COMMUNITY DIALOGUES

North-West Province

The ATLANTIC Philanthropies

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Community Dialogues
North West Province

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CONTENTS

1. INTRODUCTION

In December 2010 Health Systems Trust (HST) received funding from Atlantic Philanthropies to strengthen district and sub-district management teams' capacity to plan, allocate and utilise the available resources efficiently, to monitor and evaluate the delivery of services and, finally, to pilot PHC re-engineering. This one-year project was conducted in North West (NW) province.

South Africa has poor health outcomes relative to the resources spent in the health sector compared to most middle income countries due, in part, to the overwhelming impact of HIV. (Lancet 2009; 374: 835–46) In 2010 the South African Minister of Health, Dr Aaron Motsoaledi, requested a small team to develop proposals for re-engineering Primary Health Care (PHC) to better achieve the outcomes desired from the Department of Health's (DoH) Programme of Action. A recommendation of the team was that Chapter 5 of the National Health Act, which deals with the District Health System (DHS), should be implemented fully. The chapter requires that the provincial Member of the Executive Council for Health ensures that the district and sub-district are well managed in terms of the DHS principles. These principles include the delivery of accessible, good quality services in an equitable manner ensuring that these services are comprehensive and not fragmented and that they are delivered effectively and efficiently. They also include the need for local accountability, community participation, a developmental and inter-sectoral approach, with due consideration given to sustainability.

The Minister's call does not amount to a change in DHS policy. Alma Alta principles regarding PHC still apply. It is, in fact, a renewed call to focus fully on the DHS as a vehicle for the delivery of PHC services that would contribute to the improved health outcomes that we desire for our communities.

In this context, the Minister announced the following three streams as current priorities for PHC re-engineering:

- PHC Outreach Teams
- School Health Services
- Specialist Teams focusing on Maternal and Child Health

The World Health Organization's 1978 Alma-Ata Declaration defines PHC as essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community. This happens through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. PHC is the first level of contact of the individual, the family and the community with the national health system, bringing health care as close as possible to where people live and work. PHC addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services as required.

From October 2011 to March 2012 HST initiated and supported community dialogues in 18 of NW province's 19 sub-districts. These dialogues aimed to improve the efficiency and effectiveness of health care services through community involvement. The approach seeks to maintain a continuous process of engagement between the DoH and citizenry through active participation in discussions and together seeking solutions, as a result of which communities will be recognised as partners and accountability will be sustained. Specific objectives of the community dialogues were thus:

- To sensitize respective communities about PHC re-engineering
- To determine the level of knowledge of healthcare services through interactive sessions and meetings
- To educate communities about the available resources pertaining to outreach programmes
- To empower communities with health-related information on the National Health Insurance

- To inform and provide insight to participants on the six key priorities of the national DoH
- To build rapport that lays a foundation for sound interaction to strengthen referral systems
- To provide space where partners and stakeholders can share new information.

2. METHODOLOGY

Each of the four district management teams was provided with a copy of the community dialogue guide1 and dates and meeting locations were selected together by the district and HST's project implementers. NW DoH's PHC re-engineering pilot sites in each sub-district were used as community dialogue sites. Sub-district management structures organised the participants and venues, with assistance from HST. Representation included various stakeholders from the ward or the sub-district. The dialogues were initiated by HST staff using the USAID/John Hopkins community dialogue guide. Table 1 reflects the schedule of dialogues in the sub-districts. The average duration of the dialogue sessions was about five hours.

Table 1: Attendance at Community Dialogues in North West province, October 2011-March 2012

Date	Venue	Districts	# of Participants
25 .10.11	Ngaka Modiri Molema	Ratlou sub-district – Disaneng village (Community hall)	49
26.10.11		Tswaing sub-district – Sannieshof town (Sannieshof Community Health Centre)	51
27 .10 11	Dr Kenneth Kaunda	Ventersdorp sub-district – Mogapa village	42
28.10.11		Matlosana sub-district – Kanana township (Civic centre)	43
03.11.11	Bojanala	Madibeng sub-district – Kgabalatsane village (Community hall)	50
07.11.11	Dr Ruth Segomotsi Mompati	Kagisano Molopo sub-district, Morokweng village (Morokweng Community Health Centre)	52
08.11.11		Mamusa sub-district – Ipelegeng township (Community Church)	46
09.11.11		Lekwa-Teemane sub-district – Bloemhof town (Community hall)	52
10.11.11		Greater Taung sub-district – Manthe village (Tribal Hall)	101
11.11.11		Naledi sub-district – Vryburg town (sub-district office)	33
18.11.11	Bojanala	Moretele sub-district – Maubane village (Dept. of Agriculture Hall)	42
01.02.12	Ngaka Modiri Molema	Ditsobotla sub-district – Tlhabologang Township (Community church)	53
02.02.12		Mafikeng sub-district – Ramatlabama village (Tribal Hall)	58
03.02.12		Ramotshere Mwoiloa sub-district – Braaklagte (Tribal Hall)	52
09.02.12	Bojanala	Kgetleng sub-district (Kgetleng Community Hall)	55
10.02.12	Bojanala	Rustenburg sub-district (Phatsima Community Hall)	67
13.02.12	Bojanala	Moses Kotane sub-district (Tweelagtne Tribal Hall)	89
13.03.12	Dr Kenneth Kaunda	Tlokwe Sub-district (Tlokwe Sub-district Boardroom)	41
		TOTAL	976

1 The Guide for Conducting Community Dialogues (2009) is produced by USAID and published by Johns Hopkins for Health and Education in South Africa.

Categories of stakeholders participating in the dialogues included:

- Traditional health practitioners
- Traditional leaders
- Defence force (military health)
- Clinic committees
- Department of Labour
- Home-based care givers
- Community development workers
- Developmental partners (Wits Reproductive Health and HIV Institute)
- Religious representatives
- Support groups
- Local government
- Department of Social Development
- South African Social Services Agency (SASSA)
- NW Department of Health (PHC and District Hospitals)
- Community Policing Forums
- South African Police Services
- Department of Education.

Sub-districts were requested to identify the performance indicators in which they underperformed. Stakeholders were given brief presentations on the definitions of the chosen indicators and commissions were then formed per indicator. The indicators or programmes chosen across sub-districts were:

- Low antenatal care (ANC) booking before 20 weeks
- High tuberculosis (TB) and HIV defaulter rate
- HIV and AIDS programme
- Low prevention of mother-to-child transmission (PMTCT) uptake
- Poor child health services uptake
- High teenage pregnancy
- High home deliveries and use of traditional medicines
- Low cervical smear screening.
- Low sexually transmitted infections (STI) partner tracing

The outcome of the commissions' deliberations, together with their proposed solutions, are presented in Section 3.

3. DISCUSSIONS

The community dialogue discussions are reported per indicator or per programme, with inputs from all the sub-districts combined.

3.1 ANC bookings before 20 weeks

Pregnant women are encouraged to visit health facilities as soon as they miss their period. The NW province 2010/11 average rate for ANC booking before 20 weeks is 40%, against the national target of 70%. Possible consequences of booking late include:

- Complications related to high blood pressure
- Transmission of HIV from mother to baby
- Increased danger of still births or miscarriages
- Congenital abnormalities not being detected early
- Bleeding during pregnancy or labour
- Difficult labour.

REASONS

The commissions suggested the following reasons for women being reluctant to make a first booking for antenatal care before they are 20 weeks pregnant.

Client-related factors:

- Poor communication between parents or guardians and pregnant teenagers that discourages the latter to disclose and then present at health facilities
- Fear of male nurses where some clients alleged sexual harassment
- Fear of testing for HIV
- Cultural beliefs and ignorance on the importance of the antenatal services. (An example given in Lekwa-Teemane sub-district was beliefs among pregnant women that iron supplements make the tummy grow bigger than usual. Another example cited in Kagisano Molopo is that some clients do not disclose the pregnancy until after the first three months because of the fear of miscarriage during the first trimester.)
- Clients that live far from facilities and lack transport to travel there. (An example cited often was farming communities that have irregular or no mobile services.)
- Factors such as unplanned pregnancies, not knowing the father of the baby or pregnancy resulting from sexual assault result in the mother wanting to abort but taking time to decide and ending up not booking at the health facility for up to three months into the pregnancy
- Ignorance, lack of information and/or poor understanding result in women booking late into their pregnancies
- Preference for going to traditional health practitioners before or instead of going to the health facilities
- Patients being too ill to travel to health facilities
- Some patients use private doctors for antenatal services, even if they present at public facilities for delivery

Health-related factors:

- Health facilities staff's negative attitude discourages pregnant women to book early for antenatal services. (Examples given in Lekwa-Teemane sub-district were nurses scolding women with short spacing between pregnancies or who they considered too old for child bearing.)
- Health facilities' setup is not friendly for pregnant women
- Lack of confidentiality from staff
- Extended waiting times due to long queues at facilities
- Unsuitable operating hours at clinics, especially for working mothers and learners. (At certain clinics you are not attended to if you arrive after a certain time, even if still within the clinic's operational hours.)

RECOMMENDATIONS

Recommendations from the commissions were as follows:

Client-related factors:

- Clients need to be aware of their rights and responsibilities
- Clients need to understand the importance of antenatal services
- Clients to be educated and motivated on the use of family planning
- Men should take an active role in their partner's pregnancies and encourage them to book early
- Regular community dialogues should be conducted around sex and reproductive health topics.

Health services-related factors:

- Clients need to have confidence in client-health worker confidentiality, which staff should honour and not abuse
- Health workers must encourage clients to adhere to return dates
- Care givers and community health workers to be vigilant and supportive of pregnant women in the communities
- School health nurses to give health education to pregnant teenagers in schools and encourage them to go to health facilities early on in their pregnancies
- Staff in health facilities to strengthen health education around topics like teenage pregnancy, importance of early bookings, confronting peer pressure and reducing stigma around pregnancy
- Staff to receive in-service training on customer care and professionalism
- The compliments and complaints system in the health facilities to be improved and strengthened
- Batho Pele principles to be practiced in facilities
- NW DoH to increase the number of staff and extend service hours. (Improved services could increase staff morale and reduce waiting times.)
- The PHC outreach teams to conduct regular home visits, particularly in households with pregnant women
- Traditional birth attendants to be respected and given in-service training on regular basis
- Strengthen the referral system between DoH and traditional health practitioners
- Mobile services to provide regular visits to communities far from the facilities, especially in the farming communities.

3.2 Defaulter rates for TB and chronic conditions

The 2010/11 average TB defaulter rate for NW was 9.9%. For the purpose of reporting, discussions around defaulter rate also includes defaulting on chronic medication for other conditions like hypertension, HIV and diabetes.

REASONS

Possible reasons why clients default on their treatment raised during discussions included:

Client-related factors

- Stigma associated with the illnesses, especially HIV and TB
- Poor understanding on how medication works (Some clients stop their treatment when they start feeling better. Others leave the treatment when they start experiencing side effects.)
- Clients fear they will lose their grants when they show improvement from taking the medication
- Clients, especially migrant workers, are mobile, do not adhere to treatment and are not easily traceable
- Clients lack family support and are not encouraged to adhere to treatment. Some clients do not disclose at home and their families are, therefore, unaware that they need adherence support
- Clients default on their treatment because they have not accepted their condition and find it hard to change their way of living
- Conflicting messages from different sectors of society regarding treatment, e.g. churches and traditional health practitioners
- Clients live in dire poverty and/or far from the health facilities and therefore are unable to afford the travel costs to collect their treatment
- Clients who experience food shortages on regular basis skip their medication when they have not eaten (due to the instruction to take the medication after a meal)
- Clients take over-the-counter medication instead of the medication they are given at the health facility
- Clients default deliberately to remain eligible for their temporary disability grant.

Health service-related factors:

- Clients are discouraged by their experiences in the health facilities, such as long queues, unpleasant staff attitudes and overcrowding
- Farm workers not covered by mobile services risk losing their jobs if they take time off to collect their medication.

RECOMMENDATIONS

Recommendations from the commissions for overcoming the difficulties included the following:

Client-related factors:

- Health education to be intensified to make clients aware of how medication works and what side effects to expect. Health workers to be creative in delivering health education so as to get communities excited and attentive to the subject. A further suggestion was that health education should be extended to local radio stations, tribal meetings, funerals, schools, churches, and other suitable occasions and venues.
- Care givers to give health education in communities about basic hygiene and to support health services clients who are on treatment, together with their families
- Families and structures in the communities to support clients to adhere to their treatment and to live healthy lives
- Clients to be provided with regular, high quality adherence counselling to encourage them to accept their condition and adhere to treatment
- Enhance community members' wellbeing by encouraging food gardens and employment creation activities. In areas where water availability is problematic, community members should be encouraged to use grey water from bathing or washing to water their gardens.
- Clients to join support groups that will encourage treatment adherence. Support groups to expand beyond just HIV-positive clients to include and support clients on other chronic treatment.
- Cured TB patients to be requested to motivate clients that are still on treatment.

Health service-related factors:

- Promote health worker-client confidentiality, including amongst care givers and traditional health practitioners
- Traditional healers should be trained on adherence, appropriate health education, suitable advice to clients and they should be encouraged to liaise with the DoH
- NW DoH to liaise with farm owners to negotiate access to provide health education to farm workers, and for farm workers to be allowed to access their treatment
- Facilities to utilise clinic committees to trace treatment defaulters
- NW DoH and SASSA to plan jointly to deal with defaulters who rely on grants.

3.3 HIV and AIDS programme

Discussions around HIV and AIDS reflected the fact that people are still reluctant to test, despite high HIV prevalence rates. Possible reasons for this reluctance provided by the commissions included the following:

REASONS

Client-related factors:

- Clients still find it very hard to disclose after testing HIV-positive. The reasons may be that they are still in denial and ignorant about the condition; some fear the stigma attached to the condition; and the perceived lack of confidentiality when they test at health facilities. Some clients do not disclose to their partners out of fear of being rejected or being blamed for contracting HIV outside of their relationship.
- Some clients, especially men, do not understand the importance of testing and therefore perceive knowing their status as an added burden to their lives. These are people who generally do not use condoms.
- There are people who believe strongly in traditional practices and prefer not to use health facilities; yet some traditional health practitioners are not trained in western illnesses and treatment
- HIV prevalence is high "because people generally have low morals and discipline in their lives". In Madibeng sub-district, poor parental role modelling was cited as a reason for low morals. People still abuse alcohol and other substances and find themselves with multiple partners and are often careless or sexually abused. There are people who still engage in casual sexual activities without taking precautions. Teenagers experiment with sex at a very young age when they are not knowledgeable about sexual issues and the related consequences.
- There are still many men who rely on women's test results to see if they themselves are positive
- Some clients have personal relationships with the facility staff and do not want them to know their status
- Poverty makes some people vulnerable to abuse by others. Some people practice commercial sex to make money. Younger women turn to rich or older men for money in exchange for sex and they are unlikely to have the power to negotiate condom use.

Health service-related factors:

- Some male clients are more comfortable being seen by male health workers and since they are not common in many health facilities, those males do not use the provincial health services
- Many lay counsellors are young and older clients prefer not to be counselled and tested by them as they are uncomfortable discussing sex related issues with them
- Some clients are discouraged from testing by the long queues in the health facilities due to staff shortages or overcrowding; clients also report that they are discouraged by the signage that easily identifies those seeking HIV and AIDS services
- There are irregular, if any, mobile services to some areas, especially farms, and people do not get into the culture of testing
- Clients complain of staff attitudes in health facilities.

RECOMMENDATIONS

Recommendations from the commissions included the following:

Client-related factors:

- Men to have messages targeted at them about responsible sexual behaviour and testing. Forums to be established where men will support other men through mentoring.
- Communities to be encouraged to take responsibility for their lives and to seek information.

Health service-related factors:

- Health education to be intensified and disseminated using all possible avenues
- Staff to be supplemented in health facilities to reduce overcrowding
- The counselling skills of lay counsellors to be improved so as to increase testing rates
- Initiate strategies to reduce the stigma attached to HIV and AIDS and to encourage disclosure
- Health workers to be responsive and show a caring and respectful attitude towards clients
- Health facilities to integrate services and remove signage that identifies and segregates HIV and AIDS services (and therefore clients)
- Health facilities to encourage men and older clients to test by educating them and making them feel comfortable in accepting assistance by the existing lay counsellors.

3.4 Prevention of mother-to-child transmission

Four sub-districts identified PMTCT as one of their health priorities. The commissions looked at reasons why women do not get onto the programme and why infants are mixed fed. The possible reasons contributed by the commission members are listed below.

REASONS

Client-related factors:

- The commission dealing with this topic in Ratlou sub-district said many of their clients are migrant workers who travel as far as Northern Cape and they tend to drop out of the programme and their children are often not followed up
- Men play a minimal role in physically caring for their children, it remains a women's role
- Women still do not disclose as they face stigma related to their HIV status
- Some women live far from health facilities and are unable to travel and get relevant services. Even where there are mobile services, they are not regular and do not render certain services, such as testing and antiretroviral treatment (ARVs), that extend to PMTCT.
- New mothers do not formula feed due to cultural beliefs, especially when they have not disclosed their status. A commission member shared hearing that mothers-in-law sometimes say "…children in this family should be breastfed". Other reasons are that infants are given traditional medicine that is not sanctioned by health facilities, and they are also given food right after the umbilical cord drops around 10 days.

Health service-related factors:

- There is no working relationship between health workers and traditional birth attendants and there are women who still use the latter group and not the health facilities.

RECOMMENDATIONS

Recommendations from the commission members included the following:

Client-related factors:

- Men need to be involved in caring for and raising the child
- Men should give their partners emotional and financial support, especially when they are HIV-positive
- Other structures in the community like churches and the tribal authorities should participate in educating community members. Communities need to support clients on PMTCT.

Health service-related factors:

- Traditional healers to be capacitated, be well informed, use appropriate and approved medication and be honest with their clients. They should work with the DoH and help their clients.
- Through the outreach teams, services need to reach communities that are far from health facilities.
- Men and women should be counselled as couples and take joint decisions regarding what will happen with the baby

3.5 Child Health

Three sub-districts identified child health as an area of concern. The topics were growth monitoring, malnutrition and Vitamin A supplementation in the 12 to 59 month age group.

3.5.1 Growth Monitoring and Malnutrition

In one community dialogue concern was raised around poor growth monitoring and malnutrition. The commission members explored possible reasons and suggested recommendations. The possible reasons included:

REASONS

Client-related factors:

- Parents lack knowledge and understanding on why they need to take their children to health facilities for growth monitoring, other than when they are ill. Members highlighted that some people lose their Road-to-Health Charts (RTCs) or Booklets resulting in their children not getting immunised or followed up for growth monitoring.
- Some communities living far from health facilities are unable to afford the travel costs (and sometimes time) to take children to health facilities for check-ups and other assessments that are required for monitoring growth and development
- The number of child-headed families is increasing and there is little understanding in these homes on what needs to be done for smaller children as such families have little or no support
- Some unplanned pregnancies can put financial and emotional strain on the family and infants in the family are often neglected
- Substance abuse contributes to neglect of the children
- Some areas have poor sanitation and do not have a reliable water supply. This results in communities living in poor environmental conditions and not being able to maintain vegetable gardens, which in turn leads to health hazards and poor nutrition for the children and the family at large.

Health service-related factors:

(none contributed)

RECOMMENDATIONS

Some recommendations suggested were:

Client-related factors:

- Communities, together with relevant government departments, must collaborate and create income-generating projects to uplift the communities' socio-economic and health status
- Children in child-headed families must be identified, given the support necessary and referred for social grants and other needed interventions
- Communities with water supply and environmental health challenges should engage with local government to bring about improvements.

Health service-related factors:	
Health promotion and education have to be intensified to make people aware of the importance of monitoring children's growth and nutrition status, strengthening family planning and intensifying awareness to reduce substance abuse	Children who default at health facilities or have poor nutritional status need to be traced and followed up PHC outreach teams are expected to initiate improvements in health education, monitoring feeding infants and promoting home vegetable gardens.

3.5.2 Poor Vitamin A supplementation coverage

Certain sub-districts had a low uptake of the Vitamin A among 12 to 59 month children. The commission members contributed the following reasons:

REASONS

Client-related factors:	
Lack of awareness among parents or guardians on the need to take children to facilities to be immunised Clients are impatient to wait in queues and sometimes do not understand how services are run Mothers that do not attend antenatal care have inadequate knowledge of the healthcare services that infants and children should be receiving from the facilities Mothers who leave home to seek work or for other reasons, sometimes leave their babies with relatives who have little knowledge of the children's healthcare needs Clients who live far from health facilities may experience irregular or inconsistent mobile visits, resulting in them seldom being able to access health services	Some clients do not take good care of the health records and often forget return dates or they just ignore them Some clients are illiterate and do not always understand or remember the RTHCs Some client do not understand the importance of immunisations Some clients are impatient and will not wait in long queues in facilities Some clients, especially foreigners, fear going to the facilities particularly when they do not have identity documents as they think they will be refused services or taken to the police.

Health service-related factors:	
Shortage of vaccines in facilities Certain health facilities prefer to immunise a group of children at the same time rather than immunising one or two children and then wasting the remaining vaccine Perceptions of staff attitude in facilities deter some clients from accessing health services	Some facilities do not use the comprehensive supermarket approach (i.e. they still have specific services on specific days) resulting in working clients who are unable to attend during the week not being able to access certain services over the weekend, even if the facilities are open Some health workers do not complete the health records properly, such as omitting to record on the RTHCs the dates that clients are expected to bring their children to the facility.

RECOMMENDATIONS

Suggested solutions to the challenges included:

Client-related factors:

- Communities need to know the importance of their health cards and be encouraged to take care of them
- The department of health needs to intensify awareness campaigns and collaborate with stakeholders in the area
- All stakeholders in the area to get involved and encourage communities to use health services at their disposal.

Health service-related factors:

- Care givers and community health workers to check records of vaccines given or due when they visit households
- Health facilities to extend hours of service to accommodate those who are not able to access facilities during the day or during the week
- Health facilities to initiate “fast queues” for child health services
- Health facilities should keep a good supply of vaccines
- School health activities to be intensified so as to reach children at schools who have missed vaccinations
- Health services to be taken to communities without access to the facilities, through mobile services and outreach teams
- Encourage staff to tell clients return dates verbally, especially those who cannot read
- Help clients to understand the need for patience when queuing in facilities
- Staff at health facilities to refrain from asking clients for identity documentation.

3.6 Teenage Pregnancy

Although teenage pregnancy is a general concern across districts, only two picked it as a topic for discussions. Commission members' contributions when seeking possible reasons for the poor performance included:

REASONS

Client-related factors:

- Teenagers fall pregnant because they lack extra-mural activities, resulting in sex becoming a form of entertainment
- Teenagers experiment early with sex
- There is a lot of peer pressure and substance abuse among teenagers
- Poverty and sexual abuse play a role in this issue as teenagers find themselves engaging in commercial sex work and being abused for money. In Lekwa-Teemane sub-district the community is concerned regarding trucks that pass on the N12 road and stop in Bloemhof town where local girls prostitute
- There is poor communication between parents and their children and, thus, inadequate guidance
- Teenagers are exposed to a lot of information on social media with little or no supervision.

Health service-related factors:

- Health education is lacking content around family planning, the focus is more on HIV and AIDS.

RECOMMENDATIONS

Recommendations on what different stakeholders could do to deal with the challenges included:

Client-related factors:

- Communities should be encouraged to have conversations with their children around sexual health
- Ward committees to consider having health talks or meeting with parents and their children
- There should be teenage forums in wards where teenagers can discuss relevant issues that affect them.

Health service-related factors:

- There should be continuous health education targeting teenagers specifically
- School health programmes and services to be strengthened
- All relevant stakeholders and government departments to get involved and tackle the issue of teenage pregnancy
- Government should implement sustainable edutainment programmes and extra-mural activities in communities

3.7 Home deliveries

The NW districts are mostly rural and there are still areas where home deliveries and late referrals to health facilities occur. Some women prefer to deliver at home and use traditional medicines. The DoH is concerned about a commonly used herb, called “Kgaba” in Setswana, used to speed up labour, as it is thought to lead to increased still births and maternal deaths.

REASONS

The possible reasons for high rates of home deliveries identified during commissions were:

Client-related factors:

- Misconceptions exist in communities about delivering at home and using herbs
- Pregnant women delay seeking care until they start getting contractions
- Some pregnant women do not know their expected delivery date
- In Kagisano sub-district a traditional health practitioner told the audience that some of his colleagues “make the pregnant women drink Kgaba instead of just washing their bodies with it”. From further discussion it emerged that there are three kinds of Kgaba and that they all can be used to speed up the labour process, but that it is dangerous as it complicates the delivery and can kill both the mother and baby.
- Communities and some traditional health practitioners lack knowledge on the risks associated with home deliveries
- Some clients do not have identity documents and clinic cards so they are reluctant to go to the health facilities
- Some pregnant women do not want to be tested for HIV
- Some pregnant women do not want to be referred to the hospital if complications arise during delivery.

Health service-related factors:

- Staff attitudes intimidate pregnant women
- The emergency services (EMS) do not respond on time
- Some health facilities do not open at night and weekends
- The health facilities are far from certain villages or farming areas.

RECOMMENDATIONS

The following recommendations were made:

Client-related factors:

- Family members to support and assist pregnant women
- Pregnant women should be encouraged to move closer to the health facilities when they are about to deliver
- Clients should be educated about the necessity for referrals to hospital if there are complications at delivery.
- EMS ambulance is not on time

Health service-related factors:

- Staff in health facilities to treat clients with respect, practising positive and caring attitudes
- Clients should be encouraged to use available transport if they realise the Intensify health education and emphasise the importance of booking early and making prior arrangements for transport
- Improve EMS response times in remote and rural areas
- Pregnant women to be taught the signs of labour
- Clients should be allowed to receive clinic cards or files whether or not they have their identity documents with them
- Traditional midwives who have not registered with the DoH should be encouraged to do so and to receive appropriate and relevant training. Traditional health practitioners also need to attend training.

3.8 Cervical Screening

REASONS

Only one sub-district raised the issue of low cervical screening among clients. Possible reasons contributing to this are:

Client-related factors:

- Clients tend to choose a particular person they want to be treated by in the clinic and if this person is not available, clients will not attend
- Clients fear the unknown and do not want to disclose their status
- Lack of knowledge, even though many awareness campaigns have been conducted
- Some clients prefer to use traditional health practitioners, even though there are health conditions that they are clearly not equipped to deal with
- Clients who believe that doing a pap smear might affect fertility, while some perceive it as painful
- Clients who think if you use a condom there is no need to do pap smear.

Health service-related factors:

- Long queues discourage clients from going to facilities
- Inappropriate staff attitudes discourage clients from going to facilities
- Irregular mobile clinic visits to farming areas or distant areas discourage clients from seeking help
- The delay before laboratory results are received, because they are not done locally, discourages clients from being screened
- Clients do not use the suggestion boxes to report bad service they receive - they think that the papers are torn up or destroyed and therefore do not see any point in using them.

RECOMMENDATIONS

Some recommendations suggested by the Commission were:

Client-related factors:

- Churches to talk about health conditions that affect the community
- Schools to have health talks for learners
- Traditional health practitioners, faith based organisations and care givers should have appropriate information and talk to communities on all health conditions and PHC, not just HIV
- Communities, and especially women, should support and encourage each other to go to facilities and be screened
- Men to support and encourage their partners and peers to screen.

Health service-related factors:

- Intensify health talks and cover all conditions (not just HIV) and present them throughout the day in facilities
- Compile pamphlets in local languages to facilitate the information reaching all
- All community meetings should have a slot where someone talks about health issues
- Campaigns to be continued and clients to attend
- A complaints and compliments system should be used at all facilities to identify and thereafter address challenges and conflicts
- Community health workers to represent the department in the community and make the facilities aware of dissatisfaction noted in the communities
- NW DoH to deal with delayed laboratory results and see how they can resolve the issue
- Health services to be taken to farming areas over weekends when people are not working.

3.9 Inadequate partners' tracing for Sexually Transmitted Infections

Only one sub-district raised the issue of poor partner tracing of STI clients.

REASONS

The commission members contributed the following possible reasons:

Client-related factors:

- People are generally scared to seek help when their partners have STIs
- Some clients have many partners and do not want to be identified as such
- Some people are in denial when they are sick
- Some people only present at clinics when they are very sick
- Some clients have warts and do not want to strip naked to be examined, especially not by male nurses
- Some people prefer traditional health practitioners as they think they can be healed and made stronger by the herbs
- Lack of trust among couples lead to clients not seeking help as they tend to blame each other as to who contracted the infections from outside their home
- People are not faithful towards their partners
- Traditional health practitioners do not really know how to treat different kinds of STIs, e.g. some cut off warts and they keep on recurring.

Health service-related factors:

- Some people believe facility staff do not respect confidentiality

RECOMMENDATIONS

The commission members suggested the following recommendations:

Client-related factors:

- Both men and women to be role models in the communities. Older men not to date younger girls.
- Religious leaders to allocate time to talk to the congregation about health conditions and seeking health services:
- A pastor suggested that "morals cannot be taught but you live them", supporting the view that role models are needed and they must set the example
- A participant invoked biblical guidance encouraging "people to concentrate on the laws of the bibles. Let Exodus [chapter] 20 be a challenge to us".

Health service-related factors:

- Train traditional healers on STIs and their management
- Use different forms of health education. Distribute pamphlets in churches and schools and households over and above verbal health education.
- Encourage people to test early for HIV
- Establish free men's clinics for men who have in the past refused to go to the facilities.

4. CONCLUSION

Community dialogues are not just debates but an opportunity for stakeholders to reflect on their roles in improving the health and lives of communities. The community dialogues offer a platform for stakeholders to gain better understanding on the dynamics that might prevail, especially where values, religion, morals and cultural norms are involved. The dialogues provided greater insight on what drives communities' behaviour towards health and other social services and help identify the gaps on which the relevant Departments must focus. Community engagement and participation are critical for health and development interventions to be successful. These engagements provide the opportunity for communities to come up with their own solutions to improve the health status of the entire community.

The dialogues helped unravel some of the problems experienced by communities and provide a better understanding of issues such as traditional herbs and personal perceptions that clients have about the services. Common challenges identified during the process of the community dialogwues included:

- Inappropriate staff attitudes
- Long queues in facilities
- Poor and inadequate health promotion
- Perceived lack of confidentiality
- Poor collaboration with stakeholders
- Poor community participation
- Poor mobile clinic coverage.

More needs to be done to unravel some aspects of the communities' behaviour and to get them to talk about these issues.

The community dialogues resulted in the communities developing a better understanding of certain health system-related processes and decisions taken in dealing with health services' clients. Some of the overarching recommendations that emerged from the dialogues included:

Community level

- PHC outreach teams should utilise and strengthen the important role played by the community-based services.
- Improve clients' knowledge and understating of relevant health messages and issues.
- Conduct community dialogues, when required, on relevant health issues.
- Strengthen relations between the health services and stakeholders and representatives in the communities.

Facility level

- Strengthen referral systems between the facilities, traditional health practitioners and other community structures, such as tribal authority and religious support groups.
- Strengthen mobile services or focus PHC outreach teams' inputs in areas far from health facilities.
- Improve staff attitude towards clients.

District level

- Improve health education.
- Conduct satisfaction surveys for clients and staff.
- Hold regular meetings or dialogues with stakeholders to discuss health issues.