have the *Protocol on HIV rapid testing* or the *Protocol on voluntary HIV confidential counselling and testing*, raising the question of how effectively they are able to provide VCCT services. In general it seems that these three clinics are poorly resourced in terms of HIV/AIDS protocols and guidelines. Also, none of the facilities has a copy of the *HIV strategic plan for South Africa 2000-2005*. Only two facilities (Mapule Matsepane and GDH) have a copy of the *Management of occupational exposure to HIV*, prompting the question how the other three facilities (Betty Gaetsewe, Recreation and Masakhane) deal with occupational exposure of their staff to HIV?

Gap-attack!

None of the facilities had a resource list of HIV/AIDS service organisations that would be able to provide support to HIV+ patients. None of the facilities have a copy of the national *HIV strategic plan for South Africa 2000-2005*. Betty Gaetsewe, Recreation and Masakhane do not have a copy of *Management of occupational exposure to HIV*.

Table 57: Availability of EDL protocols and stationery

Facility	Betty Gaetsewe	Mapule Matsepane	Recreation	Masakhane	GDH
National essential drug list and standard treatment guidelines	✓	✓	✓	×	✓
EDL booklet	*Missing data*	×	×	✓	✓

It is of concern that Masakhane does not have a copy of the *National essential drug list and standards treatment guidelines*, while Mapule Matsepane and Recreation could not produce a copy of the EDL booklet.

Gap-attack!

Mapule Matsepane and Recreation do not have a copy of the EDL booklet.

There seems to be no coordinated system to ensure that all clinics have the required protocols. Some protocols are determined at provincial, or even district level, but the distribution of such material does not appear to take place in a coordinated manner. Sometimes, *'protocols'* consist of copied training presentations that were attended. However, it does happen that the coordinator for a specific programme is not able to attend relevant training sessions, and the protocol does therefore not reach the relevant facility programme coordinators, or the clinic generally.

Clinic staff members, especially at those clinics with fewer personnel, often do not have the time (or skills), to develop a comprehensive indexing and referencing system for the storage of protocols. However, despite those protocols that are used most often being generally close at hand, less frequently used ones, while available, where not always easy to find. It sometimes took a concerted effort to find some documents. Thus while it may seem from some of the data that protocols and stationery are available, clinic staff did not recognise some of the documents, and are therefore unlikely to be familiar with the contents. This has implications for continuity of care when the facility manager or programme coordinator are not available, as other staff then do no know where to find many of the documents.

Gap-attack!

There does not seem to be coordinated system to ensure effective distribution and utilisation of protocols in the Galeshewe area. PHC facilities require indexing and referencing systems to store protocols.

8. Facility and patient held PHC records

Table 58: Target dates for the implementation of record systems in PHC facilities in South Africa

PHC programme	Record system to be implemented	Target date	Reference page in the Package (Department of Health 2001b)
Maternal health	Patient-held ANC card	2001	21, 30
IMCI	*Road-to-health* card	2001	14, 19
TB	TB register	2001	25
STIs	Patient-held card	2002	24

❑ Maternal health records

Table 59: Implementation of record system and completeness of information in patient-held ANC cards

Information in ANCs	Betty Gaetsewe		Mapule Matsepane		Recreation		Masakhane		GDH	
	Imple-mented?*	Com-plete**	Imple-mented?	Com-plete	Imple-mented?	Com-plete	Imple-mented?	Com-plete	Imple-mented?	Com-plete
Date of first ANC visit	×	-	N/A	-	N/A	-	✓	100%	✓	0%
Outcome of syphilis testing		-		-		-		90%		100%
Outcome of RH testing		-		-		-		100%		100%

* Whether record system had been implemented.
** Percentage of ten randomly chosen records indicating all required information.

The Package required implementation of the patient-held ANC card by the end of 2001. Table 59 indicates that this system has been implemented only at Masakhane and GDH. From the sampled records it is clear that completion of the patient-held ANC card is fairly high at Masakhane, but that the date of first ANC visit is not indicated for any of the patients at GDH.

Gap-attack!
The date of first ANC visit is not indicated for any of the ANC patients at GDH.

Table 60: Implementation of record system and completeness of information in facility-held ANC record

Information in ANCs	Betty Gaetsewe		Mapule Matsepane		Recreation		Masakhane		GDH	
	Imple-mented?*	Com-plete**	Imple-mented?	Com-plete	Imple-mented?	Com-plete	Imple-mented?	Com-plete	Imple-mented?	Com-plete
Date of first ANC visit	N/A	-	N/A	-	N/A	-	✓	100%	✓	100%
Outcome of syphilis testing		-		-		-		100%		80%
Outcome of RH testing		-		-		-		100%		70%

* Whether record system had been implemented.
** Percentage of ten randomly chosen records indicating all required information.

Table 60 indicates that an ANC record system has been implemented at Masakhane and GDH. From the sampled records, it was that the facility-held ANC cards are kept complete

and up to date at Masakhane, but that the outcomes of syphilis and RH testing are not always indicated on these records at GDH.

Gap-attack!
Either not all ANC patients at GDH undergo syphilis and RH testing, or the results of such test are not indicated (facility-held ANC cards incomplete).

- **IMCI records**

Table 61: Implementation of record system and completeness of information in patient-held *Road-to-health* charts

Information in *Road-to-health* chart	Betty Gaetsewe		Mapule Matsepane		Recreation		Masakhane		GDH	
	Imple-mented?*	Com-plete**	Imple-mented?	Com-plete	Imple-mented?	Com-plete	Imple-mented?	Com-plete	Imple-mented?	Com-plete
First measles shot by age 12 months	✓	100%	✓	100%	✓	90%	✓	100%	✓	100%
Fully immunised by 1 year		100%		100%		100%		100%		90%

* Whether record system had been implemented.
** Percentage of ten randomly chosen records indicating all required information.

The Package required implementation of the patient-held *Road-to-health* charts by the end of 2001: the target date for full immunisation of children by age twelve months (Department of Health 2001b: 19). *Road-to-health* charts have been implemented at all five facilities in Galeshewe. The sampled *Road to Health* charts were kept up to date.

- **TB records**

Table 62: Implementation of record system and completeness of information in patient-held TB card

Information in patient-held TB card	Betty Gaetsewe		Mapule Matsepane		Recreation		Masakhane		GDH	
	Imple-mented?*	Com-plete**	Imple-mented?	Com-plete	Imple-mented?	Com-plete	Imple-mented?	Com-plete	Imple-mented?	Com-plete
Patient category	✓	100%	N/A	-	✓	100%	N/A	-	N/A	-
International disease code		100%		-		100%		-		-
Basis of decision to treat		100%		-		100%		-		-
Notification information		70%		-		100%		-		-
Regimens and doses		70%		-		90%		-		-
Sputum results		40%		-		100%		-		-

* Whether record system had been implemented.
** Percentage of ten randomly chosen records indicating all required information.

Table 63: Implementation of record system and completeness of information in facility-held TB register

Information in facility-held TB register	Betty Gaetsewe		Mapule Matsepane		Recreation		Masakhane		GDH	
	Imple-mented?*	Com-plete**	Imple-mented?	Com-plete	Imple-mented?	Com-plete	Imple-mented?	Com-plete	Imple-mented?	Com-plete
Date of registration	✓	100%	N/A	-	✓	100%	N/A	-	N/A	-
Treatment outcome		80%		-		90%		-		-

* Whether record system had been implemented.

** Percentage of ten randomly chosen records indicating all required information.

The Package required implementation of the facility-held TB register by the end of 2001. The recording of treatment outcomes on the facility-held TB register is relatively high.

❑ **STI programme records**

All STIs should be treated (according to syndromic approach) by end 2001 (Department of Health 2001a: 21, 22, 24, 30). The syndromic wall charts seem to be generally available and used by staff.

9. Referral practice

The Package (Department of Health 2001a: 14) states that all patients', whose needs fall beyond the scope of clinic staff competence, should be referred to the next level of care. In certain instances no referral systems were in place in Galeshewe. Masakhane reported having no referral system for STI patients (the clinic reported that it was following treatment protocols, and as yet had not found it necessary to refer patients). Mapule Matsepane, Recreation and Masakhane reported following the normal referral system (for adult curative care) when having to refer HIV/AIDS patients with various complications. It is a concern that GDH staff reported problems (in all cases, except for IMCI) with not receiving feedback on referred patients, especially in light of the fact that the Package encourages discussions on the merits of referrals as part of continuing education for health care providers.

❑ **Maternal health referral**

According to the norms and standards of the Package (Department of Health 2001a: 16, 17) reproductive services for women should be provided in an integrated and comprehensive manner covering preventative, promotive, curative and rehabilitative aspects of care. The standards for referral are:

- All referrals within and outside the clinic are motivated and the reasons for referral are written on the referral form.
- Patients needing additional health or social services are referred according to protocols.
- Referrals from traditional birth attendants (TBAs) should be encouraged (TBAs should be trained).

Table 64: Referral for complications during pregnancy

Facility	Referral system in writing	Comments on the functionality of the referral system
Betty Gaetsewe	N/A	N/A
Mapule Matsepane	N/A	N/A
Recreation	N/A	N/A
Masakhane	Yes	*"Working well"*
GDH	Yes	*"We do not get feedback about these patients unless we ask for it."*

Masakhane and GDH (the two facilities providing ANC services in Galeshewe) had a written referral system for patients experiencing complications during pregnancy. Although this system was working well for Masakhane, GDH reported not receiving feedback on patients who were referred.

Table 65: Referral after Pap smear, if required

Facility	Referral system in writing	Comments on the functionality of the referral system
Betty Gaetsewe	Yes	*"Working well"*
Mapule Matsepane	N/A	N/A
Recreation	N/A	N/A
Masakhane	Yes	*"Working well"*
GDH	Yes (not seen)	*"Do not get feedback"*

The three facilities doing Pap smears (Betty Gaetsewe, Masakhane and GDH) had written referral systems (although this document was not seen at GDH). Only GDH reported a problem with not receiving feedback on referred patients.

Gap attack!
GDH does not receive feedback on maternal health cases that are referred for pregnancy related complications and problematic Pap smears.

- **IMCI referral**

According to the norms and standards of the Package (Department of Health 2001a: 19, 20), promotive, preventative, curative and rehabilitative services should be given in accordance with provincial IMCI protocols at all times that the clinic is open. The standard for referrals is that children with danger signs and/or severe diseases should be referred as described in the IMCI provincial protocol.

Table 66: Referral for IMCI (very ill patients)

Facility	Referral system in writing	Comments on the functionality of the referral system
Betty Gaetsewe	Yes	*"Working well"*
Mapule Matsepane	Yes (not seen)	*"Working well"*
Recreation	Yes (not seen)	*"Working well"*
Masakhane	Yes	*"Working well"*
GDH	Yes	*"Working well"*

All the facilities in Galeshewe reported having a written referral system in place for very ill IMCI patients, although this document was not seen at Mapule Matsepane and Recreation. In all instances this system was reported to be working well.

- **TB referral**

According to the norms and standards of the Package (Department of Health 2001: 38, 39), clinic staff should follow national protocols in order to diagnose TB on clinical suspicion using sputum microscopy; provide IEC; active screening of families of TB patients; promote voluntary HIV testing; treat, dispense and follow-up using DOT; and complete the TB register. Referral standards are:

- Only patients who are ill enough to need hospitalisation are referred to hospital. They are sent with a completed TB register form as well as a proposed discharged plan.
- Patients referred to the clinic after being discharged from the hospital (with a discharge plan), are immediately followed-up so as to ensure that the discharge plan is effectively implemented.
- Before a patient is transferred to another area, he/she must be supplied with a complete transfer form and sufficient supplies of medicine. Where possible the facility to where the patient is being referred should be notified telephonically.
- If the TB patient is HIV-positive, the patient should be given a sealed and confidential letter with relevant information for the facility to where he/she is being transferred.
- TB patients with severe complications or adverse drug reactions are referred for admission to hospital.
- Children who have extensive TB or gross lymphadenopathy or who are not improving on treatment are referred.
- Where necessary, patients who need additional health or social services are referred.
- All MDR cases are referred to the Provincial MDR Committee/unit.

Table 67: Referral of very ill TB patients

Facility	Referral system in writing	Comments on the functionality of the referral system
Betty Gaetsewe	Yes	*"Not working well. The TB hospital in Jan Kempdorp has recently opened and no arrangements regarding referrals have been made with the clinics."*
Mapule Matsepane	N/A	N/A
Recreation	Yes (not seen)	*"The referral system is working well, although some problems were experienced with back-referrals. A meeting was held with the Kimberly complex to sort this out. Doctors send vague letters, but not the actual documentation of sputum results."*
Masakhane	N/A	N/A
GDH	Yes	*"No feedback is given"*

Betty Gaetsewe and Recreation, as well as GDH have written referral systems (although the TB coordinators were not able to produce these during interviews) for the referral of very ill TB patients. Although GDH does not provide TB services, the CHC does have a written policy for the referral of TB patients. Both Betty Gaetsewe and Recreation reported problems with the referral systems. GDH again mentioned not receiving any feedback.

Table 68: Referral of suspected TB cases with negative sputum

Facility	Referral system in writing	Comments on the functionality of the referral system
Betty Gaetsewe	Yes	*"Working well"*
Mapule Matsepane	No	*"Normal referral system used for ill patients being sent to doctors/hospital is followed"*
Recreation	No	*"Normal referral system used for ill patients being sent to doctors/hospital is followed"*
Masakhane	N/A	N/A
GDH	Yes	*"No feedback is given"*

Betty Gaetsewe and GDH have a written referral system in place for the referral of suspected TB patients with negative sputum. Recreation and Mapule Matsepane reported following the ('*normal*') referral system used for sick patients being referred to the doctor or hospital.

Gap attack!

There is a lack of coordination regarding referrals between Betty Gaetsewe and the recently opened TB hospital Jan Kempdorp.

- **STI referral**

According to the norms and standards of the Package (Department of Health 2001a: 31, 32), the prevention and management of STIs should be available on a daily basis at clinics. The clinic represents a comprehensive service for reproductive health and for the control of HIV/AIDS. The referral standards include:

- All patients are referred to the next level of care when their needs fall beyond the scope of competence.
- New-borns with conjunctivitis are referred after initial treatment.
- Pregnant patients in their last trimester diagnosed with herpes are referred.
- Patients with pelvic inflammatory disease are referred if sick, if they have pyrexia and tachycardia or severe tenderness, or are pregnant.
- Patients under the age of 18 years, with a painful unilateral scrotal swelling are immediately referred for a surgical opinion regarding possible torsion.

More specifically, referral guidelines are clearly presented in the '*Protocols for the management of a person with a sexually transmitted disease'* (Directorate: HIV/AIDS 1998).

Table 69: Referral of STI patients not responding to treatment after two weeks

Facility	Referral system in writing No referral system	Comments on the functionality of the referral system
Betty Gaetsewe	Yes	*"Working well"*
Mapule Matsepane	No	*Working well"*
Recreation	No	*"We do not follow a written referral policy, we use our knowledge about when to refer. This system is working."*
Masakhane	No	*"Not yet had to refer a STI patient. STI protocol steps are followed for treatment."*
GDH	Yes	*"No feedback is given"*

Betty Gaetsewe and GDH had written referral policies for STIs. Masakhane followed the STI protocol (in effect a written policy). However, Mapule Matsepane and Recreation did not have any written policies.

Gap-attack!

Nurses at Recreation reportedly use their knowledge to decide when to refer a STI patient. Thus the question arises as to whether they all have sufficient training regarding the treatment of STIs.

- **HIV/AIDS referral**

According to the norms and standards of the Package (Department of Health 2001: 33-35), a comprehensive range of services including the identification of possible cases; testing with pre- and post-counseling; the treatment of associated infections; referral of appropriate cases; education about the disease to promote a better quality of life; promote universal precautions and provide condoms; and the application of occupational exposure policies such as needle-stick injury, should be provided. The referral standards include:

- The referral of herpes zoster, oesophageal candidiasis and severe continued diarrhoea (after a trial of symptomatic treatment).

- Referral of suspected TB patients who remain sputum negative for further investigation.

Table 70: Referral of very ill HIV/AIDS patients

Facility	Referral system in writing	Comments on the functionality of the referral system
Betty Gaetsewe	Yes	*"Not working well. Kimberly Hospital sends very ill HIV/AIDS patients home. They are told to get home-based care from the clinics. Home-based care is not working well at the clinics as the volunteers were promised payment from 2000, as yet nothing has happened."*
Mapule Matsepane	No	*"Normal referral system used for ill patients being sent to doctors/hospital is followed"*
Recreation	No	*"Normal referral system used for ill patients being sent to doctors/hospital is followed"*
Masakhane	No	*"Normal referral system used for ill patients being sent to doctors/hospital is followed"*
GDH	Yes	*"No feedback is given"*

Betty Gaetsewe and GDH had written policies for the referral of very ill HIV/AIDS patients. The remaining clinics followed the normal referral policy for ill patients. A particular problem reported by Betty Gaetsewe was that Kimberly Hospital sends very ill patients home to be cared for by home-based care workers. However, home-based carers are not yet receiving payment and this system is not functioning well.

Table 71: Referral of patients with herpes zoster

Facility	Referral system in writing	Comments on the functionality of the referral system
Betty Gaetsewe	**Yes**	*"Working well"*
Mapule Matsepane	**No**	*"Normal referral system used for ill patients being sent to doctors/hospital is followed"*
Recreation	**No**	*"Normal referral system used for ill patients being sent to doctors/hospital is followed"*
Masakhane	**No**	*"Normal referral system used for ill patients being sent to doctors/hospital is followed"*
GDH	**Yes**	*"No feedback is given"*

Betty Gaetsewe and GDH had a written policy for the referral of patients with herpes zoster. The remaining clinics followed the normal referral policy for ill patients.

Table 72: Referral of patients with oesophageal candidiasis

Facility	Referral system in writing	Comments on the functionality of the referral system
Betty Gaetsewe	**Yes**	*"Working well"*
Mapule Matsepane	**No**	*"Normal referral system used for ill patients being sent to doctors/hospital is followed"*
Recreation	**No**	*"Normal referral system used for ill patients being sent to doctors/hospital is followed"*
Masakhane	**No**	*"Normal referral system used for ill patients being sent to doctors/hospital is followed"*
GDH	**Yes**	*"No feedback is given"*

Betty Gaetsewe and GDH had a written policy for the referral of patients with oesophageal candiasis. The remaining clinics followed the normal referral policy for ill patients.

Table 73: Referral of patients with severe continued diarrhoea

Facility	Referral system in writing	Comments on the functionality of the referral system
Betty Gaetsewe	**Yes**	*"Working well"*
Mapule Matsepane	**No**	*"Normal referral system used for ill patients being sent to doctors/hospital is followed"*
Recreation	**No**	*"Normal referral system used for ill patients being sent to doctors/hospital is followed"*
Masakhane	**No**	*"Normal referral system used for ill patients being sent to doctors/hospital is followed"*
GDH	**Yes**	*"No feedback is given"*

Betty Gaetsewe and GDH had a written policy for the referral of patients with severe continued diarrhoea. The remaining clinics followed the normal referral policy for ill patients.

Gap-attack!

GDH experiences problems with referral as no feedback is given regarding referred patients. What is being done to solve this problem? Do Masakhane and GDH not even take sputum samples? What happens to patients suspected of having TB? Is it not possible that these patients continue to infect others with this disease as they are sent from one health facility to another?

10. Information, education and communication (IEC) material

Information, education and communication (IEC) is an integral of the Package as a means to create awareness amongst patients as to PHC services, and their rights and obligations regarding these services. According to the Department of Health (2001b: 14, 19, 21, 22, 24, 25, 30) all of the pamphlets and posters listed in Tables 74 and 75 should have been availed in PHC facilities by the end of 2001.

Table 74: Availability of IEC pamphlets

Facility	Betty Gaetsewe		Mapule Matsepane		Recreation		Masakhane		GDH	
	Available	Local language	Available	Local language	Available	Local language	Available	Local language	Available	Local language
Emergency contraception	×	-	×		×		×		×	
Diarrhoea/ORS solution	×	-	×		×		✓	✓	×	
Breastfeeding/nutrition	×	-	×		×		✓	✓	×	
Family planning	×	-	×		×		✓	✓	×	
Malnutrition	×	-	×		×		×		×	
VCCT	×	-	✓	✓	✓	✓	✓	×	✓	×
PMTCT	×	-	×		×		×		×	
TB	×	-	×		✓	✓	✓	×	×	
STIs	×	-	×		×		×		×	
Condom use	×	-	×		✓	✓	×		×	
Percentage of all sampled pamphlets available	0%	-	10%	10%	30%	30%	50%	30%	10%	0%

Table 75: Display of posters in facilities

Facility	Betty Gaetsewe		Mapule Matsepane		Recreation		Masakhane		GDH	
	Displayed	Local language	Displayed	Local language	Displayed	Local language	Displayed	Local language	Displayed	Local language
Patient's rights charter	✓	×	✓	✓	✓	×	✓	×	✓	✓
Emergency contraception	✓	×	×		×		×		×	
Diarrhoea/ORS solution	×		×		✓	×	✓	✓	✓	×
Breastfeeding/nutrition	×		✓	×	✓	×	✓	✓	✓	×
Family planning	✓	×	×		✓	×	✓	✓	×	
Women's health charter	×		×		×		✓	×	×	
Malnutrition	×		✓	×	×		×		✓	×
VCCT	✓	×	×		✓	×	✓	×	✓	×
PMTCT	×		×		×		✓	×	✓	✓
TB	✓	×	✓	✓	✓	✓	✓	×	✓	✓
STIs	✓	×	✓	×	×		×		✓	×
Condom use	×		✓	×	×		×		✓	×
Percentage of all sampled posters displayed	50%	0%	50%	17%	50%	8%	67%	25%	75%	25%

It is clear that IEC does not seem to be high on the list of priorities of PHC facilities in Galeshewe. Masakhane had the highest availability of IEC pamphlets at only 50% availability of the different topics sampled, with only 30% of the total being available in a local language at this clinic. In some instances only one copy of a specific pamphlet was available, and in others instances patients have to ask for pamphlets, as they are not freely available. The argument, ostensibly, is that this is to prevent them from being *'wasted unnecessarily'*. A higher availability of IEC posters (compared to pamphlets) was observed, with Betty Gaetsewe, Mapule Matsepane and Recreation having 50% of all sampled topics available. However, none of these pamphlets were available in a local language at Betty Gaetsewe, only 8% at Recreation, and 17% at Mapule Matsepane. Both Masakhane and GDH had only 25% of all sampled poster topics available in a local language. (To the credit of GDH, personnel have taken the initiative to devise some of their own maternal health posters.)

Gap-attack!

Nationally available pamphlet and poster materials are not fully exploited as part of IEC relating to key PHC programmes in Galeshewe.

11. Community involvement and patient rights

With the decentralisation of the health system in South Africa and the subsequent introduction of the district health system, a move was made to empower communities to participate in the system's governance. The idea was for community health committees and community development forums to be established in order to encourage community participation in clinic matters (Levendal *et al.* 1997: 131). According to the Package (Department of Health 2001a: 14) each PHC facility should have a functioning community health committee in the facility catchment area. The concept of community involvement as

used in the context of the Package also implies that all PHC facilities should initiate and sustain community outreach activities to secure active participation of communities in health programmes (Department of Health 2002: 60).

- **Community health committees**

In Galeshewe, it was only GDH that did not have a functioning community health committee. Minutes of the last community health committee meeting were available only at Betty Gaetsewe and Recreation.

Table 76: Community health committees

	Betty Gaetsewe	Mapule Matsepane	Recreation	Masakhane	GDH
Community health committee in existence	Yes	Yes	Yes	Yes	No
Whether minutes of community health committees were available	Yes	No	Yes	No	NA

Gap-attack!
GDH is the only health facility in Galeshewe without an active community health committee.

- **Patient complaint procedure**

Each PHC facility should have a formal, clear structured complaint procedure in place (Department of Health 2001a: 11, 12).

Table 77: Patient complaint procedures

	Betty Gaetsewe	Mapule Matsepane	Recreation	Masakhane	GDH
Patient complaint procedure in place	No	Yes	Yes	Yes	Yes
Suggestion box (seen)	-	No	Yes	Missing data	Yes
Complaints handled verbally	-	-	-	Yes	Yes✓

Betty Gaetsewe has no patient complaint procedure in place. Mapule Matsepane reported having a suggestion box, but it had not yet been put up. Patient complaints at Masakhane are reportedly dealt with verbally. Therefore, in essence it is only Recreation that totally ascribes to the standards set out in the Patients' Rights Charter, namely that there be a clear structured complaint procedure in place.

Gap-attack!
Only Recreation that has formal, clear, structured complaint procedure in place?

- **Involvement of facilities in the community**

Although it was aimed to obtain specific information regarding facility personnel's involvement in community activities outside of the clinic, respondents viewed community involvement much more broadly than anticipated by the instrument[35]. This included clinic staff involvement at the clinic and in the community in providing health education; the

[35] Future studies should aim to improve the instrument in this respect.

involvement of volunteers in activities both inside and outside of the clinic; and the involvement of community members in health related activities.

There is almost no community involvement, either from staff or community workers at Mapule Matsepane and GDH. Masakhane staff and community workers appear to be the most active in community activities.

Table 78: Broad description of community involvement by PHC programme

Facility	Maternal Health	IMCI	TB	STIs	HIV/AIDS
Betty Gaetsewe		1. A trained volunteer organised birth registration education at the clinics. An attempt to roll this out into the community failed as the Department of Home Affairs did not give permission to proceed	1. TB health education at schools, taverns and taxi stops 2. Volunteers planted a vegetable garden at the clinic. Vegetables given to patients with TB and HIV/AIDS, as well as malnourished children.		1. Home-based carers do home visits.
Mapule Matsepane			N/A		1. Meeting with NAPWA, Assistant Director Health, MEC for health and community members to discuss the plight of persons with HIV/AIDS
Recreation	1. Staff at Zenzeleni House for AIDS orphans given advice on immunisations 2. Talks on childcare days (i.e. Mon and Wed) 3. Mothers given vegetable seeds to plant for their own gardens		1. TB health education at the civic centre, schools, churches and workplaces 2. SANTA youth organised TB health education		1. Demonstrations on how to use condoms 2. Allocation of personnel to provide home-based care
Masakhane	1. Mothers visited the Minister of Health in Kimberley 2. Breastfeeding week 3. Breastfeeding support group 4. Planning PMTCT	1. PEM counseling offered	1. TB Awareness Day 2. Home-based care visits 3. Vegetable gardens organised by volunteers at patients' homes 4. DOTS home visits	1. Femidon pilot clinic. Staff distribute condoms and femidons to various distribution points over weekends	
GDH			N/A		1. HIV/AIDS health talks

Gap-attack!

Not only does GDH not have an active community health committee, its staff members are also not involved in activities in the community.

CHAPTER 3

PHC MANAGEMENT, PROVISIONING AND PROGRAMMES IN GALESHEWE - GAPS, STRENGTHS AND RECOMMENDATIONS

1. Main gaps in PHC management and provisioning - Galeshewe PHC facilities

❑ Betty Gaetsewe Clinic

Table 79: Main gaps in PHC management and provisioning at Betty Gaetsewe Clinic

Issue	Gap
Staffing, programme target populations and patient load	Serious staffing shortages are perceived by this clinic. Although the clinic indeed records the highest clinical workload per nurse of the five PHC facilities in Galeshewe, nurses work only 192 of an expected 225 working days per professional nurse per year (three out of ten nurses were absent on the day of the field visit). The last-mentioned gap, however, also is smaller than at other facilities. Take note, also, that Betty Gaetsewe, by far, has the largest catchment population among the PHC facilities in Galeshewe. With only 15% of the available number of nurses (all types) in Galeshewe, Betty Gaetsewe's catchment population constitutes 41% of the total Galeshewe population. The largest number of community health workers (18) among the five facilities were engaged at Betty Gaetsewe, but only three of these are employed staff members. Compared to the two facilities staffed entirely by the Department of Health (Masakhane and GDH) Betty Gaetsewe is under-resourced with employed community health workers.
Scope and accessibility of PHC services	Routine ANC services should have been be introduced and in place at PHC facilities (clinics, mobiles and CHCs) by the end of 2001 (Department of Health 200b: 21, 30). Hence, Betty Gaetsewe should be providing the following services: ▪ TOP: By the end of 2001 clinics should have had in place: medical terminations for pregnancies under 9 weeks; daily recall up to the actual abortion procedure; and referral if the abortion did not occur within one week. Twenty-four hour CHCs should be providing comprehensive TOP services by the end of 2002 (Department of Health 2001b: 23, 30). Despite these guidelines, no facility in Galeshewe is providing TOP services. ▪ Environmental health: This entails, amongst others, information on environmental health services; information on waste management; information on water quality; and chemical and food safety. This service should have been in place at all PHC facilities by the end of 2001 (Department of Health 2001b: 26; 34; 35). Currently this service is only offered at the CHC (GDH) and not at any of the clinics in Galeshewe. ▪ Home-based care: This service is organised into special needs; i.e. growth faltering, persons needing rehabilitation and palliative care. In general, home-based care should have been in place by the end of 2002. Home visits by auxiliary nurses should have been in place by 2001 (Department of Health 2001b: 15). Hence, Betty Gaetsewe should provide home-based care services and is not. ▪ Violence/sexual abuse: This service should have been available at PHC facilities from the end of 2001 (Department of Health 2001b: 22, 23). Therefore, this service should be available at Betty Gaetsewe, although it is not. ▪ Rehabilitation: This includes, amongst others, screening and observations at clinics and home for early detection; and basic assessment, and should have been available from the end of 2001 at clinics and CHCs (Department of Health 2001b: 26; 33, 34). Only the CHC (GDH) offers this service currently, despite the fact that it should be offered by all PHC facilities. All the services that were available at Betty Gaetsewe, were available five days per week.
Programme management	The facility manager at Betty Gaetsewe has more years of facility management experience than the managers of the other five facilities. The clinic does not perceive itself to be well supported by higher-level programme managers. Although at Betty Gaetsewe the key PHC programmes are all managed/coordinated by specific nurses, key programme management is seriously affected by a lack of a multi-skilled nurse corps, implying that when the coordinator of the programme is not at the clinic, there is nobody to run the programme: *"There are times when nearly all seven professional nurses are on training or sick leave"*. In addition to requiring more staff, the clinic is in need of improved training of its nurses in the key PHC programmes. Training in the maternal health programme is specifically required. (Problems with the referral of TB patients are discussed below.) The STI programme is affected by drug supply problems and is concerned about poor follow-up of contacts. The HIV/AIDS-programme is not well supplied with rapid HIV tests and necessary stationery.
Facility equipment	Two adult scales are in need of repair. Two of the three glucometers in the clinic have expired. The vaccine refrigerator temperature was found to be too high (the refrigerator was wrongly located next to an outside wall) and the temperature record card system was not in use. In general maintenance of the cold chain requires attention at the clinic. Oxygen was not in supply at the clinic on the day of the field visit. Neither the computer nor the audiovisual equipment at the clinic are in working condition. In addition to the above, self-reported equipment needs are for a fax machine, a photocopier, and most importantly, for more consultation rooms.
Diagnostic tests	Betty Gaetsewe does not offer Rhesus tests and tests for syphilis in pregnancy. At this clinic, as elsewhere in Galeshewe, the TB sputum turn-around time is unacceptably long.

Issue	Gap
Drugs and supplies	As elsewhere in Galeshewe drug stock control cards have not been implemented. Tetanus toxoid and hepatitis B vaccine was not in supply. Betty Gaetsewe also did not have any sealed syringes with a minimum length of 32mm for intramuscular injections. As elsewhere in Galeshewe, the clinic did not stock salt and sugar or cups for children with diarrhoea (who are not dehydrated).
Protocols, registers, forms and maps	Betty Gaetsewe did not have a copy of the *Sterilisation act* or a copy of the *National guide for cervical screening programme*. ANC is not provided by this clinic, however. As the other facilities, it did not have a copy of the *National contraception guidelines* or a copy of the *Sterilisation act* either. With regard to women's health, this facility did not have a copy of the *National guide for cervical screening programme*. It further had no nutrition or child health register and also not all the necessary protocol documents that would assist them in providing an appropriate TB service. As the other facilities, it did not have a resource list of HIV/AIDS service organisations that would be able to provide support to HIV+ patients or a copy of the *National HIV strategic plan for South Africa* 2000-2005. It further did not have a copy of the protocol on management of occupational exposure to HIV.
Facility- and patient-held records	No stock control cards were in use at this clinic, as was the case in all other clinics in Galeshewe, and no ANC cards, however, the latter service was not rendered here. TB records at this facility was generally incomplete.
Referral practice	Programme-specific referral practices in Betty Gaetsewe seemed to be working well in general, except for TB and HIV/AIDS referrals: TB: There is a lack of coordination regarding referrals between Betty Gaetsewe and the recently opened TB hospital in Jan Kempdorp. Furthermore, the TB control programme at Betty Gaetsewe experiences various problems regarding collaboration with Kimberley Hospital relating to both referral to and referral from the hospital. HIV/AIDS: According to the respondent at Betty Gaetsewe, Kimberly Hospital sends very ill HIV/AIDS patients home. They are told to get home-based care from the clinics, while home-based care is not implemented at Betty Gaetsewe yet.
Information, education and communication (IEC) material	There were no pamphlets available on any of the sampled topics in Betty Gaetsewe. With regard to posters, there were none at all displayed on the clinic's waiting area walls on diarrhoea/ORS solution, breast feeding, the women's health charter, malnutrition, PMTCT or condom use. Therefore, only 50% of the sampled poster topics were displayed in this clinic. None of the posters that were displayed in this clinic were in the local languages of the area.
Community involvement and patient rights	There was no patient complaint procedure in place at this facility.

❑ Mapule Matsepane Clinic

Table 80: Main gaps in PHC management and provisioning at Mapule Matsepane Clinic

Issue	Gap
Staffing, programme target populations and patient load	Shortage of nursing staff reportedly hinders the provision of PHC such as comprehensive maternal health and TB services. Each nurse sees an average of 32 patients per day (a total of four nurses) and the clinic only has three CHWs as compared to the other facilities which have between eight and 18 CHWs. The acting facility manager was uncertain whether the CHWs are employed or not. The sessional doctor works less than the minimum ten hours per week (seven sessional hours per week) and has the lowest doctor clinical workload of all the PHC facilities in Galeshewe (18). Nurses worked an average of 180 of the 225 expected professional nurse workdays per nurse per year in the year preceding the survey. On the day of the survey, only one of the three professional nurses was on duty.
Scope and accessibility of PHC services	Of the key priority programmes under study, maternal health and TB services are not provided fully as required by the Package (Department of Health 2001b: 16-17; 38-40). With regards to maternal health, only family planning is provided. Although TB sputum samples are collected patients are thereafter referred to another facility. Mental health, environmental health, occupational health, repeat/fast queue, oral health, speech/hearing screening, radiology, rehabilitation and PMTCT are services not offered at Mapule Matsepane. All PHC services offered are provided daily (Monday to Friday) except immunisations, nutrition/growth monitoring and VCT which are only offered once a week and family planning and eye care referrals which are only offered twice a week. More importantly, there are no special times for youth health services as stipulated in the Package (Department of Health 2001a: 24).

Issue	Gap
Programme management	The facility manager has been in this post for less than a year and the acting facility manager (who was interviewed for the survey) will occupy this position for a period of six months. In both cases management experience is limited. Within the last three years (2000-2002) the clinic has not been visited by the district infection control official (should visit every three months), the IMCI trainer (should visit six weeks after training thereafter every three months), the laboratory technician, nor by the district IMCI, STI and HIV/AIDS coordinator/supervisor. The provincial PHC district supervisor has not visited the clinic in the past three years (2000-2002). However, the local municipality head of health usually visits the clinic once a year but did not do so in 2002. Also, the clinic did not receive feedback for any of the last three IMCI and HIV/AIDS reports submitted to management. Lack of visits and feedback from district management indicates poor support for PHC management at a facility level. Especially staff involved in counseling HIV/AIDS clients find a lack of support from management in this regard very disturbing. According to the Package (Department of Health 2001a: 20) annual assessment of the quality of IMCI services should be conducted by the IMCI supervisor. This assessment has never been conducted at Mapule Matsepane. No health workers are allocated to coordinate any of the key PHC programmes that could largely be attributed to the shortage of staff. Also attributed to the shortage of staff is the clinic's inability to offer comprehensive TB services. On the day the clinic was visited, only one of the three professional nurses was on duty. Increasing the staff complement from the current three professional nurses to five with a simultaneous increase in clinic space is put forth as a suggestion to improving the quality of PHC at the facility and reducing the workload of other PHC facilities in Galeshewe which offer services that are not offered at this facility, such as TB and maternal health. Contact tracing (STI patients) remains a major problem in STI management, which creates despondency among staff. The management of the EDL programme is made difficult by the absence of certain drugs from the EDL (e.g. Nalidixic acid), which are prescribed/preferred by sessional doctors. It is suggested that sessional doctors review the EDL.
Facility equipment	The Package (Department of Health 2001a: 13) stipulates that all consultation rooms/professional nurses/medical officers should be equipped with examination lights. It also stipulates that all health clinics should have a glucometer. Mapule Matsepane had no examination lights in working order (four consultation rooms) and the only glucometer that the clinic has was sent for repairs and never returned. Although Mapule Matsepane does not offer maternal health services, the Package (Department of Health 2001: 16, 21) requires all PHC facilities to have a fetal scope, delivery sets/sterile packs and a neonatal resuscitation trolley to manage uncomplicated deliveries. Mapule Matsepane does not make use of a temperature record card even though the Package (Department of Health 2001b: 23) and EDL guidelines specifically stipulate the use thereof and the regular monitoring and recording of vaccine temperatures (twice per day). Of great concern is that the only two specula at Mapule Matsepane are both not in working condition. This obviously affects the provision of STI services since it is one of the equipment utilised for STI diagnostic examinations.
Diagnostic tests	The EDL guidelines stipulate that the turn-around time for pulmonary TB tests is 48 hours. The turn-around time for TB tests at Mapule Matsepane, namely seven days, by far exceeds the standard in the EDL guidelines.
Drugs and supplies	Mapule Matsepane does not make use of stock control cards as stipulated in the Package (Department of Health 2001a: 13-15). One of the main reasons for drugs being out of stock was the late placement of drug orders by the clinic. This is more than likely attributable to the lack of a coordinator for the EDL programme at this facility. Some of the oral hormonal contraceptives had expired and no post-coital contraceptives (emergency pill) and vitamin K injectables were in stock. Mapule Matsepane had no IUCDs, Rapid Rhesus Tests and pregnancy test kits in stock even though all clinics are required to stock these maternity programme supplies (Department of Health 2001a: 13-16). Some of the gentian violet and 10% dextrose stock was expired and adrenalin was out of stock. Also not in stock at the clinic were blankets for babies in shock, oral polio vaccine, BCG vaccine, sterile water for injection, supply of iron supplementation for children and vitamin C for use in children. Some stock of ringer-lactate/normal saline and DPT vaccine had expired. Mapule Matsepane and Recreation are the only two PHC facilities in Galeshewe that do not stock rapid HIV/AIDS test kits. Rightfully so, since none of the staff have undergone training in conducting rapid HIV/AIDS tests. Although the HIV/AIDS counselor at Recreation has undergone training in rapid HIV/AIDS testing, her lack of training in nursing prevents her from administering these tests, which renders her training inadequate.
Protocols, registers, forms and maps	Although Mapule Matsepane had a map of Kimberly with all the health districts displayed on the wall, the clinic's catchment area was not clearly marked. Furthermore, no graphs with recent information (past three months) were displayed on the wall for any of the five PHC programmes under study. The clinic had no death notification and notifiable diseases reporting forms. The system for filing protocols needs to be improved. Most protocols are kept in a file with no specific referencing system. This is especially problematic when staff members need to find documents in the absence of the facility manager. Also, many of the protocols are not familiar to staff. Therefore, they are not aware of whether they have these protocols or not. Mapule Matsepane only had 36% of the required IMCI protocols, 60% of the required STI and HIV/AIDS protocols and no protocols for family planning.
Facility- and patient-held records	No problems observed
Referral practice	Mapule Matsepane does not have a written referral system specifically for each of the key PHC programmes under study. They make use of the general referral system for ill patients that need to be referred to the next level of care.
Information, education and communication (IEC) material	Mapule Matsepane did not have pamphlets on emergency contraception, diarrhoea/ORS solution, breastfeeding/nutrition, family planning, malnutrition, PMTCT, TB, STIs and condom use. Also lacking were displayed posters of emergency contraception, diarrhoea/ORS solution, family planning, women's health charter, VCCT and PMTCT. IEC material forms an integral part of preventative health care through patient education. These pamphlets and posters should have been available at all PHC facilities by end 2001 (Department of Health 2001a: 14). Mapule Matsepane reported a need for an audiovisual set that will be used for patient education.

Issue	Gap
Community involvement and patient rights	Although Mapule Matsepane has an active community committee and a patient complaint procedure in place, community involvement towards enhancing PHC in their catchment population remains low. No projects/initiatives are taking place in any of the PHC programmes under study accept for the HIV/AIDS programme. This despite the importsnt role of adequate STI management in reducing HIV-infections.

❑ Recreation Clinic

Table 81: Main gaps in PHC management and provisioning at Recreation Clinic

Issue	Gap
Staffing, programme target populations and patient load	A perceived constraint in the management of the PHC programme at this clinic is a shortage of nursing staff. Each nurse sees approximately 33 patients a day. There are nine unpaid community health workers stationed at this clinic. Although there is no national norm for patient-nurse ratio, findings from studies conducted in the Free State have shown that 35 to 40 patients per nurse per day is the ideal workload. If this is to be regarded as the norm, Recreation is not under-staffed. However, in 2000, the national average nurse clinical workload at fixed clinics was 19.8 (Viljoen *et al*. 2000). If the national average of patients consulted by a nurse per day is thus regarded as the norm, then Recreation is under-staffed. Recreation has less than the minimum ten doctor sessional hours per week (only eight sessional hours).
Scope and accessibility of PHC services	Recreation does not offer ANC (according to the Package this should be in place from 2001), Pap smears (should be in place from 2002), TOP (should be in place from 2001), VCT, PMTCT, mental health (all should be in place from 2001), eye care, oral health, rehabilitation (should be in place from 2001), environmental health (should be in place from 2001). The clinic manager reported neither having the staff nor the equipment to provide comprehensive maternal health. Immunisation, child care and nutrition/growth monitoring are available on certain days of the week, although these services are also available on other days should a patient so request it
Programme management	Visits to the clinic are a rare occurrence. The clinic is visied only by the IMCI trainer and coordinator, the TB coordinator, and the pharmacist. Written feedback on the reports submitted to PHC managers is lacking in most cases – this problem relates to PHC management in general and to all the key PHC programmes except TB. Furthermore, the last STI assessment was conducted in 2001. Self-reported management constraints included staff shortages, problems with the cleaner, temporary building for the clinic, and poor maintenance of the building by the municipality. The suggested solution to these problem was that all staff should be *'under one umbrella'*, especially in light of the fact that *'the Local Authority could no longer employ personnel'*. Constraints mentioned by the IMCI coordinator included: staff shortage, too little space for an oral rehydration corner, and shortage of drugs. Similarly, the TB coordinator also mentioned the staff shortage, a sputum turnaround time of 4-5 days and vague referral letters. Constraints mentioned by the STI coordinator were that contact tracing was difficult as patients lied about addresses, recurrence of STIs as patients do not want to use condoms, and the shortage of condoms. The HIV/AIDS counselor experienced a unique set of constraints, as she was a lay health worker, with no mentor/supervisor to support her. Furthermore, being a layperson, she is not permitted to conduct the rapid HIV test, yet has to train nurses how to do it. The EDL supervisor mentioned drug shortages at the depot and the fact that the medicine needs to be packed at the clinic, as being the main constraints she faces.
Facility equipment	Recreation lacks thermometers. This clinic did not have stethoscopes in all its consultation rooms (six). This is worrying because stethoscopes are needed in the routine screening of all patients attending PHC facilities. Neither did all the consultation rooms have blood pressure apparatus or otoscopes. Some of the glucometers were broken. Although the fact that Recreation does not have a fetal scope nor a neonatal resuscitation trolley may be explained in that this clinic does not offer ANC or comprehensive maternal health, the Department of Health (2001a: 16) sets the standard that all health clinics should have at least one fetal scope in working order and be equipped to manage uncomplicated deliveries. The vaccination refrigerator is located within three metres from air conditioning equipment, which is unacceptable as this affect the temperature of the refrigerator. Thus cold chain maintenance needs attention. Staff reported that they never use their computer. The audiovisual equipment has been stolen and this needs to be replaced.
Diagnostic tests	The EDL guidelines stipulate that AFB/smear tests for pulmonary TB be available within 48 hours, a standard that is not met by Recreation.
Drugs and supplies	Drug stock-control cards were not in place at the time of the field visit. The clinic did not have the following drugs or supplies in stock: nevirapine tablets or syrup, Mysoprostil, Rapid RH Tests, glucostix, IUCDs (all related to the maternal health programmes, which is not comprehensively implemented at this facility); salt and sugar or cups, blankets, BCG (all from the IMCI programme); Tetracycline ophthalmic (eye) ointment; and rapid HIV/AIDS test kits. Expired stock included Ringer-lactate or normal saline, iron supplementation (IMCI); and Isoniazid (TB).
Protocols, registers, forms and maps	No graphs with recent information (past three months) concerning the PHC programmes were displayed on the walls. This clinic does not have a copy of either of the two Package documents and death notification forms were not available. Furthermore, there was none of the following: family planning register, 1998 *Sterilisation Act*, 2001 *National guide for cervical screening*, *Protocol for management and referring children with growth faltering and micronutrient deficiencies and obesity*, register for child health and nutrition, Protocol for emergency referral, immunisation register, EPI manuals, cold chain contingency plans for power failures and defrosting the refrigerator, contact numbers for poison centre, TB register manual, *Tracking TB at work*, *The diagnosis and management of sexually transmitted diseases in South Africa*, and the EDL booklet. Almost none of the HIV/AIDS booklets protocols are available at this facility.

Issue	Gap
Facility- and patient-held records	No problems observed
Referral practice	Some problems were experienced with back-referrals for TB patients as doctors send vague letters without the actual documentation of sputum results to the clinic. There is not a referral system in place to deal with STI patients who do not respond to treatment after two weeks.
Information, education and communication (IEC) material	Recreation does not have any information or pamphlets on diarrhoea/ORS solution, breastfeeding, family planning, malnutrition, PMTCT, or STIs. In fact, only 30% of the selected information topics were available at this clinic. More posters than pamphlets were available at this clinic, although only half of the posters selected for observation.
Community involvement and patient rights	There is no community involvement in the IMCI and STI programmes at this facility.

❑ Masakhane Clinic[36]

Table 82: Main gaps in PHC management and provisioning at Masakhane Clinic

Issue	Gap
Staffing, programme target populations and patient load	Although the staff at this clinic reported a serious staff shortage, their daily nurse clinical workload of 33 patients is at par with most of the other clinics n Galeshewe, and below that of Betty Gaetsewe. This is also slightly lower than the lower range (35) stipulated by the Free State Department of Health. Nurses at this facility work only 175 (78%) of an expected 225 hours annually. The only other facility that works fewer hours is GDH. Of the nursing staff compliment of six, five were present on the day of the visit, with one chief professional nurse absent. Masakhane has quite a large number of CHWs (13), but a possible explanation for this could be that it has a full-time nutrition advisor, which recruits and coordinates the activities of these CHWs.
Scope and accessibility of PHC services	Of the five priority programmes under study in Galeshewe, Masakhane does not provide full TB control services as prescribed by the Package (Department of Health 2001b:21-25). Although this clinic does not provide full TB services, and does not have a register, patients registered at other clinics (mainly Betty Gaetsewe), but who fall within the catchment are of Masakhane, receive their medication from the latter, through both clinic- and community-based DOTS.
Programme management	Three of the priority programmes under study (maternal health, IMCI, TB) are coordinated by a health worker, while STIs, HIV/AIDS and EDL functions are performed by all as *'curative'*, with no one taking responsibility for the coordination of these key PHC programmes. Apart from feedback on the vitamin A supplementation report submitted by the clinic, no other written feedback had been received by the facility on any of the reports on either PHC, or the priority PHC programmes under study. The clinic has only been visited by the pharmacy supervisor during the three years preceding the survey. Staff members are in need of PEP training specifically and feel that follow-up training should be done for all programmes. In addition to this, some felt a need to rotate staff amongst activities, as well as clinics, in order to pre-empt feelings of stagnation.
Facility equipment	The equipment in need of repair reported by the clinic were two digital thermometers, two fetal scopes and one infant scale, although the facility had only two adult scales, compared to seven consultation rooms, of which six are used for consultation. The clinic staff felt that a computer would be able to lighten their administrative burden.
Diagnostic tests	All diagnostic tests related to the priority programmes under study are offered at Masakhane with turnaround time of five days for laboratory HIV, PRP and HR tests. The turnaround time for Pap smears was ten days, and that for TB, seven.
Drugs and supplies	Masakhane does not make use of stock control cards. The clinic has reported periodic drug shortages of certain chronic medication and IMCI vaccines. At the time of the survey Neristerate was out of stock. The facility also did not have glucotix and similar to all the other facilities in the survey, did not have IUCDs, which is contrary to what the Package requires (Department of Health 2001b: 16). The clinic did to have salt, sugar, litre measures or cups, used for rehydration of infants, although it did have ORS packets. It also did not have Tetracyclie eye ointment, or 10% dextrose. It was mentioned at this clinic that patients are not aware of the EDL, insisting on certain unavailable medications.

[36] Masakhane Clinic is open 5 days a week, Monday to Friday, for 8.75 hours per day. New ANC cases are seen on Tuesdays, and follow-up visits are done on Mondays, Thursdays and Fridays. The six-week post-natal visits are done on Wednesdays, as are family planning and Pap smears. Although activities are scheduled in this manner, they are reportedly available continuously, should the need arise. The clinic has a full-time nutrition advisor, who also coordinates the activities of the local CHWs. These CHWs not only undertake home-based care visits and IEC in the community, but also assist with administrative duties within the clinic.

Issue	Gap
Protocols, registers, forms and maps	Although a map of the area was available, no catchment area was indicated. Graphs with recent information was only available for HIV/AIDS, but was not displayed. The facility did not have death notification or notifiable disease reporting forms. There is no system in place for the filing of protocols, and many of the documents were not readily available. It is also a concern that although Masakhane provides, albeit limited, TB functions, it does not have any TB protocols.
Facility- and patient-held records	All sampled facility- and patient-held records seem to be fairly well completed at Masakhane.
Referral practice	Masakhane indicated that it does not have a referral policy for STI patients who do not respond after two weeks of treatment, as they stick to the protocol.
Information, education and communication (IEC) material	Although the availability of IEC material at Masakhane was relatively higher compared to that of the other four facilities in Galeshewe, one can still argue that a 50% availability of pamphlets, and 67% for posters is not sufficient. The availability of IEC material in local languages is very low, at 30% for pamphlets and 25% for posters.
Community involvement and patient rights	Although there seems to be a vibrant Community Health Committee active in Masakhane, no minutes were available (photographs of activities were displayed). Patient complaints are handled verbally within the clinic when they arise, and there is no formal patient complaint procedure. Seemingly no community activities targeted at HIV/AIDS take place.

❑ Galeshewe Day Hospital

Table 83: Main gaps in PHC management and provisioning at GDH

Issue	Gap
Staffing, programme target populations and patient load	GDH has the most favourable staff complement of the five PHC facilities in Galeshewe. The reason for this is partly tied up with the history of GDH. It used to be considered part of Kimberley hospital, functioning mainly as a step-down facility. While part of Kimberley hospital, GDH functioned under the Northern Cape provincial administration. Currently, it is under joint local and provincial authority administration, and preparations are being made for it to be handed over to the local authority. The decision to separate the two facilities was already made in 1998, and implementation of this decision started in 2000. It was separated from Kimberley hospital to become a separate entity, supposedly functioning as a CHC. The large staff compliment that is still at GDH is the result of this. Although a process is under way to re-deploy some of the staff at GDH to other facilities in Galeshewe, it seems that the process is being resisted by staff members at GDH. Despite this, or maybe because of this, it has only eight CHWs. GDH has a nurse clinical workload of 24, compared to 32 at the next lowest facility (Mapule Matsepane), and the highest of 39 at Betty Gaetsewe. This is also considerably lower that the lower range of 35 stipulated by the Free State Department of Health. The nurses at GDH also work, on average, the least number of days per annum per nurse. Of the expected 225 days, only 144 is averaged, constituting 64% of expected days. Sixty-two percent of the professional nurses in Galeshewe are stationed at GDH, but it serves only 9% of the total catchment population, with a population per nurse ration of 214, by far the lowest in Galeshewe. However, it has a utilisation rate of 47%, which is possibly influenced by the fact that for certain specialised services it already functions as a referral centre for the other clinics in the area. GDH has a full-time doctor, but also a number of more specialised sessional doctors.
Scope and accessibility of PHC services	Presently GDH serves mostly the catchment population in its immediate vicinity, with some additional *'specialised'* services being rendered to the whole of Galeshewe. GDH is open five days a week, from Mondays to Fridays, for a total of 15 hours per day. Of the programmes under study GDH does not currently provide TB services, although it does provide other services not currently in place at the other PHC facilities in Galeshewe. These include mental health, environmental and occupational health, as well as optometric services. It has a resident dentist, and the facility also runs a crisis centre and a nutrition scheme for under-privileged children. It also serves as supply depot for home-based care workers in the Kimberly area. The facility has a 24 hour maternal obstetrics unit (MOU) and is a PMTCT pilot site. However, plans are underway for it to start offering a comprehensive PHC service, including tuberculosis (TB), from middle-2003. The intention is also for GDH to become a referral facility and to offer such services as TOP to patients referred from the other four PHC facilities in Galeshewe.
Programme management	All programmes presented at GDH are coordinated by specific health workers. However, no monthly discussions on PHC indicators take place. GDH has received supervisory and support visits for most of the programmes that it presents, with the exception of IMCI and HIV/AIDS, but it is not possible to determine whether these visits were routine, or in reaction to problems being experienced. The facility has received feedback only on the STI reports submitted, while it has not submitted any report on IMCI. The CHC's staff feel that support by district and provincial management is lacking.

Issue	Gap
Facility equipment	Staff members perceive the lack of computers as seriously hampering their efficiency. Such equipment would probably be justifiable in the patient record section, pharmacy, as well as for general office administration. The facility reported numerous thermometers and four stethoscopes in need of repair. Noting the number of examination rooms, the facility could do with more of the following equipment: adult scales, as they have only five for 19 consultation rooms, fetal scopes, as they have only one (but a 24 hour MOU), ventouse and forceps. The facility reported a need for the following equipment: diagnostic sets, HB meters, blood pressure meters, a Doppler, four glucose meters, ten stethoscopes, three computers, fax machine and a photocopier. However, one will have to make a careful analysis of the patient load and staff compliment of this facility to determine how many of these items are justified. At 9°C, the refrigerator was above the maximum temperature of 8°C specified in the EDL. In addition to this the refrigerator was packed full not allowing for enough air to circulate between vaccine trays. The last recorded temperature on the temperature record card was more than three months prior to the date of the survey. Although GDH had ice packs available, it did not have a cooler bag to use during power failures, or when defrosting the refrigerator.
Diagnostic tests	As with the other clinics in Galeshewe, the national EDL guideline of 48 hours for TB is exceeded.
Drugs and supplies	GDH, as the other facilities in Galeshewe, do not make use of stock control cards. Specula seem to be in short supply at GDH. Some of the vitamin K injectables and Nevirapene syrup at the facility had expired. GDH, similar to all the other five facilities, did not have any IUCDs, which is contrary to what the Package requires (Department of Health 2001b: 16). Although it did have ORS packets, it did not have salt or sugar that could be used for infants with diarrhoea.
Protocols, registers, forms and maps	With regard to maternal health, GDH did not have copies of the *National Contraception guidelines*, *Sterilisation act* or *Saving babies report*. Concerning IMCI, it is of concern that GDH indicated that they did not have any *Road-to-health* charts. It also had no cold chain contingency plans to deal with power failures and defrosting of the refrigerator. The facility also did not have an emergency referral protocol. Furthermore, as all the other facilities in the survey, GDH does not have a copy of the national *HIV strategic plan for South Africa 2002-2005*, and could not provide a resource list of HIV/AIDS service organisations.
Facility- and patient-held records	The date of first ANC visit on the patient-held card is not indicated for any of the ANC patients at GDH, while the outcome of RPR and RH testing were not indicated on the facility-held maternity register.
Referral practice	GDH seems to have a proper referral system in place for all the programmes under investigation, although it states that it does not get feedback.
Information, education and communication (IEC) material	GDH has audiovisual equipment, but these are used for staff training purposes. Concerning IEC pamphlets, GDH had only pamphlets on 10% of the sampled topics, and none of these were in a local language. When it comes to IEC posters, GDH had the highest availability at 75%, but only 25% available in a local language.
Community involvement and patient rights	GDH is the only facility included in the survey that did not have a functioning community health committee. The only community involvement in PHC is described as HIV/AIDS *'health talks'*, which presumably take place within the CHC. The respondent suggested that a *'community element'* needs to be established in order to strengthen the functioning of the IMCI programme at the facility.

2. Main gaps in key PHC programmes – Galeshewe PHC facilities

❑ Maternal health

For the purpose of this study, maternal health is taken to include women's health (screening for cervical cancer), family planning (contraception), antenatal and maternity care, as well as termination of pregnancy (TOP). This is in line with the principles of sexual and reproductive health contained in the *Reconstruction and Development Programme* (Adar & Stevens 2000:412) which since 1994 has been recognised as a priority. Looking at family planning, the Department of Health's *National guideline on cervical cancer screening programme* (Adar & Stevens 2000: 424; Department of Health 2000: 5-6) envisions a goal within 10 years of implementation where at least 70% of women from 30 years of age will undergo at least one Pap smear, but ideally three smears over a lifetime at ten year intervals. Family planning services should ideally serve as a means for women to increase their choice and access to women's health services, and move away from the previous regime's emphasis on *'population control'*. Although it is not seen by the Department of Health as a form of contraception, the inclusion of TOP services is in line with the new emphasis on choice and access to quality

health services for women. In a similar trend, the ultimate aim of antenatal and maternal care is to reduce both maternal and neonatal mortality.

Table 84: Gaps in the maternal health programme in Galeshewe

Issue	Gap
Staffing, programme target populations and patient load	The total number of women in Galeshewe of child bearing age are 27 136, constituting 28% of the total catchment population of Galeshewe. The projected number of deliveries per month for the entire Galeshewe is 331. Currently GDH is the only facility with a maternal obstetrics unit (MOU) in the immediate area providing a 24-hour maternity service, although two other clinics (Betty Gaetsewe and Masakhane) do provide maternal health services other than routine deliveries. Therefore, the staff shortages that were reported at the latter two clinics will inevitably impact on the maternal health service that they provide.
Scope and accessibility of PHC services	None of the facilities indicated that they provide a complete maternal health service. Masakhane and GDH provide ANC services on four days a week, although it is available on the other day should it be required. These two facilities and Betty Gaetsewe provide Pap smears. Although family planning is available at all five facilities in the survey, none of the five facilities provide TOP (all cases are referred to Kimberley hospital). Plans are in process to start providing TOP services at GDH form the middle of 2003. GDH is currently functioning as a PMTCT pilot site. Betty Gaetsewe indicated that there is a general need for training of personnel involved in maternal health service. A lack of PEP training was also indicated my Masakhane.
Programme management	A local health worker at each facility coordinates maternal health at Betty Gaetsewe and Masakhane s and GDH. However, it does not seem as if any of the facilities in the area that provide maternal health services receive regular supervisory visits or feedback on the monthly reports that they submit.
Facility equipment	Masakhane reported equipment as their biggest obstacle in rendering an effective maternal health services. In this regard they would prefer a doptone to fetal scopes, or alternatively, plastic fetal scopes to metal ones, as the latter are prone to braking. Masakhane, which provides ANC services and may therefore be required to deal with unplanned deliveries, does not have a neonatal resuscitation trolley. It is a concern that GDH indicates the availability of only one fetal scope, as they have a 24-hour MOU. GDH also does not have either a Ventouse or forceps.
Diagnostic tests	With the exception of Betty Gaetsewe, all facilities provide laboratory HIV, RPR, RH and Pap smear testing, with the maximum turnaround time being 7 days.
Drugs and supplies	Injectable contraceptives, which are the most widely used by South African women (Adar & Stevens 2000:414), as well as oral hormonal contraceptives, were available at all facilities. However, some oral contraceptives at Mapule Matsepane had past their expiry date. With the exception of Mapule Matsepane, postcoital contraceptives were available at all the other facilities. Iron and folic acid, either as a combination or separately, was available at all clinics, although some had expired at Mapule Matsepane. Some vitamin K injectables and nevirapene syrup at GDH had past the expiry date. Pregnancy Test kits were not available at Mapule Matsepane, while glucostix were not available at Recreation and Masakhane s. It is of special concern that none of the facilities in Galeshewe had IUCDs available.
Protocols, registers, forms and maps	Mapule Matsepane, Recreation and Masakhane did not a family planning register, and none of the facilities had a copy of the *National contraception guidelines*. Betty Gaetsewe, Mapule Matsepane, Recreation and GDH did not have a copy of the *Sterilisation Act*, while only GDH had a copy of the *National guide for cervical screening programme*. It seems therefore that women's and maternal health protocols are not generally available in the health facilities surveyed in Galeshewe.
Facility- and patient-held records	It is a concern that the date of first ANC visit was not indicated on any of the patient-held ANC cards at GDH.
Referral practice	No problems observed.
Information, education and communication (IEC) material	None of the facilities had IEC pamphlets on emergency contraception, while only Betty Gaetsewe had a poster dealing with this. Only Masakhane had pamphlets on family planning available, although posters were available at Betty Gaetsewe, Recreation, Masakhane and GDH. Although GDH is a PMTCT pilot site, no pamphlets were available on this topic at any of the facilities. The Women's Health Charter was displayed only at Masakhane.
Community involvement and patient rights	Masakhane was the only clinic that reported a functioning breastfeeding support group.

- **IMCI**

The integrated management of childhood illnesses (IMCI) strategy was developed by the WHO and UNICEF in 1995 and adopted by South Africa in 1996. Before the IMCI strategy, successful single treatment strategies for, amongst others, the three main childhood killing diseases in South Africa including acute respiratory infection, diarrhoeal diseases and malnutrition, were developed by WHO and other international agencies that resulted in

significant reductions in deaths and hospital admissions in many countries. However, single treatment strategies had several drawbacks. Firstly, they did not emphasise prevention and promotion of good health; secondly, children often presented with more than one clinical problem, e.g. diarrhoea and pneumonia are frequently presented together in children with malnutrition and measles; and thirdly, they did not consider the well-being of the mother and carer. With IMCI, these broader aspects aimed at maintaining the well-being of the whole child are considered at every encounter with a sick child.

The IMCI strategy has three components (Department of Health 2001c: 2-3; Department of Health [s.a.]: 8-9):

- The **clinical component** involves the improvement of the health system by improving case management skills of health workers. Each child is screened for cough or difficulty breathing, diarrhoea, fever, ear problems, weight loss and anaemia. This is because the DHS has demonstrated that the main causes of morbidity and mortality are a few readily remediable illnesses, i.e. acute respiratory infection, diarrhoeal diseases and malnutrition of which the above-mentioned symptoms are the most common. The IMCI programme also prevents illnesses by promoting improved nutrition (including breast feeding, use of micronutrients and deworming of susceptible populations), vaccination, and recognition of signs at home that require immediate treatment at a health facility. Well-designed assessment and classification algorithms and treatment protocols enable health workers to decide on the severity of the illness and appropriate treatment. In addition, focused counseling of the mother or caregiver gives her the skills and knowledge to care for the ill child at home – often with no or minimum medication.
- The **health system component** aims to ensure that IMCI practitioners and health facilities have the drugs, equipment and other support elements essential for providing high quality care.
- The **community component** involves improving family and community practice. The household and community component of the IMCI strategy uses participatory methods to identify key household and community practices that are conducive to optimal child health and development.

The current study assessed a set of selected indicators measuring aspects of mostly the clinical and health system components of the IMCI programme. The following findings emphasise the most important gaps with regard to indicators of the clinical and health systems component in the five clinics in Galeshewe:

The accessibility of the IMCI programme seemed to be well established as more than one professional nurse had been trained in this programme at each of the five facilities. However, the quality of the programme as applied by the different clinics was found to be less than optimal with regard to both the clinical and the health systems components thereof. Table 85 depicts gaps in the health systems component as found in the different facilities.

Table 85: Gaps in the IMCI programme in Galeshewe

Issue	Gap
Overall responsibility for the IMCI programme	Mapule Matsepane did not have an IMCI coordinator
Programme assessment	The Package stipulates that each clinic's IMCI programme should be assessed on an annual basis. Betty Gaetsewe had undergone an assessment more than a year before the time of the survey and Mapule Matsepane indicated that it *'never'* had undergone such an assessment.
Programme-specific equipment standard	Mapule Matsepane did not have an oral re-hydration corner as specified by the Package.
Cold chain maintenance	At Betty Gaetsewe and at GDH the vaccine refrigerators' temperatures were found to be unacceptably high. Betty Gaetsewe and Mapule Matsepane s did not have temperature record cards implemented at all. GDH had a temperature record card, however, the last date recorded was more than three months before the field visit. At Betty Gaetsewe and Recreation the vaccination refrigerators were located within three metres from air conditioning equipment and at Betty Gaetsewe the refrigerator was located against an outside wall. The vaccine refrigerator at GDH was too full.
Drugs and supplies	Betty Gaetsewe, Recreation, Masakhane and GDH did not have salt and sugar or cups for children with diarrhoea (who are not dehydrated). GDH did not have any litre measures. Some of the Ringer-lactate stock in Mapule Matsepane and Recreation had expired. Betty Gaetsewe, Mapule Matsepane and Recreation did not have blankets (to keep babies/children in shock warm). Betty Gaetsewe did not have any hepatitis B vaccine in stock. Mapule Matsepane did not have any oral polio vaccine. Some of the DPT vaccines in Mapule Matsepane had expired. Betty Gaetsewe did not have any Tetanus toxoid vaccine in stock. Only GDH had BCG vaccine. Mapule Matsepane did not have sterile water for injection. Betty Gaetsewe did not have any sealed syringes with a minimum length of 32mm for intramuscular injections. Mapule Matsepane did not have any iron supplements for children. Some of the iron supplementation in Recreation had expired. Only Masakhane and GDH had vitamin C available for use in children. The vitamin B complex supplement in Mapule Matsepane was not stored according to the FEFO principle. Three of the five facilities (Recreation, Masakhane and GDH) did not have tetracycline ophthalmic (eye) ointment in stock. Some gentian violet stock was expired in Mapule Matsepane and GDH. Mapule Matsepane did not have any adrenalin. Masakhane did not have 10% dextrose.
Graphs, protocols, registers and forms	A number of items needed for IMCI programme management were not available at the clinics. There was no Nutrition/child health register/book or PEM register/book at Betty Gaetsewe. Mapule Matsepane had none of the following: graphs with recent IMCI statistics of any kind; *Protocol for managing and referring children with growth faltering*; *EPI surveillance manual*; written cold chain contingency plans for power interruptions or defrosting of refrigerator; *Protocol for management of children with HIV/AIDS*; *Protocol for emergency referral*; list of notifiable diseases, immunisation register/book; nutrition/child health register/book; official national forms for adverse effects of immunisation. Recreation had none of the following: graphs with recent IMCI statistics of any kind; *Protocol for managing and referring children with growth faltering*; EPI surveillance, vaccination or cold chain operations manuals; written cold chain contingency plans for power interruptions or defrosting of refrigerator; *Protocol for emergency referral*; poison centre contact numbers; immunisation register/book, or nutrition/child health register/book. Masakhane had none of the following: Graphs with recent IMCI statistics of any kind; *Protocol for managing and referring children with growth faltering*; EPI vaccination or cold chain maintenance manual, written cold chain contingency plans for power interruptions or defrosting of refrigerator; *Protocol for management of HIV/AIDS in children*; protocol for emergency referral; contact person numbers in case of emergency; poison centre contacts; or the official national form for adverse effects of immunisations. GDH had none of the following: *Protocol for managing and referring children with growth faltering*; written cold chain contingency plans for power interruptions or defrosting of refrigerator; protocol for emergency referral; list of notifiable diseases; official national form for adverse effects of immunisation or growth monitoring/*Road to health* charts.
Facility- and patient-held records	Ten *Road to health* charts were randomly selected at all clinics and they were evaluated for two specific EPI indicators. Firstly, whether the child received his/her first measles shot by 12 months and whether the child was fully immunised by one year. In the cases of Betty Gaetsewe, Recreation and GDH, one out of the ten babies did not receive their first measles shot by 12 months. In the cases of Betty Gaetsewe and GDH, two out of ten children each were not fully immunised by age one year.
Information, education and communication (IEC) material	Only Masakhane did have a supply of pamphlets available in the waiting area on IMCI-related issues. Betty Gaetsewe did not have any posters displayed on the walls of waiting areas on Diarrhoea/ORS solution, breastfeeding or nutrition. Mapule Matsepane had none on Diarrhoea/ORS solution and neither Masakhane nor Recreation had any on nutrition. Only Masakhane had any of these IMCI-related posters available in a local language.
Community involvement	Only Masakhane had active breastfeeding support groups.

- **TB**

The recent TB review in the Francis Baard district was discussed in paragraph 5.2. A comprehensive list of recommendations were made towards the improvement of TB control. The current study provides a perspective (primarily from the side of the PHC facility) generally supportive of the recommendations of the TB review.

Table 86: Gaps in the TB control programme in Galeshewe

Issue	Gap
Staffing, programme target populations and patient load	The TB control programme in Galeshewe is serving a population of 30 094 persons younger than 15 years and 65 274 persons of 15 years and older. Extremely poor social conditions in Galeshewe (unemployment and poverty) are thought to cause relapses of TB disease. TB incidence in the area is very high, ranging from 990 per 100 000 for the Betty Gaetsewe catchment population to a staggering 2 256 for Recreation's catchment population. The TB burden of Betty Gaetsewe and Recreation is very heavy, especially taking the limited numbers of nurses working in the TB programmes at these facilities in consideration. At Betty Gaetsewe in the four quarter preceding the study an average of 132 TB patients were on treatment at this clinic, of which an average 42 were new smear-positive cases. Over the same period at Recreation an average of 70 patients were on treatment, of which an average of 25 patients were new patients. As indicated by Recreation, there is a need to train DOT supporters at strategic points in the community.
Scope and accessibility of TB services	Comprehensive TB services (DOTS in the broad sense, not just DOT) are offered only at three of the five PHC facilities in Galeshewe. This seriously limits access to TB services in Galeshewe (a high TB incidence area). The TB programme needs to be fully implemented at Mapule Matsepane (currently only taking sputums), Masakhane (currently only providing treatment/DOT) and at GDH. Take note that Betty Gaetsewe is sometimes described as the *'central TB clinic'* in the district. The use of such concepts is in conflict with the idea of comprehensive, one-stop PHC services as stipulated by the Package. On the part of the facilities that are not yet providing TB services, and as specifically expressed by Masakhane, there is a need to train specific nurses to be dedicated to TB control (facility TB coordinators).
Programme management	In line with the recommendations of the TB review specific health workers are coordinating the TB programme at the two clinics offering full TB services in Galeshewe. However, at Betty Gaetsewe the entire TB programme sometimes is managed by an assistant. Surprisingly thus, it was only at Betty Gaetsewe that graphs containing recent information on TB control were on display. At both Betty Gaetsewe and Recreation successful treatment rates (PTB cases) are low, at 67.9% and 72.9% respectively for the previous four quarters and below the declared objective of the National TB Control Programme (and the WHO) to achieve 80% cure. Over this period the PTB interruption rate averaged 25% at Betty Gaetsewe and 16.5% at Recreation.
Facility equipment	As suggested by Recreation, visual aids are needed for TB education.
Diagnostic tests	The EDL guidelines stipulate that AFB/smear tests for pulmonary TB be available within 48 hours. This is a standard that none of the five facilities accomplished, results taking five to seven days to become available.
Drugs and supplies	Some Isoniazid stock at Recreation was expired.
Protocols, registers, forms and maps	Even, when just looking at the two facilities offering full TB services, a number of important protocols, manuals, guidelines and flow charts were not available.
Referral practice	Kimberley Hospital, reportedly, refers very ill patients to the clinic – so ill that they cannot walk. This affects especially retreatment patients who have to receive daily streptomycin injections. Patients come from the hospital with no X-ray results (sputum-negative TB patients that have to be diagnosed by X-rays) or sputum diagnostic results. Improvement of the radiology services at Kimberley Hospital is required. Getting patients admitted to the hospital, reportedly, is very difficult. Hospital staff members do not use the referral form correctly, e.g. they do not fill in the X-ray number. The PHC facilities request the hospitals to keep very ill TB patients and patients on streptomycin in hospital longer. Betty Gaetsewe reported that referral arrangements for TB patients to Jan Kempdorp Hospital had not yet been finalised.
Information, education and communication (IEC) material	TB educational pamphlets (in a local language) were only available at Recreation. Although all facilities in Galeshewe had TB posters on display at Betty Gaetsewe and Masakhane the displayed posters were not of a local language type.
Community involvement and patient rights	Activities to involve the community in TB control (TB health education at schools, taverns, taxi stops, churches, workplaces and the civic centre); vegetable gardens and provision of vegetables to TB and HIV/AIDS patients, SANTA youth-organised TB health education; TB Awareness Day; home-based care and DOT visits to TB patients; are provided by Betty Gaetsewe, Recreation and Masakhane. Mapule Matsepane and GDH, seemingly, are inactive in this respect.

- **STIs**

The control of STIs is one of the most cost-effective strategies for reducing HIV-infections. Although the Department of Health has organised various training initiatives on the correct case management of STIs, the importance of treating STIs as a key HIV-prevention strategy has not been fully realised. This lack of recognition of the importance of adequately treating STIs is evident in the unfilled posts of STI coordinators, STI drugs being out of stock at clinics, poor adherence to national treatment guidelines and low numbers of STIs diagnosed (Kenyon *et al*. 2001:168). The STI programme, which is described as the prevention and management of STD, is a service that should be available daily at clinics and it is a component of services for reproductive health and for the control of HIV/AIDS (Department of Health 2001d: 31). For the Northern Cape, it was reported by Viljoen *et al*. (2000) that all fixed clinics offer this service on a daily basis. A summary of the main gaps in STI care in Galeshewe follows.

Table 87: Gaps in the STI programme in Galeshewe

Issue	Gap
Staffing, programme target populations and patient load	High nurse clinical workload which is attributed to a shortage of staff is a general problem in four of the PHC facilities in Galeshewe (Betty Gaetsewe, Mapule Matsepane, Recreation and Masakhane). This shortage negatively affects the management of all five the priority programmes under study, including STIs.
Scope and accessibility of STI services	No problems observed as STI care is provided daily (Monday to Friday) at all PHC facilities in Galeshewe.
Programme management	Lack of a facility STI programme coordinator (at Mapule Matsepane and Masakhane), insufficient training of staff, shortage of equipment and drugs (including condoms), limited clinic space and difficulty in tracing contacts are constraints to the effective running of the STI programme. Mapule Matsepane and GDH are the only two facilities that have not been visited by the District STI coordinator within the past three years, although both facilities have received written feedback on the last reports submitted to management. STI assessments are conducted annually at all facilities accept Masakhane.
Programme equipment	Although all facilities but one (Mapule Matsepane) have at least one screened examination couch and sterile specula in working condition. Mapule Matsepane has two specula in need of repair.
Programme drugs and supplies	Condoms were reported to have been out of stock in the past at Recreation.
Protocols, registers, forms and maps	Only Betty Gaetsewe had a graph with the most recent information (past three months) on STIs displayed on the wall. Not one of the PHC facilities had all of the required STI protocols and manuals. Betty Gaetsewe, Mapule Matsepane and Recreation had three of the five protocols and Masakhane and GDH had four.
Referral practice	Of the five PHC facilities in Galeshewe, only Betty Gaetsewe and GDH have a written referral policy for STI patients. Mapule Matsepane and Recreation have a referral policy, although not in writing. Masakhane does not have a referral policy and has not as yet referred a STI patient.
Information, education and communication (IEC) material	No pamphlets on STIs were available at any of the PHC facilities in Galeshewe. Posters on STIs were only available at Betty Gaetsewe, Mapule Matsepane and GDH, although not in the local languages.
Community involvement and patient rights	Masakhane is the only PHC facility that has a STI project in the community. In light of STI control being one of the most cost-effective strategies for reducing HIV-infections, the lack of involving communities in STI control has detrimental implications for health care as a whole in Galeshewe.

Table 88: STI programme indicators for Galeshewe PHC facilities[37]

Indicator	Issue
Incidence of male urethral discharge (MUD)*	Recreation has the highest rate of MUD cases (6.9%) followed by GDH (4.3%), then Betty Gaetsewe and Masakhane s (1.6% and 1.5% respectively) and Mapule Matsepane Clinic with the lowest rate (1.1%).
STI contact tracing rate**	At Betty Gaetsewe more contacts came to the facility to be treated for STI than the number of contact slips issued over a period of three months. This could be attributed to contacts receiving contact slips from another clinic but preferring to seek help at Betty Gaetsewe. If so, it reflects positively on the STI programme at this clinic. Mapule Matsepane (76%), Recreation (78%) and especially Masakhane (54%) have low contact tracing rates less than 80%. This translates to poor STI programmes in these three facilities. According to the most recent DHIS, GDH did not distribute STI contact slips.

* Used DHIS data for the last twelve months to calculate MUD rates.

** Only DHIS data for the last three months was available at time of survey.

❑ HIV/AIDS

Table 89: Gaps in the HIV/AIDS programme in Galeshewe

Issue	Gap
Staffing, programme target populations and patient load	There is a general perceived shortage of staff at four of the five facilities (Betty Gaetsewe, Mapule Matsepane, Recreation and Masakhane), which has a negative effect on the running of all key priority programmes. Betty Gaetsewe, in particular, does not have enough staff to conduct HIV tests.
Scope and accessibility of HIV/AIDS services	Home-based care is provided by three of the five facilities in Galeshewe (i.e. Mapule Matsepane, Recreation and Masakhane), VCT by four (i.e. Betty Gaetsewe, Mapule Matsepane, Masakhane and GDH) and PMTCT only by GDH. While all five facilities offer HIV clinics for opportunistic infections daily (Monday to Friday), Mapule Matsepane offers VCT services only once per week. Only GDH provides PMTCT counseling daily.
Programme management	Shortage of supplies (rapid HIV tests and condoms), lack of stationery, lack of sufficient consultation rooms and lack of appropriate support and feedback from management, are constraints to the effective running of the HIV/AIDS programme at PHC facilities in Galeshewe. The HIV/AIDS counselor at Recreation is trained to administer HIV rapid tests but the protocol does not permit her to do so due to her not being a qualified nurse. Not one of the facilities in Galeshewe had been visited by the District HIV/AIDS coordinator within the last three years (2000-2002) and only Betty Gaetsewe has received written feedback on one of their last reports submitted to management.
Programme equipment	Betty Gaetsewe has a shortage of confidentiality files and forms.
Programme diagnostic tests	*See 'programme drugs and supplies'.*
Programme drugs and supplies	Mapule Matsepane and Recreation do not stock rapid HIV/AIDS test kits. Ordering of these test kits was reportedly a problem.
Protocols, registers, forms and maps	Of the five PHC facilities in Galeshewe, only two (Betty Gaetsewe and Masakhane) had a graph with the most recent information (past three months) on HIV/AIDS displayed on the wall. Betty Gaetsewe only had two of the 17 protocols for HIV/AIDS, Mapule Matsepane had ten, Recreation and Masakhane s had four and GDH had 14. Of the three facilities that offer home-based care (i.e. Mapule Matsepane, Recreation and Masakhane), only Recreation had the protocol *HIV/AIDS guidelines for home-based care.* Of the four facilities that offer VCT (i.e. Betty Gaetsewe, Mapule Matsepane , Masakhane and GDH), only two (Mapule Matsepane and GDH) had the *Protocol on voluntary HIV confidential counselling and testing (VCCT).*

[37] The incidence of all new STI cases treated syndromically is a less sensitive indicator of the true incidence of STIs in a catchment population, as not all of these cases will be true STIs (e.g. vaginal discharge is often not sexually transmitted). Therefore, the incidence of male urethral discharge (MUD), which indicates the proportion of all STIs that are attributed to MUD, and the percentage of STI contacts treated are more accurate indicators of STI services at a facility. The percentage of STI contacts coming for treatment at a facility is a good indicator of the quality of the health promotion component of the STI programme. This percentage should be 100%. An STI contact-tracing rate of less than 80% translates to bad service, or no privacy, or inadequate health education about the need to get partners treated (Heywood & Rhode 2002).

Issue	Gap
Referral practice	Three of the five facilities (Mapule Matsepane, Recreation and Masakhane) do not have a referral system specifically for HIV/AIDS patients (e.g. herpes zoster, oesophageal candidiasis, severe continued diarrhoea). They make use of the referral system for all ill patients being referred to the next level of care. Only Betty Gaetsewe and GDH have written referral systems specifically for HIV/AIDS patients. Lack of feedback once patients are referred is a specific problem experienced by GDH. Betty Gaetsewe is burdened by patients referred for home-based care by Kimberley Hospital. Due to the non-payment of home-based carers, Betty Gaetsewe is experiencing a shortage in the number of volunteers available to administer home-based care.
Information, education and communication (IEC) material	Mapule Matsepane and Recreation had IEC pamphlets on VCCT (in a local language). Masakhane also had IEC material on VCCT although not in the local language. GDH (the only PHC facility that offers PMTCT in Galeshewe) had IEC pamphlets on PMTCT, but not in the local language. Only Recreation had pamphlets on condom use in a local language. Mapule Matsepane did not have posters of VCCT displayed on the walls. Although posters of VCCT were displayed at Betty Gaetsewe, Recreation, Masakhane and at GDH, they were not in the local languages. GDH had posters of PMTCT in a local language, and only Mapule Matsepane and GDH had posters of condom use displayed on walls, but not in local language.
Community involvement and patient rights	*Requires further research.*

❑ EDL

Table 90: Gaps in the EDL programme in Galeshewe

Issue	Gap
Staffing, programme target populations and patient load	Mapule Matsepane and Masakhane did not allocate specific nurses towards the management of the EDL programme. Monthly staff discussions regarding the EDL programme do not take place at GDH.
Programme management	While stating that current drug supply is better than in the past (when drugs were supplied from the local authority pharmacy), Recreation reports periodic drug shortages especially of chronic medicines and sometimes of IMCI vaccines. According to Recreation these problems emanate from the hospital/depot. One consequence is that drugs need to be packed at the clinic – the clinic therefore feels that it needs helpers to pack the drugs. Mapule Matsepane reported periodic drug shortages, conceding that its orders were sometimes placed too late. The STI programme is affected by drug supply problems at Betty Gaetsewe. Stock control cards are not implemented in any Galeshewe PHC facility.
Facility equipment	At 10^0C and 9^0C respectively the vaccine refrigerator temperature was too high at Betty Gaetsewe and GDH. Betty Gaetsewe and Mapule Matsepane did not have temperature record cards implemented at all. GDH had a temperature card, however, the last date recorded was more than three months before the field visit. At Betty Gaetsewe and Recreation the vaccination refrigerators were located within three metres from air conditioning equipment. At Betty Gaetsewe the refrigerator was located against an outside wall. The vaccine refrigerator at GDH was too full.
Diagnostic tests	None of the clinics accomplished the standard set by the EDL guidelines that AFB/smear tests for pulmonary TB be available within 48 hours.
Drugs and supplies	**Maternal health programme:** Mapule Matsepane did not have any emergency contraceptives or pregnancy test kits. Betty Gaetsewe, Mapule Matsepane and Recreation did not have rapid rhesus test kits. Both Recreation and Masakhane did not have any glucostix in stock. Both Mapule Matsepane and Masakhane did not have vitamin K injectables in stock. None of the facilities in Galeshewe had IUDs. None of the facilities had misoprostil in stock. Some iron and folic acid tablets as well as oral hormonal contraceptives at Mapule Matsepane were expired. The nevirapine liquids and vitamin K injectables at GDH were not stored according to FEFO. **IMCI programme:** Betty Gaetsewe, Recreation and Masakhane s and GDH did not have salt and sugar or cups for children with diarrhoea (who are not dehydrated). GDH did not have any litre measures. Some of the Ringer-lactate stock in Mapule Matsepane and Recreation were found to have expired. Betty Gaetsewe, Mapule Matsepane and Recreation did not have blankets for babies in shock. Betty Gaetsewe did not have any hepatitis B vaccine in stock. Mapule Matsepane did not have any oral polio vaccine. Some of the DPT vaccines in Mapule Matsepane had expired. Betty Gaetsewe did not have any Tetanus toxoid vaccine in stock. Only GDH had BCG vaccine. Mapule Matsepane did not have sterile water for injection. Betty Gaetsewe did not have any sealed syringes with a minimum length of 32mm for intramuscular injections. Mapule Matsepane did not have any iron supplements for children. Some of the iron supplementation in Recreation had expired. Only Masakhane and GDH had vitamin C available for use in children. The vitamin B complex supplements at Mapule Matsepane were not stored according to the FEFO principle. Three of the five facilities (Recreation, Masakhane and GDH) did not have Tetracycline ophthalmic (eye) ointment in stock. Some gentian violet stock was expired in Mapule Matsepane and GDH. Mapule Matsepane did not have any adrenalin. Masakhane did not have 10% dextrose stock. **TB programme**: Some isoniazid stock at Recreation was expired. **STI and HIV/AIDS programmes:** Mapule Matsepane and Recreation had no rapid HIV/AIDS test kits in stock.

Issue	Gap
Protocols, registers, forms and maps	The national EDL and standard treatment guidelines were not available at Masakhane. The EDL booklet was not available at Recreation.
Record-keeping/stock management	GDH is concerned about an insufficient information system for drug management at the facility: *"There is a need for statistics to measure consumption, forecast and budget".*
Referral practice	Some doctors, reportedly, are frustrated by the limited range of drugs on the EDL.
Community involvement and patient rights	Masakhane reports a lack of cooperation and understanding amongst clients regarding the EDL.

3. Main research findings and recommendations

❑ General

The goal in all provinces is for comprehensive and integrated PHC services to be delivered at district level. In reality, this goal has not been achieved as many clinics still offer certain services on certain days (Harrison-Migochi 1998: 129). Amongst others, no PHC facility in Galeshewe offers comprehensive maternal health care (i.e. ANC, Pap smears, family planning and TOP). Two of the facilities offer only family planning services. Only two of the five PHC facilities in Galeshewe offer TB services. This seriously limits the accessibility of TB services in this area. Given the extremely high TB incidence in the Northern Cape an *'impossible'* TB burden rests on Betty Gaetsewe and Recreation – the only facilities providing full DOTS (not just *'DOT'*). At the same time it may be questioned that Betty Gaetsewe, Mapule Matsepane and Recreation do not provide ANC services. It the recommendation of this research that ANC services be rendered by all clinics in Galeshewe. They are required to do so by the Package (Department of Health 2001a: 23). It should again be stressed that, in accordance with the Package (Department of Health 2001a: 22; 2001b: 7) all PHC facilities (clinics) need to offer a one-stop integrated and comprehensive PHC service.

In general then, PHC in the Northern Cape can benefit by dedicating more attention to the implementation of the Package.[38]

Main gap

Comprehensive PHC services as outlined in the Package (Department of Health 2001a; 2001b) are not provided at individual PHC facilities in Galeshewe.

[38] In the Eastern Cape a provincial version of the Package (including a checklist) has aided the process of implementing the national Package. The checklist is interesting because it categorises necessary services by stages of life, i.e.: pregnant women, delivery, infants under one year, children of school age (six to 12 years), adolescents (13 to 18 years), adults, and the elderly. In addition to the checklist, the aims of the Eastern Cape Province Package are to indicate PHC policy on delivery of services at each facility level for all members of a community, form a framework for standard of care, facilitate implementation and operationalisation of referral services designed for different facility levels, and enable districts to develop a time frame in which to finalise their Packages at different levels. Specific advantages of the provincial Package reported by the Equity Project (2000: 4) include:

- Identification of shortcomings in equipment and training in the former *'homelands'* of Ciskei and Transkei.
- The Nursing Training Curriculum Committee used the Package to ensure that pre-service course work adequately prepares students to deliver the full range of package services.
- The checklist was used to identify mental health (training) needs in clinics.
- Regions used the Package to highlight the need for additional equipment, the need to overcome past practices of providing either promotive/preventive or curative services, the need to provide functionally integrated services, and the need for more appropriate services in urban and peri-urban areas so as to relieve the demand for services at the outpatient departments in hospitals.

- **Specific gaps affecting key PHC programmes**

Self-reported programme constraints: the main constraints for most facility managers and programme managers are staff shortages and lack of management support[39] (including monitoring and evaluation). Additional constraints often reported include lack of training, equipment, drugs and clinic space.

A serious lack of PHC management supervision: generally, the impression from the data in regard to PHC management supervision in the district (i.e. PHC supervisors) is that visits to the clinics are a rare occurrence, and when taking place are typically in reaction to problems (e.g. *'staff concerns'*), rather than being routine (i.e. pro-active) management visits.

A lack of programme coordination at the facility level: the appointment of designated coordinators for key PHC programmes is lacking at a number of facilities for most of the key PHC programmes under study.

Selective services (services on certain days): PHC facilities in Galeshewe appear to be below the national average when it comes to the regularity of PHC service provision on a daily basis (e.g. Family planning, ANC, immunisations, and TB).

Comprehensive maternal health services are lacking: facilities providing maternal health services in Galeshewe reported shortage of staff, equipment and limited clinic space as obstacles to providing comprehensive maternal health services, these being completely lacking at certain facilities and partially lacking at others.

PHC equipment needs are serious and diverse: e.g. only one of the five facilities has a steriliser in working order. The others send their equipment in need of sterilisation to Kimberley hospital – this is not cost-effective.

PHC tests are not always available and are characterised by long turn-around times: one clinic does not offer Rhesus tests and tests for syphilis in pregnancy. Sputum turn-around times were too long at all of the facilities. Why do the turn-around times for all the tests differ widely from facility to facility? Standardisation of best practices is recommended.

Some problems in drug supply: although a diversity of drug supply problems were revealed by the study, it is to the credit of the EDL programme, that it is the only key PHC programme benefitting from consistent management support through personal visits to PHC facilities.

PHC protocols: there seems to be no coordinated system to ensure that all clinics have the required protocols. Some protocols are determined at provincial, or even district level, but the distribution of such material does not appear to take place in a coordinated manner. Sometimes, *'protocols'* consist of copies of training notes or presentations. The lack of protocol

[39] First implemented in the Eastern Cape and now used in six provinces, a manual (*"A comprehensive approach to PHC: the supervision manual"*) has been developed to aid supervision of PHC services, amongst others through the application of checklists for priority programmes such as TB, STIs, immunisations, maternal and child health. This tool allows for the comparison of clinics' performance and for the identification of problems requiring immediate attention. The *Supervision manual* deals with the organisation of a manager's work, support lists, administration, information system guidelines, referral system guidelines, the *Standard treatment guidelines*, community involvement guidelines, national norms and standards, and in-depth programme reviews. (Equity Project 2002: 16-17).

availability has implications for the continuity of care when the facility manager or programme coordinator is not available (as is often the case).

Computers and audiovisual equipment needed: Galeshewe has not yet begun to fully exploit the advantages of computers in health facilities. Sadly, not even the DIO has a computer in working order, rendering quick retrieval of DHIS information for management planning purposes difficult. Audiovisual equipment is also needed in the waiting rooms of all facilities, especially in the case of facilities where the providers have little time for health education.

A lack of community involvement: GDH not have an active community health committee. Compared to the staff of other PHC facilities in Galeshewe, the staff members of this CHC are also not involved in activities in the community to any noticeable extent.

IEC problems: available (nationally) pamphlet and poster material are not fully exploited as part of IEC relating to key PHC programmes in Galeshewe.

Two issues requiring further research: the role of community health workers and home-based carers in particular: reportedly home-based carers are not yet receiving payment, despite being told that they would be employed (paid) from 2000. It would seem that generally the home-based care system is not functioning well, although this issue requires further research.

A need for staff establishment assessment: there is a dire need for specific guidelines on establishing the number of nursing staff and CHWs required to render comprehensive PHC services for the specific catchment populations of Galeshewe clinics and, especially, GDH. This is the most serious constraint facility managers perceive to exist with PHC service delivery in Galeshewe. A previous study by Massyn *et al*. (2002: 18) called for the high workload of nurses in the Frances Baard district to be addressed. Yet staff on average, and especially so at the two facilities staffed exclusively by the provincial Department of Health (Masakhane and GDH), on average work far less than the expected number of workdays expected from a professional nurse per year.

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