

PHC delivery in the Mitchells Plain Urban Renewal Site, Western Cape

Mapping gaps in the IMCI, Women's Health, TB, STI, HIV/AIDS and EDL
programmes

Joy Summerton, Michelle Engelbrecht, Kobus Meyer, Christo Heunis & Ega Janse van
Rensburg-Bonthuyzen



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Project leaders: Dingie van Rensburg & Yogan Pillay

Project coordinator: Christo Heunis

Researchers: Joy Summerton, Michelle Engelbrecht, Kobus Meyer, Christo Heunis & Ega Janse van Rensburg-Bonthuyzen

Research assistants: Hlengiwe Hlophe & Diboletlo Molehe

Data collectors: Lulama Mziba, Wally Isaacs, Thandi Mhatu & Nokukhanya Bokleni

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© Centre for Health Systems Research & Development
University of the Free State
PO Box 339
Bloemfontein 9300
SOUTH AFRICA

Contact details:

The Director
Centre for Health Systems Research & Development
University of the Free State
PO Box 339
BLOEMFONTEIN 9300
Republic of South Africa

Tel: +27-51-401 2181

Fax: +27-51-448 0370

E-mail: vrensh.hum@mail.uovs.ac.za

Website: <http://www.uovs.ac.za/faculties/humanities/chsrd>

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CHAPTER 1

THE URBAN RENEWAL STRATEGY AND THE PHC PACKAGE

1. The Urban Renewal Strategy

The *Urban Renewal Strategy* (URS¹) (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 system². Mitchells Plain in the Western Cape constitutes one of eight urban renewal sites (URs³) identified for implementation of the URS by the presidency and the government. Delivery of the URS is intended to take place through the new structures of local government, and through the support of the provincial government departments.

The study at hand is concerned with implementation of the URS as applied to public health care provision, and key primary health care (PHC) programmes in particular. The Centre for Health Systems Research & Development (CHSR&D), commissioned by the National Department of Health and The Centres for Disease Control and Prevention, undertook an assessment of the following key PHC programmes in the eight urban renewal sites³: Integrated Management of Childhood Illnesses (IMCI), Maternal/Women's Health, Tuberculosis (TB), Sexually Transmitted Illnesses (STIs), HIV/AIDS and Essential Drug List (EDL)⁴. The research in Mitchells Plain was authorised and conducted in collaboration with the Western Cape Department of Health, which includes the Provincial Administration Western Cape (PAWC) and City of Tygerberg (COT).

2. The PHC Service Package

In 1999 the Department of Health reported that the first five years after the democratisation of South Africa were focused 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. This mechanism realised in the form of the PHC Service Package. 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 2004⁵ set as the target for full provision and availability of the Package in *all* PHC facilities.

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 Galeshewe (Northern Cape); Khayelitsha and Mitchells Plain (Western Cape); Mdantsane and Motherwell (Eastern Cape); KwaMashu and KwaNongoma (KwaZulu-Natal); Elexander (Gauteng).

⁴ The malaria programme, although included in the overall research framework is reported on only in cases where URs are in areas where malaria constitutes a serious public health threat.

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

The *Primary Health Care Package* was (officially) published in 2001. Two documents were published 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 should be 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 CHCs. Because the two documents differ in terms of their internal structuring of topics, their simultaneous and supposed complementary use is sometimes difficult.

□ **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 per week.
- Access, as determined by the number of health care recipients living within five kilometers 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.
- 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 in PHC facilities (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 ensures 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**

The full implementation of the Package in any PHC facility would mean that the 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.*”⁶ Nevertheless, it may be argued that in its entirety the current Package perhaps does not emphasise 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 the PHC programmes and services by district 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 available to facilities, as well as the

⁶ 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.*”

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 the 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 Mitchells Plain, 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 was based on the Package norms and standards 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.

3. Mitchells Plain URS in brief

Mitchells Plain’s boundaries are formed by Vanguard Drive on the west, Swartkop Road on the east, the railway line on the north and the False Bay coastline on the south. Mitchells Plain has rapidly increased from six residential areas to thirteen residential areas and has an estimated population of 407 050. It is estimated that 18.46% of the economically active population is unemployed and 17.87% of households live below the poverty line (Equity Gauge Project s.a.). The key sectors of employment are manufacturing, retail and wholesale. The majority of workers commute daily to centers of employment outside of Mitchells Plain, the implication being that a large proportion of a limited salary is spent on transport costs (MCA Urban and Environmental Planners 2001: 17). An estimated 6.42% of individuals live in informal dwellings, 95.62% have access to electricity, and 95.44% of households have piped water either in dwelling or on site. A large proportion of the population (80.48%) is not on medical aid (Equity Gauge Project s.a.).

In 2001, the MCA Urban and Environmental Planners won a tender to prepare a rapid assessment of the status of the Urban Renewal Strategy Nodes. The following are some of the findings of the assessment for the Mitchells Plain Urban Renewal Strategy (MCA Urban and Developmental Planners 2001: 18-19): the Mitchells Plain Municipal Management Structure comprises executive counsellors, portfolio committees and sub-councils within wards. The Institutional Structure consists of health committees, local transformation committees, community police forum and focus area task teams. The focus area task teams comprise councillors, community representatives, local government and other authority representatives with a view to formulate integrated development plans for implementation within strategic areas of Mitchells Plain identified in the Local Area Spatial Development Framework. At the time of the assessment, the City was in the process of formulating an integrated development plan. Four focus area projects were being coordinated by the City in four areas in Mitchells Plain which were identified out of the Mitchells Plain Spatial Development Framework as areas which would be strategic for the City to invest in, in terms of improving the quality of people’s lives and also to capitalise on existing investment in infrastructure. These areas are Lentegeur, Portlands, Kapteynsklip and Tafelsig.

There are many other projects identified in the Mitchells Plain Local Area Spatial Development Framework. At the time of the assessment the City, in consultation with the local community, was in the process of developing detailed schedules of projects,

timeframes for implementation and estimated budgets. Some key needs which were identified in the assessment include (MCA Urban and Developmental Planners 2001: 19-20):

- A need for coordination with the Urban Renewal Strategy Nodes programme in order to unlock synergies
- A need to release public land for housing/mixed use development, particularly around stations and schools
- Development of the key nodes as identified by the MPSDF

It is of concern that recent information about the Urban Renewal Strategy plans and projects is not easily obtainable. This information could not be obtained for inclusion in this report. This is viewed as a serious gap in the information system of the Cape Town City Council.

4. Research strategy and methodology

□ Research aims, objectives and focal areas of analysis

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 February 2003 undertook an assessment of the following key PHC programmes in Mitchells Plain: maternal health, Integrated Management of Childhood Illnesses (IMCI), tuberculosis (TB), sexually transmitted infections (STIs), HIV/AIDS and Essential Drug List (EDL)⁷.

□ 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 Mitchells Plain and to gain understanding of the constraints inhibiting the implementation of the Package.

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 Mitchells Plain.
- to provide local, provincial and health authorities and managers with a reliable measurement of the status of the implementation of the PHC Package in Mitchells Plain 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

- Facility staffing and programme target populations
- Programme management
- Scope and accessibility of services
- Facility equipment

⁷ 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.

- 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

□ **Methodology**

Broadly, the project strategy amounts 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 specific programmes is collected, collated, supplemented and verified.
- Facilitation of planning to rectify gaps in PHC service provisioning together with local PHC managers and district information officers.

After an intensive consultation process to develop a comprehensive assessment instrument, whereby 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, the research was conducted. Based on the practical experience gained during the Galeshewe (Kimberly, Northern Cape) pilot study in November 2002, the instrument has since 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 in Mitchells Plain took place in February 2003. Fieldworkers worked in teams of two persons and one additional person moved between teams to observe IEC material, drug supply and the cold chain. One researcher was responsible for editing completed instruments and for quality control. Facility managers were visited prior to data collection to arrange specific days and times at which the facilities should be visited by the research team. Although difficulties were encountered in sticking to these pre-arranged times, they were maintained by the fieldworkers as far as it was possible. Care was taken not to interrupt the, especially 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 most or all programmes rested directly with the facility manager. On average, it took one day of fieldwork to complete the data collection for each facility. On completion of the data collection the researchers systematised and analysed the data. Where necessary, relevant organisations (e.g. NGOs) and provincial and district managers were consulted to supplement the instrument data.

All PHC facilities (fixed, mobile and satellite clinics, community health centres and maternal and obstetrics units, and youth centres) in Mitchells Plain were targeted for assessment. 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 specific programme coordinators
- conducting physical observations in the facility
- capturing information of the computerised DHIS

□ **Research feedback workshop - 6 June 2003**

A research feedback workshop for the Mitchells Plain URS was held in Cape Town on 6 June 2003. The purpose of the workshop was to present the main findings of the research to the stakeholders in Mitchells Plain, and to soundboard the findings of the research with the stakeholders with a view to enrich the research report. The presentations by the researchers covered the following topics: an orientation to the URS and the PHC Package; the strategy and methodology of the research; an extensive explanation of the research process, the findings on PHC in Mitchells Plain, and the recommendations ensuing from the research.

Twenty-one delegates attended the workshop, including representatives from the Mitchells Plain Community Health Forum, the PAWC Policy and Planning, Human Resource Development and Training, and Information Management Divisions, the Community Health Services Organisation, City of Cape Town (CCT) area and facility managers, the Metro Chief Medical Officer, the CCT epidemiologist, the CCT Environmental Health Division, the national Department of Health, and researchers of the Centre for Health Systems Research & Development. 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 workshop turned out to be more than merely unidirectional imparting of feedback from the research team. Its interactive nature allowed for the contextualisation of various identified gaps and clarification of aspects of the findings which were unclear to both stakeholders and researchers. The following issues raised at the workshop are of importance for purposes of enhancing the completeness and quality of the report:

- The City of Tygerberg (COT) local municipality has been renamed the City of Cape Town (CCT).
- The provincial management views the District Health System (DHS) as the “vehicle” for implementing the PHC Package. Therefore, providing comprehensive PHC services as stipulated by the Package is perceived as unrealistic in the absence of a DHS. Thus, the current notion that the Package is an unattainable ideal in the Western Cape.
- There are no nurse clinical workload norms in Mitchells Plain. In an attempt to address the problem of staff shortages, the provincial department of health is in the process of developing a strategy to redistribute (“reshuffle”) existing nurses at PAWC facilities based on the staffing needs of each facility.
- PAWC does not utilise DHIS data for determining staffing indicators such as nurse clinical workload, doctor clinical workload, utilisation rate, etc. due to the apparent inaccuracy of data captured on the DHIS. Thus, data for nurse and doctor clinical workdays is not collected for PAWC facilities.
- The lack of IMCI training at some facilities in Mitchells Plain is due to the adoption of a “roll out” process for IMCI training. Mitchells Plain is regarded as “low-risk”

regarding child health in relation to other districts. Therefore, they appear near the bottom of the list in terms of rolling out of IMCI training.

- Selected nurses at facilities in Mitchells Plain have been trained in adult curative care but this service has not been implemented at facilities. Therefore, nurses who have been trained in adult curative remain potential resources. Problems arise with the lapse in time post training, which will render the training these nurses have received as out-dated, if at all they can still recall the contents of their training. This is also interpreted as a loss in terms of resources utilised for the training of these nurses.
- The reported shortage of doctors at facilities, as a self-reported management constraint, is attributed to a doctor-driven PHC approach, which is perceived as an outdated view. The current view is one of a nurse-driven PHC approach. Therefore, the unavailability of doctors at clinics is not regarded as a “problem” by management.
- The use of BCG vaccine at birth is authorised for MOUs only. Clinics are required to check whether BCG was given at birth (presence of vaccination mark on arm) as part of IMCI/child health. They should refer if BCG was not given (absence of scar). Therefore, clinics in Mitchells Plain are not required to stock BCG vaccine as stipulated by the Package.
- Facilities in the Western Cape have been discouraged from using salt and sugar solution for children with diarrhoea but have not yet dehydrated due to the perceived hazards of incorrect administration of this method. Thus, they are not required to stock these two ingredients for this purpose. Policy in the Western Cape stipulates the use of ORS.
- PHC facilities in Mitchells Plain are not required to stock vitamin C for children as stipulated by the Package.
- Rafinah for the treatment of children with TB has been replaced with an alternate drug. Thus, the unavailability of refinah for children at facilities in Mitchells Plain

No clearly defined action plan was devised to address PHC gaps identified through the research. Management from both local and provincial authority present at the workshop reported that the issues raised in the report would be dealt with by the appropriate persons in the respective health divisions. No specific individuals were identified to take responsibility for this process. Plans to address staffing needs are already under discussion for both provincial and local authority facilities. Thus, the report would be utilised to inform these plans. Attendees from the Mitchells Plain Health Forum representing the community committed themselves to ensuring that change does indeed take place.

5. How to use the report

First and foremost, the report is meant to serve as baseline information on public PHC provisioning in Mitchells Plain. 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 February 2003. 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 specific 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, district or metro levels), it is recommended that management structures of the Mitchells Plain Urban Renewal Node (if in existence), as well as the management and supervisory health structures in Mitchells Plain, and in the larger metro, 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 MITCHELLS PLAIN - RESEARCH FINDINGS

1. Staffing of PHC facilities in Mitchells Plain

PHC in Mitchells Plain is provided at ten facilities, namely

- Mitchells Plain Day Hospital or Community Health Centre (CHC)
- Mitchells Plain Maternity and Obstetrics Unit (MOU)
- Westridge Clinic
- Eastridge Clinic
- Rocklands Clinic
- Weltevrede Clinic
- Strandfontein Clinic
- Lentegour Clinic
- Tafelsig Clinic
- Mitchells Plain Youth Centre

Three of the ten PHC facilities, namely Mitchells Plain Day Hospital, Mitchells Plain MOU and Mitchells Plain Youth Centre are provincial authority facilities managed by the Provincial Administration Western Cape (PAWC). The City of Tygerberg (COT) local authority manages the remaining seven PHC facilities. Mitchells Plain Youth Centre is a branch of Mitchells Plain CHC which provides family planning services to both adults and youth.

Assuming that differentiation between authorities is relevant and that it hinges mostly on the authority which pays most of the PHC staff, the number of staff paid by PAWC at the PHC facilities under study suggests that most of PHC services in Mitchells Plain are provided by staff employed by the provincial government. Thus, PHC services in Mitchells Plain retain a mostly '*provincial authority*' character, although the number of PHC facilities managed by the local authority (COT) are far more than those managed by the provincial authority (PAWC).

□ Nurses - staffing indicators and target population sizes

The most prominent constraint reported by all PHC facilities in Mitchells Plain in managing the PHC programme at large, as well as the five key priority PHC programmes under study (maternal health, IMCI, TB, STIs and HIV/AIDS), 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. This is evident in reports such as the quarterly report for the CTM South District (Department of Health, 2002a) and is further supported by interviews with various health providers in the current study. The CTM South District Report reported the resignation of four professional nurses and one senior enrolled nursing assistant in the District over a period of three months in the year preceding the current study. The result was the following adverse impacts on PHC services in Mitchells Plain:

- One professional nurse was withdrawn from Mitchells Plain Youth Centre (leaving only one professional nurse and an assistant nurse).
- TOP services were transferred back to the Reproductive Health Programme to be managed by Agency staff (one professional nurse and one enrolled nursing assistant) – therefore TOP services provided only on Tuesdays.

- Chronic disease of lifestyle clubs was discontinued.
- School health teams have been reduced from five to two teams which serve approximately 67 schools. This scaling down of teams has resulted in numerous complaints from school principals regarding the lack of school health visits to their schools.

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.

Table 1: Facility staffing indicators¹

Facility	Nurse clinical workload per day ²	Doctor clinical workload per day ³	Patients referred to doctor(%)	Utilisation rate (%) ⁴	Child caseload under 5 yrs (%) ⁵	Curative caseload under 5 yrs (%) ⁶	Expected professional nurse work days per year	Actual professional nurse work days per year
Mitchells Plain CHC	-	38 ⁷ 45 ⁷ & ⁸	-	8	0.2	100	225	-
Mitchells Plain MOU	-	-	-	2	-	-	225	-
Westridge Clinic	37	34	0.3	7	53	19	225	288
Eastridge Clinic	42	36	1.4	9	48	32	225	224
Rocklands Clinic	33	25	0.4	11	42	29	225	346
Tafelsig Clinic	13	43	0.2	.21	77	15	225	1376??
Weltevrede Clinic	28	33	0.4	26	34	43	225	365
Strandfontein Clinic	28	11	0.5	9	87	16	225	201
Lentegeur Clinic	33	50	0.6	11	40	25	225	396
Mitchells Plain Youth Centre	34 ⁹	-	-	-	-	-	225	-

1 Source: DHIS (Jan to Dec 2002)

2 Nurse clinical workload per day = total PHC headcount/nurse clinical work days (i.e. professional nurse)

3 Doctor clinical workload per day = patients seen by doctor/doctor clinical work days

4 Utilisation rate = total PHC headcount/catchment population

5 Child caseload under 5yrs = Child (0-5) PHC headcount/total PHC headcount

6 Curative caseload under 5 yrs = children under 5 yrs seen for curative purposes/PHC headcount under 5 yrs

7 Source: Department of Health 2002b - Data from July to Dec 2001

8 Workload after-hours per eight-hour shift

9 Source: Department of Health 2002b – Data for Sep to Nov 2001

- = Data not available

Gap-attack!

Data for nurse clinical workdays and doctor clinical workdays for Mitchells Plain CHC, Mitchells Plain MOU and Mitchells Plain Youth Centre are not collected in Mitchells Plain.

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 the 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 child curative caseloads under-five years for Strandfontein Clinic and Tafelsig Clinic as compared to the other facilities. This translates into increased resources spent on child curative health care at the expense of preventive and promotive care. Mitchells Plain CHC has a much lower child curative caseload compared to all the other facilities. This is as a result of the facility only providing emergency care to children under-five years.

The utilisation rates of the facilities appear low regardless of the apparent high nurse clinical workload.

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 clinical 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). Far less than 10% of patients are referred to a doctor at all the PHC facilities in Mitchells Plain.

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. According to table 1 professional nurses at five PHC facilities in Mitchells Plain worked far more than expected in the year preceding the survey. The number of days worked by each professional nurse at Weltevrede and especially Lentegeur Clinics appear unrealistically high. A possible explanation could be inaccuracy in the DHIS data. Only professional nurses at Eastridge and Strandfontein Clinics worked less than expected by one day and 24 days respectively.

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	
Mitchells Plain CHC	66 079	-	4999	22 336	123 898	92 532	71 339	78 090	216 430
Mitchells Plain MOU	66 079	204	-	-	-	-	-	-	216 430
Westridge Clinic	14 037	-	1 038	4 835	14 608	34 791	17 743	17 048	49 399
Eastridge Clinic	15 015	-	1 110	5 171	15 625	37 215	18 980	18 235	52 840
Rocklands Clinic	7 482	-	553	2 576	7 786	18 544	9 457	9 087	26 330
Tafelsig Clinic	13 693	-	1 012	4 717	14 251	33 938	17 308	16 630	48 189
Weltevrede Clinic	6 531	-	484	2 251	6 802	16 209	8 267	7 942	23 011
Strandfontein Clinic	6 191	-	458	2 132	6 443	15 343	7 825	7 518	21 786
Lentegeur Clinic	16 994	-	1 256	5 854	17 683	42 119	21 481	20 638	59 802
Mitchells Plain Youth Centre	66 079	-	-	-	-	-	-	-	-

□ Nurses

Table 3: Nursing staff establishment

Facility	Chief professional nurse		Senior professional nurse		Professional nurse		Enrolled nurse		Assistant nurse		Total		Number paid by		
	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	Provincial gov	Local gov	Nursing agency
Mitchells Plain CHC	21	13	1	1	2	2	13	7	14	6	51	29	51	0	0
Mitchells Plain MOU	4	3	3	1	8	3	3	2	8	3	26	12	26	0	0
Westridge Clinic	1	1	3 ¹	3	0	0	3 ¹	3	0	0	7	7	0	5	2
Eastridge Clinic	0	0	5 ²	3	1	1	3	2	1	1	10	7	0	10	0
Rocklands Clinic	1	1	3 ¹	2	0	0	3 ¹	2	0	0	7	5	0	5	2
Tafelsig Clinic	1	1	5 ¹	4	1	1	3	3	2	2	12	11	0	11	1
Weltevrede Clinic	1	0	6	6	0	0	1	1	2	2	10	9	0	10	0
Strandfontein Clinic	0	0	4 ¹	4	0	0	0	0	1	1	5	5	1	3	1
Lentegeur Clinic	0	0	3	2	3	3	4	4	3	3	13	12	2	11	0
Mitchells Plain Youth Centre	1	1	0	0	0	0	0	0	1	1	2	2	2	0	0
Total	30	20	33	26	15	10	33	24	32	19	143	99	82	55	6

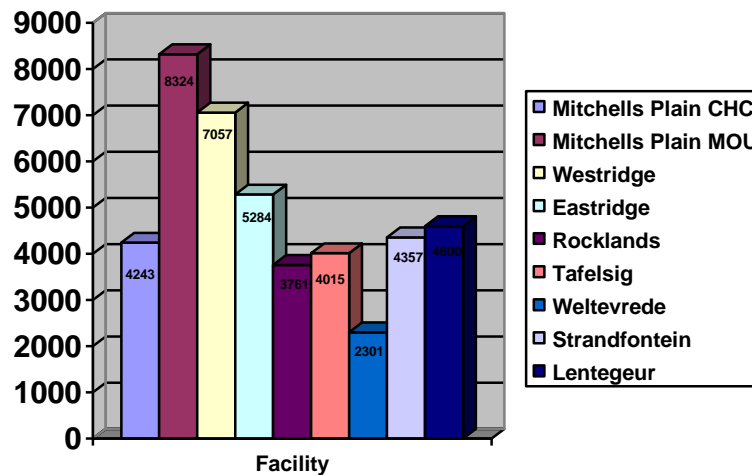
1 One nurse (part-time) employed by Nursing Services Agency

2 Two part-time nurses

Gap-attack!

Thirty percent of nurses in Mitchells Plain were absent on the day of fieldwork. The situation was the worst at Mitchells Plain CHC and MOU with 44% and 54% of the nurses absent, and best at Westridge Clinic, Strandfontein Clinic and Mitchells Plain Youth Centre. Although some nurses at Mitchells Plain CHC and MOU work after-hours, this would not be the case for all absent nurses. Management should look into the reasons for absenteeism of nurses at these two facilities.

Figure 1: Population per nurse (all types) ratio



Westridge Clinic has the second highest nurse clinical workload per day (37) and the second largest population per nurse (7 057). Similarly, Eastridge Clinic has the highest nurse clinical workload per day (42) and the third largest population per nurse. Tafelsig Clinic, on the other hand, has the lowest nurse clinical workload per day (13) and the third smallest population per nurse (4 015). This seems to point towards an unequal distribution of nurses per catchment population, which may have direct implications for nurse clinical workloads at PHC facilities in Mitchells Plain.

Discrepancies in the workload of nurses between certain facilities in Mitchells Plain are clear. Table 1 indicates that nurse clinical workloads range between 13 and 42 patients per nurse per day. At Tafelsig Clinic each professional nurse sees an average of 13 clients per day – this facility has a total of seven professional nurses. In comparison, at Eastridge Clinic each professional nurse sees an average of 42 clients per day, the clinic having a total of six professional nurses. Similarly, at Westridge Clinic each professional nurse sees an average of 37 clients per day with four professional nurses at the facility, whilst at Weltevrede Clinic each professional nurse sees an average of 28 clients per day and this facility has seven professional nurses. However, the most profound discrepancy in nurse clinical workload per day is between Tafelsig Clinic and the other facilities, especially Eastridge Clinic. Nurse clinical workload could not be determined for the three PAWC facilities, namely Mitchells Plain CHC, Mitchells Plain MOU and Mitchells Plain Youth Centre, as data for professional nurse clinical workdays is not collected for these facilities. However, a report presented at the Health Information Summit in June 2002 for

Mitchells Plain Health District, found that each professional nurse at the Mitchells Plain Youth Centre sees an average of 34 clients per day (Department of Health, 2002b).

There is still no national norm for a patient-nurse ratio. Much debate surrounds this issue including suggested formulae to calculate nurse clinical workload per facility. Regardless, there is still a need for a clearly defined national norm for the ideal number of clients per nurse per day. In 2000, the national average nurse clinical workload at fixed clinics was 19.8 and the average for the Western Cape was 25 (Viljoen *et al.* 2000: 44). If the national average of patients consulted by a nurse per day is thus regarded as the norm, then all the facilities, but Tafelsig Clinic, in Mitchells Plain are understaffed. Similarly, all the facilities, but Tafelsig Clinic, are understaffed if the Western Cape average nurse clinical workload is regarded as the norm.

Gap-attack!

There is no national norm for the number of clients a professional nurse can consult per day. Based on national and provincial (Western Cape) average nurse clinical workloads for fixed clinics, Eastridge, Westridge, Rocklands, Weltevrede, Strandfontein and Lenteguur Clinics as well as Mitchells Plain Youth Centre are understaffed.

□ **Community health workers (CHWs)**

Table 4: Employed (paid) and unpaid community health workers

Facility	Paid	Unpaid	Total no. of CHWs
Mitchells Plain CHC	7	3	10
Mitchells Plain MOU	4	0	4
Westridge Clinic	2	1	3
Eastridge Clinic	8	3	11
Rocklands Clinic	2	1	3
Tafelsig Clinic	3	0	3
Weltevrede Clinic	10	0	10
Strandfontein Clinic	2	11	13
Lenteguur Clinic	3	1	4
Mitchells Plain Youth Centre	3	0	3
Total	44	20	64

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 PHC facilities in Mitchells Plain varies from three at some facilities to thirteen at others.

Most CHWs, which include support staff, such as lay counselors and nutrition advisors, at PHC facilities in Mitchells Plain are paid. Only twenty of the 64 CHWs are not paid. CHWs play an essentially complementary and supportive role to nursing staff. This is especially important for facilities that are plagued by a shortage of staff and high patient workloads. Non-payment of CHWs more often than not leads to the loss of CHWs. Hence, the importance of paying all CHWs. Insufficient staff was reiterated at all PHC facilities, which makes the availability of CHWs at PHC facilities in Mitchells Plain vital. The absence of national guidelines or policy regarding the number and categories of CHWs required per PHC facility or per catchment population makes it difficult to draw deductions regarding the CHW establishments at the PHC facilities in Mitchells Plain. However, the number of CHWs varies from one facility to another whereby Westridge Clinic, Rocklands Clinic, Tafelsig Clinic and Mitchells Plain Youth Centre have the least number of CHWs (3 each) and Strandfontein Clinic has the most (13).

Gap-attack!

Some CHWs at six of the ten PHC facilities in Mitchells Plain (Mitchells Plain CHC, Westridge Clinic, Eastridge Clinic, Rocklands Clinic, Strandfontein Clinic and Lentegeur Clinic) are not paid. This discrepancy in paid and unpaid CHWs at a facility is most prominent at Strandfontein Clinic where only two of the thirteen CHWs are paid. All CHWs should be paid in order to retain them and to reduce the rate of CHW turnover.

□ Doctors

Table 5: Availability of doctors

Facility	Doctors		
	Full-time	Sessional	Total sessional hours per week
Mitchells Plain CHC	3	2	11
Mitchells Plain MOU	0	3	6
Westridge Clinic	0	1	4
Eastridge Clinic	0	2	7
Rocklands Clinic	0	1	7
Tafelsig Clinic	1	1	8
Weltevrede Clinic	0	1	9
Strandfontein Clinic	0	1	3 ¹
Lentegeur Clinic	0	2	4-8 ²
Mitchells Plain Youth Centre	0	0	0

1 A sessional doctor only available on alternate Mondays

2 Sessional doctor available every Tuesday for TB patients and a doctor available alternate Monday's for chronic patients

Mitchells Plain Youth Centre is the only PHC facility in Mitchells Plain that does not have either a full-time or a sessional doctor. Strandfontein Clinic is the only other facility that does not have a doctor visiting the facility at least once a week for a minimum of four hours. Strandfontein and Lentegeur Clinics only have on-site access to a doctor every second week. The two sessional doctors at Lentegeur Clinic attend only to TB patients on Tuesday's and offer curative care every alternate Monday. This arrangement appears to sideline all other patients who do not have TB but who may need to be attended to by a doctor. The minimum number of hours a doctor should spend at a clinic is two hours per day or a minimum of ten hours per week (Elgoni, 2003). In this case, only Mitchells Plain CHC and Tafelsig Clinic (also have a full-time doctor) fulfill the required number of doctor sessional hours per week.

Gap-attack!

All PHC facilities in Mitchells Plain, with the exception of Mitchells Plain CHC and Tafelsig Clinic, do not fulfill the required minimum doctor sessional hours of 10 hours per week. Mitchells Plain Youth Centre does not have a doctor (either full-time or sessional) at all.

2. Management PHC facilities and programmes

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 Mitchells Plain. This is especially so for Westridge and Rocklands Clinics which are managed by the same facility manager. To begin with the facility managers in the district are relatively inexperienced (in six of the ten cases they have two or less years experience). This makes lack of district supervision and management support (table 8) all the more disturbing.

Table 6: Number of years facility managers have been in their posts

Facility	Years
Mitchells Plain CHC	2 ¹
Mitchells Plain MOU	<1 ²
Westridge Clinic	1
Eastridge Clinic	2
Rocklands Clinic	3
Tafelsig Clinic	3
Weltevrede Clinic	2
Strandfontein Clinic	4
Lentegeur Clinic	4
Mitchells Plain Youth Centre	2

1 Facility manager was on annual leave, therefore, deputy facility manager was interviewed.

2 Facility manager has occupied post for one month.

□ Supervisor and district official visits

Table 7: Visits by supervisors and district officials in the last three years (2000-2002)¹

Facility	District infection control official	Pharmacist	IMCI trainer	Laboratory technician	District coordinator/supervisor					
					PHC	Maternal health	IMCI	TB	STIs	HIV/AIDS
Mitchells Plain CHC	Yes	Yes ²	N/A	No	Yes	No	N/A	N/A	No	Yes
Mitchells Plain MOU	No	Yes ²	N/A	No	Yes	No	N/A	N/A	N/A	Yes
Westridge Clinic	No	Yes ²	N/A	No	Yes	No	No	Yes	No	Yes
Eastridge Clinic	No	No	No	No	Yes	No	No	Yes	No	Yes
Rocklands Clinic	No	Yes	N/A	No	Yes	Can't remember	No	Yes	Yes	Can't remember
Tafelsig Clinic	No ³	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes
Weltevrede Clinic	No	No	No	No	Yes	No	Yes	Yes	Yes	Yes
Strandfontein Clinic	No	No	No	No	Yes	No	No	Yes	No	Yes
Lentegeur Clinic	No ³	No	Yes	No	Yes	No	Yes	Yes	Yes	Yes
Mitchells Plain Youth Centre	No	No	N/A	No	Yes	Yes	N/A	N/A	Yes	Yes

(Here and elsewhere in tables) N/A = Programme not offered at the facility

1 Information as reported by clinics (interviews with facility and programme managers).

2 Full-time pharmacist

3 Have an in-house infection control team

Visitation from District officials are lacking at PHC facilities in Mitchells Plain. Only one (Mitchells Plain CHC) of the ten PHC facilities has been visited by the District infection control official in the last three years (2000-2002). Five of the seven PHC facilities that do not have a full-time pharmacist have not received a visit from a pharmacist in the last three years and not one of the PHC facilities in Mitchells Plain has been visited by a laboratory technician in the last three years. Visitation from District programme coordinators for three of the five priority programmes under study (maternal health, IMCI and STIs) is also lacking at Mitchells Plain PHC facilities. Mitchells Plain Youth Centre is the only facility which has been visited by the District Maternal Health coordinator in the last three years. More than half (4) of the seven PHC facilities which offer IMCI in Mitchells Plain have not been visited by the District IMCI supervisor in the last three years. Eastridge, Weltevrede and Strandfontein Clinics have not received supervisory visits from the IMCI trainer, who trained staff at the facilities, in the last

three years. The District IMCI supervisor who also trained staff at Lentegeur Clinic is based at this clinic. It is, therefore, reported that there is constant supervision of IMCI services as well as of staff involved in the programme. Three (Westridge, Eastridge and Strandfontein Clinics) of the eight PHC facilities in Mitchells Plain which offer STI services have not been visited by a District STI coordinator in the last three years.

Gap-attack!

Although all facilities receive supervisory visits from District PHC, TB and HIV/AIDS management, these visits are still lacking for the maternal health, IMCI and STI programmes at some facilities. It is especially surprising that Mitchells Plain MOU, which offers a wide spectrum of maternal health services, does not receive supervisory visits from the designated maternal health supervisor. Why has no facility been visited by a laboratory technician? Is there a District laboratory technician assigned for Mitchells Plain PHC facilities?

Table 8: Written feedback on any one of the last three monthly PHC reports submitted to management¹

Facility	PHC	Maternal health	IMCI	TB	STIs	HIV/AIDS
Mitchells Plain CHC	No	No	N/A	N/A	No	No
Mitchells Plain MOU	N/A	No	N/A	N/A	N/A	No
Westridge Clinic	No	No	Yes	No	No	No
Eastridge Clinic	Yes	Yes	No	Yes	No	Yes
Rocklands Clinic	No	No	No	No	No	Yes
Tafelsig Clinic	Yes	No	No	Yes	Yes	Yes
Weltevrede Clinic	Yes	No	No	Yes	Yes	Yes
Strandfontein Clinic	Yes	No	No	Yes	No	No
Lentegeur Clinic	Yes	No	Yes	Yes	Yes	Yes
Mitchells Plain Youth Centre	No	No	N/A	N/A	No	No

¹ Information as reported by clinics (interviews with facility and programme managers).

Gap-attack!

Written feedback to clinics on the reports they submit to PHC managers are lacking for especially the maternal health, IMCI and STIs programmes whereby less than half the PHC facilities in Mitchells Plain receive feedback. This problem is least pronounced in the case of the TB programme. The lack of feedback is exacerbated by the failure of some clinics to submit PHC reports to managers for feedback.

Table 9: Date of last programme assessment performed

Facility	Date	
	STI	IMCI
Mitchells Plain CHC	Never	N/A
Mitchells Plain MOU	N/A	N/A
Westridge Clinic	2003	Never
Eastridge Clinic	2002	Never
Rocklands Clinic	2003	2003 ¹
Tafelsig Clinic	2002	2002
Weltevrede Clinic	Never	Never
Strandfontein Clinic	2002	Never
Lentegeur Clinic	2002	Never
Mitchells Plain Youth Centre	Never	N/A

¹ District IMCI trainer evaluated child curative services offered at Rocklands Clinic since IMCI is not offered

Gap-attack!

Mitchells Plain CHC, Weltevrede Clinic and Mitchells Plain Youth Centre do not conduct annual assessments of STI services as stipulated by the Package (Department of Health, 2000a: 31). Also, Eastridge, Weltevrede, Strandfontein and Lentegeur Clinics do not conduct annual assessments of IMCI services as stipulated by the Package (Department of Health 2000a: 19).

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

Table 10: Self-reported management constraints and suggestions for improvement: PHC programme

Facility	Constraints	Suggestions
Mitchells Plain CHC	<ul style="list-style-type: none"> ▪ Shortage of doctors ▪ Shortage of nursing staff ▪ Shortage of equipment ▪ This clinic is overloaded for their catchment area – clients from other catchment areas come here ▪ Physical and emotional abuse by the community irrespective of security 	<ul style="list-style-type: none"> ▪ Additional doctors ▪ Additional staff members ▪ Need another day center
Mitchells Plain MOU	<ul style="list-style-type: none"> ▪ Shortage of staff 	<ul style="list-style-type: none"> ▪ Employ more staff
Westridge Clinic	<ul style="list-style-type: none"> ▪ Shortage of staff - it is difficult for one manager to facilitate two clinics ▪ Due to the shortage of staff, one facility manager for two clinics ▪ Facility manager does not have enough time for administrative tasks 	<ul style="list-style-type: none"> ▪ Additional staff ▪ To add another facility manager or deputy facility manager
Eastridge Clinic	<ul style="list-style-type: none"> ▪ Staff shortage ▪ Too much work in terms of number of services rendered ▪ The political scenario is affecting changes in the facility's system 	<ul style="list-style-type: none"> ▪ Employment of more staff ▪ For growth management, more platforms for consultation and discussions are needed ▪ Improve remuneration of staff that work in special areas ▪ Improve political coordination
Rocklands Clinic	<ul style="list-style-type: none"> ▪ Shortage of staff ▪ One individual managing two facilities ▪ Heavy workload 	<ul style="list-style-type: none"> ▪ Provision of adequate staff
Tafelsig Clinic	<ul style="list-style-type: none"> ▪ Shortage of skilled staff ▪ High patient load ▪ No permanent pharmacist ▪ Shortage of equipment and delay in repairing of equipment ▪ High crime rate – gangsters usually come to the clinic and threaten staff members ▪ Low socio-economic community – child abuse, burglary, etc. 	<ul style="list-style-type: none"> ▪ Additional skilled staff members ▪ Improve supply of equipment ▪ Community upliftment programmes ▪ Permanent pharmacist
Weltevrede Clinic	<ul style="list-style-type: none"> ▪ There is no full-time doctor – have to refer patients who need to see a doctor to Red Cross each time ▪ Transport problems – ambulance delays in transporting patients for emergencies ▪ Shortage of staff 	<ul style="list-style-type: none"> ▪ Additional staff ▪ Full-time doctor for the facility
Strandfontein Clinic	<ul style="list-style-type: none"> ▪ Staff shortage ▪ Don't have someone to maintain the yard ▪ Medication is sometimes out of stock ▪ Poor maintenance and repair of equipment and building 	<ul style="list-style-type: none"> ▪ Additional staff ▪ Improvement of communication by management all round
Lentegeur Clinic	<ul style="list-style-type: none"> ▪ Budget constraints for supporting accreditation process to improve quality of services rendered ▪ Shortage of staff – the facility manager is supposed to do administration and run the clinic as well ▪ The facility is too small for the number of people utilising the facility 	<ul style="list-style-type: none"> ▪ They should allocate a budget for quality assurance ▪ More staff is needed ▪ Facility must be extended
Mitchells Plain Youth Centre	<ul style="list-style-type: none"> ▪ Staff shortage 	<ul style="list-style-type: none"> ▪ Availability of more staff

Almost all facility managers reported insufficient number of nursing staff. However, this was most evident for Rocklands and Westridge Clinics. These two Clinics are regarded as separate facilities (fixed clinics) but function as satellite clinics. This is due to the gross shortage of staff, which has made it impossible for the two facilities to function independently. Staff members who have resigned have not been replaced, thus, forcing the two facilities to share the same staff including the same facility manager since June 2002. Rocklands and Westridge Clinics operate on alternate days. This has negative implications on the availability and accessibility of services for the respective communities.

Gap-attack!

All PHC facilities in Mitchells Plain view serious staff shortages as a main constraint in managing the PHC programme. This problem is most pronounced in the case of Rocklands and Westridge Clinics. Due to a gross shortage of staff, these two clinics (classified as fixed clinics) function on alternate days. They share the same staff including the same facility manager. Shortage and delay in repairing of equipment, crime (including abuse of staff by community members) and insufficient number of doctors are additional problems reported by more than one facility.

❑ **Coordination of specific programmes**

Table 11: Whether a specific health worker coordinates the programme

Facility	Maternal health	IMCI	TB	STIs	HIV/AIDS	EDL
Mitchells Plain CHC	No	N/A	N/A	Yes	Yes	Yes
Mitchells Plain MOU	Yes	N/A	N/A	N/A	Yes	No
Westridge Clinic	Yes	Yes	N/A	Yes	Yes	Yes
Eastridge Clinic	Yes	Yes	Yes	Yes	Yes	Yes
Rocklands Clinic	Yes	Yes	Yes	Yes	Yes	Yes
Tafelsig Clinic	Yes	Yes	Yes	Yes	Yes	Yes
Weltevrede Clinic	Yes	Yes	Yes	Yes	Yes	No
Strandfontein Clinic	Yes	Yes	Yes	Yes	Yes	Yes
Lentegeur clinic	Yes	Yes	Yes	Yes	Yes	Yes
Mitchells Plain Youth Centre	Yes	N/A	N/A	Yes	Yes	Yes

It is of concern that, although specific staff are working in specific programmes, there are no designated programme coordinators. Staff that work in a specific programme on a daily basis were interviewed upon realisation that staff members do not regard themselves as coordinators. Programme coordinators are only recognised at a district level.

Gap-attack!

Specific responsibility for programme coordination is lacking at Mitchells Plain CHC for the maternal health programme and at Mitchells Plain MOU and Weltevrede Clinic programme coordination is lacking for the EDL programme. In these cases where coordination is lacking, all nurses at the facility are responsible for providing the relevant programmes.

Table 12: Monthly staff discussions on PHC indicators, as indicated by programme coordinators

Facility	Facility manager	Maternal health	TB	IMCI	STIs	HIV/AIDS	EDL
Mitchells Plain CHC	Yes	No	N/A	N/A	Yes	Yes	Yes
Mitchells Plain MOU	Yes	Yes	N/A	N/A	N/A	Yes	No
Westridge Clinic	Yes	Yes	Yes	Yes	No	Yes	No
Eastridge Clinic	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Rocklands Clinic	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Tafelsig Clinic	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Weltevrede Clinic	Yes	Yes	Yes	Yes	Yes	Yes	N/A
Strandfontein Clinic	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Lentegeur Clinic	Yes	Yes	Yes	Yes	Yes	Yes	No
Mitchells Plain Youth Centre	Yes	Yes	N/A	N/A	Yes	Yes	Yes

Gap-attack!

Only Mitchells Plain CHC does not have monthly discussions about PHC indicators with the maternal health coordinator. Monthly staff discussions about PHC indicators are also lacking at Westridge Clinic with the STI coordinator and lacking with the EDL coordinators at Mitchells Plain MOU, Westridge Clinic and Lentegeur Clinic.

□ Programme-specific management constraints

Table 13: Self-reported management constraints and suggestions for improvement: maternal health programme

Facility	Constraints	Suggestions
Mitchells Plain CHC	<ul style="list-style-type: none"> ▪ Shortage of staff, therefore, only two patients per nurse per day can be managed for Pap smears ▪ Number of patients for TOP are increasing ▪ Same patients return two or three times for more TOPs ▪ Unwillingness of nurses to do TOP – they say it goes against their belief – which is why only nursing agent nurses are involved in TOP services 	<ul style="list-style-type: none"> ▪ Increase staff ▪ Encourage willing staff to get involved in TOP services ▪ Improve education of clients about TOP
Mitchells Plain MOU	<ul style="list-style-type: none"> ▪ Shortage of staff ▪ Shortage of doctors 	<ul style="list-style-type: none"> ▪ Provision of staff and doctors
Westridge Clinic	<ul style="list-style-type: none"> ▪ Staff shortage 	<ul style="list-style-type: none"> ▪ Increase staff
Eastridge Clinic	<ul style="list-style-type: none"> ▪ Shortage of staff ▪ Shortage of equipment 	<ul style="list-style-type: none"> ▪ Provision of staff ▪ Provision of enough equipment
Rocklands Clinic	<ul style="list-style-type: none"> ▪ Staff shortage 	<ul style="list-style-type: none"> ▪ Employ more staff
Tafelsig Clinic	<ul style="list-style-type: none"> ▪ Not enough staff are trained on family planning 	<ul style="list-style-type: none"> ▪ Training of staff members ▪ Update information at least twice a year
Weltevrede Clinic	<ul style="list-style-type: none"> ▪ Clients still don't understand the menstrual cycle but given education – they panic when they don't see menses 	<ul style="list-style-type: none"> ▪ Educate clients about menstrual cycle
Strandfontein Clinic	<ul style="list-style-type: none"> ▪ Shortage of staff 	<ul style="list-style-type: none"> ▪ Provision of staff
Lentegeur Clinic	None	None
Mitchells Plain Youth Centre	<ul style="list-style-type: none"> ▪ Staff shortage 	<ul style="list-style-type: none"> ▪ More staff must be employed

Gap-attack!

Seven of the ten facilities providing maternal health services in Mitchells Plain reported shortage of staff as an obstacle to providing comprehensive maternal health services. In addition, shortage of equipment and doctors, insufficient trained staff, lack of appropriate education of clients and lack of staff willing to provide TOP services were further obstacles to providing comprehensive maternal health services. Increasing number of staff, including doctors, improving patient education, providing enough equipment and training of staff members were suggestions for improving the management of the maternal health programme in Mitchells Plain.

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

Facility	Constraints	Suggestions
Mitchells Plain CHC	N/A	N/A
Mitchells Plain MOU	N/A	N/A
Westridge Clinic	<ul style="list-style-type: none"> ▪ Staff shortage ▪ Need IMCI training – no nurses trained on IMCI 	<ul style="list-style-type: none"> ▪ Additional staff ▪ Training of nurses on IMCI
Eastridge Clinic	<ul style="list-style-type: none"> ▪ Shortage of staff ▪ Lack of training of staff members on IMCI because it is difficult to assess and treat tonsillitis clients ▪ Too many clients for one health worker which holds up the flow of patients in the clinic 	<ul style="list-style-type: none"> ▪ Health workers should undergo the integrated one month course for diagnosis and treatment (IMCI Red Cross Hospital Course) ▪ Additional staff ▪ Include examination of chest, ear and throat in the case of a fever – child cannot tell whether pain is in ear or throat and nor will mother be able to tell.
Rocklands Clinic	<ul style="list-style-type: none"> ▪ Shortage of staff ▪ Lack of skills among various staff ▪ Shortage of equipment ▪ Shortage of drugs 	<ul style="list-style-type: none"> ▪ Employment of more staff ▪ All health workers should be available for training so that there are multi-skilled health workers ▪ More equipment must be supplied ▪ Drugs must always be available in good time
Tafelsig Clinic	None	N/A
Weltevrede Clinic	<ul style="list-style-type: none"> ▪ Not all nurses are trained on IMCI which causes work overload for those who are trained ▪ IMCI only covers up to 5 years instead of up to 13 years, so one has to change assessment techniques when examining children above 5 years – change examination guidelines/protocols 	<ul style="list-style-type: none"> ▪ All nurses (including the general worker) should be trained on IMCI
Strandfontein Clinic	<ul style="list-style-type: none"> ▪ Shortage of staff ▪ Insufficient training (no course on IMCI) 	<ul style="list-style-type: none"> ▪ Provision of staff ▪ Training of staff
Lentegeur Clinic	<ul style="list-style-type: none"> ▪ Shortage of staff ▪ IMCI takes long to implement because it involves assessment and education 	<ul style="list-style-type: none"> ▪ Additional staff members ▪ Improve attitudes of staff members in order for them to have an interest in IMCI training or doing the course
Mitchells Plain Youth Centre	N/A	N/A

Gap-attack!

Staff shortage is reiterated by five of the seven PHC facilities in Mitchells Plain which offer IMCI or child health services. Lack of training in IMCI is reported by five of the seven facilities. This problem is most severe at Westridge and Rocklands Clinics (share the same staff) where no nurse has received training on IMCI.

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

Facility	Constraints	Suggestions
Mitchells Plain CHC	N/A	N/A
Mitchells Plain MOU	N/A	N/A
Westridge Clinic	<ul style="list-style-type: none"> ▪ Shortage of staff 	<ul style="list-style-type: none"> ▪ Employ more staff
Eastridge Clinic	<ul style="list-style-type: none"> ▪ There is no authorised driver to do home visits for the TB programme, therefore one of the clinic personnel has to do it 	<ul style="list-style-type: none"> ▪ Provide a driver for the TB programme
Rocklands Clinic	<ul style="list-style-type: none"> ▪ Shortage of staff ▪ Poor ventilation ▪ Shortage of TB pamphlets 	<ul style="list-style-type: none"> ▪ Provision of staff ▪ Provision of extra fans
Tafelsig Clinic	<ul style="list-style-type: none"> ▪ Lack of funding ▪ Unemployment resulting in poverty ▪ Gangsters in the community ▪ Shortage of staff members 	<ul style="list-style-type: none"> ▪ Funds must be available for TB clients ▪ Additional staff members
Weltevrede Clinic	<ul style="list-style-type: none"> ▪ Problem with defaulters – clients are emigrating to other areas ▪ Nurses have to do administration (record keeping) and render nursing care (dispensing medicines) ▪ Shortage of staff ▪ Poor sanitation in the community (squatter camps) ▪ 80% of the clients are HIV positive 	<ul style="list-style-type: none"> ▪ Training of staff members on TB ▪ Improve community infra-structure such as sanitation ▪ Provide nutritional food for clients such as maize-meal and bread regularly
Strandfontein Clinic	<ul style="list-style-type: none"> ▪ Shortage of staff resulting in insufficient time to attend to each client in totality 	<ul style="list-style-type: none"> ▪ Additional staff member specifically trained for TB programme
Lentegeur Clinic	<ul style="list-style-type: none"> ▪ Problem with clients who default treatment ▪ Clients move (relocate) and are untraceable ▪ Clients undermine family DOTS supporters and default treatment ▪ Shortage of staff 	<ul style="list-style-type: none"> ▪ Additional staff members ▪ Computerise TB programme to avoid duplication of patient records
Mitchells Plain Youth Centre	N/A	N/A

Gap-attack!

Shortage of staff was reported as a constraint in managing the TB programme by all six PHC facilities, which offer TB services in Mitchells Plain.

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

Facility	Constraints	Suggestions
Mitchells Plain CHC	<ul style="list-style-type: none"> ▪ They have a problem contacting partners ▪ Most of the STI patients are unemployed and due to unemployment they are gangsters 	<ul style="list-style-type: none"> ▪ Should provide sexual education ▪ Need more support groups for their social interaction ▪ Doctors must give them prophylactic treatment
Mitchells Plain MOU	N/A	N/A
Westridge Clinic	<ul style="list-style-type: none"> ▪ Lack of time for counseling ▪ Problems in contacting STI patients 	<ul style="list-style-type: none"> ▪ Combining STI and family planning services could save time
Eastridge Clinic	<ul style="list-style-type: none"> ▪ No authorised driver to do home visits, therefore, clinic personnel must do it 	None
Rocklands Clinic	<ul style="list-style-type: none"> ▪ Staff shortage ▪ Shortage of drugs ▪ Not enough time for consultation ▪ Combining STI, family planning and Pap smear services 	<ul style="list-style-type: none"> ▪ Employment of more health staff ▪ Improving supply of drugs from the side of the suppliers – speed up supply of drugs ▪ Improve quality of consultation by employing more staff – because of staff shortage one must rush through a consultation to attend to other patients who have been waiting for a long time ▪ Family planning, Pap smear and STI services must not be combined in one consultation - different rooms must be used to ensure the smooth running of the various programmes
Tafelsig Clinic	<ul style="list-style-type: none"> ▪ Lack of understanding on the part of the client ▪ Unable to get contacts to visit the clinic 	<ul style="list-style-type: none"> ▪ Sexual education for the community by means of pamphlets, advertisements, talks, etc.
Weltevrede Clinic	<ul style="list-style-type: none"> ▪ There is no doctor to consult when there is a problem ▪ Management of genital warts – little improvement ▪ Male partners are reluctant to visit the clinic ▪ Condom use is poor resulting in recurrent sexual infections 	<ul style="list-style-type: none"> ▪ Encourage clients to complete treatment course ▪ Health education on safe sex ▪ Encourage VCT
Strandfontein Clinic	None	N/A
Lentegeur Clinic	<ul style="list-style-type: none"> ▪ Number of STI patients is low – people don't know and don't want to use the service 	<ul style="list-style-type: none"> ▪ STI services should be advertised more
Mitchells Plain Youth Centre	<ul style="list-style-type: none"> ▪ Shortage of staff 	<ul style="list-style-type: none"> ▪ More staff should be employed

Gap-attack!

Staff and drug shortage, difficulty contacting partners as well as STI patients themselves, time constraints, recurrent episodes of STIs and lack of patient education about STI management are some of the constraints in managing the STI programme in Mitchells Plain.

Table 17: Self-reported management constraints and suggestions for improvement: HIV/AIDS programme

Facility	Constraints	Suggestions
Mitchells Plain CHC	<ul style="list-style-type: none"> ▪ Shortage of staff resulting in long queues ▪ Shortage of medicines ▪ High rate of HIV clients especially young generation 	<ul style="list-style-type: none"> ▪ Additional staff members ▪ Medication supply must be increased ▪ Health education to teenagers about HIV/AIDS ▪ Improve grant for HIV/AIDS clients especially those who are not employed
Mitchells Plain MOU	N/A	N/A
Westridge Clinic	<ul style="list-style-type: none"> ▪ Shortage of staff ▪ Time constraints – need time to build trust relations with patients in order for them to disclose 	<ul style="list-style-type: none"> ▪ Additional staff members
Eastridge Clinic	<ul style="list-style-type: none"> ▪ 	<ul style="list-style-type: none"> ▪
Rocklands Clinic	<ul style="list-style-type: none"> ▪ Lack of transport for outreach programmes ▪ Staff shortage ▪ Lack of resources to communicate with care givers 	<ul style="list-style-type: none"> ▪ Employ more staff members ▪ Provide the facility with transport ▪ Funds to be allocated for care givers initiatives in the community
Tafelsig Clinic	<ul style="list-style-type: none"> ▪ Shortage of staff 	<ul style="list-style-type: none"> ▪ Additional staff Nurses to attend training on VCT and PMTCT because some nurses have only undergone an awareness course
Weltevrede Clinic	<ul style="list-style-type: none"> ▪ The treatment that they are getting is not sufficient ▪ Unemployment is a problem 	<ul style="list-style-type: none"> ▪ Provision of grants in order to get a well-balanced diet and improve health status ▪ Provide sufficient supply of vitamins
Strandfontein Clinic	<ul style="list-style-type: none"> ▪ Staff shortage ▪ Not enough counselors ▪ Need more time for discussions and to measure activities – there is no forum to share problems and experiences with others in other areas 	<ul style="list-style-type: none"> ▪ More staff should be allocated to this section ▪ Health workers should be trained on counseling to avoid patients waiting when the trained counselor is not there ▪ Need more forums to sit and discuss issues about HIV/AIDS among various facilities
Lentegeur Clinic	None	N/A
Mitchells Plain Youth Centre	<ul style="list-style-type: none"> ▪ Staff shortage 	<ul style="list-style-type: none"> ▪ More staff should be employed

Gap-attack!

All but two facilities (Lentegeur and Weltevrede Clinics) reported staff shortage as a major impediment to providing a comprehensive HIV/AIDS programme. In addition, shortage of drugs was reported as a constraint by two facilities (Mitchells Plain CHC and Weltevrede Clinic).

Table 18: Self-reported management constraints and suggestions for improvement: EDL programme

Facility	Constraints	Suggestions
Mitchells Plain CHC	<ul style="list-style-type: none"> ▪ Shortage of staff ▪ Need one specific person to manage the pharmacy ▪ Limited space of pharmacy 	<ul style="list-style-type: none"> ▪ A survey conducted by a pharmaceutical company in Cape Town to establish the needs of a pharmacy reports that the Mitchells Plain pharmacy needs either an additional pharmacist to work half day or else two additional pharmacy assistants ▪ Create a pharmacy management post ▪ Increase size of pharmacy to be in line with volume of stock and patients
Mitchells Plain MOU	<ul style="list-style-type: none"> ▪ Shortage of staff ▪ Need one specific person to manage the pharmacy ▪ Limited space of pharmacy 	<ul style="list-style-type: none"> ▪ A survey conducted by a pharmaceutical company in Cape Town to establish the needs of a pharmacy reports that the Mitchells Plain pharmacy needs either an additional pharmacist to work half day or else two additional pharmacy assistants ▪ Create a pharmacy management post ▪ Increase size of pharmacy to be in line with volume of stock and patients
Westridge Clinic	<ul style="list-style-type: none"> ▪ Sometimes there are outstanding drugs – drug shortage ▪ There is not enough drug storage space e.g. for weekly stock ▪ It is difficult to implement the CPM intervention ▪ Have to use own (facility-manager) transport to collect repeat chronic medication from Day Hospital – vehicle is available but no authorisation to use it 	<ul style="list-style-type: none"> ▪ Train someone to do the bin cards and to issue stock on a weekly basis according to the CPM intervention ▪ Day hospital should arrange transportation of repeat chronic medication to clinic since clinic is helping the Day Hospital by providing the Day Hospital's clients with repeat medication (reducing Day Hospital's workload)
Eastridge Clinic	<ul style="list-style-type: none"> ▪ Shortage of staff ▪ No support from doctors 	<ul style="list-style-type: none"> ▪ Provision of staff ▪ Availability of doctors
Rocklands Clinic	<ul style="list-style-type: none"> ▪ A lot of responsibilities – dispensing for two clinics ▪ Performing tasks under a lot of pressure 	<ul style="list-style-type: none"> ▪ Provision of staff
Tafelsig Clinic	<ul style="list-style-type: none"> ▪ Small budget – run out of drugs ▪ Delay in delivering of drugs from the depot which causes patients being asked to return resulting in increased transport costs ▪ Drugs taken out of EDL 	<ul style="list-style-type: none"> ▪ Consultation with nurses before substituting a drug for a cheaper one ▪ Decentralisation of drug stores ▪ Simplification of the ordering – not this long process
Weltevrede Clinic	<ul style="list-style-type: none"> ▪ Shortage of staff – no one to dispense ▪ Not all HIV/AIDS drugs are available, therefore TB and HIV patients in the community are angry resulting in them shouting at nurses for turning them away without drugs 	<ul style="list-style-type: none"> ▪ Additional staff members ▪ Additional equipment for drug storage
Strandfontein Clinic	<ul style="list-style-type: none"> ▪ Don't stock specialised drugs prescribed by specialists in hospitals ▪ Removing drugs from the EDL without proper consultation – certain drugs removed from the EDL which clinics need 	<ul style="list-style-type: none"> ▪ Establishing a task team to work with problems such as drugs that are removed from the EDL – task team should check drugs removed and establish the need for those drugs through consultation with key people. Example, Ventolin syrup was removed from the EDL and not replaced
Lentegeur Clinic	<ul style="list-style-type: none"> ▪ The manager has three functions, namely, manager, nurse, stock controller ▪ Treatment for certain children referred by Red Cross Hospital is not included in EDL 	<ul style="list-style-type: none"> ▪ Need a pharmacist, even if only part-time pharmacist
Mitchells Plain Youth Centre	None	N/A

Gap-attack!

Four facilities (Mitchells Plain CHC, Mitchells Plain MOU, Eastridge Clinic and Weltevrede Clinic) reported staff shortage as a constraint to effectively managing the EDL programme. Lack of a specific EDL manager, limited space, drug shortage and insufficiency of EDL are additional constraints in the EDL programme.

12. Scope and accessibility of services

Table 19: Scope and accessibility of PHC services offered

Services	Mitchells Plain GHC	Mitchells Plain MOU	Westridge Clinic	Eastridge Clinic	Rocklands Clinic	Tafelsig Clinic	Weltevrede Clinic	Strandfontein Clinic	Lentegeur Clinic	Mitchells Plain Youth Centre
ANC		7	X	X	X	X	X	X	X	X
Uncomplicated deliveries		7	X	X	X	X	X	X	X	X
Post natal care		✓	X	✓	X	✓	X	✓	X	X
Pap smears	4 ⁴	7	3	5	3	1 ⁴	1 ⁴	1 ⁴	3 ⁴	5
Family planning (emergency contraception)	X	7	3	5	3	5	5	5	5	5
TOP (medical and surgical)	5	X	X	X	X	X	X	X	X	X
TOP counselling	✓	X	✓	✓	✓	✓	✓	✓	✓	✓
TOP referral	5	X	3	5	3	5	5	5	5	5
IMCI	X	X	X	✓	X	✓	✓	✓	✓	X
Child health/curative	X	X	3	5	3	5	5	5	5	X
Immunisations	X	X	3	5	3	5	5	5	4 ³	X
Nutrition/growth monitoring	X	X	3	5	3	5	5	5	5	X
Special hours for youth	X	X	3	X	X	X	5	X	X	5
TB treatment	X	X	5	5	3	5	5	5	5	X
Clinic-based DOTS	X	X	5	5	5	5	5	5	5	X
Walk-through DOTS	X	X	✓	✓	✓	✓	✓	✓	✓	X
STI treatment	5	X	3	5	3	5	5	5	5	5
HIV (opportunistic infections)	5	7	X	5	X	5	5	X	X	4 ⁴
VCT	5	7	3	5	3	5	5	5	5	4 ⁴
PMTCT	X	7	3	5	3	5	5	5	5	X
Adult acute curative care	7	X	X	X	X	5	X	X	X	X
Chronic disease management	7	X	5 ¹	5	2 ⁵	5	X	X	X	5
Mental health/referral	7	X	1 ⁴	X	2 ⁴	2 ⁴	X	2 ²	3 ⁴	X
Health education & promotion	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Home-based care	✓	X	X	X	X	X	X	✓	X	X
Home visits by staff	3 ⁴	X	3	X	3	5	5	2 ⁴	1 ³	X
Eye care services/referral	X	X	X	5	X	X	X	X	X	X
Oral health/referral	5	X	X	5	X	X	5	X	5	X
Repeat/fast queue	X	X ¹	X	✓	X	✓	✓	✓	X	X
Emergency care/casualty	7	X	✓	✓	✓	✓	✓	✓	✓	X
Violence/sexual abuse	✓	X	✓	✓	✓	✓	✓	✓	✓	✓
Rehabilitation	5	X	X	X	X	X	X	X	X	X

✓ Service offered

X Service not offered

Number indicates the number of days per week that the service is offered

Referred to MOU, on the same premise

1 The full-time pharmacist provides repeat medication to chronic disease patients on a daily basis without patients being seen by a nurse

2 Twice a month

3 Half days

4 Service only provided on allocated days

5 Repeat medication offered Tuesdays for 2hrs and Fridays for 2hrs

GAP-ATTACK!

ANC: routine ANC services should have been introduced and been in place at PHC facilities (clinics, mobiles and CHCs) by the end of 2001 (Department of Health 2001b: 21, 30). Despite this, only the MOU in Mitchells Plain is providing this service.

Delivery: delivery of uncomplicated pregnancies should have been in place at fixed clinics and mobile clinics by the end of 2002. All steps of normal delivery services, from reception to discharge, should have been in place by the end of 2002 at CHCs (Department of Health 2001b: 21, 35). The MOU conducts uncomplicated deliveries, while complicated deliveries are referred to Mowbray Hospital.

Post natal care: this service should have been available from the end of 2002 (Department of Health 2001b: 21). Post-natal care is only provided by four facilities, namely Mitchells Plain MOU, Eastridge Clinic, Tafelsig Clinic and Strandfontein Clinic.

Family planning: family planning services, including emergency contraception, should have been available at PHC facilities from the end of 2002 (Department of Health 2001b: 21, 31). Only Mitchells Plain CHC does not provide family planning. They refer clients to Mitchells Plain Youth Centre. It is strange that Mitchells Plain Youth Centre provides family planning services to both adults and youth, it being classified an Adolescent Friendly Clinic. Family planning services are offered to employed adults from 07H30 to 10H00. This should impact negatively on the adolescent friendly image of the clinic.

TOP: by the end of 2001 clinics should have had in place: medical terminations of 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, medical and surgical TOPs are only available at Mitchells Plain CHC.

IMCI: IMCI should have been in place at PHC facilities since the end of 2002 (Department of Health 2001b: 19; Elgoni 2003). Mitchells Plain CHC refers IMCI clients to Eastridge Clinic, whilst IMCI has not been implemented at Westridge and Rocklands Clinics. Only child curative care is offered at the latter two facilities.

Child curative: needs for curative care should be addressed at each visit and should have been in place since the end of 2002 (Department of Health 2001b: 19). Despite this, Mitchells Plain CHC does not provide child curative services.

TB: all PHC facilities should have been diagnosing and treating TB patients by the end of 2001 (Department of Health 2001b: 25, 32). Only Mitchells Plain CHC does not provide any TB services.

STIs: diagnosis and treatment as per syndromic approach should have been in place from the end of 2002 (Department of Health 2001b: 24). Mitchells Plain MOU only diagnosis syphilis in pregnant women. Thereafter, they are referred to Mitchells Plain CHC for management.

HIV/AIDS: amongst others, this service includes pre-counselling, testing and post-counselling; education and counselling to relatives/partners; provision of condoms; assessment and treatment of infections and referral to CHCs if needed. This service should have been in place by the end of 2002 (Department of Health 2001b: 25). Despite these requirements, Westridge Clinic, Rocklands Clinic, Lentegour Clinic and Strandfontein Clinic do not provide services for HIV/AIDS patients presenting with opportunistic infections.

PMTCT: only Mitchells Plain CHC does not offer PMTCT. Although Westridge and Rocklands offer PMTCT, there are as yet no recorded patients for this service.

Adult curative: this service should have been in place at PHC facilities from the end of 2002. Only two facilities in Mitchells Plain offer adult acute curative services, namely Mitchells Plain CHC and Tafelsig Clinic. It is of concern to note that Westridge Clinic, Eastridge Clinic, Rocklands Clinic, Weltevrede Clinic, Strandfontein Clinic and Lentegour Clinic do not provide adult curative services.

Chronic disease management: CHCs should have been diagnosing and treating chronic disease patients since the end of 2002. Clinics and mobile clinics should have been making a preliminary diagnosis and referring to CHCs since the end of 2002. From the end of 2005, clinics and mobiles should be diagnosing and assessing chronic diseases (Department of Health 2001b: 23, 31). Westridge Clinic, Eastridge Clinic, Rocklands Clinic, Tafelsig Clinic and Mitchells Plain Youth Centre also offer chronic disease management but to a limited degree. For example, Westridge and Rocklands Clinics only provide repeat medication for chronic disease clients who have been referred to them by Mitchells Plain CHC.

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 Eastridge Clinic and Weltevrede Clinic.

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). Despite these guidelines, home-based care is only provided by Mitchells Plain CHC and Strandfontein Clinic, and home-visits by clinic staff is not done at Eastridge Clinic.

Oral health: basic curative and preventative measures as well as referrals to the district hospital or visiting dentists should have been in place at CHCs since the end of 2002 (Department of Health 2001b: 33). Oral health services are provided by Mitchells Plain CHC, Eastridge Clinic, Weltevrede Clinic and Lentegeur Clinic. Although Westridge Clinic and Strandfontein Clinic do not offer oral health services, a dental clinic operated and managed by PAWC is available at these two facilities.

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 Mitchells Plain CHC, Tafelsig Clinic, Strandfontein Clinic, Mitchells Plain Youth Centre and not only for chronic disease patients at Westridge and Rocklands Clinics.

Violence/sexual abuse: this service should have been available at PHC facilities from end of 2001 (Department of Health 2001b: 22, 23). Only Mitchells Plain MOU does not provide this service.

Rehabilitation: this includes, amongst others, screening and observations at clinics and home for early detection; and basic assessment. It should have been available from end of 2001 at clinics and CHCs (Department of Health 2001b: 26; 33, 34). Only Mitchells Plain CHC offers this service.

GAP-ATTACK!

Mitchells Plain CHC does not provide family planning services since they have transferred this service to the Mitchells Plain Youth Centre (for both adults and youth). In addition, Mitchells Plain Youth Centre also offers Pap smears and provides chronic disease treatment to adults. It would seem as though providing services to adults at a Youth Centre, which is deemed adolescent friendly, defeats the purpose of a Youth Centre. Not one of the facilities in Mitchells Plain provides the full range of PHC services as stipulated in the Package.

Table 20: PHC facility open times

Facility	Days per week	Hours week days	Hours Saturdays	Hours Sundays	Total hours per week
Mitchells Plain CHC	7	12	24	24	108
Mitchells Plain MOU	7	24	24	24	168
Westridge Clinic	3	9	0	0	45
Eastridge Clinic	5	9	0	0	45
Rocklands Clinic	3	9	0	0	27
Tafelsig Clinic	5	9	0	0	45
Weltevrede Clinic	5	9	0	0	45
Strandfontein Clinic	5	9	0	0	45
Lentegeur Clinic	5	9	0	0	45
Mitchells Plain Youth Centre	5	9	0	0	45

According to the Package (Department of Health, 2001a: 12) a clinic should render comprehensive integrated PHC services using a one-stop approach for at least 8 hours a day, five days a week. Westridge and Rocklands Clinics do not achieve this standard. Westridge Clinic provides PHC services on Mondays, Wednesdays and Fridays, whilst Rocklands Clinic provides PHC services on Tuesdays, Thursdays and Fridays. These two facilities function on alternate days because they share the same staff and facility manager, except on Fridays whereby half of the staff work at Westridge Clinic and the other half at Rocklands Clinic. This arrangement not only places tremendous stress on the nursing staff at these facilities but to a larger extent it compromises the quality of PHC services offered at these two clinics.

GAP-ATTACK!

Westridge and Rocklands Clinics only function three days a week instead of the required five days a week. There are no PHC services in Mitchells Plain over weekends. Mitchells Plain CHC only opens for emergencies over weekends. How are individuals who are employed and are unable to go to a PHC facility during the week accommodated? For example, family planning and IMCI clients. Mitchells Plain CHC, which opens 12 hours per day, does not provide family planning and IMCI services.

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

Comparisons in the daily provision of services showed that in most instances, service provision on a daily basis in Mitchells Plain 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 *et al.* 2000: 13). The current study showed that in Mitchells Plain 70% of the facilities offered family planning on a daily basis - this is 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 only 10% of facilities offered ANC services on a daily basis in Mitchells Plain.
- 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 only 40% of facilities offered immunisation services on a daily basis in Mitchells Plain.
- 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 50% of the facilities in Mitchells Plain 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 Mitchells Plain TB care is only offered at 50% of the clinics.

- STI care was offered nationally on a daily basis in 2000 at 94.9% of the fixed facilities (Viljoen *et al.* 2000: 17). Only 70% of facilities in Mitchells Plain 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). Seventy percent of the facilities in Mitchells Plain offered VCT on a daily basis at the time of the survey.
- 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. At a far lower level of availability, adult curative services were provided at 20% of facilities in Mitchells Plain 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). Chronic services were available at 50% of the facilities in Mitchells Plain 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 were available at only 10% of facilities in Mitchells Plain on a daily basis.

GAP-ATTACK!

PHC facilities in Mitchells Plain appear to lag behind the national average in many instances when it comes to the provision of services on a daily basis. Westridge and Rocklands Clinics only provide family planning, TOP referral, Pap smears, STI treatment, PMTCT counselling, immunisations, child care, VCT and nutrition/growth monitoring services three days a week because they function on alternate days. Mental health services at Westridge Clinic and Rocklands Clinic are offered once and twice a week respectively, and only offered twice a month at Strandfontein Clinic. Lentegeur Clinic only offers immunisations four half days a week. How, then, are employed parents accommodated at Lentegeur Clinic? Mitchells Plain Youth Centre only offers HIV clinic for opportunistic infections and VCT four days a week.

4. PHC facility equipment

□ General PHC equipment

Table 21: General, diagnostic and clinical equipment¹

Facility	Adult scale	Diagnostic sets	Examination couch	Examination light	Thermometer	Stethoscope	Blood pressure meter	Otoscope	Glucometer	Steriliser
Mitchells Plain CHC	4	12	19	5	30	12	20	12	3	5
Mitchells Plain MOU	1	2	5	3	10	0	10	0	1	1
Westridge Clinic	3	2	3	3	16	4	2	2	1	1
Eastridge Clinic	3	7	10	8	12	10	8	7	2	2
Rocklands Clinic	4	7	7	2	6	7	6	7	1	2
Tafelsig Clinic	5 (3)	7(1)	11	10	20	8(1)	10(3)	7(1)	1	3
Weltevrede Clinic	4	4	10	4	30	5	13	6	2	1
Strandfontein Clinic	3	2	6	3 (1)	12	6	6	2	1	2
Lentegeur Clinic	7	3	5	4	24	6	3	3	1	4
Mitchells Plain Youth Centre	0	0	2	1	0	1	1	0	1	0

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 21, the number of consultation rooms at the ten facilities need to be considered (Table 22).

Table 22: Number of consultation rooms per facility¹

Facility	Number of consultation rooms
Mitchells Plain CHC	19 (19)
Mitchells Plain MOU	4 (4)
Westridge Clinic	5 (5)
Eastridge Clinic	12 (12)
Rocklands Clinic	7 (7)
Tafelsig Clinic	17 (17)
Weltevrede Clinic	11 (10)
Strandfontein Clinic	4 (4)
Lentegeur Clinic	12 (12) ²
Mitchells Plain Youth Centre	6 (6)

¹ The table depicts the total number of consultation rooms a facility has. The numbers in brackets refer to the number of consultation rooms that are in use.

² One room does not offer audio privacy.

Consultation rooms: the Department of Health does not specify the number of consultation rooms a facility should have but the Package (2001a: 13) does stipulate that the consultation rooms should be adequate. Although not stipulated by the Package, without a doubt, consultation rooms should offer both audio and visual privacy. Almost all consultation rooms at the PHC facilities in Mitchells Plain offer both audio and visual privacy. The exception was Lentegeur Clinic where one consultation room only offered visual privacy and not audio privacy. This has detrimental implications for client confidentiality and privacy, which is one of the standards of the Patients Rights Charter (Department of Health, 2001a: 11).

Adult scales: 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. Especially Mitchells Plain CHC is in need of more adult scales considering that they offer adult curative services. The facility only has four adult scales for 19 consultation rooms. Also in need of more adult scales are Eastridge Clinic (only 3 adult scales for 12 consultation rooms), Tafelsig Clinic (5 adult scales for 17 consultation rooms) and Weltevrede Clinic (4 adult scales for 11 consultation rooms). The need for additional adult scales is more so for facilities that offer adult curative care, namely, Mitchells Plain CHC and Tafelsig Clinic. Equipping most consultation rooms with adult scales will avoid cases whereby adult patients who need to be weighed in consultation rooms without scales have to be accompanied to another consultation room for this purpose.

Examination couches: 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. Only four facilities (Mitchells Plain CHC, Rocklands Clinic, Weltevrede Clinic) in Mitchells Plain had an examination couch in each of the consultation rooms that were in use. Facilities which appear to be in need of more examination couches in relation to the number of consultation rooms that are in use are Tafelsig Clinic, which only had eleven examination couches for seventeen consultation rooms, and Lentegeur Clinic, which only had five examination couches for twelve examination rooms.

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. Only three facilities in Mitchells Plain (Eastridge Clinic, Tafelsig Clinic, Mitchells Plain Youth Centre) had an examination light for each professional nurse. However, not one facility had an examination light for each consultation room. Worst off was Mitchells Plain CHC which only had five examination lights for 19 consultation rooms and 24 professional nurses. All consultation rooms/professional nurses/medical officers should be equipped with examination lights.

Thermometers: 80% of the facilities in Mitchells Plain had more thermometers than the number of consultation rooms. Mitchells Plain Youth Centre was the exception with no thermometers. 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 except Strandfontein Clinic which had more stethoscopes than the number of consultation rooms. Mitchells Plain MOU and Mitchells Plain Youth Centre had no stethoscopes. This is disturbing as stethoscopes are needed in the routine screening of all patients attending PHC facilities.

Blood pressure meters and otoscopes: Four facilities in Mitchells Plain had more blood pressure meters than the number of consultation rooms whilst the other six facilities had fewer blood pressure meters than number of consultation rooms. This discrepancy in the number of consultation rooms versus the number of blood pressure meters was most pronounced in the case of Lentegeur Clinic which had three blood pressure meters for twelve consultation rooms. 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)). Only Mitchells Plain MOU and Mitchells Plain Youth Centre did not have any otoscopes. 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. 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. All PHC facilities in Mitchells Plain had at least one glucometer in working order.

Sterilisers: the Package (Department of Health 2001a: 31) stipulates that all health clinics should have a steriliser. All facilities, with the exception of Mitchells Plain Youth Centre, had at least one steriliser in working condition.

Equipment in need of repair: table 21 indicates that, in total, ten general diagnostic and clinical equipment items at PHC facilities are in need of repair. However, of concern is that nine of the ten equipment items in need of repair are at Tafelsig Clinic. Maintenance of equipment at Tafelsig Clinic requires urgent attention.

Gap-attack!

It is of utmost importance that all consultation rooms offer both audio and visual privacy in order to maintain patient confidentiality as stipulated by the Patient Rights Charter (Department of Health 2000: 11). Lentegeur Clinic has one consultation room in use which does not offer audio privacy. Mitchells Plain CHC, Eastridge Clinic and Tafelsig Clinic are in need of more adult scales since the numbers are less than the number of consultation rooms in use. All, or at least most, consultation rooms need examination couches (although the exact number required by a facility is not stipulated in the Package). Tafelsig Clinic, which only had eleven examination couches for seventeen consultation rooms, and Lentegeur Clinic, which only had five examination couches for twelve examination rooms are in need of more examination couches. 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. Only three facilities in Mitchells Plain (Eastridge Clinic, Tafelsig Clinic, Mitchells Plain Youth Centre) had an examination light for each professional nurse and not one facility had an examination light for each consultation room. Mitchells Plain Youth Centre did not have a single adult scale, thermometer, otoscope and steriliser, whilst Mitchells Plain MOU did not have a stethoscope or an otoscope. Maintenance of equipment at Tafelsig Clinic requires urgent attention since nine of the ten general diagnostic equipment in need of repair at PHC facilities in Mitchells Plain, at the time of this study, are at Tafelsig Clinic.

□ **Maternity programme equipment**

Table 23: Maternity programme-specific equipment and items

	Number of foetal scopes	Delivery sets/sterile packs	Neonatal resuscitation trolley	Ventouse	Forceps	Manual vacuum aspiration (MVA) syringe	Privacy during TOP	Private recovery space after TOP
Mitchells Plain CHC	0	0	0	0	0	0	Yes	Yes
Mitchells Plain MOU	8	30	1	1	1	1	N/A	N/A
Westridge Clinic	0	0	0	0	0	0	N/A	N/A
Eastridge Clinic	0	0	0	0	0	0	N/A	N/A
Rocklands Clinic	0	0	0	0	0	0	N/A	N/A
Tafelsig Clinic	0	0	0	0	0	0	N/A	N/A
Weltevrede Clinic	0	0	0	0	0	0	N/A	N/A
Strandfontein Clinic	1	0	0	0	0	0	N/A	N/A
Lentegeur Clinic	0	0	0	0	0	0	N/A	N/A
Mitchells Plain Youth Centre	0	0	0	0	0	0	N/A	N/A

Fetal scopes: the Department of Health (2001a: 16) sets the standard that all health clinics should have at least one foetal scope in working order. Surprisingly, only Mitchells Plain MOU and Strandfontein Clinic had at least one foetal scope in working condition.

Delivery sets/sterile packs: only Mitchells Plain MOU was equipped with delivery sets or sterile packs despite the standard set by the Package (Department of Health 2001a: 16) that all PHC clinics should be equipped with either sterile packs or a delivery set.

Neonatal resuscitation trolleys: Mitchells Plain MOU is the only PHC facility that has a neonatal resuscitation trolley. According to the Package (Department of Health 2001a: 21) all PHC facilities should be equipped to manage uncomplicated deliveries.

Gap attack!

The Package states that all PHC facilities should be equipped to provide uncomplicated deliveries by end 2001 (Department of Health, 2001b: 21). Mitchells Plain MOU is the only PHC facility in Mitchells Plain equipped to deliver uncomplicated pregnancies.

□ **IMCI programme equipment**

Table 24: IMCI programme-specific equipment

Facility	Infant scale	IMCI health education videos	Emergency equipment for intravenous resuscitation of severely dehydrated children	Oral re-hydration corner
Mitchells Plain CHC	N/A	N/A	N/A	N/A
Mitchells Plain MOU	N/A	N/A	N/A	N/A
Westridge Clinic	5	0	1	1
Eastridge Clinic	2	0	1	1
Rocklands Clinic	5	2	1	0
Tafelsig Clinic	2	0 ¹	2	1
Weltevrede Clinic	1	0	2	1
Strandfontein Clinic	2	0	1	1
Lentegeur Clinic	3	0	0	0
Mitchells Plain Youth Centre	N/A	N/A	N/A	N/A

¹ Rent videos from library at Resource Centre

Gap attack!

Rocklands and Lentegeur Clinics did not have an oral rehydration corner. In addition, Lentegeur Clinic did not have emergency equipment for intravenous resuscitation of severely dehydrated children. Availability of IMCI education videos is very poor at the facilities in Mitchells Plain. Rocklands Clinic was the only facility that had IMCI education videos.

Table 25: Cold chain maintenance

Item	Mitchells Plain CHC	Mitchells Plain MOU	Westridge Clinic	Eastridge Clinic	Rocklands Clinic	Tafelsig Clinic	Weltevrede Clinic	Strandfontein Clinic	Lentegeur Clinic	Mitchells Plain Youth Centre
Refrigerator used exclusively for vaccines?	✓	✓	✓	✓	✓	✓	✓	✓	✓	N/A
Temperature at the time of the visit	9°C	9°C	6°C	6°C	7°C	5°C	6°C	5°C	4°C	N/A
Temperature record card present	✓	✓	✓	✓	✓	✓	✓	✓	✓	N/A
Date of last recording of temperature	18/2/2003	18/2/2003	19/2/2003	26/2/2003	30/1/2003	20/2/2003	21/2/2003	4/3/2003	13/2/2003	N/A
Last recorded temperature	7°C	7°C	5°C	5°C	6°C	5°C	8°C	4°C	6°C	N/A
Ice packs in the refrigerator	✓	✓	✓	✓	✓	✓	✓	✓	✓	N/A
Cold boxes in the clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	N/A
Number of days refrigerator out of order in the past month	0	0	0	0	0	0	0	0	0	N/A
Refrigerator thermometer in working condition	✓	✓	✓	✓	✓	✓	✓	✓	✓	N/A
Space for circulation between vaccines?	✓	✓	✓	✓	✓	✓	✓	✓	✓	N/A
Refrigerator located within 3 metres from a heater/air conditioner?	✗	✗	✗	✗	✗	✗	✗	✗	✗	N/A
Is the refrigerator located against an inside wall (away from direct sunlight)?	✓	✓	✓	✓	✓	✓	✓	✓	✓	N/A
Is the refrigerator located in an area where only clinic personnel have access to it?	✓	✓	✓	✓	✓	✓	✓	✓	✓	N/A
Can the door to the room in which the refrigerator is located be locked?	✓	✓	✓	✓	✓	✓	✓	✓	✓	N/A

Maintenance of temperature: all the facilities, with the exception of Mitchells Plain Youth Centre, had at least one refrigerator that they used exclusively for vaccines. This is in line with the national standard, as stipulated in the Package (Department of Health 2001a: 13). Also, all fridges had thermometers in working order for monitoring and maintaining temperatures. According to the EDL guidelines (Department of Health 1998: 87) the cold chain temperature should be maintained at between zero and eight degrees. Observations were conducted to determine the current temperatures in vaccine refrigerators. Two of the facilities' vaccine refrigerator temperatures (Mitchells Plain CHC and Mitchells Plain MOU) were found to be higher than the stipulated temperature.

Monitoring and recording of temperature: both the Package and the EDL guidelines stipulate that all PHC facilities should have temperature cards in use and that vaccine refrigerator temperatures should be regularly monitored and recorded (twice a day). All the facilities were making use of temperature record cards. The last date temperatures were recorded at all the facilities was either the day of the visit to the facility or the previous day. The last recorded temperature was within the required range as stipulated in the EDL guidelines for all the facilities.

Location of the refrigerator: the last four questions for fixed clinics in table 25 were derived from 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 to the credit of all the PHC facilities in Mitchells Plain that all of the last four requirements (for fixed clinics) stated in table 25 were met. Namely, all refrigerators were not located within three meters from a heater/air conditioner, all refrigerators were located against an inside wall, all refrigerators were located in an area where only clinic personnel have access to them and the door to the room in which the refrigerators were located could be locked.

Ice packs and cooler bags: all the facilities had ice packs in the refrigeration compartments of the vaccine refrigerators as well as cooler bags in the facilities in case of power failures and for maintaining the cold chain when vaccines need to be transported elsewhere. Also, there was enough space between each tray of vaccines to allow cold air to circulate as is stipulated by the guidelines.

Gap attack!

The vaccine refrigerator temperature at Mitchells Plain CHC and Mitchells Plain MOU was higher than the stipulated temperature of between zero and eight degrees (Department of Health 1998: 87).

□ **STI programme equipment**

Table 26: STI programme-specific equipment

Facility	Number of consultation rooms used for STI/HIV/AIDS services	Number of screened examination couches in working condition	Number of sterile specula in working condition	Condom dispensers	Dildo for condom demonstration
Mitchells Plain CHC	10	10	12	4	6
Mitchells Plain MOU	N/A	N/A	N/A	N/A	N/A
Westridge Clinic	2	3	17	2	1
Eastridge Clinic	1	1	12	1	1
Rocklands Clinic	1	1	20	9	1
Tafelsig Clinic	6	6	30	7	2
Weltevrede Clinic	1	1	15	4	1
Strandfontein Clinic	3	3	15	1	1
Lentegeur Clinic	1	1	11	4	1
Mitchells Plain Youth Centre	2	2	2	2	2

In accordance with the Package (Department of Health 2001a: 31), every PHC facility in Mitchells Plain has at least one screened examination couch and sterile specula in working condition. 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) and at least one dildo for condom demonstration.

□ **HIV/AIDS programme equipment**

Table 27: Availability of a lockable storage room

Facility	Lockable storage room for HIV/AIDS information sources
Mitchells Plain CHC	✓
Mitchells Plain MOU	✓
Westridge Clinic	X
Eastridge Clinic	✓
Rocklands Clinic	✓
Tafelsig Clinic	✓
Weltevrede Clinic	✓
Strandfontein Clinic	✓
Lentegeur Clinic	✓
Mitchells Plain Youth Centre	✓

Gap attack!

Westridge Clinic did not have a lockable storage room for HIV/AIDS information sources to be locked up and kept confidential.

□ **Emergency equipment**

Table 28: Oxygen availability

Facility	Oxygen cylinder with O ₂	Oxygen mask
Mitchells Plain CHC	45	40
Mitchells Plain MOU	2	3
Westridge Clinic	2	10
Eastridge Clinic	5	10
Rocklands Clinic	9	20
Tafelsig Clinic	14	20
Weltevrede Clinic	7	10
Strandfontein Clinic	2	10
Lentegeur Clinic	2	20
Mitchells Plain Youth Centre	0	0

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 Mitchells Plain Youth Centre, all the facilities had at least two oxygen cylinders with oxygen. Having at least two oxygen cylinders in a facility ensures that there is always back-up oxygen for emergencies in the event that one cylinder runs out of oxygen or when one cylinder is sent away to be refilled with oxygen. Similarly, all facilities, apart from Mitchells Plain Youth Centre, had oxygen masks at the time of the survey.

Gap-attack!

Mitchells Plain Youth Centre did not have oxygen cylinders and oxygen masks at the time of the survey. Is there justification for the lack of this emergency equipment at the Youth Centre?

□ **Equipment for communication and health education**

Table 29: Equipment for communication and health education

	Telephone	Telephone lines	Fax machine	Computer	Audiovisual set
Mitchells Plain CHC	17	40	2	2	4
Mitchells Plain MOU	4	7	1	2	1
Westridge Clinic	10	2	1	1	1
Eastridge Clinic	16	3	1	2	2
Rocklands Clinic	13	2	1	1	1
Tafelsig Clinic	18	18	1	2(1)	1(1)
Weltevrede Clinic	15	15	1	1	1
Strandfontein Clinic	9	2	1	1	1
Lentegeur Clinic	13	3	1	1	1
Mitchells Plain Youth Centre	1	1	0	0	1

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

As stipulated by the Package (Department of Health 2001a: 13), all facilities in Mitchells Plain 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. All facilities, with the exception of Mitchells Plain Youth Centre, had at least one fax machine and computer in working order. The facilities reported that the computers are mainly utilised to store patient records/folders, facility-based statistics, application system, facility reports, PHC graphs, patient registration information and for electronic mail purposes.

It is important for all facilities to be equipped with audiovisual sets and health education videos in a local language 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!). It is to the credit of facilities in Mitchells Plain that all of the PHC facilities had an audiovisual set which was used for health education of patients.

Gap-attack!

Why does Mitchells Plain Youth Centre not have a computer, taking into account the main uses of computers at the other facilities that are equipped with computers?

□ **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.

In general, PHC facilities in Mitchells Plain appear to enjoy reliable communication services (telephone, fax and computer) and electricity supply. Only Strandfontein Clinic experienced a one-day interruption in the use of their computer in the month preceding the survey.

□ **Self-reported equipment needs**

Mitchells Plain CHC

- Air conditioner in the dressing room
- Machine to polish the floors

Mitchells Plain MOU

- Sex monitor (for babies)
- TSB machine (for testing jaundice)

Westridge Clinic

- Missing data

Eastridge Clinic

- None reported

Rocklands Clinic

- Extractor fan/air conditioner for TB room

Tafelsig Clinic

- More trolleys
- A mop and bucket system
- A more advanced barometer
- Electronic seals
- Air conditioners/electric fans

Weltevrede Clinic

- Steriliser for water
- Nebuliser machine
- Maternity equipment such as a foetalscope, suction machine, ECG

Stranfontein Clinic

- Electric fan

Lentegeur Clinic

- Air conditioner
- Health and safety equipment
- Laryngoscopes
- Security equipment
- Room thermometers
- Fridge thermometers

Mitchells Plain Youth Centre

- Adult scale
- Blood pressure meter
- Glucometer
- Heaters
- Stethoscopes
- Vacuum cleaner
- Curtains
- Fans/air conditioner

The above-mentioned needs for equipment have to be weighed against both the patient load and the staffing establishments of the concerned facilities.

5. PHC diagnostic tests

Table 30 depicts whether important PHC diagnostic tests are offered, as well as the turn-around times of these tests.

Table 30: Diagnostic tests offered and turn-around times

Facility	HIV (laboratory)		Syphilis in pregnancy (RPR)		Screening for haemoglobin/blood group/RH (Rhesus test)		Pap smear		TB- AFB/smear	
	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
Mitchells Plain CHC	No	N/A	Yes	*7 **1	Yes	*5 **1	Yes	*14 **7	No	N/A
Mitchells Plain MOU	Yes	*7	Yes	**<1	Yes	**14	Yes	**14	No	N/A
Westridge Clinic	Yes	*1	No	N/A	No	N/A	Yes	*28-42	Yes	*3-5 **1
Eastridge Clinic	Yes	*14 **7	Yes	*7	No	N/A	Yes	*42 **42	Yes	*7 **1
Rocklands Clinic	Yes	*2	Yes	*2-4	No	N/A	Yes	*21-28	Yes	*3-5 **1
Tafelsig Clinic	Yes	*3	No	N/A	Yes	*4 **2	Yes	*14	Yes	*1 **1
Weltevrede Clinic	Yes	*14	No	N/A	Yes	*7 **2	Yes	*14 **7	Yes	*7 **3
Strandfontein Clinic	Yes	*10 **1	Yes	*7	No	N/A	Yes	*28 **1	Yes	*1 **1
Lentegeur Clinic	Yes	*2	Yes	*2 **1	No	N/A	Yes	*14 **7	Yes	*2 **2
Mitchells Plain Youth Centre	No	N/A	Yes	*28-42 **28	No	N/A	Yes	*56 **56	No	N/A

* = Turn-around time for written results

** = Turn-around time for phone/fax results

□ PHC test practices

Westridge Clinic does not make use of faxing to communicate test results in order to maintain patient confidentiality. This practice is shared by some of the other facilities especially in the case of HIV results. Although faxing is a less time consuming option to communicating test results, the fact that it may jeopardise patient confidentiality may make it a less viable practice in communicating test results that require the utmost confidentiality, such as HIV, syphilis and TB tests. Therefore, communication of test results whereby patient confidentiality should be maintained requires attention. It is recommended that management look into this matter with urgency.

It is of concern that Mitchells Plain CHC and Mitchells Plain Youth Centre do not send blood samples for HIV testing to a laboratory. Both facilities offer rapid HIV testing which require the sending of blood samples for confirmatory tests. If confirmatory tests are not performed, then these two facilities are not adhering to protocols for rapid HIV testing. What is puzzling is that Mitchells Plain MOU is the only facility that offers ANC yet seven other facilities indicated that they offer syphilis testing in pregnancy and four other facilities indicated that they offer Rhesus testing. Why do some facilities, of those facilities that do not offer ANC, offer these two ANC tests and others don't? 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 tests⁸**

Reported test turn-around times differ substantially among the ten facilities. According to the Package (Department of Health 2001a: 25) HIV test turn-around times should be available within a week. Not all the facilities' turn-around times were in line with this standard. Weltevrede Clinic does not communicate HIV test results telephonically or via fax, therefore, it takes two weeks for them to receive written results for HIV tests. It is strange that the turn-around times for written results for Weltevrede, Eastridge and Strandfontein Clinics differ substantially from that of Westridge, Rocklands, Tafelsig and Lentegeur Clinics (a difference of between 7 and 11 days). Although there are no national standards for RPR, Rhesus-tests and Pap smear turn-around times, the difference in turnaround times for especially Pap smears between Mitchells Plain Youth Centre and the other facilities as well as between Eastridge Clinic and the other facilities is alarming. 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 only Weltevrede Clinic did not accomplish.

Gap-attack!

Mitchells Plain CHC and Mitchells Plain Youth Centre do not send samples to the laboratory for HIV testing although they offer rapid HIV testing which requires confirmatory tests. Why do some facilities (e.g. Weltevrede Clinic) have a turn-around time of fourteen days for written HIV results whilst others (e.g. Westridge Clinic) have a turn-around time of one day? Although there are no national standards for turn-around times for Pap smears, the turn-around times for this test at Westridge, Eastridge, Rocklands and Mitchells Plain Youth Centre need to be investigated and reduced so that they are in line with the other PHC facilities that offer this test in Mitchells Plain.

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 Mitchells Plain stand in terms of implementing the Package in respect of the EDL programme?

The pharmacist at Mitchells Plain CHC manages the EDL programme for both the CHC and Mitchells Plain MOU. Therefore, observations for the availability of drugs and stock control for the CHC and the MOU were conducted at the pharmacy that supplies the two facilities.

⁸ As far as could be established national standards for RPR, Rhesus-tests and Pap-smears have not been laid down.

□ **Stock control**

Table 31: Use of stock control cards

Facility	Is stock control card used?	Oral hormonal contraceptives		Measles vaccine		Rifafour		Ciprofloxacin		Rapid HIV test kits	
		Yes/No	Up to date	Yes/No	Up to date	Yes/No	Up to date	Yes/No	Up to date	Yes/No	Up to date
Mitchells Plain CHC	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mitchells Plain MOU	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Westridge Clinic	Yes	Yes	Yes	No	N/A	Yes	Yes	Yes	Yes	Yes	Yes
Eastridge Clinic	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Rocklands Clinic	Yes	Yes	Yes	No	N/A	Yes	Yes	Yes	Yes	Yes	Yes
Tafelsig Clinic	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	N/A	Yes	Yes
Weltevrede Clinic	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No
Strandfontein Clinic	No										
Lentegeur Clinic	Yes	Yes	Yes	No	N/A	Yes	Yes	Yes	Yes	No	N/A
Mitchells Plain Youth Centre	No										

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. Westridge and Rocklands Clinics share stock control cards. It appears that these two clinics are regarded as one facility since they are managed by the same facility manager and run by the same staff members. Strandfontein Clinic has replaced the stock control card system with a new system which requires facility-specific minimum and maximum stock quantities. It has taken them a month to establish minimum and maximum quantities for the facility, therefore, they have not as yet updated the new system. The stock control card system appears not to be functioning as was intended. Stock control cards are only completed once stock is ordered rather than every time stock is removed from the stock room or dispensary. Therefore, the system seems more time consuming rather than as facilitating the control of stock at a facility. It is recommended that a new stock control system be implemented that serves its purpose and that is less time consuming for the EDL programme coordinator.

Gap-attack!

Strandfontein Clinic and Mitchells Plain Youth Centre did not make use of stock control cards. Westridge and Rocklands Clinics had not implemented stock control cards for measles vaccine and Tafelsig Clinic had not implemented stock control cards for Ciprofloxacin. Lentegeur Clinic had not implemented stock control cards for measles vaccine and rapid HIV test kits. Stock control cards for rifafour and rapid HIV test kits were not up to date at Weltevrede Clinic.

□ **Maternal health⁹ programme drugs and supplies**

Table 32: Maternity programme drugs

Facility	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		
	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***
Mitchells Plain CHC	-	-	-	-	-	-	-	-	-	✓	✓	✓	x	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mitchells Plain MOU	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Westridge Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	-	-	✓	✓	✓	✓	✓	✓	x	-	-	x	-	-	x	-	-	x	-	-
Eastridge Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	-	-	x	-	-	x	-	-	x	-	-
Rocklands Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	-	-	✓	✓	✓	✓	✓	✓	x	-	-	x	-	-	x	-	-	✓	✓	✓
Tafelsig Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	-	-	x	-	-	x	-	-	x	-	-
Weltevrede Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	-	-	x	-	-	x	-	-	x	-	-	x	-	-	x	-	-
Strandfontein Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Lenteguur Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	-	-	✓	✓	✓	x	-	-	x	-	-	x	-	-	x	-	-	x	-	-
Mitchells Plain Youth Centre	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	-	-	✓	✓	✓	✓	✓	✓	x	-	-	x	-	-	x	-	-	x	-	-

* ✓ = Stock available.

** ✓ = Stock organised according to the FEFO principle.

*** ✓ = No expired stock observed.

- = No data

⁹ Here defined as ante- and postnatal care and family planning.

In accordance with the Package (Department of Health 2001a: 16), all facilities which offer family planning had a supply of oral, injectable hormonal and emergency contraceptives at the time of field visits and none had expired.

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. Four facilities did not have iron and folic acid combination tablets for pregnant women in stock. The reason thereof could be that these facilities did not offer ANC. However, five of the six facilities that had stock also do not offer ANC. Is the implication that even though some facilities do not offer ANC they still dispense iron and folic acid combination tablets to pregnant women if the need arises? This discrepancy needs to be investigated and standardised. Three of the four facilities that did not stock the iron and folic acid combination tablets did, however, stock the single iron tablet as well as the single folic acid tablet which they reported were not only for pregnant women but for patients in general. The fourth facility (Lentegeur Clinic) only stocked single iron tablets. Mitchells Plain CHC, Mitchells Plain MOU and Weltevrede Clinic did not have single iron tablets in stock (although they had the combination tablets in stock), and Weltevrede and Lentegeur Clinics did not have the single folic acid tablets in stock.

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. Only Mitchells Plain MOU and Strandfontein Clinic had this in stock.

Only three of the facilities stocked nevirapine tablets and syrup. It is difficult to determine whether it is required for clinics to stock this item.

Mysoprostil was available at four facilities, although only one facility provides 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?

TABLE 33: MATERNITY PROGRAMME SUPPLIES

Facility	Pregnancy test kit	Rapid Rhesus tests	Glucostix	Uristix	Intrauterine contraceptive devices (IUCDs)
Mitchells Plain CHC	✓	✓	✓	✓	✗
Mitchells Plain MOU	✓	✓	✓	✓	✗
Westridge Clinic	✓	✗	✓	✓	✓
Eastridge Clinic	✓	✗	✓	✓	✓
Rocklands Clinic	✓	✓	✓	✓	✗
Tafelsig Clinic	✓	✓	✓	✓	✓
Weltevrede Clinic	✓	✗	✓	✓	✗
Strandfontein Clinic	✓	✓	✓	✓	✓
Lentegeur Clinic	✓	-	✓	✓	✓
Mitchells Plain Youth Centre	✓	✗	✗	✓	✗

✓ = Have in stock

✗ = Do not have in stock

According to the Package (Department of Health 2001a: 13 and 2001b: 22), all clinics should be able to screen for pregnancy when necessary and should have pregnancy tests. All facilities had pregnancy test kits at the time of the survey. All the facilities which offer rapid rhesus testing, with the exception of Weltevrede Clinic, had tests in stock. Only Mitchells Plain Youth Centre did not have 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. Only half of the facilities had these devices in stock (Westridge, Eastridge, Tafelsig, Strandfontein and Lentegour Clinics).

□ **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 34: Drugs and supplies used for rehydration

Facility	Salt and sugar			Teaspoons/millimetre measures			Litre measures			Cups			ORS packets		
	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***
Mitchells Plain CHC	✓	-	-	✓	-	-	✓	-	-	✓	-	-	✓	✓	✓
Mitchells Plain MOU	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Westridge Clinic	✓	-	-	✓	-	-	✓	-	-	✓	-	-	✓	✓	✓
Eastridge Clinic	✓	-	-	✓	-	-	✓	-	-	✓	-	-	✓	✓	✓
Rocklands Clinic	x	-	-	✓	-	-	x	-	-	✓	-	-	✓	✓	✓
Tafelsig Clinic	x	-	-	x	-	-	✓	-	-	✓	-	-	✓	✓	✓
Weltevrede Clinic	✓	-	-	✓	-	-	✓	-	-	✓	-	-	✓	✓	✓
Strandfontein Clinic	✓	-	-	✓	-	-	✓	-	-	✓	-	-	✓	✓	✓
Lentegour Clinic	✓	-	-	✓	-	-	✓	-	-	✓	-	-	✓	-	-
Mitchells Plain Youth Centre	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

* ✓ = Stock available.
 ** ✓ = Stock organised according to the FEFO principle.
 *** ✓ = No expired stock observed.
 - = Data not available/Not applicable

The Package (Department of Health 2001a: 20) states that all health clinics should have litre and teaspoon/millimetre measures, cups for feeding, and sugar and salt available for children with diarrhoea who have not yet dehydrated. Rocklands and Tafelsig Clinics did not have salt and sugar for children with diarrhoea. Also, Rocklands Clinic did not have litre measures in stock, whilst Tafelsig Clinic did not have teaspoon or millimetre measures. All the facilities had ORS packets in stock for the rehydration of dehydrated children, as well as cups for feeding.

Table 35: Drugs and supplies used in severely dehydrated children

Facility	Ringer-lactate or Normal Saline (4 sets)			Blankets (for babies in shock)		
	S*	FEFO**	NE***	S*	FEFO**	NE***
Mitchells Plain CHC	✓	✓	✓	x	-	-
Mitchells Plain MOU	-	-	-	-	-	-
Westridge Clinic	✓	✓	✓	✓	-	-
Eastridge Clinic	✓	✓	✓	✓	-	-
Rocklands Clinic	✓	✓	✓	✓	-	-
Tafelsig Clinic	✓	✓	✓	x	-	-
Weltevrede Clinic	✓	✓	✓	✓	-	-
Strandfontein Clinic	✓	✓	✓	✓	-	-
Lentegour Clinic	✓	✓	✓	x	-	-
Mitchells Plain Youth Centre	-	-	-	-	-	-

* ✓ = Stock available
 ** ✓ = Stock organised according to the FEFO principle
 *** ✓ = No expired stock observed
 - = Data not available/not applicable

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, Mitchells Plain CHC, Tafelsig Clinic and Lentegour Clinic did not have blankets with which to keep babies/children in shock warm.

Table 36: Vaccines

Facility	Oral polio vaccine			DPT (or DPT Hib) vaccine			Hepatitis B			Tetanus toxoid vaccine			BCG vaccine			Measles vaccine		
	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***
Mitchells Plain CHC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	-	-	✓	✓	✓
Mitchells Plain MOU	✓	✓	✓	-	-	-	-	-	-	-	-	-	×	-	-	-	-	-
Westridge Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	-	-	✓	✓	✓
Eastridge Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	-	-	✓	✓	✓
Rocklands Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	-	-	✓	✓	✓
Tafelsig Clinic	×	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	-	-	×	-	-
Weltevrede Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	-	-	✓	✓	✓
Strandfontein Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	-	-	✓	✓	✓
Lentegeur Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	-	-	✓	✓	✓
Mitchells Plain Youth Centre	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

*✓ = Stock available
 ***✓ = Stock organised according to the FEFO principle
 ****✓ = No expired stock observed
 ○ = Data not available/not applicable

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 none of the facilities had BCG vaccine in stock and that Tafelsig Clinic did not have oral polio and measles vaccines in stock.

BCG vaccine is administered directly after birth to a baby. It is surprising that Mitchells Plain MOU, which is the only facility that renders a delivery service, did not have this vaccination in stock. Also, 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. It is puzzling that Mitchells Plain CHC had vaccines for the IMCI programme in stock yet they do not offer IMCI.

Table 37: Supplies for vaccination programme

Facility	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		
	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***
Mitchells Plain CHC	-	-	-	-	-	-	-	-	-
Mitchells Plain MOU	✓	-	-	✓	-	-	✓	-	-
Westridge Clinic	✓	-	-	×	-	-	×	-	-
Eastridge Clinic	✓	-	-	✓	-	-	✓	-	-
Rocklands Clinic	✓	✓	✓	✓	-	-	✓	-	-
Tafelsig Clinic	✓	-	-	✓	-	-	✓	-	-
Weltevrede Clinic	✓	-	-	✓	-	-	✓	-	-
Strandfontein Clinic	✓	-	-	✓	-	-	✓	-	-
Lentegeur Clinic	✓	-	-	✓	-	-	✓	-	-
Mitchells Plain Youth Centre	-	-	-	-	-	-	-	-	-

* ✓ = Stock available
 ** ✓ = Stock organised according to the FEFO principle
 *** ✓ = No expired stock observed
 - = Data not available/not applicable

Westridge Clinic did not have any sealed syringes with a minimum length of 25mm nor any sealed syringes with a minimum length of 32mm for intramuscular injections.

Table 38: Nutritional supplements

Facility	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		
	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***
Mitchells Plain CHC	✓	✓	✓	✓	-	-	✓	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mitchells Plain MOU	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Westridge Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	-	-
Eastridge Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	-	-	✓	✓	✓
Rocklands Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tafelsig Clinic	✓	✓	✓	✗	-	-	✗	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓
Weltevrede Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	-	-	✗	-	-
Strandfontein Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	-	-	✗	-	-
Lentegeur Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mitchells Plain Youth Centre	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

* ✓ = Stock available
 ** ✓ = Stock organised according to the FEFO principle
 *** ✓ = No expired stock observed
 - = Data not available/not applicable

All facilities in Mitchells Plain had both milk and porridge products in stock with which to compliment the feeding of malnourished children, with the exception of Tafelsig Clinic which did not have the porridge product in stock. However, not all clinics had all the micronutrients as listed in the EDL guidelines (Department of Health 1998: 112). Westridge Clinic did not have vitamin B complex supplements, Eastridge Clinic did not have vitamin C supplements and Tafelsig Clinic did not have iron supplements. Both Weltevrede and Strandfontein Clinics did not have vitamin C and B complex supplements in stock.

Table 39: Antibiotics, drugs and supplies used in the management of ear, nose, throat, pulmonary and other conditions in children

Facility	Cotrimoxazole syrup (combination of trimethoprim and sulfamethoxazole)			Benzylpenicillin			Prednisolone			Salbutamol inhaler			Nebuliser/tubing masks			Child spacer (for salbutamol inhaler)		
	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***
Mitchells Plain CHC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	-	-	✓	-	-
Mitchells Plain MOU	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Westridge Clinic	✗	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-	✓	-	-
Eastridge Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-	✗	-	-
Rocklands Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-	✓	-	-
Tafelsig Clinic	✓	✓	✓	✓	✓	✓	✗	-	-	✓	✓	✓	✓	-	-	✓	-	-
Weltevrede Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-	✓	-	-
Strandfontein Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-	✓	-	-
Lentegeur clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-	✓	-	-
Mitchells Plain Youth Centre	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

* ✓ = Stock available
 ** ✓ = Stock organised according to the FEFO principle
 *** ✓ = No expired stock observed
 - = Data not available/not applicable

Four of the facilities did not have all of the necessary drugs and supplies listed in table 41. Mitchells Plain CHC did not have a nebuliser or tubing masks, Westridge Clinic did not have cotrimoxazole syrup, Eastridge Clinic did not have child spacers and Tafelsig Clinic did not have prednisolone in stock.

Table 41: Drugs used for pain and fever and worm infestation

Facility	Paracetamol ¹			Mebendazole ²		
	S*	FEFO**	NE***	S*	FEFO**	NE***
Mitchells Plain CHC	✓	✓	✓	✓	✓	✓
Mitchells Plain MOU	-	-	-	-	-	-
Westridge Clinic	✓	-	-	✓	✓	✓
Eastridge Clinic	✓	✓	✓	✓	✓	✓
Rocklands Clinic	✓	✓	✓	✓	✓	✓
Tafelsig Clinic	✓	✓	✓	✓	✓	✓
Weltevrede Clinic	✓	✓	✓	✓	✓	✓
Strandfontein Clinic	✓	✓	✓	✓	✓	✓
Lentegeur Clinic	✓	✓	✓	✓	✓	✓
Mitchells Plain Youth Centre	-	-	-	-	-	-

* ✓ = Stock available

** ✓ = Stock organised according to the FEFO principle

*** ✓ = No expired stock observed

- = Data not available/not applicable

1 Drugs for pain and fever

2 Drugs for worm infestation

All the facilities had a supply of drugs for pain and fever as well as for worm infestation.

- **Antiseptics, oral health drugs and emergency treatment supplies (anaphylactic shock, cardiac arrest and hypoglycaemic).**

Table 42: Antiseptics, oral health drugs and emergency treatment supplies

	Polyvidone iodine/chlorhexine ¹			Gentian violet ¹			Adrenalin ²			10% dextrose ²		
	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***
Mitchells Plain CHC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mitchells Plain MOU	-	-	-	-	-	-	-	-	-	-	-	-
Westridge Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	-	-
Eastridge Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rocklands Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tafelsig Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Weltevrede Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Strandfontein Clinic	✓	-	-	✗	-	-	✓	✓	✓	✓	✓	✓
Lentegeur Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mitchells Plain Youth Centre	-	-	-	-	-	-	-	-	-	-	-	-

* ✓ = Stock available

** ✓ = Stock organised according to the FEFO principle

*** ✓ = No expired stock observed

- = Data not available/not applicable

1 Antiseptics and oral health drugs

2 Emergency treatment supplies

All health clinics should be able to handle emergencies like anaphylactic shock, cardiac arrest, and hypoglycaemic coma, as these conditions are often encountered in PHC facilities. Therefore, life saving emergency drugs like adrenalin and dextrose should always be in stock. Westridge Clinic did not have any dextrose and Strandfontein Clinic did not have any gentian violet.

Gap-attack!

Rocklands and Tafelsig Clinics did not have salt and sugar for children with diarrhoea who have not yet dehydrated. Rocklands Clinic also did not have litre measures and Tafelsig Clinic did not have teaspoon/millimetre measures. Mitchells Plain CHC did not have any blankets for babies in shock, BCG vaccines and a nebuliser or tubing masks. However, Mitchells Plain CHC had other vaccines for the immunisation programme even though the facility does not offer IMCI. Why? Mitchells Plain MOU did not have any BCG vaccines which should be given at birth. Westridge Clinic did not have any BCG vaccines, sealed syringes with a minimum length of 25mm nor sealed syringes with a minimum length of 32mm, vitamin B complex, cotrimoxazole syrup and dextrose. Eastridge Clinic did not have any BCG vaccines, vitamin C and child spacers. Rocklands Clinic did not have any salt and sugar, litre measures and BCG vaccines. Tafelsig Clinic did not have any salt and sugar, teaspoon/millimetre measures, blankets for babies in shock, oral polio vaccines, BCG vaccines, measles vaccines, porridge product for infant nutrition supplementation, iron supplementation and prednisolone. Weltevrede Clinic did not have any BCG vaccines, vitamin C and vitamin B complex. Strandfontein Clinic did not have any BCG vaccines, vitamin C, vitamin B complex and gentian violet. Lentegeur Clinic did not have any blankets for babies in shock and BCG vaccines.

□ TB control programme drugs

Table 43: TB drugs

Facility	RH (refinah) for adults			RH (refinah) for children			RHZE (rifafour)			H (isoniazid)			E (ethambutol)			Streptomycin		
	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***
Mitchells Plain CHC	x	-	-	x	-	-	x	-	-	✓	-	-	✓	-	-	✓	✓	✓
Mitchells Plain MOU	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Westridge Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Eastridge Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rocklands Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tafelsig Clinic	✓	✓	✓	x	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Weltevrede Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Strandfontein Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Lentegeur Clinic	✓	✓	✓	x	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mitchells Plain Youth Centre	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

* ✓ = Stock available
 ** ✓ = Stock organised according to the FEFO principle
 *** ✓ = No expired stock observed
 - = Data not available/not applicable

It is strange that although Mitchells Plain CHC does not offer TB treatment, they had three of the TB programme drugs in stock (isoniazid, ethambutol and streptomycin). Both Tafelsig and Lentegeur Clinics did not have any refinah for children in stock.

□ STI/HIV/AIDS programme drugs and supplies

Table 44: Drugs and supplies required for the STI and HIV/AIDS programme

Facility	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					
	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***	S*	FEFO**	NE***			
Mitchells Plain CHC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Mitchells Plain MOU	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-	-	✓	-	-
Westridge Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-	-	✓	-	-
Eastridge Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-	-	✓	-	-
Rocklands Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-	-	✓	-	-
Tafelsig Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	-	-	✓	✓	✓	✓	✓	✓	-	-	-	✓	-	-
Weltevrede Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-	-	✓	-	-
Strandfontein Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-	-	✓	-	-
Lenteguur Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-	-	✓	-	-
Mitchells Plain Youth Centre	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	-	-	✓	✓	✓	✓	✓	✓	-	-	-	✓	-	-

* ✓ = Stock available
 ** ✓ = Stock organised according to the FEFO principle
 *** ✓ = No expired stock observed
 - = Data not available/not applicable

Some facilities stock ciprofloxacin in 500mg instead of 250mg tablets and flagyl in 400mg instead of 2g tablets. Almost all facilities had all the necessary drugs and supplies for the STI and HIV/AIDS programmes. Both Tafelsig Clinic and Mitchells Plain Youth Centre did not have any benzathine penicillin in stock.

Gap-attack!
 Tafelsig Clinic and Mitchells Plain Youth Centre did not have any benzathine penicillin in stock.

To the credit of the maternal health, IMCI, TB, STI, HIV/AIDS and EDL programmes none of the drugs observed were expired and all drugs were stocked according to the FEFO principle.

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 45: Display of catchment area maps

Facility	Catchment area map displayed on wall
Mitchells Plain CHC	✗
Mitchells Plain MOU	✗
Westridge Clinic	✗
Eastridge Clinic	✓
Rocklands Clinic	✓
Tafelsig Clinic	✓
Weltevrede Clinic	✓
Strandfontein Clinic	✓
Lentegeur Clinic	✗
Mitchells Plain Youth Centre	✗

Gap-attack!

Only half of the PHC facilities in Mitchells Plain had maps indicating their catchment areas displayed.

□ **Graphs**

Table 46: Display of graphs with recent information (past three months)

Facility	Maternal health	IMCI	TB	STIs	HIV/AIDS
Mitchells Plain CHC	✗	N/A	N/A	✓	✓
Mitchells Plain MOU	✗	N/A	N/A	N/A	✗
Westridge Clinic	✗	✗	✓	✗	✗
Eastridge Clinic	✓	✓	✓	✓	✓
Rocklands Clinic	✗	✗	✗	✗	✗
Tafelsig Clinic	✗	✗	✓	✗	✗
Weltevrede Clinic	✗	✗	✗	✗	✗
Strandfontein Clinic	✓	✗	✓	✓	✓
Lentegeur Clinic	✗	✗	✓	✗	✗
Mitchells Plain Youth Centre	✗	N/A	N/A	✗	✗

In some cases, graphs were available, but were not displayed. Display of catchment area maps and PHC graphs relating to all the key PHC programmes is poor in Mitchells Plain.

Gap-attack!

Only Eastridge Clinic had graphs of all the key PHC programmes it offers displayed. Rocklands Clinic, Weltevrede Clinic and Mitchells Plain Youth Centre had no graphs of the key PHC programmes they offer displayed.

□ **Protocols and stationery**

Table 47: Availability of general PHC protocols and stationery

Facility	<i>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)</i>	Death notification forms	Notifiable diseases reporting form	Referral letter
Mitchells Plain CHC	✓	✓	✓	✓
Mitchells Plain MOU	x	✓	x	✓
Westridge Clinic	✓	✓	✓	✓
Eastridge Clinic	✓	✓	✓	✓
Rocklands Clinic	✓	✓	✓	✓
Tafelsig Clinic	✓	✓	✓	✓
Weltevrede Clinic	✓	✓	✓	✓
Strandfontein Clinic	✓	x	✓	✓
Lentegeur Clinic	x	✓	✓	✓
Mitchells Plain Youth Centre	x	x	x	✓

Gap-attack!

It is of concern that three facilities (Mitchells Plain MOU, Lentegeur Clinic and Mitchells Plain Youth Centre) did not have a copy of either of the two Package documents. Strandfontein Clinic and Mitchells Plain Youth Centre did not have any death notification forms and forms for reporting notifiable diseases were not available at Mitchells Plain MOU and Mitchells Plain Youth Centre.

Table 48: Availability of family planning, women's and maternal health protocols and stationery

Facility	Family planning register	National contraception guidelines (2002)	Midwifery protocol	Executive summary of saving mothers report (1998)	Saving babies report (2001)	Maternity register	TOP register	Sterilisation Act: 1998	National guide for cervical cancer screening programme (2001)
Mitchells Plain CHC	x	✓	x	x	x	x	✓	✓	✓
Mitchells Plain MOU	x	x	x	✓	x	✓	x	x	x
Westridge Clinic	x	✓	✓	x	x	x	x	✓	✓
Eastridge Clinic	✓	✓	x	x	x	x	x	✓	✓
Rocklands Clinic	x	✓	x	x	x	x	x	✓	✓
Tafelsig Clinic	x	✓	x	x	x	x	x	✓	✓
Weltevrede Clinic	✓	✓	x	x	x	x	x	✓	✓
Strandfontein Clinic	x	✓	x	x	x	x	x	✓	✓
Lentegeur Clinic	x	✓	x	x	x	x	x	✓	✓
Mitchells Plain Youth Centre	x	✓	x	x	x	x	x	x	x

Only Eastridge Clinic and Weltevrede Clinic had a family planning register. Only Mitchells Plain MOU did not have a copy of the *National contraception guidelines* (2002). Only Westridge Clinic had a copy of the *Midwifery protocol*. Mitchells Plain MOU was the only facility which had a copy of the *Executive summary of saving mothers report* (1998) and no facility had a copy of the *Saving babies report* (2001). Mitchells Plain MOU, which is the only facility that offers uncomplicated deliveries, had a maternity register and Mitchells Plain CHC, which is the only facility that offers TOP, had a TOP register. Both Mitchells

Plain MOU and Mitchells Plain Youth Centre did not have copies of the *Sterilisation Act: 1998* and the *National guide for cervical cancer screening programme* (2001).

Gap-attack!

Mitchells Plain MOU did not have a copy of the *National contraception guidelines* (2002). Only Westridge Clinic had a copy of the *Midwifery protocol*. Mitchells Plain MOU was the only facility which had a copy of the *Executive summary of saving mothers report* (1998) and no facility had a copy of the *Saving babies report* (2001). Both Mitchells Plain MOU and Mitchells Plain Youth Centre did not have copies of the *Sterilisation Act: 1998* and the *National guide for cervical cancer screening programme* (2001).

Table 49: Availability of IMCI protocols, stationery and contact lists

	Mitchells Plain CHC	Mitchells Plain MOU	Westridge Clinic	Eastridge Clinic	Rocklands Clinic	Tafelsig Clinic	Weltevrede Clinic	Strandfontein Clinic	Lentegeur Clinic	Mitchells Plain Youth Centre
Growth monitoring/ <i>Road-to-health</i> charts	✘	✓	✓	✓	✓	✓	✓	✓	✓	N/A
<i>Protocol for managing and referring children with growth faltering and micronutrient deficiency and obesity</i>	✓	✘	✓	✓	✓	✓	✓	✓	✓	N/A
Temperature record cards	✘	✓	✓	✓	✓	✓	✓	✓	✓	N/A
Protein energy malnutrition (PEM) register/book	✓	✘	✓	✓	✓	✓	✓	✓	✓	N/A
<i>Protocol for management of children with HIV/AIDS</i>	✓	✘	✓	✓	✓	✓	✓	✓	✓	N/A
Protocol for emergency referral	✓	✓	✓	✓	✘	✓	✓	✓	✓	N/A
IMCI chart booklet or enlarged wall chart	✘	✘	✘	✓	✘	✓	✓	✘	✓	N/A
Immunisation register/book	✘	✘	✘	✓	✘	✘	✓	✘	✘	N/A
Official national form for adverse effects of immunisation	✘	✘	✓	✓	✓	✓	✓	✓	✓	N/A
EPI disease surveillance manual	✘	✓	✓	✓	✓	✓	✓	✓	✓	N/A
EPI vaccination manual	✘	✓	✓	✓	✓	✓	✓	✓	✓	N/A
EPI cold chain operations manual	✘	✓	✓	✓	✓	✓	✓	✓	✓	N/A
Written cold chain contingency plan for power interruptions/paraffin shortages/gas shortages	✓	✓	✓	✓	✓	✓	✓	✓	✓	N/A
Written cold chain contingency plan while defrosting refrigerator	✓	✘	✓	✓	✘	✓	✓	✓	✓	N/A
List of notifiable diseases	✓	✘	✓	✓	✓	✓	✓	✓	✓	N/A
Contact person/number list for emergencies	✓	✓	✓	✓	✓	✓	✓	✓	✓	N/A
Poison centre contact numbers	✓	✘	✓	✓	✓	✓	✓	✓	✓	N/A
List of names of women in breastfeeding support groups	✓	✘	✘	✘	✘	✘	✘	✓	✘	N/A
Birth notification forms	✘	✓	✘	✓	✘	✓	✓	✓	✘	N/A

Gap-attack!

Mitchells Plain CHC did not have temperature record cards. Mitchells Plain MOU did not have the *Protocol for managing and referring children with growth faltering and micronutrient deficiency and obesity*, a *Protein, energy malnutrition (PEM) register/book* and the *Protocol for management of children with HIV/AIDS*. Rocklands Clinic was the only facility that did not have the *Protocol for emergency referral*. Five facilities (Mitchells Plain CHC, Mitchells Plain MOU, Westridge Clinic, Rocklands Clinic and Strandfontein Clinic) did not have an IMCI booklet or enlarged wall chart. Only two facilities (Eastridge and Weltevrede Clinics) had either an immunisation register or book. Both Mitchells Plain CHC and MOU did not have copies of the *Official national form for adverse effects of immunisation*. Only Mitchells Plain CHC did not have copies of the *EPI disease surveillance manual*, *EPI vaccination manual* and *EPI cold chain operations manual*. Mitchells Plain MOU and Rocklands Clinic did not have a copy of the *Cold chain contingency plan while defrosting* and Mitchells Plain MOU was the only facility that did not have a list of notifiable disease and contact numbers for the Poison Centre. Only Mitchells Plain CHC and Strandfontein Clinic had a list of names of women in breastfeeding support groups. Mitchells Plain CHC, Westridge, Rocklands and Lentegeur Clinics did not have copies of birth notification forms.

Table 50: Availability of TB protocols and stationery

Facility	The training manual for health workers (1998)	The South African TB control programme practical guidelines (2000)	TB register manual	Tracking TB at work – guidelines from South Africa’s national TB control programme	DOTS training manual	Flow charts on TB diagnosis
Mitchells Plain CHC	✘	✘	✘	✘	✘	✘
Mitchells Plain MOU	N/A	N/A	N/A	N/A	N/A	N/A
Westridge Clinic	✓	✓	✓	✓	✓	✓
Eastridge Clinic	✓	✓	✓	✓	✓	✓
Rocklands Clinic	✓	✓	✓	✘	✓	✘
Tafelsig Clinic	✓	✓	✓	✓	✓	✓
Weltevrede Clinic	✓	✓	✓	✓	✓	✓
Strandfontein Clinic	✘	✓	✓	✓	✘	✓
Lentegeur Clinic	✓	✓	✓	✘	✘	✓
Mitchells Plain Youth Centre	N/A	N/A	N/A	N/A	N/A	N/A

Gap-attack!

Mitchells Plain CHC did not have any of the TB protocols and stationery. The lack thereof may be attributed to this facility not offering TB services. However, the Package (Department of Health, 2001a: 25) states that PHC facilities should provide TB treatment according to national protocols and refer to CHCs if there are any problems. Therefore, it is imperative that CHCs should have protocols for the management of TB. Strandfontein Clinic did not have *The training manual for health workers (1998)*. Both Rocklands and Lentegeur Clinics did not have copies of the protocol *Tracking TB at work – guidelines from South Africa’s national TB control programme*. Lentegeur and Strandfontein Clinics did not have a *DOTS training manual* and Rocklands Clinic did not have flow charts used for diagnosing TB.

Table 51: Availability of STI protocols and stationery

Facility	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	Protocol for the Management of a Person with a Sexually Transmitted Disease (1998)	Wall chart of the six protocols for STI management
Mitchells Plain CHC	✓	✓	✓	✓	✓
Mitchells Plain MOU	✓	✗	✗	✓	✗
Westridge Clinic	✓	✓	✓	✓	✓
Eastridge Clinic	✓	✓	✓	✓	✓
Rocklands Clinic	✗	✓	✗	✗	✗
Tafelsig Clinic	✓	✓	✓	✓	✓
Weltevrede Clinic	✓	✓	✓	✗	✓
Strandfontein Clinic	✓	✓	✓	✓	✓
Lentegeur Clinic	✗	✓	✓	✓	✓
Mitchells Plain Youth Centre	✗	✓	✗	✗	✓

Gap-attack!

Only five facilities had all the protocols for the effective management of STIs (Mitchells Plain CHC, Westridge Clinic, Eastridge Clinic, Tafelsig Clinic and Strandfontein Clinic). Rocklands Clinic, Lentegeur Clinic and Mitchells Plain Youth Centre did not have a copy of the *Training manual for the management of a person with a sexually transmitted disease*. Mitchells Plain MOU did not have a copy of either the *Syndromic case management of sexually transmitted diseases* or the *EDL booklet*. Mitchells Plain MOU, Rocklands Clinic and Mitchells Plain Youth Centre did not have the protocol *The diagnosis and management of sexually transmitted diseases in South Africa*. Three facilities, namely Rocklands Clinic, Weltevrede Clinic and Mitchells Plain Youth Centre did not have copies of the *Protocol for the management of a person with a sexually transmitted disease*. Mitchells Plain MOU and Rocklands Clinic did not have wall charts of the six protocols for STI management.

Table 52: Availability of HIV/AIDS protocols and stationery

Facility	Mitchells Plain CHC	Mitchells Plain MOU	Westridge Clinic	Eastridge Clinic	Rocklands Clinic	Tafelsig Clinic	Weltevrede Clinic	Strandfontein Clinic	Lentegeur Clinic	Mitchells Plain Youth Centre
Protocol for managing of opportunistic infections of HIV	✓	✗	✗	✓	✓	✓	✓	✗	✓	✗
Protocol for managing HIV/AIDS in children	✓	✗	✓	✓	✓	✓	✓	✓	✓	✗
Protocol for HIV rapid test quality assurance	✓	✗	✗	✓	✓	✓	✓	✗	✓	✓
Standard treatment guidelines	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓
Informed consent for HIV testing	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓
Resource list of HIV/AIDS services	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓
Protocol on HIV rapid testing	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓
Protocol on voluntary HIV confidential counselling 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	✗	✗	✓	✓	✓	✓	✓	✓	✓	✗

It is of concern that Mitchells Plain MOU only had the protocol, *Policy guidelines and recommendations for feeding infants of HIV positive mothers*, and none of the other protocols and documents on HIV/AIDS. Mitchells Plain MOU, Westridge Clinic, StrandfonteinClinic and Mitchells Plain Youth Centre did not have the *Protocol for managing of oportunistic infections of HIV*. Mitchells Plain MOU, Westridge Clinic and Strandfontein Clinic did not have the *Protocol for HIV rapid test quality assurance*. Mitchells Plain MOU was the only facility that did not have copies of the *Standard treatment guidelines*, informed consent form for HIV testing, a resource list of HIV/AIDS services and the *Protocol on HIV rapid testing*. Both Mitchells Plain MOU and Westridge Clinic did not have the *Protocol on voluntary HIV confidential counselling and testing (VCCT)*. Only four facilities (Westridge, Eastridge, Tafelsig and Weltevrede Clinics) had a copy of the *HIV strategic plan for South Africa 2000-2005*, whilst only three facilities (Westridge, Eastridge and Weltevrede Clinics) had a copy of the *Summary results of the last national HIV serological survey on women attending public health services in South Africa*. Mitchells Plain MOU, Eastridge Clinic, Tafelsig Clinic and Mitchells Plain Youth Centre did not have the protocol *Management of occupational exposure to HIV*. Mitchells Plain CHC, Mitchells Plain MOU, Rocklands Clinic, Strandfontein Clinic and Mitchells Plain Youth Centre did not have a copy of the protocol *Paediatric HIV/AIDS guidelines*. Only Mitchells Plain CHC and Strandfontein Clinic had a copy of the protocol *HIV/AIDS guidelines for home-based care*. Mitchells Plain CHC, Westridge Clinic and Mitchells Plain Youth Centre did not have the protocol *Policy guidelines and recommendations for feeding infants of HIV positive mothers*. A copy of the protocol *PMTCT guidelines* was not available at Mitchells Plain CHC, Mitchells Plain MOU and Mitchells Plain Youth Centre.

Gap-attack!

Mitchells Plain MOU only had the protocol *Policy guidelines and recommendations for feeding infants of HIV positive mothers* and none of the other protocols for HIV/AIDS. How does Mitchells Plain MOU provide an effective VCT and PMTCT service if they do not have copies of neither the *Protocol on HIV rapid testing*, *Protocol on voluntary HIV confidential counselling and testing*, *PMTCT guidelines* and informed consent forms for HIV testing? Also, how do Mitchells Plain MOU, Eastridge Clinic, Tafelsig Clinic and Mitchells Plain Youth Centre know how to deal with occupational exposure of their staff to HIV when they do not have a copy of the *Management of occupational exposure to HIV*?

Table 53: Availability of EDL protocols and stationery

Facility	EDL booklet
Mitchells Plain CHC	✓
Mitchells Plain MOU	✗
Westridge Clinic	✓
Eastridge Clinic	✓
Rocklands Clinic	✓
Tafelsig Clinic	✓
Weltevrede Clinic	✓
Strandfontein Clinic	✓
Lentegeur clinic	✓
Mitchells Plain Youth Centre	✓

Gap-attack!

Mitchells Plain MOU was the only facility that did not have a copy of the EDL booklet.

8. Facility and patient held PHC records

Table 54: 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	<i>Road-to-health</i> card	2001	14, 19
TB	TB register	2001	25
STIs	Patient-held card	2002	24

□ Maternal health records

Only facilities that offer ANC, namely Mitchells Plain MOU, are included in Table 55.

Table 55: Implementation of record system and completeness of information in patient-held ANC cards

Facility	Date of first ANC visit		Outcome of syphilis testing		Outcome of RH testing	
	Imple-mented? ¹	Com-plete ²	Imple-mented? ¹	Com-plete ²	Imple-mented? ¹	Com-plete ²
Mitchells Plain MOU	Yes	100%	Yes	70%	Yes	90%

1 Whether record system had been implemented.

2 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. Only Mitchells Plain MOU provides ANC. Table 55 indicates that the system has been implemented at the MOU. However, the completion of patient-held ANC cards needs to be improved. The outcome of syphilis testing was only indicated in seventy percent of the sampled ANC cards and ten percent of the sampled ANC cards did not have the results of RH testing recorded.

Gap attack!

Only Mitchells Plain MOU has implemented the patient-held ANC card system, although the completion of these cards needs to be improved.

Only facilities that offer ANC, namely Mitchells Plain MOU, are included in Table 56.

Table 56: Implementation of record system and completeness of information in facility-held ANC record

Facility	Date of first ANC visit		Outcome of syphilis testing		Outcome of RH testing	
	Imple-mented? ¹	Complete ²	Imple-mented?	Complete	Imple-mented?	Complete
Mitchells Plain MOU	Yes	100%	Yes	100%	Yes	80%
Westridge Clinic	N/A	N/A	N/A	N/A	N/A	N/A

1 Whether record system had been implemented.

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

Mitchells Plain MOU is the only facility that offers ANC and thus the only facility that has implemented the facility-held ANC record system. As can be deduced from table 56, completion of ANC register is fairly high. However, the outcome of RH testing is not always indicated on these records.

Gap-attack!

The facility-held ANC record has only been implemented at Mitchells Plain MOU, and outcome of RH testing is not always indicated.

□ **IMCI records**

Table 57: Implementation of record system and completeness of information in patient-held *Road-to-health* charts and paediatric register

Facility	Fully immunised by one year	
	Implemented? ¹	Complete ²
Mitchells Plain CHC	N/A	N/A
Mitchells Plain MOU	N/A	N/A
Westridge Clinic	Yes	100%
Eastridge Clinic	Yes	100%
Rocklands Clinic	Yes	100%
Tafelsig Clinic	Yes	100%
Weltevrede Clinic	Yes	100%
Strandfontein Clinic	Yes	90%
Lentegeur Clinic	Yes	100%
Mitchells Plain Youth Centre	N/A	N/A

1 Whether record system had been implemented.

2 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 the facilities Mitchells Plain that offer IMCI or child curative care. The sampled *Road to Health* charts were kept up to date with the exception of one card at Strandfontein Clinic.

Gap-attack!

One sampled patient-held *Road to Health* card at Strandfontein Clinic was not up to date (child not fully immunised by one year).

□ **TB records**

Only facilities that offer TB services are included in Table 58.

Table 58: Implementation of record system and completeness of information in patient-held TB card

Facility	Patient category		International disease code		Basis of decision to treat		Notification information		Regimens and doses		Sputum results	
	Imple-mented? ¹	Com-plete? ²	Imple-mented?	Com-plete?	Imple-mented?	Com-plete?	Imple-mented?	Com-plete?	Imple-mented?	Com-plete?	Imple-mented?	Com-plete?
Westridge Clinic	-	-	-	-	-	-	-	-	-	-	-	-
Eastridge Clinic	Yes	100%	Yes	90%	No	N/A	Yes	100%	Yes	80%	Yes	70%
Rocklands Clinic	Yes	100%	Yes	100%	Yes	50%	Yes	100%	Yes	100%	Yes	50%
Tafelsig Clinic	Yes	100%	Yes	100%	Yes	90%	Yes	100%	Yes	80%	Yes	90%
Weltevrede Clinic	Yes	100%	Yes	90%	Yes	10%	Yes	90%	Yes	90%	Yes	80%
Strandfontein Clinic	Yes	100%	Yes	100%	No	N/A	Yes	100%	Yes	80%	Yes	80%
Lentegeur clinic	Yes	100%	Yes	90%	No	N/A	Yes	80%	Yes	90%	Yes	80%

1 Whether record system had been implemented.

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

- = Data not available

The patient-held TB card system was implemented at all facilities. However, completion of these cards needs to be improved at some facilities.

Gap-attack!

The international disease code was not indicated on some of the sampled cards at Eastridge Clinic, Weltevrede Clinic and Lentegeur Clinic. The category for basis of decision to treat was not completed for some of the sampled cards at Rocklands Clinic, Tafelsig Clinic and Weltevrede Clinic, whilst completion of this category was not implemented at Eastridge Clinic, Strandfontein Clinic and Lentegeur Clinic. Only Rocklands Clinic had the regimens and doses up to date for all the sampled cards. No facility had the sputum results up to date for all the sampled cards. Rocklands Clinic only had sputum results completed for half of the sampled cards.

Only facilities that offer TB services are included in table 59.

Table 59: Implementation of record system and completeness of information in facility-held TB register

Facility	Date of registration		Treatment outcome	
	Implemented? ¹	Complete ²	Implemented?	Complete
Westridge Clinic	-	-	-	-
Eastridge Clinic	Yes	100%	Yes	100%
Rocklands Clinic	Yes	100%	Yes	100%
Tafelsig Clinic	Yes	100%	Yes	100%
Weltevrede Clinic	Yes	100%	Yes	100%
Strandfontein Clinic	No	N/A	No	N/A
Lentegeur Clinic	Yes	100%	Yes	100%

¹ Whether record system had been implemented

² Percentage of ten randomly chosen records indicating all required information

- = Data not available

The Package required implementation of the facility-held TB register by the end of 2001. Strandfontein Clinic is the only facility that still has not implemented the TB register. Strandfontein Clinic receives funds for running the TB programme from Rocklands Clinic. Therefore, they offer all the necessary TB services but their clients are registered at Rocklands Clinic. In other words, after sputum samples have been collected and sent to the laboratory, the results are sent to Rocklands Clinic where the client will be registered. Thereafter, the client's folder number will be sent to Strandfontein Clinic where the client will be managed. Rocklands Clinic provides Strandfontein Clinic with TB drugs. Although the arrangement between these two facilities appears functional, surely it is time consuming for sputum results to be sent via Rocklands Clinic each time. Also, Strandfontein Clinic, according to PHC standards, should have a TB register if it provides TB services.

Gap-attack!

Strandfontein Clinic does not have a TB register, although it offers a comprehensive TB programme.

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.

□ 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 60: Referral for complications during pregnancy

Facility	Referral system in writing	Comments on the functionality of the referral system
Mitchells Plain CHC	N/A	N/A
Mitchells Plain MOU	Yes	Working well
Westridge Clinic	N/A	N/A
Eastridge Clinic	N/A	N/A
Rocklands Clinic	N/A	N/A
Tafelsig Clinic	N/A	N/A
Weltevrede Clinic	N/A	N/A
Strandfontein Clinic	N/A	N/A
Lentegeur Clinic	N/A	N/A
Mitchells Plain Youth Centre	N/A	N/A

Table 61: Referral after Pap smear, if required

Facility	Referral system in writing	Comments on the functionality of the referral system
Mitchells Plain CHC	Yes	<i>Working well</i>
Mitchells Plain MOU	Yes	<i>Working well</i>
Westridge Clinic	Yes	<i>Working well</i>
Eastridge Clinic	No	<i>N/A</i>
Rocklands Clinic	Yes	<i>Working well</i>
Tafelsig Clinic	Yes	<ul style="list-style-type: none"> ▪ Long waiting period for an appointment at the referral centre – referral procedure needs to be reviewed ▪ Have to call the ambulance three to four times before they come
Weltevrede Clinic	Yes	<i>Working well</i>
Strandfontein Clinic	Yes	<ul style="list-style-type: none"> ▪ Some clinics don't want referral letters from professional nurses, only referral letters from doctors ▪ The ambulance takes very long to come
Lentegeur clinic	Yes	<i>Working well</i>
Mitchells Plain Youth Centre	Yes	<i>Working well</i>

Table 62: Referral if no medical TOP one week after administration of medication

Facility	Referral system in writing	Comments on the functionality of the referral system
Mitchells Plain CHC	Yes	Working well
Mitchells Plain MOU	N/A	N/A
Westridge Clinic	N/A	N/A
Eastridge Clinic	N/A	N/A
Rocklands Clinic	N/A	N/A
Tafelsig Clinic	N/A	N/A
Weltevrede Clinic	N/A	N/A
Strandfontein Clinic	N/A	N/A
Lentegeur Clinic	N/A	N/A
Mitchells Plain Youth Centre	N/A	N/A

□ 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 63 : Referral for IMCI (very ill patients)

Facility	Referral system in writing	Comments on the functionality of the referral system
Mitchells Plain CHC	N/A	N/A
Mitchells Plain MOU	N/A	N/A
Westridge Clinic	Yes	N/A
Eastridge Clinic	No	N/A
Rocklands Clinic	Yes	Working well
Tafelsig Clinic	Yes	<ul style="list-style-type: none"> ▪ Long waiting period for an appointment at the referral centre – referral procedure needs to be reviewed ▪ Have to call the ambulance three to four times before they come
Weltevrede Clinic	Yes	Working well
Strandfontein Clinic	Yes	<ul style="list-style-type: none"> ▪ Some clinics don't want referral letters from professional nurses, only referral letters from doctors ▪ The ambulance takes very long to come
Lentegeur Clinic	Yes	Working well
Mitchells Plain Youth Centre	N/A	N/A

□ 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, 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 64: Referral of very ill TB patients

Facility	Referral system in writing	Comments on the functionality of the referral system
Mitchells Plain CHC	Yes	Working well
Mitchells Plain MOU	N/A	N/A
Westridge Clinic	Yes	Working well
Eastridge Clinic	No	N/A
Rocklands Clinic	Yes	Working well
Tafelsig Clinic	Yes	<ul style="list-style-type: none"> ▪ Long waiting period for an appointment at the referral centre – referral procedure needs to be reviewed ▪ Have to call ambulance three to four times before they come
Weltevrede Clinic	Yes	Working well
Strandfontein Clinic	Yes	<ul style="list-style-type: none"> ▪ Some clinics don't want referral letters from professional nurses, only referral letters from doctors ▪ The ambulance takes very long to come
Lentegeur Clinic	Yes	Working well
Mitchells Plain Youth Centre	N/A	N/A

□ **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 65: Referral of STI patients not responding to treatment after two weeks

Facility	Referral system in writing	Comments on the functionality of the referral system
Mitchells Plain CHC	Yes	Working well
Mitchells Plain MOU	N/A	N/A
Westridge Clinic	Yes	Working well
Eastridge Clinic	Yes	Working well
Rocklands Clinic	Yes	Working well
Tafelsig Clinic	Yes	<ul style="list-style-type: none"> ▪ Long waiting period for an appointment at the referral centre – referral procedure needs to be reviewed ▪ Have to call the ambulance three to four times before they come
Weltevrede Clinic	Yes	Working well
Strandfontein Clinic	Yes	<ul style="list-style-type: none"> ▪ Some clinics don't want referral letters from professional nurses, only referral letters from doctors ▪ The ambulance takes very long to come
Lenteguur Clinic	Yes	Working well
Mitchells Plain Youth Centre	Yes	Working well

□ **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-counselling; 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 66: Referral of very ill HIV/AIDS patients

Facility	Referral system in writing	Comments on the functionality of the referral system
Mitchells Plain CHC	Yes	<i>Working well</i>
Mitchells Plain MOU	No	N/A
Westridge Clinic	Yes	Working well
Eastridge Clinic	No	N/A
Rocklands Clinic	No	▪ Doctor does referrals
Tafelsig Clinic	Yes	▪ Long waiting period for an appointment at the referral centre – referral procedure needs to be reviewed ▪ Have to call the ambulance three to four times before they come
Weltevrede Clinic	Yes	Working well
Strandfontein Clinic	Yes	▪ Some clinics don't want referral letters from professional nurses, only referral letters from doctors ▪ The ambulance takes very long to come
Lentegeur Clinic	Yes	Working well
Mitchells Plain Youth Centre	Yes	Working well

Table 67: Referral of patients with herpes zoster

Facility	Referral system in writing	Comments on the functionality of the referral system
Mitchells Plain CHC	No	▪ They treat it, do not refer
Mitchells Plain MOU	No	N/A
Westridge Clinic	Yes	Working well
Eastridge Clinic	No	
Rocklands Clinic	Yes	Working well
Tafelsig Clinic	Yes	▪ Long waiting period for an appointment at the referral centre at – referral procedure needs to be reviewed ▪ Have to call the ambulance three to four times before they come
Weltevrede Clinic	Yes	Working well
Strandfontein Clinic	Yes	▪ Some clinics don't want referral letters from professional nurses, only referral letters from doctors ▪ The ambulance takes very long to come
Lentegeur Clinic	Yes	Working well
Mitchells Plain Youth Centre	Yes	Working well

Table 68: Referral of patients with oesophageal candidiasis

Facility	Referral system in writing	Comments on the functionality of the referral system
Mitchells Plain CHC	Yes	▪ Refer to a secondary hospital
Mitchells Plain MOU	No	N/A
Westridge Clinic	Yes	Working well
Eastridge Clinic		
Rocklands Clinic	Yes	Working well
Tafelsig Clinic	Yes	▪ Long waiting period for an appointment at the referral centre at – referral procedure needs to be reviewed ▪ Have to call the ambulance three to four times before they come
Weltevrede Clinic	Yes	Working well
Strandfontein Clinic	Yes	▪ Some clinics don't want referral letters from professional nurses, only referral letters from doctors ▪ The ambulance takes very long to come
Lentegeur Clinic	Yes	Working well
Mitchells Plain Youth Centre	Yes	Working well

Table 69: Referral of patients with severe continued diarrhoea

Facility	Referral system in writing	Comments on the functionality of the referral system
Mitchells Plain CHC	Yes	Working well
Mitchells Plain MOU	No	N/A
Westridge Clinic	Yes	Working well
Eastridge Clinic	No	N/A
Rocklands Clinic	Yes	Working well
Tafelsig Clinic	Yes	<ul style="list-style-type: none"> ▪ Long waiting period for an appointment at the referral centre – referral procedure needs to be reviewed ▪ Have to call the ambulance three to four times before they come
Weltevrede Clinic	Yes	Working well
Strandfontein Clinic	Yes	<ul style="list-style-type: none"> ▪ Some clinics don't want referral letters from professional nurses, only referral letters from doctors ▪ The ambulance takes very long to come
Lentegeur Clinic	Yes	Working well
Mitchells Plain Youth Centre	Yes	Working well

Table 70: Referral of suspected TB cases with negative sputum for further examination

Facility	Referral system in writing	Comments on the functionality of the referral system
Mitchells Plain CHC	N/A	N/A
Mitchells Plain MOU	N/A	N/A
Westridge Clinic	Yes	Working well
Eastridge Clinic	No	N/A
Rocklands Clinic	Yes	Working well
Tafelsig Clinic	Yes	<ul style="list-style-type: none"> ▪ Long waiting period for an appointment at the referral centre – referral procedure needs to be reviewed ▪ Have to call the ambulance three to four times before they come
Weltevrede Clinic	Yes	Working well
Strandfontein Clinic	Yes	<ul style="list-style-type: none"> ▪ Some clinics don't want referral letters from professional nurses, only referral letters from doctors ▪ The ambulance takes very long to come
Lentegeur Clinic	Yes	Working well
Mitchells Plain Youth Centre	N/A	N/A

In most instances, facilities did not have referral policy documents specifically for each PHC programme nor for each complication for each of the priority programmes. Instead, referral procedures are within the treatment protocols for the various PHC programmes. Only Tafelsig Clinic and Strandfontein Clinic experience problems with the referral system. The other facilities in Mitchells Plain appear to be satisfied with the referral system in place at the respective facilities.

Gap-attack!

Tafelsig Clinic finds the long waiting period to get an appointment for all patients referred to the next level of care (hospital) problematic. Strandfontein Clinic experiences problems with some clinics that do not accept referral letters from nurses, only from doctors. Both clinics perceive the time it takes an ambulance to arrive at the respective facilities, for transporting patients to the next level of care, as too long.

10. Information, education and communication (IEC) material

Information, education and communication (IEC) is an integral part 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: 14-30) all of the pamphlets and posters listed in Tables 71 and 72 should have been availed in PHC facilities by the end of 2001.

Table 71: Availability of IEC pamphlets

Facility	Emergency contraception		Diarrhoea/ORS solution		Breastfeeding/ Nutrition		Family planning		Malnutrition		VCCT		PMTCT		TB		STIs		Condom use		Vitamin A supplementation		Percentage of all sampled pamphlets available	
	A ¹	L ²	A	L	A	L	A	L	A	L	A	L	A	L	A	L	A	L	A	L	A	L	A	L ³
Mitchells Plain CHC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	100	100
Mitchells Plain MOU	✗	-	✗	-	✗	-	✗	-	✗	-	✗	-	✗	-	✗	-	✗	-	✗	-	✗	-	0	0
Westridge Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	100	100
Eastridge Clinic	✗	-	✗	-	✗	-	✓	✓	✗	-	✓	✓	✗	-	✓	✓	✗	-	✓	✓	✗	-	33	33
Rocklands Clinic	✗	-	✗	-	✗	-	✗	-	✗	-	✓	✓	✗	-	✓	✓	✓	✓	✓	✓	✗	-	33	33
Tafelsig Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	100	100
Weltevrede Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	-	✓	✓	✓	✓	✓	✓	✗	-	83	83
Strandfontein Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	100	100
Lentegeur Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✗	-	✗	-	✗	-	✓	✓	✗	-	✓	✓	✗	-	50	50
Mitchells Plain Youth Centre	✓	✓	✓	✓	✓	✓	✓	✓	✗	-	✓	✓	✓	✓	✓	✓	✗	-	✓	✓	✓	✓	83	83

1 Available

2 Local language (Afrikaans/English)

3 Percentage of available in local language

✗ = Data not available/not applicable

Table 72: Display of posters in facilities

Facility	Patient's rights charter		Emergency contraception		Diarrhoea/ORS solution		Breast-feeding/ Nutrition		Vitamin A supplementation		Family planning		Women's health charter		Malnutrition		VCCT		PMTCT		TB		STIs		Condom use		Percentage of all sampled posters available		
	A ¹	L ²	A	L	A	L	A	L	A	L	A	L	A	L	A	L	A	L	A	L	A	L	A	L	A	L	A	L ³	
Mitchells Plain CHC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	100	100
Mitchells Plain MOU	✓	✓	✗	-	✗	-	✓	✓	✗	-	✓	✓	✗	-	✗	-	✓	✓	✓	✓	✓	✓	✗	-	✗	-	43	43	
Westridge Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	100	100
Eastridge Clinic	✓	✓	✗	-	✗	-	✗	-	✗	-	✓	✓	✗	-	✓	✓	✓	✓	✗	-	✓	✓	✗	-	✓	✓	43	43	
Rocklands Clinic	✓	✓	✗	-	✗	-	✓	✓	✗	-	✓	✓	✗	-	✗	-	✓	✓	✗	-	✓	✓	✓	✓	✗	-	43	43	
Tafelsig Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	100	100
Weltevrede Clinic	✗	-	✓	✓	✗	-	✓	✓	✗	-	✓	✓	✓	✓	✗	-	✓	✓	✗	-	✓	✓	✗	-	✓	✓	50	50	
Strandfontein Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	100	100
Lentegeur Clinic	✓	✗	✓	✓	✗	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	-	✓	✗	79	64	
Mitchells Plain Youth Centre	✓	✓	✗	-	✗	-	✓	✓	✓	✓	✓	✓	✓	✓	✗	-	✓	✓	✓	✓	✓	✓	✗	-	✓	✓	71	71	

1 Available

2 Local language

3 Percentage of available in local language

- = Data not available/not applicable

Display of posters and availability of pamphlets appears to be high on the list of priorities for some facilities in Mitchells Plain whilst not for others. Only four facilities (Mitchells Plain CHC, Westridge Clinic, Tafelsig Clinic and Strandfontein Clinic) had all the necessary posters and pamphlets in table 71 and 72 displayed, and in the local languages of Mitchells Plain (English and Afrikaans). Contrary to the above four facilities, Mitchells Plain MOU had none of the pamphlets in table 71 available and only 43% of the posters in table 72 were displayed. Eastridge Clinic and Rocklands clinic only had 33% of pamphlets available and 43% of posters displayed. Although most pamphlets and posters that were available and displayed at the facilities were in the local languages, Eastridge Clinic, Rocklands Clinic, Lenteguur Clinic, Weltevrede Clinic, Mitchells Plain Youth Centre and especially Mitchells Plain MOU need to place more effort into availing all the necessary pamphlets and posters for patient information, education and communication as stipulated by the Department of Health (2001b: 14-30).

Gap-attack!

Mitchells Plain MOU had no pamphlets listed in table 71 available and only had 43% of the posters in table 72 displayed. All PHC facilities in Mitchells Plain with the exception of Mitchells Plain CHC, Westridge Clinic, Tafelsig Clinic and Strandfontein Clinic need to place more effort into availing and displaying national pamphlet and poster material for patient information and education.

II. 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

The Mitchells Plain Health Committee was an initiative of the University of the Western Cape: Faculty of Medicine. It was initiated near the end of 1993 as an attempt to form a partnership between the University of the Western Cape, Peninsula Technicon and the community of Mitchells Plain. In 1994, the Mitchells Plain Health Committee Forum was established to regulate the functioning of all the health committees in Mitchells Plain. Each health committee constitutes a chairperson, vice-chairperson, secretary, vice-secretary, treasurer and eight to twelve additional members. The Mitchells Plain Health forum consists of a chief executive officer, vice chairperson, secretary, treasurer, trustee and two members from each health committee (Appie, 2003).

The main functions of the health committees are (Appie 2003):

- To work in partnership with the clinics
- To report to the Health Forum, once a month, on activities in their areas
- To work in partnership with the service providers and academic institutions
- To be part of the Urban Renewal Strategy

- To represent the committee in all organisations in Mitchells Plain
- To make recommendations to the Department of Health on matters affecting the community of Mitchells Plain
- To be the eyes and ears of the community
- To be the watchdog of the community
- To continue with the process of community empowerment

At present the health committees, as well as the health forum, are not being paid for their services rendered nor do they have any funds available to execute their functions. In 2002 the Mitchells Plain Health Committee Forum was registered in terms of the Non Profit Organisation Act No 71 of 1997 (Appie 2003).

All but two facilities in Mitchells Plain (Mitchells Plain CHC and Eastridge Clinic) had an active community health committee attached to each facility at the time of the survey. Minutes for the last community health committee meeting were available only for Tafelsig Clinic, Weltevrede Clinic, Strandfontein Clinic and Lentegeur Clinic.

Table 73: Community health committees

Facility	Community health committee in existence	Whether minutes of community health committees were available
Mitchells Plain CHC	X	N/A
Mitchells Plain MOU	✓	X
Westridge Clinic	✓	X
Eastridge Clinic	X	N/A
Rocklands Clinic	✓	X
Tafelsig Clinic	✓	✓
Weltevrede Clinic	✓	✓
Strandfontein Clinic	✓	✓
Lentegeur Clinic	✓	✓
Mitchells Plain Youth Centre	✓	X

Gap-attack!

Mitchells Plain CHC and Eastridge Clinic were the only two facilities in Mitchells Plain without an active community health committee.

□ Patient complaint procedure

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

Table 74: Patient complaint procedures

Facility	Patient complaint procedure in place	Suggestion box (seen)	Scheduled meetings with community health committee (minutes seen)
Mitchells Plain CHC	✓	✓	N/A
Mitchells Plain MOU	✓	✓	N/A
Westridge Clinic	✓	✓	N/A
Eastridge Clinic	✓	✓	N/A
Rocklands Clinic	✓	X	N/A
Tafelsig Clinic	✓	✓	N/A
Weltevrede Clinic	✓	✓	N/A
Strandfontein Clinic	✓	✓	N/A
Lentegeur Clinic	✓	✓	N/A
Mitchells Plain Youth Centre	✓	✓	N/A

Almost all facilities in Mitchells Plain had a patient complaint procedure in place which was in the form of a suggestion box. It was reported that Rocklands Clinic had a suggestion box but it was not seen.

□ **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 instrument¹⁰. This included clinic staff involvement at the clinic and in the community in providing health education; the involvement of volunteers in activities both inside and outside of the clinic; and the involvement of community members in health related activities.

¹⁰ Future studies should aim to improve the instrument in this respect.

Table 75: Broad description of community involvement by PHC programme

Facility	Maternal Health	IMCI	TB	STIs	HIV/AIDS
Mitchells Plain CHC	None reported	None reported	None reported	None reported	<ul style="list-style-type: none"> ▪ Support group meets every second Wednesday ▪ Workshops at churches
Mitchells Plain MOU	None reported (“no time for that”)	None reported	None reported	None reported	*
Westridge Clinic	None reported	<ul style="list-style-type: none"> ▪ Polio campaign in June 2002 ▪ Measles campaign in 2001 	None reported	None reported	<ul style="list-style-type: none"> ▪ AIDS Day – December 2002 ▪ Condom week – 14 February 2003
Eastridge Clinic	None reported	<ul style="list-style-type: none"> ▪ Measles Campaign in May 2002 ▪ Polio Campaign in June 2002 	<ul style="list-style-type: none"> ▪ Support groups ▪ TB Sports Day – December 2002 	None reported	<ul style="list-style-type: none"> ▪ Living with HIV/AIDS Campaign conducted at the Mitchells Plain Sports Ground in December 2002
Rocklands Clinic	None reported	<ul style="list-style-type: none"> ▪ Immunisation outreach programme – visited two primary schools for health talks ▪ Health workers went to educare and crèches to demonstrate the use of SOROL to parents 	<ul style="list-style-type: none"> ▪ On World TB Day the facility participated in campaigns conducted in different schools by presenting information on how to prevent the spread of TB 	None reported	<ul style="list-style-type: none"> ▪ HIV/AIDS sessions at a primary and secondary school ▪ Distribution of condoms at various points such as shopping malls, community centres, beaches and bottle stores.
Tafelsig Clinic	<ul style="list-style-type: none"> ▪ Health talks, videos about family planning, etc during sterilisation week (annually) ▪ Health talks about family planning during contraception week (3-7 March 2002) ▪ Supply condoms to the community during condom week (10-14 February) 	<ul style="list-style-type: none"> ▪ Measles and Polio Campaign in 2002 	<ul style="list-style-type: none"> ▪ TB Day on 24 March – health talks, poems, pamphlets, support groups, discuss issues, invite person from laboratory to explain about sputum testing. 	<ul style="list-style-type: none"> ▪ Supply condoms to the community during condom week (10-14 February) 	None reported
Weltevrede Clinic	None reported	<ul style="list-style-type: none"> ▪ Measles Campaign (once) at all the crèches in Samora Machell ▪ Polio Drops Campaign (twice) at squatter camps in Kosovo and Samora Machell 	<ul style="list-style-type: none"> ▪ Health talks at schools about TB, STI, HIV/AIDS – living with HIV/AIDS – during October, November and December 2002 	None reported	<ul style="list-style-type: none"> ▪ Weekly HIV/AIDS Campaign at schools
Strandfontein Clinic	None reported	None reported	None reported	None reported	<ul style="list-style-type: none"> ▪ Two awareness campaigns – visited informal settlements to do house to house distribution of pamphlets ▪ Church campaign – got a slot to talk specifically about HIV/AIDS and the relationship between HIV/AIDS and STIs

Lentegeur Clinic	None reported	None reported	None reported	<ul style="list-style-type: none"> ▪ Distribute condoms in the community such as at shebeens – 10 to 15 thousand condoms distributed monthly 	<ul style="list-style-type: none"> ▪ Lay counsellor does HIV/AIDS education programmes with school children – 5 schools visited
Mitchells Plain Youth Centre	<ul style="list-style-type: none"> ▪ Open Day-distributed pamphlets to people in all shops at Plaza (shopping complex) ▪ Information desk at entrance of Plaza for a week in October 2002. 	None reported	None reported	<ul style="list-style-type: none"> ▪ Distributing pamphlets about STIs at the Plaza (shopping complex) for a week in October 2002. 	<ul style="list-style-type: none"> ▪ Distributed pamphlets in and around Plaza for a week in October 2002. ▪ Information desk at the entrance of the Plaza to answer people's questions individually. ▪ In the process of implementing a programme whereby ten groundbreakers trained by Lovelife are utilised to do outreach activities at schools in Mitchells Plain.

* Facility manager has only been in post for three months; therefore, she is not aware of any community involvement in the HIV/AIDS programme

Community involvement activities for the PHC programmes under study were lacking for especially Mitchells Plain CHC, Mitchells Plain MOU, Strandfontein Clinic and Lentegeur Clinic. The facilities in Mitchells Plain showed the least community involvement for the maternal health programme. Only two facilities (Tafelsig Clinic and Mitchells Plain Youth Centre) initiated activities to involve communities in the maternal health programme. Mitchells Plain CHC, Mitchells Plain MOU, Westridge Clinic, Eastridge Clinic, Rocklands Clinic, Weltevrede Clinic, Strandfontein Clinic and Lentegeur Clinic had no out-reach or community projects for this PHC programme. Mitchells Plain CHC, Mitchells Plain MOU, Strandfontein Clinic, Lentegeur Clinic and Mitchells Plain Youth Centre did not have any recent community projects or initiatives for the IMCI programme. Community involvement projects and initiatives for the TB programme were lacking at Mitchells Plain CHC, Mitchells Plain MOU, Westridge Clinic, Weltevrede Clinic and Strandfontein Clinic. No community project and initiatives were for the STI programme was reported for Mitchells Plain CHC, Mitchells Plain MOU, Westridge Clinic, Eastridge Clinic, Rocklands Clinic, Weltevrede Clinic and Strandfontein Clinic. Tafelsig Clinic was the only facility that did not report any community involvement projects and initiatives for the HIV/AIDS programme.

Gap-attack!

Outreach projects and initiatives to encourage community involvement in the five PHC priority programmes is lacking in Mitchells Plain. More so for some programmes, such as the maternal health, IMCI, TB and STI programmes, and to a lesser extent for the HIV/AIDS programme.

12. Main gaps in key PHC programmes in Mitchells Plain

□ 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). Looking at family planning, the Department of Health's *National guideline on cervical cancer screening programme* (Department of Health 2000: 5-6) envisions a goal within ten 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 76: Gaps in the maternal health programme in Mitchells Plain

Issue	Gap
Scope and accessibility of maternal health services	The total number of women in Mitchells Plain of child bearing age is 66 079, constituting 30% of the total catchment population of Mitchells Plain. The projected number of deliveries per month for the entire Mitchells Plain is 204. Mitchells Plain MOU is the only facility which provides a maternity service in Mitchells Plain. In addition, Mitchells Plain MOU is also the only facility which offers ANC in Mitchells Plain. None of the facilities in Mitchells Plain indicated that they provide a complete maternal health service. Only four facilities provide post natal care, namely, Mitchells Plain MOU, Eastridge Clinic, Tafelsig Clinic and Strandfontein Clinic. Mitchells Plain CHC is the only facility which does not provide family planning. Mitchells Plain CHC is the only facility that offers both medical and surgical TOP. Pap smears are only offered once a week at Tafelsig, Weltevrede and Strandfontein Clinics, only three days a week at Lentegeur Clinic, and only four days a week at Mitchells Plain CHC. All maternal health services at Westridge and Rocklands Clinics are only offered three days a week – when the facilities are opened for PHC services.
Programme management	Specific responsibility for programme coordination is lacking at Mitchells Plain CHC for the maternal health programme. All the nurses at the facility are responsible for providing maternal health services. Regular supervisory visits from the District maternal health supervisor is lacking for all facilities. Mitchells Plain Youth Centre is the only facility that had received a supervisory visit from the District maternal health supervisor in the last three years. Also lacking is written feedback on monthly reports submitted for the maternal health programme. Only Eastridge Clinic has received written feedback on at least one of the last three reports submitted to management.
Programme-specific equipment	Mitchells Plain MOU is the only facility that is equipped to deliver uncomplicated deliveries. They need a sex monitor to detect the sex of the foetus as well as a TSM machine for detecting jaundice, though. All facilities should be fully equipped to handle uncomplicated deliveries.
Diagnostic tests	Although there are no national standards for Syphilis and Rhesus test turn around times, turn around times for these tests differ between facilities. There is a difference of up to six weeks in the turn-around times for Syphilis tests between Mitchells Plain Youth Centre and the other facilities. Similarly, there is a difference of up to twelve days in turn-around times for Rhesus tests between Mitchells Plain MOU and other facilities that offer this test.
Drugs and supplies	Injectable contraceptives, which are the most widely used by South African women (Adar & Stevens 2000: 414), as well as oral hormonal and emergency contraceptives, were available at all facilities that offer family planning. Four facilities did not have iron and folic acid combination tablets for pregnant women in stock. However, three of these facilities had them as separately tablets. Only two facilities (Mitchells Plain MOU and Strandfontein Clinic) stocked vitamin K injectables, and only three facilities (Mitchells Plain CHC, Mitchells Plain MOU and Strandfontein Clinic) stocked both nevirapine tablets and syrup. Of the facilities that offer Rhesus testing, Weltevrede Clinic was the only one that did not have this test in stock. Mitchells Plain Youth Centre did not have glucostix in stock and only half of the facilities (Westridge, Eastridge, Tafelsig, Strandfontein and Lentegeur Clinics) had intrauterine contraceptive devices in stock.
Graphs, protocols, registers and forms	Graphs with recent information on maternal health services offered were only displayed at Eastridge and Strandfontein Clinics. Only Eastridge Clinic and Weltevrede Clinic had a family planning register and only Mitchells Plain MOU did not have a copy of the <i>National contraception guidelines (2002)</i> . Only Westridge Clinic had a copy of the <i>Midwifery protocol</i> . Mitchells Plain MOU was the only facility that had a copy of the <i>Executive summary of saving mothers report (1998)</i> and no facility had a copy of the <i>Saving babies report (2001)</i> . Both Mitchells Plain MOU and Mitchells Plain Youth Centre did not have copies of the <i>Sterilisation Act: 1998</i> and the <i>National guide for cervical cancer screening programme (2001)</i> .
Facility- and patient-held records	Outcome of both Syphilis and Rhesus tests were not always indicated in patient-held ANC cards, nor was the outcome of Rhesus test always indicated in the facility-held ANC record at Mitchells Plain MOU.
Referral practice	Tafelsig Clinic views the long waiting period to secure an appointment for a patient at the next level of care as well as the long wait for an ambulance to collect the referred patient, as posing problems in the referral of patients in general. Strandfontein Clinic also views the long waiting period for an ambulance to collect referred patients, as well as nurses at the referral point rejecting referral letters from professional nurses, as problematic.
Information, education and communication (IEC) material	Mitchells Plain MOU, Eastridge Clinic and Rocklands Clinic had no pamphlets on emergency contraception and breastfeeding available. Mitchells Plain MOU and Rocklands Clinic had no pamphlets on family planning available. Mitchells Plain MOU, Eastridge Clinic and Rocklands Clinic had no posters on emergency contraception nor the women's health charter displayed on the walls, whilst Eastridge Clinic also did not have posters on breastfeeding displayed.
Community involvement and patient rights	Only Tafelsig Clinic and Mitchells Plain Youth Centre reported community involvement initiatives and projects such as health talks, distributing condoms and disseminating information about family planning at prominent venues in the community.

□ 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, 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, 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 counselling of the mother or caregiver gives her the skills and knowledge to care for the ill child at home – often with no or minimal 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 at the seven facilities in Mitchells Plain that offer IMCI or child care:

Table 72 depicts gaps in the health systems component as found in the different facilities.

Table 77: Gaps in the IMCI programme in Mitchells Plain

Issue	Gap
Scope and accessibility of IMCI services	No nurses at Westridge and Rocklands Clinics have undergone IMCI training. Therefore, these two facilities offer child health/curative care. IMCI is also not offered at Mitchells Plain CHC. Lentegeur Clinic only provides immunisations four half days a week. Westridge and Rocklands Clinic offer child health/curative care three days a week – when the facilities are opened for PHC services.
Programme management	More than half (4) of the seven PHC facilities that offer IMCI or child health/curative care have not been visited by the District IMCI supervisor in the last three years. Eastridge, Weltevrede and Strandfontein Clinics have not received supervisory visits from the IMCI trainer, who trained staff at these facilities, in the last three years. Only Westridge and Lentegeur Clinics have received written feedback on at least one of the last three monthly IMCI reports submitted to management. Eastridge, Weltevrede, Strandfontein and Lentegeur Clinics do not conduct annual assessments of IMCI services as stipulated by the Package (Department of Health, 2000a: 19).
Programme-specific equipment	Rocklands and Lentegeur Clinics did not have an oral rehydration corner. In addition, Lentegeur Clinic did not have emergency equipment for intravenous resuscitation of severely dehydrated children. Rocklands Clinic was the only facility that had IMCI education videos.
Cold chain maintenance	The vaccine refrigerator temperature at Mitchells Plain CHC and Mitchells Plain MOU was higher than the stipulated temperature of between zero and eight degrees (Department of Health, 1998: 87).
Drugs and supplies	Mitchells Plain CHC did not have any blankets for babies in shock, BCG vaccine and a nebuliser or tubing masks. Mitchells Plain MOU did not have any BCG vaccine which should be given at birth. Westridge Clinic did not have any BCG vaccine, sealed syringes/needles with a minimum length of 25mm nor sealed syringes with a minimum length of 32mm, vitamin B complex, cotrimoxazole syrup and dextrose. Eastridge Clinic did not have any BCG or measles vaccine, porridge product for infant nutrition supplementation, iron supplementation and prednisolone. Weltevrede Clinic did not have any BCG vaccine, vitamin C, vitamin B complex and gentian violet. Lentegeur Clinic did not have any blankets for babies in shock and no BCG vaccines.
Graphs, protocols, registers and forms	Eastridge Clinic was the only facility that displayed a graph with recent information on IMCI services offered. Mitchells Plain CHC did not have temperature record cards and only Mitchells Plain MOU did not have the <i>Protocol for managing and referring children with growth faltering and micronutrient deficiency and obesity</i> , a <i>Protein, energy malnutrition (PEM) register/book</i> and the <i>Protocol for management of children with HIV/AIDS</i> . Rocklands Clinic was the only facility that did not have the <i>Protocol for emergency referral</i> . Five facilities (Mitchells Plain CHC, Mitchells Plain MOU, Westridge Clinic, Rocklands Clinic and Strandfontein Clinic) did not have an IMCI booklet or enlarged wall chart. Only two facilities (Eastridge and Weltevrede Clinics) had either an immunisation register or book. Both Mitchells Plain CHC and MOU did not have copies of the <i>Official national form for adverse effects of immunisation</i> . Only Mitchells Plain CHC did not have copies of the <i>EPI disease surveillance manual</i> , <i>EPI vaccination manual</i> and <i>EPI cold chain operations manual</i> . Mitchells Plain MOU and Rocklands Clinic did not have a copy of the <i>Cold chain contingency plan while defrosting</i> and Mitchells Plain MOU was the only facility that did not have a list of notifiable disease and contact numbers for the Poison Centre. Only Mitchells Plain CHC and Strandfontein Clinic had a list of names of women in breastfeeding support groups. Mitchells Plain CHC, Westridge, Rocklands and Lentegeur Clinics did not have copies of birth notification forms.
Facility- and patient-held records	Ten <i>Road-to-health</i> cards were randomly selected at each facility that offered IMCI or child health/curative care to evaluate whether the child had received his/her first measles vaccination by 12 months and whether the child was fully immunised by one year. The sampled <i>Road-to-health</i> cards were kept up to date with the exception of one card at Strandfontein Clinic whereby the child was not fully immunised by one year.
Information, education and communication (IEC) material	Mitchells Plain MOU, Eastridge Clinic and Rocklands Clinic did not have pamphlets on diarrhoea/ORS solution, malnutrition and vitamin A supplementation. In addition, Lentegeur and Weltevrede Clinics did not have pamphlets on vitamin A supplementation and Lentegeur and Mitchells Plain Youth Centre did not have pamphlets on malnutrition available. Mitchells Plain MOU, Eastridge Clinic, Rocklands Clinic, Weltevrede Clinic, Lentegeur Clinic and Mitchells Plain Youth Centre had no posters on diarrhoea/ORS solution displayed on wall. Mitchells Plain MOU, Eastridge Clinic, Rocklands Clinic and Weltevrede Clinic had no posters on vitamin A supplementation displayed. Mitchells Plain MOU, Rocklands Clinic, Weltevrede Clinic and Mitchells Plain Youth Centre had no posters on malnutrition displayed on the walls.
Community involvement	Mitchells Plain CHC, Mitchells Plain MOU, Strandfontein Clinic and Lentegeur Clinic reported no community involvement projects or initiatives for the IMCI programme.

□ TB

It is reported that the Western Cape has one of the highest incidences of TB in the world (Department of Health, s.a.: 134). In 2002 the TB incidence in Cape Town was 636/100 000 population (Naidoo 2003). TB was declared a provincial emergency in 1997. One of the priorities of the Western Cape Department of Health has been to accurately quantify the TB epidemic. In doing so, the TB register was implemented which has vastly

improved the surveillance system. Although there has been a significant increase in TB cure rates in the province, the escalating incidence of the disease raises concern. In addition, the rising prevalence of HIV is likely to increase death rates due to TB as well as exacerbate the occurrence of Multiple Drug Resistance TB (Department of Health, s.a.: 134).

Some of the key components of the TB Plan compiled by the Western Cape Department of Health are:

- Improve the cure rates (achieve at least 70% cure rate for new smear positive TB cases)
- Reduce the pool of infectious cases
- Improve TB programme management
- Appoint/designate district TB/HIV co-coordinators in each district
- Implement advocacy and awareness programmes
- Improve implementation of DOTS
- Significantly shift the DOT of TB patients to communities
- Improve implementation of TB register (improve reporting rate to 100%)
- Improve microbiology (sputum turn-around times to 24-48 hours, improve bacteriology coverage and quality control)

The following are main findings of the current study regarding TB control in Mitchells Plain.

Table 78: Gaps in the TB control programme in Mitchells Plain

Issue	Gap
Staffing, programme target populations and patient load	The TB programme in Mitchells Plain is serving a total population of 216 430. The TB incidence for the district is 376/100 000 population. TB notification rate, which includes all new smear positive and new smear negative yet culture positive cases, varies from one facility to another. The notification rate at Westridge Clinic is 62/100 000 population, Tafelsig Clinic 186/100 000, Lentegeur Clinic 232/100 000, Eastridge Clinic 193/100 000, Rocklands Clinic 94/100 000 and Weltevrede Clinic 530/100 000. Why do Westridge and Rocklands Clinics have such low notification rates as compared to the incidence of the district? Does this imply that these two facilities are serving a catchment population with a low TB incidence? Also, why is the notification rate for Weltevrede Clinic so much higher than that for the other facilities as well as the incidence rate for the district? Is the implication that this facility is serving a catchment population with a high incidence of TB as compared to the catchment populations of facilities in Mitchells Plain and the District at large?
Scope and accessibility of TB services	Mitchells Plain CHC does not offer TB treatment. TB services are only offered three days a week at Rocklands Clinic – when the facility is opened for PHC services.
Programme management	Westridge and Rocklands Clinics do not receive written feedback on monthly TB reports submitted to management.
Drugs and supplies	Tafelsig and Lentegeur Clinics did not have any Refinah for children in stock.
Graphs, protocols, registers and forms	Rocklands and Weltevrede Clinics did not have graphs showing recent information about TB displayed. Mitchells Plain CHC did not have any of the TB protocols and stationery. The lack thereof may be attributed to this facility not offering TB services. However, the Package (Department of Health, 2001a: 25) states that PHC facilities should provide TB treatment according to national protocols and refer to CHCs if there are any problems. Therefore, it is imperative that CHCs should have protocols for the management of TB. Strandfontein Clinic did not have <i>The training manual for health workers</i> (1998). Both Rocklands and Lentegeur Clinics did not have copies of the protocol <i>Tracking TB at work – guidelines from South Africa's national TB control programme</i> . Lentegeur and Strandfontein Clinics did not have a <i>DOTS training manual</i> and Rocklands Clinic did not have flow charts used for diagnosing TB. Completion of patient-held TB cards needs to be improved at most facilities in Mitchells Plain. Ten patient-held TB cards were randomly selected at each of the facilities that offer TB treatment. The international disease code was not indicated on some of the sampled cards at Eastridge Clinic, Weltevrede Clinic and Lentegeur Clinic. The category for basis of decision to treat was not completed for some of the sampled cards at Rocklands, Tafelsig Clinic and Weltevrede Clinic. Only Rocklands Clinic had the regimens and doses up to date for all the sampled cards. No facility had the sputum results up to date for all the sampled cards. Rocklands Clinic only had sputum results completed for half of the sampled cards. Strandfontein Clinic provides TB diagnosis and treatment yet does not have a TB register. TB clients at Strandfontein Clinic are registered at Rocklands.
Information, education and communication (IEC) material	Mitchells Plain MOU did not have any pamphlets on TB available.
Community involvement and patient rights	Mitchells Plain CHC, Mitchells Plain MOU, Westridge Clinic, Strandfontein Clinic, Lentegeur Clinic and Mitchells Plain Youth Centre reported no community involvement activities and projects for TB control.

□ 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 Mitchells Plain follows.

Table 79: Gaps in the STI programme in Mitchells Plain

Issue	Gap
Scope and accessibility of STI services	Only Mitchells Plain MOU does not provide STI diagnosis and treatment using the Syndromic Approach for the management of STIs. They merely diagnose syphilis in pregnant women and then refer. Westridge and Rocklands Clinics only offer STI services three days a week – when these two facilities are open for PHC services.
Programme management	Staff shortage, difficulty tracing partners as well as STI patients themselves, time constraints, shortage of drugs, integrating STI and maternal health services and lack of patient education and awareness are some of the reported constraints in effectively managing the STI programme in Mitchells Plain. Mitchells Plain CHC, Westridge Clinic, Eastridge Clinic and Strandfontein Clinic have not received supervisory visits from the district STI coordinator in the last three years. Only Tafelsig and Strandfontein Clinics have received written feedback on at least one of the last three monthly reports submitted to management. Mitchells Plain CHC, Weltevrede Clinic and Mitchells Plain Youth Centre do not conduct annual assessments of STI services as stipulated by the Package (Department of Health, 2000a: 31).
Programme drugs and supplies	Tafelsig and Mitchells Plain Youth Centre did not have any benzathine penicillin in stock.
Graphs, protocols, registers and forms	Display of graphs for STI services is very poor in Mitchells Plain. Only three facilities had graphs with recent information on STI services offered displayed. Westridge, Rocklands, Tafelsig, Weltevrede, Lentegeur Clinics and Mitchells Plain Youth Centre had no graphs displayed on the walls. Only five facilities had all five of the protocols for the effective management of STIs in table 51. Mitchells Plain MOU only had two of the five protocols, Rocklands Clinic only had one, Weltevrede and Lentegeur Clinics had four and Mitchells Plain Youth Centre only had two.
Information, education and communication (IEC) material	Mitchells Plain MOU, Eastridge Clinic, Lentegeur Clinic and Mitchells Plain Youth Centre did not have any pamphlets on STIs available. Also, Mitchells Plain MOU did not have any pamphlets on condom use available. Mitchells Plain MOU had no posters on either STIs or condom use displayed on walls. Eastridge Clinic, Weltevrede Clinic, Lentegeur Clinic and Mitchells Plain Youth Centre had no posters on STIs displayed, whilst Rocklands Clinic had no posters on condom use displayed on walls.
Community involvement and patient rights	Only three facilities in Mitchells Plain were actively involving communities in STI control. Mitchells Plain CHC, Mitchells Plain MOU, Westridge Clinic, Eastridge Clinic, Rocklands Clinic, Weltevrede Clinic and Strandfontein Clinic reported no community involvement initiatives and projects for STI control. 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 Mitchells Plain.

Table 80: STI programme indicators for Mitchells Plain PHC facilities

Indicator	Issue
Incidence of male urethral discharge (MUD) ¹¹	Weltevrede Clinic has the highest rate of MUD cases (6.3%) followed by Strandfontein Clinic (1.4%), Rocklands Clinic (0.8%), Tafelsig Clinic (0.6%), Eastridge and Lentegeur Clinics (0.3%) and Westridge Clinic with lowest rate (0.1%).
STI contact tracing rate ¹²	Eastridge Clinic has a contact tracing rate of 29%, Lentegeur Clinic 32%, Rocklands Clinic 71%, Strandfontein Clinic 29%, Tafelsig Clinic 47%, Weltevrede Clinic 25% and Westridge Clinic 46%. All the facilities have low contact tracing rates (less than 80%). This translates to poor STI programmes at PHC facilities in Mitchells Plain.

□ HIV/AIDS

The HIV prevalence rate for the Western Cape was 7.1% at the end of 1999, compared to the national prevalence rate of 22.4%. Although the Western Cape has the lowest prevalence rate of all the provinces, it has the highest infection rate (from 5.2% in 1998 to 36.5% in 1999) (Department of Health s.a.: 135). The provincial Department of Health developed a detailed AIDS Plan to address the HIV/AIDS epidemic in the Western Cape. Some of the objectives of the provincial AIDS Plan are as follows:

- Reducing mother to child transmission of HIV through all means available, including the provision of ante-retroviral drugs to HIV+ mothers

¹¹ 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.

¹² 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).

- De-stigmatising HIV infection and improving social awareness amongst the communities of the Western Cape
- Ensuring coordinated commitment from all sectors of governmental and non-governmental organisations
- Making voluntary counseling and testing for HIV available at all health facilities in the province
- Ensuring a reliable supply of good quality condoms
- Promoting the correct treatment of STIs by all health care workers through training in the use of the syndromic management guidelines
- Enabling the provision of quality clinical management of HIV infection and the complications thereof, including opportunistic infections through the distribution of standard guidelines and the training of health workers in their use
- Helping organisations and communities to provide for those infected and affected by HIV through home based care
- Ensuring better coordination and cooperation between the HIV/AIDS/STI and TB programmes at all levels

The following main gaps in the HIV/AIDS programme in Mitchells Plain should shed light on some of the hindrances to achieving both national and provincial objectives for combating the HIV/AIDS epidemic in the Western Cape.

Table 81: Gaps in the HIV/AIDS programme in Mitchells Plain

Issue	Gap
Scope and accessibility of HIV/AIDS services	Westridge and Rocklands Clinics only offer VCT and PMTCT three days a week – when these two facilities are opened for PHC services. Mitchells Plain Youth Centre only provides VCT four days a week.
Programme management	Shortage of staff and drugs, as well as time constraints were some of the reported problems in managing the HIV/AIDS programme in Mitchells Plain. Mitchells Plain CHC, Mitchells Plain MOU, Westridge Clinic, Strandfontein Clinic and Mitchells Plain Youth Centre do not receive regular written feedback on monthly HIV/AIDS reports submitted to management.
Programme equipment	Westridge Clinic did not have a lockable storage room for HIV/AIDS information sources to be kept confidential.
Graphs, protocols, registers and forms	Of the ten facilities in Mitchells Plain, only three (Mitchells Plain CHC, Eastridge Clinic and Strandfontein Clinic) had a graph with recent information on HIV/AIDS services provided displayed on the wall. No facility had all 17 of the protocols for HIV/AIDS in table 52. Mitchells Plain MOU only had one of the protocols, Mitchells Plain Youth Centre had six, Mitchells Plain CHC, Westridge Clinic and Strandfontein Clinic had ten, Rocklands Clinic had 11, Tafelsig and Lentegeur Clinics had 12, Eastridge Clinic had 13 and Weltevrede Clinic had 14.
Information, education and communication (IEC) material	Mitchells Plain MOU and Lentegeur Clinic did not have any pamphlets on VCT and PMTCT available. Eastridge, Rocklands and Weltevrede Clinics did not have any pamphlets or posters on PMTCT available/displayed.
Community involvement and patient rights	Only Tafelsig Clinic reported no initiatives to involve the community in the HIV/AIDS programme.

□ EDL

Table 82: Gaps in the EDL programme in Mitchells Plain

Item	Gap
Programme management	Staff shortage, drug shortage, limited space, lack of a specific EDL coordinator/manager and insufficientness of drugs in EDL are some of the reported constraints in the effective management of the EDL programme in Mitchells Plain. Only three facilities in Mitchells Plain have a full-time pharmacist. Eastridge Clinic, Weltevrede Clinic, Strandfontein Clinic, Lentegeur Clinic and Mitchells Plain Youth Centre have not received a supervisory visit from a pharmacist in the last three years.
Facility equipment	The vaccine fridge for Mitchells Plain CHC and MOU was found to be higher than the stipulated temperature of between zero and eight degrees (Department of Health, 2001a: 87).
Diagnostic tests	Mitchells Plain CHC and Mitchells Plain Youth Centre do not send samples to the laboratory for HIV testing although they offer rapid HIV testing which requires confirmatory tests. Although there are no national standards for turn-around times for Pap smears, major discrepancies exist in turn-around times between facilities that offer this test. The turn-around time for Pap smears at Mitchells Plain Youth Centre is 56 days and 42 days for Eastridge Clinic. Whereas the turn-around time for this test is 7 days for Mitchells Plain CHC, Weltevrede Clinic and Lentegeur Clinic.
Drugs and supplies	<i>See drugs and supplies for each programme</i>
Graphs, protocols, registers and forms	Mitchells Plain MOU did not have a copy of the EDL booklet.
Record-keeping/stock management	Strandfontein Clinic and Mitchells Plain Youth Centre did not make use of stock control cards. Westridge and Rocklands Clinics had not implemented stock control cards for measles vaccine and Tafelsig Clinic had not implemented stock control cards for Cyprofloracin. Lentegeur Clinic had not implemented stock control cards for measles vaccine and rapid HIV test kits. Stock control cards for rifafour and rapid HIV test kits were not up to date at Weltevrede Clinic.
Referral practice	Exclusion of some drugs from the EDL to treat children referred from Red Cross Hospital is reported by Lentegeur Clinic. Strandfontein Clinic does not stock specialised drugs prescribed by specialists in hospitals. The facility manager at Westridge Clinic has to use her own transport to collect repeat medication for chronic disease clients who have been referred from Mitchells Plain CHC to collect treatment from Westridge Clinic.

CHAPTER 3

PHC MANAGEMENT, PROVISIONING AND PROGRAMMES IN MITCHELLS PLAIN - GAPS, STRENGTHS AND RECOMMENDATIONS

1. Strengths of PHC programmes in Mitchells Plain

Nurse-driven PHC: 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 clinical 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). Far less than 10% of patients are referred to a doctor at all the PHC facilities in Mitchells Plain.

District supervision and management: supervisory visits from the district PHC, TB and HIV/AIDS supervisors appear to take place fairly regularly at the PHC facilities in Mitchells Plain. All facilities providing these programmes received a supervisory visit from these supervisors within the last three years preceding the survey (2000-2002).

Cold chain maintenance: ten of the eleven facilities had at least one refrigerator that they used exclusively for vaccines. This is in line with the national standard, as stipulated in the Package (Department of Health 2001a: 13). Also, all fridges had thermometers in working order for monitoring and maintaining temperatures. Both the Package and the EDL guidelines stipulate that all PHC facilities should have temperature cards in use and that vaccine refrigerator temperatures should be regularly monitored and recorded (twice a day). All the facilities were making use of temperature record cards. The last date temperatures were recorded at all the facilities were either the day of the visit to the facility or the previous day. All refrigerators were not located within three meters from a heater/air conditioner, all refrigerators were located against an inside wall, all refrigerators were located in an area where only clinic personnel have access to them and the door to the room in which the refrigerators were located could be locked. All the facilities had ice packs in the refrigeration compartments of the vaccine refrigerators as well as cooler bags in the facilities in case of power failures and for maintaining the cold chain when vaccines need to be transported elsewhere. Also, there was enough space between each tray of vaccines to allow cold air to circulate as is stipulated by the guidelines.

In general, cold chain maintenance norms and standards are adhered to at PHC facilities in Mitchells Plain.

Equipment: in accordance with the Package (Department of Health 2001a: 31), every PHC facility in Mitchells Plain has at least one screened examination couch and sterile specula in working condition. 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) and at least one dildo for condom demonstration. All facilities in Mitchells Plain 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. It is to the credit of facilities in Mitchells Plain that all of the PHC facilities had an audiovisual set which was used for health education of patients.

Drugs and supplies: to the credit of the maternal health, IMCI, TB, STI, HIV/AIDS and EDL programmes none of the drugs observed were expired and all drugs were stocked according to the FEFO principle.

PHC protocols: seven out of the ten facilities in Mitchells Plain had copies of the two PHC Package documents available.

2. Gaps and weakness of PHC in Mitchells Plain

□ **Main gap**

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 Mitchells Plain offers comprehensive maternal health care (i.e. ANC, post-natal care, Pap smears, family planning and TOP). Only Mitchells Plain MOU offers ANC. Mitchells Plain CHC does not offer family planning services and only four facilities offer post-natal care. This seriously limits the accessibility of maternal health services, especially ANC and TOP (one facility for a population of 216 430), also increasing the burden on those facilities that offer these services. It is the recommendation of this research that ANC and post-natal care services be rendered by all clinics in Mitchells Plain. 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 and 2001b: 7) all PHC facilities (clinics) need to offer a one-stop integrated and comprehensive PHC service.

Main gap
No facility in Mitchells Plain provides comprehensive PHC services as outlined in the Package (Department of Health 2001a and b).

□ **Specific gaps affecting key PHC programmes and recommendations**

Self-reported programme constraints: the main constraint for most facility managers and programme managers are staff shortages. Additional constraints often reported include lack of training, equipment, drugs and clinic space. It is recommended that clearly defined norms for professional nurse clinical workload, as well as norms for number and categories of CHWs be established for PHC facilities/catchment populations in Mitchells Plain.

A serious lack of PHC District management supervision: generally, supervision and management is lacking for the maternal health, IMCI, STI and EDL programmes. Visits from district programme coordinators for these programmes need to be optimised.

Selective services (services on certain days): PHC facilities in Mitchells Plain 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).

Comprehensive maternal health services are lacking: only one facility in Mitchells Plain offers ANC and only one facility offers TOP. Facilities providing maternal health services in Mitchells Plain reported shortage of staff, equipment, insufficient training and patient education as obstacles to providing comprehensive maternal health services.

PHC equipment needs are serious and diverse: equipment needed at certain facilities in Mitchells Plain include examination couches, examination lights, sterilisers, stethoscopes,

otoscopes and computers. Repairing of equipment also needs to be improved at specific facilities, such as Tafelsig Clinic.

PHC tests are not always available and are characterised by long turn-around times: two facilities offer rapid HIV testing yet do not send samples to the laboratory for confirmatory tests. Why do the turn-around times for syphilis and Pap smear tests differ widely from facility to facility? Standardisation of best practices is recommended.

Drug supply problems: most of the facilities in Mitchells Plain did not have all the required drugs for the PHC programmes offered at each facility. Shortage of drugs and delay in the supply of drugs were some of the self-reported constraints for the EDL programme. It is recommended that supervision of the EDL programme for those facilities that do not have a full-time pharmacist be enhanced.

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. The lack of protocol availability has implications for the continuity of care when the facility manager or programme coordinator is not available. Protocols are intended to increase the competency of health care providers through guiding them in, 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.

Computers needed: the main uses of computers at facilities in Mitchells Plain include capturing and storing of patient records, facility-based statistics, facility reports and PHC graphs. These are integral tasks in the effective management of PHC programmes. Thus, Mitchells Plain Youth Centre should be equipped with a computer.

IEC problems: improving availability of pamphlet and poster material relating to key PHC programmes needs urgent attention (especially at Mitchells Plain MOU).

Two issues requiring further research:

Firstly, the role of community health workers: there are still CHWs (31%) in Mitchells Plain that are unpaid. What are the reasons therefore? What categories of CHWs and the specific number of CHWs are required per facility and catchment population? Secondly, a need for staff establishment assessment: there is a dire need for specific guidelines on establishing the number of nursing staff required to render comprehensive PHC services for the specific catchment populations of Mitchells Plain clinics. Staff shortage and/or lack of trained staff is the most serious constraint facility managers perceive to exist with PHC service delivery in Mitchells Plain.

3. Recommendations

- Facility managers and programme coordinators of each of the PHC facilities in Mitchells Plain should use this report as a manual or guide to one-by-one address and solve the identified operational gaps/deficiencies/constraints within the designated PHC facility.
- Management and supervisory structures of Mitchells Plain URS, management of health structures in the URS, as well as district/sub-district or metro/metro-substructures should

- use this report as a manual or guide to address and solve the identified gaps/deficiencies/constraints (operational and strategic issues) within the designated area.
- Every measure should be taken to better orientate, prepare and train PHC staff at PHC facilities to buy into the package and its merits, and to apply it incrementally in practice.
- Constant supervision and periodic direct surveillance of the implementation of the PHC package at PHC facilities appears to be the best manner in which to secure its implementation as well as to systematically address the gaps in the current implementation of the PHC package. This may be achieved by devising easily implementable surveillance and monitoring systems. If they indeed already exist, they need to be used more systematically and be applied with greater dedication.
- The distribution of manuals pertaining to PHC delivery needs to be put on a more effective level. It is clear that, quite often, important information documents never reach the people who should apply the guidelines contained in these documents. The unavailability of the basic PHC package documents at three of the ten facilities is a clear case in point.
- The DHIS needs to be made more reliable if it is to be used for management and planning purposes.
- It is of the utmost importance that the package be interpreted in the same way by all stakeholders (provincial authority, local authority, facility personnel) so that comprehensive PHC is provided at every PHC facility in Mitchells Plain.
- In general, PHC in Mitchells Plain can benefit by greater attention to the implementation of the Package.¹³

¹³ 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.

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