**APPENDIX 1**

**REVITALISING PRIMARY HEALTH CARE IN SOUTH AFRICA:**

**Review of primary health care package, norms and standards**

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**11 November 2010**

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# ACKNOWLEDGEMENTS

This review has been conducted with funding from the Henry J. Kaiser Family Foundation.

We wish to thank Dr Peter Barron and Hasina Subedar for facilitating access to key individuals and relevant documents. Thanks to the provincial members of the National District Health Committee and senior managers in the National Department of Health for the valuable insights provided during the telephone interviews. Dr Duane Blaauw commented on earlier drafts of sections 3 and 4. We also wish to thank Elma Burger and Professor Helen Schneider for making available documents on rehabilitation and community health workers respectively.

The views presented in this report are those of the authors and are based on an analysis of the documentation located and the inputs received during the interview process. These views do not necessarily represent the decisions, policy or views of the national Ministry of Health, government officials and/or the Henry J. Kaiser Family Foundation.

# ACRONYMS AND ABBREVIATIONS

|  |  |
| --- | --- |
| AIDS | Acquired Immunodeficiency Syndrome |
| ART | Anti-retroviral Therapy |
| ARV | Anti-retroviral  |
| BOD | Burden of disease |
| CHC | Community health centre |
| CHP | Centre for Health Policy |
| CHW | Community Health Worker |
| DALY | Disability adjusted life year |
| DALYs | Disability adjusted life years |
| DOH  | Department of Health |
| DOTS | Directly observed treatment support |
| EDL | Essential drug list |
| EPI | Expanded Programme on Immunisation |
| FEFO | First expired, first out |
| HAART | Highly active anti-retroviral treatment |
| HCT | HIV counselling and testing |
| HIV  | Human Immunodeficiency Virus |
| HOD | Head of Department |
| HR | Human Resources |
| HSS | Health Systems Strengthening  |
| IEC | Information, Education, Communication |
| IMCI | Integrated Management of Childhood Illnesses |
| LMICs | Low and middle income countries |
| M&E  | Monitoring and Evaluation |
| MCH  | Maternal and Child Health  |
| N/A | Not available/ not applicable |
| NDOH  | National Department of Health |
| NGO | Non-Governmental Organisation |
| NHI | National Health Insurance |
| NHLS | National Health Laboratory Services |
| ORT | Oral rehydration therapy |
| OVC | Orphan and vulnerable children |
| PHC  | Primary Health Care |
| PMTCT | Prevention of Mother-To-Child-Transmission |
| STI | Sexually Transmitted Infection |
| TB  | Tuberculosis |
| TOP | Termination of Pregnancy |
| UNICEF | United Nations Children’s Education Fund |
| WHO  | World Health Organization |

# EXECUTIVE SUMMARY

**Introduction**

The accompanying report contains the background, methods, results and recommendations of the review conducted by the Centre for Health Policy (CHP) of the primary health care (PHC) package of health services, as well as PHC norms and standards in South Africa. The review was commissioned at the beginning of October 2010 by the Ministerial PHC revitalisation team, established at the initiative of the honourable Minister of Health, Dr Aaron Motsoaledi.

The aims of the review was to conduct a rapid review of PHC package of health services and the PHC norms and standards and make recommendations for a revised comprehensive PHC service package, such that the proposed services:

* Assist with the achievement of health outcomes and a reduction of mortality and morbidity from the major causes of ill-health;
* Have a population orientation*,* focusing on priority health needs of geographically diverse populations;
* Include prevention, promotion and good quality, essential care.

The approach to the desktop review of the PHC package of services, norms and standards consisted of three strands, highlighted below:

* *A review and synthesis of the literature* on PHC packages in low and middle income countries (LMICs); peer reviewed journal articles and/or expert commentary on the advantages and challenges of formulating packages and norms; and evaluations of implementation of service delivery packages in LMICs.
* *Contacting expert key informants* in South Africa (six) and in four other African countries (Ethiopia, Kenya, Tanzania and Uganda), requesting information on PHC service packages and progress and challenges with implementation
* *Telephone interviews with provincial representatives* on the National District Health System Committee and experts in the national Department of Health (DOH).

**Highlights from the literature review on PHC packages**

In recent years, many LMICs have defined service packages as a key strategy to improve health system effectiveness and the equitable distribution of resources. However, the concept of PHC packages remains contested and has attracted criticisms at the level of: the underlying philosophy; the approach and processes used in their formulation; and the tendency for packages to be top-down centralised processes, ignoring the autonomy of health professionals and the varying needs of communities. Successful implementation of service packages is often accompanied by comprehensive health care reforms; a clear outline of service provision at primary, secondary and tertiary levels of care; accurate costing of resource requirements; institutionalized mechanisms for review of the interventions within the package, and pre-specified plans to update these reviews; and community participation.

**Highlights from the review of PHC package implementation in South Africa**

Eight out of nine provinces responded to the telephone survey on PHC package implementation. The PHC package has provided a vision of service delivery for health workers and managers at the district level. Reported progress includes the availability and accessibility of a wide range of PHC services and the addition of new services, such as ART provision and rehabilitation. The PHC guidelines have also facilitated planning and negotiation of additional financial resources in some instances; served as a catalyst for the development of clinical support services (e.g. laboratory services); enabled further and ongoing training of health care providers; and facilitated monitoring and evaluation of service provision.

At the same time, the assessment also highlighted wide variation in the implementation of the package across the nine provinces, illustrated by variations in the estimated provincial performance on the selected indicators. The provision of all PHC services on the same day ranges from 70% in Northern Cape, North West and Gauteng to 100% in Kwazulu-Natal and the Western Cape. The initiation of ART at eight-hour clinics is an encouraging development. However, ART initiation at CHCs varies from a low of 38% in Mpumalanga to 100% in Gauteng, Kwazulu-Natal and Western Cape, perhaps reflecting better staffing in the urban settings. The availability of a nurse with specialised mental health training appears to be a problem in all provinces, with either low reported performance, or respondents equating the existence of a professional nurse with specialised mental health skills. Only Mpumalanga and Western Cape reported that fast queues for elderly people were available in all facilities. There was also variation on awareness/ existence of organisational structures and budgets at CHC and clinics. Lastly, the existence of functioning clinic committees is an important indicator of health system responsiveness and/or accountability to communities. This varied from zero functioning clinic committees in North West province to 100% functional community structure in the Western Cape, albeit at a cluster/sub-district level.

Human Resource challenges were consistently mentioned by all provincial respondents, as a factor hampering ‘full’ implementation of the package. Similarly, a range of infrastructure, financial and other constraints were mentioned by provincial respondents. These issues have to be addressed to ensure successful implementation of the revised PHC package, norms and standards.

**Key recommendations on an essential PHC package for South Africa**

Section 5 of the report contains the recommendations on an essential package of PHC interventions for South Africa. The proposed services have **not** been costed. Prior to formal adoption of the PHC service package, accurate costing should be done to ensure affordability and feasibility of implementation.

Using the key health system building blocks of the health system, a set of generic norms and core standards for clinics and community health centres is proposed. The main criteria for the selection of the proposed package of PHC services are listed below:

* Address priority health problems in South Africa
* Improve health status and focus on morbidity and mortality from the major causes of ill- health
* Comprehensive approach, with a focus on prevention and promotion as well as cure
* Achieve intended health outcomes envisaged in the Ministerial service delivery agreement
* Target vulnerable populations e.g. disabled individuals
* Achieve a balance between a family and population focus, while responding to the demands of the population
* Focus on services that are practical, essential and comprehensive and cost-effective
* Promote equity
* Staff availability and working as a team at community-based, clinic and health centre levels

A number of key interventions and four priority focus areas within PHC are proposed.

1. Maternal, women and child health
	1. Immunisation,
	2. Antenatal care
	3. Postnatal care
	4. School health
2. HIV and tuberculosis
3. Chronic non-communicable disease
4. Violence and injuries

For each of these areas, a comprehensive approach, with a focus on prevention and promotion, is proposed. Health care activities at community, clinic and community health centre are given. Services at clinics have been defined by the level of skills of staff and not by the size of the facility. An outline of services provided in each of the focus areas is then given. Service delivery targets are given where available in the current National Strategic Plan or in recent policy documents. Given the considerable variation in capacity and availability of resources, each district should have the flexibility and capacity to offer additional services in order to address the burden of disease in their area, as well as the demands of its population.

The proposed PHC package, norms and standards should be seen as a ***guiding document, rather than a rigid, one size fit all prescription***. The team wishes to stress the following:

1. The proposed package of services should be *flexible and tailored* to the particular needs of the province and area of implementation. Priority setting and planning processes at sub-district and district levels should highlight local priorities and a profile of services should then be developed that is based on the particular profile of need in that area.
2. A broader public health approach, which emphasises prevention, is critical.
3. Prioritising specific areas does not imply that *treatment of minor ailments* and specific conditions is unimportant. These services are important and remain in the package.
4. The PHC system can only achieve the desired outcomes if it is supported by other levels of the health system in a coordinated and integrated manner. The delivery of good quality essential care relies on *effective referral relationships with and support* from district hospitals, (in addition to clinical competencies to identify when these referrals are needed).
5. The delivery of a comprehensive primary health care package requires *adequate resources:* funding, adequate, committed and motivated staff and the necessary infrastructure and clinical support services (e.g. pharmaceuticals) in order to deliver high quality and efficient services. These resource requirements are part of separate components of work, and should be completed prior to any implementation of the proposed package.
6. Addressing the *social determinants of health*, in particular, requires action at multiple levels. Although we have suggested a number of opportunities for inter-sectoral, these are indicative only, and meant to highlight an approach rather than provide a prescription.
7. Consultation with key stakeholders, flexibility in the application and implementation of the guidelines and determined efforts to strengthen implementation are needed;
8. It is essential to develop an ongoing monitoring, auditing and evaluation framework for the proposed PHC package of services, with mechanisms built in for period revisions of the PHC package, norms and standards.

# SECTION 1: CONTEXT AND BACKGROUND

## 1.1 Introduction

Since 1994, several initiatives have been implemented to promote the development of the district health system and to strengthen primary health care (PHC) in South Africa.1-4 These initiatives include, inter alia, the promulgation of the National Health Act, which formalised the legal status of the District Health System, structural and policy changes, removing access barriers through free PHC services and the clinic building programme, and implementation of health programmes for priority conditions.1-4 Although many of these initiatives increased access and care for the majority of poor South Africans, the early gains and improvements have been compromised by a multiplicity of factors, including a quadruple burden of disease, low morale among health personnel, inadequate management systems and huge gaps between policy intentions and actual implementation.1-2, 5-9 Consequently, health outcome indicators such as infant mortality, immunization rates, early childhood malnutrition, and maternal mortality are poor and not commensurate with the per capita rates of health expenditure.5, 10-12

The current health political leadership has committed itself to a substantial overhaul of the public health sector, in order to: address the complex burden of disease; improve health outcomes, access and affordability; and ensure responsiveness to the needs of the population.2 The central elements common to all these efforts are the revitalisation of PHC and the implementation of a national health insurance (NHI) system.2 The revitalisation of PHC is one of the key outputs of the service delivery agreement signed between the Minister of Health and the President of South Africa during October 2010 and is at the core of revitalising and strengthening of the South African health system.13-14 It is envisaged at the proposed ‘*NHI fund will provide an evidence-based comprehensive package of services, which includes all levels of care, namely primary, secondary and tertiary’* to all citizens and legal residents.13

During the first half of 2010, the Minister of Health established a task team to advise him on the re-engineering of PHC in South Africa.15 As part of the PHC revitalisation initiative, the Centre for Health Policy (CHP) at the School of Public Health, University of the Witwatersrand, Johannesburg, was requested to review the 2001 PHC package of health services and the PHC norms and standards to ensure that the revised PHC services are: outcomes-based; have a population orientation, and assists with the reduction of mortality and morbidity from the major causes of ill-health. CHP was contracted on 8 October 2010.

## 1.2 Specific objectives of the review

1. Review the principles, approach and methods used to develop PHC packages, with particular focus on low and middle income countries (LMIC)
2. Undertake a desktop review of the PHC package of health services, and the PHC norms and standards, specifically:
* Official/draft documents from national and provincial departments of health and from programme clusters or divisions (e.g. maternal and child health; HIV&AIDS; tuberculosis; chronic disease cluster, the office of standards compliance) on PHC service package, norms and standards;
* Official/draft documents from a limited selection of non-governmental and community-based organisations to provide examples of good practices;
* An analysis of peer reviewed literature on package of PHC services, norms and standards;
* An analysis of grey/unpublished documents obtained from the main organisations/experts that focus on PHC or district-level services (e.g. Health Systems Trust).
1. Submit and present a draft report of national, provincial and literature findings
2. Formulate an initial set of recommendations on comprehensive PHC services, norms and standards

## 1.3 Outline of the report

The next section of the report summarises the approach and methods to the review of PHC service package(s). Section 3 summarises the international context and debates on PHC packages, norms and standards. Section 4 provides an overview of the South African context, including a brief discussion of the burden of disease, the history of PHC packages in South Africa and the experience of implementing packages in South Africa. It concludes with a summary of current state of implementation based on a telephone survey of provincial health departments. Section 5 proposes an essential package of PHC services for South Africa, and a set of generic norms and standards for PHC facilities. The concluding section suggests some first steps to be taken to finalise the PHC package for South Africa and highlights key aspects that need to be taken into account in the successful implementation of the PHC service package.

# SECTION 2: APPROACH AND METHODS

## 2.1 Introduction

The approach to the desktop review of the PHC package of services, norms and standards consisted of three strands, highlighted below:

* *A review and synthesis of the literature* on PHC packages LMICS; peer reviewed journal articles and/or expert commentary on the advantages and challenges of formulating packages and norms; and evaluations of actual implementation of service delivery packages in LMICs.
* *Contacting expert key informants* in South Africa (six) and in four other African countries (Ethiopia, Kenya, Tanzania and Uganda), requesting information on PHC service packages and progress and challenges with implementation
* *Telephone interviews with provincial representatives* on the National District Health System Committee and experts in the national Department of Health (DOH).

In both the desk review and interviews, particular attention was given to examining the process and implementation outcomes of the 2001 South African PHC Package and Norms and Standards.16-17

Although these strands overlap, each is described briefly below.

## 2.2 Literature review

The MEDLINE database was searched using the Pubmed interface with the following terms: “Primary Health Care [mesh term] AND (package\* OR norm\* OR standard\*”). We were interested in obtaining information on PHC packages of other countries, examining the criteria used to select interventions; estimated costs of package; and level of attention given to an implementation and monitoring plan for the package. A search was also done with the key words well used in a previous review on this topic: ‘primary care,’ ‘primary health care, ‘evaluation’ ‘costs,’ ‘cost-effectiveness,’ and ‘effectiveness’.18 Several websites that contain sources of relevant grey literature were searched, such as the World Health Organization ([www.who.int](http://www.who.int)), the Disease Control Priorities Project (<http://www.dcp2.org>), and local organisations, such as the Health Systems Trust ([www.hst.org.za](http://www.hst.org.za)).

National DOH clinical guidelines were reviewed and we extracted the interventions that these guidelines stated should be provided at PHC level. We paid particular attention to the following documents:

* The Primary Health Care Package for South Africa – a set of norms and standards. 2000 (Last printed 2002). This document provides norms and standards for a number of priority health condition for PHC facilities and for district hospitals (Appendix 1).16
* Standard treatment guidelines for PHC (2008 edition): a number of conditions (Appendix 1) are covered in terms of a description of each condition / symptom, diagnosis, treatment and criteria for referral ( [www.doh.gov.za/docs/facts-f.html](http://www.doh.gov.za/docs/facts-f.html)). This document includes a list of essential drugs to be available at each level.
* Available “Fact sheets and Guidelines” for the management of clinical conditions. Since 1994, treatment guidelines for a number of specific clinical conditions have been printed. Those available on the National DOH website were reviewed. This list is available in Appendix 2. All guidelines were reviewed and in instances where specific activities should take place at the PHC level, these are included in the essential package of interventions.
* Documents available on the websites of Provincial Departments of Health were also obtained to determine how many were still making use of the South African 2001 PHC package in developing their strategic plans.

## 2.3 Contacting expert key informants

Ten expert key informants were contacted (six in South Africa, one each in Ethiopia, Kenya, Tanzania and Uganda), who have in-depth knowledge of PHC, or have been involved in development of PHC packages, burden or disease and/or cost-effectiveness analyses. The experts were asked for published information on PHC service packages as well as documented evidence on progress and challenges with implementation.19-22

## 2.4 Telephone interviews

The aim of the telephone interviews was to get a helicopter view of implementation of the 2001 PHC package implementation in the nine provinces. A semi-structured interview guide was developed to assess the following: awareness of the 2001/2002 PHC package and norms and standards developed by the national DOH and formal adoption by the provincial DOH; whether the Province has developed its own PHC package, norms and standards; progress with the implementation of the national PHC package; perceptions of whether the PHC package is a useful tool to improve ambulatory health care services; estimates of percentage implementation at community health centres (CHCs) and eight-hour clinics of a selection of key elements contained in the PHC package, norms and standards; successes with and challenges of implementation of the PHC package/ norms and standards; existence of provincial policies on referral system and clinical support services for PHC (e.g. laboratory, drug supplies, etc); stakeholders that should be consulted and involved in developing an updated PHC package; opinions on the balance between preventive/ promotive and curative services in the revised PHC package; and advice to the CHP team on developing a revised PHC package

The list of names of the members of the national District Health Systems Committee was obtained from the national DOH. Each provincial representative on the list was contacted, the project was explained to the person and their voluntary participation was sought. In those instances where the team was referred to another individual, the same procedure was followed. Once the person agreed to be interviewed, a suitable time for the interview was arranged. Interviews took between 20-30 minutes each; the interviewer completed the questionnaire during the interview and wrote down the verbatim responses. Two members from the Ministerial PHC task team and one national DOH senior official was also interviewed, covering only those areas in the interview schedule that were relevant.

Once all interviews were complete, one member of the research team analysed the interview findings, and used the same categories in the interview guide to record the responses in tabular form. In some instances, illustrative quotations from respondents are provided.

# SECTION 3: INTERNATIONAL CONTEXT

## 3.1 Service-delivery packages within international public health strategies

More than 30 years after the Alma-Ata PHC Declaration, the goal of “health for all”, remains off target in many countries and huge inequities remain between and within countries.23-26 The 1978 Alma-Ata Declaration on PHC, the first international declaration underlining the importance of PHC, expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world.24 The declaration articulated an overall philosophy, principles and strategies for organising health systems, underpinned by the values of equity, social justice and health as a fundamental right. The strategies of PHC include providing access to good quality health care as well as preventive and promotive services for priority health needs, inter-sectoral action at local level to address the root causes of ill-health, and enhanced community participation and accountability.27

In the early 1990s the concept of service packages was put forward as a means of moving away from the vertical programming which had characterised the preceding decade and achieving positive impact on the health of people in developing countries.18, 28 The concept was also seen as a means of redressing the continued skewed allocation of resources towards curative services, especially hospital-based care.26 The first edition of *Disease Control Priorities in Developing Countries* waspublished in 1993,29 and its findings were incorporated in the 1993 *World Development Report*, which advocated for minimum packages of care.28 These documents, of major influence in global health policy, brought together the concepts of burden of disease, disability-adjusted life years (DALYs) and cost-effectiveness analysis and provided theoretical tools for health care priority setting.18, 28 Nevertheless, despite these efforts, in large part vertical services remained, perhaps reflecting the difficulties of delivering and monitoring a wide range of services.18

In recent years, many LMICs (55 out of 69 countries in one review) have defined service packages as a key strategy to improve health system effectiveness and the equitable distribution of resources.26, 30 Service packages are also seen as tools for planning and prioritisation, assisting with a shift of resources between different levels of services (e.g. hospitals to PHC) and/or to under-resourced geographical areas and facilities.26, 31 In South Africa, the PHC package was seen as tool for quantifying staffing, infrastructure, equipment and financial requirements, providing a solid foundation for a single unified health system and contributing to greater social justice and the reduction of health inequities.17

## 3.2 Critique of the concept of a package

The concept of PHC packages has attracted criticisms at the level of: the underlying philosophy; the approach and processes used in their formulation; and the tendency for packages to be top-down centralised processes, ignoring the autonomy of health professionals and the varying needs of communities.32-34 Critics have suggested that the concept is counter to the principles of PHC enshrined in the Alma Ata Declaration.32-33 Others have argued that the package approach may be best suited to a world of insurer-purchasers where activities and outputs can be well specified and where appropriate incentives are in place to ensure that health workers carry out these activities.35 This is because most public health systems in LMICs do not resemble an insurer-purchaser arrangement.35

A defined package of services may also be seen as restricting the autonomy of health workers, diminishing the delivery of beneficial services for the individual patient.18 Critics have also raised objections to the methods used to construct packages of services.36-37 Burden of disease estimates, for example, incur the hazards of discounting future benefits, age weighting and placing values on different states of ill-health.18 Further, the analytical approaches used in cost-effectiveness estimates are criticised for their frequent exclusion of patient costs (such as transport costs and waiting time) when calculating the total costs of an intervention. Perhaps most importantly, burden of disease, costs, effects and therefore cost-effectiveness vary markedly between settings, limiting the transferability of findings across different contexts. The limited availability of locally applicable data to guide decisions is exacerbated by the dearth of information about the distribution of the burden of disease across socio‐economic groups, and the costs of addressing this burden in different socio-economic groups.18 Focusing too closely on constructing an efficiency-oriented package of services risks narrowing the scope of PHC to a set of technical interventions and ignoring the social determinants of ill-health.37-38 This can resemble the over-technical emphasis that underscored selective PHC, and can downplay the considerations of social justice and empowerment that characterised an Alma Ata primary health care approach.39 Moreover, though presented as a package, the listing of individual interventions promotes vertical programming, either subtly or overtly.40 Some argue that a locally (rather than nationally) devised package of services is preferable, based on an understanding of the local community health profile.41 A final argument against simply using cost-effectiveness as a predominant criterion in priority setting is that this ignores community expectations of health service delivery, beyond merely the reduction of death and disability.38

Proponents of service packages have argued that a defined package might well reduce the provision of some ineffective therapies (such as antibiotics for the common cold) and could also counter the tendency of health workers and other interest groups to over-emphasise the importance of addressing complex conditions and of applying new sophisticated treatments.29 Furthermore, *‘verticalisation’* is not the intention of service packaging 42 and in some settings a package has had the opposite effect.35, 43 Bringing all programme areas together in one document and developing one unified process across programme areas might well reduce the persistent fragmentation of service planning and implementation. Overall, while formulating packages of services is often a necessary planning step, their implementation is contingent on the strength of the underlying health system. The main challenge faced by health managers is not choosing which services to be delivered, but rather is figuring out ways of providing an ongoing set of services within existing capacity and resource constraints.

## 3.3 Methods for choosing interventions

To date, a range of methods have been used in the process of formulating a package of services. These include a cost-effectiveness and burden of disease approach; expert opinion; a pragmatic approach of adopting the package of services provided in best practice sites; or a hybrid approach combining some or all of the other options. Formulating a package must, as far as possible, be based on explicit and objective criteria and focus on addressing unmet needs (Table 1). These criteria can be classified as national contextual factors (e.g. the health status of the population, values of equity and social solidarity, etc); issues specific to the methods selected to guide formulation of the package; considerations stemming from the possible health care interventions; and health system factors.

Table 1: Factors to consider in formulating a PHC service package

|  |  |
| --- | --- |
| National context | * Burden of disease and demand for services
* Financial resources available to the health sector
* Interventions already agreed for implementation in national-level guidelines
* Historical structure of the health system and traditions of health practices(such as nurse versus doctor led)
* Commitment to values of equity and social solidarity
 |
| Methodology  | * Availability of high-quality local data on burden of disease and cost-effectiveness, or generalisable regional estimates of these
* The weight given to patient and public health perspectives
* Completeness of data and the provision of interventions which only accrue benefit at a much latter point in time
* Availability of evidence about services and methods of provision most likely to ensure that the poor accrue most benefit
 |
| Characteristics of possible interventions  | * Effectiveness of interventions and their impact on the burden of disease
* Cost-effectiveness of interventions
* Development of new technologies
* Social and cultural acceptability of interventions
* Focus on health promotion and prevention as well as curative and rehabilitation services
 |
| Health system factors | * Planned health sector reforms
* Decentralisation of services from hospitals to PHC
* Financial resources for the package
* Human resources and capacity (ability to attract and retain staff)
* Present efficiency of service delivery
* Coverage with existing services
* Extent to which services are already integrated
* Available physical infrastructure
* Geographic, financial and cultural accessibility of services
* Management and logistical support
* Functionality of referral system
 |

In the cost-effectiveness approach, “best health buys” are identified, based on evidence of the most successful and cost-effective interventions. This approach highlights opportunities that are ignored or underfunded, and draws attention to current investments that consume unnecessary resources. Developing and implementing packages thus provides one means of operationalising a cost-effective approach to health.29

Table 2 highlights the cost effectiveness of a cluster of interventions proposed by the World Bank as the minimum package of services.18, 28

Table 2: Cost effectiveness and annual cost per capita of selected interventions

|  |  |  |
| --- | --- | --- |
| **Interventions** | **Cost per DALY ($) middle income countries (2001)** | **Annual cost per capita ($) 2001 prices** |
| **Public Health** |
| Expanded programme on immunisation (EPI)  | 32-38 | 1.0 |
| School health programme | 48-54 | 0.8 |
| Tobacco and alcohol control programme | 57-70 | 0.4 |
| AIDS prevention programme | 16-23 | 2.5 |
| Other public health interventions (information, communication and education, vector control, disease surveillance | Not known | 3.9 |
| **Clinical services** |
| Chemotherapy for TB | 6 – 9 | 0.3 |
| Integrated management of Childhood Illnesses (IMCI) | 63 – 127 | 1.4 |
| Family planning | 127 – 190 | 2.8 |
| STI treatment | 13 – 19 | 0.4 |
| Prenatal care and delivery care | 76 – 139 | 11.1 |
| Limited care (treatment of infections, trauma) | 507 - 760 | 2.7 |

Adapted from Doherty & Govender.18

The ongoing WHO CHOICE (CHOosing Interventions that are Cost-Effective) project aims to provide policy makers with evidence to guide selection of the interventions and programmes which maximize health for the available resources.44 WHO-CHOICE reports the costs and effects of a wide range of health interventions by WHO sub-region, which can then be adapted to the demographic, epidemiological and economic situation in a country. In such an adaptation, all parameters of the model should be scrutinised and revised based on disease incidence and prevalence, intervention coverage and effectiveness, and rates of service utilization. Tables 3 and 4 give the leading ten selected risk factors as percentage causes of disease burden measured in DALYs and a summary of conclusions on the cost-effectiveness of interventions against these risks.

Table 3: Leading 10 risk factors in developing countries

|  |  |  |  |
| --- | --- | --- | --- |
| **Risk factor** | **Cause of disease burden (%) measured in DALYs** | **Risk factor** | **Cause of disease burden (%) measured in DALYs** |
| **High Mortality countries** | **Low Mortality countries** |
| Underweight | 14.9 | Alcohol | 6.2 |
| Unsafe sex | 10.2 | Blood pressure | 5.0 |
| Unsafe water, hygiene and sanitation | 5.5 | Tobacco | 4.0 |
| Indoor smoke from solid fuels | 3.7 | Underweight | 3.1 |
| Zinc deficiency | 3.2 | Overweight | 2.7 |
| Iron deficiency | 3.1 | Cholesterol | 2.1 |
| Vitamin A deficiency | 3.0 | Indoor smoke from solid fuels | 1.9 |
| Blood pressure | 2.5 | Low fruit and vegetable intake | 1.9 |
| Tobacco | 2.0 | Iron deficiency | 1.8 |
| Cholesterol | 1.9 | Unsafe water, sanitation and hygiene | 1.7 |

Source: World Health Organization, 2002:102**45**

Table 4: Conclusions on cost effective interventions against risks

| **Strategy** | **Assessment of cost effectiveness** |
| --- | --- |
| Protection of the child’s environment | * Cost effective in all settings
* Very cost effective components
	+ Some form of micronutrient supplementation
	+ Disinfection of water at point of use to reduce diarrhoeal diseases
	+ Treatment of diarrhoea and pneumonia
 |
| Preventive interventions to reduce the incidence of HIV infections | * Very cost effective although care needs to be taken when extrapolating the effectiveness of behaviour change from one setting to another
* Use of some types of antiretroviral therapy in conjunction with preventive activities is effective in most settings
* DOTS combined with testing for resistance is not cost effective in all settings although there may be other reasons to pursue this strategy
 |
| Improved water supply | * Cost effective in regions with high child mortality
 |
| Interventions to reduce the risk of CVS | * At least one type of intervention cost effective in all settings
* Population wide salt and cholesterol lowering strategies are always very cost effective – singly and combined
* Combining them with an individual risk reduction strategy is also cost effective, especially with interventions to reduce risk based on assessment of absolute risk
* The cost effectiveness of absolute risk approach could improve further if it is possible to assess accurately individual risks without the further need for lab tests.
* Increased physical activity was not evaluated but should be considered as an additional strategy
 |

Source: World Health Organization,2002:10245

The interventions with a large potential impact in health outcomes as identified by the World Health Report 2000 are shown in Table 5.46

Table 5: Interventions with a large potential impact on health outcomes

|  |  |
| --- | --- |
| Treatment of tuberculosis | DOTS. Administration of standardised short course chemotherapy to all confirmed sputum positive cases of TB under supervision |
| Maternal health and safe motherhood interventions | Family planning, prenatal and delivery care, clean and safe delivery by a trained birth attendant, post partum care and essential obstetric care for all high risk pregnancies and complications |
| Family planning | Information and education, availability and correct use of contraceptives |
| School health interventions | Health education and nutrition interventions, including anti helminthic treatment, micronutrient supplementation and school meals |
| IMCI | Case management of acute respiratory infections, diarrhoea, malaria, measles and malnutrition; immunisation, feeding counselling, micronutrient and iron supplementation, anti helminthic treatment |
| HIV / AIDS prevention | Targeted information for sex workers, mass education awareness, counselling and screening, mass treatment for STI and safe blood supply |
| Treatment of STI | Case management using the syndromic approach |
| Immunisation | As per schedule |
| Malaria | Case management and selected preventive measures |
| Tobacco control | Tobacco tax, information, nicotine replacement and legal action |
| Non-communicable diseases and injuries | Selected early screening and prevention |

Source: World Health Report 200046

The dynamic interplay, however, between cost-effectiveness, burden of disease, health system performance and equity considerations means that the process of constructing a package is more complex than a simple prescription of a set of cost-effective interventions. Nevertheless, in more than ten packages of PHC services reviewed, each had broadly similar contents, indicating a surprisingly high degree of consensus on the range of activities to be provided at primary level.17, 19-22, 26, 28-29, 31, 45, 47-49

A lengthy and labour-intensive process of formulating a service package may fail to return proportional gains. Longer processes with broader consultation may, however, increase buy-in and the likelihood of subsequent implementation of the package. A package developed quickly and at low cost, taking advantage of what is already done in the field, is perhaps the most sensible approach.33 Ultimately, the approach depends on the country context and circumstances, and recognising that a defined PHC package is only the starting point and that implementation of any health policy is brought alive by the ways in which actors, including service providers, interest groups, patients and community members, translate their understanding of legislation/ policies into their behaviours and practices.50-51

There are several risks to avoid during formulating a package of services. Resource allocation tends to follow socio-political processes rather than evidence and equity considerations, and firm negotiation plays a central role in health planning.33, 51-52 Moreover, selection of interventions can be overly influenced by interest groups and cultural considerations, and face considerable challenges in altering a previous, often long-standing, (mis)allocation of resources. Ultimately, care is needed to avoid packages merely containing all the services seen as desirable by health professionals, experts and established programme areas, without being cognisant of the resources required. Lastly, key elements of the PHC approach – equity, decentralisation and community participation – need to receive adequate attention during construction of the package.

## 3.4 The optimal size of a package

The main tensions in formulating a package of services are: deciding on the number and range of services to be included in the package; and distinguishing between the activities that might be decentralised to primary level and those that would best occur elsewhere. In principle, given the comparative advantages of PHC services in access and their potential for personalised continuous care, services should be provided at the primary rather than hospital level wherever possible.

The optimum size of the PHC package requires consideration of whether to aim for a minimum, essential or a comprehensive package. A minimum package is able to control a large portion of the disease burden, has a higher likelihood of being implemented evenly across the country, but will address a narrower range of conditions.18 A minimum package also risks ignoring the high value that society places on having a wide range of services available. For example, the private sector in South Africa is characterised by the provision of a defined, minimum benefit package, with additional services paid out-of-pocket or from top-up insurance. An essential package, by contrast, adopts an incremental approach, and was originally defined as the addition of services that can be afforded to the minimum set.28 At the other extreme, a fully comprehensive, very large package, may incur much variation in the range and quality of services implemented, and exacerbate inequities. The larger the range of services funded the larger the variation in service provision, while conversely it might be more likely that all facilities can provide a minimum set of interventions at adequate standards. Another approach is the phased implementation of interventions, where several packages of services of varying size are defined. Once a district, for example, implements a package at sufficient quality and coverage, additional larger packages are then incrementally added until the full package is delivered.53

There is often political pressure to expand the contents of packages, and to avoid explicit rationing of services, even when these additional services are unlikely to be implemented. Other factors driving a larger package include the higher satisfaction of the public with having access to a wide-range of services, and the gains in wellbeing arising from the knowledge that such services are universally available. However, a smaller package that aims to maximise health gains from a focused set of interventions at high coverage might economise on the present scarce managerial and administrative capacity. Ironically, where health systems function poorly, it may be preferable to aim for a smaller package, provided at high coverage, followed thereafter by gradual expansion of the package informed by ongoing monitoring of its outcomes. Overall, a balance is required between aiming for a minimum package with fuller coverage, targeted at the poor, or a larger package with more variation in coverage and larger inequities.54 It can also be argued that a small package may be inequitable as those wealthier are more able to purchase additional services not included in a minimum package, and that the poor may suffer catastrophic expenses when suffering from a condition excluded from the package. Overall, it may be best to construct a realistic and practically-achievable package, matched as closely as possible to the available resources and health care delivery systems.

## 3.5 Experience with implementationof PHC packages

Developing packages, norms and standards for care has been one of the key strategies used to improve the effectiveness of health systems and the equitable distribution of resources.26 On the whole, attempts to alter service delivery by defining packages have not been particularly successful to date.26 In most cases, their scope has been limited to maternal and child health care, and to health problems considered as global health priorities. The lack of attention, for example, to chronic and non-communicable diseases confirms the under-valuation of the demographic and epidemiological transitions and the lack of consideration for perceived needs and demand. The packages rarely give guidance on the division of tasks and responsibilities, or on the defining features of primary care, such as comprehensiveness, continuity or person-centredness.

Successful implementation of PHC packages is often accompanied by a comprehensive health care approach and reforms, a good example of which is provided by Brazil’s national health system – *Sistema Único de Saúde* (SUS).55-58 Key elements of the Brazilian SUS include the constitutional right to health, , thus requiring the state to provide universal and equal access to health services; PHC as the foundation of the national health system; and a broader public health approach that includes the prevention of disease; promotion of health; treating the sick and injured, and tackling serious disease.55-58 Other prerequisites for success include the coordination and integration of activities of all three levels of government in Brazil; the creation of the Family Health Programme as the main PHC strategy that seeks to provide a full range of quality health care to families in their homes, at clinics and in hospitals; and improvement in resource allocation for the programme.55

Similarly, Thailand’s health reforms in 2001 combined universal coverage with a relatively comprehensive package of services.26 Elderly, children and the poor are exempt from user fees, while others make a small co-payment. Government pays primary care providers for delivering services in the defined package. The package contents were revised over time. By 2004, just less than half the population was covered by this scheme. Financing mechanisms were specifically configured to reduce historical geographic inequalities in access to services.59 The country has the highest average yearly reduction in under-5 mortality, universal coverage of immunization and skilled birth, and low levels of inequity. In Tanzania, the Tanzania Essential Health Interventions Project (TEHIP) constructed a package predominately using burden of disease concepts rather than cost-effectiveness evidence as part of focused efforts to improve the efficiency of existing health system inputs and interventions and to optimize the functioning of the district health system.19

Box 1 summarises the key lessons to enhance implementation of PHC packages19, 26, 55-59

|  |
| --- |
| Box 1: Ensuring implementation of essential PHC packages |
| * The package should be part of comprehensive health care reforms
* It should take into account demand as well as at the full range of health needs.
* It should ideally specify what should be provided at primary, secondary and tertiary levels.
* Implementation of the package should be costed so that political decision-makers can be made aware of what will *not* be included if health care remains under-funded.
* There have to be institutionalized mechanisms for evidence-based review of the interventions within the package, and pre-specified plans to update these reviews.
* Community participation is key to successful implementation and people need to be informed about the benefits they can claim, with mechanisms of mediation and redress when claims are being denied.
* Staffing norms and financial resources need to be linked with the service package, norms and standards
* Ongoing monitoring and regular review of both the contents of the package and its implementation
 |

Sources:19, 26, 55-59

# SECTION 4: THE SOUTH AFRICAN CONTEXT

## 4.1 Burden of disease

South Africa ‘quadruple burden of disease’, consisting of HIV and AIDS, other infectious diseases, injuries and chronic diseases, has been well described.5, 10-12 The first South African National Burden of Disease study and the South African Comparative Risk Assessment identified the underlying causes of premature mortality and morbidity in 2000 and their risk factors.60-61 The findings are summarized in Table 6. An updated appraisal of the burden of disease is planned to begin in 2011.

Table 6: Risk factors and conditions accounting for South Africa’s burden of disease

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Rank** | **Disease, injury or condition** | **% total DALYs** | **Risk factor** | **% total DALYs** |
| **1** | HIV/AIDS | 30.9 | Unsafe sex/STIs  | 31.5 |
| **2** | Interpersonal violence injury  | 6.5 | Interpersonal violence (risk factor)  | 8.4 |
| **3** | Tuberculosis  | 3.7 | Alcohol harm  | 7 |
| **4** | Road traffic injury | 3 | Tobacco smoking  | 4 |
| **5** | Diarrhoeal diseases  | 2.9 | High BMI (excess bodyweight)  | 2.9 |
| **6** | Lower respiratory infections  | 2.8 | Childhood and maternal underweight  | 2.7 |
| **7** | Low birth weight  | 2.6 | Unsafe water sanitation and hygiene  | 2.6 |
| **8** | Asthma  | 2.2 | High blood pressure  | 2.4 |
| **9** | Stroke  | 2.2 | Diabetes (risk factor) | 1.6 |
| **10** | Unipolar depressive disorders  | 2 | High cholesterol  | 1.4 |
| **11** | Ischaemic heart disease  | 1.8 | Low fruit and vegetable intake  | 1.1 |
| **12** | Protein-energy malnutrition  | 1.3 | Physical inactivity  | 1.1 |
| **13** | Birth asphyxia and birth trauma  | 1.2 | Iron deficiency anaemia  | 1.1 |
| **14** | Diabetes mellitus | 1.1 | Vitamin A deficiency  | 0.7 |
| **15** | Alcohol dependence  | 1 | Indoor air pollution  | 0.4 |
| **16** | Hearing loss, adult onset  | 1 | Lead exposure  | 0.4 |
| **17** | Cataracts  | 0.9 | Urban air pollution  | 0.3 |

More recent information, up to 2007, is available about the causes of death in South Africa. As with the burden of disease, infectious diseases predominate. The contribution of mortality from the quadruple burden of disease in the country is also seen clearly in Figure 1. In addition to the infectious diseases, for example, cardiovascular diseases accounted for 13.7% of deaths in 2007 and 9.0% of deaths were attributed to non-natural causes such as transport incidents and assault.

These mortality figures do not adequately capture the burden of diseases from mental health conditions, which are very common in the country. A nationally representative survey in 2002-2004 found that 16.5% of the population had a mental disorder in the past 12 months. These were mostly depression, anxiety and substance use disorders, and about three-quarters of these conditions were untreated.62

Figure 1 Number of deaths by main groups of causes of death and year of death, 2006 and 2007



## 4.2 Ministerial priorities

Four main areas constitute the essence of the Ministerial service delivery agreement: increase life expectancy at birth; reduce maternal and child mortality rates; combating HIV / AIDS and TB; and strengthening health system effectiveness.2, 14 A recent national workshop identified required improvements in health outcomes and set targets for 2014 / 2015, listed in the table below.63

Table 7: Required improvements in health outcomes

|  |  |  |
| --- | --- | --- |
| **Indicator** | **Baseline 2009** | **Target 2014/15** |
| Life Expectancy at Birth | 53.5 years for males 57.2 year for females  | 58-60 years |
| Child Mortality | 69 per 1,000 live births | 30-45 per 1000 live births |
| HIV Prevalence (amongst 15-24 year old pregnant women | 21,7%  | Improved quality of life of People living with HIV and AIDS |
| Mother to child transmission rate of HIV | 10% | 0%-<5% |
| Percentage of eligible HIV positive women initiated on ART | 37% | All eligible pregnant women to be initiated on ART at a CD4 count of < 350 or WHO stage III or IV |
| TB Cure Rate | 64% | 85% |
| Percentage of HIV-TB co-infected patients who are on ART | 30% | 100% |

Source: Kaiser Family Foundation, Ministry of Health, 201063

## 4.3 South Africa’s experience with a comprehensive PHC package, norms and standards

A PHC package for South Africa was presented in 2001, after a three year period of planning and consultation.17 The stated intention was that the package would be implemented incrementally across the country by end 2005, and would contribute to greater social justice and equity.31 Milestones were set for measuring progress midway in this period. As in other countries, it was anticipated that the package would assist in quantifying resource requirements and inform budget negotiations between health managers and authorities. Efforts were made to estimate the costs of implementing the package at a national level and in some provinces.64-65

As part of concerted efforts to promote integration of services, the package was presented by level of service rather than by programme area or condition.31 A set of norms and standards were developed concurrently to direct the provision of services at acceptable levels.16 The 2001 PHC Package still constitutes the basis for planning of service delivery in some provinces today.47

The original intention was to audit all local authorities to quantify the gap between existing PHC services and the targets set in the package, but no evidence for this could be located. Neither could we find evidence that the milestones and final outcomes of this initiative had been systematically evaluated by the DOH as planned. A 2003 evaluation that assessed implementation of the PHC package in 66 facilities within eight Urban Renewal Nodes in five Provinces found that substantial progress had been made with: enhancing the scope of services; the capability to provide diagnostic tests; implementation of referral systems and an increase in availability of infrastructure and equipment. In the Eastern Cape, the package helped to identify shortcomings in both equipment and available training and facilitated recognition of the need to provide more comprehensive services, including the provision and functional integration of promotive, preventive and curative services.66 The PHC package was also used as an instrument to highlight the need for more appropriate services in urban and peri-urban areas, thereby relieving the demand for hospital outpatient services.66 Implementation of the PHC package was found to be less problematic in relatively well-resourced areas. Overall, there was a 47% compliance with the norms and standards specified in the package, with marked variation in performance between the indicators assessed and in the implementation of the policies contained in the package.66-67 At facility level, there was little awareness of and no special resources for monitoring the PHC package, and no instrument had been developed to measure implementation of the package.66-67 In interviews, some PHC managers felt the package was “dumped” on them, without the necessary preparations and additional resources.66 Nurses had apparently been inadequately trained in the package interventions and some were not committed to its implementation, perceiving it as another burden on already overloaded staff. There were even reports of staff actively undermining implementation of the package, and its norms and standards, a situation perhaps worsened by a perceived lack of input from PHC service providers during development of the package. The norms developed and the timelines for their implementation were viewed as being over idealistic and impractical given the limited resources available. Respondents in some facilities reported that the actual PHC package documents had not been available at their facilities. The evaluation concludes that the gaps in implementation of the package were, however, not solely due to resource constraints. Many deficiencies could be ascribed to sub-optimum management and supervision of staff, and to low staff motivation and skill levels.66

An analysis of the experience with setting norms for the delivery of mental health services provides useful insights. Extensive work was done in the early part of this decade to develop norms and standards for integrated primary mental health care in South Africa, such as number of beds per population, staff to population ratios, admission rates and community/hospital ratios.68-71 That process was intended to support integration of mental health services with PHC and the de-institutionalisation of mental health patients. Little has been done, however, to monitor systematically whether these norms were met, or influenced service provision. A study on a district on KwaZulu Natal found that mental health services remained primarily focused on emergency management of psychiatric patients and there were insufficient numbers of key categories of mental health workers within PHC settings.72

## 4.4 Rapid review of current state of PHC package implementation

We obtained responses to the telephone survey from eight out of nine provinces. In Eastern Cape, Gauteng, North West and Northern Cape; the interviews were conducted with the directors responsible for PHC. In the Free State, Mpumalanga and the Western Cape interviews were conducted with PHC managers, who are responsible for a cluster of PHC facilities in a sub-district and in Kwazulu-Natal a chief technical advisor was interviewed. In addition, one chief director at the national department of health and two Ministerial task team members were interviewed.

***4.4.1 PHC package implementation: Benefits, progress and successes***

The perceived benefits of a defined PHC package are to: set out a vision for service delivery; serve as a guide to managers, staff and communities as to services that should be provided; allow for benchmarking/ comparison of similar types of facilities (e.g. costs, staffing, outputs, etc); facilitate request for additional resources; and assist with monitoring and evaluation.

One participant noted that: “*A PHC package is essentially a vision - it spell out what our vision for service delivery is. It spell out to managers what we think should be done, what we think is aspirational.”* (Key informant 1)

A defined PHC package guides managers, staff and communities on service provision, as can be seen from their following responses:

*“It [the PHC package] is extremely useful because there needs to be terms of reference or a guide which outlines the norms and standards that need to be followed.... so that everyone does not apply his/her own rule. It has helped facilities to function within certain guidelines...even the community sometime you can use it to make them understand what is needed by the protocol based on evidence. It is good thing that you are revising it because things have changed example it [the PHC package] does not say much about HIV/ AIDS and there have been lots of changes on diagnosis, treatment, and care.”* (Mpumalanga respondent)

*“Your community knows what is available; Staff knows what services to provide. The PHC package is in line with needs, and managers know what they are responsible for.”* (Western Cape respondent)

*“It assists the department to implement PHC in a structured and standard way so that services can be monitored and evaluated; so that we can measure our performance. It also assists with developing plans.”(*Free State respondent).

Participants were also of the opinion that the package facilitates some standardisation and allows clients to know what services to expect. In line with Batho Pele principles, clients/ communities could have redress if they do not get the services specified in the package (key informant 3). The package allows for comparison of similar types of clinics in terms of costs, outputs and efficiencies. It was also felt that a package:

*“Gives health workers a clear picture of what services they should be offering; and legitimises requests for resources from managers if working at high capacity and not providing all the services; it provides patients and communities an expectation of what they can legitimately expect to receive at which type of facility. It provides guidance on access points and referrals.”* (Key informant 2)

A package is also useful for “*measuring/ judge what we do so that we know where we can improve*” (North West) and gives both the district, service [providers] and public an indication of services available, and provides a means of monitoring service development in the Province (KZN). In terms of implementation, participants indicated that in some provinces, PHC has become the corner-stone of service delivery. There has been a gradual expansion of the range of services provided, the package has facilitated programme development and the standard treatment guidelines have assisted health care providers and managers. It has also assisted with a common understanding among all stakeholders of what essential/ critical PHC services to provide.

Other reported successes of PHC package implementation include:

* Improved access (geographical, affordability) ( all provinces)
* Improved quality of care (Free State, Gauteng, Western Cape)
* Outreach services (e.g. oral health) and doctors’ visits (Northern Cape, Mpumalanga, Free State)
* Clinic supervision (Mpumalanga, Northern Cape)
* Essential drug availability (Mpumalanga, Northern Cape)
* Training of nurses (Mpumalanga, Northern Cape)
* Implementation of Batho Pele principles, patient’s rights charter (Mpumalanga)
* Provision of additional financial resources (Western Cape)
* Partnerships (Northern Cape, North West)

Table 8 shows implementation progress for a selection of key indicators contained in the 2000/01 PHC package, norms and standards.

|  | Table 8: Progress with implementation for a selection of key PHC package indicators |
| --- | --- |
| **Indicator**[[1]](#footnote-1) | **Eastern Cape** | **Free State** | **Gauteng** | **Kwazulu-Natal** | **Mpumalanga** | **Northern Cape** | **North West** | **Western Cape** |
| Provision of PHC services on the same day | * CHC- 99%
* 8-hour clinics-99% (80% of package)
 | * CHC- 90%
* 8-hour clinics-Based on referral system
 | * CHC- 70-78%
* 8-hour clinics-76%
 | * CHC- 100%
* 8-hour clinics-100% (provincial clinics)
 | * CHC-100%
* 8 hour clinic-100
 | * CHC-70%
* 8 hour clinic-60%
 | * CHC-70%
* 8 hour clinic-70-80%
 | * 100% of facilities in district, except reproductive health clinics
 |
| Initiation of antiretroviral therapy for AIDS | * CHC- 50%
* 8-hour clinics-2%
 | * CHC- 95%
* 8-hour clinic-only designated CHCs
 | * CHCs- 100%
* 8-hour clinics: 40-45%
 | * CHC- 100%
* 8-hour clinics-45%
 | * CHC & 8-hour clinic: 38%
 | * CHC-60%
* 8 hour clinic-40%
 | * CHC-70%
* 8 hour clinic-70%
 | * 75% of facilities in the sub-district
 |
| A functioning clinic committee | * CHC- 50%
* 8-hour clinics-2%
 | * CHC- 85%
* 8-hour clinics-85%
 | * CHCs: recently formed
* Clinics- 80-90%
 | * CHC- 88%
* 8-hour clinics-68%
 | * CHC & 8-hour clinic: 85%
 | * CHC-40%
* 8 hour clinic-10%
 | * Zero-not existing
 | * 100%, but done as a cluster, rather than individual facilities
 |
| A nurse with mental health training  | * Not readily available in CHCs and clinics
 | * There is a trained PN in every CHC and 8 hour clinics
 | * CHCs- 100%
* 8-hour clinics-50-60%
 | * ‘All nurses have mental health training’
 | * CHC & 8-hour clinic: 50%
 | * CHC-30%
* 8 hour clinic-30%
 | * CHC & 8-hour clinic: 40%
 | * 25%; this is a bit of a problem
 |
| Fast queue for elderly people | * Not readily available in CHCs and clinics
 | * 95%-dedicated days for elderly in CHCs and 8-hour clinics
 | * Not sure
 | * *‘In theory* 100%’
 | * CHC & 8-hour clinic: 100%
 | * CHC-50%
* 8 hour clinic-40%
 | * CHC & 8-hour clinic: 50%
 | * All
 |
| Organisational structure (organogram) | * CHC- 100%
* 8-hour clinics-100%
 | * CHC- 100%
* 8-hour clinics-90%
 | * CHC- 80-90%
* 8-hour clinic-60-70%
 | * CHC- 100%
* 8-hour clinics-100%
 | * Not sure
 | * CHC-50%
* 8 hour clinic-40%
 | * CHC & 8-hour clinic: 50%
 | * No, but people know what staffing available
 |
| Own budget | * CHC- 100%
* 8-hour clinics-0% as budget at sub-district level
 | * CHC-100%
* 8-hour clinics-budget at sub-district level
 | * CHC-100%;
* 8-hour clinic-50%
 | * CHC- 100%
* 8-hour clinics-100% (‘*but budget plundered by hospitals’*
 | * CHC & 8-hour clinic: 100%
 | * CHC-90%
* 8 hour clinic-100%
 | * CHC & 8-hour clinic: 70%
 | * Yes, facility manager knows budget and manages within delegations
 |

***4.4.2 Reported implementation challenges***

Participants reported difficulties with implementing the full package of PHC services, especially more specialised services such as termination of pregnancy (TOP) and rehabilitation. The reported challenges relate to five areas, listed below and summarised in table 9:

1. *Human Resource (HR) challenges: this category includes staff shortages, skills shortages, difficulties with staff recru*itment and retention; high staff turnover, with consequent loss of institutional memory; difficulties with teamwork; integration of staff between province and local government; staff attitudes and resistance to change
2. *Infrastructure problems*: category includes clinic infrastructure (e.g. space, lack of privacy, old infrastructure); equipment; lack of tarred roads in rural areas that damage ambulances and other vehicles; and lack of accommodation of staff
3. *Financial resources* e.g. insufficient capital budget; historical budget allocation;
4. *Referral system* e.g. lack of support from district hospitals
5. *Other challenges* e.g. inconsistent supply of information, education and communication (IEC) materials; problem of service provision by two different authorities (local government and province); patients bypassing PHC facilities; insufficient emphasis on prevention and promotion.

Table 9: Reported challenges with PHC package implementation

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Province** | **HR challenges** | **Infrastructure** | **Finances** | **Referral system** | **Other**  |
| Eastern Cape | X | X | X |  | X |
| Free State | X | X | X |  |  |
| Gauteng | X | X |  |  |  |
| Kwazulu-Natal | X |  |  |  | X |
| Mpumalanga | X | X |  | X | X |
| Northern Cape | X | X | X | X |  |
| North West | X | X |  |  |  |
| Western Cape | X |  |  |  | X |

As can be seen from Table 7, there is variation in the reported implementation of the selected PHC package indicators. Reasonably good progress has been made with implementation in the eight provinces that responded, but there is better reported progress in the urban provinces of Gauteng and the Western Cape. All provinces reported that human resource constraints were the most common reason that hampers PHC package implementation, followed by infrastructure challenges. Functioning clinic committees, a measure of accountability to users of services and communities, needs to be addressed, and in the North West it was reported that there is not a single functioning clinic committee.

# SECTION 5: A NATIONAL PHC PACKAGE FOR SOUTH AFRICA

## 5.1 Introduction

This section proposes an essential package of interventions for South Africa, based on the literature review and information presented in previous sections. The proposed services have **not** been costed. Prior to formal adoption of the PHC service package, accurate costing should be done to ensure affordability and feasibility of implementation.

This next sub-section presents a set of generic norms and core standards for clinics and community health centres. This is then followed by the key assumptions about staff categories, a generic list of community-based services, and the criteria and components of the proposed PHC package of services and interventions.

## 5.2 Norms for clinics and community health centres

1. Clinics should provide comprehensive integrated PHC services using a one-stop approach for at least 8 hours a day, five days a week.
2. The clinic should receive a supportive monitoring visit at least once a month to support personnel, monitor the quality of service and identify needs and priorities.
3. The clinic will have at least one member of staff who has completed an accredited PHC course.
4. Clinic managers should receive training in facilitation skills and PHC management.
5. An annual plan should be developed for each facility, based on a situation analysis of the community’s health needs, the routine health information data collected at the clinic and an on an evaluation of the provision of PHC services.
6. There should be a mechanism for monitoring services and quality assurance and at least one annual service audit.
7. Community perception of services should be tested at least once a year through patient interviews or anonymous patient questionnaires.

## 5.3 Core standards for clinics and community health centres

Table 10: Core clinic and CHC standards

| **Health system building block** | **Core standards** |
| --- | --- |
| **Leadership and planning** | * Each clinic has a vision/mission statement and core values that are displayed in the clinic.
* An operational plan or business plan is written each year, and progress towards achievement of its goals should be monitored with the clinic supervisor.
 |
| **Finance** | * The clinic is a cost centre, with budget divided into main categories (e.g. personnel, operational, etc).
* The monthly expenditure of each main category is known.
* Under and over spending is identified and dealt with including requests for the transfer of funds between line items (where permitted and appropriate)
 |
| **Staff**  | * The staff establishment for all categories is known and vacancies discussed with the supervisor.
* New clinic staff oriented.
* Availability of district personnel policies on recruitment, grievance and disciplinary procedures in the clinic
* Job descriptions for each staff category are in the clinic file.
* There is a performance plan/agreement which includes a personal development/ training plan for each staff member
* A performance appraisal is carried out for each member of staff at least once a year.
* The on-call roster and the clinic task list with appropriate rotation of tasks are posted.
* Attendance and absenteeism is monitored.
* There are regular staff meetings (at least once a month).
* Services and tasks not carried out due to lack of skills are identified and new training sought.
* In-service training takes place on a regular basis.
* Disciplinary problems are documented and copied to supervisor.
 |
| **Competence of Health Staff**  | **Staff are able to*** Map the clinic catchment area and set specific and achievable PHC objectives using district, national and provincial goals
* Plan and implement district focused, community based activities, where health workers are familiar with their catchment area population profile, health problems and needs and use data collected at clinic level for this purpose.
* Organise the clinic to reduce waiting times to a minimum and initiate an appointment system when necessary.
* Organise outreach services for the clinic catchment area.
* Train community health care promoters to educate caretakers and facilitate community action.

**Caring for patients*** Health providers are able to follow available disease management protocols and standard treatment guidelines
* Staff provides compassionate counselling that is sensitive to culture and the social circumstances of patients.
* Health workers are positive in their approach to patients, evaluating their needs, correcting misinformation and giving each patient a feeling of always being welcome.
* Patients are treated in privacy and with courtesy and respect
* Patients are addressed in a language that they can understand
* The rights of all patients are observed.

**Running the clinic*** A clear system for referrals and feedback on referrals is in place.
* Facility staff clearly identifiable to service users (e.g. uniforms, insignia, etc)
* The PHC facility is clean with clear signposting
* The facility is organised and accommodates the needs of patients’ confidentiality and easy access for older persons and people with disability.
* Every PHC facility has a house keeping system to ensure regular removal and safe disposal of medical waste, dirt and refuse.
* The PHC facility has a written infection control policy on protective clothing, handling of sharps, incineration, cleaning, hand hygiene, wound care, patient isolation and infection control data.
* There is compliance with and monitoring of the infection control policy
 |
| **Visits to clinic by unit supervisor**  | * There is a schedule of monthly visits stating date and time of supervisory support visits.
* There is a written record kept of feedback or results of visits.
* There is follow-up on critical incidents reported
* Should monitor progress towards goals in business plan
 |
| **Patient Education** | * Staff are able to give appropriate education to patients and communities in order to improve health awareness.
* Availability of free culturally and linguistically appropriate patients’ educational pamphlets on different health issues
* Appropriate educational posters on the wall for information and education of patients.
* Educational videos in those clinics with audio-visual equipment are on show while patients are waiting for services
 |
| **References, prints and educational materials** | * Standard treatment guidelines and the essential drug list (EDL) manual
* All relevant national and provincial health related circulars, policy documents, acts and protocols that impact on service delivery.
* Copies of the Patients Charter and Batho Pele documents available.
* Supplies of appropriate health learning materials in relevant local languages
 |
| **Referral**  | * All patients are referred to the next level of care when their needs fall beyond the scope of clinic staff competence.
* Patients with a need for additional health or social services are referred as appropriate.
* Every clinic is able to arrange transport for an emergency within one hour.
* Referrals within and outside the clinic are recorded appropriately in the registers.
* Merits of referrals are assessed and discussed as part of the continuing education of the referring health professional to improve outcomes of referrals.
 |
| **Pharmaceuticals and medical supplies**  | * Suitably secured medicine room and medicine cupboards are kept.
* Medicines and supplies as per the essential drug list for PHC, with a mechanism in place for stock control and ordering of stock
* Medicines and supplies always in stock, with a mechanism for obtaining emergency supplies when needed.
* Stocks are secure with stock cards used and up-to-date.
* Orders are placed regularly and on time and checked when received against the order.
* Stocks are kept orderly, with first expiry, first out (FEFO) followed and no expired stock.
* The drugs ordered follow essential drug list (EDL) principles.
 |
| **Infrastructure/ Building** | * Reliable supply of clean, potable running water
* Reliable power supply or power back-up system
* Maintenance of the building attended to on regular basis
* Size of building appropriate for patient load
* Adequate number of consulting rooms with wash basins, diagnostic light (one for each professional nurse and medical officer working on the same shift)
* Consultation areas allow for patient privacy
* Washing facilities for staff inside consultation areas
* Adequate number of toilets for staff and users in working order and accessible to wheelchairs.
* A sluice room and a suitable storeroom or cupboard for cleaning solutions, linen and gardening tools.
* Suitable dressing/procedure room with washable surfaces.
* A space with a table and ORT equipment and needs
* Disabled access to entrance and movement of facility
* Every clinic provides comprehensive security services to protect property and ensure safety of all people at all times.
 |
| **Equipment**  | * A diagnostic set.
* A blood pressure machines with appropriate cuffs and stethoscope.
* Scales for adults and young children and measuring tapes for height and circumference.
* Haemoglobinometer, glucometer, pregnancy test, and urine test strips.
* A battery and spare globes for auroscopes and other equipment.
* Speculums of different sizes
* A reliable means of communication (two-way radio or telephone).
* Reliable emergency transport available when needed.
* An oxygen cylinder and mask of various sizes.
* Two working refrigerators one for vaccines with a thermometer and another for medicines. If one is a gas fridge a spare cylinder should always be available.
* Condom dispensers where condoms can be obtained with ease.
* A sharps disposal system and sterilisation system.
* Equipment and containers for taking blood and other samples.
 |
| **Facilities and equipment**  | * There is an up-to-date inventory of clinic equipment and a list of broken equipment.
* There is a list of required repairs (doors, windows, water) and these have been discussed with the supervisor and clinic committee.
 |
| **Records**  | * The PHC facility utilises an integrated standard health information system that enables and assists in collecting and using data.
* The PHC facility has daily service registers, road to health charts, patient treatment cards, notification forms, and all needed laboratory request and transfer forms.
* All information on cases seen and discharged or referred is correctly recorded on the registers.
* All notifiable medical conditions are reported according to protocol.
* All registers and monthly reports are kept up to date.
* The clinic has a patient carry card or filing system that allows continuity of health care.
 |
| **Information and documentation** | * New patient cards and medico-legal forms are available.
* The laboratory specimen register is kept updated and missing results are followed up.
* Births and deaths are reported on time and on the correct form.
* The monthly PHC statistics report is accurate, done on time and filed/sent.
* Monthly and annual data are checked, graphed, displayed and discussed with staff and the health committee, and used in the business plan
* There is a catchment area map showing the important features, family census information, location of mobile clinic stops, DOTS supporters, CHWs and other outreach activities.
 |
| **Community and Home Based Activity**  | * There is a functioning community health committee in the PHC facility catchment area.
* The PHC facility receives support from the community health committee.
* The clinic has links with other stakeholders’ in the facility’s catchment area e.g. civic organisations, schools, workplaces, political leaders and ward councillors in the catchment area.
* Staff conduct regular home visits using a home visit checklist.
* A family census is conducted and information kept at clinic level
 |
| **Community**  | * The community is involved in helping with clinic facility needs.
* The community health committee is in place and meets on a regular basis (at least quarterly)
 |
| **Collaboration**  | * Health care providers collaborate with social welfare for social assistance and with other health related public sectors as appropriate.
* Health care providers collaborate with health orientated civic organisations and workplaces in the catchment area to enhance the promotion of health.
 |

## 5.4 Human resource assumptions

Although the development of staffing norms and standards is a separate work stream, the proposed PHC package is based on the human resource assumptions listed in Table 11. Furthermore, teamwork is critical to successful implementation of the PHC package, norms and standards (Table 11).

Table 11: Key assumptions about human resources for the PHC package

| **Level of service delivery** | **Health personnel** | **Services provided** |
| --- | --- | --- |
| Community-based services | Community Heath WorkersHealth PromotersSocial worker | See below |
| Clinics | Professional NursesEnrolled nursesAssistant nursesPrimary health care nursesSupport staffVisiting medical officer Visiting specialised services | Provide services 8 hours per dayAll basic services provided daily |
| CHC services | NursesPrimary health care nursesMedical OfficersFamily Physicians, dentists and rehabilitation personnel (may work throughout the district)PharmacistsSocial workersOral Hygienists | Usually 24 hour centres providing all services provided in clinics as well as * Maternity (for normal labour) and emergency services
* Emergencies
* X ray, laboratory services, physiotherapy , TOP (if accredited) and occupational health
* Medico-legal services
* Minor operations
* Dental services
* Rehabilitation services
 |

*Community Health Workers (CHWs)* are part of the primary care team and it is envisaged that they will form part of community outreach teams, headed by a professional nurse.73 They also form an important component of community based PHC services which encompass activities in the communities and households. The generic roles of CHWs are to:

* Conduct structured and comprehensive household screening and assessment relating to health priorities, and refer appropriately
* Provide education and information and support preventive action (e.g. through condom distribution)
* Provide psycho social support across the life cycle, including an integrated approach to adherence support for TB, HAART and other chronic diseases
* Provide basic home management of common health problems e.g. ORT in diarrhoea, foot care in diabetes and first aid
* Support community assessments, campaigns and inter-sectoral action.73

The proposed community-based services are listed in table 12.

Table 12: Community based PHC services

|  |  |
| --- | --- |
| **Sites** | **Activities** |
| **Community**  | Community assessment of causes of ill-health (e.g. water & sanitation, substance abuse, poor nutrition) |
| Assessment of community resources, including service providers |
| Community based interventions, including inter-sectoral action |
| **Household**  | Screening, assessment and referral across the life cycle (all age groups) |
| Provide information and support for healthy behaviours and home care |
| Provide psycho social support |
| Identify and manage (including provide adherence support for) common health problems |
| **Schools & early childhood centres**  | Screening, assessment and referral |
| Targeted interventions (e.g. educational programmes, vitamin A, de-worming and immunisation campaigns) |
| **Other health and social providers: (through referral and linking)**  | Referral and coordination of services provided in households with other sectors (in particular social development & early childhood development), non-profit organisations, community centres and any other service providersFocus on: orphaned and vulnerable children (OVC), elderly, mental health and substance abuse services, step down care |

## 5.5 The proposed PHC package

The criteria for selection of the proposed package of services are listed in table 13 below.

|  |
| --- |
| Table 13: Criteria for selection of the proposed package of services |
| * Address priority health problems in South Africa
* Improve health status and focus on morbidity and mortality from the major causes of ill- health
* Comprehensive approach, with a focus on prevention and promotion as well as cure
* Achieve intended health outcomes envisaged in the Ministerial service delivery agreement
* Target vulnerable populations e.g. disabled individuals
* Achieve a balance between a family and population focus, while responding to the demands of the population
* Focus on services that are practical, essential and comprehensive and cost-effective
* Promote equity
* Staff availability and working as a team at community-based, clinic and health centre levels
 |

A number of key interventions and four priority areas of focus within PHC are proposed.

1. Maternal, women and child health
	1. Immunisation,
	2. Antenatal care
	3. Postnatal care
	4. School health
2. HIV and tuberculosis
3. Chronic non-communicable disease
4. Violence and injuries

For each of these areas, a comprehensive approach, with a focus on prevention and promotion, is proposed. Health care activities at community, clinic and community health centre are given. Services at clinics have been defined by the level of skills of staff and not by the size of the facility. An outline of services provided in each of the focus areas is then given. Service delivery targets are given where available in the current National Strategic Plan or in recent policy documents. Given the considerable variation in capacity and availability of resources, each district should have the flexibility and capacity to offer additional services in order to address the burden of disease in their area, as well as the demands of its population.

## 5.6 Maternal, Newborn, Women and Children

***5.6.1 Introduction***

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.

***5.6.2 Goals and targets***

*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

1. Increase the number of infants who require dual therapy for PMTCT who actually receive it.
2. Ensure that 90% of children are fully immunised
3. Increase the number of districts in which 90% of children are fully immunised
4. Increase the proportion of nurse training institutions that teach IMCI
5. Increase the number of schools visited by a school health nurse at least once per year
6. 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

**5.6.3 Service components**

**Table 14: Maternal, newborn, women and children services**

| ***MATERNAL, NEWBORN, WOMEN AND CHILDREN: COMMUNITY BASED SERVICES*** |
| --- |
| Conduct structured household visits to:* identify at-risk households and individuals
* assess need for services
* 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
* 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
* 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
 |

CHC: In addition to clinic-based services

|  |
| --- |
| ***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
 |

## 5.7 HIV/AIDS and Tuberculosis

***5.7.1 Introduction***

HIV / AIDS and tuberculosis continue to account for a significant burden of disease. Prevalence figures suggest a stabilising epidemic but are still unacceptably high. New policies and strategies to strengthen prevention, treatment and care support the decentralisation of treatment and care to primary care level in order to expand access to anti-retroviral therapy. The targets for HIV / AIDS and TB are to:

1. Improve the quality of life of people living with HIV and AIDS
2. Reduce HIV incidence from 1.3% to 06%
3. Ensure that all eligible pregnant women are initiated in ART
4. Ensure that 100% of HIV-TB co-infected patients are on ART

Male medical circumcision is known to prevent a significant percentage of infections. Plan to increase access to this service are underway.

The National Strategic Plan 2007 – 2011 aims to provide an appropriate package of treatment care and support to 80% of all HIV positive people and ensure that

550,000 HIV positive people on ARV by 2014.74

Particular challenges facing the public sector with regard to tuberculosis are low cure rates and increasing number of TB patients with multi-drug resistance TB.75 Current targets for cure and care are:

* 85% cure rate for tuberculosis (currently 65%)
* Decreasing TB defaulter rate to less than 5%
* Decreasing the number patients with multi drug resistant TB
* 100% facilities implementing TB guidelines

Recent policy documents are providing for the decentralisation of the management of MDR to the primary care level. Primary health care facilities will play a significant role in providing injectables and providing DOT to all drug resistant TB patients in the area.76

Orientation of the above services to suit adolescents, and especially those at school, is required, especially at community health centre level. A priority is to establish Youth Friendly Services in all primary care facilities by 2014. This would involve

* Ensuring that services are accessible and acceptable to adolescents
* Providing a physical environment appropriate for adolescents.
* Providing staff trained to deal with this particular age group
* Providing an essential package of services which should include the following.
* Information, education and communication on sexual and reproductive health
* IEC on violence / abuse and mental health
* Information on family planning
* Pregnancy testing
* Pre and post termination counselling appropriate for adolescents
* Management of sexually transmitted infections.

Strengthening HIV / AIDS prevention, treatment and cure requires a multi-faceted response including

1. Building community AIDS competence.
2. Gender sensitive school and youth educational programmes
3. Improved housing and
4. Access to social grants

***5.7.2 Service components***

Table 15:HIV/AIDS and TB services

|  |
| --- |
| ***COMMUNITY- BASED SERVICES*** |
| Conduct structured household visits to:* identify at-risk households and individuals
* assess need for services
* 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 HIV or TB: refer for HCT and screen for TB symptoms
* Ensure that households affected by HIV and or TB have access to appropriate services, including TB treatment, regular CD4 testing, timely HAART
 |
| Provide information, education & support for healthy behaviours and appropriate home care | * Promote HIV prevention including HIV testing, condom use, partner reduction, circumcision, STI treatment
* Distribute condoms
* Advise on TB infection control in the home
 |
| Provide psychosocial support | * Provide an integrated approach to adherence support for TB, HAART and other chronic disease medication in close collaboration with facility based counsellors
 |
| Identify and manage common health problems |  |
| 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 HIV educational and treatment literacy campaigns
* Condom distribution in on-traditional outlets
* Support gender sensitive school & youth programmes
 |

| ***CLINIC BASED SERVICES*** |
| --- |
| **HIV / AIDS** |
| Provider initiated HIV testing | * Offer HIV counselling and testing at all visits
 |
| Diagnosis and management of opportunistic infections | * As per national guidelines for the management of HIV and AIDS in adults, adolescents and children
 |
| Initiation and follow-up of anti-retroviral treatment | * Identification HIV positive individuals
* Initiation on treatment as per 2010 guidelines
 |
| Adherence and self-management support Effective monitoring | * Regular follow up
* Strategy to find lost to follow up patients
* Support groups
 |
| **Tuberculosis** |
| Routine screening for tuberculosis | * Clinical suspicion as per protocols
* Diagnosis as per protocols. Collection of sputum
* Information, education and counselling to families
* Testing HIV
* Follow up and accurate data collection
* Contact screening of close contacts
 |
| Initiation and follow-up of TB treatment | * Treatment according to national protocols
* Tracing of defaulters
* Short course (DOTS)
* Tracing TB contacts
* Data management and reporting
 |
| Management of drug resistant TB patients | * Identification of high risk groups
* Screen and test symptomatic high risk groups
* Trace patients with a confirmed diagnosis of DR TB
* Notify the district coordinator
* Provide initial counselling and education of the family and patient
* Ensure monthly follow up at the clinic
* Provide DOT to all patients attending daily
* Follow up patients initiated to start community based treatment
 |
| **Sexually transmitted Infections** |
| Management of STIs | * Syndromic management of STI as per standard protocols
* Promote counselling and testing for HIV
* Referral according to protocols
* Syphilis testing according to protocols
* Health education and counselling
* Partner notification
* Provision of condoms
 |

In addition to clinic-based services

|  |
| --- |
| ***COMMUNITY HEALTH CENTRE: HIV / AIDS*** |
| HIV prevention | Male medical circumcision in selected, accredited facilities |

## 5.8 Non-communicable diseases

***5.8.1 Introduction***

The increased contribution of non-communicable diseases to the burden of diseases is increasingly recognised. Enhanced programmes for the prevention and treatment of hypertension are a national priority to reduce the incidence of strokes, congestive cardiac failure and renal failure.

Goals and specific targets:

* Increase by 50% the proportion of clinics providing comprehensive services for persons with chronic diseases.
* Assess patient satisfaction and quality of care 6 monthly by a supervisor who also evaluates the degree of community involvement in care planning.
* Minimise patient travel by prescribing supplies of drugs to last 1-3 months.
* Reduce the prevalence of overweight and obese clients and specifically to reduce the number of people with BMI greater than 30.

Prevention and treatment of non communicable diseases should include a long term care model and the promotion of a healthy lifestyle in line with national guidelines. Hypertension and diabetes are the most common non communicable diseases and focus shall initially be on these priorities. Other chronic conditions – asthma, epilepsy, and arthritis will be management according to standard treatment protocols.

Community based interventions should focus on

1. Risk factor reduction
2. Community mobilisation
3. Reaching targeted groups in schools, workplaces and recreation areas.

Promoting food outlets and food gardens, provision of amenities for exercise, especially in schools and designating smoke free areas are important areas for inter-sectoral collaboration.

|  |
| --- |
| Table 16: Non-communicable disease services |
| **NON-COMMUNICABLE DISEASES: COMMUNITY BASED SERVICES** |
| Conduct structured household visits to:* identify at-risk households and individuals
* assess need for services
* 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
 |
| * Screen adults for hypertension, diabetes and depression
* Identify other chronic diseases and disabilities, oral health or visual and hearing impairments, and ‘break through’ pain
* Facilitate access to facility or specialist care
 |
| Provide information, education & support for healthy behaviours and appropriate home care | * Provide information on risk factors for chronic diseases
* Information on chronic disease medication and importance of adherence
 |
| Provide psychosocial support | * Provide an integrated approach to adherence support for TB, HAART and other chronic disease medication in close collaboration with facility based counsellors
 |
| Identify and manage common health problems | * Provide basic stroke support and rehabilitation
* Treat dehydration and provide oral care in the elderly & sick
* Support foot care in diabetics and elderly
 |
| 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 exercise, diet and smoking cessation campaigns
 |

|  |
| --- |
| **CLINIC-BASED SERVICES** |
| **Hypertension** |
| Screening | * Identification of high risk populations
* Screening
 |
| Early treatment | * Appropriate, cost effective and comprehensive management as per national guidelines
 |
| Monitoring adherence | * Education of patient and family
* Support groups
* Tracing of defaulters
 |
| Management of complications and referral | * Early diagnosis of complications and referral when appropriate
* Appropriate follow up
 |
| **Diabetes** |
| Screening | * Identification of high risk populations
* Early diagnosis
 |
| Early treatment | * Appropriate treatment
 |
| Monitoring adherence | * Education of patients and their families
* Maintaining good patient records
 |
| Management of complications and referral | * Prevention, detection and management of complications
* Apply principles of nutrition, physical activity and weight control
* Follow up as per clinical guidelines
* Referral for foot care are per guidelines
 |
| Self management support | * Self monitoring of glycaemia
 |

In addition to clinic-based services

|  |
| --- |
| **COMMUNITY HEALTH CENTRE** |
| Management of complications and referral | * Range of services enlarged by presence of the MO.
* Interpretation of common laboratory and X ray results
* More accurate screening for complications
* Screening of mental health problems
* More specialised geriatric care – including foot care
* Palliative care consultation
 |

## 5.9 Violence and Injuries

***5.9.1 Introduction***

Coordinated inter-sectoral interventions are required to reduce unintentional and intentional injuries. In order to mitigate the long term health consequences of violence and injury, Community Health Centres will provide a trauma and emergency services. Both clinics and community health centres will provide counselling services, as well as immediate treatment following intentional injuries

Priorities are to

* Increase the proportion of emergency health staff who has basic ambulance assistance qualifications, and who are able to provide emergency care to victims of poisoning, injuries and maternal emergencies.
* Ensure that in every clinic there is at least one person trained in counselling and the management of victims of violence and rape.
* Every clinic has established working relationships with the nearest police officer and social welfare officer by having visits from them at least twice a year.
* A member of staff of every clinic has received training in the identification and management of sexual, domestic and gender related violence. The training includes gender sensitivity and counselling.

Alcohol harm constitutes one of the most significant health risk factors in South Africa after unsafe sex. Preventing alcohol abuse requires a multi-faceted inter-sectoral response. At a primary care level, activities should be focused on shifting prevailing norms about alcohol misuse.

* Identification of at risk populations and individuals – especially adolescents
* Community level programmes for alcohol prevention, starting at schools and involving a broad range of community stakeholders.
* Turnaround time for blood alcohol samples reduced to six weeks (baseline 12 weeks)
* Reduce school attendees admitting to drink alcohol and smoke tobacco.

Inter-sectoral action should include:

1. Provision of sexual assault services – multi-sectoral
2. Pedestrian and community safety initiatives
3. Reducing the availability of drugs and alcohol
4. Comprehensive approach to neighbourhood renewal.

|  |
| --- |
| Table 17: Services to combat violence and injuries |
| ***VIOLENCE AND INJURIES: COMMUNITY BASED SERVICES*** |
| Conduct structured household visits to:identify at-risk households and individuals assess need for servicesfacilitate 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
 |
| * Screen for domestic violence & substance abuse
* Facilitate access to sexual assault and mental health services
 |
| Provide information, education & support for healthy behaviours and appropriate home care | * Provide information on substance abuse
* Provide information on prevention of injuries in homes
 |
| Provide psychosocial support | * Provide post-trauma counselling
 |
| Identify and manage common health problems | * Provide first aid
 |
| 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 pedestrian safety initiatives
* Support campaigns to reduce the availability of drugs and alcohol
 |
| ***CLINIC-BASED SERVICES*** |
| Post sexual assault services | * Counselling and referral to medico legal services for consultation
* HIV testing
* Emergency contraception
* STI prophylaxis
 |
| Post trauma counselling | * Counselling and referral
 |
| Abuse of elderly | * As per national guidelines
 |
| **COMMUNITY HEALTH CENTRES** |
| Trauma and emergency services  | * Care of trauma of limbs (excluding fractures (temporary immobilisation only)
* Treatment of minor fractures
* Management of acute psychiatric cases and referral
* Preparation for urgent referral of serious trauma – proper immobilisation, IV therapy, clearing of airway
* Care of medical conditions which can be stabilised within 24 hours
* Immediate management of emergencies
	1. Basic emergency obstetric care
	2. Respiratory / cardiac emergencies
	3. Diabetic emergencies
	4. Allergic emergencies
	5. Suspected poisoning
	6. Trauma
	7. Bleeding
 |
| **Post sexual assault services** | * Medico legal services for consultation
* Counselling; HIV testing
* Emergency contraception; STI prophylaxis
 |

**5.10 Nutrition**

***5.10.1 Introduction***

Malnutrition impacts negatively on morbidity, mortality, educability and productivity.**77**Currently the country is faced with a number of nutrition related problems: increased prevalence of micronutrient deficiencies (e.g. Vitamin A and iron), malnourished children and high levels of overweight and obesity. Mild and moderate malnutrition, although not visible, continue to have public health significance. Efforts to address nutritional disorders should focus on the promotion of proper nutrition, the prevention of malnutrition and the treatment of malnutrition. Nutritional support should be provided to patients with HIV / AIDS and TB. The National 10 Point Plan states that 90% of all primary care facilities should provided nutritional support to people with HIV / AIDS and TB by 2013. Additional targets are that 80% of children under the age of five will receive Vitamin A twice a year.2

Table 18: Clinic-based nutrition services

|  |  |
| --- | --- |
| Promotion of proper nutrition | * Promote use of iodised salt
* Promote use micronutrient rich foods
 |
| Prevention of malnutrition – underweight | * Vitamin A supplementation
* Support early initiation of breast feeding
* Promotion of appropriate complementary feeding for young children
* Growth monitoring – identification of at risk children, and counselling of caregivers.
* Iron / folate supplementation of pregnant women
* Control and prevention of diarrhoeal disease.
 |
| Prevention of malnutrition – obesity | * Regular weighing by health care workers, recording of weight and feedback to patients
* Nutrition education and information on healthy diets and health risks associated with poor diets.
 |
| Treatment of malnutrition | * Refer
 |

## 5.11 Mental Health

***5.11.1 Introduction***

Mental health services at primary health care level will focus on education and awareness raising, case detection, psychosocial management and referral. In every clinic there will be at least one member of staff who has had continuing education in psychiatry or mental health (including community aspects) in the last year. All clinics will also have regular visits (for patient care, training, supervision and support) from dedicated mental health or psychiatric nurses from community health centres, hospitals or mobile teams based in the district. Specialist mental health expertise (psychiatrists, psychologists, occupational therapists) and social workers are available in community health centres. The main mental health problems include:

* Depression
* Psychosis
* Substance abuse
* Management of the victims of violence

Table 19: Mental health services

|  |  |
| --- | --- |
| Clinic level | * Education and awareness
* Identification of patients in need of mental health care
* Referral to mental health services
 |
| Community health centre | * Triage of patients needing to be seen by psychiatric nurse or more specialised staff
* Identification, assessment, management and referral
* Screening for common problems: trauma, abuse, depression, anxiety, substance abuse
* Initiate individual, group and family therapy
* Establishment of management plans for patients
 |

## 5.12 Oral Health

Oral health is central to well-being and exerts a fundamental influence on the quality of life of South Africans.78 The most prominent oral conditions encountered in the community are tooth decay, pain, tooth loss, early childhood caries, bleeding gums, loose teeth and bad breath. Other conditions that are present include oral HIV lesions, oro-facial trauma, jaw fractures, oral cancer, mouth sores, fluorosis and oral tumours. There is evidence that exposure to optimal levels of fluoride and reducing sugary foods and drinks in the diet, have a powerful impact on reducing tooth decay. Reducing tobacco exposure dramatically alters oral cancer morbidity.78 Basic oral care consists of three elements

1. Pain relief
2. First aid for oral infections and dento-alveolar trauma
3. Referral of complicated cases.78

National goals for the provision of oral health services include:

1. Increase the percentage of children age 6 who are caries free to 60%
2. Reduce the number of Decayed, Missing and Filled Teeth (DMFT) at age 12 to 1.0
3. Prioritise child oral health with a focus on school- based prevention programmes.

Specific activities at primary care level include

* Offering all antenatal women an oral health educational package
* All community health centres should offer the prescribed oral health care package.
* Mobile dental units should be considered in areas with poor access to health care services.

Table 20: Oral Health Services

|  |  |
| --- | --- |
| Prevention and promotion | * Examination
* Cleaning of teeth
* Fissure sealants
* Fluoridated toothpaste – tooth brushing programme
* Oral health education and promotion targeted at selected groups such as children, youth, pregnant women, mothers and the elderly.
* Pain relief
* Referral
 |
| Treatment | * Basic curative services, including relief of pain and infection control
* Extraction of badly decayed and severely peridontally involved teeth under local anaesthesia
* Treatment of post extraction complications such as dry sockets and bleeding
* Drainage of localised oral abscesses
* Palliative drug therapy for acute oral infections
* First aid for dento-alveolar trauma
* Referral of complicated cases to the nearest hospital
 |

## 5.13 School health services

Priorities in the provision of school health services are to increase the number of schools that are visited by a PHC nurse and provided with appropriate school health services. The School Health Policy and Implementation Guidelines are currently being revised, but services should include at least:79

* Micronutrient supplementation;
* De-worming where appropriate as per current policy;
* School feeding where appropriate, and in collaboration with the Department of Education;
* Screening for obstacles to learning, including for hearing, vision and speech impairment
* Physical examination for gross loco motor dysfunction
* Oral health checks, education and health promotion
* Anthropometric assessment
* Provision of penicillin for the prevention of rheumatic fever.
* Mental health assessment and identifying and responding to internal injuries and child abuse
* Support for life-skills education programme in schools.

## 5.14 Rehabilitation services

The goal of rehabilitation is to enable individuals to return home to their communities with the highest possible level of functional independence and the best possible quality of life, while at the same time reducing, as far as possible, the burden of care on family members and significant others.47, 80-81Rehabilitation includes measures to compensate for a loss of function or a functional limitation (for example by technical aids) and other measures intended to facilitate social adjustment or readjustment.

Community-based rehabilitation aims to:81-82

* Promote equal opportunities for people with disabilities, through inter alia, facilitating IEC activities; ensuring access to health and rehabilitation services; support establishment of self-help and support groups;
* Emphasise prevention, through the development and distribution of appropriate and up to date media on disabilities and promoting adherence to health and safety regulations, road safety tips, prevention of burns in the home.
* Provide access to rehabilitation programmes, including assessment of physical, emotional, sensory or communication disorders; provision of assistive devices; counselling and /or education of client and family or caregiver; receiving and sending out referrals to local resources and hospitals.

|  |
| --- |
| **Table 21: Rehabilitation services** |
| ***COMMUNITY BASED REHABILITATION SERVICES*** |
| Conduct structured household visits to:* identify at-risk households and individuals
* assess need for services
* facilitate access to health and social services
 | Identify vulnerable households, including people hidden because of physical disabilities Facilitate access to social grants (child care, disability, old age) and other social services (e.g. OVC)Facilitate access to assistive devicesAssist with registration of births and deaths |
| Screen for domestic violence & substance abuse |
| Promote equal opportunities for people with disabilities | * Raise awareness in educational institutions, places of employment, sports and recreation facilities, religious institutions, etc
* Distribution of up to date information on available programmes and services to persons with disabilities, their families, professionals in the field and the general public.
* Facilitate establishment of self help and support groups with full participation of people with disabilities
* Create awareness and provide knowledge regarding mental illness and anti-stigma and non-discrimination
 |
| Provide information, education & support for safety, healthy behaviours and appropriate home care | * Provide information on substance abuse, adherence to health and safety regulations, road safety tips, prevention of burns in the home
 |
| Provide psychosocial support and facilitate and support the development of self help groups | * Provide counselling
* Networking with rehabilitation and disability forums, CBOs and NGOs
 |
| Conduct community assessments & mobilise around community needs | * Address inter-sectoral issues, especially access for disabled individuals, equal opportunities, etc
* Support community campaigns which aim to promote human rights, improve coverage of key interventions, safety, etc
 |
| * Support pedestrian and other safety initiatives (e.g. for children, women
* Support campaigns to reduce the availability of drugs and alcohol
 |
| ***CLINIC-BASED SERVICES*** |
| Screening | Early detection of people with disabilities through screening and observations at the clinic and/or home visits |
|  | Assessment of physical, emotional, sensory or communication disorders |
| Assessment | Basic assessment by means of formal diagnosis by visiting professional team and issue of basic assistive devices |
|  | Early detection, assessment and treatment of impairment |
| Counselling and/or education | Of client and family/care giver |
|  | Receiving and sending out referral to local resources and CHC |
| ***COMMUNITY HEALTH CENTRES*** |
|  | * Identification, assessment, management and referral
* Screening for complications e.g. contractures, pressure sores,
* Establishment of rehabilitation management plans for patients
* Provision of assistive devices, including wheelchairs, walking aids, hearing aids, prostheses
 |

## 5.15 Optometry services

The correction of refractive errors forms a significant part of the World Health Organisation's Vision 2020 initiative to eliminate avoidable blindness. A district based programme should aim to identify, refer and provide services for children and adults who would benefit from refractive correction by:83

* Providing screening services
* Providing refractive services
* Providing cost-effective correction devices
* Establishing the appropriate referral channels

Table 22: Optometry services

|  |  |
| --- | --- |
| Screening | * Adults - in health care facilities. The focus should be on adults over the age of 60.
* Children – as part of school health services
 |
| Refraction | * Affordable and/or fully subsidised spectacles should be provided to those in need, preferably at the site of the screening or refraction. The spectacles should be of acceptable optical and safety quality.
* Criteria for the provision of glasses
	+ Anisometropia less than 0.50D
	+ Astigmatism in both eyes less than 0.75D.
	+ The acceptable limit for prism is considered to be 0.50
 |
| Screening for major ocular diseases | * Such as diabetic retinopathy, glaucoma and cataracts.
 |
| Referral | * To appropriate eye services
 |

## 5.16 Basic curative services

Although the focus of the proposed PHC package is on four critical areas, basic curative services remain a critical component of PHC. Most common illnesses should be treated as per national standard treatment guidelines. These were updated in 2008 and are (or should be) available in all PHC facilities. In line with the teams and categories of staff available at clinic and CHCs, more specialised services will be available at the CHCs.

Table 23: Basic curative services

|  |
| --- |
| ***Clinic-based services*** |
| Curative services | * First visit: history taking, BP, urine testing, full examination
* Clinical assessment and management of illness as per protocols
* Refer if necessary
* Opportunistic screening
* HIV counselling and testing
* BP
* Weight
* Urine for glucose
* Cervical screening
 |
| Vaccine preventable diseases | * Ensure availability of all vaccines
* Conduct routine immunisation services
* Outreach immunisation and campaigns if indicated (measles and meningococcal meningitis)
* Immunisation of high risk groups (H1N1) when appropriate
* Disease surveillance and notification
 |
| Leprosy | * Recognition and referral
* Management of complications
 |
| Malaria | * Early diagnosis and management as per national guidelines
* Referral where necessary
* Selected preventive measures as per national guidelines
 |
| Cholera and Diarrhoea control | * Every clinic considers itself part of the Provincial and National Diarrhoeal Disease Control Programme.
* All staff should be trained in the management of diarrhoeal disease and have continuing education every 6 months or when there are reports of cholera outbreaks in neighbouring countries or regions.
* Every clinic is able to contact and works with the environmental health officer in whose area it falls.
* Reduce mortality due to diarrhoea in children by 50% (Year 2000 Health Goals and Objectives)
 |
| Rabies | * Every clinic has a member of staff conversant with the "Guidelines for Medical Management of Rabies in South Africa.
 |
| Leprosy | * Decrease the current prevalence of leprosy in order to move towards its eradication.
* Each clinic has each year at least one staff member who has had some continuing training in Leprosy from a supervisor.
 |
| Rehabilitation | * Prevention of disability through early detection and screening as per protocols where available (ageing and prevention of blindness)
* Screening and basic assessment
* Referral
 |

|  |
| --- |
| ***COMMUNITY HEALTH CENTRES*** |
| Occupational health | * Render occupational health promotion services
* Sensitise workers to specific occupational health problems
* Primary risk assessment of occupational health exposure
* Facilitate the formation of occupational health and safety committees in the workplace
* Support data collection
 |
| Ophthalmology | * Early identification of eye diseases.
* Identification of all cases with reduce visual acuity and refer
* Fundal examination of all diabetic patients once per year and refer all cases of diabetic retinopathy
* Treatment of eye disease and trauma in line with national guidelines for the “Management and Control of Eye Conditions at Primary Care Level”
* Optometry
 |
| Genetic services | * Prevention of disease complication
* Psychosocial support to affected individuals
 |
| Community health centre | * Occupational therapy
* Physiotherapy
* Rehabilitation
* Speech therapy and audiology
* Assistive devices
* Outreach by rehabilitation workers to community and clinics
 |

## 5.17 Emergency Care

Emergency care and resuscitation services will be provided at CHCs. The aim is to provide initial management, stabilise the patient and arrange for transfer to an appropriate facility. Emergency services should include

* Basic emergency obstetric care
* Respiratory / cardiac emergencies
* Diabetic emergencies
* Allergic emergencies
* Suspected poisoning
* Trauma
* Bleeding

Table 24: Emergency services at CHCs

|  |  |
| --- | --- |
| Trauma and emergency services  | * Care of trauma of limbs (excluding fractures (temporary immobilisation only)
* Treatment of minor fractures
* Management of acute psychiatric cases and referral
* Preparation for urgent referral of serious trauma – proper immobilisation, IV therapy, clearing of airway
* Care of medical conditions which can be stabilised within 24 hours
* Immediate management of emergencies
	1. Basic emergency obstetric care
	2. Respiratory / cardiac emergencies
	3. Diabetic emergencies
	4. Allergic emergencies
	5. Suspected poisoning
	6. Trauma
	7. Bleeding
 |
| Post-sexual assault services | * Medico legal services for consultation
* Counselling
* HIV testing
* Emergency contraception
* STD prophylaxis
 |

## 5.18 Environmental health

Environmental health services are provided through regular activities carried out by environmental health officers in community health centres.

Table 25: Environmental health services

|  |  |
| --- | --- |
| Clinic level | * Information on environmental health services
* Contact number of officers to lodge complaints
* Information on waste management and water quality
* Chemical and food safety
 |
| CHC | * Environmental health promotion services
* Environmental health training programmes
* Monitor environmental health legislation enforcement
* Food safety and food hygiene services
* Services in respect of public conveniences
* Non-specialist impact / risk assessment and environmental evaluation
* Non-specialist occupational hygiene / indoor environmental quality evaluation services
* Environmental health services in formal sector and at care centres
* Services in respect of keeping animals, nuisances
* Services in respect of the collection and collation of environmental health data
* Services in respect of outbreak investigations, communicable diseases investigation, as part of a team
* Monitor health aspects of housing, water and sanitation
* Environmental health planning, zoning and license applications
* Vector control services
* Pollution control services, inspection and monitoring
* Monitor waste management services: litter control, waste storage and collection
* Environmental health services in respect of pauper burials
* Monitor food safety services
 |

## 5.19 Health education

Health education activities should be integrated into all services provided at primary health care level. All clients should receive appropriate health education, information and support. Services should be provided through:

* Face to face meetings
* Health education campaigns in high risk areas
* Social mobilization for different health programmes
* Health education material
* Media

Specific attention should be paid to a number of areas

* Reduce the use of illegal substances
* Reduce the consumption of alcohol and other drugs

## 5.20 Clinical support services

## 5.20.1 Equipment

Community health centres may have X ray and ultrasound facilities in order to support the delivery of effective health care. Operating theatres would allow minor operations to be performed.

***5.20.2 Essential Medicines***

A list of essential medicines at each level is available from the Department of Health. It is expected that all medicines are available at all times, in adequate amounts.

***5.20.3 Diagnostic Services***

Community health centres access to laboratory services.

**Haematology**

* Blood film
* Haemoglobin
* Haematocrit
* Red Blood Cell Count
* White Blood cell count and platelet count
* Differential blood count
* Erythrocyte Sedimentation Rate
* Coagulation screening tests
* Reticulocyte count
* Blood grouping and RH factor

**Serology**

* Widal test
* Rose Bengal
* C Reactive protein
* ASOT
* Rheumatoid factor
* Toxoplasmosis
* RPR
* TPHA
* Infectious Mononucleosis
* SLE
* G6PD assay
* Cooms
* Iron and TIBC

**Biochemistry**

* Blood glucose
* Renal function tests
* Liver function tests
* Lipid profile
* Hormonal assays

**Bacteriology**

**Direct Microscopy**

* General urine examination
* General stool examination

**Staining Smears**

* Gram stain
* Zeil Nelson stain
* KLB stain

**Culture**

* Urine
* Swabs
* Stool
* Throat
* Sputum
* Blood
* CSF
* STD culture swabs

**Rapid bacteriological tests**

* Anti microbial susceptibility

**Parasitology**

* Malaria parasite
* General Stool examination

**Cytology**

* Pap smear
* Urine cytology

# SECTION 6: TOWARDS PHC PACKAGE IMPLEMENTATION

## 6.1 Introduction

The renewed emphasis on PHC as the cornerstone of health care delivery and the major reforms envisaged by the NHI provide exciting opportunities for health system change in South Africa, rarely available in most countries. Although the rapid review provided a snapshot of implementation of the existing package in eight provinces, the overall package review was limited by time constraints and the inability to cost the PHC service package in the time available. Furthermore, the information obtained from provincial respondents was self-reported, and there may have been some socially desirable responses provided. Nevertheless, valuable insights were provided.

The PHC package provided a vision for health service delivery to health workers and managers at the district level. Reported progress includes the availability and accessibility of a wide range of PHC services and the addition of new services, such as ART provision and rehabilitation. The PHC guidelines have also facilitated planning and negotiation of additional financial resources in some instances; served as a catalyst for the development of clinical support services (e.g. laboratory services); enabled further and ongoing training of health care providers; and facilitated monitoring and evaluation of service provision.

At the same time, the assessment also highlighted wide variation in the implementation of the package across the nine provinces, illustrated by estimated provincial performance on the selected indicators. The provision of PHC services on the same day ranges from 70% in Northern Cape, North West and Gauteng to 100% in Kwazulu-Natal and the Western Cape. The initiation of ART at eight-hour clinics is an encouraging development. However, ART initiation at CHCs varies from a low of 38% in Mpumalanga to 100% in Gauteng, Kwazulu-Natal and Western Cape, perhaps reflecting better staffing in the urban settings. The availability of a nurse with specialised mental health training appears to be a problem in all provinces, with either low reported performance, or respondents equating the existence of a professional nurse with specialised mental health skills. Only Mpumalanga and Western Cape reported that fast queues for elderly people were available in all facilities. There was also variation on awareness/ existence of organisational structures and budgets at CHC and clinics. Lastly, the existence of functioning clinic committees is an important indicator of responsiveness and/or accountability to communities. This varied from zero functioning clinic committees in North West province to 100% functional community structure in the Western Cape, albeit at a cluster/sub-district level.

Human Resource challenges were consistently mentioned by all provincial respondents, as a factor hampering ‘full’ implementation of the package. Similarly, a range of infrastructure, financial and other constraints were mentioned by provincial respondents. These issues have to be addressed to ensure successful implementation. In the light of the assessment and the literature review, we now turn to key issues that have to be taken account in moving forward with the recommendations in this report.

## 6.2 Prerequisites for package implementation

The proposed PHC package, norms and standards should be seen as a ***guiding document, rather than a rigid, one size fit all prescription***. The team wishes to stress the following:

1. The proposed package of services should be *flexible and tailored* to the particular needs of the province and area of implementation. Priority setting and planning processes at sub-district and district levels should highlight local priorities and a profile of services should then be developed that is based on the particular profile of need in that area.
2. A broader public health approach, which emphasises prevention, is critical: all provincial respondents were of the opinion that there should be positive bias towards prevention and health promotion in the revised package, which should include empowering communities with essential health knowledge and literacy.
3. Prioritising specific areas does not imply that *treatment of minor ailments* and specific conditions is unimportant. These services are important and remain in the package.
4. The PHC system can only achieve the desired outcomes if it is supported by other levels of the health system in a coordinated and integrated manner. The delivery of good quality essential care relies on *effective referral relationships with and support* from district hospitals, (in addition to clinical competencies to identify when these referrals are needed).
5. The delivery of a comprehensive primary health care package requires *adequate resources:* funding, adequate, committed and motivated staff and the necessary infrastructure and clinical support services (e.g. pharmaceuticals) in order to deliver high quality and efficient services. These resource requirements are part of separate components of work, and should be completed prior to any implementation.
6. Addressing the *social determinants of health*, in particular, requires action at multiple levels. Although we have suggested a number of opportunities for inter-sectoral, these are indicative only, and meant to highlight an approach rather than provide a prescription.

## 6.3 Suggested next steps

We use the participants’ suggestions on the development of the revised package to conclude the report. Five main issues need to be addressed/ and or taken forward: flexibility in the application and implementation of the package; consultation with stakeholders; costing of the package and implementation requirements; efforts to strengthen implementation; monitoring, auditing, evaluation and revision. Each of these is highlighted below:

***6.3.1 Flexibility***

The recommendations must be seen as flexible guidelines, rather than a rigid prescription. Almost all the provincial respondents mentioned the need for flexibility both in the application and the implementation of the package, as can be seen from the quotes below:

*“You should not make it [the package] prescriptive. Set a minimum to allow people to go beyond. Visit some of our facilities and see what is possible and impossible do not make assumptions that clinics are the same*.”(Gauteng)

*“The task team should pilot the package in some of the provinces”* (Mpumalanga)

*“You should take into account unique circumstances of each province”* (Northern Cape)

*“Be practical: South Africa does not need international standard but its own. Focus on the basics-Take into account rural challenges; and look at the situation of allowing certain professional to perform certain functions e.g. nurses”* (North West)

***6.3.2 Consultation of stakeholders***

The recommendations contained in this document should be consulted with key health stakeholders in government (local, provincial and national); a selection of PHC/district experts and community stakeholders. Respondents suggested that stakeholders that should be consulted should include clinicians/ front-line staff; facility managers at sub-districts; clinic committees and managers at district and provincial head office levels. As two respondents noted:

*“Community and staff inputs are important as these activities are many times top-down approach”.* (Provincial respondent)

*“You have to ask: ‘who are the key players’. We also have to ask how we as a country can get more reliability at the level of delivery- That means that we have to consult with our staff-we have to deal with the distortions that arise from obtaining the views of staff, while embarking on the necessary process of consulting with them”* (Key informant)

***6.3.3 Costing of the package and implementation requirements***

The rapid assessment pointed to many of the implementation challenges, the vast majority that were directly or indirectly linked with finances. Costing of the proposed package is a critical component to ensure sustainability and successful implementation. As one respondent noted:

*“A number of issues should be addressed, including organisational structures, occupational health, infrastructure and space constraints” (Northern Cape)*

*“Baseline costing of the package is critical, and how to cost the package in order to influence the activity based budgeting. The calculation formulas should also be included” (Eastern Cape)*

***6.3.4 Concerted efforts to strengthen implementation***

Suggestions included the following:

* Recognising the importance of clinical support systems e.g. pharmaceuticals availability, space, infrastructure
* The need for integrated referral pathways and ensuring that people access services at appropriate levels
* Developing norms and standards for staffing, and defining level of skills for different health and allied professional categories and support staff.
* Avoid making contradictory recommendations e.g. the existing PHC package recommends the distribution of condoms in nearby schools, whilst the school policy promotes abstinence and prevent condom use by school children.
* Address accountability issues at sub-district, district, provincial and national levels

***6.3.5 Monitoring, auditing, evaluation and revision***

Many respondents point to the need for a clear monitoring and evaluation (M&E) framework that specifies compliance issues and consequences of non-compliance, the role of health governance structures in M&E; periodic reviews and revision of the package.

As a key informant noted:

*“Official documents are often seen as set in stone. There is no formal process of updating them or no formal review process. We have to be more flexible and build in period reviews and revisions into the policy documents we produce”.*

# LIST OF APPENDICES

**Appendix 1**

**Review of clinical categories as per PHC Norms and Standards document and indication as to whether clinical guidelines are available in each category**

| **Category as per PHC Norms and Standards** | **Service description** | **Availability of guidelines to support service delivery** |
| --- | --- | --- |
| Women’s reproductive health | Services should be provided in an integrated comprehensive manner covering preventive, promotive, curative and rehabilitative aspects of care. The focus should be in antenatal, delivery, post natal and family planning | * Cervical cancer screening programme
* Contraception guidelines for South Africa
* Saving Mothers. Essential Steps in the Management of Common Conditions Associated with Maternal Mortality (2007)
 |
| Management and prevention of genetic disorders and birth defects | These services should form part of the integrated maternal, child and women’s health care. They aim to assist individuals with a genetic disadvantage to live and reproduce normally Clinical diagnostic services, counselling, laboratory support, prevention strategies and public awareness campaigns | * Human Genetics policy guidelines for the management and prevention of genetic disorders, birth defects and disabilities (2001)
 |
| IMCI | Promotive, preventive (monitoring and promoting growth, immunisations, home care counselling, de-worming and promoting breast feeding)Curative – assessing, clarifying and treating)Rehabilitative | * Road to health chart guidelines
 |
| Management of asthma | Managing chronic asthma in infants, children and adults | * National guidelines on the management and control if asthma in children at primary level (1999)
* National guideline on the prevention of asthma in adults at primary level (2002)
 |
| Disease prevented by immunisation | Uninterrupted supply of vaccinations  | * Guidelines for the management, prevention and control of meningococcal disease in South Africa
 |
| Adolescent (10 – 19) and Youth (15 – 24) Health | Holistic approach with a focus on special needs |  |
| Management of communicable diseases | Prevention, early diagnosis and initiation of measures to prevent transmission |  |
| Cholera and Diarrhoeal Disease Control | Management and control |  |
| Dysentery | Management and control |  |
| Helminths | Schistosomiasis and cysticercosis | * Regular treatment of school going children for soil-transmitted helminths infections and bilharzia
 |
| STIs | Prevention and managementCondom distribution |  |
| HIV / AIDS | Testing, counselling, treatment of associated infections and referral | * Clinical guidelines for the management of HIV / AIDS in adults and adolescents (2010)
* South African ARV treatment guidelines (2010)
* Guidelines for the management of HIV in Children
* Clinical Guidelines: PMTCT (2010)
 |
| Malaria | Treatment | * Guidelines for the prevention of malaria (2009)
* Guidelines for the treatment of malaria (2009)
 |
| Rabies | Referral for PEP |  |
| Tuberculosis | Diagnosis, treatment and management | * Guidelines for the programmatic management of TB
* Decentralised management f MDR TB. A policy framework for SA.
 |
| Leprosy | Treatment | * Guidelines for leprosy control (2008)
 |
| Prevention of hearing loss due to otitis media | Diagnosis and treatment | * Prevention of hearing impairment due to otitis media at clinic level
 |
| Rheumatic fever | Diagnosis of sore throat and rheumatic fever. Referral | * National Guidelines of the primary prevention and prophylaxis of RF and RHD for health professionals at primary level
 |
| Trauma and Emergency | Emergency and resuscitation services |  |
| Oral health | Basic Primary Oral Health Care Services |  |
| Mental Health | Assessment, counselling and supportPrevention included in all services |  |
| Victims of sexual abuse, domestic violence and gender violence | Counselling, referral, STD prophylaxis HIV testing, emergency contraception, care of injuries and medic-legal advise |  |
| Substance Abuse | Prevention and management |  |
| Chronic diseases and geriatrics | Early diagnosis, management and harm reduction | * National guidelines in the prevention, early detection and intervention of physical abuse of older persons at primary level (2000)
* Guidelines for the promotion of active ageing in older adults at primary level (2000)
* Primary prevention of chronic diseases of lifestyle
* National Guidelines of the management of osteoporosis at hospital level and preventative measures at primary level
 |
| Diabetes | As above | * National programme for the control and management of Type 2 diabetes at primary level (1998)
* National guidelines on foot health at primary level
 |
| Hypertension | Detection, treatment and control. Prevention of target organ damage and stroke | * Hypertension. National programme for control and management at primary level (1998)
 |
| Rehabilitation services | Designing, implementing and monitoring of appropriate servicesPrevent disabling conditions, detect disabilities early and prevent complicationsBasic assessment | * Prevention of blindness in south Africa (2002)
* Management and control of eye conditions at primary level
 |

**Appendix 2**

**Conditions covered in Standard treatment Guidelines (2008)**

* Dental and oral conditions
* Gastro-intestinal conditions
* Cardio-vascular conditions
* Skin
* Obstetrics and gynaecology
* Family planning
* Kidney and urological
* Endocrine
* Infections and related conditions
* HIV
* Sexually transmitted infections
* Immunisation
* Musculoskeletal
* Central nervous system
* Respiratory
* Eye
* Ear, Nose and throat
* Pain
* Trauma and emergencies

**Appendix 3.**

**Fact Sheets and Guidelines available on department of Health website[[2]](#footnote-2)**

* [Clinical Guidelines for the Management of HIV & AIDS in Adults and Adolescents](http://www.doh.gov.za/docs/factsheets/guidelines/adult_art.pdf) 2010
* [The South African Antiretroviral Treatment Guidelines](http://www.doh.gov.za/docs/factsheets/guidelines/art.pdf) 2010
* [Guidelines for the Management of HIV in Children 2nd Edition](http://www.doh.gov.za/docs/factsheets/guidelines/paediatric.pdf) 2010
* [Clinical Guidelines: PMTCT (Prevention of Mother-to-Child Transmission)](http://www.doh.gov.za/docs/factsheets/guidelines/pmtct.pdf) 2010
* [Guidelines for an Environmental Health Officer (EHO) engaged in food poisoning investigations](http://www.doh.gov.za/docs/factsheets/microguide.pdf) - October 2001
* [Guidelines for the Prevention of Malaria in South Africa](http://www.doh.gov.za/docs/factsheets/guidelines/prevention_malaria09.pdf) - 2009
* [Guidelines for the Treatment of Malaria in South Africa](http://www.doh.gov.za/docs/factsheets/guidelines/malaria/treatment/2009guidelines-a.pdf) - 2009
* [Saving Mothers - Essential Steps in the Management of Common Conditions Associated with Maternal Mortality](http://www.doh.gov.za/docs/factsheets/guidelines/sm/index.html)
* [Guidelines for the Management, Prevention and Control of Meningococcal Disease in South Africa](http://www.doh.gov.za/docs/factsheets/guidelines/meningococcal.pdf)
* [Regular Treatment of School-Going Children for Soil-Transmitted Helminth Infections and Bilharzia](http://www.doh.gov.za/docs/factsheets/guidelines/bilhazia/treatment.pdf)
* [Guideline for Leprosy Control in South Africa](http://www.doh.gov.za/department/publications/leprosy.pdf) 2008
* [Road to Health Chart guidelines](http://www.doh.gov.za/docs/factsheets/guidelines/health/healthchart.htm) (Updated: 2003)
* [National guideline on prevention of blindness in South Africa](http://www.doh.gov.za/docs/factsheets/guidelines/blindness.pdf). 2002
* [National Guideline on Management of Osteoporosis at Hospital Level Preventative Measures at primary Level](http://www.doh.gov.za/docs/factsheets/guidelines/geriatics.html)
* [Guideline for the Promotion of Active Ageing in older Adults at Primary Level](http://www.doh.gov.za/docs/factsheets/guidelines/ageing/ageing.pdf). 2000
* [National Guideline on Prevention, Early Detection/Identification and Intervention of Physical Abuse of Older Persons at Primary Level](http://www.doh.gov.za/docs/factsheets/guidelines/abuse/abuse.pdf). 2000
* [Human Genetics Policy Guidelines for the Management and Prevention of Genetic Disorders, Birth Defects and Disabilities](http://www.doh.gov.za/docs/policy/humangenetics.pdf)
* [National Guideline on Prevention of Falls of Older Persons](http://www.doh.gov.za/docs/factsheets/guidelines/falls/falls.pdf). 1999
* [National Guideline on Management and Control of Asthma in Children at Primary Level](http://www.doh.gov.za/docs/factsheets/guidelines/asthma/asthma.pdf). April 1999
* [National programme for control and management of Diabetes Type 2 at primary level](http://www.doh.gov.za/docs/factsheets/guidelines/diabetes/diabetes.pdf). 1998
* [Hypertension National programme for control and management at primary level](http://www.doh.gov.za/docs/factsheets/guidelines/hypertension/hypertension.pdf). 1998
* [National Guidelines on Cervical Cancer](http://www.doh.gov.za/docs/factsheets/guidelines/cancer.pdf).
* [National Guidelines on Management and control of eye conditions at primary level](http://www.doh.gov.za/docs/factsheets/guidelines/eye2.pdf).
* [National Guidelines on Primary prevention of chronic diseases of lifestyle](http://www.doh.gov.za/docs/factsheets/guidelines/cdl.pdf)
* [National Guidelines on Primary Prevention and Prophylaxis of Rheumatic Fever (RF) and Rheumatic Heart Disease (RHD) for Health Professionals 0at Primary Level](http://www.doh.gov.za/docs/factsheets/guidelines/rheuma.pdf)
* [Guideline for the prevention of hearing impairment due to otitis media at clinic level](http://www.doh.gov.za/docs/factsheets/guidelines/hearing.pdf)
* [National guideline on management of asthma in adults at primary level](http://www.doh.gov.za/docs/factsheets/guidelines/final02.pdf). 2002
* [National Guideline on Management and Control of Asthma in Children at Primary Level](http://www.doh.gov.za/docs/misc/asthma-children.pdf). 2007
* [User's Guide to Primary Health Care Services](http://www.doh.gov.za/docs/factsheets/guidelines/yourclinic/index.html)
* [Practical Guidelines for Infection Control in health Care Facilities](http://www.doh.gov.za/docs/factsheets/guidelines/infection/index.html). 2003
* [Guidelines for Environmental Health Officers in the implementation of the HACCP system](http://www.doh.gov.za/docs/factsheets/haccp.pdf). 2000
* [National Guideline on Foot Health at Primary Level](http://www.doh.gov.za/docs/factsheets/guidelines/foot/foothealth.pdf).2000
* National Contraception Policy Guidelines
* Decentralised Management of Multi-Drug Resistant Tuberculosis. A policy Framework for South Africa 2010.

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**Appendix 2: Glossary of HR workers**

| **GLOSSARY** |
| --- |
|  |  **Current Role** | **Proposed role** |
| Clinical Associate | Currently the clinical associate does not exist as a category of health in both the public and private health care services | This is a new cadre of health care worker that is the mid-level worker of medical practitioners. The clinical associate is regulated by the Health Professions Council of South Africa and may only work under the direct or indirect supervision of a medical practitioner. The education and training of the clinical associate is currently prepares this category of health care worker to work only in district hospitals. |
| Community Health Worker | Community health workers are lay health workers that are deployed by communities to NPO/CBO services to support community based services. Currently most CHWs provide home based care services. | The proposed role of CHWs is for them to play an active role in the formal health care delivery service. The CHW will not be providing care but will play a role in linking families to health services, identifying high risk families and individuals. |
| Counselor | Currently there are lay counselors that provide counseling services for pre- and post- HIV testing, adherence counselors, DOTS support workers. These usually provide counseling services in one of the aforementioned areas. These counselors are not formally employed by the Department of health however they are paid from conditional grants or other types of donor funding. | The counselor proposed is a practitioner that will provide an integrated counselling service that will include pre and post diagnosis, treatment adherence, post traumatic and trauma counselling services. |
| Enrolled Nurse | Is a person who is enrolled by the SANC as a nurse after completing a two year further education and training certificate (Grade 10 + 2 years training further education and training) The enrolled nurse is not the same category as the staff nurse. | The enrolled nurse category in terms of the Nursing Act (2005) will be phased out and replaced by the staff nurse. |
| Enrolled Nursing Auxiliary | Is a person who is enrolled by the SANC as a nursing auxiliary after completing a 1 year further education and training certificate (Grade 10 + 1 years training further education and training). The enrolled nursing auxiliary is also referred to as a “nursing assistant” | The role of the enrolled nursing auxiliary will remain unchanged. In terms of the Nursing Act (Act 33 of 2005) this category of nurse is re-named auxiliary nurse. The scope of practice of a auxiliary nurse is a educated to provide elementary nursing care. |
| Home Based Carer | Home based carer is a lay health worker that provides basic care and support for activities of daily living. Currently this category of health worker is employed by NPO/CBO/NGO to provide care and support to terminally ill, elderly and persons who have full blown AIDS. Although not employed by the public health sector the services of home based care are supported through conditional grants or donor support grants. | The services of the home based carer remains unchanged expect that there should be sustainable funding mechanisms.  |
| PHC Nurse Practitioner | This is a professional nurse who has additional training in clinical nursing science, assessment, diagnosis, treatment and care. These nurses have been employed in PHC facilities especially where there are no doctors to conduct medical assessments, diagnose and treat patients. These nurses were authorized to fulfill this extended function in the public sector by the Director General in accordance with section 38 A of the Nursing Act (Act 33 of 1978). | The function of this category of nurse remains unchanged. The conditions for authorizing the functions previously rendered according to section 38A of the Act 33 of 1978 are now replaced by section 57 of Act 33 of 2005.  |
| Post Basic Pharmacist Assistant | The Pharmacy Council of South Africa (PCSA) registered the post basic pharmacy assistant as a mid-level health worker to address the challenges facing the health care system with regard to the shortage of pharmacists. Although training and registration of post basic pharmacists commenced as early as 2004 this category of mid-level health worker has not been embraced by the public health services. A concerted effort is required to increase both the production and employment of post basic pharmacist assistants in the public sector. | The post basic pharmacy assistant will play an important role in providing pharmaceutical services at a PHC clinic. |
| Professional Nurse  | is a person that meets the qualifications and clinical requirements to practice as a competent professional nurse. The professional nurse may be registered as a general nurse, midwife, psychiatric and /or community health nurse. The registration of a professional nurse in all 4 basic disciplines in nursing enables the professional nurse to practice comprehensive nursing. Not all professional nurses are comprehensively trained; a professional nurse may register only as a general nurse and/or in any one or more of the 4 basic disciplines. The professional nurse may be a 4 year diploma offered by a nursing college (the majority of the professional nurses have this qualification), a degree offered by a university or a bridging course which is a 2 year qualification to upgrade enrolled nurses to practice as a professional nurse. The bridging course only leads to registration as a general nurse and this professional nurse does not have the qualification for comprehensive practice | According to the scope of practice of a professional nurse in Act 33 of 2005 the professional nurse is a person who is qualified and competent to independentlypractise comprehensive nursing. By implication all professional nurses are required to receive comprehensive training in the 4 basic areas of nursing (general, obstetric, mental and community health). |
| Staff Nurse | This category nurse is a new category of nurse and currently there are no staff nurses registered by the SANC | The scope and education and training of this new category of staff nurse was developed in direct response to the need for a mid- level nurse and other categories of mid-level health workers as per the policy of the department of Health. The scope of this category of nurse in terms of the Nursing Act (Act 33 of 2005) is to practice basic nursing. |

**APPENDIX 2: RECOMMENDATIONS ON HUMAN RESOURCES**

| **National** |
| --- |
| **Broad Issue** | Specific application | Comment | Action | Short Term12 months | Medium term 1-2 years | Long Term2-3 Years | Responsible authority |
|  |  |  |  |  |  |  |  |
| 1. **Implementation of the re-engineered PHC service**
 |  |  | 1.1 Establish national, provincial and district implementation teams that will drive the implementation of a re-engeneerd PHC service  | √ |  |  | DG and Heads of Health |
|  |  |  | 1.2 Publish a detailed directive outlining the role, function, responsibility of the PHCT in providing PHC services | √ |  |  | National implementation team |
| 1. **Determine HR required to implement the re-engineered PHC service**
 |  |  | * 1. Conduct a HR audit determines the gap between the number of staff needed and those available.
 | √ |  |  |  |
|  |  |  | 2.2 Develop a HR recruitment strategy and plan for each province and district | √ |  |  | Provincial implementation team |
|  |  |  | 2.3 Secure finances to fund the HR requirements from treasury | √ |  |  | DG and Heads of Health |
|  |  |  | 2.3 Recruit and/or Contract staff | √ |  |  |  |
| 1. **Establish PHC teams in the 18 priority districts**
 |  |  | * 1. Conduct a HR audit determines the gap between the number of staff needed and those available.
 | √ |  |  | Provincial implementation team |
|  |  |  | 2.2 Develop a HR recruitment strategy and plan for each priority district | √ |  |  | Provincial implementation team |
|  |  |  | 2.3 Secure finances to fund the HR requirements from treasury | √ |  |  | DG and Heads of Health |
|  |  |  | 2.3 Recruit and/or Contract staff | √ |  |  | District management team |
| 1. **Have an enabling Regulatory framework for professional practice and education and training**
 | 4.1 Professional Nurse | Partially Completed | 4.1.1 Publish new scope of practice regulations | √ |  |  | HR Directorate & Legal unit |
| 4.1.2 Publish education and training regulations | √ |  |  | HR Directorate & Legal unit |
| 4.1.3 Support training institutions through a generic training curriculum and training resources that can be adapted by individual training institutions | √ |  |  | HR Directorate and SANC |
| * + 1. Develop a national strategy to provide support provinces and education institutions to implement the new qualification
 | √ |  |  | HR Directorate and SANC |
| 4.2 Midwife | Partially completed | 4.2.1 Publish scope of practice regulations | √ |  |  | HR Directorate & Legal unit |
| 4.2.2 Develop and register qualification based on revised scope of practice |  | √ |  | SANC |
| 4.2.3 Constitute an expert midwifery reference group  | √ |  |  | SANC |
| 4.3 Staff Nurse | Partially completed | 4.3.1 Publish education and training regulations | √ |  |  | HR Directorate & Legal unit |
|  |  | 4.3.2 Support training institutions through a generic training curriculum and training resources that can be adapted by individual training institutions | √ |  |  | HR Directorate & SANC |
|  |  | 4.3.3 Develop a national strategy to provide support provinces and education institutions to implement the new qualification | √ |  |  | HR Directorate and SANC |
| 2.4 Nurse Prescriber | Partially completed | 2.4.1 Publish regulations to give effect to section 56 of the Nursing Act, 2005 | √ |  |  | HR Directorate & Legal unit |
|  |  | 2.4.2 Determine and publish the prescribed educational requirement for licensing a practitioner | √ |  |  | SANC |
| 2.5 PHC Nurse | Partially completed | 2.5.1 Develop an scope of practice for advanced nurse practitioner |  | √ |  | SANC |
|  |  | 2.5.2 Develop and publish educational requirements for registration of an advanced practice nurse |  | √ |  | SANC & HR Directorate & Legal unit |
| 2.6 Clinical Associate | Completed | 2.6.1 Facilitate national mechanisms for creating clinical associate posts in district hospitals in provinces  | √ |  |  |  |
|  |  | 2.6.2 Identify funds for funding clinical associate positions | √ |  |  | HPCSA |
|  |  | 2.6.3 Develop and implement a communication strategy to communicate the role and function of the clinical associate | √ |  |  | HPCSA & HR & Communication Directorates |
| 2.7 Community Health worker | Partially Completed | 2.7.1 Publish scope of practice Policy guidelines & directives | √ |  |  | HR Directorate |
|  |  | 1.7.2 Develop and publish education and training requirements for practice | √ |  |  | HR Directorate |

| **Provincial** |
| --- |
| **ISSUE** | ACTIONS | Short term Under 12 months | Medium Term Between 1-2 Years | Long Term Between 2-3 Years | Responsible authority |
| 1. **Scale up production and recruitment to address shortage of health professionals**
 | 2.1.1 Conduct an audit to assess production capacity of the training institutions in the province | √ |  |  | Provincial HRD unit and training institutions |
|  | 2.1.2 Identify resources required to increase provincial training capacity | √ |  |  | Provincial HRD unit and training institutions |
|  | 2.1.3 Identify annual training and recruitment targets for all categories of health professionals required | √ | √ | √ | HOD Provincial HRD unit  |
|  | 2.1.4 Identify funding mechanisms for supporting training of health professionals (training post, bursaries, scholarships) | √ |  |  | HOD Provincial HRD unit  |
|  |  |  |  |  |  |
|  | 2.1.5 Determine skill mix and training targets for each category of health professional | √ |  |  | HOD Provincial HRD unit  |
|  | 2.1.6 Develop and implement a short term training strategy (in-house and outsourced training, bursary and training posts) | √ | √ |  | HOD Provincial HRD unit |
|  | 2.1.7 Secure resources and funding for implementing the training and skill development strategy | √ | √ | √ | HOD Provincial HRD unit |
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| **District/Facility Level** |
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| **ISSUE** | Actions | STM | MTM | LTM | Responsible authority |
| 1. **Mismatch between skills and competence of health professionals and requirements for the delivery of the primary health care package**
 | 4.1 Skills and competence assessment and development | 4.1.1 Conduct an annual/ periodic audit of the level of skills and competence of the staff of the facility against the required set of skills to determine the skills and competence deficit in the facility |  | √ |  |  |
|  |  | 4.1.2 Develop and implement a facility based skills development plan |  | √ |  | Team leader/facility manager |
|  |  | 4.1.3 Develop a mentorship/support programme for staff that do not the requisite skills and competence |  | √ |  | Team leader/facility manager |
|  | 4.2 Supervision and performance of PHC teams | 3.2.1 Put in place a performance and personal development plans for each employee |  | √ |  | Team leader/facility manager |
|  |  | 3.2.2 Put in place team performance targets |  | √ |  | Team leader/facility manager |
|  |  | 3.2.3 Compile policies, procedures, SOP, and protocols for implementing the primary health package at the facility |  | √ |  | Team leader/facility manager |
|  |  | 3.2.4 Conduct regular review meetings to assess progress with performance targets |  | √ | √ | Team leader/facility manager |
|  |  | 3.2.5 Conduct regular clinical audits and reviews to support good clinical governance |  | √ | √ | Clinical Leader |

**Appendix 4: Comparison of Scope of Practice of enrolled nurse and staff nurse**

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| **Comparison of Scope of Practice of the Current Enrolled Nurse with the Scope of Practice of the New Staff Nurse Category** |
| **THE SCOPE OF PRACTICE OF ENROLLED NURSES (CURRENT)** | **THE SCOPE OF PRACTICE OF STAFF NURSES (NEW)** |
| The scope of practice of an enrolled nurse shall entail the following acts and procedures as part of the nursing regimen planned and initiated by a registered nurse or registered midwife and carried out under his direct or indirect supervision: 1. The carrying out of nursing care to fulfill the health needs of a patient or a group of patients;
2. caring for a patient, and executing a nursing care plan for a patient, including the monitoring of vital signs and the observation of reactions to medication and treatment;
3. the prevention of disease and the promotion of health and family planning by means of information to individuals and groups;
4. the promotion and maintenance of the hygiene, physical comfort and reassurance of a patient;
5. the promotion and maintenance of exercise, rest and sleep with a view to the healing and rehabilitation of a patient;
6. the prevention of physical deformity and other complications in a patient;
7. the supervision over and maintenance of a supply of oxygen to a patient;
8. the supervision over and maintenance of the fluid balance of a patient;
9. the promotion of the healing of wounds and fractures, the protection of the skin and the maintenance of sensory functions in a patient;
10. the promotion and maintenance of the body regulatory mechanisms and functions in a patient;
11. the feeding of a patient;
12. the promotion and maintenance of elimination in a patient;
13. the promotion of communication by and with a patient in the execution of nursing care;
14. the promotion of the attainment of optimal health in the individual, the family, groups and the community;
15. the promotion and maintenance of an environment in which the physical and mental health of a patient are promoted;
16. preparation for and assistance with diagnostic and therapeutic acts by a registered person;
17. preparation for and assistance with surgical procedures and anaesthetic;
18. care of a dying patient and a recently deceased patient.
 | It is within the competence of a staff nurse to assume full responsibility and accountability for: The provision of basic nursing care and treatment of persons with stable and uncomplicated health conditions in all settings;Providing basic emergency careAssessing and developing a plan of nursing care for persons with stable and uncomplicated health conditions.The nursing care of persons whose health condition is stable and uncomplicated in a unit of an overall health facility or service.1. Nursing care delegated by a professional nurse

Including:1. The clinical practice of a staff nurse is to provide basic nursing care for the treatment and rehabilitation of common health problems for individuals and groups. Such practice requires a practitioner to-
2. Assess and screen the health status through basic observation, interaction and measurement;
3. Interpret data and diagnose basic nursing needs;
4. Develop nursing care plans to meet basic health care and nursing needs;
5. Take responsibility for the implementation of the care plan he/she developed;
6. Manage all aspects of delegated nursing care;
7. Ensure timeous referral and appropriate consultation with a professional nurse or midwife or other health professionals;
8. Promote health through the provision of relevant information;
9. Maintain continuity of care through reporting and communication to care givers and members of the health care team;
10. Evaluate a health care user’s progress towards expected outcomes and revise the nursing plan of care in accordance with such evaluations;
11. Create and maintain an accurate record of nursing interventions;
12. Establish and promote a supportive and helping relationship with a health care user;
13. Maintain an environment that promotes safety, security and respect of the health care user;
14. Maintain a safe environment for nursing care;
15. Advocate for the rights of health care users;
16. Promote participation of health care users in their health care and empower them towards self reliance;
17. Demonstrate and maintain clinical competence to ensure safe practice as a staff nurse.
18. Render basic life saving interventions in an emergency situation

The quality of nursing practice of a staff nurse requires the practitioner to-(1) Participate in the maintenance of set standards to improve the quality of nursing care;(2) Utilize learning opportunities to improve own nursing practice; (3) Continuously review own performance against standards of practice;**LIMITATIONS OF PRACTICE OF A STAFF NURSE**A staff nurse may not take responsibility and accountability for managing overall nursing care in a health facility or service.1. A staff nurse may only provide nursing care and treatment to persons who have complicated health problems or are in an unstable condition under the supervision of a professional nurse.
2. May not conduct a private practice.
3. A staff nurse must comply with the provisions of section 56 of the Act to assess, diagnose, prescribe treatment, keep and supply medication for prescribed illnesses and health related conditions.
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1. These were separated in the questionnaire [↑](#footnote-ref-1)
2. Where no date is given for the guidelines, it does not exist [↑](#footnote-ref-2)