Revitalising Primary Health Care in the Eastern Cape

An overview of progress and recommended support programme for Primary Health Care in the Eastern Cape Province

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List of Abbreviations and Acronyms

ANC	African National Congress
CHC	Community Health Centre
CHCOE	Community Health Centre of Excellence
CHH	Community Health Hospital
CHW	Community Health Worker
DFID	UK Department for International Development
DG	Director General
DHER	District Health Expenditure Review
DHIS	District Health Information System
DHS	District Health System
DMT	District Management Teams
DWF	Donald Woods Foundation
ECDoH	Eastern Cape Department of Health
EDI	Electronic Data Interchange
EMS	Emergency Medical Services
FET	Further Education and Training
HIS	Health Information Systems
HOD	Head of Department
HR	Human Resources
HRM & D	Human Resource Management and Development
ICT	Information and Communication Technology
IGR	Intergovernmental Relations
KSD	King Sabata Dalindyebo
LED	Local Economic Development
M&E	Monitoring and Evaluation
MCWH	Maternal, Child and Women's Health
MDG	Millennium Development Goals
MEC	Member of Executive Committee
MTEF	Medium Term Expenditure Framework
NDoH	National Department of Health
NHI	National Health Insurance
NHLS	National Health Laboratory Services
NMBM	Nelson Mandela Bay Municipality
NSDA	National Service Delivery Agreement
PDE	Patient Day Equivalents
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
QA / QI	Quality Assurance / Quality Improvement
RFP	Request for Proposals
r-PHC	Revitalisation of Primary Health Care
STP	Service Transformation Plans
VOIP	Voice over internet protocol
VPN	Virtual Private Network
WHO	World Health Organisation

Executive Summary

This paper provides an overview of the progress with implementation of the new model of primary health care (PHC) in the Eastern Cape Province. This overview was commissioned by the United Kingdom Department for International Development (DFID) with the overall purpose of "...documenting and reviewing the early provincial experience in the revitalisation of primary health care with a view to clarifying the current plans and any early lessons to inform the emerging national policy on PHC re-engineering, and to prepare a proposal for possible NDOH/DFID support."

The research has focussed on providing an overview of the proposed Revitalisation of Primary Health Care (r-PHC) programme and its implementation in 4 sub-districts through a document analysis and interviews with key informants in order to inform the preparation of a proposal for possible National Department of Health (NDOH)/DFID support. It must be noted at the outset that implementation of the Eastern Cape Department of Health (ECDoH) revitalisation of primary health care (r-PHC) programme is at a very early stage, and it is not possible to document lessons learnt.

The report provides an overview of primary health care within the international context, with reference to successful PHC models adopted in developing countries such as Brazil and Cuba. The South African national policy development process and framework is discussed and the Eastern Cape r-PHC is then located within this international and national context. The report highlights the importance of addressing maternal and neonatal health care in pursuit of improved health outcomes. The Eastern Cape r-PHC model responds directly to international good practice and has ensured the realisation of national PHC in its implementation design. In certain regards, the Eastern Cape r-PHC programme goes beyond the requirements of national policy.

Implementation of the r-PHC has been piloted in 4 sites (i.e. the sub-districts of King Sabata Dalindyebo (KSD) in the OR Tambo District, Intsika Yethu in the Chris Hani District, and Uitenhage/Despatch in the Nelson Mandela Metropolitan Municipality, as well as Duncan Village which falls within Buffalo City of the Amathole District). Some progress has been made with implementation in the different pilot areas, mainly around community mobilisation and consultation. Detailed business plans have been developed for each of the pilot areas.

The final section of the report focuses on possible areas of support that can be provided to the r-PHC, impacting in particular on maternal and neonatal health. Such support will enable the objectives of r-PHC to be met and, in doing so, allow the Eastern Cape to move closer to the achievement of the Millennium Development Goals (MDG) targets and contribute significantly to the achievement of Outcome 2 of the Negotiated Service Delivery Agreement (NSDA).

The ECDoH r-PHC, in its comprehensive and innovative design combined with ECDoH's commitment to ensuring its effective implementation, offers development cooperation agencies, health NGOs and other health stakeholders a prime space to collectively contribute to the attainment of the desired health outcomes. The ECDoH have outlined 5 priority areas for r-PHC, these being:

- Efficiency and effectiveness of business systems
- Reengineering of business processes
- Social compact
- Supply chain management reform
- Revenue generation

Potential DFID support to the r-PHC in the Eastern Cape will reduce maternal and neonatal deaths in rural South Africa through the revitalisation of primary health care.

The ***overall objective*** therefore, of the proposed support to the ECDoH r-PHC programme is to contribute to the achievement of the desired health outcomes, particularly for mothers and infants across the Province through the implementation of an effective and comprehensive r-PHC model.

At ***project purpose*** level the support intervention aims to ensure that the ECDoH is enabled to effectively execute the r-PHC in the 4 pilot areas and, in doing so, achieve the desired health outcomes whilst simultaneously identifying and sharing good practices and lessons learnt to inform the design of a replicable model.

In order to achieve the project purposes, four main ***result areas*** have been identified:

- Result 1: Increased access by mothers and infants to primary health care services through PHC outreach approach in four pilot areas
- Result 2: The decentralised District Health System in each of the four pilot areas operates effectively and efficiently
- Result 3: Social compacts are established in each pilot area to achieve optimum participation by communities, and women in particular. This includes awareness of health choices, social determinants of health and inter-sectoral collaboration.
- Result 4: ECDoH officials are enabled to effectively project manage, coordinate and implement improved services to mothers and infants through r-PH programme in four pilot areas.

The focus on maternal and infant health is in line with both the UK and South African government priorities and has been emphasised in particular at provincial level. It has been aligned with the provincial priorities as per the following table.

Eastern Cape Department of Health key priority areas	Potential DFID Support
Efficiency and effectiveness of business systems: *More effective systems include a comprehensive Community Health Worker development programme, appropriate information technology to ensure accurate, accessible patient records and availability of medicines*	**Increased access by mothers and infants to PHC services:** *More effective systems which allow better access by mothers and infants to PHC through comprehensive CHW programme which includes health promotion and education for mothers and newborns, ante natal and postnatal care, immunisation and family planning and the consolidation of health profiles through effective IT systems*
Re-engineering of business processes and supply chain management reform: *The decentralised District Health System in each of the four pilots operates effectively and efficiently through effective referral systems, delegations, appropriate staffing plans and strengthened advisory councils.*	**The decentralised DHS in each of the 4 pilot areas operates effectively and efficiently:** *Efficient patient referral systems, strengthened accountability by health services, appropriate staffing plans, the availability of medicines and effective financial management to ensure that health care is effectively extended to mothers and infants*
Social Compact: *The approach to social compacts is refined and developed to achieve optimal community participation and inter-sectoral collaboration through strengthened capacity of clinic committees, a pilot specific engagement strategy and a broad development strategy for the pilot areas*	**Social compacts are established in each of the pilot areas to achieve optimal participation by communities, women in particular, awareness of health choices and determinants of health and inter-sectoral collaboration:** *Through awareness raising amongst women in pilot communities, improved accountability of health services and the development of specific engagement strategies, women are empowered to make positive choices about their health*
Effective project management, coordination and implementation of the r-PHC in the 4 pilot areas: *Through stakeholder mapping and risk analysis, a coordination strategy, awareness raising, strengthened monitoring and evaluation systems and general technical support the pilot areas are brought to a stage where the system can be replicated*	**The ECDoH officials are enabled to effectively manage, coordinate and implement improved services to mothers and infants through the r-PHC programme in the 4 pilot areas:** *Particular emphasis on effective coordination and of implementing agencies and service providers to promote a coherent and synchronised approach to improving maternal and infant health through PHC approach*

Detailed proposed activities have been set out in Section 7.3 of this report. The proposal for support has been discussed with the ECDoH and various stakeholders in a participatory workshop which was conducted on 7th April. Comments and discussion from the workshop have been included in this proposal.

1. Introduction

Primary Health Care (PHC) has been a core component of South African government health policy since 1994 and is enshrined as the centre piece of the Reconstruction and Development Programme's health policy, which stated that:

> *"The whole National Health System must be driven by the Primary Health Care approach. This emphasises community participation and empowerment, inter-sectoral collaboration and cost-effective care, as well as integration of preventive, promotive, curative and rehabilitation services."*

Implementation of the PHC approach has nevertheless been slow and renewed attention has been focused on this area in terms of the Negotiated Service Delivery Agreement (NSDA) negotiated between the Presidency and the Minister of Health in October 2010. The Health Minister's Performance Management Agreement with the President is based on four priorities, namely:

- Improving Life Expectancy;
- Reducing Maternal Mortality Rates and Child Mortality Rates;
- Combating HIV/AIDS & TB; and
- Enhancing Health Systems Effectiveness.

A key strategy to strengthen the South African health care system is 'Re-engineering' Primary Health Care (PHC).[1] ECDoH has embraced the strategy and termed the phrase 'Revitalisation of Primary Health Care (r-PHC) which indicates both its allegiance to the national strategy and its specific Eastern Cape character. R-PHC is to be implemented in close collaboration with the provincial Departments of Health. Closely aligned to this is a focus on Maternal, Child and Women's Health (MCWH), the foundation of which is a strengthened PHC approach.

The period of greatest risk across the human lifespan is during birth and the first 28 days of life. The risks of maternal mortality and morbidity are also highest at birth and in the immediate post-natal period.[2] A PHC approach that is designed as the foundation of the health system for promoting healthy lifestyles, prevention of disease (including early detection), provision of early and quality ante- and post-natal services as well as essential infant and child health services and nutritional advice has the potential to substantially reduce the high maternal, infant and child mortality rates in the country.[3]

[1] See the National Department of Health Strategic Plan 2010/11-2012/13. This is elaborated further in the Negotiated Service Delivery Agreement (2010); the Ministerial Discussion Document on Re-engineering PHC (November 2010) (Barron, Shasha, Schneider, Naledi and Subedar) and in the Presentation to the Minister and MECs "Re-engineering Primary Health Care for South Africa: Proposed Way Forward." 2 November 2010

[2] Lawn, J (2008) Saving mothers and newborn lives – the crucial first days after birth. http://www.unicef.org/sowc09/docs/SOWC09-Panel-4.4-EN.pdf

[3] NSDA: Delivery Agreement. For Outcome 2: A long and healthy life for all South Africans. http://www.health-e.org.za/documents/3771ccea0610904ff0c3de0f09f21039.pdf

The Eastern Cape Department of Health (ECDOH) has proactively responded to the new policy challenge and initiated the PHC revitalisation process on a pilot basis in four areas. The implementation of the pilots requires health systems in the districts to be reviewed, transformed and aligned with the PHC approach. In doing so, the Province has built on the global experience in transforming health systems to provide comprehensive PHC.

2. International Context

The concept of PHC emerged in the 1970s when ideas about health care began to change, especially in relation to the developing world. Dramatic health improvements were noted in countries such as China with its community-based health care initiatives. It is now 33 years since the signing of the Alma Ata Declaration and the initiation of the World Health Organisation's (WHO) programme to promote PHC internationally.

PHC is a comprehensive, community based and decentralised approach to health which seeks to promote and improve health by locating it within a broader community development approach. It is informed by social justice and is structured around five basic principles[4]:

- universal accessibility and coverage based on needs;
- comprehensive health care with an emphasis on prevention and health promotion (but including curative and rehabilitative services);
- community participation and self-reliance;
- intersectoral collaboration to address the social determinants of health; and
- appropriate and cost-effective technology.

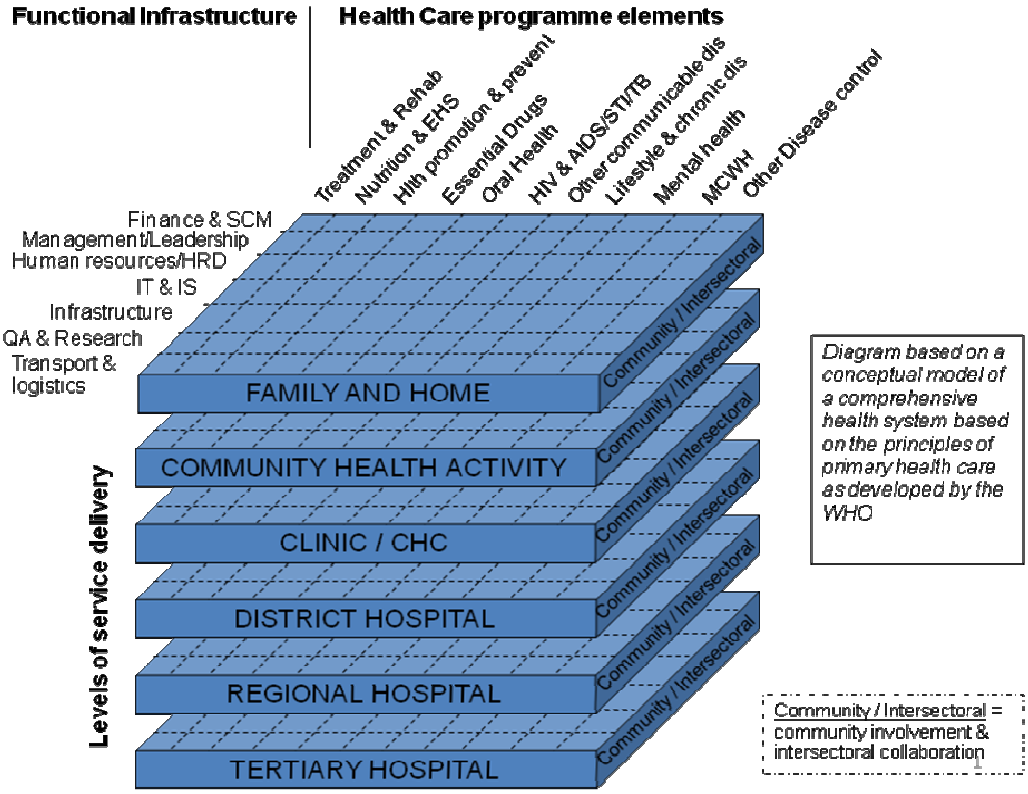
PHC recognises the necessity of reducing health inequities and the importance of addressing the underlying social, economic and political causes of poor health. It moves away from a focus on medical services towards health as a "state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity."[5]

A PHC approach therefore builds on changes not only in the health sector but also the linked areas of social and economic development. This requires integration of health systems reform with community development and poverty eradication strategies.

[4] World Health Organisation Declaration of Alma Ata 1978

[5] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946.

Figure 1: WHO model of comprehensive health system



PHC provides the building blocks of a comprehensive approach to health care which envisages different levels, each integrating different health care programme elements, which are in turn supported by various functional infrastructure components. This is depicted in the WHO "Cube" above, which indicates the interwoven nature of community participation and inter-sectoral collaboration at every level of the health service.

Eight basic programme elements comprise the Alma Ata Declaration. One such element is maternal and child health care (including family planning).[6] This is included in the WHO "Cube" above as Maternal, Child and Women's Health (MCWH). Maternal and child health is intrinsic to PHC and continues to dominate global health issues. This emphasis on maternal and child health recognises the crucial role that women and children play in development and in building stable, peaceful and productive societies.[7] Investing in the health of women has important consequences:

- It reduces poverty. Healthy women work more productively and stand to earn more throughout their lives.

[6] World Health Organisation Declaration of Alma Ata 1978

[7] UN Global Strategy for Women's and Children's Health. http://www.who.int/pmnch/topics/maternal/20100914_gswch_en.pdf

- It stimulates economic productivity and growth. Maternal and newborn deaths decrease economic growth and lead to productivity losses.
- It is cost effective. Essential health care prevents illness and disability and saves on treatment. Childhood immunisation can provide a child with a year of life free from disability.
- It helps women and children realise their fundamental human rights.[8]

Implementation of PHC requires an empowered public sector which in turn requires strengthening the core functions of government and public institutions, particularly in relation to "policy coherence, participatory governance, planning, regulation development and enforcement and standard setting".[9] The PHC approach brings greater efficiency to health services by dealing with needs at the appropriate level: with health promotion at the community level; basic health requirements attended to at local community-based clinics; more complex cases referred to community hospitals; and the most complex cases requiring specialist care treated at hospitals.

Implementation of the PHC approach introduces considerable management challenges to the public health sector: "the re-distribution of existing resources (financial, material and human) for health; a reorientation and broadening of the skills of health personnel to enable them to respond to the challenges of implementing PHC, and to work in teams as well as with other sector professionals and communities; and improved design, planning and management of the health system to facilitate greater community involvement, intersectoral collaboration and decentralisation."[10]

Complementing the PHC approach internationally is the Partnership for Maternal, Newborn and Child Health. Established in 2010, WHO and the United Nations launched this global partnership strategy to promote women's and children's health. Its core strategy, relevant to PHC, includes the following:

- Integrated delivery of health services and life-saving interventions – so women and their children can access prevention, treatment and care wherever needed.
- Stronger health systems with sufficient health workers at their core.
- Innovative approaches to financing, productive development and efficient delivery of health care
- Improved monitoring and evaluation to ensure accountability of all role players for results.
- Support for country-led health plans through increased, predictable and sustainable investment.[11]

More specifically there is growing recognition internationally of the importance of providing care to mothers and newborns. Important data from Bangladesh show that a home visit on the first or second

[8] UN Global Strategy for Women's and Children's Health. http://www.who.int/pmnch/topics/maternal/20100914_gswch_en.pdf

[9] Commission on Social Determinants of Health. Closing the Gap in a Generation: health equity through action on social determinants of health. Final Report. Geneva: World Health Organisation. 2008.

[10] Schaay, N & Sanders, D: International Perspective of Primary Health Care Over the Past 30 Years.

[11] UN Global Strategy for Women's and Children's Health. http://www.who.int/pmnch/topics/maternal/20100914_gswch_en.pdf

day after birth can reduce neonatal deaths by two-thirds.[12] Thus UNICEF is promoting the integration of post-natal care for mothers and newborns rather than separate approaches to post-partum and newborn care; the provision of routine post-natal visits at home or close to home to promote healthy behaviour and link with curative care; and early contact, ideally within 24 hours of delivery and at most within 48 hours for the first visit.[13] In order to achieve this, services need to be scaled up to ensure high coverage and quality care during this period.

Lawn (2008) argued that "many of the tasks involved in the post-natal care can be delegated to an extension worker who is adequately supervised and effectively linked with the health system."[14] Extension workers – known as community health workers[15] in South Africa, provide the backbone to the PHC approach.

Another important component of PHC is School Health Promotion. WHO acknowledges that an effective school health programme "can be one of the most cost effective investments a nation can make to simultaneously improve education and health".[16] WHO therefore promotes school health programmes as a strategic means to prevent health risks among youth and to engage the education sector in efforts to change the educational, social, economic and political conditions that affect risk.

Examples from around the world have shown how health outcomes have been dramatically improved with the implementation of PHC. Brazil has implemented a relatively simple model which has produced significant health gains, as described in box 1 below.

Box 1: Brazil's *Sistemia Unico de Saude (SUS or Unified Health System)*

In 1996 Brazil established a health system based on decentralised universal access. The key strategy for *SUS* is the Family Health Programme. It is based on a simple model with a network of multidisciplinary teams. These comprise a doctor, nurse, nurse auxiliary and four to six community health workers who work in geographically defined health areas which cover no more than 5 000 residents. A community health worker is responsible for up to 120 families and provides home visits to each family at least once a month. The community health workers, who live in the areas in which they work, are fully integrated into the health team. Whilst child and maternal health provides the core of their work, they also provide curative care, triage and referral to the health unit, health promotion for chronic disease, and support community participation.

BMJ November 2010 reports: "Brazil's Family Health Programme is probably the most impressive example worldwide of a rapidly scaled up, cost-effective, comprehensive primary health care system" (BMJ 2010[17]). Over

[12] Lawn, J (2008) Saving mothers and newborn lives – the crucial first days after birth. http://www.unicef.org/sowc09/docs/SOWC09-Panel-4.4-EN.pdf

[13] Ibid

[14] Ibid

[15] The ECDoH now refer to the cadre of community health practitioners including community health workers, doctors and nurses as Community Health Practitioners

[16] WHO (2011) School and Youth Health. http://www.who.int/school_youth_health/en/

[17] Harris, M. & Haines, A. November 2010. *Brazil's Family Health Programme.* BMJ 2010:341:c4945

the past fifteen years, infant mortality has dropped from 48 per 1000 to 17 per 1000; the proportion of underweight children has fallen by 67%[18]; and WHO reports that life expectancy for males is at 68 years and for females 75 at years.[19] Brazil has also achieved its Millennium Development Goal (MDG) targets.

Another success is the Cuban model, outlined in box 2, which decentralises services to community level, ensuring access, and emphasising promotion and prevention.

***Box 2: Primary Health Care in Cuba*:**
Community-based '*consultorios*' (clinics) are at the centre of the health system in Cuba. Family-doctor-and-nurse services are provided for about 150 families in a defined geographic area around the '*consultorio.*' The family doctor and nurse are integrated into the community and address approximately 80% of the health problems, with an emphasis on health promotion. The secondary '*policlinicos'* act as the organisational hub for 30 to 40 '*consultarios'*. '*Policlinicos'* consist of multi-disciplinary teams and offer specialised care. The results of Cuba's PHC programme have been impressive, and its health indicators demonstrate this: Cubans have one of the world's highest life expectancies of 77 years with seven deaths for every 1 000 children aged less than five years in 2004.[20]

These two country examples demonstrate that for developing countries with limited resources, PHC has the potential to dramatically improve health outcomes.[21] These models can be replicated successfully in South Africa, which has the economic resources and institutional capacity to do so.

In 2008, an international review of the status of PHC was conducted by WHO, which reaffirmed PHC as the essential approach to the improvement of global health. The message from the World Health Report was unequivocal: "Now more than ever, there are opportunities to start changing health systems towards primary health care in all countries."[22] The WHO Report cited examples from countries where PHC has been successfully implemented, indicating that significant improvements have been made in reducing the burden of disease and improving morbidity and mortality. It concluded that much more needed to be done since too many countries still showed woefully poor health outcomes, with health systems having evolved into a "patchwork of components,"[23] and vast resources still being spent on curative services.

[18] Ibid
[19] WHO Country reports: Brazil. http://www.who.int/bra/en
[20] WHO: Bulletin of the World Health Organisation: Cuba's Primary Health Care Revolution: 30 Years on. http://www.who.int/bulletin/volumes/86/5/08-030508/en/index.html
[21] A number of o PHC success stories can be identified in Africa as well. Rwanda, for example, has embarked on national wide e-Health programme and the Rwandan Ministry of Health has expressed willingness to share information on their experience.
[22] A Summary of the 2008 World Health Report: Primary Health Care: Now More Than Ever. http://who.int/whr/2008/summary.pdf
[23] Summary of 2008 World Health Report: "Primary Health Care: Now more than Ever." http://who.int/whr/2008/summary.pdf

3. South African National Policy Approach

South Africa subscribes to the United Nations Millennium Development Goals (MDGs), the attainment of which is integral to better health outcomes. MDG 4 focuses on the reduction of the Child Mortality Rate (CMR) with a target of 20 deaths per 1 000 live births. MDG 5 focuses on maternal health with the target of decreasing the Maternal Mortality Ratio (MMR) to 100 or less per 100 000 live births. The most recent MDG Country report for South Africa indicates that South Africa is not on track to meet these goals. Latest MDG country estimates report CMR at 104 per 100 000 and MMR at 625 per 100 000 - this despite the fact that South Africa spends 8.7 % of its GDP on health. This is a relatively high investment, more than any other country in Africa. Despite this, health outcomes are poor, indicating serious inefficiencies and institutional challenges within the health system. The South African government has acknowledged that these outcomes are unacceptable and that the situation needs to be addressed urgently.

PHC has guided the policy framework for the South African Health system. The African National Congress' (ANC) ***National Health Plan (1994)*** is clear in its pursuance of Primary Health Care: "Primary Health Care will form an integral part, both of the community's health system, and the overall social and economic development of the community."[24] Also included in the National Health Plan as one of the principle priority programmes is Maternal, Child and Women's Health. The revitalisation of PHC and its priority programmes were re-emphasised in the ***Polokwane Health Resolutions (2008)*** calling for the democratisation of health services to meet the needs of communities, intersectoral collaboration, a social compact, and implementation of national health insurance amongst others.

PHC is clearly elaborated in the ***White Paper on the Transformation of the Health System in South Africa (April 1997)*** which provides the foundation for re-organising the health system towards PHC and the decentralised district health system to facilitate its implementation. It also provides for restructuring the health system to give priority to Maternal, Child and Women's Health, ensuring that MCWH services are integrated into the PHC package. Chapter 5 of ***The National Health Act*** provides for the establishment of the district health system. District Health Authorities are "the main bodies responsible for ensuring access to and the delivery of health services" and "responsible for all primary health care services in its district, including independent general practitioners and community hospitals".[25]

In line with recent efforts to overhaul the health services, the need to revitalise and re-engineer PHC has been reinforced by a number of more recent national initiatives:

- The ***National Department of Health (NDOH) Strategic Plan 2010/11 – 2012/13*** is based on the Department of Health's 10-Point Plan (2009 -2014) which is aimed at creating a well-functioning health system capable of improved health outcomes. The Minister of Health, Minister Motsoaledi, has stated that "...successful implementation of these priorities... necessitates that

[24] National Health Plan, African National Congress, 1994.
[25] African National Congress, "The Reconstruction and Development Programme - A Policy Framework", 1994

we revitalise the health system using the Primary Health Care (PHC) approach."[26] A key activity within the 10 Point Plan is the strengthening of programmes focussing on Maternal, Child and Women's Health.

- The introduction of the ***National Health Insurance (NHI)*** aims to ensure universal coverage, in particular, access for the poor and vulnerable groups to quality health care. This will reduce inequities in health care financing and strengthen the public health care system by increasing revenue available to it. The NHI has profound implications for restructuring of the health system and its success will depend on the foundation laid through primary health care.

- The ***Negotiated Service Delivery Agreement (NDSA***) of October 2010 between the Minister of Health and the President contains revitalisation of PHC as one of the key outputs to Outcome 2: A Long and Healthy Life for all South Africans. "Re-engineering the health system to one that is based on a PHC approach, with emphasis on promotive and preventive health care will underlie all interventions to achieve outputs."[27] Decreasing maternal and child mortality is an important output which will be tackled through implementation of a PHC approach.[28]

- The ***Service Transformation Plans*** (STP) 2010-2025 set out long-term plans for the health sector, outlining plans to achieve vision for improving service delivery and health outcomes. STPS at provincial level provide for the service delivery plan, platform and costing for infrastructure, as well as for plans related to human resources (HR), quality improvement, drug supply, information and communication technology (ICT) and health information systems (HIS), communication, research and development and health financing. STPs are to be aligned with the NDoH's 10 Point Plan.

The call to revitalise PHC was given added impetus after a Ministerial and Members of Provincial Executive Committees (MEC) visit to Brazil in 2010. Following the visit, the Minister of Health established a task team to produce a strategy for re-engineering PHC in South Africa. The resultant ***Discussion Document*** has been approved by the Minister and MECs for Health as the basis for the implementation of PHC in SA.

The Discussion Document recognises that much has been done to implement PHC and address the burden of disease but argues that it is not sufficient. Comprehensive services need to be taken to communities with an emphasis on disease prevention, health promotion and community participation. It argues for a population based approach, focused on the improvement and measurement of health outcomes. The main components of the PHC approach, as set out in the discussion document, are:

[26] NDoH. 2010. National Department of Health Strategic Plan 2010/11 – 2012/13.
[27] NSDA. Delivery Agreement. For Outcome 2: A Long and Healthy Life for All South Africans.
[28] NSDA. Delivery Agreement. For Outcome 2: A Long and Healthy Life for All South Africans

- A '***PHC Package'*** is defined which provides for community based services; emphasis is on prevention and promotion services; additional services for HIV and school health services amongst others. An Integrated School Health Programme is currently being developed aimed at addressing the health needs of learners that contributes to their survival, growth and development.[29] Community based services are provided through PHC outreach teams, CHWs and mobilising communities.

- There is a clear ***Referral System*** to ensure a continuum of care and ***Integration of Services*** so that families and individuals are treated holistically.
- The PHC network and supporting Community Health Clinics (CHCs) and District Hospitals are coordinated through the ***decentralised District Health System (DHS),*** which is given effect through implementation of Chapter 5 of the National Health Act: "Do the basics better."[30]

- The social and economic determinants of health are addressed through ***outreach teams and intersectoral collaboration.***

- ***Quality Improvement and clinical governance*** are reinforced through ***leadership and teamwork*** which are regarded as the most important factors to successfully implement r-PHC.

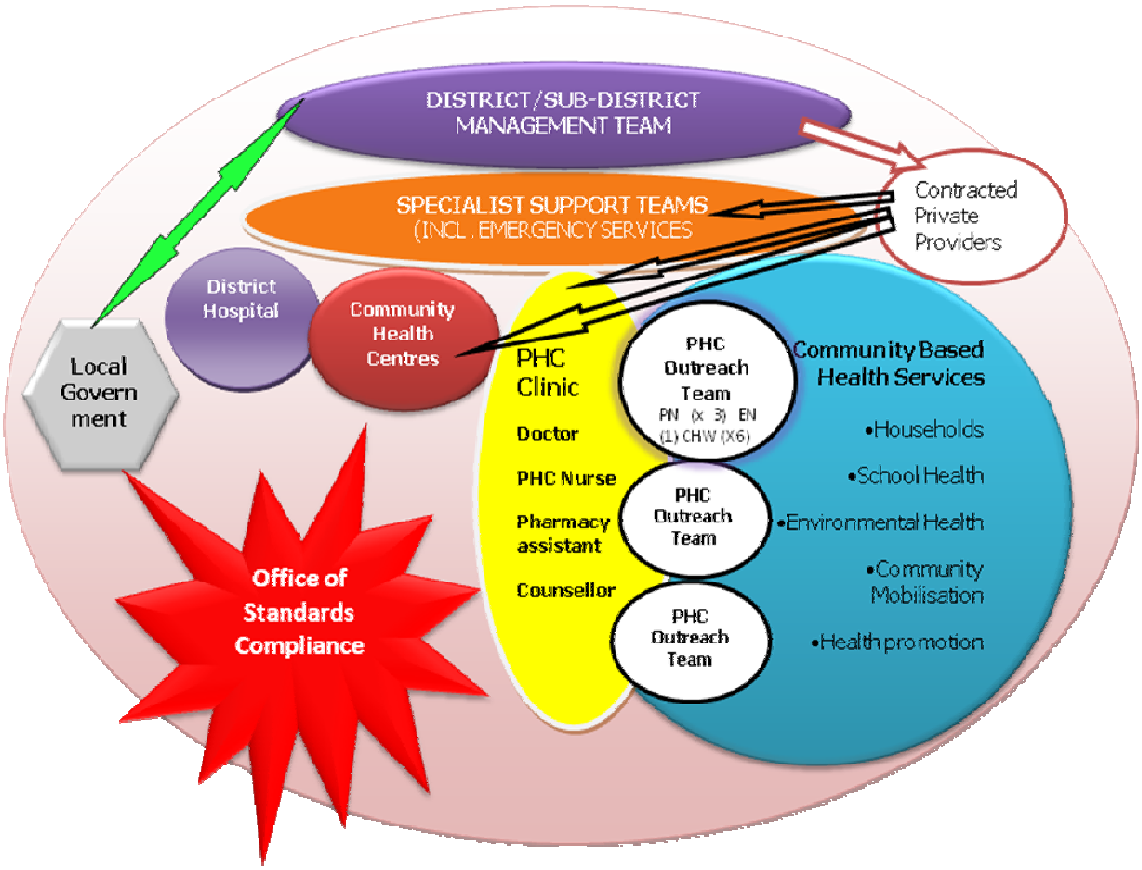
Importantly, the DHS is seen as the vehicle for the implementation of PHC. By decentralising health care to the district, the multi-sectoral elements of PHC can be better coordinated. To achieve this, the DHS needs to be strengthened, basic services better implemented and the District Management Team "...needs to be given the responsibility and consequent accountability for managing the district and being responsible for the health of the population".[31] This model is illustrated in the following diagram:

[29] NDoH: Concept Document: The Integrated School Health Programme. 2011.

[30] Barron P, Shasha W, Schneider H, Naledi T and Subedar H: Re-engineering Primary Health Care in South Africa. A Discussion Document. November 2010.

[31] ibid.

Figure 2: Model of District Health Services headed District Management Team[32]



Each clinic will support outreach teams who will be responsible for 1,500 households, the equivalent of 6,000 people. A clinic will be responsible for 10,000 people in rural areas and 24,000 in urban areas. Operational responsibility rests with the District Management Team (DMT), which is responsible for the funds, budgeting and financial management.

The process of decentralisation is combined with a more proactive approach to extension of health services: "...reaching out to families with an emphasis on keeping them well through health promotion and preventive activities."[33] This has strong synergy with the Brazilian Family Health Programme. It emphasises reaching communities and families, early identification of individuals who are at risk, greater community interaction encouraging more self-reliance and "most importantly amongst health workers - much more of a team approach to health care."

[32] This is a revised diagram and differs slightly to the one which appears in the Discussion Document. The main changes related to the inclusion of the newly formed Office of Health Standards Compliance and the composition of the core PHC clinic teams. Barron P sent via email.
[33] Barron P et al, 2010 *op cit.*

Outreach Teams are to be assembled to penetrate the community and will facilitate community participation in health. Each team is to be led by a Professional Nurse, supported by two staff nurses. Staff nurses will be responsible to support and supervise the work of six CHWs.

Pivotal to the model is the inclusion of community based CHWs who comprise the central element of revitalised PHC. They serve to shift the emphasis of health care to a systematic, bottom-up and comprehensive approach to households – promoting health and advocating for disease prevention.[34] A two-tiered system for CHWs is envisaged: some will become fully-fledged CHWs in terms of the model and others will become home-based carers doing less skilled work such as washing, cooking and looking after wounds.[35]

Integral to the PHC Package are MCWH Health Services. Key interventions which dovetail with r-PHC include the following:

- increasing access to health facilities;
- increasing the percentage of women who book for antenatal care before 20 weeks;
- increasing the percentage of mothers and babies who receive post-natal care within 3 days; and
- increasing the percentage of maternity care facilities.[36]

Specific goals include improving ante-natal care; reducing the number of children who are born with HIV and improving delivery care.[37] Appendix 3 sets out the recommended PHC Package of Care related specifically to pregnant women, newborns, women and children. Health workers will initiate HIV counselling and testing in ante-natal care. These services will be geared towards early identification of problems. Where appropriate, Prevention of Mother-to-Child Transmission (PMTCT) prophylaxis will start at 14 weeks gestation, and the directive for qualifying women who have access to treatment, care and support within 2 weeks of diagnosis will be monitored.

The referral system for pregnant women, newborns and children with high risk conditions will be reviewed and strengthened to eliminate delays. Health care workers will be trained in the use and care of essential equipment to support a regime of quality care provision. An ambulance for emergency maternity and child cases will be available to avoid delays in accessing medical attention (a common cause of maternal mortality). All maternity and neonatal facilities will have infection control in place, with regular training to ensure best practice is implemented. Facilities will be supported to ensure that

[34] CHW will spend 80 – 90% of their time in the community, deployed at household level providing services such as screening; assessment and referral; information and education; psycho-social support and basic home treatment. Full time employment with DoH is being advocated although the inclusion of CHWs within NGOs provides a cheaper option – and is also being explored. There are issues still to be addressed such as CHW training: standardisation of their basic training; agreement on appropriate competencies; and the most appropriate institutional environment for training. These will need to be resolved.

[35] Peter Barron amendment to original document

[36] National Service Delivery Agreement. Output 2: Decreasing Maternal and Child Mortality

[37] Indicators and service components for maternal and child health. Component of the NDoH Package of PHC.

effective actions are taken to avoid mortality. CHWs will visit the mother and baby and assist in promoting appropriate feeding and prevention of neonatal sepsis.

Also included in the PHC Package is the Integrated School Health Programme. The programme focuses on learner coverage, common barriers to learning and the social well-being of the learner. A school health team led by a dedicated professional nurse will implement the programme. Health assessments, screening and health promotion will form the basis of the school health programme. The programme provides a package of services for primary and high schools.

Implementing the revitalised PHC model is the key challenge, especially in the light of previous non-implementation of otherwise good policy proposals. There is a need for clear communication among health workers and local communities to market r-PHC. Recommendations on implementation also include the provision of high level support teams to the provinces to combine with provincial staff. These teams would assist and support the work of the District Management Team. Review of PHC programme is to be institutionalised at the highest level, led by the Director General (DG) at NDoH and Heads of Department (HODs) in the provinces.

4. The Eastern Cape Primary Health Care model

4.1 Overall approach

In light of the national re-engineering of PHC, the pilot implementation work being undertaken by the Eastern Cape Department of Health (ECDoH) assumes particular significance. ECDoH is implementing a new PHC approach in four pilot areas across the province, known as the **revitalisation of PHC (r-PHC)** programme. In broad terms, the ECDOH model corresponds with emerging national policy and development of the pilots has happened in parallel with the national policy process. ECDoH has, in certain areas, aimed to "improve" on national policy and to this end there are certain differences in the interpretation and implementation of policy at Provincial level. In addition ECDoH has been promoting a programme "Saving Mothers, Saving Babies" in an attempt to address its maternal and child mortality rates.[38] [39] [40]

As with the situation at the national level, the starting point has been the recognition by ECDoH that the province faces serious health challenges, which are wide ranging. It is generally accepted that the province has some of the worst health indices in the country.[41] The province has disproportionately high levels of poverty and unemployment, especially in rural areas.

[38] ECDoH Charter 3: Saving Mothers, Saving Babies

[39] Saving Mothers, Saving Babies Project Presentation March 2011

[40] Annual Performance Plan: 2009/10 – 2011/12. Saving Mothers, Saving Babies.

[41] South African Health Review (2010) quotes child mortality rate at 85,5 per 1 000 live births and life expectancy at 49,9 for females and 46,4 for males for the Eastern Cape – both well below the national average and far below the MDG targets.

Health in the Eastern Cape, as in other provinces, is generally underfunded relative to heath needs. In 2010 the ECDoH had a budget deficit of R1.3 billion, which in turn causes significant challenges such as continued inequity in access to health care, inadequate building infrastructure, limited medical equipment and ICT updates, and reduced staff morale. [42]

The Eastern Cape Provincial Government has identified the improvement of the province's health profile as one of its eight strategic priorities, indicating a high level of political commitment to address health challenges. The revitalisation of PHC is seen as crucial to transforming health in the province. The province acknowledges that its greatest challenge is to sustain reforms in service delivery. The ECDoH's Mission statement indicates the centrality of PHC to their strategy:

> *"To provide and ensure comprehensive integrated services in the Eastern Cape emphasising the primary health care approach, utilising and developing all resources to enable its present and future generations to enjoy health and quality of life."*

In line with the National Service Transformation Plan Framework,[43] the Eastern Cape has developed 18 general principles[44] which inform its work. The principles address optimal service delivery, equity, accessibility and accountability, amongst others. These principles further reinforce PHC as the fundamental approach to service delivery to be implemented through the District Health System.

The Department has located its work on PHC within a broader Public Sector Plan[45] to address service delivery and has, in turn, identified ***five priority areas*** to contribute to improved service delivery through a comprehensive and consolidated PHC approach.[46] The five priority areas for the r-PHC programme are set out below.

i. The creation of ***Social Compacts*** is fundamental to r-PHC. This includes the mobilisation of communities, increasing CHW capacity, addressing social determinants of health, and emphasising the centrality of the clinic and community health centres as pivotal to the health system.

[42] The Eastern Cape has however faced additional challenges because of corruption and financial mismanagement resulting in a significant portion of the budget being squandered. Under the leadership of the current Superintendant General a focussed and effective effort is being made to address these issues.
[43] Service Transformation Plan: Outline of the Service Transformation Plans for 2010 -2025. Strategic Planning Cluster, NDoH. March 2006, Updated November 2009.
[44] The comprehensive list is contained in Appendix 1.
[45] Public Sector Plan listed in Presentation: Preparing for the NHI.
[46] Five key areas are listed in the Presentation – *Preparing for the NHI.* Six key areas are described in the Presentation to the PEC Legotla: Transforming Health System in the Eastern Cape Province (MEC Gqobana). Dr Kotze clarified five key areas for Eastern Cape.

ii. ***Re-engineer business processes*** and build high efficiency levels. PHC is the driver for the re-engineering process. Business processes are being reorganised for the introduction of the NHI. Coordination and oversight of the process are placed at the highest level within the Department.

iii. ***Reform the Supply Chain Management*** by building in elements of transparency and efficiency, and align it with PHC. A pre-accredited central database of suppliers is being established and a second bid system will be instituted to maximise cost efficiency. Procurement is to be decentralised to district and sub-district levels and will seek to maximise local job creation through local procurement policies. This will promote local economic development and allow communities to benefit from the provision of ancillary health services.

iv. ***Increase efficiency and effectiveness*** *through d*ecentralisation, while at the same time strengthening M&E and central coordination. All systems are being reviewed to ensure value for money and optimum functioning of available systems. Continuous training, good Health Information Systems and Electronic Data Interchange (EDI) and compliant billing systems are to be brought in. Performance Management Systems and related Human Resources Management and Development systems are being strengthened.

v. ***Income Generation*** in identified facilities to increase the attraction and retention of revenue related directly to the proposed financing of health services through the NHI. Its purpose is to increase revenue and build a nucleus of facilities towards readiness for NHI policy implementation.

4.2 Service delivery model

The Service Transformation Plan (STP) elaborates a Service Delivery Model for the Province which is informed by the burden of disease, the expected demand for services and the inputs required to meet the demands.[47]

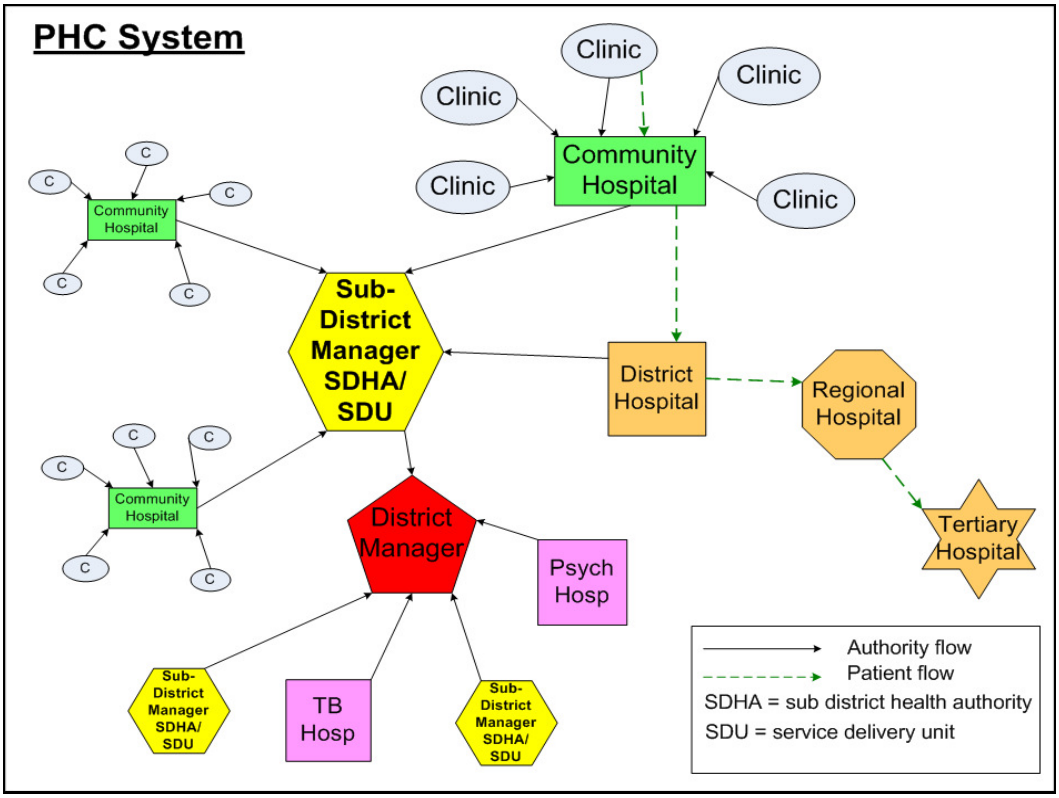
The ***foundation*** of the system is community health services in which services are taken to communities in their homes. This is provided by ***community health workers***, and includes health promotion, health prevention, and health education. The CHWs are the link between the household and the community clinic. It is recognised that there is a confusing multiplicity of types of CHWs at present, and the ECDoH is combining these into a consolidated CHW job description which provides an integrated community service. Structured household visits will serve to identify households and individuals at risk, assess the

[47] The Service Delivery Model highlights the following:
a) The vision of PHC delivered through the District Health System (DHS).
b) Service packages of care to be delivered at each level of care, as well as community based services.
c) Strategies for improving access to services.
d) Organisation and integration of health programmes.
e) Envisaged health outcomes.
f) Modernisation of Tertiary Services.

need for services and facilitate access to health and social services. This will be of particular relevance to women, newborns and children.

The next level within the PHC system is the ***community clinic***, which provides a comprehensive PHC package including screening, antenatal care, delivery care, postnatal care, PMTCT, immunisation, growth monitoring, IMCI, family planning, screening for cervical cancer, and treatment for minor ailments. ECDoH has adopted the PHC package for clinics as set out by the National Department of Health. Doctors visit the clinics on a regular rotation basis. This clinic system is augmented by specialist clinics, dealing with diabetes, hypertension, asthma, epilepsy, HIV and TB and other chronic ailments, with support services such as emergency patient transport, blood, drugs and auxiliary services.

Figure 3: ECDoH PHC service delivery model[48]



The next level of care is the ***community health centre*** (referred to by ECDoH as ***community health hospitals***), which ensures diagnosis and treatment for all referred patients. The community health centre (CHC) is a 15-bed 24-hour facility with red theatre, ultrasound, X-ray, telemedicine and National Health Laboratory Service (NHLS), staffed by at least 4 doctors and allied professionals. Each CHC is ideally linked to about 10 community clinics, and is responsible for referrals from these clinics. Again, ECDoH has adopted the NDOH PHC package for CHCs. Services include delivery care, family planning

[48] Note: ECDoH uses the term "community hospital" in the model for the community health centre.

(male and female sterilisation, infertility and genetic counselling), termination of pregnancy and adolescent health initiatives. A large proportion of the province's doctors will be permanently based at the CHCs. Telemedicine and e-health will be utilised to enhance the delivery of health services.
The district hospitals are referral centres servicing the CHCs within the district, and therefore will function in an integrated way with the clinics and CHCs. The primary service delivery unit is at a sub-district level, and the sub-district manager coordinates and manages the CHWs and clinics within the sub-district. The sub-district manager is expected to have the necessary training and experience within in the health system and is responsible for coordination and management.

The population to be served by each level of institution, and the maximum distances and travel time to each facility, are set out in the "***Optimum distribution model***" for the province. This is summarised in the following table.

Table 1: Optimum distribution model

Level of Care	Maximum Travel Time	Minimum population	Distance from patient	Distance from Facility
Clinic	30 min	8 000	5 km	10 km
Community Health Centre	2 hours	43 000	15 km	30 km
District hospital	1 hour	300 000	50 km	100 km
Regional hospital	2 hours	1 400 000	100 km	200 km
Tertiary hospital	3 hours	2 200 000	150 km	300 km

ECDoH also uses an "***efficiency model***" in its planning, which is based on 90% of the population within 5 kms of a PHC facility, 6 clinics per CHC and 6 CHC per District hospital with different figures for rural and urban areas. (Rural: 1 Clinic per 10,000 population and 1 CHC per 60,000 population / Urban: 1 Clinic per 24,000 population and 1 CHC per 144,000 population).

The two models – optimal distribution and efficiency models - will provide different answers for the distribution of facilities. The province will compare them and decide upon a level that is equitable, sustainable and as efficient as possible. This requires choices to be made about the degree of concentration of resources and the extent to which services can be delivered through outreach. The output of the full plan will therefore be an option appraisal, leading to a preferred scenario which describes a service delivery proposal with full package of services from core facilities and maximum availability of medical skills at lower levels of care.

Clear referral systems have been developed between these levels of care. The first line of treatment is the clinic, which refers patients to the CHC, and thereafter the district, regional and tertiary hospitals for increasingly specialised forms of treatment. This will substantially reduce the case load on district hospitals and allow a much greater focus on in-patient care. Referrals from the CHC must be minimised and patients sent back to the CHC as soon as possible. Referral and admission protocols also provide for

direct referral to higher levels within the health system where cases clearly warrant more specialised treatment.

4.3 Human Resources for PHC

In line with the national policy approach, Outreach Teams are the main mechanism for reaching out to the community, and providing household level services. While each team is headed by a Professional Nurse, the CHWs are the essential building block of the system. CHWs allow for a systematic, bottom-up and comprehensive approach to household health services, including health promotion and prevention of disease. In particular, they can provide the necessary support and care in the post natal period to mothers and newborns. The ratios of CHWs to population, PHC team and clinic are set out in the table below.

Table 2: PHC Outreach Team ratios

Ratio of CHW/PHC Outreach Team/Clinic to Households/Population		
	Households	**Population**
1 CHW	250	1000
1 PHC Team	1500	6000
1 Clinic	4500	18000

The current 6,500 CHWs who are on stipend are to be up-scaled to become fully accredited and professional CHWs. Some issues related to CHWs still need to be addressed and include: details of training; scope of practice; reporting lines to community and clinic; toolkits; and referral and admission protocols. These are currently being addressed by ECDoH. Professional nurses are also an integral component of the PHC outreach team but a challenge is that many professional nurses don't have PHC training and a plan to bridge this gap is being developed.

The central role of the sub-district health services manager, who heads up the sub-district health authority, is another change. The sub-district manager will be a key figure in the delivery of services and will be given added responsibility for management of the sub-district. The sub-district health services manager will need to have the necessary training in health or public health, financial management, HR management, general management and infrastructure management, and should have experience working within the district health system.

Staffing the new PHC system will be a major challenge for the province. ECDoH reports that the current vacancy rate is 56.38% (down 2.3% from 58.41 in April 2009). The high vacancy rate for medical, clinical support and rehabilitation services is of real concern to the Department. To fill remaining posts requires

R8 billion, which is not possible within MTEF allocations. The Department however, has been allocated R127 million for the appointment of new staff.[49]

Re-engineering PHC will require appropriate and strong leadership. ECDoH will focus attention on strengthening the District Management Team by providing the required support, resources and delegations. All managers in the district management team will have their skills and competencies assessed and if found to be deficient appropriate action in terms of the provinces HR policies will be taken.

4.4 Support services

Medicine and surgical supplies are a critical component of service delivery, and continuous availability is essential. Previous strategies to provide this service encountered problems. A robust Management and Control System has been established which has capabilities such as optimal security and accuracy of medicine quantities; tracking of demand stock; ability to store; batch numbers and expiry dates; and interface with Electronic Medical Patient Records. A Request for Proposals (RFP) will be issued for service providers to provide best cost Pharmaceutical Benefit Management, and an Information and Communication solution to manage chronic drugs distribution.

Emergency Medical Services: An important component of the Service Delivery Platform is Emergency Medical Services (EMS) and a turnaround strategy has been developed for EMS. During the 2010 World Cup EMS was regarded as commendable. The Department is building on this, to develop its EMS composed of a professional and dedicated workforce. The Fleet Management Contract for the Province has been extended for an additional two years, which is a drain on resources as it is very expensive. It is also building effective and efficient Asset and Inventory Management Plans. This includes R51 million to purchase and maintain 100 ambulances. Upgrading Control Centres and the Call Centre includes a computerised system in the Control Room to link with vehicles in the field. One of the Province's challenges however relates to poor road infrastructure especially in the Eastern Region of the Province.

Radiology Services: A major challenge is being faced to overhaul current x-ray infrastructure with a replacement value of R235 million[50]. X-ray facilities will be provided to the four PHC sub-districts to a value of R8 355 million, inclusive of maintenance. Technical work is being done to determine the best option for the remainder of the facilities between in-house capacities, outsourced or full maintenance lease.

ICT and health information services: The Department recognises that ICT services are a core component of the PHC model and require upgrading. It has identified the following as essential to the turnaround of

[49] Note from Peter Barron: This is an artificial waiting list as these posts are not real. What should happen is that all posts that are not funded should be abolished. This will give a realistic, "affordable" establishment and then real vacancies can be determined. The Eastern Cape has created many more posts than they need or can afford compared with other provinces.
[50] R235 million will buy one machine with 12 years maintenance or 2 machines with no maintenance contracts. It is therefore only a small portion for the four pilot areas.

its services: Virtual Private Network (VPN) with redundancy systems; ECS licence; Functionality; Communication including VOIP telephone (voice over internet protocol); Telemedicine including tele-radiology; EMS control and tracking system; Health Information System; Electronic patient record system and Transversal systems management.

4.5 Social Compact

The Social Compact is an innovative and central component of the ECDoH model, which is developed with communities at all levels of the PHC system (household, clinic, CHC, district hospital, regional hospital, and tertiary hospital). The Social Compact uses a social mobilisation process to involve citizens in health and broader community development. This is particularly important in relation to Saving Mothers, Saving Babies where campaigns have been initiated to empower communities to take informed decisions and choices, particularly with regard to pregnancy and family planning.

The Social Compact is closely linked to local economic development initiatives to which ECDoH contributes by localising procurement of soft services (e.g. security, laundry, catering, grounds/gardening, cleaning, and maintenance). Tenders for these services are offered in local areas (procurement for this is done at the sub-district level) and are transparent and accountable with appropriate monitoring and evaluation systems. Co-operatives for health services will be encouraged and linked to sub-district maintenance workshops and training (FET colleges).

Communication and mass mobilisation plans are in place to inform communities and all stakeholders about the aims and objectives of these compacts. Communities play a particular role in the selection of CHWs, which have a compact with the community to come back and work there after training. The community determines the criteria for selecting these workers and holds them accountable.

Awareness campaigns aimed at mobilising communities to reduce maternal and neonatal deaths are vital to the process. ECDoH is promoting early clinic booking for pregnant women; encouraging regular clinic attendance; counselling and support for pregnancy and childbirth; encouraging planning for transport and childbirth; and encouraging childbirth at a health facility attended by skilled personnel.[51]

Letsema Circle, an NGO, is supporting the ECDoH programme by facilitating these social compacts in each of the pilot areas. The Donald Woods Foundation (DWF) is also supporting the PHC process with a focus on a comprehensive and decentralised HIV programme at Zithulele Hospital, its allied CHC and 8 clinics as well as at the Barkly East cluster in Senqu municipality. DWF is implementing a model of wellness, integration, initiation and retention as an intervention for HIV and AIDS and TB.

[51] Eastern Cape hosts Saving Mothers, saving Babies. (2008) http://www.info.gov.za/speeches/2008/08070711451004.htm

4.6 Integrated School Health Programme:

At a secondary level, the *School Health Programme* is intended to identify learners with health problems which have not been picked up via the community health services. School health teams are to be established and these will be led by a dedicated professional nurse who has a minimum of two years experience in community health or primary health care. Re-orientation of training will be required for the school health team. Ultimately it is intended that each school should have its own school health nurse.

Simple screening will take place within the schools. For primary schools this will include: hearing assessments; vision and speech impairment screening; physical examination for gross motor dysfunction; oral health checks; anthropometric assessments and nutritional status. For high schools, a different emphasis is proposed and includes HIV counselling and testing; mental health assessment; sexuality education and reproductive health information; high risk behaviours including substance abuse and violence, and information about medical male circumcision.

Learners with health problems will be referred to the primary health care facilities, and subsequently followed up by the health team. In addition, specialised mobile units for more sophisticated screening such x-rays, audiology and eye testing, are to be commissioned. Recording of learners on the master patient index will be included in the package. In addition, learners who are particularly talented academically will be identified and provided with additional academic stimulation.

Health promotion and health education are intended to become part of the curriculum with education aimed at prevention of HIV, TB and teenage pregnancy being addressed as a priority.

4.7 Governance

The 1997 Health White Paper set out a vision for district and primary health care services that has not been fully implemented to date. The District Health System (DHS) is the central component of the health care system and drives the implementation of PHC. The boundaries of health districts coincide with district and metropolitan municipal boundaries. Health districts will be divided into sub-districts by the MEC (with the concurrence of the MEC for responsible for local government).

The National Health Act provides for District Health Councils which must be established for each health district in each province. The purpose of the District Health Council is to:

- Promote co-operative governance.
- Ensure co-ordination of planning, budgeting, provisioning and monitoring of all health services in the health district.
- Advise the provincial MEC, through the Provincial Health Councils, and the relevant municipalities on any matter regarding health or health services in the health district.

Chapter 5 of the National Health Act, which deals with the DHS, requires the MEC for Health to ensure that the district and sub-districts are well managed with respect to the principles of the DHS. These principles are the delivery of accessible, good quality services in an equitable manner ensuring that these services are comprehensive and not fragmented and that they are effectively and efficiently delivered. They also include the need for local accountability, community participation, a developmental and inter-sectoral approach accompanied by sustainability. Provincial legislation will provide for the formal creation of District Health Councils which provide oversight to the DMT.

In addition to District Health Councils, Hospital Boards regulate the establishment and functioning of all hospitals in the province. Hospital Boards have been trained and oriented on their oversight functions. Clinic Committees ensure local representation in clinic oversight and governance, and Policy Guidelines have been issued for their establishment. About 80% of clinics have clinic committees, and training for these committees is scheduled to take place.

ECDoH is intent on improving the quality of services. To this end, the Chief Directorate Quality Health Care Assurance Systems coordinates, develops and monitors quality of health care in the province. A Quality Assurance Plan is in place to address quality issues. Supervision at health facilities has been boosted with the recent publication of the Clinic Supervision Manual, and the role of supervisors has been emphasised.

5. Implementation issues

5.1 Overall approach

ECDoH subscribes to the framework for health system strengthening outlined in the WHO / Global Fund Report entitled "The Global Fund Strategic Approach to Health Systems Strengthening"[52]. This framework informs the operational support to the PHC pilots in the Eastern Cape and includes a focus on good health services, a well-performing workforce, a well-functioning health information system, a well-functioning procurement and supply chain system, a good health financing system and strong leadership and governance.

In line with international best practice, ECDoH has adopted an integrated systems approach which acknowledges that it is impossible to scale up services to any significant extent without stronger systems. Linked to this is better integration of health service delivery which is concerned with ensuring a continuum of preventive and curative services at the point of delivery, based on an agreed set of

[52] WHO, Global Fund. 2007. The Global Fund Strategic Approach to Health Systems Strengthening: Report from WHO to the Global Fund Secretariat.

interventions.[53] Included in these interventions is the programme to support mothers and neonates which has been implemented in health districts throughout the Eastern Cape.

Scaling up services to ensure high coverage and quality care for mothers and infants is also included in the programme. The following table provides delivery options with conditions of access to health facilities and human resource availability in facilities and at community level. As can be seen, the CHW is integral to the process.

Table 3: Post Natal Care Strategies: Feasibility and Implementation Challenges

	Strategies for Post natal Care Contact	Mother friendly	Provider Friendly	Implementation Challenges
1	Mother and Baby go to the facility	*	***	Requires mother to go to facility within a short time after birth. More likely after a facility birth, but still challenging in first days after birth
2	Skilled provider visits the home to provide post natal care for mother and baby	***	*	Conditional on sufficient human resources, which is challenging. Providing post natal care may not be highest priority for skilled health personnel in settings where their attendance at birth is still low. Many post natal care tasks can be delegated to another cadre. A skilled provider may be able to provide home visits during the post natal period if rural health facilities are quiet during afternoons.
3	Community health worker visits home to see mother and baby	***	*	Requires sufficient numbers of CHWs with adequate training, supervision and incentives
4	Combination: Facility birth and first post natal care visit in facility then home visit within two to three days, with subsequent post natal care visits at a health facility.	**	**	Requires a team approach between facility staff and CHWs, sufficient human resources, management and supervision, effective referral systems and efficient information tracking system so that the progress of the mother and baby is easy to track.

Lastly, ECDoH is committed to better communication of available evidence, appropriate and agreed indicators to track progress in health system performance, and robust monitoring and evaluation frameworks.

[53] Integration refers to the links between different types of service; links between the community and the formal health system; links between the public, private and voluntary sector and links between levels of the health system - from outreach, through clinics to hospitals.

5.2 Planning process for PHC pilots

Four pilot areas have been selected for the implementation of the r-PHC approach, which will subsequently be replicated throughout the province. The four areas comprise King Sabata Dalindyebo (KSD), Intsika Yethu, Uitenhage/Despatch and Duncan Village. ECDoH is working with service providers such as Letsema and DWF to support its work in piloting r-PHC in the four areas.

Business plans for each sub-district provide the basis for proposals to encourage funding from potential funders.[54] Pinnacle Health Solutions was commissioned to develop business plans for each of the pilot areas, which were completed in April 2011.

The planning process that is being followed includes the following steps (as per the STP framework)[55]:

- **Stage 1:** A situational analysis of available health facilities to assess the appropriateness of the infrastructure for service delivery. This includes:
  - Distance from nearest similar facility – against a target minimum of 100 km
  - Capital efficiency – based on the budget to replacement value ratio
  - Appropriate funding – benchmarked against the average funding per required bed for hospitals
  - Efficiency – measured against the average cost per patient day equivalent (PDE)
  - Condition – calculated on the basis of the proportion of replacement cost to repair
  - Size – measured against the normative number of beds for efficiency and clinical safety.
- **Stage 2:** Review of size and shape of sustainable service delivery.[56] Optimum choice is based upon a level that is equitable, sustainable and as efficient as possible taking into account budget, transport needs, telemedicine, etc.
- **Stage 3:** Comparative analysis of the assessments of optimal hospital numbers based on application of different criteria e.g. projected population, The District Health Information System (DHIS), efficiency.
- **Stage 4:** Size and shape of the supporting PHC network
- **Stage 5:** Supporting delivery with transport (EMS including air transport) and communications (including telemedicine)

[54] A time-lined project plan has been prepared which sets out the framework and actions required in the four sub-districts. The plan is to gather data to determine the current state of health and facilities. Based on findings, a template and conditioning matrix is to be developed. This will serve as the tool to analyse the data. Thereafter an overall business plan and a financial model are to be developed. The plan is to be refined in workshops to develop sub-district-specific business plans. With these plans, proposals are to be developed with budgets to raise working capital to support PHC. Donors, development banks, grant funds and Treasury are to be targeted.

[55] See Appendix 4 for a more detailed description of the planning approach.

[56] This would include review of the following

- **Optimum distribution**: based on population distribution and travel times to facilities at all levels of the system.
- **Efficiency**: The analysis of activity to develop thresholds for the minimum and maximum catchment populations for facilities at each level.
- **Human resources**: The analysis of minimum and required staffing levels by level of care to deliver a full package of services and the network of facilities that can be supported by them.

- **Stage 6**: Supporting delivery through the private sector :
  - provision of hospitals as part of the preferred provider network(s),
  - the options for joint ventures with private sector providers,
  - developing Service Level Agreements with local General Practitioners
  - joint venture hospitals
  - private sector sessional work in public hospitals

The six stage planning process identifies the infrastructural requirements. The CHCs that will initiate the process are those that have been identified already as per the list of "community health centres of excellence project" (CHCOE). Eventually this number will be increased to an optimum number within the constraints of the budget. The planning process will identify which clinics need to be upgraded to 24 hour services and then to CHC/Hs.

The financial year 2011/12 has a budget of just less than R1.25 billion[57] in the infrastructure programme. A detailed programme of projects has been drawn up. For the programme implementation, roles have been clarified. The Department of Public Works, as the implementing agent, procures the infrastructure that meets the needs of ECDoH, while ECDoH plans provision of infrastructure to meet service requirements. The Infrastructure Delivery Improvement Programme is co-sponsored by National Treasury as an initiative to support ECDoH.

5.3. Health Financing

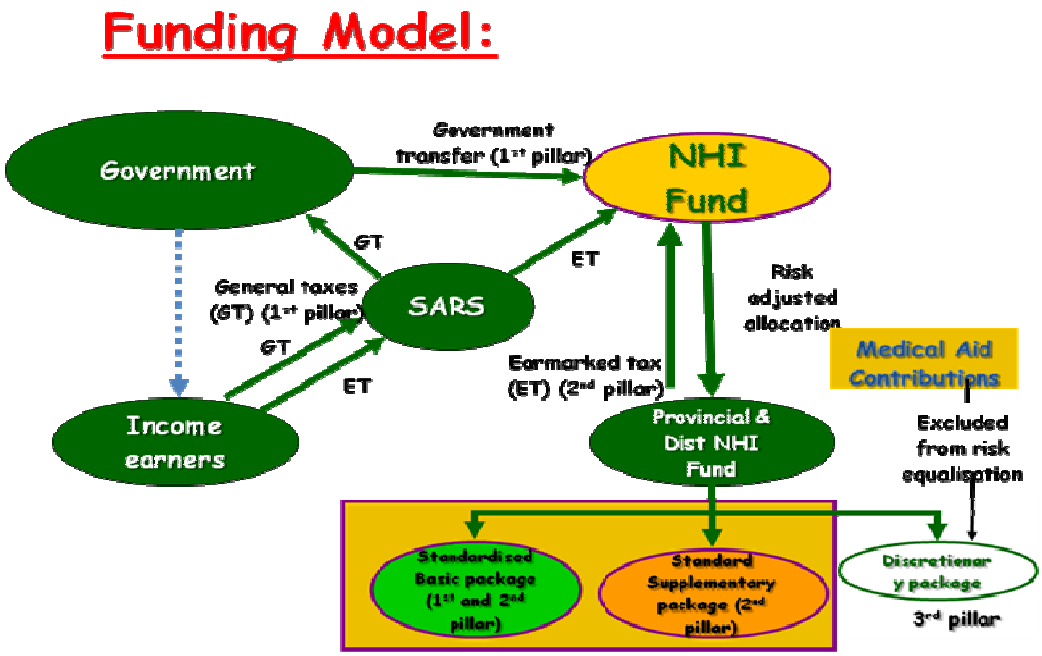
The financial requirements for this proposed "re-engineering of PHC" are being estimated in great detail and a budget will be submitted to Treasury for consideration and phased implementation. It is proposed that the full budget for the running of districts should be ring-fenced in order to protect revitalising PHC as being the highest priority in provincial spending.

However, in the medium-term, there are considerable efficiencies to be gained. One of these is the improved functioning of district hospitals where there are extremely wide variations in cost per patient day equivalents (PDEs). Another is through having clear referral policies to ensure that patients are seen at the appropriate level of care. A third is through improving the use of the District Health Expenditure Reviews (DHERs) and their impact on use of resources in the district.

The PHC model is also being implemented in anticipation of the NHI systems and procedures, and greater access will be ensured through increased income to finance NHI compliant services and facilities. The ECDoH conceptual model for future NHI and PHC funding arrangements is illustrated below:

[57] MEC Gqobana presentation to PEC Legotla

Figure 4: NHI funding model



The current finance management structure is being overhauled to ensure that critical skills are placed in the right areas, with full capacity to deal with delegations when implemented. Finance Management Systems are being installed to detect and deal with issues such as irregular expenditure and duplicate payments. This will include a price index to regulate overpricing and vetting of suppliers, and implementing the LOGIS system.

The current budget deficit of R1.3 billion for health in the province is obviously a major challenge, and there have been interventions to mitigate the budget deficit. Revenue Generation and Retention Projects are being planned as well as Risk Mitigation and improvement to Supply Chain Management Services.

5.4 Provincial coordination and M&E mechanisms

At a provincial level, the Office of the Superintendent General, through the General Manager: Project Support, coordinates the various components of r-PHC. Its purpose is to lead, design and coordinate implementation of r-PHC. A framework for transformation has been developed. This will serve to guide the implementation process. A directorate for Saving Mothers, Saving Babies is coordinating the work on ante- and post-natal care and neonate care, and reports to the Superintendent General.

Four sub-committees have been established to monitor and support various aspects of the programme within the four selected pilot areas. These sub-committees are:

- Clinical Care;
- Governance and Intergovernmental Relations (IGR);

- Information Management; and
- HR, Supply Chain and Finance.

The purpose of the **Clinical Care Sub-Committee** is to make recommendations to the project manager regarding the optimisation of clinical care. The sub-committee focuses on the management of clinical care and the role of the doctor; the pursuance of a programme for CHWs with recommendations for their management being placed away from nursing staff; the need for multi-disciplinary teams which work in the community (as is being conducted at Zithulele with the Donald Woods Foundation).

The **Governance Sub-committee** has been established to integrate sub-district structures to form a functional Sub-District Service Delivery Unit specific to the pilot sites, coordinated by the province. This is comprised of four members from each of the four participating sub-districts, hospital managers and community health hospital managers. It reports on integration with hospitals; hospital boards and clinic committees, traditional leader structures, IGRs, and meetings with municipalities. Reports from this sub-committee are favourable and indicate that broader governance structures are operational.

The **Information Management, and HR, Supply Chain and Finance Sub-committees** have drawn up their terms of reference and have provided timeframes for delivery.
A much greater emphasis is being placed on monitoring and evaluation at every level of service to ensure that the right things are being done correctly (effectiveness and quality) and for the lowest cost (efficiency). Every manager has M&E built into their job description which is integrated into their daily work. The performance appraisal of every manager is being built around the M&E component. Knowledge and information for M&E comes from routine services and support data, surveys, interactions with health workers and clients, and from observations, all of which are used for decision making.

DHIS is the backbone of the routine information system and is complemented by the BAS, PERSAL[58] and other support services data (e.g. pharmaceutical, laboratory, transport). These data are currently under-utilised by managers. Based on the success of the pilots, innovations in data management through the use of improved technologies (e.g. mobile phones) will be incorporated. There will be a planned increase in the capacity for data analysis, interpretation and use for decision making at all levels and an in-service training programme for managers.

It is recommended that there be a thorough review of the full DHIS and that this results in streamlining and improvement of the existing system and processes. The full range of community-based services needs to be underpinned by an M&E system that is incorporated into the DHIS.

[58] BAS and PERSAL are standard public service HRM programmes

6. Progress with Primary Health Care Pilots

While the business planning process has been underway, good progress has been made in laying the groundwork for r-PHC in each of the pilot areas.

6.1 Uitenhage

Uitenhage is an urban sub-district within Nelson Mandela Bay Municipality (NMBM) – a metropolitan municipality. It has a population of 263,000 people.[59] This translates into 41,813 households (31,028 residential properties and 10,785 non-categorised sites). Its major public health challenges include high levels of HIV/AIDS and TB, mother and child morbidity and mortality, chronic non-communicable disease (especially diabetes and hypertension), alcohol and drug abuse, and high accident rates among youth[60]. There are two health authorities operating in NMBM. The municipality has delegated authority to provide primary health care services through its 41 clinics whilst ECDoH also has 11 health facilities in Nelson Mandela Bay. The process to provinicialise, i.e. to bring health into a unitary authority, is currently the cause of much tension. There is limited collaboration between NMBM Health Directorate and ECDoH. An additional challenge is that the establishment of the three sub-districts within NMB has not yet been legislated.

The PHC plan for Uitenhage is well developed. It emphasises the strengthening of the DHS as the platform for service delivery. It has sought to align the NDoH's Strategic 10 point plan with PHC. It indicates the development of a strong social compact with the community, work with CHWs and the community strategy. A key area is the strengthening programmes which focus on MCWH. The sub-district is promoting intersectoral collaboration particularly with NGOs. Health promotion in the form of various settings such as schools, churches and with the elderly is being promoted.

The Social Compact has been initiated by Letsema with two one-day workshops. The first was with ECDoH staff and aimed at developing an understanding of the revitalisation process. The second workshop included stakeholder participation and started by addressing some of the concerns of the local community and challenges facing the staff at the facilities.

6.2 Intsika Yethu

Intsika Yethu is a rural sub-district within the Chris Hani District. It covers an area of 3,041 km^2 and has a population of 185,000 comprising 43,500 households.[61] It is characterised by rural poverty and its major health challenges include HIV/AIDS and TB.

Intsika Yethu Local Municipality has developed plans for revitalising PHC which include major infrastructural improvements including a new clinic building at Kuyasa and water and electricity provision at many of the clinics. It also includes broad health programmes such as MCWH; sexual and

[59] Statistics from Eastern Cape Department of Health.
[60] Nelson Mandela Bay Municipality IDP 2010/11 – 12/13; and Nelson Mandela District Department of Health
[61] Figures from Statistics South Africa, Community Survey 2007.

reproductive health; diabetes awareness; hypertension and stroke awareness. Environmental programmes focus on waste management, food control, health surveillance of premises (schools, prisons, mortuaries); water quality and disease surveillance.

Intsika Yethu has made some progress on its plans. The Social Compact has been well-developed with the support of Letsema Circle. A core team has been trained, decentralised to Ncora and projects have been identified. It has mobilised a large *Ilima* (i.e. participatory process) bringing together officials from the district, province, and national levels, representatives from mining industries, as well as the community in which it has introduced the broad concept of PHC. Intergovernmental relations meetings and meetings with traditional leaders have taken place.

Apart from the Social Compact, there has been progress in recruiting health professionals to the sub-district. Three clinics have been accredited as ARV sites and health promotion settings were established at schools and a local hospital, as well as a child friendly village established at Mdange. There has been inter-sectoral collaboration with the wards and outreach services have been extended to schools, dental and eye services. Infrastructural improvements have been made with the Kuyga clinic being established (made from shipping containers) and a pre-fabricated casualty facility being erected at Cofimvaba.

6.3 King Sabata Dalindyebo

King Sabata Dalindyebo (KSD) is a sub-district within the OR Tambo District Municipality. KSD is a primarily a rural area which includes the towns of Mthatha and Mqanduli**.** KSD covers an area of 3,019 km^2 and has a population of 445,000 people comprised of 93,300 households.[62] Approximately 81% of the population is indigent with a household income below the minimum standard of R1,500 per month.[63] The biggest threat to adult health status is HIV/AIDS with a prevalence of 22,1% in the OR Tambo District.[64] The child mortality rate is 88 per 1,000. A separate breakdown for KSD Municipal area is not available.[65]

KSD is involved currently in the development of a Social Compact and has established Core Teams at Mqanduli, Zithulele and Ncwanguba. Community projects are to be implemented, with the development of a co-operative to improve local economic development (LED) at Mqanduli. Clinical plans include the implementation of the PHC package, MCWH, improving the referral system, training of nurses in PHC and the inclusion of 110 CHWs. The infrastructure plan includes extension of the CHCs, revamping of seven clinics and maintenance of medical equipment.

A project plan with time-frames has been developed which indicates the key objectives: improve access to quality of care; improve provision of continuous water supply; strengthen HR management and

[62] Community Survey 2007 at Statistics South Africa.
[63] Annual Report for KSD 2007/08. Office of Municipal Manager Cllr Ngcobo. January 2009.
[64] Ibid
[65] Ibid

development; and, social mobilisation and community development. Human resource management needs to be improved so as to establish a 24-hour CHC with 24-hour service and increased professional nurse capacity at all clinics. Each clinic is also intended to have a pharmacy assistant for drug management.

6.4 Duncan Village

Duncan Village is an area within the Buffalo City sub-district, in the Amathole District. Duncan Village is situated within an urban area. It has a population of 64,858.[66] Health challenges include HIV/AIDS, TB, substance abuse, early childhood disease and the chronic diseases of hypertension and diabetes.[67]

A plan for the Amathole District, which includes Duncan Village, has been developed. The plan includes service delivery issues, support services, human resources, finance and infrastructure, and M&E. Service delivery addresses the priority health challenges, including MCWH, with the addition of a quality assurance component. Human resource plans include the filling of many vacant posts for nurses. CHW numbers need to be increased and training is required. Support services for information and pharmaceutical management have been identified in the plan as priorities. The finance system is to be revised to include the centralisation of the clinic into one budget as a cost centre.

Development of the Social Compact in Duncan Village is progressing well. There has been some hesitation from ward councillors but the ward committees are participating fully. Two workshops have been held in which r-PHC and the Social Compact have been discussed. The District Manager and Sub-district managers have been engaged together with staff. A large *ilima* was held on 17 March at the Duncan Village Day Hospital with stakeholder groups. Key concerns being raised are those related to the social determinants of health especially related to housing density, sanitation, refuse collection and environmental issues. This has led to the planning for a targeted inter-sectoral approach.

[66] Statistics derived from ECDoH, DHIS 1.4.0.131 Dated 18/03/2011
[67] Amathole District Health Plan 2011/2012

7. Support for the ECDoH r-PHC

The overview of progress with the implementation of a new model for PHC in the Eastern Cape Province has indicated that the ECDoH has embarked on a bold initiative to dramatically overhaul the current health system and improve its health outcomes. The Eastern Cape plans for the revitalisation of PHC have been designed and planned to a high degree of detail. International models have proven the potential impact of this approach, and the Eastern Cape r-PHC programme is aligned with international and national best practice and policy.

The r-PHC provides an opportunity to address broader social determinants of health and provide health services in a cost effective way. The ECDoH has demonstrated its commitment through the allocation of resources and time and to turning around health outcomes in the province by implementing r-PHC. This political and administrative commitment is identified in the ECDoH plans to reallocate budget funds to support the core infrastructural and staff requirements of these plans. The focussing of efforts and resources on the pilot areas positions the province well to be able to replicate a tested model throughout the Eastern Cape, and in doing so, provide good practice examples and lessons learnt to other provinces in the design of their PHC programmes.

The ECDoH r-PHC, in its comprehensive and innovative design, combined with the ECDoH's commitment to ensuring its effective implementation, offers development cooperation agencies, health NGOs and other health stakeholders a prime space to collectively contribute to the attainment of the desired health outcomes.

7.1. Alignment with ECDoH priority areas

As sustainability is a critical consideration for provision of support, interventions should seek to cohere with and complement the plans of ECDoH. The ECDoH has identified some very specific areas of required support and cooperation in order to ensure that the goals of the r-PHC are met[68]. These areas have been listed as follows:

- The establishment of a virtual private network;
- Build, operate and transfer of community health facilities (including the addition of beds to Community Health Centres);
- The provision of required medical equipment;
- The provision of radiology equipment and services;
- Funding for ambulances;
- The establishment of a patient master index to register all patient in preparation for the NHI, which will be extended to include a patient management system and health information system with a back-end and summarised front-end;

[68] Dr. S Pillay, SG, ECDoH, 21.01.11, Request for assistance for the ECDOH Turn Around Strategy

- Strengthening of pharmaceutical benefit management to include logistics and dispensing, as well as quality assurance for both acute and chronic medication;
- The provision of transport for CHWs/practitioners; and
- The establishment of an integrated school health programme.

Taking into consideration DFID's focus on "reducing maternal and neonatal deaths in rural South Africa through the revitalisation of primary health care", which is in line with both the UK and SA government priorities, an outline for potential DFID support has been built around the following 4 pillars:

1. Empowering women to make choices
2. Removing obstacles to access to health care
3. Expanding quality health services
4. Ensuring accountability

This focus has, where possible, been aligned with the 5 priority areas[69] as defined by ECDoH which are listed as:

- Efficiency and effectiveness of business systems
- Reengineering of business processes
- Social compact
- Supply chain management reform
- Revenue generation

An important point to note is that DFID, in its overall / general support to the strengthening of health systems in South Africa, has two separate support interventions related to quality assurance (QA) and NHI implementation underway. The focussing of the planned support to the QA and NHI processes within a structured piloting of r-PHC presents a developmental opportunity that cannot be missed. Lessons learnt from the integration of QA and NHI interventions aligned to a focussed r-PHC programme will prove to be invaluable at both a policy development and refinement level, as well as at implementation level.

7.2. Summary of the proposed intervention logic

At an ***overall objective***[70] level, the proposed support to the ECDoH r-PHC programme aims to contribute to the achievement of the desired health outcomes for mothers and infants across the province through the PHC approach.

[69] See Section 4.1. of this report

[70] For the purpose of this report terminology for the proposed support intervention has been kept simple as follows: **overall objective** (to which the intervention contributes); **project purpose** (changes that project intervention plans to bring about); **results** (what the intervention plans to deliver); and **activities** (what the project will do).

At a ***project purpose*** level, this support intervention aims to ensure that the ECDoH is enabled to effectively execute a PHC approach to improve the health outcomes for mothers and infants in the 4 r-PHC pilot areas and, in doing so, achieve the desired health outcomes whilst simultaneously identifying and sharing good practices and lessons learnt to inform the design of a replicable model.

In order to achieve the project purposes, 4 main ***result areas*** have been identified:

- Result 1: Increased access by mothers and infants to primary health care services through PHC outreach approach in 4 pilot areas
- Result 2: The decentralised District Health System in each of the 4 pilot areas operates effectively and efficiently
- Result 3: Social compacts are established in each pilot area to achieve optimal participation by communities, women in particular, awareness of health choices and determinants of health and inter-sectoral collaboration
- Result 4: the ECDoH officials are enabled to project manage, coordinate and implement improved services to mothers and infants through the r-PHC programme in the 4 pilot areas

These four result areas are mutually reinforcing, and need to be developed in concert in order to achieve the overall project purpose.

7.3. Proposed support activities by Result areas

The proposed activities under each result area have been identified on the basis of the document review, interviews conducted in the process of preparing this paper, as well as through a workshop in which all relevant stakeholders participated to determine the required areas of support. The proposed activities are designed to complement rather than duplicate activities already being implemented by the ECDoH and its various service providers. The activities therefore do not cover items such as staff costs, capital and operating costs that fall within ECDoH's mandate and budget. Rather the proposed activities seek to strengthen capacities to carry out planned activities. The proposed activities within this development cooperation framework (in this case the partnership between DFID and ECDoH) are activities which are integral to the implementation of the r-PHC programme and specifically to achieving the overall goal of improved health outcomes for mothers and infants across the province. A detailed description of the potential areas of DFID support is presented in Appendix 5, and summarised in the table below.

Table 4: Summary of activities by result area

Result area	Activities
1. Increased access by mothers and infants to primary health care services through PHC outreach approach in 4 pilot areas	• Develop and implement a comprehensive Community Health Practitioner (CHP) development programme to extend services to mothers and infants, and empower women as CHPs. • Train CHPs and emergency services personnel in line with curriculum to improve preventive and screening services for mothers and newborns in particular. • Support planning and project management to improve network of clinics, community health centres, and district hospitals in line with optimum distribution and efficiency models. • Improve collection and storage of information on health status of mothers and infants through a household survey and register, accessible integrated patient records and an information technology strategy. • Provide planning, technical and procurement support to implement a transport strategy to improve mobility of CHPs and EMS and access to health services by mothers and newborns. • Develop an integrated school health programme.
2. The decentralised District Health System in each of the 4 pilot areas operates effectively and efficiently	• Review and develop an appropriate and efficient patient referral system for mothers and infants specifically with regard to the CHH/CHCs. • Strengthen accountability for health services for mothers and infants through strengthened district health and advisory councils. • Develop appropriate staffing plans for decentralised health care services to mothers and infants in each of the districts for the pilot areas. • Develop and implement logistic, planning and management processes to ensure the continual availability of medicines, equipment and medical and surgical supplies to outreach facilities. • Decentralise decision making on procurement and financial management through implementing and monitoring effective and appropriate delegations.

Result area	Activities
3. Social compacts are established in each pilot area to achieve optimal participation by communities, women in particular, awareness of health choices and determinants of health and inter-sectoral collaboration	• Raise awareness amongst women in pilot communities regarding health services and choices through workshops, communications and outreach programmes. • Improve accountability and participatory governance of health services to women and infants through building the capacity of community health committees. • Undertake a status quo analysis of each of the pilot areas (including stakeholder mapping) in order to develop a pilot area specific engagement strategy. • Design, through the uses of participatory processes, a broader development strategy for each of the pilot areas. • Establish cooperatives to involve women in employment around provision of soft health care services such as cleaning, catering, laundry and maintenance.
4. The ECDoH officials are enabled to project manage, coordinate and implement improved services to mothers and infants through the r-PHC programme in the 4 pilot areas	• Undertake a comprehensive stakeholder mapping / analysis and risk analysis within each of the 4 pilot areas. • Design and implement a co-ordination strategy for key role-players. • Ensure integration of r-PHC pilots with quality improvement, quality assurance and NHI programmes • Develop and implement a broad-based r-PHC awareness raising programme. • Strengthen the existing M&E system and process. • Provide general technical support to the Coordinator and sub-committees as required

It is envisaged that the above activities will take place over a three year period, which will be the critical timeframe over which implementation of the pilots will occur.

An itemised budget for the above activities has been drawn up and is set out together with the budget assumptions in Appendix 6. It is estimated that the total funding requirement for the above activities, including project management costs (at 7.5% of overall costs) and VAT (at 14% of overall costs) is R49,834,958.00.

8. Concluding comments

Based on a review of progress with the implementation of a new model for Primary Health Care in the Eastern Cape Province, it is clear that the ECDoH has embraced global best practice and sought to give effect to the national PHC policy and the inclusion of MCWH within this. Some areas of alignment between the national and provincial models still need to be resolved, but in its overall design and detailed implementation the provincial model can be said to be piloting the national PHC policy.

The formation of social compacts and the process of community mobilisation around the revitalisation of PHC are unique features of the Eastern Cape r-PHC programme. This brings to the fore the imperative to address the broader social determinant of health, and integrates and aligns the programme with broader government development initiatives and programmes.

ECDoH has undertaken a detailed business planning exercise for each of the pilot sub-districts, which indicate the capital investment, human resources, equipment and systems development needed in each of the pilots. ECDoH has allocated resources and time for the implementation of the r-PHC programme, and plans to reallocate budget funds to support the core infrastructural and staff requirements of these plans. Donor support for the pilots will complement and support this substantial commitment of resources to these pilots by the province.

The focussing of efforts and resources on the pilot areas positions the province well to be to able to replicate a tested model throughout the Eastern Cape, and in doing so, provide good practice examples and lesson learnt to other provinces in the design of their own PHC programmes.

The future rollout of the NHI will lay the basis for the sustainable financing of the PHC system, and the implementation PHC will in turn generate substantial savings in curative health care services. PHC and NHI implementation should therefore be seen as mutually reinforcing initiatives whose integration at a pilot level will provide significant information and experience for further replication. The r-PHC pilots provides the ideal space to begin the process of integration of revitalised PHC with an emphasis on maternal and infant health, quality assurance and the promotion of universal access through the NHI. As noted earlier, DFID is already supporting the latter two reform initiatives.

ECDoH has provided additional input to this proposal from a workshop where a participatory process on 7th April 2011. The outcomes of that process have informed the final design of the request to DIFD for support to the ECDoH r-PHC programme: Improving Health Outcomes for Mothers and Infants.

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Appendix 1: General Principles Guiding the Work of ECDoH

1. Based on Primary Health Care (PHC) as the fundamental approach to service delivery in South Africa, and implemented through the District Health System (DHS);
2. Available, reliable & delivered as close to the patient as possible;
3. Delivered with the primary aim of ensuring the highest possible service and care quality;
4. Delivered by an appropriate mix of well trained, skilled, and competent staff & clinically safe;
5. Delivered by caring staff at all levels, both professionals and non-professionals;
6. Delivered from appropriate & properly maintained facilities;
7. Delivered in a manner that ensures the progressive realization of the right of access to appropriate, high-quality referral hospital care, given available resources;
8. Supported by appropriate & affordable equipment and drugs;
9. Provided in a supportive, dynamic & well managed environment;
10. Provided in an environment where leadership is effective and visible, and where accountability is paramount;
11. Provided in an environment that creates opportunities for professional growth for health care workers;
12. Planned to ensure that current centres of excellence are preserved and strengthened;
13. Planned to ensure reduction of inequities in access by strengthening and developing services;
14. Planned to ensure that the public sector becomes the employer of choice for health professionals;
15. Adequately and sustainably funded;
16. Efficient, effective and well-managed; Management and funding arrangements must promote smooth functioning of an integrated referral system;
17. Ensure that reconfiguration of tertiary hospitals does not occur in isolation from district hospitals; regional hospitals;
18. Link health professionals training to service requirements.

Appendix 2: Alignment of goals for the province[71]

MDG	NdoH Priorities	PGDP	ECDoH
Reduce child mortality	Full implementation of PHC package Improve EPI coverage – implementation of the RED strategy	Reduce by 2/3 the under five infant and child mortality rate by 2014	• Clinics as centres of excellence • Implementation and monitoring of the RED strategy • Saving Mothers Saving Babies Project • Paediatric handbook • Outreach programmes • Access to PHC services
Improve maternal health	Reduction of maternal mortality	Reduce by ¾ maternal mortality rate by 2014	• Saving mothers Saving Babies project • Training of Advanced Midwives • Outreach programmes • Improvement of the EMS – turnaround strategy • Mortality and morbidity meetings taking place in some areas
Combat HIV and AIDS	Implementation of the Comprehensive Treatment Plan	To halt, manage and improve health outcomes for HIV and AIDS and begin to reverse the spread of TB	• Increasing numbers on the comprehensive treatment plan and on ARV treatment • Intensive TB programme including 3 major districts in the province • Improve notification and follow up on TB patients
Improve other diseases	Reduction in major non-communicable disease and diseases of lifestyle	Improve access for services	• Implementation of the package of care • Health promotion programmes have been intensified. • Outreach programmes are in place • Intensification of telemedicine and number of sites and diseases covered. • Burden of disease for EC available.
Alleviation of Poverty	Alleviation of poverty	Alleviation of Poverty	• Promotion of food gardens • Utilisation of SMMEs for minor maintenance • Using local suppliers where possible eg for bread supplies

[71] ECDoH : Quality Assurance document

Appendix 3: PHC Package Indicators and Core Services for Mother and Infants[72]

Decreasing maternal mortality to less than 100 per 100 000 live births is a key health sector outcome.2 Key interventions at the primary care level to reduce maternal mortality include increasing access to health facilities, increasing the percentage of women who book for antenatal care before 20 weeks, increasing the percentage of mothers and babies who receive post natal care within 3 days, increasing the percentage of maternity care facilities, such as community health centres, that review maternal and peri-natal deaths, address identified deficiencies and enhance the skills of health care workers and improve the use of clinical guidelines.

Specific goals and targets are:

Improving antenatal care

- Increase the percentage of pregnant women receiving antenatal care
- Reducing the proportion of pre-term deliveries and low birth weight babies
- Increase number of women who book before 20 weeks
- Ensuring that basic antenatal care (BANC) is implemented in 95% of primary care facilities

Reducing the number of children who are born with HIV

- Less than 5% of babies born to HIV positive mothers are HIV positive
- Reduce the proportion of births in women below 16 years and 16 – 18 years from the existing level (13.2% in 1998)

Improving delivery care

- Increase the deliveries in institutions by trained birth attendants
- 70% of facilities should have care providers trained in Emergency Obstetric Care
- Increase percentage of mothers and babies who receive post natal care within 3 days of delivery.

With regard to improving child health, the target is to decrease child mortality from 69 per 1 000 to 30 per 1,000 live births. Key interventions, in addition to the one above that will impact on child health, are listed below:

- Increase the number of infants who require dual therapy for PMTCT who actually receive it.
- Ensure that 90% of children are fully immunised
- Increase the number of districts in which 90% of children are fully immunised

[72] From Rispel, L., Moorman, J., Chersich, M., Goudge, J., Nxumalo, N., & Ndou, T., Centre for Health Policy, School of Public Health, University of the Witwatersrand, "Revitalising Primary Health Care in South Africa -Review of primary health care package, norms and standards", 11 November 2010

- Increase the proportion of nurse training institutions that teach IMCI
- Increase the number of schools visited by a school health nurse at least once per year
- Provide penicillin for rheumatic heart disease

In order to achieve these targets, all clinics should provide immunization services at least for 5 days a week and if indicated, additional periods specifically for child health promotion and prevention. Every clinic should have a visit from the District Communicable Disease Control Coordinator every 3 months to review the EPI coverage, practices, vaccine supply, cold chain and help solve problems and provide information and skills when necessary. Every clinic should also have a senior member of staff trained in EPI who acts as a focal point for EPI programmes.

Specific interventions to reduce childhood malnutrition include regular growth monitoring to reach 75% of children <2 years, increasing the proportion of mothers who breast-feed their babies exclusively for 4-6 months, and who breast-feed their babies at 12 months and ensure that 80% children under five receive 2 doses VA annually.

Reducing mortality due to diarrhoea, measles and acute respiratory infections in children can be achieved by treating all children according to IMCI Guidelines and standard treatment guidelines. Every clinic should have at least two staff members, who have had the locally adapted IMCI training, based on the WHO/UNICEF Guidelines. A supervisor, who also evaluates the degree of community involvement in planning and implementing care, should undertake a six monthly assessment of quality of care. At least 85% of PHC facilities should have IMCI trained providers.

Reducing maternal and child mortality requires inter-sectoral collaboration including:

- The provision of child care grants for those in need
- The provision of grants for orphans and vulnerable children
- Food security
- Access to clean water and sanitation
- Early childhood development opportunities

The following service components of the PHC system will deal specifically with maternal and child health.

COMMUNITY BASED SERVICES	
Conduct structured household visits to identify at-risk households and individuals, assess need for services, and facilitate access to health and social services	Identify vulnerable households Facilitate access to social grants (child care, disability, old age) and other social services (e.g. OVC, substance abuse) Assist with registration of births and deaths
	Identify households with children and women of reproductive age Assess need for and facilitate access to key preventive and care services: early ANC, immunisation, growth and development, HIV screening and care in pregnancy and childhood, contraception, TOP and cervical screening
Provide information, education and support for healthy behaviours and appropriate home care	Promote key family practices: infant and young child feeding, newborn care, ORT, hand washing
Provide psychosocial support	Support women with post natal depression Support HIV affected & youth and child headed households
Identify and manage common health problems	Identify and treat diarrhoea (ORT and continues feeding) Identify and refer pneumonia
Conduct community assessments & mobilise around community needs	Address inter-sectoral issues, especially water and sanitation, and food security Support community campaigns which aim to promote healthy behaviours and improve coverage of key interventions
	Support immunisation, vitamin A and de-worming campaigns

CLINIC-BASED SERVICES	
Maternal	
Antenatal care	Diagnosis of pregnancy Antenatal visits and routine observations 3 – 5 times during pregnancy. Basic antenatal care should be provided as a minimum. Tetanus immunisation Detect a pregnancy at risk and refer Screening for risk factors Book for delivery Education and counselling Identification and treatment of concurrent conditions – STI's, TB, urinary tract infections and anaemia Recognition of complications and referral – pre-eclampsia etc

CLINIC-BASED SERVICES	
	Micronutrient supplementation
Prevention of mother to child transmission (PMTCT) of HIV	Routine offer of HIV counselling and testing of all pregnant women at each antenatal visit Provision of appropriate regimen to prevent mother to child transmission as per protocols Treatment of opportunistic diseases Nutritional support Psychological support Counselling on safe feeding options
Delivery care	Delivery of uncomplicated pregnancies Identification of complications and referral Reporting maternal deaths (confidential)
Postnatal care	Clinical observation of mother Screening of newborn for development impairment and genetic disorders Education on feeding / safe feeding practices Information on child preventive care Support breast feeding Advise on contraception
Women	
Family planning	Counselling Clinical examination Screening and treatment of STD HIV counselling and testing Provision of contraception as per national and provincial guidelines Breast examination as per fertility management guidelines Cervical screening as per protocol Distribution of condoms Emergency contraception
Cervical cancer screening	Cervical screening as per national guidelines Follow up and tracing of women with abnormal smears Referral if necessary HIV counselling and testing
Termination of Pregnancy	Early detection of pregnancy, counselling and referral to accredited centre HIV counselling and testing
Child Preventive Services	
Growth monitoring	Routine weighing, plot weight on road to health card, interpretation and feedback to care giver. Monthly until age of two and then every three months
Immunisation	Routine immunisation services as per current immunisation schedule

CLINIC-BASED SERVICES	
	Measles and polio campaigns when indicated Special mass campaigns during outbreaks Disease Surveillance and case reporting
VA supplementation	Supplementation of children less than five years old In accordance with policy
De-worming	Routine de-worming of pre-school and school children as per national guidelines
Child Curative Services	
IMCI	Management of illnesses as per algorithms and national protocols Referral to higher level as per protocols
Emergencies	Rehydration of children in a designated rehydration corner Management burns and simple injuries

COMMUNITY HEALTH CENTRE	
Delivery care	Delivery of uncomplicated pregnancies Ventouse and forceps delivery available
Family planning	Male and female sterilisation selected CHCs Infertility: limited initial investigations in specialised clinics Genetic counselling
Cervical cancer screening	As per clinic Abnormal results seen by MO
Termination of Pregnancy	Early detection of pregnancy Medical and surgical TOP in designated facility HIV counselling and testing
Adolescent health initiatives	Orientation of services to suit adolescents, and especially those at school

Appendix 4: ECDoH Project Planning Approach

In order to ensure that the Scope is achieved, the project will comprise the three phases presented in the table below:

Project Phase number	Project deliverables
Assessment of access to current health services	
Phase 1 (a)	Establish the location and categorisation of current primary health care services, facilities and available health workforce in the public sector, private sector and NGOs, in each of the four sub-districts Obtain the disease burden/ health issues data pertaining to each of the sub-districts Obtain the population demographic data for each of the sub-districts
Phase 1(b)	Present the following in the form of overlay maps and excel spreadsheets, and identify population groups that are underserviced, and the extent to which they are underserviced: • The population demographics • The disease burden/ health issues • The location of existing health facilities and services (public, private and NGO) • The categories, numbers and location of health care workers
Phase 1 (c)	Confirm the demographic, disease burden and workforce data generated in Phase 1(b); **and** Obtain data for estimating the impact on available health care service delivery capacity (facilities, consumables and work force capacity) caused by patients accessing higher levels of care than are necessary. This data will be needed for the modelling exercise in **Phase 3**.
Assessment of the quality/ adequacy of health services	
Phase 2 (a)	Obtain a community perspective of **health service requirements** and the key elements for inclusion in a **Social Compact** within each of the four Sub-districts.
Phase 2 (b)	Upgrade the "**Template**" (**Appendix 4**) and "**Condition rating matrix**" (**Appendix 3**) used by the ECDOH to assess the condition of the facilities and services of the community clinics and community health centres in each of the 4 selected sub-districts.

Project Phase number	Project deliverables
	This Template is to be upgraded so that it can be implemented across all four sub-districts The Template must address each of the following health system "**building blocks**" recommended by the WHO and World Bank[73] (See **Appendix 1**) as well as the **Social Compact** referred to both the National Department of Health Ten Point Plan[74] and the ECDOH Five Point Plan[75]: • Social Compact • Health services (including water and sanitation) • Workforce • Information system • Procurement and Supply Chain for essential medical products and technologies • Primary Health Care financing and financial management • Governance and leadership The Template must also incorporate DOH norms and standards.
Phase 2 (c)	Use the Primary Care Template (Appendix 4) and condition rating matrix (Appendix 3) as upgraded/ reviewed in Phase 2(b) to evaluate the existence and standard of the following capacity at listed community clinics and community health centres: • Social Compacts • Health services (including water & sanitation) • Workforce • Information system • Primary Health Care financing and financial management • Procurement and Supply Chain for essential medical products and technologies • Governance and leadership
Business Plan Development	
Phase 3 (a)	Agree what needs to be included in the business plan for each of the sub-districts (workshops)
Phase 3 (b)	Develop a **Business Plan** for each of the sub-districts for use in the ECDOH budgetary process and for raising sustainable capital and working capital funding from donors, development banks, grant funds and Treasury where appropriate.

[73] WHO, Global Fund. 2007. The Global Fund Strategic Approach to Health Systems Strengthening: Report from WHO to The Global Fund Secretariat: 2.

[74] Director General Health. 17 June 2009. Presentation to the Portfolio Committee on Health on the Strategic Plan of the National Department of Health for 2009/10-2011/12

[75] Presentation by the Superintendent-General entitled "Preparing for NHI", June 2010

Appendix 5: Summary of potential areas of DFID support to the ECDoH r-PHC

Overall objective: Health outcomes for mothers and infants across the Province are achieved through PHC approach

Project purpose: ECDoH is enabled to effectively execute a PHC approach to improve health outcomes for mothers and infants in the four r-PHC pilot areas and, in doing so, achieve the desired health outcomes whilst simultaneously identifying and sharing good practices and lessons learnt to inform the design of a replicable model.

Result 1 **Increased access by mothers and infants to primary health care services through PHC outreach approach in 4 pilot areas**		
ACTIVITY	**INTERVENTION**	**RATIONALE**
Activity 1.1	Develop and implement a comprehensive *Community Health Practitioner (*CHP) development programme to extend services to mothers and infants, and empower women as CHPs	*The cornerstone of the r-PHC is the establishment, development and implementation of a comprehensive Community Health Practitioner (CHP) programme. This will include the development of criteria for CHP selection; development of an appropriate curriculum and training modules; operationalisation of the process; ensuring proper models for supervision; career-pathing for CHPs; and monitoring and evaluation.*
Activity 1.2	Training of CHPs and emergency services personnel in line with curriculum to improve preventive and screening services for mothers and newborns in particular	*Training of CHPs in line with new curriculum, especially in the fields of health promotion, prevention, education for mothers and newborns. Training of clinic staff in comprehensive PHC package, including antenatal care, postnatal care, immunisation, family planning. Training for emergency services personnel on obstetrics and gynaecological issues.*
Activity 1.3	Support planning and project management to improve network of clinics, community health centres, and district hospitals in line with optimum distribution and efficiency models	*The R-PHC pilots will aim to improve access to health care facilities for women and infants such that no women is more than 5km from the nearest clinic, with a maximum travel time of 30 minutes, and each clinic is in turn supported by a network of community health centres, district hospitals and referral centres. Planning and project management support are required to give effect to this.*
Activity 1.4	Improve collection and storage of information on health status of mothers and infants through household survey and register, accessible integrated patient records and information technology strategy. .	*The ECDoH aims to ensure that the health profile and record of all mothers and infants is consolidated through the establishment of a patient master index, supported by virtual private networks, development of general IT systems and process, e-health, HIS, etc. A household survey and patient index will be developed in each pilot register. Focus is to be placed on sharing of experiences between developing countries on the appropriateness of technology developments, and applying these in pilot areas.*

Result 1 **Increased access by mothers and infants to primary health care services through PHC outreach approach in 4 pilot areas**		
ACTIVITY	**INTERVENTION**	**RATIONALE**
Activity 1.5	Provide planning, technical and procurement support to implement a transport strategy to improve mobility of CHPs and EMS and access to health services by mothers and newborns	*Transport of CHPs and EMS to communities, especially in rural areas, is a major challenge for the E Cape, and an appropriate transport solution needs to be designed and implemented.*
Activity 1.6	Develop an integrated school health programme	*School health programmes have been identified as a major investment in improving health and education for young people. It serves to provide a safety net for all learners to ensure that barriers to learning are addressed and learners' overall potential can be met.*

Result 2 **The decentralised District Health System in each of the 4 pilot areas operates effectively and efficiently**		
ACTIVITY	**INTERVENTION**	**RATIONALE**
Activity 2.1	Review and develop an appropriate and efficient patient referral system for mothers and infants specifically with regard to the CHH/CHCs.	*Referral systems from the local level up the system need to be streamlined: from the community to the local clinic, then community health centre and district hospital. These processes require clarity, documentation and operationalisation. Support for the design and implementation of appropriate delegations is also required, including training of personnel in the treatment protocols and referral systems.*
Activity 2.2	Strengthen accountability for health services for mothers and infants through strengthened district health and advisory councils.	*The effective functioning of the District Health Councils and their Advisory Councils is a necessary requirement of the DHS. Strengthening these governance bodies will serve to bolster another aspect of decentralised governance.*
Activity 2.3	Develop appropriate staffing plans for decentralised health care services to mothers and infants in each of the districts for the pilot areas.	*The staffing organogram and job descriptions for the pilot areas needs review and updating to ensure that it is coherent with national guidelines. A model for District Health Staffing can then be created which can be replicated throughout the Province. Standard operating procedures for each category of personnel need to be developed and communicated.*

Result 2 **The decentralised District Health System in each of the 4 pilot areas operates effectively and efficiently**		
ACTIVITY	**INTERVENTION**	**RATIONALE**
Activity 2.4	Develop and implement logistic, planning and management processes to ensure the continual availability of medicines, equipment and medical and surgical supplies to outreach facilities.	*The availability of medicines has been identified as one the 6 fast-track quality assurance priority areas. The ECDoH has identified the strengthening of pharmaceutical management to include logistics and dispensing, as well as quality assurance for both acute and chronic medication as one of the areas requiring support. For each of the four health districts provide planning and technical support to strengthen:* - *Procurement (SCM reform priority area)* - *Financial management* - *HR Management and Development*
Activity 2.5	Decentralise decision making on procurement, and financial management through implementing and monitoring effective and appropriate delegations.	*The success of the DHS relies primarily on the existence of formal and comprehensive delegations. The r-PHC pilots provide a key opportunity to realise the implementation of policy on delegations and the development of the district health system.*

Result 3 **Social compacts are established in each pilot area to achieve optimal participation by communities, women in particular, awareness of health choices and determinants of health, and inter-sectoral collaboration.**		
ACTIVITY	**INTERVENTION**	**RATIONALE**
Activity 3.1	Awareness raising amongst women in pilot communities regarding health services and choices through workshops, communications and outreach programmes.	*Social mobilisation around r-PHC outreach approach, measures to address determinants of health for mothers and babies in particular, and accountability of health service providers. Communication to include messages on women's rights, choice of family planning, feeding infants etc.*
Activity 3.2	Improve accountability and participatory governance of health services to women and infants through building the capacity of community health committees.	*Community health committees, e.g. clinic committees are pivotal to the effective implementation of r-PHC. Clinic / community health committees need to be supported to enable delivery on their key roles of oversight, social mobilisation and advocacy, and to create accountability mechanisms for CHPs. Participation by women in community health committees needs particular attention.*

Result 3 **Social compacts are established in each pilot area to achieve optimal participation by communities, women in particular, awareness of health choices and determinants of health, and inter-sectoral collaboration.**		
ACTIVITY	**INTERVENTION**	**RATIONALE**
Activity 3.3	Undertake a status quo analysis of each of the pilot areas (including stakeholder mapping) in order to develop a pilot area specific engagement strategy.	*This analysis of each of the pilot areas is required to understand the status of the broader social determinants of health such as housing, access to water, sanitation and refuse removal amongst others. The outcomes of this process will be aligned with the business plans that have been developed for each pilot area to ensure implementation.*
Activity 3.4	Design, through the uses of participatory processes, a broader development strategy for each of the pilot areas.	*Based on the status quo analysis (activity 4.2) focus needs to be put on the design and implementation of broad development strategies which seek to coordinate government and other development cooperation agencies' responses to the socio-economic development needs of each of the pilot areas.*
Activity 3.5	Establish cooperatives to involve women in employment around provision of soft health care services such as cleaning, catering, laundry and maintenance.	*The E Cape DEDEA, ECDC, IDC and other agencies provide support to cooperatives and SMEs in terms of technical support and funding. Specific assistance will be provided in order to mobilise these agencies to provide targeted support in pilot areas, to identify and link up potential partners, and to ensure ongoing success of intervention.*

Result 4 **The ECDoH officials are enabled to effectively project manage, coordinate and implement improved services to mothers and infants through the r-PHC programme in the 4 pilot areas**		
ACTIVITY	**INTERVENTION**	**RATIONALE**
Activity 4.1	Undertake a comprehensive **stakeholder** mapping / analysis and **risk analysis** within each of the 4 pilot areas.	*This analysis will be aimed at identifying all important stakeholders and risks within each of pilot areas in order to develop engagement and mitigation strategies. The analysis will also provide a comprehensive status quo report on the implementation of r-PHC. It is important to note that the focus of this analysis is on the broader conceptualisation and implementation of the r-PHC and differs from the types of stakeholder analysis and status quo reports that are required in respect of social compacts (see Result 3 above).*

Result 4 **The ECDoH officials are enabled to effectively project manage, coordinate and implement improved services to mothers and infants through the r-PHC programme in the 4 pilot areas**		
ACTIVITY	**INTERVENTION**	**RATIONALE**
Activity 4.2	Design and implement a **co-ordination strategy** for key role-players.	*Particular emphasis is to be placed on the effective coordination of implementing agencies and resource / service providers to promote a coherent and synchronised approach to improving maternal and infant health through PHC approach.*
Activity 4.3	Ensure integration of r-PHC pilots with quality improvement, quality assurance and NHI programmes	*Comprehensive integration of r-PHC, quality assurance and improvement processes and preparation for NHI is developed and implemented The r-PHC provides the ideal space to begin the process of integration of 3 key reform initiatives: revitalised PHC, quality assurances and the promotion of universal access through the NHI. Specific support will be provided to baseline assessments of facilities in pilot areas, 6 monthly follow up assessments, and support to QI programmes for maternal and newborn health and patient satisfaction surveys.*
Activity 4.4	Develop and implement a broad-based **r-PHC awareness raising** programme.	*To ensure that the programme is effective, it will need to be understood by all stakeholders, within ECDOH and beyond, as well as the broader public. To this end, a marketing and awareness programme will need to be employed to ensure wide-scale buy-in and advocacy of improving maternal and infant health through r-PHC.*
Activity 4.5	Strengthen the existing **M&E** system and process.	*The M&E system required to monitor the support intervention will have to be designed and implemented and aligned with the ECDoH's internal M&E system for the r-PHC. Where necessary, support will be provided to the refinement of the existing M&E system and the collection of data (with specific reference to the documentation of best practice and lessons learnt).*
Activity 4.6	Provide **general technical support** to the Coordinator and sub-committees as required	*The general and technical support will include technical inputs related to project management, coordination, facilitation, planning, knowledge management, M&E and other related functions of the Coordinator and sub committees. Specific emphasis is to be placed on the provision of support to ensuring that the business plans for each of the pilot areas are implemented, and target training and mentoring interventions with head office staff.*

Appendix 6: Budget for Proposed Support to ECDoH PHC programme

		Item	Assumptions	Budget[76]
Result 1: Increased access by mothers and infants to primary health care services in 4 pilot areas		**Item**	**Assumptions**	**R 13,450,000**
Activity 1.1	Develop and implement a comprehensive Community Health Professional (CHP) development programme	Develop criteria for CHP selection		R 50,000
		Develop curriculum and training modules		R 250,000
		Technical support to coordinating training	Technical support @ R50,000 x 6 months	R 300,000
		Develop career pathing for CHPs		R 100,000
		Set up M&E systems for training		R 150,000
Activity 1.2	Training of CHPs, clinic staff and emergency services personnel in line with curriculum	Training CHPs	R4000 per trainee x 500 CHPs	R 2,000,000
		Training clinic staff	R8000 per trainee x 200 clinic staff	R 1,600,000
		Training EMS staff	R8000 per EMS x 50 staff	R 400,000
Activity 1.3	Support planning and project management to improve network of clinics, community health centres, and district hospitals in line with optimum distribution and efficiency models	Technical support to planning of network		R 150,000
		Costing and budgeting support		R 250,000
		Programme implementation support	Technical support @ R50,000 x 9 months	R 450,000
Activity 1.4	Improve collection and storage of information on health status of mothers and infants through household survey and register, accessible integrated patient records and information technology strategy.	Development of patient master index system		R 500,000
		Development of VPN masterplan		R 750,000
		Document internation best practice		R 300,000
		Support to IT procurement process		R 200,000
		Conduct household surveys in pilot areas	R400,000 per pilot area	R 1,600,000
Activity 1.5	Provide planning, technical and	Develop transport strategy for CHPs and EMS	R500 000 to develop strategy	R 500,000

[76] Amounts given in South African Rands, and are exclusive of VAT, for which an additional 14% needs to be added.

		Item	Assumptions	Budget[76]
	procurement support to implement a transport strategy for CHPs and EMS	Technical support to implement strategy	Technical support @ R50,000 x 9 months	R 450,000
		Procurement support for transport strategy	Technical support @ R50,000 x 3 months	R 150,000
Activity 1.6	Develop an integrated school health programme	Training school health teams	R50,000 per school x 10 schools per sub-district x 4 pilots	R 2,000,000
		Support recruitment of school health nurses	Technical support @ R50,000 x 6 months	R 300,000
		Design specialised mobile units for screening		R 500,000
		Development of health education materials		R 500,000

Result 2: Decentralised District Health System in each of the 4 pilot areas		**Item**	**Assumptions**	**R 9,500,000**
Activity 2.1	Review and develop an appropriate and efficient patient referral system with regard to the CHH/CHCs.	Development of PHC referral system		R 500,000
		Development of PHC referral protocols		R 300,000
		Input into training curriculum		R 75,000
		Development of delegations	R50,000 per district x 4	R 200,000
		Technical support to operationalisation	R75,000 per district x 4	R 300,000
Activity 2.2	Strengthen accountability for health services for mothers and infants through strengthened district health and advisory councils.	Develop governance model for DHS		R 75,000
		Legal support to regulations for DHS		R 150,000
		Orientation programme for councils	R150,000 per council x 4	R 600,000
		Develop handbook for councils		R 150,000
Activity 2.3	Develop appropriate staffing plans for decentralised health care services to mothers and infants in each of the districts for the pilot areas.	Develop district organograms	R150,000 per district	R 600,000
		Develop standard operating procedures for each category of personnel		R 1,200,000
		Support costing and budgeting for HR	Technical support @ R50,000 x 3 months	R 150,000

		Item	Assumptions	Budget[76]
		Prepare HRM turnaround plan		R 400,000
		Technical support to HRM in each district	Technical support @ R25,000 x 6 months x 4	R 600,000
		Develop recruitment strategy		R 150,000
Activity 2.4	Develop and implement logistic, planning and management processes to ensure the continual availability of medicines, equipment and medical and surgical supplies to outreach facilities.	Review SCM practices for medicines, equipment & supplies		R 250,000
		Review financial management capacity in each district	R100,000 per district to assess capacity	R 400,000
		Prepare SCM turnaround plan		R 400,000
		Prepare financial management turnaround plan		R 500,000
		Technical support to SCM in districts	Technical support @ R25,000 x 8 months x 4	R 800,000
		Technicla support for financial management in each district	Technical support @ R25,000 x 8 months x 4	R 800,000
Activity 2.5	Decentralise decision making on procurement, and financial management through implementing and monitoring effective and appropriate delegations.	Develop delegations policy		R 150,000
		Develop pro-forma delegations		R 250,000
		Assess capacity in district to receive delegations	R75,000 per district x 4	R 300,000
		Prepare delegations for each district	R50,000 per district x 4	R 200,000

Result 3: Social compacts are established in each pilot area		**Item**	**Assumptions**	**R 5,800,000**
Activity 3.1	Awareness raising amongst women in pilot communities regarding health services and choices through workshops, communications and outreach programmes.	Prepare outreach strategy		R 100,000
		Prepare communication materials		R 250,000
		Engage community stakeholders and leaders		R 50,000
		Conduct community workshops	R25,000 x 20 workshops	R 500,000

		Item	Assumptions	Budget[76]
		Community survey to assess levels of awareness	R100,000 per survery x 4	R 400,000
Activity 3.2	Improve accountability and participatory governance of health services to women and infants through through building the capacity of community health committees.	Develop criteria for selecting committee members		R 30,000
		Develop handbook for committee members		R 150,000
		Support programme to establish committees	Technical support @ R50,000 x 8 months	R 400,000
		Training workshops for committee members	R25,000 x 20 workshops	R 500,000
Activity 3.3	Undertake a status quo analysis of each of the pilot areas (including stakeholder mappings) in order to develop a pilot area specific engagement strategy.	Prepare TOR for status quo analysis		R 20,000
		Conduct status quo analysis in pilot areas	R100,000 per survery x 4	R 400,000
		Communicate and assess results with district stakeholders	R50,000 per district x 4	R 200,000
Activity 3.4	Design, through the uses of participatory processes, a broader development strategy to for each of the pilot areas.	Prepare development strategy for pilot areas	R250,000 per district x 4	R 1,000,000
		Engage stakeholders on strategies	R50,000 per district x 4	R 200,000
		Set up M&E systems for strategies	R50,000 per district x 4	R 200,000
Activity 3.5	Establish cooperatives to involve women in employment around provision of soft health care services such as cleaning, catering, laundry and maintenance.	Engage DFIs and support facilities		R 50,000
		Conduct market analysis		R 200,000
		Prepare information material on opportunities		R 150,000
		Conduct awareness workshops	R50,000 per district x 4	R 200,000
		Support identification and establishment of cooperatives	Technical support @ R50,000 x 8 months	R 400,000
		Support contracting and monitoring of cooperatives	Technical support @ R50,000 x 8 months	R 400,000

		Item	Assumptions	Budget[76]
Result 4: ECDoH officials enabled to implement r-PHC programme in the 4 pilot areas		**Item**	**Assumptions**	**R 11,915,000**
Activity 4.1	Undertake a comprehensive stakeholder mapping / analysis and risk analysis within each of the 4 pilot areas.	Stakeholder and risk analysis	R80,000 per pilot area x 4	R 320,000
		Status quo report on implementation	R80,000 per pilot area x 4	R 320,000
		Communicate and assess results	R50,000 per district x 4	R 200,000
Activity 4.2	Design and implement a co-ordination strategy for key role-players.	Develop stakeholder coordination plan		R 150,000
		Train officials on engagement strategy		R 250,000
		Support stakeholder engagement process	Technical support @ R25,000 x 8 months	R 200,000
		Review progress and adjust plan		R 100,000
Activity 4.3	Ensure integration of r-PHC pilots with quality improvement, quality assurance and NHI programmes	Support engagement with QA, QI and NHI programmes		R 100,000
		Conduct baseline assessment of facilities in each pilot area	R25,000 per facility x 100	R 2,500,000
		Engage QA authorities on assessment		R 75,000
		Conduct 6 monthly follow up assessments	R25,000 per facility x 100	R 2,500,000
		Support QI programmes	R200,000 per district	R 800,000
Activity 4.4	Develop and implement a broad-based r-PHC awareness raising programme.	Develop marketing and awareness programme		R 250,000
		Develop communication materials		R 150,000
		Support marketing campaign	Technical support @ R50,000 x 6 months	R 300,000
		Website and social networking media		R 250,000
Activity 4.5	Strengthen the existing M&E system and process.	Develop M&E system		R 250,000
		Establish baseline data and situation		R 500,000
		Support ongoing monitoring process	Technical support @ R25,000 x 6 months	R 150,000
		Conduct baseline assessment		R 300,000

		Item	Assumptions	Budget[76]
		Concduct annual assessments	R150,000 per annum x 2	R 300,000
		Conduct close out evaluation		R 450,000
Activity 4.6	Provide general technical support to the coordinator and sub-committees as required		R250,000 per technical committee x 4, plus R500,000 for support to coordinator	R 1,500,000

Sub-total		**R 40,665,000**
Project management	7.5% of overall costs	**R 3,049,875**
VAT	14% of overall costs	**R 6,120,083**
Total		**R 49,834,958**

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