UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

SITUATIONAL ANALYSIS OF NYANDENI SUB-DISTRICT, OR TAMBO DISTRICT, EASTERN CAPE, SOUTH AFRICA, 2018

Rural Health Advocacy Project

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1. Geography

1.1 OR Tambo District Municipality

OR Tambo District is situated in the eastern region of the Eastern Cape Province. It forms part of the area previously known as the Transkei. The Transkei region was one of 10 former homelands. The health departments of these homelands were systematically underfunded with large disparities in resource distribution. The average per capita expenditure for those within the homelands were approximately a third of the rest of the country (Massyn, et al. 2017)
The city of Mthatha is the administrative and economic hub of the region. OR Tambo District has a population of 1 382 399 and a population density of 114.3 people per km^2 (Massyn, Padarath, Peer, & Day, 2017). The district covers about 80% of the region and includes five sub-districts: King Sabata Dalindyebo, Nyandeni, Mhlontlo, Port St Johns and Ngquza Hill (Massyn, Padarath, Peer, & Day, 2017). OR Tambo District is a rural district that is characterised by subsistence farming and traditional lifestyles.

Figure 1: OR Tambo Sub-districts (Source www.municipalities.co.za)

1.2 Deprivation

According to Nobel et al (2014), deprivation has four different dimensions: material employment, educational and living environment (or services) deprivation. The OR Tambo district is ranked as having one of the highest levels of deprivation within the Eastern Cape (Massyn, Padarath, Peer, & Day, 2017), with nearly 88% of the population living in an environment that is deprived (see figure 2). The Transkei region is not only the most deprived of all former homelands but experiences deprivation levels more than double that of the rest of the country (69.0% vs 33.0%), (Noble, Zembe, & Wright, 2014).

The deprivation gap between former homelands and the rest of South Africa has not declined between 2001 and 2011 (Noble, Zembe, & Wright, 2014).

Transkei	Material Deprivation %	Employment Deprivation %	Education Deprivation %	Living Environment Deprivation %
	69.0	58.4	37.2	87.8

Figure 2: Depiction of multiple deprivation in Transkei (Noble, Zembe, & Wright, 2014)

1.3 Deprivation in the Eastern Cape

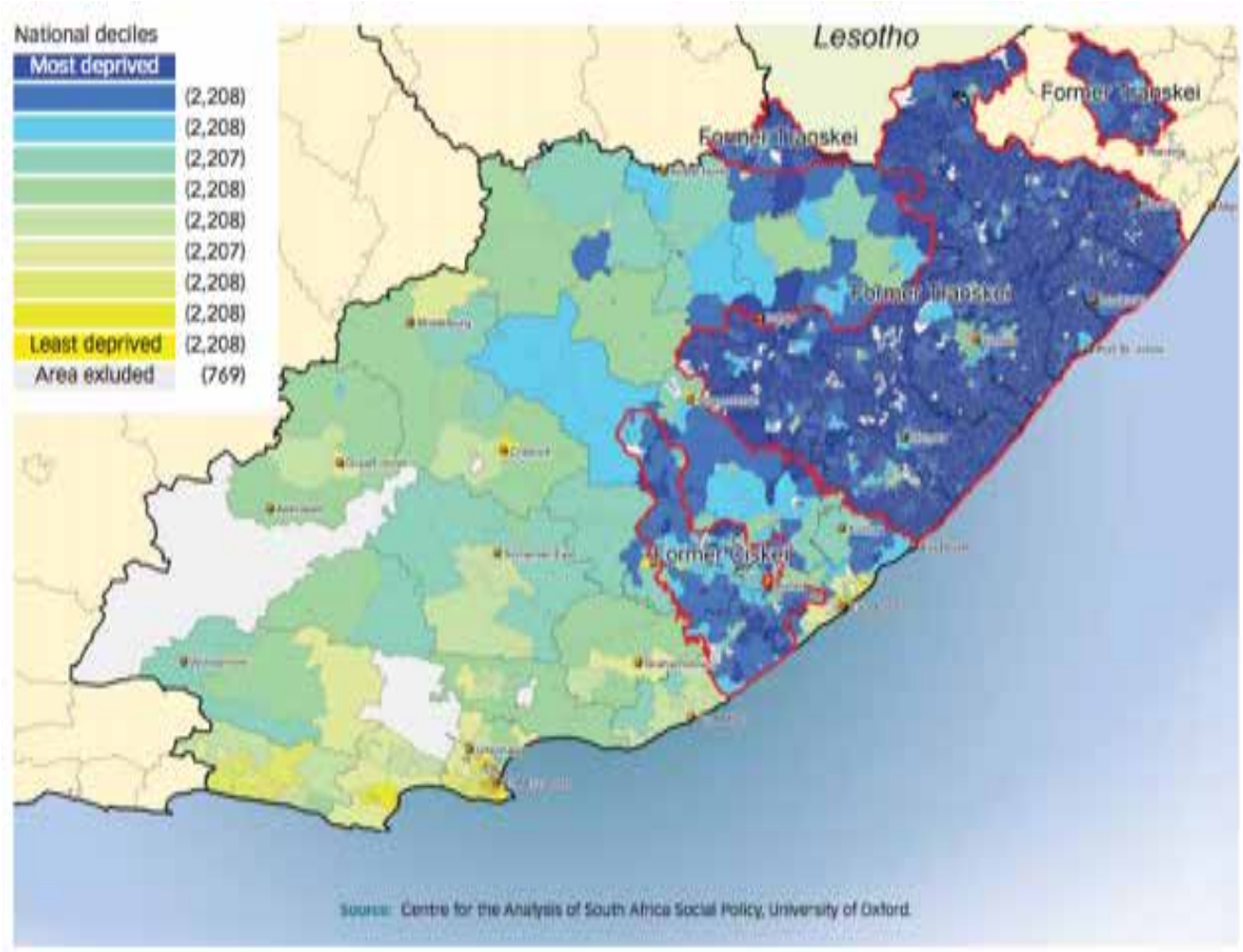


Figure 3: Deprivation map for Eastern Cape

Figure 3 represents the deprivation levels in the Eastern Cape. The most deprived areas are shaded dark blue. Areas of highest levels of multiple deprivation are concentrated in the former Transkei region (Noble, Zembe, & Wright, 2014).

2. Demography

2.1 Nyandeni Sub-District

The Nyandeni sub-district forms part of OR Tambo district and is one of the 6 sub-districts. Nyandeni sub-district comprises of Ngqeleni and Libode municipalities and is under the administrative authority of OR Tambo District. The population of Nyandeni depends largely on social grants as a primary source of income and as a result poverty, unemployment and illiteracy are common in this community (Vava, 2017).

The sub-district is dominated by scattered, low-density rural settlements. 62% of households reside in traditional or village type settlements, which are surrounded by communal grazing and arable lands (StatsSA, 2017). The majority of residential structures are self-built. Apart from a few trading stores, there is little sign of any significant economic activity within the rural settlements. Many of the families in the rural regions of the homelands, were formerly supported by men who worked as migrant laborers in local mines in Gauteng.

2.2 Population

Nyandeni has a population of 309 702. At 52%, just over half of Nyandeni's residents are under the age of 18 and the median age of the population is 18 (StatsSA, 2017). In the region 54% and 57.2% of households are female headed (StatsSA, 2017).

The health indicators in this particular region indicate that the population is young and mostly female. Nyandeni fares very poorly in child and women's health and the OR Tambo district is frequently ranked as one of the ten worst performers nationally in these areas (DHB, 2017). For instance, child health under 5 for diarrhoea, pneumonia and severe acute malnutrition all fall below the South African averages and national targets (Massyn, Padarath, Peer, & Day, 2017). To highlight the extent of the problem, OR Tambo was ranked as one of the 10 worst performers for child health under 5 diarrhoea and pneumonia and Nyandeni figures for both of these indicators are significantly higher than the OR Tambo averages. The poor performance in these programmes show the gap and thus need for effective prevention strategies, early entry into health services and improved care once in the health service (Massyn, Padarath, Peer, & Day, 2017). Growth monitoring and appropriate early intervention at primary health care level and improved management once admitted have been recommended to improve child under 5 severe acute malnutrition (Massyn, Padarath, Peer, & Day, 2017).

As with child health, women's health does not fare much better. Delivery in facility under 18 is significantly higher than the SA average (Massyn, Padarath, Peer, & Day, 2017). Antenatal client initiated on ART is below the SA average and national target.

2.3 Households

The local Xhosa community is a traditional one. People built their homes on plots of land allocated to them by the local chief or headman, in the form of homesteads; homes typically are in the form of rondavels and houses. There 61 867 households in Nyandeni Sub-District (StatsSA, 2017).

3. Socio-economic profile

3.1 Access to services

Basic amenities such as running water, electricity and sanitation are either lacking or severely limited. Access to running water, electricity and sanitation in Nyandeni are as follows: 26.5%, 11.1% and 19.3% respectively (StatsSA,2017). It can be inferred that the availability of these basic services or lack thereof have implications for health indicators in the district.

3.1.1 Water

Water Source	%
River	51%
Service Provider	23%
Rain Water Tank	10%
Spring	4%
Other	13%

Source: Wazimap 2017,StatsSA 2017 based on most recent available Census data

3.1.2 Toilet Facilities

Only 6.2% of the population have access to flushed or chemical toilets and 27.2% have no access to any toilets at all.

Type of Toilet Facility	%
Flushed Toilets	6.2%
No access to any toilets	27.2%

Source: Wazimap 2017,StatsSA 2017 based on most recent available Census data

3.1.3 Refuse Disposal

67% of the population use dumping as a way of getting rid of their refuse waste, only 1.7% are getting refuse disposal from a local authority or a private company

Refuse Disposal	%
Dumping	67%
Refuse Disposal	1.7%

Source: Wazimap, 2017 StatsSA 2017 based on most recent available Census data

3.1.4 Educational level

Most of the education institutions in Nyandeni cater to lower level schooling. Of the 426 schools in the Nyandeni area, 64% are overcrowded or highly overcrowded, according to the OR Tambo District office.

58.2% have completed Grade 9 or higher and only 22.6% have completed Matric or higher education (StatsSA, 2017). Recent reports on the school nutrition programme has put a spotlight on the failure of the National School Nutrition Programme to cater for schools in the OR Tambo District, particularly Lusikisiki. Information on the status of the school programme in Nyandeni was not available in the public domain at the time of writing.

3.1.5 Employment

As indicated, a large proportion of the population of Nyandeni depends on social grants as a primary form of income and in most cases the only source of income. As result poverty, unemployment as well as illiteracy are common in this community. A majority of the community is involved in agricultural activities; they maintain their own cornfields and cattle kraals.

13.2 % of the population is employed; this is about 80% of the rate in OR Tambo District 15.98% and about half the rate in the Eastern Cape, which is 26.03% (StatsSA, 2017).

3.1.6 Annual Income

The average annual income in Nyandeni is R15 000 (StatsSA, 2017).

4. Public Health Services in OR Tambo

The district falls into socio-economic Quintile 1, which are the country's poorest districts, and has an estimated medical scheme coverage of 4.6%. It is one of the 11 National Health Insurance (NHI) pilot districts (StatsSA, 2017).

WBOTs	Clinics	CHC	District Hospital	Regional Hospital	Central/Tertiary	Other
46	46	3	4	0	0	1

Table: Number of facilities within Nyandeni (Massyn, Padarath, Peer, & Day, 2017)

According to the WBPHCOT policy, each WBOT should serve approximately 1500 households. Based on a population of 61 867 in Nyandeni, the sub-district should have 41 teams. The higher figure at 46 can account for the larger distances and difficult terrain that WBOTs in this region have to contend with. Despite this number being higher than the recommended numbers, there are reports of wards without any WBOT teams suggesting that WBOTs within the sub-district are insufficient in meeting population need and require further strengthening. The poor maternal mortality and child health under 5 figures further emphasise the need for strengthened PHC interventions include sufficient WBOTs.

OR Tambo District	
WBOTs	124
Community Health Workers	816
Nursing Assistant	1422
Enrolled Nurse	936
Professional Nurse	1859
Medical officers	353
Pharmacist	96
Dental	16
Occupational Therapists	17
Physiotherapists	16
Speech Therapists	12

As per the WBPHCOT policy, 6-10 CHWs should be found in each WBOT. If we were to assume that each WBOT has a minimum of 6 CHWs, the OR Tambo district is then under the minimum of WBOTs per household. The OR Tambo District should ideally have 136 teams.

4.1 NHI Pilot District Progress Report OR Tambo District

Category	Indicator	2014/15	2015/16	2016/17	Nyandeni
Management PHC	Percentage ideal clinics [Percentage]		1.4	23.4	Not available
	Percentage of fixed PHC facilities with patients that have access to a medical practitioner [Percentage]		15.2	Not available	Not available
Management Inpatients	Average length of stay (district hospitals) [Days]	6.4	6.3	6.3	5.9
	Expenditure per patient day equivalent (district hospitals) [Rand (real 2015/16 prices)]	2 110.7	2111.8	2336	2427
	Inpatient bed utilization rate (district hospitals) [Percentage]	55.5	56.4	57.8	52.0
	Inpatient crude death rate [Percentage]	7.3	7.5	7.2	7.1
	OPD new client not referred rate (district hospitals) [Percentage]	52.0	57.4	56.4	60.8
Delivery	Delivery by caesarean section rate (district hospitals) [Percentage]	21.1	24.3	Not available	Not available
	Delivery in facility under 18 years rate [Percentage]	11.5	11.5	10.00	11.0
	Inpatient early neonatal death rate [per 1 000 live births]	13.7	18.1	15.1	6.5
	Maternal mortality in facility ratio [per 100 000 live births]	198.5	244.7	196.9	Not available
	Mother postnatal visit within 6 days rate [Percentage]	40.7	48.2	53.3	70.1
	Stillbirth in facility rate [per 1 000 births]	23.9	26.3	N/A	202
PMTCT	Antenatal 1st visit before 20 weeks rate [Percentage]	41.8	60.1	67.1	63.7
	Antenatal client initiated on ART rate [Percentage]	86.6	90.6	89.1	89.0
	Percentage of PCR tests positive at birth [Percentage]		1.5	Not available	Not available
Child Health	Child under 5 years diarrhoea case fatality rate [Percentage]	9.6	5.8	6.4	9.5
	Child under 5 years pneumonia case fatality rate [Percentage]	5.3	5.3	4.9	6.1
	Child under 5 years severe acute malnutrition case fatality rate [Percentage]	11.6	11.0	11.8	18.4
	Inpatient death under 5 year rate [Percentage]	17.7	16.8	Not available	13.9
	School Grade 1 screening coverage (annualised) [Percentage]	12.9	16.5	10.3	1.5
	Vitamin A dose 12-59 months coverage (annualised) [Percentage]	50.0	59.6	Not available	58.1

Immunisation	Immunisation coverage under 1 year [Percentage]	74.9	88.9	78.0	80.8
	Measles 2nd dose coverage (annualised) [Percentage]	74.0	82.9	90.1	101.5
Reproductive health	Cervical cancer screening coverage (annualised) [Percentage of women 30+ /10]	51.8	59.2	60.6	47.4
	Couple year protection rate (annualised) [Percentage]	40.0	58.7	70.2	89.2
HIV	HIV testing coverage (including ANC) [Percentage]	40.8	41.5	40.0	41.0
	Male condom distribution coverage [Condoms per male 15+]	41.2	72.5	76.3	80.4
Non-communicable diseases	Diabetes incidence (annualised) [per 1 000 population]	1.5	2.1	3.9	5.7
	Hypertension incidence (annualised) [per 1 000 population 40+]	14.8	29.9	29.0	23.7
Human Resources	Percentage of fixed PHC facilities with performance management agreement for all staff [Percentage]		13.8	Not available	Not available
	Percentage of fixed PHC facilities with staffing in line with WISN [Percentage]		0.0	Not available	Not available

Further discussion of the above indicators is in the section below:

According to the Progress Report on Status of NHI Pilot Districts 2016, OR Tambo District falls behind in performance in comparison to other pilot sites in the areas of reaching enough clinics with Ideal Clinic Status, in reaching the full number of members in the District Specialists Teams and in establishing adequate number of teams of Ward Based PHC Outreach Teams (DHB, 2016)

4.2 Performance of Priority Health Indicators

OR Tambo District performance on health indicators is depicted below looking at 10 key priority indicators

1	The Management of Primary Health Care Facilities
2	Management of inpatients
3	Deliveries
4	PMTCT
5	Child Health
6	Immunization
7	Reproductive Health
8	HIV
9	Non-communicable diseases
10	Human Resources

4.2.1 OR Tambo (DC15) Indicator performance

The following section provides an interpretation of health indicators:

Management PHCs

The percentage of ideal clinics has increased significantly. This is higher than the Eastern Cape average but below the national average (29.8).

Management of inpatients

The average length of stay (ALOS) in Nyandeni (5.9) surpasses that of the national average (4.4). The sub-district however performs better than the district which sits at 6.3. 60.8% of health users presenting at a district level hospital have not received a referral from a primary healthcare clinic. This can be attributed to an overburdened PHC or poor referral systems (Massyn, Padarath, Peer, & Day, 2017).

Delivery

Nyandeni and the OR Tambo district as whole performs very poorly in this area. The OR Tambo district is ranked as one of the 10 worst performers in the country. Nyandeni scores worse than OR Tambo. This requires urgent intervention. There are vast differences between rural, cities and metros with rural young women being much more affected than their urban counterparts (Massyn, Padarath, Peer, & Day, 2017). Targeted interventions focusing on sexual and reproductive services for adolescents require better collaboration with department of basic education to strengthen school health programmes, in order to ensure school health include prevention strategies (Massyn, Padarath, Peer, & Day, 2017).

Despite a decrease in maternal mortality rates since 2015/16, OR Tambo is still one of the 10 worst districts in this area. The validity of these figures are questionable because OR Tambo receives referrals from outside of its district borders. It is preferable to analyse data based on catchment areas rather than district (Massyn, Padarath, Peer, & Day, 2017). The data is not reflective of the health of the residents of the district but rather those accessing the service within the district.

PMTCT

The antenatal first visit before 20 weeks for the Nyandeni sub-district is below the OR Tambo and SA average. Possible reasons for the poor performance here could be health system barriers such as the difficulty with physically accessing health services at a health facility as well as weakened PHC services and insufficient coverage by WBOTs.

Child Health

Nyandeni performs very poorly in child health. OR Tambo is one of the top 5 worst districts in child under 5 diarrhoea and pneumonia. Further investigations are warranted for the poor performance in child under 5 pneumonia (Massyn, Padarath, Peer, & Day, 2017). These results warrant strengthened prevention programmes, early entry into the health system and improved care once in the health service (Massyn, Padarath, Peer, & Day, 2017). Strengthened and coordinated services at a PHC and WBOT are necessary for this to occur. Child under 5 severe acute malnutrition in Nyandeni is double that of the national average. Growth monitoring and appropriate early intervention at PHC level and improved management for those admitted are recommended.

Immunisation

Immunization coverage under 1 year has dropped in OR Tambo but improved for the measles 2nd dose coverage.

Reproductive Health

Cervical screening rates for Nyandeni fare far below the OR Tambo and SA average. This is concerning especially because of the young and female population that the sub-district has.

HIV

Nyandeni fares reasonably well in condom distribution but very poorly in HIV testing coverage.

Non-communicable diseases

OR Tambo is one of the 10 worst districts in hypertension rates above 40 and also one of the 10 worst districts in diabetes mellitus rates per 1000 individuals.

Human Resources

While there is an improvement in performance in various categories of indicators, notably in the category of Human Resources from 2015 the percentage of fixed PHC facilities with staffing in line with WISN still sits at 0.0 percent in 2016.

4.2.2 Headcount and deaths, 2013/14 – 2015/16

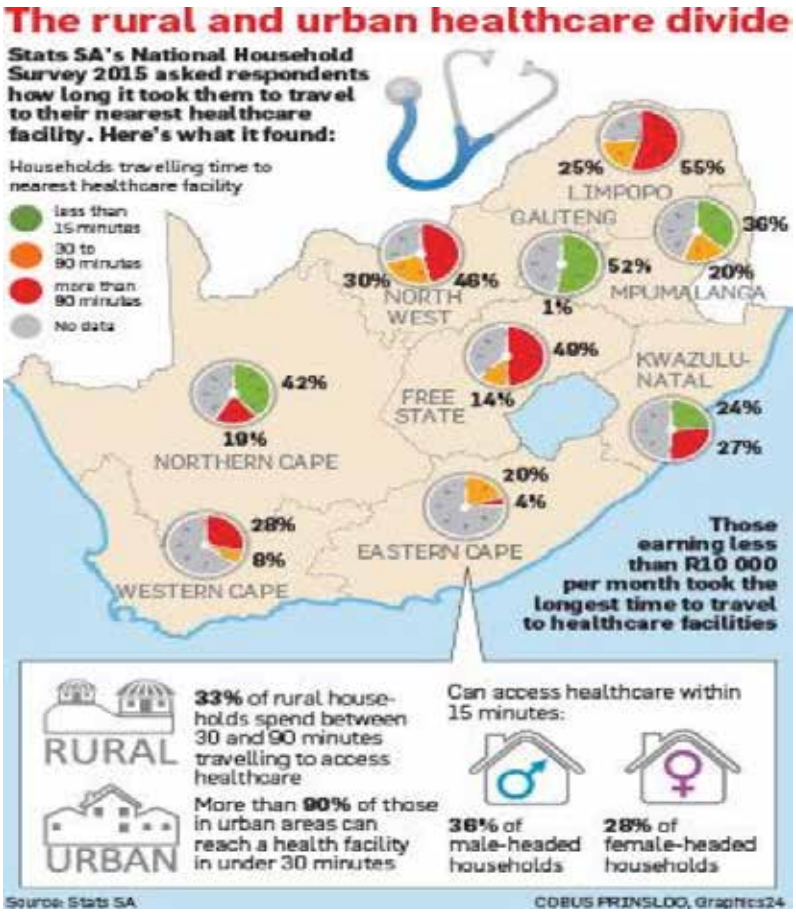
Data Element	2013/14	2014/15	2015/16
PHC headcount under 5 years	712 379	726 018	697 363
PHC headcount 5 years and older	3 582 258	3 772 244	3 704 826
Patient day equivalent	812 636	846 878	866 607
Deaths – total	6 604	6 565	6 273
Still births	845	815	807
Early neonatal deaths	429	455	539
Late neonatal deaths	96	331	161
Child under 5 years with diarrhea death	224	173	129
Child under 5 years with pneumonia death	113	105	141
Child under 5 years with severe acute malnutrition death	154	119	128

Source: District Health Barometer 2015/16

4.2. 3 Maternal and Womens Health

		Impact	Outcome		Output			
		Maternal mortality in facility ratio (per 100K)	Antenatal client initiated on ART rate %	Delivery in facility under 18 years rate %	Antenatal1st visit before 20 weeks rate%	Cervical Cancer Screening coverage %	Couple Year Protection rate WHO	Mother postnatal visit within 6 days rate %
	Nyandeni	**2016/17**	**2016/17**	**2016/17**	**2016/17**	**2016/17**	**2016/17**	**2016/17**
	Indicator	0	89.0	11.0	63.7	47.4	89.2	70.1
	Numerator	0	1234	568	5426	3926	105 384	3631
	Denominator	5213	1387	5 177	8513	9322	1 418 412	5177
	OR Tambo							
	Indicator	196	89.1	10.0	67.1	60.6	87.3	53.3
	Numerator	55	4246	2 801	18691	15926	327015	14 880
	Denominator	27 939	4765	27 925	27851	315368	4496955	27 925

Source: District Health Barometer 2016/17



Source : StatSA 2015

The image above illustrates the time taken to travel by rural communities in order to reach a health facility.

5. Health facilities in Nyandeni Sub-district

As indicated on previous sections the community in Nyandeni depends largely on public health services, through services offered mainly by Primary Health Care Clinics and two District Hospitals. While Isilimela Hospital was the third hospital in the Sub-district followed by Bambisana Hospital being the fourth, it is as of 2017 demarcated to fall in Port St. Johns and not in Nyandeni as indicated in the table below.

1. St. Barnabas Hospital (169 beds) in Libode
2. Canzibe Hospital (120 beds) in Nqgeleni
3. Isilemela Hospital
4. Bambisana Hospital

5.1 Number of Facilities in Nyandeni Sub-District

WBOT Teams	Clinics	CHC	District Hospital	Regional Hospital	Central Tertiary	Other Hospitals
43	46	3	4	0	0	1

Source: (Massyn, Padarath, Peer, & Day, 2017)

5.2 Challenges in Nyandeni Health Sub-District

Health service provision in OR Tambo District specifically in Nyandeni Sub-district has been characterized by shortages in Human Resources for Health (HRH), lack of adequate infrastructure resulting in poor staff accommodation and a lack of equipment at health facilities. These challenges have led to a deteriorating health system and have therefore led to poor access to quality health services for the community of Nyandeni.

5.3 HRH Shortages

There has been high levels of understaffing, which can be attributed to a combination of factors, which has been attributed to the reduction in budget allocations for provinces from national.

Health Care Worker shortages have been visible in various professions. Canzibe Hospital was left with one doctor for a period of months in 2017, while faced with significant nurse shortages at the neonatal and other wards. The rehab profession (physiotherapists, occupational therapist, speech therapists and audiologists) is a cadre particularly badly affected by the HRH funding and distribution challenges. Evidence of none placement of therapists has been noted, and where there are therapists there has not ever been a full staff compliment of a well functioning rehabilitation team in either St Barnabas or Canzibe Hospital. This has resulted in patients with disabilities incurring out of pocket costs to other neighbouring health facilities that are slightly better staffed or foregoing rehabilitation service all together due to the costs associated with accessing the services.

The placement of oral health professionals has also been severely over looked such as dentists, dental assistants oral hygienists. This has compromised the provision of oral health services (Vava, 2017).

The reduction in the number of medical officers placed at hospital level has led to inconsistent referrals from the primary health care facilities and health services such as Clinical Outreach programmes being stopped. This stoppage has resulted in patients incurring high out of pocket expenses. The above challenges are evident in the Nyandeni area notably at Canzibe Hospital, and St. Barnabas Hospital. Health Services in two of the Nyandeni District Hospitals will be highlighted below.

5.4 Canzibe Hospital

Canzibe Hospital is a Level 1 District Hospital with 120 beds. It is situated in Nqgeleni and serves a catchment population of 143 000. It has 13 referring primary health care facilities. The hospital serves a total of 16 wards in the Nyandeni area.

Canzibe serves both in and out patients. There are five main wards: adult general, maternity/gynecology, pediatrics, TB and short-stay. The outpatients department runs daily and also serves as a casualty after hours. Emergency surgery and minor procedures are performed in the hospital's theatres. There is an onsite NHLS laboratory, an x-ray department and dispensary, as well as an ARV unit.

Canzibe Hospital has however had a challenge of filling posts for medical officers. From 2016 to 2017 there was a gross shortage of medical officers at the health facility. Through advocacy interventions from the RHAP, ECHCAC, TAC and RuDASA the hospital currently has 1 Clinical Manager, 1 Community Service Doctor and 4 Medical Officers placed by Africa Health Placements.

The rehabilitation department at Canzibe was previously marred with HRH shortages. Rehabilitation services were previously provided solely by a volunteer foreign physiotherapist. As of 2018, the rehabilitation department comprises a single grade 1 occupational therapist, a community service physiotherapist and community service occupational therapist. Despite the increase in HRH in this area, the department is nowhere to an

adequate and diverse staff complement. There is a need for an audiologist and speech therapist. The high incidence of cerebral palsy, in particular, will necessitate the inclusion of a speech therapist. The high incidence of TB within the sub-district would also demand the skills of an audiologist. The updated organogram for this hospital does not include speech therapy and audiology services.

The grade 1 occupational therapist shows a strong commitment to the hospital. The community service physiotherapist has shown interest in being retained. This is a positive start for the rehabilitation department. Regarding this, RHAP has offered the community service physiotherapist support to be retained.

The dietetics post that was recently vacated has yet to be filled and the occupational therapist is performing some of the duties of a dietitian. She does through telephonic support from dietitians in neighbouring hospitals.

There is a strong need for the above services to be advocated for.

5.5 Health Services

1	Social services
2	Medical male circumcision
3	Family Planning
4	Emergency, OPD
5	Surgical, medical
6	Paediatric
7	Operating Theatre & CSSD
8	Maternity
9	X-Ray
10	Laboratory
11	Pharmaceutical
12	Laundry
13	Kitchen Services

5.6 Primary Health Care Facilities

Clinic Name	Clinic Name
1. Buntingville Clinic	8. Nolitha Clinic
2. Canzibe Gateway Clinic	9. Nqanda Clinic
3. Lujizweni Clinic	10. Ntibane Clinic
4. Lwandile Clinic	11. Pilani Clinic
5. Maqanyei Clinic	12. Ngqeleni Clinic
6. Mtakatye Clinic	13. Ntaphane Clinic
7. Nkumandeni Clinic	

The following provides an impression of challenges and positive developments at a number of the above clinics, as observed during field visits.

Buntingville Clinic

Buntingville Clinic is well-situated along the tar road which is closer to Mthatha for health users requiring PHC services. The clinic refers its patients to Canzibe Hospital although this does not seem feasible since it requires a patient to travel in the opposite direction when the clinic is just a short distance away from Mthatha General Hospital.

The clinic serves 13 Wards covering 9 villages. The Clinic Committee is active and often writes letters to the sub-district on clinic challenge.

Nolitha Clinic

Nolitha Clinic was previously operating out of two rondeval structures. During the time of the visit the clinic staff was preparing to move to a newly built structure across the gravel road. Some of the reported challenges included staff shortages and long waiting times for EMRS. Positive development included the support received by the WBOT, which were assisting with patients lost-to-follow-up. The clinic also did not experience significant drug stock-outs and indicated that the Central Chronic Medicine Dispensing Distribution Programme (CCMDD) was working well. In terms of staffing, four professional nurses staff the clinic, two enrolled nursing assistants, two general assistants and a visiting medical doctor twice a week. There is no grounds man and this was evident from the long uncut grass at the time of the visit.

The RHAP met with two professional nurses who indicated that the Ward Based PHC Outreach Team works well and assists with patients that are lost to follow up. A Medical Officer from Mthatha visits the clinic weekly every Thursday. The clinic seldom experience drug stock outs as their Central Chronic Medicine Dispensing Distribution Programme (CCMDD) is working well.

The clinic indicated that the new organogram has not been implemented, during the time of the visit the staff compliment was 4 Professional Nurses, 2 Enrolled Nursing Assistants, 2 General Assistants and no Grounds Man. This was evident by the long uncut grass. The nurses were concerned that EMRS takes very long to arrive to take patients to Canzibe Hospital especially expectant mothers who are due to deliver.

Nqanda Clinic

Nqanda Clinic is situated 6-10km away from Nolitha Clinic. The Operational Manager has been working in this clinic for 18 years. She indicated that there are long waiting times for patients due to understaffing her current staff compliment was 1 Community Service Professional Nurse, 1 Enrolled Nursing Assistant, 1 Data Capturer and 1 General Assistant. There is no doctor that conducts outreach to the clinic.

The team also met with Community Health Workers that are attached to the clinic they mentioned that despite their efforts pregnant women are still not attending ANC at the rate that they should be and that most mothers still delivering at home. The fact that it takes approximately 5hours for EMRS to arrive does not remedy the situation. Patients experience long waiting time for EMRS to arrive approximately 5 hours.

There are other challenges that are prevalent in the community such as high rate of teenage pregnancy due to male partners having a poor attitude towards condom use. As well as substance/drug use as dagga is grown in the area.

Lujizweni Clinic

The clinic has structural challenges related to a limited number of consulting rooms, no waiting area for patients. There was no water at the clinic during the time of the field visit; the staff relies on water from JoJo Tanks. The staff compliment was 3 Professional Nurses, 1Enrolled Nursing Assistant and 1 General Assistant.

Supervisors from Sub-District supervise the clinic monthly. In previous years Doctors from Canzibe Hospital used to visit the clinic for outreach purposes. Currently patients do not go when referred to Canzibe Hospital as it is too far. There are no services to address Patients with visual and oral problems. A remaining challenge is that there is only one ambulance for the whole of Nqgeleni, which also service Lujizweni Clinic. A volunteer physiotherapist used to conduct outreach for patients that need rehabilitation services.

Pilani Clinic

The clinic is newly built. Pilani Clinic is 10 km from Mankosi clinic The Clinic is 95km from Mthatha and caters for 33 surrounding Communities.
The main challenge was that of understaffing 2 Professional Nurses, 2 Enrolled Nursing Assistants, 2 CHWs, 1 Peer Educator, 1 Care Giver, 1 Grounds Man, 2 Volunteers.

The other problem faced by the staff is the frequent medication shortages, specifically ARVs FDC. Due the shortage of doctors at Canzibe hospital the nurses need to first call OPD at Canzibe Hospital before referring patients. A Doctor no longer visits clinic. The operational manager is a strong patient advocate and has worked with the Clinic Committee who has subsequently written a letter to the District requesting more staff at the clinic. The community also wrote a letter requesting the clinic to be upgraded to a CHC. Patients walk about 20km to access the clinic.

Lwandile Clinic

The clinic building is an old structure donated by the Dutch the clinic is remote and hard to reach. It was not originally a clinic there is therefore no waiting area for patients. The road to this clinic is an ill maintained gravel road. Patients that are referred to Canzibe Hospital from this clinic when referred for review do not go due to distance. The staff compliment at the time of the visit was 2 Professional Nurses,1 Enrolled Nursing Assistant, 1 Data Capturer and 1 General Assistant.

The clinic serves around 800 patients per month, 400-500 of these patients are children. There is however no fridge to adequately store Vaccines and there are regular electricity cuts with no back up generator in place. There are no EMRS services that support Lwandile Clinic. The clinic currently has no telephone is unable to call for support during emergencies. Supervision of the clinic is also not done regularly. There are often medication stock outs.

5.6 St. Barnabas Hospital

Our focus in this situational analysis has largely been on Canzibe Hospital and its feeder clinics. We hope that during the Learning Site Project we will get further understanding about the functioning of St. Barnabas Hospital and its clinics respectively.

St. Barnabas Hospital has a bed a capacity of 225 beds and is situated in Libode. The hospital is the largest of the three district hospitals in the Nyandeni cluster of hospitals such as Canzibe Hospital (Ngqeleni). The cluster includes Isilimela Hospital (PSJ). St Barnabas hospital is located off the R61 main road that runs through the town of Libode and it is roughly 37 km away from Umtata. It is relatively easy to access on tar road and newly renovated accommodation has been made available.

5.7 Health Services

1	Anti-Retroviral (ARV) treatment for HIV/AIDS
2	Emergency department
3	Maternity ward
4	Medical Services
5	Operating Theatre & CSSD Services
6	Out Patients Department
7	Pharmacy
8	Paediatric ward
9	Physiotherapy
10	Post Trauma Counselling Services
11	Surgical Services
12	X-Ray Services
13	NHLS Laboratory

5.8 St. Barnabas Primary Health Care Facilities

Clinic Name	Clinic Name
1. Mangcwanguleni Clinic	8. Nontsikelelo Biko Clinic
2. Makhotyana CHC	9. Nyandeni Clinic
3. Bomvini Clinic	10. Libode Clinic
4. Nkanga Clinic	11. Mampondo Clinic
5. Double Falls Clinic	12. Cwele Clinic
6. Mevana Clinic	
7. Mgwenyane Clinic	

Through the Rural Learning Site Project we hope to continue to provide evidence that speaks to highlight that human resources for health planning cannot be done in isolation, health care worker posts need to include both non-clinical support staff, planned hospital transport, consistent drug supply and decent staff accommodation (RHAP, 2017).

5.9 Conclusion

Rural health services face particular challenges in attracting and retaining good staff, there is therefore a need for innovative strategies that ensure that there are adequate health care workers in the public sector to provide quality health services (RHAP, 2017). The rural learning site project aims to collaborate with health care workers, users of the health system and community stakeholders in advocating for health services for all.

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