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TECHNICAL REPORT

End-line Assessment of Integrated People-Centered Health Services in Nelson Mandela Metro Municipality, Eastern Cape Province, South Africa

NOVEMBER 2018

This report on the application of the World Health Organization's integrated people-centered health services approach in HIV services in Eastern Cape Province of South Africa was prepared by University Research Co., LLC (URC) for review by the United States Agency for International Development (USAID) and authored by Tina Maartens, Sthembiso Mkhonto, Elvis Molai, and Carla Visser of URC through the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project. The USAID ASSIST Project is made possible by the generous support of the American people through USAID.

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Acronyms

ART	Antiretroviral therapy
ASSIST	USAID Applying Science to Strengthen and Improve Systems Project
CHC	Community health center
CHW	Community health worker
CQI	Continuous quality improvement
DOH	Department of Health
IPCHS	Integrated people-centered health services
M&E	Monitoring and evaluation
NMM	Nelson Mandela Metropolitan
DOH	Department of Health
QI	Quality improvement
URC	University Research Co., LLC
USAID	United States Agency for International Department
WHO	World Health Organization

EXECUTIVE SUMMARY

Introduction

Since 2013, the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project has been working closely with the South African Department of Health (DOH) and its partners in five provinces to accelerate the reduction of morbidity and mortality through improving access, utilization, and satisfaction with essential HIV services. Drawing on its partnership with the World Health Organization (WHO) Service Delivery and Safety Department to promote people-centered care as an essential pillar of health service quality, ASSIST secured support from the USAID Office of Health Systems to pilot WHO's global framework on integrated people-centered health services (IPCHS) in the Nelson Mandela Metropolitan District in Eastern Cape Province. USAID's expectation is that a service delivery approach that is more people-centered and integrated will better meet health system goals such as increased access to needed health services; improved health and clinical outcomes; enhanced continuity of care and satisfaction with services; expanded participation of users and communities in their own health care; improved providers' job satisfaction; reduced system inefficiencies and duplication of services; and stronger inter-sectoral collaboration in order to address other social determinants of health.

The pilot project consisted of a baseline assessment to harvest patient, provider, and decision maker perceptions and satisfaction regarding integration and patient centeredness in HIV services at onset of the project; training in quality improvement and IPCHS concepts and methodology; facility-based identification and analysis of problem areas; facility- and district-based implementation of changes to operationalize the IPCHS approach; and an end-line assessment to evaluate the impact of the interventions.

Approach

Ten sites that provide antiretroviral therapy (ART) were randomly selected in Nelson Mandela Metropolitan District in the Eastern Cape Province to be part of the sample for the pilot. As part of the baseline assessment, five patients, five providers, and one decision maker from each site were interviewed, using standardized questionnaires, during November and December 2015. In addition, community members were interviewed in three focus group discussions, with a total of 38 participants.

Findings from baseline assessments were used for identification of quality gaps and planning of improvement interventions. Changes introduced were guided by the ASSIST continuous quality improvement (CQI) approach and the five strategic directions in the WHO IPCHS framework.

Ten control sites in the same district received baseline and end-line assessments but no other IPCHS or CQI support. There has however been some influence on the control sites through communication between facility managers during primary health care program meetings, which resulted in requests to participate in the program. No deliberate support was provided to the control sites during the pilot.

Results

Feedback from patients and community members during baseline assessments highlighted aspects related to the health care environment that positively or negatively influence the health care experience of patients, such as waiting time, space, and cleanliness of facilities. Providers and decision makers felt that there were inadequate resources available for planning and organizing care, coordination and continuity of care, strengthening governance systems and accountability, empowerment and engagement of users, training, and monitoring and evaluation of services. High patient volume and conflicting demands resulted in high stress levels where providers felt emotionally drained by their work and unable to manage work demands Provider-patient interaction was challenged by limited opportunities for choice related to treatment options, limited patient involvement in health care planning, lack of self-care support, and inadequate explanation of condition and treatment to patients. Few patients reported having had contact with a community health worker in the previous six months. At the same time, patient responses also

revealed strengths in the system, such as the dignity and respect with which patients were treated, access to services, and availability of medications.

Reassessment findings following the IPCHS intervention indicated that patient perception and experience of health services in the pilot sites have improved substantially in most indicators assessed. Patient perception and experience of services in control sites did not show much improvement and in fact showed a decrease in satisfaction with the majority of indicators measured.

Results show that the clinic environment for patients improved in the intervention sites. The proportion of patients reporting conditions in the waiting area as good to excellent and the proportion of patients reported to have received services in less than two hours both increased by 19 percentage points. There was also improvement in governance and accountability where the proportion of patients who reported awareness of and involvement in clinic committees increased by 25 percentage points. There was also improvement in the relationship between providers and patients: the proportion of patients who reported that they felt confident to discuss their health concerns with providers increased by 21 percentage points; the proportion who said that they reported all side effects from treatment to their providers increased by 25 percentage points; the proportion of clients who reported that information provided on their condition was good to excellent increased by 28 percentage points; and the proportion of patients who reported that they had a choice regarding the provider they wanted to see increased by 22 percentage points. Improvement in coordination of services was evident in the proportion of patients reporting that they received support from community health workers increasing by 89 percentage points.

Improvement was also seen in the provider experience. The proportion of providers who reported that they were able to manage the conflicting demands in the work situation increased by 24 percentage points, while the proportion who reported that they spend more than 20 minutes per patient to provide person-centered care increased by 34 percentage points.

Limitations

Delays in arranging for control sites and completing baseline and end-line data collection in the control sites meant that the control sites were assessed several months after the intervention sites at both baseline and end-line. The small number of providers and patients interviewed at each site warrants viewing the quantitative results with caution, as the magnitude of the effects seen may have been affected by the small sample sizes.

Conclusions and Recommendations

Nelson Mandela Metropolitan District has good patient care systems in place that can support integrated people-centered care. Implementation of IPCHS positively influenced the patient experience of health care received. Significant improvements were demonstrated in pilot sites in empowering and engaging people, coordination of services, and creating an enabling environment for people-centered care. Little improvement and worsening conditions were experienced in control sites.

The IPCHS framework will strengthen the DOH “Ideal Clinic” strategy, especially in terms of patient centeredness, where patient-provider communication and trust are critical.

The 12-month period over which the pilot activities were implemented was too short to ensure sustainability. There were several activities that were still planned but not implemented due to the limited time of the project.

It is recommended that IPCHS should be implemented and scaled up to all facilities. The project results exceeded the resources allocated; the intervention is therefore viable for a longer-term investment.

I. INTRODUCTION

The path to universal health coverage draws attention to various barriers in access to quality health services linked to significant shortages in resources, fragmentation of health services, and lack of people-centeredness. Worldwide, it is estimated that over one billion people lack access to essential health services. In many countries, including South Africa, health services in rural areas are distant (accessibility barrier), with an average primary health care catchment area radius of 10km, inadequately staffed facilities with long waiting hours (availability barrier), and services often not conforming to people's cultural, ethnic or gender preferences (acceptability barrier). Even when people do access services, these are often of inferior quality, and in some cases, even harmful. Services tend to be fragmented, curative, hospital-based, and disease-oriented rather than person-centered, all of which further hampers access to quality health services. Fragmentation of care and lack of people-centeredness can lead to significant difficulties in access to needed services, poor quality of care, inefficient use of resources, duplication of infrastructure and services, loss of continuity of care, and low user satisfaction with services. Moreover, rapid population growth, the emergence of chronic diseases and co-morbidity, the ever-increasing demands and expectations of the population, and the need to be more efficient in health care spending, require a more integrated and people-centered approach to service delivery. These issues are longstanding yet penetrating in many countries and require a comprehensive and coherent solution.

Since 2013, the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project has been working to support the implementation of high quality HIV and AIDS services, specifically antiretroviral therapy (ART), at all levels, in Eastern Cape Province and four other USAID-priority provinces in the Republic of South Africa. Commencing initially at facility level, ASSIST staff provided technical assistance to medical staff at public health facilities to increase access to ART. Much of this was achieved through capacity development initiatives, enhancing integration of services, increasing the knowledge and skills of health care providers regarding the ART program, and use of specific quality improvement methodologies. At community level, ASSIST worked to improve ART literacy, coordinate referrals from different levels, advocate for HIV testing, and track defaulting ART clients.

Drawing on its partnership with the World Health Organization (WHO) Service Delivery and Safety Department to promote people-centered care as an essential pillar of health service quality, ASSIST secured support from the USAID Office of Health Systems to pilot WHO's Framework on Integrated People-centered Health Services (IPCHS)[1] in South Africa. Meetings were conducted between ASSIST and Nelson Mandela Metropolitan district management during August and September 2015 to achieve support for the IPCHS pilot from district health authorities.

Nelson Mandela Metropolitan Municipality is one of eight Metropolitan municipalities in South Africa. It is located on the shores of Algoa Bay in the Eastern Cape Province and covers the city of Port Elizabeth, the towns of Uitenhage and Dispatch, and the surrounding rural area. Nelson Mandela Metropolitan Municipality has an estimated population of 1,152,115 (South Africa Census 2011). The population is cosmopolitan and includes a high proportion of immigrants from other African countries.

II. IPCHS INTERVENTION

A. Coverage

The pilot IPCHS intervention was applied in one district, the Nelson Mandela Metropolitan Municipality in Eastern Cape Province of South Africa. The intervention and control sites for IPCHS were selected by the

[1] Framework on integrated people-centred health services. Report by the Secretariat. Geneva: World Health Organization; 2016 (http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf?ua=1&ua=1).

district for participation in the pilot, based on sites that were not yet part of the National Department of Health's "Ideal Clinic" program, which began in 2013 and which overlaps in some regards with the concepts of IPCHS.

Ten sites that provide antiretroviral therapy (ART) were randomly selected by district authorities to be part of the intervention. **Table 1** shows the coverage and lists the facilities participating in baseline assessment, intervention, and end-line assessment.

Ten control sites were also selected, shown in **Table 2**. To compare differences between pilot and control sites, baseline and end-line assessments were conducted at both the 10 intervention and the 10 control sites.

Provincial, district, and facility management were provided with feedback on the findings from the baseline assessments[2].

Table 1. IPCHS pilot facilities in Nelson Mandela Metropolitan Municipality

Name of the facility	Sub district	Type
UPH	B	District Hospital
Lukhanyo	B	Clinic
Mabandla	B	Clinic
Middle Street	B	Clinic
Kwazakhele	A	Clinic
Kwa-Magxaki	A	Clinic
New Brighton	A	CHC
Korsten	C	Clinic
Central Rose Street	C	Clinic
Central CHC	C	CHC

Table 2. Control facilities for the IPCHS intervention in Nelson Mandela Metropolitan Municipality

Facility	Type
Silvertown	Clinic
Park Centre	Clinic
Gustav Lamor	Clinic
Soweto	Clinic
NU 2	Clinic
Tanduxolo	Clinic
Govan Mbeki	Clinic
Gelvandale	Clinic
Schauderville	Clinic
Missionvale	Clinic

[2] Integrated people-centered health services baseline assessment: South Africa. *Technical Report*. 2016. Published by the USAID ASSIST Project. Bethesda, MD: University Research Co., LLC. Available at: https://www.usaidassist.org/resources/integrated-people-centered-health-services-baseline-assessment-south-africa

B. Assessment Methodology

In October 2015, ASSIST staff worked with WHO to develop suitable assessment tools which would be used for both the baseline and end-line assessment. Four tools were developed:

- **Patient interview tool** to measure patient perception regarding current health service status related to IPCHS dimensions such as amenities, waiting times, communication, shared decision making, self-care support, confidentiality, dignity, cultural competency of providers, emotional support from providers, continuity of care, governance, and patient recommendations.
- **Provider interview tool** to measure provider perception regarding current performance in IPCHS dimensions such as amenities, integrated care process, communication, informed choice, comprehensiveness of services, confidentiality, respect, dignity, self-care support, motivation of providers, accessibility of care, responsiveness of providers, and facility organization and management.
- **Decision maker interview tool** to measure the perception of managers regarding the current status of IPCHS in service provision regarding concepts such as governance and accountability, work environment, motivation and support of staff, reorienting the model of care, empowering and engaging patients, care coordination and care continuity, creating an enabling environment, and system responsiveness to health needs of patients.
- **Focus group discussion guide** to measure the perceptions of community members who utilized the health services in the last 12 months regarding their experiences, attitudes of staff, communication of staff, respect shown by staff, shared decision making between patient and provider, trust between patient and provider, community support, relationship with providers, access to care, community involvement in services, and recommendations.

At each site, the assessments included interviews with decision makers, providers, patients, and the community. Decision makers, who included facility managers, district managers, and other stakeholders, were interviewed in one-on-one discussions. Providers, who included facility HIV counseling and testing counsellors, professional nurses, community health workers, and administration clerks, were interviewed one-on-one. Five providers were interviewed per facility. Patients attending the clinic during the day of the assessment were interviewed one-on-one as part of the evaluation. Five patients were interviewed per facility. Community members were interviewed in three focus group discussions, with a total of 38 participants.

The four data collection tools used in the baseline and end-line assessments are provided in the **Appendix**.

C. Data Collection

ASSIST conducted baseline assessments (interviews, observations, focus group discussions) in November and December 2015. A WHO consultant accompanied ASSIST staff during the assessments at the first two facilities and the first focus group discussion. Five patients were interviewed at nine facilities, and six patients were interviewed at the tenth facility, for a total of 51 patients interviewed. At least five providers were interviewed at each facility for a total of 54; the providers interviewed included professional nurses, counsellors, administrative clerks, and community health workers. Eight decision makers were interviewed, including one district program manager, one clinic supervisor, two facility managers, and four facility operational managers. Three focus group discussions were conducted with a total of 38 community members.

Baseline assessments were conducted by ASSIST staff at the 10 control sites in August 2016. Forty patients and 42 providers were interviewed, using the same questionnaires used for pilot sites.

ASSIST conducted end-line assessments at the same 10 pilot sites in October 2016 and at the same 10 control sites in February 2017. WHO participated in end-line assessments at some sites. The same tools were used as for baseline assessments.

D. Data Analysis

ASSIST developed an Excel database to capture and analyze the information obtained from baseline assessments during October 2015. Patients were provided with three to six different options for the questions. In the analysis, the number of responses to the different options were aggregated. Responses to some questions were divided into categories or “yes” or “no” options, and responses were calculated as percentage of responses to the category. Provider and decision maker responses were aggregated and reported by the number and a percentage of responses.

Data were entered into and analyzed on an Excel spreadsheet, as well as analyzed in the statistical software Stata 10. All variables in the questionnaire were analyzed against one another.

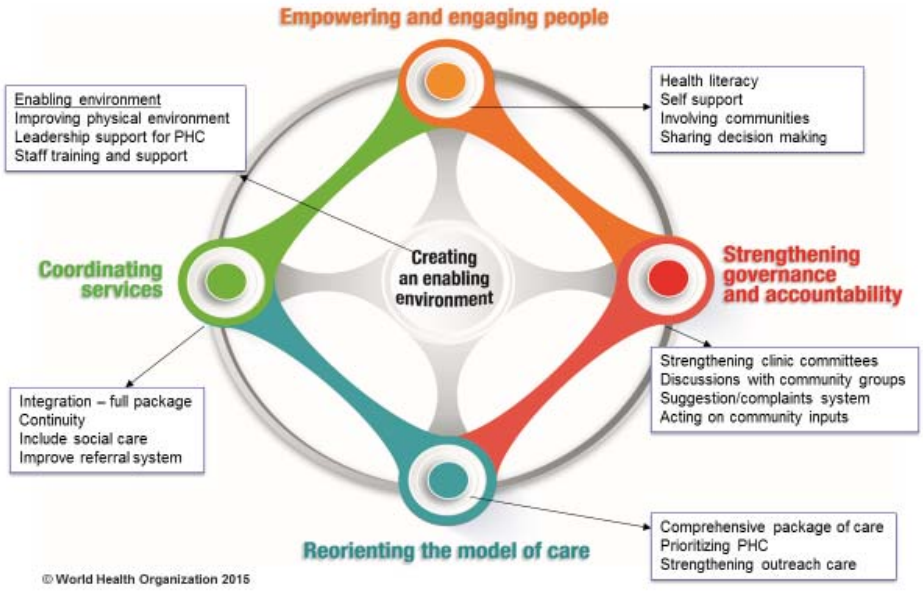
E. IPCHS Intervention

In February 2016, the IPCHS framework, depicted in **Figure 1**, and continuous quality improvement (CQI) methodology were introduced to staff and primary health care (PHC) supervisors from the pilot facilities during a two-and-a-half day workshop. Feedback from baseline findings were shared with staff during the workshop.

The ASSIST team and WHO technical officer visited each of the 10 pilot facilities to provide mentorship and coaching for implementing the IPCHS framework, using a CQI approach. During the first CQI visits, findings for each facility was shared with facility staff and mentorship and coaching were provided on problem identification, problem analysis, and identification of changes to test.

Each facility developed improvement aims based on the feedback from baseline assessments, established a QI team to lead the change, analyzed the quality problems using root cause analysis and process mapping, and identified improvement activities for testing. Changes were tested, and successful changes were implemented and scaled up.

Figure 1. Five strategies for integrated people-centered health services



1. Changes made by facilities to implement integrated people-centered care

Facilities prioritized different changes based on baseline findings. Common changes tested related to the five strategies in the WHO IPCHS framework included:

- **Empowering and engaging people**:
    - Daily health education for clients waiting for service
    - Explaining each patient's condition to them and providing take-home information where possible
    - Explaining to each patient the treatment, side effects of treatment, and how to react when experiencing side effects
    - A leaflet was developed in the three most common languages with information on how to take medication and how to manage common side effects and management.
    - Patients were involved in decision making on how best they can comply with treatment in their family and community situation.
    - Patients were informed about the role of community health workers (CHWs) and support groups and how to access the support.
- **Strengthening governance and accountability**:
    - Feedback from community focus groups and patient interviews was shared with facilities, and the problem areas identified were included in improvement plans.
    - Clinic committees that were not functional were revived and established where none existed.
    - Clinic committees became more visible, and the names, pictures and contact numbers of members were made available on a poster at the entrance of the facility.
    - Suggestion/complaints/compliment boxes were placed at the entrance to facilities. Several facilities did have complaints/suggestion boxes, however they were seldom used and there was little or no reaction to complaints made. Since implementation of the IPCHS framework, the use of the comments boxes was explained in the waiting area when patients were waiting for services. During weekly clinic meetings, where a member of the clinic committee attended, complaints boxes were opened, and complaints, compliments, and suggestions were discussed and actions to complaints were planned.
    - CHWs were available in communities, however patients only started to "feel" the support when their work was integrated with the clinic services and work was better aligned with community needs. Relationships between patients and providers improved to such an extent that providers became known by name and were often invited to family occasions, such as weddings or the christening of a child.
    - Patients were informed about the role of community health workers and support groups and how to access the support.
- **Reorienting the model of care**
    - Primary health care has been the vehicle for improving access to health care in South Africa since 1994. Much has been done in the country to reorient the model of care to place primary health care as the first point of care. Resource allocation has, however, not moved at the same pace as policy, and implementation of the PHC model and the resource demands from institutionalized care increased with the increasing burden of AIDS, TB, and other chronic conditions. The Government of South Africa proposed in 2013 a new strategy for "Ideal Clinics" which has overlapping objectives with the IPCHS framework. The "Ideal Clinic" program is being introduced in the country's 52 districts in a phased way, and the pilot and control sites chosen were yet not part of the "Ideal Clinic" program.
    - Providing comprehensive care is part of both strategies. The IPCHS focus was on a client receiving all the care he or she needs during the same visit to the facility. Previously clients had to visit different providers for different conditions, requiring more than one visit. The

"Ideal Clinic" program provided training updates for providers on the most common conditions such as HIV, TB and common conditions such as diabetes and hypertension. Some of the staff from the IPCHS sites were included in this training, and it contributed to the provision of integrated care.
    - Community health workers have been working in the Nelson Mandela Metropolitan District and provided services such as health screening, education, and mapping of communities. Results from baseline assessments showed that most clients and community members were not aware of this service. As part of the IPCHS intervention, the CHWs and clinics started to integrate their services, and CHWs improved referral to clinics while clinics contacted CHWs for client follow-up and support. Results show an increase of 89.1 percentage points amongst clients receiving support from CHWs (from 5.9% at baseline to 95% at end-line).

- **Coordinating services**
    - Coordinating services and reorienting the model of care and coordination of services overlapped in many areas, such as the community health worker service and clinic service coordination.
    - Coordination within a facility setting improved through the improved integration of services – one provider treating several conditions, as well as services from nurses, doctors, pharmacists, and other associated health services being more actively synchronized.
    - Improvement teams contributed to the coordination through representation on the team from administrative services, pharmaceutical, medical, nursing, and community health services. This led to improved working relations, better referral practices, and more coordinated planning of improvements.

- **Creating an enabling environment**
    - Cleaning and maintenance of facilities
    - Empowerment of providers through training on IPCHS, CQI, and comprehensive care
    - District management was continuously involved in and updated on the IPCHS activities.

III. RESULTS

A. Baseline Assessment

Feedback from patients and community members during baseline assessments highlighted aspects related to the health care environment that positively or negatively influence the health care experience of patients, such as waiting time, space, and cleanliness of facilities. Provider-patient interaction was challenged by limited opportunities for choice related to treatment options, limited patient involvement in health care planning, lack of self-care support, and inadequate explanation of condition and treatment to patients. Only half of patients reported that they could always discuss their health concerns with providers. Fewer than 5% of interviewed patients reported seeing a community health worker in their home or as part of a community support group. Patient responses also revealed strengths in the system, such as the dignity and respect with which patients were treated, access to services, and availability of medications.

Provider and decision maker baseline responses indicated a challenging work environment. There were concerns about space, cleanliness, and maintenance of facilities. The existing health care system did not allow for much patient choice. Providers and decision makers felt that there were inadequate resources available for: planning and organizing care, coordination and continuity of care, strengthening governance systems and accountability, empowerment and engagement of users, shaping training and skills of providers, monitoring and evaluation of services, and shaping the legal and financial framework for service provision. High patient volume and conflicting demands resulted in high stress levels where decision makers felt emotionally drained by their work and unable to manage work demands. In addition,

decision makers felt that there was little recognition for their efforts and insufficient time to adequately support providers. Providers and decision makers felt that even with limited resources, the service provided was good, patients were treated with respect and dignity, and there were good communication and management systems in place. Decision makers also indicated that they were exposed to good management and leadership role models.

B. End-line Results

Reassessment findings indicate that patient perception and experience of health services in the pilot sites have improved substantially in most indicators assessed. Patient perception and experience of services in control sites did not show much improvement and indicated a decrease in satisfaction with the majority of indicators measured.

Results show that the clinic environment for patients improved, with a 19.4 percentage-point increase in the proportion of patients reporting conditions in waiting area as good to excellent and a 19.2 percentage point increase in the proportion of patients who said they received services in less than two hours. There was also improvement in governance and accountability wherein the proportion of patients who reported awareness and involvement with clinic committees increased by 25 percentage points in the intervention facilities.

Clear improvement was also evident in the relationship between providers and patients in the five intervention sites. The proportion of patients who reported that they felt confident to discuss their health concerns with providers increased by 21.2 percentage points; the proportion of patients who said they reported all side effects from treatment to their providers increased by 25.4 percentage points; the proportion of patients who reported that information provided on their condition was good to excellent increased by 27.9 percentage points; and the proportion of patients who reported that they had a choice regarding the provider they wanted to see increased by 22 percentage points. Improvement in coordination of services was evident in a sharp increase (by 89.1 percentage points) in the proportion of patients reporting that they received support from community health workers.

Improvement was also seen in provider experience, with an increase of 24 percentage points in the proportion of providers who reported that they were able to manage the conflicting demands in the work situation. There was a 34 percentage-point increase in the proportion of providers who said that they spend more than 20 minutes per patient to provide person-centered care.

Figure 2 shows the percentage-point improvement in various indicators measured as part of empowering and engaging people and creating an enabling environment for IPCHS. The results show clear improvement in all indicators for the pilot sites while there was less improvement amongst control sites and even a negative trend in more than half of the indicators.

Figure 2. Percentage-point improvement from baseline to end-line for patient indicators measuring engagement and empowerment of patients and creating an enabling environment

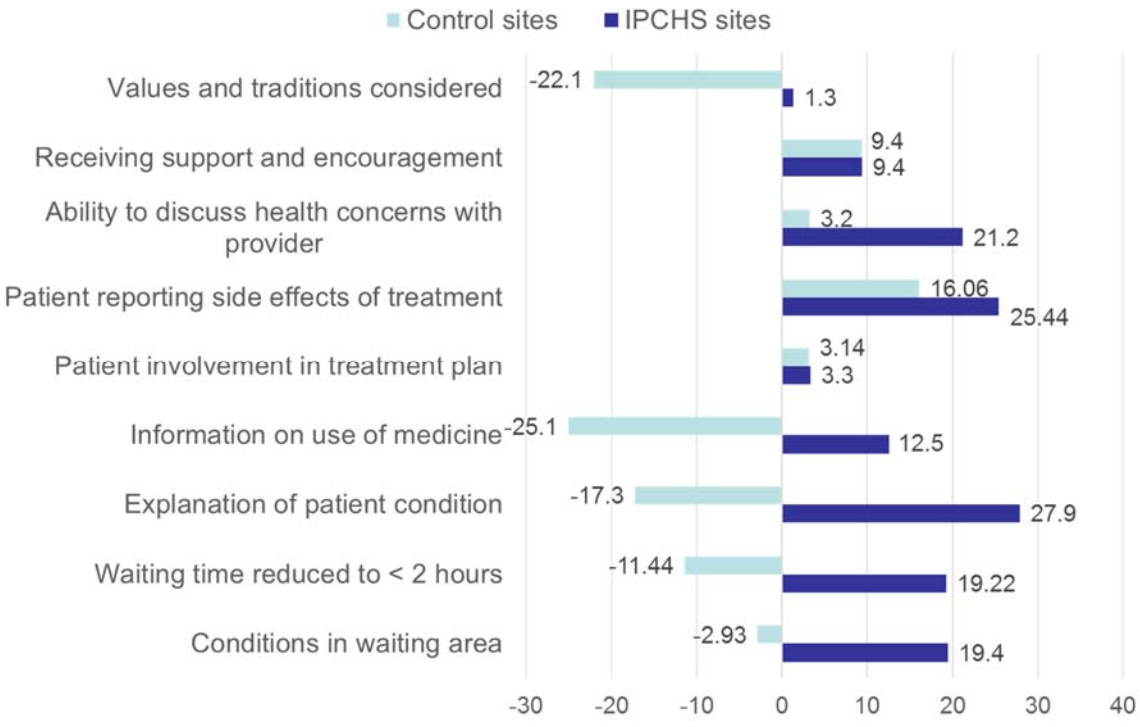
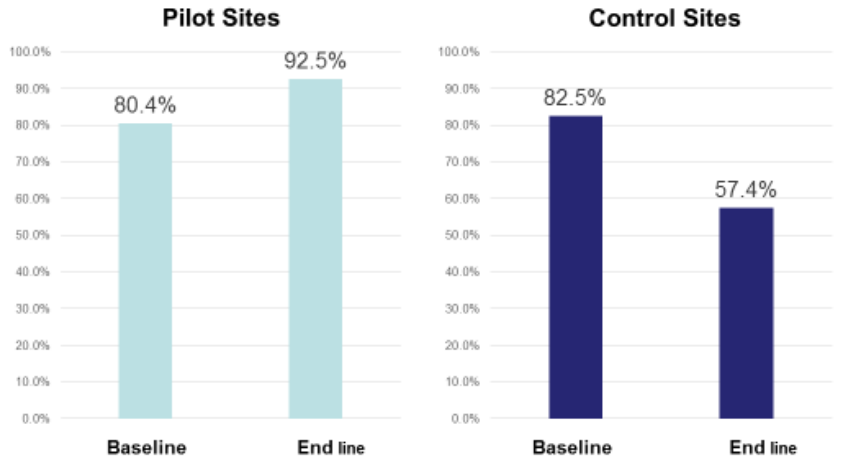


Figure 3 demonstrates the baseline and end-line scores for explanation of patient condition, reported as good to excellent, for pilot as well as control sites as reported by patients during interviews. The percentage-point difference between baseline and end-line was 12.1% for pilot sites and -25.1% for control sites.

Figure 3. Percentage of patients who reported that the provider's explanation of their condition was good or excellent



Intervention sites managed to improve on indicators related to governance and accountability, reorienting the model of care, and integration of services. Control sites demonstrated almost no improvement in the indicators. As shown in **Figure 4**, there was a 25 percentage-point increase in the proportion of clients reporting awareness and involvement with clinic committees and 89 percentage-point improvement in the proportion of patients reporting support from community health workers within the pilot sites. Control sites demonstrated only a 4 percentage-point improvement in patient ability to see the provider of choice but no appreciable change in the other indicators.

Figure 4. Percentage-point difference in patient-reported measures of governance, accountability, and integration of services in IPCHS and control sites

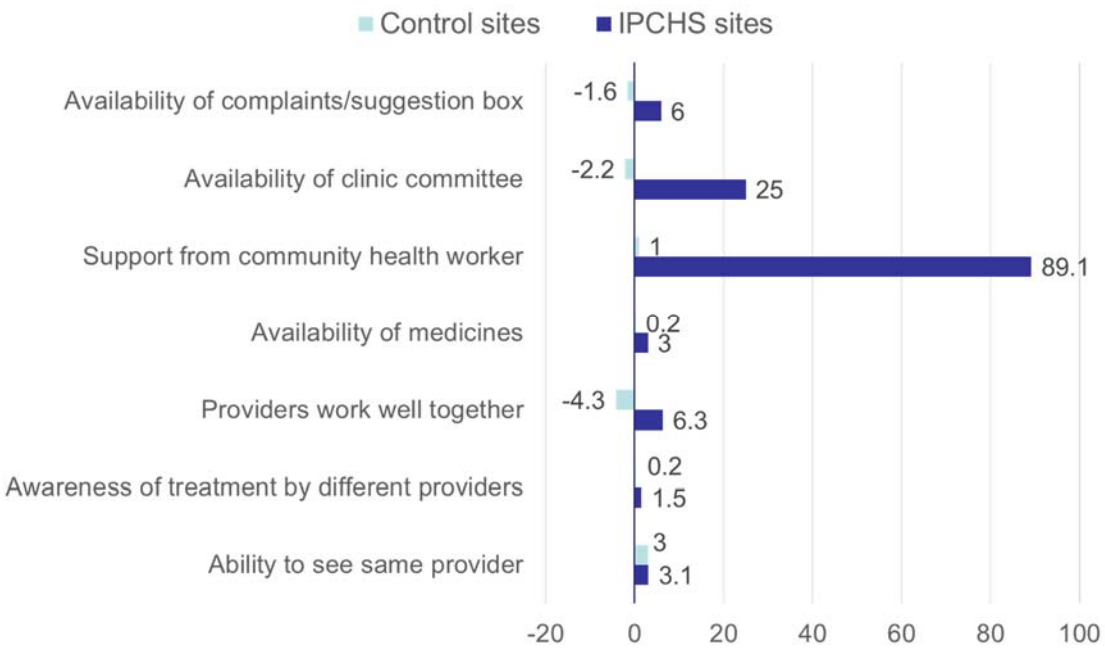
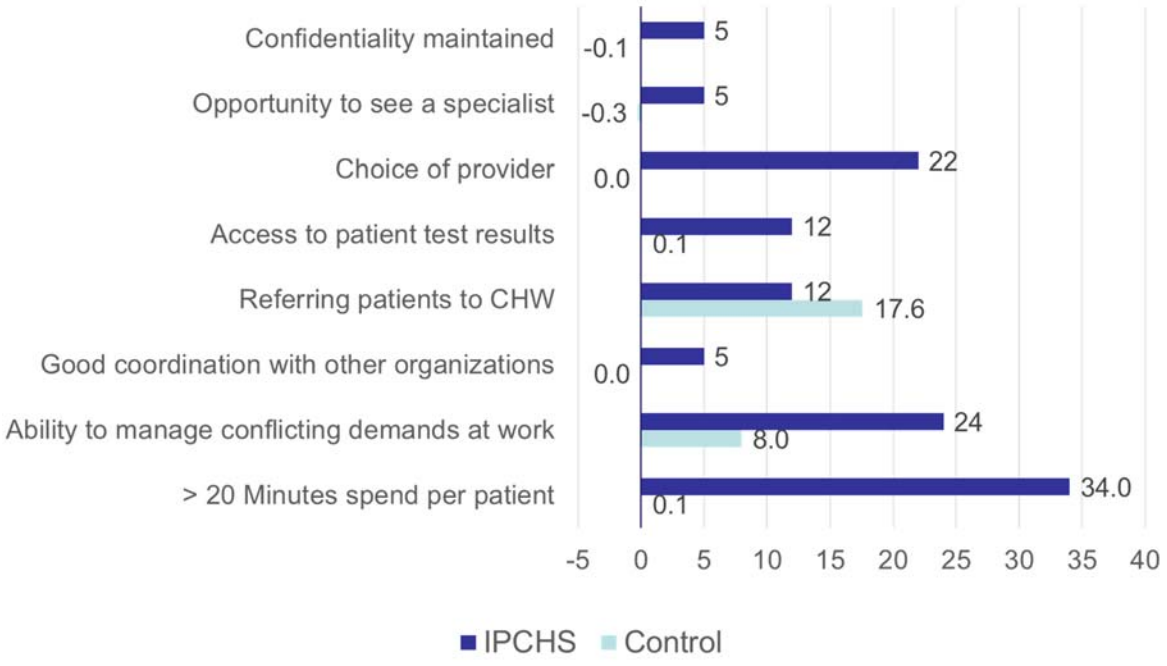


Figure 5 shows the percentage-point difference between baseline and end-line assessments for pilot and control sites in terms of provider-reported characteristics of person-centered care. The data is based on provider responses to questions. Providers from pilot sites reported improvement in all indicators measured, including:

- More providers reported that they were able to provide a choice to patients regarding choice of providers – increase of 22 percentage points.
- More providers reported that they were able to manage the conflicting demands on their time within the work situation – increase of 24 percentage points.
- More providers reported that they were able to spend more than 20 minutes per patient to provide patient-centered care – increase of 34 percentage points.

Figure 5. Percentage-point difference in provider responses in key areas of facility-level IPCHS



IV. LIMITATIONS

Delays in arranging for control sites and completing baseline and end-line data collection in the control sites meant that the control sites were assessed several months after the intervention sites at both baseline and end-line. The baseline assessment in the control sites was carried out approximately 10 months after the baseline data collection in the intervention sites. At end-line, control sites were assessed some seven months after the end-line was completed in the intervention sites to allow for a similar period of time between baseline and end-line.

The small number of providers and patients interviewed at each site warrants viewing the quantitative results with caution, as the magnitude of the effects seen may have been affected by the small sample sizes. While the quantitative results do suggest a trend in improvement in aspects of person-centered care in the intervention sites, the results seen may have been skewed by the small number of respondents from each facility.

V. CONCLUSION

Nelson Mandela Metropolitan District has good care delivery systems in place that can support integrated people-centered care. Implementation of IPCHS positively influenced the patient experience of health care received. Significant improvements were demonstrated in empowering and engaging people, coordination of services, and creating an enabling environment in the pilot sites. Little improvement and worsening conditions were experienced in the control sites.

Based on the results of the pilot, we conclude that broader implementation of the IPCHS framework will strengthen the “Ideal Clinic” strategy in South Africa, especially in terms of patient centeredness, where patient-provider communication and trust are critical.

The 12-month period over which the activities were implemented is too short to ensure sustainability. There were several activities that were still planned but not implemented due to the limited time of the project.

In the event of replication or further roll-out of the IPCHS strategy, the questionnaires for assessments should be reviewed and shortened. Several of the questions gathered information that was not used and made interviews time-consuming and reporting very complicated.

It is recommended that the IPCHS framework should be implemented and scaled up to all facilities. The project results exceed the resources allocated and utilized and is therefore viable for a longer-term investment.

APPENDIX: DATA COLLECTION TOOLS

Patient Questionnaire

Thank you for answering these questions about the care you have received regarding your HIV condition. We are trying to organise more integrated and people-centre care to meet your needs better. Your answers will help us to improve the care you receive.

We would like to hear about your own views. Your answers to the questions are confidential.

Identification

N° /__/__/__/

1. Region: EC_____ 2. District: NMM_____

3. Clinic _____ 4. Category: Patient

5. Age: /__/__/ Years 6. Gender: Male/Female

Background characteristics

7. Ethnic group:

1. Coloured
2. Black
3. Asian
4. White
5. Others

8. Level of education:

1. Cannot read
2. Basic reading
3. Primary school
4. Secondary school
5. University
6. Advanced degree

9. Sources of income:

1. Retailing
2. Agriculture
3. Fishing
4. Salary
5. Other _____

10. Average monthly income

1. <R2000
2. > R2000 < R 5000
3. > R5000 < R10 000
4. > R10 000

11. In general, how would you rate your overall health?

1. Very poor
2. Poor
3. Good
4. Very good
5. Excellent

12. Do you have any of the following longstanding conditions? (Cross ALL that apply)

1. Deafness or severe hearing impairment
2. Blindness or severe sight impairment
3. Impaired mobility due to physical condition
4. A learning disability
5. A mental health condition
6. A long-standing illness, such as cancer, HIV, diabetes, chronic heart disease, or epilepsy
7. No, I do not have a long-standing condition

Choice

13. On a scale of 0 to 10, 0 being the worst and 10 the best, how would you rate the health centre in terms of being able to see the doctor, nurse, other health care provider of your choice? _____

Quality of amenities and office staff

14. Thinking about when you visited the health centre in the last 6 months, how would you rate the conditions in the waiting room, for example space, seating and fresh air?

1. Very poor
2. Poor
3. Good
4. Very good
5. Excellent

15. In the last 6 months, how often did the office staff, such as receptionists or clerks, make you feel welcomed?

1. Never
2. Rarely
3. Sometimes
4. Frequently
5. Always

Timeliness

16. How long did you wait before being seen by your provider?

1. Less than 30 minutes
2. 30 minutes to 1 hour
3. 1 hour to 2 hours
4. 2 to 4 hours
5. More than 4 hours

17. How would you rate this waiting time?

1. Unbearable
2. Very long
3. Long
4. A little bit long
5. Fine

Communication

18. How complete was your provider's explanation of your condition and treatment?

1. Very poor
2. Poor
3. Good

4. Very good
5. Excellent

19. How easy to understand was the information provided by your provider?

1. Very difficult
2. Difficult
3. Good
4. Very good
5. Excellent

20. How would you rate the information about how to use new medicines and their possible side effects?

1. Very poor
2. Poor
3. Good
4. Very good
5. Excellent

21. Do your family and friends have opportunities to ask your provider questions if wanted?

1. Never
2. Rarely
3. Sometimes
4. Frequently
5. Always
6. Not applicable

Shared-decision making

22. In the last 6 months, how often did your provider involve you in decisions about your care?

1. Never
2. Rarely
3. Sometimes,
4. Frequently, but less than I wanted
5. As much as I wanted

Self-management support

23. Does the provider help you make a treatment plan that you could do in your daily life?

1. Never
2. Rarely
3. Sometimes
4. Frequently
5. Always

24. Are you eating the food groups advised by a health care worker?

1. Yes
2. No
3. I try to
4. I never received advice on what foods to eat

25. Are you taking your treatment as prescribed by the health care worker?

1. Always
2. Sometimes
3. Seldom

4. N/A

26. If you are not always taking your treatment as prescribed, what are the reasons?

1. I do not always have the medication
2. It makes me feel sick
3. I sometimes forget
4. N/A

27. Are you doing exercise at least three times a week?

1. Yes
2. No
3. Sometimes

28. Do you report all side effects of medication to your health care provider?

1. Always
2. Sometimes
3. Never
4. I don't know which are side effects of medication

29. How often do you wash your hands? (circle all applicable)

1. Every time after I went to the toilet
2. Before I handle food
3. At least three times a day
4. Once or twice a day
5. Less than twice a day

Confidentiality/Privacy

30. In the last 6 months, how often were your physical examinations and treatments there done so the privacy of your body was respected?

1. Never
2. Rarely
3. Sometimes
4. Frequently
5. Always

31. In the last 6 months, how often did your doctor, nurse or other health care provider keep your personal information confidential (that means that anyone whom you did not want informed could not find out about your medical conditions)?

1. Never
2. Rarely
3. Sometimes
4. Frequently
5. Always

Cultural competency

32. How confident are you that your provider thought about your values and traditions when they recommended treatments to you?

1. Not confident
2. Somewhat confident
3. Confident
4. Very confident

33. How often did you feel discriminated against by providers because of your race or ethnicity?

1. Never
2. Rarely
3. Sometimes
4. Frequently
5. Always

Dignity

34. On a scale of 0 to 10, 0 being the worst and 10 the best, how would you rate your providers for the dignity with which you were treated? _____

Emotional support/Empathy

35. How often are you able to discuss your greatest health concerns with your provider?

1. Never
2. Rarely
3. Sometimes
4. Frequently
5. Always

36. How often did providers give you support and encouragement?

1. Never
2. Rarely
3. Sometimes
4. Frequently
5. Always

Care continuity and care coordination

37. When you go to your primary care site, are you taken care of by the same provider each time?

1. Never
2. Rarely
3. Sometimes
4. Frequently
5. Always

38. Is the person who ensures your follow-up aware of health care you receive from others?

1. Never
2. Rarely
3. Sometimes
4. Frequently
5. Always
6. N/A

39. Did the different people treating and caring for you (such as GP, hospital doctors, hospital nurses, specialist nurses, community nurses) work well together to give you the best possible care?

1. Never
2. Rarely
3. Sometimes
4. Frequently
5. Always

40. Over the last six months, how many times did you come to the service and did not receive treatment because it was out of stock?

1. Three or more times
2. One to three times
3. Never

41. Were you seen by a CHW at home or in a support group in the last six months?

1. Yes
2. No

42. Were you referred to the clinic by a CHW in the last six months?

1. Yes
2. No, we do not have CHW
3. I did not need referral
4. I needed referral and did not receive any

43. Were you referred to a hospital by the clinic in the last six months?

1. Yes
2. No
3. I did not need referral to a hospital
4. I needed referral and did not receive any

44. Did you go to more than one clinic for treatment of the same condition within one week?

1. Yes
2. No

45. If the answer to 44 is yes: Why did you prefer to go to another clinic?

1. I did not receive the treatment I expected
2. I wanted a second opinion
3. I wanted more medication
4. N/A

46. Do you have an allocated treatment supporter that reminds you to take treatment?

1. Yes
2. No

47. Do you think it will be helpful to you if you had a treatment supporter?

1. Yes
2. No
3. I do not want a treatment supporter
4. N/A

48. The last time that you visited the clinic, were you screened for the following?

1. TB a) Yes b) No
2. Diabetes a) Yes b) No
3. Hypertension a) Yes b) No
4. BMI or MUAC: a) Yes b) No

Governance

49. Does your local clinic have a clinic committee?

1. Yes

2. No
3. I don’t know

50. Do you know anyone who is on the clinic committee?

1. Yes
2. No

51. Does the clinic committee ever discuss health related issues with you or anyone you know?

1. Yes
2. No
3. Not applicable

52. Does your clinic have a suggestion box or other way where you can report problems, make comments or suggestions?

1. Yes
2. No
3. I don’t know

53. If the answer in 52 was yes, ask: Have you ever put a comment or complaint in the box?

1. Yes
2. No
3. Not applicable

54. If the answer in 52 was No: ask the respondent: Why did you not make any complaints or comments?

1. I did not have anything I wished to complain or comment on
2. There was no paper or pen for me to use to write a comment/complaint
3. The clinic never responds to complaints
4. N/A

90:90:90 Targets – Client may refuse to answer these questions

HIV

55. Do you know your HIV status?

1. Yes
2. No

56. If you are HIV-negative: When was the last time that you were tested for HIV?

1. 1 - 6 months ago
2. 6 – 12 months ago
3. More than 12 months ago
4. Never

57. If you are HIV-infected: Are you on ART?

1. Yes
2. No
3. N/A

58. If you are HIV-infected: When was the last time that your CD4 was measured?

1. < 6 months ago
2. More than 6 months ago
3. N/A

59. If you are HIV-infected, when was the last time your viral load was measured?

1. <6 months ago
2. >6 but less than 12 months ago
3. More than 12 months ago
4. Never
5. N/A

Responsiveness

60. Now, on a scale of 0 to 10, 0 being the worst and 10 being the best and thinking about these elements and all the questions you answered before, how would you rate the health center?

_____ out of 10

Suggestions for improvement

61. What suggestions do you have to improve the clinic?

_____
_____
_____

Thank you

Provider Questionnaire

This questionnaire is trying to find out what you think about the health system in your district. Fifty (50) persons in your country involved in the health sector in different capacities are being asked to fill out this questionnaire.

Identification

Fiche N° /__/__/__/

1. Province: __EC_____ 2. District: ___NMM_____

3. Sub-district: _C_____ 4. Staff category :_____

5. Facility_____ 6. . Age: /__/__/ Years

7. Gender: Male/Female

Background characteristics

8. Level of education:

1. Primary school
2. Secondary school
3. University
4. Advanced degree

9. What is your occupational group?

1. Community Health Worker
2. Nurse
3. Midwife
4. Physician
5. Specialist
6. Other: _____

10. Monthly income

1. <R2000
2. > R2000 < R 5000
3. > R5000 < R10 000
4. > R10 000

11. How long have you worked at your current facility?

1. Less than one year
2. 1 to 2 years
3. 2 to 5 years
4. 5 to 10 years
5. More than 10 years

12. How long have you been in your current position?

1. Less than one year
2. 1 to 2 years
3. 2 to 5 years
4. 5 to 10 years
5. More than 10 years

13. Do you manage staff as part of your job?

1. Yes

2. No

14. Ethnicity:

    1. Coloured
    2. Asian
    3. Black
    4. White
    5. Other: _____

15. I feel emotionally drained by my work?

    1. A few times a year
    2. Monthly
    3. A few times a month
    4. A few times a week
    5. Every day
    6. Never

16. How many patients do you see in a day?

    1. Less than 5
    2. 5 to 10
    3. 10 to 20
    4. 20 to 30
    5. More than 30

17. On average, how much time do you spend with each patient?

    1. Less than 5 minutes
    2. 5 to 10 minutes
    3. 10 to 20 minutes
    4. 20 to 30 minutes
    5. More than 30 minutes

18. How would you rate the cleanliness and maintenance of health care units?

    1. Very poor
    2. Poor
    3. Good
    4. Very good
    5. Excellent

19. How would you rate access to hand washing facilities at health care units?

    1. Very poor
    2. Poor
    3. Good
    4. Very good
    5. Excellent

20. I am able to manage all the conflicting demands on my time at work.

    1. A few times a year
    2. Monthly
    3. A few times a month
    4. A few times a week
    5. Every day

Integrated care processes

21. There is good communication with other organisations providing care for my patients.

    1. Never
    2. Rarely
    3. Sometimes
    4. Usually
    5. Always

22. Is there a formal system for and or accepting referred patients?

    1. Never
    2. Rarely
    3. Sometimes
    4. Usually
    5. Always

23. When was the last time that you referred a client to a CHW for support?

    1. Never
    2. 1 – 3 months ago
    3. Last week
    4. Today
    5. Not applicable

24. How often do you have access to patient's most recent test results or exams when you need them?

    1. Never
    2. Rarely
    3. Sometimes
    4. Usually
    5. Always
    6. Not applicable

25. Do you get a report from a specialist or hospital if your patient has visited them?

    1. Never
    2. Rarely
    3. Sometimes
    4. Usually
    5. Always
    6. Not applicable

Communication:

26. How often are patients encouraged to discuss their concerns freely?

    1. Never
    2. Rarely
    3. Sometimes
    4. Usually
    5. Always

27. How often are patients encouraged to ask questions about diseases, treatment and care?

    1. Never
    2. Rarely
    3. Sometimes
    4. Usually

5. Always
6. Not applicable

Choice

28. How often do individuals have a choice between health care providers in a health care unit?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

29. How often do individuals have the opportunity to see a specialist, if they wish to?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

Comprehensiveness

30. My patient can see the following providers if needed: (Circle all that apply)

1. Health promoter/educator
2. Dietitian
3. Social worker
4. Community health worker (home visit)
5. Physiotherapist
6. Dental/oral health worker
7. Mental health worker

Confidentiality and privacy

31. How often is the confidentiality of patients' medical records preserved (except if the information is needed by other health care providers)?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

32. How often are consultations carried out in a manner that protects patient confidentiality?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

Respect and dignity

33. How often are patients treated with respect?

1. Never
2. Rarely
3. Sometimes
4. Usually

5. Always

34. How often are the human rights of patients with communicable diseases such as AIDS or tuberculosis safeguarded within the health system?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

35. How often is patient consent sought before testing or starting treatment?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

Support informed choice

36. How often are patients provided information on different treatment options?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always
6. Not applicable

37. How often are patients consulted about their preferences over different treatment options?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always
6. Not applicable

38. The needs and preferences of service users should be central in Health Services.

1. Strongly disagree
2. Somewhat disagree
3. Neither agree
4. Somewhat agree
5. Strongly agree

39. It is important to get to know each service user as an individual (eg. their medical history, social, supports, cultural factors, pre-morbid status).

1. Strongly disagree
2. Disagree
3. Neither agree nor disagree
4. Agree
5. Strongly agree
6. Not applicable

Self-care support

40. How often do you co-develop a care plan with your patient for how they can manage their condition in their daily life?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always
6. Not applicable

41. How often do you provide written information to patients about their condition or treatment in language they can understand?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always
6. Not applicable

42. I offer education about peer-based services and mutual support groups as part of the planning process.

1. Strongly disagree
2. Somewhat disagree
3. Neither agree
4. Somewhat agree
5. Strongly agree
6. Not applicable

43. How often do you screen your clients for HIV and TB?

1. Every client with every visit
2. Every adult and adolescent client with every visit
3. When I have time
4. Seldom
5. Never
6. Not applicable

44. How often do you provide information to a client on TB and HIV prevention?

1. Every client with every visit
2. Every adult and adolescent client with every visit
3. When I have time
4. Seldom
5. Never
6. Not applicable

45. How often do you weigh and do MUAC or BMI for your clients?

1. Every client with every visit
2. Every adult and adolescent client with every visit
3. Every pregnant women with every visit and BMI every 6 months
4. Every child with every visit
5. Only pregnant women, every client with HIV, TB and < 5 clients
6. When I have time

7. Seldom
8. Never
9. Not applicable

46. How often do you provide advice to your clients on nutrition?

1. Every client with every visit
2. Every adult and adolescent client with every visit
3. Pregnant women and mothers with babies only
4. When I have time
5. Seldom
6. Never
7. Not applicable

47. How often do you screen and provide information to clients on diabetes and hypertention?

1. Every client with every visit
2. Every adult and adolescent client with every visit
3. When I have time
4. Seldom
5. Never
6. Not applicable

Motivation

48. Do you think the number of patients and time you spend with each patient is appropriate?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

49. There are rewards and recognition for patient- and family-centred practice.

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

50. Staff's stress-reduction and well needs are addressed

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

51. I've become less compassionate toward people since I took this job.

1. Very mild, barely noticeable
2. Mild
3. Moderate
4. Strong
5. Very strong, very noticeable
6. Not at all

52. Working with people all day is really a strain for me.

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

53. I think about changing organizations.

    1. Never
    2. Rarely
    3. Sometimes
    4. Usually
    5. Always

54. I have enough support to get the training I need in my area of work.

    1. Never
    2. Rarely
    3. Sometimes
    4. Usually
    5. Always

55. I deal very effectively with the problems of my recipients.

    1. Never
    2. Rarely
    3. Sometimes
    4. Usually
    5. Always

56. I feel I'm positively influencing other people's lives through my work.

    1. Never
    2. Rarely
    3. Sometimes
    4. Usually
    5. Always

Organization and management

57. People providing care for my patients/service users work well together.

    1. Never
    2. Rarely
    3. Sometimes
    4. Usually
    5. Always

58. We hold staff meetings to discuss how care for our patients can be improved.

    1. A few times a year
    2. Monthly
    3. A few times a month
    4. A few times a week
    5. Every day
    6. Never

59. There is good collaboration among and between physicians and nurses.

    1. Never

2. Rarely
3. Sometimes
4. Usually
5. Always

60. Health facilities provide supervision and support to CHWs.

1. Never
2. Rarely
3. Less than needed
4. Appropriate
5. More than enough
6. Not applicable

61. I know who to whom I am accountable and am supervised.

1. Never
2. Rarely
3. Less than needed
4. Appropriate
5. More than enough

62. Do you have accessible the protocols and guidelines you need for patient care?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

63. How often do you use these protocols and guidelines?

1. A few times a year
2. Monthly
3. A few times a month
4. A few times a week
5. Every day

64. Our clinic has a system for eliciting and reviewing patient and family opinion.

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

65. I have opportunities for scientific development/continuing education.

1. Never
2. Rarely
3. Less than needed
4. Appropriate
5. More than enough

Accessibility

66. How often is the length of time spent at health care units waiting for consultation/ treatment reasonable?

1. Never

2. Rarely
3. Sometimes
4. Usually
5. Always

Responsiveness

67. Considering the seven aspects of health system function that you have reported on above, how would you rate:

- **Importance:** Please give a value between 0 and 10 to indicate your personal rating of how important the aspect is. Here, 0 means not at all important and 10 means extremely important.
- **Performance:** Please give a value between 0 and 10 to indicate your personal rating of the performance of your facility. Here, 0 means the poorest performance and 10 means the best.

Aspect of care	**Importance**	**Performance**
Integration		
Communication		
Choice of care provider/institution		
Comprehensiveness of care		
Quality of basic amenities		
Promptness of attention		
Confidentiality and privacy		
Dignity and respect		
Emotional Support and empathy		
Informed choice/autonomy		
Self-care support		
Organization and management		

68. Are any of the following social groups facing worse care and health system performance with regard to the areas above. Please include other social groups (age, gender, education level, race, religion, income level, lifestyle, beliefs, etc.) as needed. Note the areas of poor performance:

Social Group	**% Clinic population (approximate)**	**Aspect(s) of care**
Women		
Children		
Elderly		
Poorly educated		
Poor		
People living with HIV/AIDS		

69. Are you satisfied with the quality of care you give to patients/service users?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

Comments_____
_____
_____
_____

70. What suggestions do you have to improve the clinic?

_____
_____
_____
_____

Thank you

Decision Maker Questionnaire

This questionnaire is trying to find out what you think about the health system in your district. (15) Persons in your district involved in the health sector in different capacities are being asked to fill out this questionnaire.

Identification

Fiche N° /__/__/__/

1. Province : Eastern Cape
2. District : Nelson Mandela Metro
3. Sub/district: C_____
4. Staff Category _____
5. Age: /__/__/ Years
6. Gender: Male/Female

Background characteristics

7. Level of education:

    1. Cannot read
    2. Basic reading
    3. Primary school
    4. Secondary school
    5. University
    6. Advanced degree

8. What is your occupational group?

    1. Director - DM
    2. Program manager
    3. Facility operational manager
    4. Administrative support
    5. Other : _____

9. Monthly income

    1. <R2000
    2. > R2000 < R 5000
    3. > R5000 < R10 000
    4. > R10 000

10. How long have you worked at your current facility?

    1. Less than one year
    2. 1 to 2 years
    3. 2 to 5 years
    4. 5 to 10 years
    5. More than 10 years

11. How long have you been in your current position?

    1. Less than one year
    2. 1 to 2 years
    3. 2 to 5 years
    4. 5 to 10 years
    5. More than 10 years

12. Do you manage staff as part of your job?

    1. Yes

2. No

13. If yes, how many? _____

14. Ethnicity:

1. Coloured
2. Asian
3. Black
4. White
5. Other:

Governance and accountability

15. I understand that our role at the health district in relation to care provided to patients (check all appropriate)

1. Plan and organize care delivery
2. Monitor and evaluate care delivery and lead quality improvement
3. Support the coordination and continuity of services
4. Strengthening system governance and accountability
5. Support the empowerment and engagement of users
6. Shape the training and skills development of providers
7. Agree and monitor the legal and financial frameworks that support service provision

16. I have the resources (knowledge, time, and finances) to accomplish

1. Plan and organize care delivery
2. Monitor and evaluate care delivery and lead quality improvement
3. Support the coordination and continuity of services
4. Strengthening system governance and accountability
5. Support the empowerment and engagement of users
6. Shape the training and skills development of providers
7. Agree and monitor the legal and financial frameworks that support service provision

17. Providers see us as useful partners in enabling change towards more people-centred care

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

18. We have formal ways for communities to participate in decisions that affect how they care is provided

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

19. Our district has a system for collecting and reviewing patient and family opinion.

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

20. There is good collaboration among and between decision makers and providers

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

21. District staff provide supervision and support to local providers

1. Never
2. Rarely
3. Less than needed
4. Appropriate
5. More than enough

22. I know who to whom I am accountable and am supervised.

1. Never
2. Rarely
3. Less than needed
4. Appropriate
5. More than enough

23. In my district, I believe that providers are encouraged to discuss their concerns freely

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

24. In my district, I believe that providers are encouraged to ask questions about the management and improvement of care freely

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

25. In my district, I listen to the needs of my clinics managers and providers

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

26. People managing and improving care for users in my district work well together.

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

27. We hold staff meetings to discuss how care for our patients and support for our providers can be improved.

1. A few times a year
2. Monthly
3. A few times a month
4. A few times a week
5. Every day
6. Never

28. Health care should be a collaborative partnership between service user, communities, providers and district leaders

1. Strongly disagree
2. Somewhat disagree
3. Neither agree
4. Somewhat agree
5. Strongly agree

Working environment, motivation, and support

29. I feel emotionally drained by my work?

1. A few times a year
2. Monthly
3. A few times a month
4. A few times a week
5. Every day
6. Never

30. I am able to manage all the conflicting demands on my time at work.

1. A few times a year
2. Monthly
3. A few times a month
4. A few times a week
5. Every day

31. I feel I have the power to influence how care is provided in my district

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

32. I have been exposed to good role models of management and improvement of health systems

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

33. I have been exposed to good environments of management and improvement of health systems

1. Never
2. Rarely
3. Sometimes

4. Usually
5. Always

34. I am supported to develop the skills I need to manage and improve health systems

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

35. Which do you think are the main skills required to manage and improve health systems?

_____
_____
_____

36. Do you think the number of clinics and time you spend in supporting each clinic is appropriate?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always
6. NA

37. There are rewards and recognition for the district work in enabling patient- and family-centred services

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

38. Staff's stress-reduction and well needs are addressed

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

39. I've become less compassionate towards people since I took this job.

1. Very mild, barely noticeable
2. Mild
3. Moderate
4. Strong
5. Very strong, very noticeable

40. Working with people all day is really a strain for me.

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

41. I think about changing organizations.

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

42. I have enough support for training in my area of work.

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

43. I deal very effectively with the problems of my recipients.

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

Reorienting the model of care

44. Primary Health Care should be the key component in health care delivery

1. Strongly disagree
2. Somewhat disagree
3. Neither agree
4. Somewhat agree
5. Strongly agree

45. In my district, we know how to assess the population's needs and prioritize services

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

46. In my district promotion, prevention and public health interventions are as important as curative services

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

47. In my district, we are moving services closer to where the population live and work

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

48. In my district, we make accessible protocols and guidelines that provided need for patient care

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

49. In my district, I make sure providers use these protocols and guidelines

1. A few times a year
2. Monthly
3. A few times a month
4. A few times a week
5. Every day

Empowering and engaging people

50. In my district patients are treated with respect

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

51. In my district patient consent is sought before testing or starting treatment

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

52. In my district the confidentiality of patients' medical records is preserved (except if the information is needed by other health care providers)?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

53. In my district, consultations are carried out in a manner that protects patient confidentiality

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

54. The needs and preferences of service users and communities should be central in District Health Systems

1. Strongly disagree
2. Somewhat disagree
3. Neither agree
4. Somewhat agree
5. Strongly agree

55. How often do you think providers in your district supports the person to identify the goal they want to work towards and to break this down into small and achievable actions?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

56. How often you think professionals used the person life history and surrounding circumstances in the care plans you use?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

57. I think that providers consider cultural factors (such as the person's spiritual beliefs and culturally-based health/illness beliefs) in all parts of the treatment planning process

1. Strongly disagree
2. Somewhat disagree
3. Neither agree nor disagree
4. Somewhat agree
5. Strongly agree

58. I think is important that providers find out how the service user and carer feels about this episode of care (e.g. Worried about surgery, or how they will manage when discharged)

1. Strongly disagree
2. Somewhat disagree
3. Neither agree nor disagree
4. Somewhat agree
5. Strongly agree

59. Patients should be reminded that she or he can bring family members or friends to care appointments and treatment planning meetings.

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

60. I know how many carers are in my district and what their needs are

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

61. In my district, patients are provided information on different treatment options

1. Never
2. Rarely
3. Sometimes
4. Usually

5. Always

62. In my district, patients are consulted about their preferences over different treatment options

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

63. In my district, individuals have a choice between health care providers in a district?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

64. In my district, individuals have the opportunity to see a specialist, if they wish to?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

65. In my district, providers should develop a care plan with the patient for how they can manage their condition in their daily life

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

66. In my district, providers should offer each person a copy of his or her plan to keep.

1. Strongly disagree
2. Somewhat disagree
3. Neither agree
4. Somewhat agree
5. Strongly agree

67. A treatment plan should include goals and objectives that address what each person wants to get back in his or her life, not just what he or she is trying to avoid or get rid of.

1. Strongly disagree
2. Somewhat disagree
3. Neither agree
4. Somewhat agree
5. Strongly agree

68. I think that a care plan should include each person's strengths, interests, and talents in his or her plan.

1. Strongly disagree
2. Somewhat disagree
3. Neither agree
4. Somewhat agree

5. Strongly agree

69. In our district we are actively developing and linking users to peer-based services.

1. Strongly disagree
2. Somewhat disagree
3. Neither agree
4. Somewhat agree
5. Strongly agree

Care coordination and care continuity

70. Service users in my districts are allocated a key contact person who is known to the service user and their carer/s

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

71. If a service user makes contact with his health service in my district, they are directed to the most appropriate service

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

72. There is good communication between the different organisations providing care for the people in my district.

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

73. There is a formal system in my district for and or accepting referred patients

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

Creating an enabling environment

74. How often do you think you support providers to identify the service improvement goal they want to work towards and to break this down into small and achievable actions?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always
6. I don’t know

75. How often users experience barriers in access to health care services in your district?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

76. Financial mechanism and payment systems in my district have an impact on how people-centred and integrated care is provided

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

77. We are supporting providers training in people-centred and integrated care related competencies

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

78. I know how to support and lead change towards people-centred and integrated services

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

Responsiveness

79. Considering the seven aspects of health system function that you have reported on above, how would you rate?

Importance: Please give a value between 0 and 10 to indicate your personal rating of how important the aspect is. Here, 0 means not at all important and 10 means extremely important.

Performance: Please give a value between 0 and 10 to indicate your personal rating of the performance of your facility. Here, 0 means the poorest performance and 10 means the best.

Aspect of care	**Importance**	**Performance**
Governance and accountability		
Empowering and engaging people		
Care coordination and care continuity		
Choice of care provider/institution		
Comprehensiveness of care		
Quality of basic amenities		
Promptness of attention		
Confidentiality and privacy		

Aspect of care	Importance	Performance
Dignity and respect		
Informed choice/autonomy		
Self-care support		
Organization and management		
Supporting providers		
Reforming payment systems		

80. Are any of the following social groups facing worse care and health system performance with regard to the areas above. Please include other social groups (age, gender, education level, race, religion, income level, lifestyle, beliefs, etc.) as needed. Note the areas of poor performance:

Social Group	% Clinic population (approximate)	Aspect(s) of care
Women		
Children		
Elderly		
Poorly educated		
Poor		
People living with HIV/AIDS		

81. Are you satisfied with the quality of care your district provides to patients/service users?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

Comments_____
_____
_____
_____

82. What suggestions do you have to improve the way the district works?

_____
_____
_____
_____

Thank you !

Focus Group Guide

Focus Group: Demographic Details

Please answer the following questions in the spaces provided, circle or tick the most appropriate options.

1. Age:……

2. Are you: (please tick as necessary) □ Male □ Female

3. What is your ethnicity?

4. What is your education level?

5. What is your income?

Thank you for taking the time to complete this questionnaire

Focus Group: Discussion Guide

Facilitator's welcome, introduction and instructions to participants

Welcome and thank you for volunteering to take part in this focus group. You have been asked to participate as your point of view as a patient and community member is important. Your time and input is appreciated.

Introduction: This focus group discussion is designed to better understand your thoughts and feelings about health care you received in public health facilities in NMM District within the last 12 months. The focus group discussion will take no more than two hours. May I tape the discussion to facilitate its recollection? (If yes, switch on the recorder)

Anonymity: Despite being taped, I would like to assure you that the discussion will be anonymous. The tapes will be kept safely in a locked facility until they are transcribed word for word, then they will be destroyed. The transcribed notes of the focus group will contain no information that would allow individual subjects to be linked to specific statements. You should try to answer and comment as accurately and truthfully as possible. I and the other focus group participants would appreciate it if you would refrain from discussing the comments of other group members outside the focus group. If there are any questions or discussions that you do not wish to answer or participate in, you do not have to do so; however please try to answer and be as involved as possible.

Consent: Please assure that you have completed a consent form. One copy of the informed consent form should be given to me and you should keep the second copy for your records.

Demographic Details: Please also complete a copy of the demographic details questionnaire which provides us with a little more information about you.

Ground rules

- The most important rule is that only one person speaks at a time. There may be a temptation to jump in when someone is talking but please wait until they have finished.
- There are no right or wrong answers.
- You do not have to speak in any particular order.
- When you do have something to say, please do so. There are many of you in the group and it is important that I hear everyone's views.
- You do not have to agree with the views of other people in the group
- Does anyone have any questions? (answers).

- OK, let's begin

Warm up

- First, I'd like everyone to introduce themselves. Can you tell us your name and something about you?

Introductory question

I would like you to take a couple of minutes to think about your experience receiving care at a public health facility in NMM District. Would anyone share his or her experience?

Guiding questions

- What are the attitudes of staff and providers towards you? (What did people think/say/do?)
- How did the staff and doctors and nurses or community health workers communicate with you?
- How were you respected or disrespected during your visit?
- How involved were you with the decisions about your care? In what ways did that meet or fail to meet your expectations?
- Do you think that people in the community trust and use the clinic? Why or why not?
- How would you improve the clinic and your experience there?
- How would you like your family or friends to be involved in your care?
- What ways does the community support patients?
- What services provided by community health workers are helpful? What parts are not helpful?
- How would you describe the relationship you have with the providers at the facility?
- Have you had trouble accessing services when you needed them? How could this be improved?
- How could the facility better support you in caring for your conditions at during your daily life?
- Would you recommend using the health facility to your family and friends? Why or why not?
- Do you have community representatives who help make decisions at the clinic? Are they able to influence decisions? Why or why not?
- In what ways are you able to influence the services provided at the health facility? Does the community have an active role in planning or designing services?

Concluding question

- Of all the things we've discussed today, what would you say are the most important issues you would like to improve at your local facility?

Conclusion

- Thank you for participating. This has been a very successful discussion
- Your opinions will be a valuable asset to the study and to improvement efforts.
- We hope you have found the discussion interesting
- If there is anything you are unhappy with or wish to complain about, please contact ***** or speak to me later
- I would like to remind you that any comments featuring in this report will be anonymous
- Before you leave, please hand in your completed personal details questionnaire

USAID APPLYING SCIENCE TO STRENGTHEN AND IMPROVE SYSTEMS PROJECT

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