DOCTORS FOR PHC SEMINAR

ROLE OF DOCTORS IN A MULTI-DISCIPLINARY PUBLIC SECTOR PRIMARY HEALTH CARE TEAM

Report on the Doctors for Primary Health Care Symposium Held on the 28th of March 2017

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FPD

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Department:
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Contents:

List of Figures:

List of Tables:

List of Acronyms:

CHW	:	Community Health Worker
COPC	:	Community Orientated Primary Care
CSP	:	Community Service Policy
DDG	:	Deputy Director General
DHS	:	District Health System
DCST	:	District Clinical Specialist Team
FPD	:	Foundation for Professional Development
GP	:	General Practitioner
HPE	:	Health Professions' Education
HRH	:	Human Resources for Health
NDOH	:	National Department of Health
NDP	:	National Development Plan
NHI	:	National Health Insurance
NSDA	:	Negotiated Service Delivery Agreement
PHC	:	Primary health care
WBPHCOT	:	Ward-based Primary Health Care Outreach Team
WHO	:	World Health Organisation

Introduction

South Africa's two-tiered healthcare system has resulted in unequitable health outcomes, with the privileged few having disproportionate access to health services.

The Community Service Policy (CSP) was introduced in 1998 as an intervention to achieve better distribution of human resources for health in underserviced areas and to provide an enabling environment for new professionals to acquire experience. All health professions are legally required to complete a year of community service which entails remunerative work in the public sector. South Africa has since developed the Human Resources for Health (HRH) strategy (2012-2017) which takes into consideration the World Health Organisation (WHO) recommendations on the recruitment and retention of health professionals in rural and remote areas. These recommendations include rural health education interventions, enhanced regulation of rural practice, financial incentives and professional and personal support for health workers in remote and rural areas.

South Africa is in the process of working towards National Health Insurance (NHI), a health financing system designed to pool funds to provide access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socio-economic status (National Department of Health, 2015). This will be phased in over a 14 year period, through four key interventions, namely: a complete transformation of healthcare service provision and delivery; the total overhaul of the entire healthcare system; the radical change of administration and management; and the provision of a comprehensive package of care underpinned by a reengineered primary health care.

It is within this context that a series of seminars were envisioned, starting with the Community Service for Health Professionals Summit held in April 2015. Its aim was to initiate stakeholder engagement for the systematic review of the CSP using available evidence from a number of independent studies. The summit set out to understand community service in the context of the National HRH Strategy, to review the last 15 years of experience of community service doctors and dentists, to review the objectives of the CSP in South Africa, to review the guidelines and provincial implementation of the CSP in South Africa and to make appropriate recommendations.

The second seminar "Doctors for PHC Symposium" was held in the City of Tshwane at the Foundation for Professional Development's (FPD) Head Offices on 28 March 2017. The symposium was hosted by FPD and the National Department of Health. The symposium

focused on all categories of health professionals, but mainly on doctors' roles in a multi-disciplinary public sector primary health care (PHC) team.

This year's symposium set out to achieve the following objectives:

- To review studies on the placement of doctors in a public sector PHC setting
- To identify models and strategies to optimise the role of doctors in a multi-disciplinary team
- To identify knowledge gaps and areas for research.

Background

The Alma Ata Declaration of 1978 (WHO) describes PHC as a philosophy that governs the principles and strategies for the organisation of health systems, with the central focus of health as a fundamental human right. Strategies for PHC described in the declaration include providing access to good quality healthcare, preventive and promotive services, inter-sectoral action at local level to address the root causes of ill health and enhanced community participation and accountability (WHO, 1978). As a signatory to the declaration, South Africa has adopted the PHC philosophy and the WHO definition of health as 'a state of complete physical, social and mental well-being, not only the absence of disease' (WHO, 1978).

The National Health Act (Act 61 of 2003) is the legislative framework for the establishment of the national health system in South Africa. The Act also provides for the establishment of the District Health System (DHS), which consists of health districts that coincide with municipal boundaries, and the creation of District Health Councils. The DHS is viewed as the vehicle through which PHC is delivered at district and sub-district level. PHC clinics are the first point of contact for patients and provide preventative care, as well as the diagnosis and treatment of minor ailments. Professional Nurses who have received additional primary healthcare training usually render these services, with medical practitioners visiting facilities on a rotational basis. There are approximately 3 100 PHC clinics in South Africa, serving an average of 12 000 people each (Mahomed & Asmall, 2015).

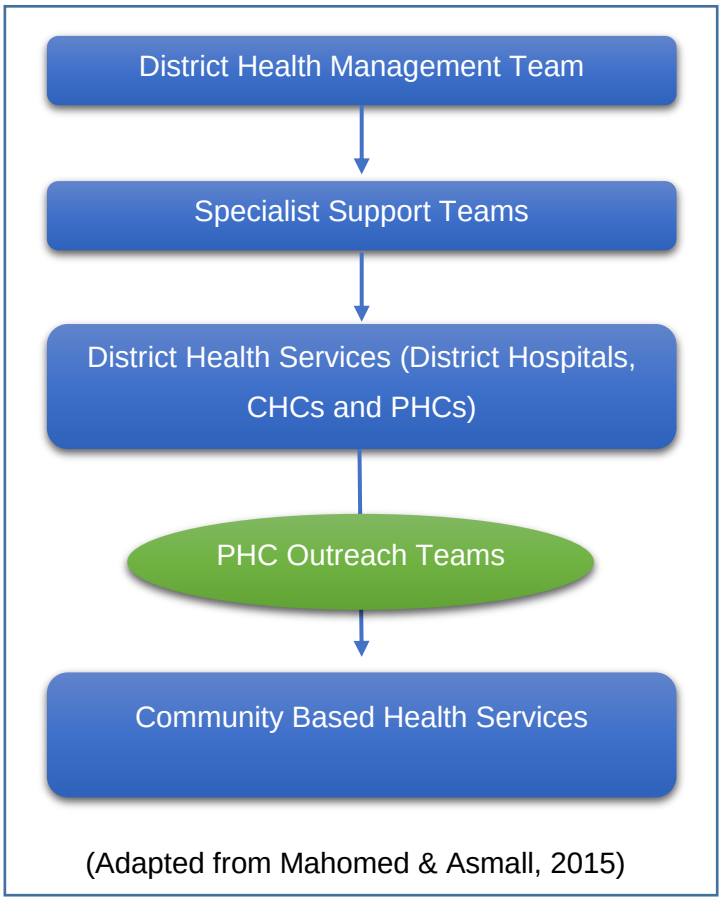


Figure 1. District Health System

The Negotiated Service Delivery Agreement (NSDA) for Health (Office of the President, 2010.) states that the priority for the health sector is to improve the health status of the entire population. This should be achieved by broadening and deepening the extent and scope of community involvement and social mobilisation in all aspects of health provision. Arising from this, the National Department of Health developed a 10-point plan (see below) for the 2010 to 2014 period.

Figure 2. National Department of Health 10 point plan (2010-2014)

Point number 4, to overhaul the healthcare system and improve its management, focuses on developing and implementing a national model for the delivery of health services based on the PHC approach and to scale up community-based promotive and preventive health services (immunisation programmes, antenatal and post-natal care, nutrition and school health services). The 10 point plan has been incorporated into the National Department of Health's Strategic (2014-2019) and National Development Plans (2030) (NDP), see Table 1.

For the purposes of this report, NDP goals 7, 8 and 9 are particularly relevant, specifically the National Department of Health's related strategic goals to reengineer PHC, make progress towards universal health coverage and improve human resources for health.

Table 1. National Development Goals and Priorities in relation to the National Department of Health Strategic Goals

NDP Goals (2030) →	NDP Priorities (2030)	→ Strategic goals (2014-2019)
1) Raise the life expectancy of South Africans to at least 70 years 2) Progressively improve TB prevention and cure 3) Reduce maternal, infant and child mortality rates 4) Significantly reduce the prevalence of non-communicable diseases 5) Reduce injury, accidents and violence by 50% from 2010 levels	Address the social determinants of health. Prevent and reduce the disease burden and promote health.	Prevent disease and reduce its burden, and promote health.
6) Complete health system reform	Strengthen the health system.	Improve health facility planning by implementing norms and standards.
		Improve financial management by improving capacity, contract management, revenue collection and supply chain management reforms.
	Improve health information systems.	Develop an efficient health management information system for improved decision making.
	Improve quality by using evidence.	Improve the quality of healthcare by setting and monitoring national norms and standards, improving systems for user feedback, increasing safety in healthcare and improving clinical governance.
7) Primary healthcare teams provide care to families and communities		Re-engineer primary healthcare by: increasing the number of ward-based outreach teams, contracting general practitioners and district specialist teams, and expand school health services.
8) Universal healthcare coverage	Financial universal healthcare coverage.	Make progress towards universal health coverage through the development of the NHI Scheme and improve the readiness of health facilities for its implementation.
9) Fill posts with skilled, committed and competent individuals	Improve human resources in the health sector.	Improve human resources for health by ensuring adequate training and accountability measures.

Reengineer Primary Healthcare

The National Department of Health follows a three stream approach to PHC re-engineering, namely ward-based PHC outreach teams; school health services and district-based clinical specialist teams (Figure 3).

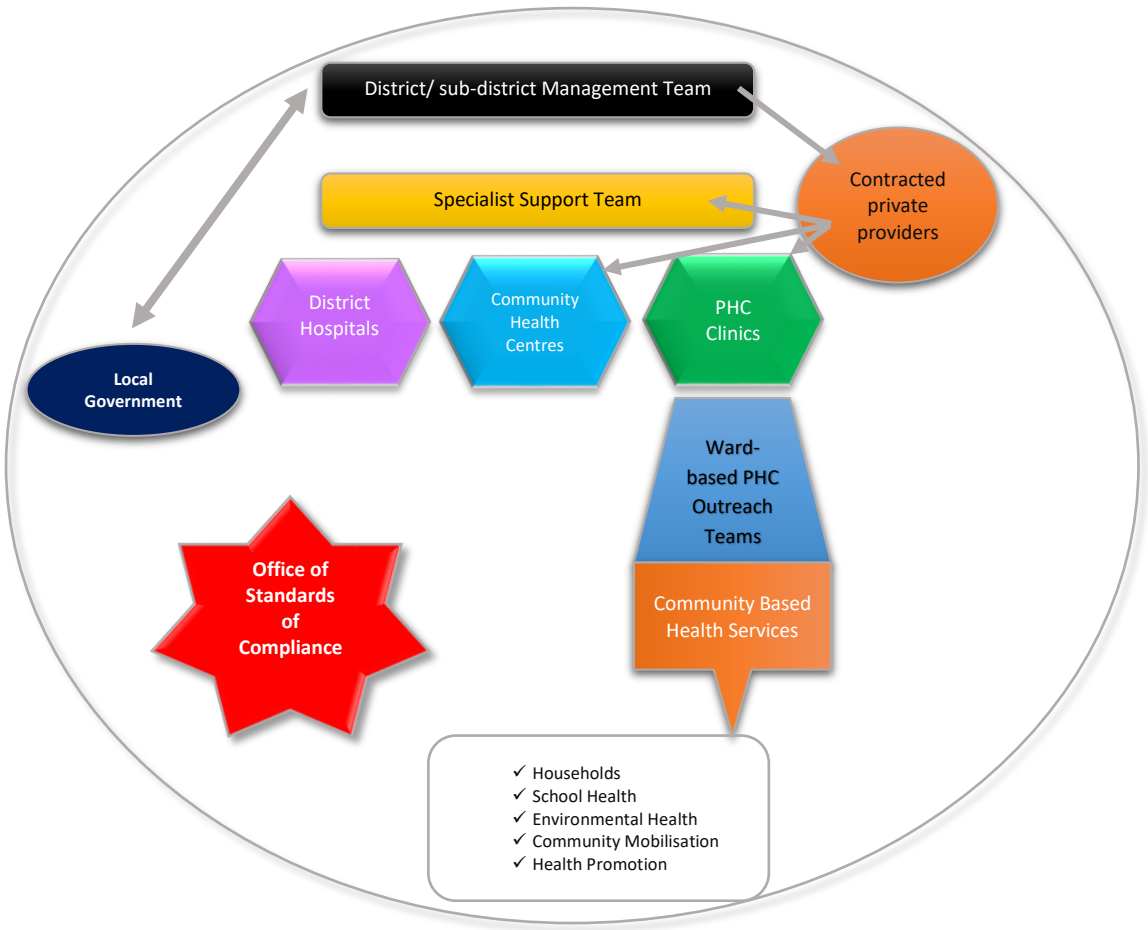


Figure 3. District Health System and PHC Reengineering

1) Ward-based PHC outreach teams (WBPHCOT)

Although South Africa has utilised Community Health Workers (CHWs) to deliver community-based health services since the Alma Ata Declaration of 1978, health outcomes were generally sub-optimal, especially in the areas of maternal and child health (Pillay & Barron, 2012). The factors causing this sub-optimal performance were inadequate training, inadequate support and supervision, no link between community-based services and health facilities, and limited or no targets for performance or quality. WBPHCOTs are a response to the limitations of past community-based health services.

In this model CHWs are placed in a team, trained well, supervised and supported, with a clear mandate of what is expected of them. Each ward should have at least one WBPHCOT (based on population size) composed of six CHWs, a professional nurse, and environmental health and health promotion practitioners. Each team is linked to a PHC facility through the professional nurse who is the team leader and responsible for ensuring that their work is targeted and linked to service delivery targets and that they are well supervised and supported.

2) School health services

School health services are focused on schools in quintiles 1 and 2 and provide services such as screening learners at key times in their learning career. Health education will also be provided to supplement the life skills programme, focusing on sexual and reproductive health. District Management ensures that the WBPHCOT work in tandem with school health services.

3) District-based clinical specialist teams (DCSTs)

Every district should be supported by a team consisting of a gynaecologist, paediatrician, anaesthetist, family physician, advanced midwife, advanced paediatric nurse and a PHC nurse. The functions of the specialist teams include strengthening clinical governance at PHC level and district hospitals, to ensure that treatment guidelines are available and used, to ensure that essential equipment is available and correctly used, to ensure that mortality review meetings are held, and to support, supervise and mentor clinicians and monitor health outcomes.

Universal Health Coverage

In terms of working towards universal health coverage, the NDP proposes that an NHI system needs to be implemented in order to improve access to quality healthcare services for the whole population and to provide financial risk protection against health-related expenditure. Comprehensive healthcare will be provided through accredited and contracted public and private providers, with a strong focus on health promotion and prevention services at community and household level (National Department of Health, 2015). NHI aims to promote equity and social solidarity through pooling risk and funds; to create one public health fund with adequate resources and funds to plan for and to effectively meet the health needs of the entire population; to ensure that healthcare is regarded as a public good and social investment; to strengthen the under-resourced public sector; and to adopt appropriate, new and innovative health service delivery models that take account of the local context and acceptability.

NHI will be phased in over a 14 year period, with the first phase (2012-2017) focusing on strengthening the public sector in preparation for NHI systems. Specifically, the establishment of an Office of Health Standards and Compliance, the appointment of District Clinical Specialists, implementing health systems strengthening initiatives such as the Ideal Clinic, launching an HRH strategy and increasing the production of healthcare professionals, creation of NHI districts and selection of pilot sites, establishing the NHI Fund and contracting private providers at primary care level. The expansion of contracted providers beyond general practitioners (GPs) also includes practitioners dealing with physical barriers to learning such as audiologists, speech therapists, oral hygienists, occupational therapists, psychologists, physiotherapists and optometrists for school going children.

The second phase (2018-2021) will involve continuing the activities identified in phase one, as well as registering the population and issuing NHI cards, purchasing PHC services from certified and accredited public and private providers at non-specialist level, and the amendment of the Medical Schemes Act.

The third and final phase (2022-2026) of NHI implementation will take place over the final four years and will focus on ensuring that the NHI Fund is fully functional. This will include contracting and accrediting providers beyond public sector hospitals and the mobilisation of additional financial resources for the NHI Fund.

South Africa's Human Resources for Health strategy

Adequate human resources for health are critical to the implementation of the National Department of Health's strategic goals and NHI. Director General Malebona Precious Matsoso stated in the preamble to the National Department of Heath's Human Resources for Health Strategy (2012-2017) that the "status of populations and communities is at times hampered by poor working environments, skill gaps and the use of inappropriate policy tools that often fail to provide best incentives or optimise performance of the health workforce. This Human Resources for Health strategy aims to close these gaps."

The vision of the HRH Strategy is to improve access to healthcare and health outcomes for all. To achieve this vision, it will be necessary to develop and employ new professionals and cadres to meet policy and health needs; increase workforce flexibility; improve working methods and productivity of the existing workforce; improve retention; and revitalise aspects of education, training and research.

The eight strategic priorities to achieve this vision include, 1) leadership and governance; 2) intelligence and planning for HRH; 3) a workforce for new service strategies ensuring value for money; 4) upscale and revitalise education, training and research; 5) academic training and service platform interfaces; 6) professional human resources management; 7) quality professional care; and 8) access in rural and remote areas. Under strategic priority three, the 'Seven Foundations of the HRH Model' describes the strengthening of all health professional categories. The categories are as follows:

1) *Community Health Workers at community level*: there will be a large community-based workforce with preventive and promotive competencies.
2) *Enhancing nursing skills and capacity*: it is necessary to identify appropriate categories of nurses for re-engineered PHC, to revise their scope of work, and increase their clinical competencies and numbers.
3) *Introduce and expand mid-level workers*: it is necessary to increase the new cadre of Clinical Associates and develop other mid-level worker categories.
4) *Expand general medical doctors and general health professionals*: there is a need for more general medical doctors at both PHC and hospital level, as well as other general health professionals such as pharmacists, dieticians, etc.
5) *Expand selected specialist doctors and other specialist professionals*: the challenge of maternal and infant mortality requires an intervention to improve the numbers of selected specialists in teams and in districts to take the lead in clinical governance.
6) *Public health specialist leaders*: more public health specialists and public health professionals are needed and their role clarified.
7) *Develop academic clinicians in all disciplines*: the development of academic clinicians is required to ensure a platform for health professional development.

The strategy also describes the workforce implications of re-engineering primary healthcare. "The role of the generalist doctor must be re-established in the PHC team as an important clinical care and teaching role" (NDoH, 2012). The general practitioner or doctor is described as a "key player" in patient referral to the appropriate level of care and plays an important role in financial viability as well as patient care and satisfaction. Additionally, private general practitioners should be recruited to serve in the PHC system and district hospitals.

The Doctors for PHC Symposium was held with the intention of reviewing current studies on the placement of doctors in a public sector PHC setting, identifying models and strategies to optimise the role of doctors in a multi-disciplinary team, and to identify knowledge gaps and

areas for research. The following sections will describe the symposium proceedings, the presentations made in response to the objectives listed above, the gaps and areas for research identified, and lastly the conclusions drawn in relation to the objectives set out.

Symposium Proceedings

Attendance

The symposium was attended by 47 attendees (please see the full list of attendees in Annexure 1). The attendees came from various organisations, institutions and backgrounds including:

- The National Department of Health
- KwaZulu-Natal Department of Health
- Free State Department of Health
- Limpopo Department of Health
- Gauteng Department of Health
- University of Witwatersrand
- University of Cape Town
- University of Pretoria
- Stellenbosch University
- The Foundation for Professional Development
- Centres for Disease Control
- Health Systems Trust
- South African Medical Association

Symposium Programme

The symposium was opened by Professor Errol Holland, who welcomed the attendees and introduced the aims and objectives of the symposium.

Ms Jeanette Hunter from National Department of Health (NDoH) started the day off by delineating NDoH's perspective on the role of doctors in the PHC setting. This was followed by a presentation on global perspectives on the use of doctors in PHC by Professor Shabir Moosa and a presentation on the training of doctors for rural PHC settings by Professor Ian Couper.

During the second half of the morning session Dr Meshack Mbokota presented data on the efficient and cost-effective utilisation of private health professionals for National Health Insurance (NHI). This was followed by Dr René English who presented the results of the external evaluation of the General Practitioner (GP) Tender project. Professor Jannie Hugo then conducted a presentation on the interface between Community Health Projects and

District Clinical Specialist Teams. The last presentation in the morning session was conducted by Professor Errol Holland on the internal evaluation of the project to second doctors to NHI district PHC clinics. Before lunch a brief session was held to respond to issues of clarity arising from the presentations.

For the afternoon session attendees were separated into three groups to discuss and identify knowledge gaps and objectives for future research. The groups were given three topics to guide their discussion: optimising the productivity of health professionals in clinics; clinical governance role of doctors; and linkages with community outreach initiatives. After the afternoon tea break rapporteurs from each group reported back on their discussions and conclusions. Professor Errol Holland concluded the discussion with a summary of the key issues, knowledge gaps and areas for future research. Ms Jeanette Hunter closed the symposium with a description of the way forward.

Symposium Presentations

Ms Jeanette Hunter

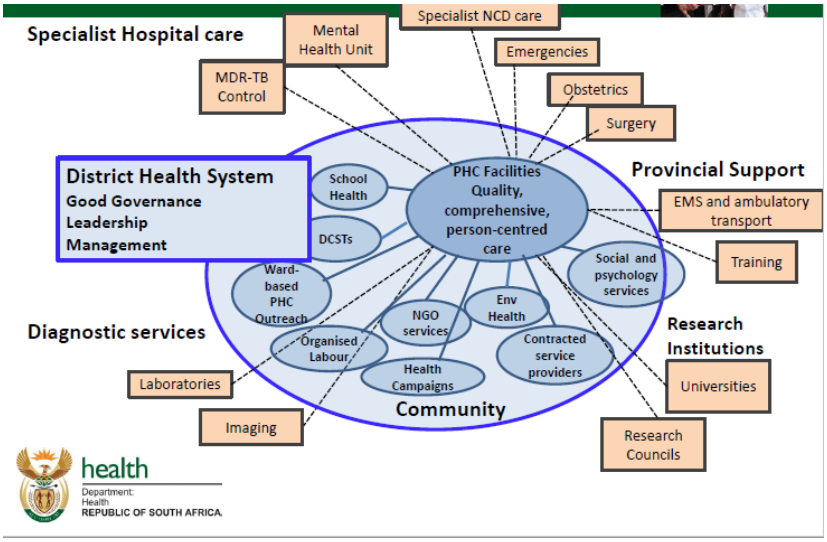
(Deputy Director General, National Department of Health)

Ms Jeanette Hunter has been the deputy-director general (DDG) in the Department of Health since March 2013. She holds a Bachelor of Arts in Nursing Science from the University of South Africa, a diploma in Community Health Nursing Science from the University of Orange Free State, a postgraduate diploma in Health Services Management from the University of Cape Town and a Master's in Business Administration from the University of Free State. Jeanette has worked in senior management positions in the Public Sector for 12 years. Before being appointed at the Department of Health, she was the chief executive officer of the Health Systems Trust.

The role of the General Practitioner in PHC

The presentation focused on delineating how the National Department of Health sees the role of the doctor in primary healthcare settings. Specifically in promoting a patient-centred multi-disciplinary team, defined as; *"a group of people with complementary skills who are committed to a common purpose, performance goals, and approach, for which they hold themselves mutually accountable".*

The diagram below illustrates the ideal PHC facility within the health system and shows the context in which doctors contribute to a multi-disciplinary team.



The specific roles doctors play in a patient-centred multi-disciplinary team include:

- drawing on the required resources and skills to effect secondary prevention and/or return patients to optimal health
- informing and consulting with patients
- adhering to national clinical guidelines
- ensuring the continuity of care
- ensuring not just appropriate referral, but good communication between primary, secondary and tertiary levels of care
- guiding and supporting good data collection
- improving the equality of outcomes as a result of better awareness of patients' circumstances and reflective practice
- promoting good working relationships between team members
- taking advantage of opportunities for education for both themselves and other team members
- optimising and using resources efficiently.

Ms Hunter recommended that, in the interest of patient-centeredness, teams should foster an environment of mutual respect, avoid individual agendas and "leave their toes at home" (i.e. blunting sensitivities about affronts to personally held perspectives arising from robust discussions).The role of facility, district, provincial and national managers was described as that of providing direction, support and facilitation.

During the clarification session it was asked whether the NDoH has developed minimum standards for the skills needed or job descriptions for PHC doctors. With regards to the

minimum standards, the DDG responded that there isn't a minimum standard for employing doctors as such, but a package of clinical guidelines linked to the clinical work that is expected from doctors working in PHC facilities. Job descriptions for the PHC doctors are only provided in their contracts. Health Systems Trust has developed job descriptions for doctors working in District Management Teams.

Associate Professor Shabir Moosa

(Senior Clinical Lecturer, Department of Family Medicine, University of Witwatersrand)

Professor Shabir Moosa leads the African Community Practice Project (AfroCP) and is a senior clinical lecturer in the Department of Family Medicine at Wits University. AfroCP is a community-orientated primary care strategy that delivers holistic quality primary healthcare that is orientated to person, family and community, with inter-professional and multidisciplinary teamwork. Professor Moosa holds a PhD from Ghent University (2015), a master's in Business Administration from the Wits Business School (2011), a masters in Family Medicine from MEDUNSA (2005), a Diploma in PHC Service Management from Wits Graduate School of Public and Development Management (1998) and an MB ChB from Natal University (1988). He is also the president-elect for WONCA Africa, the lead SA researcher in the Human Resources for African Primary Care Research Project and is on the editorial board for the British Journal of General Practice and the African Journal of Primary Health Care and Family Medicine.

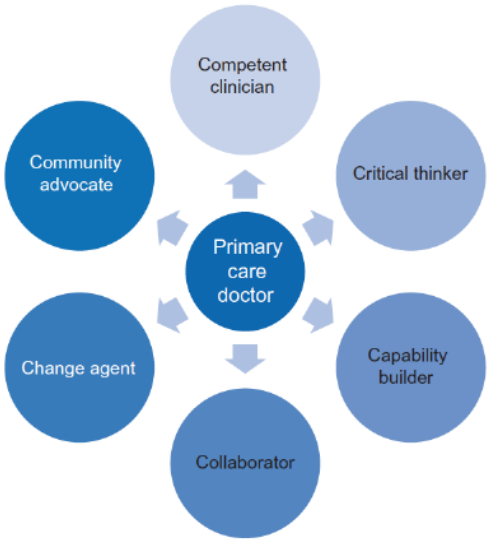
Global perspectives on the use of doctors in primary health care

The Commission on Health Employment and Economic Growth report that investing in the healthcare workforce has a return on investment ratio of 1:9, providing evidence to show that healthcare is not a cost, but an investment.

The importance of primary healthcare and the four reforms necessary to refocus health systems towards health for all have frequently been emphasised (WHO World Health Report, Primary Health Care: Now more than ever, 2008). They include universal coverage reforms, service delivery reforms, leadership reforms and public policy reforms.

Current challenges with regards to human resources for health in Africa were highlighted. These included evidence suggesting that task-shifting is not functioning as anticipated due to insufficient training and support, evidence showing that doctors on the ground in PHC facilities are struggling, and poor retention and training of healthcare professionals.

The presentation was concluded by describing the opportunity and potential to use private doctors in primary health care. A model of doctor-led teams was presented showing the roles that doctors can play, described in the figure below (R Mash, K Von Pressentin & J Blitz, 2017).



Risks to this model were noted, including private doctors' mistrust of government, their low utilisation and managing their current practice on top of new roles.

During the clarification session, a question was raised in response to the statement made that task-shifting is not functioning as expected. The attendee questioned the affordability of doctor-driven models in comparison to task-shifting. Professor Moosa responded to this query

by confirming that they are not suggesting going back to a doctor-driven model, but a model whereby the doctor provides *clinical leadership*.

Professor Ian Couper

(Director of the Ukwanda Centre for Rural Health; Professor of Rural Health at Stellenbosch University)

Before joining the Ukwanda Centre for Rural Health at Stellenbosch University in April 2015, Professor Ian Couper spent 14 years at the University of Witwatersrand as the director of the Centre for Rural Health. Professor Couper holds a Bachelor of Arts undergraduate degree, an MB ChB from Wits University, and a masters in Family Medicine from MEDUNSA.
Ian has been involved in various initiatives responding to human resources for health in rural settings, including the establishment of the Rural Doctors Association of Southern Africa (RuDASA) and the Wits Initiative for Rural Health Education,

Orientating doctors towards primary care: Transforming medical training

Professor Couper began his presentation by describing the challenges currently facing Health Professional Education (HPE) for Human Resources for Health (HRH), namely the challenges of quantity, quality and relevance. In terms of quantity, South Africa only has eight medical schools (1 per 6.4 million) producing a doctor density of 0.77 per 1 000 population. In terms of quality, South Africa is known for its high quality health professions' education programmes and as such, health profession migration has become a challenge. In terms of relevance, it was emphasised that health professions' education should put population health needs and expectations at the centre of transformation, and should be directed by the reality of health service delivery.
The Stellenbosch University Collaborative Capacity Enhancement through Engagement with Districts (SUCCEED) project's framework for implementing decentralised training (rural schools) was recommended as most likely to be effective in addressing HRH shortages in underserved and rural areas. The diagram below illustrates the overarching principles of the SUCCEED framework.

The following outcomes have been identified as motivating factors for decentralised training:
Workforce effects: decentralised training increases the likelihood of rural practice by selecting students from rural origin, having medical schools in rural areas, and placing postgraduates in underserved areas.
Educational advantages: students develop an understanding of rural problems and the skills needed to address these, they see more patients and perform more procedures, they practice continuity of care and teamwork, they develop an understanding of comprehensive and holistic care, they have a stronger learning experience than at a tertiary hospital, and they gain knowledge regarding the social determinants of health and behaviour change with the adoption of professional codes of practice.
Health service impact: service delivery and patient care is improved and there is increased access to services and quality of care. The hospital culture becomes more positive and interprofessional with the presence of students, and supervising students motivates doctors to reflect on their clinical approach and keep up to date with knowledge. Lastly doctors can see 20-30% more patients when working with students.

Professor Couper, along with Professors Reid and Hugo, presented a proposal to the National Health Council in 2015 on *Transforming the training of medical students in South Africa* on behalf of the Collaboration for Health Equity through Education and Research (CHEER). It was proposed that funding should be structured to make the educational processes of medical schools accountable to the population they serve. Conditional funding should be offered in relation to five areas, namely:

1) The proactive recruitment and selection of students from rural and underserved areas (including support to facilitate the application process for rural origin students and dedicated mentorship of students by senior students from a rural background)
2) The early, continuous and longitudinal engagement of students in community-level care (Community Orientated Primary Care (COPC))
3) The placement of primary care clinical teaching rotations in rural and remote areas (all students should have some exposure to rural sites)
4) Involvement of students in inter-professional learning and collaborative practice
5) Faculty development and support towards providing competent supervision.

In closing, Professor Couper made five recommendations based on the CHEER proposal. A national task team should be established to lead the refinement and finalisation of the proposals on behalf of the National DoH. Each health sciences faculty must develop a plan to present to National DoH on how they will respond to proposals and achieve targets over a five-year period. A specific conditional grant for transforming medical education should be established to support faculties in this endeavour. Each faculty should then develop a monitoring and evaluation plan for the above activities to document success in terms of graduate outcomes. Lastly, support should be provided for an ongoing tracking study of medical graduates, with the cooperation of the Health Professions Council of South Africa (HPCSA).

Dr Meshack Mbokota

(Specialist Obstetrician and Gynaecologist, Private Practice)

Dr Mbokota holds an MB ChB from the University of Natal and an MSc in International Management, specialising in health systems management, from the University of Liverpool. He is currently in private practice in Pretoria and the Managing Director of Bvumi investments – a healthcare consulting company. Dr Mbokota has been appointed as a clinical consultant in a number of projects over the past 10 years, including the assessment of technology at the National Health Laboratory service (NHLS), hospital business cases in the North-West province (Kenneth Kaunda district) and Mpumalanga (Nkangala District). He serves on a number of boards including the Health and Medical Publishing Group (HMPG) and Cosmo City clinics.

National Health Insurance in South Africa: The role of private health professionals

Dr Mbokota began his presentation with a brief background on healthcare in South Africa, specifically the inequity of the private vs public system and universal health coverage. He explained that NHI is the only mechanism that government can use to finance health care and achieve universal health coverage, and that the private sector is an important part of achieving this.

Private healthcare professionals have a pivotal role to play in the NHI initiative and four activities define their successful participation: their perception of NHI, the contracting model used, the reimbursement model used, and public-private partnerships. In terms of doctors' perception of NHI, it was found that negative publicity from NHI detractors effects their perception greatly, there is a poor understanding of what NHI is in South Africa, there is indecision regarding key issues such as pricing and lastly the improvements made at "pilot sites" are not communicated, leading to scepticism about progress. With regards to contracting models, doctors want a clear decision on how they will be contracted (in-contracting, out-contracting or institutional contracting). It was noted that the government found it difficult to recruit doctors to work in clinics, but that doctors were willing to be

contracted by FPD to perform the same functions. Uncertainty regarding reimbursement rates discourages doctors from subscribing to the NHI pilots, current “sessional” rates with in-contracting *is not* preferred by the majority of doctors. Public Private Partnerships create opportunities such as contracting a part of, or whole PHC service package from private doctors in their rooms, developing new infrastructure, especially in rural areas, distributing medicine to patients (with stable chronic conditions) and the provision of specialised services such as oncology and radiology.

Dr Mbokota went on to describe the “regulatory vacuum” that exists in private healthcare, specifically calling for the direct regulation of private hospitals, including making all private hospitals NPOs to remove the profit motive and monitor the quality of services. Further, private hospitals should be allowed to employ professionals and own their own laboratories and pharmacies. Lastly, it was recommended that a National Electronic Health Record should be developed.

In summary, doctors (public and private) are the cornerstone of any PHC system and NHI cannot succeed without them. However, government must address the existing regulatory vacuum to change doctors’ perception of the initiative and gain their buy-in.

Dr René English

(Director of Health Systems Research Unit, HST)

Dr English is currently the Director of the Health Systems Research Unit. She holds an MB ChB, MMED, FCPHM and PhD. She is a member of the Health Information Task Team, the National Health Information Systems of South Africa (NHISSA) Committee, and the 700 Primary Health Care Steering Committee. As well as holding honorary membership of the School of Public Health and Family Medicine at the University of Cape Town, she is a member of the South African Colleges of Medicine, the Council of the College of Public Health Medicine, and the Advisory Board of the University of KwaZulu-Natal's Centre for Rural Health.

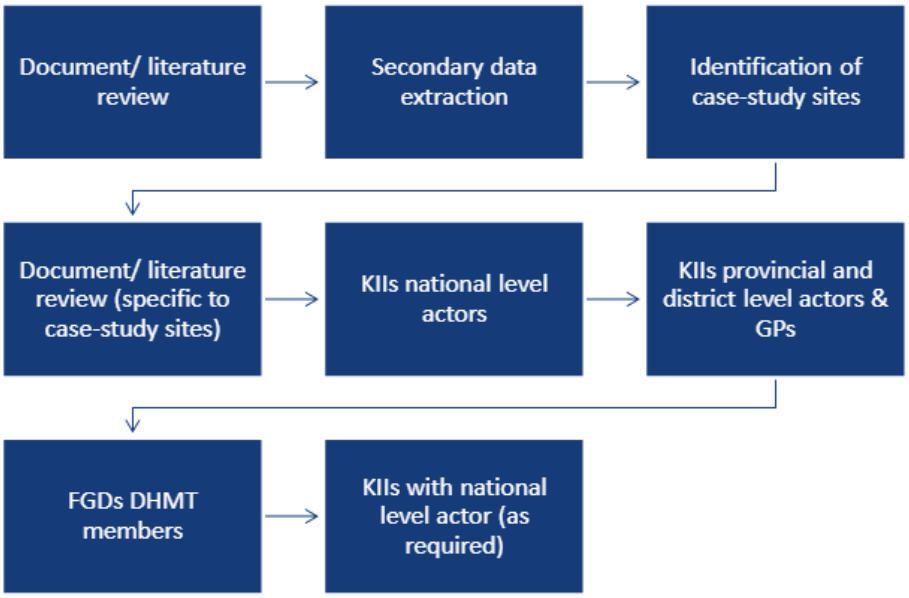
Case study on the Role of GP contracting in strengthening health systems towards universal health coverage in SA

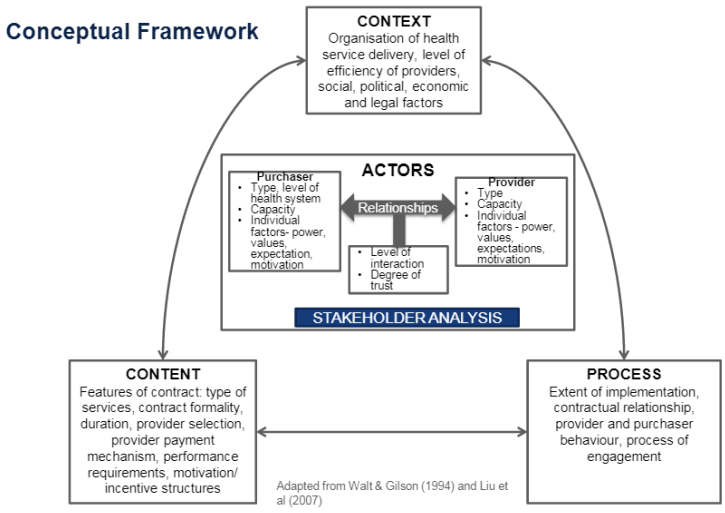
Dr English began her presentation by providing a background on the case study that was commissioned by the Alliance for Health Policy and Systems Research (AHPSR). The case study is part of a series of eight multi-country case studies looking at the role of various types of non-state providers in strengthening health systems towards universal health coverage. This study focused on the GP Contracting Initiative in South Africa which aims to improve access to essential PHC services in NHI districts, ensure quality PHC services according to national recommended guidelines and to standardise the process of contracting private doctors within the DHS. The aim of this study was to explore the extent of implementation of the GP contracting initiative, how the various actors went about implementing it and what the key factors were that enabled or hindered implementation, with a particular focus on processes of engagements and the relationships between the various actors. The study has four objectives:

1) To describe the process of implementation of the GP contracting initiative (the how) with a view to describe and understand the process of engagement with and among the actors, given specific contexts and external factors
2) To measure and describe the extent of implementation of the GP contracting initiative in selected NHI pilot districts

3) To explore key factors influencing implementation in selected NHI districts, thereby eliciting key barriers and enablers to the development of the policy and implementation thereof
4) To describe and understand the actors, their characteristics, values, expectations, motivations, experiences and understanding of the GP contracting initiative at various levels, and how this influenced implementation of the initiative.

The study used a mixed-methods approach and sampling was conducted at national, provincial and district level. The diagrams below illustrate the research approach and methods used and the conceptual framework used to guide the process.

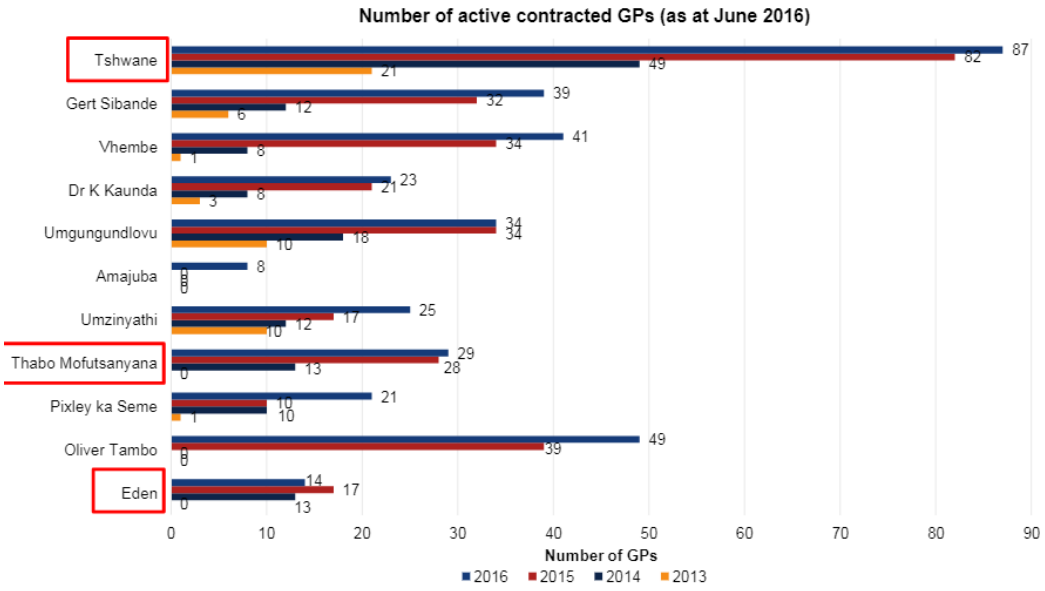




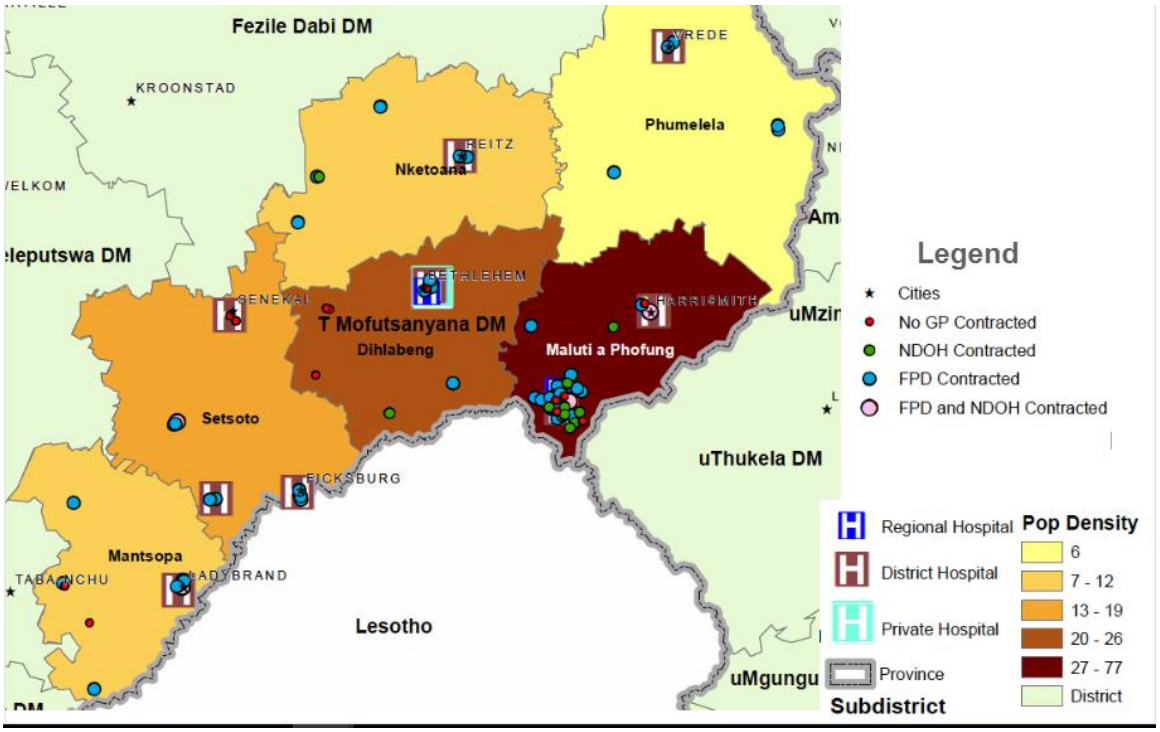
Dr English then moved on to the preliminary results of the study. In terms of the implementation process (objective 1), the following was found:

Process of engagement with GPs: At national level, more formal strategies such as roadshows and meetings are used to engage doctors. At district level, more informal engagements are used and existing networks of known doctors are drawn on.
Contractual Process: It was found that contracts are very rigid. The advantages of this rigidity include having clear definitions of roles, services, hours to be worked, etc. The disadvantages however include hampering service provision as it doesn't allow for flexibility in facilities or the hours that a doctor can work and it doesn't allow for the recognition of additional qualifications. Additionally it was found that there is uncertainty about the contract duration, specifically annual renewal leads to less job security and high turn-over of doctors.
Placement of GPs: The placement of doctors was mainly influenced by service delivery needs as identified by the district.
Monitoring of services and performance: It was found that monitoring the provision of services (hours worked) is a major administrative burden for both doctors and managers and any additional contracting should take staff and administrative burden into account. Additionally, the monitoring of services and performance management isn't done formally except for FPD contracted doctors.
Payment mechanism: The Western Cape Department of Health adapted a payment mechanism to decrease the monthly pressure of administrative burden and the risk of untimely payments. Doctors were placed on the district HR system and paid monthly through Payroll. Timesheets/ registers were used to monitor and confirm hours worked.

In terms of the extent of the implementation (objective 2), the following graph describes the number of active contracted doctors as at June 2016.



The map below shows were the doctors have been placed in selected NHI pilot districts.



With regards to objective 4, the actors' understanding, expectations, motivations and experience were described.

Role of the GP in PHC: Managers' expected doctors to provide general PHC services, mentor nurses, play a clinical governance role, reduce inappropriate referrals to higher levels of care and ultimately reduce waiting times. It was found that there was some tension between how the managers' saw the doctors' role and how the doctors saw their role. Doctors felt that their role was primarily clinical, however the high patient load impacts on their ability to perform other expected roles such as training, mentoring and clinical governance.

Motivation and incentives for GP participation: The biggest factor influencing GP's contracting was the concern regarding remuneration rates, which are not sufficiently competitive. Health system inefficiencies, such as challenges with obtaining patients' files, accessing results and the lack of equipment and resources, was another key factor that influenced doctors' participation. Other incentives to participate include flexibility in working hours, the fact that it is a lower risk job when compared to running a private practice, having access to training opportunities, leave benefits and travel reimbursements. Further, recognising additional valuable qualifications (e.g. HIV Diploma) is a potential motivating factor.

Position on GP contracting: Doctors were generally supportive of GP contracting, however frustrations regarding health systems inefficiencies detracted from this. Managers were strongly supportive of GP contracting due to the resulting decrease in service pressures and the provision of additional resources, however the increased administrative burden was noted.

The presentation was brought to a close by linking the preliminary findings of this study to the symposium discussion points.

Optimising the productivity of doctors in clinics: It was recommended that the following factors that reduce productivity should be improved upon: inefficiencies in the health system such as delays in accessing patient results, contract formalities hampering the movement of doctors to assist in other facilities and limiting the number of hours they can work, the annual renewal of contracts, the lack of required equipment and resources, and not recognising additional valuable qualifications.

Clinical governance role of doctors: Although the role of doctors pertaining to clinical governance, training and mentoring of staff is specified in the doctor's contracts, not all NDoH contracted doctors were aware of their role. FPD contracted doctors seemed to be more aware of their role. Performing clinical audits is a performance requirement for FPD

contracted doctors, while NDoH contracted doctors only conduct clinical audits as and when possible.

Key issues, knowledge gaps and areas for future research: The following were listed as potential topics for future research: methods of monitoring the quality of doctor services, options other than timesheets for monitoring working hours, and motivating factors for doctors currently working in the public sector.

Professor Jannie Hugo

(Head of Family Medicine Department, University of Pretoria)

Professor Jannie Hugo is the Head of the Department of Family Medicine at the University of Pretoria and serves on the executive of the Health Professions Council of South Africa. He previously worked at the Medical University of Southern Africa (MEDUNSA) for 17 years. He is a founder member of the Madibeng Centre for Research and was involved in setting up the Rural Health Initiative, from its infancy, prior to the merger to create AHP in 2007. He has been involved at a strategic level in the organisation since then. He leads the Community Orientated Primary Healthcare programme that has been implemented in Tshwane as a National Health Insurance Pilot.

Role of the doctor in the community

Professor Hugo began his presentation by describing the theory of Complex Adaptive Systems and how this relates to healthcare, particularly primary healthcare. PHC is a micro system and needs to have space for continuous adaptation.

An ideal clinic was described in the following way:

- A clinic should be responsible for a geographical area
- It should provide a comprehensive service
- There should be three to five WBOTs linked to the clinic
- The clinic should serve three to five wards
- The clinic should have a link to a hospital and Health Area
- The clinic should be governed by a clinic committee
- Data should be reviewed to determine risk, burden of disease, priorities, clinical governance and impact.

The ultimate role of the doctor within the PHC system is that of the trusted expert who provides clinical support and care, integrates care, coordinates and provides links to other health professions.

Private doctors (and their practices) also have a role to play as they have the resources needed (space, ICT, staff, medicines) to become health posts for Ward-based Primary Health Care Outreach Teams. They could potentially lead the teams, providing overview and guidance, as well as provide clinical care in their practices, the clinic or at the homes of patients. In terms of remuneration models, Professor Hugo recommended that payment should be based on time, capitation (or the population covered by WBPHCOT) and performance.

During the clarification session it was confirmed that it is intended for WBOTs to be gradually included in the GP contracting project. However previous applications made to the Minister of Health have not been accepted.

The WBOTs team composition was also clarified as well as the role of the Doctor within the team. It is envisioned that there will be a group of Community Health Workers with a team leader, supported by a doctor for four to eight hours a week. The doctor's role would be to provide clinical support, not to replace the team leader.

Professor Errol Holland

(Coordinator of the GP Tender Project)

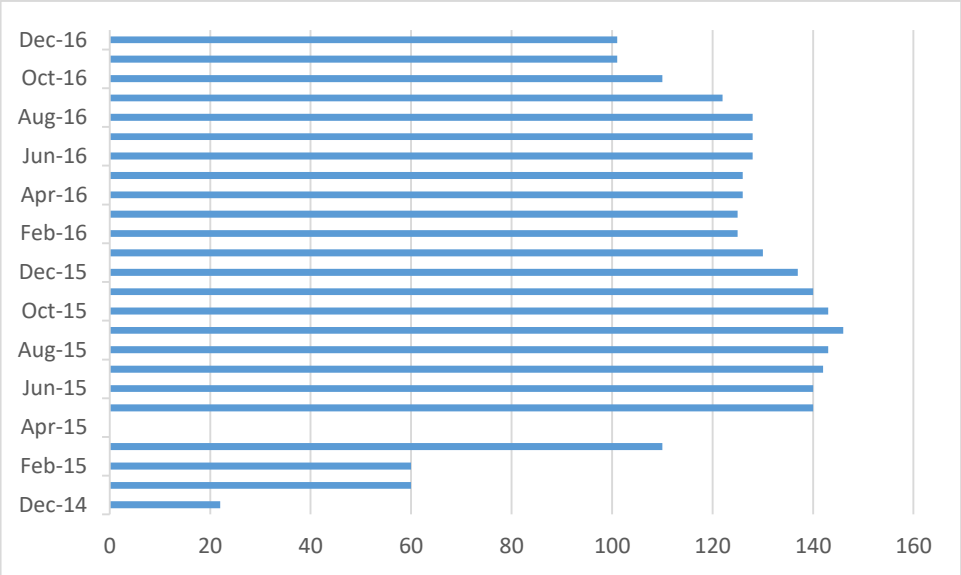
Professor Holland is a consultant for the Foundation for Professional Development and is the coordinator of the GP Tender Project, as well as being on the board of the Foundation for Human Rights. He qualified as a doctor from the University of Cape Town in 1972, and then as a specialist in internal medicine. He earned a PhD and registration in the sub-specialty of Clinical Haematology. Previously held positions include Chairperson of the South African Committee of Medical Deans, Executive Dean of the Faculty of Health Sciences at the University of Limpopo, Senior technical and strategic manager in the Office of the Special Advisor to the MEC for Health and Medical advisor in the Office of the Chief of Operations of the Gauteng Department of Health and Dean of the School of Medicine of the University of Witwatersrand.

Project to recruit and place doctors in PHC facilities in the pilot NHI districts: Lessons learnt and opportunities for the future

FPD led the project to recruit and place doctors in PHC facilities in eight pilot NHI districts. The project was implemented by a consortium of partners including the Wits Rural Health Initiative, Broadreach, Aurum Institute, and Right to Care.

NHI District	Province	PEPFAR District Support Partner
Dr Kenneth Kaunda	North West Province	WRHI
Gert Sibande	Mpumalanga	Broadreach
OR Tambo	Eastern Cape	Aurum
Thabo Mofutsanyana	Free State	Right to Care
Tshwane	Gauteng	FPD
uMgungundlovu	KwaZulu Natal	Aurum
UMzinyathi	KwaZulu Natal	Aurum
Vhembe	Limpopo	FPD

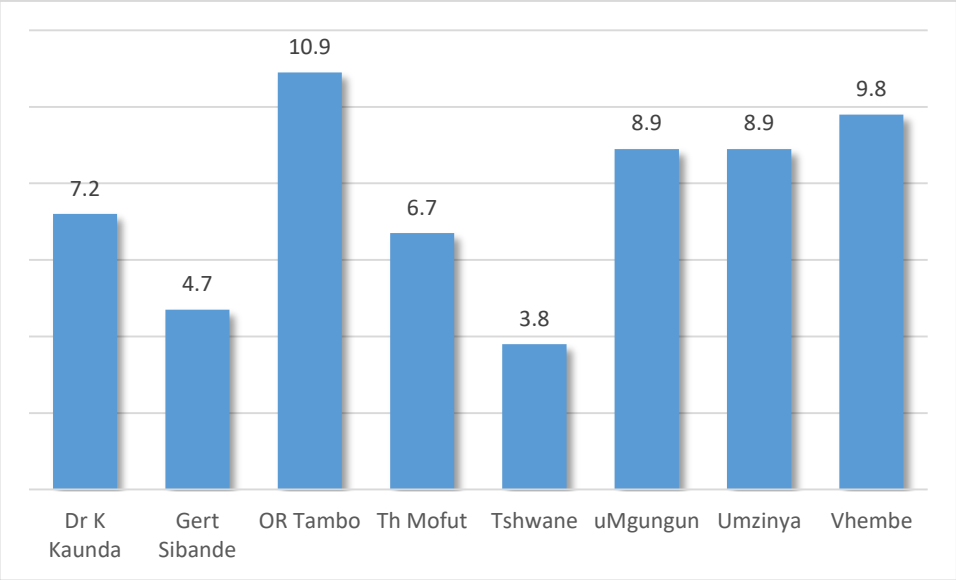
As of December 2016, 330 doctors had been recruited and placed in PHC facilities.



The recruitment rate of doctors was affected by two important decisions. Firstly the announcement in February 2015 that the number of doctors recruited should be capped at 142. Secondly, the announcement in August 2016 that the project would be closed due to financial constraints. This was subsequently retracted, however there is now a risk of irreversible mistrust and reluctance of doctors to participate in the future. FPD has made a proposal to ring-fence the funds for the full duration of the new tender in order to neutralise such threats for future programmes.

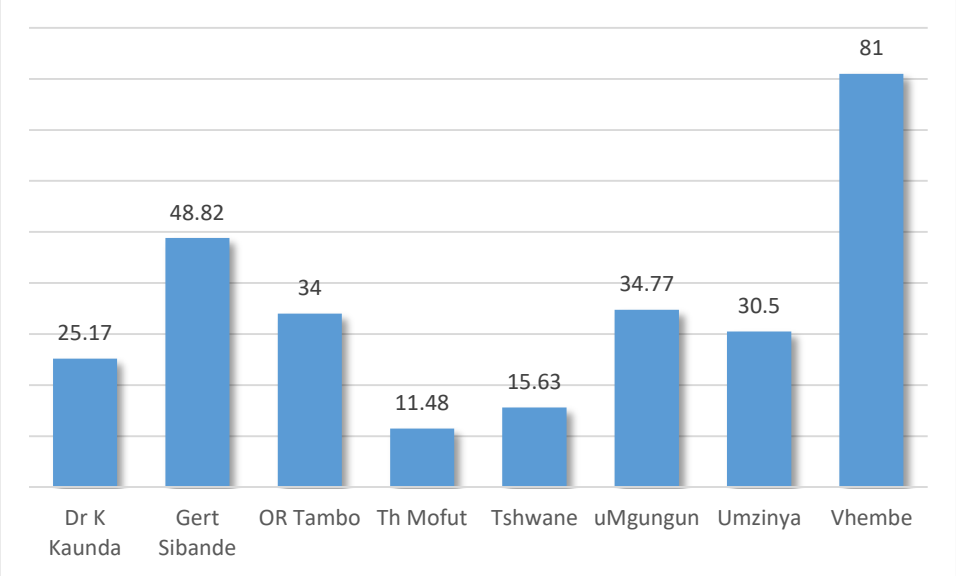
It was found that the implementation of the booking system in PHCs was essential in improving services. It also ensured that the doctors had time to carry out quality improvement tasks such as infection control inspections, drug stock checks, file reviews, nurse mentoring and training, morbidity and mortality reviews, and resolving challenges at PHC facilities.

It was found that the number of file audits conducted improved in the last 6 months of 2016. The target was five file audits per doctor per day and the average across districts was 7.6 file audits per day. Further, Tshwane moved from an average of 0.6 file audits per day in the first half of the year to 3.8 in the last half. Similarly, OR Tambo moved from 1.6 file audits per day to 10.9.



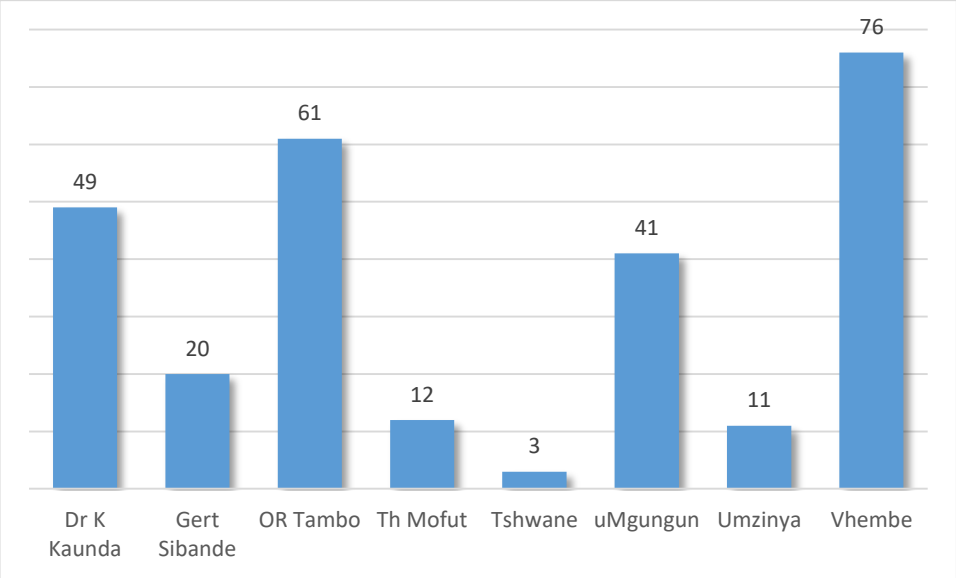
Total: 16,574 Ave 7.6/day

Mentoring and in-service training also improved in the last 6 months of 2016.



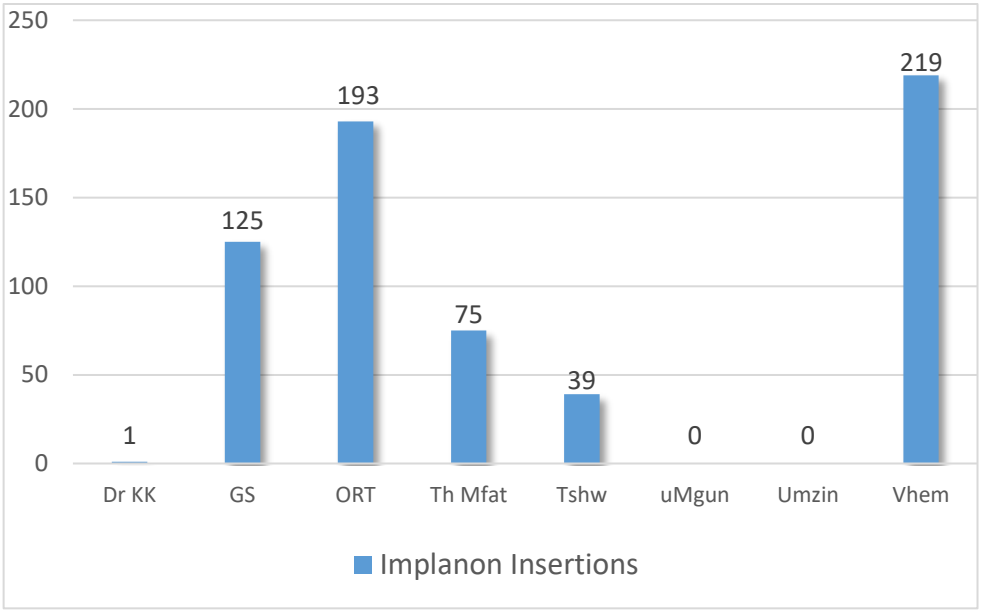
The topics of mentoring and in-service training covered the spectrum of frequent or important clinical conditions experienced such as life support, resuscitation, care and maintenance of the emergency trolley, booking patients and referrals, etc. These are all topics of importance for the improvement of the quality of care rendered at PHCs. It was recommended that doctors need more encouragement and support in terms of teaching equipment and supplies such as data projectors.

There was an average of 34.1 quality improvement projects per district in the last 6 months of 2016, with a total of 273 across districts.



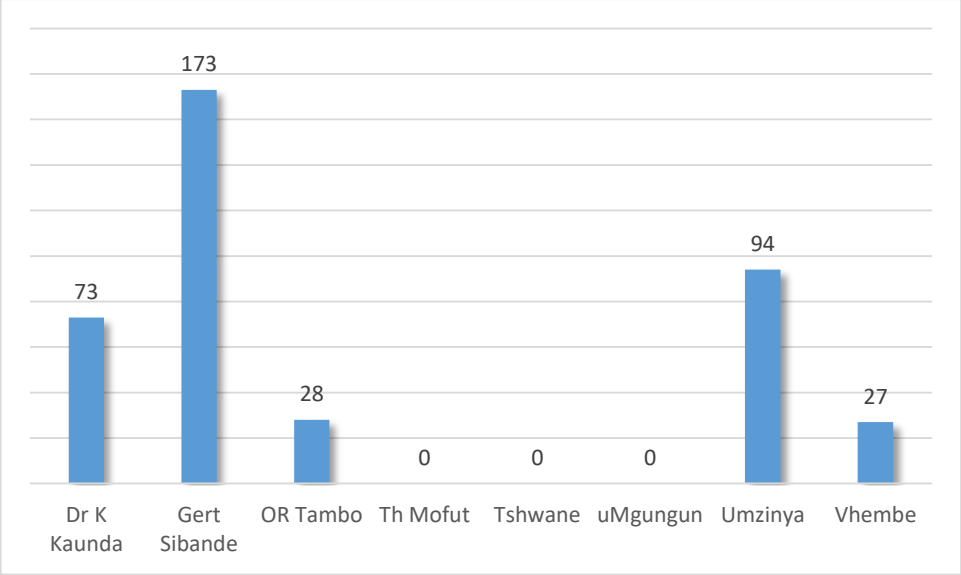
Conducting quality improvement projects was an important item in the job descriptions of doctors and carried a high weighting in their performance management. The projects were enthusiastically embraced by many of the doctors and served to improve both the standard of care and to motivate staff.

With regards to Implanon insertions, there is a high rate of removal of devices because of the perceived failure of the device to prevent pregnancies and for psychological, religious and cultural reasons. It was recommended that additional awareness campaigns and research are conducted.



Total Family Planning Procedures: Implanon Insertions: 562

In terms of medical male circumcisions (MMC), there were high rates in some districts, but none in others. This was thought to be a result of the lack of training for doctors in some districts and where doctors have been trained, they have not been optimally utilised in national MMC campaigns.

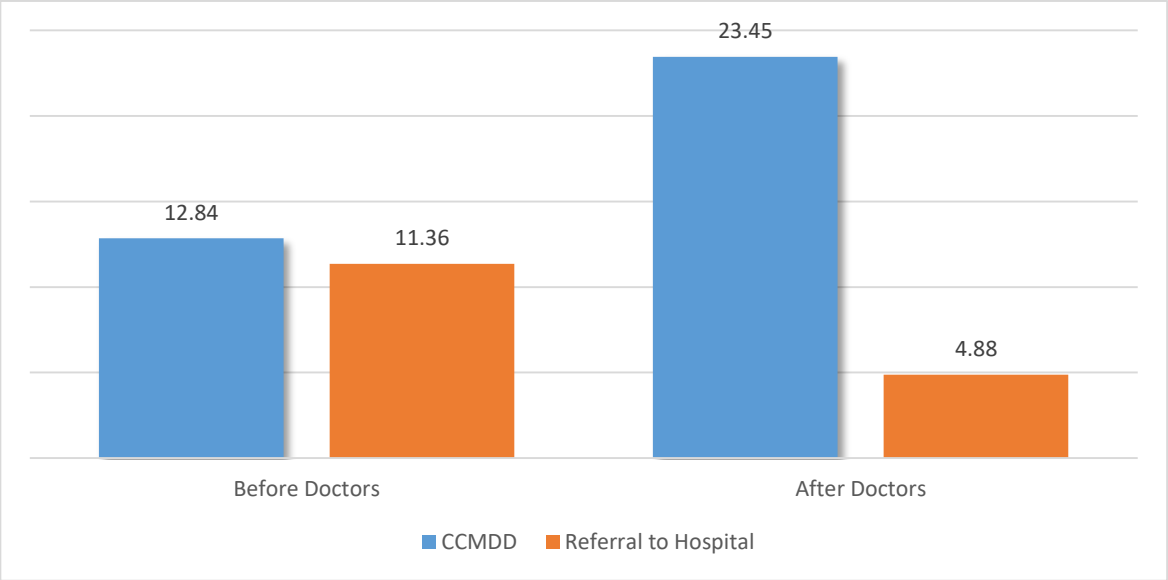


During 2016 a mobile application was piloted which monitored doctors' check-in and check-out times to accurately record service provision, record the profile of patients seen using ICD-10 criteria, monitor the completion of a checklist of daily, weekly and monthly tasks, and have

access to e-resources for rapid clinical reference. Another important module of the app is the Whistle Blowing system where doctors can report on issues and problems evident at facilities. This module of the app includes a means for collecting photographic evidence of the problems reported. The reported problems are monitored at the central office and at the management meetings. It was found that this system wasn't always well received by the district – and in some cases the provincial management. It was recommended that the system should be authorised by the NDoH as an important way to improve services at facility level.

An updated version of the app is being commissioned by FPD that will have the additional capacity to document Portfolio of Evidence data for performance management. It was recommended that new contracts make provision for obligatory electronic monitoring of all aspects of service delivery of all health professionals.

An impact study was conducted using data from 4 months prior to placing doctors and the last 4 months of their placement. It was found that the indirect impact was an improvement in the number of ARV initiations carried out by nurses and retention on ARV in both children and adults. This was thought to be a result of the diminished workload of nurses and the "halo effect" whereby nurses were positively influenced by the NDOH efforts to improve the standard of services in their facilities by the recruitment of doctors. The direct impact was an increase in the number of referrals to the CCMDD programme for patients with stable chronic conditions and a decrease in the number of referrals to hospitals. This not only saved patients from the waiting time and the expense of travelling just to collect medication, it also relieved the patient load in PHC facilities and hospitals.



It was concluded that these data provide justification for the appointment of doctors in PHC facilities.

The following three major recommendations were made:

Upgrading of supervision of health professional services: supervisors should be appointed with the sole responsibility of monitoring health professional services. They should also have regular contact with the clinic and district managers to anticipate and resolve problems and ensure that inter-professional and joint management forums are effective.

Formal inclusion of outreach activities in job descriptions: a fixed proportion (10%) of health professionals' time should be dedicated to outreach activities to promote social accountability and improve the health and social status of people in the community.

The role of doctors as Clinical Coordinators of multi-disciplinary teams of health professionals at PHC institutions: doctors should play the role of clinical coordinator, ensuring that regular and structured meetings are held in order to optimise clinical services, review clinical services, objectively measure the effectiveness of the teams' deliberations as well as that of the community councils they are involved in, and participate in facility governance.

Summary and conclusions drawn from presentations

During the presentations and discussions, various terms were used to describe the doctor's overall role within primary healthcare, including "doctor-led teams", "the trusted expert", "clinical coordinator" and "mentor". Going forward, it would be beneficial to define and streamline the scope of these activities. Professor Steve Reid described his concern that if we propose the role of the doctor as leader, without clarifying what they are the leader of, it is potentially misleading. It was suggested that their overall role should described and clarified as the *clinical leader of a primary healthcare team*.

The following is an aggregated list of the specific roles of doctors' in PHC settings, drawn from the presentations:

- To consult with and provide holistic care to patients (competent clinician)
- To look beyond biomedical models to psychosocial issues such as health promotion
- To provide clinical support and clinical governance
- To build their own, as well as other team members' capacity, and take advantage of educational opportunities
- To mentor and provide support to other team members
- To ensure continuity of care through effective referral, collaboration with other health professionals, and good communication with secondary and tertiary levels of care
- To advocate for the community and improve the equality of health outcomes through an understanding of the social determinants of health
- To ensure adherence to national guidelines
- To guide and support good data collection
- To promote good working relationships between team members
- To optimise and use resources efficiently.

GP contracting initiatives need to assess mechanisms that will respond to the challenges experienced previously, such as models of contracting and remuneration, doctors' concerns and perspectives on working in public health care facilities, and factors that optimise productivity including having timeous access to patient files, having the correct equipment and sufficient resources.

Opportunities for public-private partnerships should be explored, specifically utilising private doctors and their practices in initiatives such as ward-based outreach teams.

The education and training of medical professionals needs to take into consideration Human Resources for Health shortages, especially in rural and underserved areas, through initiatives such as decentralised training.

Gaps and areas for research

Based on the presentations and group discussions the following were identified as gaps and areas for research.

- Service provision
- Human resources, team compositions, roles and responsibilities
- Monitoring and evaluation
- Promoting interactions with communities
- Preparing for District Health Services for National Health Insurance
- All PHC facilities to be used as training centres.

Service provision

- How to address the social determinants of health more effectively.
- How to optimise preventative health and health promotion.
- Developing protocols for psychosocial support as well as medical support, using bio-psychosocial models.
- Creating enabling working environments aimed at increasing productivity.
- Developing effective administration processes (booking systems, patient file reviews, etc).
- Streamline the functioning of PHC structures.
- Investigate what motivates healthcare workers to be more productive.

Human resources, team compositions, roles and responsibilities

- Developing clear role and job definitions and accountabilities with clear and regular and reiterative communication strategies.
- Defining the appropriate skills-mix and cooperation between doctors, other health professionals and community workers.
- Assess the model of doctor-led teams (doctor as clinical leader) with management/ consultative capabilities.

- Clinical governance role of doctors based on democratic principles in their interaction with other healthcare workers needs to be determined.
- Developing a human resources retention strategy for District Health Services.
- Assessing the option of remuneration levels in recognition of additional qualifications.
- Re-looking at healthcare worker contracts:
    - Contracts should have clear scope and job descriptions – customised for the area the health worker is involved in
    - Allow for additional flexibility
    - Define contract duration
    - Define performance criteria including their role in quality assurance
    - Targets for community outreach initiatives and contact with communities to ensure effective community participation and oversight of community equity with all stakeholders involved in the health and social wellbeing of community members.
- Ensuring optimal supervision and delegation of authority (greater and more creative roles of District Clinical Specialist Teams).
- Exploring the living conditions of healthcare workers working in rural areas.

M&E

- Developing a National Electronic Record with integrated data capturing and monitoring processes.
    - The record should be community-specific
    - Should have carefully selected variables with value for service organisational improvement
    - Should have health outcomes data with relevance for clinical care as well as for interaction with the communities.
- Outcomes should be shared with communities on a structured and regular basis.

- Carefully defining parameters related to impact assessment to monitor throughout the programme.
- A platform should exist to share success stories and lessons learnt.

Promoting interactions with communities

- Developing communication approaches, orientation and information strategies to interact effectively with communities.
- Determine approaches to advocacy with active engagement with communities.
- Identify community teams with clear role and methodology definitions.
- Promote integrated and coordinated care of all aspects of community life.
- Cultural competencies and sensitivities to be defined.

Preparing District Health Services for National Health Insurance

- Determine how to better regulate the private sector involvement in NHI.
- Defining health catchment areas: NHI Units of seamless care fully integrating health care amenities and all health services
    - PHC Outreach Team in each community (COPC model)
    - Integrated Primary Care Platform Linking PHC institutions with WBOTs and other outreach initiatives
    - Define linkage role of community health workers
    - Involvement of private doctors in WBOTs (support WBOTs from their practices)
    - Protocols for referral process to private doctors
    - Develop remuneration principles for doctors
    - Protocols for referral process to PHC institutions
- Defined role of each role player in the NHI Units with structured, regular and iterative communication programmes
- Defining leadership roles
- Using technology for monitoring, control and remuneration

  - Regular and structured communication of outcomes with all role-players, including the communities
  - Modify District Health Services following comprehensive review of outcomes
- Funding for NHI Units.

All PHC facilities to be used as training centres

- Health Professions' Education directed at promotion of Human Resources for District Health Services.
- Determine training needs of all healthcare professionals
- Every health institution to act as a training site (including students and Family Medicine registrars)
- Identify leadership and management training for primary healthcare
  - Full and structured integration of District Clinical Specialist Teams to cover all aspects of training for District Health Services

Conclusion

Ms Jeanette Hunter closed the symposium by thanking the organisers of the symposium and the attendees for their participation and described the way forward:

Firstly, in the area of Human Resources Management and Development, each team member's role in a multi-disciplinary team should be clarified and guidelines developed for the implementation of this model.

Secondly, in terms of Information Management, outcome data should be relevant to all levels of healthcare (DHIS) and facilities should have the autonomy to collect and use their own data to improve service delivery.

Thirdly, community outreach initiatives, such as doctors conducting home-visits, should be considered and weighed against the cost implications.

Lastly, PHC doctors' feelings of disempowerment should be explored and understood.

References

Mahomed O, Asmall S. 2015. Development and implementation of an integrated chronic disease model in South Africa: lessons in the management of change through improving the quality of clinical practice. International Journal of Integrated Care 15(4). Found at: http://doi.org/10.5334/ijic.1454

National Department of Health. 2012. Human Resources for Health Strategy (2012-2017). Found at: http://www.gov.za/sites/www.gov.za/files/hrh_strategy_0.pdf

National Department of Health. 2015. White Paper on National Health Insurance for South Africa: towards universal health coverage. Found at: https://www.health-e.org.za/wp-content/uploads/2015/12/National-Health-Insurance-for-South-Africa-White-Paper.pdf

Office of the President. 2010. Delivery Agreement for Output 2: A long and health life for all South Africans. Found at: http://www.gov.za/sites/www.gov.za/files/delivery%20agreement%20Health%20Sector%20NSDA.pdf

Pillay, Y & Barron, P. 2012. The implementation of PHC re-engineering in South Africa. Summary drawn from the Provincial Guidelines For the Implementation of The Three Streams of PHC Reengineering, National Department of Health, South Africa. Found at: https://www.phasa.org.za/wp-content/uploads/2011/11/Pillay-The-implementation-of-PHC.pdf

R Mash, K Von Pressentin & J Blitz. 2017. Family medicine in South Africa: exploring future scenarios. South African Family Practice. Published Online. Pages 1-4. Found at: http://dx.doi.org/10.1080/20786190.2016.1272231

Republic of South Africa. National Health Act 61 of 2003. Found at: http://www.chr.up.ac.za/undp/domestic/docs/legislation_55.pdf

Republic of South Africa. National Health Amendment Act 12 of 2013. Found at: http://www.gov.za/sites/www.gov.za/files/36702_gon529_0.pdf

World Health Organisation. Declaration of Alma Ata. International Conference on Primary Health Care, Alma-Ata, USSR. 1978. Page 1. Found at: http://www.who.int/publications/almaata_declaration_en.pdf

Annexure 1: List of Attendees

TITLE	INITIALS	SURNAME	INSTITUITION
Prof.	LF	Adonis	University of Pretoria
Dr	A	Aina	SAMA
Dr	S	Asmall	National DOH
Dr	HM	Bapelo	Ekuruleni District
Mr	M	Burnet	HST
Mrs	AS	Cassim	Amajuba District
Prof.	D	Couper	Stellenbosch University
Dr	M	Dombo	National DOH
Dr	R	English	HST
Ms	RB	Faknoodea	CBD
Dr	CB	Gaunt	Wsu
Ms	Z	Hadebe	Umzinyathi
Prof.	D	Hellenberg	UCT
Dr	Prof	Holland	FPD
Dr	JFM	Hugo	University of Pretoria
Ms	J	Hunter	National DOH
Dr	TP	Kerry	DoH KZN
Mrs	LRC	Komane	Tshwane District
Dr	RA	Loone	Wits University
Mrs	TB	Luthuli	Gert Sibande District
Prof.	S	Madiba	Sefako Makgato District
Mr	M	Makhudu	Tshwane District
Dr	Z	Malan	Stellenbosch University
Dr	A	Marias	University of Pretoria
	M	Mbokota	Prov
Dr	TB	Mhlongo	LP DON
Mr	SSS	Mlenzana	OR Tambo District
Prof.	N	Mofolo	Free State Health
Dr	C	Mojapelo	SAMA
Prof.	S	Moosa	Wits University
Dr	RH	Mpateni	Fratz Viser Nprt
Dr	N	Mpwann	National DOH
Mrs	NC	Mudzauam	National DoH
Dr	L	Murieithi	HT
Prof.	H	Myezwa	Wits University
Mrs	NR	Phakati	KZN Amajuba
Mr	SC	Polelo	Free State Health
Mrs	NS	Radebe	DoH KZN
Prof.	S	Reid	University of Cape Town

Mrs	E	Rudman	University of Pretoria
Dr	E	Rwakaikara	Dr KK district
Ms	FB	Slaven	FPD
Ms	Z	Sobuza	FPD
	ABST	Tankwanchi	Wits University
Ms	FS	Tshikovhi	Vhembe District
Dr	G	Umprerres Torrh	Pixley K Seme District
Dr	EC	Wolmarans	Free State Health
Mrs	G	Wolvaardt	FPD