SAPHC 2023

SOUTH AFRICAN PRIMARY HEALTH CARE CONFERENCE

TOWARDS UNIVERSAL HEALTH COVERAGE: STRENGTHENING PRIMARY HEALTH CARE – A WHOLE OF GOVERNMENT, WHOLE OF SOCIETY APPROACH

SOUTH AFRICAN PRIMARY HEALTH CARE CONFERENCE - REPORT

14 - 16 November 2023

Eastern Cape, East London

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

planning, monitoring and evaluation
Department:
Planning, Monitoring and Evaluation
REPUBLIC OF SOUTH AFRICA

World Health Organization

HEALTH SYSTEMS TRUST

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1. ABBREVIATIONS

AI	Artificial Intelligence
BMGF	Bill and Melinda Gates Foundation
BMI	Body Mass Index
CDC	Centers for Disease Control
CHW	Community Health Worker
COPC	Community-Orientated Primary Healthcare
COVID-19	Coronavirus disease 2019, the disease caused by the novel coronavirus (SARS-CoV-2)
CSI	Corporate Social Investment
CUP	Contracting Unit for Primary Healthcare
DALY	Disability Adjusted Life-Year
DHMO	District Health Management Office
DMOC	Differentiated Model of Care
EDCTP	European and Developing Country Clinical Trials Partnership
EU	European Union
GBV	Gender-Based Violence
GDP	Gross Domestic Product
HE	Health Establishment
HEI	Higher Education Institution
HPCSA	Health Professions Council of South Africa
HSRC	Human Sciences Research Council
iAHO	Integrated African Health Observatory
KT	Knowledge Translation
M&E	Monitoring and evaluation
MMR	Maternal Mortality Rate
MTA	Material Transfer Agreement
MTSF	Medium-Term Strategic Framework

NCCEMD	National Confidential Enquiry into Maternal Deaths
NCD	Non-communicable disease
NDoH	National Department of Health
NDP	National Development Plan
NHIRD	National Health Information Repository and Data Warehouse
NHISSA	National Health Information System of South Africa
NHI	National Health Insurance
NHLS	National Health Laboratory Service
NHO	National Health Observatory
NHRC	National Health Research Committee
NHRD	National Health Research Database
NIAID	National Institute of Allergy and Infectious Diseases
NICD	National Institute of Communicable Diseases
NIH	National Institutes of Health (USA)
NMC	Notifiable Medical Condition
NRF	National Research Foundation
NSP	National Strategic Plan
OHSC	Office of Health Standards Compliance
PHC	Primary Health Care
PHRC	Provincial Health Research Committee
POPIA	Protection of Personal Information Act, 2013
R&I	Research and Innovation
RSV	Respiratory Syncytial Virus
SA	South Africa
SACMS	South African COVID-19 Modelling Consortium
SADHS	South African Demographic and Health Survey
SAMRC	South African Medical Research Council
SDG	Sustainable Development Goal
SIDS	Sudden Infant Death Syndrome
SMU	Sefako Makgatho Health Sciences University

SU	Stellenbosch University
TB	Tuberculosis
UCT	University of Cape Town
UFS	University of the Free State
UHC	Universal Health Coverage
UK	United Kingdom
USA	United States of America
USAID	United States Agency for International Development
UWC	University of the Western Cape
VIP	Violence and Injury Prevention
VOC	Variant of Concern
VOI	Variant of Interest
WHO	World Health Organization
WOGA	Whole of Government Approach
WOSA	Whole of Society Approach

2. KEY MESSAGES

Foreword by the Minister of Health Dr MJ Phaahla

The month of September 2023 marked 45 years since the historic Alma Ata Conference on Primary Health Care (PHC) in Kazakhstan, and October 2023, marked five years since the International PHC Conference in Astana. Worldwide, nations have committed to the attainment of Universal Health Coverage and enshrined this in the United Nations' Sustainable Development Goals (SDGs) to be achieved by 2030. South Africa is a signatory to the SDGs.

To give effect to the realisation of the SDGs, the National Development Plan (NDP) 2030 of South Africa re-affirmed the country's commitment to strengthening the PHC approach at the community level. There is no better time than now for South Africa, Africa, and the world to implement Universal Health Coverage to strengthen health systems.

It is therefore necessary and fitting that during this year, we reflect on and review South Africa's journey towards the ideals of PHC over our 30 years of democracy.

Inequity remains the biggest challenge to the health system, and it is threatening the sustainability of healthcare for everyone in the country. Expenditure on health in the private sector remains unabated while the public sector allocations are reduced, thus widening the inequity. Over the coming years, a series of reforms will be implemented to achieve an integrated national healthcare delivery system that makes all resources available to everyone. This but includes but not limited to the implementation of National Health Insurance (NHI).

A key focus of the 1978 Alma Ata Declaration on PHC was inequity. The Alma Ata Conference strongly reaffirmed that health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. This is a fundamental human right and the attainment of the highest possible level of health is a most important worldwide social goal.

In line with this statement in the Alma Ata Declaration, the Government of South Africa, together with stakeholders and partners strives to facilitate, for all South Africans a socially and economically productive life. We believe that PHC is key to attaining this target.

The South African District Health System (DHS), has set up services spanning from community level to PHC Services in mobile clinics, clinics and Community Health Centres (CHCs) and to higher levels of hospital care. Community-based services

include Community Health Workers Programme (CHWs), the Integrated School Health Programme (ISHP), Environmental Health Services (EHS) and the Central Chronic Medicine Dispensing and Distribution (CCMDD) Programme.

The clinical services will only be as good as the support they receive from administrative, financial, supply chain, and information and communication services. It is for this reason that we must have an appropriate balance between clinical and support resources - both financial and human resources.

I am aware that security services at PHC and other facilities have become a costly challenge. When our facilities are not properly guarded and secured it becomes stressful for health workers to perform their duties. This problem must be addressed in a multi-faceted manner by the Director General, Provincial Heads of Health and senior managers in the DHS. Multifaceted, because amongst other interventions, communities must be mobilised to assist the government in securing health facilities.

In the first 15 years of our democracy, we have significantly grown the number of people who use PHC services such that in 2013, we recorded a 120 million visits to this level. The facilities were under extreme pressure because of increased number of attendances by our communities and therefore the need for the CCMDD programme was recognised. As the CCMDD became known, it grew in popularity such that its number increased from 26 thousand people in 2014 to 5.6 million people in the last financial year.

This programme has brought some relief to Primary Health Care facility staff and to community members for whom waiting time queues have been shortened. Community health workers in South Africa contribute positively to the success of the CCMDD programme. We continue to improve the quality in PHC facilities through the Ideal Clinic Programme which has seen the number of facilities, meeting standards, grow from **10 pilot sites** in 2014 to 2046 (59%) in 2022.

We see South Africans as whole, multi-faceted human beings and we aim to provide holistic care that will cater for all, an individual and family's health needs without the inconvenience of multiple clinic visits which put further strain on their finances. For this reason, as part of the integrated clinical services model of the ideal clinic framework, we, in 2014, implemented the Adult Primary Care Model which guides health care professionals on how to manage different illnesses, including comorbidities.

While annually, millions of South Africans leave our health facilities after being satisfactorily attended to, there are however still unfortunate events taking place that leaves much to be desired. I cannot speak to an audience in the Eastern Cape Province without thinking about the young woman who lost her life after she sought care from one of our Primary Health Care facilities, after a sexual assault. This is despite the presence of a good tool such as the Adult Primary Care Model which clearly explains how someone who has been sexually assaulted need to be managed. This incident, and others in our other provinces points to the fact that more attention needs to be paid to training, supervision, and progressive discipline.

Another area that needs strengthening in our PHC services, is the Environmental Health Programme. This programme is central to the safety of South Africans from all forms of possible environmental harm and if we are to continue our good track record when it comes to the prevention, early detection and management of waterborne and foodborne illnesses, and as well as harm that could come from air pollution, we need to increase the number of environmental health officers that are appointed by municipalities.

Improvements in the health of South Africans also depend on multisectoral interventions, and in this regard, we need to work even more closely with departments of agriculture, education, housing, social development, water and sanitation, the private sector especially the food and beverage industry, NGOs, academic and research institutions, civil society and our communities. This collaboration with key stakeholders is the only way to succeed in addressing social determinants of health and without addressing the social determinants of health, we will not achieve the desired health outcomes.

To put the resources that we have to the best possible use, I cannot over-emphasise the importance of health promotion and disease prevention. This will spare healthy South Africans and the country's fiscus from high level cost health interventions. In the past 10 years and to date we are growing the proportion of funding for the DHS, which is the commitment that we have made and continue to focus on health promotion and early intervention at PHC level.

In line with the 2018 Astana Declaration on PHC, South Africa will:

- Increase capacity-building of all health cadres.

- Support research and share knowledge and experience while Provinces learn from each other best practices as well as take onboard good practices from other countries.

In doing this we will improve health outcomes by ensuring access for all people to the right care at the right time. I remind you that this aim, the aim of UHC, also requires the right funding mechanism for health services, and therefore the importance of the implementation of the NHI.

The Astana Declaration encourages countries to periodically review the implementation of this Declaration, in cooperation with stakeholders. This is the purpose of this conference. We are using this conference to hear what stakeholders are saying about South Africa's PHC services. We are eager to hear from you what in your opinion is working well and what are weaknesses. Your input will culminate in a conference report that will guide our planning and implementation of PHC services within South Africa's DHS, going forward.

Together we can and will achieve health and well-being for all, leaving no one behind.

Dr MJ Phaahla.

Minister of Health, MP

Acknowledgements by the Director General of Health, Dr Sandile Buthelezi

I wish to give special thanks to the Honourable Minister of Health Dr. Joe Phaahla and to the Honourable-Deputy Minister Dr. Sibongiseni Dhlomo for their attendance and contribution to SAPHC 2023. Dr. Matshediso Moeti, WHO Regional Director, Dr. Owen Kaluwa, WHO Country Representative and Dr. Themba Moeti, HST CEO, and Dr. Thulani Masilela, Outcomes Facilitator – DPME for their presence and contributions.

I also wish to extend special thanks to Honourable Members of Executive Council for Health who attended the SAPHC 2023 conference, namely Ms. Nomakhosazana Meth (Eastern Cape Health), Dr Mbombo (Western Cape Health and Wellness), Ms Nkomo -Ralehoko (Gauteng Health and Wellness) and Mr. Sambatha (North-West Health).

A word of gratitude is also due to the Heads of Provincial Departments of Health and their staff as well as managers and staff from the National Department of Health who played key roles in the success of the conference. I would like to also thank all our distinguished speakers and partners, without whom this conference would not have been a success. We believe that Health is a right, and we must all ensure that services are universally available, accessible, affordable, acceptable and of quality, and that they are provided without discrimination.

Message by Ms. Jeanette Hunter: Deputy-Director General Primary Health Care

There is no one-size-fits-all model for UHC and South Africa is already far along the path to UHC. Much still needs to be done and while the country is in the process of implementing the NHI to provide a better funding model for health services, we in health service provision need to focus on further strengthening our PHC services through collaboration with all required stakeholders, including with private sector service providers. This very important goal of collaboration is what SAPHC 2023 aimed to be a catalyst for and indeed succeeded to start this very important conversation that should progress to more concrete collaborative action. I sincerely thank the Director-General of Health, Dr. Sandile Buthelezi for his invaluable support for our work in this regard. Dr Buthelezi's attendance and contribution at the conference elevated the standard of this important conference.

3. OVERVIEW

This overview sets out the goals and objectives of the national PHC Conference that was held in South Africa during 14 to 17 November 2023.

The month of September 2023 marked 45 years since the historic Alma Ata Conference on PHC in Kazakhstan, and in October 2023, we marked five years since the international PHC Conference in Astana. It is therefore necessary and fitting that during this year, we reflect on and review South Africa's journey towards the ideals of PHC over our 30 years of democracy. Delegates at the conference were tasked with the responsibility of taking stock for what worked over the past years, reasons for success, and how to use what has worked to build for the future.

Secondly, a need exists to continuously improve the quality and enhance the profile of PHC services in the country, not only in anticipation of the forthcoming NHI dispensation, but also as a routine responsibility to provide accessible, affordable and acceptable services to all communities.

Thirdly, following the onset of the COVID-19 pandemic in 2020, there was a decrease in access to PHC services, partly due to the national lockdown which restricted social and economic activity as part of public health containment measures. To minimise the risk of infection, users of health services were encouraged to contact health services only in cases of absolute necessity. Access to PHC services subsequently increased in 2021 and 2022, but not to pre-COVID-19 levels. In the aftermath of the COVID-19 pandemic, wherein countries are developing pandemic prevention, preparedness and response measures, and advancing their progress towards UHC, it is imperative to emphasise the importance of the PHC approach.

Against this background, the national government of South Africa, represented by the National Department of Health (NDoH) and the Department of Planning, Monitoring and Evaluation (DPME), in **collaboration with the World Health Organization (WHO) and the Health Systems Trust (HST)** convened a national PHC conference from 14 to 17 November 2023.

3.1 GOALS

(a) To reinvigorate South Africa's commitment to the PHC approach as a strategic component of comprehensive health services in a unified health system, within an NHI dispensation.

(b) To recommit the country (i.e. government, citizens and social partners) to the PHC principles as being central to health promotion, disease prevention, and

building a people-centred and resilient health system that can adapt and respond to emerging health challenges in a rapidly changing world.[6]

3.2 SPECIFIC OBJECTIVES

The objectives of the national PHC Conference were as follows:

(a) To take stock of the implementation of the PHC approach by the democratic government from 1994 to 2023.

(b) To identify gaps in implementation and context specific areas of good practice, and share lessons learnt.

(c) To draw lessons from international experiences (such as Thailand, Vietnam, Cuba, Mauritius etc.) in the implementation of the PHC approach and delivery of PHC services, particularly from countries in the global South with socio-economic conditions that are comparable with South Africa's.

(d) To accentuate the relevance and importance of PHC in South Africa's pursuit of UHC through NHI.

(e) To prepare for the imminent implementation of District Health Management Offices. (DHMOs) and Contracting Units for Primary Healthcare Services (CUPS) in keeping with the NHI dispensation.

(f) To envision a comprehensive and unified PHC-based health system in South Africa, integrating the public and private sectors with sufficient focus on the social determinants of health.

(g) To position PHC services as the backbone for pandemic prevention, preparedness and response, drawing lessons from the COVID-19 pandemic and the cholera outbreak in 2023.

3.3 PARTICIPANTS

A total of 450 delegates participated in the November 2023 National PHC Conference. The delegates were drawn from government, non-governmental and community-based organisations (NGOs; CBOs); civil society; academia and research institutions; the private sector; organised labour; and the complementary/alternative healing sector, among others.

3.4 ORGANISATION OF WORK AND CONFERENCE PROGRAMME DEVELOPMENT

The National PHC Conference comprised plenary and breakaway sessions. The opening and closing were plenary fora, with the bulk of the conference programme which consisted of breakaway commissions and report-back sessions.

The conference attracted international speakers from countries that have successfully implemented the PHC approach and thereby improved their key health outcomes.

In addition, the conference provided an opportunity for Provincial, District and Sub-district Departments of Health in South Africa to showcase their successes in improving population health using the PHC approach. Programme space was also provided for presentations and inputs from organisations in other sectors on innovative approaches that can add value to health interventions through collaboration in the context of a whole-of-society approach.

3.5 THEME OF THE NATIONAL PHC CONFERENCE

The theme of the conference was designed by the National Department of Health NDoH in consultation with Department of Planning, Monitoring and Evaluation (DPME) in the Presidency which is “re-invigoration of the PHC approach in pursuit of UHC through NHI in South Africa”. Both the Government Communication and Information Services (GCIS) and the Communication Chief Directorate of the NDoH actively publicise the conference, before, during and after its occurrence.

3.6 TRACKS OF THE NATIONAL PHC CONFERENCE

1. Universal Health Coverage and National Health Insurance.
2. Integration of priority programmes into PHC.
3. Human resources for health and PHC.
4. Technology, digitisation and innovation for client-focused public health.
5. Addressing the social determinants of health and the effects of climate change through partnerships and collaboration.
6. Epidemic preparedness and emerging health challenges: building a resilient PHC system fit for the 21st century.
7. Supervision, monitoring and evaluation.
8. Community participation and the role of civil society.
9. Governance and leadership.
10. Health promotion and behaviour change.
11. Continuous quality improvement.
12. The service delivery platform.

3.7 OUTCOMES OF THE CONFERENCE

The output of the conference was the national declaration on PHC in the context of UHC and NHI, adopted by the Minister, Deputy Minister, nine Health MECs, and political representatives of sectors responsible for the broader social, economic and environmental determinants of health which reside beyond the health sector. This commitment will manifest in the Strategic Plans of the health sector for 2024–2029 and Annual Performance Plans (APPs) for 2024–2026, as well as in the national Medium-term Strategic Framework (MTSF) 2024–2029.

Most importantly, the delivery of revitalised PHC services should improve the experiences of care – and ultimately, the health outcomes – of all 62 million South Africans when they utilise the public health sector. The monitoring and evaluation systems of government will seek to find evidence of, among others, the infusion of the resolutions of the National PHC Conference in health sector plans in all spheres of government.

3.8 VENUE

The conference was held in the East London, Eastern Cape Province. The motivation for the choice was to contribute towards raising the profile of the province, improving the quality of health provided, boosting socio-economic development, and re-affirming that all citizens of South Africa are afforded equal rights to health and wellbeing.

4. EXECUTIVE SUMMARY

Affectionately known as eMonti by the locals, East London lies in the Buffalo City Metropolitan municipality at the mouth of the Buffalo River along the Indian Ocean. It is here where a noteworthy convention unfolded within the East London International Convention Centre, a pivotal moment in South Africa's health sector history. The South African Primary Health Care Conference, which was attended by Minister Joe Phaahla, who is regarded as a distinguished leader in public health and revered for his unwavering dedication to healthcare.

The inaugural South African Primary Health Care Conference (SAPHC) established itself as the country's premier forum on health issues providing an opportunity to mobilize leadership, including the private sector, in investing in the country's health sector.

The SAPHC conference was designed to showcase examples of transformation in action, to share lessons and models, and to promote the policies, programs, and investments needed to drive change in the health supply chains across South Africa.

Importantly, the SAPHC was to reflect on and review the country's journey towards the ideals of PHC over the last 30 years of democracy and discussed the pivotal role of the PHC in achieving the UHC in South Africa by 2030 as part of the National Development Plan (NDP).

The two-day conference brought together about 450 delegates, among them scientists and researchers, leaders from government, multilateral agencies, the private sector, civil society, development partners, youth, advocates for health, as well as the media to discuss, debate and share the latest scientific knowledge and evidence for achieving the vision of UHC and NHI in South Africa.

The conference was opened by Ms. Siphokazi Lusithi, the Eastern Cape MEC for Human Settlement and Acting Health MEC on behalf of MEC Nomakhosazana Meth. The guest of Honour was Dr Matshediso Moeti, the WHO Regional Director who delivered an address through a video-link.

SAPHC Road to the Conference

A Scientific Committee was established to develop programme. The committee then worked with the Organising Committee. The work of both Committees resulted in the following:

- A concept note for the conference was developed under the auspices of the organising committee which gave an overview of the conference, its objectives, identification of the conference tracks.
- Definition of the conference tracks under which abstracts were submitted.
- Guidelines for submission of abstracts including development of abstract templates, guidelines/criteria for abstract review.
- Management of the abstract review process (guided by the guidelines and defined criteria).
- Invitation/selection of speakers was on the basis (amongst others) of:

a. Invitation by the organising committee under the leadership of the NDoH and with contribution of DPME, WHO and HST members of the organising committee.
b. Invitation based on selection of abstracts that met the set criteria for poster, or oral presentation.

There were various teams established in addition to the above including:

- Committee for the selection and invitation of international speakers.
- Invitation for speakers who are recognised experts in their fields of practice in the country.
- Abstract based speaker selection.
- Logistics team – responsible for amongst others managing registration of participants.
- Communications team for – media liaison, popularising the conference through NDoH, HST and other websites, various media channels including social media etc.
- Information and Technology (IT) team.

SAPHC Media coverage

The two-day conference received extensive media coverage. This included active reporting by three national TV stations namely eNCA, SABC News and Newsroom-Afrika, press releases shared with Journalists, video broadcasts, visitors to the conference website and more many hits on Twitter(X) and Facebook

5. PROCEEDINGS OF THE 2023 SAPHC CONFERENCE

The Conference was held over 2 days, 15th and 16th November 2023, at East London International Convention Center in East London, Eastern Cape Province. Chairpersons and rapporteurs for each session were drawn from both the National Department of Health and Provincial Departments, and logistical and administrative support was provided by the NDoH. The conference was funded by the NDoH in partnership with Department of Planning, Monitoring & Evaluation (DPME), World Health Organization (WHO) and Health Systems Trust (HST).

Conference delegates were drawn from the following organisations

- National Department of Health
- Research Councils/Institute
- Universities
- Provincial Health Departments
- Pharmaceutical Companies
- National Government Departments
- NHRC
- Statutory Committees/Councils
- International Developmental Agencies
- RECs
- NHREC
- NGOs
- Civil Society
- Metropolitan Municipality

6. OPENING CEREMONY

The opening session was chaired and introduced by Ms. Jeanette Hunter, Deputy Director General Primary Health. The session started with the singing of the National Anthem. She welcomed all participants and said that the conference aim was to reinvigorate South Africa's commitment to the PHC approach as a strategic component of comprehensive health services in a unified health system, within a NHI dispensation. It was also to re-commit the country (i.e. government, citizens and social partners) to the PHC principles being central to health promotion, disease prevention, and building a people-centered and resilient health system that is able to adapt and respond to emerging health challenges in a rapidly changing world.

6.1 Opening and Welcome: Acting Health MEC: Ms. Siphokazi Lusithi

and acting as MEC for Health in her welcome remarks indicated that 4638 Community Health Workers were employed by the Department of Health including 798 contracted by Non-Governmental Partners. These have been funded through the Department's HIV grant. She voiced her appreciation to the theme of the Conference: Towards universal health coverage.

She said that these spoke directly to the National Development Plan's (NDP 2030) Vision of ensuring that South Africa has a health system that works for everyone and produces positive health outcomes of a long and healthy lives for all without undue financial hardships. She thereafter thanked the organizing committee for hosting the conference in the Eastern Cape and with a focus on UHC. She also noted that PHC is central, adding that UHC was about equity not equality, and about reaching and bringing those who have been left behind to the front through improved physical access to health services and increased investment in health.

The MEC made a plea for the Conference organisers to create a platform and device solutions to address emerging societal challenges that are engulfing the health system and a threat to development. She listed the following challenges as increasing trends: teenage pregnancy, psychosocial issues, gender-based violence, substance abuse, environmental issues such as food poising which has been prevalent in the province and preventable Medico-legal cases in PHC facilities.

The MEC urged everyone to do their part to ensure that challenges faced are addressed. "At the end of the day when a girl as young as ten years falls pregnant, when learners eat expired food, when ABAKHWETHA (Initiates) have complications while undergoing the right of passage to manhood, when people drink and drive and cause accidents, all these comes back to our health facilities."

She called on delegates to do their best to prevent issues that can be prevented. The MEC wished all the boys "abazoya entabeni" (boys going to the mountain for circumcision) during the initiation season well. She wished the province will not lose any initiates during the season.

"Sithi Mabahambe be Phila, Babuye be Phila" (We send them alive; they must come back alive). She invited all delegates to explore the beautiful Eastern Cape which has lots of tourist attraction areas and urged them to spend lots of money in the Eastern Cape to boost the local economy.

7. PLENARY 1: GOVERNANCE FOR UNIVERSAL HEALTH COVERAGE

7.1 Dr. Thulani Masilela: Progress challenges and implications for Universal Health Coverage.

The Outcomes Facilitator for Health in the DPME, Dr. Thulani Masilela was the first speaker of the day. Dr. Masilela's long kept secret was revealed by Professor Leslie London that he was recently conferred a PhD Degree by the University of Cape Town. Both the Minister and Deputy Minister congratulated him on his achievement.

Challenges of Present Primary Health Care in South Africa

Dr. Masilela's presentation set the tone with a sobering reflection on the current state of PHC in South Africa. His presentation told a story of social determinants contributing greatly to influencing the status of PHC. Inequality, poverty and hunger contributed to worsening general well-being of South Africans. His emphasis was on many households (12,6%) who skipped one of the day's three meals due to affordability issues and said this meant they missed out on crucial nutrition which in the end determined their overall wellbeing.

What worked well (Good practices)

In dissecting overall access to PHC services by citizens as measured by headcounts, Dr. Masilela pointed out that a total of 128,304 million people had accessed the primary healthcare services in 2013 in the country, which has decreased to 105,134 million people by year 2022. He attributed the decrease in 2022 to other government strategies initiated in 2014 such as the CCMDD programme, whose enrolment has increased from just over 26,000 by year 2014, to over 5.6 million in 2023. These may have resulted in the de-congestion of the PHC facilities by chronic patients. Overall, the country's total PHC headcount from services delivered across clinics, CHCs, Community Development Centres, Mobile Services, CCMDD, Community Health Workers and ISHP had grown from 136.7 million in 2017/18 to 138.8 million in 2022/23 (National Treasury, 2023).

Outcomes/Successes

Looking at the health outcomes, South Africa is gradually exhibiting signs and elements of improvement in maternal health. In terms of life expectancy in provinces, he alluded to a concerning variation in the outcomes of different provinces, specifically pointing out the huge gap between Free State and Western Cape where there exists a 10-year difference (life expectancy for males is 56 years in Free State, while it is 66 years in the Western Cape; for females, Free State stands at 62 years while in the Western Cape it stands at 71 years). The overall quality improvement of PHC services in the country's 3471 facilities, as measured by the Ideal Health Facility Realisation and Maintenance (IHFRM) framework and Office of Health Standards and Compliance (OHSC) compliance status, is that 58.9% of the facilities had complied by 2022/23, led by Gauteng, followed by KZN and Western Cape, respectively.

Professor Leslie London: The NHI is coming: How do we make community participation more meaningful in a plural Health System?

Professor Leslie London from the School of Public Health at the University of Cape Town (UCT) addressed the delegates about the fact that NHI is coming with the aim to achieve UHC. Government recognises that everyone needs to be on board as was the call made by the Acting MEC for Health, Eastern Cape Ms. Siphokazi Lusithi during her opening remarks.

Communities have been identified as one of the most important stakeholders and the purpose of Professor London's presentation was to address the conference on how to increase community participation to realise UHC. He shared ideas from a project he has been working on with the BRICS countries for some time now. BRICS countries comprised of Brazil, Russia, India, China and South Africa. The areas he covered included the history of community participation in health systems, evidence based around where it works and how it works, what has been happening in South Africa and what this means for the NHI. On what roles can health committees play, he emphasized the need for re-orienting services, serve the needs of communities in governance and addressing the social determinants of health (SDH).

Community participation has been viewed as a central part of the PHC approach since the Alma-Ata Declaration, which emphasises participation in planning and implementation of health care. Alma Ata emphasizes a strong role for communities. ANC Health plan in the 1990, the WHITE PAPER which was recently confirmed in the Astana Declaration celebrating 40 years of PHC was referenced during the presentation.

With the signing of the Astana Declaration to mark the 40th anniversary of the Alma-Ata Declaration, member states confirmed their commitments to community participation. Furthermore, community participation is an essential feature in the WHO's Framework on integrated, people-centred health services, which frames social participation as a way of strengthening health governance.

Existing health committees struggle with both functionality and sustainability. Furthermore, health committees played a limited role. Their primary roles focused on supporting the clinic, while they had a limited role in health governance. To a large degree, their roles were inconsistent with meaningful participation, which entails decision-making. Few health committees focused on SDH, and none influenced policy. The presentation also highlighted several factors impacting health committees, including lack of clarity on roles, health committee members' skills, presence and attitude of facility managers and ward counsellors, limited resources, support and lack of recognition.

Prof. London argued that a meaningful form for participation could entail that health committees are defined as governance structures at facility level. Health committees could also have substantial roles in addressing social determinants of health. They should have access to address issues at the policy level either directly or through a tiered community participation system. Effective and meaningful participation requires legislation that clearly outlines health committees' roles and ensures an enabling and supportive environment. This includes facility managers and ward councillors who participate in health committee meetings, training health committees, resources and support.

7.3 Dr. Matshediso Moeti: WHO Regional Director.

Dr. Matshidiso Moeti, the WHO Regional Director for Africa, delivered a significant speech at the South African PHC Conference. Her address emphasized the importance of strengthening primary health care systems to achieve UHC. She highlighted the need for a collaborative approach involving various sectors of society, governments, civil society, and international partners to strengthen health systems and ensure equitable health care for all.

Dr. Moeti also underscored the challenges of health inequity and the critical role of primary health care in addressing these disparities. She called for innovative solutions and increased investment in health systems to ensure that everyone has access to quality health services.

She highlighted that PHC is essential for providing comprehensive health services, from health promotion and disease prevention to treatment and rehabilitation, all while being accessible and affordable to everyone.

“UHC sits at the heart of achieving Health for All, and PHC is the vehicle we need to accelerate progress and succeed. The PHC approach enables us to comprehensively meet the health needs of the population from health promotion and disease prevention to treatment, rehabilitation, and if needed palliative care, and as close as feasible to people’s everyday environment, regardless of their financial situation” she stated.

7.4 Minister of Health Dr. Mathume Joe Phaahla Keynote address

Before introducing the Minister, the MEC acknowledged everyone especially all the MEC's in attendance from other Provinces.

MEC Mbombo informed the audience that Dr. Mathume Joe Phaahla holds an MBCHB degree, He not only worked in Limpopo, but also in Mpumalanga and KwaZulu-Natal. He was the first MEC of Health in Limpopo during the new dispensation before taking a position in the Education and Sports Portfolio. He did a lot of work at the sport department and was the Deputy Minister of Sports during the 2010 World cup. He was later appointed Deputy Minister of Health in 2014 until was appointed Minister of Health.

The Minister of Health Dr. Mathume Joe Phaahla launched his speech by emphasizing the significant strides South Africa has made towards health liberation. He pointed out that September 2023 marked 45 years since the landmark Alma Ata Conference on PHC in Kazakhstan and the fifth anniversary of the International PHC Conference in Astana.

He indicated that as a signatory to the United Nations' Sustainable Development Goals (SDGs), South Africa has demonstrated its key role and dedication in the global health community.

Minister Phaahla directed the conversation towards the immediate matter at hand, which is the realization of UHC. This concept, born out of the Alma Ata Conference's aspirations, is integral to achieving health equality. Upholding the principles of fairness and accessibility, UHC represents a lifeline for many who often find themselves overlooked in terms of healthcare access, said the Minister.

He acknowledged that the health sector is still plagued by inequality, a formidable barrier that threatens to exacerbate the disparities within the health system. He added that the private sector's escalating health expenditure is in stark contrast with the dwindling public sector allocations, creating a worrying chasm.
To confront this problem, Minister Phaahla underscored the pressing need for a raft of reforms. The resolution, he proposes, lies in constructing an inclusive national healthcare system that guarantees resource availability to all, irrespective of their socio-economic circumstances. The introduction of NHI is therefore a crucial stride towards this goal.

Minister Phaahla accentuated the need for a balance between clinical and supportive resources. He contended that the quality of clinical services hinges on the administrative, financial, supply chain, and information and communication services they receive, as illustrated by the role community health workers have played in the CCMDD programme's success.

Minister Phaahla acknowledged that certain areas within the health system still require fortification. The Environmental Health Programme, for instance, is crucial for South Africans' safety against potential environmental hazards. Increasing the number of environmental health practitioners appointed by municipalities is identified as a necessary measure to continue this mission.

The Minister further recognized the potency of collaboration in achieving health goals. Joint efforts across departments, coupled with partnerships with the private sector, NGOs, academic and research institutions, civil society, and communities are vital in addressing the social determinants of health.

The Minister stressed the need to concentrate on health promotion and early intervention at the PHC level, asserting that this would relieve the country's budget from high-cost health interventions.

The Minister restated the importance of the correct funding mechanism for health services and emphasized the need for the implementation of the NHI.

The Minister's address at the South African PHC Conference was more than a speech. It was a rallying call, a plea for unity, and a commitment to a common goal, a vision of health and well-being for all, leaving no one behind. While the journey towards this vision is fraught with challenges, as the Minister aptly states – together, we can and will accomplish this mission.

8. PLENARY 2: MUNICIPALITY SERVICES AND SOCIAL DETERMINANTS OF HEALTH

8.1 Prof Bob Mash: A framework for implementation of community orientated primary care in the Metro Health Services, Cape Town, South Africa:

Prof. Marsh stated that PHC is responsible for responding to community needs rather than looking at their needs (pro-active approach). Community-Oriented Primary Care (COPC) involves CHWs but does not imply that CHWs are implementing COPC, and it includes three PHC components namely:

- Highly performing CHWs platforms.
- Improved health status.
- Creates savings for the country.

Outcomes/successes from COPC

- Good health outcomes.
- Community support and engagement.
- Community participation.
- Support community-based work.
- Reduced waiting times at facilities.

What worked well (Good practices).

- Full implementation of processes for population health and COPC 10-point plan. The Community-Oriented Primary Care (COPC) 10-point plan is a comprehensive approach to integrating primary care and public health for a defined community namely:

  1. **Community Involvement**: engage the community in identifying health needs and priorities.
  2. **Comprehensive Care**: provide a wide range of health services, from prevention to treatment.
  3. **Continuity of Care**: ensure ongoing care for individuals and families.
  4. **Coordination of Care**: integrate services across different levels of the health system.
  5. **Accessibility**: make health services easily accessible to the community.
  6. **Accountability**: health providers are accountable to the community they serve.

7. **Cultural Sensitivity**: respect and incorporate cultural beliefs and practices in healthcare.
8. **Health Promotion**: focus on promoting healthy lifestyles and preventing diseases.
9. **Intersectoral Collaboration**: work with other sectors like education and housing to address social determinants of health.
10. **Evidence-Based Practice**: use data and research to inform health practices and policies[3].

- This plan aims to create a more effective and equitable healthcare system by addressing the specific needs of the community
- Full participation of stakeholders and community on health-related matters.
- Strengthening of promotion and preventive health strategies.

Challenges experienced.

- Lack of capacity for PHC and CHWs.
- Limited resources for CHWs to execute their community-based tasks.
- Data not fully integrated into facility data.
- Inadequate stakeholder engagement by health.

Recommendations

Implementation of COPC 10-point plans:

- Geographic delineation of PHC teams
- Composition of CHC teams.
- Facility-based and community-based teamwork, etc…

In conclusion, Prof. Marsh made the following recommendations:

System preparation and change management:

- Integrate governance of PHC and Community-based services.
- Provide CHWs with needed resources.
- Align CH services understanding from level of Heads of Department (HOD) to the communities.
- Participatory and collaborative sphere of leadership.

8.2 Ms. APR Cele: Environmental and Port Health in South Africa - Good Practices and Challenges

Ms. Cele, Chief Director for Environmental and Port Health in the NDoH defined Environmental Health (EH) as a critical component of PHC, and essential for an effective health system and improved health outcomes. Her presentation re-affirms Acting MEC Lusithi's statement that a large proportion of the burden of disease are preventable. She attributed EH Services to the promotion of wellness and prevention of disease, through the control of environmental conditions.

She linked the quality-of-life determination directly to the quality of the air we breathe, water quality, the food we eat, the availability of adequate shelter, sanitation and hygiene services, the use of chemicals. The presentation proposes measures to curb the rise of the quadruple burden of disease as follows:

- The need to give higher priority to addressing up-stream health determinants.
- The recognition that social determinants of health arise from the conditions in which people are born, grow, live, work and age.

She points out that South Africa environmental health services is governed in terms of the Regulations Governing the scope of profession of Environmental Health, published under the Health Professions Act, 56 of 1974, as amended, to include the following:

- Water quality monitoring and food control.
- Health surveillance of premises and environmental pollution control.
- Disposal of the dead and chemical safety amongst others.

Outcomes/successes:

- Various policy and legislative framework have been provided, including;
- National EH policy and strategy – provides a framework within which Environmental Health Services should be provided in the country.
- National Environmental Health norms and standards – provide a benchmark within which the delivery of Environmental Health Services can be monitored and assessed. Promotes standardization in the rendering of services.

Challenges experienced.

Despite the successes noted above, Ms. Cele highlighted the following challenges:

- Slow progression in the realization of the EHP/population ratio as per the WHO recommendations.
- Inadequate operational budget allocations – due to competing priorities at local government level.
- Inadequate planning for Environmental Health Services and lack of alignment with District Health Plans as prescribed within the National Health Act;
- Fragmentation of EHS within various government departments – resulting in unclear roles and responsibilities, overlaps and duplication of functions amongst others.

8.3 Mr. SN Mavundza, South African Local Government Association (SALGA): Improving the quality of Social Determinants of Health.

The purpose of the presentation from SALGA was to reflect on the state of services impacting on health outcomes and to emphasize the need for health departments to be involved in the planning, design and provision of health services. The presentation was also proposed interventions aimed at addressing social determinants of health. Mr. Mavunda started the presentation with a brief background and listed the objectives of local government as follows:

- To provide democratic and accountable government for local communities.
- To ensure the provision of services to communities in a sustainable manner.
- To promote social and economic development.

The presentation highlighted the role of local government on social determinants of health and the crucial role in the social and economic development of communities. The environment and living conditions play a critical role in places where people live and co-exist. He indicated that Local Government is the government institution closest to citizens and the one that is best placed to acquaint itself with the challenges of their communities, thus, it is a key contributor to improvements in the health and quality of life of its citizens and of all social groups.

Mr. Mavunda alluded that the 2022 Population Estimates has shown an increase in population which translates into increased demand for the services which impact on the health outcomes. It was brought to the delegates attention that migration between countries was driven largely by the quest for economic opportunities, political instability and increasingly, environmental hazards. The top five migrants to South Africa were from Zimbabwe, Mozambique, Lesotho, Malawi, and the United Kingdom; also, to note is that these five countries also maintained their rank since 2011.

There is evidence that health departments across all spheres of government have been playing a minimal role in the planning, design and provision of basic services e.g., there hasn't been an assessment of the municipal IDP's by the NDoH to determine whether the services which contributes to improved health outcomes are prioritized. Importantly, municipalities themselves are said to have not been paying

monitoring, food control, waste management monitoring, health surveillance of premises, surveillance and prevention of communicable diseases, Vector control, environmental pollution control and chemical safety monitoring.

- Continuous monitoring and evaluation of the effectiveness of the municipal and other sectoral implementation plans and system by the department.
- Improved funding, governance and oversight on the delivery of health services at local level. e.g., introducing local government support and grant funding.

8.4 Dr. Amanda Rozani: The implementation of the Integrated School Health Policy (ISHP): The Success and Short Comings

The Integrated School Health Policy (ISHP) launched in October 2012 and was signed by both the Ministers of Basic Education and Health. The co-signing of the Policy was seen as a strong political will and placed emphasis that Education was apex priority. The Policy represents one of the three strands of PHC re-engineering and is viewed within the education sector as an important component of Care and Support for Teaching and Learning (CSTL) framework.

The co-signing also indicates a commitment for close collaboration between all role-players (DOH, DBE & DSD) and a wide consultation and support. The Policy aims to improve children's health, reduce education barriers to learning and improved educational outcomes. To make provision of a comprehensive package of health services to learners in all educational phases including health education, screening, on-site services including immunisation and referral.

According to the Education Information Systems, 12,706,157 learners attended public schools in 2023. A total of 17 issues were identified as vulnerabilities impacting on health outcomes. The ISHP objective is to reach all learners with the following package of services:

- Health promotion and education and individual learner assessment and treatment.
- On-site provision of services and referral and follow-up.
- Environmental assessment of school.

The ISHP aims to assess each learner once per educational phase (GradesR/1,4,8,10). All learners who are repeating a grade or who are referred by an educator should also be assessed.

Implementation Model

The ISHP Task Team comprises of National, Provincial and District levels. The SBST and school health team must work together to ensure that learners who require referral and further services receive these services. School health teams are tasked with delivering health services to students. Each team consists of a professional nurse, an enrolled nurse, and a health promoter, with a recommended ratio of 1 team per 2,000 learners.

Grade Specific Package

Health education for all phases; age and developmentally appropriate

Achievements

- ISHP task teams established at national and provincial levels.
- Development of guidelines and training package for school health nurses.
- Training consistently done in all provinces.

8.5 Dr. N Mhlongo: Department Human Settlements

The aim of Dr. Mhlongo's presentation was to demonstrate the mutually reinforcing relationship between housing and health in informal settlements, to analyse the relationship between housing and health, and to determine possible solutions for poor health in informal settlements.

Dr. Mhlongo clarified to delegates that the human settlements are not just about building houses but instead about transforming cities and towns and building cohesive, sustainable and caring communities with closer access to work and social amenities, including sports and recreation facilities. He continued to say that where people live must also be where they can learn; where we live must also be in the proximity of where we can leisure; and that where we stay should also be where we can play, where we can pray and so on. Dr. Mhlongo said despite the Constitutional rights of access to adequate housing and health care services for everyone as enshrined in (S26&27) of the Constitution of the Republic of South Africa, healthy living conditions are non-existent in most informal settlements in South Africa.

He said the problem was dire and far worse in metros and secondary cities and has its roots in the apartheid law. Apparently, it has intensified in recent past years due to urbanisation. It manifests through poor health, mortality and social ills such as teenage pregnancy, juvenile delinquency, robbery, mugging, theft, etc. Lack of basic services and inaccessibility due to poor infrastructure.

The presentation provided positive news regarding households in formal dwellings which has seen an increase from 65.1% in 2011 to 88.5 in 2022. The informal dwellings were reported at 16.2% in 1996 and increased to 16.4% in 2001. It decreased to 13.6% in 2011 and continued to decease further to 8.1% in 2022. Key delivery statistics for human settlements are reported annually through the sector reports, and the same is confirmed by Stats SA.

The presentation emphasizes the mutually reinforcing relationship between housing and health both conceptually and practically. This was supported by Maslow's Hierarchy of Needs Theory. The key message that came out is that poor housing directly links to poor health, and this was demonstrated through the selected case studies of informal settlements.

Possible solutions and recommendations

- The Departments of Human Settlements and Health should enter into a formal agreement with clear plan of action towards planning, budgeting, and channelling their efforts to address housing and health issues in informal settlements especially in metropolitan areas and secondary/intermediate cities.
- Capacity building should be intensified in local government to monitor, manage, and improve urban planning as well as the enforcement of by-laws of illegal occupation of land. This simply means enhanced governance towards ensuring spatial principles of SPLUMA,

9.1 Dr. Victor Franscisco Figueroa Velar – Family Physician Gauteng Health: The Cuban Family Medicine Primary Health Care Experience.

Dr. Victor Velar provided a detailed background of the Cuban PHC evolution from 1984, 2005 and to date. The Cuban Family Medicine PHC principle is to guarantee access and comprehensive healthcare based on human rights, with family medicine aimed at holistic approach to individual health. The historical perspective is from 1964 where there was a need for new PHC approach that is through health area (geographical demarcation, polyclinic).

This led to the Integration of Polyclinics with secondary and tertiary level of care. South Africa borrowed the origin of District Clinical Specialist Team (DCST) from the 1974 Cuban District Basic Specialist Work Team. It is where the Registrars were integrated into the system. The paradigm shifted from the traditional Family Medicine training methods to community health centers based on the needs of the communities. The system involves other stakeholders to deal with the social determinants of health.

The success of the 1974 Cuban District Basic Specialist Work Team is recorded below:

- Improvement in National Health System Institution.
- Human capital development, 51,614 Family Physicians with other areas of competencies.
- Master's degrees (31,770), Research degrees (5,015), PhDs (1,800), Dentists (17,657), Professional Nurses (40,082), Health Technicians (39,625)

What worked well (Good practices)

- Intersectoral collaboration with other departments towards health outcomes.
- Family Medicine integration into PHC where Family Physicians work and live within the community.
- Preventative and health promotion approach.

Challenges experienced

- Political sanctions.
- Infrastructure development and maintenance.
- Access to technology and raw material.

Conclusions and Recommendations

The approach where the community interest supersedes the individual interest (community rights. versus individual rights) should be considered in South Africa. This should include:

- Paradigm shift approach where you have community involvement.
- Health promotion and prevention.
- Infrastructural development of the rural area.
- Strengthen the PHC with training institution.
  The Cuban healthcare system underwent several phases of development before achieving its current success.

9.2 Dr. Nonhlanhla Khumalo: (Wits University): My Primary Health Care Journey from Cuba to South Africa.

Dr. Nonhlanhla Khumalo took the conference delegates through her experience from her childhood days in a crowded emergency room. Many South Africans in the audience could relate with her experience of long waiting times) in a health care facility.

After being selected as a candidate for the Nelson Mandela-Fidel Castro Medical Programme, she narrated a thrilling story about the undergraduate training that did not prepare the undergraduate students for the South African health setting. Her experience of community involvement in health where they lived which is amongst the communities they served; the rights of communities were placed above the individual right in the healthcare setting. This was again also experienced during the COVID-19 pandemic.

The lack of psycho-social preparation for cultural shock in a foreign country was a major huddle for the cohort. Before commencing with the official medical programme, they were mandated to learn Spanish language which was new to them for 6-8 months. They went through an intensive health screening after a South African student was diagnosed with tuberculosis (TB). She told delegates that Cuba had limited exposure to other field of medicine such HIV and TB, trauma. She attributed the limitation to emphasis on effective PHC system and few cases of violence.

Dr. Khumalo credited the success of the Cuban Model on the following approaches:

1. Greater emphasis on health promotion and prevention.
2. Family physician with consultation rooms within the community.

What worked well (Good practices)

1. Re-integration where graduates are now exposed to other fields of medicine e.g., trauma, HIV and TB, malnutrition etc.
2. Increased number of doctors available for PHC in rural areas through the Cuban programme.
3. Increased interest in Family Medicine specialty due to exposure to the Cuban programme.

Challenges experienced

1. Re-integration of Cuban graduates into the South African setting.
2. Language barrier where students need to hear in English, interpret in Spanish and respond in English.
3. Resistance by academics to accommodate Cuban trained doctors Nelson Mandela Fidel Castro (NMFC) Programme.

Recommendations

1. Need to expand health prevention and promotion in South Africa beyond HIV and TB.
2. Expand infrastructure and equipment to PHC to retain Family Physicians (FPs) and Registrars in rural areas.
3. Prepare student psychologically for adaptation in foreign country.
4. Strengthen the buy-in of academic institutions to the Cuban programme to expand the intake.
5. Family Physicians and Registrars to form part of home visits (PHC Re-engineering).

9.3 The Nelson Mandela Fidel Castro Programme: Partnership in Practice: Prof Richard Cook of Wits University

Prof. Cook indicated that the Nelson Mandela Fidel Castro Programme has now been Integrated within the Wits School of Health. For years Wits School of Health was not receiving Cuban trained students, however, they have received the largest Cuban trained cohort since 2018. The Partnership has successfully on-boarded 4 large cohort of 125 -151 students every year with 45 facilities as training centres from tertiary hospitals to clinics.

The successes of the Partnership in Practice

1. Decentralization of health education and service delivery to the Registrar programme.
2. Curriculum and academic programme.
3. Clinical educator.
4. Academic governance.
5. Technology.

- Logistics/Operations.
- Blended learning and learning multiple system.
- Technology enabled workplace-based assessments.

What worked well (Good practices)

1. Monitoring through technology – use of App to monitor location of students.
2. E-Log books functions to monitor activities through GPS.
3. Blended learning systems.

Challenges experienced

1. Balance between academic and service delivery responsibility at PHC for Registrars - where they find themselves setting up IV lines instead of gaining knowledge.
2. Limited PHC facilities to Gauteng and North West.

Recommendations

Prof. Cook recommended that:

1. Treatment protocols and guidelines relevant to South African DHS to form basis of curriculum.
2. Explicit training in the methods of writing medico-legal case notes.

Recommendations

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2. Explicit training in the methods of writing medico-legal case notes.

10. TRACK SESSIONS: REPORT BACK - GOOD PRACTICES

Reports-back were received from the breakaway sessions, which identified good practices as well as challenges.

Session 1.1 - Track 1: Service Delivery Platform

Good Practices:

1. Not to “dish out” guidelines without capacity building of clinicians.
2. Simplify guidelines for clinicians.
3. Involvement of recipient of care - keeping patient diary
4. Integrate patients’ records - not to separate one person into different diseases.
5. Involving the clinicians in the integration of patient’s records.
6. Using data for decision making.
7. Link innovations with health outcomes.
8. A need for digitalization of patient’s records in public sector.

Session 1.2 - Track 2: Universal Health Coverage and National Health Insurance.

a). Nurse-Led Delivery of Primary Healthcare

What worked well?

- Partnership - working closely with the Department of Health, other stakeholders, dental health and ophthalmology.
- Services are delivered at the point of need.
- Use of technology - use of virtual consultations.
- Have a good clientele of ages 5 years and below and women ages 20 - 40 years.

Challenges experience

- Data management – no clear data flow SOP/ Algorithm in relation to NDoH data for DHIS and TIER.Net.
- Challenge of provision of services during COVID 19 pandemic.
- Consultation fees is R300 and if a doctor is needed an additional R100 is required - this may not be feasible for patients who cannot afford the fees.

Good practices

- Virtual consultations with a doctor.
- Electronic patient management system.
- Unjani App - patient appointments are made via the App; they can download health educational contents.
- Formulary in line with the NDoH guidelines.

- CCMDD services to 100 thousand patients at Medication Pick-up points.

b). Road to Universal Health Coverage (UHC) - South Africa's progress towards UHC

What worked well

- Developed 5 fact sheets to gather data for research (Diabetes, TB, Contraceptives, Childhood Immunizations and Service capacity and access)

Challenges experienced

- Stock-out of contraceptives.
- Myths around the use of contraceptives.
- Stigma, partner influence and side effects of contraceptives.

Good Practices

- The methodology used peer reviewed and grey literature.
- Sites within the Provinces were selected.
- Data from the District Health Barometer, South African Health Review and the Provincial Annual financial reports were used.
- Country implemented sugar tax.
- 2018 increased budget allocation for NCDs.
- Increased data collection.
- Care cascade released in 2022-2027 NSP-NCD

c). How consistent use of Synchronised National Communication in Health (SyNCH**) in Zululand District Supports Patients 'Continuity of Care.**

What worked well

- Leadership buy-in and support.
- Collaboration of DOH and the District Support Partner.
- Ability to transition SynCH from being partner driven to a DOH initiative (initially had 19 Technicians and now only two supporting the district)
- Prescribers no longer using manual documents.

Challenges

- Connectivity Network problems.
- Load shedding, which is planned electricity interruption to reduce overload on electricity demand.
- Computer literacy (technophobia).
- High staff turnover.

Good Practices

i) Facility Level:

- Operations Managers monitor the use of SyNCH.
- Script rejections are addressed within 7 days.

ii)Sub District Level

- SyNCH discussed with PHC Supervisors.
- Mitigation strategies are discussed.

iii) District Level:

- District management involved in the monitoring – hands on.

d). The Community Health Worker Program in the North West Province: A Community Health Worker Perspective.

What worked well

- Employed Outreach Team Leaders (OTLS).
- Provided the CHW with uniforms, umbrellas and raincoats.
- Clarified their scope of work as prescribed by the 2018-2019 policy framework for Ward-Based PHC Outreach Teams (WBPHCOTs).

Challenges experienced

- Framework not uniformly implemented in the provinces.
- Policy interpretation challenges amongst Health Systems Trust (HST) programme managers.
- Literacy of most cadres - they are transitioned out.
- Most Outreach Team Leaders (OTLs) are retired nurses.
- Low staff morale.
- Newly qualified staff are not motivated enough as they were not practising.
- Supervision challenges-ratio of OTLs to WBPHCOT are not enough and not standardised.

Good practices

- Implementing the programme in line with the 2018/2019 policy framework.
- Mobile devices to assist with the capturing of real time reports and assist with global positioning system location.

Session 1.3

Track 3: Integration of Priority Programmes into PHC.

Presentations:

This was a breakaway session of various topics. The session identified some good practices and challenges.

a). Traditional Health Practitioners (THP)

Presentation Title: Strengthening PHC through collaboration between public health care workers and THP: A capacity building intervention in eight districts in KZN. This was presented by Ms Andisiwe Canca.

What worked well:

- Mapping out of traditional healers to be active participants and not just stakeholders.
- Adaptation of training materials for traditional healers. (e.g., record keeping).

Challenges

- Referral system and clinical knowledge.
- Lack of guidelines and policy for THPs.
- Regulation of THPs – registration

Good practise

- Collaborating with community stakeholders (such as part of clinic committee and database).

b). Men Friendly Services

Presentation Title: Men's health: Don't leave them behind presented by Malebo Maponyane

What worked well?

- Differential models of care can optimise service delivery, increased the uptake of men services and improved client satisfaction.

Challenges:

- Most men prefer to be consulted by males.
- Human resources – limited male health care workers.
- Sustainability of the programme.

Good practise

- Men friendly facility i.e., fast queues and appointment system over the weekend in 24-hour clinics and provision of extended hours.
- Inclusion of end-users in the planning of priority programmes

c). Malaria

Presentation Title: Malaria programme review series 2019-2023: Case Management findings and recommendations to strengthen service delivery at PHC level presented by Ednah R. Baloyi

What worked well?

- Audit identified gaps in management of the malaria programme.

Challenges*:*

- There are no clear guidelines governing second line treatment when the first one failed.
- Lack of resources to manage malaria and to conduct awareness campaigns.
- Rapid tests kits are not readily available in non-endemic areas. Malaria in non-endemic areas is diagnosed late due to low index suspicion.

Good practise

- There was active participation from CHW.
- Review and audit of programme performance to inform development of the 2024-2028 strategic planning cycle.

d). Oral Health

Presentation Title: Using Decayed, Missing, and Filled Teeth (DMFT) index to guide oral disease prevention in PHC setting presented by Dr C. E. Potgieter

What went well

- Two evidence-based interventions (fluoride varnish applied at least on 3 occasions and tooth brushing programme) were shown, using the DMFT index, to be effective in preventing tooth decay.
- DMFT Index = Index on decayed, missing, filled teeth.

Challenges

- A major challenge has been in coordinating the DMFT survey.

Good practices

- Involvement of key role players (oral hygienists and CHWs) is key in implementation of oral health promotional and prevention strategies.
- Lessons: Monitor the burden of caries using DMFT index and integration of oral health prevention strategies into the current health promotion strategies on primary healthcare.

e) Cervical Cancer Screening

Presentation Title: Using mobile clinics to improve access to cervical cancer screening for women in poorly resourced areas of KwaZulu-Natal presented by Nompumelelo Ntshangase

What worked well

- The introduction of a mobile clinic for cancer screening of the women indicated that women are eager to screening but access is poor.

Challenges

- Only one mobile clinic was used during the study, which proved to be inadequate or limited the access to the service.
- The current design of the mobile clinics in terms of space does not meet the expectations for the intended clients. There seems to be a limitation in the specifications or design of the mobile clinic.

Good practise

- Women education and motivation.
- Capacity building of outreach teams to educate women at community level.
- Provision of mobile clinics to improve access to priority health programmes.

f). HIV

Presentation Title: Lessons learnt in implementing an enhanced HIV case management model in uMgungundlovu District, South Africa presented by Nkululeko Sokhela

What worked well

- Improved continuity and retention of patients on ART, when they are followed up by the same clinicians.
- Improved patient and clinicians' satisfaction.

Challenges

- Loss to follow up by youth, due to substance abuse.
- Loss to follow up by male patients.

Lessons learnt

- Improved continuity of care - service providers manage to distribute work fairly and patient flow is better.
- Improved patient experience of care - patients able to plan their week better and there is improved file flow and decreasing file losses.
- Improved waiting times by an average of two hours in most facilities - nurses able to create their administrative time through better spacing of patients and increased uptake of Differentiated Models of Care (DMoC).

g). Self-Management

Presentation Title: PHC nurses' knowledge, self-efficacy and performance of diabetes self-management support in the OR Tambo district, Eastern Cape presented by Zandile Kolosani Landu

What went well

- The study has shown that nurses are knowledgeable and confident on management of diabetes.

Challenges

- Although nurses being knowledgeable and confident on management of diabetes, the knowledge did not translate into self-efficacy and performance of self-management support in practice.

Good practice

- Training, mentorship and support of primary healthcare nurses.
- Improved assisted self-management support.
- Implementation of policy guidelines and targeted in-service training.

Session 1.4-Track 4: Human Resources for Health

Presentations were made on the following topics

1. Challenges faced by healthcare professionals in reporting Near Miss Incidents in a hospital in the Amathole District in the Eastern Cape by Lindiwe Ntlanganiso
2. Data Quality Assessment (DQA) of Malaria Information Systems in two endemic provinces in South Africa, 2020 – 2023 by Ziyanda Fekema.
3. A case study to establish the effectiveness of the Operation Phuthuma Project to reach HIV and AIDS targets: North West experienced by Ms Joan Lesetedi

These presentations highlighted some challenges summarised as follows:

1. The varying capacity and quality of facility management often present through poor supervision and/or management of staff.
2. Problems arising from lack of knowledge at facility level of reporting mechanisms and sometimes not knowing what to report e.g., surgical errors. This often gets compounded by the attitude or fear to report by health care professionals. In several instances, clinical audit meetings are held but errors are not properly analysed.
3. There is a pervasive lack of understanding of the role of support categories of workers in the health care system e.g., the role of security personnel.

The session acknowledged that these matters underlie the human resource problems in the PHC environment and that these could be grouped into the following themes:

1. Training is important and to ensure that competencies get retained throughout the work life of individuals.

2. Data and information management needs to be harmonised through interoperable information systems.

3. Absorption and retention of human capacity within the health system is critical.

Based on these, the following proposals were made:

1. Put in place capacity building programmes for facility managers.

2. Ensure continuous training and appropriate orientation of health care professionals.

3. Support staff should be orientated on the service delivery environment where they operate.

4. There should be appointment of appropriate numbers of skilled staff.

The underlying principle is that the PHC environment requires highly skilled human capacity because it acts as a gateway to higher levels of the health interventions.

Session 1.5-Track 5: Technology, digitisation & innovation for client focused public health.

Presentations for the session were made on the following topics

1. Amandla Mama: Optimizing behavioural intention and knowledge of women and their partners in the perinatal period: a randomized control trial in the Tshwane district, Gauteng province by Zwannda Kwinda.
2. Enhancing medication access in healthcare facilities: A systematic approach for Smart Locker installation by Roma Ramphal.

Virtual demand creation: Lessons learnt from a knowledge sharing and demand creation platform co-designed with Men who have sex with men in South Africa by Letitia Rambally Greener

What worked well

1. Having a "change champion" at each health facility to aid in the implementation and quality assurance of health information systems seemed to be beneficial.
2. Developing online educational materials in collaboration with clients and healthcare workers.
3. Appropriately assessing the needs and requirements before implementing a health technology solution.

Challenges

1. The introduction of health information systems or other digital solutions after service initiation often results in implementation delays. Ideally, training for digital health solutions should occur before staff commence their services.
2. There is no single platform for public health promotion and preventive health.
3. Currently there are numerous health information systems utilised in the public health sector that are not interoperable.

Good practices

1. Identify and train “change champions” when implementing health information systems at health facilities.
2. Develop/use a single platform for public health promotion and health prevention.
3. Identifying the appropriate health technology for a specific context.

From the session, the following observations on good practices and way forward were:

1. Use of a “change champion” to assist with implementation of a health information system is desirable.
2. Educational animated videos in collaboration with expectant mothers and healthcare workers is important.
3. Engaging with journalists and people that were not health-orientated to develop a public dashboard as for COVID-19.
4. Applying a standardised process for determining the feasibility of health technology implementation.

Session 1.6-Track 6: Addressing the social determinants of health through partnership.

Presentations for the session were made on the following topics

1. Thrive to Five - Building the case for a national home-based, parent-led responsive care and early learning programme by Ms. R. Rosentals.

2. A framework for intersectoral collaboration on safe water provision as a social determinant of health in South Africa. by: Ms Y. Mokgalagadi.

Context and key issues from the presentations were as follows:

1. PHC provision can be improved through collaboration and cooperation with various stakeholders, including non-governmental, governmental and community-based organisations.
2. Environmental health services are fundamental to addressing social determinants of health, particularly environmental determinants e.g., safe water;
3. Communities, families, and individuals are key to facilitating positive change and health behaviour;

Recommendations, approaches, solutions and opportunities from the presentations were:

1. Building capacity is key to ensuring the correct application of the intersectoral collaboration framework at various levels.
2. Community partners are the foundation on which Environmental Health can co-design partnerships, with careful consideration of the needs and challenges of the community;
3. Collaborations and partnerships should include a shared vision, co-developed plans for implementation and evaluation, resource alignment, joint reflection and adaptation, and shared decisions regarding any subsequent steps;

From the session, the following relevance to PHC, observations on good practices and way forward were:

1. Partnerships and collaborations with various stakeholders play a huge role in improving the quality PHC Care services
2. SDH, such as safe water, sanitation, hygiene, food and air determine the ability of PHC services to cope
3. Leadership and accountability are key for PHC services.

TRACK 7 Community Participation

Presentations for the session were made on the following topics

1. Leading from the Coal Face – A Pioneering Initiative to Strengthen Community -Based Surveillance and Response in KwaZulu-Natal Ms Babongile Mhlongo
2. Utilizing routine health data and community engagement workshops to quantify and qualify the impact of transport costs on government service access for people with disabilities by Maryke Bezuidenhout
3. Unlocking Potential: Strategies to Promote Health and Wellness Uptake Among Young Males in Deprived Areas through Youth Development Organizations Camilla J S Oborne

The presentations for the session identified several important lessons learnt in Community Participation and role of civil society. These included the following:

1. Community participation is dynamic and complex, one needs to understand the scenario the people are facing, be in touch and know your gatekeepers.
2. Primary Health Care is essential for an effective health system and improved health outcomes. In this regard, community entry is-crucial in facilitation of an uptake of key health programmes.
3. For proper community participation/engagement, we need to learn from the experiences during Covid-19. Feedback was always provided by the media to the community.
4. There is a need to reform the training of health care workers' curriculum.
5. There is a need to improve the quality of SDH through Inter-Sectoral Collaboration (ISC) for better health outcomes. Successful policy implementation relies on effective intersectoral collaboration.
6. Community Development is essential to contribute to "Health for All", which is reliant on an enabling environment for services to be provided equitably to all. Communities should be empowered with the skills to adapt to the effects of climate change and build resilient PHC services.

Track 8: Health Promotion and behaviour change:

Presentations for the session were made on the following topics

1. Reported psychological stress and physical health symptoms among medical laboratory professionals following the COVID-19 pandemic - South Africa, 2022 by Danai Kwenda
2. Health promotion through a true-peer support model, Coach Mpilo for MSM Lungile Zakwe
3. Supporting a people-centred health system to drive person-centred care: Lessons from a healthcare provider driven and co-designed patient centred care implementation science intervention Letitia Rambally Greener

Presentations for the session highlighted the following lessons from clients and community and health care providers' perspective.

1. Health promotion – empowers a person to take control over their health and its determinants through health literacy efforts and multisectoral action to influence behaviour change.
2. Health promotion has two important tiers: Prevention of diseases through
    a. health education, surveillance of disease, community disease preparedness.
    b. screening and testing (increased early awareness and action).

Challenges

1. Health promotion mainly intensified during outbreaks (Resistant behaviour and limited knowledge from the community).
2. Surveillance not conducted routinely to identify early warning sign and timeous health education/promotion (disease preparedness and timeous health promotion).
3. Health promotion limited to clients/communities and not inclusive of health care providers (Occupational health and wellness).

Best Practices

1. Integrated Health Promotion approach should include but not limited to community dialogues, and different radio slots (national and local, social media). These, led to positive changes in the community reduction incidents of untoward behaviour, evidenced by lessons from COVID19 pandemic.
2. Behavioural change was more effective when prior situational analysis was conducted (e.g. household surveys, and interviews etc).
3. Health promotion messages should be tailor-made and inclusive of the population (e.g., adolescence, youth, adults, Lesbian, Gay, Bisexual, Transgender, Queer and Intersex (LGBTQI).

TRACK 9: Continuous Quality Improvement

Presentations for the session were made on the following topics

1. How can doctors in district hospitals receive specialist internal medicine support? BAMSI - an innovative virtual approach: Dr J. Nash.
2. Triangulating the impact of distributed leadership in a quality improvement programme in South Africa: Mr W. Odendaal.
3. Every System is perfectly designed to get the results it achieves Patients experience of care and waiting times: Ms L. Dlamini.

Presentations for the session on continuous quality improvement highlighted some good practices to take forward

TRACK 10 Pandemic Preparedness

Presentations for the session were made on the following topics

1. Patterns and trends of sexual violence against adults and children pre and during the covid-19 pandemic in the Eastern Cape, South Africa by Dr Oladele Vincent Adeniyi
2. Linkage to care trends for GeneXpert Diagnosed Rifampicin Resistant Tuberculosis, North-West by Wellington Maruma
3. Nurturing the health professional educational sub-system to ensure pandemic preparedness by Christy-Joy Ras

Presentations for this session on pandemic preparedness identified some good practices as follows

Good Practices

1. Technology enhancement (virtual meeting: Microsoft Teams).
2. Administering of vaccines.
3. Electronic Vaccination Data System (EVDS)
4. Mobilization of private sector.

b). North West: Linkage to care trends for GeneXpert diagnosed Rifampicin resistant TB.

1. Strengthening the Endpoint Detection and Response (EDR) Web system through integration with the Health Professional and Related Services (HPRS) to support early alert of DR TB and enhance linkage to care. The study shows drastic improvement in the doubled performance from 40 to 76%.
2. It is recommended that the HPRA is fully implemented and supported to fully link with Home Affairs.

c). UCT: Nurturing the Health Professional educational sub-system to ensure pandemic preparedness.

1. Following the lessons from the Covid-19 pandemic that introduced virtual administrative systems to foster a learning culture to support policy-compliant interventions in the management of patients.
2. Mitigating systemic challenges that would hinder the preferred virtual learning as opposed to less desirable physical contact sessions, structured training support was implemented to frontline staff who would be trained on the APC clinical management tool.

11. POSTERS AND PRESENTATIONS PROGRAMME

A total of 16 posters were presented at the conference. These covered a range of issues including Universal Health Coverage and National Health Insurance, Integration of priority programmes into PHC, Human resources for health and PHC, Technology, digitisation and innovation for client-focused public health, Addressing the social determinants of health and the effects of climate change through partnerships and collaboration, Epidemic preparedness and emerging health

challenges: building a resilient PHC system fit for the 21st century, Supervision, monitoring and evaluation, Governance and leadership, Continuous quality improvement, Health promotion and behaviour change and community participation and the role of civil society. A synopsis of the key interventions, conclusions and recommendations from the poster sessions were presented as indicated below:

1. Towards Achieving Integrated Community-Focused Models of Care for People Living with Non-Communicable Diseases (NCDs) & HIV/TB in Eastern Cape Province, South Africa presented by

Intervention

1. Improve detection and management of chronic conditions through surveys, mentoring of healthcare workers, health promotion and education of communities on prevention and quality of care.
2. Improve access to care for patients living with chronic conditions by scaling up and enhancing the DSD models of care.

Lessons Learned

Although the project is in the infancy stage, great strides have been made through stakeholder engagement and data analysis thus assisting the project and the DoH in further defining its strategic outlook.

2. Strengthening Universal Health Coverage through disability-inclusive Primary Health Care: An action orientated toolkit for Health Care Services.

Intervention

1. An action-orientated disability inclusion toolkit for healthcare facilities in South Africa was co-created with healthcare staff and persons with disabilities in two developmental cycles.
2. In cycle one, a disability facility assessment tool was developed to increase awareness of disability accessibility and service delivery gaps in PHS in a simple and action-orientated way.
3. In cycle two, an intervention menu was created, enabling staff to identify solutions to improve accessibility and inclusion.

Lessons Learned

1. The process revealed that participating clinics only implemented a small portion of available solutions but embraced the idea of improving their facilities.

2. It also revealed that staff needed significant support to identify feasible solutions.

3. The Facilitators of the Implementation of Ward-Based Outreach Teams in Nkangala District.

Intervention

1. In 2012, Nkangala district established its first ward-based outreach team (WBOT) strategy as one aspect of the three-stream approach to Primary Health Care (PHC) re-engineering to strengthen health promotion, identify individuals at high risk of diseases, and build links between households and healthcare facilities.
2. Subsequently, an evaluation was carried out in 2016 to assess how the WBOTs programme is being implemented.

Lessons Learned

The key facilitators identified by program staff and recipients included community satisfaction with the outreach teams, high acceptance of the WBOTs, benefits derived from the WBOTs by programme staff, recipients, and health system, good relationship and collaboration with key stakeholders, provision of oversight, committed outreach teams, formalised appointment of OTLs, well defined roles and responsibilities of the outreach teams, and HCWs' satisfaction with supervision from OTLs.

4. A biopsychosocial model to improve viral load suppression and retention in care among adolescents: Application at clinic level by Mthembu N, Mbatha P, Dlamini S,

Intervention

1. Adolescents living with HIV experience poor retention in care, resulting in low adherence to antiretroviral therapy and subsequent virological failure.
2. Key contributory factors include an array of biological, psychological and social factors which are often not addressed or are overlooked in supporting the adolescent living with HIV.
3. The clinic-based intervention sought to identify and address the biopsychosocial issues that trigger the emotional, cognitive, and behavioural state of the adolescents resulting in treatment interruption, and was implemented from June to December 2022.

4. Four clinics in Zululand District, KwaZulu-Natal, were selected for implementation.
5. The key components were: capacity-building of staff on the KidzAlive social support programme; initiation and delivery of support groups for adolescents and caregivers for improved treatment adherence; and multi-disciplinary teams conducting Clinic Support Days for the provision of comprehensive HIV management.

Lessons Learned

1. At the beginning of the intervention in June 2022, the sample of 20 adolescents were virally unsuppressed.
2. In September, n=14 (70%) achieved viral suppression and in December, n=19 was virally suppressed. The viral suppression rate was therefore at 93.7%.
3. Adopting a biopsychosocial model reinforces the importance of the link between the healthcare provider and the caregiver in ensuring sustained outcomes.
4. The biopsychosocial model provides a lens through which the salient issues in the management of adolescents living with HIV can be identified and addressed, notably factors related to treatment adherence and retention in care.

5. Strengthening the quality of paediatric primary care with the Practical Approach to Care (PACK) Child: from concept to provincial implementation.

Intervention

1. PACK Child was developed and piloted in the Western Cape.
2. Adult Primary Care (APC) and Practical Approach to Care Kit (PACK) Adult are recognised by the Ideal Clinic initiative alongside IMCI as a go-to clinical decision support tool summarising national and provincial guidelines
3. The PACK Child guide collates and simplifies current evidence and policy for use in every primary health care (PHC) contact with a child 0–13 years old, extending and integrating curative and preventive care. Comprehensive in scope, it provides an approach to 63 symptoms, routine care of 16 long-term conditions, and a well child screen.
4. Now updated, and including substantial content reflecting new HIV/TB and mental health treatment policies, it is to be rolled out in the Western Cape.

Lessons Learned

1. Inclusion of long-term conditions, extension of age and screening of the well child shifted the paradigm of care from one of risk minimisation on the day (“saving the child today”) to one over time (“enabling the child to thrive”).

2. While desirable, routine screening of the well child imposed additional clinical caseload.
3. This has been mitigated through redistribution of tasks among staff (e.g., enrolled nurses interpreting weights they plot) and additional tools (e.g., 'Birth-to-two wheel').
4. Demand for a comprehensive package that addresses preventive and curative care of the child of all ages among PHC clinicians has endured, reflecting a changing profile of disease and increasingly decentralised treatment protocols for TB/HIV. PACK Child has successfully leveraged APC/PACK Adult to deliver an optimised programme for PHC.

6. Adult Primary Care Implementation at Amathole District to improve Clinical Management of a Patient at PHC by Tembela Lunika

Intervention

1. Adult Primary Care is a clinical tool guiding healthcare worker in an integrated management approach to effective patient clinical management.
2. To improve history taking by asking relevant questions leading to a correct diagnosis.
3. Integrate managing all conditions, give individual health education, and increase life expectancy.
4. Trainings conducted in 40 High volume facilities; facility Trainer then identified. Facility trainer to train the facility nurses on APC and supervise implementation. Later rolled out to all. Emphasis on facility training. Compels taking of vital signs at each visit, monitoring patients correctly. Follow patient held records. A mentoring strategy was developed. Identify and allocate mentor in each sub-district to visit facilities to coach and mentor nurses to become competent in using APC guide.

Lessons Learned

1. Training is not effective without mentoring.
2. Peer mentoring is necessary for effective learning.
3. The mentoring strategy has been approved and adopted at the province.
4. For effective implementation of mentorship, RTC is supporting the strategy by providing transport for onsite mentoring (Health establishment).

7. SRH/HIV/TB/GBV Integration in uThukela Health District

Intervention

1. Sexual and gender-based violence is a structural driver of HIV and tuberculosis – the latter being a leading cause of death among people living with HIV in South Africa.
2. Integration of operational programmes for sexual and reproductive health and HIV services, including referrals from one service to another, can maximise collective outcomes.

Lessons Learned

1. Minimum package of care achieved - clients receiving more than one service.
2. Client satisfaction improved.
3. SRHR indicators improved even during COVID-19 pandemic showing sustainability.

8. Organizational readiness and rehabilitation professionals' views on integrating tele rehabilitation (TR) into service delivery and students' clinical training.

Intervention

1. To assess the readiness of healthcare institutions that serve as clinical platforms for Stellenbosch University's rehabilitation students.
2. To explore the opinions of rehabilitation professionals regarding the integration of telerehabilitation into service delivery and students' clinical training.

Lessons Learned

1. Facilities struggle with funding and lack policies for TR, leading to financial and governance lack of readiness.
2. Professionals have positive attitudes but lack technical skills due to limited knowledge.
3. Students lack practical experience, confidence, and decision-making skills, also leading to a lack of technical readiness.

9. Psychological responses to COVID-19 amongst healthcare (HCWs) workers in South Africa during the pandemic.

Intervention


PROF B MASH
SPEAKER
DR AZ HELELO
SPEAKER

1. The overall objective of the study was to investigate the psychological responses of HCWs to COVID-19 in South Africa during the pandemic.
2. Methods: A quantitative approach using a cross-sectional survey design was used. A total of 103 questionnaires were administered.
3. Standardised and validated questionnaires were used in the survey including the Coronavirus-19 Fear Scale, the COVID- 19- related stigma scale and the COVID-19 stress scale. Data from a purposive sample was analysed using descriptive statistics and a chi-square

Lessons Learned

1. Many (76% and 54%) of respondents either knew someone close who contracted COVID or died from COVID-19 respectively.
2. Most (58%) were in favour of being vaccinated.
3. A significant proportion (42%; p= 0.009) of the HCWs felt uncomfortable when thinking about COVID-19
4. Physical reactions such as sweating, or a pounding heart was reported by 17% of the HCWs.
5. A majority of the HCWs disagreed to any form stigmatization of COVID19. Most of the HCWs expressed a need for mental health support during the COVID 19 pandemic. About three quarters of the respondents expressed a need to talk to someone about their worries about COVID 19. have someone available.

10. Pivoting an emergency response to strengthen Primary Health Care systems; the case of South Africa's COVID-19 response.

Intervention

1. In South Africa, the National Vaccine Program Management Office (VPMO), with support from USAID, was established to support the NDOH COVID-19 response.
2. The focus was to scale up COVID-19 vaccinations, through service delivery, and reaching populations at increased risk of COVID-19 morbidity and mortality.
3. introduction of electronic vaccination data systems for comprehensive COVID -19 vaccine recording, encompassing both public and private sectors, along with co-morbidity data,
4. implementation of robust health information systems, including GIS dashboards and epidemic modelling, for real-time data collection and informed decision-making,
5. strengthening of surveillance and early warning systems, particularly through wastewater surveillance, facilitating the rapid detection and response to emerging health threats,
6. investment in healthcare worker training and capacity building for pandemic preparedness and response,
7. ensuring healthcare facilities' resilience by equipping them to manage patient surges and maintain essential medical supplies,

8. promotion of community engagement and health literacy to empower the public with knowledge for disease prevention and control, especially in the context of COVID-19,
9. development of effective risk communication strategies to disseminate critical information during health emergencies,
10. collaboration with the private sector to enhance healthcare infrastructure, research, and innovation

Lessons Learned

1. These critical investments led to 37.4% of facilities integrating COVID-19 vaccinations into routine service delivery.
2. A significant proportion of at-risk populations were vaccinated: 67% of those vaccinated were over 60 years of age and 30% self-reported comorbidities: 9.4% reported living with HIV, 0.2% with TB, 4.5% with diabetes, 14.6% with hypertension, 0.8% heart disease and 0.3% lung disease and 0.2% cancer.
3. South Africa's response to COVID-19 demonstrates the importance of data-driven decisions, healthcare worker capacity, community engagement, and collaboration with stakeholders.

11. Documentation of Ideal Clinic Status Achievement in KwaZulu-Natal.

Intervention

The Ideal Clinic Realization and Maintenance Program (ICRM) introduced a set of standards for facilities and a quality improvement process involving manuals, district-based support, and external assessment.

Lessons Learned

KZN has progressed from 25% of Ideal Clinics in 2015/2016, to 50% in the following year, continued to strive the best such that its IC status in 2023/24 was 94% exceeding the set target of 85%.

12. A Multi-faceted Approach to Strengthening Pharmaceutical Systems at Primary Health Care Clinics in KwaZulu-Natal, South Africa.

Intervention

1. This study describes a multi-faceted approach to strengthen pharmaceutical systems at PHC clinics across all districts in KwaZulu-Natal. A multi-faceted approach to strengthen pharmaceutical services in all districts was applied.
2. Provincial Pharmaceutical Services embarked on a total quality improvement approach at primary health care level aligning people, processes, and tools to strengthen the delivery of pharmaceutical services.
3. Ongoing engagements took place with district and facility pharmacy managers, with a data driven approach to decision-making.
4. The focus was on standardising clinic formularies and tracer medicine lists used for routine reporting, enhancing use of pharmacy information systems, monitoring, and reporting of medicine availability using the National Surveillance Centre, the review and updating of standard operating procedures, and pharmacy staff skill sets.
5. A structured gap analysis was undertaken, and defined activities agreed to address gaps. An online questionnaire was sent to district pharmacy managers to assess the status of interventions implemented.

Lessons Learned

1. A bi-directional (top-down and bottom-up) approach was found to be effective.
2. While Provincial Pharmaceutical Services remains the overall driver of quality improvement, district and facility staff remain the implementation experts who critically review processes & tools & continuously engage & implement interventions (Feedback was received from 11/13 DPMs).
3. Pharmaceutical system strengthening requires a structured hands-on approach combined with robust monitoring and evaluation resulting in continuous medicine availability to patients.

13. Impact of collaborative psychosocial and clinical intervention for improving viral load suppression of HIV-positive children and adolescents in Primary Health Care facilities in eThekwini.

Intervention

1. In eThekwini District, children and adolescents living with HIV, particularly in locations with significant levels of poverty and poor health, are often faced with socio-economic burdens and societal stigma, which in turn leads to poor treatment adherence and unsuppressed viral load.
2. The social and clinical inequities of more adolescents contracting HIV and succumbing to AIDS are demonstrated by the inequalities fuelling the HIV epidemic, which have now been exacerbated by COVID-19.

Lessons Learned

The results showed a marked improvement in the three implementing facilities serving paediatric patients and in the four facilities where the focus was on adolescents.

14. The journey of Primary Health Care Outreach Teams taking services to the people of KwaZulu-Natal.

Intervention

This is a review of the impact of the KwaZulu-Natal PHC outreach teams in line with PHC re-engineering since their inception in 2012 to 2019/2020 financial year.

Lessons learned

1. Increase in the number of recruited dedicated personnel over the years.
2. Establishment of household champions at community- level.
3. Performance on most indicators(proxy) showing an improvement which could be attributed to the role of the Outreach teams.

15. Ensuring Quality of Clinical Care for Gender-Based Violence (GBV) in Ekurhuleni: Pilot Testing the South African adaptation of the GBV Quality Assurance Tool.

Intervention

1. A GBV Quality Assessment (QA) tool developed by WHO, CDC, and Jhpiego assesses the availability, accessibility, and quality of post-GBV clinical care and helps plan improvements.
2. We used the tool to asses services against 10 key domains, such as “Facility Infrastructure” and “Patient-Centred Care.” We are adapting this tool for South Africa, with a focus on meeting the needs of underserved populations.

Lessons Learned

1. Post-GBV health services in Ekurhuleni consistently provide comprehensive medical interventions to survivors who present to facilities, including HIV-related care, emergency contraception, antibiotics, and vaccinations.

2. Essential clinic infrastructure, documentation and supply management meet global standards. Unmet needs include improving accessibility and outreach for people with disabilities who experience GBV and specialized training for providers working with LGBTQI+ patients.

16. Enhancing Health Care Access: Best Practices for CCMDD Strategy in KwaZulu-Natal

Intervention

1. The Central Chronic Medicines Dispensing and Distribution (CCMDD) strategy in KwaZulu-Natal (KZN) is a healthcare delivery model that focuses on providing chronic medicines to patients in an efficient and patient-centred manner.
2. The strategy is designed to address the challenges of ensuring access to essential medicines for patients with chronic conditions, this is particularly important for patients in remote or underserved areas.

Lessons Learned

1. 35 Funda Fridays conducted with 2164 attendees from the operational level.
2. All 11 districts in KZN have appointed Clinical & Program managers as project leads for CCMDD.
3. The total number of active clients remaining on the program increased by 38.5% (695 143 to 963 044).

12. PLENARY 5: CLOSING

Dr. A. Zewdie: The International Institute for Primary Health Care in Ethiopia: it's role and contribution to PHC, Public Health Services and Challenges.

Background statistics

- Total Population: 110 + million
- Rural Population: 83%
- 14 Regional states and 2 City Administrations
- It is a diverse country with multi-ethnic.
- PHC coverage: 100%

Ethiopian Health care delivery system

1. The Ethiopian health services are structured into primary, secondary and tertiary levels of care.
2. The primary level of care includes primary hospitals (286), health centre's (3,831) and health posts (17,555).
3. The Primary Health Care Unit comprises five satellite health posts (the lowest-level health system facility, at the village level), a health centre and a primary hospital.
4. The secondary level of care consists of general hospitals and the tertiary level consists of specialized hospitals (70 general and 18 specialized).

The Ethiopian Health Extension Programme (HEP)

- Community-based PHC based on PHC values.
- Launched in 2003.
- Health Sector Development Plan (HSDP) evaluation finds access to health care is limited, low Health Workforce (HWF) to population ratio.
- A low-income country, a commitment to attain MDGs.
- Paradigm shift: households and communities as producers of health.
- Deployment of salaried health extension workers.

Achievements

1. 1,303 PHC leaders trained on leadership.
2. Uncontrolled Hypertension (HTN) screening 1,658.
3. 3,107 trained on Resilient Health system course.
4. 2,661 participants on 14 webinars form over 34 countries.
5. 123 Global PHC course participants.
6. 27 country delegates, experience sharing visit.
7. 1,329,262 hit counts – resource centre.
8. 550 in person and 1,400 virtual participants of International Conference on Primary Health Care (ICPHC): call to action.

Key lessons

1. PHC systems based on PHC values evolves to meet the growing and changing demand.
2. Primary Health Care (PHC) is the means to attain Universal Health Coverage (UHC).
3. Huge need to learn on best practices and country experience.
4. Local institutions are key in advancing PHC and PHC agenda.
5. High political commitment essential to accelerate the momentum.

12.2 Dr. Owen Kaluwa, Country Representative, WHO: Reflections from WHO South Africa

Dr. Kaluwa's reflection on the 2-day PHC conference touched on a number of issues summarised as follows:

He reminded the conference participants of the official definition of PHC from the 1978 Alma Ata conference: An approach to deliver essential health care made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford in the spirit of self-reliance and self-determination. (i.e.: Health care for all, by all, and with all).

He laid emphasis on the constructs of the PHC approach that were envisioned: the **Five principles:** accessibility, public participation, health promotion, appropriate technology and intersectoral cooperation; the **Four pillars:** community participation, intersectoral coordination, appropriate technologies, and support mechanisms and the e**ight components**: health education; Maternal and child health care; proper nutrition; Immunization; safe water supply; basic sanitation; Prevention and control of locally endemic diseases; treatment for common ailments.

He asked the conference to also take cognizance of how the paradigms driving PHC operationalization in African Health Systems has evolved since 1978: Selective PHC => Bamako Initiative => Cost-effectiveness => MDGs => SDGs/UHC

Revitalized PHC (Astana declaration, 2018): A whole-of-society approach to health that aims at ensuring the highest possible level and distribution of health and well-being by focusing on people's need: health promotion, disease prevention, diagnostic, treatment, rehabilitation and palliative interventions provided as close as feasible to their everyday environment.

He reminded that PHC Services centred around the person for all health and wellbeing needs (health sector, plus other sectors addressing social, economic, environmental, and political determinants), across the care continuum (promotion, prevention, diagnostic, curative, rehabilitative, palliative), for all age cohorts (pregnant mothers, newborns, children, adolescents, adults, elderly – life course)

Dr. Kaluwa went on to say that revitalized PHC approach entails the following:

1) A whole-of-society approach that
(2) focuses on addressing the integrated individual's/family's needs and preferences,
(3) along the continuum from health promotion and disease prevention to treatment, rehabilitation, and palliative care, and
(4) as close as feasible to the people's everyday environment and that these must lead to attainment of UHC, ensure Health Security and address the social determinants of Health

He talked about the need to apply strong and focused PHC approaches to develop national health systems, which will result in better systems functionality. This is the way to assure us that we will get the expected results to achieve the SDG goals and Health for All.

Dr. Kaluwa stated that, "Primary Health Care is a comprehensive approach that provides accessible, affordable, and equitable health care services. It focuses on community-based health services, prevention, health promotion, and addressing social determinants of health. Primary Health Care is essential for driving improvements in health care services and outcomes, making it the foundation of Universal Health Coverage and a resilient health system."

He charged the participants to leave the conference reminding themselves with emphasis of the following:

- Reinvigorating Primary Health Care.
- Multisectoral - working together and not in silo.
- Multidisciplinary team approach (mental health services, school health services, RMNCH services, immunization etc.)
- Integration of services – integrated PHC.
- Continuum of care from birth to death (Life-course approach)
- Need to work together with the Local Government System – to address other social determinants of health including strongly environmental health - everyone's business.
- Address inequity and ensure equality, human rights and social justice
- Strong community engagement (Empowerment)
- Adequate financing and investment across the health system (health workforce, health infrastructure, health products, delivery systems, information system, financing processes, governance and leadership processes)
- Adequate human resources- capacity, adequacy, mix, placement, equity,
- Ensure Quality of PHC services, supervision and monitoring
- Emphasis on health promotion and prevention of diseases
- Bridge the gap between PHC and secondary and tertiary services, and ensuring efficient referral system across levels of care

- Identify areas of excellence and learn from those areas. (centres of excellence, scale up best practices), scaling innovations.
- Importance of data and use of data for planning and decision making.

PHC, he said must work within a sound District Health System Policy Framework and Strategy to achieve UHC/SDG. He indicated that South Africa, is already a step in the right direction with the development of the draft South Africa District Health Systems Policy Framework and Strategy 2024 -2039stating that a good_District Health system is a vehicle through which PHC is driven to achieve UHC/Health for All/SDG).

In Conclusion, the WHO Country Representative said it has been 2 days of good deliberations. “As we leave here, let is renew our commitment to PHC. WHO is happy to be associated with the maiden SAPHC Conference. Monitoring for any progress begins from now as SA recommit and rededicate itself”.

12.3 CLOSING ADDRESS: Dr. Sibongiseni Dlhomo - Deputy Minister of Health

Dr. S. Dlhomo in his closing remarks took the opportunity to pay homage to Members of the Executive Council for Health and other dignitaries present. These included Dr. Owen Kaluwa, WHO Country Representative, Heads of Provincial Departments of Health and their staff, Managers and staff from the National Department of Health, Dr Themba Moeti, CEO of HST, Trustees of the HST, International Guests, Academics and Researchers, Representatives from the private sector and development partners, Representatives from NGOs and civil society organizations and all delegates in attendance.

He indicated that September 2023 marked 45 years since the historic Alma Ata Conference on Primary Health Care in Kazakhstan, and October 2023, marked five years since the International PHC Conference in Astana. He informed delegates that South Africa is a signatory to the SGGs.

To give effect to the realisation of the SDGs, the National Development Plan 2030 of South Africa reaffirmed the country's commitment to strengthening the PHC approach at the community level. There is no better time than now for South Africa, Africa, and the world to accelerate the implementation of UHC.

A key focus of the 1978 Alma Ata Declaration on Primary Health Care PRIMARY HEALTH CARE was the inequity in health service provision across the world. The 2018 Astana Declaration on Primary Health Care furthered the aims of Alma Ata Declaration and emphasized that countries in striving for UHC should amongst others.

1. Increase capacity-building of all health cadres.
2. Support research and share knowledge and experience while learning from each other and taking onboard good practices from other countries.

The Astana Declaration encourages countries to periodically review the implementation of this Declaration, in cooperation with stakeholders. This has been the purpose of this Conference. "We are using this conference to hear what stakeholders are saying about South Africa's Primary Health Care services. We have eagerly listened to hear from you what in your opinion is working well and what are weaknesses. Your input will culminate in a conference report that will guide our planning and implementation of Primary Health Care services within South Africa's district health system going forward" Dr. Dlhomo said.

"It is refreshing and very important that we were able to listen to the voices of PHC facility operational managers. These voices are strong, these voices know what should happen at the service delivery level and these voices must be listened to" he said.

He tabulated the following key lessons that participants need to take away from the conference:

1. The need to further strengthen community outreach services to reach patients, including those with disability. This points to the importance of the CHW programme and a need to formalise various aspects of this programme.
2. Community participation needs to be standardized and formalized.
3. The importance of E-health for record-keeping, tracing patients that migrate between facilities and for continuity of care. E-health will save money and improve outcomes. In this regard leverage existing technology to design smart future solutions.
4. Use a single digital platform for comprehensive health promotion and disease prevention.
5. The need to stop assuming that “communities know” and elevate community education approach.

13. DECLARATION BY DELEGATES FROM THE SOUTH AFRICAN PRIMARY HEALTH CARE CONFERENCE

The conference concluded with the delegates adopting the declaration

We, the representatives of the government of South Africa; organised labour; Non-governmental organisations (NGOs); Community-based Organisations; broader civil society; academic institutions; research organisations; private health sector; and our social and development partners, gathered at the South African Primary Health Care Conference embracing the theme : Towards Universal Health Coverage - Strengthening Primary Health Care in East London, on 15 and 16 November 2023, reaffirming the commitments expressed in the Declaration of Alma-Ata of 1978, the Declaration Astana of 2018, the 2030 Agenda for Sustainable Development and our National Development Plan 2030, in the pursuit of Health for All, hereby make the following commitments:

Universal Health Coverage (UHC)

We reaffirm our commitment to attain Universal Health Coverage (UHC) recognising the right for all people to access quality health services where and when required without financial hardships.

We will, within South Africa's District Health System and within available resources, prepare for the implementation of the National Health Insurance (NHI), which is South Africa's chosen pathway to achieve future funding mechanisms to support the achievement of UHC.

We will pursue the Primary Health Care (PHC) approach as the foundation and heartbeat of a system for the provision of comprehensive health services.

We will strive to mobilise resources to ensure that the District Health System Policy Framework and Strategy 2024-2029 is adequately financed and implemented.

Collaboration with partners on Social Determinants of Health

We believe that addressing Social Determinants of Health (SDH) is crucial for achieving better health outcomes, and will strengthen relations within government, across sectors and with the government's social partners.

We will strive to strengthen the district health planning process in alignment with the multisectoral District Development Model (DDM) for integrated, comprehensive and coordinated plans.

We will continue to strengthen our public health capacity for pandemic prevention, preparedness and response and improve our surveillance systems.

Service Delivery Platform

We commit ourselves to improving the overall quality of care delivered by the national health system moving towards UHC.
We will strengthen our referral system for users of health services to be referred from PHC level to the most suitable level of care in line with the package of service to receive optimal care, and access the appropriate specialist services, in accordance with their health needs.

We will attend to and manage, appropriately, persons who are down referred to PHC facilities.

We will continue to improve the service delivery platform comprising Ward Based Primary Health Care Outreach Teams (WBPHCOTs), Integrated School Health Teams (ISHTs), Environmental and Port Health services, mobile and fixed Clinics, Community Health- and Day Centre (CHCs, CDCs) and District Hospitals, amongst others, through the Ideal Health Facility Realisation and Maintenance Programme (ICRM) in South Africa.

District Clinical Specialist Teams (DCSTs) will continue to provide clinical governance, support and guidance to health facilities.

We recognize communities as our central and crucial partners in health care. We will therefore continuously strive for enhanced partnership and collaboration with communities in the development and implementation of human rights-orientated health policies and services.

We will continue to mobilise resources to build and maintain facilities with appropriately trained, qualified and skilled Human Resources for Health, who are responsive to the health needs of communities, working in a conducive environment supported by good

infrastructure, information technology infrastructure and all essential medical equipment and support systems in our facilities.

We will continue to strive for harmonization and management of data systems to enable contextual planning and astute use of resources.

We will strive for equity in the distribution of all health resources, in accordance with the health needs of communities.

We voluntarily and collectively endorse this declaration of the South African National Primary Health Care Conference, held on 15 and 16 November 2023, in Buffalo City Metropolitan Municipality, Eastern Cape Province, South Africa.


CONFERENCE
LETS
GROW
SOUTH
AFRICA
TOGETHER
SAPHC
2023
SOUTH AFRICAN
PRIMARY HEALTH CARE
CONFERENCE
World Health
Organization
TOWARDS UNIVERSAL HEALTH COVERAGE -
STRENGTHENING PRIMARY HEALTH CARE:
A WHOLE OF GOVERNMENT, WHOLE OF SOCIETY APPROACH
VISION

14. CONCLUSION

The conference affirm that Health is a development investment, not an expenditure. It is therefore important to have confidence in relevant, home-grown innovations, bringing them to scale and creating more synergy across sectors. By this Conference, a blueprint for UHC in South Africa has been created. It is therefore imperative that government of South Africa to go beyond political will and take action on global, regional and local commitments, ensuring that no one is left behind.

Health is a right and all must ensure that services are universally available, accessible, affordable and acceptable and of quality and that they are provided without discrimination. There is no one-size-fits-all model for Universal Health Coverage; there is therefore the need to strengthen collaboration between government and development partners.

All partners must prioritise the achievement of Universal Health Coverage, align their activities with government strategies and plans, coordinate their efforts and jointly monitor and report on progress. Young people and communities should self-organise, participate in discussions on Universal Health Coverage and demand their right to health.

The SAPHC 2023 was officially brought to a closed by Dr T. Masilela on behalf of the Director-General of Health, Dr. SSS Buthelezi

15. REFERENCES

1. World Health Organization. The World Health Report 2008: Primary Health Care – Now more than ever. Geneva: WHO; 2008. https://apps.who.int/iris/bitstream/handle/10665/43949/9789241563734_eng.pdf?sequence=1&isAllowed=y .
2. The Presidency, Republic of South Africa. Twenty Year Review South Africa 1994–2014. Pretoria: 2014. https://www.dpme.gov.za/news/Documents/20%20Year%20Review.pdf
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6. World Health Organization and United Nations Children's Fund. A vision for Primary Health Care in the 21st Century – Towards universal health coverage and the Sustainable Development Goals. Geneva: WHO & UNICEF; 2018. https://apps.who.int/iris/bitstream/handle/10665/328065/WHO-HIS-SDS-2018.15-eng.pdf?sequence=1&isAllowed=y.

ANNEXES

Annex A: Sponsors

1. World Health Organization (WHO).
2. Health Systems Trust (HST).

Annex B: Organising and Scientific Committee Members:

B1. Organising Committee

GOVERNMENT	HEALTH SYSTEMS TRUST	WHO
Ms. Jeanette Hunter	Dr Themba Moeti	Dr. Sithembile Dlamini-Nqeketo
Mr. Thulani Masilela	Ms. Ronel Visser	Dr. Koku Awoonor-Williams
Mr. Ramphelane Morewane	Rakshika Bhana	
Mr. Kgwiti Mahlako	Mr. James Michael Burnett	
Ms. Yvonne Mo Kgalagadi	Ms. Judith King	
Ms. Caroline Ngoepe		
Ms. Milly Bok		
Ms. Maneo Dichaba		
Dr. Evangeline Mthethwa		
Ms. Lindiwe Madikizela		

B2. Scientific Committee

NO	Name	Designation	Contact
1	Kgwiti Mahlako	Director: Primary Health Care	Kgwiti.Mahlako@health.gov.za
2	Aneliswa Cele	Chief Director: Environmental and Port Health Services	Aneliswa.Cele@health.gov.za
3	Koku Awoonor-Williams	WHO HSS Consultant	awoonorwilliamsj@who.int
4	Thulani Masilela	DDG: DPME	thulani.masilela@dpme.gov.za
5	Rakshika Bhana	Programme Manager	Rajshika.Bhana@hst.org.za
6	Michael Burnett	Senior Researcher	michael.burnett@hst.org.za
7	Fiorenza Monticelli	Business Development Specialist	Fiorenza.Monticelli@hst.org.za
8	Nqobile Myende	Research Assistant	Nqobile.Myende@hst.org.za
9	Susanna Naude	Training Manager	Susanna.Naude@hst.org.za

Annex C: Abstract Track Reviewers

No	Reviewer 1	Reviewer 2	Affiliation
1	Aneliswa Cele	Koku Awoonor-Williams	Director: Primary Health Care
2	Thulani Masilela	Kgwiti Mahlako	Chief Director: Environmental and Port Health Services
3	Nqobile Myende	Susanna Naude	WHO HSS
4	Rakshika Bhana	Ronel. Visser	DDG: DPME
5	Aneliswa Cele	Koku Awoonor-Williams	Programme Manager
6	Thulani Masilela	Kgwiti Mahlako	Senior Researcher
7	Nqobile Myende	Susanna Naude	Business Development Specialist
8	Rakshika Bhana	Ronel Visser	Research Assistant
9	Aneliswa Cele	Koku Awoonor-Williams	Training Manager

Annex D: Partner led sessions:

NO	ORGANISATION	TITLE SESSION
1.	Rural Health Advocacy Project	Rural Health Equity


SAPHC
2023


PROF B MASH
SPEAKER
DR AZ HELELO
SPEAKER

CONFERENCE PROGRAMME

SAPHC 2023

SOUTH AFRICAN PRIMARY HEALTH CARE CONFERENCE

14 – 17 NOVEMBER 2023

East London International Convention Centre

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

planning, monitoring & evaluation
Department:
Planning, Monitoring and Evaluation
REPUBLIC OF SOUTH AFRICA

World Health Organization

HEALTH SYSTEMS TRUST

2030 NDP

THEME

TOWARDS UNIVERSAL HEALTH COVERAGE – STRENGTHENING PRIMARY HEALTH CARE

SAPHC 2023
SOUTH AFRICAN PRIMARY HEALTH CARE CONFERENCE

DAY 1 — TUESDAY 14 NOVEMBER 2023

14:00 – 18:00 - **REGISTRATION & NETWORKING**

18:00 – 22:00 - **SUPPER**

DAY 2 — WEDNESDAY 15 NOVEMBER 2023

07:00–09:00	REGISTRATION		
PLENARY 1 – GOVERNANCE FOR UHC			
09:00–11:00	Official Opening: Program Director: Director -General - Dr Sandile SS Buthelezi Scribe1: Ms Charlyn Goliath Scribe 2: Ms Jennifer Coetzee Scribe 3: Ms Thembokuhle Karigani		
	09:00 – 09:05	Singing of the National anthem	Rhodes University: Makhanda Kwantu Choir
	09:05 – 09:15	Opening and welcome	Ms Nomakhosazana Meth MEC for Health Eastern Cape Department of Health
	09:15 – 09:45	Primary Health Care Services in South Africa	Mr Thulani Masilela Outcomes Facilitator for Health Department of Planning, Monitoring and Evaluation (DPME)
	09:45 – 10:05	The NHI is coming: How do we make community participation more meaningful in a plural health system?	Professor Leslie London Professor in Public Health in the School of Public Health at the University of Cape Town, South Africa

DAY 2 CONTINUED

09:00–11:00	10:05 – 10:25	Regional Perspective - Towards universal health coverage - strengthening primary health care	Dr Matshidiso Moeti WHO Regional Director WHO AFRO Region
	10:25 – 10:30	Introduction of Minister of Health	Ms Nomakhosazana Meth MEC for Health Eastern Cape Department of Health
	10:30 – 10:55	Key note address	Dr Mathume Joe Phaahla, Minister: Health
	10:55 – 11:00	Entertainment	Rhodes University: Makhanda Kwantu Choir
11:00–11:30	**TEA and POSTERS**		
PLENARY 2 – MUNICIPALITY SERVICES AND SOCIAL DETERMINANTS OF HEALTH			
11:30–13:15	Program Director: Acting Deputy Director -General - Mr Ramphelane Morewane Scribe 1: Ms Mavis Matlala Scribe 2: Ms Yvonne Mokgalagadi Scribe 3: Mr Abednego Mvula		
	11:30–11:45	A framework for implementation of community-orientated primary care in the Metro Health Services, Cape Town, South Africa	Prof Bob Mash Executive and Divisional Head Department of Family and Emergency Medicine Stellenbosch University
	11:45–12:00	Environmental and Port health in South Africa- Good practices and challenges	Ms Aneliswa PR Cele Chief Director Environmental Health and Port Health Services
	12:00–12:15	Improving the quality of social determinants of health	Mr Sikheto Nector Mavundza: Senior Manager Municipal Health South African Local Government Association
	12:15–12:30	The implementation of the integrated school health policy: the successes and shortcomings	Dr Amanda Rozani Presentation from Department of Basic Education
	12:30–12:45	The Nexus between Housing Affordability and Health: Lessons from the Informal Settlements in South Africa	Dr. Nana Mhlongo Presentation from Department of Human Settlements
	12:45 – 13:15 **DISCUSSION**		

WEDNESDAY 15 NOVEMBER 2023

13:15–14:15	**LUNCH**						
TRACKS SESSION ONE							
14:15-15:45	**Session 1.1** **Track 1** Service delivery platform	**Session 1.2** **Track 2** Universal Health Coverage and National Health Insurance	**Session 1.3** **Track 3** Integration of priority programmes into PHC	**Session 1.4** **Track 4** Human resources for health and Primary Health Care	**Session 1.5** **Track 5** Technology, digitisation & innovation for client focussed public	**Session 1.6** **Track 6** Addressing the social determinants of health through partnership	**ROUND TABLE** Session on Rural Health Equity by Rural Health Advocacy Project (in the main plenary hall) 14:00 – 15:00
	Chair Ms Jeanette R Hunter	**Chair** Prof Nicolas Crisp	**Chair** Mr Kgwiti Mahlako	**Chair** Dr Percy Mahlati	**Chair** Mr Ramphelane Morewane	**Chair** Ms Aneliswa Cele	
	Scribe 1 Ms Boitumelo Langa **Scribe** 2 Mr MO Motlhabane	**Scribe 1** Ms Felicity Basson **Scribe** 2 Mr. Simon Choma	**Scribe 1** Dr Nompumelelo Ntshangase **Scribe 2** Ms. Madidi Madolo	**Scribe 1** Ms Milly Bok **Scribe 2** Ms Thembelihle Maphalala	**Scribe 1** Mr Neeran Jooste **Scribe 2** Ms Roma Ramphal	**Scribe 1** Ms Yvonne Mokgalagadi **Scribe 2** Ms Linda Dlamini	
	14:15 -14:30						
	ID 93: Adapting Adult Primary Care (APC)/ Practical Approach to Care Kit (PACK) Adult to address multi-morbidity: towards streamlined, integrated, person-centred care Mareike Rabe	Nurse-led delivery of Primary Health Care Ms Lynda Toussaint - Unjani	ID 15: Facilitators and Barriers to the Integration of Non-communicable Diseases with HIV Care at Primary Health Care in Ethiopia: A qualitative analysis using CFIR. Abebe Sorsa Badacho	ID 52: Evaluating the Role of Primary Care in Clinical Associate Training within South African Healthcare: a Mixed Method Study Dr Sanele Ngcobo	ID 34: Amandla Mama: Optimizing behavioural intention and knowledge of women and their partners in the perinatal period: a randomized control trial in the Tshwane district, Gauteng province Zwannda Kwinda	ID 24: Pesticide Residues Seasonal Variation in Shallow Groundwater and Health Risk Assessment: Gokwe-Nemangwe ward-11, Zimbabwe Siphiwe Makamure	

DAY 2 CONTINUED

14:00-15:45	14:30 –14:45					
	ID 73: An evaluation of the pilot phase of the implementation of an integrated chronic disease clinical stationery in the Ekurhuleni health district, 2022-2023 Dr Sayuri Pillay	ID 68: Road to UHC – South Africa's progress towards universal health coverage Celene Coleman	ID 16: Sustainability of Integrated Hypertension and Diabetes with HIV Care for People Living with HIV at Primary Health Care in South Ethiopia: Implication for Integration Abebe Sorsa Badacho	ID 103: Challenges faced by Healthcare Professionals in reporting Near Miss Incidents in a Hospital, at the Amathole District, Eastern Cape Province, South Africa Lindiwe Ntlanganiso	ID 55: Enhancing medication access in healthcare facilities: A systematic approach for Smart Locker installation Roma Ramphal	ID 41: Thrive to Five - Building the case for a national home-based, parent-led responsive care and early learning programme. Rachel Rosentals-Thresher
14:00-15:45	14:45 - 15:00					
	ID 90: Comparative analysis of ideal clinic realization in Ugu District Comparative analysis of ideal clinic realization in Ugu District: does ideal status translate to ideal outcomes Linda Dlamini	ID 147: How consistent use of Synchronised National communication in Health in Zululand District supports patients' continuity of care Khambule Nandi	ID 33: Men's Health - don't leave them behind! Malebo Maponyane	ID 152: Data quality assessment of malaria information systems in two endemic provinces of South Africa, 2020 – 2023 Ziyanda Fekema	ID 96: How digital chatbots can improve skills to reduce intimate partner violence among young women in South Africa. Courtney Moxley	ID 121: A framework for intersectoral collaboration on safe water provision as a social determinant of health in South Africa MY Mokgalagadi
14:00-15:45	15:00 -15:15					
	The CHW Programme in NW Province – A CHW Perspective Lorato Sampisi	ID 65: Analysis of General Practitioner (GP) Contracting for Primary Healthcare (PHC) using the NHI strategy in Ugu District, South Africa Linda Dlamini	ID 43: Strengthening primary healthcare through collaboration between public healthcare workers and traditional health practitioners: a capacity building intervention in 8 districts in KwaZulu-Natal, South Africa Andisiwe Canca	ID 159: A case study to establish the Phuthuma project effectiveness in assisting the department to reach its HIV and AIDS targets: Experiences from the North-West province, South Africa, April 2022 - March 2023 Ms Joan Lesetedi	ID 113: Virtual demand creation: Lessons learnt from a knowledge sharing and demand creation platform co-designed with Men who have sex with men in South Africa. Letitia Rambally Greener	ID 137: Addressing the social determinants of health through partnerships and collaboration: The Environmental Health approach Dr. Moeti Kgware

WEDNESDAY 15 NOVEMBER 2023

14:00-15:45	15:15 – 15:30					
			ID 93: Adapting Adult Primary Care (APC)/ Practical Approach to Care Kit (PACK) Adult to address multi-morbidity: towards streamlined, integrated, person-centred care Mareike Rabe		ID 115: Operationalizing the COVID-19 Electronic Vaccination Data System: Lessons Learned to Inform Future Information Systems for a Life-Course Vaccination Program in South Africa Ms M Wolmarans	ID 42: Enhancing governance and leadership for transformative change in the Ideal Clinic Realization and Maintenance programme: A case study from the Limpopo province Dr Imke B Engelbrecht
	15:30 -16:00 **DISCUSSION**					
16:00 – 16:30	**TEA and POSTERS**					

TRACKS SESSION TWO						
16:30-17:30	**Session 2.1** **Track 7** Community participation and role of civil society	**Session 2.2** **Track 8** Health promotion and behaviour change	**Session 2.3** **Track 9** Continuous quality improvement	**Session 2.4** **Track 10** Epidemic preparedness, and emerging health challenges: building a resilient PHC system fit for the 21st century	**Session 2.5** **Track 3** Continued Integration of priority programmes into PHC	**Session 2.6** **Track 5** Continued Technology, digitisation and innovation for client focussed public health
	Chair Mr Jabulani Mndebele	**Chair** Dr Grace London	**Chair** Dr Cheryl Nelson	**Chair** Dr Anban Pillay	**Chair** Mr Kgwiti Mahlako	**Chair** Mr Ramphelane Morewane
	Scribe 1 Dr Jennifer Nash **Scribe** 2 Ms Anne Dibakwane	**Scribe 1** Mr Ishmael Mtungwa **Scribe 2** Ms Thembeka Semenya	**Scribe 1** Mary Setlogelo **Scribe 2** Ms Mosela Mokhutshwane-Kaudi	**Scribe 1** Mr Beketsana **Scribe 2** Ms Zama Kiti	**Scribe 1** Ms Signoria Ntshanga **Scribe 2** Ms Deliwe Nkosi	**Scribe 1** Dr Evangeline Mthethwa **Scribe 2** Ms Nicolien Bosch

DAY 2 CONTINUED

16:30-17:30	16:30 – 16:45					
	ID 9: Perspectives on substantive community participation in primary health care in Lindelani settlement, Greytown, South Africa Angela Hartwig	ID 37: Foodborne disease surveillance in Ncerha villages, Eastern Cape, South Africa: food safety a primary healthcare concern Khanya Bisholo	ID 30: How can doctors in district hospitals receive specialist internal medicine support? BAMSI - an innovative virtual approach Dr Jenny Nash	ID 18: Antimicrobial Resistance in Gauteng province, South Africa, 2014-2021 Nomathamsanqa Ndhlovu	ID 123: Using mobile clinics to improve access to cervical cancer screening for women in poorly resourced areas of KwaZulu-Natal Nompumelelo Ntshangase	ID 130: Implementation of Health Patient Registration System in Xhariep District Dr Caka EMN
16:30-17:30	16:45 – 17:00					
	ID 35: Community Engagement and Participation in delivering community-based COVID-19 vaccination in Zululand Mzikazi Masuku	ID 100: Community-Centred Health Promotion: SARCS's Response to COVID-19 in South Africa Koketso Thema	ID 39: Triangulating the impact of distributed leadership in a quality improvement programme in South Africa Willem Odendaal	ID 21: Neglected mental health of healthcare workers in the eastern cape; implications for future disaster strategies and planning Dr Oladele Vincent Adeniyi	ID 140: Malaria Programme Review Series 2019-2023: Case Management Findings and Key Recommendations to Strengthen Service Delivery at Primary Health Care Level Ednah R Baloyi	ID 149: Using Technology to digitalise intrapartum records and reduce litigation risk Dr Sibongile Mandondo
	17:00- 17:15 **DISCUSSION**					
17:15 – 18:30	**BREAK**					
18:30 – 22:00	**GALA DINNER (SPEAKERS AS WELL AS ENTERTAINMENT)**					

DAY 3 THURSDAY 16 NOVEMBER 2023

PLENARY SESSION 3 – THE NELSON MANDELA - FIDEL CASTRO MEDICAL PROGRAMME			
08:30 – 09:30	Program Director: Deputy Director -General - Dr Percy Mahlathi Scribe 1: Ms Mavis Matlala Scribe 2: Ms Yvonne Mokgalagadi Scribe 3: Mr Abednego Mvula		
	08:30 – 08:35	Opening and Welcome	Programme Director
	08:35 – 08:50	The Cuban Family Medicine Primary Health Care Experience	Dr Victor Francisco Figueroa Velar Family Physician, Gauteng Department of Health
	08:50: – 09:05	My Primary Health care Journey from Cuba to South Africa	Dr Nonhlanhla Khumalo Wits University
	09:05 – 09:20	The Nelson Mandela Fidel Castro Programme: Partnership in Practice	Professor Richard Cooke Wits University
	09:20 – 09:35 DISCUSSION		
MOVE TO PARALLEL SESSIONS			

NOTES

DAY 3 CONTINUED

TRACKS SESSION TWO CONTINUED						
09:45 – 10:45	**Session 2.1** **Track 7** Community participation and role of civil society	**Session 2.2** **Track 8** Health promotion and behaviour change	**Session 2.3** **Track 9** Continuous quality improvement	**Session 2.4** **Track 10** Epidemic preparedness, and emerging health challenges: building a resilient PHC system fit for the 21st century	**Session 2.5** **Track 3 Continued** Integration of priority programmes into PHC	**Session 2.6** **Track 5 Continued** Technology, digitisation and innovation for client focussed public health
	Chair Mr Jabulani Mndebele	**Chair** Dr Grace London	**Chair** Dr Cheryl Nelson	**Chair** Dr Anban Pillay	**Chair** Mr Kgwiti Mahlako	**Chair** Mr Ramphelane Morewane
	Scribe 1 Dr Jennifer Nash **Scribe** 2 Ms Anne Dibakwane	**Scribe 1** Mr Ishmael Mtungwa **Scribe 2** Ms Thembeka Semenya	**Scribe 1** Mary Setlogelo **Scribe 2** Ms Mosela Mokhutshwane-Kaudi	**Scribe 1** Mr Beketsana **Scribe 2** Ms Zama Kiti	**Scribe 1** Ms Signoria Ntshanga **Scribe 2** Ms Deliwe Nkosi	**Scribe 1** Dr Evangeline Mthethwa **Scribe 2** Ms Nicolien Bosch

	09:45 – 10:00					
09:45 – 10:45	ID 114: Leading from the Coal Face - A Pioneering Initiative to Strengthen Community-Based Surveillance and Response in KwaZulu Natal Ms Babongile Mhlongo	ID 139: Reported psychological stress and physical health symptoms among medical laboratory professionals following the COVID-19 pandemic - South Africa, 2022 Danai Kwenda	ID 92: Every system is perfectly designed to get the results it achieves: Patient experience of care and waiting times. Linda Dlamini	ID 22: Patterns and trends of sexual violence against adults and children pre- and during the covid-19 pandemic in the Eastern Cape, South Africa Dr Oladele Vincent Adeniyi	ID 77: Using decayed, missing and filled teeth index to guide oral disease prevention in the Primary Health Care setting Dr C.E. Potgieter	ID 151: Malaria microscopy quality improvement in support of South Africa's malaria elimination goal, with reference to the National Institute for Communicable Diseases' activities Lisa Ming Sun

THURSDAY 16 NOVEMBER 2023

09:45 – 10:45	10:00 – 10:15					
	ID 127: Utilizing routine health data and community engagement workshops to quantify and qualify the impact of transport costs on government service access for people with disabilities Maryke Bezuidenhout	ID 142: Health promotion through a true-peer support model, Coach Mpilo for MSM Lungile Zakwe	ID 122: "Without support, we are nothing" - Applying mentorship to support inter-professional collaboration: Lessons from the implementation of a multi-pronged person-centred care intervention	ID 53: Linkage to care trends for GeneXpert Diagnosed Rifampicin Resistant Tuberculosis, North-West Wellington Maruma	ID 64: Primary health care nurses' knowledge, self-efficacy and performance of diabetes self-management support in the O.R. Tambo district, Eastern Cape Zandile Kolosani Landu	ID 62: The implementation of Patient Administration System in the Primary Health Care facilities: National Health Insurance preparation Sehloho R
09:45 – 10:45	10:15 – 10:30					
	ID 105: Unlocking Potential: Strategies to Promote Health and Wellness Uptake Among Young Males in Deprived Areas through Youth Development Organizations Camilla J S Oborne	ID 120: Supporting a people-centred health system to drive person-centred care: Lessons from a healthcare provider driven and co-designed patient centred care implementation science intervention Letitia Rambally Greener	ID 47: Assessing Diagnostic Delay in Axial Spondyloarthritis in South Africa. Results from the International Map of Axial Spondyloarthritis (IMAS). Makan K	ID 129: Nurturing the health professional educational sub-system to ensure pandemic preparedness Christy-Joy Ras	ID 138: Lessons learnt in implementing an enhanced HIV case management model in uMgungundlovu District, South Africa Nkululeko Sokhela	ID 25: Implementing active surveillance for TB in the Eastern Cape Febisola Ajudua
	10:30 – 10:45 DISCUSSION					
10:45 – 11:15	TEA and POSTERS					

DAY 3 CONTINUED

PLENARY 4 – REPORT BACK – GOOD PRACTICES			
11:15–12:50	Facilitator: Dr Themba Moeti (Health System Trust)		
	11:15 – 12:50	Report on good practices Tracks 1 to 10	Session Chairs

PLENARY 5 – CLOSING			
13:00 – 14:30	Program Director: Director -General - Dr Sandile SS Buthelezi		
	13:00 - 13:10	Remarks	Programme Director
	13:10 - 13:25	The International Institute of PHC-Ethiopia; its role in the health system, its contribution to PHC/ public health services - challenges	Dr Anteneh Zewdie
	13:25 - 13:35	Reflections from WHO South Africa	Dr Owen Kaluwa
	13:40 – 13:50	Reading of the Conference Statement	DHS Team (National and Provincial)
	13:50 – 13:55	Introduction of the Deputy Minister	Dr SSS Buthelezi DG National Department of Health
	14:00 – 14:20	CLOSING ADDRESS	Dr Sibongiseni Dhlomo Deputy Minister Health
	14:20 – 14:30	CLOSURE	Programme Director
14:30	**LUNCH AND DEPARTURE**		

POSTER PROGRAMME

DAY 2 WEDNESDAY 15 NOVEMBER 2023

11:00 – 11:30	11:00 – 11:15		11:15 – 11:30	
Screen 1	71	Strengthening Universal Health Coverage through Disability Inclusive Primary Health Care: An Action-Orientated Toolkit for Health Care Services Jill Hanass-Hancock	145	Towards Achieving Integrated Community-Focused Models of Care for People Living with Non-Communicable Diseases (NCDs) and HIV/TB in Eastern Cape Province, South Africa Nosicelo Ntumase
Screen 2	17	The facilitators of the implementation of Ward-Based Outreach Teams in Nkangala district. Perspectives of Programme Staff and Recipients Dr Cheryl Nelson	26	Family Care Intervention: Evidence of an integrated approach to improve viral load suppression among adolescents living with HIV Phumzile Matolo
Screen 3	27	A biopsychosocial model to improve viral load suppression and retention in care among adolescents: application at clinic level Nomcebo Mthembu	94	Strengthening the quality of paediatric primary care with the Practical Approach to Care (PACK) Child: from concept to provincial implementation
Screen 4	108	APC (Adult Primary care) implementation at Amathole District to improve clinical management of a patient at PHC. Tembela Lunika		Integration of sexual and reproductive health, HIV, tuberculosis and sexual- and gender-based violence service programming in KwaZulu-Natal. Ms Thobekile Mpembe
Screen 5	58	SALAD: A learning alliance to strengthen the DHS in South Africa Karessa Govender	161	Early detection, care and control of hypertension and diabetes in South Africa: A community-based approach Dr Sanele L M Madela
Screen 6	74	Organisational readiness and rehabilitation professionals' views on integrating tele rehabilitation into service delivery and students' clinical training. Dr Eugene Nizeyimana	10	Climate change and primary health care in Africa: a scoping review Christian Lueme Lokotola

NOTES

POSTER PROGRAMME CONTINUED

16:00 – 16:30	16:00 – 16:15		16:15 – 16:30	
Screen 1	59	Psychological responses to COVID-19 amongst healthcare (HCWs) workers in South Africa during the pandemic Prof Indiran Govender	119	Pivoting an emergency response to strengthen primary health care systems; the case of South Africa's COVID-19 response Ms Thembakazi Leseka
Screen 2		Monitoring and reporting Human papillomavirus vaccination campaign data and aligning targets with 95-95-95 strategy implementation in KwaZulu-Natal		Documentation of Ideal Clinic status achievement in KwaZulu-Natal Ms Khumbuzile Khumalo
Screen 3	48	#Me1st Campaign: A Novel Approach to Enhancing HIV Testing and Care among South African Men Who Have Sex with Men (MSM) Palesa Khambi		Introducing the KwaZulu-Natal Integrated Multi-stakeholder Health Promotion and Wellbeing Strategy 2024/25–2029/30 Mr Jabulani Mndebele
Screen 4	91	A Multi-faceted Approach to Strengthening Pharmaceutical Systems at Primary Health Care Clinics in KwaZulu-Natal, South Africa Vusi C. Dlamini	109	Impact of collaborative psychosocial and clinical intervention for improving viral load suppression of HIV-positive children and adolescents in Primary Health Care facilities in eThekwini Zanele Sithole
Screen 5		The journey of Primary Health Care Outreach Teams taking services to the people of KwaZulu-Natal Ms Sethembile Zulu	132	Ensuring quality of clinical care for gender-based violence (GBV) in Ekurhuleni: pilot testing the South African adaptation of the GBV quality assurance tool Annah Mabunda

DAY 4 FRIDAY 17 NOVEMBER 2023

08:00 – 10:00 - **BREAKFAST & TRAVEL BACK**

NOTES

SAPHC 2023

SOUTH AFRICAN PRIMARY HEALTH CARE CONFERENCE

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

planning, monitoring & evaluation
Department:
Planning, Monitoring and Evaluation
REPUBLIC OF SOUTH AFRICA

World Health Organization

HEALTH SYSTEMS TRUST

2030 NDP

14 – 17 NOVEMBER 2023

East London International Convention Centre

Ms Jeanette Hunter
Deputy Director General

Primary Health Care
National Department of Health

Mr Ramphelane Morewane
Acting DDG

HIV/AIDS, TB and MCWH.

Prof Nicholas Crisp
Deputy Director General

National Health Insurance

Dr Anban Pillay
Deputy Director General

Health Regulation and Compliance

Dr Percy Mahlati
Deputy Director General

Hospital Services and
Human Resources Development

Thulani Masilela
Outcome Facilitator

Department of Planning,
Monitoring and Evaluation (DPME)

Ms. APR Cele

Chief Director
Environmental Health (NDoH)

Mr Kgwiti Mahlako
Acting Chief Director

District Health Services
National Department of Health

Dr Matshidiso Rebecca Moeti
Regional Director

World Health Organization (WHO)
for Africa

Dr Owen Laws Kaluwa
Resident Representative

WHO South Africa.

Dr Cheryl Nelson
Chief Director

Primary Health Care (PHC)
in Mpumalanga Province

Mr J Mndebele
Chief Director

District Health Services
KwaZulu-Natal
Department of Health

Dr Victor Figueroa

Family Physician from Cuba

Rozani Dr Amanda
Deputy Director

Department of Basic Education

Dr Grace London
Chief Director

District Health Services

Adjunct Professor Richard Cooke
Seasoned Public Health professional

Head of Department
Family Medicine,Wits University

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