Service Delivery

Preliminary lab report

November 2014
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- Context and case for change
  - Aspiration
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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
- **~40,000** doctors
- **~64,000** nurses
- **Over 50 million** patients across the country
- 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)

South Africa
- 48 million people 0.7% of the world’s population
- Twice the global average per capita burden of ill-health (DALYs)
- The highest health burden per capita of any middle-income country

- 17% of HIV global burden (23x global average) 5% of global TB burden (7x global average)
- ~1% of global burden (2-3x average for comparable income countries)
- Maternal, newborn and child health (MNCH)
- Non-communicable disease
- <1% of global burden (2-3x higher than average for developing countries)
- HIV/AIDS and Tuberculosis (TB)
- Violence and injury

1.3% of global burden of injuries (2x global average for injuries per capita, 5x global average homicide rate)

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

### Summary of South Africa’s MDG Performance

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Current SA</th>
<th>Target 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality rate</td>
<td>269 / 100 000</td>
<td>38 / 100 000</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>38 / 1000</td>
<td>18 / 1000</td>
</tr>
<tr>
<td>Child mortality rate</td>
<td>53 / 1000</td>
<td>20 / 1000</td>
</tr>
</tbody>
</table>

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

SOURCE: National Department of Health
In spite of these challenges, significant progress has been made (1/2)

<table>
<thead>
<tr>
<th><strong>Free primary health care</strong></th>
</tr>
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<tbody>
<tr>
<td>▪ Since 2006, &gt;40 million South Africans have access to free health care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Access to anti-retrovirals</strong></th>
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<tbody>
<tr>
<td>▪ Largest ARV program in the world leading to dramatic increases in life expectancy and a reduced mother-to-child transmission: 30% to below 3%.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th><strong>Choice of termination of pregnancy</strong></th>
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<tbody>
<tr>
<td>▪ Choice on Termination of Pregnancy laws introduced in 1996, reducing abortion related deaths by ~90%</td>
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<table>
<thead>
<tr>
<th><strong>Hospital revitalization program</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Hundreds of hospitals rehabilitation, 11 new district and regional hospitals built since 1998</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th><strong>Improved immunization program</strong></th>
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</thead>
<tbody>
<tr>
<td>▪ Coverage across provinces equalized, from variations of as much as 40% in 1992 to all provinces now above 70%</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th><strong>Improved malaria control</strong></th>
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</thead>
<tbody>
<tr>
<td>▪ Reduction in reported cases of malaria from as high as 60,000 people in 2001 to under 10,000 in 2009</td>
</tr>
</tbody>
</table>

**SOURCE:** An overview of Health and Health Care in South Africa 1994-2010: Priorities, Progress and Prospects for New Gains
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)

<table>
<thead>
<tr>
<th>Area</th>
<th>Description</th>
<th>Highlighted findings</th>
</tr>
</thead>
</table>
| 1 Facility type and access | Assessment of whether facility is functioning according to actual classification and accessibility to the public | ▪ ~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 | ▪ 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 | ▪ 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 | ▪ Critical staff shortages at clinics:  
  — 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)

<table>
<thead>
<tr>
<th>Area</th>
<th>Description</th>
<th>Highlighted findings</th>
</tr>
</thead>
</table>
| **5 Finances**| Assessment of financial management within the management functional area - not inc. facility budgets and expenditure reports | - Only hospitals covered with generally positive results  
  - 72% compliance with exception reporting  
  - 66% functioning within budget  
  - 88% monitor budget expenditure |
| **6 Infrastructure** | Audit of (1) building and site infrastructure (2) facility infrastructure management; and (3) whether space sufficient to meet needs | - 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 Technology** | Checks availability of functional essential medical technology | - 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 | - 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
... and deficiencies in the availability of essential drugs and equipment

<table>
<thead>
<tr>
<th>Compliance scores – access to essential medicines and supplies</th>
<th>Compliance scores – availability of functional and essential health technology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tracer medicines per Essential Drugs List</td>
<td>Maternity ward</td>
</tr>
<tr>
<td>SOPs for how Schedule 5 and 6 drugs are stores</td>
<td>Trauma/accident and emergency</td>
</tr>
<tr>
<td>Correlation between medicine prescribed and dispensed</td>
<td>General ward</td>
</tr>
<tr>
<td>Monitoring of turnaround times for critical stock</td>
<td>Maintenance</td>
</tr>
<tr>
<td></td>
<td>System in place to monitor receipt of equipment ordered</td>
</tr>
<tr>
<td>23</td>
<td>6</td>
</tr>
<tr>
<td>49</td>
<td>0</td>
</tr>
<tr>
<td>66</td>
<td>16</td>
</tr>
<tr>
<td>89</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>40</td>
</tr>
</tbody>
</table>

Key takeaways

- Clinics performed well on procedures for dispensing and storing essential drugs, but only stocked the required drugs 23% of the time.
- Despite maternal health being a top priority for the nation, availability of maternity ward equipment sits at a mere 6%.
The Service Delivery workstream addresses issues from 3 out of 8 of the performance areas from the 2012 National Health Facilities Baseline Audit.

Service delivery will address challenges identified in three areas:

<table>
<thead>
<tr>
<th>Facility classification</th>
<th>Quality of service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>▪ Lowest scores were for patient safety and security (34%)</td>
</tr>
<tr>
<td></td>
<td>▪ Second lowest score for positive and caring attitudes (30%) scored lowest</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Functionality of services</th>
<th>Human Resources</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Finances</th>
<th>Physical Infrastructure</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Health Technology</th>
<th>Medicine and Supplies management</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Poor performance across the board especially in emergency services and maternity wards</td>
<td>▪ Less than 30% compliance rate with requirement to stock Essential Drugs</td>
</tr>
<tr>
<td>▪ Compliance under 13% for both hospitals &amp; clinics</td>
<td>▪ Poor performance on functional and essential medical equipment requirements (e.g. 7% compliance with checklist of equipment required for maternal wards)</td>
</tr>
</tbody>
</table>

...that have a negative impact on patients:

- Poor patient experience
- Lack of continuity of care
- Essential medication stock out and lack of equipment prevents delivery of optimal health care

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

<table>
<thead>
<tr>
<th>Strategic Plan 2015/16 – 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> Prevent disease and reduce its burden, and promote health</td>
</tr>
<tr>
<td><strong>2.</strong> 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</td>
</tr>
<tr>
<td><strong>3.</strong> 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</td>
</tr>
<tr>
<td><strong>4.</strong> Improve health facility planning by implementing norms and standards</td>
</tr>
<tr>
<td><strong>5.</strong> Improve financial management by improving capacity, contract management, revenue collection and supply chain management reforms;</td>
</tr>
<tr>
<td><strong>6.</strong> Develop an efficient health management information system for improved decision making</td>
</tr>
<tr>
<td><strong>7.</strong> 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</td>
</tr>
<tr>
<td><strong>8.</strong> Improve human resources for health by ensuring adequate training and accountability measures</td>
</tr>
</tbody>
</table>

SOURCE: NDoH Strategic Plan 2014/15 – 2018/19
Finally, the Service Delivery workstream will address 5 out of 10 Ideal Clinic Dashboard components:

<table>
<thead>
<tr>
<th>Administration</th>
<th>ICDM/ICSM</th>
<th>Medicines, supplies &amp; lab services</th>
<th>Staffing &amp; professional standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of a doctor</td>
<td>Communication</td>
<td>Health Information Management</td>
<td>Infrastructure &amp; Support services</td>
</tr>
<tr>
<td>District Health Support Systems</td>
<td></td>
<td>Partners &amp; stakeholders</td>
<td></td>
</tr>
</tbody>
</table>
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.

Patient safety and security: 34%
Positive and caring attitudes: 30%
Infection control and prevention: 50%
Cleanliness: 50%
Waiting times: 68%

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

- I. Other communicable diseases, maternal, perinatal and nutritional
- HIV/AIDS
- II. Non-communicable diseases
- III. Injuries

Non-communicable diseases (NCDs) was the highest contributor to mortality (40.8%) and to the DALYs (33%) and the 3rd most significant contributor to YLL (22.8%)

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

**Context and Case for Change – Patient Experience**

- **Patient Experience**
  - 35 year old woman HIV positive, hypertensive and has a 6 week old baby.
  - **Visits**
    - 3 times a month for NCDs, PMTCT and Well baby clinic (immunization).
    - ART Visit: Return Date: 12 October
    - NCDs Visit to collect hypertension medication: Return date: 20 October
    - Visit for Well baby clinic: Return date: 24 October

**Vertical Delivered Curative Service:**
- Multiple patient visits
- Multiple patient files
- Poly Pharmacy
- Poor quality of care
- Poor patient outcomes

- **Lack of proper health promotion/education**
- Patient queues for her file on each visit
- After receiving her file, patient goes to Vital Room for Vital Signs
- Patient leaves facility with return date for the special condition
- Patient travels >5km to her home
- Patient goes for consultation. Medication dispensed from consulting room
- Patient goes for blood exam
- After receiving her file, patient goes to Vital Room for Vital Signs
**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

<table>
<thead>
<tr>
<th>Current</th>
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<tbody>
<tr>
<td>Months</td>
</tr>
<tr>
<td>No of Visits per month</td>
</tr>
<tr>
<td>Visits per annum</td>
</tr>
<tr>
<td>Average waiting time per visit (Hours)</td>
</tr>
<tr>
<td>Total waiting time per year (Hours)</td>
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</tbody>
</table>

**Economic Costs**

<p>| |</p>
<table>
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<tbody>
<tr>
<td>Salary Loss (Days)</td>
</tr>
<tr>
<td>Annual Salary Loss</td>
</tr>
<tr>
<td>Annual Transport Loss</td>
</tr>
<tr>
<td>Total Annual Cost</td>
</tr>
</tbody>
</table>

Productivity Loss: 36 days
Economic Loss: R5400

SOURCE: Operation Phakisa Ideal Clinic Lab 2014: Service Delivery Stream
Evidence of Low Staff Morale

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**

- Yes: 20.59%
- No: 79.41%

**Nurses’ perceptions regarding work stress**

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

- Yes: 94.12%
- No: 5.88%

- 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

SOURCE: Bhaga T. The Impact of Working Conditions on the Productivity of Nursing Staff in the Midwife Obstetrical Unit of Pretoria West Hospital. Nov. 2010
Initiatives from the Service Delivery Workstream impact other workstreams in the Healthcare Lab

<table>
<thead>
<tr>
<th>Human Resource</th>
<th>Waiting Times</th>
<th>Infrastructure</th>
<th>Sustainability &amp; Scale Up</th>
<th>Supply Chain Management</th>
<th>Institutional Arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Health System and Service Package provides demand on staffing and its profile</td>
<td>ICSM model improves patient flow in facilities and thus improves waiting times</td>
<td>Service Package with clearly defined facilities classification provides information on health facility planning and level of ICT</td>
<td>Facility classification will determine package of service</td>
<td>Input from Service Delivery defines medication, consumables, services and essential equipment for facilities</td>
<td>District Health Services provides clear District Management Team structure, process for engagement, need for alignment with other sectors and partners. (health is provincialised)</td>
</tr>
<tr>
<td></td>
<td>Integrated Health Management Information Systems provide timely access to records</td>
<td></td>
<td>Integrated Health Information &amp; Management Systems provides standardisation of M&amp;E and administration system at PHC Facilities</td>
<td></td>
<td></td>
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</tbody>
</table>
The Health Service Delivery lab worked for 6 weeks to gather and prioritise issues and to develop solutions and action plans.

<table>
<thead>
<tr>
<th>Lab preparation</th>
<th>Gathering of issues</th>
<th>Prioritization of issues</th>
<th>Developing solutions</th>
<th>Developing detail action plan</th>
<th>Finalisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gathering baseline information</td>
<td>Identification of issues</td>
<td>Prioritise based on ▪ Time horizon ▪ Impact vs. ease of implementation ▪ Sustainability/criticality</td>
<td>Discussion of possible solutions</td>
<td>Syndication with stakeholders</td>
<td>Finalization and documentation of report</td>
</tr>
<tr>
<td>Structuring problems into addressable breakdowns</td>
<td></td>
<td></td>
<td>Prioritization of solutions</td>
<td>Detailed action plan with budget, timeline, and person accountable</td>
<td>Preparation for cabinet workshop</td>
</tr>
</tbody>
</table>

- **77 issues identified**
- **29 prioritised issues**
- **8 initiatives**
- **12 action plans**
To do this work, more than 30 people from more than 15 organizations, representing ~ hours of work, regularly engaged in the Service Delivery lab.
Contents

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- **Aspiration**
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  - Solutions/ Initiatives
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  - Acronyms
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

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

- Context and case for change
- Aspiration
- **Issues and root causes**
  - Solutions/ Initiatives
  - Appendix
- Accronyms
The Service Delivery workstream identified 77 issues that affect the PHC system

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<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>1</td>
<td>Inappropriate and insufficient equipment, chemicals and supplies</td>
</tr>
<tr>
<td>2</td>
<td>Poor maintenance of infrastructure</td>
</tr>
<tr>
<td>3</td>
<td>General waste not collected</td>
</tr>
<tr>
<td>4</td>
<td>No running water</td>
</tr>
<tr>
<td>5</td>
<td>No clean linen</td>
</tr>
<tr>
<td>6</td>
<td>No sinks and soap for hand washing</td>
</tr>
<tr>
<td>7</td>
<td>Poor ventilation</td>
</tr>
<tr>
<td>8</td>
<td>Insufficient waiting areas</td>
</tr>
<tr>
<td>9</td>
<td>Lack of triaging of patients</td>
</tr>
<tr>
<td>10</td>
<td>No or insufficient protective clothing</td>
</tr>
<tr>
<td>11</td>
<td>No disposable glasses for water</td>
</tr>
<tr>
<td>12</td>
<td>No separation of waste</td>
</tr>
<tr>
<td>13</td>
<td>No relevant bags and bins for waste</td>
</tr>
<tr>
<td>14</td>
<td>Long lead times for waste collection</td>
</tr>
<tr>
<td>15</td>
<td>Insufficient and inappropriate storage space for medical and general waste</td>
</tr>
<tr>
<td>16</td>
<td>Lack of reinforcement to adherence on protocols</td>
</tr>
<tr>
<td>17</td>
<td>Poor supervision of facilities</td>
</tr>
<tr>
<td>18</td>
<td>Lack of SOP’s and policies</td>
</tr>
<tr>
<td>19</td>
<td>Lack of SLA and contract management</td>
</tr>
<tr>
<td>20</td>
<td>Lack of training for cleaners and IPC officers</td>
</tr>
<tr>
<td>21</td>
<td>No standardized clear job description for cleaners and infection control officers</td>
</tr>
<tr>
<td>22</td>
<td>No mechanism for regular review and updating of policies</td>
</tr>
<tr>
<td>23</td>
<td>Inappropriate and unclearly defined classification of facilities</td>
</tr>
<tr>
<td>24</td>
<td>Inconsistent implementation by provinces</td>
</tr>
<tr>
<td>25</td>
<td>Poor oversight and management of implementation at district level</td>
</tr>
<tr>
<td>26</td>
<td>Patient process flow not defined due to poor understanding of process flow, triage process is not defined</td>
</tr>
<tr>
<td>27</td>
<td>Inadequate demand planning</td>
</tr>
<tr>
<td>28</td>
<td>Lack of appointment scheduling system</td>
</tr>
<tr>
<td>29</td>
<td>Lack of standardization of records &amp; process</td>
</tr>
<tr>
<td>30</td>
<td>Disease specific records/files</td>
</tr>
<tr>
<td>31</td>
<td>Tidious process to retrieve files</td>
</tr>
<tr>
<td>32</td>
<td>Infrastructure limitations for automated file management</td>
</tr>
<tr>
<td>33</td>
<td>Inadequate stationery/tools</td>
</tr>
<tr>
<td>34</td>
<td>Disease centered care instead of patient centric</td>
</tr>
<tr>
<td>35</td>
<td>No integration of services</td>
</tr>
<tr>
<td>36</td>
<td>Conflicting primary health care guidelines</td>
</tr>
<tr>
<td>37</td>
<td>Inadequate health promotion and disease prevention</td>
</tr>
<tr>
<td>38</td>
<td>Lack of patient centeredness</td>
</tr>
<tr>
<td>39</td>
<td>Lack of funding and poor planning</td>
</tr>
<tr>
<td>40</td>
<td>Non-alignment between tertiary institutions and service delivery requirements</td>
</tr>
<tr>
<td>41</td>
<td>Underutilization of regional training centers</td>
</tr>
<tr>
<td>42</td>
<td>Bureaucratic supply chain management</td>
</tr>
<tr>
<td>43</td>
<td>Lack of standardization of equipment</td>
</tr>
<tr>
<td>44</td>
<td>Lack of a maintenance plan</td>
</tr>
<tr>
<td>45</td>
<td>Aged infrastructure</td>
</tr>
<tr>
<td>46</td>
<td>No uniform plans for facilities</td>
</tr>
<tr>
<td>47</td>
<td>Facilities too small</td>
</tr>
<tr>
<td>48</td>
<td>No maintenance plans</td>
</tr>
<tr>
<td>49</td>
<td>Supply chain management inadequate</td>
</tr>
<tr>
<td>50</td>
<td>Clinical Governance</td>
</tr>
<tr>
<td>51</td>
<td>No accountability for overspend on budget</td>
</tr>
<tr>
<td>52</td>
<td>Depot stock outs</td>
</tr>
<tr>
<td>53</td>
<td>Roles and responsibilities for medication management not clear</td>
</tr>
<tr>
<td>54</td>
<td>Lab results are lost and therefore unnecessarily repeated</td>
</tr>
<tr>
<td>55</td>
<td>Distance from laboratory services</td>
</tr>
<tr>
<td>56</td>
<td>Usage of results is not adequate</td>
</tr>
<tr>
<td>57</td>
<td>Lack of ownership for expensive tests Hb - FBC</td>
</tr>
<tr>
<td>58</td>
<td>Lack of information of current structure and need</td>
</tr>
<tr>
<td>59</td>
<td>Inequitable distribution of resources for service delivery</td>
</tr>
<tr>
<td>60</td>
<td>Decisions made for facility development not based on sound ethical principles</td>
</tr>
<tr>
<td>61</td>
<td>Lack of ownership and decisions not informed by practical implications</td>
</tr>
<tr>
<td>62</td>
<td>Lack of information of current structure and need</td>
</tr>
<tr>
<td>63</td>
<td>Program fragmented</td>
</tr>
<tr>
<td>64</td>
<td>Lack of accountability as profiling not done</td>
</tr>
<tr>
<td>65</td>
<td>Cannot refer to nearest hospital</td>
</tr>
<tr>
<td>66</td>
<td>No standardized referrals which include feedback mechanisms</td>
</tr>
<tr>
<td>67</td>
<td>Unstructured referrals</td>
</tr>
<tr>
<td>68</td>
<td>Patients lost in the referral system</td>
</tr>
<tr>
<td>69</td>
<td>Cannot refer to nearest hospital</td>
</tr>
<tr>
<td>70</td>
<td>No standardized referrals which include feedback mechanisms</td>
</tr>
<tr>
<td>71</td>
<td>Staff unable to treat emergencies</td>
</tr>
<tr>
<td>72</td>
<td>Poor response times</td>
</tr>
<tr>
<td>73</td>
<td>Inadequate use of resources</td>
</tr>
<tr>
<td>74</td>
<td>Lack of accountability from partners</td>
</tr>
<tr>
<td>75</td>
<td>Poor continuum</td>
</tr>
</tbody>
</table>
These were prioritised and grouped into 5 key areas underpinning poor quality service delivery from both the patient and the provider perspective:

<table>
<thead>
<tr>
<th></th>
<th>Health Services</th>
<th>District Health Service</th>
<th>Clinical, Medical Support Services and Supplies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Inadequately defined and fragmented, curative-focused, vertical health services for the appropriate level of care.</td>
<td>District Health Service is not providing an enabling environment that supports the delivery of optimal care.</td>
<td>Unavailability of appropriate and adequate medication, consumable supplies, equipment and lab services.</td>
</tr>
<tr>
<td>2</td>
<td>Dirty, unhygienic and unsafe facilities that adversely impact on patient and staff experience.</td>
<td>Lack of an integrated health management information system to support the delivery of quality healthcare.</td>
<td></td>
</tr>
</tbody>
</table>

**Cleaning, Infection Prevention and Control**

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

ISSUES AND ROOT CAUSES

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

<table>
<thead>
<tr>
<th>Ineffective, poorly functional and governed District Health System</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2A</strong> Limited community participation and mobilisation and lack of stakeholder and partner engagement including functional District Health Council</td>
</tr>
<tr>
<td><strong>2B</strong> Lack of appropriate and functional mechanisms to address social determinants of health</td>
</tr>
<tr>
<td><strong>2C</strong> Provincialization of services – Two tier governance impacts on classification of facilities and package of services delivered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>District Health Management structure does not support effective service delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2E</strong> Inadequate delegation of authority to manage financial and human resources</td>
</tr>
<tr>
<td><strong>2F</strong> Inadequate, inefficient and non-standardized management systems for SCM, maintenance and clinical, medical, support services and supplies</td>
</tr>
<tr>
<td><strong>2G</strong> Inadequately defined roles and responsibilities of the DMT, including health programme coordinators and PHC supervisors</td>
</tr>
</tbody>
</table>

### Cross-cutting issue

| Poorly defined and functioning Referral System due to Provincial/District boundaries and health facility classification |
### ISSUES AND ROOT CAUSES

**Clinical, Medical, Support Services and Supplies issues**

<table>
<thead>
<tr>
<th>Poor stock control management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3A</strong> Fragmented and non standardized ordering and delivery system</td>
</tr>
<tr>
<td><strong>3B</strong> Lack of demand planning and forecasting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Poor supply chain, contract and asset management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3D</strong> Poorly defined essential equipment list, non medical supplies, other consumables essential laboratory test for PHC</td>
</tr>
</tbody>
</table>

### Cross-cutting issue

1. Inappropriate and inadequate staff including financial and contract management skills
### Poor cleaning practices

<table>
<thead>
<tr>
<th>4A</th>
<th>No cleaning guidelines and standardized cleaning materials and equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>4B</td>
<td>Inappropriate, inadequate and untrained staff on the need to promote general hygiene and cleanliness at facility level</td>
</tr>
<tr>
<td>4C</td>
<td>Lack of education on the promotion of general hygiene and cleanliness at community level</td>
</tr>
</tbody>
</table>

### Poor infection prevention and control practices

<table>
<thead>
<tr>
<th>4D</th>
<th>Inappropriate and poorly designed and maintained infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td>4E</td>
<td>Hospi-centric infection prevention and control guideline with ineffective M&amp;E systems</td>
</tr>
</tbody>
</table>
### Issues and Root Causes

**Health Management Information Systems issues**

<table>
<thead>
<tr>
<th>Inefficient and ineffective manual systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>5A Inadequate patient records and filing systems</td>
</tr>
<tr>
<td>5B Multiple data recording and reporting tools</td>
</tr>
<tr>
<td>5C Lack of ICT infrastructure and support</td>
</tr>
<tr>
<td>5D Limited knowledge and understanding of data use to enhance quality of clinical care including service and commodity needs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fragmented electronic systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>5E Lack of a standardised integrated health information exchange to ensure patient follow up</td>
</tr>
<tr>
<td>5F Information system non-compliant to the health normative standards framework</td>
</tr>
</tbody>
</table>
ISSUES AND ROOT CAUSES

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

<table>
<thead>
<tr>
<th>Evidence/data to quantify the issue</th>
<th>Root causes</th>
<th>Reason issue has not been resolved to date</th>
</tr>
</thead>
</table>
| 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 etc. | ▪ 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 | ▪ Change in mind-set and inadequate oversight and management of implementation at district level |
| 2. Primary health care services are not offered in a standard and consistent manner. 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 therapy. | |

## ISSUES AND ROOT CAUSES

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

<table>
<thead>
<tr>
<th>Evidence/data to quantify the issue</th>
<th>Root causes</th>
<th>Reason issue has not been resolved to date</th>
</tr>
</thead>
</table>
| 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-infected. | ▪ 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 | ▪ Lack of adequate leadership  
▪ Negative staff attitudes  
▪ Disease responsive approach  
▪ Structural limitations |
| 2. This if 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 services. | | |
| 3. “Although health policy is geared towards PHC, historically the bulk of spending was on curative, highly specialised tertiary care” Primary Health Care in South Africa Since 1994 and implications for PHC re-engineering | | |

---

- **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**
**ISSUES AND ROOT CAUSES**

### Limited community participation and mobilisation and lack of stakeholder and partner engagement

<table>
<thead>
<tr>
<th>Evidence/data to quantify the issue</th>
<th>Root causes</th>
<th>Reason issue has not been resolved to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>No functional clinic committees</td>
<td>Lack of research and information to inform decision making and allocation of funds</td>
<td>Unplanned eruption of human settlements (DHS strategy)</td>
</tr>
<tr>
<td>Social Determinants of health adding to burden of disease</td>
<td>Political influence to provide services where they are not required impacting on availability of resources as well as financial resources</td>
<td>Social Determinants of health</td>
</tr>
<tr>
<td>District planning is not comprehensive to include multi-sectoral input</td>
<td>Lack of communication with communities on what is provided at which level/facility</td>
<td>Political influence on allocation of facilities</td>
</tr>
<tr>
<td>District services are not well coordinated to meet the demand</td>
<td>Poor population profiling from a clinic level to inform decisions about services</td>
<td>Poor communication between sectors</td>
</tr>
<tr>
<td>More support needed from health facility staff</td>
<td>Sectors working in silos within the public sector and between the public sector and the private sector</td>
<td></td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>Based on lessons learned</td>
<td></td>
</tr>
<tr>
<td>Staff not actively involved</td>
<td>National guidelines based on legislation</td>
<td></td>
</tr>
<tr>
<td>Overworked clinic managers</td>
<td>Resources to support the Clinic committee</td>
<td></td>
</tr>
<tr>
<td>Lack of leadership skills in clinic managers</td>
<td>Not included in budget</td>
<td></td>
</tr>
<tr>
<td>Need guidelines and direction for a functional clinical committee</td>
<td>Members don’t have money for transport and to attend</td>
<td></td>
</tr>
<tr>
<td>Based on lessons learned</td>
<td>Ongoing training for members to enable them to fulfill their roles</td>
<td></td>
</tr>
<tr>
<td>National guidelines based on legislation</td>
<td>Not all members of the CC know their roles or have the competencies to fulfill their roles adequately</td>
<td></td>
</tr>
</tbody>
</table>
### ISSUES AND ROOT CAUSES

#### Inadequate, inefficient and non-standardised management systems

**Evidence/data to quantify the issue**
- 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 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
Contents

- Context and case for change
- Aspiration
- Issues and root causes

**Solutions/ Initiatives**
- Budget
- KPI
- 3ft plans

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

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health services</td>
<td>1 patient, with multiple conditions, 1 visit, 1 file, 1 service provider</td>
</tr>
<tr>
<td>District Health System</td>
<td>Communities are engaged to enable a responsive health service</td>
</tr>
<tr>
<td>Clinical Medical Support service service</td>
<td>Patient bypasses the queue for medical dispensing, as her medication will be delivered to a convenient location within the community</td>
</tr>
<tr>
<td>Cleaning</td>
<td>Patient and staff experience a clean, safe environment at the facility</td>
</tr>
<tr>
<td>Health Management Information systems</td>
<td>Patient presents ID, and all her records are retrieved through an integrated, automated system</td>
</tr>
<tr>
<td>1 Integrated primary care; revised package of services, facility re-</td>
<td></td>
</tr>
<tr>
<td>2 Integrated clinical support</td>
<td></td>
</tr>
<tr>
<td>3 Integrated District service delivery platform</td>
<td></td>
</tr>
<tr>
<td>4 Uniformity of DMT structure and profile</td>
<td></td>
</tr>
<tr>
<td>5 Innovative medicine dispensing</td>
<td></td>
</tr>
<tr>
<td>6 Cleaning guidelines and IPC protocol</td>
<td></td>
</tr>
<tr>
<td>7 Standardised and integrated Health Management</td>
<td></td>
</tr>
<tr>
<td>8 Interoperability between eHealth systems</td>
<td></td>
</tr>
</tbody>
</table>
The initiatives developed by the Service Delivery workstream can be categorised as breakthrough, major delivery fixes or business as usual.

<table>
<thead>
<tr>
<th>Breakthrough – must win</th>
<th>Major delivery fix – effective execution</th>
<th>Business as Usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Integrated primary care; revised package of services, facility re-classification and referrals</td>
<td>3 Integrated District service delivery platform</td>
<td>6 Cleaning guidelines and IPC protocol</td>
</tr>
<tr>
<td>2 Integrated clinical support</td>
<td>4 Uniformity of DMT structure and profile</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5 Innovative medicine dispensing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7 Standardised and integrated Health Management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8 Interoperability between eHealth systems</td>
<td></td>
</tr>
</tbody>
</table>

There are several other key enablers to improve service delivery, but are being addressed by other workstreams, such as:

- 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.

<table>
<thead>
<tr>
<th>Health services</th>
<th>Initiatives</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>1. Integrated primary care; revised package of services, facility reclassification and referrals</strong></td>
<td>patient with multiple conditions, visit, file, service provider</td>
</tr>
<tr>
<td></td>
<td><strong>2. Integrated clinical support</strong></td>
<td></td>
</tr>
<tr>
<td>District Health System</td>
<td>Integrated District service delivery platform</td>
<td></td>
</tr>
<tr>
<td>Clinical Medical Support service</td>
<td>Innovative medicine dispensing</td>
<td></td>
</tr>
<tr>
<td>Cleaning</td>
<td>Cleaning guidelines and IPC protocol</td>
<td>patient and staff experience clean, safe environment at the facility</td>
</tr>
<tr>
<td>Health Management Information systems</td>
<td>Standardised and integrated Health Management</td>
<td>patient presents ID, and all records are accessed through an integrated health management information system</td>
</tr>
</tbody>
</table>
The Health Services initiatives are key to overall service delivery

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

## Enablers

<table>
<thead>
<tr>
<th><strong>District Health System</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Essential Equipment and Consumable List</strong></td>
</tr>
<tr>
<td><strong>Essential Laboratory List</strong></td>
</tr>
<tr>
<td><strong>Medicine Availability (CCMDD)</strong></td>
</tr>
<tr>
<td><strong>Infection Prevention Control (IPC)</strong></td>
</tr>
<tr>
<td><strong>Health Management Information System (HMIS)</strong></td>
</tr>
</tbody>
</table>

### Integrated Care

1. **Package of Services**
2. **Facility Definition and Classification**
3. **Seamless Referrals**
4. **Integrated Clinical Services Management (ICSM)**

### Clinical Support

1. **Clinical Programme Integration**
2. **Integrated Clinical Guidelines**

### Social Determinants of Health
## 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

<table>
<thead>
<tr>
<th>Steps</th>
<th>Outputs</th>
</tr>
</thead>
</table>
| • Establish a Technical Committee  
• Revision of the draft integrated service packages | • Approval for circulation to Provincial level for comments  
• Approval of concept by National and Provincial level  
• Norms and standards agreed  
• Costing for the revised service package completed |
1.1 Lab proposes a revised service package be adopted

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.


SOURCE: Operation Phakisa Ideal Clinic Lab 2014: Service Delivery Stream
### 1.1 Snapshot of the revised package of services in relation to the old package of services

<table>
<thead>
<tr>
<th>Existing</th>
<th>Revised</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ There were no continuity of care as care is provided on a vertical program basis</td>
<td>▪ Continuity of care is provided according to life cycle approach</td>
</tr>
<tr>
<td>▪ Continuum of care was not possible was there were overburdened on the limited professional capacity of health workers</td>
<td>▪ 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</td>
</tr>
<tr>
<td>▪ Allied services such as audiology, speech therapy, eye health, dental care and psychology is limited at hospital level only</td>
<td>▪ Extension of Allied services</td>
</tr>
</tbody>
</table>
| ▪ Community based approach did not include:  
  - Early Child Development  
  - Rehabilitative and Palliative care | ▪ Inclusion of more services to the community based services reducing the concentration at clinic level |
## Snapshot of proposed revised package of service

<table>
<thead>
<tr>
<th>Life Course</th>
<th>Continuum of Care</th>
<th>Service to be delivered</th>
<th>Community Settings</th>
<th>Types of facility</th>
<th>Level of Care</th>
<th>Service Package</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 28 Days (Neonate)</td>
<td>Preventative</td>
<td>Early Identification of risks</td>
<td>Workplace</td>
<td>Health Post</td>
<td>Preventive</td>
<td>Need for Discussion</td>
</tr>
<tr>
<td></td>
<td>Preventative</td>
<td>Violence and Injuries</td>
<td>Workplace</td>
<td>Mobile Clinic</td>
<td>Preventive</td>
<td>Applicable to area</td>
</tr>
<tr>
<td></td>
<td>Curative</td>
<td>NCD, HIV, STI, MH</td>
<td>Household</td>
<td>Satellite Clinic</td>
<td>Preventive</td>
<td>Not Applicable</td>
</tr>
<tr>
<td></td>
<td>Curative</td>
<td>Violence and Injuries</td>
<td>School</td>
<td>CDC</td>
<td>Preventive</td>
<td>Not Applicable</td>
</tr>
<tr>
<td></td>
<td>Curative</td>
<td>NCD, HIV, STI, MH</td>
<td>ECD</td>
<td>Clinic</td>
<td>Preventive</td>
<td>Not Applicable</td>
</tr>
<tr>
<td></td>
<td>Curative</td>
<td>NCD, HIV, STI, MH</td>
<td>Workplace</td>
<td>CHC</td>
<td>Preventive</td>
<td>Not Applicable</td>
</tr>
<tr>
<td></td>
<td>Curative</td>
<td>NCD, HIV, STI, MH</td>
<td>Workplace</td>
<td>District Hospital</td>
<td>Preventive</td>
<td>Not Applicable</td>
</tr>
<tr>
<td></td>
<td>Promotive</td>
<td>Early Booking</td>
<td>Healthy Lifestyle</td>
<td>High-risk pregnant woman</td>
<td>Promotive</td>
<td>Applicable to area</td>
</tr>
<tr>
<td></td>
<td>Promotive</td>
<td>Healthy Lifestyle</td>
<td>ECD</td>
<td>High-risk pregnant woman</td>
<td>Promotive</td>
<td>Applicable to area</td>
</tr>
<tr>
<td></td>
<td>Promotive</td>
<td>Early Identification of risks</td>
<td>Workplace</td>
<td>High-risk pregnant woman</td>
<td>Promotive</td>
<td>Applicable to area</td>
</tr>
<tr>
<td></td>
<td>Preventative</td>
<td>Violence and Injuries</td>
<td>Household</td>
<td>Genetic Screening</td>
<td>Preventative</td>
<td>Not Applicable</td>
</tr>
<tr>
<td></td>
<td>Preventative</td>
<td>Early Identification of risks</td>
<td>School</td>
<td>Genetic Screening</td>
<td>Preventative</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

**SOURCE:** Operation Phakisa ICRM Lab: Service Delivery Stream, 2014
1.1 Structure of Enhanced Package of Services

1 Levels of care
- District hospitals
- Community healthcare center
- Primary healthcare
- Satelite clinic
- Health post
- Mobile clinic
- Ward based outreach teams
- Integrated school health teams
- NGOs & partners

2 Continuum of care
- Health promotions
- Disease prevention
- Treatment
- Care and support
  Rehabilitation and palliative services

3 Lifecycle approach
- Prior to birth
- 0-28 days
- 28d-12m
- 1-5 yrs
- 6-18 yrs
- 18-45 yrs
- 45-60+yrs
1.3 Lab Recommends Proposed Definitions of PHC Facilities

**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 48 hours. 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.

SOURCE: Operation Phakisa., Health Lab -Service Delivery,2014
A revised classification of clinics has been proposed by the lab; services will match the new typology.

<table>
<thead>
<tr>
<th>Designation</th>
<th>Headcount per annum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Small Clinic</td>
<td>Up to 8 000</td>
</tr>
<tr>
<td>Small Clinic</td>
<td>Between 8 000 and 40 000</td>
</tr>
<tr>
<td>Medium Clinic</td>
<td>Between 40 000 and 72 000</td>
</tr>
<tr>
<td>Large Clinic</td>
<td>Between 72 000 and 152 000</td>
</tr>
<tr>
<td>Very Large Clinic</td>
<td>More than 152 000</td>
</tr>
</tbody>
</table>

**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
Inadequate referral system leads to poor retention in care

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

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

Integrated Chronic Disease Management Manual
Aims to assist Facility Operational Managers to comply with National Core Quality Standards for Health Establishment

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

National Health Act
…..If 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 question must transfer the user concerned to an appropriate public health establishment which 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
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
With effective cross referrals and involvement of community based services, the public will have faster, cheaper access to public healthcare (2/2)

<table>
<thead>
<tr>
<th>Common presenting conditions</th>
<th>Potential entry points for care (provider-, facility- and systems-level integration)</th>
<th>Other sectors/agencies (systems-level integration)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Severe physical injuries</strong></td>
<td><strong>Secondary and tertiary care</strong>&lt;br&gt;Fractures, burns, stab wounds, cuts, partial or permanent disability, ear/eye injury, dislocations, fatal injury, death</td>
<td><strong>Governmental sector/agencies</strong>&lt;br&gt;- Police&lt;br&gt;- Public prosecutor office/legal bureau&lt;br&gt;- Social welfare</td>
</tr>
<tr>
<td><strong>Sexual and reproductive health consequences</strong></td>
<td><strong>Polyclinic or hospitals</strong>&lt;br&gt;Potential entry points&lt;br&gt;- Accidents and gynaecology&lt;br&gt;- Outpatient&lt;br&gt;- Mental health/psychiatric&lt;br&gt;- Orthopaedic&lt;br&gt;- Ear, nose, throat</td>
<td></td>
</tr>
<tr>
<td><strong>Mental health consequences</strong></td>
<td><strong>Primary care</strong>&lt;br&gt;Clinic/health post, health centres&lt;br&gt;Potential entry points&lt;br&gt;- Primary health care&lt;br&gt;- Family planning/antenatal care&lt;br&gt;- STI clinics&lt;br&gt;- Maternal and child health clinics</td>
<td><strong>Nongovernmental sector</strong>&lt;br&gt;- Religious groups&lt;br&gt;- Women's support groups&lt;br&gt;- Women's NGOs (for legal aid, shelter, counselling, economic development)&lt;br&gt;- Sub-acute care&lt;br&gt;- Home based care</td>
</tr>
<tr>
<td><strong>Chronic conditions</strong></td>
<td><strong>Polyclinic or hospitals</strong>&lt;br&gt;Potential entry points&lt;br&gt;- Accidents and gynaecology&lt;br&gt;- Outpatient&lt;br&gt;- Mental health/psychiatric&lt;br&gt;- Orthopaedic&lt;br&gt;- Ear, nose, throat</td>
<td></td>
</tr>
</tbody>
</table>

### 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
## Case for Integrated Clinical Support

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Holistic care</td>
<td>▪ Time consuming per individual consultation</td>
</tr>
<tr>
<td>▪ Comprehensive</td>
<td>▪ Demand for high level multi-skilling</td>
</tr>
<tr>
<td>▪ Person focused</td>
<td></td>
</tr>
<tr>
<td>▪ Quality of care</td>
<td></td>
</tr>
</tbody>
</table>
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
2.2 Clinical guidelines integration

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.
## Challenging the measures of quality

<table>
<thead>
<tr>
<th>Current measures</th>
<th>Proposed additional measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service quality – patients satisfaction scores</td>
<td>Ethics quality - practices throughout an organization are consistent with widely accepted ethical standards, norms, or expectations for a health care organization and its</td>
</tr>
<tr>
<td>Technical quality – clinical indicators</td>
<td></td>
</tr>
<tr>
<td>Disadvantages</td>
<td></td>
</tr>
<tr>
<td>▪ Negates the professional input and clinical decision making thus leading to demoralization of staff and high turnover</td>
<td></td>
</tr>
</tbody>
</table>
2.2 Health Matrix for Clinical Guidelines (1/2)

Health Matrix for Clinical Guidelines

- Neonate (0-28 days)
- Young child (>1 mth <5 yrs)
- Older child (5 – 12 yrs)
- Adolescent (13-17 yrs)
- Adult (18-65 yrs)
- Geriatric (66+ yrs)
- Death

Type of Service

- Preventive / Promotive Services
- Curative Services: Acute / Chronic
- Rehabilitative Services
- Palliative Services
- Clinical Medico-Legal & Forensic Services

SOURCE: Dr S Asmall - 2013
Health Matrix for Clinical Guidelines (2/2)

2.2

Preventive/Promotive
- ECD - 2
- ANC-1

Curative - Acute
- Newborn-6
- Minor ailments-7
- Minor ailments-8
- Emergencies & minor ailments-9
- Other Communicable diseases-10
- HIV/TB-11
- NCD 13
- HIV/TB-12
- NCD-14
- Mental health-15
- Mental health-16
- Occupational & environmental Health-17

Curative - Chronic

Rehabilitative

Palliative

Clinical medico legal

Neonate
- 0-28 days

Young child
- >1 mth <5 yrs

Older child
- 5 – 12 yrs

Adolescent
- 13-17 yrs

Adult
- 18-65 yrs

Geriatric
- 66+yrs

Death

Population
Community
Individual

SOURCE: Dr S Asmall -2013
2.2 Proposed User-friendly Package

Integrated Management of Childhood Illness 2011

INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS

SICK CHILD AGE 2 MONTHS UP TO 5 YEARS

SICK YOUNG INFANT (BIRTH UP TO 2 MONTHS)

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.

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated primary care; revised package of services, facility re-classification and referrals</td>
<td>1 patient, with multiple conditions, 1 visit, 1 file, 1 service provider</td>
</tr>
<tr>
<td>Integrated clinical support</td>
<td></td>
</tr>
<tr>
<td>Integrated District service delivery platform</td>
<td></td>
</tr>
<tr>
<td>Uniformity of DMT structure and profile</td>
<td></td>
</tr>
<tr>
<td>Clinical Medical Support service</td>
<td>Innovative medicine dispensing</td>
</tr>
<tr>
<td>Cleaning</td>
<td>Cleaning guidelines and IPC protocol</td>
</tr>
<tr>
<td>Health Management Information systems</td>
<td>Standardised and Integrated Health Management</td>
</tr>
<tr>
<td></td>
<td>Interoperability between eHealth systems</td>
</tr>
</tbody>
</table>

Communities are engaged to enable a responsive health service.
Key initiatives to strengthen delivery of Ideal Clinic Realization and Maintenance

<table>
<thead>
<tr>
<th>Uniformity of DMT structure, delegation &amp; profile</th>
<th>Integrated Service Delivery platform</th>
<th>National Referral policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Develop of the ideal DMT profile and structure</td>
<td>▪ Conduct an in depth population profile, disease burden analysis for each district</td>
<td>▪ Review the national referral policy and implementation guidelines in collaboration with stakeholders.</td>
</tr>
<tr>
<td>▪ Assessment and gaps in competencies as compared to the ideal</td>
<td>▪ Conduct a district-based situation analysis of health facilities, community services, staffing, services, schools and NGOs in the district</td>
<td>▪ Implementation of national policy</td>
</tr>
<tr>
<td>▪ Develop a training and mentorship programme to address gaps in current capacity and structure</td>
<td>▪ Develop a district program to overcome gaps identified in the analysis</td>
<td>▪ Monitoring and evaluation of implementation of referral policy at District level</td>
</tr>
<tr>
<td>▪ Implementation plan towards a uniform structure</td>
<td>▪ Establish a multi-sectoral collaboration initiatives to address social determinants</td>
<td></td>
</tr>
</tbody>
</table>

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

SOURCE: Lab analysis
### 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).
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)

<table>
<thead>
<tr>
<th>District level</th>
<th>Sub-district, CHC &amp; Clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Different names for same components</td>
<td>▪ Different structure for different provinces</td>
</tr>
<tr>
<td>▪ No uniformity on the programme managers appointed in terms of number and</td>
<td>▪ Different services provided at the same levels of care</td>
</tr>
<tr>
<td>functions</td>
<td>▪ School services not addressed in all levels</td>
</tr>
<tr>
<td>▪ Infrastructure component not addressed in some districts</td>
<td>▪ Different names used for auxiliary services in different provinces</td>
</tr>
<tr>
<td>▪ Some with no allied professionals appointed</td>
<td>▪ Size of the structure is determined by the number of facilities in the area</td>
</tr>
<tr>
<td>▪ some with hospital &amp; PHC coordinators</td>
<td>▪ Too many managers when there are too many programmes</td>
</tr>
<tr>
<td>▪ NGO coordination not addressed in some districts</td>
<td></td>
</tr>
<tr>
<td>▪ No Pharmacy coordination</td>
<td></td>
</tr>
<tr>
<td>▪ Forensic services not addressed</td>
<td></td>
</tr>
<tr>
<td>▪ Emergency and medical coordination also not addressed</td>
<td></td>
</tr>
<tr>
<td>▪ Too many managers when there are many programmes</td>
<td></td>
</tr>
</tbody>
</table>
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
DMT structure and profile will be standardized following the proposed model (ICSM)
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
Revised district, sub district and facility structures have been proposed (1/2)

- 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
Revised district, sub district and facility structures have been proposed (2/2)
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.
4 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.

1. Develop and implement Integrated Clinical Service Management based on revised package of services.

2. Develop seamless, standardized health referral system without geographical and sectoral boundaries.

3. Develop and implement a Standardized District Management Team structure and profile.

4. Introduce an integrated service approach from District Health System (District to Facility).

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

6. Develop and implement Primary Health Facilities relevant cleaning guidelines and Infection Prevention and Control protocol with appropriate training programs.

7. Develop and implement a standardized and integrated Health Management Information System.

8. Develop and implement software to achieve interoperability between eHealth systems.
## 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.

<table>
<thead>
<tr>
<th>Option (s)</th>
<th>Mechanism</th>
<th>Plan for Rollout</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Central Chronic Medication Dispensing and Distributions (CCMDD)</td>
<td>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.</td>
</tr>
<tr>
<td>B</td>
<td>Direct Deliveries</td>
<td>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.</td>
</tr>
<tr>
<td>C</td>
<td>Mobile Pharmacy</td>
<td>Pharmaceutical services from a mobile pharmacy be provided in compliance with applicable legislation, following the pre-determined route, date, and time.</td>
</tr>
<tr>
<td>D</td>
<td>Remote Automated Dispensing Units (RADU)</td>
<td>The use of automated systems to dispense (package and label) prescription medications without an on-site pharmacist</td>
</tr>
</tbody>
</table>
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 requires monthly visits, increasing the utilization rate to more than **12** visits annually.

**Implications**

This leads to the increase of waiting times at PHC.

- **66%** Compliance
- **34%** Non-Compliance

**Waiting Times**

- **34%** of PHC Clinics does not complied 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 ;
Innovative medicine dispensing and delivery mechanism is proposed to increase patients’ convenience and reduce congestions in PHCs

The components of the framework must include:

<table>
<thead>
<tr>
<th>Legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>Modes of dispensing to satisfy the following phases / activities:</td>
</tr>
<tr>
<td>Phase 1</td>
</tr>
<tr>
<td>Phase 2</td>
</tr>
<tr>
<td>Phase 3</td>
</tr>
<tr>
<td>“Phase 4”</td>
</tr>
<tr>
<td><em>(handed over to appropriate lab work streams)</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enablers</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUPPLY CHAIN MANAGEMENT</td>
</tr>
<tr>
<td>INFRASTRUCTURE</td>
</tr>
<tr>
<td>HUMAN RESOURCE</td>
</tr>
<tr>
<td><em>(handed over to appropriate lab work streams)</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HMIS Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanism to be supported by HMIS to allow proper referral system, verification and validations of prescriptions.</td>
</tr>
</tbody>
</table>

SOURCES: Lab Discussion and Analysis
The following enforcement and fast tracking of existing amendments are proposed to allow for innovative medicine dispensing and delivery

**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

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**

**Fast Tracking amendments in Pharmacy Act 53 of 1974**

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

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

<table>
<thead>
<tr>
<th>Category of Pharmacy</th>
<th>Under Pharmacy Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>Consultant</td>
</tr>
<tr>
<td>Institutional</td>
<td>Manufacturing</td>
</tr>
<tr>
<td>Wholesale</td>
<td></td>
</tr>
</tbody>
</table>

**Pharmacy support personnel category**

- To include Courier Pharmacy
- To be phased out to
- Pharmacy technician

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

**Sources:** Lab Discussion and Analysis
Innovative Medicine Dispensing can be implemented through the expansion of the four potential modes

1. Central Chronic Medication Dispensing and Distributions (CCMDD)
   - Direct Delivery to Patient
   - Direct Delivery to Pick Up Point

2. Direct Deliveries
   - Direct Delivery to Patient

3. Mobile Pharmacy
   - Delivery through mobile unit

4. Remote Automated Dispensing Units (RADU)
   - Delivery through automated dispensing unit

PHC or District Hospital

SOURCE: Lab Discussion and Analysis
Features of Option 1: Central Chronic Medication Dispensing and Distributions (CCMDD) System

- The CCMDD receives medical supplies from the Manufacturer as per order placed from District office.
- Patient is first registered at a PHC or DH and first issue of medication dispensed by pharmacy or licensed dispenser.
- Medication is dispensed in accordance with applicable legislation (Phase 1 – 2 observed).
- Medication and medical supplies are delivered directly to the patient ensuring that patient counselling and provision of information takes place (Phase 3 of dispensing).
- Medication is delivered to collection or pick up points where it is issued by appropriately qualified personnel practicing within their prescribed scope of practice to patients or caregivers (CHW’s).

Benchmark

- CCMDD initiated in Tshwane, Northern and Eastern Cape, Free State and Mpumalange serves over 60 000 patients on ART Medication.
- Pharmacy Direct pre packs the medication which is delivered to the applicable venue for patient collection on a monthly basis.
- The positive impact is less congestion in the clinics, leading to reduced waiting times and happier patients and staff.

SOURCE: Lab Discussion and Analysis; Interview with Lab Participants
Features of Option 2: Direct Delivery

- 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
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-determined facility

SOURCE:
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

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

<table>
<thead>
<tr>
<th>National level</th>
<th>District – sub-district level</th>
<th>Health facility level</th>
<th>Options available to patient</th>
</tr>
</thead>
</table>
| Standard option | Option available | 1. How close is the patient to the options?  
2. Is the patient able to collect from the option?  
3. Who will be picking up the medicine? | Options will show to  
Patients will choose from the selection |
|                | What is available at the sub-district level? |                          |                              |

Case in point...

**Michael**  
**Location:** Sebokeng township, Emfuleni, Se dibeng district, Gauteng province  
**Chronic condition:** heart disease, diabetes, prescription (Drug A, Drug B)

<table>
<thead>
<tr>
<th>What is available at Emfuleni?</th>
<th>What is available for the patient?</th>
<th>Options shown to patient</th>
</tr>
</thead>
</table>
| A                              | 1. Option A. The closest 1 km  
Option B. The closest is 3 km | A, B   
Patients will choose from A or B |
| B                              | 2. Patient is able to collect himself  
3. The patient himself |

**Facility level**

SOURCE: Lab discussion and analysis
In the future, patients requiring medications for chronic conditions will only need to visit PHCs once every 6 months.

- **Visit 1**
  - Prescription collection or consultation?
  - Consultation
  - Prescription collection

**Pharmacy**

**Options**
- Direct Delivery
- RADU
- CCMDD
- Mobile Pharmacy (Outreach)

Chronic patients only need to come to the clinic 2 x a year unless:
- Change of health condition of the patient
- Patient move away (or other personal circumstances)

The options will be integrated via HMIS to allow registration, validation and verification process.

SOURCE: Lab discussion and analysis
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 the mapping of the available services.
- 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
- Milestone 1
  - Enforcement of Nursing Act, including training nurses to dispense other’s prescription
  - Fast tracking of Pharmacy Act Amendments

Nov 2014 – May 2015
- Milestone 2
  - Ensure Readiness of the 4 options for dispensing and distribution

Dec 2014
- Milestone 3
  - CCMDD
    - Align with NHI’s plan
  - Expansion of chronic conditions

Jan – Apr 2016
- Milestone 4
  - 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
Steps to develop the framework and implementation strategy for innovative ways of medicine dispensing and distribution

1. Pre-Project activities
   1.1 Obtain National GEO Mapping Report
   1.2 Survey for Deployment Options
   1.3 Fastrack amendments of current legislation to allow innovative medicine dispensing and distribution
   1.4 Determine the readiness of each innovative mode

2. Pilot Phase
   2.1 Select 10 sites based on survey
   2.2 Identification and Registration of Patients for each innovative mode
   2.3 Patients commence collection of medication

3. Analysis and Learning
   3.1 Adapt modes based on learnings from the pilot
   3.2 Provide guidelines for scale up and implementation for Phase 1 (1000 clinics)

4. Implementation Phase 1, 2 and 3
   4.1 Selection of the applicable sites for each phase
   4.2 Deployment of the innovative modes
   4.3 Identification and Registration of Patients for each innovative mode
   4.4 Patients commence collection of medication

5. Monitoring and Evaluation
   5.1 Monitor Implementation process
   5.2 Monitor implementation for up scaling and sustaining the processes
The initiative will have a tremendous impact in reducing the needs for non-clinical visit to PHCs

<table>
<thead>
<tr>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Assuming a sample size covered by one particular PHC is 1000 patients, 50% are patients with chronic conditions (500), For a patient with chronic conditions not including consultation and treatment for acute conditions.</em></td>
<td>Only required to visit PHC 2x a year</td>
</tr>
<tr>
<td>Visit PHCs for medical consultation and getting medication at minimum 12 times a year</td>
<td>Medications are dispensed through the options, saving 10 visits per year</td>
</tr>
<tr>
<td>1 Person 12 visits to PHC a year R96 per visit R96 x 12 = R1152</td>
<td>1 Person 2 visits to PHC a year R96 per visit R96 x 2 = R192</td>
</tr>
<tr>
<td>1-4 hours per trip 4x12 = 48 hours</td>
<td>1-4 hours per trip 4x2 = 8 hours</td>
</tr>
<tr>
<td><strong>R1152 per person 48 hours per person</strong></td>
<td><strong>R192 per person 8 hours per person</strong></td>
</tr>
</tbody>
</table>

For 1 patient, R960 and 40 hours saved for not having to come to PHCs to collect prescribed medications every year.

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

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated primary care; revised package of services, facility re-classification and referrals</td>
<td>Patient with multiple conditions, 1 visit, 1 file, 1 service provider</td>
</tr>
<tr>
<td>Integrated clinical support</td>
<td>Uniformity of DMT structure and profile</td>
</tr>
<tr>
<td>Integrated District service delivery platform</td>
<td>Patient presents ID, and all her records are retrieved through an integrated, automated system</td>
</tr>
<tr>
<td>Innovative medicine dispensing</td>
<td>Patient and staff experience a clean, safe environment at the facility</td>
</tr>
<tr>
<td>Cleaning guidelines and IPC protocol</td>
<td>Interoperability between eHealth systems</td>
</tr>
<tr>
<td>Standardised and integrated Health Management Information systems</td>
<td>Patient presents ID, and all her records are retrieved through an integrated, automated system</td>
</tr>
</tbody>
</table>
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.

**TODAY..**

Feb 2015

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

June 2015

Develop and implement intervention strategies for facilities to uplift to meet the required standards

Dec 2016

100% PHC compliance to cleanliness, infection prevention and control, and general waste management guidelines.

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

Less than 50% were compliant to infection prevention and control, and cleanliness standards

Sample cases of nosocomial infection reported recently...

**Eastern Cape and Western Cape Provinces 1996 - 2008**
- 10 out 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**
- 22 babies died from Klebsiella due to cross infection

**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.

---

1 A total of 3487 PHC facilities were assessed

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

- National Environmental Management Act No 107 of 1998
- National Environmental Management Waste Amendment Act No 26 of 2014
- Environment Conservation Act No 73 of 1989
- Hazardous Substances Act No 15 of 1973
- National Health Act No 61 of 2003
- Occupational Health and Safety Act No 85 of 1993
- Occupational Health and Safety Amendment Act No 181 of 1993
- Hazardous Biological Agents Regulations, 2001

GAPS

- National Infection Prevention & Control Policy & Strategy 2007 (Non-comprehensive, outdated & Hospi-centric)
- Non-existent National Policy / Strategy / Guidelines / Protocol for Cleanliness & Waste Management

National Core Standards for Health Establishments in South Africa (National Department of Health 2011)

IMPACT AT PROVINCE, DISTRICT, AND FACILITY LEVEL
- Non compliance to Standards and Legislation Frameworks
- No standardization of SOPs – up to interpretation of facility managers
- Ununiformed monitoring and evaluation mechanism

IMPACT ON ENABLERS
- Non standardized list of requirements and support structure to enable, improve to and sustain ideal state of cleanliness, infection prevention and control, and waste management.

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

<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Identify the gaps on the current existing guidelines on cleanliness, infection prevention and control, and waste management in the scope of primary healthcare clinics.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Identify support structures or the “enablers” to allow uplifting of primary healthcare clinics to compliance to National Core Standards¹</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Develop new Guidelines based on National Infection Prevention &amp; Control Policy &amp; Strategy 7 to include requirements for PHCs and components on cleaning, disinfection, sterilizations, and waste management</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Adopt and disseminate new guideline and strategy at all level – provincial, district, and facility level.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Develop the strategy and Intervention Plan to uplift the compliance to National Core Standards based on the new guidelines.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Compile and revise the baseline of current compliance to the National Core Standard using the audit done at the district level.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 4</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Rollout the new strategy and protocol to all provincial, district, and facility level.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Assist DHS and facilities develop own plans to uplift to / maintain desired level of compliance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Ensure that the support structures and the enablers are available at all PHC to improve and/or maintained desired level of outcomes of compliance¹</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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
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

SOURCE: Lab Discussion and Analysis
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 Medical 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
The new National Guideline for cleanliness, infection prevention and control, and waste management will be based on the following Term of Reference

<table>
<thead>
<tr>
<th>TERM OF REFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective and purpose of the guideline</td>
</tr>
<tr>
<td>Features of the Guideline</td>
</tr>
<tr>
<td>Components covered by the Guideline</td>
</tr>
<tr>
<td>Targets and aspiration</td>
</tr>
<tr>
<td>Recommendations and high level steps to achieve targets</td>
</tr>
<tr>
<td>Accountable bodies and responsibilities</td>
</tr>
</tbody>
</table>

| Creation on integrated practical guideline on cleaning, infection prevention and control and waste management for all levels of PHC classification |
| Relevant across all levels 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. |
| List of essential list of consumables and other requirements (HR, Infrastructure, Supply Chain) required to ensure compliance to National Core Standards |
| All PHCs and Health Facilities to comply to National Core Standards for cleanliness, infection prevention and control, and waste management |
| Based on some of the recommendations developed in the lab |
| Based on the RACI matrix (Responsible, Accountable, Counselling and Informed) |

SOURCE: Lab Discussion and Analysis
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 hosp-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)**
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 compliance

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
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
   4.4 Identify best performing facilities
   4.5 Acknowledge best performance of individual and facilities – group awards
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.

Infection Prevention & Control
- 2012 National Core Standards Results: 47%
- Improvement in 2015: +30%
- Improvement in 2016: +23%
- Target by 2016: 100%

Cleaning
- 2012 National Core Standards Results: 48%
- Improvement in 2015: +30%
- Improvement in 2016: +22%
- Target by 2016: 100%

Waste Management
- 2012 National Core Standards Results: 83%
- Improvement in 2015: +17%
- Target by 2016: 100%

100% compliance

- Infection Prevention & Control
- Cleaning
- Waste Management

PHC Compliance to National Core Standards
The seventh and eighth initiative support the delivery of health services through an interoperable, standardized and integrated HMIS.
Current Scenario

Challenges
1. Clinicians are expected to maintain too many/multiple paper registers.
2. Patient files are managed at multiple places in the clinics.
3. Manual calculations generate inaccuracies — adding data from tick registers used by clinicians to produce a monthly summary sheet.
4. Too many import-export processes at District/Provincial levels.
5. Many disparate patient repositories (Tier.net, MomConnect, HPRS).
6. Large backlog to capture household visits lead to data loss.
7. Many disparate mHealth systems result in multiple data repositories.
We have identified 2 key initiatives

<table>
<thead>
<tr>
<th>Initiative 7</th>
<th>Description</th>
<th>Rationale – why this initiative is needed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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.</td>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Initiative 8</th>
<th>Description</th>
<th>Rationale – why this initiative is needed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To implement Health Information Exchange (HIE) based on the Health Normative standards Framework to achieve data interoperability</td>
<td>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.</td>
</tr>
</tbody>
</table>

The following initiatives are excluded here
- HR work stream
  - 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
  - Procurement and supply of ICT Infrastructure. HMIS work stream will provide specifications for ICT Infrastructure
- Waiting Times work stream
  - 3ft Plan for defining business processes for Appointment and filing systems
  - HMIS workstream to define mechanisms to automate these in future
In line with the Health Information Systems Guiding Strategies and Policies

NHI Green Paper

2011
Proposed Health Management Information Systems Architecture

Demographic repositories
- HPRS + MPI
  - Provider registry
  - Facility registry

Clinical repositories
- Tier.net
- ETR.net
- Shared EHR

Health analytics
- DHIS and NHIRD

Security and audit services
(Defines: Who has access to which information)

Health Information Exchange (HIE)

Consumer applications
- HPRS
- ETR.NET & TIER.NET
- DHIS
- PHC IS

Paper based registers

Edge devices

Connectivity

District, Provincial and National Management
- District
- Provincial
- National

High Level Programme
- Develop and implement a standardized and integrated health management information systems (manual & electronic) in DHS
- To implement Health Information Exchange (HIE) based on the Health Normative standards Framework to achieve data interoperability.
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.
Achieve standardisation and integration of patient, facility and health information management systems (manual & electronic) in DHS

<table>
<thead>
<tr>
<th>What</th>
<th>How</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reduce administration burden at all levels of DHS</td>
<td>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 project</td>
</tr>
<tr>
<td>2. Integrate existing disease centric patient based health information systems to eliminate duplication</td>
<td>2. Integrate existing vertical Information Systems: Health Patient Registration System (HPRS), Tier.net, ETR.net and MomConnect</td>
</tr>
<tr>
<td>3. Introduce manual and electronic methods of uniquely identifying / verifying patients to prevent multiple patient files, and to establish a national patient registry</td>
<td>3. Implement Health Patient Registration System (HPRS) to digitise patient demographic details and strengthen unique patient identification / verification</td>
</tr>
<tr>
<td>4. Streamline data generated at community level into a single repository</td>
<td>4. Integrate mHealth systems with DHIS to ensure ward based data generated at community level is available in a single repository</td>
</tr>
<tr>
<td>5. Digitise aggregated data at facility level on a daily basis to minimize errors and enable generation of facility reports</td>
<td>5. Implement DHIS at facility level to digitise submission of aggregated service delivery data thereby minimising calculation errors</td>
</tr>
<tr>
<td>6. Lastly, introduce comprehensive patient based information system(s) to improve health service delivery</td>
<td>6. Implement Patient based PHC Information System¹ (include e.g. appointment system, basic digitised health record and e-prescription) in all PHC facilities</td>
</tr>
</tbody>
</table>

¹ PHC IS must provide the desired functionality, be cost effective and compliant to Health Normative Interoperability Standards Framework.
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.
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
  - Output: A system design for the Health Information Exchange

- 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)
  - Output: Detailed system description of all Demographic repositories (patient, provider, and facility), and clinical repositories (radiology, pharmacy, as well as shared electronic health record)

- 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
  - Output: A functional Patient Master Index for South Africa

- Development of an appropriate Health Normative Standards\(^1\) based integration software to enable information exchange between different information systems
  - Output: Health Information Exchange for South Africa that integrates various patient based 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 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
# Health Management Information Systems Transition from 2014 to 2019

<table>
<thead>
<tr>
<th>Efficient <strong>manual system</strong></th>
<th>Digitise <strong>aggregated data</strong></th>
<th>Shared <strong>Electronic Health Records</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2015</strong></td>
<td><strong>2015 - 2017</strong></td>
<td><strong>2019</strong></td>
</tr>
<tr>
<td>• Reduce the number of data collection tools</td>
<td>• All PHC Facilities having access to Telephone, internet and email</td>
<td>• Fully established National interoperability platform with Health Information Exchange and shared repositories to facilitate sharing of health records with higher levels of care</td>
</tr>
<tr>
<td>• Organise and streamline patient records¹</td>
<td>• Implement daily data reporting of aggregated data at facility level using DHIS.</td>
<td></td>
</tr>
<tr>
<td>• Establish an appointment system¹</td>
<td>• Automate Patient Identification using Health Patient Registration System (HPRS)</td>
<td></td>
</tr>
<tr>
<td>• Fully implement the DHMIS Policy and Procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Conduct baseline study of admin personnel</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.
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:

<table>
<thead>
<tr>
<th>Initiative concept/details/highlights</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Develop national essential list for laboratory tests, clinical and domestic equipment and consumables to support delivery of revised package of services</td>
</tr>
<tr>
<td>▪ 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</td>
</tr>
<tr>
<td>▪ Resulting in raised satisfaction and reduced complaints from staff and patients</td>
</tr>
<tr>
<td>▪ 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:</td>
</tr>
<tr>
<td>▪ IPC (incl. Waste management) and Cleaning materials and equipment List</td>
</tr>
<tr>
<td>▪ Clinic Equipment Standard List</td>
</tr>
<tr>
<td>▪ Essential Laboratory List</td>
</tr>
</tbody>
</table>

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

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

- 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

<table>
<thead>
<tr>
<th>Key Initiative</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Develop the Integrated Essential Equipment and Non-Medical Consumables List required at the health facility to provide integrated care based on the service model</td>
</tr>
<tr>
<td>2</td>
<td>Develop the Essential Laboratory List (ELL) list based 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</td>
</tr>
</tbody>
</table>
This will involve the development of 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**

- 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

**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)

<table>
<thead>
<tr>
<th>Description of Output</th>
<th>Enabler required</th>
<th>SOURCE: Lab Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Standardized DM structure &amp; profile</td>
<td>- Organogramme with delegation of authority and readiness to implement</td>
<td>Human Resource</td>
</tr>
<tr>
<td>- Clear roles and responsibilities at all levels</td>
<td>- Curriculum and training for staff (pre-service and in-service) (HRD plan)</td>
<td></td>
</tr>
<tr>
<td>- Management and clinical skills</td>
<td>- Accountability and consequence management (HRM &amp; PMDS)</td>
<td></td>
</tr>
<tr>
<td>- Employee health and wellness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Implement ICSM model to improve patient flow</td>
<td>- Integrated HMIS and patient records</td>
<td>Waiting Times</td>
</tr>
<tr>
<td>- Patient administration, filing, records and flow</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Availability of staff, equipment and supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- List of medical equipment</td>
<td>- Service package with clearly defined facilities classification</td>
<td>Infrastructure</td>
</tr>
<tr>
<td>- Cleaning protocol and guideline</td>
<td>- Maintenance</td>
<td></td>
</tr>
<tr>
<td>- Allocation of budget</td>
<td>- Delegation and Budgets</td>
<td>Financial Management</td>
</tr>
<tr>
<td>- Delegation down to operation managers</td>
<td>- Costing of the revised package</td>
<td></td>
</tr>
<tr>
<td>- Involvement of facility staff in resource allocation and budgeting</td>
<td>- Staff training and skills in FM</td>
<td></td>
</tr>
</tbody>
</table>
## Specific outputs from this lab will propel delivery of healthcare to greater heights (II)

<table>
<thead>
<tr>
<th>Description of Output</th>
<th>Enabler required</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Consistent availability of drugs and all supplies and support services</td>
<td>▪ Delegation of SCM function</td>
</tr>
<tr>
<td>▪ Defined list of essential medicines, clinical equipment and consumables</td>
<td>▪ Staff training and skills</td>
</tr>
<tr>
<td>▪ Maintenance of equipment</td>
<td>▪ Develop and implement a scale-up plan</td>
</tr>
<tr>
<td>▪ Scale up of service package</td>
<td>▪ Implementation of a clear and sustained communication strategy for all (staff, patients, communities, government departments and all sectors)</td>
</tr>
<tr>
<td>▪ Re-organisation of DHS services and PHC facilities</td>
<td>▪ Align national, provincial, district and local government</td>
</tr>
<tr>
<td>▪ Implementation of the referral policy</td>
<td>▪ Provincialisation of PHC health services</td>
</tr>
<tr>
<td>▪ Community engagement</td>
<td></td>
</tr>
<tr>
<td>▪ Clear and seamless referral pathways</td>
<td></td>
</tr>
<tr>
<td>▪ Social determinants of health addressed</td>
<td></td>
</tr>
<tr>
<td>▪ Standardized DM structure and profile</td>
<td></td>
</tr>
<tr>
<td>▪ Roles and responsibilities</td>
<td></td>
</tr>
<tr>
<td>▪ Right skills and competencies at all levels of the system</td>
<td></td>
</tr>
<tr>
<td>▪ Delegation of authority</td>
<td></td>
</tr>
</tbody>
</table>

**SOURCE: Lab Analysis**
### Initiatives from the Service Delivery Workstream impact other workstreams in the Healthcare Lab

#### Human Resource
- District Health System and Service Package provides demand for right staff with right skills
- No change in status quo for patient experience and quality of care

#### Sustainability & Scale Up
- ICSM model and implementation guide including HMIS and expanded CCMDD Available
- Poor execution of scale up and no support structures will result in loss of confidence of public in the new process

#### Waiting Times
- ICSM model improves patient administration and processing in facilities supported by an Integrated HMIS
- Waiting times will remain unacceptable to patients and workload on staff will remain very high

#### Infrastructure
- Service Package with clearly defined classification of facility levels based on population and geographical needs will inform health facility planning and commissioning
- Waiting times and quality of care will be negatively impacted

#### Institutional Arrangements
- Alignment of National Provincial & District Management structures to support inter and multi sectoral engagement
- Ease of patient referral (emergencies or planned) within health system will be curtailed
- Social determinants of health at local level will not be addressed

#### Financial Management
- Service Package allows for accurate budgeting of healthcare at facilities
- Inadequate funds to procure essential non-negotiable supplies

#### Supply Chain Management
- Defined essential medication, equipment, other consumables, and lab services
- Poor clinical management of patients due to stockout of medication and no lab results, poor infection control, dirty facilities

---

**Risks**

- District Health System and Service Package provides demand for right staff with right skills
- No change in status quo for patient experience and quality of care
- Service Package with clearly defined classification of facility levels based on population and geographical needs will inform health facility planning and commissioning
- Waiting times and quality of care will be negatively impacted
- Alignment of National Provincial & District Management structures to support inter and multi sectoral engagement
- Ease of patient referral (emergencies or planned) within health system will be curtailed
- Social determinants of health at local level will not be addressed
Contents

- Context and case for change
- Aspiration
- Issues and root causes
- **Solutions/ Initiatives**
  - **Budget**
    - KPI
    - 3ft plans
- Appendix
- Acronyms
## Detailed initiative budget – Service Delivery

**Total budget, R 9 billion**

<table>
<thead>
<tr>
<th>Nr</th>
<th>Initiative</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2017/18 – 2018/19</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Capex</td>
<td>Opex</td>
<td>Personnel and training</td>
<td>Capex</td>
</tr>
<tr>
<td>1 &amp; 2</td>
<td></td>
<td>11552255</td>
<td>44529936</td>
<td></td>
<td>56082191</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>8632000</td>
<td>1013040</td>
<td></td>
<td>9645040</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>262600</td>
<td>353500</td>
<td>820500</td>
<td>2382300</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>2127700</td>
<td>772441200</td>
<td>5802296400</td>
<td>6576865300</td>
</tr>
<tr>
<td>7 &amp; 8</td>
<td></td>
<td>39067950</td>
<td>143622000</td>
<td>7793333.333</td>
<td>1832990730</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>39067950</td>
<td>13679955</td>
<td>0</td>
<td>143622000</td>
</tr>
</tbody>
</table>
Budget overview – Service Delivery

Total budget
R 9 billion

- Personnel & Training
  - Opex
  - Capex

- Capex
- Opex
- Personnel & Training

<table>
<thead>
<tr>
<th>Year</th>
<th>Personnel &amp; Training</th>
<th>Opex</th>
<th>Capex</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
<td>14</td>
<td>39</td>
<td>53</td>
</tr>
<tr>
<td>2016/17</td>
<td>0</td>
<td>826</td>
<td>979</td>
</tr>
<tr>
<td>2017/18</td>
<td>9</td>
<td></td>
<td>42</td>
</tr>
</tbody>
</table>

Bar chart showing budget allocations for different years and categories.
Contents

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

▪ Context and case for change
▪ Aspiration
▪ Issues and root causes
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▪ Appendix
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Contents

▪ Context and case for change
▪ Aspiration
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▪ Solutions/ Initiatives

▪ Appendix
▪ Accronyms
Addressing the Social Determinants of Health

Impact of Health in all Policies

All of Government to actively respond to social determinants of health and to create the enabling environment to promote active civil society participation.
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

Source: The 8th Global Conference on Health Promotion, Helsinki, Finland, 10-14 June 2013
Clinics demonstrated a lower level of performance compared to hospital cross the board

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

- Positive and caring attitudes: 30%
- Improve patient safety and Security: 34%
- Infection prevention and control: 50%
- Cleanliness: 50%
- Availability of medicines and supplies: 54%
- Waiting times: 68%

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

- PHC Compliance - Vitals %: 25%
- Hospital Compliance - Vitals %: 47%
  - Positive and caring attitudes: 47%
  - Improve patient safety and Security: 30%
  - Infection prevention and control: 52%
  - Cleanliness: 64%
  - Availability of medicines and supplies: 62%
  - Waiting times: 68%

**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.

**SOURCE:** National Health Facilities Baseline Audit 2012
The survey also highlighted critical staff shortages in South Africa clinics, especially, of pharmacy staff.

<table>
<thead>
<tr>
<th>HR availability at 3,074 clinics across South Africa</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility manager present</td>
<td>79/21</td>
</tr>
<tr>
<td>Visit from doctor</td>
<td>53/47</td>
</tr>
<tr>
<td>Professional nurse present</td>
<td>97/3</td>
</tr>
<tr>
<td>Input from a pharmacist/equivalent</td>
<td>16/84</td>
</tr>
<tr>
<td>Lay counsellors present</td>
<td>89/11</td>
</tr>
<tr>
<td>Administration support present</td>
<td>43/57</td>
</tr>
<tr>
<td>Information management staff present</td>
<td>21/79</td>
</tr>
</tbody>
</table>

**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

SOURCE: National Health Facilities Baseline Audit 2012
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

Leads to

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

- Poor Quality of Care
- Health Service Challenges

Due to:
- Fragmented, vertical curative focussed clinical programmes
- Poorly defined package of care
- Poorly defined facility categorization

Leads to:
- Poor Health outcomes

Impacts on:
- Patient Experience
- Provider Experience
- Community Experience
...as well as the community

<table>
<thead>
<tr>
<th>Experience</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty in accessing the right service at the right level</td>
<td>Poor health outcomes</td>
</tr>
<tr>
<td></td>
<td>Reduced life expectancy</td>
</tr>
<tr>
<td></td>
<td>High morbidity and mortality rate</td>
</tr>
<tr>
<td></td>
<td>Lack of confidence in PHC</td>
</tr>
<tr>
<td>Disempowered communities that are unable to take responsibility for their own health</td>
<td></td>
</tr>
<tr>
<td>Lack of an enabling environment to support lifestyle and behaviour change</td>
<td></td>
</tr>
<tr>
<td>Social determinants of health not addressed</td>
<td></td>
</tr>
</tbody>
</table>
## Inefficient services

<table>
<thead>
<tr>
<th>Poor screening for NCDs</th>
<th>Prolonged waiting times with poor service times</th>
<th>Poor adherence to guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Screening for asthma</strong>  73%</td>
<td><strong>Median waiting time</strong>  102</td>
<td><strong>75%</strong> Treatment of asthma according to STG</td>
</tr>
<tr>
<td><strong>Screening for hypertension</strong>  40%</td>
<td><strong>Median service time</strong>  7</td>
<td><strong>85%</strong> Treatment of hypertension according to STGS</td>
</tr>
<tr>
<td><strong>Screening for diabetes</strong>  3.50%</td>
<td></td>
<td><strong>64%</strong> Treatment of Diabetes according to STGs</td>
</tr>
</tbody>
</table>

### Graphs:

- **Chart 1**: The graph shows that 3 common NCDs are not adequately screened.
- **Chart 2**: The graph highlights that the median waiting time is excessively long when compared to the service time.
- **Chart 3**: The graph reports that clinical guidelines for the treatment of NCDs are not routinely followed in more than 60% of cases.

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

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...

<table>
<thead>
<tr>
<th>Experience</th>
<th>Impact</th>
</tr>
</thead>
</table>
| Inadequate staffing:  
  - Numbers  
  - Skills Mix | Inability to provide Integrated Holistic Care |
| Vertical Curative Service | Leads to |
| Multiple supervision streams | High workloads  
  - Low Staff Morale  
  - Poor Attitudes  
  - High Attrition  
  - Lack of confidence in the systems |
Integration results in ease of access and seamless services.

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.
## 1.4 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
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

<table>
<thead>
<tr>
<th>Country</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>The Mitanin CHW Programme supporting child survival in Chhattisgarh state <em>in India is a significant example of a large scale community health worker</em> 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.</td>
</tr>
<tr>
<td>Nepal</td>
<td>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%.</td>
</tr>
</tbody>
</table>

SOURCE: Balabanova D. et al. Good Health at Low Cost 25 years on. 2011
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

SOURCE: Balabanova D. et al. Good Health at Low Cost 25 years on, 2011
Gaps in the existing PHC Package have been identified

1. The service package is not in accordance to the life course approach and full value chain of continuum of care and support.
2. 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.
3. Comprehensive community based approach is missing including Early childhood development.
4. Rehabilitative and Palliative care from the facility to the community is not included.
5. Dental services are lacking across the board at PHC Level.
6. It promotes vertical programme implementation which places additional stress on facilities.
7. Therapeutic services such as audiology, speech therapy and psychology are not outlined. Provision of these services is limited in hospitals.

SOURCE: Department of Health, Pretoria, March 2000
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.

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
This has a significant impact on Waiting Times

**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
Also impacting on Socio Economic Parameters 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.

Benchmarcking
Mobile Pharmacy

- “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.”
This has a significant impact on the following:

**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
- Loss of productivity & working hours if employed

**Quality of Care from a Patient & Provider Point of View**
- 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

_SOURCES:_ Overview of Health Sector Reforms in South Africa DEC 2011 (Human Development Resource Centre)
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
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 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
### Initiative: Cleaning and Infection Prevention Control

**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

<table>
<thead>
<tr>
<th>Initiative concept/details/highlights</th>
<th>Implementing agency</th>
</tr>
</thead>
</table>
| • 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 | • NDoH |

<table>
<thead>
<tr>
<th>Key stakeholders identified</th>
<th>Required resources</th>
</tr>
</thead>
</table>
| • Facilities Managers  
• IPC champions  
• Cleaners | • … |

<table>
<thead>
<tr>
<th>Implementation timeframe</th>
<th>Key performance indicators</th>
</tr>
</thead>
</table>
| • Start date: May 2015  
• End Date: December 2016 | • Update of the 2007 IPC policy (2015)  
• Finalise cleaning guidelines and IPC protocol (2015) |

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

▪ Context and case for change
▪ Aspiration
▪ Issues and root causes
▪ Solutions/ Initiatives
▪ Appendix

▪ Accronyms
### Health Services Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>ARVs</td>
<td>Antiretrovirals</td>
</tr>
<tr>
<td>CCMDD</td>
<td>Central Chronic Medicine Dispensing and Distribution</td>
</tr>
<tr>
<td>CDC</td>
<td>Communicable Disease Centre</td>
</tr>
<tr>
<td>CHC</td>
<td>Community Health Centre</td>
</tr>
<tr>
<td>CHPS</td>
<td>Community-based Health Planning and Service</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>DALYs</td>
<td>Disability Adjusted Life Years</td>
</tr>
<tr>
<td>DDP</td>
<td>Deputy Director General</td>
</tr>
<tr>
<td>DG</td>
<td>Director-General</td>
</tr>
<tr>
<td>DHS</td>
<td>District Health System</td>
</tr>
<tr>
<td>ECD</td>
<td>Early Childhood Development</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded programme on immunisation</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency Virus</td>
</tr>
<tr>
<td>ICDM</td>
<td>Integrated Chronic Disease Model</td>
</tr>
<tr>
<td>ICRM</td>
<td>Ideal Clinic Realisation and Maintenance</td>
</tr>
<tr>
<td>ICSM</td>
<td>Integrated Chronic Services Management</td>
</tr>
<tr>
<td>KZN</td>
<td>Kwa Zulu Natal</td>
</tr>
<tr>
<td>MCWH</td>
<td>Maternal Child and Women’s Health</td>
</tr>
<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MDR-TB</td>
<td>Multi Drug Resistant TB</td>
</tr>
<tr>
<td>MHH</td>
<td>Maternal Health</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality Rate</td>
</tr>
<tr>
<td>MRC</td>
<td>Medical Research Council</td>
</tr>
<tr>
<td>MTSF</td>
<td>Mid Term Strategic Framework</td>
</tr>
<tr>
<td>NCDs</td>
<td>Non Communicable Diseases</td>
</tr>
<tr>
<td>NDoH</td>
<td>National Department of Health</td>
</tr>
<tr>
<td>NGOs</td>
<td>Non government organisations</td>
</tr>
<tr>
<td>NHC</td>
<td>National Health Council</td>
</tr>
<tr>
<td>NHC-TAC</td>
<td>National Health Council Technical Advisory Committee</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health care</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
</tr>
<tr>
<td>STGs</td>
<td>Standard Treatment Guidelines</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted infection</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>WBOT</td>
<td>Ward based outreach teams</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>XDR-TB</td>
<td>Extensive Drug Resistant TB</td>
</tr>
<tr>
<td>YLD</td>
<td>Years Lived with Disability</td>
</tr>
<tr>
<td>YLL</td>
<td>Years of life lost</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
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<td>-------------</td>
</tr>
<tr>
<td>CD</td>
<td>Chief Director</td>
</tr>
<tr>
<td>CFO</td>
<td>Chief Financial Officer</td>
</tr>
<tr>
<td>CD M&amp;E</td>
<td>Chief Director Monitoring and Evaluation</td>
</tr>
<tr>
<td>CD PHC</td>
<td>Chief Director Primary Health Care</td>
</tr>
<tr>
<td>DG</td>
<td>Director General</td>
</tr>
<tr>
<td>DMT</td>
<td>District Management Team</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DPSA</td>
<td>Department of Public Service and Administration</td>
</tr>
<tr>
<td>JD</td>
<td>Job Description</td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>RADU</td>
<td>Remote Automated Dispensing Unit</td>
</tr>
<tr>
<td>DD</td>
<td>Direct Delivery</td>
</tr>
<tr>
<td>MP</td>
<td>Mobile Pharmacy</td>
</tr>
<tr>
<td>CCMDD</td>
<td>Central Chronic Medicine Dispensing and Delivery</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information Systems</td>
</tr>
<tr>
<td>DH</td>
<td>District Health</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Workers</td>
</tr>
<tr>
<td>ART</td>
<td>Anti Retroviral Therapy</td>
</tr>
<tr>
<td>PPP</td>
<td>Public/Private/Partnership</td>
</tr>
</tbody>
</table>
### Cleaning and IPC Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NDoH HR</td>
<td>National Department of Health Human Resource</td>
</tr>
<tr>
<td>National QA Unit</td>
<td>National Quality Assurance Unit</td>
</tr>
<tr>
<td>PDoH QA</td>
<td>Provincial Department of Health Quality Assurance</td>
</tr>
<tr>
<td>District QA</td>
<td>District Quality Assurance</td>
</tr>
<tr>
<td>NDoH HRD</td>
<td>National Department of Health Human Resource Development</td>
</tr>
<tr>
<td>IPC</td>
<td>Infection Prevention and Control</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>SOP</td>
<td>Standard Operating Procedure</td>
</tr>
<tr>
<td>CHC</td>
<td>Community Health Centre</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Healthcare Clinic</td>
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