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A baseline assessment of Department of Health partnerships with non-profit organisations

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A baseline assessment was conducted in five provinces participating in the Partnership for the Delivery of Primary Health Care Programme. It included district analysis; government capacity to manage partnerships with non-profit organisations (NPOs); NPO access, capacity and quality, and home-based care (HBC). Most districts had contracts with NPOs, identified delivery gaps to be filled by NPOs and the need to improve the management capacity of NPOs. Government capacity to manage partnerships with NPOs seemed generally sub-optimal. Partnership between NPOs and government was positive with weaknesses in rergard to funding and training. The quality of NPO service was overall satisfactory. Home-based care reported the need to improve patients' hygiene and the prevention of infection.

'n Basislyn-waardasie van vennootskappe tussen Departement van Gesondheid en nie-winsgewende organisasies

'n Waardasie van die basislyn was gehou in vyf provinsies wat deelgeneem het aan die Vennootskap vir die Lewering van Primêre Gesondheidsorgprogram. Dit sluit in 'n distrikanalise; regeringsvermoë om vennootskappe met nie-winsgewende organisasies (NWO) te bestuur; toegang, kapasiteit, kwaliteit van NWOs en tuisversorging. Die meeste distrikte wat kontak met NWOs het, het leemtes in dienslewerings geïdentifiseer om gevul te word deur NWOs en die behoefte om die kapasiteitsvermoë van NWOs te verbeter. Regeringsvermoë om vennootskappe met NWOs te bestuur, vertoon oor die algemeen onderbenut. Vennootskappe tussen NWOs en die regering was positief met leemtes in befondsing en opleiding. Die kwaliteit van NWOs was oor die algemeen bevredigend. Tuisversorging rapporteer die noodsaak om pasiente se higïene te verbeter asook die behoefte om infeksies te voorkom.

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The majority of South Africans depend on the public health sector for their health care needs (Viljoen *et al* 2000: 2-3).[1] 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. PHC is the basic mechanism for providing health care (DoH 2000a: 5). It was formally introduced in South Africa 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 PHC for all South Africans"(DoH 2000a: 4). The PHC system emphasises preventive rather than curative health care (Nicholson 2001: 3). 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 in working order for the storage of vaccines before equipping them with high-tech medicine facilities.
- There should be a multisectoral approach to health. In the PHC approach, the provision of nutrition, education, clean water and shelter become central to health care delivery (DoH 2000b: 6).

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For the sustainable development and improvement of PHC, a decentralised system is essential. South Africa has endorsed the District Health System (DHS) as the vehicle for the implementation of primary health care (Nicholson 2001: 8). 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, PHC must be delivered to all the people in the area. There must be one health authority responsible for PHC, 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 proper say concerning their own health care. As part of the core norms for health clinics there should be an annual evaluation of the provision of 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 (DoH 2000b: 3-4). The DHS is continually strengthened and developed and the delivery of service at PHC level promoted. In certain areas, care is still provided in an inequitable manner with women, children and people living in rural areas still receiving less and sometimes inferior care. There are disparities between policy and practice in PHC and the improvement in primary-level health services is very slow (Barron & Monticelli 2003).

In recent years, the contracting out of health services has increasingly gained 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 (Liu *et al* 2004: 3). Contracting out in the health sector is generally defined as the development and implementation of a documented agreement by which one party (the principal, 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: 14). Contracting out has gained popularity because of several hypothesised 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 (Loevinsohn & Harding 2005, Liu *et al* 2004: 5). Improvements in equity can be achieved by three different strategies (England 2004: 10): establishing contractual arrangements that specifically encourage providers to serve the poor and underserved; contracting with private providers in areas where predominantly poor or underserved populations live (geographic targeting), and contracting out services that would be of most benefit to the poor and underserved.

The European Union (EU) Partnership for the Delivery of Primary Health Care Programme (PDPHCP) is a six-year programme of the South African Department of Health (DoH) developed by the EU in collaboration with the government of South Africa and Britain's Department for International Development (DFID). The aim of the programme is to strengthen the delivery of PHC 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, namely Gauteng, Limpopo, KwaZulu-Natal, Eastern Cape and Western Cape (DoH 2004: 3). The EU Financing Agreement for the Partnerships for Health Programme, while specifically concerned with

contracting non-profit organisations (NPOs) for PHC service delivery, has a relatively open-ended approach to partnership:

> Accordingly, through the strengthening of the 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 (DoH 2004: 5).

Monitoring and evaluation (M & E) is seen as a significant component of the PDPHCP. 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. Baseline studies will constitute the first step in implementing the M & E component of the programme (DoH 2004: 6).

Baseline studies 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. The aim of this study was to conduct a baseline study in five target provinces participating in PDPHCP, including an assessment of government capacity to manage partnerships with NPOs which span 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, and an assessment of NPO access, capacity and quality. Subsequent to interventions, a post-intervention assessment of the PDPHCP is envisaged.

1. Methods

1.1 Sampling and procedure

In order to balance speed with depth in the evaluation, the following sampling strategy was followed in each of the five provinces: two districts purposefully sampled from those participating in the PDPHCP partnership in each province and within each district, four sub-districts and at least six NPOs were randomly selected. NPOs inclusion criteria were being funded or earmarked for funding from the PDPHCP.

The baseline study was 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 research team obtained and reviewed provincial plans and identified provincial priorities for the PDPHCP; identified the task network involved in the PDPHCP and held a meeting with representatives of this network to agree on processes and procedures of the work, and collected all background documentation, policies on NPO-government partnerships, NGO funding, and so forth. Phase 2, included interviews (including the specific tools used) with district health manager, task network members (including key informants from sectors of health, social development, finance, European Union, agriculture and municipality at different levels including sub-district, district, provincial and national), NPO managers, subdistrict health manager, and a consumer survey (HBC, support groups, health promotion). 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.

Table 1: Overview of sample and tools

5 Provinces	Public health	NPOs	Outcome/Impact
Sample	District managers (n=10) Task network[2] (national/province/ district/subdistrict) (n=108, all)	NPOs in partnership (n=37) 6-9 Service NPOs (HBC, support groups, health promotion) per province	Subdistrict managers (n=14; all) Consumer assessments (n=150) (in two provinces, one urban and one rural site)
Indicators	District needs analysis Management capacity	Organisational capacity Quality of service	Access/equity/ quality/efficiency PHC indicators HBC indicators
Tools	District needs assessment tool Partnership Management Capacity	Organisational capacity Quality of care tools: HBC/Support groups/ health promotion	Access tool (subdistrict) Consumer assessment: HBC/support groups

2 The task network members included in this instance 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.
Provincial Task Network: European Union (EU) Provincial Co-ordinator, 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, Mother & Child Health Manager, HIV/AIDS Manager, TB Manager, Corporate Services, Finance Officer, Information Officer, Municipality representative, Department of Agriculture, Clinic Intake Officer, Local Government representative, Local Service Area Manager, Special Programme Manager, and so on.
Sub-district: Social Development Officer, PHC Co-ordinator/Sub-district Manager, HIV/AIDS Co-ordinator, Programme Coordinator, Community Development Officer, Social Development Officer, Local AIDS Council, Ward Committee Chair.

Interviews were conducted either in English, Zulu or Northern Sotho, as appropriate, by senior researchers and trained professional nurses, and informed consent was obtained. In the case of interviews with the task-team network and NPO managers or NPO programme managers the content of semi-structured interviews (open-ended questions) was recorded by the senior researcher by taking notes. The senior researchers also asked their interviewees for documentation of components of the study questions. In all 108 task-network members agreed to be interviewed within the project time frame between January and April 2006. All members 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. Thirty-seven NPO assessments were done: 9 for KwaZulu-Natal, 7 in Gauteng, 3 in the Eastern Cape, 9 in the Western Cape and 9 in the Limpopo province. For the study of home-based care (HBC) clients a sample of 120 patients (15-20 per NPO) was chosen from two districts (one in KwaZulu-Natal and one in the Limpopo province). All patients were selected from the list of patients to be visited by a carer on a particular day. A professional nurse accompanied the carers to the households observing the caring process and conducting an interview with the caree in private. Data collection was conducted from January 2006 to April 2006. The study protocol was approved by the HSRC 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.

2. Research tools

2.1 District assessment

The interview schedule used for conducting face to face interviews with district and subdistrict managers included the following components: district management, finance information, social attitudes (HIV), organisational culture, beliefs about NPOs and partnership (Centre for Health Policy 2004: 10ff.).

2.2 Assessment of government capacity to manage partnerships with NPOs

The partnership management capacity index (PCMI) (Centre for Health Policy 2004) measured the management capacity for establishing and implementing government NPO partnerships within the health sector of the five target provinces. The definition and framework of capacity utilized in this tool is that of Hildebrand & Grindle (2001: 156). 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 co-ordinated 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 summarised 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 discrete stages, 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: from the interviewee (the task-team network) directly and 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. Cronbach *alpha* for the interviewee-administered PMCI was 0.91 and for the interviewer-administered PMCI was 0.94 in this sample. 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".

2.3 Assessment of NPO access, capacity and quality

NPOs were assessed on different components: generic assessment of NPOs, NPO programme assessment, and quality of care in the case of NPOs providing HBC, support groups and health promotion. In assessing the capacity and quality of NPOs, this study utilised Buch *et al*'s (2004: 3) participatory rapid appraisal tool for the evaluation of AIDS home-based-care programmes, which was modified to also include NPOs providing support groups and health promotion. Regarding NPO capacity, eight dimensions of management were assessed: 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, and 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". Regarding quality evaluation (in the case of HBC) the following components were assessed: demographic information; patient's environment; patient's basic needs; patient's hygiene and prevention of infection; patient's physical, spiritual and psychological care; planning and implementation of care; medical treatment, and evaluation of care. For example, "patient's physical, spiritual and psychological care" was assessed on the basis of four items: was a complete physical assessment done on admission of the patient by the NPO? (interviewer asked the carer); is patient's dignity and self-esteem recognised? (retrospective report analysis and observation by interviewer); is the patient's privacy maintained whenever necessary? (retrospective report analysis and observation by interviewer) and, is the patient informed of every procedure carried out on her/himself? (observation by interviewer). Response options ranged from "Yes or no", multiple response options to ratings from 1=excellent to 4=poor.

3. Data analysis

Both qualitative and quantitative procedures were used and a triangulation of data from different actors and methods was conducted. Quantitative data was analysed with descriptive statistics using SPSS version 12.1. Qualitative data was analysed using thematic content analysis.

4. Results

Results are divided into district analysis, government capacity to manage partnerships with NPOs, assessment of NPO access and capacity, and assessment of NPO service quality (example HBC).

4.1 District analysis

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.

The priorities mentioned in the various districts include but are not limited to improve PHC, reduce poverty, develop capacity, develop economy, and prevent diseases. With regard to district management capacity, all ten districts indicated the presence of management, financial and monitoring systems. Only two indicated a less than good relationship with politicians and NPOs. In terms of NPO partnership, four of the districts were aware of the existence of a policy on NPOs. Both formal and informal partnerships existed between NPOs and districts. Eight of the districts had service contracts with NPOs. All districts except two did not seem to monitor contracts. Two in three districts were continuously improving management capacity through internal and external training workshops. Six districts reported that the decision regarding when the NPOs receive payment was taken at provincial level. All districts except one collected data from NPOs on TB, HIV and demographics. Identified shortcomings generally reflected the following: understaffing, poor infrastructure, low service utilization, inaccessibility of services and

poor co-ordination; nine of the districts indicated that NPOs can fill the service delivery gaps.

- *Subdistrict-needs analysis*

The key results for the subdistrict-needs analysis are divided into two domains: outreach and NPO partnerships. In terms of outreach almost all subdistricts (12) had various outreach functions in the subdistrict performed by professional staff, health promoters, Directly Observed Therapy Supporters (DOTS) and community health workers. All subdistricts had clinics (though not all clinics) linked to Persons Living with HIV/AIDS (PLWHA) and clinics supporting HBC. With regard to NPO partnerships, focus was on participation, referral/co-ordination and support. In terms of participation there were forums involving NPOs in all the subdistricts that constituted the sample. Further, there were structures for consulting with the community across all the subdistricts. The findings revealed that with regard to referral and co-ordination, the majority of the subdistricts (11) had NPO databases developed by various teams including district task teams (DTT), provincial task teams (PTT), EU co-ordinator, HIV/AIDS co-ordinator, and DoH. However, most of these databases were not frequently updated. Further, subdistricts generally had a referral system between NPOs and facilities in the subdistrict (10). The majority of subdistricts (11) provided supplies (HBC kits) to NPOs.

4.2 Government capacity to manage partnerships with NPOs

The overall partnership management capacity was the highest for organisational 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). Partnership management capacity generally indicated a median of 2.8 sub-optimal (the optimal being 4.0), with the highest in the 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).

Table 2 indicates the stage of the different management capacity components by province as follows.

A comparison of the six different partnership management capacity components indicated that the national (Md=3.0) and provincial (Md=2.8) departments had the highest management capacity, while at district (Md=2.7) and local municipality (Md=2.5) level, management capacity was lower.

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 some of the partnership-management-capacity components is provided by covering various aspects of contract management, monitoring and evaluation, and relationship management.

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

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

- *Contract management*

In terms of contract management the following aspects were investigated: the recruitment of NPOs; the main problems with the contracting process; specific difficulties with contract management, and legal requirements for contracting NPOs.

Broadly defined, the recruitment of NPOs followed this process: a tender is drawn up 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 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 monitored.

The main problems with the contracting process which emerged from the results included: 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); NPOs not being able to provide the necessary documentation (for example, financial statements, constitution); problems with understanding contract specifications and adherence, and insufficient DoH staff to adequately conduct pre-contracting assessment site visits.

With regard to contract management, specific problems pointed out by respondents were that some of the NPOs had difficulty in understanding the terms and conditions of a contract (legal literacy). Other difficulties cited included dual contracting (provincial and district), and the safety of assessors. During site visits, the assessors' safety was sometimes at risk because some NPOs became defensive.

As far as legal requirements for contracting NPOs are concerned, the most commonly cited requirement that presented difficulty was the registration under the NPO Act. Further, the NPO concerned should have a physical address and a bank account.

- *Monitoring and evaluation*

In terms of M&E, questions were asked on how NPOs are monitored and evaluated, problems identified with the M&E process and how non-performing NPOs are identified. On the question of how NPOs are monitored and evaluated the following responses were provided: monthly meetings (monthly stakeholder forums); site visits (by personnel from the DoH or EU programme staff); submission of monthly or quarterly reports by NPO programme managers; finance and activities were evaluated through the abovementioned mechanisms, and submission of annual audited statements.

Various problems were identified with regard to the monitoring and evaluation process. On the part of government, interviewees pointed to insufficient staff in assisting with the monitoring and evaluation. On the part of NPOs, one of the problems identified was the lack of submission of monthly and quarterly reports by some NPOs.

Regarding the identification of non-performing NPOs some common responses included the following: monthly activity reports are utilised to monitor the activities of NPOs, and 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 were community feedback and impact, as well as consultations.

- *Relationship management*

In terms of relationship management, the questions dealt with NPO motivation; NPO complaints, and systems to support NPOs. One of the questions the respondents were asked sought to determine their views on what motivates NPOs to enter into a service agreement. Generally, most respondents felt that NPOs are motivated by commitment and the need to provide a service and make a difference to their community. However, there was also recognition that because of poverty and the high unemployment in the country, the emergence of some NPOs may be due to a need to create employment.

Respondents identified a number a methods for dealing with NPO complaints. These included meetings (for example consultative or stakeholder forums); telephone calls; responding in writing,

and actual visits by NPO representatives. With regard to meetings between the two parties, officials were asked during the interviews to indicate how often they meet with NPO partners. Their responses ranged from every day (12.0%) to never (10.9%). The most common response was once a month (40.2%).

- *Systems to support NPOs*

Participants were asked to describe the systems that they have in place to support NPOs with regard to general, human resources, and financial management as well as governance aspects. In most instances, the responses were quite general, such as giving advice; encouraging NPOs to support each other; having "an open door policy"; offering orientation courses; contracting another service provider to provide training; meetings, workshops, seminars, and conferences.

4.3 Assessment of NPO access and capacity

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

The NPO size ranged from 500 volunteers to four staff (median staff size = 30). The vast majority of the workers were black African (84%) and 80% were female.

In terms of governance, all NPOs had a constitution, a board, committee or other governing body (97%), and most held regular meetings. Annual reports were produced although copies were not always available. There was some evidence that scheduled meetings were not taking place as regularly as intended.

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 already had contracts with

government (65%), there were some problems with late payments (33%) and "complicated bureaucracy" (8%).

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. Other important benefits were related to communication (increased awareness of the activities of other NPOs) 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. While there appeared to be a few NPOs that were experiencing difficulties, the majority reported no problems.

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 the Western Cape, where the relationship was less than satisfactory.

A total of six NPOs stated that they did not have a board or stakeholder committee for their NPOs. Stakeholder consultations were mainly not in place as yet (51%) but there was active local council involvement (67.6%). Stakeholders were reported to make input (61.1%) and there were mechanisms in place to collaborate (91.9%). With regard to individual provinces, Limpopo scored below average with M=1.7 and KwaZulu-Natal M=2.0 (range 0 to 4, 4 being the highest).

Mechanisms to collaborate with other NPOs (91.2%) were currently in place. About 88.6% of NPOs reported that the required services were available and were offered at the nearby hospital and clinics.

Only 69.4% of NPOs stated that a home-carer-training programme was available with only 65.7% of NPOs stating that the programme was suitable to achieve required skill levels. Two in three NPOs (62.2%) did not have a training plan for all staff, while 54.5% stated that trainer skills were either not in place yet or still being set

up. Links to other training organisations were high (70.6%). Ongoing supervision was taking place (85.7%), yet continuing education (55.6%) and management training (62.2%) could be improved (cf Table 3).

Table 3: 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	2.2*	1.5
Programme suitable to achieve required skill levels	35	17.1	17.1	14.3	31.4	20.0	2.2	1.4
Training plan for all staff	37	45.9	16.2	16.2	8.1	13.5	1.3	1.5
Trainer skills	33	39.4	15.2	0.0	12.1	33.3	1.9	1.8
Links to other training	34	23.5	5.9	8.8	38.2	23.5	2.3	1.5
Ongoing supervision	35	11.4	2.9	14.3	48.6	22.9	2.7	1.2
Continuing education	36	25.0	19.4	16.7	19.4	19.4	1.9	1.5
Management training	37	13.5	24.3	21.6	27.0	13.5	2.0	1.3

*Rated from 0=not in place yet to 4=running excellently

NPOs in Limpopo (M=1.63) showed the poorest score in terms of training, while NPOs in all other provinces were above average, although KwaZulu-Natal was only just above average with a mean of 2.07 (cf Table 4).

Table 4: Mean NPO training (by province)

Province	No of NPOs	M*	SD
KwaZulu-Natal	9	2.07	0.99
Gauteng	4	2.75	0.14
Eastern Cape	3	2.54	1.32
Western Cape	9	2.22	0.66
Limpopo	5	1.63	1.54
Total	30	2.18	0.98

*Rated from 0=not in place yet to 4=running excellently

The overall mean score for services was a mean of 2.6, which was above average. NPOs in Limpopo showed the lowest mean of 2.2 with Gauteng (M=3.4) reporting the highest score for services. Few NPOs (41.7%) had a strategic plan. Interestingly, 68.8% of NPOs did monitoring but clearly due to the lower numbers of NPOs that have a strategic plan, monitoring was not checked against the plan. Annual reports were prepared by 77.8% of NPOs. When NPOs in the five provinces were compared Limpopo again showed the poorest mean score of 1.7. KwaZulu-Natal had the best result with regard to human resource management with M=3.2.

Only 69.4% of NPOs had a tracking system in place that records organisational activities. NPOs in Limpopo seemed to have the systems in place for logistics (M=3.1), with the Eastern Cape (M=2.6) being the lowest, but still above average.

4.4 Assessment of NPO service quality: home-based care (HBC) as example

Although the quality of NPO services was assessed for major service provisions, HBC, support groups and health promotion, only HBC, the most predominant service provision of the NPOs, is presented here.

An evaluation of HBC programmes provided by NPOs earmarked for funding by the EU was conducted in District A in urban KwaZulu-Natal and District B in rural Limpopo with a total of 120 patients receiving HBC. Patients can be characterised as most

being females (67.5%), pensioners, unemployed, having primary or secondary education, in the age groups of 25 to 49 and 50 to 70 years (22% were over 70 or under 25 years), 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, being mobile, able to feed independently, weak and in need of minimal support. However, HBC patients in district A NPOs were significantly more frequently seriously ill (25%) as opposed to patients in district B NPOs (5%). Due to social problems, some patients could not afford to eat a variety of food during meals and thus ate the same food for breakfast, lunch and dinner. However, a number reported to be receiving a balanced daily diet. Nursing-care programmes and contacts with professional health workers (nurses) with regard to the patients' condition were found to be poor. 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 the toilet, with drinking water at their bedside and with support to their pressure parts. A few households were reported to be small and therefore created a hazard for patients as cooking on stoves 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 a lack of access to grants, social support, stigma, patients refusing care and poor care at health facilities.

The assessment of the patient's hygiene involved an observation of the patient's environment and this included an observation of the patient's bedroom, whether the patient took regular baths using appropriate antiseptics, or soap, and whether mouth and oral care was given after the patient had had a meal. About half of the patients had their beds kept neat and dry, mouth and oral care was given after every meal, and the carer had protective clothing. A common reason given for patients whose beds were not neat and dry was that the patient stayed alone and was too sick to wash and clean their bed.

Further, stark differences were found between the two districts in terms of HBC hygiene and infection prevention. In district A, as opposed to district B's HBC, most patients received a full bed bath daily, exercise and movement was encouraged, care to back and pressure parts was given, and patients were assisted in and out of bed. This difference may largely be attributed to a higher proportion of seriously ill patients in district A. In district B, as opposed to district A, soap and antiseptics were always available in HBC and there was a procedure manual to guide on terminal care of the patient (cf Table 5). But it seems patients also displayed lower satisfaction in district A than in district B.

Table 5: Patient's hygiene and prevention of infection

Hygiene and prevention of infection (in affirmative responses)	District A		District B	
	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
Are 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
Are 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

Care-recipients were asked to rate the HBC given by the NPO carer. Overall, most recipients felt that the initial contact with the HBC centre and the nursing care given by the carer was fair to excellent. Recipients in Limpopo rated initial contact and nursing care received as significantly better than recipients receiving care from NPOs in KwaZulu-Natal.

Table 6: Satisfaction with HBC

District	Excellent		Good		Fair		Poor	
	n	%	n	%	n	%	n	%
How would you rate your initial contact with this HBC centre?								
District A, KwaZulu-Natal	1	1.7	32	53.3	24	40.0	3	5.0
District B, Limpopo	9	15.0	44	73.3	7	11.7	0	0.0
How would you rate the nursing care given by home carer?								
District A, KwaZulu-Natal	2	3.5	26	45.6	26	45.6	3	5.3
District B, Limpopo	7	11.7	43	71.7	10	16.7	0	0.0

5. Discussion, conclusions and recommendations

5.1 District analysis

The service gaps identified across the districts included understaffing/ lack of capacity, difficulty in retaining and recruiting staff, service disparities, inaccessibility of services/low service utilisation and limited funding, which affect the delivery of PHC services.The commonest priority goal identified from the district planning documents and interviews with district managers across the districts was to improve the delivery of PHC services. The districts generally believed that NPOs could fill these gaps. While the planning documents did not stipulate the potential role of NPOs in closing gaps for PHC service delivery, the district managers acknowledged that NPOs had a critical role to play in this regard. All key stakeholders, including NPO service providers, need to be fully engaged and working collaboratively if the vision of improved PHC is to be realised (DoH 2000b: 4f).

All subdistrict managers indicated that a referral system between NPOs and facilities for the provision of PHC services existed at subdistrict leveland forums involving NPOs were in place in all the subdistricts, which constituted the sample as well as joint management processes between NPOs and provincial and local government. Further, the majority of subdistricts in the study indicated that they provided supplies (HBC kits) to NPOs. Half of the subdistrict managers perceived the relationship between the subdistricts and NPOs as good and very good, while the rest were unsure or regarded it as bad.

There is clearly a functional relationship between subdistricts and NPOs that needs to be strengthened for the improvement of PHC services.

From the foregoing it is clear that NPOs add value to PHC services. Thus there is a need for government to provide clarity and direction in relation to the funding and inclusion of NPOs in the new primary health care system, and facilitate and enhance participation in line with government policy. This would have major implications for the sustainability of NPOs and the health and well-being of their communities.

5.2 Government capacity to manage partnerships with NPOs

Partnership management capacity with a median of 2.8 generally seemed sub-optimal (the optimal being 4.0), with the highest in the Western Cape (Md=3.3) and the lowest in Provinces Limpopo and Eastern Cape (Md=2.5). The higher score for the Western Cape may be explained by the fact that PDPHCP had already been implemented for two years, while other provinces were at the beginning of implementing PDPHCP. All provinces need to improve their partnership management capacity, especially the Eastern Cape and Limpopo. 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 programme management in general. Training workshops on contracting out health services to NPOs should be held for the different stakeholders in order to improve partnership management capacity.

5.3 Assessment of NPO access, capacity and quality

One of the most important aspects of this part of the assessment was the perception of the relationship between NPOs and the government. Although both NPO managers and district managers appear convinced that the partnership is potentially beneficial, there were some responses at the negative end of the spectrum of most indicators. This implies that more effort is needed to achieve a better understanding between partners and to optimise communication. 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. NPOs in Limpopo need to be encouraged to form boards or stakeholder committees; stakeholder consultations need to be encouraged; provinces KwaZulu-Natal and Limpopo need to increase their community involvement. This could be achieved by participating in community Imbizos (community leader meetings), inviting stakeholders to make inputs on the NPOs policy and plans, and through liaison with local councillors. NPOs need to be encouraged to develop a training plan for all staff; NPOs in Limpopo need encouragement to increase the training of all their staff; NPOs have to be encouraged to draw up strategic plans; strategic plans need to be utilised during the monitoring process; NPOs, especially in Limpopo, need attention with regard to drawing up strategic plans, annual reports, and to monitor work; NPOs have to be trained on government procedures and policies in order to win and fulfil tender agreements. Abramson (2001: 406) concludes that contract terms for health service delivery should also include supervision and monitoring systems as well as an evaluation plan. The contract must state who is responsible for the supervision and monitoring of the contract, as well as the frequency of contracting monitoring and evaluation. Training workshops with NPO managers should be conducted on strategic plans, training plans, monitoring and evaluation, community involvement, and communication between stakeholders.

In respect of the quality of HBC, patients must be educated on the relationship between the impact of cleanliness and their health status and be trained in keeping their household environments clean, which is to their health benefit. More training is required for carers

to help them render nursing care in the most hygienic and protective manner possible. Refresher training courses are also recommended to ensure a high standard of care. NPOs must be supplied with manuals and guides on conducting various nursing-care procedures. There is also a need to supply the NPOs with care kits to reduce the risk of infection from patients to carer in the case of highly contagious diseases. The home carer-training programme should be made easily accessible to all NPOs. Carer-professional-nurse consultations must be strengthened. 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. Adendorff (2004: 1) conducted an evaluation of HBC in Gauteng and found that carers needed training in identifying and managing common opportunistic infections. The role and side-effects of all medications used for both treatment and prophylaxis, required attention. Supervision by nurses should be formalised and be done routinely (cf also Uys 2002: 99). Control of the project should also be formalised so that the regular committee meetings regularly acted as a forum for problem solving. Record-keeping of patient visits should be much more detailed reflecting exactly what was done per visit (Adendorff 2004: 1).

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