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CHAPTER 1

THE URBAN RENEWAL STRATEGY AND THE PHC PACKAGE

1. The Urban Renewal Strategy

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

2. The PHC Service Package[4]

In 1999 the Department of Health reported that the first five years after the democratisation of South Africa were focussed largely on increasing access to health care. Henceforth, as stated in its *Health Sector Strategic Framework 1999-2004,* the Department would accelerate quality health service delivery, amongst others through *'the speeding up of an essential package of services through the [DHS]'* (one of a ten-point plan) (Department of Health 1999: 4). A mechanism was needed to define parameters for service delivery, as well as to ensure comparability in the provision of services. Having taken years to research (in partnership with the provinces) this mechanism realised in the form of the PHC Service Package during 2000 (Department of Health 2001e). The Package entails a standardised, comprehensive *'basket'* of services that are to be delivered at primary care level. Beginning in April 2000 the Package would be implemented incrementally in all provinces, with 2004[5] set as the target for full provision and availability of the Package in *all* PHC facilities. The Department of Health (2001e: 40) viewed the development of the

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[1] Also referred to as the Urban Renewal Programme (Department of Health 2002: 60).
[2] See MCA Urban and Environmental Planners (2001) for an overview of the *Urban Renewal Strategy*.
[3] The other URSs include Khayelitsha and Mitchell's Plain in the Western Cape, KwaMashu and Inanda in KwaZulu-Natal, Mdantsane in the Eastern Cape, Galeshewe in the Northern Cape and Alexandra in Gauteng.
[4] The service components described in the Package are expected to deal, as cost-effectively as possible, with the leading causes of mortality and morbidity in South Africa. It thus focuses in particular on the following (Department of Health, 2001b: 7): child health (in particular infectious diseases), STDs and HIV/AIDS, TB, reproductive health (ANC, family planning and maternity), mental health, chronic diseases (hypertension, diabetes and asthma), disabilities, trauma and injuries.
[5] While the Minister of Health (Department of Health 2001a: 2) targets 2004 for reaching *all* stated standards, the Department of Health (2001b) targets respectively end of 2001, end of 2002 and end of 2005 for the provision of specified service components.

Package as a huge advance towards the standardisation of health care on an equitable basis.[6]

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

- **Core norms of the Package**

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

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

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

- **Core standards for PHC services**

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

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

- **Mapping the gaps in PHC service provisioning**

The full implementation of the Package in any particular PHC facility would mean that that facility is offering comprehensive PHC services. Indeed this is the expectation of the national Department of Health as the first of the above-mentioned core norms of the Package refers to *'the clinic'* '(it) *renders comprehensive integrated PHC services using a one-stop approach for at least eight hours a day, five days a week'*.[7] Nevertheless, it may be argued that in its entirety the current Package perhaps does not emphasise the expectation that individual clinics should be offering *'one-stop PHC services'* - the full ambit of PHC services as described in the Package - strongly enough. In practice, and as illustrated by

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

the current study, while the full Package might be offered by the health district as a whole, the full Package is very often not offered by all individual facilities. Thus, here we are dealing with gaps between the expectation of the Package (and the Department of Health) and the actual implementation of PHC programmes and services by districts and by individual facilities.

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

The research problem, therefore, is described as the need to *'map the gaps'* in PHC service provisioning in Motherwell, 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 as and where applicable to the PHC programmes under study, and as described in the standards in the Package and other policy documents of the Department of Health[9].

3. Motherwell URS in brief[10]

Motherwell is a suburb of the Nelson Mandela Metropolitan Municipality, about 25 kilometres from the city centre of Port Elizabeth on the coast of the Eastern Cape. As such it receives the same planning and development attention that other Integrated Development Plan (IDP) areas receive. The Office of the City Engineer submitted a Business Plan to the Eastern Cape Provincial Urban Renewal Strategy Facilitation Committee on 1 March 2001, identifying key infrastructure projects that can be implemented in Motherwell over three financial years in terms of the Urban Renewal Strategy.

The development of Motherwell started around 1982. It is thus a relatively new area. Part of Motherwell was originally allocated to formal housing to accommodate people who lived in the flood plain area (Soweto-on-Sea) of Port Elizabeth. Another part was allocated as a 'transit camp' providing what was envisaged to be temporary housing to newly arrived people in the city. By the 1990s immigration had increased beyond the capacity of the 'transit camp' and consequently informal settlement increased. Motherwell was a Local Authority on its own until 1994, when the township was incorporated into the Port Elizabeth 'One City'. Motherwell can be seen as a good example of apartheid planning in Port Elizabeth. The need for mass housing resulted in farmland being acquired north of the Swartkops River at a time when no other development was taking place in the area apart from a small white suburb near the mouth of the Swartkops River.

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[8] It is a stated five-year objective of the Department of Health (2002: 59) to define an essential equipment package for PHC and to equip clinics accordingly – this would benefit future studies of the current type.

[9] See list of references.

[10] Extracted from Nodal Reports: *Motherwell Urban Renewal Node July 2002*.

The Business Plan of the Eastern Cape Provincial URS Facilitation Committee emphasises that Motherwell should not be seen in isolation, but must be viewed in the overall context of the Metropole. It also identifies key projects outside of Motherwell, such as the establishment of initiatives *en route* to the Addo Elephant Park that will reinforce linkages with existing tourist facilities, provide work opportunities and contribute to the stimulation of the local economy and that of the Province.

The population of Motherwell is estimated at approximately 360 000 people living in about 60 000 households. The majority of the residents are mostly fairly recent immigrants to the area. There is a small semi-affluent component to the community in the middle- and upper-income groups who own their own homes. The 16 neighbourhoods of Motherwell range from formal and built-up to informal and densely shack-populated. An average disposable income of R522 per month was recorded in 2001 (Rauch 2002:13). Two thirds of households earn less than R18 000 per annum (Sutcliffe 2002: 8).

Representing the Nelson Mandela Metropolitan Municipality, Mayor Faku announced in January 2003 that the Council would increase the number of health care facilities and improve the quality of care in peri-urban areas, including Motherwell (Freeman 2003).

4. Research strategy and methodology

The current study is concerned with implementation of the broad URS as applied to public health care provision, and key primary health care (PHC) programmes in particular. So commissioned by the National Health Department and the Centers for Disease Control and Prevention, the Centre for Health Systems Research & Development in February 2003 undertook an assessment of the following key PHC programmes in Motherwell: maternal health, Integrated Management of Childhood Illnesses (IMCI), tuberculosis (TB), sexually transmitted infections (STIs), HIV/AIDS and Essential Drug List (EDL)[11]. The research was authorised by and conducted in collaboration with the health division of the Nelson Mandela Metropolitan Municipality, the Eastern Cape Department of Health, the community of Motherwell in their various forms of representation and representatives of the Eastern Cape Provincial Urban Renewal Strategy Facilitation Committee.

❑ 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 Motherwell, 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 Motherwell
- to provide local and provincial and health authorities and managers with a reliable measurement of the status of the implementation of the Package in Motherwell, and,

[11] 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.

thereby, to endeavour to facilitate planning and decision-making towards well-focused, quality and comprehensive PHC services in line with the expectations of the Package
- to produce an instrument and a methodology that in future also may be adopted for self-assessment by URSs and health districts.

Focal areas of analysis

The following aspects PHC service delivery were applied as cross-cutting dimensions in the analyses of the key PHC programmes as well as the individual PHC facilities under study in Motherwell:
- Facility staffing and programme target populations
- Programme management
- Scope and accessibility of services
- Facility equipment
- Tests
- Drugs and supplies
- Protocols, registers, forms and maps
- Facility and patient held records
- Referral practice
- Information, education and communication (IEC) material
- Community involvement and patient rights
- Key outcome indicators

Research methodology

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

A preliminary community workshop - 13 February 2003

In advance of the data collection – and on request of the Motherwell stakeholders - a workshop was conducted with an array of stakeholders in Motherwell, including health managers and workers, community health workers and DOTS supporters, members of clinic and ward committees and Motherwell Health Development Forum. This workshop

rendered useful information on a wide spectrum, and can be summarised as "constraints and needs" and "suggested solutions" identified by the community:

Constraints and needs	Suggested solutions
Staff shortages at clinics, especially of fulltime doctors (only two doctors for the whole of Motherwell and they only work from 08h00 until 12h00) and pharmacists. Motherwell Health Centre should have a doctor on call since it has a maternity section. Staff morale is poor and leads to poor quality care.	The government should institute incentives to encourage doctors and nurses to remain in the country. More nurses should be employed and the working of overtime should be discouraged so that nurses are able to cope with the heavy workloads at clinics. The staff/patient ratios at clinics need to be considered. Lay councillors need logistic support and financial incentives.
Equipment shortages (e.g. syringes and needles) not supplied by local authority. There is no X-ray facility. There is a shortage of linen in hospitals and clinics. Telephones are 'mostly' unavailable.	Motherwell Health Centre should be upgraded and should have staff and equipment for X-rays, casualty, maternity and child health and curative services. In this way referral to hospitals in Port Elizabeth can be avoided.
Drug shortages are experienced on a daily basis. This causes complications such as diabetes mellitus.	None suggested.
Clinics are lacking in certain areas or are too small to accommodate the numbers of patients.	Clinics are required at Swartkops Valley and Ikamvelihle No. 29.
Lack of security results in armed robberies.	Around-the-clock patrolling around clinics by SAPS or security services. Trained security guards, satellite vehicle recovery systems and burglar alarms are required.
Ambulance services are characterised by long delays. At times ambulances do not come at all resulting in patients dying. Ambulances do not serve certain 'shack' areas. High unemployment implies that patients cannot afford to travel to hospitals themselves. Travelling problems also relate to increasing incidence of road accidents.	A 24-hour 'standby' ambulance service is required at Motherwell Health Centre. A fully functioning district hospital is needed. Traffic officers, road signs, speed bumps and school patrols are necessary. More clinic cars and mobile clinics are required.
No 24-hour, weekend and public holiday health care services are available, which especially detrimentally affects terminally ill AIDS and cancer patients.	A hospice or other centre is needed to provide a 24-hour service for the terminally ill. More home-based services are also needed.
Lack of health information in the community especially regarding HIV/AIDS, STIs and TB.	Health education campaigns are necessary in the community.
Insufficient staff training.	Improved staff training.
Local supermarkets and spaza shops maintain poor hygiene; e.g. expired products, putrid meat, stale and maggot-infested food.	Strict control by environmental health officers is necessary. Expired or stale food should be removed.
High unemployment and poverty is associated with prostitution and drug and liquor abuse by adults and teenagers.	The government should ban cheap liquor; e.g. Tap and Umtshovalale. Poverty alleviation programmes such as food gardens should be in place. Existing plots for food gardens are insufficient.
Air pollution by African Hide Company, Pelts Company and Wastech.	None suggested.
'Funding'	The URS should contribute to the funding and development of health services in Motherwell. Incentives should be provided to health workers to perform their duties.

Provincial administration health services vs. local authority services.	None suggested.
No coordination of community projects in Motherwell.	None suggested.
Insufficient monitoring and evaluation of health services in Motherwell.	Continuous monitoring and evaluation of health services in Motherwell should take place.
Motherwell is an area with high rates of HIV/AIDS transmission.	VCT should be offered at all clinics. Continuous, effective HIV/AIDS education should take place. More health staff should be employed. Prophylactic treatment for rape victims is required.
TB control is detrimentally affected due to DOTS not being universally implemented; e.g. no DOTS at Wells estates. High non-adherence to treatment among TB patients.	A Hospice is required for the terminally ill. Feeding schemes for TB patients are required. Greater accessibility of health services needed.
Maternal health is threatened by the poor ambulance services and abuse of women.	Ambulance services should be improved. ANC services should be provided at all clinics – which necessitates adequate staffing. Centres for abuse victims should be made available.
Child health is negatively affected by malnutrition and abuse.	Sustainable nutritional programmes should be in place. Centre for abuse victims needed.
STI care is made difficult by a lack of openness in the community and medicine being out of stock at times. Rape and non-compliance with treatment are further problems.	Effective health education, availability of drugs and an accessible rape crisis centre are needed.

❑ Data collection

Data collection took place in February 2002. Four data gatherers and a fieldwork manager/editor worked in a team. Much time was required of the facility managers to obtain all the information. This was especially the case where the coordination of all the programmes rested directly with the facility manager. On average it took two days of fieldwork to complete the data collection for each facility. On completion of daily data collection the fieldwork manager/editor and data gatherers held a debriefing session to systematically discuss each focal area of the analysis, identify problems in the data and missing data, and to supplement the instrument data with qualitative observations. Return visits to all the facilities were made to correct problematic data and fill in the gaps where missing data occurred.

All seven of the PHC public health facilities (three fixed clinics, a satellite clinic, two mobile units and the CHC) in Motherwell providing PHC services 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 key programme coordinators
- conducting physical observations in the facility
- capturing information off the computerised DHIS

❑ Research feedback workshop - 2 June 2003

A research feedback workshop was held in Motherwell on 2 June 2003. The workshop was attended by 48 representatives from the Motherwell community, health services and management and the URS Node Committee. At the workshop the researchers presented

the research findings. The presentations 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 Motherwell, and the recommendations ensuing from the research. The workshop was characterised by lively interaction and exchange between the researchers and the Motherwell stakeholders. 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 meeting was concluded by decisions on how the report and research findings were to be dealt with further. Representatives of the Nelson Mandela Metro Health Department, the Motherwell URS Node Committee structure and the Motherwell Community Health Forum undertook to act on the report by feeding the information into existing structures and to plan interventions. The overseer of this process is Dr Charmaine Pailman and her office can be contacted at the following telephone number: 041 505 4449.

5. How to use the report

First and foremost, the report is meant to serve as baseline information on public PHC provisioning in Motherwell. 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 Motherwell Urban Renewal Node (if in existence), as well as the management and supervisory health structures in Motherwell, 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 MOTHERWELL - RESEARCH FINDINGS

1. Staffing of PHC facilities in Motherwell

PHC services in Motherwell are provided by seven facilities, i.e. the Motherwell community health centre (MCHC), NU 2, NU 8 and NU 11 fixed clinics, TandoXolo satellite clinic, and the Coega and the Motherwell mobiles. The Motherwell CHC functions under the provincial Department of Health, while all the fixed and mobile clinics report to the Nelson Mandela Metro Authority. Thus PHC service delivery in Motherwell has thus a predominantly *'local authority'* character:

Motherwell CHC: all staff members are province-employed (32 professional and 17 enrolled nurses). Two sessional doctors visit this clinic from 08:00 to 12:00 every day. The facility's outpatient department (OPD) is open on weekdays between 07:00 and 16:00 and the labour ward and casualty unit function 24 hours per day, seven days per week.

NU 2 fixed clinic: all but one of the seven professional nurses at this clinic are employed by the Metro. One professional nurse is employed by a private nursing agency. Additionally, there is one enrolled nurse employed by the Local Authority at this clinic. A sessional doctor visits the clinic once per week, on Thursdays, for two hours to attend to patients in need of medical care. The clinic is open between 07:45 and 16:00 on weekdays only.

NU 8 fixed clinic: the Metro employs seven of the eight professional nurses at this clinic. One professional nurse and the only enrolled nurse are employed by a private nursing agency. A doctor visits this clinic on two days per week for two hours each day. The clinic is open between 07:45 and 16:00 on weekdays only.

NU 11 fixed clinic: the Metro employs five of the six professional nurses, and one enrolled nurse at this clinic. One professional nurse is employed by a private nursing agency. A sessional doctor visits this clinic on Thursdays for two hours. The facility is open to patients from 07:00 to 16:00 on weekdays.

TanduXolo satellite clinic: all four the professional nurses and the Metro employs the one enrolled nurse at this satellite clinic. No sessional doctor visits this facility, but TB patients requiring the services of a doctor are referred to NU 11 and those who require the services of a doctor for other conditions, are referred to Motherwell CHC. The clinic is open between 07:45 and 16:00, Monday to Friday.

Motherwell mobile clinic: the Metro employs all the three professional nurses and health educator serving on this mobile unit. The province employs one health advisor working with the mobile team. No doctor goes out with this mobile clinic, but patients are referred to NU 8 clinic, which is the base clinic for this unit, which is served by a doctor on a weekly basis. The mobile clinic operates between 09:00 in the morning and 12:00 in the afternoon within the Motherwell community at specific points. The rest of the day is spent doing home visits and administration.

Coega mobile clinic: the two professional nurses and one enrolled nurse who serve on the Coega mobile clinic are all paid by the Metro. This outreach programme is attending to

areas in the Port Elizabeth outskirts e.g. the community relocated from Coega, as well as the communities of Colchester, Tarrental, Cerobos Well's Estate and Ardale. The mobile clinic operates from Monday to Thursday and on Fridays they have a fixed point in Coega, at their base station, where a sessional doctor attends to referred patients between 09:00 and 13:00. The Coega mobile operates from 07:45 to 16:00 on weekdays.

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

Table 1: Nursing staff establishment

Facility	Professional nurses[1]		Enrolled nurses		Assistant nurses		Total	
	Normally	On day of visit	Normally	On day of visit	Normally	On day of visit	Normally	On day of visit
Motherwell CHC	28[2]	21[3]	17	7[4]	0	0	**45**	**28**
NU 2	7	5	1	1	0	0	**8**	**6**
NU 8	8[5]	7[6]	1[7]	1	0	0	**9**	**8**
NU 11	7[8]	7	1	1	0	0	**8**	**8**
TanduXolo	4	4	1	0[9]	0	0	**5**	**4**
Coega mobile	2	2	1	1	0	0	**3**	**3**
Motherwell mobile	3	3	0	0	0	0	**3[10]**	**3**

1 This includes chief professional nurses, senior professional and professional nurses.
2 There are 32 professional nurses employed at the CHC, of who four are officially off duty every day.
3 Of the 32 professional nurses at this facility, four were officially off duty; two were on study/course attendance leave, three on leave and two on sick leave.
4 Ten of the enrolled nurses were absent on the day of the field visit; two were on leave, six on study leave and two on sick leave.
5 One of the professional nurses is from a privately owned nursing agency.
6 One of the professional nurses was off sick on the day of the survey.
7 The enrolled nurse is also from a privately owned nursing agency.
8 One of the professional nurses on the staff establishment of NU 11 is employed on a part-time basis – this person is paid by a private nursing agency – the Local Authority pays all the other personnel.
9 The enrolled nurse on the staff establishment of TanduXolo satellite was on leave on the day of the field visit.
10 One health educator is part of this staff establishment as well. She has a clerical function, and does health education and home visits.

Factors indicative of staffing requirements at facility level include nurse clinical workload and utilisation rate. Most of the respondents at the Motherwell facilities reported a shortage of staff. This shortage reportedly compromises the quality of PHC service provision and limits the provision of comprehensive PHC by facilities as per Package guidelines. However, although there is no national norm for a patient-nurse ratio, findings from studies conducted in the Free State has shown that 35 to 40 patients per nurse per day is the ideal workload.[12] This norm has seemingly been adopted in other provinces too. If this norm is applied to Motherwell, the implications are that all the PHC services in Motherwell are in fact overstaffed. Other factors should be taken into consideration, however, e.g. the fact that none of the clinics (with the exception of Motherwell CHC) have dispensary support personnel, which automatically implies that the laborious tasks of drug management and drug dispensing are the responsibility of the nursing personnel at the clinics and mobile clinics, which significantly reduces the time to their avail for clinical work. Additionally, nursing support personnel, i.e. enrolled nurses and especially assistant nurses, are virtually non-existent, which means that professional nurses at the facilities have to provide basic services (e.g. wound dressing, temperature readings, taking blood pressure readings, etc.) that could be done by nursing support personnel. This further reduces the time they have to their avail for more complicated clinical procedures.

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

Table 2: Facility staffing indicators[1]

Facility	Nurse clinical workload per day[2]	Utilisation rate (%)[3]	Absenteeism rate	Average sick leave days per nurse per month
Motherwell CHC	24.5	4.9	62.5	1.6
NU 2	28.9	2.2	15.0	1.6
NU 8	36.9	3.0	14.1	1.6
NU 11	27.9	2.0	16.1	2.0
TanduXolo satellite	20.2	2.4	9.9	1.4
Coega mobile	22.2	6.5	3.4	0.7
Motherwell mobile	24.1	4.3	10.2	1.3

1 Source: DHIS (January to Dec ember 2002).
2 Nurse clinical workload per day = total PHC headcount/nurse clinical working days.
3 Utilisation rate = total PHC headcount/target population.

The table shows large discrepancies in the workload of nurses between the PHC services in Motherwell. Average workloads range from 20.2 patients seen per nurse per day by the TanduXolo satellite to 36.9 patients per nurse per day at NU 8 clinic. One would expect that the mobile clinic nurses would see fewer patients than the satellite clinic as they travel to different points during the day. The scopes of service of the different facilities have to be kept in mind; in particular the TanduXolo satellite's scope is quite limited, at least they do not render services that are not rendered by any of the two mobiles. On the contrary, especially the Coega mobile has a broader scope of service than TanduXolo satellite. On the other hand, NU 8 clinic, which shows by far the highest clinical workload, also has the most comprehensive scope of services rendered in Motherwell, short of the Motherwell CHC.

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.

Gap-attack!

The severe discrepancy between the clinical workload in NU 8 and the other PHC facilities in Motherwell need to be addressed. There seems to be a severe lack of nursing support personnel at Motherwell PHC facilities. To further confound this situation, ten of the seventeen enrolled nurses at Motherwell CHC were absent on the day of the field visit - two were on leave, six on study leave and another two on sick leave. In explanation, according to the South African Nursing Council, a bridging course is being offered to Enrolled Nurses to assist them in upgrading to professional nurses. The duration of this course is two years. Enrolled nurses take turns to attend the course in order not to leave a complete gap in the services. This staff category is therefore being phased out completely. This process unfortunately leaves the services without replacement of the staff attending the course, which causes pressure on the staff that remains within the clinics. The new staff organogram in planning will reportedly include more enrolled nursing assistants as support staff.

Absenteeism of professional nurses at Motherwell CHC also seems to be problematic. Of the 32 professional nurses employed at this centre, only four are officially off duty at a time. On the day of the field visit, an additional two were on study/course attendance leave, three on leave and two on sick leave. NU 11 and the two mobile clinics were the only facilities with a full staff establishment on the field visit days.

Table 3: Referral rate to doctor[1]

Facility	Referral rate to doctor (%)[2]
Motherwell CHC	5.0
NU 2	0.8
NU 8	0.7
NU 11	0.8
TanduXolo satellite	-
Coega mobile	9.6
Motherwell mobile	-
Average for district	3.0

1 Source: DHIS (January to December 2002).
2 Percentage of total headcount referred to a medical officer.

The number of referrals to a doctor is a useful indicator for training or equipment needs. It is expected of nurses to address at least 90% of all clinical cases and to refer not more than 10% of clinic cases to a doctor. A high referral rate means that nurses are not utilised to their full potential or that they are not adequately trained or equipped (Heywood & Rhode 2002: 115). Less than 10% of patients are referred to a doctor at all of the PHC facilities in Motherwell, with the Coega mobile showing the highest referral rate at 9.6%.

- **Support workers other than nursing staff**

There appears to be no national guidelines or policies regarding the number of CHWs and support workers other than nursing staff, required for a facility or per catchment population. However, the number of supporters at Motherwell facilities varied considerably from five at TanduXolo satellite to 14 at the Coega mobile. In general, support workers are a very valuable resource for Motherwell PHC services.

The types of support workers varied, including health educators/advisors, DOTS supporters, and general volunteers assisting at some of the clinics. Their training included formal health education training, DOTS supporter training, and HIV/AIDS training. Some of them serve only certain days of the week, while others work from Monday to Friday. Some are community-based and other clinic-based, supporting nursing personnel as needed. However, respondents at the Motherwell facilities indicated that they have problems keeping their home-based carers and/or DOTS supporters active at this stage, as these people were promised remuneration a long time ago already and nothing was forthcoming yet. Numerous trained home-based carers and DOTS supporters were lost to the services as a result of this. Note that only ten of the 58 support workers were paid at the time of the survey, implying that 48 support workers were volunteers and did not receive any payment for services rendered.

NGOs, e.g. Hospice and the Red Cross, are also involved in home-based care in Motherwell. The respondent at Motherwell CHC indicated that they have contact with these NGOs and let them know when home-based care is required. She further indicated a need for more lay counsellors to assist with VCT at the clinic. At the time of the survey the lay counsellors only assist on Wednesdays. The need is for lay counsellors every day of the week.

Table 4: Employed (paid) and unpaid support workers

Facility	Paid	Unpaid	Total no. Of support workers
Motherwell CHC	2[1]	5[2]	7
NU 2	4[3]	0	4
NU 8	2[4]	7[5]	9
NU 11	1[6]	8[7]	9
TanduXolo satellite	1[8]	4[9]	5
Coega mobile	0	14[10]	14
Motherwell mobile	0	10[11]	10

1 Two paid health educators were trained by the Local Authority and visit all the clinics in Motherwell, giving health education to clients waiting in the clinic. They also run a food garden project in Motherwell.
2 Five unpaid support workers/DOTS supporters are involved with the DOTS programme as supporters, as well as life skills education for HIV/AIDS programme and are also involved in the breast feeding support groups. They are also trained lay counsellors involved with the HIV/AIDS support group that meets once per week at the CHC and are assisting with counselling of clients to be tested for HIV/AIDS. They help out at the clinic on Wednesdays.
3 Two health educators, paid by the Local Authority, visit the clinic on a regular basis to give health education. Two community health workers, paid by the province, act as DOTS supporters.
4 One of these support workers help out in the clinic with clients and the other goes out with the mobile clinic that operates from NU 8 clinic – both mostly do health education.
5 There are seven active unpaid DOTS supporters working at this clinic.
6 This person is a health advisor and is paid by the province. She mostly works on family planning but also does health education with regard to STIs and HIV/AIDS.
7 These unpaid volunteers are involved with TB DOTS. They also cook soup at the clinic and distribute the soup and bread to all clients in need, old people, TB patients and HIV/AIDS clients.
8 A paid health educator serves TanduXolo satellite.
9 TanduXolo satellite is served by two unpaid DOTS supporters and two general volunteers who help out in the satellite clinic, e.g. with motivation of patients and health education.
10 Coega mobile have a total of 14 unpaid active DOTS supporters.
11 They are community-based DOTS supporters.

Gap-attack!

It is imperative that an effort should be made to retain the support workers in Motherwell, either by paying them, as was reportedly promised, or by clarifying confusion about promises not acted upon. It will be a severe loss to the PHC services in Motherwell if they were to loose their unpaid volunteers altogether.

Representatives at the Metro Health Department and service providers in Motherwell responded on this data in the following way: DOT supporters are volunteers who are offering their services without gain, and that they are empowered in the process. It was also indicated that an incentive or stipend from the National Department of Health would be implemented soon. This will be a once-off occurrence.

A group of DOT supporters linked to one of the clinics also responded with their grievances following the workshop. They indicated that they have been active since right after their training in 1999. Clients have to visit them at home on a daily basis to receive their medication. The personnel at the clinic initially undertook to deliver the necessary medication to their homes every day, but this never happened so they have to travel to the clinic to obtain the medication for their patients. Reportedly, their most serious problem, however, is the fact that the patients arrive at their homes hungry, without having had anything to eat, as they are mostly extremely poor. Some of the patients ask them for food, which they provide if they have and it sometimes happen that a patient collapses in their homes, too shy to ask for something to eat before they take their medication. They make a plea that TB patients are provided with some food. They further ask for more training, some stationery and some form of identification to show that they are DOT supporters.

❑ Doctors

Table 5: Availability of doctors

Facility	Doctors			
	Number of full-time doctors at facility	Number of sessional doctors visiting facility	Number who can speak local language	Total no of sessional hours per week
Motherwell CHC	0	2	1	40
NU 2	0	1	1	2[1]
NU 8	0	1	1	2[1]
NU 11	0	1	1	2
TanduXolo satellite	0	0	N/A	N/A
Coega mobile	0	1	1	2
Motherwell mobile	0	0	N/A	N/A

1 The official sessional hours for these doctors are two hours per visit, but they usually stay until all the referred clients for that day were all seen.

2 The respondent indicated that they refer their patients to the doctor at NU 8, which is the base clinic of this mobile unit.

Apart from TanduXolo satellite and the Motherwell mobile, all the facilities had sessional doctors at least once per week. Motherwell CHC had two doctors for four hours each every weekday.

> **Gap-attack!**
>
> There are no doctors available at any of the Motherwell facilities during the afternoon. A solution to this problem, as suggested by the respondent at Motherwell CHC, would be a full-time doctor at the CHC, as referred patients in need of immediate care during afternoons are referred to the district hospital at this stage, which is inconvenient for patients as the hospital is quite far and ambulance services are unreliable. Service providers who attended the feedback workshop also recommend a full time doctor at the Motherwell CHC, as critical times when doctors are needed are after hours, night duty, weekends and public holidays. At that stage they had no doctor sessions at these critical times.

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 …"*

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

Facility	Years
Motherwell CHC	9
NU 2	8
NU 8	9
NU 11	13
TanduXolo satellite	15
Coega mobile	7
Motherwell mobile	1

The facility managers in Motherwell are well experienced. Only the manager on the Motherwell mobile has one year of experience, all the others have seven years or more experience.

❑ Supervisor and district official visits

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

Facility	District infection control official	Pharmacist	IMCI trainer	Laboratory technician	District coordinator/supervisor					
					PHC	Maternal health	IMCI	TB	STIs	HIV/AIDS
Motherwell CHC	✓[1]	✗[2]	N/A[3]	✗[4]	✓[5]	✗[6]	✗[3]	✗[7]	✓[8]	✓[9]
NU 2	✗[4]	✗[4]	✗	✗[4]	✓	Uncertain[10]	✗[3]	✓	✓	✓
NU 8	✗[11]	✗[4]	N/A[3]	✗[4]	✓[15]	✓[14]	✓[12]	✓[15]	N/A[13]	N/A[13]
NU 11	✗	✓[17]	✗	✗[4]	✓[18]	✗[19]	✗[20]	✓[21]	N/A[13]	N/A[13]
TanduXolo satellite	✗[4]	✗	✓[26]	✗[4]	✓[23]	✓[24]	✓[25]	✓[27]	N/A[13]	N/A[13]
Coega mobile	✗[4]	✗	N/A[3]	✗[4]	✓[28]	✓[29]	✗[30]	✗[31]	✓[32]	✗[33]
Motherwell mobile	✓[35]	✓[34]	N/A[3]	✗[4]	✓[37]	✗[4]	✗[30]	✗[36]	✗[4]	✗[4]

1 Stationed at the facility.
2 They only have two assistant pharmacists at facility; no qualified pharmacist 'ever' visits them.
3 None of the staff at these facilities have been trained in IMCI.
4 Reportedly never visits the facilities.
5 The nursing service manager (middle manager) from the district office.
6 Only the programme supervisor at the facility manages the programme, no maternal manager from district or provincial office visits the facility.
7 The TB coordinator never visits the CHC.
8 The last visit was in November 2002.
9 The VCT/PMTCT coordinator visited the clinic in October 2002 – however, the CHC manager drives the VCT programme – there is no real external supervision as the external supervisor is not trained in VCT – HIV/AIDS coordination is really in practice the responsibility of this facility manager.
10 The respondent was uncertain whether such a supervisor visited the facility in the past three years.
11 They are called away from the clinic for workshops in this regard.
12 The EPI supervisor did visit the clinic in January 2003, none of the staff have however been trained in IMCI.
13 These respondents at NU 8, NU 11 and TanduXolo satellite indicated that there is no supervisor for the STI or HIV/AIDS .programmes in Motherwell. The question arises why some clinics in Motherwell seem to have these programme coordinators and these ones not?
14 The last visit was around October 2002.
15 The last visit occurred around September 2002.
16 The general supervisor last visited the clinic in January 2003.
17 A pharmacist visits this clinic once in four months. The question that arises here is why does this pharmacist only visit this specific clinic and not the others?
18 The chief community health nurse last visited the clinic towards the end of 2002.
19 There is reportedly no maternal/women's health supervisor for this clinic.
20 The personnel of this clinic have reportedly been trained in IMCI but there is no IMCI supervisor for this clinic.
21 The TB coordinator last visited the NU 11 clinic in 2001, more than a year ago.
22 NU 11 was the only facility, apart from Motherwell CHC, that received a visit from the infection control nurse.
23 The Chief Community Health Nurse last visited this clinic in November 2002.
24 TanduXolo satellite last received a visit from the maternal health supervisor in October 2002.
25 TanduXolo satellite last received a visit from their IMCI supervisor in November 2002.
26 TanduXolo satellite received a visit by their IMCI trainer once in 2002.
27 TanduXolo satellite last received a visit from their TB supervisor in January 2003.
28 Coega mobile received their last visit by a general supervisor in February 2003.
29 This supervisor last visited Coega mobile in September 2002.
30 The staff of Coega mobile did not yet receive training in IMCI yet at the time of the survey. They also reported that any supervisor never visits them from a child health programme.
31 The Coega mobile respondent indicated that they do go for monthly meetings to the TB coordinator, but they do not receive any visits from her.
32 The respondent from Coega mobile indicated that they last received a visit by an STI supervisor in the first quarter of 2002.
33 The respondent from Coega mobile indicated that they have never received any visit from an HIV/AIDS supervisor or coordinator.
34 Strangely enough the respondent at Motherwell mobile indicated that a pharmacist did visit NU 8 clinic, while the respondent from NU 8 indicated that the pharmacist did not visit this clinic. NU 8 is the base clinic for this mobile unit. They order their drugs from this clinic and it is stored in the dispensary of NU 8.
35 The respondent at the Motherwell mobile indicated that the infection control nurse last visited them at the base clinic in July 2002 to see whether they have enough stock for infectious diseases. The respondent at NU 8 fixed clinic, however, indicated that the infection control nurse did not visit them in the past three years. The question arises whether it is possible that this supervisor will only visit the mobile staff at NU 8 clinic. Both these facilities are Local Authority.
36 The respondent at Motherwell mobile indicated that they do not receive visits from the TB coordinator, although they go to her for monthly meetings.
37 The chief community health nurse last visited this mobile clinic in February 2003.

Generally, the impression from the data in regard to general PHC management supervision in Motherwell is that the services are very well supported. The general nursing supervisor or chief community health nurse of Motherwell visited all the facilities at least once, sometimes more often, in the year preceding the survey. However, this is seemingly the only source from which facilities receive frequent management support. None of the other programme managers or supervisors visited all the facilities in Motherwell in the past three years.

The infection control nurse visited only Coega mobile during the past three years and there is an infection control nurse stationed at Motherwell CHC. None of the other facilities received a visit from this supervisor.

A pharmacist/dispensary supervisor visited only NU 11 clinic in the past three years, and at a frequency of once in four months. However, there exists confusion between the respondents from NU 8 and the Motherwell mobile service, as the respondent from NU 8 indicated that no pharmacist visited the facility in the past three years, while the respondent at Motherwell mobile indicated that this person did visit NU 8 in the past year. The Motherwell mobile drugs are ordered and kept at NU 8 clinic, which serves as its base clinic. The question arises here why the pharmacist visits NU 11 four times per year and does not visit the other facilities (apart from NU 8 where there was uncertainty surrounding supervisory visits).

Personnel at only three of the seven facilities in Motherwell have been trained in IMCI at the time of the survey. These included NU 2 and NU 11 clinics and TanduXolo satellite. Of these three facilities, only the TanduXolo satellite respondent indicated that they received an in-facility visit by the IMCI trainer and supervisor since they were trained.

No laboratory technician has reportedly ever visited any of the Motherwell facilities.

A maternal health or family planning supervisor reportedly visited only NU 8, TanduXolo satellite and the Coega mobile in the past three years. The respondent at NU 2 clinic was uncertain whether they received any such visit during this time period.

Although the TB programme coordinator reportedly supports the programme in Motherwell sufficiently, she does not always visit the clinics, but regularly calls the relevant clinic personnel to her for discussions and meetings. The Motherwell CHC and the Coega and Motherwell mobiles did not receive any in-facility visits from her in the past three years.

The STI and HIV/AIDS programmes at PHC facilities in Motherwell seem in dire need of support. Although three facilities indicated that they received a visit from an HIV/AIDS programme supervisor in the past three years and two indicated that they received such a visit from an STI supervisor, the respondents from NU 8, NU 11 and TanduXholo indicated that there are in fact no supervisors for these two programmes in the Motherwell area. The confusion surrounding this issue and/or the lack of supervision and support for these two PHC programmes need to be addressed as soon as possible.

Gap-attack!

None of the programme managers or supervisors, apart from the general PHC manager/chief community nurse, visited all the facilities in Motherwell in the past three years. In most of the cases not even half of the facilities received in-facility visits from these supervisors. All the respondents at the Motherwell facilities indicated that they have never received a visit from a laboratory technician. Personnel of only three of the seven facilities in Motherwell have been trained in IMCI at the time of the survey. There is a severe lack of support and supervision by the HIV/AIDS and STI supervisors in Motherwell. Some of the respondents reported that there are no STI or HIV/AIDS programme supervisors for Motherwell. Only two of the respondents indicated that supervisory visits were received from such officials or managers in the past three years.

The service providers and the Metro Health Department responded as follows to this data: there are no appointed or designated programme managers, as the Nelson Mandela Municipality is still undergoing transformation. The present supervisors are performing their core functions in addition to running these programmes. The Senior Pharmacist and Deputy Nursing Service Manager for the Metro indicated that they visited all health facilities in September 2002. The Provincial Pharmacist does not visit the pharmacy of the Motherwell CHC from Dora Nginza Hospital, while two assistant pharmacists man it only.

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

Facility	PHC	Maternal health	IMCI	TB	STIs	HIV/AIDS
Motherwell CHC	✓[1]	×	×[2]	✓	×	×
NU 2	✓	×[3]	✓[4]	✓	✓	✓
NU 8	✓	×	✓[4]	×[6]	×[5]	×[5]
NU 11	×[7]	×[8]	×[9]	✓	×[5]	×[5]
TanduXolo satellite	✓	×	×	✓	×[5]	×[5]
Coega mobile	×	×	×[10]	✓	×	×[11]
Motherwell mobile	✓	×	×[12]	✓	×	×

1 One of the district information officers (DIOs) gave written feedback on low immunisation coverage, an insufficient number of babies are weighed, high referral rate to hospital, as well as the high TB treatment interruption rate.
2 No IMCI; only child health - feedback were received from the DIO on low rate of baby weighing and low immunisation coverage.
3 The respondent was uncertain whether such a supervisor visited the clinic within the past three years and no feedback was received on any of the reports submitted during the past three months.
4 IMCI as an integrated programme is not rendered at these facilities – no one trained – they did receive written feedback on child health issues though.
5 The respondents at NU 8, NU 11 and TanduXholo satellite indicated that there is no STI or HIV/AIDS supervisors for the facilities in Motherwell and that they do not receive any written feedback on these reports.
6 The respondent reported that they submit TB statistics monthly but do not receive any feedback.
7 According to the respondent from NU 11, the chief community health nurse gives feedback on a one-to-one basis.
8 There is reportedly no such supervisor for NU 11 and TanduXolo satellite.
9 The personnel of this clinic have reportedly been trained in IMCI but there is no IMCI supervisor for this clinic and they do not receive any written feedback on their reports.
10 No one at Coega mobile was trained in IMCI at the time of the survey. They do not receive any written feedback on child health issues either.
11 The respondent from Coega mobile indicated that they have never received any visit from an HIV/AIDS supervisor or coordinator and that they do not receive any feedback on HIV/AIDS reports either.
12 No one was trained in IMCI at this clinic at the time of the survey. They did not receive written feedback on child health issues.

Gap-attack!

Written feedback to clinics on the reports they submit to PHC managers are lacking in most cases – this problem relates to PHC management in general and to all the key PHC programmes. This problem is least pronounced in the case of the TB programme. Responses of the Metro Health Department and service providers in Motherwell on this data were as follows: written feedback is being submitted by the Information System Managers to all facilities. The data is then analysed and discussed on a monthly basis. None of the community health nurses were trained in IMCI, only 7 received in-service education by trained tutors. IMCI training is the responsibility of the provincial Department of Health under the Mother, Child and Women Health Sub-directorate.

Table 9: Date of last programme assessment performed

Facility	Date	
	STI (DISCA)	IMCI
Motherwell CHC	×	N/A[1]
NU 2	October 2002	×
NU 8	×	N/A[1]
NU 11	November 2002	January 2003
TanduXolo satellite	×	November 2002
Coega mobile	×	N/A[1]
Motherwell mobile	×	N/A[1]

1 Staff reportedly not trained in IMCI yet.

Gap-attack!

DISCA is seemingly only implemented at two of the seven facilities in Motherwell, as five of the facility respondents indicated that they have never heard of the DISCA tool.

❑ Constraints in managing the PHC programme and suggestions for improvement

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

Facility	Constraints	Suggestions
Motherwell CHC	▪ Insufficient doctor hours - clinics refer patients to CHC when in need of a doctor. A substantial number of these referred patients reach the CHC only later in the day and because the doctors only visit the CHC in the morning, these patients need to be referred to hospital for the attention of a doctor, which significantly increases the referral rate to hospital ▪ The CHC is in need of a radiographer, as they have an existing X-ray department with full equipment, but because there is no operator, this resource is not utilised. Patients have to be referred to the district hospital for X-rays. ▪ There is no pharmacist at the CHC (only two pharmacy assistants), which is problematic because this limits the EDL drugs to the avail of the visiting doctors for prescription. Consequently, cards need to be sent to hospital for necessary drugs. With the appointment of a full time pharmacist, all needed drugs could be kept and dispensed by the CHC pharmacy ▪ The operating theatre at the CHC is not being utiliSed, as there is no anaesthetist. With the appointment of an anaesthetist, minor operations will be possible at the CHC, which will decrease the minor operation load at the hospital ▪ The labour ward is too small. There are only two beds and two or three more beds are needed ▪ There is no transport to the avail of the staff of the CHC to trace TB patients and do support group visits ▪ Equipment items needed, i.e. there is a shortage of suction machines, bonanometers, oxygen cylinders, resuscitation trolleys and another incubator ▪ Overall shortage of nursing staff	▪ Full time doctor to be employed at CHC ▪ Full time radiographer to be employed at CHC ▪ Full time pharmacist to be employed at CHC ▪ Anaesthetist needed at the CHC ▪ Expand the labour ward ▪ Transport for staff needed ▪ Supply CHC with more suction machines, bonanometers, oxygen cylinders, resuscitation trolleys and another incubator ▪ More nursing staff should be employed at CHC
NU 2	▪ Staff shortage reported here – those who left have never been replaced ▪ More doctor hours needed, doctor should visit at least three times per week, ill patients frequently have to be referred to hospital or CHC - they are unable to render a full spectrum of services as the doctor does not visit often enough, ▪ There are no social workers available to attend to the social problems of clients ▪ Ambulance takes very long to arrive and nurses sometimes have to use their own transport to get patients to the hospital	▪ More professional nurses needed ▪ Doctor to visit clinic more often ▪ Social workers need to be made available ▪ Ambulance delays need to be addressed
NU 8	▪ High workload reported – the respondent indicated that the nurse/patient ratio is too low ▪ Nurses are not replaced when they leave ▪ The EDL need to be improved	▪ More nurses need to be employed in this clinic to improve working conditions ▪ High rate of unemployment in the community needs to be addressed ▪ Projects needed to keep youth busy in a constructive manner
NU 11	▪ Staff shortage ▪ Staff absenteeism also reported to be a problem	▪ More staff need to be employed at this clinic

TanduXolo satellite	▪ As this satellite clinic is run from a shack, there is no electricity or running water, which makes it very difficult for the personnel. The patients have no privacy. The nurses do not feel safe in the area. ▪ A shortage of staff was also reported to be a problem, however, there is no space in the shack for more staff to work	▪ All these problems might be solved soon as they are moving to a formal clinic building to function as a fixed clinic, with running water, electricity and more privacy for patients.
Coega mobile	▪ They reportedly experience a staff shortage – they are only three and when one of them falls ill, they really have a problems arise ▪ The long distances they have to drive tires them ▪ Staff can never have lunch because then patients have to wait for them ▪ There is no shelters for patients at certain points – patients stand in the sun and the rain waiting for service	▪ Shelters for patients at the different points should be provided
Motherwell mobile	▪ Shortage of certain medicine types in this mobile clinic – not because they do not order enough but because they do not receive the amounts they order	▪ Drug shortages in area need to be addressed

Gap-attack!

Six of the seven facilities in Motherwell view staff shortages/high workloads as an important constraint experienced in managing the PHC programme. A shortage of doctor hours, a lack of space at clinics for clinical work and for patients, equipment shortages and drug shortages were further reported to be problematic.

❑ Coordination of specific programmes

Table 11: Whether a specific health worker coordinates the programme in the clinic

Facility	Maternal health	IMCI	TB	STIs	HIV/AIDS	EDL
Motherwell CHC	✓	✓[1]	✓	×	✓	✓
NU 2	✓	✓	✓	✓	✓	✓
NU 8	✓	✓[1]	✓	✓	✓	✓
NU 11	✓	✓	✓	✓	✓	✓
TanduXolo satellite	✓	✓	✓	✓[2]	✓[2]	✓[2]
Coega mobile	×[3]	×[3]	×[3]	×[3]	×[3]	✓[3]
Motherwell mobile	×[4]	×[4]	×[4]	×[4]	×[4]	✓

1 Reportedly no one at Motherwell CHC, NU 8, Coega or Motherwell mobiles were trained in IMCI at the time of the survey. There, however, was one person responsible for child health/EPI in Motherwell CHC and NU 8. The nurses of the mobile units share the responsibility for these programmes.
2 One professional nurse coordinates STI, HIV/AIDS and EDL at TanduXolo satellite.
3 Because there are only two professional nurses working on this mobile clinic and in the satellite on Fridays, they share all the programmes between them, with the exception of the EDL programme, for which the enrolled nurse on the staff establishment takes responsibility.
4 The personnel of Motherwell mobile manage all the programmes together, except for EDL, which only one professional nurse is responsible for.

In most cases, specifically designated nurses took overall responsibility for PHC programmes at clinic level, except for Motherwell CHC, the respondent of which indicated that there was no-one designated for their STI programme, and the two mobile services, because their staff numbers are reportedly too limited to divide responsibility. They therefore share the responsibility for the different programmes, except for EDL, for which a specific staff member is designated in both cases.

Gap-attack!

Specific responsibility for programme coordination is lacking at the two mobile clinics in the area for all programmes except EDL, and at the Motherwell CHC, except for the STI programme.

Table 12: Regular staff discussions on PHC indicators

Facility	Maternal health	IMCI	TB	STIs	HIV/AIDS	EDL
Motherwell CHC	✓	✓[1]	✓	✓	✓	×
NU 2	✓[2]	✓	✓[2]	✓[2]	✓[2]	✓[2]
NU 8	✓	✓[1]	✓	✓	✓	✓
NU 11	✓	✓	✓	✓	✓	✓
TanduXolo satellite	×	×	×	×	×	×
Coega mobile	×	×	×	×	×	×
Motherwell mobile	✓[3]	✓[1]	✓[3]	✓[3]	✓[3]	✓[3]

1 No one at these facilities has been trained in IMCI yet. They do however discuss child health issues.
2 They are called to a central place (Corsten Centre) outside the clinic to workshop PHC monthly indicators.
3 The respondent at Motherwell mobile indicated that they have quarterly staff discussions on PHC indicators.

Gap-attack!
TanduXolo satellite and Coega mobile do not have regular in-service staff discussions on their PHC indicators.

❑ Programme-specific management constraints

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

Facility	Constraints	Suggestions
Motherwell CHC	▪ Equipment shortage – no bonanometer for this programme at this stage – three sent in for repair – bonanometer in casualty are used for this programme at this stage – no glucometer for this programme either ▪ Transport needed for maternity patients to hospital in cases of emergency, e.g. for patients with pregnancy induced hypertension or diabetes in pregnancy ▪ Telephone to their avail are frequently out of order and then they have to look for a public phone in vicinity	▪ Improve equipment supply as mentioned ▪ Transport for emergency cases should be supplied or ambulance service improved ▪ Reliability of telephone line to their avail should be improved ▪ Full time doctor needed at facility to reduce patient transfers to hospital
NU 2	▪ This clinic do not provide the full spectrum of maternity services – only family planning – need expressed to render the full spectrum of services – but for that they need full training and more space and personnel ▪ They reportedly need more space to render family planning services effectively	▪ Need more staff to render a full maternal health service ▪ Need more space – clinic need to be extended
NU 8	▪ There is an increase in teenage pregnancy ▪ Poverty is escalating the Motherwell community	▪ The cause of the high rate of teenage pregnancy need to be identified and something need to be done to address it ▪ Job creation needed for the community of Motherwell – especially amongst the youth in the community
NU 11	▪ The family planning clients have to wait to be seen as the treatment room is used for all clients. They should be able just to come and go, not wait so long – i.e. there is no real fast queue or separate section in the clinic for family planning	▪ A separate section for family planning should be created so their waiting time could be reduced.
TanduXolo satellite	▪ No privacy for patients	▪ Moving to the new fixed building will solve this problem
Coega mobile	▪ They have no modern foetal scopes, the old ones reportedly does not work well	▪ They need modern foetal scopes
Motherwell mobile	▪ They reported problems with family planning drugs that become unobtainable at times ▪ They are out of stock of family planning cards since January 2002 – now they have to give patients a piece of paper, which they lose easily	▪ The unavailability of certain drug types need to be addressed ▪ They need to have family planning cards for their clients again

Gap-attack!

Equipment shortages in the maternal health programmes were reported to be most problematic at Motherwell CHC (bonanometers and a glucometer) and the Coega mobile (more efficient foetal scopes). The Motherwell CHC further reported a need for a reliable ambulance service and telephone line. The respondent at NU 2 clinic reported a need for ANC staff training to facilitate rendering this service at the clinic. At this stage they only provide family planning services. The NU 2 and NU 11 respondents reported that they need more clinic space to effectively provide family planning services. The respondent at NU 11 indicated that the lack of space in the clinic, and the fact that they have to share the treatment room with other programmes, provides a fast queue for family planning patients impossible. The respondent at NU 8 clinic indicated that the escalating teenage pregnancy incidence in Motherwell needs to be addressed. Of greatest concern to the TanduXolo satellite respondent was the lack of patient privacy at the satellite clinic. The Motherwell mobile respondent indicated that unavailability of drugs and family planning patient cards to be their most serious maternal health programme constraints.

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

Facility	Constraints	Suggestions
Motherwell CHC	▪ Mothers tend to forget road to health cards ▪ They mostly lack milk and porridge stock for their PEM scheme ▪ Drug shortages – they frequently are out of certain antibiotics, panado syrup and BCG and measles vaccine stock and they do not receive cough mixture at all anymore ▪ Equipment shortage – they only have one infant scale and it was borrowed from another clinic	▪ All relevant staff need to be trained in IMCI ▪ Community need to be oriented in child health issues, CHWs should be trained to do health education in community ▪ Need a television/video recorder set to screen health education videos on child health issues for patients who are waiting at the clinic with their children ▪ Need frequent milk and porridge stock and drug control need improvement ▪ Need to be supplied with infant scales ▪ News papers and local radio stations need to be involved by printing/broadcasting information on child health
NU 2	▪ No-one at the clinic properly trained in IMCI and a need for this training was expressed, to better equip them to handle children's problems ▪ There is a shortage of staff assigned to child health, most are assigned to adult programmes ▪ Drug shortages are experienced from time-to-time, e.g. sometimes they have no polio vaccine for two to three days ▪ Not enough space in the clinic to effectively provide all services	▪ More professional nurses should be employed at this clinic ▪ Those working with children should be fully trained in IMCI ▪ Drug shortage hiccups should be addressed ▪ More consultation rooms should be build at the clinic ▪ A full time doctor should be employed here, which will reduce the referral rate significantly ▪ Feedback from hospital on patients referred there but treated at this clinic is necessary
NU 8	▪ The clinic is small and congested ▪ Shortage of drugs – if drugs run out they are not allowed to order before the stipulated time	▪ The clinic need to be extended so that there will be more space ▪ Medicines should be made more readily available
NU 11	▪ The respondent reported a staff shortage in the clinic ▪ The consulting room used for child health is too small, and there is only one where immunisation and weighing are done	▪ More staff should be employed at this clinic ▪ A larger consultation room should be availed to this programme – or more space should be provided
TanduXolo satellite	▪ The satellite clinic is a shack, no electricity, and no running water. Immunisations are kept in a cool bag. They use the refrigerator of NU 11, which is their base clinic, to store their vaccines overnight. ▪ A shortage of staff reported ▪ The satellite clinic is too small ▪ It is impossible to manage emergencies here – they have to refer to Motherwell CHC ▪ Lack of equipment ▪ No doctor visits this satellite clinic	▪ Moving to the newly build fixed clinic will hopefully solve most of these problems ▪ More staff should be employed when they are there ▪ A doctor should visit this new clinic
Coega mobile	▪ None of them have been trained in IMCI yet at the time of the survey ▪ Because they are short staffed (2 professional nurses and 1 enrolled nurse) they are mostly unable to attend the training courses because they feel that they cannot just leave the mobile or satellite clinics and go off on training	▪ They need training in IMCI ▪ More staff should be employed
Motherwell mobile	▪ Their measles and combact vaccines are frequently unobtainable from the main dispensary ▪ Milk and porridge products for their PEM scheme is frequently unobtainable	▪ Address the problems with availability of certain vaccines ▪ Address the scarcity of PEM nutritional products

* Because no one at some of the facilities was trained in IMCI at the time of the survey, the questions were posed with regard to the child health programme at these facilities (Motherwell CHC, NU 8, Coega and Motherwell mobiles).

Gap-attack!

Four facility respondents each as the major constraints in their IMCI/child health programmes reiterated a shortage of staff and drugs. Three of the facility respondents identified limited clinic space as a serous constraint, while two of the facilities indicated equipment shortages and a shortage of PEM scheme milk and porridge as serious constraints in their IMCI/child health programmes.

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

Facility	Constraints	Suggestions
Motherwell CHC	▪ Lack of transport to do defaulter follow-up ▪ Lack of food for patients who have to take medication every day ▪ TB district coordinator does not visit facility ▪ No facility-specific feedback received	▪ Need transport for follow-up and tracking defaulters ▪ Need feeding for TB patients ▪ TB district coordinator need to visit clinics and give specific feedback
NU 2	▪ The registration of TB patients takes very long ▪ Need additional consultation room for TB patients ▪ Need more staff to be assigned to TB patients ▪ TB drugs sometimes not effective	▪ Stationery for registration of TB patients should be reconsidered to involve the minimum writing ▪ Need another consultation room for TB patients ▪ Need another staff member to work with TB patients ▪ Improve TB drug effectiveness
NU 8	▪ This clinic reportedly has a very high defaulter rate as a result of malnutrition and unemployment in the community – they have nothing to eat before they have to take their medication and although the Red Cross supplies some food, it is not enough for everyone ▪ A shortage of staff makes it difficult to trace defaulters ▪ The transfer rate is high as patients move away often – those who move away are not easy to trace ▪ There is too much duplication in the recording system, i.e. the register, the blue file, green patient held cards, patient file and reporting system – this is a time consuming process and it leaves less time to trace defaulters, even though they have transport to do so	▪ Job creation for people in community necessary ▪ More food supplies for TB patients needed ▪ Employ more staff ▪ Reduce paper work
NU 11	▪ The respondent reported a shortage of staff at the clinic ▪ The respondent reported that they have problems doing home visits, as the crime rate in Motherwell is very high. They are reluctant to use the transport to their avail as a result of their fear of being hijacked	▪ An addition of staff should be considered ▪ The crime rate in Motherwell needs to be addressed. One way of doing this is by working toward more involvement from the community
TanduXolo satellite	▪ The consultation rooms are too small ▪ There is no running water for drinking and to wash hands. ▪ There are not enough toilet facilities. Males and females use the same toilet ▪ The walls of the shack are dirty and this creates unhygienic conditions	▪ More staff should be employed to help out in the TB programme and to help with tracing patients when they default as well as to arrange awareness campaigns ▪ More space should be provided ▪ Salaries of nurses need improvement
Coega mobile	▪ No problems reported	▪ None suggested
Motherwell mobile	▪ They frequently run short of TB medication	▪ Address the drug unavailability problems in the area

Gap-attack!

Three of the facilities identified a lack of staff to be a serious TB programme management constraint. Two facilities indicated a lack of food for TB patients before they take their medication, time consuming TB patient registration and a lack of space as important factors constraining effective TB control.

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

Facility	Constraints	Suggestions
Motherwell CHC	▪ No coordinator for this programme to work out drug orders ▪ Shortage of staff	▪ Need coordinator for this programme and more staff to implement the programme
NU 2	▪ Patients do not bring their partners to the clinic with them – which implies that one is treated but not the other which makes re-infection a problem ▪ Patients are reluctant to use condoms – the partner at the clinic blames the other for not wanting to use condoms	▪ If only STI contacts can be traced, re-infection rates can be reduced significantly ▪ More health education on the use of condoms to prevent the spread of STIs and HIV/AIDS needed
NU 8	▪ Shortage of drugs – at the time of the survey they reportedly had no drugs to treat STI patients – they were told that they would have to wait two weeks for certain drug items ▪ Partners of STI patients do not come for treatment – continuous re-infection is therefore problematic	▪ Drugs should be made more readily available ▪ Contacts of STI patients need to come to clinic ▪ Health education campaigns on STIs necessary
NU 11	▪ Non-compliance of patients is a serious problem ▪ STI patients don't bring their partners to the clinic for treatment ▪ There is a shortage of STI drugs. They also have problems with the pharmacists, who tell them to wait for their turn when they order medication. This is very frustrating.	▪ The pharmacist must make sure that they receive drug stocks as soon as possible after ordering it.
TanduXolo satellite	▪ The partners of STI patients do not come for treatment ▪ Frequent drug shortages are experienced in the STI programme	▪ Drug shortages should be addressed ▪ A strategy is needed to persuade STI clients to bring along their partners for treatment and health education
Coega mobile	▪ They reportedly do not see much STIs – no problems reported	▪ None suggested
Motherwell mobile	▪ The lack of privacy for patients in the mobile unit is not acceptable	▪ None suggested

Gap-attack!

Four out of the seven facilities indicated that the fact that STI patients do not bring their partners to the clinic for treatment is a serious constraint in clinic-based STI programme management. At three facilities, respondents indicated that they frequently suffer STI drug shortages at their clinics. Other constraints mentioned were a shortage of staff, patient non-compliance, and reluctance to use condoms. The respondent at Motherwell mobile indicated that the lack of patient privacy in the mobile clinic (especially audio privacy) is problematic.

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

Facility	Constraints	Suggestions
Motherwell CHC	▪ Lay councillors only help out at the clinic once per week. Nurses have to spend too much time counselling, which is time consuming and they do not get around to their other work	▪ Full time lay councillors needed. They also need to be paid by government.
NU 2	▪ The secrecy surrounding the disease is problematic. You are unable to tell the girlfriend or boyfriend if a client is HIV positive, so the infected person keeps on infecting others.	▪ None suggested
NU 8	▪ VCT takes a long time for every patient and since there is a shortage of staff, other patients who have to wait long, suffer. ▪ Because of shortage of staff, there is no time to visit AIDS orphans ▪ Vitamin B tablets and Folic acid used as boosters were reportedly out of stock for a while already at this clinic and because of very high unemployment and malnutrition rates amongst HIV positive patients, patients get very ill	▪ More staff should be employed to do VCT and visit AIDS orphans ▪ Drug shortages and delays should be addressed ▪ HIV positive patients should be encouraged in a way to tell their partners that they are HIV positive so that the partners can take precautions and that the partner can also go for a test. This is especially a problem among male partners who do not tell the females about their HIV positive status
NU 11	▪ Most HIV/AIDS clients are not working and poverty is a real problem. They mostly have nothing to eat and become very ill as a result and ultimately die prematurely. ▪ There is no communication between the provincial department and the municipality, e.g. patients are referred from Motherwell CHC with no blood results.	▪ More boosters are needed for HIV/AIDS clients e.g. vitamin B tablets, ferrous sulphate and folic acid. ▪ Communication between province and local authority needs to be optimised
TanduXolo satellite	▪ A lack of patient privacy was reported to be the most serious concern	▪ Hopefully the newly built clinic with separate consultation rooms will solve this problem
Coega mobile	▪ Patients flock to the ir clinic to be tested for HIV/AIDS (VCT) on Fridays so they can receive grants	▪ None suggested
Motherwell mobile	▪ No problems reported	▪ None suggested

Gap-attack!

Problems surrounding VCT were most frequently reported at the Motherwell facilities, i.e. Motherwell CHC needs more lay councillors to assist with counselling of VCT patients, the respondent from NU 8 reported that because VCT takes so long, other patients have to wait too long. Coega mobile also reported that patients flock in numbers to the clinics on Fridays for VCT, wanting to qualify for an HIV/AIDS grant if found positive. The respondent from NU 11 reported that HIV/AIDS patients mostly have nothing to eat and that poverty and hunger is a serious problem among these patients. The respondent further reported a communication breakdown between Motherwell CHC and this facility, as patients are referred back with no blood results. The respondent at NU 8 reported that their vitamin B tablets and other boosters used for HIV/AIDS patients have been out of stock for quite some time, and because most HIV/AIDS patients are unemployed, malnutrition and severe illness is a problem.

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

Facility	Constraints	Suggestions
Motherwell CHC	▪ No pharmacist at facility – only two assistant pharmacists who cannot dispense and supervise drugs prescribed by doctors especially	▪ Need full time pharmacist to supervise and dispense all the necessary drugs ▪ Need bars in front of windows for safety of the staff in the CHC ▪ Need microphones to call patients to the dispensing window – the waiting area of the dispensary is large and it is difficult for patients to hear when they are called
NU 2	▪ Not enough staff to manage the drugs ▪ Not enough room to store drugs properly ▪ Drug shortages experienced	▪ Hire more staff ▪ Provide more drug storage space ▪ Address drug shortage problem
NU 8	▪ Nurses at this clinic manage the dispensary and do the dispensing of drugs and therefore the nursing service in the clinic is less efficient	▪ Pharmacist and/or pharmacy assistants should be appointed at the clinic to manage the dispensary and the dispensing of drugs
NU 11	▪ Nurses at the clinic are tied up with consultations and do not have time to keep the bin cards up to date, check for expired drugs to dispense drugs ▪ Chronic drugs for hypertensives, Diabetics and Psychotic clients are not kept in the clinic and the patients have to travel far to obtain these ▪ Nurses are not trained in drug management – only briefly oriented by Mr Beja when he visited	▪ They need a pharmacist at the facility or have a visiting pharmacist to regulate the drugs every month and update the bin cards and check for drug expiry dates that is coming near ▪ Chronic drugs need to be available at this clinic ▪ Nurses need to be better trained in drug management if they cannot appoint a pharmacist at the clinic
TanduXolo satellite	▪ All the drugs are kept in a cupboard in one of the consultation rooms ▪ The nurses dispense the drugs themselves	▪ A proper dispensary room is needed for their drugs ▪ Someone needed to properly manage and dispense the drugs, e.g. an assistant pharmacist
Coega mobile	▪ The enrolled nurse responsible for the EDL programme at this facility indicated that she experiences a severe lack of time to order drugs and to manage the dispensary as she goes out with the mobile clinic for four days per week. Fridays, at the base clinic, she does all the dressings and injections. She does not have enough time for EDL	▪ They need someone else to manage the dispensary at Coega
Motherwell mobile	▪ The availability of drugs is not good. The respondent reported that they frequently run out of drugs – not because they did not order, but because it is unavailable at their supplier dispensary	▪ Address the shortage of drugs in the area

Gap-attack!

Five of the seven respondents interviewed about constraints in the management of drugs, indicated that the nursing personnel at the facilities do not have sufficient time for drug management. Only the CHC had assistant pharmacists. In all other cases drugs were managed by nursing personnel. This provides the efficiency of the nursing/clinical services at the facilities less efficient and it reduces the nursing hours available for clinical procedures. The respondent at Motherwell CHC indicated a need for a fully qualified pharmacist, as the EDL scope (limited because there is no pharmacist) is not sufficient for the needs of the sessional doctors. Drug shortages were also mentioned as a serious constraint in the management of the EDL programme. Service providers in Motherwell indicated at the feedback workshop that there is a dire need for pharmacists and pharmacy assistants for all health facilities in Motherwell.

3. Scope and accessibility of services

Table 19: Scope of PHC services offered

Services	Motherwell CHC	NU 2	NU 8	NU 11	TanduXolo satellite	Coega mobile	Motherwell mobile
ANC	✓	✗	✓	✗	✗	✓	✗
Complicated delivery	✗	✗	✗	✗	✗	✗	✗
Uncomplicated delivery	✓	✗	✗	✗	✗	✗	✗
Family planning	✓	✓	✓	✓	✓	✓	✓
Medical TOP	✗	✗	✗	✗	✗	✗	✗
Surgical TOP	✗	✗	✗	✗	✗	✗	✗
TOP counselling	✓	✓	✓	✓	✗	✗	✗
Pap smears	✓	✓[9]	✓	✓	✗	✓[14]	✓[16]
Post-natal care	✓	✗	✓	✗	✗	✓	✗
Child health	✓	✓	✓	✓	✓	✓	✓
Adult acute curative care	✓	✓	✓	✓	✓	✓	✓
Chronic disease management	✓	✗	✗	✗	✗	✓	✗
STIs	✓	✓	✓	✓	✓	✓	✓
TB care	✓	✓	✓	✓	✓	✓	✓
Mental health	✓	✗	✗	✗[1]	✗	✗	✗
Nutrition	✓	✓[10]	✓	✓[6]	✓	✓	✓
Health education/promotion	✓	✓	✓	✓[7]	✓	✓	✓
Home-based care	✗[13]	✓	✓	✗	✓	✗	✓
Repeat/fast queue for DOTS	✓	✓	✓	✓	✓	No[15]	No
Repeat/fast queue for chronics	✗	N/A[8]	N/A[8]	N/A[8]	N/A[8]	N/A[15]	N/A[8]
Basic oral health	✓[12]	✗[2]	✗[2]	✗[2]	✗[2]	✗	✗
Emergency care/casualty	✓	✗	✗	✗	✗	✗	✗
Violence/sexual abuse	✓	✗	✗	✗	✗	✗	✗
VCT	✓	✗	✓	✗[4]	✗	✓	✗
PMTCT	✓	✗	✓[5]	✓[5]	✓[5]	✗	✗

1 Although NU 11 does not offer mental health services, there is a visiting psychiatric nurse who meets clients half way around the area. This way it is more convenient for the clients and they do not have to travel all the way to the Motherwell CHC.
2 Basic oral health here mostly entails health education on the care of teeth at the Motherwell clinics.
3 Cases of violence and sexual abuse arriving at NU 11 are referred to the district surgeon.
4 NU 11 clients who qualify for VCT are referred to NU 8.
5 NU 8, NU 11, and TanduXolo satellite provide PMTCT clients of Motherwell CHC and Dora Nginza Hospital with continuation of treatment.
6 Children in need visiting NU 11 receive porridge and nutrition in various forms. Operation Hunger supports TB patients and other clients in need of food by providing ingredients for soup cooked by voluntary workers and DOT supporters. SANTA provides the clinic with two loaves of bread per day for the TB patients.
7 NGOs in the area assist with health education at NU 11 and Hospice pays the clinic a visit from time to time to advise on services.
8 No chronic disease management services provided at any of the Motherwell fixed clinics, only at the CHC and Coega mobile.
9 Pap smears are only done for steriliSation clients at NU 2.
10 Nutrition supplementation is only given to underweight clients.
11 Motherwell CHC provides mental health services on a daily basis.
12 A dentist serves Motherwell CHC five days per week.
13 Motherwell CHC does not provide home-based care, as there are NGOs who reportedly do this.
14 They book for Fridays so that they can do it in the base clinic – they are unable to do this in the mobile.
15 Only at the base clinic – this clinic operates as a mobile clinic four out of the five weekdays.
16 Pap smears are not done in the mobile unit, clients have to go to their consultation room at NU 8 for these.

ANC: routine ANC services should have been be introduced and in place at PHC facilities (clinics, mobiles and CHCs) by the end of 2001 (Department of Health 2001b: 21, 30). Only three of the Motherwell facilities (Motherwell CHC, NU 8, Coega mobile) provided this service at the time of the survey.

Pap smears: Pap smear services should have been in place at the end of 2002 (Department of Health 2001b: 22, 23, 31). All facilities provided this service at the time of the survey, except TanduXolo satellite. The two mobile clinics, however, only provided this service at their base clinics, booking patients throughout the week for this service.

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, no facility in Motherwell is providing any of these TOP services. The Metro Department of Health responded to this: There are designated sites for this service. All hospitals in the Metro are rendering this service and also the Marie Stopes private service. Staff members only share information with clients and afterwards refer them to the relevant sites.

TB: all PHC facilities should have been diagnosing and treating TB patients by the end of 2001 (Department of Health 2001b: 25, 32). Comprehensive PHC TB services were available at all the facilities in Motherwell at the time of the survey.

Walk through DOTS: in order to make the service user-friendlier, a walk through service for patients on DOTS should have been available from the end of 2001 (Department of Health 2001b: 28). This service was available at all Motherwell PHC facilities, except, understandably, the two mobile units.

VCT: VCT should be available at all PHC facilities by the end of March 2003 (Elgoni 2003). The survey was conducted in February 2003, by which time only Motherwell CHC and NU 8 provided this service. The Coega mobile provided this service on Fridays, when they have a fixed point in their base clinic.

PMTCT: Motherwell CHC, NU 8, NU 11 and TanduXolo satellite provided a PMTCT service at the time of the study. NU 8, NU 11, and TanduXolo satellite provided PMTCT clients of Motherwell CHC and Dora Nginza Hospital with continuation of treatment.

Mental health: by the end of 2001, mental health services should have been available at all PHC facilities (Department of Health 2001b: 27, 28, 33). At that stage only Motherwell CHC provided this service.

Home-based care: this service is organised into special needs; i.e. growth faltering, persons needing rehabilitation and palliative care. Home-based care should have been in place by the end of 2002. Home visits by auxiliary nurses should have been in place by 2001 (Department of Health 2001b: 15). Hence, Motherwell CHC, NU 11 and the Coega mobile should provide home-based care services. The respondent at Motherwell CHC indicated that NGOs takes responsibility for their home-based care needs.

Repeat/fast queue for chronics: 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 is only available at Motherwell CHC, who apart from the Coega mobile is the only facility that provides chronic disease management. The Coega mobile clinic has a fast queue for their patients as well, but only on Fridays when they have a fixed point in their base clinic.

Emergency care: casualty services should have been implemented at CHCs by the end of 2001 (Department of Health 2001b: 35). This service is offered at the Motherwell CHC.

Violence/sexual abuse: this service should have been available at PHC facilities from the end of 2001 (Department of Health 2001b: 22, 23). Therefore, this service should be available at all the facilities, not just at Motherwell CHC as it was at the time of the survey.

Gap-attack!

Routine ANC services should have been introduced and in place at PHC facilities (clinics, mobiles and CHCs) by the end of 2001 (Department of Health 2001b: 21, 30). Only three of the Motherwell facilities (Motherwell CHC, NU 8, Coega mobile) provided this service at the time of the survey.

According to the Package, 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 have been providing comprehensive TOP services by the end of 2002 (Department of Health 2001b: 23, 30). Despite these guidelines, no facility in Motherwell is providing any of these TOP services.

VCT should be available at all PHC facilities by the end of March 2003 (Elgoni 2003). The survey was conducted in February 2003, by which time only Motherwell CHC and NU 8 provided this service.

By the end of 2001, mental health services should have been available at all PHC facilities (Department of Health 2001b: 27, 28, 33). At the time of the survey only Motherwell CHC provided this service.

Home-based care should have been in place by the end of 2002. Home visits by auxiliary nurses should have been in place by 2001 (Department of Health 2001b: 15). Hence, Motherwell CHC, NU 11 and the Coega mobile should provide home-based care services.

Repeat fast queue for chronics should have been implemented at PHC facilities by the end of 2001 (Department of Health 2001b: 27). This service is only available at Motherwell CHC, who apart from the Coega mobile is the only facility that provides chronic disease management. The Coega mobile clinic has a fast queue for their patients as well, but only on Fridays when they are at their base clinic.

This service should have been available at PHC facilities from the end of 2001 (Department of Health 2001b: 22, 23). Therefore, this service should be available at all the facilities, not just at Motherwell CHC as it was at the time of the survey.

Table 20: PHC facility operational times

Facility	Days per week	Hours week days	Hours Saturdays	Hours Sundays	Total hours per week
Motherwell CHC	7[1]	24	24	24	168
NU 2	5	8¼	0	0	42.5
NU 8	5	8¼	0	0	42.5
NU 11	5	9	0	0	45
TanduXolo satellite	5	8¼	0	0	42.5
Coega mobile	5[2]	8¼	0	0	42.5
Motherwell mobile	5	4[3]	0	0	20[3]

1 Motherwell CHC OPD is open seven days per week from 07:00 to 16:00 hours while the labour and casualty departments are open seven days per week for 24 hours per day.
2 Coega mobile clinic runs from Monday to Thursday. On Friday the base clinic is open and they have a visiting doctor.
3 These hours are only an indication of when the mobile clinic is available to clients. The rest of their working day is spent at the base clinic on preparations, home visits and administration.

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 do not offer certain services on certain days, or do not offer them at all. (Harrison-Migochi 1998: 129). The situation in Motherwell revealed that although certain services are available on certain days, should a patient present at a clinic on a day that that service is not provided; he/she would not automatically be turned away. The Motherwell CHC, for instance, offers chronic care 'clinics' on certain days of the week, e.g. diabetes cases are seen once per week, hypertension cases twice per week, asthma cases are seen on Mondays and epilepsy cases on Fridays, although these services are available should a patient be unable to attend on the designated day. PMTCT counselling, emergency contraception and delivery services are available seven days per week for 24 hours per day, as is casualty/emergency services. No eye care clinic or any clinic for opportunistic infection in HIV/AIDS patients is available at the CHC and TOP and rehabilitation for disability services have to be found elsewhere. The facility does not offer home based care or home visits either and genetic counselling has to be found elsewhere as well. With regard to the services provided daily, Motherwell CHC appears to be offering the most comprehensive PHC service amongst the seven facilities under study. Also considering the large nursing component (32 nurses) and the size of the facility (24 consultation rooms in use and 4 not in use), one would expect an even more comprehensive service to be provided by this CHC. It is clear that the facilities in Motherwell have far to go in terms of providing the services as set out in the Package (Department of Health 2001a; 2001b).

Table 21: Number of days PHC services offered

Services	Motherwell CHC		NU 2		NU 8		NU 11		TanduXolo satellite		Coega mobile		Motherwell mobile	
	Days/ week	Other days if needed	Days/ week	Other days if needed	Days week	Other days if needed	Days week	Other days if needed	Days/ week	Other days if needed	Day week	Other days if needed	Days/ week	Other days if needed
Antenatal care	5	-	0	-	5	-	0	-	0	-	5	-	0	-
Family planning	5	-	5	-	5	-	5	-	5	-	5	-	5	-
Emergency contraception	7	-	0	-	5	-	5	-	0	-	0	-	0	-
Pap smears	5		5	-	5	-	5	-	0	-	1[9]	0	5[14]	-
TOP referral	5	-	5	-	5	-	5	-	0	-	5	-	0	-
Medical TOP	0	-	0	-	0	-	0	-	0	-	0	-	0	-
Surgical TOP	0	-	0	-	0	-	0	-	0	-	0	-	0	-
Immunisations	5	-	5	-	5	-	5	-	5	-	5	-	5	-
Child care/curative	5	-	5	-	5	-	5	-	5	-	5	-	5	-
TB treatment	5	-	5	-	5	-	5	-	5	-	5	-	5	-
Clinic-based DOT	5	-	5	-	5	-	5	-	5	-	5	-	5	-
STI treatment	5	-	5	-	5	-	5	-	5	-	1[9]	0	5	-
HIV clinic for opportunistic infections	0	-	0[2]	-	0	-	0	-	0	-	0	-	0	-
VCT	5	-	0	-	4	-	0	-	0	-	1[10]	0	0	-
PMTCT counselling	7	-	0	-	5	-	5	-	0	-	0	-	0	-
Delivery/ maternity	7	-	0	-	0	-	0	-	0	-	0[11]	-	0	-
Nutrition/growth monitoring	5	-	5	-	5	-	5	-	5	-	5	-	5	-
Basic eye care/refer	5[3]	-	5[3]	-	5[3]	-	5	-	5	-	5	-	5	-
Basic oral health/referral	5	-	5	-	5	-	5	-	5	-	5	-	5	-
Home visits by facility staff	0	-	0	-	5	-	0	-	0	-	5	-	5	-
Special hours for youth	5	-	0	-	0[4]	-	0	-	0	-	N/A[12]	-	N/A[13]	-
Adult curative	5	-	5	-	5	-	5	-	5	-	5	-	5	-
Chronic diseases[1]	1-2	✓	0	-	0[5]	-	0	-	0	-	5	-	0	-
Mental health	5	-	0	-	0[5]	-	0	½[7]	0	-	0	-	0	-
Genetic counselling	0	-	0	-	0[6]	-	0	-	0	-	0	-	0	-

1 The Motherwell CHC offers chronic care 'clinics' on certain days of the week, e.g. diabetes cases are seen once per week, hypertension cases twice per week, asthma cases are seen on Mondays and epilepsy cases on Fridays, although these services are available should a patient be unable to attend on the designated day.
2 This service is integrated with other adult and child health services.
3 They only treat eye infections – no optometry service.
4 The youth mostly use the youth centre in Motherwell.
5 They refer to Motherwell CHC.
6 They refer to the genetic clinic.
7 A provincial nurse specialising in mental health visits NU 11 clinic for half a day per month to see the mental health patients.
8 None
9 Coega mobile only do Pap smears and STI examinations on Fridays when the base clinic is open. They book for Pap smears and STI examinations while out on the mobile the rest of the week, as they cannot provide these services in the mobile due to a lack of patient privacy.
10 Coega mobile only do VCT on Fridays at the base clinic where there is enough time, space and privacy for patients. They book for VCT as they go around in the mobile clinic during the rest of the week.
11 They however do it in emergency cases, even in the mobile clinic if necessary.
12 Coega provides mobile clinic services for most of the week.
13 This is a mobile clinic and because they do not have a fixed point, they are unable to have special hours for youth.
14 The Motherwell mobile only does Pap smears at the base clinic, which is NU 8.

GAP-ATTACK!

Facilities in Motherwell appear to be behind the national average in many instances when it comes to the scope of services provided, especially with regard to ANC, chronic disease management, TOP, VCT, and home visits by facility staff.

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

The comparisons revealed the following:

- Family planning services on a daily basis in the Eastern Cape increased from 87% in 1997 to 99% in 1999 and then slightly 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 Motherwell 100% of the facilities offered family planning on a daily basis - this is well above 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 two facilities offered ANC services on a daily basis in Motherwell, one of which is Motherwell CHC, that has certain clinic days for certain chronic conditions, but do offer the services on other days as well. Overall, only three facilities in Motherwell offer chronic disease management services at all.
- 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 all facilities offered immunisation services on a daily basis in Motherwell.
- 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, a 100% of the facilities in Motherwell offered child care services on a daily basis in 2003.
- TB care was offered nationally on a daily basis in 2000 at 84.1% of the fixed facilities (Viljoen *et al.* 2000: 19). In Motherwell TB care was offered in all (100%) of the facilities, which is well above the national average of 84.1% set in 2000.
- STI care was offered nationally on a daily basis in 2000 at 94.9% of the fixed facilities (Viljoen *et al.* 2000: 17). Only one facility, i.e. Coega mobile, did not offer STI care on a daily basis, due to lack of patient privacy. They do however book patients for this service on Fridays, when they operate from their base clinic.
- HIV testing was offered nationally on a daily basis during 2000 at 56.2% of fixed clinics (Viljoen *et al.* 2000: 20). Six of the seven facilities in Motherwell offered either VCT or HIV testing on a daily basis. Coega mobile offered this service only on Fridays at their base clinic.
- 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. The facilities in Motherwell again compared very well to these averages, as 100% of them offered adult curative care on a daily basis.

- Chronic care on a daily basis in the Eastern Cape increased from 81% in 1997 to 91% in 1999 and 93% in 2000 (Mahlalela 2000: 56). At a far lower level of availability, chronic services were provided at only three of the seven facilities at all, and at two of the facilities on a daily basis, although, again, the Motherwell CHC arranges these services on different days, even though it is available on all other days of the week, should the need arise.
- 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). These services were only available at one of the Motherwell facilities on a daily basis and at another, half a day per month at a venue outside the clinic.

4. PHC facility equipment

❑ General PHC equipment

Table 22: General, diagnostic and clinical equipment[1]

Item	Motherwell CHC	NU 2	NU 8	NU 11	TanduXolo satellite	Coega mobile	Motherwell mobile
Adult scale	1 (8)	3	4	1	1	2[4]	1
Diagnostic sets	1 (6)	2 (1)	1 (2)	2	1	3[5]	0
Examination couch	17 (2)	6	6	7	1	5[6]	1
Examination light	2 (1)	1	5	7	0	2[7] (1)	1
Thermometer	32[2] (0)[3]	5 (5)	20	10	10	12[8]	4
Stethoscope	5 (18)	6 (3)	4 (1)	7	4	2	1
Blood pressure meter	1 (26)	4 (2)	5 (2)	7	1	5[9]	1
Otoscope	1 (6)	3 (1)	5 (2)	3	1	1	0
Glucometer	2 (1)	2 (1)	1	1	0	2[10]	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.
2 Twenty clinical and 12 rectal thermometers.
3 If the thermometers break, they are replaced immediately; they have no problems with this.
4 One of the Coega adult scales is used in the base clinic and the other one in the mobile clinic.
5 Two of the Coega diagnostic sets are used in the base clinic and the other one in the mobile.
6 There are four examination couches in the base clinic of the Coega mobile and one in the mobile – the one in the mobile is reportedly too small.
7 Two of the blood pressure meters to the avail of the Coega mobile are wall mounted in the base clinic. The other three are portable.
8 There is one examination light in the doctor's room at the base clinic and a portable torch for use in the mobile and base clinic. The examination light in the mobile clinic is out of order.
9 There are ten thermometers in the base clinic, five oral and five rectal, while there are two in the mobile unit, one oral and one rectal.
10 There is one glucometer in the Coega mobile and one in the base clinic.

Apart from NU 2 and NU 8, fixed and mobile clinics in Motherwell do not seem to experience serious problems with regard to broken equipment. It is clear, however, that the CHC is experiencing serious problems with out of order equipment that is not repaired or replaced. Reportedly, the Local Authority collects all the broken equipment from clinics every month for repair. The provincial department is however in charge of the CHC and they clearly do not offer the CHC sufficient support with regard to their equipment needs and the repair or replacement of broken equipment.

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

Table 23: Number of consultation rooms in use per facility

Item	Motherwell CHC	NU 2	NU 8	NU 11	TanduXolo satellite	Coega mobile	Motherwell mobile
Number of consultation rooms	24 (4)[1]	6	6	5	3[2]	3[3]	2[4]

1. The number in brackets depicts the number of consultation rooms that are not in use.
2. None of the consultation rooms in TanduXolo satellite offer audio or visual privacy
3. There are three consultation rooms in the Coega base clinic that are used on Fridays, one to the avail of the doctor and the other two to the avail of the nurses.
4. This mobile unit has a consultation room in the base clinic, which is NU 8, and then the one in the mobile unit self.

Adult scales: the respondent Motherwell CHC indicated that there is only one adult scale in working condition in the facility, eight of their adult scales are out of order. This implies that only one of the 24 consultation rooms at this facility has an adult scale in working condition, which means that all adult patients who need to be weighed need to be accompanied to this scale for weighing. This is an incomprehensible situation. 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 NU 2 and NU 8 clinics are in a favourable position, they respectively have three and four adult scales and both have six consultation rooms in use.

Examination couches: NU 2 and NU 8 clinics are in a comparably favourable position regarding examination couches, as every consultation room is equipped with an examination couch, while NU 11 and Coega base in fact have more examination couches than consultation rooms. Motherwell CHC only has 17 examination couches in working order for their 24 consultation rooms. The Department of Health (2001a: 13) does not set a standard for the number of examination couches needed in health clinics. However, it goes without saying that all, or at least most, consultation rooms need examination couches.

Examination lights: it is specifically stipulated by the Department of Health (2001a: 13) that every professional nurse and medical officer working on the same shift should be equipped with an examination light. The Motherwell CHC was again alarmingly short of examination lights. There are 28 professional nurses on the same shift at a time, as well as two doctors in the mornings, five days per week. Yet they only had a mere two examination lights to the avail of the entire facility. TanduXolo satellite did not have an examination light at all for their four professional nurses. Only Coega mobile had an examination light for every professional nurse on their staff. All the other clinics had less than one examination light per professional nurse on the same shift at the time of the survey.

Diagnostic sets: it is stipulated by the Department of Health (2001a: 13) that all PHC facilities should have at least one diagnostic set. The Motherwell mobile did not have one diagnostic set, while the Motherwell CHC had only one complete diagnostic set in the entire facility with 32 nurses per shift and 24 consultation rooms. All the other facilities had at least one complete diagnostic set.

Thermometers: thermometers in working order did not seem to be a problem at any of the facilities in Motherwell.

Stethoscopes: the unavailability of stethoscopes in working order again proved to be a serious problem in the Motherwell CHC. They had 18 stethoscopes that were out of order at the time of the survey, while only five in the entire facility were in working order. This is disturbing, as stethoscopes are needed in the routine screening of the majority of patients attending PHC facilities.

Blood pressure meters and otoscopes: blood pressure meters in Motherwell CHC again proved to be completely insufficient, as there was only one in working condition at the facility on the day of the field visit. A total of 26 blood pressure meters were out of order!. The need for blood pressure meters is clear as this is equipment used in the everyday screening of most patient categories (even though it is again not specifically stipulated by the Department of Health (2001a: 13). Arguably, otoscopes might be less important (not mentioned in the Package). NU 8 clinic was best off, with five otoscopes, while Motherwell CHC had only one.

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 it, however, it is recommended that all clinics have at least one in a working condition. However, both TanduXolo satellite and the Motherwell mobile did not have glucometers at all at the time of the survey.

Equipment in need of repair: Table 22 indicates that 68 items of equipment in Motherwell CHC were out of order at the time of the survey. Maintenance of equipment in this facility requires urgent attention. Reparation of existing equipment alone will greatly improve the capacity of the facility to deliver quality PHC services. The 21 broken pieces of equipment among the other facilities in Motherwell also need attention.

Gap-attack!

Apart from thermometers, the Motherwell CHC, with its 32 professional nurses on duty at a time and 24 consultation rooms in use, is in dire need of additional equipment of nearly all kinds. The most serious needs are additional adult scales (they only have one in working condition), diagnostic sets (they only have one complete set in working condition), examination lights (they only have two in working condition), stethoscopes (they only have five in working condition), and blood pressure meters (they only have one in working condition).

Among the seven PHC facilities in Motherwell, a total of 89 pieces of equipment were out of order at the time of the survey. The vast majority of these (68) were found in the Motherwell CHC. Urgent attention is required regarding equipment maintenance at the Motherwell CHC, but also overall in Motherwell PHC facilities.

- **Maternity programme equipment**

Table 24: Maternity programme-specific equipment and items

Item	Motherwell CHC	NU 2	NU 8	NU 11	TanduXolo satellite	Coega mobile	Motherwell mobile
Number of foetal scopes	3	N/A[4]	3	0[6]	0[6]	1	0[6]
Delivery sets	0[1]	0[4]	0[4]	0[6]	0[6]	1	0[6]
Sterile packs	0[1]	0[5]	0[5]	0[6]	0[6]	0	0
Neonatal resuscitation trolley	1	0[4]	0[4]	0[6]	0[6]	1	0[6]
Ventouse	0[2]	0[4]	0[4]	0[6]	0[6]	0[7]	0[8]
Forceps	0[2]	0[4]	1	0[6]	0[6]	0[7]	0[6]
Manual vacuum aspiration (MVA) syringe	0[3]	0[4]	0[4]	0[6]	0[6]	0[7]	0[6]
Privacy during TOP	0[3]	0[3]	0[3]	0[6]	0[6]	0[7]	0[6]
Private recovery space after TOP	0[3]	0[3]	0[3]	0[6]	0[6]	0[7]	0[6]

1 No delivery sets or sterile packs at the day of the survey – this has been sent to hospital for autoclaving – this means that if women gave birth here today, there would have been no sterile equipment to assist her.
2 No complicated deliveries done at the facility.
3 No TOP done here.
4 No deliveries done here.
5 Sterile are usually necessary for the Pap smears, however, there were none available at this clinic on the day we visited. They do however have a steriliser in working condition, which might be used towards this end.
6 No ANC, Maternity or TOP services are provided at NU 11, TanduXolo satellite or Motherwell mobile.
7 The Coega mobile does no TOP or deliveries.
8 They only have a ventise nebuliser machine..

The Department of Health (2001a: 16) sets the standard that all health clinics should have at least one foetal scope in working order. In Motherwell, however, against policy standards, only three facilities provide ANC services, all three of which did have foetal scopes at the time of the survey. Of the seven facilities visited in Motherwell, only the CHC is a designated PHC service that provides a delivery service. Yet there was no delivery sets or sterile packs available on the day of the survey. No TOP services are provided at any of the Motherwell facilities. Therefore, in summary, all deliveries are referred to the Motherwell CHC and all TOP candidates to the Dora Nginza Hospital, the referral hospital for the area.

Gap-attack!

Of the seven PHC facilities in Motherwell, only the Motherwell CHC is a designated PHC service that provides a delivery service. Yet there were no delivery sets or sterile packs in the facility on the day of the survey.

❑ **IMCI programme equipment**

Table 25: IMCI programme-specific equipment*

Item	Motherwell CHC	NU 2	NU 8	NU 11	TanduXolo satellite	Coega mobile	Motherwell mobile
Infant scale	1 (0)[1]	2	1	1[6]	1	2[7]	1
IMCI health education videos	0 (0)	1	1	0	0	0	N/A[9]
Measuring tapes for height and circumference	2 (2)	1	2	1	1	2[7]	1
Patella hammer	6 (4)	1	0	1	0	1[8]	0
Emergency equipment for intravenous resuscitation of severely dehydrated children	Yes[2]	Yes[3]	No[4]	Yes	No	No	No
Oral re-hydration corner	No	No	No	No[2]	No	No	N/A[9]

*Numbers in brackets depicts number in need of repair.

1 The one infant scale they have is borrowed from the Local Authority – they do not have their own.

2 The respondent indicated that they are frequently out of stock with regard to this item – she further indicated that they also need a device to calculate drip drops for children as well as a drip room at the CHC.

3 There is a litre of boiled cooled water every day, ready to be mixed with a rehydration solution e.g. ORS.

4 All severely dehydrated babies are referred to the Motherwell Health Centre.

5 NU 11 has no oral rehydration corner; the reason given is that there is no space for such a corner. However, the respondent indicated that there is always prepared ORS solution kept in the refrigerator ready for use.

6 The respondent from NU 11 indicated that they are in need of another infant scale. They recently were left without an infant scale for three months when they waited for theirs to be replaced. During this time, they could not weigh any babies.

7 There are one each of these measuring tapes and infant scales to the avail of the Coega mobile, one for the mobile unit and one for the base clinic.

8 There is one patella hammer in the base clinic, in the doctor's room.

9 This is a mobile unit and therefore it is not possible for them to have an oral re-hydration corner.

In accordance with the Package (Department of Health 2001a: 13) all the facilities in Motherwell had one or more infant scales. Not in line with the Package (Department of Health 2001b: 20) was that not all the facilities had emergency equipment for intravenous resuscitation of severely dehydrated children. Only Motherwell CHC, NU 2 and NU 11 clinics had this emergency equipment available on the day of the field visit. None of the facilities had an oral rehydration corner as stipulated by the Package (Department of Health 2001b: 20). The feedback workshop attendees responded that treatment rooms are used for rehydration services.

Gap-attack!

Only Motherwell CHC, NU 2 and NU 11 clinics had emergency equipment for intravenous resuscitation of severely dehydrated children, available on the day of the field visit, as stipulated by the Package (Department of Health 2001b: 20). None of the facilities had an oral rehydration corner as stipulated by the Package (Department of Health 2001b: 20).

❑ Cold chain maintenance

A range of observations was made in the facilities to determine the efficiency of the cold chain maintenance for vaccines.

Table 26: Cold chain maintenance

Item	Motherwell CHC	NU 2	NU 8	NU 11	TanduXolo satellite	Coega mobile[2]	Motherwell mobile[5]
Temperature record card present	✓	✓	✓	✓	N/A[1]	✓	✓
Last temperature recording	Same day	Same day	Same day	Same day	N/A[1]	Same day	Same day
Last recorded temperature	6⁰C	5⁰C	8⁰C	8⁰C	N/A[1]	2⁰C	8⁰C
Temperature at the time of the visit	7⁰C	4⁰C	8⁰C	8⁰C	N/A[1]	8⁰C	8⁰C
Number of days refrigerator out of order in the past month	0	0	0	2	N/A[1]	4	0
Electricity, gas, or paraffin driven refrigerator	Electricity	Electricity	Electricity	Electricity	N/A[1]	Electricity	Electricity
Refrigerator used exclusively for vaccines?	✓	✓	✓	✓	N/A[1]	×[3]	✓
Freezer compartment in refrigerator	✓	✓	✓	✓	N/A[1]	✓	✓
Ice packs in the refrigeration compartment	✓	✓	✓	✓	N/A[1]	✓	✓
Bottle/s of water in bottom of refrigerator	✓	×	✓	✓	N/A[1]	✓	✓
Space for circulation between vaccines?	×	×	✓	✓	N/A[1]	×[4]	✓
Refrigerator located at least 3 metres from a heater/air conditioner?	✓	✓	✓	✓	N/A[1]	✓	✓
Is the refrigerator located against an inside wall (away from direct sunlight)?	✓	✓	✓	✓	N/A[1]	✓	✓
Is the refrigerator located in an area where only clinic personnel have access to it?	✓	✓	✓	×	N/A[1]	✓	✓
Can the door to the room in which the refrigerator is located be locked?	✓	✓	✓	✓	N/A[1]	✓	✓

1 There is no refrigerator in this satellite clinic. They use the refrigerator at NU 11 to store their vaccines over night. They do not use a thermometer in the cooler box for cold chain maintenance.
2 The information in this table concerning Coega mobile only represents the conditions of cold chain maintenance at the Coega base clinic refrigerator. A cool box is used for cold chain maintenance in the mobile unit. No thermometer is used in this cool box. They also have no base refrigerator in the mobile unit.
3 The staff at the Coega mobile their vaccine refrigerator to keep water and cold drinks cool for them as well, reportedly because they only have one refrigerator to their avail. The Package (Department of Health 2001a: 13) specifies that all health clinics should have at least two working refrigerators to their avail, one for vaccines and the other for medicine. Yet, no provision is made for staff refreshments.
4 This is a small bar refrigerator. There is not enough space inside to store vaccines 5cm apart for circulation of cold air in between.
5 The Motherwell mobile uses the refrigerator of NU 8, which is represented in this table. They travel with a cooler bag. There were however no thermometer in the cooler bag. There is no base refrigerator in the mobile unit. Feedback workshop attendees indicted that their mobiles are not designed for base fridges.

Maintenance of temperature: all the facilities, apart from the Coega mobile, had a refrigerator that they used exclusively for vaccines and ice packs. The staff at the Coega mobile uses their vaccine refrigerator to keep water and cold drinks cool as well, reportedly because they only have one refrigerator to their avail. The Package (Department of Health 2001a: 13) specifies that all health clinics should have at least two working refrigerators to their avail, one for vaccines and the other for medicine. No provision is made for staff refreshments.

Observations on the prevailing temperatures in vaccine refrigerators: all the temperatures in the facilities' vaccine refrigerators were found to be acceptable according to the EDL guidelines (Department of Health 1998: 87), which stipulates that the cold chain temperature be maintained at between zero and eight degrees.

Monitoring and recording of temperature: both the Package (Department of Health 2001b: 23) and the EDL guidelines (Department of Health 1998: 86) stipulate that all PHC facilities should have temperature record cards in use so that vaccine refrigerator temperatures should be regularly monitored and recorded (twice per day). All the Motherwell PHC facilities had temperature cards and recorded temperatures at least on a daily basis.

Location of the refrigerator: the last four questions in Table 27 were derived from the EPI review instrument utilised in the EPI review conducted in the Free State during 2001. (The instrument was compiled by the national Review Coordinator: Assistant Director of EPI in South Africa.) It was found that in none of the facilities, the vaccination refrigerators were located within three metres from air conditioning equipment, which would be unacceptable as this equipment mostly produces heat and could affect the temperatures in the refrigerator. Furthermore, none of the refrigerators was located against an outside wall, which would be unacceptable as outside walls absorb sunlight which could also cause unwanted heat close to the refrigerator. The refrigerator at NU 11 was not located in an area where only clinic personnel had access to it. All the vaccination refrigerators were located in an area where the door can be locked.

Ice packs, cooler bags and thermometers: all the clinics had ice packs in the refrigeration compartments of the vaccine refrigerators as well as cooler bags in case of power failures and for maintaining the cold chain when vaccines need to be transported elsewhere, also working thermometers, as stipulated by the EDL guidelines (Department of Health 1998: 86). However, the vaccine refrigerators at Motherwell CHC, NU 2 and the Coega mobile were too full and there was not enough space (5cm) between each tray of vaccines to allow cold air to move around, as is stipulated by the EDL guidelines (Department of Health 1998: 86).

The two mobiles (Coega and Motherwell) as well as TanduXolo satellite made use of cooler bags to keep their vaccines cool during the daytime. None of these cooler bags, however, had thermometers in them to monitor the temperatures inside. Not one of the mobile units had base refrigerators in working condition. Attendees at the feedback workshop indicated that their mobile clinics were not designed for base refrigerators.

Overall, with the exception of a few things, cold chain maintenance in Motherwell facilities is overall relatively up to standard. The most serious concern is the fact that neither the satellite nor the two mobile clinics carry thermometers in their cooler bags for temperature monitoring.

Gap-attack!

The Coega mobile had only one refrigerator and did not use it exclusively for vaccines, but used it to keep cold drinks and drinking water cold for themselves. The Package (Department of Health 2001a: 13) specifies that all health clinics should have at least two working refrigerators to their avail, one for vaccines and the other for medicine. Although they only have one refrigerator, no provision is made for staff refreshments.

The refrigerator at NU 11 was not located in an area where only clinic personnel had access to it.

The vaccine refrigerators at Motherwell CHC, NU 2 and the Coega mobile were too full and there was not enough space (5cm) between each tray of vaccines to allow cold air to circulate, as is stipulated by the EDL guidelines (Department of Health 1998: 86).

None of these cooler bags used by the satellite clinic and two mobiles in Motherwell had thermometers in them to monitor the temperatures inside.

Not one of the mobile units had base refrigerators in working condition.

- **STI programme equipment**

Table 27: STI and HIV/AIDS programme-specific equipment

Item	Motherwell CHC	NU 2	NU 8	NU 11	TanduXolo satellite	Coega mobile	Motherwell mobile
Number of screened examination couches in working condition	0[1]	0	2	2	1	1[5]	0
Number of sterile specula in working condition	0[2]	1	0	14	0[4]	22[6]	1[8]
Number of condom dispenser/s with condoms in an accessible place where patients do not have to ask for them	1	1	0[3]	2	1	1[7]	N/A
Dildo/s for condom demonstration	2	1	1	1	2	2	1

1 None of the examination couches are screened – however there are doors to the consultation rooms[13].
2 This programme has no sterile specula to their avail – all specula are kept in the labour ward and they have to borrow from them if they need it.
3 The respondent indicated that if they place condom dispensers in the waiting room, children come and take condoms "to make balloons". Condoms are now kept in the reception office where patients need to ask for them. She added, however, that patients know where they have to ask for condoms.
4 TanduXolo satellite does not do Pap smears or deliveries and therefore do not require specula.
5 Only the Coega base clinic has a screened examination couch that can be utilised. The mobile couch is reportedly too small to use for STI examinations.
6 Ten of the sterile specula to the avail of the Coega mobile can be re-used after steriliSation, while they had 12 disposable ones in stock at the time of the survey.
7 They only have one in the base clinic. The mobile clients understandably have to ask for condoms.
8 The Motherwell mobile has sterile specula in the base clinic. They do not do Pap smears in the mobile clinic.

In accordance with the Package (Department of Health 2001a: 31), every health clinic should have at least one screened examination couch in working condition. Field workers did not observe any screened examination couches in Motherwell CHC nor NU 2. Attendees of the feedback workshop responded to this data that all examination couches have screens around them for client privacy, although field workers did not observe it. Motherwell CHC did not have any sterile specula on the day of the field visit, even though they do offer Pap smear and delivery services. TanduXolo satellite did not have specula either, however, they do not provide maternity or Pap smear services. All facilities, apart from NU 8, had at least one condom dispenser in an accessible place (where patients do not have to ask for them – Department of Health 2001a: 31-33).

[13] Whether they are locked during consultation or not is beyond the scope of this research.

Gap-attack!

In accordance with the Package (Department of Health 2001a: 31), every health clinic should have at least one screened examination couch in working condition. Field workers did not observe any of these at neither Motherwell CHC nor NU 2, although attendees of the feedback workshop said that all examination couches have screens around them for client privacy.
Motherwell CHC did not have any sterile specula on the day of the field visit, even though they do offer Pap smear and delivery services. NU 8 did not have a condom dispenser in an accessible place (where patients do not have to ask for them (Department of Health 2001a: 31-33).

❑ HIV/AIDS programme equipment

Table 28: Availability of a lockable storage room

Item	Motherwell CHC	NU 2	NU 8	NU 11	TanduXolo satellite	Coega mobile	Motherwell mobile
Lockable storage/filing room/cabinet for HIV/AIDS information sources	✓	✓	✓	✓	×[1]	✓	✓[2]

1 TanduXolo satellite does not keep any patient files. Clients keep all their files with them.
2 They lock their files away in the base clinic, NU 8.

All the facilities, except TanduXolo satellite, had a lockable storage room for HIV/AIDS information sources to be locked up and kept confidential.[14] The reason why they do not have such a room is that patients keep all their files with them. They do not keep any patient files in the facility.

❑ Sterilisation equipment and practices

Table 29: Sterilisation infrastructure per facility*

	Motherwell CHC	NU 2	NU 8	NU 11	TanduXolo satellite	Coega mobile	Motherwell mobile
Steriliser	1[1]	1	2 (1)	1	0	1	0[4]
Autoclave	0 (1)[2]	0	0	0	0	0[3]	0

* Number in brackets depicts the number of cylinders in need of oxygen and masks in need of sterilisation or repair respectively
1 They borrowed a small steriliser from the Local Authority – only appropriate to sterilise specula.
2 Numbers in brackets depicts equipment items out of order.
3 The Coega mobile mostly use disposable equipment that does not need a sterilisation.
4 They sterilise their equipment at the base clinics, in the case of TanduXolo satellite at NU 11 clinic and in the case of the Motherwell mobile, at NU 8.

The Package (Department of Health 2001a: 31) stipulates that all health clinics should have a steriliser. All facilities, apart from TanduXolo satellite and the Motherwell mobile had sterilisers. These two facilities, however, use the sterilisers at their base clinics.

❑ Emergency equipment

Table 30: Oxygen availability*

Item	Motherwell CHC	NU 2	NU 8	NU 11	TanduXolo satellite	Coega mobile	Motherwell mobile
Oxygen cylinder/s with 0_2	7 (0)[1]	1	2	2	1	2[2]	0
Oxygen mask/s	2 (2)[2]	1	2	1	1	2[2]	0

* Number in brackets depicts the number of cylinders in need of oxygen and masks in need of steriliSation or repair respectively.
1 Six are oxygen wall sockets and the seventh, a mobile cylinder – a need for more mobile cylinders was expressed.
2 Two of the four masks in the CHC were sent away to be sterilised on the day of the survey – the respondent indicated a dire need for more oxygen masks, some for adults and for children.
3 One each of the Coega oxygen cylinders and oxygen masks are used in the base clinic and one each in the mobile unit.

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[14] It is recommended that future studies establish whether these rooms are actually used to this end, as it is beyond the scope of this study to determine that.

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 the Motherwell mobile, all the facilities had an oxygen cylinder with oxygen and masks.

Gap-attack!
The Motherwell mobile did not have an oxygen cylinder with oxygen at the time of the survey, as is stipulated by the Package (Department of Health 2001a: 13).

❑ Equipment for communication and health education

Table 31: Equipment for communication and health education*

Item	Motherwell CHC	NU 2	NU 8	NU 11	TanduXolo satellite	Coega mobile	Motherwell mobile
Telephone/s	12	4	5	8	0[5]	1[8]	0[10]
Telephone line/s	2	1	1	2 (1)[2]	0[6]	1[8]	0
Fax machine/s	1	1	1	0 (1)[3]	0[6]	0	0
Computer/s	1[1]	0	0	0	0[7]	0	0
Audio-visual set/s	1	2	1	1[4]	0[7]	1[9]	0

* Number in brackets indicates number in need of repair.
1 The computer at Motherwell CHC is not utilised at all – the reason provided was that the printer is out of order and therefore the computer is useless to the facility.
2 The only line at NU 11 is out of order. The nurses make use of the two public phone lines in the clinic.
3 The fax machine at NU 11 is not working, as the telephone line at the clinic is faulty.
4 The audio-visual set at this facility is utilised for health education sessions.
5 They use a personal cell phone for communication at TanduXolo satellite.
6 There is no landline in TanduXolo satellite.
7 There is no electricity at TanduXolo satellite.
8 The Coega base clinic has a telephone line.
9 The Coega base clinic sometimes utilises their audio-visual set for health education on Fridays.
10 The Motherwell mobile did not have a two-way radio either. They have to use their personal cell phones if they need to communicate.

As stipulated by the Package (Department of Health 2001a: 13), all health clinics should be equipped with a reliable means of communication, either a two-way radio or a telephone. Only three of the seven facilities in Motherwell (Motherwell CHC, NU 2 and NU 8 clinics) were equipped with relatively reliable official communication equipment for everyday use (only NU 8 clinic reported that their telephone line was out of order for 1 day during the month preceding the survey). Neither TanduXolo satellite nor the Motherwell mobile had any official means of communication (they only had their personal cell phones). The Coega mobile clinic personnel also make use of their personal cell phones when travelling around to their points from Monday to Thursday, but did have an official land line in working condition at their base clinic. NU 11 had no official landline either and utilises the two public phones on the premises.

All the fixed facilities had fax machines, although NU 11 reported that their fax machine could not be utilised, as they do not have a landline in working order. Motherwell CHC was the only facility with a computer. They did however, not utilise it at all, reportedly because the printer is out of order. The question arises why this expensive piece of equipment was bought but is not maintained. This question goes for all the other pieces of equipment (77 on those we asked about alone) in the Motherwell CHC as well.

All facilities, apart from, understandably, TanduXolo satellite (that do not have an electricity supply) and the Motherwell mobile had audio-visual equipment to their avail.

Gap-attack!

As stipulated by the Package (Department of Health 2001a: 13), all health clinics should be equipped with a reliable means of communication, either a two-way radio or a telephone. Only three of the seven facilities in Motherwell (Motherwell CHC, NU 2 and NU 8 clinics) were equipped with relatively reliable official communication equipment for everyday use. Motherwell CHC was the only facility with a computer. They did, however, not utilise it at all, reportedly because the printer has been out of order for a long time. The question arises why this expensive piece of equipment was bought but is not maintained in a working condition. This question goes for all the other broken pieces of equipment (77 of those we asked about alone) in the Motherwell CHC as well.

- **Self-reported equipment needs**

Motherwell CHC:

- Benches for patients to sit on: the majority of their patients have to sit on the floor while waiting to be served.
- Four suction bottles: they prefer the old type; the new type is reportedly unreliable.
- More wall mounted blood pressure metres.
- A steriliser of their own: the one they used at the time of the survey was borrowed from the Local Authority.
- An autoclave in working condition: theirs is broken.
- A printer in working order.
- A public address system (intercom) to communicate with patients and personnel in the waiting areas. This is specifically much needed in the pharmacy department and the records office.
- Transport: they do not have transport at all and therefore cannot trace patients.
- They need a refrigerator of their own for vaccines: at the time of the survey they are borrowing one from the local authority.
- Ceiling fans.
- Heaters for every consultation room.
- A CTG machine in the labour ward.

NU 2 fixed clinic:

- More bonanometers in working order, preferably wall mounted bonanometers for each consultation room.
- Better lighting for Pap smears: the fixed light to their avail is not sufficient.
- More specula.

NU 8 clinic:

- More chairs in the waiting areas.
- More space for waiting areas.
- More space and beds for a delivery ward.

NU 11 fixed clinic:

- The respondent from this clinic indicated that they do not need any additional equipment.

TanduXolo satellite:

- A dire need for more space was the most important need expressed by the respondent at this facility.

Coega mobile:

- An air conditioning system or fans both in the mobile and the fixed building.
- An X-ray visual light in the doctor's room at the base clinic to enable him to read X-rays.
- A larger refrigerator: the one they have is too small for its purpose.
- A nebuliser.

Motherwell mobile:

- More blood pressure machines, otoscopes, stethoscopes, adult scales.
- An HB meter and a glucometer.

The above-mentioned needs for equipment have to be weighed against both the patient load and the staffing establishments of the concerned facilities. However, the Motherwell CHC is clearly in need of more equipment, as was seen throughout this section of the report.

- **Electricity supply**

In accordance with the Package (Department of Health 2001a: 13), all PHC facilities should enjoy a reliable electricity supply. This was not always the case in Motherwell. Interruptions in the month preceding the survey ranged from 30 minutes at NU 2 clinic, three hours each at the CHC and NU 8 clinics, and five days at NU 11. The Coega mobile uses their vehicle battery for power and had no problems with it at the time. Strangely enough, the respondent at Motherwell mobile reported that they experience power interruptions at their base clinic (NU 8) every week for an hour or two, while the respondent there indicated that they only had one three-hour interruption in the month preceding the survey.

Gap-attack!

In accordance with the Package (Department of Health 2001a: 13), all PHC facilities should enjoy a reliable electricity supply. This was not always the case in Motherwell as power interruptions in the month preceding the survey were reported by six of the seven clinics. NU 11 experienced a power interruption of five days.

5. PHC diagnostic tests

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

Table 32: Diagnostic tests offered and turn-around times

Test	Motherwell CHC		NU 2		NU 8[3]		NU 11		TanduXolo satellite		Coega mobile		Motherwell mobile	
	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)	Offered?	Turn-around time (days)	Offered?	Turn-around time (days)
HIV (laboratory)	✓	4	✓	2	×[2]	-	✓	2	✓	7	✓	3	×[2]	-
Syphilis in pregnancy (RPR)	✓	3.5	✓	2	✓	3	×[1]	-	×	-	✓	3.5	✓	5
Screening for haemoglobin/blood group/RH (Rhesus test)	✓	3.5	×[1]	-	×	-	×[1]	-	×	-	✓	7	×[1]	-
Pap smear	✓	5	✓	14	✓	2-3	✓	7	×	-	✓	14	✓	5
TB – AFB/smear	✓	2	✓	1	✓	2-3	✓	2	✓	3	✓	1	✓	5

1 No ANC services provided at these facilities.
2 The respondents at both NU 8 and Motherwell mobile indicated that they only do VCT.
3 The respondent from NU 8 were asked the same questions about test turn-around times on two separate days and her responses differed substantially on these two occasions. The responses from the re-interview are depicted here. It was clear that she does not accurately know the turn-around times for these tests, e.g. she indicated that a Pap smear result could be available after one day if she phones. Is this really possible?
4 NU 11 and does not provide ANC services.

- **PHC test practices**

The respondents from both NU 8 clinic and Motherwell mobile indicated that they only offer VCT and no other laboratory tests for HIV/AIDS suspects. The Metro Department of Health however believe that HIV/AIDS laboratory tests are being offered by all the Motherwell facilities. The Motherwell mobile only does VCT at their base clinic (NU 8). Pap smears are offered by all the facilities except TanduXolo satellite, as they do not have a private consulting room for this. All the facilities offer AFB tests for suspected TB cases.

The respondent at NU 8 clinic indicated that they do not offer screening for haemoglobin/blood group/RH (Rhesus tests) at all, although they did offer ANC services. The Metro Department of Health responded to this data. According to them this clinic do offer these tests. However, the respondent on the day of the field visit was under a different impression. Both other clinics offering ANC services did offer this test. All three clinics offering ANC services did offer syphilis tests to pregnant mothers.

- **Turn-around times for tests[15]**

Reported test turn-around times differ substantially among the seven facilities[16]. According to the Package (Department of Health 2001a: 25) HIV test turn-around times should be available within a week. All Motherwell facilities which offered these tests, reported turn-around times in line with this guideline. 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 four of the seven facilities accomplished (Motherwell CHC, NU 2 and NU 11 fixed clinics and Coega mobile. If Motherwell was a rural area, this might have been understandable, but seeing that there is a laboratory available within this urban area and some reported sputum turn-around times are below the standard, the situation requires district management attention.

[15] As far as could be established national standards for RPR, Rhesus-tests and Pap smears have not been laid down.
[16] Plausibly, the respondents were not all well informed about the turn-around times – verification of this data by district programme managers is recommended.

Gap-attack!

Respondents at NU 8 clinic and Motherwell mobile indicated that they only offer VCT and no other laboratory tests for HIV/AIDS suspects. The Motherwell mobile only offers VCT at their base clinic (NU 8).

The respondent at NU 8 clinic indicated that they do not offer screening for haemoglobin/blood group/RH (Rhesus tests) at all, although they do offer ANC services.

Reported test turn-around times differ substantially among the seven facilities.

The TB Control Programme guidelines (Department of Health 2000: 14) stipulate that AFB/smear tests results for pulmonary TB are available within 48 hours, a standard that only four of the seven facilities accomplished. NU 8, TanduXolo satellite and the Motherwell mobile did not accomplish this.

Plausibly, the respondents were not all well informed about the turn-around times of tests offered at their clinics – verification of this data by district programme managers is recommended. Representatives at the Metro Department of Health responded to this data after the feedback workshop. According to them, sputum microscopy has a turn-around time of 48 hours, culture and sensitivity five to seven days and for MDR TB diagnosis, one month. They also reported that results can be obtained telephonically should the need arise. Question is how will the clinic/s without access to an official telephone go about this.

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 Motherwell stand in terms of implementing the Package in respect of the EDL programme?

The Motherwell mobile is not represented in the section on drugs and supplies as they use the same drug store as NU 8 (their base clinic) as well as order their drugs with this clinic. The information depicted under NU 8 in the table, also represents the drug situation of the Motherwell mobile.

- **Stock control**

As stipulated by the Package (Department of Health 2001a: 13), all health clinics need to be equipped with stock control cards and these should be kept up to date. However, although six of the seven facilities had stock control cards (although not for all drug programmes) none of the facilities had stock-control cards that were all up to date. This situation, as previously mentioned, could be ascribed to the fact that none of the fixed or mobile clinics or the satellite clinic had dispensary support personnel. TanduXolo satellite did not use any stock control cards at all. Why the Motherwell CHC did not have an up-to-date stock control system is another question, as they have two pharmacy assistants employed at the facility. On the positive side all the facilities had secure lockable storage rooms or cupboards for drug stocks, which is in accordance with the Package.

Gap-attack!

Stock control cards are not implemented in TanduXolo satellite. None of the stock control cards at any of the other facilities were all up to date. Representatives of the Metro Health Department indicated after the feedback workshop that the implementation of the pharmacy assistant programme could solve this problem.

❑ Maternal health[17] programme drugs and supplies

Table 33: Maternity programme drugs

Item	Motherwell CHC			NU 2			NU 8			NU 11			TanduXolo satellite			Coega mobile		
	S [1]	FEFO [2]	NE [3]	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Injectable contraceptives	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Oral hormonal contraceptives	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×
Post-coital contraceptives (emergency pill)	✓	✓	×	✓	✓	✓	×	-	-	×	-	-	×	-	-	✓	✓	✓
Iron/ 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	×	-	-	×	-	-	×	-	-	×	-	-	×	-	-	×	-	-

1 ✓ = Stock available.
2 ✓ = Stock organised according to the FEFO principle.
3 ✓ = No expired stock observed.

In accordance with the Package (Department of Health 2001a: 16), all facilities had a supply of oral and injectable hormonal contraceptives at the time of field visits, although some of the oral hormonal contraceptives at Motherwell CHC and Motherwell mobile had expired. Only three of the six facilities represented in this table had a supply of emergency contraceptives. NU 8, NU 11 and TanduXolo satellite did not have any in stock at the time of the survey.

In accordance with the EDL guidelines (Department of Health: 1998: 70), all antenatal patients should receive routine iron and folic acid supplementation as a preventative measure. Not all facilities had these tablets in stock. Motherwell CHC did not have any folic acid supplements in stock, while NU 8 and TanduXolo satellite did not have any iron tablets in stock. TanduXolo satellite, however, do not offer ANC services, but Motherwell CHC and NU 8 do offer these services and it is therefore imperative that they have these supplements in stock. Some of the folic acid tablets at the Coega mobile dispensary were expired and not stored according to the FEFO principle.

The EDL guidelines (Department of Health 1998: 73) further specify that all babies should receive vitamin K IM 1mg immediately after birth to prevent

[17] Here defined as ante- and postnatal care and family planning.

hypoprothrombinaemia. Motherwell CHC, the only facility that provides delivery services in Motherwell, did have this item in stock.

The Motherwell CHC did have nevirapine in stock, as they did implement PMTCT at the time of the survey. It is difficult to determine whether the other clinics are required to stock this item. Even though it is not part of the essential drug list for clinics, the Package (Department of Health 2001a: 18, 33) does specify that post-exposure prophylaxis of occupationally acquired HIV exposure (e.g. needle stick injuries) should be stocked.

Mysoprostil was not available at any of the clinics as none of them provided TOP services. However it is stipulated in the Package (Department 2001b: 18, 23) that medical TOPs should be done at CHCs and PHC clinics, if the pregnancy has lasted nine weeks or less.

TABLE 34: MATERNITY PROGRAMME SUPPLIES

Item	Motherwell CHC			NU 2			NU 8			NU 11			TanduXolo			Coega mobile		
	S[1]	FEFO[2]	NE[3]	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Pregnancy test Kit	✓	✓	✗	✗	-	-	✗	-	-	✗	-	-	✗	-	-	✗	-	-
Rapid Rhesus Tests	✗	-	-	✗	-	-	✗	-	-	✗	-	-	✗	-	-	✗	-	-
Glucostix	✓	✓	✓	✗	-	-	✓	✓	✓	✓	-	-	✗	-	-	✓	✓	✓
Uristix	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Intrauterine contraceptive devices (IUCDs)	✗	-	-	✗	-	-	✗	-	-	✗	-	-	✗	-	-	✗	-	-

1 ✓ = Stock available.
2 ✓ = Stock organised according to the FEFO principle.
3 ✓ = No expired stock observed.

According to the Package (Department of Health 2001a: 13; 2001b: 22), all clinics should be able to screen for pregnancy when necessary and should have pregnancy tests. Only Motherwell CHC had these kits in stock and some of them were expired. None of the Motherwell facilities had implemented rapid Rhesus tests at the time of the survey; therefore none of them had these test kits in stock.

Neither NU 2 clinic nor Coega mobile had glucostix in stock at the time of the survey, although they both indicated that they have glucometers. All facilities had uristix in stock at the time of the survey, but some of the stock at Motherwell CHC had expired.

The Package (Department of Health 2001a: 16) stipulates that all health clinics should have intrauterine contraceptive devices. None of the clinics in Motherwell had these devices in stock. Representatives of the Metro Health Department indicated after the feedback workshop that few staff members are skilled in rendering this service in the whole metro; they are under the impression that clients are no longer using this method as a method of choice.

Gap-attack!

Some of the oral hormonal contraceptives at Motherwell CHC and Motherwell mobile were expired. NU 8, NU 11 and TanduXolo satellite did not have any emergency contraceptives in stock on the field visit days. 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. Motherwell CHC did not have any folic acid supplements in stock, while NU 8 and TanduXolo satellite did not have any iron tablets in stock. TanduXolo satellite did not offer ANC services, but Motherwell CHC and NU 8 do offer these services and it is therefore imperative that they have these supplements in stock. Some of the folic acid tablets at the Coega mobile dispensary were expired and not stored according to the FEFO principle. According to the Package (Department of Health 2001a: 13; 2001b: 22), all clinics should be able to screen for pregnancy when necessary and should have pregnancy tests. Only Motherwell CHC had these kits in stock and some of them were expired.

Gap-attack!

Neither NU 2 clinic nor Coega mobile had glucostix in stock at the time of the survey, although they both indicated that they do have glucometers. Some of the uristix stock at the Motherwell CHC had expired at the time of the survey. The Package (Department of Health 2001a: 16) stipulates that all health clinics should have intrauterine contraceptive devices. None of the clinics in Motherwell had these devices in stock. Representatives from the Metro Health Department indicated after the feedback workshop that there are few staff members who are skilled in rendering this service in the whole metro and they are under the impression that clients are no longer using this method as a method of choice.

- **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 implementing the IMCI/child health programme. All the drugs observed at the facilities are listed in the EDL guidelines (Department of Health: 1998).

Table 35: Drugs and supplies used for rehydration

Item	Motherwell CHC			NU 2			NU 8			NU 11			TanduXolo			Coega mobile		
	S[1]	FEFO[2]	NE[3]	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Salt and sugar	✗	-	-	✗	-	-	✗	-	-	✗	-	-	✗	-	-	✗	-	-
Teaspoons/millimeter measures	✗	-	-	✓	-	-	✗	-	-	✗	-	-	✗	-	-	✓	-	-
Litre measures	✓	-	-	✗	-	-	✗	-	-	✗	-	-	✗	-	-	✗	-	-
Cups	✓	-	-	✓	-	-	✗	-	-	✗	-	-	✗	-	-	✓	-	-
ORS packets	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

1 ✓ = Stock available.
2 ✓ = Stock organised according to the FEFO principle.
3 ✓ = No expired stock observed.

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. None of the faculties met this standard. All the facilities had ORS packets in stock for the rehydration of dehydrated children and it would seem like ORS packets are used for children with diarrhoea whether they are dehydrated or not. These packets are more expensive than a homemade salt and sugar solution and it is recommended that that the solution is only used in cases not dehydrated.

Table 36: Drugs and supplies used in severely dehydrated children

Item	Motherwell CHC			NU 2			NU 8			NU 11			TanduXolo			Coega mobile		
	S[1]	FEFO[2]	NE[3]	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Ringer-lactate or Normal Saline (4 sets)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	-	-	✓	✓	✓
Blankets (for babies in shock)	✓	-	-	×	-	-	×	-	-	×	-	-	✓	-	-	✓	-	-

1 ✓ = Stock available.
2 ✓ = Stock organised according to the FEFO principle.
3 ✓ = No expired stock observed.

The Package (Department of Health 2001a: 62) specifies that all clinics should stock ringer-lactate or normal saline for use in children with severe dehydration. TanduXolo satellite did not have one of these items in stock. Three of the six facilities represented in this table (NU 2, NU 8, NU 11), did not have any blankets with which to keep babies/children in shock warm.

Table 37: Vaccines

Item	Motherwell CHC			NU 2			NU 8			NU 11			TanduXolo			Coega mobile		
	S[1]	FEFO[2]	NE[3]	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Oral polio vaccine	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
DPT (or DPT Hib) vaccine	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hepatitis B	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tetanus toxoid vaccine	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
BCG vaccine	✓	✓	✓	×	-	-	×	-	-	✓	✓	✓	×	-	-	×	-	-
Measles	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

1 ✓ = Stock available.
2 ✓ = Stock organised according to the FEFO principle.
3 ✓ = No expired stock observed.

Vaccination is an important component of the IMCI/child health 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. It is therefore encouraging that all the listed vaccines were in stock on the field visit days, all were stored according to the FEFO principle, were they not from the same batch, and none were expired. The only exception was BCG, but this is mostly given just after birth in a maternity ward and the Motherwell CHC did have a supply of this vaccine in stock. However, according to a set of guidelines (six booklets) produced in collaboration with the Equity Project (Department of Health [s.a.] *Priorities in child health: easily digestible information for health workers on managing the young child)*, if no visible scar appears 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. Disturbing in this light is the fact that none of the other two facilities offering post-natal care (NU 8, Coega mobile) had BCG vaccine in stock on the field visit days. Representatives of the Metro Health Department, however, responded to this information after the feedback workshop. They indicated that intradermal BCG was introduced in the year 2000 and according to the EPI policy it must be checked at 6 weeks and during subsequent visits but it may not

be repeated. It is clear from this that policy documents to the avail of health workers are not always consistent.

Table 38: Supplies for vaccination programme

Item	Motherwell CHC	NU 2	NU 8	NU 11	TanduXolo	Coega mobile
Sterile water for injection	✓	✓	✓	✓	✓	✓

1 ✓ = Stock available.
2 ✓ = Stock organised according to the FEFO principle.
3 ✓ = No expired stock observed.

Coega mobile did not have a porridge product in stock on the field visit day. All facilities in Motherwell, however, had a milk product in stock. These products are used to supplement the feeding of malnourished children. However, not all clinics had all the micronutrients as listed in the EDL guidelines (Department of Health 1998: 112). NU 2 and Coega mobile did not have iron supplements for children, while neither Motherwell CHC nor NU 11 had any vitamin A supplements in stock. None of the clinics stocked vitamin C tablets for children. All facilities had vitamin B complex supplements in stock.

Table 39: Nutritional supplements

Item	Motherwell CHC			NU 2			NU 8			NU 11			TanduXolo			Coega mobile		
	S[1]	FEFO[2]	NE[3]	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Infant nutrition supplements: Milk	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Infant nutrition supplements: Porridge product	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	-	-
Supply of iron supplementation for children	✓	✓	✓	×	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	-	-
Vitamin A capsules or solution	✓	×	✓	✓	✓	✓	✓	✓	✓	×	-	-	✓	✓	✓	✓	✓	✓
Vitamin C for use in children	×	-	-	×	-	-	×	-	-	×	-	-	×	-	-	×	-	-
Vitamin B complex for use in children	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

1 ✓ = Stock available.
2 ✓ = Stock organised according to the FEFO principle.
3 ✓ = No expired stock observed.

Table 40: Antibiotics, drugs and supplies used in the management of ear, nose, throat and pulmonary and other conditions in children

Item	Motherwell CHC			NU 2			NU 8			NU 11			TanduXolo			Coega mobile		
	S[1]	FEFO[2]	NE[3]	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Cotrimoxazole syrup (combination of trimethoprim and sulfamethoxadole)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Benzylpenicillin	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	-	-
Prednisolone	✓	✓	✓	✓	✓	✓	×	-	-	✓	✓	×	×	-	-	✓	✓	✓
Salbutamol inhaler	✓	✓	✓	✓	×	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nebuliser/tubing masks	✓	-	-	✓	-	-	✓	-	-	✓	-	-	✓	-	-	×	-	-
Child spacer (for salbutomol inhaler)	✓	-	-	✓	-	-	✓	-	-	✓	-	-	✓	-	-	×	-	-

1 ✓ = Stock available.
2 ✓ = Stock organised according to the FEFO principle.
3 ✓ = No expired stock observed.

All facilities in Motherwell had cotrimoxazole syrup and benzylpenicillin in stock at the time of the survey and none of the stock were expired or stored incorrectly. NU 8 clinic and TanduXolo satellite did not have any prednisolone in stock on the field visit days, while some of this stock in NU 11 was expired. All facilities had salbutamol inhalers, however, some of these in NU 2 clinic were expired and/or not stored according to the FEFO principle. All the facilities also had nebuliser, although the Coega mobile respondent reported that their nebuliser was expired and that they do not have tubing masks.

Table 41: Drugs used for pain and fever

Item	Motherwell CHC			NU 2			NU 8			NU 11			TanduXolo			Coega mobile		
	S[1]	FEFO[2]	NE[3]	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Paracetamol	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

1 ✓ = Stock available.
2 ✓ = Stock organised according to the FEFO principle.
3 ✓ = No expired stock observed.

All facilities had a supply of paracetamol for pain and fever and none was expired or incorrectly stored.

Table 42: Drugs used for worm infestation

Item	Motherwell CHC			NU 2			NU 8			NU 11			TanduXolo			Coega mobile		
	S[1]	FEFO[2]	NE[3]	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Mebendazole	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

1 ✓ = Stock available.
2 ✓ = Stock organised according to the FEFO principle.
3 ✓ = No expired stock observed.

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

Table 43: Antiseptics and oral health drugs

Item	Motherwell CHC			NU 2			NU 8			NU 11			TanduXolo			Coega mobile		
	S[1]	FEFO[2]	NE[3]	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Povidone iodine/chlorhexine	✗	-	-	✗	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gentian violet	✓	✓	✓	✗	-	-	✓	✓	✓	✗	-	-	✓	✓	✗	✓	✓	✓

1 ✓ = Stock available.
2 ✓ = Stock organised according to the FEFO principle.
3 ✓ = No expired stock observed.

Both Motherwell CHC and NU 2 did not have povidone iodine in stock. All the other facilities did have this in stock, it was stored according to the FEFO principle and no stock was expired. Neither NU 2 nor NU 11 had any gentian violet in stock and some of this stock at TanduXolo satellite was expired.

Table 44: Emergency treatment supplies (anaphylactic shock, cardiac arrest and hypoglycaemic)

Item	Motherwell CHC			NU 2			NU 8			NU 11			TanduXolo			Coega mobile		
	S[1]	FEFO[2]	NE[3]	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Adrenalin	✗	-	-	✗	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
10% dextrose	✗	-	-	✗	-	-	✓	✓	✓	✓	✓	✓	✗	-	-	✗	-	-

1 ✓ = Stock available.
2 ✓ = Stock organised according to the FEFO principle.
3 ✓ = No expired stock observed.

All health clinics should be able to handle emergencies like anaphylactic shock, cardiac arrest, and hypoglucaemic coma, as these conditions are often encountered in PHC

facilities. Therefore, life saving emergency drugs like adrenalin and dextrose should always be in stock. Nevertheless, only NU 8 and NU 11 had these two items in stock at the time of the survey. Both TanduXolo satellite and Coega mobile only had adrenalin. Neither Motherwell CHC nor NU 2 had any of these items in stock at the time of the survey.

Gap-attack!

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. None of the facilities met this standard. ORS packets are more expensive than a homemade salt and sugar solution and it is recommended that that only the homemade solution is used in cases not dehydrated.

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. TanduXolo satellite did not have one of these items in stock.

Three of the six facilities represented (NU 2, NU 8, NU 11), did not have any blankets with which to keep babies/children in shock warm.

BCG vaccine was out of stock at NU 8 and Coega mobile, the two facilities, apart from Motherwell CHC that offers post-natal care. Even though this is mostly given just after birth in a maternity ward (and the Motherwell CHC did have a supply of this vaccine in stock), according to guidelines developed in collaboration with the Equity Project in the form of a series of six booklets (Department of Health [s.a.] ***Priorities in child health: easily digestible information for health workers on managing the young child)***, if no visible scar appears after six weeks of vaccination, it is necessary to repeat the vaccination. The question arises whether the professional nurses at the three facilities providing post-natal care screen babies for the BCG-scar after six weeks and administer it again if no scar develops. The fact that NU 8 and Coega mobile did not have any of the stock at the time of the field visit raises this question even more pertinently. Representatives of the Metro Health Department, however, responded to this information after the feedback workshop. They indicated that intradermal BCG was introduced in the year 2000 and according to the EPI Policy it must be checked at 6 weeks and during subsequent visits but it may not be repeated. It is clear from this that policy documents to the avail of health workers are not always consistent.

Gap-attack!

Coega mobile did not have a porridge product in stock on the field visit day. Not all facilities had all the micronutrients as listed in the EDL guidelines (Department of Health 1998: 112). NU 2 and Coega mobile did not have any iron supplements for children, while neither Motherwell CHC nor NU 11 had any vitamin A supplements in stock.

NU 8 clinic and TanduXolo satellite did not have any prednisolone in stock on the field visit days, while some of this stock in NU 11 was expired. Some of the salbutamol inhalers in NU 2 clinic were expired and/or not stored according to the FEFO principle.

The Coega mobile respondent reported that their nebuliser was expired and that they do not have tubing masks. Both Motherwell CHC and NU 2 did not have polyvidone iodine in stock. Neither NU 2 nor NU 11 had any gentian violet in stock and some of this stock in TanduXolo satellite was expired.

All health clinics should be able to handle emergencies like anaphylactic shock, cardiac arrest, and hypoglucaemic coma, as these conditions are often encountered in PHC facilities. Therefore, life saving emergency drugs like adrenalin and dextrose should always be in stock. Nevertheless, only NU 8 and NU 11 had these two items in stock at the time of the survey. Both TanduXolo satellite and Coega mobile had only had adrenalin. Neither Motherwell CHC nor NU 2 had any of these items in stock at the time of the survey.

- **TB control programme drugs**

Table 45: TB drugs

Item	Motherwell CHC			NU 2			NU 8			NU 11			TanduXolo			Coega mobile		
	S[1]	FEFO[2]	NE[3]	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
RH (refinah) for adults and children	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
RHZE (rifafour)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
H (isoniazid)	✗	-	-	✗	-	-	✓	✓	✓	✓	✓	✓	✗	-	-	✗	-	-
E (Ethambutol	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	-	-
Streptomycin	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

1 ✓ = Stock available.
2 ✓ = Stock organised according to the FEFO principle.
3 ✓ = No expired stock observed.

Few problems were encountered with regard to TB drug stocks at clinics. No expired drugs were found and all stock was stored according to the FEFO principle. However, Coega mobile did not have any ethambutol in single form and Motherwell CHC, NU 2 and TanduXolo satellite and the Coega mobile did not have any isoniazid. Confusion existed whether these drugs should still to be used in its single form in any of the TB regimens. According to the *South African Tuberculosis Control Programme* document, however, these drugs in their single form should be used in certain cases. Ethambutol in its single form is part of the drug regimen for adult re-treatment patients in the continuation phase and isoniazid should be given for six months as chemoprophylaxis to children under the age of 5 years, who are in close household contact with a smear positive case of pulmonary TB or who are tuberculin skin test positive (Department of Health, 2000: 29&31).

Gap-attack!

Ethambutol was not available in its single form at the Coega mobile; Motherwell CHC, NU 2, TanduXolo satellite and Coega mobile did not stock isoniazid in its single form.

- **STI/HIV/AIDS programme drugs and supplies**

Table 46: Drugs and supplies required for the STI and HIV/AIDS programmes

Item	Motherwell CHC			NU 2			NU 8			NU 11			TanduXolo			Coega mobile		
	S[1]	FEFO[2]	NE[3]	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE	S	FEFO	NE
Ciprofloxacin (250 mg tabs)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Flagyl (2 g tabs)	✗	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Erythromycin (250 mg tabs)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗
Doxycycline (100 mg tabs)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Benzathine penicillin	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Condoms	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Latex gloves	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rapid HIV/AIDS test kits	✓	✓	✓	✗	-	-	✓	✓	✓	✗	-	-	✗	-	-	✗	-	-
Sharps disposal containers	✓	-	-	✓	-	-	✓	-	-	✓	-	-	✗	-	-	✓	-	-

1 ✓ = Stock available.
2 ✓ = Stock organised according to the FEFO principle.
3 ✓ = No expired stock observed.

STI and HIV/AIDS drugs and supplies were found to be generally in stock at the time of the survey, with only a few exceptions. Motherwell CHC did not have any 2mg flagyl tablets in stock, while some of the erythromycin 250mg tablets at the Coega mobile were found to be expired. NU 2, NU 11, TanduXolo satellite and the Coega mobile did not have any rapid HIV/AIDS test kits. Coega mobile, however, was the only facility that offered VCT that did not have these kits in stock. Disturbingly, TanduXolo satellite reportedly did not have any sharps disposal containers.

Gap-attack!

Most of the STI and HIV/AIDS drugs and supplies were found to be in stock at the time of the survey, with the exception of only a few.
Motherwell CHC did not have any 2mg flagyl tablets.
Some of the erythromycin 250mg tablets at the Coega mobile were found to be expired.
Coega mobile, where rapid HIV/AIDS tests were done, did not have these kits in stock at the time of the survey.
Disturbingly, TanduXolo satellite reportedly did not have any sharps disposal containers.

7. PHC 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 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 *"[all] relevant national and provincial health related circulars, policy documents, acts and protocols that impact on service delivery"*. 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.

❑ Graphs

Table 47: Display of graphs with recent information (past three months)[2]

Facility	Maternal health	IMCI	TB	STIs	HIV/AIDS
Motherwell CHC	×	×	×	×	×
NU 2	×	×	×	×	×
NU 8	✓	✓	✓	✓	✓
NU 11	✓	✓	✓	✓	×
TanduXolo satellite	×	×	×	×	×
Coega mobile	×[1]	×[1]	×[1]	×[1]	×[1]
Motherwell mobile	×[1]	×[1]	×[1]	×[1]	×[1]

1 There were no graphs displayed at the base clinics of the two mobiles either.
2 In some cases, graphs were reportedly available in files, but were not displayed.

Gap-attack!

Of the seven facilities in Motherwell, only one (NU 8) displayed recent PHC graphs relating to all the key PHC programmes under study. NU 11 displayed recent graphs relating to all, except for the HIV/AIDS programme.

- **Protocols and stationery**

The Motherwell mobile is not represented in the tables containing information on protocols and stationery, as the respondent indicated that they share these materials with their base clinic (NU 8).

Table 48: Availability of general PHC protocols and stationery

Facility	Motherwell CHC	NU 2	NU 8	NU 11	TanduXolo satellite	Coega mobile
The primary health care package for South Africa – a set of norms and standards (Department of Health 2001a)/*A comprehensive primary health care package for South Africa* (Department of Health 2001b)	×	✓	✓	×	✓	×
Death notification forms	×	×	×	✓	×	✓
Notifiable diseases reporting form	✓	✓	✓	✓	✓	✓
Referral letter	×	✓	✓	✓	✓	✓

Notifiable diseases reporting forms were generally available. Motherwell CHC, NU 11 and Coega mobile did not have either of the two Package documents. Death notification forms were not available at Motherwell, NU 11, NU 8 and TanduXolo satellite, while Motherwell CHC did not have any referral letters in stock.

Gap-attack!

Motherwell CHC, NU 11 and Coega mobile did not have either of the two Package documents. Death notification forms were not available at four of the seven facilities in Motherwell (Motherwell CHC, NU 8, NU 11, TanduXolo satellite). Motherwell CHC did not have any referral letters.

Table 49: Availability of family planning, women's and maternal health protocols and stationery

Facility	Motherwell CHC	NU 2	NU 8	NU 11	TanduXolo satellite	Coega mobile
Family planning register	✓	×	×	✓	×	×
National contraception guidelines (2002)	×	×	×	×	×	×
Sterilisation Act (1998)	×	×	×	×	×	×
National guide for cervical cancer screening programme (2001)	×	×	×	×	×	✓
Midwifery protocol	✓	×	×	×	×	×
Executive summary of saving mothers report (1998)	✓	✓	×	×	✓	×
Saving babies report (2001)	×	×	×	×	✓	×
Maternity register	✓	×	×	×	×	×
TOP register	×	×	×	×	×	×

None of the six PHC facilities in Motherwell, represented in the table above, had all the protocols and stationery listed in the above table. None of the six facilities had a copy of the *National contraception guidelines* (2002) or Sterilisation Act (1998), while only Coega mobile had a *National guide for cervical cancer screening programme*. Only Motherwell CHC and NU 11 had a family planning register. The only facility (Motherwell CHC) that provides maternity services had a Midwifery Protocol, an executive summary of the *Saving mothers report* and a maternity register. However, this facility (Motherwell CHC) did not have a *Saving babies report* (2001). None of the facilities had a TOP register because none of them offer TOP services. TOPs are currently referred to Dora Nginza Hospital.

Gap-attack!

None of the facilities in Motherwell had all the listed protocols for family planning, women's and maternal health. One of the facilities (NU 8) could not produce any of these items, three (NU 2, NU 11, Coega mobile) could only produce one, TanduXolo satellite could produce only two and the Motherwell CHC could produce only four.

Table 50: Availability of IMCI (child health) protocols, stationery and contact lists

Facility	Motherwell CHC	NU 2	NU 8	NU 11	TanduXolo satellite	Coega mobile
Growth monitoring/Road-to-health charts	✓	✓	✓	×	✓	✓
Protocol for managing and referring children with growth faltering and micronutrient deficiency and obesity	✓	×	×	×	×	×
Protein energy malnutrition (PEM) register/book	✓	×	×	✓	×	×
Protocol for management of children with HIV/AIDS	✓	✓	×	✓	×	✓
Protocol for emergency referral	×	×	×	×	×	×
IMCI chart booklet or enlarged wall chart	×	×	×	✓	×	×
Immunisation register/book	×	✓	×	✓	×	×
Official national form for adverse effects of immunisation	×	✓	×	✓	×	×
EPI disease surveillance manual	✓	✓	×	×	×	✓
EPI vaccination manual	×	×	×	×	×	×
EPI cold chain operations manual	×	×	×	×	×	✓
Written cold chain contingency plan for power interruptions	×	×	×	×	×	✓
Written cold chain contingency plan while defrosting refrigerator	×	×	×	×	×	✓
List of notifiable diseases	✓	×	×	✓	×	×
Contact person/number list for emergencies	✓	✓	×	×	✓	×
Poison centre contact numbers	×	×	×	×	×	×
List of names of women in breastfeeding support groups	×	×	×	×	×	×
Birth notification forms	✓	×	✓	×	×	✓
Temperature record card	✓	✓	✓	✓	×	✓

None of the stationery and protocols for the IMCI/child health programme could be produced by all the facilities in Motherwell.

Gap-attack!

None of the six facilities represented in the table facilities had the protocol for emergency referral, EPI vaccination manual, poison centre contact numbers or a list of names of women in breastfeeding support groups. NU 11 did not have copies of Growth monitoring/Road-to-health charts. Motherwell CHC is the only facility that had a copy of the Protocol for managing and referring children with growth faltering and micronutrient deficiency and obesity, while only Coega had an EPI cold chain operations manual, written cold chain contingency plan for power interruptions /paraffin shortages/gas shortages and written cold chain contingency plan while defrosting refrigerator. Furthermore, only Motherwell CHC and NU 11 clinics had PEM registers and two of the four facilities did not have a protocol for management of children with HIV/AIDS. NU 2 and NU 11 were the only two facilities that had immunisation registers/books and official national forms for adverse effects of immunisation. Four of the six facilities (NU 2, NU 8, TanduXolo satellite, Coega mobile) could not produce any list of notifiable diseases.

Table 51: Availability of TB protocols and stationery

Facility	Motherwell CHC	NU 2	NU 8	NU 11	TanduXolo satellite	Coega mobile
TB training manual for health workers 1998	×	×	×	×	×	×
The South African TB control programme practical guidelines (2000)	✓	✓	✓	✓	×	✓
Tracking TB at work – guidelines from South Africa's national TB control programme	×	×	×	×	×	×
DOTS training manual	✓	✓	✓	✓	×	×
Flow charts on TB diagnosis	✓	✓	×	✓	×	×

The six facilities represented in the table could again not all produce a copy of the five listed items.

Gap-attack!
TanduXolo satellite could not produce a copy of *The South African TB control programme practical guidelines* (2000). None of the facilities had either a copy of TB training manual for health workers (1998) or tracking TB at work guidelines from South Africa's national TB control programme. TanduXolo satellite and Coega mobile did not have a DOTS training manual, while NU 8, TanduXolo satellite and Coega mobile did not have flow charts for TB diagnosis.

Table 52: Availability of STI protocols and stationery

Facility	Motherwell CHC	NU 2	NU 8	NU 11	TanduXolo satellite	Coega mobile
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	✓	✓	✓	✓	✓	×

STI protocols were more readily available at Motherwell PHC facilities. With the exception of Coega mobile (that could not produce even one of the listed protocols), most other protocols could be produced.

Gap-attack!
Two of the six facilities represented in this table (Motherwell CHC, Coega mobile) did not have training manuals for the management of a person with a sexually transmitted disease (1999). All the other facilities, with the exception of Coega mobile, could produce the other four protocols listed in the table.

Table 53: Availability of HIV/AIDS protocols and stationery

Facility	Motherwell CHC	NU 2	NU 8	NU 11	TanduXolo satellite	Coega mobile
Protocol for managing of opportunistic infections of HIV	✓	✓	×	✓	×	✓
Protocol for managing HIV/AIDS in children	✓	✓	×	✓	×	✓
Protocol for HIV rapid test quality assurance	✓	×	×	×	×	✓
Informed consent for HIV testing	✓	✓	×	✓	✓	×
Resource list of HIV/AIDS services	×	×	×	✓	×	×
Protocol on HIV rapid testing	✓	×	×	×	×	✓
Protocol on voluntary HIV confidential 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	✓	×	✓	✓	×	×

None of the Motherwell facilities represented in this table could produce all 15 items listed in Table 53. Motherwell CHC fared best by producing 12 of the 15 and TanduXolo satellite fared worse. Alarmingly, this satellite clinic could only produce two of the 15 items.

Gap-attack!

TanduXolo satellite could only produce two of the 15 items listed in the table above, while both NU 2 and NU 8 respectively, could produce only five. The Coega mobile (9), NU 11 (11) and Motherwell CHC (12) fared better in this regard. With the HIV/AIDS programme being a priority programme in PHC, this data sketches an alarming picture.

Table 54: Availability of EDL protocols and stationery

Facility	Motherwell CHC	NU 2	NU 8	NU 11	TanduXolo satellite	Coega mobile
EDL booklet	✓	✓	✓	✓	✓	✓

All the facilities in Motherwell could produce a copy of the EDL booklet.

There seems to be no coordinated system to ensure that all clinics have the required protocols. Some protocols are determined at provincial, or even district level, but the distribution of such material does not appear to take place in a coordinated manner.

Clinic staff members, especially at those clinics with fewer personnel, often do not have the time (or skills), to develop a comprehensive indexing and referencing system for the storage of protocols. However, despite those protocols that are used most often being generally close at hand, less frequently used ones, while available, where not always easy to find. It sometimes took a concerted effort to find some documents. Thus, while it may seem from some of the data that protocols and stationery are available, clinic staff did not recognise some of the documents, and are therefore unlikely to be familiar with the contents. This has implications for continuity of care when the facility manager or programme coordinator are not available, as other staff then do not know where to find many of the documents.

Gap-attack!
There does not seem to be coordinated system to ensure effective distribution and utilisation of protocols in Motherwell. PHC facilities require indexing and referencing systems to store protocols.

8. Facility and patient held PHC records

Table 55: 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 chart	2001	21, 30
IMCI	*Road-to-health* chart	2001	14, 19
TB	TB register	2001	25
STIs	Patient-held card	2002	24

❑ Maternal health records

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

Information in ANCs	Motherwell CHC		NU 2		NU 8		NU 11		TanduXolo satellite		Coega mobile		Motherwell mobile	
	Imple-ented?[1]	Complete[2]	Imple-mented?	Complete	Imple-mented?	Complete	Imple-mented?	Complete	Imple-mented?	Complete	Imple-mented?	Complete	Imple-mented?	Complete
Date of first ANC visit	✓	100%	N/A[3]	-	✓	100%	N/A[3]	-	N/A[3]	-	✓	0%	N/A[3]	-
Outcome of syphilis testing		100%		-		100%		-		-		0%		-
Outcome of RH testing		100%		-		100%		-		-		0%		-

1 Whether record system had been implemented.
2 Percentage of ten conveniently chosen records indicating all required information.
3 No ANC services provided at NU 2, NU 11, TanduXolo satellite or Motherwell mobile.

The Package required implementation of the patient-held ANC card by the end of 2001. Ten ANC patient-held cards were conveniently sampled at all three the facilities offering ANC services, as all had these ANC cards implemented. However, neither outcomes of syphilis tests nor outcomes of RH tests were recorded in any of the ten sampled cards at Coega mobile. The cards at Motherwell CHC and NU 8 contained all the required information.

Gap-attack!
Neither outcomes of syphilis tests nor outcomes of RH tests were recorded in any of the ten sampled cards at Coega mobile.

Table 57: Implementation of record system and completeness of information in facility-held ANC record

Information in ANCs	Motherwell CHC[3]		NU 2		NU 8		NU 11		TanduXolo satellite		Coega mobile		Motherwell mobile	
	Imple-mented?[1]	Complete[2]	Imple-mented?	Complete	Imple-mented?	Complete	Imple-mented?	Complete	Imple-mented?	Complete	Imple-mented?	Complete	Imple-mented?	Complete
Date of first ANC visit	✓	100%	N/A[4]	-	✓	100%	N/A[4]	-	N/A[4]	-	×[5]	-	N/A[4]	-
Outcome of syphilis testing		100%		-		100%		-		-		-		-
Outcome of RH testing		100&%		-		100&%		-		-		-		-

1 Whether record system had been implemented.
2 Percentage of ten conveniently chosen records indicating all required information.
3 These were found in the blood specimen register.
4 No ANC services provided at NU 2, NU 11,TanduXolo satellite or Motherwell mobile.
5 The Coega mobile did not use a maternity register.

Maternity registers were only implemented at two of the three facilities (Motherwell CHC, NU 8) providing ANC services in Motherwell. All information verified (date of first ANC visit, outcome of syphilis testing and outcome of RH testing) was recorded in these two registers. The Coega mobile did not use any maternity register.

Gap-attack!
The Coega mobile did not make use of a maternity register.

- **IMCI records**

Table 58: Implementation of record system and completeness of information in patient-held Road-to-health charts

Information in *Road-to-health* chart	Motherwell CHC		NU 2		NU 8		NU 11		TanduXolo satellite		Coega mobile		Motherwell mobile	
	Imple-mented?[1]	Complete[2]	Imple-mented?	Complete	Imple-mented?	Complete	Imple-mented?	Complete	Imple-mented?	Complete	Imple-mented?	Complete	Imple-mented?	Complete
First measles shot by age 12 months	✓[3]	100%	✓	100%	✓	90%	✓	100%	✓	100%	✓	100%	✓	100%
Fully immunised by 1 year		100%		100%		90%		100%		100%		100%		100%

1 Whether record system had been implemented.
2 Percentage of ten conveniently chosen records indicating all required information.
3 Road to health charts is kept in patient files at the facility, which is not the right way of doing.

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 seven facilities in Motherwell. Ten charts were sampled at each of the seven facilities. All information the research team was looking for was recorded and up to date. Additionally,

it could be concluded from the recorded data that nearly all of the sampled children (represented by the charts) received their first measles shot by the age of 12 months and were fully immunised at one year. Only one of the seventy cards sampled showed that the child did not receive his/her first measles shot by 12 months and that the child was not fully immunised by one year. This child was treated at NU 8 clinic. A problematic situation was however encountered at Motherwell CHC, and that is that the charts of the children treated at this facility were kept in their patient facility-held files and not by their mothers. This situation is problematic because, should a mother travel or move away from the area, she would be left without this chart and a nurse at another clinic would not have the information required on the progress of this child.

Gap-attack!
The Motherwell CHC kept Road-to-health charts in their facility-held patient files. This situation is problematic because, should a mother travel or move away from the area, she would be left without these charts and a nurse at another clinic would not have the information required on the progress of this child.

- **TB records**

Table 59: Implementation of record system and completeness of information in patient-held TB card

Information in patient-held TB card	Motherwell CHC[3]		NU 2		NU 8		NU 11		TanduXolo satellite		Coega mobile		Motherwell mobile	
	Imple-mented?[1]	Complete[2]	Imple-mented?	Complete	Imple-mented?	Complete	Imple-mented?	Complete	Imple-mented?	Complete	Imple-mented?	Complete	Imple-mented?	Complete
Patient category recorded	✓	100%	✓	90%	✓	100%	✓	100%	✓	100%	✓	90%	✓	80%
International disease code recorded		100%		100%		100%		100%		100%		90%		100%
Basis of decision to treat recorded		-[3]		-[3]		-[3]		-[3]		-[3]		-[3]		-[3]
Notification information recorded		100%		70%		100%		100%		100%		100%		80%
Regimens and doses up to date		90%		100%		100%		100%		100%		100%		100%
Sputum results up to date		80%		60%		100%		100%		100%		70%		60%

3 Whether record system had been implemented.
4 Percentage of ten conveniently chosen records indicating all required information.
5 Some of the cards did not have this category printed anywhere on the card, therefore, this category was eliminated.

Ten patient held TB treatment cards were conveniently sampled at each of the seven facilities. Data gatherers looked for completeness with regard to six items on the cards, i.e. patient category, international disease code, basis of decision to treat, notification information (date), whether regimens and doses were up to date and whether recorded sputum results were up to date. Only three of the facilities (NU 8, NU 11, TanduXolo satellite) met the standard of 100% completeness in all these categories. Curiously, some of the cards did not have a 'basis of decision to treat' category.

Gap-attack!
The patient-held TB cards (green cards) of four (Motherwell CHC, NU 2, and Coega and Motherwell mobiles) out of the seven facilities in Motherwell were not sufficiently completed. Furthermore, the patient-held TB cards used in the Motherwell PHC facilities were not all standardised. Some of them did not have a 'basis of decision to treat' category.

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

Information in *Road-to-health* chart***	Motherwell CHC[3]		NU 2		NU 8		NU 11		TanduXolo satellite		Coega mobile		Motherwell mobile	
	Imple-mented?	Complete	Imple-mented?	Complete	Imple-mented?	Complete	Imple-mented?	Complete	Imple-mented?	Complete	Imple-mented?	Complete	Imple-mented?	Complete
Date of registration	✓	100%	✓	100%	✓	100%	✓	100%	✓	100%	✓	100%	✓	90%
Treatment outcome		100%		100%		100%		100%		100%		100%		60%

The first ten TB register inscriptions in January 2002 were utilised for the information in this table.

The Package required implementation of the facility-held TB register by the end of 2001. The TB registers containing information on patients registered on 1 January 2002 were utilised for this exercise, as outcomes would already have been available for all patients at the time of the survey (February 2003). Ten patients were selected. The recording of treatment outcomes in the facility-held TB registers of the Motherwell facilities was found to be 100% complete, except for the Motherwell mobile.

9. Referral practice

The Package (Department of Health 2001a: 14) states that all patients, whose needs fall beyond the scope of clinic staff competence, should be referred to the next level of care. In certain instances, referral systems were problematic in Motherwell, although overall, few problems were experienced.

❑ 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 61: Referral for complications during pregnancy

Facility	Comments on the functionality of the referral system
Motherwell CHC	Ambulance arrives after a long time – varies between 1 and 12 hours
NU 2	N/A[1]
NU 8	No problems reported
NU 11	N/A[1]
TanduXolo satellite	N/A[1]
Coega mobile	No problems reported
Motherwell mobile	N/A[1]

1 No ANC or delivery services provided at NU 2, NU 11,TanduXolo satellite or Motherwell mobile.

Only one of the respondents (Motherwell CHC) indicated that they have a problem with referral of pregnant patients who develop complications. The ambulance reportedly arrives after a long delay that could vary between one and twelve hours.

Table 62: Referral after Pap smear, if required

Facility	Comments on the functionality of the referral system
Motherwell CHC	No problems reported
NU 2	No problems reported
NU 8	They have a problem with obtaining their Pap smear results from the hospital. They mostly have to phone the hospital for these.
NU 11	No problems reported
TanduXolo satellite	N/A[1]
Coega mobile	No problems reported
Motherwell mobile	No problems reported

1 Pap smears are not done at this facility. The respondent indicated that Pap smears are is not in the Municipality protocol

Only NU 8 clinic reported a problem with referral after Pap smears, if required. The problem is not really a referral problem, but a problem with their referral hospital laboratory. Reportedly, obtaining their Pap smear results from this laboratory causes frustration. The respondent indicated that they mostly have to phone for these.

- **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 provided in accordance with provincial IMCI protocols at all times that a facility 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	Comments on the functionality of the referral system
Motherwell CHC	Ambulance arrives after a long time – varies between 1 and 12 hours
NU 2	They have not been trained in referring children and are uncertain where to refer them, so they are following general referral protocol
NU 8	No problems reported
NU 11	No problems reported
TanduXolo satellite	No problems reported
Coega mobile	No problems reported
Motherwell mobile	No problems reported

Two of the facilities in Motherwell indicated that they do experience problems with the referral of very ill children. Motherwell CHC indicated that ambulance delay of between one and twelve hours is problematic. The respondent at NU 2 indicated that they have not been trained in the referral of children; they do not have a protocol and are, therefore, uncertain where to refer very ill children. They were using the protocol for general patient referral at that stage.

- **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 to ensure that the discharge plan is implemented.
- Before a patient is transferred to another area, he/she must be supplied with a complete transfer form and a sufficient supply of medicine. Where possible the facility to where the patient is being referred should be notified telephonically.
- If the TB patient is HIV-positive, the patient should be given a sealed and confidential letter with relevant information for the facility to where he/she is being transferred.
- TB patients with severe complications or adverse drug reactions are referred for hospital admission.
- 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	Comments on the functionality of the referral system
Motherwell CHC	There is a shortage of beds at referral hospital, it is difficult to admit very ill TB patients – also problem with ambulance that arrives only between 1 and 12 hours after it has been phoned
NU 2	No problems reported
NU 8	No problems reported
NU 11	No problems reported
TanduXolo satellite	This system is working well as they work with a referral book. They phone the hospital to book a patient and the patient brings back a copy of the form on which all treatment received by the patient is stated.
Coega mobile	No problems reported
Motherwell mobile	No problems reported

The respondent at Motherwell CHC indicated that there is a shortage of beds for very ill TB patients at the referral hospital. Furthermore, she again reported ambulance delays as being a serious problem.

Table 65: Suspected TB cases with negative sputum

Facility	Comments on the functionality of the referral system
Motherwell CHC	This is working well as we have a sessional doctor on Tuesdays who work with problematic TB patients
NU 2	No problems reported
NU 8	No problems reported
NU 11	No problems reported
TanduXolo satellite	A TB suspect with negative sputum is referred to a doctor who sends the patient for X-rays and/or requests a culture test from the laboratory. This system is working well
Coega mobile	These cases are referred to the visiting doctor and he refers further if the need arises – no problems with these
Motherwell mobile	No problems reported – they refer to the NU 8 sessional doctor, he refers patients further should it be necessary

No problems were reported regarding referral of suspected cases with negative sputum, as all of these patients are referred to sessional doctors in the area.

- **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 staff 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 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.

Table 66: Referral of STI patients not responding to treatment after two weeks

Facility	Comments on the functionality of the referral system
Motherwell CHC	No problems reported
NU 2	No problems reported
NU 8	No problems reported
NU 11	No problems reported
TanduXolo satellite	These patients are referred to Motherwell CHC. There are no problems with this.
Coega mobile	No problems reported
Motherwell mobile	No problems reported

No problems were reported regarding referral of STI patients not responding to treatment after two weeks. The respondent at TanduXolo satellite indicated that their patients are referred to the Motherwell CHC for further observation.

- **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 67: Referral of very ill HIV/AIDS patients

Facility	Comments on the functionality of the referral system
Motherwell CHC	Ambulance arrives after too long delay – varies between 1 and 12 hours Positive about referral system; they can refer to NGOs for home based care, e.g. Hospice and NAPWA
NU 2	Refer patients to the Dora Nginza Hospital or to the CHC in the morning while the doctor is still there.
NU 8	No problems reported
NU 11	No problems reported
TanduXolo satellite	These patients are transferred to Motherwell CHC and there are no problems with these referrals.
Coega mobile	No problems reported
Motherwell mobile	No problems reported

No problems were reported regarding referral of very ill HIV/AIDS patients. NU 2 indicated that they refer these patients to the Dora Nginza Hospital, while TanduXolo satellite reportedly refer these patients to the Motherwell CHC.

Table 68: Referral of patients with herpes zoster

Facility	Comments on the functionality of the referral system
Motherwell CHC	No problems reported
NU 2	No problems reported
NU 8	No problems reported
NU 11	No problems reported
TanduXolo satellite	These patients are mostly treated at the satellite clinic and not referred
Coega mobile	No problems reported
Motherwell mobile	They mostly treat this themselves with calamime lotion and something for pain

No problems were reported at any of the facilities with regard to referral of patients with herpes zoster.

Table 69: Referral of patients with oesophageal candidiasis

Facility	Comments on the functionality of the referral system
Motherwell CHC	Patients are referred to Livingstone Hospital, but they are not attended to properly– they come back to this CHC without the condition being controlled – the doctor who is supposed to do it there does not do it properly. The drug prescribed to control this condition is not available at this CHC and the other clinics in area.
NU 2	They refer these patients to the hospital but reported that they do not receive feedback as to how these patients are treated and whether their condition improved or not
NU 8	No problems reported
NU 11	No problems reported
TanduXolo satellite	Referrals are problematic as the patients are treated at the hospital and when they return, there is no accompanying record describing the treatment received there or follow-up instructions for that matter.
Coega mobile	No problems reported
Motherwell mobile	No problems reported

Three of the facilities indicated that they experience problems with the referral of patients with oesophageal candidiasis. The respondent at Motherwell CHC reportedly refers their patients to Livingstone Hospital, where patients are not attended to properly. Apparently they come back to this CHC without the condition being controlled. The doctor who is supposed to treat these patients there does not do it properly. The drug prescribed to control this condition is not available at this CHC or the other facilities in the area. The respondent at NU 2 reported that they do not receive feedback in any form from Livingstone Hospital on the patients they refer there for the condition. The respondent at TanduXolo satellite had similar complaints and indicated that patients come back to the facility after having been treated at this hospital without any record describing the treatment they received there or follow-up instructions.

Table 70: Referral of patients with severe continued diarrhoea

Facility	Comments on the functionality of the referral system
Motherwell CHC	There are not enough beds at the referral hospital to admit patients with this condition. They are treated in casualty and sent home while they are still severely ill. Consequently, they try to control this condition at the CHC, supervised by the sessional doctors.
NU 2	Refer these patients to the hospital, but reported they do not receive feedback from the hospital at all.
NU 8	No problems reported
NU 11	No problems reported
TanduXolo satellite	The referral of patients with severe continued diarrhoea is not problematic as such, but after being treated at the hospital, they do not return to the clinic
Coega mobile	No problems reported
Motherwell mobile	No problems reported

Two of the respondents indicated that they experience problems with the referral system of patients with severe continued diarrhoea. The respondent at Motherwell CHC reported

that there are not enough beds at the referral hospital to admit patients with this condition. They are treated in casualty and sent home while they are still severely ill. Consequently, they try to control this condition at the CHC, supervised by the sessional doctors. The respondent at NU 2 indicated that they refer these patients to the hospital, but reportedly do not receive feedback from the hospital at all.

GAP-ATTACK!

The respondent at one of the three facilities offering ANC services in Motherwell reported that they have a problem with referral of pregnant patients who develop complications. The ambulance service is reportedly unreliable and arrives only after long delays, ranging from one hour to twelve hours.

Only NU 8 clinic reported a problem with referral after Pap smears, if required. The problem is not really a referral problem, but a problem with their referral hospital laboratory. Reportedly, obtaining their Pap smear results from this laboratory causes frustration. The respondent indicated that they mostly have to phone for this.

The respondent at NU 2 indicated that they have not been trained in the referral of children and they do not have a protocol. They are therefore uncertain where to refer very ill children. They were using the protocol for general patient referral.

The respondent at Motherwell CHC indicated that there is a shortage of beds for very ill TB patients at the referral hospital.

Three of the facilities indicated that they experience problems with the referral of patients with oesophageal candidiasis. The respondent at Motherwell CHC reportedly refers their patients to Livingstone hospital, where patients are not attended to properly. Apparently they come back to this CHC without the condition being controlled. The doctor who is supposed to treat these patients there does not do it properly. The drug prescribed to control this condition is not available at this CHC or the other facilities in the area. The respondent at NU 2 reported that they do not receive feedback in any form from this hospital on the patients they refer there for the condition. The respondent at TanduXolo satellite had similar complaints and indicated that patients come back to the facility after having been treated at this hospital without any record describing the treatment they received there or follow-up instructions, accompanying them.

Gap-attack!

Two of the respondents indicated that they experience problems with the referral system of patients with severe continued diarrhoea. The respondent at Motherwell CHC reported that there are not enough beds at the referral hospital to admit patients with this condition. They are treated in casualty and sent home while they are still severely ill. Consequently, they try to control this condition at the CHC, supervised by the sessional doctors. The respondent at NU 2 indicated that they refer these patients to the hospital, but reportedly do not receive feedback from the hospital at all.

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, 19, 21, 22, 24, 25, 30) all of the pamphlets and posters listed in Tables 74 and 75 should have been availed in PHC facilities by the end of 2001.

Table 71: Availability of IEC pamphlets

Pamphlet theme	Motherwell CHC		NU 2		NU 8		NU 11		TanduXolo satellite		Coega fixed point	
	Available	Local language	Available	Local language	Available	Local language	Available	Local language	Available	Local language	Available	Local language
Emergency contraception	✗	-	✗	-	✗	-	✗	-	✗	-	✗	-
Diarrhoea/ORS solution	✗	-	✗	-	✗	-	✗	-	✗	-	✗	-
Breastfeeding/nutrition	✗	-	✗	-	✗	-	✗	-	✗	-	✗	-
Vitamin A supplementation	✗	-	✗	-	✗	-	✗	-	✗	-	✗	-
Family planning	✗	-	✗	-	✗	-	✗	-	✗	-	✗	-
Malnutrition	✗	-	✗	-	✗	-	✗	-	✗	-	✗	-
VCCT	✗	-	✗	-	✗	-	✗	-	✗	-	✗	-
PMTCT	✗	-	✗	-	✗	-	✗	-	✗	-	✗	-
TB	✗	-	✗	-	✗	-	✓	✓	✗	-	✗	-
STIs	✗	-	✗	-	✗	-	✗	-	✗	-	✗	-
Condom use	✗	-	✗	-	✗	-	✗	-	✗	-	✗	-

IEC pamphlet availability in Motherwell facilities was nearly non-existent. Only NU 11 had any pamphlets at all, and for that matter, only TB pamphlets. The TB pamphlets in this clinic were in the local language.

Table 72: Display of posters in facilities

Pamphlet theme	Motherwell CHC		NU 2		NU 8		NU 11		TanduXolo satellite		Coega fixed point	
	Available	Local language	Available	Local language	Available	Local language	Available	Local language	Available	Local language	Available	Local language
Patient's rights charter	✓	✗	✗	-	✓	✗	✗	-	✗	-	✗	-
Emergency contraception	✗	-	✗	-	✗	-	✗	-	✗	-	✗	-
Diarrhoea/ORS solution	✓	✓	✗	-	✗	-	✗	-	✗	-	✗	-
Breastfeeding/nutrition	✓	✓	✓	✗	✓	✗	✗	-	✗	-	✗	-
Vitamin A supplementation	✓	✗	✗	-	✓	✗	✓	✗	✗	-	✗	-
Family planning	✓	✗	✗	-	✓	✗	✓	✗	✓	✗	✗	-
Women's health charter	✓	✗	✗	-	✗	-	✓	✗	✗	-	✗	-
Malnutrition	✓	✗	✗	-	✗	-	✗	-	✗	-	✗	-
VCCT	✓	✗	✓	✗	✗	-	✗	-	✗	-	✓	✓
PMTCT	✓	✗	✓	✗	✓	✗	✗	-	✗	-	✗	-
TB	✓	✓	✓	✓	✓	✓	✓	✓	✗	-	✓	✓
STIs	✓	✗	✓	✗	✗	-	✓	✗	✗	-	✗	-
Condom use	✗	-	✓	✓	✗	-	✓	✗	✗	-	✓	✗
Percentage of all sampled posters displayed	85%	23%	46%	15%	46%	8%	46%	8%	8%	0%	23%	15%

It is clear that IEC does not seem to be high on the list of priorities of PHC facilities in Motherwell. Motherwell CHC showed the highest availability of displayed posters at 85%. The information on those displayed was however mostly not in a local language (only 23% were in a local language). None of the other facilities had even half the posters listed in the table above. Coega and NU 2 had only 15% of listed posters available in a local language, while bothNU 8 and NU 11 had 8%. However, none of the sampled posters were available in a local language at TanduXolo satellite. It is however understandable that the latter facility had few posters on display, as the walls in the facility are not really suitable for poster displays (the clinic is housed in a small shack).

GAP-ATTACK!

Nationally available pamphlet and poster materials are not fully exploited as part of IEC relating to key PHC programmes in Motherwell. It is clear that IEC does not seem to be high on the list of priorities of PHC facilities in this area. IEC pamphlet availability in Motherwell facilities was nearly non-existent.
Only NU 11 had any pamphlets at all, and for that matter, only TB pamphlets.
Apart from Motherwell CHC (that had 85% overall on display of which 23% were in a local language), none of the other facilities had even half the posters listed in the table above on display.

11. Community involvement and patient rights

With the decentralisation of the health system in South Africa and the subsequent introduction of the district health system, a move was made to empower communities to participate in the system's governance. The idea was for community health committees and community development forums to be established in order to encourage community participation in clinic matters (Levendal *et al.* 1997: 131). According to the Package (Department of Health 2001a: 14) each PHC facility should have a functioning community health committee in the facility catchment area. The concept of community involvement as used in the context of the Package also implies that all PHC facilities should initiate and sustain community outreach activities to secure active participation of communities in health programmes (Department of Health 2002: 60).

❑ Community health committees

In Motherwell, the Motherwell mobile did not have a community health committee. This is however understandable, as this mobile clinic has a very vast service/catchment area. The minutes of community health committee meetings could not be produced by five of the six facility respondents where committees did exist, but they did explain that the secretaries of these committees, who are community members, keep these minutes.

Table 73: Community health committees

	Motherwell CHC[3]	NU 2	NU 8	NU 11	TanduXolo satellite	Coega mobile	Motherwell mobile
Community health committee in existence	✓	✓	✓	✓	✓	✓	×
Whether minutes of community health committees were available	✓	×	×[1]	×[1]	×[1]	✓	×

1 The minutes were not seen but the respondents from NU 8, NU 11 and TanduXolo satellite explained that the secretaries of these committees, who are community members, keep the minutes.

❑ Patient complaint procedures

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

Table 74: Patient complaint procedures

	Motherwell CHC[3]	NU 2	NU 8	NU 11	TanduXolo satellite	Coega mobile	Motherwell mobile
Patient complaint procedure in place	✓	✓	✓	✗[4]	✓	✓	✗
Complaints handled verbally	✓[1]	✓[2]	✓[3]	✓	✓[5]	✓[6]	✗

1 Patients attending Motherwell CHC either write complaints down or talk to the nurse in charge of CHC and she takes down a report – meeting held with shop steward of Union, member of Union, nurse in charge, deputy nurse and patient present. All except patient present when staff member reprimanded as well.
2 The respondent from NU 2 indicated that they follow a standard protocol with complaints – they listen to the story of both patient and accused separately in the presence of community representatives and other relevant structures.
3 The sister in charge of NU 8 attends to any problems that might develop and settles these where possible. If the problem is above her scope, she reports to the nursing supervisor of Motherwell. She also involves community and union members where appropriate.
4 Although the respondent at NU 11 indicated that there is no formal procedure to handle complaints, it was also indicated that they make use of a suggestion box in the clinic.
5 Patient complaints are resolved through the health committee at this clinic. If a patient has a problem, they talk to the committee and the committee takes it up with the staff of the Coega mobile. If personnel have a problem with a patient, they also go to the committee and talk to them and they talk to the patient and solve the problem.
6 When there is a patient complaint, the staff of the clinic talks to the complaining patient, with a community member present, and make sure the patient leaves satisfied that the problem was resolved.

Apart from the Motherwell mobile, all respondents indicated that they do have a patient complaint procedure or suggestion box in place at their facilities.

GAP-ATTACK!
The Motherwell mobile reported that they did not have any patient complaint procedure in place.

CHAPTER 3

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

1. General

The goal in all provinces is for comprehensive and integrated PHC services to be delivered at district level. In reality, this goal has not been achieved in Motherwell facilities yet, as not one of the facilities offers a comprehensive service as specified by the Package (Harrison-Migochi 1998: 129). Amongst others, not all PHC facilities in Motherwell offer comprehensive maternal health care (i.e. ANC, post-natal care, Pap smears, and family planning). Only three facilities (Motherwell CHC, NU 8, Coega mobile) offer ANC and post-natal care services, while only Motherwell CHC and Coega mobile offer chronic disease management and only Motherwell CHC offers mental health and violence/sexual abuse services. It the recommendation of this research that the above-mentioned services is provided by all facilities in Motherwell, as this is required by the Package (Department of Health 2001a: 23). Problematic reasons for not being able to provide these services at all the facilities should be resolved. It should again be stressed that, in accordance with the Package (Department of Health 2001a: 22; 2001b: 7) all PHC facilities (clinics) need to offer a one-stop integrated and comprehensive PHC service. In general, PHC services and the community in Motherwell can only benefit by greater attention to the implementation of the Package.[18]

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

2. Specific gaps affecting key PHC programmes

Self-reported programme constraints: the main constraints for most facility managers and programme managers are a lack of staff, drugs, and clinic space.

A lack of PHC programme and support services supervision and support[19]: generally, the impression from the data in regard to PHC management supervision in the area (besides

[18] 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.

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

the general PHC/nursing supervisor) is that visits to the clinics are a rare occurrence. There is especially a severe lack of HIV/AIDS and STI programme supervision and support. Confusion even existed whether these two programmes are coordinated by a designated manager at all. None of the facilities received any visits from laboratory technicians in the past three years and a district infection control official and pharmacist were only received at two of the seven facilities in the past three years.

PHC equipment needs are serious and diverse: the situation regarding equipment at Motherwell CHC is nearly incomprehensible. There is a dire need for more equipment in working condition at this facility. A total of 77 pieces of a list of equipment types assessed were found to be out of order.

PHC tests are not always available and are characterised by long turn-around times: reported test turn-around times differed substantially among the seven facilities. Plausibly the respondents were not all well informed about the turn-around times of tests offered at their clinics. Some problems were reported concerning difficulty obtaining test results from the laboratory service and some turn-around times for tests were below standard.

Some problems in drug supply: a diversity of drug supply problems were revealed by the study, and virtually no management support through personal visits to PHC facilities were received by the facilities. Dispensary/pharmacy support personnel are direly needed in the facilities as nursing personnel manages in-facility dispensing and ordering of drugs with little support.

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 (as is often the case).

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

Two issues requiring further research: firstly, the role of community health workers and home-based carers in particular: reportedly trained volunteers have not yet received a stipend, despite being told that they would be paid long ago already. Secondly, a need for staff establishment assessment: there is a dire need for specific guidelines on establishing the number of nursing staff required to provide comprehensive PHC services for the specific catchment population of Motherwell facilities and. According to the nurse clinical workload figures for the individual facilities, on average, staff at all facilities work less than are expected of them. However, the fact that none of the clinics (with the exception of Motherwell CHC) have dispensary support personnel, which automatically implies that the laborious tasks of drug management and drug dispensing are the responsibility of nursing personnel, which significantly reduces the time to their avail for clinical work. Additionally, nursing support personnel, especially assistant nurses, are virtually non-existent in the facilities, which implies that professional nurses have to provide basic services (e.g. wound dressing, temperature readings, taking blood pressure readings, etc.) that could be done by nursing support personnel. This further reduces the time they have to their avail for more complicated clinical procedures.

3. Motherwell PHC facilities - a main strength in management, provisioning and programmes

An important observation made in Motherwell at the time of the research and at the feedback workshop, as well as was shown by the research, is that there is active community involvement at the fixed clinics in Motherwell, as well as an interest in the public health matters of Motherwell. All the fixed clinics were found to have active community health committees and the debriefing session prior to the research was well attended by community members and councillors alike, as was the feedback workshop.

4. Main recommendations

- More equal redeployment and redistribution of available staff and equipment within URSs appears to be a viable strategy. The information gathered by the research (mapping of gaps) could very specifically facilitate such redeployment and redistribution by serving as guidelines for where and how corrections ought to be made. But, again, the current structural and functional fragmentation of PHC in districts, metros and URSs proves to be a major hindrance for such rectifying interventions at PHC facilities.
- Dispensary support personnel for all clinics in Motherwell are recommended. Should this be impossible, additional nursing staff with sufficient training to do this work, are recommended, as none of the clinics have dispensary support personnel (except Motherwell CHC who have two assistant pharmacists), which automatically implies that the laborious tasks of drug management and drug dispensing are the responsibility of the nursing personnel at the clinics, which significantly reduces the time to their avail for clinical work.
- The lack of specific PHC programme supervision and support in Motherwell need to be addressed. Programme specific managers need to be designated where there is no specific manager per programme in order to improve programme monitoring and specific programme application within PHC facilities.
- Every measure should be taken to better orientate, prepare and train PHC staff at PHC facilities (and PHC programme coordinators) better 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 (and its norms and standards) at PHC facilities, as well as in the larger URS, district or metro areas, seem to be the only way to making progress and securing the implementation of the PHC package and to systematically address the gaps in the current implementation of the PHC package. Similarly, monitoring of the implementation of the PHC package (from inside and from outside) is necessary in order to determine either progress or backsliding in implementation, or to set short and longer-term objectives for incremental implementation of the PHC package and programmes. To these ends, easily implementable surveillance or monitoring systems need to be devised, and if they indeed already exist, they need to be used more systematically and be applied with greater dedication. Once off identification of gaps and deficiencies does not suffice. Additionally, consideration needs to be given to establishing Quality Assurance Units at the provincial level. This may be one way of securing the implementation of the PHC package.

- Equipment maintenance in Motherwell PHC facilities needs attention, especially with reference to the Motherwell CHC equipment situation.
- A diversity of drug supply and distribution problems was revealed by the study, and virtually no pharmacy management support through personal visits to PHC facilities were received by the facilities. It is recommended that these problems be solved.
- A coordinated system to ensure that all clinics have the required protocols, need to be developed and the distribution of manuals pertaining to PHC delivery needs to be optimised. 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 is a clear case in point – a policy that never reach the level of application.
- The lack of pamphlet and poster material availability and display in Motherwell facilities needs attention.
- The distribution of manuals pertaining to PHC delivery needs to be optimised. 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 is a clear case in point – a policy that never reaches the level of application.
- Within the larger metro area, special URS-funds (and also special PHC-funds) should be ring-fenced for specifically addressing the current gaps in delivery of the PHC package, both in the larger metro and in the Motherwell URS.
- Some of the identified gaps and deficiencies in the application of the PHC package are indeed of a more serious nature that others. In this respect certain gaps and deficiencies - such as the use of expired drugs, lack of HIV/AIDS services, etc. - should be prioritised for immediate corrective action.
- There is, on the one hand, a need to demystify the DHIS by rendering it user-friendly. On the other hand, the DHIS need to be made more reliable and trustworthy if it is to be used for management and planning purposes.

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