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PROVINCIAL GUIDELINES FOR THE IMPLEMENTATION OF THE THREE STREAMS OF PHC RE-ENGINEERING

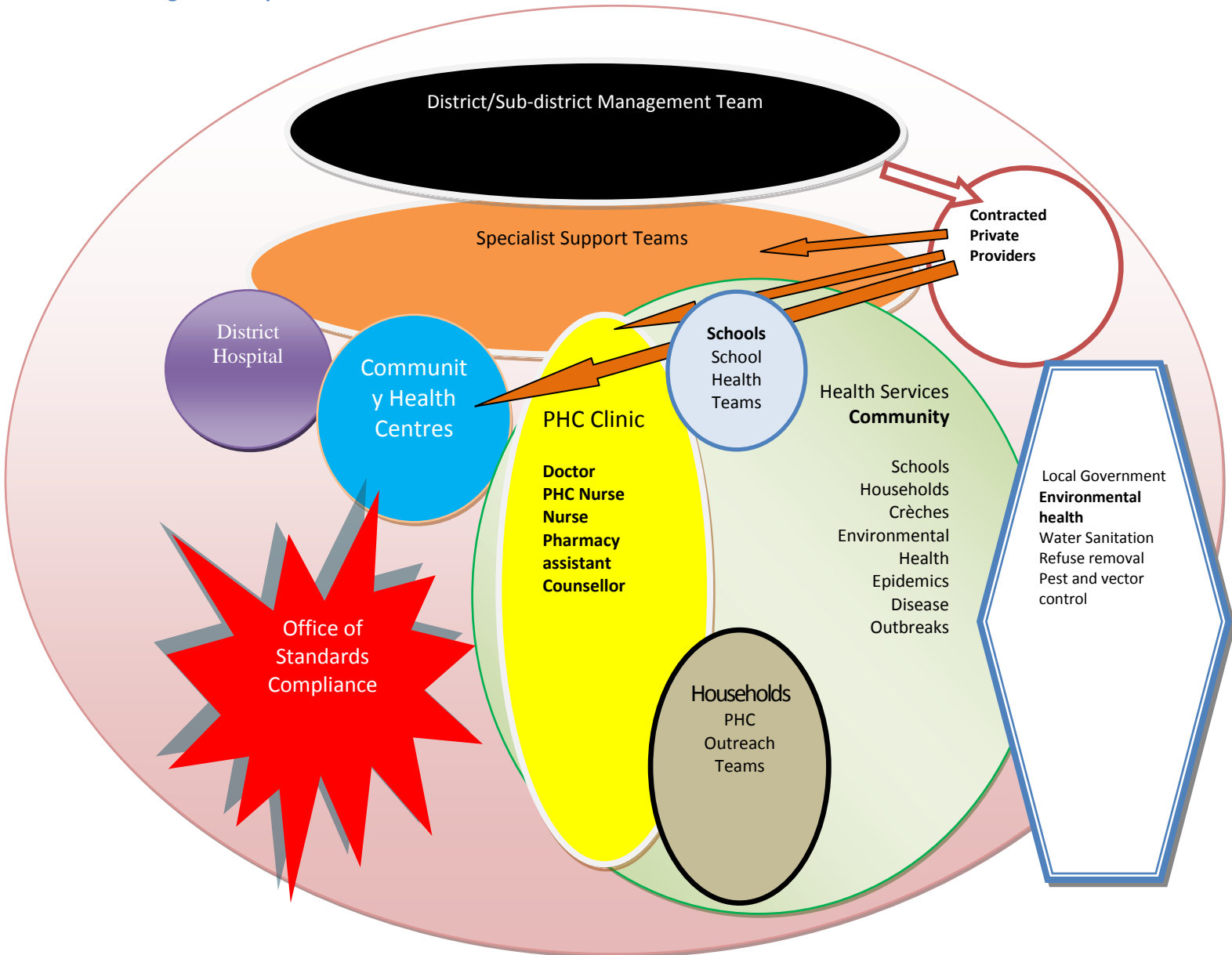
1. Introduction

- 1.1. The National Health Council has mandated that in order to improve health outcomes significant steps be taken to restructure the health system. This is one of the 10 points in the five year Health Sector 10 Point Plan, noted as 'overhauling the healthcare system'. It is also the fourth pillar of the Negotiated Service Delivery Agreement as 'strengthening the effectiveness of the health system'.
- 1.2. In order to learn lessons from other countries the Minister and MECs visited Brazil in 2010 and came back with a vision for the re-engineering of primary health care. 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 (La Forgia, 2009). Upon returning home the Minister established a small team to elaborate a South African model to strengthen primary health care. This team produced the first narrative document and presentation to an extended NHC meeting (Barron et al, 2010).
- 1.3. At the NHC meeting, the basic concept presented was adopted with the caveat that we build a South African model 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 together with guidelines for their implementation.
- 1.4. ***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 DHIS amongst others is 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.
- 1.5. In particular it means DMTs, Sub-DMTs and district hospital CEOs being 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

1.6. The diagrammatic presentation of the district model is shown below

Figure 1 Proposed PHC model



2. Three streams of PHC re-engineering

- 2.1 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. This model was also part of the Minister's budget speech in the National Assembly early this year.
- 2.2 The model contains three streams: (a) a ward based PHC outreach team for each electoral ward; (b) strengthening school health services; and (c) district based clinical specialist teams with an initial focus on improving maternal and child health.

2.1 Ward based PHC outreach teams

- 2.1.1 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 (Sepulveda et al, 2006). The role of community health workers in many countries has contributed to better health outcomes (WHO 2007). So why is it that with South Africa's 72 000 community based health workers (NDOH audit, 2011) at an estimated cost of R2.4b (Schneider) that we are unable to generate better health outcomes?
- 2.1.2 It is suggested that this is the result of a multiplicity of factors related to community based health workers. 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; funded through NGOs with inadequate accountability; limited or no targets for either coverage or quality to be reached (see also HST's report 'Community Health Workers: a brief description of the HST experience' and Lehman and Sanders, 2007 'Community Health Workers: what we know about them') .
- 2.1.3 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.
- 2.1.4 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 catchment population that they are responsible for. 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.
- 2.1.5 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 4-5 community health workers and are expected to serve a population of about 7 660 people. The roles of the PHC outreach team will include (additional details are found in the separate documents dealing with the PHC outreach teams):

- Promoting health
- Preventing ill health
- Providing information and education to communities and households on a range of health and related matters
- Environmental health, especially those aspects impacting directly on households and communities
- Psychosocial support in collaboration with community care givers supported by the Department of Social Development
- Early detection and intervention of health problems and illnesses
- Follow-up and support to persons with health problems including adherence to treatment
- Treatment of minor ailments
- Basic first aid and emergency interventions

2.1.5 Given the key role that CHWs will play, they should, over time be directly managed by the Department of Health (as opposed to NGOs). This has already happened in KZN. However, even as we finalise strategies for direct management by the Department, all districts should audit the number of community based workers in the district, who employs them and what they do, what impact they are making etc. This audit should result in a reorganisation of how community based workers function. Each group should also be linked to a PHC facility with a nurse in each facility, 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 – this approach has been adopted in the Western Cape.

2.1.6 The roles of CHWs (as part of the PHC outreach teams) will include:

- Conduct community, household and individual health assessments and identify health needs and risks (actual and potential) and facilitate the family or an individual to seek the appropriate health service;
- Promote the health of the households and the individuals within these households
- Refer persons for further assessment and testing after performing simple basic screening
- Provide limited, simple health interventions in a household (e.g. basic first aid, oral rehydration and any other basic intervention that she or he is trained to provide)

- Provide psycho-social support and manage interventions such as treatment defaulter tracing and adherence support.

2.1.7 The NDOH is currently finalizing a curriculum for CHW training (and PHC outreach team orientation) and will make available the curriculum and training material by the end of September 2011. The target is to train 5000 CHWs by December 2011. Districts that are ready to deploy the PHC outreach teams should indicate their readiness and identify the teams to be oriented and CHWs to be trained as part of the first batch.

2.1.8 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.

2.1.8 Frequently asked questions and responses:

- Where will the additional professional staff come from?
 - Districts should identify staff that are under-utilised and increase efficiency of existing personnel in PHC and district hospitals; in addition, retired nurses and additional staff should be employed
- Where will the budget come from?
 - Efficiencies in district operations should be the first priority – noting that as community based services are improved, the number of referrals that can be dealt with at this level should decrease the volume of patients (even if increased case finding initially increases the load on facilities); secondly National Treasury has made additional funding for these teams available in the current MTEF
- What do we do about current contracts with NGOs who are employing CHWs?
 - We need to work with these NGOs to firstly improve the efficiency of how they work and how they work with the facility and sub-district management; secondly, we need to inform NGOs that their roles are changing and that over the next two years they will cease to be funded to employ CHWs as this will be done by the DOH, instead they should be funded to do social mobilisation and other community level activities which will complement the work of the PHC outreach teams

2.2 School health services

- 2.2.1 In 2003 the Department of Health 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.
- 2.2.2 Working with the Departments of Basic Education and Social Development, the Department of Health has revised the School Health Policy and implementation guidelines. These will be jointly launched by the Ministers before the end of December 2011.
- 2.2.3 Whilst we would like 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 we focus on schools in quintiles 1 and 2 (the poorest schools) and also prioritise a selected range of services. For example we could prioritise screening of all grades R and grades 1, ensuring that all those that attend ECD and primary school are fully immunized, and that in secondary schools we prioritise strengthening the life skills programme with specific focus on sexual and reproductive health and the reduction of alcohol consumption.
- 2.2.4 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.
- 2.2.5 In order to prepare for this formal launch, all districts should: (a) audit the current school health services (personnel, services offered); (b) plan to expand the services with additional personnel, again considering efficiencies and the redeployment of nurses and hiring retired nurses with the immediate priority of providing a limited range of services, with expansion as resources become available
- 2.2.6 District management must 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. The PHC outreach teams must also investigate home circumstances of children who do not attend school or are failing to thrive upon referral by the school health nurse.

2.3 District based specialist teams

- 2.3.1 Given the unacceptably high infant, child and maternal mortality in most of our 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 and primary health care nurse.
- 2.3.2 A task team has been appointed to develop details around how the team will function but 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.
- 2.3.3 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; that essential equipment is available and that these are correctly used; that mortality review meetings are held, are of good quality and that recommendations from these meetings are implemented; support and supervise and mentor clinicians; and monitor health outcomes.
- 2.3.4 It is envisaged that posts for these teams will be advertised by the end of September 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.
- 2.3.5 District management teams, with provincial support, should begin to audit the specialist support they currently receive as well as its added value. Districts should start planning how to strengthen their current support and plan to expand this support over time, in line with the decisions of the NHC.
- 2.3.6 These teams will work closely with the PHC outreach teams.

3. Monitoring and evaluation

- 3.1 To obtain maximum value from the investments envisaged in implementing the three streams of PHC re-engineering, it is critical that proper systems for monitoring and evaluation are put in place early.
- 3.2 Currently the NDOH is busy designing new recording and reporting systems for CHW teams and school health services with appropriate indicators. These will be available from the beginning of October. The NDOH will develop a small set of indicators for inclusion in the DHIS that will be used

to monitor outcomes and will also develop a set of input and process indicators to complement these for purposes of monitoring and evaluation.

- 3.3 As districts begin to develop 2012/13 District Health Plans, they should ensure that clear thought is given to how current resources will be re-prioritized and what new resources will be required to implement the three streams of PHC re-engineering.

4. Conclusions

- 4.1 The NHC mandates are clear. The health system must be overhauled to produce better health outcomes. The three streams of PHC re-engineering are also clearly defined by the NHC.
- 4.2 All provinces will be supported by the NDOH to implement the three streams.
- 4.3 These guidelines to provinces and districts will be augmented by specific guidelines around the three streams (e.g. detailed guidelines about employment and training of CHWs) as well as guidelines to development and other partners supporting districts. These additional guidelines will be distributed as and when they become available.

4. References

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