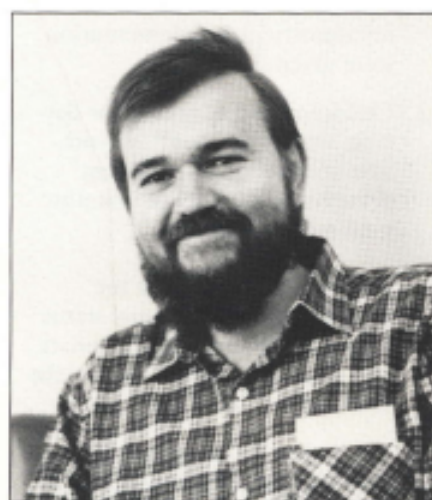


Report on an Evaluation of a Nutrition unit in Winterveld, South Africa.

Unstructured interviews: Part 2

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Curriculum vitae

Paulo Ferrinho had his school education in Mocambique and then went on to the University of Cape Town to obtain the MBChB in 1980. He did his internship at the Groote Schuur hospital in Cape Town and then worked at the Gelukspan Community Hospital from 1982 to 1986. After that he became a registrar in Community Health at the University of the Witwatersrand. He then became the Clinic Manager and Director for Research of the Alexandra Health Centre and University Clinic/Institute for Urban Primary Health Care until 1991. Currently he is at the Institute of Tropical Medicine and Hygiene in Lisbon. Although specialising in Community Health, his professional interest remains in support to primary health care.

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Summary

We report on an evaluation of a Nutrition Rehabilitation Unit (NRU) at the request of Medecin du Monde (South Africa) on behalf of the St Peter's Health Centre (SPHC) in Winterveld.^{1,2} Winterveld is a sprawling squatter camp north of Pretoria, the capital of South Africa, with huge socio-economic and environmental problems. The prevalence of protein-energy malnutrition in the community was recently measured but the results are still not available. Nevertheless malnutrition is a common clinical problem at the SPHC. For this reason a NRU was initiated in 1989.

The evaluation had two main components: an unstructured interview with health workers at SPHC and the NRU, and an analysis of all the records of patients admitted to the unit since it opened. Here we report on the findings of the unstructured interviews. Many of the problems at the NRU are related to managerial failures that could be corrected with very simple and basic steps as discussed.

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Nutrition Surveys; Ambulatory Care Facilities; Organisation and Administration; Evaluation Studies.

The results of the unstructured interviews

The unstructured interviews with managers of the St Peter's Health Centre (SPHC) and with nutrition rehabilitation workers (NRWs) at the nutrition rehabilitation unit (NRU) focussed essentially on qualitative impressions on management issues and quality of care. The main findings are summarised in observations 1 to 22.

1. The interviews revealed background information similar to that reported in the evaluation of the SPHC. The lack of: well defined management structures; clear line management; management procedures; written conditions of employment; and of written job descriptions all contributed to a sense of not knowing how to fit into the SPHC.
2. The professional nurses also perceived the SPHC as grossly understaffed. Most work pressure was seen as coming from demand for curative care.
3. The purpose of the NRU was not clear. The staff was not sure if they are trying to have a community impact or if they have a responsibility to "patients". It is not clear if they were an extension of the Gold Field's Nutrition Unit (GFNU), or of the SPHC curative clinic or an unselective feeding scheme.
4. The NRU was staffed by 2 lay health workers with limited skills. Because of the pressure of clinical work in the SPHC one of the lay health workers was briefly removed from nutritional work. As a result the minimum ratio of child-mother pair/NRW was at least 15 to 1. Home assessments

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and follow up of defaulters was discontinued for a short period in 1991.

5. None of the NRW's was aware of the objectives for either the SPHC or the NRU.
6. There was a status problem. Both NRW's were unhappy about their current professional classification. One of them reported that she was trying to complete high school to study further and "be a real health worker, not a lay health worker". None was aware of prospects for self-development and promotion in their current job.
7. The NRW's felt that they had never been trained. This despite the fact that they attended some training programmes at the GFNU. It was my impression that this probably was related to the fact that they were never given a certificate for any of the training received.
8. The NRW's perceive their knowledge and skills as too limited for the job. They did not know how to examine a child, they had no understanding of child development, only one of them felt confident that she knew how to stimulate mothers and children (she later stated that she never did it), they were also unable to mention any criteria to decide when to discharge children.
9. Until August 1990 the NRU's children were closely supervised by the director of the GFNU at least on a weekly basis. The children were discharged by him, sick cases were assessed, and new cases were checked. Since he left in 1990 the supervision has been

left to the professional nurses of the SPHC and to doctors from MEDUNSA and in private practice who, on a voluntary basis, alternate to come once a week to see the children. Only one of the 3 doctors involved seems to have had previous clinical experience with malnourished children. This resulted in a drop in the quality and in loss of continuity of care.

10. Case finding seemed more service based than community orientated.
11. Children were admitted for a variety of nutritional problems: underweight, kwashiorkor,

Many of the problems are related to managerial failures.

marasmus, etc. Usually the nutritional diagnosis was not written anywhere.

Cases of severe malnutrition were not managed at the NRU, but rather referred to the GFNU or the Garankuwa Hospital (GH). Still, "mild kwashis" were frequently admitted to the NRU rather than referred. On admission they were checked by either the doctor or the professional nurse (depending on the day). The urine was not always tested to exclude pyuria (which, if present, is treated as an urinary tract infection), and the patient was then entered on the routine of the NRU (Table I of Part 1). Not all children had a PPD on admission (Heaf test). No vitamin or other

micronutrient supplementation were given.

12. Children were admitted for day care, weekly or monthly visits. The criteria for the different patterns of attendance was not spelt out clearly.

It seemed that some of the supervision of nutritional status by the NRW's was inappropriate and should be carried out by the Well Baby Clinic (WBC) staff.

13. There were no protocols for management of malnutrition at the SPHC's curative clinic, at the WBC or at the NRU.
14. The impression was that daily care consisted of weighing, feeding and delivery of health talks. The medical aspects of malnutrition were not properly addressed (particularly in severe malnutrition), gardening was neglected, maternal involvement was limited and psychological needs of both the mother and the child were not addressed.
15. All children had their weight checked on admission and on a daily basis. Height was rarely checked and arm circumferences and head circumferences were checked even more rarely. It was our impression that these measurements were not plotted in percentile charts. As they were not entered in a graphic format, it was difficult to visualize the child's growth.
16. Children and mothers were kept under overcrowded conditions.
17. The data on the records includes admission data that was not always relevant and even when relevant was not always

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associated with appropriate corrective action.

18. Lack of clearly spelt out stock control procedures and difficulties with supplies resulted in situations where the NRU frequently ran out of some items (split peas, brown beans, mealie meal).
19. Because of conflicting pressure for space the ante-natal clinic (ANC) on Wednesday mornings displaced mothers and children into a small kitchen where they are left unattended.
20. The work at the NRU seemed to have been "medicalised". Feeding was perceived as the main reason for the existence of the NRU. Gardening was not done well, health education was resisted by the mothers, who were "shy" and "unwilling" to participate either by giving lectures themselves or by partaking in role plays. Health education centered around

readmission rates, "not so high" mortality for children in the scheme, prolonged case-holding with low discharge rates, etc. Still no one could produce precise numbers to support these statements. It seemed that collating, analysing, reporting and discussing health information was not done and was not seen as the important management tool that it should be.

22. It was the impression of the staff that food production at the household level was limited and not very feasible because of land pressure. Because of this, gardening at the NRU was not taken seriously. The two methods considered appropriate (doors and tyres) were not practiced. These impressions and practices ignored the finding that most households of children discharged from the GFNU have some sort of food production activity, mostly vegetable gardening.

The Mission and Goals should then be debated with all the staff and each staff member should know precisely how their job contributes to the furthering of the Mission.

2. Structures for operational and line management.

As the number of staff members and the size of the operations are still relatively small, line and operational management structures could remain very

A job description for each member of staff essential.

lectures and songs. The content related to GOBI-FF, with a great emphasis on nutrition. Demonstrations were done to teach about oral fluid therapy of diarrhoeal diseases. There was little 1-1 interaction between mothers and NRWs, all the work being addressed to groups.

21. The health workers spoke of impressions of increasing workloads, high default rates of mothers in the scheme, high

Conclusions and Recommendations

This section will be divided into general conclusions and recommendations and more specific to the NRU.

Conclusions and recommendations applicable to the SPHC in general

1. Mission, goals and objectives.

A small group of senior staff should meet with a facilitator for a two day workshop to debate and phrase the Mission and Goals for the SPHC.

Medical aspects of malnutrition need to be addressed.

simple but clearly defined. Each worker should know who his/her immediate supervisor is. A job description for each staff member is an essential line and management tool.

3. Conditions of employment.

We suggest that the SPHC could adopt simple conditions of employment as similar as possible to those of the public sector. This should be associated with appropriate grievance, disciplinary, promotion and appointment procedures.

4. Career structures.

All staff members should have a clear career structure, with different grades for each staff group and several notches within each grade (even for the NRWs).

5. Staff complement.

The staff complement is limited,

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preventing staff from attending in-service training and from attending to some of the activities at the SPHC (eg home visiting). The lay health worker and the professional nurse complement should be increased.

6. Health information.

Strengthening the managerial function in the SPHC implies development of appropriate health information systems and the skill to use the information.

Conclusions and recommendations specific to the NRU

It was impossible to give a comprehensive and definitive set of recommendations. The recommendations should be seen as suggestions to guide the discussion at the SPHC. Also, until a number of aspects have been clarified (eg the purpose of the SPHC) it will not be possible to be assertive in our recommendations.

1. Purpose

It is important that the staff should be aware whether they are trying to have a community impact or if they have a responsibility to "patients"; if they are an extension of the GFNU, or of the SPHC curative clinic or an unselective feeding scheme. This decision will have implications for the development of the NRU.

2. Staffing

The patient-to-staff ratio will depend on the purpose and on the admission criteria as well as the management protocols. Still as a rough guideline it should not exceed 5-8 to 1.

3. Supervision

There is a need for operational as well as line supervision of the NRU and its staff. It should be done regularly and clearly spelt out in somebody's job description. Clinical supervision could be daily, by the local professional nurses and weekly, on a referral system, by visiting medical practitioners.

4. Admission criteria

In view of the very high prevalence of severe malnutrition in the community,² admissions to the unit should be restricted to

Gardening should be prioritised.

marasmus, kwashiorkor or growth faltering for more than 4 months. Further supervision of growth monitoring and food supplementation should be transferred to the WBC.

5. Case finding

Source of referral should be clearly spelt out in the patient records. Decision on case finding should be postponed until the nutritional priorities in the community have been decided upon and until the role of the WBC and the curative services has been defined.

6. Protocols

Protocols for management of malnutrition are needed at the SPHC's curative clinic, at the WBC and for the NRU. The

function of the WBC is particularly important as it will complement the work of the NRU.

7. Quality of daily care

The medical aspects of malnutrition need to be addressed better (particularly in severe malnutrition), gardening should be prioritised, maternal involvement should be strengthened and psychological needs of both the mother and the child should be addressed. Continuity of care should be provided by the SPHC staff and the visiting doctor should see only referrals and problem cases. This will require training of the professional nurses to fulfil this function competently.

8. Follow-up care

Follow-up and its purpose should be strengthened.

9. Anthropometric measurements

Besides weight, height should be checked on admission and plotted on percentile charts. The progression of weight gain should be monitored in a graphic form.

10. Overcrowding

Overcrowding should be kept to a minimum. This could be done most effectively by subdividing the patients into groups, under different supervisors but with parallel activities, in different areas of the SPHC.

11. Record keeping

The routine data collection on admission should collect data

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relevant for child care, community intervention and evaluation of the unit. A detailed protocol for data collection was proposed.

12. *Health education*

The purpose of health education is to increase knowledge in the context of empowering families to address the problem of malnutrition. The fact that mothers still blame themselves for their children's malnutrition one year after discharge from the GFNU points to the failure of existing educational efforts².

The observation that, also one year later, $1/3$ of the children had a different childminder,² points to the need to target a group larger than the childminder attending the nutrition rehabilitation programme.

The strategies for education of individuals, family and community should be planned thoroughly before implementation. The skills to do this will require appropriate training.

13. *Community work and community development*

Community work is what the health workers do for the community. It involves education, home visiting, etc. Community development is what the community does for itself, usually with the help of health workers. Projects like women's groups, communal gardens, bulk buying schemes, cooperatives and other self-help programmes are all examples of community development efforts.

Up to now the SPHC has done community work but has not actively encouraged community development. Both are extremely important if the problem of malnutrition is to be addressed in its whole complexity.

The two areas for obvious development are therefore to improve the quality of community work already carried out as well as to encourage community development activities that would help to combat the problem of malnutrition. If funds can be found the SPHC should consider employing a community development officer with appropriate social sciences training.

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It requires courage to request an independent evaluation of one's work. It reflects even more courage to allow public debate of the not always positive findings. We express our appreciation to the management team of the SPHC for reflecting both types of courage. We would like to express appreciation to all those that gave their time to talk to us. From the Alexandra Health Centre, David Robb and Pascal Ngakane provided useful comments on this report.