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Ndlovu: The clock ticks

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Always when I come to Africa I'm sad about the useless death, the destruction and failures I see. Today I have seen that there is also hope. Ndlovu gives me a feeling I haven't had for a long time being in Africa.

Sir Richard Branson, 2005.[1]

INTRODUCTION

The phone rang. Dr Hugo Tempelman could not conceal his excitement when he saw the number. "That's the call I've been waiting for!" After a short conversation, he hung up, and punched the air: "It's official! This means hundreds, no thousands of jobs, and even more lives saved." The phone call was from a representative Hof the Dutch Embassy in South Africa, awarding Hugo a grant of several million US$ over four years (with a guarantee for another four years if targets were met) to expand to other locations in South Africa the Ndlovu clinic and community development programs he had founded in the rural town of Elandsdoorn.

Visibly emotional for a moment, he then called his wife and collaborator, Liesje, to tell her the good news, ending with, "I know this is no time to celebrate yet, the work is just beginning." Although Hugo was tremendously excited, he also felt a heavy burden. "Hundreds of people are depending on us to get this right," he explained. He knew there were risks involved in reproducing something that he and Liesje had spent 15 years developing. What exactly should they replicate? What variation should they allow between locations, and what should be kept rigidly constant? What risks had he simply not thought of?

Hugo walked out to the clinic courtyard. As if to remind him of the gravity of their task, a hearse was being loaded with a recently deceased patient. Although such a sight was inevitable in a clinic, Hugo's emotions showed again as he whispered, *"We cannot celebrate today; this is a reminder of how much work we still have in front of us."*

NDLOVU: THE BEGINNINGS

Born in the Netherlands in 1960, Hugo Tempelman earned his medical degree in 1990. Rather than becoming a specialist, he believed he could put his medical degree to better use in South Africa. His wife, Liesje, also liked the idea, so they moved to Groblersdal, two hours north-east of Johannesburg, and Hugo signed on as chief medical officer at

[1] Source: http://www.ndlovu.com/nl/hugoandliesje.html, last accessed October 28, 2010.

the Philadelphia Hospital in nearby Dennilton. After three years he became Head of the Paramedical Services in the Department of Health of the former homeland KwaNdebele.

1994 was a watershed year for South Africa, with the first fully democratic elections after the end of the apartheid era. Hugo anticipated that he might be "too white" to continue having much impact in government service. He had noticed there were no private health care facilities in the general area. Following his dream to put his medical training to good use, he started his own private clinic to, in his words, "bring first-world health care to a third-world country."

As Hugo recalled, "we took out a second mortgage on their home for 168,000 rand[2], bought 40,000 bricks, and planned to build a new clinic down the road from the hospital, in Elandsdoorn. On the first day of construction the builder didn't show up. I thought, 'What on earth am I doing?' I engaged some people passing by who were eager for work, and the next day the builder showed up too. By September 1994, the Ndlovu clinic opened for business with one doctor (Hugo), three employees, and Liesje handling procurement and finance. The first months were rough, with the bank asking its money back, but by 1995, Ndlovu added a second doctor, and a third in 1997.

Most patients could not afford anything beyond primary care, so they had to be referred to the (free) government hospital for anything more. Despite this, Ndlovu expanded, first opening a nutritional unit, which was later moved to four off-site locations. A tuberculosis (TB) unit followed, growing from 94 patients in 1996 to 2,000 new patients in 2007. Hugo negotiated to get free TB drugs from the South African Department of Health in exchange for offering free care, making Ndlovu a rare non-governmental organization (NGO) in South Africa to have a formal partnership with the government.

When, in 1995, a *Mkuhulu* (respectable male elder) asked Hugo to bring him a postage stamp from Groblersdal, Hugo realized that Elandsdoorn had no post office. Hugo got the man his stamp, and got him a post office too. Inequality was still endemic in South Africa: two post offices served Groblersdal's 5,000 white people, while Elandsdoorn Moutse, with its 160,000 blacks, had none. Hugo applied to open a post office branch within the clinic pharmacy, so residents could post their letters, send and receive faxes, and collect their aspirin and antibiotics all at once. One year of bureaucracy later, the post office opened, giving Elandsdoorn its very own zip code: 0485. The old *Mkuhulu* spoke for many when he said, "Thank you! Elandsdoorn is now on the map."

Many patients, particularly those with HIV/AIDS, suffered from malnutrition. Hugo decided to help patients plant a variety of crops in their gardens to provide a balanced and nutritious diet. Hugo knew that bringing the necessary water to Elandsdoorn was not a high priority for the government. The lake behind the nearby Loskop Dam held five years of water supply for the farmers connected to the 640 km of canals flowing around Elandsdoorn, but not a drop went to the 160,000 residents.

[2] As of Summer 2008, this was just over US$20,000.

Drinking water was also scarce in Elandsdoorn. As Liesje noted, "After school, our children swim, play soccer, hockey or cricket. The children from the townships are given a wheelbarrow and two 20-liter canisters to get water, often a 5-15 km walk away. This is their contribution to the daily struggle for survival."

Hugo and Liesje initiated the Elandsdoorn Development Trust (EDT). Donations from individuals enabled 23 projects, where EDT paid for the installation, pumps, tanks, and 10 taps for each pipe, the community being responsible for maintenance. To illustrate the community's commitment, Hugo asked, "Isn't it incredible that these pumps have never been stolen or damaged, in a country infamous for its crime?" Walking down the street from the clinic, he pointed to one of the taps providing free drinking water. "If you try to mess with that tap, the people here will kill you," he said, without exaggeration.

He summarized his approach: "We first gained the community's confidence by providing health care, then we began to understand their other needs and started to fill them." The success that Liesje and Hugo had been able to achieve was increasingly widely recognized. In 2005, they were named Knight of the Order of Orange-Nassau by Queen Beatrix of the Netherlands.

THE SOUTH AFRICAN CHALLENGE

The two-hour drive from Johannesburg to Elandsdoorn (see **Exhibit 1**) begins with the N1 motorway traversing the glitzy shopping and residential area of Sandton, that became Johannesburg's new commercial district when many businesses (including the stock market) fled there from the central business district to escape the violent crime that followed the 1994 elections. The N1 continues north past Pretoria, the legislative capital, before exiting onto the R25, a two-lane highway through what feels like an endless savannah-like landscape despite the 120 km/hr speed limit. Except for the occasional baboon along the road, traffic is sparse.

The small town of Groblersdal is signposted from 100 km away, but the first signs of Elandsdoorn are the Ndlovu billboards (see **Exhibit 2**) with texts such as "Be Wise, Condomize," and "Women, Don't Let Your Men Dick-tate You". This explicitness is in stark contrast with the government's confused approach to HIV/AIDS education. "Some people have started referring to Elandsdoorn as 'Condom City'," laughed Hugo.

The R25 is Elandsdoorn's only paved road; the Ndlovu Medical Center is on a dirt road. There are virtually no cars or bicycles. Single-storey homes line the roads, some built with brick, others more ramshackle. The few shops and eating establishments are almost indistinguishable from houses. By contrast, the mostly-white town of Groblersdal, where Hugo and Liesje and most of the senior managers and doctors of the Ndlovu Medical Center live, has a full selection of shops, services, restaurants, and paved roads.

Elandsdoorn is typical of many rural communities in South Africa: very limited drinking water, no high quality health care facilities prior to Ndlovu, no decent educational facilities, and marginal infrastructure. About 20% of its people are infected with

HIV/AIDS, of whom 60% also have tuberculosis (TB). Other diseases are rife, and malnutrition is widespread. Average income is below 10,500 rand[3] per year, and unemployment is approximately 60%. The existence of a market for sputum from TB sufferers exemplifies the desperation and lack of education: people buy and swallow this sputum to be diagnosed as TB positive, which entitles them to some government aid.

The origins of this desperation are complex, and cannot be separated from the history of serial colonization and, subsequently, the "apartheid" regime that was in place from 1948 to 1994. The first Europeans to visit South Africa were the Portuguese in 1487. In 1652 the Dutch East India Company founded a small settlement, bringing slaves from Indonesia, Madagascar and India. During the 1800s the British gained control. The discoveries of diamonds in 1867 and gold in 1884 further spurred economic growth and immigration, but also drove the indigenous population into increased subjugation.

South Africa started to gain independence in 1910, but power remained firmly with the whites. Successive governments enforced ever stricter separation between blacks and whites, sometimes tearing down vibrant but largely black towns to build new white towns. The black population was expelled from the cities and forced to live in townships, such as Soweto ("South Western Townships") outside Johannesburg. In 1976 the mostly Zulu and Xhose-speaking black population protested a bill requiring that instruction in all schools be in Afrikaans. The crackdown and subsequent violence in Soweto left 566 dead and led to the emergence of a real resistance movement which, together with international sanctions, led to the downfall of the apartheid regime in 1993 when the African National Congress (ANC) won the first free elections and Nelson Mandela became president.

The white and black populations still enjoy vastly different living standards. The ANC-dominated government struggles to match the high hopes that existed in 1994. It is not uncommon to hear black residents say things like "at least the apartheid government got things done." (The case-writers heard this twice within a few days.)

This pernicious inequity is an inevitable source of mistrust. It was also one of the forces driving Hugo, who likes to quote Archbishop Desmond Tutu: "When the missionaries came to Africa they had the Bible and we had the land. They said 'Let us pray.' We closed our eyes. When we opened them, we had the Bible and they had the land."

Hugo believed that bringing first-class health care to an underserved community was the way to build trust, which allowed him to address other community needs without the distrust he might otherwise have encountered. Looking to the future, Hugo was optimistic based on the changes he had seen within Elandsdoorn, but he was also deeply worried about what he called the second wave of the AIDS epidemic: the 10-12% of children who were AIDS orphans, who would grow up with no parental guidance.

[3] As of Summer 2008, this was just under US$ 1,400 per year.

NDLOVU TODAY

The umbrella organization now known as the Ndlovu Care Group (NCG) has two main locations and several satellite offices and outreach programs. The original location is the Ndlovu Care Group Elandsdoorn, in Moutse, Limpopo, that serves a population of 120,000-140,000 people. The second location, known as Bhubezi, is 400 km away in Lillydale, in the Boshabelo District of Mpumalanga; it serves a population of 70,000 people, and an additional 650,000 people live in the Bushbuck Ridge area within a 50 km radius.

The Ndlovu Care Group Elandsdoorn also has a mobile team (with a doctor, nurses, counselors, and administrative staff) to provide occupational HIV care on-site at farms. It runs a satellite operation, launched in 2007 in collaboration with an NGO that started its antiretroviral (ARV) program under Ndlovu's guidance. This satellite location cares for more than 500 HIV-positive patients, of which approximately 250 are on antiretroviral therapy (ART). More such satellites are planned for the future.

Ndlovu's programs fall into four main categories: the clinical operation (on-site and off-site); the Ndlovu Aids Awareness Program (NAAP); the Ndlovu Child Care Program (NCCP); and a collection of community outreach programs. Summary financial information on the Ndlovu Care Group is shown in **Exhibits 4 and 5**, a chronological overview of major milestones in **Exhibit 6,** and other selected facts in **Exhibit 7**.

The Ndlovu clinic

The clinic, where Ndlovu began, has grown to four doctors, seeing 140 patients per day between them. Demand still exceeds capacity; as Hugo explained, "We still have to close the gates after 140 patients; I prefer to have quarrels outside the gate than quarrels about poor service." The Elandsdoorn clinic currently has 1800 people on HIV/AIDS treatment, and saw 1500 new TB cases in 2007. Somewhat unusually, Hugo insists that every patient be assigned to one doctor, who is accountable for their patients' wellbeing. This is easier said than done, as Hugo also insists that a doctor should give a patient all the time s/he needs. Moreover, except for Highly Active Antiretroviral Therapy (HAART) patients, the clinic does not take appointments; it's first-come, first-served. At midnight, 20 cars may show up to collect a number that will ensure them of an early slot; by 5:00 a.m., the next batch of patients arrives (another 5-10 people) to wait for their turn. The clinic runs two shifts: 7:00 a.m. to 4:00 p.m., and 9:00 a.m. to 6:00 p.m. To balance the workload across doctors, they all work until the last patient has left. To keep the flow moving, the staff gives the doctors five patient files at a time and calls five patients into the smaller waiting area next to the doctors' offices.

The clinic supervisor and administrator is Penny Mbatha, who reports to Dr Moraba. Penny has been with Ndlovu since 1997. She started at the post office, when there were only 8-9 staff members. Now Penny's duties include supervising the receptionist; supervising the data capturers who enter information from patient charts into the computer systems; checking whether the data on the charts is correct; and bookkeeping.

Among other duties, she needs to check 250-300 files every day (for instance, for HAART medication she checks whether the chart has the right code, name, and amount). She catches about five errors per day, and attributes the data capturers' mistakes to the doctors' handwriting, and to data capturing being the most short-staffed function in the clinic. Before a patient can take a prescription to the pharmacist, it has to be entered in the system, which causes delay and puts the data capturers under time pressure. Penny has reduced the time she needs to spend checking these data from two hours to 30 minutes a day.

Penny spends a lot of time following up with Medical Aids (private insurance companies) and checking on payment status. If she notices that a patient has been waiting in the reception area too long, she will sometimes help that patient. Despite this daunting set of responsibilities, she thrives on her job; she says that "the hardest moments are when I cannot help, such as when a crucial medication is out of stock". She loves working at Ndlovu, although she admits it is challenging; she characterizes it as "a game you have to play; you have to lose yourself in it for the patient to win." Having grown up in the area, Penny appreciates the improvements that have been made, including, the access to water and the tennis courts.

Another building has housed the prevention of mother-to-child transmission (PMTCT) program since 2003. With over 400 births per year in the clinic, Hugo saw he could help raise a new, HIV-free generation, by combining education and treatment for mother and child. To date, 98% of all newborns delivered by HIV-positive women at Ndlovu are HIV-free, in stunning contrast to the nearly 35% infection rate elsewhere.

The Ndlovu Aids Awareness Program (NAAP)

Ntwanano Shilubane, the NAAP project manager, joined Ndlovu in 2008. After earning a degree in political science and an honors degree in international politics, he started an MBA in health management, but had to put that aside for financial reasons. (He has now re-started that program, studying from home.) Prior to Ndlovu, Ntwanano worked at various NGOs in South Africa and in the UK as a project manager, and has held a variety of government positions. He got the job after a single interview with Hugo and the Ndlovu human resource manager. Initially Ntwanano reported directly to Hugo, but now reports to Mariette Slabbert, the new COO.

NAAP has five teams, one each for farms, communities, schools, outreach, and sports. Each team has a coordinator, who reports to Ntwanano for tactical issues such as skills audits or defining work processes, and to Roger Sibeko, the NAAP field manager, for operational issues. Roger, a Soweto native who speaks several African languages, joined Ndlovu a month before Ntwanano; before that he had held various jobs, including tourist guide, driver, researcher, and bodyguard.

The farm team works with the Department of Agriculture. When initiating a new project, the team first explains to the farm owner what they will do to educate employees. Once

the farm owner agrees, they send a peer educator to hold AIDS-awareness sessions. The peer educators, or counselors, are members of the target community, who have received HIV/AIDS training from Ndlovu. After several such sessions, once the counselors think the farm workers understand enough about HIV/AIDS, they bring a mobile VCT (voluntary counseling and testing) team to the farm. All farm workers who choose to do so undergo further pre-counseling before being tested in a private room and receiving the results within 10-15 minutes. In a typical VCT session, 100 patients might be tested, of which some 15 would test HIV-positive. To further ensure privacy, the team arranges for a Ndlovu doctor to visit the farm soon after the VCT session. They call the patients who tested positive to suggest that they meet the doctor. Of the 15 who tested positive, 5-10 might show up, in addition to 20-25 employees who visit the doctor for any other complaints, so nobody knows who is HIV-positive.

The NAAP outreach team trains peer educators in different organizations. In the past the outreach teams would go anywhere, but Roger is trying to focus on local companies which allows the teams to leave Elandsdoorn at 6 a.m., arrive on site by 8-9 a.m., and be back home by 7 p.m. They occasionally stay overnight when traveling to more remote locations if the company invites them to. While explaining the importance of peer educators, Roger contrasts the VCT session at the farms with the VCT program he saw at one of the mines: employees waited for their test results in a common area. Even though the results were not announced in public, the staff would tell some employees "you go through that door" while sending others another way. The NAAP outreach team is now training some of the peer educators at that mine. The NAAP community team is similar to the outreach team, but typically stays within a 50 km radius.

The NAAP school team works in partnership with the Department of Education, but had to adopt a different approach because performing VCT on-site at schools is not allowed. When the NAAP peer educators visit a school, the teacher will spend some time on general life skills, while the peer educators discuss issues specific to HIV/AIDS. After several such sessions, the NAAP school team will plan a VCT session off-site, for instance by arranging a sports event and bringing the children to a location where they can do the testing and counseling.

So far, the five teams operate largely independently from one another. To encourage exchange of ideas between the teams, and to address the ambiguity about the teams' domains, Roger and Ntwanano are merging the community and outreach teams, and the schools and sports teams.

Roger and Ntwanano are making several other changes. They noticed that NAAP was operating largely independently from the rest of Ndlovu, but should collaborate more closely with the Ndlovu Child Care Programs. It was not easy for Roger and Ntwanano to make the junior staff on both sides recognize this, but now NAAP and NCCP are working hand-in-glove.

Ntwanano noticed that NAAP did not have a uniform brand so he developed a consistent message and color scheme. He is re-doing the work processes, putting more detailed

descriptions of those processes into "LogFrame"[4], and translating them into a project management framework. A firm believer in documentation, he is now capturing data on the number of VCT interactions, where those people are from, and how many children they have. Roger explains how the NAAP team is working with the monitoring and evaluation (M&E) team: "One M&E lady is here at NAAP, and she is asking us to do more detailed planning. We used to have six-month plans before, for instance we would say we want to do 5000 VCTs, distribute 10,000 condoms, etc., but the targets were often set very high, so the teams underperformed. Now, instead, we're focusing on monthly or weekly targets, and after each week or event, we do a SWOT analysis to find out why the targets were or were not met."

Roger and Ntwanano find interacting with the peer educators both rewarding and challenging. Ntwanano feels that he can make a real contribution by working with these young people, but he finds that "the peer educators often come to Ndlovu thinking this is the end of the road. The challenge is to show them that it's really just the beginning; there's so much opportunity out there." Talking with all the NAAP employees, he saw their ambitions and skills. Roger confirms that "we are doing skills audits of the peer educators, we may send some to school, not for our benefit but to empower the individual." One thing he enjoys about working at Ndlovu is that "they are asking young people how best to do their job."

Roger sometimes accompanies the teams in the field, especially when the peer educators need him as an interpreter. Every time he sees patients walking out of a VCT test trembling he is reminded of the emotionally draining side of the peer educators' work. Every month they meet with a psychologist to help them cope.

Roger and Ntwanano have ideas about how to improve NAAP, but they both wish they had more time to put those ideas into practice. In Roger's experience, "There are always unexpected things happening; for instance, the team is out at an event, but they don't have a generator, so I have to bring it; or they forgot to bring condoms so I have to drive over." Ntwanano is also no stranger to interruptions, caused by invoices needing immediate attention or the ongoing construction of the amphitheatre, another of Hugo's pet projects. All this keeps them very busy. As Roger puts it, "We start at 6:30 a.m. and knock off at 7 p.m.; if you don't have passion, you don't survive here."

The Ndlovu Child Care Program (NCCP)

Jennifer Stuart is the program manager for the Ndlovu Child Care Program. She joined in 2005, having just earned a degree in women's studies in Durban. Themba Dlamini is the NCCP project manager. Jennifer's job is more external, focused on growth, while

[4] "LogFrame" is the planning tool that Ndlovu uses to monitor outputs of certain activities in order to reach objectives. It is based on *The Logical Framework Approach (LFA): Handbook for objectives-oriented planning*, Norad, 1999, Fourth Edition.

Ngombi's work is more operational. Between them, they oversee programs related to dental care, nutrition, and nature.

Jennifer added a new program for orphans and vulnerable children (OVC), the only OVC program in the immediate area. She recalls how they were unique in seeking out government partnership from the start: "The first six months it was just me, there were no large NGOs doing child care in the area; there were just some small community groups. We offered these groups a place to refer children to, and started after-school and Saturday programs, where OVC children were taught life skills, drama, etc. After each event the children got together with a counselor for a debriefing; for instance, they would discuss the soccer game they just played."

The Friends of Loskop program blends science education with recreation by bringing 6,000 children to the nearby Loskop Nature Reserve to experience nature, a rare opportunity for children growing up in townships. It also, unintentionally, highlights another major challenge in South Africa: the severe water pollution caused by the local dam and mines is slowly killing the animals that the children are taught to enjoy.

Themba explains, "What is great about Ndlovu is it's a one-stop shop for children, so we really need to integrate across our programs (NAAP, child programs, and treatment). For instance, if a child is HIV-positive, he or she needs treatment, but we also need to work on awareness for family and neighbors." Jennifer agrees wholeheartedly, "The last two years we've all been working so hard, we're all on our own island." She gives two examples of missed opportunities. First, if a child is HIV-positive, some counselors refer him to the Ndlovu home treatment program which provides additional support beyond medicine and treatment. Other times, the counselors only refer the child for regular treatment, with no additional support. Second, the child care program was trying to establish relationships with schools, only to discover that NAAP was already working with the same schools.

Jennifer is optimistic that better integrating their activities with other groups at Ndlovu will yield results. Even though everybody is busy, "we hold each other accountable: if two people agree on something they'll make it happen. If something is not done when it should be you will hear about it."

Part NCCP's work is inevitably reactive, but Jennifer credits their standard operating procedures and their reliable, efficient data management system for keeping things on running. She is particularly proud of the GPS-based map of patients' locations. "Most children in our system don't have addresses, it's just 'by the third tree after the yellow shack.' We're using this simple GPS device to register the locations of each household so when the counselors return they can drive straight to the house instead of circling around forever trying to find it. Eventually each program will have a map with colored flags, for HAART, TB, nutrition, child care, and other programs."

Jennifer enjoys the atmosphere at Ndlovu. In other organizations people often feel stifled, and struggle to get support for ideas. Ndlovu is different: "Here, if you can

articulate an idea and get Hugo and Liesje excited, you go do it. In this kind of work, that's crucial. This job is all about passion; it's about innovation, growing, fun, etc." She believes that the "inspired leadership of Hugo and Liesje" is what makes Ndlovu work so well. Jennifer does find that management and staff are still not close enough, and management living outside the community does not help. She also wishes the community would take more initiative and ownership. "The community wants to get paid before they do anything, but we're trying to help them help themselves."

Community development

After health and child care, "community development" covers a range of programs, some formal, and some more accidental, under the umbrella of the "Elandsdoorn Development Trust (EDT)." These include the water programs, the sports program, a bakery, and a diaper factory, in addition to information technology (IT) education, a scholarship program, and facility improvements for the Mologadi preschool.

Located around the corner from the clinic, the sports fields are popular with locals and used all day and into the evening. Hugo had heard that Johan Cruijff, a Dutch soccer legend, was providing funding for football fields in the Netherlands, and asked, "Why not here?" Hugo's passion must have played a role in convincing Cruijff to visit Elandsdoorn, resulting in the star donating the first Cruijff fields outside the Netherlands. Hugo laughs when he recalls Cruijff's experience: "He loved it here. Finally he was in a place where nobody recognized him."

Next to the sports fields is a fully-equipped fitness center, another rarity for a township. One block further is the site where Ndlovu is building an amphitheatre and multi-purpose community facility. Hugo sketched the design for this center himself.

Ndlovu runs several ancillary enterprises for the community's benefit. The bakery was started in 1998, when Phuti Mariba, a staff member, complained to Hugo that his workers often had to travel far (and sometimes to three different shops) to get their lunch. During the conversation, Hugo learned that Phuti's wife baked up to 200 loaves of bread each day in the little oven in her kitchen, around the clock, just so that the family could survive. Together with the Dutch foundation "Bakers for Bakers," and with financial support from Herman van Veen (a Dutch entertainer), a full range of bakery equipment was shipped to Elandsdoorn from the Netherlands. A retired Dutch baker helped to set up the bakery, after which the Maribas managed it, offering Elandsdoorn warm, fresh bread for the first time. The bakery now has 16 employees and bakes about 3,000 loaves every day, in addition to selling cakes, sandwiches, and cold drinks.

The diaper factory has more tragic roots. Many women only find out that they are HIV-positive when they become pregnant, and their husbands often leave them immediately. Therefore, an unintended consequence of Ndlovu's HIV/AIDS programs is that there are now HIV-positive single mothers with no source of income. When an opportunity arose to buy a machine for producing disposable diapers, Hugo jumped on it. Five women now

work in the factory, producing 600 diapers a day, giving the maternity clinic a regular supply of diapers, and selling them at lower prices than the local supermarket.

Touring Elandsdoorn with Hugo as guide is quite an experience. Everybody seems to know him, he is constantly stopping for a chat, asking how people are, or just joking with them. While driving, Hugo also pointed out two of the local entrepreneurs that he helped launch. "That's a car wash. One day, Mafika walked up to me and said, 'Mr. Hugo, the Ndlovu cars are dirty, may I wash them?' I kept on refusing but he insisted. In the end I let him, and he did a good job. I loaned him some money, and now he has his own car wash." Pointing to another house, he continued: "That's where Vusi lives. He's a real entrepreneur. He wanted to paint. He already had a VAT number[5] and five employees lined up, but no jobs. We let him do some painting, after that he got a big job in Johannesburg. He needed money to buy equipment, and we loaned him 28,000 rand[6]. When he returned to pay me back, he then borrowed even more to buy a car."

Funding

To support these activities, Hugo has tapped into several sources of funds. Some activities are fully or partly self-sustaining; for instance, the clinic does charge for some services, and the bakery and diaper factory are or will be self-supporting. The majority of funding comes from governments and NGOs, but such grants typically only cover treatment and medication and not the broader community development activities that Hugo is committed to. For such other activities, Hugo has incorporated non-profit organizations in the Netherlands and in Germany.[7] "We are very transparent - I show donors that we can live a comfortable life here. After one year, we had two million rand, and another foundation is going to give two to three million more. We keep the money there (in Germany) until we need it here." The Friends of Loskop is funded through this foundation. As Hugo puts it, "It's neat, but not life-saving, so nobody wants to fund it; we got the Dutch and German foundations to support it."

The biggest challenge, in Hugo's view, is the impossibility of creating reserves in a charity setting. He has raised enough funds to buy himself some flexibility, however, so when one budget is exhausted he can sometimes reallocate funds from elsewhere.

[5] All firms must have a Value Added Tax number in order to be incorporated.

[6] As of Summer 2008, this was about $6,400.

[7] The public relations representative of Herman van Veen, the Dutch entertainer who funded the bakery and was popular in Germany, had made a documentary about Ndlovu. Hugo attended the premiere in Berlin with an audience of 600 wealthy people. He then created the "Tempelman Stiftung," using his own name only because he was told it was better for marketing. Several people from German media firms also attended the premiere, so Hugo frequently appears on talk shows there.

MANAGING THE GROWING NDLOVU ECOSYSTEM

Although Ndlovu had changed dramatically since its early days, Hugo's first three hires were still there. One started as a cleaner and was now managing the data capturing department; another started as a translator but then moved to the pharmacy.[8]

In the early days, Hugo hired only unqualified people and trained them himself. He was convinced that attitudes were more important than specific skills. Mariette, the COO, continued that philosophy: "I hire attitudes; I train skills." That started to change when the first computer arrived in 1996, and the clinic needed different skills. It changed even more when the clinic switched from 12-hour to around-the-clock operation in 1998. Ndlovu needed more nurses and more professional staff. This started to create a split within the organization due to the strong hierarchical tradition within the nursing profession, where seniority was advertised with military-style stripes. Referring to these stripes as "fruit salad," Hugo's experience was that more stripes often meant less willingness to do real work. Hugo would rather hire locals and have money flow back into the local community than import capacity from elsewhere.

An extreme example of Hugo's recruiting style was the 31-year-old job candidate with 16 years missing on his resume, which Hugo guessed correctly corresponded to a prison sentence. The candidate declined to give details but reassured Hugo that he had not killed or raped anyone. Hugo liked the man's attitude and hired him. After a few good years at Ndlovu the man moved on to a respectable job in the area. Asked whether this was symptomatic of a broader retention challenge, Hugo counters, "Quite the contrary, you should make yourself a training house so people can get themselves a better life. All NGOs want at least five years experience, so Ndlovu is a great place for people to start."

Hugo admitted that this approach to hiring does have its limitations. "We can only grow local people to a certain level. If you try to go beyond that, you disappoint them, and that is risky. In this culture, you cannot show anger or disappointment with an employee in front of others."

On the other hand, Mariette found that "a big surprise to me is that everyone here understands reality, employees know when they cannot grow further. The managers here are very young but very mature." Mariette did encourage them to develop themselves as much as possible: "I provide a safety net, but they have to jump first."

Hugo's passion came with a temper, although he said, "I have learned to control my short fuse. Once, I was with a patient when the bakery called because something needed fixing. As soon as I was finished with the patient I went over to the bakery and fixed whatever it was. I was almost ready to go back to my patients when the bakery employee asked, 'Now that you're here, can you also...' I exploded, swearing profusely. I am very

[8] Hugo recalls discovering that she was severely shortsighted and unable to read prescriptions. She worked completely from memory, recognizing patients, or hearing the prescription being dictated. Hugo drove her to buy glasses; he remembered how ecstatic she was on the way home to be able to see oranges in the trees.

focused, and was prepared to step out to do precisely what they had asked for, but I was not prepared for the extra request."

The rapid growth at Ndlovu forced some changes in management style. Walking around the clinic, Hugo said, "Everything you see grew out of enthusiasm. We didn't do things systematically but relied on intuition and hard work." Liesje confirmed this: "I constantly have to curb Hugo's enthusiasm. He is the accelerator; I am the brake pedal." Hugo put it less delicately: "Liesje says I run too fast, the rest have to follow in my slipstream and clean up my sh*t." He clarified, "We did have program managers, but they all reported directly to me. We all worked extremely hard, and I was also still doctoring at that time. Every one to two months we held management meetings at our house, from 8.30-10.30 p.m., followed by some good wine, because we did not want to have meetings during the day." Hugo evidently recognized the need to take stock: "Since November 2007, we have not started any new initiatives, we are only working on organizational development. This consolidation provides a baseline for our future growth."

That recognition did not come without pain. As Hugo recalled, "We were approached by Richard Branson, Anglo-American[9] and a third partner to open another clinic. I insisted they fund a management team to handle coordination across locations. They agreed to split the cost for the autonomous treatment center (ATC) team to manage the new clinic. This gave us the financial space we needed to hire and upgrade people. We opened Bhubezi in April 2007. Unfortunately, the third partner withdrew, so we only got two thirds of the funding, so we couldn't hire the full team yet. I was stretched too thin and started using resources from Ndlovu to support our new Bhubezi venture."

Hugo saw the writing on the wall: "I was getting sloppy, I was getting on people's nerves. It became grim. I got a wake-up call when a girl who came from the Netherlands left after four months because she said she didn't recognize the man who hired her."

Perhaps, the most dramatic moment in Ndlovu's growth occurred a few years ago. Hugo had already hired a second doctor in 1995, and a third in 1997 who focused exclusively on seeing patients, which allowed Hugo to do many other things besides practicing medicine. Hugo relived the moment when he finally had to choose between being a doctor or a manager: "We had just hired four new management staff in three months, so our management team had doubled. I felt we needed to spend time together as a team, and rather than have Tempelman do it again, I hired a consultant to come in for a day, in January 2005. She did the usual vision and mission exercises with the team, while I was thinking □what a load of rubbish.' Later she made us all sit around an African campfire, in sequence from the most recent hire to the most senior (me), and asked us to talk about our first day on the job. After that, the consultant handed me my stethoscope, and gave me a choice: □Hang it around your neck, or hang it up on that tree.' I was speechless, I got myself a glass of wine and a cigar and left the meeting." Recounting this moment years later, Hugo's emotions still showed. "I came back, and hung the stethoscope up on

[9] Anglo-American is a global diversified mining group with headquarters in London, UK.

a tree. For two years I didn't go back to the office where I used to see patients. Nowadays I do occasionally see patients for half a day but absolutely no more than that."

The final blow came in November 2007 when Hugo had to fire three people in one week. Hugo believed the firings were legitimate, but the workforce went on strike. "There was a communication breakdown. Since then, we've done a lot on labor relations and capacity building, but I'm not trained for this. I'm an epidemiologist who had to climb a steep learning curve to learn how to run an organization. We had created all these new jobs but now we had to put in place processes to support those jobs."

A key step came when Hugo hired Mariette Slabbert, previously CEO of a smaller hospital in Pretoria, to be Ndlovu's chief operating officer. Hugo interviewed her in May 2008, and instantly knew he had found the right person. She joined Ndlovu in June 2008.

Mariette thoroughly enjoyed her new job. "This is a dream job for me. It's amazing to have an opportunity to step in Hugo's footsteps." As she familiarized herself with Ndlovu, she said, "The four words I heard a lot were fun, funky, holistic, and dynamic." Mariette started off by identifying organizational processes that needed streamlining. "I prepared a toolkit for the clinic, which covers VCT, wellness, and ARV, and I will do the same for other programs. I'm making standardized toolkits for the counselors, which will help them to manage their sessions and to build their confidence, and to ensure that they don't miss anything."

Hugo's vision was becoming clearer. Part of the management team needed for the expansion was in place, and now that Hugo was no longer involved in day-to-day operations he could dedicate himself to realizing his grand vision.

THE EXPANSION PLAN

The idea of replicating the success he had achieved with Ndlovu and Elandsdoorn had been germinating in Hugo's mind for some time, but a chance visit by the Dutch ambassador in October 2007 turned out to be a catalyst. "They were very impressed with what they saw. The ambassador took me to my office on Saturday morning and said tell me your dream." That got Hugo to start articulating his dream on paper, as the ambassador had hinted that he was interested in funding Ndlovu. Around that time, a friend of a friend who had built an investment bank was looking for work. He helped Hugo to draft a strategic plan and a 40-week change plan, an experience Hugo remembers fondly: "I really enjoyed the process of writing and reflecting. That is one of the biggest challenges of operating in the nonprofit world. Donors need to understand that time for reflection also needs to be paid, otherwise you keep drifting further from your goals." That strategic plan (see **Exhibits 7** through **12**) was the foundation for the grant proposal that Hugo wrote for the Dutch government. "Writing the proposal was a very useful exercise," Hugo commented, "It will allow us to replicate the Ndlovu model and create a top layer to coordinate across multiple locations."

Hugo was proud recounting the latest turn of events: "Apparently a retired investment banker somewhere wanted to give something back to the community by starting a clinic. After two years the Ministry of Health finally said, 'Okay, but follow Tempelman's model.' I hadn't heard anything about this until very recently. He and I had a great conversation but I don't have capacity now to take this on. Six months from now it would be easy, it is a great project, but I'm afraid of delivering a failure." That fear of failure did not stop Hugo: "The Memorandum of Understanding MOU is almost signed, even though it's 340 km from Ndlovu; Bhubezi is 400 km away from Ndlovu, and the two new clinics are 180 km apart."

Exhibit 10 shows the proposed organization chart for the Ndlovu Care Group, the new coordinating superstructure. Three boxes show the main groups: the Ndlovu Care Group Elandsdoorn, the Bhubezi clinic located in Lillydale; and other future sites referred to as Ndlovu Care Group X (**Exhibit 11)**. Further expansion would come from satellite locations, owned and operated by others but drawing on the Ndlovu Care Group's management expertise. Mariette anticipates opening one new location and two satellite locations per year.

Hugo has no illusions about these changes: "I told everyone that the plan would not cost jobs and could in fact help people with their careers, but I also know that not everyone will fit in." When asked where the greatest challenges will lie, Hugo and Mariette gave slightly different answers. Hugo said, "The biggest challenge is finding people in the local community with the same level of passion as you have." Mariette countered, "The biggest challenge will be retention because it takes a lot of time to train people."

Mariette was confident that they would be able to balance between letting individual sites be autonomous and sharing best practices across locations. "Our second location is also working very well; the people there are very enthusiastic. For instance, they have put an appointment system in place in Bhubezi. We will do that here too. I plan to introduce some competition between locations."

AFTER THE PHONE CALL

As the initial euphoria from the Dutch embassy's phone call began to wear off, Hugo's mind turned to the challenges ahead. Many pieces of his dream were beginning to fall in place, some slowly, others a little faster than he would have liked. There was no denying the tremendous opportunity provided by this long-term funding, but Hugo was also keenly aware that mismanaging the expansion could not only mean a missed opportunity, it could even destroy everything he had built. Leaving things the way they were was not an option for Hugo, the potential was too great. Moreover, Hugo did not have a history of shying away from risks, although he saw it differently: "I'm not afraid to put things in place, but I've hardly taken any risks. I try to foresee problems before making a decision." Hugo elaborated: "No projects have failed because we always started from community needs. Of course, we sometimes have problems. For instance, the

bakery was losing money for a while, but we brought in a new manager who turned it around. Or take the sports program – at first it was not self-sustaining, so we moved it under HIV education and it is now well-funded. Changes sometime take longer than expected, but you have to change. If you stand still, you decline."

Hugo knew that expanding Ndlovu meant amplifying these challenges. And although he was optimistic and excited, he couldn't help wondering, "What am I forgetting? What will the challenges be? What can I do to reduce the risk?"

Exhibit 1: Hugo and Liesje Tempelman

Source: http://www.helpelandsdoorn.com/pageID_3217536.html, last accessed October 28, 2010

Exhibit 2: Map of South Africa, showing Elandsdoorn

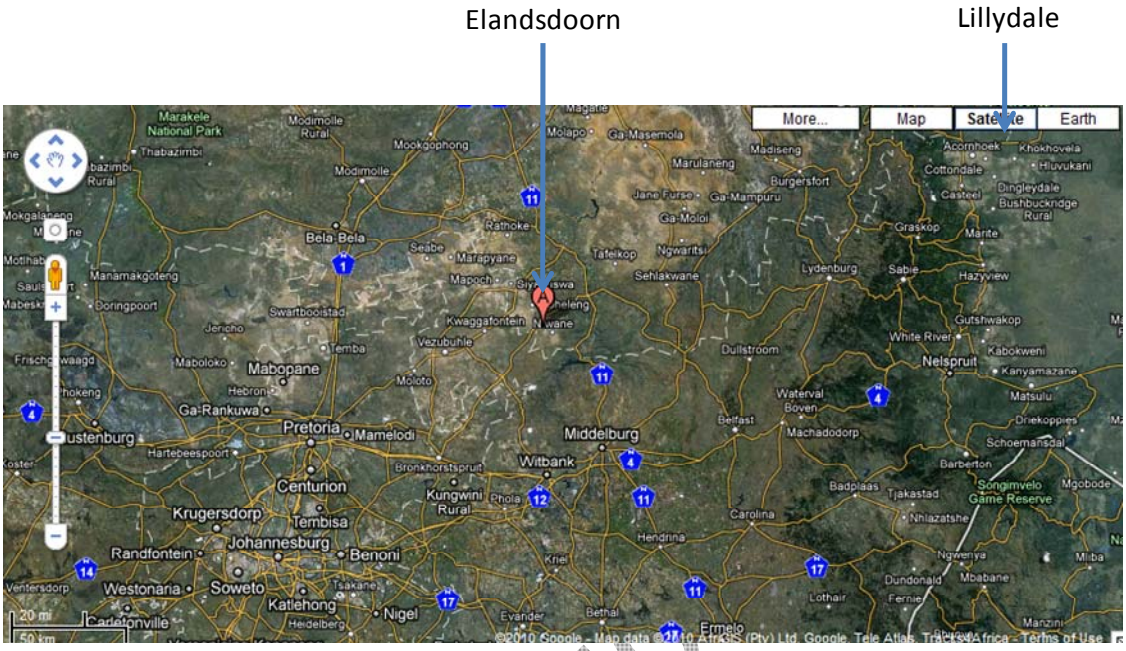


Exhibit 3: Photos of Elandsdoorn and Ndlovu

Photo 1: Sample billboard in Elandsdoorn.

Photo 2: Another sample billboard in Elandsdoorn

Photo 3: The parking area at the Ndlovu Medical Center.

Photo 4: Makeshift wheelchairs at the entrance to the Ndlovu Medical Center.

Photo 5: The Ndlovu Medical Center has its own fueling station.

Photo 6: Restaurant and car wash outside the Ndlovu Medical Center.

Exhibit 4: Balance sheet for Ndlovu Medical Trust, 2008[10]

NDLOVU MEDICAL TRUST

BALANCE SHEET AT

29 FEBRUARY 2008

	NOTE	2008 ZAR	2008 $
ASSETS			
NET CURRENT ASSETS		4 436 950	625 688
TOTAL ASSETS		**4 436 950**	**625 688**
CAPITAL AND LIABILITIES			
CAPITAL		3 835 638	541 757
Ndlova AIDS Avareness Program		2 274 188	321 213
Colombine Matemity Clinic		(176 213)	(24 890)
Highly Active Anti-Retroviral Treatment		(151 004)	(21 328)
Ndlova Nutritional Unit		(208 872)	(29 502)
NMT TB Project		239 857	33 878
Management Ndlovu Group		704 563	99 506
Ngwerya Community Dentsl Program		(424 853)	60 007
Bhubesi Autonomous Treatment Centre		1 578 035	222 886
LIABILITIES		601 312	84 931
TOTAL CAPITAL AND LIABILITIES		**4 436 950**	**625 688**

[10] Consolidated statements are not available for years prior to 2008.

Exhibit 5: Income statement for Ndlovu Medical Trust, 2008[11]

NDLOVU MEDICAL TRUST

INCOME STATEMENT AT

29 FEBRUARY 2008

	2008 ZAR	2008 $
INCOME	**3 834 863**	**541 647**
Admin and Labour	1 000 249	141 278
Donations	189 425	26 755
Sundry Income	2 383 191	336 609
Ward Fees	99 170	14 007
Interest Received	162 828	22 998
EXPENSES	**26 376 112**	**3 725 440**
Accounting	28 707	4 055
Accommodation	8 820	1 246
Administration	624 390	88 191
Advertising	51 826	7 320
Bank Charges	24 977	3 528
Labour	1 209 858	170 884
Building Expenses	687 463	97 099
Consultation and medication	168 069	23 739
Computer Expenses	14 650	2 069
Counselling	97 693	13 798
Cleaning	73 475	10 378
Development	507 696	71 708
Electricity and Water	88 375	12 482
Events & Promotion	612 667	86 535
Food Expenses	381 731	53 917
Strategic Planning	78 210	11 047
Interest paid	15 637	2 209
Insurance and Licences	48 602	6 865
Repairs, Maintenance and assets	445 237	62 887
Rent Paid	53 800	7 599
Laboratory Purchases	2 978 865	420 744
Leasing	16 097	2 274
Legal Fees	4 800	678
Linen	5 821	822
Medical Purchases	5 458 342	770 952
Monitoring and Evaluations	12 600	1 780
Motor vehicle Expenses	21 630	3 055
Telephone and postage	231 442	44 133
Travel and transport expenses	1 541 158	217 678
Training	462 843	65 373
Salaries and Wages	9 563 421	1 350 766
Staff Welfare	99 618	14 070
Security	97 254	13 376
Services	239 090	33 770
Subscription	114 515	16 174
Stationery and Printing	306 733	43 324
NET (SHORTAGE)/SURPLUS FOR THE YEAR	**(22 541 249)**	**(3 183 792)**
FUNDED BY : DONATIONS RECEIVED	23 335 490	3 295 973

[11] Consolidated statements are not available for years prior to 2008.

Exhibit 6: Chronology of Ndlovu's development[12]

1994 Start and opening of Ndlovu Medical Centre a township based community general practice

1996 Opening 1st Ndlovu Nutritional Unit in Elandsdoorn

1997 Start Ndlovu Tuberculoses Program in cooperation with Provincial and National Dep. of Health

1998 Start Ndlovu Aids Awareness Program, NAAP

1999 Opening Ndlovu Maternity Clinic (24-hours)

1999 Opening of the Bakery in Elandsdoorn

2001 Opening 2nd Ndlovu Nutritional Unit and 1st water tap

2001 Expansion of Ndlovu Tuberculosis Program with defaulter-tracing

2001 Start Ndlovu Information Technology Training

2002 Op Opening 3rd Ndlovu Nutritional Unit

2003 Start of Dental Program under the name Ngwenya Comm. Dental Care Program (NCDCP-program)

2003 Expansion of Ndlovu Tuberculosis Program with contact tracing and community TB

2003 Start of Ndlovu Highly Active Anti-Retroviral Therapy (HAART-program)

2003 Start of Prevention of Mother To Child Transmission of HIV (PMTCT-program)

2003 Start Waste Care Program Elandsdoorn

2004 Opening 4th Ndlovu Nutritional Unit

2004 Start of mobile HAART project for farm workers

2004 Opening Sport Grounds in cooperation with the Johan Cruijff Foundation

2005 Start of a community Voluntary Counseling- and Testing program (VCT-program)

2005 Start Nappy Factory Elandsdoorn

2006 Start of Orphans & Vulnerable Children Program (OVC-Program)

2007 Opening of 1st ATC satellite clinic at Vaalwater (Waterberg Welfare Society)

2007 Opening of Bhubezi, Lillydale

[12] Source: "Strategic Plan Ndlovu: The Concept for Community Care", version 5-22-2008.

Exhibit 7: Selected facts about Ndlovu Care Group

- Number of patients seen per year at the clinic in Elandsdoorn: 11,000 – 12,000
- HIV patients: 11,000 known patients in the ARV program, of which 5,900 initiated on treatment, of which 3,950 currently on ARVs; 3-year retention rate of over 78%
- Maternity clinic: 350 deliveries per year
- Ndlovu Child Care Program (NCCP): 3500 children enrolled
- Within NCCP:
    - 25-30 children enrolled at any point in time in the Ndlovu Nutritional Units, average stay 3 months
    - 160 children enrolled in the three participating pre-schools
- Ndlovu Aids Awareness Program (NAAP): worked with two farms, one was handed over to government care, the other still under NAAP with approximately 60 patients on treatment; after one year the farm's HR manager noticed a reduction of sick leave and no more HIV-related deaths

Exhibit 8: Excerpts from the strategic plan[13]

The vision statement of the NCG is 'Empowering towards Wellness'.

NCG mission: To empower communities towards Health, Childcare, and Community Development in South Africa in cooperation with other Non Governmental Organisations, Corporates, and relevant Government Departments. The NCG objective is to advance rural communities, and scale up services through the NCG Rural Advancement Program (RAP).

NCG developed an applicable and replicable Care Model for scaling up services in communities through:

- Local capacity building for sustained community development and improved standard of living in rural areas
- Information, awareness, and education on health related issues to promote behaviour change, early care seeking behaviour and prevent more HIV infections
- Affordable and integrated Primary Health Care (PHC), Malaria, TB and HIV/AIDS Care to promote personal wellbeing and community health in general
- Childcare Programs to address the needs and life skills of Orphans and other Vulnerable Children (OVC)
- Research, Monitoring & Evaluation to ensure evidence based interventions and improved outcomes
- Replicating the NCG Model within the public sector and other NGO's to assist in the upliftment of health and community systems across Southern Africa.

NCG values

- Fun
- Funky
- Holistic
- Dynamic
- Innovative

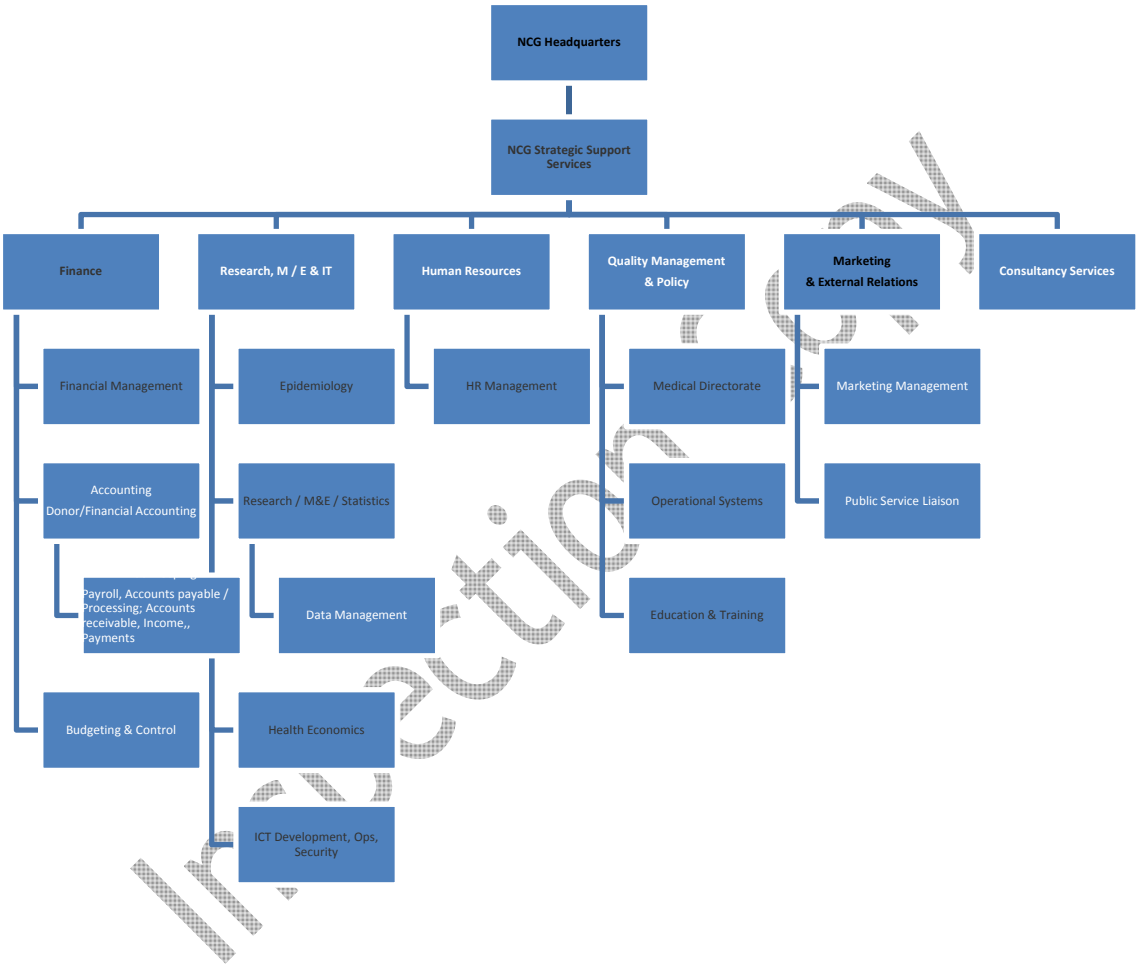
[13] The material here is taken from "Strategic Plan Ndlovu Care Group: The Model for Rural Community Health & Community Care Services", pp. 4-5, 17/10/2009, available online, and is largely identical to that from the strategic plan dated 5/8/2008 that is referenced elsewhere in this case.

Exhibit 9: 3-year plan for Ndlovu's expansion[14]

Step	Description	Period
	CONSOLIDATION STAGE	
1	Implement new organizational structure and appoint good management	from 2008 to mid 2009
2	Implementation of Management Cycle	from 2009
	PREPARATION	
3	Research for third Ndlovu Care Group	2009 - mid 2009
4	Get in touch with local community / governmental organizations	mid 2009 - end 2009
5	Find sponsor for third Ndlovu Care Group	mid 2009 - end 2009
6	Create master plan for implementation and construction	mid 2009 - end 2009
	EXPANSION	
8	Expand activities in Elandsdoorn & Lillydale	from 2008 onwards
9	Construct Ndlovu Care Group 3	from 2010
10	Appoint and train personnel for Ndlovu Care Group 3	from 2010
11	Opening Ndlovu Care Group 3	Q4 2010

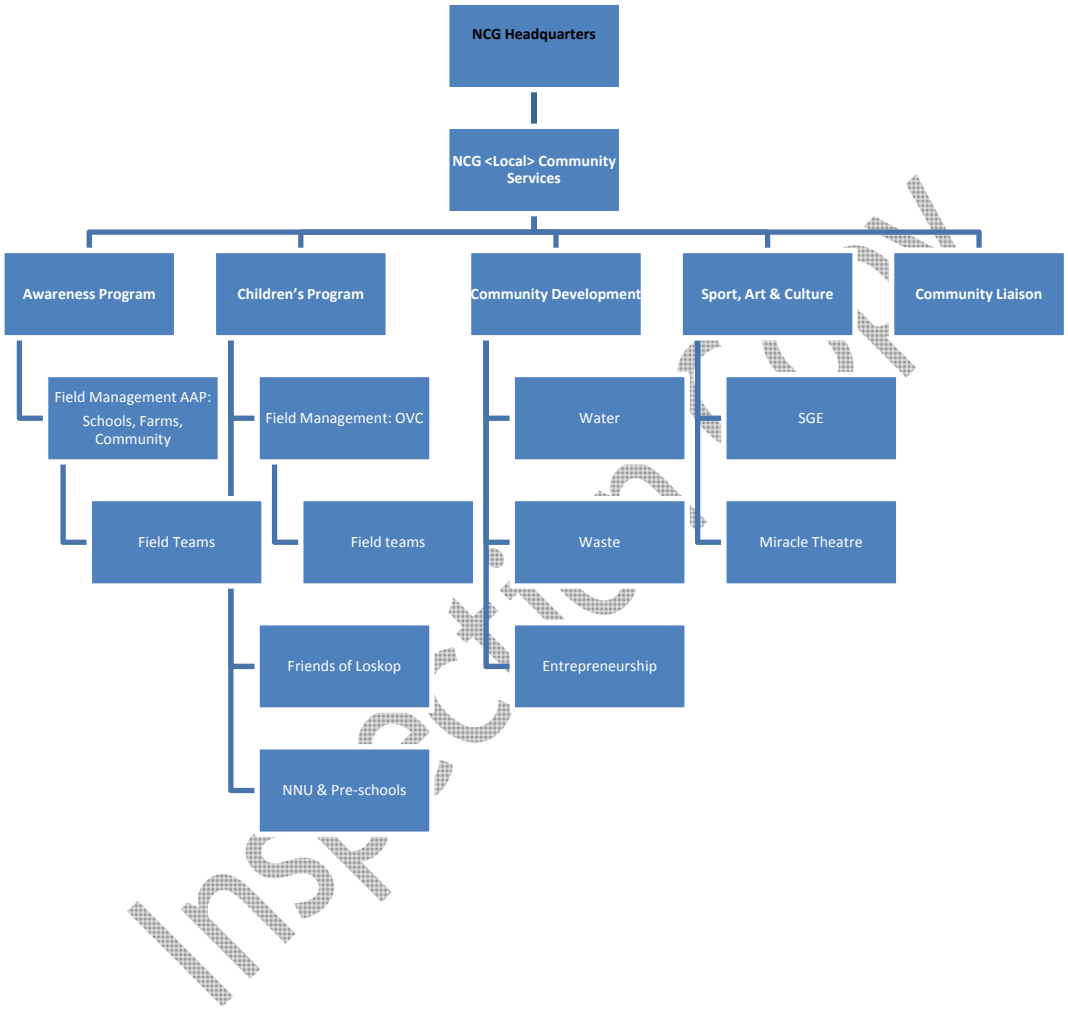
[14] Source: "Strategic Plan Ndlovu: The Concept for Community Care", version 5-22-2008.

Exhibit 10: Proposed organization chart for Ndlovu Care Group[15]



[15] Source: Dr Hugo Tempelman, July 2008.

Exhibit 11: Proposed organization chart for a local Ndlovu Care Group[16]



[16] Source: Dr Hugo Tempelman, July 2008.

Exhibit 12: SWOT analysis from the strategic plan[17]

	Strengths	Weakness
Staff	Competent team Dynamic Innovative Open-minded Visionary leadership Dedicated Fun approach Expertise	Difficult to attract & retain staff Limited synergy & referral amongst departments Training & Coaching of local staff Succession planning
Financial	Spread risk through multiple funders Good financial controls	Limited government partnership – accreditation at Ndlovu Not direct PEPFAR sponsorship
Facilities	1st world facilities NCGs situated in rural areas	Reaching capacity
Marketing	Strong positive image Good reputation National Recognition: Impumelelo & CPSI NCG brand appreciated by competitors Credibility	Limited branding Weak internal communication No newsletter Professionalise all programs
Delivery	Product leadership Operational excellence Hi-tech Convenient Community involvement	Operational benchmarking – private sector customer service Infection control
Product	Differentiated Holistic approach High Quality Reproducible Good outcomes	Private practice declining Not documented Cost studies

	Opportunities	Threats
Political	Better relationship with Government Transfer of NCG chronic care model to NDoH More funding PPP	BEE Demarcation
Economic	Popularity of HIV/AIDS with donors Export to Africa	High interest rates Global economy
Social	Operate in rural areas	Extreme poverty Trend towards alternative medicine AIDS prevalence Child headed households Poor education & health infrastructure
Technology	New technology in health	Cost

[17] The material here is taken from "Strategic Plan Ndlovu Care Group: The Model for Rural Community Health & Community Care Services", pp. 18-19, 17/10/2009, available online, and is largely identical to that from the strategic plan dated 5/8/2008 that is referenced elsewhere in this case.