NATIONAL LAUNCH AND INDUCTION OF THE DISTRICT CLINICAL SPECIALIST TEAMS WORKSHOP REPORT

27th and 28th September 2012

St George Hotel

Irene, Gauteng

health

Department:
Health
REPUBLIC OF SOUTH AFRICA

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EXECUTIVE SUMMARY

"This event signifies the importance of dreaming the impossible"
"You will need to lead, inspire and teach"

Dr Aaron Motsoaledi, Minister of Health

The national launch and induction of the District Clinical Specialist Teams was held on the 27th and 28th September 2012 at the St George Hotel in Irene, Gauteng. This workshop was the first in a series of 8 workshops that make up the National Induction and Orientation Programme for District Clinical Specialist Teams that will take newly recruited members through an intensive one-year training programme to equip them to carry out their roles in the district effectively.

This report covers the proceedings of this workshop and also provides a comprehensive background to the workshop, including the Governments' policy response to the state of maternal and child health in South Africa, the PHC re-engineering drive, of which the DCST programme is one of three streams, the vision for DCSTs and the recommendations for their training encapsulated in Ministerial Task Team Report on DCSTS and an outline of the objectives and content of the one-year National Induction and Orientation Programme.

The objectives of the national launch and induction of the DCSTs were to:

- Officially launch the DCST stream of the Primary Health care re-engineering strategy.
- Initiate the national induction and orientation programme and toolkit for the DCSTs that will:
  - Ensure a common understanding of the national vision and intended purpose of the stream
  - Clarify the roles and responsibilities of the DCSTs, and
  - Ensure consistent implementation in all provinces.
- Allow teams to interact with each other and other role players toward team building and establishing partnerships of support.

This meeting was attended by approximately 318 people including;

- The Minister of Health, who delivered the key note address,
- The Deputy Minister of Health,
- The Director General for Health,
- The Deputy Director General for HIV, TB and MCH,

- Key representatives from the office of the Presidency and NDOH representing the Maternal Health, Child Health and District Health System Directorates and Primary Health Care,
- MECs for Health from 6 provinces,
- PHC and MCH managers/coordinators from the Provincial Departments of Health,
- District managers and district PHC and MHC programme managers/coordinators,
- Provincial and district specialists,
- Members of the DCSTs
- Development partners from over 13 institutions and organsiations.

The proceedings of Day One opened with an inspiring address by the Minister of Health who reported encouraging progress with respect to overall recruitment of specialists thus far as well as challenges to recruitment, especially in rural districts. 172 out of a possible 364 (47%) posts have been filled, including:

Obstetricians (17) and senior medical officers with diplomas and significant experience in obstetrics (3)	20
Advanced midwives	34
Paediatricians	17
Paediatric nurses	23
Family physicians	34
Primary health care nurses	35

There are clearly also serious challenges; Cacadu, Francis Baard and John Taolo Gaetsewe districts have made no appointments while Chris Hani, Alfred Nzo, Namaqwa and Siyanda have only appointed advanced midwives to date.

The Minister gave the history of the establishment of the Ministerial Task Team and the valuable work it had done. He highlighted the roles of the DCSTs as a whole, their relationship with the district management team and the province in relation to reporting and accountability emphasized the need for DCSTs to work closely with, support and complement the other two streams of PHC re-engineering and stressed the importance inter-sectoral collaboration to address the determinants of health and ill-health.

The Minister's address was followed by a focus on the state of maternal, neonatal, child health outcomes in South Africa. There were presentations based on three reports in this

session, one from each of the three Ministerial Committees on Maternal, Perinatal and Child Deaths:

- Saving Mothers 2008 – 2010, by the National Committee for the Confidential Enquiry into Maternal Deaths (NCCEMD).
- The National Perinatal Mortality and Morbidity Committee (NaPeMMCo) Triennial Report 2008 – 2010.
- 1st Triennial Report of the Committee on Morbidity and Mortality in Children Under 5 Years (CoMMiC)

The full presentations are available of the NDOH website and summaries of the presentations are provided in the body of the report.

The final presentation of the day was devoted to a summary of the Ministerial Task Team Report on DCSTs.

On Day Two, participants joined smaller breakaway groups for the two morning sessions. In the first session participants were divided into groups by province, thus yielding 4 groups of roughly equal size that were mixed in terms of disciplines. For session two, participants were divided into four groups representing the DCST specialty dyads; PHC, maternal health, child health and district management teams. The objectives of these sessions are outlined in detail in the body of the report but the topics for discussion included:

- The characteristics and practices that facilitate effective inter-disciplinary team work.
- Role definition for the team as a whole and for the dyads within it.
- How DCSTs fit into district structures and reporting lines and accountability within the district and province
- Key stakeholders that DCSTs need to communicate and link with and communication needs and channels.
- Priority areas that require focused interventions at district level to improve maternal and child health outcomes.
- Tools and good practices that can be implemented to facilitate quick wins.
- Identifying mentors who can support DCSTs.

The conclusions and recommendations below are a synthesis of the key conclusions and recommendations arising from the presentations of day One, the discussion in the breakaway sessions of Day two and the discussion that followed the plenary reports from the 8 breakaway sessions:

DCST roles, responsibilities, reporting lines

- DCSTs must develop clear standard operating procedures for roles, reporting and accounting lines that are coherent with the principles outlined in the *Ministerial Task team Report on District Clinical Support Teams in South Africa.*
- DCSTS should report to and are accountable to the District Manager.
- DCSTs should have a clinical reporting line to the provincial specialists.
- DCSTs are members of the DMT and should work closely with it and the relevant District Programme Managers, such as PHC and MNCWH.
- DCSTs must participate actively in developing the District Health Plans (DHPs), developing DMT capacity where necessary, and reflecting the goals, activities and budgets of the teams therein.
- DCSTs must have a clear communication strategy and plan that involves all key stakeholders including:
    - The DM and the DMT, including the PHC and MNCWH Managers/Coordinators.
    - Provincial Specialist/s,
    - Facilities
    - PHC Outreach Teams and School Health Services
    - Inter-sectoral partners
    - The community
- This communication plan should be guided by principle of using existing structures, strengthened where necessary.
- The DCSTs need to work closely with school health services and ward-based PHC outreach teams.
- DCSTs should play a role in reviving or strengthening District Health Councils.

Support DCSTs need to work effectively

- The breakaway groups clearly defined the resources they felt were essential for effective and efficient DCST functioning.
- Many of these resources are not budgeted for in the current DHPs and the lack of these resources is hampering team function.
- The NDOH will coordinate a process of identifying resource gaps in DCSTs by sending DCSTs a template which they can use to communicate their resource needs.

This nationwide resource gap audit will then be used to plan for ensuring that DCSTs receive essential resources as soon as possible.

- Leadership and management training is needed and will be included in the year-long national induction programme.
- Dr Pillay also noted the need to review national, provincial and district PHC structures to provide guidance and support to PHC specialist in the DCSTs.
- Dr Pillay indicated that the NDOH would be approaching the deans of universities and the heads of nursing colleges in the near future to discus ways that these academic institutions could support DCSTs, especially in districts that are battling to recruit specialists.
- There is a need to facilitate cross-provincial sharing and support for DCSTs.

PRIORITIES FOR DCSTS

- DCSTS should get to know the data from their districts so that they can identify gaps and develop work plans that respond to these gaps. The work plans should also respond to the priorities outlines in the *Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition in South Africa 2012 – 2016* and *South Africa's National strategic Plan for a Campaign of Accelerated Reduction of Maternal and Child mortality in Africa (CARMMA)*.
- Clinical governance includes:
    - Supportive supervision of doctors and nurses using data for improvement, clinical guidelines and protocols,
    - DCSTs should model inter-disciplinary team work to clinicians in facilities and get doctors and nurses to work together for maximum synergy and
    - Provide or facilitate access to in-service training, e.g., ESMOE, EOST, PEP, SAINC, IMCI.
- There is a long list of priority areas for DCST action. Thus, there is a need to prioritise activities that have potentially high impact in the shorter term ("quick wins") and a strong-evidence basis to ensure that mortality rates drop rapidly. The CARMMA priorities are examples of this.
- DCSTS need to design operational research to develop an evidence basis for what works in their districts. Results need to be shared with other DCSTs.
- It is important to strengthen all 3 streams of PHC Re-engineering and define the role that DCSTs should play in strengthening school, community and household MCH services.

TOOLS

- The DCSTs should communicate up to date clinical guidelines and protocols to facilities and support adherence to these. Facilities should be accountable for following the protocols correctly and a key place to support this is during morbidity and mortality reviews. The focus of such reviews is on learning and avoiding the repetition of mistakes rather than punishment.
- The partogram, which is a powerful tool if used correctly.
- Use of the South African Initiative on Neonatal Care (SAINC) *Essential Newborn Care Quality Improvement Toolkit.*
- There is a need to develop indicators to measure DCST performance. The *Ministerial Task team Report on District Clinical Support Teams in South Africa* outlines a set of indicators for this. The NDOH will draft a "dashboard" of indicators that DCSTs can review and use within two weeks of the workshop.

SHARING LESIONS AND TOOLS

- The NDOH will create a national resource website for DCSTs. All the material from this workshop (presentations, reports, guidelines, tools, etc) will be loaded onto this website. In the interim, these materials will appear on the NDOH website (http://doh.gov.za/list.php?type=Maternal and child health) in the week following this workshop.
- DCSTs can use journal clubs to stimulate learning and exploration of best practices.
- DCST experiences and learning can be shared with other DCSTs and stakeholders in district MCH forums.
- National and provincial meetings will provide forums for sharing and learning. Many DCSTs have already started working and have used this workshop as an opportunity to share their experiences and how they have approached the challenges they have encountered, e.g., communication styles that have facilitated entry into facilities. The national induction process will continue at provincial level and these workshops will provide space for feedback and sharing of challenges and good practices.

GLOSSARY

AIDS	Acquired Immunodeficiency Syndrome
CARMMA	Campaign on Accelerated Reduction of Maternal and Child Health Mortality
DCST	District Clinical Specialist Teams
DM	District Manager
DMT	District Management Team
EOST	Emergency Obstetric Simulation Training
ESMOE	Essential Steps in Management of Obstetric Emergency
MCH	Maternal and Child health
MDG/s	Millennium Development Goals
MNCWH	Maternal, Newborn, Child and Women's Health
NDOH	National Department of Health
NSDA	Negotiated Service Delivery Agreement
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission of HIV
SAINC	South African Initiative on Neonatal Care

1 BACKGROUND

1.1 Maternal and child health context

South Africa, relative to other middle-income countries, has relatively poor maternal and child health outcomes. This is despite significant health system transformation since 1994 to redress fragmentation and gross inequity, improved access to health care, especially in rural areas, the development of sound evidence-based policy and relatively high spending as a portion of the Gross Domestic Product.(1, 2) In 2008, South Africa was listed as one of 12 countries in the world where the child mortality rate and maternal mortality ratio (MMR) were higher than in 1990, despite concerted efforts to achieve the Millennium Development Goals for maternal and child health.(3) The high prevalence of HIV and AIDS, weak health systems and continuing poverty and poor environmental conditions are the major contributors to this death toll.(2, 4) Although there is evidence that infant and child mortality have decreased since 2006,(5) these mortality rates remain unacceptably high and the national MMR continues to rise.(6)

1.2 The policy response to the maternal and child health context

South Africa's commitment to reducing illness and deaths amongst mothers and children is reflected in a strong policy framework. The National Department of Health, in its *Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition in South Africa 2012 – 2016*, outlines priority interventions to reduce maternal, newborn and child mortality and the key strategies to implement these interventions. These interventions are evidence-based and have the potential for high impact. However they can only be effective if they are delivered within a well-functioning health system.

The Fourth Session of the African Union (AU) Conference of Ministers of Health held in Addis Ababa, Ethiopia (2009) launched the *Campaign on Accelerated Reduction of Maternal and Child Health Mortality (CARMMA),* which was also endorsed by the Fifteenth Ordinary Session of the AU (2010) and resulted in the development of a list of Actions on Maternal, Newborn and Child Health (MNCH) and Development in Africa by 2015. Governments' commitments were to launch CARMMA and broaden it as an advocacy strategy for MNCH. CARMMA is designed to be nationally driven and owned and aims to accelerate the reduction of maternal and child morbidity through accelerated implementation of evidence-based interventions (recommendations and strategies) essential to improve maternal and child health. To attain these objectives the focus will be on effective advocacy for quality maternal and child health care, health system strengthening, community empowerment and involvement and effective collaboration with partners and relevant stakeholders.

South Africa adopted the CARMMA strategy in 2012. Six key components along with corresponding activities and expected outcomes were identified

1. Strengthening access to comprehensive sexual and reproductive health services, with specific focus on family planning
2. Advocacy and promotion of early antenatal care attendance/booking
3. Improving access to skilled birth attendance
4. Strengthening human resources for maternal and child health
5. Improving child survival through promotion of breastfeeding, provision of facilities for lactating mothers in health facilities where children are admitted amongst others, and
6. Intensifying management of HIV positive pregnant women and mothers and HIV infected and affected children.

South Africa's commitment to improving MNCWH is further demonstrated by its investment in and reform of the health system. In particular, the *Negotiated Service Delivery Agreement,* signed by the Minister of Health and the President of South Africa, is the key governmental strategy for reducing maternal and child health mortality (Output 2). Strengthening health system effectiveness (Output 4) is the primary mechanism for delivering and improving care and guiding health system reform. This is all embedded in the Primary Health Care (PHC) philosophy which emphasises community involvement with a focus on PHC re-engineering (sub-output of Output 4).

1.3 PHC Re-engineering

The PHC re-engineering process is being implemented nationally to strengthen the health system: to build up preventive and promotive services which have been neglected over the last 10 years and increase the coverage, quality and impact of curative services. The PHC re-engineering process prioritises three streams:

1. The deployment of **ward based PHC outreach teams** to support delivery of maternal and child health services at household and community level and involve community members in safeguarding their own health;
2. Strengthening school health services; and
3. The deployment of district based clinical specialist teams (DCSTs).

1.4 Vision for the District Clinical Support Team Programme

The DCSTs will provide a support function and will facilitate the delivery of effective services, as per the District Health Plans, that focus on quality care of health care and improved health outcomes for mothers, newborns and children within a health district.

DCSTs will provide support to clinics, community health centres and district hospitals and work with the health workers and District Management to support:

- The availability and adherence to clinical protocols clinical protocols and standard treatment guidelines;
- Supervision, education, training and mentorship to upgrade the clinical competence of health workers on maternal and child health;
- Adequately equipped health facilities;
- Establishment, maintenance and improvement of systems to support the delivery of care (including referral systems, information systems, communication systems, and supply systems);
- Establishment of effective audits of the quality of care and of quality improvement cycles; and
- Effective monitoring and evaluation systems.

Given that many failures in delivering quality of care are due to breakdowns in the health system associated with ineffective leadership and poor accountability as is indicated in the saving mothers and saving children reports, a major thrust of the work of the DCSTs must be to develop effective leadership and accountability at various levels within the health system.[1]

[1] Voce, A and Philpott H. Draft DCST Induction and Orientation Framework. Public Health Medicine, School of Nursing and Public Health, College of Health Sciences, University of KwaZulu-Natal. July 2012.

2 THE NATIONAL DCST INDUCTION AND ORIENTATION PROGRAMME

Task teams were established to guide and inform the planning for each of the three streams of PHC re-engineering. The key objective of the DCST Ministerial Task Team (DCST MTT) was to advise the NDOH on the design of district based specialist teams and provide recommendations on how these teams will function. The MTT has written a report of their deliberations and recommendations, *District Clinical Specialist Teams in South Africa. Ministerial Task Team Report to the Honourable Minister of Health, Dr Aaron Motsoaledi*. [2]

The DCST MTT also made recommendations on the design of the training programme for DCSTs. The MTT proposed that new DCST members should participate in an intensive one-year induction and orientation programme. This programme should be centrally managed by the NDOH for the first wave of appointments to ensure consistent and standardized implementation of the initial teams, alignment with their intended purpose, equity, initial monitoring of progress and cross-provincial learning. The Provincial Departments of Health would then be responsible for taking this forward and continuing with induction and orientation of new staff.

2.1 Objectives of the national induction and orientation programme

By the end of the one-year induction and orientation programme DCST members should be able to:

- Describe their vision and specific goals for the work of the team in their specific district;
- Use a range of methods to improve the quality of clinical care;
- Provide effective education and clinical training to individuals, small and large groups;
- Identify weaknesses and improve the performance of the health system;
- Support the development and implementation of community-based interventions;
- Support district and facility level management activities;
- Function effectively as a team; and
- Evaluate and report on their work.

[2] National Department of Health. District Clinical Specialist Teams in South Africa. Ministerial Task Team Report to the Honourable Minister of Health, Dr Aaron Motsoaledi. October 2012. http://www.doh.gov.za/docs/reports/2012/District_Clinical_Specialist_Teams_in_South_Africa_Report.pdf

Further, by the end of the initial orientation workshop, District Managers should be able to identify how the DCSTs will fit into their district structures and how they will relate to and engage with each other.

2.2 Outline of the national induction and orientation programme

The recommendations from the DCST MTT suggested that the programme consist of 8 workshops over a period of a year. The first workshop is a centralised two-day workshop with the Minister of Health presiding to provide the vision and to foster team work between all appointed DCSTs, DMTs and Provincial MCH and PHC Managers, from all provinces and districts. This will be followed by the rest of the proposed workshops, each three days long, in the Provinces. While the first two workshops will be scheduled close together, the remaining workshops will be scheduled at 6 week intervals as follows:

Workshop 1: Central orientation (2 days)

- Introduction to the national policies on revitalising primary care, specifically the DCSTs,
- Introduction to the induction and orientation programme,
- Introduction to each other and initial team formation.

Workshop 2:

- Strengthen team formation and exploration of personal learning styles,
- Content related to identifying weaknesses and performance of the district health system, and
- Planning of situational analysis and how to introduce themselves to key stakeholders in the province and district where they work.

Workshop 3:

- Finalise situational analysis report, present to twin team, prioritise goals for the year,
- Session on content related to implementation of evidence based guidelines, quality improvement cycles and critical event reviews,
- Session on educational and clinical training skills,
- Session on how to report on team activities, and
- Planning of activities for the next six weeks.

Workshop 4:

- Feedback and critical reflection on activities,

- Content on community-based interventions (COPC, evidence),
- Selected content on home/community level guidelines, and
- Planning of activities for next six weeks.

Workshop 5:

- Feedback and critical reflection on activities,
- Session on educational and clinical training skills,
- Selected content on primary care level guidelines, and
- Planning of activities for next six weeks.

Workshop 6:

- Feedback and critical reflection on activities,
- Reflection on team functioning,
- Selected content on district level guidelines, including reflection on referral hospital services, and
- Planning of activities for next six weeks.

Workshop 7:

- Feedback and critical reflection on activities,
- Session on educational and training issues,
- Remaining content on primary care level guidelines, and
- Planning of activities for next six weeks.

Workshop 8:

- Feedback and critical reflection on activities,
- Critical reflection on team functioning,
- Remaining content on district level guidelines, and
- Planning of activities for next six weeks.

3 THE NATIONAL LAUNCH AND INDUCTION OF THE DISTRICT CLINICAL SPECIALIST TEAMS

The national launch and induction of the District Clinical Specialist Teams was held on the 27th and 28th September 2012 at the St George Hotel in Irene, Gauteng.

3.1 Objectives

The objectives of the national launch and induction of the DCSTs were to:

- Officially launch the DCST stream of the Primary Health care re-engineering strategy.
- Initiate the induction and orientation programme and toolkit for the DCSTs that will:
  - Ensure a common understanding of the national vision and intended purpose of the stream
  - Clarify the roles and responsibilities of the DCSTs, and
  - Ensure consistent implementation in all provinces.
- Allow teams to interact with each other and other role players toward team building and establishing partnerships of support.

3.2 Workshop programme

Table 1: DCST induction workshop programme

Day 1: 27 September 2012		
Time	Session	Facilitator/Presenter
10h00 - 12h00	Arrival and registration	All
12h00 - 13h30	Lunch	All
14h00 - 14h15	Remarks and introduction of the Honourable Minister of health, Dr Aaron Motsoaledi	Deputy Minister of Health: Ms Gwen Ramokgopa
14h15 – 15h45	Address by the Honourable Minister	Dr A Motsoaledi
15h45 - 16h15	Questions and comments	All

Day 1: 27 September 2012		
Time	Session	Facilitator/Presenter
16h15 -16h45	Tea	
16h45 - 17h45	The State of Maternal, Neonatal, Infant and Child health outcomes in SA: A consolidated report from the three Ministerial Committees on Maternal, Perinatal and Child Deaths	Professor Jack Moodley, Dr Natasha Rhoda and Dr Neil McKerrow
17h45 - 18h15	Efforts to strengthen the Health System and make it responsive: PHC Re-engineering Policy – three streams	Dr Y Pillay
18h15 -18h30	Ministerial Task Team (MTT) on DCSTs report: Overview of recommendations for implementation	Professor Jack Moodley
18h30 – 18h45	Questions and comments	All
18h45 -19h00	Closing remarks and invitation to dinner	Ms Precious Matsoso
19h00	Gala dinner: Guest Speaker Paul Campbell, Harvard University School of Public Health	All

Day 2: 28 September 2012	
Time	Session
08h30 – 10h00	Four breakaway groups: inter-disciplinary groups organized by province: ▪ Gauteng and Western Cape ▪ Mpumalanga, Limpopo, and North West ▪ KwaZulu-Natal

Day 2: 28 September 2012	
Time	Session
	▪ Northern Cape, Eastern Cape and Free State ▪ Discussion: ▪ Key practices to facilitate inter-disciplinary team work ▪ Communication within the team and with key stakeholders ▪ Resources needed for effective team function ▪ Reporting and accountability ▪ Solutions to challenges to effective team function
10h00 – 11h30	Four breakaway groups: organized into dyads: PHC nurses and family physicians Paediatric nurses and paediatricians Advanced midwives, Obstetricians and Aneasthetists District Managers and District Programme Managers/Coordinators Discussion: Role definition for dyads and the team as a whole Priority areas for DCST focus to improve MNCWH outcomes Tools, good practices and quick wins Mentors for DCSTs
11h30 – 12h00	Tea
12h00 – 13h00	Plenary feedback from breakaway sessions
13h00 – 13h45	Highlight common vision and plan of work for teams in provinces
13h45 – 14h00	Closing remark and vote of thanks
14h00	Lunch and departure

3.3 Attendance

The workshop was attended by 318 people, including[3]:

- The Minister of Health, Dr Aaron Motsoaledi, who gave the keynote address on Day One,
- The Deputy Minister of Health, Ms Gwen Ramokgopa,
- The Director General for Health, Ms Precious Matsoso,
- The Deputy Director General for HIV, TB and MCH, Dr Yogan Pillay,
- Key representatives from the office of the Presidency and NDOH representing the Maternal Health, Child Health and District Health System Directorates and Primary Health Care,
- The new National DCST Coordinator, Ms Ntomboxolo Bandezi
- Members of the Executive Committee (MECs) for Health from 6 provinces; Eastern Cape, Gauteng, Limpopo, Mpumalanga, North West and Free State (Acting MEC),
- PHC and MCH Managers and Coordinators from the Provincial Departments of Health,
- District Managers and District PHC and MHC Programme Managers/Coordinators,
- Provincial and district specialists,
- Members of the DCSTs4
- Partners, at national and provincial level, including;
    - UNICEF
    - DFID
    - CDC
    - WHO
    - PEPFAR
    - The Futures Group
    - Health Systems Trust
    - Save the Children UK (SCUK)
    - Social Development Direct

[3] The complete attendance register is attached as Appendix 1
[4] It is not possible, from the information in the attendance register, to give an accurate breakdown of the numbers of each category of specialists present across provinces.

- PATH
- I-TECH
- Right To Care
- University of the Witwatersrand

3.4 Proceedings - Day One

3.4.1 Welcome

The Director General for Health, Ms Precious Matsoso, opened the workshop proceedings and introduced the Deputy Minister of Health, Dr Gwen Ramokgopa. Dr Ramokgopa set the tone for the workshop by referring to the need for an attitude of "business unusual" in order to fight the high levels of disease and death that has engulfed our country. She then introduced the Minister of Health, Dr Aaron Motsoaledi.

3.4.2 The address by the Minister of Health

"Today's event signifies the importance of dreaming the impossible"
"You will need to lead, inspire and teach"

Dr Aaron Motsoaledi, Minister of Health

The key points of the Minister's address are summarised as follows[5]:

- Many people highlighted the challenges to the concept of DCSTS; some were skeptical about the chances of finding specialists to staff DCSTs and others cautioned that most clinicians are trained to think about individual patients and would have to be reoriented to think about population or public health issues.
- A Ministerial Task Team, consisting of senior and very experienced medical specialists and nurses, and chaired by Professor Jack Moodley, was appointed to advise the Minister about the composition and function of the DCSTs and the experience tat the members would need. More will be heard about the work of this task team later.
- Progress with recruitment for the DCSTs is encouraging:
    - 172 out of a possible 364 (47%) posts have been filled, including:

Obstetricians (17) and senior medical officers with diplomas and significant experience in obstetrics (3)	20
Advanced midwives	34

[5] The full text of the Minister's speech is included as Appendix 2 and can be accessed on the internet: http://www.doh.gov.za/show.php?id=3767

Paediatricians	17
Paediatric nurses	23
Family physicians	34
Primary health care nurses	35

- UMgungundlovu district has a full complement of 7 DCST members
- Four districts have almost full complements:
  - Tshwane and uMzinyathi districts are missing a paediatric nurse
  - Ekurhuleni district is missing an anaesthetist
  - Bojanala district is missing an anaesthetist and a paediatric nurse

- There are also serious challenges:
  - Cacadu, Francis Baard and John Taolo Gaetsewe districts have made no appointments
  - Chris Hani, Alfred Nzo, Namaqwa and Siyanda have only appointed advanced midwives to date

- DCSTs from one of three streams of PHC Re-engineering. The other two streams are the ward- based PHC outreach teams and the new school health programme
  - Each PHC Outreach team, composed of a professional nurse and community health workers, will be responsible for a case load and visit every household. Their primary role will prevention and health promotion in families and communities and their work will complement the work of the DCSTs through facilitating early identification and referral and promoting adherence to treatment and care. 5000 community health workers have received re-orientation training and a further 5000 are undergoing the same process.
  - The school health programme will be launched in October 2012 and will take services to schools using mobiles that will provide PHC, dental and optometry services.

- The key functions of the DCST will include:
  - Getting to know the district that you will work in: this means getting to understand the demography, the disease trends, the major causes of mortality, as well as the availability of health services in terms of both coverage and quality;
    - Providing strategic leadership and support to the district with particular emphasis on maternal and child health; and

- Providing clinical leadership and mentorship to ensure that doctors and nurses especially are adequately trained and supervised.

- The DCSTS, PHC outreach teams and school health teams should work with the district management team as one unit.
- DCSTs will be accountable to the district manager administratively and clinically to the provincial specialists. Where there are no provincial specialists, alternative arrangements will be made, e.g. to the head of department at a local university.
- Health heads of department and district managers have been invited to attend this event so that they understand how DCSTs will operate and be able to support DCSTs in their work.
- The Health Data Advisory and Co-ordination Committee (HDACC), established to advise the NDOH on the life expectancy and mortality rates, reviewed all available data and reported on life expectancy, infant and child mortality rates and the maternal mortality ratio. These are much too high and are significantly higher than the 2014 MDG targets.
- There are many determinants of health and ill-health. DCSTs cannot make progress to reach the MDG targets alone and must work with all the resources in the district, including those that fall outside the health sector.
- DCSTs must remember to consult with the communities they will work for and with, including community leaders and health workers.
- And finally: *"I wish to thank you for accepting these positions and the responsibilities that come with them and wish you good luck in your work."*

Questions and comments in response to the Minister's speech

The Minister invited questions and comments from the floor in response to his address.

- There is a concern that many managers are political appointees and not always equipped with the necessary skills and attitude for the job and this would undermine the ability of DCSTs to function effectively.
- DCSTs are unable to pursue their work because they lack essential resources such as transport, laptops, office space, etc.
- Is there an academic role to be played by specialists?
- There is a lack of clarity about the different roles of DCST members and existing district specialists.
- What is being done about the poor EMS services in Gauteng?
- What are the reporting channels for the DCST in the district?
- There is a high rate of attrition of newly trained community health workers in John Taolo Gaetsewe district because there is no implementation of PHC outreach teams.
- Is the DCST programme aligned with universities? Do the universities know what is happening?
- Medical students should have an extended period of internship in labour ward and theatre so that they get more exposure to maternal health priorities and learn essential skills - to learn how to perform caesarian sections properly and tie knots securely.
- There is concern about poor security in facilities and that facility staff are in danger. Many facilities were rated very poorly in the security evaluated and tender fraud has undermined security.

The Minister pointed out that many of the questions would be answered in the course of the workshop; he elected to address selected comments and invited his colleagues on the podium, to respond as appropriate:

- Vaccines are non-negotiable supplies for health facilities. Allowing vaccine stocks to run out is a form of "biological warfare".
- Dr Hope Papo, the Health MEC for Gauteng acknowledged the problems with the Gauteng EMS: there is currently no head of EMS, many ambulances are immobilized despite needing only minor repairs and there is a shortage of emergency personnel. Addressing solutions to this crisis is a priority for the current financial year.
- The Deputy Director General introduced three new NDOH staff members who would support the DCST programme:

- Dr Ntomboxolo Bandezi, the new National DCST Coordinator, present at the workshop,
- Mr Elroy Paulus, the new National Outreach Teams Coordinator will start in October 2012, and
- Dr Toko Zondi, the National Quality Coordinator

Contact details were provided for Dr Pillay and Dr Bandezi:

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3.4.3 The State of Maternal, Neonatal, Infant and Child health outcomes in SA

Three presentations, from each of the three Ministerial Committees on Maternal, Perinatal and Child Deaths, formed part of this session.

The Saving Mothers report 2008 – 2010

Presented by Professor Jack Moodley[6]

- The process of the Confidential Enquiry into Maternal deaths followed by the National Committee for the Confidential Enquiry into Maternal Deaths (NCCEMD) was described.
- 4867 maternal deaths were reported in the triennium 2008 to 2010 and the institutional MMR has increased across all levels of care when compared with 2005-2007.
    - In terms of absolute numbers, KwaZulu-Natal, Gauteng, Eastern Cape and Limpopo (in order of decreasing numbers) had the most maternal deaths in the triennium 2008 to 2010. However, when calculating the institutional

[6] http://www.doh.gov.za/docs/presentations/2012/PowerPoint_Saving_Mothers_2008-2010.pdf

maternal mortality ratio (MMR), Free State, Northern Cape and North West were more than 15% above the national average while the MMRs for Gauteng and Western Cape were more than 15% below the national average.

- The institutional MMR increases across levels of care with the highest MMR at level 3 hospitals.

- Conditions where the biggest impact can be made on preventing maternal deaths include:
  - Non-pregnancy related infections (HIV&AIDS) – 28% of deaths
  - Obstetric haemorrhage – 14% of deaths
  - Hypertension – 14% of deaths
- Avoidable factors, missed opportunities and substandard care were identified:
  - Patient related:
    - Accessing health care services
    - Unsafe miscarriages
  - Administrative:
    - Transport between facilities
    - Access to ICU
    - Access to blood
    - Inadequate staff
    - Health care providers
    - Not assess patients properly
    - Delay in referral
    - Not follow standard protocols
- The NCCEMD has summarised its recommendations into 5 key points, **the 5 Hs**, namely:
- **H**IV
- **H**aemorrhage
- **H**ypertension

  } the three biggest causes of maternal deaths

- **H**ealth worker training and
- **H**ealth system strengthening
- The recommended actions under each component was explored in detail

Questions and comments in response to Professor Moodley's presentation

Questions and comments were invited. Professor Moodley's responses are included with each question/comment:

- Should punitive action be taken against staff when the review of the maternal death within 72 hours uncovers negligence?
    - The maternal death review is not a punitive process but rather a learning process directed at improving future practice and outcomes. However, if there are clearly repeated mistakes and training the particular staff member does not help then sanction needs to be considered.
- In KZN, some EMS managers fight about and resist the deployment of dedicated obstetric and neonatal ambulances. An unequivocal statement about this is needed from the NDOH and must be communicated to stakeholders.
    - The MEC for Health in KwaZulu-Natal agreed with this proposal.
- What is happening with maternity waiting lodges?
    - This is a priority. One does not necessarily need to construct new buildings. Wards and existing buildings can be converted.

The National Perinatal Mortality and Morbidity Committee (NaPeMMCo) Triennial Report 2008 -2010

Presented by Dr Natasha Rhoda[7]

- The sources of data that feed into the perinatal mortality report were described, including the DHIS, Stat SA, Perinatal Problem Identification Program (PPIP), Child Healthcare Identification Program (Child PIP), the Demographic Health Survey and the Private Sector (Life Healthcare, Netcare, Mediclinic).
- Approximately 1,011,788 babies were born in facilities in 2009 and there was a 15% increase in the number of recorded births from 2004 to 2009.
- The trends (from DHIS data) in stillbirths, early neonatal deaths and Perinatal mortality from 2004 to 2009 were shown and an improvement in these indicators is evident although there are concerns about data accuracy and completeness:
    - Stillbirths: More than 20 000 viable babies die each year before they are born and the number of stillbirths has increased from 2004 to 2009.
    - Early neonatal deaths: About 8000 to 900 babies die in the first week of life per year. The trend in the number of early neonatal deaths from 2004 to 2009 was shown and early neonatal mortality rate has remained stable.

[7] http://www.doh.gov.za/docs/presentations/2012/PowerPoint_Perinatal_Mortality_and_Morbidity_Committee_Triennial_Report.pdf

- Perinatal mortality: The national perinatal mortality rate for 2009 was 29.8 per 1000 births in comparison with 34.1 in 2004

- Private sector data:
  - The caesarian section rate is very high (68%)
  - The stillbirth rate is low relative to the public sector – 6.5 per 1000 births
  - The neonatal MR is 4.0 per 1000 births
- Neonatal conditions account for 31% of all infants deaths in 2008 (Stats SA). Of these, preterm birth was the most common cause of death (9%), followed by infections in the perinatal period (6%) and birth asphyxia (6%).
- The Perinatal Problem Identification Program (PPIP) was described.
- The national PNMR according to PPIP data was approximately 35/1000 births (500g)
- Trend in deliveries by levels of care, perinatal mortality rate, early neonatal death rate, primary obstetric causes of death and final causes of neonatal death were shown and interpreted.
  - There are three major primary obstetric causes of death:
    - Spontaneous preterm birth
    - Birth asphyxia and trauma
    - Placenta/placental bed disease (including pre-eclampsia/eclampsia and abruptio placenta)
  - Neonatal mortality are significantly higher in women <18 years of age and those older than 34 years than in women between the ages of 20 and 34 years of age.
- Avoidable factors related immaturity and birth asphyxia (the two most common causes of death), for the administrator and the health care provider, were elucidated.
- Finally, the presentation outlined the recommendations which were detailed under 4 headings:
  - Improve access to appropriate healthcare
  - Improve quality of care
  - Ensure that appropriate resources are made available
  - Auditing and monitoring for all facilities

There were no questions following this presentation.

Status of Child health in South Africa

Presented by Dr Neil McKerrow[8]

- South Africa is committed to MDG4, reducing the Under 5 mortality rate (U5MR) from approximately 60 in 1990 to 20 in 2015. The current status varies according to the data source:
    - StatsSA (MDG Country Report) 104 (2007)
    - HDACC 56 (2009)
    - CoMMiC 59.8 (2008)
- Trends in U5MR were shown and discussed. In 2008, over 60 000 South African children under 5 years of age died and three-quarters of these were less than one year old.
- The major causes of childhood death are:
    - Neonatal conditions
    - Diarrhoeal disease
    - Acute respiratory infections
    - Malnutrition
    - TB
    - HIV/AIDS and malnutrition contribute heavily as both primary and underlying causes of child mortality
- A discussion of health indicators show great variation across provinces in terms of resources and health outputs, e.g., Western Cape has one paediatrician/9,900 children while Mpumalanga has 1/1,1 million. Again, the immunization coverage in the Western Cape is 103.9% while it is 72.45 in Mpumalanga.
- Modifiable factors were identified at the household, PHC, casualty and ward levels:
    - Home
        - Delay in seeking care
        - Failure to recognise severity of illness
        - Inadequate nutrition
    - PHC level
        - IMCI not used for patient assessment
        - Did not arrive at clinic/OPD on day of referral
        - Delayed referral for growth faltering/malnutrition

[8] http://www.doh.gov.za/docs/presentations/2012/PowerPoint_Status_of_Child_Health_in_SA.pdf

- A&E
  - Inadequate investigation
  - Inappropriate antibiotics
  - Inadequate history
  - Inadequate examination
- Ward
  - Lack of nurses
  - Inadequate assessment of management at previous admission
  - Inadequate resuscitation facilities

- There have been notable successes including; the expansion of EPI to include Pneumovac and the rotavirus vaccine, the reduction of the national early MTCT rate to around 2%, increasing paediatric ART coverage to 50% and the recommitment to breastfeeding.
- Challenges to improving child health include community practices, the lack of effective preventive and promotive programmes, inadequate access to appropriate levels of care and the quality of care.
- In response to these challenges, CoMMiC made proposals:
  - A strategic child health plan to guide a coordinated response to these challenges – this was launched in May 2012
  - Strengthen and focus pre-service, post-graduate and in-service training in child health and paediatrics.
  - Develop a Framework for the delivery of Essential Health Care Services that sets out:
    - Essential Package of Care for children;
    - Norms and standards for child health services.
  - Strengthen Community-based care services; PHC outreach programmes and a family booklet that lists 16 key family practices for child survival
  - Strengthen and complement existing priority child survival programmes including:
    - HIV/AIDS – PMTCT and paediatric HAART;
    - Primary healthcare services – IMCI, Expanded Programme on Immunization (EPI), Vitamin A supplementation, nutrition, TB and childhood emergencies;
    - Hospital services – enhanced management of common paediatric emergencies and fostering non-rotation of core staff.

- The drivers fort he implementation of these recommendations should be district paediatricians in every geographical area and child health forums at district and provincial levels.
- And finally:

"We know what the problems are, we know what to do, but, we need to create a culture of responsibility and accountability to ensure that we do it."

No questions followed this presentation

Key points of the final MTT report on district clinical specialists[9]

Presented by Professor Jack Moodley

The key points of this presentation are summarized as follows:

- Professor Moodley outlined the brief, methodology, scope of stakeholder consultations of the MTT before starting on the recommendations.
- A DCST will be placed in every district of South Africa comprising:
    - Obstetrician & Gynaecologist / Advanced Midwife
    - Paediatrician / Paediatric nurse
    - Family Physician
    - Primary health care nurse
    - Anaesthetist in an expanded role (to oversee emergency paediatric and medical care)
        - A minimum team is defined as a nurse and doctor from the same district or a nurse and doctor from adjacent districts. Sessional work should not be allowed.
- The district clinical specialists should function as a Team first and as individuals or dyads second, i.e., they should meet face to face at least monthly and prepare reports jointly.
- The role of the DCST will be:
    - To improve quality of services through clinical governance of all health programmes in a district
    - Clinical training through supportive supervision,
    - Monitoring, evaluation of clinical services,
    - Supporting district level organisational services,

[9] The full copy of this presentation is available on the NDOH website

- Supporting health systems and logistics, and
- Collaboration, communication & reporting, teaching & operational research activities,
  - DCSTS members will have baseline performance assessments followed by quarterly assessments, according to standard national guidelines, based on these roles.

- DCSTs should report to:
  - The district manager, who is their direct line manager, for ensuring their work is included in district planning & financial budgeting processes, and for other administrative issues.
  - To the province, for ensuring discipline specific standards are defined and adhered to, and to provincial specialist for personnel development and support.

- The roles and responsibilities of the provincial specialist are:
  - Oversight of discipline throughout the Province to ensure:
    - Equity in distribution of services & resources
    - Uniform systems & standards at all levels & facilities in the Province
    - Mentorship and support of DCST members,
    - Surveillance, monitoring and evaluation of programmes & services related to discipline in all facilities and districts in the Province,
    - Collaboration with District Managers & Provincial Programme Managers, and
    - Reporting to structures in the Provincial DOH.
  - Where regional/area specialists and university community obstetricians and paediatricians exist, the provincial specialist will have to communicate to clarify their respective roles and interaction.

- Regarding human resources in rural areas, the NDOH should revisit rural retention policy to improve coverage of specialists in rural areas. Some options to consider are;
  - Community service for specialists,
  - Rotation as part of registrar training, and
  - Periods of specialist deployment in regional hospitals in under-serve total areas.

- The MTT proposed a one-year induction programme that will be conducted by the NDOH for the first crop of appointments to ensure consistency and then delegated to provinces thereafter.

- There should be a national oversight committee, chaired by the Director General or the Deputy Director General and reporting to the National Health Council, for at least a two-year period that will monitor and advise on the DCSTs.

There were no questions from the floor following professor Moodley's presentation.

3.4.4 Final input for the day

Dr Yogan Pillay gave the final input of the evening, with additional information about DCST function and responding to several issues that were clearly burning issues for participants:

- The NDOH will draft a template that will be sent to each district to complete so that the resource needs for effective DCST functioning can be assessed.
- DCSTs report to and are accountable to the district managers administratively and for the allocation of resources to the team. The DM "holds the district purse". DCSTS are accountable for clinical purposes to the provincial specialists or the person designated by the HOD for health.
- DCSTs need to participate actively in the development of district health plans (DHPs). They should review the DHP that is currently under development and include the DCST role therein. Resources for DCST function can only be prioritized if they are included in the DHP budget.
- The national induction and orientation training programme will take place over one year. The next step in this process will be a 3-day workshop held in provinces, run by facilitators appointed by the NDOH, to plan for the district baseline assessments.

3.5 Proceedings – Day Two

On day two, participants joined smaller breakaway groups for the two morning sessions.

3.5.1 Composition of breakaway groups and objectives for each session

Session 1

- There were four inter-disciplinary groups organized in provinces so that there were comparable numbers in each group.
- The objectives of this session were to:
    - Allow teams from the same province to interact with each other as the first step in developing partnerships across districts.
    - Explore the characteristics and practices that facilitate effective inter-disciplinary team work.
    - Identify key stakeholders that DCSTs need to communicate and link with and explore communication needs and channels within DCSTs and between DCSTs and these key stakeholders at district, provincial and national level.
    - To explore how DCSTs fit into district structures and agree on reporting lines and accountability within the district and province.
    - To identify potential challenges to effective team function and explore solutions to these.

Session 2:

- There were four groups consisting of separate DCST specialty dyads; PHC, maternal health, child health and District Management Teams.
- The objectives of this session were to:
    - Define roles for the team as a whole and for the dyads within it.
    - Identify priority areas for each specialty that require focused interventions at district level to improve maternal and child health outcomes.
    - Share tools and good practices that can be implemented to facilitate quick wins.
    - Identity mentors and partnerships to support DCSTs, especially those that are largely incomplete and those that do not have access to provincial specialists.

These groups were well facilitated by national and provincial experts in public health and maternal and child health. The Facilitation Guide for the Day Two breakaway sessions is included as Appendix 3.

Table 2: Breakdown of the breakaway groups and corresponding facilitators

Facilitators	Session 1 groups	Session 2 groups
Professor Jannie Hugo Dr Nokuthula Sibiya Dr Khetisa Taole	Gauteng and Western Cape	PHC nurses and family physicians
Dr Sharon Matela Ms Bongi Mafokeng Professor Lesley Bamford Dr Nonhlanhla Dlamini	Mpumalanga, Limpopo, and North West	Paediatric nurses and paediatricians
Prof Jack Moodley Ms Dolly Nyasulu Dr Nat Khaole	KwaZulu-Natal	Advanced midwives, Obstetricians and Aneasthetists
Dr Peter Barron Dr Jennifer Reddy	Northern Cape, Eastern Cape and Free State	District Managers and District Programme Managers/Coordinators

3.5.2 Outcomes of Session 1

Team work

"The currency of teamwork is information and not power"

Gauteng breakaway group

"We need to focus on the targets of the team and not just pursue the goals of the individual disciplines"

Eastern Cape, Northern Cape and Free State breakaway group

Participants were asked to identify the values and practices that foster inter-disciplinary team work and to prioritise those they would like to see active in their DCSTs. There was remarkable consensus across the groups and key themes emerged again and again:

- Every group highlighted the need for each DCST to share a **common purpose** and a **common vision** as to how they would achieve this purpose. They saw the need for DCSTs to articulate this common vision as soon as possible in the development of clear objectives, roles, communication channels, a code of conduct and plans. Many participants noted that "territoriality" could limit the building of a shared vision and integrated action.
- Many participants underlined the importance of team relationships based on **humility** and **mutual respect** for each member and not bound by the traditional hierarchies that often undermine team work in the medical profession.

- Each team must define **clear roles** for each member of the team and for the team as a whole. It is critical that each member understands what they will be doing on a daily basis, how this fits into the overall objectives of the team and how each member complements and can support the other members.
- All the groups also highlighted the need for **the early election of a team leader for each DCST.** Some small groups suggested that this should be a rotating position.
- Much of the discussion revolved around the need for **effective and efficient communication,** what this meant and how to structuralise this into the teams' workings. Important factors included:
    - Regular informal face to face, telephonic and email communication between members of dyads and all team members
    - Set times for regular face to face meetings
    - Clear reporting lines within the team and between the team and other structures/stakeholders
    - An understanding of how to make decisions by consensus
    - Plans for how to deal with conflict within the team
- The teams need to **evaluate their work on a regular basis** and work collectively to identify gaps and solve problems. Members must be ready to learn from their mistakes and face challenges as a team.
- Ongoing and regular **performance appraisal and feedback** to team member is important.
- Participants described DCSTs where members could share a sense of belonging and participation, be open with each other, agree to disagree, celebrate diversity as a strength, help each other and share resources and expertise to achieve a common goal.

Communication, accountability and reporting

"There is a danger that the DCST becomes another vertical unit. The key question is how to ensure their integration into the district"

District Managers breakaway group

The groups addressed the question of how communication would happen within the inter-disciplinary DCSTs and between the DCSTs and key district and provincial stakeholders. All groups were concerned that reporting and accounting lines needed to be clarified and that there was a potential for confusion of the roles of DCSTs and existing district Programme Managers/Coordinators.

- There is a need for a **clear communication plan** and systems that cover:

- Regular, informal communication between dyads and other team members and
- Regular, formal face to face meetings with the whole DCST – set times that are “ring-fenced” for this purpose.

- And communication with:
  - District Manager and the District Management team (DMT), including the PHC and MNCWH managers/coordinators.
  - Provincial Specialist/s,
  - Facilities – DCSTs should be the bridge that facilitate integration of Primary Health Care Clinics, Community Health Centres and district and regional hospitals,
  - PHC Outreach teams and School Health Services
  - Inter-sectoral partners
  - The community

- The teams should to elect a **leader** who facilitates participation and open communication within the group and who can interact on behalf of the group with other stakeholders.

- The DCST is **accountable to and reports to the District Manager** (DM), who is their line manager.

- There was some discussion as to whether the provincial specialists or the DMs should be responsible for the **performance appraisals** of DCST members. The consensus was that DMs are best placed to do this.

- The DCST should **work closely with the District Management Team** (DMT) and should be represented in various DMT meetings as appropriate. This will be informed by existing channels, forums and structures in the district but these can be adapted or strengthened as necessary to ensure that DCSTs are included and visible in the district. The setting up of a rash of new structures has the potential to stress the district and should be avoided. The idea is to achieve an effective balance between the amount of time spent in meetings, which should be efficient and kept to the necessary minimum, and the amount of time spent in the field so DCST members can fulfill their primary role of clinical support.

- The DCSTs should maintain a **clinical reporting line to the Provincial Specialist**/s. In provinces with no provincial specialists, this might be a University-based specialist. The NDOH will hold a meeting with university deans to explore this.

- DCSTs will need to **market themselves**, recognising that not all personnel will initially understand or fully welcome collaboration. They can do this by identifying,

targeting and attending meetings that are already taking place in the district and by developing a diplomatic entry strategy for initiating interaction with facilities.

- The **DM can market the DCSTs and facilitate communication** between the DCST and other district DOH structures and health facilities by making introductions and raising the profile of DCSTs at appropriate meetings/structures.
- The different roles of and the relationship and communication between **district programme managers/coordinators**, e.g., Primary Health Care Managers, MCWH Coordinators, and the DCST need to be clarified. There was general concern that these personnel might feel threatened by DCST members because of a misconception that their respective roles were duplicated. This highlighted the need for open and clear communication within the DMT.
- **Mechanisms for communication** were suggested including telephonic and face-to-face contact, emails, formal meetings, reports and workshops. This can be facilitated by sharing up to date telephone and email lists and ensuring DCST members communicate their weekly schedules and whereabouts to their team mates.
- Participants requested the contact details of the Deputy Director General for HIV, TB and MCH, Dr Yogan Pillay. These were supplied.

Resources needed

"All of us are specialists but not all of us are leaders or managers. We need to develop these skills."

Eastern Cape, Northern Cape and Free State breakaway group

- Many DCST members were very concerned about the lack of resources necessary for them to function effectively. They felt the following material or administrative resources were essential:
    - Dedicated office space with access to telephones, furniture (desks, chairs, etc) and stationery,
    - Laptop computers with connectivity and printers,
    - Data projectors for training,
    - Cell phone allowances,
    - Fax machine,
    - Transport,
    - Accommodation when travelling for outreach to distant areas,
    - Administrative support, including data capture. This was not budgeted for,
    - Access to data, e.g., DHIS data,
    - A central location that acts as resource centre for DCSTs

- Medical equipment and commodities must be available in facilities. The DCSTs would also benefit from having demo models of these for training purposes.

- There is a desperate need to fill vacant DCST posts, especially in rural districts. Recruitment and retention strategies are needed and salary scales and rural allowances should be standardized. One group suggested that posts should be advertised internationally.
- Most of the items above have not been budgeted for. It was recommended that there should be a dedicated budget for DCSTs and some groups suggested that in future, DCSTS could be funded by a conditional grant to ensure "ring fencing".
- The DCSTs felt they needed support now from DMs to ensure that resources were made available to teams.
- The PHC group felt that the role of the PHC dyad in the DCST was not as clear as the roles of the paediatric and obstetric dyads. The PHC Programme lacks a Director or Manager that is dedicated to PHC.

Solutions to key challenges

The four groups prioritized key challenges facing the DCSTs and formulated solutions to ameliorate these. They challenges and their solutions are summarized in the table below.

Table 3: Solutions to key challenges

Challenge	Solution
Insufficient/no budget for essential DCST resources	➢ Work with the DM to identify non-negotiable resources needed for effective DCST function now ➢ Draft budget for necessary resources and ensure DCST activities are worked into future district budgets
Incomplete DCST teams and ongoing attrition	➢ Present teams should look for local capacity to address critical vacant posts. ➢ There should be continuous open advertisement at province level and constant recruiting to fill all gaps ➢ Need clear attraction and retention strategy, especially for rural districts
Rural allowance	➢ This must be standardized and fairly applied.
Dual role of some posts - expectations to do both jobs	➢ Vacated posts should be advertised as soon as possible. ➢ There is a need for flexibility at district level based

Challenge	Solution
	on need. For example, as MCWH coordinator will need PHC skills, could accept midwives.
Lack of provincial specialists in some provinces	➢ Need to explore joint appointments with universities
Clinical guidelines not always available or up to date on intranet	➢ Designate one person at provincial level to keep up to date and present protocols as required.
PHC is a “step child” and is unsupported.	➢ Need a national forum to define the roles of PHC specialists in the DCST, norms and standards for PHC and indicators for assessing PHC strengthening ➢ Review PHC structures and come up with a “fit for purpose” forum for PHC for it at district level. ➢ May need to describe a PHC supervisory team – (PHC supervisor, district specialist) who reports to the DM.
Acceptance of team by facility managers and staff, especially by local government facilities and structures	➢ Develop an entry strategy for facilities that includes diplomacy, humility and clear communication. ➢ Use formal introduction channels and prepare a formal presentation that explains the goals and activities of the DCST ➢ Communicate that DCSTs are there to provide a service and collaborate, not “supervise”.
DCST to DCST interactions	➢ Create forums for DCSTS from different districts to interact, learn, share, inspire and grow
Transport problems: Not eligible for subsidised car Allowance may not be enough to cover actual transport expenses.	➢ Coordinate and streamline outreach activities of team members so that several team members share transport and minimize costs. ➢ Lodge specific grievances where actual expenditure is not covered. ➢ May need a provincial review in line with expectations for DCST
There is a need for professional development opportunities, especially with respect to management and leadership skills.	➢ NDOH should include this in the national induction programme and DCSTs should identify courses and opportunities for this sort of development.

Challenge	Solution
Communication and creating synergy with other PHC re-engineering streams could be neglected	➢ Clarify complementary roles of the DCSTs, PHC outreach teams and school health services and how they can work together. ➢ Set up communication channels with PHC outreach teams and school health services.
Communication with NDOH and PDOH	➢ NDOH and PDOH should communicate timeously and directly with DCSTs about meetings ➢ Create a gmail group to facilitate inclusive communication ➢ DCSTs need to have access to NDOH and PDOH for support with communication when problems are discovered
DCST members do not work effectively, i.e., attend meetings but fail to provide face to face support in clinical environments	➢ Need clear role definitions ➢ DCST to regularly review activities and impact as a team, help members understand how to carry out their role practically and solve problems collectively ➢ Need a strong team leader who communicates well, is in touch with team members and can motivate them

3.5.3 Outcomes of Session 2

The role of DCSTs

Although the discussion about the role of DCSTs occurred in discipline-specific groups, there was coherence in the reports that emerged from the different groups.

- Supportive supervision of doctors and nurses of doctors and nurses, providing mentoring and coaching,
- Clinical leadership and governance,
- Ensure that up to date protocols are available and adhered to in facilities,
- Identify training needs of doctor and nurses, provide on-site clinical training and fire-drills and communicate with provincial and district training coordinators to ensure that training needs are met,
- DCST members should be leaders in:
    - Promoting a holistic approach to MNCWH, i.e., supporting preventive and promotive services, community involvement in health care and the work of the PHC ward-based outreach teams

- Modeling inter-disciplinary team work
- Promoting and mapping the way forward for integration of comprehensive MNCWH services,

- DCSTs need to work closely with PHC ward-based outreach teams.
- Monitoring and evaluation, including supporting mortality audits and conducting operational research. DCST members should get to know their districts through the baseline evaluation and conduct regular audits to inform district planning. The gaps and priorities indentified should guide the DCST activities.
- Review and support quality improvement projects to improve systems that support delivery of care, e.g., referral systems, procurement and supply, information management.
- DCSTs should support the revival of district health committees and clinic committees
- Few teams have a paediatric dyad, therefore there needs to be a flexible approach to accessing support from other sources, e.g., support from the paediatrician at the regional hospital or the provincial paediatrician.
- Members of dyads also need to work closely with and support other members of the team.

Priority areas for improvement of MNCWH outcomes, tools, good practices and potential mentors

All groups reiterated the need for DCSTs to focus on ensuring that updated clinical protocols are available and adhered to in facilities, strengthening the use of health information for improvement (especially supporting mortality audits) and conducting root cause analysis to identify gaps that must be addressed as priorities. The table below summarizes the top priority areas for attention, tools and good practices to be used, and roles of mentors in improvement of MNCWH outcomes

Table 4: Top priority areas to improve MNCWH outcomes

Group	Priority areas	Tools/good practices	Mentors
PHC nurses and family physicians	• Facilitate the integration of policies and programmes • Strengthening of ward-based PHC Outreach Teams • Strengthen health promotion • Improve management	***Tools**:* • Assist clinics to use dashboard indicators for improvement • BANC checklist • PHC Outreach Teams need a tool to screen for early	• Identify provincial mentors, e.g., provincial specialists • Foster partnerships with universities, with experienced family physicians

Group	Priority areas	Tools/good practices	Mentors
	of pregnant women i.e. early booking and regular ANC visits, early HIV testing • Proper care of babies • Play a role in nutrition and community-based facilities to get a better take on mother and child health • Appraise service delivery in terms of access and hours of operation, availability of medicine and equipment for the maternity and human resource for PHC. Address shortfalls. • Get to know the diverse communities that facilities and PHC Outreach Teams serve - focus on community diagnosis and profiling.	pregnancy so that they can refer pregnant women early for ANC to an outpost or a facility • Need a tool to create a profile of the community so that services can respond to that profile • Red flag: ARV down referral tool • *Good practice:* • Operation Thuma Mina – midwives take responsibility for an identified caseload of patients from booking to postnatal care • Phila Ma Project for cervical screening • Set targets for PHC nurses, e.g., One pap smear/professional nurse/day	• Existing development partners can assist with research, such as MRC, Centres for Rural Health at universities • Start inter-provincial partnerships with other DCSTs to share success stories • Create a PHC forum at the local level • Hold journal clubs
Paediatric nurses and paediatricians	• Community: supporting outreach teams and social mobilisation, school health • PHC level care: IMCI, EPI, PMTCT, NIMART • Acute paediatrics including emergency care • Care of children with long term conditions	***Tools:*** • *Essential Newborn Care Quality Improvement Toolkit* ***Good practices:*** • Nutrition monitoring at community and facility levels • Leveraging support/resources from developmental and other partners	• A Provincial MNCWH forum should include DCST members as well as MCWH programme managers, other members of ministerial committee members, Child PIP and PIPP co-coordinators, and other stake-holders.

Group	Priority areas	Tools/good practices	Mentors
	• Newborn care		• This forum can be replicated at district level.
Advanced midwives, Obstetricians and Aneasthetists	***The CARMMA priorities, specifically:*** • Quality of services – especially by improving skills and attention to minimum equipment requirements • PMTCT, HIV, EOC, Family Planning, teenage pregnancy and post partum care • H's as per report, with emphasis on health systems strengthening and HCW training • Training doctors in anesthetics • Referral policy and emergency transport services • Ensure uploading and use of partogram • Cervical cancer screening	• ESMOE training • Training for doctors on CS • Use of Audit tools and QA tools • Implementation of the Maternity guidelines and Standardised maternal mortality meetings • Implementation of SAINC • Action Framework for PMTCT and Data for Action reporting	***Areas lacking DCST specialists:*** • Involve university and other specialists in area. • Pair with adjacent district that doers have specialist/s • Website of resources for DCSTs • Provincial specialists should get involved in outreach to support DCSTs • More interaction with PHC Outreach Teams to better understand communities

4 SYNTHESIS AND KEY RECOMMENDATIONS

Following the plenary reports from the morning breakaway sessions, Dr Yogan Pillay summarised the conclusions and recommendations emanating from the reports and responded to some of the challenges with clarifications and proposals. Following his presentation, Dr Pillay opened the floor to questions and the points that were discussed are included below.

4.1 DCST roles, responsibilities, reporting lines

- DCSTs must develop clear standard operating procedures for roles, reporting and accounting lines that are coherent with the principles outlined in the *Ministerial Task team Report on District Clinical Support Teams in South Africa.* The roles of family physicians and PHC nurses are less defined than the roles of the obstetric and paediatric dyads. These roles need to be clearly defined, for scenarios in which other disciplines are present and in which they are alone in the DCST.
- DCSTS should report to and are accountable to the District Manager.
- DCSTs should have a clinical reporting line to the provincial specialists.
- DCSTs are members of the DMT and should work closely with it and the relevant District Programme Managers, such as PHC and MNCWH.
- DCSTs must participate actively in developing the District Health Plans (DHPs), developing DMT capacity where necessary, and reflecting the goals, activities and budgets of the teams therein.
- DCSTs must have a clear communication strategy and plan that involves all key stakeholders including:
    - The DM and the DMT, including the PHC and MNCWH Managers/Coordinators.
    - Provincial Specialist/s,
    - Facilities
    - PHC Outreach Teams and School Health Services
    - Inter-sectoral partners
    - The community
- This communication plan should be guided by principle of using existing structures, strengthened where necessary.
- The DCSTs need to define how they will complement and work closely with school health services and ward-based PHC Outreach Teams.

- DCSTs should play a role in reviving or strengthening District Health Councils.

4.2 Support DCSTs need to work effectively

- The breakaway groups clearly defined the resources they felt were essential for effective and efficient DCST functioning (see above).
- Many of these resources are not budgeted for in the current DHPs and the lack of these resources is hampering team function.
- Dr Pillay proposed that the NDOH will coordinate a process of identifying resource gaps in DCSTs, including appointments, salaries, administrative support, office space and commodities, medical equipment and transport, with each province. He committed the NDOH to sending DCSTs a template (within a week) that they could complete to communicate their resource needs. This nationwide resource gap audit will then be used to plan for ensuring that DCSTs receive essential resources as soon as possible.
- Dr Pillay noted the expressed need for leadership and management training and emphasized that the NDOH would ensure that the year-long national induction programme would include training to develop DCST members as leaders and managers.
- Dr Pillay also noted the need to review national, provincial and district PHC structures to provide guidance and support to PHC specialist in the DCSTs.
- Dr Pillay indicated that the NDOH would be approaching the deans of universities and the heads of nursing colleges in the near future to discus ways that these academic institutions could support DCSTs, especially in districts that are battling to recruit specialists.
- There is a need to facilitate cross-provincial sharing and support for DCSTs.
- There was a question from the floor about the length of the induction process and the need of DCSTs for guidance about what they should be doing in the interim between this workshop and the next. Dr Pillay pointed out that provincial workshops would follow this national workshop within weeks and that the DCSTs would soon be planning and embarking on their baseline reviews**.** The *Framework for the National District Clinical Specialist Teams Induction Workshop* gives an overview of the structure and content of the national DCST induction programme and the *Ministerial Task team Report on District Clinical Support Teams in South Africa* provides guidance on the roles and activities of DCSTs. Both these documents were handed out to participants and they will appear on the NDOH website.

4.3 Priorities for DCSTs

- DCSTS should get to know the data from their districts so that they can identify gaps and develop work plans that respond to these gaps. The work plans should also respond to the priorities outlines in the *Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition in South Africa 2012 – 2016* and *South Africa's National strategic Plan for a Campaign of Accelerated Reduction of Maternal and Child mortality in Africa (CARMMA)*.
- Clinical governance includes:
    - Supportive supervision of doctors and nurses using data for improvement, clinical guidelines and protocols,
    - DCSTs should model inter-disciplinary team work to clinicians in facilities and get doctors and nurses to work together for maximum synergy and
    - Provide or facilitate access to in-service training, e.g., ESMOE, EOST, PEP, SAINC, IMCI.
- There is a long list of priority areas for DCST action. Thus, there is a need to prioritise activities that have potentially high impact in the shorter term ("quick wins") and a strong-evidence basis to ensure that mortality rates drop rapidly. The CARMMA priorities are examples of this.
- Dr Pillay described the African-continent wide CARMMA initiative and outlined the CARMMA priorities as follows:
    - Exclusive breastfeeding
    - Improved contraceptive services
    - Improvement of the PMTCT programme
    - Improved outcomes for babies and mothers
        - ESMOE (Essential steps in the management of obstetric emergencies)
        - KMC (kangaroo mother care)
        - Obstetric waiting homes
        - Improved transport (obstetric ambulances)
- He also outlined the 5 components of the Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition in South Africa 2012 – 2016 and pointed out that MNCWH Strategic Plan and the CARMMA document are included in the flash disk resource pack received by each participant.
- DCSTS need to design operational research to develop an evidence basis for what works in their districts. Results need to be shared with other DCSTs.

- Dr Pillay highlighted the importance of strengthening all 3 streams of PHC Re-engineering and the role that DCSTs should play in strengthening community and household MCH services, focusing on prevention and promotion of health and strengthening social mobilisation to increase demand for health care and appropriate health seeking behaviour.

4.4 Tools

- The DCSTs should communicate up to date clinical guidelines and protocols to facilities and support adherence to these. Facilities should be accountable for following the protocols correctly and a key place to support this is during morbidity and mortality reviews. The focus of such reviews is on learning and avoiding the repetition of mistakes rather than punishment.
- The partogram, which is a powerful tool if used correctly.
- Use of the South African Initiative on Neonatal Care (SAINC) *Essential Newborn Care Quality Improvement Toolkit.*
- There is a need to develop indicators to measure DCST performance. The *Ministerial Task team Report on District Clinical Support Teams in South Africa* outlines a set of indicators for this. Dr Pillay committed the NDOH to drafting a "dashboard" of indicators that DCSTs can review and use within two weeks of the workshop.

4.5 Sharing lesions and tools

- The NDOH will create a national resource website for DCSTs. All the material from this workshop (presentations, reports, guidelines, tools, etc) will be loaded onto this website. In the interim, these materials will appear on the NDOH website (www.health.gov.za) in the week following this workshop.
- DCSTs can use journal clubs to stimulate learning and exploration of best practices.
- DCST experiences and learning can be shared with other DCSTs and stakeholders in district MCH forums.
- National and provincial meetings will provide forums for sharing and learning. Many DCSTs have already started working and have used this workshop as an opportunity to share their experiences and how they have approached the challenges they have encountered, e.g., communication styles that have facilitated entry into facilities. The national induction process will continue at provincial level and these workshops will provide space for feedback and sharing of challenges and good practices.
- The National DCST Induction Launch Workshop report will be available in three weeks.

5 VOTE OF THANKS

Dr Pillay thanked the following people for their contributions to a successful workshop:

- All the participants for responding at short notice and for the quality of their participation,
- The leaders for their vision and clear leadership in forging a way forward to improve maternal, newborn and child health and survival in South Africa,
- All the presenters, facilitators, scribes and reporters,
- The organisers of the workshop, the RMCH Programme, specifically the Futures Group and Health Systems Trust (HST). Ms Gugu Ngubane, from Futures Group and the Team Leader of RMCH Programme and Ms Petro Rousseau from HST were singled out for special recognition.
- Lastly, Dr Pillay thanked the staff in his office who worked round the clock to make the travel to the workshop happen, specifically, Ms Magda Fourie and Elizabeth Modise.

6 APPENDIX

Appendix 1 – Attendance list

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
Dr Aaron Motsoaledi	Department of Health	National		Minister of Health	Yes	No
Dr Gwen Malegwale Ramokgopa	Department of Health	National		Deputy Minister of Health	Yes	No
Ms Malebona Precious Matsoso	NDOH	National		Director General	Yes	No
Dr Yogan Pillay	NDOH	National		Deputy Director	Yes	Yes
Dr Dlamini Nonhlanhla	NDOH	National		Chief Director - Child Health	Yes	Yes
Dr Nono Simelele	NDOH	National			Yes	Yes
Prof Lesley Bamford	NDOH	National		Specialist	Yes	Yes
Dr Peter Barron	NDOH	National		Technical Advisor	Yes	Yes
Dr Khethisa Taole	NDOH	National		Director PHC	Yes	Yes
Mr Morewane R	NDOH	National		Chief Director	Yes	Yes
Ms Lindiwe Dladla	NDOH	National			Yes	Yes

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
Dr Ntomboxolo Bandezi	NDOH /HLSP	National		National DCST - Coordinator	Yes	Yes
Dr Nat Khaole	NDOH	National			Yes	Yes
Ms Sebotse Ngake	NDOH	National			Yes	Yes
Hasiwa Subedar	NDOH	National		Technical Advisor	Yes	Yes
Precious Robinson	NDOH	National		Technical Advisor	Yes	Yes
Mr B Asia	NDOH	National		DHS	Yes	Yes
Phuti Mashiane	NDOH	National		Assistant Director	Yes	Yes
Ms Nolwazi Gasa	DPME/Presidency	National		DDG	Yes	Yes
Mohay Makhosane	PATH	National		HSS Officer	Yes	Yes
Dr Siobhan Crowley	UNICEF			Chief Health	Yes	Yes
Sarah Barber	WHO					
Sagie Pillay	NHLS					
James Maloney	PEPFAR			Coordinator	Yes	
Rose Makopo	NDOH			CD:MNWH	Yes	Yes
Filale Mabelebele	NDOH			CD:MNWH	Yes	Yes

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
Nobomi Ntinganti	NDOH			CD:MNWH	Yes	Yes
Lorinda Nieuwoudt	NDOH			CD:MNWH	Yes	Yes
M Ntuli	WHO		NPO		Yes	
L Olive	ECDOH	EC	NMBD	District Manager	Yes	Yes
Ms Nozuko P Mabono	ECDOH	EC	OR Tambo	Advanced Midwife	Yes	Yes
Ms Essinah Nosisi Nohaji	ECDOH	EC	OR Tambo	Advanced Midwife	Yes	Yes
Ms Ngese NG	ECDOH	EC	OR Tambo	DCST - Paeds Nurse	Yes	Yes
Mr Xolela Somahela	HST	EC	OR Tambo	Provincial Coordinator	Yes	Yes
Hon Sicelo Gqobana	ECDOH	EC	Provincial	MEC - Eastern Cape	Yes	No
Ms Ndileka Gaba	ECDOH	EC	Provincial	Manager	Yes	Yes
Ms Dinah Morapedi	ECDOH	EC	Provincial	Manager	Yes	Yes
Sesi R Noge	DOH	FS	Fezile Dabi	District Manager	Yes	Yes
Dr Mbisha Kalala B	DOH	FS	Fezile Dabi	Family Physician	Yes	Yes
Ms Khomari DL	DOH	FS	Fezile Dabi	Paeds Nurse	Yes	Yes

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
Ms Radebe Lulu	DOH	FS	Fezile Dabi	Adv Midwife	Yes	Yes
Ms Korkie Sandra	DOH	FS	Fezile Dabi	DCST - PHC Nurse	Yes	Yes
Ms Khumalo DF	DOH	FS	Fezile Dabi	MCWH Coordinator	Yes	Yes
Ms Motampane MH	DOH	FS	LejwelePutswa	DCST - Paeds Nurse	Yes	Yes
Ms Motete MR	DOH	FS	LejwelePutswa	Adv Midwife	Yes	Yes
Dr Akinbohun OJ	DOH	FS	LejwelePutswa	Family medicine	Yes	Yes
Msibi Sibusiso R	DOH	FS	LejwelePutswa	PHC Nurse	Yes	Yes
Dr Akweyo N	DOH	FS	LejwelePutswa	Family Physician	Yes	Yes
Monnye M Enea	DOH	FS	LejwelePutswa	Acting District Manager	Yes	Yes
Dr V Mooya	DOH	FS	Mangaung	Family Physician	Yes	Yes
Ms Moshoeshoe MM	DOH	FS	Mangaung	PHC Nurse	Yes	Yes
Ms Moshe NR	DOH	FS	Mangaung	Adv Midwife	Yes	Yes
Ms Nkhobo MM	DOH	FS	Mangaung	Paediatric Nurse	Yes	Yes
Mr Mojaki	DOH	FS	Mangaung	Acting District Manager	Yes	Yes

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
Sesing A	DOH	FS	Maternal Unit	MCWH Coordinator	Yes	Yes
Adalene van Jaarsveld	DOH	FS	Namakwa	Adv. District NP	Yes	Yes
Hon Ngubentombi Fezi	DOH	FS	Provincial	MEC - Free State	No	No
Ms Me W Motlolometsi	DOH	FS	Provincial	Provincial Specialist	Yes	Yes
Dr Kabane S	DOH	FS	Provincial	HOD	Yes	Yes
Mr Bohlale David	DOH	FS	Provincial	Manager	Yes	Yes
Booysen Me V	DOH	FS	Provincial	Neonatal Nursing Specialist	Yes	Yes
Dr Schoon MG	DOH	FS	Provincial	Chief Specialist	Yes	Yes
Sepele S Matela	DOH	FS	Provincial	Specialist	Yes	Yes
Masasa MME	DOH	FS	Thabo Mofutsanyane	DCST - Adv Midwife	Yes	Yes
Somtjato MM	DOH	FS	Thabo Mofutsanyane	DCST - PHC	Yes	Yes
Dr Akeke V	DOH	FS	Thabo Mofutsanyane	Family Physician	Yes	Yes
Pitso Ntibih	DOH	FS	Thabo	Paeds Nurse	Yes	Yes

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
			Mofutsanyane			
Sibeko SR	DOH	FS	Thabo Mofutsanyane	District Manager	Yes	Yes
Ramokotjo ML	DOH	FS	Thabo Mofutsanyane	PHC Manager	Yes	Yes
Ramalitsi PP	DOH	FS	Xhariep	DCST - Adv. Midwife	Yes	Yes
Dr Kalume Tshibango	DOH	FS	Xhariep	DCST - Family Physician	Yes	Yes
Ms Mpopo ME	DOH	FS	Xhariep	DCST - PHC nurse	Yes	Yes
Moathloli LL	DOH	FS	Xhariep	Acting District Manager	Yes	Yes
Prof Haroon Saloojee	Wits	GP		Professor	Yes	Yes
CN Mnyani	Anova Health	GP			Yes	Yes
Liesbeth Mangate	NDOH	GP		Acting AU/NEPAD Coordinator	Yes	Yes
Puleng Ramataboe	CDC	GP		CT Branch	Yes	Yes
Mary Magashoa	CDC	GP		PMTCT- Paeds	Yes	Yes
Sithembiso Velaphi	NaPeMMCo	GP		Member	Yes	Yes

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
				NaPeMMCo		
Zay Selima	DOH	GP		Acting Directo - DHS	Yes	Yes
Meisie Leruthe	DOH	GP		CD:MNWH	Yes	Yes
Sipho Mahlathi	NHLS	GP		Executive Manager	Yes	Yes
Haroon Saloojee	Wits	GP		Paediatrician	Yes	Yes
Ms Mosadi PP	DOH	GP	Ekurhuleni	DCST - Adv. Midwife	Yes	Yes
Dr Modise ML	DOH	GP	Ekurhuleni	DCST - Family Physician	Yes	Yes
Dr Bapela	DOH	GP	Ekurhuleni	Paediatrician	Yes	Yes
Dr Kusari Basu	DOH	GP	Ekurhuleni			
Ms Mosadi PP	DOH	GP	Ekurhuleni			
Ms Sekgonyane MS	DOH	GP	Ekurhuleni	DCST - Paeds Nurse	Yes	Yes
Ms Maseko Nomvula	DOH	GP	Ekurhuleni		Yes	
Modise C	DOH	GP	Ekurhuleni	Director		
Ms Kodisang Deliwe	DOH	GP	Ekurhuleni	Deputy Director		

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
Dr Basu J	DOH	GP	Ekurhuleni	DCST - Obs & Gynae	Yes	Yes
Dr Agbo S	DOH	GP	Ekurhuleni	District Family Physician	Yes	Yes
Dr NM Lembethe	DOH	GP	JHB Metro	DCST - Obs & Gynae	Yes	Yes
Prof Buchmann	DOH	GP	JHB Metro	DCST	Yes	Yes
Dr Mphahlele R	DOH	GP	JHB Metro	Specialist	Yes	Yes
Dr Olusola EO	DOH	GP	JHB Metro	Specialist	Yes	Yes
Ms Raymond N	DOH	GP	JHB Metro	Paediatric Nurse	Yes	Yes
Ms Makgotlhoe Mary	DOH	GP	JHB Metro	DCST -Adv. Midwife	Yes	Yes
Ms Maseleni Maria	DOH	GP	JHB Metro	PHC	Yes	Yes
Mahlangu EN	DOH	GP	JHB Metro	DD Programmes	Yes	Yes
Thulane Madonsela	DOH	GP	JHB Metro	Chief Director	Yes	Yes
Dr Gugu Ngubane	Futures Group	GP	National	Chief of Party - RMCH Programme	Yes	Yes
Ms Petro Rousseau	HST	GP	National	DTL - Technical - RMCH	Yes	Yes

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
Ms Sophy Mabasa	PATH	GP	National	Nutrition Specialist	Yes	Yes
Dr Smita Kumar	USAID	GP	National	Technical Advisor	Yes	Yes
Melinda van Zyl	SCUK	GP	National	Programme Director	Yes	Yes
Fiorenza Martirelli	HST	GP	National	Technical Advisor	Yes	Yes
Angela McIntyre	SCUK	GP	National	Health Advisor	Yes	Yes
Hester Du Bruyn	HST	GP	National	Project Manager	Yes	Yes
Ms Chipo Shereni	Futures Group	GP	National	Accounts Assistant	Yes	Yes
Mr Brian Ng'andu	Futures Group	GP	National	Data and Monitoring Manager	Yes	Yes
Ms Elsie Ntuli	Futures Group	GP	National	Admin & Log Manager	Yes	Yes
Dr NA Skeyile	Futures Group	GP	National	MCH-Technical Advisor	Yes	Yes
Ms Melinda Potgieter	Futures Group	GP	National	Data Demand and Use Advisor	Yes	Yes
Ms Ellen Hagerman	SDD	GP	National	Demand & Accountability - TA	Yes	Yes

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
Dr Albert Bakor	I-TECH	GP	National	Country Director	Yes	Yes
Ms Sibongile Monareng	NDOH	GP	National	Project Specialist	Yes	Yes
Thoko Ndaba	SCUK	GP	National	Project Manager	Yes	Yes
Hon Anthony Papo	GP Provincial Gov	GP	Provincial	MEC - Gauteng	No	No
Ms Shimulani Claudia	I-TECH	GP	Provincial	Director – HSS	Yes	Yes
Ms Thandi Chaane	Gauteng Health	GP	Provincial	Chief Director	Yes	Yes
Ria van Walt	DOH	GP	Provincial		Yes	Yes
Dr Kamy Chetty	GP Provincial Government	GP	Provincial	HOD		
Thabile Vezi	RTC	GP	RTC	MO-PPM	Yes	Yes
Ms MC Dichaba	DOH	GP	Sedibeng	Deputy Director	Yes	Yes
Dr Themba L Zwane	DOH	GP	Sedibeng	DCST - Obs & Gynae	Yes	Yes
Ms Sejake Senate	DOH	GP	Sedibeng	Assistant Director - MCWH	Yes	Yes
Ms Tsoane Joyce N	DOH	GP	Sedibeng	DCST - Paeds Nurse	yes	Yes
Ms Mkonanzi Aletta	DOH	GP	Sedibeng	Midwife	Yes	Yes

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
Ms Sigh Indroma	DOH	GP	Sedibeng	DCST - PHC	Yes	Yes
Lekwetji Mamabo	DOH	GP	Thswane	PHC Reengineering	Yes	Yes
JFM Hugo	UP	GP	Thswane	Family Physician	Yes	Yes
Dr Oosthuizen S	DOH	GP	Tshwane	District Family Physician	Yes	Yes
Dr Tshukudu ME	DOH	GP	Tshwane Metro	Paediatrician	Yes	Yes
Dr Pe Mya	DOH	GP	Tshwane Metro	DCST - Anaesthetist	Yes	Yes
Ms Sithole KE	DOH	GP	Tshwane Metro	Adv Midwife	Yes	Yes
Ms Mfolo MVH	DOH	GP	Tshwane Metro	PHC Nurse	Yes	Yes
Mmathapelo Kedadi	DOH	GP	Tshwane Metro	MCWH Coordinator	Yes	Yes
Dr Win T	DOH	GP	West Rand Dist Council	Principal Paediatrician	Yes	Yes
Dr Abrahams G	DOH	GP	West Rand Dist Council	Principal Family Physician	Yes	Yes
Ms Khoto A	DOH	GP	West Rand Dist Council	Paed Nurse	Yes	Yes

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
Ms Jooste *R*	DOH	GP	West Rand Dist Council	Adv Midwife	Yes	Yes
Ms Mamke Mmuoe O	DOH	GP	West Rand Dist Council	DCST - PHC	Yes	
Tshidi Matsaba	DOH	GP	West Rand Distr	Acting Director	Yes	Yes
Marousi Mzondi	DOH	GP	West Rand District	Assistant Director - MCWH	Yes	Yes
Dr Neil McKerrow	MTT/COMM	KZN			Yes	Yes
Dr Anna Silvia Voce	UKZN	KZN			Yes	Yes
Charles Hervey Vaughan-Williams	DOH	KZN		Family Physician	Yes	Yes
Sibongile Zungu	DOH	KZN		? HOD	Yes	Yes
D Nyasulu	UKZN	KZN		Adv. Midwife	Yes	Yes
Mr James Mabhalane Nkosi	DOH	KZN	Amajuba	Deputy Manager	Yes	Yes
Masothole Patricia Langa	DOH	KZN	Amajuba	PHC Specialist	Yes	Yes
Khanyisile Barbara Moloi	DOH	KZN	Amajuba	OM PMRT	Yes	Yes

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
Siphesihle Nobuhle Mnyandu	DOH	KZN	Amajuba	MCNWH - Trainer	Yes	Yes
Ms Ntombi Phakathi	DOH	KZN	Amajuba	Advanced Midwife	Yes	Yes
Prof J Moodley	NDOH	KZN	eThekwini	MH Specialist	Yes	Yes
Mrs Duduzile Ntombela	DOH	KZN	eThekwini	DCST - PHC	Yes	Yes
Ms Lindiwe Ngwenya	DOH	KZN	eThekwini	DCST - Adv. Midwife	Yes	Yes
Ms Nokuthula Sibiya	DUT	KZN	eThekwini	HOD - Nursing	Yes	Yes
Mrs Maria Lindiwe Ngwenya		KZN	eThekwini		Yes	Yes
Mrs Cynthia Cabangile Gumede	DOH	KZN	eThekwini	DCST - Peads	Yes	Yes
Mrs Duduzile Ntombela		KZN	eThekwini	DCST - PHC	Yes	Yes
Dladla Thandi Penelope	DOH	KZN	Ethekwini		Yes	Yes
Dr Mojaleta Maseloa	DOH	KZN	Ilembe	DCST - Family Physician	Yes	Yes
Thembelihle Rosemary Mungwe	DOH	KZN	Ilembe	OM -PMTCT	Yes	Yes
Dr Marlanee Noopanar	DoH	KZN	Ilembe	DCST - Family	Yes	Yes

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
				Physician		
Mrs Thoko Somahle Mary Radebe	DOH	KZN	iLembe	DCST	Yes	Yes
Mrs N Nokwethemba Khumalo	DOH	KZN	iLembe	Primary Health Care	Yes	Yes
Mornica Thandiwe Mazibuko	DOH	KZN	iLembe	OM - MCWH	Yes	Yes
Mrs Primrose N Dladla	DOH	KZN	iLembe		Yes	Yes
Dr Waasila Jassat	HST	KZN	National		Yes	Yes
S'thandwa Mnqayi	DOH	KZN	Provincial	DM: SRH	Yes	Yes
Dr Neil Francis Moran	DOH	KZN	Provincial	Provincial Obstetrician	Yes	Yes
Ms Eunice Zanele Hadebe	DOH	KZN	Provincial	Provincial C oordinator - PHC	Yes	Yes
Dina Bongekile Mofokeng	DOH	KZN	Provincial		Yes	Yes
Mr Sibongile Shezi	HST -SA SURE	KZN	Provincial	Provincial Coordinator	Yes	Yes
Dr Victoria Mubaiwa	PDOH	KZN	Provincial	Manager	Yes	Yes

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
Dr Meera Chhagan,	UKZN	KZN	Provincial	Child Health Specialist	Yes	Yes
Janet Dalton	DOH	KZN	Provincial	Manager	Yes	Yes
Rob Reimers	UKZN	KZN	Provincial	Leadership/Management	Yes	Yes
Dr Sibongile Zungu	KZN Provincial Government	KZN	Provincial	HOD	Yes	Yes
Nokuzola Cynthia Mzolo	DOH	KZN	Sisonke	DCST - Adv Midwife	yes	yes
Mrs. N.S Radebe	DOH	KZN	Sisonke	District manager	Yes	Yes
Mr BH Sthembiso Makhaye	DOH	KZN	Sisonke	Deputy District Manager	Yes	Yes
Mrs Priscilla Makhaye	DOH	KZN	Sisonke	DCST - PHC	Yes	Yes
Margaret Thandeka Zulu	DOH	KZN	Sisonke		Yes	Yes
Mrs Lorna Margaret Reddy	DOH	KZN	Ugu	Paeds Nurse	Yes	Yes
Dr Veeran Chetty	DOH	KZN	Ugu	Deputy Manager	Yes	Yes
Ms BWL Nompumelelo Shibe	DOH	KZN	Ugu	PMTCT - STA	Yes	Yes

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
Ms Bertha Cornelia Msomi	DOH	KZN	Ugu	MCWH Coordinator	Yes	Yes
Dr Gustav Tom	DOH	KZN	Ugu	DCST - Family Physician	Yes	Yes
Mrs Priscilla Jabulile Tobo	DOH	KZN	Ugu	DCST - Adv	Yes	Yes
Lindi Ndelu	DOH	KZN	Ugu	ANM - PHC	Yes	Yes
Mrs Bagcinile Eugenia Mqadi	DOH	KZN	Ugu	PHC Nurse	Yes	Yes
Ms Victoria B Shezi	DOH	KZN	Ugu	AMM	Yes	Yes
Ms Michaelina H Khumalo	DOH	KZN	Ugu	Acting District Manager	Yes	Yes
Ms Kholeka Yako	DOH	KZN	Ugu	AMM - PHC	Yes	Yes
Dr Meera Chhagan	UKZN	KZN	UKZN	HOD - MCH	Yes	Yes
Ntombile Mayvis Zuma-Mkhonza	DOH	KZN	Umgungundlovu	District Manager	Yes	Yes
Mrs. Hlobisile Langa	DOH	KZN	Umgungundlovu	DCST - PHC	Yes	Yes
Dr Charles Batchelder	DOH	KZN	Umgungundlovu	DCST - Obs & Gynae	Yes	Yes

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
Mrs. Kholeka Makhathini	DOH	KZN	Umgungundlovu	DCST - Adv. Midwife	Yes	Yes
Mrs. Busie Mhlongo	DOH	KZN	Umgungundlovu	MCWH	Yes	Yes
Mrs. Siphiwe Maseko	DOH	KZN	Umgungundlovu	MCWH - PMTCT	Yes	Yes
Patricia Thembelihle Vilakazi	DOH	KZN	Umgungundlovu	DCST - Paeds	Yes	Yes
Shuaib Kauchali	DOH	KZN	Umgungundlovu	DCST - Paeds	Yes	Yes
Dr Timothy Kerry	DOH	KZN	Umgungundlovu	Manager	Yes	Yes
TM Dlamini	DOH	KZN	Umkhanyakude	MCWH	Yes	Yes
Makhosazane Princess Thembe	DOH	KZN	Umkhanyakude	District Manager	Yes	Yes
Zamakhosi P Mkhomane	DOH	KZN	Umkhanyakude	DCST - Paeds nurse	Yes	Yes
Mrs Zamakhosi P Mkhumane	DOH	KZN	Umkhanyakude	DCST - Paediatrics	Yes	Yes
Mrs Dumazile Ruth Maoela		KZN	Umkhanyakude	DCST - PHC nurse	Yes	Yes
Ms Thobile Monica Simelane	DOH	KZN	uMkhanyakude	DDM	Yes	Yes

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
Richard Giles Bartlett	DOH	KZN	Umzinyathi	Clinical manager	Yes	Yes
Doreen Lindiwe Sethembile Zulu	DOH	KZN	Umzinyathi	PHC Specialist	Yes	Yes
Gugu Charlotte Shabangu	DOH	KZN	Umzinyathi		Yes	Yes
Dr Chika Deciderius Ifebuzor	DOH	KZN	Umzinyathi	DCST - Family Physician	Yes	Yes
Bongi Maria Ngubane	DOH	KZN	Umzinyathi	MCWH - PMTCT	Yes	Yes
Ms Thobekile Mpembe	DOH	KZN	Uthukela	DCST - Adv.Midwife	Yes	Yes
Mrs Thobekile Joice Mpembe	DOH	KZN	Uthukela	DCST - Adv. Midwife	Yes	Yes
Mrs Nomalanga Ndhlovu	DOH	KZN	Uthukela	DCST - PHC	Yes	Yes
Nomusa I Maphalala	DOH	KZN	uThukela	DDM	Yes	Yes
Thandeka Zulu		KZN	uThukela		Yes	Yes
Nomusa I Maphalala	DOH	KZN	Uthukela	DDM	Yes	Yes
Ms SP Hadebe	DOH	KZN	Uthungulu	Clinical Programmes manager	Yes	

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
Ms Martha Fakazile Cilo	DOH	KZN	Uthungulu	MCWH Coordinator	Yes	Yes
Dr Gerda Ursula Wessels	DOH	KZN	uThungulu	DCST - Obs & Gynae	Yes	Yes
Mfowethu M Zungu	DOH	KZN	uThungulu	District manager	Yes	Yes
Mrs Ntokozo Princess Dladla	DOH	KZN	uThungulu	DCST - PHC	Yes	Yes
Lucky Senzo Khumalo	DOH	KZN	Zululand	DDM: Clinical	Yes	Yes
Mrs Khanyisile N Qwabe	DOH	KZN	Zululand	DCST - Paeds Nurse	Yes	Yes
Ms Daphne Memela	DOH	KZN	Zululand	Director	Yes	Yes
Mrs Winfrieda Tozana Buthelezi	DOH	KZN	Zululand	DCST - PHC	Yes	Yes
Ntombizodwa Dladla	DOH	KZN	Zululand	DCST	Yes	Yes
Ms Daisy Mafubedu	Limp Provincial Government	LIMP	Provincial	HOD		
Dr Robertson A		Limpopo		Peadiatrician		
Dr Zuckerman M		Limpopo		Paediatrician		
Dr Sitali W		Limpopo		DMO (Obs &		

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
				Gynae)		
Ms Machavana MM		Limpopo		PHC Nurse		
Ms Mashishi MJ		Limpopo		Paeds Nurse		
Ms Selala ME		Limpopo		PHC Nurse		
Ms Makua M		Limpopo		PHC Nurse		
Annie Robertson	U limpopo	Limpopo		Paediatrician	Yes	Yes
Ms Sape WM	DOH	Limpopo	Capricorn	PHC Nurse	Yes	
Mr Thobejane MP	DOH	Limpopo	Capricorn	DEM	Yes	
Ms Maumela Mboneni	DOH	Limpopo	Capricorn	Senoir Manager	Yes	Yes
Ms Matidze ME	DOH	Limpopo	DMT	Senoir Manager MCH	Yes	Yes
Dr Miles Janet	Letaba	Limpopo	Mopani	DCST - Paediatrician	Yes	Yes
Ms Ngobeni MN	DOH	Limpopo	Mopani	DCST - PHC nurse		
Dr Bogale MS	DOH	Limpopo	Mopani	DEM	Yes	
Mashele M	DOH	Limpopo	Mopani	MCWH Manager	Yes	Yes
Ms Mashishi MJ	DOH	Limpopo	Mopani	DCST - Paeds	Yes	Yes

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
				Nurse		
Ms Mokaba ME	DOH	Limpopo	NSD	MNSD	Yes	
Hon Dr Norman Mabasa	Limpopo Provincial Gov	Limpopo	Provincial	MEC - Limpopo	Yes	No
Dr Shoyeb Mohammad	PMHC	Limpopo	Provincial	Head of Unit	Yes	Yes
Dr Kgaphole NP	DOH	Limpopo	Provincial	GM/DHS	Yes	Yes
Ms Linan M Maepa	DOH	Limpopo	Sekhukhune	DEM	Yes	Yes
Dr Omoighe RO	DOH	Limpopo	Sekhukhune	Family medicine	Yes	Yes
Mogalagadi Makua	DOH	Limpopo	Sekhukhune	DCST - PHC	Yes	Yes
Dr Mulimisi Ramavhuya	Vhembe Fam. Distr Med	Limpopo	Vhembe	F. Physician	Yes	Yes
Ms Raliphaswa M Reginah		Limpopo	Vhembe	Deputy Manager	Yes	Yes
Mr Sirwali		Limpopo	Vhembe	ADEM	Yes	
Ms Phampha MP	DOH	Limpopo	Vhembe	MCWH Coordinator	Yes	Yes
Dr Owo OI	DOH	Limpopo	Waterberg	F.Physician	Yes	Yes
Mr Moetlo G J	DOH	Limpopo	Waterberg	DEM	Yes	Yes

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
Ms Mokwena Matlala	DOH	Limpopo	Waterberg	DCST - Adv Midwife	Yes	Yes
Dr BC Spies	DOH	MP		DCST - Paediatrician	Yes	Yes
Ms Mdhluli P	DOH	MP	Ehlanzeni	DCST - Adv. Midwife	Yes	Yes
Dr M Mahfoudhi	Tintswalo	MP	Ehlanzeni	Paediatrician	Yes	Yes
Ms Madonsela TZ	DOH	MP	Ehlanzeni	District Director	Yes	Yes
Ms Poyo NE	DOH	MP	Ehlanzeni	Assistant Manager	Yes	Yes
Dr Goosen GA	DOH	MP	Ehlanzeni	Clinical MO	Yes	Yes
Dr Spies BC	Themba	MP	Ehlanzeni	Paediatrician	Yes	Yes
Ms Mdhluli Pansy	DOH	MP	Ehlanzeni		Yes	Yes
Ms Mtungwa Babsy Gladys	DOH	MP	Ehlanzeni	Paeds Nurse	Yes	Yes
Ms Selala E	DOH	MP	Ehlanzeni	PHC Specialist	Yes	Yes
Ms Taute R	DOH	MP	ENkangala	MCWYH	Yes	Yes
Ms Hlatshwayo NG	DOH	MP	Gert Sibande	GM/DHS	Yes	Yes
Ms Mabunda KC	DOH	MP	Gert Sibande	Assistant Director -	Yes	Yes

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
				MCWH		
Dr Chundu RC	DOH	MP	Gert Sibande	Head of Unit	Yes	Yes
Ms Mabuza FN	DOH	MP	Gert Sibande	Paeds Nurse	Yes	Yes
Ms Mabunda KG		MP	Gert Sibande		Yes	Yes
Ms Ngwenya CN	DOH	MP	Gert Sibande	DCST - PHC	Yes	Yes
Ms Mokoena ML	DOH	MP	Nkangala	DCST - Adv. Midwife	Yes	Yes
Ms Senamela NSR	DOH	MP	Nkangala	PHC	Yes	Yes
Ms Mtshweni ZP	DOH	MP	Nkangala	Child Health Specialist	Yes	Yes
Josh Motlhamme	DOH	MP	Nkangala	District manager	Yes	Yes
Hon. Dr Mkasi Rhulani	MP Provincial Gov	MP	Provincial	MEC - Mpumalang	Yes	No
Ms Ida S Makwetla	DOH	MP	Provincial	Provincial C oordinator - PHC	Yes	Yes
Savera Mohangi	DOH	MP	Provincial	Director	Yes	Yes
Dr Roland E Mhlanga	DOH	MP	Provincial	Specialist	Yes	Yes
Ms Mdluli DC	DOH	MP	Provincial	Prov. Manager	Yes	Yes

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
Mr Mzikawande Mnisi	MP Provincial Government	MP	Provincial	HOD		
Ms Mercedes Fredericks	HST	NC		Provincial Coordinator	Yes	Yes
Ms Thupane Aletta	DOH	NC	Frances Baard	Adv.Midwife	Yes	Yes
Ms Disipi G G	DOH	NC	JT Gaetsewe	PHC Specialist	Yes	Yes
Dr Jansen Ahmat	DOH	NC	JT Gaetsewe	Paediatrician	Yes	Yes
Dr Ahmad Jassen	DOH	NC	JTGaetsewe	DCST - Paediatrician	Yes	Yes
Ms Adalene van Jaarsveld	DOH	NC	Namakwa	MNCYWH	Yes	Yes
Ms Lekhoati M Makekana	DOH	NC	Pixley ka Seme	DCST-Adv. Midwife	Yes	Yes
Ms Thabapelo Goitsemang	DOH	NC	Pixley ka Seme	Adv. Paeds nurse	Yes	Yes
Dr Jacobs KL	DOH	NC	Pixley ka Seme	DCST	Yes	Yes
Ms Mackenzi Cindy E	DOH	NC	Pixley kaSeme	Coordinator	Yes	Yes
Ms Eckard Mariette	DOH	NC	Pixley kaSeme	District Manager	Yes	Yes
Ms Ferris Rene Alicia	DOH	NC	Pixley kaSeme	DCST -	Yes	Yes

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
				Paediatrician		
Mr Mxolisi Sokatsha	NC Provincial Gov	NC	Provincial	MEC - Northern Cape	Yes	No
Ms Molelekwa Audrey	DOH	NC	Provincial	DHS + PHC	Yes	Yes
	NC Provincial Government	NC	Provincial	HOD		
Ms Van Wyk LC	DOH	NC	Siyanda	MNCWYH	Yes	Yes
Ms Molefe Maria CB	DOH	NW	Bojanala	DCST - PHC Nurse	Yes	Yes
Ms Molefe NE	DOH	NW	Bojanala	PHC Nurse	Yes	Yes
Dr Sono LL	DOH	NW	Bojanala	DCST - Paediatrician	Yes	Yes
Dr. Offiong Bassey	DOH	NW	Bojanala	DCST - Family Physician	Yes	Yes
Dr. Hukuimwe Roger	DOH	NW	Bojanala	HOD	Yes	Yes
Ms. Tuludi Magdalene	DOH	NW	Bojanala	PHC Nurse	Yes	Yes
Dr. Tumbo John	DOH	NW	Bojanala	DCST - Family Physician	Yes	Yes
Monica Bolae	DOH	NW	Bojanala	DCST - Midwife	Yes	Yes

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
Dr Claire van Deventer	DOH	NW	Dr K Kaunda	DCST - Family Physician	Yes	Yes
Dr Edrone Rwakaikara	DOH	NW	Dr K Kaunda	DCST - Family Physician	Yes	Yes
Dr Erika du Plessis	NWDOH	NW	Dr K Kaunda		Yes	Yes
Ms Thembeka Zenzile	DOH	NW	Dr K Kaunda	PHC Specialist	Yes	Yes
Ms MP Siko	DOH	NW	Dr K Kaunda		Yes	Yes
Dr Ota Onwuagbo	DOH	NW	Dr K Kaunda	MO	Yes	Yes
Ms MC Dhlamini	NWDOH	NW	Dr K Kaunda	Child Health nurse	Yes	Yes
Dr Njie AB		NW	Ngaka Modiri Molemo	District Family Physician	Yes	Yes
Dr Kwet BKN	DOH	NW	Ngaka Modiri Molemo	DCST	Yes	Yes
Dr Kabongo D	DOH	NW	Ngaka Modiri Molemo	DCST -Family Physician	Yes	Yes
Ms Sithole PJ	DOH	NW	Ngaka Modiri Molemo	PHC Manager	Yes	Yes
Hon. Dr. Magome Masike	NW Provincial Gov	NW	Provincial	MEC - North West	Yes	No

Name & Surname	Organization / Institution	Province	District	Designation	27/09/2012	28/09/2012
Ms CN Modise	DOH	NW	Provincial	Deputy Director - MCWH	Yes	Yes
Ms GB Tsele	DOH	NW	Provincial	Director - MCWH/N	Yes	Yes
Dr SE Abizu	DOH	NW	Ruth Mompati	DCST - Family Physician	Yes	Yes
Ms Mokgotsi Lebogang	DOH	NW	Ruth Mompati	DCST - PHC nurse	yes	Yes
Ms Magdaline M Ttlolokwane	DOH	NW	Taung	RSM	Yes	Yes
Dr Farley Cleghorn	Futures Group	SA		CTO	Yes	No
Ms Liz Mallas	Futures Group	SA		Deputy Director, CHSS	Yes	No
Dr Bob Fryatt	DFID	SA		Advisor	Yes	No
Ms Natasha R Rhoda	NaPeMMCo	WC		Chair	Yes	Yes

APPENDIX 2 – SPEECH DELIVERED BY THE MINISTER OF HEALTH

SPEECH FOR THE MINISTER: LAUNCH OF THE INDUCTION PROGRAMME OF THE CLINCIAL SPECIALIST TEAMS, 27 SEPTEMBER 2012, ST GEORGES HOTEL, GAUTENG

Programme director, Me Precious Matsoso

The Deputy Minister of Health Dr Gwen Ramokgopa

The MECs of Health present

HODS of Health

Our development partners

Our special guests, the members of the District Clinical Specialist Teams from provinces

Distinguished Guests

Ladies and Gentlemen

Good afternoon

This is indeed a very important occasion for the country! When I conceptualised the idea of teams of specialists, working in our districts to improve the quality of care so that we can reduce maternal and child mortality and improve maternal and child health, I remember many people, including officials asking where we will get the specialists from! I told them that we cannot fail before we try and today's event signifies the importance of dreaming of the impossible!

Our beloved former President, Tate Nelson Mandela is often quoted as saying: "It always seems impossible until it is done".

As you may know, before I proceeded I consulted with the Deans of the Medical Schools. They told me that this was a very good idea but they also cautioned that we may not find the people and that most of the clinicians are trained to think about individual patients. This meant that once employed the district clinical specialist team members will have to be oriented to also think about population or public health issues.

After this consultation I appointed a Ministerial Task Team that Prof Jack Moodley chaired. It included a number of senior and very experienced medical specialists and nurses, as well as the Chair of the Medical Deans committee. This committee advised me and the National Health Council on the team's composition, what experience was needed etc. As you can see from the programme they will also be presenting later this afternoon so I will not provide further details of their work.

At present, through the initial advertisements, I am happy to announce that we have appointed the following medical specialists and senior nurses nation- wide:

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

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

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

As is obvious from this list, the rural districts which are usually the more challenged with a greater burden of disease and also a lack of access to health services, are the districts that have the fewest specialists! This level of inequity must be corrected and we are committed to doing so.

This gives us a total of 172 appointments made of a possible 364 or 47% of posts filled. As you can see you are the first cohort, pioneers in this field!

I am providing these statistics only for illustrative purposes to show the districts where we have done well and those where we have thus far struggled to fill positions. For those districts that as yet have no members of the team or very few we will have to find innovative ways of recruiting these specialists. We are exploring a number of options in this regard, including appointing specialists in acting capacities and having contracts with medical schools.

When I conceptualised the District Clinical Specialist Team idea, it was to strengthen primary health care and the district health system. As you know these teams form part of the three streams of PHC re-engineering. The other two streams are the municipal ward based PHC outreach teams which will be composed of a professional nurse and community health workers as well as the new school health programme.

As part of the ward based PHC outreach teams we have re-oriented more than 5000 community health workers and another 5000 are in the process of being re-oriented. The

teams will be responsible for a catchment area and visit every household. Their primary roles are prevention and health promotion in both families and communities. These teams will assist us in early identification and referral and also focus on improving adherence to treatment and care. They will work closely with other community based workers, including home based carers employed by the Department of Social Development.

With respect to the school health programme, which will be launched in October, we will be taking services to schools using mobiles. We will have a set of three mobiles that will visit schools. This includes a mobile that will provide a comprehensive set of PHC services, a fully equipped dental mobile as well as a mobile that will provide optometry services. We will provide more details on the school health programme which we developed with the Department of Basic Education at the launch.

Let me turn now to the work of the District Clinical Specialist Teams. As we pointed out in the adverts which you all reacted to, your key functions will include:

- Getting to know the district that you will work in: this means getting to understand the demography, the disease trends, the major causes of mortality, as well as the availability of health services in terms of both coverage and quality;
- Providing strategic leadership and support to the district with particular emphasis on maternal and child health; and
- Providing clinical leadership and mentorship to ensure that doctors and nurses especially are adequately trained and supervised.

Clearly this will require close attention to detail, especially the use of routinely collected data to monitor the various programme areas so that appropriate and early action can be taken to mitigate any clinical risks that may arise.

Practically, this means visiting facilities, doing clinical audits, observing clinical practices, conducting morbidity and mortality reviews (or at least reviewing the minutes of these meetings to see if the correct conclusions were reached and if appropriate action was taken to ensure that medical errors do not recur).

It is also clear that you will have a significant role to play in liaising with the district management teams as well as the school health teams and the ward based PHC teams. I would like these teams and the district management team to work as a single unit. The goal is to reduce maternal, infant and child mortality in each district as rapidly as possible.

In terms of accountability, each team will be accountable to the district manager administratively and clinically to the provincial specialists where these have already been appointed. Where they have not been appointed each province will ensure that there is a defined line of accountability. For example in provinces with a medical school, the teams will be accountable to the head of department. This arrangements will be finalised by the Head of the provincial Department of Health.

HODs and district managers, who are also present today, will need to ensure that the DCSTs have all the support that they need to do their work. This is why I also requested provinces to ensure that district managers also attend this induction so that they too fully understand how the DCSTs will operate and what their roles are in ensuring that this is a success.

As you may know the Health Data Advisory and Co-ordination Committee (HDACC), consisting of eminent statisticians, demographers and actuarial scientists, which we established to advise the Department on the life expectancy and mortality rates, reviewed all available data and reported the following data and targets for 2014:

- Life expectancy at birth was 56.5 years (54 for males and 59 for females) in 2009 with a 2014 target of 58.5 years;
- Under 5 mortality in 2009 was 56/1000 live births with a target of 50/1000 in 2014;
- Infant mortality of 40/1000 live births in 2009 with a target of 36/1000 in 2014;
- Neonatal mortality of 14/1000 live births with a target of 12/1000 by 2014; and
- Maternal mortality ratio of 310/100 000 in 2008 with a target of 270/100 000 by 2014.

As you can see from this data, they are much too high and significantly higher than the MDG targets.

Clearly, you may not be able to do this alone! We recognise that there are many determinants of health and ill-health. This means that besides working as teams, each team will have to work with all the resources in the district, both those that are in the health sector and those that are outside our sector to ensure that we reach MDGs at least!

So in essence this is your task. Your task is to help the district that you are working in to reach the MDG targets by 2015 and beyond!

So in conclusion, may I say that the hopes of the nation to decrease neonatal, infant, child and maternal mortality rates and to improve the health of women, mothers and children in particular. Clearly the family physicians in the team together with the clinical PHC nurses will also focus on the general health of communities in the districts that you will be serving.

Be sure to consult with the communities that you will work for and with. This includes the leaders in these communities as well as health workers. You will need to lead, inspire and teach where necessary.

I am sure that you are all up to the task and that in a year's time we will already see the results of your work. I, together with the MECs will be taking a very keen interest in your work and will be closely monitoring the impact of your efforts.

I wish to thank you for accepting these positions and the responsibilities that come with them and wish you good luck in your work.

I thank you!!!

APPENDIX 3 – DAY TWO FACILITATION GUIDE FOR BREAKAWAY GROUPS

Group 1	Plenary	PHC	Prof Jannie Hugo Dr Nokuthula Sibiya Dr Khetisa Taole
Group 2	Acropolis 1	Paeds	Dr Sharon Matela Mrs Bongi Mafokeng Prof Lesley Bamford Dr Nonhlanhla Dlamini
Group 3	Acropolis 2	Obs	Prof Jack Moodley Mrs Dolly Nyasulu Dr Nat Khaole
Group 4	Acropolis 3	DMT	Dr Peter Barron Dr Jennifer Reddy Mr Rams Morewane

GROUP SESSION: 08h30 – 10h00
MULTIDISCIPLINARY TEAMS IN PROVINCES

Group	Provinces	Room	Facilitator	Scribe
Group 1	GP, WC	Plenary	PHC	Ellen
Group 2	MP, LP, NW	Acropolis 1	Paeds	Lesley / Melinda
Group 3	KZN	Acropolis 2	Obs	Siobhan
Group 4	NC, EC, FS	Acropolis 3	DMT	Fiorenza

Team work

Turn to your immediate neighbours of 3 and discuss - 5 minutes

- Have you ever worked as part of a multi-disciplinary team?
- How did that make you feel?
- What was different about that as opposed working in a group?
- What do you think will make it work well

Identify 4 Key Practices needed for Team work

- How will communication happen in dyad/DCST and within facilities/districts?
- What resources do teams need to function effectively?
- Who will the team report to?

- What are solutions to key challenges facing DMTs and DCST?

GROUP SESSION: 10h15 – 11h30
DISCIPLINE SPECIFIC GROUPS

Group	Provinces	Room	Facilitator	Scribe
Group 1	FP/PHC nurse	Plenary	PHC	Ellen
Group 2	Paeds	Acropolis 1	Paeds	Lesley / Melinda
Group 3	Obs/Aneas	Acropolis 2	Obs	Siobhan
Group 4	DMT	Acropolis 3	DMT	Fiorenza

Brainstorm in buzz groups of 10

- Understand and agree roles of dyads/DCST
- Identify priority areas of focus that need attention to improve MNCH outcomes
- Share tools and good practices that can be implemented for quick wins/strengthened clinical governance
- Identify mentors/support for all provinces/disciplines, e.g. trans provincial

Report back from table one new topic per table

APPENDIX 4 – NOTES FROM THE 8 BREAKAWAY GROUP DISCUSSIONS

Session 1: Provincial groups

Limpopo, North West and Mpumalanga – Lesley Bamford
Friday 28 September 2012, Session 1

FEEDBACK ON TEAM WORK QUESTIONS

Have you ever worked in a Multi-disciplinary team? Yes

How did that make you feel?

- Initially one feels uncomfortable and unsure
- Some discomfort due to lack of clarity regarding roles, expectations
- But as one gets to know the team it boosts one's sense of belonging and confidence
- Motivated towards achievement of a common goal
- Felt appreciated and empowered with a sense of collective responsibility
- Diversity with different expertise, provides opportunity for learning and nurturing

The Difference between a Group and a Team

- Teams work together towards the same goal – everyone participates and complements each other. Diversity is recognised and valued.
- Learn skills from each other, able to have a broader focus
- All members are all equal, work together towards a common goal.
- Goal-orientated – leads to better performance and achievement
- Need to compromise, move out of one's comfort zone.
- Humility needs to be the heart of the team – recognising one's own and others strengths and weaknesses. May need to sacrifice one's own individual identity and develop a team identity.
- Possible to provide comprehensive (integrated) care

What will make the teams work?

- Need to have a common vision, learn together and be prepared to learn from mistakes
- Role clarification, clear communication and regular feedback, good interpersonal relationships with mutual respect

- Shared goal and sense of achievement. Also sharing of resources and expertise.
- Clear leadership (role of coach) to be identified in the team, clear reporting lines, plans for how to deal with conflict and make decisions (consensus), continuance of performance appraisal and feedback
- Based on mutual respect, not on hierarchical relationships
- Need to set standards regarding working of team: roles and responsibilities, code of conduct, communication and feedback.
- Success factors: Joint situation analysis, planning and training, sharing resources, involve stake-holders (including community), monitoring and feedback system
- Threats – domination of some leading to isolation of others, lack of commitment, task-shifting, lack of shared vision and goals (pursuit of individual discipline goals).

FEEDBACK REGARDING FUNCTIONING OF DCST TEAMS

Structures and communication

- Systems for communication need to be in place – will be informed by existing channels, protocols, but need to make sure that DCST are included (and VISIBLE) in the organisational structures.
- Teams will need to **MARKET** themselves – identify and target key meetings that are already taking place e.g. DCST must become a standing item on meetings such as DMT meetings
- Clarity needed regarding roles of MCWH programmes/other pre-existing DOH structures.
- Need to have clarity regarding the relationship with clinical structures – need to be bridge between PHC level, district level, regional hospital. NDOH needs to provide policy direction – may be some variation in implementation in different provinces by virtue of existing structures.
- Relationship and communication between other PHC re-engineering structures (eg Primary Health Care Manager, MCWH coordinators) and DCST also needs to be clarified.
- Recommended that DCST teams are funded through conditional grant to ensure ringfencing

Resources needed for effective functioning

- Human Resources: Provinces will need to ensure that they attract and retain team members (rural allowances, etc)
- Must make sure that all team members have the necessary knowledge and skills through an induction process.

- Other resources should be linked to job description. Specific items include:
    - Administrative support (including data capturing skills)
    - Transport
    - Physical space – offices, training venue, etc
    - Communication tools – laptops, cell phones
    - Tools for teaching - data projector, etc
    - Accommodation – mentioned in advert, but only temporary accommodation has been provided.
    - Commodities
    - All of the above have budgetary implications – not currently funded
- Need to ensure that vacated posts are filled (advertise internationally).

Who will the team report to?

- Administratively/managerially: District Management Team
- Clinical: Provincial Specialist (may be Head of Academic Department or other person where no provincial specialist in place). This still needs to be clarified and communicated to all role-players.
- What is the role of provincial programme managers?
- Need to be appropriate co-ordinating structures at provincial and district levels.

Meeting notes from the KZN Group
Friday 28 September 2012, Session 1

4 KEY PRACTICES NEEDED FOR TEAM WORK

- Defined roles and responsibilities for all members
- Good communications between members/regular meetings
- Sense of belonging and participation
- Collective approach for gap identification and problem solving
- Common plan, vision and objectives
- Early selection of spokesperson/team leader

How communication will happen?

- Use existing communication channels DMT, meetings, sub districts meeting OSS, DTT meetings

- Up and down in line Managment, clinics-hosp, and sideways to team members, also include MCWH coordinator
- Use planned scheduled visits to facilities
- Comm within DCST team, weekly, beginning + end, planned together,
- Identify some to facilitate meetings
- Ensure work within entire team not just dyads
- Regular ring fenced weekly meeting (eg Monday)
- Email list for team, cell phone list,
- Request coordination of any competing national provincial meetings/training
- Quarterly meeting with DMT
- Develop Predictable plan for entering facilities

Resources teams need to function effectively

- Dedicated transport/ accommodation for distant areas
- Medical equipment (e.g. demo models for training)
- Dedicated space
- Resource center - fully equipped, printers, journal access
- Lap tops/connectivity (cell phone, 3G) and projection for teaching
- Admin support (PA)
- Furniture, Budget- including for research
- Resources- from DM, channeled through that way, participate on budgetary team
- Rural allowance- standardize

Who will the team report to?

- District performance is the responsibility of DM, there fore DCST report to them
- Line manager = DM
- Some will reports to District clinical managers
- Performance monitoring will be done by DM
- Provincial specialist - will input on monitoring, standardisation across Districts
- Provincial staff – will have oversight of District performance

- DCST – leaders/managers, you are part of the district team and will be part of the reporting process form that level

Table 5: DCST challenges and proposed solutions

Challenges	Solution
Incomplete teams and attrition	➢ Present team Identify missing roles and look for local capacity to address the gaps identified. ➢ Continuous open advertisement at province level , constantly be recruiting to fill all gaps ➢ Need clear attraction and retention strategy
Dual role of some posts-expectations to do both jobs	➢ Vacated posts should be advertised as soon as possible. May need to bend rules, e.g as MCWH will need PHC skills , could we accept midwives, flexibility about this at a district level based on need.
Clinical guidelines not always available or upto date on intranet	➢ Designate one person at provincial level to keep up to date and present
PHC – being considered as a step child, unsupported	➢ Review PHC structure and come up with a 'fit for purpose' structure for it at local level . May need to describe a PHC supervisory team – (PHC supervisor, DS) who reports to DM
Acceptance of team by hospitals	➢ Diplomacy, clear communication to hospital
Rural allowance	➢ Fairly applied
DCST to DCST interactions	➢ Need to ensure teas are able to interact, learn , share and grow
Transport – inconsistencies , not eligible for subsidized car, allowance is included in package and may not be enough	➢ Lodge specific grievance where actuals not covered . May need a provincial review in line with expectations for DCST
Professional development opportunities especially for Management and leadership	➢ DCST national and provincial team should identify courses and opportunities for this sort of development

Meeting Notes from the Gauteng group - Ellen Hagerman
Friday 28 September 2012, Session 1

Have you ever worked as part of a multi-disciplinary team? Yes

How did that make you feel?

- we regard it as a continuum and everybody must give their input and everybody comes for their specialty
- -recognition
- -you belong
- -shared experiences: have different members of the team with different expertise, you can resolve all sorts of problems within a team. Each person brings his or her experience.

What was different about that as opposed working in a group?

What do you think will make it work well

- common purpose
- good communication: must communicate as a team and be able to work together and share ideas-respect
- leadership: somebody must take the leadership role and there must a noticeable on leadership
- focus on the target
- agree to disagree
- when you start, you have to be careful and take the time to get to know one another as you may have territorial issue
- need for a common purpose and inspiration
- it is important for each member to know each other's role to understand what support each person can provide
- we are at the beginning and need to look at the grey areas where people overlap.
- One of the issues in team work is to say the currency of teamwork is information and not power.

How will communication happen in dyad/DCST and within facilities/districts?

- communication would be more effective if supported by the management team. We are encouraging that when it comes to implementing changes it should be done through the DMT and communication should come via the DMT

- team has to strong communication internally e.g. regular meetings so that whenever challenges emerge, they are addressed as a team
- -communication at different levels and between the different districts; with the facilities; with the community itself so whatever you are planning, everyone knows
- there are also need for reports
- dyad meet on the Monday to discuss what happens with paediatrics and then meet with the whole multi-disciplinary team and they present the report of the previous week to the DMT which is verified and accepted by the district team and then get input from the DMT
- discussion with the team should be part of the social mobilization and should be around supporting the district around the DMT. The District Manager is the one who must give leadership
- need for telephone numbers of Deputy at NDOH
- concern with channel reporting> there is a need to meet.

What resources do teams need to function effectively?

- cell phones
- transport since we have to drive long distances i.e. petrol cost
- teaching aids e.g. overhead projectors
- computers and laptops
- office space
- printers
- office secretary

Who will the team report to?

What are solutions to key challenges facing DMTs and DCST?

1. Local Authority:-there is a diversity of communication: provincial, district and local. We are having problem communicating with the local government. Unless there is an introduction, they will not meet with us
    - our district specialist team meets once a week. We discuss about last week
    - after the DCST is introduced and after we have travelled, never encountered any resistance. After we communicated and clarified that we are there to provide services, it helped. Good communications can help.
    - proper introduction and have a formal presentation for the District Health Teams

- need to include in the service level agreement with the local government i.e. work through the structures since they exist.
- communicate telephonically and electronically.

2. Too Many Meetings: Informal communication is very effective with a basic structure of a few meetings. Be together through supervision and mentoring rather than sitting around a board room.
3. District Email Group: to share whatever we want among the district and a web site.
4. Have an open-door policy to Chief Directors:
5. Specialist Teams form part of the DMTs: have them present once a month in a formal meeting
6. Reporting: The District Managers are ultimately responsible so there is a need for a direct report to the District Managers. Select one representative in the DMT.
7. Need to meet regularly and program what they will do
8. Communication between Higher Authority and DMTs: needs to be improved. There should be a block email at each level and whole teams should be part of the block so that a reply is sent to all.
9. DCST should meet around the patient
10. Provincial Specialist is non-existent in Gauteng: concern that something in one district is different from another district so could lead to lack of coordination so support the idea of a provincial specialist. Prof Eckhart Buchmann is the one provincial specialist for the whole province and is looking at all the specialists. There is no budget for each specialist so need for discipline specific groups. Work with the universities for joint employment. We need to be clear what Prof. Buchman will be doing vis a vis the other specialists and there will be a need for guidance at the higher level.
11. Fast-track procurement: find a way to fast track procurement and maintenance
12. Role of the Universities: The three universities should be able to do that.
13. Budget: It needs to be clarified urgently. It is not clear who is supposed to provide our working tools. We have offices but had to go to the hospitals to get desks and computers.
14. Communication to the ward-based outreach teams: need to ensure that this communication is not forgotten.
15. Plan B for communication: This should be access to NDOH to sort things out when problems are discovered.

16. Provincial and District Officers need to formally introduce the DCST to the local authority management: to ensure that DCST does not appear as intruders in their clinics
17. District specialist team communication should be centrliazed: Communication should come directly from NDOH and provinces in relation to meetings. Consider creating a common gmail group. We should not have to wait to go through the various channels such that the team gets information at the last minute and deadlines are often missed.
18. Regular Meeting attendance
19. A Member of the District Specialist Team should be part of the DMT
20. Resources: for the team itself
21. Resistance from facility managers to team activities: communication in advance through informal and formal communication
22. Discovering and dealing with dysfunctional systems: e.g. doctors in CHCs not working their hours, EMS, serious shortage of facilities, equipment and staff. Need for advocacy, communication and information. Innovations to make current systems more efficient in the face of resource constraints
23. Failure of managers to understand role of teams: good communication from team and from province/national/local government
24. Danger of sinking to a level where people don't work: if not motivated, supervised or accountability, then team team members may simply stop working – they would attend all necessary meetings and activities but not support face-to-face clinical environments
25. Danger of becoming stale, uninspired, lacking innovation: need to continually stimulate teams through interaction

Meeting notes from the Northern Cape, Free State and Eastern Cape Group – Fiorenza Monticelli

Friday 28 September 2012, Session 1

How did working as part of a multi-disciplinary team make you feel?

- Most have been exposed to inter-disciplinary teams and have had positive experiences
- At first, difficult but then when hearing the input of other specialists, they have understood the importance of such teams
- Must have a leader, who is open to the opinions from other specialties

- When you work as a DST, no one is more important than the other e.g. nurse vs. family physician
- Everyone works towards a goal and everyone respects each goals
- Good for personal and professional growth
- Good for idea exchange

What was different about that as opposed working in a group?

- In groups, roles are not always clear; the difference is that in multi-disciplinary teams, everyone knows what they are supposed to achieve
- Duplication occurs less in a multidisciplinary team compared to a group
- Patients feel more secure as they are exposed to a variety of experiences with multi-disciplinary teams
- The teams should have a shared vision and common goals around what they want to achieve
- These teams take ownership for the decisions made by the team

What do you think will make it work well?

- Important to pursue the inter-sectoral collaboration with different stakeholders to address social determinants of health
- To make it work well, there needs to be
    - Team leader
    - Terms of Reference indicating what they want to achieve
    - Shared Vision
    - Effective communication and report writing
- Respect is critical
- Build on existing structures; don't come to restart everything
- Regular meetings with guidance and protocols
- Regular reviews and audits
- Benchmarking of best practices
- Integrity of data
- Helping each other
- Complimenting each other
- Joint planning and evaluation

Potential Challenges

- All of us are specialists but not necessarily leaders or managers so all of them need leadership or management skills
- Might be challenging in that some people may require more mentoring, could also lead to exploitation
- Risk of exhaustion

How will communication happen?

- **Regular meetings** where feedback is given
- Reports from each discipline
- Communicate with the external world especially with facilities the teams will support
- Attend community meetings
- **Different platforms of communication**
    - The Dyad need frequent face-to-face meetings and should live near each other
    - Formal meetings should occur daily and informal meetings could occur when traveling
    - DST teams – three types of platforms
        - Formal platform with each other for the whole team once a month
        - Formal platform with clinical managers e.g. lead obstetrician/paediatrician, program coordinators so these problems are presented to province managers
        - Should occur in a provincial structure – monthly provincial meetings with the district specialist meetings
- **Mechanism for communication**: telephone, face-to-face, emails, meetings, reports, workshops
- **Design for communication:** How do they communicate with each other? There should be a schedule shared for each person so they know where they are in order to enable communication
- Both structures must be involved with the Review meetings
- Open channels: People should be approachable, available 24/7, with a positive attitude

What resources do teams need to function effectively?

- Critical to have office space and furniture

- Accommodation when travelling for outreach
- Mobile printer
- Telephones
- Fax machine
- Stationery
- Support Staff
- Support from the District Manager to ensure resources are available
- Transport-types of transport
- Dedicated budget for this team
- Data accessibility

Who will the team report to?

- District management for administrative support
- Provincial specialist for clinical support
- HOD
- **Key question:** Who does the actual Performance Management Development System?

What are solutions to key challenges facing DMTs and DCST?

- Role clarification
- To be seen and accepted as part of the team
- Continuous, effective communication
- Regular reporting and feedback
- Commitment from all role players in the District
- DCST must have its own funding
- Support from the District
- Need to be inducted into some of the processes required e.g. travel reimbursement

Session 2: Discipline-specific groups

Obstetricians /Midwives/Anaesthetist - Eckhart Buchmann
Friday 28 September 2012, Session 2

Roles of dyad/DCST

- Clinical governance
- Supportive supervision (of Doctors and nurses)
- Mentoring coaching and integration of services
- Operational research
- Oversee data quality
- Build a culture of complementary care (specialists + nurses)
- Look at technical and systems issues within districts
- Support Protocols, training + fire drills
- Advocacy for attention to **comprehensive** MNCWH
- Sit analysis of district - to get to know baseline, also regular periodic structured audits (as part of DM oversight and as part of developing districts plans)
- Get to know and support DHC and PHC outreach activities

Priority areas to focus on

- Quality of services – esp. skills of human resources and attention to minimum equipment requirements
- PMTCT, HIV, EOC, Family Planning, teenage pregnancy and post partum care
- Improve monitoring and evaluation, data quality, use of data
- 5 H's as per report, emphasize on health systems strengthening and HCW training
- Training doctors in anaesthetics
- Ensure protocols are in place
- Root cause analysis and plan around the gaps identified
- Referral policy and Emergency transport services
- Ensure uploading and use of partogram
- Women's health cervical cancer screening
- (note these all fall within CARMMA priorities)

Good practices/quick wins identified

- ESMOE training
- Training for doctors on CS
- Use of Audit tools and QA tools
- Implementation of the Maternity guidelines and Standardised maternal mortality meetings
- Implementation of SAINC
- Implementation of Action Framework for PMTCT and Data for action reporting

Identify mentors/ support

- Areas lacking DCST specialist- involve university and other specialists in area, use institutions to id own mentors
- District pairings/partnering
- Web site for teams
- 'Outreach' by some provincial specialists
- More interaction with PHC outreach teams so that better understand communities

Meeting notes from the PAEDIATRIC GROUP - Lesley Bamford
Friday 28 September 2012, Session 2

- Roles of dyads/DCST
    - Few teams have a paediatric dyad- therefore needs to be an flexible approach (paediatrics, family physician to support from other sources e.g. paediatrician at regional hospital, provincial paediatrician)
    - Focus: Clinical governance, priority programmes, communication
    - Need to link with other members of the DCST
    - Role is to identify the gaps: Nurse will focus on more PHC clinics, Paediatrician more on hospitals
    - Provide support to: doctors, nurses, programme managers, PHC outreach teams, mentors.
    - Functions: supporting existing programmes and PHC re-engineering processes, identifying key gaps, supporting mortality audits and other monitoring systems.

Priority areas of focus on to improve MNCH outcomes

- Newborn Care (KMC)

- Emergency Care for Children
- EPI
- IMCI including child NIMART/TB screening
- Chronic conditions (including HIV, TB)
- PHC outreach teams
- IYCF including promotion of exclusive breastfeeding
- Mortality audits
- Birth defects (FAS)
- Undernutrition (esp. growth monitoring and response to growth faltering/stunting)
- Psycho-social issues

Main categories

- Community: outreach teams and social mobilisation, school health
- PHC level care: IMCI, EPI, PMTCT, NIMART
- Acute paediatrics including emergency care
- Care of children with long term conditions
- Newborn care

Tools and good practices

- Improving newborn care is a priority and the DCST are well-placed to address this issue, and the Toolkit is available!
- Mobilising resources from various stake-holders.
- Nutrition monitoring at community and facility levels
- Leveraging support/resources from developmental and other partners

Structures

Provincial MNCH forum should include DCST members as well as MCWH programme managers, other members of ministerial committee members, Child PIP and PIPP co-ordinators, and other stake-holders.

This can be replicated at district level.

Meeting notes from the DMT group
Friday 28 September 2012, Session 2

What are the roles of the dyad/DCST-Reporting and Accountability?

- Dyad will have direct communication with DCST
- The DCST will report and be accountable to the District Manager
- There will be a need for clinical and technical support and communication-will be on a dotted line with the provincial specialists
- For m and e, performance management, regular reporting, monitoring outcomes and performance will be directly with the district manager
- Placement of the team should be in the district management offices
- There are vertical and horizontal communication lines with the specialty teams e.g. monitoring of maternal deaths; accountability officer will be the district management
- DCST is very divisive-there are common goals, the culture of the team within a team needs to be understood
- Line management is to the DMT
- Accountability to the DCST and DMT
- Individually to the DM
- Technically to the provincial team?
- Delivering as a collective team regardless of which team you are in
- The DCST has to be part of the DMT. Their activities will be in the district health plan and resources in the district budget. Accountable to the District Manager. At the provincial level, they will continue to provide technical support to the team as has always been the case. Existence of this team is to strengthen the team to achieve improved health outcomes
- Mentoring and support to DM
- DM should take full responsibility for all that occurs in the District
- There should be a clinical head, preferably Family Physician who is part of the DMT who should take charge of the specialists and takes responsibility to monitor and understand their needs and issues
- There is a perception that DCSTs are not accepting them into the DM. The DMs were left out of the planning and appointing of the DCSTs. The province should communicate clearly not just with the DCSTs and the DM. Those open lines of communication should be transparent. Where there is still a sense of exclusion, the

DM should find physical and other signals so that they do feel included, make sure they are located at the DMT. There should be a lot of interaction between the DCST and DMT. Frequent open and transparent

- All communication and reporting should be through the District Manager (who oversees the budget)
- Do not agree the DCST need to report directly to the Provincial Coordinator
- For the District to have a budget, they need a costed plan. Then all units need to come together to discuss the activities for the next financial year. After using the money for the financial year, they need to account it. We are creating a vertical unit. If we keep on this track, we will be asking in the future how to integrate to other units
- For the DMT to be able to run this unit, it needs to be included in the performance management of the District Manager. Need to guard against creating vertical program

Meeting Notes from the PHC group - Ellen Hagerman
Friday 28 September 2012, Session 2

1. **Roles**
    - -communicate protocols where there is a need.
    - -strengthening PHC at the household level
    - -focus on ward-based health services
    - -school health services
    - -focus on CHWs
    - -need to identify steps in terms of equipment, facilities, skills
    - -role of DCST is clinical leadership and governance
    - -be involved with integration of services and map the way forward
    - -quality assurance: facilitating quality improvement projects; national cost standards; make sure that the district committees are revived
    - -leadership role
    - -mediator between the sub-districts
    - -support training and core elaboration including mentoring
    - -focusing on preventive and promotive measures
    - -be a leader in promoting holistic approach .e.g organize community dialogues, producing protocols and guidelines, identifying skills gaps
2. **Priority Areas of Focus**
    - -bring about integration of policies

- -strengthening family health teams and outreach teams and do
- -health promotion
- -proper management of pregnant women i.e. early booking, testing for ANC, and babies
- -integration of different programs and play a role in nutrition and community-based facilities to get a better take on mother and child health
- -monitoring implementation in line with MMCH
- -service delivery in terms of access and hours of operation, availability of medicine and equipment for the maternity and human resource for PHC. All these things happen at the level of the clinic
- -knowing our communities since they are diverse. Focus on community diagnostic and profiling.

3. Tools and Good Practices

- develop a form to be used to screen for early pregnancy. With that form, can re-direct patients to a facility or an outpost
- health clinics to achieve their dashboard indicators in each facility
- recruit dedicated good staff into key areas
- compulsory implementation of supervision manual
- comply with existing standards and protocols
- red flag: ARV down referral tool
- BANC check list
- in-depth program review tools
- best practices
- operation Thumamina: midwife takes ownership from booking, delivery, post-natal care
- Phili Ma Project: cervical screening Mini-campaigns
- set targets for PHC nurses: one pap smear/professional nurse/day
- clinical governance: clinical effectiveness, journal clubs
- conduct regular clinical audits, peer reviews, benchmark in other provinces
- operation manual on midwife: doing follow ups, phoning the patient, developing relationships
- pillar
- PHC clinics: one patient per day and helps to step up improved maternal care

- already a lot of tools; -need some kind of community profile and basing interventions according to the community profile

4. Mentors/Support

- fostering partnerships with stakeholders e.g. universities
- issues of benchmarking between districts/areas
- provincial mentors
- getting together with colleagues and discussing our issues in a non-structured way.
- provincial specialists are there to help us
- developmental partners that we have already e.g. MRC, Centre for Rural Health for research, university colleagues are very available, accessing family physicians who have been practising a long time
- start inter-provincial partnerships to share success stories
- as a group, thought of provincial specialists and universities
- not all provinces have provinces have provincial specialists so outreach to universities
- between provinces, link up with experienced leaders
- trans-provincial to share each other's documents to move faster
- PPPs
- recognize role and support to get from public health specialists e.g. collection of data to be able to respond appropriately.
- create a PHC forum at the national level e.g. role out of HIV/AIDS had a forum
- no reference to non-communicable diseases. It should be added.
- need for role clarification not just for chronic diseases, TB, violence and a need for a list of indicators about what PHC should address
- don't have a director or manager that is specifically working on PHC to link this program
- issue of norms and standards of PHC
- consider developing clear indicators for PHC
- other communicable diseases will be attended but focus will be to meet goals by 2015
- overtime for family physicians should be clarified
- indicators of PDMS but it is not clear what are the specific indicators

- easy for paediatricians and gynaecologists on role definition. For family physicians, need to define role about quality assurance, quality audits, proper record keeping. If the basics of PHC are not done, then the other programs will not succeed so we need to ensure that the basics are done correctly e.g. assessing how records are kept can you enable to assess how the nurses are performing, information keeping and communications.
- National Forum for PHC to look at our roles and try to define them.

7 REFERENCES

1. NPC. National Development Plan: Vision for 2030.2011.
2. Chopra M, Lawn JE, Sanders D, Barron P, Abdool Karim SS, Bradshaw D, et al. Achieving the health Millennium Development Goals for South Africa: challenges and priorities. Lancet. 2009 Sep 19;374(9694):1023-31.
3. Chopra M, Daviaud E, Pattinson R, Fonn S, Lawn JE. Saving the lives of South Africa's mothers, babies, and children: can the health system deliver? Lancet. 2009 Sep 5;374(9692):835-46.
4. Chigwedere P, Seage GR, 3rd, Gruskin S, Lee TH, Essex M. Estimating the lost benefits of antiretroviral drug use in South Africa. J Acquir Immune Defic Syndr. 2008 Dec 1;49(4):410-5.
5. StatsSA. Mortality and causes of death in South Africa, 2009: Findings from death notification. (P0309.3) Statistics South Africa; 20112010: Available from: http://www.statssa.gov.za/publications/P03093/P030932008.pdf.
6. NDOH. Saving Mothers: Fifth Report on Confidential Equiry into Maternal Deaths in
5. South Africa: 2008 - 2010: National Department of Health2012.