Report on recommendations from the Symposium:

'Building Partnerships to Implement

Community-based Health Services in Primary Health Care'

20 – 22 September 2011

INTRODUCTION

The Symposium on *'Building partnerships to implement community-based health services in primary health care'* was held in Boksburg from 20 -22 September 2011. Formally hosted by SANAC, it was a sequel to the symposium held the previous year which addressed the emerging proposals for nationwide community health workers.

The purpose of this Symposium, however, was to obtain an overview of the new policies arising from the national re-engineering of Primary Health Care (PHC), the plans for their implementation and what the challenges might be – and to discuss these in a multi-sectoral forum. As such, it was designed to include a broad range of community-based PHC practitioners including community health workers (CHWs) and home-based care (HBC) workers, non-profit service organizations and government.

The Symposium was attended by 189 delegates - 119 (63%) from civil society, 55 (30%) from government and 15 (7%) from international organizations. The attendance of this range of delegates has made this one of the most representative gatherings of primary health care service providers, practitioners, policy makers and implementers for many years.

The Symposium programme is given in Appendix A – and members of the steering committee in Appendix B.

Profiles of delegates

Civil society participation comprised small home-based care organisations, hospices, larger AIDS service organizations, training bodies, higher education institutions and networks and associations - the latter including the AIDS Foundation, NACOSA (Networking HIV/Aids Community of South Africa) , HPCA (Hospice Palliative Care Association of S.A.), HIVSA, WITS Rural Health Advocacy Project and Kheth'impilo, among others. In addition, a significant a number of representative bodies attended - namely the HBC Alliance, IVCC (Interim Voluntary Carers' Committee), DENOSA (Democratic Nursing Organisation of SA), SADNU (South African Democratic Nurses' Union), HOSPERSA (Health and Other Service Personnel Trade Union of SA) and NEHAWU (National Education, Health and Allied Workers' Union). Higher education institutions included UCT (University of Cape Town), UWC (University of the Western Cape) and Wits (University of the Witwatersrand).

Of the 53 delegates from government departments of health, 19 were from the national Department and 34 from the nine provincial departments (Eastern Cape (5), Free State (5), Gauteng (7), KZN (4), Limpopo (2), Mpumalanga (2), North West (4), Northern Cape (3), Western Cape (2)). Many representatives were at Chief Director, Director or Deputy Director level. In addition there were two delegates from the Health and Welfare SETA.

The international organizations from which 15 delegates came were CARE South Africa, CDC, ELMA Philanthropies, the Future's Group, HLSP, Johns Hopkins Health & Education in S.A., OXFAM, PEPFAR, the US Embassy and USAID.

Given this delegate profile, we believe that the recommendations arising from this Symposium should be taken as an expression of a credible sample of people implementing primary health care throughout South Africa.

RECOMMENDATIONS

The Symposium included 6 Breakaway Group. The purpose of the Breakaway Groups was to develop recommendations around designated themes. The themes for Breakaway Groups were:

- The composition, roles and scope of practice of members of the PHC Outreach Team
- Employment issues relating to members of the PHC Outreach Team
- Recruitment and training of members of the PHC Outreach Team
- Strengthening district / sub-district health systems
- Challenges of implementing the re-engineering of PHC strategy at the provincial, district and sub-district levels
- Monitoring and evaluating implementation of the re-engineering of PHC

Following the presentation of the recommendations from each Breakaway Group in the final Plenary, delegates were asked to indicate their level of support for each recommendation. Just under three quarters of the delegates (72%) expressed their opinions on the recommendations. A total of 66 recommendations were made – all of which are presented below, grouped thematically according to recommendations rather than Breakaway Group themes. The wording has sometimes been edited slightly so that the meaning is clearer. In order to retain a degree of neutrality, reference to specific organizations in the recommendations has been excluded. The level of support each recommendation received from the total number of delegates who voted, and from the number of delegates who voted by sector, is shown below each recommendation.

1. STRENGTHENING THE DISTRICT AND SUB-DISTRICT HEALTH SYSTEM

Six recommendations were made with regards to the strengthening of the district and sub-district health system – all of which were well supported across sectors. These emphasize the need for partnerships between the government and the NPO sector in the planning and implementation of PHC; the need for inter-sectoral collaboration; establishing forums and structures for accountability at sub-district or ward level; and inclusive referral systems.

1.1 The District Health System (DHS) as originally defined in the Government White Paper of 1997 should be redefined more inclusively, to incorporate:

1.1.1 the relevant unit of analysis, namely the sub-district (or ward where applicable)

1.1.2 increased community and NPO representation

1.1.3 consideration of the social determinants of health as additional areas of responsibility for all stakeholders

1.1.4 emphasis on collaboration (including intersectoral where relevant).

(Group 4 Recommendation 1)

Support:	Total: 99%	Civil Soc: 100%	Labour: 96%	Gov: 100%	International org: 100%

1.2 Considering the importance of partnerships in compiling and implementing service delivery plans, an extensive audit/mapping process should be undertaken at sub-district / ward level to identify:

1.2.1 NPOs and services provided

1.2.2 community-based organisations and services offered

1.2.3 human resource capacity and skill sets within management levels within all organisations involved in service delivery

1.2.4 gaps in/needs for service delivery where evident, and organisations who may address these gaps/needs.

(Group 4 Recommendation 7)

Support:	Total: 100%	Civil Soc: 100%	Labour: 100%	Gov: 100%	International org: 100%

1.3 District and sub-district health councils and clinic and hospital committees (as outlined in the National Health Act) need to function as lines of accountability for PHC Teams. *(Group 1 Recommendation 10)*

Support:	Total: 96%	Civil Soc: 100%	Labour: 96%	Gov: 90%	International org: 100%

1.4 In order to provide accountability for PHC services, single ward committees should be created. These committees should be inclusive of all key stakeholders and will appoint a chairperson to liaise with the District and Provincial Health Councils. The Provincial and District Health Councils will thereby oversee PHC implementation at the ward level. *(Group 5 Recommendation 4)*

Support:	Total: 92%	Civil Soc: 96%	Labour: 93%	Gov: 92%	International org: 71%

1.5 Concerning partnership structures for collaboration, forums should be established at local sub-district/ward level, inclusive of representatives from communities, NPOs, government (multisectoral), and elected officials. They should incorporate a mechanism or agency to hold the forum members accountable for service delivery against an agreed upon health care and broader social development strategy. *(Group 4 Recommendation 3)*

Support:	Total: 97%	Civil Soc: 100%	Labour: 93%	Gov: 96%	International org: 100%

1.6 A clear referral system from facilities to CHW and HBC workers and vice versa must be established, including for persons lost to follow-up. *(Group 1 Recommendation 7)*

Support:	Total: 98%	Civil Soc: 100%	Labour: 96%	Gov: 97%	International org: 100%

2. RECRUITMENT OF CHWS AND HBCS

The recruitment and selection of CHWs – largely from the current cohort of approximately 60 000 'lay' health workers – raises a number of issues regarding the process of recruitment and the criteria against which they are selected. Matric was not needed and across the sectors the level of formal education required by CHWs and HBCs was contentious. Rather a skills test for basic numeracy and literacy and experience in community care work and personal maturity were seen as more important.

2.1 Recruitment and selection mechanisms should be transparent and include community participation and accountability. *(Group 3 Recommendation 2)*

Support:	Total: 93%	Civil Soc: 96%	Labour: 88%	Gov: 92%	International org: 83%

2.2 The recruitment of the CHWs should be the responsibility of the organisation (state or NPO) responsible for managing them. *(Group 3 Recommendation 1)*

Support:	Total: 92%	Civil Soc: 94%	Labour: 91%	Gov: 89%	International org: 86%

2.3 Initially, all CHWs should be recruited from the existing cadre of care workers. *(Group 3 Recommendation 3)*

Support:	Total: 93%	Civil Soc: 91%	Labour: 96%	Gov: 93%	International org: 100%

2.4 Men should be actively recruited as CHWs and HBCs – despite not being part of the existing cadre. *(Group 3 Recommendation 5)*

Support:	Total: 95%	Civil Soc: 96%	Labour: 100%	Gov: 89%	International org: 86%

2.5 Matric is not a requirement for being employed as a HBC, CHW or supervisor although they should have some level of formal schooling (like Grade 10/Std 8). Rather everyone to undergo a literacy and numeracy skills test. *(Group 3 Recommendation 6a)*

Support:	Total: 95%	Civil Soc: 94%	Labour: 96%	Gov: 92%	International org: 100%

2.6 Newly recruited CHWs must have achieved a minimum of Grade 10 (Std 8) education. *(Group 5 Recommendation 5a)*

Support:	Total: 87%	Civil Soc: 83%	Labour: 59%	Gov: 92%	International org: 100%

2.7 However, CHWs absorbed into the system do not have to have Grade 10 (Std 8) education – but rather must only possess functional literacy and numeracy. They will be provided with the support necessary to up-skill. *(Group 5 Recommendation 5b)*

Support:	Total: 89%	Civil Soc: 95%	Labour: 93%	Gov: 73%	International org: 86%

2.8 If matric remains a criterion for accessing mid-level posts, CHWs without (a good enough) matric will need to undertake supplementary schooling in additional to vocational training. *(Group 3 Recommendation 8b)*

Support:	Total: 93%	Civil Soc: 94%	Labour: 84%	Gov: 100%	International org: 100%

2.9 Experience in some form of community care work should be an important criterion when selecting CHWs and HBCs – as well as personal maturity (rather than just age). *(Group 3 Recommendation 6b)*

Support:	Total: 99%	Civil Soc: 100%	Labour: 100%	Gov: 96%	International org: 100%

3. COMPOSITION OF THE PHC OUTREACH TEAM

The proposed composition of the PHC Outreach Team does not make provision for the care at home of patients who are desperately ill. It was recommended that HBCs be appointed on an equal footing in respect to conditions of service and as part of the PHC team, to provide HBC as part of PHC, failing which patients are likely to end up in hospital at considerable cost to the state.

Although the original Discussion Document on the re-engineering of PHC makes reference to home based carers, their position, conditions of employment and scope of work within, or in relation to, the PHC Outreach Team has not been clarified. Although there appeared to be consensus that HBC workers should be part of the PHC Outreach Team there was a degree of uncertainty as to whether they should be employed by government or NPOs, or both. Examples were given where NPOs were successfully contracted by government to provide home based care services.

3.1 The country still requires HBCs and some of the current cadre will continue to do this work. *(Group 3 Recommendation 4)*

Support:	Total: 91%	Civil Soc: 94%	Labour: 92%	Gov: 85%	International org: 86%

3.2 HBC workers should form part of the PHC team and consideration should be given to government employing them. (*Group 1 Recommendation 2a)*

Support:	Total: 93%	Civil Soc: 96%	Labour: 88%	Gov: 92%	International org: 83%

3.3 HBC work should remain an NPO/NGO competency, including employment, training, monitoring and supervision *(Group 1 Recommendation 1a)*

Support:	Total: 65%	Civil Soc: 75%	Labour: 57%	Gov: 57%	International org: 57%

4. CONDITIONS OF EMPLOYMENT OF CHWS AND HBCS

In some provinces HBC workers and counsellors are currently being taken onto the government pay roll system - at the existing wage rates which NPOs were paying, which varies from R500 to R1 500 per month for some counsellors. In KZN these rates have been standardized at R1500 pm.

In other provinces, the HBC workers and counsellors remain in the employ of NPOs at various wages rates. The conditions of employment for PEPFAR and Global Fund funded projects also varies greatly.

There is an urgent need for both standardization of wages and conditions of employment and improved wages for these workers. There should be no in-principle discrimination between HBC and CHW workers. The principle of equal pay for equal work should apply. This is not presently the case and is not the case in the model proposed by Ministerial TTT for PHC re-engineering.

With regards to the employment of HBC workers there were contradictory recommendations. Some delegates felt that HBC workers should be employed by government (Recommendation 4.1), while others felt they should continue to be employed by NPOs (Recommendation 10.5) – while a third set suggested that they may be employed by either government or NPOs depending on the context which may vary between provinces, districts and sub-districts.

4.1 Government should employ all CHWs and HBCs. (See also recommendation 10.5.) *(Group 2 Recommendation 1)*

Support:	Total: 57%	Civil Soc: 56%	Labour: 68%	Gov: 53%	International org: 50%

4.2 The state employment of all CHWs and HBCs should be progressively realized, as funds allow. *(Group 2 Recommendation 2)*

Support:	Total: 86%	Civil Soc: 81%	Labour: 87%	Gov: 87%	International org: 100%

4.3 While provinces must be given flexibility to implement according to their disparate needs, capacities and their PHC models, conditions of employment and training must be comprehensively standardized. *(Group 5 Recommendation 2)*

Support:	Total: 98%	Civil Soc: 100%	Labour: 96%	Gov: 100%	International org: 100%

4.4 The conditions of employment for HBCs to be the same as for CHWs. *(Group 1 Recommendation 1b)*

Support:	Total: 88%	Civil Soc: 94%	Labour: 81%	Gov: 82%	International org: 100%

4.5 CHWs and HBCs should be paid equally. *(Group 3 Recommendation 4)*

Support:	Total: 91%	Civil Soc: 94%	Labour: 92%	Gov: 85%	International org: 86%

4.6 There should be a minimum wage and benefits determined in terms of the job specifications for CHWs and HBCs. *(Group 2 Recommendation 3)*

Support:	Total: 99%	Civil Soc: 100%	Labour: 100%	Gov: 97%	International org: 100%

4.7 Human resource management must feed into current human resource systems (*Group 5 Recommendation 8)*

Support:	Total: 95%	Civil Soc: 96%	Labour: 93%	Gov: 96%	International org: 83%

4.8 Adequate steps to be taken to address security needs of CHWs. *(Group 1 Recommendation 9)*

Support:	Total: 97%	Civil Soc: 100%	Labour: 91%	Gov: 97%	International org: 100%

4.9 The wellness programmes of government should be made available to all CHWs and HBCs in their employ. *(Group 2 Recommendation 4)*

Support:	Total: 96%	Civil Soc: 100%	Labour: 92%	Gov: 91%	International org: 100%

4.10 In terms of qualification and recognition of CHWs and HBCs, the support that can be given to them by other sectors within the profession should be assessed. *(Group 2 Recommendation 7)*

Support:	Total: 97%	Civil Soc: 100%	Labour: 100%	Gov: 94%	International org: 88%

5. SCOPE OF WORK OF THE PHC OUTREACH TEAM

CHWs as part of the PHC teams will be responsible for early case finding, referral and support across a range of chronic disease and trauma areas. The initial focus will be on maternal and child health and welfare and HIV-TB - but other areas will be implemented over the next two or three years. It is recommended that other critical areas such as pneumonia treatment (which would require an amendment to existing regulation on dispensing) and mental health be included in the scope of work. Mechanisms for addressing the palliative care needs of patients who are seriously ill should also be established.

5.1 Expansion of scope of work: CHWs and HBCs should be seen as front line HIV prevention workers *(Group 1 Recommendation 3c)*

Support:	Total: 97%	Civil Soc: 100%	Labour: 100%	Gov: 100%	International org: 100%

5.2 Expansion of scope of work: mental health and contraception to be included *(Group 1 Recommendation 3b)*

Support:	Total: 87%	Civil Soc: 88%	Labour: 83%	Gov: 93%	International org: 71%

5.3 Expansion of scope of work: over time, CHWs and HBCs to be empowered to diagnose and provide treatment for pneumonia and to be able to treat minor illnesses (there may be a need to adapt legal frameworks to allow for this). *(Group 1 Recommendation 3a)*

Support:	Total: 70%	Civil Soc: 86%	Labour: 67%	Gov: 44%	International org: 67%

5.4 The relationship between the roles of HBC workers and CHWs should be flexible so that, where necessary, these roles can be performed by one person (e.g. in rural areas where there are large distances and low population density.) *(Group 1 Recommendation 5)*

Support:	Total: 91%	Civil Soc: 92%	Labour: 83%	Gov: 93%	International org: 100%

6. SUPERVISION OF CHWS AND HBCS

International and domestic experience in CHW programmes clearly shows the importance of supervision in programme implementation. Community-based workers without a fixed workplace need strong support and reinforcement to both deliver consistent output and consistent quality. In SA we have many experienced CHWs who could provide a level of detailed supervision which would reserve the time of the professional nurse PHC-Team leader for clinical supervision and intervention.

6.1 Supervision of CHWs must be accomplished by a three-tier approach: (i) Clinical governance must be conducted by a facility manager; (ii) Clinical support, mentorship and team leadership must be conducted by a professional nurse; (iii) administration and community field supervision may be conducted by a senior CHW. *(Group 5 Recommendation 6)*

Support:	Total: 95%	Civil Soc: 96%	Labour: 93%	Gov: 93%	International org: 100%

6.2 CHW supervisors should be appointed for routine day-to-day supervision including monitoring and evaluation, relationship with community etc, and professional nurses should be responsible for clinical supervision. *(Group 1 Recommendation 6)*

Support:	Total: 93%	Civil Soc: 98%	Labour: 91%	Gov: 86%	International org: 100%

7. TRAINING MEMBERS OF THE PHC OUTREACH TEAM

Training must equip CHWs and HBCs to do the work prescribed in the scope of work for each post. Among the current cadre of 'lay' health workers, however, there exists a wide range of relevant skills and competences, learned in a variety of ways and to different standards. While four qualifications exist on the National Qualifications Framework, a plethora of courses has been offered over the past ten to fifteen years – both reputable and more ad hoc. An approach to training must take these into account, while also ensuring that a minimum set of skills and competence are acquired to a certain basic standard. At the same time, training processes need to consider the minimal formal education many of the experienced workers have.

The need for stakeholder participation in developing national qualifications – and a common core curriculum for both HBCs and CHWs - were supported. The exit levels were more controversial, however, with the issue of matric equivalence drawing diverse opinion (7.5).

7.1 CHWs and HBCs should be professionally recognised, and a professional qualification with national accreditation should be developed for both CHWs and HBCs. *(Group 2 Recommendation 6) and (Group 3 Recommendation 7a);*

Support:	Total: 93%	Civil Soc: 94%	Labour: 96%	Gov: 88%	International org: 100%
Support:	Total: 98%	Civil Soc: 98%	Labour: 100%	Gov: 96%	International org: 100%

7.2 The process of reviewing existing /developing new qualifications should draw on existing experience, curricula, materials etc of both NPOs and RTCs. *(Group 3 Recommendation 7b)*

Support:	Total: 98%	Civil Soc: 100%	Labour: 96%	Gov: 76%	International org: 100%

7.3 The process of reviewing/ developing qualifications suitable for the roles of the outreach team must include civil society and labour stakeholders. *(Group 3 Recommendation 8c)*

Support:	Total: 95%	Civil Soc: 96%	Labour: 100%	Gov: 96%	International org: 71%

7.4 The same basic training, which should comply with national standards, should be provided to HBCs and CHWs. *(Group 1 Recommendation 4)*

Support:	Total: 98%	Civil Soc: 98%	Labour: 100%	Gov: 96%	International org: 100%

7.5 CHW training should be vocational, and the exit level may not be equivalent to matric. *(Group 3 Recommendation 8a)*

Support:	Total: 82%	Civil Soc: 87%	Labour: 93%	Gov: 75%	International org: 100%

7.6 Although HBCs, CHWs and supervisors will have various levels and types of experience, individual RPL is not recommended. Rather they should all attend the same training as this has a range of benefits which override any repetition - namely the team is trained together, and standard operating procedures and consistent quality standards are conveyed. *(Group 3 Recommendation 9a)*

Support:	Total: 88%	Civil Soc: 90%	Labour: 87%	Gov: 87%	International org: 83%

7.7 Learner's who have previously been assessed for various components of the "new" curriculum, should attend the training but need not be assessed again, however. *(Group 3 Recommendation 9b)*

Support:	Total: 81%	Civil Soc: 83%	Labour: 88%	Gov: 75%	International org: 67%

7.8 Supervisors should attend training with their team of CHWs/HBCs so that they are familiar with content and challenges encountered in the training. *(Group 3 Recommendation 10)*

Support:	Total: 98%	Civil Soc: 96%	Labour: 100%	Gov: 100%	International org: 100%

7.9 Both the state and NPOs should provide the accredited training. *(Group 3 Recommendation 11a)*

Support:	Total: 90%	Civil Soc: 96%	Labour: 84%	Gov: 83%	International org: 86%

8. MONITORING AND EVALUATION

Monitoring of input and having a measure of the outcomes (evaluation) is critical to the success of this programme. Without this information, weaknesses in implementation will not be systematically observed and necessary corrective action taken. One of the key requirements (see 8.7 below) is that the M&E system should link to the process of governance and the human resource management system so the quantity and quality of input delivered by CHWs can be monitored with a feedback loop to management and to accountability structures. The recommendations gained consistently high support across sectors.

8.1 The monitoring and evaluation system should cover the four burdens of disease and report regularly and frequently: quarterly, annually, mid-term. *(Group 6 Recommendation 1)*

Support:	Total: 98%	Civil Soc: 96%	Labour: 100%	Gov: 100%	International org: 100%

8.2 Clearly and realistically define the contribution that CHWs would make to national goals (e.g. TB interruption rate; early bookings for ante natal care). CHW contribution should not be viewed as only biomedical, but should also reflect the quality of relationships and of work done (e.g. how they interact with households and role players across the referral system). *(Group 6 Recommendation 2b)*

Support:	Total: 100%	Civil Soc: 100%	Labour: 100%	Gov: 100%	International org: 100%

8.3 Monitoring & evaluation must be accomplished by a national standardized tool that feeds into District Health Information System (DHIS) *(Group 5 Recommendation 7)*

Support:	Total: 99%	Civil Soc: 100%	Labour: 97%	Gov: 100%	International org: 100%

8.4 Different sources of information that would enable a comprehensive picture and an M&E system that would move away from target setting to problem-solving (i.e set key questions that would produce data providing a full picture, measure several indicators allowing triangulation of data, include not only quantitative but also qualitative data, e.g. on behaviour change; perform team analysis of information that look at trends) *(Group 6 Recommendation 2c)*

Support:	Total: 97%	Civil Soc: 100%	Labour: 96%	Gov: 95%	International org: 91%

8.5 Recommendations at programme/ district/ provincial level: Start the M&E process with situation analysis that provides baseline data. This must include also the social, institutional and environmental. *(Group 6 Recommendation 2a)*

Support:	Total: 100%	Civil Soc: 100%	Labour: 100%	Gov: 100%	International org: n/a

8.6 Recommendations at community level: Develop local feedback loops that are responsive to local need and are part of the national M&E framework. *(Group 6 Recommendation 3a)*

Support:	Total: 97%	Civil Soc: 98%	Labour: 100%	Gov: 100%	International org: 80%

8.7 Link the M&E process explicitly to a real governance process, also at a local level (e.g. via clinic committees, hospital boards, ward political structures, and other civil society structures and networks). *(Group 6 Recommendation 3b)*

Support:	Total: 97%	Civil Soc: 98%	Labour: 96%	Gov: 95%	International org: 100%

8.8 While mixed method M&E is beneficial at a local level, move towards electronic inputting of information. *(Group 6 Recommendation 3d)*

Support:	Total: 98%	Civil Soc: 100%	Labour: 96%	Gov: 100%	International org: 91%

8.9 Build capacity for data to be captured, verified and utilised at a local level. *(Group 6 Recommendation 3c)*

Support:	Total: 100%	Civil Soc: 100%	Labour: 100%	Gov: 100%	International org: n/a

9. ISSUES ABOUT IMPLEMENTATION OF THE PHC MODEL

There was strong support for a national generic PHC model. It was recognized however, and evident from the case studies presented, that this model may be implemented differently in different provinces and health districts depending on their specific interpretation of the model, needs, resources and capabilities. Given the potential variations in terms of implementation, it is important to identify core indicators that constitute an efficient and effective PHC system at district and sub-district level and to use these indicators, rather than a prescribed model, to monitor successful implementation.

Concern was expressed about the 'speed' of implementation and the readiness of provinces and districts to implement the model. It was felt that implementation should be incremental with adequate time for reflection on lessons learnt to improve further implementation.

9.1 A national model for PHC must be implemented. *(Group 5 Recommendation 1)*

Support:	Total: 98%	Civil Soc: 98%	Labour: 100%	Gov: 100%	International org: 86%

9.2 While provinces must be given flexibility to implement according to their disparate needs, capacities and their PHC models, conditions of employment and training must be comprehensively standardised. *(Group 5 Recommendation 2)*

Support:	Total: 98%	Civil Soc: 100%	Labour: 96%	Gov: 100%	International org: 100%

9.3 Transitional implementation of PHC at the provincial level must be accomplished incrementally while recognizing the immediacy of health rights and needs. The timeframe for implementation provided in Annexure V Road Map of the Toolkit: Ward Based PHC Outreach Teams, Implementation Toolkit should be applied accompanied by increased communication regarding all areas of the steps to be taken. *(Group 5 Recommendation 3)*

Support:	Total: 94%	Civil Soc: 96%	Labour: 86%	Gov: 100%	International org: 86%

9.4 There needs to be adequate communication to secure buy-in and support for the PHC Outreach programme. *(Group 1 Recommendation 8)*

Support:	Total: 98%	Civil Soc: 100%	Labour: 96%	Gov: 97%	International org: 100%

10. THE ROLE OF NPO SECTOR

The NPO sector has a long history of providing community home-based services in South Africa – a role that has been intensified in the context of the HIV/AIDS pandemic. Funded through various sources, many NPOs have increasingly been contracted by the state to offer these services – a situation which may change as the state seeks to employ CHWs in particular. These recommendations focus on promoting a partnership between the state and civil society – both to ensure there is sufficient capacity to deliver community-based services to all, as well as to continue to benefit from the considerable investment made in developing these services in NPOs over time.

While there was consistently high support for the idea of partnership, there was much less support for HBC work remaining an NPO/NGO competency.

10.1 NPOs and the DoH should be proactive in embracing the opportunities that mutual collaboration presents, including the necessity for re-positioning of services where necessary, and recognizing their respective contributions to the delivery of PHC. *(Group 4 Recommendation 6)*

Support:	Total: 98%	Civil Soc: 98%	Labour: 96%	Gov: 100%	International org: 100%

10.2 The role of the NPOs as partners with the state within each sub-district/ward should be determined in agreement with other partners at local level, to fill the gaps in plans towards achieving desired heath outcomes for communities. *(Group 4 Recommendation 2)*

Support:	Total: 99%	Civil Soc: 100%	Labour: 96%	Gov: 100%	International org: 100%

10.3 Government should outsource to NPOs various support services like monitoring and evaluation, data collection, debriefing, training and advocacy, in relation to both HBCs and CHWs. *(Group 1 Recommendation 2b)*

Support:	Total: 85%	Civil Soc: 90%	Labour: 83%	Gov: 74%	International org: 100%

10.4 NPOs should have specialist functions recognised and used by government with respect to CHWs and HBCs. *(Group 2 Recommendation 5)*

Support:	Total: 95%	Civil Soc: 98%	Labour: 84%	Gov: 97%	International org: 100%

10.5 HBC work should remain an NPO/NGO competency, including employment, training, monitoring and supervision *(Group 1 Recommendation 1a)*

Support:	Total: 65%	Civil Soc: 75%	Labour: 57%	Gov: 57%	International org: 57%

10.6 NPOs independent of government should form an organization or coalition to represent their interests – drawing existing organizations in order to evaluate and strengthen them. *(Group 5 Recommendation 9)*

Support:	Total: 91%	Civil Soc: 94%	Labour: 82%	Gov: 93%	International org: 88%

10.7 Notwithstanding that the NPO presence is most relevant at a local level, it is recommended that an extensive, "grassroots-up" consultative process be undertaken to establish a national NPO body (with a mandate to represent the collective interest of the sector) that has representation at provincial, district and local level; in addition mechanisms and capacity to consult with the sector on all levels must be established. *(Group 4 Recommendation 5)*

Support:	Total: 100%	Civil Soc: 100%	Labour: 100%	Gov: 100%	International org: 100%

11. Professional Association for CHWs and HBCs

Primary health care has a critical role to play in the emergence of National Health Insurance. The goal has to be to greatly reduce the number of people occupying beds in hospital because of chronic illness such as HIV and TB, diabetes and hypertension and to greatly improve maternal and child health and welfare and reduce morbidity and mortality amongst pregnant women and their children. In so doing, overall health care costs and demands will be reduced, making the NHI feasible.

CHWs will be critical to achieving this goal at population level. Given the importance of this goal, a professional association of CHW and HBC workers is needed to regulate their affairs and input into all process affecting them.

11.1 Considering the vital role of the CHWs and HBCs in improving health outcomes in South Africa, it is recommended that these groups consider the establishment of a professional body to facilitate their taking their rightful place alongside other established cadres of health workers. *(Group 4 Recommendation 4)*

Support:	Total: 94%	Civil Soc: 96%	Labour: 96%	Gov: 89%	International org: 83%

11.2 The formation of a professional association for CHWs and HBCs should be considered. *(Group 2 Recommendation 8a)*

Support:	Total: 91%	Civil Soc: 96%	Labour: 79%	Gov: 91%	International org: 88%

11.3 CHWs and HBCs should be professionally recognised, and a professional qualification be developed. *(Group 2 Recommendation 6)*

Support:	Total: 93%	Civil Soc: 94%	Labour: 96%	Gov: 88%	International org: 100%

11.4 Following the establishment of qualifications, steps should be taken to form a statutory body for CHWs and HBC workers which regulates ethical and professional standards and the license to practice. *(Group 1 Recommendation 11)*

Support:	Total: 95%	Civil Soc: 96%	Labour: 96%	Gov: 93%	International org: 100%

11.5 The professional association could be an additional part of an existing association. *(Group 2 Recommendation 8b)*

Support:	Total: 80%	Civil Soc: 77%	Labour: 78%	Gov: 83%	International org: 86%

11.6 A council must be formed and registered to regulate the CHW /HBC profession. *(Group 3 Recommendation 10)*

Support:	Total: 98%	Civil Soc: 96%	Labour: 100%	Gov: 100%	International org: 100%

CONCLUSION

Attended by a wide spectrum of government, NPO, labour, academic, donor and international organisations, this Symposium was arguably one of the most representative gatherings of policy makers and practitioners in the health sector. Although it was co-ordinated by the NPO sector, attendance and participation by national and provincial department of health representatives was particularly appreciated and significant.

The Symposium was characterised by recognition of the importance of co-operation between government and NPOs as well as a willingness on the part of both sectors to work in a more collaborative and inclusive way in the interests of effective implementation of the new PHC policy.

The recommendations from the Symposium are far reaching and provide a clear agenda for ongoing deliberation and collaboration between government and the civil society at national, provincial, district and sub-district levels. Mechanisms to facilitate these processes will be put in place.

WAY FORWARD

An expanded cadre of 35 delegates from all parts of the country, including several from government, volunteered to work on the outcomes of the Symposium. To this end, an ad hoc Joint PHC Forum (JPHCF) will be established. The initial purpose of the Forum will be

- to take the recommendations of the Symposium forward
- to pool information on the progress and challenges experienced in implementing the PHC policy and
- to liaise with government at various levels, as suitable.

The exact purpose of the Forum will be further developed at a follow-up meeting with those who have volunteered to be part of the ongoing process.

Appendix A

PROGRAMME

TUESDAY 20 September

All sessions take place in the King Shaka in the Domestic Centre (21 on the map)

11h00 – 14h00	**Arrival, registration and lunch**
14h00 – 14h15	**Welcome and introduction** – Dr Jack Lewis for Symposium Steering Committee
	RE-ENGINEERING PRIMARY HEALTH CARE IN SOUTH AFRICA – POLICIES, STRATEGIES AND IMPLEMENTATION Chair: Prof Ashraf Coovadia*, Dept of Paediatrics and Child Health, Wits*
14h15 – 14h45	Plenary presentation **Keynote address** - Dr Malebona Matsoso, *Director General, National Dept of Health*
14h45 – 15h30	Plenary presentation **Re-engineering PHC in SA – policy and strategy and implementation plans** - Dr Yogan Pillay*, Deputy Director General: Strategic Health Programmes, National Department of Health*
15h30 – 16h00	**TEA**
16h00 – 16h45	Plenary presentation **Challenges of PHC Re-engineering** - Prof Helen Schneider, *School of Public Health, UWC*
16h45 – 17h30	Plenary panel presentation **An overview of the role of civil society in provision of community-based health care** - Ms Bridget Lloyd*, Peoples' Health Movement* - Dr Gugu Ngubane, *HLSP* - Mrs Anna Genu, *SACLA and Interim Voluntary Carers' Committee*

17h30 – 18h30	**Workshop** *(optional - in plenary venue)* **Creating evidence through mapping: A demonstration of strategic mapping and discussion of its value to PHC** – Ms Janine Mitchell, *Foundation for Professional Development*

19h00 – 21h00	**DINNER** *(for delegates staying overnight)*

WEDNESDAY 21 September

From 6am	**BREAKFAST**
08h30 – 08h45	Plenary introduction **Conference themes, structure & processes**
	RE-ENGINEERING PRIMARY HEALTH CARE IN SOUTH AFRICA: IMPLEMENTATION – HOW DO WE DO IT? Chair: Ms Lihle Dlamini, *Treatment Action Campaign (TAC)*
08h45 – 10h15	Plenary panel presentation **Progress and challenges with implementation: Gauteng** - Ms Nongezo Mekgwe, *DOH (Gauteng)* - Dr Manei Letebele, *DOH (Gauteng)* - Ms Magdel Williams *(Kings Hope Trust)* *Discussion and contributions from the floor.*
10h15 – 10h45	**TEA**
10h45 – 12h15	Plenary panel presentation **Progress and challenges with implementation: KZN** - Mr Londo Langa*, DoH (KZN)* - Ms Fezile Hadebe, *Bhekuzulu Self-Sufficient Project* - Dr Irwin Friedman, *Seed Trust* *Discussion and contributions from the floor.*
12h15 – 12h30	Introduction to breakaway groups
12h30 – 13h30	**LUNCH**
	BREAKAWAY GROUPS *(Venues to be announced before lunch)*
13h30– 15h15	**Group 1: The composition, roles and scope of practice of members of the PHC Outreach Team** *Facilitated by Dr Gugu Ngubane & Ms Nikki Stein*
	Group 2: Employment issues relating to members of the PHC Outreach Team *Facilitated by Mr Andre Wagner & Mr Matumo Shilongo*
	Group 3: Recruitment and training of members of the PHC Outreach Team *Facilitated by Ms Penny Morrell & Ms Yashmita Naidoo*
	Group 4: Strengthening district / sub-district health systems *Facilitated by Dr Richard Cooke & Ms Abigail Dreyer*
	Group 5: Challenges of implementing the re-engineering of PHC strategy at the provincial, district and sub-district levels *Facilitated by Mr Lawrence Mbalati & Mr John Stephens*
	Group 6: Monitoring and evaluating the implementation of the Re-engineering of PHC *Facilitated by Prof Helen Schneider & Dr Ermien van Pletzen*

15h15 – 15h45	**TEA**
15h45 – 17h30	**Breakaway groups (continued)**
18h30 – 21h00	**DINNER** *(for delegates staying overnight)*

THURSDAY 22 September

From 6am	**BREAKFAST** *****Book out of rooms before sessions start*****
09h00 – 9h15	Introduction
	REPORTBACKS FROM BREAKAWAY GROUPS Chair: Assoc Prof Uta Lehmann, *School of Public Health, UWC*
09h15 – 10h45	Plenary reportback **Breakaway Groups 1-3 report back,** followed by discussion and assessment of support for recommendations
10h45 – 11h15	**TEA**
11h15 – 12h45	Plenary reportback **Breakaway Groups 4-6 report back (cont),** followed by discussion and assessment of support for recommendations
12h45 – 13h00	Plenary presentation **Summary and closure including the way forward** – Dr Jack Lewis for Symposium Steering Committee
13h00 – 14h00	**LUNCH and departure**

Appendix B

Symposium Steering Committee

AIDS Foundation of SA	Debbie Mathew
Catholic Health Care Association (CATHCA)	Yvonne Morgan
Community Media Trust (CMT)	Jack Lewis
Hospice Palliative Care Association (HPCA)	Josef Lazarus
Interim Voluntary Carers' Committee (IVCC)	Anna Genu
Networking HIV/AIDS Community of South Africa (NACOSA)	Hannerie White
National Education Health and Allied Workers' Union (NEHAWU)	Sheila Barsel
Section 27	Skumbuso Maphumulo
Treatment Action Committee (TAC)	Amelia Mfiki and Vuyokazi Gonyela
School of Public Health, University of the Western Cape (UWC)	Penny Morrell