

***CELEBRATING THE ACHIEVEMENTS OF ALMA ATA:
STRENGTHENING PRIMARY HEALTH CARE IN
SOUTH AFRICA***

CONFERENCE REPORT

24-26 August 2003, Kopanong Conference Centre, Gauteng

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1 EXECUTIVE SUMMARY

1.1 Background

This executive summary serves to provide an overview of the conference 'Celebrating the Achievements of Alma Ata: Strengthening Primary Health Care' in South Africa held on 24 – 26 August 2003. Twenty five years ago the WHO and UNICEF led an international process that resulted in the drafting and signing of the Alma Ata Declaration in the former USSR. This Declaration launched the international movement to strengthen and expand primary health care using the primary health care approach internationally. The 25th anniversary of the Alma Ata was a unique opportunity for South Africa to reflect on the progress, challenges and way forward in Primary Health Care; celebrate the Alma Ata Declaration; test the Declaration against the needs for Primary Health Care in the 21st century and to develop key priorities for PHC for the next 5 years formulated into the *Kopanong Declaration on Primary Health Care*.

1.2 Conference Framework

The three pillars of Alma Ata were used as key themes of the conference to which international keynote speakers from Kenya, Brazil and Australia were invited. These themes were equity, intersectoral collaboration and community participation. In addition, the conference looked at the additional themes of strengthening health systems, human resources for primary health care and priority health care programmes. Technical teams, comprising participants from other government sectors, community members, training institutions, the private sector, NGOs and CBOs engaged in debate to arrive at recommendations drawn from six thematic commissions around which the conference was structured. The outcome of the 6 commissions was the *Kopanong Declaration on Primary Health Care*.

1.3 Technical Themes

The purpose of the technical themes was to determine past achievements and current challenges confronting PHC with the aim of identifying reasons and developing key priorities out of this investigation.

The first of the technical themes focussed on the question of **equity** with respect to the distribution and adequacy of resources. The outcome of this thematic deliberation is a ten year strategic plan dedicated to the development of the

Management, Economic, Social and Human (MESH) infrastructure, equity in per capita PHC expenditure and strengthening the distribution of human resources. The second technical theme addressed the question of **community involvement in health** and focussed on the reorientation of the system of ownership of PHC, capacity building, enhancing budgets for community involvement in health and aligning legislative frameworks in support of these endeavours. The third technical theme examined the issue of **strengthening health systems** and proposed Healthcare 2010 as an output model focussing on admissions and contacts to ensure quality care at all levels. **Human resources for PHC** served as the fourth technical theme which proposed key priorities for the next five years including the development of a national human resource plan for the country and provinces as well as developing mechanisms to impact on the current brain drain from South Africa. Technical theme five, **priority PHC programmes**, emphasised the need for a marketing strategy as well as the reallocation of resources whilst theme six, **intersectoral collaboration**, proposed a number of priorities including an audit of intersectoral activities, the rationalisation of policy and planning as well as prioritising public awareness.

1.4 Recommendations

The conference concluded with the adoption of the ***Kopanong Declaration on Primary Health Care*** which focuses on concrete strategies to reduce inequities in the allocation of resources; committing funds for community involvement; focussing resources on priority health programmes; implementing coherent human resource plans; recommitting to the principles of PHC and strengthening PHC through intersectoral forums.

2 ACKNOWLEDGEMENTS

The organisers of the conference wish to acknowledge the following without whose guidance and participation this conference would not have been possible:

The Minister of Health: for her leadership and insistence that South Africa be the first country in the world to celebrate the 25th anniversary of the signing of the Alma Ata Declaration;

The presenters, especially our international guests and keynote speakers;

Chairpersons, facilitators and rapporteurs;

Our sponsors: DFID, the EU and Italian Co-operation;

Ms Elise Levendal and her team for event management and for taking care of the logistics;

Ms Merle Caminsky for drafting this report;

The organising committee: Dr Yogan Pillay (convenor); Dr Eddie Mhlanga; and Ms Jo-Anne Collige; and

Delegates from far and wide without whose participation the conference would not have been a success.

Dr Yogan Pillay (on behalf of the organising committee)

3 INTRODUCTION

The Celebrating Alma Ata 1978 – 2003 to Strengthen Primary Health Care in South Africa Conference was held on 24-26 August 2003 at the Kopanong Conference Centre in Gauteng, South Africa to mark the twenty-fifth anniversary of the Alma Ata Declaration, and to re-commit South Africa to the principles of the Primary Health Care Approach.

The Alma Ata Declaration was adopted at the First International Conference on Primary Health Care held in Alma Ata in the former USSR on 6-12 September 1978. The conference was convened under the auspices of the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF). The goal of the first conference, twenty five years ago, was to achieve 'Health for All by the Year 2000'.

David A. Tejada de Rivero, former Peruvian Health Minister and WHO's deputy director-general between 1974 and 1985 was the key organizer of the Alma-Ata conference. He summarised the ten points of the Alma Ata Declaration as follows:

- I. Health is a state of complete physical, mental and social well-being and is a fundamental human right. Attaining the highest possible level of health is a worldwide social goal that requires the action of many sectors.
- II. The existing gross inequality in people's health status is unacceptable and is of common concern to all countries and people.
- III. Economic and social development is essential to attaining health for all, and health is essential to sustained development and world peace.
- IV. People have the right and duty to participate in planning and implementing health care.
- V. A main goal of governments and the international community should be the attainment by all peoples by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this goal.
- VI. Primary health care is based on practical, scientifically sound and socially acceptable methods and technology made universally accessible through

people's full participation and at a cost that the community and country can afford. It is the central function of the health system and its first level of contact, bringing health care as close as possible to where people live and work.

- VII. Primary health care evolves from a country's own conditions and addresses the main health problems in the community. It should lead to progressive improvement of health care for all while giving priority to those most in need.
- VIII. Governments should formulate policies and plans of action to make primary health care part of a comprehensive national health system, in coordination with other sectors. This requires political will to mobilize domestic and external resources.
- IX. The attainment of health in any one country directly concerns and benefits every other country. All countries should cooperate in the development and operation of primary health care throughout the world.
- X. An acceptable level of health for all people by 2000 can be attained through better use of the world's resources, much of which is spent on military conflict.

Five global conferences on health promotion have been held since 1978, and their accomplishments are briefly covered here:

'The Ottawa Charter for Health Promotion' was an outcome of the First International Conference on Health Promotion held in Ottawa, Canada in 1986. The charter recognised that efforts both at organisational and individual levels, from public policy to personal behaviour, were necessary to provide the conditions for good health. The second international conference was held in Adelaide in 1988, and the 'Adelaide Recommendations on Healthy Public Policy' stressed that policies in all sectors influenced health outcomes. It called on all agencies to consider their impacts on the health and identified four areas for focused action: women' health, improving food security, safety and nutrition, reducing alcohol and tobacco use, and creating supportive environments for health.

'Creating Supportive Environments for Health' was the focal point of the third international conference held in Sundsvall, Sweden in 1991. The 'Sundsvall Statement on Supportive Environments for Health' acknowledged that deteriorating

social-economic and physical environments were negatively influencing health status. The statement placed people at the centre of development and contributed towards the formulation of Agenda 21 adopted at the first World Summit on Sustainable Development held in Rio in 1992.

In 1997, the Fourth International Conference on Health Promotion was held in Jakarta, Indonesia to evaluate the Ottawa Charter. Experiences showed that appropriate health promotion strategies contributed positively towards the prevention of disease. The 'Jakarta Declaration on Leading Health Promotion into the 21st Century' focused on social responsibility, empowering the community and the individual, partnerships, investments and infrastructure. These priorities were adopted at the World Health Assembly in 1998 as part of the 'Resolution on Health Promotion' that was subsequently taken into the next millennium at the fifth Global Conference on Health Promotion (5GCHP) held in Mexico City on 5-9 June 2000. Eighty six Ministers of Health demonstrated their countries' political commitment to health promotion by signing the 'Ministerial Statement for the Promotion of Health: From Ideas to Action' at the 5GCHP.

It is against the backdrop of these positive developments towards health promotion that the South African Alma Ata conference was held. Furthermore, a resolution was passed this year at the 56th World Health Assembly of the World Health Organisation requesting that member states "...examine the lessons of the past 25 years, review definitions and strategies and identify future strategic directions for primary health care...". It was in the light of this call that the South African Minister of Health, Dr. M. Tshabalala-Msimang decided to host this Primary Health Care conference to review the strategy of the National Health Department in the 10th year of democracy. The conference was convened with the following objectives:

- To celebrate and revisit the Alma Ata Declaration and review South Africa's progress in Primary Health Care;
- To test the provisions of the Declaration against the need for the Primary Health Care approach in the 21st century;
- To test the South African experience of implementing the Primary Health Care approach; and

- To develop key priorities for Primary Health Care for the next 5 years and codify these proposals into the Kopenong Declaration on Primary Health Care.

4 CONFERENCE STRUCTURE

The conference commenced with an opening ceremony held on Sunday 24 August 2003 that highlighted the key issues facing Primary Health Care in the 21st century. Conference sessions were initiated the following day with an extended plenary establishing the backdrop of Primary Health Care endeavours in South Africa followed by parallel thematic commissions mirroring the Alma Ata Declaration, namely:

1. Equity
2. Community Involvement in Health
3. Strengthening Health Systems
4. Human Resources for Primary Health Care
5. Priority PHC Programmes
6. Intersectoral Collaboration.

The first day of conference sessions explored what developments had worked well in the field, what had not, what lessons were learnt from the experiences and what contributions could be integrated into concrete proposals for a clear five year vision. On the second day, the six commissions developed specific key priority areas for implementation over the next five years and these were presented at the closing session for adoption. The proposals were discussed in plenary, and the 'Kopenong Declaration on the Future of Primary Health Care' was drawn up to close the conference. The full text of the Declaration appears as *Appendix A*.

5 OPENING CEREMONY

Dr. M. Tshabalala-Msimang, the National Minister of Health, delivered the opening address. She was followed by Ms. Penina Ochola-Odhiamo, of Plan International who presented the keynote address 'Key issues in Primary Health Care for the 21st Century'.

5.1 Opening Address

Dr. Tshabalala-Msimang welcomed international and South African guests, including local government councillors, health workers, representatives of NGOs and academia. She reminded delegates of the decisions taken by health workers at the first national conference of the National Progressive Primary Health Care Network in 1987. That conference called for 'Progressive Primary Health Care' to distinguish it from the existing health practices of the apartheid government. The conference adopted four principles of progressive PHC viz., commitment to socio-economic change, community accountability, comprehensive care and concerned health worker practice. These mirrored the three pillars of the Alma Ata Declaration - equity, community participation and intersectoral collaboration.

Dr. Tshabalala-Msimang further informed delegates of the current concerns of government. Efforts are being focused on ensuring integrated development – a key component of the PHC approach. To support this, government departments have been clustered to support closer cooperation and evidence of this is found in the co-operation of a range of government departments in the implementation of the Integrated Sustainable Rural Development Strategy in thirteen priority nodes across the country. Another example is the joint implementation of a co-ordinated nutrition strategy jointly by the Departments of Agriculture, Social Development and Health.

Progress has been made in removing payment as a barrier to access to PHC services. People with disabilities, for example, now have free access to health services, and more than 700 clinics have been built or upgraded to mainly serve the most vulnerable and needy communities. Community service has been introduced for doctors and other health professionals to ensure that rural and under serviced areas have access to professional health care. Other focus areas have been to ensure that every facility has a fully trained PHC nurse; creating a mid level worker in a range of disciplines and strengthening the community health worker programmes. Most surveys indicate that 80% of the public are satisfied with the health care they receive whilst the remaining 20% are unhappy largely with the attitude of health workers and the lack of drugs.

While much progress has been made challenges remain such as ensuring that all citizens have access to a comprehensive basket of PHC services and that the distribution of resources is equitable. The target date for the full implementation of

the basket of PHC services for everyone is 2004 but challenges remain to achieve this.

Dr. Tshabalala-Msimang concluded by noting that the conference will give participants the opportunity ‘...to collectively review our achievements and deliberate on what it is we need to do to improve service delivery to realise the vision of the Alma Ata Declaration. We need to find new ways of doing things if the tried and tested methods do not work. We need to commit ourselves to ensuring a better life for all.”

5.2 Keynote address

Ms. Ochala-Odhiamo’s address, *‘Reversing the Pyramid and Empowering the People’* examined the health care situation before Alma Ata; the promises of the Declaration; achievements since its adoption and some of the lessons learnt in its implementation. The address concluded with a list of issues that require attention and a proposed way forward.

Provision of health services pre-Alma Ata, as Ms. Ochala-Odhiamo pointed out, was characterised by the majority of a population being underserved, poorly trained health workers, a top-down provision of health services and services that were not people centred but rather facility focussed. The principles of primary health care, as contained in the Alma Ata, shifted the paradigm of health care by acknowledging that:

- ◆ There is an inextricable link between health and human development
- ◆ Community participation is vital
- ◆ The need to ensure sustainability in health, empowerment, ownership, self realisation and self-reliance
- ◆ Comprehensive intersectoral collaboration is required
- ◆ Appropriate technology that is affordable, accessible, available and acceptable needs to be employed
- ◆ Health system management must include re-orientation of the health workers and devolution of health services

There have been many achievements since the adoption of the Alma Ata such as: increased community involvement and empowerment; development of a new cadre of health workers; increased demystification of health issues; application of available

and appropriate technology; political commitment; and an increasing emphasis on the social context of health care management. Questions remain on issues such as representation in participation processes, the feasibility of voluntarism, adequate capacity and the threats of global conflict.

Ms. Ochala-Odhiamo's recommendations for the way forward included: the refocusing of health on the household; promoting the participation of children and youth; curriculum revision to include PHC in all schools of Health Sciences; revise policies to mainstream gender in PHC; that peace be central to all governments of Africa; and that poverty reduction be made practical.

6. PLENARY OPENING SESSION

The opening plenary session set the backdrop for the conference. Presentations were given by:

- ◆ Professor Gavin Mooney of Curtin University, Australia, who presented a keynote address entitled, *'Equity in funding Primary Health Care: Some experiences from Aboriginal Australia'*.
- ◆ Dr Ayanda Ntsaluba, National Director General of Health, South Africa, submitted the Primary Health Care Scorecard demonstrating what has been achieved in South Africa thus far.
- ◆ Mrs. Selina Maphorogo, Senior Nursing Assistant at the Elim Care Group Project, represented the community in her presentation, *'Primary Health Care: Voice from the community'*.
- ◆ Dr Armando De Negri Filho *'The Brazilian Experience of the last 15 years'*

'Equity in funding Primary Health Care: Some experiences from Aboriginal Australia'.

Professor Mooney's paper presented work done for the Commonwealth Grants Commission to determine how resources should be allocated for health amongst indigenous communities in Australia. The paper presented a number of key principles with respect to equity. *The full paper is available as Annexure 9.1.*

Professor Mooney noted that in many respects the equity vision of Alma Ata has not succeeded because there is a lack of compassion to drive equity and furthermore there is a lack of leadership in the world around the values of the Declaration. He stated that the challenge lies in making PHC more than slogans; in ensuring that community voices are heard and in ensuring that communities get the necessary skills to be participants in PHC.

He posed an often neglected question, "what is the good of health care?" In answer to this question, aside from the obvious answer of better health, he added that a community looks for information about health; it wants its autonomy and dignity respected and it wants equity of resources. He added that it is the community who should define good health care; it is their values which should drive it.

The aboriginal people of Australia have an average life expectancy of 20 years below the national norm. A traditional sickness based needs approach would argue that it is necessary to put in all the required resources where there is poorer health to improve this outcome. Dr Mooney argues that this is a superficial view that looks at the size of the problem rather than the capacity to benefit. He proposes that there needs to be consideration of the benefits of the resources i.e. ‘the idea of value’ when planning for equity. Since major causes of poor health are located in the environment and poor social conditions, investment of resources should be here where there is likely to be a better return on the investment. Dr Mooney argued that capacity to benefit was most significant when environmental factors resulted in health problems.

A further approach towards equity undertaken in Australia has involved upgrading the management, economic resources, social functioning and human infrastructure before investing in individual health initiatives. The approach called MESH (Management Economic Social and Human infrastructure) argues that not every community has the capacity to take advantage of allocated resources. Where the salient elements of MESH are missing, this provides forewarning of resources that are likely to be wasted or used ineffectively.

Dr Mooney posed the question: “What good do we seek to achieve from the allocation of health care resources to different communities or regions?” In answering his own question he observed that the goal might be broader than health. In the case of the Aboriginal definition of need this includes cultural security, physical well-being; good environment, and freedom from poverty. Cultural security refers to the health system not compromising cultural values etc of the Aboriginal people. It aims to ensure that cultural differences do not produce barriers to service access.

This approach to healthcare resources allocation may be useful to South Africa. However, what is deemed “good” in South Africa is likely to differ from the Australian perspective. Utilisation of these principles within the South African context must be endorsed by stakeholders who will ensure that it is consistent with their value systems. Dr. Mooney concluded by recommending that deficiencies in data must not be a deterrent to progress. In his view, ‘to get the principles right and use initially rough data which can be improved over time is to be preferred to letting data availability determine the process’.

Primary Health Care Scorecard: What have we achieved?

Dr Ntsaluba presented the PHC scorecard to evaluate the national Department of Health's accomplishments in the last nine years. He stressed that it had been recognised that while it was necessary not only to be technically adept in a range of health areas but that improving relations between service provider and the community was just as important. *The full text is provided as Appendix 9.2.*

His review of health care was undertaken using key principles of the Alma Ata and against the backdrop of the '*White Paper for the Transformation of the Health System in South Africa*' (1997) which has as its objectives:

- (a) To unify fragmented health services at all levels into a comprehensive and integrated NHS;
- (b) To promote equity, accessibility and utilisation of health services;
- (c) To extend the availability and ensure the appropriateness of health services;
- (d) To develop health promotion activities;
- (e) To develop the human resources available to the health sector;
- (f) To foster community participation across the health sector; and
- (g) To improve health sector planning and the monitoring of health status and services.

PHC is acknowledged as the foundation of the national health system. The **package of PHC services** ensures access and free health care for children under 6 years old, pregnant and lactating mothers, the disabled as well as all who need it. This has resulted in an increase in clinic usage. At least 701 clinics have been built and upgraded since 1995. Services such as Voluntary Counselling and Testing and home and community-based care have been added to the package of services. The impact of this package of services means that 7 million people have improved access to PHC services. This package of services provides certainty around what is offered and it facilitates equity of provision.

Historically PHC services were (and to some extent continue to be) provided by both **province and municipalities**, and this led to duplication and difficulties in separating roles for each of the spheres of government. The issues however, are close to

finalization and will be legislated in the National Health Bill . It is envisaged that metro and district municipalities will fund and deliver environmental health services. Other PHC services will be the responsibility of provinces, but these may be delegated for implementation by municipalities, subject to agreement between these two spheres of government.

Planning has focused on to strengthen health systems delivery. The National Health Bill focuses on improving planning tools to aid the sustainable rendering of primary health care. District health plans and reporting requirements are provided for in the bill and these are designed to inform the local government Integrated Development Planning process and the provincial budgeting process. Good planning requires good data and a national minimum data set has been instituted and 98% of PHC facilities nationwide provide monthly reports. Government is working on improving the quality and use of this data. Drug management is also receiving attention.

Improving and maintaining **human resources** is a key obstacle to PHC delivery, and the department believes that improving working conditions will assist in reversing the losses of experienced staff to the private sector and the overseas job market. Quality of buildings and equipment, management and training must be improved. Clients must be empowered and a credible complaint system must be established.

Quality is recognized as a key area and a directorate at national level has been created to give leadership in this regard. The department has implemented the Batho Pele programme and has begun training supervisors. Mechanisms to deal with complaints have been implemented. In addition, the supervisory system has been strengthened but resources have to be provided to ensure that the work can be monitored.

The White Paper addresses **equity** however health care spending is not increasing. The degree of inter-provincial inequity in overall health expenditure is decreasing. There are large inequalities amongst provinces when one considers PHC expenditures. A possible reason for lower expenditures predominantly in rural districts and provinces is their inability to attract staff. The Mosvold bursary scheme in KwaZulu-Natal provides students with bursaries and contracts them to work in their own communities for qualifying. Similar training arrangements need to be developed in partnership with training institutions.

Community participation on issues such as policy development has been encouraged through committees set up in clinics and community health centers but it

is not clear how active these committees are and how responsive the health system is to their input. Community participation has also been enhanced through the TB DOTS programme and through the involvement of volunteers and community health workers in home and community based care programmes.

Intersectoral collaboration even within government has proved difficult however there are encouraging examples of intersectoral collaboration such as the clustering approach that the government has adopted.

‘Primary Health Care: Voice from the community’.

This presentation provided an example of 36 years of caring! Even before the Alma Ata Declaration, a pillar of PHC was unfolding in Limpopo Province. Speaker, Mrs. Maphorogo of the Elim Health Care Group related how groups of volunteers have organised themselves as far back as 1976 in what is now Limpopo Province. Their aim was to understand health problems in their communities. Specifically, they assisted the healthcare team at the Elim Hospital to overcome Trachoma in the 1970s. The volunteers’ efforts were rewarded with a marked reduction in trachoma infection rates. However, the care groups insisted on continuing their community outreach programme, assisting with other community health problems such as malnutrition, diarrhoea and HIV/AIDS.

When addressing the initial trachoma outbreak, a holistic approach was adopted where interventions were directed towards communities, as opposed to individuals, and covered both treatment and prevention. Training for the care groups was facilitated by Nursing Assistants and community participation facilitated through the traditional leaders. Other interventions included:

- Addressing diarrhoea and vomiting with e.g. oral re-hydration fluids demonstration.
- Addressing malnutrition with small home gardens, communal gardens and cooking demonstrations
- Promoting the start-up of small income-generating projects
- Education and training mothers on health issues and encouraging them to take their children to the under- 5 clinic

Care groups are actively involved with education on the prevention of HIV transmission. They encourage the community to take care of HIV-positive people and

child headed households, and support the sick with food parcels and transportation to hospitals and clinics and with referrals to the relevant service providers.

Mrs. Maphorogo concluded by voicing the concerns of the community, stating that most of the people who are suffering are women and children; that poverty is a major threat to health; water and sanitation is inadequate; and that there is a shortage of medicines, staff and ambulances and poor access to transportation to conduct community work. There is still a large gap between service providers and recipients, although volunteers are helping to bridge this gap to some extent. The community stressed that care groups are an integral part of the health care team and are willing to share the responsibilities for community health. They called on government to assist them to form more effective partnerships.

‘The Brazilian Experience of the last 15 years’

Dr Armando De Negri Filho addressed the conference on the Brazilian experience over the last 15 years of community mobilisation and social involvement in building the national health system. He described Brazil as a country of 178 million people living in 27 states and 5600 municipalities. From 1964 - 1985 it was governed by a dictatorship during which time health care services were available to the formal working sector whilst the majority of people outside of this sector depended on charitable organisations to provide health care.

Academics, trade unions, the Catholic Church and community leaders campaigned for universal access to a national health system. The value of ‘right to health’ saw the health sector becoming an important terrain of struggle. The outcome of this activism was the National Health Conference of 1986 from which the transformation of the Brazilian health system began. Three major principles emerged at the conference – universal access, access to all levels of care and equity in terms of provision. In 1988, universal access to health care became part of the Brazilian constitution and legislation was passed two years later to give effect to this provision. Efforts by conservative interests to undermine these developments have been defeated by the 5600 municipalities each of which has a health council.

Health councils are made up of at least 50% community representatives with other members being government representatives, health workers and private health care providers under contract to the National Health Service. Health councils have the power to approve health plans and budgets. Local authorities have to present plans

and budgets to the local health council and revise these until they are approved. Social participation has meaningful power and focuses on making decisions.

The relationship between social participation and primary health care is very strong. Health planning is a 'bottom up process' and priorities are based specifically on local requirements and guidelines. Intersectoral initiatives have resulted in health planning being linked to broader planning processes allowing for an effective response to social inequalities. The participative processes in Brazil are independent of government thereby ensuring that people have the power to criticize and are in a position to assist officials in moving processes forward. The president of the national health council is not necessarily the Minister of Health. This non-alignment allows for a more dynamic relationship between people and their social representatives.

7 A CONVERSATION WITH THE AUDIENCE

A panel of speakers undertook a conversation with the audience presenting key issues facing PHC. The panel, chaired by Dr Malcolm Segall comprised of:

Tim Evans	WHO
Nellie Manzini	Limpopo Province
Nana Bonga	KwaZulu-Natal, Progressive Primary Health Care
David Saunders	University of the Western Cape
Linda Bali	Western Cape

The discussion probed the current functioning of PHC in a largely ambivalent and harsh world climate. The audience echoed some of the issues raised by the speakers.

Summary of the panel discussion

Malcolm Segall contributed to the discussion by noting that PHC as a discourse has largely disappeared for international agencies and that it is driving forward in a relatively hostile world environment.

Tim Evans stated that PHC in all its facets relies on mobilising the human workforce which is vital to an effective health system. He noted that this component, which consumes between 60% - 80% of the cost in providing health care, gets little recognition and support. He stressed that people are the key to vital health systems

and therefore it is critical to develop 'health citizenry'. He stated that people in the health system must have an understanding of the principles of PHC and what these mean in practice. He added that South Africa is not exempt from external global influences such as the loss of staff to the northern hemisphere – a trend that is likely to be extended and one that PHC has to be alert to and so PHC has to be committed to investing in human beings.

Nellie Manzini considered 16 years in health and observed that government's policy with respect to PHC has been evident in clinic upgrading and building programmes for example. Speaking from her position as a provincial Head of Department, she noted that she is faced with a host of competing priorities. Elements of PHC are largely invisible and therefore when faced with prioritising, they are the ones which get dispensed of. Key challenges include how to manage the competing needs of people for free water, free health etc; levels of care versus access and quality of care.

Nana Bonga highlighted four underlying principles of the PHC approach namely accessibility, self reliance, appropriate technology and cost effectiveness and intersectoral action for health and noted the visibility of the South African government's efforts with respect to the Alma Ata Declaration. Within the current framework, she stressed the need to reorientate health workers; revisit the boundaries of PHC; enhance the community voice; develop community work as an extension of PHC; and develop retention strategies for staff.

Linda Bali spoke from his grassroots experience, in the Western Cape, of setting up health committees and noted some of the problems confronting the effective establishment and functioning of these committees. The main problem is that volunteers are not working due to a lack of clarity of purpose regarding the tasks of health committees. In informal settlements, difficulties are experienced in establishing committees; the role of health committees are not understood by the communities;; the role of health committees are not understood by nurses and in some cases people are defrauding the committees.

Audience contributions

Four key themes emerged from the discussion raised by the audience – financial concerns, policy issues, role of practitioners and community participation.

Financial concerns: Whilst PHC brings services closer to people, there is insufficient budget to actively support this process. A point frequently made by the audience was that there needs to be an active protection of PHC resources. Budgets should be ring-fenced by the Treasury Department and if this is not possible then funds should be devolved down.

Policy issues: The discussion that followed showed that experiences vary from area to area. Whilst the White Paper raises health committees as an important aspect of PHC, it is necessary that there are mechanisms to facilitate that health committees are recognised more extensively. The value of the health committees is apparent. .

Roles of practitioners: There is a need to re-emphasise the role of traditional healers. The point was made that traditional healers are a resource that is not seen as legitimate by the health system. However, large numbers of people particularly in the rural areas are visiting them. The issue posed was the impact of continuing to ignore this group of practitioners. The challenge facing PHC is to assist these healers in being organised around a number of issues including that of home based care. In addition, if there is no consultation with the traditional healers, the pressure of seeing doctors in the clinics becomes a serious problem facing the service providers. This is an opportunity to educate people who have power in communities. It was proposed that traditional healers be linked to nurses and doctors not around 'how' to do things but 'around' what they are doing.

The position of nurses was highlighted as well. It was noted that it is through the nurse that health care is brought to under-served communities. However, the PHC nurse gets overburdened by numerous programmes and this is heightened by the pressure of HIV and AIDS whereby the nurse is required to counsel patients and families. Nurses are not equipped in all instances to handle HIV and AIDS. The practical issue that needs to be addressed is the extent to which nurses are being equipped and supported to deal with the work overload. A call was made for people

to think more broadly and see how things are done in other countries where assistants and health care workers are key resources. In line with this it was proposed that the department of health should consider contracting others such as intersectoral committees to undertake projects on the ground.

The role of managers was also raised by the floor. Effective planning, implementation and management are critical components of PHC and require a seamless line between those who manage and those who implement however discussion noted that this is not the case. The point was made that managers also need good supporting structures to meet expectations.

Community participation: Whilst community participation was a key theme, a member of the audience argued that the definition of 'community participation' is not a shared one and it needs to be for purpose of clarity in action. A panel member responded that it is not possible to define community participation but that one needs to look at where people participate and where you have good results. The issue was expanded with the point that there is discussion about community participation in a generalised manner but inadequate discussion about the participation of health workers in the communities they serve. In the absence of regulatory mechanisms, health workers are not involved in making decisions. The We often speak of community needs but we neglect to pinpoint their strengths and assets that can support excellence. There are a cadre of workers who need to be monitored but also given freedom. Ultimately, we need a leadership strategy to identify the stage when communities do become the leaders to engage the health sector.

8 TECHNICAL THEMES AND CASE STUDIES

Parallel discussions reviewed PHC accomplishments in six key areas, namely Equity, Community Involvement in Health, Strengthening Health Systems, Human Resources for PHC, Priority PHC Programmes, and Intersectoral Collaboration. Each of these themes was examined to determine what has been achieved, what has worked and what has not, the reasons in each case and to develop key priorities for PHC for the next 5 and 10 years.

8.1 Technical Theme 1: EQUITY

Equity was evaluated by firstly examining the distribution and adequacy of resources to meet primary health care service delivery needs and then presenting possible solutions to address the deficiencies. Three papers were presented focussing on *'The Distribution and Adequacy of Resources.'* Steve Thomas reviewed public financing aspects and Princess Matwa presented *'Human Resources for Health: maldistribution and the current brain drain'*. These issues were looked at in greater detail by Xoli Mahlahlela in his presentation of a case study dealing with service delivery in the Eastern Cape. Solutions were offered in the session *'Tackling the Problems'* in the respective presentations of Haroon Wadee, Vera Scott and Thulasizwe Shezi, *'Considering Public-Private Interactions (PPIs) in the South African Health Sector – Implications for PHC'*, *'Developing and Implementing a formula for Redistribution of Resources – Cape Town Equity Gauge'* and *'Empowering communities to access their Health Rights'*.

The commission reached consensus on the **vision** for this technical theme which reads as follows::

"We don't have to let this happen – things can be different and equitable."

The **preamble** states:

- ◆ 25 years on from Alma-Ata, intersectoral collaboration requires working with the Department of Trade and Industry and the Department of Finance in addition to traditional social sector departments
- ◆ Clear government commitment and policy to address equity issues in PHC, accompanied by advocacy and community empowerment
- ◆ Equity in PHC is as an intermediate goal. The ultimate goal is equity for health, notably by employment generation, poverty alleviation and investment in other sectors like education, housing, water and sanitation
- ◆ Involvement of communities in identifying need and documenting inequities

The **ten year strategic plan for equity** in Primary Health Care is divided into 2 thrusts:

The **first five years**:

- ◆ Dedicated to the development of the Management, Economic, Social and Human (MESH) infrastructure; the achievement of horizontal equity in per capita PHC spending and strengthening human resources distribution.

The **six – ten year period**:

- ◆ Dedicated to strengthening budget allocation for PHC, equity in PHC budgets, improving cross subsidisation, eliminate tax breaks

Developing MESH Capacity

Period	Targets	Objective/Activity	Output	Responsible stakeholder
Y1-Y2	10 Year Strategic Plan for Equity	Establishment of Equity Strategy Group including civil society to develop a 10 year Strategic plan for equity, with targets and implementation strategies Participatory development of a 10 Year Strategic Plan for Equity drawing from existing work, DHERS, research	10 Year Strategic Plan for Equity Equity Targets for PHC Documented Implementation Strategies	National and Provincial DoH Civil society
Y2	5 year plan for MESH infrastructure Additional resources for MESH infrastructure	Development of a plan to build MESH infrastructure	MESH infrastructure Development Plan	National and Provincial DoH Civil society NGOs Academic institutions
Y3 – Y5	Dedicated funding set aside for MESH (not only health) Cost effective resource allocation	Implementation of strategies to strengthen MESH infrastructure Redistribution of budget	Objective improvement in MESH infrastructure compared audit report (i.e. baseline) Improved programme performance	National and Provincial DoH Civil Society NGOs Academic institutions

Horizontal equity in per capita PHC spending

Period	Target	Objective/Activity	Output	Responsibility
Y1 – Y2	Define and disseminate health sector position on GATTS to protect health and health systems from implications of GATTS agreements Bringing National and Provincial Treasuries on board re: equity in PHC financing	Explore the health implications of GATTS Discuss with DTI the health consequences of trade agreements Discuss with DTI the health consequences of Trade Agreements DoH, Provincial DoH and Treasury to develop strategies for ensuring sustainable PHC financing (capital and recurrent budgets; revision of equitable share formula; consider emerging tools for resource allocation (e.g. normative funding models)	MoU between DoH and DTI regarding GATTS DTI consults with DoH and stakeholders re GATTS Documented strategy for protecting PHC Finances; new, revised, “equitable” Equitable Share Formula	National DoH DTI Civil society National and Provincial DoH Civil Society NGOs Academic Institutions
Y2	Increased PHC funding guided by definition of service delivery platforms based on District Health Planning Guidelines	Increase PHC funding in least resourced districts to an acceptable minimum (of R100-00)	Actual increase in PHC funding. All districts spending R100 or more on PHC	National and Provincial DoH National and Provincial Treasury Civil Society NGOs Academic institutions
Y2 – Y5	Per capita PHC budget sufficient to pay for PHC package by 2005/6 budgets (and beyond)	Restructuring of PHC budget to cover the PHC package (informed by costing of package)	2005/06 budgets adequate to cover PHC package	National and Provincial DoH National and Provincial Treasury Civil society NGOs Academic Institutions

Human Resources

Period	Target	Objective/Activity	Output	Responsibility
Y2	Equitable distribution of health workers No unfunded/vacant posts in rural development nodes	Comprehensive human resource strategy Policies to control importing of health care providers from other countries Decentralisation of training to rural areas Academic complexes to provide training and support Inclusive incentive scheme	Comprehensive HR Strategy Policy on migration of health personnel Increased numbers of health workers in rural areas	National and Provincial DoH DTI National and Provincial Treasuries
Y2	Establish Community Health Workers as integral to health system Introduce standard conditions of employment	Develop national policy on community health workers	Policy on CHW	National and Provincial DoH

Next 6 – 10 Years

Period	Target	Objective/Activity	Output	Responsibility
Y6 – Y10	Equity in PHC Budgets	<ul style="list-style-type: none"> ▪ Strengthen budget allocation for PHC ▪ Improve cross subsidisation of public by private Eliminate tax breaks	Equitable resource allocation of PHC	

Public Private Interactions (PPIs)

The team stated that PPIs are not a strategic priority for PHC and that PPIs need to be considered carefully for a number of reasons, particularly the ability of the public sector to manage contracts.

Period	Target	Objective/Activity	Output	Responsibility
Y2 – Y5	Develop guidelines for PPIs to create a unified vision and approach More interactions with the not-for-profit sector	Development of national guidelines for PPIs and PHC settings Development of more SLAs between DoH and not-for-profit sector	Guidelines for PPIs, SLAs	National and Provincial DoH National and Provincial Treasury

8.2 Technical Theme 2: COMMUNITY INVOLVEMENT IN HEALTH

This theme investigated the status of community involvement in health in South Africa. Felicia Manjiya and chairperson of a clinic committee presented a paper entitled, *‘Building of Clinic Committees*. Johannes Mokgatle examined community involvement in environmental health in his paper, *‘Key lessons of Community Involvement in Environmental Health using De- Worming as a catalyst’* whilst A.N. Kheswa presented *‘Partnerships for health: the Alfred Nzo Municipality Experience’* as a case study. Bridget Lloyd discussed *‘The changing role of an NGO in relation to health service delivery and advocacy.’*

The group reached consensus on the **vision and priorities for the next 10 years.**

The vision for this technical theme states:

“Translate the policies that have already been developed into action so that we move towards partnerships in community involvement in health”

The **projection for achievements in five years time** focuses on the reorientation of the system for ownership of PHC in communities; sustainable budgeting for community participation in health; capacity building for accountability and states that there should be:

- ◆ a fully decentralised system where communities would determine needs

- ◆ communities have ownership of health services
- ◆ an understanding of a comprehensive approach to health care amongst all stakeholders from management to communities
- ◆ re-orientation of training for health service providers to be responsive to community needs/involvement
- ◆ increased accountability of service providers to communities
- ◆ full alignment of legislative frameworks across departments for co-ordinated development and involvement
- ◆ sustainable budgets for community involvement in health
- ◆ government funding available to NGOs and CBOs for community capacity building
- ◆ capacitating small CBOs to have direct access to funding
- ◆ access to information and sustained funding for CBOs mobilising for community projects
- ◆ committees to be accountable to the broader community by imparting information
- ◆ less time spent in committee meetings and more time amongst communities
- ◆ education, awareness raising and capacity building would take place in all communities
- ◆ communities to be respected and acknowledged for the work they have been doing over many years

It was agreed that in **the first year, priorities** are:

- ◆ for each community to establish a health committee according to catchment areas with reference to the provisions of the National Health Bill;
- ◆ that hospital boards be operational at every hospital
- ◆ each health district to run development programmes
- ◆ for re-orientating all stakeholders, including community and service providers, towards a developmental framework away from a disease focus
- ◆ for participatory planning within the health districts, involving all stakeholders, and according to community defined needs
- ◆ for reviving networking and advocacy roles of NGOs/CBOs
- ◆ that the national health department will finalise policies on community health workers
- ◆ clarification of roles and responsibilities of the various role-players who facilitate community involvement in health (e.g. Government, NGOs, CBOs)

- ◆ for government commitment and accountability to partnership with communities through formal contacts

Submission for the Kopanong Declaration:

That there will be committed funding and budgets for sustaining community involvement in health through regular area summits leading to provincial summits.

8.3 Technical Theme 3: STRENGTHENING HEALTH SYSTEMS

Technical Theme 3 examined ways of strengthening health systems. Nomso Arosi and Ntomboxolo Dweba addressed the issue of *'Improving quality care – the role of supervisors'*. Alta Odendaal presented a paper entitled *'Using information to improve district health services: Thabo Mofutsanyana District'*; a presentation on *'Ensuring proper drug management'*; Lucy Gilson presented *'Intergovernmental Co-ordination* and Craig Househam spoke on *'Restructuring Health Services: the Western Cape experience'*.

The technical group feedback on achievements and weaknesses looked specifically at support systems, the role of supervisors and supervision, utilising information systems and drug management.

Efforts at improving supervision resulted in increased motivation of staff, greater involvement of stakeholders, effective implementation of the supervisor's manual and the adoption of a performance improvement approach (PIA). Difficulties were also highlighted, and included timeframes not being met, additional staff not being available for added responsibilities, the lack of transport and the inadequate involvement of Non-Governmental Organisations (NGOs) and Community Based Organisations (CBOs). The supervisor programme yielded positive results such as the collective understanding by the staff of the need for quality care, an improvement in record keeping and documentation and clients having a better understanding of their responsibility for their own health. Workload pressure, however, de-motivated staff. It was proposed that dedicated supervisors be appointed for all clinics, that relevant training be provided to

ensure effective supervision, and monitoring and support, including transport, be provided.

HISP software was used to improve District Health Information Systems. A decentralised structure was implemented, together with setting of targets and building of support networks. Staff members were trained on health information systems and data collection was initiated to generate baseline information and to improve the system. With this process, targets were being realised with real numbers. Poor communication flow, the absence of dedicated posts and lack of comprehensive stakeholder involvement hampered progress. It was concluded that Information Systems could substantially improve service delivery and therefore needed to be prioritised. Managers must be trained in health information, and monthly feedback must be provided to health facilities.

Proper drug management was also crucial for an efficient health system. Legislation and policy frameworks that were in place, including the national drug policy and norms and standards, Also, good human resources management made a positive contribution. Supply chain management and the provision and dispensing of chronic medicines, however, proved to be challenges. The World Bank reported in 1994 that in Africa only 12% of every dollar spent on drugs actually reached clients. It is therefore necessary that legislation and policies be implemented, that there is an increased focus on the management of chronic medicines and that supply chain management be strengthened. The latter would include procurement, warehousing, distribution, prescribing and utilisation.

The technical team noted that if health systems were not improved, inequities and inefficiencies would continue. This would result in compromised health care and a potential budget deficit of R1,14 bn in the health budget of 2010.

The team proposed **Healthcare 2010** as an output model focussing on admissions and contacts with the following underlying principles:

- ◆ quality care at all levels
- ◆ accessibility of care
- ◆ efficiency
- ◆ cost effectiveness
- ◆ primary health care approach

- ◆ collaboration between all levels of care

The underlying principles of Healthcare 2010 are to ensure quality care at all levels.

Healthcare 2010 must adopt the primary health care approach, be efficient, cost-effective and ensure collaboration between all levels of care. Key strategies will be to re-shape, re-engineer and re-prioritise, taking into consideration that 90% of health contacts will occur at the primary level, 8% at the secondary levels and 2% at the tertiary level. Healthcare 2010 therefore will mean increased spending at PHC level for home-based care, prevention and promotion, and additional staff will be required including doctors, nurses, nurse assistants, mid-level health workers and support from community-based organisations. PHC visits will remain at over 3 per person per year with PHC attendances increasing from 11 to 13 million. It would be necessary to promote the 'Healthy City' concept so as to reduce the burden on the health system.

It was agreed that the **key priorities for PHC for the next five years** are:

- **Finalise implementation of District Health System with respect to**
 - legislative regulatory framework
 - boundaries
 - governance
 - sustainable funding
 - human resource management and development
 - transformational management (developing strategies for coordination within complex health system)
- **Undertake**
 - implementation of supervisory manual
 - use information for decision making
 - ensure proper drug management
 - strengthen PHC by responding to Priority Health Programs e.g. HIV and AIDS
 - define and advance an Essential Research Agenda to address PHC needs and priorities

8.4 Technical Theme 4: HUMAN RESOURCES FOR PHC

This theme examined factors relating to the issue of human resource management for PHC. Tshishi Ngubo and Nana Bongo presented a paper entitled '*The Role and Management of Community Health Workers*', Ben McGarry spoke to '*Youth Service And Volunteers in Primary Health Care*', and Thuli Zondi presented a paper on '*Levels and Factors Associated with Burn-Out in Primary Health Care Nurses*'. Steve Reid delivered a paper entitled '*Community service: Does it Strengthen Rural Health?*' and a case study entitled '*The Training of Primary Health Care Nurses in Limpopo*' was presented by Freda Ngombeni.

Progress was reported in the provision of enabling legislation and policies providing for free health services as one example. There is also political commitment, sufficient management support, comprehensive training in clinical skills, acceptance and transformation for PHC, strong and vibrant NGOs, greater interface with government and other agencies, the concept of clinically trained PHC nurses and increased access to services.

Barriers to progress include graduates lacking CBHC skills and competencies, and PHC not being sufficiently covered in basic training. There has been poor application of staffing norms; inadequate staffing patterns for PHC and DHS and appropriate PHC teams are not in place. There is an increased workload for the nurses due to the shortage and mal-distribution of personnel and to increased access for communities and an increase in non-nursing duties.

Other problems that were encountered include poor recruitment and retention strategies especially in rural areas; the different conditions of services due to there being two bargaining councils; the multi-skilling of professionals excluding the nurses leading to exploitation of nurses; changing community perceptions of free services; dealing with long queues and complaints and inadequate mobilization of communities as a resource pool.

It is important to recognise that intersectoral collaboration is not working; there is migration of the population to urban areas; South African graduates are poor in PHC skills and health care systems have been poorly prepared to deal with the 'brain drain'.

It is therefore necessary that supervision, mentorship and support be strengthened, students appropriately socialised, the benefits of exchange programmes be realised and that there is better organisational development so that community services are rendered in a sustainable manner.

The Community Health Worker (CHW) category requires particular attention. A CHW is defined as a volunteer care-giver but it has now become necessary that the status of the CHW be clarified in terms of standardisation of payment and institutionalisation and regulation.

It was agreed that the **key priorities for human resources for PHC for the next five years** are:

- The development of a national human resource plan for the country with guidelines on staffing norms
- The formulation of a human resources development plan for each province
- The formulation of a human resource plan for decentralisation
 - The above must also recognise reliance beyond professionals.
 - These plans must take into account the Human Sciences Research Council study on the impact HIV/AIDS in the workplace.
 - Other issues that must be considered for instituting appropriate human resources management systems are transportation, medicines and support.
- Career path development for PHC
- Current employees must be retained
- Develop mechanisms to attract health workers to return from abroad to jobs in South Africa
- Opportunities must be created and PPIs with doctors must be strengthened in the public sector
- Comprehensive district medical officer services must be provided
- Conditions of service must be prepared for a single public service
- Nurses must be released from their non-nursing duties
- There must be adequate resource allocation for PHC
- Infrastructure must be improved and capacity building must be provided to leaders and management

- Solutions must be sought from outside of the health domain by linking with other sectors
- Increase involvement of youth in health service provision such as the strengthening of NAFCI
- Revisit basic training which currently excludes PHC
- Revisit the workload of nurses
- Develop a plan for CHWs and volunteers to ensure that their critical support continues as part of health service delivery
- There is a need for implementation, monitoring and evaluation of plans on an annual and a five-yearly timeframe
- Research in PHC is necessary at the workplace and by academics, directed by questions being generated nationally.

The way forward:

- The role of HR in the implementation of PHC services is critical for the success of effective and efficient service delivery at community level
- The provision of sufficient financial resources will play a critical role and may require ring fencing to fully meet the objectives of PHC

8.5 Technical Theme 5: PRIORITY PHC PROGRAMMES

Priority PHC programmes that were reported on during this parallel session included '*Improving TB cure rates: roles for all stakeholders*' presented by Gladys Crisp-Mokoto, '*IMCI – improving child health through collaboration*' presented by David Sanders, '*Improving VCT uptake in a District: the role of Primary Health Care in a case study of Lejweleputswa District*' by Bongo Nazo and Ruth Marumo and '*Community-Based Rehabilitation Services*' by Thabisile Sishi. These topics covered programmes in the North-West, the Eastern Cape, the Free State and Kwa-Zulu Natal provinces respectively.

The commission proposed that a high level statement be released by Health MINMEC in September 2003 to show its re-commitment to PHC. A task team would be set up at the end of September 2003 and it is expected that a marketing strategy would be in place for implementation in January 2004. Provincial policies and activities for marketing and promotion should be in place by June 2004.

Resources will have to be re-allocated for PHC. National leadership must be identified to serve as a driver for advancement in PHC. Budgets allocations are required and a human resource plan must be devised and implemented.

Resources must therefore be allocated for promotional and preventative service; an appropriate information system must be in place and services must be linked to the principles of Batho Pele. Communication and marketing tools such as newsletters must be utilised and a policy is required for community and mid-level workers. Mentoring and support must be ensured for care workers. The burden of HIV/AIDS, particularly its socio-economic impacts and its impact on human resources must be taken into consideration in all aspects of PHC delivery.

In the civil society domain, a PHC initiative is required to re-educate management, health care workers and communities. Communities must be motivated to take ownership for their own health rights and responsibilities. Academic and research institutions must ensure that their curricula are transformed to take into consideration PHC and health and community development needs. These institutions could play a major role in the re-education of management, health workers and communities and in the mentoring and support for care providers.

8.6 Technical Theme 6: INTERSECTORAL COLLABORATION

The technical team was represented by Provincial departments, CBOs, NGOs, AMREF, DFID, Children's Institutes and homes, Ukuvuka PPP, the Mvula Trust and the national departments of Health and of Water Affairs and Forestry. It highlighted that although community participation, PPPs and integration were popular subjects for discussion, people still maintained vertical approaches to health care without thinking about how resources could be brought together to start working in teams. It was noted that district managers from rural districts did not participate in the team.

This group discussed intersectoral collaboration by examining '*Sanitation and Health*' (Mvula Trust), '*Building and Activating Response teams in a Collaboration between the Department of Health and Department of Water*' (Zama Zincume, Marie Brisly and Cyprian Mazubani), '*Intersectoral Collaboration and*

Development' (Nonceba Gulwa) and '*Vulnerable Children in the context of HIV and AIDS – need for a Collaborative Response*' (Maylene Shungking).

The **vision** for this technical theme states:

Move from health vulnerability to resilience and to make health and well being the business of all sectors of South African society by maximising the use of resources for social and economic transformation and through effective, vibrant intersectoral collaboration to realise the national vision of a “Better Life for All”.

The presentation on **sanitation and health** looked at the reasons for hygiene in sanitation and who were the responsible parties in ensuring that requirements for hygiene are met. A process flow chart on establishing sanitation projects was also provided. Partners were identified together with a list of inputs that was required of them.

The presentation on **building and activating outbreak response teams** noted that in the initial response to an outbreak, it is important that stakeholders are mobilised and information is obtained from the affected communities. This assists in determining the cause and effects of the outbreak. In building and activating outbreak response teams, the roles of each sector have to be recognised, particularly with respect to their areas of specialisation. Planning, implementation, monitoring and evaluation have to be in place.

In utilising **intersectoral collaboration** for development, the presentation highlighted the importance to firstly establish what problem needs to be addressed and how other people perceive the problem. This can be used as a point of interaction and collaboration for action research. Advocacy is required to promote intersectoral collaboration and an integrated training development program must be put in place.

The presentation '*Vulnerable Children in the context of HIV and AIDS – need for a Collaborative Response*' noted the commitment to children's rights as articulated in the African Charter and the Constitution. The PHC approach was one of prevention and promotion and it is important that weaknesses in the system be identified to ascertain whether children's health needs are being met. Responses

are essential to address these needs and present both an opportunity and an urgent call for collaboration.

Challenges that remain include: the inclusion of communities when there is a problem to be investigated; the inclusion of an already overworked clinic staff; the consideration of gender issues in local government integrated planning; the involvement of ward councillors in establishing health committees; rivalry amongst government departments and within departments and the efforts of response teams not being sustained after intervention.

A social cluster forum co-ordinates function amongst social departments such as Health, Education and Social Development, but these activities are restricted largely to the national sphere. Clarity is required on the expectations of stakeholders especially for Integrated Development Planning (IDP) in the local sphere, for example in the provision of roads in rural areas. Intersectoral collaboration must be re-defined to include stakeholders at all levels. Capacity needs must be determined and the 'big brother' attitude amongst some sectors in an emergency or disaster must be addressed. Big business must get involved to a greater extent.

There have been achievements in intersectoral collaboration in the national, provincial and local government spheres. There are specific structures to facilitate intersectoral collaboration, namely the Social cluster and the National Integrated Plan for HIV/AIDS. There are also National and Provincial Programmes of action. Good collaborative efforts have been noted in the PNSP and the NSTT (Sanitation). In the local sphere there are numerous examples of good collaboration within the IDP process and in the Victim Empowerment Centres.

It was important to define the role of the various stakeholders. Government must establish policies, provide leadership, support. It must also lead co-ordination, monitoring and evaluation efforts and must mobilise human and material resources to meet the objectives of intersectoral collaboration. Civil society has important roles in advocacy, education and information sharing and in influencing policy decisions. It can assist with monitoring, facilitation and the implementation of policies.

Academic institutions can engage in research, training and development at all levels and in curriculum development and the alignment of programmes that support government policies and address the needs of the communities. Research institutions can conduct research that is relevant to grassroots needs, for example Primary Health Care and social development issues. Trials that are conducted must be relevant to preventative care and research findings must be disseminated to communities so that it is used at the local level. Research focus must be on intersectoral collaboration. The public service must implement policies, facilitate programs and projects and liaise and communicate to ensure information dissemination. The private sector should support government initiatives by providing resources to communities, provide financial resources, teaching expertise and management development to the public sector through PPPs.

It was agreed that **the priorities for intersectoral collaboration** to be addressed in the next **five years** are that:

- ◆ In the first year, there must be an audit of all intersectoral activities that are taking place. Best practices and structures must be put in place at all levels, but especially to serve district health systems
- ◆ Policy and planning must be rationalised, with special emphasis on the IDP and processes that relate to NGOs
- ◆ Indicators must be developed as a barometer for measuring performance
- ◆ Programmes and projects that cut across departments are to be identified
- ◆ Both rural and urban nodal programmes to be included
- ◆ Public awareness is a priority and the GCIS and other forms of media must be employed for meeting communication needs
- ◆ Identified programmes and projects to be implemented
- ◆ Monitoring and evaluation to be in place.

Year	Activity	Outcome
2004/05	Audit Rationalise Policy Public awareness	Audits and database
2005/06	Policy and strategy development Develop barometer Identify programmes and projects	Rationalise policy and strategy Tools for monitoring

	Start implementation	
2006/07	Continue implementation Start monitoring	Clear implementation plans Public awareness strategy formalised
2007/09	Continue implementation Monitoring and evaluation	Functioning partnerships in all provinces Resource base identified and pooled 5 year evaluation
2010-2020	Continue implementation Monitoring and evaluation	Indication of improved health and wellbeing

9 POSTER SESSION

The poster session, introduced and assessed by Professor John Bennett, provided a visual presentation of 14 Primary Health Care programmes and issues from all provinces. Some key themes emerged strongly reflecting on the achievements and challenges facing PHC practitioners. These themes included the issues of functional integration, cross boundary municipalities, financial effectiveness and the constraints placed on implementation and sustainability of programmes.

The poster *Improving Financial Management Skills for Effective PHC Service Delivery in Bohlabela, Limpopo Province* provided a case study of a successful intervention to support financial effectiveness. The cross boundary district of Bushbuckridge and Maruleng, with a population of 600 000 people, had PHC managers who had limited management skills, did not manage their own budgets and therefore could not link funds to health activities. They were fully dependent on finance managers. An intervention was initiated whereby a skills development programme was set up for programme managers. Trained staff increased from 16% in 2001/2002 to 70% in 2002/2003. The outcome was that staff are now able to work within the planning and budgeting cycle and provide appropriate direction to health programmes with improved service delivery. This is done with limited support from finance managers.

The *Kgalagadi Development Node* poster dealt with the issue of enhancing functional integration between services provided by the provincial Departments of Health and the District Municipality. The existence of 6 uncoordinated administration offices generating fragmented and duplicated services; operating different management

systems and implementing different strategies impacts negatively on service delivery. The presenters outlined different strategies to support integration of services and these include a PHC audit and a District Health System review. To date the process has resulted in the partial integration of the environmental health services.

The Mpumalanga Health Department presented 2 large AIDS quilts made by home based care groups demonstrating community involvement in health issues. The visual aspect of their input was supported by 6 awareness posters dealing with key health issues being addressed by the department. These included '*Cholera Control in Mpumalanga*', '*Health Promoting Schools in Mpumalanga*', '*Parasite Intervention in Mpumalanga*', and '*Baby Friendly Hospital Initiative In Mpumalanga*'.

The Valley Trust Rehabilitation Programme, located in the Valley of a 1000 Hills in KwaZulu-Natal, presented the historical development of an innovative community based rehabilitation programme designed for supporting people with disabilities including severe cerebral palsy, cognitive impairment, epilepsy, spinal cord injury to name a few. It commenced in the early 1990s relying on therapeutic provision by university students. Over time, sustainable delivery issues emerged and these were addressed in 2001 with the introduction of a full time team of therapists located in different communities. The programme is now divided into a facility based intervention and a community based rehabilitation programme. The current constraints facing the programme are transportation needs in difficult terrain and to cover a wide area; funding of operating costs and the lack of recognition of Community Rehabilitation Workers.

10 RECOMMENDATIONS AND CONCLUSIONS

The Minister of Health of Malawi gave a vote of thanks in the concluding session of the conference. He noted that the values of the Alma Ata are still real today and that there is a need to refocus international effort in this regard. He added that the world owes a vote of thanks to South Africa for the reminder of the need to revisit the PHC promise - a reminder reinvigorated by many success stories as evidenced in the technical themes and poster presentations.

The Minister of Health of South Africa, Dr. Manto Tshabalala – Msimang, reflected on the significance of the conference and some of the themes that emerged. Some of her key comments are highlighted here. *The full text is attached as Annexure 9.3.*

“It is clear from the outset that we have a substantial body of health workers in this country who are passionately committed to primary health care and who are able to argue its continued relevance in a changing world.”

“One of the themes that was repeatedly sounded during the past two days is that the world has changed profoundly since the signing of Alma Ata. Many of us are living in countries that have undergone deep political changes for the better in the intervening period.... Such political change opens up new possibilities for primary health care...it is clear that there is no single road to success and we have a lot to learn from each other’s experiences. It is equally clear that we still have a long way to go in translating the democratic culture into community-base health care delivery.”

The Minister further raised some of the debates that resonated throughout the conference in pursuit of “...humane, people-centred processes...” She highlighted the impact of globalisation; the importance of sound planning in a participative manner; efficient management and integration of technical processes; the need for ownership of PHC by health workers and the translation of concepts into practice.

Minister Tshabalala – Msimang concluded her speech with a **Statement on Equity**.

“Today, I want to make a pledge to you not only to talk of justice in health care but to deliver justice and equity in health care. Our people demand such justice – our people deserve such justice.

To this end I will establish an ‘Equity Strategy and Monitoring Group’ drawing on the voice of the community as well as experts in the field. There are to be charged with three tasks:

First to develop a strategy to build the necessary human, social and management infrastructure to allow the delivery of better primary health care to those most in need.

Second, to develop a strategy over 5 years to deliver primary health care on the basis of equal expenditure per capita.

Thirdly, to develop a strategy over 10 years to deliver primary health care on the basis of equity- where equity will reflect the voice of the people.

The Minister thanked the many organisers and contributors who made the conference a reality, with special reference to Dr. Ntsaluba who was ending his term as Director-General following an excellent contribution to public health that started in the ANC camps whilst he was in exile during the apartheid era.

Minister Tshabalala – Msimang concluded the conference with the adoption of the 'The Kopanong Declaration on Primary Health Care' which is as follows:

'The Kopanong Declaration on Primary Health Care'

'We, community members, academics, members of NGOs and CBOs, representatives of government, officials and guests meeting at Benoni, Gauteng on the eve of the 25th anniversary of the signing of the Alma Ata Declaration in the former USSR, having assessed South Africa's achievements and challenges in implementing primary health care using the primary health care approach,

Noting:

1. The progress made in implementing primary health care nationally; and
2. The challenges that remain;

Hereby resolve that the key focus of the agenda for strengthening primary health care over the next five years will include:

1. Concrete strategies and processes, with clear targets, to reduce inequities in the allocation of resources for primary health care with a focus on both horizontal and vertical equity over the next 10 years.
2. Committed funding and budgets for sustaining community involvement in health through, *inter alia* regular area summits leading to provincial summits.

3. Strengthening the health system by focusing investment of resources on priority health programmes and by accelerating the implementation of the DHS including its various components.
4. Develop, implement and monitor the implementation of coherent human resource plans at district, provincial and national levels based on national guidelines including the strengthening of recruitment and retention strategies.
5. Re-invigorated committed to the principles of the PHC approach by all partners with effective national and provincial leadership.
6. Strengthening of PHC through the development of intersectoral forums at every level but especially at the facility and district levels.

We will use the performance management system of government and the accountability mechanisms in each municipality, province and nationally to assess and report on progress each year on the six areas listed above.

11 ANNEXURES

11.1 *PHC funding: recognising the problems as a route to finding the solutions. Some relevant experiences from Aboriginal Australia*

Gavin Mooney, Social and Public Health Economics Research Group (SPHERE), Curtin University

The need for a new approach

This paper deals with the question of equitable resource allocation in primary health care. It is based on work done in Aboriginal health in Australia where the question addressed was how best to allocate additional resources across different regions or Aboriginal communities. It was developed by the author and others for the Commonwealth Grants Commission which is the body in Australia charged with deciding how to allocate Commonwealth (i.e. national government) revenues across the states and territories. This was done in the specific context of that body's Inquiry into Indigenous Funding which looked at the question of how to allocate funds for Indigenous health care across different regions of the country (CGC 2001).

The paper argues that the basis on which such resource allocation formulae are normally built is less than ideal. This is in essence because such formulae tend to see the relevant issues in terms of the size of the problem rather than of the capacity to benefit in the way that resources are allocated. Among other things, the new approach spelt out in this paper takes account of the idea of value added i.e. focusing on attempting to improve existing situations. If there is a desire to improve on some existing position, this entails firstly defining what the good is that is then to be improved. Consequently in addressing resource allocation issues, the starting point of this new approach is the determination of what it is that the resources are to achieve i.e. the nature of the good.

It is also the case that with respect to the allocation of resources geographically across different regions/communities, some of these have an existing ability to function better than do others in terms of their use of resources for new or incremental programs. Most resource allocation formulae do not take account of this differential in 'infrastructure' across different regions/ communities. It is considered to be a major advantage of this new approach that it does take this aspect (called 'MESH infrastructure – see below) into account.

Concentrating on 'capacity to benefit' might give undue emphasis to concerns with efficiency as opposed to equity. While efficiency does matter, equity is taken into account in the approach in two ways. First the capacity to benefit is weighted to take account of the relative disadvantage of different communities/regions who might receive funding through this approach. Second, and as explained below, where there is a lack of infrastructure to allow communities to develop their capacity to benefit, then an aspect of the allocation of funds would provide monies specifically to allow that infrastructure to be built.

In the next section, some of the problems with existing resource allocation formulae are spelt out. Section 3 then addresses the question of the nature of the good that resource allocation might address. Because of the author's relative unfamiliarity with South Africa, the example used here is from Aboriginal health in Australia. In section 4 the approach of weighted capacity to benefit and MESH infrastructure is outlined. A brief conclusion is presented in section 5.

Existing resource allocation formulae

Most of the resource allocation formulae that exist in health care can be traced back to the Resource Allocation Working Party (RAWP) formula devised for England in 1976 (DHSS 1976). For example the Resource Development Formula in New South

Wales (NSW Health Department 1996) is a grandchild of that RAWP approach.

The essence of all such formulae is that the greater the health problems in a particular geographical region *ceteris paribus* the greater should be the resources allocated to that region. Thus if there are only two regions both with the same size and distribution by age and sex of population but one is in some sense twice as sick as the other, then the sicker region would receive more resources. Usually such formulae go on to argue that the resources should be twice as great reflecting the fact that there is twice the sickness. This means that the size of the problem, and then only the size of the *health* problem, is the imperative that is driving resource allocation. While the logic of this is perhaps understandable, it is not necessarily the way to go or at least not necessarily the best way to go.

While it would be reasonable to expect that a region that has more health problems should receive more health care resources, it is not necessarily the case that this should be done pro rata. This of course must depend on what the objectives of the exercise are and also on the relative productivity of resources in the two areas. We are here discussing the question of the allocation of *health care* resources and it is clear that some health problems are less amenable to health care interventions than are others. For some there are more effective and efficient health care interventions available. Some may be better addressed through housing or education or some other social service rather than from the health care budget. There are potential problems in the logic that assumes that the productivity of health care resources is a function of the size of the health problem.

Taking a step back it is suggested that there is a need to think through anew what these resource allocation formulae are about. They must be concerned with pursuing some objective. What is that objective? It may well be to maximise the health of the

population. Allocating health care resources pro rata with the size of the health problem however is unlikely to achieve this end. That would only occur if the marginal return from each intervention was the same for every extra, say, 1000 rand invested. It also assumes that the only goal that is sought with health care resources is health. That may be true but needs as a minimum to be tested. It is thus unclear at best as to what the underlying objective is. Since most of these formulae are seen in terms of fairness or equity then it is reasonable to think that part of objective relates to fairness. Yet again any equity objective lying behind such allocations is not clear. Just what good will such allocations of resources achieve?

A further difficulty with these formulae relates to issues of measurement. Given that the difficulties involved in finding appropriate measures for morbidity to determine how sick a community or region is, then it is frequently the case that mortality is used instead. Clearly, and this has been investigated in detail in the literature, there are problems in assuming that morbidity and mortality move in direct proportion with one another. Frequently what is used in this context are standardised mortality ratios i.e. SMRs which are mortality rates adjusted for the age and sex of the population. The assumption here is that if there is an SMR of 130 in a region compared to the overall national average of 100, then that region, other things being equal, should receive 30% more resources per capita than is average for example across the whole country. Now to assume that *this* 30% indicates that *the problem* is 30% greater involves a difficult logic. We are dealing with two very different scales here and the relationship between them is most unlikely to be directly proportional. Nor as indicated, even if that were accepted, could we reasonably assume that that justified exactly the same proportional increase in resources.

While these issues of measurement are clearly problematical, the fact that such existing resource allocation formulae are not explicit about what good they hope to

achieve is a potentially more fundamental problem. Consequently when considering improving on these formulae in the next section, that is the starting point.

What is difficult to assess is how much difference altering this part of any formula will make. This has not been tested to date.

The nature of the good

What good do we seek to achieve from the allocation of health care resources to different communities or regions? One possibility is that we want to maximise the health of different people. This is in essence an efficiency goal. It might be however that what we seek to maximise is something wider than health. For example in certain instances we might seek to inform, create reassurance, to treat with dignity, to treat with respect. All of these may contribute to health but they may also be objectives in their own right and not simply instrumental in the pursuit of health.

It may also be that the nature of the good embraces some concerns with equity or fairness. Indeed it is normally the case that so-called resource allocation formulae are concerned to some extent, often indeed a large extent, with equity. This may be couched in different terms, for example equality of health, equal access for equal need or equal use for equal need. These are but three possibilities. It can also be useful to distinguish between distributive justice and procedural justice where the former is concerned with the fairness of the distribution of outcomes such as in equal health and the latter is concerned with fairness of the procedures or the processes such as in equal access for equal need. The distinction is also made between horizontal equity (the equal treatment of equals) and vertical equity (which is the unequal but equitable treatment of unequals). While there is considerable debate in the literature as to which particular definition of equity is the most appropriate that debate is not pursued in this paper, at least not directly. Underlying the philosophy of this paper however it is the view that the issue of equity should be determined

according to the informed preferences of the people affected.

It is the case when dealing with Aboriginal health in Australia that any consideration of the nature of the good of health care is likely to draw on some Aboriginal definition of need. Thus, for example, with others the author has laid out previously (CGC 2001) that that definition of need includes four components: 1. cultural security; 2. physical well-being; 3. good environment; and 4. freedom from poverty. This is a wider more holistic definition of health need than is customary in non-Aboriginal health services in Australia. What this "good" is in South Africa is clearly not for the author but for South Africans to judge.

Further details of these four components are unnecessary for this paper except perhaps with respect to cultural security which will almost certainly have close parallels in South Africa. This has been defined as follows

Cultural Security is a commitment that the construct and provision of services offered by the health system will not compromise the legitimate cultural rights, views, values and expectations of Aboriginal people. It is a recognition, appreciation and response to the impact of cultural diversity on the utilisation and provision of effective clinical care, public health and health systems administration. Cultural Security is about ensuring that the delivery of health services is of such a quality that no one person is afforded a less favourable outcome simply because they hold a different cultural outlook (Houston 2001).

The first major component of this approach relates to the capacity to benefit as a form of need. It has to be emphasised immediately that this is not looking at the issue of the size of the problem as with the standard concept of need in resource allocation formulae but instead is concerned with the question of *improvement*, i.e. doing better,

in essence working with whatever concept of good is agreed. It seems highly likely that a sizeable component of this capacity to benefit will be perceived in terms of capacity to improve health. There is no reason to believe that people will restrict the nature of this benefit to health alone. That remains to be tested. Certainly in surveys in the general population in Australia, there is evidence that benefits from health care resources are not necessarily restricted to any conventional concept of health (Mooney 2000).

Further how ideally to measure capacity to benefit is not yet clear. In the context of work done by the author and others for the Indigenous Funding Inquiry for the Commonwealth Grants Commission (CGC 2001) it was argued that capacity to benefit was greatest where the health problems were caused by environmental factors or, perhaps more accurately, since it may not be the same thing, where the most efficient interventions lie in environmental health. It was further argued that the second greatest marginal return was likely to be in social health and thirdly and last the return would be lowest in trying to change individual behaviour which was having adverse effects on health.

The second component involves a weighting factor for this capacity to benefit. This reflects the idea that according to social preferences, it may be the case that the value attached to nominally equal benefits will be different depending on who the recipients are. For example people who are in poor health compared to those in relatively good health may have the equivalent health benefits weighted socially more highly. There is in other words a recognition that in terms of equity it is not necessarily the case that all benefits from health-care resources be weighted equally irrespective of the characteristics of the people who receive them. In the context of a formula for allocating resources across different Aboriginal peoples in different communities then this weighting would reflect relative disadvantage. This might be in

terms of, for example, income, health, socio-economic status or education. There are a number of possibilities. What should constitute 'disadvantage' in this context should be determined according to the preferences of the society. In the context in which we were working in Australia, we were dealing with the allocation of resources to different groups of Aboriginal people. It is then for Aboriginal people to decide what constitutes disadvantage. It is also for them to determine according to their preferences the relative weights to be attached to different degrees of disadvantage. As between Aboriginal and non-Aboriginal benefits of health care, in other surveys weights of between 1.2 and 2.5 have been suggested (Mooney 2000).

Thirdly there is what we have called "MESH infrastructure" where MESH is Management Economic Social and Human infrastructure. This concept arose in recognition of the fact that not all Aboriginal communities are equally well placed to take full benefit of the resources allocated to them to build programmes, for example in diabetic health or in eye disease. It is difficult to pin down precisely what is incorporated in MESH. The concept arose in discussion with leading figures in Aboriginal health in Western Australia who recognised that some communities function better with respect to investing in programmes than do others. MESH involves good management, it requires the availability of resources, it requires a socially well functioning community and ideally good human resources, particularly in terms of leadership skills. Where each of these is present then the likelihood that programmes on specific health problems will be able to be implemented efficiently is greater. Where some or all of these elements are missing then resources may well be wasted or at most be used to lesser effect.

The idea of including MESH in the resource allocation formula is to reflect the fact that communities vary in their capacity to function and to manage resources well. If this element were not included, then those communities which have a low capacity to

benefit because this kind of infrastructure is missing or is low might never or seldom get adequate resources, even if they are disadvantaged communities whose capacity to benefit would be weighted positively to take account of that disadvantage. Consequently it is argued that any allocation of funding overall should be made in such a way as to take account of two factors: first the relative ability of the community to invest successfully in programmes i.e. the capacity to benefit weighted according to some index of disadvantage; and second an element which allows communities which have low MESH infrastructure to develop this. There are parallels here between capital and running costs with the MESH infrastructure being somewhat similar to the capital element and the other element, the capacity to benefit (weighted) being more like running costs.

There is a need for research into MESH. This is required at a number of levels. First while with Aboriginal colleagues it was possible for everyone to recognise the existence of MESH and perhaps yet more importantly its non-existence in many communities, nonetheless research is needed to pin down this entity more precisely. Research is also needed to establish how best to build and develop MESH most efficiently where this is non-existent or inadequate. Yet further research is needed to examine what the impact of MESH is on the capacity to benefit of a community. It also follows that there is a need for discussion as to what proportion of overall MESH will be present in the total allocation of funding across different Aboriginal communities. It is of course possible to argue that monies for MESH should not come strictly from the health budget but should be 'off the top' since MESH will almost certainly be relevant to other programmes and not solely health programmes.

The final element of this proposed approach involves taking account of relevant relative cost differentials across regions or communities. These relate primarily to access issues in terms of distance and cultural security.

Communities and regions will vary in terms of their geographical position and their remoteness and may also differ in terms of cultural security. There is a need to build into any approach on resource allocation an allowance for these factors. In Australia we have proposed the use of the notion of equally productive equally atttractive (EPEA) positions. The idea here entails assessing what the effect is of distance taking account for example of time spent in visiting clients in more remote areas. It also involves any additional costs arising first in attracting staff to more remote areas and secondly any extra costs arising in retaining them in these areas. Some of these elements may be embraced through higher salaries but it may be that more generous leave entitlements or professional training would be more efficient ways of both attracting and retaining staff in more remote areas.

With respect to cultural security in Australia, this involves trying to ensure that Aboriginal people because of cultural differences face no greater access barriers to services than do non-Aboriginal people. It remains the case that for many, especially mainstream services, but also some specific Aboriginal services that barriers remain in terms of cultural appropriateness and the extent to which services are designed for Aboriginal people and not just in terms of training staff in cultural awareness.

Conclusion

We have in the context of the Commonwealth Grants Commission in Australia attempted to operationalise the formula for the state of Western Australia (WA). The numbers that we have used are more tentative than would be ideal. Nonetheless what we have achieved there suggests that the approach can be practically useful and that it is possible to make it user-policy friendly.

It is also the case that we were able to present the results of this analysis to various key Aboriginal figures in WA and to get their endorsement not only of the approach but the resultant allocations for different regions within WA.

It remains the case that there is a major research agenda if this approach is to be adopted in Australia or South Africa. What is particularly important in addition to any research looking at the usefulness of the approach is also recognition of the need to gain wider endorsement among the relevant people and communities of this approach and to ensure that the value judgments that are required are based on the informed preferences of the relevant people and communities.

While this paper has been focussed on the question of the allocation of resources across different Aboriginal communities or regions in Australia, the parallels with the situation in South Africa are strong. With the knowledge I have of the South African health care system with suitable modifications especially with respect to funding arrangements, I am confident that the approach can be applied successfully here. There are data problems. I do not believe however that data should determine what the right approach is but principles. To get the principles right and use initially rough data which can be improved over time is to be preferred in my view to letting data availability determine the process. The principles are simple: establish what good is

to be achieved; see how that good can be made better with the resources available; where there are regions which need help to create the infrastructure to do better, make allocations of funds for this in the resource allocation formula; and make due allowance in the allocations for variations in the costs of access across the different regions.

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11.2 NATIONAL PHC CONFERENCE: REFLECTIONS ON ACHIEVEMENTS OF THE PAST 9 YEARS AND WORK THAT REMAINS: A PHC SCORECARD

Presented by: Dr Ayanda Ntsaluba, 25 August 2003

INTRODUCTION

This is a good time to reflect on how well we have done in the past 9 years in the development and implementation of policies pertaining of primary health care for two reasons. Firstly, we are entering a milestone 10 years of democratic government next year and led by the Presidency government is preparing a 10 year review of its efforts and a celebration of ten years of freedom. The second is somewhat personal.

This is my last meeting as Director-General of the Department of Health which I joined in 1995.

I will not provide a history of primary health care internationally as this has been covered by others save to say that after a swing towards a technical approach to service provision in the 1980s there is recognition that whilst we need to be technically skilled in a range of areas, provision of health care requires a serious consideration of human issues like sensitivity to people's needs, attitudes, beliefs, emotions. This means that to improve quality of care we need to improve the way in which health systems and providers interact with users, their families and communities. This is at the heart of the primary health care approach.

Health is inextricably linked to development. This has long been recognised in South Africa. You will recall that in the 1940s we had a vibrant community health centre movement in this country which linked health with development in very defined ways. I am referring here for example to the Pholela Health Centre in what was then Natal.

Fast forwarding to the 1980s, at the height of state brutality against progressive forces, a range of individuals and organisations came together to form the National Progressive Primary Health Care Network. The Minister did allude to this in her speech last night. Some of the individuals involved in the formation of the NPPHCN are here today and have assisted in the development of the ANC Health Plan and the White Paper for the Transformation of the Health System in South Africa.

Let me turn now to a review of PHC – the scorecard. What I will do is use the White Paper as the backdrop against which I am reviewing our performance. I will also do this using the key pillars of the Alma Ata Declaration.

SCORECARD

The key issues then that we will focus on are the following:

- Vision and mission
- Package of PHC services – improving access
- Roles of province and municipalities
- Systems to render PHC (including DHP&R, drug supply, DHIS)

- Human resources & capacity for PHC
- Quality
- Equity/resource allocation
- Community Participation
- Intersectoral collaboration

Vision and mission

The vision for PHC and the PHC approach is in the White Paper, in the Policy for a District Health Systems and in the Health Sector Strategic Framework, 1999-2004 popularly known as the 10 Point Plan. The mission statement in the White Paper reads as follows with respect to the Department of Health's role: "To provide leadership and guidance to the National Health System in its efforts to promote and monitor the health of all people in South Africa, and to provide caring and effective services through a primary health care approach" (p. 13). The 10 Point Plan prioritises the accelerated delivery of primary health services in partnership with other government sectors and with communities.

Primary health care is the foundation of the national health system. In the remainder of this presentation we will see to what extent the vision is being reached. In particular we must assess to what extent we have delivered services using the PHC approach.

Package of PHC services: improving access

In 1994 President Mandela announced that health services for children under 6 and pregnant and lactating women will receive care free at the point of delivery. This programme was expanded in 1996 when PHC was provided free to all who needed it. This effectively removed fee for service for millions of South Africans and we have seen an increase in clinic attendances since. This year President Mbeki announced that the disabled will receive free health services. In addition, 701 clinics were built and upgraded since 1995, largely in under-served areas. This means that about 7 million people have better access to PHC services.

In 1999 we published the comprehensive package of PHC services and we set ourselves the target of full implementation by 2004. Since 1999 we have added

services to this package in the last 2-3 years. Services like Voluntary Counselling and Testing and home and community-based care.

The reasons that we have taken this approach is two fold: (a) it provides some certainty on what range of services we will provide; and (b) it is one way in which we can ensure equity in service provision.

How are we doing in implementing the package? If the health district is the catchment area in which we expect the full basket of PHC services to be delivered then we can say that most districts render the full package. However, given that these are large geographic areas this is somewhat meaningless. On the other hand we cannot expect every clinic to render the full spectrum of services given that many are single nurse facilities. Through the District Health Planning process which I will speak to later we are in the process of conducting thorough audits in each province which will not be once off or snapshots but will be part of the annual planning and reporting cycle.

One issue that we need to review is the extent to which this package is provided using the PHC approach – which takes into account issues of poverty and its impact on health. We will return to the other pillars of the PHC approach like equity, community participation and intersectoral collaboration. I am sure that during the small group discussions we will explore this issue in some depth.

Roles of provinces and municipalities in funding and rendering PHC services

Historically and currently, based on the provisions of the Health Act of 1977 both provinces and municipalities fund and render primary health care. This has led to significant duplication and fragmentation. We have adopted the District Health System as the vehicle for the provision of PHC. However, it is fair to say that given the scale, process and timing of transformation of the various components of government we have struggled to finalise the roles of these two spheres of government.

Having said this, I think that we are close to finalising this issue which will be codified in the National Health Act once it is debated and passed by Parliament. The vision is that primary health care should ideally be rendered by metropolitan and district municipalities. However, there are a range of capacity and transactional issues that

we have to sort out before this can happen. To give certainty we have defined municipal health services, which are the function of metropolitan and district municipalities, as a defined list of environmental health services. We anticipate that from 1 July 2004 metro and district municipalities will both fund and render environmental health services. Provinces may decentralise other PHC services which provinces have to fund, to municipalities if agreed between the two parties.

Systems to render PHC (including DHP&R, drug supply, DHIS)

We have worked in a few specific areas to strengthen systems for delivery. I wish to touch on three of these. Let me start with the planning process. We have provided for district health plans and reporting requirements in the National Health Bill. The development of these plans will have to be related to the process of developing Integrated Development Plans which are the responsibility of local government. We have developed, with technical assistance from the Equity Project and HST, District Health Planning and Reporting Guidelines and districts are currently in the process of using these guidelines. We anticipate that outputs from this process will feed into the provincial planning process which in turn will fit into the provincial budgeting process. I wish to emphasise that planning is not an end in itself but to lead the budgeting process and to strengthen and focus implementation and delivery of services.

One of the ingredients to develop good plans is data. We have historically and currently collected lots of data. However, there were and to some extent still are at least three problems: (a) data is of poor quality; (b) data is not standardised; and (c) managers do not often turn data into information for management and planning. However, various corrective measures have been introduced to address these issues.

We have since 1997/8 developed and implemented a national minimum data set for both hospitals and PHC. 98% of PHC facilities nationwide report routine data, we are now working on improving both use and the quality of the data. The software has been developed by a team based at the University of the Western Cape in partnership with the Department and with funding from NORAD and USAID. This software is now also being used in countries as diverse as China, Cuba and Mozambique.

One of the expectations of patients when they come to our facilities (perhaps we have conditioned them) is medicines. We need to ensure the effective ordering, delivery and use of medicines. In addition, there is a need to ensure that the cold chain is intact to maintain the integrity of our EPI programme. With the decision regarding ARVs, the team that is crafting the operational plan will need to look at this issue and put in place strategies to further strengthen drug distribution and use.

Human resources capacity for PHC

We decided fairly early on that the front line health worker will be the primary health care nurse. A large number of nurses have been trained but there are two problems: (a) our training strategy needs strengthening; and (b) our retention strategy needs revision. Nurses often complain that they are overworked, especially since the free health care policies. Our experienced nurses are also leaving the public sector for the private health sector and for jobs overseas. We are currently engaged in seeking ways to reverse these trends. We think that improved working conditions will assist in this regard.

We are working with the statutory councils to develop mid-level workers in a range of categories. We have already begun to train pharmacy assistants and are currently looking at a medical or clinical assistant category at present. We are clear that this does not mean second grade health care for those areas to which we cannot attract professional nurses, pharmacists and doctors.

Quality

The need to improve quality was recognised early on and provided for in the White Paper. A directorate at national level was created to provide leadership in this area. There are a range of things that can improve quality, including new buildings, new and properly maintained equipment, good management, good clinical training, well motivated staff, functioning complaints systems and users who know and demand that their rights are met.

We have implemented Batho Pele – which is a government-wide programme. We have developed and implemented mechanisms to handle complaints. We have built many new clinics, as I stated before 701 of them. We have trained personnel both in management and clinical skills. Surveys done on patient satisfaction show

consistently that about 80% of users are happy with the services. However, it is of concern that about 20% are not. Clearly we need to focus on the pockets of facilities where poor services are rendered and on the health workers for whatever reason do not provide high quality care.

One of the key areas in which a fair amount of work has been done with our donor and NGO partners has been in strengthening the supervisory system. When we reviewed the NHS in 1999 we recognised that this was an area of weakness. We have developed a national supervisory manual and trained many supervisors. What we need to do now is to formal the system, provide supervisors with the resources to go their work – like transport - and monitor the impact of their work on service delivery.

Equity/resource allocation

One of the goals set out in the White Paper is to “promote equity, accessibility and utilisation of health services”. The goal has three objectives: “(i) increasing access to integrated health care services for all South Africans, focusing on the rural, peri-urban and urban poor and the aged, with an emphasis on vulnerable groups; (ii) establish health care financing policies to promote greater equity between people living in rural and urban areas, and between people served by the public and private health sectors; and (iii) distribute health personnel throughout the country in an equitable manner”.

What are the overall health expenditure trends? Health care spending in 1995/96 was R29.7 billion (2002/03 prices) and R35.5 billion in 1996/7. However, spending in 1997/98 and 1998/99 fell by over 9% and 4% respectively. After this there was a slow and uneven recovery in spending to reach R33.8 billion in 2002/03 - which is less in real terms than the spending in 1996/97. Some real rise in health expenditure is projected during the current MTEF period to reach an amount of R36.8 billion (in 2002/03 prices) in 2005/06, although little increase is anticipated for the outer MTEF year. All this means is that the size of the health cake is not growing very fast at all – in fact it is growing at a rate less than GDP!

Now what is the situation with respect to inter-provincial equity? In 1995/96 the ratio of health expenditure per uninsured person in the highest to the lowest spending province was 3.7. This ratio fell dramatically in 1996/97 to 2.9, an effect mainly of the large increase in allocation by the Function Committee to Limpopo. The ratio then

declined gradually to reach 2.1 in 2002/03 and is projected to fall further to 1.8 by the end of the current MTEF period. This indicator thus shows a narrowing of provincial inequality in health financial allocations.

Finally let us look at what has happened to PHC expenditure. There are large inequities between provinces. Research conducted by the Health Economics Unit of UCT suggests that some provinces spent R75 per capita whilst others spent up to R246 per capita (2001/02). There are also intra-provincial inequities in expenditure. Some districts spent as little as R42 per capita whilst others spent as much as R389 per capita in 2001/02. This needs to be benchmarked against the approximately R200 per capita we think the PHC package I mentioned earlier would have cost. Clearly we have much more work to do to get equity in PHC expenditure. One of the key issues that may account for low spent on some districts and provinces is inability to attract staff. In this context, rural districts and predominately rural provinces will suffer unless we are able to develop strategies to recruit and retain staff in rural areas.

One of the reasons that we introduced community service, first with doctors and now with most professional groups is to be able to increase the number of various categories of health professionals in rural areas. Let us see how we are doing by focusing on the percentage of community services allocated to the rural nodes. Whilst some 18% of the population live in the 13 rural nodes in 2003 13% of community service doctors, 14% dentists and 8% of community service pharmacists were allocated there. Clearly this programme is moving in the right direction but more community service pharmacists in particular need to be allocated to the rural nodes. We hope that the integrated rural development strategy of government, the rural and scarce skills allowance and the hospital revitalisation programme will attract health professionals to work and live in rural areas. The innovative Mosvold bursary scheme in KwaZulu-Natal is another example of what can be done to recruit students from rural areas, provide them with bursaries to study and then contract them to work in the community from which they came. Such programmes need to be replicated and training institutions encouraged to select such students. We therefore need greater partnerships with training institutions in this regard.

Community Participation

The White Paper lists three principles regarding community participation. These include: "All South Africans should be equipped with the information and the means for identifying behavioural change conducive to improvements in their health; people should be afforded the opportunity of participating actively in various aspects of the planning and provision of health services; and the Department of Health should provide the public with regular updates on progress, results and emerging issues related to its work, and should ensure that people participate in the development of national policy". These issues are repeated in the Policy for a District Health System and the 10 Point Plan.

At clinic and community health centre level most of these facilities have committees. Some provinces have already legislated a role for such committees and those that have not will have to once the National Health Bill is passed. However, what is unclear is how active these structures are and how responsible the health system is to their opinions and comments. The National Health Bill also provides for national (and provincial) health consultative committees which is a means of both communicating policies and services and also to consult on a range of issues. The requirement to draft plans and produce annual reports alluded to above is yet another means of being accountable to the public.

Another area in which community participation has been strengthened is around TB DOTs and home and community based care both through volunteers and community health workers. We must however, be very careful not to burden already fragile communities with additional non-remunerative work.

The HIV and AIDs pandemic has required that we increase health promotion and health education. In partnership with such organisations as Soul City and LoveLife we have increased community awareness of a large range of health issues. Results of behavioural studies also suggest improvement in behavioural indicators such as delayed abstinence, increase in condom use and drop in the number of sexual partners in younger age categories. In 1998, the South African Demographic and Health Survey found that 17.1% of women aged 20-24 had no sexual partner which was significantly lower than the 2002 findings by Shisana and Simbayi that 31% of women aged 20-24 had no sexual partners. These results appear to suggest that the

educational programmes that government and its social partners are implementing are effective.

Whilst there has been some activity in the area of facilitating community participation we need to find creative ways of strengthening and sustaining community participation in ways that empower communities.

Intersectoral collaboration

The final area that I wish to review is that of intersectoral collaboration. The importance of intersectoral collaboration to health was acknowledged in the White Paper. The National Health System was described as incorporating all stakeholders – government departments, NGOs, the private sector and communities. In addition, this issue was adopted as one of 12 principles that underpin the district health system.

What is clear is that intersectoral collaboration even within government is not easy. Government has instituted a clustering approach of national and provincial departments to enhance intersectoral collaboration within government. In addition, the South African National AIDs Council and their provincial and district analogues attest to the importance of intersectoral collaboration.

The recent (about two years old) strategy of government to identify the poorest districts in the country (both rural and urban) and to ask national and provincial government to work closely with municipalities in these districts to work together to accelerate development and service delivery is yet another example of how government is trying to improve intersectoral action.

The creation of epidemic response teams, cholera response teams which consist of provincial and local government representatives and representation from the Departments of Health, Water and Forestry, the SANDF etc is further testimony that we must and can work together.

However, it is clear that this is another area that requires more creative models.

Conclusions

Permit me to conclude. On each of the nine key areas we have undoubtedly made progress. However, in each of the nine areas we have more work to do. I am hopeful that the presentations in the small groups as well as the posters will both provide best practices and also stimulate us to think in new ways so that when we present to plenary tomorrow we will not only have a shopping list of things that need to be done but more importantly we will have concrete suggestions on how we will achieve the goals we set at Alma Ata and in the White Paper on the Transformation of the Health System for South Africa.

I thank you!

11.3 MINISTER'S SPEECH TO THE PHC CONFERENCE, 24 AUGUST 2003

On behalf of the government and the people of South Africa I wish to welcome our guests both from Africa and beyond. In addition, I wish to welcome MECs for Health and local government councillors and health workers and representatives of NGOs to this very important event. The Deputy President would have liked to have been here to welcome you but he had another pressing engagement outside the country.

We are here to celebrate the 25th anniversary of the Alma Ata Declaration and perhaps as importantly to review our experiences and plan for the next 5 years. We must ensure that the time we spend together leaves us invigorated. We welcome the contributions of our guests, Dr Tim Evans, assistant Director-General of the WHO, Ms Penina Ochola of Plan International based in Johannesburg, Professor Gavin Mooney from Curtin University and Dr Armando Nigre from Porto Allegre in Brazil.

Some of you will recall that on 19 September 1987, 16 years ago, more than 300 health workers from 100 different organisations gathered in Johannesburg at the first national conference of the Progressive Health Care Network. One of the key discussions at the workshop was the term Primary health Care and the decision to adopt the term Progressive Primary Health Care to distinguish it from the apartheid health practices of the government at the time.

Four pillars of progressive PHC were adopted at this conference which are relevant today as it was in 1987. These are (a) commitment to socio-economic change; (b) community accountability; (c) comprehensive care; and (d) concerned health worker practice.

These four pillars draw on the three key pillars of the PHC approach as adopted at Alma Ata in September 1978. These are: equity; community participation; and intersectoral collaboration.

This year the WHO decided, at the 56th World Health Assembly, to celebrate the 25th anniversary of the Alma Ata Declaration. The resolution adopted requested Member States to *inter alia*, “ensure that the development of primary health care is adequately resourced in order to contribute to the reduction of health inequities; to strengthen human resource capacity for primary health care...; to support the active involvement of local communities and voluntary groups in primary health care; and to support research in order to identify effective methods of monitoring and strengthening primary health care...”.

It also requested the Director General of the WHO to convene a meeting with stakeholders to “...examine the lessons of the past 25 years, review definitions and strategies, and identify future strategic directions for primary health care...”. Dr Evans will be able to brief us on where and when this meeting is to take place.

In response to the WHA decision, and to review our own strategy as we move to the 10th year of our democracy, I decided to host this conference. As you look around you will see that all our partners are represented: all three spheres of government; statutory health councils; the private sector; NGOs and CBOs; and academics. We would have liked to have had many people meeting with us but resource constraints did not permit this. This means that each of us has a responsibility to both actively participate in the discussions and to feedback to those who could not be here.

We have very specific objectives for this conference. We want to celebrate the 25th anniversary of Alma Ata, but not as we would celebrate a birthday or a wedding anniversary. We need to review the Declaration – which each of us has been provided with a copy of – and test the provisions against the need for the PHC approach in the 21st century and our experiences of implementing the PHC approach to date.

In organising this conference we chose six themes that mirror the Alma Ata Declaration. These are the topics that the small groups will discuss today and come to the plenary tomorrow with concrete proposals. We would like to see these proposals codified into the Koponong Declaration on Primary Health Care.

As government we have been concerned about how to ensure integrated development – a key aspect of the PHC approach. We have clustered government departments at both national and provincial levels to facilitate closer co-operation. While this approach is still relatively new gains have already been made. For example, government departments are co-ordinating their efforts in the 13 rural nodes announced by the President more than a year ago. In addition, the Departments of Agriculture, Social Development and Health are working together to implement a co-ordinated and comprehensive nutrition strategy. Further, provinces and municipalities are expected to work together to develop and implement integrated development plans based on national policies. These are relatively new initiatives and as we gain experience and develop expertise the quality of the plans we develop and our interventions will improve.

The ANC government has removed ability to pay for PHC services as a barrier to access, most recently to people with disabilities. In addition, since 1995 we have built and upgraded more than 700 clinics to improve access to our most vulnerable and needy communities. We have introduced community service first for doctors and over the last few years for a range of health professionals, again in order to ensure that people in rural and other under-served areas have access to these health professionals.

We are trying to ensure that everyone gets access to a comprehensive package of PHC services – this was developed in 1999 and our target was full implementation by 2004. We know that we have not reached this target as yet largely because of resource constraints. However, we are committed to this objective and will ensure that every person in our country can have access to this basket of services regardless of where she or he lives.

We took a conscious decision that nurses will be the front line health worker and that a fully trained PHC nurse will be available in every facility. We remain committed to reaching this target. In order to assist the PHCN and other health professionals,

precisely because of we are not able to retain all personnel trained in South Africa for a variety of reasons, we have embarked on a process of creating mid level workers in a range of areas, including pharmacy, nursing, medicine, etc. In addition, we recognise that community outreach and community development is as important as services rendered in a clinic and have re-examined the role of the community health worker cadre. In this regard we have decided to strengthen our community health worker programmes throughout the country.

I must add however, that we are not designing two health systems, one for urban areas in which highly trained health professionals provide services and another for rural and other under-served areas in which nurses, mid-level workers and community health workers provide services. We need to ensure that the personnel mix and skills mix of health workers are not distributed inequitably. Equity in distribution of resources is not negotiable.

What is also not negotiable is the provision of quality primary health care. Most surveys conducted recently suggest that 80% of users of public health services are happy with the quality of care that they received. However, the remaining 20% are not. There are two main reasons given for this, namely attitude of health workers and lack of drugs. The second reason is easier to solve than the first. We introduced Batho Pele as both a philosophy and a programme of action, we held many workshops on these principles but yet users of our services complain about our attitude to them. We must all commit ourselves to improving our communication and relationship with communities we serve and patients we see. There can be no good excuse for treating patients badly. Managers must ensure that they treat health professionals well so that they in turn can treat their patients and the communities they interact with well.

Families and communities play a very important role in ensuring that family and community members are well cared for especially when they are ill. They therefore are an extension of the health system. It is critical therefore that the health system supports families and communities in ensuring that their members stay healthy and that they are supported when they are ill. Diseases like malaria, TB and HIV and AIDS require active community involvement which the health system must support. TB DOTS supports, home-based carers, teachers who identify children who are not thriving, traditional healers who see community members with symptoms of TB or

STIs and then refer to the health system are important allies in our quest for a healthy life for all.

Permit me to conclude:

This is a wonderful opportunity for us to collectively review our achievements and deliberate on what it is we need to do to improve service delivery to realise the vision of the Alma Ata Declaration. We need to find new ways of doing things if the tried and tested methods do not work. We need to commit ourselves to ensuring a better life for all.

It gives me great pleasure to declare this conference open and to wish you fruitful discussions. I will be returning tomorrow to hear your proposals as you collectively fashion the Koponong Declaration on Primary Health Care.

I thank you!