




ANNUAL NATIONAL HEALTH PLAN 2007/08

NATIONAL DEPARTMENT OF HEALTH
MAY 2007

health

Department:
Health
REPUBLIC OF SOUTH AFRICA

TABLE OF CONTENTS

FOREWORD BY THE MINISTER OF HEALTH

The Annual National Health Plan (ANHP) 2007/08 is the second to be developed since the National Health Act (NHA) of 2003 was passed. The first plan, the ANHP 2006/07, was adopted by the National Health Council (NHC) in May 2006.

The ANHP 2007/08 originates from the National Health System (NHS) priorities agreed upon by the NHC in 2006. It provides an outline of the milestones to be achieved during 2007/08 to accelerate our progress towards these priorities.

The development of the ANHP 2007/08 has been guided by the progress made by National and Provincial Departments of Health with the implementation of the previous plan, the ANHP 2006/07. This plan is therefore grounded on a realistic assessment of what is achievable and what is not, in the light of the funding constraints faced by the health sector.

The targets originally set for the financial year 2006/07 have been retained in the ANHP 2007/08. This has been done to allow the National and Provincial Departments an additional year of implementation to consolidate their progress.

Most importantly, the ANHP 2007/08 reflects the priorities submitted by the health sector to the Presidency in July 2007, as part of the Presidential Priorities for Immediate Government Action for 2007-2009. We must therefore pull all stops to ensure that these priorities are implemented, and the set milestones achieved.

Our vision is an accessible, good quality and caring health system, founded on the Primary Health Care (PHC) approach. Our people deserve this. To achieve this, we need to steadfastly implement measures to strengthen our health care system, and ensure that it responds adequately to the health needs of the people of South Africa.

We must ensure that our health system is appropriately designed, sustainable, assured of a steady supply of adequately trained, appropriately remunerated, and well-motivated cadre of health workers, working in conducive and adequately equipped environments. It is therefore imperative that health sector needs are appropriately identified and costed, and converted into good quality plans that can fortify our efforts at mobilising resources for the public health sector, which we all agree is under-funded.

In future, the Annual National Health Plans must incorporate the plans of the

private health sector. We must promote integrated planning, and through our plans, inform our people about what we seek to achieve, as to the two health sectors.
Working independently but in unison, we can provide South Africans with the best possible quality health care service.

Then we will truly be on our way to attaining the National Health System envisaged in the National Health Act of 2003.

On behalf of the NHC, I hereby endorse the ANHP 2007/08. During the course of this financial year, the NHC expects regular progress reports from both the National and Provincial Departments of Health about the implementation of this plan.

DR. M.E. TSHABALALA-MSIMANG, MP
MINISTER OF HEALTH
DATE: 08/11/2007

STATEMENT FROM THE DIRECTOR-GENERAL

As the Minister has indicated, the Annual National Health Plan for 2007/08 represents our second effort as the public health sector to produce a single national plan, reflecting our collective vision for health service delivery, with clear objectives, indicators and targets for monitoring our progress towards this vision. Our first effort is embodied in the ANHP 2006/07, which was approved by the NHC in May 2006.

It is therefore imperative for the health sector to take stock of progress made towards the objectives of ANHP 2006/07, prior to commencing with the implementing this current plan.

Drawing from the National Health Systems (NHS) priorities, a set of turnkey activities was identified for implementation in the ANHP 2006/07, and clear targets and indicators for monitoring progress were developed. All these targets aimed to accelerate improvements in health service delivery to the people of South Africa, particularly those who are entirely dependent on the State for their health needs.

A review of strides made with the implementation of the five NHS priorities reveals significant achievements in several key areas, as well as persistent constraints in numerous others.

With regard to Priority 1, the Development of Service Transformation Plans (STPs), a lot of was achieved during 2006/07. All nine provinces produced and costed their STPs for 2007/08-2014/15; as well as their Provincial Annual Plans for 2007/08-2009/10, and Business Plans for improving Emergency Medical Services (EMS). The Western Cape Department of Health produced a Comprehensive Service Plan, which has a long-range focus.

However, progress was much slower than anticipated in the following areas: development of plans for the implementation of the Modernisation of Tertiary Services (MTS); development of full transport systems for the delivery of patients to hospitals and specialists to lower levels of care; development and implementation of telemedicine plans; and implementation of ICD 10 coding at tertiary and regional hospitals.

In relation to Priority 2, Strengthening Human Resources, areas of success included: the development of draft Provincial Human Resource Plans by eight of the nine provinces; development and implementation of Service Level Agreements (SLAs) with private sector doctors and specialists for sessional work in the public health sector; increased intake of nursing students by training

institutions in eight of the nine provinces; training of Hospital CEOs in various management courses, and most importantly, agreement around improvements in the remuneration levels of health workers.

Areas of slow progress across provinces included: delays in the mapping of the distribution of staff as well as agreement on provincial baseline levels for staffing of tertiary and regional hospitals and Primary Health Care (PHC) facilities.

With regard to Priority 3, Strengthening Infrastructure, areas of successful implementation included: increases in the number of hospitals enrolled in the Hospital Revitalisation Project (HRP), which exceeded the set target of 42 for 2006/07; successful transfer of forensic services including mortuaries, from the South African Police Services to the Provincial Departments of Health; and the restructuring of the Community Health Centres (CHCs) in line with STPs.

Areas where slow progress manifested itself during 2006/07 included: inadequate funding for the HRP, which resulted in some projects being temporarily suspended; delayed submission of new business cases for the HRP, which resulted in fewer business cases approved than the set target of 27 for 2006/07; inadequate upgrading of hospitals that were not part of the HRP; and lack of increases in maintenance expenditure to reach the targeted 2.5% of the budget.

In terms of Priority 4: Improving Quality of Care, significant strides were made in areas such as: routine monitoring of clinical audits in Tertiary and Level 2 hospitals; routine management of complaints from service users in Tertiary and Level 2 hospitals; development of Provincial Infection Control Policies; and the appointment and training of Infection Control Officers in institutions across eight of the nine provinces.

Areas of difficulty with the implementation of Priority 4 included: poor supervision of Primary Health Care (PHC) facilities; inability to achieve a 10% increase in the deployed fleet of Planned Patient Transport, as well as the inability to achieve a 10% increase in the deployed fleet of EMS road ambulances. The targets for increasing the deployed fleet of PPT and EMS vehicles may need to be reviewed to assess if they are realistic. Should they be found to be pragmatic, then all possible resources should be mobilised to accelerate implementation during 2007/08.

In relations to Priority 5, Strengthening Strategic Health Programmes, areas of good progress included: implementation of accelerated HIV prevention; promotion of healthy lifestyles; implementation of community-based Move for

Health Programmes; and identification of more than 1 000 Health Promoting Schools.

Areas of slow progress during 2006/07, which must gain momentum in 2007/08 include: implementation of the TB Crisis Plan; implementation of the School Health Policy and improving the management of chronic diseases. There were significant challenges in the latter area, with gaps identified in interventions such as: strengthening the follow-up of patients with priority chronic conditions; strengthening referral systems for chronic care patients; strengthening the self-management of patients; development of a National Policy and Guidelines for the treatment of and care of survivors of domestic violence; development of a comprehensive plans for the provision of psychosocial support for survivors of gender-based violence; and the training of professional nurses and medical practitioners on sexual assault care practice.

Many useful lessons have been learnt from the implementation of the ANHP for 2006/07. The achievements highlighted above have convinced us that the focus areas identified and targets set were accurate.

We must be impatient with ourselves where we have made slow progress with the implementation of key strategic health programmes, such as improving PHC supervision; implementing the TB Crisis Control; strengthening the management of chronic conditions; and the development of policies and guidelines for and the training of professional nurses and medical practitioners on sexual assault care practice. As the Minister has pointed out, for 2007/08, we have retained the targets originally set for 2006/07, to ensure that we consolidate our progress. In future, our budget bids to National Treasury must reflect greater alignment between NHS priorities and resource requirements.

Concerted effort and commitment should also be dedicated to Presidential Priorities for Immediate Government Action for 2007-2009, to which the health sector submitted its inputs in July 2007. These must be implemented with vigour.

I commit the Technical Committee of the NHC to ensure the successful implementation of the ANHP 2007/08.

_____

DIRECTOR-GENERAL

DATE: 14/09/2007

CHAPTER 1:

VISION, MISSION AND SITUATIONAL ANALYSIS

1.1 Vision

An accessible, caring and high quality health system.

1.2. Mission

To improve health status through the prevention of illnesses and promotion of healthy lifestyles and to consistently improve the health care delivery system by focusing on access, equity, efficiency, quality and sustainability.

1.3. Political and Legislative Mandates

The National Health Act of 2003, in Section 21(5) stipulates that the Director-General of the National Department of Health (NDoH) will integrate the health plans of the National Department and Provincial Departments annually and submit integrated health plans to the National Health Council (NHC). An Annual National Health Plan (ANHP) for the entire health system is therefore a legal requirement.

Monitoring of the ANHP and regular reporting to the NHC on progress is also essential. This will assist the health sector to identify good practices as well impediments to progress, and to address these timeously. Furthermore, the Public Finance Management Act of 1999 (as amended) places an obligation on accounting officers of departments to establish procedures for quarterly reporting to the Executive Authority to facilitate effective performance monitoring, evaluation and corrective action.

1.4. Brief Overview of the Health Sector Performance

A review of public health sector performance during 2003/04-2006/07, reflects diverse achievements and challenges in combating communicable diseases, non-communicable diseases and strengthening health promotion and health systems. In this section we provide an overview of outcomes with more detail per budget programme being included in subsequent sections.

With regard to combating communicable diseases, the health sector has had several achievements for this period. National immunisation coverage improved

from 82% in 2004/05, to 84% in 2006/07. This ensured the protection of South African children against vaccine preventable diseases. The health sector's comprehensive response to HIV and AIDS was also implemented and rapidly expanded. A significant increase was recorded in the proportion of public health facilities offering Voluntary Counseling and Testing (from 80% in 2004/05 to 90% in 2006/07) and those providing Prevention of Mother-to-Child Transmission (PTMCT) services (increasing from 60% in 2004/05 to almost 90% in 2006/07). Increasing numbers of health service users agreed to be tested, even though the uptake rates of both VCT and PMCT have not reached our own targets.

The treatment programme for HIV and AIDS has been cascaded down from the 52 districts to 136 of the 184 municipalities. Nutrition supplements were provided to people living with debilitating conditions. Malaria incidence and deaths have been reduced in the three malaria-endemic provinces (KwaZulu-Natal, Limpopo and Mpumalanga) and malaria control has been strengthened in the Maputo corridor, amongst others. This decline is a direct result of the various interventions made by the public health sector, including: increasing indoor residual spraying with an overall coverage of more than 80% of households, and completing the spraying before the peak in malaria transmission; use of artemisinin based combination therapy by the malaria affected provinces that reduces parasite carriage; intensified surveillance leading to early detection of any rise in malaria cases in high risk areas; capacitation of epidemic preparedness teams to respond to seasonal outbreaks; advocacy with mass community mobilisation; and training of healthcare workers in the malaria affected areas. Collaboration amongst African countries plays a significant role in improving the effectiveness of the malaria control programme since malaria vectors (mosquitoes) have no regard for national borders.

In terms of combating non-communicable diseases, the public health sector reached numerous milestones, including the following: elimination of a documented two-year backlog in medical assistive devices; public sector hospitals have been made more physically accessible to people with physical disabilities; provision of access to Choice on Termination of Pregnancy to 344 477 women over a seven-year period (1997-2004). A Confidential Inquiry into Maternal Deaths has been institutionalised. Cataract surgery operations have restored the sight of more than one million elderly South Africans annually between 2004/05 and 2005/06. The supply of safe and reliable blood units was increased by more than 10% per annum, and a non-discriminatory risk model for assessing blood donors was developed and implemented.

The National Department also initiated healthy lifestyle campaigns including Vuka South Africa, Move for your Health, in which more than 120 000 South Africans participated in 2005/06. Through legislation, all citizens are protected

against the harmful effects of tobacco and all users of alcohol will be informed of its harmful effects through appropriate labeling when the regulations are completed during 2007/08.

Several pieces of legislation were also passed to ensure that all South Africans have access to safe and affordable medicines, which are dispensed by appropriately qualified personnel and that all pharmacies are licensed.

In terms of strengthening of health systems, the Department introduced rural and scarce skills allowances to ensure retention of its skilled health care providers. Between 2004 and 2005, the public health sector recorded a net gain of an additional 452 medical practitioners, 1 417 nurses and 80 pharmacists. Furthermore, permits were extended for 115 Cuban doctors still serving within the Government-to-Government agreement for a period of three years, and their registration with HPCSA was extended.

Infrastructure provision was strengthened with Provincial Departments building more clinics and Community Health Centres (CHCs). More than 42 hospitals are being upgraded or replaced during 2006/07 as part of the hospital revitalisation project. In 2007/08 there will be 39 active projects. This is because the rest had to be temporarily stopped due to the unavailability of funds.

Outstanding challenges from 2003/04-2006/07, which will continue to be addressed during 2007/08-2008/09, include decreasing the burden of disease from both communicable and non-communicable diseases and improving the availability and quality of resources, including human resources for health needed to deliver health services in the public sector.

The National Health Systems priorities for 2007/08, which are discussed in detail in Chapter 3 and Chapter 4 of this document, are informed by these challenges, as well as the imperative to accelerate progress towards the Millennium Development Goals (MDGs).

CHAPTER 2

REVIEW OF PROGRESS WITH THE IMPLEMENTATION OF THE ANNUAL NATIONAL HEALTH PLAN 2006/07

This Chapter presents a synopsis of progress made by Provincial Departments of Health towards the five NHS priorities for 2006/07. Progress made and challenges encountered are discussed for each of the five NHS priorities.

2.1. DEVELOPMENT OF SERVICE TRANSFORMATION PLANS (STPs) AND ANNUAL PERFORMANCE PLANS (APPs)

All nine provinces completed their Annual Performance Plans for 2007/08-2009/10, as required by legislation. Furthermore, eight of the nine Provincial Departments of Health completed their Service Transformation Plans (STPs) for 2007/08-2014/15, using the Integrated Health Planning Framework (IHPF), a planning tool developed by the National Department of Health. The Western Cape Department of Health developed a Comprehensive Service Plan, which was approved by the Provincial Cabinet in July 2006. The National Department of Health accepted this service plan as part of the STP process.

The STPs assisted Provincial Departments of Health to review the shape and size of their health services, and to develop an appropriate, adequately resourced and sustainable health service delivery platform, which begins to respond to current health challenges facing each province and the country. The Provincial Departments of Health also conducted scenario planning, drawing from the four scenarios developed by the Presidency in 2003. Each province chose a likely scenario (or preferred option) for service delivery, based on its analysis of internal and external environmental factors that could influence outcomes.

All the Provincial STPs were good quality plans, reflecting the detailed analyses of the current shape and size of their services, and an attempt to reshape the system using objective criteria. Significant lessons for planning and budgeting emerged from Provincial STPs, which are briefly outlined below:

2.1.1. Primary Health Care (PHC)

All Provincial STPs affirmed Primary Health Care (PHC) delivered through the District Health System (DHS) as the fundamental approach to the delivery of health care services. An integrated approach to strengthening PHC services, which includes enhancing infrastructure for PHC service delivery, and re-classifying some Level 1 hospitals, was presented by provinces. However,

although PHC was endorsed in all Provincial STPs, different models for PHC service delivery were discernible, especially between urban and rural provinces (doctor-led versus nurse-focused PHC).

2.1.2. Need for an integrated approach to infrastructure inclusive of both PHC facilities and Hospitals

STPs provide a good basis for identifying infrastructural needs, and prioritising hospitals for the Hospital Revitalisation Project. The STPs looked at the health system in its entirety, and developed integrated plans for both PHC facilities and hospitals. The importance of well established hospital services to support PHC service delivery was accentuated. For 2008/09, an integrated infrastructure bid including needs of both hospitals and PHC should be developed.

2.1.3. Need for Provincial Human Resource Plans

Most Provincial Departments of Health produced their Draft Human Resource Plans during 2006/07, though these had not yet been finalised or formally adopted by the provinces. A need exists for these plans to be finalised, and to reflect an appropriate staff mix, based on an agreed approach. This should inform costing of additional human resource requirements.

2.1.4. Need for norms for the health sector

STPs reflect a need for the health sector to agree on common norms, or a range of norms. Provinces such as KwaZulu-Natal use the norms of 10 000 - 30 000 people per clinic and 60 000-120 000 people per Community Health Centre (CHC). The more densely populated provinces such as Gauteng and the Western Cape used different sets of norms. Gauteng Province uses catchment populations of 24 000 per clinic and 144 000 per CHC. The Western Cape applies the norm of 30 000 population per clinic; 30 000 population per CHC (small CHC) and 120 000 population per CHC (large CHCs).

2.1.5. Strengthening of provincial planning capacity

The development of STPs reflects that provincial planning processes must be a collaborative effort amongst all budget programmes. Furthermore, Provincial Strategic Planning Units need to be strengthened by enhancing their capacity and authority to co-ordinate planning processes.

2.1.6. Province-specific highlights

The Draft STP for 2007/08 of the Free State Department of Health adopted the District Health System (DHS) as the key approach to health service delivery in the Free State. The STP explored various scenarios, which looked at the province with and without cross boundary service users from neighbouring provinces and countries. Each hospital was then analysed in terms of its total cost to correction for each of the four scenarios. The Free State Department of Health provides Level 2 services to cross-boundary referrals from Eastern Cape (270 000), Northern Cape (30 000) and Lesotho (86 000). The current service delivery platform of the Free State Department of Health consists of one tertiary hospital, five regional hospitals and 22 district hospitals. Bed numbers exclude CHC beds and private beds. The proposed service delivery platform of the Free State Department of Health consists of one tertiary hospital for an adjusted uninsured population of 3 701 335; three regional hospitals for an adjusted population of 2 643 992 (0.9 million population per hospital); and 11 district hospitals for an adjusted uninsured population of 2 266 128 (0.2 million people per hospital). The Free State STP will be finalised during 2007.

Due to the densely populated nature of Gauteng, the Provincial Department of Health estimated its catchment populations at 24 000 per PHC clinic and 144 000 per CHC. Based on this norm, it was estimated that the province required 407 new clinics and 68 new CHCs. The Gauteng Department of Health estimates that 97% of the province's population has access to a clinic within five kilometers.

The key feature of the STP process in KwaZulu-Natal was the wide consultations that were undertaken, with key stakeholders such as organised labour, the Health Portfolio Committee, and District Management Teams inclusive of local government representatives. Like the Free State and Gauteng, the KwaZulu-Natal Department of Health took a policy decision to adopt PHC as its fundamental approach to service delivery. Hence the STP for 2007/08/-2009/10 provided for a substantial increase in the number of CHCs and clinics in all districts of the province. The STP also proposed the following service delivery platform: three tertiary hospitals, one in each of the three management areas of the province; nine regional hospitals (currently 12 exist); 32 district hospitals (currently 42 exist); 14 specialised hospitals (currently 19 exist); 176 CHCs (currently only 14 exist) and 1 054 fixed clinics (currently only 525 exist).

Both the Limpopo and Mpumalanga Departments of Health adopted Shosholoza as the preferred scenario for the province. This is the most positive of the four scenarios, with high social cohesion and a supportive external environment. The predicted economic growth is high and successful programmes ensure

a maximum impact on health status and sexual behaviour. The outcome is therefore the highest population. The Limpopo Department of Health and Social Development constructed its STP as an option appraisal document (rather than a rigorous plan), based on its preferred scenario. The key assumptions of the STP of Limpopo are that it will provide a service delivery platform with a full package of services from core facilities and maximum availability of medical skills at all levels of care.

The PHC infrastructure of the Limpopo Department of Health and Social Development consists of 392 clinics (and 22 sheltered visiting points) and 26 CHCs. The STP of the province projects a need of 89 clinics and eight CHCs.

The STP of the Mpumalanga Department of Health was encompassed within the Provincial APP for 2007/09-2009/10. The total population of the province was estimated at 3 398 442. In 2006/07, the PHC service delivery platform consisted of 302 clinics and 36 CHCs. However, in terms of the provincial norms, a total of 340 clinics and 61 CHCs were required. This implied a gap of 38 clinics and 25 CHCs. With regard to hospital services, Mpumalanga adopted a norm of one district hospital per 300 000 population and one regional hospital per 1.4 million population. It also adopted the Modernisation of Tertiary Service (MTS) recommendation that the province needed one tertiary hospital located in Nelspruit. Mpumalanga has 23 district hospitals, including two inherited from Limpopo, but the IHPF suggests it requires only 11. The 12 district hospitals in excess would be rationalised during the MTEF period, starting with those deemed to be functioning ineffectively, after intensive consultations with the affected communities. In keeping with IHPF and MTS recommendations, the Mpumalanga Department of Health allocated its regional hospitals across its three districts. The STP proposed that Witbank Hospital should serve as the regional facility for Nkangala District, with Ermelo Hospital serving as the regional hospital for Gert Sibande District. Regional services for Ehlanzeni would be provided by specialist departments “complexed” between Rob Ferreira and Themba Hospitals.

The North West Department of Health indicated that its STP was undertaken as a process of long-term planning, within a horizon leading up to 2014. The total population of the province was estimated at 3 948 522 in 2005/06, and was projected to grow to 4164 020 by 2010. During 2006/07, the service delivery platform of the North West consisted of two regional (Level 2) hospital complexes, one provincial hospital, two psychiatric hospitals, 27 district and community hospitals, 51 CHCs and 253 fixed clinics. One of the key highlights of the North West STP was a realisation that “community hospitals” lacked the resources and capacity to perform like hospitals. The North West Department of Health STP identified eight such hospitals and recommended that all of them

be immediately re-classified as CHCs. A further recommendation was that the number of beds in these community hospitals be reduced. These CHCs were to be supported to function optimally to support surrounding clinics. The North West Department of Health produced the first draft of the STP, but could not complete its costing.

The Draft STP of the Northern Cape for 2007-2014 was aligned to other relevant policy documents, including Vision 2014, the 10-year strategy of the Department, and the resolutions of the Provincial Health Summit of 2005. During 2006/07, the service delivery platform of the Northern Cape Department of Health consisted of 14 district hospitals, two regional hospitals, one hospital providing limited Level 3 services, 7 community hospitals, and 19 CHCs. In its STP, the Northern Cape explored four Scenarios A, B, C and D, each of which presented a particular option for service delivery in the province. Scenario A proposes few larger district hospitals, more community hospitals, CHCs, clinics, expansion of EMS and Air Mercy services and expansion of Level 2 services to three hospitals The similarity between Scenarios B, C, and D was that they all propose a total of 30 Level 1 hospitals, with Level 2 services expanded to Upington, De Aar and Kuruman, and tertiary services rendered at Kimberley Hospital.

The slight differences between the three options were that Scenario B proposed 30 Level 1 hospitals with IHPF norms used to determine number of beds; while Scenario C proposed 30 Level 1 hospitals with adjusted norms appropriate for the Northern Cape context; and finally Scenario D suggested 30 Level 1 hospitals, with a prescribed minimum of 30 beds, and increased staff ratios to meet the norms set in Vision 2014.

Like the Free State Department of Health, the Northern Cape STP made clear linkages with the hospital revitalisation project. The STP proposed a new facility in Kgalagadi District, which would replace the Kuruman and Tshwaragano Hospitals. It was further stated that the Kgalagadi facility would be prioritised in the development of business cases for the hospital revitalisation project. Again like the Free State, the Northern Cape Department of Health worked continuously on its STP for 2007/08, and indicated its intention to submit a revised version to the National Department of Health in the course of 2007. The province plans update the based on the revised model of IHPF is made available.

In Kwa-Zulu-Natal, EMRS has also continued to make significant progress with the implementation of the PPT Programme. During 2006/07, this service transported an average of 22 000 patients per month. Service delivery commenced with a phased approach in MTEF 2004/05 with four districts

operating a PPT Programme and has now been extended to include 11 districts (thus, 100% Provincial PPT coverage).

2.1.7. Development of Business Plans for Emergency Medical Services (EMS)

All Provincial Departments of Health completed their EMS business plans. The Eastern Cape Department of Health developed an EMS Turnaround Strategy, which it started implementing in 2006/07. Both the Free State and Limpopo Departments of Health completed their plans in May 2006. The Provincial EMRS Plan aims to substantially increase Emergency Care Practitioners, to enable the province to reach its norm of one ambulance per 10 000 population. EMRS services in KwaZulu-Natal were decentralised to districts to promote accessibility and provision of an integrated package of services. The North West Department of Health completed its EMS plan and submitted it to the Departmental Executive Management Committee for approval. The province has earmarked an amount of R42 million for the preparations for the World Cup 2010. Similarly, the Northern Cape Business Plan was fully inclusive of preparations for the FIFA World Cup in 2010. The North West EMS Plan, which is fully inclusive of the 2010 FIFA World Cup, was developed and submitted to the National Department of Health. The Western Cape Department of Health also presented its Comprehensive Service Plan for EMS to the National Committee for EMS.

2.1.8. Development of Modernisation of Tertiary Services (MTS) Plan

Four out of nine provinces reported having produced MTS plans, against a target of nine out of nine for the 2006/07 ANHP. These were the Free State, Gauteng, Mpumalanga, and the Western Cape.

The Free State Department of Health produced the third draft of their MTS Business Plan, discussed it with the relevant role players, and also presented it to the National Department of Health for comments. The Mpumalanga Department of Health also submitted the business case for its new tertiary hospital in line with MTS targets to the National Department of Health. The Western Cape Department of Health indicated that it was awaiting the MTS Plan. However, the province acquired LINAC equipment for radio-oncology services at Groote Schuur and Tygerberg Hospitals. The Eastern Cape Department of Health produced hospital improvement plans, but not MTS plans.

2.1.9. Development of full transport systems plans for the delivery of patients to hospitals and specialists to lower levels of care

Six out of nine provinces reported progress towards this target.
The Eastern Cape Department of Health included its PPT plan in its hospital improvement plan. In the Free State, a colour coding system was implemented to ensure that patients receive priority attention according to need. In Gauteng, Planned Patient Transport (PPT) was implemented in all districts. Family medicine specialists and principal psychiatrists for community psychiatrist services were appointed. Outreach programmes were also developed for other specialists. The Limpopo Department of Health developed a PPT plan and partially implemented it. In Mpumalanga, a service delivery plan was developed for PPT, which proposed that PPT be taken over by EMS as from 2007/08, as this function was previously with hospitals. The take-over of PPT by EMS in the Mpumalanga Department of Health would be phased out over three years, due to insufficient funds. In the Western Cape, the Healthnet patient transport system was designed and implemented.

2.1.10. Implementation of Telemedicine

Seven out of nine provinces reported progress towards this target.

In the Eastern Cape Department of Health, the e-Health programme started in 2000, and comprised of five programmes including telemedicine. The full Telemedicine District Hospital package included: Teledermatology, TeleECG/ Spirometry, TeleRadiology, TeleTrauma (Video Conferencing) and Mindset Health Channel Teledermatology. Mindset Health Channel Teledermatology equipment was delivered to 12 district hospitals, and TeleECG equipment to 18 district hospitals. Forty-three sites of the Mindset Health Channel were fully functional in the Eastern Cape. This channel was used for heath education and health promotion for health workers and patients. In the Free State, senior officials visited telemedicine sites and attended conferences in Canada. The final draft of the Free State STP includes inputs on telemedicine. The Gauteng Department of Health indicated that the province was 98% urbanised, and therefore telemedicine was not a priority. In Limpopo, six live sites were operational, and linked to the University of KwaZulu-Natal for tutorials. In the Mpumalanga Department of Health, implementation of telemedicine focused on teleradiology, but this service was not fully functional as problems were experienced with the system. However, provincial plans were developed for the full implementation of telemedicine in 2007/08. In the North West, a comprehensive plan on telemedicine was developed as part of the STP.

2.1.11. Strengthening effective planning and monitoring of implementation

With regard to effective planning and monitoring and evaluation, the target for 2006/07 was for all provinces to develop strategic planning units closely linked to information and monitoring and Evaluation Units. Seven out of nine provinces reported progress towards this target.

In the Eastern Cape, the Department of Health reconfigured the Strategic Planning Unit and monitoring and evaluation functions into one Chief Directorate called Integrated Strategic Planning and Organisational Performance. Key indicators were identified for monitoring performance against agreed targets for the 2007/08 financial year. In the Free State, a newly approved macro structure was implemented which linked Strategic Planning, Monitoring and Evaluation and Information Management. However, the Monitoring and Evaluation Unit still needed to be established. In the Gauteng, Department of Health, a Strategic Planning and monitoring and Evaluation Unit was established. In KwaZulu-Natal, a Strategic Planning, Monitoring, Evaluation and Data Management Unit (Chief Directorate) was established in Head Office during 2006/07. Similar structures were also created in each district to ensure linkages between the Annual Performance Plan, the District Health Plans, Data Management and Monitoring.

In the Mpumalanga Department of Health, the Strategic Planning Directorate comprised Monitoring and Evaluation, Health Information and Policy. However, a new proposed organogram reflected two separate directorates, Strategic Planning and Policy and Health Information and monitoring and Evaluation. In the Northern Cape, the Strategic Planning Unit was established, consisting of four personnel members (including an Administrative Clerk). The Unit was responsible for both planning and monitoring the implementation of the Annual Performance Plan, working closely with Information Management Unit. In the Western Cape, the Directorate: Policy and Planning was responsible for the collation of the Annual Performance Plan. The Directorate: Information Management was responsible for the collation of the quarterly and annual reports. Both these directorates were located within the Chief Directorate: Professional Support Services.

2.1.12. Full implementation of delegations at all levels (especially at hospital level)

The target for 2006/07 was for provinces to audit and strengthen existing delegations by September 2006. Seven out of nine Provincial Departments of Health reported on progress towards this target.

In the Eastern Cape Department of Health, delegations were given to District Managers and Complex and Cluster CEOs (or Managers). In the Free State, human resource delegations were reviewed annually. A task team was developed to restructure human resource delegations, and expected to complete its work in October 2007. In the Gauteng Department of Health, delegations were implemented as required. In KwaZulu-Natal, although hospital managers signed performance agreements, this was mainly compliance-driven and was not aligned and linked to the strategic objectives of the Department. The implementation of the Performance Management Development System (PMDS) in the province would also be fast-tracked through a focused capacity building initiative. Also, in Kwa-Zulu-Natal careful consideration has been given to ensure that there is sufficient capacity and readiness in districts to assume responsibility and accountability for decentralised functions and delegations.

In the Limpopo Department of Health and Social Development, all existing delegations were audited and strengthened, especially delegations for CEOs of hospitals. In the Mpumalanga Department of Health, human resource delegations were given to all Hospital CEOs and District Managers. Appointment delegations from Levels 1 to 5, as well as financial delegations of R100 000 threshold were given to Senior Managers. In the Western Cape Department of Health, all human resource functions were delegated to hospital level. Financial delegations were put in place to ensure the effective functioning of hospitals. The Supply Chain Management delegations were also revised and became effective from 1 January 2007.

The North West and Northern Cape Departments of Health did not provide an update on this issue.

2.1.13. Implementation of ICD 10

The target for 2006/07 was for all tertiary hospitals, and 33% of Level 2 hospitals to routinely report on ICD coding. Seven out of nine Provincial Departments of Health provided progress reports on this target.

ICD coding was successfully implemented in four provinces, the Free State, Limpopo and Northern Cape and Western Cape. In the Free State Department of Health, ICD 10 coding was implemented at the Academic Health Complex and Regional Hospitals, as required. In the Northern Cape, training on ICD 10 was done, and coding was implemented at all Level 1 facilities. In the Western Cape Department of Health, it has always been standing departmental policy that all hospitals use ICD10 diagnosis coding for all patients. Central hospitals (all tertiary and ±20% of Level 2 services) routinely reported ICD10 coding. In the Limpopo Department of Health and Social Development, ICD 10 coding was

also implemented.

Implementation of ICD 10 coding in Gauteng, Mpumalanga and the Northern Cape was slower than anticipated. In the Mpumalanga Department of Health, the training of officials on the revised code list was postponed as a revision of the code list had not been finalised. Reporting according to ICD 10 therefore did not start. The Eastern Cape and Gauteng Departments of Health reported a slow uptake of ICD10 coding reporting. In KwaZulu-Natal there is also a slow uptake on ICD 10 coding. The North West did not provide an update on ICD 10 coding.

On the whole, there was uneven implementation of ICD 10 coding by Provincial Departments of Health during 2006/07.

2.2. STRENGTHENING HUMAN RESOURCES

2.2.1. Mapping of staff distribution of all staff

The target for 2006/07 was for provinces to fully map the distribution of staff and agree on appropriate provincial baseline levels of staffing for tertiary and Level 2 services. Only four out of nine Provincial Departments of Health, namely Gauteng, KwaZulu-Natal, Northern Cape and Western Cape provided progress reports on this target

In the Gauteng Department of Health, the staff establishment for all levels of services was approved. In the Northern Cape Department of Health, the organisational structure was reviewed, updated and aligned with the service delivery model. In the Western Cape Department of Health, a fully aligned organisational structure was in place. This would be adapted to the Comprehensive Service Plan, which was in the process of being consulted and finalised. In the KwaZulu-Natal Department of Health, although there is still a very big gap between posts filled and posts approved for both PHC facilities and district hospitals, the mapping of staff distribution is in place.

In the Free State Department of Health, the mapping exercise was not completed as the province was awaiting finalisation of its Human Resource Plan. In the Mpumalanga Department of Health, an audit of staff distribution was still being conducted, and the proportion of staff required at each service point was not finalised.

There was also significant under-reporting by Provincial Departments of Health on the mapping of the distribution of PHC staff and agreement on an appropriate

baseline level of staffing for PHC.

2.2.2. Fully articulated Human Resource Plan for the delivery of the objective (i.e. to achieve 100% staffing in all disciplines (clinical specialties) in all facilities

The target for 2006/07 was for provinces to begin to develop Human Resource Plans to improve staffing levels in tertiary, secondary and PHC services. All nine Provincial Departments of Health provided progress reports on this target.

In the Eastern Cape Department of Health, a draft Human Resource Plan was developed. Consultative processes with internal stakeholders and trade unions were also started, and these would be followed by private sector consultations. In the Gauteng Department of Health, the Human Resource Plan was almost completed, and it was linked to the National Human Resource Plan. In the KwaZulu-Natal Department of Health, the Human Resource Plan was developed as an integral part of the STP process. The plan addressed the future human resource requirements of the province, including providing an indication of the number of health workers to be trained. Key human resource challenges faced by KwaZulu-Natal included insufficiencies related to staff recruitment and retention plans, as well as high absenteeism and turnover rates. The province also identified a need to strengthen the Performance Management and Development System (PMDS), which appeared to be compliance-driven, as well as the Skills Development Plans, which were not aligned to Departmental priorities. The Limpopo Department of Health and Social Development produced the second draft of its Human Resource Plan in line with national guidelines. Like the Eastern Cape Department of Health, Limpopo also commenced the process of consultation with the labour unions. Similarly, the Mpumalanga Department of Health developed a draft Human Resource Plan and conducted consultations with management and labour representatives.

In the North West Department of Health, a Departmental Human Resource Plan was developed and submitted to management for approval. Like KwaZulu-Natal, the Northern Cape Department of Health developed its Human Resource Plan and aligned to its STP, and the Modernisation of Tertiary Services (MTS) Plan. The first draft of this plan was tabled for comment to senior managers in March 2007 and would be finalised in 2007/08. Finally, the Western Cape Department of Health developed a framework to do human resource planning, fully consulted on it, and once the Comprehensive Service Plan is finalised the Human Resource Plan will be developed. The province further indicated that the broad elements of the staffing requirements were inherent in the Comprehensive Service Plan.

On the whole, most Provincial Departments of Health reported significant strides towards the development of Provincial Human Resource Plans during 2006/07. Only the Free State Department of Health reported that its Human Resource Plan could not be implemented because the Department was awaiting the launch of the National Human Resources for Health Plan. The latter plan was launched by the Minister in April 2006.

2.2.3. Agree SLA with General Practitioners and specialists for sessional work in public sector facilities

The target for 2006/07 was for Provincial Departments of Health to agree on Service Level Agreements (SLAs) with General Practitioners and specialists for sessional work in public sector facilities. Eight out of the nine Provincial Departments of Health provided progress reports on this target.

The Eastern Cape Department of Health was involved in Public-Private-Partnerships, which amongst others, will also assist with skills development and transfer. However, it was not clear whether SLAs with private sector health providers were in place or not.

The Gauteng Department of Health entered into a SLA with specialists for sessional work in public sector facilities. In the Limpopo Department of Health and Social Development, 60% of specialists working in public facilities were private sessional doctors and specialists. Similarly, in the Mpumalanga Department of Health, ongoing sessional work was done by General Practitioners and specialists. In the North West Department of Health, all institutions had Institutional SLA's for sessional work. However, the North West Department of Health did not have a Provincial SLA with private General Practitioner and specialists. In the Northern Cape Department of Health, SLAs with private sector General Practitioners were also in place. In the Western Cape, specialists were appointed in sessional posts in central hospitals, and general practitioners in district hospitals, particularly in the rural areas.

Only the Free State Department of Health indicated it had not yet implemented agreements with specialists for sessional work in the public sector.

2.2.4. Improve remuneration levels

The target for 2006/07 was for the health sector to agree on revised remuneration levels for all staff. Eight out of nine Provincial Departments of Health provided progress reports on this target.

The eight provinces, Eastern Cape, Free State, Gauteng, Limpopo, Mpumalanga, North West, Northern Cape and Western Cape indicated that they, together with the National Department of Health were involved in discussions with the Department of Public Service and Administration (DPSA) and National Treasury to review and improve the remuneration levels of all health workers. The provinces would implement the final remuneration framework that would be agreed upon during the salary review process. The new dispensation will be implemented in phases, starting with the conditions of service of professional nurses, staff nurses and nursing assistants. Other occupational classes will follow in 2008. The Free State Department of Health also indicated that its new remuneration dispensation for health professionals would be linked to the relevant job evaluation results. Due to funding limitations, it would not be possible financially and logistically, to implement all these career classes at once.

The North West Department of Health indicated that it would implement the improved remuneration of health workers during 2007/08, targeting professional nurses only, and that an amount of R77 million had been allocated for that purpose. The province also experienced a deficit of R23 million, which impeded it from completing this process. Other health professionals such as doctors, dentists and pharmacists were targeted for 2008/09; and other professional groups in 2009/10.

2.2.5. Increase training of nurses (re-opening of nursing schools)

The target for 2006/07 was for the health sector to identify additional training resources (e.g. colleges and tutors etc). Nine out of nine Provincial Departments of Health provided progress reports on this target.

The Eastern Cape Department of Health approved the establishment of three new satellite campuses namely, Dora Nginza, Andries Vosloo and Mary Theresa, and also agreed that Holy Cross would replace Rietvlei as a training centre. The number of lecturer posts in the satellite campuses would be increased to a total of 79. The MEC for Health also approved the creation of 1 196 posts of enrolled nurses and enrolled nursing assistants on the establishment of Lilitha College of Nursing.

In the Free State Department of Health, an Extended Nursing Education Programme was developed to meet the training requirements of the province and alleviate nursing personnel shortages. The program was approved in September 2005 and subsequently, the student intake within the Diploma in Nursing (General, Psychiatry, Community Nursing) and Midwifery increased from 100 to 250 first year nursing students. The Gauteng Department of Health

also identified additional training resources. In the province of KwaZulu-Natal, there were 4 585 basic and post basic nursing students estimated to be in training during 2006/07.

The Limpopo Department of Health and Social Development also significantly increased the intake of nursing students in the existing colleges. Amongst others, a total of 670 nursing students were accepted for the four-year training programme; 330 students for the diploma (i.e. bridging course), and 117 for the enrolled nursing course.

The Mpumalanga Department of Health had an intake of 100 nursing students in September 2006, but did not indicate whether this was higher or lower than that of previous years. The province also appointed a Registrar for its Nursing College, and continued with negotiations with other provinces and private institutions to increase its infrastructure for clinical placement. The North West Department of Health also continued its negotiations with Goldfields Mine Hospitals to train enrolled nurses for the province. The Northern Cape Department of Health also increased the intake of nursing students, but did not provide figures. The province established a principal agreement with the Free State University for the training of nurses, and also explored alternative avenues of increasing student nurse intake. In the Western Cape Department of Health, a concerted effort was made to increase the number of students in training both at the Nursing College and at the Nursing Schools and a steady increase in the numbers was achieved.

2.2.6. Training of Hospital CEOs

The target for 2006/07 was for Provincial Departments of Health to audit and strengthen existing programmes for the training of Hospital CEOs, and increase the proportion of trained CEOs to 25%. Only six out of the nine Provincial Departments of Health provided progress reports on this target.

In three provinces, Gauteng, Limpopo and Mpumalanga, 100% of permanently appointed CEO's completed or were undergoing formal training.

In the Eastern Cape, 14 of 18 Cluster Managers were enrolled for a District Health Management and Leadership course and would complete the programme at the end of 2007. In the Northern Cape, eight Hospital Managers were registered for a Diploma/Masters in Public Health at Wits University.

In the Free State Province 11 of 16 CEO's (68.7%) registered for a hospital management course at the University of Pretoria and five CEO's were trained on

Operational Hospital Management. KwaZulu-Natal, North West and Western Cape did not provide updates on this issue.

2.3. PRIORITY 3: PHYSICAL INFRASTRUCTURE

2.3.1. Increase in the number of hospitals in the hospital revitalisation project

The target for 2006/07 was for 42 hospitals to be started on site, in progress or completed. This target was exceeded. In 2006/07, the number of hospitals in the hospital revitalization programme increased from 37 to 46 projects. Of these, 32 projects were in construction and 14 were at different planning stages (i.e. development of the project brief and design of the facilities).

The breakdown of the 46 hospital projects per province is as follows:

- Eastern Cape (six hospitals namely: Frontier, St. Elizabeth's, Mary Theresa, St. Lucy's, St. Patrick's and Madwaleni);
- Free State (four hospitals namely: Boitumelo, Pelonomi, Trompsburg and Free State Psychiatric complex);
- Gauteng [six hospitals namely: Mamelodi, Zola (Jabulani), CHB 1, Natalspruit and Chris Hani 2 and 3(AE&T, OPD) and Germiston];
- KwaZulu-Natal (seven hospitals namely: King George V, Ngwelezane, Hlabisa, Rietvlei, Madadeni, Dr. Pixley Seme and Dr. John Dube);
- Limpopo (five hospitals namely Maphuta Malatjie, Letaba, Thabamoopo, Thabazimbi and Musina);
- Mpumalanga (five hospitals namely: Piet Retief, Themba, Rob Ferreira, Ermelo, New Nelspruit Tertiary and New Psychiatry);
- North West (four hospitals: Moses Kotane, Vryburg, Brits and Bophelong);
- Northern Cape [five hospitals namely: Psychiatric (West End), Upington (Gordonia), Barkely West, De Aar and Postmasburg];
- Western Cape (four hospitals namely: Vredenburg B, George B, Worcester, and Paar). Three hospitals in the Western Cape, Mitchell's Plain, Khayelitsha and Valkenburg were still in the planning phase.

The following hospitals were officially opened in 2006/07:

- Madikane Ka Zulu Memorial Hospital in the Eastern Cape
- (8 September 2006)
- George Hospital in the Western Cape (30 June 2006)
- Lebowakgomo Hospital in Limpopo (30 March 2007)

2.3.2. Approved business cases, including MTS hospitals

The target for 2006/07 was for 27 new business cases to be completed and approved by May 2007.

There was limited reporting on progress towards this target, with only three out of nine provinces providing reports. The National DoH indicated that the set target was not reached because most of the business cases in various provinces were not consistent with the Provincial Service Transformation Plan (STPs).

To accelerate infrastructure delivery the following business cases were approved:

- Free State Province (Lady Brand, Dihlabeng, Trompsburg, Bloemfontein District and Free State Psychiatric Complex);
- Limpopo Province (Thabazimbi and Musina Hospitals);
- North West Province (Zeerust/Lehurutse, Ditsobotla, Brits and Tswaing hospitals);
- Western Cape Province (Tygerburg, Mosselbay, Victoria, Brooklyn Chest and Hottentots Holland Hospitals).

2.3.3. Forensic services transfers

The target for 2006/07 was for 30% of forensic mortuaries to be rebuilt. Eight of nine Provincial Departments of Health provided progress reports on this target.

Eight provinces reported that forensic services had been transferred from the South African Police Service (SAPS) to the Provincial Departments of Health, but the implementation of other aspects of their transfer plans, including the upgrading of facilities, was still in progress. These were Eastern Cape, Free State, Gauteng, KwaZulu-Natal, Limpopo, Mpumalanga, Northern Cape and Western Cape.

In the Eastern Cape Department of Health, 100% of Regional Managers (four officials) and 100% of Mortuary Managers (15 officials) were appointed. A total of 148 out of 188 Forensic Pathology Officers were also appointed. In terms of infrastructure, the Provincial Department of Health contracted a service provider known as COEGA to facilitate the rehabilitation of 14 former SAPS mortuaries and the construction of 17 new mortuaries. Tenders for these projects were advertised. In the Free State Department of Health, planning processes for the Bloemfontein mortuary were finalised, but funding was still awaited.

The Mpumalanga Department of Health developed a transfer plan, which facilitated the successful transfer of forensic services. The Northern Cape

Department of Health was still busy with the take-over of services from the SAPS. The strategic positions in the forensic unit had been filled, and the new officials inducted. In March 2007, the Northern Cape Department of Health also appointed the principal agent and contractors for the upgrading of mortuaries. In the Western Cape Department of Health, emergency repairs and upgrades were done in four of 18 forensic facilities, and the replacement of six of the 18 facilities was still in progress. Tenders were also awarded for new facilities at George, Hermanus, Paarl, Worcester and Malmesbury. Plans was also being developed for new facilities and upgrades for Salt River, Tygerberg, Beaufort West, Vredendal, Stellenbosch, Wolseley, Knysna, Mossel Bay, Oudtshoorn and Laignsburg.

The KwaZulu-Natal Department made substantial progress during 2006/07 with the take-over of the forensic medical pathology and mortuary services from the SAPS. Implementation progress is monitored against the business plan submitted for utilisation of the conditional grant. As from MTEF 2007/08, capacity in district offices will be further strengthened to take full responsibility for the management and provisioning of mortuary services in each district.

2.3.4. Worst 20% of non-revitalisation hospitals receiving essential upgrades

Six of the nine provinces reported on progress towards this target.

In the Eastern Cape, a project implementation plan (B6) for 2006/07-2008/09 was developed, and 20 district hospitals were included in the Provincial Letsema Project. Painting, landscaping and tree felling was done. In the Free State Department of Health, sixnon-revitalisation hospitals were upgraded namely Elizabeth Ross, Thebe, Tokollo, Diamant, Thusanong and Katleho District Hospitals.

In Gauteng and Limpopo, maintenance of facilities was continuously carried out.

In the Mpumalanga Department of Health, plans for facility upgrading were implemented at non-revitalisation hospitals in Evander, Sabie, KwaMhlanga, Witbank, Delmas and Middelburg pharmacy depot. In the Western Cape Department of Health major capital upgrading projects were in progress at Red Cross, Mowbray, Caledon and Riversdale Hospitals. The following hospitals had major renovation projects of R2 million or more: Alexandra, GF Jooste, Karl Bremer, Stikland, Tygerberg, Groote Schuur and Red Cross.

2.3.5. Maintenance expenditure increased to 2.5% of budget in all provinces

Six out of nine provinces reported on progress towards this target.

In the Eastern Cape Department of Health, maintenance guidelines were issued to regional, and district hospitals, district managers, LSA managers and complexes during infrastructure road shows conducted in March 2007. Infrastructure issues were also included in District Health Plans. Gauteng increased its maintenance budget by 34% from 2006/07 to 2007/08. In the KwaZulu-Natal Department of Health physical infrastructure was strengthened in various ways including the following: all hospitals developed maintenance plans, all regional hospitals developed Capital Expenditure Plans (CAPEX), all hospitals developed asset plans. However, equipment maintenance plans still needed to be developed.

As it was the case in the Eastern Cape the Mpumalanga Department of Health issued guidelines to hospital managers as part of the Provincial Hospital Improvement Plan. In the Western Cape the projected maintenance expenditure was 2.2 % of the budget (1.04% on equipment and 1.16% on buildings).

The Free State Department of Health maintenance budget increased from the allocated R7 million to R18 million during the 2006/07 financial year.

2.3.6. Audit of the size and condition of all PHC facilities

The National Department of Health will commission a comprehensive audit of all PHC facilities during 2007/08, taking into account the audits conducted by several provinces previously. In keeping with this, both the Eastern Cape and Gauteng Departments of Health indicated that their PHC facilities would be audited during 2007/08.

In Limpopo, 497 facilities were audited by the Centre for Scientific and Industrial Research (CSIR) and 266 were found to be in need of upgrades. In Mpumalanga a basic audit of all PHC facilities was conducted and a report was compiled. In the Western Cape, a total of 183 rural clinics previously managed by municipalities were taken over by the provincial government. A survey was done to determine conditions, suitability and to prioritise upgrades. In the North West Department of Health, an audit of PHC facilities was completed and plans developed to infrastructure gaps. Similarly, a short-term implementation plan was developed in the Free State.

2.3.7. Implementation of Service Transformation Plan for Community Health Centres (CHCs)

The target for 2006/07 was the restructuring of Community Health Centres (CHCs) in accordance with the Provincial STPs. This entailed the mapping of clinics, CHCs and hospitals and a development of a service delivery platform. Eight of the nine provinces reported on progress towards this target.

In the Eastern Cape Department of Health, a business plan for 30 CHCs was developed for strengthening the provision of 24-hour services as well as the implementation of the full package of services. This would be linked to the transformation of CHCs as outlined in the STP. In the Gauteng Department of Health, the mapping of clinics was completed and aservice platform was identified and implementation plan developed. In KwaZulu-Natal, clinics were classified into three categories as a means to strengthen PHC infrastructure and as part of the STP process undertaken during 2006/07. These were: Category A clinics, Category B clinics and Category C clinics. While all categories of clinics would serve a similar catchment population, the package of services and opening hours would differ, depending on the disease profile, and proximity to other health institutions. Infrastructure requirements of clinics were determined and aligned to the STP. In Limpopo, the STP CHC restructuring was implemented, but no details were provided.

In the Mpumalanga Department of Health, a PHC model based on IHPF was developed which would include the rationalisation of certain hospitals to be downgraded to CHCs. The North West Department of Health also developed options as part of the Service Transformation Plan. In the Western Cape, service needs were determined and mapped in the Comprehensive Service Plan. All new CHCs, clinics and upgrades would be constructed in accordance with the service platform defined in the Comprehensive Service Plan. New CHCs were under construction in Brown's Farm, Swellendam, Montagu, Simondium, Stanford and Wellington.

In the Free State, the mapping of clinics, CHCs and hospitals had not yet commenced.

2.4. PRIORITY 4: QUALITY OF CARE

2.4.1. Clinical audits routinely monitored in all tertiary hospitals, 25% of level 2 hospitals

All nine provinces reported on progress towards this target

In the Eastern Cape, a clinical audit policy was finalised and approved, which would be implemented as from 2007/08. Clinical Audit Committees were

appointed in three tertiary, two regional and 47 district hospitals. In Gauteng, all tertiary hospitals and 25% of Level 2 services conducted routine clinical audits. In the Free State, a clinical risk management policy was approved.

In KwaZulu-Natal, internal auditing was implemented in district hospitals with a focus on Batho Pele, Minimum Norms and Standards and Access to Care. Infection control teams were functional in all hospitals. Furthermore, Annual Patient Satisfaction Surveys conducted in the province indicated that 80% of patients were satisfied with the services that they received. Two hospitals in KwaZulu-Natal were accredited via the COHASA accreditation programme, but the Provincial Department was unable to meet the Clinical Governance required standards. The KwaZulu-Natal Department of Health identified the monitoring and evaluation and improvement of quality of care as areas requiring substantial attention. In Mpumalanga, clinical audits were conducted at all tertiary facilities and at 66% of Level 2 hospitals. Furthermore, 75% of managers have been trained (to conduct clinical audits).

A hundred percent of facilities in Limpopo and 33% of facilities in the North West conducted clinical surveys.. In the Northern Cape, two Level 2 hospitals conducted clinical audits. In the Western Cape, 100% of tertiary hospitals conducted clinical audits, but this was not the case with secondary hospitals. The Western Cape Department of Health implemented a structured system for monitoring morbidity and percentage of services conducting clinical audits. The province receives quarterly M&M reports from all facilities.

2.4.2. Complaints mechanisms routinely managed in all tertiary hospitals, and 25% Level 2 hospitals

Eight of the nine provinces reported on progress towards this target.

In the Eastern Cape, a complaints management system was introduced in all health facilities. Workshops were conducted for facility personnel on the management and reporting of complaints. During 2006/07, only 40% of districts submitted reports to the Provincial Department of Health about complaints registered in their respective facilities. Two of the three hospital complexes also submitted reports to the Provincial Department. The call centre received Class 1 and 2 complaints that relate to death and permanent disability. These were investigated by the Provincial Department. Of the 3 200 complaints received by the Eastern Cape Department of Health from April 2006 to March 2007, a total of 2 273 were resolved.

In the Free State, a toll free number was used for receiving complaints and compliments from the community. Those in need of referral were referred to

relevant institutions for investigation. In the Gauteng Department of Health, a complaints (management) mechanism was implemented in 100% of hospitals. Client satisfaction surveys were conducted in 34 hospitals, and waiting times were assessed in 33 hospitals and 30 PHC facilities. In the Mpumalanga Department of Health, 60% of complaints received by the province were resolved within 25 days. Furthermore, client satisfaction surveys were conducted in 34 hospitals. In the Limpopo Department of Health and Social Development, 100% of hospitals addressed complaints within 60 days.

In the North West Department of Health, a uniform complaint (management) mechanism was implemented in all facilities. In the Northern Cape, 100% of complaints received at the level of the institutions were resolved within less than 25 days. The Western Cape Department of Health developed a structured system for the monitoring and management of complaints. This was implemented by 100% of tertiary and secondary facilities. The Provincial Department of Health received quarterly returns from facilities reflecting the number and categories of complaints and compliments received per quarter.

2.4.3. Quarterly planned support visits to PHC facilities;

There was poor reporting by provinces on this indicator. The North West Department of Health reported that its PHC supervision visit rate was 86%, while the Free State Department of Health reported a figure of 63%.

2.4.4. Infection control

The target for 2006/07 was for infection control management to be effected in all tertiary and Level 2 hospitals, 25% of district hospitals and CHCs. All the provinces reported on progress towards this target.

In the Eastern Cape, an infection control policy was finalised and Infection Control Committees established in 100% of tertiary, regional and district hospitals and CHCs. In the Free State Department of Health, 23 professional nurses were sent for an infection control course at Wits University. Furthermore, the Provincial Quality Assurance Unit commenced with its own infection control training at clinics located in the Thabo Mofutsanyana and Lejweleputswa Districts. Infection control measures were implemented in 100% of hospitals in Gauteng. These were not specified.

In KwaZulu-Natal, in 2006/07 an estimated 70% of tertiary hospitals had infection control policies in place. This represented an increase of 50% from the 2004/05 year. The same applied to compliance with infection control policies. In Mpumalanga, the Department produced the first draft of the Prevention and

Control of Infection Policy Guidelines in August 2006. The province will develop infection control structures in keeping with these guidelines. The North West Department of Health appointed infection control nurses at all Level 1 hospitals. In Limpopo infection control structures were in place and functional. The province commenced with the process of separating TB patients from general patients.

In the Northern Cape Department of Health, posts were created for at least one infection control practitioner at each of the 14 hospitals across the province. In addition a pilot programme was introduced at the Kerman and Kimberley Hospitals focusing on how to use the infection control quality assessment tool, aimed at identifying gaps within infection control and the subsequent development and implementation of quality improvement measures. In the Western Cape Department of Health, an Infection Prevention Control Policy was approved on 12 November 2006. All tertiary hospitals in the Western Cape have an Infection Control Practitioner.

2.4.5. 10% of increase in Planned Patient Transport fleet deployed

Seven of the nine provinces reported on progress towards this target, with the exception of North West and the Northern Cape.

In the Eastern Cape, ten additional Planned Patient Transport (PPT) vehicles were deployed. In the Free State, 35 new vehicles with a carrying capacity of 22 patients were procured. However, these were replacements vehicles, and not an increase in the fleet. In the Gauteng Department of Health, a 'maternal ambulance' was implemented in all districts, to facilitate easy access of pregnant women to health facilities.

In KwaZulu-Natal, EMRS has also continued to make significant progress with the implementation of the PPT Programme. During 2006/07, this service transported an average of 22 000 patients per month. Service delivery commenced with a phased approach in MTEF 2004/05 with four districts operating a PPT Programme and has now been extended to include eleven districts (thus, 100% Provincial PPT coverage).

Limpopo also increased its fleet to 181 properly equipped ambulances, ten rescue vehicles, one disaster bus and six multi-casualty buses. It remains unclear how PPT was strengthened. In Mpumalanga a plan was developed to improve Planned Patient Transport Services (PPTS), and will be implemented in 2007/08. the Mpumalanga Department of Health indicated that PPTS would only be rolled out to selective areas, whereas other areas would remain under hospital management. In the Western Cape, ten additional patient transporters were acquired for the Metro and 26 drivers were appointed. It was planned that

a further 20 drivers would be appointed in January 2007.

2.4.6. 10% of increase in EMS road ambulance fleet deployed

Few provinces (five of the nine) reported on progress towards this target. Of these provinces, only the Western Cape Department of Health achieved the set target. The province indicated that a shift system in the Metro was changed to match the emergency rates, which improved the peak fleet deployment by more than 10%.

In the Eastern Cape, 91 additional ambulances and ten rescue vehicles were deployed. The Gauteng Department of Health obtained additional vehicles, but did not achieve the 10% increase in EMS road ambulance fleet deployment. In the Free State Department of Health, 52 new ambulances were procured and distributed in September 2006. These ambulances replaced vehicles that were accident damaged and beyond economical repair. Thus no increase in EMS road ambulance fleet took place.

In KwaZulu-Natal, the Department of Health purchased a total of 200 ambulances (50 replacements and 150 for expansion) in 2005/06. The purchase of these vehicles had a positive effect on reducing downtime for service and repairs. It has also improved the condition of the fleet by reducing the maximum mileage of all vehicles to under500 000 km.

In Mpumalanga, seven additional stations were opened during March 2007 to increase access to EMS services. A further ten ambulances and 13 response vehicles were delivered in December 2006. A total of 20 4X4 ambulances and three rescue vehicles were delivered in March 2007. It remains unclear however, whether these additional vehicles represent a 10% in road ambulance fleet deployment.

2.4.7. Air EMS service started or SLA effected in all provinces

Six of the nine provinces reported on progress towards this target, namely: Eastern Cape, Free State, Gauteng, KwaZulu-Natal, Mpumalanga and the Western Cape.

The Eastern Cape, Gauteng, KwaZulu-Natal and Western Cape Departments of Health reported progress towards this objective. In the Eastern Cape, interim SLAs were signed with service providers to provide the services. A tender was in the process of being finalised. In Gauteng, a SLA for the provision of air EMS services was signed. The Western Cape Department of Health implemented a complete programme of Air EMS.

The province indicated that it its current funding was not sufficient for the service. The KwaZulu-Natal Department of Health entered into a three-year contract with Air Mercy Services (Aero medical Services), for the provisioning of two helicopters and one fixed wing aircraft to the Department. This service made a positive impact in long distance transfers, especially with pregnant women, new-born babies and children, as well as with primary response to critically injured patients where there are no Advanced Life Support Practitioners available.

In the Free State, the SLA for air ambulance or flying doctor services were not finalised. The Mpumalanga Department of Health also did not achieve this objective, but indicated that air ambulance services were planned and budgeted for the 2007/08 year.

2.4.8. Private sector agreements in place for patient referrals

There was poor reporting on this target, with only five provinces, the Eastern Cape, Free State, Gauteng, Mpumalanga and the Western Cape providing progress reports.

In the Eastern Cape, SLAs were signed with private companies to provide services in cases of unavailability of the Eastern Cape Department of Health vehicles. In Gauteng, transport systems for patient referrals were put in place. In the Free State, patient referrals were handled by EMS, and the private sector was mobilised only when public units were busy. In Mpumalanga, standing informal agreements were in place with the private sector for patient referrals. In the Western Cape, agreements were concluded to include ER24 and Lifecare into the communication centers. However, agreements on the funding of private sector dispatch are not yet in place.

2.4.9. Supervision plan included in all provincial strategic plans (Part B)

The Eastern Cape, Gauteng and North West Provinces attained supervision rates of 71%, 85% and 86% respectively. In the Free State, a clinical supervisory manual and policy were approved. In the Mpumalanga Department of Health, clinics, CHCs and district hospitals were monitored and evaluated on the implementation of clinic supervision through analysing reports and feedback meetings. However, most Provincial Departments of Health did not develop a supervision plan for inclusion in their APPs for 2007/08-2009/10.

2.5. PRIORITY 5: PRIORITY HEALTH PROGRAMMES

With regard to strengthening health programmes, major emphasis was placed

on strengthening interventions to address two critical communicable diseases, HIV and AIDS and TB. Key interventions included: accelerated prevention of HIV; and implementation of the TB Crisis Plan. Key preventative initiatives relating to illnesses of lifestyle were also highlighted for accelerated implementation.

2.5.1. Accelerated HIV prevention

Five of the nine provinces reported on progress towards this target, namely: Free State, Gauteng, KwaZulu-Natal, Mpumalanga and the Western Cape.

In the Free State Department of Health, health education activities were implemented during High Transmission Area (HTA) service provision, which was provided continuously by the volunteers in HTA sites. The province established 11 HTA sites, at an average of two per district, including rural and urban sites. The Free State Department of Health also established a sentinel surveillance site consisting of: one clinical sentinel surveillance component, two microbiological sentinel surveillance components, and three drug resistance monitoring components. In Gauteng, training in various aspects of prevention including VCT was accelerated. The implementation of the Comprehensive Plan for HIV and AIDS Care, Management and Treatment (CCMT) was also strengthened.

As it was the case in Gauteng, the KwaZulu-Natal Department of Health strengthened its strategic health programmes through the accelerated implementation of the CCMT Plan, and the treatment of related diseases. The Department continued its rollout of prevention programmes and also integrated the management of HAST (HIV, AIDS, Sexually Transmitted Infections and Tuberculosis) services, with renewed emphasis on the uptake of HAST services by children. KwaZulu-Natal indicated that 100% of its fixed PHC facilities offered PMCTC. However, one of the challenges faced by the programme was that the Sexually Transmitted Infections (STI) partner treatment rate in the province decreased from 26% in 2004/05 to 22% in 2005/06. In Mpumalanga, an implementation plan for HIV prevention was developed, and Antenatal Care (ANC) workshops were conducted in three districts. The Western Cape Department of Health implemented a diversity of interventions to fortify and accelerate HIV prevention.

2.5.2. Increased health seeking behaviour and early presentation for ulcers through social mobilisation campaigns reaching 30% of high risk communities

Only a few provinces reported progress on this objective. In the Mpumalanga Department of Health, STI awareness campaigns were conducted on a regular basis on district and sub-district level. In the Western Cape, the STI programme achieved a partner treatment rate of 19.6% during 2006. The VCT rate for STI clients increased during the April to September period.

2.5.3. Implementation of the TB Crisis Plan

Six of the nine provinces reported on progress towards this target, namely: Eastern Cape, Free State, Gauteng, KwaZulu-Natal, Mpumalanga and the Western Cape.

In the Eastern Cape, an operational plan was developed focusing on the following key elements: strengthening of human resources; decreasing turn around times (TAT) for laboratory specimen, strengthening DOTS implementation in the districts and increasing cure rates.

With regard to strengthening human resources, 40 data capturers and two monitoring and evaluation officers were appointed at Nelson Mandela Metropole and OR Tambo districts. In terms of decreasing TAT for laboratory specimens, the National Health Laboratory Services provided daily courier services to all PHC facilities. The province noted some improvement in that 60% of specimens were received within 48 hours, although this was still below the provincial target of 85%. Two dedicated DOT supporters were allocated to each clinic, and the province started to integrate the Community Health Workers into the TB programme. Two TB crisis districts (OR Tambo and Nelson Mandela Metropole) reached the target of a 10% increase in the TB cure rate, but this was not the case in Amathole. Another challenge that faced the provinces was the increase in XDR-TB. A total of 68 XDR TB cases were confirmed, of which 54 were from the crisis districts.

The Free State Department of Health launched its TB Crisis Management Plan in Kroonstad in July 2006. The Department also succeeded in tracing 32 TB treatment defaulters, and in re-integrating them intro the treatment programme. TB refresher courses were also conducted for 52 volunteers, which increased the number of volunteers trained to 202. The volunteers continued to conduct door to door campaigns to increase awareness and treatment compliance. TB support groups were also established in four local municipalities namely: Moqhaka, Nngwathe, Metsimaholo and Mafube. An awareness campaign known as Operation Kgutlela (Operation Go Back) was also launched in April 2006 at Parys.

Implementation of the TB Crisis Plan in Gauteng (City of Johannesburg)

progressed well during 2006/07. Improvements were noted in the smear conversion rates and TB cure rates.

In KwaZulu-Natal, the Department continued to address the huge burden of TB, further fuelled by poverty and HIV. During 2005/06, the province had an incidence rate of 728 cases per 100 000 of the population, of which 303 cases per 100 000 were new smear positive pulmonary cases. The Provincial TB Crisis Management Plan consisted of various components including the following: strengthening interventions to curb MDR TB; integrated TB and HIV activities; health system strengthening; prioritisation and assessment of high TB burden institutions; continuous training of health care workers in TB guidelines; and the implementation of a comprehensive advocacy and social mobilisation programme. Appropriate staffing also strengthened the capacity to improve TB surveillance, reporting and recording. The KZN Department of Health also implemented a fully developed TB Control Programme based on the World Health Organisation (WHO) Directly Observable Treatment Strategy (DOTS) and the National TB Programme. The TB Programme was initially hospital based, and a concerted effort was made to devolve and unpack the programme to PHC level, to make it more accessible to the communities of the province. About 79% of clinics in the province have begun to diagnose and treat TB patients. The province noted a TB treatment interruption rate of 16% and a turnaround time of less than 48 hours for TB sputa specimens. Despite good DOTS coverage the “New TB” cure rate was 33%, and was below the provincial target of 45%.

The Mpumalanga Department of Health developed an integrated TB Crisis Plan, with clear indicators and targets. The Department also conducted a TB blitz at Dr. J.S. Moroka local municipality, in Nkangala district.

The Western Cape Department of Health also recorded improvements in several TB programme indicators. The province indicated that the two-month smear conversion rate for April to June 2006 was 68%, which reflected an improvement from the 59% achieved during October to December 2005. The three-month smear conversion rate for July to September 2006 was 80% as compared to 79% for October to December 2005. The cure rate for July to September 2005 was 71% as compared to 69% for April to September 2004. The province attributed these improvements to an increase in cure rates in the five prioritised sub-districts for the TB Crisis Plan in the Western Cape. In the North West, TB cure rates improved from 51.8 to 54.1%. The province also started two projects on improvement on TB care in Kagisano-Molopo and Moses Kotane. The North West also earmarked an amount of R34.5 million in 2007/08 for TB services.

2.5.4. Accelerated promotion of healthy lifestyles

During 2006/07, Provincial Departments of Health implemented a diversity of programmes and interventions to promote healthy lifestyles. In addition, two provinces, the Northern Cape and the Western Cape developed detailed implementation plans for the healthy lifestyles programmes.

In Gauteng, a healthy lifestyle programme was designed and implemented. In the Free State, plans for the healthy lifestyles programme were implemented in urban and rural schools, seven workplaces, three healthy hospitals and one village. Five focal areas were emphasised. In KwaZulu-Natal, interventions to fortify nutrition were strengthened. Since 2001, the province has implemented Vitamin A supplementation for all children less than five years, to reduce morbidity and mortality. Children have received a dose every six months until the age of five years. A protein energy malnutrition (PEM) scheme for targeted groups of the community, especially children less than five years, chronically ill patients, pregnant and lactating women and TB, HIV and AIDS patients have been implemented. During 2005/06, the proportion of underweight children less than five years decreased from 1.5% to 1.3%. During 2006/07, PEM supplements were provided to 74 476 children under five years; 85 472 HIV and AIDS patients; 59 056 people living with TB and 28 248 people living with other types of malnutrition.

The establishment of food gardens was also accelerated. 220 PHC clinics in KwaZulu-Natal established food gardens, which was part of the strategy to strengthen household food security and establish sustainability in food supply. The Department also commenced with similar initiatives at hospitals.

With regard to child health, KwaZulu-Natal recorded an average coverage rate of 76.4% throughout 2005/06 year. In five districts (Amajuba, Zululand, iLembe, Umkhanyakude and eThekwini), the immunisation rate was below the national yarget of 90%. The “Reach Every District” Strategy (the RED Strategy) was introduced in eThekwini Metro in November 2005. A total of 12 PHC clinics participated in the programme, resulting in improved community communication and an increase in the numbers of children immunised. The implementation of this strategy in other districts is scheduled for MTEF 2007/08. 80% of the National Immunisation Target for Acute Flaccid Paralysis was achieved with no confirmed reported instances of Polio.

Strategies to address infant mortality in KwaZulu-Natal targeted the expansion and enhancement of growth monitoring, the implementation of a comprehensive immunisation programme and ensuring that health care workers are trained in the Integrated Management of Childhood Illnesses (IMCI) Strategy. Many of the successes in reducing child and maternal mortality were eroded by the impact

of the HIV and AIDS epidemic.

Twenty-seven hospitals initially implemented the "Perinatal Problem Identification Programme" (PPIP). Advocacy and training to use this audit system is an ongoing process. Five additional hospitals were included in the "Child Health Problem Identification Programme (CHPIP)". A review of the implementation of the Integrated Management of Childhood Illnesses (IMCI) strategy was completed in all districts and the results were made available to District Management Teams in order to design and implement interventions aimed at improving quality of care. By February 2006, 47% of professional nurses working in PHC facilities were trained in IMCI. A total of 67 medical officers were also trained during this period.

In Limpopo, all five districts started implementing the Healthy Lifestyles Programme in June 2006. In the Mpumalanga Department of Health, 18 community mobilisation activities were conducted, and 22 support groups were established. A total of 140 adverts were flighted through the radio, to enhance awareness of health lifestyles. A total of 1 027 health education sessions were conducted, which reached 41 186 clients.

In the North West Department of Health, no specific document was developed for healthy lifestyle implementation, but this was incorporated into operational plans. There were also no specific health programmes for Community-Based Move for Health in each district. But each district had an integrated programme incorporated into their operational plans.

The Northern Cape developed a detailed healthy lifestyle implementation plan. The Provincial Move for Health Programme includes action plans for nutrition, physical activity, monitoring of the implementation of the Tobacco Control Amendment Act, safe sexual health practices and prevention of drug and alcohol abuse. The Western Cape Department of Health also compiled a provincial plan for 2006-2008. The plan was piloted in the Cape Town Metro, and will be finalised in the other districts.

2.5.5. Community based Move for Health programmes

Provinces established community based Move for Health programmes with varying degrees of success. In the Free State, one "Move for Health" programme was integrated into action plans of six schools partaking in a Non Communicable Disease (NCD) capacity building project, as well as in health promoting schools. In Mpumalanga, continuous outreach activities were implemented at provincial, district and local level. Thirteen Move for Health groups were established (walking clubs). In the Northern Cape, worksite physical activity programmes

where various government departments participate in male and female soccer matches were established. A number of age appropriate physical activity plans were also developed, for the aged and school going youth. In the Western Cape, two of the six districts (Cape Metro and Westcoast) developed programmes. Only the Gauteng Department of Health reported that implementation was on track during 2006/07, but set targets were not met.

2.5.6. Health Promoting Schools

More than 1 000 Health Promoting Schools were identified in eight provinces during 2006/07. These were as follows: Eastern Cape (528); Free State (60 urban and 18 rural health promoting schools); Gauteng (14); KwaZulu-Natal (154); Limpopo (60); Mpumalanga (113); North West (59); Northern Cape (38); and Western Cape (150).

In the Eastern Cape, the province also established a Provincial Health Promoting Schools Committee, which included a representative from the Provincial Department of Education (PDoE). A Provincial Health Promoting Schools Policy was also drafted jointly with the Department of Education. In the North West, an audit of Health Promoting Schools was conducted, which verified the exact number of these schools. The North West also indicated that due to limited resources, no dedicated health promoters were appointed to some of the sub-districts for ongoing support.

2.5.7. Implementation of the School Health Policy

Provincial Departments of Health reported various degrees of progress with the implementation of the School Health Policy. The proportion of schools in each province implementing the policy was reported as follows: Eastern Cape (6.8%); Gauteng (57%); KwaZulu-Natal (2.83%); Limpopo (7.5%); Mpumalanga (ranges from 4.8%-7% across districts); North West (59%?); Northern Cape (38%); and Western Cape (ranges from 0%-97% across districts).

The Free State Department of Health implemented a school health policy in all its districts. A total of 19 131 learners were assessed and 144 schools were reached. Phases 1 to 3 of school health services were implemented in the province.

2.5.8. Improving the management of chronic diseases

Strengthening the follow-up of patients with priority conditions treated in PHC facilities

At national level, two workshops were held with provincial programme managers, which included an annual information session, and a provincial visit.

The National Department of Health also observed an improvement in the availability of guidelines at facilities, as well as varying levels of utilisation by health care providers. Increased in-service training on utilisation was also noted. Provincial Departments of Health also requested updated versions of existing guidelines as well as reprinting of those which are out of stock. Most provinces also strengthened the monitoring and evaluation of implementation of guidelines.

Province-specific progress was also reported. The Limpopo Department of Health and Social Development facilitated 20 workshops to improve the follow-up of patients with priority conditions treated in PHC facilities. In the Mpumalanga Department of Health, 174 health professionals were trained on the national policy guideline for chronic diseases. In addition, 141 health professionals, including nurses and doctors, were trained on the national policy guideline on hypertension. Thirty-five health professionals were trained on cardiovascular diseases. In the Western Cape, nine different workshops were conducted, focusing on aspects such as implementation of support groups; audit of diabetes care feedback; and rapid appraisals on the management of chronic diseases. An inter-regional conference was also held where minimum package of service for chronic diseases was agreed upon.

Strengthening of referral systems for chronic care patients

At national level, the Department observed that all provinces based their referral patterns for chronic care patients on clinical guidelines. However the efficacy of the referral system was dependent on various factors including availability of resources within the district, transport systems as well as the socio-economic status of the patients. The establishment of a Standardised Referral Pattern commenced in 2006, but remained incomplete, and will need strengthening going forward.
At provincial level, only a few provinces (four of the nine) reported progress on this objective.

Both the Free State and Limpopo established formal referral systems for chronic patients. The Free State also continued to implement the national guidelines on management of chronic diseases.In Mpumalanga, a provincial protocol for diabetes, asthma and hypertension were developed and distributed to stakeholders. These protocols indicate to health care providers how to manage chronic conditions and when to refer patients to the next level. In the Western Cape, the referral system has been in place in all six districts as guidelines and

algorithms are used. A system of referral to and from tertiary, secondary and district hospitals to the HBC programme and back is in place.

Strengthening the self-management patients

An national level, the Therapeutic Education for Health Care Provider's Protocol was finalised, and preparations for piloting it commenced. Also, the Stages of Change Model, which focuses on the patient, was developed to be used in conjunction with this Protocol. At provincial level, only a few provinces (three out of the nine) reported progress on this objective.

In the Free State, draft guidelines for the implementation of therapeutic education programmes for patients were developed, sent out for comments and implemented. The Limpopo Department of Health and Social Development established a palliative care programme. In the Western Cape, therapeutic education programmes have been in place in all facilities dealing with chronic diseases. A total of 124 support groups in the province assisted in complementing the therapeutic education.

Development of a comprehensive programme for the treatment and care of survivors of gender based violence

Once more, only a few provinces reported on progress with this objective.

In the Free State, the National Policy on Sexual Assault Care was disseminated to all district hospitals. All forensic nurses and medical practitioners rendering services to victims of sexual assault managed victims according to this policy. In Limpopo, an implementation plan was developed and implemented in all hospitals and six CHCs. The Mpumalanga Department of Health established a Provincial Sexual Assault Forum on 23 May 2006, for the development of the plan. The Western Cape Department of Health has implemented the Comprehensive Management of Sexual Assault Plan since 2001.

Audit report of all specialised services (forensic clinic services, one-stop centres and Victim Empowerment Centres) produced

In the Free State, an audit of victim support facilities was conducted in October 2006, in the Thabo Mofutsanyana District. A need for debriefing personnel involved in the management of victims of violence was identified. The audit focused on issues such as specially designated areas with the reception area, consulting rooms, examination room, shower and toilets, availability of policies, treatment and referral protocol. In Mpumalanga, a Monitoring and Evaluation Tool was designed for the purpose of auditing, which included areas such as

care (crisis) room, services, and personnel providing sexual assault care. Three facilities were subsequently audited namely: Rob Ferreira Hospital, Othandweni Violence Referral and Management Centre and Themba Hospital Audit reports were compiled. Mpumalanga has a total of 15 nurses with forensic training. In the Western Cape, an audit tool for sexual assault care services was developed and tested in two health districts in the province.

National Policy and Guidelines for the Treatment and Care of Survivors of Domestic Violence developed

It was anticipated in 2006/07 that a National Policy and Guidelines for the Treatment and Care of Survivors of Domestic Violence would be developed by the National Department of Health in consultation with provinces. This was not achieved.

The Free State Department of Health indicated that although this policy was not developed, facilities were expected to cater for both genders when addressing gender-based violence. In Limpopo, draft provincial policy guidelines were made available. Mpumalanga developed a provincial policy on national sexual assault care, which was distributed to all facilities in the province. In addition, the National Management Guidelines were made available to facilities. The Mpumalanga Department of Health also produced aprovincial PEP policy and distributed it for comments. In the Western Cape, the policy and guidelines for the treatment and care of sexual assault survivors were implemented at 42 centres in the province. The province has not developed a policy on domestic violence.

Comprehensive plans for the provision of psychosocial support for survivors of gender-based violence developed

Only Mpumalanga and the Western Cape reported progress with the development of comprehensive plans for the provision of psychosocial support for survivors of gender-based violence.

The Comprehensive Sexual Assault Care Plan of the Mpumalanga Department of Health encouraged referrals of the survivors to all service providers to promote provision of psychosocial support. In the Western Cape, NGOs and the Department of Social Services continued to provide psychosocial support to a small number of survivors. The province identified gaps in the provision of the service, which require further expansion.

Although the Free State Department of Health did not develop a similar policy, facilities were expected to cater for both genders when addressing gender-

based violence.

Training workshops for professional nurses and medical practitioners focusing on sexual assault care practice

The ANHP of 2006/07 required the National Department of Health to conduct nine training workshopsfor professional nurses and medical practitioners on sexual assault care practice, including implementation of policy guidelines, and Provincial Departments of Health to identify health care providers to participate in workshops, and to support the implementation of guidelines. This did not proceed as planned.

The Free State Department of Health finalised the training plan for an intersectoral training course that aimed to cover the entire comprehensive package of services for victims of sexual assault. A total of 150 participants had been targeted for training and the breakdown of participants was as follows: 90 participants were from health and 54 participants were selected from stakeholders i.e. Social Development, SAPS, NGO's and the Department of Justice. In total 144 participants have been trained. The Limpopo Department of Health and Social Development conducted several workshops for its health care workers. One provincial workshop for nurses and all other professionals from five districts, while two workshops were conducted for medical doctors. An intersectoral workshop including the military, the SAPS, condom distributors and NGOs was also conducted.

In Mpumalanga, 91 professional nurses and 186 lay counsellors were trained on the provision of Post-Exposure Prophylaxis (PEP) and after Sexual Assault. The province also conducted three District Sexual Assault Awareness campaigns. In the Western Cape, nine workshops were conducted in three districts.

CHAPTER 3:

NATIONAL HEALTH SYSTEM (NHS) PRIORITIES FOR 2007/08 AND PRIORITIES FOR IMMEDIATE GOVERNMENT ACTION FOR 2007-2009

3.1. National Health System Priorities for 2007/08

For the period 2007/08 the National Health Council (NHC) has adopted the same set of five National Health System (NHS) priorities from the 2006/07 financial year. However, the NHS priorities for 2007/08 extend their focus to include Maternal Child and Women's Health, under Strengthening Strategic Health Programmes. The NHS priorities for 2007/08 are:

a) Development of service transformation plans;
b) Strengthening of human resources;
c) Strengthening physical infrastructure;
d) Improving quality of care; and
e) Strengthening strategic health programmes (accelerated HIV prevention, implementation of the TB Crisis Management Plan, strengthening Maternal, Child and Women's Health by implementing the Reach Every District (RED) Strategy and the recommendations of the Saving Mothers: Third Report on Confidential Enquiries into Maternal Deaths in South Africa 2002-2004).

3.2. Saving Mothers: Third Report on Confidential Enquiries into Maternal Deaths in South Africa 2002-2004

The ten recommendations of the Saving Mothers: Third Report on Confidential Enquiries into Maternal Deaths in South Africa 2002-2004 are as follows:

a) Protocols on the management of important conditions causing maternal deaths must be available and utilised appropriately. All midwives and doctors must be trained on the use of these protocols;
b) All pregnant women should be offered information on, screening for and appropriate management of communicable and non-communicable diseases;
c) Criteria for referral and referral routes must be established and utilised appropriately in all provinces;
d) Emergency transport facilities must be available for all pregnant and post-partum women and their babies with complications (at any site);
e) Staffing and equipment norms must be established for each level of care and for every health institution concerned with the care of pregnant women;

f) Blood for transfusion must be available at every institution where Caesarian sections are performed;
g) Contraceptive use must be promoted through education and service provision and the number of mortalities from unsafe abortion must be reduced;
h) Correct use of the partogram should become the norm in each institution conducting births. A quality assurance programme should be implemented, using an appropriate tool;
i) Skills in anesthesia should be improved at all levels of care, particularly at Level 1 hospitals; and
j) Women, families and communities at large must be empowered, involved and participate actively in activities, projects and programmes aiming at improving maternal and neonatal health as well as reproductive health in general.

It is essential that the implementation of these recommendations is strengthened, as part of enhancing South Africa's strides toward the Millennium Development Goals (MDGs), particularly the health-related MDGs.

3.3. Priorities for Immediate Government Action 2007-2009

In July 2007, the Presidency requested all government departments to submit a set of high-level priorities for inclusion in the Priorities for Immediate Government Action. The implementation of these priorities would have to be accelerated during 2007-2009.

The priorities forwarded by the National Department of Health to the Presidency focus on the following broad areas:

a) Strengthening the management of Tuberculosis;
b) Implementation of the National Strategic Plan for HIV and AIDS 2007-2011;
c) Expansion of the implementation of the Comprehensive Plan for HIV and AIDS Care, Treatment and Management (CCMT);
d) Strengthening TB and HIV collaborative efforts;
e) Strengthening the implementation of key strategies for effective malaria control in South Africa;
f) Strengthening inter-country and cross-border malaria control initiatives;
g) Improving the management of childhood illnesses;
h) Achieving measles elimination;
i) Ensure polio outbreak and importation preparedness;
j) Improving maternal, child, and women's health and nutrition;
k) Improving micronutrient control;

l) Facilitating the country's preparedness to prevent and respond to communicable diseases and outbreaks during the FIFA World Cup in 2010;
m) Contributing to poverty alleviation through the Expanded Public Works Programme (EPWP) by appointing unemployed matriculants as Data Capturers;
n) Contribute to poverty alleviation by expanding and strengthening the delivery of Primary Health Care through the Partnerships for the delivery of Primary Health Care Project (PDPHCP), funded by the European Union (EU);
o) Contribute to poverty alleviation by expanding and strengthening the role of NGOs and CBOs in curbing the impact of HIV and AIDS.

As is evident from the foregoing, the Priorities for Immediate Government Action 2007-2009, are not stand-alone activities, but are interwoven into health sector interventions to strengthen priority health programmes. These are presented in detail in Annexure 1.

CHAPTER 4

SUMMARY OF THE ANNUAL HEALTH PLAN 200/08

This Chapter presents a synopsis of the ANHP 2007/08, and highlights the outputs that the National and Provincial DoHs are expected to deliver in 2007/08, for each of the 5 NHS priorities for 2007/08. The full version of the ANHP 2007/08 is reflected in Annexure 1.

3.1. Development of Service Transformation Plans

3.1.1. Application of the Integrated Health Planning Framework (IHPF)

As indicated in the earlier chapters, 8/9 Provincial DoHs developed their Service Transformation Plans in 2006. What is required by June 2007 is an update of the Provincial STPs, informed by a continuous assessment of the internal and external environment, and option appraisals conducted by each province. The National DoH will continue to support Provinces to use the Integrated Health Planning Framework (IHPF) for this purpose.

3.1.2. Strengthening the delivery of Emergency Medical Services

With all 9 Provinces having developed their business plans for Emergency Medical Services (EMS) in 2006/07, the focus for 2007/08 is on the implementation of these plans.

3.1.2. Strengthening the management of implementation processes

Effective planning and monitoring of implementation

With most Provinces having succeeded in revising organisational structures, to align the location and function of the Strategic Planning, Health Information Systems and Monitoring and Evaluation Units, collaboration between these units must be strengthened. The use of information for planning and management should be included in the KPIs of managers.

Provincial management support to Districts and Hospital CEOs should be strengthened. Increased focus should be placed on enhancing routine reporting on ICD 10 coding.

3.2. Strengthening Human Resources

In keeping with the NHS Priorities, the ANHP 2007/08 requires the health sector

to achieve, amongst others, the following targets: updated Provincial HR Plans; a fully mapped distribution of all staff and agreement on appropriate baseline level of staffing by discipline for Tertiary and Level 2 services; 25% reduction in vacancy rates through SLAs with the Private Sector for sessional work in the public service; 10% reduction in staff turn over, 10% increase in recruitment and training of additional nursing students.

3.3. Physical Infrastructure

3.3.1. Strengthening Hospital Infrastructure

In terms of NHS Priorities for 2007/08, the target for 2007/08 is for 42 hospitals to be started on site, or completed, and for 27 new business cases to be completed and approved in May 2007. 30% of mortuaries are to be rebuilt, worst 20% of hospitals upgraded and maintenance expenditure increased to 3.5% in all provinces. The latter will be a key challenge, since provinces could not increase their maintenance expenditure to 2.5% during 2006/07.

3.3.2. Strengthening PHC Infrastructure

NHS Priorities for 2007/08 require that Primary Health Care (PHC) infrastructure be improved during the financial year. In terms of these priorities, the targets for 2007/08 include: completion of the audit of required accommodation, and preparation of business plans by all provinces by September 2007, as well as the restructuring of Community Health Centres (CHCs) according to the STP requirements.

3.4. Improve Quality of Care

3.4.1. Improve Quality of Care in all Hospitals

The NHS priorities for 2006/07-2008/09 include amongst others, the following targets for 2007/08: Clinical audits routinely monitored in all Tertiary Hospitals and 25% of Level 2 hospitals; complaints mechanisms routinely managed in all Tertiary Hospitals and 25% of Level 2 hospitals, and infection control management effected in all tertiary and level 2 hospitals, 25% of district hospitals and CHC's. Supervision plans must also be included in all Provincial Annual Performance Plans for 2008/09 (Part B).

3.5. Strengthening Strategic Health Programmes

3.5.1. Strengthen interventions to curb Communicable Diseases

In keeping with the WHO-AFRO resolutions of 2006, and the Presidential Priorities for 2007-2009, the ANHP 2007/08 requires each Province to achieve the following: strengthen TB Management and Control; implement the National Strategic Plan for HIV and AIDS 2007-2011; expand the implementation of the Comprehensive Plan for HIV and AIDS Care, Treatment and Management (CCMT); Strengthen TB and HIV collaborative efforts; strengthen the implementation of key strategies for effective malaria control in South Africa; and strengthen inter-country and cross-border malaria control initiatives (in affected provinces).

3.5.3. Healthy Lifestyles

The ANHP 2007/08 requires that all Provinces should develop andimplement community based nutrition campaigns; expand the health promoting schools project and implement the amended the Tobacco Products Control Amendment Act. :

3.5.4. Strengthening Maternal, Child and Women's Health

With regard to the strengthening of Maternal, Child and Women's Health, the ANHP 2007/08 requires amongst others, that: at least 50% of health districts implement the Reach Every District (RED) strategy; that 70% of districts have more than 90% immunisation coverage, that the 10 recommendations of the Confidential Enquiry into Maternal deaths are implemented National and Provincial also expected to achieve the following: improve the management of childhood illnesses through IMCI; achieve measles elimination; ensure Polio outbreak and importation preparedness and improve micronutrient malnutrition control.

3.5.5. Priorities for Immediate Government Action

As indicated in Chapter 3, the priorities for Immediate Government Action for 2007-2009, must also be implemented.

CHAPTER 5: CONCLUSION

The foregoing chapters have presented the Annual National Health Plan for (ANHP) 2007/08.

The ANHP is a synopsis of the key activities that National and Provincial Departments of Health will implement during 2007/08, in keeping with National Health System priorities. Many other activities than are reflected here will also be implemented, which are the core functions of the health sector. The ANHP has lifted up only the key milestones.

The ANHP 2007/08 builds on the progress made by the health sector during 2006/07, and lessons learnt during the implementation process.

As indicated by the Minister at the outset, National and Provincial Departments of Health must submit regular reports to the National Health Council on progress with the ANHP 2007/08. The Health Departments must reflect both the targets achieved, as well as those targets that could not be achieved due to resource constraints (and other factors). Efforts must also be made to strengthen relations with the private health sector, to facilitate the development of joint plans in future.

ANNEXURE 1:

DETAILED ANNUAL NATIONAL HEALTH PLAN 2007/08

TABLE: KEY PRIORITIES, INDICATORS AND TARGETS

PRIORITY 1. SERVICE TRANSFORMATION PLAN

All provinces produced long range plans known as Service Transformation Plans (STPs) in 2006/07, for the period 2007/08-2014/15. The key task for 2007/08 is to ensure the implementation and monitoring of these STPs, and to update them for 2008/09, to inform the budget bid process commencing in June 2007.

Activity	Indicators	Targets 2007/08	Responsibility
Application of the Integrated Health Planning Framework	Scenarios developed by all provinces	100% of provinces with preferred option by June 2007	NDoH: model and framework PDoH: scenarios
Provincial APP	Part A completed	100% of provinces with Service Transformation Plans (STP) drafted (or updated where applicable) by end of June 2007	NDoH: Part A framework PDoH: Service transformation plans completed, including at least all of the five priority items scheduled in this priority framework
		EMS business plans completed by May 2007	NDoH: Strategic framework. PDoH: Business plans
		MTS (tertiary hospitals) implementation plan agreed by all provinces by December 2007	NDoH: MTS process framework. PDoH: Business plans
		HR – see priority 2	

PRIORITY 1: SERVICE TRANSFORMATION PLAN

Activity	Indicators	Targets 2007/08	Responsibility
Provincial APP	Part A completed	Develop full transport systems plan for delivery of patients to hospitals and specialists to lower care levels	NDoH: Analysis of transport mode economics PDoH: Service delivery plans
		Develop full plan for utilisation of telemedicine links to increase specialist availability	NDoH: SWOT analysis of pilot projects PDoH: Implementation plans
		Develop risk assessment for each component of plan	NDoH: Develop risk assessment matrix PDoH: Risk assessment
	Part B	100% of provinces with detailed implementation plans by December 2007	PDoH: Operationalising of Part A strategies into Part B for MTEF
Implementation management	Effective planning and implementation monitoring	All provinces to have developed strategic planning units closely linked to information and monitoring and evaluation units	NDoH: Implement new organogram and link KPI's to priorities targets PDoH: Implementation of best practice guidelines from review
	Fully implement delegations at all levels but especially at hospital level	Audit and strengthen existing delegations by September 2007	NDoH: Coordinate and monitor progress PDoH: Fast track implementation of delegations

PRIORITY 1: SERVICE TRANSFORMATION PLAN

Activity	Indicators	Targets 2007/08	Responsibility
Implementation management	Health Information Systems	At least one province and National Department to be fully operational on DHIS 1.4 (including trained personnel to collect and use data at all levels)	NDoH: Roll out training of DHIS 1.4. Develop tracer indicators from data set and data quality index PDoH: Appoint and train adequate personnel to deliver timely and accurate information
		RFP and assessment of patient information system service provider	NDoH: issue RFP and contract selected system PDoH: Develop implementation plan
		All tertiary, 33% Level 2 hospitals to be routinely reporting ICD10 coding	NDoH: link ICD10 codes to packages for level of care, commencing with NTSG funded procedures PDoH: Implement training programme and ensure adequate appointments to roll out coding
	Monitoring and evaluation	Timely data reporting into Quarterly Reporting System used at all levels of the health system by September 2007	NDoH: revise QRS data sets to reflect priorities PDoH: Ensure capacity to deliver accurate and timely information transfer

PRIORITY 2: HUMAN RESOURCES

As personnel consumes over 60% of the budget consistently across all parts of the health system, the Human Resource Plan is the most important part of the Service Transformation Plan. The objective is to restructure the service platform and the modes of delivery in such a way to achieve 100% staffing in all disciplines (clinical specialties) in all facilities offering tertiary, secondary and PHC services.

Activity	Indicators	Targets 2007/08	Responsibility
Staff distribution	Proportion of establishment in each service point by level of care	Fully mapped distribution of all staff and agreement on appropriate baseline level of staffing by discipline for tertiary and Level 2 services	NDoH: Provide target minimum staff levels and activity thresholds by specialty and hospital type PDoH: Map current and required staff against delivery points, levels of care and outreach services.
		Fully mapped distribution of all PHC staff and agreement on appropriate baseline level of staffing for PHC, and establishment of posts required to deliver a quality PHC service	

PRIORITY 2: HUMAN RESOURCES

Activity	Indicators	Targets 2007/08	Responsibility
Private sector partnerships	Private sector specialists in public facilities	Agree SLA with General Practitioners and specialists for sessional work in public sector facilities	NDoH: Develop SLA frameworks for guidance to provinces. Review remuneration levels for sessional contractors PDoH: Implement frameworks
Remuneration levels	Recruitment and retention of all staff	Agree on revised remuneration levels of all staff	NDoH: Finalise with treasury and DPSA health sector remuneration negotiation process PDoH: Implement agreement
Increase training of nurses (re-opening of nursing schools)		Identify additional training resources (colleges, tutors, etc)	NDoH: Identify, with NDoE, potential for increase and projected demand PDoH: Negotiate with provincial training colleges

PRIORITY 2: HUMAN RESOURCES

Activity	Indicators	Targets 2007/08	Responsibility
Training of hospital CEOs	% of hospital CEOs trained	Audit and strengthen existing programmes and enroll 25%	NDoH: Identify guidelines for curricula and criteria for training in hospital management programmes PDoH: Develop action plan and prioritisation for CEO training

PRIORITY 3: PHYSICAL INFRASTRUCTURE

As the distribution of facilities fundamentally affects the staffing requirements, rationalisation of the service delivery platform and matching these two resource components is the next priority.

Activity	Indicators	Targets 2007/08	Responsibility
Hospital revitalisation	Funded hospitals in plan	42 hospitals started on site, in progress or completed	NDoH: Develop skill base for support to provinces and assessment of business cases. Develop framework for MTS hospitals implementation plans and business cases PDoH: Develop MTS hospital business plans and all business cases in line with service transformation plans
	Approved business cases, including MTS hospitals	At least 27 new business cases completed and approved by May 2006	
	Forensic services transfers	30% of forensic mortuaries rebuilt	NDoH: Identify, with SAPS and PDoH all current and prospective sites and broker transfer PDoH: Develop and implement transfer plan
	Maintenance increased	Worst 20% of non revitalisation hospitals receiving essential upgrades	NDoH: Develop, with PDoH, assessment and prioritisation criteria for essential upgrades PDoH: Develop implementation plan for upgrades

PRIORITY 3: PHYSICAL INFRASTRUCTURE

Activity	Indicators	Targets 2007/08	Responsibility
Hospital revitalisation	Maintenance increased	Maintenance expenditure increased to 2.5% of budget in all provinces	NDoH: Monitor progress on monthly expenditure and manage grant transfers against achievement PDoH: Issue guidelines to managers for maintenance requirements and expenditure
	Essential equipment provision	Agreement on essential equipment packages (EQL) for all levels of care	NDoH: Facilitate review of available data and implement study for completion of EQL PDoH: Implement audits and identify priorities for provision in line with EQL
Primary Health Care (PHC)	Designated staff accommodated	Audit of required accommodation and business plan prepared by all provinces by September 2007	NDoH: Provide framework for business plans in line with policy. Assess taxation issues PDoH: Develop business plans and implementation (procurement) process related to funding source
	Intersectoral infrastructure provision	Agreement on gaps in intersectoral infrastructure	NDoH: Review survey data on intersectoral infrastructure gaps. Implement, with PDoH update of review and broker intersectoral collaboration on closure PDoH: Develop implementation plans for inclusion in IDPs

PRIORITY 3: PHYSICAL INFRASTRUCTURE

Activity	Indicators	Targets 2007/08	Responsibility
Primary Health Care (PHC)	Facilities audited	Audit of size and condition of all PHC facilities completed	NDoH: Develop and distribute survey framework with criteria for essential upgrades and prioritisation process PDoH: Identify and develop implementation plan for essential upgrades
	CHCs development	STP CHC restructuring implemented	NDoH: Provide IHPF assessment and normative base for distribution of CHCs to achieve policy targets PDoH: Map clinics, CHCs and hospitals and identify service platform. Develop implementation plan

PRIORITY 4: QUALITY OF CARE

Improved quality of care in the restructured service platform is essential to the delivery of the required outcomes and the Department's vision and mission.

Activity	Indicators	Targets 2007/08	Responsibility
Hospital improvement plans	Clinical audits	Clinical audits routinely monitored in all tertiary hospitals, 25% of Level 2 hospitals	NDoH: Include clinical audits in routine reporting system and monitor progress. Consider key outcomes for reporting PDoH: Implement appropriate training to management teams and monitor outcomes
	Complaints mechanisms	Complaints mechanisms routinely managed in all tertiary hospitals, 25% Level 2 hospitals	NDoH: Audit complaints mechanisms, develop best practice guidelines and consider outcomes requiring reporting PDoH: Develop or strengthen complaints mechanisms in line with best practice guidelines
	Infection control	Infection control management effected in all tertiary and Level 2 hospitals, 25% of district hospitals and CHCs	NDoH: Audit infection control management systems, develop best practice guidelines and consider outcomes requiring reporting PDoH: Develop or strengthen infection control structures in line with best practice guidelines

PRIORITY 4: QUALITY OF CARE

Activity	Indicators	Targets 2007/08	Responsibility
Improving access to services	Transport systems	10% of increase in planned patient transport fleet deployed	NDoH: Complete, with PDoH, business planning process for EMS, PPT and air road transport interface. Develop National proposal for air transport deployment and criteria. Develop SLA guidelines for private sector delivery of transport components PDoH: Develop implementation plans for deployment of transport and training of staff based on business plans
		10% of increase in EMS road ambulance fleet deployed	
		Flying doctor services started or SLA effected in all provinces	
		Air EMS service started or SLA effected in all provinces	
		Private sector agreements in place for patient referrals	

PRIORITY 4: QUALITY OF CARE

Activity	Indicators	Targets 2007/08	Responsibility
Improving access to services	Telemedicine	Hub and spoke systems developed in accordance with STP	NDoH: Develop guidelines for best practice utilisation of telemedicine based on pilots PDoH: Develop implementation plans for skills decentralisation using telemedicine, flying doctors services and private sector practitioners
Supervision	Supervision rate for PHC	Supervision plan included in all provincial strategic plans (Part B)	NDoH: Include monitoring of supervision rate in routine reporting systems PDoH: Develop and implement plans for increasing supervision rate to target levels

.

PRIORITY 5: PRIORITY HEALTH PROGRAMMES

Whilst efforts will continue to strengthen all health programmes, the two critical communicable disease programmes should enjoy additional priority during the next two to three years. These are: Strengthening the TB Management Programme; implementation of the National Strategic Plan for HIV and AIDS; and improving Maternal, Child and Women's Health and Nutrition. In addition the key preventative initiatives relating to illnesses of lifestyle must also receive special attention.

ACTIVITY	INDICATORS	TARGETS 2007/08	RESPONSIBILITY
Strengthen TB management **(Presidential Priority for 2007-2009)**	Provide dedicated TB personnel provided at provincial, district and sub-district level in all provinces. Special focus will be placed on the four districts where the TB Crisis Management Plan is being implemented, namely: Amatole and Nelson Mandela Metro (Eastern Cape); City of Johannesburg (Gauteng); and Ethekwini Metro (KwaZulu-Natal)	Dedicated TB personnel provided at provincial, district and sub-district level in all provinces, particularly in the four districts where the TB Crisis Management Plan is being implemented, namely: Amatole and Nelson Mandela Metro (Eastern Cape); City of Johannesburg (Gauteng); and Ethekwini Metro (KwaZulu-Natal)	National and Provincial Departments of Health
Strengthen the implementation of DOTS **(Presidential Priority for 2007-2009)**	% of TB patients on DOT	60%	National and Provincial Departments of Health
	% of new smear positive PTB patients who converted at two months (from positive to negative)	70%	National and Provincial Departments of Health
Improve TB case detection **(Presidential Priority for 2007-2009)**	% of PTB suspects whose sputum was tested	100%	National and Provincial Departments of Health

ACTIVITY	INDICATORS	TARGETS 2007/08	RESPONSIBILITY
Social mobilisation to destigmatise TB, ensure early presentation and treatment completion **(Presidential Priority for 2007-2009)**	% of new smear positive PTB patients defaulting at the end of the intensive phase of treatment	≤10%	National and Provincial Departments of Health
Ensure good quality of TB services **(Presidential Priority for 2007-2009)**	% of health facilities with a TAT of 48 hours or less	50%	National and Provincial Departments of Health
Manage MDR-TB patients effectively **(Presidential Priority for 2007-2009)**	% of MDR-TB among new patients	≤1%	National and Provincial Departments of Health
	% of MDR-TB among re-treatment patients	≤6%	National and Provincial Departments of Health
Manage XDR-TB patients effectively **(Presidential Priority for 2007-2009)**	% of XDR-TB initiated on treatment	100%	National and Provincial Departments of Health
	% of XDR-TB among all MDR-TB patients	≤5%	National and Provincial Departments of Health

ACTIVITY	INDICATORS	TARGETS 2007/08	RESPONSIBILITY
Implementation of the National Strategic Plan for HIV and AIDS 2007-2011 **(Presidential Priority for 2007-2009)**	Strengthening of the implementation of the four key priority areas of the NSP namely: (i) prevention; (ii) treatment, care and support; (iii) monitoring, research and surveillance; (iv) human rights and access to justice	Measurable reduction in the incidence of HIV Provision of an appropriate package of treatment, care and support services Strengthening of the monitoring and evaluation of the NSP, with 4-7% of the total HIV and AIDS budget dedicated to this purpose Attainment of a social environment that promotes voluntary testing for HIV and provision of treatment and social support to all who need these	National and Provincial Departments of Health
	Increase the proportion of health facilities providing Comprehensive HIV Care including ART	10%	National and Provincial Departments of Health
Accelerate the implementation of prevention interventions for HIV and AIDS **(Presidential Priority for 2007-2009)**	% of public health facilities offering VCT	100%	National and Provincial DoHs
	% of public health facilities offering PMTCT	100%	National and Provincial Departments of Health
	Number of male condoms distributed	425 million	National and Provincial Departments of Health
	Number of female condoms distributed	3.5 million	

ACTIVITY	INDICATORS	TARGETS 2007/08	RESPONSIBILITY
Strengthen implementation of the Comprehensive Plan for HIV and AIDS **(Presidential Priority for 2007-2009)**	%of local municipalities with at least one accredited service point for the Comprehensive Plan for HIV and AIDS	All 284 local municipalities (100%) with at least one accredited service point for the Comprehensive Plan for HIV and AIDS	National and Provincial Departments of Health
Strengthen TB and HIV Collaborative activities **(Presidential Priority for 2007-2009)**	Proportion of TB patients tested for HIV	35%	National and Provincial Departments of Health
Strengthen implementation of key strategies for effective malaria control in South Africa **(Presidential Priority for 2007-2009)**	% reduction in annual malaria cases and deaths	10%	National and Provincial Departments of Health
Strengthen inter-country and cross border malaria control initiatives **(Presidential Priority for 2007-2009)**	Development and implementation of the RSA–Zimbabwe Malaria elimination strategy	RSA–Zimbabwe Malaria elimination strategy developed and implemented by March 2008	National and Provincial Departments of Health
Facilitate country 2010 preparedness to prevent and respond to communicable diseases and outbreaks **(Presidential Priority for 2007-2009)**	2010 communicable diseases control strategic plan finalised and costed	2010 communicable diseases control strategic plan finalised and costed by March 2008	National Department of Health

ACTIVITY	INDICATORS	TARGETS 2007/08	RESPONSIBILITY
Improve the management of childhood illnesses **(Presidential Priority for 2007-2009)**	% of facilities that are saturated with IMCI health care providers (i.e. 60% of health care providers managing children trained in IMCI)	70%	National and Provincial Departments of Health
	% of health districts with more than 90% full immunisation coverage	70%	National and Provincial Departments of Health
	% of districts with staff trained in implementing the RED strategy	50%	National and Provincial Departments of Health
	Measles vaccine coverage	>70% in 80% of districts	National and Provincial Departments of Health
	DPT3 to Measles vaccine dropout rate	<20% in 80% of districts	National and Provincial Departments of Health
Achieve Measles Elimination **(Presidential Priority for 2007-2009)**	% reduction in measles cases, compared to 2005 cases	Reduce by 50% from the 615 confirmed measles cases reported in RSA in 2005	National and Provincial Department of Health
Ensure Polio outbreak and importation preparedness **(Presidential Priority for 2007-2009)**	Polio Free Certification Documentation accepted by the African Regional Certification Commission	Annual Update of Polio Free Certification documentation prepared and submitted to ARCC and Laboratory Containment conducted	National Department of Health

ACTIVITY	INDICATORS	TARGETS 2007/08	RESPONSIBILITY
Improve micronutrient malnutrition control **(Presidential Priority for 2007-2009)**	% of children 6-12 months; 13-60 months and post-partum mothers receiving Vitamin A supplementation	6-12 months: 100% 13-60 months: 55% Post-partum: 65%	National and Provincial Departments of Health
Facilitate and coordinate monitoring of millers for food fortification **(Presidential Priority for 2007-2009)**	% of millers complying with fortification regulations	30% (90/300)	National Department of Health
Improve Maternal, Child and Women's Health	Implementation of the ten Recommendations of the Saving Mothers: Third Report on Confidential Enquiries into Maternal Deaths (CEMD) in South Africa 2002-2004	100% of provinces implementing the recommendations of the Saving Mothers: Third Report on Confidential Enquiries into Maternal Deaths (CEMD) in South Africa 2002-2004	Provincial Departments of Health with support from the National Department of Health

ACTIVITY	INDICATORS	TARGETS 2007/08	RESPONSIBILITY
Ongoing implementation of the Healthy Lifestyles Programme for South Africa **(Presidential Priority for 2007-2009)** Implement community-based nutrition campaigns	Number of community-based food garden projects	20 per province	NDoH: Develop guidelines for targeted programmes for appropriate community based activities PDoH: Develop context specific plans for community implementation
Expand the health promoting schools project	Number of schools participating in the Health Promoting Schools Project	3 500 schools	NDoH: Promote concept as priority in Department of Education (DoE) PDoH: Develop programme with PDoE
	% of schools implementing Schools Health Policy	80%	NDoH: Popularise the School Health Policy in conjunction with the Department of Education (DoE) PDoH: Develop programme with PDoE
Implement the amended Tobacco Products Control Amendment Act	% of schools developing and implementing smoking polices	80%	NDoH: Promote concept of policy as priority PDoH: Develop implementation plan with PDoE

ACTIVITY	INDICATORS	TARGETS 2007/08	RESPONSIBILITY
Contribute to poverty alleviation through the Expanded Public Works Programme (EPWP) by appointing unemployed matriculants as Data Capturers **(Presidential Priority for 2007-2009)**	Number of unemployed matriculations across all nine provinces recruited through the internship mechanism and trained in Health Information Systems (HIS) and employed on a one year contract	1 100 unemployed matriculations across all nine provinces to be recruited, trained and appointed on a one-year contract during 2007/08	National Department of Health to mobilise the resources required for this project Provincial Departments of Health to assist in the recruitment and placement of data capturers in various facilities, and insupervising their work
Contribute to poverty alleviation by expanding and strengthening the delivery of Primary Health Care through the Partnerships for the delivery of Primary Health Care Project (PDPHCP), funded by the European Union (EU) **(Presidential Priority for 2007-2009)**	Number of South African Non-Profit making Organisations (NPOs) funded through the PDPHCP to support the government in the delivery of PHC services in all nine provinces.	460 South African Non-Profit making Organisations (NPOs), will be funded through the PDPHCP during 2007/08 A total of R95 million will be disbursed to the 460 NPOs	National Department of Health to provide the resources required for this project,through the PDPHC Provincial Departments of Health to assist in identifying NPOs that are eligible for funding, and once funded, monitor their performance

ACTIVITY	INDICATORS	TARGETS 2007/08	RESPONSIBILITY
Contribute to poverty alleviation by expanding and strengthening the role of NGOs and CBOs in curbing the impact of HIV and AIDS **(Presidential Priority for 2007-2009)**	Number of national NGOs funded by the National Department of Health to participate in the government's response to HIV and AIDS	More than 60 National NGOs will be funded by the National Department of Health during 2007/08	National Department of Health to provide funding for National NGOs Provincial Departments of Health to assist in identifying eligible NGOs, and once funded, monitor their performance

ANNEXURE 2: RESOURCE ALLOCATION TO THE HEALTH SECTOR MEDIUM-TERM EXPENDITURE ESTIMATES OF THE NATIONAL DEPARTMENT OF HEALTH FOR 2OO7/08-2009/10 (INCLUDING CONDITIONAL GRANTS TO PROVINCES)

PROGRAMME	MEDIUM-TERM EXPENDITURE ESTIMATE (R' THOUSAND)		
	2007/08	2008/09	2009/10
1. ADMINISTRATION	205 467	206 914	218 210
2. STRATEGIC HEALTH PROGRAMMES	3 216 723	3 461 165	3 896 242
3. HEALTH SERVICE DELIVERY	9 160 592	10 197 827	11 004 350
4. HUMAN RESOURCES	72 350	77 857	80 628
TOTAL	**12 655 132**	**13 943 763**	**15 199 430**

MEDIUM-TERM EXPENDITURE ESTIMATES OF THE NINE PROVINCIAL DEPARTMENTS OF HEALTH FOR 2007/08-2009/10

PROVINCIAL DEPARTMENTS OF HEALTH	MEDIUM-TERM EXPENDITURE ESTIMATES (R' BILLIONS)		
	2007/08	2008/09	2009/10
Eastern Cape	8 143	8 551	8 551
Free State	3 643	3 879	4 156
Gauteng	12 052	12 189	12 996
KwaZulu-Natal	13 413	13 719	14 422
Limpopo	6 096	6 604	7 052
Mpumalanga	3 595	3 947	4 261
Northern Cape	1 460	1 567	1 692
North West	3 755	3 983	4 240
Western Cape	7 095	7 585	7 688
TOTAL	**59 252**	**62 023**	**65 059**

PER CAPITA FUNDING ACROSS PROVINCES

PROVINCIAL DEPARTMENTS OF HEALTH	MEDIUM-TERM EXPENDITURE ESTIMATES (RANDS)		
	2007/08	2008/09	2009/10
Eastern Cape	1 290	1 407	1 458
Free State	1 395	1 543	1 713
Gauteng	1 681	1 765	1 951
KwaZulu-Natal	1 508	1 602	1 746
Limpopo	1 195	1 344	1 488
Mpumalanga	1 162	1 325	1 483
Northern Cape	1 571	1 752	1 960
North West	1 226	1 351	1 490
Western Cape	1 933	2 146	2 255
TOTAL	**1 451**	**1 577**	**1 714**

health

Department:
Health
REPUBLIC OF SOUTH AFRICA

Layout and design by: Hotspot Communication
Tel: 011 834 1562
Cell: 082 408 4780