PHC re-engineering in South Africa: are we making progress?

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From recent pronouncements made by the Department of Health (DOH) it would appear that the DOH has recently discovered primary health care (PHC), or at worst recently re-discovered PHC. South Africans have been at the forefront of developing the ideas around the PHC approach and the implementation of community oriented PHC since the late 1930s and early 1940s as anyone who has read the work of Sidney and Emily Kark will know (1). This work predates the iconic Alma Ata conference in 1978 at which PHC gained international prominence and acceptance by the World Health Organization (WHO). The PHC approach espoused at Alma Ata took seriously the importance of the social determinants of health. These appear to have been rediscovered by the WHO as reflected by the appointment of the Commission on the Social Determinants of Health by the Director-General of the WHO and the subsequent adoption of the Commission's report by the WHO 2008.

So in the context of these international trends, South Africa too appears to have re-discovered the importance of the social determinants of health and PHC. I argue that we are re-discovering PHC not only because of the early history of implementation of PHC in the country but also because PHC as the foundation of the national health system has been policy of successive governments elected since 1994. The district health system (DHS) was adopted. A PHC package of services was designed. District management teams have been appointed. So what is the case for PHC re-engineering? In a previous PHASA newsletter already an article appeared focussing on this development (2), this article highlights some of the latest developments.

The case for PHC re-engineering

The case for revisiting the functionality of the DHS and the implementation of PHC services arises out of an analysis of health outcomes. Whilst recognizing that health services alone will not produce better health outcomes, it is clear, as I will demonstrate below, that despite relatively high levels of inputs (finances, human resources) health outcomes in South Africa remain below par.

The DOH recently launched a report that produced baseline statistics that reflect the status of health care in South Africa (3). This report was commissioned by the DOH, but produced independently by experts from the country and from various UN agencies. The report suggests that in 2009 the mortality rates were as follows:

- Maternal mortality ratio (MMR): 310/100 000
- Neonatal mortality rate: 14/1000
- Infant mortality rate: 40/1000
- Under 5 mortality rate: 56/1000

In addition, the report suggests that life expectancy at birth was 56.5 years with females at 59 and males at 54 years.

Whilst the above data (especially the MMR) are lower than data published to date on South Africa, for example the last UNGASS report noted that the MMR was over 600/100 000, it is clear that the country is doing poorly relative to its status as a middle income country. This makes the case for the overhauling of the health system as reflected in the 10 Point Plan as well as the National Service Delivery Agreement's (NSDA) four priority areas that is increasing life expectancy, reducing maternal and child mortality rates, combating HIV and AIDS and decreasing the burden of disease from TB, and strengthening the effectiveness of the health system. From the list of NSDA priorities it is clear that any attempt to reach the targets set must involve strengthening PHC. As a logical consequence of this came the decision to re-engineer and strengthen PHC and the DHS.

After much reflection, which included a visit to Brazil to understand how this country was able to reduce mortality rates over a relatively short period of time, the DOH, in addition to strengthening the DHS, adopted a three stream priority approach to re-engineering of PHC. These three streams are:

- Deployment of ward based PHC outreach teams;
- Strengthening school health services; and
- Deployment of district based clinical specialist teams.

It is recognized that these interventions must take place within the context of strengthening the DHS. This includes: the strengthening of planning and budgeting at district level; strengthening community participation; strengthening inter-sectoral collaboration; strengthening the functionality of district hospitals; strengthening the district management teams and their ability to plan, support implementation, through amongst other things supportive supervision at all levels, as well as monitor outcomes.

Progress and next steps

The work to strengthen PHC builds on the good practices that existed in the past but also provides greater focus as well as greater political support for PHC. It also benefits from the recognition that the implementation of a national health insurance system will not succeed if the public health system in general and PHC in particular are not strengthened.

Ward based PHC outreach teams

An audit commissioned by the DOH found that there were more than 72 000 community based health care workers (CHWs) in the country. They include community health workers (volunteers and those that receive stipends), lay counsellors, DOTS supporters, home based carers, etc. Payment of stipends is largely through NGOs contracted by the provincial departments and those funded by development partners. What is clear, however, is that there are several challenges with this model. These include: lack of co-ordination; poor training; lack of supervision; no evidence of impact.

In order to change the model it was decided that: (a) a model for the deployment of CHWs should be developed; (b) that training is standardized; and (c) that over time all CHWs should formally be part of the DOH.

With respect to the model, each municipal ward, of which there are 4000 nationally, should have at least one PHC outreach team (but this will be dependent on the population, geography, burden of disease, etc). The teams will be made of a PHC nurses, 6 CHWs and where possible a health promoter and an environmental health practitioner. The approach is that the team will visit all households in their catchment area (working closely with community based workers from other departments to avoid duplication of effort) and document the demography and epidemiology of these households so that we know who lives in the ward and what their health status is.

Between October 2011 and Mid December 2011, with the assistance of development partners, more than 365 PHC nurses and 3000 CHWs selected by provincial DOHs (including a few environmental health practitioners and health promoters) were reoriented. The reorientation (called reorientation because one of the selection criteria was that people had to have had some training and worked as CHW for at least one year) focused on the new approach, the importance of team work, the need to focus on community mobilization as well as health promotion and prevention and that the initial priorities included maternal and child health, HIV and TB. These teams are now in the field and are being coached to implement the approach.

The next steps include: (a) reorientation of additional teams; (b) standardizing the curriculum for CHW training; (c) working with other Departments to strengthen the harmonization of community based workers and (d) monitoring the impact of the work of these teams.

School health services

A joint task team comprising officials from the Departments of Basic Education and Health has reviewed the 2003 School Health Policy and has revised it to reflect current thinking around the package of services, which grades should be targeted etc. In addition, the team has been developing a more coherent implementation plan to strengthen the delivery of school health services.

At present there are some 265 dedicated school health nurses. However, some provinces, such as the Eastern Cape and Limpopo do not have these and all provinces have a significant shortage of school health nurses relative to the services that should be provided. The current school health nurses appear to largely focus on conducting basic screening, especially of grade R and grade 1 children and then refer them to health facilities if necessary.

The new approach will increase the number of school health nurses, significantly over time but will initially prioritize quintile 1 and 2 schools (i.e. the poorer schools) with respect to both screening and health promotion activities. In addition, for those schools that are far from health facilities mobile services will be made available at the school to provide a range of services which will include dentistry and optometry as well as sexual and reproductive health services.

District based clinical specialist teams

Although there are high maternal, neonatal, infant and child mortality rates in the country as indicated above, paradoxically for the vast majority of people there is fairly adequate access to services. As a result the need to improve the quality of clinical care within most health districts was identified as a priority. It was therefore decided that experienced clinicians should be appointed to oversee and strengthen the quality of care at district level, starting with maternal

and child health, by supervising, supporting and mentoring existing personnel. The team will include a gynaecologist, a paediatrician, an anaesthetist, a family physician, an advanced midwife, an advanced paediatric nurse and a PHC trained nurse.

Adverts were placed both locally and in international medical journals inviting health professionals in these categories with significant experience, and a few thousand applications were received by the closing date. The next step which we are in the process of includes: provincial visits to discuss the process of deployment and priority districts; the short listing and interviewing of applicants, orientation of teams to ensure a population based approach amongst others, etc. The timeline for appointment is 1 April 2012 for the first teams.

In conclusion, the three streams of PHC re-engineering require much thought, effort and collaboration with all relevant stakeholders to succeed. In addition, it needs a robust monitoring and evaluation system in combination with operations research, to ensure that the models work, that changes to the model can be made swiftly if the desired results are not being achieved and ultimately to ensure that health outcomes are achieved.

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

References:

1. Pillay Y, Barron P. A primary health care system: let's make it work. The Thinker. 2011;27: 8-11.
2. Pillay Y, Baron P. The implementation of PHC re-engineering in South Africa. PHASA newsletter 15 November 2011. http://www.phasa.org.za/articles/the-implementation-of-phc-re-engineering-in-south-africa.html (Accessed 8 February 2012).
3. Department of Health. Health data advisory and co-ordination committee report. Pretoria; Department of Health: 2011.