



REPUBLIC OF SOUTH AFRICA



Service Delivery

Preliminary lab report

November 2014

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CONTEXT AND CASE FOR CHANGE

The South African primary health system covers over 50 million people in 9 provinces and 52 districts

R 82bn

in government funding in 2014



~3,100 public health clinics

65-77% hospital bed occupancy



Over 50 million patients across the country



~40,000 doctors

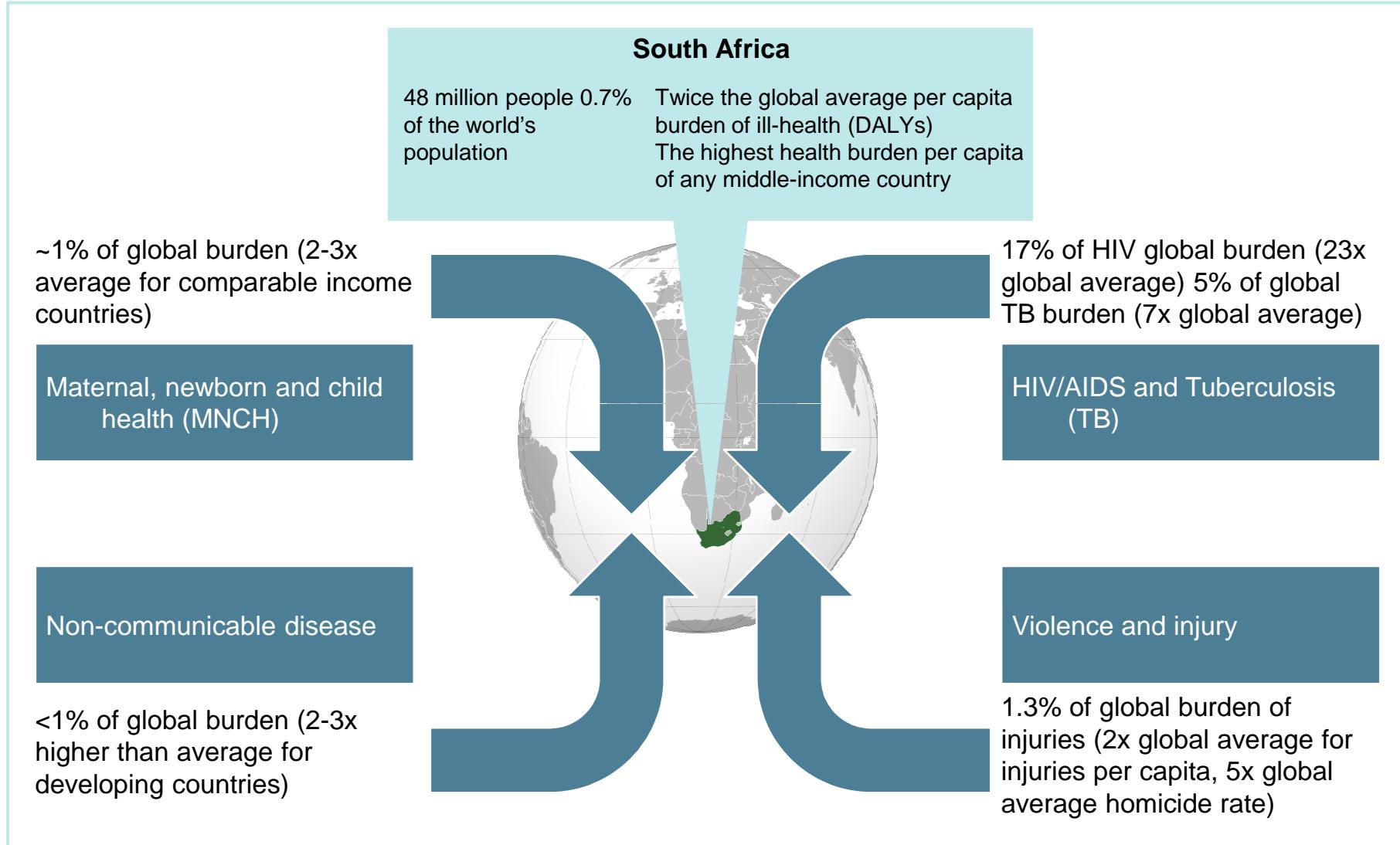


~64,000 nurses

An estimated 80% of doctors and nurses work in the private sector

SOURCE: Health Systems Trust; Local Government website; World Health Organisation, Business Monitor International

Currently South Africa is experiencing a Quadruple Burden of Disease (1/2)



SOURCE: The Lancet – South Africa's health: Departing for a Better Future? : Report on the burden of diseases in South Africa, volume 374, Issue 9693, 12 September 2009

Currently South Africa is experiencing a Quadruple Burden of Disease (2/2)

Summary of South Africa's MDG Performance

Indicator	Current SA	Target 2015
Maternal mortality rate	269 / 100 000	38 / 100 000
Infant mortality rate	38 / 1000	18 / 1000
Child mortality rate	53 / 1000	20 / 1000

SOURCE: National Department of Health, 2014

As well as the impact of social and economic conditions on the health of the population – social determinants of health



21% of South Africans live in informal dwellings



20% of South African households live on less than R13 a day



36% of South African households have no access to refuse removal



27% of South African households have no access to improved sanitation

In spite of these challenges, significant progress has been made (1/2)

Free primary health care



- Since 2006, >40 million South Africans have access to free health care

Access to anti-retrovirals



- Largest ARV program in the world leading to dramatic increases in life expectancy and a reduced mother-to-child transmission: 30% to below 3%.

Choice of termination of pregnancy



- Choice on Termination of Pregnancy laws introduced in 1996, reducing abortion related deaths by ~90%

Hospital revitalization program



- Hundreds of hospitals rehabilitation, 11 new district and regional hospitals built since 1998

Improved immunization program



- Coverage across provinces equalized, from variations of as much as 40% in 1992 to all provinces now above 70%

Improved malaria control



- Reduction in reported cases of malaria from as high as 60,000 people in 2001 to under 10,000 in 2009

In spite of these challenges, significant progress has been made (1/2)

Life expectancy of **61.3** in 2012, up from 57.1 years in 2009

Infant mortality of **27/1000** down from 39/1000 in 2009

Up to **92%** coverage for immunisations, up from 40% in 1992

2.7 million eligible patients provided with access to ARVs – the largest ART program in the world

130 million visits to primary healthcare facilities annually

82% of South Africans depend entirely on public primary healthcare system

PHC utilisation rate of **2.5** visits

However, there are gaps that still need to be addressed, as highlighted by the recent National Health Care Facilities Audit (1/2)

Area	Description	Highlighted findings	Detailed on next pages
1 Facility type and access	Assessment of whether facility is functioning according to actual classification and accessibility to the public	<ul style="list-style-type: none"> ▪ ~2% of facilities found to be functioning other than in accordance with their classification ▪ Almost all facilities in the country accessible by road (96%), taxi (87%) bus (58%), train (9%) - distance on foot not assessed 	
2 Priority areas for quality of service	Assessment against the health Minister's 6 priority areas for patient centered care: (1) positive and caring attitudes; (2) waiting times; (3) cleanliness; (4) patient safety; (5) infection prevention and control; (6) availability of medicines and supplies	<ul style="list-style-type: none"> ▪ Lowest scores were for patient safety and security (34%) and positive and caring attitudes (30%) scored lowest ▪ Highest scores were for waiting times (68%) ▪ Gauteng best performing at both provincial and district level, Northern Cape lowest 	
3 Functional Areas	Measures performance in 5 functional areas: clinical, infrastructure, management patient care, support services	<ul style="list-style-type: none"> ▪ Compliance lowest for clinical services (38%), followed by management (43%) ▪ Compliance highest for patient care (53%) 	
4 HR	Assesses gaps in selected categories of staffing considered crucial to ensure high quality, efficiently delivered scope for each type of facility	<ul style="list-style-type: none"> ▪ Critical staff shortages at clinics: <ul style="list-style-type: none"> – 21% had no manager – 47% no visits from doctors – 84% lacked input from pharmacists – 79% had no information management staff 	

SOURCE: National Health Facilities Baseline Audit 2012

However, there are gaps that still need to be addressed, as highlighted by the recent National Health Care Facilities Audit (2/2)

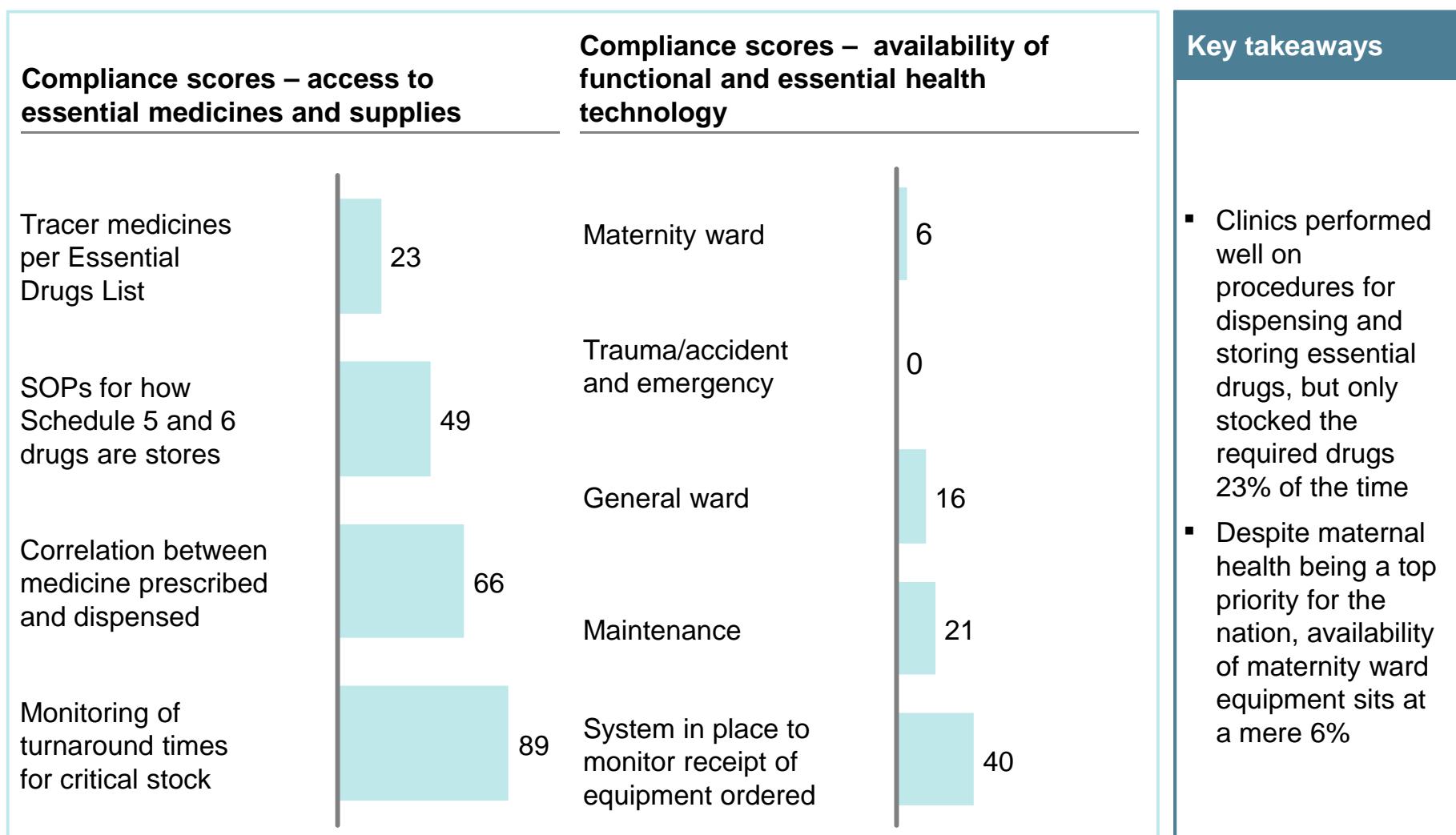
Area	Description	Highlighted findings	Detailed on next pages
5 Finances	Assessment of financial management within the management functional area - not inc. facility budgets and expenditure reports	<ul style="list-style-type: none"> ▪ Only hospitals covered with generally positive results <ul style="list-style-type: none"> – 72% compliance with exception reporting – 66% functioning within budget – 88% monitor budget expenditure 	
6 Infra-structure	Audit of (1) building and site infrastructure (2) facility infrastructure management; and (3) whether space sufficient to meet needs	<ul style="list-style-type: none"> ▪ Average overall score of 65% with higher scores for hospitals (70%) than PHCs (64%) ▪ Gauteng ranked highest (70%) and Northern Cape lowest (56%) ▪ ~30% of clinics found to have asbestos components 	
7 Health Tech-nology	Checks availability of functional essential medical technology	<ul style="list-style-type: none"> ▪ Poor performance across the board especially in emergency services and maternity wards ▪ Compliance under 13% for both hospitals & clinics 	
8 Medicines and supplies management	Checks for access to essential medical products, vaccines and technologies	<ul style="list-style-type: none"> ▪ Less than 30% compliance rate with requirement to stock Essential Drugs ▪ Poor performance on functional and essential medical equipment requirements (e.g. 7% compliance with checklist of equipment required for maternal wards) 	

... and deficiencies in the availability of essential drugs and equipment

Percent



PHC compliance
– vitals



The Service Delivery workstream addresses issues from 3 out of 8 of the performance areas from the 2012 National Health Facilities Baseline Audit

 Scope of service delivery

Service delivery will address challenges identified in three areas...		...that have a negative impact on patients
Facility classification	Quality of service <ul style="list-style-type: none"> ▪ Lowest scores were for patient safety and security (34%) ▪ Second lowest score for positive and caring attitudes (30%) scored lowest 	
Functionality of services	Human Resources	<ul style="list-style-type: none"> ▪ Poor patient experience ▪ Lack of continuity of care ▪ Essential medication stock out and lack of equipment prevents delivery of optimal health care
Finances	Physical Infrastructure	
Health Technology <ul style="list-style-type: none"> ▪ Poor performance across the board especially in emergency services and maternity wards ▪ Compliance under 13% for both hospitals & clinics 	Medicine and Supplies management <ul style="list-style-type: none"> ▪ Less than 30% compliance rate with requirement to stock Essential Drugs ▪ Poor performance on functional and essential medical equipment requirements (e.g. 7% compliance with checklist of equipment required for maternal wards) 	

SOURCE: National Health Facilities Baseline Audit 2012

It also touches 4 out of 8 priorities from the National Department of Health's 5-year plan

 Service Delivery Scope

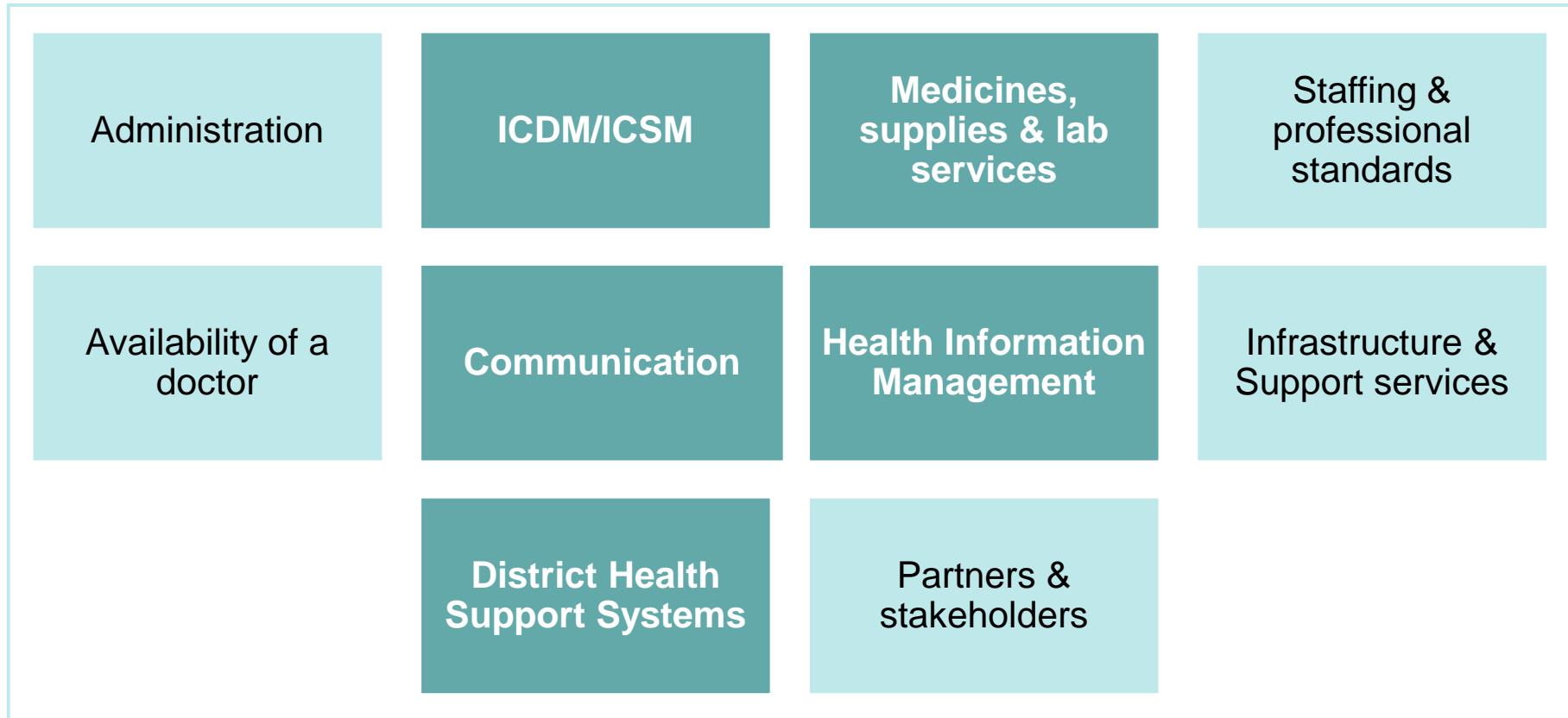
Strategic Goals

Strategic Plan 2015/16 – 2018/19

- | | |
|---|--|
| <ol style="list-style-type: none"> 1 Prevent disease and reduce its burden, and promote health 2 Make progress towards universal health coverage through the development of the National Health Insurance Scheme, and improve the readiness of health facilities for its implementation 3 Re-engineer primary health care by: increasing the number of ward based outreach teams, contracting general practitioners, and district specialist teams; and expanding school health services 4 Improve health facility planning by implementing norms and standards 5 Improve financial management by improving capacity, contract management, revenue collection and supply chain management reforms; 6 Develop an efficient health management information system for improved decision making 7 Improve the quality of care by setting and monitoring national norms and standards, improving system for user feedback, increasing safety in health care, and by improving clinical governance 8 Improve human resources for health by ensuring adequate training and accountability measures | 1 4 5
1 2
3
1 2 |
|---|--|

Finally, the Service Delivery workstream will address 5 out of 10 Ideal Clinic Dashboard components

 Scope of service delivery



The key challenges facing the South African healthcare system, can be classified into 3 main categories

Accessibility

- Equal access to healthcare and medication

Patient and provider Experience

- Patient's experience of services rendered, facilities as well as time spent
- Providers well-being as well as ability and willingness to provide high quality healthcare

Health outcomes

- Impact on patient and provider's health and safety

Supported by findings from the National Health Facilities Baseline Audit (2012)

Facilities are functioning outside of their classifications due to unclear package of services and correct facility classification

Quality of services: Facilities (hospitals and PHC) scored poorly in compliance with vital measures against priority areas

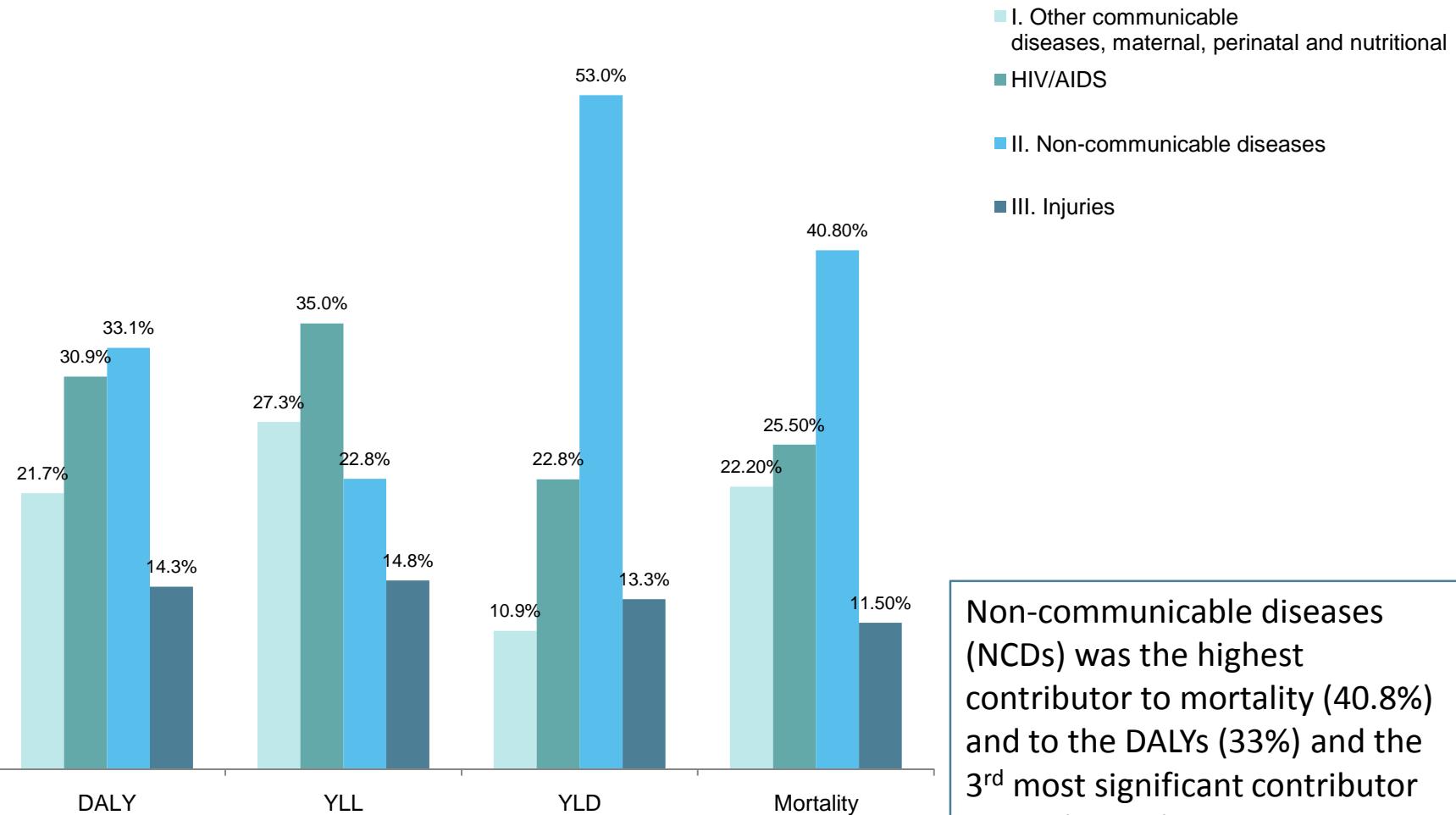


Primary care facilities on average scored lower than hospitals in all priority areas

Functionality of services: Clinical Services scored poorly compared to other functional areas (38%) i.e., Infrastructure, management, patient care, support services and clinical care

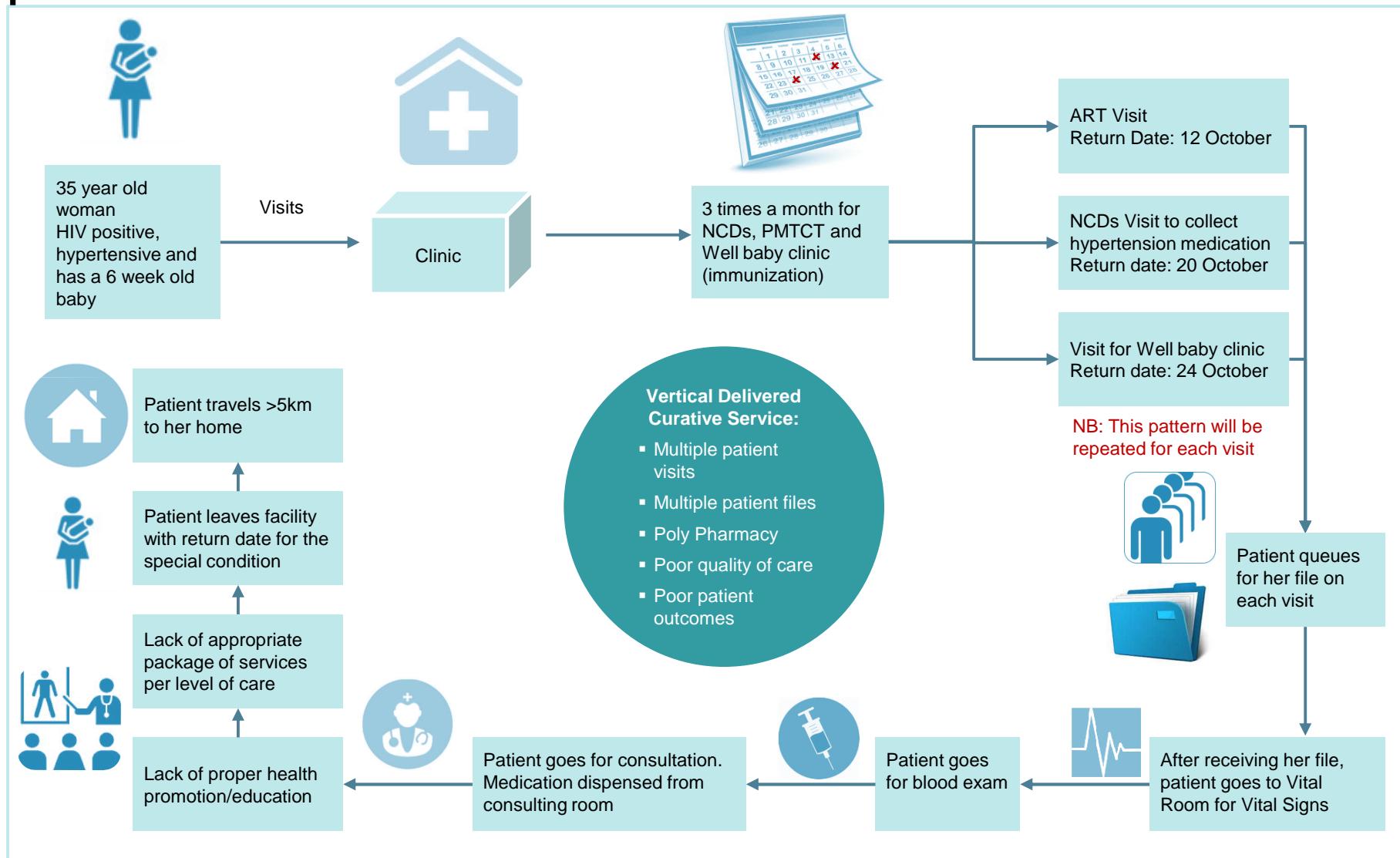
Range of services: Limited PHC services provided e.g. oral health services lacking across the board

The impact of this is poor quality of life and reduced life expectancy



SOURCE: World Health Organisation. The Global Burden of Disease: 2004 update. Geneva: World Health Organisation, 2004

Currently patients experience services that are vertically delivered and curative focused, making it time consuming, costly and unpleasant for the patient



1 Current Economic and Social Burden: Patient productivity lost and negative experience

A 35 year old female domestic worker, who is diabetic and HIV+ with a 6 week old baby, visits the clinic 3 times per month for ART, diabetic medication and well baby services.

Assumptions: A basic salary of R2420 (R110 p/d based on 22 working days per month) and a cost of R40 for roundtrip transport per visit

	Current
Months	12
No of Visits per month	3
Visits per annum	36
Average waiting time per visit (Hours)	6
Total waiting time per year (Hours)	216

**Productivity Loss: 36days
Economic Loss: R5400**

Economic Costs

Salary Loss (Days)	36
Annual Salary Loss	R3960
Annual Transport Loss	R1440
Total Annual Cost	R5400

SOURCE: Operation Phakisa Ideal Clinic Lab 2014: Service Delivery Stream

Evidence of Low Staff Morale



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

The impact of working conditions on the productivity of Nursing staff in the midwife obstetrical unit of Pretoria West hospital

by

Taramati Bhaga

Submitted in partial fulfillment of the requirements for the degree

MSW (EAP)

At the

Department of Social Work and Criminology

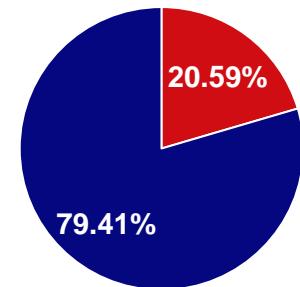
Faculty of Humanities

University Of Pretoria

Supervisor: Dr. J. Sekudu

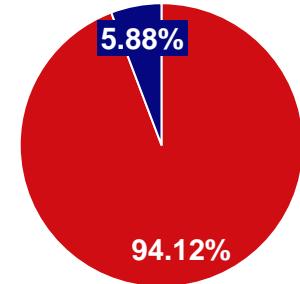
November 2010

Nurses' satisfaction with working conditions



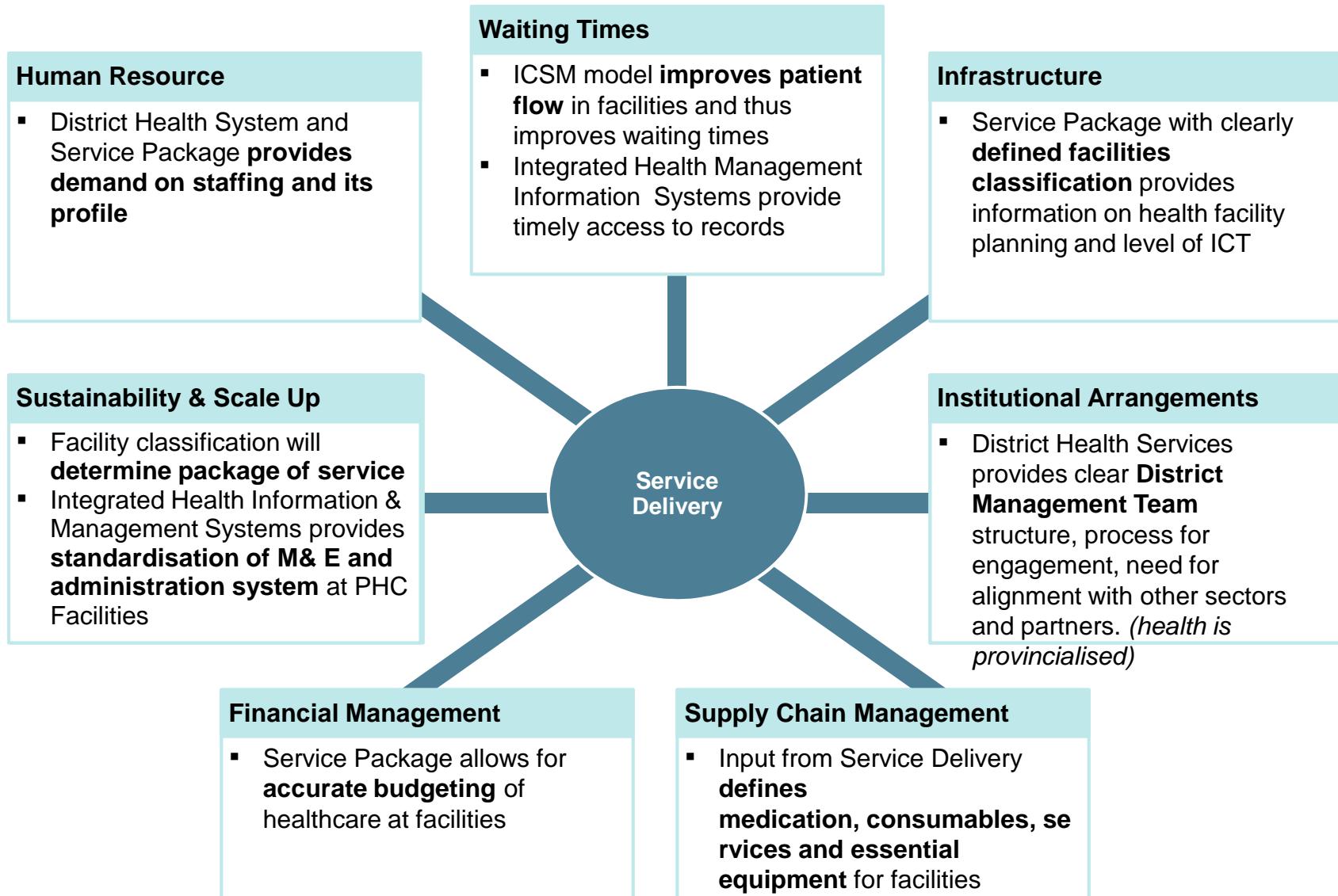
Nurses' perceptions regarding work stress

The respondents had to indicate whether or not more nurses were affected by work stress than other health care professionals.

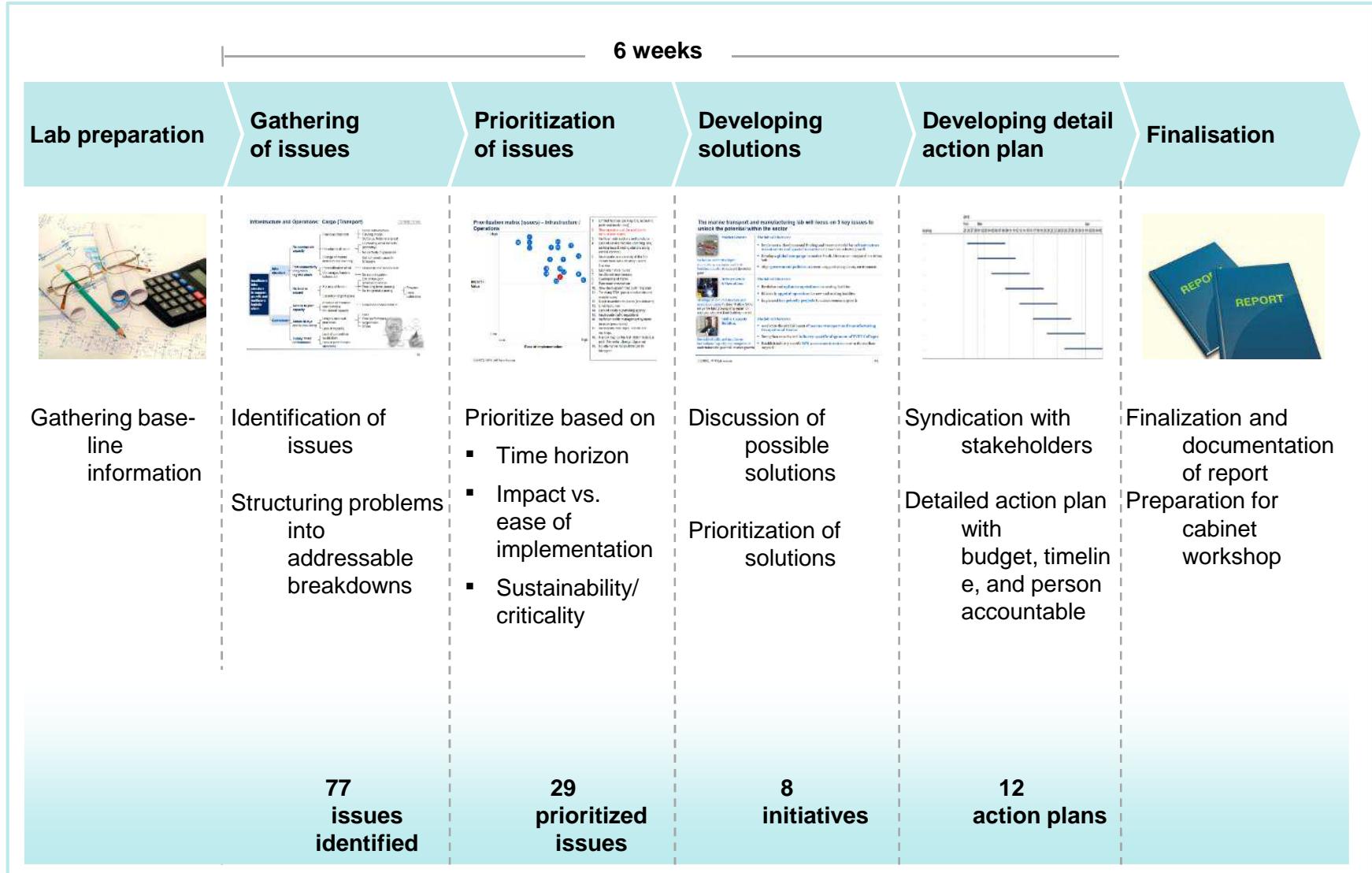


- **79.4% of nurses were dissatisfied with working conditions** in the midwife obstetrical unit of Pretoria West Hospital
- **94.1% of nurses reported being more affected by work stress** than other healthcare professionals

Initiatives from the Service Delivery Workstream impact other workstreams in the Healthcare Lab

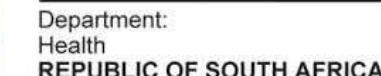
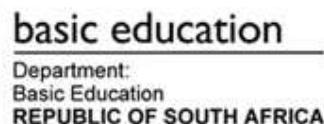


The Health Service Delivery lab worked for 6 weeks to gather and prioritise issues and to develop solutions and action plans



CONTEXT AND CASE FOR CHANGE

To do this work, more than 30 people from more than 15 organizations, representing ~ hours of work, regularly engaged in the Service Delivery lab



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What does Ideal Service Delivery for Primary Healthcare look like in 2018/19?

- Promotion of healthy lifestyle for all by providing information and education to communities to empower them to take individual responsibility for their own health
- All PHC facilities provide a uniform good quality of care
- Facilities have essential medicine, clinical equipment and supplies
- PHC facilities are clean, safe and comfortable for staff and patients
- PHC services are supported by knowledgeable, skilled and motivated staff
- Patients are transferred to the nearest referral facility with ease
- Communities are empowered to engage on the social determinants of health through community consultative fora process

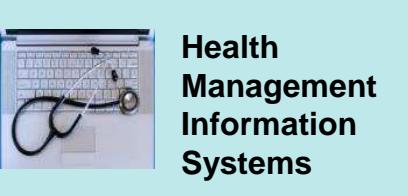


**For all Primary Healthcare facilities in South Africa
to deliver optimal quality, integrated healthcare from
both the patient, healthcare provider and
community perspectives by 2018/2019**



...which cascades into the aspiration of the different areas

 Key initiative
 Enablers

	Health Services	<p>1 100% of clinics will provide comprehensive holistic and integrated clinical care via defined package of service</p>
	District Health Systems	<p>2 All 52 districts will provide an enabling environment that supports the delivery of care including community engagement and inter-sectoral collaboration to improve patient's experience</p>
	Clinical, Medical, Support Services and Supplies	<p>3 Every patient will receive medicine timeously and in the most effective way</p>
	Cleaning, Infection Prevention and Control	<p>4 100% of clinics will provide health services in a clean and safe environment</p>
	Health Management Information Systems	<p>5 100% of clinics will be supported by an integrated health management information system</p>

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The Service Delivery workstream identified 77 issues that affect the PHC system

1	Inappropriate and insufficient equipment, chemicals and supplies	27	Inadequate demand planning	54	Roles and responsibilities for medication management not clear
2	Poor maintenance of infrastructure	28	Lack of appointment scheduling system	55	Lab results are lost and therefore unnecessarily repeated
3	General waste not collected	29	Lack of standardization of records & process	56	Distance from laboratory services
4	No running water	30	Disease specific records/files	57	Usage of results is not adequate
5	No clean linen	31	Tedious process to retrieve files	58	Lack of ownership for expensive tests Hb - FBC
6	No sinks and soap for hand washing	32	Infrastructure limitations for automated file management	59	Lack of information of current structure and need
7	Poor ventilation	33	Inadequate stationery/tools	60	Inequitable distribution of resources for service delivery
8	Insufficient waiting areas	34	Disease centered care instead of patient centric	61	Decisions made for facility development not based on sound ethical principles
9	Lack of triaging of patients	35	No integration of services	62	Lack of ownership and decisions not informed by practical implications
10	No or insufficient protective clothing	36	Conflicting primary health care guidelines	63	Lack of information of current structure and need
11	No disposable glasses for water	37	Inadequate health promotion and disease prevention	64	Program fragmented
12	No separation of waste	38	Lack of patient centeredness	65	Lack of accountability as profiling not done
13	No relevant bags and bins for waste	39	Lack of funding and poor planning	66	Cannot refer to nearest hospital
14	Long lead times for waste collection	40	Non-alignment between tertiary institutions and service delivery requirements	67	No standardized referrals which include feedback mechanisms
15	Insufficient and inappropriate storage space for medical and general waste	41	Underutilization of regional training centers	68	Unstructured referrals
16	Lack of reinforcement to adherence on protocols	42	Bureaucratic supply chain management	69	Patients lost in the referral system
17	Poor supervision of facilities	43	Lack of standardization of equipment	70	Cannot refer to nearest hospital
18	Lack of SOP's and policies	44	Lack of a maintenance plan	71	No standardized referrals which include feedback mechanisms
19	Lack of SLA and contract management	45	Aged infrastructure	72	Staff unable to treat emergencies
20	Lack of training for cleaners and IPC officers	46	No uniform plans for facilities	73	Poor response times
21	No standardized clear job description for cleaners and infection control officers	47	Facilities too small	74	No vehicles available
22	No mechanism for regular review and updating of policies	48	No maintenance plans	75	Inadequate use of resources
23	Inappropriate and unclearly defined classification of facilities	49	Supply chain management inadequate	76	Lack of accountability from partners
24	Inconsistent implementation by provinces	50	Clinical Governance	77	Poor continuum
25	Poor oversight and management of implementation at district level	51	No accountability for overspend on budget		
26	Patient process flow not defined due to poor understanding of process flow, triage process is not defined	52	Depot stock outs		

ISSUES AND ROOT CAUSES

These were prioritised and grouped into 5 key areas underpinning poor quality service delivery from both the patient and the provider perspective

- [Blue square] Improve accessibility to patient
- [Light blue square] Improve patient experience at the clinic
- [Purple square] Deliver quality healthcare from patient and Provider perspective

1 Health Services Inadequately defined and fragmented, curative-focused, vertical health services for the appropriate level of care 	2 District Health Service District Health Service is not providing an enabling environment that supports the delivery of optimal care 	3 Clinical, Medical Support Services and Supplies Unavailability of appropriate and adequate medication, consumable supplies, equipment and lab services. 
4 Cleaning, Infection Prevention and Control Dirty, unhygienic and unsafe facilities that adversely impact on patient and staff experience 	5 Health Management Information Systems Lack of an integrated health management information system to support the delivery of quality healthcare 	

Health Services issues

 Details to follow

 Issues dealt with in other workstreams

Disorganized service delivery platform

- 1A** Inadequately defined Package of Services for each appropriate level of care
- 1B** Inefficient patient flow due to inadequate infrastructure
- 1C** Poor patient administration (appointments, demand planning, patient records)

Poor quality of clinical care

- 1D** Vertical programmes that are disease focused and inadequately address the continuum of care
- 1E** Inadequately and inappropriately skilled/trained / mentored clinical staff
- 1F** Inappropriate use of lab tests and results
- 1G** Inappropriate and insufficient essential equipment, medicines and consumable supplies

District Health Service issues

 Details to follow

Ineffective, poorly functional and governed District Health System

- 2A** Limited community participation and mobilisation and lack of stakeholder and partner engagement including functional District Health Council
- 2B** Lack of appropriate and functional mechanisms to address social determinants of health
- 2C** Provincialization of services – Two tier governance impacts on classification of facilities and package of services delivered

District Health Management structure does not support effective service delivery

- 2E** Inadequate delegation of authority to manage financial and human resources
- 2F** Inadequate, inefficient and non-standardized management systems for SCM, maintenance and clinical, medical, support services and supplies
- 2G** Inadequately defined roles and responsibilities of the DMT, including health programme coordinators and PHC supervisors

Cross-cutting issue

- 2D** Poorly defined and functioning Referral System due to Provincial/District boundaries and health facility classification

Clinical, Medical, Support Services and Supplies issues

Poor stock control management

- 3A** Fragmented and non standardized ordering and delivery system
- 3B** Lack of demand planning and forecasting

Poor supply chain, contract and asset management

- 3D** Poorly defined essential equipment list, non medical supplies, other consumables essential laboratory test for PHC

Cross-cutting issue

1. Inappropriate and inadequate staff including financial and contract management skills

Cleaning, Infection Prevention and Control issues

● Issues dealt with in other workstreams

Poor cleaning practices

- 4A** No cleaning guidelines and standardized cleaning materials and equipment
- 4B** Inappropriate, inadequate and untrained staff on the need to promote general hygiene and cleanliness at facility level
- 4C** Lack of education on the promotion of general hygiene and cleanliness at community level

Poor infection prevention and control practices

- 4D** Inappropriate and poorly designed and maintained infrastructure
- 4E** Hospi-centric infection prevention and control guideline with ineffective M&E systems

Health Management Information Systems issues

● Issues dealt with in other workstreams

Inefficient and ineffective manual systems

- 5A** Inadequate patient records and filing systems
- 5B** Multiple data recording and reporting tools
- 5C** Lack of ICT infrastructure and support
- 5D** Limited knowledge and understanding of data use to enhance quality of clinical care including service and commodity needs

Fragmented electronic systems

- 5E** Lack of a standardised integrated health information exchange to ensure patient follow up
- 5F** Information system non-compliant to the health normative standards framework

1A Inadequately defined Package of Services for each appropriate level of care

Evidence/data to quantify the issue	Root causes	Reason issue has not been resolved to date
<p>1. Limitations with the current PHC package (2000) which does not take into consideration recent developments such as service challenges imposed by HIV epidemic, inefficiency of present service delivery process etc¹.</p> <p>2. Primary health care services are not offered in a standard and consistent manner.² The Health Care Facilities Baseline Audit National Summary Report 2012 shows that “all PHC facilities do not provide the full spectrum of PHC services”. For example, 93% offered immunization and TB services while 75% offered antiretroviral therapy³.</p>	<ul style="list-style-type: none"> ▪ Regular reviews and updating of policies are not done periodically and systematically. ▪ Current package of services not adequately responding to the quadruple burden of disease ▪ Inappropriate and unclearly defined classification of facilities ▪ Inconsistent implementation by provinces in districts ▪ Poor oversight and management of implementation at district level 	<ul style="list-style-type: none"> ▪ Change in mind-set and inadequate oversight and management of implementation at district level

SOURCE: Draft on Package of PHC Services; 14 September 2014. (pp. 8-9), National Department of Health, S. Dookie and S. Singh. *Primary health services at district level in South Africa: a critique of the primary health care approach*. BMC Family Practice 2012, 13:67 doi:10.1186/1471-2296-13-67 3. Health Care Facilities Baseline Audit National Summary Report 2012. Health Systems Trust, 2012. Ch4, pp 37.

1D Vertical programmes that are disease focused and inadequately address the continuum of care

Evidence/data to quantify the issue	Root causes	Reason issue has not been resolved to date
<p>1. The South Africa Health review 2012/13 shows that there is lack of integration of services between the HIV programme, and both tuberculosis (TB) and antenatal services, despite evidence that 70% of patients were TB-infected¹.</p> <p>2. This is further shown in the WHO review of HIV, TB and PMTCT services in 2013 which notes sub-optimal integration and no definition of mechanisms for integration of services².</p> <p>3. “Although health policy is geared towards PHC, historically the bulk of spending was on curative, highly specialised tertiary carePrimary Health Care in South Africa Since 1994 and implications for PHC re-engineering¹</p>	<ul style="list-style-type: none"> ▪ Disease centered care instead of patient centric ▪ No integration of services ▪ Conflicting primary health care guidelines ▪ Inadequate health promotion & disease prevention ▪ Lack of patient centeredness 	<ul style="list-style-type: none"> ▪ Lack of adequate leadership ▪ Negative staff attitudes ▪ Disease responsive approach ▪ Structural limitations

- SOURCE: South African Health Review. Health Systems Trust. 2012/13. Ch. 4, pp37,
- Joint Review of HIV, TB and PMTCT Programmes in South Africa Report, April 2014, pp8

2A Limited community participation and mobilisation and lack of stakeholder and partner engagement

Evidence/data to quantify the issue

- No functional clinic committees
- Social Determinants of health adding to burden of disease
- District planning is not comprehensive to include multi-sectoral input
- District services are not well coordinated to meet the demand
- More support needed from health facility staff
- Attitude of staff
- Staff not actively involved
- Overworked clinic managers
- Lack of leadership skills in clinic managers
- Need guidelines and direction for a functional clinical committee
- Based on lessons learned
- National guidelines based on legislation
- Resources to support the Clinic committee
- Not included in budget
- Members don't have money for transport and to attend
- Ongoing training for members to enable them to fulfill their roles
- Not all members of the CC know their roles or have the competencies to fulfill their roles adequately

Root causes

- Lack of research and information to inform decision making and allocation of funds
- Political influence to provide services where they are not required impacting on availability of resources as well as financial resources
- Lack of communication with communities on what is provided at which level/facility
- Poor population profiling from a clinic level to inform decisions about services
- Sectors working in silos within the public sector and between the public sector and the private sector

Reason issue has not been resolved to date

- Unplanned eruption of human settlements (DHS strategy)
- Social Determinants of health
- Political influence on allocation of facilities
- Poor communication between sectors

2F Inadequate, inefficient and non-standardised management systems

Evidence/data to quantify the issue

- The Navrongo experiment(Ghana) illustrated that by relocating nurses to communities and re-orientating management systems to be more supportive of accessible community-based nursing care, childhood mortality was reduced by a third in seven years and the total fertility rate declined by one birth in a decade(HST- International Perspective on Primary Health Care over the past 30 years).
- HST-Lessons learnt in implementation of Primary Health Care : Experiences from health districts in South Africa(2003):
 - The first lesson is that without a permanently appointed management team, which is given full responsibility and accountability for being in charge of health services in the district, it is difficult to make sustainable improvement.
 - The second lesson is that the role of the national and provincial health department should be one of guidance, protection from undue pressure, support and nurturing of their districts

Root causes

- Lack of alignment between national, provincial and district levels
- New management levels developed for each programme when it is implemented
- Inadequate job profiling and job descriptions when positions are created and not reviewed annually
- Lack of consequences and rewards for poor or good performance
- Real and perceived better conditions of employment for private sector

Reason issue has not been resolved to date

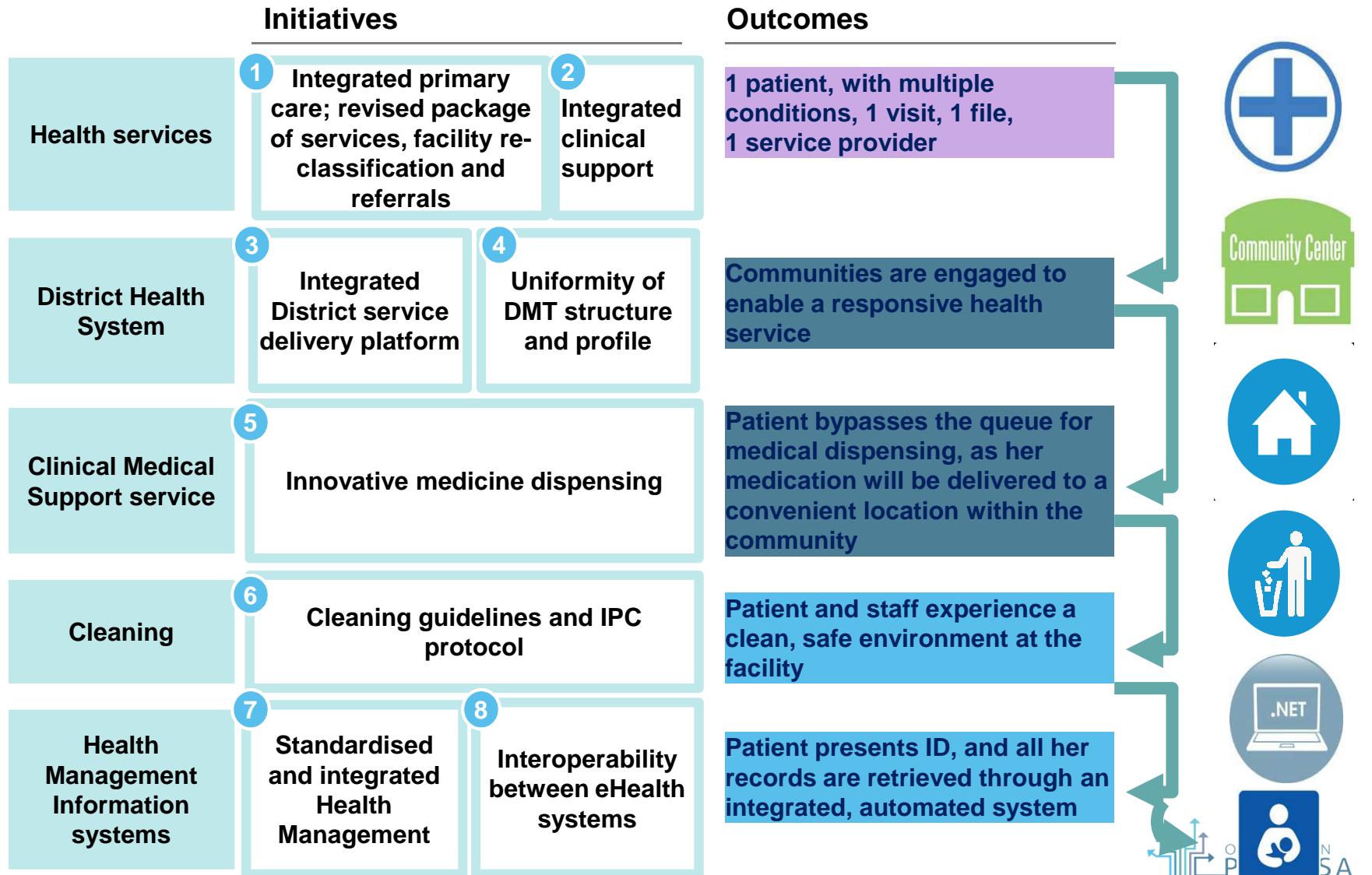
- Inadequate delegation of authority to manage financial and human resources
- Inadequate , inefficient and non standardized management structures for implementation of a national service package
- Inadequately defined roles and responsibilities of the DMT, including health programme coordinators and PHC supervisors
- The relationship between the operational manager and other district health team members is not always well understood which includes reporting lines and supervisory responsibilities
- No uniform understanding of the roles and responsibilities of the programme manager and the clinic supervisor in terms of facility supervision
- The lower levels of management has limited role in determining how health financial resources are spent in the district.
- Poor management skills limits oversight, planning, coordination and monitoring of health system activities at all levels
- The Operations manager is often a part of the patient care team due to staff shortages and inappropriate clinic staff structure. This leads to overwork and burnout due to the added administrative duties.
- Poorly developed performance agreements between management and subordinates compromises effective performance assessments
- Large number of programme managers who give input into facilities leading to fragmented health services and unequal quality of programme delivery

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The workstream identified 8 high impact initiatives, directly addressing the 5 key issues identified

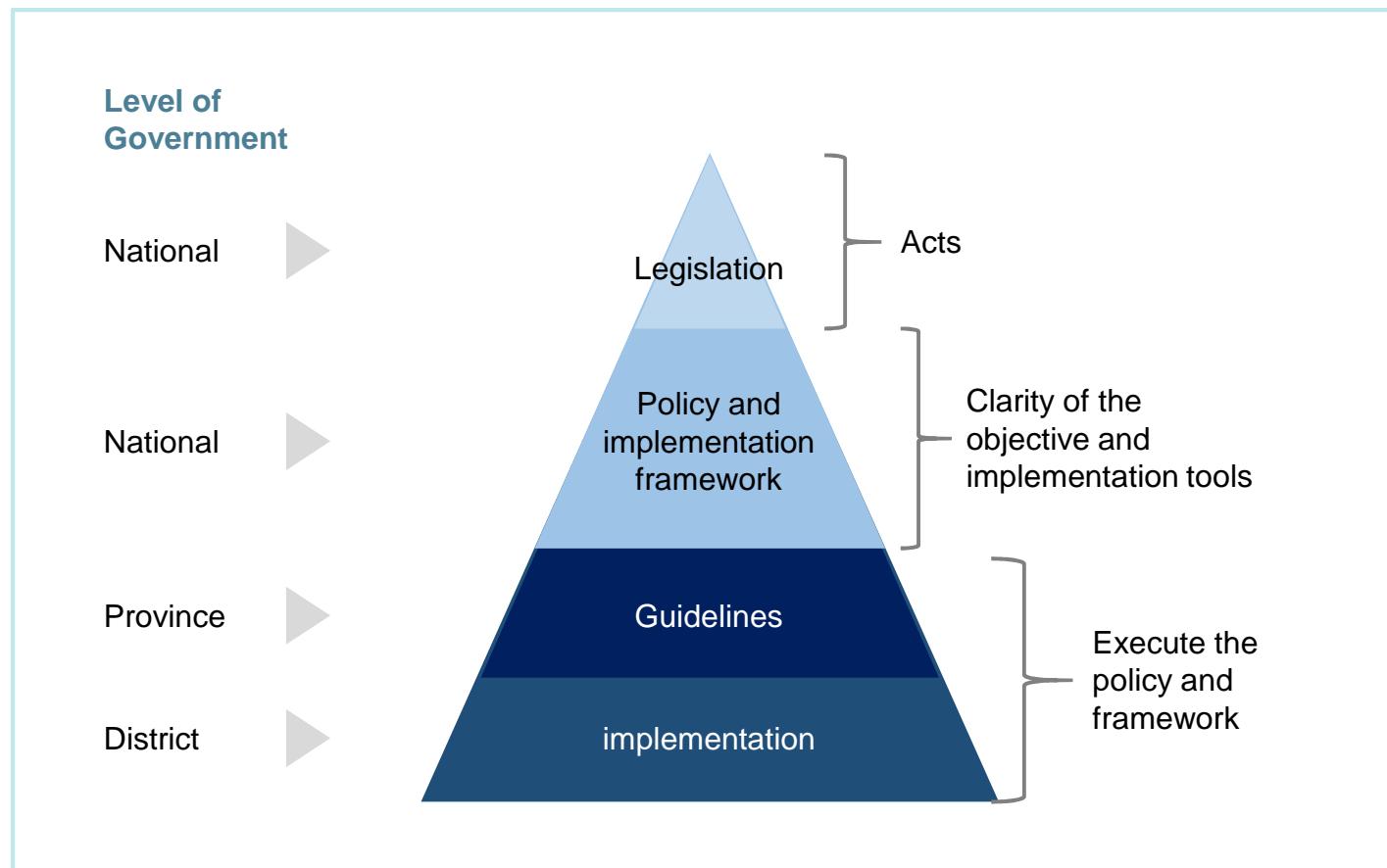
- Improve accessibility to patient
- Improve patient experience at the clinic
- Deliver quality healthcare from patient and Provider perspective



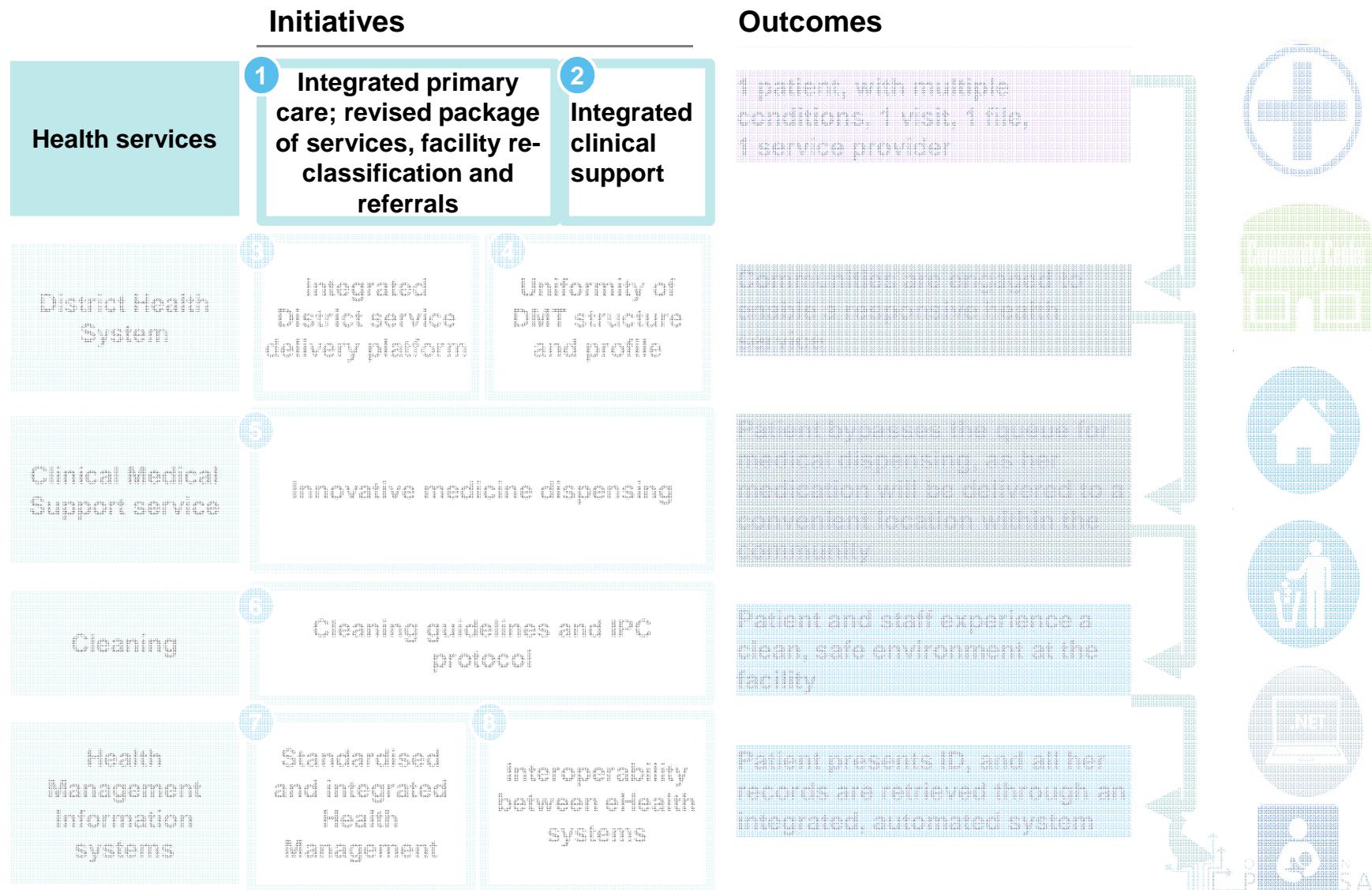
The initiatives developed by the Service Delivery workstream can be categorised as breakthrough, major delivery fixes or business as usual

Breakthrough – must win	Major delivery fix – effective execution	Business as Usual
<p>1 Integrated primary care; revised package of services, facility reclassification and referrals</p> <p>2 Integrated clinical support</p>	<p>3 Integrated District service delivery platform</p> <p>4 Uniformity of DMT structure and profile</p> <p>5 Innovative medicine dispensing</p> <p>6 Standardised and integrated Health Management</p> <p>7 Interoperability between eHealth systems</p>	<p>Business as Usual</p> <p>6 Cleaning guidelines and IPC protocol</p> <p>There are several other key enablers to improve service delivery, but are being addressed by other workstreams, such as:</p> <ul style="list-style-type: none">▪ Developing a national essential list for laboratory tests, clinical and domestic equipment and consumables to support delivery of revised package of services▪ Establishing proper structures, roles and responsibilities for clinic support personnel

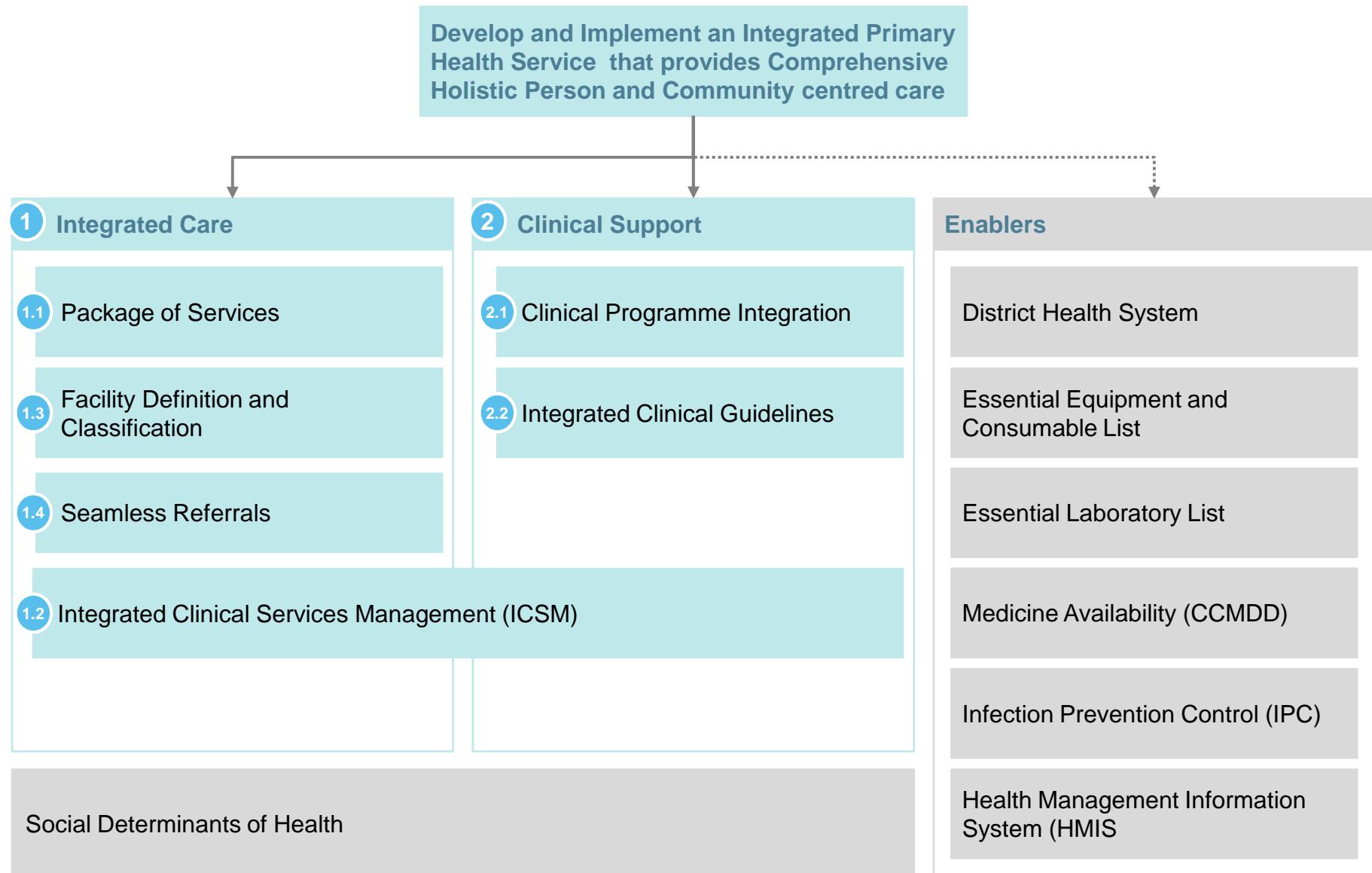
Each initiative in Service Delivery starts by providing clarity on the policy and implementation framework, certainty of guidelines to facilitate effective delivery system during implementation



The first and second initiatives will improve the delivery of Quality Health Services through integrated Clinical Service Management across the continuum of care



The Health Services initiatives are key to overall service delivery



1.1

Finalise the proposed package of services based on the continuum of care across the life cycle of an individual with a seamless transition between community and health facility

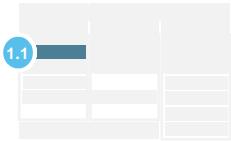
1.1

	1 Review the 1 st draft of the integrated service packages	2 National Consultative Forum review	3 Provincial consultation	4 Develop norms and standards for PHC service	5 Approval of completed documentation of the new PHC service package	6 All stakeholders consultation (facility, district and provincial)	7 Scale Up to nation wide
Steps	<ul style="list-style-type: none"> Establish a Technical Committee Revision of the draft integrated service packages 	<ul style="list-style-type: none"> Validate the proposed reclassification based on population growth and migration Consultation with Provincial 	<ul style="list-style-type: none"> Syndication with all Provincial level on the revised package of services 	<ul style="list-style-type: none"> Develop and approval of norms and standards Develop costing for service packages 	<ul style="list-style-type: none"> Roll out communication plans to all staff, community leaders, other government departments, public and patient for their feedback 	<ul style="list-style-type: none"> Produce revised handbook on revised package of services 	<ul style="list-style-type: none"> Scaling up the integrated services to nation wide
Outputs	<ul style="list-style-type: none"> 2nd draft of the integrated service packages for N 	<ul style="list-style-type: none"> Approval for circulation to Provincial level for comments 	<ul style="list-style-type: none"> Approval of concept by National and Provincial level 	<ul style="list-style-type: none"> Norms and standards agreed Costing for the revised service package completed 	<ul style="list-style-type: none"> Establish key measures of success for pilot site Select pilot site based on readiness from implementer and patient 	<ul style="list-style-type: none"> Document uploaded for public comments 	<ul style="list-style-type: none"> Continuous Monitoring and Evaluation

1.1

Lab proposes a revised service package be adopted

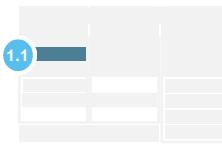
1.1



1. The package is reorganised according to the life course approach (continuum of care) where the cycle starts prior to birth up to death.
2. The package also clearly identifies what care is provided and from which type of facility or level the care should be sourced
3. The package of services was reorganised into the following main areas :
 - Promotive
 - Preventative
 - Curative
 - Rehabilitation
 - Palliative
4. The package was further aligned to include the PHC Re-Engineering streams
5. Types of facilities included are from Health Posts to District Hospitals.
6. Comprehensive community based approach underpins the service package. This includes: household, school, ECD, workplace.
7. Service package for a Health Post is clarified
8. Package includes special services like Oral Health, Eye Health, Podiatry.

1.1

Snapshot of the revised package of services in relation to the old package of services



Continuum of care

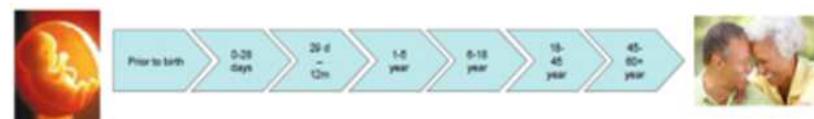
- There were no continuity of care as care is provided on a vertical program basis

Existing



Revised

- Continuity of care is provided according to life cycle approach



Classification of facilities

- Allied services such as audiology, speech therapy, eye health, dental care and psychology is limited at hospital level only
- Community based approach did not include:
 - Early Child Development
 - Rehabilitative and Palliative care

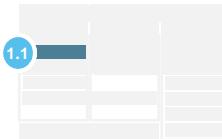
- Continuum of care is provided with the assistance of community based services through involvement of school, WBOT, NGOs, allowing for health promotion, disease prevention and care and support



- Extension of Allied services
- Inclusion of more services to the community based services reducing the concentration at clinic level



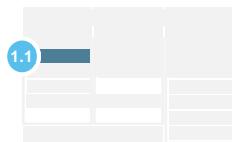
Snapshot of proposed revised package of service



Life Course	Continuum of Care	Service to be delivered	Level of Care										Service Package	
			Community Settings				Types of facility							
			Household	School	ECD	Workplace	Health Post	Mobile Clinic	Satellite Clinic	Clinic	CDC	CHC	District Hospital	
Prior to Birth (applicable to the mother & foetus)	Promotive	Early Booking												High-risk pregnant woman
		Healthy Lifestyle												High-risk pregnant woman
		Violence and Injuries												
	Preventative	Early identification of risks										Genetic Screening		
		NCD, HIV, STI, MH					NCD, HIV, STI, MH		NCD, HIV, STI, MH					
	Curative	Violence and Injuries												
	Rehabilitative													
	Palliative													
0 – 28 Days (Neonate)	Promotive	Nutrition												
		Post-Natal Screening of neonate												
	Preventative	EPI				WBOT/ School health								
		PMTCT				WBOT/ School health								
		Violence and Injuries												
		Screen New-borns for development impairment and genetic disorders			WBOT/ School health									

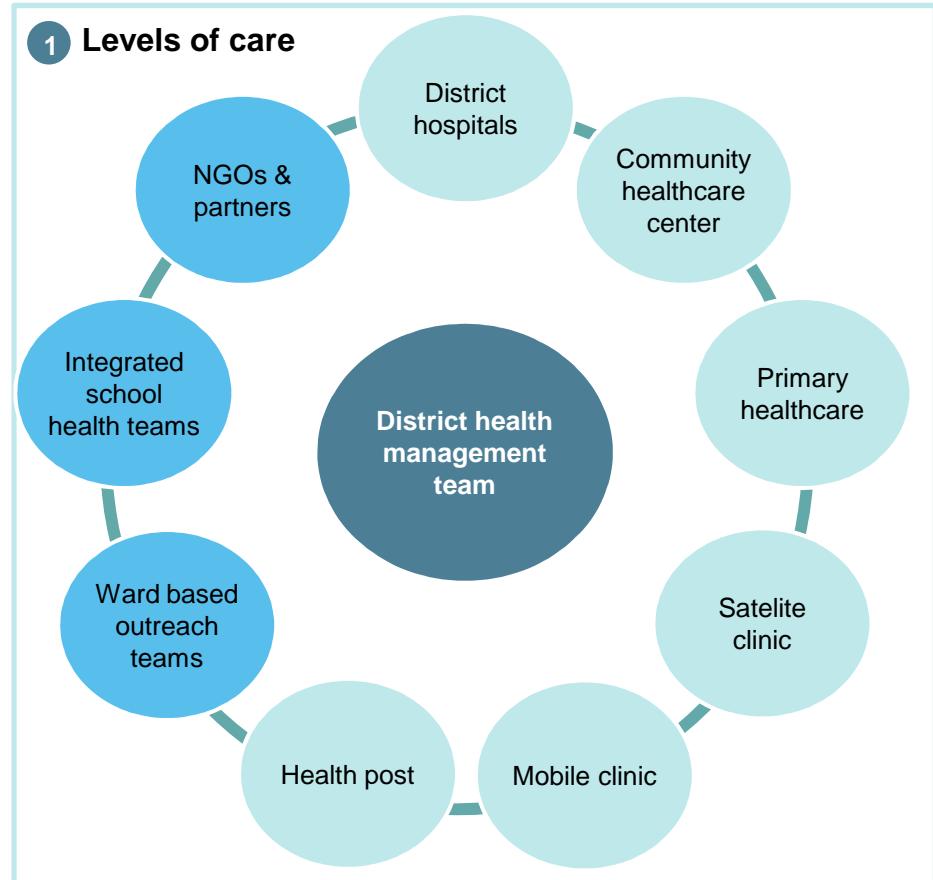
SOURCE: Operation Phakisa ICRM Lab: Service Delivery Stream, 2014

1.1 Structure of Enhanced Package of Services

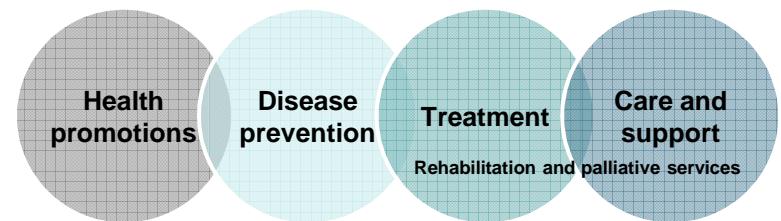


Community based services

1 Levels of care



2 Continuum of care

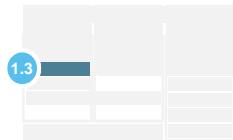


3 Lifecycle approach



Prior to birth 0-28 days 28d-12m 1-5 yrs 6-18 yrs 18-45yrs 45-60+yrs





Health Post

Is a place at which Community Health Workers, interact, report and receive guidance and instruction. They provide services in the households and community

Mobile Clinic

A mobile clinic is a service from which a range of PHC Services are provided and where a mobile unit/bus/car provides the resources for the service. This service is provided on fixed routes and at a number of points which are visited on a regular basis. Some visiting points may involve the use of a room in a building, but the resources (equipment, stock, etc) are provided from the mobile when the service is available and are not maintained at the visiting point

Satellite Clinic

A facility that is a fixed building where one or more rooms are permanently equipped and from which a range of PHC services are provided. It is open for up to 8 hours per day and less than 4 days per week

Clinic

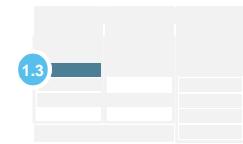
An appropriately permanently equipped facility at which a complete range of PHC services including outreach services are provided. It opens at least 8 hours a day at least 5 days per week

Community Health Centre

Community health centre provides a package of comprehensive health services as defined by norms and standards on a 24 hour basis. This facility has full time doctors, ambulance station and beds where health care users can be observed for a maximum of 48hours. It has a procedure room (not an operating theatre), radiological services (X-Ray), laboratory, oral health services, rehabilitation, pharmacy, general and maternity facilities and services. Environmental services and nutrition services is part of the package provided by CHC. CHC should support all PHC facilities and community based health services that are within the catchment area

1.3

A revised classification of clinics has been proposed by the lab; services will match the new typology



Designation	Headcount per annum
▪ Very Small Clinic	▪ Up to 8 000
▪ Small Clinic	▪ Between 8 000 and 40 000
▪ Medium Clinic	▪ Between 40 000 and 72 000
▪ Large Clinic	▪ Between 72 000 and 152 000
▪ Very Large Clinic	▪ More than 152 000

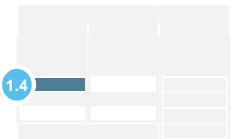
Methodology: The clinics were “sized” by workload, and groupings further reduced according to some empirical affinities

SOURCE: Proposed Classification of Primary Health Care Clinics , NDOH, 2014

1.4

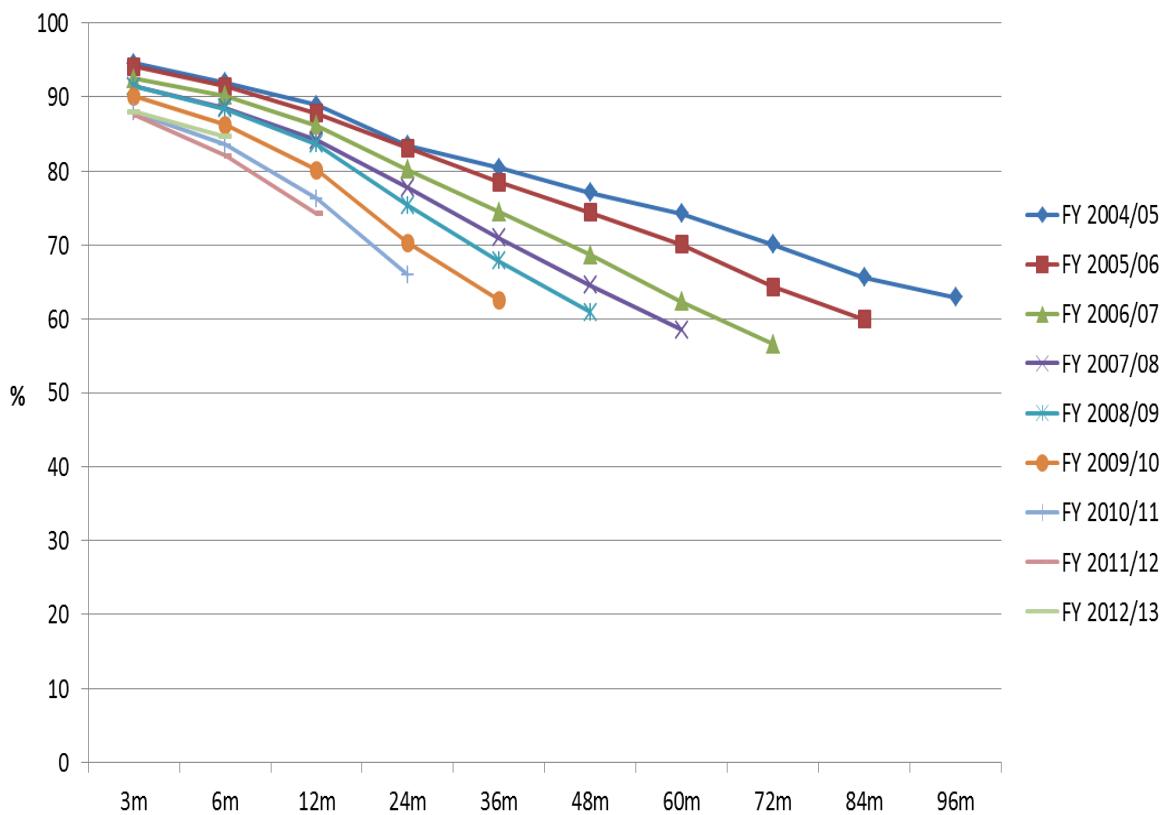
Inadequate referral system leads to poor retention in care

1.4



Percentage adults remaining on ART by duration

(Data from 352 phase 6 sites)



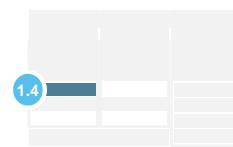
- The longer patients are on ARVs, the more chance they have of being lost to follow up. However, due to an inefficient, seamless and standardised referral system we are unable to adequately track patients moving between facilities

SOURCE: Joint Review of HIV, TB and PMTCT Programmes in SA, Main Report, April 2014, DoH

1.4

Despite policy statement and statutes calling for cross referral, the implementation remains poor

1.4

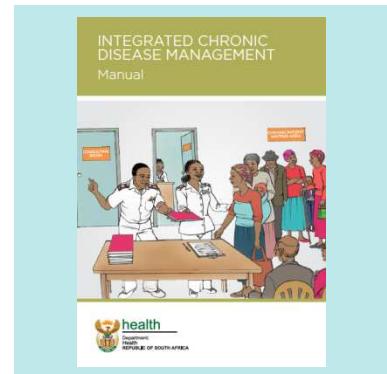
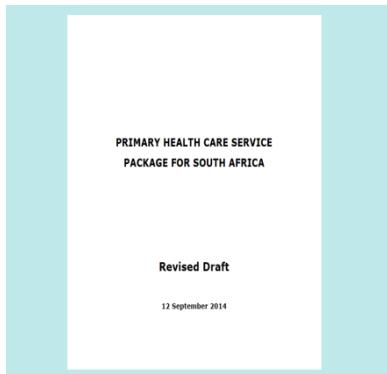


Primary Care 101	A clinical Management guideline intended to be used by all health care practitioners in PHC to manage common symptoms and chronic conditions	14 reference for referrals	Integrated Chronic Disease Management Manual	Aims to assist Facility Operational Managers to comply with National Core Quality Standards for Health Establishment	45 reference for referrals
Primary Healthcare Service Package for South Africa	A functional referral system that enables prompt and speedy management of patients in need of secondary or tertiary care is an integral part of PHC service	87 reference for referrals	National Health ActIf a public health establishment is not capable of providing the necessary treatment of care, the public health establishment in question must transfer the user concerned to an appropriate public health establishment which is capable of providing the necessary treatment of care.....	

- 23% of facilities (hospital and clinics) do not have a referral guideline
- Referral policies are not standardized and vary according to facilities and districts
- No detailed strategy for referral across provinces and also districts
- There are inadequate mechanisms for referral

We will develop a cross referral strategy and implementation plan that includes community based services to ensure better outreach of care and improve the patient's health, economic and social benefits

Successful implementation of programs rests on a successful referral system



PC 101

14 References to up and down referrals

- A clinical Management guideline intended to be used by all health care practitioners in PHC to manage common symptoms and chronic conditions for adults

Primary Health care Service Package for South Africa

87 References to up and down referrals

- A clinical Management guideline intended to be used by all health care practitioners in PHC to manage common symptoms and chronic conditions for adults

Integrated Chronic Disease Management Manual

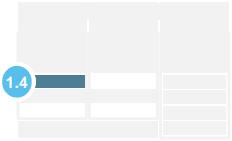
45 References to up and down referrals

- Aims to assist Facility Operational Managers to comply with National Core Quality Standards for Health Establishments

National Health Act

- If a public health establishment is not capable of providing the necessary treatment or care, the public health establishment concerned must transfer the user to an appropriate public health establishment which is capable of providing the necessary treatment or care in

Overview: A Seamless, Standardized health referral system without geographical and sectoral boundaries

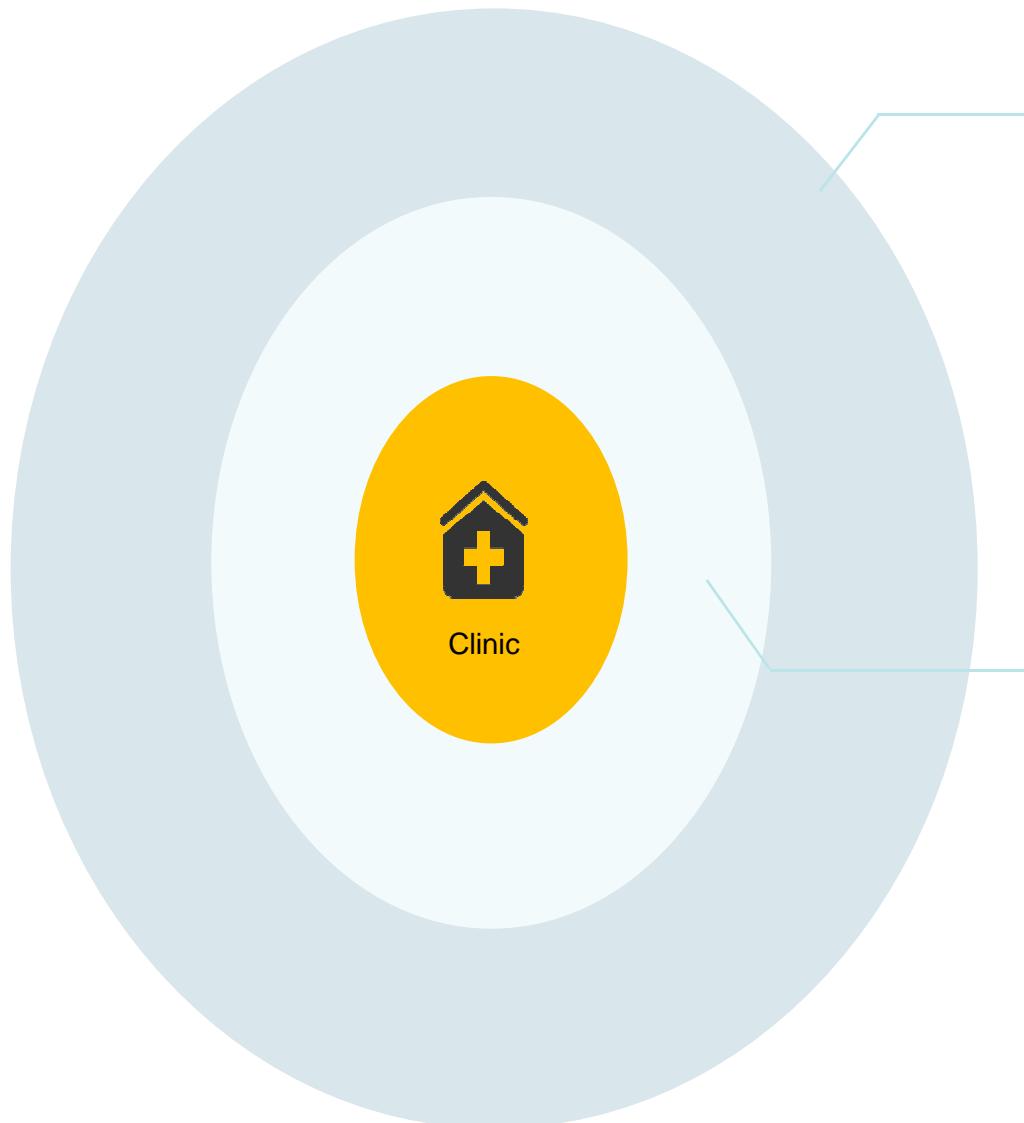
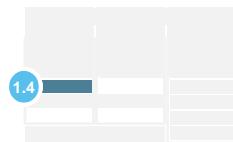


- Establish feedback mechanisms for referring organisations
- Training in referral system to all healthcare providers and included in curriculum
- Ensure referral across facilities is not restricted by boundaries by enabling invoicing across different provinces
- Community awareness campaigns and other information sharing on the referral system
- Information technology to enhance referral system



1.4

With effective cross referrals and involvement of community based services, the public will have faster, cheaper access to public healthcare (1/2)



Community Based Service

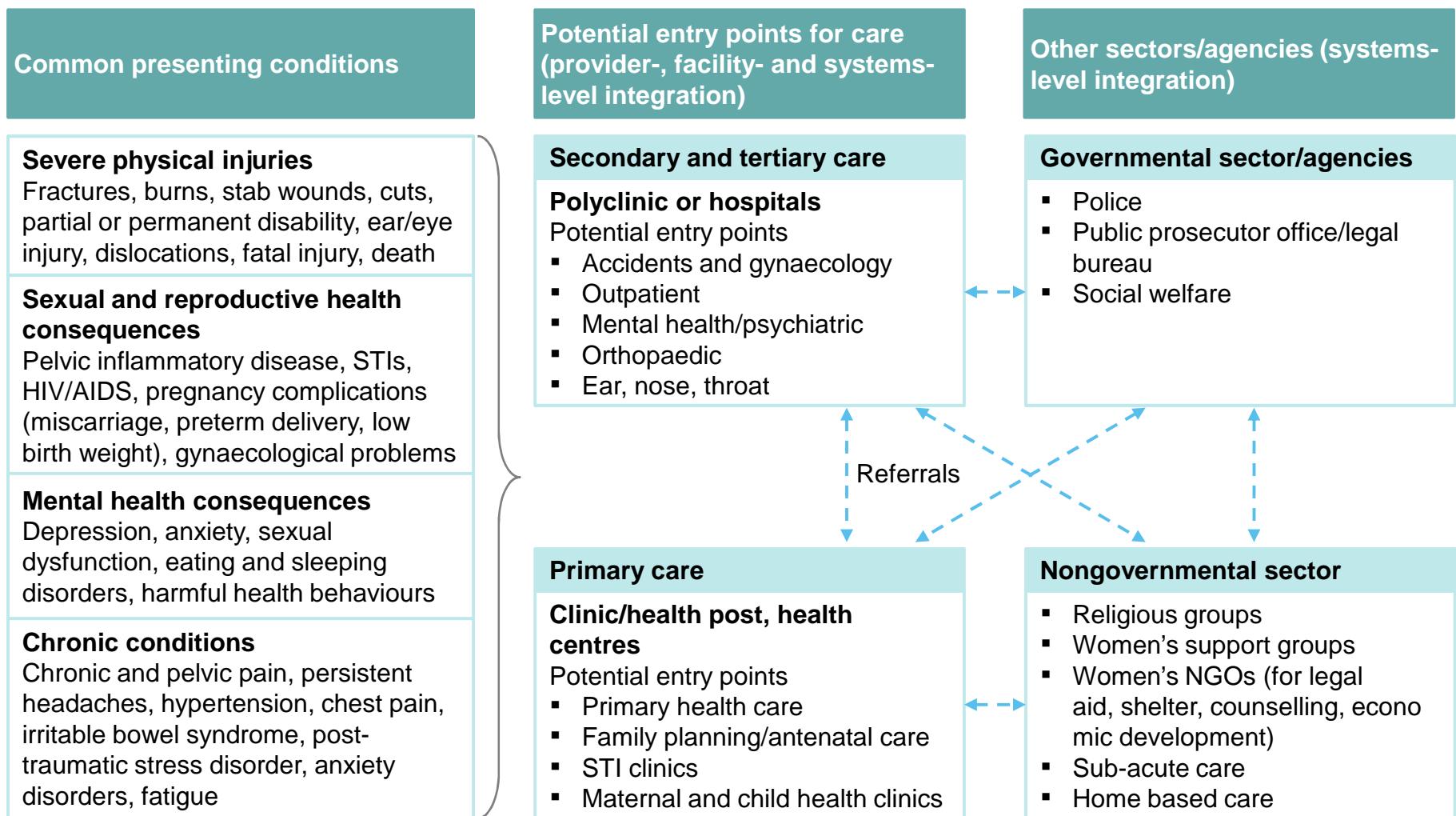
- Home Base Care
- School
- WBOT
- Traditional Healer
- General Practitioner

Other health facilities beyond the district

1.4

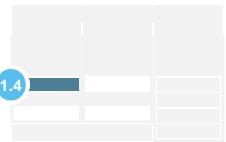
With effective cross referrals and involvement of community based services, the public will have faster, cheaper access to public healthcare (2/2)

1.4



SOURCE: "Health-sector Responses to Intimate Partner Violence in Low- and Middle-income Settings: A Review of Current Models, Challenges and Opportunities." Bulletin of the World Health Organization

What referral policy should contain

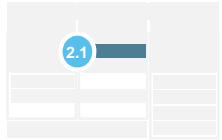


Key principles required to make a referral process work effectively

- Timely access to relevant patient information
- Effective communication between all organisations along the continuum
- Available resources across the continuum (Human and other)
- Everyone to be implementing the process and using the system tools

“A functional referral system that enables prompt and speedy management of patients in need of secondary or tertiary care is an integral part of PHC service.” PHC Service Package

SOURCE: Benguela “Strengthening the public referral systems in KwaZulu Natal Province, South Africa, Final Referral system project report



Pros

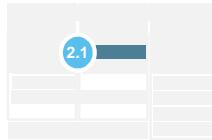
- Holistic care
- Comprehensive
- Person focused
- Quality of care

Cons

- Time consuming per individual consultation
- Demand for high level multi-skilling

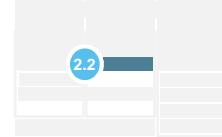
2.1

Clinical programme integration



- Clinical programme integration (HIV,TB,NCDs,MCWH)
- Review and align national clinical programme policies to reflect continuum of care and life cycle approach seamlessly at facility and community levels
- Review and revise national programme specific clinical guidelines as per revised policies
- Review and align clinical programme supervision, coaching and mentorship
- Develop and implement a change management programme to address shift from vertical to comprehensive integrated care

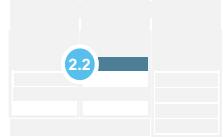




5 Clinical guidelines integration

- 5.1 Review and revise existing and; develop new (where applicable) clinical guidelines in relation to the proposed package of services.
- 5.2 Develop a user - friendly integrated package of clinical guidelines for the appropriate levels of care.
- 5.3 Develop and implement strategies to capacitate new and existing health workers on the integrated clinical guidelines and the revised programme policies.





Current measures

Service quality – patients satisfaction scores

Technical quality – clinical indicators

Disadvantages

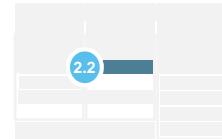
- Negates the professional input and clinical decision making thus leading to demoralization of staff and high turnover

Proposed additional measure

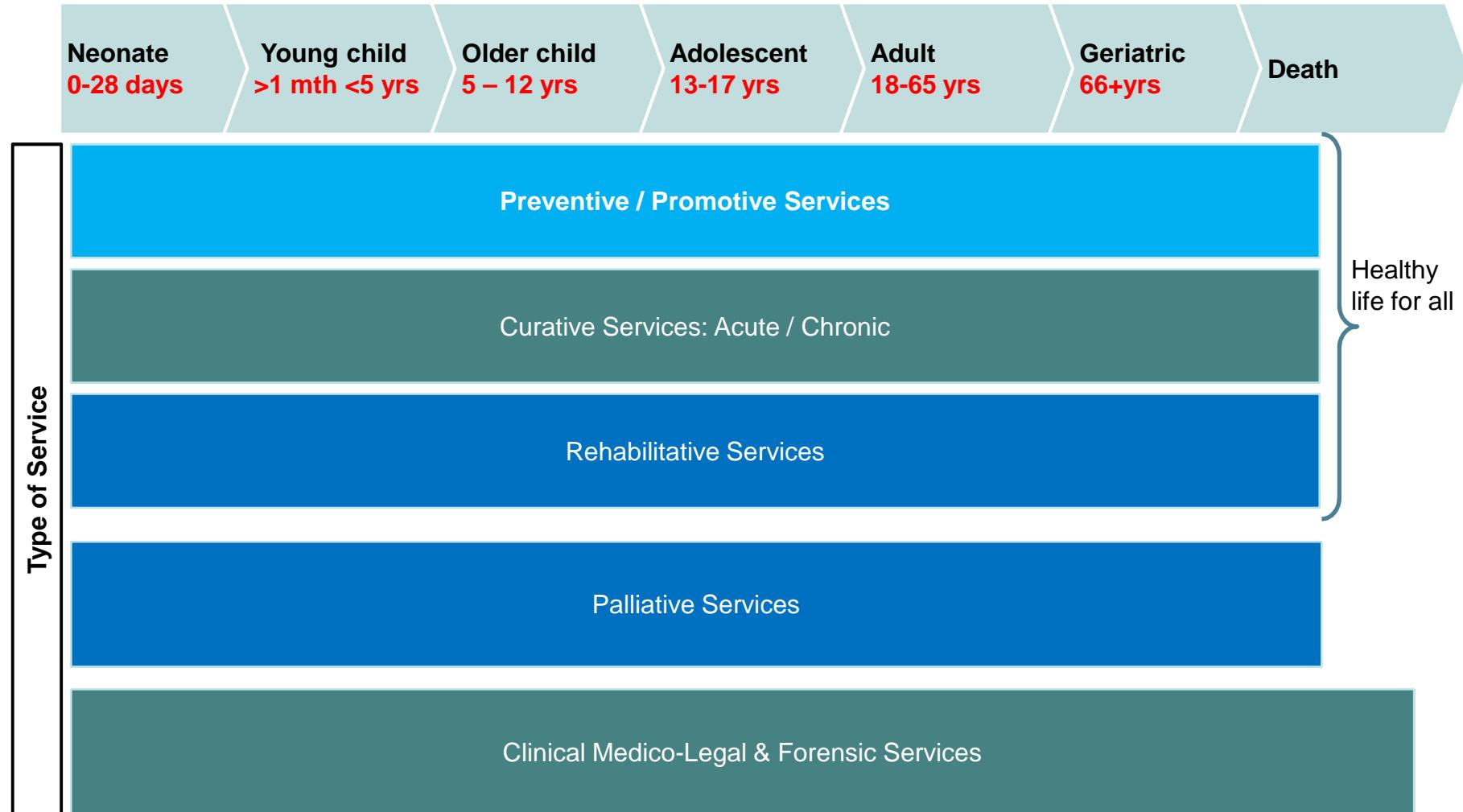
Ethics quality - practices throughout an organization are consistent with widely accepted ethical standards, norms, or expectations for a health care organization and its

2.2

Health Matrix for Clinical Guidelines(1/2)



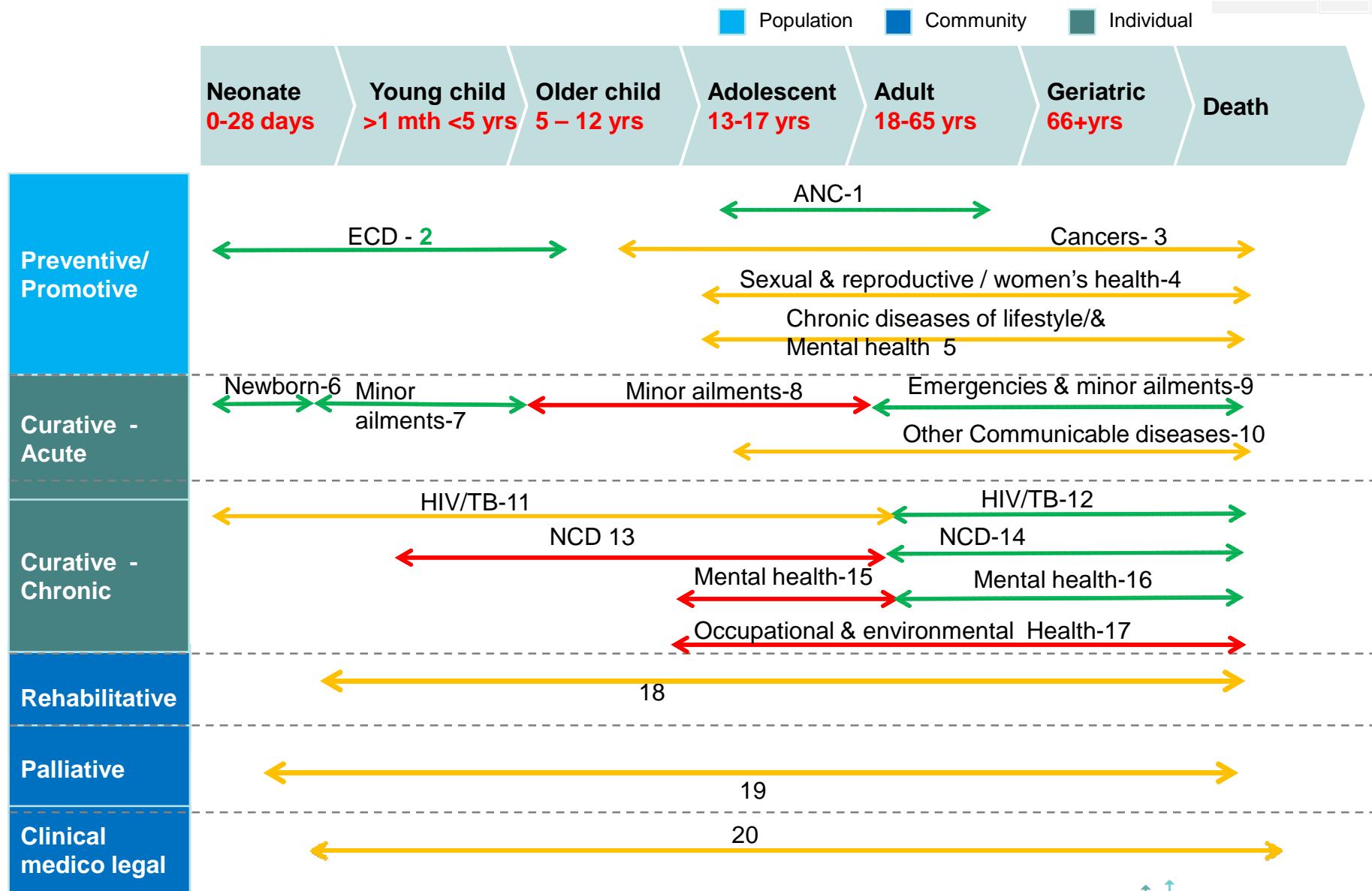
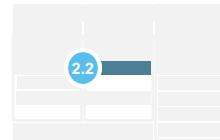
Population Community Individual



SOURCE: Dr S Asmall -2013

2.2

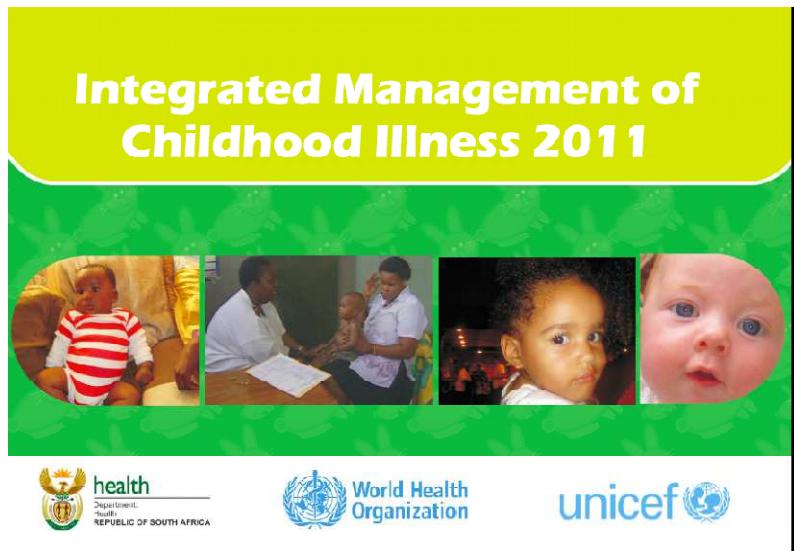
Health Matrix for Clinical Guidelines(2/2)



SOURCE: Dr S Asmall -2013

2.2 Proposed User-friendly Package

2.2



INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS	
SICK CHILD AGE 2 MONTHS UP TO 5 YEARS	SICK YOUNG INFANT (BIRTH UP TO 2 MONTHS)
Assess, Classify and Identify Treatment	Assess, Classify and Identify Treatment
General Danger Signs 2	Possible Bacterial Infection and Jaundice 30
Cough or difficult breathing 2	Damn 31
Wheezing 2	HIV infection 31
Diarrhoea 3	Feeding and Growth in Breastfed Infants 33
Fever 4	Feeding and Growth in non-Breastfed Infants 34
Malaria 4	Special Risk Factors 35
Ear problem 6	Immunization Status 35
Malnutrition and Anaemia 7	Other Problems 35
HIV infection 8	Mother's Health 35
TB 8	
Immunization status 9	
Other problems 9	
Oral Drugs	Treat the Young Infant and Counsel the Mother
Amoxicillin 10	Enteral Feeding 38
Co-codamol 10	Ceftriaxone 38
Cromizazole 10	Diarrhoea 38
Erythromycin 10	Rutin Supplementation 37
Antitussives	Immunize Every Sick Young Infant 37
Prednisolone for Recurrent Wheeze 11	Local Infections at Home 37
Salbutamol for Wheeze 11	Correct Positioning and Attachment for Breastfeeding 38
HIV positive therapy 12	Replace Breastfed Feeds 39
Treat for TB	General home care 40
Antiretroviral Drugs	When to Return 40
Zinc 12	
Iron 13	
Paracetamol 13	
Mebendazole 19	
Vitamin A 19	
Treatment for Local Infections	
Dry eye - wash and give eardrops 14	
Mouth Ulcers 14	
Thrush 14	
Soothe the Throat, relieve the cough 14	
Eye Infection (measles) 14	
Treatments in Clinic Only	
Cefixime 15	
Diazepam 15	
Salbutamol for wheeze & severe classification 15	
Nebulized Salbutamol 15	
Prednisolone for stridor or recurrent wheeze 15	
Prevent low blood sugar 16	
Treat low blood sugar 16	
Oxygen 16	

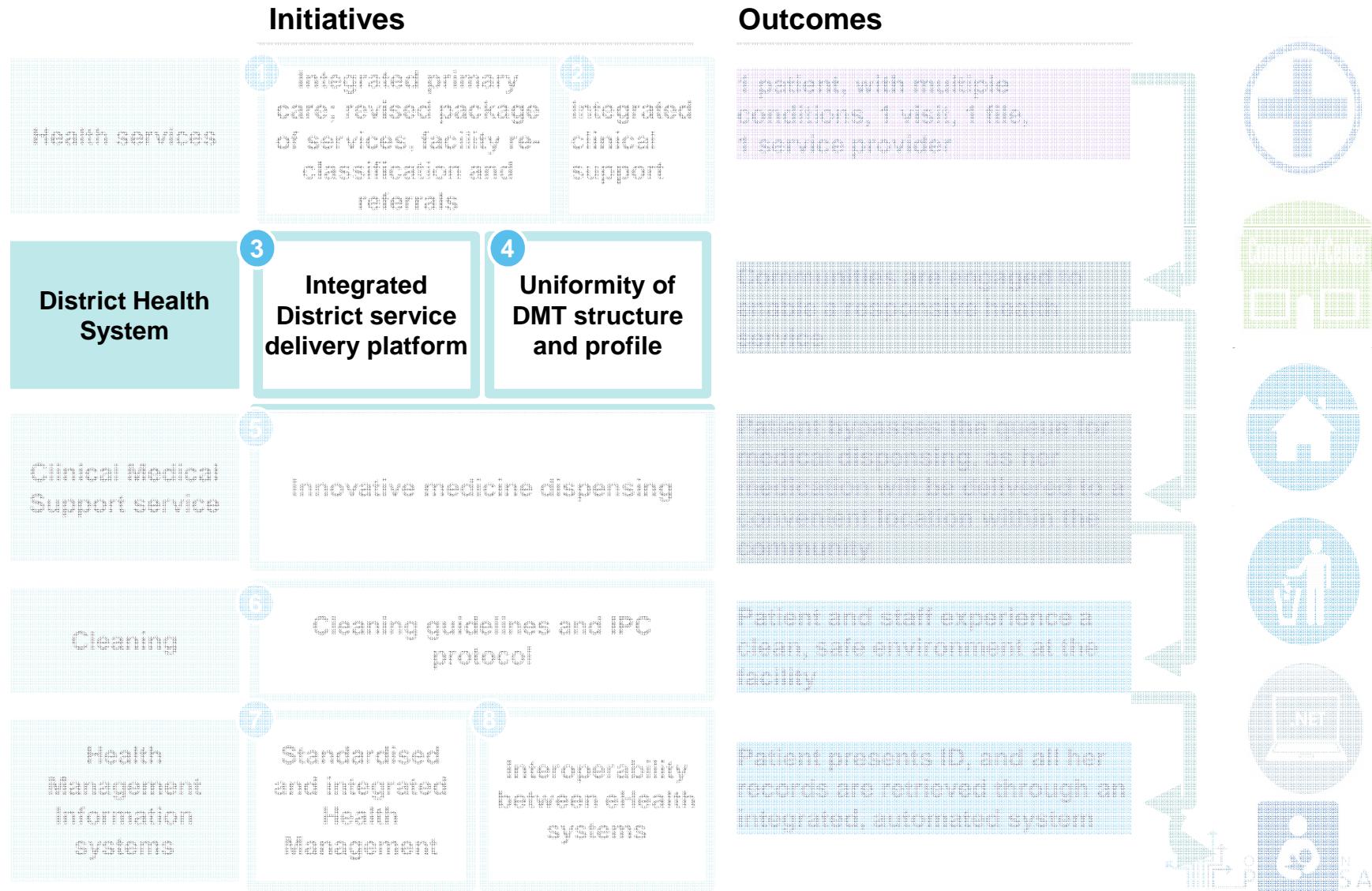
1

South Africa 2011



STANDARD TREATMENT GUIDELINES AND ESSENTIAL MEDICINES LIST FOR SOUTH AFRICA	
PRIMARY HEALTH CARE LEVEL	
2008 EDITION	

The third and fourth initiative will improve the function of District Health Systems in delivering quality healthcare



Key initiatives to strengthen delivery of Ideal Clinic Realization and Maintenance

Uniformity of DMT structure, delegation & profile



- Develop of the ideal DMT profile and structure
- Assessment and gaps in competencies as compared to the ideal
- Develop a training and mentorship programme to address gaps in current capacity and structure
- Implementation plan towards a uniform structure

Integrated Service Delivery platform



- Conduct an in depth population profile, disease burden analysis for each district
- Conduct a district-based situation analysis of health facilities, community services, staffing, services, schools and NGOs in the district
- Develop a district program to overcome gaps identified in the analysis
- Establish a multi-sectoral collaboration initiatives to address social determinants
- Implementation of programme in 52 districts
- Ongoing M&E of implemented progr

National Referral policy



- Review the national referral policy and implementation guidelines in collaboration with stakeholders.
- Implementation of natinal policy
- Monitoring and evaluation of implementation of referral policy at District level

- ✓ Standardised DMT Structure with relevant competencies and relevant authority
- ✓ Service Delivery is integrated (including EMS and addresses Social Determinants of Health)

SOURCE: Lab analysis

3 Integrated Service approach from District Health System

Context

- The Social Determinants of health have a high impact on the health outcomes of communities. Health facilities are expected to deliver high quality service to improve patient outcomes with limited support and collaboration with other sectors

Case for Change

- A clinic will not be able to operate without the appropriate support and resources and therefore unable to deliver a quality care.
- Not all patients receive the same quality of holistic care across the country.
- This is aggravated with a centralized approach and lack of appropriate delegations being given.
- Staffing and the allocation of staff are inequitable and not based on a model which contribute to quality care.
- There is currently no properly structured multi-sectoral collaboration to ensure a prompt provision of resources and delivery of a quality health service to address the social determinants of health
- A lack of leadership at the district level for effective multi sectoral collaboration

3 Integrated Service approach from District Health System (District to Facility)

Elimination of fragmentation within the district health system to ensure collaboration and joint service planning to address the social determinants of health

- Comprehensive planning at district level which is then further operationalised to individual facility level
- Multi-sectoral collaboration when planning new initiatives to ensure preventive, promotive, curative and environmental services are included
- Ensure community involvement in planning through community structures and management of these structures
- Minimisation of guiding documents to inform service provision at facility level
- District partners and NGOs to be coordinated to ensure service delivery/Technical assistance is in line with district health priorities and is integrated for sustainability
- Training on strategic planning

The solution will result in a well coordinated systemic accountability with a peer review, teamwork for a high value care within the district health system(district and facility).

3 Recommendations and Steps for Implementation

- Conduct an in-depth population profile/disease burden analysis for each district
- Conduct a situation analysis of health facilities, community services, staffing, services, schools and NGOs in the district
- Develop strategy to overcome gaps identified in the analysis
- Implementation of strategy
- Ongoing M&E



3 Impact

- Coordination of services at a district level so the patient is provided with the right service, by the correct service provider, at the right time
- District planning includes NGOs, CBOs, Schools and all services provided in the district
- Effective multi-sectoral collaborative structures in place
- Social determinants of health show improvement



Differences noted in district structures (Eastern Cape, KwaZulu-Natal, Limpopo and Mpumalanga)

District level	Sub-district, CHC & Clinics
<ul style="list-style-type: none"> ▪ Different names for same components ▪ No uniformity on the programme managers appointed in terms of number and functions ▪ Infrastructure component not addressed in some districts ▪ Some with no allied professionals appointed ▪ some with hospital & PHC coordinators ▪ NGO coordination not addressed in some districts ▪ No Pharmacy coordination ▪ Forensic services not addressed ▪ Emergency and medical coordination also not addressed ▪ Too many managers when there are many programmes 	<ul style="list-style-type: none"> ▪ Different structure for different provinces ▪ Different services provided at the same levels of care ▪ School services not addressed in all levels ▪ Different names used for auxiliary services in different provinces ▪ Size of the structure is determined by the number of facilities in the area ▪ Too many managers when there are too many programmes

4 Compelling case for initiative

- Inadequate delegation of authority to manage financial and human resources
- Inadequate, inefficient and non standardized management structures for implementation of a national service package
- Inadequately defined roles and responsibilities of the DMT, including health programme coordinators and PHC supervisors
- The relationship between the operational manager and other district health team members is not always well understood which includes reporting lines and supervisory responsibilities
- No uniform understanding of the roles and responsibilities of the programme manager and the clinic supervisor in terms of facility supervision
- The lower levels of management has limited role in determining how health financial resources are spent in the district.
- Poor management skills limits oversight, planning, coordination and monitoring of health system activities at all levels
- The Operations manager is often a part of the patient care team due to staff shortages and inappropriate clinic staff structure. This leads to overwork and burnout due to the added administrative duties.
- Poorly developed performance agreements between management and subordinates compromises effective performance assessments
- Large number of programme managers who give input into facilities leading to fragmented health services and unequal quality of programme delivery

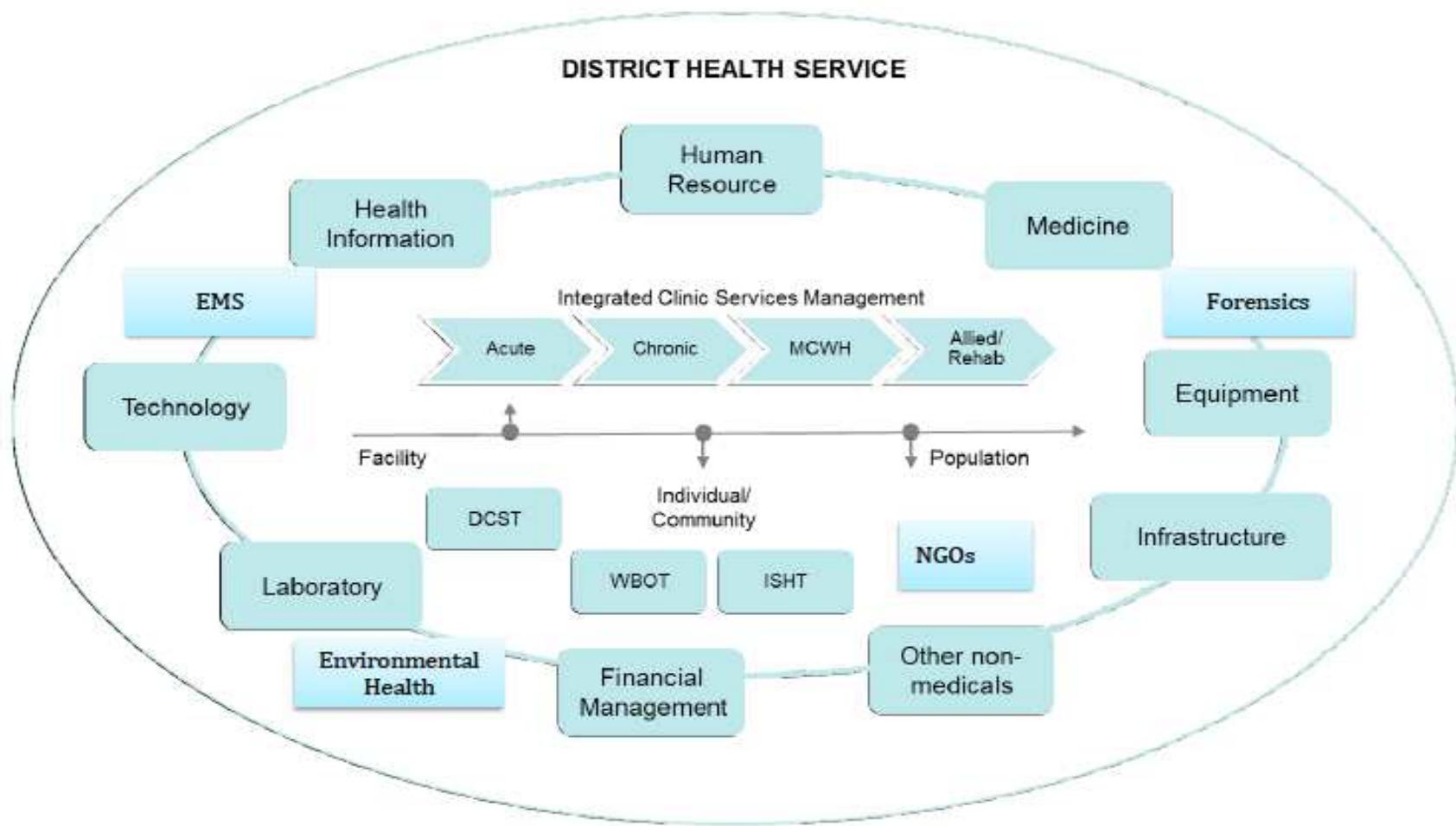
4 Develop and implement a standardized DMT structure and profile

To develop a generic DMT structure with clearly defined accountabilities to deliver on national service delivery mandates by 2018

- Profiling of District and sub district management team including clinic supervisors and operational manager positions to be done
- Defining of the DMT structure as well as supervisory support that will establish and support an enabling environment towards improved health outcomes and achieving an efficient and effective District health system
- Services to be aligned and coordinated between District Hospital, PHC facility, EMS, DCSTs, WBOTs and HBC service providers through integrated management structures
- Rolling out of structure to all 52 districts

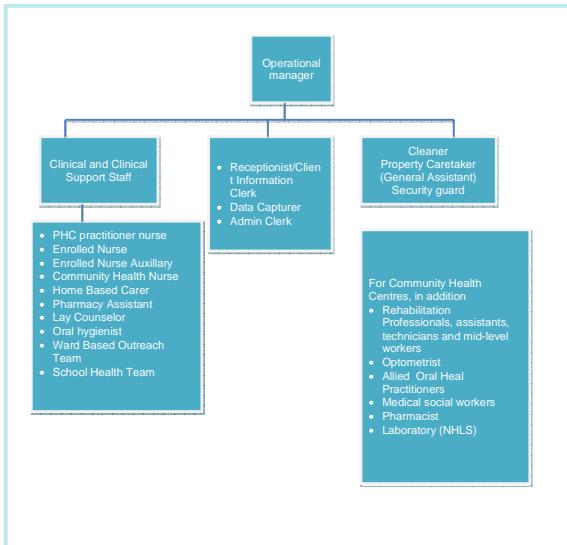
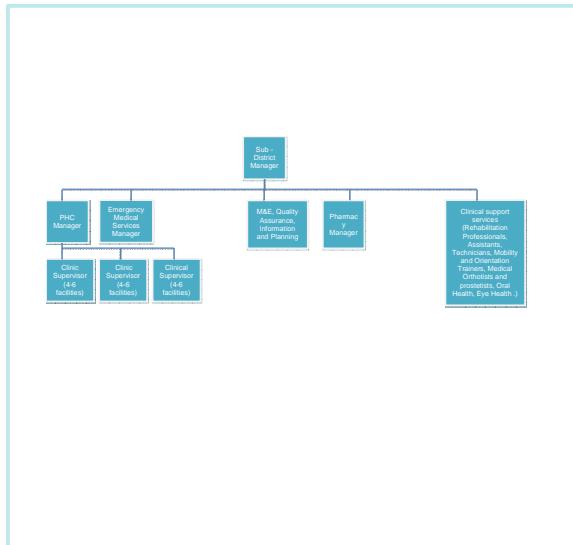
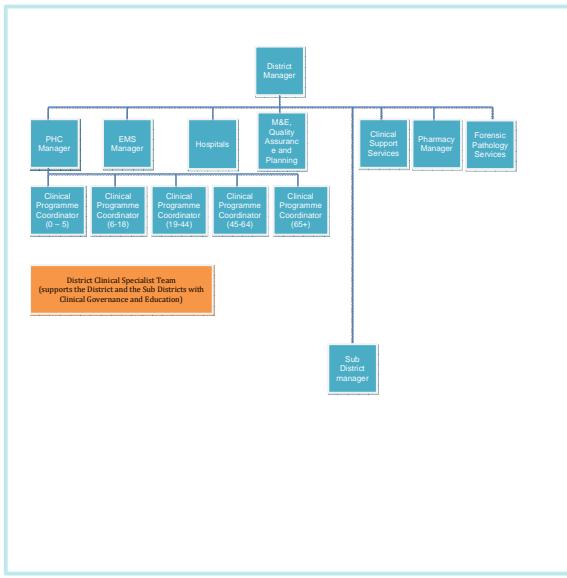
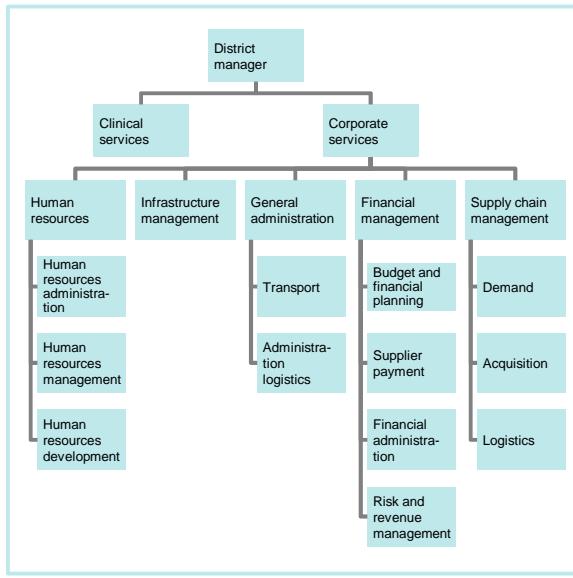
An appropriate DMT and supervisory support will improve service delivery at facility level

4 DMT structure and profile will be standardized following the proposed model (ICSM)



Developed for ICSM model – Dr S Asmall & Dr O Mahomed, 2014

Revised district, sub district and facility structures proposed

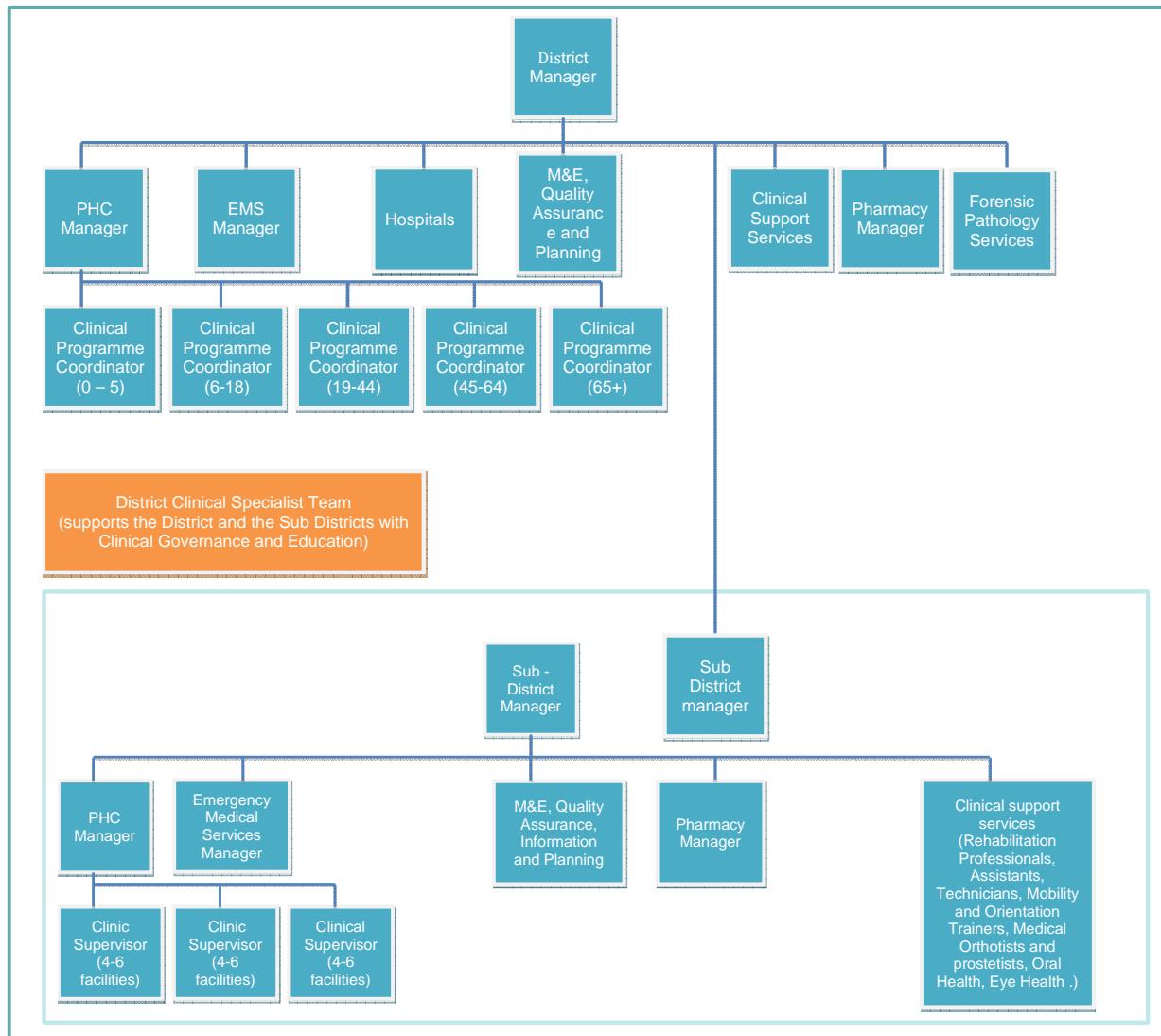


Proposed Changes

- District Hospitals to fall under the District manager and be represented on the sub district level
- Programme managers set up for programmes according to age group rather than disease
- Programme managers present at the provincial level
- Clinic supervisors proposed at sub district level to oversee and provide mentorship to 4 clinics
- Clinic supervisors trained in all areas and take responsibility for their clinics' performance

4

Revised district, sub district and facility structures have been proposed (1/2)



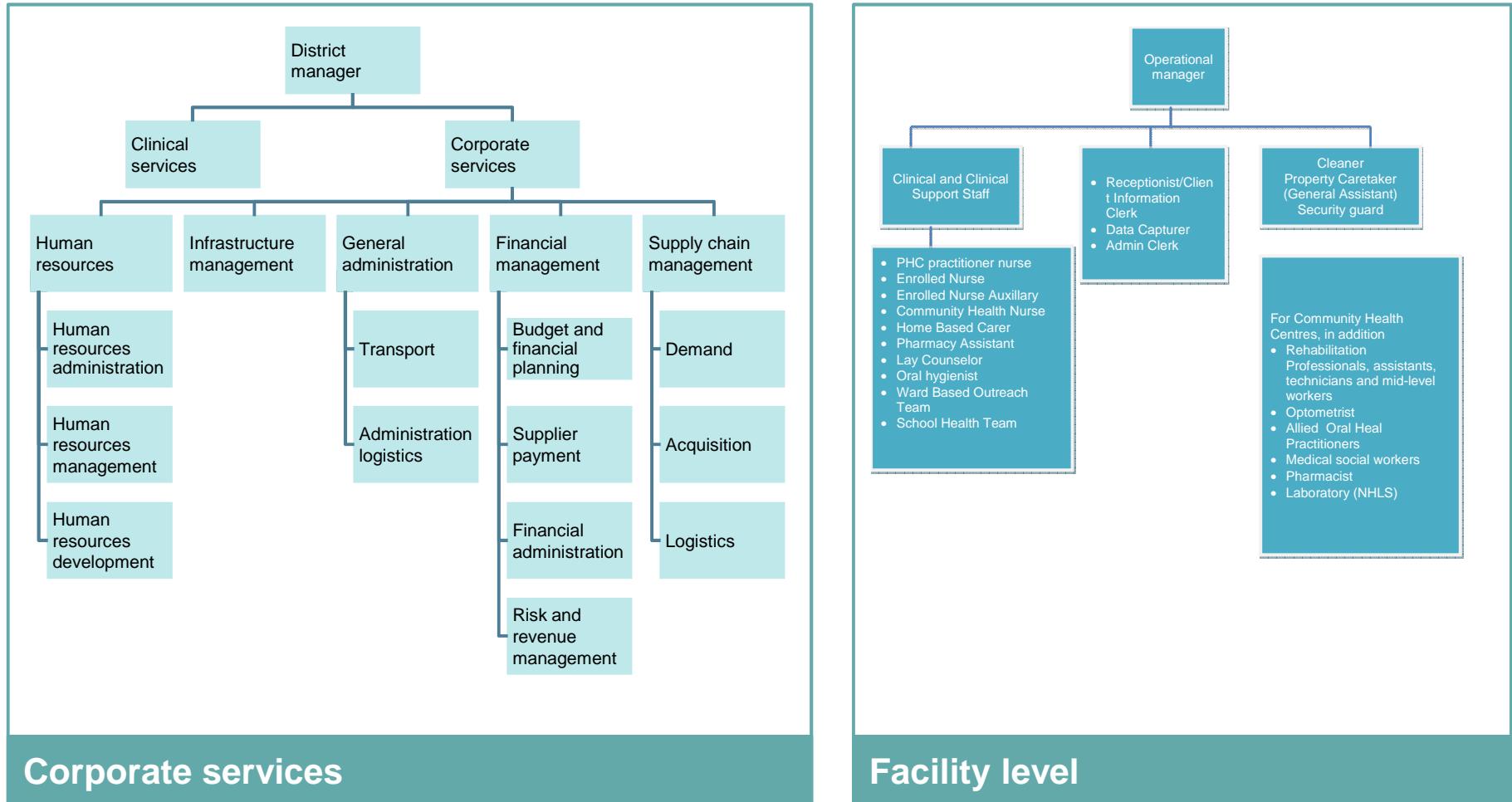
Proposed Changes

- District Hospitals to be fully integrated at sub district level
- Provincial and National programme managers to be rationalised in accordance with the life stage approach
- Clinic supervisors proposed at sub district level to oversee and provide oversight and mentorship to 4 clinics
- Clinic supervisors to be trained in all areas (multi-skilled) to take responsibility for their clinics' performance

4

Revised district, sub district and facility structures have been proposed (2/2)

Proposed corporate and facility level structure



4

Case studies on DHS

- The Navrango experiment(Ghana) illustrated that by relocating nurses to communities and re-orientating management systems to be more supportive of accessible community-based nursing care, childhood mortality was reduced by a third in seven years and the total fertility rate declined by one birth in a decade(HST-International Perspective on Primary Health Care over the past 30 years)
- HST-Lessons learnt in implementation of Primary Health Care : Experiences from health districts in South Africa(2003):
 - The first lesson is that without a permanently appointed management team, which is given full responsibility and accountability for being in charge of health services in the district, it is difficult to make sustainable improvement
 - The second lesson is that the role of the national and provincial health department should be one of guidance, protection from undue pressure, support and nurturing of their districts



Recommendations and Steps for Implementation

- Eliminate programme management structure and implement clinical management structure to support facilities, DCSTs and WBOTs
- Capacitate Clinical Supervisors to provide support to Operational managers in the implementation of all programs and NCS
- Hold clinical supervisors accountable for facility/teams' performance they are responsible for
- Profiling of district and sub district management team, clinical managers and operational managers
- Engage district health partners and NGOs to assist in implementation where possible

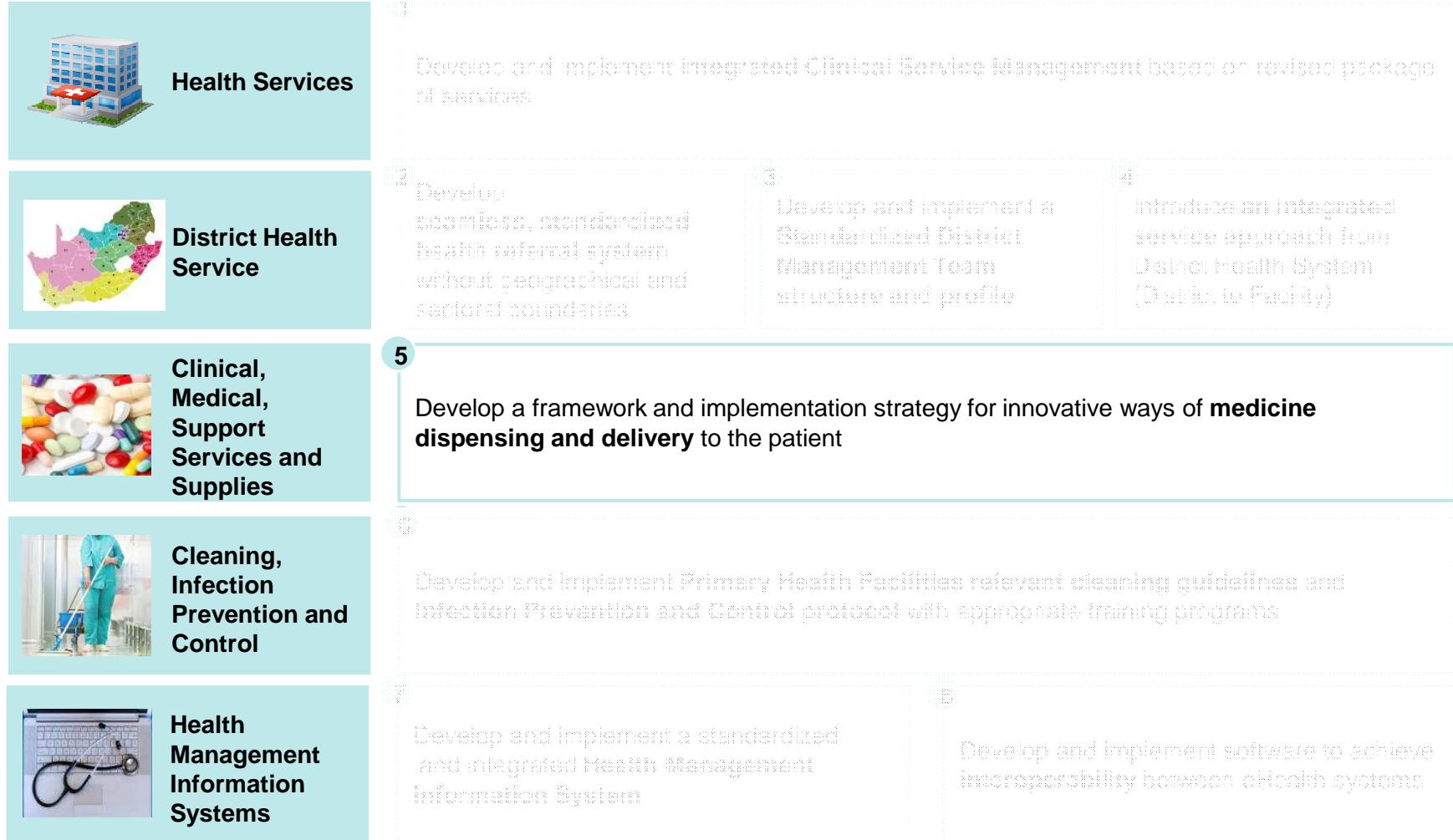


Impact

- A more holistic approach to patient care
- Improved facility performance due to improved supervision and support
- Cost effectiveness through improved district management
- Greater local control over health activities of the district health system



The fifth initiative aims to improve the access for medications prescribed to patients with chronic conditions, at the patients' convenience



5

Develop a framework and implementation strategy for innovative ways of medicine dispensing and delivery to the patient

Multiple ways of alternatively dispensing prescribed medications based on the geographic locations of the patients with all chronic condition, based on patients' choice and convenience, without having to go to PHC every month.

Option (s)	Mechanism	Plan for Rollout
A Central Chronic Medication Dispensing and Distributions (CCMDD)	Expansion on National Health Institute's CCMDD (dispensation of prescriptions for patients with certain chronic conditions and distribution of already dispensed patient medicine parcels to pickup points) to include all chronic conditions.	<p>2016 All PHCs to implement the innovative options to dispense and delivery</p> 
B Direct Deliveries	Direct deliveries from a "courier pharmacy" to a community or institutional pharmacy or consultation rooms of an authorized prescriber or PHC or satellite clinic health post.	<p>Phase 3 (Jul – Oct 2016)</p>
C Mobile Pharmacy	Pharmaceutical services from a mobile pharmacy be provided in compliance with applicable legislation, following the pre-determined route, date, and time.	<p>Phase 1 (Jan – Apr 2016)</p> <p>Phase 2 (Apr– Jul 2016)</p> <p>Pilot (Feb– Dec 2015) 10 initial PHCs across different districts and rurality.</p>
D Remote Automated Dispensing Units (RADU)	The use of automated systems to dispense (package and label) prescription medications without an on-site pharmacist	<p>Project preparation (Nov 2014 – May 2015)</p> <p>Geo Mapping analysis & service mapping Readiness of Dispensing and Distribution Options Survey Legislations/Regulations enforcements / fast-tracking of amendments</p>

5

Patients with chronic conditions served by the public system need to collect their repeat prescription medication monthly at PHCs, leading to congestion

Current Situation

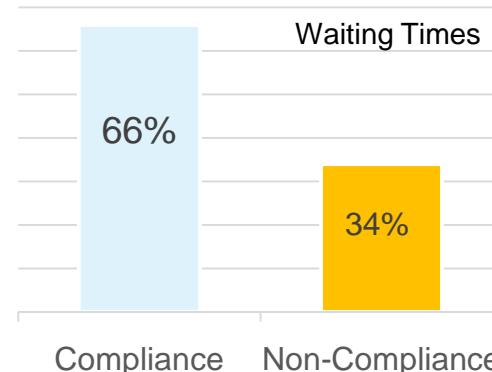
Target for PHC Utilization Rate is **3.5** visits annually



However, at least 50% of patients seen in PHC clinics are chronic patients that require monthly visits, increasing the utilization rate to more than **12** visits annually

Implications

This leads to the increase of waiting times at PHC....



34% of PHC Clinics does not comply with the standard waiting times

Impact on socio economy and productivity

Average total costs per visit

R96

(inclusive of transport, fee, substitute labor, income loss)

Median travel time

1- 4 hours

for a round trip

..in addition to the increased congestions at PHCs, increasing workload of the PHC health workers and taking away the time from acute patients / chronic patients requiring immediate medical attentions.

SOURCES: Provincial Profile from National Department of Health, 2014

The National Health Care Facilities Baseline Audit: National Summary Report 2012 ;

Cost to patients of obtaining treatment for HIV/AIDS in South Africa: SAMJ, July 2007, Vol.97, No.7

5

Innovative medicine dispensing and delivery mechanism is proposed to increase patients' convenience and reduce congestions in PHCs

The components of the framework must include:

Legislation



Enforcement and fast-tracking of amendments of appropriate legislations and regulations to allow the activities related to the new proposed mechanism to be carried out legally and effectively while ensuring patient safety.

Clear scope of responsibilities for functions and roles involved in prescribing, dispensing and delivery of medicines



Enablers

SUPPLY CHAIN MANAGEMENT
INFRASTRUCTURE
HUMAN RESOURCE

*(handed over to appropriate lab work streams)

Mechanism

The dispensing and delivery system for Chronic Medication at PHC Level in South Africa that allow for flexibility in where and at what time the patients can collect their medication.

Modes of dispensing to satisfy the following phases / activities :

Phase 1	Prescription Evaluation
Phase 2	Preparation of Prescription
Phase 3	Patients Counseling
"Phase 4"	Wholesale Distribution

*to be dealt with when courier pharmacy become legislated

HMIS Support

Mechanism to be supported by HMIS to allow proper referral system, verification and validations of prescriptions.

SOURCES: Lab Discussion and Analysis

5

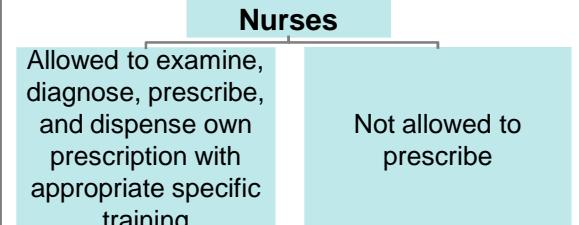
The following enforcement and fast tracking of existing amendments are proposed to allow for innovative medicine dispensing and delivery

1

Authorization of Nurses to be prescribers in terms of Medicine Control Act 101 of 1965

- To remove confusion on the role of nurses in being able to prescribe and dispense own prescription and being an authorized prescriber

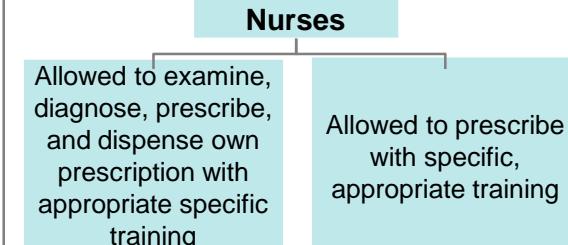
NOW



Since 2005, due to the burden of workload, several directives were circulated to extend the provision 56(6) to allow all nurses to prescribe and a pharmacist to dispense which is

ILLEGAL

AFTER ENFORCEMENT



Specific nurses are permitted to examine, diagnose, prescribe and/or dispense own prescription depending on the level of training and prescribe

2

Fast Tracking amendments in Pharmacy Act 53 of 1974

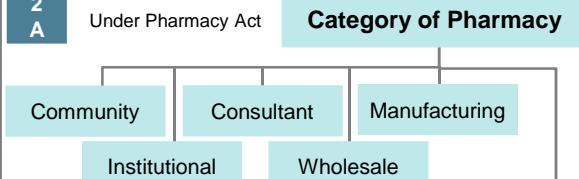
2 A

To fast-track the provision of courier pharmacy that comply with the current legislative framework

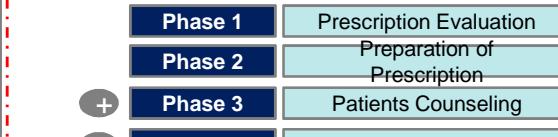
2 B

To fast-track the transition from the Pharmacy assistants to Pharmacy technicians who has more comprehensive role in dispense medication

2 A

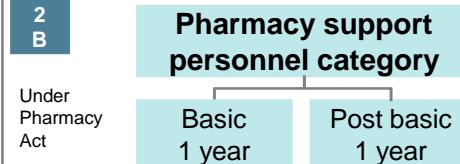


*To include Courier Pharmacy

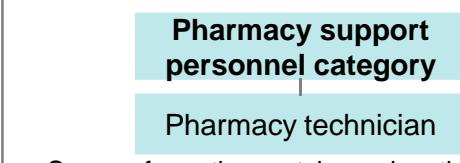


Allow for expansion of CCMDD and direct delivery

2 B



To be phased out
to

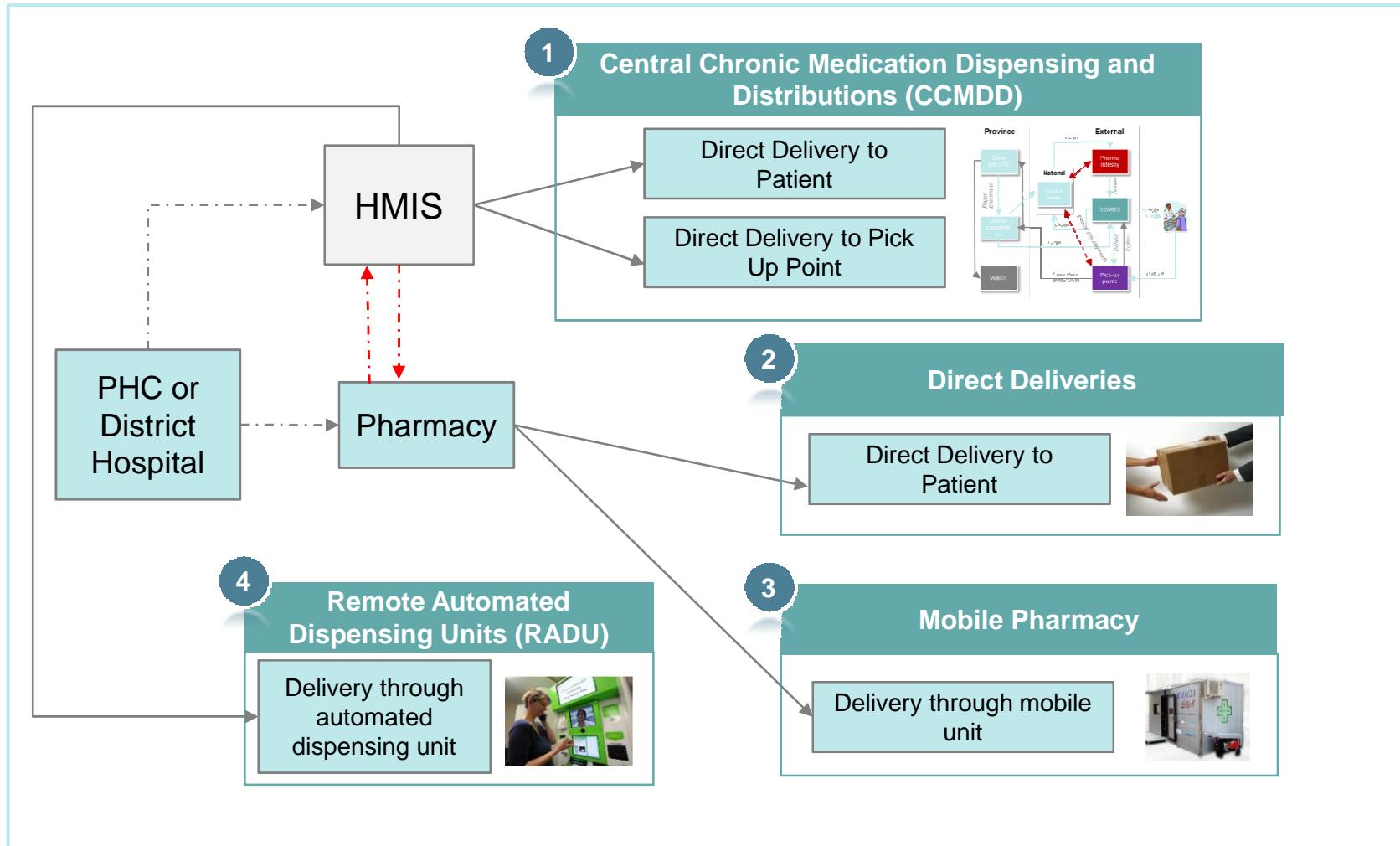


Scope of practice matches education skills
Able to work more independently
Allow for career progression

SOURCES: Lab Discussion and Analysis

5

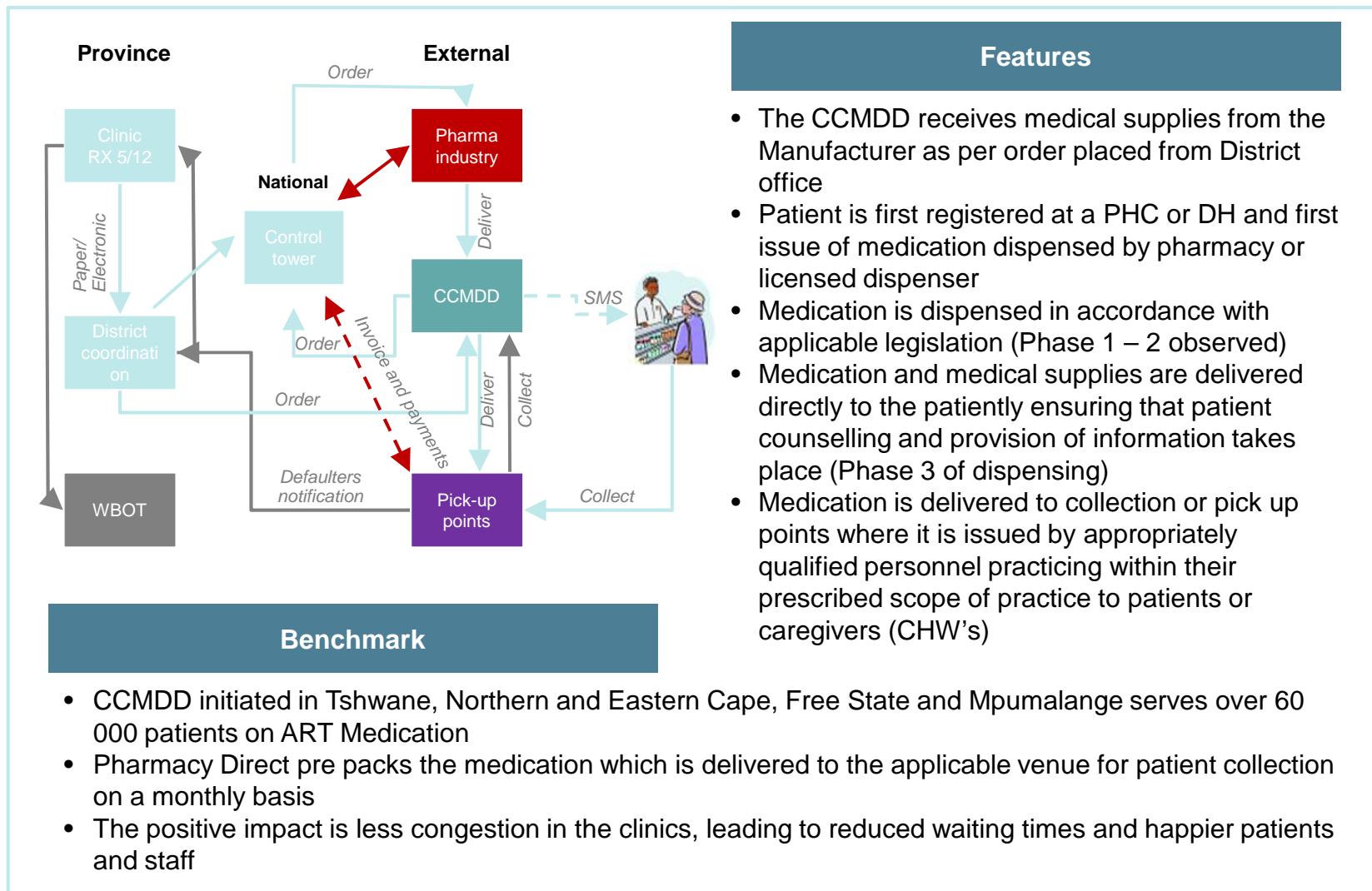
Innovative Medicine Dispensing can be implemented through the expansion of the four potential modes



SOURCE: Lab Discussion and Analysis

5

Features of Option 1: Central Chronic Medication Dispensing and Distributions (CCMDD) System



SOURCE: Lab Discussion and Analysis; Interview with Lab Participants

5

Features of Option 2: Direct Delivery



Features

- Direct deliveries are done from a “Courier Pharmacy” to the patient in line with legislative provisions
- Direct deliveries from a community or institutional pharmacy or consultation rooms of an authorized prescriber or PHC or satellite clinic
- Prescribed Legislative conditions pertaining to transportation, distribution and storage of medicines must be complied with
- Patients to register for this mode via the District
- Schedule to be created for patient delivery so patients know date and time of delivery

Benchmark

- This option is currently provided by some private healthcare providers in South Africa.

SOURCE: Lab Discussion

5 Features of Option 3: Mobile Pharmacy



Features

- Pharmaceutical services from a mobile pharmacy are to be provided in compliance with applicable legislation
- Such services are to be provided from a licensed, registered pharmacy.
- Patients are to register for this service for a specific district and be notified of the schedule.
- The mobile facility will follow these principles per district :
 - Pre determined route, date, and time
- Patient will collect medication as arranged
- CHW also eligible to collect medication on behalf of pre determined patients
- The service can also take the form of an outreach where a certain community is offered services in a predetermined area for a pre-determined period

Benchmark

- In South Africa, Phelophepa Train , the 18 coach mobile clinic, has travelled 100 929 km's in the last 17 years treating 7.2 million patients. The mobile clinic stocks more than 100 000 items of medication, supplying more than 24 000 prescriptions to patients annually
- Robertson Hospital in the Western Cape in collaboration with the 7 clinics it serves is able to deliver medication to 1000 patients in a 4 hour period of time at a pre determine facility

SOURCE: American Friends: Phelophepa Train of Hope, <http://trainofhope.org/>
Rhoda Kadalie, Service Delivery: Rural Health. The New Age,
http://www.thenewage.co.za/blogdetail.aspx?mid=186&blog_id=%201234
“Rural Pharmacist Walks Away with national Excellence Award”,
<http://www.westerncape.gov.za/news/rural-pharmacist-walks-away-national-excellence-award>

5 Features of Option 4: Remote Automated Dispensing Units (RADU)



Features

- A typical remote-dispensing system is monitored remotely by a pharmacist at a central/supervising pharmacy and includes
 - secure, automated medication dispensing hardware that is
 - capable of producing patient-specific packages of medications on demand/presentation of a prescription.
- The secure medication dispensing unit is placed on-site at the care facility or non-healthcare locations (such as Universities, workplaces and retail locations) and
- filled with pharmacist-checked medication canisters.
- When patient needs medication, the prescription
 - is submitted to a pharmacist at the central pharmacy,
 - the pharmacist reviews the prescription and, when approved,
 - the medications are subsequently dispensed from the on-site dispensing unit at the remote care facility.
- Medications come out of the dispensing machine printed with the patient's name, medication name, and other relevant information.

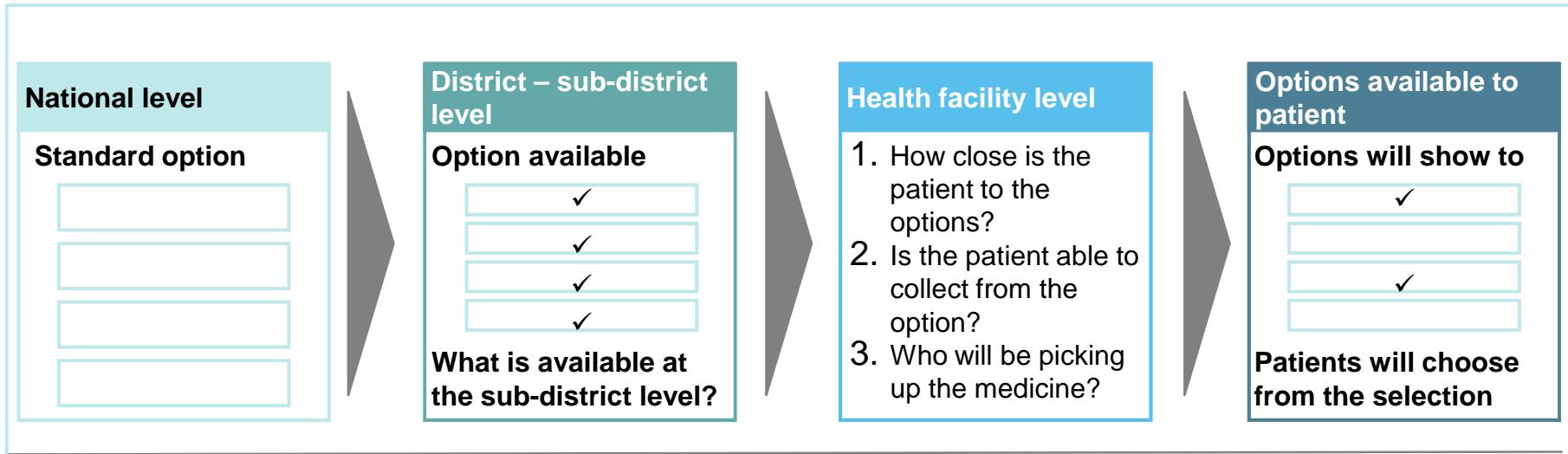
Benchmark

- In 2011 Ontario, Canada has implemented RADU's to improve medicine access in remote, rural communities
- 93% of patients utilizing the new technology were satisfied with the service, patients were also better educated about the dispensed medication following a conversation with the pharmacist

SOURCE: Health Council of Canada , Health Innovation Challenge 2011/2012

5

Options available to dispense medicine will depend on the location of the patient



Case in point...

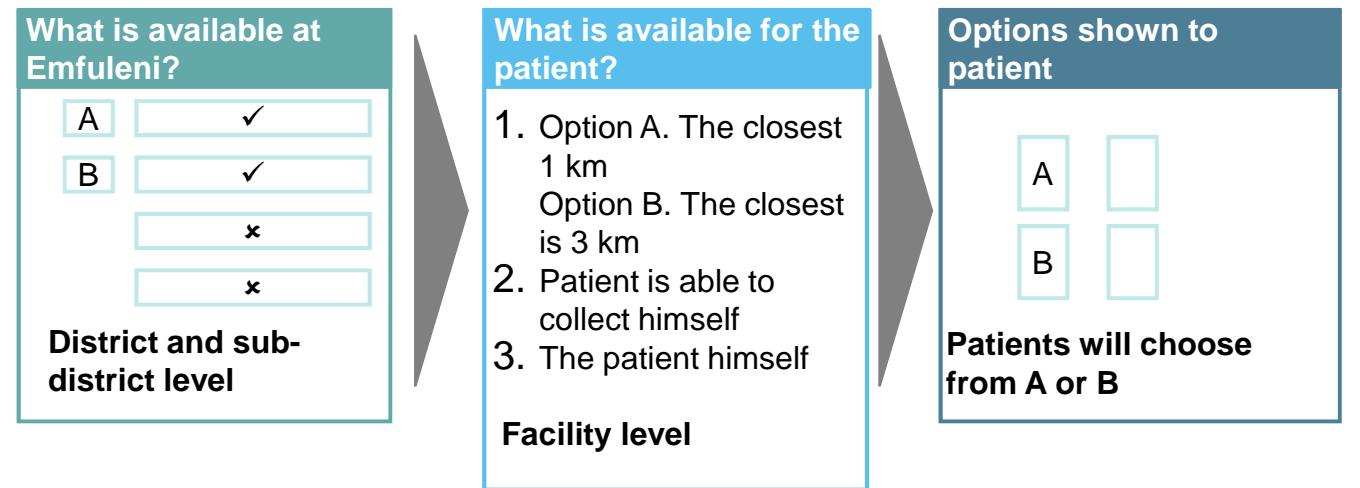
Michael

Location: Sebokeng township, Emfuleni, Sedibeng district, Gauteng province

Chronic condition: heart disease, diabetes, prescription (Drug A, Drug B)

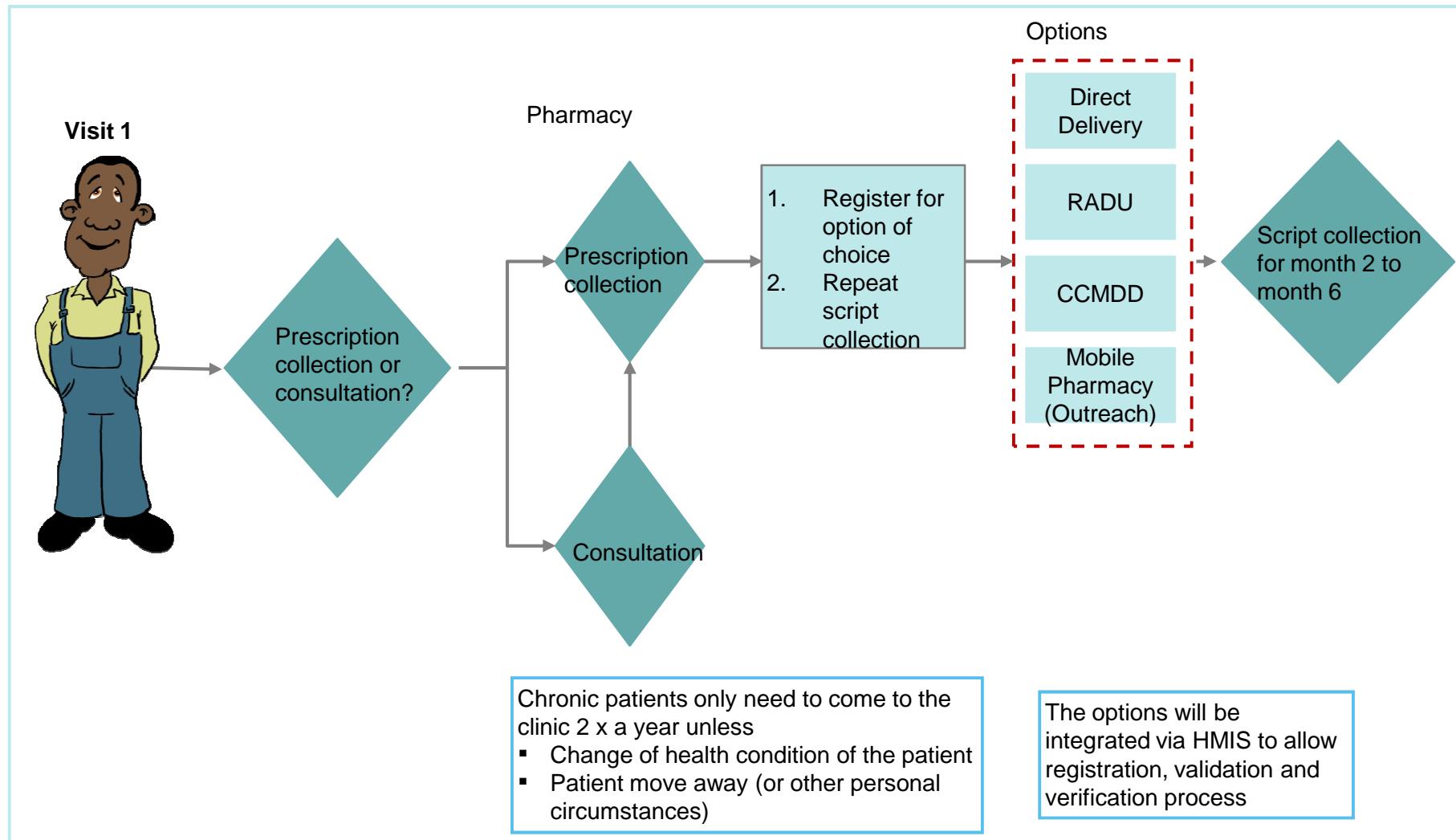
B)

SOURCE: Lab discussion and analysis



5

In the future, patients requiring medications for chronic conditions will only need to visit PHCs once every 6 month



SOURCE: Lab discussion and analysis

5

Implementation and Rollout plan for the new innovative medicine dispensing & delivery will kick off in December 2014

Pre-implementation Phase (Nov 2014 – May 2015)

Nov 2014

- Identify legislations requirements
- Identify possible modes of medicine dispensing and distribution
- Identify supporting components to enable the innovative dispensing and distribution

*Done during the lab

Dec 2014

- Receive finalized Geo-Mapping results on the location of facilities and
- ~~Analysis~~ Analysis of the Geo-Mapping results and the mapping of the available services .



Feb– Dec 2015

Pilot Selection of 10 PHCs across different district and PHCs

Nov 2014 - Mar 2015

- 3**
- Enforcement of Nursing Act, including training nurses to dispense other's prescription
 - Fast tracking of Pharmacy Act Amendments

Milestone 1

Nov 2014 – May 2015

- 4** Ensure Readiness of the 4 options for dispensing and distributions

CCMDD

Align with NHI's plan
Expansion of chronic conditions

Milestone 2

DIRECT DELIVERY

Identification of service provider

MOBILE DELIVERY

Procurement: by NDoH and /or PPP?
RADU
Geomapping Results to determine suitability

Nov 2014 - Apr 2015

Ensure supporting components are in place

5

SUPPLY CHAIN MANAGEMENT	
INFRASTRUCTURE	HMIS
HUMAN RESOURCE	PPP

To be taken up by appropriate work stream

Nov 2014 – Apr 2015

6

Survey on suitability of the options, mapped based on the results of service geo-mapping

Facility Name:

1. Requirement 1
2. Requirement 2
3. Requirement 3
-

Milestone 3

Milestone 4

Jan – Apr 2016

Phase 1 Rollout to the next 700 PHCs

Apr – Jul 2016

Milestone 5

Phase 2 Rollout to next 1500 PHCs

Jul – Oct 2016

Milestone 6

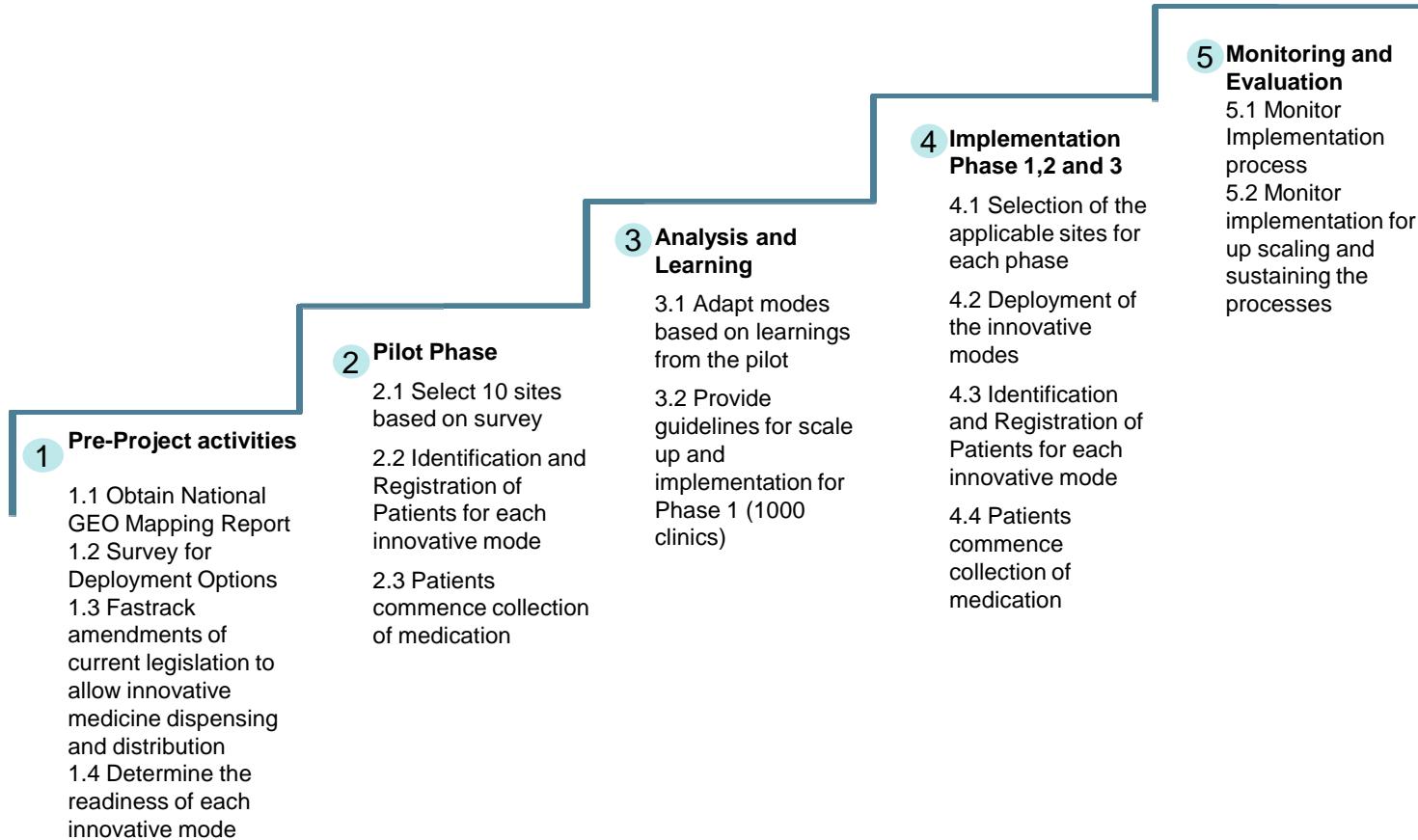
Phase 3 Rollout to next 1277 PHCs

All PHCs will provide the options by 2016

5

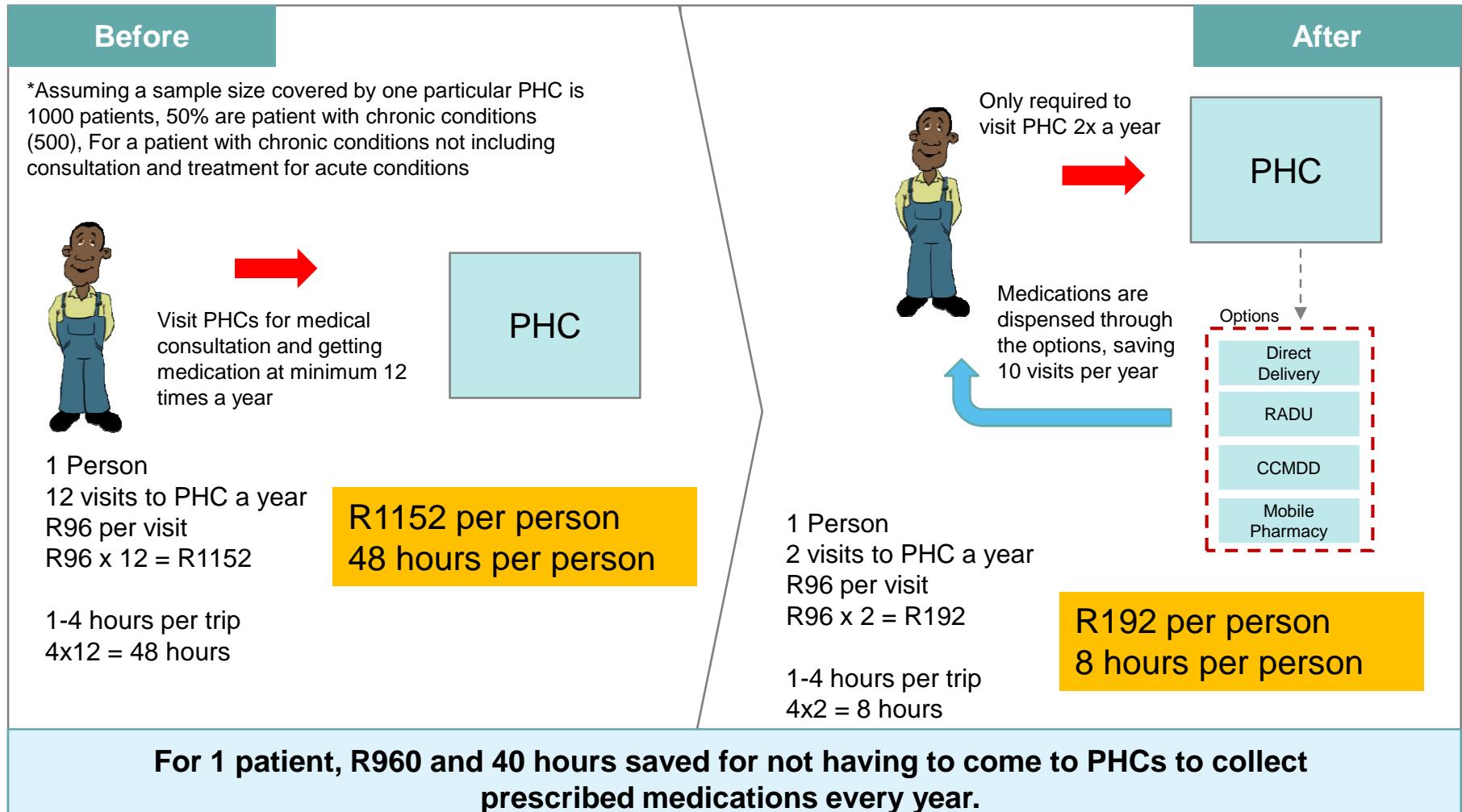
Steps to develop the framework and implementation strategy for innovative ways of medicine dispensing and distribution

1000ft



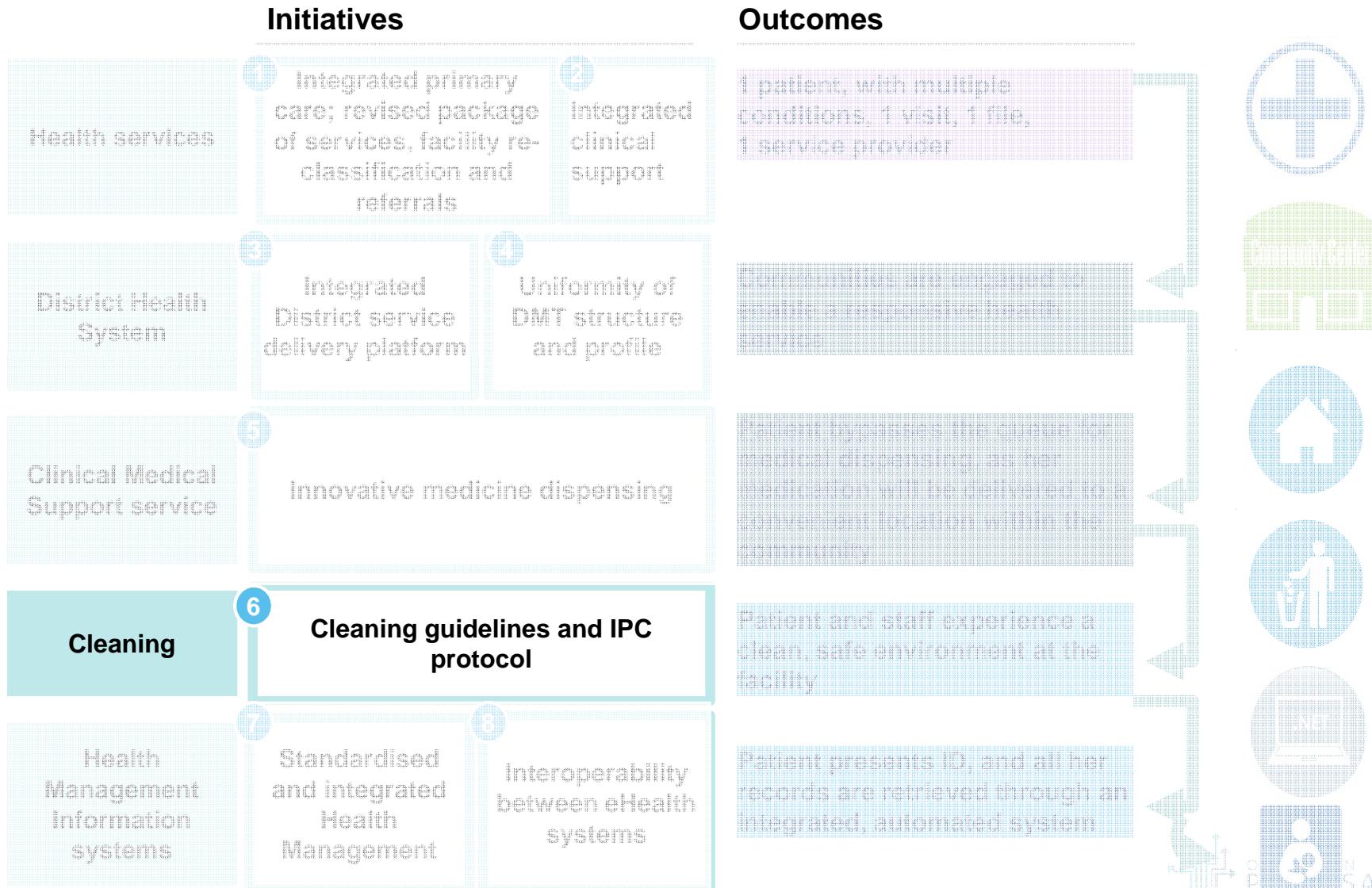
5

The initiative will have a tremendous impact in reducing the needs for non-clinical visit to PHCs



SOURCE: Provincial Profile from National Department of Health, 2014, Cost to patients of obtaining treatment for HIV/AIDS in South Africa: SAMJ, July 2007, Vol.97, No.7

The sixth initiative insures the delivery of quality health services through cleaning, infection and prevention control



6

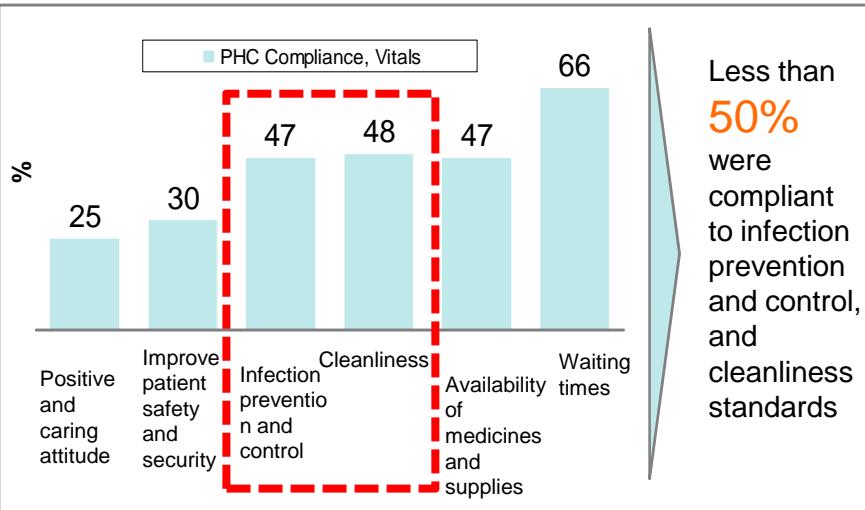
Develop and implement PHC relevant cleaning guidelines, Infection Prevention, and Control protocol with appropriate training programs

Develop standard, uniform and appropriate guidelines and protocols that will be disseminated and adopted by all PHCs across different provinces, district and sub-district in the Republic of South Africa.



6

South Africa is not doing well in terms of cleanliness, infection prevention and control, and general waste management at primary healthcare facilities



478
facilities had no domestic waste removed
129
facilities had no medical waste removed
56
facilities were without water

*Only seven provinces extended the contracts to cover collection of medical waste from clinics. Interruption of medical waste removal results from expired service level agreements (SLA) and due to inadequately monitored or non-renewal of the SLA.

Sample cases of nosocomial infection reported recently...

Eastern Cape and Western Cape Provinces 1996 - 2008

- 10 out of 334 patients treated for Extensive Drug Resistant TB (XDR-TB) were health care workers and all had received an average of 2.4 courses of TB treatment before the diagnosis of XDR-TB
- 8 out of 10 were HIV negative and 4 out of 10 died despite treatment
- 22 babies died from Klebsiella due to cross infection

Mahatma Gandhi Hospital (Ethekwini, KZN) May – June 2005

Church of Scotland District Hospital (Tugela Ferry, KZN) 2005 - 2006

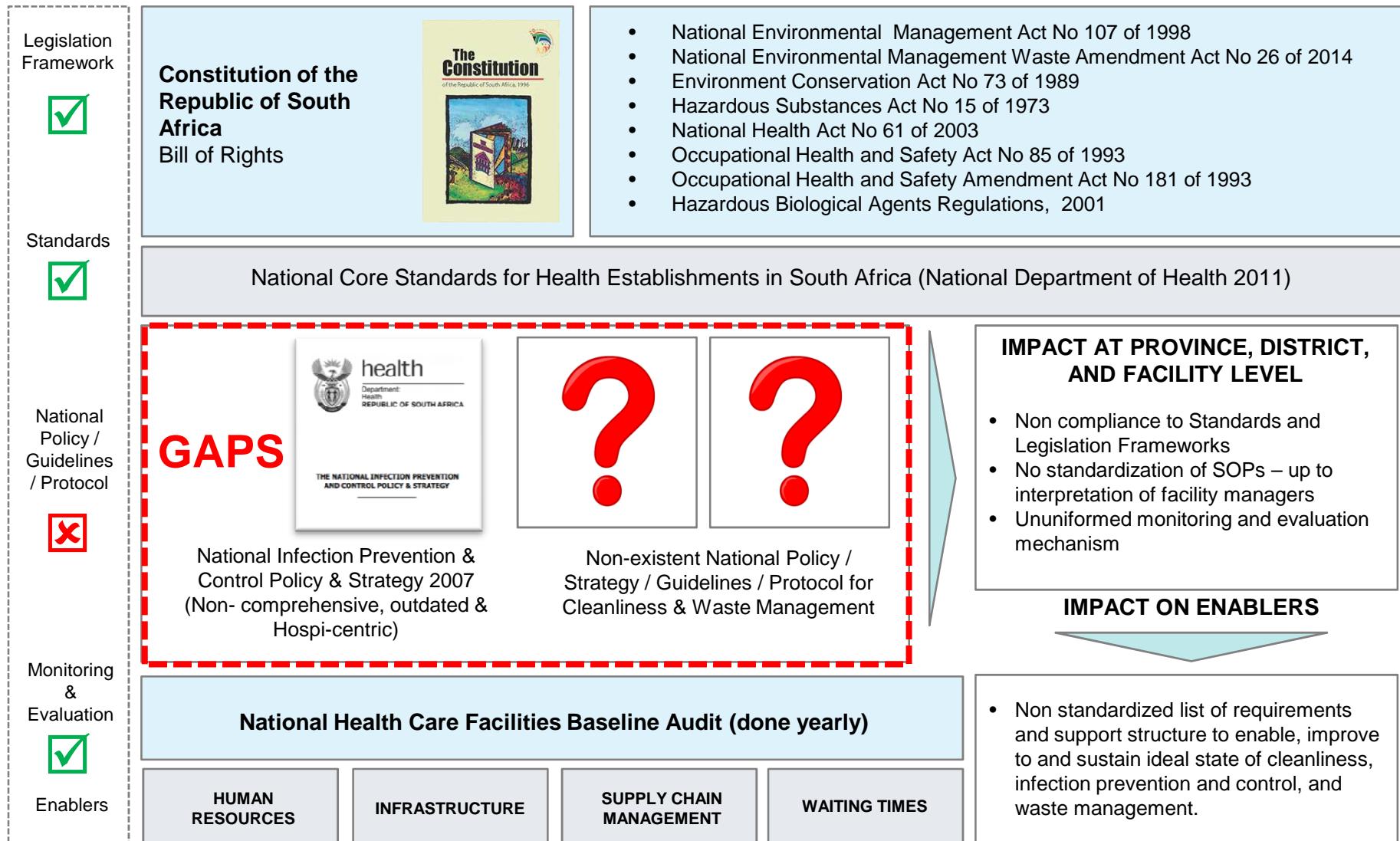
- Nosocomial transmission of Extensive Drug Resistant (XDR-TB) due to inadequate IPC in the wards leads to 52/53 death in a year.
- 221 Multi Drug Resistant TB (MDR-TB) patients were diagnosed with XDR-TB and all were HIV positive.
- 55% had no previous history of TB treatment , 67% had been recently hospitalised before the diagnosis of XDR-TB and 55% had similar strains.

¹A total of 3487 PHC facilities were assessed

SOURCE: The National Health Care Facilities Baseline Audit: National Summary Report 2012

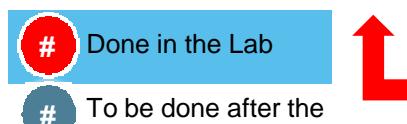
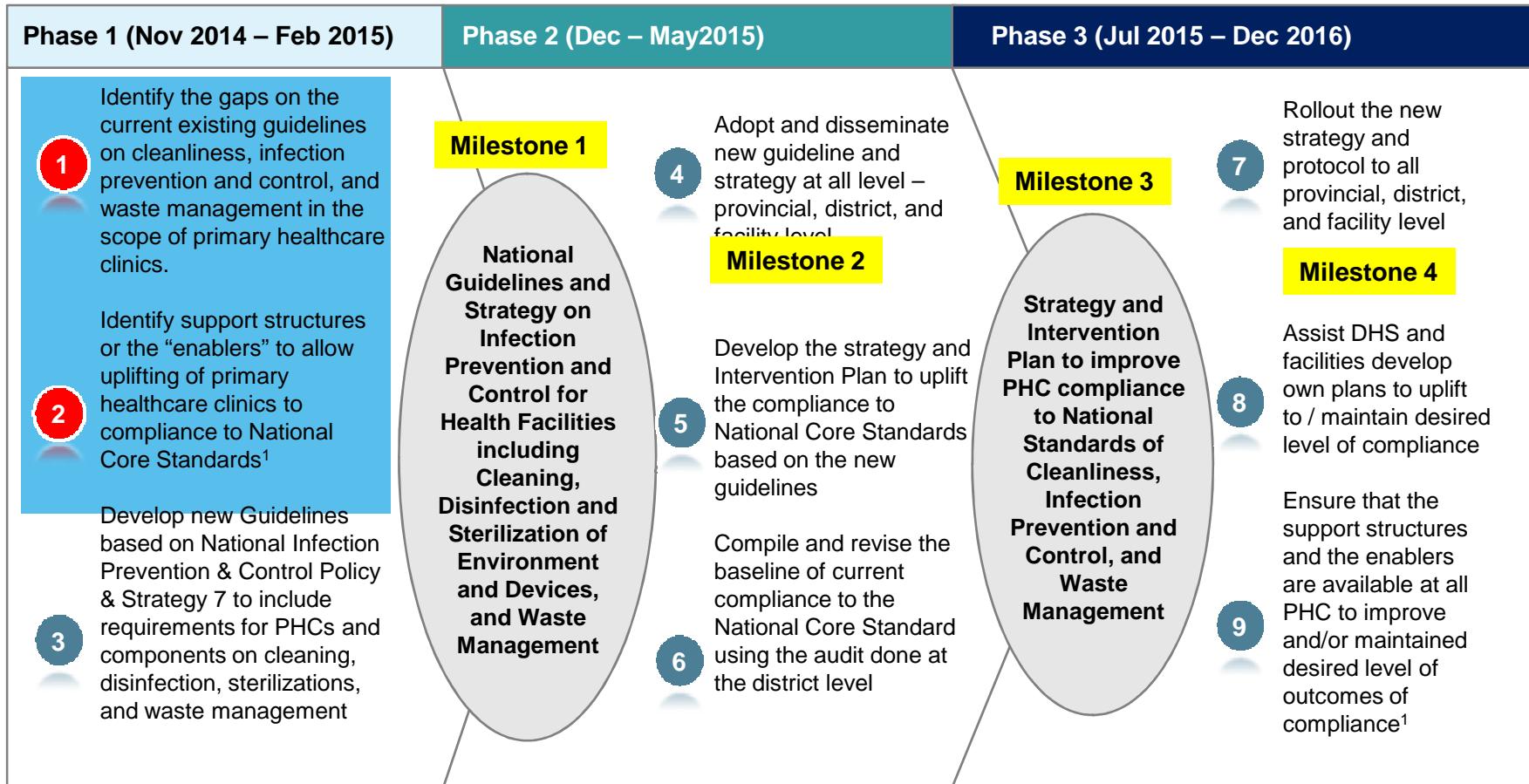
6

Outdated or nonexistent related National Policy, Strategy, Guidelines and/or Protocol are identified as the root cause of the situation



SOURCE: Lab Analysis; DOH – Quality Assurance presentation in the lab;
 Auditor General Report on the assessment of medical waste management as well as infrastructure conditions in selected provinces in Western Cape DOH. August 2007

6 To close the gap, the following three-phased approach is proposed, together with M&E mechanism to ensure sustainability



Monitoring & Evaluation Mechanism to ensure Sustainability

Development of “Champions” to ensure adherence to the guidelines
 Ensure availability of support structures and enablers¹
 Compile results of facilities audit in quarterly basis to ensure compliance

¹ To be taken up by Infrastructure, Supply Chain Management, and Human Resources Work Streams
 SOURCE: Lab Discussion

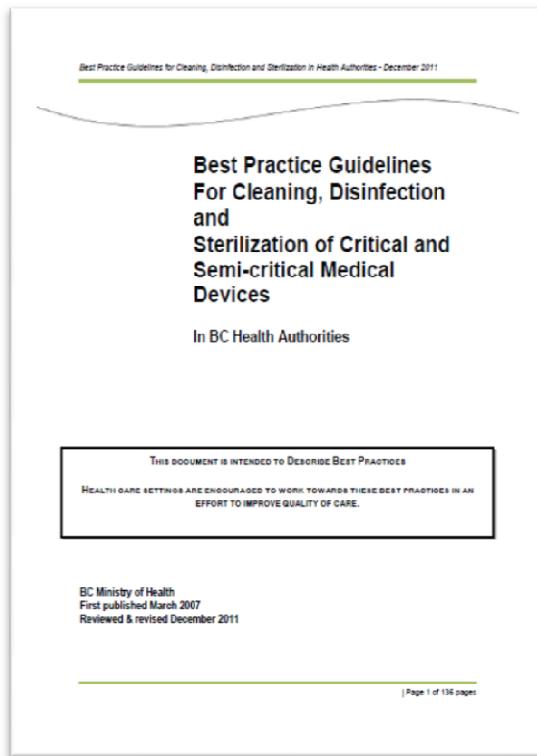
6 The lab proposes the following recommendations to be taken into account in the finalisation of the new Guideline

1. Process must be driven by Directorate of Office of Standards Compliance under NDoH..
2. Members of the multi-sectoral team must come from NGO, universities, National Department of Health Quality Assurance unit, Waste Management unit, Primary Health Care unit, Office of Standard Compliance, Department of Environmental Affairs, two provincial representative from quality and infection control, one representative from the districts and one representative from private sectors
3. The team must benchmark from the World Health Organization infection prevention and control waste management and cleaning guidelines, the 2007 National Infection Prevention and Control Policy & Strategy and private sector guidelines
4. The guidelines to be developed must integrate infection prevention and control, cleanliness and waste management in one document
5. The guidelines must be aligned with the level of care as per proposed package and classification of facilities e.g. community, mobile clinic, health post, satellite clinic, clinic and CHC

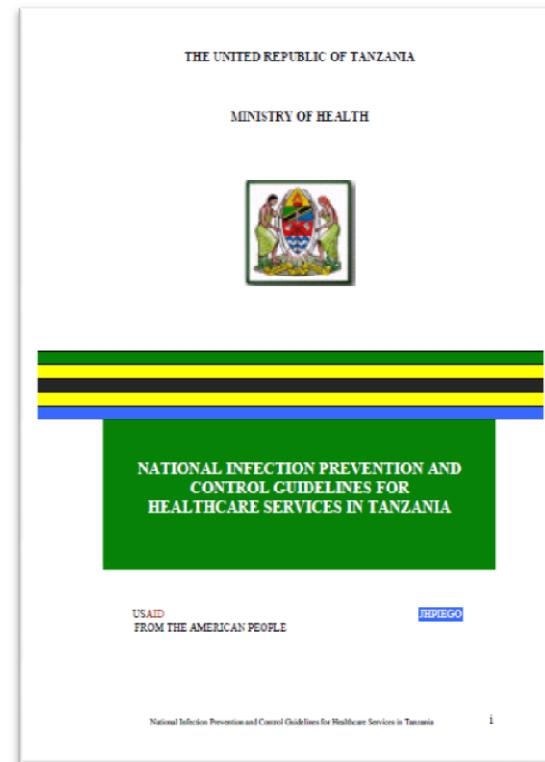
The guideline must include the following:

- Budget-how should the budget for infection prevention control, waste management and cleanliness be managed including the procurement procedure including forms that need to be completed
- Management- Supervision, key performance indicators to be used to monitor the implementation of guidelines, assessments that need to take place
- Material to be used which include equipment, consumables and supplies
- Methods the actual procedure on how to conduct cleaning, infection prevention control and waste management
- Manpower- what staff are needed to perform the various duties, training manual, performance management

6 The following best practice or existing guidelines will be used (among others) as reference to develop the guidelines



Best Practice Guidelines For Cleaning, Disinfection and Sterilization of Critical and Semi-critical Devices by British Columbia Health Authorities, Ontario, Canada



National Infection Prevention and Control Guidelines for Healthcare Services in Tanzania, Ministry of Health, the United Republic of Tanzania

6

The new National Guideline for cleanliness, infection prevention and control, and waste management will be based on the following Term of Reference

TERM OF REFERENCE

- | | |
|---|--|
| <input checked="" type="checkbox"/> Objective and purpose of the guideline | Creation on integrated practical guideline on cleaning, infection prevention and control and waste management for all levels of PHC classification |
| <input checked="" type="checkbox"/> Features of the Guideline | Relevant across all level and size of PHC and Health Facility, Cleaning (sterilization, disinfection and washing) for both medical devices (critical and semi-critical) and environment, infection prevention and control, and waste management. |
| <input checked="" type="checkbox"/> Components covered by the Guideline | List of essential list of consumables and other requirements (HR, Infrastructure, Supply Chain) required to ensure compliance to National Core Standards |
| <input checked="" type="checkbox"/> Targets and aspiration | All PHCs and Health Facilities to comply to National Core Standards for cleanliness, infection prevention and control, and waste management |
| <input checked="" type="checkbox"/> Recommendations and high level steps to achieve targets | Based on some of the recommendations developed in the lab |
| <input checked="" type="checkbox"/> Accountable bodies and responsibilities | Based on the RACI matrix (Responsible, Accountable, Counseled and Informed) |

SOURCE: Lab Discussion and Analysis

6

The draft Terms of Reference was developed in the lab and will be reviewed to become the basis of the guiding principles for the New guidelines

TERMS OF REFERENCE

Draft 20 November 2014

INTEGRATED PRACTICAL GUIDELINE ON CLEANING, INFECTION PREVENTION CONTROL AND WASTE MANAGEMENT FOR ALL LEVELS OF PHC CLASSIFICATION

INTRODUCTION

Following baseline National Core Standards audit results of 2012, all of audited PHC facilities did not perform well on IPC, cleaning and waste management.

There were no guidelines in respect to cleaning and waste management. The infection prevention control guideline was hospi-centric and review overdue (last review was 2007).

There was no integration of the above mentioned three and therefore no integration in monitoring and evaluation of above leading to insufficient and ineffective outcomes.

In order to close the identified gaps, infection prevention control guideline was aligned to PHC, integration of IPC, cleaning and waste management was done.

PURPOSE

The integrated IPC, cleaning and waste management guideline is developed to assist all PHC facilities of all classification levels across the country to achieve improved outcome and effective monitoring and evaluation.

OBJECTIVE

The general objective of these practical guidelines is to provide administrators and health care workers with the tools to enable them to implement the IPC, cleaning and waste management programme effectively in order to protect themselves and others from cross infections.

AREAS COVERED BY THE GUIDELINES (NON- EXHAUSTIVE)

SOURCE: Lab Discussion and Analysis

6

The lab also proposes development of (1) Strategy for Intervention and (2) M&E mechanism to uplift the condition of the PHCs and ensure sustainability

- 1 Development of National Intervention Strategy and Protocols, to be disseminated and shared with all districts and Health Facilities

Develop the National Guidelines and Protocol for Intervention Plan to uplift the compliance to National Core Standards

Compile and revise the baseline of current compliance to the National Core Standard using the audit done at the district level

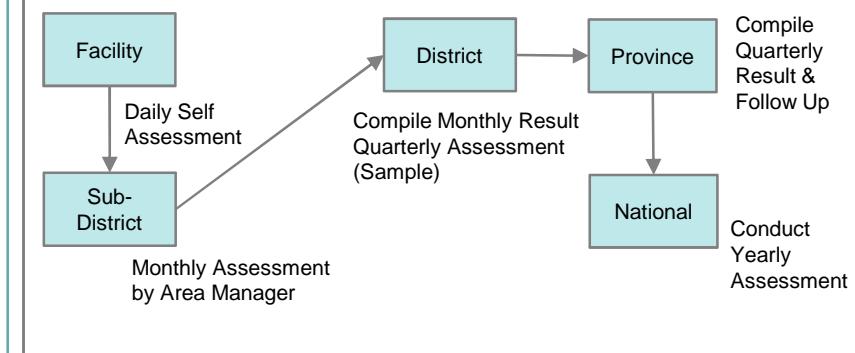
Assist DHS and facilities develop own plans to uplift to / maintain desired level of compliance

Ensure that the support structures and the enablers are available at all PHC to improve and/or maintained desired level of outcomes of compliance¹

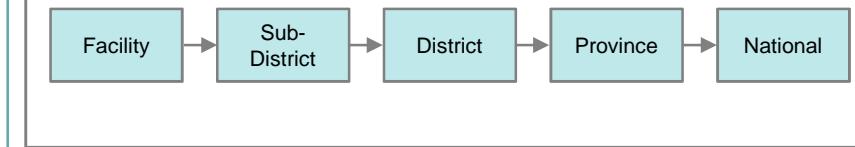
- 2 Mechanism for Monitoring & Evaluation (M&E) to ensure sustainability

Identification of “Champions” for integration of cleaning, waste management and infection prevention and control at facility, District, Province and National levels.

Create accountability and reporting structure from facility to National level



Strengthening monitoring mechanism to ensure chain of compliance from all level.



¹ To be taken up by Infrastructure, Supply Chain Management, and Human Resources Work Streams
SOURCE: Lab Discussion and Analysis

6

Steps to be taken improve the cleanliness, infection prevention and waste management in PHC

1000ft

1 Develop guidelines, SOPs and protocols for cleaning, infection prevention and control and waste management

- 1.1 Identify experts in the field of IPC, Cleaning and Waste Management
- 1.2 Create multisectoral team to finalize draft of guideline
- 1.3 Workshop for stakeholders
- 1.4 Disseminate draft to provinces for input
- 1.5 Finalize and then back to province , then district and facilities

2 Develop intervention strategies for facilities to meet the required standards

- 2.1 Appoint District IPC , Cleaning and Waste Management Champion
- 2.2 Train the trainers (Champion) to train other personnel on complying to the new guidelines.
- 2.3 Develop a strategy that can be used by the facilities to uplift the status of compliance to the standards.

3 Ensure compliance to the new guidelines

- 3.1 Disseminate checklist to cover cleaning, IPC and Waste Management components to all provinces, districts, sub-districts and facilities
- 3.2 Ensure that the requirements and essential list are available in the works to achieve compliance to the standards

4 Ensure sustainability

- 4.1 Ensure that Cleaning, IPC, Waste Management target is always 100% in all facilities (non-negotiable)
- 4.2 Peer evaluation , supervisor and facility manager red flag
- 4.3 Perform District audit facilities quarterly Identify best performing facilities
- 4.4 Acknowledge best performance of individual and facilities – group awards

6

This initiative will drive full compliance to National Core Standards on IPC, Cleanliness and Waste Management by 2016

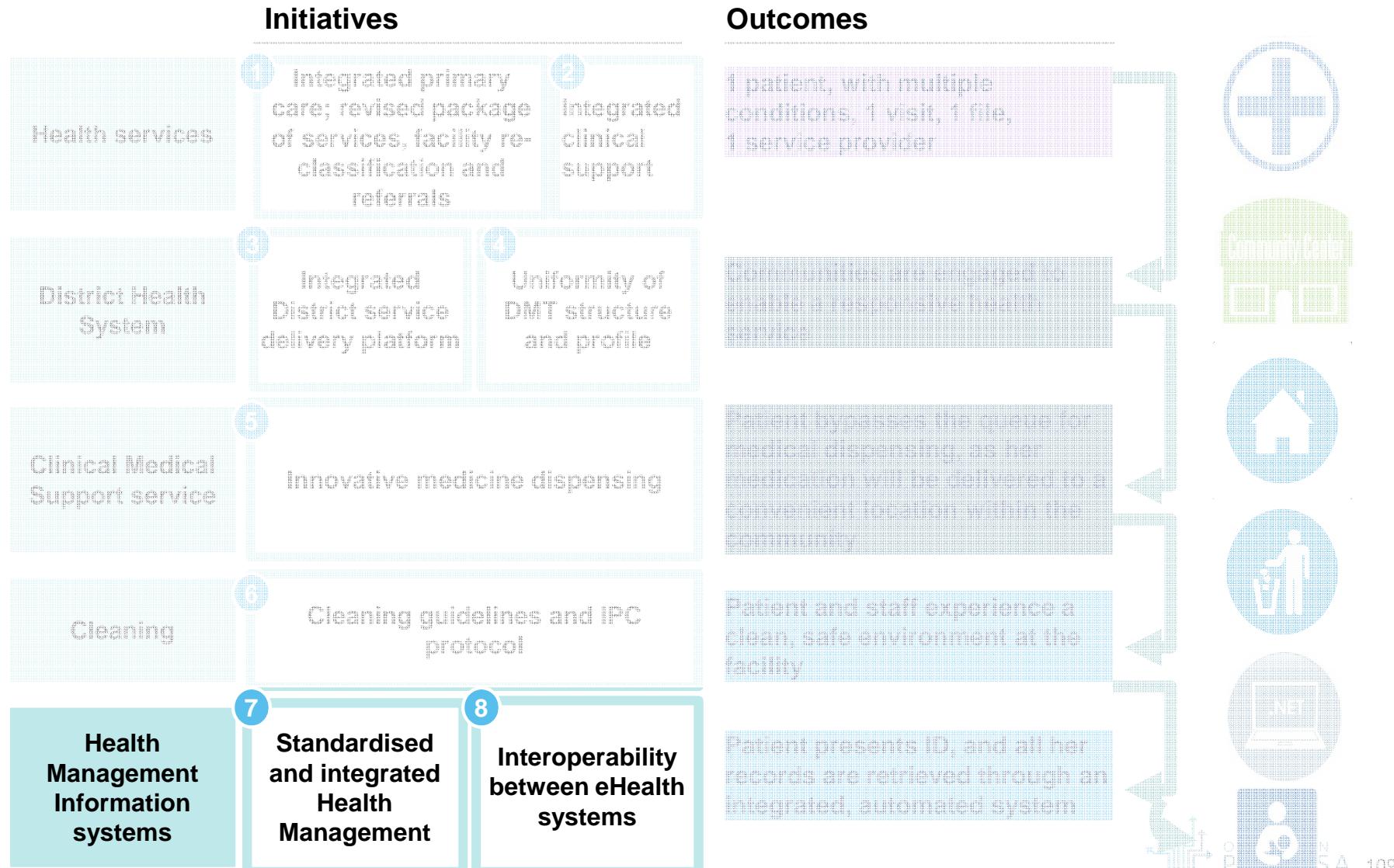
- 1 Develop new comprehensive guidelines and disseminate to all facilities
- 2 Develop new intervention strategies and disseminate to all facilities
- 3 Assist DHS and ensure supporting enablers / structures are in place
- 4 Strengthening Monitoring & Evaluating mechanism from National to Facility level.



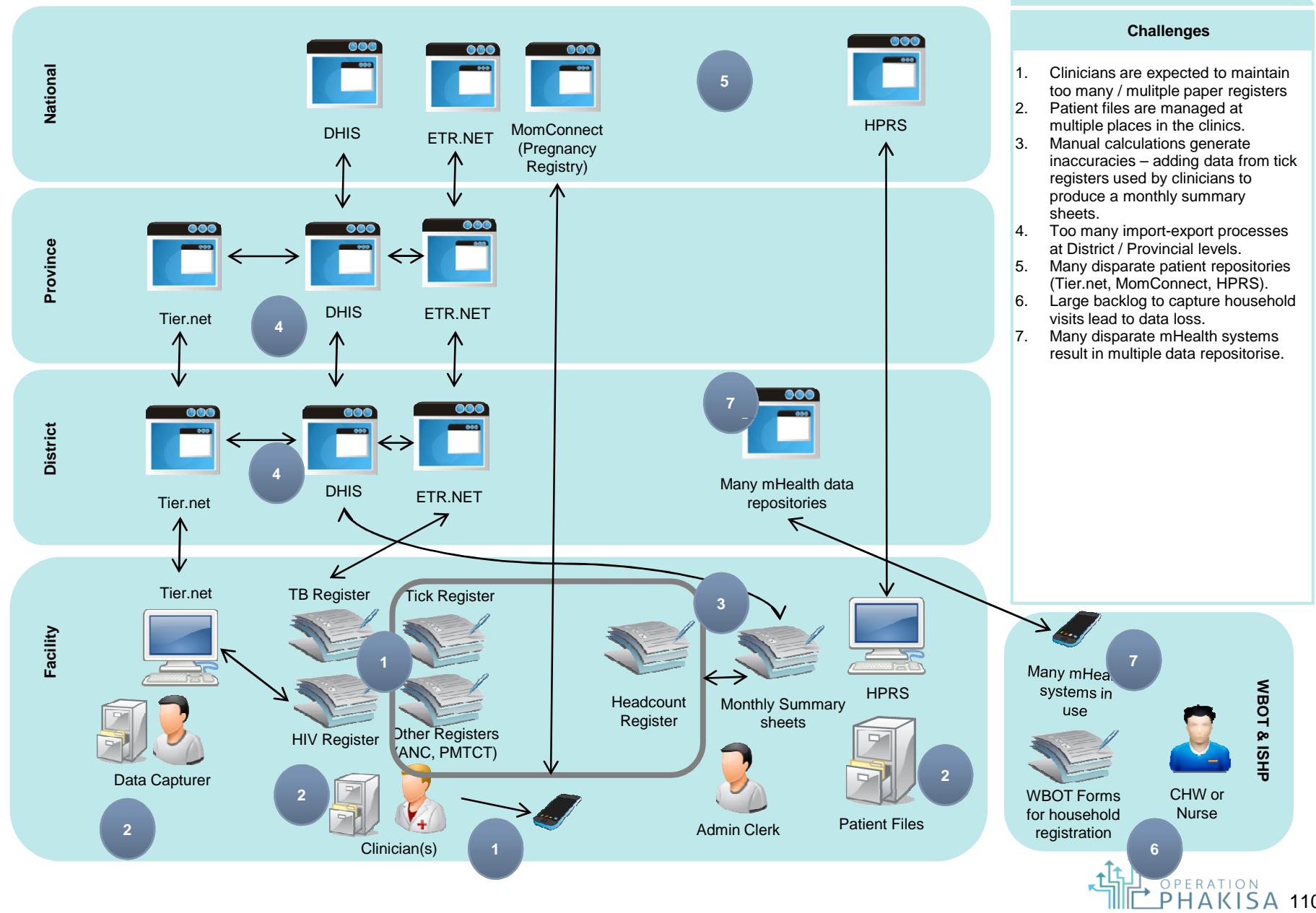
100%
compliance

- Infection Prevention & Control
- Cleaning
- Waste Management

The seventh and eighth initiative support the delivery of health services through an interoperable, standardized and integrated HMIS



Current Scenario

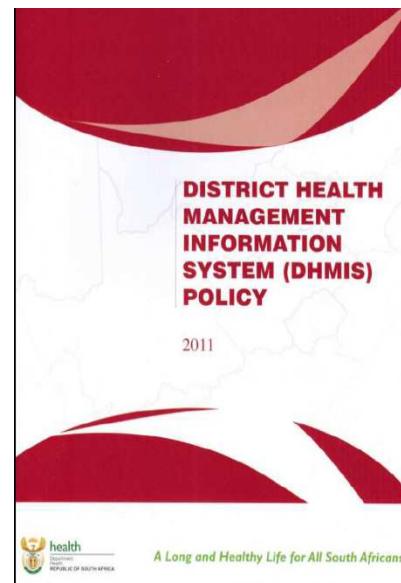
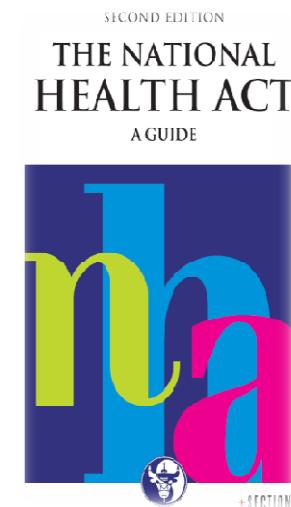


We have identified 2 key initiatives

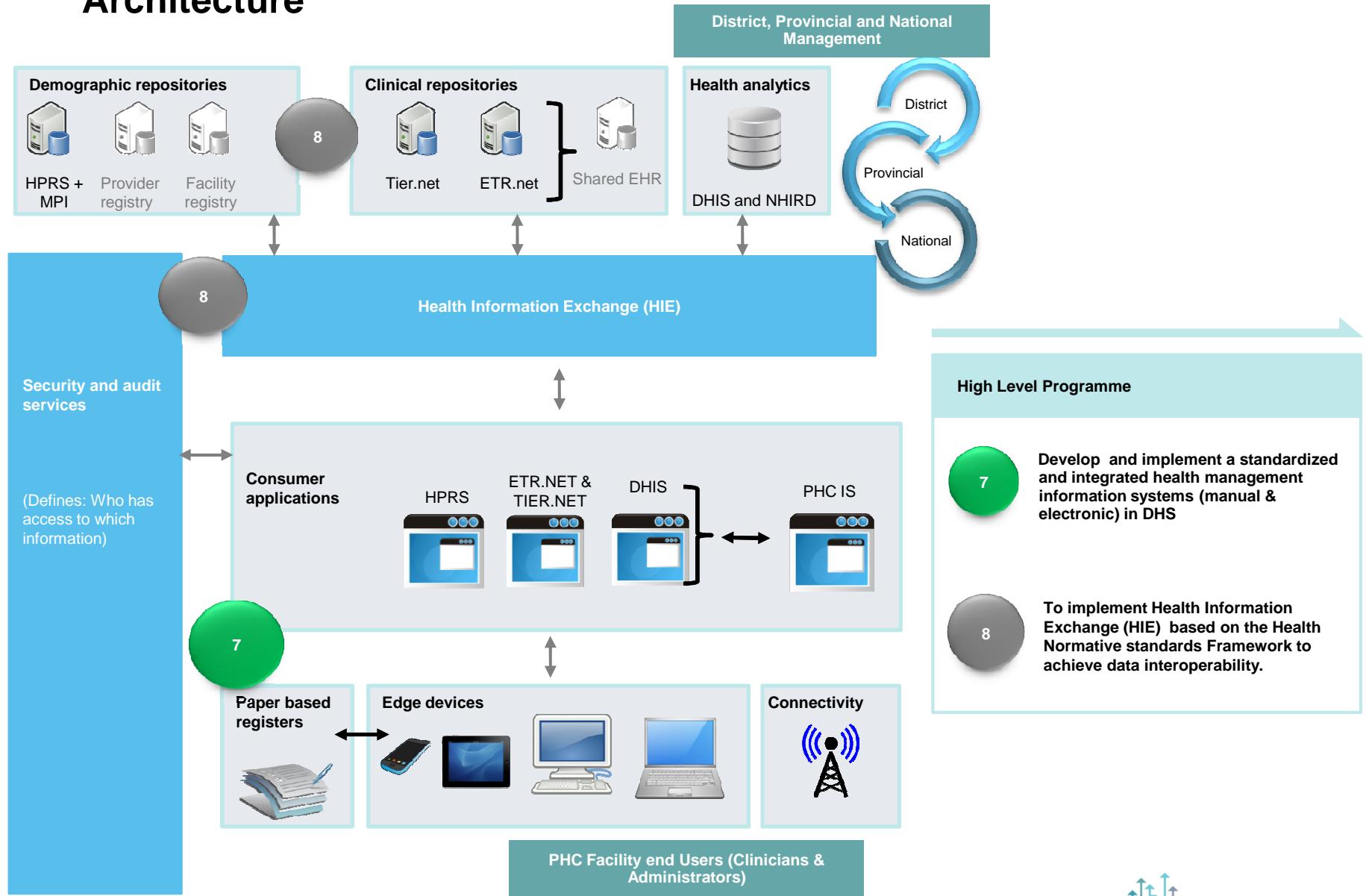
	Description	Rationale – why this initiative is needed	The following initiatives are excluded here
Initiative 7	<ul style="list-style-type: none">▪ To implement a standardized, integrated Health Management Information System (HMIS) that will provide comprehensive, timely and reliable evidence for tracking and improving health service delivery.	<ul style="list-style-type: none">▪ High administrative burden on PHC Facilities. Inconsistent management and filing of patient records and too many data collection tools in facilities have a detrimental effect on quality of care, waiting times, efficiency.▪ The prospective PHC IS to be deployed at facilities must be carefully selected, planned and standardised in order to effectively support the care processes, facility management (appointments, stock , HR, leave, patient queues etc.) and surveillance	<ul style="list-style-type: none">▪ HR work stream<ul style="list-style-type: none">– Appointment and appropriate use of all admin personnel by integrating all admin functions to be carried out at PHC Facilities (includes data capturing and filing)– Training (data collection and use of information)▪ Infrastructure Work stream<ul style="list-style-type: none">– Procurement and supply of ICT Infrastructure. HMIS work stream will provide specifications for ICT Infrastructure▪ Waiting Times work stream<ul style="list-style-type: none">– 3ft Plan for defining business processes for Appointment and filing systems– HMIS workstream to define mechanisms to automate these in future
Initiative 8	<ul style="list-style-type: none">▪ To implement Health Information Exchange (HIE) based on the Health Normative standards Framework to achieve data interaoperability	<ul style="list-style-type: none">▪ In order to establish a national integrated interoperable HIS, an appropriate, standards based integration platform is required to manage information exchange between systems and required demographic and clinical registries and repositories (Health information exchange, patient registry, facility registry, provider registry and shared electronic health record)	

SOURCE: Source

In line with the Health Information Systems Guiding Strategies and Policies



7 Proposed Health Management Information Systems Architecture

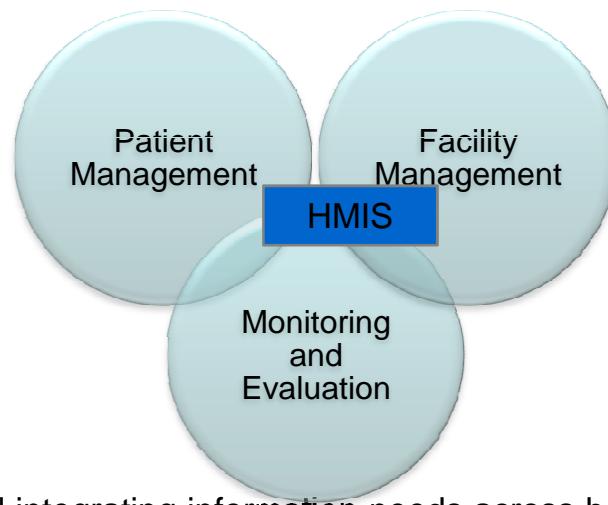


7 Develop and implement a standardized and integrated health management information system

To implement a standardized, integrated Health Management Information System (HMIS) that will provide comprehensive, timely and reliable evidence for tracking and improving health service delivery.

Initiative concept/details/highlights

to establish a Health Management Information System (HMIS) to address patient management, facility management, monitoring and evaluation, and planning requirements.



Defining and integrating information needs across health programmes by designing standardised data collections tools, and progressively implementing interoperable electronic systems will improve the quality of data, reduce administration burden, and increase patient satisfaction.

Implementing agency

- National / Provincial DoH

Key stakeholders identified

SITA, IT Industry, Heads of National/, Provincial & District IT and Information Management Departments.

Implementation timeframe

- Start date: Immediately
- End Date: 31 Mar 2019

Key performance indicators

- 2014: Standardized data collection tools
- 2015: Implementing Patient ID solution, DHIS and selection of PHC IS
- 2016: Implement PHC IS
- 2017: Integrate PHC IS with interoperability platform.
- 2019: National Wide implementation of HMIS.

7 Achieve standardisation and integration of patient, facility and health information management systems (manual & electronic) in DHS

What	How
<ol style="list-style-type: none">1. Reduce administration burden at all levels of DHS2. Integrate existing disease centric patient based health information systems to eliminate duplication3. Introduce manual and electronic methods of uniquely identifying / verifying patients to prevent multiple patient files, and to establish a national patient registry4. Streamline data generated at community level into a single repository5. Digitise aggregated data at facility level on a daily basis to minimize errors and enable generation of facility reports6. Lastly, introduce comprehensive patient based information system(s) to improve health service delivery	<ol style="list-style-type: none">1. Integrate information needs of all levels to reduce the number of data collection tools (at all levels in DHS) thereby standardising data collection process as per recommendations of register rationalisation project2. Integrate existing vertical Information Systems: Health Patient Registration System (HPRS), Tier.net, ETR.net and MomConnect3. Implement Health Patient Registration System (HPRS) to digitise patient demographic details and strengthen unique patient identification / verification4. Integrate mHealth systems with DHIS to ensure ward based data generated at community level is available in a single repository5. Implement DHIS at facility level to digitise submission of aggregated service delivery data thereby minimising calculation errors6. Implement Patient based PHC Information System¹ (include e.g. appointment system, basic digitised heath record and e-prescription) in all PHC facilities

¹ PHC IS must provide the desired functionality, be cost effective and compliant to Health Normative Interoperability Standards Framework.

8 Develop and implement the software platform to achieve interoperability between all eHealth systems

To implement Health Information Exchange (HIE) based on the Health Normative standards Framework to achieve data interoperability

Initiative concept/details/highlights

This initiative is critical to improve continuum of care. It is a key enabler to facilitate exchange of patient records between different health facilities, levels of care as well as other specialist information systems (Laboratories, Radiology, and Pharmacy).

This initiative will target:

1. Description, Design, and development of a Health Information Exchange and all shared repositories (patient, provider, and clinical) to enable interoperability
2. Establishing a certification mechanism to certify compliance of Health Information Systems to Health Normative Standards Framework.

8 Implement Health Information Exchange (HIE) based on the Health Normative standards Framework to achieve data interoperability

- Define and adopt an appropriate software architecture coupled with comprehensive and rigorous information standards* in order to ensure interoperability over the long term
- Define shared demographic and clinical repositories as well as and security and audit services (i.e., Roles and responsibilities for capturing, processing and accessing information)
- A Master Patient Index (MPI) software is required for matching, cleansing, and profiling of individual entities, ensuring that data is capable of being retrieved regardless of how many systems reference this entity with different identifiers or names
- Development of an appropriate Health Normative Standards¹ based integration software to enable information exchange between different information systems
- Implement Health Normative Standards Framework by identifying a certification mechanism so that information system vendors can test their system(s) against Health Normative Standards Framework

Output

- A system design for the Health Information Exchange
- Detailed system description of all Demographic repositories (patient, provider, and facility), and clinical repositories (radiology, pharmacy, as well as shared electronic health record)
- A functional Patient Master Index for South Africa
- Health Information Exchange for South Africa that integrates various patient based information systems
- A certification mechanism established to test compliance against Health Normative Standards Framework

¹ Health Normative Interoperability Standards Framework was approved by National Health Council and subsequently gazetted by the National Department of Health in April 2014

7 8 Health Management Information Systems Transition from 2014 to 2019

Efficient manual system Digitise aggregated data



2015

- Reduce the number of data collection tools
- Organise and streamline patient records¹
- Establish an appointment system¹
- Fully implement the DHMIS Policy and Procedures
- Conduct baseline study of admin personnel



2015 - 2017

- All PHC Facilities having access to Telephone, internet and email
- Implement daily data reporting of aggregated data at facility level using DHIS.
- Automate Patient Identification using Health Patient Registration System (HPRS)

Automate operations

Implement patient based PHC Information System:



2017 - 2018

- Basic Electronic Health Record system (diagnosis and treatment)
- Appointment scheduling
- Stock management and prescriptions.



Shared Electronic Health Records

2019

- Fully established National interoperability platform with Health Information Exchange and shared repositories to facilitate sharing of health records with higher levels of care



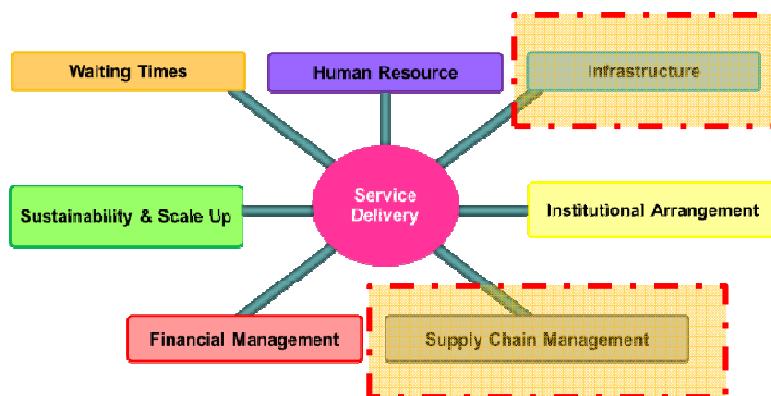
¹ Waiting Times Work Stream

Cross Syndications

2 cross-work stream initiatives to be handed over to Infrastructure / Supply Chain and Human Resources work streams

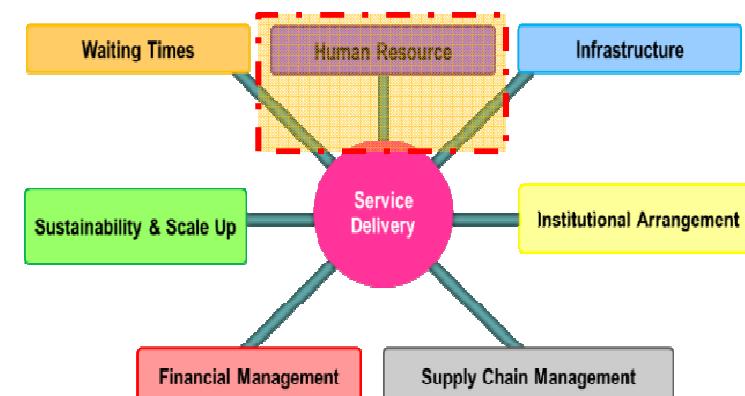
Standardized Support Materials

Develop an essential list for laboratory tests, clinical equipment and consumables, will be further addressed by the Infrastructure and Supply Chain Management work streams



Scope of Support Personnel

Propose structures, roles and responsibilities for clinic support personnel, which will be further addressed by Human Resources work stream



SOURCE: SA Healthcare Lab

One key initiative under support services will be further addressed by the Infrastructure and Supply Chain Management workstreams

To effectively manage cross infection, and improve health and safety of patients and staff in each facility

Initiative concept/details/highlights

- Develop national essential list for laboratory tests, clinical and domestic equipment and consumables to support delivery of revised package of services
- Standardised lists are required to ensure adequate availability of essential equipment at the right quality levels, appropriate service delivery, and timely and effective patient management
- Resulting in raised satisfaction and reduced complaints from staff and patients
- Currently there are provincial as well as draft lists, which the Lab team has started to refine and combine in reaching a standardised list, including:
 - IPC (incl. Waste management) and Cleaning materials and equipment List
 - Clinic Equipment Standard List
 - Essential Laboratory List

Next steps

- Update lists using:
 - The service package
 - The level of service
 - References – WHO essential list
 - Classification of facilities
 - Determine SLA requirements -maintenance plan
- Hand initiative over to Infrastructure and Supply Chain

Clean and safe facilities, with adequate infection control and waste management

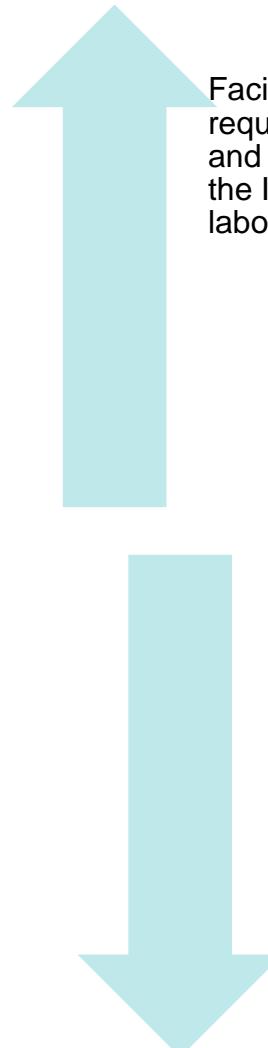
This is to ensure that essential medical equipment and consumables are available to support the service delivery model

Developing essential equipment and non-medical supplies lists

- Ensure that ideal clinic have the necessary equipment, non-medical consumables and access to laboratory testing to support the Integrated Clinical Service Model (ICSM)



The following steps are involved in developing essential equipment and non-medical supplies lists



Facilities do not have the requisite medical equipment and consumables as well as the inappropriate usage of laboratory service

- Develop equipment list
- Develop non-medical consumables list
- Develop Essential Laboratory List (ELL)

Facilities have the required medical equipment and consumables including the appropriate use of laboratory services to deliver on the service model

Key Initiative	Description
1	Develop the Integrated Essential Equipment and Non-Medical Consumables List required at the health facility to provide integrated care based on the service model
2	Develop the Essential Laboratory List (ELL) list based on laboratory best practices and the Integrated Chronic Service Model (ICSM). The ELL can then be used to develop a PHC laboratory Handbook and the PHC request Form

This will involve the development the Integrated Essential Non-Medical Equipment and Consumables List (IEMCE)

Initiative details

What is to be done?

- Develop Essential Non-Medical Equipment required
- Develop Essential Medical Consumables required

Who is responsible?

Service Stream

Timeline

- Begin implementation in 2015
- Two years to complete

Stakeholders

- NDOH
- Partners

Impact

- Develop Essential Non-Medical Equipment list to ensure that health facilities comply with the set minimum standard to deliver on the service model, e.g., emergency equipment for patient resuscitation
- Develop Essential Medical consumable list to ensure that health facilities have all the items required for service delivery, e.g., gloves

Develop the Essential Laboratory List (ELL) list

100 feet

Initiative details

What is to be done?

- Develop ELL
- Develop PHC Laboratory Handbook
- Develop PHC Request Form

Who is responsible?

ELL and Handbook Development
(Ruth Lekalakala, Shaidah Asmal & Naseem Cassim)

Timeline

- Begin implementation in 2015
- Two years to complete

Stakeholders

- NDOH
- NHLS
- Partners

Impact

- Develop ELL to
 - Align test requests to the ICSM
 - Significantly improve utilisation of laboratory services
 - Reduce unnecessary test requests
- Develop PHC Handbook to
 - Significantly improve utilisation of laboratory services
 - Improve staff understanding on specimen collection and request form completion
- Develop PHC Request Form to
 - Limit PHC testing to the ELL



Proposed structures, roles and responsibilities for clinic support personnel, has been identified and will be further addressed by HR work stream

To establish proper structures, roles and responsibilities for *clinic support* personnel

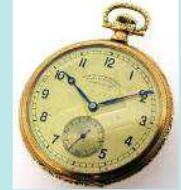
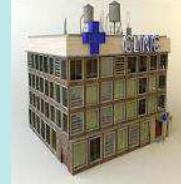
Initiative concept/details/highlights

- There are structures, roles and responsibilities for clinic support personnel in district health services (DHS)
- Structures, roles and responsibilities are inadequate for clinic support personnel which include clinical and non-clinical staff at district level (clinics, CHCs and district hospitals)
- Establish proper structures, roles and responsibilities for clinic support personnel through a Task Team (TT) of Key Stakeholders with the NDoH as the convener. TT to consult with other external appropriate stakeholders to prevent gaps
- This would lead to efficient and effective clinic support personnel

Next steps

- Finalise list of roles and personnel required for optimal service delivery
- Hand initiative over to Infrastructure and Supply Chain

Specific outputs from this lab will propel delivery of healthcare to greater heights (I)

Description of Output	Enabler required	
<ul style="list-style-type: none">▪ Standardized DM structure&profile▪ Clear roles and responsibilities at all levels▪ Management and clinical skills▪ Employee health and wellness	<ul style="list-style-type: none">▪ Organogramme with delegation of authority and readiness to implement▪ Curriculum and training for staff (pre-service and in-service) (HRD plan)▪ Accountability and consequence management (HRM & PMDS)	<p>Human Resource</p> 
<ul style="list-style-type: none">▪ Implement ICSM model to improve patient flow▪ Patient administration, filing, records and flow▪ Availability of staff, equipment and supplies	<ul style="list-style-type: none">▪ Integrated HMIS and patient records	<p>Waiting Times</p> 
<ul style="list-style-type: none">▪ List of medical equipment▪ Cleaning protocol and guideline	<ul style="list-style-type: none">▪ Service package with clearly defined facilities classification▪ Maintenance	<p>Infrastructure</p> 
<ul style="list-style-type: none">▪ Allocation of budget▪ Delegation down to operation managers▪ Involvement of facility staff in resource allocation and budgeting	<ul style="list-style-type: none">▪ Delegation and Budgets▪ Costing of the revised package▪ Staff training and skills in FM	<p>Financial Management</p> 

SOURCE: Lab Analysis

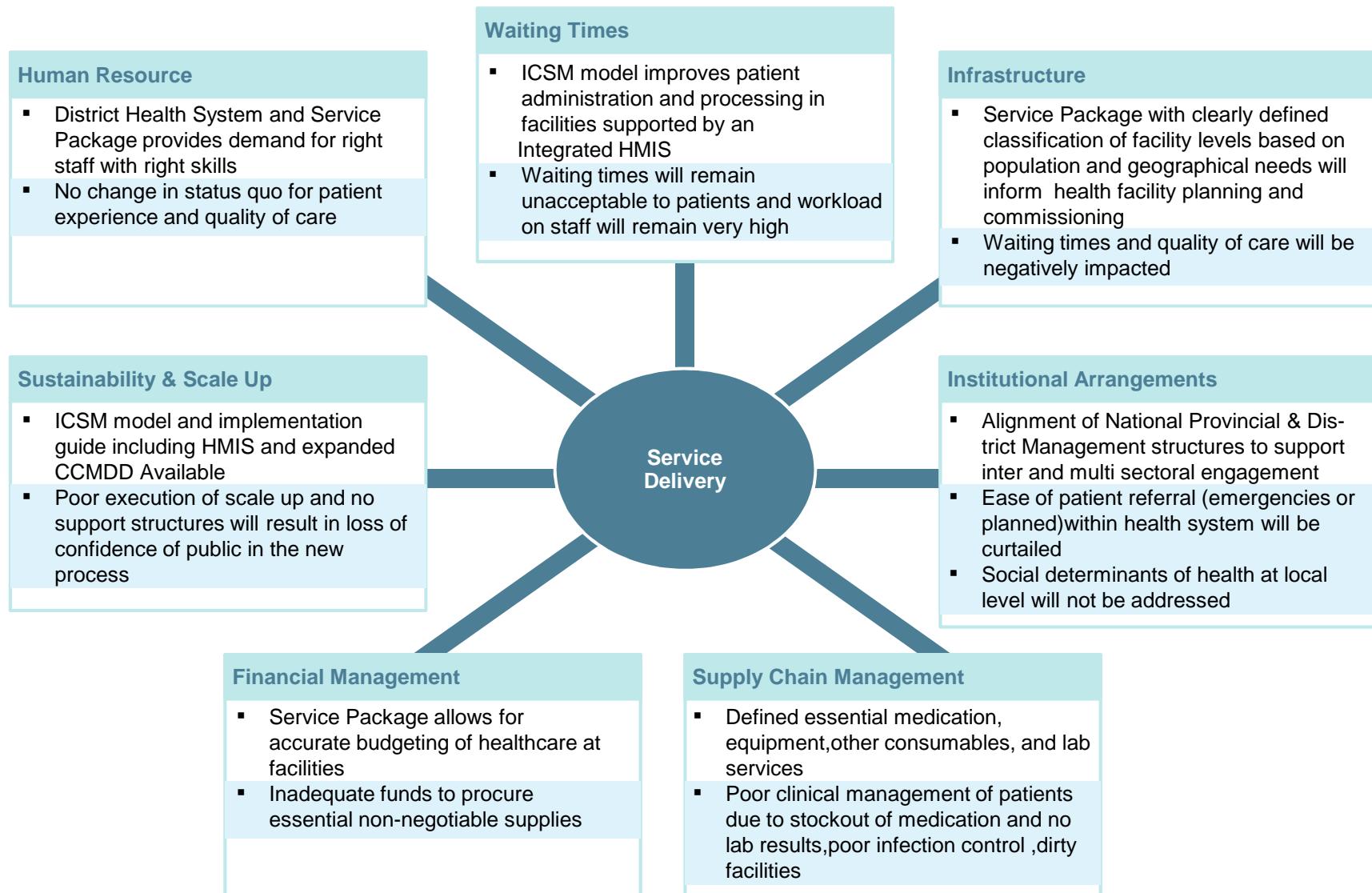
Specific outputs from this lab will propel delivery of healthcare to greater heights (II)

Description of Output	Enabler required	
<ul style="list-style-type: none">▪ Consistent availability of drugs and all supplies and support services▪ Defined list of essential medicines, clinical equipment and consumables▪ Maintenance of equipment▪ Scale up of service package▪ Re-organisation of DHS services and PHC facilities▪ Implementation of the referral policy▪ Community engagement	<ul style="list-style-type: none">▪ Delegation of SCM function▪ Staff training and skills	Supply Chain Management 
<ul style="list-style-type: none">▪ Clear and seamless referral pathways▪ Social determinants of health addressed▪ Standardized DM structure and profile▪ Roles and responsibilities▪ Right skills and competencies at all levels of the system▪ Delegation of authority	<ul style="list-style-type: none">▪ Develop and implement a scale-up plan▪ Implementation of a clear and sustained communication strategy for all (staff, patients, communities, government departments and all sectors)	Sustainability & Scale Up 
	<ul style="list-style-type: none">▪ Align national, provincial, district and local government▪ Provincialisation of PHC health services	Institutional Arrangements 

SOURCE: Lab Analysis

Initiatives from the Service Delivery Workstream impact other workstreams in the Healthcare Lab

Risks



Contents

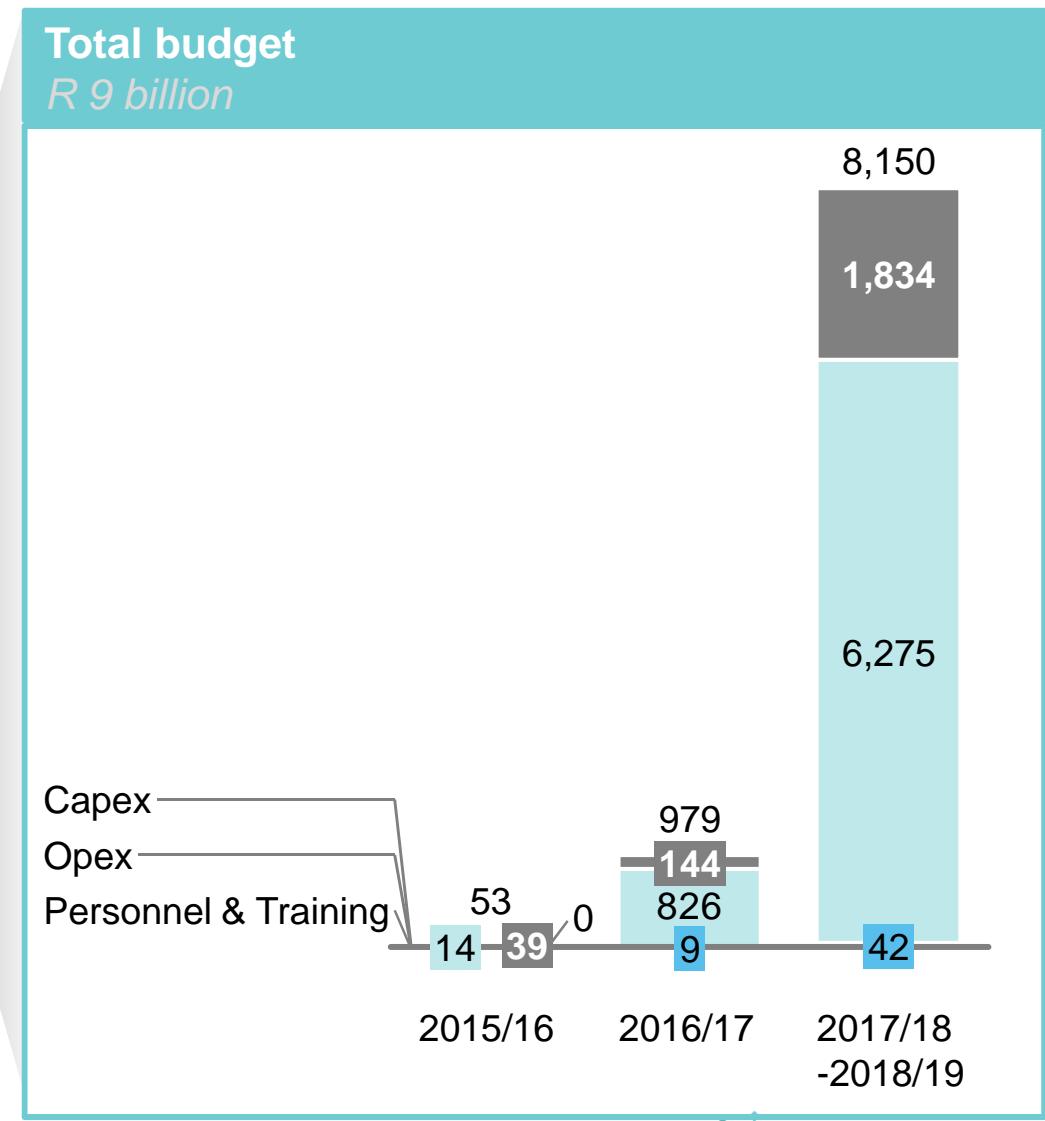
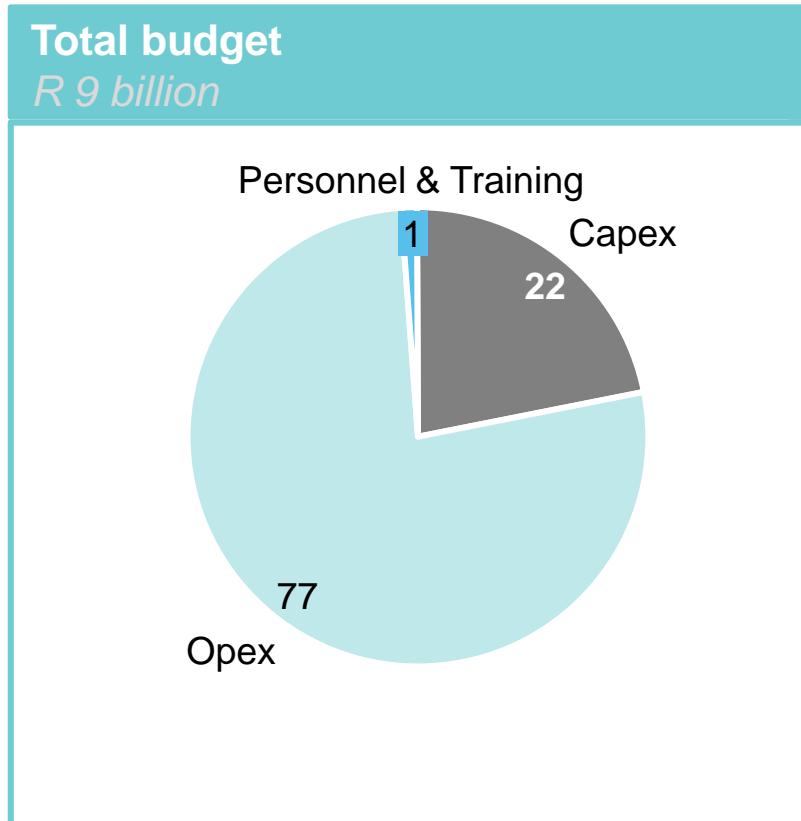
- Context and case for change
- Aspiration
- Issues and root causes
- **Solutions/ Initiatives**
 - Budget
 - KPI
 - 3ft plans
- Appendix
- Accronyms

Detailed initiative budget – Service Delivery

Total budget, R 9 billion

Nr	Initiative	2014/15			2015/16			2017/18 – 2018/19			Total
		Capex	Opex	Personnel and training	Capex	Opex	Personnel and training	Capex	Opex	Personnel and training	
	1 & 2		11552255			44529936					56082191
	3				8632000		1013040				9645040
	4				262600		353500	820500	2382300		3818900
	5		2127700		772441200				5802296400		6576865300
	7 & 8	39067950			143622000		7793333.333	1832990730	469948005	41505066.7	2534927085
	Total	39067950	13679955	0	143622000	825865736	9159873.333	1833811230	6274626705	41505066.7	9181338516

Budget overview – Service Delivery



Contents

- Context and case for change
- Aspiration
- Issues and root causes
- **Solutions/ Initiatives**
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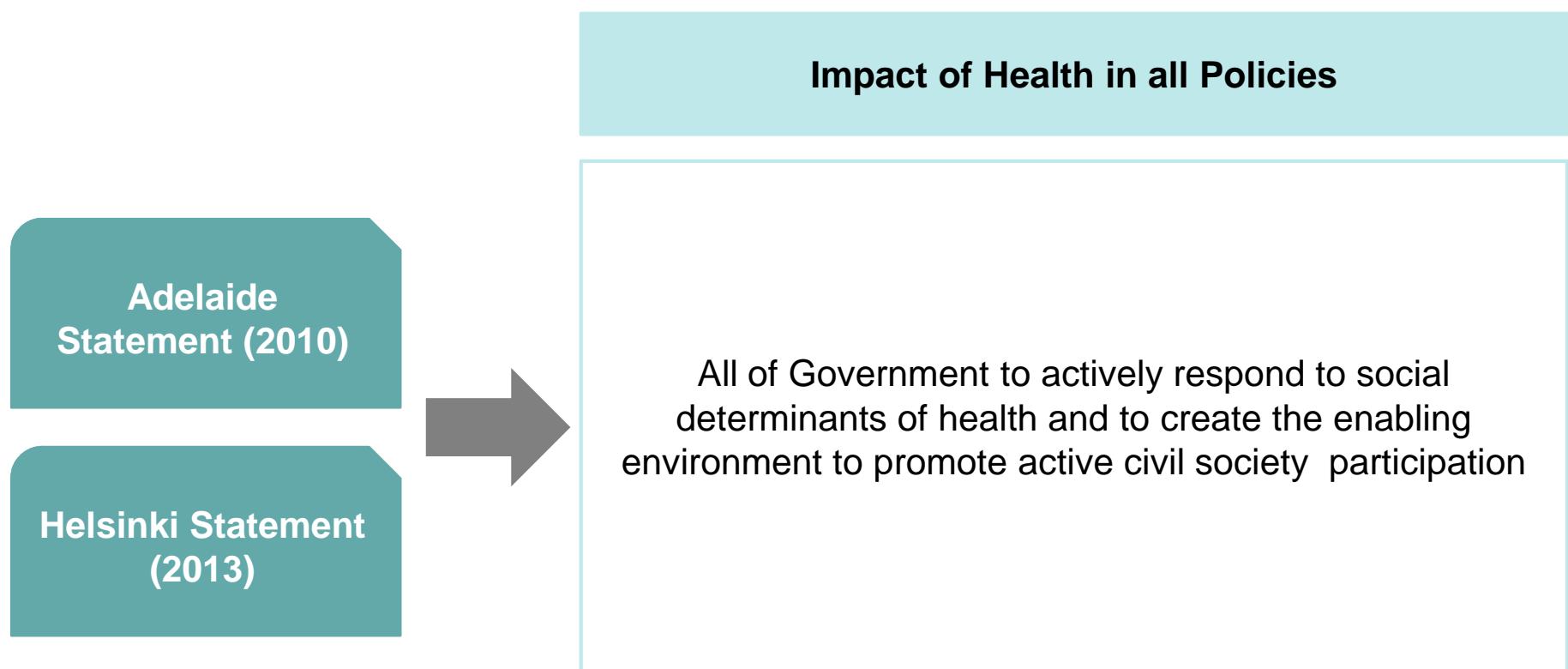
Contents

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Addressing the Social Determinants of Health



The Adelaide Statement on Health in All Policies

Engages leaders and policy-makers at all levels of government—local, regional, national and international emphasizes that **government objectives** are best achieved when **all sectors** include **health and well-being as a key component of policy development**. This is because the causes of health and well-being lie outside the health sector and are socially and economically formed.

The Adelaide Statement outlines the need for a **new social contract** between all sectors to advance human development, sustainability and equity, as well as to improve health outcomes. This requires a **new form of governance** where there is joined-up leadership **within governments, across all sectors and between levels of government**.

The Statement highlights the contribution of the health sector in resolving complex problems across government.



The Helsinki Statement on Health in All Policies (2013)

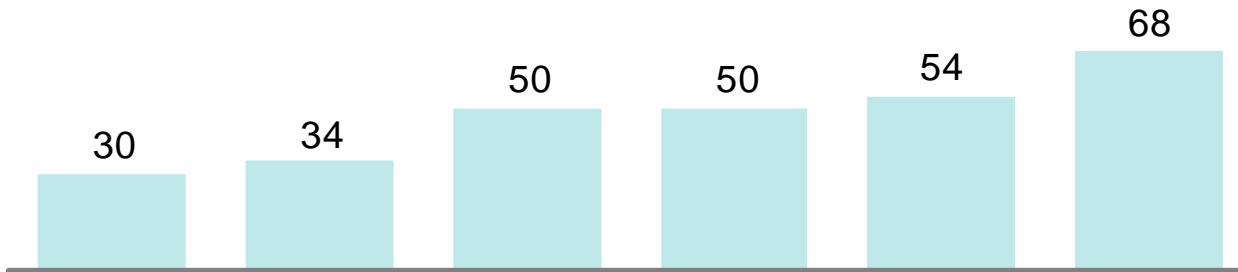
The building blocks essential for Health In All Policies are

- Strong alliances and partnerships with mutual interests and shared targets and accountability
- Whole-of-government commitment by engaging the head of government, cabinet, and, or, parliament, and administration leadership
- High-level policy processes
- Consultative approaches for stakeholder advocacy and endorsement
- Pool intellectual resources, integrating research and sharing field experience
- Feedback mechanisms – evaluate & monitor at the highest level

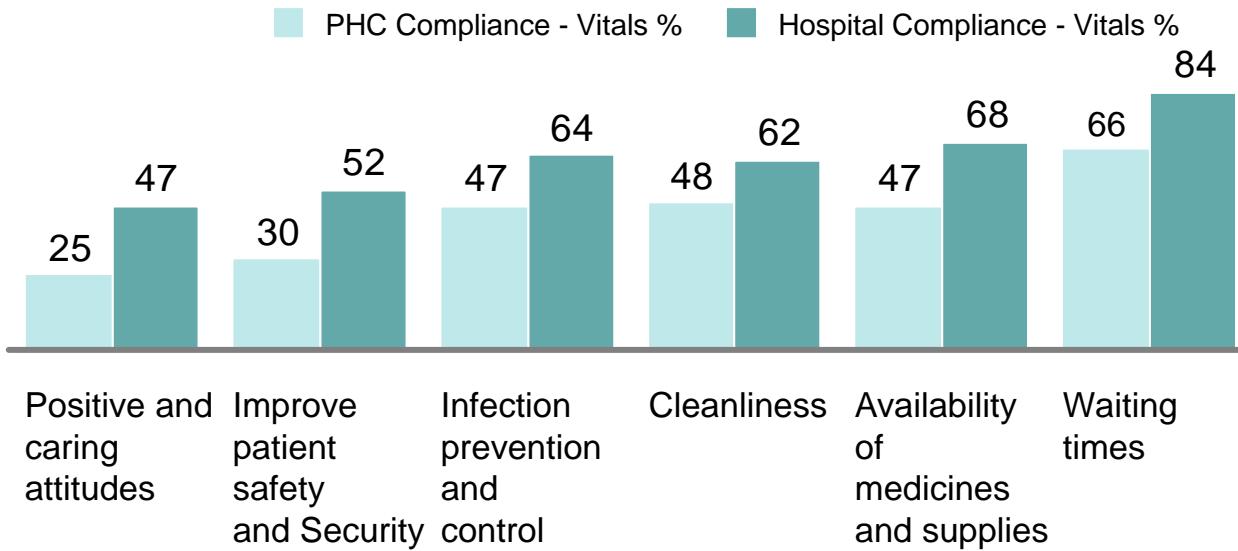


Clinics demonstrated a lower level of performance compared to hospital cross the board

Compliance scores for the six priority areas on vital measures, 2011



Compliance scores for the six priority areas on vital measures for PHC and hospitals, 2011



Key takeaways

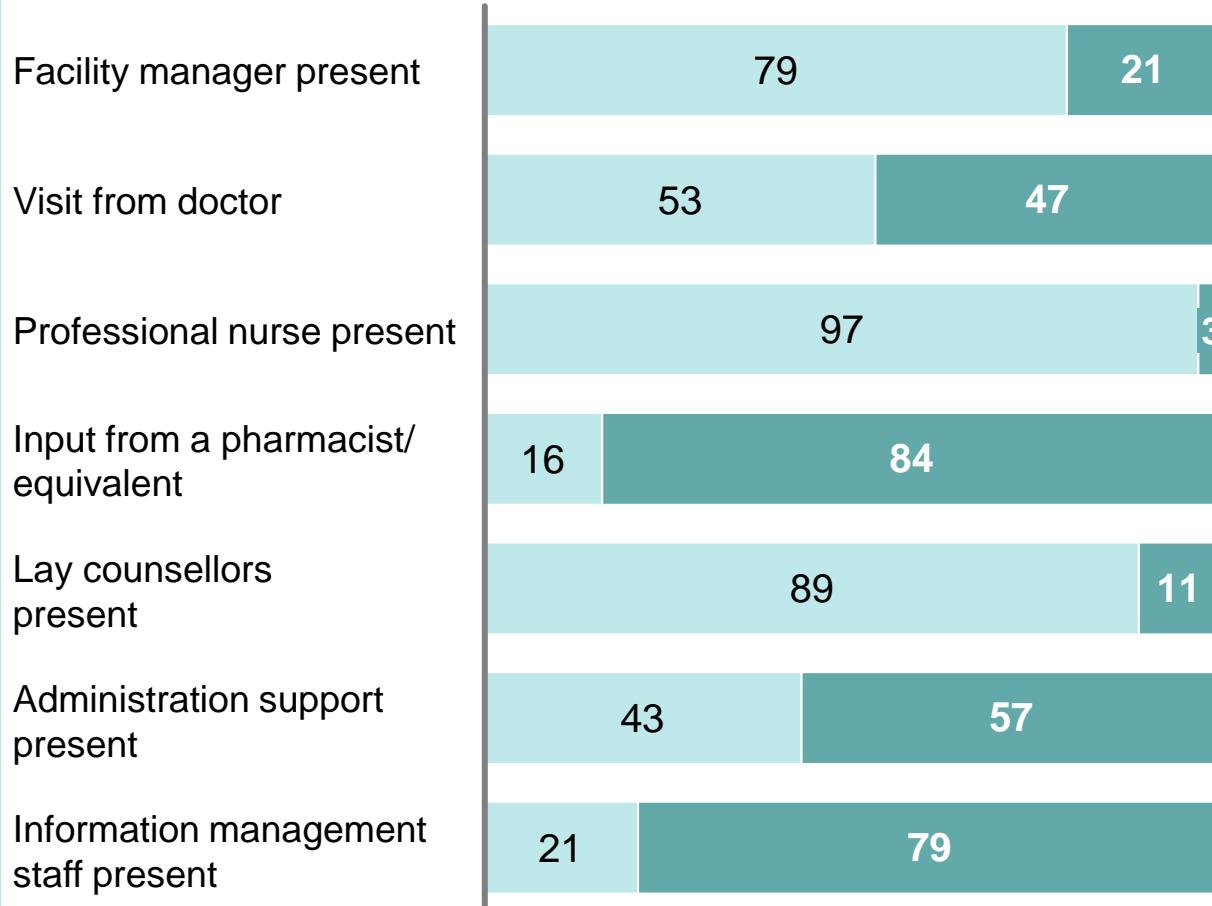
- The six priority areas have been identified by NDoH as **fundamental to the provision of quality health care** in all establishments
- Overall, positive and caring attitudes (30%) and patient safety (34%) had the lowest scores
- At a facility level, PHC facilities scored on average lower in all 6 priority areas**
- These results underline the need for the Ideal Clinics Initiative

The survey also highlighted critical staff shortages in South Africa clinics, especially, of pharmacy staff



HR availability at 3,074 clinics across South Africa

Percent



Key insights

- Lack of administrative and information management staff increases nursing staff's workload
- Presence and effectiveness of facility manager identified as key success criteria for IDCs needs urgent attention
- Shortage of pharmacists also critical

1 The patient experiences services that are vertical and curative focused, making it unpleasant, time consuming and costly (2/2)

Three separate clinic visits per month
Long waiting times
Inadequate health education



High defaulter rate
Non-compliance to medication
Poor Treatment response
Life expectancy below 50 years

Neglect social responsibilities and roles
or
Delegate social responsibilities and
roles

Need time off work
Loss of employment
Travel costs



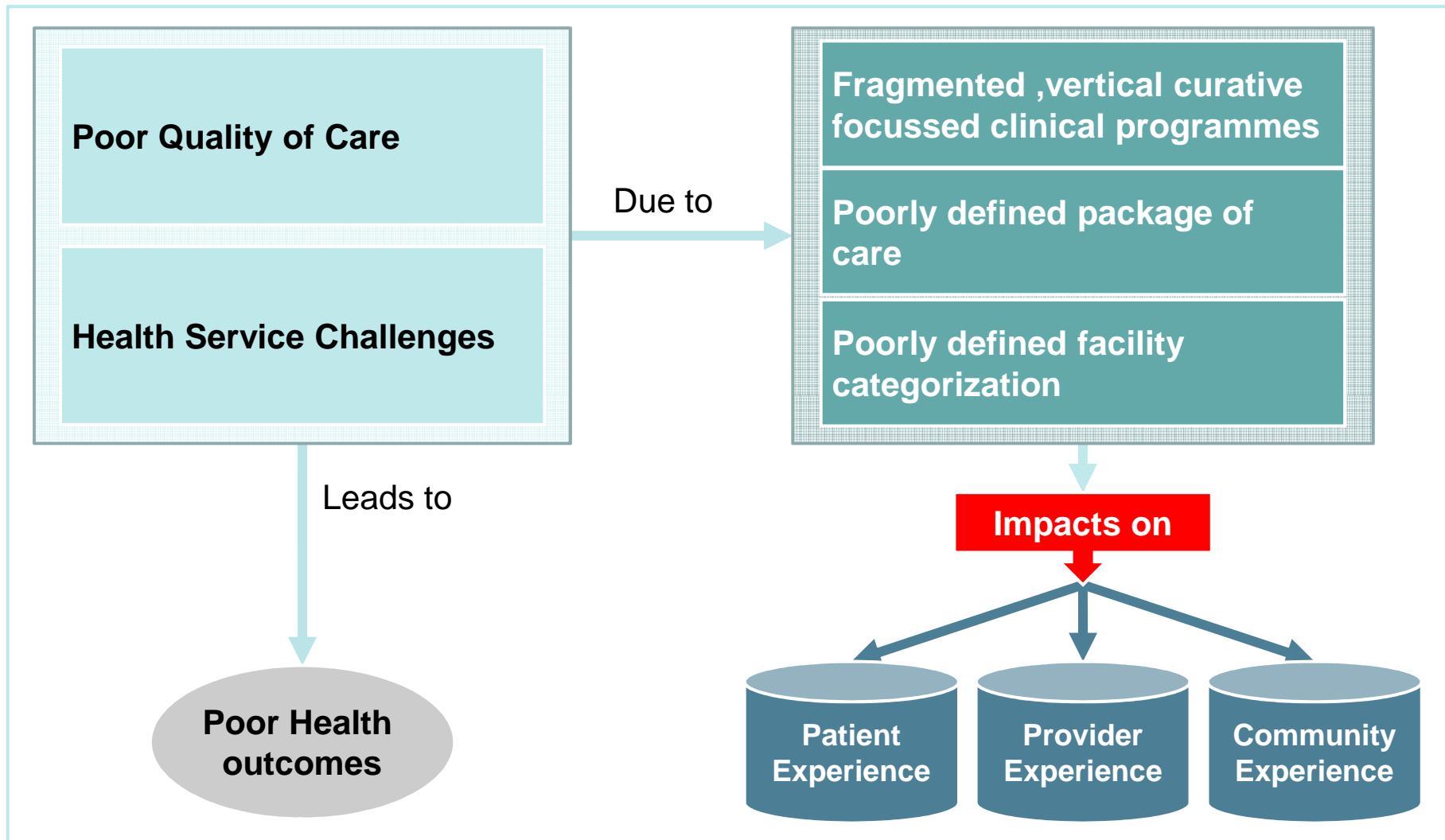
Health burden



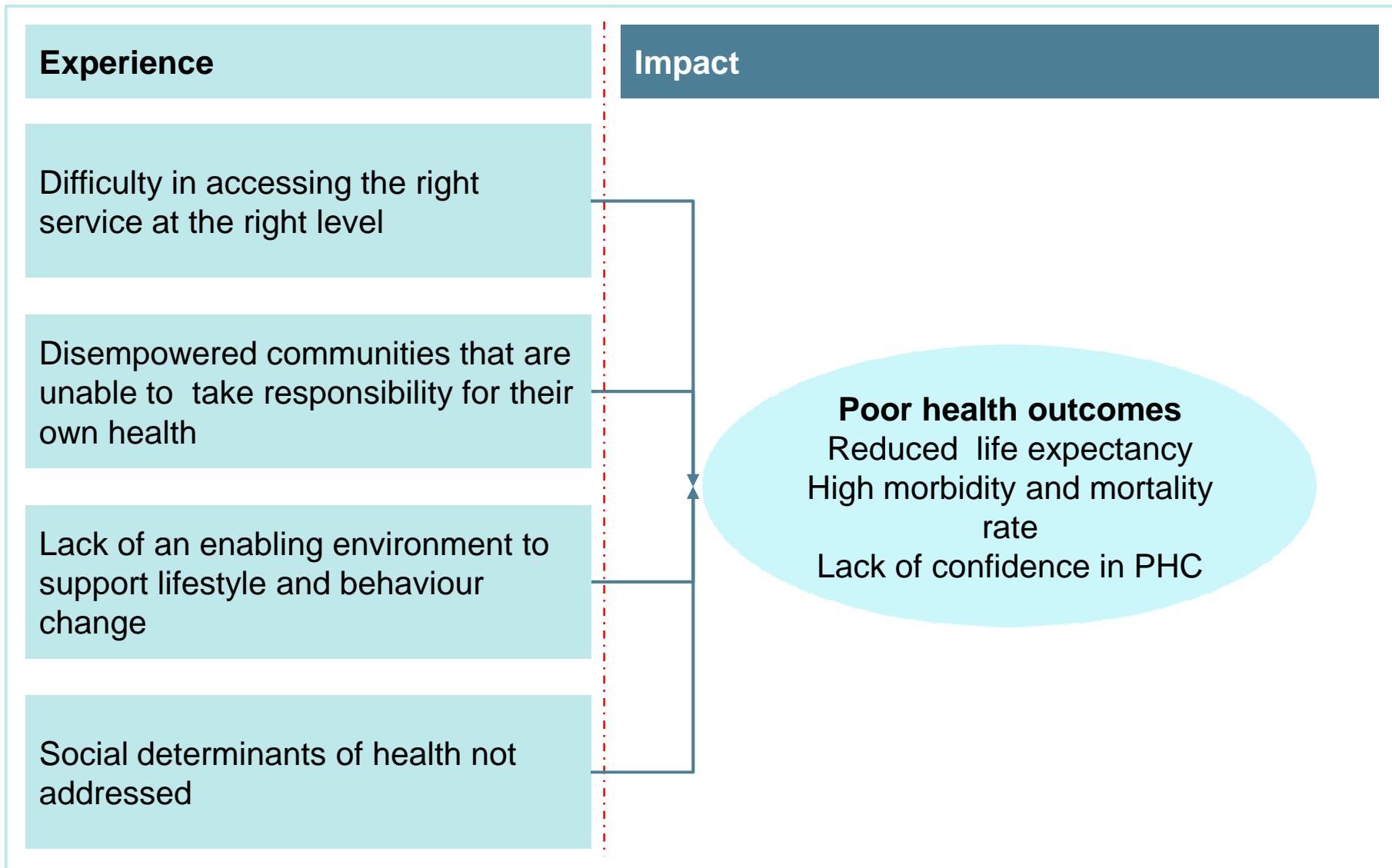
Social burden

Economic burden

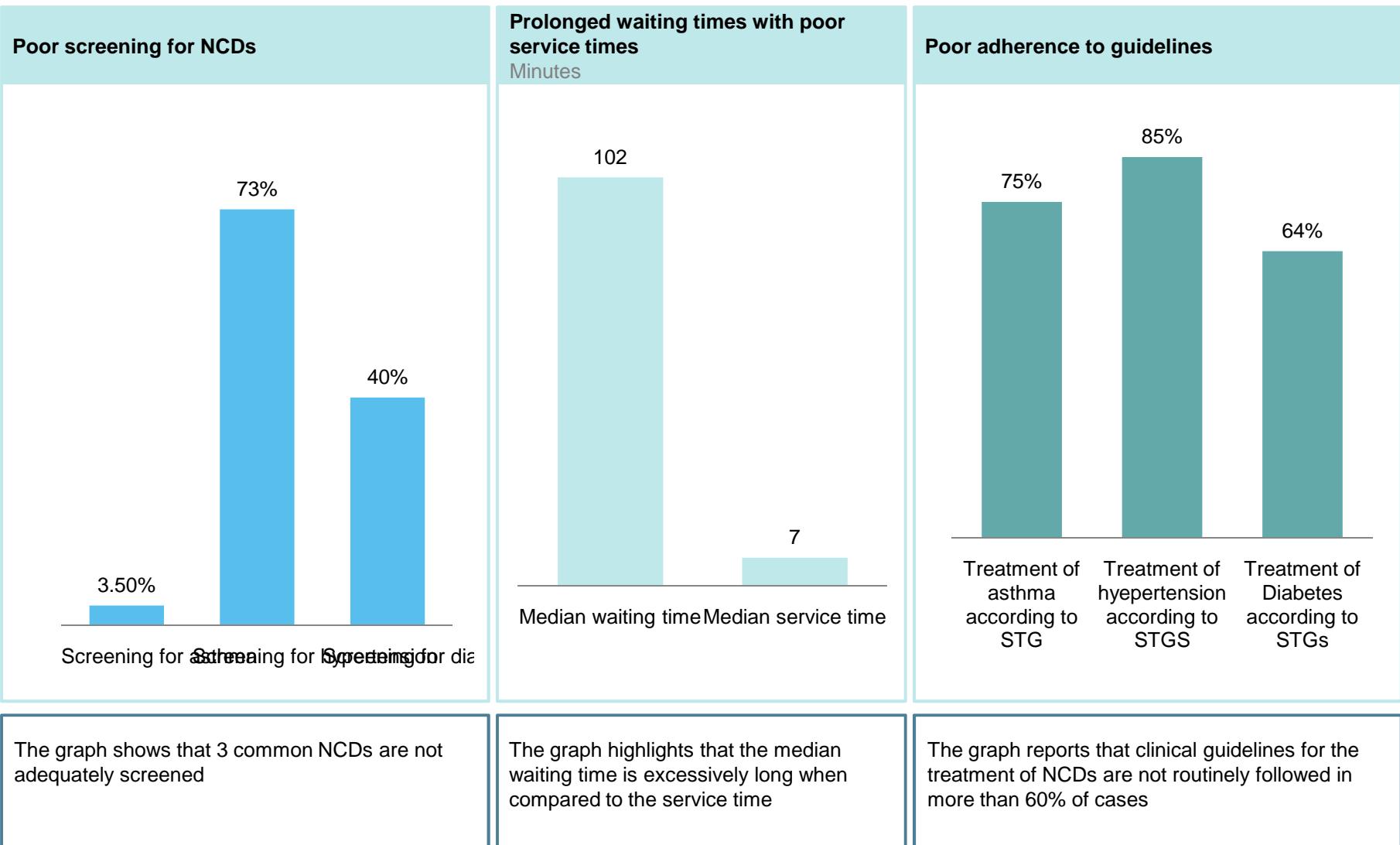
1 Poor quality of care and health service challenges lead to poor health outcomes



1 ...as well as the community



1 Inefficient services

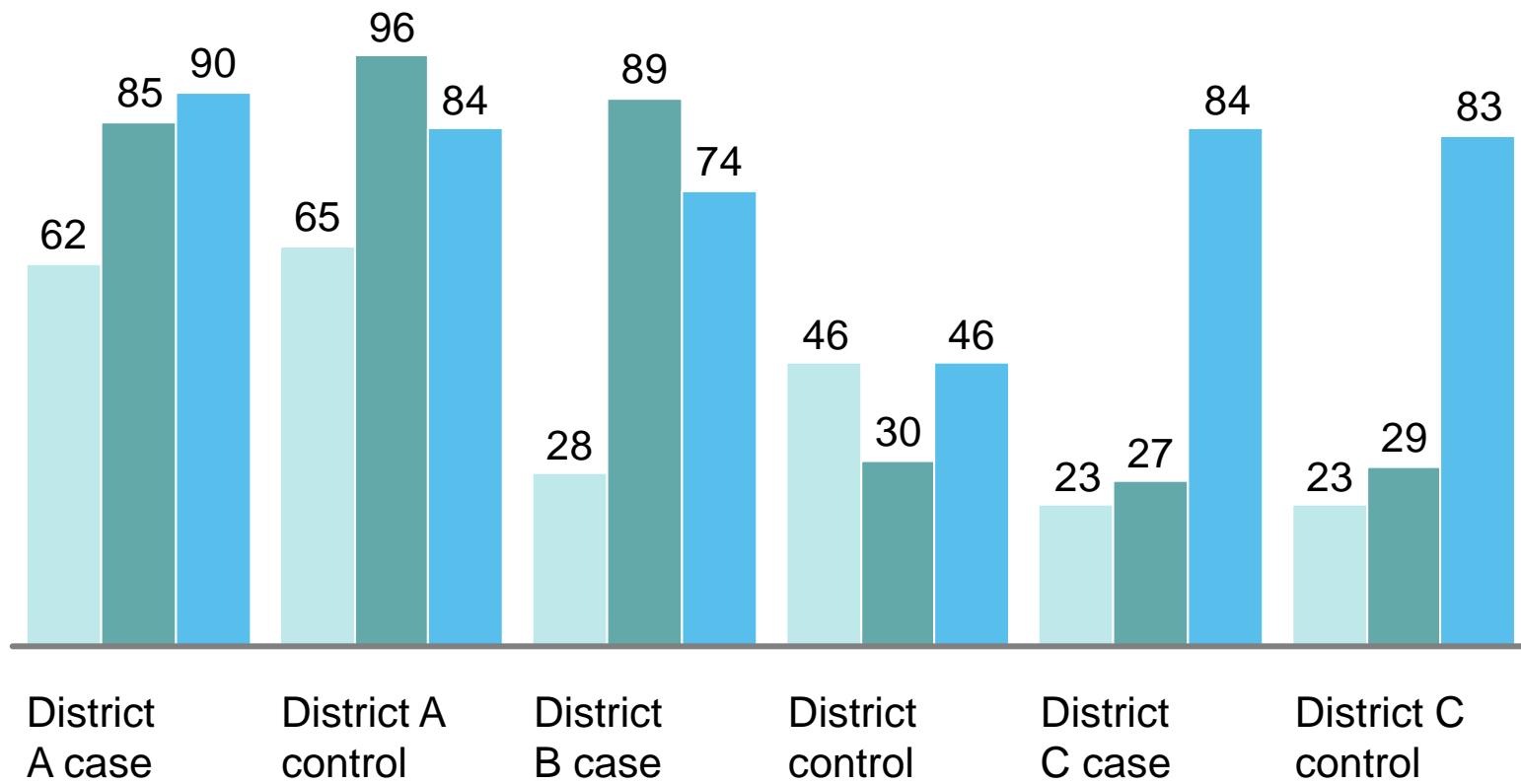


SOURCE: Waiting times , Client experiences and Quality of care ; Mahomed O; Asmall S 2013

1 Quality of Care Improvement

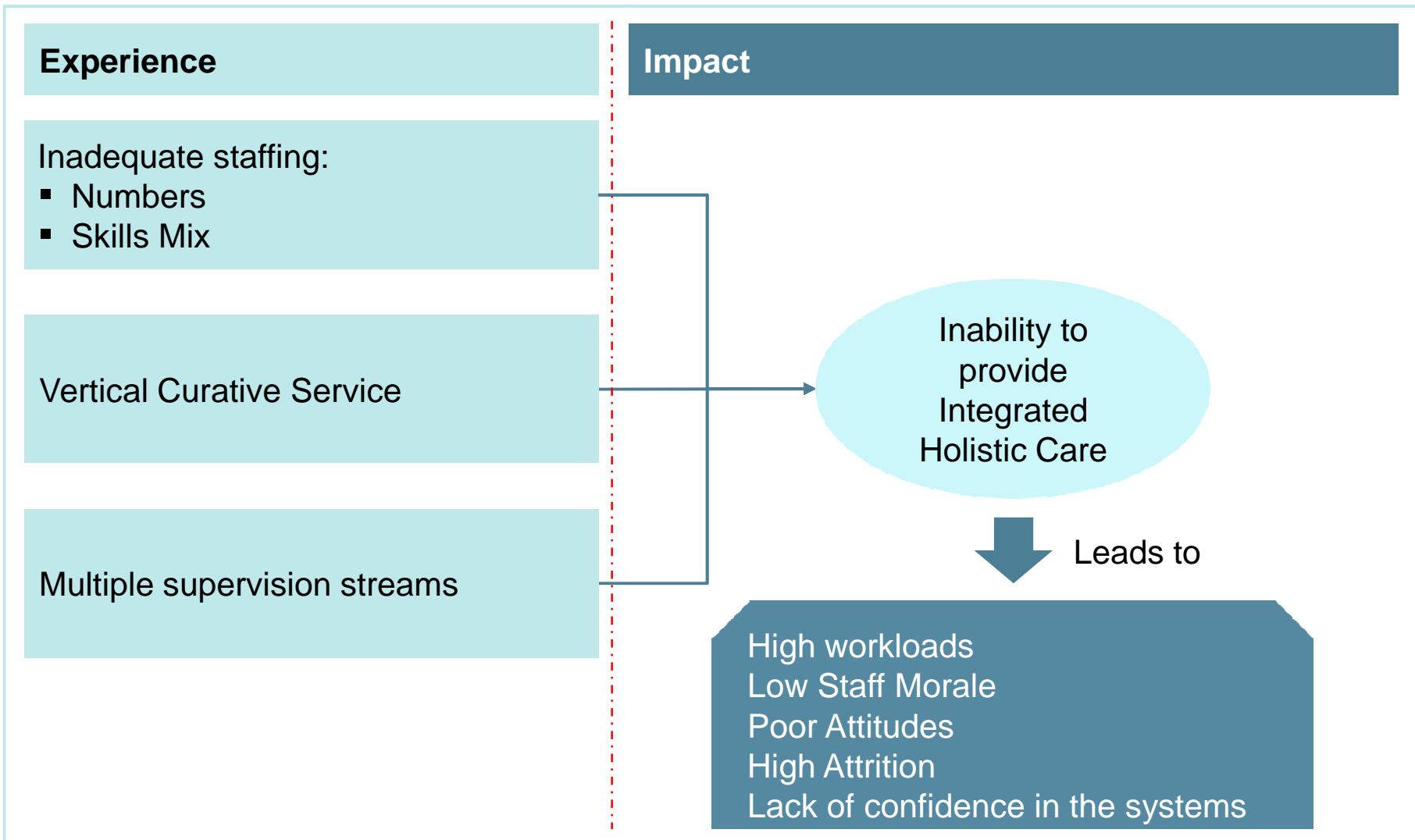
Baseline
3 months
6 months

Change in quality of clinical records: baseline, 3 and 6 months post training



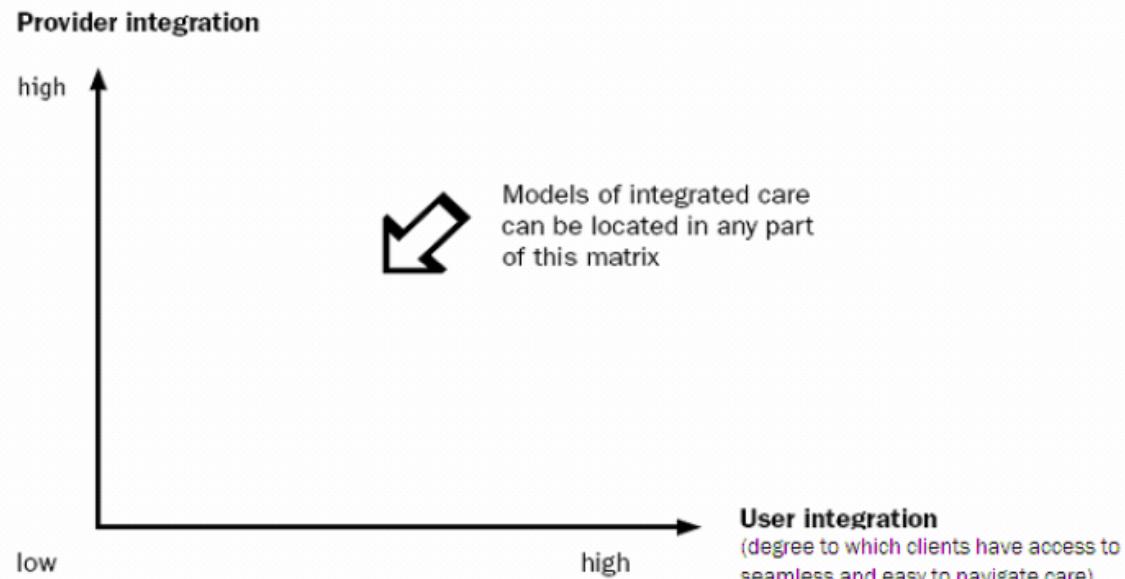
SOURCE: Waiting times , Client experiences and Quality of care ; Mahomed O; Asmall S 2013

1 This vertical and curative focus also impacts negatively on the healthcare provider...



1 The Integrated Care Matrix

Figure 2 – The Integrated Care Matrix (7)



Integration results in ease of access and seamless services.

SOURCE: Integrated health services – what and why? World Health Organisation. Technical Brief No 1, May 2008

Case for Integrated Care

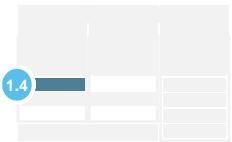
Pros

Many benefits are claimed for integrated health services – they can be **cost-effective, client-oriented, equitable** and **locally owned**. The “cost” part of cost-effectiveness is based on the idea that it is more economically efficient to share resources (particularly human resources) than have them devoted to one particular disease. The “effectiveness” is based on the idea that it makes sense to deal with a whole person (plus his or her family, sexual contacts etc.), rather than focusing separately on just one health problem in an individual.

Cons

Where the wider health system does not function well, it makes no sense (or is too risky) to change a separate programme which works well. The high quality work of programme which provides a rather narrow range of services to an excellent standard is jeopardized by integration AIDS exceptionalism – i.e. the argument that the nature of the HIV epidemic means that it is important to regard HIV/AIDS services as a special case which needs to be well-resourced, expanded quickly and “protected” from the inefficiencies of the broader health system. As with all these supposedly yes/no arguments, the reality is more nuanced, along a continuum of integration. AIDS exceptionalism does not imply that no HIV/AIDS services can be integrated.

Referral systems



Issues

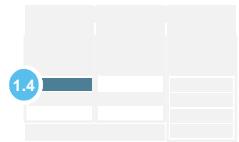
- Draft policy in place since 2007 but not approved
- Cannot refer to the nearest hospital due to geographical boundary limits
- No standardised referral system which includes feedback mechanisms
- Patients lost to follow up due to poor referral system
- No inclusion of community services in referral policies

Results from a survey of 35 hospitals and clinics

- 23% do not have a referral policy to guide referrals from the facility
- Referral policies are not standardised and vary according to facilities and districts
- No standard definition of policy sites had SOPs /Guidelines/policy all being described as policy Provinces, districts and sites have different referral policies
- No proof of version control or signed off mechanisms of Referral policy

1.4

A Seamless, Standardized health referral system without geographical and sectoral boundaries



Context

- Currently boundary limits for district health system
- Closest appropriate facility is often in another province, therefore patients cannot be referred
- Unstructured and non-standardized referral system, leading to patients being lost in the referral system
- Lack of feedback on patients referred

Case for Change

- The Continuum of care is not maintained and there is escalation of cost of care as people enter at the wrong point
- The segregated nature of healthcare (private and public as well the failure of the referral system) results in a duplication of services
- The provincial boundaries cause delays in service provision as they are either ignored by referring staff or circumvented by patients as they seem impractical resulting in poor health outcomes
- The lack of institutional arrangements including arrangement's between the private and public sector negate the efforts to implement a formalized referral system

1 Evidence supporting community engagement to improve health outcomes



India -The Mitanin CHW Programme supporting child survival in Chhattisgarh state *in India is a significant example of a large scale community health worker programme which has created community empowerment with a focus on improving child survival. Evidenced by the decrease in infant mortality from 85 deaths per 1 000 live births in 2002 to 65 deaths per 1 000 live births in 2005.*



Nepal -With the help of a one year community-based participatory educational intervention delivered through monthly women's group meetings convened by local women in the Makwanpur district, Nepal was shown to reduce neonatal mortality by 30%.

1 Evidence supporting community engagement to improve health outcomes



Bangladesh - Several factors outside of the health system have contributed to health gains by Bangladesh. These include:

Education- Improvement in primary education enrolment from 74% (1991) to 87% (2005), and literacy from 15% in women to 54% , and 38.9% in men to 61% over the period from 1980-2008

Women empowerment – through education and income-generation activities, improved communication and connectivity (e.g., mobile phones), involvement in microcredit schemes, older age at marriage and exposure to media



Ghana – Used the Community-based Health Planning and Service (CHPS) Initiative, based on the Navrongo model that advocates for the active participation of communities in the provision of their own healthcare. This involved:

Relocation of nurses to communities

Reorientation of the management system to be more supportive of accessible community-based nursing care

This led to reduced childhood mortality by 33% in 7 years and the total fertility rate declined by 1 birth in a decade

1 Gaps in the existing PHC Package have been identified

The Primary Health Care Package for South Africa – a set of norms and standards

Part 1 Norms and standards for health clinics

Part 2 Norms and standards for community based clinic initiated services

Department of Health

Pretoria

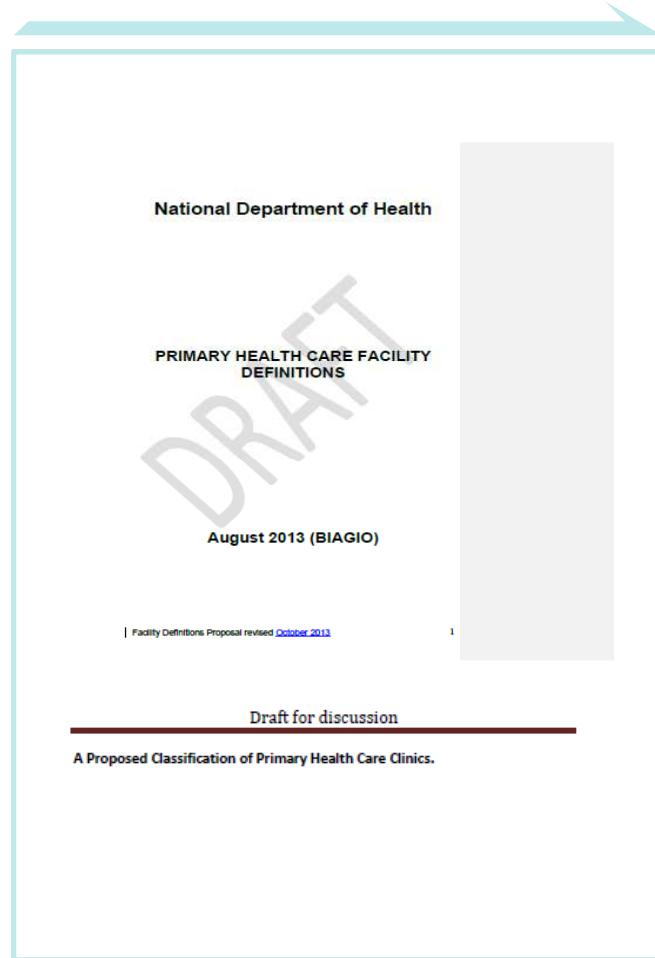
March 2000

- The service package is not in accordance to the life course approach and full value chain of continuum of care and support.
- Communities are not sure as to what services they can expect at the different levels, thus the situation of them skipping to higher level facilities for care.
- Comprehensive community based approach is missing including Early childhood development
- Rehabilitative and Palliative care from the facility to the community is not included
- Dental services are lacking across the board at PHC Level
- It promotes vertical programme implementation which places additional stress on facilities .
- Therapeutic services such as audiology, speech therapy and psychology are not outlined. Provision of these services is limited in hospitals.

Lab Analysis, 2014

SOURCE: Department of Health, Pretoria, March 2000

1 Poorly defined and classified PHC Facilities



- Some facilities are classified as for example CHC, but are run as a PHC Clinic
- No standardised model of how and what a facility should look like
- No Model to inform on community needs for establishment of health facilities
- Definition and classification of PHC facilities not in line with the package of care
- Referral pathway to appropriate level of care affected by the poor mismatch of classification and package of care provided.

Lab Analysis, 2014

SOURCE: PHC Facility development, NDOH, August 2014. Proposed Classification of PHC Clinics, NDOH, 2014

Overall Lab Charter (Service Delivery)

Lab aspiration: Ensure that all facilities deliver comprehensive, holistic health services of optimum quality in an integrated manner to ensure satisfactory patient experience through

- Delivery of organized personal and population-centered quality health services using evidence based practice.
- Implement a standardised, integrated national HMIS
- All facilities have 100% availability of medicines and that patients have unfettered access to medicines at all times
- All facilities comply 100% to NCS in relation to infection control and cleanliness
- Development of a sustainable, standardised, efficient community centred DHS that is comprehensive, accessible, equitable and quality driven.

Criteria and measures for success

- Alignment of national, provincial, district, sub-district and clinic priority and programs-including annual performance plans
- Integrated comprehensive clinical services provided at all clinics that align to community and population needs
- All facilities to have lean patient flow processes that fully support the delivery of standardised packages of care.
- Fully functional integrated HIMS that provides quality information to all levels (district, provincial & national) when required in a desired format.
- Identified and agreed upon models that complies with legislation for the innovative supply of medicines to the patient
- Implemented directive from MoH pertaining to list of non-negotiable cleaning material and equipment and maintain status of readiness to deal with public health emergency
- Standardised DHS Structures across the country

Stakeholders for syndication

- DoH Human Resources for Health
- Dept of Finance-Treasury
- DoH Supply Chain
- DoH Infrastructure
- Dept of Public Works
- DoH Environmental Health
- Dept of Water Affairs and Sanitation
- Dept of Social Development
- Dept of Human Settlements
- Dept of Transport
- Dept of Safety and Security
- Dept of Education
- Healthcare Professional Service Provider Councils
- Community representative organizations
- Trade Unions
- Service providers
- Healthcare Facility managers
- District and Local government authority
- Inter sectoral meetings.
- Private Sector
- NGOs

Boundaries and limits

- Limited to primary healthcare clinics and community health centers, mobile and satellite
- Existing legislation and regulations should inform discussions

Timeframe for resolutions

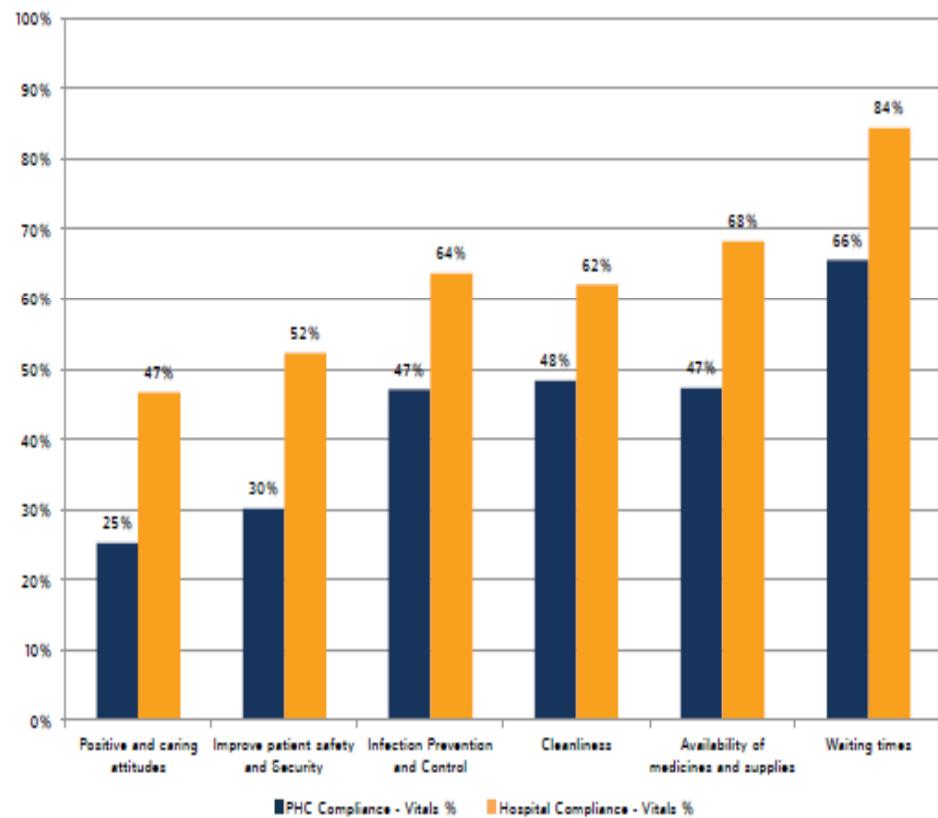
- Implementation within 5 years

CONTEXT

This has a significant impact on Waiting Times

The National Health Care Facilities Baseline Audit National Summary Report 2012

Figure 14: Compliance to the six priority areas on vital measures for PHC and hospitals, 2011



**Only 64% of PHC Clinics
complied with Waiting Times**

SOURCES: The National Health Care Facilities Baseline Audit: National Summary Report 2012

CONTEXT

Also impacting on Socio Economic Parameters and Productivity

Socio Economic and Productivity



- The average total costs (transport, fee, substitute labor, income loss) per visit was R 96 across the entire sample in study source
- Median Travel time ranged from 1-4 hours at an average cost of R 40 for a round trip
- A single visit costs an average of 11% of the households monthly expenditure
- Loss of productivity & working hours if employed



Time taken from work
to attend clinic to collect
Medication

SOURCES: Cost to patients of obtaining treatment for HIV/AIDS in South Africa: SAMJ, July 2007, Vol.97, No.7; Overview of Health Sector Reforms in South Africa DEC 2011 (Human Development Resource Centre)

Benchmarking Mobile Pharmacy

- Rhoda Kadalie. Service Delivery: Rural health. The New Age accessed from http://www.thenewage.co.za/blogdetail.aspx?mid=186&blog_id=%201234
- “Quality healthcare in South Africa is concentrated in the urban areas. For the 46% of the country’s population who live in rural areas, access to adequate health facilities is more often than not an exception to the rule”.
- “It is an 18-coach train that brings medical specialists to rural communities and for nine months it journeys about 5937km to 37 rural towns in four provinces, providing basic and affordable primary health care to 430650 people annually.”
- “After travelling 100929km in its 17 years of operation (with 20 permanent staff), Phelophepa has treated 7.2 million patients, temporarily employed 35300 local people during its week-long stays in towns, and offered 12750 medical students from universities invaluable experiences in primary health care provision.”
- “At every stop, four local nurses are employed to do basic testing such as blood pressure readings while people wait outside for their private consultations on board the train.”
- “Subsequently, if medication is needed, patients pay R5 per prescription and for children there is no charge. Picture labels are placed on each prescription to cater for the illiterate. Phelophepa’s pharmacy stocks more than 100000 items of medication, while supplying more than 24000 prescriptions to patients annually.”

CONTEXT

This has a significant impact on the following..

Socio Economic and Productivity



A

- The average total costs (transport, fee, substitute labor, income loss) per visit was R 96 across the entire sample in study source
- Median Travel time ranged from 1-4 hours at an average cost of R 40 for a round trip
- Loss of productivity & working hours if employed

Quality of Care from a Patient & Provider Point of View



B

- Increased of Utilization of Primary Healthcare Facilities
- At least 50% of patients seen in the PHC clinics require monthly visits thus increasing the Utilization Rate to at least 12 X per year
- Only 64% of PHC Clinics complied with Waiting Times

Initiative 1a: Finalize and implement an Integrated Primary Healthcare Service

Objective: Develop and Implement an Integrated Primary Health Service that provides Comprehensive Holistic Person and Community-centred care

Initiative concept/details/highlights

1. Develop and implement PHC Package of Services
 - 1.1 Review and revise package of services based on burden of disease, level of care and continuum of care across the life span
 - 1.2 Finalize and obtain approval of proposed package
 - 1.3 Develop and implement a plan for the approved package of service
2. Develop and implement approved Facility Definitions and Classifications
 - 2.1 Review and standardize definitions and classifications of facilities
 - 2.2 Develop a strategy for re-classification of facilities
 - 2.3 Develop a communication strategy for informing the community
 - 2.4 Finalize and obtain approval for 1, 2 and 3
 - 2.5 Develop and implement a plan for facility reclassification
3. Develop a national policy and implementation framework for referral routes
 - 3.1 Review and revise existing draft referral policies
 - 3.2 Finalize and obtain approval
 - 3.3 Develop and implement a plan for referral routes

Owner

- NDoH → DG of Health

Key stakeholders identified

- National Health Council (NHC)
- NHC Technical Advisory Committee (N-TEC)
- DDG PHC
- Provincial Senior Management Team
- District Manager
- Local government
- Community based structures and clinic committees

Required resources

- Investment (ZAR): R

Implementation timeframe

- Start date: 1 December 2014
- End Date: 31 March 2019

Key milestones

- March 2015: Finalize package of service
- Sept 2015: Finalize clinical protocols and attach to PHC package
- March 2015: Facility definition and classification
- March 2016: Integrated care in NHI facilities
- March 2019: Integrated care implemented in 3500 facilities

Integrated health services

Initiative 1b: Develop and implement Integrated Clinical Support (based on ICDM and ICSM principles)

Objective: Develop and Implement Integrated Clinical Support that facilitates Comprehensive Holistic Person and Community-centred care

Initiative concept/details/highlights

1. Clinical Programme Integration
 - 1.1 Review and align national clinical programme policies to reflect continuum of care and life cycle approach for the seamless movement of patients between facility and community levels
 - 1.2 Review and revise national programme specific clinical guidelines to align with revised programme policies
 - 1.3 Review and align clinical programme supervision, coaching and mentorship
 - 1.4 Develop and implement a change management programme to address shift from vertical curative care to comprehensive integrated care.
2. Integrated Clinical Guidelines
 - 2.1 Review and revise existing and; develop new (where applicable) clinical guidelines in relation to the proposed package of services.
 - 2.2 Develop a user - friendly integrated package of clinical guidelines for the appropriate levels of care.
 - 2.3 Develop and implement strategies to capacitate new and existing health workers on the integrated clinical guidelines and the revised programme policies.

Owner

- NDoH → DG of Health

Key stakeholders identified

- National Health Council (NHC)
- NHC Technical Advisory Committee (N-TEC)
- DDG PHC
- Provincial Senior Management Team
- District Manager
- Local government
- Community based structures and clinic committees

Required resources

- Investment (ZAR): R

Implementation timeframe

- Start date: 1 December 2014
- End Date: 31 March 2019

Key milestones

- March 2016: Finalize clinical programme integration
- March 2016: Finalize integrated clinical guidelines
- March 2017: Implemented at NHI facilities
- March 2019: Implemented at 3500 facilities

Integrated clinical support

3 Integrated Service approach from District Health System (District to Facility)

Elimination of fragmentation within the district health system (district to facility) and to ensure collaboration and joint service planning to address the social determinants of health

Initiative concept/details/highlights

- There is currently no properly structured multi-disciplinary team at facility level to ensure a prompt provision of resources and delivery of a quality health service. This is due to the gap that exist between the district and facility.
- Shortage of human resources and the current unsuitably qualified management team with a centralized approach and no appropriate delegation to the lowest level.
- The proposed solution is to properly restructure the management team with both clinical and management skills and relevant delegations to drive facility programs towards quality health service.
- The result of the proposal would be an efficient and effective integrated service delivery team that plans, cost , implement, monitor and evaluates programs to ensure the delivery of a world class health service
- Improved multi-sectoral collaboration to address social determinants, involving community forums and various levels of the district health system

Implementing agency

- NDoH

Key stakeholders identified

- Facility Manager
- Operational Managers
- Logistician: Manager
- HR Manager
- Budget Manager
- EMS Manager
- Statutory Managers
- HIMS Manager

Required resources

- Adequately trained multi-disciplinary team

Implementation timeframe

- Start date: Jan 2015
- End Date: 30 August 2015

Key performance indicators

- The formulation of a multi-disciplinary team in the 52 districts for the different levels of the district health system by June 2015.

The solution will result in a well coordinated systemic accountability with a peer review, teamwork for a high value care within the district health system(district and facility).

Initiative 8: Develop and implement the software platform to achieve interoperability between all eHealth systems

To implement Health Information Exchange (HIE) based on the Health Normative standards Framework to achieve data interoperability.

Initiative concept/details/highlights

This initiative is critical to improve continuum of care. It is a key enabler to facilitate exchange of patient records between different health facilities, levels of care as well as other specialist information systems (Laboratories, Radiology, and Pharmacy).

This initiative will target:

1. Description, Design, and development of a Health Information Exchange and all shared repositories (patient, provider, and clinical) to enable interoperability.
2. Establishing a certification mechanism to certify compliance of Health Information Systems to Health Normative Standards Framework.

Implementing agency

- NDoH

Key stakeholders identified

- National DoH partners
- CSIR
- Heads of National/Provincial & District IT Departments

Required resources

- Dedicated Project Team with expert support
- Investment : R26m

Implementation timeframe

- Start date: 01 Jul 2014
- End Date: 31 Mar 2019

Key performance indicators

- 2015: Basic HIE version 1 established to integrate existing programmatic information systems
- 2016: All components of HIE fully defined.
- 2019: Fully integrated national platform for eHealth integration

6 Develop and implement PHC relevant cleaning guidelines and IPC protocol with appropriate training programs

Effectively manage cross infection, and improve health and safety of patients and staff in each facility

Initiative concept/details/highlights

- There are currently no standardised cleaning guidelines and Infection Prevention and Control (IPC) protocols, resulting in increased risk of cross infection as well as low patient and staff satisfaction in many of the PHCs
- Insufficient cleaning materials, supplies, equipment and untrained staff pose as major challenges in adequate cleanliness and hygiene
- A comprehensive cleaning and supervision plan, incorporating sufficient resources as well as training will be rolled out
- This will result in satisfactory levels of cleanliness and safety for staff and patients; a 20% reduction in complaints, and a 20% increase in staff satisfaction

Implementing agency

- NDoH

Key stakeholders identified

- Facilities Managers
- IPC champions
- Cleaners

Required resources

- ...

Implementation timeframe

- Start date: May 2015
- End Date: December 2016

Clean and safe facilities, with adequate infection control and waste management

Key performance indicators

- Update of the 2007 IPC policy (2015)
- Finalise cleaning guidelines and IPC protocol (2015)

Contents

- Context and case for change
- Aspiration
- Issues and root causes
- Solutions/ Initiatives
- Appendix
- **Accronyms**

Health Services Acronyms

AIDS – Acquired Immune Deficiency Syndrome
ANC – Antenatal Care
ART – Antiretroviral Therapy
ARVs – Antiretrovirals
CCMDD - Central Chronic Medicine Dispensing and Distribution
CDC – Communicable Disease Centre
CHC – Community Health Centre
CHPS – Community-based Health Planning and Service
CHW – Community Health Worker
DALYs – Disability Adjusted Life Years
DDP – Deputy Director General
DG – Director-General
DHS – District Health System
ECD – Early Childhood Development
EPI – Expanded programme on immunisation
HIV – Human immunodeficiency Virus
ICDM – Integrated Chronic Disease Model
ICRM – Ideal Clinic Realisation and Maintenance
ICSM – Integrated Chronic Services Management
KZN – Kwa Zulu Natal
MCWH – Maternal Child and Women's Health

MDGs – Millennium Development Goals
MDR-TB – Multi Drug Resistant TB
MH – Maternal Health
MMR – Maternal Mortality Rate
MRC – Medical Research Council
MTSF – Mid Term Strategic Framework
NCDs – Non Communicable Diseases
NDoH – National Department of Health
NGOs – Non government organisations
NHC – National Health Council
NHC-TAC – National Health Council Technical Advisory Committee
PHC – Primary Health care
PMTCT – Prevention of Mother to Child Transmission
STGs – Standard Treatment Guidelines
STI – Sexually Transmitted infection
TB – Tuberculosis
WBOT – Ward based outreach teams
WHO – World Health Organisation
XDR-TB – Extensive Drug Resistant TB
YLD – Years Lived with Disability
YLL – Years of life lost

DHS Acronyms

CD – Chief Director
CFO – Chief Financial Officer
CD M&E – Chief Director Monitoring and Evaluation
CD PHC – Chief Director Primary Health Care
DG – Director General
DMT – District Management Team
DoH – Department of Health
DPSA – Department of Public Service and

Administration

FY – Financial Year
HRD – Human Resource Director
HRM – Human Resource Manager
CD HR – Chief Director Human Resource
JD – Job Description

KPI – Key Performance Indicators
M&E – Monitoring and Evaluation
NGO – Non Government Organization
PDoH-IHRM – Provincial Department of Health

Integrated Human Resources Management

PHC – Primary Health Care
PMTCT – Prevention of Mother to Child Transmission
SCM – Supply Chain Management
UNICEF – United Nations Children's Fund
WHO – World Health Organization

Medicine Dispensing Acronyms

RADU – Remote Automated Dispensing Unit

DD – Direct Delivery

MP – Mobile Pharmacy

CCMDD – Central Chronic Medicine Dispensing and Delivery

PHC – Primary Health Care

HMIS – Health Management Information Systems

DH – District Health

CHW – Community Health Workers

ART – Anti Retroviral Therapy

PPP – Public/Private/Partnership

Cleaning and IPC Acronyms

NDoH HR – National Department of Health Human Resource

National QA Unit – National Quality Assurance Unit

PDoH QA – Provincial Department of Health Quality Assurance

District QA – District Quality Assurance

NDoH HRD – National Department of Health Human Resource Development

IPC – Infection Prevention and Control

DoH – Department of Health

SOP – Standard Operating Procedure

CHC – Community Health Centres

PHC – Primary Healthcare Clinic