

A STRATEGY TO ENHANCE HEALTH SERVICES IN RURAL AND OTHER DEPRIVED AREAS: 2008 - 2013

1. BACKGROUND AND PURPOSE OF THE STRATEGY

There is a widely held view that health services are inequitably provided in rural and deprived areas of the country despite a range of progressive policies adopted and implemented since 1994. As well given the relatively higher levels of deprivation in rural areas the social determinants of health contribute more significantly to the burden of disease in rural and other under-served areas.

Both the 1998 and 2003 South African Demographic and Health Surveys have shown that for a number of health indicators, people living in rural areas are worse off than their urban counterparts. Clearly, both the social determinants of health as well as access to health services are contributory and need to be tackled. The purpose of this strategy therefore is to propose practical interventions for rural areas of the country to improve access to health services as well as to improve the quality of care provided to residents of rural areas.

In planning to strengthen health services in rural and other deprived areas the following principles should apply: (a) equity in the distribution of resources based on need; (b) equitable access to health services provided either in communities or by health facilities; and (c) provision of the best possible health services in terms of quality of care. In other words, health services provided to communities in these areas should not be or should not be perceived to be second rate – in comparison to public health services provided to urban dwellers.

2. DEFINITION OF RURAL AREAS

In both the national and international literature there is little consensus on what constitutes a rural area. A number of criteria can be suggested to highlight inadequate access to health services and more general relatively high levels of deprivation. These include; areas that currently have limited access to health services because they are outside of cities and towns; farming and other communities with very low population density; and areas that are poorly served with basic services like water, sanitation, electricity, schools, supermarkets, etc.

Instead of trying to resolve the definition of rural (and remote etc) for the purpose of this strategy the proxy we shall use a deprivation index to identify rural and other deprived areas for additional support. Rural communities, almost by definition, are relatively resource poor compared to their urban counterparts. This strategy therefore applies in particular to those districts and sub-districts that are most highly deprived and are listed in annex 1.

3. SITUATION ANALYSIS

3.1 Poor health status & poor health infrastructure

The fact that rural communities and other deprived communities have, in general, poorer health status than their urban counterparts is well known. The 1998 South African Demographic and Health Survey found that the infant mortality rate was 32,6/1000 live births in urban areas and 52,2 in non-urban areas. Similar the survey found that under 5 mortality was 43,2 in urban areas and 71,2 in non-urban areas. It also found that 10,8% of children from urban areas survey had diarrhoea compared to 15,7% of non-urban children. The total fertility rate in urban areas was found to be 2,3 compared to 3,9 in non-urban areas. Men in non-urban areas reported significantly more STI symptoms that those in urban areas (14,3% compared to 8,1%).

The SADHS (2003) found that 5 years later there was still a difference between infant mortality in urban and rural areas. The IMR in urban areas was found in 2003 to be 41/1000 whilst the non-urban IMR was 45/1000. Similarly the under 5 mortality in rural areas was found to be 57/1000 and 51/1000 in urban areas – with the rural province of Eastern Cape having a IMR of 67/1000 and under 5 mortality rate of 78/1000. The survey also found that about 34% of deliveries in urban areas are attended by a doctor but only 13% of those living in rural areas are attended to by a doctor. Over 8% of rural women deliver at home compared with less than 2% in urban areas. The survey also found – a measure of quality of care - that young mothers living in rural areas and those with limited education was less likely to have been informed about possible pregnancy related complications.

The 2007 Antenatal Survey of women using public health facilities found that nationally 28% of women were HIV positive (a decline for the second successive year of 1%). Of the 22 rural and highly deprived districts Ilembe had the highest prevalence at 41.5% and Vhembe the lowest at 15.2% with the average for the 22 districts being 22.05%.

Given that the rural areas have a higher burden of morbidity and mortality than urban areas it is critical that we have an additional focus on these areas to ensure that we achieve the Millennium Development Goals.

Lack of proper infrastructure like roads make access to rural areas difficult which in turn decreases the lifespan of vehicles and makes response times for emergency vehicles high. Besides accessibility to EMS other issues that dependent on good road infrastructure such as supervision also suffers in rural areas.

Lack of communication infrastructure keeps both communities and health professionals isolated. Isolation and lack of communication with colleagues is often cited as a reason for migration into the towns and cities.

3.2 Lack of sufficient health personnel

While South Africa has a general shortage of most categories of health providers, in particular doctors, nurses, dentists and pharmacists, a major challenge is that the bulk of most categories, with the possible exception of nurses, work in the private health sector. So while the public health sector experiences general shortages it is the rural areas of the country where the shortages are most acute.

These issues are however not new. The problems and a range of recommendations are contained in the National Human Resource Strategy (2000). Given their importance to rural development they are quoted in detail below:

“It is difficult to retain staff in rural areas; there is a lack of an attractive career structure to entice doctors away from urban areas. This leads to a lack of doctors in remote rural areas. It has been difficult to retain rural doctors, and in some areas, the small size of the population does not warrant assigning one. What is required is a new way of thinking about how the necessary services may be provided to those areas, while insuring that residents receive quality care. It will require a new and creative vision of staffing for these under-populated areas. One possibility is to use nurse practitioners to fill some or all of the gaps in services to these communities. Another possibility is to expand the skills of existing technical workers with enhanced competencies (e.g., nurses, pharmacy technicians, EHOs, etc.). Utilising multi-purpose unskilled/semi-skilled workers, etc., combining driver, cleaner, grounds care work in rural areas (though it may raise the issue of exploitation from the unions).

“The role and practice of the generalist doctor in rural community hospitals in South Africa is extremely wide and poorly documented. In the absence of specialist support, the rural generalist is called upon to perform clinical duties ranging from primary care to emergency surgical operations within the health team. The definition of the general practitioner is someone who is able to “deal with any patient, with any problem, at any time.” Often these doctors have had little or no formal training in the procedures that they have been asked to perform. It has been recommended that doctors be formally trained in community-based medicine so that they can better cope with the tasks that they are asked to perform in those settings. It is recommended that medical students spend at least 25-30% of their formal training time in community-based locations, i.e. outside hospitals, in the first instance. A study of 7209 procedures in KwaZulu-Natal (KZN) and the Northern Province (NP) hospitals, the need for training and educating of rural doctors is highlighted. General surgical procedures accounted for the largest proportion of procedures (46% in KZN and 44% in the NP) followed by obstetrics and gynaecological procedures (43% in KZN and 36% in the NP). Skill in Caesarean section for example is a standard practice for rural hospital generalist but is rare in urban hospitals. Some of the other procedures performed by rural generalists include incisions and drainage, circumcisions, debridement, excision, lump/other laparotomy, skin grafts, suturing, removal of foreign bodies, and hernia repair. Apart from these surgical interventions rural doctors are also required to administer anaesthesia - - a vital skill. These examples highlight the range of clinical services that rural doctors provide in order to meet the needs of their communities.

It is recommended that doctors acquire specifically defined skills for practice in the absence of specialist services during their student internship, internship and community service years and that this be monitored.

“In rural areas, a paucity of pharmacists exists. The shortage exists because many of the pharmacists are recruited into the private sector. In the Eastern Cape, Pharmacist Assistants are being trained to assume the tasks of a Pharmacist and are supervised from a distance. The introduction of the community service programme in the year 2001 may facilitate student access to training and may redress the shortage in rural communities. With the advent of the programme, it is estimated that between 420 and 450 pharmacists will enter the public sector.

“In many instances, changing the scopes of practices of the various categories of nurses will only reflect the work in which they are presently engaged. Sometimes, when they are left unsupervised, particularly at sites without doctors, nurses perform tasks outside their scopes of practice. These tasks differ among provinces. Representatives from DENOSA felt that these nurses need more supervision. Several examples illustrate the relationship between the changes in the scopes of practice, their relationship to the tasks workers actually perform, and the advantages of multiple entry and exit points in curriculum to both the worker and the health care system. It is known that nurses, particularly those in rural areas, provide services that are prohibited by their scopes of practice. They provide these services because they are necessary and because the appropriate professionals, usually doctors, are unavailable. For example, in the Eastern Cape, Enrolled Nursing Assistants are called upon to perform circumcisions but they are prohibited from doing them in Gauteng”.

4 VISION & GOALS FOR RURAL HEALTH SERVICES

The vision for rural health services is: be equitable in access and quality to people living in rural areas as urban health services are to people living in urban areas.

The goals for the South African rural health service are:

- Strengthen district health plans to ensure that social determinants of health are engaged with fully through community participation and intersectoral action
- Revise the service delivery platform for each rural area with a view to increase access to health services;
- Ensure the deployment of adequately trained health personnel in the community and at health facilities that serve rural areas;
- Ensure the establishment of a functional referral system as well as an emergency medical service with adequate response times;
- Ensure that district and sub-district management teams are adequately trained to deal with the provision of services in rural areas.

Note: the goals, activities etc are detailed in a table in the annex

The overall targets for the sub-districts, to be achieved by 2013, that are targeted in this strategy are:

- Reduce the prevalence of underweight children under 5 years of age by at least one third

- Achieve an immunisation rate for measles of at least 95%
- Increase vitamin A coverage in children aged 13-60 months to least 95%
- Reduce the under 5 mortality rate by at least half
- Increase the percentage of women delivering at health facilities and attended by a skilled health professional to 99%
- Reduce maternal mortality rate by at least two thirds
- Decrease the prevalence of HIV in pregnant women by at least half
- Increase the contraceptive coverage rate to at least 70% (condoms)
- Decrease the malaria prevalence and death rate from malaria by at least half
- Increase the proportion of TB cases detected and cured under DOTS to at least 80% of all cases

5 CURRENT GOVERNMENT-LED INITIATIVES

5.1 Integrated Sustainable Rural Development Programme

In 2001 the Presidency announced the ISRDP with 13 rural nodes and 8 urban nodes that were singled out as most deserving of systematic improvement. National and provincial government departments were requested to prioritise these areas for intervention and strengthening of public services. To facilitate joint action and to monitor activities a workplan has been developed and regular reports on progress are presented to the Forum of South African Directors-General (FOSAD) Social Cluster meetings.

As can be seen in Table 1, the designated rural nodes comprise more than 16.9% of the total population of the country.

Table 1: Population per rural node, STATSSA 2007.

PROVINCE	NODE	POPULATION
EC	CHRIS HANI	798 589
	UKHAHLAMBA	308 363
	OR TAMBO	1 862 218
	ALFRED NZO	479 395
FS	THABO MOFUTSANYANE	694 322
KZN	UGU	709 916
	UMZINYATHI	495 726
	ZULULAND	902 878
	UMKHANYAKUDE	614 029
LP	GREATER SEKHUKHUNE	767 179 1 090 437
NC/NW	KGALAGADI	173 452
WC	CENTRAL KAROO	60 486 56 222
TOTAL		8 185 547

Total SA population 2007: 48 502 036

The Department of Health has used the entire EU donor assistance for primary health care to support improvements in health systems and health service delivery in the rural nodes. Technical assistance is provided by a range of consultants who work alongside counterparts (health personnel of both provinces and local government) and to build management and clinical skills and capacity.

Using the expanded list of districts and sub-districts based on the first two quintiles of the deprivation index (top 20% most deprived districts and sub-districts), the total population that this strategy will target is..... as listed in the table below

DISTRICTS	SUB-DISTRICTS	POPULATION

5.2 Initiatives aimed at improving numbers of health providers

The Department of Health has responded to the shortage of health providers in the public sector in general and in under-served areas in particular through a range of initiatives. These include: (a) the recruitment of foreign doctors as a short to medium term strategy; (b) the implementation of community service for doctors initially and now for a large range of health professionals; (c) scarce skills and rural allowances for health professionals; and (d) the occupation specific dispensation.

The Department has entered into a country-to-country agreement with Cuba, Iran, Tunisia to provide doctors that would work in rural and other under-served areas of the country.

Table 2 illustrates the number of health providers for a selected number of categories which have been allocated the rural nodes in 2003. It should however be noted that the total numbers of community service doctors, dentists and pharmacists allocated in 2003 were: 1072; 49; 344 respectively. This means that 12,69%, 14,29, and 8,14% of doctors, dentists, pharmacists were allocated to the rural nodes - somewhat short of the 18% that one would have expected given the proportion of the population living in the nodes. Clearly, given the heavy burden of disease in rural areas one should see greater numbers of community service health professionals allocated to these areas.

Table: Allocation of community service health professionals to facilities in the most deprived sub-districts, 2008

PROVINC E	DISTRICTS	Doctors	Dentist s	Pharmacist s	Nurses	EHPs
EC	O.R. Tambo					
	Alfred Nzo					
	Chris Hani					
	Amathole					

	Ukhahlamba					
KZN	Umzinyathi					
	Umkhanyakude					
	Zululand					
	Sisonke					
	Ugu					
	Uthukela					
	iLembe					
	Uthungulu					
Free State	Thabo Mofutsanyane					
Limpopo	Greater Sekhukhune					
	Vhembe					
	Capricorn					
	Mopani					
Mpumalanga	Ehlanzeni					
Northern Cape	Kgalagadi					
North West	Bophirima					
	Central					

Note that only three categories were selected to make the point in the table above but that clearly all professional categories are important.

A strategy adopted by the Department to increase the number of suitably qualified health workers is the creation of mid-level workers in a range of categories. One example that is already implement is that of the pharmacy assistant. In addition, the Walter Sisulu University has enrolled the first cohort of students in the clinical assistant category (mid-level doctor).

5.3 Scarce and Rural Allowances

5.4 Clinic upgrading and building programme and the Hospital Revitalisation Programme

It is acknowledged that health personnel like others wish to work in an environment that is conducive with good quality buildings, the necessary equipment etc. It is also acknowledged that many public health facilities are in poor condition.

A national clinic building and upgrading programme (CUBP) was initiated in 1995/6 and more than 1600 new clinics were built and/or upgraded – most in rural and

under-served areas. This means that on average 1.6m South Africans have better access to PHC services. In addition, a large hospital revitalisation programme (previously known as the hospital rehabilitation and reconstruction programme) commenced in 1997/8. Currently, there are 31 hospitals that are part of the programme which includes upgrading of infrastructure, equipment, management strengthening and improvements in quality of care. Eight entirely new hospitals have been built under this programme to date.

Table 3 illustrates which rural nodes are currently benefiting from the Hospital Revitalisation Project. It should be noted however, the provinces also have rehabilitation programmes for hospitals which are not reflected in the table below.

Table 3: Location of hospital revitalisation projects

PROVINCE	DISTRICTS	Hospitals completed	Hospitals in revit programmes
EC	O.R. Tambo		
	Alfred Nzo		
	Chris Hani		
	Amathole		
	Ukhahlamba		
KZN	Umzinyathi		
	Umkhanyakude		
	Zululand		
	Sisonke		
	Ugu		
	Uthukela		
	iLembe		
	Uthungulu		
Free State	Thabo Mofutsanyane		
Limpopo	Greater Sekhukhune		
	Vhembe		
	Capricorn		
	Mopani		
Mpumulan ga	Ehlanzeni		
Northern Cape	Kgalagadi		
North West	Bophirima		
	Central		

5.5 Initiatives to strengthen health programmes

5.5.1 Deployment of TB Defaulter tracing teams

In February 2008 seventy two teams of community care givers (supported by professional nurses) were deployed in sub-districts which had the highest number of TB defaulters. These TB defaulter teams were tasked with tracing each defaulter and ensuring that they were restarted on TB treatment. By the end of June 2008 these teams had successfully traced 92% of TB defaulters in the areas in which they were deployed and 63% of the defaulters were initiated on treatment. This initiative will enable the country to move towards reducing the TB defaulter rate from 10% to 7% as stated in the President's 2008 State of the Nation Address.

Of the areas targeted by this strategy, the following districts are the same as those targeted by the TB tracing teams:

5.5.2 Integrated Management of Childhood Illnesses

Implementation of the community and household component of IMCI will assist in the reduction of infant and child deaths. In July 2008 a decision was taken to strengthen the implementation of the community and household component of IMCI by deploying teams of community care givers in sub-districts with the highest risk of child mortality. These sub-districts were selected based on their levels of relative deprivation (as in this strategy) and by looking at their performance on the following indicators: immunisation coverage; Vitamin A coverage (1-5 yrs); percentage of ANC clients tested; and % of deliveries in facilities.

Using these indicators the following districts, that are common to the list in the annex, were highlighted as those most at risk for high child mortality: Amathole; Alfred Nzo; Ukhahlamba; OR Tambo; Zululand; Ilembe; Umkhanyakude; Bophirima; Chris Hani; Ehlanzeni; and Thabo Mofutsanyane.

6 WHAT ELSE NEEDS TO BE DONE/NEXT STEPS?

6.1 Provision of infrastructure and dedicated support in rural areas

Health professionals like other professionals are essentially middle class individuals who desire middle class things and have middle class values. This implies that whilst not all the comforts of urban life needs to be or can be provided in rural areas, intersectoral collaboration is required by government departments to ensure that key social goods and services are available in rural areas. These include good schools, good roads, electricity, clean water and good security. These social goods are also important for all those that live in rural areas as they are examples of the social determinants of health!

Whilst the designation of the 13 rural nodes and the establishment of the Integrated Rural Development Programme are intended to accelerate development in the nodes, greater effort needs to be put to improving living and working conditions in these areas. Decent accommodation for health professionals in designated rural areas needs to be provided at a highly subsidized rate.

Table 4: Total and PHC per capita expenditure in rural and other deprived areas (need to update to 2007/08 figures)

PROVINCE	DISTRICTS	Per capita PHC exp (2006/07)
EC	O.R. Tambo	R 201
	Alfred Nzo	R203
	Chris Hani	R254
	Amathole	
	Ukhahlamba	R207
KZN	Umzinyathi	R230
	Umkhanyakude	R308
	Zululand	R217
	Sisonke	
	Ugu	R218
	Uthukela	R193
	iLembe	R216
Free State	Uthungulu	R193
	Thabo Mofutsanyane	R212
Limpopo	Greater Sekhukhune	R162
	Vhembe	R201
	Capricorn	R191
	Mopani	
Mpumulanga	Ehlanzeni	R184
Northern Cape	Kgalagadi	R275
North West	Bophirima	
	Central	

The table above reveals that even between rural and deprived districts there is a wide range of PHC expenditure per capita – ranging from a high of R308 in Umkhanyakude in KwaZulu-Natal to low of R162 in Greater Sekhukhune in Limpopo province.

6.2 Recruitment and registration of foreign doctors

According to the Rural Doctors Association of South Africa (RuDASA), “foreign doctors from other countries have filled the gap in many rural hospitals for years, and have provided the senior support and experience that is vital in many institutions. However, with the successively tight restrictions on the registration of foreign-qualified doctors by the HPCSA, together with the increasing difficulties foreign doctors experience with the Department of Home Affairs in obtaining and renewing work permits, this essential source of doctors for rural hospitals has been completely cut off. This does not make sense with respect to the countries which can afford to export doctors, and those whose graduates were recognized in SA until recently (e.g. UK, Belgium, etc). Those foreign doctors already providing valuable, often irreplaceable service in rural hospitals are being made to feel increasingly insecure and unwelcome, and are migrating in significant numbers to other countries where they are welcomed, thus further depleting South African rural hospitals of experienced personnel”.

The HPCSA and the Department of Health need to review the employment of foreign doctors especially those from countries with excess doctors and those from developed countries. Even if these doctors apply to work in South Africa for short periods they should be welcomed provided that they are prepared to work in under-served areas and their qualifications are comparable to those of South African trained doctors. Clearly the same principle should also apply to other health professions.

6.3 Strengthening the contribution of community service health professionals

RuDASA suggests that the introduction of community service (CS) has improved the availability of doctors in rural and under-served areas in some provinces, but two serious shortcomings of the scheme are becoming apparent (a) the lack of senior doctors to supervise them; and (b) the fact that only a quarter of CS doctors are in fact allocated to rural hospitals. The most needy hospitals appear to be avoided by CS doctors in their choices, and a number of rural hospitals in the Eastern Cape which desperately need more staff, for example, had no CS doctors in 2001. In addition, the annual turnover of CS doctors who need to be trained on the job each year, and the high proportion of them who head overseas after their year, are issues of concern.

A related issue is the need to use community service to retain these health professionals in the public health system, especially in rural areas once their one year of community service is complete. The implementation of an orientation programme coupled with ongoing support to these young health professionals is one way of achieving this as was illustrated in the case of pharmacists in the Eastern Cape. This means the support and promotion of **senior** professionals in rural areas, as they provide the support to junior colleagues. To attract and retain senior health professionals appropriate career paths need to be developed, including the recognition of rural generalists as specialists in terms of salary scales. Mentoring and opportunities for professional development for junior personnel are crucial.

Whilst the use of community service professionals will strengthen rural health services, it is imperative that permanent posts are not used for community service. Such a practice will not allow community service professionals to take up permanent posts upon completion as these posts may be required for the next batch of community service health professionals. Specific community service posts should be created to ensure that posts for seniors are available as it is the latter who are needed to ensure proper supervision, support and mentorship of the community service professionals as well as to ensure quality patient care.

6.4 Strengthening the referral and support system

It is critical that primary health care services are supported by the district hospitals in the district and that district hospitals are supported by regional hospitals. This is particularly important in rural and other deprived areas that are often under-staffed and also to prevent unnecessary referrals of people from these areas to far off health facilities.

Provincial Departments of Health must therefore, when planning health services for the province as a whole develop plans to ensure that resources are made available at regional hospitals to support district hospitals and for district hospitals to support primary health care facilities.

6.5 Strengthening linkages between rural health providers and academic institutions and roles of academic/training institutions

Many health providers who work in rural areas complain of isolation. A range of strategies can and should be employed to decrease the feeling of isolation. Some examples include: use of telemedicine (this is currently established in a number of sites); linking academic institutions to rural facilities so that specialists from the academic institution support health providers in specific facilities use of these facilities to train students under the academic health centre approach, conduct of collaborative research, etc.

Undergraduate training needs to be restructured to include early and continued exposure to rural areas. For postgraduate training we propose the development of distance education methods that do not require the students to leave their working environment or the need to move to a city to study.

It is also proposed that one criterion for selection of candidates for specialist training should include whether the candidate has served in a rural area, in the either the public or private health sector, with preference being given to those that serve in the public health sector. This may also encourage health professionals who wish to specialise to work in rural areas. Clearly, one would need to an agreed upon definition of rural areas before such a policy is implemented.

One mechanism to ensure that specialists also work in rural areas would be to require training institutions who hire specialists to make this part of the job

description. Another mechanism is to make it part of the contract of specialist training.

Telehealth/telemedicine is one way that technology can be used to bridge the divide between rural communities and their urban counterparts. A number of telemedicine sites have been established by the Department that are used to 'refer' patients to specialists in tertiary hospitals and for teaching and learning. These need to be expanded and a comprehensive programme developed around telehealth.

6.6 Role of Communities

Accountability of health workers to the communities that they serve, and reciprocal accountability of communities to the health professionals that work in rural areas, is an important principle that underlies the PHC approach. For example, District Health Councils should know who their students are in training, and keep them accountable during the training period to return and serve once they have qualified. All community service health professionals should be introduced to the local Mayor, the traditional leaders and the District Manager. Communities can also play a role in ensuring the safety of health workers, and in providing the social environment that attracts health professionals to stay on in rural areas.

6.7 Strengthening rural and other highly deprived municipalities

It is clear that government as a whole has a responsibility to ensure that the infrastructure of rural areas is strengthened. In this context municipalities, both district and local, have a significant role to play in strengthening the capacity of rural and other under-served areas to attract and retain professionals. Such a strategy will also stem the tide of urbanisation or at least slow the rate down so that urban development can keep pace with the rate of migration.

7 MONITORING AND EVALUATION

All components of the national and provincial Departments of Health must play a role in ensuring that rural areas get the resources that they need and are able to use these resources efficiently. The implementation of the strategic plan as detailed in the annex will be monitored by the Strategic Planning Cluster of the national Department of Health together with the other relevant clusters in the national department of health.

8 CONCLUSIONS

The challenges in rural areas, if what we find in the rural nodes is anything to go by are enormous. While the Department with its partners have intervened in a number of ways, much more and a few different things need to be done. This document attempts to locate the issues confronting rural health, outlines some of the existing interventions and proposes a few additional short to medium strategies.

Clearly, any strategy to improve health services cannot stop at policy or strategy formulation. It must be implemented.

9 PROCESS TOWARD FINALISATION AND IMPLEMENTATION OF THE DOCUMENT

The following process is proposed:

1. Presentation to Management Committee
2. Presentation to the Workshop on Community Care Givers;
3. Revision of draft based on comments and submission the Technical Committee of the NHC and thereafter to the NHC.

ANNEX 1: LIST OF RELATIVELY HIGHLY DEPRIVED DISTRICTS & SUB-DISTRICTS BY PROVINCE

PROVINCE	DISTRICTS	SUB-DISTRICTS
EC	O.R. Tambo	
	Alfred Nzo	
	Chris Hani	
	Amathole	
	Ukhahlamba	
KZN	Umzinyathi	
	Umkhanyakude	
	Zululand	
	Sisonke	
	Ugu	
	Uthukela	
	iLembe	
Free State	Uthungulu	
	Thabo Mofutsanyane	
Limpopo	Greater Sekhukhune	
	Vhembe	
	Capricorn	
	Mopani	
Mpumulanga	Ehlanzeni	
Northern Cape	Kgalagadi	
North West	Bophirima	
	Central	

**IMPLEMENTATION PLAN FOR THE ENHANCEMENT OF HEALTH SERVICES IN RURAL & OTHER DEPRIVED AREAS,
2008-2013**

GOALS	KEY ACTIVITIES	TARGETS	RESPONSIBILITY	TIMEFRAMES
1. Tackling the social determinants of health	<ul style="list-style-type: none"> Revise the District Health Plans to ensure that health plans includes the district's roles in dealing with the Social Determinants of Health 	<ul style="list-style-type: none"> Revised DHPs in place 	<ul style="list-style-type: none"> Districts and sub-districts 	February 2009 (and annually to coincide with the IDP cycle)
	<ul style="list-style-type: none"> Work with the DoE to strengthen the school nutrition programme 	<ul style="list-style-type: none"> Nutritional status of all primary school children monitored 	<ul style="list-style-type: none"> Districts with schools 	Annual assessments
	<ul style="list-style-type: none"> Work with Social Development and Education to strengthen early childhood development 	<ul style="list-style-type: none"> Growth monitoring and nutritional status of all children in ECD sites monitored 	<ul style="list-style-type: none"> Districts with ECD sites 	Annual assessments
	<ul style="list-style-type: none"> Strengthen community participation (district council; sub-district committee; facility-based committees) 	<ul style="list-style-type: none"> Committees fully functional 	<ul style="list-style-type: none"> District and sub-district management & facility management 	December 2008 (review their functionality 6 monthly and strengthen if necessary)
	<ul style="list-style-type: none"> Monitor access of households to clean water, sanitation 	<ul style="list-style-type: none"> Annual monitoring of changes in access to water and sanitation 	<ul style="list-style-type: none"> Districts and sub-districts 	<ul style="list-style-type: none"> February 2009 (and annually to coincide with the IDP cycle)
2. Improve access to health services	<ul style="list-style-type: none"> Review and revise service delivery platform to decrease travel time to health services 	<ul style="list-style-type: none"> Revised service delivery plan to be finalised Travel time (on foot) to first point of care should be no longer than 1 hour 	<ul style="list-style-type: none"> Provinces 	February 2009 (with annual reviews and revisions to coincide with the budget cycle)

	<ul style="list-style-type: none"> Decrease TB defaulter rates 	<ul style="list-style-type: none"> Tracer teams implemented 	<ul style="list-style-type: none"> Provinces with support from national 	Tracer teams in place in selected sub-districts with quarterly progress reports by December 2008
	<ul style="list-style-type: none"> Initiate facility improvement plan (current and new) 	<ul style="list-style-type: none"> As in revised service delivery plan 	<ul style="list-style-type: none"> Provinces 	April 2009
	<ul style="list-style-type: none"> Strengthen community based services 	<ul style="list-style-type: none"> Revised service delivery plan to include component on community based services that will be supported by the district Strengthen community and household IMCI – & report progress to NHC 	<ul style="list-style-type: none"> District and sub-district 	<ul style="list-style-type: none"> February 2009 (and annually to coincide with the budget cycle) IMCI teams to be established by September 2008 with first progress report due in January 2009 (thereafter quarterly reports)
	<ul style="list-style-type: none"> Decrease EMS response time to 40 min 	<ul style="list-style-type: none"> Develop district/sub-district EMS plan 	<ul style="list-style-type: none"> Province & district/sub-district 	February 2009 (and review annually to coincide with budget cycle)

	<ul style="list-style-type: none"> Strengthen referral systems & support by regional hospitals to district hospitals & district hospitals to PHC facilities 	<ul style="list-style-type: none"> Develop and implement planned patient transport Review referral system, & strengthen & monitor its efficiency Develop & implement plan to strengthen clinical support by regional hospitals to district hospitals & district hospitals to PHC facilities 	<ul style="list-style-type: none"> District, sub-district, facility management 	February 2009 (quarterly reviews to be done on performance)
	<ul style="list-style-type: none"> Monitor key health output indicators (against DHPs) 	<ul style="list-style-type: none"> Quarterly reviews done by sub-districts and districts & corrective action taken 	<ul style="list-style-type: none"> DHMTs & sub-district management 	Quarterly
3. Ensure adequate staffing levels	<ul style="list-style-type: none"> Develop district HR plan 	<ul style="list-style-type: none"> Plan developed & approved by province 	District management team	February 2009 (and reviewed annually to coincide with budget cycle)
	<ul style="list-style-type: none"> Ensure sufficient accommodation for staff 	<ul style="list-style-type: none"> Staff housing plan to be part of infrastructure & maintenance plan 	District management team	February 2009 (and reviewed annually to coincide with budget cycle)

	<ul style="list-style-type: none"> Strengthen supervision and support systems (including access to computers, telehealth, etc) 	<ul style="list-style-type: none"> Supervision and support plan for all categories of staff developed and implemented All facilities to be supervised monthly with written reports that are assessed by the supervisor's manager Bi-monthly DHMT visits to each sub-district to 	<ul style="list-style-type: none"> District management with support from province Supervisors & their managers DHMTs 	<ul style="list-style-type: none"> December 2008 and reviewed annually Monthly supervision visits to all facilities Bimonthly supervision visits by the DHMT to each sub-district
	<ul style="list-style-type: none"> 			
4. Strengthening logistics and support services	<ul style="list-style-type: none"> Ensure availability of products on the EDL at all facilities 	<ul style="list-style-type: none"> Zero stockout of EDL 	District, sub-district and facility management	Monthly reviews to be done and corrective action taken
	<ul style="list-style-type: none"> Audit of medical equipment 	<ul style="list-style-type: none"> Audit done and request for new equipment placed Equipment maintenance plan in place 	Facility management supervised by sub-district management team	<ul style="list-style-type: none"> Annual audit of equipment Equipment maintenance plan in place by December 2008 and revised 6 monthly
	<ul style="list-style-type: none"> Decrease lab turn around time 	<ul style="list-style-type: none"> Tracer is TB sputa: <48 hr turnaround time 	<ul style="list-style-type: none"> Facility management, and DHMT with support from province 	<ul style="list-style-type: none"> December 2009 (check TB strat plan timeframes)
5. Strengthen DHMTs	<ul style="list-style-type: none"> Assessment of capacity of DHMT, sub-district management and facility management 	<ul style="list-style-type: none"> Capacity assessment complete & plan to strengthen management in place 	<ul style="list-style-type: none"> Province (with support from NDOH) with DHMTs, sub- 	<ul style="list-style-type: none"> February 2009 (and annually)

			district and facility management	
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