A RURAL HEALTH STRATEGY FOR SOUTH AFRICA

PURPOSE

1. The purposes of this document are:
   a. To present a coherent, practical strategy to improve health services in rural areas in the period 2006-2009
   b. To focus the attention of national, provincial and local government elected representatives and officials, and of communities and civil society groups, on what THEY can do to help improve rural health services.

SUMMARY

2. Te vision for rural health services in 2009 is that these services will:
   - Be as equal in quality and accessibility to rural people, as urban services are to their clients
   - Be comprehensive
   - Have efficient referral systems
   - Fully involve local communities

3. Fourteen specific goals are set out. These include developing an agreed, government wide de**h**finition of what are rural and remote rural areas, targets for access to personal primary health care, emergency medical and municipal health services, systems for referrals, health posts, and community involvement, targets for staffing and supervision, availability of drugs, equipment, transport, accommodation and incentives for professional staff, and appropriate plans and quarterly monitoring.

4. Ten key actions will be taken to achieve this vision and these goals:
   - Develop an agreed definition of rural
   - Make rural areas more visible
   - Mobilize financial and other non-human resources
   - Train, recruit and retain human resources
   - Provide appropriate supervision and management support
   - Develop support systems
   - Focus on priority programmes
   - Develop partnerships
   - Mobilize academic and training institutions
   - Monitor and evaluate service delivery and progress

5. Responsibilities for implementation are identified at community, district, provincial, training institutional and national levels.

6. Reference is made to other relevant policies and strategies.

INTRODUCTION

7. There are strong commitments from the South African government and from many outside government, to promote rural development and to improve the quality of life in rural communities. The Departments of Health in all three spheres share this commitment and want to work with other departments and other stakeholders to improve the quality of health care in rural areas.

8. In November 2004 the Department of Health hosted a conference on Health in the Rural Nodes. At that conference, papers were presented from all the 13 rural nodes, and one from the Rural Doctors Association of South Africa (RuDASA). At the final session of the conference, delegates agreed on a number of issues and ideas, arising out of the papers and the discussion, that should be included in a Rural Health Strategy.

9. This draft strategy is a product of that conference and of subsequent work by a small task team. It has been endorsed by the National District Health Systems Committee and is recommended to the Technical Committee of the National Health Council for consideration and possible adoption by the National Health Council.

VISION & GOALS FOR RURAL HEALTH CARE IN 2009

10. **The vision** for rural health services in 2009 is that these services will:
    - Be as equal in quality and accessibility to rural people, as urban services are to their clients
    - Be comprehensive
    - Have efficient referral systems
    - Fully involve local communities

11. **Specific goals for rural health care in 2009 include:**
    a. There will be a clear, formal and shared understanding nationally of how rural and remote rural areas are **defined**, by all government departments, including national and provincial treasuries and StatsSA.

    b. Services at fixed **Primary Health Care** facilities [community health centres (CHCs) and clinics] will be free and accessible within 5km of 90% of the population, and mobile health services will cover another 8% of the population at least once a week.

c. **Emergency services** will be available 24 hours a day within each municipality, and ambulance response time will be less than one hour for any fixed facility, and less than 30 minutes for 70% of facilities.

d. **Municipal Health Services** will be provided in all areas with appropriate attention being given to the availability of safe water and sanitation, health and hygiene education, waste management and air pollution, as well as to appropriate outbreak reporting and response. Other environmental health services such as malaria control will also be coordinated with all district health services.

e. A clear and well functioning **referral system** will cater to rural and remote areas, facilitating access to community health centres and district hospitals and, as needed, to regional and central hospitals, with written referrals back to relevant PHC providers.

f. **Local communities** will be involved in rural health services through clinic and health centre committees, hospital boards and District Health Councils, as well as through appropriate local communication strategies. 90% of fixed facilities will have a clinic or health centre committee or a hospital board that meets at least six times a year, has written minutes, and has lists of members and their contact details displayed in the relevant facility. All health workers will have a community-oriented approach to their duties and responsibilities.

g. Every PHC facility and district hospital will have an agreed **staff establishment,** a vacancy rate of < 15% for professional staff for at least 10 months of each financial year, all staff doing consultations will have appropriate training and support, and every district hospital will have a **doctor on call** for emergencies 24 hours a day, every day. New ways will be found to draw more private general practitioners in to see patients in public PHC facilities.

h. Every fixed PHC facility and district hospital will have a **designated supervisor** at the sub-district or district level who visits the facility at least once every month, 90% of PHC facilities will be visited by a doctor once a week, and every district hospital will be visited by a specialist and by allied health professionals once a month.

i. Clinics will in turn support **health posts** where community members and the health services can contact community care givers, and from where these care givers will go out.

j. **Transport & communication** will be improved to ensure that TB sputa and other specimens can be submitted regularly from every fixed PHC facility, and results obtained, and that transport will be available for regular visits to clinics by supervisors and doctors, and to district hospitals by supervisors, specialists and others.

k. **Adequate accommodation** will be provided for professional staff in designated rural areas at no extra expense to themselves, wherever they render a 24-hour service.

l. **Incentives for professional staff** will include additional remuneration on the basis of fair and logical criteria according to the hospitability of the area and greater access to study leave and relevant professional development courses and conferences. Professional staff in regional hospitals that are situated in rural areas will receive a proportion of the benefits of those in rural district hospitals and community health centres.

m. Rural health **facilities** will be fully **supplied** with drugs and vaccines according to the EDL, as well as consumables, and equipment, on an equal level with urban facilities.

n. For every district, there will be an annual **district health plan** that includes specific plans for district hospitals and PHC facilities, and service delivery targets that are **monitored and reviewed** at least every 3 months. This plan will be a component of the Integrated Development Plan (IDP) for the district and the importance of inter-sectoral collaboration in rural development will be emphasized.

DEFINITION

12. There is in March 2006 no agreed definition of “rural” in South Africa. The term is used loosely for different purposes and this causes confusion.

13. In the past, Statistics South Africa (StatsSA) classified areas proclaimed as municipalities (mostly the cities and “white” towns and their associated “townships”) as urban, and everything else as rural. In the 2001 census these old boundaries were still used because it allowed comparison with data from previous census reports. However all parts of South Africa now fall within a municipality and StatsSA no longer reports on “rural” versus “urban” populations because there is no official definition of rural. All municipalities include one or more towns, though many of these towns are small and have very few amenities, and all except the metropolitan municipalities include areas that are to some degree “rural”.

14. Eleven district municipalities and 2 local municipalities were identified in 2001 as “rural nodes” but they include some local municipalities with a large town such as Queenstown and other local municipalities that are “deep rural”. There are also other deep rural areas that are not included in any of the 13 rural nodes.

15. The dividing lines between city, peri-urban, large town, small town, farm and deep rural areas are very blurred. This works to the disadvantage of people in the most impoverished areas of the country. For example, the rural allowance for doctors which is meant to help attract people to very disadvantaged areas, is paid at the same rate whether the doctor is working in Hermanus, in Mthatha or in Madwaleni. The fact that this allowance has helped to retain doctors in some of the most remote areas shows that even a very blunt instrument can help, and suggests that better targeted allowances could help even more.

16. It is suggested that every local municipality should be categorized according to the dominant settlement pattern and access to amenities in that municipality. Draft categorization should be done by an inter-departmental technical committee that includes, at least, StatsSA, the Municipal Demarcation Board, dplg, Treasury and Health. The final categorization should be gazetted by the Minister of Provincial & Local Government. Each municipality could then be placed into one of the following categories:
    - **Metropolitan area**: Metropolitan municipality.
    - **Other urban area**: Local municipality that includes a city or large town and has mostly tarred roads, mostly piped water and flush sanitation, and a wide choice of services.
    - **Close rural area**: Local municipality that has small towns, > 50% of people live within 5 km of a tarred road, most have piped water but a limited choice of services within that local municipality
    - **Deep rural area**: Local municipality that has small towns and/or old “resettlement areas”, > 50% of people live more than 5km from a tarred road, > 25% of people use water from streams, rivers, dams or rainwater tanks and people have a very limited choice of services within that municipality.

17. For most purposes, people living in the first two types of area would be classified as “urban” and those in the latter two as “rural”. For certain purposes however, such as the level of rural allowance, a distinction could be made between “close rural” and “deep rural”.

18. Most municipalities could easily be classified in to one of these four categories. There will be some debate about a few of them and conditions will change over time with economic and infrastructure development, but the advantages of an accepted classification for all areas would be

considerable. It is not desirable to re-classify an area every few years because this makes comparisons difficult over time, and so it would be best to accept that the initial classification will apply for at least ten years.

CURRENT SITUATION

19. The situation in each of the 13 rural nodes is well described in the 2002 StatsSA publication Measuring Rural Development, in the reports on each node written in November 2004 by the facilitators in the Rural DHS Project (available on the Department of Health and Health System Trust websites *www.health.gov.za* and *www.hst.org.za*) and in various ISRDP reports available from dplg.

20. Other useful information is available in the District Health Information System (DHIS) and in reports on Health Financing produced by the Department of Health and/or by the Health Economics Unit at UCT.

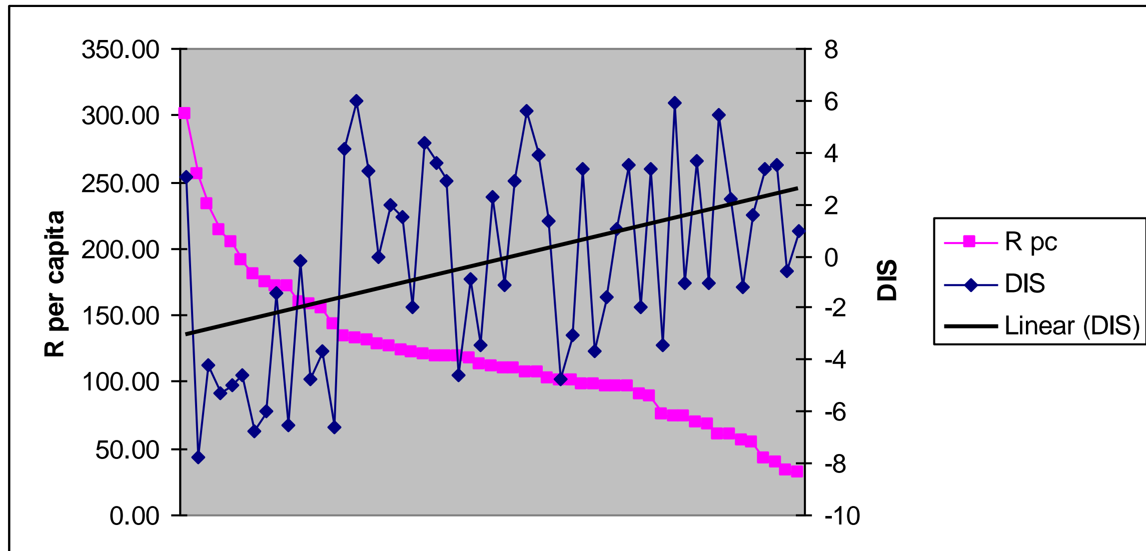
21. The depth of poverty in the rural areas is illustrated by three indicators extracted from the StatsSA report. These indicators in Table 1 are average values across the district. Some communities are much worse off than even these values suggest.

Table 1: Indicators of Poverty in the ISRDP nodes in 2001

Province	Rural Node	Unemployment (expanded)	No hygienic sanitation	No access to safe water
		% people 15-65 yrs	% households	% households
E Cape	Alfred Nzo	50	98	67
	Chris Hani	40	78	54
	OR Tambo	52	92	87
	Ukahlamba	48	85	62
Free State	Thabo Mofutsanyane	43	58	4
KZN	Ugu	49	70	64
	Umkhanyakude	53	84	78
	Umzinyathi	62	81	69
	Zululand	54	70	60
Limpopo & Mpumalanga	Bohlabelo	69	92	33
	Sekhukhune	65	90	60
N Cape & N West	Kgalagadi	53	63	42
W Cape	Central Karoo	44	20	3
South Africa	National Average	37	38	

22. Figure 1 (diagram 5.1) is taken from a July 2003 paper by Thomas et al and shows that the most deprived districts (those with highest deprivation indices) have the lowest per capita expenditure on PHC services. In other words, those with the greatest needs have the least spent on their PHC services.

Figure 1 (Diagram 5.1): Financing per capita vs. Deprivation across health districts in South Africa 2001/02



Key: DIS is deprivation index score and Linear (DIS) is a linear trend line for the DIS.

TEN STRATEGIES TO ACHIEVE THE GOALS IDENTIFIED

23. **Develop an agreed definition of “rural”**

   a. The National Department of Health (NDoH) will convene a task team with other relevant government departments to develop proposals for a definition of “rural” that is robust, simple and clear. Once consensus is reached at a technical level, this definition will then be presented to the relevant Ministers for a policy decision. Once approved, a technical committee can recommend a classification for each local and metropolitan municipality and the Minister of Provincial & Local Government can be requested to gazette his decisions.

24. **Make rural areas more visible**

    a. Specific efforts will be made to ensure that health service managers, the media and the general public are more aware of what happens in rural areas. The good work done by dedicated staff, and the advantages of rural life, must be made known and must be talked about, as well as the problems.

    b. Monitoring and evaluation at district, provincial and national levels of all indicators in the District Health Information System (DHIS), feedback to facility, sub-district and municipal managers, and public recognition where services are doing well, will all help to make rural areas more visible and more attractive to staff.

25. **Mobilize financial and other non-human resources**

    a. The national and provincial budgets and the Division of Revenue Act (DORA) adopted in February 2006 include some very positive potential benefits for rural areas. Municipal health services are now listed in the DORA as one of the "basic" services that must be provided (by district municipalities) from their "equitable share", and additional funds have been provided for this. At the same time, provinces have allocated significant additional funds to personal PHC services in the financial years 2006/07 to 2008/09. The challenge is to ensure that these additional funds for MHS and for personal PHC really benefit and transform services in rural areas.

    b. The package of PHC services that should be accessible to every uninsured person in South Africa will be reviewed and revised.

    c. Calculations will be done of the funds needed per capita to provide this package of PHC services and efforts will be made to ensure sufficient allocations, by provinces and muncipalities, <u>equitably to each health district</u>. National and provincial treasuries will have a vital role to play in these processes. Good quality data from the DHIS and from District Health Expenditure Reviews (DHERs) will also assist in motivating for additional resources for rural health services.

    d. The largest portion of any district health budget goes to personnel costs. Also, the "capacity to absorb" and use funds well depends on a complex set of factors. For these reasons, budget allocations will be linked to efforts to improve recruitment and retention of skilled staff, and to efforts to measure and improve "capacity to absorb" funds in the district.

e. Other resources that will be mobilized to improve rural health and to promote rural development will include funds and (where possible) labour intensive methods to improve roads and public transport, water supplies, electricity and sanitation. Local agricultural projects will be supported to improve nutrition and to promote local economic activity.

f. Policies will be co-ordinated and closer ties will be forged at local, district and provincial levels between all those responsible for health, education and social development services.

26. **Train, recruit & retain Human Resources**

a. Section 33(2) of the National Health Act requires that "each health district develops and implements a district human resource plan in accordance with national guidelines …" A method for preparing a district human resource (HR) plan in a rural area, based on the actual workload at different PHC facilities, has been developed and will be incorporated into national guidelines. Similar work will be done to facilitate HR planning for district hospitals. In time, each district HR plan will include career planning and management support, and a performance appraisal system for managers.

b. Each district HR plan must fit within the national HR framework and policies, and within the relevant provincial plans, but there will be room to accommodate local conditions and priorities. Local innovation and local initiatives will be encouraged.

c. Training in rural areas will be strongly encouraged. Trainees will be recruited from rural areas for all categories of health professionals. More men will be recruited as professional and enrolled nurses and as enrolled nursing assistants. Clinical assistants and other mid-level workers will be trained, and wherever possible trainees will be recruited locally, training teams will conduct courses in rural areas, there will be an emphasis on building teams, and distance education and in-service training will be supported.

d. Training of generalist Community Health Workers or Community Care Givers will be accelerated. They will mostly be employed by Non Profit Organizations, often with funding from provinces. They will be encouraged to set up health posts (often a room in a house) where they can be contacted by community members and/or by the health services, and they will visit people in their homes.

e. Specific recruitment and retention strategies will be developed. These will include the refinement of rural allowances and their

extension to other categories of health professionals. Policies on study leave, special leave to attend conferences and other policies will be developed and implemented to benefit staff in rural areas even more than their urban counterparts.

27. **Provide appropriate supervision & management support**

   a. Provinces will prioritise advertising and filling management posts in rural areas and will aim to have less than 5% of such posts occupied by people in acting positions.

   b. Teams of clinic supervisors will be appointed in each sub-district, with one supervisor responsible full time for a group of clinics +/- a CHC. Every fixed PHC facility will be visited at least once a month by a supervisor who will provide both supervision and support, using the Clinic Supervisor's Manual. These visits and any problems identified will be recorded and appropriate actions and improvements will be monitored. The supervisors will be part of sub-district management teams, and managers of priority programmes will be encouraged to support and work through them.

   c. Transport for planned visits by clinic supervisors is essential and will take priority over the need for transport to take managers to meetings called at national, provincial or district offices.

   d. Equally important as support to PHC facilities will be support to district hospitals. Appropriate supervisors from provincial or district offices will visit each district hospital at least once a month to help solve problems and build well functioning hospital management teams. These teams will be encouraged to use the Guidebook for District Hospital Managers, and managers will be trained and mentored.

   e. Specific orientation and support will also be provided for community service professionals.

   f. Each province will also have a specific plan of how it will intervene to support a rural hospital or PHC facility whose services are threatened with crisis by sudden illness or loss of staff.

28. **Develop support systems**

   a. A range of support systems will be strengthened to facilitate service delivery in rural areas. These will include:
      i. Communication systems: verbal, written and electronic;

ii. Two way referral systems between clinics, GPs and hospitals;
iii. Transport systems for emergencies, planned patient transport, supervision, management and staff transport, and transport of laboratory specimens, medicines and other supplies;
iv. Community support systems including clinic committees, hospital boards and District Health Councils
v. HR, procurement and general admin support systems at district and sub-district levels.
vi. Information Systems, particularly the DHIS

29. Focus on priority programmes

a. Although all services in the PHC package will be provided, there will be an emphasis on national priorities, including achieving the Millennium Development Goals (MDGs) adopted by the United Nations.

b. National priority programmes include:
   i. TB (<u>the</u> top priority for 2006 – 2009)
   ii. Malaria (where relevant)
   iii. HIV & AIDS & STI
   iv. IMCI (including immunization)
   v. Reproductive health (including maternal mortality)
   vi. Health promotion (especially on diseases of lifestyle & nutrition)

30. Develop partnerships

a. With communities
b. With NGOs
c. With private providers
d. With faith-based organizations

31. Mobilize Academic & Training Institutions

a. Academic and training institutions must become more involved in on-going training and education in rural areas where their graduates are expected to work. Academic complexes must include facilities in rural areas as part of their academic teaching platform.

b. More academics need to understand the challenges, and rewards, of service provision in remote rural areas. They must tailor their basic teaching to take account of those realities, must themselves do and encourage research in such areas, and must develop appropriate distance learning modules and support systems for

health professionals in those areas. E-mail tutorials, telemedicine and tele-education are tools that can be used much more widely than they are at present.

c. Those who fund students at academic and training institutions, including national and provincial departments, must insist that the training is appropriate for service delivery in the public sector in South Africa.

32. Monitor & Evaluate

a. The main tools for monitoring the performance of district level services will be the monthly and quarterly reports. Data are submitted monthly into the District Health Information System (DHIS) and from this the standard indicators of the Minimum Indicator Data Set are calculated. These will be reviewed monthly in every sub-district and district, and will be used for the quarterly reports (required in terms of the PFMA) in which indicators are compared with the targets specified in the District Health Plan.

b. The District Health Council will receive and review the quarterly reports and will also liaise closely with managers, clinic committees and community members to help improve service delivery in specific facilities.

c. Patient satisfaction surveys will continue to be done regularly.

RESPONSIBILITIES FOR IMPLEMENTATION

33. Community Responsibilities

a. Be advocates in support of facility, sub-district and district staff
b. Ensure all staff, and especially professionals from outside the community, feel welcome, safe and appreciated
c. Participate in budget reviews and lobby for increased resources where needed
d. Support and serve on clinic committees and hospital boards, ensure feedback to the community, and actively help to plan, monitor and evaluate health services and development
e. Mobilize and raise awareness to encourage community members
    i. To promote their own health and development
    ii. To support health promotion and health campaigns
    iii. To monitor and comment on quality of services
f. Be well informed about health and health services, and ensure that the community has access to relevant information

34. District level Responsibilities (Provinces and District & Metro Municipalities)

a. Ensure adequate budgets and staff for Municipal Health Services
b. Provide high quality personal PHC and municipal health services
c. Build community participation and support
d. Encourage staff to be involved with community concerns & activities
e. Collect good quality data (DHIS, DHERs, etc)
f. Compare sub-districts and facilities with each other
g. Develop District Health Plan, including HR plan, and monitor and report on progress through monthly and quarterly reports
h. Propose a district health budget and present proposals to District Health Council
i. Lobby and push and fight for resources

35. Provincial Responsibilities

a. Establish District Health Councils as specified in National Health Act (S31 & 32) and enact relevant provincial legislation.
b. Subdivide budget programme 2, District Health Services and the constituent sub-programmes per district, and monitor expenditure.
c. A clearly identified District Manager and team responsible for the budget for personal PHC services throughout the district.
d. District manager and team have the authority, within their budget, to advertise and fill posts and to make other relevant decisions.
e. Less than 5% of management posts at district, sub-district and facility levels in rural areas filled by people in an acting capacity.
f. Ensure that each district has an appropriate district health plan, take it seriously when allocating budgets and monitor delivery against each plan.
g. Visit all sub-districts and many facilities, protect managers from *ad hoc* meetings at provincial level, and discuss with local managers the data and information that they have provided about services.
h. Provide good support in HR, procurement, IT, transport etc
i. Move steadily to greater equity in the allocation, between districts, of funds, staff and equipment.

36. Responsibilities of academic & training institutions

a. Academic and training institutions have a vital role to play in supporting rural health services, through appropriate curricular, outreach and decentralization strategies. These include:
   - Ensuring that the proportion of admissions of students of rural origin applicants is at least 25%
   - Appropriate academic literacy and support programmes for disadvantaged students

- Early and continued exposure of students to rural areas during their training
- Community-based educational experiences within the curricula, with academic credit
- Visits to rural facilities by academic staff on a regular basis
- Distance and decentralized post-graduate educational programmes
- Use of telemedicine technology where appropriate
- Nursing colleges in rural areas

37. National Responsibilities

a. Facilitate a widely accepted definition of “rural areas”
b. Help to make rural areas more visible
c. Acknowledge progress and current initiatives
d. Issue District Health Planning guidelines, as well as norms, standards, other guidelines and tools
e. Publish a national HR framework and plan that will assist district and provincial managers to recruit and retain skilled staff
f. Help to increase the financial and other resources available for PHC and for rural areas
g. Support research on how to increase “absorptive capacity” and to ensure that additional resources are used effectively.

LINKAGES WITH OTHER POLICIES & STRATEGIES

- National Health Act 2003
- NEPAD Health Strategy
- Rural Development Framework 1997
- Comprehensive plan for the treatment, care and support of HIV & AIDS
- Urban development strategy
- Rural transport strategy