



DHS News

Newsletter of the District Health System

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Editorial

In this issue we outline activities that should be part of the routine functions of the district health management team, led by the district manager. Given that there are four outcomes in the National Health Service Delivery Agreement (NSDA) that the Minister signed with the President and with all the MECs for Health, these priorities must be implemented at every level of the health system. These priorities are:

- Improve life expectancy
- Decrease the burden of disease from HIV and TB
- Decrease infant, child and maternal mortality rates
- Improve the effectiveness of the health system

As districts finalise district health plans (DHPs), they must ensure that specific activities are included in these plans to achieve the above outcomes. Given that district health plans are operational plans, they must reflect the specific activities that each district must implement to reach district targets that link to both provincial and national targets. This means setting targets to be achieved with respect to the following: TB smear conversion rates at 2 months; TB cure rates; TB defaulter rates; HCT/PICT rates; PMTCT rates; number of patients on ARV treatment; institutional and district wide infant, child and maternal mortality rates. DHPs should reflect on upstream factors as well as downstream factors

that contribute to decreasing the burden of disease. In order to monitor the impact of these activities, district management teams must hold monthly and quarterly meetings using the data from the District Health Information System (DHIS). District management teams must also ensure that every facility in the district is appropriately supervised to ensure continuous improvements in quality. Development partners must work with district and sub-district as well as facility managers to ensure that interventions are targeted and that the impact of interventions are monitored via validated data in the DHIS.

The implementation of PHC re-engineering is progressing with activities in districts, provinces and at the national level. Please send progress reports from districts with data on what changes you are beginning to see so that this information can be included in the next DHS News.

The rest of the newsletter provides more specific information on the priorities. The last section focuses on the need to integrate the work of development partners and ensure that their assistance focuses on district, provincial and national priorities to ensure alignment and sustainability.

Dr Yogan Pillay

PHC re-engineering and DHS strengthening

As mentioned in the last DHS News, the National Health Council has adopted three streams to be implemented for PHC.

They are:

- 1) a ward based PHC outreach team for each municipal ward;
- 2) strengthened school health services; and
- 3) district based clinical specialist teams.

These streams are in addition to the strengthening of the district health system as a whole, which includes strengthening the functioning of the district management team, strengthening planning through the District Health Expenditure Reviews and the DHPs, and strengthening the collection, collation, analysis and use of information.

As we close out 2011 every effort must be made to review progress against the 2011/12 DHPs and the finalisation of 2012/13 DHPs that will lead implementation of activities, which will improve service delivery and the achievement of health outcomes in ways that move us as a country towards achieving the Millennium Development Goals (MDGs).

One of the key challenges in meeting the MDGs is to deal effectively with the upstream factors that impact negatively on health outcomes. Intersectoral action is key to ensuring that upstream factors are successfully dealt with. In addition, a few key health interventions can also assist. For example the most important contributors to infant, child and maternal mortality are well known. Every effort must be made by district management teams to address the key causes of mortality within each district. The implementation of the three streams of PHC engineering will assist this effort.

To date the NDOH with the assistance of the Foundation for Professional Development has developed a re-orientation package and more than 1180 CHWs, 135 PNs and 48 trainers trained since October 2011. We plan to reorient sufficient CHWs and PNs for 313 ward based teams by the end of 2011.

Child and maternal health

The National Department appointed a team of experts to review all data on infant, under five and maternal mortality to reach agreement of mortality rates. This process resulted in agreement on the mortality rates which were publicly launched by the Minister of Health. The agreed upon national maternity mortality is 310/ 100 000. It is expected that we will reduce this figure by at least 10% by 2014 (to 270/100 000). Similarly the mortality rate for neonates is currently 14/1000 live births with the target of 12/1000 live births by 2014; infant mortality is current at 40/1000 live births with the target of 36/1000 live births by 2014; under 5 mortality is at 56/1000 live births with a target of 50/1000 live births by 2014.

How will we achieve these targets? Much of the work done within the district health system will contribute to the achievement of these targets. We know what the major causes of morbidity are. We also know what supply side and key demand side interventions are needed to reduce mortality. For example, we know that the major causes of under-5 mortality are: HIV, diarrhoea, pneumonia and severe malnutrition. We also know that during summer diarrhoea is a key cause of mortality and that we need to design and implement a district-wide plan during summer to limit the number of cases and deaths. Every district manager should be expected to report on what measures they have implemented to decrease cases and deaths from diarrhoea. Similarly as we move into autumn and then winter the same applies to pneumonia.

HIV and AIDs and TB

December 1 is World AIDS Day when we typically review our achievements during the year and re-commit ourselves to doing more to halt the HIV epidemic in the next year. During this year's World AIDS Day, to be hosted by the Eastern

Cape in Nelson Mandela Bay Metro, President Zuma will launch the 2012-2016 National Strategic Plan for HIV, STIs and TB. This five year Plan has four vision statements, five goals and four strategic objectives.

The 20 year vision of the NSP is to achieve:

- Zero new HIV and TB infections;
- Zero new infections due to vertical transmission;
- Zero preventable deaths associated with HIV and TB; and
- Zero discrimination associated with HIV and TB.

The goals of the NSP are:

- Reduce new HIV infections by at least 50% using combination prevention approaches;
- Initiate at least 80% of eligible patients on antiretroviral treatment (ART), with 70% alive and on treatment five years after initiation;
- Reduce the number of new TB infections as well as deaths from TB by 50%;
- Ensure an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the NSP; and
- Reduce self-reported stigma related to HIV and TB by at least 50%.

And the four strategic objectives are:

1. Address social and structural barriers to HIV, STI and TB prevention, care and impact;
2. Prevent new HIV, STI and TB infections;
3. Sustain health and wellness; and
4. Increase protection of human rights and improve access to justice.

The NSP will be used by all provinces and all sectors of the South African National AIDS Council to develop implementation plans. The health sector therefore needs to ensure that detailed implementation plans for HIV, STIs and TB are developed for implementation commencing on 1 April 2012.

Progress on the ART Tiered Implementation

In the past few weeks significant progress has been made in implementing the 3-tiered ART M&E system. Between 26 September and 7 October, 135 people from all 9 provinces were oriented and trained on tiers 1 and 2 through a nationally run master training at the University of Cape Town. Participants spent the majority of the time learning how to implement TIER.net (the non-networked electronic register). There were representatives from NDOH, provincial and district offices as well as from many of the PEPFAR partners. The goal of this master training was to enable participants to return to their area of work to train others, implement and support the tiered monitoring system with a strong focus

on the clinic re-organisation that is required to support this process. A notable success of the training was giving partners and DOH staff the opportunity to sit with each other and to discuss how they plan to implement the tiered system in their respective provinces.

While the training was a success, it also brought up the need to enforce standard definitions of indicators and how to report them and to ensure that provinces are not being asked to report nationally on information not produced by tiers 1 and 2 (nothing beyond the 6 monthly and the 27 quarterly indicators should be required for reporting, as agreed upon by the NHC). In addition, it brought up the immediate need for the DHIS to be aligned to receive the new ART indicators as well as to align to the DHIS policy and data flow.

At the end of the master training, every province was requested to submit implementation plans by 14 October, which will be followed by technical support visits from the national implementation team starting in the beginning of November. These visits are meant to help support provinces during their implementation of TIER.net in their chosen start sites. In the meantime, provinces should expect delivery of the national clinical stationery starting on 21 October and should begin using it in all ART sites. To date, plans have been received from six provinces and technical support visits have been conducted in these provinces. In total, these provinces have identified 103 facilities to pilot in and have commenced training and implementation in these sites. Eight facilities have fully implemented and back captured their patient data. A tremendous achievement!

The NDOH is in the process of setting up a call centre to receive problems and provide support with the tiered system. Additionally the NDOH is setting up a link on the NDOH website specifically to post announcements about and materials relating to the tiered implementation strategy. We hope both these resources will become available before the end of the year. **Currently, the national implementation team is gearing up to support the implementation of TIER.net in at least one facility per district by March 2012!** For any questions, please contact the tiered implementation project managers, Terrance Magoro and Catherine White, at magoro@health.gov.za and cwhite@clintonhealthaccess.org and join the national tiered ART M&E discussion group through tiered-art-m-and-e@googlegroups.com.

Maximising the contributions of Developmental Partners

On 26 September 2011 the national DOH met with district support partners (DSPs) funded by USAID, through PEPFAR, and CDC to discuss how DSPs can support the Primary Health Care (PHC) re-engineering plan. Most of the 52 health districts are supported by PEPFAR and a nominated lead DSP has been allocated to each district. Some DSPs cover more than one district. The list of PEPFAR DSPs is available from leshas@health.gov.za. Some existing international DSPs will

be replaced by local partners and meetings will have to be held at provincial and district level to ensure that there is a smooth handover.

The purpose of the meeting was:

- To learn from the NDOH how PEPFAR DSP partners can support the PHC re-engineering plan.
- To improve collaboration among all PEPFAR partners, including those who have been in operation for a long time, as well as new partners.
- To hear about exciting programmes that we can take to scale and discuss challenges.
- To all agree on the road forward.

There was consensus from all at the meeting that the DSPs are there to support and to assist the efforts of the South African Government and the departments of health to strengthen health programmes as well as the health system by assisting us to implement the re-engineering of PHC and its components. Currently there is strong leadership being provided by the Minister of Health and this needs to be followed by strengthened management and leadership throughout the health system so as to ensure that there is “one line of march”.

It was agreed that all the work of the DSPs needs to be directed by the district management team (DMT) and that the essence of this work needs to be incorporated into the district health plan (DHP) so that there is one overall plan guiding all implementation activities within the district. Districts need support to make their plans more feasible and they need support in the activities that can achieve their targets. The district health plan has 2 parts – looking backwards (using annual reviews and expenditure reviews –DHERs) to establish the baseline and looking forwards to set the targets that the DHP will accomplish. DSPs can assist districts to do quarterly reviews of data, and provide support with planning and completing templates.

One of the specific key areas of support that DSPs will provide is around the newly adopted M&E systems of the ART programme. (See section above for more details). The DSPs are currently in the complicated process of aligning their work more around technical assistance and less around direct service provision. This process will take time and during this change over no patient who is currently on ART treatment will be neglected as a result of the change.

In addition, DSPs will continue to support the TB control programme including infection control; implementation of integration of TB and HIV as well as the monitoring via the ETR.net system.

There was also discussion of the role of DSPs in the three streams of PHC re-engineering. School health services are in the process of being revised in terms of the expectations of increased coverage (initially focusing on schools in the poorest areas, viz., Quintiles 1 and 2 schools) of screening as well as increased health promotion and education including around sexual and reproductive health. In terms of PHC outreach teams (core staff: a professional nurse as well as CHWs) around 5000 CHWs are in the process of being re-oriented by the end of 2011. DSPs can assist with the new approach to these two streams which are expected to have an impact on key health indicators in every health district.

Some of the suggestions tabled at the meeting include:

- Improved communication which is critical for everyone having the same view of the vision for strengthening the health system. The DHS discussion list (hosted by HST) will be resuscitated to facilitate discussion around a range of relevant topics. Please get all DMT members to subscribe by sending an email to dhs-lg@lists.hst.org.za
- There should be one information system at district level (no parallel systems) and DSPs can get access to DHIS data (as well as other systems such as ETR.net) by signing a data user's agreement.

Please send comments and inputs from district experiences for the next DHS News. Send all contributions to Pillay@health.gov.za.