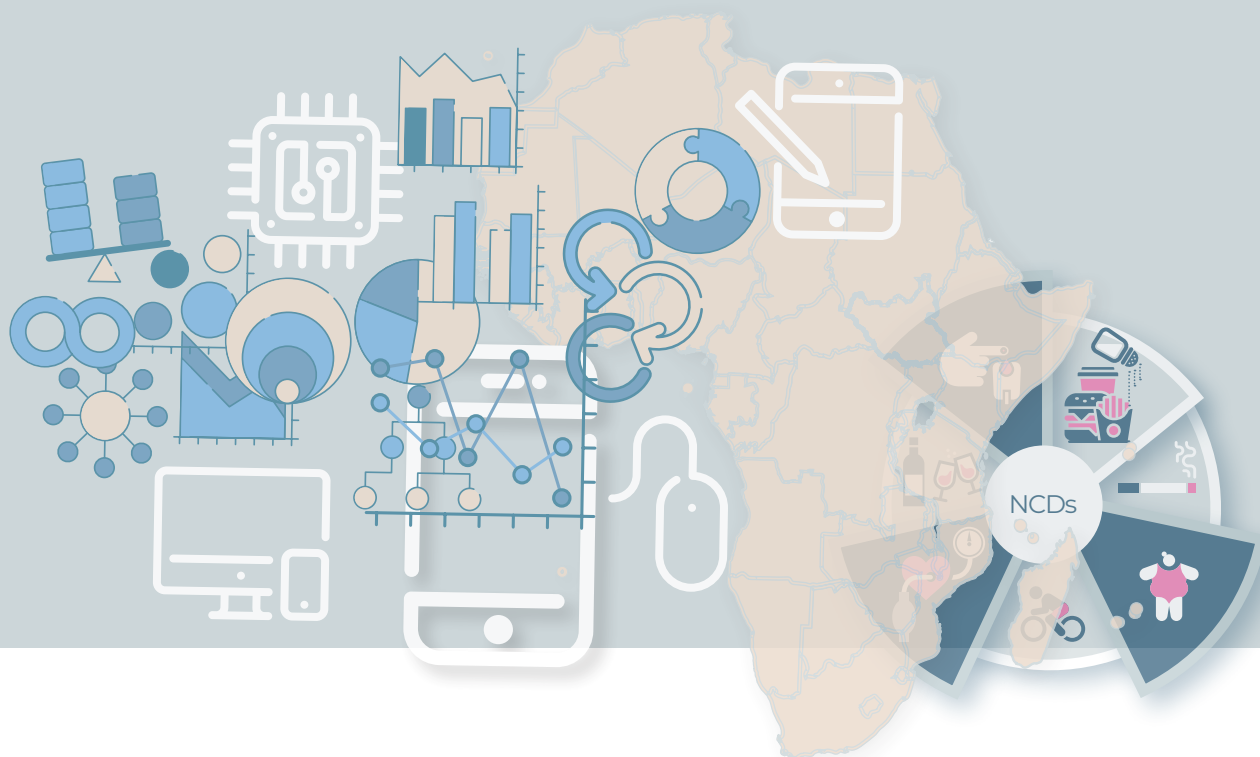


BHPSA

BETTER HEALTH PROGRAMME
SOUTH AFRICA

STORIES FROM THE BETTER HEALTH PROGRAMME, SOUTH AFRICA

2020-2022



British
High Commission
Pretoria



health

Department:
Health
REPUBLIC OF SOUTH AFRICA

M
M
MOTT
MACDONALD

STORIES FROM THE BETTER HEALTH PROGRAMME 2020-2022

The Better Health Programme, South Africa (BHPSA) has worked closely with the National Department of Health (NDoH) and other partners to strengthen the South African health system. During our three years we have offered technical support, capacity building and knowledge exchange designed to complement key national health reforms.

BHPSA is funded by the UK Foreign, Commonwealth and Development Office (FCDO), and is the flagship health programme in the bilateral partnership between the British High Commission (BHC) in Pretoria and the South African government. The programme is underpinned by the considerable expertise of the arms-length bodies of the UK NHS.

These are the collected case studies and stories from the three years of BHPSA's lifetime. The stories cover BHPSA highlights on the topics of noncommunicable diseases, quality assurance, quality improvement and pandemic preparedness. They range from webinar reports to news, commentary and human interest.



CONTENTS

CASE STUDIES

Noncommunicable diseases

NCDs and COVID-19 in South Africa. What have we learned? September 2020.	4
Safe health workers, safe patients. November 2020.	7
NCD learning engagement. March 2021.	10
World Obesity Day. March 2021.	14
Strengthening data on noncommunicable diseases. September 2021.	16
Talking about veg and fruit. February 2022.	21
New skills for community health workers. February 2022.	25
It's a plan! The new NSP for NCDs. July 2022.	30

Quality assurance and quality improvement

Virtual learning for the Office of Health Standards Compliance. November 2020.	34
Towards quality emergency medical services. April 2021.	36
Seeking the Truth, Ombud twinning agreement. April 2021.	39
The power of a choir of radio stations, OHSC communications. October 2021.	42
The wisdom of peers, OHO webinar. October 2021.	46

Pandemic preparedness

Inspecting South Africa's COVID-19 field hospitals. August 2020.	48
What is shielding? Protecting the vulnerable from COVID-19. June 2021.	50
Behind the vaccine rollout. February 2022.	53

SUMMARY REPORTS, FACT SHEETS AND COMMENTARIES

Situational analysis of NCD data. February 2021.	56
Multisectoral and multi-stakeholder approaches to tackling NCDs. February 2021.	60
Alignment of standalone NCD strategies with the NSP. February 2021.	63
SBCC framework for preventing NCDs. February 2021.	66
Overview of patient safety. May 2021.	71
A review of patient feedback systems in SA. May 2021.	74
A review of patient safety reporting in SA. May 2021.	78
The National Health Quality Improvement Plan. May 2021.	82
Review of quality improvement and quality assurance programmes. May 2021.	84
Shielding and COVID-19. June 2021.	88
NCDs, UHC and NHI. Unpacking the links, and the acronyms, July 2021.	91
Gender and obesity in South Africa. September 2021.	94
Digital health in the real world. May 2022.	97

BHPSA

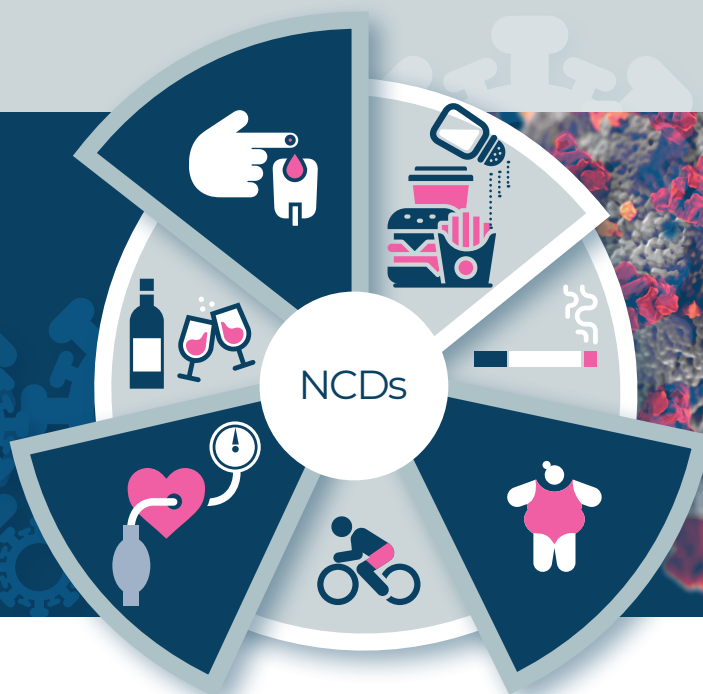
BETTER HEALTH PROGRAMME
SOUTH AFRICA

CASE STUDIES

SEPTEMBER 2020

NCDs and COVID-19 in South Africa

WHAT HAVE WE LEARNED?



Since the start of the COVID-19 epidemic in China it was clear that people living with noncommunicable (NCDs) diseases were more vulnerable to severe COVID-19 illness and death. On September 15, leading South African experts discussed the links between the two diseases in a webinar hosted by the Better Health Programme (BHPSA) in conjunction with the World Health Organization (WHO) and the SA National Department of Health (NDoH). This webinar arose out of a substantial review of global evidence requested from BHPSA by the NDoH in April, in order to guide their COVID-19 public health strategy.

The webinar was opened by Nick Latta, the UK Prosperity Counsellor in South Africa, and skilfully chaired by WHO's NCD adviser in South Africa, Dr Kibachio Joseph Mwangi, both of whom framed the session with remarks on how coronavirus had exposed the extent of the NCD epidemic in the country. Prof Jean-Marie Dangou, WHO AFRO region's NCD coordinator, noted that additionally, the COVID-19 epidemic had disrupted NCD services across the continent and had become an amplifier for health system weaknesses.

Expert evidence



Prof Tarryn Young, from the University of Stellenbosch's Centre for Evidence-based Health Care, presented the early global evidence from the BHPSA-funded study. A review of over 80 academic papers (May to mid-June 2020) concluded that the risk of hospitalisation, severe illness and death for COVID-19 was much higher in patients who

had heart disease, diabetes and hypertension. Patients whose diabetes was well controlled were at less risk than those with uncontrolled disease.

More recent evidence from South Africa was presented by Dr Mary Ann Davies a public health specialist and doctor in the Western Cape Department of Health (WCDoH) and Dr Waasila Jassat from the National Institute of Disease Control (NICD).

Dr Davies' findings from the WCDoh's database of nearly 3.5 million patients in the region included 22,000 cases of COVID-19 and 625 deaths. Dr Jassat's evidence was from the new national COVID-19 database (DATCOV) representing all private sector and 64% of public sector hospitals. Both presentations demonstrated the same pattern as the global evidence: namely increased COVID-19 risk (severe infections and deaths) for those patients with hypertension, heart disease and diabetes. COVID-19 risk was also higher in males and older patients.

Diabetes and hypertension in the Western Cape province



Dr Mary Ann Davies

In brief, the Western Cape study showed that half of all COVID-19 deaths were attributable to diabetes and 14% to hypertension.

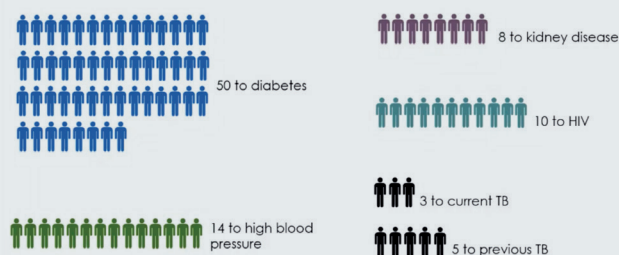
More detailed results, shown in the figure below, demonstrate that the risk (HR) of dying of COVID 19 is between five and 12 times greater in those with diabetes than those without. And the risk of death is much greater

in those with uncontrolled or poorly controlled diabetes (HbA1c levels).

The COVID-19 risks for South Africans with diabetes were considerably higher than found in similar international studies. Part of the explanation for this is the high level of late diagnosis of diabetes in South Africa, which may have resulted in widespread micro-vascular disease, another risk for COVID-19. Of 250,000 people living with diabetes in the Western Cape, only about half have been screened, and of those, over half have uncontrolled diabetes.

How much are these factors contributing to COVID-19 deaths in

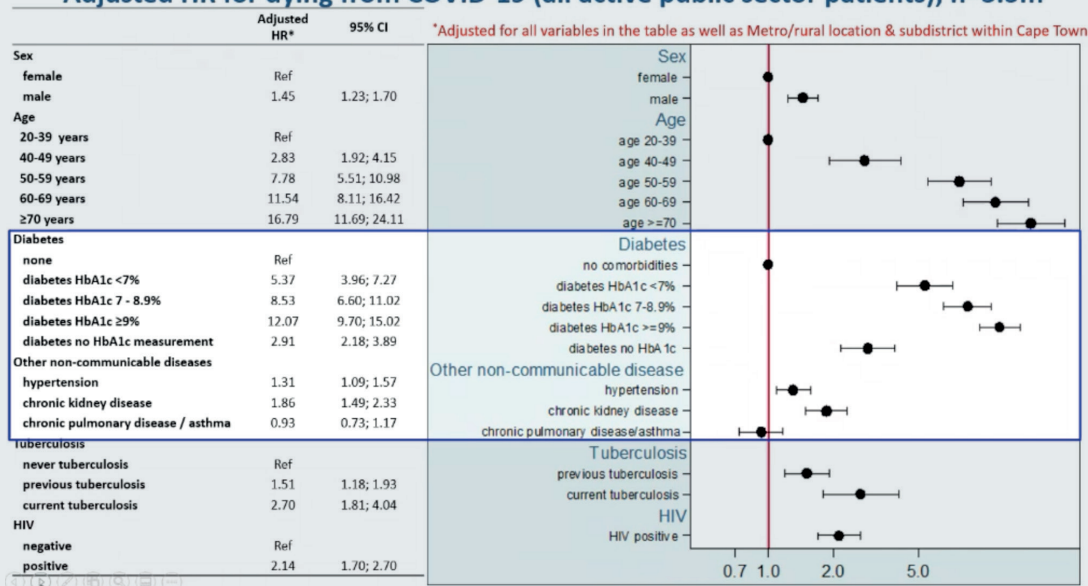
For every 100 people in the public sector who have died from COVID-19 – we can attribute as follows:



Inadequate access to quality health services is more pronounced for poor and vulnerable South Africans: the Western Cape study showed that the COVID-19/NCD crisis was rooted in engrained socio-economic inequalities, that shape the broad disease pattern of the region. For example, the rate of COVID-19 deaths per million in Klipfontein and Khayelitsha townships of the Western Cape was 1,199 and 858 respectively in comparison with the average for the region of 638 (and the global average of 120).

Dr Davies emphasised that the new local data proved invaluable for decision-making in the province. It led to the development of a new programme for people living with diabetes, who received telephone counselling even if they were not hospitalised with COVID-19.

Adjusted HR for dying from COVID-19 (all active public sector patients); n=3.5m



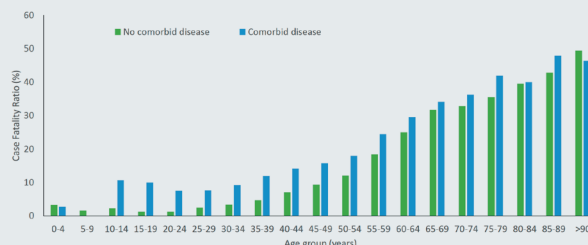
The national picture



The national hospital data, presented by **Dr Wassila Jassat**, again confirmed the influence of NCDs and other comorbidities on COVID-19 risk. This was particularly pronounced for younger age groups, as the data on case fatality ratio below shows.

The DATCOV database also included data that suggested that obesity is a severe risk for South African COVID-19 patients, significantly increasing the case fatality ratio in obese patients who are also living diabetes and hypertension.

Case fatality ratio among 8571 individuals with in-hospital outcome (discharges and deaths) by age group and presence of comorbid condition, South Africa, 5 March-22 August 2020



Government response



Sandyha Singh, Director of the NCD cluster in the NDoH, confirmed that the evidence presented by the three experts has already been used by the NDoH to inform guidelines, care pathways and protocols for NCDs in the context of COVID-19. The evidence has also shaped the messaging in a communications strategy focussing on NCDs and

promoting healthy lifestyles. NCD comorbidities are also being integrated into existing surveillance tools.

She also provided a brief overview of the escalating burden of NCDs in the provinces and the government's commitment to including NCDs in an integrated and cohesive care platform as part of the national Ideal Clinic initiative.

Building back better

Singh also emphasized the NDOH's intention to build on gains and knowledge developed through the COVID-19 emergency to strengthen future programming and service delivery for NCDs. For example, the evidence has informed a greater focus on prevention of overweight and obesity, which will have benefits beyond the COVID-19 epidemic. The NDoH will also add its voice to the regional pandemic response regarding social and commercial determinants of NCDs.

The Minister of Health has determined that "building back better" means the NCD response should be located within defined populations and rooted in district and household level actions. Strengthening the community health worker

NCD programme and community mobilisation at district level will both be fundamental to the new approach.

Funding challenges have also been highlighted as the COVID-19 emergency has raised the importance of co- and multimorbidities and the need to address these in an integrated, rather than vertical system. Previously national budgets and donor support have focussed on HIV and TB.

Discussion

In the discussion after the presentations, attention was focussed on data systems. The Western Cape data system, which is not an electronic record, is a by-product of patient care rather than a surveillance system in and of itself. In this province each patient has a unique identifier and this allows health records to be integrated into an overall database. This system has been built up over years, but the COVID-19 epidemic presented the challenge of integrating laboratory results as well as private sector records.

The national DATCOV system, on the other hand, was developed in a period of five months, to monitor the COVID emergency. Dr Jassat spoke on how this system leveraged an urgent crisis to create buy-in for a new platform to integrate public and private sector data, including for NCDs and other comorbidities. This "pop-up" data system has broken a logjam of many years to create a rudimentary electronic record, and lessons learned will be important for the creation of the interoperable, integrated electronic data system needed for NHI.

Speakers also discussed the positive impact of COVID-19 on strengthening partnerships around NCDs. In the Western Cape, the crisis strengthened existing partnerships between provincial dept and universities. Nationally, partnerships with civil society and the private sector have grown and the intention is to formalise these in a multisectoral committee for NCDs. ■

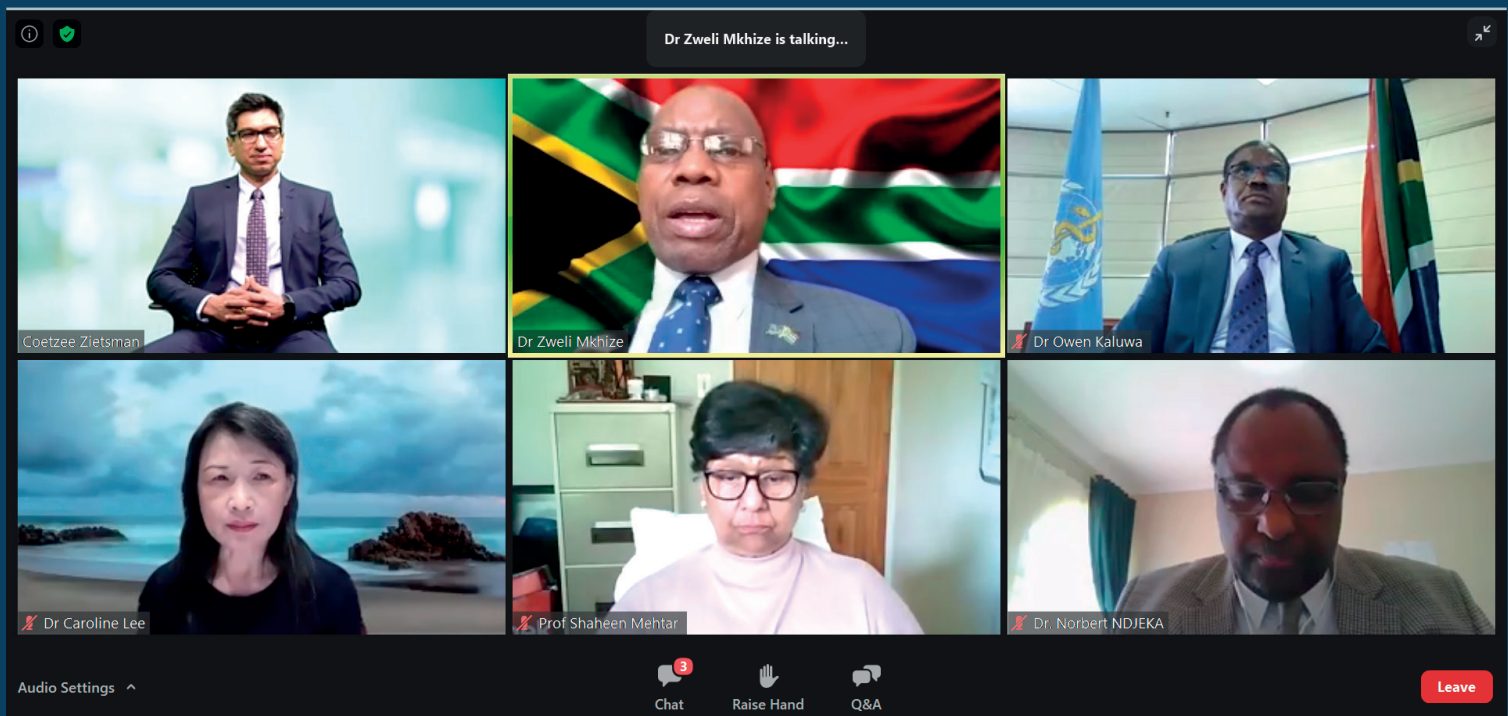
BHPSA

BETTER HEALTH PROGRAMME
SOUTH AFRICA

STORIES

NOVEMBER 2020

Safe health workers, safe patients



Presenters at the World Patient Safety Day webinar on September 17

“I will ensure that all healthcare workers in our hospital not only stay physically well but also psychologically. We will hold daily morning meetings ... and end-of shift-huddles to give the nurses a platform to discuss anything that might have happened...”

Webinar participant

The COVID-19 pandemic has put the global health workforce on the frontline: saving lives, sometimes at their own expense. The South African National Department of Health (NDoH) used the opportunity of World Patient Safety Day to honour the country's health workers and to highlight strategies to keep them safe in the context of the epidemic and beyond.

A multi-partner event



A small team worked together to plan a Zoom-based webinar and social media kit for World Patient Safety Day. It was led by the NDoH Quality Assurance Directorate and Communications Unit and included members of the BHPSA Team, including a specialist health communications agency and the FCDO Health Adviser from the High Commission.

The webinar was planned as a multi-partner event, with participants from private, public and non-profit organisations. In particular, it aimed to reach staff at SA health facilities.

Webinar presenters were selected both on the grounds of their expert knowledge and their ability to represent critical stakeholders. They included the WHO country representative; the coordinator of an NGO, the Healthcare Workers Care Network; an expert in infection prevention and control and the representative of the Democratic Nursing Organisation of South Africa.

Participant organisations spread the word among their networks and the team made use of the existing NDoH Knowledge Hub, which has an extensive database of health professionals in the public sector, to reach their audience. Invitations were sent to over 8,000 health workers. Selected health journalists were also invited to attend the webinar and received a media release after the event.

The social media toolkit consisted of nine Twitter and Facebook posts advertising the webinar and health worker safety issues, and included a video statement of support from the British High Commissioner which was posted on the NDoH official Twitter feed following the event.

Ministerial support



The webinar was opened by the SA Minister of Health, Dr Zweli Mkhize, who told listeners "Safe quality care should not be the preserve of the elite, nor should it be an aspiration for distant future aspiration, it should be part of the DNA of all our health system" He stressed that the wellbeing of health workers and the safety of patients are inseparable and must be addressed comprehensively.

The Minister said a total of 32,429 health workers had contracted COVID-19 and 257 had succumbed to the virus as of 11 September 2020. In response, he launched a new national strategy to protect the physical and mental health of health workers in the context of COVID-19. This strategy, which focusses on education, training and social support, had been compiled with support from the BHPSA programme.

Reaching health workers



The webinar streamed on the NDoH Facebook site, which was successful in reaching its intended audience. Over 1,275 people registered and a preliminary breakdown of participants suggested that the majority were health

facility managers and health workers (34% and 31% respectively) followed by health officials and leadership (18%), and NGOs (5%).

Data from the NDoH Facebook account showed excellent results with a reach of 351,615 and 23,486 video views.

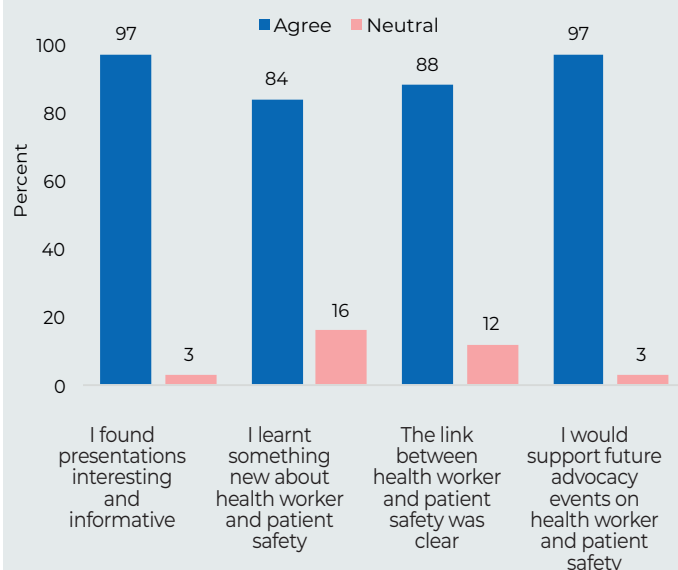
Facebook livestream analytics

Reach	Engagements	Video views	Comments and shares
351,615	10,021	23,486	2,063

The NDoH tweeted five pieces of educational and awareness content from the social media toolkit and video items received over 1,000 views. The NDoH also posted a video tweet from the UK High Commissioner in which he expressed support for the COVID-19 response and World Patient Safety Day which garnered over 1,300 views.

Participants responded favourably to the webinar, as is illustrated by the evaluation survey results.

Participant responses to webinar evaluation survey



Lessons learned



As this was a national government event it was governed by strict protocols and processes and at times the service delivery team was challenged by its limited control over events and deliverables. However, the message of World Patient Safety Day 2020 resonated with health managers and workers and the NDoH would not have achieved this without the added support from BHPSA.

One of the spinoffs of working with multiple NDoH departments was that this was the first collaborative effort involving the NDoH Quality Assurance Directorate and the online education programme of the Knowledge Hub managed by the NDoH HR cluster. This will hopefully be the start of a fruitful relationship and many more webinars on quality of care.

On BHPSA's part, relationships - including with WHO - were strengthened and this will carry momentum for the programme into the future. BHPSA was officially recognised and thanked by the Deputy Minister of Health for its support to the event ■

More:

Listen to the webinar recording.

https://www.facebook.com/watch/live/?v=353477615839530&ref=watch_permalink

Read the NDoH Strategy to protect the health and safety of health workers in the face of the COVID-19 pandemic.

<https://www.knowledgehub.org.za/system/files/elibdownloads/2020-09/Strategy%20to%20protect%20the%20HS%20of%20health%20Workers.pdf>

NCD LEARNING ENGAGEMENT



“Your comprehensive support in year one was ground-breaking.”

Sandyha Singh
Director of NCDs, National Department of Health

On March 1, 2021, BHPSA hosted a webinar to share year one programme learning about noncommunicable diseases (NCDs). It was attended by over 50 people from national and provincial departments of health, civil society organisations and other interested parties. Several senior NCD managers and provincial coordinators were on the call and participated actively in the discussion afterwards.

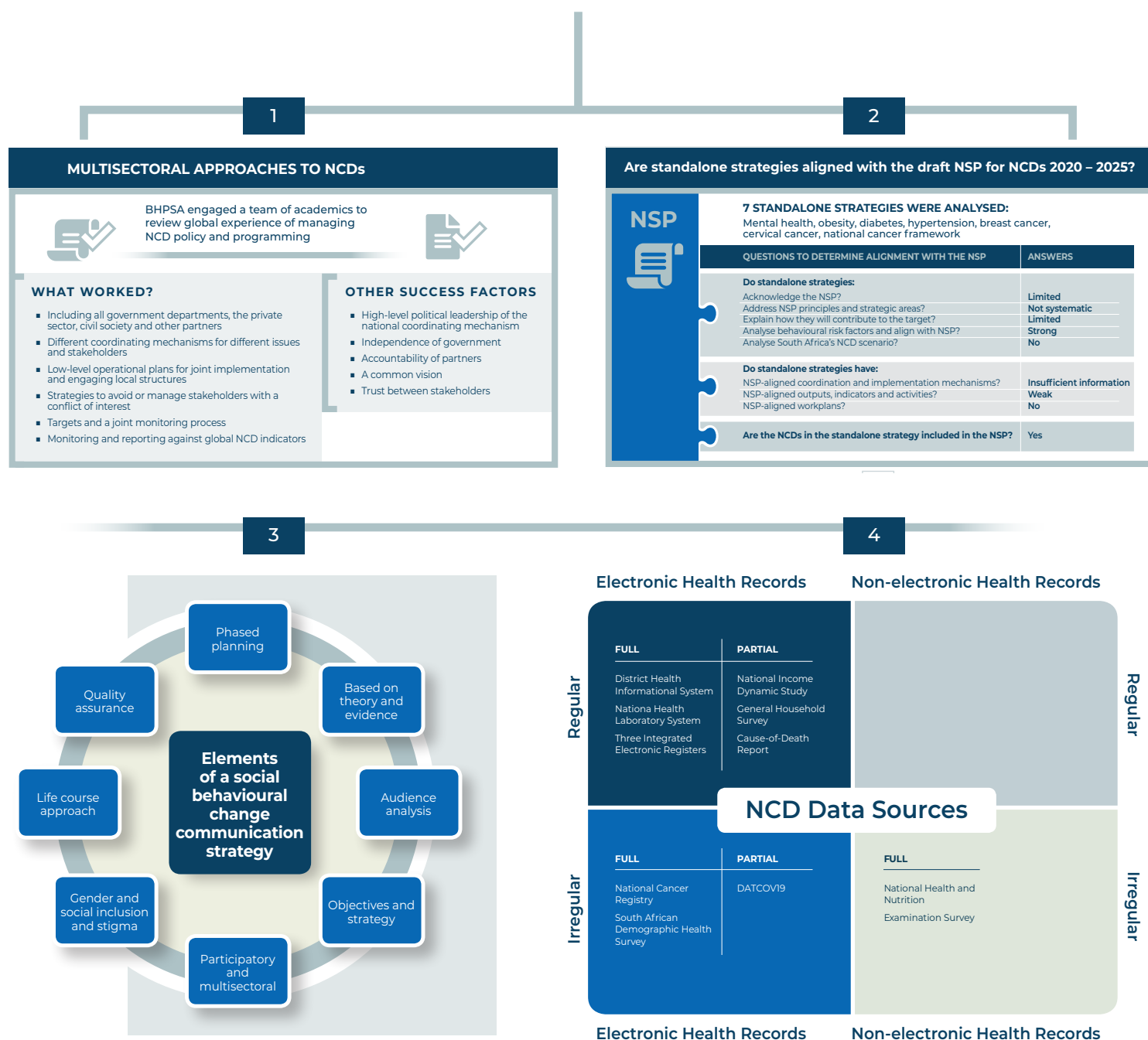
Sandhya Singh, Director of NCDs in the NDoH, began by thanking BHPSA for the work saying “your comprehensive support in year one was ground-breaking as the country struggled against the COVID-19 pandemic, which revealed serious gaps in our health system’s ability to effectively respond to people living with NCDs and who were at risk from serious illness.”

FOUR REPORTS

BHPSA presented findings and recommendations on the following topics.

1. **Multisectoral approaches to NCDs, the global evidence;**
2. **The alignment between the country's stand-alone NCD programmes and policies with the new National Strategic Plan for Noncommunicable diseases (2021-2026);**
3. **A framework for social and behaviour change communication programmes for NCDs; and**
4. **The NCD data and surveillance ecosystem and recommendations for improvement.**

The reports were well received, with Dr Vicki Pinkey-Atkinson (South African NCD Alliance Head) declaring "Everything I have been asking for has been highlighted and I feel that I can retire now!"



NCD DATA

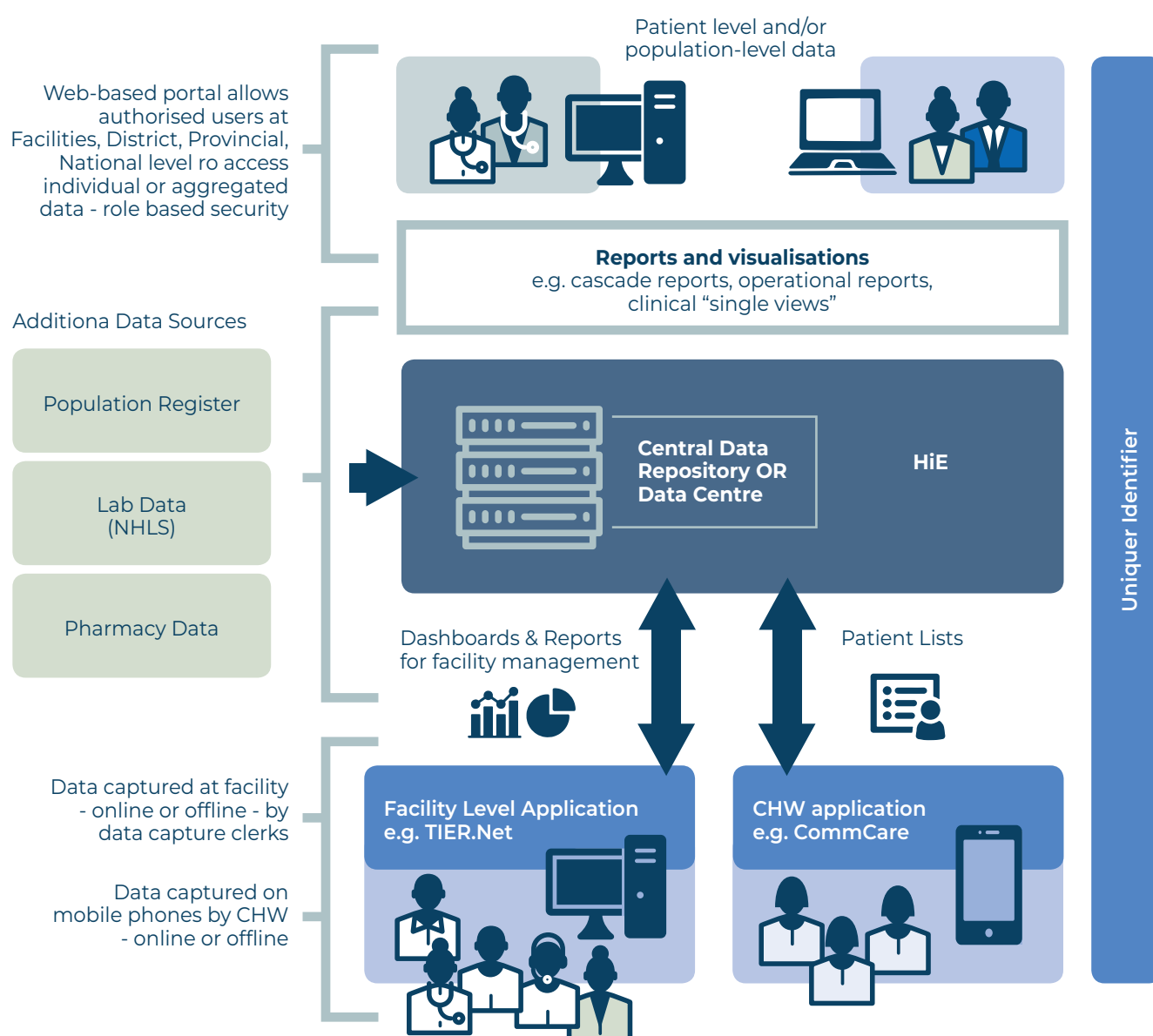
The presentation on South Africa's NCD data challenges and solutions attracted the most discussion due to shared perceptions of the need for reform in this area. The presentation showed that there is a lack of comprehensive electronic data on NCDs, especially in facilities, and where there is data, it is not integrated or interoperable.

Not only is the current data and data collection system unfit for purpose, the lack of data is a barrier to the recognition of the severity of the NCD epidemic in the country. This was described by Singh as a cycle of disadvantage. "We have been struggling

to make the case for NCDs, but Treasury needs data... so we have never been able to make this case."

A key recommendation in the presentation was to learn lessons from the country's advanced HIV and TB information systems. The watchwords here are "adapt, adopt and re-use". The proposal is to use the routine NCD data that is already captured at facility and community levels, and leverage that to develop a simple data set. This would enable the drawing up of reports and visualisations in the short term. In the long term, additional data sources could be added.

Conceptual Solution | NCD data



TIME FOR IMPROVEMENT

Provincial and facility managers spoke about their long struggle to improve NCD surveillance, and in particular to expand the District Health Information System to collect appropriate NCD data. A member of the Mpumalanga province DoH said 74% of people in the province who died of COVID-19, died of complications from diabetes and hypertension. She added, “We can’t tell you how many people we have for diabetes, it [DHIS] cannot give you a register that will indicate a control rate or default rate. For her, the presentation came at the right time because the COVID-19 pandemic has revealed the urgency of the situation.

Participants agreed that the time was ripe for improvements and that there are already some examples of viable solutions. For example, Prof Deb Basu, Academic and Clinical Head of Public Health Medicine at Steve Biko Academic Hospital, shared the experience of one Johannesburg clinic which has been using the HIV data collection system (tier.net) for more than a year to capture multimorbidities. Singh also pointed out that the Western Cape province has a good data system for NCDs driven through a provincial data centre using unique patient identifiers, which may be a model for other provinces.

Singh closed the meeting by summarising the way forward. “We won’t be able to implement National Health Insurance (NHI) if we can’t reduce the number of patients who have complications from NCDs. And this all hinges on integrated data systems.” She also referred to the recommendations of the “standalone report” saying that it pinpointed the importance of policy cohesion around NCDs at provincial and national levels.

A recording of the webinar and summaries of the reports are available at the links below.

- NCD Learning Engagement webinar recording: <https://bit.ly/3cDGg0A>
- [Multisectoral approaches to NCDs, the global evidence;](#)
- [The alignment between the country’s stand-alone NCD programmes and policies with the new National Strategic Plan for NCDs\(2021-2026\);](#)
- [A framework for social and behaviour change communication programmes for NCDs;](#)
- [The NCD data and surveillance ecosystem and recommendations for improvement.](#)

BHPSA

BETTER HEALTH PROGRAMME
SOUTH AFRICA

CASE STUDIES

MARCH 2021

WORLD OBESITY DAY

“You cannot clap
with one hand.”

African proverb, Joseph Mwangi
WHO NCD Adviser

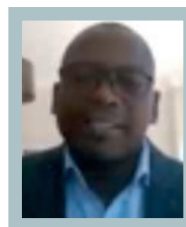


With nearly half of the adult population obese or overweight, South Africa has an urgent need to tackle its escalating obesity crisis. To raise awareness of this challenge, the National Department of Health (NDoH) commemorated World Obesity Day on March 4, 2021 with technical support from BHPSA.

THE BIG PICTURE



The webinar was opened by Dr **Joseph Mwangi**, World Health Organization (WHO) NCD adviser in South Africa, who set the scene with a global snapshot of obesity: 800 million people around the world are already living with the disease and childhood obesity is expected to increase by 60% over the next decade.



Deputy Director for NCDs in the NDoH, **Itumeleng Setlhare**, explained that obesity is an important modifiable risk factor for NCDs such as diabetes and hypertension, which are a heavy burden on the health system. In addition, these multimorbidities have been linked to severe

COVID-19 disease and death. Setlhare said it is important to strengthen NCD prevention by improving health literacy and implementing strategies to reduce tobacco use, harmful use of alcohol, unhealthy diets, physical inactivity and air pollution. One of the great challenges for the country is to make healthy diets accessible when people are surrounded by unhealthy foods.

WIDE REACH

The NDoH shared the webinar invitation with stakeholders engaged in previous national nutrition week commemorations, including provincial departments of health. Participating NGOs were invited to publicise the webinar on their respective social media platforms.

Two hundred and forty people joined the webinar including national and provincial NCD and nutrition coordinators and other interested parties. The one-hour webinar was successful in creating interest and engagement on the topic, and a press release, written by the Association for Dietetics in South Africa (ASDA), was published in five online newspapers.



Rebhone Ntsie, Director for Nutrition in the NDoH, followed up by emphasising that obesity was just one part of the triple burden of malnutrition in South Africa: overnutrition, undernutrition and micronutrient malnutrition (particularly deficiencies in

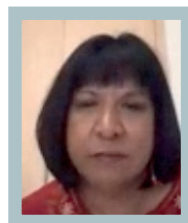
Vitamin A, D and iron). While seemingly different, these types of malnutrition can occur even within the same household. She quoted two recent studies show that hunger, particularly child hunger, and food insecurity in the country has worsened considerably during the COVID-19 pandemic.

THE NDOH RESPONSE

Ntsie provided a brief outline of NDoH policy and programming in response to SA's obesity and nutrition crises:

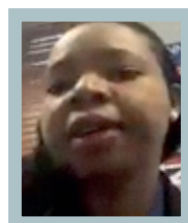
- **The National Food and Nutrition Plan (2018-2023).** This is a multisectoral approach to address the triple burden of malnutrition, including a communication strategy that aims to influence people across the life cycle to make informed food and nutrition choices.
- **The Strategy for the Prevention and Control of Obesity (2015-2020).** This is currently being updated, with support from BHPSA and other partners. The review team will include a range of technical experts specialising in the prevention and control of obesity.
- **Front of Package Labelling on Foods (FoPL).** Research has been conducted and a simplified warning message developed for packaged foods, which will soon become mandatory.
- **The National Dietary Intake Study.** This will aid the development of evidence-based interventions and inform the updated obesity strategy.

BHPSA SUPPORT



BHPSA was afforded the opportunity to present on our support to the various NDoH NCD strategies. **Vimla Moodley**, BHPSA's NCD workstream lead, described the programme's work as part of the UK Foreign, Commonwealth and Development Office's (FCDO)

Prosperity Fund and its focus on NCDs. In addition to supporting the obesity strategy review, BHPSA has given technical support to the finalisation of the National Strategic Plan for NCDs and will be working to strengthen the capacity of community health workers to provide NCD services, amongst other support.



BHPSA's FCDO Adviser **Tori Bungane**, also gave a verbal message of support expressing pride at being able to contribute to this important event. She mentioned that there have been similar campaigns in the UK around food labelling (FoPL) and marketing unhealthy foods to children.

Mwangi responded with thanks and appreciation of FCDO support, quoting the African proverb "you cannot clap with one hand".

CONCLUSION

Other verbal and written messages of support came from the WHO, UNICEF, Clinton Health Access Initiative (CHAI) and NGOs in the field such as the ASDA, and the Heart and Stroke Foundation as well as other government bodies.

Ntsie and Mwangi thanked all partners who participated in the webinar and urged them to bring attention to the issues discussed and the World Obesity Day theme "Every Body needs everybody."



View the webinar recording here...
<https://www.youtube.com/watch?v=ep9NnjGwguU>

STRENGTHENING DATA ON NONCOMMUNICABLE DISEASES

“These are principles for the ideal NCD data solution: patient centric, interoperable, uses existing software tools and open source technologies, re-uses and improves existing systems.”

Chris Seebregts, Jembi/BHPSA consultant.

Comprehensive and accurate data is the basis of understanding the burden of any disease, and tracking progress on tackling it. Most importantly, data and health information drive quality patient care and reduce operational costs by making administration and management more efficient.

In 2013 the World Health Organization (WHO) agreed 25 key indicators to monitor data on noncommunicable diseases (NCDs). The SA National Department of Health (NDoH) has signed up to this, and the new draft National Strategic Plan for NCDs (2021-2026) is fully aligned to the WHO indicators. However, these indicators are not included in the current SA National Indicator Data Set (NIDS), nor collected systematically.

This BHPSA Case Study provides an overview of the current challenges around national NCD data and how BHPSA is supporting the NDoH to improve this situation.

CURRENT NCD DATA AND DATA SYSTEMS

The first phase of BHPSA's work on NCD data was a review of the status of national NCD data sets and data collection systems.

STANDARD SOURCES OF DATA

Surveys (Occasional)

- SA Demographic Health Survey
- SA National and Nutrition Survey

Routine

- District Health Information System
- Cause of death reports

ALTERNATIVE SOURCES OF DATA

Pharmacy data Laboratory data

SURVEYS

Information on South Africa's growing NCD crisis comes from many different sources. The most authoritative of these are two national surveys, conducted every few years.

- The South African Demographic and Health survey (SADHS) collects data on the following NCDs: high blood pressure, heart attack or angina, cancer, stroke, high blood cholesterol, diabetes, chronic bronchitis, chronic obstructive pulmonary disease and asthma. It also looks at risk factors for NCDs such as alcohol and tobacco use, and obesity. The survey examines

the NCD status of men and women (15 – 49 years) in sample communities which are representative of the whole country. It pools the information from questionnaires and biological screening of people in 11,000 households.

- The South African National Health and Nutrition Survey (SANHANES) collects data on the health and nutritional status of 5,000 representative households with respect to prevalence of NCDs, specifically cardiovascular disease, diabetes and hypertension, and their risk factors (diet, physical activity and tobacco use). This survey also uses questionnaires and interviews in combination with health measurements obtained from clinical examinations and tests.

These are both excellent and comprehensive surveys, which give a good indication of the national burden of the full range of NCDs. However, they are too expensive to repeat annually, which means that their data is often out of date. In fact, the most recent data from SADHS and SANHANES are from 2016 and 2012 respectively.

ROUTINE DATA

There are also several sources of routine data that provide information on NCDs on an ongoing basis. Two of the most commonly cited are the District Health Information System (DHIS) and the Cause of Death (COD) mortality report. These again are very detailed and useful data sources; however, they are not without challenges.

- DHIS collects health statistics from people using all public sector primary health care facilities. These data are recorded in a number of different paper registers and the tallies are captured in an electronic database and are available at district, provincial and national levels. The data are collected according to the NIDS, which for NCDs is currently very limited, as noted above. For example, for hypertension and diabetes, it uses records of those diagnosed and undergoing treatment for the first time as proxies for incidence, and does not include data on blood pressure or blood glucose. The burden on frontline health care workers to record an increasing number of data elements across many manual systems is also a significant factor that affects the accuracy, timeliness and completeness and quality of this data.
- The annual mortality report by StatsSA uses statistics from the National Population Register that records causes of death from all causes. The cause of death data is very detailed and disaggregates deaths by age and gender across all disease categories. However, it is produced infrequently, with the most recent report relating to 2018.

So, it seems that neither the national surveys nor the routine data are adequate to track South Africa's burgeoning NCD crisis. This is in contrast to HIV and TB, which has a specialised system developed with substantial investment over many years, TIER.Net. This system collects the patient-level data that drives patient care.

Another challenge to health data collection in South Africa is the absence of a unique patient identifier, or number, used universally across the health system. This means, among other problems, that the data generated by the DHIS is sometimes inaccurate, as repeat visits may not be classified as the same patient, i.e. patients may be counted twice. South Africa is currently implementing the Health Patient Registration System (HPRS), which when complete, will give all patients a unique identifier. The Western Cape province already uses their own unique identifier, Clinicom.

ALTERNATIVE DATA SOURCES

Given the challenges described above, an alternative method of quantifying the burden of disease through an analysis of other data sources may give a more accurate picture of prevalence of diagnosed NCDs. These include:

- Pharmacy records, which identify patients who have been prescribed drugs. There are several different pharmacy systems operating nationally including Chronic Medicine Dispensing and Distribution (CCMD) for stable patients, which is managed by the NDoH, and two dedicated Western Cape Provincial Department of Health (WC-PDH) systems.
- Laboratory records that show results for diagnosis and monitoring of diabetes. There is one laboratory system used nationally, the National Health Laboratory Services (NHLS).

These data sources can be used to infer cases, where the full patient record data is simply not available.

SOLUTIONS

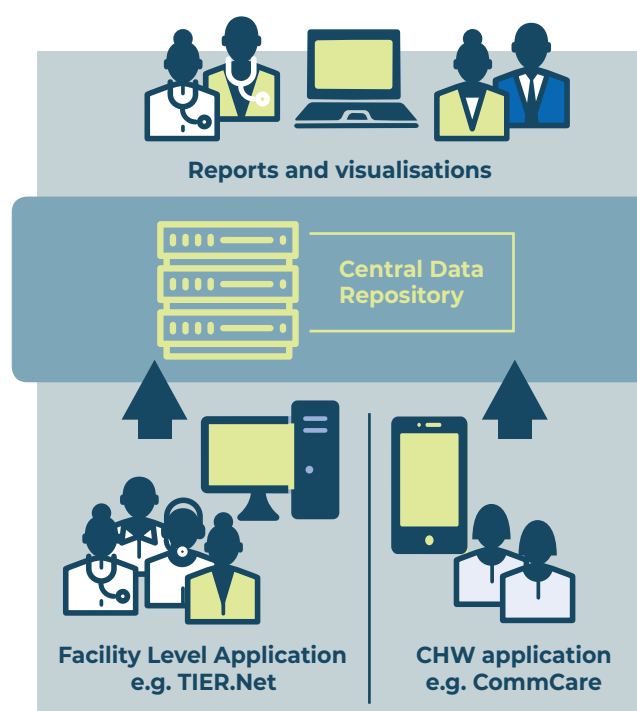


Figure 1: Conceptual solution

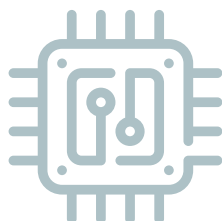
As a result of the year one rapid review, BHPSA digital consultant Jembi identified a number of possible solutions for the collection of NCD data. They included:

1. The “reformist” solution: extending the NIDS to include additional key indicators for NCD surveillance to be collected through the existing DHIS;
2. The “add-on” solution: extending TIER.Net to collect patient NCD data at primary care level; and
3. The “bells-and-whistles” solution: following an approach used in the Western Cape, develop a system using existing technologies to include the collection of NCD data from a range of sources such as health facilities (ie patient care), community (ie from community health workers, CHW), laboratories, pharmacies and population-level surveys. This data would be fed into a sophisticated centralised data warehouse with strong data management and data analytics capability. It would enable comprehensive assessment of burden of disease as well as efficient management of chronic care.

Option 3 involves the use of open source software (Open IHP and OpenHIM) to enable interoperability between the different systems, allowing them to exchange data with the centralised data warehouse. This would include matching and linking of patient records from multiple sources, to minimise duplicate records and support a longitudinal patient record.

While this “bells-and-whistles” option is an ideal state, it will be years in the making and will require much research and several different implementation steps. To date, the WC-PDoH has the most sophisticated data collection system and using this approach and the learnings from this will provide some insight into how the phasing of Option 3 may take place.

Different electronic systems are in use across different provinces in South Africa and the infrastructure to support any digital health solutions varies considerably between provinces and between rural and urban settings. Therefore, the system in use in the WC cannot simply be re-used as-is; rather, the experiences may be leveraged to support this work in other provinces through knowledge sharing and capacity building. The interoperability framework and some of the technologies may also be adapted or enhanced to support this work in other provinces to meet their specific needs. All this can only take place within the broader NHI data systems architecture, currently being developed by the NDoH.



VALIDATION WORKSHOP

After the initial scoping review, BHPSA's digital consultant, Jembi, continued to work on possible solutions for the SA NCD data collection system, in conjunction with public health officials from the WC-PDoH and UCT.

In early July 2021, a virtual workshop was held with the NDoH to discuss BHPSA/Jembi proposals for ongoing work on NCD data. It was attended by officials from the relevant NDoH departments, BHPSA consultants and team members, WC-PDOH staff, WHO and other stakeholders.

Jembi's CEO, Chris Seebregts introduced the objectives of the meeting: to discuss a proposed pilot study of the implementation of a digital health system for collecting and collating data on diabetes and hypertension by extending existing systems already in use in the Western Cape province. These include a facility-based health information system, which will be adapted/configured to collect selected NCD data (Capture-OpenIHP) and a community-based system using an existing CHW health information system (Catch and Match), both of which are linked to the Provincial Health Data Centre in the Western Cape. Seebregts said the fundamental principles of the work were to be people-centred, to use existing software tools, to create an interoperable system using open-source technologies and to re-use and improve systems that are already functioning well.

The following presentations were made:

- Bilqees Sayed from the NDoH NCD cluster described the background of the NCD crisis and NCD data challenges.
- Lindiwe Madikizela from the NDoH described the NDoH CHW programme, which includes the screening and basic management of hypertension and diabetes.
- Andrew Boule from the WC-PDoH presented on the province's use of personal-level health data to improve chronic care. The WC-PDoH uses unique patient identification and interoperable systems, which enable them to integrate health facility workflows and consolidate patient-level data. This system is not yet optimised for NCD data. Figure 1 below shows the structure of, and number of possible outputs from such a system at national level.
- Andrea Mendelsohn from the WC-PDoH demonstrated the Single Patient Viewer (SPV) in use in the province. This enables a comprehensive overview of individual patient care and outcomes, as well as facility and district-level reports on chronic and other diseases.
- Arne von Delft – demonstrated the Catch and Match mobile phone application used by CHW in the Western Cape to identify risk and refer people to health services.

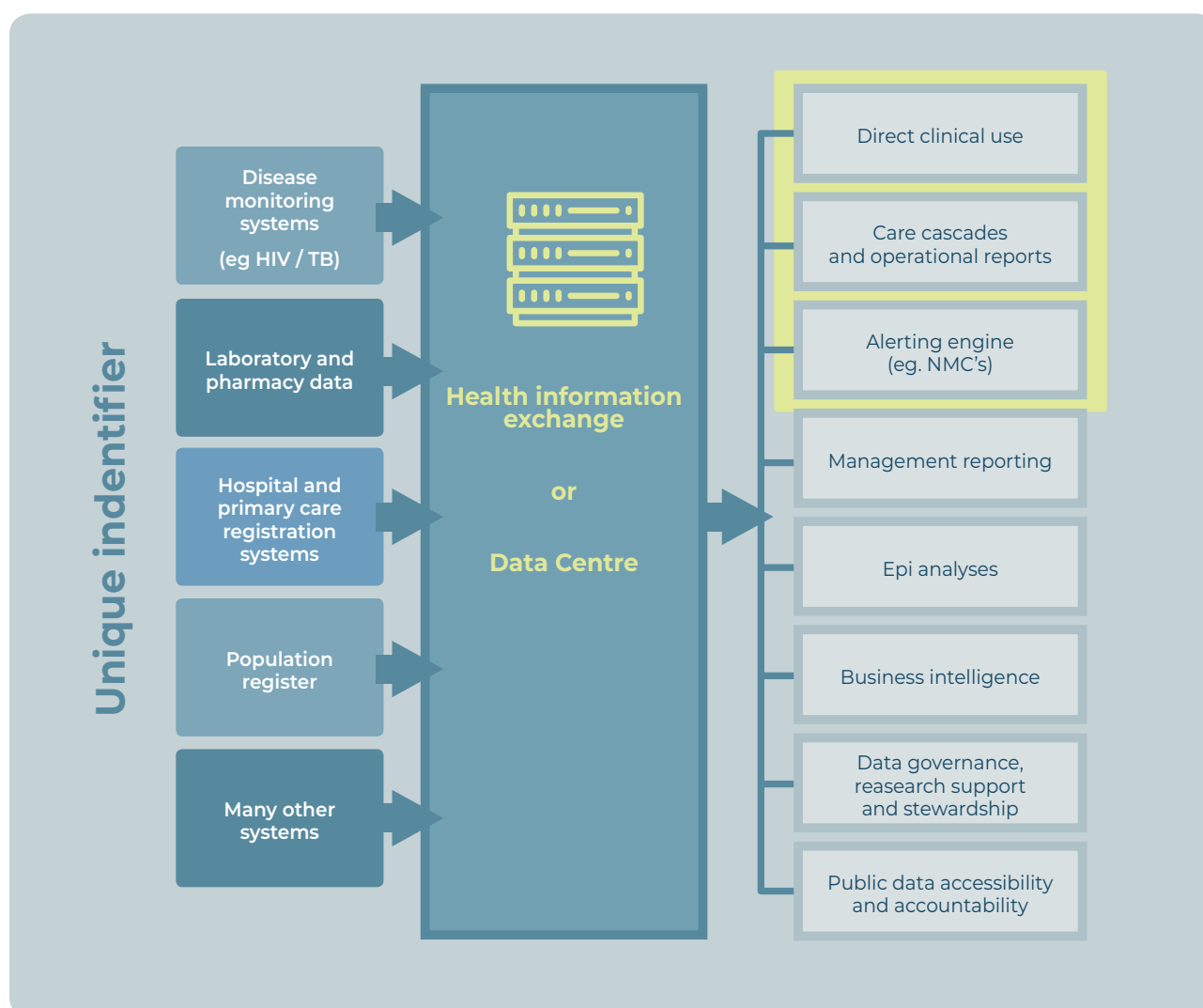


Figure 2: Idealised data system

NDoH participants expressed great interest in the potential of adapting the WC-PDoH systems to strengthen NCD data collection across the country. Concerns were expressed around the implementation of a pilot that cannot be taken to scale, or that collapses with the end of donor support. For example, an app for electronic CHW data was developed and then piloted over a period of two years in five health districts, but could not be taken to scale because of lack of funding and a sustainable business case. Another concern was around the availability of appropriately skilled human resources to implement and maintain the system.

From the side of the digital experts, there are still many implementation gaps and challenges to be met, particularly in relation to NCD data. A pilot or operational research programme will be invaluable in understanding how feasible it would be to adapt these systems for national use.

OPERATIONAL RESEARCH

Building on previous work and the validation workshop, Jembi has now designed two operational research programmes which will test aspects of these systems and fill in any gaps. These projects are focussed on the most prevalent NCDs - diabetes and hypertension. They are both small pilots that are realistic within the timeframe of BHPSA, but will also provide the basis for a national NCD data collection system that is fit for purpose and prepare the roadmap for future interventions after BHPSA has ended.

- **Alternative approaches to diabetes data:** The aim of this research is to support the NDoH to understand the burden of diabetes from existing data sources and has the potential to be extended to other diseases. This approach is already in use within the WC-PDoH, which uses existing laboratory and pharmacy data. This project will investigate whether this approach can be applied in another environment/province

by analysing the data from identified sources for a selected geographic area. This is dependent on being granted access to the data by the custodians of this data. Ideally, the individual patient-level data would provide very valuable insights; however, even at an aggregated level an analysis could prove useful. This research will also look at matching and linking patient records with a range of different unique identifiers such as HPRS, South African identity documents and passports, and demographic data.

- CHW hypertension screening: This is an operational research project to investigate the feasibility of using an mHealth application (mobile app) to collect hypertension screening data from routine community visits by CHWs. They will use blood pressure measuring devices to identify patients at risk, record this data electronically on their phones and refer patients to the primary health care clinic. Potentially this project will develop a method to estimate the burden of hypertension at community level. The project will focus on the feasibility of this approach rather than any particular mobile technology, and will provide a set of generic specifications and recommendations that will support provinces and NDoH to evaluate mobile tools for adoption.

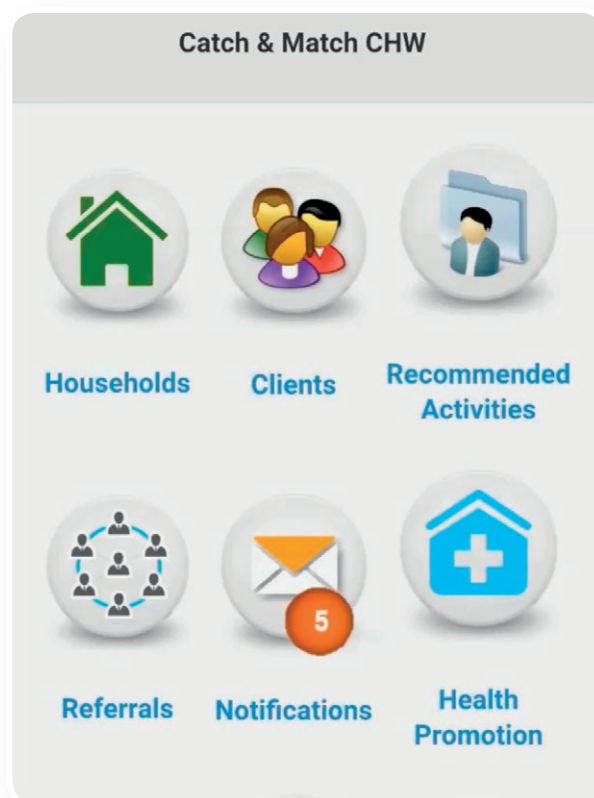


Figure 3: CHW app home screen

CONCLUSION

South Africa faces a long and winding road to perfect NCD data. But this is an essential journey to take. The two BHPSA pilots will provide proof of concept, and the engagement of the NDoH indicates that this work will be sustained and scaled nationally. One of the key lessons learned in other projects is that the software is not the most important component of the system - investment in digital infrastructure, capacity building and long-term financial support for the on-going maintenance and technical support of the software are more critical. Thus, the research projects will focus on a reference implementation to provide evidence for key principles and guidelines that can support such projects in future, rather than building another digital tool. Planning for long term financial sustainability and buy-in from all the key stakeholders will be fundamental to its success.



TALKING ABOUT VEG AND FRUIT

SUPPORTING THE NATIONAL NUTRITION WEEK 2021 CAMPAIGN

All the evidence points to the fact that poor quality diets are a major cause of illness and death across the globe. One simple way to address this is to include more vegetables and fruit in our daily meals. But research shows that between 1994 and 2012 people in South Africa have been eating less vegetables as they increased their intake of ultra-processed convenience foods.

For this reason, in 2021, the National Department of Health (NDoH) chose the theme “eat more vegetables and fruit every day” for the annual National Nutrition Week campaign (NNW). A wide range of government and nongovernmental collaborators were involved in developing and implementing the campaign, which ran from 9-15 October.

On request of the NDoH, BHPSA contracted a team of experts on Social and Behaviour Change Communication (SBCC) from the University of the Witwatersrand to support the campaign. This included support to strengthen planning and reporting templates as well as pre-testing materials. The team also provided resources to conduct an in-depth evaluation to see how well the campaign worked. This is the first such evaluation of a National Nutrition Week campaign and is intended to strengthen national nutrition and obesity campaigns in future years.



THE CAMPAIGN

The campaign focussed on different aspects of vegetable and fruit consumption, such as health benefits; affordability; veg and fruit as healthy snacks; portion size; preparation; and child and infant feeding. It involved dissemination of informative infographics in print and social media formats; a national social media campaign; media interviews and articles on the benefits of eating more vegetables and fruit as well as interpersonal talks and activities at health facilities and schools. Campaign implementers from government, health organisations, professional associations and the retail sector were identified at provincial and local levels and were encouraged to tailor activities to their contexts.



Before the campaign began, the expert SBCC team tested the infographics with focus groups who gave good suggestions on how they could be improved.

The media campaign was a great success, resulting in 114 print, broadcast and online articles, which potentially reached around 15 million people. The cost of placing advertisements to receive the same coverage would have cost the NDoH over R4 million.

THE EVALUATION

The evaluation on the NNW campaign was a mixed-methods study using surveys, in-depth interviews and implementers' reports. The expert SBCC team evaluated two different aspects of the campaign: how it influenced ordinary people's beliefs and behaviour, and the views of NNW implementers on the campaign process. Both aspects of the evaluation will feed into and strengthen future campaigns.

Headline news from the implementers, was that the NNW 2021 campaign was broadly perceived to be an improvement on previous campaigns. Implementers said that the planning processes had significantly improved, and the materials were user-friendly and rich in messaging that targeted nutritional behaviour change.

IMPLEMENTER, ON PRE-TESTING:

I thought it was a brilliant process - to actually understand what the end user thinks of these pamphlets. Some of the things [they said] were truly shocking but absolutely true at the end of the day. Because what I realised was when we normally develop materials, we evaluate them using the same type of people... health workers, dietitians... which was not as useful as asking the community to comment. So yes, I would definitely want to use that process again.

Implementers made several practical recommendations that will be considered when designing next year's programme, as well as the NDoH campaign planned for World Obesity Day on 4 March 2022.

WHAT WE LEARNED

The quantitative survey (88 respondents) found that baseline knowledge of the value of eating vegetables and fruit was generally high. Those who had been exposed to the campaign were marginally more likely to eat at least three vegetables per day as compared with those unexposed. However, while knowledge was high, only a small number of people in both groups were eating the recommended daily portions of vegetables and fruit. Less than a third (31.8%) of the sample said they ate three or more vegetables per day, while only half (46.6%) reported eating two or more portions of fruit.

More positively, the survey showed that the campaign significantly improved confidence that fruit and vegetables were affordable. It also improved peoples' understanding of the timing of when to introduce complementary feeding (including fruit and vegetables) to children.

INTERVIEWER: *Now that you have received the information and you attended the event at the preschool, how likely are you to eat more vegetables and fruits?*

INTERVIEWEE: *Even more motivated, I think. And I think the other thing, ma'am, was the team that visited us were shining examples of healthy eating, all of them. Even their own snacks while they were with us were fresh fruit, and they shared fresh fruit and vegetables with us. So, the message was reinforced by how they presented, how they looked, how they dressed, and what they brought along. And it made the children very keen. When the children answered questions correctly, they were given fresh fruit, and that has really reinforced, and so we are all sold on the idea.*

THE NATIONAL FOOD ENVIRONMENT

In addition to the measuring the influence of the campaign, the evaluation was rich in insight into people's dietary practices and beliefs. For example, it was able to throw light on the discrepancy between "knowing and doing" highlighted above.

More than half the survey respondents said that vegetables and fruit were too expensive. People seem to compare the prices of fruit and vegetables with alternatives, which they believe are cheaper.

INTERVIEWEE: *Yes it is expensive, but people are willing to pay monies for junk, for foods that is not going to benefit you in any way...It is expensive though...Where you would pay R10 for something unhealthy, healthier options could be R30 and R40, so I think we need to try and change that.*

Apart from the expense, ultra-processed and junk foods are often more readily available than fresh food, especially in and around school premises. Some parents felt that school tuck shops should offer vegetables and fruit as healthy snacks.

Other barriers to healthy eating included a lack of knowledge on how to grow, store and prepare fresh foods; catering for "picky" children; and the influence of food marketing.

INTERVIEWEE: *It is very hard to get good fruits and vegetables. A lot of it ... they are stale and a lot of the times ...we get apples and they are sour and so it is very difficult, it is definitely not very easy.*

RECOMMENDATIONS

Lessons from the study resulted in a detailed set of recommendations on strengthening both the content and the process of future campaigns.

Content recommendations, to name a few, included focussing more on action-based knowledge and skills; developing targeted messages for people living with noncommunicable diseases; and devising communication strategies to decrease the appeal of ultra-processed foods.

Process recommendations included embedding NNW messages in longer-running campaigns; leveraging partnerships to source funding; and providing more guidance to implementers on adapting resources to local contexts, among others.

The overarching recommendation was to use these recommendations for campaigns on other topics.

INTERVIEWEE: *What I learnt from the nutrition week I am now doing it this way, three times a day, which is something fun to my kids, because they were not interested. But now the way we are doing it, we are doing it in a fun way. They are enjoying it, they put more attention on it, so it is something which is nice. We are doing it three times a day.*



CONCLUSION

Thanks to the outcome evaluation, for the first time, NNW implementers can begin answering the question, “So what?” in terms of how the campaign has influenced people’s understanding and behaviours.

The quantitative survey illuminated patterns of knowledge, beliefs and self-efficacy about eating vegetables and fruit, and these patterns validated the messages that were selected for the campaign.

The modest positive associations identified between NNW campaign exposure and some communication objective targets were encouraging. There were no findings that suggested exposure to NNW was associated with worse knowledge, beliefs or self-efficacy.

Taken together with the broader literature, it was concluded that the outcome evaluation reinforces the value of NNW as a campaign and provides direction for future messaging.

BHPSA SUPPORT

BHPSA support for NNW 2021 built on work done in year one of the programme by the same team of consultants. This included developing a generic SBCC framework for the NDoH and an evaluation of NNW 2020



BHPSA

BETTER HEALTH PROGRAMME
SOUTH AFRICA

CASE STUDY

MARCH 2022



Eastern Cape community health workers assembling for training

NEW SKILLS FOR COMMUNITY HEALTH WORKERS

In September 2021 a group of blue-uniformed health workers gathered excitedly at Bloemfontein's Pelsonomi Hospital. These were not regular nurses signing up for their day shift, but community health workers (CHWs) from a nearby clinic who had been chosen to test a package of new training materials on noncommunicable diseases (NCDs).

The training materials had been developed by the Knowledge Translation Unit (KTU) at the University of Cape Town, with BHPSA support, in a response to a request from the National Department of Health (NDoH).

“This is very good because it has pictures. As you’re teaching someone, it’s easier for them to understand when you’re teaching them. They’re also enthusiastic to follow what we’re teaching.”

*Community health worker on
the new NCD training*

THE NEW NCD CHAPTER

The materials for the NCD Chapter included reference manuals for trainers and CHWs, as well as two booklets - a job aid and screening tools - to be used in the community. The materials cover the key topics of cardiovascular disease, diabetes, hypertension and cancer. CHWs are also advised on the best way to encourage clients to make healthy lifestyle choices such as keeping active, eating well, avoiding tobacco, alcohol and drugs, and having safer sex.

The reference materials provide detailed information on all topics, and the job aid is an A5 booklet that summarises key messages, which CHWs can carry on their rounds.

The training materials give step-by-step guidance on how to explain and screen for NCDs as well as supporting clients with education, adherence to medication and referrals to the clinic.

Central to the concept of the chapter is the reinforcement of training with on-the-job experience. To this end, there is a manual for outreach team leaders on work-integrated learning (WIL). The structured eight-week programme refreshes learning from the trainings and encourages the CHWs to practice their skills in the field. It guides them through these practical tasks and empowers them with the skills to interpret and act upon their findings. A practical record allows them to demonstrate how they are implementing this in the community. This record supports the outreach team leaders to assess levels of competency and address any gaps identified.



COMMUNITY HEALTH WORKERS AND NCDs

Teams of community health workers (CHWs) visit people in their homes across the country providing basic screening, health support and educational services. Collectively they have the potential to reach million households with healthcare in underserved and rural areas of South Africa.

Each group of CHWs is overseen by an outreach team leader (OTL), usually a nurse, linked to the local primary care clinic to which the CHW refer more complex cases. These Ward-based Primary Health Care Community Outreach Teams (WBPHCOT) are an essential part of the national primary care system and have played a critical role during the COVID-19 pandemic. Their focus is on maternal and child health, HIV, TB and sexual health; but CHWs are expected to advise on all common health issues.

With the growing epidemic of diabetes, hypertension and other noncommunicable diseases (NCDs), the National Department of Health (NDoH) recognised the importance for CHWs to be up to date on these issues. In 2020 the NDoH requested BHPSA support for a review of the existing NCD module in the national training manual for CHWs. Expert reviewers found that the current materials covered a wide range of important topics on NCDs as well as the lifestyle factors that put people at risk of developing them. However, while the materials were heavy on technical information, they lacked practical guidance and job aids that would support CHWs to promote a healthy lifestyle and conduct basic screening and referrals.

In response to the review, BHPSA was asked to revise the NCD module, and staff from the Knowledge Translation Unit (KTU) at University of Cape Town were tasked to develop revised materials.

THE TRAINING

The full training package uses a cascade model of training to allow for future scale up. A Master Trainer from the province is trained to deliver an abbreviated curriculum to the OTLs. The OTLs then in turn deliver the training to larger groups of CHWs.

A pilot was carried out in September and October to test the materials. It followed the same approach, only the initial training was done by the KTU consultants. A total of 3 Master Trainers, 8 OTLs and 67 CHWs were trained using this approach. They conducted a total of 6 pilot trainings in the Free State and Eastern Cape Provinces.

The training focuses on the basics of NCDs and how to use the materials and consisted of lectures, discussions, small group activities and practical guidance. Activities included roleplays and practical sessions, for example how to check blood pressure.

The sessions were well received by the CHWs who particularly appreciated the fact that the materials were clear and well-illustrated and that they had plenty of opportunity for questions, discussions and practical activities. One CHW told the trainers “Now because we have knowledge and equipment it will be easier for us to do our job and the community will be happy for the services that we bring for them.” Feedback from the OTLs was also positive, for example: “My job as an OTL will be much simpler as this training has equipped the CHWs with the ability to assess and refer. The OTL will just help to guide and oversee some of the challenges.”

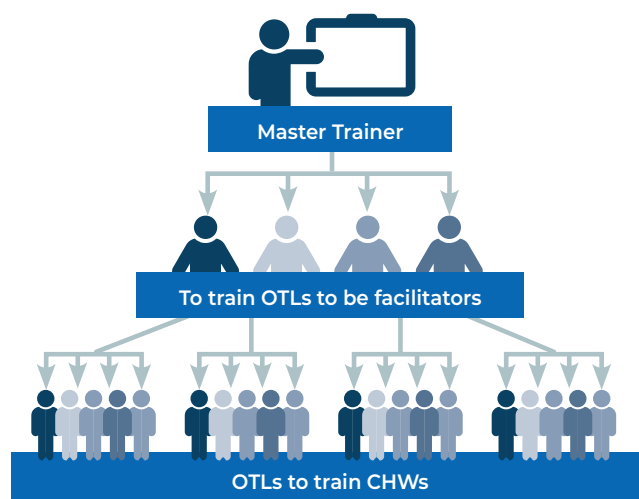
The CHWs involved in the pilot were provided with back packs that included a blood pressure monitor and batteries, a lightweight mechanical scale and a tape measure.

REFINING THE MATERIALS

After the first training in Free State, course developers made a few adjustments to the materials and a few weeks later a second session was held with a second group in the same venue. In October, the revised materials were tested in two further training sessions in the Eastern Cape.

Pre- and post- assessment questionnaires were completed to check that the training had reached its mark. As the graphic below shows, CHWs improved their knowledge and abilities to deal with NCDs in the community.

The testing sessions enabled the course developers to adapt the materials for maximum accessibility. They were also able to determine optimum conditions for the cascade model of training to work.



The training cascade



Learning how to check blood pressure



Distributing backpacks donated by AstraZeneca



The Eastern Cape setting

WHAT HAPPENED NEXT

In late November, focus group interviews were held with all the CHWs to explore how they were experiencing the WIL package.

Report back on the WIL package were positive and encouraging. The CHWs appeared to be coping well with the assigned tasks and reported that they were able to integrate it easily into their existing work days. They seemed to approve of the weekly structure, noting that it helped them to track their progress, fostering independence and peer support. One CHW said: “This way we can correct and help each other amongst ourselves...so we can practise before OTL comes.”

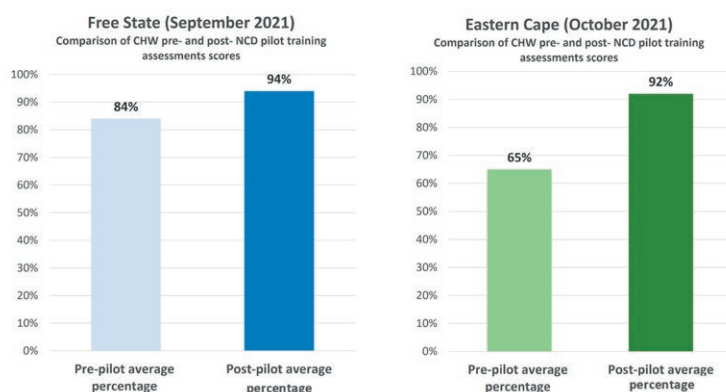
The OTLs also felt that the WIL package helped to clarify roles and responsibilities and improve communication and referrals to and from the clinics. For example: “Many don’t know what WBOT all is about, but after we explained to her with the material that you gave us, that is when she started having a picture of what is expected from us.”

Importantly, the CHWs coped well with the new additional task of measuring blood pressures in the field. They reported very few problems and seemed confident and proud that they were now able to take this service to their clients. The completed records in the WIL package showed that the CHWs

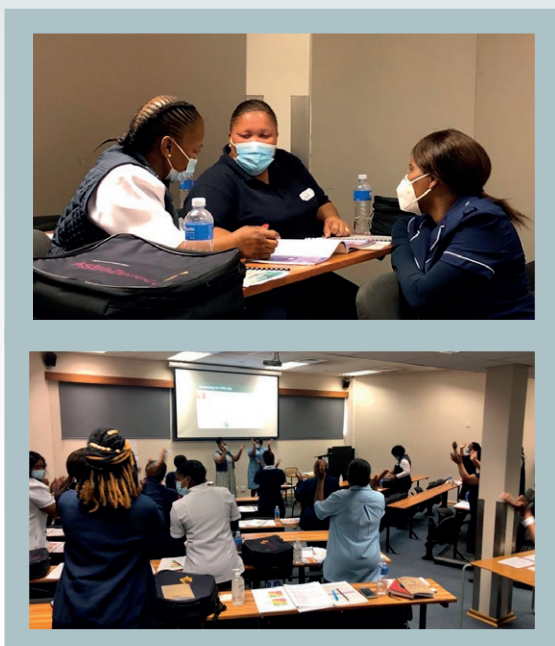
were not only able to measure the blood pressure but interpret the results and act appropriately in response to them.

Once all feedback had been gathered and analysed, final amendments were made to the package before BHPSA formally handed over to the NDoH for sign off on 15 December 2021.

When the new NCD module is integrated back into the National CHW training programme and rolled out as part of a bigger ministerial campaign, it has the potential to reach into communities across the country bringing improved NCD services to the people and a greater sense of pride for this well-loved health cadre.



Pre- and post-test assessments in each pilot province

*Focus group**Small group work and training session*

ABOUT KTU

The Knowledge Translation Unit of the Desmond Tutu Health Foundation, University of Cape Town was founded in 2005 to address priority health issues through education, research and service. It is a leading institution in the health systems research field and their primary care policy-to-practice programme, PACK, has been used in several African countries and Brazil and is currently being introduced in Indonesia to support these countries' primary care reforms.

BHPSA

BETTER HEALTH PROGRAMME
SOUTH AFRICA

CASE STUDY

JULY 2022

IT'S A PLAN! THE NEW NSP FOR NCDs



“ Provincial and civil society teams will be the true champions of the NSP. ”

*Sandyha Singh, Director:
Noncommunicable Diseases; National
Department of Health*

*Deputy Minister of Health Dr Sibongiseni
Dhlomo with community health workers,
Somerset East, NSP launch.*

One bright wintry morning in May, people gathered on a playing field in a small township in the Eastern Cape province. This was no ordinary community meeting, but an occasion to commemorate World No Tobacco Day and launch the government's new national plan to combat noncommunicable diseases (NCDs). Local community health workers set up a smaller tent outside the main marquee to check the blood

pressure of willing participants, and mobile clinics were offering screening for other noncommunicable diseases as well as advice on quitting smoking.

This was the healthy festive atmosphere that welcomed speakers including the Deputy Health Minister, Dr Sibongiseni Dhlomo, dignitaries from the Eastern Cape government, and representatives from the World Health Organization, the British High Commission and civil society organisations.

NSP launch, Somerset East, left to right: Atiya Mosam (BHPSA technical writer), Prof Debashis Basu (Steve Biko academic Hospital), Tori Bungane (British High Commission Health Attaché), with Razana Allie and Busi Nkosi representing the SANCD Alliance.



THE LAUNCH

Dr Owen Kaluma from the WHO Country Office spoke about the growing burden of NCDs on the continent and Myles Ritchie from the UK-funded Better Health Programme South Africa (BHPSA) spoke about the importance of partnerships in the implementation of the new multisectoral National Strategic Plan for Non-communicable Diseases (2022-2027).

Dr Dhlomo used his keynote speech to focus on smoking data released as part of the Global Adult Tobacco survey. The survey, conducted in South Africa by the SA Medical Research Institute, showed that 29% of adults (41.7% of men and 17.9% of women) are currently using tobacco. Dhlomo said “These results are demonstrating the urgency for government to tighten regulatory measures to control tobacco. The GATS results will address some of the clauses of the draft Tobacco Bill [Control of Tobacco Products and Electronic Delivery Systems Bill] that is currently being processed.”

Dhlomo is also concerned about the expense of smoking. “South Africans spend about R263 per month on manufactured cigarettes. That is 75% (three-quarters) of the monthly COVID-19 social relief of R350,” he said. “Cigarettes exacerbate poverty.”

After the launch, he told a journalist from the SABC that the government would ramp up its anti-smoking awareness campaign. While industry objects to the potential loss of R12billion to the economy, Dhlomo said the actual cost of premature death and illness from smoking is R43billion – nearly four times greater.

ABOUT THE PLAN

The National Strategic Plan for the Prevention and Control of Non-communicable Diseases (2022-2027) aims to move the country closer to the Sustainable Development Goals of reducing premature mortality from NCDs+ by one third by 2030. (The + indicates mental disorders and disabilities in addition to conventional NCDs such as diabetes and hypertension).

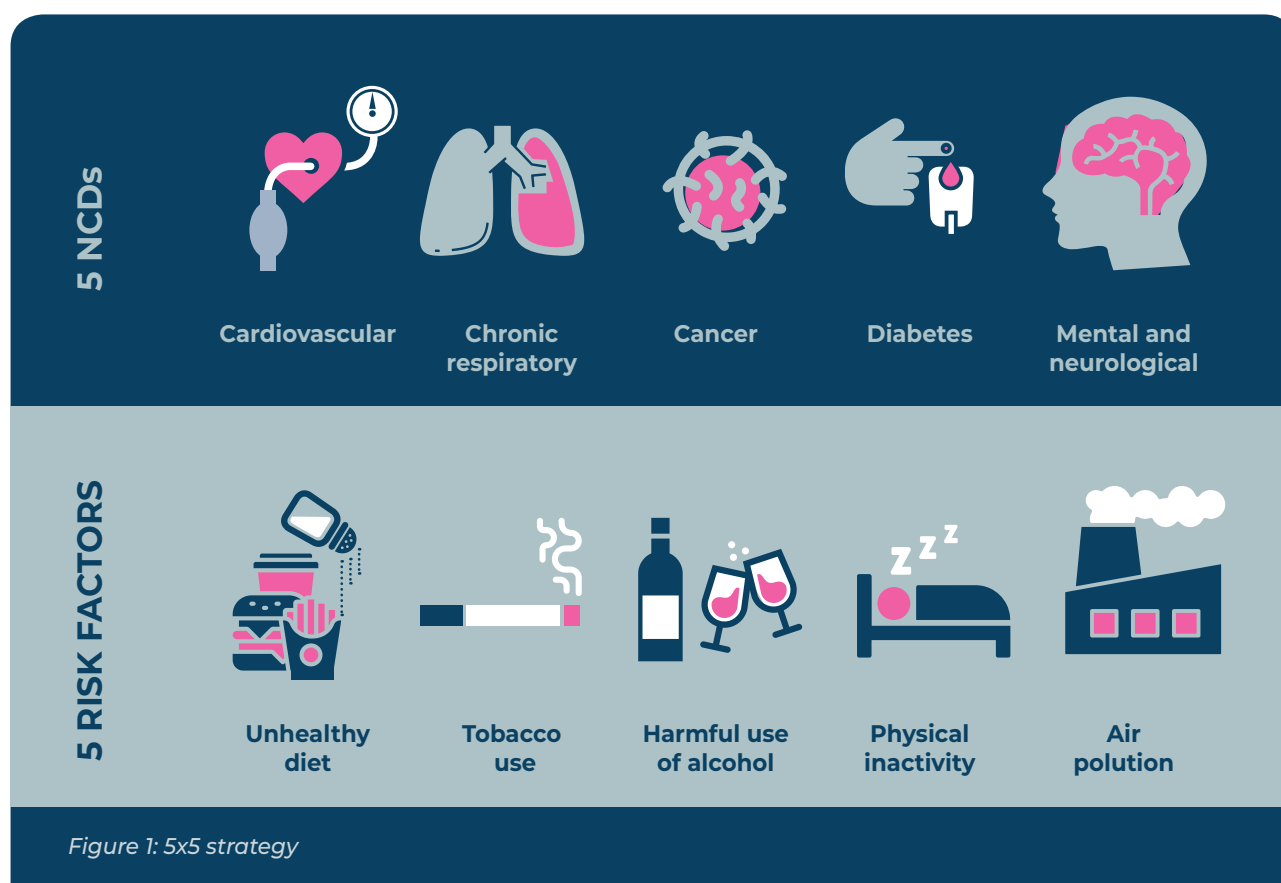
The NSP was developed by a team of experts and validated through a lengthy consultation process that included all stakeholders within and outside of the health system. This important process was facilitated by an expert writer funded by BHPSA.



(Left) Sandhya Singh, Director: Noncommunicable Diseases; National Department of Health

(Below) Dr Sibongiseni Dhlomo (Deputy Minister of Health) with Vimla Moodley (BHPSA NCD lead) left, and Tori Bungane (British High Commission Health Attaché) right, at NSP technical launch, Johannesburg.





Two key strategies of the NSP are:

- The 5x5 strategy. This refers to approaches to address the five major NCDs (cardiovascular diseases, cancer, chronic respiratory diseases, diabetes and mental health, including neurological conditions); and the five behavioural risk factors for NCDs (tobacco use, unhealthy diet, physical inactivity, harmful use of alcohol and air pollution).
- A cascade providing targets for hypertension and diabetes outcomes. The NSP has adopted a 90-60-50 cascade for diabetes and hypertension, meaning that by 2030:
 - -90% of all people over 18 will know whether they have raised blood pressure and/or raised blood glucose.
 - -60% of those diagnosed with raised blood pressure or blood glucose will receive intervention; and
 - -50% of people receiving interventions are controlled.

It is the first time South Africa has used a cascade approach, which has been so successful for tracking and advocacy for HIV treatment globally.

The five detailed goals of the NSP are to:

- Prevent and control NCD+;
- Promote and enable health and wellness across the life course;
- Ensure people living with NCDs+ receive integrated, people-centred health services;
- Promote and support national capacity for high-quality research and development for the prevention and control of NCDs+; and
- Monitor strategic trends and determinants of NCDs+ to evaluate progress in their prevention and control.

The NSP spells out detailed activities to achieve each one of these goals.

The provincial departments of health are responsible for implementing the NSP through the district health system. Other health and non-health stakeholders are also critical to the success of this multisectoral plan.



WHO's Joseph Mwangi Kibachi wakes up the meeting, NSP technical launch, Johannesburg.



Dr Vicki Pinkney-Atkinson, Director of the SA NCD Alliance (SANCDAs), left and Vimla Moodley, BHPSA NCD lead at the NSP technical launch, Johannesburg

WHAT HAPPENED NEXT

At the end of June, the National Department of Health (NDoH) hosted a WHO-funded consultation with the provinces on the NSP. This was the technical launch of the NSP, in which provinces presented the first drafts of their NCD implementation plans for the next five years.

A range of NCD experts and stakeholders also presented at the meeting, adding a rich context for provincial planners. Civil society speakers included Dr Vicki Pinkney-Atkinson, Director of the SA NCD Alliance (SANCDAs) who said "I am so thrilled with this strategic plan, and I am so thrilled that the provinces are here. It has to work, and it has to work for me!" Pinkney-Atkinson praised the multisectoral process of developing the plan, saying that since

2020 SANCDAs had worked hard to ensure that the plan reflected the needs of people living with NCDs. She also spoke about her trials in accessing NCD care in the public sector.

The director of NCDs in the NDoH, Sandhya Singh, gave a high-level overview of the plan and stressed that a paradigm shift is needed at all levels to prioritise NCDs. She said, "Provincial and civil society teams will be the true champions", in ensuring the NSP goals are met. She identified surveillance as one of the biggest health system challenges to measuring, and therefore meeting, the NCD targets.

BHPSA participated actively in the planning of a dedicated session at the technical launch on the challenges of NCD surveillance and data systems.

► [Download the full NSP here...](#)

► [Read more about the GATS/SA survey here...](#)

Virtual learning for the Office of Health Standards Compliance



Office of Health Standards Compliance
Ensuring quality and safety in health care

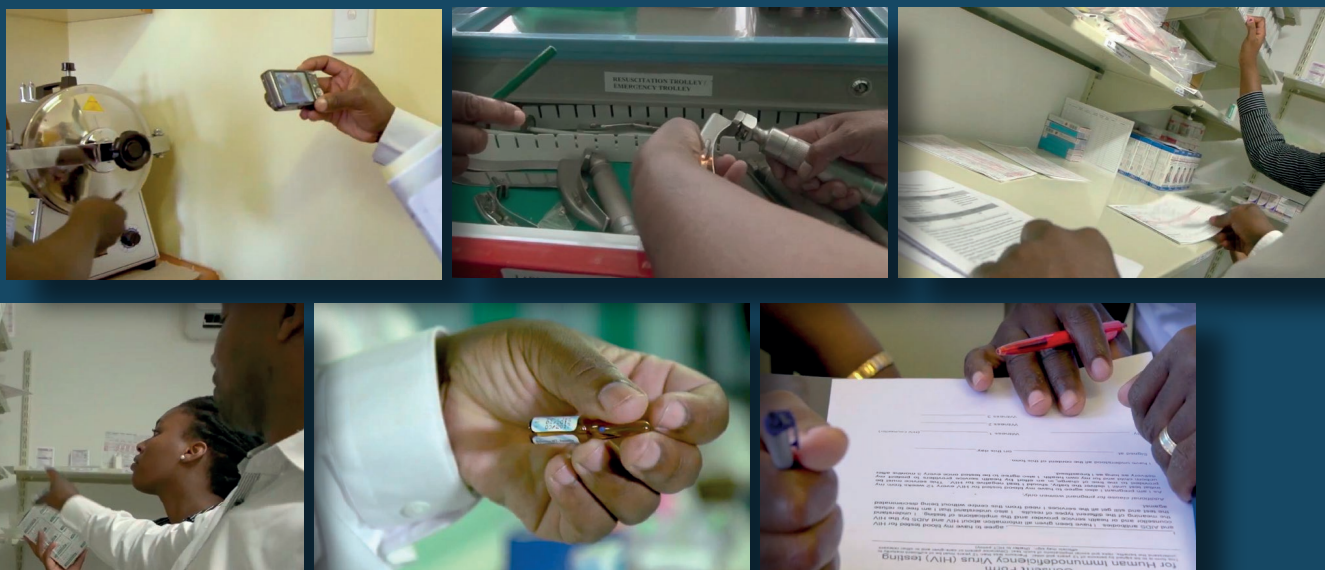


CareQuality
Commission

The Office of Health Standards Compliance (OHSC) is a regulatory authority, which has the mandate of ensuring that all health establishments in South Africa comply with established health standards and offer quality health services. The OHSC's current team of 41 health inspectors is required to visit over 3,000 health facilities every year and these will have to be certified before they can be part of the planned National Health Insurance.

BHPSA has supported the OHSC by developing a sampling strategy and inspection business case that examines different methodologies, resourcing tactics and financial models to increase the OHSC's capacity to carry out their inspections. This five-month study was informed by learning sessions with England's equivalent body, the Care Quality Commission (CQC). These aimed to strengthen the OHSC's important work in regulating the country's health facilities by sharing key lessons from England.





Mock inspections by OHSC in progress, South Africa 2014.

Managing the workload

In August and September 2020, representatives of the CQC, the OHSC and BHPSA engaged in two virtual learning events on inspection strategies for primary medical services and hospitals. The Q&A sessions focussed on strategies to manage the huge volume of inspections that must be conducted by such a small team. CQC shared their experience around both physical and remote inspections, which includes remote data analysis and site visits.

While remote inspections are relevant in a time of COVID-19, and require a reduced inspection capacity, it became clear that these are not currently appropriate in South Africa as only a small percentage of facilities have been inspected to date. This means that a solid baseline is still to be established. Once all facilities have been physically inspected at least once, the OHSC will look to applying a number of efficiency levers such as remote inspections, outsourcing and standards twinning with other regulatory bodies already active in the facilities.

OHSC participants were interested in the CQC's system-driven analytics, which enable them to get early warning on potential red-flag areas and at-risk facilities, while also being able to aggregate such data for reporting and policy purposes. It was also noted that there was immense value in the CQC's approach to streamlining the reporting process and the reports themselves. This results in easily accessible and digestible information being made available, not only to stakeholders in the health fraternity, but also to the general public.

In addition, the CQC also highlighted the critical importance of building and maintaining credibility with stakeholders, both within the health fraternity - such as hospital managers and policymakers - and outside of it, which includes the UK's patient base and the general public.

For the OHSC, a good communication strategy that creates visibility and builds trust would be central to any success in achieving their mandate. BHPSA has already begun supporting the OHSC to develop a stakeholder engagement and communication strategy that will be implemented in the coming months. The first group of stakeholders identified are the country's 9,000 private sector GPs, many of whom are unaware of the fact that their facilities are required to be inspected and certificated by the OHSC.

Positive outcomes

The OHSC participants reported that the sessions were extremely valuable and that they appreciated the openness of the CQC in sharing their experiences. The technical input from the learning sessions strengthened the draft business case and resulted in a flow of CQC documents (e.g. policy papers, standard operating procedures, guidelines) to support the OHSC's development process. As a direct result of the willingness of the CQC to openly share their experience, the Chief Executive Officer (CEO) of the OHSC invited the CQC to comment and reflect on the draft inspection strategy and sampling methodology within the business case.

In early October, the draft business case was presented to the OHSC Board, which consists of a number of highly respected healthcare professionals from both the public and private sectors. The Board approved the new direction proposed in the business case, saying it provided them with optimism for the future of the OHSC. A summary of the document has also been presented to the Minister of Health.

TOWARDS QUALITY EMERGENCY MEDICAL SERVICES (EMS)



In early November, BHPSA went to the Western Cape accompanied by a top team of health officials. Their mission: to workshop the Ideal EMS Framework Tool and to discuss a range of the nationally-driven quality improvement efforts and how they can strengthen emergency services in the Western Cape Province. The team included members of the National Department of Health (NDoH) Emergency Medical Services, the Quality Assurance Directorate, as well as the Office of Health Standards Compliance. They conducted a two-day workshop, and spent a further day assessing one of the stations of the Western Cape Emergency Medical Services (EMS).

The meeting was hosted at the EMS Communication Centre at Tygerberg Hospital, Cape Town. Attendees from provincial EMS services included the EMS Operations, District, Sub-District, Communication Centre and Information Managers from the Western Cape Province.

The Western Cape Communication Centre is responsible for receiving emergency calls for medical help from the public as well as health facilities that come from across the four regions of the City of Cape Town. They must then dispatch the closest appropriate ambulance, crewed by paramedics and Intermediate Life Support Practitioners, as required.



The Centre Manager took us on a tour of the Communications Centre demonstrating their up-to-date technology that enables them to identify callers via their Computer Aided Dispatch System (CAD) and geographical location (by "What3Words") and dispatch ambulances at speed. This centre co-ordinates 58 city emergency services which handle an average of 1,000 calls a day, resulting in an average of 600 responses per 24-hour period. Approximately 80% of patients are treated and transported to a health facility. The ambulances that are dispatched to patients that are critically ill or injured are backed up by the Advanced Response Units as well as the Aeromedical Services.

Three interlinking quality improvement and quality assurance programmes were discussed in the workshop. These are the National Health Quality Improvement Plan (NHQIP); the Ideal Emergency Medical Service Framework and the OHSC quality assurance strategy. BHPSA is providing some support to the NHQIP and is engaged in ongoing technical assistance to strengthen the Office of Health Standards Compliance.

THE TOOLS AND FRAMEWORK

Days one and two of the visit were given over to presentations and discussions about the EMS Ideal Framework and the national quality improvement strategy.

Raveen Naidoo, who heads the NDoH EMS, presented on the draft Ideal EMS Framework, which sets out norms and standards for services across the country. It covers six domains of health care which are: facilities and infrastructure, patient rights; clinical governance and clinical care; clinical support services; leadership and governance; and operational management (unique to EMS).

This framework has been used to create a tool for assessment across the six domains which are in turn divided into vital, essential, important or aspirational. These will be measured by observation, interviews and document review.

After a lively discussion, this was followed by a presentation on the NHQIP by Catherine Mbuyane, Director of the Quality Assurance Directorate in the NDOH. The NHQIP is one of the key drivers of quality improvement at national level and aims to

establish at least two Quality Learning Centres in each province. These will include hospitals, primary care and EMS services (public and private) and form the focus for learning and disseminating skills for quality improvement. Best-performing facilities and personnel will be identified to lead the clusters.

The presentation outlined the phases in implementation of the NHQIP, including training of assessors to conduct self-assessment and peer review by facilities (using the Ideal EMS Framework in this case); the development of facility-based quality improvement plans; and support and mentoring visits. After these phases have been completed an external evaluation will be carried out by the OHSC to assess whether the facility meets requirements for certification and accreditation for National Health Insurance (NHI).

PUTTING TOOLS TO THE TEST

On the second day of the visit, participants had the opportunity of working carefully through the Ideal EMS tool which enabled them to understand how it would work and how it would fit into the wider regulatory framework. Some gaps were identified by attendees including the need for measures around staff safety.

This was of particular concern to Mitchell's Plain EMS staff who have to work in extremely dangerous conditions, with staff being held up at gunpoint and ambulances stripped of equipment on a daily basis. These assaults have led to a situation where, at any given point, EMS workers are off with post-traumatic stress disorder, and the remaining staff are under additional pressure. EMS participants requested that the standards include Victim Support for EMS staff as well as measurements of security such as dashboard cameras for ambulances that work in areas of high violence.

On day three, the team headed off to the Mitchells Plain EMS to test the tool in one of the busiest trauma regions of the city. They were warmly welcomed by staff members who were keen to get



involved and to improve the quality of their services as well as the overall safety and cleanliness of their site.

A self-assessment was conducted with the final score of 75%, and achieved a silver status: the EMS station had scored well for a first go at the tool. Obvious areas were identified for improvement with assistance from NDoH EMS and Quality Assurance Team.

OBSERVATIONS

BHPSA noted that the need for improved communication around the OHSC and its role. Out of a working group of approximately 15 people, only one person had heard of the OHSC and participants were very surprised to hear that the EMS would have to be assessed and certified by OHSC before they would be eligible for NHI. This observation will be fed into BHPSA's support for the OHSC communications strategy which is now underway.

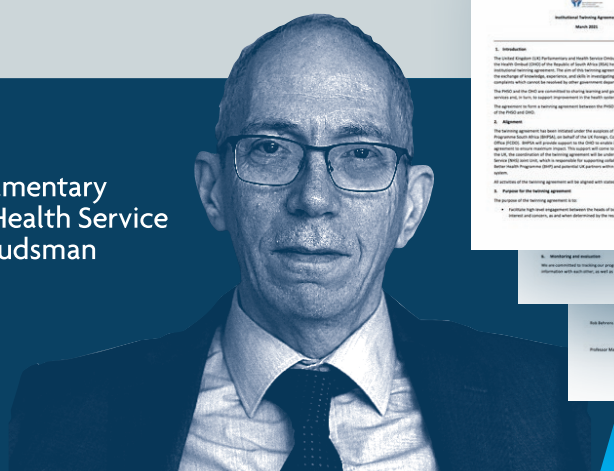
It was rewarding to see the interest and enthusiasm about quality improvement shown by the Western Cape Emergency Medical Services (EMS) participants. They were positive about implementing the Ideal EMS framework and excited to be part of a national initiative along with all the different health facilities in the country.

SEEKING THE TRUTH

THE ROLE OF THE OFFICE OF THE HEALTH OMBUDS



Parliamentary
and Health Service
Ombudsman



Rob Behrens, CBE

UK Parliamentary and Health Service Ombudsman



Professor Malegapuru Makgoba

South African Health Ombudsman

In March 2021, Professor Malegapuru Makgoba (MM), Office of the South African Health Ombud, and Rob Behrens (RB), the United Kingdom Parliamentary and Health Service Ombudsman, signed a twinning agreement that will foster cooperation and the exchange of knowledge, experience, and skills in investigating and managing health sector complaints. They shared their excitement about the agreement and spoke to BHPSA about the important role of the Health Ombud's office. The twinning agreement was facilitated by BHPSA, which is also supporting the ongoing work.

This conversation has been edited.

RB: This is a really special day. It has been a very fast process since we got together in London to talk about this. I'm really thrilled to be on the point of signing this agreement. It comes at the perfect time as we move out of the pandemic and try and learn from it, so it's important and it's an emotional moment for me.

MM: I'm equally happy to be at this juncture and to put my signature to this important agreement, which is quite unique for our two countries, but more importantly for this portfolio of Health Ombuds for both countries. I hope that this will really be a very meaningful agreement that can advance the processes that we're involved in every day in promoting health services in our countries.

RB: It is true, it's an agreement between two organisations, not between two people, and we will ensure that there are lots of people who will benefit

from this, and we will have lots of round table discussions and arguments and try to sort out big problems in a way that is going to be in the public interest. So, thank you and I look forward to starting straight away.

There are three things that we need to focus on in the first year: firstly we need to look at leadership development and training for those who undertake the investigations; secondly we need to look at trust and the complaints handling process and how we can learn from each other about how that is done; and thirdly - a very difficult issue - is how to use expert clinical advice in investigations which is central to having the competence and the trust of service users and clinicians.

MM: That is what we discussed. I just wanted to emphasise the last point - the use of clinical experts. Since we are operating within a clinical environment, this is very, very important to put the minds of the public at ease but also to give us up-to-date information that can be useful in the evaluations of the investigations.

RB: I think that's absolutely right and the more transparent we can be about how we use clinical advice the greater trust we can build with those people who want to understand that they have had a fair hearing, not from a vested interest, but from objective advice which is reliable and can set the standard.

MM: The other thing that I just want to emphasise is that the role we play is really based on a very simple principle: we are there to seek the truth on behalf of people who are troubled. So on one hand our role is to establish the truth, and on the other is actually to realise that we're dealing with troubled souls that we need to, in some way or another, counsel so the two roles play into each other all the time and the important thing is to not allow ourselves to become political mandarins where we are influenced by what politicians want or what lawyers want but what the case actually requires us to do. That I see as an important guiding principle.

RB: That a beautiful articulation of what Ombuds do in terms of independence - not being influenced by anybody else. Impartiality; so that we hear both sides when we look at cases. And critically, we have got a lot of challenges to deliver on empathy with souls who, as you say are troubled. They may be traumatised by what happened to them and we have to have the skills to be able to deal appropriately and compassionately with people like that without taking sides. That is a big, big challenge and I look forward to and that discussion in particular as we've got a lot to learn.



[Watch the short video of the virtual launch ...](#)

MM: I agree with you that we have a lot to learn from each other and I suppose at the end of the day we need to understand that we we're not going to be here forever and we need to leave some footprints that ensure that what we have been doing continues to be done at the highest level with the highest trust and the highest of integrity that the position demands.

RB: Succession planning is critical as you say and this is going to be great in planting seeds which are going to nourish and develop. So, let's get started.

[They sign the agreement]

BHPSA: Could you speak about the important role of Ombud office and how it can strengthen health systems.

RB: So basically, we are the last port of call for citizens making complaints about the health service and, in Britain, central government departments. We in the UK combine the role of the public protector and the health ombud – it is one office. We make decisions impartially without taking sides and as transparently as possible and the key thing which makes us attractive is that we're not only impartial it's a service which is free to use. So, unlike the courts, you don't have to pay money in order to be represented and to have your case heard, and that's very important to people who can't afford large legal fees. As far as the use of the ombudsman is concerned, it helps to build trust in the system. The trust in the health service in the UK is very high actually, but is increased when people know that they have an independent body that they can go to, to say "this is not gone well, it's gone wrong, there's been poor service and I want it looked at independently". We produce thousands of decisions a year which enabled people to say something has gone wrong, it is now being put right and I can move on. So, it's a way of holding the health service to account and exposing weaknesses so that we can learn from them altogether and make the systems better.

MM: South Africa is a country in transition and transformation, and part of that process is to transform and change the health system in South Africa. The Office of the Health Ombud is part of this new dimension to try and improve the quality of the health services but also improve the quality of the people and the systems that provide that health service. The second part of this is that, as we transform in South Africa, we have to join the international community and learn from best practises and standards by interacting with other offices of health ombuds in the international community to define our standards and define our values as we improve and provide universal healthcare services. I think what we have to remember is that this is a first, and a new thing in the South African health system, unlike what you have in the UK. So, what we're doing is really building from the foundations, learning from the best international practices, like being part of the International Ombudsman Institute, and people like Rob and his team.

BHPSA: How will this twinning arrangement benefit you?

RB: I have always believed that comparative learning, exchanging between organisations in the same country and different countries, is a very good way of learning, of thinking critically about what you're doing. It's a conversation which is absolutely necessary to open the mind to make sure that that we're learning from the best possible sources

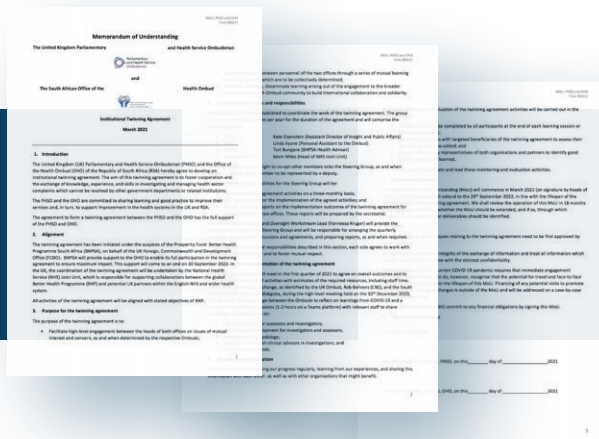
and that's why this agreement is so exciting to me because there's so much to learn from the Health Ombud in South Africa and we're going to do that vigorously and with great excitement.

MM: When I took this job as Health Ombud I realised that there was no capacity in South Africa for this kind of work and one of the areas I identified with the former Minister of Health, Dr Motseledi, was that part of my tenure here is to leave capacity - strong capacity or what people normally call succession planning. I wanted to be able to build an office that would be staffed by people who are well qualified and professional to be able to carry out the high standards and the empathy that is required by this office.

BHPSA: Could you speak a bit more about the International Ombudsman Institute, and the importance of building international solidarity

RB: The International Ombudsman Institute is a wonderful network of 150 countries of national and functional Ombuds who get together on a regular basis to debate ideas and to think about how to improve the service we offer, and our visibility. For most of us, one of the biggest challenges that we find is that citizens are not terribly familiar with what our officers can do and the potential that they have to improve their lives. So, we have to work together to find ways to become more prominent in the public imagination so that people who need us can use us.

THE TWINNING AGREEMENT



THE POWER OF A CHOIR OF SMALL RADIO STATIONS

RAISING PUBLIC AWARENESS OF
A HEALTH WATCHDOG IN SOUTH AFRICA



Launch of the OHSC call centre, 2016

On a chilly June evening, thanks to satellite technology, officials from the South African Office of Health Standards Compliance (OHSC) had the novel experience of discussing their role in improving the quality of healthcare in the presence of listeners from 80 community radio stations.

The OHSC is the body charged with enforcing compliance with minimum standards for health establishments. It recognises the need to harness public support in support of its mission.

"We believe health service users can play a significant role in holding management of both private and public health establishments to account," says OHSC Chief Executive Officer Dr Sipiwe Mndaweni. "They are our eyes and ears on the ground, in and out of health facilities daily, while we can only inspect each establishment once in several years. But we have a mountain to climb in terms of public education before we can expect this kind of confident action by service users."



The OHSC call centre currently receives some 2,400 complaints annually from members of the public and the number has risen steadily over the years. This speaks to a degree of public awareness of the role of the OHSC. However, complainants are mostly from major urban areas while quality shortcomings are generally greater in rural areas.

Senior Manager for Communication and Stakeholder Relations Ricardo Mahlakanya explains: "In the last few years we have travelled the country and conducted meetings in a wide range of communities. We tended to focus on rural districts where there are fewer mass media options and hold information sessions at taxi ranks, in hospital and clinic waiting areas, and in conjunction with traditional leaders."

He says his team realised they were reaching relatively few people in return for the time, effort and budget invested in these roadshows. As they began to explore other options, the hammer-blow of COVID-19 came down and temporarily put paid to further face-to-face public meetings. But the alternative of paid mass media campaigns – while yielding the audience size the OHSC dreamed of – was way beyond the communication budget of the Office.

Assistance in thinking through this dilemma came through support from the Better Health Programme South Africa (BHPSA). Among the specialists commissioned by BHPSA to support the OHSC was a communication consultancy, Meropa Communications.

Meropa worked with the OHSC communication unit to produce a pragmatic communication strategy, designed to boost communication to various types of health establishments as well as health service users.

The strategy envisaged an upscaling of use of the mass media to reach more members of the public more frequently. There were two components to this: traditional public relations practice, which solicits the interest of journalists based on the newsworthiness or importance of the "story" on offer, and sponsorship of radio interviews, where payment secures a defined amount of airtime.

While sponsored programmes on major national radio stations were beyond the OHSC's reach, community radio stations represented a more realistic option.

(Left) Call centre in action, 2021]

"Paid time on community radio was affordable and offered good reach into rural communities but we faced two significant hurdles," said Mahlakanya. "Officials in our office were a bit nervous about interacting with the media and we needed their participation because of their depth of experience. And secondly, many community radio stations had limited administrative capacity and could not meet the requirements of our supply chain policy. So how were we to contract with them?"

The media-aversion of OHSC management was addressed by offering training in interview skills to executive and senior managers. Meropa was asked to provide media training capacity. COVID-19 numbers were surging at the time of the training, so the training sessions were presented digitally, and mock interviews were conducted on webcam. Technical guidance covered both scripted and unscripted interviews, and some simulated interviews used a script that was ready and waiting for the community radio intervention.

Building on this momentum, Mahlakanya and his team resolved the supply chain impasse by utilising the community radio programme of the Government Communication and Information System (GCIS). This offered simultaneous satellite broadcast from the GCIS studio to 80 community radio stations, with a call-in line for the public.

Three OHSC managers readily agreed to participate in the hour-long programme, each doing an interview with

the presenter on a different aspect of the OHSC's work and fielding callers' questions. They were Advocate Makhwedi Makgopa-Madisa, Director: Certification and Enforcement; Dr Thokoe Makola, Director: Health Systems, Data Analysis and Research; and Ms Dikeledi Tsukudu, Executive Manager: Compliance Inspectorate.

Although the programme was presented in English, the managers spoke several South African languages and were encouraged to repeat key points in an indigenous language and answer questions in the caller's language of choice. The presenter's questions were predictable, as they were scripted, and OHSC managers were encouraged to use the scripted answers only as a guide on which they could build.

The programme not only provided information about the OHSC's role and activities, but also focused on the idea of quality standards, what they cover and

why specific standards are important. The idea was to help service users judge when they have cause to complain and encourage them to do so.

"Overall, we were satisfied with the initiative – we gained the platform we needed, our managers were credible and approachable, and we answered questions in a helpful way," reflected Mahlakanya. "We made some trade-offs – for example, we would like to have been able to use more South Africa languages and GCIS lacked capacity to monitor the participation of stations. But the efficiency of the model and the way it reduced the number of interviews by using simultaneous satellite transmission were definite pluses."

The OHSC, which takes its regulatory mandate from the National Health Amendment Act of 2013, has two main instruments at its disposal:

- The inspection of health establishments to ascertain their degree of compliance with legislated norms and standards. Inspections are followed either by the certification of the establishment as compliant or the initiation of a process to improve the standard of care and achieve compliance.
- The receipt and resolution of complaints from members of the public about substandard care. While the majority of complaints are speedily resolved through the mediation of OHSC call centre staff, some are complex and require expert investigation.

BHPSA

BETTER HEALTH PROGRAMME
SOUTH AFRICA

CASE STUDY

OCTOBER 2021

THE WISDOM OF PEERS

THE UK AND SA OMBUDS MEET AGAIN



Parliamentary
and Health Service
Ombudsman



Rob Behrens, CBE

UK Parliamentary and Health Service Ombudsman



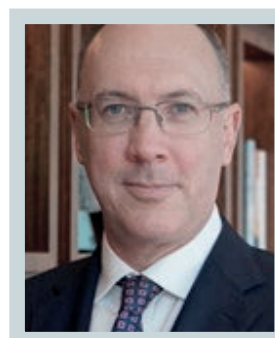
Professor Malegapuru Makgoba

South African Health Ombudsman

Who is best equipped to review an organisation and what are the benefits of a Peer Review?

In September 2021, teams from the offices of the UK and South African Ombud met in an online forum to discuss the Peer Review process. This meeting was a continuation of the conversation between the heads of the UK Parliamentary and Health Service Ombudsman (PHSO) Rob Behrens, and the SA Office of Health Ombud (OHO) Prof Malegapuru Makgoba, at the launch of the twinning agreement between the two offices in April 2021.

The British High Commissioner in South Africa, Antony Phillipson, welcomed participants saying that one of the priorities of the British High Commission (BHC) was to support key issues that affect societies. He expressed his pleasure at the fact that the BHC's Better Health Programme, South Africa (BHPSA) is supporting the formal partnership between the two organisations, with the aim of strengthening oversight and accountability in the SA health system. The meeting was chaired by the BHC Health Attaché, Tori Bungane, and attended by 12 members of the two offices and BHPSA.



**British High Commissioner in
South Africa, Antony Phillipson**

SHARING EXPERIENCE

The PHSO's chair, Rob Behrens opened the meeting by sharing PHSO's own experience of Peer Review in 2018. In his opinion, the selection of the review panel team, particularly the Chair, is of great importance. In the case of the 2018 review, Behrens invited a team of three reviewers that included the Chair of the International Ombudsman Institute (IOI), an academic with Ombud experience and a Financial Ombudsman to form the review panel. This small team undertook a paper audit, based on documents concerning the PHSO's financing and broader arrangements. This was followed by a two-day site visit in which the review team had the freedom to conduct private interviews with the staff.

The scope and purpose of the Peer Review was to assess the value for money of the PHSO's spending, with reference to current best practice in the ombudsman sector. The review team adopted an expanded view of value for money, where they considered all the operations of the office, rather than just the number of cases investigated. This included a range of policy proposals as well as a large number of preliminary assessments or investigations where the PHSO provided applicants with advice and guidance.

The Peer Review panel then produced a report, which they defended in Parliament. The broad conclusion of the report was positive: "Under its current leadership, the organisation is moving out of 'critical care' and into 'recovery'. Overall, from facing a set of severe challenges, the organisation is on its way to becoming an efficient and effective modern ombudsman service, which provides significant value for its stakeholders."

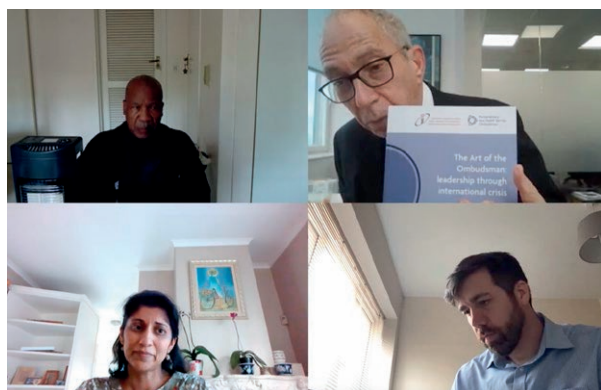
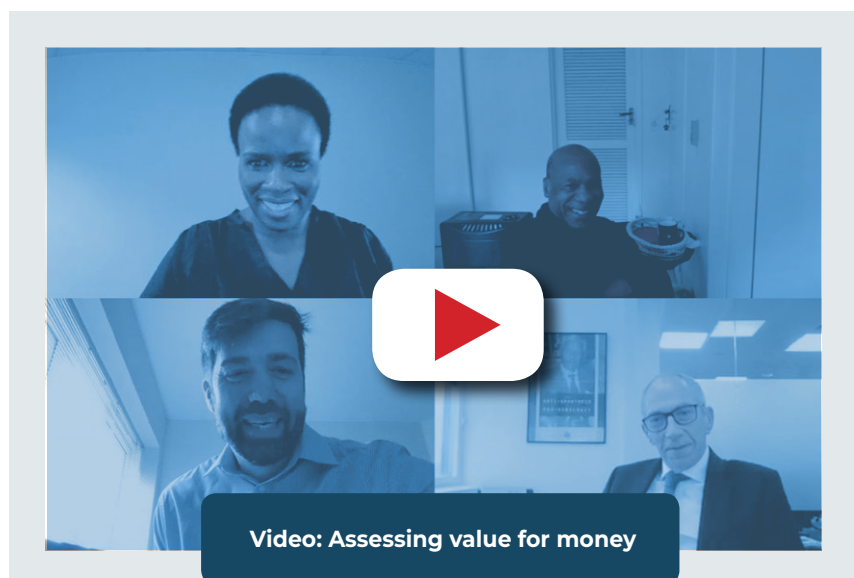
The report identified strengths and weaknesses of the organisation. Included in the latter were outmoded IT systems and the need to provide more training and independence to case handlers. The report had many positive outcomes, including greater public acceptance and credibility. Acting on the perceived weaknesses also strengthened the organisation.

PRINCIPLES OF PEER REVIEW

James Hand, PHSO's Assistant Director of Business Management, shared some pointers on processes and principles of Peer Reviews. The strength of a Peer Review is that it enables learning from the good practices of other offices, but because it is an external review it is seen as authoritative. The Peer Review process is also more cost-effective than a review conducted by paid consultants. One of the challenges of the Peer Review process is that there is a risk of professional insularity.

In 2019, the PHSO and the IOI hosted a Peer Review conference in London, which resulted in formal guidance for recipients and participants. Critical to the success of a Peer Review is an approach that is both collegial and independent. The selection of reviewers is to be validated by the IOI and Terms of Reference of the review must be negotiated between reviewers and the recipient office. It is important, however, that reviewers have unrestricted access to ombudsman office staff. Reviewers should share initial findings with the recipient office but they must have editorial control of the final product.

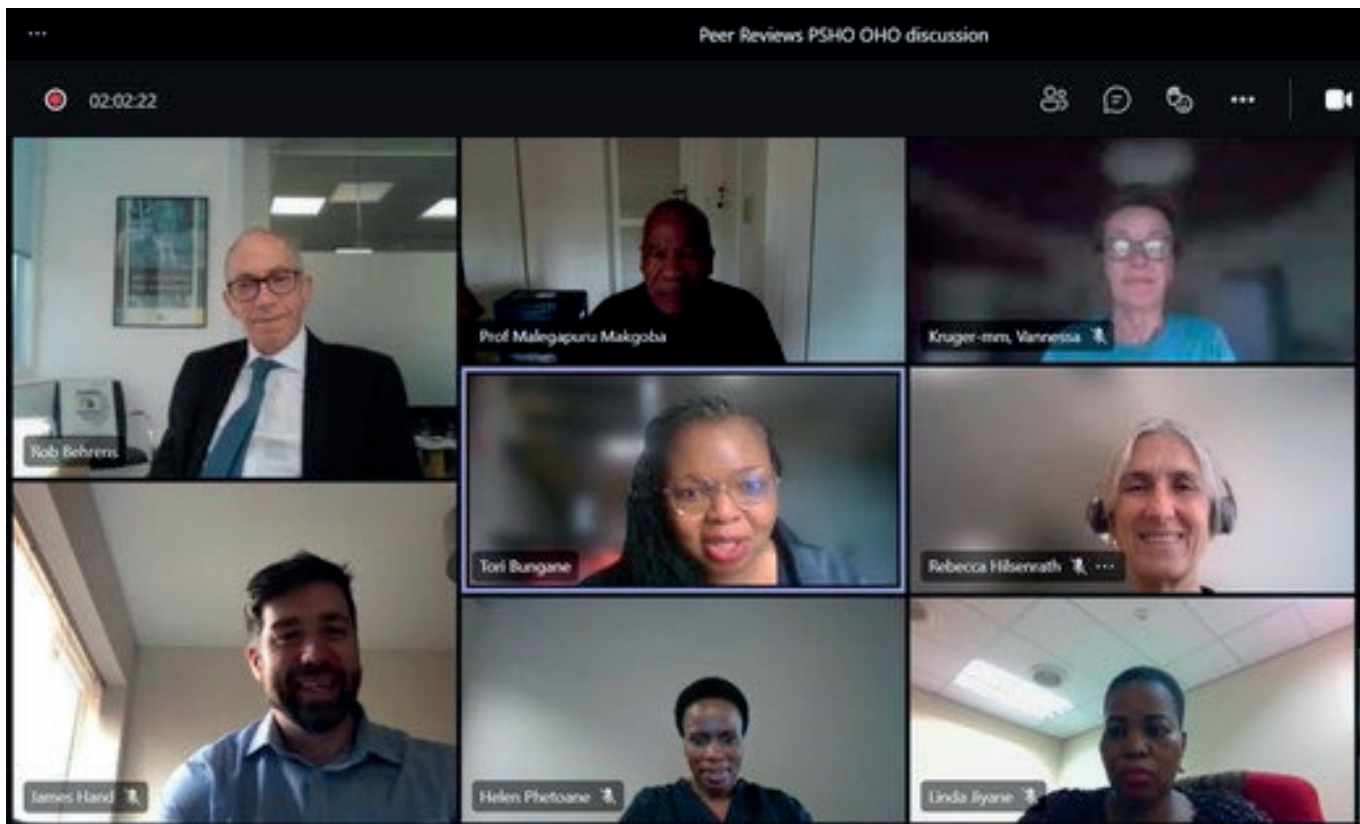
The Peer Review guidance documents are available on the [IOI website](#).



Q&A

The South African OHO team had many questions for their UK colleagues. OHO Chair Makgoba wanted to know how a Peer Review would operate in South Africa where the societal context is different. "You are like a functioning oiled machine in a stable... democracy – we are in a democracy that is unstable – and with that come other imponderables."

UK's Behrens confirmed that a Peer Review would work in South Africa, saying the main difference between the PHSO and the OHO is that the UK office is only politically accountable to the Queen and Parliament, whereas the SA office reports directly to the Minister of Health.



The meeting discussed many other issues relating to the size and composition of the review team, the cost of a review, the best time to conduct a Peer Review and whether a Peer Review is a credible tool for accountability. Participants also discussed the challenges of the COVID-19 pandemic and how it had affected their offices. OHO's Monnatau Tlholoe commented that the pandemic gave them the opportunity to work through the case backlog, enabling them to close 173 out of 284 cases.

In conclusion, the meeting discussed the desirability of conducting a Peer Review of the OHO. Prof Makhoba said that his main concern was whether the work they are doing is having an impact on strengthening the SA health service.

A Peer Review could establish the public worth of the office and increase credibility and visibility of the organisation. Watch this space!

[Read more about the PHSO](#)[Read more about the OHO](#)

Inspecting South Africa's COVID-19 field hospitals



“ We were really scared the night before and couldn't sleep, but after the inspection we felt so happy we were able to contribute to the COVID-19 response. ”

*Inspector from the Office for
Health Standards Compliance (OHSC)*

◀ Health inspectors from the OHSC being briefed by facility manager outside Nasrec.

On July 21, 12 OHSC health inspectors began assessing the quality of South Africa's temporary health facilities adapted for COVID-19 patients. Tablets in hand, they visited three very different establishments in Gauteng, North West and Northern Cape provinces, which provide quarantine, isolation and treatment for those infected and affected by the virus.

The health inspectors were testing a new rapid inspection tool designed with support from the Better Health Programme (BHPSA) to quality-assure temporary facilities established by provincial departments of health to cope with the surge of COVID-19 patients. The tool is adapted from existing National Infection Prevention and Control guidelines for regular health facility inspections, with an added focus on infection prevention control and personal protective equipment.

Audit tool

The tool, developed in a period of less than two weeks, is based on a simple framework and divided into components which provide the OHSC with an understanding of the management, administration and functioning of COVID-19 field hospitals.

Given the relatively uncomplicated service delivery within the field hospitals (for example there are no out-patient services or emergency/trauma units), the functional areas usually applied by the OHSC were not adapted for use in COVID-19 field hospitals. A new framework was therefore developed built on the following components:

- Management and administration
- Case management
- Human resources
- Infection prevention and control
- Infrastructure
- Linen, laundry and waste
- Cleaning and catering
- Medicines and medical Consumables
- Equipment
- Occupational health and safety



Oxygen points are being installed to cater for 400 seriously ill patients.



More new medical beds, July 21.

The findings of these rapid inspections will assist health establishments to assess the quality of services provided in field hospitals and further assist inspectors to develop benchmarking standards aimed at promoting the quality of care provided to users and improving the safety of personnel providing health services in these health establishments which have been rapidly set up in response to a public health crisis.

The inspectors' first stop was the Nasrec Intermediate Care Field Centre, which is a temporary facility repurposed from Johannesburg's giant exhibition and conference centre. It was initially designed to provide 2,000 quarantine beds, but as infections in the province surged, plans were made to adapt 600 beds - and then another 800 - to provide low acuity care. As more patients need a higher level of care, ICU beds with piped oxygen are being added. By 12 August, there will be 1500 beds including 130 medical beds with piped oxygen.

The team was welcomed by the Facility Manager, Dr Vis Naidoo, who took the them on a walkabout of the facility explaining how a small team transformed the entire facility from empty halls to a functioning field hospital. Afterwards, inspectors said that the new wards being built in the exhibition halls looked "spooky", but once inside a functioning ward, they were astounded that it felt just like a proper hospital.

On the same day, another team of inspectors moved tested the tool at an independent field hospital managed by a mining company in North West province and a former rehabilitation unit at the Northern Cape's Kimberly hospital.

The tool performed well across the different kinds of facilities and was judged by the inspectors to be fit for purpose. The pilot did indicate that a few modifications were required, and the inspectors requested the addition of a section where they could note good ideas and the good practice that they saw in the facilities. The tool will also be adapted for use in hospitals that are cordoning off wards for COVID-19 patients.

At the feedback session, where all the inspectors were brought together to share their impressions of the different facilities they had seen and the usability of the tool, they agreed that they felt a sense of privilege at being able to contribute to such an important part of South Africa's response to the COVID-19 crisis.

After this first day of testing the tool was adjusted and has since been used for inspections in other provinces.

WHAT IS SHIELDING?

Protecting the vulnerable from COVID-19



Médecins sans Frontières pilot shielding programme, Eshowe, KwaZulu Natal.

How can we shield the most vulnerable people from COVID-19? In response to a request from the NCD cluster of the National Department of Health (NDoH), on April 21 BHPSA hosted a webinar to explore the many issues around shielding within the South African context. It was co-hosted by the NDoH and the World Health Organization who both participated in the conceptualisation of the event.

The aim was to increase the awareness of shielding, particularly among provincial departments of health. This involves understanding different approaches

to shielding and the different categories of people who need to be shielded. The webinar also shared key messages, guiding principles and resources for effective shielding interventions.

The meeting was ably chaired by the WHO's Dr Joseph Mwangi and opening remarks made by Itumeleng Setlhare from the NCD cluster of the NDoH. He emphasised that the NDoH is committed to reducing infections among the most vulnerable populations, particularly the aged and people living with NCDs.

NEVER WASTE A GOOD CRISIS!

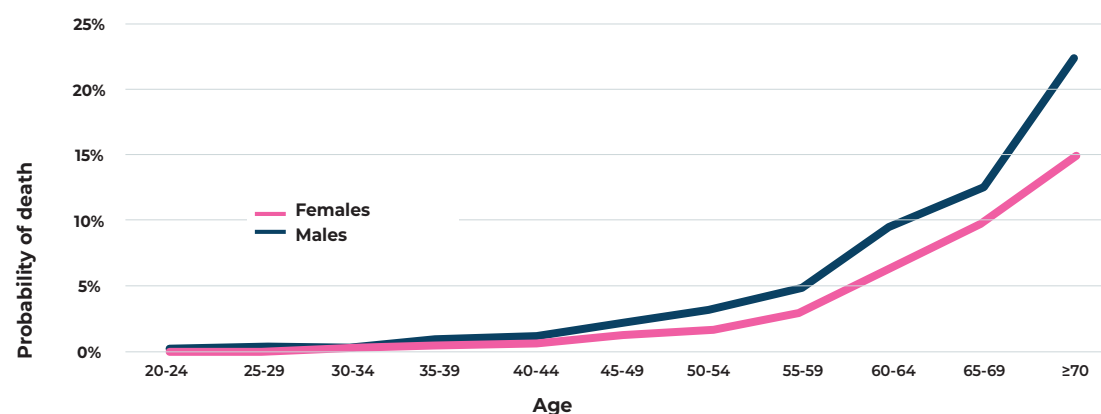
Dr Yogan Pillay, head of the Clinton Health Access Initiative (CHAI) in South Africa, provided the background of the syndemic, or synergistic epidemics of COVID-19 and NCDs, and gave the rationale for shielding. He also showed that initial approaches to shielding in South Africa, such as quarantine and isolation, were unsuccessful as people were reluctant to leave their homes. Shielding may be possible he said, but interventions will only work if they meet local needs. Practical shielding interventions include providing information, non-pharmaceutical interventions such as wearing masks, distancing and hand washing, expanded COVID-19 testing and vaccination.

Pillay's take-home point was that the COVID-19 pandemic has highlighted the need for a new paradigm to respond to NCDs – one which is patient-centred and patient-led. If we learn lessons from COVID-19 and implement them, the crisis will not be wasted.

WHO ARE THE MOST VULNERABLE?

Prof Mary-Anne Davies from the Western Cape Department of Health, presented clinical and demographic data from South Africa and other countries that showed that age is the single most important risk factor for severe COVID-19 and death. The risk, of dying after 30 days of infection, increases steeply from the age of 55 years for both men and women. Other comorbidities, particularly diabetes, hypertension, obesity and uncontrolled HIV and TB, also significantly increase the risk. These then are the groups who most need to be shielded from COVID-19 infection.

Figure 1: Probability of death by 30 days since COVID-19 diagnosis by age (adjusted for comorbidities)



SHIELDING ADVICE AND KEY MESSAGES

Prof Lara Fairall and Daniella Georgeu-Pepper from the Knowledge Translation Unit, University of Cape Town, presented their work on shielding. The three key messages for vulnerable people are: stay at home, if you do go out or spend time with others keep a physical distance, wear a mask and wash hands often.

Fairall noted that shielding recommendations so far have been informed by modelling, not evidence, and have had variable levels of success. Long-term shielding may also harm people's physical and mental health through decreased physical activity, social isolation, reduced health care and loss of income. However, shielding has played an important role in protecting vulnerable people before vaccines were available. Some countries recommend that even after vaccination, vulnerable people should avoid high-risk settings and still wear masks when going out.

Georgeu-Pepper shared the resources available from KTU, which consist of booklets, posters and videos. Clinical content is targeted at health care workers and communities and posters and informational booklets on keeping safe from COVID-19 are available from www.coronawise.org.za.

SHIELDING IN PRACTICE

Dr Liesbet Ohler, from *Medicins sans Frontières* (MSF), shared a community-based approach to shielding which they have piloted in one area of KwaZulu Natal. The pilot programme focuses on engaging key community members in the implementation of shielding and demonstrates how a shielding package can be integrated with the core services provided by community health workers (CHW) who are part of ward-based outreach teams (WBOTS).

The process includes identifying hotspots for COVID-19 transmission as well as vulnerable people in those communities. Two supervisors train community health workers to deliver a shielding package. A champion from the community is also appointed in the area. The shielding package includes education and materials, identification of safe zones in the home to accommodate the vulnerable, and identification of a trusted person to help with shopping and collection of medication and grants.

The MSF pilot demonstrates that it is possible to incorporate shielding into the routine activities of WBOTs if they are properly trained.

DISCUSSION AND CONCLUSION

Participants were keen to discuss the practical implications of shielding in low- and middle-income countries. It was felt that there was a need to understand vulnerability as more than just risk of severe health outcomes and to widen it to include issues such as access to employment/income and social and health services as well as the possible negative impact on mental well-being.

There was a strong feeling that shielding in its pure form (staying home etc.) is not sustainable over the long term as it presents health and socio-economic harms.

Some concluding points made by presenters were:

- The pandemic has had lessons for the NCD community including the need for social mobilisation by an integrated group across all NCDs.
- The difficulties of implementing conventional shielding means we need to vaccinate the vulnerable as soon as possible.
- There needs to be a shift in focus to move health from formal facilities to communities and households where people can take charge of their health and longer-term NCD prevention.
- Shielding in resource-poor settings is feasible with trained community health workers.



BHPSA

BETTER HEALTH PROGRAMME
SOUTH AFRICA

CASE STUDY

MARCH 2022

BEHIND THE VACCINE ROLLOUT



“The ability of the UK government to pivot its programme so quickly to support the development and establishment of the vaccine reimbursement programme has been phenomenal. It demonstrates the importance of donor programmes to be agile and responsive in supporting NDoH priorities, and in this case a public health emergency.”

*Dr Nicholas Crisp,
Deputy Director General in the National
Department of Health and head of the
SA vaccine programme*

To most of us standing in a COVID-19 vaccine queue it might seem that the state's biggest challenge is to buy the drugs and train health workers to use them. But behind that single injection in your arm lies a sophisticated system designed to ensure the smooth rollout of the vaccine programme.

Dr Nicholas Crisp, the Deputy Director General and head of the SA vaccine programme in the National Department of Health (NDoH), tells it like this: “A system had to be designed quickly to create order out of the potential chaos of vaccinating people with and without health insurance, in both public and private sector facilities, and keeping a national record of every vaccine event.”

Since September 2021, the UK government, through its flagship health initiative in South Africa, the Better Health Programme, pivoted quickly to support the NDoH by mobilising two teams of highly skilled technical specialists to design and implement the digital system that combines public and private sector patients and facilities to register, as well as a system to reimburse each vaccination event in the country.

RAPID START

The first step, which began in April 2021, was to rapidly design a digital system to record every vaccination with details of the recipient and where it took place.

The Electronic Vaccination Data System (EVDS) starts with a platform for self-registration and online booking, which enables the NDoH to verify that people are eligible and match them to their closest site. Once a person is fully vaccinated, the system provides a vaccination certificate with a domestically scannable QR code that verifies the vaccination to the data on the system.

But it does not end there. Behind the scenes, the EVDS is an important tool for planning and information. It feeds internal management dashboards and provides a 16-week forecasting model, both of which support NDoH decision-making for more targeted interventions in groups where vaccine uptake is low. The [dashboard](#) also keeps the public informed about the progress of the vaccine rollout.



“Without donor support,” says Crisp, “we would never have been able to develop and expand the EVDS platform so quickly. BHPSA really came to the rescue when our first tranche of donor funding ended in September.”

EVDS is critical to the functionality of the vaccine rollout. Firstly, it is connected to the supply chain system that ensures the vaccines and essential consumables are available when and where they are needed. Secondly, it includes a master list of all public and private vaccination sites that provides basic information on all facilities and ensures that they meet the required health and security standards (including pharmacy licences). This list, developed from scratch, is now a live database that is updated continually as new facilities are added. This is the first comprehensive and up to date record of registered public and private sites across the country and, in itself, is a major contribution to the country's centralised Health Information System. Every vaccinator that is trained is registered to a site.

UNITING PUBLIC AND PRIVATE SECTORS

As soon as the COVID-19 vaccine became available, the South African government committed to offering vaccinations free of charge to all citizens. While the initial goal was to vaccinate 87% of the whole population, the current more realistic target is 70% of the adult population.

The state became the sole procurer and contracted three established drug distributors to manage the importation, storage and supply of vaccines to registered vaccination sites. However, the private sector, realising the magnitude of the public health threat, volunteered to collaborate with the state to ensure that vaccination targets are reached. From the start it was agreed that people without

medical insurance could be vaccinated at private sites, and those insured, at public sites. This was to make access as easy as possible. As such, COVID-19 vaccination sites were set up in both the public and private sector. There are an estimated 7,000 COVID-19 vaccination sites nationwide, of which around half are run by the private sector. However, counting sites is complex as there are many satellite or outreach and ‘pop-up’ sites.

“This is the largest single collaboration between the public and private sector to address a public health emergency – an excellent example of how NHI can work in South Africa,” says Crisp, who is also in charge of NHI.

This crossover of vaccinees between the public and private sector increases access and coverage. But for it to work, it depends on a large and complex reimbursement programme on the agreed tariffs. There is a R80.50 service fee per vaccination to cover site and consumable costs, borne by the government or the private medical scheme.

The reimbursement process comes into effect when an insured person goes to a public site to be vaccinated, and an uninsured person goes to a private site for their vaccination. In the case of an insured person vaccinated at a public site, NDoH can claim the costs of the vaccination from the person's medical scheme. In the case of an uninsured person vaccinated at a private site, the private site can claim the costs of the vaccination from the NDoH. This is not a cash payment but rather a credit note system, which is offset against the amount the private site owes the NDoH for the vaccine stock received, through an approved credit limit.

For obvious reasons this Vaccine Reimbursement Programme (VRP) was not in place at the start of the vaccination drive. BHPSA stepped in here and immediately mobilised a team of senior chartered

“This is the largest single collaboration between the public and private sector to address a public health emergency – an excellent example of how NHI can work in South Africa.”

Dr Nicholas Crisp

accountants and an IT firm to scope out and implement a series of complex transactional flows as well as a sophisticated back-end IT system, called the control and reconciliation tool (CART) which is housed within the NDoH IT environment. The system is live for claims from medical schemes to the state, and as of the end of January 2022, over R500m in claims have been issued to medical schemes for vaccinations provided in May and June 2021. Just over R100m has been received in revenue.

“The ability of the UK government to pivot its programme so quickly to support the development and establishment of the vaccine reimbursement programme has been phenomenal,” says Crisp. “It demonstrates the importance of donor programmes to be agile and responsive in supporting NDoH priorities, and in this case a public health emergency.”

FROM VACCINES TO NHI

The creation of the EVDS and VRP has required considerable donor and other resources. But it has also provided valuable lessons that will feed directly into the aims and ambition of NHI, South Africa’s strategy to achieve universal health coverage (UHC).

Digital systems that have been created for patient records and reimbursement can be adapted for broader health service delivery under NHI. For example, the Vaccine Reimbursement Programme is the largest reimbursement to the private sector by the state on a commonly agreed set of tariffs.

The newly created Master Facility List is also an important first step in registering providers to be funded under NHI.

In addition, the cooperation between public and private sector stakeholders has brought them closer together than previously imagined. Since the start of the vaccine programme a number of cross sectoral management and governance structures have been established, involving representatives from both sectors. This is an example of solidarity and common cause to overcome COVID-19 which has had a devastating impact on all aspects of South African life.

BHPSA Team Leader, Myles Ritchie, concludes. “From a BHPSA programme perspective, support to the COVID-19 EVDS and reimbursement systems has been an excellent example of value for money for the UK government - in terms of the input costs of technical assistance versus revenue collection by the state and private sector. It has also helped to build sound and strong relationships with the senior management of the NDoH, leading on these initiatives for government.”

Report on the situational analysis of noncommunicable disease data and health information systems

ABOUT THIS REPORT

The availability of quality data and information strategies can assist healthcare institutions to reduce the damaging effect of noncommunicable diseases (NCDs). Data drive the health information system, which is needed to manage the quality of patient care and to reduce operational costs by making administration and management processes more organised and efficient.

This is a summary report of an in-depth situational analysis of the current status of data and health information systems for NCDs. The work was commissioned by the NCD Cluster at the National Department of Health (NDoH) to inform the development of the monitoring and evaluation framework of the new National Strategic Plan (NSP) for Non-Communicable Disease 2021–2026.

► [The full report is available here ...](#)

A. REVIEW OF DATA SETS FOR NONCOMMUNICABLE DISEASES AND NSP

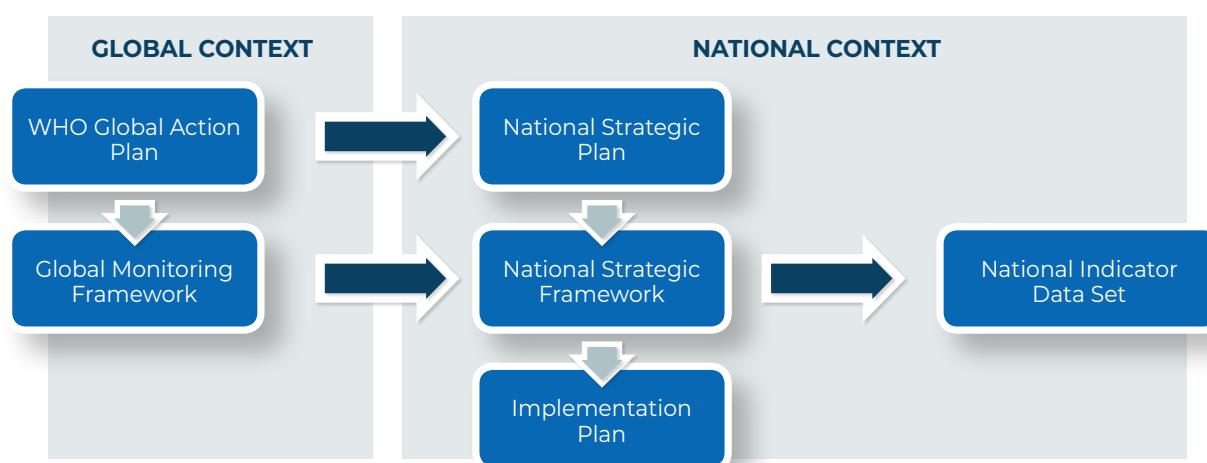
1. Background

To understand the current state of NCD data in South Africa requires an understanding of the ecosystem within which it is created, maintained and utilised. Three key elements of this ecosystem are:

- The World Health Organization (WHO) Global Monitoring Framework (GMF), which serves as the global standard and includes 25 mandatory indicators;
- The National Strategic Framework (NSF) of the draft NSP, which lists prescribed objectives with predefined indicators; and
- The National Indicator Data Set (NIDS), which houses the metadata for the NCD data set, under the custodianship of the NDoH.

■ Figure 1: Elements of the NCD ecosystem in South Africa

The draft NSP for NCDs is the primary source for the performance indicators within the NIDS; hence, the NSP was reviewed to assess its achievability within the context of the WHO GMF and the NIDS. The NIDS was simultaneously assessed for its completeness and compliance with GMF-prescribed formats.



2. Review of the NSP (May 2020 version)

The report identifies some key constraints regarding the successful implementation of the draft NSP. Many of these constraints are due to a significant proportion of the planned activities not being adequate to achieve the expected outputs. The review found that 36% of the expected outputs are unlikely to be achieved due to a misalignment between the outputs and the activities intended to produce them. Another key finding showed that a significant proportion (50%) of the indicators cannot be regarded as valid measurements of progress towards the achievement of the objectives or outputs that they are intended to track.

The review also looked at key input indicators upon which the success of NSP implementation would depend. Three categories were considered: financial resources, structures or organisational arrangements, and systems.

An analysis of the *resource category* found that resourcing for the NSP is problematic due to the lack of a dedicated budget (such as a national conditional grant for NCDs) and the absence of costed activities within the plan.

With regard to the *structures*, the draft NSP attempts to identify key stakeholders and partners and to define their roles and responsibilities. However, the structures are limited due to legal and regulatory constraints, which impact on the organisation's ability to execute decisions and to secure resources.

In terms of *systems*, although the NSP adopts a multisectoral approach, the formal coordination mechanism for implementation of the NSP for NCDs is yet to be established.

3. NSP, NIDS and WHO GMF: issues of alignment

The report found that both the objectives and indicators of the NSP are standardised and aligned with the WHO GMF. This ensures consistency and comparability across geographies and for different periods. It also allows the South African health authorities to track national performance whilst comparing standardised indicator outputs with those of similar countries.

An analysis of the NIDS shows that it contains only three NCD-related indicators. Moreover, because

the indicators in the NIDS are not prescribed by the WHO GMF, they are voluntary indicators. Of greater concern is that none of the 25 WHO-prescribed (mandatory) NCD indicators are currently defined in the NIDS. This implies that NDoH is non-compliant with the WHO GMF standard.

In conclusion, the national NCD surveillance system is currently rudimentary and does not support the collection of data for the 25 recommended indicators. Existing NCD data collection systems are fragmented, often paper-based, and siloed. There is a need to improve the completeness of death registration and the quality of cause-of-death information. Morbidity data and quality of care information are not generally collected and risk-factor monitoring through routine population-based surveys needs to be instituted at regular intervals. The outbreak of the COVID-19 pandemic in 2020 has further exposed the gap in the availability of data for NCDs.

4. Conclusion

Despite the constraints with NCD data and information as listed above, NDoH should be commended for the manner in which it set out to reduce the preventable and avoidable burden of morbidity, mortality and disability due to noncommunicable diseases by adopting a multisectoral approach in the draft NSP for NCDs. The WHO NCD Progress Monitor (2020) also lists South Africa within 68% of selected upper middle-income countries who have set time-bound national targets based on WHO guidance. This is further acknowledgement of the progress being made towards addressing NCD challenges.

B. VIABILITY OF INTEGRATED HEALTH INFORMATION SYSTEM FOR NCDs

1. Background

Based on the findings and recommendations in Part A, the objective of this section was to undertake a rapid assessment of NCD data systems, data elements and recommended NIDS, and to make recommendations on a possible digital solution for the integration of NCD data sets and strengthening of NCD surveillance systems within the health information system in South Africa.

Health information systems for monitoring chronic NCDs in South Africa are less advanced than those for infectious diseases, particularly tuberculosis (TB) and HIV, and for maternal and child health.

The three main data capture software systems deployed in South Africa for HIV and TB data are: Three Interlinked Electronic Registers (TIER.Net), the electronic TB Register (ETR.Net) and the District Health Information System (DHIS). TIER.NET is an integrated system for capturing and managing HIV and TB patient care and treatment information in South Africa.

The District Health Information System (DHIS) is a routine system for tracking health service delivery in the public health sector and is one of the vital components of a comprehensive Health Management Information System (HMIS).

Also relevant is the Health Patient Registration System (HPRS), which is used to capture patient registration details and assign a unique Health Patient Registration Number (HPRN) at primary health facilities and synchronise this data with a central server.

2. Key findings

The report on the viability of an integrated information system found that NCDs and HIV follow a chronic care model, with similar workflows and patterns of use. This means lessons can be learned from the introduction of digital solutions for HIV surveillance, and that the same system architecture and data exchange patterns can be repurposed or extended to collect and report NCD data.

It is feasible that existing data collection systems, most notably TIER.Net, could be enhanced to include NCD data collected at facility level. Similarly, existing software components could be used to support integration of NCD data from a variety of different source systems. This needs to follow the standards mandated in the national Health Normative Standards Framework (HNSF) for Interoperability in South Africa.

3. Conclusion

This rapid review identified a number of steps that will be needed to complete the work on integrated health information systems for NCDs. These include:

- Holding a validation meeting with key NDoH stakeholders;
- Carrying out a detailed systems requirement analysis;

- Designing a detailed system architecture to support the requirements both immediate and in the future; and
- Developing an implementation plan.

In conclusion, the international experience regarding the identification of data sources for NCDs shows that many data sources will be required, and many of these are outside the health sector. Any digital solution to support an integrated NCD surveillance system should therefore consider lessons learned from other experiences, both locally and internationally. The technical solution architecture should be driven by the prioritised needs of the NDoH and the requirements of the National Health Normative Standards Framework (HNSF) in order to provide a sound foundation that will allow for the system to evolve and mature over time. The principles of *adopt and adapt* should inform any technical solution; the reuse of existing software components should take priority over introducing and/or developing new software systems from scratch. A phased implementation approach focused on introducing small, incremental improvements followed by cycles of robust testing, will lead to a more effective solution in the long term.

C. RECOMMENDATIONS

NCD data and information

1. Facilitate a mandate for an NCD multisectoral coordination mechanism that includes supportive legislation, dedicated resources and the authority to act.
2. Ensure legally enforceable commitments for sustained participation in the multisectoral coordination mechanism for implementation of the NSP for NCDs.
3. Provide adequate and dedicated resources for implementation of the NSP.
4. Cost the NSP Implementation Plan and create a cost centre for this purpose.
5. Include NCD data coordination and surveillance within the role and function of the National Public Health Institute of South Africa (NAPHISA), once it is established.
6. Restructure the NDoH Budget Vote by repositioning NCD as a programme instead of a sub-programme.

7. Establish a national NCD surveillance, monitoring, and evaluation system to track implementation of the strategy, using a Monitoring and Evaluation Framework.
8. Revise the indicators and finalise the implementation plan of the NSP.
9. Complete the NCD Indicator Data Dictionary to include the prescribed WHO GMF NCD indicators in the NIDS.
10. Address existing constraints within the information system to allow for integration and effective surveillance.

Integrated health information system

11. Follow a phased approach to develop, implement and test an interoperable digital solution that will support the collection and reporting of NCD data at a public health, facility and community level. This includes:
 - Strengthening the public health response by expanding the existing District Health Information System (DHIS) monitoring and evaluation system for NCD indicators;
 - Strengthening the facility-based response by introducing a TIER.Net instance configured to capture and manage NCD data;

- Extend the TIER.Net system to include OpenIHP software and system. This will support the integration of additional source systems to form a richer, more comprehensive data set. These systems could include NHLS data, survey data, vital registration data; and
- Strengthen the community-based response through interfacing with the existing community health worker (CHW) systems, such as CommCare. This will allow the collection of NCD data collected during household visits, such as screening and treatment adherence information.

12. Develop a data governance policy to provide the essential framework to support the integration of data from multiple source systems, both within the health sector, and from other domains such as civil registration.



Multisectoral and multistakeholder approaches to tackling noncommunicable diseases (NCDs)

ABOUT THIS REPORT

This is a summary report of an in-depth review of global experience on multisectoral and multistakeholder approaches to NCD programmes. The review was commissioned in response to a request from National Department of Health (NDoH) for research and documentation to support implementation of the National Strategic Plan (NSP) for Noncommunicable Diseases 2020 – 2025. (May 2020 version).

The literature on NCD risk factors and implementation of NCD programmes was found to be patchy, hence the full report examines other non-NCD health initiatives that engaged across sectors and with multiple stakeholders. These include initiatives to address HIV, TB and STIs in South Africa, whole-of-society approaches to health, case studies of intersectoral action, and approaches to support Health in All Policies. The full report has an extensive reference list that includes academic and grey literature on multisectoral and multistakeholder approaches to a range of NCDs and other topics in South Africa and in high-, low- and middle-income countries across the globe.¹

This report suggests how to make multisectoral and multistakeholder approaches work, rather than what those approaches should attempt to do.

► [The full report is available here ...](#)

¹ Case studies and examples are drawn from the following regions and countries: south-eastern Europe, Caribbean, UK, Malta, Montenegro, Slovenia, Portugal, Norway, Canada, Brazil, Mexico, Iran, Philippines, Kenya, Ghana, Zambia, Nepal, Pakistan and India.

BACKGROUND

In South Africa, NCDs account for a high percentage of the disease burden and are the main cause of death for people over the age of 40. The most prominent NCDs are cardiovascular disease, Type 2 diabetes, cancer and chronic lung disease. The prevalence of NCDs in South Africa continues to rise due to an increase in risk factors such as an ageing population, unequal access to healthcare services, poverty, and a lack of quality education.

According to the Global Burden of Disease Study, 2017, NCDs accounted for 39% of South Africa's total burden of disease measured by disability-adjusted life years (DALYs). NCDs are not only detrimental to the health of the population, they also threaten the country's development and economic growth. It is estimated that losses from diabetes, stroke and coronary heart disease cost the South African government approximately R26 billion between 2006 and 2015. In addition to this, the cost of loss of productivity – largely due to NCDs – amounted to 6.7% of GDP in 2015; it is estimated that this will increase to 7% of GDP by 2030.

The National Strategic Plan (NSP) for Noncommunicable Diseases (2020 – 2025), which is currently being finalised by the NDoH, recognises that achievement of its strategic objectives depends largely on multisectoral and multistakeholder approaches that will address the increase in multiple morbidities and the burden of NCDs. This report draws on lessons from other countries with the aim of supporting the successful multisectoral and multistakeholder implementation of the South African NSP.

MULTISECTORAL APPROACHES TO NCDs



BHPSA engaged a team of academics to review global experience of managing NCD policy and programming



WHAT WORKED?

- Including all government departments, the private sector, civil society and other partners
- Different coordinating mechanisms for different issues and stakeholders
- Low-level operational plans for joint implementation and engaging local structures
- Strategies to avoid or manage stakeholders with a conflict of interest
- Targets and a joint monitoring process
- Monitoring and reporting against global NCD indicators

OTHER SUCCESS FACTORS

- High-level political leadership of the national coordinating mechanism
- Independence of government
- Accountability of partners
- A common vision
- Trust between stakeholders

WHAT WE LEARNED

An examination of the experiences of other countries suggests several principles and factors that may be considered to strengthen the NCD response. The key lessons are summarised below.

1. A multisectoral approach

- There is a need to work with government and nongovernmental stakeholders beyond the health sector. This is because noncommunicable diseases arise from many factors outside the control of the health sector alone.
- The broader South African Government (SAG) has the potential to function as a regulator and catalyst to shape the national NCD effort and stakeholder involvement.
- There is a need to broker relationships and manage power differentials between stakeholders; significant time and resources must be committed to forming and leading new context-specific arrangements of partnership and collaboration.
- A key task is building and maintaining consensus across stakeholders to agree on a shared vision.

2. Stakeholders

The three main stakeholder groups that need to be part of the formal NCD response are:

- **Government sectors outside the NDoH:** These include other government ministries, such as the Department of Basic Education (DBE), the Department of Social Development (DSD), the Department of Agriculture, Land Reform and Rural

Development (DALRRD) and the Department of Trade, Industry and Competition (the dtic). This sector should also include parliamentarians and parliamentary committees, for example, the Portfolio Committee on Health. Some government ministries, however, may have conflicting views on economic growth versus social goals. The NDoH should endeavour to shape NCD health goals to address other sectoral goals.

- **Civil society groups (CSOs):** CSOs play an important role in advocacy, accountability and other functions like promoting gender equality and social inclusion. Although civil society groups are likely to be strongly incentivised to engage with the national NCD effort, some may face challenges in terms of their capacity and remit.
- **Private sector:** Many private sector stakeholders produce and sell products that drive and exacerbate NCDs. So, although private sector engagement is essential, it is important that individual stakeholder interests align with those of the NDoH, and stakeholders must be motivated to engage constructively. Some private sector organisations may have too much invested in commercial determinants of health to be constructive partners.

3. National coordination mechanisms

- Countries studied have used a variety of mechanisms for multisectoral engagement – from consultation to full partnership in formal structures.
- A range of different mechanisms across different issues and groups of stakeholders may be necessary to implement the NSP.
- Successful joint working arrangements used in other countries consider the characteristics of stakeholders, their motivations and mutual dependencies.
- High-level political leadership could be mobilised to sit above sectors and guide the response.
- Deliberate efforts are needed to create successful joint working arrangements and build trust between stakeholders.
- Successful countries tend to adopt a measured, step-by-step approach to developing lasting, well-managed and coherent institutional arrangements.

4. Common planning

- Efforts should be made to engage all stakeholders in building a common vision for tackling NCDs.
- It is necessary to develop costed, lower-level operational plans that can be implemented jointly with other sectors, levels of government and groups of stakeholders.
- Action plans must be realistic and have defined, concrete and measurable steps towards achieving their objectives.

5. Conflict of interest

- The experiences of other countries reveal that conflict of interest is a major issue and should be anticipated and planned for. A common example is accepting sports sponsorships from the fast-food industry.
- A systematic approach will assist in identifying stakeholders whose conflicts of interest can be managed and stakeholders that should be avoided.
- Stakeholders should be expected to sign up to the transparent strategies that are developed to manage conflicts of interest.
- The government must be independent of interest groups.

6. Local coordination mechanisms

- Local structures are essential to the response because they have knowledge of local needs and potential interventions.
- Local coordination mechanisms should be designed for meaningful participation and should have sufficient powers and resources to function properly.

7. Accountability

- Accountability mechanisms must be negotiated up front with all stakeholders to guide implementation and behaviour.
- Plans must identify the responsible partners, and must also specify the financial commitments, timelines and expected results.
- High-level leadership beyond that of the NDoH may be required to ensure accountability from other sectors.

8. Monitoring implementation and impact

The draft NSP (May 2020) has a national monitoring framework of 30 targets with 36 associated indicators and detailed implementations plans with associated outputs, indicators and activities. The experiences of other countries suggest that further engagement with stakeholders on the content of the monitoring framework might be needed. Refinements include:

- **NSP monitoring framework** could include targets, output indicators and lead agencies for each strategic objective.
- A **joint monitoring process** should operate horizontally and vertically and facilitate data flowing up and down the system to keep all levels and stakeholders engaged and informed.
- The framework should enable **monitoring and reporting against global NCD indicators** of the World Health Organization.

Assessment of alignment of individual NCD and other strategies against the Draft South Africa National Strategic Plan for the Prevention and Control of Noncommunicable Disease (2020 – 2025)

ABOUT THIS REPORT

This report is a summary of an in-depth assessment of the alignment of seven standalone noncommunicable disease (NCD) strategies and 15 overlapping strategies with the draft South African National Strategic Plan (NSP) for Noncommunicable Diseases (NCDs), 2020 – 2025 (May 2020 version).

This NSP for NCDs is intended to combine all existing efforts to address NCDs, presenting a common vision, mission, objectives, goals, targets and guiding principles for action. However, there are several existing national standalone strategies to deal with NCDs and NCD risk that predate this draft national plan. These include national strategies on obesity, cancers and mental health as described in Diagram 1 below.

Broader health strategies, plans and policies, are also relevant to NCDs. These overlapping strategies include policies and guidelines on: infant and child feeding; youth and school health; adult primary care; HIV and TB; maternity care; health promotion and clinical services as well as the National Department of Health (NDoH) Strategic Plan (2020/21 to 2024/25) and the national health plan (Negotiated Service Delivery Agreement).

At the request of the NDoH, BHPSA commissioned a team of researchers to assess the extent to which the standalone and overlapping strategies are aligned to the draft NSP (or not aligned), and to make recommendations for strengthening the national NCD response.

► [The full report is available here ...](#)

Are standalone strategies aligned with the draft NSP for NCDs 2020 – 2025?

NSP



7 STANDALONE STRATEGIES WERE ANALYSED:

Mental health, obesity, diabetes, hypertension, breast cancer, cervical cancer, national cancer framework

QUESTIONS TO DETERMINE ALIGNMENT WITH THE NSP	ANSWERS
Do standalone strategies:	
Acknowledge the NSP?	Limited
Address NSP principles and strategic areas?	Not systematic
Explain how they will contribute to the target?	Limited
Analyse behavioural risk factors and align with NSP?	Strong
Analyse South Africa's NCD scenario?	No
Do standalone strategies have:	
NSP-aligned coordination and implementation mechanisms?	Insufficient information
NSP-aligned outputs, indicators and activities?	Weak
NSP-aligned workplans?	No
Are the NCDs in the standalone strategy included in the NSP?	Yes

CONCEPTUAL FRAMEWORK

For the assessment, assumptions were made about what full alignment of standalone and overlapping strategies with the NCD would look like. Potential categories for alignment were identified as: strategic overview, background analysis, approach, and targets and monitoring. A series of questions were developed to probe the extent of alignment in each category (see table above).

FINDINGS

Overall, little alignment was found between the strategies analysed and the NSP. Where there is alignment it is largely coincidental, rather than the result of the NSP acting as a high-level strategy helping to prioritise and determine lower-level inputs. In part, this is a product of timing, as all the standalone strategies were developed before the current NSP was drafted. However, few of them make any reference to the previous NSP, which implies they were not aligned to that version either.

Findings include:

- **The NSP impact target:** There is little acknowledgement in the strategies of the comprehensive NCD target, which is 'To reduce, by one third, premature mortality of noncommunicable diseases through prevention and treatment, and promote mental health and well-being, by 2030'.
- **Behavioural risk factors:** Alignment of behavioural risk factors and NCDs in the standalone strategies is strong, but weaker in the overlapping strategies.
- **Principles:** Most of the strategies, both standalone and overlapping, pick up on many of the principles of the NSP. However, this is not done in a systematic or consistent manner.
- **Strategic areas:** Although the standalone strategies reflect the five strategic action areas of the NSP (governance, reduction of risk factors, early detection and effective NCD management, high quality NCD research and surveillance) this is not done in a way that suggests a coordinated, systematic approach with the NSP guiding priority-setting.
- **Strategic objectives:** Although many of the standalone strategies touch on the NSP's seven strategic objectives, this is not systematic. Alignment of the overlapping strategies is much lower.
- **Implementation arrangements:** The standalone strategies are stronger than the overlapping ones on the importance of integrated care. Whilst coordination mechanisms are mentioned by most of the strategies, there is insufficient information to identify how these would link with the proposed coordination mechanisms in the NSP.
- **Targets and monitoring:** None of the strategies, standalone or overlapping, are well-aligned with the NSP, mostly because targets, outputs, activities, and indicators are missing from the lower-level strategies.

RECOMMENDATIONS

The timing to improve the alignment of strategies with the NSP is favourable. The NSP draft is near finalisation and the policies and guidelines of at least 12 of the standalone strategies are due to be updated and revised. This is an opportunity for the NDoH to position NCDs front and centre of strategic thinking and implementation, in the immediate future.

The priority recommendations to achieve this are:

- Clarify the relationship between the NSP and the standalone strategies so that it is clear that the NSP should have strategic primacy.
- Examine the organisational structure of NDoH to ensure a consolidated and coherent structure which enables systematic monitoring and reporting of policies and programmes that contribute to NCDs.
- Develop lower-level strategies, policies and guidelines where they are missing e.g., for cardiovascular disease and stroke.
- Use the experience of implementing the previous NSP, ensuring lessons are carried through into the individual strategies as well as the final version of the NSP.
- Revisit the level of aspiration in the NSP and the associated strategies, ensuring the adoption of realistic targets and outputs with stakeholders responsible for implementation.
- Elaborate the National Monitoring Framework to develop a robust M&E plan that is based on shared indicators across both standalone and overlapping strategies.
- Begin work on updating the national indicator dataset.
- Develop guidance on the formulation of updated and new standalone strategies in consultation with the teams developing individual strategies.
- Develop similar guidance for new and revised overlapping strategies.

Social and behaviour change communication for the prevention of noncommunicable diseases (NCDs)

ABOUT THIS REPORT

This report summarises two studies that were requested by the South African National Department of Health (NDoH) to strengthen their approach to social and behaviour change communication (SBCC) for the prevention of NCDs.

- **Section A** discusses an evidence-based and systematic approach to SBCC and provides the ideal components of a framework for an SBCC strategy. It also provides evidence that could be used to design an SBCC strategy for NCDs in South Africa; and
- **Section B** uses the quality assurance tool in the above framework to analyse the strengths and weaknesses of one national campaign: National Nutrition and Obesity Week (NNOW, October 2020).

The context for this work is the development of the new National Strategic Plan for NCDs (2021–2026). The SBCC framework is designed to complement the primary prevention focus of the NSP, and the NNOW analysis aims to provide insights into strengthening future SBCC campaigns.

The complete versions of both documents are available online:

- ▶ **Formative components of a SBCC strategy for NCD Prevention in South Africa**
- ▶ **Report on the evaluation a selected National NCD campaign: National Nutrition and Obesity Week (NNOW)**

A. FRAMEWORK FOR AN SBCC STRATEGY FOR THE PREVENTION OF NONCOMMUNICABLE DISEASES

This summary focusses on elements of an evidence-based SBCC strategy, rather than on the more detailed evidence on which to base the strategy, which is described in Chapter Two of the full-length report.

The framework that follows aims to provide the basis for the development of an SBCC strategy by:

- Introducing the key components required for any SBCC strategy;
- Modelling the process of planning a SBCC strategy specific to the primary prevention of NCDs in South Africa; and
- Recommending ways to prevent NCDs in South Africa, using key SBCC insights.

■ **Figure 1: SBCC framework**

Key elements of an effective SBCC strategy

The report provides step-by-step insights into how an SBCC strategy for NCD prevention could be designed using evidence and best practices. Key elements of an SBCC framework are summarised in Figure 1 and discussed in more detail below.



1. Planned process

The planning framework for the SBCC process includes the following sequential phases:

- **Inquiry phase:** To understand the national situation and audiences. This situational analysis report culminates in a clear problem statement.
- **Design phase:** To prioritise audiences, based on the evidence above, to develop an SBCC strategy.
- **Create and test phase:** To rigorously test any communication products or processes proposed in the strategy.
- **Implementation and monitoring phases** of the final strategy.
- **Evaluation phase:** This often leads to adaptations or replanning for the next programme cycle, based on results.

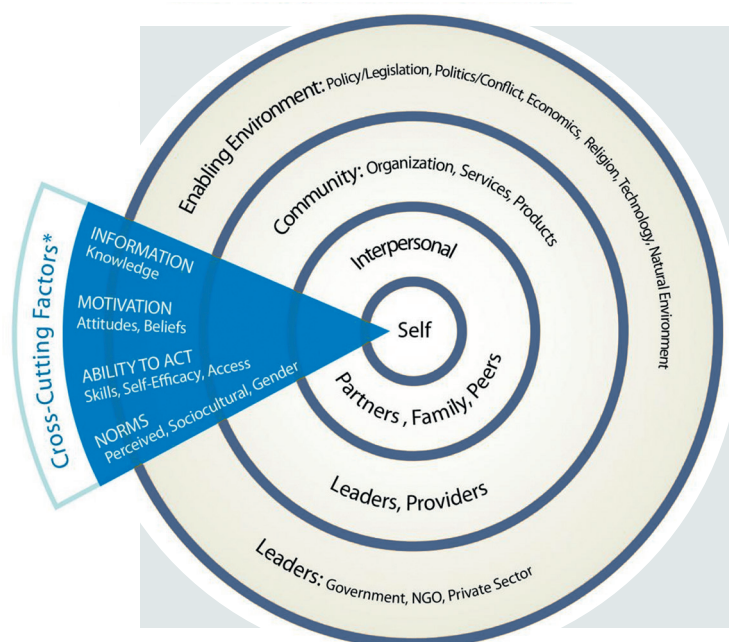
2. Based on theory and evidence

The recommended theoretical approach to SBCC is based on a socioecological model that illustrates how social and structural environments influence individuals and the decisions they make. The political and economic environments of a society influence community dynamics and vice versa, as shown in Figure 2 below.

The socioecological model is used to analyse the context and design and plan SBCC strategies for different audiences and across different NCD prevention programmes.

The inquiry phase of the planning process for any SBCC programme must be based on different types of evidence available on both the intended audience and the NCD landscape. Evidence types include social, epidemiological, environmental, behavioural and evidence on the efficacy of possible interventions.

■ **Figure 2: Socioecological model for change**



STANDARDS FOR SBCC QUALITY

- Follow a planned process
- Draw on context-relevant evidence
- Ground in theory, from inquiry until evaluation
- Apply audience insight and segmentation
- Define communication objectives
- Use a mix of strategic approaches, aligned to communication objectives
- Model participatory approaches
- Support multi-sectoral action
- Promote gender equity and social inclusion
- Avoid stigmatising people or conditions
- Reflect a life-course perspective

3. Audience specific

The audience is the group of people for whom (or with whom) the strategy is designed. Audiences are divided into:

- **Primary audience:** The group that will benefit from the changes (e.g. adolescent girls);
- **Influencing audiences:** Those who influence the primary audience (e.g. peers of adolescent girls); and
- **Target audience:** This is the group for whom the specific communication strategy is designed. The target audience may be the same as the primary audience, but may also be those who have most agency in change (e.g. adolescent caregivers).

4. Clear SBCC objectives

Spelling out clear communication objectives is fundamental to SBCC. Communication objectives seek to focus on the underlying factors of the behaviours that are barriers to change, or that may facilitate behaviour change. In this way communication or SBCC objectives are different to programme objectives. For example, a programme objective might be *'increasing physical activity in adolescent girls'*, while the communication objective for that programme would be *'increasing self-efficacy to participate in school sport'* and the

strategy would then be focussed on the full range of activities that could do this.

5. Strategic approaches

SBCC operates through three main strategic approaches:

- behaviour change communication that aims to change knowledge and behaviour of individuals;
- social mobilisation for wider participation and ownership;
- and advocacy aimed at raising resources and political and social commitment.

Strategic approaches should specify activities and potential channels appropriate for the audience and context. A channel is the medium through which communication takes place. It can be unidirectional, e.g. television, or one that can enable dialogue, in the case of a training or interpersonal communication.

6. Participatory and multisectoral

Ideally, a range of partners should be involved in the SBCC planning process and include affected communities and sectors outside of organisations that deal specifically with health, such as the NDoH. [\(See more on this topic in: Multisectoral and multistakeholder approaches to tackling noncommunicable diseases \(NCDs\) available for download here ...\)](#) ►

7. Gender equity, social inclusion and stigma prevention

Any SBCC strategy should be sensitive to gender inequality and social exclusion and should aim to include strategies to prevent these, as well as preventing stigma.

8. Life course approach

According to estimates by WHO, 70% of premature deaths in adulthood, globally, are due to behaviours that began in adolescence. It is thus important to consider at which life stage we should engage with people to bring about change. For NCD prevention, this requires us to decide when in the life course we are likely to have the biggest impact.

9. Quality assurance

High quality SBCC campaigns should be able to demonstrate that they have been based on the above principles and elements. The report includes a quality assurance tool that can be used to support planning of new campaigns and measure the quality of specific campaigns that have already been conducted. This tool, and its application to one national campaign, is discussed in Section B below.

B. EVALUATION OF AN NCD CAMPAIGN: NATIONAL NUTRITION AND OBESITY WEEK (NNOW)

Each year the Directorate: Nutrition in the NDoH, commemorates National Nutrition and Obesity Week (NNOW), and in 2020 this campaign took place between 9 and 19 October. This report summarises a rapid evaluation of the 2020 NNOW campaign using the quality assurance tool described in 9, above.

Background

The year 2020 marked a particularly important year for nutrition and obesity, as the COVID-19 pandemic demonstrated that poor nutrition (both over- and under-nutrition) and obesity increase vulnerability to COVID-19. In particular, the South African data on severe disease and mortality highlighted the country's NCD epidemic.

This is the context for piloting of the SBCC quality assurance tool. The evaluation was conducted within the COVID-19 context, in a short time frame (November 2020). Through a participatory process, involving interviews with seven key stakeholders, the tool enabled the team to score the performance of the NNOW campaign in four key domains linked to the SBCC quality standards. In addition, documents were used to verify and expand on information from interviews.

Four domains

The four domains in the quality assurance tool are: institutional systems; planning and design; implementation; and monitoring and evaluation.

1. Institutional systems: This domain tests the strength of the institution/s leading the campaign. It reviews systems that directly influence SBCC intervention planning and implementation. They include internal SBCC mechanisms; human resource systems; management information; and reporting systems.

2. Plan and design: This domain evaluates necessary components for planning and design, such as situation analyses built on evidence; priority setting; and design elements that address the identified health or other social barriers to change, among other key components.

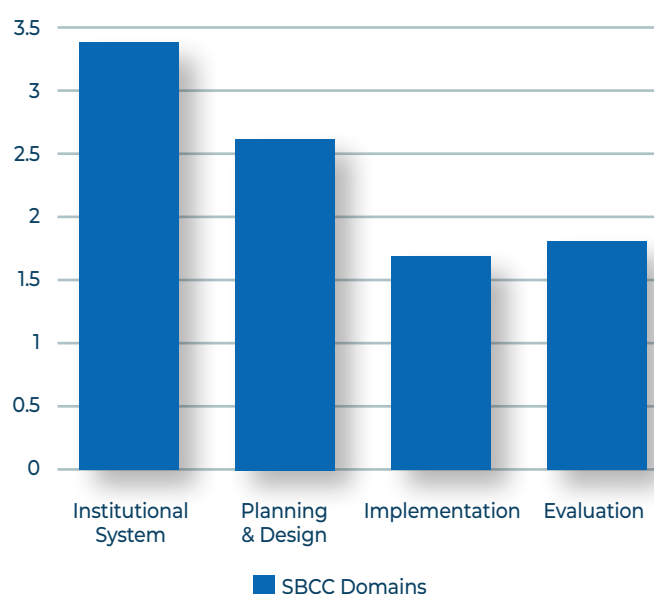
3. Implement and monitor: This domain covers best practices for implementing and monitoring SBCC programmes, including the development and use of implementation and monitoring plans; coordinating implementation with other programmes; supervision and mentoring; and having staff and SBCC development plans, etc.

4. Evaluate, scale and sustain: This domain covers the components needed to evaluate SBCC and to scale and sustain the programme, including evaluation; documentation and dissemination of results; and how programme data are used for adaptation.

Results

Domain 1, the Institutional Systems context, scored highest with 3.38/4.00 followed by Domain 2, Planning and Designing (2.62/4.00). Domains 3 and 4, Implementation and Evaluation scored 1.69/4.00 and 1.80/4.00 respectively.

■ **Figure 3: Self-assessment by domain**



This pattern of scores is common, reflecting a gap between concepts (mandates and plans) and action (implementation and evaluation). The former typically score higher than the latter.

The richness of the evaluation process was in the conversations that led to the scores, not the actual scores themselves, which are detailed in the results section and form the basis for a number of recommendations. A few highlights from the process are as follows:

NNOW strengths: The evaluation found that the NNOW campaign process focused on bringing together a broad range of stakeholders to select the annual theme and develop messages for a coordinated communication strategy. The stakeholders who participated in the 2020 NNOW campaign were highly committed and reputable technical experts and organisations. Resulting campaign materials were clearly branded and of a professional quality, and produced in a wide variety of formats (print, social media, visual and audio).

NNOW weaknesses: Less attention was given to the underlying mechanisms that could assist with making the campaign more focused and efficient (e.g. a costed workplan, a theory of change and a monitoring and evaluation plan) and to quality assurance processes, such as consistent pretesting of materials and data-quality mechanisms. A cross-cutting concern expressed by all participants was NDoH's heavy reliance on collaborators to finance the NNOW campaign. Another concern was that monitoring was inconsistent and there were no plans (or resources) for evaluating the impact of these annual efforts.

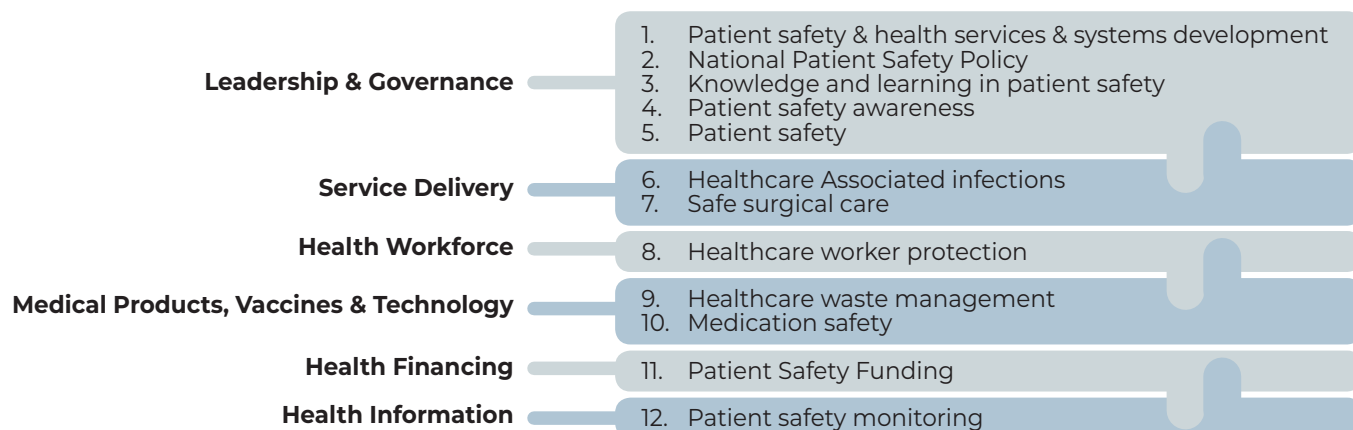
Overview of patient safety

INTRODUCTION

It is estimated that one in ten patients across the globe are harmed when receiving care in hospitals, and that half this harm is avoidable or preventable. Around 42 million adverse events happen during hospitalisations world-wide annually, and two thirds of these take place in low and middle-income countries.

Patient safety can be described as ensuring that people who use the health system experience maximum benefit and minimum risk. It is a key underpinning of a well-functioning health system. However, the ability to tackle patient safety is often hampered by the fear of retaliation, and punitive systems linked to the reporting of adverse events.

The WHO African Regional Office (WHO AFRO) has developed guidance for patient safety systems. It identifies twelve action areas aligned with the six WHO building blocks for a quality health system.



■ **Figure 1. WHO's 12 principles of patient safety**

South Africa recognises patient safety as a crucial part of quality of care and as such it has been integrated within the National Quality Assurance Department in the National Department of Health (NDoH). Patient safety also forms part of the National Standards that are monitored by the Office of Health Standards Compliance (OHSC). The national policy for Patient Safety Incident Reporting and Learning (PSIRL) was launched in July 2016 to move towards more systematic incident reporting across the country.

ABOUT THE REPORT

On request from the NDoH, the Better Health Programme South Africa engaged expert consultants to review progress towards implementing principles of patient safety in South Africa against a global landscape of patient safety initiatives. The review used the 12 WHO principles to assess progress towards a comprehensive safety system in South Africa. In addition, a survey was conducted in provinces to understand the extent of the implementation of the PSIRL.

This document is a summary of the full 44-page report *Patient Safety Review and Way Forward, January 2021*, and focusses on the South African findings.

FINDINGS

1. A comprehensive patient safety system

Desk research and in-depth discussions with key stakeholders enabled a rapid evaluation of South Africa's progress towards patient safety using the 12 WHO action areas. The summary score shown in the table below can be misleading as each of the areas is comprised of several components, each of which is discussed and assessed more in detail in the full report. However, it does provide an indication of progress towards each of the action areas, and an understanding of what still needs to be implemented. As can be seen, most actions fall into the category designated Orange or "not fully operational".

PROGRESS AGAINST THE 12 WHO PRINCIPLES

■	Indicator exists and is fully operational/implemented
■	Indicator exists but not fully operational/implemented
■	Indicator not found in source documents/not being implemented
	Insufficient information to determine if indicator exists or is implemented

Patient Safety Principle	Score	Description of status
1. Patient safety and health services, and systems development	■	Safety is integrated into quality assurance and is one of the National Core Standards. However, there is a lack of integration at the national, provincial and district level.
2. National patient safety policy	■	Patient Safety Incident Reporting and Learning (PSIRL) policy exists and is disseminated. There is no national safety policy, but separate policies exist in other departments.
3. Knowledge and learning in patient safety	■	PSIRL allows for patient safety committees at all levels of healthcare to foster an environment of knowledge sharing and learning. This is implemented variably across the provinces.
4. Patient safety awareness raising	■	Localised efforts exist but patient safety data is not publicly available and systematic communication programmes are not being implemented.
5. Patient safety partnerships	■	While many civil society organisations are active in health, none focus exclusively on patient safety.
6. Healthcare Associated Infections	■	Infection Prevention Control policy and guidelines exist, and work is progressing towards antimicrobial resistance (AMR) stewardship.
7. Safe Surgical Care	■	SA uses the WHO Safe Surgery checklist but implementation is not monitored or audited systematically in the public or private sector.
8. Medication Safety	■	Regulatory authority and the essential medicines list are well established and functional, but implementation of incident reporting and developing a culture of safety will require significant input.
9. Health Worker Protection	■	Provision of PPE, policies for finger-stick exposure, availability of vaccines and post-exposure prophylactics for HIV exist. Latent TB treatment could improve.
10. Healthcare waste management	■	Environmental policies exist but under different ministries in the government. Implementation is variable across the provinces.
11. Patient safety funding	■	While funding for certain aspects exists, there is no clear ring-fenced budget allocation for patient safety which impacts the implementation of activities at provincial and district levels.
12. Patient safety surveillance and research	■	Academic research is independent, however there is no national research agenda and no clear funding streams in the country to promote patient safety research. There is no national patient safety surveillance programme, meaning that data collected is not easily available and progress cannot be monitored.

2. Provincial implementation survey

A snapshot survey was sent to all nine provincial departments of health to better understand the current status of patient safety activities. Responses were received from six provinces: KwaZulu-Natal, Eastern Cape, Northern Cape, Gauteng, North West, and Mpumalanga.

In summary, the survey showed that while most provinces have a policy/guidance document on patient safety, there is a lack of implementation and monitoring. None of the provinces felt that facilities had implemented a blame-free safety culture among staff. More specifically:

- Few districts have functioning patient safety committees and those that do, have been disrupted by COVID-19 restrictions.
- There was no standard way in which reports were compiled at the district level, with some compiling quarterly reports and others annual reports.
- Most responding provinces conducted training on patient safety management, but they largely waited for requests from districts or hospitals to carry this out.

All respondents felt that they needed further support from the NDoH, and that the national department should inculcate a culture of patient safety as a responsibility of all health care workers at all levels.

THE WAY FORWARD

The current fragmented picture at national and sub-national levels, with overlapping and unaligned initiatives, presents a serious obstacle to a comprehensive patient safety ecosystem in South Africa. The analysis of the 12 WHO action areas as well as the Lancet Commission report shows that the availability and use of data in relation to patient safety is one of the biggest barriers to successful implementation. Other challenges include the lack of a research agenda, and the lack of coordination between civil society, academia and government.

One approach to solving this would be to hold a national Patient Safety Think Tank for all stakeholders in the public and private health sectors. The goal would be to reach agreement on a common roadmap towards a comprehensive national patient safety environment, anchored in quality improvement.

This Think Tank would also assist the NDoH with a understanding of the metrics and data pertaining to patient safety. It could also develop an investment case for patient safety; a research agenda to gain further understanding of impactful interventions; and engage with health economists on the utility of ring-fenced funding for improving patient care.

A review of patient feedback systems

INTRODUCTION

Information about the patient's experience of care (PEC) in the health system is critical to the delivery of quality health care services.

PEC data can be used to highlight those aspects of care that need improvement. When carefully used, this data can help to educate medical staff about their achievements as well as their failures, assisting them to be more responsive to their patients' needs. In addition, this information allows managerial judgement to be exercised from an informed position.

To meet the demand for PEC data in South Africa there are several existing patient feedback systems in use, in both the public and private health sector. Many of these systems utilise digital technology, such as mobile phone applications or web portals, to collect data. However, these systems are developed and managed by different organisations and the data is not integrated.

ABOUT THE REPORT

The Better Health Programme South Africa (BHPSA) commissioned expert consultants to undertake a rapid desktop review of digital patient feedback systems in South Africa and the UK. The aim was to understand the current SA landscape and identify possible ways to strengthen, integrate and improve patient feedback systems.

This document is a brief summary of the 53-page report Patient Feedback Systems Review Report, September 2020, and focuses on the South African material in the report.

SYSTEMS REVIEWED

The report reviewed several systems to capture patient experience that are currently in use in South Africa. These are:

- **Patient Satisfaction Assessment mobile application:** This tool is available on a mobile phone and enables patients to rate satisfaction across six categories. It has been developed as a proof-of-concept mobile app and trialled in 288 primary healthcare and 50 hospitals across eight provinces.
- **Ideal Clinic feedback systems in primary health care:** This is a detailed dashboard used to rate services according to a range of criteria. Patient feedback forms are available via the website and are available in all 11 official languages, and can be downloaded and printed. While feedback forms are available to all, this is a resource largely aimed at healthcare workers. The patient feedback forms that have been filled in are then captured into the electronic system by authorised users.
- **The complaints and compliments system of the Office of Health Standards Compliance and Health Ombud:** This system is used by the national OHSC call centre to log all complaints or compliments received via a number of channels such as email, telephone and online forms.
- **National Complaints App:** new mobile app being launched in June 2021 to provide a channel for patients to directly lodge a complaint. The data will be captured into the Ideal Clinic platform and available at facility, district, provincial and national level for tracking, resolution and reporting.

- **MomConnect:** This is a free mobile messaging (SMS and WhatsApp) programme for pregnant women and mothers of infants which aims to promote safe motherhood and improve pregnancy outcomes. MomConnect includes a help desk feature which allows women registered on the system to ask maternal and child health related questions and to provide feedback on health services received at public health clinics. This is delivered in over 95% of public health clinics across South Africa, reaching over 70% of eligible women and has over 800,000 active users at any one time.
- **Mpilo app:** This is an android app suitable for smartphones and is designed to receive feedback in public health institutions across Gauteng province.
- **Private sector feedback forms:** Netcare is the largest provider of private health care in South Africa. Netcare makes use of both an iPad-driven feedback system during in-patient stays and a five-minute electronic post-discharge survey that is emailed to patients. The data from these surveys is publicly available on their website. It is aggregated per facility.
- **CommCare:** This is one of several mobile applications used by community health workers, which includes patient feedback.

The above have been developed as siloed systems, which are part of independent projects. This has resulted in duplication of function and information being collected, which is inefficient and can create negative perceptions among both patients and healthcare workers.

Common barriers to use

Everyone accessing the public health system should be able to provide feedback on the service they receive, but the review identified several common barriers to use. These were:

- Resistance or intimidation by facility staff;
- Lack of any response or feedback regarding complaints;
- Language and literacy barriers;
- Internet / mobile accessibility and cost;
- Cognitive or learning disabilities;
- Visual and hearing disabilities; and
- Physical disabilities.

SOLUTIONS AND RECOMMENDATIONS

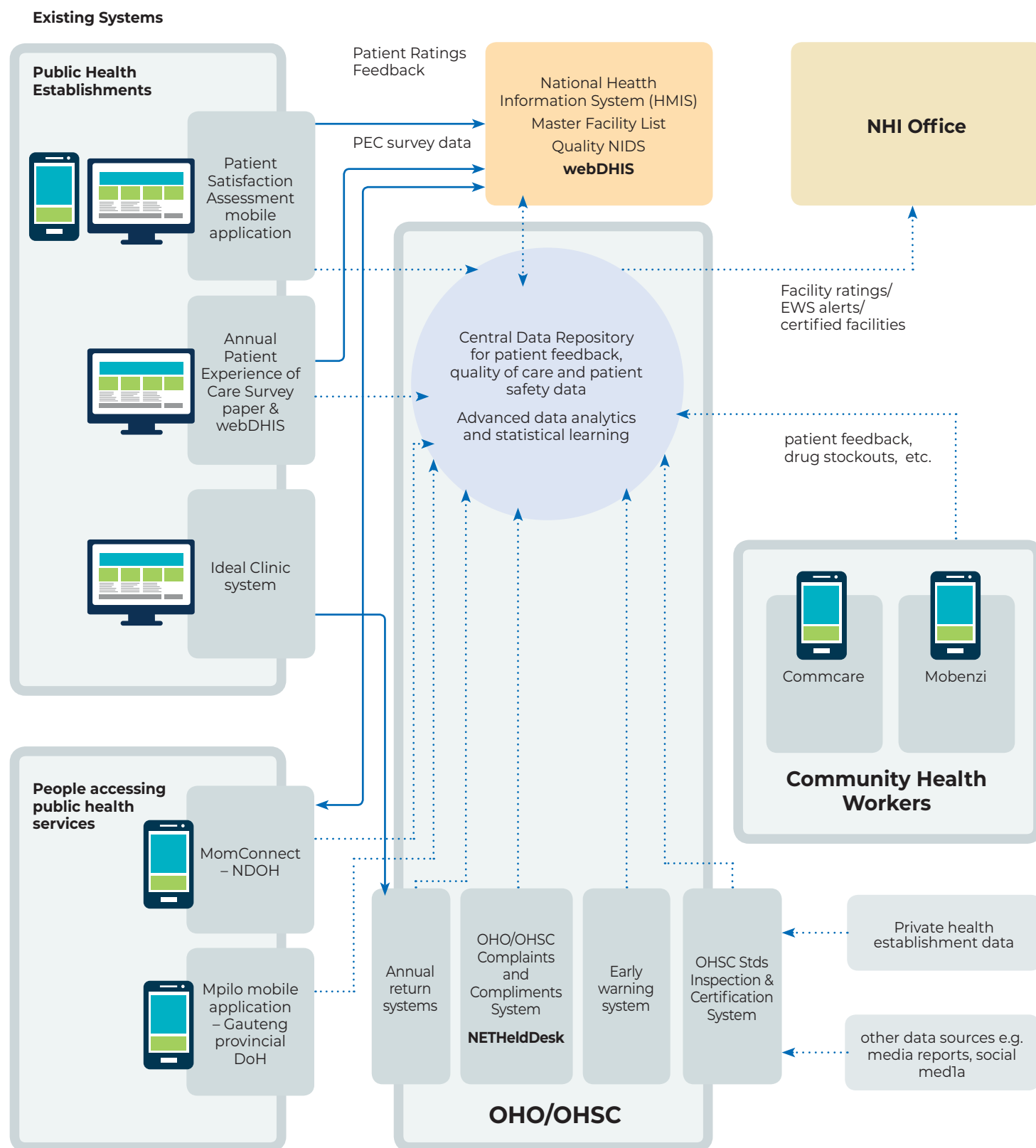
1. Central repository

The different systems reviewed are targeted at different groups and collect different types of data. However, there is potential to integrate these different data sources to provide a more holistic and complete view. A centralised repository for collecting and collating patient feedback, quality of care and patient safety data could integrate information from different sources. This would serve as a platform to obtain deeper insights from data analyses as well as providing a coherent and consistent reporting framework.

The report proposes a conceptual system architecture to enable interoperability of patient feedback systems and to consolidate data across a number of these systems, based on common patterns of use. The integration of both qualitative and quantitative data from a variety of different sources can provide a rich data set. This is represented schematically in Figure 1.

The context diagram on page three is a conceptual view of how the different patient feedback systems could potentially be integrated to provide a more comprehensive and complete view of the quality data and patient safety data being collected. In addition, the diagram shows a number of potential sources of quality and safety data, namely from CHW programmes, private health establishments and the media. The diagram indicates how the central data repository could function as a source of valuable information for the new National Health Information System (HMIS) which brings together data across the public health system, as well as extract information from the HMIS (for example the facility location and contact details).

CONTEXT DIAGRAM Patient feedback Data



■ **Figure 1: Conceptual architecture for centralised PEC data system**

2. Designing for improved accessibility

The use of responsive online forms may solve many potential accessibility problems, by removing the need for the download process. Advantages of a responsive form are that it can be accessed from most devices, as well as updated quickly according to feedback from patients and testers. A single hosted version avoids versioning problems that occur with app updates and printed forms. Online forms also remove the need for users to have mobile phones and data, which are required to access mobile apps.

Other solutions to improve accessibility involve using good design principles to ensure the feedback system is appropriate for the target audience. This includes use of appropriate languages as well as strategies to improve access for people with limited vision and other disabilities.

3. Data governance

Data governance policies should be developed to enable the collection, curation and use of integrated patient feedback data whilst providing the necessary protections.



A review of patient safety reporting in South Africa

INTRODUCTION

Patient safety is a fundamental element of healthcare, and inadequate patient safety is widely recognised as a public health concern, leading to unnecessary deaths and costing governments millions.

It is believed that only around 10-20% of errors globally are ever reported. However, of those, 90-95% cause no harm to patients. There is a wealth of literature that describes different factors that contribute to under- or misreporting of incidents by healthcare workers. These include weak patient safety cultures; fear of punishment; not knowing who is responsible for reporting; lack of user-friendly reporting systems; and lack of time.

Simple user-friendly reporting systems are essential to overcome the barriers and challenges to reporting patient safety incidents. The World Health Organization (WHO) has provided global guidance for a clear, standardised Patient Safety Incident Reporting System (PSIRS) in the form of the Minimum Information Model (MIM). The MIM reporting system set out three layers of reporting for each incident. These are:

- Description – what happened
- Explanation – why it happened
- Remedial action – what action was taken

South Africa has recognised that patient safety is a crucial part of quality of care. In 2016 it was decided to develop a unified national system for reporting patient safety incidents (PSI) within the public health system using the WHO MIM-based system. A rapid assessment of MIM was undertaken by the National Department of Health (NDoH) which found that the classifications and categories, as set out by the WHO, were possibly too extensive. These were then refined for local use and implementation of the Patient Safety Incident Reporting System (PSIRS) began in 2018.

ABOUT THE REPORT

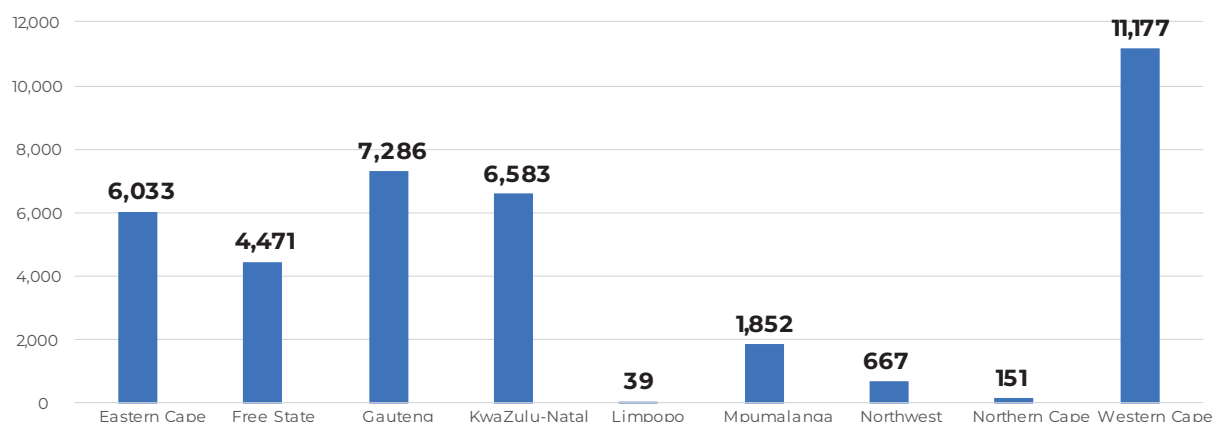
On request from the NDoH, the Better Health Programme South Africa (BHPSA) commissioned two consultants to undertake an analysis of patient safety incidents reported over a two-year period (1st April 2018 to 31st March 2020). The key objectives were to understand whether the MIM classification system is being used correctly; to identify trends of misuse; and to make suggestions for the future to support improved use of the system.

Anonymised data was extracted from PSIRS which accounted for all reported incidents from all nine provinces. A total number of 38,861 incidents were extracted and analysed. These accounted for incidents recorded at 851 public facilities including hospitals (district, regional, tertiary, central and specialised), clinics and community health centres (CHCs).

This document is a brief summary of the findings of the consultants written up as a 46-page report:

“Data analysis and review of the Patient Safety Incident Reporting Data based on the WHO Minimum Information Model.” January 2021.

QUANTITATIVE FINDINGS



■ **Figure 1: Incidents recorded per province**

The Western Cape leads the provinces in incident reporting, followed by Gauteng, KwaZulu-Natal and Eastern Cape. It is important to note that high levels of reporting are not necessarily indicative of a less safe environment for the patient but instead could highlight a good reporting culture.

A quantitative analysis of the incident reports resulted in the following findings:

Increase over time: incident reporting increased over the period of study, from April 2018 to March 2020.

Time of day: most incidents were reported during the morning hours and the peak time that incidents occurred was at 8am. After 3pm, there was a steady decline in incidents until 4am.

Location of incident: over 80% of all incidents took place on inpatient wards.

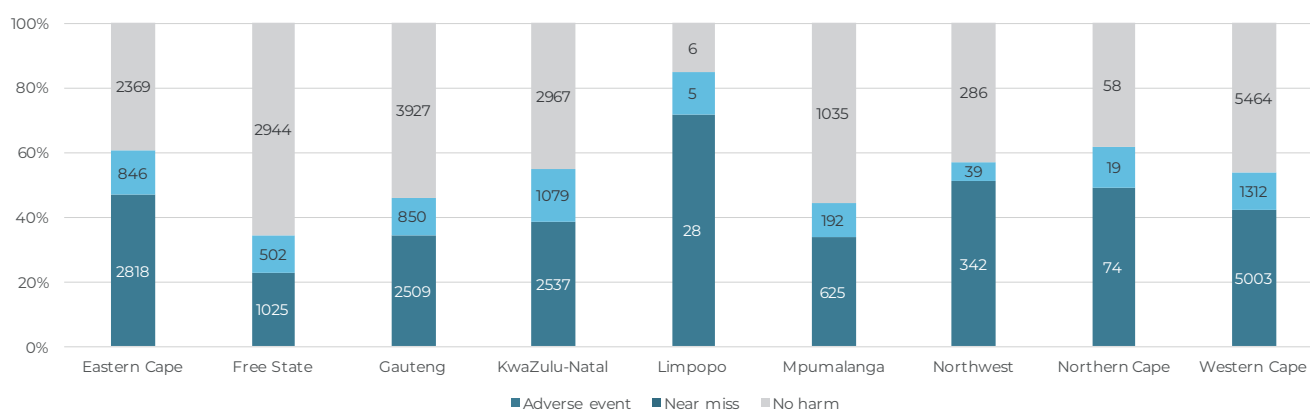
Incident severity: 49% of all incidents resulted in a harmful, adverse effect and 51% recorded as either no harm or near misses.

Classification of incident: the main classification of incident was noted as “behaviour” and accounted for 32% of all incidents. This was followed by the “other” category at 23%.

Contributing factors: patient factors were regarded as the main contributing factor for incidents, followed by staff factors.

Patient outcomes: 32% of incidents resulted in mild harm, with 29% recording no harm to the patient. 18% of incidents recorded death as the patient outcome.

Organisational outcomes: the most common recorded organisational outcomes were an “increase in required resource allocation for the patient”. A small percentage of cases resulted in a damaged reputation, formal complaint, property damage, legal ramifications and media attention.



■ **Figure 2: Degree of harm from incident, by province**

QUALITATIVE FINDINGS

Language: data entries were entered predominantly in English but other languages were used.

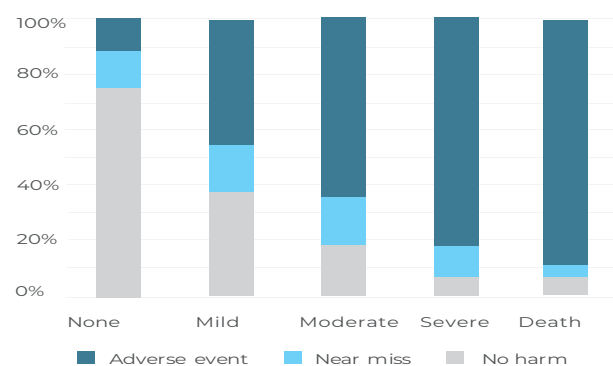
Reporting standard care: on occasions, poor outcomes were reported when a patient safety incident had not necessarily occurred.

Variation in detail: text descriptions varied from meticulous detail to lack of any narrative at all (7%).

Standard text descriptions: on occasions, duplicate responses were provided for different incidents which raises the risk of the entries being viewed as a “tick box” exercise, missing specific detail of the incident or learning.

Inconsistency: there were often discrepancies between text descriptions and quantitative data for the same incident (see Figure 3 below). There was also inconsistency between how the incident was categorised.

‘Other’ category: There was widespread overuse of the “other” category. For example, when categorising types of incident, 40% of all deaths were marked as “other”.



■ **Figure 3: Comparing patient outcome with severity attributed to incident**

Findings were also made on the usability of the SA PSIRS. These included:

Terminology and jargon: the language in the classification system was not always clear to the user.

Sequencing: the order of the questions in the PSIRS was not always intuitive or in a natural order.

Level of information: the system includes additional questions which are not always necessary for notification of incident.

RECOMMENDATIONS

1. Optimal use of PSIRS

The report offers a number of considerations to improve the usage of the PSIRS.

User-friendly interface: A number of changes could improve usability including updating the sequence of inputs to support storytelling; and design features, such as single column forms and simple navigation mechanisms. Other additions could include the functionality to attach more detailed files to reports and a spell checker.

Guidance: More accessible, real-time/interactive guidance can support users of the system. ‘Tooltips’ or text labels could provide an extra layer of support, for example by providing information on what needs to be included in different sections.

Refinement of categories and subcategories: a detailed list of suggestions for language/ classification changes are provided that could enhance the efficiency and usability of the system. These relate to incident type, contributing factors and outcomes. The list is available from the NDoH.

Introduce a new Severity Assessment Code (SAC). The SAC rating used in NDoH is based on three categories that describe permanent harm, temporary harm and mild harm (SAC1, 2 and 3 respectively). However, this three-tier classification does not allow the accurate classification of “no harm” or “near miss” incidents. Introducing SAC4, to capture “no harm” or “near miss” could increase the accuracy of the system.

Include response, action and mitigation for the future. A multi-incident root cause analysis is useful for investigating recurring problems and the changes needed to prevent them. While the PSIRS allows for this, it is not clear that it is routinely used.

Record where and how the learning has been disseminated. Detailed documentation of learning from incidents could have benefits for all users. The lack of feedback from incident reporting has been highlighted as inhibiting the willingness of staff to report incidents.

Include “time to report” and “time to close” in the dashboard. These aspects are an indication of how systems may be improving over time and therefore need to be included in reporting.

2. Wider support for patient safety incident reporting

The report identifies several ways to strengthen the use of the PSIRS.

Training and how-to guides. Tailored training may be targeted for different staff groups. Guides could include a decision-making tool to support the categorisation of an incident, and a framework for incident narrative.

What does good look like? Having a benchmark with which to compare the management of incidents could be beneficial. For example, NHS England has a central capability to review, interrogate and respond to patient safety incident reports.

Consider incorporating patient complaints, or perhaps near-miss events, as early indicators of unsafe care.

Promote reporting responsibilities across teams. Multi-professional reporting across all departments is a key indicator of a robust reporting culture and should be part of the future aim.



National Health Quality Improvement Plan

What is it?

The National Health Quality Improvement Plan (NHQIP) was one of the interventions emerging from the Presidential Health Summit held in October 2018. It provides a roadmap to improve the quality of the health system in preparation for accreditation for National Health Insurance (NHI).

NHQIP aims to build capacity around quality improvement and support provinces to move from a mindset of 'compliance with quality standards' to a new mindset of 'continuous quality improvement' in order to improve patient outcomes.

A Technical Working Group worked throughout 2020 to develop a strategy to implement the Plan. In March 2021 kickoff meetings were held with provinces and the private sector.

How will it work?

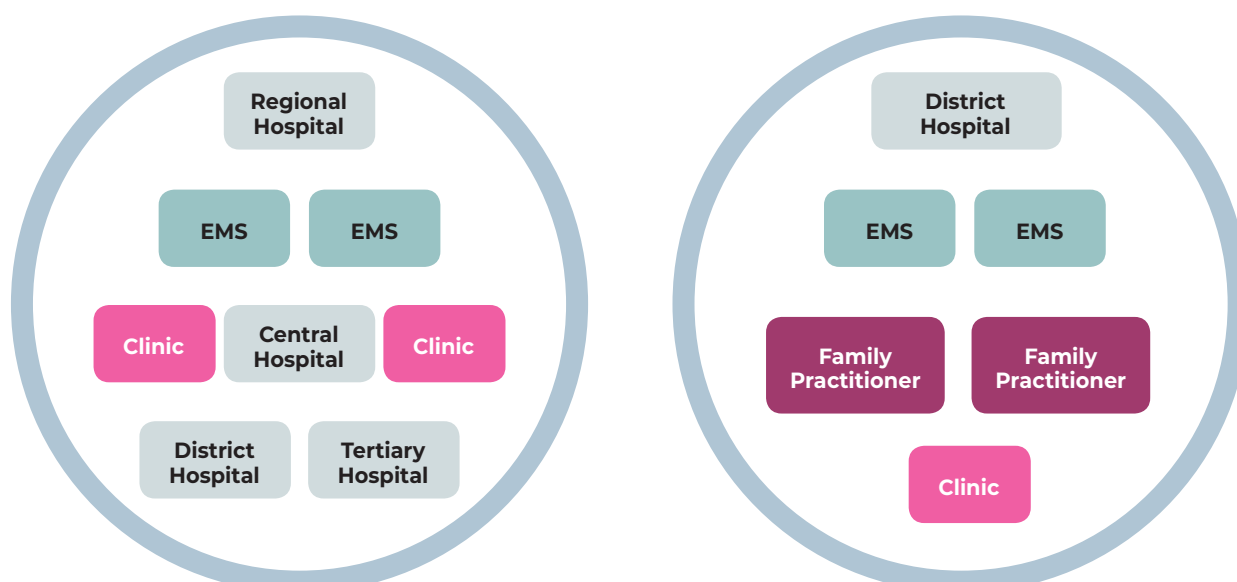
Quality Learning Centres (QLCs) will be established across the country, with two pilot centres per province being established. A Quality Learning

Centre is a cluster of facilities in a geographic area made up of hospitals, primary healthcare facilities (PHC), Emergency Medical Services (EMS), private hospitals, private EMS, and family practitioner (GP) practices. These will be the focus for learning and disseminating quality improvement knowledge and skills to all facilities in the cluster..

Facilities that become part of the Quality Learning Centres will be carefully selected to include:

- Hospitals that are performing well;
- Facilities close to compliance with the standards of Office of Health Standards Compliance (OHSC), and Ideal Clinic or Ideal Hospital programmes; and
- Facilities that have some experience in implementing quality improvement programmes.

These facilities have been identified by the provincial departments of health.



Phased implementation

Implementation will take place in phases:

- Firstly, training workshops will be conducted for selected personnel from the facilities to give them the skills to assess quality and implement quality improvement initiatives.
- All facilities will undertake a self-assessment to embed learning, develop ownership of the process and share knowledge.
- Baseline assessments will be carried out at all the participating facilities by the OHSC. These will assess all the departments in the facilities against the national standards. The data will be used to identify shortcomings and develop appropriate quality improvement plans to address root causes using tried and tested methodologies.
- Facility staff will be empowered to make improvements in their own departments and test the impact of the improvements by analysing the data.
- Every two months, support visits from the Technical Working Group will review progress and troubleshoot obstacles. Service leads will be identified to continue with the programme and continue to train others.
- In between the support visits, the facility teams will carry out self-assessments and implement the quality improvements that are required. Remote support will be provided through group learning sessions.

- At each support visit, progress will be reviewed with representatives from all Quality Learning Centres. Provincial leads will be identified, and action plans developed together with leadership from provinces.
- External evaluation by the OHSC will be carried out to determine if the facility meets the certification requirements.
- Finally, reports will be made on the state of readiness of the facility, and the training and learnings will be rolled over to the establishment of a new QLC with mentorship from the certified cluster of facilities.

Expected outcomes

The establishment of QLCs and quality improvement training is expected to improve health services across the country. The NHQIP will support the OHSC certification processes and ultimately prepare the facilities for NHI accreditation.

Where are we now?

By May 2021, Provincial NHQIP Leadership teams have identified the facilities to participate in the first QLCs, have performed in-depth SWOT analyses in these QLCs, identifying priorities for immediate action, and the first training sessions will be rolled out in early June 2021.

Rapid review of South African quality improvement and assurance programmes

Introduction

The delivery of quality health care is a constitutional obligation in South Africa. The 2019 Lancet Global Health Commission on High Quality Health Systems Report for South Africa found that there is a wide range of quality improvement (QI) and quality assurance (QA) programmes being delivered by government, non-governmental organisations (NGOs), and academic and research institutions in South Africa.¹ However, there is little collaboration between the different bodies responsible, duplication of efforts, and often confusion in the leadership of programmes. This is exacerbated by capacity weaknesses within the public sector, leading to many of the QI programmes being driven by external organisations and donors. Hence, the lasting impact of quality-improvement initiatives is limited.

The Better Health Programme South Africa has the mandate to support the Government to strengthen the quality of care in the country. To clearly understand the potential and opportunities for the programme, BHPSA undertook a rapid review of the current QI/QA landscape. This review identified key areas for QI/QA strengthening for future work.

This document is a brief summary of the 33-page report *Rapid review of national QI/QA programmes, issues of alignment and opportunities*, July 2020.

¹ South African Lancet National Commission. Confronting the right to ethical and accountable quality health care in South Africa: A consensus report. Pretoria: National Department of Health, 2019.

Context for QI/QA

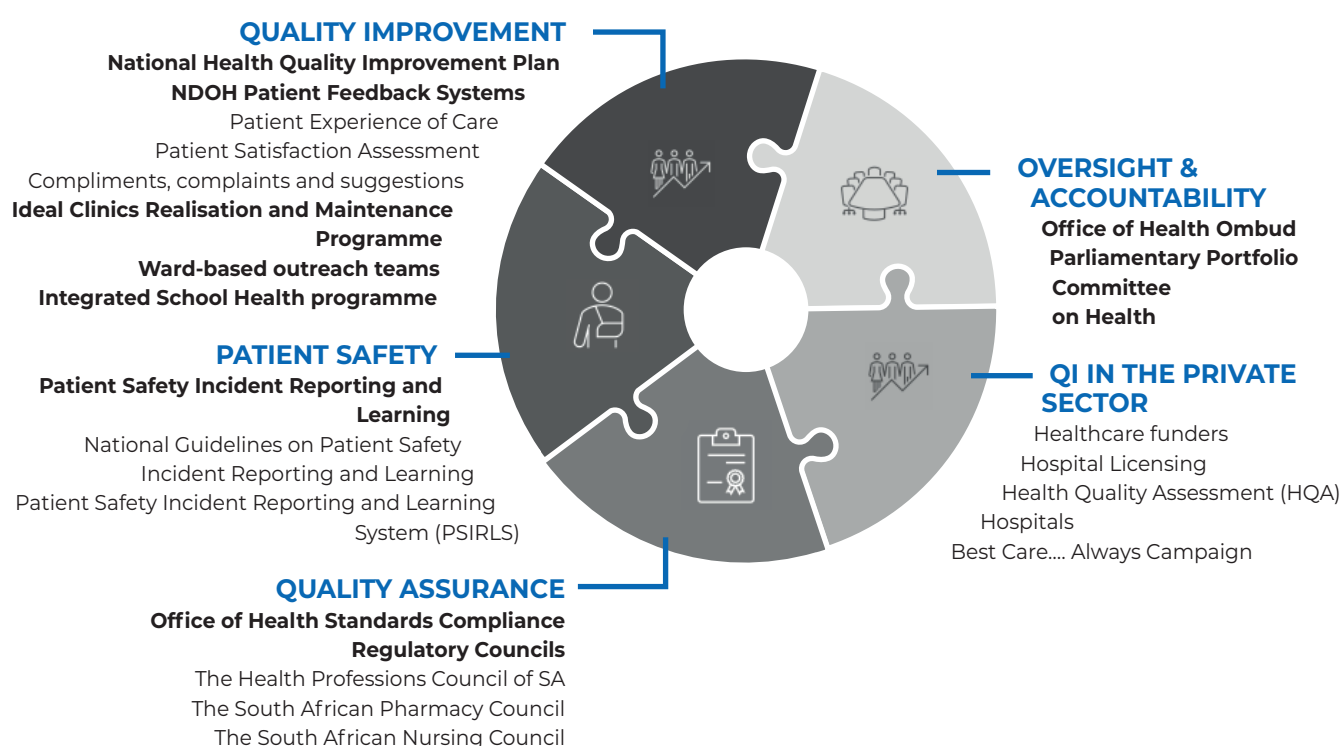
The policy context for strengthening QI/QA is favourable. In the past few years key processes and events have provided the impetus for health sector reform. These are:

- **The National Health Insurance (NHI) Bill and associated policy papers.** NHI aims to “achieve the progressive realisation of the right of access to quality personal health care services”.
- **South African Lancet National Commission - Confronting the right to ethical and accountable quality health care in South Africa: A consensus report (National Department of Health, 2019).** This identified gaps in health governance, human resources for health, health information systems and other areas that are causing poor quality care and ultimately, avoidable loss of lives. A key recommendation was to revolutionise the quality of care.
- **Development of a national strategic framework for a high-quality health system in South Africa (Begg et al, 2018).** This consensus document defined core quality dimensions as safe, timely, equitable, efficient, effective, accessible and people-centred, and proposed a framework to achieve this.
- **Presidential Health Summit:** Strengthening the South African Health System towards an integrated and unified health system (2018). This national multi-partner summit identified key health systems weaknesses. Six of the recommendations were related to quality improvement.

Overview of QA/QI programmes

Figure 1 below describes the six key and interlocking areas of quality improvement and quality assurance in South Africa.

■ Figure 1: QA and QI programmes and initiatives



These QI/QA programmes are managed by many entities at different levels across the health sector as shown in Figure 2 on page four.

Gaps and challenges

The review identified key areas in the QI/QA arena that call for strengthening and improvement. Many of these issues can initially be enunciated in an overarching and coherent QI strategy or framework and then achieved through careful monitoring and implementation of such a framework.

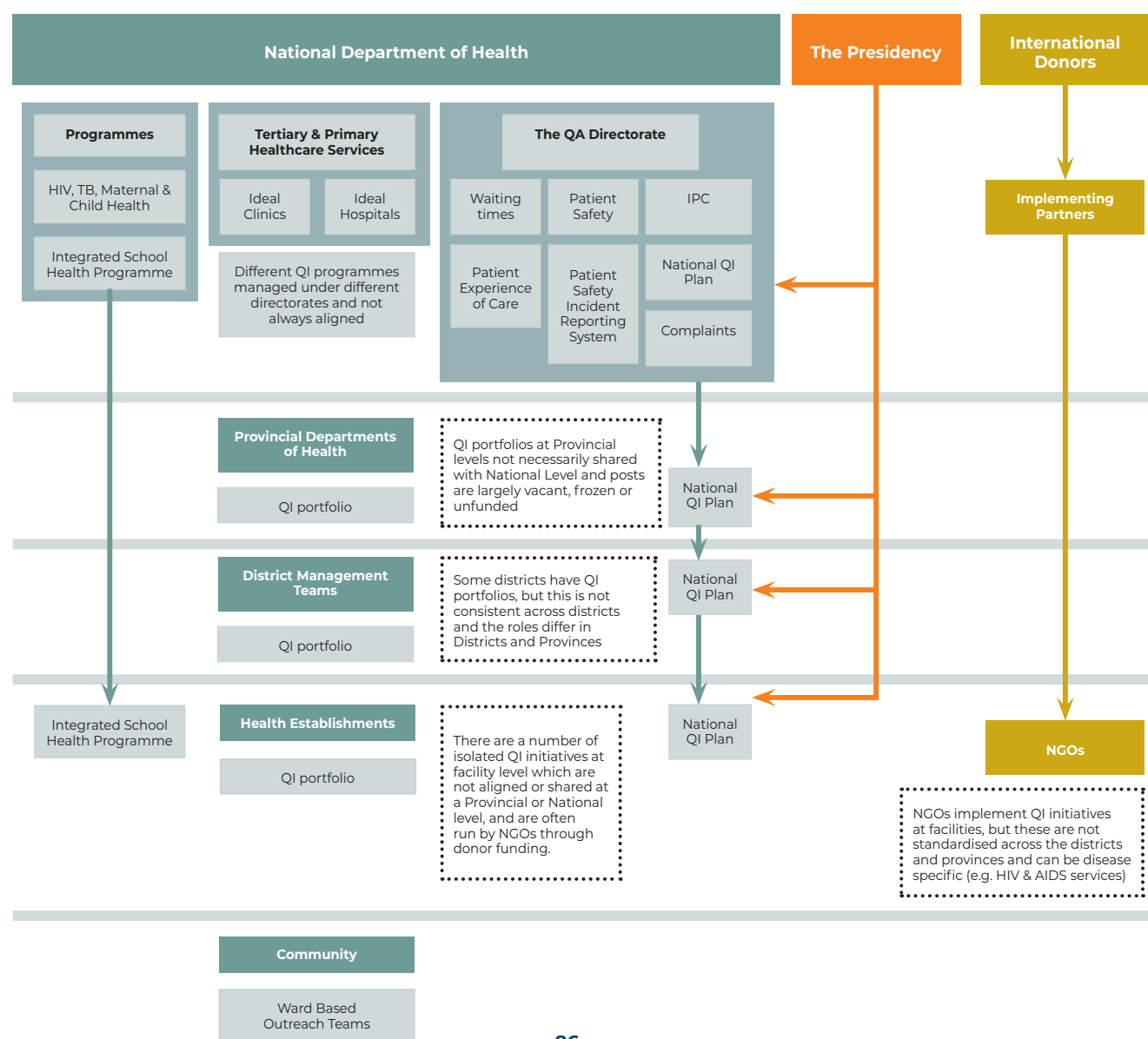
- **Agreed definitions for quality.** Currently there are no local generally agreed definitions for quality. Terms such as 'quality assurance' and 'quality improvement' are used interchangeably. Patient safety sometimes is incorporated as part of a wider definition of QI and sometimes stands alone. This lack of standardisation results

in institutional confusion and a general lack of coherence between interventions.

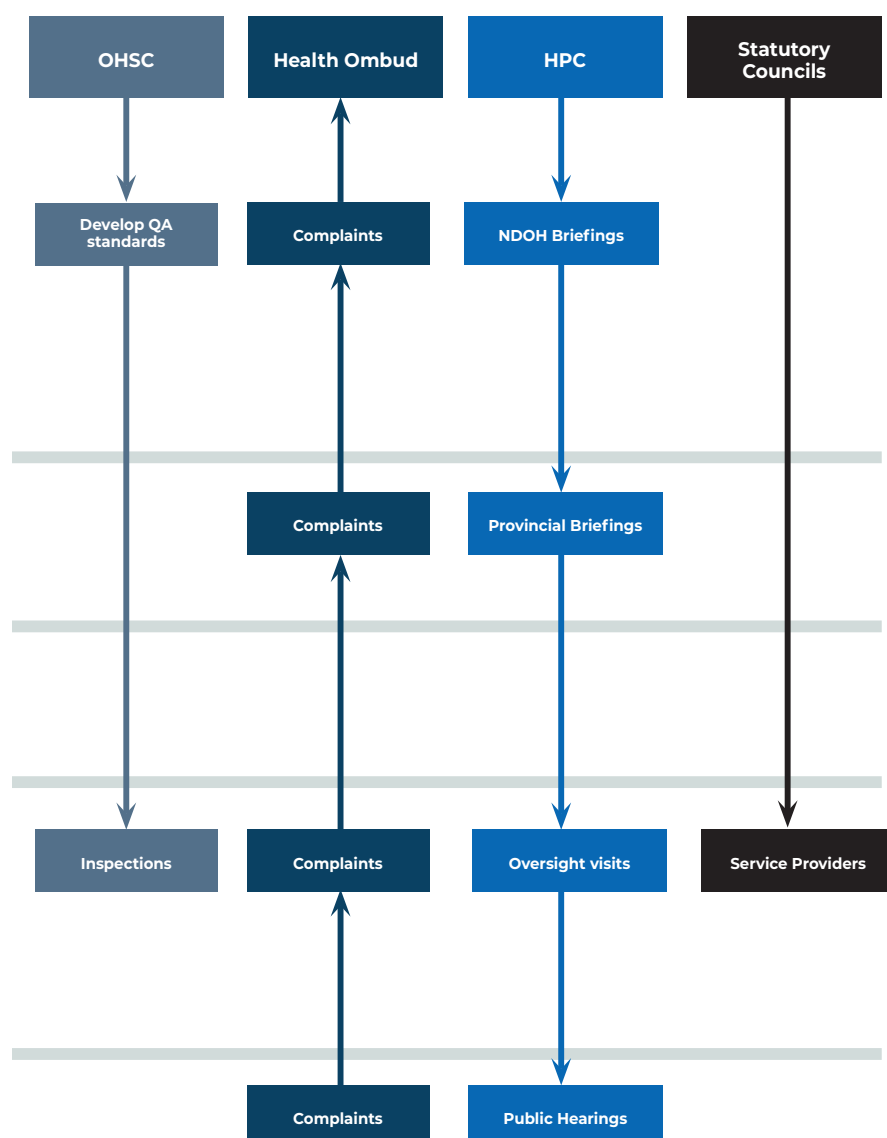
- **The continuum of quality-enhancing interventions.** QI happens at all levels of the system, and is a set of behaviours as opposed to one programme. Policy and strategy should embrace the notion that while there are a number of quality-enhancing interventions, some must come before others. Currently there is an attempt to support all processes equally, which creates confusion. For example, there is confusion about the role of the regulatory process to certify health institutions and the role of NDoH to drive ongoing improvement.
- **National QI/QA messaging and campaigns.** Although the aim is to deliver quality health this is not backed up by clear and powerful quality of care campaigns in the public sector.

- **QI at the heart of leadership.** Quality of care and improvement should be at the heart of what drives the work of hospital or clinic managers. This is often assumed but many of these individuals require the necessary capacity development to understand what this entails in practice.
- **Leading and coordinating system-wide quality management.** NDoH is currently structured in a way that means quality is mainstreamed across all programmes with only a small and largely under resourced QA unit at the level of directorate. The current objectives of the directorate are limited to a few QI interventions, such as patient safety and patient experience of care. The current budget and human resource constraints of the directorate prevent it from offering overall leadership and coordination of a national response to improving quality of health services.
- **QI 'projectness'.** There is evidence that staff in health establishments are fatigued by a succession of once-off QI projects.
- **Standard metrics to monitor and measure outcomes, and the sharing of data.** It is important to align the data collection and monitoring systems across the health sector. Currently there is no standard set of QI indicators, instead there are those monitored through the Ideal Clinic, the EWS indicators monitored by the OHSC, and the results of the PEC, PSIRL and Patient Safety Assessment which are analysed at a national level but results are not widely distributed. The standardisation and the sharing of data and analyses will ultimately improve co-ordination and implementation of quality strategies at scale.

■ Figure 2: Responsibility for QA/QI programmes



- **QI at the heart of leadership.** Quality of care and improvement should be at the heart of what drives the work of hospital or clinic managers. This is often assumed but many of these individuals require the necessary capacity development to understand what this entails in practice.
- **Leading and coordinating system-wide quality management.** NDoH is currently structured in a way that means quality is mainstreamed across all programmes with only a small and largely under resourced QA unit at the level of directorate. The current objectives of the directorate are limited to a few QI interventions, such as patient safety and patient experience of care. The current budget and human resource constraints of the directorate prevent it from offering overall leadership and coordination of a national response to improving quality of health services.
- **QI 'projectness'.** There is evidence that staff in health establishments are fatigued by a succession of once-off QI projects.
- **Standard metrics to monitor and measure outcomes, and the sharing of data.** It is important to align the data collection and monitoring systems across the health sector. Currently there is no standard set of QI indicators, instead there are those monitored through the Ideal Clinic, the EWS indicators monitored by the OHSC, and the results of the PEC, PSIRL and Patient Safety Assessment which are analysed at a national level but results are not widely distributed. The standardisation and the sharing of data and analyses will ultimately improve co-ordination and implementation of quality strategies at scale.



Shielding and COVID-19

This fact sheet is based on a webinar co-hosted in April 2021 by the South African National Department of Health (NDoH) and the World Health Organization Africa (WHO Africa) and supported by the Better Health Programme, South Africa.

The recording of the webinar is available at: <https://youtu.be/Hz5a33J-NcA>

WHAT IS SHIELDING?

Shielding is a term used to describe the protection of individuals at high risk of severe COVID-19 illness by separating them from the general population. Shielding is most important when infection rates in a community are high.

Shielding has been interpreted in different ways. In some countries, shielding means helping vulnerable people to live safely and separately from their families and neighbours until COVID-19 can be controlled, or vaccine and treatment options become available. In the South African context, it may include the separation of individuals at high risk in a designated space within the same household.

Key messages on shielding

Key messages on shielding for vulnerable people cover ideal behavior. For example

1. Stay at home and do not have visitors to the house.
2. Adopt safe behaviours inside and outside the home. These include:
 - Keep a physical distance from others;
 - Avoid crowds, close contact and confined spaces;
 - Wear an appropriate face mask;
 - Sit outside, when convenient;
 - Ensure good ventilation, keep windows and doors open;
 - Wash hands frequently;
 - Use sanitisers, if available;
 - Seek medical assistance, if unwell; and
 - Continue to take your medications as directed.

A comprehensive approach to shielding may not be practical or possible in most South African communities, but vulnerable people should still be able to practice physical distancing, wear facemasks and wash hands frequently.

WHO SHOULD BE SHIELDED?

Research in South Africa has identified the most vulnerable groups for severe COVID-19 disease and death according to the following risk factors:

- 1. Age** is the most important risk factor for severe COVID-19, with the probability of death increasing strongly for those over the age of 59 years.

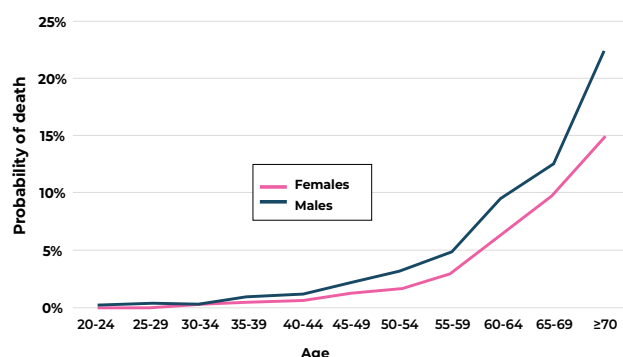


Figure 1: Probability of death by 30 days since COVID-19 diagnosis by age (adjusted for comorbidities)

Source: SA hospital data

- 2. People with uncontrolled diabetes and hypertension** are extremely vulnerable to poor COVID-19 outcomes.
- 3. Other comorbidities** also increase the risk of severe death and disease. The most important of these are obesity, uncontrolled HIV and TB, and kidney disease.

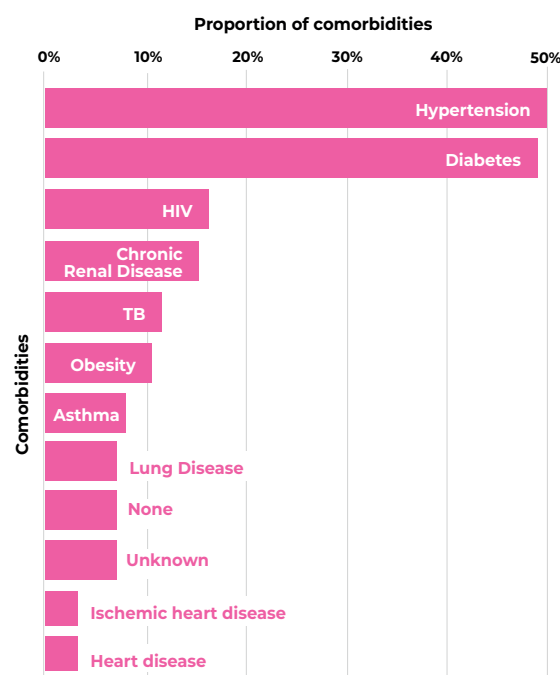


Figure 2: Proportion of comorbidities and deaths at Groote Schuur Hospital

Source: NDoH presentation, 2020

APPROACHES TO SHIELDING

Shielding is not always practical or possible, for example where people live in crowded conditions, and other approaches should be used.

1. Information, Education and Communication (IEC) campaigns on shielding

People with vulnerabilities, and their families, carers and communities need correct information and advice about their COVID-19 risk, and the strategies they can use to minimise it. IEC campaigns could be conducted in all communities.

Booklets on shielding and COVID-19 are widely available. For example, the Knowledge Translation Unit of the University of Cape Town have produced a series of pamphlets, which are available in English, Afrikaans and isiXhosa, and can be downloaded from their website at <https://www.coronawise.org.za/>

2. Community shielding programmes

The NGO Médecins Sans Frontières (MSF) has implemented a pilot community-based shielding programme in two areas of KwaZulu Natal. The programme involves community leaders including isindunas, and is implemented by community health workers (CHWs) who identify those who are at risk.

CHWs provide education, including pamphlets on COVID-19, and help affected families identify green or safe zones for the vulnerable person in their homestead. They also identify a trusted person who will collect grants, medication and shopping so that the vulnerable person does not have to go out. A COVID-19 champion is appointed who continues educating the community on COVID-19.

3. Health system strategies

Alongside shielding there are several strategies that are necessary to protect vulnerable groups from COVID-19. These include:

- Promoting early health seeking behaviours and intensifying screening and point-of-care diagnosis for noncommunicable diseases.
- Increasing COVID-19 testing.
- Providing vaccinations for people most at risk.

Shielding may be harmful

Shielding can protect the vulnerable against COVID-19 but it can also have negative effects for vulnerable people. These are:

- Decreased physical activity;
- Social isolation and loneliness;
- Mental health problems such as anxiety;
- Impaired care and health-seeking; and
- Loss of income.

Shielding after vaccination

Once a vulnerable person has been vaccinated it is still important for them to protect themselves. This is because no vaccination can be guaranteed to give 100% protection to every person.

Many countries recommend that fully vaccinated people should continue to wear masks outside the home and avoid crowded or high-risk settings, particularly when COVID transmission is high.

ADDITIONAL RESOURCES

Social Science in Humanitarian Action Platform:

- [Key considerations: emerging evidence on shielding vulnerable groups during COVID-19.](#)

SA pilot and training materials, MSF

- [Shielding programme for vulnerable community members during the COVID-19 epidemic](#)
- [Shielding programme, induction and training](#)

World Health Organization

- [Technical guidance on coronavirus disease \(COVID-19\)](#)
- [Maintaining essential health services: operational guidance for the COVID-19 context interim guidance](#)

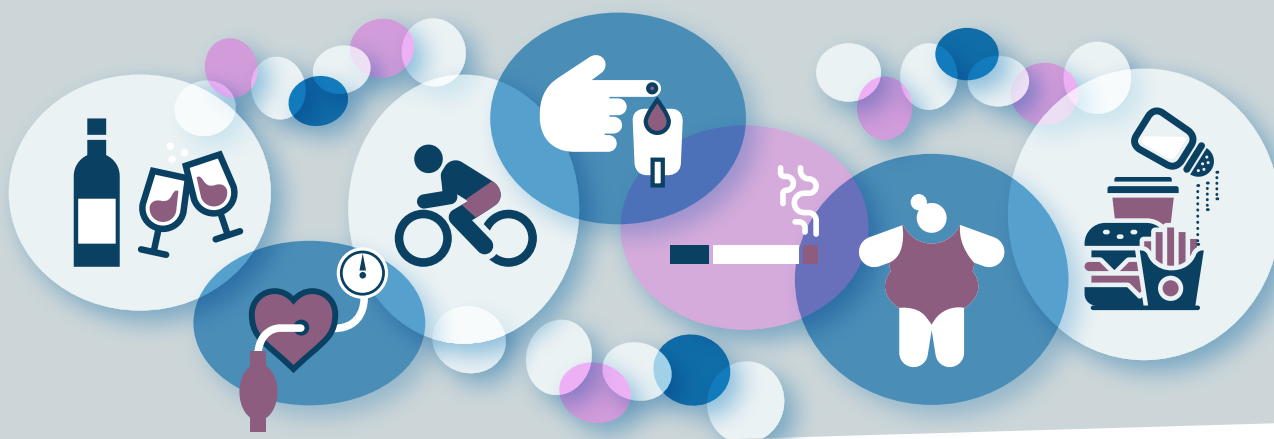
UK government

- [Guidance on shielding and protecting who are clinically extremely vulnerable to COVID-19](#)

More guidance is available on the [annotated resource list](#) provided in the webinar.

NCDS, UHC AND NHI

UNPACKING THE LINKS – AND THE ACRONYMS



UHC

The World Health Organization (WHO) describes Universal Health Coverage (UHC) as health care where “all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course.”¹ UHC was one of the targets set when world leaders adopted the Sustainable Development Goals (SDGs) in 2015.

South Africa has confirmed its commitment to UHC and has translated it into a concrete programme – National Health Insurance (NHI) – which aims to provide universal, quality health care to all South Africans regardless of their socio-economic status. Currently, Parliament is hearing submissions on the NHI Bill of 2019, which is in its final stages.

NCDS

The rising global burden of noncommunicable diseases (NCDs) and its economic cost have long been of concern to world leaders who have committed to addressing NCDs at UN General Assembly high-level meetings since 2011. In 2016, NCDs were included in SDG Target 3.4: “By 2030, reduce by one-third,

premature mortality from NCDs through prevention and treatment and promote mental health and well-being”.

The 2018 UN General Assembly identified the key NCDs as cardiovascular disease, chronic respiratory diseases, cancer, diabetes, and mental health conditions, which together cause 71% of deaths worldwide. Key NCD risks are unhealthy diet, tobacco use, air pollution, harmful use of alcohol and physical inactivity.²

The 2020 Lancet NCDs and injuries (NCDI) Poverty Commission argues for a broader approach that includes those NCDs not linked to preventable risk behaviour, which disproportionately impact the poor. These are type 1 and malnutrition-associated diabetes, rheumatic heart disease, childhood cancers, asthma, chronic kidney disease, epilepsy, mental health conditions, trauma, and other conditions. The Commission investigated the impact of NCDI Poverty for the world's poorest billion and found that NCDIs constitute more than a third of the disease burden; around half of this burden is due to causes afflicting children and young adults.³

¹ [https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc))

² World Health Organization. (2018). Third United Nations high-level meeting on NCDs. In WHO <https://www.who.int/ncds/governance/third-un-meeting/en>.

³ Bukhman, G., Mocumbi, A. O., Atun, R., Becker, A. E., Bhutta, Z., Binagwaho, A., ... & Wroe, E. B. (2020). The Lancet NCDI Poverty Commission: bridging a gap in universal health coverage for the poorest billion. *The Lancet*, 396(10256), 991-1044.

NCDs IN SOUTH AFRICA

The true scale of NCDs in South Africa is difficult to estimate with any certainty due to data challenges and the complexity of NCD conditions. However, many studies point to a heavy burden of disease with the WHO estimating that NCDs accounted for 51% of all deaths in the country in 2016.⁴

The 2010 Burden of Disease study by the SA Medical Research Council (SAMRC) showed that by 2010, NCDs accounted for 39% of total deaths in South Africa.⁵ More than a third (36%) of these deaths occurred in people younger than 60 years, ostensibly the economically productive workforce. While overall mortality from NCDs declined slightly (by 0.4%) between 1997 and 2010, trends for different diseases varied. For example, there was an increase in mortality from diabetes mellitus, renal disease and endocrine/nutritional and blood disorders, which was attributed to lifestyle changes. The decrease in mortality rates from ischaemic heart disease, lung cancer, chronic obstructive pulmonary disease and asthma was attributed to the effects of tobacco control interventions.

The annual SAMRC report on mortality discusses the probability of dying prematurely, between the ages of 30 and 70 years, due to an NCD. In 2017, this probability was 34% for males, 24% for females, and 29% overall, with no significant change between 2011 and 2016. The highest single cause of death from NCDs was cardiovascular disease, followed by cancer, diabetes and chronic respiratory disease.⁶

This epidemic of NCDs is not confined to urban areas. One study in rural KwaZulu-Natal found that out of 570 people screened 71% were obese, 33% had hypertension, 20% had high blood cholesterol and 12% had major depressive symptoms.⁷

Obesity, in itself considered an NCD as well as a major risk factor for other NCDs, is a serious condition among female South Africans. A 2016 survey in South Africa found that 27% of women were overweight, and 41% were obese (a fifth were severely obese). The majority of men were in the normal range, with 31% being overweight or obese.⁸

NCDs AND UHC

The Lancet NCDI Poverty Commission concluded that NCDI poverty is one of the largest gaps and largest opportunities for UHC. “The Commission shows that addressing NCDIs is key to achieving progress towards universal health coverage (UHC), with NCDIs

accounting for 60–70% of the UHC financing needs in the low-income and lower middle-income countries”.⁹

The global NCD Alliance argues that the NCD epidemic poses a unique challenge to three dimensions of UHC. Firstly, access and availability to essential NCD services remains unacceptably low in many low- and middle-income countries (LMICs); secondly, major inequalities exist in terms of NCD risk, access to services, and health outcomes; and thirdly, the NCD epidemic imposes a huge economic burden on national budgets and can push households into poverty. Achievement of UHC will therefore be dependent on prioritising NCD prevention and control in UHC design.¹⁰

On the other hand, the Alliance argues that lessons learned from the NCD response can help support pathways to UHC. These include a focus on health promotion and prevention, multisectoral approaches, addressing the social and commercial determinants of health, and domestic innovative financing mechanisms (including taxation on unhealthy products). Reducing the NCD burden will also strengthen a country's capacity to achieve universal health access by reducing the huge economic burden these diseases place on the state.

The WHO's Global Action Plan for the Control of NCDs 2013–2020 recommends that countries strengthen their health systems and address NCDs through people-centred primary healthcare (PHC) and UHC. Recommendations include ‘Best Buys’, guidance on the most cost-effective interventions to prevent NCDs, which include the WHO Package of Essential Noncommunicable disease interventions (WHO PEN), cost-effective interventions for the early detection and management of NCDs.¹¹ More recently, PEN-Plus has emerged as an integrated strategy that builds on the WHO PEN to increase the quality of services for severe chronic NCDs at primary referral facilities and focuses on the broader set of conditions relating to NCDI Poverty.¹²

SA'S NCD SERVICE GAP

There is no comprehensive analysis of access to NCD screening, treatment, support and prevention services in South Africa, but several studies suggest that there are significant NCD service gaps.

Studies primarily focussed on HIV screening point to high levels of undiagnosed NCDs. For example, a recent study in northern KwaZulu-Natal screened over 17,000 HIV-positive people for diabetes, high blood pressure, nutritional status (obesity and malnutrition), tobacco and alcohol use, as well as HIV and tuberculosis. The study found that the majority of people with tuberculosis, diabetes or hypertension were either undiagnosed or not well controlled. Among the study participants, half of those 15 years

4 World Health Organization. (2018) Noncommunicable Diseases (NCD) Country Profiles: South Africa. https://www.who.int/nmh/countries/zaf_en.pdf

5 Nojilana, B., Bradshaw, D., Pillay-van Wyk, V., Msemburi, W., Somdyala, N., Joubert, J. D., ... & Dorrington, R. E. (2016). Persistent burden from non-communicable diseases in South Africa needs strong action. *South African Medical Journal*, 106(5), 436–437.

6 Dorrington, R.E., Bradshaw, D., Laubscher, R., Nannan, N. (2019). Rapid mortality surveillance report, 2017. Cape Town: South African Medical Research Council. ISBN: 978-1-928340-36-2.

7 Van Heerden, A., Barnabas, R. V., Norris, S. A., Micklesfield, L. K., van Rooyen, H., & Celum, C. (2017). High prevalence of HIV and non-communicable disease (NCD) risk factors in rural KwaZulu-Natal, South Africa. *Journal of the International AIDS Society*, 20(2), e25012.

8 National Department of Health (NDoH), Statistics South Africa (Stats SA), South African Medical Research Council (SAMRC), and ICF. (2019). South Africa demographic and health survey 2016. *Pretoria, South Africa*.

9 Zuccala, E., Horton, R. Reframing the NCD agenda: a matter of justice and equity. (2020) *The Lancet* 396 (10256) 939–940.

10 NCD Alliance. Policy Brief: Universal Health Coverage and noncommunicable diseases, a mutually reinforcing agenda. 2014 https://ncdalliance.org/sites/default/files/resource_files/UHC%20and%20NCDs%202014_A4_final_web.pdf

11 Tesema, A. G., Ajisegiri, W. S., Abimbola, S., Balane, C., Kengne, A. P., Shiferaw, F., ... & Peiris, D. (2020). How well are non-communicable disease services being integrated into primary health care in Africa: a review of progress against World Health Organization's African regional targets. *PLoS one*, 15(10), e0240984.

12 <http://www.ncdipoverty.org/penplus-implementation-rfi>

and older had at least one active disease, and 12% had two or more diseases.¹³

Another study reviewed case folders from nine primary care centres in Cape Town of 491 adolescents (10–24 years) living with HIV and found limited NCD screening and health promotion.¹⁴ Only 55% of folders had any information on other comorbidities, and only 62% had information on risk factors. Of the participants with documented comorbidities, 11% had an NCD diagnosis, with chronic respiratory diseases (60%) and mental disorders (37%) being most common. Despite this, only one participant was documented as receiving treatment for asthma. Of those with documented anthropometrics, 48% were overweight or obese. Only 26% had a documented health-promoting intervention. A key finding of this study was that poor documentation and screening demonstrates missed opportunities for detecting NCDs and NCD risk in primary health care, and for early intervention.

NCDs may be poorly controlled after diagnosis and initiation of care. For example, the 2019 Western Cape Burden of Disease review found that around 70% of diabetics in care had uncontrolled glucose levels.¹⁵

NCDs, NHI AND UHC

Closing the NCD service gap is fundamental to achieving UHC through NHI. This includes scaling up screening and treatment for NCDs as well as prevention through health promotion and addressing structural determinants of key NCD risks. Fundamental to this challenge is the strengthening of health information systems to provide timely and accurate data on NCDs and the NCD service gap.

The SA National Strategic Plan for NCDs, which is currently in development, commits the country to the SGD target of reducing NCDs by one third, by 2030. It is an integrated 'whole-of-health' plan that relies on multisectoral collaboration to address all aspects of NCDs. However, there are concerns that the NHI

Bill in its current form is heavily focussed on curative aspects of NCDs.¹⁶ A team commenting in *BMJ Global Health* concluded that this is a challenge common to many African countries: "The political will for UHC in Africa will miss the opportunity to turn the tide of this emerging NCD epidemic in Africa, if not oriented to a systems-for-health rather than a solely healthcare-centric approach. A successful approach needs to proactively incorporate wider health determinants (sectors)—housing, planning, waste management, education, governance and finance,

among others—in strategies to improve health. This includes aligning governance and accountability

mechanisms and strategic objectives of all 'health determinant' sectors for health creation and long-term cost savings."¹⁷

BHPSA is supporting the NDoH to close the NCD gap as one of the pathways to achieving UHC.

The work includes strengthening the national policy environment, community outreach and digital data sets for NCDs.

Key policy support has been for the development of the new multisectoral NCD NSP (2021–2026) and the five-year National Obesity Strategy (2021–2026). BHPSA is also supporting the strengthening of the NCD component in community health worker training through revising the training module and an implementation pilot.

[Read more about BHPSA support for NCDs and UHC here](#)

¹³ Wong, E. B., Olivier, S., Gunda, R., Koole, O., Surujdeen, A., Gareta, D., ... & Harilall, S. (2021). Convergence of infectious and non-communicable disease epidemics in rural South Africa: a cross-sectional, population-based multimorbidity study. *The Lancet Global Health*, 9(7), e967–e976.

¹⁴ Kamkuemah, M., Gausi, B., & Oni, T. (2020). Missed opportunities for NCD multimorbidity prevention in adolescents and youth living with HIV in urban South Africa. *BMC public health*, 20, 1–11.

¹⁵ *ibid*

¹⁶ Freeman, M., Simmonds, J. E., & Parry, C. D. H. (2020). Health promotion: How government can ensure that the National Health Insurance Fund has a fighting chance. *SAMJ: South African Medical Journal*, 110(3), 188–191.

¹⁷ Oni, T., Mogo, E., Ahmed, A., & Davies, J. I. (2019). Breaking down the silos of Universal Health Coverage: towards systems for the primary prevention of non-communicable diseases in Africa. *BMJ global health*, 4(4), e001717.



GENDER AND OBESITY IN SOUTH AFRICA



What is the relationship between gender and obesity in South Africa and how is this changing over time? This rapid BHPSA report delves into a range of recent research reports and older national surveys to try and shed some light on this serious and growing problem.

MEN AND WOMEN

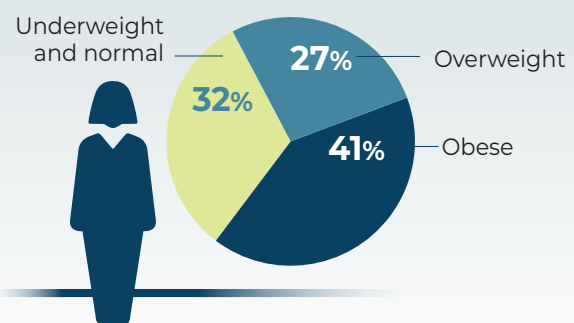
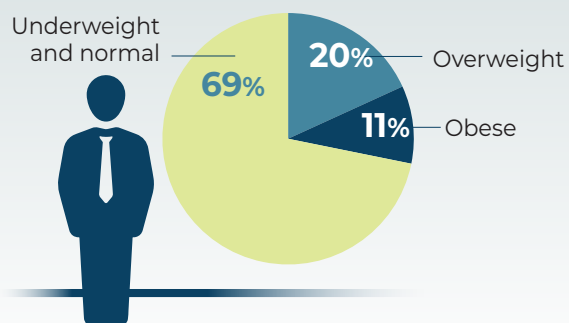


Figure 1: Prevalence of obesity and overweight in adult South Africans, 2016

The most recent national survey, the SA Demographic Health Survey (SADHS) of 2016 shows that more than two thirds of South African (SA) women have serious problems with their weight.¹ This alarming fraction can be broken

¹ National Department of Health (NDoH), Statistics South Africa (Stats SA), South African Medical Research Council (SAMRC), and ICF. (2019) *SA Demographic Health Survey, 2016*. 9. Pretoria, South Africa, and Rockville, Maryland, USA.

down into the 27% who are overweight and the 41% who are obese (one fifth of those, seriously so).² These figures are very similar to those from another national survey of 2012, which shows that one quarter of SA women are overweight and 40.1% were obese.³

Both the above surveys found that overweight and obesity among women was around double that of men. For example, in the SADHS only 32% of women had normal weight or were underweight in comparison with 69% of men.

Many other smaller, but more recent, studies show the same gender disparity. For example, a 2021 article looking at noncommunicable diseases (NCDs) and HIV among adults attending a clinic in urban Soweto found that 46.8% of women were overweight or obese in comparison with 19.7% of men.⁴ Another study in rural KwaZulu-Natal found that 60% of the female participants were obese compared with 19% of the men.⁵

INCREASING PREVALENCE

The female obesity crisis has been gathering pace for decades. The SADHS shows that the prevalence of overweight or obesity increased from 56% in 1998 to 68% in 2016.⁶ Figure 2 shows the findings of the 2020 Global Nutrition Report, which used modelling and a range of sources to chart the increase in obesity and overweight among SA adults, male and females between 2005 and 2020.⁷

GIRLS AND BOYS

In South Africa gender disparities in overweight are present from childhood. The 2012 SANHANES 1 study found that the prevalence of overweight was significantly higher in girls aged 2 to 14 years than in boys (16.5% and 11.5% respectively), as was obesity, which affected 7.1% of girls and 4.7% of boys.⁸

A cross sectional study among school learners (aged 7 to 18 years) in the Western Cape found that 19.7% of girls were overweight in comparison with 9.4% of boys, while 9.1% of girls and 4.5% of boys were obese.⁹ The same pattern is also seen in a rural municipality in Limpopo province where girls were nearly three times more likely to be overweight or obese than boys.¹⁰

WHY THE “TWO O’s” MATTER

Many people who are overweight or obese are also fit and healthy, but they are predisposed to serious NCDs such as heart problems, high blood pressure and diabetes. In South Africa these diseases account for over half of all premature deaths each year.¹¹ For this reason, the “two O’s” are seen as a major public health challenge.

One recent study tracked healthy overweight/obese individuals in Southern Africa over ten years and found that at least half of them developed metabolic syndrome. Metabolic syndrome is a cluster of

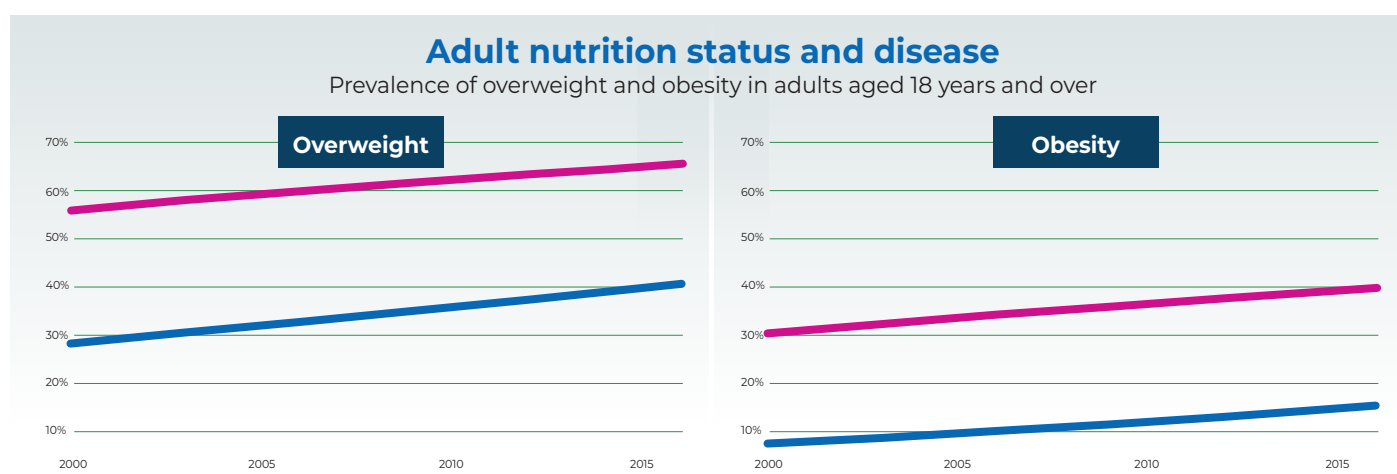


Figure 2: Increase in prevalence of overweight and obesity among SA adults

2 Overweight is described as weight for height or Body Mass Index (BMI). Overweight is defined as a BMI of 25-29.9, obese is BMI 30 and above, severely obese is BMI 35.

3 Shisana, O., Labadarios, D., Rehle, T. et al. (2014) *The South African National Health and Nutrition Examination Survey, 2012: SANHANES-1: the health and nutritional status of the nation*. 2014 (ed). Cape Town: HSRC Press.

4 Hopkins, K., Hlongwane, K., Otjombe et al. (2021) The substantial burden of non-communicable diseases and HIV-comorbidity amongst adults: Screening results from an integrated HIV testing services clinic for adults in Soweto, South Africa. *The Lancet* DOI: <https://doi.org/10.1016/j.eclinm.2021.101015>

5 Kushitor, B., Sanuade, O., and PhD; L Baatiema, L et al. (2021) Non-communicable disease comorbidities in KwaZulu-Natal Province, South Africa. *S Afr Med J* 2021;111(2):149-158. <https://doi.org/10.7196/SAMJ.2021.v111i2.14744>

6 NDoH 2019, op. cit.

7 Global Nutrition Report 2020. <https://globalnutritionreport.org/resources/nutrition-profiles/africa/southern-africa/south-africa/>

8 Shisana et al 2014, Op cit.

9 Negash, S., Agyemang, C., Matsha, T.E. et al. (2017) Differential prevalence and associations of overweight and obesity by gender and population group among school learners in South Africa: a cross-sectional study. *BMC Obes* 4, 29. <https://doi.org/10.1186/s40608-017-0165-1>

10 Debeila S, Modjadji P, Madiba S. High prevalence of overall overweight/obesity and abdominal obesity amongst adolescents: An emerging nutritional problem in rural high schools in Limpopo Province, South Africa. *Afr J Prim Health Care Fam Med*. 2021;13(1), a2596. <https://doi.org/10.4102/phcfm.v13i1.2596>

11 WHO, Factsheet. South Africa. https://www.who.int/nmh/countries/zaf_en.pdf

diseases, including obesity, high blood pressure, high blood cholesterol and insulin resistance (a precursor to diabetes). At baseline more than a quarter of women and around 10% of men were healthily overweight or obese, but after ten years 12.3% of the healthy women and 4.7% of the men had developed metabolic syndrome.¹²

For many affected people, obesity and overweight are linked to NCDs from the start. In the KwaZulu-Natal study above, a higher proportion of people who were overweight and obese had hypertension (30% and 45%, respectively) compared with those who were of normal weight (12%). Approximately 14% of those who were obese were living with diabetes and of these, only around 84% of the women were on treatment, compared with 100% of the men.¹³

Research shows that the Type 2 Diabetes (T2DM) epidemic in South Africa mirrors the gendered pattern of rising obesity.¹⁴ A recent systematic review of the prevalence of T2DM in South Africa pooled the data from 11 population-based studies and concluded that T2DM prevalence was consistently higher in females compared to males, and attributed this to higher rates of obesity and insulin resistance in women compared to men.¹⁵

Childhood obesity is a strong risk factor for adult obesity and other NCDs and is therefore of great concern. In the study of Western Cape learners above, the cardio-metabolic diseases of hypertension and high blood cholesterol were already prevalent in the affected schoolchildren.¹⁶

INTERNATIONAL COMPARISONS

So how are we doing as a country? Is the female obesity crisis as severe in other parts of the world?

The short answer is 'no'.

One study comparing prevalence of BMI and obesity in 16 African countries in the SADC region found that in 2019 South Africa had the highest prevalence of obesity, with an average in adult females of 44.7%. Neighbouring countries of Swaziland and Lesotho ranked second and third with 33.9% and 31.6% respectively. The least affected countries, the DRC and Madagascar, had adult female obesity prevalence of 5.6% and 7.0% respectively. This study also showed that the percent of overweight South African women increased between 1990 and 2019 from 57% to 71.3% (a 15.3% increase) in comparison with the SADC average, which increased from 31.4% to 39.7% (an 8.3% increase).¹⁷

This gendered pattern of obesity and overweight is common in Africa and the Middle East.¹⁸ However, it is not a biological inevitability. In most high income and upper middle-income countries, the pattern is reversed in both adults and children. The 2019 Childhood Atlas of Obesity shows that, among children 5-9 years old, the prevalence of obesity was higher in boys than girls in 188 high income and upper middle-income countries. In half of these countries the prevalence in males was almost double female prevalence.¹⁹

12 Kruger, H., Ricci, C., Pieters, M., et al. (2021) Lifestyle factors associated with the transition from healthy to unhealthy adiposity among black South African adults over 10 years. *Nutrition, Metabolism and Cardiovascular Diseases*, Volume 31, Issue 7, 2021, Pages 2023-2032, ISSN 0939-4753, <https://doi.org/10.1016/j.numecd.2021.03.017>.

13 Kushitor et al, 2021, op. cit.

14 Averetta S., Stacey B., and Wanga, Y. (2014) Decomposing race and gender differences in underweight and obesity in South Africa. *Economics & Human Biology*. V15. December 2014, Pages 23-40. <https://doi.org/10.1016/j.ehb.2014.05.003>

15 Pfeiffer, C., Pillay-van Wyk, V., Turawa E., et al. (2021) Prevalence of Type 2 Diabetes in South Africa: A Systematic Review and Meta-Analysis. *Int. J. Environ. Res. Public Health* 2021, 18(11), 5868; <https://doi.org/10.3390/ijerph18115868>

16 Negash et al, 2017, op cit.

17 Gona, P., Kimokoti R., Gona C., et al. (2021) Changes in body mass index, obesity, and overweight in Southern Africa development countries, 1990 to 2019: Findings from the *Global Burden of Disease, Injuries, and Risk Factors Study*. First published: 07 May 2021. <https://doi.org/10.1002/osp4.519>

18 Kanter, R. and Caballero, B. (2012) Global Gender Disparities in Obesity: A Review. *Adv Nutr*. 2012 Jul; 3(4): 491-498. Published online 2012 Jul 6. doi: [10.3945/an.112.002063](https://doi.org/10.3945/an.112.002063)

19 Shah B, Tombeau, K., Fuller A, et al. (2020) Sex and gender differences in childhood obesity: contributing to the research agenda. *BMJ Nutrition, Prevention & Health* 2020;3:e000074. doi:10.1136/bmjnp-2020-000074

BHPSA

BETTER HEALTH PROGRAMME
SOUTH AFRICA

CASE STUDY

MAY 2022



“We are still caught up in project-based digital health interventionism - we have so many siloed systems we call it ‘pilotitis’.”

*Simon Ndira,
CEO CompellingWorks and Cooper/Smith
Malawi Country Director*

DIGITAL HEALTH IN THE REAL WORLD

On May 5, 2022, Mott MacDonald hosted a side session at the Global Digital Development Forum¹, a virtual conference on major digital themes relevant to international development.

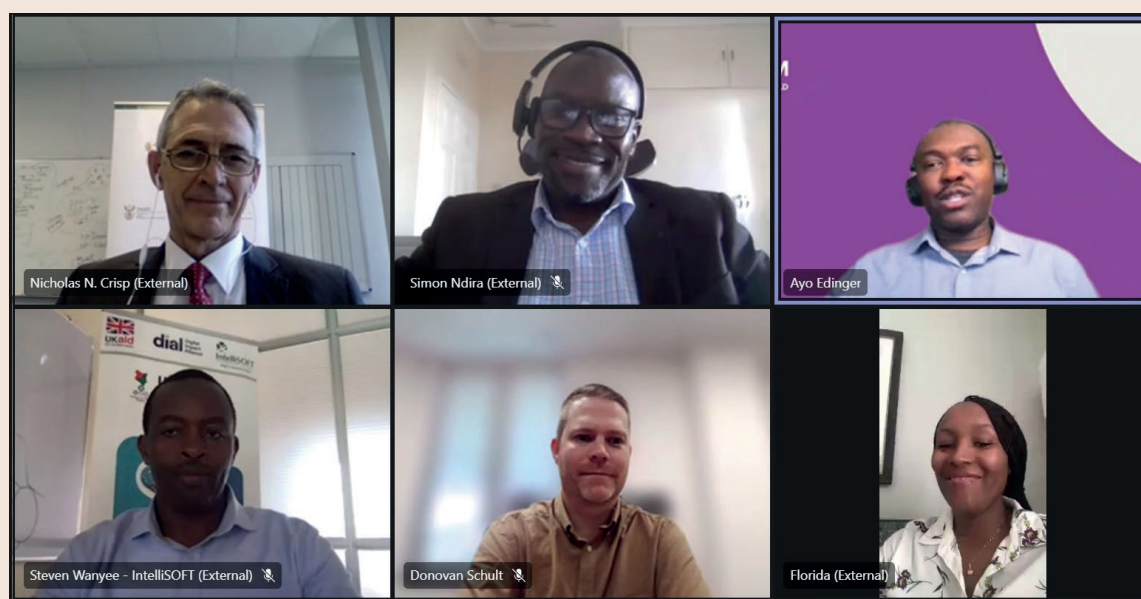
Mott MacDonald’s session illustrated the Forum’s theme of locally led development by bringing in country-based experts from Malawi, Kenya, South Africa and Tanzania to share their experiences and insights from the frontlines of digital health implementation. They spoke on the disparity between well-intentioned digital interventions and implementation realities in sub-Saharan Africa. Mott MacDonald’s Global Digital Health Consultant, Ayo Edinger ably facilitated the conversation.

THE CHALLENGE OF INTEROPERABILITY

A central problem was identified by all speakers: the plethora of local projects and solutions which fail to support an integrated national health information system.

Speaking of Mott MacDonald’s experience of Malawi’s HIV data programme, Dr Simon Ndira said, “While there are good intentions from health development partners as well as from government and all the key stakeholders on the ground, we have issues around interoperability and around standards.” Dr Nicholas Crisp, Deputy Director General in the South African Department of Health agreed. “We have quite nice pretty-looking apps and other programmes that can tell you all about HIV in a certain district, or COVID in a certain district,” he said. “But they can’t tell you whether that person

¹ <https://digitaldevforum.com/>



Participants in the panel (clockwise): Dr Nicholas Crisp, Deputy Director, National Health Insurance, South Africa; Dr Simon Ndira, Cooper/Smith Country Director, Malawi; Ayo Edinger, Senior Global Digital Health Consultant, Mott MacDonald, UK; Dr Florida Muro, Head of Community Health Department, Tanzania; Donovan Schult, IT Manager, MPAMOT South Africa; Steven Wanyee, IntelliSOFT Consulting, Kenya

had a test, or whether they got their medicines, or whether they are the same person that we saw this week - or last week."

The South African government's answer to this challenge is to develop one national patient-centred system in which each service user has a unique registration number (HPRS). All relevant health information for that patient will be on their file and owned by the patient. Health professionals and planners will have access to elements of the data as needed. The HPRS, which has already registered 57 million people, will be the digital basis of the proposed National Health Insurance system.

"That's not to say we can't use mHealth and other apps going forward," said Crisp. "We will still be able to do that for teaching, conveying information and so on, but we need a proper integrated patient information system if we're really going to look after people properly."

THE CHALLENGE OF UPTAKE

Another problem shared by many countries is the challenge of persuading health workers and service users to embrace digital solutions. Dr Florida Muro, Head of the Community Health Department in Tanzania, described some findings from Mott MacDonald's evaluation of Tanzania's immunisation data programme. Most health workers at primary care level responded enthusiastically to a system that would replace the laborious paper-based record keeping. But older staff were hesitant. "They had fear of technology and many of them would call themselves BBC, which means "born before

computers," said Muro. "When they label themselves like this, already they feel less competent." With support and additional training, however, they became more confident in the system and overcame their reservations.

There was much talk about how to increase digital literacy and uptake of labour-saving technologies. Steven Wanyee, a global digital health consultant based in Kenya, believes that digital health should be as easy online banking. "I mean, people who are completely illiterate, they use it, they pay for the overhead development, without thinking twice about it... who taught our grandmothers? ... they use it really effortlessly." Part of the solution lies in making health workers and service users understand the benefits of digital technologies. "It needs to be really intuitive," says Wanyee. "What digital health is doing for me, whether it's helping me see patients faster, provide better care, [then] I'll naturally use it. You know, I don't even need to be trained for three days by anybody."

Other obvious challenges encountered in low-income countries are poor internet interconnectivity and the expense of buying data, which sometimes falls on individual health workers.

THE CHALLENGE OF OWNERSHIP

The experts felt that national ownership and leadership is key to overcoming challenges, particularly in donor-funded programmes.

"I think our message to donors and to funders is that it's not enough to come with your agenda into this country to try and make that work," said

Edinger. “You need to tie into what is important to government, figure out the government agenda and how can you plug into it. Political, economic and other factors are key to ensuring that our solutions are not just good on paper, but also good on the ground and good for the real-life users.”

National governments have an important role to play in the success of digital programmes. A participant from CDC commented in the chat that, while there are expectations that holistic health information systems will be implemented rapidly, the necessary underlying governance structures, workforce or infrastructure may not be in place. Waynee emphasised the point: “So we can keep going around generating evidence, coming up with all sorts of guidelines... but until the government decides that this is important to us...it doesn’t matter what you do.”

Donovan Schult, IT Expert with MPAMOT in South Africa agreed. “One of the biggest challenges is the resourcing of skills transfer and long-term commitment to grow and maintain systems after implementation. So, it’s full system ownership that I like to focus on because I believe that the system needs to be owned by the people who use it. You can’t have a consultant owning a system.”

But things are improving. Ndira spoke about Malawi’s journey that began in 2018, before which digital health was absent from the Ministry of Health organogram. Today it has its own unit with a workforce of 26, albeit donor-funded, staff. “Now we are discussing... how to retain digital health professionals in government. With public rates, within three months they will all be gone.”

COVID-19 SOLUTIONS

When COVID-19 struck there was a global surge in digital innovation. In Malawi, Ndira explained that the HIV data project was pivoted to COVID vaccination tracking in three months. Eight months later they had developed a COVID-19 e-certificate that is officially recognised by UK government.

Crisp described how, in South Africa, an electronic COVID-19 vaccination platform (EVDS) was built onto the existing patient record system in three weeks without any additional budget. The next task was to develop a system that facilitated the vaccination of public and private sector patients at sites of their choice, and enabled reimbursement in both sectors. “Fortunately,” said Schult, “the foundation was a very strong data system that was already developed by the NDoH. We were able to leverage this to deploy a cloud-based system... It had to be affordable but not compromise integrity.”

“What we have also managed to do is to integrate our national laboratory service data,” said Crisp. All PCR tests and all other antigen tests that are done within all the [public and private sector] laboratories in the country are also captured onto the same system and integrated.” This has enabled the NDoH to match who got what vaccination and to trace, over time, the viral immune response. In addition, the system is now linked to all private and public hospitals and provides information on people in ward beds, on oxygen or in ICU, as well as the location of vacant beds.

For Edinger, the South African experience is very exciting. “What stood out is...the fact that you were using existing government systems and building into that to ensure that the government is able to own and scale that. And also, your use of local developers,” he said. “I think that’s really key... As someone who is also from the global South, I have a passion for using local talent, local expertise and I think that is one of the success stories that has come out of this [epidemic].”

These learnings highlight the gap in the digital health ecosystem. Mott MacDonald’s experience with evaluating digital health programmes across Africa means that we approach digital health implementation with a whole-of-system mindset to ensure we drive adoption of technology, strengthen weak health systems and contribute to wider health impact.



Keep up to date by subscribing to the BHPSA newsletters here:

<https://hssncds.co.za/subscribe>

BHPSA

BETTER HEALTH PROGRAMME
SOUTH AFRICA

FOR MORE INFORMATION CONTACT

TORI BUNGANE

British High Commission, Health Attaché

tori.bungane@fcdo.gov.uk

MYLES RITCHIE

Better Health Programme, SA Team Lead, Mott MacDonald

myles.ritchie@mottmac.com

The Better Health Programme, South Africa (BHPSA) is a health system strengthening programme funded by the UK government through the British High Commission in Pretoria and managed by Mott MacDonald.



British
High Commission
Pretoria



health

Department:
Health
REPUBLIC OF SOUTH AFRICA

M
M
MOTT
MACDONALD