

RURAL-PROOFING THE PRIMARY HEALTH CARE RE-ENGINEERING STRATEGY

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EXECUTIVE SUMMARY

The Rural Health Advocacy Project (RHAP), the Rural Doctors Association of South Africa (RuDASA), the Wits Centre for Rural Health and KZN Centre for Rural Health strongly support the drive by Government to re-engineer primary health care (PHC). We agree that a strengthened PHC approach within a functional District Health System (DHS) is imperative to improving national health outcomes. It is against this background that we have welcomed the request by the Director-General of Health and the PHC Advisor to the Minister to comment on the PHC Strategy from a rural health care perspective. Whilst fully supporting the overall purpose of the strategy, we argue that certain elements have not adequately taken into account opportunities and challenges related to health care provision in rural areas. In this submission we make a number of recommendations that could enhance the health outcomes of rural citizens and contribute to the realisation of their rights to comprehensive access to health care.

This submission is structured according to the four key steps to improved rural health care identified by the RHAP: rural-friendly policies; equitable and sufficient financing for rural health care; sufficient, well-supported and caring human resources for rural health care; and implementation of policies in effective and efficient rural health care systems.

RHAP GOAL 1: POLICY - NEW AND EXISTING POLICIES ARE RURAL FRIENDLY

1. The criteria for good quality primary health care (PHC) are accepted internationally. **PHC must be person-oriented over time, comprehensive, integrated and well-understood by the consumer as the first-contact point of care.** While we are concerned that there are problems related to healthcare delivery in rural areas (not least human resource shortages and poor management), we argue that each of these four criteria can be well met in rural areas, if there are sufficient and appropriate resources.
2. We firmly agree with the three objectives of the PHC plan:
 - to strengthen the district health system
 - to place greater emphasis on population-based health and outcomes through proactive measures in the community, and
 - to pay greater attention to those factors outside of the health sector that impact on health.At the same time we urge that the **existing PHC strengths be recognised and resourced.** As attention rightly turns to the clinics and communities in an effort to improve PHC, **the role of the district hospital** in rural areas received less attention in the plan, but must be carefully nurtured for its major support role in PHC to date.
3. In paying greater attention to the social determinants of health in a community-based approach, we welcome policy in support of forming PHC outreach teams with Community Health Workers (CHWs). We stress however that **NOT ONLY CHWs BUT ALSO Home based carers need 1) to be increased in number and 2) be employed within the formal health sector.** Should the two

fall under different employers (e.g. government and NGO respectively), then **building their working relationship** that is so vital for delivering assistance in the household, will be more difficult. The **teamwork between the health professionals (at all health facilities) and home-based carers** may also be compromised. Should only one category of community worker be included in the formal team, we believe that **more debate around the scope of practice and the numbers of workers is required**; clinical care in the home for example, may be urgent and time-consuming, distracting from the broader tasks of health promotion and screening.

RHAP GOAL 2: FINANCE - RURAL HEALTH CARE RECEIVES THE FINANCIAL RESOURCES TO PROVIDE A QUALITY, EQUITABLE SERVICE TO RURAL CITIZENS

4. While acknowledging the use of traditional cost-efficiency analyses to decide on PHC interventions, the baseline levels of both health and non-health indicators are very poor in many rural areas. **Health is a condition of social and economic wellbeing. Healthier rural families are better capacitated to work, learn and contribute to society improvement.** Increased investments in rural health care have, therefore, direct and indirect benefits.
5. We agree PHC requires attention in both urban and rural areas. We strongly believe, however, that **the consequences of a rural patient failing to access a quality health care system are often more difficult to rectify than in urban areas.** These consequences are, therefore, more serious and costly to the whole health system in the long run.
6. While agreeing that capacitating PHC is aimed at improving the health and lives of all the uninsured in South Africa, we know that **rural communities historically receive support below the critical level required to achieve its intended impact and sustainability**; special attention to prioritising financial resources for rural PHC is therefore required.

RHAP GOAL 3: HUMAN RESOURCES FOR HEALTH - EVERY RURAL CITIZEN HAS ADEQUATE ACCESS TO CARING, QUALIFIED HEALTH CARE TEAMS

7. Considering the current staff shortages of nurses, doctors and other disciplines, and the inequitable distribution of available HR between rural and urban areas, there is an **urgent need for a comprehensive HRH plan.** This must incorporate strategies for the production, recruitment and retention of the PHC teams and the entire rural health workforce at large. Including a review of the Occupational Specific Dispensation (currently disincentivising rural health professionals) and the rural allowance, this should be addressed with utmost urgency to lay the HRH foundation for the PHC plan to succeed.
8. The planned 1 CHW per 250 households is unlikely to yield enough CHWs in most rural areas. The following variables will contribute to **a formula for calculating the optimum number of CHWs in each sub-district**: baseline health indicators, density of households, topography of area, scope of practice, presence of home-based carers, availability and budget for

public/designated transport, and level of social compact in the area. The impact of these CHWs is also strongly influenced by the effectiveness of their supervision. This needs close attention.

9. We stress that **primary health care is a specialised discipline** in health delivery and training. **Nursing staff must receive specialised training in primary health care** in order to be properly effective. This is especially required in rural health care, where reliance on individual, not collective capability, is more the norm in these isolated and poorly resourced areas.
10. During the period that enrolled nurses are trained as staff nurses (to lead PHC outreach teams), we are concerned that the **training and number of professional nurses to substitute in the interim are all insufficient** for successful PHC outreach in rural areas. Specific mentoring and training will be required for these professional nurses.
11. It is a requirement of the PHC plan that community health centres (CHCs) are staffed with doctors. To achieve this, HR plans must be supported with resources to ensure these **CHCs are direct “extensions” of the district hospital with respect to the supervision, training and social networking of doctors**. Many rural doctors fear isolation and therefore resist placements in remote CHCs, and therefore strategies need to be employed to break this isolation. In rural areas, a critical mass of doctors is essential for the functioning of both district hospitals and the sub-districts they serve, including CHCs.
12. The PHC plan requires training of post-basic pharmacy assistants. The process of staffing facilities with these appropriately trained staff will be slow. **We recommend the use of basic-trained pharmacy assistants to do outreach to CHC and clinics. We recognise the drastic shortage of pharmacy personnel, and we are acutely aware of the need for the multi-disciplinary team to shoulder the responsibilities** collectively, under the guidance of the **available pharmacist**.
13. **The PHC plan will be helped by ensuring the success** of the new Bachelor of Medical Clinical Practice (Clinical Associates or ClinA's) training. Although employed **at district hospitals alone, the ClinA will be important to the successful rollout of the PHC plan**, because they will free up doctors for outreach. Posts must be created for ClinA's at district hospitals. Community service must be a requirement, as for other health professionals. Awareness of their role and function must be actively improved amongst other cadres of health professional, especially since the ClinAs are not, by definition, independent clinicians.

**RHAP GOAL 3: IMPLEMENTATION - POLICIES ARE IMPLEMENTED IN
EFFECTIVE AND EFFICIENT RURAL HEALTH SYSTEMS**

14. Efficient referrals would be hugely cost-saving on the current system, as well as lowering morbidity and mortality. A key objective is to create **a seamless continuum of care** from a patient's home through all levels of care up to tertiary institutions (and in the return direction). The **district health system (DHS) is part of this continuum, not a separate system** because of the renewed focus and attention it now receives. **District-based specialist support teams must not replace outreach by specialists at regional hospitals** to the DHS. The former will facilitate outreach from the regional level. Duplication of specialists (e.g. obstetrician, paediatrician) at district and regional level is not counter-productive, but the fact that few specialists are available

underlines the **important coordinating role of the district-based specialist, namely the family physician (FP)**. Family physicians function as clinicians first and foremost but will play a vital role in the integration and quality of health services within the (sub)district. Collaborating, managing, capacity-building and consulting to the PHC services are all skills required by the FP, who is primarily community-based. Furthermore, some FPs will form part of the District Management Team as being responsible for clinical governance, but they will operate at the coalface of PHC delivery, not at the district office. If district support defined by the use of other specialists predominantly, this will inevitably cause inequity, as fewer rural districts are likely to attract and retain the specialists required, given the shortages.

15. We request that implementation of the PHC plan pays careful attention to the **sensitive dynamic between off-site supervisors and facility management** at all levels of PHC. A facilitative, rather than authoritative, approach should be adopted by both parties during visits. **Trust and teamwork between clinical and non-clinical staff** needs special attention to improve on the current situation.
16. In the interests of community ownership of PHC, we call for **District Health Councils** to be put in place, in accordance with the National Health Act (NHA). Similarly, we call for the **proper functioning of Hospital Boards and Clinic Committees** as per NHA requirement, particularly in support of the Patients Rights Charter in rural areas. **Key sections of the NHA, however, are yet to be promulgated**. This is long-overdue.
17. While supportive of delegating authority for implementation of the PHC budget to the District Management team, this must be coupled with **measures to improve transparency, accountability and consultation on the allocation and use of the finances**.
18. Currently the **District Health Information System (DHIS) is not meeting the requirements for monitoring and evaluation of health care delivery**. Quality and accuracy of information is poor, too much information is collected, and the data is biased towards hospital indicators. Little, if any, management action is taken on any useful information. **Well-functioning community level information systems or surveillance need to be set up**. Community-level data is vital to be able to demonstrate impact.
19. The dynamics of rural health care require a customised approach to patient records and referrals. **Patient-held records, as an aid to continuity of care within the district health system are very useful**. If implementing electronic systems, a parallel strategy to strengthen the continuity of the care/referral pipeline with patient-held records is not counter-productive. Similarly, the NHA requires discharge summaries (from referral hospitals) to be written only if the patient was admitted on referral, but allows mere verbal feedback (via the patient) after an outpatient visit. Relying on clinical feedback via the patient does not work in rural (or urban) areas: we call for mandatory written referral summaries for outpatients, not only for discharged in-patients
20. We note the PHC plan will consider the topic of **administrative support** at a later date. This is urgent, as sub-standard and/or incapacitated administration is often a key barrier to improved health care delivery in rural areas.

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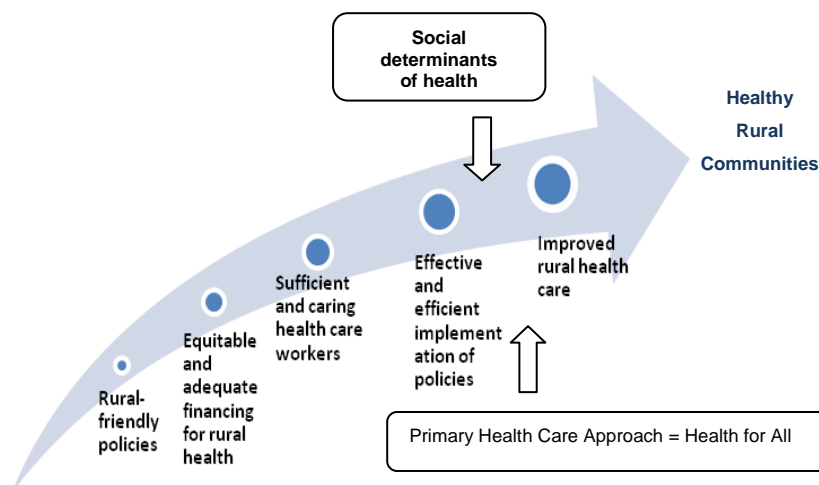
1. INTRODUCTION

The RHAP, RuDASA and Wits Centre for Rural Health strongly support the drive by Government to re-engineer primary health care (PHC). We agree that a strengthened PHC approach within a functional District Health System is imperative to improving national health outcomes. National health outcomes cannot be improved, however, without a strong focus on the rural health care context in any policy-making; given that 43% of the South African population resides in rural areas.

It is against this background that we welcome the request by the Director-General of Health and the PHC Advisor to the Minister to comment on the PHC Strategy from a rural health care perspective. Whilst fully supporting the overall purpose of the strategy, we argue that certain elements have not adequately taken into account opportunities and challenges related to health care provision in rural areas. In this submission we make a number of recommendations that could enhance the health outcomes of rural citizens and contribute to the realisation of their rights to comprehensive access to health care.

Other PHC re-engineering efforts internationally (e.g. Brazil and Thailand) were driven by a rural focus. The PHC drive in Thailand, for example, was underpinned by resourcing health care outside of urban areas, with both facilities and health workers resourced in rural communities¹. In addition, we will do well to remember the international success (Israel, United States, and Cuba) of the South African model of Community-Oriented Primary Care (COPC). A primary health care model originally conceived and implemented in South Africa by Sydney and Emily Kark in the 1940s, COPC implementation was halted by the apartheid government. It was first delivered in rural – significantly not urban - areas of Kwa-Zulu Natal².

The Rural Health Advocacy Project has identified four key steps central to improving health care for rural communities, with the PHC approach as the central starting point. These are:



¹ M.J. Ditton, L. Lehane. Towards realising primary health care for the rural poor in Thailand: health policy in action Available at <http://asiapacific.anu.edu.au/newmandala/wp.../Ditton-and-Lehane-2009.pdf>

² Tollman SM. The Pholela Health Centre--the origins of community-oriented primary health care (COPC). An appreciation of the work of Sidney and Emily Kark. S.Afr Med Journal 1994 Oct;84(10):653-8

- Step 1) **POLICY: New and existing policies are rural-friendly**
- Step 2) **FINANCE: Rural health care receives the financial resources to provide a quality, equitable service to rural citizens**
- Step 3) **HUMAN RESOURCES FOR RURAL HEALTH (HR4RH): Every rural citizen has adequate access to caring, qualified health care teams.**
- Step 4) **IMPLEMENTATION: Policies are implemented in effective and efficient health systems**

Our response to the PHC plan is grouped according to these four steps.

2. POLICY: NEW AND EXISTING POLICIES ARE RURAL FRIENDLY

The PHC plan recommends three main objectives: 1) to strengthen the district health system 2) to place greater emphasis on population-based health and outcomes through proactive measures in the community, and 3) pay greater attention to those factors outside of the health sector that impact on health. The implication is that achieving these with additional resources will lead to good primary health care.

It is important to “rural-proof” this PHC plan, in order to lay the groundwork for improved health outcomes. In this regard, therefore, tackling the straightforward question below will enrich the policy debates.

2.1 How can good primary care be delivered in rural areas?

What is considered as “good” primary care? The recommendations made in the PHC plan are in concert with the famed Alma-Ata Declaration around PHC goals in 1978³. Similarly the four criteria initially proposed by acclaimed PHC-advocate Barbara Starfield are together also a concise version of the Alma Ata Declaration around primary care⁴. These four criteria are:

- **Consumer awareness of first-contact care**
- **Person-oriented care over time**
- **Comprehensive care**
- **Integrated care**

These components of good primary care are written in mission statements of primary health care academies and institutions world-wide, and are discussed below to champion the potential of rural health. Table 1 on the next page lists these criteria of GOOD PHC and provides a summary comparison to **demonstrate the suitability of rural facilities to provide good care - should access and resources be increased**, – and to illustrate that rural PHC is not as problematic as might be believed.

³ Available at www.who.int/hpr/NPH/docs/declaration_almaata.pdf

⁴ B. Starfield, KW. Lemke, R. Herbert, WD. Pavlovich, G. Anderson Comorbidity and the Use of Primary Care and Specialist Care in the Elderly. *Annals of Family Medicine* 2005 May; 3(3):215-22

"GOOD" PHC CRITERIA	Criteria met in RURAL DHS settings?	Criteria met in URBAN DHS settings?	RURAL VS URBAN: SUITABILITY FOR EXTRA PHC RESOURCES
Consumer awareness of first-contact care	HINDERED by high levels of deprivation characterised by illiteracy and little patient advocacy of good PHC, but HELPED by the notion that the DHS is well- established in minds of community. Few and sparse health facilities simplifies community understanding and acceptance of first-contact care, and lowers risk of competing/over-used specialised facilities with referral abuse.	HELPED by easy access, and more informed communities. HINDERING factor: many health care facilities and services, huge demand, less clarity as to the functions of health services, hazy referral routes, confusing catchment areas, and competing/over-used specialised facilities	Rural health consumer does not take access to health care for granted, will respond well to community ownership of PHC process, as well as PHC re-engineering in general.
Person-oriented care over time	HINDERED by poor access to the facilities in remote areas and health professionals, but HELPED by health workers living in/close to communities.	HINDERED when PHC services are silo-ed, uncoordinated and overburdened, services duplicated and divisive, high patient numbers mean continuity of care difficult, easy to treat patient as a number.	While access to health care is the main problem in rural areas, facilities are already suited to holistic, family oriented PHC care at autonomous "one-stop" shop.
Comprehensive care	HINDERED by few health professionals and access difficulties for patients but HELPED by having fewer silo-ed programmes and fewer obstacles to referral abuse result in team-oriented "jack-of-all-trades" health care providers.	HINDERED when huge patient burden leads to short consultations, pressure to "push the queue" at facility, culture of low threshold for referral because specialists available, HELPED when repeat visits easy for more comprehensive care.	Rural health professionals are experienced in comprehensive clinical management and leadership, community interaction, multi-disciplinary work, and task sharing.
Integrated care	HINDERED by delayed and ineffective referrals, poor communication between facilities, poor EMS service, poor feedback and discharge summaries from higher facilities.	HINDERED when facilities overrun at all levels of facility, especially tertiary, with both urban and rural referrals.	Urban referral centres are over-burdened. Capacitating rural care will reduce overall numbers of referrals significantly.

Table 1: Suitability of rural health care for increased resource allocation

The argument for access to comprehensive, primary health care in rural areas goes beyond meeting the health rights of communities, and meeting the national goals of improving health outcomes. It is also more cost-effective:

There are various factors impeding rural communities from accessing the first level of care timeously, and as a result rural patients tend to present at a later stage in the course of disease/illness. This leads to

- 1) more than cost-effective numbers of patients being referred to higher levels of care,
- 2) patients self-presenting to the more complex, specialised level of care – often in urban setting.

In addition, when confronted with a failing health system, impoverished rural patients already facing great difficulty accessing health care, may give up, as research has shown⁵. This suggests that the consequences of a failing health system, such as in the case of inefficient referrals, are not as easily rectified as in urban areas.

These factors represent significant cost drivers to the SA health system as a whole and justify allocating a larger proportion of the available resources to avoid such failures.

2.2 District Health System

We agree the district model is the vehicle by which all primary health care must be delivered. As table 1 suggests, the district health system in rural areas is well suited for better health returns on resources invested in primary health care. This is a *potential* advantage only however, and depends on detailed localised operational plans, not the least HRH plans. The PHC plan is not being introduced in a vacuum, so everyone involved must be aware of current issues that will impact the likelihood of success.

2.2.1 Current district hospital (DH) “hub”

Rural patients may travel to a DH or a community health centre (CHC) to receive primary care, and not to the clinics. This is especially the case when drugs and consumables are not available at clinics, where referrals up and down the health facility ladder are coordinated by the DH team, where services are historically doctor-led from DH-level (e.g. antiretroviral ARV initiation) and where geographically a district hospital is more accessible than the CHC. In addition, medical doctors historically favour employment at the district hospitals over the CHCs and clinics. A bypass fee at DH level, to “punish” patients who came to the hospital without referral cannot be charged in the event of poor access to comprehensive PHC services locally, with insufficient drugs and human resource shortages.

⁵ See for instance: Goudge J, Gilson L, Russel S, Gumede T, Mills S. Affordability, availability and acceptability barriers to health care for the chronically ill: Longitudinal case studies from South Africa. *BMC Health*

Obstetric care is also a case in point. There are many rural sub-districts in which the DH currently hosts by far the greater proportion of deliveries every month. Attempts to decrease maternal and child mortality have included DH-led strategies to greatly strengthen adherence to Basic Antenatal Care guidelines, establishment of high-risk clinics at DH level, and the addition of a DH Waiting Mothers Area where expectant mothers spend a few days awaiting delivery. **Capacitating the PHC system must maintain the strong working relationships and teamwork between all the health facilities in the district.** Dependent on the particular district, there is therefore merit in maintaining the role of the DH as the significant player in rural health. **While the CHC/clinic link is very much the “health care delivery hub”, the DH must be seen as the operational “support hub” for that delivery.** Yes, the district management team (DMT) must provide the overall management, policy and budget direction, but must be wary of undermining the role of the DH in the DH-CHC-clinic-community team. Both the DMT, the new PHC managers (former programme managers) and the high level support teams must play as much of a facilitative role as possible, and be wary of too much of an authoritative role.

In addition, the role that the DH team plays in facilitating the involvement of specialist teams at PHC level is not to be under-estimated. **Including the doctor outreach, many other DH roles will have a PHC outreach function (mental health, dentistry, rehabilitation). There are currently many parallel outreach initiatives** initiated by DH management that will need to be coordinated with management at sub-district and district level. Moreover, the DH can coordinate the support by the secondary and tertiary level facilities of PHC. The latter have, after all, catchment areas for which they are responsible, notwithstanding any overlap of responsibility with that of the district hospital. **Good quality referral protocols, coupled with outreach to DH level, should be the result.**

2.2.2 The importance of Home Carers (Home based workers) and Community Health Workers (CHWs) in the health care system.

One simple observation is that there is far more treatment than prevention happening in the health care system currently. Rectifying this by increasing the prevention efforts will be the responsibility of the PHC outreach teams, most notably the **Community Health Workers**. Helping to deal with the current situation of a system overwhelmed with demand for treatment and quality follow-up, however, is the all-important **Home Carer**. Effective supervision of these health workers is key to the success of the PHC plan.

Home Carers

Of significance is the daily battle of public health professionals who experience 20% of their patients taking up 80% of their time! Much of this time is dealt with administrative issues to try and ensure proper follow-up and referral in pursuit of good continuity of care for their patients. This fails time and time again in the public health sector, but in particular in rural health settings:

1. **Care and treatment is poorly supported with respect to follow-up and continuity of care, partly owing to difficulty of access and/or poor referral systems.** Such poor follow-up negates the benefit of any intervention, be it the many outpatient examples, or the fewer but very costly admissions (especially if surgery is involved). With increased community access to primary care, an early consequence will most certainly be a disproportionate absolute number of “treatment failures”, unless after care and follow-up is ensured by the Home Carer as an integral part of the PHC team.
2. Follow-up and aftercare must happen in the community (preferably at patients’ home) rather than the facility as much as possible, owing to the difficulties with access to the facilities, particularly for ill patients. If not, such important facility efficiency indicators such as average length of stay (ALOS), cost per patient day equivalent and bed utilisation rate (BUR) change to unacceptable levels. The crucial link between home and facility is illustrated in the management of mental illness. This is best managed by understanding the functionality of a patient over time. **The Home Carer (under supervision of the nurse) provides this more time-intensive interaction with the family at the home, observing the patient during repeated visits, so allowing for a seamless and informed referral between home and facility when required. Other examples are provided in the illustrative comparison between CHW and Home Carer worker scope of practice in APPENDIX 1.**
3. Were these Home Carers employed outside the formal sector, there is a risk that they will be involved only at a late stage in the course of a patient’s illness; unless the risk is recognised and managed through seamless integration of the services of the Home Carer into the PHC team. This would ensure, for instance, that palliative care is provided to a patient with a life-threatening disease upon discharge from hospital, and not only closer to end-of-life care which is outdated and wrong.
4. Crucial areas of follow-up care such as post-surgery, home rehabilitation or treatment of pressure sores need particular attention. Thanks to the Home Carer, a bed-ridden patient can be discharged from hospital and cared for by his/her family in bed at home, and will on occasion only come in to hospital for respite care. Without this Home Carer the hospital-based health care worker may have no choice but to keep the patient in hospital. This “community bed” provides huge cost savings to the hospital.
5. Lastly, we believe that the critical role played by Home Carers in the Health System and their challenging working conditions, demand fair pay, proper training and supervision. They must be recognised through their formal adoption into the health system, rather than being treated as a by-product.

It is vital that the Home Carer be as integrated a member of the health care team as the doctor or nurse, to best optimize their role in cross-cutting across the home-clinic-CHC-DH axis. This axis will be far stronger for the involvement of the Home Carer.

Community Health Workers (CHW)

The correct mix of CHW duties is listed in the PHC plan on page 12: screening/assessment/referral, education, psychosocial support and basic home treatment within households, as well as assessments/campaigns/screening within the community, schools and early learning centres. They have a big task, and are vital to the future of the health system in South Africa. Of the top-ranked risk factors accounting for SA's burden of disease, simple but repeated education and awareness campaigns reduce the risk of the entire top four: Unsafe sex, interpersonal violence, alcohol intake and tobacco smoking⁶. Community Health Workers can effectively provide this intervention.

We are in agreement that community health workers be employed formally within the state health system. They are the vital tool to improved health promotion and education. Care must be taken to avoid treating this cadre of health worker as the panacea of problems in primary health care without the accompanying resources required to be effective. More attention is required to establish the extent of their role in the household and communities. There are a number of factors to consider in rural areas:

1. Areas to cover between households are often vast;
2. Topography and the conditions of the roads may make movement between households difficult
3. Households are sometimes grouped together in villages, otherwise they may be scattered over large areas.
4. The number of people in occupying one household in rural areas is under-estimated at 4 in the PHC plan⁷.
5. Far more use of mobile clinics can be realised in the rural areas where the household density is low, as long as used for the specific intention of community outreach, and not supervisory and administrative visits.
6. Rural individuals are busy. Finding people at home at the time of the visit is far from guaranteed, and prior communication by mobile phone is difficult in poor, non-electrified areas.
7. Considerable time spent influencing health-seeking behaviour within the household (members can often be at odds) is often underestimated by policy makers
8. Basic treatment needs to be kept to a minimum if health promotion is to be prioritised, but the former is often household members' primary concern during a visit by the CHW. **CHWs have to have close partnerships with Home Carers to whom they can refer such concerns.**
9. Monitoring of CHW activities by nursing staff within the PHC team will be difficult when the CHW is based in the community; he/she has to be helped with good transport between community and clinic. That on-site training is preferred in the PHC plan is welcomed, but again this training and supervision will need to be properly resourced in order to be constructive and effective.
10. PHC outreach teams might not be limited to a minimum number of households in a geographical sense. Intermittent targeting of community gatherings (social grant paydays for

⁶ Rispel L. et al. Revitalising PHC in South Africa: Review of primary health care package, norms and standards, Centre for Health Policy, University of Witwatersrand; p 58

⁷ Average figure from SA General Household Survey 2009, www.statssa.gov.za/publications/P0318/P0318June2009.pdf

doing screening, schools for doing education) is not ideal and runs the risk of being politicised. Outreach teams must rather be responsible for a designated community. Unless properly resourced, PHC outreach will resort to targeting of community gatherings; their actions will be ineffective and only measured with considerable difficulty.

The PHC plan refers to the KwaZulu Natal Premier's flagship projects in support of its proposals, but these projects have norms of 1 CHW per only 50 households in the 50 poorest wards, and only 80 in more affluent urban wards⁸. Furthermore, the PHC plan references the Thailand model, but there Village Health Communicators are each responsible for only 8-15 households each⁹. **Rural communities, for their widespread distribution, difficult topography and significantly widespread involvement of each CHW, require a similar low number of households per CHW.**

3. FINANCE: RURAL HEALTH CARE RECEIVES THE FINANCIAL RESOURCES TO PROVIDE A QUALITY, EQUITABLE SERVICE TO RURAL CITIZENS

It is clear that rural health in SA is in sub-optimal shape. Were special rural support to be universally accepted as "the right thing to do" on the grounds of equity principles, then the drive to rural and national health could proceed unchecked. It is also clear, however, that primary health care is not in the best shape anywhere in South Africa, rural or urban. An objective look at the benefits of financing resources for rural health care is therefore required, which raises the following question.

Where in the traditional efficiency and equity debates are there sound arguments for allocating more resources to rural health?

Resourcing rural - the logic using efficiency principles

The PHC plan references the call of the National Department of Health to tackle the quadruple burden of disease, namely HIV/AIDS and TB, High Maternal and Child mortality, Non-communicating diseases and Violence and Injury. Cost-efficiency analysis focuses on costing specific interventions to combat these most significant contributors to the burden of disease, with the additional comparison against the corresponding increase in disability-adjusted life years (DALYs). The emotive and highly-problematic "burdens" are used as a starting point, while the goal is reduced prevalence and improved health outcomes. Indeed, rural communities have a high burden of these diseases, and desperately need improved health outcomes. At first glance, therefore, these reasons to use a cost efficiency analysis – and not consider rural communities as unique – are apparently credible.

⁸ Available at www.kwazulunatal.gov.za/.../flagship.../SocialSectorFlagshipProgrammeDocument.pdf

⁹ MJ. Ditton, L. Lehane. Towards realising primary health care for the rural poor in Thailand: health policy in action_Available at <http://asiapacific.anu.edu.au/newmandala/wp.../Ditton-and-Lehane-2009.pdf>

However, this process does not take into account the quality and efficiency of the health system in which the interventions are implemented. Nor are health systems static entities; they represent ongoing interactions between unique communities and health care workers around issues of access to ongoing education around health promotion, consistent quality care and treatment, and continuity of integrated care. Such interactions are more difficult and less efficient in the rural setting and therefore require proportionately more assistance. The PHC plan **warns against a one-size fits all approach to primary health care**; and this warning provides the rationale for rural-proofing. **The rural health care context is unique and is deserving of extra resources.**

To succeed in rural health care delivery requires a modification of the cost-efficiency approach. The focus must shift to a cost-benefit analysis, rather than taking a look at cost effectiveness on its own. It is well-established that the rural populations are worse off on a “wellness count” (including health, income, education) than urban counterparts¹⁰. Indirect benefits of extra PHC resources such as improving childrens’ learning capacity in primary school (for reaching developmental milestones) may occur in both rural and urban areas, but the poorest schools - and the most vulnerable children - are in rural areas¹¹. Direct non-health benefits such as time and money saved thanks to improved access to primary health care (notorious in rural areas) are certainly also benefits to warrant the cost.

The urban health care system is unbreakably linked to its “local” rural health care system, mostly through the referral pipeline. Moreover on a national level, it can be argued that a greater proportion of “first contacts” with the government health system should happen within rural primary care. 43% of the SA population live in rural communities to start with¹², and the urban migration is burdening the urban system thanks to the lack of rural development. Individuals have been pulled to the cities in the hope of jobs, but they have also been pushed away by lack of rural development at home. Health care is one vital element of rural development; its success facilitating development in other areas.

Resourcing rural - the logic using the equity principles

A common argument for favouring marginalised groups, such as those in rural areas, centres on equity demands. Section 27 of the SA Constitution guarantees the right of everyone to health care, food, water and security¹³. Many people in rural areas are certainly not enjoying realisation of this health right. Addressing equity and access issues is often the theme behind credible international

¹⁰ SAHRC. Public Inquiry: Access to health services- 2007. The most deprived districts in SA are rural. Poverty has long been recognised as a major cause of ill-health and as a barrier to accessing health care services, and the issue of poverty was raised repeatedly during the public hearings as an impediment to accessing health care services in South Africa.

¹¹ Snap Survey 2010. Numbers calculated from table of list of public schools and number of learners in Concept Document: School Health Screening. Joint Initiative DoE and DoH. Compiled by the School Health Screening Task Team. Unpublished preliminary data. November 2010 mzimba.se@dbe.gov. 9956 schools classified in poorest quintile, of which 7948 (80%) are in rural areas.

¹² Stats SA, Migration and Urbanisation in SA, 2006Stats are based on Census 2001, which represent the latest official Stats SA statistics on rural population. Current definition used by Stats SA to refer to rural: “Proportion of population living in a non-urban environment”

¹³ SA Constitution 1996 www.info.gov.za/documents/constitution

consensus on health care reforms, implying the need to focus on the more remote and rural communities with poor access to primary health care¹⁴.

Providing equal treatment for equal needs is important. A rural-based and an urban-based man with a femur fracture present to a health facility; each has the right to the same health outcome, irrespective of the cost. Unequal treatments for unequal need can also be argued -typically in support of expensive treatments such as transplant patients who have the greatest to gain for the intervention. The logic supporting this unequal treatment equally holds, however, when considering the uneducated, unemployed, poor rural woman. She is the most “sick” in social determinants of health, and often biological health, and is therefore justifiably favoured with respect to resource allocation to her health care.

Experience suggests the Department of Health recognises the ethical duty to do everything possible to help those in immediate life-threatening distress, irrespective of how costly or how small the benefit is (known as the rule of rescue by Ethics scholars). This is the equivalent to giving first preference to *the most* severe health conditions, notably emergency care for life-threatening illnesses. This ethical (but often most visible and political) response is most costly in the rural remote areas, where helicopter/fixed wing aircraft are often required. **The cost-savings of preventing this emergency evacuation is immediately evident when capacitating rural health care with extra resources up-stream during primary care, so reducing the likelihood of such life-threatening presentations later.**

4. HUMAN RESOURCES FOR RURAL HEALTH – EVERY RURAL CITIZEN HAS ADEQUATE ACCESS TO CARING, QUALIFIED HEALTH CARE TEAMS

Within the health system, the vital ingredient to success is a critical staffing level and teamwork. These are nowhere more relevant than in remote rural settings. The resignation of one or two doctors, a single professional nurse at a clinic, and/or a single physiotherapist can decimate a small team at a rural facility, just as one “bad egg” (individual or relationship) can have a serious negative impact on productivity and morale of the small team. **Each rural district needs a “damage-control” strategy to initiate in the event of resignations.** Extra resources must be available to support it, including a ring-fenced budget to use in paying additional health professionals to urgently cover for these resignations.

¹⁴ The World Health Report 2008 – Primary Health Care: Now More Than Ever calls for “reforms that ensure that health systems contribute to health equity, social justice and the end of exclusion, primarily by moving towards universal access and social health protection”

4.1 *Medical Practitioners on outreach*

The PHC plan acknowledges that the scarcity of doctors in rural areas will impact the delivery of support services for improved PHC. Contracting part-time GPs in these areas is offered as a solution. **We agree there is evidence supporting the value and importance of GP involvement¹⁵, but it is often very impractical to engage GPs at rural facilities, not least for the time it takes to travel to the facility.** Most rural communities do not have a GP working therein. Working overtime at a DH or CHC is practically very difficult for a GP if the facility is very remote.

Innovative strategies are required for the recruitment and retention of doctors in rural areas. With the implementation of the PHC plan, placing doctors at CHCs will be important to the success of the plan. Doctors are, however, in short supply for DHs, let alone CHCs. According to the PHC plan, doctors will be responsible for quality and clinical governance at CHCs. Yet, to date, most efforts of CHCs to recruit/retain doctors to the rural facility to work independently of the local DH have been largely unsuccessful. Rural CHC posts are generally unpopular due to perceived isolation, little senior support, and stagnation in terms of academic and practical learning. The rural allowance and recent OSD changes are both recognised as less successful in incentivising doctors to work in rural areas than the equivalent for nursing staff. On both a functional and marketing level, rural facility managers must develop the DH-CHC link into a single unit of operation. HR strategies must include the objective of providing a full service at a rural CHC over time.

Practically, **it is vital that the DH and CHC are seen as a unit**, especially since recruitment of couples (not necessarily both health professionals) is best for retention, but often only one doctor is required at a CHC. Lateral thinking is required to identify employment options for a non-health partner. Such opportunities are often linked to health facilities, but more often at DH level. Furthermore, quality of life is enhanced by social interaction, which will more often be available in the vicinity of the DH (especially required by foreign and “out of town” doctors). A CHC doctor will increase involvement at CHC over time (anything from within 6 months or over 2/3 yrs depending on sub-district). Ultimately, only a functioning DH-CHC unit will allow a doctor to be employed directly to a CHC-based post. The sub-district Family Physician (FP) and the DH clinical leadership (FP and/or Clinical Operations Officer) will play a critical role in supporting this step-wise capacity building at the CHC.

Special arrangements and special budgets must be provided for where the CHC is a long distance from the DH.

The DoH at national and provincial level should require each DMT to devise and implement HR strategies (with crucial input from senior clinicians) rather than reactive advertising of posts alone.

¹⁵ JM Tumbo, JFM Hugo, ID Couper The involvement of private general practitioners in visiting primary healthcare clinics. South African Family Practice, August 2006; Vol 48, No 7.

4.2 Nursing staff on outreach

The culture of outreach into the communities is not wholly inculcated in the minds of all the nursing staff, as it is far from entrenched in the minds of medical practitioners. A professional nurse can receive additional training in community health nursing, but other options of midwifery and psychiatry are more popular and practical at facility level. A definite HR and training strategy to ensure motivated individuals is therefore required, and the formation of a new cadre of nurse, the staff nurse goes, a long way to assist in this objective. That their training will establish their role in outreach and their management of CHWs is vital. There are rural health facilities that have a nursing college attached; these provide an important source of human resource as the students provide supervised care for patients as part of their training.

The main HR problem in implementing the PHC plan in rural area is finding extra professional nurses to work in rural areas to provide for the PHC outreach rollout over a 3-yr period to “cover” while staff nurse training is done. Over 20 000 are required for the clinics alone, and few want to come to rural areas. Enrolled nurses are also in short supply nationally¹⁶ and will favour posts in urban areas once trained as staff nurses. Occupational Specific Dispensation (OSD) does incentivise occupying a PHC nursing post over a general nursing post¹⁷, but the PHC plan is quiet on reviewing the OSD to incentivise rural nursing staff (as needs to happen with ALL categories of rural health professional). To further complicate this transition period, the standard training for nurses currently does not include training in primary care, and will need to be changed accordingly.

A solution may be to carve the catchment area into smaller defined populations and targeting each sequentially. On an administrative level, districts are often too big and unmanageable, but the PHC outreach team targeting villages sequentially on the ground may be necessary. This can provide for both community health awareness and a village diagnosis in broad terms, as well as helping secure access to further health care in discussions with the community members. Starting in a second geographical section may mean less ongoing attention in the first, and is far from ideal.

It is surprising that the primary health care nurse is regarded as part of the specialist support team, rather than an integral member of the PHC (outreach) team itself. Having this PHC specialist away from the coal face, suggests primary care is simple enough to merely shift responsibility to lower level professionals, which is not the case. Furthermore, the PHC plan implies that professional nurses without additional training can simply take up the key role in PHC teams, whereas their current training does not equip them for this; again there is the implication that primary care is easy and can be done by anyone. Professional nurses taking up these roles will need specific orientation and training to equip them, as well as ongoing mentoring and support, because their contribution is pivotal to the success of the plan.

¹⁶ E. Daviaud & M. Chopra. How much is not enough? Human resources requirements for primary health care: a case study from South Africa. Bulletin of the World Health Organization January 2008; 86 (1) www.who.int/bulletin/volumes/86/1/07-042283.pdf

¹⁷ Implementation of Occupational Specific Dispensation (OSD's) for the occupations Professional Nurse, Staff Nurse and nursing Assistant in the public service www.dpsa.gov.za/r_documents.asp

4.3 Community Health Workers (CHWs) and Home-Based Carers

The rural factors influencing HR issues around CHWs and Home-based carers have been detailed previously in this document. **The total of 41440 CHWs proposed in the PHC plan is too few.** The current estimate of Home Carers needed for the uninsured population is 20710, which equates to half the expected numbers of CHWs. This approximates to just short of 5 HBC and 10 CHWs per ward respectively. 10 CHWs per ward may be sufficient but only if average duration of visit is short and their scope of practice is limited. **5 Home Carers per ward is worryingly small.** That Home Carers are not seamlessly integrated into the pipeline of health care as formal employees of the Department of Health (DoH), is as much of a problem. **The alternative of employment within an NGO or equivalent is unavailable or under-funded in some of the more rural areas.**

It is acknowledged earlier in this document that the merit of a households/health worker measurement in deciding numbers of CHWs (and Home Carers) is questionable. It is therefore proposed that a formula is devised to calculate the optimum number of CHWs as a multiple of the number agreed for urban areas. This formula, provided in table 2, can include weighted variables for each area, to be used as a guide to equitable resource allocation:

Formula for allocation of CHWs to designated area in rural communities	
Baseline health indicators (more CHWs if poor)	Presence of home-based carers (Fewer CHWs if present, as scope of practice is less)
Density of households (more CHWs if sparse)	Availability of public transport (fewer CHWs if good and budget available)
Topography of area (more CHWs if patient access to health care is difficult)	Presence/absence of designated CHW transport (fewer CHWs if available)
Scope of practice (fewer CHWs if scope limited to health promotion)	Level of social compact in area (fewer CHWs if level of cohesion/motivation in society high)

Table 2: Variables in formula for allocation of CHWS to rural areas

Without the Home Carers, the PHC salary bill (85% of total bill) is estimated at 10% of the public health budget (page 29 PHC plan). Significantly, the budgets and responsibility need to be decentralised, as in other successful models of PHC. The Brazilian National Health Commission, for example, decentralises budgets and responsibility to PHC level in “municipios” (municipalities) for local health management¹⁸.

The majority of Home Carers and CHWs are women; to attract more men is vital. The suggestion is that formal employment within the health sector, with the accompanying job security, will be an incentive to attract men and so address the gender imbalance. That the majority group of CHWs will

¹⁸ C. Collins, J. Araujo, J Barbosa. Decentralising the health sector: Issues in Brazil. Health Policy, Volume 52, Issue2, June 2000, Pages 113-127

remain women is likely, however, and their role is also important in using primary care to empower women in otherwise patriarchal societies¹⁹.

The traditional healers are left out of the PHC plan. In rural areas, their role is vital and appreciated by the community. There is certainly a role as community health workers that the traditional healers can provide, but at least engagement with the Councils of Traditional Leaders on their important role in this extended PHC platform is vital.

4.4 *Specialist support teams*

Specialist teams are important at district level for direct support of the DHS, as well as facilitating the involvement of regional specialists on outreach to district health facilities. The District Family Physician is the key to facilitating the teamwork between DHS staff and the specialist teams, be they district or regionally based²⁰.

Specialist support teams need to include rehabilitation staff. The PHC plan generally underplays the importance of rehabilitation staff in rural areas. The disciplines of physiotherapy and occupational therapy are well suited to rural medicine. These professions are not as specialist-oriented in the sense of narrowing their scope of practice, but rather build on the existing base-line skills to become more competent. Secondly, their health care interventions are valued in the rural setting for being hugely effective but largely low-tech (e.g. dry needling techniques for chronic pain relief, and neurodevelopment therapy for cerebral palsy children). Generic rehabilitation assistants should play a vital role in district hospitals, especially in rural settings, as they often form the background of a department with a high turn-over of professional staff.

The presumption that there will be a source – particularly when needed to be a rural source – of these specialists, from where they will be conducting cross-cutting outreach, is misplaced. **To specify again, we request that Occupation Specific Dispensation be reviewed to attract health professionals (including doctors) to rural areas.**

4.5 *Pharmacist Assistants*

All categories of pharmacist and pharmacist assistants are in short supply in the SA public service. The proposed 8418 post-basic pharmacist assistants will need to be trained. We request that the basic pharmacist assistant be used in clinics (in an outreach role from DH if necessary). While principally under supervision of the pharmacist, the doctor (on outreach) and professional nurse will play a role in supervising and support as part of a multi-disciplinary approach.

¹⁹ As urged in the 62nd World Health Assembly (WHA) resolution on Primary Health Care of May 2009: “to promote active participation by all people, and re-emphasize the empowering of communities, especially women, in the processes of developing and implementing policy and improving health and health care, in order to support the renewal of primary health care”

²⁰ For a full discussion on outreach at all levels of the (rural) health system, from regional to HBC outreach, see Versteeg M, Couper I. Position Paper: Rural Health - Key to a Healthy Nation. Johannesburg: Rural Health Advocacy Project, 2011. Available at www.rhap.org.za

4.6 *Clinical Associates*

Despite their planned employment in district hospitals only, the importance of the Bachelor of Medical Clinical Practice to primary health care re-engineering cannot be overemphasised. These Clinical Associates (ClinAs) will alleviate the procedural duties of doctors at district hospitals, allowing the latter to focus on more strategic issues such as the community health diagnoses, training and management, and outreach to other facilities when necessary. The planned minimum number of four ClinAs per DH is too few however, as shift work will demand more to offer the 24 hour service alongside doctors.

It is surprising that community service have not been legislated and arranged for ClinAs. As Clinical Associates, they work in a multi-disciplinary team by definition. A default level of supervision is required, after which the level of autonomy will be determined by more senior members of the team (senior ClinA's or doctors) at their discretion. They never, by definition, work as independent clinicians. In addition, every other category of health professional has to complete community service. This and other strategies are required to keep ClinAs in the public sector, including establishing posts for their employment.

5. IMPLEMENTATION: POLICIES ARE IMPLEMENTED IN EFFECTIVE AND EFFICIENT RURAL HEALTH SYSTEMS

5.1 PHC package implementation in rural areas

The desktop review of the PHC package in the PHC plan does not consider best practices in the rural setting specifically, but did acknowledge that the package needs to be flexible considering the resources and circumstances. An essential package in health policy was, in fact, originally defined as the addition of services that can be afforded to the minimum set. The preferred rural approach includes a phased implementation of interventions, where several packages of services of varying size are defined. Providing enough supply of health care (e.g. budget, service package, and other resources) to meet the demand (i.e. catchment population and burden of disease) is the key, mindful that a match is more often difficult in rural areas, for geographical and logistical reasons.

5.2 Quality improvement and clinical governance in rural health care delivery

Decentralisation of the health care responsibility to district management teams (DMT) as much as possible (including budgets) is encouraging. Worryingly though, a top-down influence over management at facility level may remain in the form of PHC managers (formally programme managers), the specialist support teams, and supervisors appointed by the province to visit facilities within districts. For rural areas mostly being remote, the disastrous effect of poor management is greatly amplified for the manager(s) in question being situated off-site. Staff expect managers to be firm in their approach, but flexible when the occasion demands. This is easier when the manager

has a hands-on involvement, which is difficult if he/she is based off-site. Frequent conflicts between DH Managers (based at DH) and Chief Executive Officers (based off-site and often responsible for more than one facility) is a case in point.

Similarly, we agree the DMT should be given authority, but care must be taken not to detract attention from the clinicians who are working on behalf of the patient. It is always in the patient's best interest if authority lies with those individuals directly responsible for the objective of excellence in care, namely the clinicians.

Comment on each of the main points in the PHC plan under clinical governance (pts 20-28, page 6-7) is made in table 3:

AS PROPOSED IN PHC PLAN	RHAP/RuDASA COMMENT ON RURAL CONTEXT
Provincial supervisors will conduct facility visits	Authority must be decentralised to district and facility where possible. Facilitative, not authoritative, approach is required if supervisors are based off-site, due to their sub-optimal knowledge and credibility (real or perceived)
Minimum of 1 visit/month/facility from trained supervisor	Not enough to be credible or effective in rural areas, unless supplemented by telephone and/or video-conferencing
Regular use of the "Supervisory Manual" updated and distributed recently, as basis for supervisory visits to clinic, CHCs and district hospitals	Needs to guide supervisors in capacitating and supporting the facility- and community-based staff
Written standardised report done at each visit by the facility manager and the supervisor	Management on the ground to be engaged in the report requirements
All current programme managers of DMT and sub-DMT will be redesignated as PHC managers who will conduct supervision and supervise the supervisors	<ul style="list-style-type: none"> • Clinical leadership in DMTs is vital, including accountability for key indicators as part of a Performance Management and Development Scheme (PMDS). Quality of clinical referrals • No clarity on role of PHC managers is given, and visits have the potential to distract from proper running of the facilities, unless regular visits are conducted to gain good knowledge and understanding • PHC managers must focus on integrated care, avoiding vertical programming where managers pressure staff to meet their particular objectives (e.g. attend their particular meetings and training courses)
District Support Specialist Team	Facilities and community to give input on the composition of this team
Family Physician (FP) has overall responsibility for district-	This is vital. Delivery of rural health care, however, may require an FP for each sub-district, not larger district. Moreover, current rural communities are heavily reliant on the DH. In turn, the DH sucks in

specific strategy, clinical governance, technical support and M&E of clinical service quality for district	resources. DH doctors must conduct outreach visits to CHC and clinics, but their schedule is ruled by the busy DH outpatients department (OPD). Teamwork between the clinical leadership of the DH and the sub-district is therefore vital to help address such problems.
District hospitals will have a clinical operations officer responsible for clinical services	
To monitor (clinical) services at CHCs: medical officer, at PHC: PHC supervisors and at community level: Professional/Staff nurse	Danger of poor supervision of CHWs at community level, particularly during first three years while staff nurses are trained-up.

Table 4: Clinical governance and rural context

The importance of the Family Physician (FP) as leader of the multi-disciplinary team is underlined when considering the option of nurses reporting to the FP. Teams must take a careful look at where line authority (superior-subordinate relationship) or staff authority (advisory only) will benefit service delivery, irrespective of the traditional divisions of authority by profession.

5.3 Leadership and community engagement in rural health

Community ownership of the process of PHC re-engineering is not promoted enough in the plan. The National Health Act already allows for community engagement on many levels, but some sections need to be formally promulgated before the Act has the teeth to be truly helpful to communities²¹. An example of how plans and rules have not considered the rural setting is the National Health Act's insistence that discharge summaries are written for in-patients, but outpatient feedback to a referring facility can be given verbally to the patient. When time between visits to the facilities is long in rural areas, a written note is vital to the continuity of care. Once that patient returns to a PHC facility with no feedback letter or knowledge of the next steps to be taken, the receiving health professional and patient are left in the dark.

At a local level, the authority and influence of those committees on which community representation is possible must be strengthened. The Hospital Board and Clinic Committees are all relevant examples provided for in Chapter Six of the National Health Act (NHA) but not yet formally promulgated. Improving community access to, and understanding of, the obligations of the government with respect to delivery of health care – as set out in the NHA and others - will benefit the more marginalised in particular, including rural groups.

²¹ The National Health Act (61 Of 2003): A Guide. Available at www.section27.org.za/wp-content/uploads/2010/national-health-act.pdf. The review comments that as of 9 September 2008, key chapters of the Act had not been promulgated

In addition, while the PHC plan includes reference to the Supervisory Manual for supervisors recently completed, no mention is made of the Hospital Board training manual also in circulation. The latter will promote a grass-roots influence on health care delivery.

The rural community voice must be heard right up the leadership hierarchy. In the event of provinces incorporating the six metro municipalities under local government management, some big urban players will be brought into the fold, possibly at the expense of rural influence. The Brazilian model of PHC has a number of "Offices" promoting PHC independent of the Ministry of Health (e.g. Office of Health Promotion Fund which is funded by a "sin tax "of 2%)²². Will the Department of Rural Development plan to play a similar role for rural health in South Africa, or should an alternative be suggested?

Intersectoral collaboration is currently more advanced in urban than in many rural settings. A drive to improve this collaboration will naturally build these existing relationships, and potentially drown out the voice of rural communities attempting to improve self-determination of health care delivery. Again, the Thailand model provides inspiration, suggesting South Africa should have similar CHW representation in various forums to the Village Health Communicators (VHCs) in the Thai system. These VHCs are present in all PHC settings, not just the low level rural ones²³.

Lessons can be learned from the Thailand PHC model. The Thais identified a lack of participatory orientation and the necessary skills among local government workers in promoting and supporting community participation; and inadequate opportunities for villagers to manage their own community development process i.e. data collection, planning and decision making. Efforts to find solutions culminated in a set of Basic Minimum Needs (BMN) to be used by the villagers and government officials across different Ministries²⁴. With 8 BMN indicators (32 measurable indices), the set of Basic Minimum Needs can provide PHC in SA with help in directing everyone involved with delivery of care, including boosting advocacy amongst the communities themselves. This will especially assist in rural areas, where the gap between reality and this expected minimums is often wide. Such goals might work more on the practical, local level than the Millennium Development Goals, applicable on the broader policy and public health stage.

5.4 Information technology in monitoring and evaluation of rural health care

Emphasis is placed on the use of information technology as a tool for vitally important data management, but technology must assist with communication in rural areas in particular. That is communication not only with patients, but to build teamwork and continuity of care between facilities, including support of academic and training initiatives across facilities (tele- and video conferencing).

Electronic records are useful. The use of patient-held records, however, as an aid to continuity of care within the district health model is also very useful, and often preferable. If implementing

²² See note 14.

²³ See note 1.

²⁴ www.unsystem.org/scn/archives/thailand/ch11.htm#b14BasicMinimumNeedsandQualityofLifeMovement73,74,75

electronic systems, a parallel strategy to strengthen the continuity of the care/referral pipeline with patient-held records is not counter-productive.

While acknowledging its limitations, the GIS (Geographical Information Systems, referred in the section on Social Determinants of Health) is an exciting tool to identify specific areas of inequity in rural primary health care. Although it does not cater for many non-spatial determinants of health care delivery, it is a useful information system that stores, edits, analyzes, shares, and displays geographic information for informing decision making.

Significantly, neither the SA census 2001 nor the SA Household Survey 2009 differentiates between urban and rural communities²⁵. They are useful but community-level data is, however, vital to be able to demonstrate impact. Well-functioning community level information systems or surveillance need to be set up. Adequate resources in terms of technical assistance and funding allocated to this. Equally important is local management of data to support the decentralisation of authority called for in the PHC plan.

There is significant evidence that the District Health Information System utilises scarce local resources in collecting far more information than is used to improve care at a local level.

5.5 Finance and budgeting in rural health care

Rural health administration is generally poor with respect to finance, budgeting and procurement. In principle, decentralising control of the budget for PHC to the DMT is the right strategy, but there needs to be proper transparency, accountability and consultation with health professionals on use and allocation of these finances.

Considerable reference to the Public Finance and Management Act (PFMA) will need to guide the integration of all sources of funding towards PHC improvement, especially where donor funding is significant (often dominant in rural areas),

That we are taking PHC into the community must not suggest that we can neglect the dire need for financing of additional accommodation at the health facilities for health and administration professionals. In many rural facilities today, poor accommodation has an impact on the operation and sustainability of the facility health services.

²⁵Available at www.statssa.gov.za/publications/P0318/P0318June2009.pdf and www.statssa.gov.za/census01/html/c2001primtables.asp

6. CONCLUSION

This document has covered some of the important considerations around allocation of resources allocated to primary care in rural areas. We call on all South Africans to gain a clearer perspective on the plight of rural people in South Africa with respect to their impaired access to quality health care. We argue for preference in allocation of PHC resources to these rural communities, and that new health strategies and programmes are first piloted in rural areas for their “rural feasibility.”

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APPENDIX 1-VITAL ROLES OF COMMUNITY HEALTH WORKERS AND HOME BASE CARERS

Scenarios in table below represent extremes of care in urban versus rural settings, illustrating the consequences of failure of the rural health system:

- Community health workers have tasks of health promotion, chronic disease screening and inter-sectoral collaboration in promoting wellness within the home, as part of PHC outreach team
- Home based carers have task of ensuring continuity of care: providing palliative care, post surgery instructions, rehabilitation home-exercises and adherence to medication under supervision of PHC outreach team (cross-cutting benefit for different facilities)

TIMELINE	37 yr old RURAL lady with abnormal cervical cells	37 yr old URBAN lady with abnormal cervical cells	Comment on Patient	Comment on Health System
2 months		Dx of abn. pap smear at clinic, referred to regional centre	Good level of education and awareness around seriousness of follow-up	
4 months		Child ill so misses Gynae appointment, but motivated to push for early re-booking		
	Dx of abn. pap smear at clinic and referred to District Hospital		Infrequent access to health facilities as poor and isolated	PHC facility-based, no push to promote pap smears
		Attends Gynae OPD, booked for curative action	EASY ACCESS	Informed consent ethical and easy
6 months	Attends district hospital and referred to Gynae OPD with old pap smear result			Attends DH as DHS in place, but referral centre busy, so appointment in 2/12
		Surgical procedure done as day-case CURED with no symptoms to date		
7 months	Misses Gynae OPD owing to no money for taxi. Given later appointment		Patient empowerment/advocacy poor so doesn't push re-booking	DH re-books appointment when pt presents
1 yr	Attends Gynae OPD and pap smear repeated		Child grant used for taxi fare from home to DH	PTV used as transport from DH to regional hosp
2 yrs	Repeat pap smear results indicate cancer of Cervix Stage 3		First symptoms: bleeding per vagina so presents to DH	Surgery not indicated
26 months	Chemotherapy given			Expensive
28 months	Radiation therapy given			Expensive
30 months	Palliative/Respite care			Expensive IF provided only at DH/CHC. Cost per PDE and ALOS will increase above targets.
34 months	Patient DIES		POOR ACCESS	
3 yrs	Fewer pap smears marketed to/done on other 37 yr old ladies with undiagnosed cancer of cervix			Same staff responsible for both screening and treating so both done sub-optimally

Dx =diagnosis, DH = district hospital, CHC = community health clinic, PHC = primary health care, Gynae OPD = gynaecology outpatients dept., PTV = Patient transport vehicle, PDE= patient day equivalent, ALOS = average length of stay, abn, = abnormal