BASELINE ASSESSMENT:
EUROPEAN UNION PARTNERSHIPS FOR THE DELIVERY OF PRIMARY HEALTH CARE PROGRAMME IN SOUTH AFRICA

Report compiled for:
European Union Partnership for the
Delivery of Primary Health Care Programme in South Africa

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Social Aspects of HIV/AIDS and Health
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Table of Contents

Figures

Tables

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Abbreviations and Acronyms

ANC	Antenatal Care
AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti Retroviral
BCEA	Basic Conditions of Employment Act
BIG	Basic Income Grant
CEEEO	Communicable diseases, Epidemiology, Environmental, EPI, and Occupational Health
CEO	Chief Executive Officer
CBO	Community Based Organisation
CHC	Community Health Centre
CHP	Centre for Health Policy
CHW	Community Health Worker
CUBP	Clinic Upgrading and Building Programme
DFID	Department for International Development
DHIS	District Health Information System
DHMT	District Health Management Team
DHS	District Health System
DoH	Department of Health
DOTS	Directly Observed Treatment Short-Course
DTT	District Task Team
EEA	Employment Equity Project
EGP	Equity Gauge Project
EPI	Extended Programme on Immunisation
EU	European Union
FBO	Faith Based Organisation
HAST	HIV/AIDS, STIs and TB
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
HST	Health Systems Trust
IDP	Integrated Development Plan
IMCI	Intergrated Management of Childhood Illness
INK	Inanda, Ntuzuma and KwaMashu
IQR	Interquartile Range
IPHC	Intergrated Primary Health Care
ISDS	Initiative for Sub-district support
KSD	King Sabata Dalindyebo
LG	Local Government
LRA	Labour Relations Act
LSA	Local Service Area
MEC	Member of Executive Council
MCWH	Mother Child and Women's Health
MDS	Management Development Services
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
M	Mean
M&E	Monitoring and Evaluation
MTCT	Mother to Child Transmission
NGO	Non Governmental Organisation
NPO	Non Profit Organisation
NPMU	National Project Management Unit
PDPHCP	Partnership for the Delivery of Primary Health Care Programme
PHC	Primary Health Care

PMCI	Partnership Management Capacity Index
PMTCT	Prevention of Mother to Child Transmission
PPMU	Provincial Project Management Unit
PPP	Public-Private Partnership
PWA	People with AIDS
REC	Research Ethics Committee
SD	Standard Deviation
SLA	Service Level Agreement
SPSS	Statistical Package for the Social Sciences
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infections
TOP	Termination of Pregrancy
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

Executive summary

Background

In their quest to strengthen the delivery of PHC services in South Africa, the European Union, the Government of South Africa and UK's Department for International Development collaboratively developed a six year government/NPO partnership programme called Partnership for the delivery of Primary Health Care Programme (PDPHCP). The programme is implemented in 5 provinces – Gauteng, Limpopo, KwaZulu-Natal, Eastern Cape and Western Cape.

Overall Purpose

To ensure more accessible, affordable and quality PHC in the 5 provinces participating in PDPHCP.

Broad Objective

To complete a comprehensive baseline evaluation in 5 provinces involved in PDPHCP which will form a benchmark against which change can be measured with particular emphasis on societal, organizational and individual indicators.

Methods

The study employed a pre-post design, using both qualitative and quantitative methods to assess partnership indicators. The baseline study (pre-test) constitutes the first step of the design phase of PDPHCP.

The elements of the baseline studies include:

- An assessment of government capacity to manage partnerships with NPOs which spans both provincial and district spheres
- An area-based district analysis, which includes an assessment of district infrastructure, PHC services (focusing on gaps which NPOs could fill) and NPO partnerships
- An assessment of NPO access, capacity and quality

Sampling and procedure

In order to balance speed with depth in the evaluation the following sampling strategy was followed in each province:

- Two districts purposefully sampled from those participating in the PDPHCP partnership in each province.
- Within each district, four sub-districts and at least six NPOs were randomly selected

NPOs inclusion criteria are being funded or earmarked for funding from the PDPHC programme.

Data collection was conducted from January 2006 to April 2006. Table 1 below describes and provides a breakdown of the sample, the different categories of the respondents, tools used to interview them and the area of outcome/impact assessment. Row 1 of the table gives the number of provinces (5) that were sampled, row 2 shows the breakdown of the sample in terms of Public health respondents interviewed, non profit organisations (NPO) in the partnership that were interviewed and the services they provide. Row 3 shows the indicators measured both under the public health and NPO categories and row 4 provides the tools that were used to assess

management capacity of the district management to implement the partnership objectives and NPO capacity to deliver the services and the quality of the services they provide to the community. Column 3 indicates the outcome/impact assessment areas assessed from sub-district managers and NPO users.

The Table 1 further shows that total number of respondents interviewed under the Public health category were 100, 36 NPOs were engaged, 14 sub-district managers and 150 service recipients were interviewed in two provinces KwaZulu-Natal and Limpopo.

Table 1: Overview of sample and tools

5 Ex Prov	Public health	NPOs	Outcome/Impact
Sample:	-District managers (n=10) -Task network (National/province/district/ sub-district) (n=108, all) -NPO database audit (n=31)	NPOs in partnership (n=36) -6 Service NPOs (HBC, support groups, health promotion) per province (9 in KwaZulu-Natal and 9 in Limpopo)	Sub-district managers (n=14; all) Consumer assessments (n=150) (in two provinces only, urban KwaZulu-Natal and rural Limpopo Province)
Indicators	-District needs analysis -Management capacity	-Organisational capacity -Quality of service	Access/Equity/Quality/ Efficiency PHC indicators: HBC & Support groups indicators
Tools	-District needs assessment tool -NPO database audit -Management Capacity	-Organisational capacity -Quality of care tools: HBC/Support groups/health promotion	-Access… tool (sub-district) -Household tool: External support for chronically ill -Consumer assessment: HBC -Consumer assessment: support grou

Phase 1 and 2

Baseline studies were conducted in a phased approach. Phase 1 involved open-ended interviews to get agreement on the procedures of the study, to get a broad overview of the situation in each province and to plan for the detailed data collection in phase 2.

Specifically in phase 1 the teams:

- Obtained and reviewed provincial plans and identified provincial priorities for the PDPHC programme;
- Identified the task network involved in the PDPHC programme and held a meeting with representatives of this network to agree on processes and procedures of the work;
- Collected all background documentation, policies on NPO-government partnerships, NGO funding etc.; and
- Obtained ethical clearance from the Human Sciences Research Council Ethics Committee and Provincial Health Departments for the studies.

Phase 2, included interviews (including the specific tools used) with (1) District health manager (2) Task network members, (3) NPO managers, (4) Sub-district health manager and (5) Consumer survey (home-based care and support groups for PLWHA), as follows:

Procedure

Research tools used have been developed and pilot tested in Gauteng by the Centre for Health Policy (2004). Interviews were conducted in English, Zulu and Northern Sotho by senior researchers and trained professional nurses, and informed consent was obtained. The content of semi-structured interviews (open-ended questions) was recorded by the senior researcher by taking notes. Self-administered sections of the questionnaires were administered by senior researchers. The senior researchers also asked for documentation of components of the study questions from their interviewees. Provincial visits were conducted in September and October 2005. Data collection was conducted from January 2006 to April 2006. The study protocol was approved by the Human Sciences Research Council Ethics Committee (REC 1/10/08/05). In all cases, the interviews were conducted after the interviewees had consented in writing to participate in the study. Interviewees were guaranteed anonymity, confidentiality and also informed about their right to refuse to participate in the study.

Data Management

The provincial field work coordinators gave the completed data collection instruments to the research manager in accordance with their allocated provinces. Each field work co-ordinator, with the assistance of the statistician and data capturers, coded and entered the data in SPSS. Once the data had been captured, the statistician ensured that it was cleaned.

Data analysis

Both qualitative and quantitative procedures were used and a triangulation of data from different actors and methods was conducted. Quantitative data were analysed using SPSS. Qualitative data was analysed using thematic content analysis. The team leader and the two senior experts analysed the data, together with the statistician, in accordance with the analysis strategy that was agreed upon at the design phase.

Area-based district needs analysis

The district needs assessment was conducted in 5 provinces. Within each province, 2 district municipalities were randomly selected – KZN (eThekwini/Zululand), LP (Waterberg /Sekhukhune), WC (CT Metro/Boland Overberg), EC (OR Tambo/Amathole) and Gauteng (JHB metro/Tshwane). In each case, the district manager was interviewed using a semi-structured interview schedule. Key results are divided into district priorities, district management capacity (district management team, planning, human resources, financial systems, health information system, provincial and local government, governance and local participation and ability to partner with NPOs) and contextual factors influencing partnerships.

Results

District priorities: The priorities mentioned in the various districts include but are not limited to: improve PHC, reduce poverty, develop capacity, develop economy and prevent diseases.
District management capacity: All 10 districts indicate the presence of management, financial and monitoring systems. Only 2 indicate a less than a good relationship with politicians and NPOs.

NPOs partnerships: About 40% of the districts are aware of the existence of a policy on NPOs. Both formal and informal partnerships exist between NPOs and districts. About 80% of the districts have service contracts with NPOs. The Amathole district in the Eastern Cape has as many of contracts with the NPOs as 27. Only the Ethekwini district reported that it does not have management capacity. All districts, except the Amathole and Ethekwini districts do not seem to monitor contracts. The majority (60%) of the districts are continuously improving

management capacity through internal and external training workshops. About 6 districts reported that the decision regarding when the NPOs get paid is taken at provincial level. All districts except the Eastern Cape collect data from NPOs in TB, HIV and demographics. Identified gaps generally reflect the following: understaffing, poor infrastructure, low service utilization, inaccessibility of services and poor co-ordination. About 90% of the districts, except for Amathole district indicated that NPOs can fill the service delivery gaps.

Recommendations

- The role of NPOs should be clearly delineated in district priorities
- More human resources are needed for districts whose DHMTs are not adequately staffed.
- District councils to be established in districts that currently don't have them
- 3-year health plans for sub-district need to be developed in some districts
- Health budgets to be developed in all districts
- There is a need to improve the relationship between local and provincial governments.
- Districts should use their DHIS effectively to ensure that they have data on all PHC indicators
- NPO policies should be developed in all districts
- A standardised system of managing partnerships should be developed
- Standard methods to monitor contracts should be developed
- There is a need for capacity development to manage partnerships
- The identified service gaps need to be addressed, especially lack of capacity, staff recruitment and retention
- Districts to utilise NPOs more effectively to close service gaps

Sub-district needs analysis

Further, within each district, two sub-districts were randomly selected. Therefore, in each province four sub-districts were selected for the study amounting to a total of 20 sub-districts in the five provinces. However, only 14 sub-districts agreed to participate in the study - Three in KZN (INK, Abaqulusi and Ulundi), four in Gauteng (Alexandra, Orange farm, Tshwane C/S & Soshanguve), two in EC (BC & KSD), One in WC (Thee Waterkloof), and four in LP (Fetakgomo, Makhuduthamaga, Mogalakwena and Lephalale). In each case the sub-district manager (or designated persons e.g. PHC co-ordinator) was interviewed using an interview schedule. Key results are divided into two domains: PHC access, coverage, and quality of PHC with specific reference to facilities/staffing, outreach, outputs, outcomes, and LG/provincial integration and NPO partnerships with focus on participation, referral/coordination and support.

Results

Facilities: All the sub-districts had satellite clinics, PHC clinics, CHCs, however, the majority of them did not operate after hours.

Staffing: almost all sub-districts (12) had a training plan for the sub-district.

Outreach: Almost all sub-districts (12) had various outreach functions in the sub-district performed by professional staff, health promoters, DOTS supporters and CHWs. All sub-districts had clinics (though not all clinics) linked to PLWHA and clinics supporting HBC.

Outcomes: Indicators for TB were provided in some sub-districts. Other sub-districts did not have them readily available.

Local and provincial governments integration: Nine (9) sub-districts had a joint local government/provincial team and 10 had a joint reporting of information for sub-district.

NPO Partnerships

Participation: There were forums involving NPOs in all the sub-districts that constituted the sample. Further, there were structures for consulting with the community across all the sub-districts.

Referral and co-ordination: The majority of the sub-districts (11) had NPO databases developed by various people DTT, PTT, EU Co-ordinator, HIV/AIDS co-ordinator, DOH; however, most of these databases were not frequently updated. Further, sub-districts generally had had a referral system between NPOs and facilities in the sub-district (10).

Support: The majority of sub-districts (11) provided supplies (e.g. HBC kits) to NPOs

Recommendations

- Constantly update NPO databases
- Assist sub-districts in having health information systems that have MTCT coverage statistics and keep statistics on TB indicators in order to assess the outcomes of their services
- Determine ways in which NPOs can assist health facilities so that they can operate after hours.

NPO databases assessment

Thirty-one participants (EU PDPHCP coordinators at provincial & district level, district information officers, and other task team network members) in all 5 provinces were interviewed. Results indicate that most essential ratings for possible purposes of databases on NPOs were (1) An information system for monitoring and evaluating partnerships at district and provincial level, (2) An information system for monitoring NPO contracts, and (3) To provide an understanding of health related activities in an area so that can incorporate into government planning. Most participants knew of existing NPO databases. Further, interviewees with an endorsement of 60% and more indicated for 9 different types of NPO service delivery categories (e.g. Home-based care, HIV prevention, TB) that they should be categorized as "large", while five (with an endorsement of 60% and above) NPO activity areas were categorized as "medium" (e.g. mental health, disability and reproductive health). From a list of 13 possible NPO database indicators, for most indicators participants felt that they should be added or included into an NPO data audit list (e.g. "No. and scope of HIV and AIDS PHC services offered by contracted NPOs per selected district per annum", and "Percentage of training HIV and AIDS and PHC training NPOs whose training is accredited by the Health and Welfare SETA per annum"), while 40-55% felt that five from the 13 indicators should be removed (e.g. "Number of HIV and AIDS and PHC networking, training and other support NPOs per district/province per annum" and "Total number of clients accessing contracted NPO PHC services by type of service in the province per annum").

Recommendation

Existing NPO databases should be utilized for a central database and a core list of perhaps 10 indicators for the NPO database should be agreed upon.

Government capacity to manage partnerships with NPOs

In all 108 task network members agreed to be interviewed within the project time frame between January to April 2006. All were interviewed with a semi-structured interview guide and a partnership management capacity rating was done by the researcher. In addition the

Partnership Management Capacity Index (PMCI) was filled in by 79 of the 108 participants. Partnership management capacity in relation to NPOs was assessed on a scale from 1 to 4, the higher the score the higher the capacity and "4" being the optimal capacity. The PMCI was measured in two forms: 1) from the interviewee (the task team network) directly and 2) from the senior researcher on the basis of a semi-structured interview and collected materials from the task team network interviewee. The PMCI ratings from the interviewee and interviewer were averaged to come up with an overall PMCI. Partnership management capacity seemed generally with a median of 2.8 sub-optimal (the optimal being 4.0), with the highest in Western Cape (Md=3.3), followed by Gauteng (Md=2.8) and KwaZulu-Natal (Md=2.8) and the lowest in Limpopo (Md=2.5) and the Eastern Cape (Md=2.5). The higher score for Western Cape may be explained by the fact that the PDPHC programme has already been implemented for two years, while other provinces are at the beginning of implementing PDPHCP. The following Table 2 indicates the stage of the different management capacity components by province.

Table 2: Partnership management capacity by six management capacity component by province

Partnership management capacity component	Province	Median
Strategic planning for partnerships (Md=2.8)	KwaZulu-Natal	2.6
	Gauteng	2.9
	Eastern Cape	3.3
	Western Cape	2.8
	Limpopo	2.5
Formal programme arrangements for partnerships (Md=2.5)	KwaZulu-Natal	2.7
	Gauteng	2.1
	Eastern Cape	2.9
	Western Cape	3.4
	Limpopo	2.4
General programme management (Md=2.3)	KwaZulu-Natal	2.8
	Gauteng	2.2
	Eastern Cape	2.0
	Western Cape	3.1
	Limpopo	2.0
Contract management (Md=2.5)	KwaZulu-Natal	3.0
	Gauteng	3.1
	Eastern Cape	1.7
	Western Cape	3.6
	Limpopo	2.5
Relationship management (Md=2.8)	KwaZulu-Natal	3.0
	Gauteng	2.9
	Eastern Cape	2.1
	Western Cape	3.3
	Limpopo	2.7
Organisational context (Md=3.1)	KwaZulu-Natal	2.8
	Gauteng	3.5
	Eastern Cape	2.7
	Western Cape	3.3
	Limpopo	2.8

Looking at the six different partnership management capacity components, the national and provincial departments had the highest management capacity, while at district and local municipality level management capacity was lower.

Recommendations

- All provinces need to improve their partnership management capacity, especially Eastern Cape and Limpopo provinces.
- The government public health sector needs to particularly improve on the following indicators of NPO partnership: Financial systems (Md=2.0); Programme learning (Md=2.0); Internal capacity development (Md=2.0); Managing poor performance (Md=2.0); Partnership policy (Md=2.5); Partnership programme planning (Md=2.5); Allocation of roles & responsibilities (Md=2.5); Delegation of authority (Md=2.5); Information systems (Md=2.5); Contract monitoring (Md=2.5); Communication with NPOs (Md=2.5); and Organisational culture (Md=2.5).
- In addition, partnership management capacity needs to be strengthened at district and local municipality level, and in general programme (Md=2.3) and contract (Md=2.5) management.

The qualitative analysis concentrated on the open-ended questions. The responses to these questions were grouped together on the basis of the common ideas shared. A summary of the partnership management capacity components is provided.

Organisational arrangements

Allocation of roles, responsibilities and decision making in the partnership programme

In general, the national task team has an oversight role, provincial task teams are responsible for the coordination and monitoring of the partnership programme, district task teams and sub-district ensure to implementation, and NPOs are ultimately responsible for service delivery (i.e. service packages).

General programme management

Learning from mistakes

The most common examples of where the programme learnt from its mistakes include the following: the call for proposals advertisements had not been specific to project sites; pre contract site evaluations had been inadequate; and lack of monitoring and evaluation of progress.

Contract management

Recruitment of NPOs

Broadly, the recruitment of NPOs follows this process: a tender is designed and published in local and national newspapers (a call for proposals for work to be done). This is then followed by a briefing session with all the NPOs followed by the evaluation of applications received to determine administrative compliance. Successful applicants go through to the adjudication process where an adjudication panel or a selected committee will further evaluate them against set criteria. A contract training session with successful NPOs follows. Lastly, a contract is signed. Activities and services will then be implemented by the NPO and be monitored.

The main problems with the contracting process

The following problems emerged from the results: lack of necessary skills and capacity to deliver the required service; submission of false information by NPOs; lack of management skills (for example, governance, project management, financial accountability and so on); NPOs not being able to provide the necessary documentation (for example, financial statements,

constitution and so on); problems with understanding contract specifications and adherence; and insufficient staff in the Department of Health to adequately conduct pre-contracting assessment site visits.

Contract management specific difficulties

Respondents pointed out that NPOs that some NPOs have difficulties understanding the terms and conditions of a contract (i.e. legal literacy). Other difficulties cited include dual contracting (provincial and district), and the safety of assessors being at risk. During site visits, the assessors' safety is sometimes at risk because some NPOs become defensive.

Legal requirements for contracting NPOs

The most commonly cited requirement is registration under the NPO Act. Further, the NPO concerned should have a physical address and a bank account.

Monitoring and evaluation

On the question of how NPOs are monitored and evaluated these are the responses provided: monthly meetings (i.e. monthly stakeholder forums); site visits (by personnel from the Department of Health or EU programme staff); submission of monthly or quarterly reports by NPO programmes managers; finance and activities are evaluated through the above-mentioned mechanisms; and submission of annual audited statements.

Problems identified with the monitoring and evaluation process

Problems identified with the monitoring and evaluation process were variously expressed. On the side of government, interviewees pointed to insufficient staff to assist with the monitoring and evaluation. While on the side of NPOs, one of the problems identified is the lack of submission of monthly and quarterly reports by some NPOs.

How non-performing NPOs are identified

Some common responses cited include the following: monthly activity reports are utilized to monitor the activities of NPOs. NPOs are visited regularly where possible. NPOs are also expected to submit their financial statements to determine the utilization of funding. Other indicators of performance cited are community feedback and impact, as well as consultations.

Relationship management

Motivations of NPOs

One of the questions asked of the respondents sought to determine their views on what motivates NPOs to do what they do. Generally, most respondents felt that NPOs are motivated by commitment and the need to service and make a difference in their community. However, there was also recognition that as a result of poverty and the high unemployment in the country, the emergence of some NPOs may be due to a need to create employment.

NPO complaints

A number a methods for dealing with NPO complaints were identified by respondents. These include meetings (for example consultative or stakeholder forums), telephone calls, in writing and actual visits by NPO representative. Regarding meetings between the two parties, officials were asked during the interviews to indicate how often they meet with NPO partners. Responses varied between every day at 12% to never at 10.9%. The most common response was once a month at 40.2%.

Systems to support NPOs

Respondents were asked to describe the systems that they have in place to support NPOs with general, human resources, and financial management, as well as governance. In most instances, the responses were quite general. These included advices, encouraging NPOs to support each other, 'an open door policy', offering orientation courses, contracting another service provider to provide training, meeting, workshops, seminars, and conferences.

Organisational context

Organisational culture of the department

The majority of the interviewees were from the Department of Health, with some that included local government and the Department of Social Development officials. The descriptions looked both inward in the department itself (for example, the Department of Health itself) and outward in terms of how accessible the organisation is to the public. Some described their organisations as flexible, democratic, caring and warm, as well as participative. However, other respondents were less approving. Conversely, the latter perceived their organisations as rigid and inflexible, bureaucratic and hierarchical.

The relationship between provincial and local government

A number of respondents appear to feel positive about the relationship between provincial and local government. Most described it as being good, functional and satisfactory. However, others were less so. These interviewees pointed to a number of challenges in this regard, including: duplication of services, and lack of cooperation in some areas.

Recommendations

All provinces need to improve their partnership management capacity, especially Eastern Cape and Limpopo provinces.
The government public health sector needs to particularly improve on the following indicators of NPO partnership: Financial systems (Md=2.0); Programme learning (Md=2.0); Internal capacity development (Md=2.0); Managing poor performance (Md=2.0); Partnership policy (Md=2.5); Partnership programme planning (Md=2.5); Allocation of roles & responsibilities (Md=2.5); Delegation of authority (Md=2.5); Information systems (Md=2.5); Contract monitoring (Md=2.5); Communication with NPOs (Md=2.5); and Organisational culture (Md=2.5).
In addition, partnership management capacity needs to be strengthened at district and local municipality level, and in general programme (Md=2.3) and contract (Md=2.5) management.

Assessment of NPO access, capacity and quality

Generic Assessment of NPOs

Thirty-seven NPOs were assessed. The median age of NPOs was 6 years and about a third (35%) reported an expanding programme with nearly a quarter (22%) having increased staff over the past three years. All but one of the NPOs was registered, and that one was in the process of registering. The services being offered represent a range of primary health care functions including care for PLWHA, including support/counselling and home-based care, health promotion including nutrition, TB, reproductive health and prevention of HIV infection. Other services include care for the physically and mentally disabled.

There is variation in size for the NPOs examined, ranging from those with 500 volunteers to organisations with only 4 staff (median staff size = 30). The vast majority of the workers are black (84%) and female (80%).

In terms of governance, all NPOs had a constitution, and a Board, committee or other governing body (97%); most of these hold regular meetings. Annual reports are produced although copies were not always available. There was some evidence that meetings were not taking place as regularly as intended, e.g. a quarterly meeting may not have taken place within the last 3 months.

Managers' impressions of the partnership between the NPOs and government were generally positive and most cited funding as the most important benefit. For those who had already had contracts with government (65%), there were some problems with late payments (33%) and complicated bureaucracy (8%).

Attitudes of managers to HIV, AIDS and poverty were generally positive and reflected enlightened views. There were, however, some respondents who felt very strongly about issues such as disclosure, even to the point of agreeing that failure to disclose one's status to a sexual partner should be regarded as a criminal offence.

Organisational cultures were generally positive with a few respondents in each category indicating that some NPOs may be more autocratic than others.

Assessments of the relationship between government and NPOs were also positive on the whole although there were some NPOs, especially in KwaZulu-Natal and, to a lesser extent, in Western Cape, where the relationship was less than satisfactory.

One of the most important aspects of this part of the evaluation is the perception of the relationship between the NPO and the government. Whilst both NPO Managers and District Managers appear convinced that the partnership is potentially beneficial, there were some responses for the negative end of the spectrum of most indicators. This implies that more effort is needed to achieve a better understanding between partners and that communication is optimised. By way of encouragement, there were examples of positive responses for all the indicators and these could be drawn upon to identify 'best practice' models.

NPO programme assessment

In evaluating the capacity and quality of NPOs, this study utilised the Buch et al (2004) participatory rapid appraisal tool for the evaluation of AIDS home based care programmes, which was modified to also include support groups and health promotion. Eleven dimensions of management were assessed from 37 NPO programme managers in five provinces. NPO capacity indicators were assessed on a scale from 0 to 4, where 0 = "not in place yet", 1 = "still setting up", 2 = "started", 3 = "running adequately" and 4 = "running excellently". Results indicated that the 6 NPOs in Limpopo province stated that they do not have a board or stakeholder committee for their NPOs.

Community Involvement: Stakeholder consultations are mainly not in place as yet (51.4%) but there is active local council involvement (67.6%). Stakeholders are reported to be making input (61.1%) and there are mechanisms in place to collaborate (91.9%). With regards to individual provinces, Limpopo scored below average (2) with M=1.72 and KwaZulu-Natal (M=1.97).
Collaboration: Currently there are mechanisms in place to collaborate with other NPOs (91.2% & M=3.12). About 88.6% of NPOs stated that needed services are available and are offered at the nearby hospital and clinics.
Training: Only 69.4% of NPOs stated that a home carer-training programme is available with only 65.7% of NPOs stating that the programme is suitable to achieve required skill levels. The majority of NPOs (62.2%) do not have a training plan for all staff with 54.5% stating that trainer

skills are either not in place yet or still being set up. Limpopo (M=1.63) showed the poorest score in terms of training.
Services: The overall Mean score for services is shown as above average as M=2.59. Limpopo showed the lowest Mean of 2.18 with Gauteng (M=3.40) reporting the highest.
Planning & Monitoring: Few NPOs (41.7%) have a strategic plan. Interestingly, 68.8% of NPOs do monitoring but clearly due to the lower numbers of NPOs that have a strategic plan; this monitoring is not checked against the plan. Annual reports are being prepared by 77.8% of NPOs.
Limpopo again showed the poorest Mean score of 1.66.
Human Resource Management: KwaZulu-Natal shows the best result with regards to Human Resource Management with M=3.21. Total Mean was high at 2.89.
Supply systems and logistical operations: Only 69.4% of NPOs have a tracking system in place that records organisational activities. NPOs in Limpopo seem to have the systems in place for logistics (M=3.10) with Eastern Cape (M=2.57) the lowest but still above average.

Recommendations

- NPOs in Limpopo need to be encouraged to form boards or stakeholder committees.
- Stakeholder consultations need to be encouraged
- Limpopo and KwaZulu-Natal need to increase their community involvement. This could be through participating in community Imbizo's, inviting stakeholders to input on the NPOs policy and plans and through liaisons with local councillors.
- Home carer-training programme should be made easily available to all NPOs
- NPOs need to be encouraged to develop training plan for all staff
- NPOs in Limpopo need to be encouraged to increase training of all their staff.
- NPOs need to be encouraged to draw up strategic plans
- Strategic plans need to be utilised during monitoring process.
- NPOs especially in Limpopo needs attention with regards to drawing up strategic plans, annual reports, and to do monitoring of work.

Household situation of chronically ill persons receiving home-based care

One-hundred and nineteen carees, 59 in eThekwini district (Presidential note) in KwaZulu-Natal and 60 Waterberg district (Mogalakwena sub-district) in Limpopo were interviewed on their household situation by a nurse researcher. Ninety-five (83%) of the carees indicated that they had someone in their household who had been very sick for more than three months in the last 12 months, 72% had someone in their household who had been bedridden for a period of three or more months, and 32% had someone in their household who had died after having been sick for more than 3 months. Further, most respondents indicated that their household had received free emotional care (89%), followed by free medical support (85%) and free social support (50%). Further, for a sick person in the house hospital or clinic help or care was received by 92%, from relatives 50%, from friends 13%, from a religious organization 28 %, from a community organisation 57% and all had received help or care from an NPO.

One in three households (33%) had at least one orphan. In less than one in five (18%) of the orphans a parent or parents had left behind property. More than half had received free medical care in the past 12 months, one-thirds free emotional and social support, and one on in five had received free material and school-related assistance.

Recommendation

Psychosocial services for orphans should be increased.

Home-based care assessment

An evaluation of home-based care programmes provided by NPOs earmarked for funding by the EU was conducted in eThekwini (urban), KwaZulu-Natal and Waterberg district (rural) in Limpopo Province with a total of 120 patients receiving home-based care. In general, most patients were females, pensioners and unemployed patients. They had primary school education, mostly in age ranges of 25-49 and 50-70yrs, and had been on the HBC programme for 24 to 36 months. Assessment of patients' conditions and mobility revealed that most patients were reported ill and were described as being mobile, able to feed independently, weak and in need of minimal support. Due to social problems, some patients could not afford to eat a variety of meal and thus ate the same meal for breakfast, lunch and dinner. Most, however, were reported to be receiving a balanced daily diet. Nursing care Programmes and contacts with Professional health workers (Nurses) with regard to the patients' condition was found to be poor, especially in KZN. Record keeping and patient confidentiality were, however, found to be adequate. In general, most patients rated their relationships with their families and carers as good. Because most patients were reported to be mobile and could therefore help themselves, only a few patients needed help when going to toilet, with drinking water at their bedsides and with support to their pressure parts. A few households were reported to be small and therefore created a hazard for patients who used stoves to cook as this compromised their respiratory health. The spiritual, physical, and psychological care of patients was adequate. Family support in the absence of carers was also reported to be adequate. Common problems faced by the carers, patients and patient families and/or partners were described as lack of access to grants, social support, stigma, patients refusing care and poor care at health facilities.

Recommendations

- Government and various relevant stakeholders need to increase social support to those patients suffering as a result of poverty. Patients staying alone, critically ill and those that are bedridden must be given priority.
- Patients must be educated on the relationship between impact of cleanliness and their health status and be trained how to keep their households environments clean to their health benefit.
- More training is required for carers to help them render nursing care in a most hygienic and protective manner possible. NPOs must be supplied with and be trained on manual and guides to conducting various nursing care procedures. There is also a need to supply the NPOs with care kits to ensure less risk of infections from patients to carer in cases of highly contagious diseases
- Carers need to be trained on patient confidentiality during care. Families must also be counselled to respect patient opinions on various important family issues in order to raise their self-esteem.
- NPOs need to be trained on development of alternative care plans and more training for family members is necessary to help when the carer is not available for any reason. Carer-professional Nurse Consultations must be strengthened.
- Government intervention is required to help address social problems that are already barriers to quality health care for the terminally home-based patients.
- NPOs must be encouraged to establish links with health care institutions for referrals of patients, to get advice on how best to care for the patients and to review nursing care plans.

Support groups

An exploratory qualitative study was conducted with the aim of exploring, describing and understanding the relationship between NPOs and their support group clients. The study wanted to explore what clients viewed as the ultimate support group in the hope of understanding client needs and thus improving service delivery. The study population comprised of three randomly selected European Union (EU) funded NPOs providing support groups for PLWHA in eThekweni district, KwaZulu-Natal Province. All NPO members attending support groups were

included in the study population. In total, 34 support group members from the three selected NPOs participated in the focus group sessions, 79.4% female and 20.6% male, mean age 38.8.

Results indicated that all group members had a general understanding of support. During focus group discussions it was realised that most members were experiencing high degree of stigma at home and needed a so-called 'safe space' to escape to and discuss issues with people experiencing similar problems. Respondents wanted the group to consist of 10 PLWHA as members. Participants wanted the support group to meet in the morning, preferably around 10am. The length and frequency of a support group session was debated among the different groups. All participants stated that they require skills to would allow them to help themselves and others in the community. These skills include gardening and woodwork to counselling skills (income generating activities). Interestingly, participants also requested HIV education so as they could properly understand the virus and help the community understand it to reduce stigma (social responsibility). Participants also stated that support groups could also organise to arrange for food parcels from different sponsors

Recommendations

- Encourage NPOs to start support groups, as PLWHA need a safe place to congregate and discuss issues they may be experiencing.
- New definition of support group: Support groups for PLWHA must not only concentrate on providing counselling needs to members but need to expand to provide other support such as gardening and provide skills so as people could engage in other activities (income generating) so as they do not feel as a burden to their families and the community in general. It is important to recognise that each group would have their own skill requirements ranging from gardening, and woodwork to counselling. As such, each group should be allowed to discuss and choose what skills they require and rank from most important to least.
- Provide training to NPOs on running and maintaining of support groups
- Support groups should be small (10 members) to encourage all members to participate
- Peer group discussions including peer experience and peer counselling are important to support group members.
- Members need to be used as a vital source of first person experience and be given the opportunity to go into the community to educate.
- Each group needs to decide on their own the length and frequency of the focus group.
- Support group members need training on how to source funding for educational training, to access food parcels and to write proposals to receive funding.

Chapter 1: Orientation of the study

1.1 Primary health care services in South Africa

The majority of South Africans depend on the public health sector for their health care needs (Viljoen et al., 2000). In many areas of South Africa, the Primary Health Care (PHC) facilities are the only available or easily accessible health service for local communities. As a result, PHC services, providers and facilities carry a large burden and responsibility for the provision of health care in South Africa. Primary Health Care is the basic mechanism for providing health care (Department of Health, 2000). It was formally introduced in April 1994 as the major principle for health care provision with the implementation of two policies, "Free Health care for pregnant mothers and children under the age of six years" as well the "Universal Access to Primary Health Care for All South Africans"(Department of Health, 2000). The Primary Health Care system emphasises preventive rather than curative health care (Nicholson, 2001). The PHC approach is based on the following principles:

- Resources must be distributed equitably. Areas that have the least resources should be given the most assistance.
- Communities should be involved in the planning, provision and monitoring of their health service.
- Greater emphasis should be placed on services that help prevent disease and promote good quality health.
- Technology must be appropriate to the level of health care, ensuring that all clinics have fridges that work for the storage of vaccines before equipping them with high-tech medicine facilities.
- There should be a multi-sectoral approach to health. In the Primary Health Care approach, the provision of nutrition, education, clean water and shelter become central to health care delivery.

For the sustainable development and improvement of primary health care, a decentralised system is essential. South Africa has endorsed the District Health System (DHS) as the vehicle for implementation of primary health care (Nicholson, 2001). The major reason for having health districts is to allow communities to interact with the people who manage health and to allow health workers to interact with people in other sectors that affect health, such as Water Affairs. Government health workers can also work together with non-government workers and with private health workers. In each district, Primary health care must be delivered to all the people in the area, there must be one health authority responsible for primary health care, including community-based services, clinics and district hospitals, decisions about health care for a district should be made by that district's health authority and health council and communities should have a real say concerning their own health care.

Core norms for health clinics

- The clinic renders comprehensive integrated PHC services using a one-stop approach for at least 8 hours a day, five days a week.
- Access, as measured by the proportion of people living within 5km of a clinic, is improved.
- The clinic receives a supportive monitoring visit at least once a month to support personnel, monitor the quality of service and identify needs and priorities.
- The clinic has at least one member of staff who has completed a recognised PHC course.
- Doctors and other specialised professionals are accessible for consultation, support and referral and provide periodic visits.

- Clinic managers receive training in facilitation skills and primary health care management.
- There is an annual evaluation of the provision of the PHC services to reduce the gap between needs and service provision using a situation analysis of the community's health needs and the regular health information data collected at the clinic.
- There is annual plan based on this evaluation.
- The clinic has a mechanism for monitoring services and quality assurance and at least one annual service audit.
- Community perception of services is tested at least twice a year through patient interviews or anonymous patient questionnaires.

Women's reproductive health

Women are provided with reproductive services in an integrated comprehensive manner that covers preventive, curative, promotive and rehabilitative aspects of care. The focus is on antenatal, delivery, postnatal and family planning care.

Management of childhood illness

Monitoring and promoting growth, immunisations, home care counseling, de-worming and promoting breast feeding, curative (assessing, classifying and treating) and rehabilitative services are given in accordance with provincial IMCI protocols at all times that the clinic is open.

Sexually transmitted diseases and HIV/AIDS

The prevention and management of STDs is a service that should be available daily at all clinics and is a component of services for reproductive health and for control of HIV/AIDS. Every clinic should at least have one member of staff, but preferably all professional staff, trained in the management of STDs. Also, every clinic should have at least one member of staff, who has been trained for STD, trained as a counselor for HIV/AIDS/STD.

There is evidence indicating that the removal of financial barriers to Primary Health Care Services has led to increase in numbers of PHC services users (DoH, 2000). The DHS is continually strengthened and developed and delivery of service at PHC level promoted. In some places, care is still provided in an inequitable manner with women, children and people living in rural areas still getting less and sometimes inferior care
.
There are gaps between policy and practice in primary health care and improving primary level health services is very slow (Barron & Monticelli, 2003). The Initiative for Sub-district Support (ISDS) is improving the technical aspects of primary health care delivery, while also balancing this with a developmental approach that empowers local staff. The ISDS has worked in the nine provinces in all types of districts ranging from the most well resourced metropolitan districts to the poorest of rural districts.

A Primary Health Care Package has been developed which suggests a range of services that should be available to every community. Municipal health services may not be the same as the primary health care package and therefore it is likely that the amount of resources available in a municipality will probably be the factor that decides what services can be offered and how much of each service will be delivered. The MEC for local government in each province may adjust the responsibilities of a municipality if it does not have the capacity to deliver the services. A municipality can enter into partnerships with a neighbouring municipality or the private sector to provide some of its services.

District hospitals form an important and integral part of the district health system. They are crucial for providing administrative and technical support to primary health care services, and for providing basic hospital services. Some provinces argue that district clinics and community health centres will be more effective if a hospital is not at the center of a district health system. This is may be true in urban areas, but in rural areas district hospitals usually play an important role in supporting primary health care and most provinces still have to make decisions about this.

It is possible that greater decentralisation will result in increased inequity. It is therefore important for national and provincial government to monitor spending on health across municipalities and find ways of re-distributing resources in favour of the poorest municipalities.

The responsibility for the delivery of comprehensive PHC can never completely belong to one level of the health system – it requires an integrated health care system where different levels of management and administration work together in a complimentary manner.

1.2 Contracting out health services

In recent years, the contracting out of health services has gained increasing favour among donor agencies and national governments. Contracting out has largely been motivated by perceived inefficiencies of public health care delivery systems. Typically, under contractual arrangements, public agencies contract out specific health care services to the private sector or, less commonly, to autonomised public entities. Only limited evidence exists, however, on the impact contracting out has had on access, equity, efficiency, and quality of primary health care services (Liu et al., 2004).

Contracting out in the health sector is generally defined as the development and implementation of a documented agreement by which one party (the principle, purchaser, or contractor) provides compensation to another party (the agent, provider, or contractee) in exchange for a defined set of health services for a defined target population (England 2000). Contracts may specify the types, quantity, and quality of services that the provider is to deliver. A contract can also specify the intended health outcomes associated with the delivery of the contracted services.

The practice of contracting out began in industrialized countries outside the health sector. Specifically, member countries of the Organization for Economic Cooperation and Development started contracting services in the transportation, public utilities (water, gas, and electricity), and municipal sanitation sectors, only later extending contracting to the education and health sectors. The contracting out of health care services spread to developing countries in the mid 1990s, largely influenced by an ideological (and corresponding programmatic) shift on the part of multilateral and bilateral donor agencies towards contracting out. Currently, governments in as many as 30 to 40 developing countries have contracted out some type of health care service (Liu et al., 2004).

Contracting out has gained popularity because of several hypothesized advantages it has over direct public sector provision and because of perceived public sector shortcomings; many believe that contracted providers can provide health care more efficiently than the public sector and that contracted providers may be held to a higher level of accountability, as governments are likely to be more objective in evaluating the work of contracted providers than in evaluating their own. Supporters of contracting out also believe that a contract allows the government to shift its role from the provision of health care to tasks that may better reflect its core strengths, such as financing health care and monitoring provider performance. Additionally, a number of authors have documented improvements in access, equity, efficiency, and quality of health care under contractual arrangements. Detractors of contracting out argue that it may incur high transaction costs, it could result in an adversarial relationship between purchasers and providers, and it may not be effective because health care itself has low contractibility (ibid.).

Scant literature has been published on the impact contracting has had on access, equity, quality, and efficiency of health care services delivery. More extensive and rigorous research is needed before one can draw firm conclusions about contracting out's short- and long-term impact on these dimensions. Donor agencies sponsor most developing country contracting activities and, correspondingly, most of the literature on contracting is in the form of donor-sponsored papers and reports. Typically, purchasers in these situations are national governments who receive donor support for purchasing contracted health care services, while contractees are usually private providers (including nongovernmental organizations, private hospitals, and individual health workers). The goal of most contracting-out initiatives is to improve the target population's access to specified basic health care services (ibid.).

Evidence from a range of sources suggests that contracting out can improve access to health care services by increasing the provision, utilization, and coverage of these services. Most monitoring and evaluation efforts focus on this particular outcome more than on measuring contracting's impact on health care equity, quality, and/or efficiency, an imbalance that requires rectification. It appears that contracting out can improve equity in health services delivery if programs are appropriately targeted. Improvements in equity can be achieved by three different strategies (England 2004): (1) establishing contractual arrangements that specifically encourage providers to serve the poor and underserved; (2) contracting with private providers in areas where predominantly poor or underserved populations live (geographic targeting); and (3) contracting out services that would be of most benefit to the poor and underserved.

It is still unclear, however, whether contracted services are more effective in addressing equity than direct public sector provision would be. In terms of the impact contracting has had on the quality of health care services, contracting-out projects are more likely to improve quality of care if (1) quality is operationally defined and indicators associated with quality are well developed; (2) quality indicators correspond to the service delivery processes specified in the contract; and (3) quality indicators (e.g., health outcomes) have an established association with utilization of contracted services. It was not possible to ascertain whether contracting out improves quality of care when compared with direct public provision, as quality has been either undefined or inconsistently defined across projects and generally there have been no control groups included in evaluations. It is also unclear what impact contracting out has on efficiency. While some studies suggest that contracted providers can deliver services at a lower cost than public providers, it remains unclear whether contracting lowers the overall cost of service delivery to the purchaser. It has also not been possible to demonstrate that contracting out increases the efficiency of the overall health system (Liu et al., 2004).

1.3 Conceptual framework

The framework delineates four types of information that should be included to effectively evaluate contracting-out reforms. The first is information on the contracting-out intervention itself. One should consider several characteristics of the intervention: the types of services the contract covers, the contract's formality, the contract's duration, the selection of the contractee, the specification of performance requirements, and contract payment mechanisms. The second type of information to be considered involves the external environment; this includes characteristics of the overall health sector, as well as of the financial and legal settings in which the intervention takes place. The third type of information required is the response of providers and purchasers both within and outside the contracting out scheme. This includes information on how the contractee manages inputs, outputs, and outcomes, and the actions of the contractor and contractee to monitor performance. It also requires data on responses that occur outside the intervention, such as responses in the provider market, and responses affecting other government health services. Finally, it is necessary to collect information on the impact of the contracting-out intervention. Impact can be measured in terms of the intervention's effect on access, equity, quality, and efficiency of health services. The framework will be used to guide

the development of indicators, which cover each component of the framework, although specific indicators may vary depending on the specific contracting-out interventions.

Figure 1: Framework for Evaluating Primary Health Care "Contracting-out" Initiatives

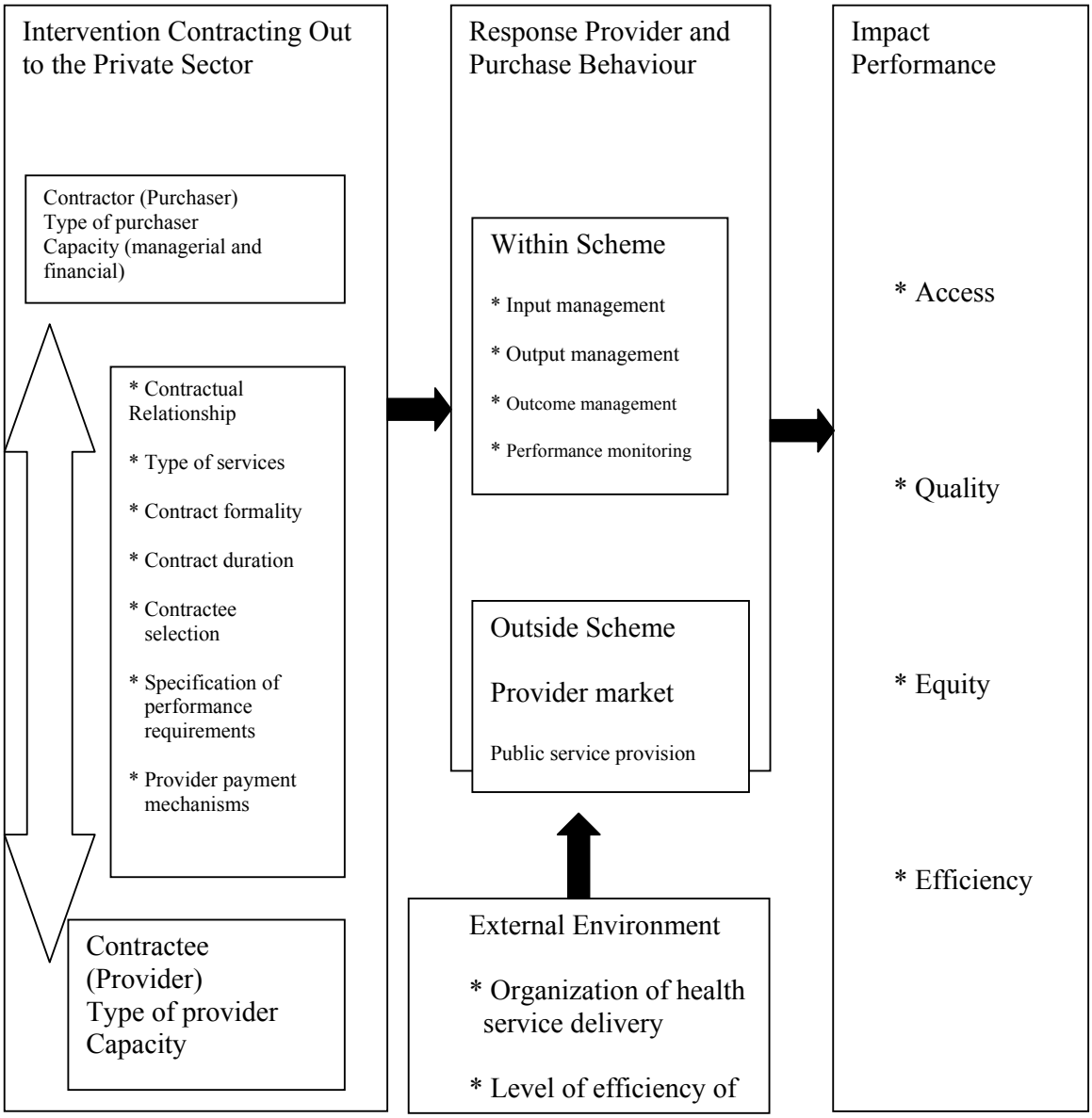


Figure 1 presents a diagramme of the conceptual framework. Four broad and mutually interactive types of information will be considered in the evaluation of contracting out

Partnerships in PHC: (1) the intervention, including the characteristics of the contractor, the provider, and the contractual relationship; (2) the external environment; (3) the response of providers and purchasers both within and outside the contracting-out scheme; and (4) the impact

of the intervention. Collecting and analyzing information on all four dimensions is necessary to investigate whether contracting out is achieving its intended objectives and the factors that determine its effectiveness. As depicted in Figure 1, two parties are involved in the contractual relationship. One party is the government, serving as a purchaser or contractor for health care services. Its major function in the contracting arrangement is financing, with the overall objective of improving health system performance.

The financial and managerial capacity of the contractor is likely to affect the effectiveness of contracting. The ability of the contractor to pay the provider in a timely manner is likely to be important. Obviously, this means that contracting may be problematic in resource-starved environments where it is difficult to pay providers in a timely manner. Moreover, because the contract obligates resources, it may negatively influence the government's ability to deliver services of acceptable quality outside the contracting-out initiative. The capacity of the contractor to manage the contract is also likely to be important. Critical management functions include procurement, oversight, performance assessment, and payment.

The other relevant party is the provider or contractee (here the NPO). The provider's major function is health service provision, and its general objective is to financially break even (if they are not-for-profit NGOs). The public-private status of the provider may impact the effectiveness of contracting out if the provider's objective is affected by whether they are public or private. While it has been assumed that private providers are more productive and better motivated than public providers, there is little empirical evidence to support this premise. The key question here is whether public-private status and the level of autonomy are key determinants of provider productivity, and how these characteristics influence the effectiveness of contracting-out interventions.

The effects of contracting out on primary health care service delivery are likely to be influenced by the characteristics of the contractual relationship between the contractor and the contractee. Several characteristics that may be important to consider in the evaluation are (1) the type of services covered by the contract, (2) the formality of the contract, (3) the duration of the contract, (4) the selection of the contractee, (4) the specification of performance requirements, and (5) the payment mechanisms.

The external environment refers to a number of characteristics of the health sector and the financial and legal environments. These factors make up the environment surrounding the contracting-out intervention, and while most of these external factors are unlikely to be influenced in the short-run by health sector policy, they can potentially be key determinants of the success or failure of the intervention.

The effectiveness of contracting on health systems performance depends on how providers and purchasers – operating both within and outside the contracting-out intervention – respond to the intervention. Within the intervention, key responses that are depicted in Figure 1 as influencing health systems performance are the actions of the contractee to manage inputs, outputs, and outcomes, and the actions of the contractor and contractee to monitor performance. However, sufficiently understanding the influence contracting out has on health system performance – which is the primary albeit sweeping objective of evaluation research – also requires understanding the responses that occur outside the scheme. These responses include those occurring within the provider market and responses affecting government services delivered outside the contracting-out intervention.

The overriding objective of evaluating contracting out is to assess the impact of alternative types of interventions on the primary health care system's performance. As indicated on the right-hand side of Figure 1, performance is defined in four dimensions: access, quality, equity, and efficiency. Assessing the changes in all four dimensions as a result of contracting out is important in producing evidence that can be used to provide a comprehensive understanding of how the initiative influences the primary health care system.

1.4 The EU Partnership for the Delivery of Primary Health Care Programme (PDPHCP)

The PDPHCP is a six-year programme of the Department of Health developed by the European Union in collaboration with the Government of South Africa and the UK's Department for International Development (DFID). The aim of the Programme is to strengthen the delivery of primary health care services (especially those addressing HIV/AIDS) by supporting the development of partnerships between government and non-profit service organisations. The Programme is operational in five provinces (Gauteng, Limpopo, KwaZulu-Natal, Eastern Cape and Western Cape).

The EU Financing Agreement for the Partnerships for Health Programme, while specifically concerned with contracting Non-Profit Organisations (NPOs) for Primary Health Care (PHC) service delivery, has a relatively open-ended approach to partnership:

> *"Accordingly, through the strengthening of the District Health System (DHS) and the development of partnerships with non-profit service providers (NGOs and Community Based Organisations CBOs) this programme will strengthen co-operation between non-profit providers and Government through the creation of formalised partnerships for the delivery of PHC. This programme therefore focuses on the strengthening of the DHS and in particular on the delivery of PHC services."*

Monitoring and evaluation (M & E) is seen as a significant component of the Partnerships for Health Programme. An M & E conceptual framework was developed as part of the design phase of the Programme and outlined the need to develop indicators to monitor processes, outcomes and impact, as well as individuals, institutions and context. The baseline studies will constitute the first step in implementing the M & E component of the programme. The Human Sciences Research Council (HSRC) was contracted to complete the baseline studies.

The new South African health system adopted the Primary Health Care (PHC) approach in delivering PHC services because this approach is the most effective and cost effective means of improving the population's health (Department of Health, 1997). The approach involves a health system led by PHC services, which are at the base of an integrated district health system. The PHC services range from personal promotive and preventive service such as health education, nutrition/dietetic services, family planning, immunisation and screening for common diseases; personal curative services for acute minor ailments, trauma, endemic, other communicable and some chronic diseases; maternal and child health services such as antenatal care deliveries, post-natal and neonatal care; provision of essential drugs; PHC level investigative services such as radiology and pathology; basic rehabilitative and physical therapy services; basic oral health services; basic optometry services; mental health services; and medical social work services offered by various health professionals such as nurses, doctors, pharmacists, radiographers, nutritionists, dieticians, social workers, dental therapists, health educators, occupational therapists, environmental health officers and pathologists. It is important that these services are provided in an equitable, effective and efficient manner. One way of ensuring the latter is to conduct baseline studies that are geared towards measuring availability, affordability, accessibility, effectiveness, efficiency and quality of PHC service provision. Such information would be used in the planning and management of PHC services. In this regard, the Department of Health of South Africa, in collaboration with the European Commission, developed a six-year Partnership for the Delivery of Primary Health Care Programme (PDPHCP) including HIV/AIDS Programme in order to strengthen the delivery of PHC services (especially those addressing HIV/AIDS) by supporting the development of partnerships between government and non-profit service organizations (NPOs). Five provinces are participating in the programme, namely: Gauteng, Limpopo, KwaZulu-Natal, Eastern Cape and Western Cape.

1.5 Purpose of the study

The overall purpose of conducting a baseline study is to ensure more accessible, affordable, quality PHC for the poorest communities in 5 target provinces by drawing out lessons and recommendations from the successes and failures, and to feed these into both ongoing and future PHC programmes and to develop a conceptual and operational framework to support these programmes.

1.6. Broad Objective of the study

To complete comprehensive baseline studies/evaluations in 5 target provinces participating in PDPHCP including HIV/AIDS programmes that will form a benchmark against which change (positive, negative, intended or unintended) can be measured, with particular emphasis on key societal, organizational and individual indicators. The findings of provincial baseline evaluations will be consolidated into a national baseline evaluation report for the PDPHCP.

Chapter 2: Overall study methods

2.1 Research design

The research design is a pre-post research design, attributing changes in indicators only after careful and comprehensive analysis, and encouraging indirect evaluation approaches and qualitative studies to further assess the impact of contracting-out programmes.

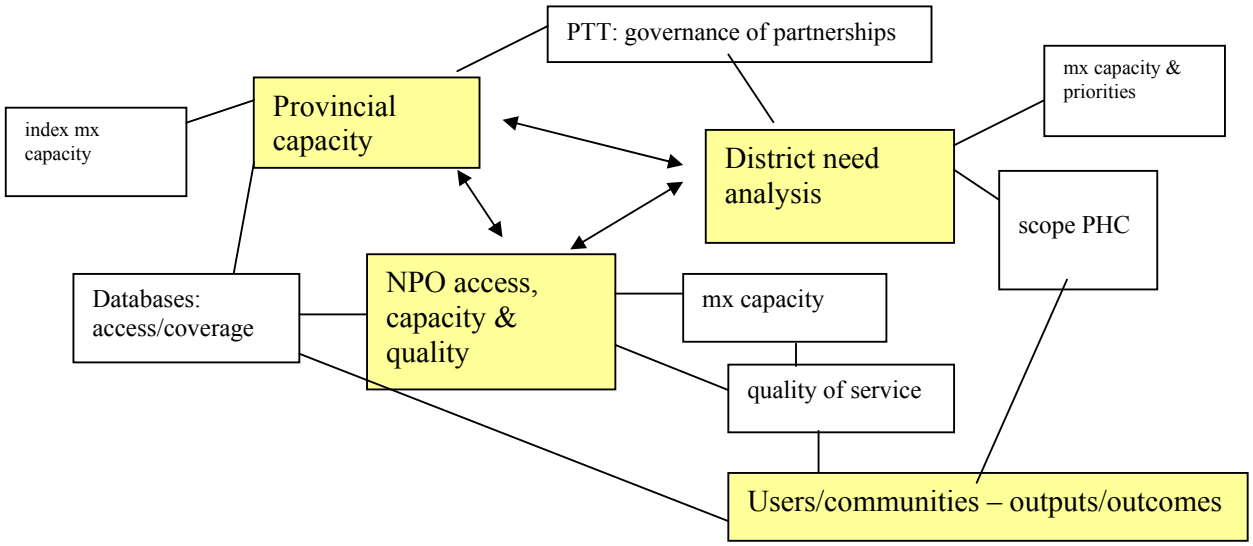
The elements of the baseline studies include:

- An assessment of government capacity to manage partnerships with NPOs which spans both provincial and district spheres
- An area-based district analysis, which includes an assessment of district infrastructure, PHC services (focusing on gaps which NPOs could fill) and NPO partnerships
- An assessment of NPO access, capacity and quality

2.2 Instruments

The various tools and their links to the groups of actors implicated in Partnership for Health are summarised in Figure 2 below.

Figure 3: Groups of actors in Partnership for Health and their relationship to specific tools



2.3 Sampling

In order to balance speed with depth in the evaluation the following sampling strategy was followed in each province (Figure 3):

- Two districts purposefully sampled from those participating in the PDPHCP partnership in each province.
- Within each district, four sub-districts and at least six NPOs randomly selected

NPOs inclusion criteria are being funded or earmarked for funding from the PDPHC programme.

Figure 4: Sampling strategy

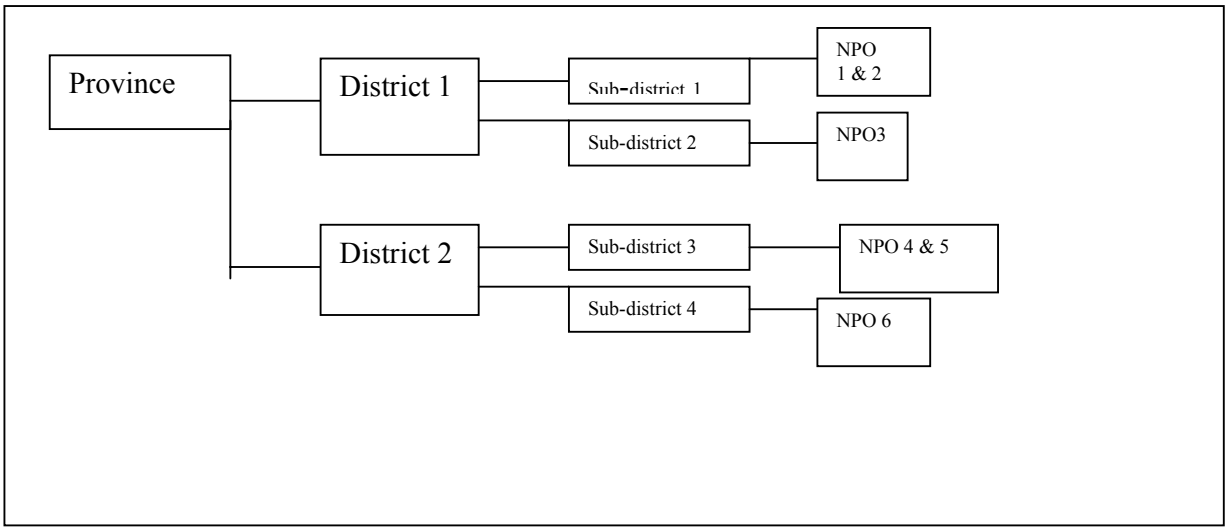


Table 3: Overview of sample and tools

5 Ex Prov	Public health	NPOs	Outcome/Impact
Sample:	-District managers (n=10) -Task network (National/province/district/ sub-district) (n=108, all) -NPO database audit (n=31)	NPOs in partnership (n=37) -6 Service NPOs (HBC, support groups, health promotion) per province (9 in KwaZulu-Natal and 9 in Limpopo)	Sub-district managers (n=14; all) Consumer assessments (n=150) (in two provinces only, urban KwaZulu-Nata rural Limpopo Province)
Indicators	-District needs analysis -Management capacity	-Organisational capacity -Quality of service	Access/Equity/Quality/ Efficiency PHC indicators: HBC & Support groups indicators
Tools	-District needs assessment tool -NPO database audit -Management Capacity	-Organisational capacity -Quality of care tools: HBC/Support groups/health promotion	-Access… tool (sub-district) -Household tool: External support for chronically ill -Consumer assessment: Home-based car -Consumer assessment: support groups

App=Appendix

Phase 1 and 2

Baseline studies were conducted in a phased approach. Phase 1 involved open-ended interviews to get agreement on the procedures of the study, to get a broad overview of the situation in each province and to plan for the detailed data collection in phase 2.

Specifically in phase 1 the teams:

- Obtained and reviewed provincial plans and identified provincial priorities for the PDPHC programme;
- Identified the task network involved in the PDPHC programme and held a meeting with representatives of this network to agree on processes and procedures of the work;
- Collected all background documentation, policies on NPO-government partnerships, NGO funding etc.; and
- Obtained ethical clearance from the Human Sciences Research Council Ethics Committee and Provincial Health Departments for the studies.

2.4 Procedure

Research tools used have been developed and pilot tested in Gauteng by the Centre for Health Policy (2004).

Interviews were conducted in English, Zulu and Northern Sotho by senior researchers and trained professional nurses, and informed consent was be taken. The content of semi-structured interviews (open-ended questions) was recorded by the senior researcher by taking notes. Self-administered sections of the questionnaires were administered by senior researchers. The senior researchers also asked for documentation of components of the study questions from their interviewees. Provincial visits were conducted in September and October 2005. Data collection was conducted from January 2006 to April 2006. The study protocol was approved by the Human Sciences Research Council Ethics Committee (REC 1/10/08/05).

2.5 Data management

The fieldwork coordinator gave the completed provincial data collection instruments to the research manager in accordance with their allocated provinces. Each fieldwork coordinator, with the assistance of the junior expert (statistician) and data captures coded and entered the data into the appropriate package (SPSS). Once the data had been captured, the statistician ensured that it was cleaned.

2.6 Data analysis

Both qualitative and quantitative procedures were used and a triangulation of data from different actors and methods was conducted. Quantitative data were analysed using SPSS. Qualitative data were analysed using thematic content analysis. The team leader and the two senior experts analysed the data, together with the statistician, in accordance with the analysis strategy that was agreed upon at the study design phase.

Chapter 3: Area based district needs analysis

3.1 Introduction

The South African government has adopted Primary Health Care (PHC) as the philosophy to deliver health service in this country (Department of Health, 2000; Nicholson, 2001). The District Health System (DHS) model has been adopted as the strategy to implement the PHC philosophy (McCoy & Engelbrecht, 1999). The DHS is the means to achieve the end of an equitable, efficient and effective health system based on the principles of PHC approach.

This means that the DHS is more than just a structure or form of organization. It is the combination of a set of activities that includes community involvement (through non-government organizations, clinic health committees), integrated and comprehensive health care delivery, intersectoral collaboration and a strong 'bottom-up' approach to planning, policy development, and management.

The underlying essence of the DHS is the organization of health care according to geographic sub-divisions of the country, which are managed through a decentralized management structure. The district management structure is the point or level at which different services that impact on health, such as agriculture, sanitation and water are integrated into a comprehensive and holistic approach to health care. The DHS approach represent a significant departure from the previous segregated, separation of curative from preventative and hospital oriented health delivery system in South Africa.

In addition, the DHS was introduced to meet the health care needs of all South African citizens, provide a simple, logical service, allow local decisions to be made locally, allow communities to be involved in designing the service they use and focus on improving health and shifting focus away from being mainly health services administration to really improving the quality of care (Harrison et al 2003).

As a measure to further improve health delivery, large districts are further divided into sub-districts. The sub-districts are also guided by the same PHC principles as that of the district such as a multicultural approach to health care, as well as strong community participation and involvement. This includes non-government organizations (NGOs), community based organizations (CBOs), and faith-based organizations (FBOs) (Harrison, 1996).

This section of the report focuses on needs analysis at district and sub-district levels in the 5 targeted provinces. The district needs analysis involved the following three dimensions:

- District level assessments of: health priorities, capacity (organizational and systems) and contextual factors that can influence the outcomes of partnership agreements
- Sub-district assessments of access or coverage to PHC services in both the public and NPO sectors, as well the existence of coordinated referral networks (including the continuum of care for HIV) between providers
- Assessments of quality provided by both public sector clinics and NPOs

3.2 Objectives

The objectives of the district needs assessment were:

- To identify gaps in access and quality of PHC services which could be filled by NPOs (and in the follow-up evaluation to assess whether these quality gaps have been filled)
- To assess the capacity of districts to work with NPOs including contextual factors which could influence the outcomes of partnership agreements

- To assess the capacity of NPOs to work with districts

3.3 Methods

3.3.1 Study Design

An exploratory-descriptive study was conducted among district and sub-district health managers in Limpopo (LP), Gauteng (GP), Western Cape (WC), Eastern Cape (EC), and KwaZulu-Natal (KZN) provinces.

3.3.2 Population and Sampling

The district needs assessment was conducted in 5 provinces. Within each province, 2 district municipalities were purposefully selected – KZN (eThekwini/Zululand), LP (Waterberg/Sekhukhune), WC (CT metro/Boland Overberg), EC (OR Tambo/Amathole) and Gauteng (JHB metro/Tshwane). In each case, the district manager was interviewed using a semi-structured interview schedule. Key results are divided into district priorities, district management capacity (district management team, planning, human resources, financial systems, health information system, provincial and local government, governance and local participation and ability to partner with NPOs) and contextual factors influencing partnerships. Further, within each district, two sub-districts were randomly selected. Therefore, in each province four sub-districts were selected for the study amounting to a total of 20 sub-districts in the five provinces. However, only 14 sub-districts agreed to participate in the study - Three in KZN (INK, Abaqulusi and Ulundi), four in Gauteng (Alexandra, Orange farm, Tshwane Central & Soshanguve), two in EC (BC & KSD), One in WC (Thee Waterkloof), and four in LP (Fetakgomo, Makhuduthamaga, Mogalakwena and Lephalale). In each case the sub-district manager (or designated persons e.g. PHC co-ordinator) was interviewed using an interview schedule. Key results are divided into two domains: PHC access, coverage, and quality of PHC with specific reference to facilities/staffing, outreach, outputs, outcomes, and LG/provincial integration and NPO partnerships with focus on participation, referral/coordination and support.

Table 4: Study sites for district assessments

PROVINCE	DISTRICTS	DISTRICT TYPE	SUB-DISTRICTS
LIMPOPO	Sekhukhune	Rural	Fetakgomo
	Waterberg	Rural	Makhuduthamaga
			Mogalankwena
			Lephalale
WESTERN CAPE	Cape Metro	Urban	Thee Waterkloof
	Boland Overberg	Rural	
EASTERN CAPE	Amathole	Urban	Buffalo City
			King Sabata
	OR Thambo	Rural	Dalindyebo
KWA-ZULU NATAL	District Health Manjes	Urban	eThekwini (INK)
	Zululand District Health	Rural	Abaqulusi
			Ulundi
GAUTENG	Johannesburg	Urban	Alexanda
	Tswane	Urban	Orange farm
			Soshanguve
			Tshwane Central

3.3.3 Data Collection Methods

a) Face-to-face interviews were conducted with district health managers and sub-district health managers. Other data collection methods included; b) review of documents and c) reports (plans obtained) and d) completion of self-administered questionnaire (attitudes and organizational culture); e) collection of routine data from planning documents, MDS and TB programme and from special surveys (e.g. PHC audit).

3.3.4 Data Collection Instrument

The interview schedule used for conducting face to face interviews with district and sub-district managers, included the following components: District management, Finance information, Social attitudes (HIV), Organizational culture, Beliefs about NPOs and partnership (Center for Health Policy, 2004). Detailed instrument can be found in the appendices.

3.4 Results

The area-based district needs analysis is divided into a district assessment, a sub-district assessment and an NPO database assessment.

3.4.1 District assessment

Table 5:District priorities, management capacity and NPO partnerships.
NB: For a detailed breakdown of district analysis by provinces see Appendix A

Dimensions and Elements	**LP**		**WC**		**EC**		**KZN**		**GT**	
	Sekhukhune	**Waterberg**	**Cape Metro**	**Boland Overberg**	**Amathole**	**OR Thambo**	**Ethekwini**	**Zululand District Health**	**JHB**	**Tshwane**
District Priorities *(these are articulated or written in reports)*	None.	To improve PHC, effective and efficient delivery, and the revitalization of the district	To reduce poverty and reduce health	Poverty relief through comprehensive development	Implement IDP	Capacity building and service delivery at local level	Strengthening of PHC services, HR management and development, finance and resource management	Economic development and improving service delivery	Improved health of JHB citizens.	Provision of strengthened PHC in order to reduce preventable diseases
District Management Capacity	Management, financial and monitoring systems, relations with political and NPOs are just okay.	Management, financial and monitoring systems, good relations with political and NPOs	Management, financial and monitoring systems, relations with political and NPOs are good.	Management, financial and monitoring systems, relations with political and NPOs are just okay.	Management, financial and monitoring systems, good relations with political and NPOs	Management, financial and monitoring systems	Management, financial systems and very good relationships	Management, financial systems and very good relationships	Good relationships, management, financial and monitoring systems.	Good relationships, management, financial and monitoring systems.
NPO Partnerships *(these are articulated or written in reports)*										
Is there a policy on NPOs in the district?	Don't know	No	Yes	No	No	No	No	Yes	Yes	Yes
What forms of partnerships exist?	Not specified	Not specified	Formal-SLA	Informal and informal	Informal	Informal	Informal	Formal and informal	Formal - MOA with HIV/AIDS NPOs, informal	Formal and informal

Does the district have any service contracts with NPOs?	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes
If yes, how many?	No response	1	30 non-EU and 29 EU	12 with HBC NPOs, 5 with HIV NPOs, 3 with Welfare NPOs	27	None	Not applicable	6 DOH and 14 EU	No response	1
How are the partnerships managed?	EU personnel	Community liaison officer	District	District	EU guidelines	LSA managers monitor NPOs	No monitoring and evaluation capacity	Unit managers	Quarterly monitoring	Regular interactions (meetings)
How are the contracts monitored?	On site visit or monthly meetings	Monthly expenditure reports	Monthly report or meetings	Onsite visits and financial reports	No response	According to ToRs	No contracts	Written reports	Monthly reports	Monitoring tool
Are there any aspects relating to improving management capacity to manage partnerships?	Yes	Yes	Yes	Yes	No response	Yes	No	No	No	Yes
If yes, what are the strategies	Internal or external training workshops	Capacity development	Management development	Management training	No response	Project management, financial management and public service regulations	Not applicable	Not applicable	Not applicable	Capacity building of managers
Who determines when NPOs get paid?	NPO finance committee	Provincial office	District manager	Written contract	Province and EUPDPHCP	Province	Province guided by PFMA	Province (HIV unit)	District director	Province and district jointly
Do NPOs submit financial statements before receiving quarterly statements?	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes
Do you collect data	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes

from NPOs?								
If so, on what?	TB cure and facility levels	TB cure and facility levels	Service rendered, financial information, demographic data and Infrastructural information.	Staff compliment and expenditure	Not applicable	Not applicable	Staff complement and expenditure	Patient demographics and services received	PHC head counts, TB cure rates, EPI and HIV/AIDS	DOTS or other illnesses
What are the service gaps?	Challenges in implementing full PGHC package	Understaffed, difficulty in recruiting and retaining professional nurses	Limited funding or too much paperwork	Implementation challenges	Vastness and poor infrastructure	Shortage of personnel and high population	Understaffed	Lack of access to health care and low service utilization	Service disparities, inaccessibility to services and poorly coordinated awareness campaigns	Different governments structures, poor referrals and lack of capacity
Can NPOs fill the service gaps?	Yes	Yes	Yes	Yes	No response	Yes	Yes	Yes	Yes	Yes

District priorities

All the districts were able to verbally articulate their goals and priorities and also had them in written in planning documents. They goals included among others, economic development, HR development, provision of accessible, effective and efficient health care, improve and strengthen PHC, reduce incidence of preventable diseases, strengthen district health services at all levels of health – primary, secondary and tertiary. However, the potential role of NPOs was not clearly articulated verbally and in written planning documents.

District management capacity

District management capacity encompasses the following dimensions: district management team, planning, human resources, financial systems, health information system, provincial and local government, governance and community participation and ability to partner with NPOS. Key findings for each of the above-mentioned are discussed below and the recommendations are given at the end.

District Management Health Team: All districts had a district health management team except JHB metro. In terms of human resources, they also had 5 or more members except in three districts (Sekhukhune, Waterberg and Amathole). Generally, the support functions of the DHMTs (finance, human resources, drug supplies, programmes) were clearly delineated. Half of the districts had a district council. Almost all districts (8) had a staff training strategy.
Planning: More than half of the districts (6) had DHTM organogram, 3 year health plan at district levels (9), operational plans for the current year at district levels (90) and sub-district levels (6), annual reports for last financial year (7), 5 year IDP for the district (9) and there was

a link between the IDP and provincial planning process (7). Only 4 districts had 3-year health plans for sub-districts.

Financial systems: Generally districts had financial systems in place, i.e. health expenditure reviews (10), cost centre accounting by facility in the district (8), NPOs submitted financial statements before getting/receiving financial instalments (9) and district tender committees (7). However, only 4 had a health district budget.

Province and local government: There was evidence of joint processes and management structures in all districts. The majority of districts perceived the existing mechanisms as functional/highly functional (7). Half of the districts (5) perceived the relationship between province and local government as just OK, 3 perceived it as v.good/good. The relationship between local politicians and the DHMT was perceived as good (8). In terms of collaborative work, 5 districts had MOU and MOAs with province and 4 had SLAs.

District Health Information Systems: The majority of districts had implemented DHIS (9), collected data from provincial government clinics (10), local government clinics (8) NGOs (8) and also collected data on TB indicators (10). They also had a mechanism for crosschecking information sent from clinics (9). Be that as it may, still some districts could not provide statistics on the PHC services.

Ability to partner with NPOs: The majority of the districts had district mechanisms to manage NPO contracts (8), database on NPOs (10). Only 4 districts had an NPO policy. Eight (8) districts had SLAs with NPOs. All districts had either formal, informal or both formal and informal partnerships with NPOs. The partnerships were managed through various mechanisms-LSAs, unit managers, regular interactions, and community liaison officers among others. There seemed to be no uniform system of managing partnerships across districts. Contracts were also monitored differently across the districts, i.e. on-site visits, submission of monthly reports, monthly expenditure reports, "If they don't deliver, we withdraw funding", meetings, audited financial reports. Again, there was no uniform way of monitoring contracts. It was indicated by 6 districts that there are aspects of the NPO policy relating to the improvement of management capacity or ability to manage partnerships. Service gaps identified across districts included understaffing/lack of capacity, difficulty in retaining and recruiting staff, challenges in implementing PHC package, service disparities, inaccessibility of services/low service utilisation and limited funding. Districts generally believed that NPOs could fill their gaps in service delivery.

Recommendations

- The role of NPOs should be clearly delineated in district priorities
- More human resources are needed for districts whose DHMTs are not adequately staffed.
- District councils to be established in districts that currently don't have them
- 3-year health plans for sub-district need to be developed in some districts
- Health budgets to be developed in all districts
- There is a need to improve the relationship between local and provincial governments.
- Districts should use their DHIS effectively to ensure that they have data on all PHC indicators
- NPO policies should be developed in all districts
- A standardised system of managing partnerships should be developed
- Standard methods to monitor contracts should be developed
- There is a need for capacity development to manage partnerships
- The identified service gaps need to be addressed, especially lack of capacity, staff recruitment and retention
- Districts to utilise NPOs more effectively to close service gaps

3.4.2 Sub-district PHC coverage, access and quality

Table 6: Sub-district PHC coverage, access and quality
NB: For a detailed breakdown of the sub-district needs analysis see Appendix A

			LP				GT				EC		KZN			WC
Domains	**Elements**	**Indicators**	**Fetakgomo**	**Makhuduthamaga**	**Mogalakwena**	**Lephalale**	**Alexandra**	**Orange Farm**	**Tshwane C/S**	**Soshanguve**	**BC**	**KSD**	**INK**	**Abaqulusi**	**Ulundi**	**Thee Waterkloof**
Sub-district PHC coverage, access and quality	**Facilities**	# of satellite clinics	11	17	0	No response	No response	No response	3	2	2	34	8	1	16	8
		# of PHC clinics	No response	18	6	6	7	4	27	6	101	No response	None	19	None	1
		# of CHC	1	No response	0	0	1	1	2	1	6	5	No response	1	None	1
		# of mobile clinics	2	4	0	0	No response	No response	2	1	16	4	No response	0	0	8
		Audit of PHC package done	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
		Access to PHC package items	Yes	Yes	Yes	Yes	Yes See details below	Yes See details below	Yes See details below	Yes See details below	Yes See details below	Yes See details below	Yes See details below	Yes See details below	Yes See details below	Yes See details below
		Proportion of clinics open after hours/ 24 hours	None	1	No response	0	No response	No response	None	None	6	5	None	1	None	None
	Staffing	# of professional nurses in PHC	11	95	0	42	19	24	Don't know	No response	60	47	Don't know	112	54	13
		# of doctors in PHC	0	No response	0	0	1	14	Don't know	No response	3	1	Don't know	No response	5	0
		# of professional nurse vacant posts/total posts	No information	No information	No information	No information	No information	No information	No information	No information	No information	No information	No information	No information	No information	No information

		Presence of a training plan for staff	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Outreach	Availability and type of outreach worker in the district	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
		# OF outreach workers	7	None	None	Not Specified	79	561	527	15	506	15	No response	150	553	161
		# of facilities supporting HBC	8	17	35	12	0	5	8	11	101	No response	Not Known	15	No response	6
		# of facilities supporting PLWA support group	11	3	35	12	7	4	4	11	0	13	No response	10	16	3
	Outputs	# of visits to PHC facilities in last year	15	No response	17	Yes	26	Not known	1,026 3 m	619731	24	22	No response	No response	No response	Don't know
		Mean number of patients per clinic nurse per day	35	25	24	24	45	35	40	35	40	No response	No response	78	55	55
		MTCT prevention coverage	See details below	See details below	No information	No information	See details below	See details below	See details below	See details below	See details below	See details below	See details below	See details below	See details below	Not provided
	Outcomes	TB treatment completion	No response	3.3	No response	No response	73.3	4.7	1060	56	54	31	No response	78	No response	81 %
		Cure rates in sub-district	3	63.3	No response	50.30 %	60.2	75.3	78	54	40	42	No response	75	No response	81 %
		Immunization coverage	81.80%	54.50 %	49.20 %		90.3	Not known	90.80 %	82.3	110	116	No response	88. 30	No response	80 %
	LG/provincial integration	Presence of integrated: Service provision	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

		management structures	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No response	Yes	Yes
		Joint NPO management processes	No	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No response	No	Yes

Facilities: All the sub-districts had satellite clinics, PHC clinics, CHCs, however, the majority of them did not operate after hours.
Staffing: almost all sub-districts (12) had a training plan for the sub-district.
Outreach: Almost all sub-districts (12) had various outreach functions in the sub-district performed by professional staff, health promoters, DOTS supporters and CHWs. All sub-districts had clinics (though not all clinics) linked to PLWHA and clinics supporting HBC.
Outputs: The number of visits to PHC facilities per sub-district ranged from once to about 24 times per year. The mean number of patients per clinic nurse per day ranged from 24 to 135. In most sub-districts (11), it was reported that each nurse saw between 24 and 55 patients per day. The statistics for MTCT coverage were not provided in some sub-districts . In those districts that supplied the statistics, the number of pregnant women seen ranged from 147 to 30 526; the number of women tested for HIV ranged from 1 to 8057; the number of women who tested HIV+ ranged from 7 to 1910; the number of women receiving NVP ranged from 5 to 701 across the sub-districts; the number of infants receiving breast milk substitutes ranged from 41 to 58032. Women were generally not followed up at 3,6 and 12 months.
Outcomes: Indicators for TB were provided in some sub-districts. Other sub-districts did not have them readily available.
Local and provincial governments integration: Nine (9) sub-districts had a joint local government/provincial team and 10 had a joint reporting of information for sub-district.

NPO Partnerships

Participation: There were forums involving NPOs in the sub-districts. Further, there were structures for consulting with the community across all the sub-districts.
Referral and co-ordination: The majority of the sub-districts (11) had NPO databases developed by various people DTT, PTT, EU Co-ordinator, HIV/AIDS co-ordinator, DOH; however, most of these databases were not frequently updated. Further, sub-districts generally had had a referral system between NPOs and facilities in the sub-district (10).
Support: The majority of sub-districts (11) provided supplies (e.g. HBC kits) to NPOs

Recommendations

- NPO databases should be frequently updated
- Sub-districts should have health information systems that have MTCT coverage statistics
- There is a need for follow up of women at 3, 6, and 12 months across the districts.
- Increase the number of facilities that operate after hours within sub-districts

Sub-districts to keep information on TB indicators readily available in order to assess the outcomes of their services

Chapter 4: NPO database assessment

4.1. Purpose of NPO databases

The most essential ratings for possible purposes of databases on NPOs were (1) An information system for monitoring and evaluating partnerships at district and provincial level, (2) An information system for monitoring NPO contracts, and (3) To provide an understanding of health related activities in an area so that can incorporate into government planning (see Table 3.1.9).

4.2. Objectives

The objectives of this part of the study were to:

- obtain the views of provincial and district stakeholders on the purpose, content and location of an NPO database
- conduct an inventory of existing provincial databases and how they may be incorporated into a consolidated NPO database
- propose a set of core indicators for evaluating PDPHCP which can be obtained for the provincial NPO databases

The information collected is formative in nature and will feed into the development of the actual NPO databases, which are a core management tool of the PDPHCP.

4.3. Sample

Thirty-one participants (EU PDPHCP coordinators at provincial & district level, district information officers, and other task team network members) in all 5 provinces were interviewed with a semi-structured questionnaire by a senior researcher from the HSRC.

4.4. Results

Table 7: NPO data base
Possible purposes of NPO databases rated as essential (e), useful (u) nice, and (n) to have possible purposes (affirmative responses in percent)

Possible purposes	Information needed	Ranking: "e"	"u"	"n"
1. An information system for monitoring and evaluating partnerships at district and provincial level	6 monthly updated information on geographical access/coverage, utilisation, by type	74.2	25.8	0
2. An information system for monitoring NPO contracts	Quarterly updated information (financial and activities) on individual NPOs	74.2	19.4	6.5
3. To provide an understanding of health related activities in an area so that can incorporate into government planning	Type & scope of activities, access/coverage and utilisation (age and gender)	67.7	29.0	3.2
4. To provide lists of NPOs for programme managers i.e. categorised into type of activity	Relevant categorisation of activities	48.4	32.3	19.4
5. To provide a list of NPOs that could be invited to participate in coordination, planning and M&E activities	Contact details	45.2	48.4	6.5
6. To provide a list of NPOs that could	Capacity to enter into partnership;	41.9	51.6	6.5

potentially be contracted for service delivery, training or NPO support	training accreditation			
7. Information tool for NPOs for networking, linking purposes	As above	32.3	58.1	9.7
8. Identifies the networks, alliances or consortia linking NPOs	Networking	19.4	64.5	16.1

4.4.1 Content of NPO databases

In an open-ended question participants were asked about "what information an NPO database should collect". The following items were identified:

- Contact details
- Registration details
- Staff details
- Service coverage (area, type)
- Beneficiary details (number, categories)
- Funding sources
- Financial management system
- Budget information (allocated, utilized)
- Management capacity
- Skills gaps
- M & E information
- Burden of disease in particular areas (e.g. TB and HIV)
- Poverty programmes coverage

Further, interviewees with an endorsement of 60% and more indicated for 9 different types of NPO service delivery categories (e.g. Home-based care, HIV prevention, TB) that they should be categorized as "large", while five (with an endorsement of 60% and above) NPO activity areas were categorized as "medium" (e.g. mental health, disability and reproductive health (see Table 8).

Table 8: How should NPOs be categorised in the database? (in percent of responses)

Area	Activity	Large*	Medium	Small
Direct Service delivery	a. HIV prevention	85.7	14.3	0
	b. HIV home-based care	90.5	9.5	0
	c. HIV PWA support group	76.2	23.8	0
	d. HIV counselling	76.2	23.8	0
	e. Nutrition	70.0	25.0	5.0
	f. TB	81.8	18.2	0
	g. Poverty alleviation	54.5	31.8	13.6
	h. Mental health	28.6	66.7	4.8
	i. Disability	35.0	60.0	5.0
	j. Reproductive health (Contraception)	33.3	61.9	4.8
	k. Reproductive health (Pregnancy)	33.3	61.9	4.8
	l. Reproductive health (STIs)	71.4	28.6	0
	m. Other PHC	47.1	35.3	17.6
Service to other NGOs	a. Networking	33.3	57.1	9.5
	b. Training	66.7	33.3	0
	c. Other kinds of support	15.8	84.2	0

*On the basis of criteria such as numbers of full-time staff, locally, provincially, nationally.

4.4.2 Existing NPO databases

Most participants knew of existing NPO databases (see Table 9)

Table 9: Existing NPO databases

	n	%
a. HIV (HBC, PWA support, other)	25	80.6
b. TB	19	63.3
c. Nutrition	15	51.7
d. Mental Health and disability	20	64.5
e. NPOs registered under the NPO Act	20	64.5
f. Regional/District Database	19	63.3

4.4.3 Indicators for NPO databases

Most participants indicated that annual applications for NPO funding (87%) and routine monitoring and reporting information (79%) should be collected from NPOs (see Table 10)

Table 10: What information is collected from NPOs on a regular basis? (affirmative responses in percent)

	%
a. Annual applications for NPO funding	86.7
b. Application for registration in terms of NPO Act	59.3
c. Special surveys e.g. on home-based-care by the National Department of Social Development	41.7
d. Mental Health and disability	29.6
e. NPOs registered under the NPO Act	59.3
f. Routine monitoring and reporting information	78.6

Depending on the agreed purpose, the database will have a number of fields some of which are core across all provinces and some specifically tailored to the needs of the province. The database will provide a key source of quantitative information to monitor and evaluate the PDPHC programme.

The following are PDPHCP indicators and items of data that could be best measured/obtained through the database.

Participants were asked to either endorse or not endorse from a list of possible indicators (Table). For most indicators participants felt that they should be added or included into an NPO data audit list (e.g. "No. and scope of HIV and AIDS PHC services offered by contracted NPOs per selected district per annum", and "Percentage of training HIV and AIDS and PHC training NPOs whose training is accredited by the Health and Welfare SETA per annum"), while 40-55% felt that five from the 13 indicators should be removed (e.g. "Number of HIV and AIDS and PHC networking, training and other support NPOs per district/province per annum" and "Total number of clients accessing contracted NPO PHC services by type of service in the province per annum") (see Table 11).

Table 11: Database indicators

Indicator	Should be REMOVED	Should be ADDED
1. Total number of clients accessing contracted NPO PHC services per annum in selected districts of 5 target provinces.	45.5	54.5
2. Total number of clients accessing contracted NPO PHC services per annum per 1000 population in selected districts of 5 target provinces	22.2	77.8
3. Total number of clients accessing contracted NPO PHC services by type of service in the province per annum	50.0	50.0
4. Total number of clients accessing contracted NPO PHC services by type of service per 1000 population in the province per annum	22.2	77.8
5. Total number of service level agreements with NPO service providers established and implemented per target province/municipality per annum.	50.0	50.0
6. Mean amount of government funding per service level agreement per annum	36.4	63.6
7. Percentage of implemented partnership agreements targeting vulnerable, immobile or isolated members of the community per province/municipality per annum.	44.4	55.6
8. Percentage of implemented partnership agreements targeting disadvantaged communities per province/municipality per annum.	20.0	80.0
9. No. and scope of HIV and AIDS PHC services offered by contracted NPOs per selected district per annum.	14.3	85.7
10. Total number of clients accessing contracted NPO HIV and AIDS PHC services per annum in selected districts of 5 target provinces.	25.0	75.0
11. Number of HIV and AIDS and PHC networking, training and other support NPOs per district/province per annum	55.6	44.4
12. Percentage of training HIV and AIDS and PHC training NPOs whose training is accredited by the Health and Welfare SETA per annum	14.3	85.7
13. Number of NPOs not contracted by (receiving funds from) government per district	36.4	63.6

4.4.4 Recommendation

- Existing NPO databases should be utilized for a central database and a core list of perhaps 10 indicators for the NPO database should be agreed upon.

Chapter 5: Government capacity to manage partnerships with NPOs

5.1. Sample and procedure

The task network members included here were from five provinces and also from the national Department of Health. The target list of identified task network members included by level:

National Task Network: HIV/AIDS Cluster, Finance Section, PHC, District and Development Cluster, NPMU.

Provincial Task Network: EU Provincial Coordinator, EU Finance Officer, EU M & E Officer, TB Control Manager, NGO & HBC Unit Manager, Senior Manager IPHC, MCWH & N Unit, Senior Manager Strategic Management & Policy,
Social development (Nutritional Services Manager), District health services cluster, Finance (contract, revenue & legal unit)

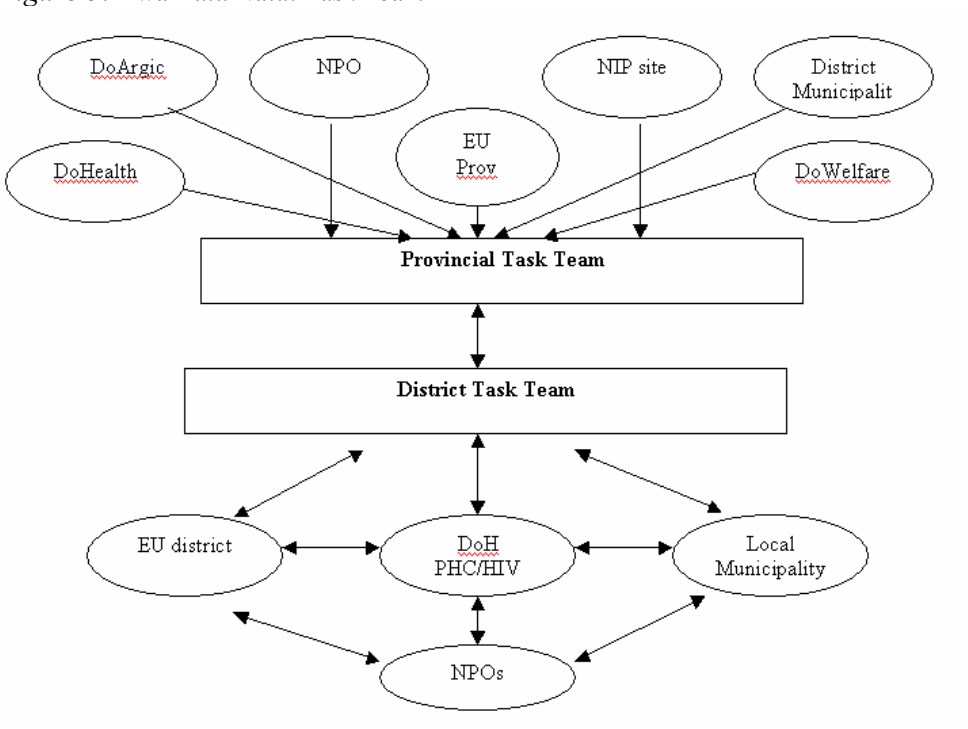
District Task Network: District Manager, PHC programme manager, EU Programme Manager, Social development Officer, MCWH & N Manager,
HIV/AIDS Manager, TB Manager, CEEO Manager, Corporate Services,
Finance Officer, Information Officer, Municipality representative, NIP Site Coordinator, Department of Agriculture, Clinic intake Officer, Local government representative, Local Service Area Manager, Special Program Manager (EC).

Sub-district: Social Development Officer, PHC Coordinator/Sub-district Manager, HIV/AIDS Coordinator, Programme Coordinator, Community Development Officer, Social Development Officer, Local AIDS Council, Ward Committee Chair.

In all 108 task network members agreed to be interviewed; 25 refused. Reasons for refusal included a) an appointment could not be scheduled within the project time frame between January to April 2006, b) felt they were ignorant about NPOs, c) felt they would not have the required information, and d) needed a letter from the national Department of Health. All were interviewed with a semi-structured interview guide and a partnership management capacity rating was done by the researcher. In addition the PMCI was filled in by 79 of the 108 participants (most could not fill in this part in time, or time did not allow them to fill it).

5.1.1 Kwa-Zulu Natal Task Team

Figure 5: Kwa-Zulu Natal Task Team



For each province a task team network diagramme was developed by the researcher in consultation with the provincial EU PDPHCP coordinators and other team members of the network. Each task team network is described in the following five figures:

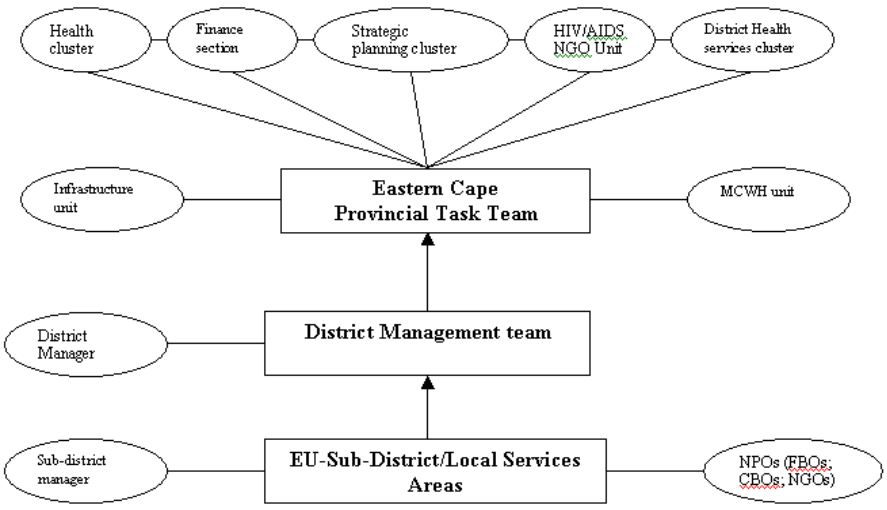
The diagram can be explained as follows:

Within KwaZulu-Natal, senior members of the Department of Agriculture, NPOs, NIP site coordinator, District Municipality, Department of Welfare, Department of Health and the European Union all work together within an overall body known as the Provincial Task Team (PTT). Although each of the organizations work independently of each other, when activities require them to work together, the do so via the PTT. The PTT members meet once a month to discuss issues surrounding health in the province of KZN and coordinate activities between the different stakeholders. Should the need arise; the PTT can call an emergency meeting at any time.

An example of a PTT meeting could be to discuss the setting up of a community garden to better improve nutrition of those affected by HIV. In this example, the Department of Health, together with the department of Agriculture, NPOs, NIP site coordinators, municipality and so on would meet to discuss issues of land for the project, training, supplies, ownership, water provision and so on. The PTT's discussions and agreed upon plans are then taken down to the district level though the District Task Team (DTT) to be actioned. The DTT, which is made up of similar members as the PTT but of a district rank, actions the plans either through the EU district coordinators, DoH Primary Health Care (PHC) coordinators or through the local municipality. These plans are further filtered down to the NPOs themselves. This network though is not a top down network. Should the NPO or any other body at the lower levels of the network have a concern or issue, they communicate their issues to the DTT in a bottom up approach. Should members of the DTT not be able to address the issue, the concern is taken up to the PTT level as shown in the diagram.

5.1.2 Eastern Cape Task Team

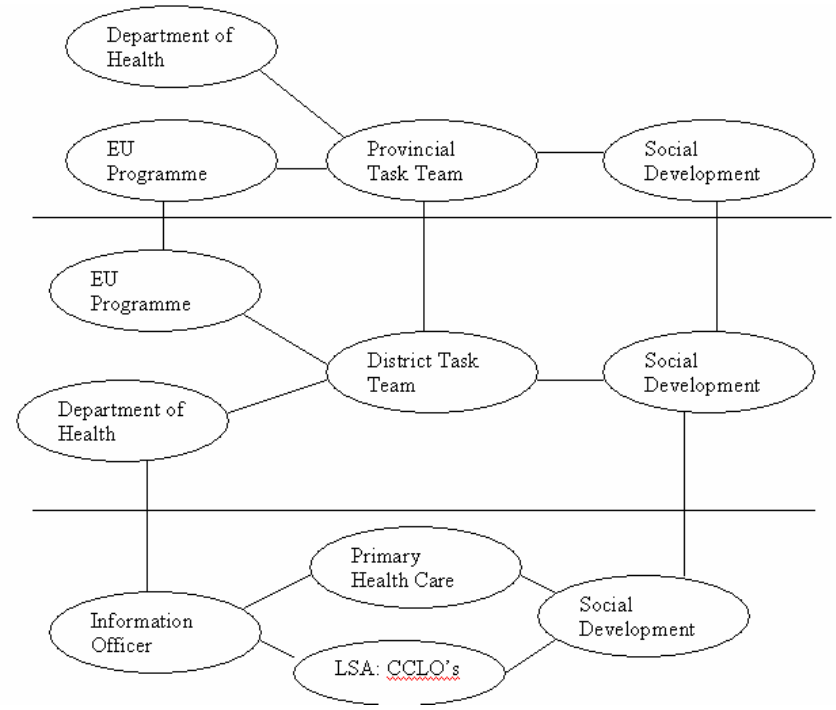
Figure 6: Eastern Cape Task Team



The Eastern Cape Provincial Task Team consists of representatives from different structures, namely (Figure 5): health cluster; finance section; strategic planning cluster; HIV/AIDS NGO Unit; district health services cluster; infrastructure unit; and the MCWH Unit. The central role of the Task Team is planning, allocation of budgets, attending to health personnel issues, as well as coordination of service delivery. There are quarterly steering committee meetings whose aim is to strengthen collaboration and create a more sustainable decision making structure. In the Eastern Cape, health activities are conducted at a sub-district level (LSA), hence the districts are not functional. Districts only consist of district managers. However, the sub-district level (LSA) is accountable to the district manager. District and sub-district managers monitor all the activities provided by institutions and individuals providing health care in the districts including government and non-governmental organisations. The sub-district level (LSA) comprises of representatives from the local authorities and the community health committee. The community health committee consists of service providers from clinics, community hospitals and the director of health services. The role of the sub-district level (LSA) is to promote primary health care and to plan, coordinate, support, supervise, as well as evaluate services based on provincial norms, policies and guidelines. The sub-district level (LSA) will receive a budget for primary health care and will allocate this to different community level services including community hospitals in the LSA.

5.1.3 Limpopo Task Team

Figure 7: Limpopo Task Team



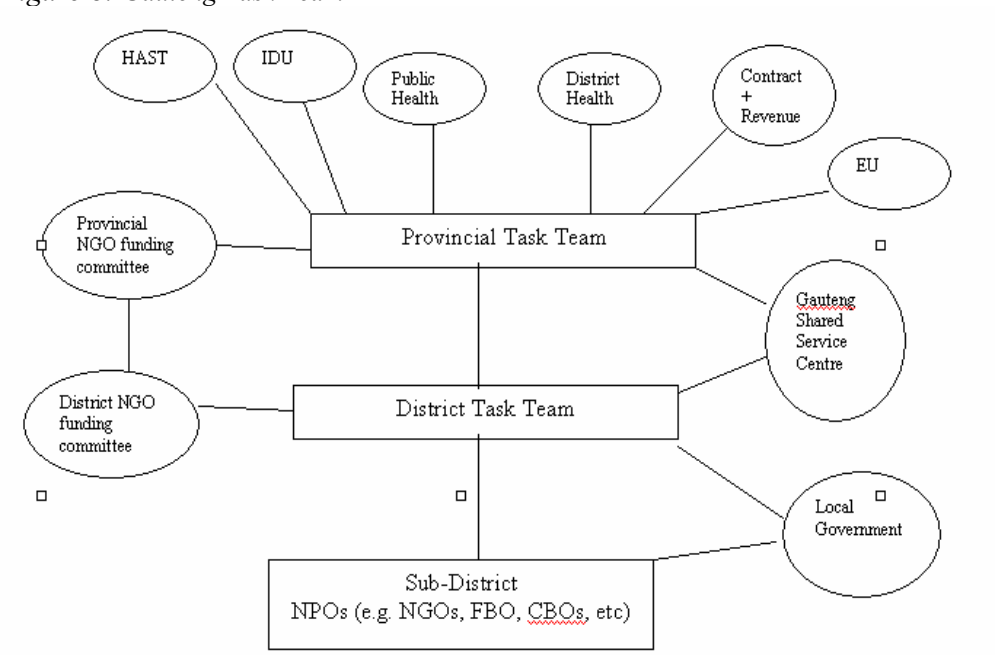
In Limpopo Province, divisions are according to districts which are then divided into sub-districts. The sub-districts are further divided into local service areas (LSAs). In the Department of Health and Social Development, Chief Community liaison Officers (CCLOs) are assigned to the LSAs and report separately to the Sub-district PHC coordinator (Professional Nurse) development Officer (Social Worker) on service information regarding PHC (e.g. TB cure rates, IMCI, reproductive health, HIV, etc.) and Social services (e.g. food security, poverty alleviation, social grants, etc.), respectively. Both the PHC Coordinator and the Social Worker co-ordinate functions at the sub-district level while working hand-in-hand with sub-district structures such as the Local AIDS Council (LAC). Information collected by the CCLOs is collated and relayed to the sub-district information Officer. The sub-district PHC Coordinator and the Social development Officer report separately to the health department (District IPHC Programme Manager) and Social development Officer (District Social Worker) at the district, respectively.

At the district level, all the program managers together with the social development office form a district task team (DTT). Both the DTT and the district manager (also part of the DTT) are encouraged to be a part of the integrated development planning (IDP) committee whose duty is to integrate all district service plans into one document. In some districts, additional structures such as the hospital board committees are encouraged to be a part of the IDP committee while reporting to the district manager. All these structures serve as forums for community participation. However, the various programs do report separately and directly to the program managers and senior cluster managers at the Provincial level. The district manager reports directly to the senior manager district health services and the head of department at the Provincial level. The EU Programme Manager at the district level also forms a part of the DTT.

At the provincial level, the EU Programme reports directly to the District health services senior manager who together with other senior managers and the social development form the Provincial task team (PTT). The PTT reports to the HOD.

5.1.4 Gauteng Task Team

Figure 8: Gauteng Task Team

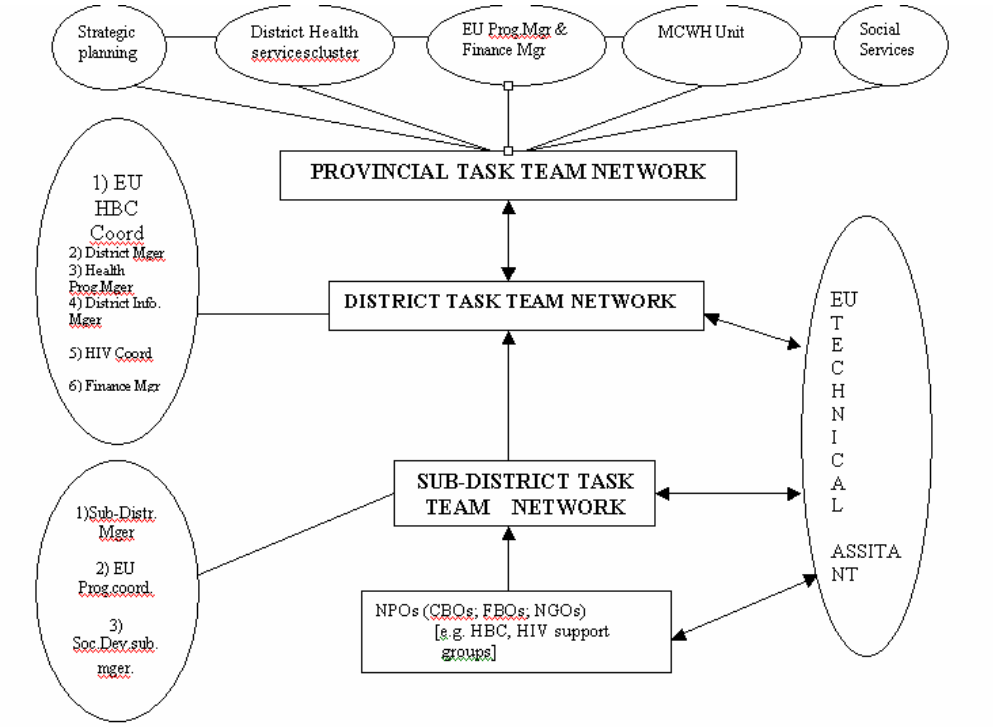


One way of describing the Gauteng task network and how the relationships involved operate is by looking at the way NPOs are selected for funding through this structure. The provincial office .i.e. the provincial task team (consisting of HAST, Interdepartmental AIDS Unit, public and district health, contract and revenue, as well as the EU provincial office) will put out an advertisement for NPO services. NPOs at sub-district level will submit applications for funding to the provincial office. The provincial task team will then sort out received applications according to the districts where the services are to be provided.

The district funding committee, consisting of district managers, and the district task teams (HAST, Interdepartmental AIDS Unit, sub-district managers and the EU district office) adjudicates applications and submits recommended applicants to the provincial funding committee (consisting of provincial managers and the provincial task team). In turn, the provincial funding committee will then liaise with the provincial task team, where applications are finalised. The provincial task team will inform the district task teams, who in turn will inform the sub-district task teams of successful applications. The district task teams also inform local government. Gauteng Shared Services Centre liaises with the provincial and district task teams to release payments to the NPOs. At the moment the district task team is not involved with EU related payments of NPOs – this is still only done at the provincial level. As the programme progresses, payments will be devolved to the districts.

5.1.5 Western Cape Task Team

Figure 9: Western Cape Task Team



The Provincial Task Team Network (PTTN) comprise of the District Health services cluster, Strategic Planning cluster, Social services cluster, EU programme manager, EU Finance manager, and Mother and Child welfare and health unit. The PTTN, meets on monthly basis to deliberate and plan on health issues affecting the province. Merges and analyses all data received from the different districts, transmit to the national office and provide feedback to the districts. On regular intervals the PTTN meets with the District management team to discuss and strategise on the implimentation of the District health plan. The two teams also discuss health challenges faced by the districts, district peformance on key health indicators, health resources and so on. District team liase with sub-districts team for monitoring and evaluation of the strategic plan, provides feedback to NPOs on a quarterly basis. The sub-District Task Team (SDTTN) comprises of the sub-District manager, EU programme coordinator, Scial Development manager, EU Technical Assistants, and Local AIDS councillor(s). The SDTTN impliment the district strategic plan. The EU Technical assistant coordinates the implimentation of the plan by the NPOs and community health centres at sub-districy level. EU Technical assistant reports to the District task team on NPO performance on regular basis.

5.2 Measure

The partnership management capacity index (Centre for Health Policy, 2004) measures the management capacity for establishing and implementing government: NPO partnerships within the health sector of the 5 target provinces. It incorporates the rapid assessment of Provincial Task Teams (as a programme governance/management structure). It has been developed and structured as a quantifiable index that can be represented visually in the form of a Radar Diagramme.

The definition and framework of capacity utilized in this tool is that of Hildebrand and Grindle (2001). They define capacity as the "Ability to perform appropriate tasks effectively, efficiently,

and sustainability". In their framework the influences on capacity include individual competence, ability to establish coordinated task networks, organizational systems and culture as well as the broader public sector institutional environment. The assessment of capacity needs to address each of these components in relation to the tasks to be performed.

This tool focuses on capacity to engage in partnership, rather than general management, although touching on generic organizational and management issues. The management tasks or functions associated with NPO partnership have been summarized as: partnership strategy/planning, general partnership management, contract management and relationship management.

Capacity in each of these areas is likely to occur along a continuum rather than being simply present or absent. For the purposes of developing a numerical index, capacity has been defined as a series of discreet stages (1-4).

These various dimensions of capacity can be summarised as follows (Figure 3.2.6):

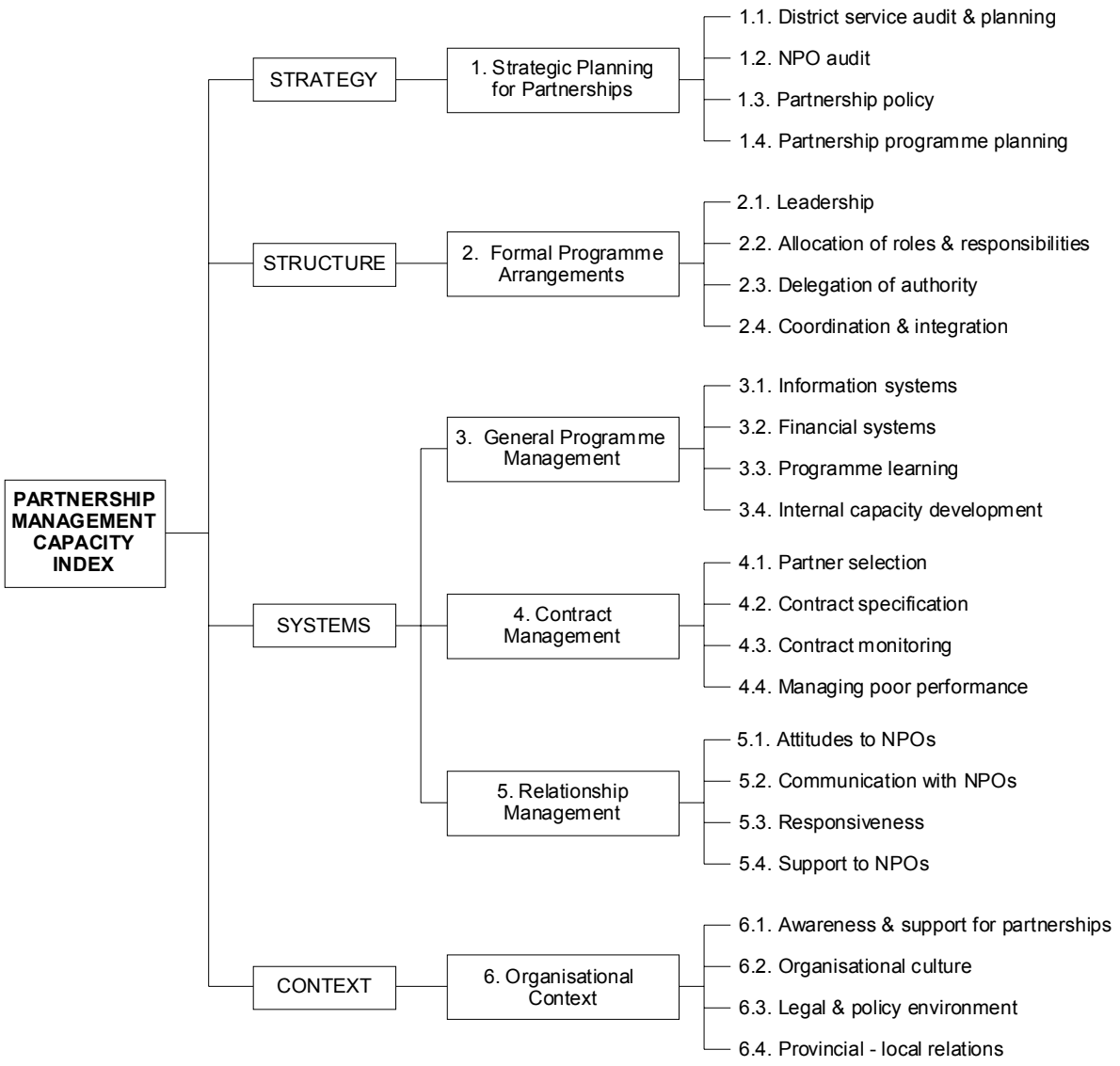
- Partnership Management Functions
  "What needs to be done?"
  "Breakdown of functions required for managing partnerships
- Components of Capacity
  "What is required to get things done?"
  Different components of capacity (following Hildebrand & Grindle)
- Stages of Capacity Development
  "How far are we in developing the required capacity?"
  Evaluation of capacity against benchmarks for Stages 1 to 4

The conceptual framework has been operationalised into a management capacity index (MCI) as follows:

- Functions and components have been organised into 4 domains (strategy, structure, systems and context) and 6 elements (Figure 9)
- Four key indicators have been identified for each element
- Four stages of capacity development have been defined for each indicator. Each stage may include several components and in the evaluation process it is important to choose the description that best fits current status

The partnership management capacity index (PMCI) measures assesses six domains of partnership management, i.e. 1) strategic planning for partnerships, 2) formal programme arrangements, etc. (see Figure 9).

Figure 10: Domains of the partnership management capacity index



5.3 Example item

Organisational culture

Stage 1	Stage 2	Stage 3	Stage 4
The health department is very hierarchical and bureaucratic making it difficult to get things done. Programme management is autocratic. The obsession with rules and procedures leaves little room for flexibility and innovation. People do not have the resources required to do their work and inter-personal problems are common.	The traditional bureaucratic hierarchy is not rigidly enforced and programme management is more consultative. People are occasionally not able to do their work because of resource constraints. Most staff members stick to their formal defined roles but will usually help and support their colleagues.	The organisation has developed informal mechanisms for getting things done in spite of bureaucratic rules and procedures. Staff members generally enjoy their work. Resource constraints are unusual and colleagues are mostly supportive and helpful.	Have been active steps to promote innovation and flexibility. Most people are positive about their work. Colleagues generally supportive and helpful. Inter-personal problems are unusual. Everyone has the resources required to do their work. democratic

Cronbach alpha for the interviewee administered PMCI was .91 and for the interviewer administered PMCI was .94 in this sample.

Partnership management capacity in relation to NPOs was assessed on a scale from 1 to 4, the higher the score the higher the capacity. The PMCI was measured in two forms: 1) from the interviewee (the task team network) directly and 2) from the senior researcher on the basis of a semi-structured interview and collected materials from the task team network interviewee. The ratings (10%) from the researcher were cross-validated by an external researcher and an agreement of 84% was found. The best measure for central tendency is the "mean". Since some of the management capacity components showed a skewed distribution, we described central tendency with "median".

5.4 Results

Results are divided into (1) stage of capacity development for all indicators across all 5 provinces, (2) partnership management capacity by province, (3) Partnership management capacity components and task network levels, and (4) Partnership management capacity components by province.

5.4.1 Stage of partnership management capacity development for all indicators across all 5 provinces

Table 12: Stage of capacity development for each indicator (rated from 1 to 4, 4 being the highest)
(The last column represents the average between interviewer and interviewee rated management capacity levels)

	Interviewee rated	**Interviewer rated**	**Average**
	Median (Md)	Md	Md
1 Strategic planning for partnerships	3.0	2.3	2.8
1.1 District service audit & planning	4.0	2.0	3.0
1.2 NPO audit	3.0	3.0	3.0
1.3 Partnership policy	3.0	2.0	2.5
1.4 Partnership programme planning	3.0	2.0	2.5
2. Organisational arrangements for partnerships	3.0	2.0	2.5
2.1 Leadership			
2.2 Allocation of roles & responsibilities	3.0	3.0	3.0
2.3 Delegation of authority	3.0	2.0	2.5
2.4 Coordination and integration	3.0	2.0	2.5
	3.0	3.0	3.0
3. General programme management	2.5	2.0	2.3
3.1 Information systems	3.0	2.0	2.5
3.2 Financial systems	2.0	2.0	2.0
3.3 Programme learning	2.0	2.0	2.0
3.4 Internal capacity development	2.0	2.0	2.0
4. Contract management	3.0	2.0	2.5
4.1 Partner selection	2.0	2.0	2.0
4.2 Contract specification	3.0	3.0	3.0
4.3 Contract monitoring	3.0	2.0	2.5
4.4 Managing poor performance	3.0	1.0	2.0
5. Relationship management	3.0	2.5	2.8
5.1 Attitude to NPOs	3.0	3.0	3.0
5.2 Communication with NPOs	3.0	2.0	2.5
5.3 Responsiveness	3.0	3.0	3.0
5.4 Provision of support	3.0	3.0	3.0
6. Organisational context	3.1	3.0	3.1
6.1 Awareness and support for partnerships	3.0	3.0	3.0
6.2 Organisational culture	3.0	2.0	2.5
6.3 Legal and policy environment	4.0	4.0	4.0
6.4 Provincial - local relations	3.0	2.0	3.0

Concerning the 24 indicators of partnership management capacity the following were at or almost at optimal stage of capacity:

- Legal and policy environment (Md=4.0)
- Contract specification (Md=3.0)
- Awareness and support for partnerships (Md=3.0)
- Attitude towards NPOs (Md=3.0)
- Provision of support (Md=3.0)

And the following were at a low stage of capacity:

- Financial systems (Md=2.0)
- Programme learning (Md=2.0)

- Internal capacity development (Md=2.0)
- Managing poor performance (Md=2.0)
- Partnership policy (Md=2.5); Partnership programme planning (Md=2.5)
- Allocation of roles & responsibilities (Md=2.5); Delegation of authority (Md=2.5)
- Information systems (Md=2.5)
- Contract monitoring (Md=2.5)
- Communication with NPOs (Md=2.5)
- Organisational culture (Md=2.5)

5.4.1.1 Qualitative analysis of major indicators

The following forms a part of the report that focuses on some of the open-ended questions in the Management Capacity Index. The responses to the questions report on in this section were read through a number of times before they were grouped together on the basis of the common ideas that they appeared to represent.

The following partnership management capacity components will be described:

- Organisational arrangements for partnerships
- General programme management
- Contract management
- Relationship management
- Organisational context

Organisational arrangements for partnerships

- Allocation of roles, responsibilities and decision making in the partnership programme

Responses varied among different respondents. Some respondents, for example, indicated that district and sub-district managers allocate roles and responsibilities. However, what seems to appear in these responses is that the national task team has an oversight role, provincial task teams are responsible for the coordination and monitoring of the partnership programme, district task teams and sub-district ensure to implementation, and NPOs are ultimately responsible for service delivery (i.e. service packages). The task teams are constituted by various roles players within the Department of Health, and other stakeholders (for example, local government, other government departments, community members and so on). Decision-making processes fall within these structures. Of concern, though, was the number of task team members who were not quite sure how roles and responsibilities were allocated. There were also some respondents who reported that roles and responsibilities had not been adequately defined and clarified.

General programme management

- Programme learning. Examples where the programme has learnt from its mistakes

- A number of respondents pointed out that the call for proposals advertisements had not been specific to project sites. This resulted in the reception of a high number of applications, which included applicants not working in the identified pilot sites.
- In general, there was also a feeling from some respondents that pre contract site evaluations had been inadequate. One of the ramifications of this is that the funding partner is unable to pick up on any falsified information by the NPO. One reason this is not done adequately at least is the lack human resources or insufficient manpower. This

is not necessarily a reflection of people's experiences with the EU partnerships programme per se but partnerships in general.

- Lack of monitoring and evaluation is another challenge identified. This is attributed, once again, to lack of human resources:

"Due to lack of human resources there is no monitoring and evaluation and we have resolved that this an area that we need to improve on"

The view expressed reflects not just reflections on the EU programme but also government NPO partnership experiences in general.

Contract management

- Recruitment of NPOs

Interviewees were asked to describe the current process for contracting and selecting NPOs. There seemed to be a general understanding among interviewees of how the process works, except for those respondents who were either not very involved or lacked information. The contracting process described hereafter refers specifically to the EU contracting process. In terms of the process itself, a tender is designed and published in local and national newspapers (a call for proposals for work to be done). This is followed by a briefing session with all the NPOs. After the briefing session and the closing date, the applications are evaluated to determine compliance with administrative funding specifications for all applicants.

Successful applicants go through to the adjudication process where an adjudication panel or a selected committee will further evaluate them against set criteria. However, it should be noted that unsuccessful applications are stored in the database for future reference. The evaluation teams may consist of various stakeholders represented in district and sub-district task networks. NPOs that make the grade will have their requested budgets assessed. Amounts and evaluation reports of each organisation will be recommended for approval by the EU or the national or provincial offices of the National Department of Health. Once approval is granted, successful and unsuccessful NPOs are informed. This is followed by a contract training session with successful NPOs. The purpose of this session is to assist NPOs to understand the contract terms and conditions, especially the expectations of the funder and the legal terminology. Once the contract is signed funds are transferred in tranches based on the services delivered. Activities and services are also supposed to be monitored on regular basis (for example, monthly or quarterly).

- The main problems with the contracting process

On the basis of responses in the study problems with the contracting process can be grouped into four areas, namely: lack of capacity; delay in funding; monitoring and evaluation; and contract management difficulties. On the issue of lack of capacity, a number of weaknesses were identified. These include:

- Lack of necessary skills and capacity to deliver the required service.
- Submission of false information by NPOs.
- Lack of management skills (for example, governance, project management, financial accountability and so on).
- NPOs not being able to provide the necessary documentation (for example, financial statements, constitution and so on).
- Problems with understanding contract specifications and adherence.
- Insufficient staff in the Department of Health to adequately conduct pre-contracting assessment site visits.

Respondents indicated that there were delays in funding. Regarding this issue they cited difficulties contracting on time, that funds were released late, and delays in approval either from the EU or the National Department of Health. In some areas it was indicated by respondents that even though the call for proposals and the selection of NPOs had long been made, the funds had still not been released.

A number of problems were identified under monitoring and evaluation. These, though, mainly centre on lack of adherence with funding specifications. Respondents mentioned NPOs not adhering to process requirements, misappropriation or misuse of funds, and delays in submission of reports (monthly or quarterly reports). On the side of government, the lack of a standard monitoring tool was reported.

Contract management specific difficulties reported include:

- NPOs not understanding the terms and conditions of a contract (i.e. legal literacy).
- Dual contracting (provincial and district).
- The safety of assessors being at risk. During site visits, the assessors' safety is sometimes at risk because some NPOs become defensive.

- Legal requirements for contracting NPOs

The most common responses to the question on the legal requirements for contracting NPOs is that the particular NPO concerned should have a constitution and be registered under the NPO Act. The NPO should have a physical address and a bank account. Other legal requirements cited although less frequently include submission of audited financial statements, a representative boards of directors, and compliance with the Public Finance Management Act (although this applies to government and not to the NPOs), submit a proposal and produce a budget breakdown. Furthermore, the NPO should have in existence for at least a year before it enters a partnership contract.

- Monitoring and evaluation

On the question of monitoring and evaluation, answers fell into the following responses:

- Monthly meetings (i.e. monthly stakeholder forums)
- Site visits (by personnel from the Department of Health or EU programme staff).
- Submission of monthly or quarterly reports by NPO programmes managers.
- Finance and activities are evaluated through the above-mentioned mechanisms. This includes assessment of financial claims to determine whether previous monies were correctly spent.
- Submission of annual audited statements.

Other responses

- Don't know
- Not in place yet.

A few of the respondents mentioned the use of a monitoring tool in response to this question. However, no further clarification was provided. With the exception of the Western Cape Province, where the EU Partnership programme has been running, in the other provinces the process had just begun. For number respondents from those provinces that have just started, they responded by indicating that they had just contracted.

- The main problems with the monitoring and evaluation

Although problems identified with the monitoring and evaluation process were variously expressed; however, when grouped into a single theme, they all appear to centre around the issue of capacity. Lack of capacity applies to both the NPOs and the government department concerned in the partnership. On the side of the government, this includes largely insufficient human resources. The difficulty of this issue is highlighted by one of the respondents:

> *"When one NPO operates in more than one sub-district, it is difficult to monitor its impact".*

The insufficiency of human resources tends to have negatively affected the number of site visits pre and during the contract. This in turn compromises the physical validation of reports and statistics submitted by NPOs. Some felt that not enough is being done to evaluate utilization of funds by the NPOs. Also, on the government side, the other impediment to an efficient monitoring and evaluation system is the absence, by what some indicated, of a monitoring and evaluation tool. However, with regards to the EU Partnership programme there was a feeling from the provinces that have just started that the process is still new, and thus there are no substantive experiences to reflect on.

NPOs were identified as lacking capacity in a number of areas. One of these areas is the non-submission of either monthly or quarterly reports. For some respondents, this betrays the inability to adhere to contract specifications, while some viewed it as non-cooperative. There also appears to be a suggestion by some that some NPOs are not operating in good faith because the information they provide of their activities is either not accurate or it is false. However, this view is tempered by those respondents who recognise that submission of *'false'* or inaccurate information is not intentional – it reveals lack of capacity in report writing. For example, according to one respondent *"most NPOs don't have manager skills and writing skills".*

- How non-performing NPOs are identified

The question of how NPOs that are not performing are identified emerges directly from the monitoring and evaluation process. Monthly activity reports are utilized to monitor the activities of NPOs. NPOs are visited regularly where possible. Furthermore, NPOs are also expected to submit their financial statements to determine the utilization of funding. Partner NPOs interact government partners on regularly through a number of mechanisms, such as forum meetings (where a number of stakeholders may be represented), visitations by both sides, in writing, by telephone and so on. To a certain extent, there appears to be a suggestion that these mechanisms serve as proxies or as indirect indicators of performance. The other indicators cited are community feedback and impact, as well as consultations. In particular, this may include a *"dissatisfied clientele"* and complaints from community members. Specific to the EU programme, however, for some respondents it was difficult to provide a response because they "not yet at that stage".

Relationship management

- The motivations of NPOs

This particular issue centers on why NPOs do what they do. Government officials identified as motivating factors pertaining to NPOs. There was recognition that NPOs are driven primarily by a need to services their communities. Flowing from this is an appreciation of their vital and significant role in extending service delivery to communities. There is also appreciation of their commitment, passion, love and willingness to serve their respective communities. In the context of a high HIV prevalence rate in a number of communities throughout South Africa, some non-profit organisations are driven by a need to make a difference. Yet, there was also recognition by the respondents of other factors motivating non-profit organisations. Due to the high rate of unemployment in the country, the emergence of some NPOs may be due to a need to create

employment. Closely related to this is the question of financial gain or motivation. However, NPOs are also viewed as playing a capacity building role. NPOs provide an opportunity for training and skills development (particularly among the community health workers).

- NPO complaints

Partnerships of any kind are characterised by grievances and complaints. This applies just as much government and NPO partnerships as any partnerships. Respondents identified a number a methods through which they receive and respond to NPO complaints and concerns. These include meetings (for example consultative or stakeholder forums), telephone calls, in writing and actual visits by NPO representative. Regarding meetings between the two parties, officials were asked during the interviews to indicate how often they meet with NPO partners. Responses varied between every day at 12% to never at 10.9%. The most common response was once a month at 40.2%.

In the case of a grievance, one of the respondents cited a grievance procedure starting at sub-district level all the way to the district level. Government partners utilize the same methods to respond to NPO complaints. These also include discussions, programme managers visiting NPOs, in writing and so on.

Other methods through which complaints may be lodged or responded to include emails, faxes, as well as progress reports.

- Systems to support NPOs

Respondents were asked to describe the systems they have in place to support NPOs with general management, human resources, financial management, and governance. In most instances, the responses were quite general. These included advices, encouraging NPOs to support each other, 'an open door policy', offering orientation courses, contracting another service provider to provide training, meeting, workshops, seminars, and conferences. One respondent pointed out that appointed technical assistants and programme do lend support in the areas identified above during site visits and through other interactive processes between themselves and NPOs (i.e. the monitoring and evaluation process). Another respondent indicated that EU Partnership programme specifically has started providing 'general management training and general guidelines on structural organizational issues'. Also, it was also pointed by one respondent that a district EU finance person can be availed to assist NPOs with financial matters.

Organisational context

- Organisational culture of the department

Based on interviewees' varying responses it appears different people experience their organisational cultures differently. The majority of the interviewees were from the Department of Health, with some that included local government and the Department of Social Development officials. The descriptions looked both inward in the department itself (for example, the Department of Health itself) and outward in terms of how accessible the organisation is to the public.

Some described their organisations as flexible, democratic, caring and warm, as well as participative. However, other respondents were less approving. Conversely, the latter perceived their organisations as rigid and inflexible, bureaucratic and hierarchical. One respondent described his/her department:

"The organisational culture is not good. You find that other people do more work but get paid the same salary as others that do less work."

On the question of the bureaucracy, another respondent expressed the following sentiments:

"Our organisational culture at a municipal level is okay and people are supportive, but then when you up to the levels of district and province, the bureaucracy is more pronounced."

The above-mentioned extract highlights not just the issue of bureaucracy but also the hierarchy. However, it is interesting to note that for the questions *'Is there flexibility?'* and *'Do people support each other?'* 75.7% and 90.1% respectively said yes.

- The relationship between provincial and local government

A number of respondents appear to feel positive about the relationship between provincial and local government. Most described it as being good, functional and satisfactory:

"There is a positive working relationship between the two spheres of government. The task teams work very closely with one another. They plan together strategies on service delivery."

Others, however, were less so. Some viewed as having challenges. These include duplication of services, and lack of cooperation in some areas. One respondent felt that roles and responsibilities were 'not a hundred clarified'. One local officials interviewed said it poor because local government is seen 'as a dump site'. Another respondent described as tense.

Generally, though, there is overwhelming support for strengthening of ties and integration in order to improve service delivery.

5.4.2 Partnership management capacity by province

Partnership management capacity seemed generally with a median of 2.8 sub-optimal; the optimal being 4.0), with the highest in Western Cape (Md=3.3), followed by Gauteng (Md=2.8) and KwaZulu-Natal (Md=2.8) and the lowest in Limpopo (Md=2.5) and the Eastern Cape (Md=2.5) (see Table 13).

Table 13: Partnership management capacity by province (range 1 to 4, 4 the highest)

	Interviewee rated			Interviewer rated			Average
	N	Md	SD	N	Md	SD	Md
KwaZulu-Natal	23	2.8	.6	22	2.8	.4	2.8
Gauteng	16	2.9	.6	17	2.6	.3	2.8
Eastern Cape	7	2.6	.5	18	2.3	.4	2.5
Western Cape	14	3.4	.4	19	3.1	.5	3.3*
Limpopo	19	3.1	.4	28	1.9	.3	2.5
National#				4	3.0	.3	3.0
Total	79	3.0	.5	108	2.5	.7	2.8

##National was only done by interviewer rating (respondents did not fill in the interviewee rated version)
*significantly higher in the Western Cape

5.4.3 Partnership management capacity components and task network levels

The overall partnership management capacity was the highest for organizational context (Md=3.1), followed by relationship management (Md=2.8), strategic planning (Md=2.7), contract management (Md=2.5), general programme management (Md=2.3) and formal programme management (Md=2.0). Looking at the six different partnership management capacity components, the national and provincial departments had the highest management capacity, while at district and local municipality level management capacity was lower; this was, however, only in one case significant (see Table 14).

Table 14: PMCI components and task team network by level

		Interviewee rated			Interviewer rated			Aver age
		N	Md	SD	N	Md	SD	
Strategic planning	National#				4	3.0	.3	3.0
	Provincial level	9	3.3	.8	15	2.0	.7	2.7
	District/region	43	3.3	.7	64	2.4	.8	2.9
	Local government	7	3.0	.7	10	1.9	.4	2.5
	Total	59	3.0	.71	89	2.3	.8	**2.7**
Formal programme arrangements	National				4	3.0	.1	3.0
	Provincial level	11	3.3*	.8	15	2.0	.9	2.7
	District/region	41	3.0	.7	65	2.3	.9	2.7
	Local government	9	3.0	.8	11	1.8	.9	2.4
	Total	61	3.0	.7	91	2.0	.9	**2.5**
General programme management	National				4	2.9	.3	2.9
	Provincial level	8	3.1	.5	12	1.6	.8	2.4
	District/region	34	2.5	.7	58	2.3	.9	2.4
	Local government	7	2.5	.7	11	1.8	.3	2.2
	Total	49	2.5	.7	85	2.0	.8	**2.3**
Contract management	National				4	3.0	.2	3.0
	Provincial level	9	3.3	.7	12	2.3	.7	2.8
	District/region	30	3.0	.8	53	2.0	.9	2.5
	Local government	6	2.6	.5	9	1.8	.6	2.2
	Total	45	3.0	.8	78	2.0	.8	**2.5**
Relationship management	National				4	3.4	.2	3.4
	Provincial level	9	3.5	.8	14	2.4	.7	3.0
	District/region	43	2.8	.7	57	2.5	.6	2.7
	Local government	8	2.6	.7	11	2.3	.7	2.5
	Total	60	3.0	.7	86	2.5	.6	**2.8**
Organisational context	National				4	3.0	.00	3.0
	Provincial level	9	3.5	.8	15	3.3	.7	3.4
	District/region	34	2.8	.7	53	3.0	.5	2.9
	Local government	7	2.6	.7	11	3.5	.6	2.9

	Total	50	3.1	.7	79	3.0	.6	**3.1**

#National was only done by interviewer rating (respondents did not fill in the interviewee rated version)
*significantly higher at provincial then that at district level.

5.4.4 PMCI components by province

Strategic planning management capacity was higher in the Eastern Cape (Md=3.3) and Gauteng (Md=2.9) and lower in Limpopo (Md=2.5) and KwaZulu-Natal (Md=2.6).
Formal programme arrangements were higher in the Western Cape (Md=3.4) and lower in Gauteng (Md=2.1) and Limpopo (Md=2.4).
General programme management was higher in Western Cape (Md=3.1) and KwaZulu-Natal (Md=2.8) and lower in the Eastern Cape (Md=2.0) and Limpopo (Md=2.0). Contract management was higher in Western Cape (Md=3.6) and Gauteng (Md=3.1) and lower in Eastern Cape (Md=1.7) and Limpopo (Md=2.5). Relationship management was higher in the Western Cape (Md=3.3), KwaZulu-Natal (Md=3.0) and Gauteng (Md=2.9) and lower in the Eastern Cape (Md=2.1). Organisational context was high across all provinces, with the highest in Gauteng (Md=3.5) and the Western Cape (Md=3.3) (see Table 15).

Table 15: PMCI components by province

		Interviewee rated			**Interviewer rated**			**Average**
		N	Md	SD	N	Md	SD	Md
Strategic planning	KwaZulu-Natal	17	2.8	.7	16	2.3	.6	2.6
	Gauteng	14	3.5	.7	10	2.3	.5	2.9
	Eastern Cape	7	3.5	.7	17	3.0	.7	3.3
	Western Cape	7	2.8	1.0	19	2.8	.9	2.8
	Limpopo	14	3.1	.4	27	1.8	.4	2.5
Formal programme arrangements	KwaZulu-Natal	16	2.8	.8	13	2.5	.8	2.7
	Gauteng	13	2.3	.7	15	1.8	.8	2.1
	Eastern Cape	7	3.3	.2	17	2.5	.9	2.9
	Western Cape	9	3.5	.8	20	3.3	.9	3.4
	Limpopo	16	3.3	.7	26	1.4	.5	2.4
General programme management	KwaZulu-Natal	12	2.5	.7	11	3.0	.6	2.8
	Gauteng	9	2.5	.7	11	1.8	.4	2.2
	Eastern Cape	5	2.5	.6	15	1.5	.6	2.0
	Western Cape	10	3.0	.8	17	3.3	.9	3.1
	Limpopo	13	2.5	.6	27	1.5	.4	2.0
Contract management	KwaZulu-Natal	11	3.0	.6	12	3.0	.7	3.0
	Gauteng	8	2.8	.7	3	3.3	.1	3.1
	Eastern Cape	4	1.5	.9	14	1.8	.4	1.7
	Western Cape	8	3.8	.5	18	3.3	.8	3.6
	Limpopo	14	3.1	.7	27	1.8	.3	2.5
Relationship management	KwaZulu-Natal	14	3.0	.7	14	2.9	.7	3.0
	Gauteng	11	2.8	.8	8	3.0	.5	2.9
	Eastern Cape	6	2.1	.5	13	2.0	.5	2.1

	Western Cape	11	3.5	.8	20	3.1	.5	3.3
	Limpopo	18	3.0	.7	27	2.3	.3	2.7
Organisational context	KwaZulu-Natal	11	2.8	.7	10	2.8	.8	2.8
	Gauteng	10	3.5	.6	9	3.5	.3	3.5
	Eastern Cape	6	2.4	.4	17	3.0	.5	2.7
	Western Cape	7	3.5	.5	17	3.0	.5	3.3
	Limpopo	16	3.3	.8	26	2.3	.5	2.8

The summary of scores for each capacity indicator is represented graphically in a summary radar diagramme in the following Figures 10.

Figure 11: Presentation of PMCI indicators for KwaZulu-Natal

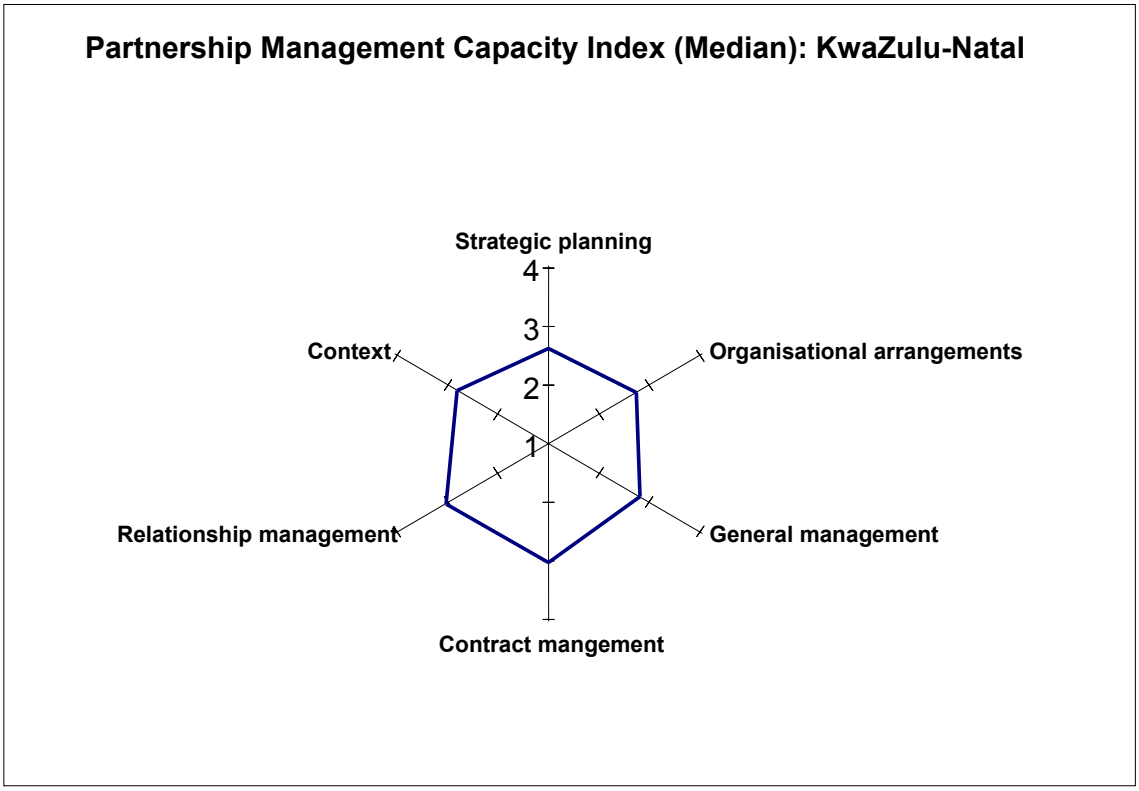


Figure 12: Presentation of PMCI indicators for Gauteng

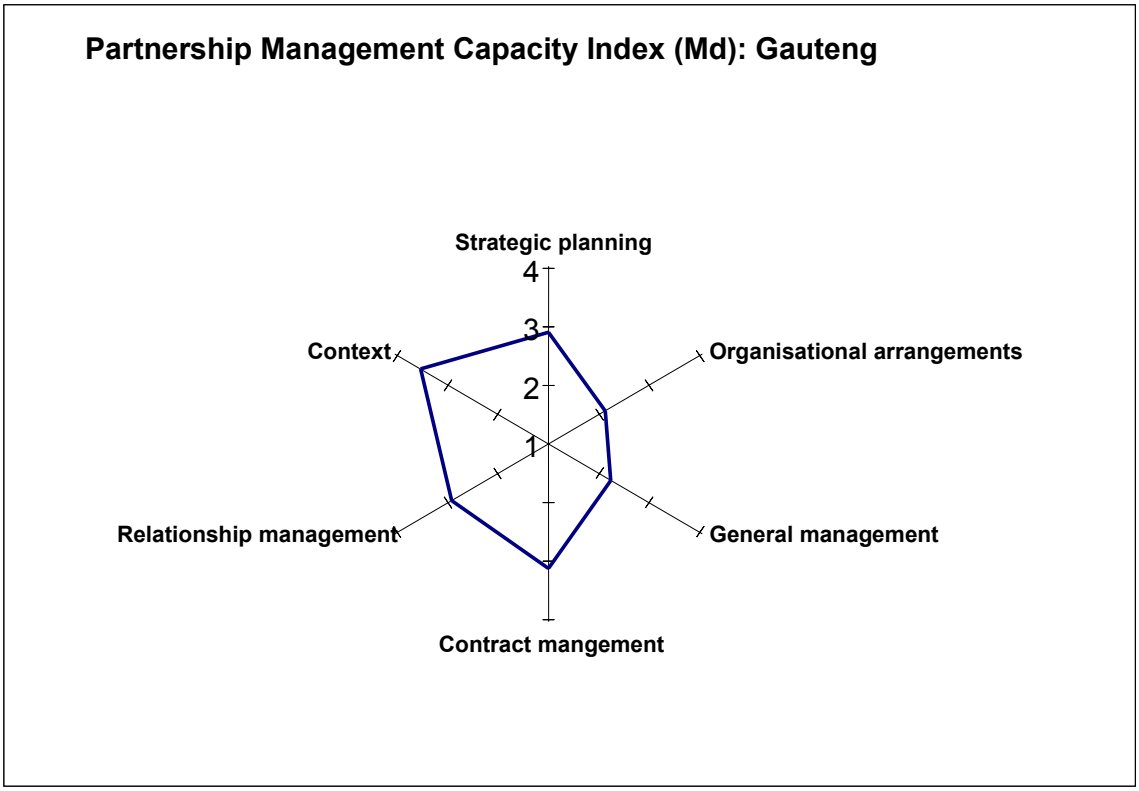


Figure 13: Presentation of PMCI indicators for Eastern Cape

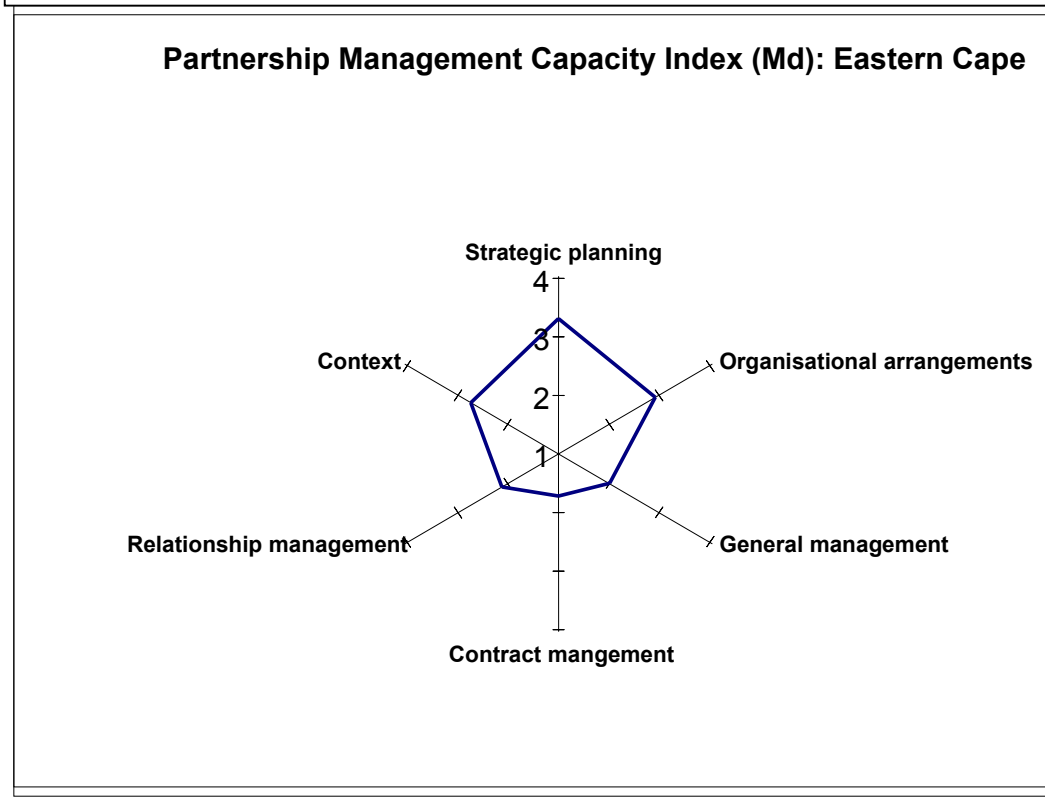


Figure 14: Presentation of PMCI indicators for Western Cape

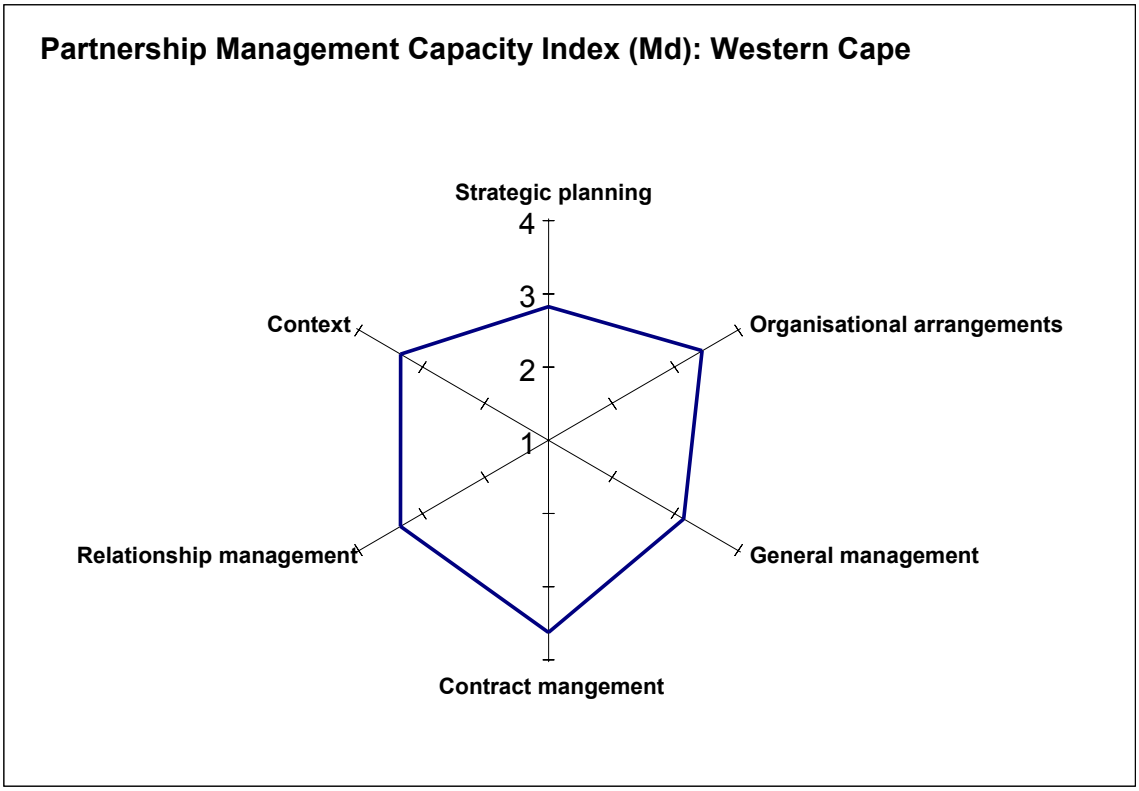
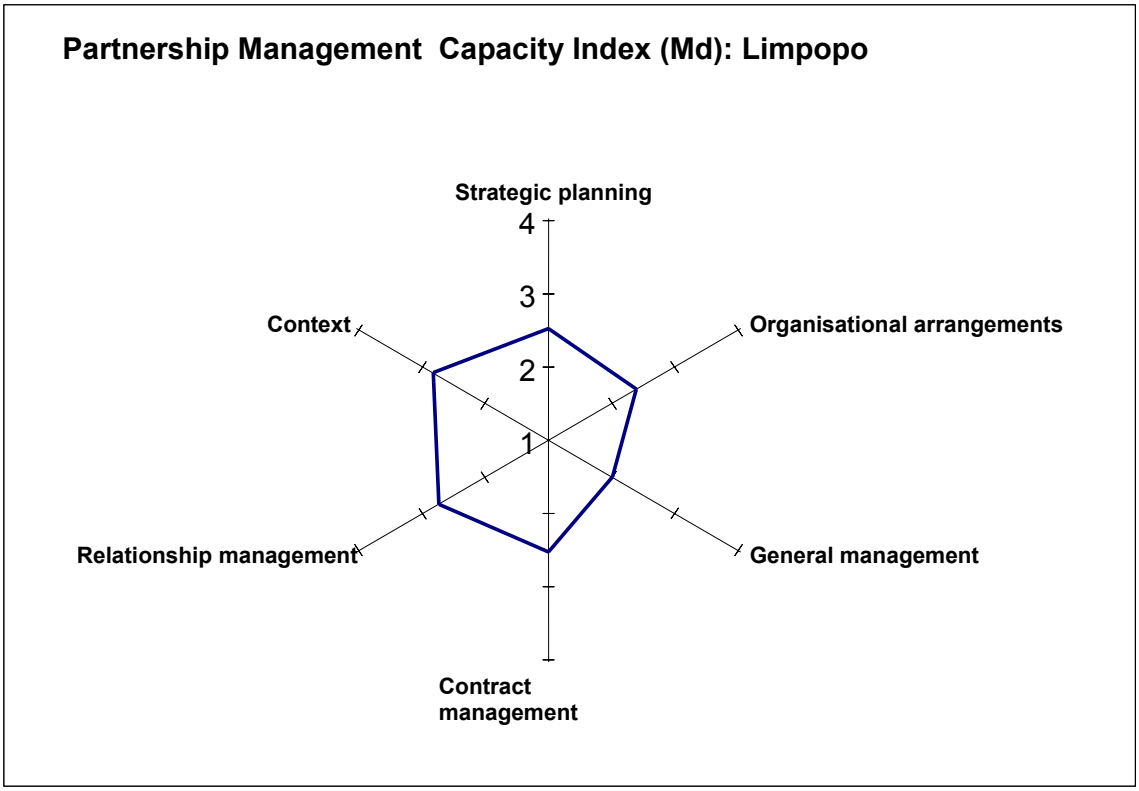


Figure 15: Presentation of PMCI indicators for Limpopo



5.4.5 Conclusion and recommendations

Partnership management capacity seemed generally with a median of 2.8 sub-optimal (the optimal being 4.0), with the highest in Western Cape (Md=3.3), followed by Gauteng (Md=2.8) and KwaZulu-Natal (Md=2.8) and the lowest in Limpopo (Md=2.5) and the Eastern Cape (Md=2.5). The higher score for Western Cape may be explained by the fact that PDPHc programme has already been implemented for two years, while other provinces are at the beginning of implementing PDPHCP.

All provinces need to improve their partnership management capacity, especially Eastern Cape and Limpopo provinces.

The government public health sector needs to particularly improve on the following indicators of NPO partnership: Financial systems (Md=2.0); Programme learning (Md=2.0); Internal capacity development (Md=2.0); Managing poor performance (Md=2.0); Partnership policy (Md=2.5); Partnership programme planning (Md=2.5); Allocation of roles & responsibilities (Md=2.5); Delegation of authority (Md=2.5); Information systems (Md=2.5); Contract monitoring (Md=2.5); Communication with NPOs (Md=2.5); and Organisational culture (Md=2.5).

In addition, partnership management capacity needs to be strengthened at district and local municipality level, and in general programme management.

Chapter 6: Assessment of NPO Access, Capacity and Quality

This sections is divided into (1) generic assessment of NPOs, (2) NPO programme assessment, (3) Household situation of chronically ill persons receiving home-based care, (4) Home-based care assessment, and (5) Support group assessment

6.1 Generic Assessment of NPOs

6.1.1 Sample

Thirty seven questionnaires were completed, 9 for KwaZulu-Natal, 7 in Gauteng, 3 in the Eastern Cape, 9 in the Western Cape and 9 in Limpopo. The majority of the interviewees were designated as Managers (17) or Co-ordinators (12), with the rest of the sample comprising Chairpersons or Administrative or Financial officers. As shown in Table 16, the sample covered both urban and rural areas and NPOs covering both small and large geographical areas.

Table 16: Areas which the NPOs serve

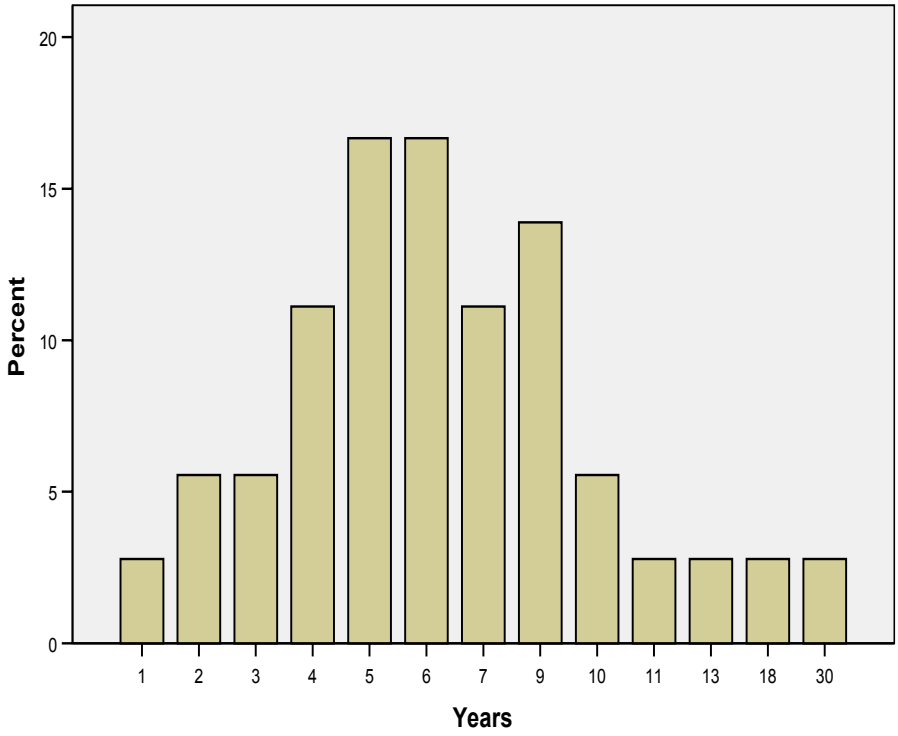
Province		Region/Sub district	Towns
KwaZulu-Natal	1	No sub district: report of Inanda Ntuzuma KwaMashu (INK)	
	2	No sub district, township eLindelani, Communities section C, Damini, Sholeni, Mancinza, Nkomani, D central	
	3	INK region of North sub district	Township Kwa Mashu Durban
	4	North sub district of eThekwini	Kwa Mashu
	5	Abaqulusi district, rural Vryheid sub district	eMondlo
	6	Rural sub district at Ulundi	Committees of Nhlungwane
	7	Zululand region rural	Community of Ulundi, Songoyane, Nsila, Sisihwili, Ntendeka ,Ulundi A, B, C, D, Zondele
	8	Inanda semi-urban mainly squatter area	Inanda
	9	INK region	
Gauteng	1	Alexandra area	Alexandra area
	2	Soshanguve South (informal settlement)	
	3	Alexandra area	Alexandra area
	4	Tshwane	Atteridgeville (informal settlement most clients) some from RDP houses and formal areas
	5	Alexandra as a whole + Mayibuye (Midrand) informal settlements	
	6	Region II Orange Farm ext 2,3,4,5,6,8, D1,2	
	7	Atteridgeville (central sub district)	Atteridgeville lotus gardens Saulsville (informal settlement)
Eastern Cape	1	Buffalo City	East London
	2	KSD-Mhlontlo	Mthatha-Qumbu

Province		Region/Sub district	Towns
	3	Duncan village-parts of Pefferville	East London
Western Cape	1	Oostenberg	Wesbank, Sarepta, Happy Valley, Blackheath, Blue Downs, Eerste River, Kteinila.
	2	Metro	Maitland, Tygerberg
	3	Southern	Athlone, Rondebosch East
	4	Boland Overberg Witzenberg	Bella vista, Ceres, PA Hamlet, Tulbagh, op die Berg nduli
	5	Boland /Overberg	Worcester, de Doorns, Rawsonville
	6	Klipfontein /Khayelitsha	Cape Town
	7	Khayelitsha	Khayelitsha, Wallacedene,
	8	Tygerberg Central	Cape Town
	9	Breede River	Ashton
Limpopo	1	Brooklyn, Mohwanekoma, Makoshala, Matlakatle.	Jane Furse, Makhuduthamaga sub-district
	2	Mogalakwena, Banana, Makube, Matsitsileng, Blinluden, Serapies, Hlogoyanku, Ham, Tenerieff	Banana/Mokopane
	3	Limpopo	Mokopane
	4	Lephalale sub-district Malapong village	Lephalale
	5	Lephalale area ward1-12	Lephalale area
	6	Botshabelo,Moshate,Mashung,Madithame, Makhaleme,Steneng,Mabotsaneng,Ditlabaneng,Dithopo,Maisola & Makgwanyane.	Apel-Fetakgomo municipality.
	7	Rite, Maebe, Mapulaneng, Lekheseng, Ga-phasha, Ga-Tibella, Lekgwanapana.	Mohlaletsi section
	8	Lephalale	Bela Bela
	9	Missing	Missing

6.1.2 Background of the NPOs and governance

All but one of the NPOs had been in existence for 2 years or more (Figure 15). The mean was 7 years with NPOs in the Western Cape generally being older. The oldest NPO has been operating for 30 years.

Figure 16: Number of years the NPOs have been functioning



All of the NPOs had a constitution and 97% of these were available for examination. Ninety-two per cent of the NPOs had a mission statement and 94% of these were available as hard copies.

Staff meetings were held regularly in the majority (81%) of NPOs and these are usually chaired by the manager, director or coordinator (Table 17). In a few NPOs, the chairperson is a rotating appointment and in some others the meetings were said to be "informal".

Table 17: Frequency of staff meetings

	Frequency	Percent
Daily	2	6.7
Weekly	18	60.0
Monthly	10	33.3
Total	30	100.0

As expected, due to the method of sample selection, most of the NPOs had missions related to care and/or treatment, especially home-based care . Other responses indicated various types of communication, ranging from advocacy, related to rights issues and stigma, information about available services, and health promotion messages related to healthy lifestyle and reduction of HIV infection risk. Other services offered included counselling and various aspects of Primary Health Care.

Table 18: Primary mission of the NPOs

Mission	N	%
Care/treatment	14	37.8
Home Based Care	9	24.3
Advocacy	5	13.5
Information	3	8.1
Prevention	3	8.1
Counseling	1	2.7
Other	2	5.4
Total	37	100.0

Most of the NPOs reported expansion of their services during the past three years. These changes cannot be directly ascribed to the EU funding, since it was not yet available in most areas at the time of the survey. However, it was clear from respondents' answers to other questions that funding was a key component for expansion of services and motivation of staff (see Tables 18 and 19).

Table 19: Reports of major changes over the past 3 years

	N	%
Expanded service	13	35.1
More staff	8	21.6
Networking	3	8.1
More equipment	3	8.1
Less stigma	2	5.4
Health improving	1	2.7
Loss of staff	1	2.7
Incentives	1	2.7
HIV testing	1	2.7
None	1	2.7
Other	3	8.1
Total	37	100.0

All the NPOs were registered and some are registered in more than one category (Table 20).

Table 20: Registration status by Province

	Provinces					
Registration Status	KwaZulu-Natal	Gauteng	Eastern Cape	Western Cape	Limpopo	Total
Non Profit Organisation	9	7	3	8	8	35
Section 21 company	1			5		6
A Trust	1			1		2
Total	9	7	3	9	8	36

One missing value

All but one of the NPO Managers reported having a governing board, committee or other structure to whom they reported, which met either monthly (38%) or quarterly (63%), although not all were meeting regularly and 7% had not met within the past three months. Eighty six percent of the NPOs submit reports to the Board. Sixty seven percent of the NPOs had an annual plan but only 62% of these were available as hard copies. Eighty six percent said that they produce annual reports and 90% of these were able to provide a copy of last year's report.

6.1.3 Services provided by the organisation

Mission statements tend to be rather cryptic and the services actually delivered indicate a more comprehensive model of primary health care than the mission statements alone would seem to imply (Table 21).

Table 21: Types of activities carried out by the organisations

Activity	n	%
HIV home-based care	32	86.5
Nutrition	29	78.4
TB	29	78.4
HIV counseling	28	75.7
Poverty alleviation	27	73.0
HIV prevention	27	73.0
PLWHA support group	20	54.1
Other PHC	13	35.1
Support for the disabled	21	56.8
Support for the mentally ill	12	32.4
Reproductive health	11	29.7

'HIV home-based care' refers to home-based care specifically for HIV patients. In terms of support for the mentally ill and disabled persons, the questionnaire did not distinguish between general support services and home-based care. 'Reproductive health services' reported by NPOs are assumed to refer to contraception and prevention of sexually transmitted infections.

The majority (73%) of the NPOs were involved in networks of various kinds and about half (51%) provided some kind of training to other NPOs (Table 22).

Table 22: Services to other NPOs

Activity	n	%
Networking	27	73.0
Training	19	51.4
Other kinds of support	14	5.2

A wide range of activities was reported by the NPO managers but there is enormous variation in both numbers reached (Table 23) and frequency of services offered. For example, some activities take place only once per month or "as required", while others were offered on a daily basis. Similarly some activities inevitably target groups, as in the case of PLWHA support groups, while others have to be individual in their orientation, such as home-based care.

Table 23: Average numbers being reached

	N	Mean	SD	Max	Min
Mean number of males involved	30	41	49	253	5
Mean number of females involved	30	74	103	516	11

6.1.4 Human resources

The largest NPO has 500 volunteers and the vast majority of staff involved are black females (Table 24). The number of salaried staff ranged between 4 and 80, with an average of 34.

Table 24: NPO staffing

	Mean	SD	Max	Min
Total salaried staff (N)	33.50	22.67	80	4
Total female staff (%)	80%	16%	100%	25%
Total black staff (%)	84%	20%	100%	0%

Motivation of volunteers was achieved through various means, including presents (73%); training courses (54%); monetary benefits (43%); praise for good work (43%); awards (22%); and other incentives, such as outings or parties (1%).

6.1.5 Experiences of the partnership

When asked about the benefits of the partnership between the NPO and government, the most frequent response was that funding was making, or would make, operations easier (Table 25). Other important benefits related to communication (i.e. increased awareness of the activities of others) and availability of supplies, including food parcels. Conversely, when asked about problems with the partnership, many of the problems related to delays, especially with payments and complex systems, sometimes resulting in slow implementation (Table 26). While there appear to be a few NPOs that are experiencing difficulties, the majority reported no problems.

Table 25: Good aspects of the partnership with government

	Frequency	%
Funding	10	27.0
Communication	6	16.2
Supplies	5	13.5
Training	5	13.5
Improved services	4	10.8
None	2	5.4
Other	2	5.4
Too early to tell	2	5.4
Cooperation	1	2.7
Total	37	100.0

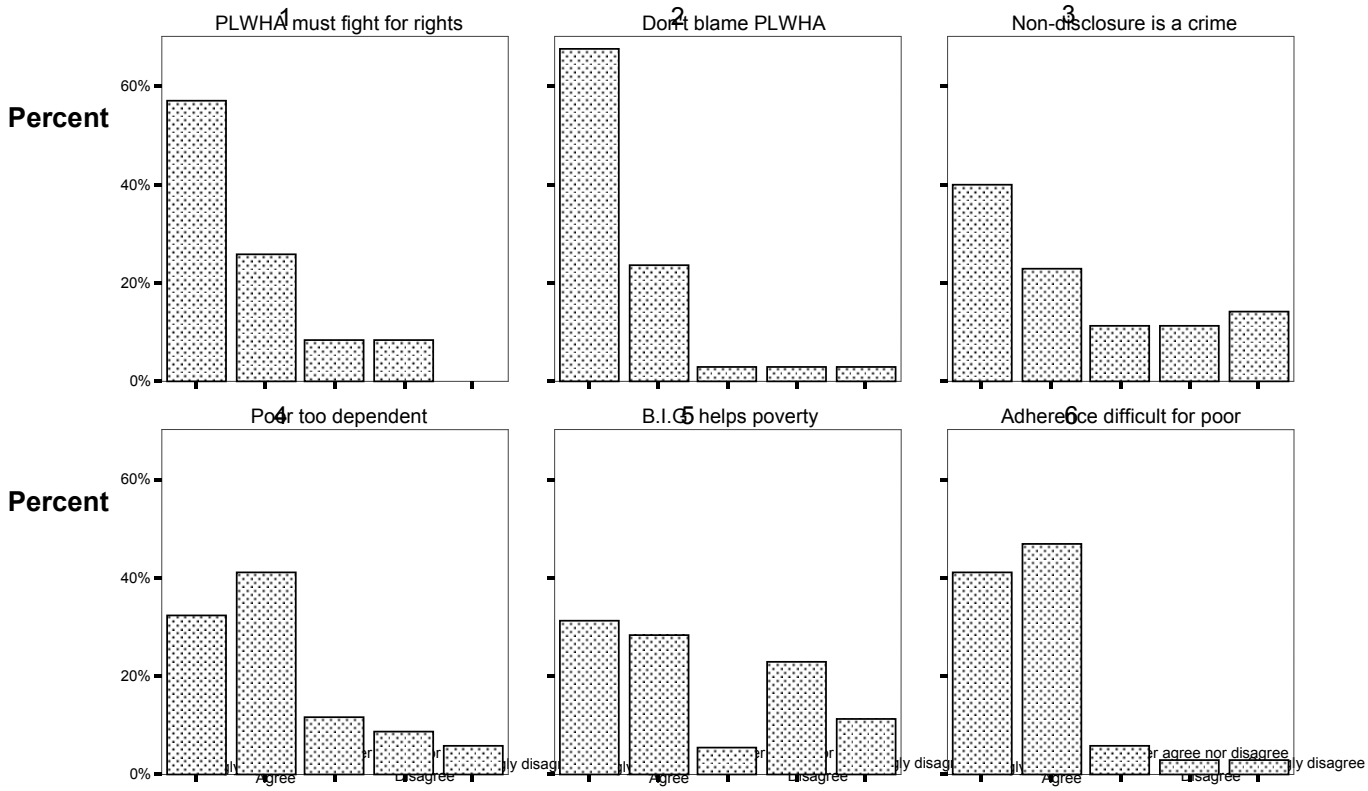
Table 26: Problems experienced in the partnership with government

	Frequency	%
None	18	48.6
Late payments	8	21.6
Communication	4	10.8
Supplies	2	5.4
Complex systems	2	5.4
Delays in implementation	2	5.4
Other	1	2.7
Total	37	100.0

6.1.6 Organisational culture and attitudes to partnership

A self-administered questionnaire was used to assess managers' attitudes to HIV, AIDS and poverty; the prevailing organisational culture; and the relationship between NPOs and government. Questions took the form of statements with which the respondent was asked to indicate their level of agreement or disagreement, ranging from 'strongly agree' to 'strongly disagree', using a five point scale. Similar questionnaires were used for both NPO managers and District Managers.

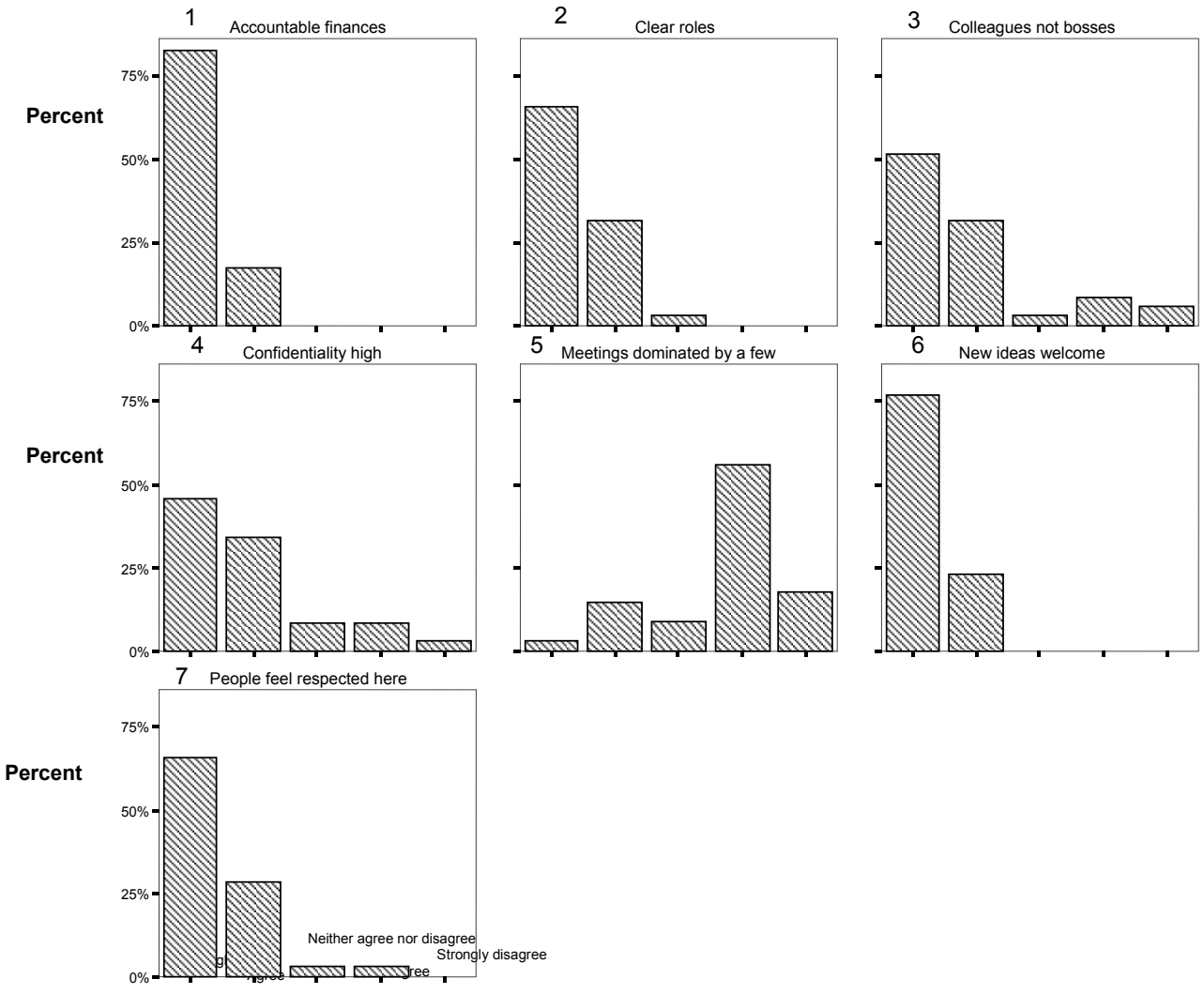
Figure 17: General attitude to HIV, AIDS and poverty - NPO managers' view



In terms of their general attitude (Figure 16, graphs 1-3), NPO managers seemed to be appropriately disposed to persons living with HIV and AIDS. However, there was more variation in the response to the statement "People who do not disclose their HIV status to their sexual partners should be prosecuted". This suggests that some managers feel very strongly about non-disclosure and that they would support legal measures to facilitate disclosure to partners. In terms of the role of poverty (Figure 16, graphs 4-6) managers feel that the poor are too dependent on government handouts and that a Basic Income Grant (B.I.G.) might be a better solution. They also acknowledge that the poor have difficulties in taking medication regularly (adherence) (Fig 16, graph 6).

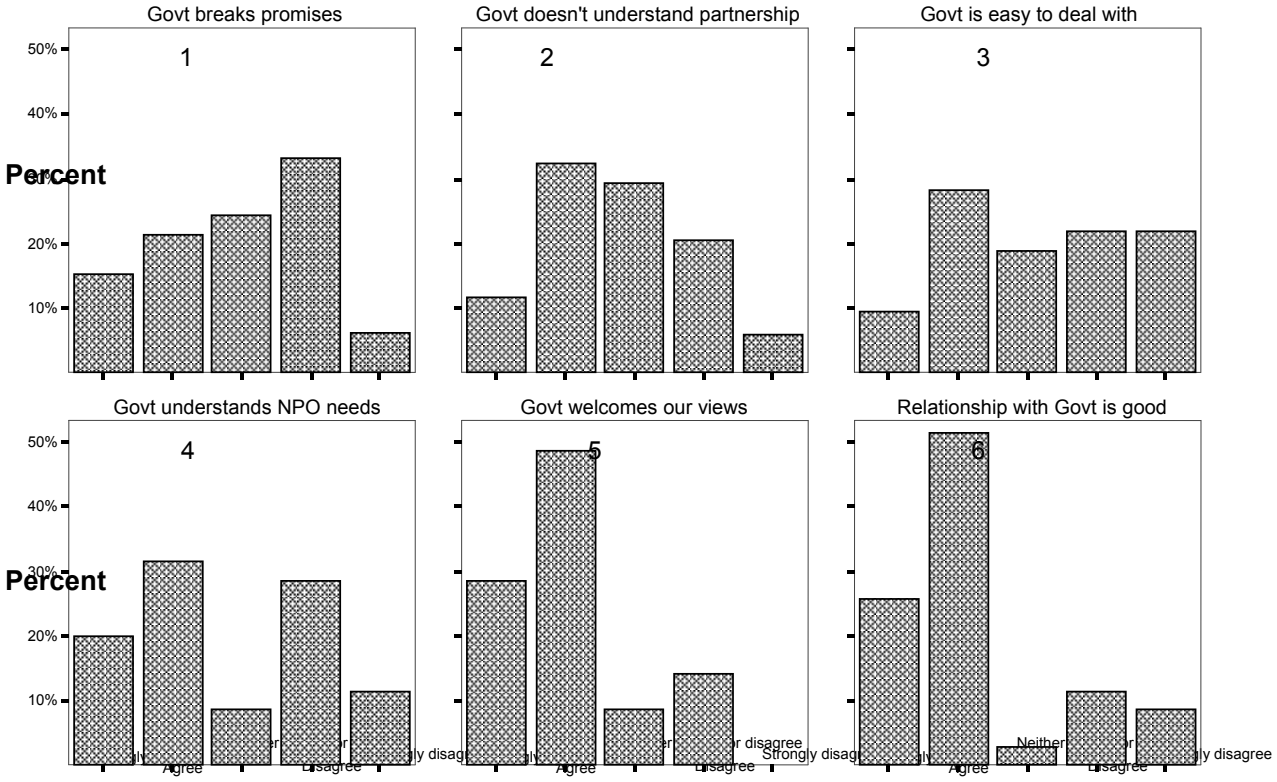
Generally the NPO managers had a positive view of their organisations (Figure 17), and this was endorsed by their deputies. Areas where there was more variation included whether managers were regarded as "colleagues or bosses" (Figure 17, graph 3) and whether meetings were dominated by a few people (Figure 17, graph 5). The spread of responses to the statement about confidentiality (Figure 17, graph 4) was probably due to the wording, which referred to "going overboard on the issue of confidentiality". Whilst most seemed to agree that confidentiality was important, clearly some did not think they were "going overboard" with the issue.

Figure 18: Organisational culture - NPO managers' view



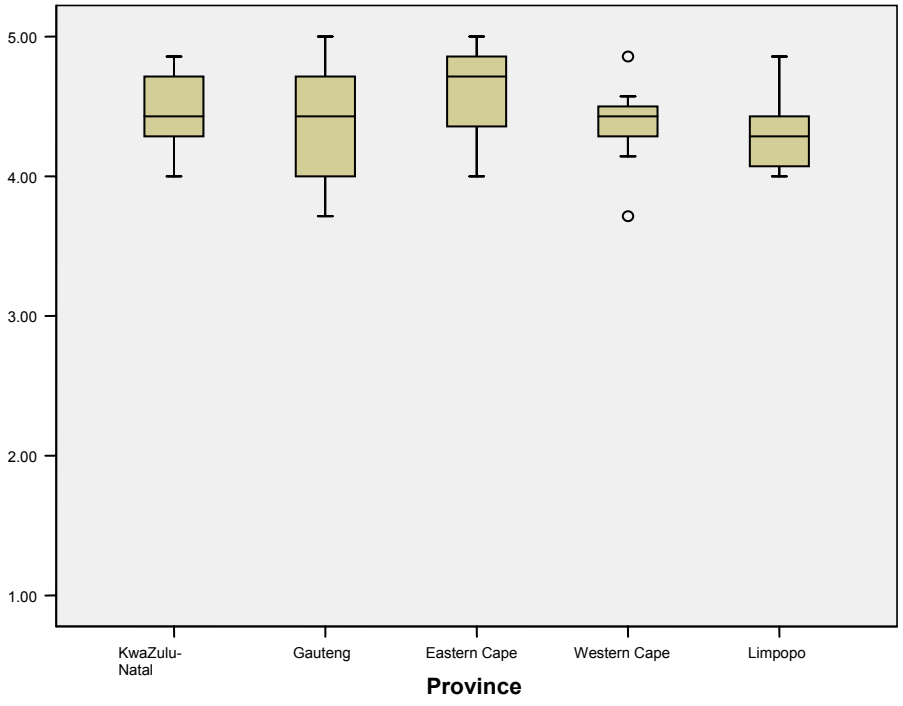
Perhaps the most telling aspect of this part of the evaluation is the section of the questionnaire dealing with perceptions of the relationship between the NPO and the government (Figure 18). With the exception of the statement "Government welcomes our views" (figure 18, graph 5), there were some NPO managers identifying with the negative end of the spectrum in terms of the relationship for all statements (Figure 18, graphs 1, 2, 3, 4 & 6). Conversely, there are some NPO managers who were happy with the situation for all the indicators so the relationship appears to be working well in some areas.

Figure 19: Relationship between NPO and Government - NPO Managers' view



In order to assess regional variations in the organisational culture and the relationship between the NPOs and government, the various indicators were converted to a single score for each of these categories. The calculation is corrected for negative and positive statements in order to arrive at a unidirectional mean index. Using this method, a score of 5 indicates strong positive perceptions and a score of 1 strong negative perception. The results are displayed using a 'box and whisker' plot[1]. As can be seen from Figure 19, the organisational culture was rated consistently high (nearly all scores above 4).

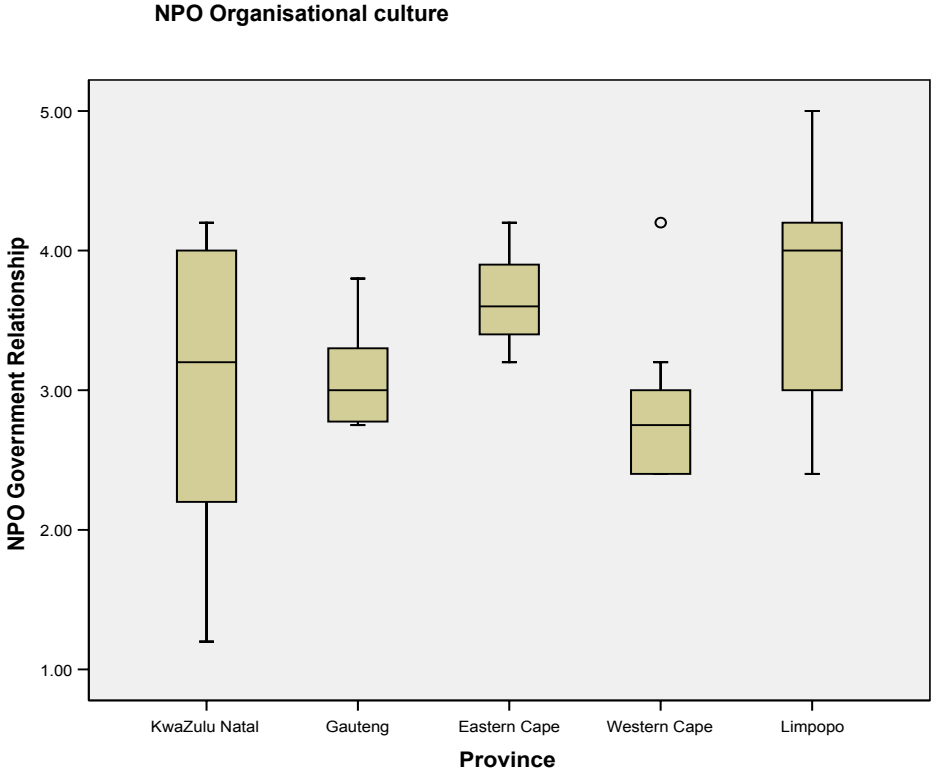
Figure 20: Median scores for indicators related to NPO organisational culture - NPO managers' view



[1] A box and whisker plot shows the median value as a central line within a box representing the interquartile range of the 25th to the 75th percentile. The lines above and below the box show the range of values, excluding extreme values which fall between 1.5 IQR's and 3 IQR's from the end of a box, which are shown as small circles.

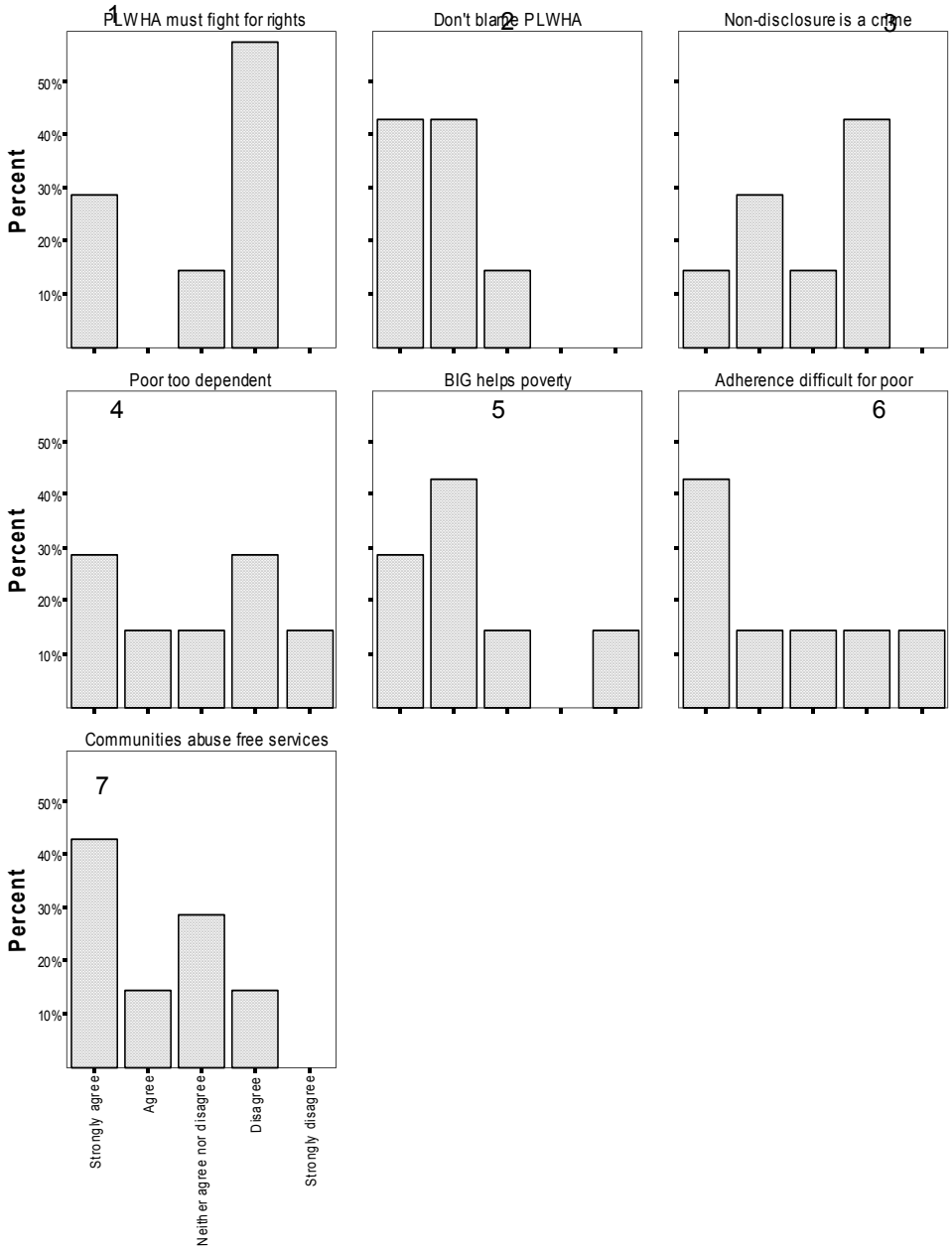
However, the situation with regard to the relationship with government is much more varied and it is clear that in KwaZulu-Natal and Western Cape there are some NPO managers who have a negative perception of their relationship with government (Figure 20). Given that the central value of 3 represents "neither agree nor disagree", the mid level scores are no great cause for concern. However, there are many scores below 3 in both KwaZulu-Natal and the Western Cape, which may be indicative of a need for further investigation of the situation in these areas.

Figure 21: Median scores for indicators related to NPO/government relationship - NPO managers' view



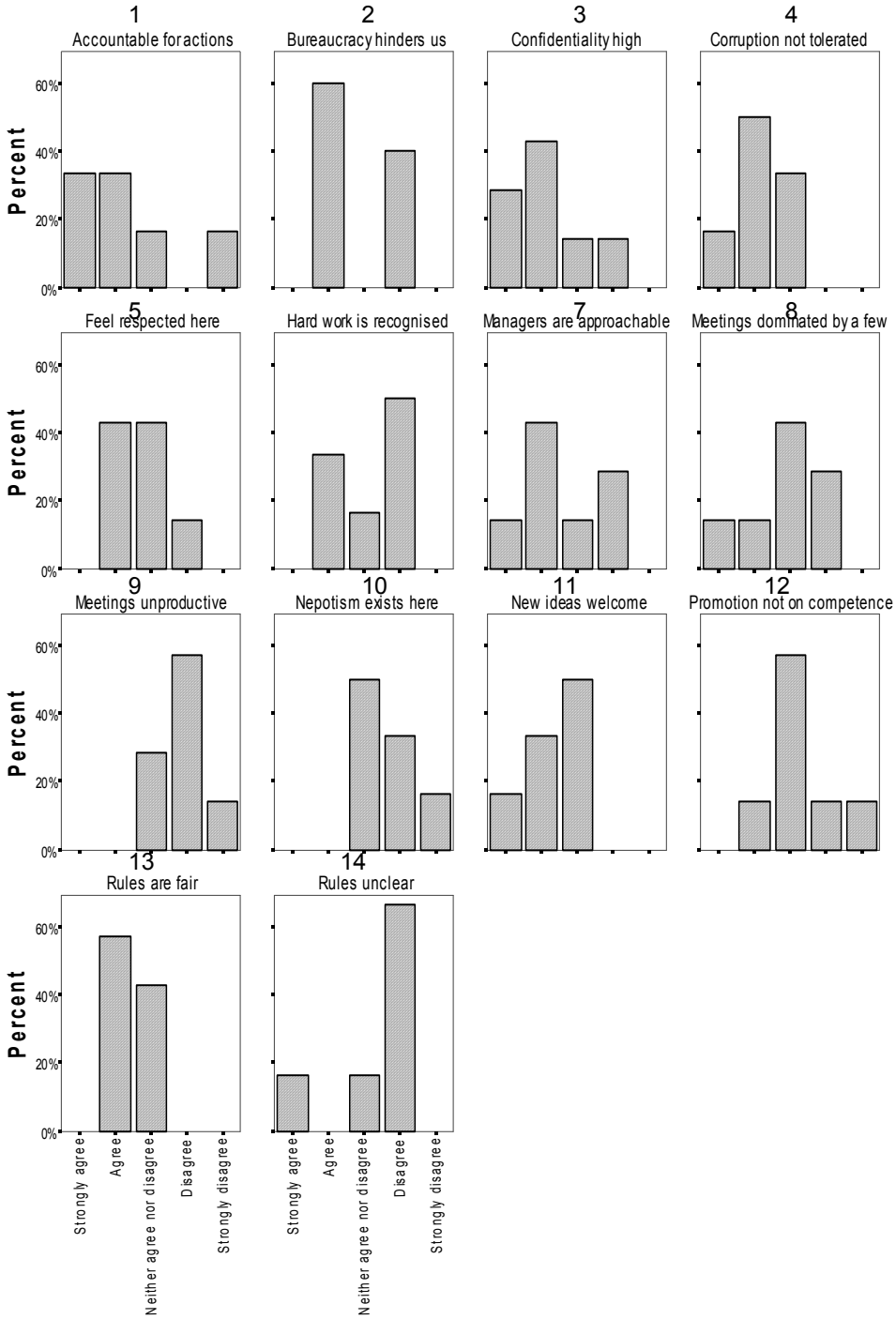
The responses of District Managers (DM) to a similar battery of questions are shown in the following figures (Figures 21). There was a striking difference between the attitude of DMs and their NPO counterparts in terms of their view on PLWHA having to "fight for their rights for anything to change" (Figures 16 vs. Figure 21, graph 1). The majority of DMs did not feel that PLWHA should have to fight. DMs also appeared more tolerant of people's right to non-disclosure (Figure 16 vs. Figure 21, graph 3). The last question in the set relating to general attitudes was an additional one, namely, "Communities tend to abuse free health services" and the majority of DMs agreed with this statement (Figure 21, graph 7).

Figure 22: General attitude to HIV, AIDS and poverty - District managers' view



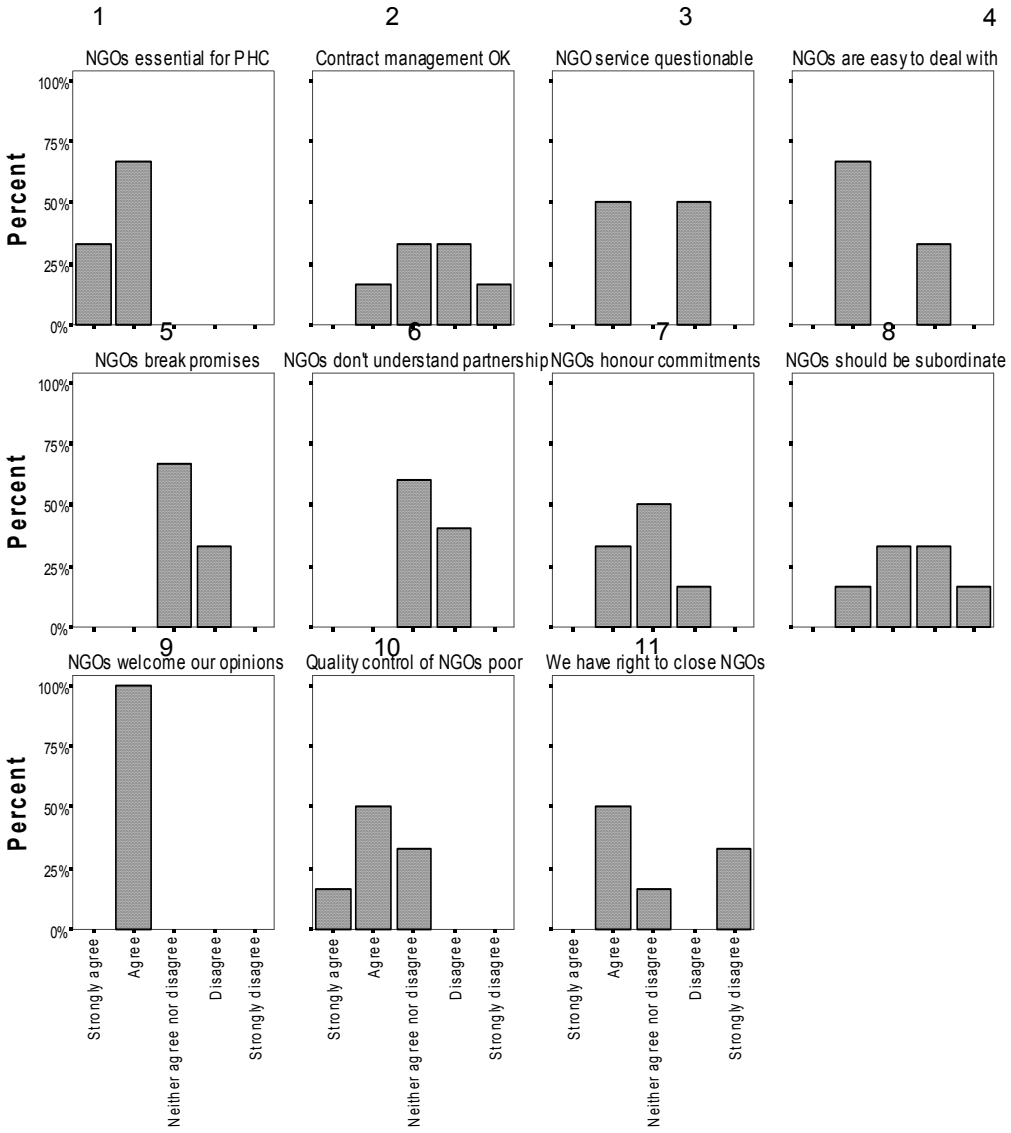
Generally DMs had a positive view of their organisational culture, although bureaucracy was an issue for some, hard work is not always recognised and managers are not always approachable (Figure 22, graphs 2, 6 and 7).

Figure 23: Organisational culture - District managers' view



Areas of the government/NPO relationship that appear unsatisfactory included contract management, quality of service, communication and quality control, all of which were rated poor by some of the DMs (Figure 23, graphs 2, 3, 4, & 10).

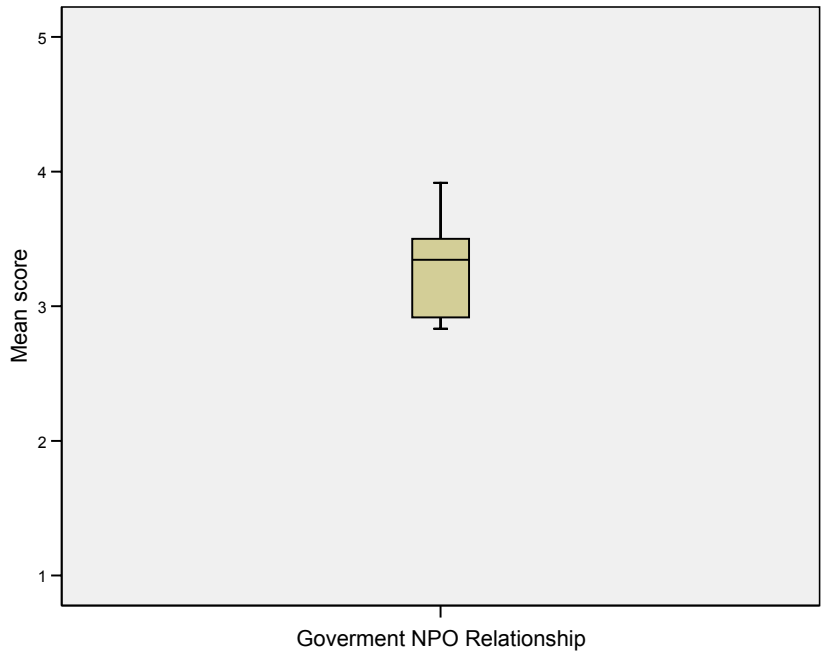
Figure 24: Relationship between NPO and Government - District Managers' view



Owing to the much smaller sample size for the District Managers and the tendency for some respondents not to answer all questions, it was not possible to compare attitudes across provinces, as was done for the NPO Managers. However, the combined results were used to create a median score for organizational culture and the government/NPO relationship (Figure 24, Figure 25). The median scores were above three, indicating a positive rating, although they were considerably lower than those achieved for similar indicators in the NPOs.

Figure 25: Median scores for indicators related to government organisational culture (District managers' view)

Figure 26: Median scores for indicators related to Government/NPO relationship - District managers' view



6.1.6 Conclusions and recommendations

One of the most important aspects of this part of the evaluation is the perception of the relationship between the NPO and the government. Whilst both NPO Managers and District Managers appear convinced that the partnership is potentially beneficial, there were some responses for the negative end of the spectrum of most indicators. This implies that more is effort is needed to ensure better understanding between partners and that communication is optimised. By way of encouragement, there were examples of positive responses for all the indicators and these could be drawn upon to identify 'best practice' models.

The issue of delays in release of funds by government needs to be addressed urgently. Cash-flow problems meant that and some NPO managers/coordinators were struggling to keep disgruntled staff members when salaries or other payments were delayed. This might lead to high staff turnover rates and impact negatively on the partnership and service delivery at sub-district level.

Chapter 7: NPO Programme Assessment

7.1 Sample

The sample of NPOs for this study included only NPOs funded by the European Union (EU) through the Provincial Department of Health in Gauteng, Western Cape, Limpopo, KwaZulu-Natal and Eastern Cape. These provinces were selected as the EU currently funds or has plans to fund NPOs in these provinces only. Within each province, one urban health district and one rural health district was selected for the study where possible. This was done so as to compare differences between urban and rural districts within provinces. Within Gauteng though, there are no true rural districts, therefore 2 urban districts were randomly selected for the study and within Limpopo, two rural districts were selected as the EU funded NPOs which are situated in rural districts only. Further, NPO numbers were doubled in Water berg (Limpopo) and eThekwini (KZN) in order to compare differences between a rural district in Limpopo and an urban district in KwaZulu-Natal.

Table 27: Actual and realised NPO sample per province and district

Province	District	Actual Sample	Realised Sample
Western Cape	Metro (urban)	3	6
	Boland overburg (rural)	3	3
Eastern Cape	Amatole (urban)	3	1
	OR Tambo (rural)	3	3
Gauteng	Johannesburg (urban)	3	3
	Tshwane (urban)	3	3
Limpopo	Waterberg (rural)	6	6
	Sekhukhune (rural)	3	3
KwaZulu-Natal	ethekwini (urban)	6	6
	Zululand (rural)	3	3
Totals		36	37

Table 27 above shows the actual and realised sample for the study. As can be seen, Eastern Cape's sample was not realised in Amatole district. Western Cape on the other hand over realised its sample for the Metro district. Give reasons why this was the case.

Within the districts, lists of EU funded NPOs were obtained from the provincial EU coordinator or the district EU program manager. Simple random sampling was then used to sample NPOs for the study. Within eThekwini, lists were divided between NPOs that provided home based care (HBC) only and those that provided support group services as well as HBC. Simple random sampling was then used to select an equal amount of NPO that provided HBC (3) only and those that also provided support group services (3).

7.2 Procedure

The information was gathered by trained researchers during January 2006 to April 2006. The questionnaire was interview-administered mainly at the NPO offices . Within the NPO, the interview took place in a private setting which included the office of the official who was available. In almost all the cases, the interview was administered to the NPO coordinator and in some cases, it was the NPO director/program manager. It is important to note that during the interview process, the interviewee invited other NPO members, including finance administrators, home based carers, and supervisors to the interview session. Answering the

questionnaire therefore became a collective effort. The indicator and its meaning was first read out to the respondents followed by the five point scale of possible answers. The respondents and researchers discussed the potential answers to the indicator and consensus was reached between respondents and the researchers for rating of each indicator. Certain indicators such as client records or storage areas required the researchers to physically inspect the client records and storage areas and rate it accordingly. Again, discussions were held with respondents and consensus was agreed upon before recording information on the questionnaire.

7.3 Measure

In evaluating the programme management and quality of NPOs, this study utilised the Buch et al. (2004) participatory rapid appraisal tool for the evaluation of AIDS home based care programmes. The management domains included in this study are:

- Board / Management Committee,
- Community / Stakeholder Involvement including AIDS/HIV patients and their families,
- Collaboration,
- Training,
- Services (by home carers),
- Planning and Monitoring,
- Human Resource Management,
- Supply systems / logistics.

NPO capacity indicators were assessed on a scale from 0 to 4, where 0 = “not in place yet”, 1 = “still setting up”, 2 = “started”, 3 = “running adequately” and 4 = “running excellently”. As can therefore be seen, the higher the score, the higher the capacity and output of the NPO with the average being 2.

Percentage calculations for each indicator based on the above-mentioned scales are made overall. The mean and standard deviation are also included for each indicator. Mean and standard deviation calculations are also made for the provincial breakdown of results thus showing overall provincial ratings for the indicator as a whole.

At the start of the interview process, the researcher handed the information sheet and consent form to the respondent. The study was explained to the respondent and all questions were answered. The respondent was also informed of his/her rights as a participant and was also informed of their right to withdraw from the study at any point without negative consequences. Once consent was signed, the researcher proceeded with the questionnaire.

7.4 Results

Results are presented according to the eight programme management indicators assessed here.

7.4.1 Board / Management Committee

Table 28: Is there a Board or a community or stakeholder committee

	Yes	No	Total
KwaZulu-Natal	9	0	9
Gauteng	6	0	6
Eastern Cape	4	0	4
Western Cape	9	0	9
Limpopo	3	6	9
Total	31	6	37

As can be seen from Table 28 only 6 NPOs in Limpopo province stated that they do not have a board or stakeholder committee for their NPO. The remaining 31 NPOs all had board members of a stakeholder committee.

7.4.2 Community / Stakeholder Involvement including AIDS / HIV patients and their families

The stakeholders in these instances are sick AIDS patients, HIV positive patients, frail care persons, families of these ill patients and the community. As an NPO is set up and in this study, funded to care for these stakeholders, it is important to establish if NPOs actively involve relevant stakeholders in its decision and policy making. This type of assessment is not always easy to make and indicators are used while evaluating the organisation.

Activity: Actively seeks out and is responsive to community needs

Stakeholder consultation

- Stakeholders informed and able to provide directly or indirect input to policy making and implementation

Active local council involvement in the organisation

- Local council rep on Board / Management Committee
- Liaison with local councilors

Responsiveness to input

- Stakeholder input is used to inform policy and service development.

Mechanisms in place to collaborate with other organisations

- Regular contacts?
- (in)formal meetings attended?

Table 29: Indicator of Overall Community Involvement (overall)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Stakeholder consultation	37	32.4	18.9	16.2	24.3	8.1	1.57	1.39
Active local council involvement	37	13.5	18.9	16.2	27.0	24.3	2.30	1.39
Responsiveness to input	36	33.3	5.6	11.1	27.8	22.2	2.00	1.62
Mechanisms in place to collaborate	37	2.7	5.4	10.8	32.4	48.6	3.19	1.02

The above indicators show stakeholder consultations is mainly not in place as yet (51.4%) but there is active local council involvement (67.6%). Stakeholders are reported to be making input (61.1%) and there are mechanisms in place to collaborate (91.9%).

Table 30: Mean Community Involvement (by province)

Province	N	M	SD
KZN	9	1.97	0.643
GT	6	2.54	0.534
EC	3	2.75	1.146
WC	9	2.64	0.741
LP	9	1.72	1.349
Total	36	2.24	0.958

With regards to individual provinces and their scoring of community involvement, NPOs in the Eastern Cape (M=2.75), followed by Western Cape (M=2.64) and Gauteng (M=2.54) seem generally above average (average being 2). Limpopo Province scored below average with M=1.72 and KwaZulu-Natal (M=1.97) was just below average with regards to community involvement.

7.4.3 Collaboration

Collaboration is essential as NPOs cannot do everything. An NPO need to set up networks with other NPOs in the area, also with clinics, hospitals and other organisations. By setting up such networks, the best service is offered to the client.

Activity: Collaborates with other NPOs (in HBC, Support provision, HIV and AIDS and in Development and Welfare) and with Health Services.

Collaboration with Other NPOs

Mechanisms in place to collaborate with other organisations

- Regular contacts?
- (in)formal meetings attended?

Duplication avoided

- Clarity among NPOs re which services each offers best.
- Equitable sharing of patient load between the various organisations
- Services offered to other NPOs as needed

Collaboration with Hospitals and Clinics

- Appropriate & accessible health care
- Needed range of service available
- Offered at nearby hospital and clinics

Arrangements in place with local clinics / hospitals for support

- Can source consultation services
- Drugs available
- Provision of supplies

Recruitment of clients

- Suitable system in place for recruitment of new clients. (Referral system, advertising, self-referral)

Table 31: Overall NPO Collaboration with other NPOs and Health Institutions

	N	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
With Other NPOs								
Mechanisms in place to collaborate	34	2.9	5.9	5.9	47.1	38.2	3.12	0.97
Duplication avoided	33	12.1	6.1	6.1	30.3	45.5	2.91	1.37
Equitable sharing	27	29.6	0.0	7.4	37.0	25.9	2.30	1.61
Services offered	35	2.9	5.7	14.3	42.9	34.3	3.00	1.00
With hospitals & clinics								
Appropriate & accessible health care	35	5.7	5.7	8.6	34.3	45.7	3.09	1.14
Arrangements in place	35	11.4	5.7	11.4	31.4	40.0	2.83	1.33
Recruitment of clients	36	11.1	5.6	0.0	30.6	52.8	3.08	1.33

Currently there are mechanisms in place to collaborate with other NPOs (91.2% & M=3.12). Clarity among NPOs in terms of which services each offers best, are in place (81.8%) and 70.4% of NPOs stated that there is equitable sharing of patient load between the various organisations with 91.4% stating that they offer services to other NPOs as needed.

With regards to collaboration with hospitals and clinics, the majority of NPOs (88.6%) stated that the needed range of service are available and are offered at the nearby hospital and clinics. There are arrangements in place with local clinics / hospitals for support (82.9%) and there is a suitable system in place for recruitment of new clients (83.3%).

Table 32: Mean NPO Collaboration (by province) with other NPOs and Health Institutions

Province	N	M	SD
KZN	8	2.77	0.43
GT	3	3.33	0.29
EC	1	3.29	0.31
WC	8	3.04	0.43
LP	2	2.86	0.81
Total	22	2.97	0.46

All provinces are above average in terms of collaboration. Gauteng (M=3.33) shows highest collaboration with the weakest being KwaZulu-Natal (M=2.77) although still above average.

7.4.4 Training

In order for an NPO to function efficiently, training is needed at all levels, including HR, finance, management and most importantly the carer. This section looks at NPO training as per the below indicators:

Activity: In-service and outreach training service

Home carer training programme available

- Formal / Informal
- Includes sufficient theoretical and practical training
- Materials available

Programme suitable to achieve required skill levels

- Set of defined skills that the home carer should attain at end of training
- Skills list written down (Look at it)

Training plan for all staff

- View plan if written, or clarify verbally

Trainer Skills

- Trainers skilled to train (qualifications of trainers)
- Percentage of in-house training

Links to other training

- Links to other training programmes and organisations (which ones?)

Ongoing supervision

- Ongoing supervision and evaluation, self-evaluation.
- (See schedule of supervisory visits if there is one)

Continuing education

A programme of continuing education and training is avaialbe for all staff

Management training

- Type of training and frequency is defined training includes finance, human resources, operational management

Table 33: Overall NPO Training

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Home carer/health training	36	25.0	5.6	16.7	30.6	22.2	2.19	1.50
Prog suitable to achieve required skill levels	35	17.1	17.1	14.3	31.4	20.0	2.20	1.41
Training plan for all staff	37	45.9	16.2	16.2	8.1	13.5	1.27	1.46
Trainer Skills	33	39.4	15.2	0.0	12.1	33.3	1.85	1.80
Links to other training	34	23.5	5.9	8.8	38.2	23.5	2.32	1.51
Ongoing supervision	35	11.4	2.9	14.3	48.6	22.9	2.69	1.20
Continuing education	36	25.0	19.4	16.7	19.4	19.4	1.89	1.48
Management training	37	13.5	24.3	21.6	27.0	13.5	2.03	1.28

Only 69.4% of NPOs stated that a home carer-training programme is available with only 65.7% of NPOs stating that the programme is suitable to achieve required skill levels. Majority of NPOs (62.2%) do not have a training plan for all staff with 54.5% stating that trainer skills are either not in place yet or still being set up. Links to other training organisations are high (70.6%). Ongoing supervision is taking place (85.7%) yet continuing education (55.6%) and management training (62.2%) could be improved.

Table 34: Mean NPO Training (by province)

Province	N	M	SD
KZN	9	2.07	0.99
GT	4	2.75	0.14
EC	3	2.54	1.32
WC	9	2.22	0.66
LP	5	1.63	1.54
Total	30	2.18	0.98

Limpopo (M=1.63) showed the poorest score in terms of training. All other provinces were above average although KwaZulu-Natal was only just above average with a Mean of 2.07.

7.4.5. Services (by home carers/support providers)

The core functions of NPOs are the services offered by carers. This section aims is to understand how much work the carers do and what other responsibilities they have. Indicators that assess this include:

Activity: home base care service in place

Structure of home visits system

- Defined expectations of work hours /Number of visits expected for bed-ridden patients and ambulatory patients.
- Can accommodate near / far patients.
- Visits regular enough for required care e.g. bed bound

Patient register kept and is updated

- Look at the register and assess suitability and use

Support/Health promotion groups

- Support/Health promotion groups have carers/educators assigned who provide support/health promotion to attendees

Family support

- Training of families to look after their ill relative by home carer.
- Check if training is built into the time spent with ill patient or extra?

Orphan Care

- Have established / running an orphan care programme
- making progress with the programme as planned.

Table 35: Overall Services offered by NPO and carers

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Structure of home visits system	34	8.8	2.9	8.8	38.2	41.2	3.00	1.20
Patient register kept & updated	35	20.0	2.9	5.7	25.7	45.7	2.74	1.55
Support groups/health promotion	33	15.2	0.0	18.2	21.2	45.5	2.82	1.42
Family support	36	11.1	5.6	8.3	44.4	30.6	2.78	1.26
Orphan Care	36	27.8	8.3	19.4	22.2	22.2	2.03	1.54

According to 88.2% of NPOs, there is a defined expectation of work hours /number of visits expected for bed-ridden patients and ambulatory patients, they can accommodate near / far patients and visits regular enough for required care e.g. bed bound. 77.1% of NPOs keep a patient register and updates it. 84.8% of NPOs have support groups that have carers assigned who provide support to attendees with 83.3% of NPOs stating that they give family support to look after their sick relative. Only 63.9% of NPOs stated that they have an established / running an orphan care programme.

Table 36: Mean Services offered by NPO and carers (by province)

Province	N	M	SD
KZN	8	2.90	0.90
GT	1	3.40	0.35
EC	3	3.47	0.23
WC	8	2.30	0.26
LP	9	2.18	1.01
Total	29	2.59	0.85

The overall Mean score for services is shown as above average as M=2.59. Limpopo showed the lowest Mean of 2.18 with Gauteng (M=3.40) reporting the highest.

7.4.6 Planning and Monitoring

As NPO grow, then need to plan strategically in order to give the best service and prove themselves to funders. This section explores if NPO plan and monitor their work.

Strategic Plan

- Strategic plan in place (Review it if written)
- Clear sense of where the project would like to be 3-5 years from now.
- Has a listing of activities that need to be done in the next year.

Monitoring

- Can explain how self monitoring is done against plan
- deals actively with problems

Annual reports

- Annual report prepared
- Distributed to all relevant including sponsors and stakeholders

Participatory Planning

- Staff and stakeholder participation in planning process

Table 37: Overall NPO Planning & Monitoring

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Strategic Plan	36	47.2	11.1	2.8	19.4	19.4	1.53	1.68
Monotoring	32	12.5	18.8	9.4	21.9	37.5	2.53	1.48
Annual reports	36	8.3	13.9	8.3	30.6	38.9	2.78	1.33
Participatory Planning	36	22.2	8.3	8.3	33.3	27.8	2.36	1.53

Few NPOs (41.7%) have a strategic plan. Interestingly, 68.8% of NPOs do monitoring but clearly due to the lower numbers of NPOs that have a strategic plan, this monitoring is not checked against the plan. Annual reports are being prepared by 77.8% of NPOs.

Table 38: Mean NPO Planning & Monitoring (by province)

Province	N	M	SD
KZN	5	2.30	1.15
GT	6	2.71	1.16
EC	4	3.44	0.80
WC	9	2.44	1.12
LP	8	1.66	1.49
Total	32	2.40	1.25

In terms of planning and monitoring, Limpopo showed the poorest Mean score of 1.66. All other provinces were above average.

7.4.7 Human Resource Management

In order for NPOs to run efficiently and be effective, they need to manage their work force. This section assesses the most important aspects of human resource management.

Recruitment and selection

- System in place that avoids favouritism and allows all an opportunity and selects the right people as carers.

Conditions of service / stipend

- Conditions of service / stipend clear for all
- Conditions written down (Look at copy)

Job Description

- Written job descriptions for all staff (Look at copy)

Legislative Compliance

- Meets legal requirements for work and discipline, e.g. LRA, BCEA, leave conditions, etc

Staff morale and support

- Counseling / support structure / group therapy, etc in place for staff
- Strategies to keep morale up is in place

Monitoring and Review

- System for monitoring and review of quality of care and work in place
- reviews and monitoring done on a regular basis (Frequent enough)

Staff turnover and Absenteeism

- Percentage (estimate?) unplanned staff turnover among volunteers, home based carers and management / admin staff acceptable.
- Annual absenteeism rate among salaried staff acceptable

Home based carers/ supporters: Their views on:

- Morale
- Commitment
- Attitude
- Self perception of skills
- Training needs
- Strengths and weaknesses
- Ideas for improvement
- Supervisory visits
- Supervisory supports
- And the programme in general and how to improve it

This last indicator was assessed during the interview process as well as during the tour of the NPO and while meeting with the carers.

Table 39: Overall Human Resource Management by NPO

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Recruitment and selection	37	13.5	0.0	8.1	37.8	40.5	2.92	1.32
Conditions of services / stipend	36	16.7	11.1	8.3	25.0	38.9	2.58	1.51
Job Description	34	20.6	0.0	8.8	29.4	41.2	2.71	1.52
Legislative Compliance	36	25.0	11.1	11.1	30.6	22.2	2.14	1.53
Staff Morale and Support	36	11.1	8.3	8.3	30.6	41.7	2.83	1.36
Monitoring and Review	35	11.4	8.6	11.4	34.3	34.3	2.71	1.34
Staff turnover and Absenteeism	34	5.9	5.9	5.9	32.4	50.0	3.15	1.15
HBC/health promoters views	25	4.0	0.0	12.0	24.0	60.0	3.36	0.99

The NPOs (86.5%) stated that there are systems in place that avoids favoritism and allows all an opportunity and selects the right people as carers. 72.2% of NPOs stated that conditions of service/stipend is clear for all and that these conditions are written down. 79.4% of NPOs report having written job descriptions for all staff and 63.9% state that they meet legal requirements for work and discipline, e.g. LRA, BCEA, leave conditions, etc. With regards to staff morale, 80.6% of NPOs state that they have counselling/support structure/group therapy, etc in place for staff and also have strategies to keep morale up. 80% of NPOs stated that they have system for monitoring and review of quality of care and work. 88.2% state that percentage unplanned staff turnover and absenteeism rate among volunteers, home based carers and management/admin staff acceptable. With regards to home based carers or health promoters views on the work they do, the majority (M=3.36) seem to be enjoying their work in that morale is high, they are committed, have a positive attitude, have ideas for improvement, are supported by supervisors and so on.

Table 40: Mean NPO Human Resource Management (by province)

Province	N	M	SD
KZN	6	3.21	0.71
GT	3	3.00	0.57
EC	3	3.13	0.57
WC	4	2.78	1.03
LP	8	2.56	0.95
Total	24	2.89	0.81

KwaZulu-Natal shows the best result with regards to Human Resource Management with M=3.21. Total Mean was high at 2.89.

7.4.8 Supply systems / logistics (Look around the premises)

Efficient operation also requires that an organisation has a working logistics system. There are two important aspects of a supply systems management. The first is to ensure that the organisation has the materials it needs to do its work and that there are no gaps in supplies. The second is to be sure that here is a system to avoid theft and misuse of the organisations property. This section explores this with the following indicators:

Tracking System

- System (computerised or manual) in place that records organisational activities

Ordering / donations

- System of ordering / soliciting donations to ensure required stock is in place.

Storage

- Storage area and means of avoiding leakage e.g. register of incoming and out-going supplies is in place

Security

- Supplies are secure and responsible person has been put in charge
- Premises and staff safety secured

Transport

- Accessible and available transport, including taxis, for home carers. (Home carers should walk if nearby)

Electronic communication

- Fax / copier available
- Computers in effective use
- Have internet / e-mail facilities

Client record files

- Suitable format for storing client info
- Well maintained (up to date)
- Easy to find (proper filing system)
- Confidentiality ensured

Table 41: Overall NPO Supply systems and logistical operations

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Tracking System	36	16.7	13.9	8.3	30.6	30.6	2.44	1.48
Ordering / donations	36	11.1	8.3	11.1	25.0	44.4	2.83	1.38
Starage	37	8.1	8.1	5.4	24.3	54.1	3.08	1.29
Security	37	16.2	5.4	5.4	24.3	48.6	2.84	1.50
Transport	37	8.1	5.4	2.7	29.7	54.1	3.16	1.23
Electronic communication	37	18.9	10.8	8.1	18.9	43.2	2.57	1.59
Client record files	34	2.9	11.8	5.9	41.2	38.2	3.00	1.10

Only 69.4% of NPOs have a tracking system) in place that records organisational activities. 80.6% of NPOs stated that there is a system is in place for ordering/soliciting donations to ensure required stock. Storage of supplies with a register to monitor usage was shown to be in place by 83.8%. 78.4% stated that security was in place and 86.5% stated that the NPO does have accessible and available transport, including taxis, for home carers. Electronic communication were only available to 70.3% of NPOs and 85.3% of NPOs stated that client records are well maintained (up to date), easy to find (proper filing system), and that confidentiality is ensured.

Table 42: Mean NPO Supply systems and logistical operations (by province)

Province	N	M	SD
KZN	8	2.91	0.98
GT	5	2.86	0.76
EC	4	2.57	1.34
WC	7	2.71	0.53
LP	9	3.10	1.01
Total	33	2.87	0.89

NPOs in Limpopo seems to have the systems in place for logistics (M=3.10) with Eastern Cape (M=2.57) the lowest but still above average.

7.4.9 Recommendations

- NPOs in Limpopo need to be encouraged to form boards or stakeholder committees.
- Stakeholder consultations need to be encouraged
- Limpopo and KwaZulu-Natal need to increase their community involvement. This could be through participating in community Imbizo's, inviting stakeholders to input on the NPOs policy and plans and through liaisons with local councillors.
- Home carer-training programme should be made easily available to all NPOs
- NPOs need to be encouraged to develop training plan for all staff
- NPOs in Limpopo need to be encouraged to increase training of all their staff.
- NPOs need to be encouraged to draw up strategic plans
- Strategic plans need to be utilised during monitoring process.
- NPOs especially in Limpopo needs attention with regards to drawing up strategic plans, annual reports, and to do monitoring of work.

Chapter 8: Household Situation of Chronically Ill Persons Receiving Home-Based Care

8.1 Sample and procedure

One-hundred and nineteen carees (one refused), 59 in eThekwini district (Presidential note) in KwaZulu-Natal and 60 in Waterberg district (Mogalakwena sub-district) in Limpopo were interviewed on their household situation by a nurse researcher. In five cases the caree was a child, and in these cases the parent or guardian was interviewed.

The mean age of the respondents was 48.3 years (SD=15.1) [52.1 years (SD=15.2) in KwaZulu-Natal and 44.7 years (SD=14.2) in Limpopo Province], with on average 4.3 (SD=3.5) children living with the respondent [4.7 in KwaZulu-Natal and 3.9 in Limpopo], 3.5 of these were biological children (SD=10.4).

8.2 Results

8.2.1 Carer characteristics

Ninety-five (83%) of the carees indicated that they had someone in their household who had been very sick for more than three months in the last 12 months, 72% had someone in their household who had been bedridden for a period of three or more months, and 32% had someone in their household who had died after having been sick for more than 3 months. Most respondents indicated that their household had received free emotional care (89%), followed by free medical support (85%) and free social support (50%). Further, for a sick person in the house, help or care was received by 92% from a hospital or clinic, from relatives 50%, from friends 13%, from a religious organization 28 %, from a community organisation 57% and all had received help or care from an NPO (see Table 43).

Table 43: Care characteristics by province in this sample in affirmative responses

	KwaZulu-Natal		**Limpopo**		**Total**	
	n	%	n	%	n	%
Has anyone in your household, including yourself, been very sick for more than three months?	49	83.1	46	82.1	95	82.6
Has anyone in your household, including yourself, been bedridden for a period of three or more months	43	82.7	30	61.2	72	72.3
Has anyone in your household, died after being sick for more than three months?	20	38.5	13	25.5	33	32.0
Did your household receive any of the following because of the sick person/people…						
…Free medical support once/month during the illness	41	78.8	43	91.5	84	84.8
…Free emotional support in the last 30 days	46	88.5	42	89.4	88	88.9
…Free material support in the last 30 days	31	60.8	29	63.0	60	61.9
…Free social support in the last 30 days	19	36.5	30	63.8	49	49.5
For the sick person/people, did your						

household receive help or care from any of the following…						
HOSP./CLINIC STAFF	45	90.0	44	93.6	89	91.8
RELATIVE(S)	28	54.9	19	43.2	47	49.5
FRIEND(S)	16	34.8	4	9.8	20	23.0
RELIGIOUS ORGANISATION	19	41.3	6	14.0	25	28.1
COMMUNITY GROUP/ORGANISATION	49	98.0	0		49	57.0
NPO	59	100	60	100	119	100

8.2.2 Care characteristics of orphans

One in three households (33%) had at least one orphan. In less than one in five (18%) of the orphans a parent or parents had left behind property. More than half had received free medical care in the past 12 months, one-third free emotional and social support, one in five had received free material and school-related assistance (see Table 44).

Table 44: Orphans from carer household survey by province in affirmative responses

	KwaZulu-Natal	Limpopo	Total
	n	n	n
	20	17	37
Children under the age of 18 years in household whose father, mother or both parents had died	35.1%	29.8%	32.5%
Number of orphans per household 1 2 3+	 12 5 4	 6 6 4	 18 11 8
Parent(s) left behind property for orphans	2	5	7
Did your household receive any of the following because of an orphan in your household…			
…Free medical support within the last 12 months	14	7	21
…Free emotional support in the last 3 months	5	10	15
…Free material support in the last 3 months	5	2	7
…Free social support in the last 3 months	6	7	13
…Free school-related assistance within the last 12 months	2	5	7

8.2.3 Recommendation

Psychosocial services for orphans should be increased.

Chapter 9: Home-Based Care Assessment

9.1 Aim and objectives

The aim of this section of the study was to conduct a quality assessment of home-based care provided by Non-Profit Organisations (NPOs), which were earmarked for funding by the European Union (EU), through an evaluation of observed care provision to chronically ill patients. The objectives of this part of the study have been summarised as follows:

- To conduct a baseline study to assess the ability and capacity of NPOs to provide quality home-based care to chronically ill patients;
- To assess and rate relationships between carers, patients and health professionals, with regards to patient conditions; and
- To rate nursing care skills of carers assigned to home-based care Programmes.

9.2 Sample and procedure

The evaluations were conducted in KwaZulu-Natal (KZN) and Limpopo (LP) provinces by a professional nurse. One district was chosen in each Province namely, Waterberg (rural), in Limpopo, and Ethekwini (urban), in KwaZulu-Natal. Four NPOs were chosen in KZN while three were chosen in LP. Selection of the NPOs was based primarily on whether the NPO provides home-based care. NPOs in close proximity to each other were selected in order to manage traveling costs. A sample of 60 patients was chosen in each district (i.e. 15 per NPO in KZN and 20 per NPO in LP). Only chronically ill patients cared for by the chosen NPOs were included in the study.

The selcted NPOs were first characterised through a structured questionnaire administered by a researcher in consultation with NPO managers and employees during January 2006 to April 2006 (described in section 4.7). The questionnaire was interview-administered mainly at the offices of the NPO. Within the NPO, the interview took place in a private setting. This private setting included the office if one was available. In almost all cases the interview was administered to the NPO coordinator and in some cases, it was the NPO director/program manager. It is important to note that during the interview process, the interviewee invited other NPO members, including finance administrators, home based carers, and supervisors to the interview session. Answering the questionnaire therefore became a collective effort. For this section of the study the NPO characteriststics are given in the context of staffing, training and community involvement.

All patients were selected from the list of patients to be visited by a carer on a particular day. A professional nurse then accompanied the carers to the households to do the observations. The nurse had been trained on the study tool and the data collection procedures before visiting the patients. At the patient's home the carer introduced the nurse, explaining the purpose of the visit and why the observation was done. Patients who agreed to participate in the study were then asked to sign a consent form. The nurse noted, during the observation, the need to excuse herself when the situation warranted it, the need to ask both the carer and the patient certain questions that couldn't be completed through mere observation, and the need to have the carer excuse herself from the observation as some patients were more comfortable in sharing information in the absence of the carer. The observation of care was conducted in a private environment. The research nurse wore professional attire and had a name tag on in order to maintain the patient's confidence in them. The approach of the observation was, therefore, supportive and motivational throughout. It is important to note that in cases where the patient was a minor (<18 years) consent was sought from the parent and/or the patient.

9.3 Measure

The tool used was a structured observation guide developed by Buch et al. (2004), which contained 12 content areas. The tool is designed to specifically assess and evaluate home-based care given to AIDS patients. Care evaluation is based on the patient' demographics or background information (with 7 items), patient's environment (with 7 items), patient's basic needs (with 6 items), patient's hygiene and prevention of infection (with 13 items), patient's physical, spiritual, and psychological care (with 7 items), planning and implementation of care (with 13 items), medical treatment (with 6 items), the patient's family (with 4 items), problems of health worker/patient and family (with 7 items), evaluation of care (with 6 items), ethical code for home carer behaviour (with 1 item), and patient direct interview (with 3 items). Each content area was assessed and the tool concluded with the nurse's remarks and rating of care provided by the carer to the particular patient. Responses ranged from a simple 'Yes or No', direct responses, choosing from given options (multiple responses), to ratings on a 1=Excellent, 2=Good, 3=Fair, to 4=Poor scale. Each section on the questionnaire concluded with the evaluator's comments/notes about the area assessed. Some questions in the tool were asked to the carer and some to the patient, either in retrospect or on the current situation.

The tool used for the characterisation of the selected NPOs is described under in section 4.7 (assessment of NPO access, capacity and quality).

9.4 Data analysis

Descriptive statistics were calculated using SPSS version 14.0. Data on patients' age was categorized in ranges with the last age range reflecting those patients who were 70 years and above. Patient occupation was categorised as employed, unemployed and pensioner. The category of unemployed patients reflected those who were probably unemployed due to their illnesses or any other factor, except for ageing, while 'Pensioner' was a category of unemployed patients who were over the pension age (60 for women and 65 for men). Data on patient education was categorised as no education, primary school education and high school education.

9.5 Results

9.5.1 Response rate

All visited patients [n=120 (60=KZN, 60=LP)] and NPOs (7) agreed to participate in the study. Each observation lasted between 60 and 90 minutes and between 4 and 6 observations could be done per day. In each district the observations to complete the study lasted for 3 weeks.

9.5.2 NPO characteristics

Staffing

For most NPOs, the categories of staff were 1) support personnel, normally including the chairperson, the project Manager or Coordinator, the financial officer, and the secretary and 2) the carer. It was found that in some NPOs some of the support staff also worked as carers. All carers reported to the project manager or coordinator.

Community involvement

Table 45 shows data on visitations by different categories of persons visiting NPOs on different time basis.

Table 45: Frequency of visits by personnel to NPOs

Personnel	Daily		Three times a week		Once a week		Less than once a week	
	KZN	LP	KZN	LP	KZN	LP	KZN	LP
Professional nurses								3
Enrolled nurse								1
Trained HBC worker	3	7	36	42	10	9	2	0
Volunteers			1	1	3	1		
Family	50	47	0	2			1	7
Religious/spiritual leader	3	1	1	0	14	0	3	3

It appeared that family members visited the NPOs more frequently on a daily basis (50=ZN, 47=LP), followed trained HBC workers three times a week (36=KZN, 42=LP). It was interesting to note that the least number of visitations were from professional nurses.

Training

Out of the 7 NPOs, 5 of them (4 in KZN, and 1 LP) had conducted internal training and sent some of their staff members to an external training course. For the 1 NPO in LP, in-house training was limited to patient counseling but there was no information on the contents of the external training attended by the NPO employees. In general, only a few NPO employees would be able to benefit directly from a training course because NPOs are only allowed to send up to a maximum of 3 attendees to training courses or workshops. In-house training sessions received by the NPOs in KZN concentrated on the following topics: basic patient counseling, cancer, parenting, home-based care, stress management, HIV awareness.

Only 1 NPO in KZN mentioned that some of their employees had attended a SETA-accredited course and only 5 of their salaried employees and 5 volunteers benefited from the course.

9.5.3 Care evaluation

Patient demographics and characteristics

Table 46 summarises patient demographics and characteristics in terms of gender, condition and mobility and age distribution.

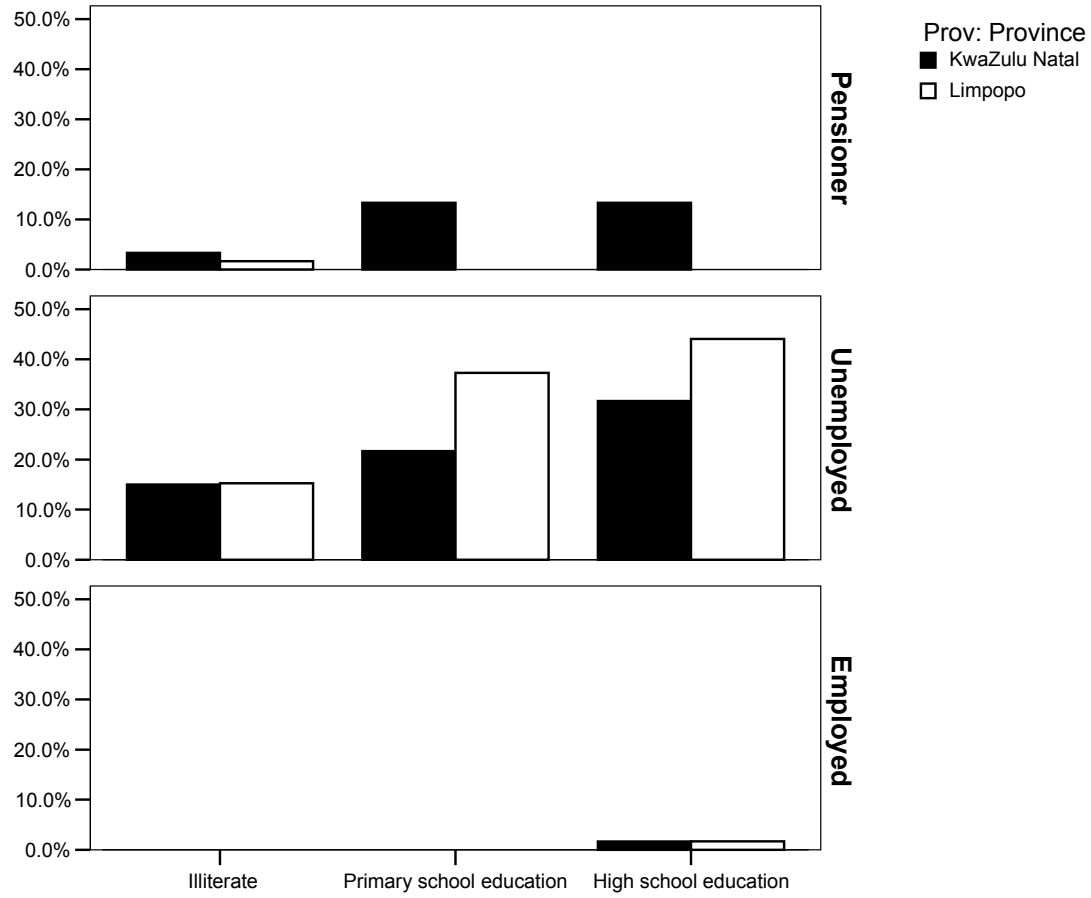
Table 46: Patient demographics

	Patient characteristics			
	KwaZulu-Natal		Limpopo	
	n	%	n	%
	Gender			
Male	17	28.3	22	36.7
Female	43	71.7	38	63.3
	Patient's condition and mobility			
Critically ill	0	0.0	1	1.7
Very ill	11	25.0	2	3.3
Ill	24	54.5	45	75.0
Not so well	9	20.5	15	20.0
Age distribution				
<=5	7	**1.7**	**0**	**0.0**
6-24	11	**18.3**	**4**	**6.7**
25-49	25	**41.7**	**39**	**65.0**
50-70	17	**28.3**	**13**	**21.7**
71+	6	**10.0**	**4**	**6.7**

Most of the patients who participated in the study were females. Only a few patients were seen to be critically or very. Most patients were reported to be 'ill' or just 'not so well' indicating that most could feed themselves and were mobile. a few patients (17 in KZN and 19 in LP) had declared their illness status to their family.

In terms of age distribution, the overall minimum and maximum ages recorded were 2 and 92 years, respectively. The median age was found to be 41 years. For both Provinces, most patients were in the age range of 25-49, with 65.0% reported for LP and 41.7% for KZN. A least percentage of the in LP were in the age ranges of 6-24 and 50-70 with a 6.7% reported in both categories. For KZN, the least percentage of 1.7 was reported for patients in the age category of <=5 years. Patient education levels within specified employment status are shown by Figure 26.

Figure 27: Patient education level in a specified employment status



Only 2 participants (1 in each province) in the study were employed. The majority of the participants fell into the unemployed category. Most of these, however, had a high school education (grade 8 to 12). Looking at the figure above, it seems that the numbers increased from illiterate (had no formal education) to high school education within the unemployed category. There were 18 pensioners in KZN compared to only 1 LP who participated in the study.

Patients' basic needs

Table 47 shows the durations (in categories) for which patients have been on HBC programme, per Province

Table 47: Patient duration (in months) on HBC program per Province

Province	How long (in months) has the patient been on the home-based care program										Total	
	<6		6-12		12-24		24-36		36+			
	n	%	n	%	n	%	n	%	n	%	n	%
KwaZulu-Natal	35	60.3	7	12.1	6	10.3	7	12.1	3	5.2	58	100%
Limpopo	15	25.0	13	21.7	9	15.0	13	21.7	10	16.7	60	100.0

Most patients have been on HBC programme for a period of less than 6 months (KZN=60.3%, LP=25.0%). In LP, the least number of patients were those who had been on have been on HBC programme for a period of between 12 to 24 months (n=9, 15.0%). In KZN, the least number of patients were those who had been on the HBC programme for a period equal to 36 months and more (n=3, 5.2%). Table 4 presents findings on some of the common basic needs of chronically ill patients.

Table 48: Comparison of patients' basic needs

Patient's basic needs (in affirmative responses)	KZN		LP	
	n	%	n	%
Does the patient need to be fed or assisted during a meal?	11	73.3	4	26.7
Are relevant accessories within the patient's reach?	21	35.0	16	26.7
Is there drinking water within reach at patient's bedside?	21	61.8	13	38.2
Does the patient get assistance when s/he visits the toilet?	19	76.0	6	24.0
Does patient have access to antiretroviral drugs?	10	29.4	24	70.6
Does the patient have painkillers? (if applicable)	16	42.1	22	57.9
Are relevant accessories within patient's reach?	21	56.8	16	43.2

In KZN, 38.5% of patients received symptomatic treatment compared to 61.5% in LP, during the observations. Just over 70% of patients in LP had access to antiretroviral drugs compared to 29% in KZN. In general, fewer of these patients were aware of antiretroviral side effects. In LP only 4 patients (26.7%) have to be assisted during a meal, compared to 11 (73.3%) in KZN. This is in agreement with findings that only a few patients were critically or very ill in both Provinces Most patients were reported to be 'ill' or just 'not so well' indicating that most could feed themselves and were mobile.

Patients' nutritional supply

In terms of nutritional supply analysis, it is important to note that patients from the 2 provinces had different meal compositions. For most patients in KZN, breakfast consisted of foods such as *philani porridge* and *phuthu* with milk or curry. Breakfast for most patients in LP included *bread, porridge and tea*. Fewer patients had *PVM porridge either with tea or milk* for breakfast compared to KZN. It was interesting to note that most patients in LP preferred the same meal for lunch, composed mainly of *Porridge (Pap) or rice or macaroni and vegetables (morogo)*. This differs significantly with findings from KZN, where patients preferred a variety of meals for lunch. Although most of the patients there preferred *porridge (Pap) or rice or macaroni and vegetables* for lunch, other patients preferred to add protein (egg/meat/fish/chicken), to their meal while others preferred *phuthu or rice with curry*. For a

few patients, lunch varied from *bread and tea* to *bread or porridge with fruits*. Most patients in LP had the same meal for dinner as they had for lunch. In KZN, most patients had varying meals for breakfast,lunch and dinner. Most patients there enjoyed 'other' types of meal composed *bryani, rice and curry, phuthu with sour milk or chicken curry or potatoes mixed with vegetables.*

The patient's environment

Table 49 shows information on the assessment of the patients' environment during the observations. Patient's environment was assessed on neatness, cleanliness, comfort, and layout.

Table 49: Assessment of patient's environment

Patient's environment (in affirmative responses)	**KZN % (n)**		**LP % (n)**	
	n	**%**	**n**	**%**
Is the patient's environment clean?	59	49.6	50	46.7
Is the patient addressed by hi/her name?	57	53.3	50	50.4
Is patient's bedroom well ventilated?	55	53.4	48	46.6
Is there any evidence of medico legal hazards?	1	14.3	6	85.7

According to the nurses' assessment it seems that most patients had a clean and neat environment, with 49.6% reported for KZN and 46.7% reported for KZN. In addition, most of these patients had well ventilated rooms. There was some evidence of medico-legal hazards for only 1 patient in KZN and 6 in LP. Some of the evidence in KZN included bad roads and no toilets around the patient's environment. In LP, however, the nurse reported the use of smoking stoves for cooking for most patients, which can be very detrimental, especially in patients with diseases like TB and asthma. Overall, the patients' environment was rated as bad (5.0%), moderate (51.7%), good (36.7%) and excellent (6.7%) in KZN, compared to bad (16.7%), moderate (46.7%), good (28.3%) and excellent (8.3%) in LP.

Patient's hygiene and prevention of infection

Table 50 shows analysis of information regarding the patient's environment with regards to measures to maintain hygiene and prevent infection.

Table 50: Patient's hygiene and prevention of infection

Hygiene and prevention of infection (in affirmative responses)	KZN % (n)		LP % (n)	
	n	%	N	%
Is the patient's bed kept neat and dry?	58	52.7	52	47.3
Does patient receive a full bed bath daily?	54	84.4	10	15.6
Is mouth and oral care given after every meal?	18	48.6	19	51.4
Is exercise and movement in bed encouraged?	17	73.9	6	26.1
If bedridden, is care to back and pressure parts given?	3	75.0	1	25.0
Is patient assisted in and out of bed if necessary?	18	75.0	6	25.0
Does the carer have protective clothing?	33	50.8	32	49.2
Is soap and antiseptic always available?	10	14.9	57	85.1
Is there a procedure manual to guide terminal care of patient?	0	0.0	27	100.0

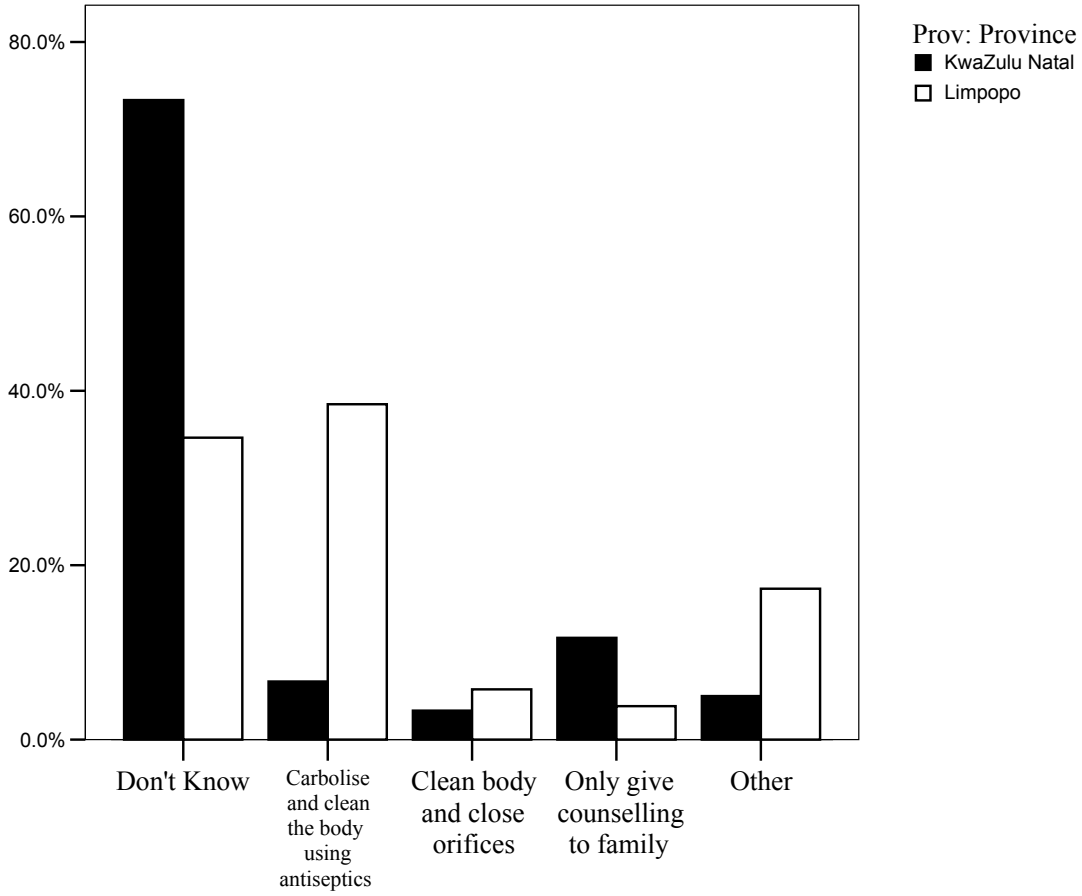
Assessment of the patient's hygiene involved observation of the environment around the patient and this included observation of the patient's bedroom, whether the patient takes regular baths using appropriate antiseptics, or soap, and whether mouth and oral care was given after the patient has had a meal. Most patients had their beds kept neat and dry. The study found that 52.7% of patients in KZN had neat and dry beds compared to 47.3% in LP. A common reason given for patients whose beds were not neat and dry was that the patient stays alone and was too sick to wash clean their bed. However, most patients (84.4%) in KZN were reported to receive a full bed bath daily compared to only 15.6% in LP. For most patients a common reason was that they did not require bed bath as they were mobile. For bedridden patients, bed movements and exercises are necessary, but only a few patients were bedridden.

During this assessment, carers were also asked how they would dispose of patient's secretions and dressings. The responses varied from wrapping secretions and dressings in a plastic bag and then throwing into a rubbish bin or toilet, wrapping them in a tissue and throwing them in a rubbish bin and throwing the waste into a river. Most of the explanations given were rated as adequate by the nurse. In most cases, carers did not wear protective clothing when providing care to the patient. In KZN, in only 50.8% of cases observed did the carers wear protective clothing compared to 49.2% in LP. Most of the carers in KZN wore rubber gloves only, while a few carried an apron and antiseptic soap. Description of protective clothing worn by carers in LP was not given.

Most carers did not know what hygienic procedures to follow when a patient dies. Explanations and procedures given by carers are summarised in the bar graph below (Figure

27). Most carers (72.9%) in KZN did not know what procedures to follow after a patient dies compared to 34.6% in LP. Most carers in LP said they would carbolise and clean the body after using antiseptics. Other carers would rather just give counselling (bereavement support) to the family as a way of helping deal with the death of the patient but not go to the extent of touching the body.

Figure 28: Hygienic procedures indicated by carers when dealing with a dead body



Physical, spiritual, and psychological care

Table 51 shows analysis of patients' physical, spiritual and psychological care. The patient should be seen in totality as a physical, spiritual and a psychosocial being, when nursing care is planned.

Table 51: Patient's physical, spiritual, and psychological care assessment (in affirmative responses)

Patient's physical, spiritual and physiological care	KZN % (n)		LP % (n)	
	n	%	n	%
Was a complete physical assessment done on admission of the patient by the NPO?(asked to the carer)	10	31.3	22	68.8
Is patient's dignity and self-esteem recognised? (restrospective report analysis and observation)	27	33.8	53	66.3
Is patient's privacy maintained whenever necessary? (retrospective report analysis and observation)	50	46.7	57	53.3
Is patient informed of every procedure carried out on her/himself? (observation)	47	46.5	54	53.5
Is the patient's privacy protected during relevant nursing procedures?	50	46.7	57	53.3

For a few patients in KZN (31.3%), a complete physical assessment was done on admission to the HBC Programme by the NPOs compared to 68.8% in LP. In general, most patients were informed of the procedures carried out on them during care. In cases where explanations for procedures were not given, the Nurses found that most patients have been with the carer for a long time and needed no explanation on what is going to happen as they either trusted the carer or the activity was just routine work. Some patients mentioned that what carers do is just sit and observe as they take their medications and that there are no invasive or sensitive procedures involved during care.

Planning and implementation of nursing care

Table 52 shows information analysis after assessment of nursing care planning and implementation. The nursing care plan is according to identified needs and symptoms, and in accordance with medical treatment.

Table 52: Assessment of planning and implementation of nursing care

Nursing care implementation (in affirmative responses)	KZN %(n)		LP % (n)	
	n	%	N	%
Is there a nursing care plan set up? (asked to the carer)	2	11.8	15	88.2
Are the patient's health records adequately kept? (asked carer and records assessed)	58	49.6	59	50.4
Do records reflect the changing condition of the patient? (records assessed)	39	41.1	56	58.9
Are all patient interventions reflected in the report? (records assessed)	38	40.9	55	59.1
Are interventions discussed or explained to the patient in advance? (asked carer and patient)	53	48.2	57	51.8
Does the professional Nurse discuss progress of the disease with patient? (asked carer and patient)	0	0.0	18	100.0
Is confidentiality of client records maintained? (asked carer and based on observation)	57	50.0	57	50.0
Does carer consult with a senior professional nurse before any referrals are done?	0	0.0	54	100.0
Are records of all referrals kept by the carer?	57	49.1	59	50.9
Are family/partner kept up to date about the patient's progress/regression?	49	49.0	51	51.0

In both Provinces, most carers did not have nursing care plans for their patients. Nursing care plans existed in only 11.8% of the cases observed in KZN compared to 88.2% in LP. Overall, the nursing care plans were discussed in most cases with the patients (40.8%), followed by the patient's family (18.3%) and with a professional nurse in the least number of cases (3.3%). Assessment of patient records by the nurse showed that patient record keeping was adequate at 98.3% in KZN and 100.0% in LP. Of the observed records, 66.1% in KZN reflected the patient's changing condition compared to 94.9% In LP. Patient interventions were reflected in 64.4% of assessed patient records in KZN compared to 94.8% in LP. In 88.3% of the cases in KZN, interventions were explained to the patient in advance compared to 95.0% in LP. Only in few cases were interventions not discussed at all or discussed with the patient's family.

There were indications that the carer relied on the patient's family to explain procedures and interventions to be carried out. There seems to be a non-existent carer consultation with a professional Nurse in KZN compared to fewer cases in LP (31.6%). Table says 100% In general, consultation by both the carer and the patient's family with a professional nurse to discuss the patient's condition was poor. Nonetheless, record keeping and confidentiality of patient records was adequate with all NPOs. This is because most NPOs kept patient records at their offices, where only the carer and the programme coordinator would have access to them. Families and relatives are not allowed unsupervised access to the patient's records without consent of the patient.

None of the NPOs/carers in KZN had a procedure manual for dealing with a terminally ill patient and only 100.0% (n=27) of carers in LP reported that they had a manual and all of them followed the manual. Most carers who did not have the manual mentioned that their

NPO did not have such a manual or were only providing care without having received any formal training thereon.

Medical treatment and other care issues

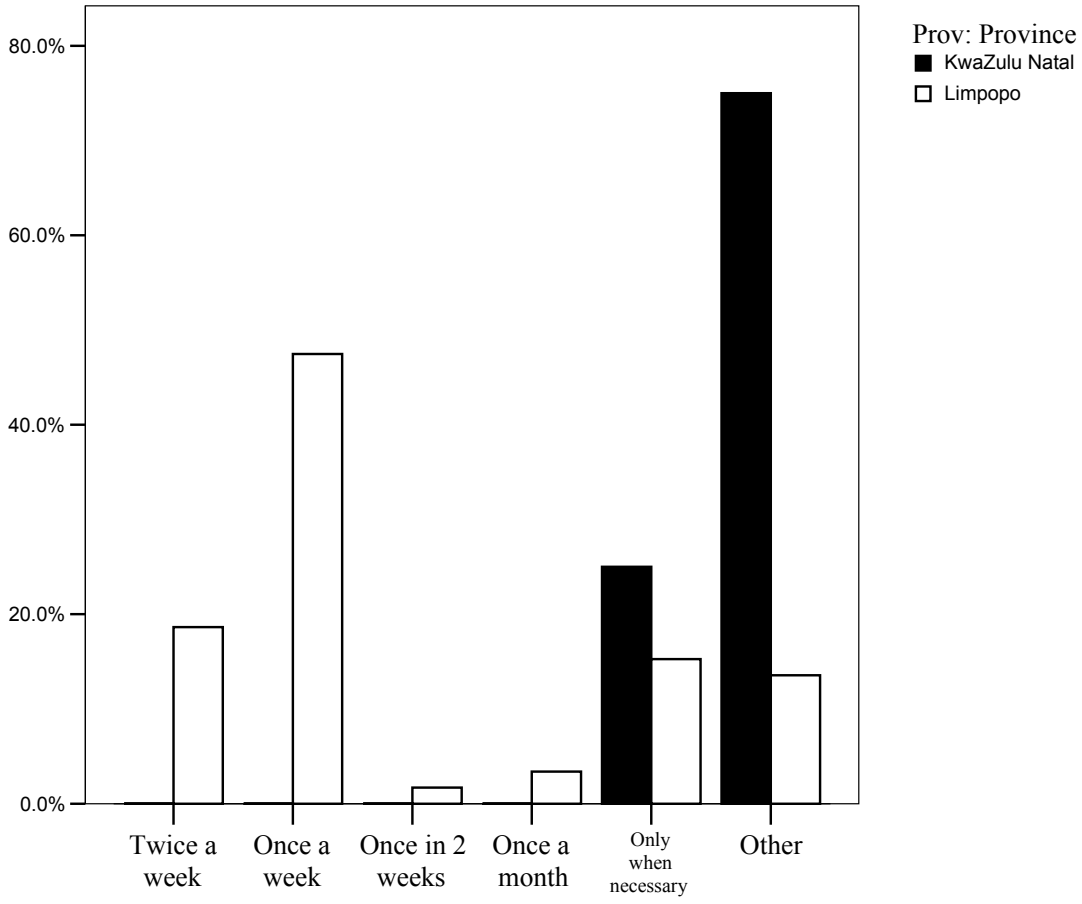
Findings on assessment of medical treatment and other care issues are presented by Table 53.

Table 53: Assessment of other nursing plans (in affirmative responses)

Is there trained family member/members who offer care in the absence of a carer?	**KZN**		**LP**	
	n	**%**	**n**	**%**
Yes	29	46.0	34	54.0
Not yet trained	19	63.3	11	36.7
No one available to be trained	11	52.4	10	46.7
Other	1	16.7	5	83.3
If family is available, is it supportive?	44	95.7	50	98.0
Does family have good relationship with carer?	40	44.0	51	56.0
Is patient medication taken correctly?	52	96.3	56	96.6
Is there a guide on how and when to take medication?	51	94.4	57	95.0

In most cases, administration of medication was done correctly. In 94.4% of all observed cases in KZN and 95.0% in LP carers had guides on how and when to take medication. In both provinces, about half of the observed patients' family members had been trained to care for the patients in the absence of the carer. The study found that carer–professional nurse consultations with regard to the patients' clinical care issues were poor in KZN as opposed to LP (Figure 28).

Figure 29: Frequency of carer-professional Nurse Meetings



Problems of carer/patient and family

In assessing problems and difficulties faced by the carer in providing quality care, the study found a number of problems and difficulties reported in both provinces. These problems were reported by both the patient and carer and are summarised as below.

Problems and difficulties ***faced by carer:***

- Refusal of care by a health care institution (hospital/clinic/health care centre)
- Poverty, unemployment and lack of care social services, e.g. social grants
- Patient refusing care from the carer
- Lack of care materials
- Carer using own resources to care for patient

Problems and difficulties ***faced by the patient:***

- Poor health care services at a health care institution
- Poverty, unemployment and lack of access to social services, e.g. social grants
- No family members

- Very sick
- Lack of transport to a clinic or hospital
- Fear of revealing their status and/or stigma
- Lack of care materials

Problems and difficulties ***faced by family/friend/partner:***

- Patient does not comply with medical treatment
- Poverty, unemployment and lack of access to social services
- Fear of stigma
- Patient being very sick
- Other family members being ill and not being able to care for the patient
- Partner complaining of lack of intimacy as a result of the patient's condition

Table 54: Patient ratings of care and support from HBC, carer, family members/neighbours/friends

How would you rate your initial contact with this Home Based Care Centre?								
	Excellent		Good		Fair		Poor	
	n	%	n	%	n	%	n	%
Kwazulu-Natal	1	1.7	32	53.3	24	40.0	3	5.0
Limpopo	9	15.0	44	73.3	7	11.7	0	0.0
How would you rate the nursing care given by home carer?								
Kwazulu-Natal	2	3.5	26	45.6	26	45.6	3	5.3
Limpopo	7	11.7	43	71.7	10	16.7	0	0.0
How would you rate the care given by family members/ neighbours/ friends?								
Kwazulu-Natal	6	10.3	41	70.7	10	17.2	1	1.7
Limpopo	7	13.0	30	55.6	15	27.8	2	3.7

Patient ratings of the relationships in terms of care and support from HBC center, carers, family members/neighbours/friends are summarised by Table 10. In general, patients rated most of their relstionships with home based care centers, family members, family members, neighbours and friends as good. A few patients rated care given by the mentioned groups as poor.

When asked about what could be done to improve the quality of care to the patients, a number of issues were raised by the carers and have been summarised below:

- Continued home-based care
- Love, affection and no discrimination towards the patients
- Hospices must be built in the community to take care of the terminally ill
- Encourage patients to disclose their status
- Preventative and curative health education must be given to patients and their families
- Good nutrition
- Counselling must be provided to the families of sick patients to help them cope with the stress of dealing with the patient
- Incentives to carers
- Continuous supply of care materials including food parcels and medication
- Job creation for disabled patients
- Emotional and social support
- Encourage patients to attend support group meetings

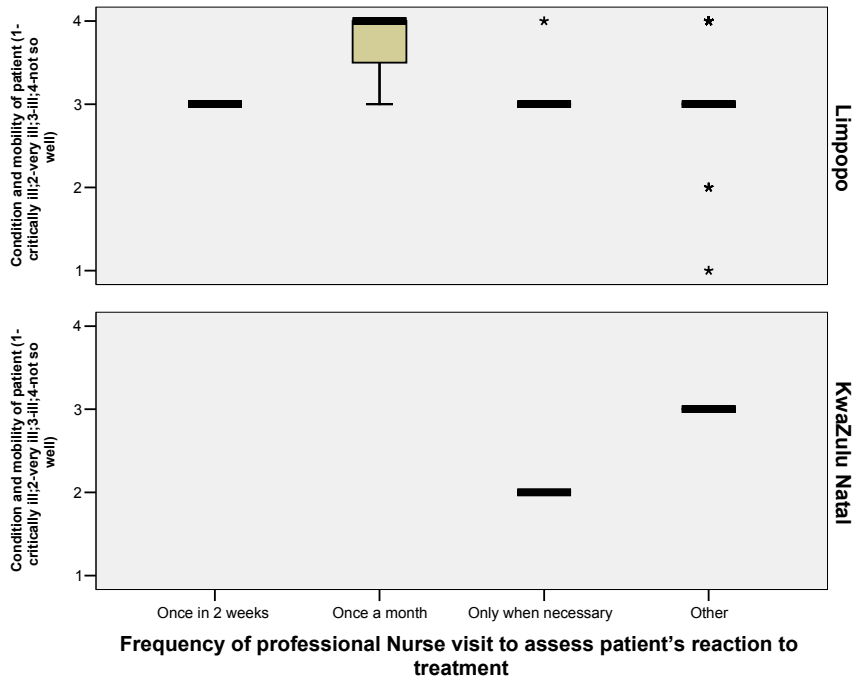
In the opinion of the family/friend/partner the following can help improve the quality of care to patients:

- Social behaviour change by the patient
- Hospices must be built in the community to take care of the terminally ill
- Continuous supply of care materials including food parcels and medication
- Good nutrition
- Teach patients on importance of taking medication regularly
- Love, affection and no discrimination towards the patient
- Regular visits by a health professional

Evaluation of care

Quality of care was evaluated based on interaction of the carer with a health professional, modification of nursing care plans, and the frequency of visits made by a health professional to the patient's home to assess progress/regression of the patient's condition, as well as to assess patient's reaction to treatment (see Figure 29).

Figure 30: Frequency of professional Nurse home visits to chronically ill patients



The study found that NPO/carer interaction with a professional nurse was minimal in KZN compared to LP. Further, there were no indications of discussions about nursing care plans for the patients in KZN. In LP, however, 27.5% of cases (N=55) with nursing care plans had their plans modified to accommodate patient's needs. A parallel assessment of NPO background information conducted by interviewing NPO managers and employees in both Provinces revealed minimal NPO attachment to services of a Professional Nurse. Only 2 of the assessed NPOs in KZN had some contact with at least 1 Professional Nurse. In LP, however, NPO background information assessment revealed that only 1 NPO enjoyed services of Doctor while the other 2 NPOs were based at a clinic although there was no indication of attachment to a health professional. It can be assumed that frequency of professional nurse visits to assess patient's reaction to treatment could be determined by many factors including the condition and mobility of the patient among others as shown by Figure 6. Only a few (n=4) of the assessed patients were visited by a senior professional nurse in KZN. The frequencies of the visits were only "when necessary" (25%) and other (75%). In LP, 55 of the assessed patients were being visited by a senior health professional nurse with visit frequencies including once in 2 weeks (1.8%), once a month (5.5%), only when necessary (25.5%) and other (67.3%).

Questions directed to the Patient

Questions directed to the patient were asked in the absence of the carer and family members and were aimed at assessing the patient's rating of his/her initial contact with HBC centre, the nursing care provided by the carers, the relationship between the carer and the patient's family and, lastly, the relationship between the family and the patient. In KZN, most patients rated initial contact with their HBC centre as good (40.7%), followed by fair (40.7%), poor (5.1%) and excellent (1.7%). In LP most patients also rated their initial contact with the HBC centre as good (73.3%), excellent (15.0%), and fair (11.7%). No one in LP rated their relationship with the HBC centre as poor. A common reason given for poor ratings in KZN

was that NPOs didn't provide health care education. The patients also rated the nursing care provided by their carers. Most patients in KZN rated the care as fair (46.4%), good (44.6%), 5.4% (poor) and excellent (3.6%). Again in LP no one rated the care as poor, but most patients rated it as good (71.7%), followed by fair (16.7%) and excellent (11.7%).

9.6 Limitations

Observations to assess quality are always guilty of bias. In assessing quality of care, one of the difficulties is to differentiate between what carers can do when you are observing them and what they actually do in the home when you are not there. The challenges in the study were mainly from the methodology prescribed and the tool itself. The tool used was designed to assess care given specifically to PLWHA. In this study, however, assessment of care was not limited to PLWHA but included all chronically and/or critically ill patients who suffered other illnesses, including diabetes, tuberculosis, mental illness, etc. As a result, certain questions were not applicable in non-HIV/AIDS cases. Care rating and evaluation might also be influenced by the assessor's own view and therefore the use of different assessors will eventually generate ratings based on different views, criteria and knowledge of care.

9.7 Discussion and recommendations

An evaluation of home-based care programmes provided by NPOs earmarked for funding by the EU was conducted in Ethekwini (urban), KwaZulu-Natal and Waterberg district (rural) in Limpopo Province. In terms of the programmes and nursing care, these were poor in both Provinces due to minimal contacts between professional nurses and carers. This might be attributable to reported minimal home visits by a professional nurse to assess progress/regression of the patients' conditions and their reactions to treatment. Respect for patient's privacy was satisfactory. This is important to uplift patient confidence in carers and for the self-esteem of patients. Most patients rated their relationship with their carers and families as good. There was, however, an observed need to help improve nursing care by carers and this could be done by first addressing a number of social problems faced by the patients, their families and the carers as a result of the patient's condition and by providing necessary training to carers. A few patients reported having access to ARVs, although few of that group were aware of ARVs' side effects.

In assessing the basic needs of the patients, the study found that a few patients needed to be fed or assisted during meals, had drinking water by their bedside and had assistance when visiting the toilet. There was a significant difference in meal preferences between patients in both Provinces. It was, however, noted that some patients had the same meal for lunch as they had for breakfast. However, most patients had the same meal for dinner as they had for lunch. Poverty and poor mental health were blamed for poor diet in some cases. Patients who stayed alone and had difficulty walking, could not cook often and therefore preferred to have to cook once and have the same meal throughout the day.

Some households were small and patients used smoking stoves for cooking and this affected the progress of their conditions. In such cases patients used one room to sleep, cook and eat. For patients who stayed alone and were too ill to walk, it was difficult to find most necessary accessories within their reach. The situation with these patients is that most of them had unclean households, with lots of unclean clothes and food lying around. According to the observations done by the nurses, most patients had their beds kept neat and dry. With regards to oral and mouth hygiene, however, this was a problem for most patients as only few a patients exercise oral and mouth hygiene after a meal. Hygienic procedures like wearing protective clothing for nursing care, availability of soap and antiseptics, availability of

hygienic procedure manuals and manuals to guide terminal care was poor in both Provinces. Most carers did not know what hygienic procedures were necessary after a patient dies.

Physical, spiritual and psychological care was adequate but with room for improvement. It appears that for most patients, privacy is recognized during nursing care and that most patients in LP were told of the care procedures to be carried on them beforehand. For most other cases this was, however, not applicable. There were some inadequacies observed with regards to patients' opinions on decision-making on a variety of issues. It was noted that for important issues such referrals and making of wills, patient's opinion was often not considered. Patients' opinions were given noticeably more attention when visitors arrived at home and when calling a priest. Failure to recognize a patient's opinion on important family matters can, in most cases, lead to the patient feeing alienated and stigmatized, thus reducing their self-esteem.

Other care issues, besides nursing care, focused on the family support base, the relationship between the carer and the patient's family, and relations (meetings/visits) between a health professional and the carer with regards to the patient's family. It is expected that the patient's family should be fully informed about the patient's progress and treatment, subject to the patient's consent. Meetings between carers and professional nurses regarding the patient's condition are poor in Limpopo and non-existent in KwaZulu-Natal. In general, relationships between the carers, their patients and family/partners or friends were rated as good by the nurse, the carer and the patients.

The study further assessed problems faced by the carer, the patient and the family/partner as a result of the patient's condition as well as relationships that existed between them. Problems by all concerned included amongst others refusal of care by patients, patients being rejected at health care institutions, lack of care materials such as medications, poverty and stigma. When asked to give opinions on what could be done to improve quality of care, most respondents indicated a need for continued supply of care materials, love and affection for the sickly, good nutrition, counselling to both family and patients, responsible social behaviour by patients, the need for hospices, and regular visits by health professionals. In the KwaZulu-Natal sites, carers go to the extent of using their own resources, including money, to help their patients. Some patients were reported to be staying alone while other patients did not have anyone in their families who is knowledgeable to care for them. It was also noted that the poor standard of care in some cases needed services of a professional nurse. In LP, some carers did not have contact with patient's family members, as they were never available. It is reported that some families are not interested in the progress/regression of the patient's condition while other patients stayed alone and others did not disclose their status to their families. Evaluation of patient care in general revealed poor interaction between carers, family members and health professionals. This influences quality of care.

Recommendations

- Government and various relevant stakeholders need to increase social support to those patients suffering as a result of poverty. Patients staying alone, critically ill and those that are bedridden must be given priority.
- Patients must be educated on the relationship between cleanliness and their health status and be trained how to keep their household environments clean.
- More training is required for carers to help them render nursing care in the most hygienic and protective manner possible. NPOs must be supplied with and be trained on manuals and guides for conducting various nursing care procedures. There is also a need to supply the NPOs with care kits to ensure less risk of infections from patients to carers in cases of highly contagious diseases.

- Carers need to be trained on patient confidentiality during care. Families must also be counselled to respect patient opinions on various important family issues in order to raise their self-esteem.
- NPOs need to be trained on development of alternative care plans and more training for family members is necessary to help when the carer is not available for any reason. Carer-professional Nurse Consultations must be strengthened.
- Government intervention is required to help address social problems that are already barriers to quality health care for the terminally ill home-based patients.
- NPOs should be encouraged to establish links with health care institutions for referrals of patients, to get advice on how best to care for the patients and to review nursing care plans.

Chapter 10: Support Groups

10.1. Introduction

10.1.1 Support groups for PLWHA and those affected

A support group has been defined as a structure or meeting wherein people with common challenges, concerns and needs come together to support one another in various aspects of daily living and functioning, such as emotional, spiritual, physical and psychological needs (DoH, 2003b).

Support groups provide an environment where people who share similar life stressors or affliction can share information, knowledge, ideas and experiences. Support groups operate on the basic premise that people need one another to survive in the world both physically and emotionally. Support groups are ideal for dealing with the effects of stigma, isolation, loneliness and other consequences of being HIV positive (DoH, 2003b). Support groups have a number of advantages, which include the following:

- Providing a sense of belonging
- Facilitating and enabling expressions and sharing of feelings
- Relieving stress
- Nurturing and building members by providing emotional support
- Providing mutual support
- Educating members on HIV/AIDS and related issues
- Preparing members to be comfortable with disclosure
- Educating members in terms of their human and legal rights
- Promoting Positive living.

Many support groups in South Africa especially those run informally make use of very little resources (Schneider, 2004). Schneider (2004) reports that the major challenges facing these community programmes as included:

- Initiating and managing programmes in a context of poverty
- Organisational structure, staff capacity and access to resources
- Ability to form linkages and partnerships
- Recruiting and providing incentives for volunteers
- Expectations regarding income generating activities
- Providing services in a climate of stigma and secrecy

(Russell & Schneider, 2000).

10.2. Description of NPOs and their Support Groups in this study

NPOs in the study were located in the townships of KwaMashu and Ntuzuma. These NPOs started as either a branch of a church; by a person who was affected by the loss of her children to AIDS; or by a retired professional nurse who wanted to give back to the community and alleviate some of the suffering caused by AIDS. As the NPOs grew, they recognised a need for social support in the form of a group. As such, the NPO initiated support groups.

Current support group members are made up of only PLWHA. Relatives or friends of PLWHA are therefore not included in the support group. The number of support group members per session range from 10 in one NPO to over 40 in each of the other two NPOs. The support groups meet once a month, usually a Tuesday or Thursday, at 10 a.m. and meet

for approximately 2-3 hours. The venue for the support group meeting is provided by the NPO and is usually held at the premises of the NPO. The study NPOs operated out of small two to three roomed offices and as such, the support group meetings usually took place outside, except in the case of one NPO that had the facilities to operate indoors as it only had 10 support group members.

As an incentive, NPOs provide cooked food to support group members after the group session. NPOs also provided food parcels to support group members but only if they had any. These food parcels were obtained from the DoH (HIV/AIDS unit) and comprised of enriched maize-meal and sugar beans.

In the study sample, three NPOs that rendered support group services to PLWHA together with HBC were targeted for inclusion into the study. All three NPOs staffing consisted of a governing body, a coordinator, administration staff and carers. The number of carers ranged from 13 to 22.

With regards to the training or skills of those that take responsibility for the support group sessions, this study found that one coordinator of the three NPOs had a SETA accredited course to train in support group facilitation. As such, all 13 of her carers received in-house training on counselling and support group facilitation. With regards to the other two NPOs, two people from one NPO received support group training and 19 people from the other NPO received counselling training. Besides the above mentioned; training in depression, stress management and counselling was also given to various members of all three NPOs.

10.3 Specific Objectives of the Study

- To determine what PLWHA want from support groups.
- To determine the quality of services provided by the support groups including their relevance to the needs of PLWHA.
- To determine the extent to which support groups form part of a continuum of care
- To determine how to improve support groups in line with what PLWHA need.

10.4 Methodology

10.4.1 Study Design

An exploratory qualitative study was conducted with the aim of exploring, describing and understanding the relationship between NPOs and their support group clients. The study wanted to explore what clients viewed as the ultimate support group in the hope of understanding client needs and thus improving service delivery.

10.4.2 Population

The study population comprised of three European Union (EU) funded NPOs providing support groups for PLWHA in Ethekweni district, KwaZulu-Natal Province. All NPO members attending support groups were included in the study population.

10.4.3 Sampling

Sampling of NPOs was done using stratified random sampling method. With stratified random sampling, the population is first divided into a number of parts or 'strata' according to some characteristic, chosen to be related to the major variables being studied. In this study, all EU funded NPOs in KwaZulu-Natal were stratified into the two districts the study was conducted in, namely Ethekweni and Zululand districts. Within Ethekweni district, the EU funded NPOs were further stratified into those who provided support group services (6) and

those who did not. Of the six NPOs that provided support group services, three NPOs were then randomly selected. Within each NPO, all support group members that wanted to participate in the focused group session were included in the sample. A total of 5 focus groups were completed. It is important to note that due to the nature of the virus (HIV/AIDS) some support group members were not available on the scheduled day of the focus group as they were sick.

In total, 34 support group members from the three selected NPOs participated in the focus group sessions. Of these, 79.4% were female and 20.6% were male.

10.4.4 Data collection method

Data were collected through the use of focus group interviews. The researcher chose focus group interviews because they: produce a wider range of information, ideas and insight than individual responses secured separately; allow for one participant's remark to trigger a chain reaction from other participants; bring about original ideas compared to individual interviews; give the participants an opportunity to actively participate in the study process and in improving their own lives and provide opportunities for members to become aware of, to expand and to change their thoughts, feelings and behaviour regarding self and others (Martins, Loubsor & Van Wyk, 1999; and Schurink, Schurink & Poggenpoel, 1998).

10.4.5 Focus group guiding questions

The study utilised the Centre for Health Policy's (2004) guide to conducting focus groups for support groups for chronically ill.

The four themes and corresponding guiding questions/issues included:

- Introduction and warm-up
    - Facilitator and note-taker introduce themselves, give a brief overview of what the project is about and briefly introduce the idea of qualitative research and focus groups including providing ground rules and basic expectations,
    - Information sheet handed out and informed consent obtained.
- The Ideal Support Group
    - "Imagine an ideal situation where there are no constraints on money, time, personnel or other resources – where you can do things in any way that you want to. If you were given the opportunity to implement a support group in this situation, how would you go about it or what would you do in this support group?
    - Probe about activities, services and needs that are very important in an 'ideal' support group.
    - Why are Support Groups Needed?
    - What do People want from a Support Group?
        - Activities participants require from a support group
- Actual experience with the Support Group,
    - How do people become members of this support group?
    - How would you describe the people who come to this support group? Who comes?
    - If you think back to the ideal support group we designed earlier, how does this compare with this group?
- Working Towards Solutions.
    - Facilitators worked through the list of problems that were mentioned in the previous section of the discussion, with an emphasis on solving them and taking action to bring participants' experiences more in line with the ideal developed in the first part of the discussion.

10.4.6 Conducting Focus Groups

Moderator selection and preparation: 2 moderators (a Senior Researcher and a Professional Nurse) were chosen as facilitators or moderators of focus group discussions. These moderators were chosen because they assessed, among others, communication skills such as listening, probing, reflecting, paraphrasing, attending, observing and responding which researchers maintain that they are necessary when conducting focus group interviews (Clark, Riley, Wilkie & Wood, 1998; De Vos & Fouché, 1998; Feldman, 1995; Lindlof, 1995 and Schurink *et al.* 1998). However, further training was provided to the moderators to ensure that they were well prepared to deal with anticipated problems such as the disruptive behaviour of an emergent leader among participants and also to help them to: develop a genuine interest in hearing other people's thoughts and feelings, become spontaneous, have a sense of humour, become empathic, be able to admit own biases, express thoughts clearly and be flexible.

Size of focus groups: The average number of participants in each group was 7. The group size was small enough for all the participants to have the opportunity to share insights, to identify themselves as members, to engage in face-to-face interaction and to exchange thoughts and feelings among themselves. It was also large enough to provide diversity of perceptions as recommended in literature (Schurink *et al.* 1998; Feldman, 1995; Smit, 1995; Leggett, 1997 & Folch-Lyon et al, 1981).

Procedure: Discussions were held in both English and isiZulu. During the Introduction and Warm-up, the facilitator and note-taker introduced themselves, gave a brief overview of what the project is about, briefly introduced the idea of qualitative research and focus groups, and provide ground rules and basic expectations. At this point, information sheets and consent forms were handed out.

The session began with the discussion of what 'The Ideal Support Group' should be in the eyes of the participants. The aim of this section was to obtain a picture of the participants' ideal support group in a situation where there are no constraints on time, money or other resources. This was done to understand the needs the participants would like to have met. Participants were told: "Imagine an ideal situation where there are no constraints on money, time, personnel or other resources – where you can do things in any way that you want to. If you were given the opportunity to implement a support group in this situation, how would you go about it or what would you do in this support group? Remember, you can do or have anything you want, anywhere you want and you can include anyone you want".

This formed the basis for further explorations of their actual experiences with the support group, as seen below. The ideas that the participants came up with were written down for later use.

Once all ideas were exhausted, the facilitator steered discussions around the 'Actual Experience with the current Support Group'. The aim of this section was to use the picture of the ideal support group built up above as the basis for a discussion of the participants' actual experiences with their support group by using the ideal characteristics as a point of reference and for the purpose of comparison. We wanted to find out what the participants think about the quality of the services offered and to what extent the support group meets their needs.

The session concluded with discussions around 'Working Towards Solutions'. The aim of this discussion was to bring the discussions about the ideal group and actual experiences full-circle by asking the participants to come up with suggestions for overcoming the problems that have already been mentioned. This is useful because it could help the NGOs to run better support groups.

10.4.7 Quantitative Component

At the conclusion of the focus group session, participants were reminded of the 10-minute self-administered questionnaire. The facilitator introduced the questionnaire and provided the necessary explanations with regard to purpose, the procedure for completing and handing in the questionnaire. Each question in the questionnaire was read out aloud in both English and isiZulu to all participants with relevant responses if necessary (pre-coded questions) by the facilitator and participants filled out responses. The note-taker assisted any participant that needed help.

The questionnaire consisted of three sections, with section one comprising of six questions, section two comprising of 10 questions, and section three comprising of 11 questions. Questions in section one included biographic questions, section two included HIV status knowledge of self, and behaviour of people around participant. The final section included questions on participant's general knowledge of HIV.

10.4.8 Data Analysis

All focus group sessions were tape-recorded. Tapes were then transcribed verbatim and translated from isiZulu into English by trained transcribers and translators. Utilising AtlasTi, a qualitative analysis tool, the major emerging issues across the major themes were drawn and analysed through thematic content analysis in an attempt to answer the key questions.

With regards to the quantitative questionnaire, trained data captures captured each questionnaire onto SPSS, a quantitative analysis tool. This data was then double checked to ensure quality of data capturing. Descriptive statistics were calculated using SPSS package (version 14.0).

10.4.9 Trustworthiness

Qualitative data analysis requires clear, explicit reporting of data so that the reader will be confident of, and can verify, reported conclusions. It requires keeping analytic strategies, coherent, manageable and repeatable as the study proceeds (Miles and Huberman (1994). The researcher adopted various strategies to ensure trustworthiness of the interpretation of the data espoused by Miles and Huberman (1994). These included:

- *Participant checking:* Periodic feedback sessions were held to present the results of the data collection to the participants to test whether they agree with them.
- *Data cross-checking:* this activity involved the researcher stepping back to consider what the analysed data mean and to assess their implications for the questions at hand. This helped the researcher to ensure that the data are credible, defensible, warranted, and able to withstand alternative explanations.
- *Moderator reviews:* the focus group moderators had regular meetings to cross-check the quality of each other's data sets.
- *Ongoing reflection on data:* the researcher began the analysis almost in tandem with data collection. This helped the researcher to identify tentative interpretations or emerging hypotheses during the fieldwork process. While some of the hypotheses were refined or overturned or rejected at the end of the study, they provided an important account of the unfolding analysis and the internal dialogue that accompanied the process.
- *Peer reviews:* the researcher brought two peers who were knowledgeable on qualitative analysis as well as the substantive issues involved in the study, into the analytic process. Approximately 20% of the data were given to these peers to rate the initial coding. These peers served as a cross-check, sounding board, and source of new ideas and cross-fertilization. An agreement of 96% was obtained.

10.4.10 Ethical Considerations

All participants in the study were provided with informed consent information sheets, which stated clearly the purpose of the research. These documents were read out to participants in English and isiZulu. Respondents were given an opportunity to decline participating before or at any point in the study. Anonymity and confidentiality was assured to all participants. The research team answered all participant questions.

To maintain confidentiality, participants are not identified by name or organisational affiliation in the report.

10.4.11 Study Limitations

- Only NPOs providing support groups and funded by the EU were included in this study.
- Participants (support group members) too sick on the day of the focus group were excluded from the sample.

10.5 Results and Discussions

Results will be presented in 2 sections. The first section, 'sample characteristics' gives the results of the support group member's self-administered questionnaire. This is followed by the qualitative results (section 2) showing what participants view, an ideal support group should be. As such, current quality of service will be discussed as well as future solutions.

10.5.1 Sample Characteristics

The mean age of respondents was 38.8 (SD=10.3), ranging from 20 years to 65 years old. With regards to sex of respondents, 79.4% of respondents were female as can be seen from Table 55 below.

Table 55: Demographic information of respondents

	n	%
Male	7	20.6
Female	27	79.4
Employed part time	1	2.9
Unemployed	33	97.1
Do you receive any grants from the government at present?	16 (yes)	47.1
Are you currently taking or have you ever taken anti-retroviral drugs?	9 (yes)	26.5

During the qualitative aspect of the study, the number of males versus females was discussed. Respondents stated that males did not want to get tested for HIV and even when they found out they were HIV positive, they did not want to be a part of a support group as can be seen from the quotes below. Due to this, participants were of the view that more education is required for males.

"They [Males] don't want to test and they don't want to attend the support group."[Male support group member]

"Males don't attend support groups, even if they know their status. They run away all over, they don't want to disclose their status. They don't want to go to a clinic or hospital." [Male support group member]

"I wanted to say that males need a lot of education because men don't want to visit clinics to get some information. We do have people who are HIV and go in to the community but now we want to try and go to different companies to teach them because some are infected and they don't live with their wives so they take that infection to their wives because they always resist going to testing. We were so lucky because we managed to join the support group." [Male support group member]

With regards to employment status, 97.1 % stated they were unemployed (see Table 56). It will be seen later in the results that due to this unemployment, participants wanted support groups to provide other activities besides counselling. Only 47.1% of participants currently receive a government grant. Although all participants were HIV positive, only 26.5% were taking antiretroviral drugs (see Table 56).

Most members (64.7%) joined the support group in 2006 as can be seen in Table 2.

Table 56: When did you join this support group?

Year	n	%
2000	1	2.9
2001	5	14.7
2005	6	17.6
2006	22	64.7
Total	34	100

With regards to stigma, only 55.9% of respondents stated that their family was supportive to very supportive (see table 57). 79.4% though stated that members of the support group were supportive to very supportive. None stated any negative comments about members of the support group. Respondents viewed the support members as more supportive then their families as seen in table 3. Interestingly, 29.4% of respondents choose not to answer the question regarding the supportive nature of their family members compared to 20.6% for the response of support group members.

Table 57: Supportive nature of family as compared to support group members

	Family		Support group members	
	n	%	n	%
Unsupportive	5	14.7	0	0
Supportive	8	23.5	4	11.8
Very supportive	11	32.4	23	67.6
Total	24	70.6	27	79.4
Missing	10	29.4	7	20.6
Total	34	100	34	100

67.6% and 64.7% of respondents heard of antiretroviral therapy and opportunistic infections respectively yet only 23.5% heard of adherence (see table 58).

Table 58: ARV, Adherence and OI knowledge

Have you heard of the following: Yes		
	n	%
Antiretroviral therapy	23	67.6
Adherence	8	23.5
Opportunistic infections	22	64.7

20.6% of respondents believed that there are drugs that can cure HIV. With regards to the remaining knowledge questions surrounding HIV, most participants had a good knowledge of the virus (see table 59). With understanding of TB and ARV treatment, majority of respondents knew the length of time the treatment should be taken.

Table 59: HIV and TB knowledge

	Correct response	n	%
There are drugs that can cure HIV	TRUE	7	20.6
In SA nevirapine is mostly used to prevent mother-to-child transmission of HIV	TRUE	26	76.5
The goverment is considering making ARV available to everybody who needs them	TRUE	28	82.4
Once you start anti-retroviral treatment you must continue for life	TRUE	26	76.5
If you start anti-retroviral treatment it is not a problem to stop the treatment for a while	TRUE	1	2.9
TB treatment is usually taken for how long	6 Months	29	85.3
ARV therapy is usually taken for how long	Life Long	26	76.5

The Ideal Support Group

Participant Definition of a Support Group

Participants were first asked to define what to them is a support group. All group members had a general understanding of support as can be seen from the two quotes from different support group members below:

> *"A support group is a number of people with the same status or with the same illness sharing their views, putting support to each other, comforting each other and doing counselling."*

> *"A support group is place where you get support when you have a problem; it's where you get any opinion about any problem, whether at home or anywhere."*

It is important to recognise that in the definition given by respondents, the respondent specifically made reference to *"people with the same status"*. As we will see below, respondents want their ideal support group to consist only of PLWHA.

10.5.2 Why are Support Groups Needed?

During focus group discussions with current support group members, it was realised that most members were experiencing high degree of stigma at home and needed a so-called 'safe space' to escape to and discuss issues with people experiencing similar problems. This qualitative finding is interesting as in the above-mentioned quantitative section, we find that table 3 shows that only 14.7% of respondents stated that family members were unsupportive.

It was also important for group members to be identified within a group of people with the same experiences. A sense of belonging was needed. This 'safe space', according to the participants is the NPO run support group as can be seen from the quotes below:

> *"It helps us because we come together, we share our problems like at home, I don't have food and people hate me because I'm HIV. So here we eat, we share ideas, we reduce the stress."*

> *"I agree we need help, we need people who can give us food, soap and other things, like I don't have any family, my parents died, I stay with my aunt, but now that I'm sick she discriminate against me. If I have to go to the bath, I don't have to use their soap. She tells the children do not to touch what I have used; I need to find my own things. I survive with the food that I get here from the support center, because I have my treatment here, so I need support."*

> *"Some people have problems, and they have nowhere to go, if you are sick sometimes your relatives neglect you, you can come here and discuss with the group they can help you."*

10.5.3 What do People want from a Support Group?

All participants currently belong to an NPO run support group that on average meets once a month. Respondents were asked what they would want from a support group. Their responses are reported below in terms of (a) the administration aspect of a support group and (b) activities participants require from a support group.

(a.) Administration aspects of the support group

This relates to time, venue, membership, and general administration aspects necessary fro running a support group.

Of the five focus groups, four indicated that they would like to have a support with a membership of 10 people who are HIV positive as can be seen below:

> *"We have said that our support group must have ten members; it does not matter whether they are females or males, and their age does not matter."*

The reason for having a small membership is:

> *"Because we can meet and discuss problems openly because we are a small group."*

"What we know about this home based care is that they exist, we are more at KwaMashu, if we say all of them must come and join here, we will not meet the needs of the people, they will be many people in the group, so its better if we have different groups so that people can get help in a good way, there are many home based care places, we will end up with nothing if we can let all of them to come and join us."

It is envisaged that an NPO will run many support groups with each comprising of 10 members. As membership increases, more support groups will be started. In this way, individual members will not be lost in large groups dominated by few members. This methodology is very similar to the theory that grounds the conducting of focus group sessions which clearly states that as groups grow too large (possibly over 12-15), individual participants voices will be lost to that of a few dominant personalities in the group (Leggett, 1997 and Folch-Lyon et al, 1981).

With regards to who should be allowed to become members of a support group, participants were mixed but after much discussion, the majority stated that they wanted the group to consist only of PLWHA as can be seen from the quote below:

"Family members discriminate they and us hate us they don't treat us very well. Some of you have not disclosed their status to their family because they are afraid. The families do not eat the food that we cook."

"We will be too much if we are joined by family, so we only need poor and sick people."

It was also stated that if those affected (not infected with HIV themselves) should join the group, then those affected need to keep confidential all that is discussed in the group for fear of discrimination as many members although HIV positive have not disclosed their status publicly for fear of being ostracized.

"But those affected people should always know that they have to keep a secret of these people because they may not come here and listen to the people's problems and go and talk about it outside. We talk about things here and we leave them here and we talk about them when we meet again."

Participants wanted the support group to meet in the morning, preferably around 10am. This was stated so as members would have enough time in the morning for their home /family responsibilities before being available for the group.

"We have other responsibilities so 10 o'clock is O.K."

"Because when we wake up in the morning, we do our home thing at 10h00 we will all be finish we will be free to come to the support group."

The length and frequency of a support group session was debated among the different groups. A range of responses were given leading the researchers to believe that each individual group should be allowed to make this decision on their own. Currently support groups are run once a month, but it is believed that more sessions are needed – at minimum once a week. Responses from participants included:

"We will once a week to talk."

"Three hours."
"I think 2 times a week is very good."

"We meet 4 to 5 hours."

Participants believed that potential members would come to know of a support group by a number of ways including through VCT nurse, NPO, HBC carer and word of mouth as evident in the quotes below:

"The home based care always go door to door to their patient, and the homes based care knows about the needs of the patient and the family they know how to identify their patient."

"If you come for a test and you test positive, we will help you to attend the nearest support group."

"I think the clinic should have a list of all support groups around in their area so that if I found someone anywhere I can tell them to attend their nearest support group. If you stay at Inanda, I can tell you that there is a support group at Inanda near your area."

"I was ill, so I came to take my tablets [at NPO]. I was told to join."

(b) Activities participants require from a support group

Although participants correctly pointed out the definition of a support group, discussions around participant needs revealed that participants require more then counselling support. All participants stated that they require skills to would allow them to help themselves and others in the community. These skills include gardening and woodwork to counselling skills (income generating activities). Interestingly, participants also requested HIV education so as they could properly understand the virus and help the community understand it to reduce stigma (social responsibility) as can be seen from these quotes:

"My experience at the group session is that some other people as we have mentioned, that we need projects, you find people saying in other support groups, they are very poor, they don't have anything to do, they don't want to do things for themselves, they always wait for someone to come and give them something. So we go around and encourage people to work for themselves."

"We will learn how to do woodwork. Because in our community there are people have no tables and chairs in their houses so we can do that and sell it with less price."

"We can learn more about HIV because there is a higher risk of HIV, more especially on teenagers. We want to be taught and then we can take the information to the people"

"We want to learn counseling skills. We need counseling skills, and how to deal with stress, because some people know their status, that they are HIV, but they don't accept it."

"As people who are working in the community, we find lot of problems, especially from women. Some other women find it difficult to disclose to their husband because they will abuse them. Some of them are abused. When you come to their community, they will tell you most the problems are domestic problems. We want to be taught how to deal with people who are abused domestically, to know where to take them to work very closely with social workers and clinics so that they can recognize us, and that they must that we are there for the people, as my colleague has said about projects,

we also need projects because most of the people are very poor. They have no money. They have to come here and do something that could benefit then at the end of the day, so we need skills and to have some project to our community because there is no jobs and when we are sick we got no place to go."

"Healthy food we can plant, but we don't have a garden."

As participants required education/skills, they were asked where funding would come for a trainer to train participants. Participants clearly stated that training should come from the government and other non-governmental organisations as stated below:

"I think we can ask from government, other organizations like NGO's, the TAC organization, AIDS law projects."

Currently the Department of Health provides HIV education and counselling training with the Department of Social Development. Department of Agriculture provides training on food gardening.

Participants also stated that support groups could also organise to arrange for food parcels from different sponsors as see in these quotes:

"We need food parcels, once a month."

"I think we will get a sponsor, Spar and Shoprite."

10.5.4 Current Support Group Experience

Through the discussion, we learned that most groups currently meet once a month and that all groups are continually growing. New members are referred into the group through the VCT site as members of one NPO stated:

Because we are gathered here in this place, there is a visiting site [VCT] here and all the people who are here need to come and attend the support group

Other members joined the current support group either because they were invited by home-based carers of the NPO or they came on their own accord seeking assistance as the following quotes show:

"The home based care always go door to door to their patient…"

"Someone invited me to come and join the group."

"I was not feeling good. I was here to get food and my treatment. The lady that gives us food told me to join the group."

"I was ill, so I came to take my tablets. I was told to join."

The current support groups are expanding:

"The support group is increasing every day because people want to learn more about their risk because they have heard that HIV kills."

The expansion of support groups is positive as it shows that PLWHA are in need of group support. The problem though arises as the group grows and continues to operate as one group. This was mentioned above as individual groups grow to exceed 40 members per group.

In current groups though, respondents had positive and negative views of the group. Some positive responses included:

> *"We are free and have achieved something. If we have problems, we come here, they take you to a room, and talk to you, you are free then you are open.*"

> *"It supports us with food and money."*

Some negative quotes include:

> *"Is that in the current one [the 'ideal support group] you are teaching us that we will meet twice not once like the old one."*

> *"I think they should change the way they give us food. They should at least give us food twice a week because we don't have food."*

> *"We need to have exercise equipment, we need to exercise"*

10.5.5 Working Towards Solutions

During the focus group discussions, respondents always provided solutions. These have been stated above in the section "the ideal support group" and are summarized here.

The biggest problem faced by all respondents is poverty:

> *"…the biggest problem is poverty"*

As such, respondents wanted a support group that would give them something more then just group counselling support but also, support in terms of income generating activities as well as providing PLWHA food.

It is envisaged that as a small group of 10 comes together, they will receive education on counselling, woodwork, sewing and other income generating activities. They will meet for group counselling (possibly an hour) and spend the rest of the time engaged in income generating activities. Quotes include:

> *"We will learn how to do woodwork."*

> *"Because in our community there are people have no tables and chairs in their houses so we can do that and sell it with less price."*

Besides income generation activities, respondents also wanted education so as they could become involved in social responsibility activities as seen in these quotes:

> *"I think counselling skills is very important. Because when people come here, we can counsel them."*

> *"I think what we can do in our group; we can accommodate people with HIV so that people can come, because we have to learn about our status and to educate people about drugs."*

"I think we can ask from government, other organizations like NGO's, the TAC organization, base [AIDS] law projects."

"We want to be taught and then we can take the information to the people."

"We need counseling skills, and how to deal with stress, because some people know their status, that they are HIV, but they don't accept it."

"As people who are working in the community, we find lot of problems, especially from women. Some other women find it difficult to disclose to their husband because they will abuse them. Some of them are abused. When you come to their community, they will tell you most the problems are domestic problems. We want to be taught how to deal with people who are abused domestically, to know where to take them to work very closely with social workers and clinics so that they can recognize us, and that they must that we are there for the people, as my colleague has said about projects, we also need projects because most of the people are very poor. They have no money. They have to come here and do something that could benefit then at the end of the day, so we need skills and to have some project to our community because there is no jobs and when we are sick we got no place to go."

"I wanted to say that males need a lot of education because men don't want to visit clinics to get some information. We do have people who are HIV and go in to the community but now we want to try and go to different companies to teach them because some are infected and they don't live with their wives so they take that infection to their wives because they always resist going to testing. We were so lucky because we managed to join the support group."

With regards to food parcels, respondents wanted to arrange for sponsors to supply food parcels once a month to all members as can be seen from these quotes:

"We need food parcels."

"Vegetables, porridge and other things."

"12.5 maize meal, 5kg beans, meat, 10 kg and vegetables."

"Yes all the members should get the food."

"Once a month."

"I think we will get a sponsor."

"We will ask for support in shops like Shoprite, Spar and other shops. I like Shoprite because they advertise on radio that anyone who needs help, how to contact them. They give us numbers to phone if we need help and people are getting help."

10.6 Conclusion and recommendations

- Encourage NPOs to start support groups, as PLWHA need a safe place to congregate and discuss issues they may be experiencing.
- New definition of support group: Support groups for PLWHA must not only concentrate on providing counselling needs to members but need to expand to provide other support such as gardening and provide skills so as people could engage in other activities (income generating) so as they do not feel as a burden to their families and the community in general. It is important to recognise that each group would have

their own skill requirements ranging from gardening, and woodwork to counselling. As such, each group should be allowed to discuss and choose what skills they require and rank from most important to least.

- Provide training to NPOs on running and maintaining of support groups
- Support groups should be small (10 members) to encourage all members to participate
- Peer group discussions including peer experience and peer counselling are important to support group members.
- Members need to be used as a vital source of first person experience and be given the opportunity to go into the community to educate.
- Each group needs to decide on their own the length and frequency of the support group.
- Support group members need training on how to source funding for educational training, to access food parcels and to write proposals to receive funding.

Appendices

Appendix 1: Area Based District Needs Analysis

Responses to questions regarding District priorities, District Management Capacity and NPO partnerships.

Please note: *"See below"* indicates that more detailed information on the point is available in the narrative part below the table.

Table 60: Districts in Limpopo: Waterberg and Sekhukhune

Dimensions and elements	**Waterberg**	**Sekhukhune**
District priorities *(these are articulated or they are written in the planning documents)*	See below	See below
District Management Capacity	See below	See below
NPO partnerships *(these are articulated or they are written in the planning documents)*		
Is there a policy on NPOs in the district?	No	Don't know
What forms of partnerships exist?	Not specified	Not specified
Does the district have any service contracts with NPOs	Yes	Yes
If yes, how many?	1	No response
How are the partnerships managed?	Community Liaison Officers	EU personnel
How are contracts monitored?	Monthly Expenditure reports	On-site visits/monthly meetings
Are there any aspects relating to improving management capacity to manage partnerships	Yes	Yes
If yes, what are the strategies?	Capacity development	Internal/external training workshops
What are the service gaps	Understaffed, difficulty in recruiting and retaining professional nurses	Challenges in implementing full PGHC package
Can NGOs fill the gaps in the district	Yes	Yes

District priorities: Verbally articulated Waterberg district priorities included: to improve PHC, effective and efficient service delivery and revitalization of the district. According to the District Health Plan (2006/2007), the Waterberg DM seeks to render effective, efficient and sustainable services to ensure a better life for all. Its priorities include: water, sanitation and drought relief, roads and storm water, economic development, transport, environmental management, health and social development, disaster management, community participation and communication, institutional development, education, safety and security, sports, arts and culture and electricity. There were no verbally articulated priorities in Sekhukhune and neither written information on the Sekhukhune district priorities.

District Management Capacity: The Waterberg district has a district management team consisting of Finance Manager and human resources practitioner whose roles were not outlined. The Sekhukhune district also has the district management team consisting of finance manager, HIV/AIDS manager, sub-district manager and district manager whose roles have

not been outlined either. The Waterberg district has planning documents, i.e. a 3 year health plan and operational plans at district and sub-district levels and an IDP. However, the district does not have an organogram, annual report and also there is no link between the IDP and provincial planning processes. The Sekhukhune district has no organogram, 3-year health plans at district and sub-district levels and annual report for last financial year. It has operational plans for current year at district and sub-district levels and the IDP.

Both the districts have financial systems in place - a district health budget, district tender committee. Waterberg has a cost centre accounting system whereas Sekhukhune does not. In both districts, NPOs submit financial statements before receiving quarterly instalments. Provincial office and NPO finance committee determines who gets paid in Waterberg and Sekhukhune respectively. The two districts have a health information system whose data is collected from provincial government clinics, local government clinics (only in Waterberg) and NPOs on TB/HIV/OVC.

The current TB cure rate for the Waterberg is 62% and for Sekhukhune is 60%. The percentage of facilities in both districts that give returns of TB patients is 100% in both districts. There is a mechanism for cross-checking information sent from clinics in both the two districts. In terms of provincial and local governance, there are joint processes between local government and province at district, sub-district and facility levels in the form of DTT, PTT, and various meetings and forums. The existing mechanisms were said to be functional in Waterberg and functional to a lesser extent in Sekhukhune.

Each district has a council. The relationship between local politicians and the district management team was said to be good in Waterberg and just ok in Sekhukhune. The relationship between province and local government was said to be just ok in Sekhukhune, there was no response from Waterberg.

NPO partnerships: The above table shows that the districts in question either have no policy on NPOs or don't know about it. The two districts, however, both have service contracts with NPOs. Partnerships in Waterberg are managed by the Community liaison Officer meanwhile in the Sekhukhune district they are managed by EU personnel. In the Waterberg district, contracts are monitored through monthly expenditure report while in the Sekhukhune districts they are monitored through monthly meetings and on-site visits. Both the two districts acknowledged that there were aspects that needed to be improved in managing partnerships. In this regard, they indicated that there was a need for capacity development to manage partnerships.

In terms of payment of NPOs, the provincial office determined which NPOs get paid in the Waterberg district. However, in the Sekhukhune district, payment of NPOs is determined by the NPO finance committee. Both districts submitted financial statements before receiving quarterly statements and they collected data from NPOs.

Table 61: Sub-districts in Limpopo: Fetakgomo, Makhuduthamaga, Mogalakwena & Lephalale

Domains	Elements	Indicators	Fetakgomo	Makhuduthamaga	Mogalakwena	Lephalale
Sub-district PHC coverage, access and quality	**Facilities**	Number of satellite clinics/sub-district population	11	17	0	No response
		Number of PHC clinics	No response	18	6	6
		Number of CHC	1	No response	0	0
		Number of mobile clinics	2	4	0	0
		Audit of PHC package has been done in sub-district	Yes	Yes	Yes	Yes
		Access to PHC package items in sub-district	Yes	Yes	Yes	Yes
		Proportion of clinics open after hours and 24 hours	None	1	No response	0
	Staffing	Number of professional nurses in PHC in the sub-district/sub-district population	11	95	0	42
		Number of doctors in PHC in sub-district/sub-district population	0	No response	0	0
		Number of professional nurse vacant posts/total posts in sub-district	See below	See below	See below	See below
		Presence of a training plan for sub-district staff	Yes	Yes	No	No
	Outreach	Availability and type of outreach worker in the district	Yes	Yes	Yes	Yes
		Number of outreach workers in sub-district	See below	See below	See below	See below
		Number of facilities in sub-district supporting home-based care	8	17	35	12
		Number of facilities supporting a PWA support group	11	3	35	12
	Outputs (DHIS, 2005)	Number of visits to PHC facilities/per sub-district population in last year	1.6	1.7	1.7	1.5
		Mean number of patients per professional (clinic) nurse per day	25 (13)	18 (10)	23 (12)	24 (11)
		MTCT prevention coverage:				
		-Proportion of antenatal clients tested for HIV	56%	39%	70%	52%
		-Nevirapine uptake rate among pregnant women with HIV	69%	83%	68%	72%

	Outcomes (DHIS, 2005)	TB treatment completion Cure rates in sub-district Immunization coverage	1.7% 18.6% 94%	9.3% 26.6% 98%	32.1% 42.1% 82%	15.5% 57.7% 57%
	LG/provincial integration	Presence of integrated: □ Service provision □ Sub-district management structures □ Joint NPO management processes	 Yes Yes No	 Yes Yes Yes	 Yes No No	 Yes Yes No
NPO Partnerships	**Participation**	Presence of forums involving NPOs in the sub-district Presence of ward level/clinic health committees	Yes Yes	Yes Yes	Yes Yes	Yes Yes
	Referral and coordination	Existence of NPO database for the sub-district Referral links with NPOs: within facilities, referral outside facilities Perceived strengths and weaknesses of relationship	See below No See below	See below Yes See below	See below No See below	See below Yes See below
	Support	Provision of training or supplies to NPOs	Yes	Yes	Yes	Yes

Facilities/staffing: Catchment population of sub-districts: Fetakgomo – 920 84.00 with 11 satellite clinics (2 operating after hours), 1 CHC, 2 mobile clinics, 11 nurses and no doctors. The catchment population in Makhuduthamaga is 261 885.00 with 17 satellite clinics (6 operating after hours), 18 PHCs (6 operating after hours), 4 mobile clinics, 95 nurses and no doctors. In Lephalale the catchment population is 101 000 with 6 PHCs and 6 mobiles, 4 nurses and no doctors. In Mogalakwena the catchment population is 309 000, 25 PHCs, 10 mobile, no nurses and doctors at local level. Three core PHC services provided by clinics in the sub-district: Fetakgomo: TB management and HIV/AIDS, MCWH and preventive primitive health; Makhuduthamaga: minor ailments, ANC, MCWH and PMTCT/VCT; Lephalale: communicable diseases, EPI, HIV/VCT/PMTCT; Mogalakwena: Communicable diseases, mental health, EPI and HIV/VCT/PMTCT. Not all clinics provide PHC services daily. Generally PHC services are provided daily in the 4 districts with few exceptions. Fetakgomo and Makhuduthamaga had training plans while Mogalakwena and Lephalale did not have them.

Outreach: There are outreach activities in FT – 7 professional staff based in mobile clinics, treating minor ailments, paid and trained by DOH. There are no outreach services in Makhuduthamage and Lephalale. In Mogalakwena it was indicated that there are outreach services though they were not specified. Clinics supporting PLWHA – 11 in Fetakgomo, 3 in Makhuduthamaga. 12 in Mogalakwe and 35 in Lephalale. Clinics providing HBC- 8 in Fetakgomo, 17 in Makhuduthamaga, 6 in Mogalakwe and 12 in Lephalale.

Outputs: The mean number of patients per clinic nurse per day is 35, 25, 24 and 24 for FT, MT, MK and LP respectively and the number of visits to PHC facilities per sub-district population per year is 15 and 17 for FT and MK respectively. MTCT coverage for FT was 831 pregnant women, 113 pregnant women tested for HIV, 7 pregnant women HIV + and 5 pregnant women receiving NVP. The number of VCT clients in the previous month was 234. In MT, the distribution was as follows: 433 pregnant women, 433 pregnant women tested for HIV, 21 pregnant women HIV + and 16 pregnant women receiving NVP, 646 number of

VCT clients in last month, 3 children diagnosed with malnutrition in last 3 months and 3 children referred with malnutrition in last 3 months. None of the HIV+ women were followed up at 3, 6 and 12 months.

Outcomes: TB indicators for FT – 81.8% children from 12 to 23 months who are fully immunized. Number of HBC seen for last reporting not provided. For MT, TB treatment indicators are as follows: 3.3% treatment completion, 63.3% cure rates, 545 (information not available in %) for children from 12 to 23 months who are fully immunized. For MK, 49.2% for children from 12 to 23 months who are fully immunized. Other statistics are not available. Similarly in Lephalale, 50.3% for children from 12 to 23 months who are fully immunized. Other statistics are not available. Nothing was reported for HBC across the 4 districts.

NPO partnerships: In FT, they have an NPO database which was developed by the DTT in 2004 and updated in 2005. They also have a database of funded NPOs, also developed by DTT, up to 2004. In MT, they also have an NPO database and a database of funded NPOs being developed by the EU office, the dates thereof were not known. In MK and LP, no information was provided in this regard. The 2 sub-districts (FT/MK) have no referral links with NPOs. The other two has links (MT/LP). All the 4 districts provided materials and supplies to NPOs. The relationship between NPOs and 3 districts was generally considered as follows: FT - The relationship is good; MT - The relationship is excellent; MK - The relationship is not fully functional and LP – it was said that a more integrated approach is needed. All districts have structures in place for consulting with the community in the sub-districts.

Table 62: Districts in Gauteng: JHB Metro and Tshwane

Dimensions and elements	JHB Metro	Tshwane
District priorities *(these are articulated or written in reports)*	See below	See below
District Management Capacity	See below	See below
NPO partnerships *(these are articulated or written in reports)*		
Is there a policy on NPOs in the district?	Yes	Yes
What forms of partnerships exist?	Formal- MOA with HIV/AIDS NPOs/Informal	Formal/Informal
Does the district have any service contracts with NPOs	Yes	Yes
If yes, how many?	No response	One
How are the partnerships managed?	Quarterly monitoring	Regular interactions (meetings)
How are contracts monitored?	Monthly reports	Monitoring tool
Are there any aspects relating to improving management capacity to manage partnerships	No	Yes
If yes, what are the strategies?	N/A	Capacity building of managers
Who determines when NPOs get paid?	District Director	Province & district jointly
Do NPOs submit financial statements before receiving quarterly statements?	Yes	Yes
Do you collect data from NPOs?	Yes	Yes
If so, on what?	PHC headcounts, TB cure rates, EPI, HIV/AIDS	DOTS/illnesses
What are the service gaps	Service disparities, inaccessibility to services, poorly co-ordinated awareness campaigns	Different government structures, poor referrals, lack of capacity
Can NGOs fill the gaps in the district	Yes	Yes

District priorities: The verbally articulated goals of JHB metro were meant to meet the strategic objectives of the district (i.e. health promotion). The goals written in district health plan (2006-2007) is to promote and protect the health of the people especially those most vulnerable to illness and injury. Their mission is improved general health, improved well-being and increased life expectancy of the citizens of JHB. Their vision is "health for a better life". For Tshwane, the verbally articulated goals were to ensure provision of accessible and effective health care, to reduce the incidence of preventable diseases and to strengthen district health services at all levels. The goals written in the district health plan for Tshwane (2005-2007) were the same as JHB metro ones.

District management capacity: Tshwane district has an organogram and a district management team has a finance manager, HIV/AIDS manager, project manager, program manager, HR practitioner, project co-ordinator, committee member, sub-district manager, local AIDS council, information services manager, procurement officer. The roles of each have been clearly delineated. JHB metro does not have a district management team and an organogram. Both districts have a 3-year health plan at district and sub-district levels, operational plans at district and sub-district levels, annual reports for last financial year. Tshwane has an IDP and JHB does not have. There is no link between IDP and provincial planning processes in JHB metro while there are links in Tshwane. In both districts there are joint meetings or processes between province and local government in the district in the form

of Provincial Health Councils, Provincial Health Advisory committees focusing on sub-district development planning, improvement of health services and quality health care.

The existing mechanisms were perceived as functional and just ok in Tshwane and JHB metro respectively. In both districts, the relationship between province and local government was said to be just ok and the two districts did not have a district council. Both districts rated the relationship between local politicians and the district management team as being good. In terms of financial systems, both districts had no district health budget. Payment was determined by the district director in JHB metro, by province and district jointly in Tshwane. In both districts, NPOs submitted financial statements before getting quarterly instalments, there were cost centre accounting systems, districts health expenditure reviews had been prepared, but there were no district tender committees. In terms of health information systems, both districts collected data from provincial government clinics and NPOs and have systems for cross-checking information sent from clinics. Tshwane also collected data from local government clinics whereas JHB did not. In both districts data was collected on TB – 64% cure rates for JHB and 65% for Tshwane, 30% of facilities in the district that give returns of TB patients in JHB and 100% in Tshwane.

NPO partnerships: Both districts had policies on NPOs, had formal and informal partnerships with NPOs, service contracts with NPOs, submitted financial statements before receiving quarterly statements, collected data from NPOs, acknowledged that there were service gaps in their districts, which NPOs can fill. Partnerships in JHB metro are managed through quarterly reports and in Tshwane they are managed through regular interactions (e.g. meetings). The JHB metro did not see any need for improving management capacity to manage partnerships whereas Tshwane district saw the need to improve management capacity to manage partnerships by building the capacity of managers. In terms of payment of NPOs, the district director determines which NPOs should get paid in the JHB metro, while in the Tshwane district, the decision regarding payment of NPOs is made jointly by the district and the province.

Table 63: Sub-districts in Gauteng: Alexandra, Orange Farm, Tshwane-Central and Soshanguve

Domains	Elements	Indicators	Alexandra	Orange farm	Tshwane Central	Soshanguve
Sub-district PHC coverage, access and quality	Facilities	Number of satellite clinics/sub-district population	No response	No response	3	2
		Number of PHC clinics	7	4	27	6
		Number of CHC	1	1	2	1
		Number of mobile clinics	No response	No response	2	2
		Audit of PHC package has been done in sub-district	Yes	Yes	Yes	Yes
		Access to PHC package items in sub-district	See below	See below	See below	See below
		Proportion of clinics open after hours and 24 hours	No response	No response	None	None
	Staffing	Number of professional nurses in PHC in the sub-district/sub-district population	19	No response	Don't know	No response
		Number of doctors in PHC in sub-district/sub-district population	1	14	188	6
		Number of professional nurse vacant posts/total posts in sub-district	See below	See below	See below	See below
		Presence of a training plan for sub-district staff	Yes	Yes	Yes	Yes
	Outreach	Availability and type of outreach worker in the district (see description below)	Yes	Yes	Yes	Yes
		Number of outreach workers in sub-district	See below	See below	See below	See below
		Number of facilities in sub-district supporting home-based care	0	5	8	11
		Number of facilities supporting a PWA support group	7	4	4	11
	Outputs	Number of visits to PHC facilities	26	Not known	1,102643m	619731
		Mean number of patients per clinic nurse per day	45	35	40	35

		MTCT prevention coverage	See below	See below	See below	See below
	Outcomes	TB treatment completion	73.3	4.7	1060	56
		Cure rates in sub-district	60.2	75.3	78	54
		Immunization coverage	90.3	Not known	90.80%	82.3
	LG/provincial integration	Presence of integrated:				
		□ Service provision	Yes	Yes	Yes	Yes
		□ Sub-district management structures	Yes	Yes	Yes	Yes
		□ Joint NPO management processes	Yes	Yes	Yes	Yes
NPO Partnerships	Participation	Presence of forums involving NPOs in the sub-district	Yes	Yes	Yes	Yes
		Presence of ward level/clinic health committees	Yes	Yes	Yes	Yes
	Referral and coordination	Existence of NPO database for the sub-district	No	Yes	Yes	Yes
		Referral links with NPOs: within facilities, referral outside facilities	Yes	Yes	Yes	Yes
		Perceived strengths and weaknesses of relationship	See below	See below	See below	See below
			Yes	Yes	Yes	Yes
	Support	Provision of training or supplies to NPOs	No	Yes	Yes	Yes

Facilities/staffing: Catchment population of sub-districts: Alexandra – 275 000, 7 PHCs and 1 CHC, 19 nurses and 1 doctor; Orange Farm – 253547.00 with 4 PHCs, 1 CHC, 48 nurses and 24 doctors; Tshwane Central – 17 000 000, 3 satellite clinics, 27 PHC clinics, 2 CHC, 2 mobiles – there is no information on numbers of doctors and nurses, and Soshanguve – 399 666, 2 satellite clinics, 6 PHCs, 1 CHC and 1 mobile – there is no information on numbers of doctors and nurses.

Three core PHC services are provided by clinics in the sub-district: Alexandra: MCHW, communicable diseases; Orange Farm: Curative, immunization and HIV/VCT/PMTCT; Tshwane Central: MCHW, chronic diseases and TB care; Soshanguve: TOP, HBC, Chronic care infections, MCHW, rehabilitation and oral health. Generally facilities provide all PHC services daily with a few exceptions. All the 4 sub-districts had training plans.

Outreach: There are outreach activities in the 4 districts. Alex – 39 professional staff, 14 health promoters, 14 DOTS supporters, 12 HBCs; Orange Farm – 52 professional staff, 5 health promoters, 77 DOTS supporters, 252 CHW, 175 HBCs; Tshwane Central & Southern -

38 professional staff, 25 health promoters, 218 DOTS supporters, 246 HBCs/CHWs; Soshanguve - 8 professional staff and 7 health promoters.

Outputs: The mean number of patients per clinic nurse per day is 45, 35, 40 and 35 for Alex, Orange Farm, Tshwane Central and Soshanguve respectively and the number of visits to PHC facilities per sub-district population per year is 2.6 for Alex, not mentioned for orange farm, 1.1 for Tshwane Central and 619731 for Soshanguve.

MTCT coverage for Soshanguve was 8166 pregnant women, 5898 pregnant women tested for HIV, 1 653 pregnant women HIV + and 508 pregnant women receiving NVP, 58 032 infants receiving breast milk substitutes. The number of VCT clients in the previous month was 515; no stats for orange farm; Tshwane Central: 6982 pregnant women, 8057 pregnant women tested for HIV, 1910 pregnant women HIV+ and 658 pregnant women receiving NVP, 2211 infants receiving breast milk substitutes, 749 HIV positive women followed at 3 months, 1174 women followed at 6 months, 212 women followed at 12 months. 15698 number of VCT clients in last month, 223 children diagnosed with malnutrition in last 3 months and 43 children referred with malnutrition in last 3 months.

Outcomes: TB indicators for Alex – 73.3% completion rates, 60.2% cure rates, 90.3% children from 12 to 23 months who are fully immunized. Orange Farm – 4.7 treatment completion, 75.3% cure rates. Tshwane Central – 1060 (only the number) treatment completion, 78% cure rates and 90.8% children from 12-23 months who are fully immunized. Soshanguve – 56% treatment completion, 54% cure rates and 82.3% children from 12 to 23 months who are fully immunized.
Nothing was reported for HBC across the 4 districts.

NPO partnerships: All sub-districts have an NPO database except Alexandra. The 4 sub-districts have referral links with NPOs. All the 4 districts provide materials and supplies to NPOs. Comments about the relationship with NPOs are: Alexandra: Healthy working relationship; Orange Farm: Excellent working relationship - Open communication and reciprocal referral system; Tshwane Central: Good working relationship and Soshanguve – good working relationship. All districts have structures in place for consulting with the community in the sub-districts.

Table 64: Districts in Eastern Cape: OR Tambo and Amathole

Dimensions and elements	**OR Tambo**	**Amathole**
District priorities *(these are articulated or written in the reports)*	See below	See below
District Management Capacity	See below	See below
NPO partnerships *(these are articulated or written in the reports)*		
Is there a policy on NPOs in the district?	No	No
What forms of partnerships exist?	Informal	Informal
Does the district have any service contracts with NPOs	No	Yes
If yes, how many?	-	27
How are the partnerships managed?	LSA managers monitor NPOs	EU guidelines
How are contracts monitored?	According to TOR	No response
Are there any aspects relating to improving management capacity to manage partnerships	Yes	No response

If yes, what are the strategies?	Project management, financial management, public service regulations	No response
Who determines when NPOs get paid?	Province	Province & EUPDPHCP
Do NPOs submit financial statements before receiving quarterly statements?	No	Yes
Do you collect data from NPOs?	No	No
If so, on what?	N/A	N/A
What are the service gaps	Shortage of personnel, high population	Vastness, poor infrastructure
Can NGOs fill the gaps in the district	Yes	No response

District Priorities: verbally articulated goals in OR Tambo were capacity building and service delivery at local level. In Amatole DM report to have planned to implement IDP. No written documents were received regarding the two districts' priorities.

District management capacity: Both districts have district health management teams. Amathole had an organogram while OR Tambo did not have. Both had 3-year health plans and current year operational plans at district levels and sub-district levels but there is no health plan for Amathole at sub-district level. OR Tambo had an annual plan while Amathole did not have. There are IDPs in the two districts, district health councils as well as the link between the IDP and provincial planning processes. There are joint meetings or processes between province and local government in the form of LSA meetings, district health council and district health advisory. Both have a district council.

The relationship between province and local government was said to be good in Amathole, no response was given from OR Tambo. The existing mechanisms for provincial and local government interaction were perceived as functional in OR Tambo and highly functional in Amathole. The relationship between local politicians and the district management team was described as good in OR Tambo and very good in Amathole. Both districts had health budgets in place. In both cases the province decided on which NPOs get paid, NPOs had to submit financial statements before receiving quarterly statements in Amathole, there was a district tender committee in Amathole, district health expenditure budgets and cost center accounting systems in both districts. Both districts collected information from provincial government clinics; local government clinics but none from NPOs. They collected data on TB – 41% cure rates in Amathole, it is unknown in OR Tambo. Percentages of facilities that gave returns of TB patients were not specified. There was a system for cross-checking information sent from clinics in both districts.

NPO partnerships: Both districts did not have a policy on NPOs in the district, had informal partnerships with NPOs and did not collect data from NPOs. In terms of service contracts with NPOs, Amathole indicated that they had 27 while OR Tambo had none.

Partnerships in OR Tambo are managed by LSA managers and in Amathole they are managed through EU guidelines. In terms of contract monitoring, OR Tambo indicated that they use ToRs and Amathhole did not respond to this question. The province in OR Tambo determines payment of NPOs and in Amathole it is detrmined by EUPDPHCP and province. Both districts identified service gaps such as shortage of personnel, high population (OR Tambo), vastness of the district and poor infrastructure (Amathole). OR Tambo indicated that service gaps could be closed by NPOs. No response was given from Amathole District Municipality in this regard.

Table 65: Sub-districts in Amathole District Municipality: Buffalo City and KSD.

Domains	Elements	Indicators	BC	KSD
Sub-district PHC coverage, access and quality	Facilities	Number of satellite clinics/sub-district population	2	34
		Number of PHC clinics	101	No response
		Number of CHC	6	5
		Number of mobile clinics	16	4
		Audit of PHC package has been done in sub-district	Yes	Yes
		Access to PHC package items in sub-district	See below	See below
		Proportion of clinics open after hours and 24 hours	6 clinics	5 CHC
	Staffing	Number of professional nurses in PHC in the sub-district/sub-district population	60	47
		Number of doctors in PHC in sub-district/sub-district population	3	1
		Number of professional nurse vacant posts/total posts in sub-district	Not provided	Not provided
		Presence of a training plan for sub-district staff	Yes	Yes
	Outreach	Availability and type of outreach worker in the district (see description below)	Yes	Yes
		Number of outreach workers in sub-district	506	15
		Number of facilities in sub-district supporting home-based care	101	Not specified
		Number of facilities supporting a PWA support group	0	13
	Outputs	Number of visits to PHC facilities/per sub-district population in last year	24	22
		Mean number of patients per day		24
		MTCT prevention coverage	See below	See below
	Outcomes	TB treatment completion	52%	31%
		Cure rates in sub-district	40%	42%
		Immunization coverage	110%	116%
	LG/provincial integration	Presence of integrated:		
		□ Service provision	Yes	Yes
		□ Sub-district management structures	Yes	Yes
		□ Joint NPO management processes	Yes	Yes
NPO Partnerships	Participation	Presence of forums involving NPOs in the sub-district	Yes, LSA meetings	Yes, PTT/DTT

		Presence of ward level/clinic health committees	Yes	Yes
	Referral and coordination	Existence of NPO database for the sub-district	Yes	Yes
		Referral links with NPOs: within facilities, referral outside facilities	No	No
		Perceived strengths and weaknesses of relationship	Relationship not well established	Capacity building needed to enhance relationship
	Support	Provision of training or supplies to NPOs	No response	No

Facilities/staffing: The catchment population of Buffalo City sub-district: 830566.00 with 2 satellite clinics, 101 PHC, 6 CHC, 16 mobile clinics with only 6 clinics that open after hours. It has approximately 60 nurses and 1 doctor. The catchment population for KSD is 454 000 with 34 satellite clinics, 5 CHC (also open after hours) and 4 mobile clinics. It has 47 nurses and 1 doctor. Three core PHC services provided by clinics in BC: they provide minor ailments; administer health programmes: TB, HIV/AIDS, MCWH and make referrals. Three core PHC services provided by clinics in KSD are: administer health programmes: TB, HIV/AIDS; provide expanded programme on immunization and MCWH and TB control and treatment. Not all clinics provide PHC services daily. The services are provided daily by all clinics in BC are as follows: curative care, immunisation, IMCI, ANC/PNC, PMTCT, VCT, VCT with rapid testing, TB care, mental health, rape counseling and TOP. In as far as ARVs for pregnant women, ARVs for others, only 5 clinics provided them and not on a daily basis. Similarly curative care, immunisation, PMTCT, VCT, VCT with rapid testing were provided daily by clinics in KSD. No responses were given on other PHC services in KSD. Both sub-districts have training plans.

Outreach: There are outreach activities in BC – 16 professional staff based in mobile clinics, treating minor ailments, paid and trained by DOH; 12 health promoters based in LSAs, doing health promotion, paid by DOH and 480 CHW based in clinics, providing health education, paid by NPOs and trained by DOH. Similarly, there are outreach services in KSD – 10 professional staff, based in mobile clinics, providing mobile health services, paid by DOH and 5 health promoters, based in LSA, providing health education, there is no indication of whether they are paid and trained.

Outputs: The mean number of patients per clinic nurse per day is 40 and the number of visits to PHC facilities per sub-district population per year is 24 in BC, with each clinic being visited twice a month by a clinic supervisor. No information was provided regarding MTCT coverage for BC. With regards to KSD, the mean number of patient per clinic nurse per day is 24 and the number of visits to PHC facilities per sub-district population per year was 2.2. In terms of MTCT coverage, there were 30 526 pregnant mothers, 5033 pregnant women tested for HIV, 1308 pregnant women HIV positive, 701 pregnant women receiving NVP, 3400 infants receiving breast milk substitutes. None of the HIV+ women were followed up at 3, 6 and 12 months.

Outcomes: TB indicators for BC – 52% treatment completion and 40% cure rates in the last reporting year as well as 110% children from 12 to 23 months who are fully immunized. Number of HBC seen for last reporting not provided. For KSD, TB treatment indicators are as

follows: 31% treatment completion, 42% cure rates, 116% for children from 12 to 23 months who are fully immunized.

NPO partnerships: In BC, they have an NPO database, which was developed by the DTT in 2003 and updated in 2005. They also have a database of 27 funded NPOs, also developed by DTT, in 2006 and also updated in the same year. In KSD, they also have an NPO database and a database of funded NPOs being developed by the EU office in 2005 and 2006 respectively. The 2 sub-districts have no referral links with NPOs and do not provide materials and supplies to NPOs. The relationship between NPOs and 3 districts was generally considered underdeveloped. All districts have structures in place for consulting with the community in the sub-districts.

Table 66: Districts in KwaZulu-Natal

Dimensions and elements	**Zululand**	**Ethekwini**
District priorities *(these were articulated or written in reports)*	See below	See below
District Management Capacity	See below	See below
NPO partnerships *(these were articulated or written in reports)*		
Is there a policy on NPOs in the district?	Yes	No
What forms of partnerships exist?	Formal/Informal	Informal
Does the district have any service contracts with NPOs	Yes	No
If yes, how many?	DOH – 6, EU –14	N/A
How are the partnerships managed?	Unit managers	No M&E capacity
How are contracts monitored?	Written reports	No contracts
Are there any aspects relating to improving management capacity to manage partnerships	No	No
If yes, what are the strategies?	N/A	N/A
Who determines when NPOs get paid?	Province (HIV unit)	Province guided by PFMA
Do NPOs submit financial statements before receiving quarterly statements?	Yes	Yes
Do you collect data from NPOs?	Yes	Yes
If so, on what?	Patients demographics and services receive	Staff complement, expenditure
What are the service gaps	Lack of access to health care, low service utilization	Understaffed
Can NGOs fill the gaps in the district	Yes	Yes

District priorities: The verbally articulated goals in Zululand DM were economic development and improving service delivery and in eThekwini DM were HR management and development, strengthening of PHC services and finance and resource management. The priorities for the district as outlined in the District Health Plan (2006/2007) of Zululand District included development and upgrading of health facilities infrastructure, recruitment and retention of personnel, human rights and community participation, comprehensive management of STI/HIV and AIDS, TB and Health Promotion, maternal child and women's health, poverty alleviation and delivery of PHC and district hospital package.

District management capacity: Both districts have district health management teams with more than six members. They have organograms, IDPs, annual reports for current financial year, 3-year health plans and current year operational plans at district levels, none at sub-district levels. There is a link between the IDP and provincial planning processes in both the two districts. There are joint meetings or processes between province and local government in the form of DMT, Service Providers Forum, DTT, PTT. Zululand has a district council but eThekwini does not. The relationship between local politicians and the district management team was described as good and very good in Zululand and eThekwini respectively. The Zululand district had a district health budget; no response was given for eThekwini. In both cases the province decided on which NPOs get paid, NPOs had to submit financial statements before receiving quarterly statements, there were district tender committees, district health expenditure budgets, and cost center accounting systems. Both the two districts collected information from provincial government clinics, local government clinics and NPOs. They collected data on TB – 51% cure rates in Zululand and 35% in eThekwini. In Zululand, 90% of facilities gave returns of TB patients; no response was given for eThekwini. There was a system for crosschecking information sent from clinics in Zululand; no response was given for eThekwini.

NPO partnerships: Both the two districts felt that there were no aspects relating to improving capacity of managing partnerships. In both provinces, the province determines which NPOs get paid. NPOs submitted financial statements before receiving quarterly statements. They collected data from NPOs and acknowledged to have service gaps (e.g. lack of access to health care, low service utilization, understaffed), which can be closed by NPOs. Zululand had service contracts (DOH – 6, EU – 14) while eThekwini had none. Unit managers manage partnerships in Zululand DM while in eThekwini it was mentioned that there is no Monitoring and Evaluation capacity. Zululand DM monitored contracts through written reports.

Table 67: Sub-districts in KZN

Domains	Elements	Indicators	INK	Abaqulusi	Ulundi
Sub-district PHC coverage, access and quality	Facilities	Number of satellite clinics/sub-district population	8	1	16
		Number of PHC clinics	None	19	None
		Number of CHC	No response	1	None
		Number of mobile clinics	No response		
		Audit of PHC package has been done in sub-district	Yes	4	4
		Access to PHC package items in sub-district	See below	See below	See below
		Proportion of clinics open after hours and 24 hours	None	1	None
	Staffing	Number of professional nurses in PHC in the sub-district/sub-district population	Don't know	112	54
		Number of doctors in PHC in sub-district/sub-district population	Don't know	No response	5
		Number of professional nurse vacant posts/total posts in sub-district	See below	See below	See below
		Presence of a training plan for sub-district staff	Yes	Yes	Yes
	Outreach	Availability and type of outreach worker in the district (see description below)	Yes	Yes	Yes
		Number of outreach workers in sub-district	See below	See below	See below
		Number of facilities in sub-district supporting home-based care	No response	15	No response
		Number of facilities supporting a PWA support group	No response	10	16
	Outputs	Number of visits to PHC facilities/per sub-district population in last year	No response	No response	No response
		Mean number of patients per clinic nurse per day	No response	78	55
		MTCT prevention coverage:	See below	See below	See below

	Outcomes	TB treatment completion	No response	76	No response
		Cure rates in sub-district	No response	75	No response
		Immunization coverage	No response	88.30%	No response
	LG/provincial integration	Presence of integrated:			
		□ Service provision	Yes	Yes	Yes
		□ Sub-district management structures	Yes	No response	Yes
		□ Joint NPO management processes	Yes	No response	No
NPO Partnerships	Participation	Presence of forums involving NPOs in the sub-district	Yes	Yes	Yes
		Presence of ward level/clinic health committees	Yes	Yes	Yes
	Referral and coordination	Existence of NPO database for the sub-district	Yes	Yes	Yes
		Referral links with NPOs: within facilities, referral outside facilities	Yes	Yes	Yes
		Perceived strengths and weaknesses of relationship	Weak relationship	Weak relationship	Relationship not good
	Support	Provision of training or supplies to NPOs	Yes	Yes	Yes

Facilities and staffing: The catchment population of sub-districts: INK – the catchment population, number of nurses and doctors are not known; there are 8 clinics only none of which operate after-hours. At Abaqulusi the catchment population is 598606.00 with 1 satellite clinic, 19 PHC clinics, 1 CHC and 4 mobile clinics and a staff complement of 112 nurses and 6 doctors. Ulundi's catchment area is 120 000.00. people, 16 satellite clinics all offering PHC services and 4 mobile clinics. The staff complement includes 54 nurses and 5 doctors. Three core PHC services provided by clinics in the sub-district: INK: Communicable diseases, HIV/AIDS/STIs; Abaqulusi: MCWH, minor ailments and immunization; Ulundi: Immunization and chronic diseases. Not all clinics provide PHC services daily. The services provided daily are as follows: The services provided daily by all clinics in INK are as follows: curative care, immunization, IMCI, ANC/PNC, PMTCT, VCT, VCT with rapid testing, TB care, mental health, rape counseling and TOP. In as far as ARVs for pregnant women, ARVs for others, only 5 clinics provided them and not on a daily basis. Similarly, all the above-mentioned PHC services are offered by Abaqulusi, including ARVs for pregnant women andd others (offered in 6 clinics on a daily basis respectively). The same services are offered by all clinics in Ulundi except TOP. All the sub-districts have training plans.

Outreach: There are outreach services in INK. However, the number of people involved in these services could not be specified. Similarly, there are outreach activities in Ulundi – 5 professional staff based in hospitals, providing specialised services, paid by DOH and trained by College; 120 DOTS supporters, based in clinics, dealing with TB management, unpaid but

trained by DOH and 178 CHW based in clinics, conducting home visits, paid and trained by DOH. There are 250 HBC, dealing with HIV and chronic illness, not paid but trained by DOH. Further, there are outreach services in Abaqulusi – 35 DOTS supporters, based in clinics, doing providing mobile TB management, unpaid and trained by DOH and 115 CHWs, based in clinics, providing health education, paid and trained by The Valley Trust NGO. There are HBCs whose number could not be specified, providing health education, paid and trained by EU.

Outputs: The mean number of patients per clinic nurse per day and the number of visits to PHC facilities per sub-district population per year were not specified at INK. No information was provided regarding MTCT coverage for INK, Ulundi and Abaqulusi. With regards to Ulundi, the mean number of patients per clinic nurse per day is 55 and the number of visits to PHC facilities per sub-district population per year was not specified. The mean number of patients per clinic nurse per day was 78 and the number of visits to PHC facilities per sub-district population per year was not specified at Abaqulusi.

Outcomes: TB indicators for INK and Ulundi were not provided. For KSD, TB treatment indicators are as follows: 76% treatment completion, 75% cure rates, 88.3% for children from 12 to 23 months who are fully immunized.

NPO partnerships: In INK, they have an NPO database, which was developed by the DTT in 2003 and was never updated. They also have a database of funded NPOs, developed by DOH/EU in 2003 and updated 2005. In Ulundi, they also have an NPO database and a database of funded NPOs being developed by the EU office in 2005 respectively. In Abaqulusi they have NPO and funded NPO databases which were developed by the DOH in 2004 and were updated in 2006. The 3 sub-districts have referral links with NPOs and provide materials and supplies to NPOs. The relationship between NPOs and 3 districts was generally considered weak. All districts have structures in place for consulting with the community in the sub-districts.

Table 68: Districts in Western Cape

	Western Cape Metro	**Boland Overberg**
NPO partnerships		
Is there a policy on NPOs in the district?	Yes	No
What forms of partnerships exist?	Formal- SLA	Informal/Informal
Does the district have any service contracts with NPOs	Yes	Yes
If yes, how many?	30- non EU, 29 for EU	12 with HBC NPOs, 5 with HIV NPOs, 3 with welfare NPOs
How are the partnerships managed?	District	District
How are contracts monitored?	Monthly reports/meetings	On=site visits, financial reports
Are there any aspects relating to improving management capacity to manage partnerships	Yes	Yes
If yes, what are the strategies?	Management development	Management training
Who determines when NPOs get paid?	District manager	Written contract
Do NPOs submit financial statements	Yes	No

before receiving quarterly statements?		
Do you collect data from NPOs?	Yes	Yes
If so, on what?	Services rendered, financial information, demographic data and infrastructural information	Staff complement, expenditure
What are the service gaps	Limited funding/too much paperwork	Implementation challenges
Can NGOs fill the gaps in the district	Yes	Yes

District priorities: The verbally articulated goals for Boland Overberg were poverty relief through comprehensive development and for Cape Town metro were also to reduce poverty and improve health. According to the Boland Overberg Annual Health Status Report (2004), the strategic goals and objectives were to strengthen level 2 capacity, to realign TB hospital, to reshape district hospitals, to improve health facility based PHC services, to improve community based PHC services and to improve regional office functioning. According to Cape Town Metro District Health Plan (2006/2007), the priority is to render PHC services and district hospital services including preventive, promotive and curative services.

District management capacity: Both districts had DHMTs with more five members, organograms, annual reports, IDPs (which were linked to provincial processes) , 3-year health plans and operational plans at district levels (none at sub-district levels). There were joint processes/meetings between province and local government, i.e. Executive and bilateral meetings. The existing mechanisms for provincial/local government interaction were viewed as functional and highly functional in Boland Overberg and Cape Town Metro respectively. The relationships between province and government were perceived as good in both provinces. Both districts had no district councils. They rated the relationship between local politicians and the DMT as being just ok (Boland Overberg) and very good (Cape Town Metro). Boland Overberg had district health budget while Cape Town Metro did not. In Boland Overberg, payment of the NPOs was determined through written contracts while in Cape Town Metro the district determined it. NPOs submitted financial statements before getting quarterly statements in both districts. They had district health expenditure budgets, district health committees and cost centre accounting systems. Both the two districts collected information from provincial government clinics, local government clinics and NPOs. They collected data on TB – 86% cure rates in Boland Overberg and 71% in Cape Town Metro and both 100% of facilities giving returns of TB patients. There was a system for cross-checking information sent from clinics in both districts.

NPO Partnerships: Both districts had service contracts, had formal and informal partnerships, which are managed by their districts, collected data from their NPOs and identified service gaps, which could be filled by NPOs. In Western Cape Metro DM, NPOs submitted financial statements before receiving quarterly statements; the opposite is true for Boland Overberg. District manager in the WC metro determined payment of NPOs. And in the Boland Overberg it was determined through a written contract. The WC metro DM monitored their contracts through monthly reports or meetings and Boland monitored contracts through on-site visits and financial reports.

Table 69: Sub-district in Western Cape: Thee Waterklooflocal

Domains	Elements	Indicators	Thee Waterkloof
Sub-district PHC coverage, access and quality	Facilities	Number of satellite clinics/sub-district population	8
		Number of PHC clinics	1
		Number of CHC	1
		Number of mobile clinics	8
		Audit of PHC package has been done in sub-district	Yes
		Access to PHC package items in sub-district	Yes
		Proportion of clinics open after hours and 24 hours	None
	Staffing	Number of professional nurses in PHC in the sub-district/sub-district population	13
		Number of doctors in PHC in sub-district/sub-district population	0
		Number of professional nurse vacant posts/total posts in sub-district	See below
		Presence of a training plan for sub-district staff	Yes
	Outreach	Availability and type of outreach worker in the district (see description below)	Yes
		Number of outreach workers in sub-district	161
		Number of facilities in sub-district supporting home-based care	6
		Number of facilities supporting a PWA support group	3
	Outputs	Number of visits to PHC facilities/per sub-district population in last year	Don't know
		Mean number of patients per day	55
		MTCT prevention coverage:	Not provided
	Outcomes	TB treatment completion	81%
		Cure rates in sub-district	81%
		Immunization coverage	80%
	LG/provincial integration	Presence of integrated:	
		□ Service provision	Yes
		□ Sub-district management structures	Yes
		□ Joint NPO management processes	Yes
NPO Partnerships	Participation	Presence of forums involving NPOs in the sub-district	Yes
		Presence of ward level/clinic health committees	Yes
	Referral and coordination	Existence of NPO database for the sub-district	Yes
		Referral links with NPOs: within facilities, referral outside facilities	Yes
		Perceived strengths and weaknesses of relationship	See below

	Support	Provision of training or supplies to NPOs	Yes

Facilities and staffing: The catchment population of Thee Waterkloof sub-district 93 000.00 with 8 satellite clinics, 1 PHC, 1 CHC and 8 mobile clinics, none of which work after hours. They have 13 nurses and no doctors. Core PHC services include preventive cure, curative care and maternity service. Not all clinics provide PHC services daily. The services provided daily are as follows: curative care, immunization, IMCI, ANC/PNC, PMTCT, VCT, VCT with rapid testing, TB care, mental health, rape counseling a including ARVs for pregnant women but not for others. The clinics do not provide TOP. The sub-districts have a training plan.

Outreach: There are outreach services in Thee Waterkloof – 8 professional staff based in hospitals, providing comprehensive services, paid and trained by DOH; 2 health promoters paid and trained by DOH doing health promotion; 13 DOTS supporters, based in clinics, dealing with TB management, paid by Global Fund and trained by DOH and 100 CHW based in clinics, conducting home visits, unpaid and trained by DOH. There are 38 HBC, dealing with HIV and chronic illness, paid by EU and trained by DOH.

Outputs: The mean number of patients per clinic nurse per day is 55 and the number of visits to PHC facilities per sub-district population per year was not known. No information was provided regarding MTCT coverage for this sub-district.

Outcomes: TB indicators for the district was: 81% treatment completion, 81% cure rates, 80% for children from 12 to 23 months who are fully immunized.

NPO partnerships: In Thee Waterkloof, there is an NPO database, which was developed by the DTT in 1993 and updated in 2005. They also have a database of funded NPOs, developed by DOH/EU in 2004 and updated 2005. The sub-district has referral links with NPOs and provides materials and supplies to NPOs. The relationship between NPOs and the district was generally considered good. The district has structures in place for consulting with the community in the sub-districts.

Conclusions and recommendations

Key results are divided into district priorities, district management capacity (district management team, planning, human resources, financial systems, health information system, provincial and local government, governance and local participation and ability to partner with NPOs) and contextual factors influencing partnerships.

District priorities

All the districts were able to verbally articulate their goals and priorities and also had them in planning documents. Their goals included among others, economic development, HR development, provision of accessible, effective and efficient health care, improve and strengthen PHC, reduce incidence of preventable diseases, strengthen district health services at all levels of health – primary, secondary and tertiary. However, the potential role of NPOs was not clearly articulated verbally and in written planning documents.

District management capacity

District management capacity encompasses the following dimensions: district management team, planning, human resources, financial systems, health information systems, provincial and local government, governance and community participation and ability to partner with NPOS. Key findings for each of the above-mentioned are discussed below and the recommendations are given at the end.

District Management Health Team: All districts had a district health management team except JHB metro. In terms of human resources, they also had 5 or more members except in three districts (Sekhukhune, Waterberg and Amathole). Generally, the support functions of the DHMTs (finance, human resources, drug supplies, programmes), were clearly delineated. Half of the districts had a district council. Almost all districts (8) had a staff training strategy.
Planning: More than half of the districts (6) had DHTM organogram, 3 year health plan at district levels (9), operational plans for the current year at district levels (90) and sub-district levels (6), annual reports for last financial year (7), 5 year IDP for the district (9) and there was a link between the IDP and provincial planning process (7). Only 4 districts had 3-year health plans for sub-districts.

Financial systems: Generally, districts had financial systems in place, i.e. health expenditure reviews (10), cost centre accounting by facility in the district (8), NPOs submitted financial statements before receiving financial instalments (9) and district tender committees (7). However, only 4 had a health district budget.

Province and local government: There was evidence of joint processes and management structures in all districts. The majority of districts perceived the existing mechanisms as functional or highly functional (7). Half of the districts (5) perceived the relationship between province and local government as just ok, 3 perceived it as very good or good. The relationship between local politicians and the DHMT was perceived as good (8). In terms of collaborative work, 5 districts had MOUs and MOAs with provinces and 4 had SLAs.
District Health Information Systems: The majority of districts had implemented DHIS (9), collected data from provincial government clinics (10), local government clinics (8) NGOs (8) and also collected data on TB indicators (10). Each also had a mechanism for crosschecking information sent from clinics (9). Even the, still some districts could not provide statistics on the PHC services.

Ability to partner with NPOs: The majority of the districts had district mechanisms to manage NPO contracts (8), database on NPOs (10). Only 4 districts had an NPO policy. Eight (8) districts had SLAs with NPOs. All districts had either formal, informal or both formal and informal partnerships with NPOs. The partnerships were managed through various mechanisms- LSAs, unit managers, regular interactions, and community liaison officers among others. There seemes to be no uniform system of managing partnerships across districts. Contracts were also monitored differently across the districts, i.e. on-site visits, submission of monthly reports, monthly expenditure reports, "If they don't deliver, we withdraw funding", meetings, audited financial reports. Again, there was no uniform way of monitoring contracts. It was indicated by 6 districts that there are aspects of the NPO policy relating to the improvement of management capacity or ability to manage partnerships. Service gaps identified across districts included understaffing/lack of capacity, difficulty in retaining and recruiting staff, challenges in implementing PHC package, service disparities, inaccessibility of services/low service utilisation and limited funding. Districts generally believed that NPOs could fill their gaps in service delivery.

Recommendations

- The role of NPOs should be clearly delineated.
- More human resources are needed for districts whose DHMTs are not adequately staffed.
- District councils should be established in districts that currently do not have them.
- 3-year health plans for sub-districts need to be developed in some districts
- Health budgets should be put in place in all districts.
- There is a need to improve the relationship between local and provincial governments.

- Districts should use their DHIS effectively to ensure that they have data on all PHC indicators.
- NPO policies should be developed in all districts.
- A standardised system of managing partnerships should be developed.
- Standard methods to monitor contracts should be developed and utilized across all districts.
- There is a need for capacity development so that partnerships are managed efficiently and effectively.
- The identified service gaps need to be addressed, especially the lack of capacity, staff recruitment and retention.
- Districts should be encouraged to utilise NPOs more effectively in order to close service gaps.

For the sub-districts, key results are divided into two domains: PHC access, coverage, and quality of PHC with specific reference to facilities/staffing, outreach, outputs, outcomes, and LG/provincial integration and NPO partnerships with focus on participation, referral/coordination and support.

Sub-district PHC coverage, access and quality

Facilities: All the sub-districts had satellite clinics, PHC clinics, CHCs. However, the majority of them did not operate after working hours.

Staffing: The majority of sub-districts (12) had training plans.

Outreach: Almost all sub-districts (12) had various outreach functions in the sub-district performed by professional staff, health promoters, DOTS supporters and CHWs. All sub-districts had clinics. Not all clinics though linked to PLWHA supporting HBC.

Outputs: The number of visits to PHC facilities per sub-district ranged from once to about 24 times per year. The mean number of patients per clinic nurse per day ranged from 24 to 135. In most sub-districts (11), it was reported that each nurse saw between 24 and 55 patients per day. The statistics for MTCT coverage were not provided in some sub-districts. In those districts that supplied the statistics, the number of pregnant women seen ranged from 147 to 30 526; the number of women tested for HIV ranged from 1 to 8057; the number of women who tested HIV+ ranged from 7 to 1910; the number of women receiving NVP ranged from 5 to 701 across the sub-districts; the number of infants receiving breast milk substitutes ranged from 41 to 58032. Women were generally not followed up at 3,6 and 12 months.

Outcomes: Some sub-districts provided Indicators for TB. Other sub-districts did not have them readily available.

Localand provincial governments integration: Nine (9) sub-districts had a joint local government/provincial team and 10 had a joint reporting of information for sub-district.

NPO Partnerships

Participation: There were forums involving NPOs in the sub-districts. Further, there were structures for consulting with the community across all the sub-districts.

Referral and co-ordination: The majority of the sub-districts (11) had NPO databases developed by various people DTT, PTT, EU Co-ordinator, HIV/AIDS co-ordinator, DOH; however, most of these databases were not frequently updated. Further, sub-districts generally had had a referral system between NPOs and facilities in the sub-district (10).

Support: The majority of sub-districts (11) provided supplies (e.g. HBC kits) to NPOs

Recommendations

- NPO databases should be frequently updated
- Sub-districts health information systems should also keep MTCT coverage statistics.
- There is a need for follow up of women at 3, 6, and 12 months across the districts.
- The number of facilities that operate after hours within sub-districts should be increased.
- Sub-districts should keep information on TB indicators readily available in order to assess the outcomes of their services

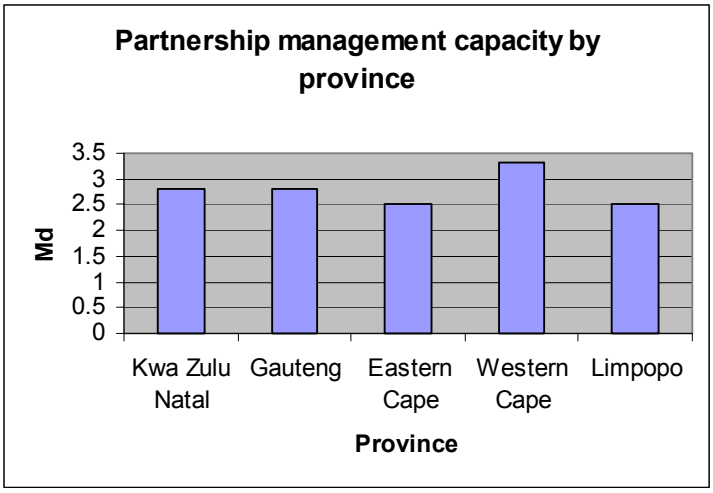
Appendix 2: PMCI

Table 70: Partnership management capacity by province (range 1 to 4, 4 the highest)

	Interviewee rated			Interviewer rated			Average
	N	Md	SD	N	Md	SD	Md
KwaZulu-Natal	23	2.8	.6	22	2.8	.4	2.8
Gauteng	16	2.9	.6	17	2.6	.3	2.8
Eastern Cape	7	2.6	.5	18	2.3	.4	2.5
Western Cape	14	3.4	.4	19	3.1	.5	3.3*
Limpopo	19	3.1	.4	28	1.9	.3	2.5
National#				4	3.0	.3	3.0
Total	79	3.0	.5	108	2.5	.7	2.8

##National was only done by interviewer rating (respondents did not fill in the interviewee rated version)
*significantly higher in the Western Cape

Figure 31: Partnership management capacity by province



Kwa Zulu Natal

1. Strategic planning	Interviewee rated	Interviewer rated	Average
District service and planning	3.0	4.0	3.5
NPO audit	3.0	3.0	3.0
Partnership policy	2.0	2.0	2.0
Partnership programme planning	1.0	2.0	1.5
2. Organisational arrangements			
Leadership	3.0	3.0	3.0
Allocation of roles and responsibilities	3.0	2.5	2.8
Delegation of authority	2.5	3.0	2.8
Coordination & integration	3.0	3.0	3.0
3. General programme management			
Information systems	2.5	2.0	2.3
Financial systems	4.0	2.0	3.0
Programme learning	2.0	2.0	2.0
Internal capacity development	2.5	2.0	2.3
4. Contract management			
Partner selection	2.0	2.0	2.0
Contract specification	3.0	3.0	3.0
Contract monitoring	3.0	3.0	3.0
Managing poor performance	3.0	3.0	3.0
5. Relationship management			
Attitude to NPOs	3.0	3.0	3.0

Communication with NPOs	3.0	3.0	3.0
Responsiveness	3.0	3.0	3.0
Provision of support	3.0	3.0	3.0
6. Organisational context			
Awareness and support for partnerships	3.0	3.0	3.0
Organisational culture	3.0	3.0	3.0
Legal and policy environment	4.0	4.0	4.0
Provincial – local relations	3.0	3.0	3.0

Gauteng

1. Strategic planning	Interviewee rated	Interviewer rated	Average
District service and planning	1.0	4.0	2.5
NPO audit	3.0	3.5	3.3
Partnership policy	3.0.	4.0	3.5
Partnership programme planning	2.0	3.0	2.5
2. Organisational arrangements			
Leadership	3.0	3.0	3.0
Allocation of roles and responsibilities	1.0	2.0	1.5
Delegation of authority	2.0	2.0	2.0
Coordination & integration	1.0	2.5	1.8
3. General programme management			
Information systems	3.0	3.0	3.0

Financial systems	2.0	2.0	2.0
Programme learning	1.0	2.0	1.5
Internal capacity development	2.0	2.5	2.3
4. Contract management			
Partner selection	3.0	3.0	3.0
Contract specification	3.0	3.0	3.0
Contract monitoring	2.0	2.0	2.0
Managing poor performance	2.0	2.0	2.0
5. Relationship management			
Attitude to NPOs	3.0	3.0	3.0
Communication with NPOs	3.0	3.0	3.0
Responsiveness	3.0	2.0	2.5
Provision of support	2.0	3.0	2.5
6. Organisational context			
Awareness and support for partnerships	4.0	3.0	3.5
Organisational culture	4.0	3.0	3.5
Legal and policy environment	4.0	4.0	4.0
Provincial – local relations	2.0	3.0	2.5

Eastern Cape

1. Strategic planning	Interviewee rated	Interviewer rated	Average
District service and planning	4.0	4.0	4.0
NPO audit	2.0	3.0	2.5

Partnership policy	2.0	3.0	2.5
Partnership programme planning	2.0	3.0	2.5
2. Organisational arrangements			
Leadership	3.0	4.0	3.5
Allocation of roles and responsibilities	3.0	3.0	3.0
Delegation of authority	2.0	4.0	3.0
Coordination & integration	2.0	3.0	2.5
3. General programme management			
Information systems	2.0	2.0	2.0
Financial systems	2.0	2.0	2.0
Programme learning	1.0	2.0	1.5
Internal capacity development	2.0	2.0	2.0
4. Contract management			
Partner selection	1.0	2.0	1.5
Contract specification	2.0	2.0	2.0
Contract monitoring	1.0	1.5	1.3
Managing poor performance	2.0	2.0	2.0
5. Relationship management			
Attitude to NPOs	2.0	3.0	2.5
Communication with NPOs	1.0	2.0	1.5
Responsiveness	2.0	2.0	2.0
Provision of support	4.0	2.0	3.0
6. Organisational			

context			
Awareness and support for partnerships	4.0	3.0	3.5
Organisational culture	2.0	2.0	2.0
Legal and policy environment	4.0	2.5	3.3
Provincial – local relations	2.5	3.0	2.8

Western Cape

1. Strategic planning	Interviewee rated	Interviewer rated	Average
District service and planning	2.5	4.0	3.3
NPO audit	3.0	4.0	3.5
Partnership policy	3.0	3.0	3.0
Partnership programme planning	2.5	3.0	2.8
2. Organisational arrangements			
Leadership	3.0	4.0	3.5
Allocation of roles and responsibilities	3.0	3.0	3.0
Delegation of authority	3.5	4.0	3.8
Coordination & integration	4.0	3.0	3.5
3. General programme management			
Information systems	3.0	3.0	3.0
Financial systems	4.0	3.0	3.5
Programme learning	3.0	2.5	2.8
Internal capacity development	3.0	2.0	2.5
4. Contract			

management			
Partner selection	3.0	3.0	3.0
Contract specification	3.0	4.0	3.5
Contract monitoring	3.0	3.0	3.0
Managing poor performance	4.0	2.0	3.0
5. Relationship management			
Attitude to NPOs	3.0	3.0	3.0
Communication with NPOs	3.0	3.0	3.0
Responsiveness	3.0	3.0	3.0
Provision of support	3.5	3.5	3.5
6. Organisational context			
Awareness and support for partnerships	3.0	3.0	3.0
Organisational culture	1.0	2.0	1.5
Legal and policy environment	4.0	3.0	3.5
Provincial – local relations	3.0	4.0	3.5

Limpopo

1. Strategic planning	Interviewee rated	Interviewer rated	Average
District service and planning	1.0	3.0	2.0
NPO audit	2.0	3.0	2.5
Partnership policy	2.0	3.0	2.5
Partnership programme planning	1.0	2.5	1.8
2. Organisational arrangements			
Leadership	2.0	4.0	3.0

Allocation of roles and responsibilities	1.0	3.0	2.0
Delegation of authority	1.0	4.0	2.5
Coordination & integration	2.0	3.0	2.5
3. General programme management			
Information systems	2.0	3.0	2.5
Financial systems	1.0	3.0	2.0
Programme learning	2.0	2.0	2.0
Internal capacity development	1.0	3.0	2.0
4. Contract management			
Partner selection	2.0	3.5	2.8
Contract specification	3.0	4.0	3.5
Contract monitoring	2.0	3.0	2.5
Managing poor performance	1.0	4.0	2.5
5. Relationship management			
Attitude to NPOs	3.0	3.0	3.0
Communication with NPOs	1.0	3.5	2.3
Responsiveness	3.0	3.0	3.0
Provision of support	2.0	4.0	3.0
6. Organisational context			
Awareness and support for partnerships	3.0	3.0	3.0
Organisational culture	2.0	2.5	2.3
Legal and policy	4.0	4.0	4.0

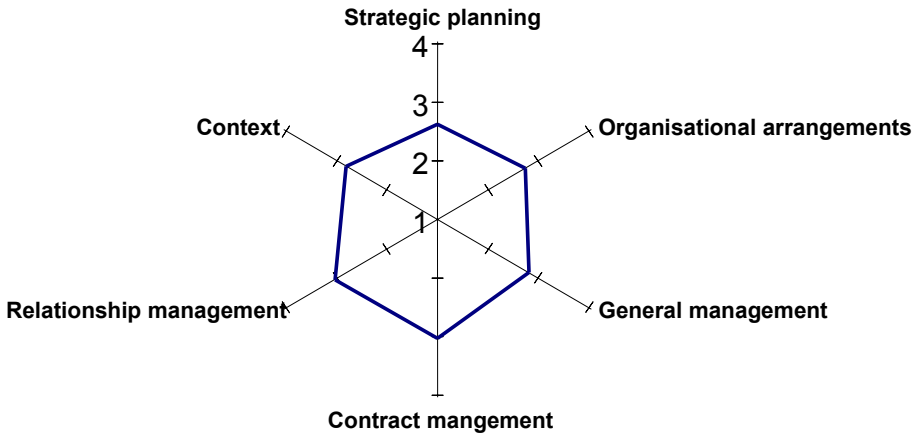
environment

Provincial – local relations	2.0	3.0	2.5

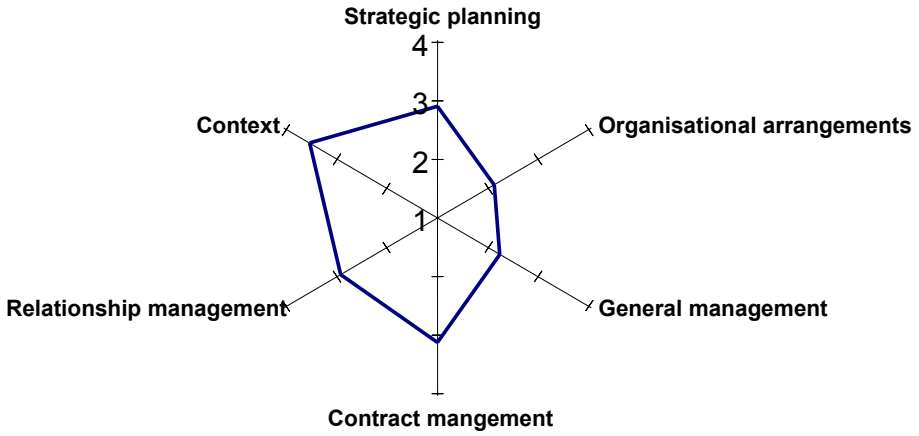
Table 71: Partnership management components by province

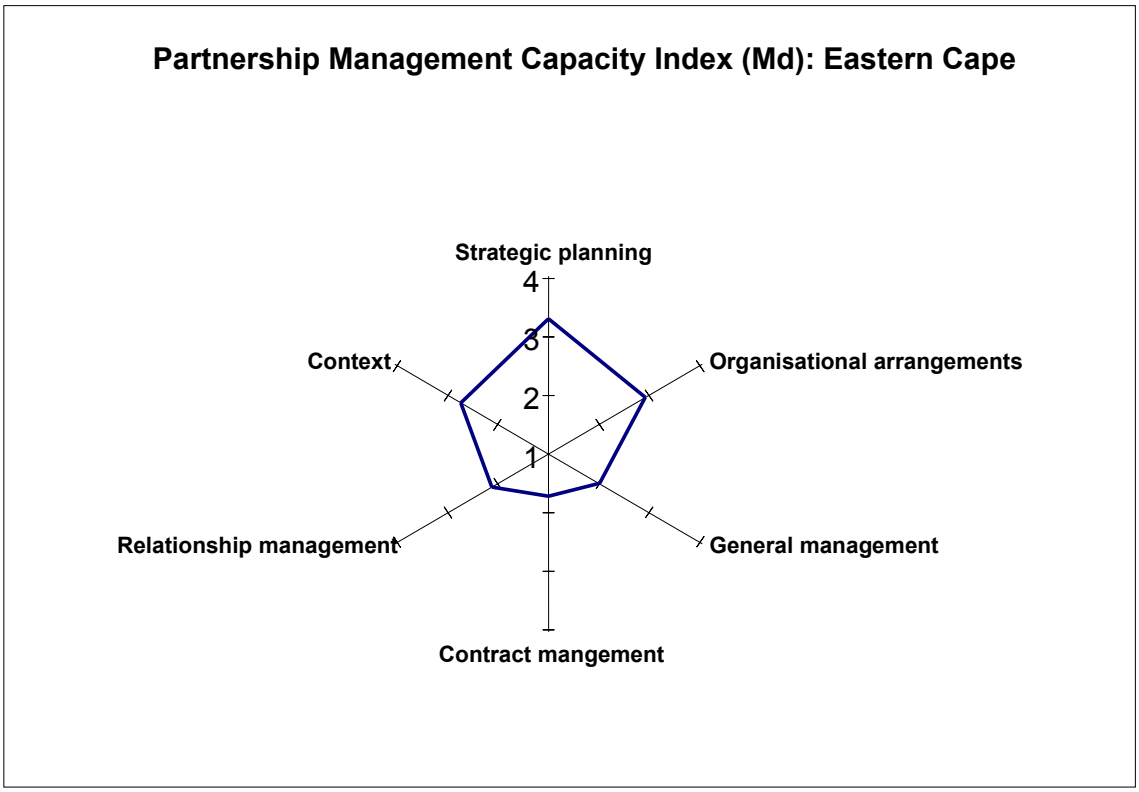
		Interviewee rated			Interviewer rated			Average
		N	Md	SD	N	Md	SD	Md
Strategic planning	KwaZulu-Natal	17	2.8	.7	16	2.3	.6	2.6
	Gauteng	14	3.5	.7	10	2.3	.5	2.9
	Eastern Cape	7	3.5	.7	17	3.0	.7	3.3
	Western Cape	7	2.8	1.0	19	2.8	.9	2.8
	Limpopo	14	3.1	.4	27	1.8	.4	2.5
Formal programme arrangements	KwaZulu-Natal	16	2.8	.8	13	2.5	.8	2.7
	Gauteng	13	2.3	.7	15	1.8	.8	2.1
	Eastern Cape	7	3.3	.2	17	2.5	.9	2.9
	Western Cape	9	3.5	.8	20	3.3	.9	3.4
	Limpopo	16	3.3	.7	26	1.4	.5	2.4
General programme management	KwaZulu-Natal	12	2.5	.7	11	3.0	.6	2.8
	Gauteng	9	2.5	.7	11	1.8	.4	2.2
	Eastern Cape	5	2.5	.6	15	1.5	.6	2.0
	Western Cape	10	3.0	.8	17	3.3	.9	3.1
	Limpopo	13	2.5	.6	27	1.5	.4	2.0
Contract management	KwaZulu-Natal	11	3.0	.6	12	3.0	.7	3.0
	Gauteng	8	2.8	.7	3	3.3	.1	3.1
	Eastern Cape	4	1.5	.9	14	1.8	.4	1.7
	Western Cape	8	3.8	.5	18	3.3	.8	3.6
	Limpopo	14	3.1	.7	27	1.8	.3	2.5
Relationship management	KwaZulu-Natal	14	3.0	.7	14	2.9	.7	3.0
	Gauteng	11	2.8	.8	8	3.0	.5	2.9
	Eastern Cape	6	2.1	.5	13	2.0	.5	2.1
	Western Cape	11	3.5	.8	20	3.1	.5	3.3
	Limpopo	18	3.0	.7	27	2.3	.3	2.7
Organisational context	KwaZulu-Natal	11	2.8	.7	10	2.8	.8	2.8
	Gauteng	10	3.5	.6	9	3.5	.3	3.5
	Eastern Cape	6	2.4	.4	17	3.0	.5	2.7
	Western Cape	7	3.5	.5	17	3.0	.5	3.3
	Limpopo	16	3.3	.8	26	2.3	.5	2.8

Partnership Management Capacity Index (Median): KwaZulu-Natal

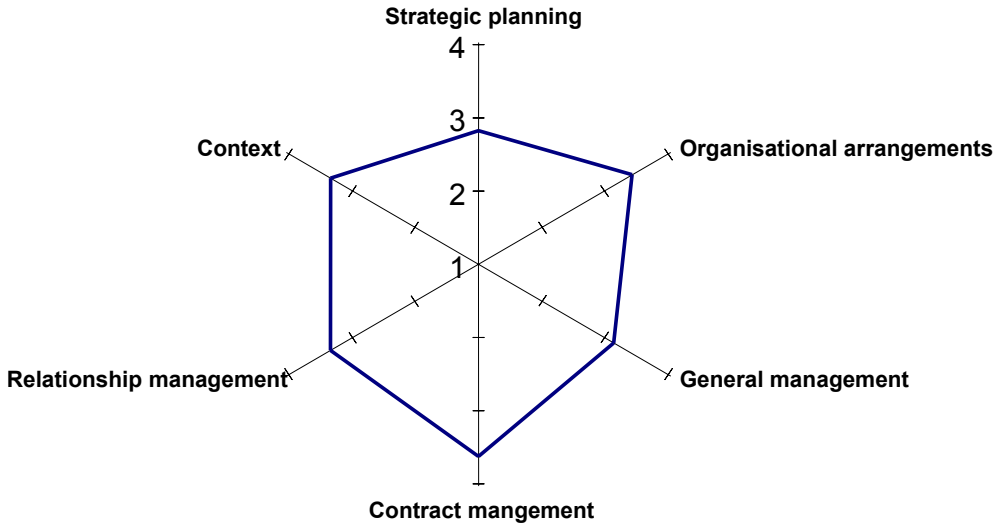


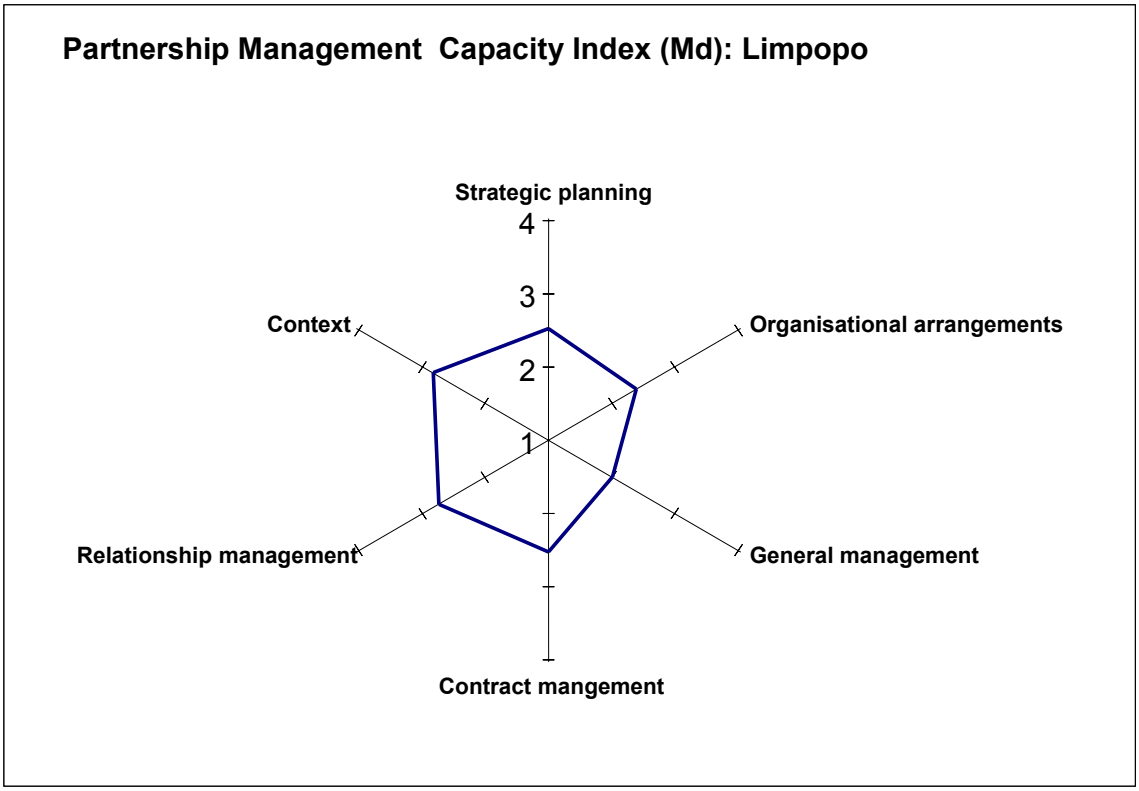
Partnership Management Capacity Index (Md): Gauteng




Partnership Management Capacity Index (Md): Eastern Cape
Strategic planning
4
3
2
1
Organisational arrangements
General management
Contract mangement
Relationship management
Context

Partnership Management Capacity Index (Md): Western Cape




Partnership Management Capacity Index (Md): Limpopo
Strategic planning
4
3
2
1
Organisational arrangements
General management
Contract mangement
Relationship management
Context

Appendix 3 Assessment of NPO access, capacity and quality

Provincial level analyses

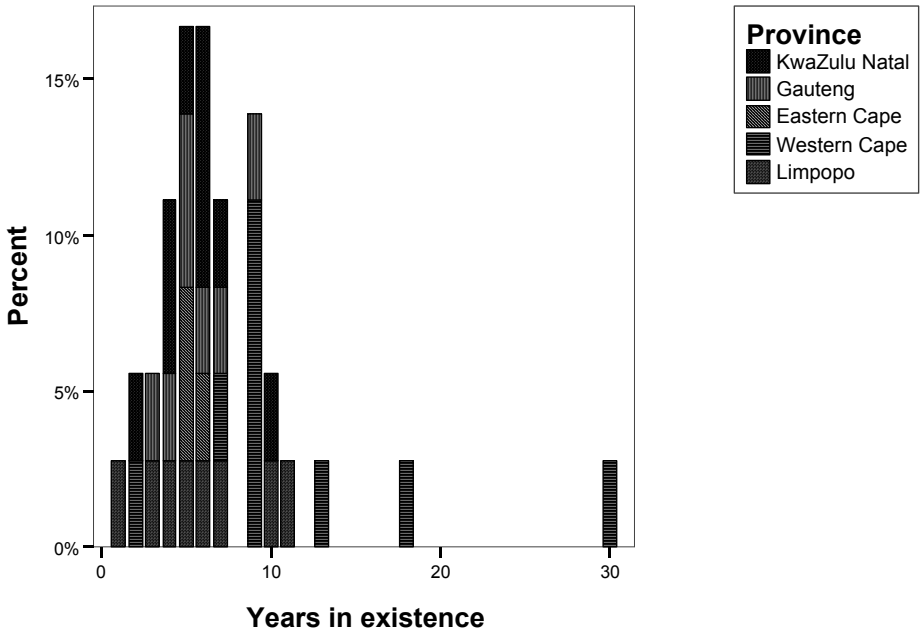
Sample

Thirty seven questionnaires were completed, 9 for KwaZulu-Natal, 7 in Gauteng, 3 in the Eastern Cape, 9 in the Western Cape and 9 in Limpopo. The majority of the interviewees were designated as Managers (17) or Co-ordinators (12), with the rest of the sample comprising Chairpersons or Administrative or Financial officers.

General assessment of the NPOs

The NPOs in the Western Cape were generally older than those in KwaZulu-Natal and Gauteng (**Error! Reference source not found.**31).

Figure 32: Number of years the NPOs have been functioning



Most NPOs hold weekly staff meetings and the situation is similar across the five provinces (Table *72*72).

Table 72 For those NPOs that hold staff meetings, the frequency of staff meetings

		Province					Total
		KwaZulu-Natal	Gauteng	Eastern Cape	Western Cape	Limpopo	
Daily	Count			1	1		2
	% within Province			33.3%	11.1%		6.7%
Weekly	Count	6	2	2	4	4	18
	% within Province	85.7%	40.0%	66.7%	44.4%	66.7%	60.0%
Monthly	Count	1	3		4	2	10
	% within Province	14.3%	60.0%		44.4%	33.3%	33.3%
Total	Count	7	5	3	9	6	30

The range of activities, according to formal mission statements, is summarised in **Error! Reference source not found.**73. Changes in activities over the last three years are shown in Table *74*74 and the description of the actual services delivered is shown in Table *75*75.

Table 73: Primary mission of the NPOs

			Province					Total
			KwaZulu-Natal	Gauteng	Eastern Cape	Western Cape	Limpopo	
Mission	Care/treatment	Count	2	2	3	3	4	14
		% within Province	22.2%	28.6%	100.0%	33.3%	44.4%	37.8%
	Home Based Care	Count	2	1		4	2	9
		% within Province	22.2%	14.3%		44.4%	22.2%	24.3%
	Advocacy	Count	1	2		1	1	5
		% within Province	11.1%	28.6%		11.1%	11.1%	13.5%
	Information	Count	1	1			1	3
		% within Province	11.1%	14.3%			11.1%	8.1%
	Prevention	Count	2			1		3
		% within Province	22.2%			11.1%		8.1%
	Counselling	Count		1				1
		% within Province		14.3%				2.7%
	Other	Count	1				1	2

	% within Province	11.1%				11.1%	5.4%
Total	Count	9	7	3	9	9	37

Table 74 Reports of major changes over the past 3 years

			Province					
			KwaZulu-Natal	Gauteng	Eastern Cape	Western Cape	Limpopo	Total
Major changes in last 3 years	Expanded service	Count	5	2	2	4		13
		% within Province	55.6%	28.6%	66.7%	44.4%		35.1%
	More staff	Count	2	1		4	1	8
		% within Province	22.2%	14.3%		44.4%	11.1%	21.6%
	Networking	Count		2		1		3
		% within Province		28.6%		11.1%		8.1%
	More equipment	Count					3	3
		% within Province					33.3%	8.1%
	Less stigma	Count		1			1	2
		% within Province		14.3%			11.1%	5.4%
	Health improving	Count			1			1
		% within Province			33.3%			2.7%
	Loss of staff	Count		1				1
		% within Province		14.3%				2.7%
	Incentives	Count					1	1
		% within Province					11.1%	2.7%
	HIV testing	Count	1					1
		% within Province	11.1%					2.7%
	None	Count					1	1
		% within Province					11.1%	2.7%
	Other	Count	1				2	3
		% within Province	11.1%				22.2%	8.1%
Total		Count	9	7	3	9	9	37

Table 75 Types of activities carried out by the NPOs

		Province					
		KwaZulu-Natal	Gauteng	Eastern Cape	Western Cape	Limpopo	Total
Activities	HIV home-based care[a]	9	6	3	7	7	32
	Nutrition	8	6	3	4	8	29
	TB	6	7	3	6	7	29
	HIV counselling	8	7	3	5	5	28
	Poverty alleviation	6	5	3	5	8	27
	HIV prevention	5	7	3	5	7	27
	Disability	4	4	3	4	6	21
	PLWHA support group	6	5	3	4	2	20
	Mental health	1	4	0	2	5	12
	Reproductive health	1	4	1	2	3	11
	Other PHC	1	1	3	4	4	13
Total		9	7	3	9	9	37

[a] Home based care specifically for PLWHA

The majority of NPOs are involved in networks of various kinds and just over half offer training to other NPOs (Table *76*76). Networking appeared to be a feature of the majority of NPOs with the exception of those in KwaZulu-Natal.

Table 76 Services to other NPOs

		Province					
		KwaZulu-Natal	Gauteng	Eastern Cape	Western Cape	Limpopo	Total
Activities	Networking	1	7	3	9	7	27
	Training	2	4	2	5	6	19
	Other kinds of support	0	6	2	3	3	14
Total		9	7	3	9	9	37

Experiences of the partnership

A variety of issues were raised regarding the positive and negative aspects of the partnership between NPOs and government and these appear to be fairly evenly spread between the provinces (Table 7777 and Table 7878).

Table 77 Good aspects of the partnership with government

		Province					Total
		KwaZulu-Natal	Gauteng	Eastern Cape	Western Cape	Limpopo	
Good aspects of partnership	Funding	3	2	0	3	2	10
	Communication	0	1	0	3	2	6
	Supplies	2	0	0	2	1	5
	Training	1	1	1	0	2	5
	Improved services	1	0	0	1	2	4
	None	2	0	0	0	0	2
	Other	0	1	1	0	0	2
	Too early to tell	0	2	0	0	0	2
	Cooperation	0	0	1	0	0	1
Total		9	7	3	9	9	37

Table 78 Problems experienced in the partnership with government

		Province					Total
		KwaZulu-Natal	Gauteng	Eastern Cape	Western Cape	Limpopo	
Problems with govt	None	8	2	1	2	5	18
	Late payments	0	3	1	3	1	8
	Communication	0	1	0	2	1	4
	Supplies	1	0	0	1	0	2
	Complex system	0	0	0	1	1	2
	Delays in implementation	0	1	1	0	0	2
	Other	0	0	0	0	1	1
Total		9	7	3	9	9	37

Organisational culture and attitudes to partnership

A self-administered questionnaire was used to assess managers' attitudes to HIV, AIDS and poverty; the prevailing organisational culture; and the relationship between NPOs and government. Questions took the form of statements with which the respondent was asked to indicate their level of agreement or disagreement, ranging from 'strongly agree' to 'strongly disagree', using a five point scale. Similar questionnaires were used for both NPO managers and District Managers.

Whilst some analysis by province is provided in the main part of the report (Section 3.3), additional province-specific information is provided below. It should be noted that the District Managers' responses at province level effectively represent the opinions of individuals, as a result of the small sample size and missing data.

Figure 33: General attitudes to HIV, AIDS and poverty - NPO managers' views by province

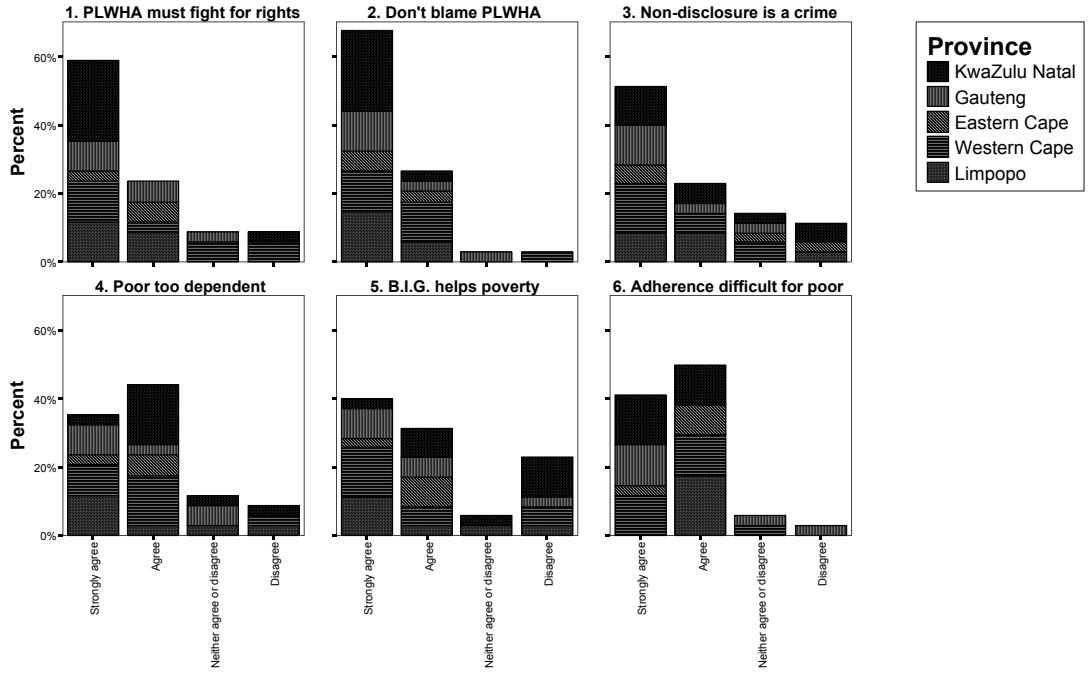
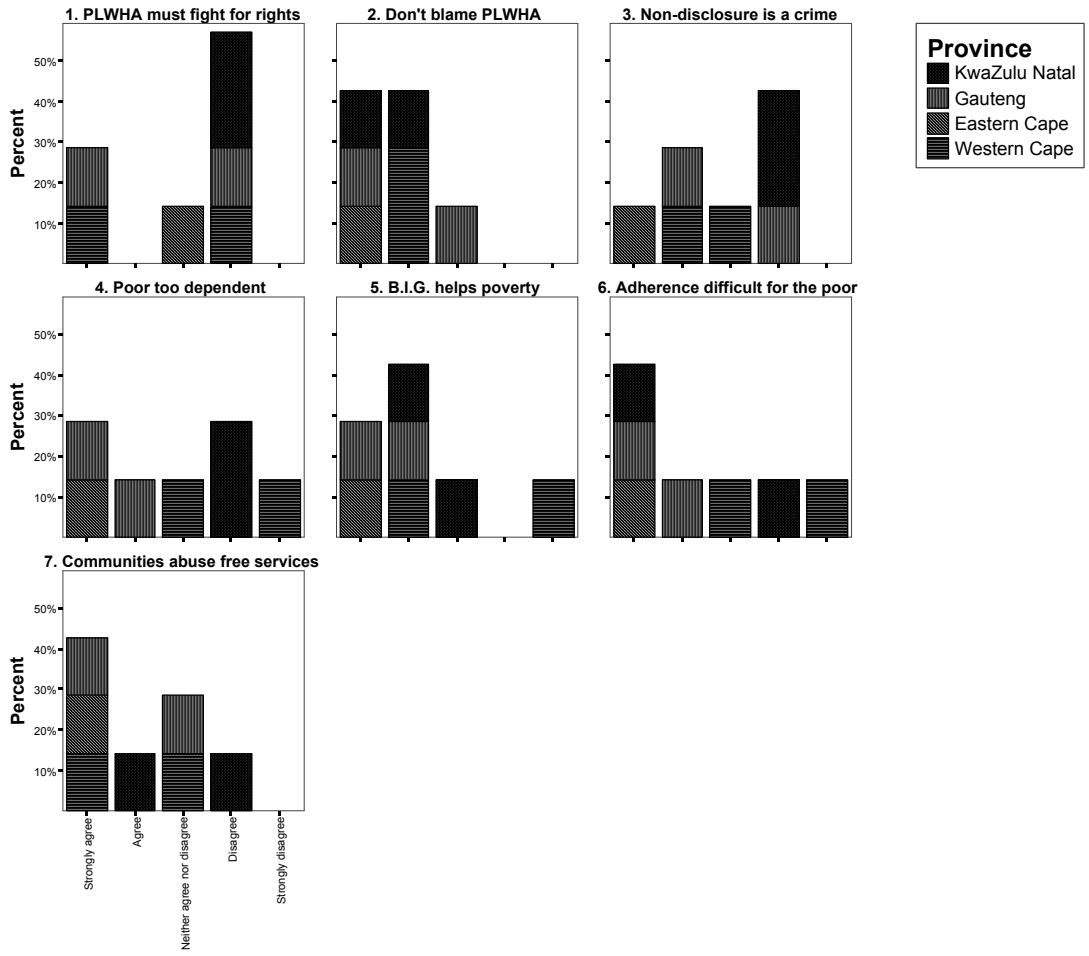


Figure 34: General attidutes to HIV, AIDS and poverty - District managers' views by province



Appendix 4 : NPO Assessment per Province

KwaZulu-Natal

Table 79: Indicator of Overall Community Involvement (KZN)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Stakeholder consultation	9	66.7	11.1	11.1	11.1	0.0	0.67	1.12
Active local council involvement	9	0.0	11.1	33.3	44.4	11.1	2.56	0.88
Responsiveness to input	9	55.6	11.1	0.0	33.3	0.0	1.11	1.45
Mechanisms in place to collaborate	9	0.0	0.0	0.0	44.4	55.6	3.56	0.53

Table 80: NPO Collaboration with Other NPOs and Health Institutions (KZN)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
With Other NPOs								
Mechanisms in place to collaborate	9	0.0	0.0	0.0	44.4	55.6	3.56	0.53
Duplication avoided	9	11.1	0.0	11.1	11.1	66.7	3.22	1.39
Equitable sharing	9	66.7	0.0	11.1	22.2	0.0	0.89	1.36
Services offered	9	11.1	0.0	11.1	55.6	22.2	2.78	1.20
With hospitals & clinics								
Appropriate & accessible health care	8	12.5	0.0	12.5	62.5	12.5	2.63	1.19
Arrangements in place	9	0.0	11.1	33.3	33.3	22.2	2.67	1.00
Recruitment of clients	9	0.0	0.0	0.0	33.3	66.7	3.67	0.50

Table 81: NPO Training (KZN)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Home carer/health training	9	11.1	11.1	11.1	44.4	22.2	2.56	1.33
Prog suitable to achieve required skill levels	9	11.1	11.1	0.0	44.4	33.3	2.78	1.39
Training plan for all staff	9	22.2	33.3	22.2	0.0	22.2	1.67	1.50
Trainer Skills	9	66.7	11.1	0.0	0.0	22.2	1.00	1.73
Links to other training	9	0.0	11.1	11.1	55.6	22.2	2.89	0.93
Ongoing supervision	9	11.1	0.0	11.1	66.7	11.1	2.67	1.12
Continuing education	9	11.1	33.3	33.3	11.1	11.1	1.78	1.20
Management training	9	11.1	66.7	11.1	11.1	0.0	1.22	0.83

Table 82: Services Offered by NPO and Carers (KZN)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Structure of home visits system	9	11.1	0.0	22.2	11.1	55.6	3.00	1.41
Patient register kept & updated	9	11.1	0.0	11.1	33.3	44.4	3.00	1.32
Support groups/health promotion	8	12.5	0.0	12.5	0.0	75.0	3.25	1.49
Family support	9	0.0	22.2	0.0	44.4	33.3	2.89	1.17
Orphan Care	9	0.0	22.2	22.2	22.2	33.3	2.67	1.22

Table 83: NPO Planning & Monitoring (KZN)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Strategic Plan	9	66.7	11.1	0.0	11.1	11.1	0.89	1.54
Monitoring	5	40.0	0.0	20.0	0.0	40.0	2.00	2.00
Annual reports	9	11.1	22.2	11.1	22.2	33.3	2.44	1.51
Participatory Planning	9	11.1	22.2	11.1	44.4	11.1	2.22	1.30

Table 84: Human Resource Management by NPO (KZN)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Recruitment and selection	9	0.0	0.0	0.0	33.3	66.7	3.67	0.50
Conditions of services / stipend	8	0.0	12.5	0.0	12.5	75.0	3.50	1.07
Job Description	7	14.3	0.0	0.0	28.6	57.1	3.14	1.46
Legislative Compliance	8	50.0	25.0	0.0	12.5	12.5	1.13	1.55
Staff Morale and Support	9	0.0	0.0	0.0	44.4	55.6	3.56	0.53
Monitoring and Review	9	0.0	11.1	0.0	11.1	77.8	3.56	1.01
Staff turnover and Absenteeism	9	11.1	0.0	11.1	22.2	55.6	3.11	1.36
HBC/health promoters views	7	0.0	0.0	14.3	28.6	57.1	3.43	0.79

Table 85: NPO Supply Systems and Logistical Operations (KZN)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Tracking System	9	22.2	33.3	11.1	11.1	22.2	1.78	1.56
Ordering / donations	9	11.1	22.2	11.1	11.1	44.4	2.56	1.59

Storage	9	0.0	22.2	0.0	22.2	55.6	3.11	1.27
Security	9	11.1	0.0	0.0	11.1	77.8	3.44	1.33
Transport	9	0.0	0.0	0.0	0.0	100.0	4.00	0.00
Electronic communication	9	11.1	0.0	11.1	33.3	44.4	3.00	1.32
Client record files	8	0.0	25.0	0.0	62.5	12.5	2.63	1.06

Gauteng

Table 86: Indicator of Overall Community Involvement (GT)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Stakeholder consultation	6	0.0	33.3	33.3	16.7	16.7	2.17	1.17
Active local council involvement	6	0.0	33.3	50.0	0.0	16.7	2.00	1.10
Responsiveness to input	6	0.0	0.0	50.0	16.7	33.3	2.83	0.98
Mechanisms in place to collaborate	6	0.0	0.0	16.7	50.0	33.3	3.17	0.75

Table 87: NPO Collaboration with Other NPOs and Health Institutions (GT)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
With Other NPOs								
Mechanisms in place to collaborate	5	0.0	0.0	20.0	60.0	20.0	3.00	0.71
Duplication avoided	4	0.0	0.0	0.0	50.0	50.0	3.50	0.58
Equitable sharing	6	16.7	0.0	16.7	33.3	33.3	2.67	1.51
Services offered	6	0.0	16.7	16.7	33.3	33.3	2.83	1.17
With hospitals & clinics								
Appropriate & accessible health care	6	0.0	0.0	0.0	33.3	66.7	3.67	0.52
Arrangements in place	5	0.0	0.0	0.0	40.0	60.0	3.60	0.55
Recruitment of clients	6	0.0	0.0	0.0	33.3	66.7	3.67	0.52

Table 88: NPO Training (GT)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Home carer/health training	5	0.0	0.0	20.0	60.0	20.0	3.00	0.71
Prog suitable to achieve required skill levels	5	0.0	0.0	60.0	20.0	20.0	2.60	0.89
Training plan for all staff	6	50.0	0.0	33.3	16.7	0.0	1.17	1.33
Trainer Skills	6	0.0	33.3	0.0	33.3	33.3	2.67	1.37
Links to other training	5	0.0	0.0	20.0	20.0	60.0	3.40	0.89
Ongoing supervision	6	0.0	0.0	16.7	50.0	33.3	3.17	0.75
Continuing education	6	0.0	16.7	33.3	33.3	16.7	2.50	1.05
Management training	6	0.0	0.0	66.7	33.3	0.0	2.33	0.52

Table 89: Services Offered by NPO and Carers (GT)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Structure of home visits system	5	0.0	0.0	0.0	60.0	40.0	3.40	0.55
Patient register kept & updated	5	0.0	0.0	0.0	20.0	80.0	3.80	0.45
Support groups/health promotion	3	0.0	0.0	0.0	33.3	66.7	3.67	0.58
Family support	5	0.0	0.0	20.0	60.0	20.0	3.00	0.71
Orphan Care	5	0.0	20.0	20.0	40.0	20.0	2.60	1.14

Table 90: NPO Planning & Monitoring (GT)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Strategic Plan	6	33.3	0.0	16.7	16.7	33.3	2.17	1.83
Monitoring	6	0.0	33.3	0.0	33.3	33.3	2.67	1.37
Annual reports	6	0.0	16.7	0.0	16.7	66.7	3.33	1.21
Participatory Planning	6	16.7	0.0	16.7	33.3	33.3	2.67	1.51

Table 91: Human Resource Management by NPO (GT)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Recruitment and selection	6	0.0	0.0	16.7	50.0	33.3	3.17	0.75
Conditions of services / stipend	6	33.3	0.0	0.0	16.7	50.0	2.50	1.97
Job Description	6	0.0	0.0	16.7	50.0	33.3	3.17	0.75
Legislative Compliance	6	33.3	0.0	16.7	50.0	0.0	1.83	1.47
Staff Morale and Support	6	0.0	0.0	33.3	33.3	33.3	3.00	0.89
Monitoring and Review	6	0.0	0.0	16.7	66.7	16.7	3.00	0.63
Staff turnover and Absenteeism	6	0.0	0.0	0.0	83.3	16.7	3.17	0.41
HBC/health promoters views	3	0.0	0.0	0.0	66.7	33.3	3.33	0.58

Table 92: NPO Supply Systems and Logistical Operations (GT)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Tracking System	5	20.0	0.0	0.0	20.0	60.0	3.00	1.73
Ordering / donations	6	16.7	0.0	0.0	50.0	33.3	2.83	1.47
Storage	6	0.0	0.0	16.7	33.3	50.0	3.33	0.82
Security	6	16.7	16.7	0.0	33.3	33.3	2.50	1.64

Transport	6	16.7	16.7	16.7	33.3	16.7	2.17	1.47
Electronic communication	6	33.3	16.7	16.7	16.7	16.7	1.67	1.63
Client record files	5	0.0	0.0	0.0	40.0	60.0	3.60	0.55

Eastern Cape

Table 93: Indicator of Overall Community Involvement (EC)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Stakeholder consultation	4	25.0	0.0	25.0	50.0	0.0	2.00	1.41
Active local council involvement	4	0.0	0.0	0.0	25.0	75.0	3.75	0.50
Responsiveness to input	3	33.3	0.0	0.0	33.3	33.3	2.33	2.08
Mechanisms in place to collaborate	4	0.0	0.0	25.0	0.0	75.0	3.50	1.00

Table 94: NPO Collaboration with Other NPOs and Health Institutions (EC)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
With Other NPOs								
Mechanisms in place to collaborate	4	0.0	0.0	25.0	25.0	50.0	3.25	0.96
Duplication avoided	4	0.0	0.0	25.0	25.0	50.0	3.25	0.96
Equitable sharing	2	0.0	0.0	0.0	0.0	100.0	4.00	0.00
Services offered	4	0.0	25.0	25.0	50.0	0.0	2.25	0.96
With hospitals & clinics								
Appropriate & accessible health care	3	0.0	0.0	33.3	33.3	33.3	3.00	1.00
Arrangements in place	3	33.3	0.0	0.0	33.3	33.3	2.33	2.08
Recruitment of clients	3	0.0	0.0	0.0	0.0	100.0	4.00	0.00

Table 95: NPO Training (EC)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Home carer/health training	4	0.0	0.0	50.0	25.0	25.0	2.75	0.96
Prog suitable to achieve required skill levels	4	0.0	25.0	0.0	50.0	25.0	2.75	1.26
Training plan for all staff	4	50.0	25.0	0.0	0.0	25.0	1.25	1.89
Trainer Skills	3	33.3	0.0	0.0	0.0	66.7	2.67	2.31
Links to other training	3	0.0	0.0	33.3	33.3	33.3	3.00	1.00
Ongoing supervision	3	0.0	0.0	0.0	66.7	33.3	3.33	0.58
Continuing education	3	0.0	33.3	0.0	33.3	33.3	2.67	1.53
Management training	4	25.0	25.0	25.0	25.0	0.0	1.50	1.29

Table 96: Services Offered by NPO and Carers (EC)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Structure of home visits system	3	0.0	0.0	0.0	33.3	66.7	3.67	0.58
Patient register kept & updated	3	0.0	0.0	0.0	0.0	100.0	4.00	0.00
Support groups/health promotion	4	0.0	0.0	25.0	25.0	50.0	3.25	0.96
Family support	4	0.0	0.0	0.0	25.0	75.0	3.75	0.50
Orphan Care	4	25.0	0.0	50.0	25.0	0.0	1.75	1.26

Table 97: NPO Planning & Monitoring (EC)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Strategic Plan	4	0.0	25.0	0.0	50.0	25.0	2.75	1.26
Monitoring	4	0.0	0.0	25.0	0.0	75.0	3.50	1.00
Annual reports	4	0.0	0.0	25.0	0.0	75.0	3.50	1.00
Participatory Planning	4	0.0	0.0	0.0	0.0	100.0	4.00	0.00

Table 98: Human Resource Management by NPO (EC)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Recruitment and selection	4	0.0	0.0	0.0	25.0	75.0	3.75	0.50
Conditions of services / stipend	4	25.0	25.0	0.0	25.0	25.0	2.00	1.83
Job Description	4	0.0	0.0	0.0	25.0	75.0	3.75	0.50
Legislative Compliance	4	25.0	25.0	0.0	50.0	0.0	1.75	1.50
Staff Morale and Support	4	0.0	25.0	0.0	50.0	25.0	2.75	1.26
Monitoring and Review	4	0.0	0.0	0.0	75.0	25.0	3.25	0.50
Staff turnover and Absenteeism	4	0.0	25.0	25.0	0.0	50.0	2.75	1.50
HBC/health promoters views	3	0.0	0.0	33.3	0.0	66.7	3.33	1.15

Table 99: NPO Supply Systems and Logistical Operations (EC)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Tracking System	4	25.0	25.0	0.0	25.0	25.0	2.00	1.83
Ordering / donations	4	0.0	0.0	25.0	0.0	75.0	3.50	1.00
Storage	4	50.0	0.0	0.0	0.0	50.0	2.00	2.31
Security	4	25.0	25.0	0.0	0.0	50.0	2.25	2.06
Transport	4	25.0	0.0	0.0	25.0	50.0	2.75	1.89
Electronic communication	4	25.0	25.0	25.0	0.0	25.0	1.75	1.71
Client record files	4	0.0	0.0	0.0	25.0	75.0	3.75	0.50

Western Cape

Table 100: Indicator of Overall Community Involvement (WC)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Stakeholder consultation	9	11.1	22.2	11.1	44.4	11.1	2.22	1.30
Active local council involvement	9	22.2	11.1	0.0	33.3	33.3	2.44	1.67
Responsiveness to input	9	11.1	11.1	11.1	33.3	33.3	2.67	1.41
Mechanisms in place to collaborate	9	0.0	0.0	11.1	55.6	33.3	3.22	0.67

Table 101: NPO Collaboration with Other NPOs and Health Institutions (WC)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
With Other NPOs								
Mechanisms in place to collaborate	9	0.0	11.1	0.0	88.9	0.0	2.78	0.67
Duplication avoided	9	22.2	11.1	0.0	55.6	11.1	2.22	1.48
Equitable sharing	8	12.5	0.0	0.0	75.0	12.5	2.75	1.16
Services offered	8	0.0	0.0	12.5	62.5	25.0	3.13	0.64
With hospitals & clinics								
Appropriate & accessible health care	9	0.0	0.0	11.1	44.4	44.4	3.33	0.71
Arrangements in place	9	0.0	11.1	11.1	44.4	33.3	3.00	1.00
Recruitment of clients	9	0.0	0.0	0.0	66.7	33.3	3.33	0.50

Table 102: NPO Training (WC)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Home carer/health training	9	33.3	11.1	11.1	22.2	22.2	1.89	1.69
Prog suitable to achieve required skill levels	9	11.1	22.2	22.2	33.3	11.1	2.11	1.27
Training plan for all staff	9	33.3	22.2	22.2	22.2	0.0	1.33	1.22
Trainer Skills	9	22.2	22.2	0.0	22.2	33.3	2.22	1.72
Links to other training	9	22.2	11.1	0.0	66.7	0.0	2.11	1.36
Ongoing supervision	9	11.1	0.0	0.0	55.6	33.3	3.00	1.22
Continuing education	9	11.1	22.2	0.0	22.2	44.4	2.67	1.58
Management training	9	22.2	0.0	11.1	44.4	22.2	2.44	1.51

Table 103: Services Offered by NPO and Carers (WC)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Structure of home visits system	8	12.5	0.0	12.5	62.5	12.5	2.63	1.19
Patient register kept & updated	9	0.0	0.0	0.0	55.6	44.4	3.44	0.53
Support groups/health promotion	9	11.1	0.0	22.2	33.3	33.3	2.78	1.30
Family support	9	22.2	0.0	11.1	33.3	33.3	2.56	1.59
Orphan Care	9	88.9	0.0	0.0	11.1	0.0	0.33	1.00

Table 104: NPO Planning & Monitoring (WC)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Strategic Plan	9	44.4	11.1	0.0	33.3	11.1	1.56	1.67
Monitoring	9	11.1	0.0	11.1	44.4	33.3	2.89	1.27
Annual reports	9	11.1	11.1	0.0	55.6	22.2	2.67	1.32
Participatory Planning	9	11.1	0.0	11.1	66.7	11.1	2.67	1.12

Table 105: Human Resource Management by NPO (WC)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Recruitment and selection	9	0.0	0.0	22.2	55.6	22.2	3.00	0.71
Conditions of services / stipend	9	0.0	0.0	22.2	66.7	11.1	2.89	0.60
Job Description	8	0.0	0.0	25.0	50.0	25.0	3.00	0.76
Legislative Compliance	9	0.0	11.1	22.2	55.6	11.1	2.67	0.87
Staff Morale and Support	8	0.0	25.0	12.5	37.5	25.0	2.63	1.19
Monitoring and Review	7	0.0	14.3	14.3	57.1	14.3	2.71	0.95
Staff turnover and Absenteeism	6	16.7	16.7	0.0	66.7	0.0	2.17	1.33
HBC/health promoters views	4	25.0	0.0	25.0	25.0	25.0	2.25	1.71

Table 106: NPO Supply Systems and Logistical Operations (WC)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Tracking System	9	0.0	0.0	22.2	66.7	11.1	2.89	0.60
Ordering / donations	8	12.5	12.5	0.0	50.0	25.0	2.63	1.41
Storage	9	11.1	11.1	11.1	44.4	22.2	2.56	1.33
Security	9	22.2	0.0	22.2	44.4	11.1	2.22	1.39
Transport	9	11.1	11.1	0.0	66.7	11.1	2.56	1.24
Electronic communication	9	11.1	0.0	0.0	33.3	55.6	3.22	1.30
Client record files	8	0.0	0.0	25.0	50.0	25.0	3.00	0.76

Limpopo

Table 107: Indicator of Overall Community Involvement (LP)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Stakeholder consultation	9	44.4	22.2	11.1	11.1	11.1	1.22	1.48
Active local council involvement	9	33.3	33.3	0.0	22.2	11.1	1.44	1.51
Responsiveness to input	9	55.6	0.0	0.0	22.2	22.2	1.56	1.88
Mechanisms in place to collaborate	9	11.1	22.2	11.1	0.0	55.6	2.67	1.66

Table 108: NPO Collaboration with Other NPOs and Health Institutions (LP)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
With Other NPOs								
Mechanisms in place to collaborate	7	14.3	14.3	0.0	0.0	71.4	3.00	1.73
Duplication avoided	7	14.3	14.3	0.0	14.3	57.1	2.86	1.68
Equitable sharing	2	0.0	0.0	0.0	0.0	100.0	4.00	0.00
Services offered	8	0.0	0.0	12.5	12.5	75.0	3.63	0.74
With hospitals & clinics								
Appropriate & accessible health care	9	11.1	22.2	0.0	0.0	66.7	2.89	1.69
Arrangements in place	9	33.3	0.0	0.0	11.1	55.6	2.56	1.94
Recruitment of clients	9	44.4	22.2	0.0	0.0	33.3	1.56	1.88

Table 109: NPO Training (LP)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Home carer/health training	9	55.6	0.0	11.1	11.1	22.2	1.44	1.81
Prog suitable to achieve required skill levels	8	50.0	25.0	0.0	12.5	12.5	1.13	1.55
Training plan for all staff	9	77.8	0.0	0.0	0.0	22.2	0.89	1.76
Trainer Skills	6	66.7	0.0	0.0	0.0	33.3	1.33	2.07
Links to other training	8	75.0	0.0	0.0	0.0	25.0	1.00	1.85
Ongoing supervision	8	25.0	12.5	37.5	12.5	12.5	1.75	1.39
Continuing education	9	77.8	0.0	11.1	11.1	0.0	0.56	1.13
Management training	9	11.1	22.2	11.1	22.2	33.3	2.44	1.51

Table 110: Services Offered by NPO and Carers (LP)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Structure of home visits system	9	11.11	11.11	0.00	33.33	44.44	2.89	1.45
Patient register kept & updated	9	66.67	11.11	11.11	0.00	11.11	0.78	1.39
Support groups/health promotion	9	33.33	0.00	22.22	22.22	22.22	2.00	1.66
Family support	9	22.22	0.00	11.11	55.56	11.11	2.33	1.41
Orphan Care	9	11.11	0.00	22.22	22.22	44.44	2.89	1.36

Table 111: NPO Planning & Monitoring (LP)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Strategic Plan	8	62.5	12.5	0.0	0.0	25.0	1.13	1.81
Monitoring	8	12.5	50.0	0.0	12.5	25.0	1.88	1.55
Annual reports	8	12.5	12.5	12.5	37.5	25.0	2.50	1.41
Participatory Planning	8	62.5	12.5	0.0	0.0	25.0	1.13	1.81

Table 112: Human Resource Management by NPO (LP)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Recruitment and selection	9	55.6	0.0	0.0	22.2	22.2	1.56	1.88
Conditions of services / stipend	9	33.3	22.2	11.1	0.0	33.3	1.78	1.79
Job Description	9	66.7	0.0	0.0	0.0	33.3	1.33	2.00
Legislative Compliance	9	22.2	0.0	11.1	0.0	66.7	2.89	1.76
Staff Morale and Support	9	44.4	0.0	0.0	0.0	55.6	2.22	2.11
Monitoring and Review	9	44.4	11.1	22.2	0.0	22.2	1.44	1.67
Staff turnover and Absenteeism	9	0.0	0.0	0.0	0.0	100.0	4.00	0.00
HBC/health promoters views	8	0.0	0.0	0.0	12.5	87.5	3.88	0.35

Table 113: NPO Supply Systems and Logistical Operations (LP)

	n	Not in place yet (%)	Still setting up (%)	Started (%)	Running adequately (%)	Running excellently (%)	M	SD
Tracking System	9	22.2	11.1	0.0	22.2	44.4	2.56	1.74
Ordering / donations	9	11.1	0.0	22.2	11.1	55.6	3.00	1.41
Storage	9	0.0	0.0	0.0	11.1	88.9	3.89	0.33
Security	9	11.1	0.0	0.0	22.2	66.7	3.33	1.32
Transport	9	0.0	0.0	0.0	22.2	77.8	3.78	0.44
Electronic communication	9	22.2	22.2	0.0	0.0	55.6	2.44	1.88
Client record files	9	11.1	22.2	0.0	22.2	44.4	2.67	1.58

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