

REPORT ON THE RH & HIV/AIDS FHI 360 SOUTH AFRICA

Mobile Services Unit Project

Lessons for Health Systems Strengthening



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Lessons for Health Systems Strengthening

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REPUBLIC OF SOUTH AFRICA



SOUTH AFRICANS AND AMERICANS
IN PARTNERSHIP TO FIGHT HIV/AIDS
PEPFAR



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ACKNOWLEDGEMENTS

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We would like to thank the staff of the MSU services for their dedication to the project, the officials of the Department of Health for their support in ensuring that there are medical supplies and test kits, and the communities for welcoming our teams and forming strong partnerships in support of the project.

List of Abbreviations

ARV	Antiretroviral
CBO	Community Based Organisation
DHB	District Health Barometer
FHI	Family Health International
HBC	Home Based Care
ICPC	Integrated Community Palliative Care
LTA	Local Traditional Authority
MSU	Mobile Services Unit
NHI	National Health Insurance
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
TB	Tuberculosis
USAID	United States Agency for International Development

INTRODUCTION

A high performing health system is characterized by quality, efficiency, and equity in the ability to access to services. The situation in South Africa's health system, however, falls short of this characterization. Rather, the health care system has been described as a two-tiered system with a large proportion of funding allocated through medical schemes and various hospital care plans in the private sector. The private sector mainly benefits those who are employed, having a large portion of their health care paid by their employers. Consequently, those with medical scheme coverage have a wide choice of providers operating in the private sector while those with public sector funding are mainly limited to access public sector institutions which have a significant shortage of health care providers. This is largely due to the fact that a significant proportion of financial and human resources for health are located in the private health sector serving only an estimated 16.2% of the population with private health insurance coverage.

The public sector, in comparison, is under-resourced relative to disease burden of the population it serves. It has disproportionately less human resources than the private sector yet it has to manage significantly higher patient numbers. The recent estimates showed that there are 4,900 patients per general practitioner in the public sector compared to 243 patients for a general practitioner in the private sector. There are almost 23,000 patients for a pharmacist in the public sector relative to just 1,900 patients to a pharmacist in the private sector. (NHI Green Paper, 2011)

RATIONALE FOR MOBILE SERVICES

The Mobile Service Unit (MSU) concept was introduced by FHI360 South Africa (FHISA) in 2008 to provide an integrated Reproductive Health (RH) and HIV services to remote and underserved provinces in South Africa. In partnership with the Government of South Africa (GoSA) and PEPFAR funding from USAID/ South Africa ,the project was launched in four provinces: Eastern Cape (OR Tambo District); KwaZulu Natal (Amajuba District); Limpopo (Greater Sekhukhune District) and Mpumalanga (Gert Sibande & Ehlanzeni Districts).

FHISA developed a standardized framework for engaging with provinces. This document outlined the services that were going to be provided at the MSU and explained roles and responsibilities for each stakeholder. The main thrust of the Memorandum of Understanding (MOU) was to work with the department to provide improved access to PHC services placing an emphasis on integrated HIV and AIDS; diagnosis and treatment of Sexually Transmitted Infections (STIs) and Sexual & Reproductive Health (SRH) services. Some of the key strategic areas of the intervention included:

- Support existing Home-based Care (HBC) programmes
- Improved access to essential health services
- Provide a link for Antiretroviral (ARV) services
- Community health education and health promotion

PLANNING AND INITIATION PHASE OF THE MSU ACTIVITY

Community Entry

The MSU staff, under the leadership of an FHISA coordinator arranged for the initial community entry meeting with the Local Traditional Authority (LTA) consisting of community leaders and counselors. Following this meeting, the leadership further engaged the community at various community fora to ensure buy-in by most of community members. Once there was general agreement, the local leadership granted permission for FHISA to provide health services and informed the community members about the existence of the MSU.

Engagement with District Health Office

Officials from the department of health at the district/sub-district level for the proposed MSU sites were formally informed of the MSU through the provincial office. This meeting ensured that there was common understanding between the district office staff and FHI staff. The role clarification process went over the following points:

- Communication channels (i.e. the first line of communication from MSU staff to district and from district to MSU staff, methods of communication etc.)
- The referral system (i.e. referral resources including referral forms, process, referral feedback from facilities on clients who are started on ARV/TB treatment etc.)
- Information management (i.e. reporting forms, reporting dates, responsible manager, etc.).
- Inventory management of commodities provided by the facilities (including medication and test kits).

The district office was responsible for introducing the MSU staff to the facility managers of those facilities to which clients are referred. In certain instances this is also the facility where the MSU staff gets the medical consumables. Variations existed where this role was delegated to the sub-district manager who ensured that the MSU staff met with all the relevant officials in the district/sub-district. This included introductions to the facility (clinics and hospitals) and staff (service providers and managers). Additional meetings between the MSU coordinators and district/sub-district staff were held to develop a schedule of the mobile unit visits to the selected mobile service points.

The schedule was distributed amongst the community and the relevant facilities by the MSU staff and community health workers. The MSU coordinator working closely with the CBOs and other care supporters informed the community about the MSU services provided and visitation dates, clinic times and the possible parking point for the MSU. Some communities had problems with accessing the station for the mobile services point and requested that it be moved to another location that was more acceptable and convenient for the community. Community leadership, together with MSU staff, had to agree to the changes. In some of the villages, for example, the community designated a house as a safe point for the MSU to park and render services.

FHISA was running other projects or activities in various other districts, and the intent was that the MSU would integrate with these projects. Of note is the Integrated Community Palliative Care (ICPC) subproject in partnership with Community Based Organisations (CBOs) to provide care and support services in the communities. The Home-Based Care Organizations already in existence in the community collaborated with the MSU and became part of all community discussions or introductory meetings and dealings regarding strategic community penetration. The MSU staff along with the HBC organisations were introduced to the community stakeholders i.e. school principals, clinic/hospital staff, police, local authorities and church leaders.

The conceptual design and underlying assumption was that this approach would provide an opportunity for the clients to take responsibility for their own health and access services during convenient times, save time and money for transport to health facilities, and strengthen the links with health service providers like home based care (HBC) projects, clinics and hospitals.

PROJECT RATIONALE

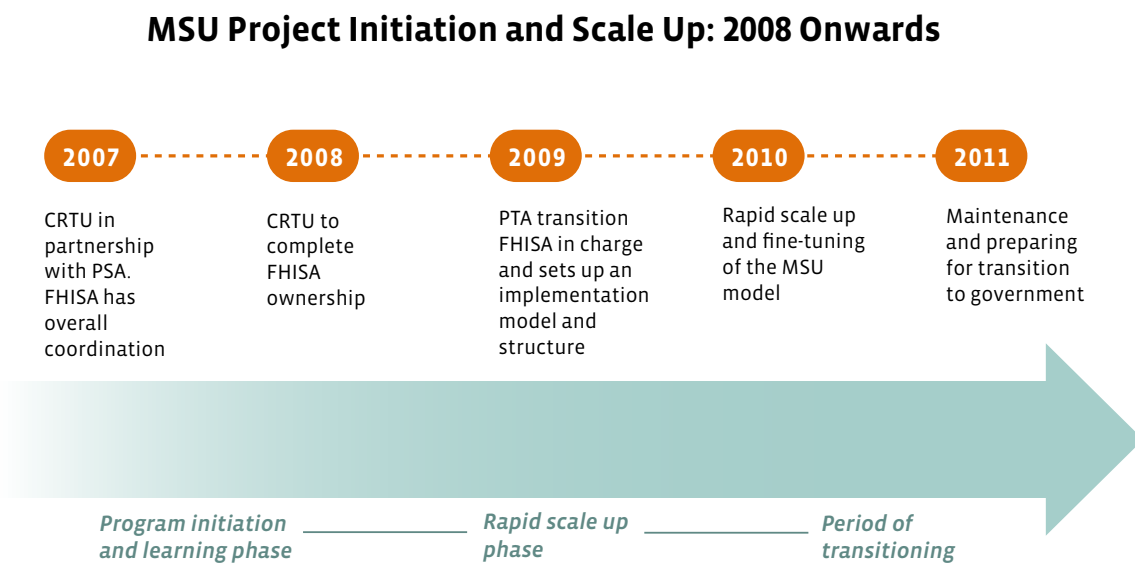
The uptake of contraceptive services and voluntary counseling and testing (VCT) in the public sector facilities in South Africa has been slow. Consequently, there is a need to find innovative ways to strengthen the availability and acceptability of both contraceptives and HIV counseling and testing. Some of the reasons cited for this poor uptake of reproductive and HIV services relate to unreliable supply of medicines. This is particularly true for antiretroviral treatment as in most government institutions clients have to wait for long periods to receive the ARVs. The costs clients have to incur when travelling to seek care or obtain renewed supplies (e.g. ARVs, injectables, pills) are also a deterrent.

In response to the challenge of low uptake of sexual reproductive health services and HIV Counseling and Testing, the Project Support Association (PSASA) and FHI 360 (then known as Family Health International) partnered to establish a program that sought to provide integrated sexual and reproductive health and Voluntary Counseling and Testing (VCT) services, utilizing Home Based Care (HBC) projects in target communities as an entry point. The model was such that-HBC volunteers identified clients during their routine household visits and marketed the new mobile services within walking distances to the client's home.

The primary objective of the MSU project was to ensure that RH/HIV health services were available to citizens with the greatest need for them within a short distance from their households. The intention was that improved access to services would result in a positive impact on health outcomes resulting from poor access. Historically the four provinces named above have had challenges in providing access to health services. The South African public health system measures access to services through the Primary Health Care (PHC) utilisation rate. The average PHC utilisation rate in 2010/11 was 2.3 visits per person per year while the target was 3.5 visits per person. The PHC utilisation rate of the four provinces ranged from a low of 2.4 to a high of 2.6, well below the target for the country.

Figure 1 below illustrates how the MSU project was introduced and how the project has grown since inception. Initially the program identified a total of 10 home based care (HBC) projects in the Greater Tubatse and Thabachweu Municipalities in Northern area of Mpumalanga. About seven of the sites were in Ehlanzeni district in Mpumalanga while only three sites were in the greater Sekhukhune in Limpopo Province. The Home Based Care Projects are funded by a partner organization called Project Support Association of Southern Africa (PSA SA) and linked to Government Health facilities in their localities.

Figure 1: Depiction of the evolution of MSU services



Initiation Phase: The first community sensitization activities were conducted in the ten HBC sites through informal training sessions. These sessions were aimed at preparing HBC volunteers with the knowledge of how the mobile service unit (MSU) would be operating in order for the volunteers to effectively market the services in their respective communities. Additionally, the training also included role clarification for the HBC volunteers in supporting the MSU team while at the same time continuing providing health care services to the communities they serve. The training was facilitated by a lead person from the PSASA as they had already established relationships with the communities.

MSU site initiation was preceded by an extensive training of the nurses who were appointed to establish an MSU service. FHI SA developed and presented a five-day intensive module for nurses in preparation for MSU placement. The primary target audiences were nurses who were working in the health facilities where the MSU is going to provide health care services. The purpose of the training was to equip the nurses in the afore-mentioned facilities with RH knowledge and skills and ensure a standard level of care between the MSU and the government facilities within the district as part of strengthening primary health care. During the training, time was spent reflecting on the referral forms that were going to be used by the MSU team to ensure that there was a common understanding of the referral processes between the MSU and public sector facilities receiving the referred clients.

Following the initial training, MSU nurses were seconded for 10 days to an NGO (Thembaletu in Mpumalanga Tonga) to receive on-site training on HIV counseling and testing. Each nurse was given adequate opportunity to improve their skills and self-efficacy through testing at least 50 clients within 10 days. In addition, the MSU nurses also attended the training on integration of family planning and HCT services together with the government nurses

Scale up Phase: The MSU subproject was launched in 2008 under the Contraceptive and Reproductive Health Technologies Research Utilisation (CRTU) program, a five-year USAID cooperative agreement awarded to FHI in 2005. The specific focus areas for CRTU were to increase the range and use of safe effective and affordable contraceptive methods and reproductive health technologies. The CRTU was a 5-year project. Before that agreement concluded, FHI 360 was awarded the Preventive Technologies Agreement (PTA) in August 2009. The PTA's main aim was to support the development of new prevention initiatives and support activities that advance the USAID's global agenda for HIV prevention including the integration of family planning and HIV services. The Mobile Services Unit Project matched the objectives of the new cooperative agreement and was transitioned to the PTA in December 2009.

Another transition occurred in the MSU project during the first half of 2009. Over this period, more MSU service were being introduced to other provinces and thus it made sense for FHISA to be directly involved in the implementation of the project as the size and the scale of the project was rapidly exceeding capacity of PSA as a service provider. Based on this, USAID South Africa was supportive of FHISA assuming direct responsibility for the MSU project, including staffing and service provision, and

FHISA therefore transitioned from overseeing the project to being an implementing agency. The shift in strategy from technical assistance to direct service delivery had one unfortunate resulting that direct service delivery was a much more costly proposition and hence FHI 360 had to end its support to the MSUs sooner than it had hoped and anticipated. The original intent was for FHISA to operate the MSUs for 4-5 years and transition these to the provincial departments of health in 2013.

PURPOSE OF THE REPORT

This report was commissioned to provide an in-depth understanding of the FHI 360 Mobile Services Unit (MSU) project in South Africa. The project is being transitioned from FHI 360 to the Department of Health as per original agreement. This report describes the MSU project, its history, implementation, outcomes and charts a way forward as an end of the project report.

METHODOLOGY

The MSU project employed a combination of strategies to collect data for analysis and reporting. Firstly, a retrospective desktop review of project inception documents, quarterly and annual reports FHI360 global database reports was done. Meetings and discussions were also held with project management team.

Secondly, face-to-face and telephonic interviews were conducted with MSU project staff at national and district level, department of health district/sub-district officials and in certain areas selected community participants. Due to project time and financial constraints only two of the four districts (Ermelo and Newcastle) were visited and face-to-face interviews were conducted there. The decision to select these sites was arrived at based on the number of staff and patient volumes at the sites, the diversity of the implementation models at the sites and the logistical feasibility to conduct the interviews within the specified time frames.

The same structured interview guide was used for both the face-to-face and telephonic interviews in an attempt to standardize the data collection process. The questions asked on the interviewee's role in the MSU, number of years associated with MSU, describing daily activities etc. A total of 24 participants were interviewed during the second phase of the process; the majority of the participants were MSU project staff who provided an in-depth understanding of the way the mobile services unit operates. The description of the MSU project and daily operations based on the desktop review and the interviews are presented in the following section.

GENERAL PROJECT DESCRIPTION

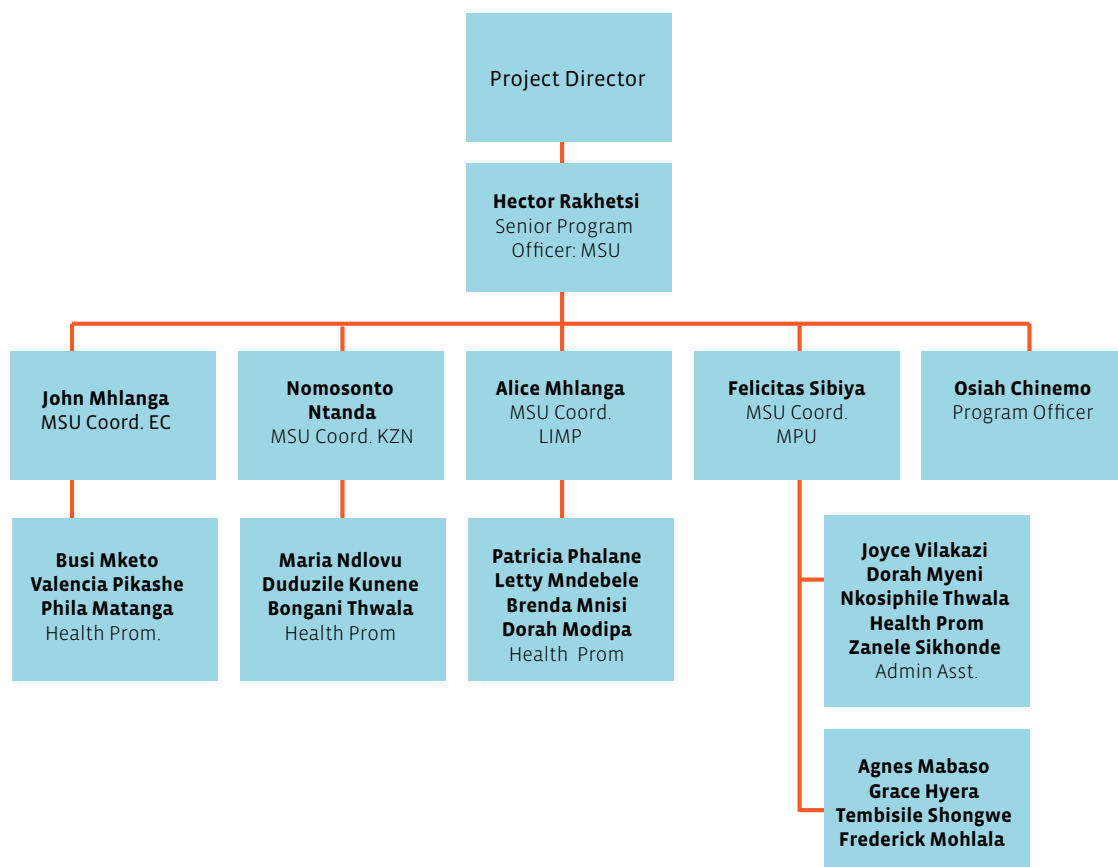
THE PROCESS OF MSU DEVELOPMENT AND EXPANSION FOR FHISA

The mobile services unit services expanded from humble beginnings of one MSU vehicle servicing 10 cross-border sites in Mpumalanga and Limpopo provinces. Furthermore, the project evolved from being run by a partner organisation to being a fully -fledged subprogramme of FHI 360 in the South Africa country office with project staff in both the country office and at the MSU sites in the four provinces.

PROJECT MANAGEMENT AND ORGANOGRAM

Initially, the program was headed by a program director, with a total of 22 staff members in the country office and the provincial MSU site offices. The MSU team was ultimately responsible for providing clinical services to a total of 89 sites spread across four provinces. The most recent project organogram is illustrated in the figure 2 below.

Figure 2: MSU Project Organogram



Project Implementation

MSU PACKAGE OF SERVICES

INFRASTRUCTURE

For the project to attain its objectives and implement the FP/HIV project outreach successfully, it was necessary to plan and quantify the required tools that would provide an enabling environment for the delivery of quality clinical services. Consumables and other material were identified as a basic need for successful execution of the task at hand. Among other resources, the following were identified, analyzed and procured:

Transport: a mini-bus was bought and converted into a vehicle that can be used as a counseling room, examination room and a testing room. These activities take place at different levels of VCT and are carried out by two different staff. The vehicle also transports the team to places where activities are planned to take place.

Inside design:

- One couch
- A small table and two fixed chairs for the nurse and the client at the middle of the vehicle
- Four seats behind the driver's chair for couple counseling
- One long wooden cabinet with drawers and sliding doors for medication, testing kits and other medical consumables
- Two long curtains to maintain privacy during consultation
- Two lights to for use when doing examination or in the evening
- Tinted windows to promote privacy during consultation

One nurse uses the inside space as a consulting room with curtains used to maintain privacy.



Medical equipment: One blood pressure machine, weighing scale, stethoscope, and other consumables such as linen savers, hand gloves, testing kits, disposable refuse bags, were put together for the VCT project.

Office equipment and stationery: This included the demographic data collection forms to record clients and project information in the field and fat files. It also included a computer and office cabinets to keep folders for the clients

Staff and HR: The typical core team for the MSU was comprised of an **MSU coordinator** (a professional nurse by training); **2 professional nurses**, to provide clinical services and a **health promoter** to provide health education and administrative assistant at mobile points. In reality it was often difficult to recruit and retain the full complement of three nurses.

SERVICE ORGANISATION AND DELIVERY

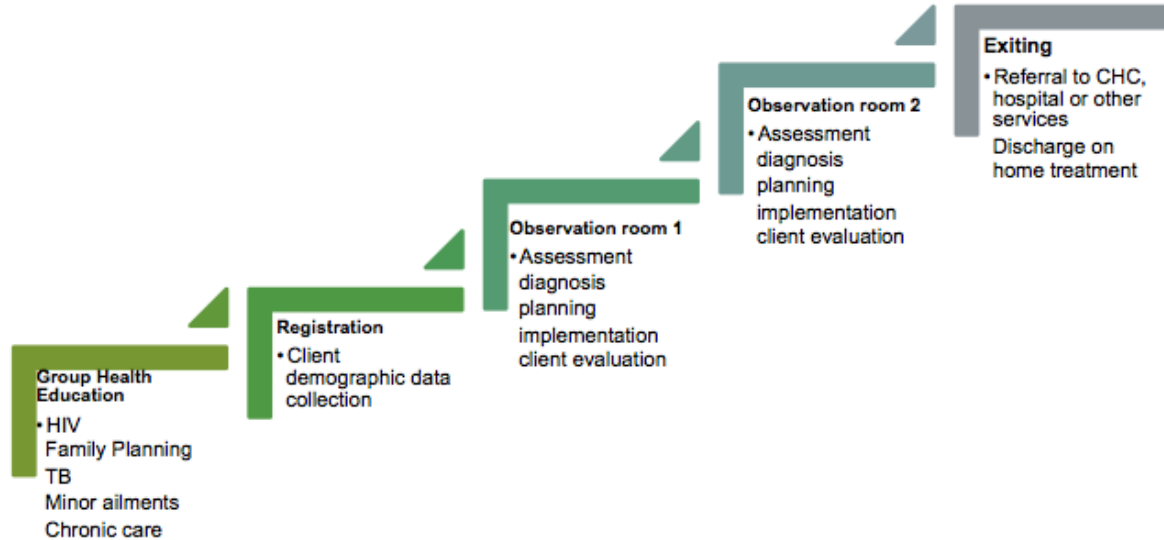
In the beginning, as part of the PEPFAR funded programmes, the MSU under a RH/population cooperative agreement (CRTU) was aimed at HIV/SRH integration. However, factors on the ground necessitated a change in strategy and the provision of comprehensive PHC services similar to that provided by government mobile services. Among the primary reasons for this change were: i) that the community requested treatment of minor ailments and chronic conditions; ii) the need to counteract stigma towards HIV infected people (During the launch of the MSUs in 2008/2009 there was still a lot of stigma towards HIV infected people. Consequently some community members were reluctant to access MSU services for fear of being stigmatized as having HIV). However, if the services provided were more comprehensive, then other people would not know what service a person was using, therefore reducing suspicion about whether a person is HIV infected or not.



The intended package of services included a range of comprehensive Primary Care Services which include:

- **Community mobilisation:** raising awareness on the availability and utilisation of services,
- **Prevention:** of HIV infections and education on how to prevent STI transmission and acquisition.
- Additional prevention services included health education on cervical cancer. Special emphasis was placed on early diagnosis through identification of symptoms and signs. Additional screening services were provided for TB through early diagnosis based on symptoms and signs.
- **Treatment:** syndromic management was provided for sexually transmitted infections. Additional treatment for acute and chronic conditions was available on the MSU. Most of the medications that are on the essential drugs list (EDL) were available from the MSU, as is the case for most clinics and mobile services for government. Initially, there were concerns with regard to providing medication to non-government staff. However, following dialogue and the setting up of proper M&E systems, this was overcome and all MSUs could provide treatment.
- **Care and support** delivered close to where people live. The MSU programme was designed to bring services to the people, thus improving access and health outcomes.

Figure 3: Patient flow Diagram at MSU Service Point



Routine Activities at MSU Site: as illustrated in figure 1 above, the first activity on arrival and assembly of equipment is presenting a health talk. A topic is selected depending on the target group of the day. For example, if the target is mothers of childbearing age the health promoter will talk about family planning, STI or nutrition for the infants. The MSU also responded to events such as breast cancer month, immunization campaigns and youth month. The events on the health calendar guided the MSU team as to what information to give to the people.



Above the health promoter is facilitating a health talk on oral pill method using simple IEC material that can be understood by low literacy populations in rural areas.

The second stage was registration and gathering of demographic information using the client registration form and keeping this information confidential in a client folder. Additionally, the health promoter attended to clients on a one on one basis ensuring that each client received specifically tailored health education addressing individual issues that could not be addressed in the group session. The health promoter in certain instances issued information leaflets and pamphlets to re-enforce the information discussed during group health education. As health promoters do not have in-depth disease specific knowledge, they always referred the client to the nurse for issues beyond their scope. When the health promoter completed the client registration form, she/he would then guide the client to the nurse's consultation room or request the client to wait if the nurse was busy with another client.

Following the completion of registration stage, the health promoter was to ensure a smooth flow of clients as they queue to be seen by the nurse. The clients are triaged such that those who are coughing a lot (and suspected of TB) would be seen first to reduce the chances of infecting others.

The final stage was the nurse's consultation; here the client received the required service and additional



services as initiated by the nurse. For example; “a client who came to the MSU complaining of a headache, the nurse would use this presenting complaint as a draw card to initiate a discussion of family planning and HCT.

After the consultation the nurse decided whether to refer client to community health centre/ hospital or arrange for review date at the MSU.

Recording and Data collection tools in the MSU: each client encounter had to be registered and recorded in one or more of the following forms or registers:

- Patient register forms
- PHC register
- HCT register
- Client register book
- Referral form
- TB screening and specimen register



There was a routine protocol on how this data was collated at the end of the day, week and month. Following an agreed standard verification process at site level, the data was aggregated as per programme indicators and sent to the central office. This is the data that is used to assess routine programme performance and is also part of the FHI Global Database. Additionally, the PHC data was summarised in the monthly forms supplied by the department of health. This information was used by the department to account for the supplies, i.e. medicines, test kits and other consumables supplied to the MSU.

SERVICE STATISTICS

The Primary Health Care Headcount is the total number of clients seen at the MSU including chronic diseases, minor ailments and child health services. This is a true reflection of the clinical workload that the staff is experiencing at MSU. Routinely, at the end of the month the PHC headcount figures are submitted to the department of health as it is one of the mechanisms used by the department to monitor the performance of the MSU and thus justifies giving test kits, medical supplies and related consumables.

PHC Headcount-Eastern Cape			
	2009	2010	2011
<5	114	207	387
5 yrs and older	1867	3233	3504
Total	1981	3440	3891
Total for 3 years			9312

The MSU service data is presented below per province to provide a better understanding of the volume of clients seen. The data has been aggregated for all service points and districts and presented as provincial data.

PHC Headcount-KZN			
	2009	2010	2011
<5	224	574	479
5 yrs and older	1946	4144	3194
Total	2170	4718	3673
Total for 3 years			10561

Over the reporting period, the PHC headcount for children under 5 years of age has ranged from a low of 6% in the Eastern Cape in 2009 to a high of 20% in Mpumalanga by 2011.

PHC Headcount-KZN			
	2009	2010	2011
<5	224	574	479
5 yrs and older	1946	4144	3194
Total	2170	4718	3673
Total for 3 years			10561

The trends over the years for all four provinces have been upwards with increases in attendance of children under 5 years at MSU clinics.

PHC Headcount-Mpumalanga			
	2009	2010	2011
<5	558	1334	2285
5 yrs and older	2853	7025	9223
Total	3411	8359	11508
Total for 3 years			23278

This is an encouraging development as it links well with the Negotiated Service Delivery Agreement (NSDA-output 3) and provides for improved access to health services for children.

QUALITY ASSURANCE

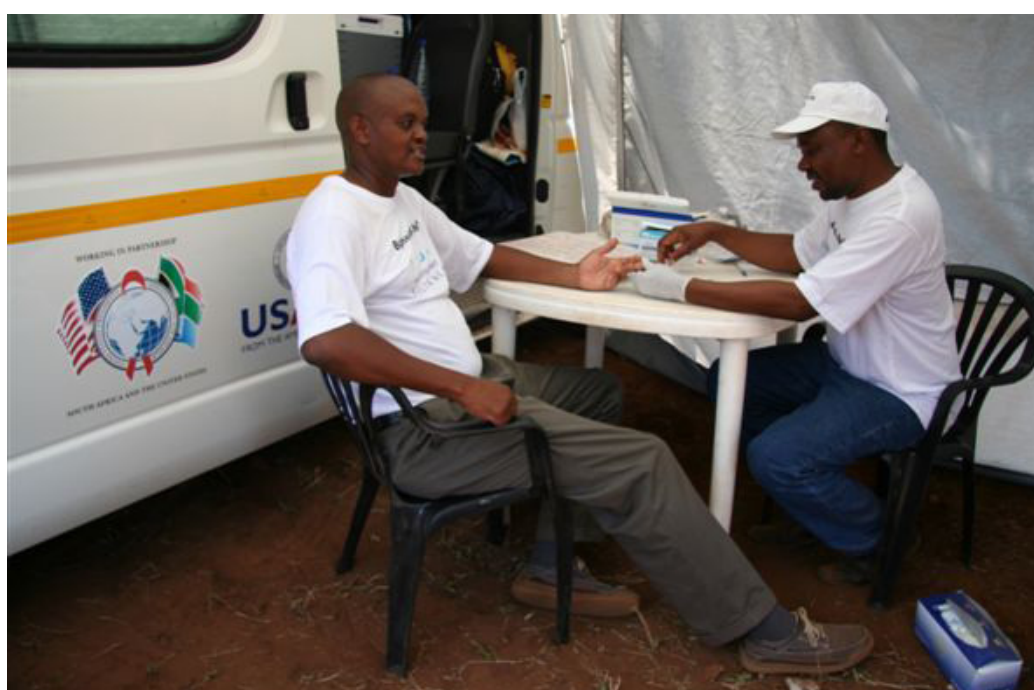
A mobile service guideline was developed to aid the MSU staff in implementing a standardized quality of care. This guide also set the norms on what clients could expect when visiting the MSUs at all sites. Furthermore, the guideline detailed the roles of each member of the MSU and contained policies and procedures, including a code of conduct for the MSU staff. Moreover, the guideline outlined all the services that were supposed to be delivered and included protocols and guidelines for patient management in each programmatic area. This document made the supervisory visits by the programme managers easy as they could check adherence to this guideline in addition to other tools they had to assess quality..

Eastern Cape

Descriptive Summary: Mobile Service Units (MSUs) were set up in the OR Tambo's, King Sabata Dalindyebo sub-district. The base station for the MSU was in Mvezo village which has an estimated population of 2,000 people. The other 3 villages neighbouring Mvezo were also selected as service points where the MSU provided services. The service points included the following villages: Magele, Mayoli, Ngaphezulu and Gateway 1&2. These are four mobile service points were set-up to provide a number of services as described previously.

The MSU received medical supplies and test kits from the provincial government through the government medicines depot. They were always fully stocked and prepared for their service points and hardly had stock outs, a factor that made them preferred by the communities. Additionally, there were no long queues and patients were seen promptly, with empathy and respect. The vehicle was well equipped and staff was able to do most of basic health screening such as blood pressure and glucose measurement.

The MSU also participated in district campaigns and were often the first ones to arrive and setup in preparation for HCT and related campaigns. Some of the benefits the MSU brought to the community were that it saved the community a return travel of about 60kms to access services at the nearest clinic facility.





KwaZulu Natal

Descriptive Summary: The Mobile Services Unit in this province was established in Newcastle with close cooperation of the district manager of Amajuba district. The base station for the MSU vehicle was Newcastle hospital with staff accommodated in an office near the hospital. The mobile vehicle serviced 10 Sites in Amajuba Districts under 3 sub-districts of Emadadeni; Utrecht and Newcastle. The mobile service points are segmented as follows; six service points in Madadeni, two each in Newcastle and Utrecht. The greatest need was identified in Madadeni where there are only two government clinics servicing a large population. Reportedly there are no private general medical practitioners in the area which made the services of the mobile clinic extremely valuable for the community. The number of patients seen in Madadeni stops could be as high as 50 patients per day resulting in long hours for the staff at the MSU.

The arrangement with the district office was such that the MSU staff collected medicines and consumables from the hospital in the area they serve. Unlike in other provinces where there was one supply point, here there were three points for collection of medicines and other supplies. The clinical services offered included:

- pre-test counseling; HIV testing using the screening rapid HIV antibody test and translation of HIV results and post-test counseling.
- second confirmatory test conducted when the screening test is reactive.
- screened for TB for those diagnosed with HIV; and initiation of prophylaxis treatment (co-trimoxazole)
- Collect blood for CD4 and take to the nearest health center

This mobile had the advantage of working closely with hospitals in Newcastle, Madadeni and Utrecht. This meant that they had easy access to the laboratories and could do more in terms of conducting CD4 testing and referring patients for initiation of Antiretroviral Therapy.

Case Study-Best Practice Example:

Medical Waste Management in KZN MSU

The MSU in KZN complied with the district management committee of the Medical Waste Management control in the promotion of procedures and practices which will reduce the risk of the spread of disease and occurrence of accidents associated with medical waste. The MSU coordinator liaised with the Hospital Infection control committee and was granted permission for the MSU to work in collaboration with the Hospital Waste Management Officer.

The waste management protocol indicates that all medical waste should be disposed in the incinerator in the Hospital where the mobile is parked daily after outreach activities. The medical waste management protocol was thus applied in the MSUs where strict use of color-coding of waste product container was applied. The color scheme was such that red was used for blood contaminated waste and yellow or black for used but non-hazardous swabs, syringe plastic containers etc. Additionally, used syringes are put into strong containers which are resistant to puncture. Universal precautions as per medical waste protocol were adhered to by the MSU staff. This includes the use gloves when injecting patients and collecting all contaminated medical waste, storing in the vehicle during the day before disposal in the hospital incinerator,

ACTION PLAN

Provide training to the MSU staff and develop awareness of the health, safety and environmental issues relating to medical waste and how these can affect employees in their daily work.

Limpopo

Descriptive Summary: The MSU in Limpopo provided services to 11 sites including cross border sites with Mpumalanga. Since inception the MOU has been functioning in this way, however in 2012, the Limpopo Department of Health indicated that they would like the MSU to service the province exclusively, cutting out the Mpumalanga arrangements. These sentiments are well captured by one of the respondents when she said:

“We are happy with the start as we are focusing on the MSU objectives integrating HIV, FP and Sexual Reproductive Health. BUT the question Greater Tubatse is waiting for is, when FHI is going to support Limpopo 100%”.

The clinical services offered were:

- the MSU do pre-test counseling,
- HIV testing using the Screening Rapid HIV antibody test,
- Translation of HIV results and post-test counseling.
- Second confirmatory test can be done if the test is reactive.
- Once the result is confirmed then the client is screened for TB
- Initiation of chemoprophylaxis treatment (Co-trimoxazole)
- Referred for CD4 to a nearby health center

In early 2012, the Limpopo government mobile clinics team requested that the FHI 360-MSU team conduct joint visits with the government mobile clinic. The strategy was that the FHI360 mobile would conduct health education, HCT, screening and provide counselling, while the DoH mobile would concentrate on curative services such as treatment of minor and chronic ailments and be responsible for medication and consumables.

Success Story:

Limpopo Case Study

This is the story of Sophie Khumbula (not real name) from a village called Difakgate 20km out of Burgersfort in Limpopo Province. It was in 2009 when Sophie aged 17 years of age came to MSU to seek family planning services. On demographic information gathering Sophie did not want to elaborate much and would give snap answers to the health promoter. She went on to tell the Health promoter that she knew her HIV status and that she was HIV negative.

On one-on-one with the Professional nurse during consultation Sophie looked sad, withdrawn and miserable. She mentioned that she wanted a family planning method and she kept quiet and she did not want to talk again.

The nurse politely asked Sophie to relax and feel free to express herself in discussing her health problem. Again the nurse expressed that once Sophie opened up he would be in a position to provide a specific client centered health service to her. The Nurse asked Sophie if she was in a relationship and how the relationship was working. He also asked if the parents were at home and how things are working at school. Sophie agreed that she was in a relationship and its working well and that she was staying with her mother and all is well. The nurse asked the last time she did a HIV test. Sophie stated that it was two weeks before the day she came to MSU. The nurse asked Sophie if she was willing to share the outcome of the HIV test results. Sophie admitted that she tested positive to HIV test and this was worrying her a lot. She was not able to tell either her mother or her boyfriend. She even mentioned she was coming to the MSU to do a repeat test in case the first test was not correct. After the repeat test in the MSU the nurse told her that the result is the same with what she received at the clinic.

The MSU nurse continued to provide on-going post- test counseling support to Sophie. Sophie was referred to the hospital for ELISA test, TB sputum collection and screening and CD4+ cell count. One month later the MSUs nurse went to the hospital to make sure that Sophie went to the hospital and to check the result of the CD4 count. The CD4 count result was more than 700 cell/mm³.

With the help of the hospital, a full clinical assessment was done on Sophie's physical and psychological health status. The MSU continued to carryout regular check-ups at least every four months to help the nurses to make decision on when to start the client on chemoprophylaxis and refer for ART when necessary. The MSU helped Sophie out of her denial, and through continuous support, the CD4 remain controlled. This has delayed ARV initiative.

Since 2009 Sophie is coping well with her condition. The MSU helped Sophie to:

- Disclose her status to her mother and the boyfriend
- Delay initiation of ART through psychological and physical support
- Accept her condition and live a health positive life.

Mpumalanga

Descriptive Summary: The MSU service in Mpumalanga province is the largest both in terms of staff complement and staff numbers. There are two mobile vehicles which have two routes, i.e. Albert Luthuli sub-district and Pixley KaSeme. The Mpumalanga mobiles serviced a total of 57 sites. The Pixley kaSeme mobile is mainly within farming communities in the sub-district. The mobiles collect their medication and consumables from Embhuleni hospital pharmacy (Albert Luthuli mobile) and Amersfoort clinic (Pixley ka Seme mobile). There were four professional nurses in the Mpumalanga team-2 per vehicle. The visits were arranged such that the mobile team visited each site twice a month. The mobile service points ranged from schools, carpports, churches, garages and houses made available by community members. Mpumalanga seems to have had the highest proportions of service points located in primary schools and in farms. The school service points allowed greater community attendance through popularization by the school teachers and learners.

The clinical services offered were:

- HCT including: pre-test counseling, HIV testing using the screening rapid HIV antibody test and post-test counseling.
- Second confirmatory test can be done if the test is reactive.
- For HIV positive clients there was screening for TB
- Initiation of chemoprophylaxis treatment (Co-trimoxazole)
- Collect blood for CD4 and take to the laboratory and follow the results after one week

Some MSU staff has cited difficulty encountered during farm visits in some of the service points due to employers refusing their employee's access to MSU. In contrast, some MSU staff reported that farmers were reported to access MSU services, as this was the only health service available in the area. Even though other farmers allowed their employees to access the MSU during lunch-time, the time was not adequate for older employees to walk fast to the MSU and back to work. In future, a structured and systematic process of engagement with the farmers will be required to avoid the problems encountered. This omission is in stark contrast to the process outlined above on how other communities were engaged through their leadership, a similar exercise with the farming organisation leadership and introduction should have taken place. To ensure an uninterrupted provision of services the Provincial Departments of Health and FHI360 engaged in an MOU which was signed by both parties to bring it to force.

Memoranda of Understanding (MOUs) and Transitioning of MSUs

The purpose of signing MOUs was to provide a mechanism of working with the provincial Department of Health. The provincial Departments have the responsibility of implementing health programmes directly or in partnership with private providers such as NGOs and for profit private providers.

All the activities to be carried out within the scope of the project are governed by the MOUs. It was imperative therefore to have MOUs in place to ensure that there is agreement and common understanding of the scope of the project and clearly describe the roles and responsibilities of each partner.

The recently renewed MOUs had a clause stating that "the MOU is subject to annual review", this was an oversight. Normally an MOU is signed for a period of 3-5 years in line with the current administration's term of office and their strategic plans. What needs to be reviewed annually is the operational plan to ensure alignment with the departments' Annual Performance Plan (APP). In future projects FHI 360 should ensure that MOUs are in place for longer than a year so that they are respected even if there is a change of leadership in the Department of Health.



CROSS-CUTTING THEMES

Staff shortages: the services provided by the MSU could have had a wider coverage if the initial plan of having three professional nurses and a coordinator was adhered to, as this would mean that there are four professional nurses that could deliver clinical services. There was shortage of staff in instances when a nurse had to go on leave or was not available due to family responsibilities. Additionally, this meant that the nursing staff could hardly go for training without compromising service delivery. In the end, the nurses missed a number of training opportunities including the nurse-initiated management of ART (NIMART).

Other staff categories that were needed were community health workers; such workers were there in the beginning of the project in some provinces. However, due to financial constraints, the community health workers left the programme following incidents of not receiving monthly stipends. These stipends were, from FHI 360's understanding, to be provided by government.

During the HCT campaigns, the MSU teams had to travel to areas beyond the base station putting pressure on staff to work long hours.

MSU vehicle: The choice of vehicle, i.e. a Toyota Quantum, was not ideal for most provinces as the mobile service points are in rural villages with no tarred roads. This presented a serious problem during the rainy season, as some communities were inaccessible. Additionally, the MSU vehicle configuration had its limitations and rendered some of the services such as examination of pregnant women and doing pap-smears for screening of cervical cancer impossible. Thus, a decision was taken by FHI 360 project managers not to provide these services due to limited space in the vehicle and client privacy concerns.

Service Organisation: In one province for example, the nearest referral point was more than 15 kilometers away and there is no regular transport. The only transport available would leave the village at 07:00 am returning at 18:00, meaning patients would have to be away from their homes for an entire day. Moreover, the return trip cost about R30 or more which was a huge barrier for the indigent in the community.

Consequently, a number of patients ended up not going to the higher-level institution for secondary or tertiary care. The MSU was a well-conceived model to provide first level of care; however there is continued need for careful planning to ensure access to secondary and tertiary services is possible. Some provinces do have a dedicated patient transport while others do not. The provinces without a transport system could investigate a patient transport system where passengers are pre-booked to be taken to facilities providing a higher level of care. This is particularly significant because OR Tambo, Amajuba and Gert Sibande have been selected as pilot districts for the implementation of the National Health Insurance (NHI). The NHI principles among others the social protection of citizens from costs related to accessing health services. The lack of dedicated transport results in extremely poor individuals having to spend their limited financial resources on transport to access health services.

SELECTED PROGRAMME INDICATORS

The programme collected data for reporting to funders and for producing reports for analysis by programme managers, identifying areas that may need strengthening. A set of core indicators were selected to illustrate programme performance over a 3-year period. This section consists of data that was required for PEPFAR reporting with special emphasis on SRH, STI, Condom distribution, HCT and HIV&AIDS treatment and care programme areas.

The programme also produced data relating to PHC headcount, management of acute and chronic illnesses and reporting on consumables used. This data was required by the department of health and was collected monthly on the summary forms provided by the department. It was reported through the District Health information and thus is not accounted for here to avoid double counting.

Table 1: Prevention Interventions-General Population and MARPs

INDICATOR NAME	2009	2010	2011	Total
No of people reached	8,653	18,259	19,932	46,844

The table above presents the number of people who were reached through community campaigns including the HCT campaign launched by the President of South Africa in April 2010, with the target of testing 15 million people by 2011.

The Minister of Health championed the HCT campaign and asked all partners in public and private sector (both for profit and not for profit). Due to the intense nature of the campaign and the activities coordinated at provincial head office with clear targets on the number of people to be reached. The number of people reached in 2010 and 2011 is more than double the number in 2009 when there was no high profile campaign. The MSU played an instrumental role in reaching hard to reach populations in rural and under-served areas in the provinces they were participating in. Some of the mobiles travelled a distance of more than 200 kilometers to reach communities in these villages.

Table 2: STI treatment and HIV Prevention

INDICATOR NAME	2009	2010	2011	Total
No of male condoms distributed	982	3,166	3,923	8,066
No of clients seeking STI care	395	243	399	1,037

HIV prevention is an important strategy in increasing life expectancy and combating HIV and AIDS. Thus, interventions targeting the reduction in HIV transmission form an essential arsenal in the fight against HIV and AIDS. To this end, the distribution of condoms and early diagnosis and treatment of sexually transmitted infections are key components of the syndromic management of STIs in South Africa. The MSU provided both these services to the population they served.

The numbers have remained constant over the 3-year period indicating consistency in the data. The STI data is inconsistent with data from the district health barometer which uses data from the routine district health information system. The STI prevalence in three of the five districts where MSU were operational was higher than the national average. Only Greater Sekhukhune and Gert Sibande reported STI prevalence rates way below the national average. Perhaps the inter-district variation resulted in the seemingly low numbers of STI clients seen at the mobile clinics. The routine PHC data from the department of health indicate that approximately 10% of PHC headcount will be associated with seeking care for STI related illnesses. In this instance we do not have a headcount for the mobile and therefore cannot make inferences on the data as provided.

The condom distribution trend in table 2 follows a similar trend to that of mobilisation and advocacy. Condom distribution was an essential component of the HCT campaign between April 2010 and June 2011. The Minister of health had ambitious plans to distribute 1 billion condoms over this period. The total number of condoms distributed almost quadrupled from 982 in 2009 to 3,923 in 2011. All health workers were implored to work hard in ensuring that the HCT campaign is a success and the MSU staff in the four provinces was no exception as they worked closely with officials from the department of health.

Table 3: HIV Testing and Counseling Services

INDICATOR NAME	2009	2010	2011	Total
No of clients tested for HIV	711	2,646	3,334	6,691
No referred for CD4 test	43	569	259	871

Similarly the trends in the number of clients tested for HIV are much higher in 2010-2011 reporting periods; the most probable cause is the HCT campaign. The national HIV prevalence rate from the DHIS in 2010/11 as reported in the DHB (2011) is 22% while the antenatal survey sero-prevalence is 29, 4 and 30.2 % for 2009 and 2010 respectively (Source: NDOH 2009, 2010 Antenatal Care Surveys). According to the DHB 2011, Mpumalanga has reported the highest prevalence with Gert Sibande at 34% while Ehlanzeni is at 32%. The MSU is active in these districts; this picture corroborates the observation of MSU staff who indicated this as the most significant health problem they encounter in their mobiles. The MSU services have to ensure that they assist in referring clients who have been diagnosed with HIV infection to access ARV service points. Some MSUs provide counselling and testing for HIV while others are able to collect blood for CD4 tests and refer clients to ARV service points with a complete screen and full set of results to minimise delays in accessing care. The ability to conduct a full screen has been noted among the mobile services working close with hospitals where CD4 tests are done. In some provinces, MSU staffs were not allowed to collect blood for CD4 testing and only refer clients for further screening. This latter process can result in delays in accessing care, as some clients have to travel long distances to the ARV service points.

Table 4: Access to Sexual and Reproductive Health

INDICATOR NAME	2009	2010	2011	Total
No of people accessing FP services	2,137	5,771	5,907	13,815

Access to Sexual and Reproductive Health Services was one of the initial objectives of the MSU programme. The MSU staff is well trained to providing counseling on contraceptive choices. The trends reflected on this table are similar to the other information as reported above. Accessing family planning services is described as providing a family planning method to a woman who came to the MSU seeking such services. The methods were made available at the MSU and ranged from, oral contraceptives; injectable contraceptives and condoms.

It is encouraging to note that access to family planning services can be improved with dedicated resources and skilled staff. This is an area of strength for the MSU and it has to be enhanced to improve coverage in order to reduce unintended and unwanted pregnancies. The development of targeted interventions particularly aiming at teenage pregnancies could be linked with the MSU and other government mobile services.

LESSONS LEARNT

The MSUs seem to be well positioned and capable of health education and promotion work with community leaders. They serve as a bridge between government facilities and community based structures. The MSUs might use this trust to assist communities to take responsibility for their health by playing an active role in structures such as ward committees, clinic committees hospital and district health boards as envisaged in the National Health Act of 2003.

The current administration came into office in 2009 and made pronouncements on the vision and guiding principles for the NDOH over the next five years. The overarching document is the 10 point plan which outlines a number of priorities to which partners have to align themselves. Most importantly, another key change in the landscape was the outcomes based approach introduced by the President of the Republic of South Africa where Ministers have to sign performance agreements with him. This agreement is known as the Negotiated Service Delivery Agreement (NSDA). The NSDA has a set of four main areas and targets have been set within each area for the entire health sector to work towards. The four NSDA outputs are i) increasing Life Expectancy; ii) decreasing maternal and child mortality iii) combating HIV/AIDS and TB; and iv) Strengthening Health System Effectiveness. All stakeholders in the health sector are expected to align themselves to the NSDA priorities

The MSU project had an opportunity to reorganize and demonstrate how the activities on the ground align to the four priorities. This was a missed opportunity as senior government officials' performance is monitored in line with these priorities. This could potentially have made it easy to engage senior government officials in preparation for signing of MOUs and exploring possible future collaboration. It is essential that projects such as the MSU can link to the priorities of the Department of Health as this makes it easy to convince government officials that the partnership will be of mutual benefit and assist government in improving health outcomes.

There is an overlap between MSU and National Health Insurance -pilot districts. As a service provider that was the link between communities, home based care organisations, clinics and hospitals there is an opportunity to provide technical assistance on district service organisation and coordination. Through the MSU project, FHI360 has gained an-in-depth knowledge of the needs of the communities and are able to provide strategic advice on the package of services within an NHI environment.

The department of health has developed an AID Effectiveness framework whereby all development partners have to align their funding priorities with those of the department of health. Thus, development partners have signed a commitment to work within the parameters of this framework. Consequently, partners receiving funding from these development organisations are expected to implement programmes that are aligned to the framework. Some partners have identified the capacity constraints in the department of health and have seconded staff to the various chief directorates and programmes in line with their areas of competence. This has

ensured that these partners (NPOs)/service providers' activities are aligned to the NDoH and can have quick turnaround times when requests are made for technical assistance. FHI has to identify a strategic programme where it can second staff to ensure that the organisation is in tune with the activities of the department.

The untimely cut in funding for the MSU project makes it difficult to play within FHI 360's global strength such as SRH and HIV services moving forward. The MSU has identified an opportunity to provide technical assistance in the coordination of mobile services. This should be explored further utilizing the established relations with sub-district and district managers.

RECOMMENDATIONS

- Where possible, MSUs should be encouraged to test for CD4 test in order to prepare the clients for ARV clinics with a full set of results.
- A health post should be sought for housing the couch, light and other essential equipment to enable effective use of the MSU. In some provinces, the community provided a space i.e. a house or church for service provision. Establishing partnerships with local communities engenders a sense of ownership and value as the community is taking part in the provision of health services for all in the village.
- Space was often a constant constraint and if the service provision of the MSU could be expanded outside of a single vehicle more services could be offered such as pap smears and examination of pregnant women
- Some of the nurses felt that there was a need for a dedicated driver, as they had to drive the MSU vehicle, which was bigger than their cars and they ended up exhausted at the end of the day. Additional staff required was a data collector as there was a need to capture data on an ongoing basis. In certain instances, nurses ended up having assist the health promoter as the health promoter was also expected to capture the data and update clinical files.

CONCLUSION

At inception the MSU project objectives were:

- i) to build the communication and referral skills of HBC volunteers regarding family planning as an effective PMTCT method;
- ii) to build the skills of HBC volunteers to provide basic information and referrals for VCT and ARV services, and to assist HBC clients to adhere to the treatment regimen;
- iii) to strengthen mechanisms between HBC programs and FP, VCT, and ARV services; and
- iv) to increase access to integrated HIV and RH services through five mobile service units (MSU) in Mpumalanga, Kwa-Zulu Natal (KZN), Eastern Cape and Limpopo Provinces (LP)

However, the MSU project had to evolve due to the practical implementation experiences on the ground. These included the fact that in the original concept, FHI360 was not involved in direct service delivery through the MSU but had an oversight role. Additionally, the conceptual framework was based on Home Based Care Volunteers being an integral part of the project. Both these assumptions did not hold as the project evolved as FHI360 had to implement the project and the sub-partner PSSA which had employed the HBC volunteers was no longer in the picture.

This reprogramming therefore meant that objectives one to three could not be realised as in the original plan and fell away during the transitioning from PSSA to FHI360. The remaining objective was to integrate HIV services and Reproductive services. The analysis of project reports and interviews with key stakeholders suggest that this objective was realised.

As the project evolved there were other objectives that were “inadvertently added” based on clients and department of health requests. The requests were that MSUs not only focus on RH/HIV integration but also provide treatment for minor ailments and chronic conditions. However, these changes were implemented immediately to ensure that the clinical services are not interrupted while permission was sought from headquarters. This responsiveness, was a strength and a weakness at the same time, in that while the MSU project did not follow proper administrative channels of amending the project scope and objectives on paper-which is a weakness; the MSU project team did not alienate the clients and department by not responding to the request for services that were not on their plan-which was a strength.

Evidence from the service data suggests that most of the clients seen at MSUs were indeed those who sought care for minor ailments and chronic conditions. If this were to be used as one of the MSU project outcome objectives, the finding would be that the MSU project was successful.

Finally, the question still remains-should the MSUs be continued by the provincial government and if so what model should be followed. The answer to this is complex and is heavily reliant on the success the department will achieve in implementing the re-engineered primary health care programme. The municipal ward based primary health care model will have family health teams. The family health teams will consist of a nurse, a health promotion practitioner and community health workers. The family health teams will be the link between the communities and health services. The MSUs model would be ideal to support this family health team as they go to each household to provide screening services, immunization, health education and referral to clinics and hospitals. The experience from the FHI360- MSU model if not used as is, could be adapted so that FHI360 provides technical support for coordinating mobile services and strengthening SRH services.

ANNEXURE A:

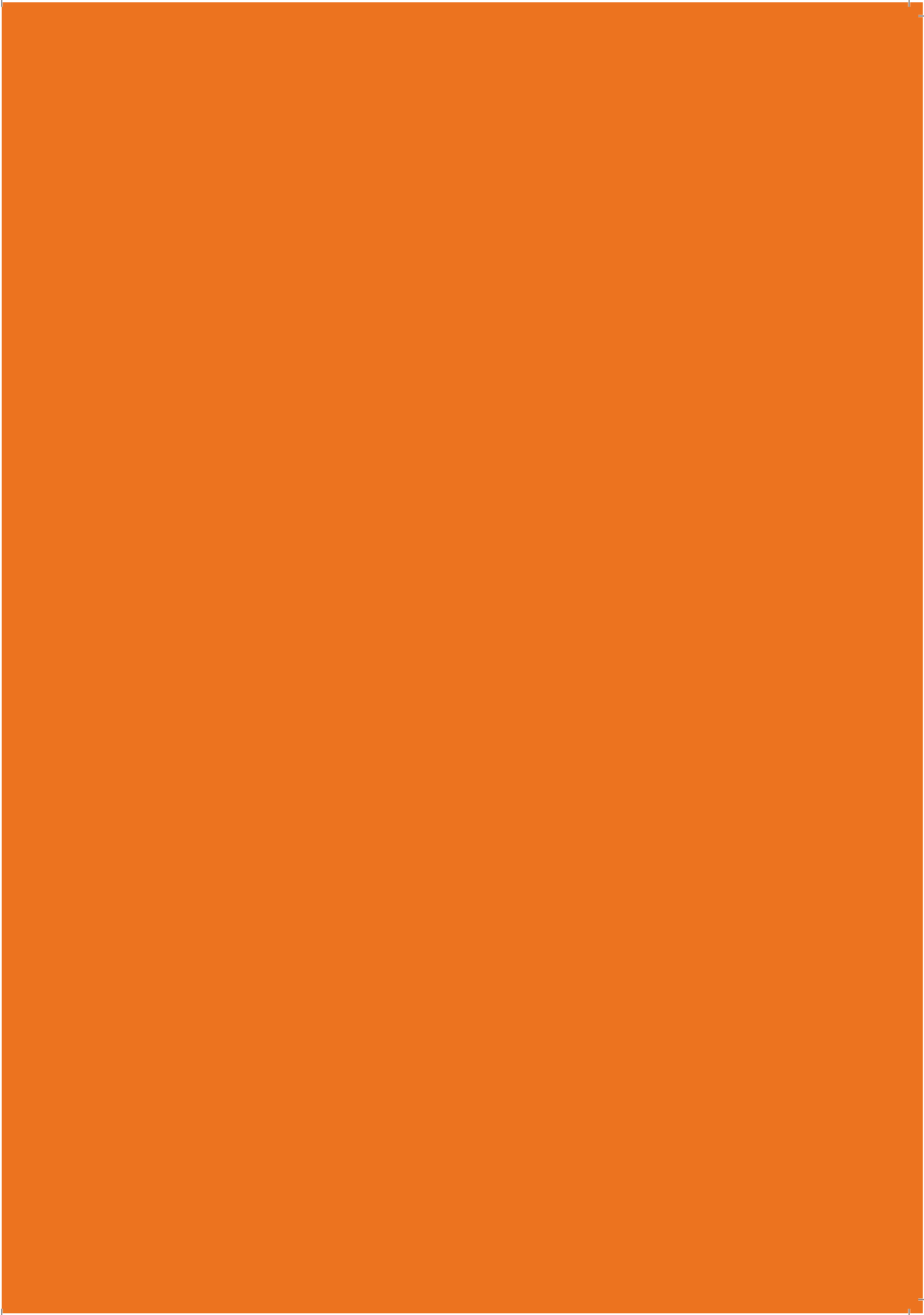
Roles and responsibilities of each partner have been outlined below.

Department of Health's Role and Responsibilities

- Provision of HIV rapid testing kits
- Provision of Sputum bottles for TB
- Management of chronic illnesses
- Provision of Contraceptives
- Provision of Medication for minor ailments
- STI treatment, provision of male and female condoms
- Provision of IEC material, policies, programme guidelines and protocols
- Supervise services provided by FHI, M&E
- Provide daily registers, monthly summary forms
- Facilitate and accept referrals

FHI 360's Role and Responsibilities

- Purchase and maintain the MSU vehicle
- Provide VCT services for HIV
- Provide STI services
- Provide family planning services
- Screen for ARV eligibility and refer to an ART service point
- Provide TB screening services
- Provide treatment for minor and chronic ailments
- Raise community awareness to improve access to services
- Produce monthly data to report on performance
- Acknowledge the department in formal publications



the 1990s, the number of people in the world who are living in poverty has increased from 1.1 billion to 1.6 billion (World Bank 2000).

There are a number of reasons why the number of people living in poverty has increased. One of the main reasons is that the world's population has increased. In 1990, there were 5.3 billion people in the world, and by 2000, there were 6.1 billion people. This means that there are now 800 million more people in the world than there were in 1990.

Another reason why the number of people living in poverty has increased is that the world's economy has not grown fast enough. In 1990, the world's economy was worth \$2.5 trillion, and by 2000, it was worth \$3.5 trillion. This means that the world's economy has only grown by 40% in 10 years.

There are a number of reasons why the world's economy has not grown fast enough. One of the main reasons is that the world's population is growing so fast that it is putting a strain on the world's resources. This means that there is not enough food, water, and energy to go around.

Another reason why the world's economy has not grown fast enough is that the world's population is becoming older. In 1990, the average age of a person in the world was 25 years old, and by 2000, it was 27 years old. This means that there are now more people who are retired and less people who are working.

There are a number of things that can be done to help reduce the number of people living in poverty. One of the most important things is to help the world's economy grow faster. This can be done by investing in infrastructure, such as roads, bridges, and schools.

Another important thing is to help the world's population become younger. This can be done by providing family planning services, such as birth control pills and condoms.

There are a number of other things that can be done to help reduce the number of people living in poverty. These include providing education, healthcare, and social services.

It is important to remember that poverty is a complex problem, and it will take a long time to solve. However, if we all work together, we can make a difference.

There are a number of organizations that are working to help reduce the number of people living in poverty. These include the World Bank, the International Monetary Fund, and the United Nations.

It is important to support these organizations and to help them raise money to do their work. This can be done by donating money or volunteering your time.

There are a number of things that you can do to help reduce the number of people living in poverty. These include donating money, volunteering your time, and raising awareness of the problem.

It is important to remember that poverty is a problem that affects everyone. We all have a responsibility to help reduce the number of people living in poverty.