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PROJECT PAPER

FOR THE

EQUITY IN INTEGRATED PRIMARY HEALTH CARE PROJECT

("The *EQUITY* Project")

Project Number 674-0320

USAID/South Africa, 31 July 1995

TABLE OF CONTENTS

LIST OF ACRONYMS

I.	EXECUTIVE SUMMARY	1
A.	Project Summary	1
B.	Project Guidance	2
C.	Design Participation	2
II.	STATEMENT OF THE PROBLEM	4
A.	Results of Inequities and Ineffectiveness	4
B.	The Health System and the Need for Restructuring	5
III.	USAID STRATEGY FOR DEALING WITH THE PROBLEM	5
A.	Relation of USAID/South Africa Strategic Objective for PHN to Bureau and Agency Strategies and Goals	5
B.	Relationship of USAID Strategic Objective to GNU Reconstruction and Development Program (RDP) Objectives for Health	7
C.	Purpose of the EQUITY Project	7
D.	Rationale for Project Approach	7
E.	Bridging Activities	9
IV.	ASSISTANCE INTERVENTIONS	9
A.	Increased Access to an Integrated Package of PHC Services in the Focus Province	9
B.	An Effective Referral System in Place in the Focus Province	10
C.	An Enhanced Capacity to Manage the Integrated PHC Program at National Level and in the Focus Province	10
D.	Increased Effectiveness and Efficiency of PHC Service Delivery at the Provincial Level and Below	11
E.	Institutionalized Capacity for PHC Training	11
F.	Improved Information Base for Decision-making, Program Development, and Management	12
G.	Continuation of HIV/AIDS Activities	13
V.	PLAN OF ACTION	13
A.	Increased Access	15
B.	An Effective Referral System	20
C.	Enhanced Management Capacity	21
D.	Increased Efficiency and Effectiveness	22
E.	Institutionalized Training Capacity	25
F.	Improved Information Base	26
G.	Continuation of HIV/AIDS Activities	29
H.	Implementation Arrangements	30
I.	Conditions and Covenants	31

- J. Results Package Framework 33
- VI. DEFINITION OF SUCCESS 33
 - A. Strategic Objective Indicators 33
 - B. Project Output Indicators 34
 - C. Revalidation Plan (Monitoring and Evaluation) 36
- VII. PROJECT FEASIBILITY 37
 - A. Summary of Project Analyses: Issues and Potential Risks Related to
Project Success 37
 - 1. Economic 37
 - 2. Social 37
 - 3. Technical 38
 - 4. Institutional 38
 - B. Key Project Assumptions 40

ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
ARC	Agricultural Research Council
BASICS	Basic Institutional Strengthening for Child Survival
CBO	Community-Based Organization
CHC	Community Health Committee
CHW	Community Health Worker
CPSP	Country Program Strategy Plan
CS	Child Survival
CSIR	Council on Science and Industrial Research
CSM	Contraceptive Social Marketing
DFA	Development Fund for Africa
DHA	District Health Authority
DHS	Demographic and Health Survey
DOH	Department of Health (national)
DOHW	Department of Health and Welfare (Eastern Cape Province)
DPT	Diphtheria, Pertussis, Tetanus
ENHR	Essential National Health Research
EPI	Expanded Program of Immunization
EQUITY	Equity in Integrated Primary Health Services
EU	European Union
FP	Family Planning
FSN	Foreign Service National
GDP	Gross Domestic Product
GNU	Government of National Unity
HCP	Health Care Point
HDD	Health Development Division (USAID/SA)
HIV	Human Immuno-deficiency Virus
HIS	Health Information System
HMIS	Health Management Information System
HSRC	Human Sciences Research Council
HST	Health Systems Trust
IEC	Information, Education and Communication
IEE	Initial Environmental Examination
IET	Information, Education and Training
IMR	Infant Mortality Rate
IPPF	International Planned Parenthood Federation
MCH	Maternal and Child Health
MEC	Member of Executive Committee
MEDUNSA	Medical University of South Africa
MER	Monitoring and Evaluation Review
MMR	Maternal Mortality Rate
MOH	Ministry of Health
MRC	Medical Research Council
NACOSA	National AIDS Convention of South Africa

NGO Non-governmental Organization

ACRONYMS (cont'd)

NHS	National Health System
ODA	Overseas Development Administration
OR	Operations Research
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
OSD	Office of Social Development
PHC	Primary Health Care
PHN	Population, Health and Nutrition
PID	Project Identification Document
PP	Project Paper
PPC	Bureau for Planning and Policy Coordination (USAID/W)
PSC	Personal Services Contract
RDP	Reconstruction and Development Programme
REDSO/ESA	Regional Economic Development Services Office for East and Southern Africa
ReHMIS	Regional Health Management Information System
RH	Reproductive Health
RSA	Republic of South Africa
SMT	Strategic Management Team
STDs	Sexually Transmitted Diseases
TA	Technical Assistance
TB	Tuberculosis
UCT	University of Cape Town
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
UNITRA	University of Transkei
USAID	United States Agency for International Development
USAID/SA	USAID Mission to South Africa
USAID/W	USAID/Washington
VHW	Village Health Worker
WHO	World Health Organization

I. EXECUTIVE SUMMARY

A. Project Summary

The Equity in Integrated Primary Health Care Project (the EQUITY Project) is a proposed seven-year, \$50 million assistance effort that will facilitate the Government of National Unity's (GNU's) efforts to resolve what may be its largest public health challenge. The formidable task is to provide integrated primary health services to all South Africans by rectifying the inequities in the provision of health services brought about and supported by apartheid.

Problems related to child survival, reproductive health, STDs/HIV/AIDS, and tuberculosis (TB), frequently addressed through primary health care, are as serious for the underserved population in South Africa as for the populations in other sub-Saharan countries. The underlying problem is a highly fragmented, uncoordinated, and inefficient health system that has historically placed strong emphasis on high-technology curative care, and relatively little attention to serving the black population in the rural areas and the townships. The need is to restructure, strengthen coordination of, and increase the efficiency and effectiveness of the public-sector delivery system. It is only through success in these efforts that the GNU can bring about equity and access to services for the majority of the population -- a population that is largely black², often rural, with particularly vulnerable sub-groups, including women of reproductive age, children, and adolescents.

The EQUITY Project will support the GNU's efforts to restructure the health system to be more efficient and effective, and better able to provide essential, equitable, quality health services to the entire population, particularly those currently underserved. The EQUITY Project will provide support to make the restructured system operational in a focus province, the Eastern Cape. Concurrently, it will assist central and provincial administrations in utilizing the lessons learned in the focus province to replicate the system nationwide. The project will also build the capacity of the national Department of Health (DOH)³ to plan and implement the program of integrated primary health care services nationwide.

In assisting the GNU to operationalize the restructured system down to the community level, the project will strive to achieve six major outputs over a seven-year period: (1) increase access to a package of essential, integrated primary health care services in the focus province; (2) develop an effective referral system in the focus province to maximize access to needed health care services; (3) enhance public-sector capacity to manage an integrated primary health care program down to the community level; (4) improve the efficiency and effectiveness of primary health care (PHC) service delivery in the focus province; (5)

The term "black" is used in this document to refer collectively to South African individuals of African, Colored and Asian (Indian) descent. These groups which comprise the majority population are also referred to as historically disadvantaged by apartheid, or the underserved population. This usage conforms to that used by USAID/SA in its recent Concept Paper describing the framework of its long-term development assistance to South Africa.

Throughout this document, "DOH" refers to the national Department of Health.

institutionalize the capacity for effective PHC training at all levels; and (6) improve the information base for decision making, program development and management. Additionally, the EQUITY Project will provide limited funding to support continued assistance to HIV/AIDS programs, which will be delivered through NGOs both within the focus province and in other areas, in support of the national HIV/AIDS Action Plan.

The EQUITY Project design incorporates two phases. Most project outcomes are targeted initially at the focus province, and generally will be accomplished within the first four years under Phase 1 (1995-99). However, the design also incorporates intensive involvement of both the national DOH and all nine provinces in the planning and implementation process. Thus, when EQUITY-assisted health system components work in the focus province, they will be rapidly expanded to other provinces. This expansion will generally occur during Phase 2 (years 5-7), and depending on the resources available to the other provinces -- beyond those available under the EQUITY Project -- the expansion may or may not be complete in all of the other eight provinces. This project and program strategy is designed to ensure that the national PHC system is as fully institutionalized and sustainable as possible by the completion of USAID/SA assistance. While most systems development will actually occur at district and provincial level, certain of the capacity-building activities of the project will have wider scope. An example is the development of needed training capacities in such areas as health management and PHC training in selected universities, technikons, and training schools.

Since the EQUITY Project is focused on systems development rather than service delivery, the increased efficiency and effectiveness of the new systems may not show dramatic impact on health status during the life of the project. However, the project accomplishments in achieving improved access to PHC services will lay the foundation for real, sustainable improvements in health status in the years ahead.

B. Project Guidance

This project paper has been written following the guidance presented in the Project Development Interim Directive, issued by USAID/Washington's Bureau of Planning and Policy Coordination (PPC) in November 1994. Therefore, the design team has emphasized the linkages between the project purpose and the Mission's and Agency's strategic objectives, on achieving results, and on maintaining flexibility in project implementation.

C. Design Participation

Collaboration in the design of the EQUITY Project began with the development of the project concept in May-June 1994. USAID/South Africa (USAID/SA) representatives met not only with the Honorable Minister of Health and key DOH officials, but also with major South African health sector organizations and individuals. Together, this group provided both a source of ideas about what the project should accomplish, and a sounding board as the overall project concept was developed.

During the development of the Project Identification Document (PID) in October 1994, the PID design team met with many of the same officials and experts so that they could contribute to the overall project framework and the identification of critical project interventions. These consultations continued until December 1994, at which point USAID/SA formally approved the PID. The PID was subsequently reviewed and approved in USAID/Washington (USAID/W) in January 1995.

In anticipation of the Project Paper (PP) design effort, in late January the DOH and USAID/SA began to hold weekly EQUITY Project progress meetings. These meetings encouraged discussions not only about the project focus and content, but also about how the design process should be carried out. The major elements in the design process included (1) an initial one-day, national-level project design workshop which was designed to involve central DOH officials, representatives from all nine provinces, and relevant NGO and donor representatives; (2) a three-day field trip to Eastern Cape Province (the "focus province"); (3) participation of both national DOH and Eastern Cape Department of Health and Welfare (DOHW)⁴ officials in intensive consultations as the document was drafted; (4) a follow-up workshop to obtain broad input and feedback on the first draft of the PP, leading to a revised, final draft; (5) participation of Eastern Cape stakeholders through the use of focus group discussions and a worksession with both government and NGO health service providers; (6) the development of an Eastern Cape Province EQUITY Project Steering Committee; and (7) joint review of the final draft to ensure full agreement by both the DOH and USAID/SA.

Donor coordination. At a different level, USAID/SA has invested considerable time and effort with other relevant donors in the health sector to ensure that donor resources are effectively coordinated. USAID/SA's initiative with these key donors -- especially the European Union (EU), the British Overseas Development Administration (ODA), the World Bank and UNICEF -- has been instrumental in achieving this objective. Collaboration has included not only the more usual donor-with-donor and donor-with-government meetings, but also coordinated, short-term TA visits to develop plans for linked activities. Another important example is coordination among donors to ensure that focus-province types of efforts are distributed among a number of provinces (to ensure an equitable distribution of donor resources), and that such activities are complementary. This continuing, close working relationship among donors in the health sector will have a major impact on the effective use of both donor and GNU resources.

This extensive and intensive participation of relevant parties in the EQUITY Project design process has led to a PP document that represents mutual agreement on the project purpose and outputs, as well as on major project interventions and implementation steps. Without this collaboration, both the design process and outcome would have been much more difficult to achieve.

Throughout this document, "DOHW" refers to the Department of Health and Welfare of the Eastern Cape Province. Since most of the provincial departments responsible for health are also responsible for welfare, they are also DOHWs. Occasionally this acronym may be used to indicate the generic provincial department responsible for health; if so, the context is clear.

II. STATEMENT OF THE PROBLEM

The major public health challenge for South Africa is to provide equity in basic health care to all South Africans, and in the process to rectify the underlying inequities in the provision of health services brought about or supported by apartheid.

A. Results of Inequities and Ineffectiveness

The inequities and the ineffectiveness of the past political and health systems can be seen from a few basic health status indicators. These indicators reflect the inequities that have led the GNU to designate approximately one-third of its RDP priority areas to those dealing with restructuring and shifting of resources.

Child survival. The infant mortality rate (IMR) among African children is nearly 10 times higher than that of white children. The life expectancy of African and colored children at birth is 10 years less than that of white children. While diarrheal disease is the major cause of death among 1-4 year old African and colored children, it accounts for only 4% of deaths of white children in this age category. In 1990, 74,283 cases of TB were identified for ages 1-4, and of these, African and colored children accounted for 98%. As with many other countries, early weaning of babies and low birth weight are both serious child survival problems. While breastfeeding is sustained for longer periods in rural areas, the duration of breastfeeding is declining, and the benefit of providing only breast milk for a period of 4 to 6 months is not widely appreciated or practiced.

Reproductive health and family planning. The quality and effectiveness of reproductive health services are clearly poorest for South Africa's historically disadvantaged populations. Between 31% and 66% of women in rural areas give birth at home and a significant proportion of these births are unassisted by trained persons. The most common causes of maternal mortality are sepsis, hemorrhage, and hypertension. The contribution of complications from illegal abortions and obstructed labor to the maternal mortality rate (MMR) is unknown, but the evidence indicates that illegal abortions are a significant contributor. In addition, two of the main contributors of morbidity and mortality among adolescents are pregnancy and sexually transmitted diseases, yet health programs specifically targeting the youth are virtually non-existent.

Family planning has been a sensitive and political issue in the past. Now the GNU has the opportunity to develop effective maternal and child health care and women's services -- as part of the PHC service package -- that will meet the needs of clients to space and/or limit births in order to improve the health of both the mothers and children.

STDs/HIV/AIDS. Recent estimates indicate that the number of HIV-infected people doubles every 12-13 months, and that 550 people are infected with the virus every day. The highest incidence is among the 20-24 year age group. Projections indicate that, unless current trends are reduced, between 18% and 24% of the adult population will be HIV-infected by the year

2000; that the cumulative death toll will be 2.3 million; and that there will be about 1.5 million AIDS orphans. The vast majority of these HIV/AIDS victims are Africans. A township-based study found that 20% of adolescents over 15 years old are treated at least once annually for an STD, and 10-15% of women attending family planning clinics have STD infections.

B. The Health System and the Need for Restructuring

South Africa has had a highly fragmented public health service that actually consisted of a three-tier, 14 department (ministry) "system" designed to serve the different population groups separately. Communication among the various tiers and within tiers was generally poor -- rendering the services structurally, functionally, and politically fragmented.

Since health services evolved within apartheid, resource allocations neglected geographical areas with large proportions of black and especially rural populations, and also favored high-technology curative health care for those whom it did serve. The result was an inequitable system, reflected by the health status indicators in the preceding sub-section. All of these factors -- fragmentation, curative focus, and lack of community participation -- resulted in a large, underserved population which was deprived of even basic primary health care.

III. USAID STRATEGY FOR DEALING WITH THE PROBLEM

A. Relation of USAID/South Africa Strategic Objective for PHN to Bureau and Agency Strategies and Goals

USAID/South Africa is currently developing its strategic objective (SO) framework and its country program strategic plan. The EQUITY Project has been designed to achieve the Mission's strategic objective for the health sector: to " support the development of a unified system to provide integrated primary health care services to underserved populations." This SO is supportive of the overall Agency strategic goal of "stabilizing world population growth and protecting human health" by: (a) emphasizing the development of an integrated approach to the delivery of family planning and other services that enhance women's health and children's well-being and survival; (b) enhancing the capacity of local institutions, communities and individuals to identify and solve their health and family planning problems; and (c) addressing the technical and managerial aspects of health and family planning program sustainability. In particular, the SO supports the USAID PHN Strategy objective of "making programs responsive and accountable to the end-user."

This SO is also indirectly supportive of the Agency's strategic objectives of reducing unintended pregnancies; maternal, infant and child morbidity and mortality; and STD transmission with a focus on HIV. The USAID/SA program will support these objectives by focusing on improving the availability of, access to, and utilization of key health interventions through development and improvement of support and delivery systems. An

important cross-cutting theme in this effort will be sustainability, which will be promoted by building host-country capacity to plan and manage its new health system.

USAID/South Africa's program also will directly support the Africa Bureau's Child Survival Strategy, which in turn is designed to support and implement the overall USAID Child Survival Strategy, with emphasis on the particular challenges facing Africa. The Africa Bureau's Child Survival Strategy clearly states that "where effective health systems are put in place to support child survival initiatives, these systems provide the basis for a package of essential health care and family planning services which benefits the entire population -- a package of services which is a highly cost-effective means of improving health care, particularly for rural and poor populations." The USAID/SA program will directly support two of the three principal objectives of this strategy, while indirectly supporting the third. These three objectives are to:

- ▶ Strengthen health systems in Africa to ensure adequate personnel and logistical support for specific interventions, and to increase both coverage and utilization rates for services.
- ▶ Strengthen the capabilities of African institutions, both public and private, for the provision and management of high-quality health care services.
- ▶ Reduce morbidity and mortality in Africa's under-five population through the successful implementation of targeted interventions.

In supporting these objectives, the USAID/South Africa health strategy will adhere substantively to the following strategic directions outlined in USAID's Child Survival Strategy:

- ▶ Continue the successful implementation of focused interventions while promoting integration at the service delivery level.
- ▶ Strengthen health support systems required for sustainable service delivery.
- ▶ Provide institutional support for ministries of health.
- ▶ Encourage partnerships of ministries of health with NGOs and the commercial private sector.
- ▶ Promote equitable coverage of populations.
- ▶ Promote demand for services, with an emphasis on increasing utilization rates and the level of community participation.

B. Relationship of USAID Strategic Objective to GNU Reconstruction and Development Program (RDP) Objectives for Health

The most current policy formulation in the South African health sector is the DOH document, "Health Priorities of the Reconstruction and Development Program" (October 1994), which lists the GNU's priority areas for health. The majority of these priority areas for action respond to the constraints that have produced inequities and inefficiencies in health care, and focus on the GNU's plan to restructure and rationalize the present health system in order to provide more equitable access to quality essential services by the large disadvantaged population. Through extensive dialogue between the DOH and USAID/SA it was possible to identify those areas of highest priority to the GNU which also coincide with USAID priorities and predominant capabilities, and which are not already being supported in a major way by other donors. As a consequence, it was decided that the EQUITY Project should support those priority areas which focus on (a) the GNU's efforts to restructure and unify its national and provincial health programs and administrations, and (b) the development and implementation of an integrated primary health care program which incorporates those interventions considered of highest priority by USAID. The project will also place emphasis on strengthening inter-sectoral linkages between the health system and areas such as water, sanitation, housing, transportation and education which directly impact on the effectiveness of the health delivery system.

C. Purpose of the EQUITY Project

As noted, the EQUITY Project purpose coincides both in focus and time frame with the USAID/South Africa strategic objective for the PHN sector. **The purpose of the project is "to support the development of a unified system to provide integrated primary health care services to underserved populations".** As implied in the project title, the goal to which the project is expected to contribute is equitable access to quality health care for all South Africans. The program outcomes are considered intermediate-level results that guide programs and activities and allow USAID/South Africa to monitor progress.

D. Rationale for Project Approach

The EQUITY Project will take a capacity-building and systems development approach. It will assist the GNU to change and strengthen its health service delivery system so that quality essential services can be made available to all South Africans, especially those currently underserved. It will do this by concentrating support initially in a single province, Eastern Cape, in order to have sufficient resources available to develop the new system and make it fully operational. The Eastern Cape was selected by the DOH based on the following criteria which were mutually agreed upon with USAID: That the focus province (1) be representative with respect to key factors (e.g., urban vs. rural balance, general level of development, population density); (2) have a sufficient level of physical and human resource infrastructure in place to ensure that project implementation will not be unduly hampered; (3) have a supportive administrative structure (e.g., new provincial management structure in place and key positions filled); and (4) need the capacity-building support that the EQUITY Project will provide. The national scope of the project will be achieved by continually interacting with health personnel of other provinces and sharing the lessons learned in Eastern Cape with these other provinces so that replication and implementation of workable systems can proceed rapidly throughout the country. This 'focus province' approach has other

advantages: (1) it will make a sustainable impact on the health system possible in Eastern Cape province, and (2) it will make the project much more manageable from both USAID and the GNU standpoints.

The rationale for supporting the development of an integrated primary health care system rather than the delivery of specific health interventions, such as family planning or oral rehydration therapy, is based on more than the fact that the GNU has identified such a system as the cornerstone of its new health system. It is also based on lessons learned from health and child survival programs elsewhere in Africa. In particular, USAID's child survival strategy of the 1980s, which was based largely on a selective primary health care approach, proved only a qualified success. There is a growing consensus that while efforts in both expanded programs of immunization (EPI) and oral rehydration therapy (ORT) were very successful during the 1980s, coverage levels have now plateaued or are even decreasing. The principal lesson learned from this is that such interventions cannot be sustained without a functioning health system, and that much greater attention must be given to reinforcing the support components of integrated health systems. It has also been found that improvements in health systems increase access to primary health care and provide essential support for family planning programs and other health interventions. The recently completed institutional analysis for the PP design has strongly supported this view for South Africa by stressing that, "a working system will enable clinical program success and not vice versa", and that "until a new system is in place and until new managers have direction, there is unlikely to be movement at the [PHC] service delivery level."

Findings from child survival programs implemented in Africa during the 1980s argue for an integrated approach to service delivery, since the major causes of morbidity and mortality are linked and mutually reinforcing. These findings have prompted the development of various models for more effectively delivering a package of PHC services, such as the "sick child algorithm" and "integrated case management." These models of integrated service delivery are intended to ensure that for every client contact the complete needs of the mother and child are addressed and that opportunities are not missed. As indicated above, the importance of integrated systems is recognized in USAID's population, health and child survival strategies.

E. Bridging Activities

In view of the fact that the EQUITY Project will not likely begin full implementation until mid-1996 when the technical assistance (TA) team of the institutional contractor is in place, the GNU and USAID/SA have identified several high-priority activities that should be initiated before that time in order to lay the foundations for more rapid implementation later. These activities, termed "bridging activities," are being supported by the Global Bureau's field support funds and will not draw on EQUITY Project funding. Approximately \$2.8 million of Global Bureau field support has been made available in FY 95; some modest additional funds may be available in FY 96.

The bridging activities which will be supported between 1995-1997 are: (1) a nationwide demographic and health survey (DHS), (2) a national-level situation analysis, (3) development of an in-service management training program for health professionals, and (4) development of an in-service training program in integrated primary health care for rural nurse clinicians. Both the demographic and health survey and the situation analysis will oversample in the Eastern Cape Province, so that additional analyses will be available both to serve as a project baseline and to provide current information for project planning and implementation. All of these bridging activities will be developed and implemented to ensure that they provide continuity with similar activities that will continue under the EQUITY Project.

IV. ASSISTANCE INTERVENTIONS

A. Increased Access to an Integrated Package of PHC Services in the Focus Province

At present, there is no single structure for delivery of essential primary health care services, and preventive and promotive services for mothers, women and children are weak. In many places, different services are offered by different personnel on different days and in different structures. In many rural clinics where staffing is inadequate, only selected services are offered each day and often clinic hours are short. The existing system is oriented towards secondary and tertiary care, centered in static health facilities and often dominated by academic institutions. This fragmented organization of services and predominantly curative orientation not only lower effective access to health services but also result in the very inefficient utilization of available human and financial resources. They also contribute to the tremendous disparities in morbidity and mortality which currently exist between whites and other racial groups, since these disparities are largely attributable to conditions which could be easily prevented by effective PHC services delivered at peripheral levels of the health system, or even within the community itself.

Secondary and tertiary care facilities are largely concentrated in urban, predominantly white, areas and deliver a limited range of PHC services. Few private sector clinics and hospitals provide PHC services. In rural areas there is maldistribution of clinic facilities. The staff at most delivery sites are trained primarily to deliver curative services and have little understanding of or commitment to the delivery of comprehensive primary health care. Overall, the system lacks a customer focus, and pervasive negative attitudes towards clients

by health providers have resulted in considerable numbers seeking care outside the public health system.

The GNU has already begun the process of consolidating the fragmented health system, redistributing services in an equitable manner, and drastically changing health care priorities to ensure that integrated primary health care, with its community orientation and attention to priority health problems, can be achieved. This restructuring of the health system is intended to draw the different health authorities, and to some degree the private sector, into one unified health system at all levels -- central, provincial, district, local government and community -- and to make an integrated package of essential PHC services available to the entire population. The EQUITY Project will support these efforts as they will clearly contribute to the shared goal of more equitable access to health care by all South Africans.

B. An Effective Referral System in Place in the Focus Province

The unplanned and checkered distribution of clinics in the townships and rural areas and the lack of private-sector alternatives have resulted in over-utilization of hospitals, especially in the cities. One study has shown that up to 80% of patients seeking care at hospital emergency rooms could be treated effectively at a lower-level facility. The results of this situation are the higher cost and typically poorer quality PHC services in hospitals due to the pressure on the staff and facilities, and the under-utilization of more appropriate health facilities at the periphery.

Although referral facilities exist and tend to dominate the current service delivery system, there is no uniform or universal referral system in support of primary health care. Where such referral systems do function they are often inefficient or costly, with peripheral clinics often being tied to a single referral hospital; very rarely is there effective management of the system. To implement the effective, integrated primary health care system envisioned by the GNU, and to ensure the most effective utilization of available facilities and services at all levels, the EQUITY Project will assist in the development and implementation of an effective referral system at primary, secondary and tertiary care levels in Eastern Cape Province. Lessons learned will be used in replicating the system in the other provinces.

C. An Enhanced Capacity to Manage the Integrated PHC Program at National Level and in the Focus Province

The ultimate objective of the national health system is for integrated PHC service delivery to be delivered primarily at local government level. There is widespread realization that the managerial skills are inadequate to reach this objective -- to deal with the planned organizational changes, the integration and devolution of services, the greater emphasis on the PHC approach, a decentralized delivery system with a district focus, and the emphasis on increased efficiency and equity. Some progress which will lead to improved managerial skills is taking place; for example, most provincial DOHWs have begun to establish their own human resource planning and development units, which will coordinate training to meet identified requirements. ODA and the EU are supporting the development of such units in

three provinces. Specific courses relevant for interventions such as child survival and HIV/AIDS also are available from a variety of institutions, but generally these have a technical focus and do not deal with broader management issues.

With an entirely new organizational structure and health system being put in place, and with many new faces occupying newly created positions, a comprehensive health management program must be developed which can support the operationalization of this new system at all levels. The EQUITY Project will provide the support needed to achieve this in the Eastern Cape Province and at the national DOH.

D. Increased Effectiveness and Efficiency of PHC Service Delivery at the Provincial Level and Below

The past fragmented delivery of health services has resulted in an ineffective, inefficient health delivery system. This is particularly true in what is now Eastern Cape Province, which previously included two separate "independent states," Transkei and Ciskei, as well as portions of the Republic of South Africa (RSA). Not only did these areas have separate and distinct health systems, but there were at best only loose linkages among them. While some areas had systems that worked relatively better than others, and lessons may be learned from those systems, it is not clear whether those "good" systems are sustainable or replicable. What all areas shared in common were a health system and budget that reflected an emphasis on curative health services (especially at secondary and tertiary levels), and a system which put little emphasis on accountability. In most cases, administrations have had to account for expenditure as a pure bookkeeping exercise. There was little or no discipline applied in cases of overspending, and maladministration was tolerated.

The GNU, through the RDP, has committed itself to redress the geographical imbalances of the past. The national DOH and the nine provinces have decided to structure the new budget process in a different way. The objective is to make the areas of real resource consumption more visible by relating expenditure to outcome, while being able to assess results against inputs. The challenge now is for the provinces to begin the process of reallocation of resources with increased emphasis both on integrated primary health care and on more efficient utilization of available resources. The task of undertaking these challenges in a geographically and administratively new province will require considerable capacity building. THE EQUITY Project will help meet the need for improved management and other support systems -- from basic accounting and budgeting, to logistics management, to strategic planning, and to cost-effective methods for delivering health care.

E. Institutionalized Capacity for PHC Training

The development of human resources is a specific RDP health priority. It is clear that if an increased focus on integrated primary health care is to take place, a tremendous effort at reorienting and training health providers is necessary. Medical, nursing and other health professions education are currently based on the curative model. There is little in the existing medical curriculum that stresses demography, epidemiology, planning, community involvement, management, or other important elements of a primary health care system. Consequently, pre-service as well as in-service training curricula and materials have to be developed or modified, so that cadres from medical doctors to community health workers become knowledgeable, skilled, and committed to the PHC goals of the RDP.

This is particularly true for nurses who form the overwhelming resource base for managing and delivering primary health care within the formal delivery system. Currently, 90% of South African nurses are trained in the 30 nursing colleges in the country, while the remainder are trained in universities. The curricula of both kinds of nursing programs are designed to train nurses principally for hospital care, making the structure one which is driven from the top down. Hospital care is given undue attention while preventive, promotional, and community-level care are under-emphasized. In other words, while South Africa produces excellent quality health professionals, much of their training is inappropriate to meet PHC objectives.

The challenge of providing both pre-service training program reorientation and the follow-up in-service training is great. This will require developing revised curricula and training strategies, strengthening existing programs, utilizing other existing training resources (e.g., NGOs), and ensuring the sustainability of all these efforts. The EQUITY Project will support capacity-building in all of these areas, with emphasis in the Eastern Cape Province.

F. Improved Information Base for Decision-making, Program Development, and Management

As a result of the fragmentation of service delivery there are currently no comprehensive, reliable data on health care inputs, services and outcomes. Even basic demographic data are unreliable and there is no epidemiological baseline available against which to measure progress in improving health status. This situation poses a serious constraint to logical planning. Without key information, even broad planning is extremely difficult. From the standpoint of the restructuring process this situation is compounded by the absence of comprehensive public- and private-sector data, and the ignorance of both the public and private sectors about the other's activities. This is nowhere more apparent than in Eastern Cape Province, although the provincial Department of Health and Welfare (DOHW) has plans to develop units at provincial, regional and district office levels to support such information needs.

To restructure the health system effectively at all levels and to facilitate the most appropriate and cost-effective reallocation of financial and other resources both among and within

provinces, good baseline information on existing physical and organizational infrastructure will be required. This should be provided by the nationwide DHS and situation analysis planned under the pre-project bridging activities. However, while the lengthier process of evolving a national health information system is underway, provinces will need to have an immediate, minimal information collection mechanism that will provide planning and monitoring data. In order to maximize the utility of data collection efforts, staff at all levels of the system will require training in the use of appropriate indicators to guide them in their own planning and management of services. The EQUITY Project is designed to support the establishment of a comprehensive information system which can provide the kinds of information needed for the restructuring process at the provincial level and below.

G. Continuation of HIV/AIDS Activities

HIV/AIDS is one of the RDP health priority areas, and the DOH intends to pursue a comprehensive national program in order to limit the devastating impact of this disease. USAID/South Africa has supported high-priority HIV/AIDS activities through NGOs at both national and community levels for more than four years. With the implementation of the EQUITY Project, USAID/SA's assistance in the HIV/AIDS area will be integrated into the project's mechanisms for providing critical support to NGOs over the next few years, and to ensure their sustainability where their roles are critical over the long term. As described in Section V.G, this assistance will be available to meet high-priority needs at national, provincial and local levels.

V. PLAN OF ACTION

The RDP presents a broad agenda for improving basic health services and redressing the inequities of service delivery within the current South African health system. USAID/SA and the DOH have jointly identified areas where project resources can provide significant impact in assisting South Africa's efforts to bring about an equitable, integrated system of basic health services needed to address the health problems already noted. The major project emphasis will be on assisting the GNU to develop an effective delivery system for providing these services. The major outputs that will guide the project and reflect success are discussed in the following sub-sections.

The fragmentation of the system under apartheid resulted not only in inequitable access to health care, but also to tremendous inefficiencies in the health system. Large segments of the population, in particular the rural African population and those in squatter settlements, often lack the most basic services due to a lack of adequate facilities and trained staff. Where services are available, they are often of a lesser standard than those available to other segments of the population.

The GNU has already embarked on its program to consolidate the present fragmented health system into a unified system from national to community level. At the same time, the health care system has to deal with the very real implications resulting from the decision to expand

the number of provinces from four to nine. In addition, the RDP emphasizes the district level as the focus of its efforts to improve access to the whole health care system, including access to PHC services. Taking these factors into account, the restructuring program will (a) place a much greater emphasis on preventive and promotive health care, (b) rationalize the delivery of curative health care to make it more cost-efficient, (c) decentralize the newly restructured health system to bring about greater involvement of communities in determining their health care needs, and (d) make a reasonable standard of health care available to all South Africans, in particular to those residing in the rural areas and squatter settlements and those most at risk -- women, children, and adolescents.

The DOH has recently completed its design of the new structure for the national health system; the details of the district-level component will be finalized following the local elections scheduled for November 1995. In assisting the GNU to operationalize this new system down to the community level, the EQUITY Project will strive to attain six major outputs over a seven-year period. In the focus province, the project will: (a) Increase access to a package of integrated primary health care services; (b) put in place a referral system to maximize access by all members of the public to PHC services, and the range of other available health care services; (c) increase the effectiveness and efficiency of health care delivery; and (d) institutionalize the capacity for PHC training. In both the focus province and at the central level, the project will (a) enhance the public sector's capacity to manage an integrated PHC program down to the community level in both the public and private sectors, and (b) improve the information base for decision making, program development and management. Primary health care services, as defined here, consist of maternal, child and women's health services, reproductive health services, STD/HIV/AIDS, and TB -- all of which are included in the GNU's essential package of primary health care services. While all of these services have both preventive and curative components, the project will place particular emphasis on the preventive and promotive aspects of the program. The project will not support the actual delivery of services except as part of research or pilot activities to determine more effective ways to deliver these services.

The project activities described below have been mutually agreed between the DOH and USAID/SA to be necessary for the development and implementation of an improved primary health care system. As noted earlier, the EQUITY Project will fund a TA team to assist the DOH in its restructuring effort. This team, under the overall guidance and direction of GNU health authorities, will be responsible for implementing the activities. The initial Annual Action Plan will be developed by the DOH prior to the arrival of the TA team; however, for subsequent project years the action plans will be developed (with TA team assistance) prior to the end of the preceding project year. These Annual Action Plans, developed jointly by the DOH and the TA team, will establish priorities for the implementation of project activities, and will delineate both the time frame and implementation responsibilities.

The EQUITY Project design incorporates two phases. Most project outcomes are targeted initially at the focus province, and generally will be accomplished within the first four years under Phase 1 (1995-99). However, the design also incorporates intensive involvement of both the national DOH and all nine provinces in the planning and implementation process. Thus, when EQUITY-assisted health system components work in the focus province, the

DOH intends to expand them rapidly to other provinces. This expansion will generally occur during Phase 2 (years 5-7), and depending on the resources available to the other provinces - beyond those available under the EQUITY Project -- the expansion may proceed at a different pace in each of the other eight provinces. This project and program strategy is designed to ensure that the national PHC system is as fully institutionalized and sustainable as possible by the completion of USAID/SA assistance.

A. Increased Access

Output 1: Increased access to an integrated package of PHC services in the focus province.

The EQUITY Project will support the GNU's efforts to increase the availability of an integrated package of primary health care services through a series of activities which focus on three types of assistance:

- 1. Assistance to planners and decision-makers at all levels to strengthen strategic planning, establish and prioritize major program outcomes, schedule and implement activities designed to improve access, and involve communities in decisions which affect them;**
- 2. Assistance where facilities are in place, but there are barriers to access; and**
- 3. Assistance for underserved areas where access to services is constrained by the lack of adequate health care points (HCPs).**

Factors which either enhance or hinder access include provider skills, attitudes and motivation; human and physical resources such as equipment and drugs; location of fixed and outreach services; client cost; service time; quality; and community awareness and involvement.

All of these factors must be addressed to improve access to and use of PHC services. The project will strive to make user-friendly, high-quality services accessible. This support is categorized in three ways: (a) strategic planning, (b) operations research, and (c) capacity-building.

a. Strategic Planning

The importance of strategic planning has been clearly demonstrated during the initial year of the DOH's activities within the new GNU structure. The EQUITY Project will assist the

national DOH and the provincial DOHWs to expand and institutionalize the strategic planning process, as outlined below:

- ▶ Help establish a strong linkage among the Eastern Cape DOHW, the Eastern Cape EQUITY Project Steering Committee, and the EQUITY Project TA team to ensure that project resources and activities reinforce the department's priority PHC programs and activities.
- ▶ Assist the Eastern Cape DOHW (and later the other provinces) to develop and implement an overall strategic planning process, and to formulate a strategic plan for the province. This strategy and plan should include effective mechanisms for broad government and community participation; in turn, these mechanisms should apply to the provincial, regional, district and local levels.

Such mechanisms may include holding participatory forums at each level to obtain broad inputs from key stakeholders (DOHW, other government units, NGOs, educational and research institutions, private-sector representatives, etc.). These consensus-building elements should be a permanent part of the process to ensure that stakeholders (especially community representatives) will continue to have an important role in the decision-making process. Team-building activities may also be important in ensuring close collaboration not only in the planning process but in implementation as well. These mechanisms should also include ways to develop partnership strategies and linkages among sectors (e.g., water supply, roads, telecommunications) to help achieve a synergistic effect among provincial resources targeted at improving the quality of life of the people.

- ▶ Help to assess available resources within the province, and compare with the needs that evolve from the planning process thus far. The situation analysis which is being carried out as one of the bridging activities should provide useful information about many of the critical resources (e.g., facilities, personnel, transport, communication).
- ▶ Based on community and other input, and recognizing the limitations of the identified available resources, assist the DOHW to develop an implementation strategy and first-year action plan, with appropriate targets, for expanding access to PHC services in the province.
- ▶ Facilitate action plan implementation, including such aspects as retraining and/or reassignment of personnel, shifting budgetary allocations to match the needs identified in the action plan, etc.
- ▶ Assist in monitoring action plan progress, and in repeating the action plan process in each subsequent year.

- ▶ Assist the Eastern Cape DOHW to assess the impact of the recent National Health Insurance System report,⁵ and the eventual policy outcomes, on the strategic planning process for the province.
- ▶ Assist the Eastern Cape DOHW to incorporate the guidelines of the recent report on the district health system,⁶ and to follow the report's proposed steps to accomplish "the way forward" in finalizing the district health system.

Once the initial strategic planning cycle has been carried out in the Eastern Cape Province, the EQUITY Project will support a workshop involving all provinces to provide an understanding of the process and to make plans to implement the same planning cycle in the other provinces.

b. Operations Research

Operations research (OR) will be used in the EQUITY Project in a variety of ways to help determine the best alternative methods by which access to PHC services can be increased. Specific OR studies will normally be identified during the development of annual work plans, but proposals from other sources will also be considered. Examples of useful OR investigations are as follows:

- ▶ Determine the most cost-effective ways to involve the various providers in the private sector (including NGOs and parastatals) can contribute to improved access. For example, these might include consultant rosters for mobile services, direct involvement in the referral system, and social marketing for PHC commodities such as condoms and rehydration salts (ORS).
- ▶ Assess the implications of involving traditional healers and other non-formal health service providers in providing PHC services. For example, support an observation tour to an appropriate country to review the experience of traditional healer involvement in and contribution to PHC services.
- ▶ Determine effective ways to meet the specific informational and service needs of particularly vulnerable and underserved groups such as adolescents and pregnant women.
- ▶ Assess effective ways to organize and implement an outreach screening program for TB.

"Restructuring the National Health System for Universal Primary Health Care" (3 parts), Report of the Committee of Inquiry into a National Health Insurance System, June 19, 1995, Department of Health, Pretoria.

"Development of A District Health System in South Africa," June 1995, Department of Health, Pretoria.

Operations research will be conducted as needed throughout the life of the project to assess other effective ways to improve access. Specific OR study interventions will normally be determined during the annual action plan development process.

c. Capacity Building

The EQUITY Project technical and institutional analyses both stressed that capacity building is the key to improving the health delivery system in general and access to services in particular. Human resource development, with emphasis on in-service training at least in the early stages, is critical to capacity building in all elements of the system. Assessment of training needs and priorities should be an integral part of the annual action planning process. In addition, the following illustrative examples indicate critical areas where capacity building is likely to be required.

- ▶ Assist in accelerating the decentralization process, especially at the district and local levels. One useful activity would be to support a study tour for appropriate decision-makers and others to a country or countries currently implementing effective decentralized health services similar to the evolving South African framework. Follow up with TA which will advance the decentralization process at provincial levels and below.
- ▶ Develop a roster of South African-based consultants who have expertise in a variety of key areas that support integrated primary health care. This would include experts in both the planning/management and service delivery aspects of health delivery systems, and specifically PHC. These experts could be called upon for short-term technical assistance as needed.
- ▶ Assist in expanding service delivery capacity to ensure that the range of reproductive health services, including all approved contraceptive methods, are readily available at all appropriate service sites. This area is discussed more fully in Section E below.
- ▶ Similarly, support the development of programs and delivery modes especially designed to meet the needs of the adolescent population. These should include key services such as family life education and related areas, education against drug abuse, etc. These program interventions might be initiated as pilot programs, or perhaps associated with an operations research study to help determine which mix of services and mode of delivery is most effective.

2. Assistance where facilities are in place, but there are barriers to access. Representative activities include the following:

- ▶ Provide two- to three-day orientation workshops at hospital and clinic levels during Year 1. There is a clear need to orient health providers about the PHC approach, to describe how the new administrative and service delivery structures are being introduced, and to ensure improved motivation of health workers at all levels. Interpersonal communications among health providers historically has been poor, and can be partially attributed to the former inflexible, hierarchical patterns of authority. Health workers also feel uninformed about decisions being made which affect them. As a starting point for improved worker motivation these workshops will include: (a) recent developments in the restructuring of health services and the integration of PHC services, (b) revised goals, objectives, roles and responsibilities at all service levels, and (c) team-building exercises.
- ▶ Develop and implement a program of refresher training for all levels of health workers, including on-the-job training and other types of in-service training to improve the delivery of intergrated primary health care services. This training is further described in Section C and E below.
- ▶ Assess the availability and appropriateness of information, education and communication (IEC) materials to promote PHC in general as well as specific, priority PHC interventions. Provide support for the development of new IEC materials as needed, as well as the adaptation and/or reprint of materials, broadcasts, and other types of messages and information as appropriate. These materials obviously should not be limited only to those currently in use in South Africa.
- ▶ Review inventories, determine essential equipment needs, identify resource gaps, and provide essential equipment that will improve access by providing a broader range of services at HCPs.

3. Activities which are directed towards assistance for underserved areas where access to services is constrained by lack of adequate health care points. Representative activities include the following:

- ▶ Based on the situation analysis to be carried out as one of the bridging activities, together with the DOH's Regional Health Management Information System (ReHMIS) and its geographical information system orientation, assist the DOHW to conduct an analysis of the Eastern Cape Province to determine the type and location of new HCPs to be established, in order of priority. This analysis should also take into account new district boundaries as they are developed as an outcome of the scheduled November 1995 local elections.
- ▶ As an integrated component of this analysis, help to assess alternative ways to provide access during the interim period prior to the time that new HCPs are established and functioning. This should involve consideration of using other "non-health" community resources (e.g., pre-school groups) as a focal point for providing limited health care services to meet immediate needs.

- ▶ Assist in developing linkages among USAID-funded early childhood development (ECD) activities (e.g., Educare) and district- and local-level health authorities. The reason is that many ECD activities are already providing key health services at many rural ECD sites; with coordination, these basic service delivery sites could be expanded to serve a larger client group than the children initially targeted.

B. An Effective Referral System

Output 2: An effective referral system in place in the focus province.

There are major disparities in the effectiveness and efficiency of the referral mechanisms in the Eastern Cape Province. There are a myriad of causes for the malfunctioning of the systems -- most related to the use and availability of transport, poor or no communication linkages, and lack of clear and consistent clinical and management protocols.

Although the situation analysis (bridging activity) should provide a broad overview of the referral system, the EQUITY Project will support a more in-depth assessment to determine the problems and potential solutions. The conclusions and recommendations of this assessment will be considered first at the Eastern Cape Province level, to ensure that the overall action plan incorporates activities to improve the referral system. However, since most referral system problems and solutions are likely to be similar among the other provinces, the Eastern Cape assessment will also be the focus of a workshop for representatives from all of the provinces. Based on the outcome of this workshop, the EQUITY Project will support activities which are expected to lead to a more efficient and effective referral system. The following activities are illustrative of those which the Eastern Cape assessment and workshop may deem important to carry out.

- ▶ Development and implementation of a plan which will improve the efficiency of the existing health transport system and foster the use of alternate transport, so that ambulance services are restricted to emergency cases and alternative modes of transport are used for non-emergencies.
- ▶ Development and implementation of a training program for drivers and maintenance personnel, to include improving driving skills, as well as how to manage and maintain vehicles properly.
- ▶ Development and implementation of clinical and management referral protocols (emergency and non-emergency) for all levels of the system to avoid under-referral and over-referral, and to foster more effective utilization of services at all levels.

These protocols may become one important module of in-service training programs for relevant categories of health workers (see Section E below).

- ▶ Development and implementation of a strategy to obtain community input on the current referral system and how it might be improved to meet their needs better.
- ▶ Development and implementation of an improved two-way communication system to promote the transfer of emergency cases, to enhance the consultation process and to strengthen follow-up of clients.
- ▶ Development and implementation of an interim plan to make the best use of available health workers (including consultant physicians and specialists), equipment and other resources until the improved referral system is functioning effectively.
- ▶ Recommendations for referral options among the public sector, non-governmental, private and non-formal sectors.
- ▶ Incorporation of data on referral patterns and outcomes into ReHMIS so that referral system effectiveness can be monitored and evaluated on an ongoing basis; and can inform health managers on adjustments needed in the allocation of financial and human resources.

These illustrative activities and/or others as appropriate should result in an improved referral system in the Eastern Cape Province during Phase 1. Lessons learned in the Eastern Cape should be useful in working with the other provinces to make similar improvements during Phase 2.

C. Enhanced Management Capacity

Output 3: An enhanced capacity to manage the integrated primary health care program at central level and in the focus province.

The RDP has identified improved management throughout the health care system as one of the most critical needs to ensure that the system achieves its goal of providing equitable access to essential health care by all South Africans. Given the greatly expanded authority and responsibility at the provincial level and below for the organization and delivery of health services, these levels will be the focus of management improvement assistance under the EQUITY Project. Management improvement comprises both enhancing skills and improving the systems by which programs and activities are managed. The EQUITY Project addresses both areas. Management systems improvement is discussed in subsection D.3 below; this subsection proposes the following illustrative activities to achieve management capacity-building.

- ▶ As described in Section E below, from May 30 through June 2, 1995, initial short-term technical assistance under the EQUITY Project bridging activities assisted in carrying out both a two-day national workshop and a follow-up two-day task force dealing with both PHC training in general and health management training in particular. The outcome of the task force was a draft framework and action plan for improving and institutionalizing training resources for PHC, including management training. The bridging activity resources will also help to ensure that critical in-service management training will be provided in the near future, through the mechanisms and resources identified in the task force report. EQUITY Project resources will continue to be available to facilitate the implementation of the task force's proposed framework and action plan. The framework and action plan (and the individual provincial action plans) should achieve the objective of capacity-building in management by improving skills of managers at provincial, regional, district and local levels.
- ▶ To ensure maximum utilization of South African expertise, assist in developing and maintaining a roster of South African health management consultants who can be called on to provide short-term technical assistance in relevant health management areas (e.g., training, financial management, budgeting, supervision, strategic planning, monitoring and evaluation). Such consultants can be used to supplement the management training program that is part of the task force's framework and action plan.
- ▶ In support of the management training activities described above, it may be helpful to facilitate the creation of dynamic linkages between South African and U.S.-based institutions with mutual interests. USAID/SA's Tertiary Education Linkages Project (TELP), being implemented by USAID's Human Resources Development Division,

may be able to support these kinds of linkages. The EQUITY Project can supplement TELP resources as needed (e.g., study tours, short-term technical assistance).

- ▶ In developing the long-term management training improvement strategy envisioned by the task force, it will likely be necessary to support long-term professional education in the management area. The EQUITY Project is prepared to fund such diploma and/or degree programs in South Africa, in other African countries, and in the U.S., as appropriate.

D. Increased Efficiency and Effectiveness

Output 4: Increased efficiency and effectiveness of PHC service delivery in the focus province

Due to its history of fragmentation and multiple health authorities at different levels, South Africa's health care system suffers from many inefficiencies. Many of the national-level constraints and opportunities are being addressed by the GNU as it reforms the health system and delineates and clarifies authorities and responsibilities. However, other opportunities to improve efficiency and effectiveness exist at the provincial level and below. These opportunities can be summarized in four areas: (1) Greater integration of PHC services, (2) better resource reallocation between curative and preventive services, (3) management systems improvement, and (4) improvements in cost-effectiveness. The EQUITY Project will assist the DOH and the Eastern Cape Province to explore the range of feasible interventions among these four categories to increase efficiency and effectiveness of PHC services.

1. PHC service integration. The primary purpose of integrating PHC services is to improve the clients' access to those services; however, integration should often increase cost effectiveness (see subsection 4 below). In the process of integrating PHC services, selected programs that typically operate "vertically" now will be truly integrated into the range of PHC services offered at certain HCPs, while others will be adapted so that initial services (e.g., screening) will be more accessible or "integrated," while other levels of service (e.g., treatment, follow-up) may continue to have a "vertical" component in at least in the foreseeable future. The EQUITY Project will assist in this integration process in a number of ways, as suggested by the following illustrative examples (initially in the Eastern Cape Province):

- ▶ Assist in conducting an analysis of the current degree of service integration in the province to provide the basis for prioritizing initiatives.

- ▶ Together with the DOH and all of the provinces, determine the optimal range of integrated PHC services at each HCP level (e.g., health center, clinic, mobile site).
- ▶ Among other alternatives, consider existing models, technologies, and protocols for integrated case management that have been implemented successfully in other countries, especially in Africa. Study tours and other such mechanisms may be appropriate to assess such technologies in action.
- ▶ Assist in implementing the most promising technologies, perhaps via operations research methodologies, in order to assess those which will be most effective in South Africa. Facilitate the evaluation of these efforts and, where appropriate, assist in replicating the most effective schemes to other sites within the province.

2. Resource reallocation. Because of its historic focus on curative care catering to the aging white population, serious misallocation of resources exists between curative and preventive services in the health care system inherited by the GNU. As much as three-fourths of public health expenditures were curative in nature. The policies of the GNU have made major advances in redressing this imbalance, especially with the strong focus on accessible PHC services. Much remains to be done, however, to operationalize this national policy at the provincial level. The EQUITY Project will provide assistance initially to the Eastern Cape Province in the following illustrative ways:

- ▶ Assist in reviewing the current resource allocations between preventive and curative care services in the province, as well as the geographic distribution of those services and the proportions of the total resources among major line items. This health budget and expenditure review should analyze the trends in the sources and uses of funds for each level of care. Such periodic reviews can form the basis for consultations and dialogue on how health resources can be reallocated geographically as well as across services and among major line items.
- ▶ Based on these resource allocation reviews, facilitate the design of specific strategies to reallocate resources and identify appropriate policies and other actions that will help to achieve these strategies. Assist DOHW officials to assess these options, to share the options with relevant stakeholders, and to implement agreed upon resource reallocation proposals.
- ▶ Assist in developing and operationalizing the new, decentralized budgeting system. Under the new system the DOH makes allocations to the provinces, which in turn make allocations to their respective regions, districts and local levels. [Note that this system ties in with the strategic planning effort discussed in Section V.A above.] Although the details of needed assistance are not possible to determine now, the EQUITY Project will provide TA as needed to assist provincial officials in the decentralized planning, budgeting, and management process.

3. Management systems improvement. The critical need to improve health management systems has already been stressed (Section V.C above). The EQUITY Project will assist the Eastern Cape Province to develop and implement improved management systems in the following illustrative ways:

- ▶ Through collaboration with relevant stakeholders, facilitate the development and implementation of a management improvement strategy that -- together with the capacity-building activities just described -- will help to strengthen and streamline the management process (planning, decision-making, managing, monitoring and evaluating) at the provincial level and below. This strategy is likely to address, among other things, management systems and mechanisms that will be needed to manage effectively the health care system from the provincial level to the community.
- ▶ Based on the management improvement strategy, assist in adapting existing systems (e.g., planning, budgeting, accounting, personnel, facility and equipment maintenance) to achieve the objectives of the strategy.

4. Improving cost effectiveness. Although the primary focus of both the GNU and the EQUITY Project is in improving access to PHC services, sustainability of the system is also required. Therefore, the EQUITY Project will provide assistance to the Eastern Cape Province (initially) to improve the cost-effectiveness of health services through the following illustrative activities:

- ▶ Assist in carrying out baseline studies on unit costs of health services at all levels of care (primary, secondary, and tertiary). The baseline studies will likely include health service providers at the community level (e.g., community health workers, traditional healers).
- ▶ Using the results of the baseline studies, assist in building a consensus among all stakeholders to implement needed cost-effectiveness reforms; and in developing a strategy and action plan for achieving these key reforms. This cost-effectiveness strategy might include such different elements as (1) free services, (2) enforcement of the existing cost-sharing mechanisms (e.g., fee-for-service structures), and (3) increased cost sharing (user fees) for selected (perhaps curative) services. This latter area could include mandatory payments by medical aid schemes where services provided are covered by the schemes.
- ▶ Assist in implementing the action plan.

E. Institutionalized Training Capacity

Output 5: Institutionalized capacity for PHC training

As indicated in the discussion of Output 3 (Section V.C), in early June 1995, with technical assistance from the USAID-funded bridging activities, a PHC training task force developed a draft framework and action plan for improving and institutionalizing training resources for PHC. The framework and resulting action plan comprise the following five key action areas.

- Structures, mechanisms and procedures for planning, designing, implementing and evaluating training
- Relationships among the provincial and national departments of health and other stakeholders, especially with regard to training resources, guidelines, other support, and redistribution (equity)
- Availability (by province) of training resources, i.e., people, facilities, research, existing and innovative training programs/experiments
- Priorities for training, i.e., who, what, where, when. [Consensus was reached that the provinces will be addressing the "how."]
- Desired competencies (i.e., objectives of training) in PHC orientation, clinical skills, and management

The task force then developed a framework for a provincial action plan, to be considered and modified as needed by each province to match their respective priorities, etc. The task force report also incorporates two sets of recommendations -- one for the national DOH and one for the provinces. Finally, the report provides a chart of recommended priorities for PHC training. Since the task force was intended to be a temporary body, and since it had fulfilled its role in developing a framework for how PHC training should be developed in the long term, the task force recommended that the DOH establish a Human Resources Development (HRD) Core Group, comprised of both DOH and provincial-level HRD staff, to provide continuity for future activities and progress. [The DOH has already established the Core Group.]

Thus, the role of the EQUITY Project in supporting PHC training will be to provide assistance as needed -- beyond that available through the bridging activities -- to achieve the long-term PHC training objectives of the health care system. This role is expected to include the following activities:

- ▶ Assist the Eastern Cape Province, and later the other provinces, to implement both their respective action plans and the agreed-upon recommendations for the provincial level.

- ▶ Assist the DOH to implement the agreed-upon recommendations for the DOH level.
- ▶ In support of these PHC training activities, facilitate linkages between South African and U.S. institutions with common interests (as discussed under Output 3).
- ▶ As with Output 3, support long-term professional education as needed to ensure sufficient in-country training resources.

F. Improved Information Base

Output 6: Improved information base for decision-making, program development, and management

Due to the fragmented nature of the previous health care system, there have been no uniform reporting requirements and no integrated national health information system. Until a comprehensive national health information system is operational, both the DOH and the provinces will continue to have difficulty in a number of key areas: (1) monitoring the health status of all South Africans, particularly those currently underserved; (2) assessing existing health services and the relative effectiveness of interventions; (3) setting national health goals and objectives, and determining health priorities based on the needs of the people; and (4) developing realistic policies and plans.

Fortunately, one of the national committees established a year ago by the DOH is dealing with the very issues just identified. The Committee on the National Health Information System for South Africa (NHIS/SA) has come a long way during the year in identifying goals and objectives, major components, and the key responsibilities of the various levels of the health care system.⁷ The principal goal of the NHIS/SA is to develop a comprehensive NHIS that includes the public and private sectors at local, district, provincial and national levels.

The comprehensive objectives of the NHIS/SA are as follows:

- Provide information for managing health services.
- Measure the health status of the South African population.
- Monitor and measure progress of implementation of RDP priorities.
- Develop health status indicators appropriate for national, provincial, and district levels.

- Identify and create, where necessary, national data sources to measure progress toward national health objectives.
- Develop and disseminate among national, provincial and district levels, procedures for collecting comparable data for each of the national objectives.
- Develop and implement a national process to identify significant gaps in the nation's disease prevention and health promotion data, including data for groups requiring special attention.
- Provide training at the provincial level so that information is optimally used.
- Publish and use information for resource allocation.
- Develop procedures for communicating results to all levels. [This communication could be part of an overall periodic newsletter that would highlight information of interest and usefulness to health care workers in general.]

One of the principles adopted by the Committee is that the NHIS/SA would be an overall parent system comprising the following seven component systems: (1) socio-demographics, (2) health status, (3) health resources (human resources, health finances, physical facilities, equipment, drugs, other stock control), (4) health care provision, (5) health care utilization, (6) health promotion and public information, and (7) health care coverage.

The EQUITY Project will contribute to the development and institutionalization of the NHIS/SA both at the national and provincial levels. This support will involve the following three components: (1) national baseline surveys and analyses and periodic updates, (2) development and refinement of the provincial-level NHIS/SA components, and (3) capacity building at both the national and provincial levels to ensure that NHIS/SA components are fully institutionalized.

In close collaboration with the DOH and the NHIS/SA Committee, and in support of their respective objectives and annual workplans, the EQUITY Project will assist with the following activities:

- ▶ Support two national-level demographic and health surveys (DHS). The first will be carried out in 1996 and will be funded through the bridging activities. The second will be conducted in Year 4 or 5. These national surveys will include oversampling in the Eastern Cape Province to provide baseline information for EQUITY Project use, as well as data for overall program planning, policy development and management. These Eastern Cape data will also allow for additional planning, policy and program analyses, and should provide guidance for how such data can benefit the other provinces in the future.

- ▶ Support a national situation analysis that will augment currently available studies and provide a comprehensive situation analysis of the health care system. This survey will be planned and implemented through close collaboration with the NHIS/SA Committee to ensure (a) that the survey fills needed gaps in available information but doesn't duplicate it, and (b) that the survey components, as much as possible, can be adapted to become elements of the NHIS/SA in the future -- thus reducing or eliminating the need for such expensive surveys in the future. As with the DHS, the EQUITY Project will assist in developing useful analyses of the data for management purposes.
- ▶ In close coordination with DOH and the NHIS/SA Committee, assist the Eastern Cape DOHW to develop, implement, and effectively utilize its provincial HIS at provincial, regional, district and local levels.
- ▶ Assist, perhaps through the use of operations research, in developing mechanisms to link the most important service site in primary health care -- the home -- to the NHIS/SA in simple and effective ways that don't require costly and time-consuming survey methods. This might be done, for example, through exploring different home-based (patient-retained) health cards and/or simplified clinic recording procedures that can provide key home-based information on a regular basis.
- ▶ Assist in establishing dynamic linkages for sharing and borrowing technical developments and experiences among provinces and the DOH. These linkages will be strengthened through the following illustrative ways:
 - Technical consultations and exchanges among provinces, the DOH, and the NHIS/SA Committee.
 - Periodic "lessons learned" workshops or conferences for senior provincial and central DOH decision makers.
 - Periodic "technical issues" workshops or conferences for people with specific technical area responsibilities in the provinces, the DOH, and the NHIS/SA Committee.
 - Study tours both within and outside of South Africa, as appropriate.

- Support for dissemination activities such as a periodic newsletter for the NHIS/SA system, instructional videos, and public-oriented communication to publicize important information about the NHIS/SA system and its analyses.

G. Continuation of HIV/AIDS Activities

HIV/AIDS is one of the RDP health priority areas, and the DOH intends to pursue a comprehensive program in order to limit the devastating impact and spread of this disease. USAID/South Africa has supported high-priority HIV/AIDS activities through NGOs at both national and community levels for more than four years. Other donors -- notably the European Union and the British Overseas Development Administration (ODA) -- are also planning to provide significant funding for HIV/AIDS activities, beginning within the next year.

One key element of USAID's support has been assistance to the National AIDS Convention of South Africa (NACOSA) to develop the draft national HIV/AIDS action plan, which was recently approved by the DOH as the national plan. The balance of USAID's assistance thus far has generally been directed toward HIV/AIDS awareness and prevention activities at both national and community levels; limited support has been provided to NGOs to develop and operate community-based care for people with AIDS.

With the implementation of the EQUITY Project, USAID's assistance in the HIV/AIDS area will be integrated into the project's mechanisms for providing critical support to NGOs over the next few years. Thus, through collaboration with the national HIV/AIDS program, the EQUITY Project will make the following kinds of support available for HIV/AIDS: (1) Funding for critical provincial- and community-based HIV/AIDS programs (including through NGOs) to ensure that needed HIV/AIDS resources are available as part of the integrated PHC services package in all nine provinces; and (2) selected support to mutually agreed priority activities under the national HIV/AIDS plan, where other resources are not available. As with the rest of the EQUITY Project, HIV/AIDS assistance will be carefully designed and phased to ensure that needed activities are sustainable within the overall life of project. Where appropriate, this will include increasing DOH support for critical NGO services as EQUITY support is phased out.

H. Implementation Arrangements

All project activities and interventions will be undertaken in close coordination with officials of the national DOH and/or the provincial departments. Through the Annual Action Plan mechanism, the DOH and the provincial departments, with assistance from the institutional contractor's TA team, will systematically identify appropriate project interventions, determine which implementation options will be selected and who will implement them, and monitor progress in achieving results. In some instances, the TA team may actually carry out the activity on behalf of the GNU; in most cases, the team will merely facilitate implementation by the GNU.

Successful implementation is dependent on strong collaboration among the GNU, the TA team, and USAID/SA. As indicated in the earlier discussion of participation in the project design (Section I.C), that collaboration has already begun through coordination groups at both national and provincial levels. During the actual implementation of the EQUITY Project, overall implementation will be coordinated through a single DOH official in the national DOH; for activities within the Eastern Cape Province, one official of the provincial DOHW will have overall coordination responsibility. The position titles of these two officials will be provided by the GNU in accordance with one of the conditions precedent of the project grant agreement (see Section I below). The EQUITY Project Steering Committee in the Eastern Cape Province will act as an advisory body to the DOHW with regard to project activities in the province. Critical inter-sectoral linkages and coordination (e.g., water, sanitation, transportation, education, communications) will be managed by the DOHW.

While this PP provides an overall framework for the EQUITY Project, actual implementation will proceed on the basis of approved Annual Action Plans, which will be developed jointly by the national DOH, the Eastern Cape DOHW, and the institutional contractor. These Annual Action Plans will specify the agreed-upon activities to be undertaken; the time frame and action agent(s) for implementation; projected costs; and where appropriate, the sharing of costs between the GNU and USAID. Thus, these Annual Action Plans, once approved by USAID/SA, will be the critical documents for guiding actual project implementation.

Achieving sustainability of the health management systems and other major project outcomes is vital if the EQUITY Project is to achieve its purpose. The GNU has stated categorically that USAID contributions to overall project resources are to be considered outside the government's budget and will not be utilized to pay project-related recurrent expenditures. Project interventions, both in the focus province and at the national level, have been specifically designed to minimize the impact on recurrent expenditures. Those GNU financial commitments that are required are incorporated in the budget reflecting the GNU contribution to the project (see Section VIII). Thus, both the GNU and USAID envision that EQUITY Project accomplishments will be sustained throughout their useful life after USAID assistance has ended.

I. Conditions and Covenants

In an effort to ensure the timely provision of project resources, and in turn to accomplish the project outcomes within the life of project, the following conditions and covenants will be included in the grant agreement.

1. Conditions Precedent to Disbursement

a. First Disbursement

(1) Prior to the first disbursement of funds under the Grant, or to the issuance by USAID of documentation pursuant to which any disbursement may be made, the Grantee will, except as the Parties may otherwise agree in writing, furnish to USAID, in form and substance satisfactory to USAID:

(a) A written statement setting forth the names and titles of those persons in the Government of National Unity who are authorized to sign Project documents and communications, together with a specimen signature of each such person specified in such statement; and

(b) An opinion of counsel acceptable to USAID that this Agreement has been duly authorized and/or ratified by, and executed on behalf of, the Grantee, and that it constitutes a valid and legally binding obligation of the Grantee in accordance with all of its terms and conditions.

(2) Prior to the first disbursement under the Grant, except for technical assistance to the Grantee and action plan preparation costs, or to the issuance by USAID of any documentation pursuant to which disbursement will be made, to finance Project implementation in the Eastern Cape Province, the Grantee will, except as the Parties may otherwise agree in writing, furnish to USAID, in form and substance satisfactory to USAID, a detailed, time-phased, annual action plan, including clearly delineated roles and responsibilities for all Grantee Project personnel, for Project activities scheduled to take place in the Project Year 1 which ends on September 30, 1996.

b. Additional Disbursements

(1) Prior to any disbursement under the Grant for Project Year 2, beginning October 1, 1996 and Project Years thereafter, or to the issuance by USAID of documentation pursuant to which disbursement will be made, the Grantee will, except as the Parties may otherwise agree in writing, furnish to USAID, in form and substance satisfactory to USAID, a detailed annual action plan for the Project, including clearly delineated roles and responsibilities for all Grantee Project personnel, for Project activities scheduled to take place in the respective following Project Year beginning on October 1.

(2) Prior to the final award of the institutional technical assistance contract, the Grantee will provide, in form and substance satisfactory to USAID:

(a) Documentation indicating (i) the principal officer within the national Department of Health and the principal officer within the Eastern Cape Province Department of Health and Welfare who shall have overall EQUITY Project management responsibility on behalf of the Grantee at their respective levels; and (ii) counterparts to the key personnel of the technical assistance contract team.

(b) Documentation detailing the final organizational structure of both the national Department of Health and the Eastern Cape Province Department of Health and Welfare.

c. Notification. When USAID has determined that the conditions precedent specified in Section 4.1 or 4.2, as the case may be, have been met, USAID will promptly so notify the Grantee.

d. Terminal Dates for Conditions Precedent

(1) If all of the conditions specified in Section 4.1 have not been met within 90 days from the date of this Agreement, or such later date as USAID may agree to in writing, USAID, at its option, may terminate this Agreement by written notice to the Grantee.

(2) If all of the conditions precedent specified in Section 4.2 have not been met within the time set forth in Project Implementation Letters, USAID, at its option, may cancel the then undisbursed balance of the Grant, to the extent not irrevocably committed to third parties, and may terminate this Agreement by written notice to the Grantee.

2. Special Covenants

a. Project Evaluation. The parties agree to establish an evaluation program within EQUITY based on mutual review of progress and a project assessment 12 months after EQUITY begins. Except as the Parties otherwise agree in writing, the program will include, during the implementation of the Project and/or at one or more points thereafter:

- ▶ evaluation of progress towards attainment of the objectives of the Project;
- ▶ identification and evaluation of problem areas or constraints which may inhibit such attainment;
- ▶ assessment of how such information may be used to help overcome such problems; and
- ▶ evaluation, to the degree feasible, of the overall development impact of the Project.

b. Support for Non-governmental Organizations. In order to ensure sufficient resources within the broad health sector to accomplish the Project purpose, the Project will involve entities outside of Government, including non-governmental organizations (NGOs). In instances where the Grantee and USAID mutually agree, the Grantee will provide support for critical NGO services as Project resources are phased out.

c. Phase 2 Project Expansion. The Grantee agrees to take such steps and measures as are necessary to implement the Project in a manner as to ensure the successful accomplishment of the Project purpose. This shall include providing the human and financial resources necessary to accomplish the successful expansion of the systems developed during Phase 1 throughout the other eight provinces of the Republic of South Africa.

J. Results Package Framework

In line with USAID's latest project design guidance, the EQUITY Project places emphasis on **results**. Periodic monitoring and evaluation will determine whether project interventions need to be modified to ensure that these results are achieved. The project design incorporates flexibility (through the development of Annual Action Plans) in order to ensure that necessary modifications can be made to adapt to changing conditions and requirements.

VI. DEFINITION OF SUCCESS

A. Strategic Objective Indicators

The EQUITY Project is unique in being not only the first major USAID bilateral project with the GNU, but also the first Mission project **designed** to fully achieve a strategic objective: To support the development of a unified system to provide integrated primary health care services to underserved populations.

The EQUITY Project design incorporates two phases. Most project outcomes are targeted initially at the focus province, and generally will be accomplished within the first four years under Phase 1 (1995-99). However, the design also incorporates intensive involvement of both the national DOH and all nine provinces in the planning and implementation process. Thus, when EQUITY-assisted health system components work in the focus province, they will be rapidly expanded to other provinces. This expansion will generally occur during the three years of Phase 2 (2000-2002), and depending on the resources available to the other provinces -- beyond those available under the EQUITY Project -- the expansion may or may not be complete in all of the other eight provinces by the end of Phase 2. However, this project and program strategy is designed to ensure that the national PHC system is as fully institutionalized and sustainable as possible by the completion of USAID/SA assistance. The final project evaluation will determine the extent to which the objectives of both phases have been achieved.

Since the strategy of the EQUITY Project is systems development, not service delivery, the project outcomes relate to accomplishments in establishing and strengthening health system elements. The result of these system improvements will be increased use of PHC services, and the eventual outcome of that increased use will be improvement in health status (e.g., lower infant and child mortality, reduced fertility, increased life expectancy). However, since this increased use will not occur until late in the project life, we do not expect major health status improvements by the project completion date. On the other hand, such improvements are expected in subsequent years, and have been factored into the assessment of cost-effectiveness within the project's economic analysis. The DOH is currently developing a comprehensive set of targets for its programs, and many of these are likely to be relevant to the areas supported by the EQUITY Project. In such cases, these targets will be incorporated as indicators for the EQUITY Project as well.

B. Project Output Indicators

As described earlier, the EQUITY Project has six major, interrelated project outputs. For each output there are typically two indicators of accomplishment, based on the two project phases. These are summarized below for each output, and area also reflected in the EQUITY Project logical framework (Annex A).

1. Access to an integrated package of PHC services in the focus province has been increased.

- ▶ By 1999, an integrated PHC service package will be implemented effectively in the focus province.
- ▶ By 2002, 80 percent of health care points in the focus province will be delivering an appropriate package of quality, integrated PHC services.
- ▶ By 2002, total PHC services delivered in the focus province will have increased by at least 25 percent.
- ▶ By 2002, the integrated service package will be implemented in most if not all of the other eight provinces.

2. An effective referral system is functioning in the focus province.

- ▶ By 1999, an effective referral system will be functioning in the focus province.
- ▶ By 2002, client visits to clinics and health centers in the focus province will increase by 10 percent as a result of the referral system.
- ▶ By 2002, effective referral systems will be functioning in most if not all of the other eight provinces.

3. The capacity to manage the integrated PHC program has been enhanced at central level and in the focus province.

- ▶ By 1999, improved management systems will be operating at all levels both in the central DOH and within the focus province.
- ▶ By 2002, improved management systems will be operating at all levels in most if not all of the other eight provinces.

4. The effectiveness and efficiency of PHC service delivery has been increased at the provincial level and below.

- ▶ By 1999, the effectiveness and efficiency of PHC service delivery in the focus province will be increased.
- ▶ By 2002, the effectiveness and efficiency of PHC service delivery will be increased in most if not all of the other eight provinces.

5. The capacity for PHC training has been institutionalized.

- ▶ By 1999, PHC training capacity will be institutionalized in the focus province.
- ▶ By 2002, PHC training capacity will be institutionalized in most if not all of the other eight provinces.

6. The information base for policy-making, program development and management has been improved.

- ▶ By 1999, an effective health information system will be operating in the focus province, and will be used both for policy, planning and programmatic decisions and for program monitoring.
- ▶ By 2002, an effective health information system will be operating and will be used in most if not all of the other eight provinces.

Gender impact. In addition to the specific project output achievements, the EQUITY Project will have a major impact on South African women, especially among the underserved population. First, the majority of clients of PHC services are women who will benefit directly from improved basic health care services, as well as indirectly from the improved health status of their children. Second, SO4 will have a major impact on building women's capacity -- increasing the capacity not only of female health workers (who are in the majority) through training, but also of community-based women who will be empowered to improve their status and the quality of health care through community health development activities. Finally, even programs specifically targeted at men will directly benefit women; for example, programs to encourage men to use family planning methods with their partners, and programs to encourage the use of safe sex to prevent HIV/AIDS and other STDs.

C. Revalidation Plan (Monitoring and Evaluation)

1. Monitoring

Project activities will be monitored on an ongoing basis by the TA team of the institutional contractor; periodic progress reports will be submitted to the GNU and USAID in accordance with contractual provisions. In addition, representatives of the national DOH, the Eastern Cape DOHW, and USAID's Health Development Division will conduct frequent site visits to monitor progress in the field. Periodic (e.g., monthly) review meetings will also be held among the TA team, mutually agreed DOH and Eastern Cape DOHW representatives, and USAID.

Annual progress reviews, involving representatives from all nine provinces and other stakeholders, will be held. During these annual reviews the current annual action plan will be reviewed to assess the degree of accomplishment of the plan, as well as constraints hampering progress and additional opportunities that may exist. The outcome of these annual progress reviews will influence the content of the action plan for the following year, and will allow for adjustments in project indicators and perhaps even outputs. These annual progress reviews will provide the information required for USAID/SA's annual Assessment of Program Impact, which is both used for Mission progress monitoring and submitted to USAID/Washington.

2. Evaluation

As described in Section III.E, USAID-funded bridging activities will carry out both a nationwide demographic and health survey and a health system situation analysis during Year 1. These surveys will provide a baseline from which achievement of project objectives can be measured. Once these surveys have been completed, the detailed progress indicators for the six project outputs (Logical Framework, Annex A) may be modified. Such modifications may also arise when the national DOH finalizes the comprehensive package of health indicators currently being developed, since these indicators will likely be adopted by the EQUITY Project as measures of project success.

There will be two major external evaluations of the project. A mid-term evaluation will be conducted after the completion of Phase 1 (i.e., early in Year 5). The mid-term evaluation will measure and document progress attained in meeting project objectives, problems encountered, and management effectiveness; it also might recommend modifications in project design to take advantage of additional opportunities to enhance project success. A final impact evaluation will be conducted during year 7 to document project accomplishments in relation to desired project outcomes.

VII. PROJECT FEASIBILITY

This section discusses the key issues related to the success of the EQUITY Project, as well as major risks to successful achievement of project objectives, and key assumptions that are necessary to ensure that the Project will proceed as planned and achieve its purpose and attain SO4.

A. Summary of Project Analyses: Issues and Potential Risks Related to Project Success

The subsections below summarize the principal issues identified in the respective project analyses (Annexes E through H) in the four major areas analyzed -- economic, social, technical, and institutional. The reader is referred to the respective annexes for the details of each analysis.

1. Economic Analysis

The national health budget remained nearly constant for 1995/96. In real terms this is at least 10% less than the previous year. This level of funding is not expected to increase proportionally because the GNU has adopted strict fiscal policies to help ensure fiscal responsibility, especially in view of the GNU's large debt burden. This highlights the need to improve the efficiency of the national health system to enable the provision of services to the underserved. In order to support the restructuring of the health system and redistribution of resources, the DOH has undertaken strong efforts to distribute budget resources according to both total population and per capita income by province.

For the DOH budget allocation to Eastern Cape, two important decisions have yet to be made: (1) the geographical allocation of the budget among the five regions, and (2) the allocation of an increased proportion of the budget to primary health care. Budgetary decisions in future years hold important implications for the PHC restructuring and systems development activities planned by the EQUITY Project.

2. Social Analysis

There are two basic social issues related to gender that must be kept in mind for successful project implementation. The first is that women play the central role in family health, and it is essential that women's organizations, such as the Mothers' Union, be integrally involved in the planning and implementation of PHC programs at the community level. These groups are not only the most knowledgeable about family health but also the most sensitive to women's needs -- not only as the focal point of family health but also as key recipients of PHC services.

The second issue is that South African women, particularly rural women, are subjected to an undisguised exercise of patriarchal dominance that is manifested in legal, social and economic domination by male heads of households over their dependents. Consequently, a successful PHC program must include a focus on motivating males to acknowledge the rights and roles of females in rural society. Emphasizing these rights and roles should be an

explicit part of the community priority-setting process that will be undertaken in the community development process, especially in rural areas.

The Social Analysis also highlighted the need to establish a mechanism to ensure full participation of communities in planning and monitoring integrated PHC services. It is critical through such a mechanism to establish partnership agreements with the communities being served, respecting and incorporating their institutional and traditional leadership structures.

3. Technical Analysis

This analysis indicates that there are no unidentified national technical capacity or capability issues that will present significant risks to the success of the EQUITY Project. The real technical issues are those articulated by the RDP: Ensuring that national health resources are equitably focused and distributed, and that needed capabilities are developed to ensure that all South Africans have equitable access to essential health services. These, of course, are the very issues that the EQUITY Project has undertaken to help resolve.

Although secondary- and tertiary-level facilities dominate the current health care system and consume most of its resources, the referral system in support of primary health care is weak and often non-existent. Technical capacity needs to be strengthened to support peripheral health services, with appropriate referral to higher levels. Appropriate case management in the home and at entry-level health care points must be developed, and health care workers at all levels require reorienting to the PHC approach and training in clinical and management skills, as appropriate. Again, these are principal issues which the EQUITY Project will be addressing.

4. Institutional Analysis

Due to dramatic political and social changes underway in South Africa, there are a number of major institutional issues that could affect implementation of the EQUITY Project. The institutional analysis groups these issues in the following seven areas: 1) administrative structures, 2) human and organizational capacity, 3) morale, 4) stability and security, 5) local governments' roles in providing health services, 6) distribution and availability of resources, and 7) openness to non-governmental partnerships.

As an example of how dynamic the South African environment can be, several of the following issues, which were identified when the institutional analysis was finalized in March 1995, have moderated to a large extent. While none should be eliminated from the list as potential problem areas, many are currently not so serious as they are portrayed in the analysis itself and the summary paragraphs below.

Administrative structures. The structure of public administration currently is not within the powers of the line ministries, in this instance health. The major personnel, financial and logistical matters are the domain of the Public Service Commission, Treasury, and the Department of State Expenditure. Statutes, regulations and codes established and/or enforced

by these governmental units provide a rigid framework for public administration and allow little or no latitude for innovation or adaptation to local circumstances. In addition, the effects of the current provincial model with only one "accountable officer" for the whole public administration will depend on the incumbent's attitude to decentralization through delegation -- an essential ingredient to the success of primary health care.

Human and organizational capacity. The new provincial-level organizational structures and staffing are not yet fully in place, and this severely limits short-term capacity. Thus, until the new system is in place and new managers have been given authority and direction, there will be little improvement at the service level. While the EQUITY Project will assist by training both managerial and technical staff to respond to the demands brought about by these changes, rapid devolution of authority, responsibility, and guidance must take place.

Morale. Change brings about uncertainty. Some of the implications during this transition period are that restless officials have sought other employment and morale has been low. It has often been difficult to fill critical posts, and to obtain approval for essential expenditure. There is strong competition for senior positions, but some new managers don't yet have the confidence of their staffs. All of these problems are transient in nature, but have affected morale during the initial year of transition.

Stability and security. There is considerable confusion and even suspicion concerning the local government elections which are scheduled for November 1995. Peaceful transition and stability at the local level are particularly important for the health care system, since the constitution provides for primary health services to be managed by local governments. In addition, the level of social disorder exhibited by violence and illegal strike actions in some areas is high, with the result that access to services is limited by physical insecurity.

Local government's role in health service provision. Before health districts can function well, solutions will have to be found for local government structures that now separate urban and rural communities, making integrated service delivery and referral extremely difficult. In addition, a satisfactory resolution of the historical differences in salaries and benefits between local and provincial health workers will have to be achieved. These issues are already being addressed, although many cannot be fully resolved until the implications of the local elections are clear.

Distribution and availability of resources. The GNU has made the policy decisions that will lead to a redistribution of health sector resources and an emphasis on PHC. However, the major problem will be putting initial plans into action, since the maldistribution of resources cannot be overcome rapidly. For the EQUITY Project to be fully successful, it will be essential to have the appropriate distribution and availability of supportive resources.

Openness to non-government partners. In order to ensure sufficient resources within the broad health sector to accomplish the project purpose, the EQUITY Project foresees involving entities outside of government, including NGOs and the non-formal sector. Policies at all levels with regard to the long-term role of NGOs in the health sector are not yet clear. The willingness of provincial- and district-level decision-makers to accept the active role of health NGOs and to help ensure their sustainability will be critical to the impact NGOs can have in meeting critical needs within the health care system.

B. Key Project Assumptions

In addition to identifying the above issues and potential risks to the successful implementation of the EQUITY Project, there are a number of key assumptions that have been made about how conditions beyond the control of the project will unfold. These are summarized in relation to the level of the project where their potential impact would be felt; that is, goal, purpose, and outputs. These assumptions appear in chart form, along with the overall project structure, in the Project Logical Framework in Annex A.

1. Assumptions affecting the project goal

- ▶ There will continue to be adequate funding for health in the national government budget.
- ▶ The South African economy will remain stable or will improve.

2. Assumptions affecting purpose-to-goal links

- ▶ Planned democracy and governance progress will occur at national, provincial and local levels.
- ▶ Health system restructuring and financing to promote PHC will continue to occur at the provincial level.
- ▶ The public service management function will be rationalized.
- ▶ Traditional structures will continue to support integrated PHC.

- ▶ Non-public entities⁸ will be actively involved in the new health system.

3. Assumptions affecting output-to-purpose links

- ▶ All identified entry-point and referral entities (e.g., NGOs, work-based and missionary health facilities, DOH HCPs) will participate in the referral system.
- ▶ Basic infrastructural services, such as roads, water supply, and sanitation are developed in the rural areas.

As the EQUITY Project moves through the grant agreement and implementation stages, if any of the preceding assumptions are no longer correct, the change(s) should be assessed and if needed, modifications should be made in project outcomes and/or indicators.

Non-public entities include NGOs, community-based organizations (CBOs), mass-based organizations, and other private-sector organizations and institutions.

Attachment No. 10
SAMPLE GUIDELINE
FOR
QUARTERLY PERFORMANCE REPORTS
(for technical or professional services contracts)

Contractor _____
Contract # _____
Reporting period: _____ to _____

Section I- CONTRACTOR'S REPORT

Section I, which the contractor prepares, consists of two parts. The first part is a narrative of progress on major activities and the second part requires data entry only.

A. Narrative:

The narrative should cover each of the five elements described below. Element #1 should not exceed a paragraph. Element #2 may require a short paragraph to summarize each expected result. For element #3, a sentence on each activity should be sufficient to describe what is in process during the quarter. (Distinguish among core, buy-in and sub-contracting activities) Element # 4 is the essential part of the report. Of particular interest are issues regarding timeliness, technical quality and cost-effectiveness of each of the activities or delivery orders in progress. Element # 5 provides the opportunity to draw attention to possible problems or to adjustments which would enhance the delivery of the services being provided.

- 1. Background:** Describe briefly the overall contract final objective in terms of level of effort, if appropriate, and total estimated cost needed to accomplish objective.
- 2. Expected Results:** Summarize the specific results expected at conclusion of contract
- 3a. Current core activities:** Describe briefly each of the major activities in process during current quarter as found in work plans and/or contract.
- 3b. Current buy-ins:** Summarize objective of each active delivery order under companion contract.

3c. Current subcontracting activities: Describe briefly each subcontracting activity and identify the subcontractor.

4. Performance: For each of the activities described in number 3a (core), b (buy-ins), and c (subcontracting) above, state whether on-target or not, and comment, particularly in terms of comparing actual accomplishments with the objectives, deliverables, or requirements established for the period, and explain reasons why objectives, deliverables or requirements were not met, as appropriate.

5. Statement of Work: Comment as to whether circumstances have changed which would require modification in any elements of the statement of work.

Level of effort data should be expressed in person months and needs to be furnished on level of effort contracts only. Financial data may be an estimated amount and can be rounded to the nearest thousandth.

B. Administrative Information:

Contract Data: Total level of effort* _____p/m
Total estimated cost \$ _____

- 1. Level of effort* (last three months): _____p/m
- 2. Cumulative level of effort* _____p/m
- 3. Unused level of effort* _____p/m
- 4. Expenditures (last three months): \$ _____
- 5. Cumulative expenditures to date: \$ _____
- 6. Remaining unexpended balance: \$ _____

*Applies to level of effort contracts only

Section II - PROJECT OFFICER'S COMMENTS

The cognizant project officer, acting in his/her capacity as the contract officer's technical representative as specified in the contract agreement, will complete section II and pass his/her comments on to the cognizant contracting officer. The project officer will acknowledge receipt and provide feed-back, as appropriate, to the contractor using established communication channels.

1. Comment on contractor's technical performance (quality of technical assistance, professional services, and/or products) and provide examples, if appropriate.

2. Comment on contractor's administrative performance (timeliness in meeting schedules and/or delivering materials/products) during the quarter and give example(s), if appropriate.
3. Comment on contractor's management (cost-effectiveness, quality of communication with staff and with USAID for the quarter and provide examples as appropriate.
4. React to contractor's assessment of performance regarding any of the activities/deliverables described in section IA, number 4 above.
5. Note areas for potential contractor improvement regarding management/provision of any services related to the activities/deliverables and/or specific contract results.

Project Officer/Office Symbol. _____ Date _____

Section III - CONTRACT OFFICE'S COMMENT

The cognizant Contract Office personnel will complete Section III in consultation with the cognizant project officer and mutually agree on any actions that need to be taken. Feed-back should be given to the contractor within five working days.

1. Comment on any areas of concern particularly regarding Contractor's response to questions 4 and 5 in Section I above and Project Office's response to question 3 in Section II above.
2. Identify actions to support, correct, or improve contractor's performance (show-cause notice, cure notice, contract modification, incremental funding, technical direction to contractor, approvals and/or clearances, interpretations of statement of work or adjustments in work plans, feed-back to contractor regarding performance and/or deliverables) that need to be taken and indicate action officer and due date.

Contract Officer/Office Symbol _____ Date _____

Attachment No. 11

MEC FOR HEALTH AND WELFARE
EASTERN CAPE PROVINCE

GUIDELINES FOR THE IMPLEMENTATION OF A
COMPREHENSIVE PRIMARY HEALTH CARE PACKAGE

PHC COMMISSION
DECEMBER 1994

CONTENTS

FOREWORD:

PREMIER

MEC FOR HEALTH AND WELFARE

ABBREVIATIONS AND ACRONYMS

1. CHAPTER 1: INTRODUCTION AND BACKGROUND

- 1.1 Background and Terms of Reference
- 1.2 Historical Background
- 1.3 Philosophy of PHC
- 1.4 Conceptual Framework
- 1.5 RDP Priorities
- 1.6 Priorities of Eastern Cape Provinces
- 1.7 Role of Government regarding PHC at:
 - 1.7.1 National Level
 - 1.7.2 Provincial Level
 - 1.7.3 Sub Provincial Regional Level
 - 1.7.4 District Level
 - 1.7.5 Ward Level
 - 1.7.6 Community Level
 - 1.7.7 Donors and NGOs

2. CHAPTER 2: OVERALL PROVINCIAL STRUCTURE

- 2.1 Administration and the linkage with the services
- 2.2 Training Institutions
- 2.3 Professional Bodies
- 2.4 District Level
- 2.5 Referral System

3. CHAPTER 3: ESSENTIAL PHC PACKAGE

- 3.1 Access
- 3.2 Intersectoral Collaboration
- 3.3 Community Involvement
- 3.4 Information, Education and Communication
- 3.5 Maternal, Child and Womens Health
 - 3.5.1 Maternal Care
 - 3.5.2 Reproductive Health
 - 3.5.3 EPI
 - 3.5.4 Young Child under 1 year

- 3.5.5 Child up to 5 years
- 3.5.6 Primary School Child
- 3.5.7 Teenage/Adolescent

3.6 Communicable Disease Control

- Tuberculosis
- Diarrhoeal Disease

- Acute Respiratory Disease

- Otitis Media
- Rheumatic Fever
- Typhoid
- Hepatitis
- STD/HIV
- Meningitis
- Scabies

3.7 Treatment of Diseases and Injuries and Emergencies.

- 3.8 Essential Drugs**
- 3.9 Geriatric Care**
- 3.10 The Disabled and Rehabilitation**
- 3.11 Occupational Health**
- 3.12 Dental Health**
- 3.13 Mental Health**
- 3.14 Environmental Health**
- 3.15 Nutritional Services**

4. CHAPTER 4: HOSPITALS, HEALTH CENTRES AND CLINICS

- 4.1 Hospital Services**
- 4.2 Laboratory Services**
- 4.3 X-Rays**
- 4.4 Health Centre**
- 4.5 Clinic**
- 4.6 Health Post**
- 4.7 Mobile Clinics**

5. CHAPTER 5: COMMUNITY BASED HEALTH CARE

6. CHAPTER 6: TRAINING AND EDUCATION

7. CHAPTER 7: LOGISTICS

- 7.1 Communication**
- 7.2 Transport**
- 7.3 Supplies, Storage, Maintenance**

8. CHAPTER 8: OPERATIONALIZING PHC

9. ANNEXES:

9.1 ESSENTIAL DRUG LIST FOR:

- Health Centres
- Clinics
- Mobile
- Home Visiting Bag
- School Visits

9.2 MEMBERS OF PHC COMMISSION

9.3 MATERNAL AND CHILD HEALTH

- Maternal Health
- Child Health

ABBREVIATIONS AND ACRONYMS

A	AMREF	African Medical and Research Foundation
	ANC	African National Congress
	AIDS	Acquired Immune Deficiency Syndrome
	ARI	Acute Respiratory Infections
B	BF	Breast Feeding
	BCG	Bacille Calmette Guerin
C	CPA	Cape Provincial Administration
	CDD	Control of Diarrhoeal Disease
	CHW	Community Health Worker
	CBO	Community Based Organisation
D	DNHPD	Department of National health and Population
	DT	Diphtheria Tetanus
	DHMT	District Health Management Team
	DPT	Diphtheria Pertussis Tetanus
E	EPI	Expanded Programme on Immunization
	EL	East London
	ENT	Ear Nose and Throat
H	HIV	Human Immunodeficiency Virus
	HIS	Health Information System
	HLM	Health Learning Material
I	IMR	Infant Mortality Rate
	IEC	Information Education Communication
	IV	Intravenous
K	KAP	Knowledge, Attitudes Practices
M	MEC	Member Executive Council
	MCH	Maternal, Child Health
	MCWH	Maternal Child Womens Health

N	NACOSA	National AIDS Convention of South Africa
	NHS	National Health Service
	NGO	Non Government Organisation
	NPPHC	National Progressive Primary Health Care
O	ORS	Oral Rehydration Salts or Solution
	OPD	Out Patients Department
	ORT	Oral Rehydration Therapy
P	PHC	Primary Health Care
	PE	Port Elizabeth
R	RDP	Reconstruction and Development Programme
	RPR	Rapid Plasma Reagin
S	STD	Sexually Transmitted Diseases
T	TB	Tuberculosis
	TBA	Traditional Birth Attendant
	TV	Television
W	WHO	World Health Organisation

CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1 BACKGROUND

The Eastern Province is one of the 9 Provinces of South Africa which was most deprived of resources and most fragmented with different administrations under the Apartheid era. The former Eastern Cape and Border area had health services delivered separately, for different races and different services, by the Cape Provincial Administration, the National Department of Health and Population Development and, the House of Representatives and the House of Assembly. The Ciskei and Transkei were "Independent States" with their own Ministries of Health and were able to develop more integrated services for their largely rural populations.

Before the non-racial election a process of change had started in the health services, a more correct view of Primary Health Care came into existence, and three of the racial health services in the Eastern Cape were integrated.

A Health Forum was created which before the election started to plan the new integrated health services for the Province which was to be created and which included Ciskei and Transkei.

Two documents were available early in 1994:

- A National health Plan for South Africa - ANC May 1994
- Reconstruction and Development Programme.

Both of these were elaborated with extensive participation of great numbers of stakeholders and experts and each included a Vision, Situation Analysis, Policies, Priorities and Activities. Both embraced Primary Health Care as their approach with full community participation. These documents guided the deliberation of many subsequent meetings of the Health Forum and the Strategic Management Team (SMT) and the Commissions which were created after the election. Dr. T. Thomas became the Member for Health of the Executive Council (MEC) and Dr. M. Tom the Strategic Manager. The Strategic Management Team had individuals appointed to convene nine important Commissions one of which was Primary Health Care. (The others being emergency services, training, legislation, finance, health information, nutrition, districts, and hospitals). The Primary Health Care Commission with 31 members (Appendix ...) met on ... occasions and was responsible for preparing the first draft of this report for submission to the MEC. During the meetings of the SMT the new structure for the health services in the Eastern Province was developed. Organograms were prepared for the new Provincial Health Department at Bisho and for the 5 sub-provincial (regional) Health Departments at East London (Central), Port Elizabeth (Western), Umtata (Eastern), Queenstown (Northern), Kokstad (North-Eastern). These sub-provincial administrations all have Primary Health Care

Divisions which have similar units to the Provincial Level except that only the sub-provincial level has nutrition.

Map with sub-Provinces

Some of the Important Socio-Economic Indicators of the Eastern Province are given below:

Socio-Economic Indicators (Development Bank of Southern Africa) 1994

- * Area (Km²) 170616
- * Population ('000 1993) 6,665,4
- * Density (persons per Km²) 39.1
- * Functional urbanization (%) 55,4
- * Literacy Rate (% 1991) 59,0
- * Labour force ('000, 1991) 1319
- * Unemployment rate 23,6
- * Male absenteeism rate -31,3
- * Dependency ratio 3,7
- * Nominal GGP (Rm 1988) 13630,0
- * Growth (1980-1988) 2,74
- * Nominal GGP per capita (R) 2317
- * Personal income per capita (R) 1358
- * Life expectancy (1991) 59,6
- * % Live births to women under twenty 13,1
- * % children age 6-14 not in school 9,4
- * Infant Mortality Rate 58,2
- * Total Fertility Rate 4,6
- * Hospital beds per 1000 population 4,6
- * Fixed treatment points 586
- * Total black population non-urban 4,244,143
- * Total black population urban 1,594,515
- * Notifiable conditions per 100,000 population for
 - congenital syphilis 4,79
 - measles 51,72
 - tuberculosis 220,00
 - typhoid 1,71
 - viral hepatitis 2,46
- * % Eastern Region (former Transkei)
 - Under 5 years: 13,6
 - Over 60 years: 8,3

Some data were available separately for 1988-92 for the former Ciskei and Transkei (Uyirwoth and Kustner)

IMR

Ciskei 42 per 1000 live births

Transkei 80 per 1000 live births (1988)

Measles Immunization Coverage

Ciskei 90%

Transkei 60%

Stunting

Ciskei 19.8%

Transkei 25%

Wasting

Ciskei 2.9%
Transkei 3.6%
Underweight
Ciskei 9%
Transkei 25%

Use of ORS for Home Management Diarrhoea

Ciskei 13.4%
Transkei 56.3%

Low Birth Weight

Ciskei 10%
Transkei 10%

1.3 PHILOSOPHY OF PRIMARY HEALTH CARE AND MISSION AND VISION STATEMENT

Principles of Primary Health Care

- Promotion of health and specific protection of the population is important for sustained economic and social development and contributes to the quality of life.
- Equitable, affordable, available, accessible and acceptable health services are a requirement for the effective and efficient rendering of health services in South Africa.

- Primary health care is an integral part of a country's comprehensive health care system and of its social and economic development.
- There is a mutual relationship and interdependency of health, social and economic development. Primary health care forms an integral part of the socio economic development process.
- The involvement in addition to the health sector, of all related aspects of national and community development, in particular education, agriculture, animal husbandry, water, food, housing, works departments, communications and industry and other sectors, and demands the coordination of all those sectors.
- Primary health care must be implemented, maintained, co-ordinated, monitored and evaluated in terms of national policy, strategies and plans of action.
- Emphasis should be on rendering Primary Health Care services at the lowest possible appropriate effective level within regional, magisterial, local authority and community contexts, based on available expertise and local needs.
- The political will and commitment to primary health care must be embodied in legislative, budgetary and organisational structures aimed at the provision of primary health care.

- Primary health care is the nucleus of a comprehensive health system supported by an effective referral system, consultation, training and research at secondary and tertiary level. These secondary and tertiary health services must be maintained in order to ensure support of primary health care.
- Resources must be allocated to communities in an equitable manner with additional allocations for disadvantaged communities.
- Primary health care demands maximal community involvement as well as maximal, informed, responsible personal and non-personal self-care by the individual. It follows a sensitive participative approach and uses simple, practical and understandable methods and procedures.
- Community members have the right and duty to participate in the planning and implementation of their health care both individually and collectively. Community involvement and participation are the cornerstones of primary health care.
- Primary health care and other health related services must be coordinated and managed at local level and with the participation of the community.
- Local political, administrative and social patterns must determine how the planning, execution and control of primary health care programs at grassroots level can take place.
- In determining the priorities for the rendering of health services, the felt and identified needs of the community must also receive consideration.
- Methods and techniques must be acceptable to those using them as well as to those on whom they will be applied.
- Leadership from the community must be identified, recognised and involved.
- A balance must be maintained between national standards and local needs and resources. It is accepted that for integrated service rendering primary health care is a horizontal program but in specific areas there is a need for vertical control and support. Such areas will be identified.

The ANC National Health Plan for South African states as follows:

"Every person has the right to achieve optimal health, and the ANC is committed to the promotion of health using the Primary Health Care Approach as the underlying philosophy for Restructuring the health system. Primary Health Care (PHC) will form an integral part both of the country's health system and of the overall social and economic development of the community. Central to the PHC approach is full

community participation in the planning, provision, control and monitoring of services. Democratically

elected representatives will play a major role in the structure of the health services.

.... The ANC is committed to the promotion of health through prevention and education.

.... It aims to reduce inequalities in access to health services, especially in the rural areas and deprived communities."

The Eastern Region of the Province had the following mission statement:

"The Eastern Province is committed to the pursuit of the WHO Goal as defined in 1977 namely the attainment of health, i.e. the best possible physical, mental, and social well-being, by all people by the year 2000 and further commits itself to strengthen the Primary Health Care approach as propagated at Alma Ata in 1978."

In the Reconstruction and Development Programme the need for reorientation to Primary Health Care is included and it emphasises that the central tenets of PHC philosophy need stressing - prevention and appropriate curative care, intersectoral involvement in health, community participation and social justice.

The Eastern Province Mission Statement follows:

MISSION AND VISION

To achieve the highest state of health, social well being and development for the people of the Province of the Eastern Cape. To Promote the health of all South Africans and to create and support a caring, efficient, comprehensive national health system that involves and serves all individuals and communities in an equitable manner through a Primary Health Carte Approach using professional and scientific means.

1. HEALTH VISION

Equity

The health of people of the Province of Eastern Cape will be secured and improved mainly through the achievement of equitable social and economic development such as the level of employment, the standards of education, and the provision of housing, clean water, sanitation and electricity. In addition, reduction in the levels of

violence and malnutrition, and promotion of healthy lifestyles should be addressed, as well as the provision of accessible health care services.

Right to Health

Every person has the right to achieve optimal health, and it is the responsibility of the state to provide the conditions to achieve this. Health and health care, like other social services, and particularly where they serve women and children, must not be allowed to suffer due to debts owed by the province to the national government.

Primary Health Care Approach

The Department is committed to the promotion of health through prevention and education. The Primary Health Care approach is the philosophy for the restructuring of the health system. It aims to reduce inequalities in access to health services, especially in the rural areas and deprived communities.

Part of National Health System

The Health Department of the Eastern Cape Province will be part of a single comprehensive, equitable and integrated National Health System. All existing public sector departments of health (Ciskei, Transkei, DNHPD, and CPA) including local authority, military and prison services will be integrated into a Provincial Health System which will be second tier authority to the NHS. All racial, ethnic, tribal and gender discrimination will be eradicated. Both public and private health providers will operate within a common framework that will encourage efficiency and high quality care.

Co-ordination and Decentralisation

The provision of health care will be co-ordinated among local and district authorities. Authority over, responsibility for, and control over funds will be decentralised to the lowest level possible that is compatible with national planning, and the maintenance of good quality care. Clinics, health centres, independent practitioners, community health workers and villages will be the main points of first contact with the health system. Once a national policy integrating traditional healers has been accepted, these practitioners will be another first contact with the health system. Rural health services will be made accessible with particular attention given to improving transport.

Priorities

Health services will be planned and regulated to ensure that resources are rationally and effectively used, to make

basic health care available to all the people of the Province giving priority to the most vulnerable groups. Maternal and Child care, the protection of the environment, services in the rural areas, women's health and the care of the disabled will be prioritised. Appropriate services to adolescents and to young adults will be a focus on the prevention and control of major risk factors and diseases, especially AIDS, tuberculosis, measles, gastro-intestinal disease, and common cancers.

Promotion of Health

Attention will also be given to health education on sexuality, child spacing, oral health, substance abuse, environmental and occupational health. Health workers at all levels will promote general health and encourage healthy life styles. The government will also seek to establish appropriate mechanisms that will lead to the integration of traditional and other complementary healers into the health system.

Respect for All

Within the health system health workers must respect the right of all people to be treated with dignity and respect. A Charter of Patients' Rights will be introduced. Furthermore, individuals, interest groups and communities have the right to participate in the process of formulating and implementing health policy.

Health Information System

Appropriate and reliable data will be systematically collected and analyzed as part of a comprehensive health information system essential for the Provincial Health planning and management purposes. It will also allow for promotion of relevant research to address the most important health problems of the community. The public and private sectors will be required to collect and submit relevant data in order to facilitate planning at local, provincial and national levels. The health information system of the Provincial Health System will thus gather universal, opportune, reliable, simple and action oriented types of data to inform the entire system and increase its effectiveness.

Reconstruction and Development Programme

The priorities of the Reconstruction and Development Programme will take precedence in our programmes.

Glossary of Terms used in Primary Health Care

Health

Health refers to the physical, mental and social well-being of people and includes the influence of the environment on health.

Primary Health Care

Primary Health Care is essential health care based on scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health systems, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where the people live and work and constitutes the first element of a continuing health care process.

The key words are defined as follows:

Accessibility

The continuing and organised supply of an equitable level of health care that is within easy reach of all citizens geographically, functionally, financially and culturally.

Geographical accessibility means that the distance, travelling time and means of transport must be acceptable to the community.

Financial accessibility means that these services can be afforded by the community and the State.

Functional accessibility means that the appropriate type of care is made available to those individuals who need it when necessary.

Affordability

A level of health care which the community and authorities can afford.

Equity

The absence of subgroup variability and discrepancy.

Acceptability

A level of health care which is acceptable to the community and health worker.

Availability

Services must be readily available to members of the community.

Effectiveness

It is the extent to which a specific intervention, procedure, regimen, or service when deployed in the field, does what it is intended to do for a defined population.

Efficiency

The end results achieved in relation to the effort expended in terms of money, resources and time. The extent to which the resources used to provide a specific intervention procedure, regimen or service of known efficacy and effectiveness are minimised. It is therefore a measure of the economy (or cost in resources) with which a procedure of known efficacy and effectiveness is carried out.

1.4 CONCEPTUAL FRAMEWORK

Primary Health Care must be accessible, acceptable, affordable and appropriate and thus must be available at community level and be well managed. Skilled staff, equipment and drugs must be available at different levels even for the most complex conditions made possible through a process of referral. The levels of administration higher up the scale towards National level must all support the more numerous small hospitals, health centres, clinics and community-based activities which become the focal point of the health system. Primary Health Care is an approach, a system and not only a level of first contact for care. In the Eastern Cape Province, oriented to PHC, all services will be geared to support the periphery through referral, technical support, supervision, training, involvement of other sectors. The hospitals in Eastern Cape Province will have a big role to play in PHC although the Health Centres and Clinics will be more important because of their greater number and accessibility to the bulk of the population and hence greater overall utilization.

The levels of service provision, management and supervision of PHC, community involvement, intersectoral linkage, facilities and staff for service provision can be shown in the following diagram.

The activities in the essential PHC package will include identification of the proportion of cases for referral to more distant, more skilled more costly management at various levels. The proportion of cases seen at community level who reach quaternary care is represented diagrammatically. The district health system is the area within which PHC is implemented whilst sub-provincial and Provincial levels provide support and referral facilities.

LEVEL OF SERVICE PROVISION, FACILITIES, PERSONNEL	MANAGEMENT AND ADMINISTRATION	LINKAGE TO COMMUNITY AND OTHER SECTIONS
<u>COMMUNITY-BASED HEALTH CARE.</u> <u>SELF CARE. HEALTH POSTS, MOBILE STATIONS SATELLITE POSTS. NURSES HOME VISITS.</u> CHW, TBA, Trad Practitioners, Private Practitioners	Residents Association SANCO Health Section Community Group	Local Health Forum Local Development Committee NGOS. NPPHC
<u>HEALTH CENTRES CLINICS</u> <u>COMPREHENSIVE PHC</u> Professional PHC Nurses Enrolled Nurses Part Time doctors Lab. Assistant Driver	Health Committee PHC Management Team Visiting District Health Management Team	Community Health Forum Health Centre Advisory Committee
<u>DISTRICT SUBSTRUCTURE</u> <u>COMMUNITY HOSPITAL FIRST LEVEL</u> <u>REFERRAL HOSPITAL "WARD HOSPITAL"</u> General duty doctors Professional Nurses Lab. Technologist Radiographer	District Council Health Unit Health Management Team	Development Committee with PHC Sub-Committee Advisory Committee to Hospital
<u>SUBPROVINCIAL OR REGIONAL HOSPITAL</u> Second Level Referral Hospital Some specialists	Sub-Provincial Regional Health Dept. PHC Unit.	Development Committee PHC Sub-Committee Advisory Committee
<u>PROVINCIAL HOSPITAL</u> Third Level Referral Hospital All Specialists	Provincial Health Department PHC Division	Development Committee PHC Sub-Committee Advisory Committee

<u>ACADEMIC</u> <u>QUATERNARY</u> <u>HOSPITAL</u> Super Specialists	National Health	
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In this framework note that the biggest and most important part are the top two sections for the community which forms the focal point of PHC. The other levels below are to support the community by providing for referral, training, supplies, supervision.

Accessibility, affordability, acceptability, and appropriateness are the key words in the provision of PHC.

The important parts of the infrastructure for PHC are:

- Accessible facilities
- Suitably trained Staff
- A functional rapid referral system
- Supply and logistics
- Training and continuing education for human resources
- An administrative and management system
- Linkage with the community
- Coordination with other sectors and development activities
- A good health information system
- Demographic data to allow for a population-based and not a facility based system.

The comprehensive package of essential health care consists of:

PERSONAL SERVICES

- Maternal Child and Womens Health Services
- Communicable Disease control and management
- Diagnosis (including basic laboratory service) and treatment of diseases and injuries
- Health promotion, information, education and communication
- Food and Nutrition
- Immunization
- Mental Health
- Oral Health
- Rehabilitation
- Care of the aged
- Occupational Health

NON PERSONAL

- Water and Sanitation
- Refuse removal
- Healthy housing
- Pollution Control
- Vector Control
- Food Hygiene
- Occupational Health
- Information System and Epidemiological Analysis

1.5 THE RECONSTRUCTION AND DEVELOPMENT PROGRAMME HEALTH PRIORITIES

The 23 priorities for Health are listed as follows:

Restructuring and Shifting Resources

1. Fragmentation
2. Community Participation
3. Rural Health Services
4. Curative emphasis
5. Human Resource Development
6. Traditional Healers
7. Emergency Health Services.

Nutrition

8. Undernutrition

Maternal and Child Health

9. Preventive and Promotive Services for Children
10. Reproductive Health
11. Reproductive Rights

Specific Diseases and Conditions

12. Sexually transmitted diseases and HIV/AIDS
13. Chronic Diseases
14. Care of the Aged
15. Disability
16. Mental Health
17. Substance abuse
18. Occupational Health
19. Adolescent Health

Drug and Technology Policies

20. Drug Policy
21. Technology Policy

Information and Research

22. Health Information Systems
23. Health Research

Important determinants of health such as development, poverty, housing, employment, education, water and sanitation need emphasis on intersectoral cooperation.

In the programme document these problems are elaborated with a problem statement, description of the nature and extent of the problem, objective and interventions. The direction, emphases and spirit of the Reconstruction and Development Programme need to be the basis for the Primary Health Care Programme in the Eastern Province.

1.6 THE PRIORITIES OF THE EASTERN CAPE PROVINCE

1. A comprehensive situation analysis
2. Unification of Fragmented Health Services
3. Increased access to:
 - safe water
 - health services/centres
 - sanitation
 - emergency services
 - essential drugs and immunization
 - telecommunication
 - transport/logistics
 - electrification
4. Improved Rural Health - both human resources and material resources to be increased: new clinics and services.
5. Implementation of a Comprehensive Primary Health Service within a District Health System.
 - Advisory boards and councils
 - Shift from curative to comprehensive
 - To include treatment of chronic disease, rehabilitation and care of the aged.
 - Integration of mental health services into PHC.
6. Implementation of a uniform Health Information System.
7. Community involvement
8. Improved nutrition of 0-5 years
9. Control of STD/HIV/AIDS, TB, Typhoid, Measles
10. Entrench the Bill of Rights of Clients/Patients
11. Maternal and Child Health to include also nutrition, reproductive health, school health and genetic services.
12. Health promotion
13. Environmental health
14. Occupational health
15. Oral Health
16. Injuries.

1.7 ROLE OF GOVERNMENT REGARDING PHC AT DIFFERENT LEVELS

The Health functions of the Central Department and in the Province have included the following:
(Only those immediately supportive of PHC have been shown here)

- 1.7.1. **National Department of Health**
 - * Promoting of health, healthy lifestyles and healthy policies;

- * Ensuring the promotion of community participation in the planning, provision and evaluation of health services;
- * Determining and issuing of norms and standards for, inter alia:
 - Nutritional intervention;
 - Environmental conditions;
 - Provision of health services, including social, physical and mental health care;
 - Genetic services;
 - Training of medical, dental, nursing and other auxiliary health staff;
- * Identifying national health goals and priorities and ensure the monitoring of progress in their implementation;

- * Participating in the equitable allocation of financial resources through the development of formulae and other methods;
- * Planning, developing and regulating human resources for health care and health professions;
- * Developing and maintaining a National Health Information System;
- * Ensuring the provision of services for the control of communicable diseases;
- * Ensuring the provision of Occupational Health Services.

1.7.1

Provincial Departments of Health:

- ** Ensuring the provision of comprehensive primary health care services;
- * Ensuring the provision of community hospital services;
- * Ensuring the provision of regional hospital services;
- * Ensuring appropriate human resources management and development;
- * Ensuring the rendering and co-ordination of medical emergency services;
- * Ensuring the planning and management of a provincial health information system;
- * Ensuring quality control of all health services and facilities;
- * Formulating and implementing provincial health policy, norms standards and legislation;
- * Ensuring interprovincial and intersectoral co-ordination and collaboration;
- * Ensuring the co-ordination of funding and financial management (budgetary process) for

District Health Authorities (provincial health services);

- * Ensuring the provision of technical and logistical support to District Health Authorities;
- * Ensuring the rendering of specific provincial service programmes, eg. TB programmes;
- * Ensuring the provision of non-personal health services;
- * Ensuring the provision and maintenance of equipment, vehicles and health care facilities;
- * Ensuring the effective consultation regarding health matters at community level;
- * Ensuring the provision of occupational health services;

1.7.3 The Role of the Sub-Provincial Office (Region), District Council:

- Provision of Specialist Services
- Coordinating work of District Sub-structures
- Monitoring District Sub-Structure Services and Expenditure
- Supply from storage depot.
- Liaison with Regional Hospital

1.7.4 The Role of District Health (District Sub-Structure) Office

Control of several community hospitals
Support to Wards
Coordination, Information, Finance, Human resources of wards
Health Systems Research

1.7.5 Role of Ward Level

Community Hospital and Health Centres
Delivery of Comprehensive PHC Supervised by Management Team

1.7.6 Community

Advisory to Health Centres and Clinics managed through Officer in charge
Work with community organisation and other sectors.
Support of Community-based Health Care.

1.7.7 Role of Donors and NGOs

Donors and NGOs are to support government planned activities and can be requested to channel their activities into those areas most in need.

CHAPTER 2: OVERALL PROVINCIAL STRUCTURE

2.1 Administration of PHC and the Linkage with Services

The comprehensive PHC service package of elements of care will be effectively implemented at community level below the hospitals which however will be reoriented to support P.H.C.

There are levels administratively below District Level although all the services comprise part of the District Health System. The envisaged level is Ward level where a ward will be part of the District Substructure and perhaps now equivalent to a Magisterial District. A ward might have a hospital - a subdistrict hospital. (In future with population growth and development of local government the ward may become a district in which case its hospital would become the district hospital).

A ward will have one or more community health centres and several clinics and outreach or mobile clinic activities depending on its demographic features.

The administration of a ward health service will be by a management team attached to one of the health centres or the hospital and this management team will have a designated Ward Health Manager. The management team in turn receive technical support and supervision from the Health Department of the Sub-Provincial (Regional) District

Reproductive health and community-based distribution of
contraceptives
STD/HIV
Training of CHW
Reorganisation of Integrated MCH

2.3 PROFESSIONAL BODIES

The professional bodies of concern to PHC are the:

- * Medical Council
- * Medical Association and separate Associations eg.
Paediatric, Obs/Gyne, Psychiatry
- * Nursing Council
- * Nursing Association ? Midwives Association
- * Pharmacy ? Council
- * Pharmacy Association
- * Environmental Health Officer.
- * Allied professional associations (Physiotherapists
etc)
- * Traditional Healers Association

These bodies have a crucial role in establishing the acceptable levels of training and hence developing curricula supportive of PHC, and can play a role in reorienting professions towards health promotion, prevention and away from an inappropriate high-tech curative orientation. (Scientifically based high technology can however be of great use in PHC but must be within what the province and communities can afford). Professional bodies can also play a important role in assuring the quality of care and the standard of accreditation of health facilities especially those used for training.

2.4 THE DISTRICT LEVEL FOR PHC IN EASTERN CAPE PROVINCE

The formulation of Districts with all sectors operating within a geographical area controlled by a system of Local Government is still being developed. When this is clear it will be possible to develop a District Health System which is defined thus:

"A district health system based on primary health care is a more or less self-contained segment of the National Health System. It comprises first and foremost a well-defined population, living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district whether governmental, social security, non-governmental, private and traditional. A district health system therefore consists of a large variety of interrelated elements that contribute to health and other related sectors. It includes self-care and all health care workers and facilities, up to and including the hospital at the first referral level and the appropriate laboratory, other diagnostic and logistic support services.

Its component elements need to be well-coordinated by an officer assigned to this function in order to draw together all these elements and institutions into a fully comprehensive range of promotive, preventive, curative and rehabilitative health activities".

In the Eastern Cape Province the process of decentralization so essential for PHC started with the following steps and levels shown in a series of maps (with population size).

- STEP 1: Centralization
- FROM: Old map with Ciskei and Transkei
- TO: New map with Bisho as new Provincial Health Department and Organogram 6,000 000 population
- STEP 2: Decentralization
- TO: New District Councils or Sub Province or Regions (4 ? 5) population 1,500 000 Decentralization especially of specialist referral levels as well as administrative functions. Administrative decentralization Organogram
- STEP 3: Further decentralization to sub structures population about 500,000 Map of District Sub Structures (Large areas some equivalent to old Regional Services Councils and with many old magisterial districts) Hospitals
- STEP 4: Map showing wards (? old magisterial districts) Health Centres, some with hospitals population about 50 000
- STEP 5: Community Level - Health Centres/Clinics
- STEP 6: Neighbourhood and Community-based Health Care

As mentioned in the definition the appointment of an officer to coordinate the district is essential and this person must have management and epidemiology skills.

The "District" at present is probably the District Sub-Structure which will have a larger hospital designated as the District Hospital and probably one or more smaller Hospitals. There will be many health centres, clinics and one or more mobile clinics visiting many posts or satellite clinics (which use buildings not designed as clinics). Private practitioners and traditional healers will be brought into the system by the efforts of the District Health Officer and District Health Management Team (DHMT). The structures within this "District Sub-Structure" with a population of about 400 000 will be:

A District Sub-Structure Development Committee falling under the District Authority. There will be several Community Hospitals perhaps one with essential specialists.

There will probably be 16 of these areas each will have about 9-22 health wards with population of about 50 000.

As population grows and local government become stronger at lower levels it might well be that the ward becomes the future District just as the District Sub-Structure is closer to the concept of a District at present.

At each level there will be:

- Some form of Development Committee which links the different sectors for planning and resource allocation.
- An advisory Council/Committee to establish Community Involvement
- Management Team and Administration separate from the clinical services such as the hospital, but which will have authority over the hospital.

The important infrastructure elements of PHC at the District level are:

- Accessible health facilities
- Referral mechanisms between facilities to enable patients to move to higher levels of skill when needed.
- A logistic system for procuring, delivery, storing of supplies and equipment and for maintaining communication between levels.
- Demographic knowledge and a health information system that can establish rates and differentials in rates between areas or populations.
- Health personnel, appropriately trained and with a method of continuing education and supervision.
- Administration, planning and financing - as a team
- Health Systems Research to improve quality and availability of Services.
- Structures for ensuring intersectoral coordination
- Structure for ensuring community involvement.

2.5 THE REFERRAL SYSTEM

Referral implies that a patient is sent from one health unit or person or level to another which is better able to diagnose or manage the condition.

Within a district referral is usually from a clinic or health centre to the hospital. However referral can start with a community-based health worker or TBA to the health centre and then to the hospital.

Free health care will be given to all under 6 children and pregnant women (See Annexa on Gazetted instruction) at the Primary level of Government/Public Clinic, Mobile or Health

Centre and at the Public Hospital level if referred. By-passing referral and going straight to a hospital will be charged unless an emergency, or certified indigent by a District Surgeon.

Referral is usually for diagnostic or management purposes and within a District:

Laboratory Facilities are available as follows:

- Clinic and Mobile - Urine dipsticks
Collection of sputum only
 - Health Centre - Laboratory with Laboratory Assistant able to do:
 - RPR test for syphilis
 - Stool microscopy
 - Sputum microscopy
 - Haemoglobin WBC. S.R.
 - Urinalysis
 - District Hospital
Laboratory with Technologist and Assistant able to do
 - all basic hospital tests
 - HIV
 - Sub-Provincial Regional Hospital
 - All tests
 - Microbiology and sensitivity
 - Provincial - Full range all procedures
- X RAY:** Health Centre: Fractures
Chest
- Hospitals: Most Routine X Rays
 - Province - All specialized procedures and scans

The level of skill/expertise which determines referrals is as follows:

- Clinic - PHC Nurse or Enrolled Nurses
- Mobile/Health Centre - PHC Nurses Some specialized in Paediatrics, Obstetrics, Mental Health
- Visiting Doctor

- 1st Level Hospital
 - General Duty Doctors
 - Professional Nurses/Midwives
 - Pharmacist
 - Physiotherapist
 - Radiographer
 - Lab. Technologist
 - Hospital Superintendent and Administrator
 - Visiting Specialists
- 2nd Level Hospital - Some Specialists
Better diagnostic facilities
- 3rd Level Provincial Hospital - All specialists
All allied professionals
All diagnostic equipment
- 4th Level Quaternary Hospital - Super Specialists
(Academic Hospitals) Transplants

Not in Province - these services purchased from other Provinces.

Special Hospitals - Psychiatry
Tuberculosis
(Military and Prison)
Special Facilities - Safe houses for battered women
Hospices for terminal care

Referral is not only done up a hierarchical ladder but also in reverse where it might consist of feedback on a patients condition - or it might be referral back for follow-up, long term or home care.

Emergency Referral

PHC requires easy access to Communication and Transport facilities. These include

Communication: Radio links - solar power if no electricity
Telephones

Fax

Post

Transport: Fully equipped ambulances and trained staff

Intersectoral Links: Links with Post Office

Police

Works

Private business

NGOs

CHAPTER 3: ESSENTIAL PHC PACKAGE

3.1 ACCESS

It is clear that more Health Centres and Clinics will have to be established in rural areas especially those at present undeserved with all services including education, roads, housing, police. Incentives for staff to serve in these ~~are~~ will have to be considered. Good housing, water and sanitation, electricity will have to be provided.

Access is not only needed to essential basic services, but for those in special need accessibility to referral services will also be important. A health centre which can only provide for normal delivery will have to have an ambulance and a community hospital within reach which can provide services such as a caesarean section. Accessibility must be to a range of resources such as essential drugs, laboratory and diagnostic service and higher levels of technical skill.

Access is bound up with equity. If access is not equitable in different regions or districts it will be shown also by differentials in mortality rates, morbidity rates, EPI coverage, TB incidence.

Goal:

To make comprehensive Primary Health Care services accessible within reasonable distance from where people live and work .

Strategy:

Comprehensive package of care available at every facility.

Build fixed clinics

Satellite clinics

Outreach/Mobile clinic

Community Health Workers

Self-reliance

Improved Transport: Intersectoral Collaboration

Roads, Transport, Rivers, Works Department

Activities:

- Assessment of population, distribution, density and existing facilities.
- Situation Analysis (with maps, health units and population density) to pinpoint areas with poor access. Decide most urgent needs and prioritize
- Catchment areas to be defined round all facilities using geographical information.
- Planning at local level according to local needs, and community assessment
- Broad policy guidelines from National/Provincial level to be put into practice at Sub-Provincial level.
- Community involvement to identify need and location of fixed/mobile clinics.
- Prioritising of facilities within budget and Local Authority.
- Proper allocation of budget for each section e.g. transport, medication.
- Review of nursing norm and population coverage of each clinic based on correct census figure.
- In each District review access in relation to fixed facilities and mobile clinics, ensure referral from

clinic/health centres/community hospital and referral hospital.

Resources:

Planning Unit to establish Provincial Guidelines and co-ordinate building of all health facilities.
Sub Provincial Planning Unit
District Planning Units

Evaluation:

Survey of patients expenditure on travel and time taken.
Mapping (Jan 1995 and Dec 1995) with 5km circles drawn round facilities plus population density.
Shift of resources from urban to rural areas to establish equity.
Qualitative assessment of community satisfaction with accessibility.

Indicators:

- Distribution of Budget: % Shift to rural areas
- % of population within 5km and 10km of Primary Health Care Service.
- % facilities with trained PHC nurses
- Ratio population: trained PHC nurses and to advanced trained midwives

Time Frame:

In RDP some of the priorities will be addressed +/- 2 years.
Effort to improve access in Transkei visible by end 1995.

3.2 INTERSECTORAL COLLABORATION

In addition to the health sector all related sectors and aspects of community development (i.e. agriculture, food, industry, education, housing, public works, communications and others) have a role in achieving Health for All.

Goals:

To establish linkages and partnerships with all related sectors.
To get health on the agenda of other sectors.
To obtain use of all resources for health.
To set up structures which facilitate collaboration and co-ordination.

Strategy:

To get consensus on the health contributions of other sectors. (the role they can play in health care).
To set up structures for collaboration and co-ordination at all levels, i.e. Provincial, sub-provincial, district, sub-district and local level.

To establish Provincial district, and sub-district development committees, with subcommittees for PHC
To ensure use of resources for health in other sectors which will complement those of health sector.

Activities:

- To have multi-sectoral Primary Health Care workshops at provincial and district level with the different sectors to try and break down barriers and facilitate co-ordination.
- To train facilitators for the process from different sectors.
- To orientate all health workers to the intersectoral approach.
- To establish health input in planning meetings of the other sectors.
- Linkages with agricultural sector in relationship to nutrition.
- Linkages with education sector on development of children.
- Linkages with commercial sector on health needs of community.
- Linkages with information sectors, i.e. media.
- Linkages with public works and road sectors to establish access to facilities and to maintain facilities.
- Linkages with safety and security sectors.
- Meetings to be more multisectoral to facilitate effective utilisation of meetings.

Resources:

Emphasize the resources of other sectors in relation to health.

Develop health interest and strengthen capacity of workers in other sectors i.e. agriculture, education.

Use farmers as resources.

Use peer educators from other sectors.

Spaza's, taxi's, transport services.

Mass media, TV, radio, jingles produced by other sectors.

Free air time for health messages.

Time Frame:

One Multi-sector Primary Health Care Workshop in January 1994.

Plan 5 sub-regional multisectoral workshops in early 1995.

Evaluation:

Evaluation of Primary Health Care processes by end of 1995.
KAP studies with other sectors.

Indicators:

Existence of some multisectoral committees on the different levels.

3.3 COMMUNITY INVOLVEMENT

Goal:

To make community participation the basis of Primary Health Care Services.

To have all communities involved in health through a process of empowerment.

Strategies:

Peoples participatory planning in action.

To establish health advisory councils at all levels.

Activities:

- Needs assessment with community involvement.
- Analysis of problems and how they can be solved.
- Actions to be followed to solve problems.
- Building up, and training more of communities own resource persons.
- Training of facilitators and trainers in community participation.
- Adapting curriculum of formal training programmes to include community participation strategies.
- To continue discussions on role of CHW, and methods of reward and ways of providing incentives.

Resources:

Community leadership

Community mobilised

N.G.O.'s who are already trained.

Time Frame:

Continuous process to beyond 2000.

Evaluation:

Needs assessment with community involvement completed.

Leadership and organisational structure emerging.

Resource mobilisation.

Harmonious management evident.

Indicators:

Number of health advisory council's established and functioning at different levels.

Number of Health Clinics built with community involvement as measured by needs assessment, leadership, resource mobilisation.

3.4 HEALTH PROMOTION; INFORMATION, EDUCATION COMMUNICATION (IEC), MARKETING/SOCIAL MOBILIZATION; HEALTH EDUCATION

Introduction

In the past health education was a topdown process with limited community involvement and little evaluation. The priority is to change from mere information giving to a more comprehensive approach including that outlined in the

Ottawa Charter for Health Promotion and the processes included in Social Mobilisation.

THE OTTAWA CHARTER

defined health promotion as the process of enabling people to increase control over and to improve their health - it is not just the responsibility of the health sector but goes beyond healthy life-styles to well being. Health promotion requires making conditions favourable for health through **ADVOCACY** and by reducing differences in health status and ensuring equal opportunities and resources it **ENABLES** people to achieve their full health potential. Health promotion requires coordinated action by many organisations and sectors and there is a need to **MEDIATE** between different interests to achieve health.

The Charter listed 5 areas for action:

- Build health public policy and supportive legislation
- All sectors to be politically accountable for effects on health
- Create a health supportive environment (physical, social, cultural environment)
- Develop personal skills by improving health knowledge and developing personal and social capacity and life skills
- Strengthen community action - participation in defining priorities, making decisions and implementing strategies
- Reorientation of health services to participate in above activities and refocus planning and resources to recognise and deal with underlying causes of ill health.

The National Health Plan for South Africa stresses that Health promotion is central to the success of PHC Health Promotion's role includes:

- responsibility for community participation
- Community development
- Intersectoral development
- Education
- Mass media campaigns
- Disease prevention and health promotion for womens health, HIV/AIDS, Adolescent health

The Provincial level will develop research and provide for training at Regional and District levels. District levels will assist training of community workers if communities request it and will help implementation of a school health programme.

Previously the National Department of Health had marketing activities for health interventions but these were not available in the Eastern region.

Three activities are involve in Social Mobilization and these have been defined by Neill McKee as:

"**Advocacy** consists of the organization of information into argument to be communicated through various interpersonal and media channels with a view to gaining political and social leadership acceptance and preparing a society for a particular development programme.

Social mobilization is the process of bringing together all feasible and practical inter-sectoral social allies to raise people's awareness of and demand for a particular development programme, to assist in the delivery of resources and services and to strengthen community participation for sustainability and self-reliance.

Programme communication is the process of identifying, segmenting and targeting specific groups/audiences with particular strategies, messages or training programmes through various mass media and interpersonal channels, traditional and non-traditional."*

* (Social Mobilization and Social Marketing in Developing Communities - Lessons for Communicators - Neill McKee Southbound Penang 2nd Edition 1993).

The essence of these approaches is that they must be multidisciplinary, intersectoral and involve communities, and that through a range of activities and enabling conditions they influence and change ideas, concepts, attitudes and behaviour conducive to improved health.

GOALS

- To Achieve behavioral and lifestyle changes that lead to health promotion, disease prevention and better use of services when needed.
- Provide opportunities for people to learn how to identify and analyze health and health-related problems, and how to set their own targets;
- Make health and health-related information easily accessible to the community, including information on practical, effective, safe and economical ways of attaining good health and of coping with disease and disability;
- Assist people to develop alternative solutions for solving the health and health-related problems they have identified;
- Create awareness of the importance of effective communication in fostering mutual understanding and support between the people and the health care providers;

- Stimulate communities to set priorities among the different health problems they have identified

Existing Policies

Written policies were received from the Local Authority, Department of National Health and Population Development and the Cape Provincial Administration. Verbal reports were given by the members from the Transkei, Ciskei and Drakensberg areas which were extracted from the existing policies and experience.

The Department of National Health and Population Development has a clear policy based on the OTTAWA

CHARTER, CPA and the Local Authority have small fragmented policies.

Assessment of Existing Health Promotion Policies

- Emphasis is on top down education and fragmented services.
- Limited community participation or involvement.
- Attempts for health promotion were made but of a limited scale.
- Department of National Health's action doubtful in terms of implementation although they worked according to the OTTAWA CHARTER.
- The Department of Health kept information to themselves.
- No self-reliance of the people and self determination.
- Feeble attempts at mediating for co-ordinated approach mostly ending up as lip service, never got off the ground.
- Developing skills to a certain extent but with problems of not covering the whole population.
- Health Promotion conference in OTTAWA excluded South Africa and other underdeveloped countries but concentrated on industrialised countries.
- No focus on achieving equity in health.
- Resources limited to cities and no equity either.
- No co-ordinated effort because of fragmentation.
- It is significant that the ANC policy has taken points from the OTTAWA CHARTER, it is now the duty of the service providers to implement and evaluate continuously.

Priorities for Change:

- Re-orientate outlook of health policy from being information giving to inclusiveness of OTTAWA CHARTER concepts e.g. advocate, enable, mediate.

- Do away with fragmentation so as to ensure equity of resource allocation and enable effective implementation.
- Emphasis must be on comprehensive collaborative and co-ordinated approach.
- Curriculum review in order to effect changes in professional education and training.
- Re-train existing staff in participative group methods.
- Specific objectives can be developed for desired behaviour - use of condoms, contraceptive use, early rehydration in diarrhoea, not starting or stopping smoking and use of drugs.

Aim:

- To establish Health Promotion/IEC/Health Learning Material Unit at provincial level which will enable and support Regions and Districts to develop health promotion activities.

Strategies

Community involvement in health
 Ensure intersectoral approach through workshops, meetings, development committees
 The use of mass media (Radio and Television)
 To investigate efficiency/effectiveness of health learning materials (HLM) by pre-testing material and assessing if culturally acceptable and effective.
 To use more participative methods in health education i.e. starter posters, stories, slides, plays depicting a problem which will lead to discussion and community analysing own problem and developing solutions.
 Peer group education and activities
 Child to child programmes
 School-to-community programmes.

Activities and Time Frame

- As the first step adopt the OTTAWA CHARTER in its entirety.
- Advocacy at Provincial Level for good health as a major resource for social, economic and personal development and an important dimension of quality of life. Aim at making the political, environmental, behavioural and biological factors favourable for health.
- Train staff in participative group methods, and adult education techniques
- Develop material in appropriate languages
- Re-orientation of health personnel to concept of health promotion

Time Frame of Important Activities

- Look at National guidelines for I.E.C. on health promotion - as soon as possible.

- Establish unit at provincial level to bring together media and communication specialists to work for health - March 1995
- Liaise with human resources commission about a multisectoral workshop in February 1995 including government departments, non-governmental organisations, professional bodies, Health and Info systems, to:
 - * Look at national guidelines for health promotion.
 - * Adopt the Ottawa Charter in its entirety at least for the present, later review.
 - * See to the establishment of I.E.C. Unit at provincial level.
 - * Ensure intersectoral collaboration.
 - * Use mass media (Radio and television).
- Re-train staff in participative group methods, and concept of health promotion - early 1995.
- Liaise with human resources regarding appropriate training at colleges, universities and technikons - January 1995
- Develop material in appropriate languages - as soon as possible.
- Networking with other regions and between regions and provinces - beginning of 1995.

Resources

University of Transkei/Fort Hare
 Mass media- Radio and television - Rhodes University
 Health educators trained at diploma level - all districts
 Health educators trained at auxiliary level - all health centres.
 Equipment: slides, generators etc. Obtain an inventory of equipment available and redistribute as necessary.

Evaluation

KAP/behaviour studies in communities June 1995 and June 1997
 Acceptability and availability studies.
 Research by groups in academic institutions.

Indicators

% of health material that has been pre-tested
 Other indicators related to topic - eg. topics in "Facts for Life"
 Use indicators for specific activities/goals where IEC is a main strategy.



Introduction

Maternal health is defined for this programme as including all aspects of health care of a women from conception until her last child is 5 years old. This is because the mother-child dyad is an important concept for clinical work, and the nurturing and care provided by the mother in her maternal role is very important for the child and the integrity of the family.

The more usual definition of maternal health pertains to a state of complete physical mental and social well-being and not merely the absence of disease or infirmity of women during pregnancy, child birth and the postnatal period - perhaps up to one year.

Womens health relates to any matter which affects the health of women exclusively, that impacts predominantly on women differently from that of men.

Reproductive health also involves the WHO definition of health but addresses the reproductive processes, functions, and system at all stages of life. It implies people are able to have responsible satisfying and safe sex lives and can reproduce and have the freedom to decide if, when, and how often, to do so. It includes both women and men.

Child health includes for this programme the following age groups:

Infants: Under 1

Adolescents: persons aged 10-19 (two important sub-groups 10-15/16-19)

Child: person up to the age of 18

Youth: persons aged 15-24 (when "youth group" are mentioned)

Child is also more conveniently divided into 1-3, 3-5

Primary school

Secondary School

Mission:

- To ensure that accessible, appropriate, affordable comprehensive primary health care services are delivered to all **children** with dignity and compassion. Should secondary or quaternary care be needed all children should have easy access to it.
- To ensure the provision of safe **maternal** comprehensive Primary Health Care services that are accessible, affordable and appropriate. Provision must be made for the referral to an appropriate level if necessary.
- To ensure that reproductive health care is available for all **women**, and that women as heads of a very large

proportion of households are ensured a state of health which enables them to live a socially and economically rewarding life.

The **Provinces Vision** is that all pregnant women and children have ready access to Comprehensive Primary Health Care services with balanced attention to prevention, education, early detection and primary care. Immediate referral to whatever level of care is needed. The Population Development and R.D.P. programmes should succeed in improving standards and quality of living.

NOTE: As maternal and Child health is so important and large a part of PHC it is dealt with in two ways in these guidelines. A separate annexe reviews MCH activities as needed at different levels and different health units of the referral chain.

3.5.1

MATERNAL CARE

Goals and Objectives:

- Reduce maternal mortality rate.
- Reduce maternal morbidity rate.
- 90% of women to attend ANC.
- 90% of women delivered by trained attendant or supervised delivery in hygienic conditions.
- Access to Genetic Counselling Services.
- Maternity benefits during pregnancy in all industries, and all pregnant workers.
- Hospitals: "Baby and family friendly Initiative" in all hospitals by end 1995.
- Tetanus toxoid for all women of reproductive age and attending antenatal services.

Strategies:

- Ante-Natal and post natal care at all points of service delivery.
- Maternal beds to be available at all Health Centres and clinics on a 24 hour basis (For use of TBA/trained midwife in clinics).
- Training of TBA and CHW in identifying high risk for referral and in Community organised waiting house at Health Centres.
- Improved communication: telephone/radio.
- Improve legislation and working conditions - B/F facilities at workplace, child care facilities.
- Improve transport/ambulance services.
- Ensure staff security and improved living condition - restrooms and meals, for extended clinic hours and night service.

Reduce delay within home of recognition of problem/emergency, and reduce delay in referral and in obtaining rapid care within hospital. Include Genetic Counselling as part of clinic services.

Activities:

- Establish MCH committees to assist the development of Maternal and Child Care.
- Immunise all pregnant women against tetanus.
- Rationalisation of ambulance services.
- Investigate community based transport system.
- Caesarean Sections possible at District Hospital Level.
- Investigate and standardise patient kept Ante Natal Care cards.
- Compile essential drug lists for Ante Natal Care and also list to provide to TBA.
- Cost analysis of extended facilities for 24 hours services.
- Ensuring water and electricity to all health facilities.
- Laboratory facilities to be improved - RPR test for syphilis and HIV and TB tests to be available at all Health Centres.

Resources:

Minimum requirements provided to TBA's, but TBA training only if District Health System with referral in place.

Essential drugs available in all units.

Improved communication and ambulance services.

Improved staff numbers to allow extended service.

Time Frame:

Least served areas to be brought up to par by end of 1995.

Improve general level of maternity services.

Improved referral/transport/communication by February 1995.

Evaluation:

Rapid evaluation method - surveys in January 1995.

Periodic quality assessment of maternity services.

Review all critical incidents and maternal deaths.

Indicators:

Perinatal mortality.

Maternal morbidity rates

Number of maternal deaths

Low Birth weight
Incidence of Congenital Syphilis
% of Births attended to by trained personnel.
% of Births attended in Hospital and Health Centre.
Mean antenatal attendances per pregnancy.
% Hospitals : Baby Friendly Initiative

3.5.2

REPRODUCTIVE HEALTH SERVICES

Goals and Objectives:

- To facilitate the integration of single purpose family planning clinics into comprehensive Primary Health Care Services.
- To ensure that a comprehensive reproductive health service is available at every service point, integrated into PHC.
- To ensure that all methods for preventing of pregnancies are available at every service point, including the morning after pill.
- To ensure the availability of cervical screening and treatment programme when this becomes National policy.

To improve health care for infertile - and post-menopausal women and ensure a referral service is available when needed.

To enable a woman to take control of her own reproduction.

Improve health and well being of women.

Empowerment of women (against violence, sexual harassment in workplace) with life skills.

Strategy:

To re-orientate and retrain health staff.

I.E.C. : community to know about Family Planning and demand the service.

Increased availability of equipment and service (extended services).

To facilitate laparoscopic sterilization on OPD demand. Mobile theatre unit to facilitate laparoscopic sterilization in rural areas.

Safe abortion available.

Life skills in schools.

Improve male participation in planning families.

Activities:

- Situational analysis in all sub-provincial areas regarding reproductive health services.
- Establish macro-plan to re-orientate nurses and other health workers.
- Develop education programme for service users, including rural women.

- Develop a protocol for screening for cancer available to all women (Breast and cervix) by 1996-1997/
- Re-organization of services to facilitate comprehensive services.
- Establish needs for training and re-orientation of staff.
- Co-operation with legal section re: abortion
- Improve accurate registration of births and deaths.
- To do research into reproductive attitudes.
- Review of school curriculum.
- Review of nurses training school curriculum.
- IEC focused on men.
- Training of community-based distributors of contraceptives.
- Continuing Health Education to change attitudes and beliefs.

Resources:

Estimate for extra staff and resources.
Retraining of staff.
Supplies for community-based distribution

Time Frame:

December 1995

Evaluation:

Evaluation of Life-skills courses
K.A.P. study - health workers and women
Establish a provincial cancer registry.

Indicators:

- Total fertility Rate
- Teenage Pregnancy Rate
- % of Family Planning acceptors in women of reproductive age groups.
- % Facilities providing services daily.
- % Districts with courses on Life Skills for women.

3.5.3

E.P.I.

Introduction:

The Eastern Cape Province aligns itself with the National EPI policy and WHO materials. It is extremely important that an EPI manager be appointed at Provincial level and also a cold chain manager. Each region should also have a cold chain manager so that the cold chain can be improved and standardized in all areas.

International goals to be accepted i.e. 80% full immunization coverage, polio elimination by 1995 and eradication by 1998. Measles reduction 90%

morbidity and 95% mortality by 1995. Virtual elimination of neonatal tetanus by 1995.

Strategies:

Provincial and regional workshops on results, of immunization review and coverage survey.

Increased social mobilisation and communication programme

No missed opportunities (immunise sick babies)

Involve G.P.'s/private sector

Increased access by having daily immunisation clinic.

To standardize road to health cards.

Involvement of community own resource people (CHW, TBA, Traditional practitioners).

Activities:

- Establish EPI Advisory group to Plan EPI for Province with representatives from sub regions.
- Improve cold chain and standardize (including thermometers)
- Training in Knowledge, Attitude and Procedures of health workers.
- Mass campaigns: - eliminate Polio, reduce measles especially in Transkei.
- Follow recommendations of Review team.
- Appoint Cold Chain Manager/Immunisation Manager, at Provincial Level.
- At district/clinic level a person should also accept responsibility for cold chain and immunization.
- Cold chain manager will train people to maintain fridges as well, and will also do Provincial assessment of needs for cold chain improvement.

- Radio programmes, Written material in Xhosa, posters.
- Involve other sectors and social groups.
- Involve private practitioners.
- Improve notification of immunizable diseases, births and deaths.
- Chart immunization coverage in each health unit.
- Workshops on inclusion of new Hepatitis B vaccine.
- Workshop to prepare for Polio mass immunization.
- Special effort to improve coverage in Eastern region of Province.

- Facilitate workshops on all changes and new policies.

Resources:

Provincial Level: Cold chain specialist and EPI Manager, and Epidemiologist.

District Level: Nurse or H.I. with other duties. Local Clinic level, professional nurses.

Need to ensure that cold chain and EPI receive attention, and staff will have received continuing education and written material.

Based on results of survey/review, will need additional resources i.e. vaccines, fridges, equipment, transport, trained human resources.

Improve Health Information system, District Computers.

Evaluation:

% Immunisation coverage - do standardized district level surveys in October 1995.

Reduction in incidence of Whooping cough, Diphtheria, Polio and measles, neonatal tetanus, military tuberculosis and TB meningitis in children.

District: DMT to analyze figures

Indicators:

Disease specific Morbidity - and Mortality figures and as rates for regions.

% Fully immunized by age 1 year.

Time Frame:

By end of 1995.

3.5.4

CHILD HEALTH CARE

Categories

- Neonatal, and under 1 year
- Up to 5 years
- 5-14 Primary School
- Teenage and Secondary School

3.5.4.1 UNDER 1 YEAR (INCLUDING NEONATAL)

Goal:

- To reduce neonatal mortality
- Reduce mortality and morbidity from priority diseases eg. Acute Respiratory Infection and Diarrhoeal Disease
- Improve Nutrition and development. Every child to achieve its potential for growth and development.

- To eliminate micro-nutrient deficiencies (Vit A, Iron, Iodine)
See EPI for goals for immunizable diseases
- To improve the health and development of children.

Strategy:

Good ante natal care, and safe delivery
 Improve care of low birth weight babies
 Breastfeeding.
 Improving Maternal capacity for care.
 Early detection of disabilities.
 Growth monitoring
 Clean water and sanitation.
 Oral Rehydration Therapy - standardisation of messages - use "Facts for Life" - translate into Xhosa - approach UNICEF to publish.

Standardize management of Acute Respiratory Infections (ARI), and Diarrhoea
 Outbreak investigation
 Intersectoral policies for food security.
 Training of staff/communities: ARI, CDD, use of Road to Health card.
 Good logistics and good supplies of essential drugs and equipment.

Activities:

- Health Education to start in Ante Natal period. See MCH strategies and activities.
- Establishing of breastfeeding support groups.
- Policy for B/F at Workplace and in hospitals and declaration from Minister that above should be adhered to.
- Re-orientate and retraining of staff approach to B/F - to emphasize advantages.
- Develop Health Education package (dramatised radio discussions on child care).
- Training nurses in early detection of disabilities i.e. blindness, deafness - by Deafness NGO.
- Identify missed opportunities for immunization.
- Survey facilities for disability and rehabilitation and improve availability of facilities.
- Special training of clinic nurses in paediatric assessment and care.

- Nurses to be trained on WHO packages on diarrhoeal diseases, and ARI.
- Use of Standardised child care cards held by mothers.
- Surveys for height for age, weight for height.
- Community involvement in growth monitoring, especially in second and third years of life.
- Communitys' own resource people to give health education on breastfeeding and oral rehydration.

Resources:

PHC trained professional nurses C.H.W., TBA, Community members.

Time Frame:

By end 1995

Evaluation:

See Communicable Diseases and EPI and Nutrition.

Indicators:

See Communicable Diseases and EPI and Nutrition.

- Neonatal mortality Rate.
- Infant mortality rate.

3.5.4.2 **UP TO 5 YEARS**

Goals:

- Clinics to establish adequate health surveillance of 1-5 years, pre-schools and creches (includes environment, growth monitoring, deworming, booster immunisation) to have an ongoing programme.
- Prevent stunting.
- Detect child abuse early.

Strategy:

- To establish parent - preschool manager-health worker links (parent-teacher association and health worker).
- Training of preschool teachers as CHW.
- Improve nutrition by education, early treatment of infections and supplementation when needed (food and Vit A).

Activities:

- Community-based participatory health education sessions
- Health officer to evaluate the environment.
- Community based growth monitoring.

- Home visits and creche visits by clinic staff.
- Link poor homes with nutrition teams
- ARI and CDD programmes available at all facilities.
- Deworm in areas with Ascaris.

Resources:

PHC Nurses, Creche staff, Parents, CHW

Time Frame:

Every Health Facility to be following up children in this age group by end 1995

Evaluation:

Growth surveys (including height)
KAP of mothers

Indicators:

% Regularly weighed in 2nd and 3rd years life.
% Diarrhoea treated with ORS.
% ARI correctly treated (audit)
Disease specific incidence rates ARI, Diarrhoea
Under 5 Mortality rate
Under 5 morbidity from nutritional def. diseases.
% stunted

3.4.5.3 **PRIMARY SCHOOL**

Goals:

- Improve health and development of all school children.
- To facilitate optimum utilisation of schooling (education).

Strategy:

Emphasize school outreach programmes from clinics and elimination of vertical school nurse programme.

Training school teachers as CHW in Primary Health Care.

Health education to be part of school curriculum. Life skills training to start in primary school (leadership, assertiveness).

Links with school feeding.

Activities:

- Training in child-to-child programmes
- Establish linkages with parent-teacher-pupil-health worker.
- Special arrangements for "big" schools e.g. school nurses.

- Visits by health staff from nearest clinics. (staff assigned to different schools in catchment area)
- Involve other disciplines e.g. child protection and child welfare

Resources:

Retrain prof.nurses in all of the above.
 Standardise equipment and treatment management schedules
 Well equipped mobiles.
 School feeding programme.
 Essential drugs to be available for nurses to take with them to schools.
 Nurses specially trained in school health to assist in orienting other nurses to taking on role of visiting schools in catchment area of clinic or H.C.

Time Frame:

At least to have started by end 1995 in all schools.

Evaluation:

Periodic nutritional surveys
 Vision screening done on all entrants.

Indicators:

% schools with service from nearby H.C. and Clinic.

3.4.5.4 **TEENAGE/ADOLESCENT/SECONDARY SCHOOLS**

Goals:

To improve social and emotional adjustment and wellbeing of teenagers and facilitate healthy development. (includes reducing unwanted pregnancies, and suicides)
 To prevent drug and substance abuse.
 To link, health, secondary education and youth programmes.
 To educate the adolescent on marriage, home care and child rearing.

Strategies:

- Intensify Life skills programmes through other media and social groups (churches, political, sport).
- Intersectoral collaboration with government sectors , NGO and Community based organisations - care for children in difficult circumstances.
- Increased involvement of parents and coordination with social workers.

Activities:

- PHC Nurses to visit schools in catchment areas
- School to community activity
- Continued life skills group discussions - this programme should be developed jointly by teachers, youth and parents and must be sensitive to cultural and religious aspects.
- Training peer group educators on STD/HIV
- Child-to-parent, child-to-child programmes.
- Home visits, especially to children not in schools and with problems.
- Links with social workers.
- Train assistant social workers.
- Training teachers in early recognition of problems.
- Provide contraceptives at schools after community discussion.

Resources:

Develop linkages with other sectors i.e. Social Welfare., Trained Teachers.

Health workers to participate actively in youth programmes.

Improve Transport

Time Frame:

End of 1995.

Evaluation:

- Periodic surveys of unwanted adolescent parenthood.
- KAP of youth.
- Routine notification of STD's and HIV infection by age.
- Data should be disaggregated to different age groups
 - 11-13 early adolescence
 - 14-16 mid adolescence
 - 17-19 late adolescence

Indicators:

Prevalence of unwanted adolescent parenthood

Rates of Alcohol and Drug abuse.

Adolescent Traffic accidents.

Adolescent STD and HIV.

Number of school drop-outs by gender.

Ages/gender of street children.

Number of life skills groups in community in which health staff participated.

% schools with peer-group educators for HIV/AIDS/STD.

3.6 COMMUNICABLE DISEASE CONTROL

Introduction

Communicable diseases are very important causes of mortality and morbidity especially in children and PHC includes emphasis on health promotion and behaviour change, prevention especially immunization, and early diagnosis, treatment and management (which also often interrupts transmission) and rehabilitation when needed.

The immunizable diseases are covered separately in EPI and diagnosis and treatment are described in existing protocols. (Vitamin A should be given to cases of measles).

Surveillance is important and every health unit should map cases of measles, TB, typhoid. Incidence charts (weekly) should be kept of measles, diarrhoea, acute lower respiratory tract infection. Disease notification and recording must be accurate and identification must use official published case definitions and criteria.

In endemic areas Malaria, Schistosomiasis, Intestinal Helminths and Rabies and Trachoma are important but these are not dealt with here. They should have special protocols.

Priorities

- Immunizable Diseases - see EPI
- Tuberculosis
- Diarrhoeal Disease
- Acute respiratory Diseases (Lower - Pneumonia and Bronchiolitis)
- Upper - otitis media
 - streptococcal pharyngitis/Tonsillitis leading to Rheumatic Fever)
- STD/HIV/AIDS
- Typhoid
- Hepatitis
- Meningitis
- Scabies

3.6.1

TUBERCULOSIS

Goal:

To prevent transmission of the disease, and improve control and management of TB.

To implement the National TB Policy.

Aims:

To improve resistance and immunity of the population.

To do early diagnosis and treat effectively.

To decrease the time between symptoms, diagnosis and initiating treatment.

Strategy:

- Identity sputum positive cases: Active and passive case-finding
- Improve community knowledge through health education
- Advocate intersectorally for:
 - Improved housing, nutrition and social development.
- Improve patient compliance with family, employer or school involvement.
- Improve access to drugs i.e. CHW and supervised treatment for outpatients.
- Improve nutrition by emphasising self reliance e.g. vegetable gardens. Education on nutrition.
- BCG for all newborns

Activities:

- District health system must co-ordinate all activities re TB - Should have one person on TB on DHMT - to also keep district register.
- To establish field laboratories.
- Action groups in community.
- Set up facilities for supervised outpatient treatment
- TB to be included in all Ongoing Training programmes.
- TB registers and records to be standardised and computerised at district level to monitor service.
- Arrangement for available separate TB beds at every hospital.
- Training of community based support.
- Community theatre to educate community on demanding sputum examination.
- Monitor EPI programme for BCG.

Resources:

Utilising beds in smaller hospitals but in separate wards
More labs available and lab. staff i.e. lab assistants.
Logistic officer at district level to determine needs in area, moving of supplies.
Packed centralized system for drugs.
Employment of pharmacy assistants at health centre level.

DHMT should have separate pharmacist for district (separate from hospital).

Trained people in community and workplaces for supervised outpatient treatment.

Time Frame:

TB control integrated in PHC by 1995

Evaluation:

Periodic quality of care review
Province to review incidence rate by district.
Number sputa examined monthly by ward.

Indicators:

TB incidence rate.
TB mortality
Multiple Drug Resistance rate.
Defaulter rate.
TB proportional Morbidity rate.
TB incidence in children under 5.

3.6.2

DIARRHOEAL DISEASES

The following written policies are available

- Dept. of National Health
- C.P.A. Policies
- Module 14
- Paediatric Priorities
- Do's and Don'ts in Prescribing

Assessment of existing policy:

- Oral and Intravenous rehydration solution are used in all diarrhoeal diseases. Rehydration procedure carried out according to the degree of dehydration, ranging between oral hydration and intravenous fluids.
- Medical/Drug treatment differs according to the cause. Anti-microbial drugs are used according to the causative organism or health status of the patient.
- Antibiotics are prescribed as well when there is accompanying infection, or special indications.
- Anti-diarrhoeals are discouraged.
- Use of home-made oral rehydration solution is encouraged.

Goal:

To reduce both morbidity and mortality from diarrhoeal diseases.

Objectives:

- To reduce mortality from diarrhoeal diseases by early prevention and treatment of dehydration through oral rehydration.
- To prevent and control outbreaks of diarrhoeal disease such as Cholera and Shigellosis and Salmonellosis.
- To reduce morbidity from diarrhoeal diseases by health education and environmental improvement.

Strategies and Priorities:**Standardise management procedures**

Train mothers, and health workers in oral rehydration ("hands-on-training").

Increase and maintain breast feeding.

Through intersectoral action improve water supplies and sanitation, and food hygiene

Improve hygiene knowledge and practices - starting in home and school

Follow up and control outbreaks - (especially those with a large number of adults involved or those with fever and blood in stools (dysentery))

Activities: (Time Frame)

- Train CHW and mothers in early oral rehydration with home fluids and in the recognition of dehydration (ongoing).
- Train health workers using WHO modules on CDD (March 1995) - a standardized approach.
- Set up an oral rehydration corners in the Health Centres and hospital outpatients.
- IEC on diarrhoeal disease prevention and ORT (as soon as possible).
- Breast Feeding promotion (ongoing)
- Liaise with environmental health officers for improved food hygiene and township hygiene (immediately).
- Advocacy with local authorities for water and sanitation improvement (ongoing).
- Graph diarrhoeal disease incidence in all health units (January 1995).
- Train professional nurses on oral rehydration (with mothers) and insertion of scalp vein sets for intravenous therapy but put emphasis on oral rehydration and teach costs of IV fluid.

Resources:

CHW and Community Health Educators

Social mobilization of womens group to improve environment.

Environmental health officers and assistants

NGOs working in community development.

Mass media for communication.

Evaluation:

Mortality figures from Diarrhoeal disease to be recorded.

Surveys by health officers of water use and sanitation, food hygiene

Review of practices in health units for management of diarrhoea.

KAP mothers in community on causes, prevention of diarrhoea and on early giving of extra fluids to prevent dehydration, and constitution of oral rehydration solution or use of ORS sachets.

Indicators:

Incidence of Diarrhoeal disease to be graphed.

% cases received ORT.

% homes with clean toilets.

% homes with safe water within 10 minutes.

% cases needing referral or I.V. treatment.

3.6.3

ACUTE RESPIRATORY INFECTIONS (ARI)

Written policies were available from:

- Dept. of National Health
- C.P.A. policies
- Primary Clinical Care Manual

Assessment of existing policy

- Medicinal/Drug treatment differs according to the cause.
- Cough mixture - used a lot.
- Paracetamol for pain and pyrexia as required.
- Antibiotic when bacterial infection is present.
- Bronchodilator (Salbutamol) as inhalant solution or syrup or tablet.
- Referral to hospital according to patient's clinical signs and symptoms.

Goal:

To reduce both morbidity and mortality from ARI.

Aims:

To standardize treatment based on assessment of severity.

To reduce mortality from acute lower respiratory infections

To reduce morbidity and complications from ARI, especially otitis media and streptococcal throat infections.

Strategies:

Train mothers and staff to differentiate degree of severity.

Appropriate treatment to be available for severe and very severe infections.

Prevent ARI through improved environment - smoke control - intersectoral collaboration and move to use of electricity.

Immunization.
Breast feeding
Vitamin A supplementation.

Activities and Time Frame:

- Train CHW and womens groups in identifying lower acute respiratory infection - 1995
- IEC of public about signs of ARI, mass media and health learning materials. Provide literature and videos in appropriate languages. - ongoing.
- Train staff in standardized management of all grades of ARI including ear infections using WHO modules - February 1995.
- Establish essential drugs availability for ARI - including supply of oxygen.
- Avoid missing opportunities for immunization.
- Health Education on Vit A rich foods, smoke in houses, breast feeding.
- Vit A supplementation in clinics and creche.
- Informal training of teachers in spread of infection, and handling of pupils with asthma or respiratory symptoms.

Resources:

CHW/TBA/Traditional Healers/private Practitioners/NGO after suitable workshops.
Supply of essential drugs for all units including clinics, satellites, mobiles and home visit bags.
Health centre and hospital beds.

Evaluation:

Periodic review of quality of care in health units at all levels.
KAP staff and mothers.
Graphs of acute lower respiratory infection and asthma on wall of clinics.

Indicators:

Disease specific death rate.
Incidence ARI - pneumonia, bronchiolitis, laryngo-tracheitis, diphtheria, whooping cough, measles bronchopneumonia, chronic otitis media, rheumatic fever.

3.6.3.1 OTITIS MEDIA

Aim:

To reduce the incidence of chronic otitis media and hearing loss.

Strategy:

To examine every child with upper respiratory infection or fever with an otoscope and initiate treatment early.

To treat all cases of discharging ear.

Activity:

Training of staff in WHO ARI module.

Resources:

Otoscope and batteries and spare bulbs.
Essential drugs.

3.6.3.2 RHEUMATIC FEVER

Aim:

To treat effectively streptococcal infections.
To prevent rheumatic cardiac complications.

Strategies:

To diagnose streptococcal infections and treat adequately.
To put all rheumatic fever cases on prophylactic antibiotics, to prevent the need for surgery.

Activities:

Improve laboratory facilities.
Train workers.
Keep register of rheumatic fever patients and ensure compliance with prophylaxis.

Resources:

Adequate supply essential drugs.
Training of CHW to follow up.

3.6.4 TYPHOID

Goal:

To improve environmental sanitation and food hygiene to the point where typhoid is no longer a public health problem.

Aim:

To reduce incidence of typhoid.
To reduce case fatality of typhoid.

Strategies:

Involvement of environmental health officers.
Improvement of water and sanitation and food catering establishments.
Follow up of all cases.
Health education of the public.
Immunization if needed in prisons and military camps.

Activities:

Improvement of laboratory facilities.
Improved water and sanitation with local authorities.
Improved food hygiene and education of food workers.
Epidemiological investigation of cases and outbreaks.
Development of appropriate health learning materials for the public.

3.6.5

HEPATITIS**Written policies exist:**

- Dept. of National Health
- C.P.A. Policies
- Cecilia Makiwane policy
- Primary Clinical Care Manual

Assessment of existing policy:

- Notification of all patients.
- Avoidance of medication that is metabolised in liver, e.g. sedatives, analgesics, oral contraceptives and methyldopa.
- Avoidance of fatty foods and alcohol.
- Protocol re disposal of faeces and washing of hands after handling excreta.
- Isolation nursing.
- Bedrest strictly followed.
- Vitamin B Co. and multivitamin therapy.
- Referral for hospitalisation with signs of liver failure, e.g. severe vomiting, severe abdominal pain, not responding after 2-3 weeks of observation.
- Administration of Hepatitis A and B vaccine to staff.
- Prevention by immunization of children: Hepatitis B vaccine - 3 doses with DPT/Polio at 6 weeks, 10 weeks and 14 weeks now on EPI schedule.

Goal

To reduce incidence, mortality from and prevalence of Hepatitis.

Priorities:

- Immunization of children against Hepatitis B
- Standardisation of treatment policies.
- Reduce mortality from hepatitis by prevention through immunization, health education, early detection and treatment of hepatitis.
- Improve hygiene, knowledge and practices.
- Purification of water supplies and provision of sanitation.
- Improve food hygiene and make available hygienic basic foodstuffs.
- Immunization health personnel.

Proposals

- Promotion of intersectoral collaboration.
- Facilities for health education in all health rendering services.
- Advocacy emphasized in all aspects of health promotion.
- Keep statistics of hepatitis - computer information system.
- Follow-up and control outbreaks.
- Check antibodies of all health workers and give Hepatitis A and B vaccine accordingly.

Implementation and time frames

- Train mothers, women's groups and CHW in detecting early signs of hepatitis. - ongoing
- Literature and videos in appropriate language on hepatitis. - especially before hepatitis B vaccine introduced in 1995.
- Liaise with environmental health workers for improved food hygiene and township hygiene.]
- Advocacy with local authority for improvement of water and sanitation.
- Graph hepatitis incidence in all health units.
- Give hepatitis vaccine to all children born from 1995 onwards - April 1995
- Give hepatitis vaccine to all health personnel according to blood results - April 1995

Evaluation:

- Analysis of incidence and mortality figures from hepatitis.
- Surveys by health officers of water use and sanitation.
- KAP of health workers, parents, teachers.
- Review of practices in health units.
- Serology surveys Hepatitis B - baseline 1995.

Indicator:

- Coverage of children born from 1995 onwards with immunization (3 shots) against Hepatitis B.

3.6.6 STD AND HIV/AIDS

These conditions share sexual mode of transmission and some STD also a vertical mode of transmission to the foetus and newborn (HIV, Syphilis, Gonorrhoea, Chlamydia, Herpes). They are dealt with in the NACOSA National Aids Plan for South Africa.

3.6.6.1 SEXUALLY TRANSMITTED DISEASE

Written policies were available from:

- Dept. of National Health
- CPA Policies

- Primary Health Care Formulary
- Primary Clinical Care Manual
- NACOSA National AIDS Plan.

Assessment of existing policy

- Medicinal/Drug treatment differs according to the cause.
- Treatment regimens and recommended duration of treatment must be followed strictly to ensure that these conditions are treated properly.
- NACOSA integration of STD and HIV control not yet in place.

Priorities:

- Standardisation of treatment policies using WHO syndromic approach.
- Reduce morbidity from STD by prevention through health education, early detection and treatment.
- Facilities to be provided in prisons and psychiatric hospitals to provide for biological and emotional needs of inmates - provide condoms.

Proposals:

- Advocacy and promotion of intersectoral collaboration - education, information, improvement of housing and creation jobs.
- Facilities for health education in all health rendering services.
- Make use of all available material and human resources - make it part of comprehensive primary health service and not special STD clinics.
- Keep statistics of STD's by age and sex - computer information system.
- Follow-up and control outbreaks e.g. in prisons, schools certain communities.
- Curriculum in schools to be revised and include sexuality education.
- Provide contact slips to all patients with STD.
- All patients with STD to be counselled about AIDS and to be given condoms.

Implementation and time frame

- Training of staff in syndromic approach (WHO modules) - March 1995
- Train mothers, women's groups and CHW in detecting early signs of STD's. - now
- Literature and videos in appropriate languages on STD's and AIDS. - March 1995
- Graph STD's incidence in all health units. - March 1995
- Teachers and parents education and involvement of community health workers. - now.

- Integration Health dept STD activities and NGO/NACOSA activities - from January 1995
- Formulation of support groups - 1995
- Involvement of religious groups and media - 1995

Evaluation:

- Analysis of morbidity figures from STD's and connection with AIDS. Graph incidence by age and sex.
- Surveys by health personnel regarding levels knowledge of STD's, and AIDS in communities on a regular basis - KAP (especially Youth, mothers and women).
- Review of treatment practices in health units.

HIV/AIDS

Implement the NACOSA policy and take the procedures down to district level through a series of workshops involving all sectors and communities.

Implement the STD policy as a measure to decrease transmission of HIV.

MENINGITIS

The following written policies exist:

- Dept. of National Health
- CPA Policies
- City Health Dept. - E.L. Municipality Epidemic Plan
- Primary Clinical Care Manual

Assessment of existing policy

Treatment depends on the cause.

Meningococcal Meningitis

- Treatment - Patients hospitalized, contacts traced, given prophylactic Rifampicin, throat/nasal swabs taken, monitored daily for 5 days.
- Notification procedure standardised as per epidemic plan.
- Precautions taken for protection of staff.
- Vaccine available for communities at risk after typing organism.
- Elimination/Reduction of Spread
 - Carriers identified by means of nasal swabs
 - Isolation of patients
 - Disinfection of articles, soiled by throat or nasal discharges
 - Strict observance of Notification protocol

Priorities:

- Standardisation of diagnosis and treatment policies.

- Standardisation of notification protocols.
 - Health education with regard to the following:
 - Personal and environmental hygiene
 - Control and supervision of boarding houses, schools, hostels, army, youth camps, etc.
 - Prevention of overcrowding
 - Detection of carriers and treatment
- Make information available on all of the above.

Proposals:

- Promotion of intersectoral collaboration
- Follow-up and control outbreaks
- Health education package for schools, hostels, and facilities for health education in all health rendering services.
- Infection control liaison meetings with all relevant role-players on a regular basis.
- Keep statistics of all cases and contacts - Computer Information System.
- Identification and monitoring of high risk communities.

Activities:

- Educate mothers, women's groups and CHW in detection of early signs of meningitis
- Train health workers on epidemic plans.
- Create health education package for schools, hostels, etc., in all relevant languages for use if there are cases.
- Advocacy with Local Authority for improved housing to prevent overcrowding.
- Liaise with environmental health workers for improved hygiene and overcrowding elimination.
- Consider Haemophilis influenza immunization when this becomes policy of EPI.

Evaluation:

- Analysis of mortality and morbidity figures
- Surveys by health officers into home hygiene and housing conditions.
- Surveys by health personnel regarding levels of knowledge in communities, schools, hostels, army, etc. - KAP.
- Audit of notification protocol followed after an outbreak and re-education of relevant parties.

3.6.8

SCABIES

Written policies exist:

- Dept. of National Health
- CPA Policies
- Primary Clinical Care Manual

Assessment of existing policy

- Ascabiol (20% benzyl benzoate) is used in adults without septic scabies and open wounds.
- Tetmosol soap is used by infants, adults and contacts and washing of clothes.
- Penicillin (oral/intramuscular) is used in all infected scabies.

Priorities:

- Standardisation of treatment policies, i.e. use of antibiotics and treatment of family.
- Reduce morbidity from infected scabies by prevention through health education, early detection and treatment of scabies.
- Encourage basic personal hygiene, knowledge and practices.
- Improve overcrowded housing, water supplies and sanitization.
- Make information on common skin conditions available.

Proposals

- Intersectoral collaboration for better housing and water supplies.
- Keep statistics of scabies and map epidemic outbreaks
- Follow-up and control outbreaks
- School outreach programmes from clinics.

Activities:

- Training school teachers in early detection and personal hygiene.
- Training of health workers and mothers in proper personal hygiene
- Proper washing and ironing of clothes and bedlinen with effective anti-scabial medicine.
- Epidemiological investigation of cases and outbreak.
- Treatment according to standardized protocol.

Evaluation:

- Review of practices in health units.
- KAP parents, teachers, CHW, staff
- Routine house visits, school visits.

3.7 TREATMENT OF DISEASES; INJURIES AND EMERGENCIES

Goals/Objectives:

To make treatment of common diseases (including chronic diseases) and injuries available at every service point.
 To have appropriately trained Primary Health Care nurses for early detection, diagnosis, referral and treatment.
 To facilitate continued care of chronic disease.
 To prevent lifestyle diseases.

To initiate immediate emergency care as appropriate at point of first contact.

To establish community involvement in dealing with major promotive and preventive activities.

Strategy:

Standardised protocols for treatment.

IEC - use mass media for prevention of life style diseases.

Readjustment of TB health programmes to accommodate working parents. Channels used for health programmes to be accessible to communities.

Cooperation activities: Private practitioners, NGO, Social and Religious groups, traditional healers.

Improve referral system: community; transport; roads.

To establish incentives for health staff in rural clinics, working with increased numbers of patients.

To develop a team approach in every clinical institution, in mobile teams and in district health management teams.

To facilitate linkage and referral between different levels of care - primary, secondary, tertiary.

To establish mechanisms to ensure the availability of drugs at each service point. Establish sub provincial depots.

Monitor issue and prescribing of Drugs.

Extension of Generic drugs - Extend the list and encourage use by general practitioners.

To empower communities to deliver basic first aid.

Issue basic First Aid equipment to community.

Districts to have computerized system for updating of continuing education of all staff.

To establish norms for different levels of equipment.

Re-allocation of budget to supply essentials e.g. drugs, staff.

Radio/telephone - vehicles.

Establish norms for staff per patients.

Activities:

Retraining of all Primary Health Care workers.

Human Resource Unit to determine how many trained Primary Health Care nurses are available and where they are stationed.

Careful approval of all courses available and to standardise the courses.

To review the scope of practice of nurses service in co-operation with the Nursing Council eg. X-ray requisition and interpretation.

Essential drug lists to be compiled for different levels of staffing, different levels of care.

Improve communication between institutions.

Regular visits of staff e.g. doctors to health centres, specialists from provincial level to district hospitals.

Regular monthly district health management meetings with advisory committees to discuss health problems and plan action.

Exchange of staff between institutions - this would have to be short term and discussion need to be held on legality and conditions of service regulations.

Monthly district health meetings.

Develop team work.

Comprehensive PHC includes health promotion, disease prevention, early diagnosis, treatment (and referral when needed), limitation of disability and rehabilitation.

For any disease (e.g. stroke) or injury (e.g. traffic accidents) a district as a whole or a community health centre should have a team that can cover those aspects. Such a team will include PHC nurses, doctors, pharmacists, radiographers, laboratory technologists or assistants, physiotherapists, community health educator, ambulance driver, data clerk, social worker.

This team at health centre level should be trained in team work by the District Health Management Team and or by the management of the hospital. Joint quality of care reviews, team meetings, meetings with community committees will help to build the team spirit.

Resources:

Restructure facilities to provide comprehensive service.
Look at facilities and equipment - define clinics, CHC.

Time Frame:

Depends on resources being available.

Evaluation:

Audit quality of care.
KAP surveys of staff and patients and community.
Community/Clinics survey.
Average response time and waiting time for emergencies.

Indicators:

% Units with 24 hour emergency services available.
% of Units with daily curative services available.
% Units that have community facilities such as CHW posts, satellite clinics.
Average response time for emergency services.
Prevalence rates chronic diseases e.g. life style disease. (Chronic obstructive respiratory disease).
Incidence rates of specific diseases.
Disease specific mortality rates.

3.8 ESSENTIAL DRUGS

Introduction:

Defined as most cost effective drugs within a specific institution for essential, basic care. Different levels of service will have different lists.

Goals and Objectives:

Optimum provision of drugs required by a community within the constraints of the allocated budget, while considering the other needs of Primary Health Care.

To ensure equitable distribution of drugs in proportion to need.

To establish therapeutic guidelines.

To facilitate speedy delivery of medications to clinic points.

To diminish "bogus" prescribing and quack treatment.

Strategy:

Set up an advisory body.

Improved control of drugs and security.

Labelling for illiterate people.

Ensure effective patient education.

Maintenance of cold chain.

Creation of district pharmacists post, separate from hospital if possible.

Activity:

Upgrade and computerise existing depots.

Retraining and orientation of depot managers.

Ensure secure transport and storage of drugs.

District pharmacist to continuously facilitate and monitor distribution points.

Resources:

Decentralized depots

Train pharmacy assistants

To establish an adequate prepacking unit

Evaluation:

Survey of shortage experienced for specific drugs.

KAP study on staff prescribing and patients interpretation.

Patient's knowledge of correct dosage.

Percentage of drugs adequately labelled.

Survey of average consultation time/average dispensing time.

Monitoring of expiry of different drugs at different levels.

Indicator:

Availability of essential drugs at all service points.

Availability of health learning material (HLM units).

Average costs of Drugs per patient at different facilities.

% prescription with antibiotics per facility.

3.9 GERIATRIC CARE

Introduction

Three categories were identified:

55 - 59 - with problems but not eligible for pension.

60 - 79 - old age with age being verified by events

80 + - frail aged.

The aged especially require social services but it is difficult to verify the distribution of social workers. Some good models exist eg. Homes for Coloured people in PE linked to home-based care, Feeding Centres, Geriatric day

centres with meals, Geriatric Centre attached to Health Centre and Creche.

Goals:

- To provide care for people who because of age are dependent, isolated, disabled, ill, or needing care.
- To provide appropriate care for those people who consider themselves as "old" and in need of care.
- To achieve 80% level of patient held health records

Strategies:

- Prepare older people for retirement before leaving industry - equip them with skills.
- Screening services and health promotion.
- Advocacy and empowerment of communities to set up community-based care and home-based care.
- Prevent abuse of old people (physical, mental, economic)
- Work with and coordinate NGO and CBO.
- Work closely with social welfare services.
- Promote safe and effective issuing of pensions.
- Move social workers and social work assistants to the community and health centres.
- Advocacy to end gender discrimination in respect of pension schemes.
- Through RDP community to devise means of protecting the old.

Activities:

- Survey and analyze problems experienced by aged in catchment area of health units.
- Keep Register of Chronically ill aged.
- Create more social welfare assistants.
- Social services to pay attention to and advocate for:
 - pensions
 - free electricity
 - free medical services
 - tickets for transport
- P.O., banks and clinics to be more "old age friendly"
- Set up more community-based care centres and day-care units.

- Establish institutional norms for old age homes - for all races, government grants and subsidies to be available.
- Every district to have:
 - beds for acute care of old
 - beds for terminal care
 - beds for frail care
- Link care with other activities eg. preschools, community gardens at health centres.
- Workshops in community to focus on needs of aged.
- Red cross training for home-care givers
- Government subsidies for home-care volunteers
- Rural mobile clinic to specially look for old people in need of assistance - work with local CHW.
- Intersectoral collaboration to provide job opportunities and development for the aged and to start community proposals.
- Advise and monitor community based and N.G.O. nutritional feeding schemes.
- Health units to have time allocated for home visits to the aged.
- Meet annually with community in joint session to plan activities of health centre with specific time for attention to care of aged and how the services should be organised.
- Review and develop further modules on care of aged for In-service training of health workers.
- To alert social services and other relevant organisations on abuse of aged i.e. physically, mentally and materially.
- To train community based workers in home care of the aged.
- Establish criteria of quality of care for health centre outpatients.

Resources:

NGO's & CBO's

Community based social workers and assistants.

Community health workers.

Church organizations and care aged.

Intersectoral collaboration to provide job opportunities and development of the aged and to start community proposals.

Advise and monitor community based and NGO nutritional feeding schemes.

Health units to have time allocated for home visits to the aged.

Meet annually with community in joint session to plan activities of health centre with specific time for attention to care of the aged and how the services should be organised.

Evaluation:

- 6 Monthly evaluation of geriatric registers to determine problems in geriatric community.
- Review of death certificates to determine major causes of death.
- Bi-annual verbal autopsy surveys in communities.
- Periodic surveys of geriatric problems in community and C.B.O's and N.G.O.'s including financial aspects of care.
- Assessment of hospital admissions, their causes, delays.
- Assess quality of care received in hospitals, and health centre.

Indicators:

- Age specific morbidity and mortality rates.
- Number of health care units with old age component in health care plan.
- Percentage of people over 60 years who receive adequate treatment for:
 - Hypertension
 - Diabetes.

Compare these % with incidence rates for communities internationally.

Time Frame:

- Continuous with immediate affect.

3.10 THE DISABLED AND REHABILITATION**Introduction**

Some physical or mental impairments are inherited or congenital and if present at birth create a problem in nurturing, socialization and development. A blind, deaf, spastic or mentally retarded child needs breast feeding, good nutrition, love and tender care, learning language and other skills as much as a child without impairment.

Impairment (e.g. a paralysis) can lead to disability (a limp from contractures) and a handicap (inability to get a job and stigmatization). It is possible to limit this progression. A deaf child need not become handicapped or only minimally so.

With disabilities that affect a previously able individual e.g. a stroke or an amputation the process of rehabilitation must also start early and include physical, mental/emotional, social and vocational aspects - teamwork with the individual and family.

Goals:

The goal is to enable the disabled to become independent and to reach their potential for achieving a socially and economically productive life.

Aim:

To provide physical, mental, social and vocational rehabilitation within the PHC approach.

Strategies:

- To increase primary prevention of disability by improved maternal care, immunization, education.
- To increase secondary prevention of progression of disability to handicap by early identification and rehabilitation.

- To rehabilitate the disabled as near home as possible.
- Promote community awareness of the problem and resources available.
- Include rehabilitation training of PHC nurses and also school teachers.
- Conscientize community and stimulate community involvement in community-based rehabilitation.
- Advocacy for legislation and its implementation about rights of disabled, jobs for disabled and "disabled friendly" buildings and services.
- Early diagnosis through screening procedures.

Activities:

- Newborns with impairments to be managed early by MCH team plus rehabilitation groups.
- Information, education and communication to diminish stigmatization (Leprosy, TB, AIDS, Cripples, Mentally ill or retarded, epileptics)
- Survey in community served by Health Centre with community involvement.
- Workshops to obtain intersectoral participation (e.g. with education).
- Catalogue for referral purposes all agencies, NGOs, special schools, specialists for investigation and treatment.
- Training of community health workers as community-based rehabilitation workers.

- Facilitate mainstream education in local schools for all minor disabilities.
- Work with social workers on problems of grants, free skin treatment for albinos, free treatment for rehabilitation procedures, grants for equipment (e.g. wheelchairs).
- Community workshops for aids for the disabled.
- Family training and counselling to enable family members to care for disabled.

- Arrange roster for visits physiotherapists, occupational therapists, speech therapists.
- Consider transport arrangements for disabled to fit with other demands, social workers to arrange bus/taxi coupons.
- Involve private sector (transport, bursaries).
- Standardize screening procedure for blindness, deafness in infants.
- Reorient WHO modules on community based rehabilitation to local situation - translate into Xhosa.

Resources:

Provincial residential centres for specialized rehabilitation, some existing and some to be developed.
 Physiotherapists, Occupational therapists.
 Eye, ENT, Orthopaedic specialists at Provincial and regional referral hospitals or to visit District level periodically.
 Mothers and CHW trained.
 Workshops for repair, maintenance hearing aids, wheel chairs, etc.
 Social workers to arrange subsidies e.g. for spectacles.
 Support groups in community.
 Vocational training centres and sheltered workshops.
 Training of physiotherapy assistants to train mothers.
 Teachers trained in identifying hearing, visual problems.

Time Frame:

Initiate surveys by March and complete by June 1995.
 Training package for Community-based Rehabilitation by October 1995.

Evaluation:

Establish registers.
 Repeat surveys 1998.
 Outcome reports of special centres.
 Follow up survey of those rehabilitated.
 Audit of employment conditions.

Indicators:

Proportional frequency of disabling conditions
 Age specific morbidity rates for blindness, deafness, crippling.
 % staff trained in rehabilitation.
 % disabled diagnosed late.
 % disabled gainfully employed.
 % government buildings "disabled friendly".
 % wards in districts with community-based rehabilitation.

3.11 OCCUPATIONAL HEALTH

Goals:

- Reduce occupation related mortality and morbidity. e.g. Industrial accidents.
- To identify high risk occupations.
- Enable all workers access to community health services.
- IHSEP industrial health & safety educational programme.
- To keep workers productive and supporting their families.

Strategies:

- Involvement jointly of employers, employees & health services... (policy)
- Work with existing structures i.e. trade (IHSEP) N.G.O. Unions.
- Special emphasis on gender issues in workplace (reproductive health).
- Strong emphasis on occupational risks, safety, hygiene for employers/employees.
- Advocacy for relevant legislation for province with emphasis on farm labour.
- Disseminate information on Workmans Compensation and procedures.

Activities:

- Survey of major occupations to quantify risks and problems.
- Establish joint information system and activities with human resources on all levels.
- Analyze poisonings & accidents relating to farming activities with view to determine policies to prevent same.
- Assess health services in industries with employers/employees e.g.
 - Motor Industries
 - Port
 - Railways
 - Garment industries
 - Hotel & Tourist industries
 - Transport industry
 - Fishing.
- To include in all health services a sensitivity to occupational background.

Resources:

- Trained people within human resources.
- Environmental health officers
- Trained management.
- People trained by management.
- N.G.O.'s
- Trade Unions.

- General practitioners & District Surgeons.
- To establish occupational health units at provincial, sub-provincial, PE, East London and Butterworth.
- Training & development of Health Learning Material (HLM) with special emphasis on occupational health problems in province.
- CHW and mobile teams to be trained in problems associated with agriculture.
- Record incidence of occupation related health problems in health centres.
- Liaise with Domestic Workers Union on Problems experienced and advise accordingly.
- Prepare guidelines for health centres in collaboration with human resources, information and private sector.
- Include in discussions with traditional practitioners aspects of occupational health.
- Workshop on social & psychological aspects of occupational health with relevant stake holders.

Time Frame:

- Establish occupational health units by March 1995.

Evaluation:

- Incidence of occupational health problems from routine returns & sample surveys.
- Change of provincial legislature & local by-laws and regulations.

Indicators:

- Nosa star rating of industries.
- % workers with occupational problems in specific occupation over specific time.
- Breaches of existing legislation & warnings.
- Incidence rates for specific occupational diseases or injuries.

CHAPTER 4: HOSPITALS, HEALTH CENTRES AND CLINICS

4.1 HOSPITALS

The hospital management is separate from the management of the Primary health Services for the communities but falls under the authority of the District Officer of Health or Health Manager. The health centres and clinics do not have to depend on the finances or drugs of the hospital as they are administered separately.

Hospitals however do support Primary Health Care through:

- Becoming Community oriented and having demographic knowledge of the District
- Providing referral services and continuity of patient care
- Providing XRay and laboratory facilities for referred patients

- Providing staff to visit smaller health units
 - doctors
 - physiotherapist
 - dentist
 - mental health nurse
 - laboratory technologist to supervise quality of work of health centre laboratory
- Assisting with training of health staff. Those hospitals with trained facilitators will train trainers at health centres
- Supplementary ambulance services
- Equipment repair
- Organizing refresher courses and exchange of staff

4.2 COMMUNITY HEALTH CENTRE

The Community Health Centre is the real focal point for Primary Health Care as it is from here that support is provided to Community-based Health Care and to smaller clinics within the first level of local government. It is from here that outreach and service for satellite clinics operates. The Community Health Centre will be under the day to day management of the health centre team advised by a local committee. Supervision will come from the Health Management Team of the District Local Council or the District Sub-structure or the ward, which-ever is in place.

Community Health Centres are not only centres for comprehensive health care (health promotion, prevention, diagnosis and treatment, and rehabilitation) but are also social centres and centres of development activities. Ideally they might provide offices for environmental health officers, social workers and community development officers. They will have a large waiting hall that can be used for community meetings. Closer liaison with traditional healers to be facilitated.

A Community Health Centre will have staff housing so that it can offer 24 hour on-call services. It will have good security and a watchman, a reliable water source and electricity supply (i.e. a generator if no Eskom).

The siting of these units will be at nodal points where there is a concentration of people, cross roads and bus/taxi service, police, church, shops. Hence they might also have a communal vegetable garden and a creche in their grounds.

The organisation of the work of the Community Health Centre will be based on:

- Patient and children friendly service
- Short queuing times

- Daily integrated maternal, childrens and womens services
- Daily morbidity care
- Extended hours in periurban or urban areas eg. 5-6.30pm
- Knowledge of the community served with maps and demographic data

Home Visit/Outreach to:

- Follow up cases (twins, low birth weight, malnutrition, measles, TB, STD)
- Visit chronically ill old people
- School visits
- Give talks to community groups (women, youth, church)
- Visits to community health workers
- Training sessions for TBA, CHW and traditional healers
- Satellite clinics for community growth monitoring/immunization/treatment/FP/MCH - the essential PHC package.
- Mobile clinics to remote farms and small villages
- Where necessary because of topographical features to undertake support/supervision of clinics
- Use of the small laboratory to identify syphilis and TB. (Such cases will then be sent to the District hospital for HIV tests if consent is obtained after counselling).

4.3 CLINICS, HEALTH POSTS, MOBILE CLINICS

Clinics:

Clinics are smaller than Health Centres and usually only have 1-2 Professional nurses and perhaps an enrolled nurse. They do not always provide 24 hour services nor maternity delivery but in remote areas these might be provided.

They provide a comprehensive service and all the components of MCWH care.

Home visits and School Health visits are to be included in staff job descriptions.

One or more clinics may be supervised by the Hospital or a Health Centre whichever is nearest or most convenient for transport reasons.

Clinics may or may not have a vehicle and driver, they will all have radio/telephone communication with Health Centre and Hospital.

A Satellite Clinic

Is always in relation to a health centre or clinic with transport. It is a periodic clinic (eg. once a week or once in 2 weeks) which takes place in a building not constructed for the purpose (eg. creche, church hall,

125

unused private building) but it might have some equipment and furniture. It should be established and maintained through community involvement.

Health Post

A health post is a room or building put up or provided by the community and it provides a venue for work by a Community Health Worker or a visiting team from a Health Centre or Clinic (mobile, outreach). It usually functions part-time allowing the CHW time to do home and community visits. It would be a base for a community-based distributor of contraceptives or for community-based rehabilitation work with a group of disabled children. A health post can have a stock of very basic drugs and supplies

- ORS Sachet
- Eye ointment
- Benzyl Benzoate
- Mebendazole
- Dressings
- Condoms
- A first aid kit
- Paracetamol

Mobile Clinic

Mobile clinics reach communities/groups of families who are not served by static clinics. They however only provide an intermittent service and so are no real substitute for an accessible static clinic that is available daily. The aim is to build more static clinics rather than to rely indefinitely on mobile clinics but this depends on population density and distances between communities.

A mobile clinic is usually specially designed and equipped but it is small and has no space for antenatal examinations nor is it very private. Mobile clinics can however take staff and their drugs and equipment to, for example, a farm where a room is provided for consultations and talks and demonstrations and growth monitoring and immunization. If mobile clinic stops also have a local CHW then there is a community-based "station-master" to provide continuity between visits and to remind cases to come for follow up (TB, Immunized children, STD partners).

Mobile clinic itineraries should be worked out with the communities - to ensure the correct sites for stops are chosen and that frequency and days are suitable.

It is especially in the farming areas of Eastern Cape Province that mobile clinics have proved useful as either several adjacent farms can be visited at one site or a sequence of stops arranged. Farmers and farm labourers committees need to be consulted in the arrangements.

Mobile clinics should provide a comprehensive service and single purpose visits are not effective except perhaps for the occasional immunization campaign - but all antigens should be available and a specific age group targeted, for example all children under 5 for polio immunization and other immunizations as needed.

All the drugs of the essential drug list for a health centre should be carried so that STD, Hypertension, convulsions and pneumonia can have treatment started or continued prior to referral if necessary. Patient retained cards must be routine. The usual health information record tally sheets, registers and notification forms must also be used.

Mobile clinics must have computerised or register records of mileage, times, patients seen, driver, fuel consumption so that any problems or inefficiency are identified and remedied.

CHAPTER 5: COMMUNITY-BASED HEALTH CARE

Community-based health care is that segment of health care which is based in the community. The community does its own needs assessment and analyses its problems and decides on action which will improve health. These actions may be to remedy the manifestations of ill health e.g. ORT for diarrhoea or may remedy causes such as improving water and sanitation. Community-based health care is related to community development and is multisectoral.

The health sector (District Health Management Team, Hospital, Health Centres or Clinic) can assist and support the community to manage its approach to health in many ways:

- Through community meetings to arouse peoples awareness of PHC and to stimulate organisation which can lead to participation in needs assessment.
- By workshops to stimulate intersectoral activities coupled with community involvement.
- To provide training for CHW, TBA and Traditional Healers and other community members if requested by the community.
- Assistance with technical assistance to set up community depots for some essential supplies eg. condoms, ORS sachets to be managed by the community.
- Assistance in starting activities such as the "Bamako Initiative" to ensure continuity of, or increase of activities such as CHW training and remuneration, or maintenance of a water supply.
- By becoming community oriented a health unit can come closer to the community and the partnership between health service and community action is increased.
- A joint health information system can be started which links CHW's data with clinic data.

- Establishing an advisory committee for the clinic/health centre with community membership which can lead to improved management and interaction between clinic-based and community-based health activities.

At present some community health workers or community educators are employed by the health services - these represent an extension of the health services into the community.

In some places NGO's eg. NPPHC have trained and remunerate CHW and these are closer to the community.

These are still options for part-time (e.g. 2 afternoons per week) CHW covering a small number of homes or a street or segment of an informal settlement to be trained by the clinics as volunteers, but they are responsible to community groups eg. church groups, street committees or residents committees.

Community Health Workers need continued support in the form of continuing education or monthly meetings for peer-group stimulation and supervision. Some areas e.g. Northern Region have developed farm CHW and this model might be extended. Former Ciskei and Border region have had training supported by the Kellogg Foundation as have areas supervised by the Faculty of Medicine University of Transkei in Umtata.

AMREF from Kenya has trained a number of facilitators who can now train trainers and mobilize communities. This was done through Winter and Summer Schools in University of Western Cape and will probably continue for another year until the process becomes self sufficient.

The training of TBAs in areas where large numbers of mothers deliver at home might be undertaken if the following are considered:

- TBA delivers very few babies per year
- TBA training can lead to a very small reduction of Maternal Mortality through clean delivery and persuading mothers to have tetanus immunization and treatment for anaemia.
- TBA can identify problems but need a rapid method of referral within hours so TBA training should preferably only be undertaken when a district health system is functioning with transport, blood transfusion and caesarean section available.
- TBA can provide support to mothers in the post-partum period and can advise on breast feeding.

Traditional practitioners could have an immediate impact on some aspects of PHC if they were interested in training for some cooperative actions eg:

- Notification of measles, neonatal tetanus and acute flaccid paralysis (after training in case definition)
- Teaching mothers about ORT
- Advising mothers on immunization

- Recognising and referring severe acute respiratory infection
- Referring patients with chronic cough for sputum examinations
- Advising clients about condom use.

The role of traditional practitioners in Mental Health and AIDS/STD is still being discussed.

CHAPTER 6: TRAINING

Goal:

To change the focus of health care services to a holistic, comprehensive Primary Health Care approach with a greater emphasis on community participation, health promotion, and disease prevention.

To increase the spectrum of training by broadening training programmes to include auxiliary categories.

Objective:

To strengthen the management skills for integrated comprehensive PHC of all workers at different levels.

Strategies:

Re-orientation of existing curricula.

Training of facilitators and trainers.

Community involvement in training. Community training areas.

Learning from other examples i.e. Valley Trust, other countries.

Coordination with voluntary health groups e.g. Health forum and with Non-government Organisations skilled in participatory methods.

Activities:

Computerisation of names of participants for all training courses/programmes for Province.

Training/orientation of traditional practitioners in Primary Health Care if they request it.

Review of health curricula to re-orientation of Primary Health Care approach.

Workshop to plan the integration of training in respect of new programmes or approaches e.g. EPI/CDD/STD/HIV/MCH/ARI.

Identify areas or programmes to learn from and plan visits for staff in practical service management and rendering e.g. Kenya, Zimbabwe, Lesotho.

Develop libraries and other information centres at Provincial and district level.

Develop local HLM.

Develop community training health centres.

Training in maintenance and logistic support to be included in basic package of PHC training.

Training district health management teams.

Following elements to be addressed through training:

- Appropriately trained Primary Health Care nurses in diagnosis and treatment.

- Auxiliary categories i.e. radiography-, pharmacy and laboratory assistant and assistant social workers.
- EPI and cold chain managers.
- Community Supervisors.
- First Aid courses to communities.
- Traditional Birth attendants - if District Health Systems established with Hospital.
- Health workers in work with Youth Groups.
- Retraining of all workers in Primary Health Care approach.
- Facilitators and trainers in community participation.
- Consumer education in use of medications.
- Peer Group education e.g. child-to-child.
- Packages for health workers on participatory methods.
- Health workers on Paediatric Assessment and Care.
- Re-orientation of health workers in health education and health promotion.
- Training health workers in : Acute Respiratory Infections (A.R.I.) Oral Rehydration Therapy (ORT) and Control of STD/HIV.

Resources:

More transport for community visits.

Redistribution of training aids.

Investigate facilities available : Mount Coke and Dora Nginza Hospital, all universities, technicians and nursing colleges to be utilised as resources.

Schools of Public Health or develop Eastern Cape Province School.

Facilitators already trained (eg. by AMREF).

(More equity in distribution of resources is needed).

Time Frame:

50% of activities by end of 1995.

75% of activities by end of 1996.

Liaison between colleges, universities and technicians by end 1995

Establishment of Unit at Provincial Level.

Evaluation:

Survey of level of competency and skills of health providers through random sample.

Indicators:

% Of health staff re-orientated.

% Of curricula reviewed.

CHAPTER 7: LOGISTICS

Introduction:

A logistics system has many components and planning and budgeting will be done at Provincial and Regional Levels initially. Procurement, receipt and inspection, bulk storage, warehousing, inventory control will also be done at Provincial and regional levels and pharmacists will be involved for drugs and vaccines.

At the District level requisition, local storage and distribution, transport, maintenance and repair, and communication are essential. Also under a logistic system it is necessary to include environmental management of health facilities, records and reporting, training and supervision, evaluation and setting up of a computer system.

7.1 Communication

Communication between health units and different levels of the health service is critical for PHC. Referral and Supervision, ordering of supplies, improving patient care all need some form of communication that has to be budgeted for. Radio links, telephones, fax, postal services, couriers are some methods. Transport is needed for face to face communication of supervisors; in communication with specialists in Regional hospitals or communication with doctors in the district hospital about patient care which can often save lives. This facility is a form of support for isolated nurses in rural health centres.

Where electricity is not available solar panels can power the radios. But these forms of communication need repair and maintenance and this might not be available at district level.

7.2 Transport

Transport support functions are:

- To deliver supplies to PHC centres.
- To transport personnel - supervisors, new staff,
- For mobile units and outreach work.
- Movement of patients from PHC units to more sophisticated health care facilities.
- Transmission of information from and to health units.
- For emergency programmes eg. epidemic control.

Requirements for transport and available resources have to be very carefully assessed before new orders are placed. As a first step regions should obtain information on community size, roads, location of facilities, need for mobile clinics or special activities. It is then necessary to decide if

standardization is necessary for maintenance and spare parts. In some areas local purchase and repairs might be a better option than bulk purchase and maintenance at Provincial or Regional headquarters. Economy is important and fourwheel drive should be used in only certain areas.

Smaller more economical vehicles must be considered also.

Motor cycles and bicycles for outreach are used in many countries but are perhaps less suitable in areas where violence and theft are problems. Considerations for transport must include:

- Maintenance
- Fuel, spare parts, control, drivers, records.

Some of the protocols needed are:

- A daily maintenance checklist for vehicles
- Record books to check consumption of fuel and use.
- Ambulance equipment supply checklist.
- Mobile clinic checklist.

Ambulances and Emergency Services

The present services in the Province need evaluation and review and consideration of the best system for each region.

Ambulance staff training has to be reviewed and a continuing system of training started.

Use of personal Vehicles

At present enormous sums are being spent on staff moving between regional headquarters and Provincial headquarters. This needs to be considered as well as the dangers to staff of daily travel for long distances such as PE to Bisho or East London.

7.3 Supplies, Storage, Maintenance

The situation of depots for drugs, cold stores for vaccines are being considered by the Pharmacists at Provincial and Regional level but this is difficult without the managers in place and the districts delineated.

Maintenance of medical equipment, vehicles, cold chain equipment, buildings, basic services such as water, electricity, sewerage require intersectoral cooperation with the private sector, and works department.

These aspects are also critical for smooth implementation of PHC and maintenance of high quality services and staff morale and patient confidence.

CHAPTER 8: OPERATIONALISING PHC

Operationalizing PHC in the Eastern Cape Province requires the following steps:

1. Printing the PHC proposals from the PHC Commission and distributing it to the members of other Commissions.
2. Engaging in dialogue with other Commissions:
 - Work study - on norm of staffing for various health units now that some guidelines of the duties and functions are clear.
 - Developing with the National Provincial leaders and Work Study Group the job description of Provincial, Regional and PHC directors and a job description for the District Public Health Officer (Manager). These should be appointed early. When these managers are appointed Provincial and Regional PHC detailed plans should be developed.
 - District Commission which will have outline districts could start a process of inventories in relation to demographic structure to determine equity.
 - Discussion of Training needs to be discussed with Human Resources Training.
 - Human Resources and Finance to consider problems of lack of equity as shown by differentials in IMR, Morbidity rates clinic/population/distance, EPI coverage, poverty, TB incidence.
3. These meetings of PHC commission with other commissions could take place between two or ultimately all Commissions in a workshop.
4. The MEC Health Sector, when all the data is collated and analyzed, should meet with all other sectors in an intersectoral planning session to consider how to rectify the lack of equity as shown in health, disease and health service differentials.
5. Hospitals will require workshops to reorientate them to support PHC.
6. The logistic system and drug distribution will have to be modified to suit new district requirements.
7. Regional multisectoral workshops with NGO participation will be needed as RDP proceeds and some NGO become funded.
8. The Provincial and Regional Epidemiology/Information sections will have to provide demographic data for every health institution so that they can become population based rather than patient based.

9. Facilitators will be needed for all the many training workshops to standardize management/treatment for ARI, Diarrhoea, STD, EPI. The local resources of Universities, Colleges, Technicians could be mobilized.

CHAPTER 9: ANNEXES

9.1 ESSENTIAL DRUG LIST FOR PRIMARY HEALTH CARE CLINICS

Analgesic/Antipyretic

Aspirin Soluble 300mg
Paracetamol Tablets
Paracetamol Syrup
Ibuprofen 200mg

Antihistamine/Influenza

Paracetamol, Phenyramine Co Tablets
Paracetamol, Phenyramine Co Syrup
Chlorpheniramine 4mg Tablets
Promethazine 10 + 25mg Tablets
Promethazine Syrup
Mepyramine Maleate Tablets
Mist Tussi Infans
Demazin Decongestant rup
Decongestant Nose Drops
Diphenhydramine Expect

Cardio-Vascular Drugs

Amiloride/Hydrochlorothiazide Tablets
Digoxin 0,25mg Tablets
Hydroflumethiazide, Reserpine, KCL 25mg
Glyceryl Trinitrate
Furosemide 40mg Tablets
Methyldopa 250mg
Atenolol 50mg
Propranolol 10mg
Hydrochlorothiazide 25mg
Reserpine 0,25mg Tablets + 0,1mg Tablets
Pot Chlor 500 mg Tablets
Brinadine

Anthelmintics

Albendazole
Mebendazole
Piperazine Citrate
Niclosamide
Praziquantal (Bilharzia endemic areas)

Gastro Intestinal Tract

Hyoscine Butylbromide Tablets
Dicyclomine
Mag Trisil Co Tablets
Diphenoxylate Atropine
Oral Rehydration Salts (sachets)
Oral Rehydration Solution
Sennosides A+B Tablets
Fleet Enema
Aloh/Mg Trisdlicate Mixture
Glycerine Supp.
Microlax Enema

Ophthalmic

Decongestant Eye Drops
Choloramphenicol Eye Drops + Ointment
Fluoresceine Minims
Oxybuprocaine Drops
Antihistamine Eye Drops

Vitamin

Vitamin A Preparations
Vit B Co Tablets
Multivitamin
Prenatal Vitamins + Minerals
Folic Acid Tablets
Calcium Tablets
Ferrous Sulphate Co Tabs
Multivitamin with Iron Syrup

Anticonvulsives

Phenytoin Sodium 100mg
Phenobarbitone 30mg
Carbamezapine 200mg
Diazepam 10mmg/2ml Injections (Status Epilepticus) (used rectally)

Antidiabetic

Metformin 500mg
Glibenclamide 5mg
Tolbutamide

Asthma

Theophyllin Tablets + Syrup
Salbutamol 2 + 4mg Tablets
Salbutamol Syrup
Salbutamol Inhaler and Solution
Beclomethazone Inhaler

Antimicrobial and Antiprotozoal

Amoxycillin Capsules and suspension
Ampicillin Capsules and Suspension

Pen VK Tablets
Pen VK Suspension
Co-Trimoxazole Tablets
Co-Trimoxazole Suspension
Doxycycline 100mg Capsules
Tetracycline 250mg Capsules
Nystatin Suspension
Metronidazole Tablets
Metronidazole Suspension
Cloxacillin Capsules
Cloxacillin Suspension
Griseofulvin 125mg Tablets

General

Bismuth Subgallate Co Suppositories
Hydrocortisone 1% Cream
Betamethazone Valerate Cream + Ointment
Glyco Thymol Mouthwash
Povidone Iodine Solution + Ointment
Gentian Violet
Merthiolate Tinct
Cetrimide + Chlorhexidine Solution
Sodium Hypochlorite Solution
Throat Lozenges
Mist Pot Cit or EQ Granules
Ung Acid Benz Co
Zinc Oxide and Lanolin Ointment
Liquid Paraffin (Cradle Cap)
Cyclizine HCL Tablets
Cyclizine HCL Suppositories
Cyclizine HCL Injection
Lignocaine with/without Vasoconstrictor
Local anaesthetic spray
Tolnaftate Solution and Cream
Benzyl Benzoate Appl
Monosulfiram Soap
Calamine Lotion
Gamma Benzene Hexachloride Shampoo + Application
Nystatin Cream/Ointment
Achromide Cream
Aserbine Cream

Tuberculosis Services

Isoniazid 100mg
Isoniazid 200mg
Ethambutol 100mg, 400mg + Syrup
Pyrazinamide 500mg
Rifampicin 15mg, 400mg, 600mg, syrup
Rifampicin/Isoniazid/Pyrazinamide (Rifater)
Streptomycin
Terizidone
Tebesium
Ciprofloxacin Oral

Ethionamide 250mg Tablets

Sexually Transmitted Disease Services

Benzathine Penicillin Injection
Benzyl Penicillin Injection
Cefotaxime Injection
Cefoxitin Injection
Ciprofloxacin 250mg
Clotrimazole Pess + Cream
Co-Trimoxazole Oral
Doxycycline 100mg
Tetracycline 250mg Caps
Erythromycin 250mg Tablets
Erythromycin Stearate 125mg Suspension
Ketaconazole Oral
Metronidazole Oral
Miconazole Pess + Cream
Nystatin Pess + Cream
Procaine Pen G Aqueous
Spectinomycin Injection
Probenecid Oral
Ofloxacin 200mg Tablets
Podophyllin Tinct

Emergency Tray

Adrenaline Injection 1mg/ml
Dextrose Injection 50% in 20ml/ampule
Diasepam Injection 5mg/ml
Hydrocortisone Injection 50mg/ml
Sodium Chloride 0,9%/200ml
Darrows in Dextrose 200ml
Theophyllin Injection 500mg/ml
Anthisan Injection
Normal Saline 0,9% 1000ml
Plasmolyte L 1000ml
Atropine injeciton 0,5mg/ml

Obstetric Tray

Syntometrine
Konakion
Neonatal narcan

Family Planning

1.1 Oral
"Biphasil"
"Marvelon"
"Mercilon"
"Micro-Novum"
"Microval"
"Nordette"
"Nordiol"
"Ovral 28"
"Triphasil"

"Tri-novum"

1.2 **IUD's**

"Dalcept" 375

"Dalcept" 250 short

1.3 **Injectables**

"Nur-Isterate"

"Depo-Provera"

"Petogen"

1.4 **Barrier Methods**

Condoms with Nonoxyl-9

Delfen Jelly

1.5 **Treatment**

Betadine vag. gel

Gyno Pevral

IMMUNISATION

All vaccines, antisera and diagnostic skin test material as approved by the Department for services rendered.

B.C.G. vaccine

D.T. vaccine

D.W.T. vaccine (DPT vaccine)

Hepatitis B

Influenza

Measles vaccine

Poliomyelitis vaccine

Rabies Immune Human Globulin

Rabies Vaccine

Tetanus formol toxoid and antitoxin

Tuberculin Mono test

Tuberculin P.P.D. (Mantoux) diagnosticum

Tuberculin Tine Test

Typhoid vaccine

Yellow fever vaccine - only authorised District Surgeon Services (Provinces)

9.2 **ANNEXE**

MEMBERS OF PHC COMMISSION

E. Pretorius Queenstown

H. Vermaak Port Elizabeth

R.N. Madikazi Bisho

N. Ngqandu Mdantsane

R. Bata

R. M. Mzileni Bisho

N. B. Quhula Bisho

T.M. Dayimani Port Elizabeth

E. Boniswa Loliwe East London

G. Ndukana King Williamstown

Bondlian Solomon East London
R. Garwood East London
Zoe Kati King Williamstown
N. Putta Bisho
N. V. Newman Umtata
V.V. Mgudlwa Umtata
M. Mkumatela Umtata
N.L. Matiwane Umtata
C. Scheard East London
R. Pienaar Port Elizabeth
F.J. Bennett Grahamstown
M. Maqina Port Elizabeth
E. Mlameli Storkspruit Herschel
N. Mzinyati Umtata
P. Smith Port Elizabeth
L. Msauli Duncan Village East London
Ms Mzinyati
L.N. Peteni King Williamstown
B.S. Noruka East London
P. Tshwete King Williamstown
N. Noruka King Williamstown

Five Working Groups were established each with representatives from all regions

Topics

1. Communicable Diseases, General Diseases, Essential Drugs
2. Geriatric Care, Rehabilitation
3. Information, Education, Communication
4. Occupational Health
5. Maternal and Child Health

The Terms of Reference for these groups were:

- Assess existing policies
- Prioritize areas to formulate policies
- Formulate proposals for policy
- Make suggestions for implementation and Time Frames
- Evaluation of suggested actions.

Health staff assigned to topics

Topic 1: Mr H Vermaak PE, Dr M. Maqina PE, Dr J Luluwa Umtata, Mrs R. Garwood EL, Mrs N Matiwane Umtata, Dr Msauli Duncan Village, Dr Chandran Sterkspruit, Mrs R Garwood, Mr H Vermaak, Mrs N L Matiwani, Ms T M Dayimani, Mrs A Goddard, Mr M Finnigan, Dr P Knox, Mrs N Fikelepi, Ms B E Loliwe, Ms E L Marawu, Mrs J P Webster, Mrs Z A Burse, Mrs P Lotz, Ms VV Ben-Mazwi, Ms N Kosnug, Ms M Mpotulo, Mrs R Hansen, Mrs L B Zill, Mrs N E Soloman, Ms E Philips, Ms N Ngqandi, Ms Z Kati, Ms E N Putta, Mrs S D Koen, Ms B Kumalo

- Topic 2:** Mrs V.V. Mgudlwa Umtata, Mrs E Mlamleli Sterkspruit, Ms Veldsman PE, Ms Z Kati King Williamstown
- Topic 3:** Ms N. Ngqandu Mdantsance, Dr B. Noruka EL, Ms T. Dayimani PE, Ms B. Steenekamp Ugie, N. Mzinyati Umtata, E. B. Loliwe EL, V. Mayana PE, N Masiza Sterkspruit, N. Madikzi Bisho, Ntsiky Ngqandu Mdantsane, Bongani Noruka East London, T. Dayimani Greenacres PE, Mrs B. Steenekamp Ugie, Nokwanda Mzinyati, E.B. Loliwe East London.
- Topic 4:** T. Oliver PE, Mrs Daniel Aliwal North, Mrs Nompuku Umtata, A. Auckett, Mrs Soldaat, IHEP Rep.
- Topic 5:** G. Ndukana King williamstown, B. Mzileni Bisho, M. Mkumatela Umtata, P. Smith PE, E. Pretorius Queenstown, B. Damons PE, J. Brown Barkley East, Dr Newman Umtata, Prof Nazo Umtata, Dr Boon Mdantsane.

Communicable Disease and Drugs

N.L. Matiwane Umtata, T.M. Dayimani PE, A.B. Goddard East London, M.T. Finnigan East London, P. Knox Duncan Village, N. Fitelyz, B.E. Loliwe Ciskei, E.L. Maralvu Duncan Village, E.N. Putta, J.P. Webster Amatola, Z A Bursey Amatola, S.D. Koen Stormberg, P Lotz East London, B. Kumalo Umtata, V.V. BenMazwi Port Elizabeth, N. Kosing, H Vermaak Port Elizabeth, R. Garwood East London.

Communicable Diseases and Drugs

Mandisa Mpotulu, E.L. Marawu Duncan Village, N. E. Fikelopi, R Hansen East London, Ne E Solomon, L. B Zill, E Phillips, P. Knox Duncan Village, N.L. Matiwane Umtata, N.M. Baliso Stormberg, N. Tuswa, S Stemela, H. Lutye, N. Landqela, R. Mhandi, Ntsiky Ngqandu, Thandi Dayimani, E.N. Putta, Zoe Kati, Johanna Webster, Russel Garwood.

Annexe

9.3 Maternal and Child Health

9.3.1 Objectives for Maternal Health

- To ensure safe pregnancies, labour and childbirth and pre-and post natal care of women in the childbearing age.
- To ensure that 80% of pregnant mothers are immunized against Tetanus at least once during pregnancy.
- To provide folate and iron supplementation to all pregnant mothers who visit a ante-natal service.
- Preparation of mother for parenting skills
- Preparation of mothers for breastfeeding and promotion of breastfeeding starting on ante-natal period.

The necessary activities, implementation, monitoring, evaluation and indicators are set out at the 4 levels of the Provincial Health Services.

PRIMARY LEVEL - HOME, COMMUNITY

OBJECTIVES	IMPLEMENTATION	MONITORING/EVALUATION/INDICATORS
<ul style="list-style-type: none"> - To provide safe home deliveries by providing home care services with adequate and efficient referral systems. - Develop self care and home care programmes with community participation. - Identify traditional birth attendants and Community Health Workers. - Develop Community transport system to assist with referral 	<ul style="list-style-type: none"> - Develop training packages for Traditional birth attendants and Community health workers in areas where this is indicated. - Do a situational analysis re transport available and transport needed within communities to establish an effective system for referral. - Develop appropriate community based Health Education material. 	<ul style="list-style-type: none"> - % of women receiving ante-natal care. - % of women being delivered by a trained attendant (Traditional or professional) - % of women returning for post natal care. - maternal morbidity and mortality rates. - Perinatal, Neonatal, Mortality rates
	<ul style="list-style-type: none"> - Establish communication network from clinic to referral hospital. (Radio Linkage) (Quality radio) 	<ul style="list-style-type: none"> - % of live births with a weight of 2,5 kg or more
		<ul style="list-style-type: none"> - % of women immunized against tetanus Toxoid. - % with a Tetanus Toxoid Record Card

HEALTH POST, MOBILE CLINIC, STATIC CLINIC, COMMUNITY HEALTH CENTRE

OBJECTIVES	IMPLEMENTATION	MONITORING/EVALUATION/INDICATORS

<ul style="list-style-type: none"> - To ensure the availability and accessibility of adequate ante-natal services (Ante-natal services must be available at every service point. - To ensure that adequate labour facilities and post-natal care to all women, are available. To be integrated into PHC Services. - To provide adequate transport, including during emergencies as well as efficient referral channels to secondary, tertiary levels. 	<ul style="list-style-type: none"> - Unification of services as soon as possible. - Access needs in terms of resources to make ante-natal services available at every service point. - Develop uniform patient kept ante-natal record system as part of a comprehensive pt kept record system. - Do situational analysis to establish needs for emergency services. (liaise with commission for emergency services). 	<ul style="list-style-type: none"> - Notification of births and deaths. - Ratio's of delivery beds per capita. - Monitoring of referral networks. - Ratio of trained personnel capita in various advanced categories such as family practitioners, advanced midwives, etc.
<ul style="list-style-type: none"> - To provide adequate training to all categories of PHC personnel involved in maternal care and delivery, including traditional birth attendants and community health workers. - To discourage the use of drugs, alcohol and tobacco and the use and abuse of other substances. - To ensure that effective laboratory services are readily accessible at Primary Health Care Level. - Rapid test Rh - Rapid test for syphilis - Cervical Cancer 	<ul style="list-style-type: none"> - Develop a uniform curriculum for the training of PHC nurses (Education Commission) - Develop a package to reorientate nurses regarding the PHC approach. - Develop Health Education material against the use of tobacco, alcohol and drugs (appropriate and acceptable culturally) - Investigate the possibility of field laboratories at clinic level. 	<ul style="list-style-type: none"> - Monitoring of training standards. - Monitoring of referral networks. - % of women delivered who were vaccinated against Tetanus. - % of mothers who's UR status is known birth.

SECONDARY LEVEL CARE: DISTRICT HOSPITAL

OBJECTIVES	IMPLEMENTATION	MONITORING/EVALUATION/INDICATORS
<ul style="list-style-type: none"> - To ensure that comprehensive maternal health services are available at district level. - To ensure that suitably equipped theatres with suitably trained staff are available at district level. - Admission facilities must be available at Community Hospital level with general maternal specialist care. - Doctors at district level must be encouraged to do diploma in obstetrics and Gynaecology. - Implement distance learning package re maternal and child health in all areas. 	<ul style="list-style-type: none"> - Nursing and medical staff that are suitably trained must be available. - Assessment of beds available at district level for maternal care. - (Responsibility of Hospital commission) 	<ul style="list-style-type: none"> - Maternal deaths and causes - Caesarean Section Rate - Audit of quality and rapidity of care.

TERTIARY CARE SPECIALIST HOSPITALS

OBJECTIVES	IMPLEMENTATION	MONITORING/EVALUATION/INDICATORS
<ul style="list-style-type: none"> - To ensure that intensive care facilities are available for maternal care. - To ensure that specialist surgical and outpatient facilities are available at tertiary level. 	<ul style="list-style-type: none"> - Nursing and Medical staff must be available who are suitably trained. - General specialist obstetric care must be available. (Establish Nursing as well as medical norms for tertiary hospital care). - Training facilities to be established to cater for practitioners of advanced care i.e. advanced Midwifery. 	<ul style="list-style-type: none"> - % of women that received care at tertiary level. % of beds available for tertiary care.

Attachment No. 13

National Drug Policy for South Africa

Table of contents

PAGE

Foreword	i
Acknowledgements	ii
Preface	1
1.1 Process	1
1.2 Use of the NDP document	1
1.3 Implementation of the National Drug Policy for South Africa	2
Introduction	3
2.1 Health objectives	3
2.2 Economic objectives	4
2.3 National development objectives	4
Legislation and regulations	5
3.1 Medicines Control Council	5
3.2 Registration of drugs and supplies	5
3.3 Registration/licensing of practitioners and premises	6
3.4 Inspection	7
3.5 Drug quality control laboratory	7
3.6 Quality assurance	7
Drug pricing	9
4.1 Rationalization of the pricing structure	9
4.2 The use of generic drugs	10
Drug selection	11
Procurement and distribution	13
6.1 Financing	13
6.2 Procurement	13
6.3 Storage and safeguarding of drugs in the public sector	14
6.4 Distribution	14
6.5 Local manufacture of drugs	15
6.6 Disposal of expired and unwanted drugs	15
Rational use of drugs	17
7.1 Education and Training	17

144

7.2 Drug information	18
7.3 Appropriate prescribing	18
7.4 Dispensing	19
7.5 Hospital therapeutic committees	19
7.6 The role of pharmacists	19
7.7 Advertising and marketing of drugs	20
Human resources development	21
Research and development	23
1. Technical cooperation with other countries and international agencies	24
2. Traditional medicines	25
3. Monitoring and evaluation	26
4. Concluding remarks	27