A Health Workers Training Manual

COMMUNITY ENGAGEMENT for QUALITY CARE

2015

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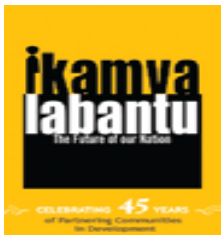
A LEARNING NETWORK INITIATIVE



The **Learning Network** is a collection of five civil society organisations based in Cape Town**:** The Women's Circle, Ikamva Labantu, Epilepsy South Africa, Women on Farms Project and the Cape Metro Health Forum and two higher education institutions including; the University of Cape Town (UCT) and University of the Western Cape (UWC).

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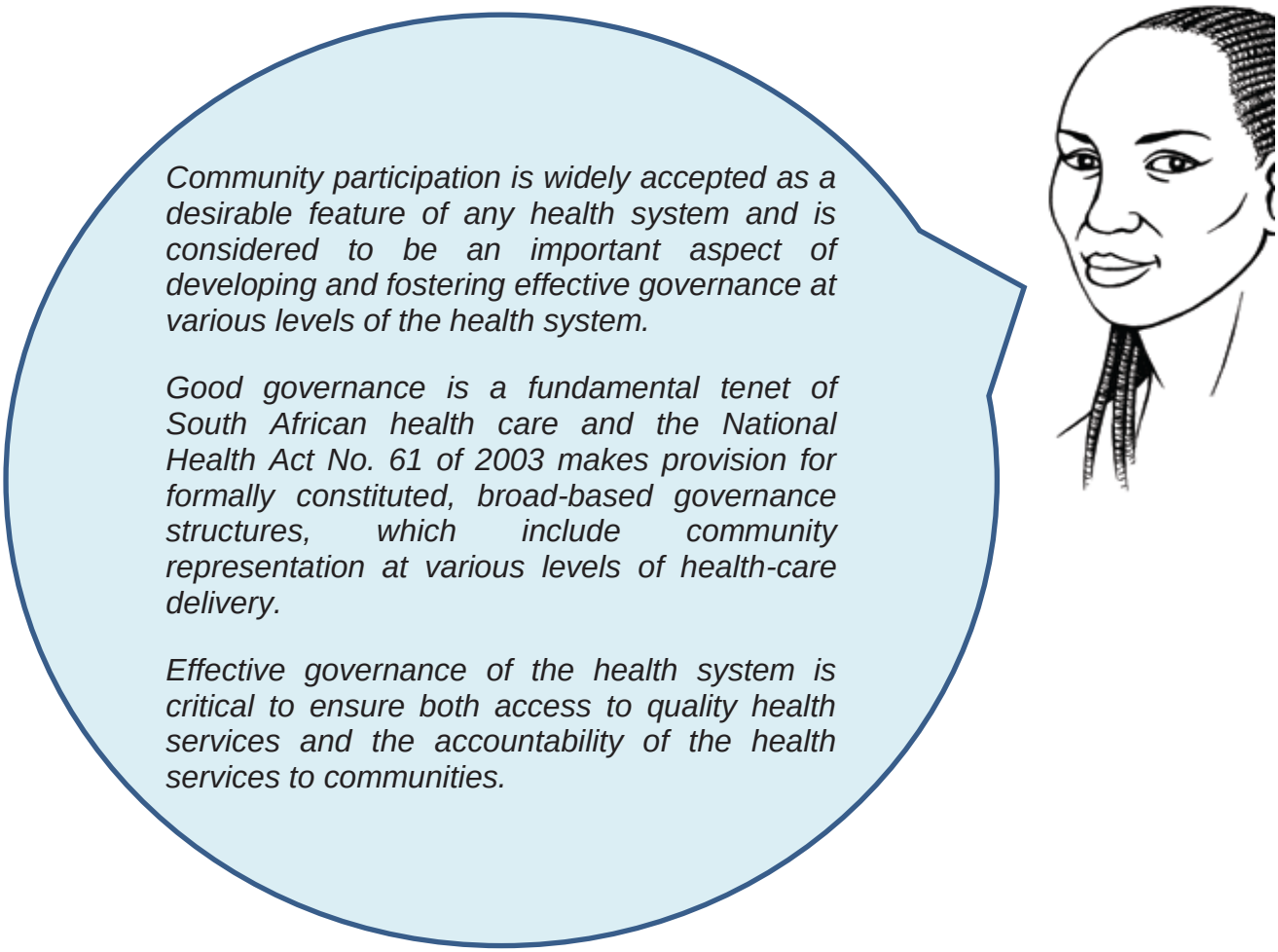
MPH Student, **Gimenne Zwama** provided feedback on the draft manual.

WORKSHOP METHOD: The manual uses interactive training methods to pursue the following goals;

Introduction

Welcome to the first edition of the Community Engagement for Quality Care training manual for health workers.



Community participation is widely accepted as a desirable feature of any health system and is considered to be an important aspect of developing and fostering effective governance at various levels of the health system.

Good governance is a fundamental tenet of South African health care and the National Health Act No. 61 of 2003 makes provision for formally constituted, broad-based governance structures, which include community representation at various levels of health-care delivery.

Effective governance of the health system is critical to ensure both access to quality health services and the accountability of the health services to communities.

Cooperation and collaboration between health workers and community members is a foundational principle of the primary health care approach. National draft policy exists to ensure that community health committees are established as facility partners and as a link to represent community interests.

The National Health Act 2003 provides for the establishment of health committees (Section 42) and is based on an understanding that access to health is a human right (The Constitution of South Africa Act 108 0f 1996; Section 27).

Health committees are essential in order to develop and promote effective communication strategies to increase a) public knowledge of services, b) their right to access these and c) to be treated with dignity. Health committees can also provide information to health-care service users, about the role and function of the health care service, user obligations and the importance of working together with health-care providers to ensure an equitable, efficient and caring service for all.

This manual provides information about health committees, community participation, democracy, health and human rights, leadership, power, partnership and engagement between the health care providers and communities. Supplementary information is provided in an electronic format in order for you to be able to have ready access to relevant legislation, policy and other resources.

As described in **the Health Committee Training** manual: Health committees are called by different names in different contexts: health committees; community health committees; health centre committees, facility Committees and clinic committees. In this manual the terms community health committee and health committee are used interchangeably.

This training manual is designed to be interactive, and participants are expected to take an active role in the training sessions. It is accompanied by a facilitator guide, in order that those who have been trained are in turn able to train others, and in doing so we hope that all health care workers will over time have the opportunity to engage with the information in the manual.

– Pat Mayers

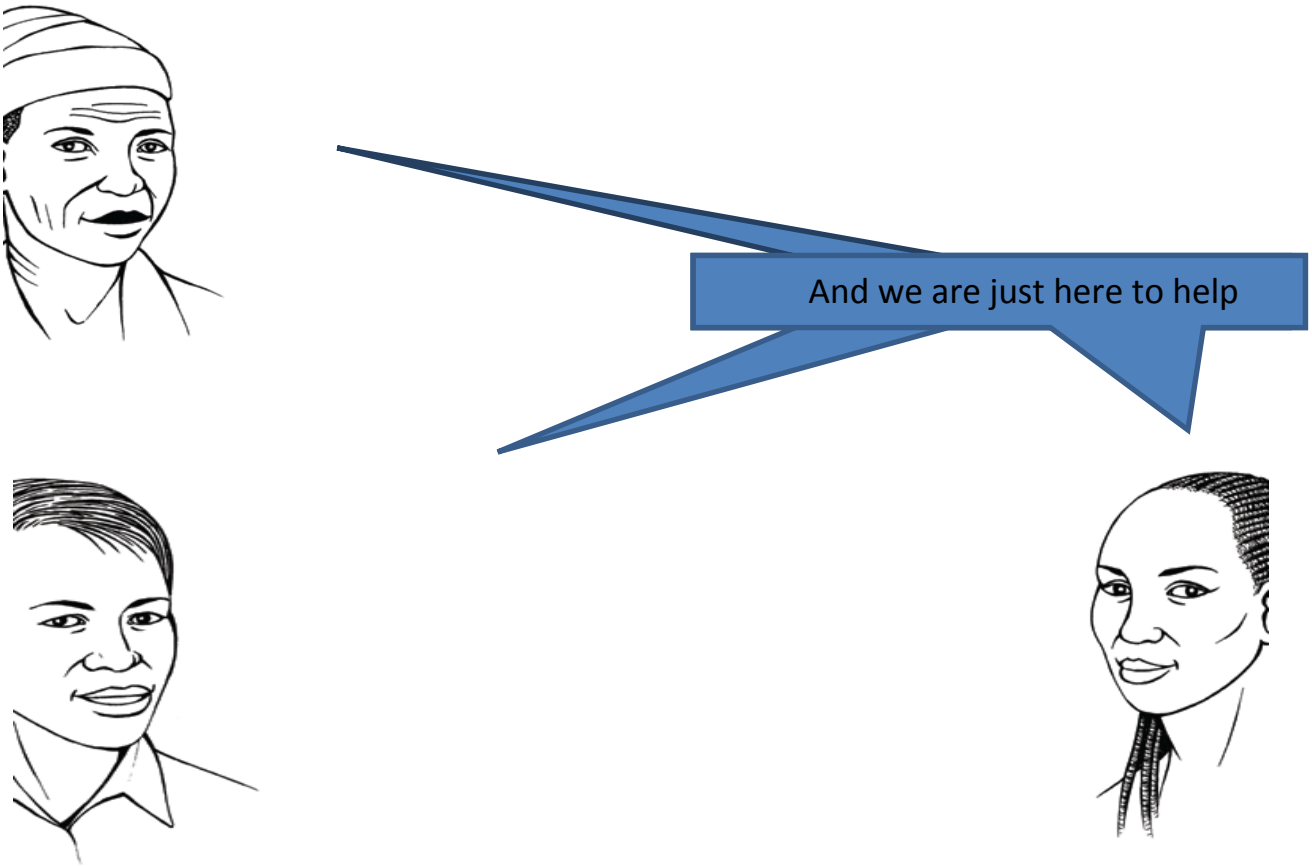
CONTENTS

1. RELATIONSHIP BUILDING

VISION: ***"An environment where people participate in their own health in cooperation with health-care providers, in order to establish accessible, equitable and quality care."*** **Pat Mayers**

LEARNING OBJECTIVES:

- **Review our obligations for treating all persons with compassion and care.**
- **Review health codes of conduct that reflect on relationship-building.**
- **Discuss various aspects of relationship-building.**



1.1 Practicing Inter-personal Respect

Let's start!

Our Democracy, our Ubuntu, our *Batho Pele* and a number of other national commitments, ties us to the development of a human rights culture.

As health workers, we are particularly responsible for creating an environment of care and compassion.

ICE-BREAKER ACTIVITY

ACTIVITY 1: THINKING GROUP TIME: 20 minutes

Method: Buzz session 'Confession'
Purpose: Review the facility culture of inter-personal relations with patients.

Procedure: The facilitator clarifies that these stories will not be shared in plenary and that both participants are bound by the ethics of confidentiality.

Participants find a partner. Each person describes an incident with a patient, or relative of a patient, when they forgot their 'Ubuntu'.

After each person has had approximately 5 minutes to share their story, the facilitator asks participants to brainstorm the reasons for this lapse.

Relationship-building is a human endeavour more than a learned skill. It is something that requires internal reflection on our personal ethics, communication skills and attitudes towards others who require our attention. Becoming a health worker commits us to the need to constantly reflect on our working environment. This includes the power dynamic between us and the health facility clients. It also means that we have to reflect on our own progress, in addressing our daily challenges.

In addition, as health workers, we are bound to professional and health ethics and by the various national and international human rights endeavours, to which South Africa as a country is committed.

Batho Pele principles (Appendix provided), provides a guide to the kind of atmosphere and culture that we should have at the health facilities. The Patient's Rights Charter looks at the rights of all parties.

EVALUATIVE ACTIVITY

ACTIVITY 2: THE POWER OF LISTENING TIME: 20 minutes

Method: Buzz sessions
Purpose: To understand the differnince between listening and hearing.
Procedure: Participants are asked to sit facing each other in pairs. Each person gets five minutes to talk about a time in their life when they were discriminated against. The listening person is not allowed to interrupt for the duration of five minutes. The facilitator then brainstorm what it felt like to be listened to and what it felt like to give someone full attention. The responses are written up.

LEARNING ACTIVITY

ACTIVITY 3: ATTENDING TO PURPOSE TIME: 1 hour

Method: Group-work

Purpose: To examine methods for respect-building, using the Patient's Rights Charter.

Procedure: Participants review each of the bullets under patients' rights and brainstorm ways in which the facility can improve.

PATIENTS' RIGHTS AND RESPONSIBILITIES

According to the national **Patient's Rights** charter, every patient has the right to:

- A healthy and safe environment.
- Participate in decision-making concerning their health.
- Access to health care services which include:
  - Receiving timely emergency care
  - Treatment and rehabilitation
  - Provision for special needs
  - Counselling
  - Palliative care
  - A positive disposition
  - Health information
- Knowledge of one's own health insurance / medical aid scheme
- Choice of health services
- Be treated by a named health care provider
- Confidentiality and privacy
- Informed consent
- Refusal of treatment
- Be referred for a second opinion
- Continuity of care
- Complain about health services

Every patient or client has the following **responsibilities**:

- To take care of his or her health.
- To care for and protect the environment.
- To respect the rights of other patients and health providers.
- To utilise the health care system properly and not abuse it.
- To know his or her local health service and what they offer.
- To provide health care providers with the relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes.
- To advise the health care providers on his or her wishes with regard to his or her death.
- To comply with the prescribed treatment or rehabilitation procedures.
- To enquire about the related costs of the treatment and / or rehabilitation and arrange for payment.
- To take care of health records in his or her possession.

EVALUATIVE ACTIVITY

ACTIVITY 4: STAYING IN TOUCH WITH OURSELVES TIME: 15 minutes

Method: Reading aloud in Plenary
Purpose: To review the history of compassion within the health profession.
Procedure: Participants take turns reading through ‘’Healing and the Culture of Care’ that follows and reflect on whether this is still applied.

1.2. Healing and the Culture of Care

> *"Nurses care for individuals of all ages and cultural backgrounds who are healthy and ill in a holistic manner based on the individual's physical, emotional, psychological, intellectual, social, and spiritual needs. The profession combines physical science, social science, nursing theory, and technology in caring for those individuals."* Florence Nightingale. **http://www.biography.com/people/florence-nightingale-9423539**

The nursing profession has developed throughout history with improvements in practice, types of caregivers, roles, and policy changes, but nursing remains a profession of caring and service to those in need. Many notable nurses have worked to revolutionize this career and have allowed nursing to evolve, while simultaneously providing better care and circumstances in many situations.

In 1853, Florence Nightingale served as a nurse during the Crimean War, during which she not only cared for the injured but set standards of cleanliness in the areas where she worked; her sanitary reforms reduced the overall incidence of infection where they were implemented. Nightingale authored a book called Notes on Nursing, which was written as a set of guidelines for other nurses. She subsequently opened one of the first nursing schools, the Florence Nightingale School for Nurses in London in 1860.

"The most basic of all human needs is the need to understand and be understood. The best way to understand people is to listen to them." — Ralph G. Nichols

Nightingale placed the comfort and needs of the patient ahead of the pursuit of science.

It seems that comfort and respect for patients needs is no longer associated with public health facilities, although there are institutions like hospices, which have maintained the ethos of care and consideration.

At the end of the 19th century, more nurses began to work toward changing policy in leadership and education in nursing schools, recognizing their role as more than that of a bedside caregiver. By implementing change, many nurses went beyond the scope of care to educate those in leadership about the need for prevention and to reach some groups of people who were not able to access care. Today's nurses are vital members of the health team, and have taken on roles and functions which previously were restricted to medical professionals.

Nursing staff play a pivotal role at public health facilities and therefore have a priority role for restoring the confidence of the public. The nurses are the frontline health activists, whose responsiveness and demeanour toward their patients can make the overall experience at a health facility, a lot better.

Declaration of Geneva.

The Declaration of Geneva (Physician's Oath) was adopted by the General Assembly of the World Medical Association (WMA) at Geneva in 1948, amended in 1968, 1983, 1994 and editorially revised in 2005 and 2006. It is a declaration of a physician's dedication to the humanitarian goals of medicine, a declaration that was especially important in view of the medical crimes which had just been committed in Nazi Germany. The Declaration of Geneva was intended as a revision of the Hippocratic Oath, to a formulation of that oath's moral truths that could be comprehended and acknowledged in a modern way.

ALL HEALTH WORKERS

ACTIVITY 5: THINKING GROUP TIME: 20 minutes

Method: Buzz session

Purpose: Be familiar with the Declaration of Geneva.

Procedure: Participants read through the paragraph that follows and respond to the following questions.

1. What is meant by "*practicing my profession with conscience and dignity*?"

2. Under which circumstances will "*the health of my patient*" not be the first consideration?

Nurses' pledge

I solemnly pledge myself to the service of humanity and will endeavour to practice my profession with conscience and with dignity

I will maintain by all the means in my power the honour and the noble traditions of my profession

The total health of my patients will be my first consideration

I will hold in confidence all personal matters coming to my knowledge

In addition, inter-personal respect is required in any workplace, not just by people who are bound by oaths of their profession. People who generally communicate with the public should also operate at a high level of consciousness about;

- Personal level of fatigue
- Patient's boundaries
- Time Management and scheduling

In relation to health committees members it includes respecting their deadlines and the time of health committee members.

1.2.1. Reflecting on our Compassion Compass

ACTIVITY 6: STAYING IN TOUCH WITH OURSELVES TIME: 30 minutes

Method: Group-work

Purpose: To reflect on our understanding of compassion.

Procedure: Each person in the group provides their definition of compassion and why they feel it defines compassion. A 'scribe' writes up the results and groups provide feedback in plenary.

In a brainstorm, participants reflect on whether it is practiced in reality, how realistic it is and what can be done to create a more compassionate environment for patients.

Draw a compass, and each person indicates on the compass, where their compassion lies in relation to North, moving clockwise.

Sometimes fatigue and burnout lead to a lack of compassion. Health professionals who are faced with trauma, illness and anxiety on a daily basis have to be able to recognise the signs of burn-out so that they are able to take time out to care for themselves, as they often care for others. In addition it is estimated that health workers see, on average, 60 patients per day, which probably differs in scale depending on the population size for which a particular facility provides services.

1.2.2. Reflection on Dual Obligations.

Health workers have a dual obligation. The one obligation is toward their employer and the other is toward the patients. In a quick discussion, reflect on which obligation takes precedence. Read more about Dual Loyalties and Professional Obligations by Professor Leslie London and Dual Obligations and Human Rights, London et al., inserted as an appendix on page 57.

Section 35 of the S.A. Constitution (Act 108 of 1996), deals with the abuse of power toward people who are detained or imprisoned. It is also a case that highlights the dual obligations of health workers.

LEARNING ACTIVITY

ACTIVITY 7: ATTENDING TO PURPOSE TIME: 15 minutes

Method: Group work
Purpose: To reflect on the dual obligations of health workers.
Procedure: Read through the case study below and discuss the questions that follow.

1. In terms of dual obligations of health workers, which obligation should take precedence when dealing with such severe injuries?
2. Discuss what the responsibility of the health worker was, under these conditions.
3. Discuss your challenges with respect to dual loyalty in your facility.

Case Study

In September 1977 Stephen Bantu Biko died 6 days after being detained and questioned by police. The first doctor who was called in to examine Biko was told that he was acting strangely and did not respond to questions. The doctor found that he was unable to coordinate his movements and found bruising and swelling on various parts of his body.

The doctor did not ask Biko how he was injured and he reported that he found no evidence of abnormality or illness. As his condition got worse Biko was examined by other doctors who found various signs of evidence of brain damage (slurred speech, left sided weakness and blood in his spinal fluid) but none of them reacted with urgency or provided any treatment.

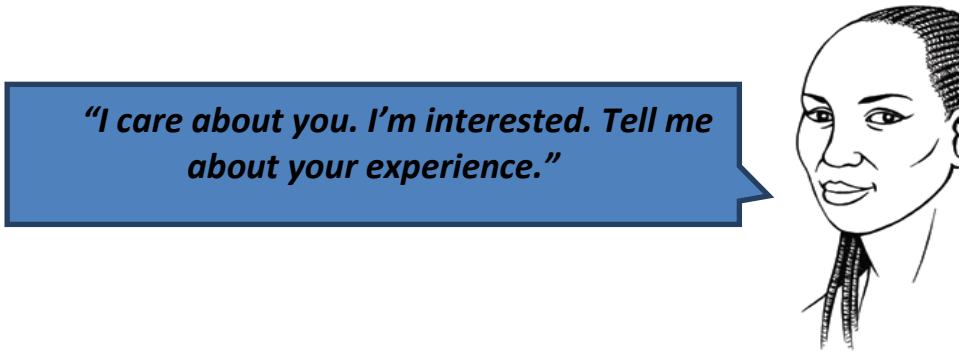
An inquest into his death found that he died of severe head injuries. Seven years later the doctors who attended to Steve Biko were found guilty of improper conduct. Health and Democracy. Hassim, Heywood and Berger. 2007

1.2.3. Reflecting on Mindfulness

Mindfulness is not just about paying attention, but also about ***how*** you pay attention. Mindfulness includes being compassionate, providing kind attention, holding the compassionate awareness, and responding with empathy.

Instead of being angry or impatient, it is useful to first address the feelings within yourself. We can reflect on what it is that is making us feel impatient. We proactively attempt to develop a form of self-awareness and become more mindful of our own feelings, within the moment.

In this way, we begin to cultivate kindness toward ourselves. Sometimes a mantra helps and as a health professional we can practice repeating the mantra;



Develop your own mantra!

Because of the nature and pace of health work, sometimes we might need a reminder in our environment that keeps calling our attention back to the practice of mindfulness. It could be a poster on the wall, a bracelet or even a button that we wear, which reminds us to be mindful of our countenance toward others.

Source: Greater Good. The science of Happiness

1.2.4. Reflecting on Professionalism

What is professionalism? It implies, among others, a commitment to the highest standards of excellence in the practice of health-care, accountability, and respect for others.

Professionalism is demonstrated in a number of ways in the health care setting:

- The manner in which we carry out our duties.
- Respecting the time for which we are paid to provide these services.
- The way we address others and the courtesy and consideration shown in communication with others.

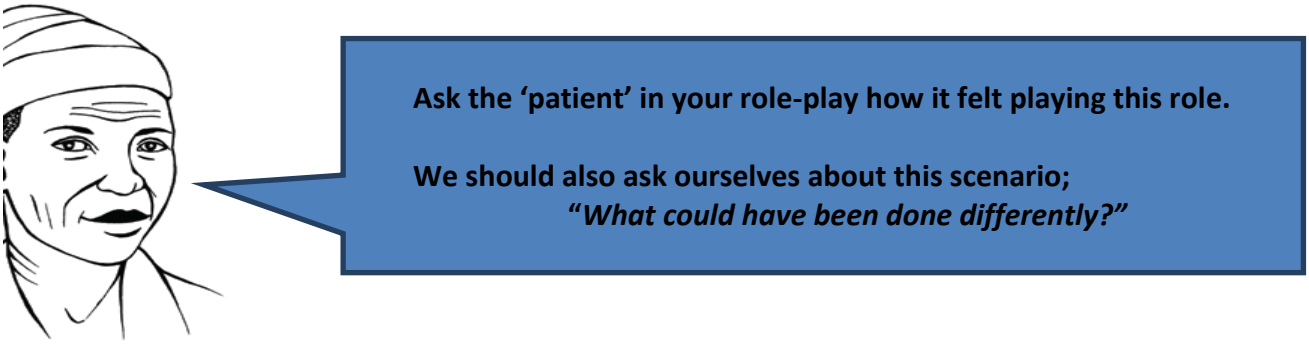
ACTIVITY 8: THINKING GROUP TIME: 1 hour

Method: Role-play

Purpose: Examine the effects of unprofessional behaviour.

Procedure: Participants volunteer to act out the following scenario. One participant stands in the background with flash cards showing how much time has elapsed by estimating real time for the reception queue, sitting in the waiting room, outside the doctor's office etc.

A patient attending a clinic because of excessive menstrual bleeding is told at reception to "*Sit in the queue*" in an abrupt manner, after dropping her clinic card.
1 hour: After an hour, she goes to the bathroom to change and her name is called out during this time.
1h 15min: On return, another patient next to her asks her name and explains that her name was called out.
1h 30min: She goes to reception and is severely and publicly reprimanded by the receptionist.
3 hours: She goes back to her seat and after a while is given her file and instructed to queue for her blood pressure.
5 hours: After this she is referred to another waiting room to see the doctor.
6 hours: The doctor reads her file and with no communication, writes out her pharmacy prescription.
6h 30min: Collects her medication.
6h 35min: Goes to the bathroom.



Discuss the following two questions;

1. Is this scenario possible at our health facilities?
2. What would make this patient's journey through the facility more tolerable?

EVALUATIVE ACTIVITY

ACTIVITY 9: STAYING IN TOUCH WITH OURSELVES TIME: 30 minutes

Method: Buzz session
Purpose: To apply Patients' Rights considerations to our human rights intention.
Procedure: With a partner, participants examine how many human rights (at the back of manual) were violated in the role-play scenario and write these up.
1. Participants are asked to generate a list of other Codes of Conduct to which health workers have to subscribe.

1.2.5. Communication

Communication is the key to all our interactions, throughout our lives. Our communication with our children, spouses and co-workers will determine the quality of these relationships over time.

Verbal communication is therefore very important. It is, however, also true that non-verbal communication makes up 80% of what we are conveying.

LEARNING ACTIVITY

ACTIVITY 10: ATTENDING TO PURPOSE TIME: 15 minutes

Method: Group work
Purpose: To examine the difference between verbal and non-verbal communication.
Procedure: Review the following scenarios and discuss what is being communicated;

1. A mom with a baby tells a health worker that her child is running a very high fever and needs to be seen urgently. The health worker, without stopping his stride, responds; "*Every case here is urgent*." What is being communicated non-verbally?
2. A health worker responding to a rape victim who is brought in by the police in the middle of the night, tells the patient to get onto the bed for examination. The health worker briefly turns her back in order to put on gloves and asks; "*What were you doing outside so late at night*?" What is being communicated verbally and non-verbally?

Communication beyond the personal, i.e. verbal and non-verbal also happens in the written form. Patients often have to provide Informed Consent for certain procedures. This has to be done in written form and has to be retained as evidence.

1.2.6. Difficulties Faced by Health Workers

It has to be acknowledged that health facilities are over-burdened. The long queues and difficult hours that health workers have to cope with can test anyone's patience. At some facilities, staff shortages add to the daily stress. In an article entitled 'Voices of Primary Health Care Facility Workers' written by Petrida Ijumba of Health Systems Trust, the concerns of some health workers are captured in the following ways;

"*They say there's a shortage of staff ... even if I'm having patients in the maternity, I am unable to monitor them effectively because I have to go to general side as patients are waiting.*"

One nurse has no time to fulfil one of her major roles. *"... I am the sister in charge but have no time for administrative duties because the clinic gets so full*."

Some nurses feel that although they have invested their time in undergoing training, this has not added value to the quality of care they provide to their patients. "*Although we are trained to suture wounds we do not have suturing materials in the clinic. We send people to the hospital ... even those we can suture. Also, we do not provide delivery services although we are trained to deliver babies*."

The yearning for more staff is loud and the work-load is hardly bearable for some; "*We are seeing many more patients nowadays ...We have been sent a lot of chronic cases and it is not getting better, it is getting worse ... the load is actually getting worse. We need much more staff at the reception, to work with that load in front ... people sit like that for hours, by the time they come to you they are frustrated, they are mad at you and I mean it's not my fault."*

Some are overwhelmed by the number of patients "*From the time that you come to duty the patients are so many that you cannot even go for tea. So you just say let me finish them and they are just coming*."

Within this context, doctors and nurses are just human and our communication sometimes reflects the fatigue, the strain and the impatience that health workers can develop as a consequence.

It is, however, incumbent upon the health worker, as a paid public health worker, to behave in a professional and restrained manner.

1.2.7. Reflecting on Informed Consent

Patients have to be given sufficient time to read through such documentation. Informed consent also requires that health workers explain to patients what the procedures involve and any possible consequences of these.

ACTIVITY 11: THINKING GROUP TIME: 15 minutes

Method: Brainstorm

Purpose: To reflect on the provision of Informed Consent.

Procedure: Participants read through the case study and in plenary discuss what information the patient needs, in order to provide informed consent.

CASE STUDY

A young woman of 22 years of age is admitted to hospital as she has contracted TB from a co-worker at the store where she works. She is told that she needs treatment and has to be put on a course of TB medication. What information does she need?

Informed consent in ethics usually refers to the idea that a person must be fully informed about and understand the potential benefits and risks of their choice of treatment. An uninformed person is at risk of mistakenly making a choice not reflective of his or her values or wishes.

Patients can elect to make their own medical decisions, or can delegate decision-making authority to another party. If the patient is incapacitated, laws around the world designate different processes for obtaining informed consent, typically by having a person appointed by the patient or their next of kin make decisions for them. The value of Informed Consent is closely related to the values of autonomy and truth telling. (http://new.samls.co.za/node/410). A useful explanation of aspects of informed consent is available on this website: http://www.nhs.uk/conditions/consent-to-treatment/Pages/Introduction.aspx

1.3. Values, Ethics and Morals

ACTIVITY 12: THINKING GROUP	TIME: 15 minutes
Method:	Read in Plenary
Purpose:	To reflect on the meaning of ethics, values and morals.
Procedure:	Participants read through the text and the facilitator stops from time to time to allow for discussion, generating examples and providing clarity.

Sometimes we use words like values and ethics without having a common understanding of what it means. The following text will go through various definitions in order to reach a common understanding of these related words.

Values **are personal rules** and people's values define what they want personally. Values are the rules by which we make decisions about right and wrong, should and shouldn't, good and bad, for ourselves.

Values are the goals towards which you aspire. They largely define the core of your identity. More importantly, they are the source of your motivation to improve yourself. If you did not value self-improvement, for example, you would not study.

If you don't understand your values, you won't understand how to orient yourself in a direction that is likely to be satisfying. Your behaviour, your actions will be more oriented towards putting out fires (satisfying your immediate needs), and less oriented towards developing your long term potential. You won't have a plan. You will instead, just be reactive; because if you don't understand what your values are, you don't know what motivates you or what could motivate you - towards becoming a better person.

Values are beliefs held by a person or **social group** in which they have an emotional investment. Example: conservative values vs. liberal values.

Ethics **are professional standards.** Ethics are the rules or standards governing the conduct of a person or the members of a profession or place of employment.

You can have professional ethics, but you seldom hear about professional morals. Ethics tend to be codified into a formal system or set of rules which are explicitly adopted by a group of people. Thus you have medical ethics. Ethics are thus internally defined and adopted, whilst morals tend to be externally imposed on other people.

If you accuse someone of being unethical, it is equivalent of calling them unprofessional and may well be taken as a significant insult and perceived more personally than if you called them immoral (which of course they may also not like).

Morals are group norms that we ascribe to individual, personal behaviour. Morals are values that we pick up from the social groups that surround us. If you were born in a nudist camp, you would be socialized in a way that recognizes the body as beautiful and would not necessarily be tainted by religious moral codes that require the human form to be covered.

Alternately, if we are accustomed to an environment where the group norm regards such behaviour as sinful, it becomes part of our moral code of behaviour, not just for ourselves but which we also use to judge the behaviour of others around us. Imposing our moral values on other people is referred to as being judgmental.

CASE STUDY

ACTIVITY 13: STAYING IN TOUCH WITH OURSELVES TIME: 30 minutes

Method: Brainstorm
Purpose: To reflect on values, ethics and morals.
Procedure: A health worker, who has strict religious beliefs, tells a patient that she cannot assist with the termination of pregnancy but she will get a colleague to assist.

Is she acting on 1) Personal values, 2) Professional ethics, 3) Social morals.

Discuss her professional ethics.

So what?

It is important that health workers not only understand the differences between their own values, morals and ethics, but also be able to assess those of the patients that they see. It provides an opportunity to move beyond cultural, gender or social differences and find a place for a common understanding and a means of communication without judgment.

Applying professional ethics puts you on a higher moral platform and encourages the other person to join you.

EVALUATIVE EXERCISE

ACTIVITY 14: STAYING IN TOUCH WITH OURSELVES TIME: 15 minutes

Method: Individual exercise
Purpose: To reflect on personal values.
Procedure: Each person reflects on the question "*What are my values*?" and completes the table that follows.

Write a list of 5 things that you value;

In yourself	In Others	In life

A few willing participants can share their values as a means of making comparisons about diverse values in the same environment.

ACTIVITY 15: THINKING GROUP TIME: 15 minutes

Method: Brainstorm
Purpose: To reflect on the value of ethics.
Procedure: Participants brainstorm the meaning of the following statement and the facilitator writes up the responses. "*An ethic of service is at war with a craving for gain*".

1.4 Medical Ethics

Medical ethics is a system of moral principles that apply values and judgments to the practice of medicine. http://en.wikipedia.org/wiki/Medical_ethics

It recognizes four basic moral principles, which are to be judged and weighed against each other, with attention given to the scope of their application. The four principles are:

- Respect for autonomy - the patient has the right to refuse or choose their treatment. (*Voluntas aegroti suprema lex*.)
- Beneficence - a practitioner should act in the best interest of the patient. (*Salus aegroti suprema lex*.)
- Non-maleficence - "*first, do no harm*" (*primum non nocere*).
- Justice - concerns the distribution of scarce health resources, and the decision of who gets what treatment (fairness and equality).

Medical ethics further includes the ethical duty of compassion.

1.4.1 Confidentiality in Health care

Confidentiality is commonly applied to conversations between doctors and patients. This concept is commonly known as patient-physician privilege. Any profession that deals with people's sensitive personal information is bound by the same expectations of confidentiality and health-care is no different. However, your duty of confidentiality relates not only to sensitive health information but to all information you hold about your patients.

The National Health Act (NHA) no. 61 of 2003, declares that this information must not be given to others, unless the patient consents or if you can justify the disclosure. This includes demographic data and the dates and times of any appointments your patients may have made, or consultations they may have attended. The fact that an individual may be a patient of yours or registered with your practice is also confidential.

You are only permitted to reveal confidential information about a patient in certain circumstances –In the terms of a statutory provision:

- At the instruction of a court
- When it is in the public interest
- With the written consent of a parent or guardian of a minor under the age of 12 years
- In the case of a deceased patient with the written consent of the next of kin or the executor of the deceased's estate.

http://www.medicalprotection.org/southafrica/factsheets/confidentiality-general-principles

Legal protections prevent physicians from revealing their discussions with patients, even under oath in court.

- Confidentiality is an important issue in primary care ethics, where physicians care for many patients from the same family and community, and where third parties often request information from the considerable medical database typically gathered in primary health care.
- This covers both individual and collective confidentiality. Confidentiality in relation to medical ethics also covers the broader society and other potential, interested parties including:
    - employers and their representatives
    - trade unions and their representatives
    - health professionals
    - social security and insurance administrators
    - researchers
    - Media representatives.

In addition to health professionals, administrative staff should also receive in-staff training regarding the confidentiality of the patient's information and the need for professional ethics in this regard. As part of governance at a health facility, each facility should have a code of conduct for breaching confidential information, in addition to practicing non-discrimination. All administrators, general workers and security personnel should receive in-house training, in

relation to what this means. Health committee members can also be included in these staff development sessions.

Many so-called "ethical conflicts" in medical ethics are traceable back to a lack of communication including communication breakdown between patients and their health-care team, between family members, or between members of the medical community.

Poor Management or governance practice can also lead to poor confidentiality practices at the health facility. These breakdowns should be remedied, and many apparently insurmountable "ethics" problems can be solved with open lines of communication. A complaints procedure at the health facility will quickly establish when health workers are breaking confidentiality.

Feedback from health committee training provides a very worrying picture of health workers constantly violating patient's rights to confidentiality, particularly as it relates to persons living with HIV.

Confidentiality is the practice of keeping harmful, shameful or embarrassing patient information within proper bounds. It differs from privacy in that it always entails a relationship.

Confidentiality in medicine serves two purposes;

Firstly, it ensures respect for the patient's privacy and acknowledges the patient's feeling of vulnerability.

Secondly, it improves the level of health care by permitting the patient to trust the health professional with very personal information.

All personnel have different functions and responsibilities at the health facility but are commonly bound by confidentially ethics.

	Facility Manager	Receptionist	Doctors Nurses	Pharmacist
Role	Oversight	Assist Public	Treatment and care	Dispense medication
Responsibility	Develop management systems e.g. Code of Conduct	Professional Helpful Respectful	Provide full information on illness and prescribed medication	Verbal and written instruction on correct use of medication

HPCSA Ethical Rules:
http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_1_guidelines_good_prac.pdf

According to HPCSA Ethical rules, Section 14, confidentiality may only be breached if:

- ✓ The patient consents to that disclosure in writing.
- ✓ A court order or any law requires that disclosure or
- ✓ Non-disclosure of the information represents a serious threat to public health.

LEARNING ACTIVITY

ACTIVITY 16: ATTENDING TO PURPOSE TIME: 15 minutes

Method: Buzz session
Purpose: To reflect on confidentiality.
Procedure: Read through the following case study with a partner and discuss the role of the health worker from a confidentiality perspective.

The case of HIV: Mr. X, a 30-year-old man, has just tested positive for HIV. He asks his doctor not to tell his wife and says he is not ready to disclose to her yet. What should the doctor do?

Should the doctor respect Mr. X's autonomy and confidentiality and not tell his wife, or does he have an obligation to tell her to protect her (beneficence)?

The guidelines of the South African Medical Association (SAMA) recommend that the doctor may disclose the patient's HIV status to the sexual partner/s **only** if all the following conditions are met and the patient is still reluctant to disclose after counselling:

(a) The sexual partner/s should be known and clearly identifiable;
(b) The sexual partner should be at real risk of being infected. In other words, the doctor believes the patient is posing a risk to the sexual partner;
(c) The patient should be told that the doctor is going to breach his/her duty to maintain confidentiality. SAMA recommends that the patient be permitted a specified period of time to tell the partner him/herself;
(d) Once these steps have been followed the doctor may disclose the HIV status to the partner.

Pre-test counselling and/or referral of the person to a counselling, support and/or treatment facility should be offered.

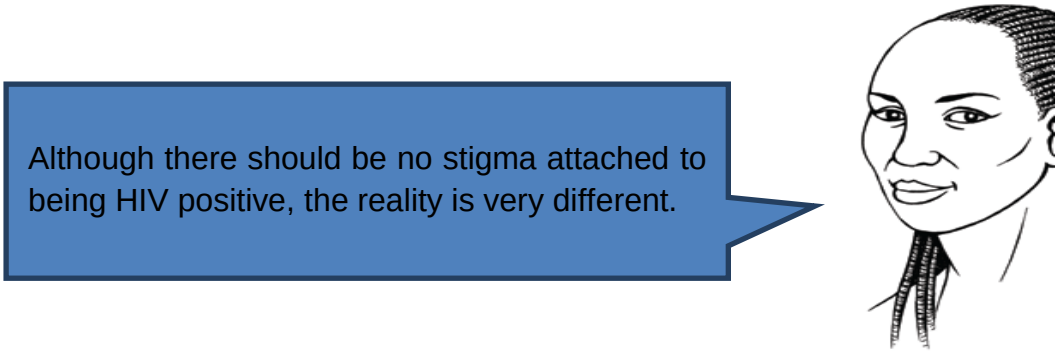
The HPCSA HIV guideline recommends that the doctor use his or her discretion in deciding whether or not to disclose information to the sexual partner, taking into account the risks involved (http://www.hpcsa.co.za/).

Similarly, the SA Nursing Council http://doctors-hospitals-medical-cape-town-south-africa.blaauwberg.net/south_african_medical_associations/south_african_nursing_council_sanc policy states that patients have a right to:

- confidentiality;
- non-judgmental, effective nursing according to personal needs;
- empathy for the social dilemma of AIDS and HIV-positive patients;
- expert accompaniment for themselves, their families and communities, in order to continue a normal, responsible life;
- protection and life, in the case of the unborn child (http://www.sanc.co.za/policyhiv.htm)

Lack of confidentiality in clinics: Health committee members report that facilities use colour-coding on the outside of the files and that everyone can clearly identify the HIV positive patients. In addition, it is often reported that health workers will call out in a public space;

"*Those coming for ARV's, please queue here.*"



1.4.2 Respect for Human Rights

The human rights era started with the formation of the United Nations in 1945, which was charged with the promotion of human rights. The Universal Declaration of Human Rights (1948) was the first major document to define human rights. Medical doctors have an ethical duty to protect the human rights and human dignity of the patient so the advent of a document that defines human rights has had its effect on medical ethics. Most codes of medical ethics now require respect for the human rights of the patient.

Other human rights values include:

- Respect for persons - the patient (and the person treating the patient) have the right to be treated with dignity.
- Truthfulness and honesty - the concept of Informed Consent has increased in importance since the historical events of the Doctors' Trial of the Nuremberg trials and Tuskegee syphilis experiment. http://en.wikipedia.org/wiki/Nuremberg_Code

What does our Constitution say?

The Constitution of South Africa protects the rights of people living with HIV. It doesn't allow discrimination and protects people's right to privacy and confidentiality. In South Africa, there aren't any laws that force people to tell others about their HIV status.

People who do test positive should tell their partner, so that they can be protected and also have an HIV test. People with HIV/AIDS in South Africa are protected by the Bill of Rights and have the same rights which protect all citizens.

There can be no discrimination against anyone who has HIV/AIDS.

- They have the right to medical treatment and care from the health and welfare services.
- Children with HIV are allowed to attend any school.
- No one can be fired from a job just because they are HIV positive.
- No one can be forced to have an HIV test before getting a job or while at work.
- Test results cannot be shown to anyone else without the permission of the person who had the test.
- Pregnant women with HIV have the right to make a choice about their pregnancy.

FURTHER READING:

1. Patient's Rights Charter. http://www.doh.gov.za/docs/legislation/patientsright.
2. Declaration of Geneva. http://en.wikipedia.org/wiki/Declaration_of_Geneva
3. Dual Loyalties and Ethical Human Rights Obligations. Professor Leslie London.http://onlinelibrary.wiley.com/doi/10.1002/ajim.20148/pdf\
4. Informed Consent in South Africa. Professor Carstens. http://new.samls.co.za/node/410
5. South African Medical Association http://en.wikipedia.org/wiki/South
6. South African Nursing Council. http://www.sanc.co.za/
7. Health Professionals Council of South Africa. http://www.hpcsa.co.za/
8. The Basic rights of People Living with AIDS. http://www.health4men.co.za/resources/entry/the_rights_of_people_with_hiv_and_aids/
9. http://www.timetothink.com/thinking-environment/the-ten-components/ease-think/

THINGS TO THINK ABOUT…

1. How can our health facility improve the quality of care to our local community and patients in general?
2. Where can we find posters that indicate empathy for sex workers, people who have different sexual orientation to 'the norm' or any messages that value diversity?
3. How does our facility inculcate professional practices that indicate a high level of confidentiality for vulnerable patients?

2. Health Committees and Governance

VISION: "*Health Services that are responsive to community engagement through an enabling environment*." Primary Health Care Act

LEARNING OBJECTIVES

- **Examine the role of facility governance in working with health committees.**
- **Reflect on various national and international commitments to community involvement in health.**
- **Review Governance practices to create a human rights culture at health facilities.**

2.1. Role and Functions of Health Committees

Our aim should be to incorporate community representation into daily facility management.

How then, do we include collaboration with the health committee members, in our day-to-day governance?

2.1.1. Governance

Clinic governance refers to a systematic approach for maintaining and improving the quality of patient care within the health facility. It embraces;

- High standards of patient care
- Transparent responsibility
- Accountability in management for standards of care and
- Consistent systems evaluation for improved service delivery

It requires ongoing training of all health staff and the support staff at health facilities, particularly in relation to developing up-dated systems for procurement, maintenance and storage of medicines. In relation to patient care, it also means ongoing staff development related to communication, new legislation and human and project management and other health-related training.

2.1.2. Governance and the Community Participation Debate

- What is the rationale for public participation in health facility management?
- What should be the extent of health committee involvement at the health facility?
- What relationship should the health committee have with local government services?

These are legitimate questions that health workers should have in relation to health committees. What are your views?

ICE-BREAKER ACTIVITY

ACTIVITY 1: THINKING GROUP TIME: 15 minutes

Method: Buzz session
Purpose: Share thoughts on community participation.
Procedure: Introduce yourself to someone that you do not know very well. Tell them your views on community participation at the health facility. Each person gets a turn of approximately 7 minutes.

2.1.3. What do our Laws say?

S.A. Legislation

The National Health Act (2003) makes it a statutory requirement that each health facility should have a health committee**. Section 42** of the National Health Act (NHA) deals with health committees in the following way:

(1) Provincial legislation must at least provide for the establishment in the province in question of a committee for:
  (a) A clinic or a group of clinics
  (b) A community health centre; or
  (c) A clinic and a community health centre or a group of clinics and community health centres.

(2) Any committee contemplated in subsection (1) must at least include-
  (a) One or more local government councillors;
  (b) One or more members of the community served by the health facility; and
  (c) The head of the clinic or health centre in question.

(3) The functions of a committee must be prescribed in the provincial legislation in question.

The legislation requires that provinces implement the health committee functions as part of health governance at health facilities. Health facilities are required to recognise the rights of communities to have a say in their own health and health committees serve as a body of people representing the community that the health facility is meant to serve.

EVALUATIVE ACTIVITY

ACTIVITY 2: STAYING IN TOUCH WITH OURSELVES TIME: 45 minutes

Method: Group Work
Purpose: To brainstorm the obligations of various levels of government in ensuring community participation in health. In groups decided by the facilitator, participants reflect on the following and feedback in a plenary session.

1. What is the role of national government in relation to the legislation?
2. What is the role of provincial government in relation to the legislation?
3. What is the role of health workers in relation to the legislation?

S.A. Constitution

In **Section 7** of the Constitution, the government is required to respect, protect, fulfil and promote the right to health.

Section 24 makes reference to a healthy environment.

Section 27 focuses on the conditions needed for health and includes a right that needs to be realized immediately; "*No one may be refused the right to medical treatmen*t."

Section 28 protects the rights of vulnerable groups such as children and their right to "*basic nutrition, shelter, basic health care and social services*."

The back of the manual contains more information on our Constitution and provides information on local government mechanisms for implementation.

2.1.4. Strategies for Community Engagement

Community empowerment, therefore, is more than the involvement, participation or engagement of communities. It implies community ownership and action that explicitly aims at social and political change. Community empowerment is a process of community members re-negotiating power in order to gain more control over the quality of healthcare and health services rendered by the government, which they elected into power.

It significantly also addresses the legitimate human right to equitable access to health-care services and the right to dignity as spelled out in our Constitution.

ACTIVITY 3: THINKING GROUP TIME: 1 hour

Method: Group Work
Purpose: Participants reflect on community involvement at health facilities.
Procedure: In groups participants read through the rationale for health committee and complete both Table 1 and Table 2.

2.1.5. Rationale for Health Committees

- Health committee members provide an opportunity for faster responses to patient needs.
- Working with the facility they introduce facility accountability and transparency.
- Improved service delivery.
- Better information flow to the community about requirements or changes at the facility.
- The can facilitate the creation of sustainable health promotion projects.
- Can assist with resolving conflicts at queues, the complaints procedure and between the community and health facility.
- They provide increased energy and motivation among local stakeholders, in relation to health issues.
- Health committees provide expanded opportunities for political representation.

Table 1

Suggestions The Health Facility could . . .	Make a comment: This is something we should do because…….
Organise a meeting to discuss what a health committee is and how the community can engage with the health facility and define roles and responsibilities.	
Organise meetings on a regular basis to ensure proper feedback between health committee and the facility.	
Put up posters at the facility to ensure that the health committee members are visible to the community.	
Invite the health committee to have regular, mutually agreed upon, ‘office hours’ at the clinic.	

Allow the health committee sub-groups to have presentations at the facility e.g. nutrition during pregnancy, abuse prevention etc.	
Distribute material on health committees at the health facility.	
Share a process with the health committee for addressing patient complaints.	
Add your suggestions	

Health workers are required to have a good understanding of why community members should be involved in health and health services.

In the National Department of Health's Draft Policy, a number of functions are listed for health committees listed in the following table, look at these and discuss how you understand that function and whether you community members should be doing it. Remember this is only a draft policy, and you may disagree with the Department of Health.

Table 2

Function	**How do we understand the role – described in our own words**	**Should HCs be doing it? Give reasons (why/why not**	**What would enable them to do it?**
Assist and support facility with policy and strategy			
Advise and provide technical support			
Oversight			
Financial and expenditure review			
Staffing and personal issues			
Community participation			
Advocacy and fundraising			

Discuss in plenary whether there are any roles described in the policy that you believe health committees should not be involved in, then proceed with **Table 3**.

This relationship should be facilitated by the facility manager and within the draft guidelines, the relationship is negotiated. We include the roles and responsibilities of health committee

members as generated by the Southern sub-district as an example. The second column was identified as sub-group activities and not core health committee functions.

SOUTHERN SUB DISTRICT HEALTH COMMITTEE FUNCTIONS

Group 1

Core Functions	Sub-group activities
Management and administration of health committees. Host meetings consisting of chair, secretary, treasurer, health educators and sub-group representatives.	Recruit, screen, identify suitable candidates for HBC, ECD, feeding scheme, abuse prevention –qualified educators with experience and expertise.
Fund-raising Health facility support	Fund-raising, transport for disabled, elderly, frail.

Group 2

Core Functions	Sub-group activities
Co-ordinate training for HBC and ensure accredited trainers.	Training and Home based care
Accountable to the community we represent	Educate communities on specific health issues.
Act as link between local community and local clinic	Go out to ECD to assist with measle campaign and polio drops.
Assess, monitor and understand community challenges and resources and provide feedback to local councillor, facility and community.	Fund-raising
Actively involved in facility decision e.g. employment of staff.	Run soup kitchens

Group 3

Core Functions	Sub-group activities
Elections every 2 years. Public meetings with community to identify health issues and report on HC activities	Soup kitchens and feeding schemes
Ensure community education on health issues	Be visible in community e.g. door-to-door campaigns, visit educares etc.
Address community concerns and complaints at the health facility.	Do surveys at clinics etc.
Smart marketing of HC	Provide feedback to community in a specified time.
Address community concerns speedily and effectively	

Group 4

Core Functions	Sub-group activities
Ensure resources, material, equipment and information on health.	Feeding schemes for everybody
Transparency on activities	Workshops for the community
Regular group-work and training	Fund-raising activities
Regular meetings to report on progress and reflect on additional health concerns	Visibility in the community

EVALUATIVE ACTIVITY

ACTIVITY 4: STAYING IN TOUCH WITH OURSELVES TIME: 15 minutes

Method: Group-Work

Purpose: Reflect on core functions of community health committees at your facility asking the question; "*What should the core functions of community health committees be at our health facility*?"

Table 3

Tasks we believe our health committee should be involved in:

1. _____
2. _____
3. _____
4. _____
5. _____

Health committee members play a significant role in health promotion and addressing some of the social determinants of health. These include education on domestic violence and child abuse prevention, working with youth to reduce drug and alcohol abuse and teenage pregnancy - and training women's groups on nutrition and other health promoting topics. Health committee members also put a lot of their own time and resources into the provision of soup kitchens.

ACTIVITY 5: HOSTING A HEALTH COMMITTEE MEETING TIME: 25 minutes

Method: Role-play
Purpose: To consolidate understanding of meeting preparation.
Procedure: Set up a role play of a meeting with a Health Committee. An agenda has been set. It includes a discussion of the vision for the Health Committee. Distribute the following roles:

Chairperson
Secretary
Treasurer
Facility manager
Councillor
Ordinary members for feedback

The agenda needs to be set. The chairperson needs to take this responsibility and is able to consult others within the committee. The agenda needs to include a discussion on two concerns that have been raised by the local communities:

The long queues and waiting times for all clients at the clinic
The complaints box is not trusted

EVALUATIVE ACTIVITY

ACTIVITY 4: HOSTING A HEALTH COMMITTEE MEETING TIME: 20 minutes

Method: Group-Work
Purpose: Reflect on the role-play

Questions for the 'attendees'
1. How did the meeting go?
2. What worked well?
3. What suggestions do you have to improve the meeting?
4. Any other comments?

Questions for the 'minute takers'
1. What is your feedback on the meeting?
2. What did you note in your set of minutes?
3. Did you make specific note of who is responsible for specific tasks?
4. Did you take note of timeframes and deadlines?
5. Discuss and compare the minutes.

2.2. International Commitments

Community involvement in health is contained in international obligations. The Alma Ata Declaration, most notable in recent efforts at community inclusion.

LEARNING ACTIVITY

ACTIVITY 6: ATTENDING TO PURPOSE TIME: 30 minutes

Method: Plenary session
Purpose: To understand the international obligations that legitimizes community participation in their own health.
Procedure: Participants take turns reading through international obligations for ensuring community participation in issues affecting their own health. The facilitator stops to provide clarity, as required.

2.2.1. Alma Ata Declaration

The **Declaration of Alma-Ata** http://www.who.int/publications/almaata_declaration_en.pdf was adopted at the International Conference on Primary Health Care (PHC), Almaty (formerly Alma-Ata), Kazakhstan (formerly Kazakh Soviet Socialist Republic), 6-12 September 1978. It expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all people. It was the first international declaration underlining the importance of primary health care. The primary health care approach has since then been accepted by member countries of the World Health Organization (WHO) as the key to achieving the goal of "Health For All" initially only in developing countries. This subsequently was extended to all countries.

It urged governments, the World Health Organisation (WHO), United Nations International Children's Education Fund (UNICEF), and other international organisations, as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health workers and the world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries.

The declaration highlighted the inequality between the developed and the developing countries and termed it politically, socially and economically unacceptable.

This unacceptability relates to;

- Health as a socio-economic issue and as a human right.
- Calling for socio-economic development as a pre-requisite to the attainment of health for all.
- Participation of people in groups, or as individuals in planning and implementing their health-care, was declared both a human right and a duty.
- The role of the state.

The role of the state in providing adequate health and social measures was emphasised. It enunciated the call for "*Health for All*" which became a campaign of the WHO in the coming years. It defined "Health for All" as the attainment by all peoples of the world, by the year 2000. It speaks of a level of health that will permit everyone to lead a socially and economically productive life. The declaration urges governments, international organizations and the whole world community, to take this up as a main social target in the spirit of social justice.

Primary health care, often abbreviated as "PHC", has been defined 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*." Alma Ata. 1978. WHO

In other words, PHC is an approach to health beyond the traditional health care system that focuses on health equity-producing social policy. PHC includes all areas that play a role in health, such as access to health services, environment and lifestyle.

2.2.2. Millennium Development Goals also addresses global health needs and identifies the social determinants of health that need to be addressed;

MILLENNIUM DEVELOPMENT GOALS

Goal 1: Eradicate Extreme Poverty and Hunger;
Goal 2: Achieve Universal Primary Education
Goal 3: Promote Gender Equality and Empower Women;
Goal 4: Reduce Child Mortality
Goal 5: Improve Maternal Health
Goal 6: Combat HIV/AIDS, Malaria and other Diseases
Goal 7: Ensure Environmental Sustainability
Goal 8: Develop a Global Partnership for Development:

2.2.3. World Health Organisation

Community empowerment refers to the process of enabling communities to increase control over their lives. "Communities" are groups of people that may or may not be spatially connected, but who share common interests, concerns or identities.

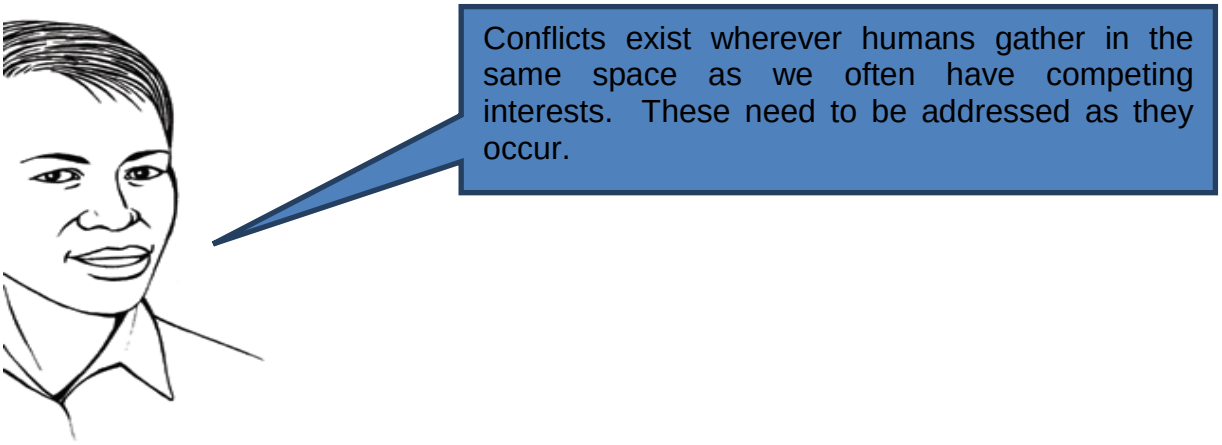
These communities could be local, national or international, with specific or broad interests. 'Empowerment' refers to the process by which people gain control over the factors and decisions that shape their lives. It is the process by which they increase their assets and attributes and build capacities to gain access, partners, networks and/or a voice, in order to gain control over their lives.

"Enabling" implies that people cannot "be empowered" by others; they can only empower themselves by acquiring more of power's different forms (Health Promotion in Action. G. Laverack, 2008). It assumes that people are their own assets, and the role of the external agent is to catalyse, facilitate or "accompany" the community in acquiring power. http://www.who.int/en

Monitoring the Health Committee - Lessons learned in Kenya. The facility should also monitor, on an ongoing basis, the impact of health committee activities at health facilities and as community representatives. A Kenyan monitoring mechanism for health committee function at facilities reported the following;

- There was an increased utilisation of the health facilities and services; the dispensaries were better stocked with drugs and other supplies – and more women were involved in the management of the service.
- As indicated by the above record of achievements, there was a marked improvement in both preventive and curative services.
- With regard to tackling corruption, there were a number of occasions when those mismanaging the dispensaries' funds were held to account.
- With regard to improvements in information flows, the dispensary management information systems marked a significant improvement in communication with the community and in planning by the staff and committee members.
- And there was certainly an increased energy and motivation among the committee members. http://www.who.int/management/healthfacilitycommitteesgovernance.pdf?ua=1

2.3. Conflict Management and Dealing with Competing Issues.



In other words, all possible areas of concern should go onto the agenda when meeting with health committees and discussed for resolution. The resolutions taken at meetings with health committees should be documented.

The key is to recognize the potential for conflict and address these concerns openly in the regular meetings and the discussion should be documented for future referral purposes. Let's first understand conflict, its triggers and various methods for addressing these.

LEARNING ACTIVITY

ACTIVITY 7: ATTENDING TO PURPOSE TIME: 30 minutes

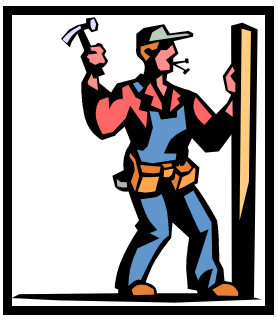
Method: Buzz session
Purpose: To review our conflict resolution skills
Procedure: Participants take turns reflecting how they will handle the following scenario.

A health committee member is assisting a patient with a complaint. A health worker interrupts and informs the patient that he needs to complete the complaint on his own and drop it in the complaints box, ignoring the health committee member. The health committee member interrupts saying that the patient has a right to be assisted. As facility manager, you are a third party in the scenario. Reflect on how you will handle this situation.

Remember: The different conflict resolution methods are not 'good' or 'bad'.

Conflict Modalities: Identify Yourself



1. **Roll-over:** Roll-over refers to submission or obeying instruction.
2. **Smasher**: A smasher sees fighting as the only option; confrontation, using force.
3. **Negotiator:** A negotiator will use compromise; working together, collaboration.
4. **Builder**: A builder resolves a problem.

Different situations require different conflict resolution styles, depending on the circumstances.

- Sometimes you have to fight e.g. if your life or livelihood is in danger.
- When a child is told to clean her/his room or when a work supervisor gives you a task, roll-over is possibly the best option.
- When two children are fighting over space in a room, building or negotiating could be considered.

1. List two examples where each of the above is appropriate in your work setting.
2. What could have prevented the conflict in the previous activity?
3. Does your health facility have a policy on addressing complaints? Discuss.

Effective communication is central to addressing conflicts. Here are some tips.

- Separate the individual from the situation and deal with the situation in relation to the policy and by addressing the problem.

- Be impartial. Seek a win-win situation so that neither party feels unfairly treated.

- Keep the patient's best interest in mind so that the intervention in the conflict, also addresses the patient's needs.

- Use objective criteria, e.g. refer to the facility policy.

2.4 Embracing Diversity

South Africa has been dubbed the Rainbow nation by Archbishop Desmond Tutu because of our uniquely, diverse country.

We have eleven different official languages, representing a range of people from diverse backgrounds.

In addition, our constitution binds us to practicing respect for all cultures and religions and compels us to accept our diversity. This includes all kinds of differences, including sexual orientation and choice of occupation. In other words, we should not discriminate.

The culture of any institution is based on the values of its leader. If the leader values democratic practice, this will filter through the different levels of the organisation.

If the leader is corrupt, this too will filter through the structures.

A culture of valuing and accepting diversity, therefore, should be pro-actively practiced by the facility manager or unit manager, at a health facility.

Other staff will soon follow the leader's example.

ICE-BREAKER ACTIVITY

ACTIVITY 8: THINKING GROUP TIME: 20 minutes

Method: Plenary

Purpose: To reflect on what we have in common with others

Procedure: Participants sit in a circle and the facilitator calls out things that participants have in common e.g. "*Brown hair*!" All the people with brown hair swop seats and the facilitator grabs one seat. The participant who is left standing calls out another commonality until sufficient 'things in common' have been extracted.

South Africa is a melting pot of different cultures and religions and we all have the same rights, according to our Constitution. People from different backgrounds and who speak different languages attend health facilities - and getting the person healthy should be our primary concern.

Every patient has the right to be treated timeously and with compassion.

EVALUATIVE ACTIVITY

ACTIVITY 9: STAYING IN TOUCH WITH OURSELVES TIME: 30 minutes

Method: Group-work

Purpose: To examine the role of Governance in establishing non-discriminatory practice.

Procedure: Read through the following anecdotal reports and then answer the questions that follow. Share the discussions in plenary.

ANECDOTAL REPORT 1:
The health facility staff does not respect the confidentiality of patients with HIV. They call out openly "*Are you coming for your anti-retrovirals? All the Aids patients at this door please.*" Health Committee members. August 2014.

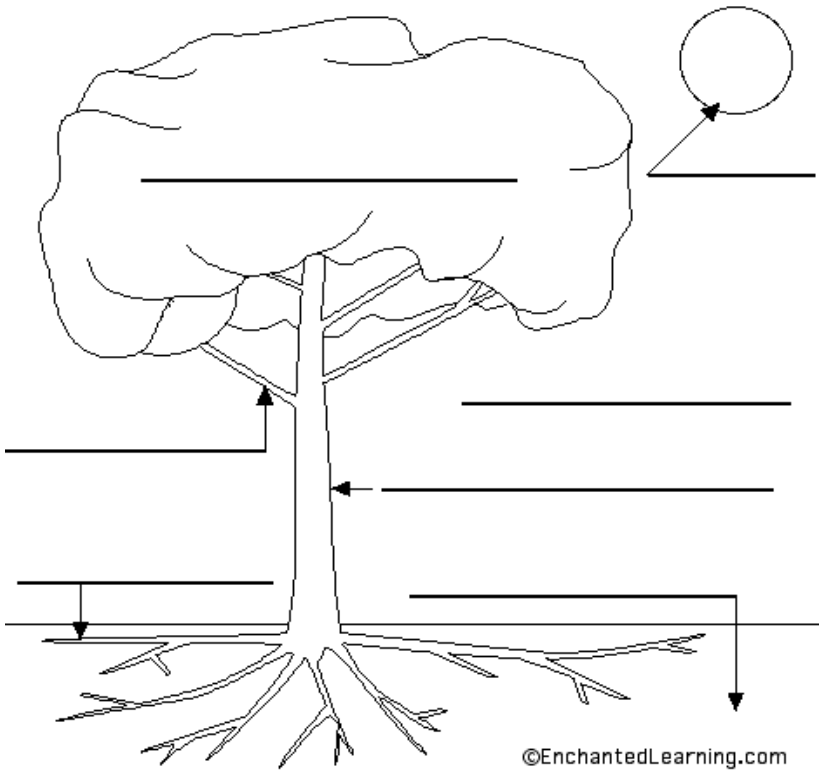
ANECDOTAL REPORT 2:
"*My sixteen-year-old daughter went to Mowbray maternity last night already. It is now thirteen hours later and she is still in labour. She asked the doctor for a caesarian and he told her she should have thought about that when she opened her legs*." November 2013. Worried mom on her way to Mowbray Maternity Hospital.

1. Who was discriminated against and how?
2. Who is responsible for addressing this problem and how?
3. What is the Governance responsibility to make sure that this practice is stopped?
4. What is the best way for this patient to complain?
5. Review the Western Cape Patient Centred **Maternity Care Code of Conduct** on page 59 and discuss steps needed at your facility to achieve compliance.

ACTIVITY 10: STAYING IN TOUCH WITH OURSELVES TIME: 30 minutes

Method: Individual-work
Purpose: To reflect on cultural identity.
Procedure: Participants draw a tree with roots and in each root write on the different cultural aspects to their identity.

Participants provide feedback in plenary and the facilitator assists with getting people to recognize the different cultural influences in most people's lives. The facilitator talks about embracing diversity and unique attributes of individuals and how it contributes toward beauty.



Participants are asked to reflect on the various case studies in the last three activities and from the list below, identify which type of discrimination was being practiced.

- Cultural
- Ethnicity
- Gender
- Sexual Orientation
- Race
- Sex Workers
- Class
- Animosity
- Other (e.g. appearance, poverty)

The facilitator asks the participants to provide anecdotes of different forms of discrimination and these are written up in a plenary session.

THINKING ACTIVITY

ACTIVITY 11: THINKING GROUP TIME: 20 minutes

Method: Buzz session

Purpose: Share experiences of human rights violations.

Procedure: Participants find a partner and share an example of a time when their human rights were violated. Each person gets a turn of approximately 5 minutes. The facilitator rights up some examples of human rights violations in a plenary.

2.4.1 Violence against Women and Children

A number of health rights violations in South Africa are based on our inability to embrace diversity. Of special mention here, is definitely the health-rights of all women regardless of their sexual orientation or socio-economic status. Rape statistics in South Africa are alarming and children, too, are victims of sexual and physical violence. Health care workers, police officers and social workers require ongoing training in order to handle these cases with the required sensitivity. In the cases of all kinds of assault, the J88 form must be completed. This assists the victim through the legal process.

2.4.2 Teenage Pregnancy and Maternal Needs

The high levels of violence and sexual coercion also play a significant role in the rate of teenage pregnancy that we see at our facilities. Again, sensitivity training which can impact on how we treat these patients becomes very important. Judgmental attitudes toward single mothers happen as a norm in society, despite that single-parenting makes up a very significant proportion of families. The health committee training provided an indication that young girls are further victimized at health facilities through voice tone, comments and judgmental attitudes by health workers. In addition, moms with babies need access to a range of facilities. The health facility should, for instance, have a place specifically designated for moms to change nappies. It is not a favour provided by the facility. It is a human right to be treated with dignity.

2.4.3 The Elderly and People with Disabilities

Reports that older people who suffer from Dementia are labelled as ‘witches’ at some health facilities, adds to the disturbing picture of health workers practicing discrimination in various forms. In addition, persons with a disability, whether these are physical or people with mental challenges are entitled to be treated with dignity and respect. This relates to both attitudes and physical access to toilets and other special needs requirements. In facility governance, health facility managers should reflect on these in relation to budgeting and planning for the facility.

Creating a space that embraces diversity includes a number of other groups in society that often receive second-class treatment. These include refugees, migrants, lesbians and gay people (LGBTI) and people living with HIV/Aids. Facility managers can play a crucial role in creating a culture at the facility that recognises the human rights of all citizens and health service users, through the governance practices that become part of the facility policy and day-to-day practices of all staff employed at the health facility.

Additional Reading:

1. Nurses Code of Ethics in South Africa. http://www.sanc.co.za/pdf
2. SANC. The rights of nurses. www.sanc.co.za/policyrights.
3. Informed Consent. Paper by Professor Carstens. http://new.samls.co.za/node/410

THINGS TO THINK ABOUT…

Evolutionary functions for Health Committees

- To increase community interest in the health planning process of a district.
- To work with the District Health Management Teams (DHMTs) to coordinate and monitor the implementation of the government and non-governmental health programmes in the district.
- To identify implementation problems and seek corrective action.
- To act as advocates for cost sharing and promote health awareness among the general public.
- To oversee the general operations and management of the health facility.
- To advise the community on matters related to the promotion of health services.
- To represent and articulate community interests on matters pertaining to health in local development forums.
- To facilitate a feedback process to the community pertaining to the operations and management of the health facility.
- To implement community decisions pertaining to their own health.
- To mobilise community resources towards the development of health services within the area.

FURTHER READING

Appendix 1: Extracts from the Constitution of the Republic of South Africa

Based on Negotiation

An integral part of the negotiations to end apartheid in South Africa was the creation of a new, non-discriminatory constitution for the country. the Interim Constitution of 1993, which was formally enacted by Parliament and came into force on 27 April 1994. http://www.gov.za/documents/constitution/1996/a108-96.pdf

Preamble

"*We, the people of South Africa,*
Recognise the injustices of our past;
Honour those who suffered for justice and freedom in our land;
Respect those who have worked to build and develop our country; and
Believe that South Africa belongs to all who live in it, united in our diversity.
We therefore, through our freely elected representatives, adopt this Constitution as the supreme law of the Republic so as to — Heal the divisions of the past and establish a society based on democratic values, social justice and fundamental human rights;
Lay the foundations for a democratic and open society in which government is based on the will of the people and every citizen is equally protected by law;
Improve the quality of life of all citizens and free the potential of each person; and
Build a united and democratic South Africa able to take its rightful place as a sovereign state in the family of nations.
May God protect our People"

The Bill of Rights

The heart of the Constitution is the Bill of Rights. It upholds the rights of all citizens to be treated with dignity. The Bill of Rights enshrines the right to administrative action. This requires that all spheres of government ensure that their administrative act in a lawful, reasonable and fair way with citizens who are equal before the law.

Citizens are entitled to expect fair and dignified treatment at any institution that is run by the public purse, tax money of ordinary and all citizens. The Bill of Rights includes socio-economic rights, such as the right to live in a healthy environment, to have access to adequate housing, access to health care services and sufficient food and water.

Community members are important stakeholders. The health committee is meant to represent the community. They speak for the community and represent the community's interest.

Part of the task of ensuring a strong relationship with the community is to ensure that their needs, concerns and complaints are addressed and to ensure that the health service is both accessible to them and of a good quality.

Community members can in turn also provide reciprocal support to the needs of health workers and their families.

Chapter 2 is the Bill of Rights which enumerates the civil, political, economic, social and cultural human rights of the people of South Africa. Most of these rights apply to anyone in the country, with the exception of the right to vote, the right to work and the right to enter the country, which apply only to citizens. They also apply to juristic persons to the extent that they are applicable, taking into account the nature of the right.

The rights enumerated are:

- Section 9: the **right to equality before the law** and **freedom from discrimination**. Prohibited grounds of discrimination include race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.
- Section 10: the **right to human dignity**.
- Section 11: the **right to life**, which has been held to prohibit capital punishment,[8] but does not prohibit abortion.[9]
- Section 12: the **right to freedom** and security of the person, including protection against arbitrary detention and detention without trial, the right to be protected against violence, freedom from torture, freedom from cruel, inhuman or degrading punishment, the right to bodily integrity, and reproductive rights.
- Section 13: **freedom from slavery**, servitude or forced labour.
- Section 14: the **right to privacy**, including protection against search and seizure, and the privacy of correspondence.
- Section 15: **freedom of thought** and freedom of religion.
- Section 16: **freedom of speech** and expression, including freedom of the press and academic freedom. Explicitly excluded are propaganda for war, incitement to violence and hate speech.
- Section 17: f**reedom of assembly** and the right to protest.
- Section 18: **freedom of association**.
- Section 19: the **right to vote** and universal adult suffrage; the **right to stand for public office**; the right to free, fair and regular elections; and the right to form, join and campaign for a political party.
- Section 20: **no citizen may be deprived of citizenship**.
- Section 21: **freedom of movement**, including the right to leave South Africa, the right of citizens to a passport and the right to enter South Africa.
- Section 22: **the right to choose a trade, occupation or profession**, although these may be regulated by law.
- Section 23: **labour rights**, including **the right to unionise** and the right to strike.
- Section 24: **the right to a healthy environment** and the right to have the environment protected.
- Section 25: **the right to property**, limited in that property may only be expropriated under a law of general application (not arbitrarily), for a public purpose and with the payment of compensation.
- Section 26: **the right to housing**, including the right to due process with regard to court-ordered eviction and demolition.
- Section 27: **the rights to food**, **water, health care and social assistance**, which the state must progressively realise within the limits of its resources.
- Section 28: **children's rights**, including the right to a name and nationality, the right to family or parental care, the right to a basic standard of living, the right to be protected from maltreatment and abuse, the protection from inappropriate child labour, the right not to be detained except as a last resort, the paramountcy of the best interests of the child and the right to an independent lawyer in court cases involving the child, and the prohibition of the military use of children.
- Section 29: **the right to education**, including a universal right to basic education.

- Section 30: **the right to use the language of one's choice** and to participate in the cultural life of one's choice.
- Section 31**: The rights of cultural, religious or linguistic communities to enjoy their culture, practice** their religion and use their language.
- Section 32: **the right of access to information**, including all information held by the government.
- Section 33: **the right to justice** in administrative action by the government.
- Section 34: **the right of access to the courts**.
- Section 35: **the rights of arrested, detained and accused people**, including the right to silence, protection against self-incrimination, the right to counsel and legal aid, the right to a fair trial, the presumption of innocence and the prohibition of double jeopardy and *ex post facto* crimes.

Section 37 allows certain rights to be limited during a state of emergency but places strict procedural limits on the declaration of states of emergency and provides for the rights of people detained as a result.

Appendix 2: Democracy and Local Government

DEMOCRACY: From the Greek words Demos (people) and Kratos (Power), defined as a form of government in which citizens participate equally, through elected representatives.

No consensus exists on how to define democracy; rather it is identified by a set of characteristics;

- Equality
- Freedom
- Rule of law
- Every vote has equal weight

Government by the people
Definition 1: Government by the people, determined by the majority.
Definition 2: Capacity of all citizens to participate fully and freely in the arrangement of their society.

Different Types of Democracy:

Direct Democracy:	Citizens participate in decision-making personally and not through elected representatives (Swiss).
Representative Democracy:	Election of government officials by the people who are being represented.
Presidential Democracy:	The public elects the president through free and fair elections.
Parliamentary democracy:	The government is appointed by parliamentary representatives.
Constitutional Democracy:	Representative democracy, where elected representatives exercise decision-making power subject to the rule of law and moderated by a constitution.

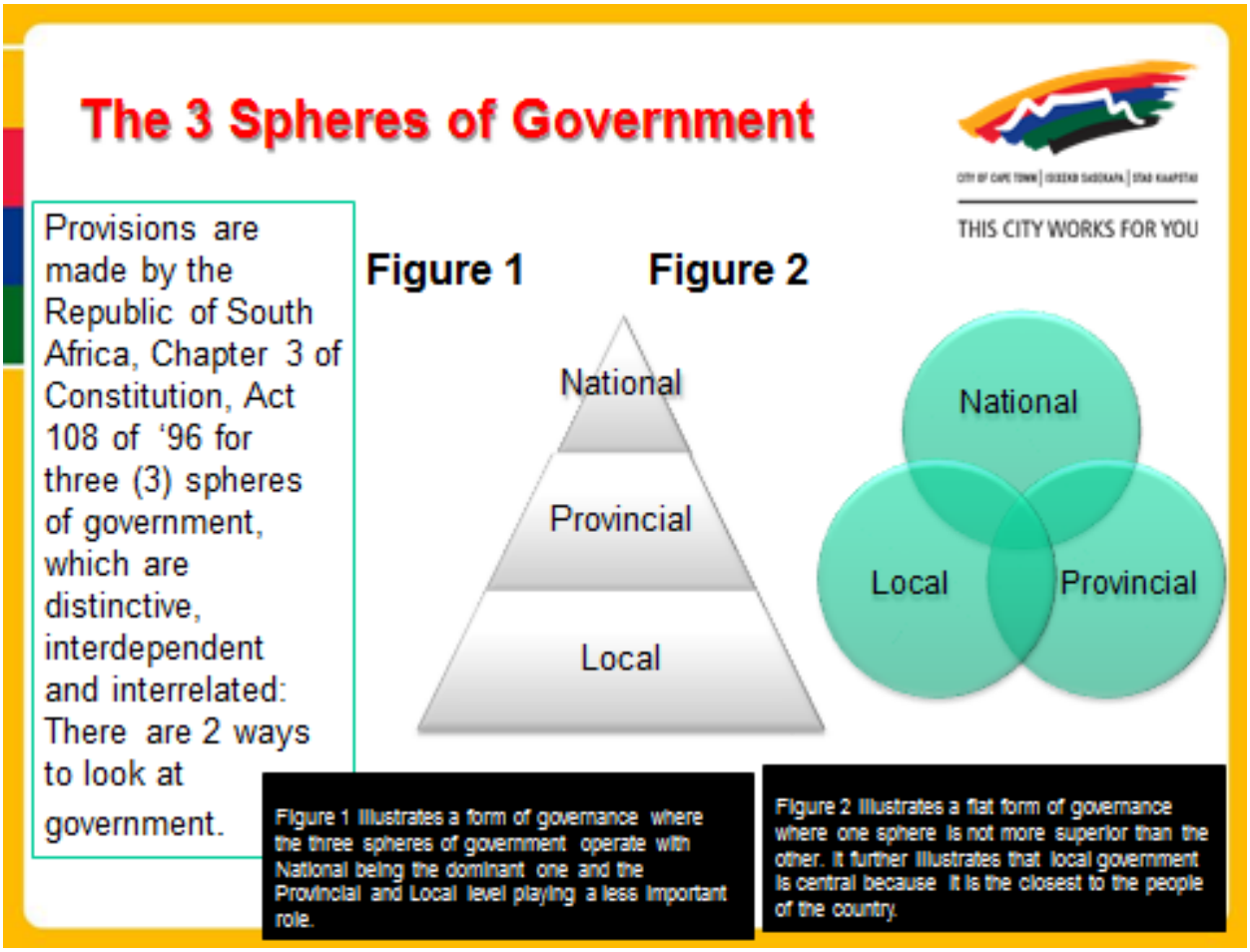
The Constitution of the Republic of South Africa sets out the system of governance for the country.

It sets out three spheres of government, which are distinctive, interdependent and interrelated:

- National Government
- Provincial Government
- Local Government

Local government is the sphere of government that is closest to the people. It is made up of municipalities. Each municipality has a council, which must consult the local community and other stakeholders about how to govern in that municipality.

These slides were taken from the City Of Cape Town's Ward Committee Training. 2013

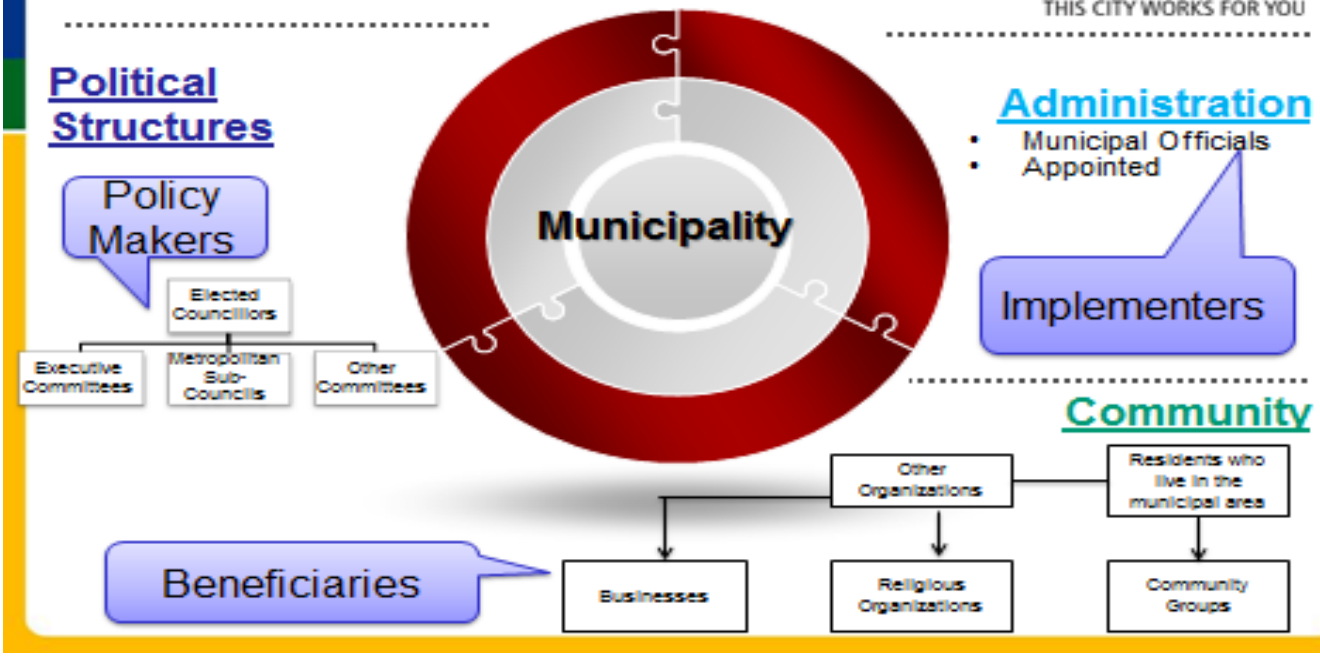


Objectives of Local Government. Section 152

a) To provide democratic and accountable government for local communities.
b) To ensure the provision of services to communities in a sustainable manner.
c) To promote social and economic development.
d) To promote a safe and healthy environment

Municipalities Consist of:

THIS CITY WORKS FOR YOU



Political Structures

THIS CITY WORKS FOR YOU

The political structures of a municipality are made up of elected representatives or councillors.

These councillors provide political direction to the municipality.

They are accountable to the communities who elected them.

Appendix 3: Complaint/Compliment Form

MEMBERS OF THE PUBLIC

Please write your suggestion or complaint in the space provided below and place the form in one of the Complaint/Suggestion Boxes located in the facility.

If such a box does not exist or is not visible, please hand your complaint to a health committee member.

Name of Complainant: _____ Date: _____

Name of Health Facility: _____

Name and job position of staff member involved in complaint or compliment:

_____

Incident: _____

_____

_____

_____

Full Details:

Title: (Mr. Mrs. Ms. Miss. Dr.): Please circle.

First Name: ……..

Surname: …….

Contact address: ……

Contact No.: ……..

Email: ……

How was the incident resolved?

_____

_____

Date: _____

Signed by: _____

Appendix 4

What is Batho Pele?

The term **Batho Pele** means **'People First'**. In this context, Batho Pele means putting other people first before considering your own needs/yourself.
How? By identifying small but important things that can immediately improve the quality of service you provide to your customer.

11 Batho Pele Principles:-

1. Consultation
We can only assume to know what our customers want. The only way we can find out for certain is by asking them. This can be done through surveys, questionnaires, meetings, suggestion boxes, izimbizo and by talking to our customers. It's important to report back to customers so they know what to expect, and to our staff so they know what is expected from us.

2. Service Standards
Citizens should be told about the level and quality of the services they receive.
If possible they should be given an opportunity to choose the service they want.
The standards we set are the tools we can use to measure our performance, and therefore need to be realistic depending on available resources. We should also be able to measure these standards so that everyone can see if they are being met.

3. Access
There is much more involved when referring to access. It means making it easy for our customers to benefit from the services we provide. Easy access can be made possible by: - having wheelchair ramps, disabled parking bays, taking our services out to the community. Staff attitude may determine how approachable your component/directorate/department is.

4. Courtesy
We must be polite and friendly to our customers. Customers should be treated with respect and consideration. We must always be willing to assist. Telephone etiquette is vital. All our correspondence must be respectful.

5. Information
Citizens should be given full accurate information about the public services they are entitled to receive. Information is about reaching all our customers to make sure they are well informed about the services our department provides. This may be done in a number of ways-for example through newspapers, radio, posters and leaflets. It's important to remember that different customers have different needs and they do not all speak the same language.

6. Openness and Transparency
We should be open about our day to day activities, how much our departments receive, how that money is spent. This information should be available to the public. Annual reports, strategic plans, service commitment charters, etc. must be made available to the public.
We should tell our customers where to complain and how to do it.

7. Redress
Redress is making it easy for people to tell us if they are unhappy with our service. We should train staff to deal with complaints in a friendly, helpful manner.
An apology, full explanation and effective, speedy remedy should be offered when the

promised standards of service have not been delivered.
When complaints are made, we must give our customers a sympathetic ear.
Have positive Reponses to complaints.

8. Value for Money
We need to make the best use of available resources. Avoid wastage of time, money, and other resources. It also means eliminating waste, fraud and corruption and finding new ways of improving services at little or no cost.

9. Encouraging Innovation and Rewarding Excellence
Innovation: using new ways of doing things
Encourage partnerships with different sectors in order to improve service delivery.
Rewarding Excellence is also about rewarding the staff who "go the extra mile" in making it all happen.

10. Customer Impact
If we put all the Batho Pele Principles into practice, we then increase the chances of improvement in our service delivery. This in turn will have a positive impact on our customers. It is about how the nine principles link together to show how we have improved our overall service delivery. Here we look at the benefits we have given to our customers both internally and externally.

11. Leadership and Strategic Direction
Our leaders must create an atmosphere which allows for creativity. Management must ensure that goals are set and that planning is done.

Appendix 5. Extracts from Draft Policy on Health Governance Structures. July 2013.

Background

The national health Act 61 of 2003 directs the state to take reasonable legislative measures to achieve the realization of the right to health.

Purpose of the Policy

The Primary Health Care (PHC) approach emphasizes the need for inter-sectoral collaboration that the provision of health services alone does not create healthy **communities** and that the social determinants of health must be addressed through meaningful participation of the community.

Governance Structures as Organs of Power

The National Health System will actively promote community participation in the planning, provision, control and monitoring of health services. Fundamental to this approach is accountability to local communities and decentralization of decision-making. The essence of the policy is to empower communities to take part in the provision of health services where they live.

Appendix 6.

Extracts from Dual Loyalties and Ethical and Human Rights Obligations of Occupational Health Professionals.

L London - American journal of industrial medicine, 2005 - Wiley Online Library

Abstract.

Background

Underlying most ethical dilemmas in occupational health practice is the problem of Dual Loyalties where health professionals have simultaneous obligations, explicit or implicit, to a third party, usually a private employer.

Methods

A literature review was undertaken of case studies of workplace occupational health conflicts, international human rights and ethical codes and strategies for managing dual loyalties, complemented by iterative discussions in an international working group convened to address the problem of Dual Loyalties.

Results

Violations of the worker-patient's human rights may arise from: (1) the incompatibility of simultaneous obligations; (2) pressure on the professional from the third party; and (3) separation of the health professional's clinical role from that of a social agent. The practitioner's contractual relationship with the third party is often the underlying problem, being far more explicit than their moral obligation to patients, and encouraging a social identification at the expense of a practitioner's professional identity.

Conclusions

Because existing ethical guidelines lack specificity on managing Dual Loyalties in occupational health, guidelines that draw on human rights standards have been developed by the working group. These guidelines propose standards for individual professional conduct and complementary institutional mechanisms to address the problem. Am. J. Ind. Med. 47:322–332, 2005. © 2005 Wiley-Liss, Inc.

Dual Loyalty and Human Rights in Health Professional Practice. Rubenstein LS, London L, Baldwin-Ragaven L. The Dual Loyalty Working Group. (2002).

…Dual Loyalty and Human Rights

Dual loyalty becomes especially problematic when the health professional acts to support the interests of the state or other entity instead of those of the individual in a manner that violates the human rights of the individual. The most insidious human rights violations stemming from dual loyalty arise in health practice under a repressive government, where pervasive human rights abuses, combined with restrictions on freedom of expression, render it difficult both to

resist state demands and to report abuses. In addition, closed institutions, such as jails, prisons, psychiatric facilities and the military, impose high demands for allegiance on health professionals even in the face of often-common human rights violations against individuals held there. But violations of human rights at the behest of the state by health professionals also take place in open societies, for example, in cases of institutionalized bias or discrimination against women, members of a particular ethnic or religious group, refugees and immigrants, or patients who are politically or socially stigmatized. Violations of people's rights of access to health care may also arise from policies imposed by governments, or in health systems, including privately managed health systems, in which health professionals are called upon to withhold treatment from certain groups of people in discriminatory ways…

…Although fulfillment of the right to the highest attainable standard of health is subject to resource limitations and of course does not require that every health service (e.g. cosmetic surgery) be made available to all, the Committee makes clear that the Covenant obliges "each State party to take the necessary steps to the maximum of its available resources and failure to do so constitutes a violation."

Moreover, the Committee sets out "core" obligations that exist irrespective of resource constraints. These include, among others, non-discriminatory and equitable access to health care services "especially for marginalized groups," maternal and child health care services, availability of immunizations against infectious diseases, a public health strategy for the society, essential drugs and access to information about the main health problems in the community…

…In sum, both the human rights and bioethics approaches generally attempt to promote morally desirable outcomes. Just as bioethics reasoning seeks to balance contrasting principles, human rights approaches sometimes have to balance competing rights. Yet, even though in recent years many professional bodies have adopted human rights principles in their ethical codes, there has been insufficient attention paid to bringing these two paradigms or discourses together conceptually.

It is possible to operate within an ethics framework in ways that focus only on the dyadic relationship of the clinician and patient without considering the context in which that relationship is constructed. Likewise, there is little uniformity on how to weigh conflicting principles of bioethics or how far to extend their scope. In the case of dual loyalty, respect for human rights (insofar as this connotes respect for human dignity and the inviolability of personhood) is a pre-condition to engaging in ethical decision-making. Where human rights are at stake in a dual loyalty conflict, it is necessary to look to human rights norms to guide the resolution of these conflicts.

Appendix 7.

Patient-centred Maternity Care

Developed by Dr. Keith Cloete with the Western Cape Department of Health Task Team

The **Patient Centred Maternity Care (PCMC), Code of Conduct** was developed to address the concern at the high levels of abuse of maternity patients. It is supported by a patient survey.

"*The concern has come partly from continuing reports from medical students attached to facilities about ongoing disrespect and abuse of women particularly in labour. This includes some of the sites that are PCMC pilot sites.*

The task team, led by Dr. Keith Cloete, to address this problem started working in 2012 and went far in devising the code of good practice in maternity care that follows, developing monitoring tools, (patient survey) setting up training and debriefing mechanism and producing educational pamphlets for clients and staff." Sue Fawcus

Pre-Amble:

- The Western Cape Department of Health has committed itself to patient-centred care as a fundamental principle in its draft 2020 strategy.
- The Department has adopted the core values of caring, competence, accountability, integrity, responsiveness and respect (C^2AIR^2).
- The optimal care for a pregnant woman and her unborn baby is the cornerstone on well-functioning health system.

1. Every woman, every couple seeking maternity care have the *right* to effective health care and the *right* to be treated with respect and dignity

	Code of Practice	Implementation	Monitoring
	Friendly reception by security personnel, receptionists, clerks and health personnel	• Training in Batho Pele principles, interpersonal relations and conflict resolution • All staff to be clearly identified with name tags • Community education about appropriate documentation to be brought to antenatal clinics, but lack of such documents should NOT prevent appropriate patients being booked	• Patient exit interviews and/or questionnaires • Compliments, complaints and suggestion boxes

	Zero tolerance for acts of verbal and physical abuse by health personnel towards women in labour such as: • Verbal and emotional abuse - humiliation, ridicule, threatening words, offensive words • Physical abuse - hitting, slapping, punching. • Abuse of 'omission' – abandonment of required care. • Discrimination against vulnerable groups such as teenagers and foreign nationals.	• Existing Code of professional conduct for all heath workers to be reinforced • The code of practice for patient-centred maternity care should be displayed in facilities and communicated to all health workers. • Zero tolerance to include the application of progressive disciplinary measures in respect of every transgression • Functioning Compliments and Complaints procedures in each facility • Functioning system of reporting and investigating adverse incidents in each facility, with minutes of meetings that specify educational and/or remedial responses. • Leadership training and support for clinical managers in complaints, adverse events, and disciplinary processes.	• Patient exit interviews and /or questionnaires • Documentation of adverse incident reporting • Auditing of complaints and compliments register • Documentation of complaints and responses to complaints • Documentation of disciplinary procedures in facilities • Number of staff trained in leadership.
	Evidence-based and effective obstetric care	• Clinical Management Protocols should be evidence-based, updated and disseminated • Checklists specifying conditions for discharge of women in false or latent labour must be developed and complied with, so as to prevent inappropriate discharge in labour. • On site in-service training • Clinical outreach	• Availability of clinical management protocols • Weekly or monthly morbidity and mortality monitoring
	Debriefing and support for health professionals working in labour wards on day and night shifts	• Facilitated debriefing and reflection meetings with Labour ward staff on a regular and continuing basis (by ICAS or equivalent). • Training in empathic care using local resources such as 'secret history' approach, BBI,.MBFI or compassionate birth approach. • Training in skills to care for severely distressed or agitated women in labour (often labeled as 'unco-operative') • Compliments process and methods of showing appreciation of staff for compliments; and / or work targets achieved	• Documented occurrence of meetings and attendance list • Documented training in empathic care. • Monitoring of compliments and achievements
	Clean, adequately	• Inventory to be prepared of essential stock	• Intermittent

	equipped facility with sufficient linen, consumables, equipment and essential medications	levels • Timeous ordering of supplies • Effective Laundry services • Facility and Sub- District managers to ensure availability of supplies	audit of stocks, supplies and equipment with a check list to ensure adherence
	Infrastructure and space should be sufficient to enable privacy, comfort, companions in attendance, and to accommodate women for observations in early labour, as well as in active labour, and during delivery	• Site assessments by sub-district, facility and operational managers • Costed maintenance and infrastructure improvement plans to be devised and implemented. • Budget for infrastructural changes for patient and staff facilities • Thick long curtains around cubicles to ensure privacy but adhering to infection control regulations	• Periodic inspection of facilities • Monitoring of infrastructure improvements.

2. Every woman, every couple has the *right* to information about pregnancy and the necessary obstetric care			
	Code of Practice	**Implementation**	**Monitoring**
	Women to be provided with ongoing information about their pregnancy and labour; and permission sought before any procedure including vaginal examination.	• Provide educational materials • Adequately staffed antenatal clinics to allow time for explanation • Training in listening and communication skills; and skills for debriefing patients after difficult delivery. • Training in the meaning and content of informed consent • Training in bereavement support and counseling • Provision of patient access to longer term counseling and professional support in the event of adverse outcomes or experiences	• Patient exit interviews and/or questionnaires • Documented training sessions.
	Antenatal education and preparation for Labour	• Interactive health promotion events on preparation for Labour, to occur during antenatal visits. • Appropriate cadre of staff (e.g. Community Care workers (CCWs) or health promotors) to conduct these sessions in BANC clinics, MOUs and hospitals • Involvement of CCWs for education and labour preparation during home visits	• Documented antenatal preparation services • Documented home visits by Community Care Workers (CCWs)

3. Every woman to have a chosen personal and/or facility provided companion in labour

	Code of Practice	Implementation	Monitoring
	Each women to have chosen personal companion in Labour (latent and active phase of labour) and at antenatal clinic visits,	• Implement Companion in Labour Policy (Metro West policy to be adapted to become a provincial document) • Expanded waiting areas • Ensure privacy and security of patients and staff	• Monitor attendance of companions • Target: 75% of women in active labour
	Each women to have an appropriate assistant in Labour	• Employ at least 2 appropriate assistants per shift at each MOU, and maternity hospital.	• Monitor availability of appropriate assistants • Target: 100% at all maternity facilities

4. Maternity facilities to be responsive to communities they serve

	Code of Practice	Implementation	Monitoring
	Facilitate Community involvement and dialogue around maternity service provision	• Open days at facilities for community • System for community representation at facility management level, on clinic committees or health facility boards • Systems for CBS workers to liaise with facility management • Participation in District health forums	• Documented community liaison meetings with minutes and recommendations • Numbers of open days

PATIENT SURVEY - PASIENTE VRAELYS - IMIBUZO NGESIGULAN

Facility Name: _____ Date/Datum/ Umhla: _____

Time: _____

Questions	Yes/Ja/Ewe Happy	No/Nee/Hayi Unhappy	Comments: Please indicate if you're refering to Antenatal clinic, Labour ward or Postnatal clinic?
1. How do you feel about the way you were treated by the staff?	☺	☹	
2. Did the clinic have the supplies & equipment to care for you?	☺	☹	
3. Were decisions about your care and the care of your baby discussed with you?	☺	☹	
4. Were you helped to cope with the pain during labour?	☺	☹	
5. Did you have a companion with you during labour?	☺	☹	

Sources of Information

AKHS Kenya: Best Practices in community-based health initiatives.

Baldwin. L.-Ragaven, J. de Gruchy, & L. London, L. (Eds.). (1999). An Ambulance of the Wrong Colour. Health Professionals, Human Rights and Ethics in South Africa. Cape Town: UCT Press.

Carstens, P. informed consent in South African medical law with reference to legislative developments. Retrieved from: http://new.samls.co.za/node/410

City of Cape Town, Ward Committee Training Slides.

Declaration of Geneva. Available from: http://www.wma.net/en/30publications/10policies/g1/

Health Committee Training Manual. UCT School of Public Health. 2014

Health Professions Council of South Africa. http://www.hpcsa.co.za/

Kling, S. (2010). Confidentiality in Medicine. *Current Allergy & Clinical Immunology, 23*(4), 196-198. http://www.allergysa.org/journals/Nov2010/196%20Confidentiality.pdf

London, L. (2005). Dual Loyalties and the Ethical and Human Rights Obligations of Occupational Health Professionals. *American Journal of Industrial Medicine, 47*, 322-332. Rubenstein LS, London

L, Baldwin-Ragaven L and the Dual Loyalty Working Group. (2002). Dual Loyalty and Human Rights in health professional practice. Physicians for Human Rights and University of Cape Town. Boston, 2002.Available at URL: https://s3.amazonaws.com/PHR_Reports/dualloyalties-2002-report.pdf

London, L., & Baldwin-Ragaven, L. (2006). Human rights obligations in health care. *CME, 24*(1), 20-24.

Naidoo, Y. (2012) The Rights of People living with HIV and AIDS. HIVSA - 23 January 2012. Available from:
http://www.health4men.co.za/resources/entry/the_rights_of_people_with_hiv_and_aids/

Nurses Code of Ethics in South Africa. http://www.sanc.co.za/pdf

Patient's Rights Charter. http://www.doh.gov.za/docs/legislation/patientsright.

SA Nursing Council. The rights of nurses. www.sanc.co.za/policyrights

South African Medical Association https://www.samedical.org/

South African Nursing Council. http://www.sanc.co.za/

The Basic rights of People Living with AIDS.
http://www.health4men.co.za/resources/entry/the_rights_of_people_with_hiv_and_aids/

Voices of Primary Health Care Facility Workers.
http://healthlink.org.za/pubs/sahr/2002/chapter10.pdf

- Patient Centred Maternity Care. Western Cape Department of Health. Draft 2020 strategy. Dr. Keith Cloete and Western Cape Department of Health Obstetrics,Task Team.

Additional Resources

De Savigny, D. &, Adam, T. eds. (2009). Systems Thinking For Health Systems Strengthening. Geneva: Alliance for Health Policy and System Research & World Health Organization. Available from: http://whqlibdoc.who.int/publications/2009/9789241563895_eng.pdf

Department of Community Safety and Liaison. Province of Kwa-Zulu Natal. 2011. http://www.kzncomsafety.gov.za/Default.aspx?tabid=232

Department of Health, Western Cape Government. (2013). Health Care 2030. Cape Town: Western Cape Department of Health. Available from: http://www.westerncape.gov.za/text/2013/October/health-care-2030-9-oct-2013.pdf

Dual Loyalty and Ethical Obligations. Rubenstein LS, London L, Baldwin-Ragaven L and the Dual Loyalty Working Group. (2002). Dual Loyalty and Human Rights in health professional practice. Proposed guidelines and institutional mechanisms. A project of the International Dual Loyalty Working Group. Physicians for Human Rights and University of Cape Town. Boston, 2002.Available at URL: https://s3.amazonaws.com/PHR_Reports/dualloyalties-2002-report.pdf

Health and Democracy; A guide to human rights, health law and policy in post-apartheid South Africa. A. Hassim, M. Heywood and J. Berger. Cape Town. 2007.

Health policy and systems research: A methodology reader. Geneva: Alliance for Health Policy and System Research & World Health Organisation. Gilson, L. ed. (2012). Available from: http://www.who.int/alliance-hpsr/resources/alliancehpsr_reader.pdf

Health promotion in action: from local to global empowerment. Labonté R. and Laverack G. (2008) http://www.who.int/healthpromotion/conferences/7gchp/track1/en/

Leadership and Governance within the South African Health System. Lucy Gilson and Judith Daire. School of Public Health and Family Medicine. University of Cape Town. http://www.rmchsa.org/wp-content/resources/resources_by_theme/ClinicalGovernance/Leadership_GovernanceSAHealthSystem.pdf

National Health Act. 2003. http://www.saflii.org/za/legis/consol_act/nha2003147/

Other Community Health Models: India Community Monitoring National Report.pdf https://vula.uct.ac.za/access/content/attachment/21e1b098-dcd8-401c-995e-18e74f7daeac/_anon_/4c837c10-fa62-49cc-90b7- efc9778b9143/

School of Public Health, UWC. (2013). Population Health and Development: A Primary Health Care Approach II. Module Guide for the Masters in Public Health. Bellville: SOPH, UWC.

School of Public Health, UWC. (2013). Introducing Public Health: Its Basis and Scope. Module Guide for the Postgraduate Diploma in Public Health. Bellville: SOPH, UWC.

Training and Research Support Centre (TARSC), and Ifakara Health Development Centre with EQUINET. (2006). Organising People's Power for Health: Participatory Methods for a People-Centred Health System. Available from: http://www.equinetafrica.org/bibl/docs/EQUINET%20PRA%20toolkit%20for%20web.pdf

United Nations General Assembly. (1948). The Universal Declaration of Human Rights. Resolution *217 A (III)* Retrieved from http://www.unhchr.ch/udhr/lang/eng.htm

World Health Organisation. (2000). The World Health Report 2000. Health Systems: Improving Performance. Geneva: WHO. Available from: http://www.who.int/whr/2000/en/

World Health Organisation. (2007). Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action. Geneva: WHO. Available from: http://www.who.int/healthsystems/strategy/everybodys_business.pdf

WHO. Key concepts: Social determinants of health. Website: http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/index.html

WHO: CSDH (Commission on the Social Determinants of Health). (2008). Executive Summary: Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Geneva: WHO: 1-33. [Online], Available: http://www.who.int/social_determinants/thecommission/finalreport/en/index.html