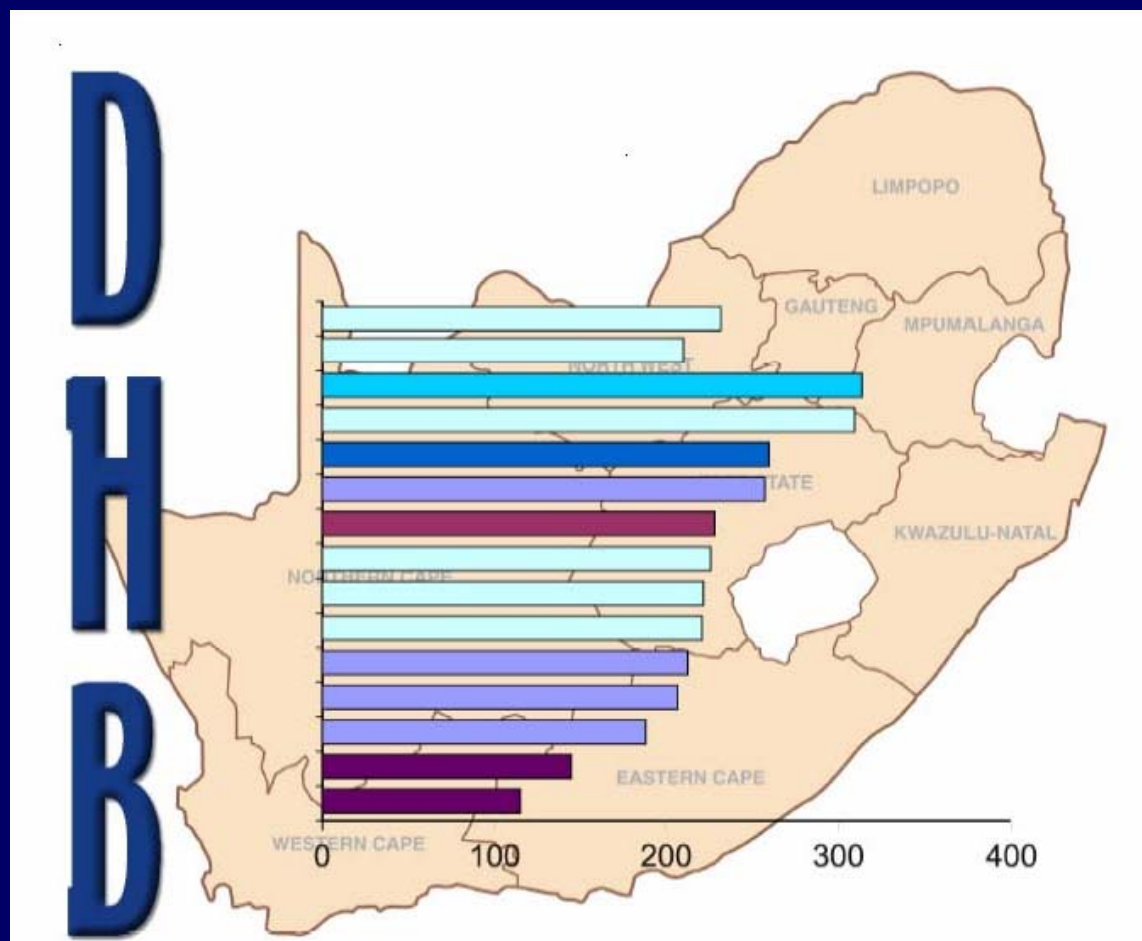


The District Health Barometer

A tool to monitor progress and support improvement of equitable provision of primary health care



What is the purpose of the DHB?



To function as a **TOOL** to monitor *progress* and support ***improvement of equitable*** provision of primary health care by:

- Illustrating important aspects of the health system at district level through analysis of indicators.
- Ranking , classifying and analysing health districts (in various groupings eg. *metros, provinces, ISRDP sites*), by indicators
- Comparing these indicators over time.
- Portraying data as is, in order to highlight performance and / or data quality issues. Thus, if the data look implausible - it merely highlights data quality issues at source which need attention.

Background

- One of the main goals of the South African health system is to provide **equitable access** to and **quality** of health care.
- Oversupply of data coexists with need for objective and transparent monitoring information.
- In order to meet this need HST successfully piloted a *District Health Barometer* (DHB) in 2005, in collaboration with the National Department of Health.
- Guided by an advisory committee made up of DOH managers at national, provincial and district level, including experts and stakeholders from the academic and research arenas.
- Two reports published: DHB year 1, covering 2004 data and DHB 2005/06. DHB 2006/07 is due January 2008

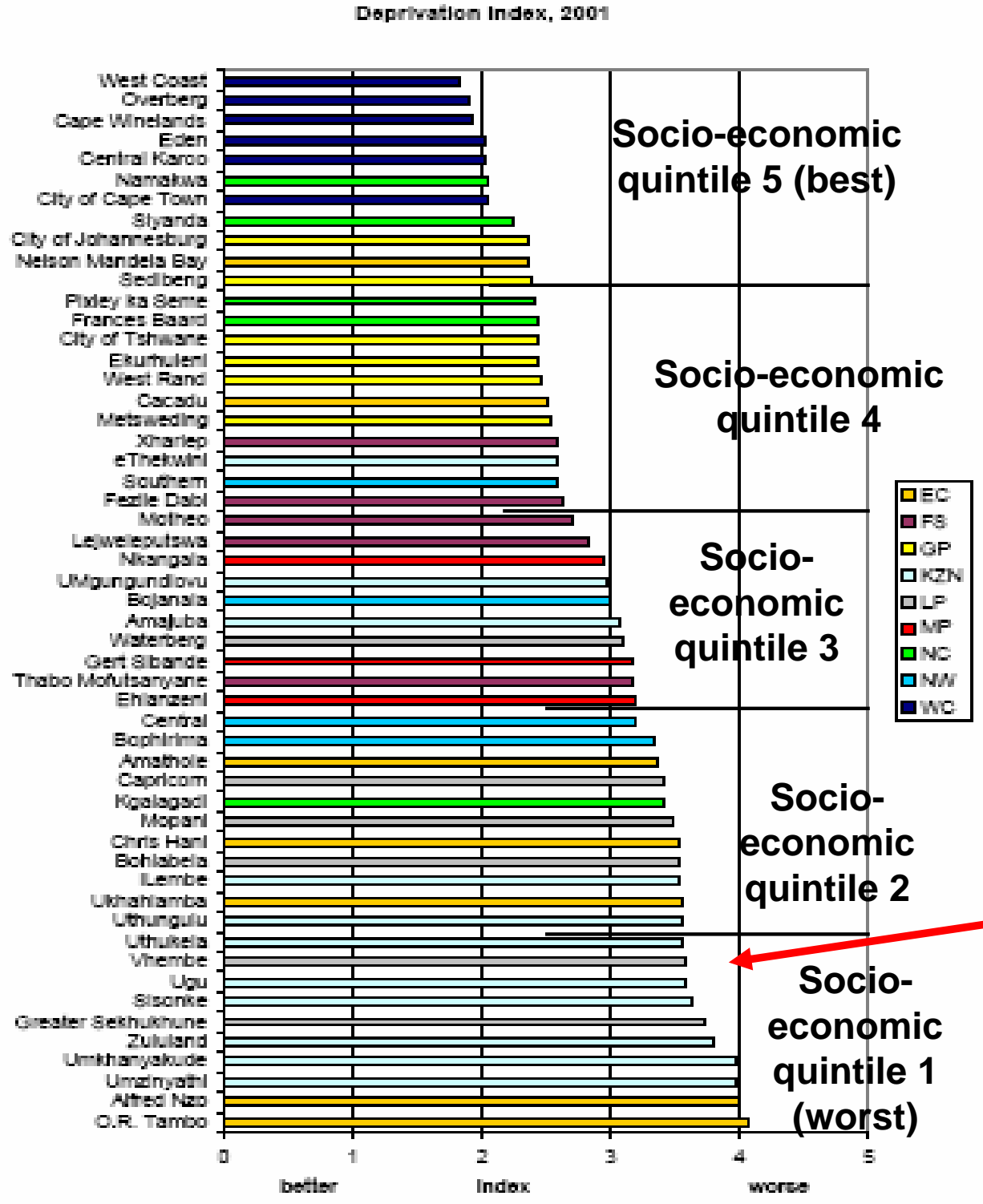
Methodology



- Data sources :
 - DHIS,
 - StatsSA,
 - Treasury (BAS)* data ,
 - National TB register
 - Directly from the district / province. (seldom)
- No data values received are changed (corrected)
- Averages have been calculated, ie for metro and ISRDP districts and PCE values are calculated from the data received from Treasury.
- The DHIS data is extracted at the end of June, once the official data set has been signed off by the districts and provinces and sent to Treasury and the NDOH.
- Data is illustrated in graphs, maps and tables to make it easier to read for comparative purposes.
- Where the data is not publicly available, such as with the DHIS and Treasury data, HST have asked for and received written permission to use the data for each DHB published.
- Data illustration examples follow
- * North West (Walker System)



Deprivation index 2001 and Socio-economic quintiles

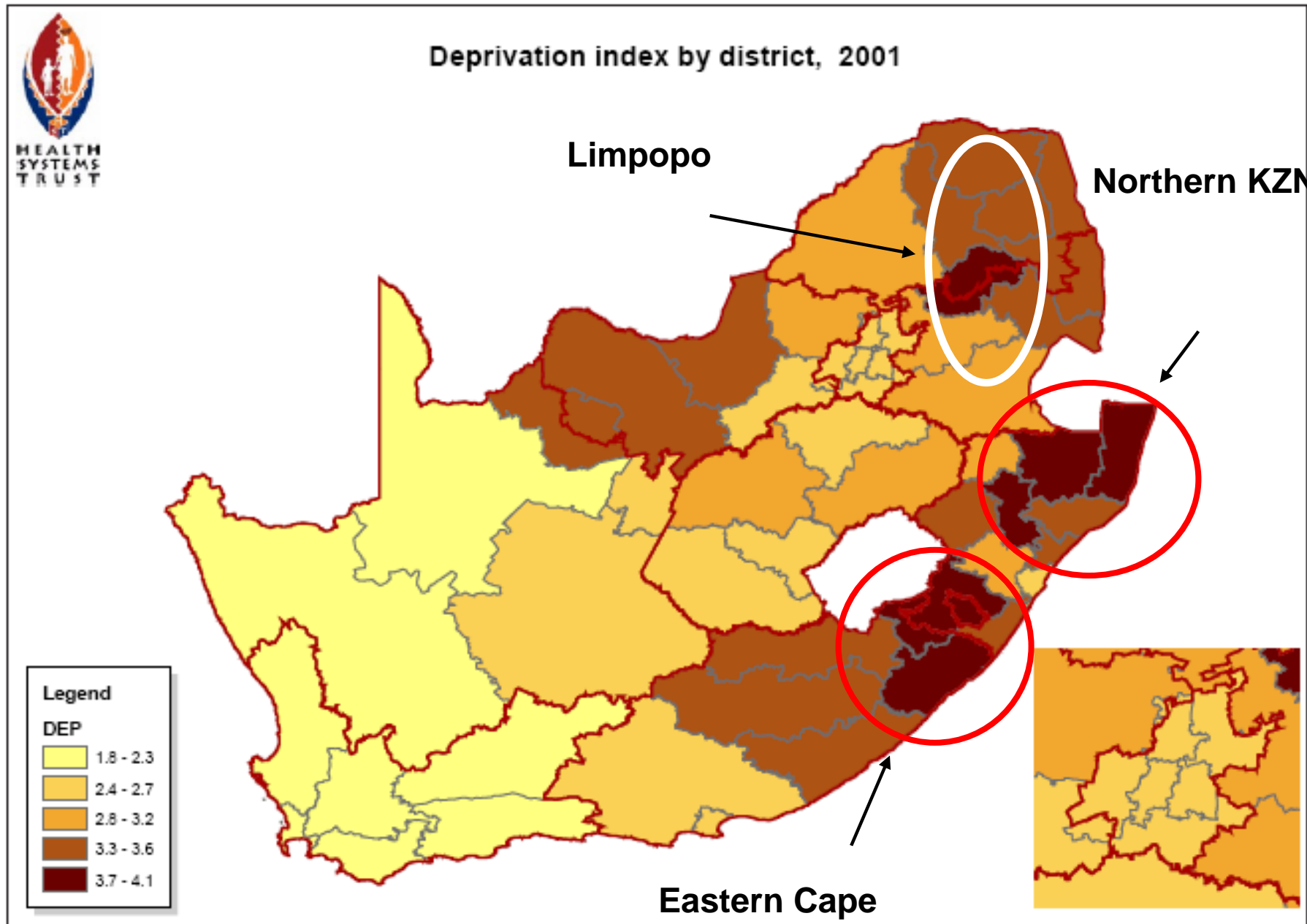


- Ugu
- Uthukela*
- Vhembe*, Sisonke*
- Gr Sekukhune
- Zululand
- Umkhanyakude
- Umzinyathi
- Alfred Nzo
- O.R. Tambo
- * Not ISRDP

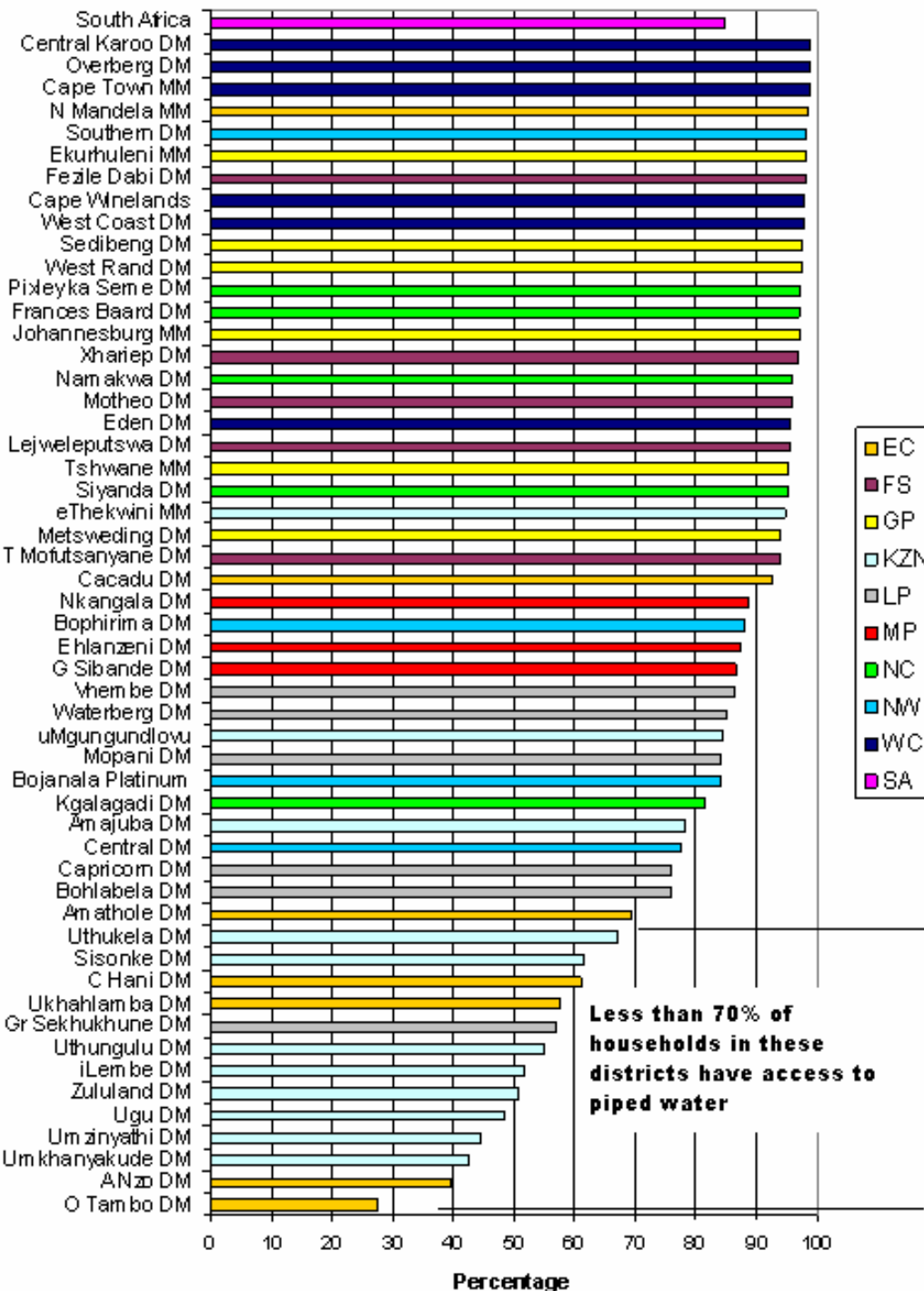
Deprivation index 2001



Map 1: Deprivation index by district in South Africa, 2001



Percentage of households with access to piped water, 2001



% Household access to piped water, 2001



- Ilembe
- C. Hani
- Ukhahlamba,
- Ugu
- Uthukela
- Vhembe,
- Sisonke
- Gr Sekukhune
- Zululand
- Umkhanyakude
- Umzinyathi
- Alfred Nzo
- O.R.Tambo

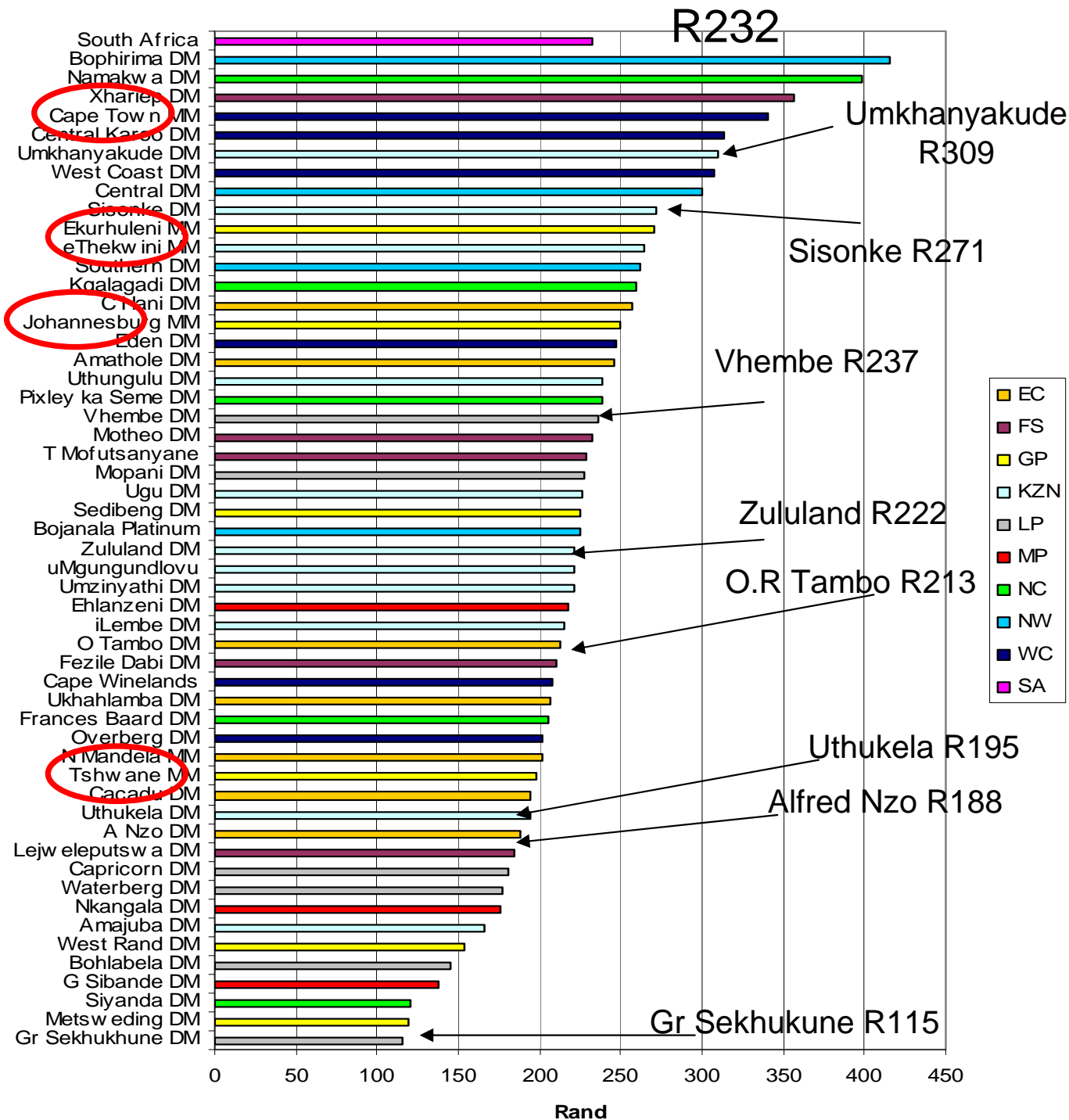
There is a correlation between the districts which have less than 70% of households with access to piped water, and those districts grouped into the lowest socio-economic quintile

Less than 70% of households in these districts have access to piped water

Per capita expenditure, 2005/06

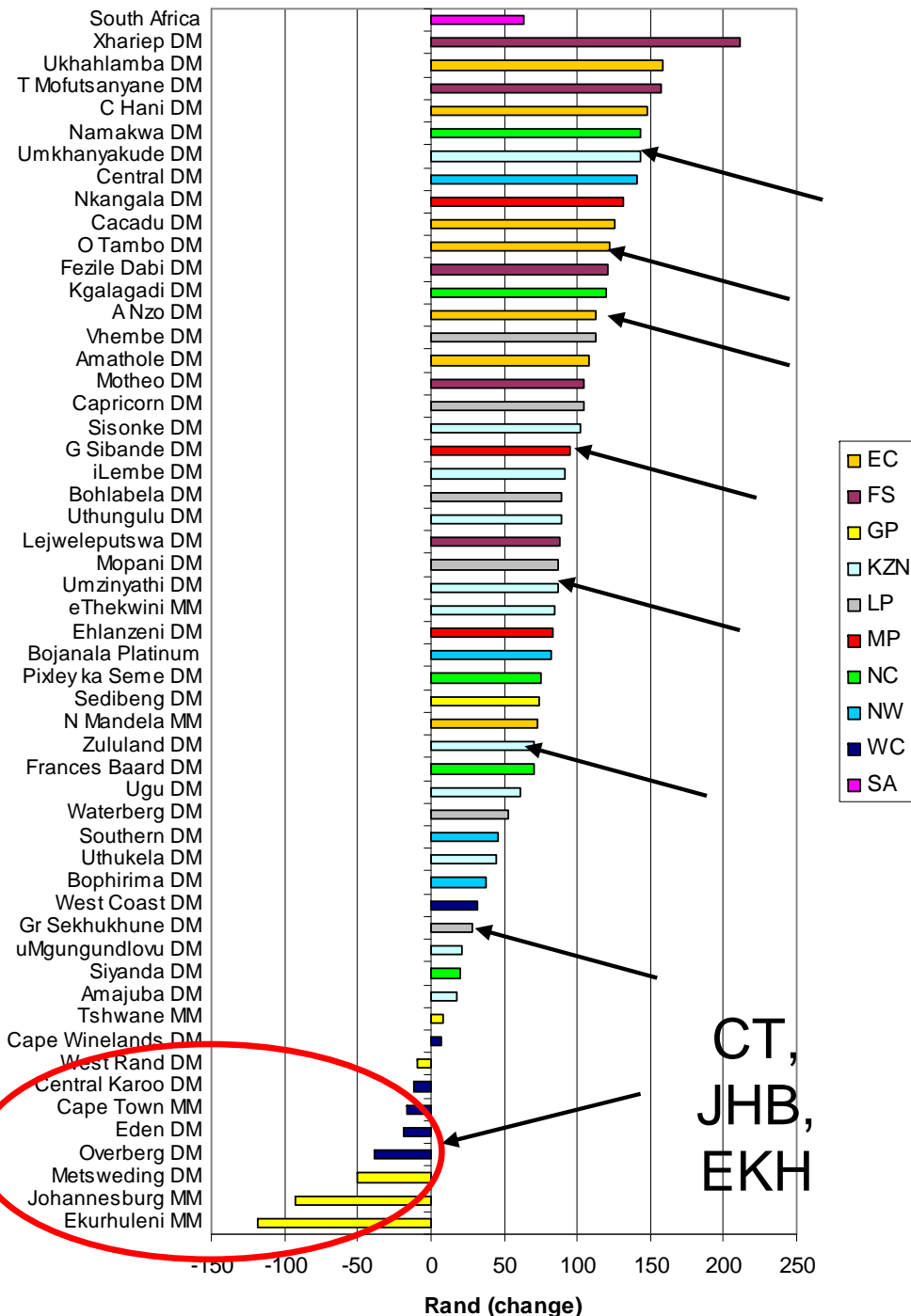


Per Capita Expenditure 2005/06



Rand

Change in per capita expenditure 2001/02 to 2005/06

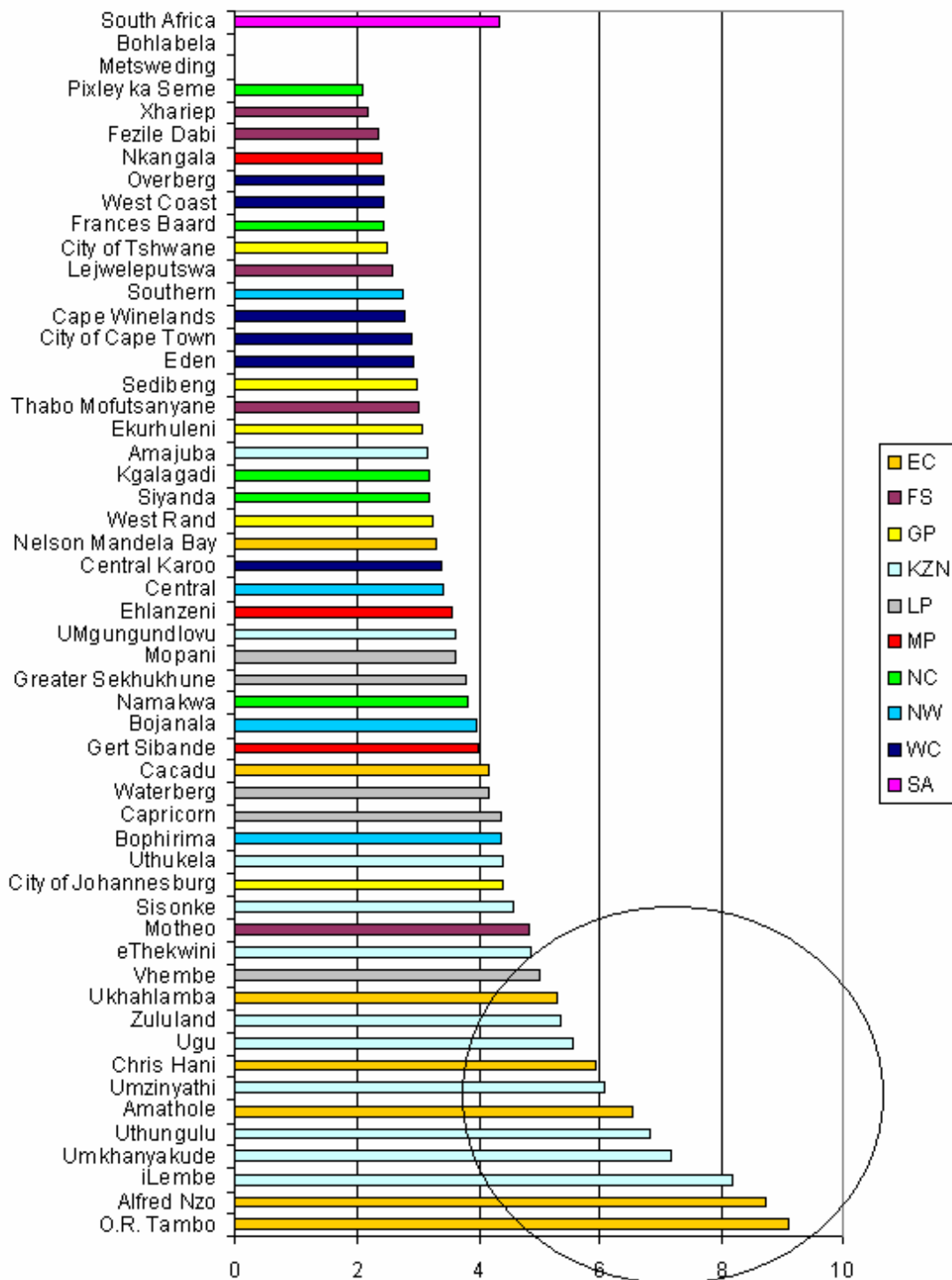


Absolute change in per capita expenditure 2001/2 to 2005/6

Overall the trends show there is a move towards greater equity in health funding in primary health care.



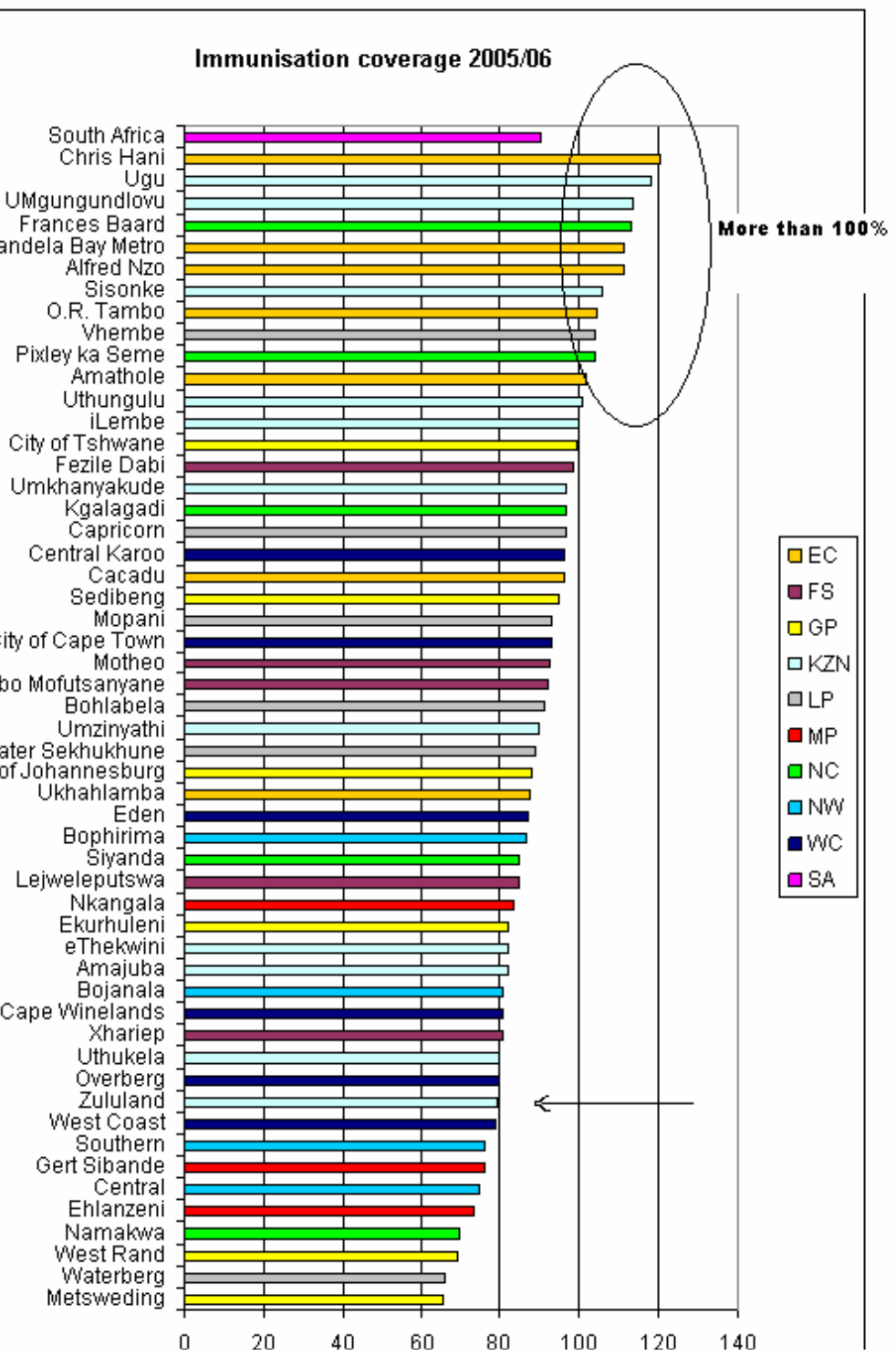
Average length of stay, 2005/06



Average length of stay in a district hospital 2005/6



Patients in many of the ISRDP districts have a longer average length of stay in a district hospital than their counterparts in other better resourced districts.



Immunisation Coverage 2005/6

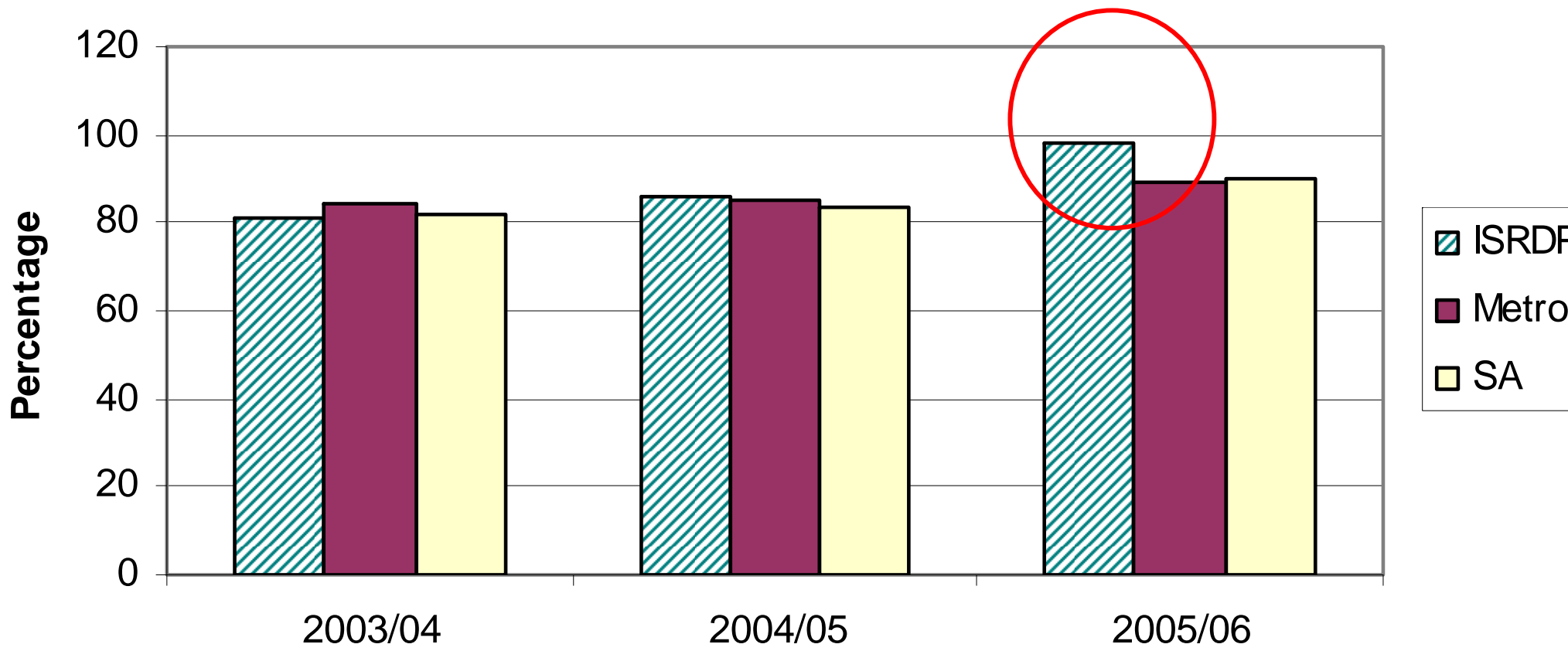
R307

- average immunisation coverage in SA = 90%
- ranges from a low of 66% for Metsweding to a high of 120% for Chris Hani
- undercount of population <1yr affects indicator

Do urban and rural children get vaccinated at the same levels?

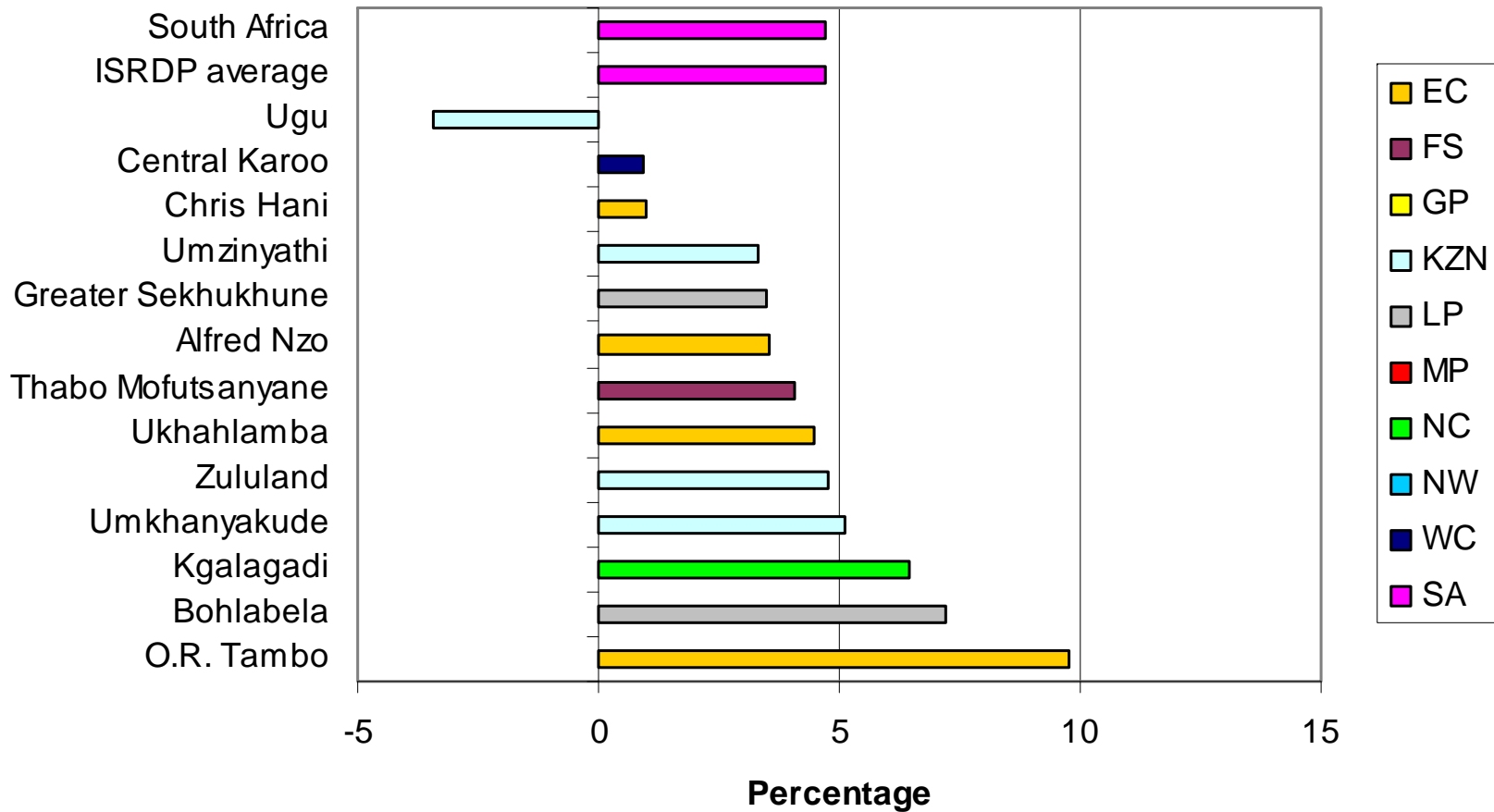


Immunisation coverage averages 2003/4-2005/6



Immunisation drop-out rate (DTP1-3) 2005/6 in the ISRDP districts

Immunisation drop out rate (DTP1-3), 2005/06



TB Smear conversion rate 2004-2006 and TB cure rate 2003-2005 for districts in the lowest socio-economic quintile

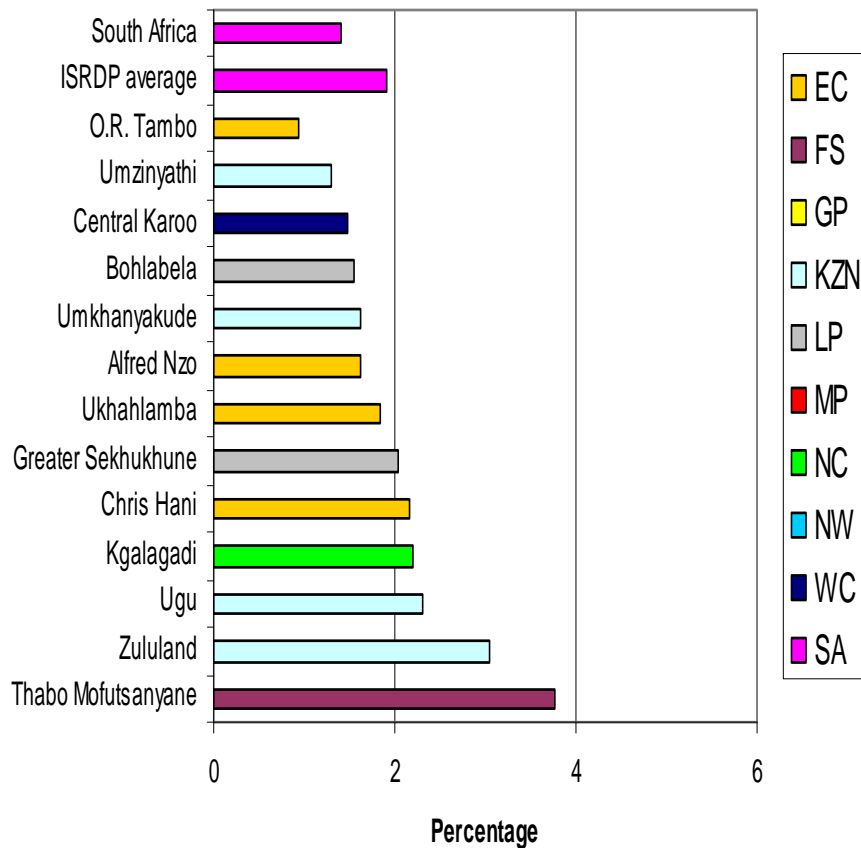
District	Socio-economic quintile	Smear conversion rate					TB cure rate					
		2001	2004	2005	2006*	Rank 2006*	change 2004-06*	2003	2004	2005*	Rank 2005*	change 2003-05*
Alfred Nzo (EC)	1		38.8	40.8	39.2	48	0.4	42.5	35.9	48.4	42	5.9
O.R. Tambo (EC)	1		34.9	40.4	48.4	36	13.5	35.3	35.3	64.0	26	28.7
Sisonke (KZN)	1		42.1	40.3	36.2	50	-5.9	23.7	50.6	49.2	41	25.5
Ugu (KZN)	1		41.0	35.4	42.0	43	1.0	37.6	33.4	33.8	50	-3.8
Umkhanyakude (KZN)	1		47.1	44.0	41.4	45	-5.7	30.0	34.9	41.8	46	11.8
Umzinyathi (KZN)	1		57.1	62.9	69.0	11	11.9	53.6	55.1	65.8	19	12.2
Uthukela (KZN)	1		35.5	42.0	40.9	47	5.4	36.1	40.2	44.5	44	8.4
Zululand (KZN)	1		48.0	47.5	58.0	22	10.0	40.4	51.3	66.3	18	25.9
Greater Sekhukhune ^[1] (LP)	1		53.7	40.1	41.4	45	-12.3	49.1	54.8	54.0	36	4.9
Vhembe (LP) ¹²	1		65.0	73.1	76.8	2	11.8	63.4	75.1	72.0	5	8.6
South Africa			46.6	50.5	55.8		9.2	56.7	50.8	57.6		0.9

Children <5 not gaining weight rate, ISRDP and Metro districts compared 2005/06



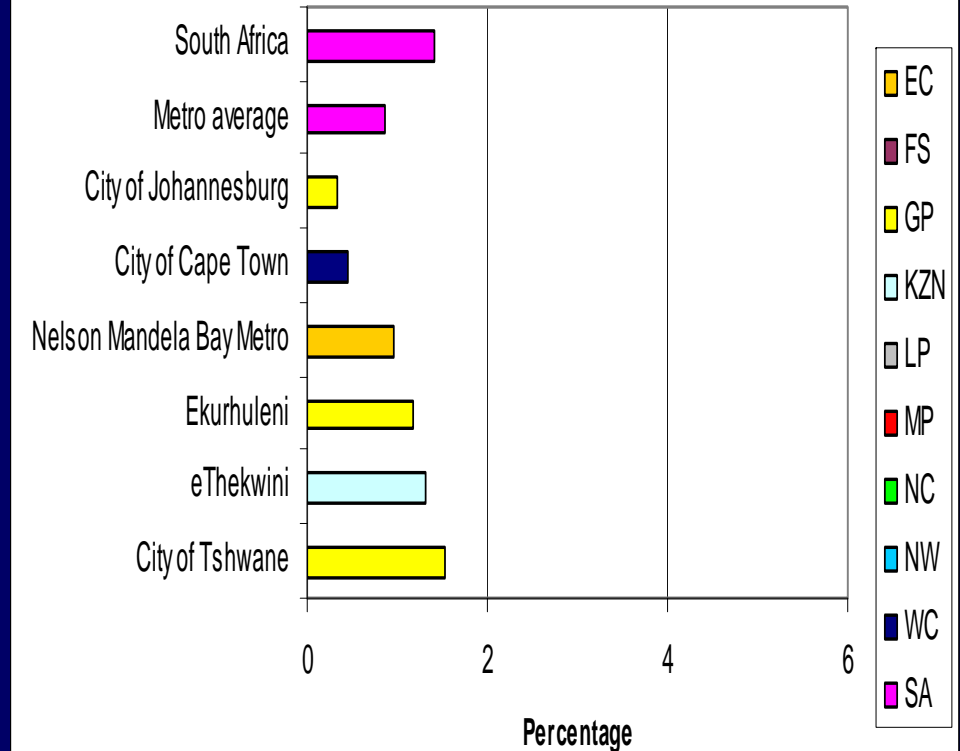
ISRDP

Not gaining weight rate, 2005/06

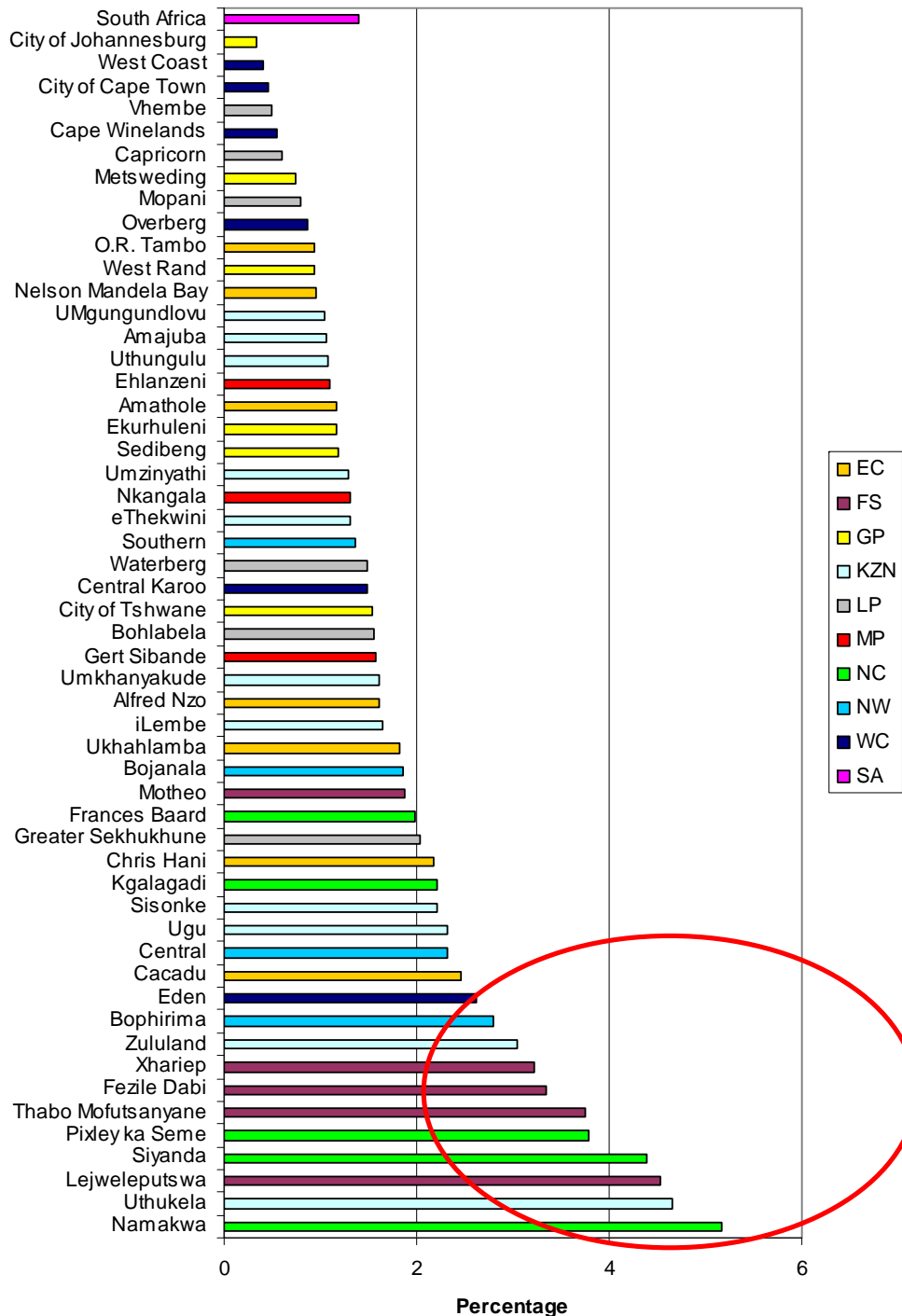


METRO

Not gaining weight rate, 2005/06



Not gaining weight rate, 2005/06



Children <5 not gaining weight rate,
all districts, 2005/06

Xhariep (FS)

Fezile Dabi (FS)

Thabo Mofutsanyane (FS)

Pixley ka Seme (NC)

Siyanda (NC)

Lejweleputswa (FS)

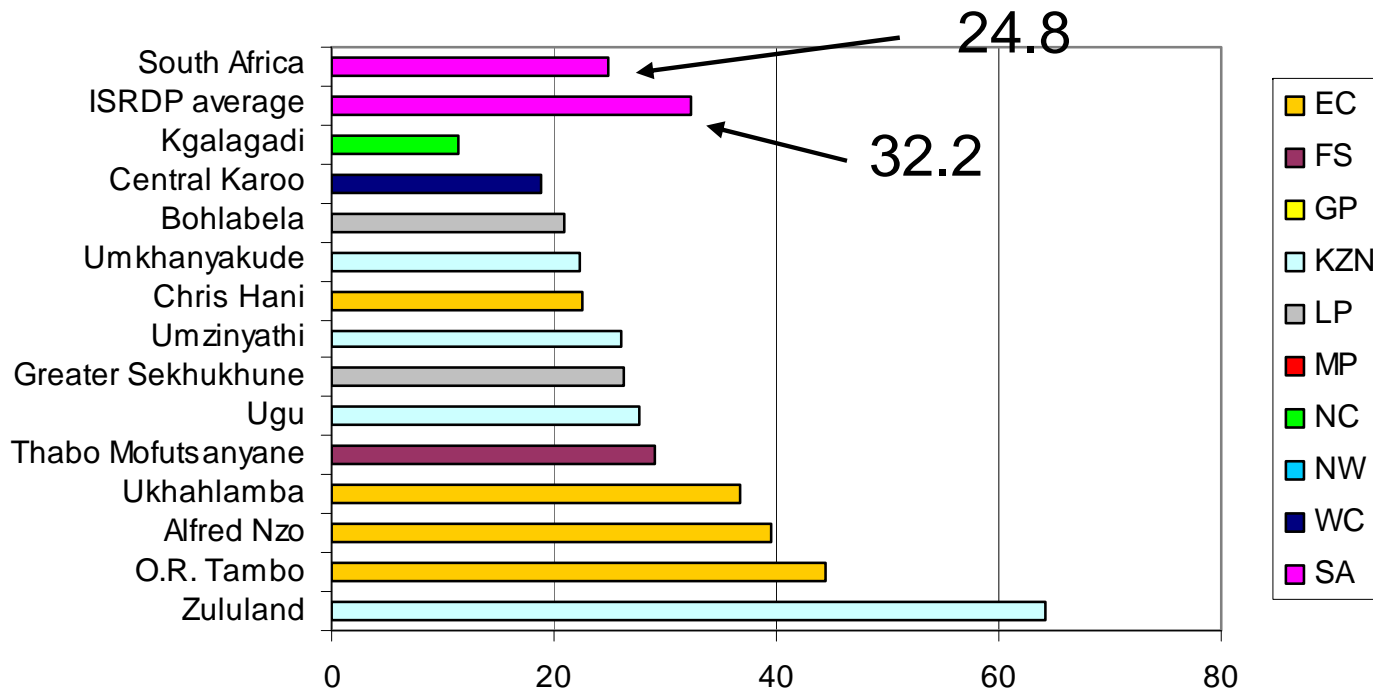
Namakwa (NC)

Zululand & Uthukela (KZN)

Stillbirth rate, 2005/06 ISRDP and Metro districts



Stillbirth rate, 2005/06

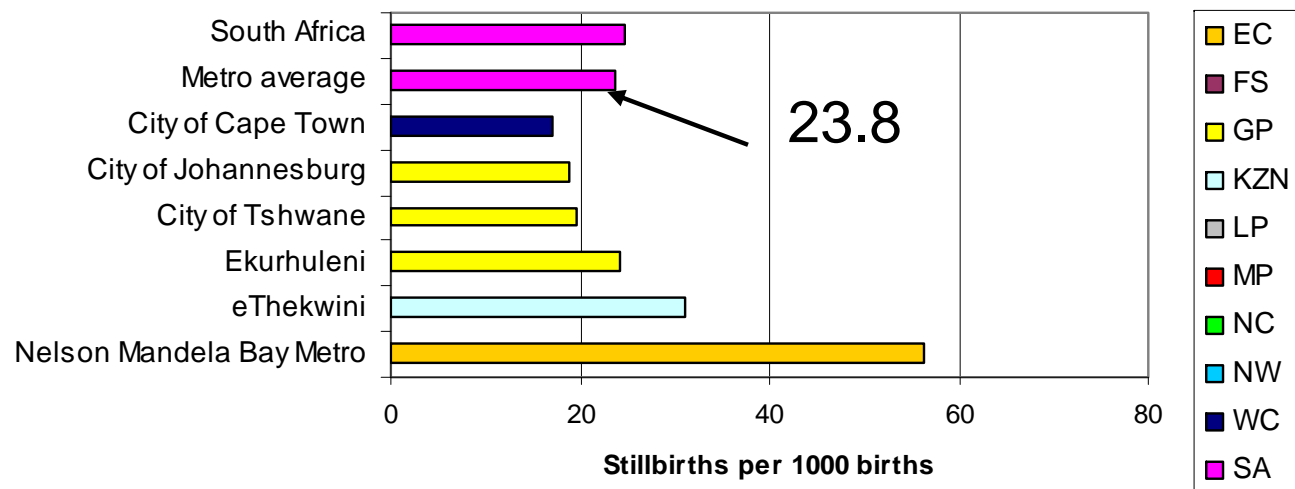


Why do Zululand, OR Tambo, A Nzo (ISRDP, rural), and Nelson Mandela metro (urban) have such unacceptably high stillbirth rates?

• **Developed countries 5 deaths per 1000**

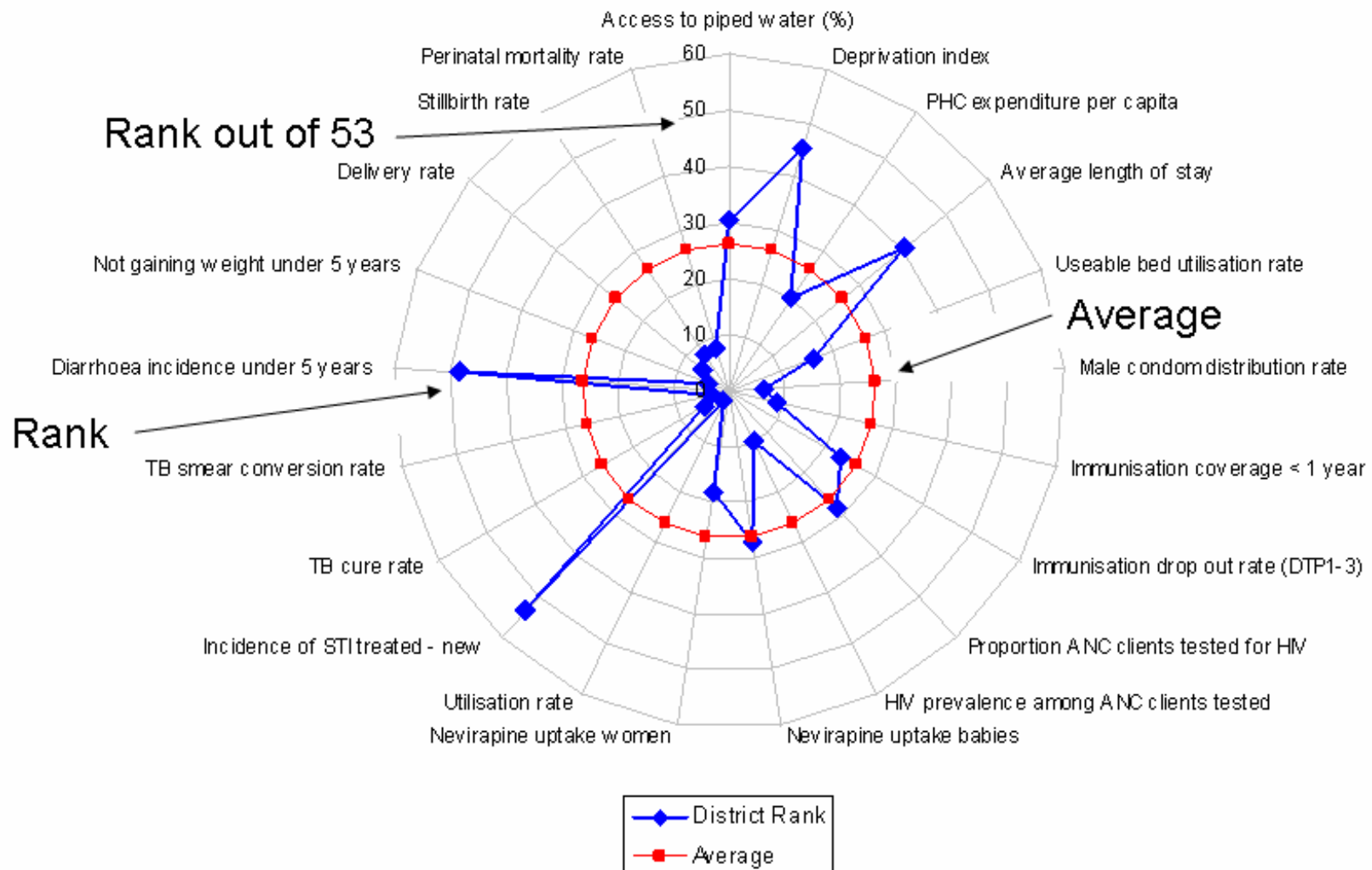
• **Developing countries 30 deaths per 1000**

Stillbirth rate, 2005/06

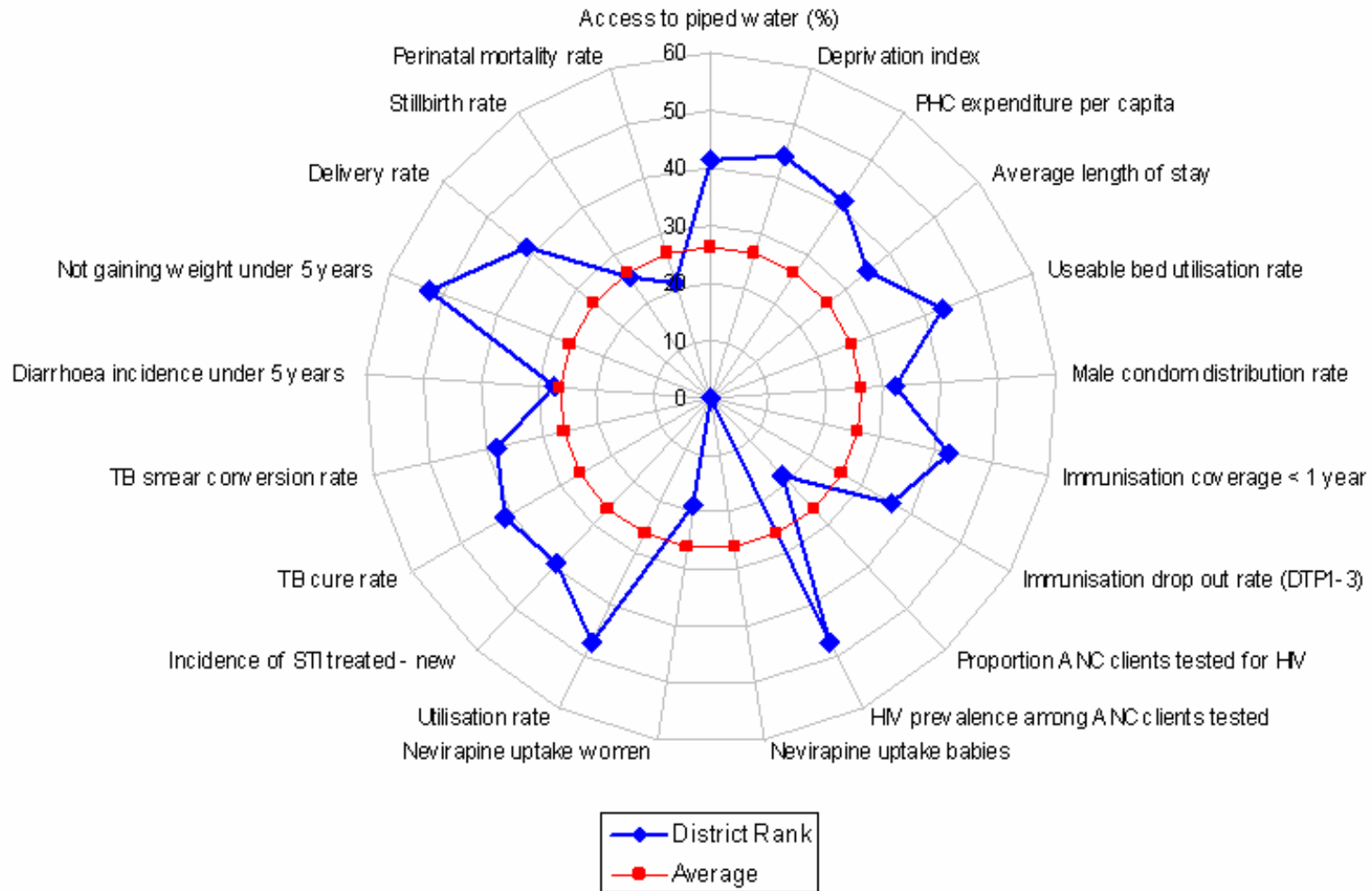


Spider Graphs – a different way to view district performance

Vhembe District (LP)



Uthukela District, KZN



The closer to the centre, the better

Further investigation

- Are the overall trends which show that there is a move towards greater equity in health funding in primary health care continuing and are they having the desired results in that the more disadvantaged areas are able to use these funds appropriately?
- Why do patients in many of the ISRDP and socio-economically disadvantaged districts, have a longer average length of stay in a district hospital than their counterparts in other better resourced districts?
- If it is true that many of the rural and disadvantaged areas are indeed managing to provide an effective immunisation service, why are other health areas in these districts not achieving the same results and what can be learnt from the immunisation programme that can positively influence other programmes?

Further investigation

Are Vhembe's results with respect to TB a true reflection? Which lessons learnt and successful systems implemented in this district can be shared, particularly with those districts with populations that are similarly disadvantaged?

Why do Zululand, OR Tambo, A Nzo (ISRDP, rural), and Nelson Mandela metro (urban) have such unacceptably high stillbirth rates? Is it due to data quality or is there another reason?

When comparing two similarly socio-economically disadvantaged districts, such as Vhembe and Uthukela, why does their performance in health delivery differ so vastly, what can be learnt from Vhembe and what can be done to assist Uthukela district?

CONCLUSIONS

- Routine service level data collected is transformed into information that leads to action
- Inequities between rural and urban districts and districts with populations of differing socio-economic levels are highlighted
- Improved feedback
- Tool for M&E, strategic planning at province & national level
- Improved transparency of performance of health sector
- Leads to continuous improvement of data quality of DHIS



THANK YOU

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