Lessons from the Gert Sibande pilot district in Mpumalanga, South Africa

November 2016
NATIONAL HEALTH INSURANCE
WHERE WE ARE AND WHERE WE’RE GOING

Lessons from the Gert Sibande pilot district in Mpumalanga, South Africa

November 2016

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FOREWORD

TAC Mpumalanga Provincial Office Bearers

The Treatment Action Campaign (TAC) has always been at the forefront of advocating and fighting for the right to quality basic health care for all. Over the years the TAC has engaged with various stake holders in an attempt to build a public health care system that will cover and protect the poorest of poor and the most vulnerable.

In 2011, the Gert Sibande District in Mpumalanga was put forward as an NHI pilot district. It was envisaged that the NHI piloting would revive the ailing health care system in Gert Sibande that was marred by medicine stock outs, inadequate infrastructure and a shortage of human resources. We hoped that the primary health care system would undergo a complete overhaul.

In 2013, the TAC and SECTION27 started monitoring the implementation of the NHI programme in the district, by visiting various health care facilities across the district and speaking to healthcare practitioners and patients to get a sense of what the new NHI policy meant for ordinary citizens on the ground.

The monitoring process allowed us to understand both the positive changes brought about by NHI and the shortcomings of NHI. It is clear however that there is still much work to be done to ensure that people have access to quality health care in Gert Sibande.

TAC will continue to fight for ordinary citizens and society at large by closely monitoring implementation of NHI reforms to ensure that the public health system works efficiently and effectively in the struggle to combat HIV/AIDS and tuberculosis and to serve the people of South Africa.
In 2013, the Treatment Action Campaign (TAC) and SECTION27 started working together to monitor the piloting of National Health Insurance (NHI) in Gert Sibande, Mpumalanga.

In order to collect the information for this report, over a period of one year, TAC and SECTION27 visited various health care facilities, including clinics, community health centres and hospitals across the district. For each of the visits, the following aspects were investigated:

+ The state of infrastructure
+ The existence and functioning of a clinic committee
+ Whether the facility adheres to the six core standards as set out in the reengineering phase of NHI implementation
+ Whether the facility has access to a doctor

During the visits, community mobilisers also noted any other issues that were raised, either challenges faced or positive changes seen under the piloting.

After a year of on the ground research, the information was compiled into this report titled, "NHI: Lessons from Gert Sibande"

The thinking was that the report could be used as a tool for various stakeholders in the health care system to have a better understanding of what the health care system in Gert Sibande actually looks like, for both health practitioners and patients. The report was also envisaged as a document that could be used as a tool of engagement in order to facilitate conversation with different stakeholders, and to allow them to see where they could improve the system individually or in partnership with others.

On 15 September 2016, SECTION27 hosted an NHI Seminar at Cassim Park in Ermelo. The seminar was attended by representatives of the provincial Department of Health, members of different health unions, a representative of the Office of Health Standards Compliance, organisations representing health care service users and members of the public. The purpose of the seminar was to discuss the findings in the report and elicit feedback.

The seminar yielded fruitful engagement. After the report was presented, Department of Health representatives were given an opportunity to respond and to discuss how they envisage NHI reforms improving access to health care services in the District. The engagement was honest and detailed. Where the Department fell short, they acknowledged the shortfalls.

What we have now is a report that has been updated with various inputs from the seminar. We hope that the report accurately reflects the different views and ideas put forward and can help in leading to consensus about what is needed to make the health care system in Gert Sibande work better for both practitioners and patients.
INTRODUCTION TO THE NHI

National Health Insurance is intended to be the solution to the litany of problems in the South African health care system, primary among them the inequitable distribution of financial and human resources across the public and private sectors. It promises to shake up the current funding and access system, to strengthen the state as the sole purchaser of health services, to push down prices in the private sector. As such it has, over the last decade, been on the tip of many tongues.

The policy-making process has, however, been slow. The White Paper on the Transformation of the Health Care System in 1997 and the National Health Act 61 of 2003 were some of the first attempts at improving quality, equitable access, efficiency and effectiveness of the health system. The NHI Green Paper of August 2011 started to define some of the features of NHI but its lack of clarity and specificity ensured that it was widely criticized and it was four years until the White Paper was published in December 2015.

SECTION27 has, since as early as 2008, worked with the National Department of Health in the development of NHI policy. We have made numerous detailed submissions and have met with the Department in the early policy-making stages including on the Ministerial Task Team and other structures and in relation to a previous draft of the White Paper. We have provided the Department with advice and research on a range of specific topics related to NHI. We made a submission on the NHI White Paper on 7 June 2016.
We are deeply concerned about the prospects of a successful NHI in the light of the dire state of the health system at present.

- Stock outs of essential medication continues across the country.
- The private sector, inadequately regulated while we waited for the Competition Commission Market Inquiry, is expensive and powerful.
- The Office of Health Standards Compliance assessment of health establishments has indicated (in a report to Parliament in March 2016) that on average, health facilities across the country received a 46% score – well below the required standards. Facilities in Mpumalanga averaged 44% and in Gert Sibande facilities received a 36% average score on vital measures – the fourth lowest scoring district.
- Our work in the Eastern Cape on emergency medical services shows widespread lack of access to emergency medical treatment, a constitutional right that is not subject to progressive realization.
- Many clinics in Gert Sibande lack flushing toilets.
- Appallingly slow progress on the policy on community health workers and the continuous abuse of such health workers by provincial departments of health has seen both the arrest of community health workers in the Free State for peacefully protesting their dismissal, and the attempt by the Gauteng Department of Health to force community health workers to enter into employment contracts with a payment system company, appointed initially to manage payroll and attendance, with the result that patients across the province are being left without care to develop bedsores and infections.
- Provincial departments of health, riding on political tensions, stubbornly refuse to implement national policy and legislation.

A dysfunctional health system costs lives. Unfortunately, our health system has been in a state of dysfunction for some time. While universal health coverage is undoubtedly needed, for NHI to function, it needs a strong base. We do not have that base.

The identification of pilot sites and piloting of NHI-related interventions should have been an opportunity to test and cost alternative interventions and to start to develop a stronger base for NHI in some of the most problematic districts. Unfortunately, wholly inadequate business plans across all NHI pilot districts and a lack of reflection, five years after pilot districts were identified, on the outcomes of piloting means that it is unclear what lessons have been learnt during the time in which NHI has been piloted; whether piloting is over or, if not, for how long piloting will continue.

This publication draws from SECTION27's submission on the NHI White Paper and from the work, over the past two years, of SECTION27 community mobiliser, Sfiso Nkala, who works with partner organization the Treatment Action Campaign, in Gert Sibande, the pilot district in Mpumalanga. We look at NHI through the lens of this pilot district. We seek to establish what has happened; what hasn't; and what lessons can be learned and applied to NHI generally. We then identify what we consider to be some of the key health system improvements required to make possible NHI and the vital improvement in equity in health that it promises.
This generator at iSwepe Clinic (above) is not functioning due to lack of maintenance. Other clinics do not have the diesel needed to run these generators – diesel which is supposed to be supplied by the Department of Public Works. Pictured below is the waiting room at Phola Park Clinic.
In 2012, ten health districts were selected by the National Department of Health to pilot NHI. The pilot districts were chosen to focus health system reforms to benefit the most vulnerable sections of society across the country; to reduce high maternal and child mortality through district-based health interventions; and to strengthen the performance of the public health system in readiness for the full roll-out of NHI. The selection of pilots was based on indicators including socio-economic, health service performance, rurality and financial and resource management.

Gert Sibande district was selected as the NHI pilot site for Mpumalanga. Gert Sibande is the largest of the three districts in Mpumalanga and covers 40% of the province. According to the 2014/15 Integrated Development Plan released by the Gert Sibande District Municipality, the ante-natal HIV prevalence rate of the district is 46.1%, compared with a prevalence of 29% nationally.

The Health Systems Trust District Health Barometer of 2014/15 gives further detail. In the under 5-year age group, communicable diseases and maternal, perinatal and nutritional conditions accounted for 80% of deaths. Diarrheal diseases, lower respiratory infections, preterm birth complications, birth asphyxia, HIV and AIDS and protein-energy malnutrition are the leading causes of death in this group. Gert Sibande has the highest under-5 severe acute malnutrition case fatality rate in the country. The facility infant (under-1 year) and child (under-5 years) mortality rate were 11.8 and 8.4 respectively in 2011 and were both above the national average of 8.1% and 5.5% respectively. Only 79% of children under 1 year are immunised, compared to a national average of 89.8%. In the 15–24-year age group, HIV accounted for 40.7% of deaths in females and 16.6% of deaths in males. In the 25–64-year age group, approximately 37% of males and females died from HIV and TB.

Professional nurses in Gert Sibande see on average 35.8 patients per day, compared to a national average of 29.4 patients.

While there is much need, the implementation of the NHI has been slow in the district. Four years later, many clinics are still waiting for infrastructure improvements under the primary health care re-engineering. In this phase, existing clinics should have had their facilities upgraded, but by mid-2016 many clinics still had inadequate infrastructure that had not been upgraded. Many clinics were still faced with staff shortages and were under resourced.
Examination room (above) and broken cleaning equipment (below) at Driefontein Clinic. Cleaners do not have the detergents needed to do their job properly.
WHAT WAS THE PLAN?

The NHI grants

There are two NHI-related conditional grants. The direct grant started in 2012/13 and allowed for three years of spending. The funding was provided directly to provincial departments of health. In the first year, R11.5 million was allocated to Gert Sibande; in the second year, R4.8 million was allocated and in the third year, R7.7 million was allocated (of which Gert Sibande spent 48%, 77% and 42% respectively). The decrease in allocation reflects the shift to the indirect grant. The underspending on the grant hints at the structural weaknesses in the district.

The indirect grant started in 2013/14 and is managed by the National Department of Health on behalf of the provincial health departments. The indirect grant was established to deal with the underspending and poor performance of the direct grant. It is important to note, however, that a National Treasury presentation of June 2015 indicates that although the indirect grant was established to deal with the underspending on the direct grant, the National Department of Health had, at that point, demonstrated no greater capacity than provinces to deliver as both spending and performance is significantly below target.

The Gert Sibande Business Plan 2013/14

One of the requirements of a conditional grant (such as the direct NHI grant) is that a business plan is developed to identify the challenges sought to be tackled and the key deliverables identified. The development of a business plan is meant to allow for a combination of top down and bottom up planning and to establish a measure of accountability for the funds provided.

The most recent publically available business plan for the direct NHI grant to Gert Sibande is for the 2013/14 financial year. The 2013/14 Gert Sibande business plan identified the following as potential challenges facing the implementation of NHI in the district:
+ there is a lack of specialists at Ermelo Hospital, the only regional hospital in the district and which now has to function as a district hospital, due to the inability of the district to attract and retain specialists and skilled health professionals;
+ there has been an under spending of the grant by the district; and
+ there are delays in procurement or payments.

The key deliverables, as laid out in the business plan were as follows:

1. Enhance district capacity in the areas of planning and monitoring and evaluation, including to:
   + appoint one M&E coordinator in the district;
   + train 10 hospital boards and 72 clinic committees on their duties;
   + hold four district M&E meetings;
   + train 100 managers on financial management and acquisition and demand;
   + conduct seven on-site training sessions by the district clinical specialist teams.

2. Improve supply chain management systems and processes to support efficient and effective health services provision within the district, including to:
   + train primary health care managers, primary health care supervisors and operational managers for primary health care facilities on financial management and acquisition and demand;
   + capacitate members of the bid committee and SCM staff in acquisition and demand.

3. Strengthen the referral system based on a re-engineered primary health care platform with a particular focus in rural and previously disadvantaged areas, including:
   + capacitate professional nurses on drug management and dispensing of medication, thereby decreasing referrals to hospitals for collection of medication;
   + procure screening audiometers, Snellen charts and scales with heights for 18 school health teams;
   + workshop to orientate staff at all levels on the approved referral policy thereby leading to improved implementation;
   + the district clinical specialist teams to provide onsite training to staff in the primary health care facilities on clinical care and capacitate the municipal ward based primary health care outreach teams.

The development of a business plan is meant to allow for a combination of top down and bottom up planning and to establish a measure of accountability for the funds provided.
WHAT HAS HAPPENED IN GERT SIBANDE?

There is little official public analysis of the experience of the NHI pilot districts, making it difficult to establish whether the key deliverables identified have been achieved. The Director-General referred to the pilot districts in her 18-month review, published in the South African Health Review 2012/13, but did not make specific reference to particular districts. In mid-2015, the Department of Health made presentations to the Select Committee on Appropriations and the Portfolio Committee on Health. In those presentations, the Department of Health revealed the following concerning Gert Sibande:

+ Gert Sibande had 92.86% GP PHC facility coverage in March 2015, of which around 60% were contracted by National or Mpumalanga Departments of Health, 9% were full time employed doctors, just under 7% were doctors doing outreach from hospitals and 23% were NGO doctors.
+ Only 42.3% of the 2014/15 NHI grant for Gert Sibande was spent.
+ Of the 182 ward based primary health care outreach teams required to meet the identified ratio of 1:1500 households in Gert Sibande, only 64 were registered as at January 2015.

Given the lack of reporting on progress in Gert Sibande and the importance of that reporting for taking lessons from the piloting process for application to NHI in general, our monitoring of access to health care services in various facilities in the district provides useful insight to the state of NHI piloting in the district.

In the following section, we consider the issues that some clinics in the districts face, four years after Gert Sibande being declared a pilot district. We profile Ubuhle Bempilo, a clinic in Breyten, and Fernie-2 Clinic and Diepdale Clinic in the Chief Albert Luthuli Municipality. These facilities illustrate some of the emerging good stories of NHI in Gert Sibande. We then take a snapshot of some of the other clinics in the district and the challenges that they continue to face. Finally, we look at the work of civil society in the province and plans for the future.
Thembli Luthuli, the Deputy Chief Director of NHI in Gert Sibande, kindly agreed to present to the NHI seminar held on 15 September 2016. She presented on the progress made and challenges experienced by the Gert Sibande District in the implementation of NHI.

The District Clinical Specialist Team has been established but the District has struggled to retain team members. At this point, only the Advanced Midwife and the Obstetrician-Gynecologist have remained on the team. The District has advertised to replace other members but has had difficulty filling these posts.

16 School Health Teams have been developed with professional nurses leading school health teams. The teams are incomplete due to shortages of lower category nursing staff. One of the key problems with development of the school health programme is that while the National Department of Health procures various mobile clinics for the district, they do not provide the staff required nor can the NHI grant be used for staffing the mobiles.

The District aims to have 138 Ward Based Primary Health Care Outreach Teams. Currently 48 have been established and 46 are functional. The District aims to have a further 38 functional WBPHCOT by the end of the financial year.

The National Department of Health has appointed the FPD Consortium to recruit and place contracted GPs in clinics and community health centres. Direct contracting through the district office is also continuing to increase coverage. In total 29 doctors have been contracted for the district and they are serving 43 facilities. Some other facilities are served by sessional doctors. There is currently a hold on contracting new or additional doctors by the National Department of Health, until further notice. This is due to budgetary constraints.

Central Chronic Medicines Dispensing and Distribution – 40 468 patients on ART and other chronic medications have been registered. The target is the registration of 56 000 patients. 16 external pick up points have been enrolled, of which 13 are functional. 1 262 patients are using these external pick up points at present. The Department identifies the reticence of health facility staff to register patients as a challenge, together with the fact that pick up points are enrolled by the National Department of Health, following a lengthy process.

The electronic Health Patient Registration System was installed in all facilities by November 2015 and Gert Sibande is one of two districts in the country that has implemented electronic registration.

12 facilities have obtained Ideal Clinic Status. The District aims to ensure that all clinics reach ideal clinic status by March 2017.

An additional 22 GP consulting rooms are being built and five new facilities are being built by the National Department of Health.

The District is working hard to improve access to health care services. There is a need for more and better communication between the Department and civil society to ensure that people who live in Gert Sibande know what the Department is doing and can own it.
Many drains at iSwepe Clinic are blocked and overflowing (above). Patient records room at Winifred Maboa Clinic prior to the recent introduction of a new filing system (below).
Over a period of two years, Sfiso Nkala, SECTION27 community mobiliser in Gert Sibande, has monitored the implementation of NHI in the district, conducted community health rights and NHI awareness sessions, communicated with facility, district and provincial management, organised sit ins and other forms of protest, and supported the provincial health department in implementing health system reforms.

His monitoring work involves interviewing the Operational Manager of a facility, if possible, to establish the challenges she faces each day. He speaks to health care service users at the facility. He inspects infrastructure to check if the facility has adequate space for medicine storage and a waiting area, consultation rooms and patient toilets. He establishes whether clinic committees exist in a facility, whether they are active and know their responsibilities. He assesses whether the facility complies with the core standards of infection control, security, availability of medicines, waiting time, cleanliness and staff attitudes. If stock outs are experienced, he tries to establish what factors lead to the stock outs. If a doctor has been contracted, he establishes when the doctor attends the facility and tries to speak to the doctor.

The purpose of Sfiso’s monitoring is to find ways to support the clinics to ensure the success of NHI implementation; to check if the NHI grant is being effectively utilised; to ensure informed advocacy for improved health services; to capacitate and support clinic committees and to ensure participation in NHI implementation from all stakeholders.

Ubuhle Bempilo scored the following results in a district survey conducted in the last quarter of 2015 to measure compliance with standards in the following areas:

1. Infection control: 96.6%
2. Security: 91.5%
3. Availability of Medication: 93.4%
4. Waiting times: 55%
5. Cleanliness: 91.3%
6. Staff attitude: 90.6%

Infrastructure and staffing is important but equally important is health care service users who are actively involved in the governance of the facility. Ubuhle Bempilo has a highly functional clinic committee. The clinic committee is made up of community members and clinic staff members. It is in this forum that community members can raise any questions or concerns that they have about the CHC. The clinic committee at Ubuhle Bempilo meets quarterly and hosts emergency meetings if needs be. Once a week a member of the committee checks on the complaints box and takes up the queries with the staff.

The clinic committee is actively working with the facility on decreasing waiting times – an ongoing challenge at the clinic where patients wait on average an hour and a half to see a member of staff.

The clinic committee also started a vegetable garden at the clinic. They are involved in various community drives, including collecting clothes. Towards the end of last year the CHC hosted an open day to inform the community about the services available at the CHC, the committee was heavily involved in this, making various presentations to the community.

Ubuhle Bempilo is a good example of the power of an active clinic committee and complaints management process in the functioning of a health facility.
Proper doors for the pit toilet at Driefontein Clinic, but no basin to wash hands (above). Patients waiting outside MN Cindi Clinic (below).
In April 2015, activists from SECTION27 and the Treatment Action Campaign (TAC) visited Fernie-2 Clinic, Mthonjeni Clinic and the Driefontein Community Health Centre. The initial purpose of the visits were to gather information pertaining to stock outs but the visits also uncovered a number of common problems. One such problem was understaffing, which leads to the few available nurses working extremely long shifts. Basic infrastructure was also a major concern where facilities lacked running water, or only had cold water. Many facilities did not have any back-up system in case of load shedding. This left important and life-saving electronic equipment unable to function, putting the lives of patients at risk. Inadequate security, defective equipment, a lack of ambulances and stock outs of medication completed the picture of health facilities in distress.

The activists realised that they had to take action. SECTION27 and TAC members within the district engaged both the district and provincial leaders in health, including the Head of Department, in an attempt to bring the department’s attention to the problems faced by the clinics. Despite their persistent efforts to engage the provincial department of health, the department remained unresponsive.

In light of this, SECTION27 and TAC mobilized its membership on the ground to organise sit-ins at the HOD’s offices and at the affected clinics. These demonstrations were organized as a means to put pressure on the department to spur them into action.

It was the large turnout from the advocacy groups and ordinary citizens that provided enough pressure to convince the Head of Department to attend a meeting with activists on 29 April 2015.

The meeting discussed a turn-around strategy for improving the clinics in the district. The strategy focussed on the levels of staffing, availability of clean water, and general infrastructural improvement of clinics in the district. It was agreed that SECTION27, TAC and the local councillor would monitor implementation of the turn-around strategy. It was further agreed that there would be a report on progress and challenges facing NHI in the district.

In line with the demanded for a turn-around strategy, the Department started improving some of the clinics within the district. Perhaps one of the most important improvements can be seen at Fernie-2 Clinic. Following the intervention, there is access to clean water at the facility, provided through the installation of water tanks. Patients no longer have to use pit toilets as they now have access to flushing toilets. The clinic has a doctor that arrives every Tuesday to see patients, providing important care and also decreasing patient waiting times considerably. Most of the medication needed for patients is available due to a better system every two weeks. A food garden has been established at the clinic. The clinic committee received training and supervised renovations at the clinic.

While Fernie-2 Clinic is not perfect, the situation at the facility has improved immeasurably. Advocacy and mobilisation is increasingly vital for improving a health system that remains unable to provide the most basic needs to its citizens. Putting the power back in the hands of the people allows them to take back their health care system and ensure that their needs are fulfilled. The story of Fernie-2 Clinic shows how people joining together and speaking in unison has a powerful ability to bring about change.

In August 2015, three years after piloting in Gert Sibande began, Diepdale Clinic was in shambles. The four roomed facility that saw an average of 1800 patients per month was working without a doctor, with no access to water, and with no administrative resources. The clinic was also faced with staff shortages.

Nearly a year later, under the NHI programme, the clinic has had renovations that have seen the number of consultation rooms doubled. The clinic received an additional four roomed park home, including a kitchen, waiting area and a disability friendly toilet. The clinic received internet access and new computers. Although the infrastructure had been upgraded, human resources and staff shortages were still a huge concern at the clinic. The clinic that sees about 65 patients a day only has three nurses, one of whom only does house visits. The two remaining sisters alternate their shifts. The clinic still does not have a doctor and therefore refers its serious cases to another local clinic. They do however have monthly visits from a dentist, optometrist and physiotherapist.

While the focus in NHI piloting has been infrastructural, without attention being paid to human resources needs, clinics such as Diepdale remain in a state of distress.
A snapshot of clinics

<table>
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<th>FACILITY</th>
<th>Nurses (incl PN, EN, NA)</th>
<th>Additional staff members</th>
<th>Doctor and how often/how many hours</th>
<th>Dentist</th>
<th>Patient intake</th>
<th>Consulting rooms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vukuzakhe Clinic</td>
<td>11</td>
<td>1 health promoter, 1 Groundsman, 2 General assistant, 1 Data capturer, 2 Lay counsellors</td>
<td>1 doctor, Once a week, 2 hrs.</td>
<td>No dentist</td>
<td>2900PM</td>
<td>3</td>
</tr>
<tr>
<td>Driefontein Clinic</td>
<td>16</td>
<td>11</td>
<td>1 doctor, Once a week, 6 hrs.</td>
<td>1, Once a week, 4 hrs</td>
<td>3000PM</td>
<td>4</td>
</tr>
<tr>
<td>Winnie Maboa Clinic</td>
<td>14</td>
<td>4 Nursing assistants, 3 Admin Clerks, 6 Cleaners, 1 Driver, 1 Health promoter</td>
<td>1 doctor, 5 days a week, 8 hrs.</td>
<td>No dentist</td>
<td>3800-4500PM</td>
<td>5</td>
</tr>
<tr>
<td>Iswepe Clinic</td>
<td>10</td>
<td>20</td>
<td>1 doctor, 5 days a week, 8 hrs.</td>
<td>1, Once a month only for those with appointments</td>
<td>2500PM</td>
<td>4</td>
</tr>
<tr>
<td>Sead Clinic</td>
<td>10</td>
<td>4 Enrolled nurses, 2 Assistant Nurses, 1 Data capturer, 1 Clerk, 2 Groundsmen, 7 General assistants, 2 Lay counsellors</td>
<td>1 doctor, 5 days a week, 4 hrs.</td>
<td>No dentist</td>
<td>2500PM</td>
<td></td>
</tr>
<tr>
<td>MN Cindi</td>
<td>17</td>
<td>10</td>
<td>1 doctor, 5 days a week, 8 hrs, (Clinical associate)</td>
<td>Dentist Monday to Thursday for two hours</td>
<td>2700PM</td>
<td>8</td>
</tr>
<tr>
<td>Phola Park</td>
<td>9</td>
<td>5</td>
<td>1 doctor, 5 days a week, 8 hrs.</td>
<td>1</td>
<td>2800PM</td>
<td>7</td>
</tr>
<tr>
<td>Waiting rooms and capacity thereof</td>
<td>Storeroom</td>
<td>Toilets for patients</td>
<td>Equipment</td>
<td>Clinic Committee</td>
<td>Back up Generator (functional)</td>
<td>Major Changes to facilities.</td>
</tr>
<tr>
<td>-----------------------------------</td>
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<tr>
<td>1 area, 24 patients</td>
<td>1 medicine room</td>
<td>3</td>
<td>Short of AED machines</td>
<td>Exists, but do not attend monthly meetings</td>
<td>No</td>
<td>Provided with an additional 6 park homes</td>
</tr>
<tr>
<td>1 area</td>
<td>3 storerooms</td>
<td>8</td>
<td>Two water tanks are broken</td>
<td>Not Functional</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>2 areas, 75 patients in total</td>
<td>7</td>
<td>Not enough vital equipment in consultation rooms</td>
<td>Not functional</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 areas, 78 patients in total</td>
<td>1 small storeroom, Dry, Bulk and open stock</td>
<td>6</td>
<td>Fully equipped</td>
<td>No clinic committee</td>
<td>No generator or water tank</td>
<td></td>
</tr>
<tr>
<td>Open area, 50 patients</td>
<td>Bulk storeroom and dry storeroom</td>
<td>2</td>
<td>Fully equipped</td>
<td>Clinic committee term expired</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Small area, 30 patients</td>
<td>1 dry storeroom and 1 open storeroom</td>
<td>Flushing toilets for patients and staff</td>
<td>Fully equipped</td>
<td>Clinic committee term expired</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>1 area, 50 patients</td>
<td>1 dry storeroom and 1 open storeroom</td>
<td>Flushing toilets for males and females</td>
<td>Shortage of BP machines</td>
<td>Clinic committee term expired</td>
<td>Yes</td>
<td>Facility was rebuilt after it was torched during protest in 2009</td>
</tr>
<tr>
<td>FACILITY</td>
<td>Nurses (incl PN, EN, NA)</td>
<td>Additional staff members (Data capturers/ general assistant/ lay counsellors/ admin Clerks/ Groundsmen/ health promoters)</td>
<td>Doctor and how often/how many hours</td>
<td>Dentist</td>
<td>Patient intake</td>
<td>Consulting rooms</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------</td>
<td>-------------------------------------------------------------------</td>
<td>------------------------------------</td>
<td>---------</td>
<td>----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Kwazanle Clinic</td>
<td>9</td>
<td>4 (No admin clerk, no groundsmen)</td>
<td>Contract expired 19 August but was coming 5 days a week for half a day</td>
<td>No dentist</td>
<td>1800PM</td>
<td>3</td>
</tr>
<tr>
<td>Mthonjeni Clinic</td>
<td>9</td>
<td>6</td>
<td>1 doctor daily, 8 hrs</td>
<td>No dentist</td>
<td>4000</td>
<td>5</td>
</tr>
<tr>
<td>Volksrust Clinic</td>
<td>17</td>
<td>6</td>
<td>1 doctor 2 days a week, 2 hrs</td>
<td>1 dentist, daily</td>
<td>2500PM</td>
<td>7 (+6 in a park home – not yet functional)</td>
</tr>
<tr>
<td>Mzinoni Clinic</td>
<td>6</td>
<td>8</td>
<td>1 doctor 5 days a week, 5 hrs</td>
<td>No dentist</td>
<td>2300PM</td>
<td>4</td>
</tr>
<tr>
<td>Ubuhe Bempilo</td>
<td>15</td>
<td>17</td>
<td>1 doctor 2 days a week, 5.5 hrs</td>
<td>1 Once a week</td>
<td>200 Per day</td>
<td>8</td>
</tr>
<tr>
<td>Fernie-2</td>
<td>8</td>
<td>9</td>
<td>1 doctor once a week, hrs</td>
<td>1 Once a week</td>
<td>2600PM</td>
<td>2</td>
</tr>
<tr>
<td>Diepdale</td>
<td>9</td>
<td>7</td>
<td>No doctor</td>
<td>No dentist</td>
<td>1900PM</td>
<td>7</td>
</tr>
<tr>
<td>Waiting rooms and capacity thereof</td>
<td>Storeroom</td>
<td>Toilets for patients</td>
<td>Equipment</td>
<td>Clinic Committee</td>
<td>Back up Generator (functional)</td>
<td>Major Changes to facilities</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-----------</td>
<td>----------------------</td>
<td>-----------</td>
<td>------------------</td>
<td>-------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>1 area, 50 patients</td>
<td>1</td>
<td>1</td>
<td>No HB measure, had one baby scale but lent it (clinic needs 2)</td>
<td>Dysfunctional</td>
<td>No generator or water tank</td>
<td></td>
</tr>
<tr>
<td>1 area takes 30 patients and others wait in the corridor</td>
<td>1</td>
<td>2</td>
<td>No HB meter</td>
<td>Functional, holds regular meetings</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>1 area, 50 patients</td>
<td>1 storeroom and 1 bulk open storeroom</td>
<td>2</td>
<td>Adequate</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>1 open area, 50 patients</td>
<td>1 storeroom</td>
<td>2 patients, 1 disabled</td>
<td>Not enough, no AED</td>
<td>Term of office expired but it was functional</td>
<td>Yes, but not functional</td>
<td></td>
</tr>
<tr>
<td>1 open area, 100 patients</td>
<td>2 storerooms</td>
<td>60 % of toilets not fully functional. 1 toilet for disable, 2 male toilets, 5 female toilets, 4 staff toilets, 4 toilets in 4 consulting rooms, 1 pharmacy toilet, 3 maternity toilets and 1 for security guard. 1 toilet per room in the nurses home.</td>
<td>Fully equipped</td>
<td>Expired term of office, it used to be fully functional</td>
<td>Yes</td>
<td>The clinic facility was rebuilt by Extrata mine as a CSI project.</td>
</tr>
<tr>
<td>1 room, 50 patients</td>
<td>1 storeroom</td>
<td>2</td>
<td>Fully equipped</td>
<td>Functional. Meetings held</td>
<td>No</td>
<td>Community protest and a sit in held in 2014, saw the improvement of services at the clinic</td>
</tr>
<tr>
<td>1 room</td>
<td>2 storerooms</td>
<td>2</td>
<td>Fully equipped</td>
<td>Expired term of office</td>
<td>No</td>
<td>In August 2015, an additional 4 park homes were made available to the clinic</td>
</tr>
</tbody>
</table>
LESSONS FROM GERT SIBANDE

The purpose of piloting is to test innovations and learn lessons for full implementation. While the piloting programme in Gert Sibande has been imperfect, three important lessons emerge:

+ an active clinic committee is vital for a well-functioning health facility
+ community activism is extremely powerful in improving conditions at health facilities
+ infrastructure is important but equally important is human resources

These are lessons both for those implementing NHI and for activists working on health rights and access in the country.

CIVIL SOCIETY AT WORK

Civil society is hard at work in Gert Sibande. In April and May 2016, local and district meetings were held by SECTION27 and the Treatment Action Campaign across the province and a Provincial Health Assembly was held on 20 May 2016 and attended by 180 people including community members, activists and district and provincial health officials. The attendees identified human resources, emergency medical services, access to health care services for key populations including the elderly, people living with disabilities and LGBTIQ communities and access to mobile clinics and facilities as priority issues. A coalition of civil society stakeholders, formed as a result of the local, district and provincial health assemblies is scheduled to meet with the provincial department of health to discuss the areas of need for health system reform, NHI implementation and stakeholder participation.

A significant shortcoming of the Gert Sibande piloting programme has been the inadequacy of consultation and stakeholder engagement. There has been one Department of Health consultation per municipality in the piloting period and most health care service users, civil society organisations, unions and other interested groups remain unaware of progress or shortcomings. Civil society has worked hard to ameliorate this shortcoming and better communication will be a key demand in future engagement with the department.
WHERE TO FROM HERE FOR NHI

WHAT IS NEEDED TO MAKE NHI WORK

It is not our argument that the health system should reach a state of perfection before NHI is implemented. This is, of course, impossible. However, we are very far from a functioning health care system and the White Paper, the most recent NHI policy document, lacks specificity on how the serious defects in the system will be overcome. It is imperative that planning is adequately developed to ensure a smooth re-arrangement of the national health system and to create a strong platform for moving towards an integrated health system that promotes financial risk protection and offers universal coverage.

Our experience in health system advocacy in Gert Sibande and elsewhere includes human rights education and working with community based organisations in strengthening health care services and health establishments. This experience suggests that there are some areas or issues that deserve and require greater focus within the health system strengthening initiatives led by the Department to provide a strong platform for NHI. We deal with each below.

1. Community Health Care Workers

There has, since the 1997 White Paper on the Transformation of the Health Care System, been recognition of the importance of Community Health Care Workers (CHWs) to a health system based on prevention and primary health care. The White Paper makes mention of CHWs once - as components of Ward Based Primary Health Care Outreach Teams (WBPHCOT) - but provides no further information. The Municipal WBPHCOT Policy Framework and Strategy has been in draft form since 2012. The “Investment Case for Ward-Based Primary Health Care Outreach Teams” was, we understand, recently presented to Treasury.

In the meantime, the treatment and status of CHWs in different provinces differs markedly. CHWs are not recognised by the formal public health sector, their qualifications are not standardised, and they are largely employed by NGOs.

In Free State, CHWs were dismissed and on 10 July 2014 over 100 CHWs were arrested for protesting their dismissal. In Gauteng, the provincial department is attempting to shift the employment of CHWs to a payroll management company. While this in itself is a very problematic approach, in addition no provision has been made for the transitional period and as a result patients who had been receiving home based care are suffering considerably. CHWs are vital to the reliable provision of health promotion and prevention services and basic health care services. They will also be vital for implementation of the new HIV “test and treat” policy, announced in the Minister’s budget speech on 10 May 2016. Research to be published shortly by Medics Sans Frontiers suggests that the withdrawal of lay counsellors in umlazi Municipality substantially decreased clinic based HIV testing. If these findings are representative of the experience province-wide (and potential experience nationwide), they illustrate how lay counsellor withdrawal may jeopardise efforts to deliver the 90-90-90 strategy.

Given the role of CHWs in realising the vision of National Health Insurance, the continued uncertainty at national and provincial level and in the White Paper can no longer be accepted. We therefore request the urgent conclusion of the policy development and implementation process.
2. Governance: Clinic Committees and Hospital Boards

Clinic committees and hospital boards are a fundamental component of the South African health system and are intended to be part of the planning, prioritisation and management of health services. They are purpose to partner with health facility staff to strategically guide the operation of the clinic to make it more responsive to the needs of the local community. The National Health Act 61 of 2003 makes specific reference to clinic committees and hospital boards and requires provincial legislation to give content to these bodies. The White Paper envisages an enhanced role for clinic committees to represent community views and perform a health promotion role.

The existence of these community governance structures and particularly their optimal functioning ensures the effective governance and the accountability of the health services to communities. The case of Ubuhle Bempi is a case in point.

Although there are multiple policy documents that entrench these community governance structures in the health system, there is evidence that the implementation of health committees has been uneven at best. In 2003, only 59% of clinics and community health centres had clinic committees and not only had this figure remained static since 2000, it transpired that only 35% of these had met in the recent past. Further to this, in 2008, the National Department of Health found that only 57% of clinics reported having clinic committees. The province that reported the highest number of clinic committees was the Eastern Cape with 73% of facilities reporting having clinic committees and the province with the lowest was Mpumalanga with 31% of facilities report having clinic committees.1

We have found that in some health facilities, clinic committees function very well by providing an important link between the facility and the users of that facility. Unfortunately, because there is no national standard for the structures’ role and function, election or appointment of members, training or empowerment, their impact is patchy. In some health facilities the governance structure is very politicised and members are appointed by ward councillors. In others, members are appointed by Operational Managers and are accountable to them. Few clinic committees have been trained on their roles and the tools available to ensure that they are able to fulfil those roles.

This is how we think the system can be fixed:

1. In order to ensure the optimal functioning of clinic committees and their uniform existence, there should be an urgent development of the national guidelines on clinic committees to harmonise legislation and practice across provinces (albeit most provinces do not have legislation on clinic committees). The guidelines could echo the principles from the Policy on the Management of Public Hospitals (GN 186 GG 35101 of 2 March 2012). The guidelines should clarify a range of procedural issues such as the means of constituting and operating governance structures, nomination procedures, terms of office, roles and responsibilities, communication channels, codes of conduct and how governance structures’ functionality is maintained. The South African Schools Act 84 of 1996 is instructive in that it is specific in describing both the responsibilities of School Governing Bodies (SGBs) and the obligations on provincial departments to oversee the operations of SGBs, develop codes of conduct and processes for election, provide training etc. A similar approach should be taken to health committees.

2. If these governance structures are to fulfill their envisaged role it is critical that a detailed training programme is developed and conducted for clinic committee members. The training must ensure that members of clinic committees will be knowledgeable about issues relating to the right of access to health care services, governance of health care facilities, understanding community needs, conflict resolution and dispute management. Funding should be provided for the training of clinic committees.

3. Issues related to local government must be addressed. One such issue is linking meaningfully local government and health services. Ward councillors particularly must be trained regarding their role in clinic committees. It must be ensured that a key performance area for a ward councillor is compliance with the requirement to participate in a clinic committee.

4. Clinic committees and hospital boards cannot be expected to operate without funds. While it may be appropriate that, like SGB members, clinic committee members are not remunerated, it is impossible for them to play a governance, oversight and health promotion role without funding. It is also impossible for them to be adequately equipped to play this role without being trained - an exercise that also requires funding.

3. Emergency Medical Services

The White Paper notes the need to use both public and private ambulances and emergency centres to provide emergency medical treatment to anyone who needs it. It is specific in stating that all ambulances will be of the same colour and will be accessible through the same telephone number. We support this approach.

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We are also aware of the National Department Health’s focus on Emergency Medical Services (EMS) as an area for regulatory reform and its efforts to make the required changes to the regulatory framework.

Our concern centres on the unavailability of quality and appropriate EMS in the public or private sectors in many parts of the country especially in rural areas with often very difficult terrain. This is the case in Gert Sibande and is also the case in the Eastern Cape where an October 2015 report from the South African Human Rights Commission records how, in some parts of the Eastern Cape, people had never before seen an ambulance in their village. When they required emergency medical treatment they would have to forego that treatment, or to pay huge sums of money for private cars to transport them to health facilities. In many parts of the province, ambulances, while available, were notoriously unreliable, taking up to several days but usually 6 – 8 hours to arrive at a scene often with only one staff member on board (who would need to drive the vehicle rather than provide care) and with limited equipment or medication. These ambulances were little more than inefficient taxis.

The poor state of the EMS system in the Eastern Cape and elsewhere is important in the context of the development of NHI policy. There are very few private providers of EMS in the rural areas and so the incorporation of public and private providers into the system would not resolve the problem.

What is required urgently is the provision of more, and more appropriate, EMS vehicles; the employment of qualified skilled personnel; the development of monitoring and tracking systems; the employment of more personnel and the publicising of complaints mechanisms. This, we argue, requires that in settings that are rural, there needs to be a greater and different allocation of resources (financial and otherwise).

The specific need to improve the public sector EMS system given the unavailability of private services in some areas is not dealt with in the White Paper. The improvement of the EMS system would go a long way to ensure universal access to health care services in an emergency if the above issues were considered.

4. Consultation and communication

While there has been some progress in Gert Sibande, much of it is unknown to civil society and the users of the health care system. This is largely because there has been insufficient consultation on the implementation of health system reforms and the institutional structures that allow for consultation and discussion about health systems issues are not in place. There is, for example, no District Health Consultative Forum in Gert Sibande. The establishment of such a forum is an important first step to better communication between the District and civil society. The recent establishment of the civil society coalition also has the potential to improve communication.

5. Human Resources for Health and retention

There is mention in the White Paper of the importance of human resources to the success of NHI. The 2012 National Human Resources for Health Strategy is alluded to as the roadmap for the planning, development, provisioning, distribution and management of human resources. Specific mention is made of the “rapid production” of specific categories of health professionals, the use of WISN (the Workload Indicator of Staffing Needs, the method used to indicate staffing needs of health facilities), the need to incentivise health workers to provide service in rural areas, and the need for retention strategies.

We have three primary concerns about the way in which the National Department of Health intends to deal with the issue of human resources.

1. The 2012 strategy is just that: a strategy giving broad direction and not a plan, the implementation of which has been considered. While we agree with much of the direction of the 2012 strategy, we are concerned that there appears to have been no further action towards the development of a comprehensive human resources plan and its implementation. The Minister has not developed regulations on human resources, as he is empowered to do by section 90 of the National Health Act 61 of 2003, which means that there is no consistency in human resources planning across provinces. The WISN tool has been in the process of implementation for many years. A number of provinces, including KwaZulu-Natal, the North West and the Eastern Cape, have in the past year frozen posts or instituted moratoria on the hiring and replacement of staff due to budgetary constraints. A plan and budget based on the 2012 strategy is urgently required.

2. The White Paper provides at page 42 that “improving the quality of life of health professionals working in..."
rural areas will require a multi-sectoral response to providing basic social infrastructure and amenities. This statement suggests, first, that retention is only a problem in rural areas. This is not the case. Second, it appears to relegate the problem of retention to one requiring action by other sectors, presumably including Departments of Roads, Education, Water and Sanitation etc. The difficulty here is that research and our own experience, has shown that there are many reasons why health care workers leave the public health system. Some would require multi-sectoral responses but many are directly health system related: poor management, under-staffing, medication stock-outs, the unavailability of equipment, non-payment of salaries or over time etc. These are some of the most common reasons health care workers leave public sector health facilities. They are also within the direct ambit of the health system and require attention if we are to improve retention.

3. No indication is given of the budget for an improved human resources base. The Constitutional Court has repeatedly held that for a plan for the realisation of rights to be considered reasonable, appropriate financial resources must be made available. In this case there is neither a plan nor a budget.

6. Accountability and political considerations

The legitimacy of NHI will depend heavily on accountability, transparency and cooperation. There is no indication in the White Paper that these issues have been appropriately considered.

There is a need for clarity on the responsibility and role of provinces and districts in the implementation of NHI. While this may be one of the more politically difficult issues to tackle, it is vital for those responsible for the implementation of the policy to know exactly what is expected of them in fulfilling their legal responsibilities and also for the South African public, currently caught in the middle of the structural problems between national, provincial and district authorities, to understand how NHI is going to improve the health system. Clarity will strengthen accountability and increase the chances of the successful rolling out of the NHI. It would also give credence to the principle of cooperative governance in the Constitution. SECTION27 has, over the years, provided advice to the Department on this issue.

At a facility level, there are significant challenges facing management, including the lack of skills in and support for those who occupy management positions in health care facilities. Consideration needs to be given to situations where managers lack the necessary skills or where there is a complete lack of management.

Finally, issue of corruption, which we see as having a crippling effect on the government’s capability in providing health care services, is not adequately addressed. More than merely stating that the NHI Commission will be an external oversight mechanism, the White Paper must give much more detail on how the NHI Fund and the NHI Commission will be insulated from corruption, abuse and mismanagement.

The NHI has great promise but as with everything, the devil is in the detail. Unfortunately, we do not yet know the detail. The piloting process in Gert Sibande has shown very limited success and provides important lessons for NHI as whole although the infrastructural, human resources and governance weaknesses in the district are far from resolved. More fundamentally though, NHI requires more than a few “tweaks” to the funding system for health. There are key health systems failures that demand urgent attention to provide a strong and stable base for NHI to ensure its success and the establishment of a fair and equitable health system in South Africa.
