



# DHS News

## NEWSLETTER OF THE DISTRICT HEALTH SYSTEM

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### EDITORIAL

As we enter the second half of the calendar year and as we head into the third quarter of the financial year, it's time to take stock of progress and realign programmes to meet our targets. September also marks the start of spring and the rain! This means that even as we evaluate the progress we made in controlling mortality from pneumonia we need to ensure that we have prepared for the diarrhoea season that lies ahead. Communities must be prepared to recognise the signs of diarrhoea early and try home-made ORS solutions, early referrals to clinics must be encouraged, every health facility must have an ORS corner, nurses must be aware of the signs and symptoms and must be able to treat and refer appropriately.

Each district is expected to have quarterly review meetings during which managers responsible for programmes and systems meet and review the data of the quarter so that everyone in the district (health workers and communities alike) can be informed about progress and challenges. Those districts that are yet to have their quarter one review are strongly encouraged to have one during October. Congratulations to those that already had a review meeting. *DHS News* looks forward to hearing from districts that already had the first quarter reviews!

In this issue of *DHS News* we summarise the key features of the Contraception and Fertility Policy that the National Health Council approved at its meeting of 31 August. We also provide progress reports on the three streams of PHC re-engineering as well as progress in rolling out the three tier system for capturing ART data.

Best wishes, Dr. Yogan Pillay

## **MUNICIPAL WARD-BASED PHC TEAMS**

One way to ensure that we are ready for the diarrhoea season is to mobilise the large number of community health workers that we have in the country! This is why the Minister wants us to accelerate the reorientation and deployment of the ward-based PHC outreach teams. Every municipal ward, prioritising those in the NHI pilot districts, must over time have at least one ward based team. All districts are expected to have plans to expand the number of teams that are deployed, with associated training plans.

Since the last issue of DHS News we can report that countrywide the first 5000 CHWs trained have completed their field training and more than 200 teams have started to visit homes since March 2012. Communities and households have welcomed the work of the CHWs and the outreach teams. One example of the positive outcome of their work was when they identified that pregnant women in a particular area who were mainly foreign immigrants were reluctant to book earlier at the clinic due to fear that they could not produce a South African ID document. This matter was quickly resolved through education of the women and bringing this concern to the attention of the clinic staff.

An orientation programme and training material for team leaders was piloted in the North West and their orientation has now commenced in all provinces. In addition the CHW training material for phase 1 was reviewed and developed for phase 2 and 25 trainers have been trained per province so that the orientation and training of ward teams can be accelerated.

All provinces have participated in the development of an occupational qualification for CHW working on the ward-based outreach teams with the Quality Council of Trades and Occupations (QCTO). This qualification is now at an advanced stage before it is ready for final submission to the QCTO.

With the assistance of the University of the Western Cape we are piloting an information system to monitor the work of the ward-based teams for household registration, referral and screening tools and forms, and reporting templates for the ward-based outreach teams are all finalised and ready for use. There are also detailed instructions that guide CHWs and ward-based outreach team leaders in their use. All CHW and team leader training is updated to include training on the use of these. These tools were also reviewed and approved by NHISSA and will be formally adopted at the next NHISSA meeting in early October.

An audit of the number of ward-based teams appointed by provinces is being finalised. Reports from seven of nine provinces received to date indicate that 472 teams have been established in 337 wards in the country. These figures do not include the teams established in KwaZulu-Natal and the Western Cape.

## **SCHOOL HEALTH SERVICES**

School health nurses and programme managers have been hard at work over the past few months.

School health nurse master trainers have been trained in all provinces. These trainers will be responsible for ensuring that all existing school health nurses are re-orientated and new

school health nurses are trained. The training focuses on equipping nurses to provide the expanded package of school health services, and on ensuring that they work in close collaboration with officials from other departments, especially the Department of Basic Education. Provinces are now busy with training at district level – a number of provinces have already trained school health nurses in all of their districts.

Ten sets of specialised school health mobiles are currently being procured. Each set includes a PHC mobile, an Eye Care mobile and a Dental mobile. These mobiles will be deployed in the NHI pilot sites. The Integrated School Health Policy (ISHP) specifically targets learners from the most disadvantaged schools (Quintile 1 and 2 schools) who often experience difficulties in accessing health services – thus the mobiles will play a key role in improving access to services and thereby health outcomes for learners in these areas.

Provinces will soon need to develop implementation plans for 2012/13. These plans will need to focus on ensuring that all targeted learners in Quintile 1 and Quintile 2 schools are reached with the full package of ISHP services. During the coming months, the national team will be focusing on ensuring that systems for monitoring the performance of the programme at provincial and district level are in place, and on supporting provincial and district teams to meet the coverage targets.

The Minister of Health and the Deputy Minister of Basic Education recently addressed the associations of school governing bodies, school principals as well as teacher organisations on the integrated school health policy. The policy and delivery system was approved by all those present and recognised as a vital component of ensuring that learners are healthy so that they can benefit maximally from being in school. The meeting decided that a toolkit be prepared for use by the school governing boards (SGBs) in the interaction with parents so that the health services to be provided can be fully explained to parents, in particular about services related to sexual and reproductive health and medical male circumcision. These services will be offered to schools and SGBs and parents will decide on how they will be provided.

President Zuma will formally launch the school health programme on 11 October in Cullinan, Pretoria.

## **DISTRICT CLINICAL SPECIALIST TEAMS (DCSTs)**

**DHS News** readers will recall that in previous issues the rationale and roles for seven senior and experienced health professionals to be deployed in each health district to strengthen clinical governance was described. Much progress has been made in the appointment of these teams. Whilst not all districts are covered and many are only partially covered by these teams, more than 170 doctors and nurses have been appointed by provinces to function as members of the district clinical specialist teams.

A national induction and orientation programme is being planned to ensure that members of teams together with district managers and MCH coordinators are fully briefed about their roles, tools that they will use etc. It is critical that district managers and their teams work closely with the district clinical specialist teams to ensure that the quality of care provided in all health facilities in the district are improved.

The Minister of Health launched the induction programme of the DCSTs on 27-28 September 2012. At the launch the Minister reported the following:

*“At present, through the initial advertisements, I am happy to announce that we have appointed the following medical specialists and senior nurses nationwide:*

- *17 obstetricians and 3 senior medical officers with diplomas and significant experience in obstetrics;*
- *17 paediatricians;*
- *34 family physicians;*
- *9 anaesthetists;*
- *34 advanced midwives;*
- *23 paediatric nurses; and*
- *35 primary health care nurses.*

*While only 1 district (Umgungundlovu) currently has the full complement of 7 members of the team, two districts, Tshwane and Umzinayti, have almost a full complement, they are both only missing a paediatric nurse; Ekurhuleni too has almost a full complement but they are missing an anaesthetist; and Bojanala is missing an anaesthetist and a paediatric nurse.*

*On the other side of the scale, in some districts, we have serious problems in recruiting. Cacadu, Francis Baard and John Taole Gaetswe have made no appointments and Chris Hani, Alfred Nzo, Namaqwa and Siyanda have only appointed advanced midwives to date”.*

The two-day national induction programme will be followed by a 3-day programme in each province. In addition, other strategies are being considered to fill the vacant posts, in particular those in rural areas and in the NHI pilot districts.

## **CONTRACEPTIVE AND FERTILITY POLICY**

As noted in the editorial, the National Health Council approved the Contraception and Fertility Policy and Guidelines at its most recent meeting. Improving the family planning programme is one of the seven interventions that the Minister of Health launched on 4 May 2012 as part of our Campaign on the Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA) strategy.

This new policy replaces the policy that was developed 10 years ago and takes into account the advances in science, considers the implications of contraception for people living with HIV and is squarely placed within a human rights perspective. Finally the policy focuses on the importance of an integrated approach to contraception and the need to expand the mix of contraceptive available in our facilities.

There are six things that are key to a well implemented contraceptive policy (read also family planning). These are:

- Inform communities about contraception and fertility planning;
- Remind health workers about the importance of contraception;

- Ensure that health workers use every opportunity to promote contraceptives (provider-initiated family planning);
- Ensure that health workers are fully trained in the full range of available contraceptives;
- Ensure that the full range of contraceptives are available in every health facility; and
- Ensure that we monitor the success of our contraceptive services.

The first two points in the list above requires a robust communication strategy within the district.

The policy document can be found on the National Department of Health's website: [www.doh.gov.za](http://www.doh.gov.za).

## **ARV MONITORING: THE THREE TIER SYSTEM**

The past two years have seen three processes unfold to strengthen antiretroviral therapy (ART) data management. The first was the introduction of the standardised monitoring system, the 3-Tiered ART monitoring strategy. The second, the alignment of the DHIS to receive the data produced by this system and the third standard operating procedures (SOPs) for the 3-Tiered system.

In 2010 the National Health Council endorsed the standardised ART monitoring and evaluation (M&E) system nationally. The system is comprised of standardised clinical stationery that supports clinical management and supplies the information for the three tiers. The three tiers are Tier 1: a paper register, Tier 2: a non-networked electronic register (Tier.Net) and Tier 3: an electronic medical record (SmARTer).

All three tiers produce the same core set of data, 6 monthly data elements and 27 quarterly data elements. The data elements, both monthly and quarterly, provide the data required to report to DORA and produce the minimum data required to monitor the ART service. This process allows for a focus on the quality interpretation of data.

### **The Alignment of the DHIS**

In April 2012 the DHIS was aligned to receive the data produced by the 3-Tiered system. All the standardised data elements are now captured into the DHIS and all data management activities will be directed towards DHIS data.

The monthly data is manually entered into the DHIS irrespective of which of the three tiers produced this data. The quarterly cohort data is manually generated at Tier 1 sites and then captured into the DHIS. Tier 2 and Tier 3 sites produce the same data at the push of a button and electronically imported into the DHIS.

### **The ART M&E SOPs**

The third process is the completion of standard operating procedures (SOPs). These SOPs outlines the roles and responsibilities in ART data management and stresses the patient centred approach. Specifically the responsibilities of information managers and HAST managers for ART data management is highlighted. It also guides sub-district, district and provincial managers to give appropriate feedback to facilities. This serves

three valuable purposes. It enables facilities to verify which data was reported; that it was correctly captured and to routinely monitor their programme.

The SOPs also guide the facility-level administrative management and filing of reported data which will satisfy the Auditor-General's requirements. The SOPS provide practical ways to use the data.

If you require a copy of the SOPs please contact Mr. Terrance Magoro [Magoro@health.gov.za](mailto:Magoro@health.gov.za) or Ms. Catherine White [cwhite@clintonhealthaccess.org](mailto:cwhite@clintonhealthaccess.org).

**For more information on any of the issues covered in this DHS News please email [pillay@health.gov.za](mailto:pillay@health.gov.za).**