

# METRO DISTRICT HEALTH SERVICES

## SOCIAL CAPITAL PROJECT – PROGRESS REPORT

### APRIL 2006

The Western Cape Department of Health's strategy on Social Capital Formation strategy arose out a decision at Provincial Cabinet level to support communities in becoming more self reliant, more socially aware and responsible. This strategy rests on:

- full community participation and
- collaboration between all spheres of government and civil society.

The MDHS focussed on specific interventions in Khayelitsha & Mitchell's Plain sub-districts and satellite sites across the Metropole. These interventions focussed on **child survival**, **youth at school**, people with **chronic illnesses** and **building internal human capital**

Achievements to date:

- Formal Social Capital management structures are in place – District, Khayelitsha and Mitchell's Plain sub-districts.
- Inter-sectoral task teams in the 2 sub-districts - to reduce duplication and fragmentation within spheres of government in Khayelitsha & Mitchell's Plain
- Internal Human Capital development -Fostering an understanding of Social Capital Formation within MDHS, strengthening of MDHS School Health Services, Computer literacy drive for all staff.
- Encouraging volunteerism within facilities and communities.
- Community Health Workers (CHW's) have been employed across the Metropole
  - 135 Community IMCI workers
  - 75 support groups facilitators for CDL,
  - 20 Eye Care case finders, mobility trainers
  - 50 supporting Health Promoting Schools initiatives
  - 60 in Khayelitsha on diarrhoea prevention strategies, during the diarrhoea season

## 1. Child Survival Interventions

### a) Integrated Management of Childhood Illness (IMCI)

IMCI is a strategy developed by the World Health Organisation's Division of Child Health and Development and UNICEF. It has been introduced in more than 30 countries around the world to address morbidity and mortality in children under five years. The strategy focuses on the child as a whole, in the family and community context, rather than on a single disease or condition. IMCI rests on:

- improvement in case management of sick children
- access to appropriate health care services
- improvement in health practices in households and communities
- improvement in the general standard of living of the communities

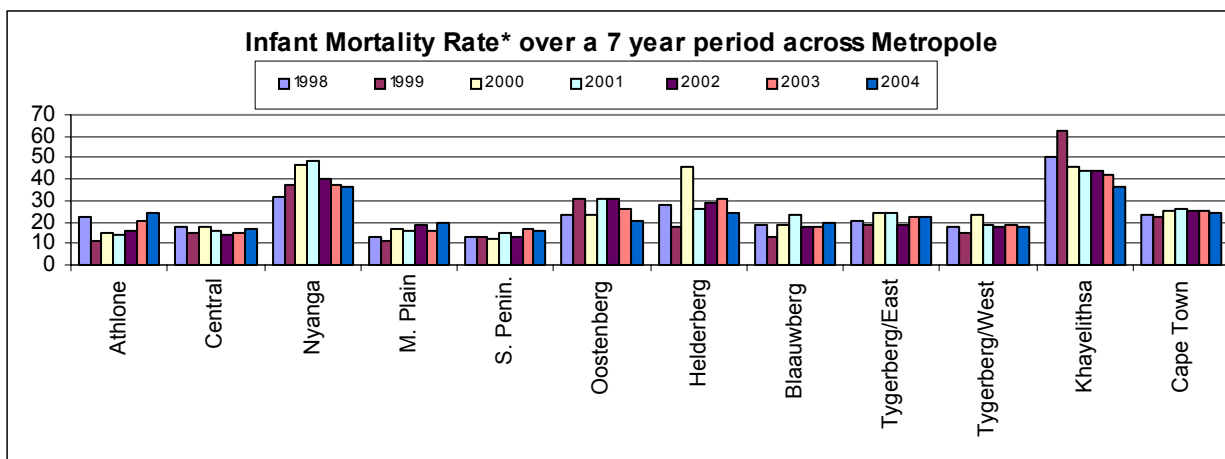
The Western Cape Department of Health guidelines have been developed to complement the WHO's list and adapt it to include priority conditions affecting children in the Western Cape specifically. These illnesses are managed from when the child is one-week-old to five years old: Diarrhoea, Acute Respiratory Infections, Malnutrition, TB, HIV/AIDS, Child Abuse and Meningitis.

Primary health care staff is trained to identify children who have these illnesses. Sick children are assessed according to their symptoms and signs. Treatment is given if necessary, and the caregiver/parent is counselled and is advised on the follow-up of the patient Severely ill children are urgently referred to hospital, moderately ill children get specific treatment at primary health care level and at home and those that are mildly are given supportive therapy and counselling

MDHS, through the Social Capital Project, strengthened the existing community IMCI initiative that has been in place for 5 years already but experienced funding problems last year. To date **135 fully trained Community IMCI workers are employed** through NPO's, located in 9 sites across the following subdistricts:

- **Khayelitsha,**
- **Mitchell's Plain,**
- **Northern Panorama – Wallacedene, Bloemkombos, Kraaifontein**
- **Klipfontien - Nyanga**
- **Tygerberg - Belhar**

These workers have been trained by an NPO, St Johns, using manuals developed locally. In 2005 more than **40,000 home visits were done**. Malnutrition, inadequate immunisation and diarrhoea were the main problems identified.



## b) Diarrhoea Prevention Campaign

Diarrhoeal illness is one of the top 5 causes of infant mortality and morbidity in spite of highly preventable and easily treatable. This impact is linked to poor hygiene behaviour, inadequate supply of clean water and sanitation, presence of other infectious diseases (e.g. HIV) and poor nutrition. Mortality is also the consequence of not recognising danger signs, the lack of re-hydration practices within the home and delays in seeking medical assistance.

This campaign seeks to link the above chain of events, the socio-economic determinants of diarrhoeal disease and improve the health services' response to a child in need. This initiative forms part of the Provincial DoH intervention to reduce the mortality and morbidity rates due to diarrhoeal disease that occur specifically during the "diarrhoea season" (January to May). The intervention has both a community-based preventative component and a service based curative component.

The objective was a mass campaign in the prioritised areas informing caregivers of promotive/preventative measures that should be taken to reduce the incidence of cases and to improve the response to such cases within the home and community.

Progress to date:

- MEC for Health; P Uys launched the Campaign in Mitchell's Plain – 14<sup>th</sup> November 2005.
- Inter-sectoral task team set up and joint planning was done – particularly with the Khayelitsha Water & Sanitation Forum, COCT & DWAF to develop an integrated approach to health promotion, disease prevention and improved service delivery.
- Development of culturally appropriate information material. This health promotional material was distributed through radio messages and door-to-door pamphleteering.
- **Employment of 63 community workers in Khayelitsha** since 27<sup>th</sup> March 2006, in collaboration with DWAF for specifically for this period. They are deployed in 10 identified informal settlement sites. In addition to the expected lack of adequate taps and toilets, the inadequate removal of refuse was identified as another problem.
- There has also been good collaboration between the community IMCI workers, the community School Health workers funded by the Social Capital Project and the School Health Nurses on diarrhoea prevention strategies across the Metro e.g. HAND WASHING campaign since November 2005.
- Linking to Oral re-hydration corners with all the clinics and CHCs and improved referral system to these facilities.



Some of the 63 CHWs employed via the Red Cross Society, doing door-to-door campaigning in the Site B area.



## 2. Health Promoting Schools (HPS) and Youth

The vision of developing of the school as a supportive environment for the development of healthy members of the school and the broader community is part the National School Health Policy and the Health Promoting Schools initiative in particular. The last few years have seen the shrinking of this service across the Metropole and the main initiative of the Social Capital Project has been to strengthen this service and develop the school as a hub for community activity.

Progress to date

- Employment of 6 ENA's to assist the depleted School Health Teams in Khayelitsha & Mitchell's Plain
- **Employment of 50 School Health CHWs across the Metro** to assist School Health services, to develop Health Promoting schools initiative and support general community based initiatives e.g. diarrhoea campaign
- Development of training package and training 40 CHWs in basic First Aid, School health services and Health Promoting schools activities.



Some of the 50 School Health CHWs that have completed their in-service training and a group thanking the MDHS team



### 3. Chronic Diseases of Lifestyle (CDL)

Increasing urbanisation and changing lifestyles have increased the incidence of chronic non-communicable diseases (i.e. Diabetes, Hypertension, Asthma, Epilepsy and Arthritis) and accounted for 54% of all deaths in the Metropole in 2001. The social disintegration and inequality, compounded by poverty, have hindered the individual's capacity to respond to impact of these diseases. The usual risk factors of obesity, inappropriate diets, smoking, heavy drinking and lack of exercise apply in all communities, but is increasing in communities already burdened with the other diseases of poverty.

Over 50% of all visits to the CHCs are for treatment of CDL and the burden of the complications of these illnesses can be reduced through better adherence and health promoting behaviour. After correct diagnosis and treatment the patients can be helped via therapeutic groups in the CHC and support groups in the community to become more self-reliant and live healthier lives. The social capital project contributed to the development of community based support groups by funding the employment of community CDL support workers.

Progress to date:

- **Employment of 75 CHWs across the Metro** to facilitate the support groups since November 2005 – doing screening, health promotion activities and off-site dispensing
- Development of training material (e.g. FLIP CHART) and ongoing training of staff and these CHW's
- Full integration of these groups into the services at the CHCs through appropriate referrals into and out of these support groups.



Nyanga CDL support group session: approximately 20 clients attend a session once a month. 20 CHWs employed via NPO (SACLA) run 4 groups a week – for medication, screening, health promotion talks, exercise, foot care etc.



Mitchells Plain CDL Support group where 30 clients meet per session for similar activities.

### 4. Community Eye Care

The elimination of avoidable blindness has both a social and moral imperative as visual disability has far-reaching social, economic and quality-of-life implications. The SA National Prevention of Blindness Programme is a component of the WHO "Vision 2020" plan to eliminate avoidable blindness by the year 2020.

The prevalence of Blindness in SA is 0.75% (i.e. 7 out of every 1000) with 80% being preventable and/or easily treatable – Cataracts, Glaucoma and Trauma. In children it is strongly correlated to malnutrition, Vitamin A deficiency, measles, trauma and maternal health and obstetric care (e.g. premature births).

**Progress to date:**

**a) Eye care awareness week in October 2005 – to refract grade 1 learners in disadvantaged schools**

This activity resulted in strong ties and networking links with all the health care professionals taking part in the initiative - 23 optometrists, 2 ophthalmologists, 3 orthoptists, nursing staff and volunteers; as well as ties with the private sector & NPO's – Cape Gateway initiative with Ster Kinekor, Mitchells Plain Mall & Library and the Soetwater Environmental Center. The following outcomes were reported:

- Screening of 4321 school children,
- Issuing of 518 pairs of spectacles within 21 days
- 58 children immediately referred for secondary treatment
- 540 learners participated in an art competition - 6 schools and 2 libraries involved
- 768 pairs of spectacles for recycling, were collected by learners

**b) Community Screening**

The initiation of an ongoing project to screen the elderly and indigent and supply readers on the spot where indicated. So far 600 readers have been issued, mainly in Mitchell Plain, Khayelitsha, Nyanga.

**c) Community eye care workers**

In collaboration with League of the Friends of the Blind (LOFOB) **17-community case finders were employed** and work in Khayelithsa, Mitchell's Plain and Nyanga

- Recognised as the first initiative in SA that will address the career-pathing from CHW into Ophthalmic Technical Assistants (HPCSA registered) – 1 worker already placed at TBH
- Developed training material, protocols and manuals, in service training completed to do screening, basic low visual aid assessments and mobility instruction for activities of daily living
- This year screened 524 persons by going door-to-door, 140 had eye problems and 83 were severely impaired.



Eye Care awareness week – testing school children in Mitchell's Plain Library and judging an art competition in Fish Hoek.



Signing of agreement with NPO (LOFOB). Community Eye Care case finder at work.

## 5. Fostering Volunteerism

The organisation has also **built on the existing tradition of volunteerism in the City** by honouring and mobilising volunteers that work at facilities and within their own communities. They assist where there were staff shortages; improve communication between the facilities and their communities and contribute to the empowerment of their communities

Progress to date:

- Honoured volunteers working within MDHS facilities in November 2005 – Minister of Health: P. Uys handed out the certificates of appreciation to over 80 volunteers.
- Honouring of community based volunteers in partnership with the Health Committees in the Metro– current multi-media exhibition that will travel to each sub-district and possibly wider that will be used as one of the tools to mobilise volunteers and encourage membership of the Health Committees across the Metropole & Province.



The Minister of Health: Mr P Uys, Dr Bitalo & some of the volunteers working within CHCs and District Hospitals that were honoured on the 17<sup>th</sup> November 2005 at Woodstock Hospital



## 6. Internal Human Capital development

The building a strong team of workers within MDHS to take on the numerous tasks and challenges that lie ahead especially, the increased burden of disease and the implementation of the new comprehensive service plan. Another task is the development of a culture in the organisation where trust, integration, respect, accountability and cooperation is actively pursued while understanding the concept of social capital formation.

Progress to date

- Setting up of management and support structures for the Social Capital Project in Woodstock, Mitchell's Plain and Khayelitsha.
- Appointing key staff to complete the School Health Teams (OT, Audiologist, ENAs) and a Community Liaison Officer in each sub-district.
- Training sessions for managers and production staff in the concept of Social Capital – by UWC (SOPH)
- Setting up of an IT & Health Information center to support all staff – to care for IT equipment that was recently acquired as part of the Provincial roll-out and improve IT & HI skills of all staff.
- Setting up inter-sectoral and task teams in the 2 designated sites – to coordinate all interventions.



**The Social Capital Project staff  
and some task team members.**

