



**BUILDING BRIDGES:
A REPORT TO THE
MASSACHUSETTS – SOUTH AFRICA
HEALTH CARE TASK FORCE**

November 2000

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EXECUTIVE SUMMARY

The Commonwealth of Massachusetts has had a close relationship with the people of South Africa for many decades, contributing substantially to the international effort to bring an end to apartheid. Similarly, Massachusetts has made a commitment to building the new South Africa through its ongoing academic, corporate, and governmental relationships and through a 1997 twinning agreement between the state and the Province of the Eastern Cape. One product of that twinning agreement has been the establishment of the Massachusetts - South Africa Health Task Force through the Massachusetts Department of Public Health. The Task Force will support the development of mutually beneficial initiatives in the areas of public health and medicine. This report was prepared for the Task Force by a recent Massachusetts delegation to the Eastern Cape and provides a preliminary blueprint for future joint ventures. The Executive Summary highlights the activities and findings of the South Africa Health Care Delegation and summarizes their recommendations for moving forward.

The Eastern Cape Province

Located on the Indian Ocean, the Eastern Cape Province is a topographically diverse geographic region roughly the size of Massachusetts and with a similar population base. Encompassing two of the former homelands, as well as part of the former South Africa, the Eastern Cape has two major urban areas and extensive rural environs. In terms of resources, employment opportunities, and governmental and service infrastructures, this center of African National Congress activity has been one of the most historically disadvantaged areas of South Africa. The choice of the Eastern Cape for a twinning relationship with Massachusetts reflects both prior commitments between Massachusetts and the people of South Africa as well as a determination by the national South African government to support the development of this critical region. The twinning agreement between Massachusetts and the Eastern Cape anticipates collaborations in the areas of economic development, information technology, and health care delivery. Significant medical and public health needs and evolving initiatives in the province provide ample opportunity for coordinated efforts through the newly established Massachusetts-South Africa Health Task Force.

The July 2000 Massachusetts-South Africa Health Care Delegation

As one of its first activities, the Massachusetts - South Africa Health Task Force sponsored a Health Care Delegation which visited the Eastern Cape Province in July, 2000. The 18-member mission, representing multiple areas of public health and medicine, included legislative and administrative governmental personnel, industry partners, clinical practitioners, and representatives from philanthropic and social service agencies. Co-led by Representative Byron Rushing and Massachusetts Department of Public Health Assistant Commissioner, Dr. Jean McGuire, the group spent a week in the Eastern Cape meeting with government officials, academic collaborators, international aid representatives, clinicians, and community

organizations. Site visits were conducted in diverse urban and rural areas and focused on public

health and medical service delivery concerns previously identified by Eastern Cape collaborators. These included: TB control; HIV prevention and care; maternal and child health; rural and urban primary care delivery models; academic medicine capacity development; and public health surveillance and administrative system needs.

Observations from the Field

Strengths as a Basis for Future Development

In the course of its week of meetings, the Delegation observed many strengths within the Eastern Cape's public health and medical delivery structures. They included: strong national and provincial primary care and other public health and medical service delivery plans; comprehensive, protocol-driven, nursing clinical management and program administration; innovative public health media campaigns; evolving private and public care delivery coordination; and targeted programming for special health needs. Exemplary preventive health programs were observed in the areas of TB control, teen pregnancy, elder abuse, other domestic violence, child witness to violence, and AIDS.

Site visits to several clinical and other community-based settings indicated the availability of creative, cross-disciplinary services, often accessible through a single point of entry. Emerging public-private collaborations and a growing NGO sector suggest diverse opportunities for new development in the future. Though many clinical settings were serving large numbers of patients in sometimes severely under-resourced conditions, the Delegation observed well-administered, respectful services organized around targeted local needs and capacities.

Throughout its travels, the Delegation experienced as the greatest strength of the Eastern Cape people the obvious hope and energy born of the struggle against apartheid. This is the primary strength upon which future collaborations will build.

Challenges that Emerged

Though excellent blueprints for public health service delivery exist, the provincial health ministry faces a daunting task in bridging the distance between existing action plans and the current capacity for program implementation. This gap between planning and implementation is largely related to historic and current administrative and resource challenges. The provincial government faces the burdens of continuing to integrate three different governmental systems of public health and medical care delivery and reimbursement – systems which are a legacy of apartheid policies in the region - while simultaneously meeting national goals of universal access and of administrative and fiscal devolution. These efforts require the active redistribution of prior resource allocations; the re-engineering of diverse personnel and other health administrative structures; and the development of multiple decentralized systems of service delivery and management.

Critical public health planning, management, and service challenges were identified, including: under-developed disease surveillance capacity; under-financed and insufficient laboratory and pharmacy services; inadequate and sometimes poorly maintained facilities; limited numbers of trained middle and upper level health services planning, delivery and other management staff;

and insufficient administrative support systems for personnel recruitment, hiring and supervision; inventory control; and fiscal planning and oversight for centralized and decentralized activities.

Finally, throughout the trip the Delegation noted the extent to which issues of economic development were inevitably inter-twined both with the health risks of citizens and with the ability to improve health care access. The health of citizens in the province is deeply dependent on improvements in sanitation, housing, and employment.

Benefits of Collaboration for Massachusetts

In pursuing the twinning agreement several years ago, the Commonwealth recognized the considerable benefit to the state of reinforcing and extending historic experiences of global collaboration. As noted elsewhere in the report, Massachusetts now has many academic and industry related efforts underway in the new South Africa. Those related to medical care delivery and public health stand to greatly benefit from the close inter-governmental coordination anticipated through the Health Task Force. Significant development opportunities were identified in the areas of health facility construction; laboratory and pharmacy services delivery system development; manpower training; academic and other clinical research capacity development; and health administrative, fiscal, and other information systems planning. Potential participants in these efforts include not just Massachusetts corporate and academic partners, but also public health administrators and policy makers, community based service organizations, and medical, public health, nursing and other student programs.

The Delegation anticipated other benefits to the citizens of Massachusetts through this collaboration. From health-related economic development activities to nurse-managed syndromic treatment models to novel public health campaigns, the Delegation observed innovative efforts which could inform practices here in the Commonwealth. The opportunities to engage Massachusetts communities and organizations in global learning and collaborative action is considerable. Additionally, the Delegation noted the potential advantages of this collaboration to the growing numbers of Sub-Saharan individuals living in the state.

Finally, the Task Force's work presents an opportunity to assist and leverage Massachusetts' private sector interest in the region. South Africa is by far the wealthiest and most developed nation in the sub-Saharan region and therefore an obvious choice for those businesses hoping to expand their operations to Africa. Additionally, South Africa serves as a gateway to other regional opportunities through its role as a leading member of the Southern African Development Community (SADC), a regional economic trading association that includes 14 countries in Southern Africa. Of particular interest to the Task Force is South Africa's role in SADC as Chair of the Health Committee.

Recommendations

The Delegation has preliminarily identified three broad areas in which potential collaborations should be considered. They include:

- Support for the development of the provincial Department of Health's capacity to survey,

plan for, resource, and manage the delivery of public health and medical services in the province;

- Support for and projects with the medical school and the University of Transkei in Umtata in its evolving collaborative efforts with the region's district and local health departments and the NGO sector. (Umtata is the childhood home of former President Mandela and the site of a crucial historically black medical school.);
- Assistance to selective non-governmental organizations (NGO) whose goals and activities are of mutual public health interest to the Province and to collaborators here in Massachusetts.

Several specific proposals have been generated by the Delegation for review by the Task Force and by the Eastern Cape representatives. They include:

- Surveillance system development and training and other managerial support assistance to assure the successful transition of the USAID-funded Equity Project currently supporting the public health system development in the Eastern Cape;
- Targeted training support for the medical school, particularly in the area of telemedicine;
- Development of domestic violence related curricula and protocols for forensic nursing, police and health center personnel in the Umtata region;
- Support for the AIDS shelter development currently underway in the Grahamstown region;
- Expansion of the peer-led youth HIV program development being modeled through the Kaiser Foundation's LOVE LIFE project;
- Technical assistance to the Kellogg Foundation clinic expansions currently underway in the Eastern Cape.

Moving Forward

The Massachusetts-South Africa Health Task Force and representatives of the Eastern Cape will review the Delegation's report during the month of November in anticipation of identifying short-term and long-term development priorities. The Delegation members remain available to assist in the realization of this important venture.

MASSACHUSETTS – SOUTH AFRICA HEALTH CARE TASK FORCE

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GLOSSARY OF TERMS

CADRE	Centre for AIDS Development, Research and Evaluation
CCHERS	Community Center for Health Education, Research and Service
CSIR	Council for Scientific and Industrial Research
DHS	District Health Services
DOT	Direct Observed Therapy
ECDOH	Eastern Cape Department of Health
NAPWA	National Association of People Living With HIV/AIDS
NDOH	National Department of Health
NGO	Non Governmental Organization
NHLS	National Health Laboratory Service
NSPH	National School of Public Health
PPP	Public Private Partnership
SADC	Southern African Development Community
UNITRA	University of Transkei
WHO	World Health Organization

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A REPORT TO THE MASSACHUSETTS - SOUTH AFRICA HEALTH CARE TASK FORCE

1. OVERVIEW

1.1 History of Massachusetts – South Africa Relationship

The Commonwealth of Massachusetts has a long and respected history of support for South Africa's democratic movement. Having been a leader in the international effort to bring an end to apartheid, Massachusetts was home to a number of exemplary public and private initiatives that challenged South Africa's policies of racial discrimination and gave hope and support to the country's democratic movement. As a result, the Commonwealth enjoys an unusually high degree of recognition and appreciation within South Africa. This reputation continues to be strengthened as many Massachusetts governmental departments, educational institutions, private agencies, businesses, and individual residents remain committed to South Africa's democratic development.

Massachusetts colleges and universities continue to provide scholarships and academic support to South Africa's emerging entrepreneurs, managers, health care professionals, educators, and development experts, while maintaining contact with the growing network of alumni/e who have already become leaders in South Africa's public and private sectors. Numerous Massachusetts academic institutions and private development agencies are directly engaged inside the country through ground-breaking ventures ranging from the establishment of tele-medicine centers to the promotion of women's business leadership, from university curriculum development to primary health care delivery. In the private sector, Massachusetts companies have identified opportunities and expanded their involvement with South Africa. Currently, more than 40 Massachusetts corporations, including Gillette Company, Reebok International, Monitor Company, Polaroid, and EMC Corporation are doing business in South Africa, with several of the largest having established offices within the country.

An important step in the growing partnership between the two regions took place in 1995 when then-Governor William Weld led a successful Trade Mission to South Africa. The Trade Mission inspired a process of identifying structural mechanisms that could be put into place and strengthen the already considerable ties that existed between the Commonwealth and South Africa. It was therefore not surprising that on January 27, 1997, the Commonwealth of Massachusetts and South Africa's Province of the Eastern Cape signed a Sister State-Province Agreement which pledged cooperation between the two regions in the areas of trade, investment, culture, environment, education and technology exchange and tourism. This agreement specifically called for the establishment of close ties between educational and medical institutions to foster exchanges and ongoing collaborations. The agreement resulted in a number of initiatives, including a Trade Mission to the Eastern Cape led by Senator Dianne Wilkerson in 1997.

Building upon the spirit of the Sister State-Province Agreement, Dr. Howard Koh, Massachusetts Commissioner of Public Health sent a letter to the Eastern Cape Department of Health in 1998, proposing the development of an ongoing partnership between the two Departments of Health. In April of 1999 the Department co-sponsored the Massachusetts – South Africa Health Care

Forum which brought together key public and private sector leaders to explore potential collaborations between the two regions.

It is under the auspices of the Sister State-Province Agreement and Commissioner Koh's initial efforts that the Massachusetts Department of Public Health established a permanent ***Massachusetts – South Africa Health Task Force*** on April 26, 2000. The Task Force was established to identify strategic preventive and therapeutic health-related opportunities for partnership development between Massachusetts and South Africa in areas of mutual interest including technology, delivery of services, clinical training, health infrastructure development, and research. These efforts build upon existing health exchanges between Massachusetts entities and other bilateral relationships in the Eastern Cape. Areas of focus for the Task Force will be driven by epidemiological and infrastructure concerns identified by Eastern Cape Province representatives and will selectively reflect those arenas in which Massachusetts capability and interest have been identified. The Task Force is envisioned as a broad-based effort, encompassing the activities of public and private institutions, governmental and non-governmental agencies, business leaders and experts in key health-related fields.

The July 2000 Health Care Delegation traveled to the 13th International AIDS Conference in Durban and then to the Eastern Cape Province as the first initiative of the ***Massachusetts – South Africa Health Task Force***. South Africa Partners, Inc., which has provided technical and logistical support for the development of the twinning agreement and the permanent Task Force, coordinated the work of the delegation.

1.2 History of July 2000 Health Care Delegation

In response to requests from the Eastern Cape Provincial government, the 18-member delegation, representing multiple areas of public health and medicine, including legislative and administrative governmental personnel, industry partners, clinical practitioners; and representatives from philanthropic and social service agencies traveled to South Africa (*see Appendix B for complete list of delegates*). The delegation, co-led by Representative Byron Rushing and Massachusetts Department of Health Assistant Commissioner, Jean McGuire, brought expertise in areas as diverse as surveillance, infectious disease research, pediatric and internal medicine, service delivery administration and reimbursement, and consumer and community mobilization.

The travel dates for the delegation were set to take advantage of the fact that Durban, South Africa was hosting the 13th International AIDS Conference. This unique opportunity allowed five delegation members and a representative of South Africa Partners to attend the conference prior to traveling to the Eastern Cape Province. In addition to a general update on the status of the worldwide AIDS epidemic, the conference provided delegation members with important background information about the specifics of the AIDS epidemic in South Africa. It also provided a venue for more informal meetings with national South African Department of Health officials and representatives from the USAID Health Desk.

The group from Durban joined the remaining delegation members on July 15th and the July 2000 Health Care Delegation spent a week traveling in the Eastern Cape Province, meeting with

provincial health department officials, government representatives, and visiting projects in both the urban and rural districts of the province. The Health Care Delegation offered an important opportunity to witness first hand the challenges faced by health care providers in the Eastern Cape Province. It also provided delegation members with a better understanding of the provincial health department's organizational structure, policy initiatives, and restructuring plan. A great deal of time was spent during the week traveling with key members of senior staff which offered an opportunity for more detailed discussion in the field.

1.3 Health Care Delegation Goals

- Establish a clear mechanism for ongoing contact between the Eastern Cape and Massachusetts Departments of Health to ensure adequate follow-up and future collaboration.
- Identify key health issues that are being addressed by the Eastern Cape Department of Health.
- Identify key health issues that are being addressed by Eastern Cape NGOs and CBOs.
- Share best practices from the Massachusetts and Eastern Cape experiences, including surveillance practices and prevention education strategies.
- Identify NGOs for potential partnerships with MA organizations and determine how to maintain future contact.
- Identify potential training needs and exchange/training opportunities for managers in the health system.
- Establish contact with key decision makers in public hospitals, and training facilities and develop a mechanism for maintaining links.
- Make contact with national and local offices of National Association of Persons Living with HIV/AIDS (NAPWA) offices and determine how to maintain future contact.
- Make contact with organizations associated with the faith community and its response to HIV/AIDS. Determine how to maintain future contact.
- Learn how the Eastern Cape Department of Health handles communications related to public health issues.
- Make contact with the USAID office in South Africa and arrange a meeting to discuss how this initiative could be linked to or build upon already existing efforts.

1.4 Key Bilateral Relationships

There are already several important bilateral relationships operating in the Eastern Cape Province that will provide a solid base of knowledge and support for any efforts undertaken by the Massachusetts – South Africa Health Task Force. The most important of these is the USAID funded EQUITY Project which is seeking to institute a primary health care system across the province. Technical assistance for this effort is being provided by Management Sciences for Health, based in Jamaica Plain, Massachusetts. Through the EQUITY Project, the ECDOH is building management capacity, creating an integrated package of essential services for the province's network of clinics, establishing quality care standards, improving drug management and strengthening financial controls. Although initially focused on the Eastern Cape, the

EQUITY Project is now beginning to roll out its program to other needy provinces.

Additional bilateral relationships operating in the Province of the Eastern Cape that are of interest are those being carried out in partnership with the University of Massachusetts Medical School, New England Medical Center, Johns Hopkins University, Howard University, Boston University, Simmons College of Nursing, and Wheaton College.

Faculty and students from the University of Massachusetts Medical School in Worcester have completed the second year of an HIV/AIDS testing program based at the University of Transkei (UNITRA). As part of a larger project in South Africa, the New England Medical Center is engaged in supporting telemedicine and infomatics development, and faculty from UNITRA are participating in the program.

Earlier this year, Johns Hopkins University and Rhodes University established the Centre for AIDS Development, Research and Evaluation (CADRE) with the purpose of strengthening research capacity related to the HIV/AIDS epidemic. CADRE will draw together international, national (South African), and community-based research related to the disease in order to strengthen future intervention strategies. Howard University Medical School is engaged in a partnership with the Faculty of Medicine and Health Sciences at the UNITRA. This partnership is focusing on the area of trauma medicine and includes faculty and student exchanges.

Faculty of Boston University School of Public Health are involved in supporting Eastern Cape provincial environmental health initiatives. Wheaton College and the University of Port Elizabeth Health Sciences Division have recently initiated faculty exchanges.

It is also worth noting, that the Health Delegation was able to visit three of four community health centers that were founded by community groups with the support of the Kellogg Foundation. These clinics are all located in the Umtata area and are affiliated with the Faculty of Medicine and Health Sciences at the University of Transkei. The Community Center for Health Education, Research, and Service (CCHERS), a Boston-based, Kellogg-funded project with a similar university/community partnership, has had a working relationship with these health centers for the past 10 years.

Several additional bilateral collaborations, not based in the Eastern Cape, might eventually provide some benefit to the efforts of the Task Force. The University of Massachusetts School of Public Health on the Amherst campus, for example, was selected by USAID to provide technical assistance to the new National School of Public Health (NSPH), based at the Medical University of South Africa near Pretoria. The NSPH will eventually provide technical assistance to emerging public health programs across the country, including the one based at the University of Transkei.

MIT, and two partner US institutions, are working with several South African Technikons (similar to our community colleges) to upgrade their math and science curricula. In addition, there are several initiatives within the Harvard School of Public Health and Medical School that might impact the work of the Task Force. None are directly focused on the Eastern Cape, but

there may be some benefit that could be identified.

1.5 South African Contacts

The July 2000 Health Care Delegation benefited from South Africa Partners' ties to the South Africa Embassy in Washington, DC and the provincial government of the Eastern Cape. This history expedited the process of identifying mutually agreed upon goals for the Health Care Delegation and the development of a travel itinerary.

In the US, Ambassador Sheila Sisulu who was present at the official launch of the Massachusetts – South Africa Health Task Force, offered the assistance of the Embassy during the planning process. Also helpful, was South Africa's National Department of Health (NDOH) Representative to The Americas, Dr. Glaudine Mtshali, who is also based at the Embassy. (Dr. Glaudine Mtshali is a former resident of the Commonwealth and has received an advanced degree from the University of Massachusetts at Amherst.)

Dr. Mtshali arranged for those Health Care Delegation members who were in Durban, to meet with Dr. Ayanda Ntsaluba, the NDOH Director-General. This meeting provided an opportunity to inform the Director-General about our planned activities in the Eastern Cape and solicit the national department's support for follow-up initiatives. Also present at this meeting was Ambassador Sheila Sisulu.

In the Eastern Cape, planning for the Health Delegation was greatly assisted by Dr. Bevan Goqwana, the Provincial Minister of Health, and Dr. Sipiwo Stamper, Permanent Secretary for the Department. Under their leadership, the specifics of the itinerary were finalized and both participated in several key meetings during the week. They have each agreed to help facilitate the follow-up to the visit.

1.6 Rationale for Future Relationship

The Delegation's work was carried out in concert with the scope of activities outlined in the twinning agreement between the Commonwealth and the Eastern Cape. The report summarizes areas of need identified by Eastern Cape representatives and Delegation members and recommends a series of principles and selective actions for moving forward (*see Sections 5 & 6*). In making these recommendations, the Delegation has focused primarily on the development and assistance concerns within the Eastern Cape. However, the Delegation also recognizes the considerable benefit to the Commonwealth that can be realized through the successful pursuit of joint efforts with the Province.

First, the Eastern Cape collaboration represents a further realization of the mission of the Massachusetts Department of Public Health which includes assuring that "the people of the Commonwealth receive quality health care" through building partnerships that "protect, preserve, and improve the health of all the Commonwealth's residents." Lessons learned from the South African experience will be of benefit to diverse residents of the Commonwealth including, among others, the growing numbers of sub-Saharan residents of the state, public health administrators and policy makers, community-based service organizations, medical personnel and students, and industry partners. The following are some of the arenas of strength and/or

opportunity for Massachusetts identified in the Eastern Cape:

- Alternative models for community mobilization in public health campaigns;
- Novel manpower development opportunities;
- Evolving systems of protocol-driven clinical care in low resource areas;
- Practical training and educational experiences for students of rural and family medicine and public health management;
- Expanding medical and public health research and service delivery investments across public and private sectors;
- Innovative explicit and low literacy public health campaign materials;
- Models for improved integration of public health concerns in economic and other spheres of government; and
- Comprehensive youth peer public health programs.

These and other arenas will provide learning and replication opportunities for public health and clinical programs here in Massachusetts.

Secondly, the process of formalizing future collaboration through the work of the Massachusetts-South Africa Health Task Force will provide a platform for expanding already existing Massachusetts relationships with South Africa in ways that are of mutual benefit to both regions. As noted previously, Massachusetts colleges and universities are already engaged in a number of important health-related programs in South Africa, including in the Eastern Cape. They will be advantaged by new commitments to the region and by the coordination and support for Massachusetts' efforts through the Task Force. Additionally, these existing academic efforts in South Africa will enhance the ability of the Task Force to carry out its mission.

Finally, the Task Force's work also presents an opportunity to assist and leverage Massachusetts' private sector interest in the region. South Africa is by far the wealthiest and most developed nation in the sub-Saharan region and therefore an obvious choice for those businesses hoping to expand their operations to Africa. Additionally, South Africa serves as a gateway to other regional opportunities through its role as a leading member of the Southern African Development Community (SADC), a regional economic trading association that includes 14 countries in Southern Africa.¹ Of particular interest to the Task Force is South Africa's role in SADC as Chair of the Health Committee. The recent Delegation trip further reinforced the possibilities of private sector development interest. Biopure, Inc., a Massachusetts bio-technology firm currently completing clinical trial work in South Africa, participated in the Delegation and found the trip very helpful as the company seeks to increase its efforts in the country. Future Task Force activities are expected to be similarly beneficial.

2. Specific Areas Highlighted by the Eastern Cape Department of Health

The week that the delegation spent in the Eastern Cape Province was an opportunity to meet with government officials, senior managers, clinicians, and community activists. Delegation members

were given a detailed briefing by the Department, which covered a wide range of information,

¹ Members of SADC are: Angola; Botswana; Democratic Republic of Congo; Lesotho; Malawi; Mauritius; Mozambique; Namibia; Seychelles; South Africa; Swaziland; Tanzania; Zambia; and Zimbabwe.

including historical background, current status of programs, and future goals.

2.1 Creating Equity in the Province

Delegation members learned of the challenges faced in 1994 by the first democratically elected South African government as it sought to dismantle the inequities of apartheid. Every aspect of government had to be reorganized and new priorities put into place.

Under apartheid, the South African health care system was characterized by racial and geographic disparities, fragmentation and duplication, and an over-emphasis on highly technical hospital-based care that was only available to the wealthiest 17% of the population who could afford private insurance. The world's first heart transplant performed in Cape Town in 1967 is an example of what this system of healthcare could offer. At the same time (and often in close proximity), third world conditions existed in South Africa's townships and rural areas which were characterized by inadequate or non-existent facilities, staff, drugs and laboratories. Among the black population, these conditions increased the vulnerability to preventable diseases and death from curable infection. Studies completed in 1994 showed that township and rural areas saw unusually high infant, under-five and maternal mortality rates.

As it sought to reorganize and re-deploy scarce resources, the new government faced the challenge of integrating the 14 separate Departments of Health that had been created under apartheid to serve different racial groups in different geographical areas. State funds that had once been disproportionately used to support the needs of white communities (approximately 13% of the population), now needed to be more equitably distributed to serve the entire population. After 1994, South Africa's National Department of Health (NDOH) began emphasizing increased access to sustainable primary health services, and its programs increased attention on the rural, peri-urban and urban poor, and the elderly.

2.2 Eastern Cape Health Care Program

The Province of the Eastern Cape is one of nine provinces in South Africa. Two-thirds of its residents live in rural areas, while only one-third is considered urban. Like the NDOH, the Eastern Cape Department of Health (ECDOH) faced significant challenges associated with the restructuring of its health care system, including the integration of three separate administrative structures.²

Since 1994, the ECDOH has pursued an integrated, decentralized approach to health care delivery. This has called for a restructuring of its hospitals and clinics, stressing local management and control. To better serve the local population, the province has been divided into six districts and one metropolitan area. Senior managers are engaged in the process of devolution of oversight for these districts to the local level, including areas of personnel, finance, and governance.

The transformation has surfaced a number of obstacles, including the need for personnel and human resource development; implementation of an effective patient referral system; and the

² The current boundaries of the Province of the Eastern Cape include the two large former homelands of the Ciskei and the Transkei and a portion of the former Cape Province.

institutionalization of better financial controls. The shortage of trained personnel in the province is significant. While the department has a job listing of 33, 000, it is functioning with a vacancy rate of more than 30%.

2.3 Services

The restructuring of the ECDOH has been an enormous undertaking. During our initial briefing session, we were given an overview of the department's key areas of concentration.

a. District Health Services

District Health Services (DHS), which oversees clinics, community health centers, and district hospitals, receives approximately two-thirds of the ECDOH budget. There are currently 86 district hospitals and 300 clinics and community health centers. DHS utilizes WHO standards for a district hospital which call for a facility with 30 to 300 beds, staffed by generalist doctors, receiving patients from primary health facilities. District hospitals are expected to then refer patients to regional/provincial hospitals as needed.

Seeking to compensate for the inequities created by the apartheid system, the ECDOH is working to ensure a more equitable distribution of health care facilities. The Department has adopted WHO standards for clinic locations and has set a goal of no patient having to walk further than 5K to receive medical assistance. This will require building new clinics and closing or merging others.

District management structures have begun transferring decision-making away from the provincial level, but because of the budget crisis, personnel-related issues remain centralized. As one manager indicated, this is not by choice, but by necessity. Until adequate monitoring systems are in place, decisions related to financial expenditures and hiring of personnel will need to remain at the provincial level.

There are currently 800 public sector doctors in the province, mainly in the Port Elizabeth, East London, and Umtata areas. The recently implemented strategy of requiring community service for all graduating medical students has provided the province with an additional 100 doctors who can work under the supervision of experienced physicians. There is a severe shortage of pharmacists in the province and generally in many hospitals the running of pharmacies is handled by pharmacy assistants. Other specialists that are in short supply include dentists, physio and occupational therapists, and speech therapists (there are two).

At the same time, nursing services are very well developed in the Eastern Cape. Over the course of our travels, the delegation recognized the strong role that nursing plays in the successful delivery of health care services. This is a strength which can support any future partnerships.

DHS has initiated a *Hospital Transformation Project* which is working to bring about uniform staffing standards throughout district hospitals and clinics. This initiative is

supported by the *Hospital Management and Organizational Support Program* which is funded through EQUITY Project. This program has been initiated in 19 hospitals located in Regions D and E (the poorest districts in the former Transkei) to improve management skills.

b. Public/Private Partnerships

“Disadvantaged communities need greater access to quality health care, but given budget constraints, this can only happen if additional resources are generated/and or if resources are used more efficiently. Many public hospitals have deteriorated while private hospitals have proliferated and thrived, draining doctors, patients and income from the public sector. Greater integration of public and private health sector services can help make better use of health care resources and can increase equity.”³

In an attempt to improve the quality of care in public hospitals, the ECDOH and the EQUITY Project have embarked on a process of creating model Public/Private Partnerships (PPP). In these partnerships, public hospitals create incentives for private physicians to utilize the beds and services of public hospitals for their patients. In this way, public institutions are strengthened and lower health care costs are passed on to consumers.

Our delegation learned about a successful public/private partnership in the town of Uitenhage which lowered health care premiums by 30% for employees of a local factory and created a private 25-bed ward at the hospital. This relationship generates additional revenues for the hospital which are used to improve services for public patients. The PPP model is now being discussed at the national level and standards are being developed in consultation with the provinces. Legislation to regulate these partnerships is being drawn up and discussions are underway that will lead to frameworks for service level agreements, contracts, and management and personnel models.

c. HIV/AIDS

Statistics published at the time of the 13th International AIDS Conference, put the HIV infection rate in the Eastern Cape at 18% and the raising infection rate threatens to undermine the development gains of the past few years. Hoping to stem the tide, the ECDOH has made HIV/AIDS the number one priority for all of its departments, and each department has had to develop its own program to address the HIV/AIDS epidemic. Because TB, STDs, and other communicable diseases cannot be separated from HIV/AIDS, they too have been prioritized.

National government has established a dynamic national structure to focus attention on the HIV/AIDS epidemic. As part of this National AIDS Council, an Eastern Cape AIDS

³ “Successful Public/Private Health Partnerships: the Uitenhage Experience,” EQUITY Project Report.

Council has been launched. It includes representatives from all levels of civil society along with government representatives. The National AIDS Council reports directly to the national Cabinet, advising government on strategies, reviewing performance, and supporting the process of social mobilization.

A multi-sectoral Eastern Cape Partnership designed to oversee the implementation of national initiatives has been established and includes representatives from all provincial government departments. Reporting to this Partnership is the Social Needs Cluster (an inter-departmental structure) which is headed by the Department of Health. The Social Needs Cluster has developed an integrated plan which includes: Lifeskills (a program of the Dept. of Education); Health Promotion Outreach (a program of the Dept. of Health); Voluntary Counseling & Testing (Health Dept. driven, but cuts across all departments); Children and Family Program (home-based care coordinated by Dept. of Welfare). These very inclusive structures are designed to stress the fact that HIV/AIDS is not simply a health issue, but a developmental issue that must have everyone in the province working together to solve the problem. As one of our members wrote, "Problems of unemployment and housing are the most crippling. The only way that our relationship with the Eastern Cape will work, is if we address the issues of unemployment and housing (economic development) while addressing those of health. If we can do this we will make a difference."

The ECDOH HIV/AIDS program adheres to the national frameworks, which are: prevention; treatment, care, and support; research, monitoring, and evaluation; and the protection of human rights. Immediate goals of the ECDOH HIV/AIDS program are:

- Strengthen youth education programs
- Increase access to VCT
- Reduce mother-to-child transmissions

d. Maternal, Child, and Women's Health

The Department of Maternal, Child, and Women's Health operates under the national frameworks for primary health care delivery which call for universal access to primary health care, 24 hour service to all communities, and free health services to pregnant women and children under six.

A major concern of the department is the high mortality for pregnant women and children under five. Figures presented at the briefing session in Bisho for 1999 mortality rates were:

- 80.5/1,000 for children under five
- 61.2/1,000 for live infant births
- 24.7/1,000 for neonatal
- 131/1,000 for maternal

The department has prioritized improving and maximizing access to efficient and effective maternal, child, and women's health services and set a goal of reducing death rates 30% by 2003. The family planning component of this department has focused

attention on increasing the availability of contraception at all primary health facilities. Providing easy access to condoms will also help with HIV prevention. An immunization goal of increasing coverage to 90% by 2001 has been set. Meanwhile, the department expects to meet its part of the WHO goal of a polio-free South Africa by the end of this year, and eliminate measles infection by the end of 2002.

Some accomplishments of the sub-directorate are:

- Implementation of the Maternal Death Notification Policy (established in 1997, this requires all facilities that perform deliveries, must notify maternal deaths)
- Implementation of Termination of Pregnancy Act (procedures are still done at hospital level, vacuum aspirations are still only being performed by doctors, but the department has started to train nurses in this procedure and so far, 24 nurses have been trained)
- Training of Advanced Mid-Wives has been performed at McCord Hospital in Durban (attempts are being made to bring this course to the new Nelson Mandela Hospital being built in Umtata, which will bring down the cost of training)
- Training of family planning providers on post-abortion counseling to ensure a reduction of future unplanned pregnancies

The department is continuing its effort to integrate services across the province, although the process is complicated by the existence of so many different administrations (homelands, local authorities, provincial) which operated under the past government. As a result, creating one unified system throughout the province has been extremely difficult. Lack of laboratory services means that most mothers go into delivery without their providers knowing their blood type or HIV status. Budgetary constraints have meant a severe shortage of management capacity for all programs, further complicating issues of personnel, financial management, and maintaining standards of quality care. Transportation remains a significant obstacle both for health professionals trying to reach rural communities, and rural residents traveling to clinics and hospitals. Many clinics still complain of not having access to essential drugs.

e. TB and Communicable Diseases

In 1996, when the WHO visited South Africa to do a situational analysis, it discovered that there were inadequate and different TB control programs operating throughout the country. To rectify the situation, it was recommended that each province should establish a demonstration and training district to implement a model TB control program and judge its success. In the Eastern Cape, Port Elizabeth was selected as the site because clinics and hospitals in this area have the necessary minimum infrastructure (fax, telephone, etc.) needed to succeed. The pilot was launched in 1997 with 1,000 patients. Success was to be determined by the measure of sputum conversion rates. In the first quarter there was a 43% conversion rate and by the end of the year the rate was up to 60%. At the instruction of the NDOH, the province increased the number of demonstration and training districts and by the end of 1998, it had successfully established ten programs. The cumulative conversion rate for these ten programs rose to 74%. At the same time, 32% of patients were re-treatment cases, which is very high. In fact there were more re-treatment cases

than new TB cases. In 1999, the province continued to add more districts and by the end of the year, only four districts in the province had not received the training. In 1998, 32,000 patients were diagnosed with TB and in 1999 there were 30,000, a decline of 5%.

Because of a high incidence of patients not completing their drug regimen leading to the development of drug-resistant strains of TB, the province is implementing a Direct Observed Therapy (DOT) strategy in cooperation with non-governmental organizations. This program trains DOT support workers who track down patients and ensure that they are taking their medications. If the patient does not arrive at a clinic to take their medication, the DOT worker will immediately go out and locate the patient.

Other initiatives that are designed to increase TB control interventions include working with registered nurses who are being trained to identify TB cases and start treatment right away. In the past, nurses had to wait for a doctor to prescribe a drug. (In some areas there could be up to a year wait for a doctor.) There is also a need to improve turn-around time for test results. The optimum turn-around time for results is 24-48 hours. In urban areas there is currently a 24 hour turn-around time, however, rural areas lag very far behind. Lack of transportation and communication options in the rural areas causes unacceptable delays. The Department is hoping to improve these conditions.

f. Health Promotion Strategies

There is currently no one in the province assigned to coordinate health promotion strategies. Individual departments incorporate health promotion strategies as needed into their own activities. This includes utilizing existing networks of support groups to disseminate health promotion messages (e.g. breast feeding support groups). They work with traditional healers and traditional leaders to ensure that the messages they convey are consistent with those of the ECDOH. Recently, the Department began working with individuals infected with the HIV virus to help with AIDS health promotion messages.

Posters (mainly from the NDOH) are distributed throughout the province and are displayed in public areas – shopping centers, clinics, etc. Workshops are held in communities to engage residents in the development and implementation of health care policies. Pamphlets geared toward health care professionals are produced and distributed across the province, and opportunities for health care professionals to get together around specific issues are created. School districts hold in-service training seminars for teachers which focus on health issues. Since the ECDOH is involved in school feeding programs, they have an opportunity to work with teachers to disseminate health messages to the students (e.g. HIV/AIDS, hygiene).

The Department works with a Port Elizabeth radio station that reaches 2.4 million listeners to distribute important health promotion messages. Every Friday, from 8-9pm the station broadcasts a phone-in health show in Xhosa and the response has been quite good. They also use more local stations, like Radio Ciskei, which broadcasts a talk-show every Tuesday morning at 10:30am. Local newspapers publicize larger campaigns like Breast Feeding Week.

Some district hospitals, clinics, and district offices have established communications committees that reach their particular constituencies. The ECDOH works with these committees to disseminate information. In some communities, these efforts are coordinated with and supported by local NGOs that have specific health-related interests (e.g. HIV, nutrition).

2.4 Infrastructure Development

a. Surveillance

The overarching concern in the area of surveillance is the identification and tracking of the high incidence of HIV/AIDS. The Department needs to improve its system of data collection, both in terms of raw numbers of those infected and the mapping of where these infections are most prevalent. The EQUITY Project (a US-AID funded project, administered through the ECDOH) has made some significant progress in the establishment of a primary Health Care Health Information System, collecting and analyzing data gathered from clinics. A similar District Hospital Information System is in the process of being established. The ECDOH expressed concern that as the end of the EQUITY Project contract draws near, that the gains that have been made in the area of surveillance will be lost without some continued outside support. At present, no provincial wide, computerized data collection system exists. A plan for implementing such a system has been discussed and a proposal has been produced, however, funding has yet to be identified.

b. Management Capacity

The province has identified several areas of concern as they relate to improving management capacity throughout its health care system. The EQUITY Project has identified areas of concern and has concentrated on improving managerial skills – both clinical and departmental – in these areas. Specific target areas for the improvement of managerial skills are:

- Managing priority diseases at health care facilities
- Ensuring minimum standards of quality of care in hospitals and clinics
- Developing effective personnel management systems
- Improving the use of surveillance data for decision making
- Ensuring the availability of essential drugs
- Strengthening financial systems (e.g. budgeting, budget planning, expenditure reviews)
- Improving the management of health services at all levels (provincial, district, clinic)

As in the case of surveillance, the Department is concerned with continued support after the EQUITY Project contract has been completed.

Also, the EDCOH expressed a need to extend its computer-based management systems from the provincial level (where they are operating reasonably well), down to the district level. In this way, provincial and district offices could ensure coordination and cooperation. Proposals have been drawn up, but funds need to be secured to purchase

equipment and implement the system.

c. Labs

The Parliament of South Africa has enacted legislation to establish a single National Health Laboratory Service (NHLS) to replace all existing national and provincial public laboratories. This laboratory service will operate as a quasi-independent government agency (a parastatal, as they are referred to in South Africa). While it will report to Cabinet, the NHLS will operate independently of any department of government.

It is expected that the NHLS will not be fully implemented for 3-4 years. In the meantime, the ECDOH has identified short term services that are needed, particularly those which focus on TB & HIV/AIDS.

d. Pharmacy

On several occasions, we heard about the severe shortage of pharmacists in the Eastern Cape. Ultimately, additional personnel are needed at many health care facilities to improve the functioning of pharmacies – ensuring access to essential drugs and medical supplies and improving data collection related to drug use and expenditures.

e. Physical Plant Improvements and Maintenance

Many clinics and hospitals in the Eastern Cape are in need of physical improvement. A renovation and upgrading plan has been developed in cooperation with the Council for Scientific and Industrial Research (CSIR). Funds, however, have not yet been secured.

In addition to renovations and upgrading, the Department is seeking assistance in the training of managers in charge of the maintenance of these physical plants. Similarly, they are in need of training for personnel in charge of maintaining equipment housed within these facilities.

f. Development of an Effective NGO Partnership Network

The ECDOH recognizes that the non-governmental sector is a critical partner in health care delivery. They would like some assistance in the development of an effective NGO network that would allow the ECDOH and NGOs to work together to increase community participation in areas such as: TB testing and follow-up; the development of home-based care for AIDS patients; and community-based solutions to address the growing number of orphans. The Department would also like assistance in developing programs that successfully utilize community participation in evaluating the effectiveness of ongoing programs. For example, the ECDOH has instituted nutrition programs in all state-run schools. They would like to develop community monitoring and evaluation systems to ensure that these programs are effective.

(See Appendix D for highlights of the ECDOH Strategic Plan.)

3. SITE VISITS SUMMARY

After meetings with the Department of Health held in the provincial capital of Bisho, the Health

Care Delegation spent several days visiting local sites around the province. In order to gather as much information as possible in a short period of time, the delegation was split into two groups. Half traveled to the urban centers of Grahamstown and Port Elizabeth, while the other half traveled to the rural areas in and around Umtata, the largest city in the former homeland of the Transkei. (*see Appendix A for a complete itinerary of meetings.*)

Delegation members met with district health officials, local government representatives, and many dynamic community organizations. We were very fortunate to be hosted by the Mayors of Umtata and Grahamstown, and the City Council of Port Elizabeth. In Umtata and Port Elizabeth we learned of successful university, government, and community partnerships that are increasing coordination and the utilization of scarce resources. District health officials provided the delegation with an overview of the restructuring process now underway which will transfer more control for health care delivery to local authorities.

Site visits to rural and urban health clinics provided the delegation with a better understanding of the challenges to providing a more equitable distribution of health care services across the province. These obstacles may be lack of infrastructure, like many of the rural clinics in Umtata that do not have running water and depend on shipments to replenish their water tanks, or the shortage of staff which makes 24-hour coverage an unattainable goal. These obstacles, however, do not diminish the dedication of providers and the high level of care they are able to deliver under the circumstances.

Over the course of the week, we met with several impressive youth programs, including the Eastern Cape Youth Development project, based in Duncan Village, a township just outside East London, and the Love Life Project, based in Port Elizabeth. Both were organized and led by young people and each demonstrated a high degree of success in recruiting peers who agreed to practice HIV prevention and reach out to others with their prevention messages.

The delegation identified a vibrant network of non-governmental organizations that provide a broad range of services, from domestic abuse counseling to teenage pregnancy prevention, from care for AIDS orphans to substance abuse intervention. An afternoon session organized by the Masimanyane Women's Support Centre brought together more than 20 local East London community based organizations seeking to learn more about the possibility of identifying international partners.

As part of our debriefing process, delegation members met with Eastern Cape Premier, Reverend A.M. Stofile, Dr. Tom, the Director-General from the Office of the Premier, and Dr. Goqwana.

4. OBSERVATIONS FROM THE FIELD

This section summarizes the observations of the delegation relative to future planning efforts between the Eastern Cape and the Commonwealth of Massachusetts. These sections include and expand upon conclusionary comments provided to the Bisho provincial government representatives on the final day of the visit. They are meant as a partial reflection of a complex and ongoing process of re-development and understandably are limited by the time and the capacity of the visiting group. The delegation looks forward to the Task Force representatives

being able to enlarge their understanding of the strengths and needs of the Eastern Cape province through dialogue and future work together on behalf of the Eastern Cape.

4.1 Strengths as a Basis for Future Development

The first and perhaps most important strengths identified by the delegates were the spirit, hope, energy, and commitment of the people of the Eastern Cape and of South Africa more broadly. The delegation understood these capacities to be a product of the shared struggle and victory over apartheid – it is a national resource, crucial to the work ahead. Therefore, any collaboration anticipated by the Commonwealth must be able to adequately honor the self-determination, consensual decision-making, and collective processes that are being incorporated into the evolution of the new South African government. This requires trust-building and negotiation not always present in bilateral development efforts.

There were numerous systemic, personnel, and planning capacities that the delegation noted as the basis for future program development. They included:

- strong national health planning documents, including preventive and therapeutic protocols for numerous health arenas;
- evolving provincial planning efforts;
- competent provincial and district program leadership in many areas;
- excellent nursing competencies, commitment, and role diversification, particularly in protocol-driven clinical service delivery and in local, district, and provincial program administration;
- a significant focus on community-led and community-specific problem solving; and
- skilled, though unevenly available, capacity in the growing non-governmental service sector.

Additionally, two recent program initiatives spoke to evolving provincial capabilities in complex infectious disease planning and intervention. The recent TB surveillance and disease intervention efforts undertaken in response to the WHO review provided evidence of the evolving capacity to link critical epidemiologic information to effective program development and disease intervention. Although still nascent, the AIDS information and program efforts give credence to significant information dissemination capacity in the Eastern Cape and hold promise for expanded efforts in voluntary counseling and testing and in patient and family support.

Among the unique capacities the delegation observed throughout the provincial programs was the extent to which challenging psycho-social-medical problems were dealt with in an explicit, public manner and had evolved, in some cases, innovative programming. Specifically, in the areas of elder abuse, child abuse, other domestic violence, child witness to violence, teen pregnancy, and AIDS, there were extensive public information materials which were visible, direct and easily understandable, often taking better advantage of low-literate, pictorial messages than the US generally achieves. In a manner also rarely seen in the US, these materials, particularly in the AIDS arena, actively displayed significant community members and leaders, including President Mbeki. The emphasis on creating community level conversations about and commitment to critical health prevention efforts was striking - even churches are a source of dialogue about AIDS prevention and other critical issues.

Site visits to several clinical and other community-based programs in these diverse service arenas indicated the availability of creative, cross-disciplinary services often accessible through a single point of entry. Two examples were the domestic violence program at the regional hospital in Port Elizabeth staffed jointly by the local police and medical and social service personnel and a similar multi-disciplinary approach to the child witness to violence program at Cecilia Makiwane.

The delegation's visit to the provincial JP Santa TB Hospital in the Port Elizabeth area gave ample testimony to the capacity of the province to maintain a well-run residential setting of such critical importance. And the medical school in Umtata offers great promise in terms of further building the clinical and research capacity of this under-resourced area. The medical school and the University had several collaborative community clinical and public health programs in development, as did the University of Port Elizabeth whose township collaborative may be a useful model for replication in other settings with international partners.

Throughout the site visits, the delegation observed dedicated clinicians serving large numbers of patients in sometimes severely under-resourced conditions with a great deal of respect and equanimity. Settings appeared to be welcoming and well-managed in spite of difficult circumstances.

4.2 Challenges that Emerged

Perhaps the greatest challenge faced by the provincial health ministry right now is the significant distance that exists between the existing action plans and the current capacity for program implementation. This challenge is critical both because realizable, intermediate objectives are necessary for achieving the planned system development goals and because private and public partners from the local to the international level need to realistically know where they can engage the change process and see outcomes that are reliable. Assessing the actual status of provincial initiatives from disease surveillance to public-private partnership development to devolution efforts will be important to complete as the tenure of the EQUITY Project comes to a close. Such a review could be the basis of both intermediate and longer-term goal setting.

The gap between planning and implementation is largely related to historic and current administrative and resource issues that have been discussed elsewhere in this document. First and foremost is the prior disenfranchisement of this province which impacts both its current service funding base from the national government as well as its infrastructure, employment and other capacities which affect the health status and health care access of its citizens. Secondly, the provincial government is faced with the burdens of integrating three different governmental systems of public health and medical care delivery and reimbursement and of simultaneously meeting national goals of universal access and of administrative and fiscal devolution. These processes require, among other things, active redistribution of prior resource allocations, from historically white and urban tertiary and other care settings to community-based clinical sites in both urban and rural areas; resolution of, in some cases, very different personnel and other administrative practices; and the development of multiple decentralized systems of service delivery and management.

In the arena of service delivery, the provincial minister and his staff, along with program representatives in the field, were very revealing about current challenges. They include:

- under-developed disease surveillance capacity;
- under-financed and insufficient laboratory and pharmacy services;
- inadequate and sometimes poorly maintained facilities;
- limited numbers of trained middle and upper level health services planning, delivery and other management staff; and
- insufficient administrative support systems for personnel recruitment, hiring and supervision; inventory control; and fiscal planning and oversight for centralized and decentralized activities.

In addition, provincial budgetary management practices limit the ability of the health ministry to adequately plan resource allocation and redirection of resources as needed.

Improving access to care across rural and urban areas and meeting the demands of devolution has revealed serious challenges in manpower planning, training, re-deployment, and pay equity. Some of these difficulties are further exacerbated by historic patterns of service referrals between different levels of clinical providers. All of these issues are complicated by the relative fiscal and political claim historically made by acute, hospital-based care as opposed to preventive, community-based, clinic setting care.

The provincial plan calls for a feeder system of very local, sometimes minimally staffed clinic settings through clinics, community health centers, district hospitals and then regional and tertiary care settings. The expectation is that referral to more resourced settings will be dependent on clinical need. There are historic provider and patient practices that will continue to make achieving this triaged system of patient flow a challenge for some time. However, there were also selected site-based capacity problems at every level that impede progress. They included limited water and pharmaceutical capacity at some local clinics; very problematic laboratory access, particularly in rural areas; insufficient nursing, physician and other clinical staff at various service levels; and insufficient technician capacity, even where there might be working x-ray and other diagnostic machinery. Given available resources, some of the health capacity needs could potentially be partially addressed by the development of mid-level and outreach service providers, something which has not been addressed by the department yet except in selective areas like TB control.

The delegation was unable to fully understand the dilemmas faced in terms of resource allocation and program development decisions, although it was obvious that the provincial government faces many challenging negotiations with local partners as it attempts to both develop and devolve a system of more universal access. The provincial representatives also indicated that they have sometimes faced poorly planned international, donor, and other initiatives to address the gaps in resources. For example, some clinical sites have been built through philanthropic or other efforts without their clinician and other capacity needs having been adequately assessed by the donor entity or coordinated with the provincial government. Improved future planning, particularly for collaborative efforts with other partners, will need to rely upon a full assessment

of differential service delivery, personnel, and other capacity issues throughout the districts.

Public-health related social and other support service delivery were observed to be taking place through numerous NGO efforts. Some observed by the delegation included a hospice setting for people with AIDS, a teen HIV prevention program managed by Planned Parenthood, and a battered women's program. The delegation was impressed by the service delivery commitment and skills represented by the diverse NGO sector at various site visits and in the group meeting in East London. Their discussions indicated future social and health-related service need development, including, among other things, the need to organize and finance community based responses to the growing problem of AIDS orphans. It does not appear, however, that the provincial government has had the time or capacity yet to develop strategic plans for engaging this sector. This is a critical challenge for the future as these groups represent important service capacity and political importance. Development of strategic planning and relationships in this arena is necessary.

Finally, throughout the trip the delegation noted the extent to which issues of economic development were inevitably inter-twined both with the health risks of citizens and with the ability to improve health care access. The health of citizens in the province is deeply dependent on improvements in sanitation, housing, and employment. Public health planning, particularly regarding reduced maternal morbidity and mortality, improved child survival, and improved HIV, STD, and TB prevention, diagnosis, and treatment, must be integrated with targeted economic development efforts.

4.3 Principles for Massachusetts-Eastern Cape Collaborations

- The twinning agreement between Massachusetts and the Eastern Cape is between two governmental entities – therefore, all activities sponsored through the agreement should be fully reviewed by both and be clearly responsive to local and provincial planning and needs.
- This twinning effort is new for Massachusetts. Collaborative projects must be selected on the basis of their viability and should build upon existing capacity development efforts underway within the province.
- Collaborative efforts should not be duplicative of other bilateral, philanthropic, industry or academic health initiatives but should, where possible, assist in the replication of successful activities. Sustainability should be a significant criteria for supported projects.
- A strong lesson from the delegation's visit was the importance of relationship and trust-building efforts as a prelude to successful ventures. Massachusetts should optimize opportunities for public health, medical, industry, and other community representatives to become familiar with the needs, philosophies, and systems of the Eastern Cape. This should include sponsoring and leveraging capacity for training and other in-country project-related Massachusetts delegations at least annually as well as support for South Africans to attend mentoring and other training opportunities here.
- Massachusetts should work to develop community understanding of and participation in this initiative through selective public communications and

targeted work with potential Massachusetts industry, trade, finance, medical, and public health collaborators, including academic settings, and community-based organizations.

- Both governmental partners should maintain permanent planning groups to oversee this effort.

5. RECOMMENDATIONS

The delegation has preliminarily identified three broad areas in which potential collaborations should be considered. They include:

- Efforts to support further development of the provincial department of health's capacity to survey, plan for, resource, and manage the delivery of public health and medical services in the province.
- Support for and projects with the medical school and the University in Umtata in its evolving collaborative efforts with the region's district and local health departments and the NGO sector.
- Selective direct NGO collaborations of mutual interest in the Province and to collaborators here in Massachusetts. These efforts would particularly seek to develop bilateral NGO relationships, support capacity development critical to meeting overall Provincial health goals, and assist in the evolution of a strong NGO sector with meaningful ties to local, district, and provincial government processes.

While final selection of activities within these arenas must occur through negotiation with the in-country partners, the delegation identified several proposals in each category. They include:

- In the area of provincial department capacity development, priority consideration should be given to training and other support needs to assure a successful Equity Project transition. This should begin with an immediate bilateral review of the status of all EQUITY Project efforts and the identification of areas for immediate and longer term support. Surveillance systems development and managerial training and support are two likely areas for collaboration.
- In the Umtata region, several requests for assistance would present good initial projects: the identification of potential TAHPP partners among Massachusetts medical, public health, and nursing; the development of domestic violence related curricula and protocols for forensic nursing, police, and health center personnel and for cooperating NGOs; and the identification of and support for training opportunities for senior administrators at the new Nelson Mandela Hospital.
- In the arena of direct NGO sector collaborations, several areas of potential cooperation were identified during site visits. They included: the AIDS shelter development currently underway in Grahamstown; the Motherwell Health Centre's HIV and TB program development, particularly in terms of youth HIV outreach, behavior change support, and the development of voluntary counseling and testing efforts; the youth development work in Duncan Village township in East London, where replication of some of the Love Life Project efforts in Port Elizabeth may be possible; Kellogg Foundation funded community health centers in Umtata; and the planned new women's health center development associated

with Masimanyane in the East London area.

A more comprehensive list of other potential areas of support and collaboration is contained in Appendix C and represents both requests received during the trip as well as areas of need identified by the delegation. The delegation recommends a matrix approach to considering opportunities for support and collaboration that could accommodate low burden as well as more ambitious, and likely expensive, interventions. For instance, in terms of possible surveillance and management system and skill development activities, the response from Massachusetts could be as diverse as:

- e-mail linkage between similarly situated surveillance and administrative personnel in the state and provincial health departments;
 - analytic support from Massachusetts-based public health academic settings, perhaps in collaboration with UNITRA or other academic colleagues in the Eastern Cape, to assist in critical provincial epidemiologic and other report writing;
 - Massachusetts industry assistance in providing or networking critical surveillance and management support MIS systems;
 - sponsored trips to Massachusetts for selected Eastern Cape public health officials and managers to shadow US colleagues and to observe alternative system
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- APHA, perhaps to provide press for this report and the emerging collaborations.
- Initiation of some of the more modest steps as soon as possible after receipt of a response from the Eastern Cape, hopefully no later than early December.
 - Commitment to meet as a Task Force no less than once each quarter to build the ongoing collaboration efforts, with the first of those meetings taking place in December of this year after receipt of the Eastern Cape response.

The delegation understands that this effort needs ongoing staffed coordination and recommends a modest commitment to South Africa Partners to support the effort as well as the specific designation of MDPH personnel who will be part of an ongoing coordination team. In addition, the delegation believes that the Task Force should support the sponsorship of at least one annual trip each of training teams to South Africa and of South African representatives to the Commonwealth to assure the development of close and trustful working relationships. Finally, the delegation members are desirous of making themselves available to support the ongoing work of the Task Force and look forward to making contributions to this effort in the future.

6.2 Eastern Cape DOH

At the end of the delegation's visit, the representatives of the Eastern Cape Department of Health indicated their commitment to establishing a permanent in-country task force to support this bilateral effort. The delegation looks forward to that group and the DOH reviewing this document in an expeditious manner and making recommendations to the Massachusetts Task Force about priorities for moving forward. The delegation recommends that South Africa Partners facilitate those communications and that the response from the Eastern Cape DOH be reviewed by the Task Force as soon as possible after its receipt. The delegation also recommends that any visits by Eastern Cape representatives to Massachusetts, including those anticipated during the APHA, be used as a time to also strategize about and formalize next steps in this ongoing process. These collaborations can only be successful if they are first grounded in the needs and concerns of the Province.

APPENDIX

- A. July 2000 Health Care Delegation Itinerary
- B. Delegation Members
- C. Summary of Potential Collaborations Identified at Meetings
- D. Highlights of the E Cape Strategic Plan 1999-2004

A. HEALTH CARE DELEGATION ITINERARY

The itinerary for the July 2000 Health Care Delegation was established in cooperation with the Eastern Cape Department of Health and reflects the specific interests and expertise of the Health Care Delegation delegates.

15 July Arrival in East London

16 July Attend local church service
Meet with Youth Group in Duncan Village
Lunch/Tour the surrounding area
Dinner with Eastern Cape Health Department Representatives

17 July Orientation Meeting conducted by E Cape Health Department Team
Lunch

GROUP 1:

Drive to Umtata
Free Evening

GROUP 2:

Drive to Grahamstown
Dinner hosted by Mayor which included representatives of several community organizations.

18 July

GROUP 1:

Meeting with Prof. Surka, Vice Dean, Department of Medicine and Health Sciences, UNITRA
Visit to Bizaya Clinic with Dr. Goqwana
Meeting with Senior Departmental Representatives, UNITRA
Free Evening

GROUP 2:

Breakfast meeting with Director of the Centre for AIDS Development Research and Evaluation (CADRE)
Travel to Port Elizabeth
Meeting with Port Elizabeth Department of Health Representatives
Field Trip to visit community-based projects
Visit to JP Santa Hospital
Visit to House of Resurrection

19 July

GROUP 1:

Visit Ngangeizwe Clinic
Tour Umtata General Hospital and Meeting with Administrative Staff
Visit to Mbekweni Clinic
Visit Nelson Mandela Museum
Dinner with Mayor and City Council

GROUP 2:

Meeting with Representatives of Port Elizabeth Department of Health
Meeting with local chapter of Nat'l. Assoc. of People With AIDS
Visit Yizuzahke Clinic
Visit Ncedo Care Centre
Lunch at University of Port Elizabeth
Meeting with staff of Livingstone Hospital
Dinner with City Council Members

20 July

Group 1 & Group 2 travel to East London
Meet with Staff of Cecilia Makiwane Hospital in Mdantsane Township
Visit with Masimanyane Women's Support Centre
Dinner with Premier Stofile and Dr. Goqwana

21 July

Drive to Bisho
Meet with Health Department Representatives for debriefing and next steps
Depart East London for Johannesburg and then on to New York and Boston

22 July

Arrive Boston

B. HEALTH CARE DELEGATION PARTICIPANTS

- Roger Berry, Senior Director, Emerging Markets Practice, GPC/O'Neill & Associates
- Gary Daffin, Executive Director, Black HIV/AIDS Coalition
- William Eudailey, Vice President, BioPure
- Mr. Elmer Freeman, Exec. Director, Ctr for Community Health Education, Research and Service
- Paula Gabriela Freitas, Program Associate, South Africa Partners
- Mr. Andrew Fullem, Director of Surveillance, Massachusetts Department of Public Health
- Donna Gittens, President & CEO, causemedia, inc.
- Dr. Barbara Herbert, Lawrence General Hospital
- Mr. Edward Jacobs, Senior Vice President, BioPure
- Anna Faith Jones, President & CEO, The Boston Foundation
- Temba Maqubela, Board Member, South Africa Partners
- Jean McGuire, PhD, Director, AIDS Bureau, Massachusetts Department of Public Health
- Carel Mulder, PhD, Professor of Pharmacology, Molecular Genetics and Microbiology, University of Massachusetts Medical School
- Dr. Nicole Prudent, Boston University School of Medicine
- Dr. John Rich, Medical Director, Boston Public Health Commission
- Hon. Byron Rushing, State Representative, Commonwealth of Massachusetts
- Shirley Royster, Co-Chair, Statewide Advisory Board, MA Department of Public Health
- Marti Wilson-Taylor, President & CEO, Boston YWCA
- Mary Tiseo, Executive Director, South Africa Partners
- William Walczak, Executive Director, Codman Square Health Center

C. SUMMARY OF POTENTIAL COLLABORATIONS IDENTIFIED AT MEETINGS:

Academic

- Short-term visits by medical professionals for lectures at UNITRA and in-service training for local clinic personnel
- Assist in identification of potential funding sources for proposals generated by UNITRA departments
- Identification of potential partners for joint research projects with UNITRA, including partnerships with newly created TAHPP (The Academic Health Promotion Program which is a collaboration between UNITRA, Univ. of the North, and the University of the Witswatersrand).
- Support proposed UNITRA HIV/AIDS Centre which will have both clinical and prevention and care programs (the Centre is being established in cooperation with local NGOs)
- Work with Unitra in developing curricula for forensic nursing, police personnel working with child witnesses, health center staff, etc.
- Support for tele-medicine strategies

Administrative

- Strengthening the capacity of management personnel
- Contracting management training
- Assist with transfer of management functions to local control
- Management training and support for new Nelson Mandela Hospital senior administrators
- Support development of managers for nascent health districts
- Assist with rehabilitation of existing hospitals and clinics
- Provide models for labor relations

Clinical

- Supply publications and journals for medical libraries in clinics
- Short-term visits by medical professionals for in-service training for local clinic personnel (combine with lectures at UNITRA)
- Support the four existing Kellogg-initiated health clinics that are now part of the UNITRA network
- Support the development of Mother-Child Bonding programs
- Training support for development of clinic to hospital referral systems
- Support the development of immunization strategies
- Utilize Community Health Workers in ongoing surveys
- Support for the Domestic Violence Program at Umtata General Hospital

Non-governmental

- Examples of successful and failed behavioral change programs
- Strategies for reaching youth out of school

- Developing school-based programs that utilized peer counseling models
- Assist in creation of model community health center, including: management, mapping, surveying, human resources, board development, referrals, reporting data, maternal child health and assessment tools, role modeling, and outreach
- Capacity-building for small community-based organizations (CBOs) in order to “grow” them
- Clarification of breast-feeding arguments surrounding transmission of HIV
- Training for traditional healers
- Exchange programs for NGOs
- Support and training for prevention programs including: family planning; youth services; HIV; anonymous testing; women’s empowerment; domestic violence; teen pregnancy; violence; and substance abuse.

D. HIGHLIGHTS FROM THE EASTERN CAPE DEPARTMENT OF HEALTH STRATEGIC PLAN 1999-2003

The department has established the following strategic objectives:

Hospital Services

- Plan, develop and deliver hospital services in an equitable manner
- Reclassify hospitals, identifying those which will remain provincial hospitals and those which will become district hospitals, working directly with local primary health clinics
- Redistribute beds equitably across the province.
- Develop an academic health complex in Umtata
- Strengthen hospital management systems, particularly financial controls, efficiency and quality assurance.
- Establish day surgery and ambulatory services

District Health Services

- Plan, develop, and deliver district health services.
- Integrate existing public health care services, including those operating at local, municipal, and provincial level in order to eliminate fragmentation.
- Improve and extend access to primary health care through the building of new facilities, initiating a network of mobile services, and improving community outreach and collaboration among health and non-health programs.
- Establish an effective patient referral system.
- Create realistic public health facilities separate from hospitals.
- Develop and establish a district health authorities to ensure full health coverage and strong management systems within a given geographic area.

Equitable Resource Allocation

- Establish budget allocations according to population (per capita) health needs and not according to traditional criteria such as cost reductions and cost controls.

Human Resource Development

- Consider establishing Human Services University that would offer courses for health care professionals.
- Transform nursing education and justify existing colleges and nursing programs.
- Consider the establishment of an Institute for Public Health and primary health in-service training.
- Work in collaboration with technical colleges to ensure that health engineering skills are enhanced, i.e. establish a maintenance training course using the National Qualification Frameworks.

- Ensure that all Public Service personnel have an adequate understanding of relevant legislation such as the Labor Relations Act and the Financial and Treasury Rules.

Outsourcing

- Identify operational services that can be outsourced such as catering, laundry, housekeeping, gardening, maintenance, etc.

Private/Public Partnerships

- Explore, develop and implement public/private services to better utilize existing resources.
- Coordinate and control all private health initiatives.

Personnel

- Develop a human resources plan for redeployment of personnel to public health care services in under-serviced areas.
- Determine staffing level requirements according to work loads and programs.
- Develop and implement a plan to equitably distribute skills between the rural and urban areas (including incentive plans).
- Develop technical skills such as information technology, computer literacy, financial skills, project management skills, facility maintenance, and administration.

Financial Controls

- Strive to have program managers take charge of their budgets.
- Strengthen maintenance of financial controls, cash flow management, management accounting, internal audits, and cost reduction measures.

Enhanced Support Services

- Develop and establish management information systems and hospital and district information systems and ensure there is a strong capacity for surveillance and research.
- Ensure facility management and maintenance systems that promote a healthy environment and extend the life of buildings and equipment.