The implementation of PHC re-engineering in South Africa

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As part of the health sector's contribution to the overall government strategy of "A Long and Healthy Life for All South Africans" the Minister of Health has a signed performance agreement (the negotiated service delivery agreement – the NSDA) with the President where he has committed himself and the Members of the Executive Council (MECs) of the nine provinces to four main outputs:

- Increasing Life Expectancy
- Decreasing Maternal and Child mortality
- Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis
- Strengthening Health System Effectiveness (1)

In order to learn lessons the Minister and MECs visited Brazil in 2010 and came back with a vision for the re-engineering of primary health care (PHC). Brazil was able to improve health outcomes by inter alia expanding the role of community agents working in teams with health professionals in designated catchment areas (2). Upon returning home the Minister established a small team to elaborate a South African model to strengthen PHC. This team produced the first narrative document (3) which was adopted by the National Health Council in November 2010 with the caveat that the South African model be based on the ward system as had been started in KwaZulu-Natal. Since this meeting in November 2010 a number of innovations have been added to the basic model. These additions to the model will be described in the section below.

District Health System

The re-engineering process does not detract from the need to strengthen the district health system – which continues to be the institutional vehicle for the delivery of PHC and district hospital services. This means that district management, sub-district management as well as management of all facilities within the district must continue to be strengthened, that district health plans are developed (and strengthened) and that the existing information systems be used to monitor and strengthen service delivery. It also means that quality of care must be improved through better supervision and clinical governance and paying attention to the basics, amongst other systemic interventions.

In particular it means District Management Teams (DMTs), Sub-DMTs and district hospital CEOs must be responsible and accountable for all the services that take place in all the facilities

and communities in the districts. It means that district, sub-district and hospital plans must take into account the key ministerial priorities and focus on these, including improving the systems for PHC as well as the three focused streams. It means regular monitoring of all key performance indicators related to these and taking remedial action swiftly when these do not improve as planned. The diagrammatic presentation of the district model is shown in Figure 1.

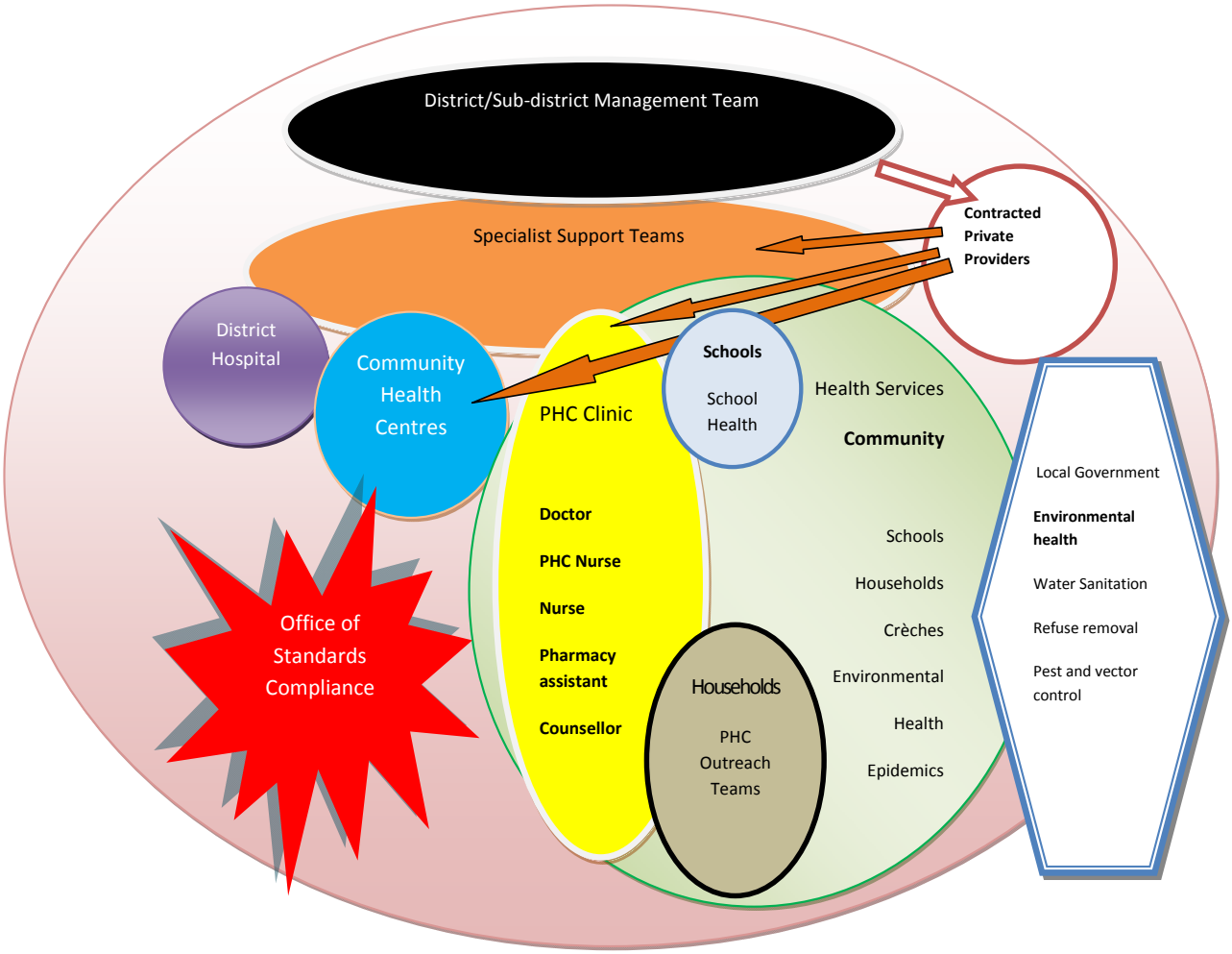

Figure 1. Proposed PHC model.

Three streams of PHC re-engineering

In discussion with the Minister and after debate in the National Health Council, a three stream approach to PHC re-engineering has been adopted by the Department of Health (DoH). This model was also part of the Minister's budget speech in the National Assembly early this year. These three streams are a ward based PHC outreach team for each electoral ward; strengthening school health services; and district based clinical specialist teams with an initial focus on improving maternal and child health.

Ward based PHC outreach teams

Evidence from many countries suggests that provision of home and community based health services and their links with the fixed PHC facilities in particular are critical to good health outcomes, especially child health outcomes (4). The role of community health workers (CHWs) in many countries has contributed to better health outcomes (5).

Although South Africa already has around 72000 CHWs health outcomes are generally accepted to be sub-optimal especially in the areas of maternal and child health. Reasons for this include a number of factors related to CHWs. These include inadequate training; inadequate support and supervision; random distribution with poor coverage; no link between the community based services and services offered by fixed health facilities; funding being channelled through non-governmental organizations (NGOs) with inadequate accountability; limited or no targets for either coverage or quality to be reached. These factors have been expanded in a number of reports (6 , 7).

The impact of HIV on key impact indicators has also contributed considerably to the relatively poor health indicators and is independent of interventions made by CHWs or other health workers and interventions.

Many of these factors can be corrected if CHWs were part of a team, were well trained, supported and supervised with a clear mandate both in terms of what they are expected to do as well as the catchment population for whom they are responsible. The ward based PHC outreach team is designed to correct these limitations in the way community based health services are currently provided in the country.

Each ward should have one or more PHC outreach teams. These teams are composed of a professional nurse, environmental health and health promotion practitioners as well as 6 CHWs. The main functions of these teams is to promote good health and prevent ill health through a variety of interventions based on the concept of a healthy community, a healthy family, a healthy individual and a healthy environment.

Each team should also be linked to a PHC facility through the professional nurse who is the team leader. The team leader is responsible for ensuring that their work is targeted and linked to service delivery targets and that they are adequately supported and supervised.

The National D0H has finalized an interim curriculum for CHW training (and PHC outreach team orientation) and this curriculum and training material has now been made available. The target is to re-orient 5000 existing CHWs by December 2011. This process started in early October with the National DoH working in conjunction with development partners and provincial DoH.

Ideally each ward within the district should be covered with a PHC outreach team. There are 4,277 electoral wards in South Africa. The population sizes of wards are variable as is the geography and density of each ward. Urban wards are highly populated with high density whilst rural wards are sparsely populated and often with poor road and other infrastructure. This means that ward populations may range from less than 1000 in some wards to more than 20 000 in others. This means that district management must work out what is the best way to distribute the PHC outreach teams. As additional resources become available, priority must be given to hard to reach areas, and vulnerable communities and homes within the district. Over time all wards should be covered.

To achieve success will require that all stakeholders and partners of government work together to achieve the same aims. To this extent the National DoH has had a number of meetings with civil society organisations and developmental partners to ensure that everyone is pulling in the same direction.

School health services

In 2003 the DoH adopted a national policy on school health services. However, the reality is that school health services are poorly resourced and therefore school health services are unevenly provided within and between provinces.

Working with the Departments of Basic Education and Social Development, the DoH has revised the School Health Policy and implementation guidelines. These will be jointly launched by the Ministers before the end of December 2011.

Whilst it is desirable to have a school health nurse in every school, the reality is that with 29 000 schools in the country, this is not possible in the short to medium term. It is therefore proposed that there is focus on schools in quintiles 1 and 2 (the poorest schools) and also prioritise a selected range of services. These services will include screening of learners at key times in their school career. For example there will be screening of all grades R and grades 1, for a variety of developmental conditions such as vision and hearing, as well as ensuring that all children are fully immunized. There will also be health education in selected grades to supplement the life skills programme. This health education will focus on sexual and reproductive health, so for example in grade 4 this will start with health education on understanding the body and how the reproductive system works.

As more resources become available the above package of services will be expanded to the full range of school health services as outlined in the revised policy. To implement this programme an audit of the current school health services will be carried out. In addition there will be an expansion of the services with additional personnel, through redeployment of nurses and hiring

retired nurses. The immediate priority is to provide a limited range of services in the poorest schools, with expansion as resources become available.

District management will also ensure that the PHC outreach teams work in tandem with school health services. It is possible that in some areas, the PHC outreach team will provide or assist in the provision of school health services.

District based specialist teams

Given the unacceptably high infant, child and maternal mortality in most of the districts the National Health Council has agreed that every district should be supported by a team consisting of a gynaecologist, paediatrician, anaesthetist, family physician, advanced midwife, advanced paediatric nurse and a PHC nurse.

A task team has been appointed to develop details around how these teams will function by building on what exists in each province. Many provinces already have outreach specialist services provided by regional specialists. Also many provinces already have family physicians working in districts. The idea is to formalise the composition and functionality of these teams, as well as to ensure that all districts have these teams.

The basic functions of the specialist teams are to:

- strengthen clinical governance at PHC level as well as in district hospitals;
- to ensure that treatment guidelines and protocols are available and are used;
- to ensure that essential equipment is available and that these are correctly used;
- to ensure that mortality review meetings are held, are of good quality and that recommendations from these meetings are implemented;
- to support and supervise and mentor clinicians; and monitor health outcomes.

The posts for these teams were advertised at the beginning of October with posts being filled towards the latter part of the year. Every district will appoint specialists. Those districts without any specialist support at present will be prioritized in appointing specialists. In addition universities will ensure that specialists employed by medical schools will rotate through the posts that provinces will create in each district. These teams will work closely with the PHC outreach teams.

Conclusions

The National Health Council has given clear direction to the health system around PHC re-engineering, and the associated three streams. To achieve the goal of a long and healthy life for all South Africans the health system must be overhauled to produce better health outcomes. All stakeholders will have to work in partnership and unison to achieve these results.

Note of the authors: This paper draws upon and summarises a document distributed to the provinces by the National DoH in September, 2012. "Provincial Guidelines For The Implementation Of The Three Streams Of PHC Re-Engineering".

Note that the views expressed in this article are those of the author(s) and do not necessarily represent the views of PHASA.

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