PHC RE-ENGINEERING
BACKGROUND

• Lack of progress on key health indicators (infant, child and maternal mortality, HIV, TB)
• National Service Delivery Agreement
  – Increase life expectancy
  – Decrease child and maternal mortality
  – Decrease the burden of disease from HIV and TB
  – Improve the effectiveness of the health system
• International experience shows that strengthening health systems, PHC in particular is key to improving health outcomes
NHC DECISIONS

• Visit of Minister and MECs to Brazil to explore how they improved health outcomes
• Impressed with their PHC system
• Requested a small team to work on proposals based on the Brazilian model
• Team expanded to include individuals with provincial and private sector experience
DISTRICT HEALTH SYSTEM

• No change in policy with respect to the DHS
• Vehicle for the delivery of PHC services
• Basic components of the DHS need strengthening (e.g. management responsibility and accountability at all levels; improved supervision and quality of care)
• Alma Alta principles apply
Key Points for Strengthening DHS

- Effective Management & Governance e.g. DMT & DHC
- Planning - Up Down & Horizontal
- Health Information Management
- M & E
- Effective Supervisory System
- Quality Assurance / Quality Improvement
  - National Core Standards for Health Establishments
  - 1000 facility QIP initiative
3 STREAMS OF PHC RE-ENGINEERING

- PHC OUTREACH TEAMS
- SCHOOL HEALTH SERVICES
- SPECIALIST TEAMS FOCUSING ON MATERNAL AND CHILD HEALTH
PHC OUTREACH TEAMS

• Establishment of PHC outreach teams at ward level

• Within each ward, every 7660 population (1620 households) will be covered by a PHC outreach team (on average but depending on density, burden of disease, geography)

• Each team will be composed of a PHC nurse and 6 CHWs (1 CHW will be ‘responsible’ for 250 households)

• Include EHP and health promotion practitioners depending on need
PHC OUTREACH TEAM

- Responsible for 1500 Families
- No. of teams in a Ward (determined by population size)
- Preventative, promotive, curative and rehabilitative services (work with EHOs)
- Community Services including schools, crèches, and early learning centres & home based care services.

Professional Nurses x 2
(Team leader)
Enrolled nurse x 1
(Facility based)

CHW 250 families

CHW 250 Families

CHW 250 Families

Professional nurse x 1
(Community based)
ROLES OF CHW IN PHC TEAM

Community Health Worker

- Household/family registration
- Household/family assessment
- Health promotion
- Children under 5 (IMCI); pregnant women;
- TB; HIV, Chronic diseases
- Community mobilisation & Advocacy
- Health Campaigns
- School Health; Creches
PHC TEAMS: GENERIC FUNCTIONS

- Know the demography of the catchment population
- Know the epidemiology
- Health promotion and prevention (household and community)
- Screening and referral
- Palliative care
- Social mobilisation
- Linking resources to community needs to improve health outcomes
FUNCTIONS OF CHWS

• Update Resource Profile of Community in conjunction with other Depts (DSD)

• Work with support groups

• Work with CBOs to plan and conduct community-based health promotion programmes

• Attend community meetings

• Link with school health teams

• Support and promote health at crèches, ECD centres, old age homes
Functions of CHWs: in the household

- Identifying and registration of households (Year 1 100% of households)
- Conduct household assessments (35% of households in year 1)
- Focus to be on maternal and child health, HIV, TB, Chronic Diseases
- Conduct household visits for maternal and child intervention according to protocols and burden of disease
STEPS TO ESTABLISH PHC OUTREACH TEAMS

• Determine number of teams needed and composition by ward (district)

• Select CHWs from currently ‘employed’ that meet national criteria

• Commence training of CHWs using national standards

• Select and appoint nurses (and EHPs, HP)

• Establish and orientate teams (public health)

• Ensure clear reporting lines and M/E system
Provincial Distribution of Community Based Health Workers

- ECape: 6,267
- F State: 3,194
- Gauteng: 6,388
- KZ Natal: 17,677
- Limpopo: 8,443
- Mpumalanga: 8,431
- NW: 6,640
- NCape: 2,431
- WCape: 3,816
# Provincial Distribution of Categories of Community Based Health Workers

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<thead>
<tr>
<th>Category</th>
<th>E Cape</th>
<th>F State</th>
<th>Gauteng</th>
<th>KZ Natal</th>
<th>Limpopo</th>
<th>Mpumalanga</th>
<th>N West</th>
<th>N Cape</th>
<th>W Cape</th>
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<td>Peer Educators/Supporters</td>
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<td>-</td>
<td>350</td>
<td>288</td>
<td>500</td>
<td>137</td>
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<td>Lay counsellors</td>
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<td>1,641</td>
<td>1,800</td>
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<td>2,479</td>
<td>3,847</td>
<td>9,100</td>
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<td>Total Number of CHWs</td>
<td>6,267</td>
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<td>6,388</td>
<td>12,70</td>
<td>8,443</td>
<td>8,431</td>
<td>6,589</td>
<td>2,431</td>
<td>3,490</td>
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SCHOOL HEALTH SERVICES

• School Health Policy adopted in 2003
• Implementation has been very limited due to resource constraints
• Minister requested that the policy be revised and that he launches it with the Minister of Basic Education
• Minister directed that the package includes reproductive health services and integrates HCT
SCHOOL HEALTH SERVICES

• Mandate is: have health presence in every school
• National finalising core package of services for ECD, primary and secondary schools
• Need to employ more school health nurses/teams and deploy them
• Strengthen M/E to show impact of school health
SCHOOL HEALTH: NEXT STEPS

• Clearly this needs to build on what exists with rapid scale up
• Proposal is that we start with schools in quintile 1 districts (over 10,000 schools!)
• Need to prioritise within quintile 1 and group schools
• Hire more school health nurses
• Ensure clear reporting lines (school health at district, PHC nurse in ward team)
• Strong M/E
DEPLOYMENT OF SPECIALIST TEAMS

• National Health Council (NHC) directed that specialist teams to improve maternal and child health be deployed to cover every health district

• Teams to be composed of: principal Obs & gynae, Paeds, Family Physician, Advanced Midwife and PHCN
Specialist teams

- District populations vary from: 65 000 (Central Karoo) to 3.4m (COJ) – and with great density variations as well
- We have developed (with the chairs of the Ministerial Committees) core sets of responsibilities and job descriptions for part of the team (obgyn and paeds) – rest is work in progress
- Minister/DG started a process of consulting with specialist groups
- Minister appointed task team to advise (meeting already held)
SPECIALIST TEAMS: ROLES

• Work with institutional based specialists.

• Adopt a population based focus and participate in outreach activities for the development and support of all health facilities in the catchment area of their institution.

• Their primary function remains the development and support of an acceptable standard of clinical care throughout the district for which they are responsible.

• Will not be used to cover staff shortages in the regional hospital (however, may provide some clinical services to ensure own competency is maintained and to continue registration).
SPECIALIST TEAMS: MATERNAL CARE

• Strengthen family planning services
• Improve proportion of women that attend antenatal care in the first trimester; improve the quality of ANC (e.g. early testing for HIV, use of barrier contraception during pregnancy to maintain HIV negative status)
• Ensure that all eligible mothers receive all components of the PMTCT programme
• Improve the quality of intrapartum and emergency obstetric care (through training the relevant health workers)
• Ensure HAART cover for HIV positive breastfeeding mothers
• Ensure that systems for caring for healthy as well as small or ill newborn infants are in place, in line with the National Newborn guidelines.

• Monitor and improve the quality of newborn care using a quality improvement package such as the Limpopo Initiative for Newborn Care.

• Ensure that systems are in place to follow-up neonates after delivery (at least one visit during the first six days after discharge).

• Ensure that HIV exposed infants receive appropriate care and follow-up.
SPECIALIST TEAMS: CHILDREN UNDER 5

- Ensure children receive package of preventive & curative care addressing main causes of child mortality – diarrhoea, pneumonia, HIV and under-nutrition. Key components include:
  - Improved household practices especially improved young child feeding (increased breastfeeding rates).
  - Improved coverage of key preventive services such as immunization, Vitamin A supplementation, deworming, early identification of HIV infection.
  - Improved case management of children with common childhood illnesses through improved implementation of IMCI (including provision of ART)
  - Improved hospital care of ill children
KEY IMPLEMENTATION ISSUES

• Timeframes:
  – Advertise specialist posts by end July
  – Launch school health programme in December
  – Start integration of CHWs and focus their activities in each ward

• Where to start with these interventions?

• Should we try to implement all three streams in the same ward/district?

• How do we link with the preparation for implementation of NHI process?

• M&E to show that PHC re-engineering is making a difference
RESOURCES

• 2011/12
  – PHC: R100M
  – MCH: R228M (+HIV conditional grants)
• 2012/13
  – PHC: R400M
  – MCH: R501M
• 2013/14
  – PHC: R700M
  – MCH: R700M
WHAT DO WE NEED FROM THE MEETING?

• Reactions to the presentation on how it addresses the areas of challenges and how this can be incorporated into the work already done

• Key constraints and how to get around them

• Consensus on what each district needs to do

• Timeframes to develop district plans and inclusion of these into the DHP’s

• Role to be played by the development partners to support the programmes
Thank You