DEPARTMENT: HEALTH
Republic of South Africa

PRIMARY HEALTH CARE PROGRESS

REPORT

2000

CLUSTER:

HEALTH MONITORING AND EVALUATION

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PREFACE

PRIMARY HEALTH CARE – 2000 IN CONTEXT

Primary Health Care was formally introduced to South Africa from April 1994 as the driving principle for health care provision in South African with the implementation of two policies, “Free Health for pregnant mothers and children under the age of six years” as well the “Universal Access to Primary Health Care for All South Africans”. This gives special emphasis to the development of clinics and basic health care programmes such as safe motherhood, child health and nutrition, expanded immunisation, management of communicable disease and the treatment of chronic ailments.

The first report that was published in June 1997 highlighted progress made within a number of important programmes and strategies initiated for the implementation of Primary Health Care, including the Presidential Lead Projects. This is the second progress report on the successes and achievements around areas of priority and the implementation of Primary Health Care in South Africa.
The report touched on a number of policies that have implications for the implementation of Primary Health Care, including:

Free Health Care for pregnant women and children under the age of six
Free Primary Health Care to all
District Health System
Essential Drug List and Legislation on Pharmaceuticals
Confidential Enquiry into Maternal Deaths
Mental Health
Human Resources
Choice of Termination of Pregnancy
Building of Clinics in Rural Areas

INTRODUCTION

This report provides an overview of achievements by the Department of Health in the provision of Primary Health Care. Firstly the methods used to compile this report are outlined below, followed by a national overview of Department of Health’s Presidential Lead Projects and other work undertaken by Departmental programmes as it relates to Primary Health Care in South Africa. Secondly, where possible, comparisons between the 1994 and the 2000 figures are provided. Finally, provincial profiles are provided. As South Africa enters the new millennium one of our major developmental challenges continues to be inequity and the need to accelerate the provision of good quality integrated care to all South Africans. We are committed to providing all South Africans with good quality, integrated health care, and have declared Primary Health Care delivered through the District Health System as the mechanism for achieving this goal.

Since its adoption great strides have been made in increasing access to care. For example, hundreds of new clinics have been built and access to essential health care has also improved through the removal of financial barriers to use. Both of these activities have resulted in an increased use of public Primary Health Care facilities. In addition, over the past four years there has also been major legislative activity, for example, the introduction of the Termination of Pregnancy Act No 92 of 1996 (provided women with the legal freedom of reproductive choices) and other acts. Moreover, essential drugs and standard treatment guidelines have been developed and implemented for both Primary Health Care and hospitals. Also of importance has been the introduction of community service for newly qualified doctors in South Africa.

There is however much more work to be done. The Minister has therefore prioritised the acceleration of improving access to Primary Health Care for all South Africa. Specifically, the following have been identified as key areas for action:

- Improved access to care for all South Africans, particularly for people living in rural and historically disadvantaged areas
- The need to improve quality of care throughout the health system
- Speed up the development of the District Health System
- Ensure 100% availability of drugs in the Essential Drug List in all Primary Health Care facilities
- Ensure appropriately trained personnel are available in all Primary Health Care facilities
- Eradicate polio and sustain gains made in reducing the burden of ill health due to Measles, and achieve 90% full immunisation by first birthday countrywide.
- Reduce maternal mortality and improve reproductive choice
- Unfold a telemedicine network to support our Primary Health Care system.

METHODOLOGY

This report draws on information collected from various sources, both primary and secondary.

2.1 Data sources

Data sources accessed include:

- Primary Health Care monitoring form
- Information from national directorates responsible for the co-ordination of different programmes
- Information from studies such as the South African Demographic and Health Survey and the HIV
- Antenatal Survey
- Facilities survey

2.1.1 Primary Health Care Monitoring Form

The data is collected from all Primary Health Care clinics and one of the tools used to collect data for this report was the Primary Health Care monitoring form. It was developed in consultation with National and Provincial Departments of Health as well as other stakeholders. The form and the associated indicators were finalised at a workshop held in Port Elizabeth in January 1999 (see Appendix A for a copy of the new Primary Health Care form). The National Health Information System of South Africa (NHIS/SA) Committee accepted the form and the Provincial Health Restructuring Committee ratified it.

The data is sent to the national office via provincial, regional and district offices on a monthly basis. Currently the data is collected and collated using the District Health Information System Software developed by the Health Information System Programme (HISP) consultants. This new system is currently used in all provinces to routinely report on PHC.

2.1.2 Information from National Directorates

Some of the National Programmes are responsible for the collection of information for planning. Major areas include; HIV/AIDS; Tuberculosis; Primary School Nutrition Project; Clinic Upgrade and Building Programme; Drug Policy; and Free Health Care.

2.1.3 National Surveys

Data from national surveys have used throughout this report. These include: The annual HIV antenatal survey; the South African Demographic and Health Survey; October Household Survey and the Facility Survey.

2.1.4 **Other Sources:**

The Directorate Health Systems Research, Research Co-ordination and Epidemiology also manages a number of surveillance systems, namely the Tuberculosis Register, Termination of Pregnancy information, Maternal Mortality confidential enquiry statistics, STD surveillance (annual syphilis amongst women), Routine Immunisation & Notifiable Medical Conditions. Where appropriate, data from these sources are used in this report. Information contained in the annual South African Health Review has also been drawn on in the completion of this document.

Data Limitations

Measures have been taken to ensure the high quality of data collected by the department. In most cases there has been and continues to be great improvement in the reliability and validity of national and provincial data, particularly with regard to the HIV antenatal survey data. In sum the major limitations with the data collected through the Primary Health Care form are as follows:

- Lack of both baseline and current data
- Differences in data collection mechanisms and reporting formats across and between provinces
- Lack of standardisation of data collection tools.

The new DHIS Software will go a long way in overcoming these problems, however the implementation of this system has only just begun and is yet to be rolled out to all provinces.

To follow then is an overview of the activities with regard to Primary Health Care monitoring, the implementation of Presidential Lead Projects and other programmes as they relate to Primary Health Care in the country.

3. PRIMARY HEALTH CARE UTILISATION DATA

Information on utilisation rates in health facilities in South Africa has been lacking and most of the available data is from the Primary Health Care form. Provincial information staff was asked to provide data on PHC visits (a PHC visit was defined as constituting a visit to a mobile or fixed clinic, community health centre or a day hospital) between 1994 and 1999 by type of service used.

However, data from some of the provinces is in headcounts (All individual patients seen during the period (usually month). Each patient is counted once for each day they appear at the facility, regardless of the number of services provided on the day(s) they were seen). As can be noted from the data submitted for 1998 and 1999 there has been some improvement. Not all provinces could provide information in the requested format i.e. visits broken down by fixed clinic, mobile clinic, community health centre and day hospital. Differences across the provinces are explained in the footnotes.

Table 1. Number of Contacts at PHC facilities by province for 1994 -1999

Province	1994	1995	1996	1997	1998	1999
EC					13,061,784	15,251,426
FS1			1,873,030	2,567,150	1,957,965	3,511,972
GP2	1,651,681	1,548,408	3,160,781	2,339,209	11,792,952	12,215,025
KZN3	10,474,385		13,314,384	3,641,108	12,859,158	19,476,079
MPU4				3,336,710	4,797,586	5,278,428
NC5		210,582	597,085	642,158	718,616	1,527,208
NP			2,323,883	1,537,399	7,929,576	8,987,150
NW6			6,510,851	6,947,197	8,948,138	2,290,291
WC			8,585,445	9,771,193	10,864,360	9,734,037
Total	12,126,066	1,758,990	35,222,888	2,523,794	67,021,961	78,271,616

(Source: Provincial Departments of Health, 1999)

This data supports anecdotal evidence that suggests that implementation of the Free Health Care policy and Clinic Upgrading and Building Programme (CUBP) have led to an increase in the utilisation of PHC services. (More information on these policies is provided in a later section of this report).

4. RDP PRESIDENTIAL LEAD PROJECTS

In 1994, the then President, in his inaugural address to the country, identified a number of health priority projects known as the Reconstruction and Development Project Presidential Lead Projects. These continue to be priority projects of health and include the following:

Clinic Upgrading Building and Programme
Free Health Care
HIV/AIDS
Primary School Nutrition Programme

4.1 Clinic Upgrading and Building Programme

Since the new government came to power in 1994, it committed itself to the upliftment of the previously disadvantaged communities. This was mainly achieved through the application of RDP funds. With regards to health service provision, the government focused on Primary Health Care. This policy has led to an increased requirement for clinics on a national basis. As a result, one of the programmes funded by the RDP was the Clinic Upgrading and Building Programme (CUBP).
The first phase of the CUBP commenced in the 1994/95 financial year, followed by phase two in 1995/96, and phase three 1996/97. From the start of the programme up till the end of 1999 a total of 506 new clinics were built using RDP, IDT and provincial funding. Also, a further 252 existing clinics had major upgrading such as the building of new maternity sections, and 2298 clinics received new equipment and/or had minor upgrading done to the value of R10, 000 per clinic. A total of 113 “visiting points” have also been built. Most of these consist of at least one consulting room and a hall and are used as a clinic on one day a week. (Table 2. Refers)

[1] Data for 1994 & 1995 not available as clinics collected own data
[2] Not all regions submitted data
[3] Data for 1994 & 1995 put together
[4] Data not collected separately. Figures include FP, ANC, PNC, deliveries, minor ailments & well child
[5] Data for 1994 not collected
[6] Not all regions submitted data for 1998

Table 2. Clinics built since 1994

	Completed			Commissioned		
	RDP	IDT	Total	RDP	IDT	Total
Clinics	438	68	506	413	68	481
Visiting Points	-	113	113	-	113	113
Upgrades	212	40	252	210	40	250

(Source: Health Facilities Planning, Department of Health, 1999)

An additional 37 clinics are under construction under the RDP programme. Of the new clinics built, 95% are commissioned and in operation. As a result of the CUBP, new clinics have been built or rehabilitated, further increasing access to care for all South Africans. The number of PHC delivery units per provinces is reflected in Table 3.

Table 3. Number of PHC delivery units for 1999

Province	Clinics	CHC	Mobiles	Visiting Points	Total
East. Cape	724	12	43	1	780
Free State	212	5	78	3	298
Gauteng	333	26	62	17	438
Kwa-Zulu Natal	365	1	166	97	629
Mpumalanga	221	28	91	46	386
Northern Cape	96	6	13	37	152
Northern Province	506	0	95	63	664
North West	380	20	71	3	474
Western Cape	340	0	136	55	531
Total	3177	98	755	322	4352

(Source: Health Facilities Planning, Department of Health, 1999)

4.2 Free Health Care

In May 1994, the Free Health Care (FHC) Policy for pregnant women and children under six years of age was introduced. Data drawn from a study conducted by McCoy and Barron (1996) provides information on utilisation of outpatients and antenatal care for a sample of selected facilities. Results which are shown in the tables 4 below, which show monthly averages for the 12 months before (1993-1994) the FHC policy and 12 months after (1994-1995) the implementation of the policy.

Table 4. Total OPD Attendance and Paediatric OPD attendance, 1993-1995)

Facility	Total OPD attendance			Paediatric OPD attendance		
	Before	After	% Change	Before	After	% Change
5 fixed Kwa-Mashu clinics	11979	14007	+14%			
L Bam Hospital	2572	3162	+23%	401	644	+27%
King Edward Hospital	37161	37639	+1%	5032	6451	+28%
Empangeni clinic	3325	4413	+33%			
Thokoza clinic	8830	10825	+23%	2018	3468	+72%
Empangeni Hospital	1695	2594	+53%			
Ngwelezane Hospital	7995	7612	-5%	767	771	+4%
Kwa - Dabeka clinic	10697	14802	+6%	3529	5093	+44%
Pinetown clinic	13815	17858	+29%	2457	3129	+27%

Welkom clinic	14109	14955	+6%	5235	5727	+9%
J Clinic	2352	2769	+18%	1188	1610	+36%
White location clinic	1387	1532	+11%	287	395	+38%
Alexandra clinic				1642	1792	+9%
Natalspruit Hospital				100294	140559	+61%
Leratong Hospital				17578	27024	+40%
Sebokeng Hospital				24535	34217	+39%
Baragwanath Hospital				7857	9287	+19%
Cecilia Makiwane	18294	18354		1618	1778	+10%
Rosedal clinic	719	2438	+240	223	766	+243%
Holy Cross Hospital	3104	3646	+17%	1403	2253	+62%
Goldfields Hospital	11115	14170	+28%	940	1933	+106%
Total	149149	170776	+14.5%	144612	292404	+102.2%

(Source: McCoy and Barron, 1996)

The increase in clinic attendance since the introduction of Free Health Care suggest that the previous system of user fees was a deterrent to people using health care services. Table 5 compares the number of antenatal attendance before and after the introduction of Free Health Care. Data from tables 4 and 5 suggest an increase in the utilisation of clinics.

Table 5. Antenatal clinic data (McCoy, 1996)

Facility	**ANC attendance**			**1st ANC attendance**		
	Before	After	% Change	Before	After	% Change
6 fixed Kwa - Mashu clinics	1636	1536	-6%			
Kwa - Mashu polyclinic	1783	1850	+4%			
King Edward hospital	2492	2181	-13%			
Empangeni clinic	69	76	+10%	30	20	-33%
Thokoza clinic	754	1287	+71%	246	423	+72%
Empangeni hospital	37	60	+62%			
Ngwelezane hospital	812	735	-9%			
Kwa- Dabeka clinic	1046	1501	+44%	228	324	+42%
7 Clinics	1644	2082	+27%	395	459	+16%
Pinetown clinic	611	992	+62%	157	311	+98%
Hlabisa hospital	485	468	-3%	61	69	+13%
Goldfields hospital	925	1460	+58%			
J clinic	282	293	+4%	60	57	-5%
D clinic	133	172	+29%	30	41	+37%
Pelonomi hospital	2152	2053	-5%	432	389	-10%
Manapo Regional hospital	481	686	+43%			
Elizabeth Ross hospital	159	197	+24%	28	35	+25%
RSC clinics	31	21	-33%	7	2	-45%
RSC mobile clinics	35	40	+14%	26	13	-50%
Eden Donges hospital	282	406	+44%	154	231	+495%
Laettitia Bam Day hospital	310	412	+33%	90	105	+17%
LUJ clinic	75	87	+16%	26	24	
Knysna hospital	254	384	+51%	91	92	
Holy Cross hospital	320	500	+56%	149	274	-84%
Uitenhage hospital	86	103	+20%			
Alexandra clinic	26060	23343	-10%			

Cecilia Makiwane hospital	581	384	-35%			
Total	43535	54617	+25.4%	2210	2869	+29.8%

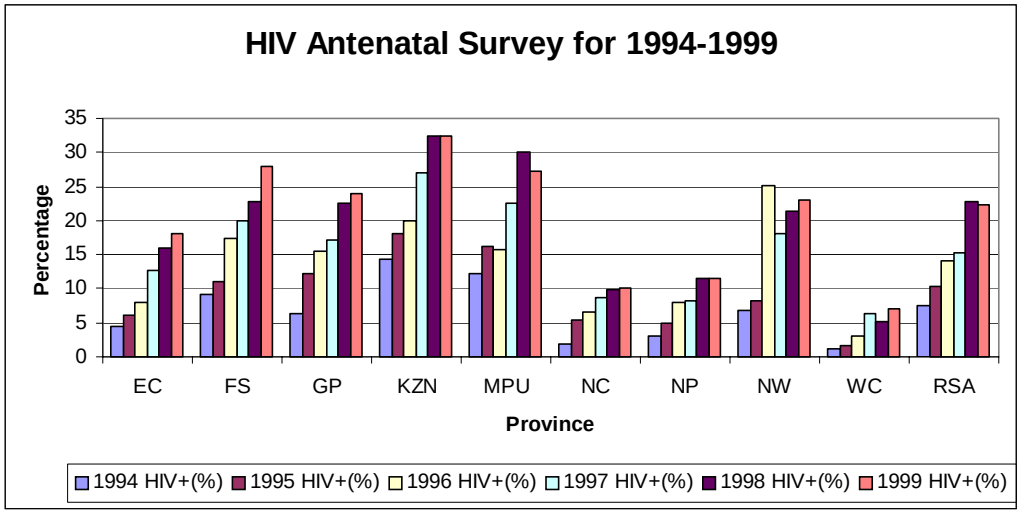
(Source: McCoy, 1996)

4.3 HIV/AIDS

The HIV/AIDS epidemic in South African is growing rapidly. It is estimated that 1 500 people are becoming infected annually. Projections indicate that within three years almost a quarter of a million South Africans will die of AIDS annually. Currently, over 3.2 million people are infected with HIV.

The National HIV Antenatal Survey conducted yearly among pregnant women attending antenatal care provides the best available information on the spread of HIV in South Africa. Table 6 provides summary of data from the annual surveys.

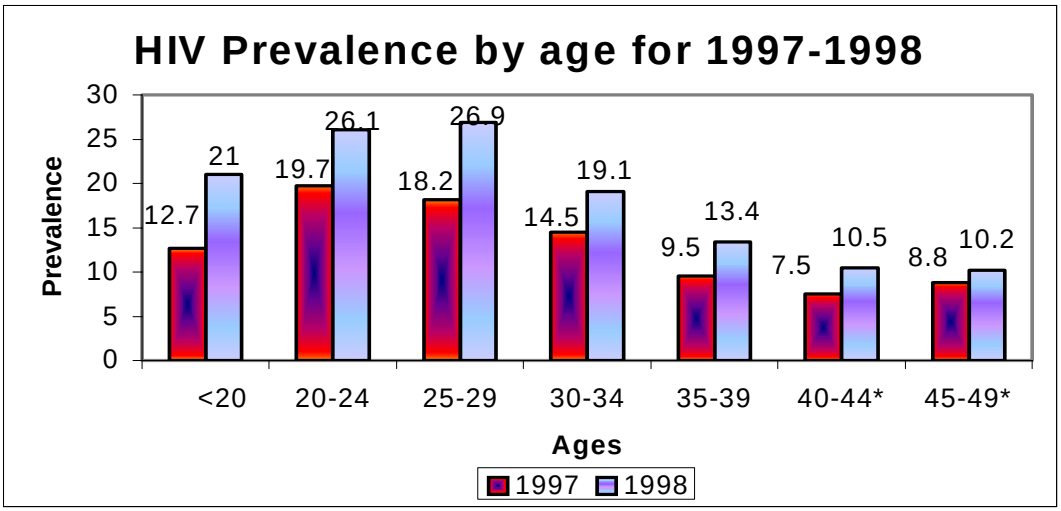
Figure 1. HIV Antenatal Survey estimates by Province, 1994-1998



(Source: 1998 HIV Seroprevalence Survey, 1998)

The 1998 survey indicated that 22.8% (based on 15 301 blood samples tested) of women attending antenatal clinics of the public health facilities were infected with HIV by the end of 1998. This represents a 33.8% national increase in the prevalence level of HIV infection since 1997.

Figure 2. HIV Prevalence by age for 1997 and 1998



(Source: 1998 HIV Seroprevalence Survey, 1998)

Figure 2 indicates that women in their twenties continue to have the highest rates of infection, whilst rates of increase from year to year are highest among teenage girls. HIV/AIDS prevention campaigns are being targeted towards young South Africans. This emphasis is supported by findings from the South African Demographic and Health Survey that showed that whilst respondents were aware of HIV/AIDS, the information they had was not always adequate. For example, just over 50% of teenagers did not know that person who looked healthy or fat could be HIV positive. Positive action is being implemented to stem the rapidly rising epidemic.

4.4 **Integrated Nutrition Programme / Primary School Nutrition Programme**

The Primary School Nutrition Programme (PSNP) of the Integrated Nutrition Programme (INP) was implemented on 1 September 1994 following the announcement by the President in the State of the Nation Address on 24 May 1994: "that a national school feeding programme be implemented within 100 days, the focus of which includes, school feeding, nutrition education and health promotion". The budget for the year 1999/2000 for the INP/PSNP was R554, 677,000. Table 7 gives the RDP and INP/PSNP conditional grant allocations by financial year.

Table 7. RDP and Conditional Grant Allocations by Financial Year

Financial Year	PSNP	INP Focus Area	Type of allocation	Total
1994/1995	R 472,840,000		RDP	R 472,840,000
1995/1996	R 500,000,000		RDP	R 500,000,000
1996/1997	R 496,000,000		RDP	R 496,000,000
1997/1998	R 496,000,000		RDP	R 496,000,000
1998/1999	R 465,941,132	R 59,818,868	Conditional Grant	R 525,760,000
1999/2000	R 457,941,362	R 96,731,638	Conditional Grant	R 554,677,000

(Source: Directorate: Nutrition, 1999)

An evaluation of the programme included the number of schools participating in the school feeding projects, a number of primary school pupils reached through school as well as the financial status of the school feeding projects in general. Apart from these efforts the staff in the provinces were trained on the school feeding projects statistical formats for monitoring purposes of the INP during 1999. This project not only benefited school children but it created employment and also allowed for community participation and participation by some enterprises. The project can be seen as having been successful judging by the results of the schools surveyed. The survey showed that just fewer than 90%.

Moreover, during the 1999/2000 financial years, the reporting formats to obtain information from the provinces were updated and changed, and all the provinces were trained. It was also realised that provinces did not have capacity and enough skills to complete the formats and as a result, three provinces haven't submitted their reports. Given this problem, the Directorate: Nutrition is in the process of developing a minimum data set that the provinces and regions will be able to complete with minimum capacity.

4.4.1 Programme Highlights

The number of schools reached in November 1999 were 7 075 compared with the 14 549 reached during March 1998. Table 8 shows the number of schools that participated in the feeding projects.

Table 8. No. of schools participating in school feeding projects for 1999

Province	Total	Targeted	Reached	% Covered of Total	% Coverage of Targeted	Rank according to % Covered of Targeted
EC	1,963	1,571	1,571	80.0%	100.0%	5
FS	286	276	286	100.0%	103.6%	1
GP	2,032	800	610	30.0%	76.3%	7
KZN	5,529	5,141	7	0.0%	0.0%	
MPU	2,361	1,243	1,243	52.6%	100.0%	3
NC	1,660	980	980	59.0%	100.0%	4
NP	3,214	2,456	8	0.0%	0.0%	
NW	3,948	2,775	2,385	60.4%	85.9%	6
WC	1,091	907	936	85.79%	103.2%	2
Total	22,084	16,149	7,075	32.0%	43.8%	

(Source: Directorate: Nutrition, 1999)

The number of children served during November 1999 were 2 332 056 against 5 021 575 served in March 1998. Table 9 indicates the number of school pupils targeted and reached through school feeding projects during November 1999.

Table 9. No. of School Pupils Reached Through School Feeding Projects

Province	Total	Targeted	Reached	% Covered of Total	% Coverage of Targeted	Rank according to % Covered of Targeted
EC	538,124	535,985	380,185	70.70%	70.00%	7
FS	116,386	116,340	116,386	100.00%	100.00%	2
GP	335,097	1 50000	134,501	40.10%	89.70%	5
KZN	1,854,223	1,092,820	9	0.00%	0.00%	
MPU	535,194	461,420	461,420	86.20%	100.00%	1
NC	8,889,000	241,537	227,099	25.50%	94.00%	3
NP	1,450,000	1,395,489	10	0.00%	0.00%	
NW	1,837,847	1,178,026	1,012,465	55.10%	85.90%	6
WC	366,718	274,808	256,990	70.08%	93.52%	4
Total	15,922,589	5,446,425	2,332,056	32.00%	43.80%	

(Source: Directorate: Nutrition, 1999)

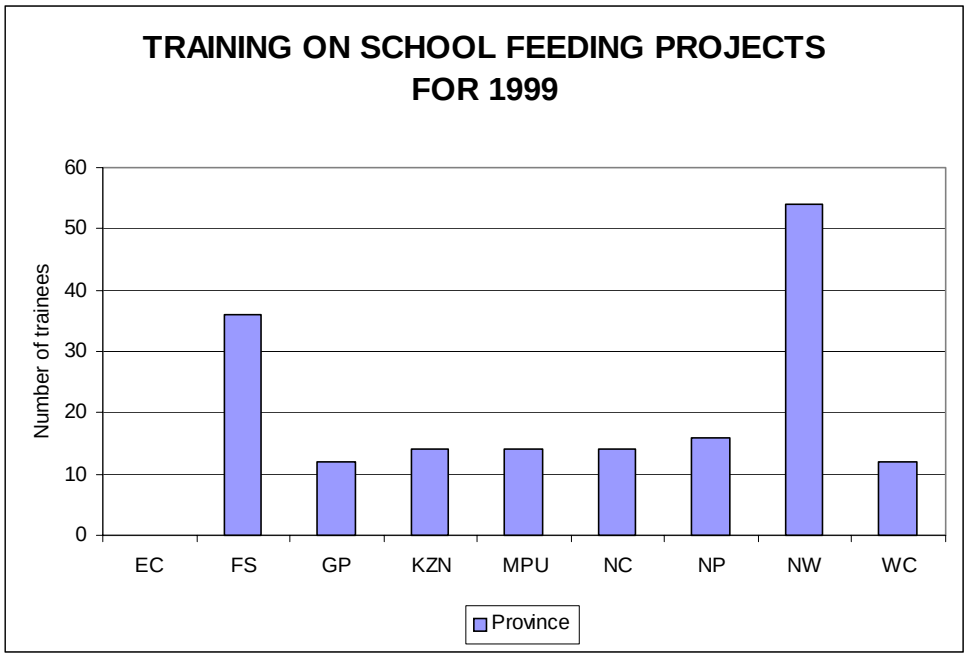
There were 84 people employed between April 1999 to November 1999 and 9 315 were volunteers from communities who participated in project activities during November 1999. Of these, 9 269 were compensated volunteers and 46 non-compensated volunteers. The total of number of 68 enterprises (12 medium, 34 small, 0 very small and 22 micro food suppliers) participated in delivering food during November 1999.

A total of 24 persons were trained on INP programme in the period April 1998 to November 1999. (None were trained in November). During April to September 1999 training on the school feeding projects statistical formats for monitoring purposes of the INP programme, was given to provincial staff.

[7] Information not available
[8] Information not available
[9] Information not available
[10] Information not available

As these formats were changed and updates, as well as the completion thereof in future at district level, most provinces were not in position to complete these forms for the first and second quarters of reporting. This implied that statistical information was only received from five provinces (Free State, Gauteng, Mpumalanga, Northern Cape and North West) for the reporting quarters April-June and July-September 1999. Table 10 indicates the number of trainees on INP Programme per Province.

Figure 3. The number of Trainees per province



(Source: Directorate: Nutrition, 1999)

The provinces have spent approximately 13,90% of the available funds, in the period April 1999 – November 1999. Actual expenditure was reported as R63 663 519 for November 1999. A total budget of R458 million was made available for the 1999/2000 financial years. Table 11 depicts school feeding budget allocation projects per province.

Table 11. School feeding budget allocation per province: 1999/2000

Province	Conditional Grant Allocation	School Feeding Allocation	Percentage of Budget Allocation used for School Feeding
Eastern Cape	R 125,558,760	R 103,133,933	0.821
Free State	R 37,517,924	R 19,800,000	0.528
Gauteng	R 52,069,544	R 3,200,000	0.83
Kwa–Zulu Natal	R 126,163,275	R 95,095,000	0.754
Mpumalanga	R 37,836,534	R 36,601,437	0.967
Northern Cape	R 9,615,273	R 9,140,233	0.951
Northern Province	R 100,982,526	R 90,000,000	0.891
North West	R 37,514,759	R 36,405,759	0.97
Western Cape	R 27,418,405	R 24,569,000	0.896
Total	R 554,677,000	R 457,945,362	0.826

(Source: Directorate: Nutrition, 1999)

5. MANAGEMENT MECHANISMS AND PHC

Primary Health Care is the primary mechanism for health care provision in South Africa, which cuts across many departmental programmes and initiatives. In order to effectively deliver Primary Health Care, a number of management and support systems are being developed and implemented throughout the country. This section therefore reports on some of the activities that are relevant to and in support of the provision of Primary Health Care in South Africa. These include:

District Health System
Human Resources
Information Systems
Legislation
Quality of Care
Financing PHC

5.1 District Health System

Progress towards a District Health System is at different stages of development in the provinces. The process of demarcating district boundaries in all the provinces started in 1995. At present, a total of 42 health regions and 174 health districts have been defined. Most provinces encountered difficulties in the integration of health district boundaries due to the lack of a legal framework. Provinces such as Eastern Cape, Free State, Mpumalanga, North West and Northern Province have defined organograms for their district. Gauteng Province has established a joint Organogram Task Team made up of Provincial District Health Systems Committee to work together to ensure the incorporation of local authority organograms.

Health Management structures have been established and all nine provinces have appointed regional managers. Provinces that have appointed district managers include Northern Province (25); Mpumalanga (16); North West (16); Eastern Cape (15) and Northern Cape (6). All districts in Mpumalanga have management teams. Interim District Health Management Teams or Interim District Coordinators have been appointed in the other provinces. Gauteng has established Regional District Health Systems Committees (RDHSC) that meets monthly.

Information sharing is poorly coordinated throughout the health system and it is inadequately cascaded to the different levels within provinces. The establishment of a proper information system at district level is, therefore urgently needed to ensure proper management of health services and to improve the quality of health service delivery. As the framework of the national Health Information System of South Africa, all provinces have accepted the establishment of the District Health Information Systems as important strategy in the improvement of health management and service delivery in the country. At present, all provinces are involved in developing strategies for information collection.

5.2 Human Resources

Nurses provide the bulk of service provision in the public health sector. This emphasis is most striking at the primary care level. Given this emphasis the need for well-trained primary level staff is imperative.

Table 12 below provides data on the number of full-time primary health care nurses (PHCNs) and Professional nurses per clinic in each province. PHCNs are health care providers who have received a formal certificate or diploma in nursing.

Table 12. Number and Percentage of Clinics with at Least One Full-Time PHCN and Mean Number of PHCNs per Clinic for 1998

Province	No. Clinics with at least one PHCN	Clinics with at least one PHCN (%)	Mean PHCNS per Clinic	Total Clinics Surveyed
EC	0	0	0	66
FS	7	25	1.7	28
GP	12	75	2.8	16
KZN	21	67.7	2.6	31
MPU	6	25	1.7	24
NC	0	0	0	9
NP	11	24.4	2.3	45
NW	14	50	1.7	28
WC	27	84.4	2.3	32
Total	98	35.1	2.3	279

(Source: Pick et al, 1998)

These figures, taken from a recently conducted 1998 national survey, show that some clinics do not have at least one full-time professional nurse on their staff establishment, that PHCNs are much fewer and unevenly distributed across provinces. The Human Resources Directorate reports that training activities in South Africa have been initiated at both National and Provincial level. At the National level, the Department of Health has worked in collaboration with three organisations (Gold Field, SAMS and USAID) in the provision of PHC training. These three organisations played a facilitating role during the training of the South African health personnel. Table 13 provides data on the number of PHCNs who completed various training by organisations and provinces. Findings in Table 13 reflect a concentration of training activity in the Eastern Cape.

Table 13. Capacity Building Programmes Coordinated by NDoH by Facilitator (June 1995-1998)

	Gold Field	SAMS	USAID	Total
Eastern Cape	17	17	21	55
Free State	7	15		22
Gauteng	10	25		35
Kwa-Zulu-Natal	6	2		8
Mpumalanga	12	19		31

Northern Cape	6			6
Northern Province	12	5		17
North West	12	14		26
Western Cape	5	3		8
South Africa	87	89	21	197

(Source: Directorate: Human Resource Development, 1998)

The main bulk of training activities have occurred within the Provincial Departments of Health as illustrated in Table 14 below.

Table 14. PHCNs Trained by Provincial Initiatives

Province	**Number**	**%**
Eastern Cape	176	3.7
Free State	114	2.4
Gauteng	112	2.4
Kwa-Zulu-Natal	23	0.49
Mpumalanga	13	0.41
Northern Cape	129	2.7
Northern Province	1862	39.6
North West	209	4.4
Western Cape	2062	43.9
South Africa	4700	100.0

(Source: Directorate: Human Resource Development, 1998)

The vast bulk of this training has consisted of short courses in the fields of Primary Health Care Management; Reorientation to Primary Health Care principles; Public Health Management at Primary Health Care level; Primary Health Care in Mental Health; Paediatric Primary Health Care, Primary Health Care Clinical Nurses Practitioners, Primary Health Care Nursing Programmes.

5.3 **Telemedicine**

Telemedicine can be broadly defined as the use of information and telecommunications technologies to provide medical information and services at a distance. The objective of the South African Telemedicine System is to deliver health care services at a distance to South African rural communities. This is one of the activities that are occurring within the DoH towards the improvement of the health information systems in order to support and enhance the provision of Primary Health Care and the development of the District Health System.

The project, comprising three phases commenced in July 1999. Phase I of the pilot has been delivered with 28 functional sites and work on this phase culminated in a National Telemedicine Conference 2000 A – Contribution to the African Renaissance that was held on the 22-24

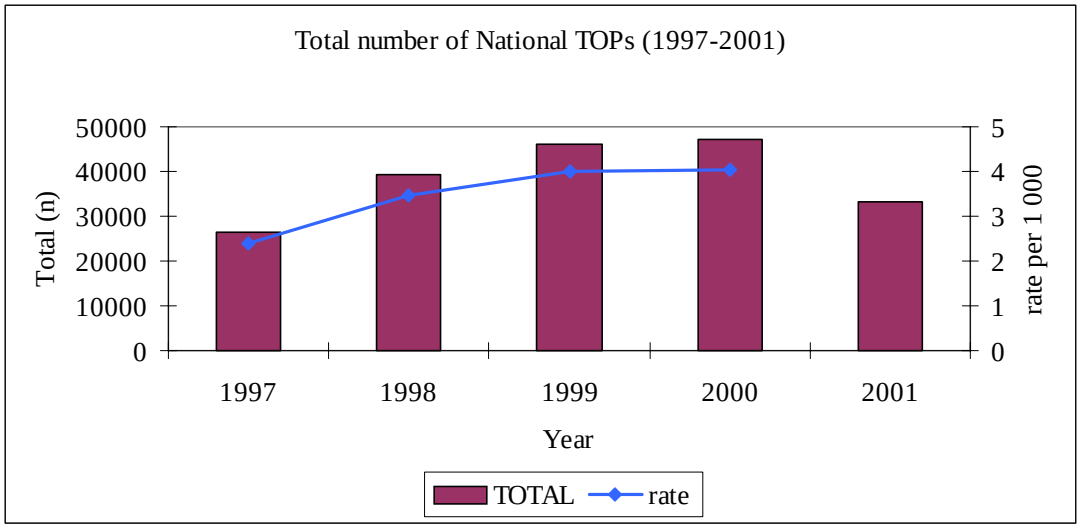
November 2000. The DoH will build on these over the next five years resulting in a comprehensive network that will also link some of the institutions to the SADC region.

5.4 Legislation

Several pieces of legislation have been passed over the years with some having a bearing on PHC delivery. One of these is the Choice of Termination of Pregnancy (TOP) Act that was passed on the 1st February 1997. The act provided a framework within which women in South Africa can exercise their constitutional rights to reproductive choices.

The total number of TOPs performed in South Africa has steadily increased from 26 401 in 1997 to 47203 in 2000 (Figure 1). The total to date is 33 350 ending September 2001. This figure is less than the 40 882 procedures reported for the same period in 2000. Whereas efforts to strengthen current family planning practices are under way, it is too early to rule out late reporting as the reason for this difference. Data has not been received from all provinces and it is therefore quite possible that this years total figures will equal if not exceed those of 2000. A cumulative total of 192 14 TOPs have been performed since the implementation of the act in 1997. The National rate of TOPs per 1 000 women (15-49 age group) has steadily increased from 2.38 per 1 000 in 1997 to 4.02 per 1 000 in 2000 (figure 1).

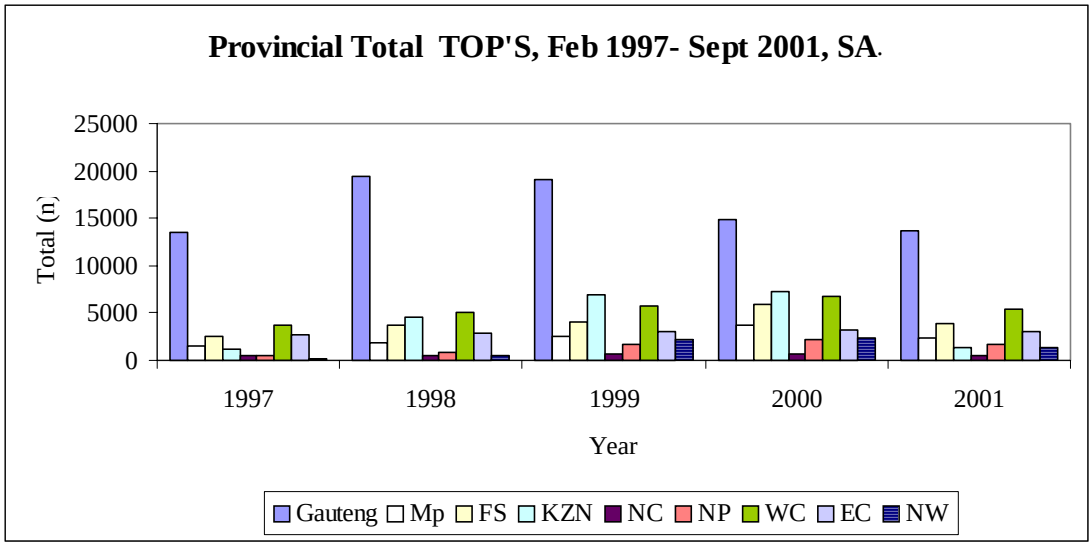
Figure 4: National TOPs for Feb 97-Sept 01 and the rate of TOPs per 1 000 for 97-00



(Source: Health Systems Research, Research Co-ordination & Epidemiology Directorate, National Department of Health)

Gauteng has consistently reported the highest number of TOPs performed for the period Feb 1997 to Sept 2001 (Figure 2). The decline demonstrated in Kwa-Zulu Natal from 2000 – 2001 is a result of missing data and not a true reflection of the situation. The Western Cape has reported the third highest number of TOPs whilst the Northern Cape conducts the lowest number.

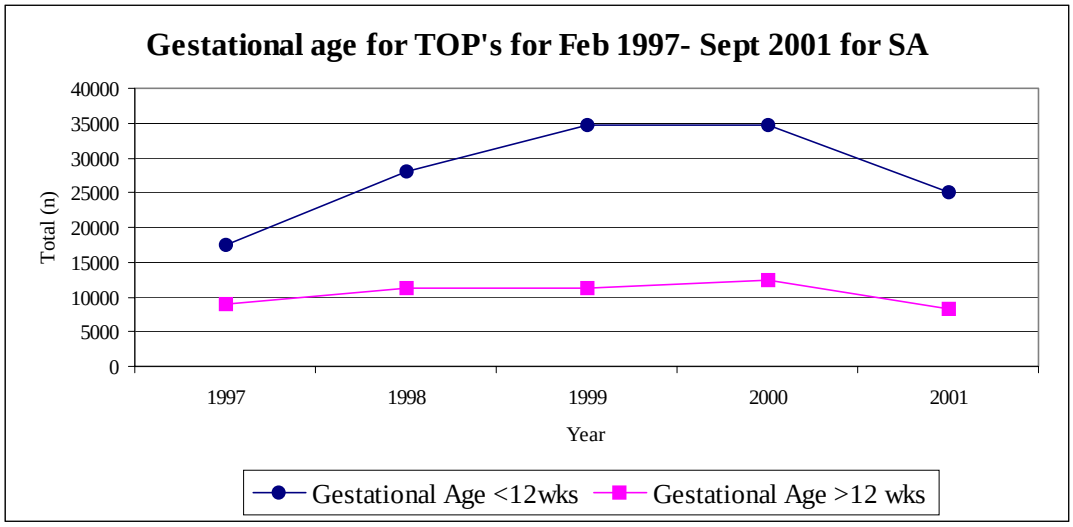
Figure 5: The total Provincial TOPs performed, Feb 1997 – Sept 2001, South Africa



(Source: Health Systems Research, Research Co-ordination & Epidemiology Directorate, National Department of Health)

The gestational age is grouped into two categories namely < 12 weeks and > 12 weeks. From Feb 1997 to September 2001, the majority of TOPs have been conducted on foetus' less than 12 weeks of age (Figure 3).

Figure 6: Gestational Age for TOP for Feb 1997-Sept 2001 for SA



(Source: Health Systems Research, Research Co-ordination & Epidemiology Directorate, National Department of Health)
Note: All decreases presented graphically from 2000 to 2001 are a result of incomplete data submission and do not reflect actual decreases in the number of TOPs performed.

5.5 Quality of Care

The Department has prioritised the issue of quality of care. In so doing, has begun working on the development of a national service framework. This involves among other things, the development of clear national standards for services and treatments for primary health care to address how PHC services should be configured and staffed. The aims of this process was to improve access to high quality, effective care, reduce underhealth variation between PHC services, help to meet

the Year 2000 health goals, objectives and indicators, targets and to set out expectations for care for service users. In addition to this, the Department has launched a Patient Charter underscored by Batho Pele principles, and the process of developing Patients Complaints Procedures and mechanisms to monitor this process are currently underway.

5.6 **Financing PHC**

The allocation for the implementation for the PHC was made available since 1995 through the Medium Term Expenditure Projections as illustrated in table 15.

Table 15. Primary Health Care Expenditure (millions of rand – 1995 prices)

Expenditure	**1995/96**	**1996/97**	**1997/98**	**1998/99**	**1999/00**	**2000/2001**	**Average annual change (%)**
Current	4,768	5,140	5,593	6,061	6,547	7,050	8,1
Capital	105	175	182	189	196	204	
- government	105						
- aid		175	182	189	196	204	
Total government	4,873	5,140	5,540	6,061	6,547	705011	7,7
Total PHC	4,873	5,315	5,775	6,250	6,743	7,253	8,3

(Source: Restructuring the National Health System for Universal Primary Health Care, 1996)

The total amount budgeted for the year 1995/1996 was R4 873 million and this included district hospitals outpatient care. This also provided for an average of 1,8 PHC visits per person. This included expenditure on an aggregated level for PHC activities at clinics, public health programmes and outpatients departments in hospitals. It was envisaged that PHC spending would increase whilst the academic hospital expenditure would fall. A National Health Accounts Project that will be completed shortly will provide information on the actual expenditure on PHC for the year 1996/1997.

6. PRIMARY HEALTH CARE AND THE CORE PACKAGE

The Department of Health has begun to define a minimum basket of Primary Health Care services that are to be common to the whole country. The Core Package represents the services that should be rendered in order for Primary Health Care services to be fully comprehensive, and in so doing assists the Department of Health in quantifying what is needed in terms of staffing, infrastructure, equipment and financial resources for the provision of Primary Health Care services within a district.

6.1 **Essential Drug List**

In 1996 a National Essential Drug Programme was introduced followed by the launch of Essential Drug List (EDL) and Standard Treatment Guidelines (STGs) for Primary Health Care. The list and the guidelines were developed from the most prevalent diseases that are present to a Primary Health Care facility for the majority of the population. This EDL was to serve as the basis for ensuring that essential drugs are available at all Primary Health Care facilities at all times.

In December 1998, the revised edition of the EDL/STGs for Primary Health Care was launched to ensure acceptability and friendliness to the users at Primary Health Care level. This was

[11] Provides for an average of 2.8 visits per person in comparison with 1.8 visits in 1995/1996

launched simultaneously with the EDL/STGs for Hospital level, an important milestone in the implementation of the objectives of the National Drug Policy of ensuring that adequate and reliable supply of safe, cost-effective drugs of acceptable quality are available and accessible to all South African citizens.

A study was conducted which formed the basis for the review of the EDL/STGs for Primary Health Care. In response to users' request the following items were included in the revised edition:

- Problem-based approach in the form of flow charts;
- Brief description of the disease condition;
- Management objectives;
- Non-drug treatment;
- Criteria for referral;
- Section on Patient Education in Chronic Conditions.

This was all to assist health workers to improve patient compliance and thus the quality of health. The development of EDL/STGs is an ongoing process that will be reviewed and updated regularly, based on comments, recommendations and motivations to amend the publication received from the users to ensure wide participation in developing a truly national, enabling and facilitating document. A process of realigning the tenders to be according the EDL was then embarked upon to ensure that items bought on State Tender are on the EDL to implement the NDP objectives of making essential drugs affordable.

Health workers handling medicines have been trained on drug supply management techniques to improve the availability of essential drugs at health facilities. The principles of effective and rational prescribing have been taught to prescribers to ensure the rational use of the essential drugs available. Legislation is being facilitated to introduce community service for Pharmacists in 2001, thus making pharmaceutical services accessible to previously disadvantaged communities.

6.2 **Tuberculosis Control**

South Africa faces one of the worst tuberculosis epidemics in the world, with disease rates (average is at 377 per 100, 000 population) more than double those observed in other developing countries. In 1997 107 000 Tuberculosis (TB) cases were reported and 10 000 patients die annually. Over 2 000 people fell sick with multi-drug resistance TB in 1996. In 1996 in recognition of this problem, the Minister of Health declared TB a health priority and thus marked the introduction of the Directly Observed Treatment, Short Course (DOTS) as a national strategy to curb the problem. DOTs has now been introduced into 63 Demonstration and Training Districts nationwide. Proper monitoring of TB only began in November 1996. Table 16 provides TB data in South Africa.

Table 16. Treatment Outcome indicators as on 6/11/98

	Number of PTB cases		Cure Rates in % [1]		Successful Treatment in % [2]		Treatment interruption in % [3]	
Province	1996	1997	1996	1997	1996	1997	1996	1997
EC	22,646	24,253	51	51	71	68	19	20

FS	8,949	8,693	54	48	77	77	14	13
GP	10,235	14,128	59	60	74	73	17	17
KZN	15,376	21,009	42	44	69	67	22	22
MPU	2,483	3,178	57	56	76	75	15	12
NC	2,144	4,336	57	61	67	70	18	19
NP	4,023	4,698	53	53	77	76	14	14
NW	5,568	6,288	37	51	72	78	19	15
WC	19,831	20,387	51	58	71	70	21	21
RSA	91,115	104,619	54	57	73	73	18	18

(Source: Health Systems Research and Epidemiology - 1998)

The figures show that although there has been some success in treatment completion and cure rates, they appear to be limited. However, a more accurate measurement of current TB programme activities are the smear conversion rates measured after the intensive phase at 2-3 months. Of the 63 Demonstration and Training Districts, 24 reported a smear conversion rate of over 85%. This failure to curb TB in South Africa is multifaceted and of course linked to the rapidly increasing AIDS epidemic. TB again has been recognised as a major public health issue. This is reflected in the Director General's request that the National TB Control Programme reports directly to him on a regular basis.

6.3 **Maternal and Reproductive Health**

Currently rates of maternal deaths in South Africa are very high, at 150 deaths annually per 100,000 live births. This is 22 times higher than maternal death rates in developed countries, but nearly 4 times less than in many developing countries such as Kenya, Zimbabwe and Zambia.

The recently released "Saving Mothers" report, initiated by the Department of Health, is based on an analysis of data on 676 women who died during pregnancy, labour or within 6 weeks of giving birth during 1998. The report provides South Africa with insights into this pressing problem and highlights areas where interventions are needed. The report found five major causes of maternal death in South Africa. These are: Complications of hypertensive conditions in pregnancy (23.2%), AIDS (14.5%), obstetric haemorrhage (13.3%), pregnancy related sepsis (11.9%) and pre-existing medical conditions (10.4%), mainly pre-existing cardiac disease. These causes of death accounted for 73.3% of all the deaths reported. It also shows that older women, especially women 30 years of age and older are more likely to die than younger women. Moreover, women during their first pregnancy and women who had 5 or more pregnancies are at significant risk, whilst deaths occur more frequently in African women.

As we know, added care and attention is needed when treating these groups of women. In particular, women who are older than 30 or who have had many children need to be counselled as to the additional risks they may face when having a child. The enquiry shows that most maternal deaths are occurring in secondary hospitals, and that in almost half of all the maternal deaths there is a missed opportunity for preventing death. These are factors related to the behaviour of the woman herself or of the community where she lives. For example, we have observed that women are not attending antenatal care, or are delaying seeking help, resulting in the most tragic of outcomes – death. The enquiry has also highlighted the need to address the quality of care provided to women in South Africa's health services. Major problems identified are poor problem identification (12.4%), delayed or lack of referral of problems (16.2%) and not following standard protocols (16.2%). All these problems are found to occur at the primary care level.

The recently conducted South African Demographic and Health Survey shows that of all women who gave birth during the five years proceeding 1998, 84% received medical assistance from either a doctor, a nurse or a midwife. In other words, 16% of the women delivered without medical assistance. The Primary Health Care package which outlines what must be available at each level of care will go some way in ensuring that at each level where a woman goes into labour there is a basic infrastructure and that emergencies can be managed speedily and appropriately.

"Saving mothers" highlights some strengths but also concerns for aspects of our health care delivery system. The high rate of deaths of South African mothers during pregnancy and childbirth is clearly not due to a global lack of knowledge on how to manage severely ill pregnant women. The knowledge is there but for many of the reasons highlighted by this Enquiry, this knowledge is not being applied within our health care services. Clearly there are major challenges ahead to decreasing the rate of maternal deaths in South Africa. "Saving Mothers" provides us with concrete recommendations to begin addressing this problem. The National Committee on Confidential Enquiries into Maternal Deaths of South Africa carried out this Enquiry and developed the report. It is an important starting point to fight the battle to Save our Mothers and reduce the deaths of women in our health facilities.

6.4 **Expanded Programme on Immunisation (EPI)**

The Expanded Programme on Immunisation in South Africa (EPI: SA) provides children with immunisation against measles, diphtheria, tetanus, whooping cough, Hepatitis B, polio and tuberculosis.

The 1994 South African Health Review report indicated that the Programme functioned very well despite many limitations such as fragmented services and reporting structures.
The immunisation coverage data for 1994 will serve as a baseline, however trend data could not be provided due to lack of routinely reported information from the provinces. There are still problems with regard to the 1998 routinely reported data as indicated in Table 17 that outlines the immunisation coverage in South Africa from 1993 to 1998.

Table 17. Vaccination Status of SA Children Aged 12-23 Months for 1993, 1994 & 1998

% Children			
Vaccine received	199312	1994	199813
BCG	68	94.8	96.8
DPT1		91.1	93.3
DPT2		86.6	86.2
DPT3	81	73.4	76.4
OPV0			91.2
OPV1		89.1	91.0
OPV2		84.5	82.7
OPV3+	81	71.5	72.1
Measles	77	76.4	82.2
ALL	68	63.3	63.4

(Source: SAVACG, 1995; DHS, 1998)

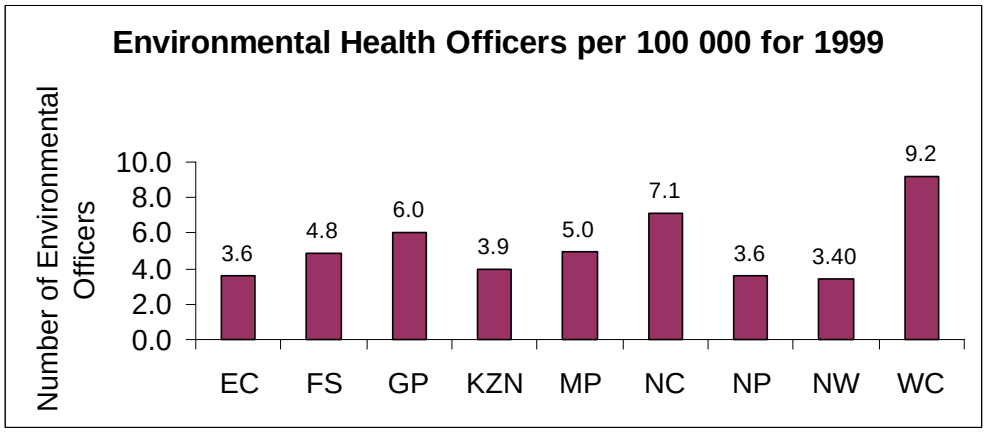
[12] These data are obviously limited given the extent of reporting prior to 1994, the fragmentation of services and reporting structures and the repeated changes in the immunisation schedules and reporting forms in the past five years. Moreover, these data do not include doses given in former self-governing and independent territories in South Africa.
[13] Data is from the 1998 Demographic and Health Survey.

The figures in the table above, shows that immunisation coverage has increased from 63.3 to 63.4 from 1994 to 1998. Comparisons with 1993 data are not possible as discussed in the footnote.

6.5 Environmental Health

The process of transforming the Development of Environmental Health Human resources was discussed and accepted at the Provincial Health Restructuring Committee meeting. The Department of Health in consultation with the Professional Board of Environmental Health and South African Institute for Environmental Health formed a Working Group in order to undertake the process of transformation forward.

Figure 7. Number of Environmental Health Officers per 100 000: 1999



(Source: Directorate Environmental Health 1999)

The distribution of health personnel was one of the major tasks of the Department of Health. Figure 3 indicates the distribution of Environmental Health Officers in the country by province. Western Cape has highest number of Environmental Health practitioners as compared to other provinces. The most rural provinces which include Eastern Cape, Northern Province and North West had fewer number of environmental officers distribution.

7. CONCLUSIONS

We have seen many successes with the implementation of Primary Health Care in South Africa. Over the past four years we have built hundreds of new clinics with over 90% of them being commissioned. There is evidence to support that the removal of financial barriers to Primary Health Care services have resulted in increase usage countrywide.

The Department of Health in close collaboration with its stakeholders has introduced the concept of patient's rights with the launching of the Patient's Charter in order to promote better quality care in our services. Moreover, the District Health System continues to be strengthened and developed and integrated service delivery at the Primary Health Care level promoted.

A new standard form for Primary Health Care has been introduced and information on the services provided should be available. The piloting of Telemedicine has begun and specialist care should reach rural communities.

There is however much more that needs attention. This report highlights many of the public health challenges, which must be urgently addressed lest we be crippled by the increased burden

of disease. We must ensure our children are properly immunised. We must educate our youth on the impact and realities of HIV and AIDS. We must continue to properly treat and care for people with STDs and TB.

Care, in some places, is still provided in an inequitable manner with women, children and people living in rural areas still getting less and sometimes inferior care.

These are just some of the challenges we face as we enter the new millennium. However, as we continue to promote Primary Health Care through the District Health System, we will and can continue to strive for more equitable and better quality care in order to improve the health status of all South Africans.